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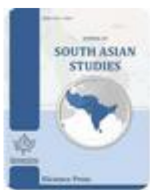

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Factors Affecting Social Adjustment of the Persons with Disabilities in Rural Punjab, Pakistan

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A B S T R A C T

Persons with disabilities are the marginalized persons in the community and facing different community related issues in Punjab province of Pakistan. In Pakistan, living standard of rural community is meager and there is strong association between disability and poverty. A quantitative study was conducted on disabled persons living in rural areas of Punjab. A proportionate sample of 400 respondents was collected from three main districts of Punjab i.e., Faisalabad, Multan and Rawalpindi from November 2016 to June 2017. Level of social adjustment was measured by using a compound variable consisting of statements related to daily activities of these persons. Univariate and bivariate testing were used for data analysis. In this study, majority of the respondents thought that emotional support by non-disabled persons, family support for daily activities, community support for social wellbeing and health structure support to be a productive part of society were important factors of social adjustment for disabled persons living in rural community. Regarding socio-economic background as a whole, it was observed that majorities of the respondents were male by gender from lower class with secondary and higher secondary school education but dependent on others to fulfil their financial requirements. Regarding overall social adjustment, majority of disabled persons stated to have low level of social adjustment even with provision of both more and less health structure support, greater community support, more and less family support and greater emotional support. On the contrary, few respondents were enjoying high level of social adjustment. To provide education and increased level of awareness regarding needs of disabled persons is recommended for the non-disabled persons of the community. Disabled persons should be provided with trainings and some professional skills to live an independent life in the community. Government should implement international anti-discriminatory law to protect the rights of disabled persons.

Keywords: Cooperation, Disability, Facilitation, Marginalized, Poverty, Rural Community, Social adjustment.

INTRODUCTION

Persons with disabilities are increasing in numbers day by day both in developed and developing countries, which is an alarming situation for humanity. In developed countries, the persons who remained alive after second world war, majority of them were disabled. In the next generation of these disabled persons, most of the newborns acquired disability. While in, developing countries, the number of disabled persons is rising with the passage of time. Standard of health is very poor in Pakistan (Nadir *et al*., 2006). The Government of Pakistan spends as low as almost 1% of GDP on health. This is the reason that infant mortality rate is very high. So, some infants with no or less proper medication suffer from mild to severe disability throughout their life.

The persons with disabilities are underprivileged and marginalized in many parts of the world. They are disregarded and neglected part of the society. They are ignored in consideration of basic rights. They live their lives in the limitations like limited social group and friends, limited cultural activities and even limited recreation. Members of the society influence a lot in the limitations of these debilitated persons. The non-disabled do not let the disables to share social life. They consciously or unconsciously criticize them negatively due to ignorance and unawareness. Members of the

society do not like to send them a marriage proposal, not only because of their disability but also with the fear of birth of disabled babies. So, the persons with disabilities are disgraced and marginalized. They face the typical attitude all over the world.

LITERATURE REVIEW

Shaffer *et al. (*2009) narrated that emotional mistreatment of the community and lack of social support exerted undesirable impression on them through facing disapproval and social antagonism within the social arrangement. These emotional disturbances result in social extraction and aggression during childhood and adolescence. These factors are more significant for males rather than females.

Similarly, Shagufta *et al. (*2010) examined a deep effect of disability on child as well as on other family members. Disabled child needs more attention and special care of the family members regarding financial, emotional and social concentration. No medical treatment or self-medication and marriages within family are the majors causes of disabilities.

Although awareness about deformity or disability is necessary but the conscious people may also condemn the adverse implications of dealing and impairment. They may guide those who have meager awareness and information about treatment and rehabilitation of these individuals. Most of the parents wish for treatment of their special kids, which is not possible except rehabilitation (Ownsworth *et al*., 2006).

There is a significant correlation between poverty and disablement. Both have a vicious cycle as physical disabilities make harder to earn daily living which create blockades in the access to health precautions and healthy life spending (WHO, 2011).

United Nation report (2009) narrated that it was difficult for disabled persons to adjust in social setting almost throughout the world. Behavioral issues keep them emotionally disturbed, which leads to low self-respect, depression, low gratification and anxiety from their lives. Resultantly, dominance of recession does not allow the disabled persons to settle down their lives in the normal situation of society.

Molloy et. *al. (*2003) included 103 disabled persons in a survey for their daily life and concluded that there had a progress in the society and opportunities for disabled persons are enormously increased. A wide range of attitude and experience showed positive as well as negative effects on persons. Negative attitude towards disabilities may cause self-esteem and low opportunities for disabled and positive attitude may improve health effects on both physical and mental health. This also increases employment opportunity for these disabled persons.

Shaffer *et al. (*2009) emphasized on interaction family members with disabled persons. Gender differences also affects self-esteem of disabled persons. More attention is given to male disabled than female ones. Furthermore, society as a whole plays an important role for support and emotional behaviour. Lacking emotional exploitation and social support develop social antagonism and disapproval within social setting, which result in aggression and social extraction in all age of disabled persons.

Likewise, Neeraja (2013) illustrated in a study that students with invisible learning disability might lead to detrimental behaviour for several reasons. They might feel sad, angry, lonely, hopeless, or irritated because of paying attention to their difficulties. They might have challenges with social, academics, domestic and emotional aspects. They may overcome these problems through parental attention and joining special education courses. There is a fundamental need to create awareness and conduct programme regarding disability and problems related to disability.

Joseph (2006) stated that only parsons could take care of disabled persons. Other family members are only well-wishers are just companion for time beings. Parents are emotionally touched with their children and deal better with their difficulties and problems. Moreover, they have skill to deal with and can give them good self-help and good training to spend their daily life.

However, Aslam *et al. (*2011) conclude in their study that social adjustment was also required for disabled persons, but these disabled persons were facing with various social problems which had diverse influence of their disabilities on them.

Similarly, Aiden and McCarthy (2014) described that negative attitude of the members of the community creates hurdles for leisure time, education, transport facilities and social interactions outside their home. In short, people with disabilities face many hurdles and need of disability related training and disaster relief personals (United Nations, 2011).

Naz *et al. (*202) stated that most of the disables face prejudice attitude of distrust from family. Employer's

discrimination and transport problems during travelling were addressed as main issues of disables. They further narrated that the parents should give preference abilities of disables over disabilities. They suggested that awareness and education were the key factors for acceptance of disables. Government should play role to take disciplinary actions against discriminators.

Ownsworth *et al.* (2006) narrated that awareness about disability was a common criterion but knowledge about treatment and rehabilitation were rare. Those who knew should condemn the negative consequences of dealing and impairment. In some cases, habilitation of disability in one body parts is possible. They should strengthen other body parts instead of losing money and efforts on the disabled part which is not possible to cure.

For better public outlook, negative attitude of the community members may be highlighted and condemned. Persons with disabilities are the human beings and have right to live like non-disabled persons but they are called special persons due to some disabilities.

The main objective of this study was to create awareness in the lives of persons with disabilities due to which they could live an independent life. This philosophy depends upon the belief that a disabled person has capabilities to live an independent life by using their talent, fortes and strengths rather than making their weakness as hurdles in the way of success.

MATERIALS AND METHODS

Population of the Study

Punjab was selected for conducting the study on persons with disabilities. Quantitative study was conducted for collecting data. Multistage sampling techniques were used for collecting data from disabled persons. To collect information, distribution of area was done in such a way that whole Punjab was covered in the research i.e., three sites each from Northern zone (Rawalpindi Division), Central zone (Faisalabad Division) and Southern Zone (Multan Division). The unit of the population was the persons with disabilities both male and female aged from 05 to 56 years old. In case of less aged persons, parents were contacted.

Sample Size

The data was collected from November 2016 to June 2017 with the well-designed interview schedule. Sample size of 400 respondents was selected by using proportionate (average of 10 years) and purposive sampling from the three districts of Punjab whereas 120 respondents from Rawalpindi, 180 respondents from Faisalabad and 100 respondents from Multan were approached for this study.

Data Analysis

Data of the research were analyzed by using statistical package for social sciences (SPSS). Both descriptive and inferential techniques were used for data analysis. Frequencies and percentages were measured in Univariate analysis. Chi square and Gama statistics were measured in bivariate analysis to check the association of dependent and independent variables. STATISTIX 8.1 was used for analysis.

RESULTS

Majority of the respondents (73%) were male and 27% females (Fig. 1). Highest %age of respondents (Fig. 2) had age ranging from 26-35 years (27%), closely followed by 36-45 (26.7%) and 16-25 (21.7%). It is notable that respondents of age 46-55 had a considerable percentage (17%) who were disable. Disabled individuals having age above 56 years old (3.0%) and 5-15 years (4.5%) were very less in number.

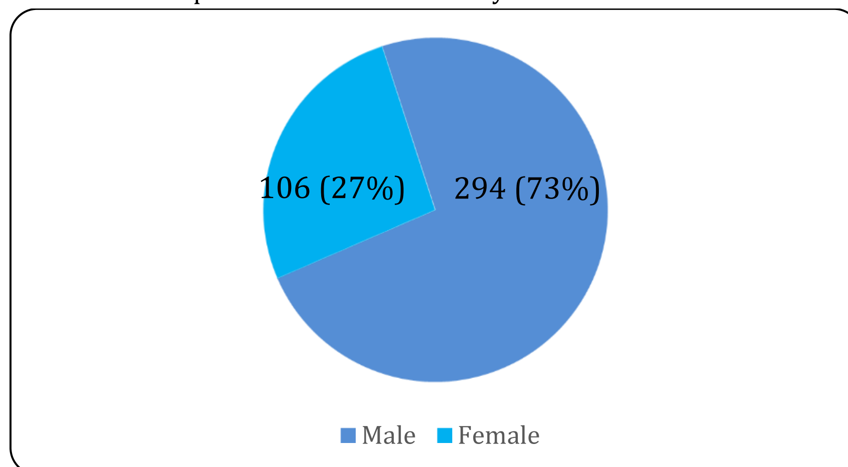

Figure 1. Distribution of male and female respondents.

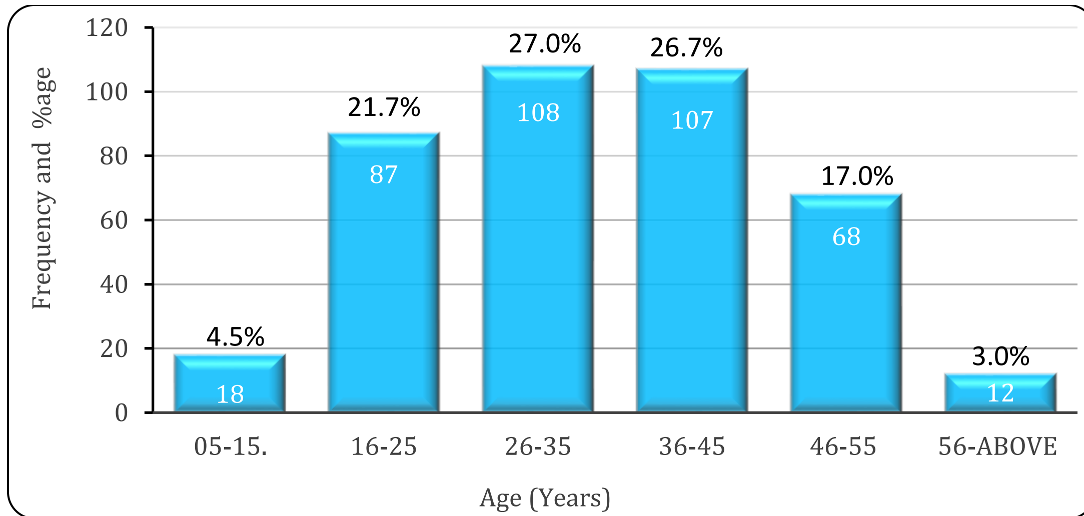

Figure 2. Distribution of respondents according to different age groups.

Regarding monthly household income, majority of disables (40.75 %) had Rs. 15000-25000 monthly income, followed by those (31.5%) having income of Rs. 5000-15000 (Fig. 3). Very few disables had an earning of above Rs. 45000. It showed that disability was a harder for a decent earning in the area. It was further observed that majority of respondents (42.75%) were dependent economically, while 43.2% disables were earning their own (Fig. 4). 23.0% disabled persons were living their lives from other sources.

Regarding level of education (Fig. 5), majority of the respondents were matriculate (22.8%), intermediate (17.0%) and graduate (12.8%). A sizeable number of primary (11.0%) and middle pass (9.8%) disables was also documented. Although less in number but there were disables who had masters (3.5%) and M.Phil./ Ph.D. (1.3%) degree.

Regarding social adjustment of persons with disabilities, majority of the respondents (57.75%) stated that their level of social adjustment was low while 28.50% respondents agreed with that of moderate level of social adjustment (Fig. 6). Only 13.75% respondents narrated high level of social adjustment.

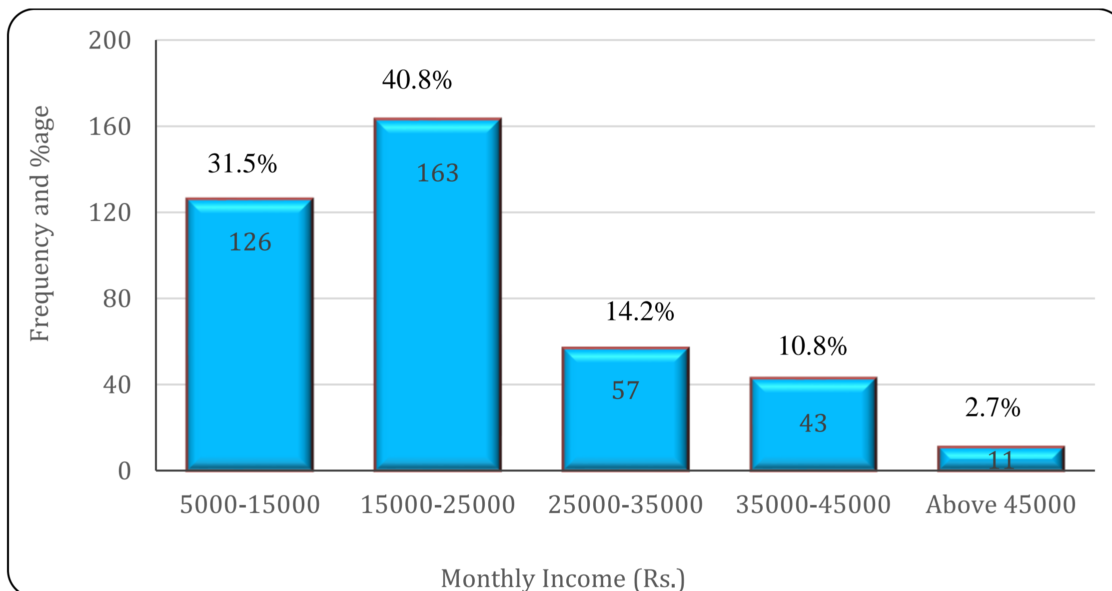

Figure 3. Distribution of respondents according to their household income.

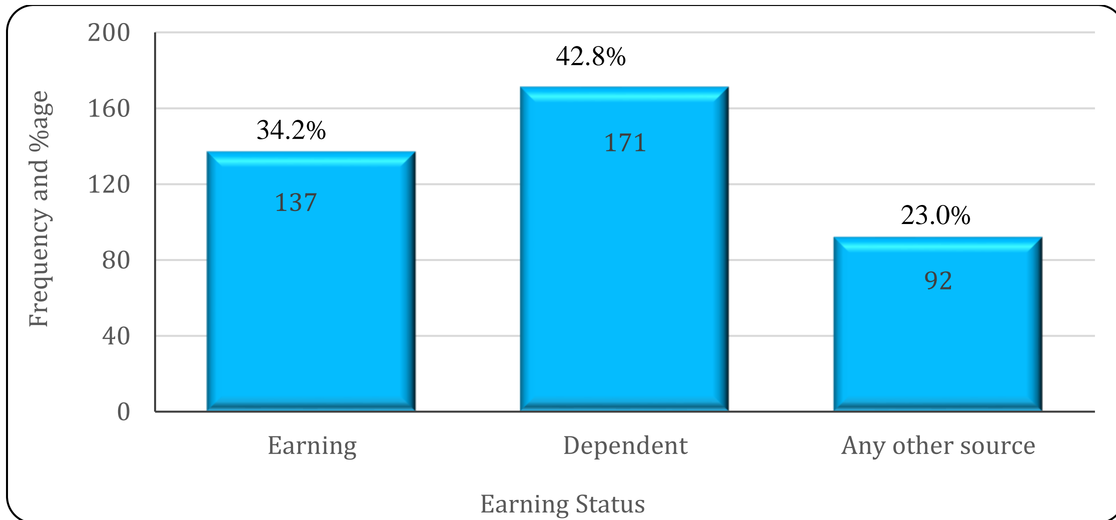

Figure 4. Distribution of respondents according to their earning status.

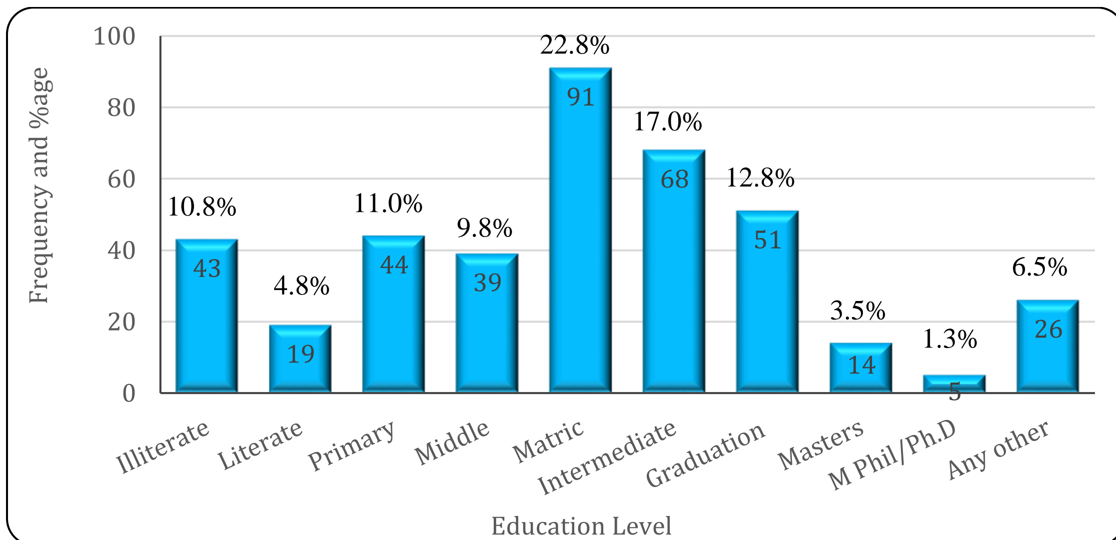

Figure 5. Distribution of respondents according to their education level.

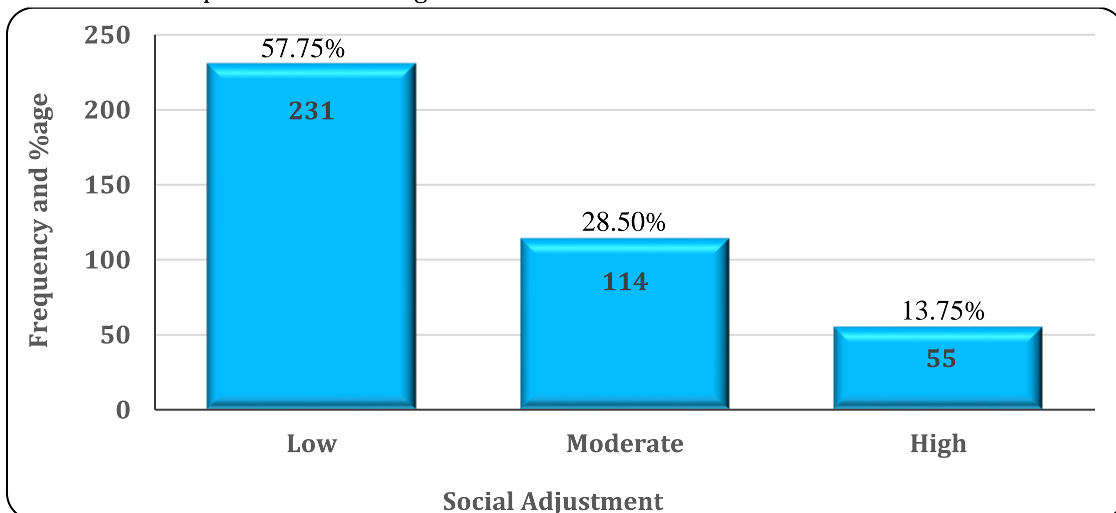

Figure 6. Distribution of respondents according to their level of social adjustment.

Majority of the respondents (58.50%) replied that health structure support did not have a crucial role for social adjustment of the disabled persons, whereas 29.75% respondents agreed to moderate level of importance and 11.75% respondents considered it highly important factor for social adjustment of disabled persons (Table 1). On the contrary, majority of the respondents considered community support (60.25%), family support (41.75%) and emotional support (57.25%) as highly important factors for social adjustment of disabled persons. It was followed by disabled persons who agreed that community support (25.50%), family support (37.75%) and emotional support (28.25%) had significant role to some extent for social adjustment of the disabled persons (Table 1).

Table 1. Distribution of respondents according to different supports for social adjustment of disabled persons.

	Health Structure Support	Community Support	Family support	Emotional support
To great extent	47 (11.75%)	241 (60.25%)	167 (41.75%)	229 (57.25%)
To some extent	119 (29.75%)	102 (25.50%)	143 (35.75%)	113 (28.25%)
Not at all	234 (58.50%)	57 (14.25%)	90 (22.50%)	58 (14.50%)
Total	400	400	400	400

Bivariate Analysis

Regarding overall social adjustment, 57.75% respondents opined that their level of social adjustment was low while 28.50% respondents agreed with that they were at moderate level of social adjustment (Table 2-5). Only 13.75% respondents had high level of social adjustment.

Bivariate analysis regarding social adjustment (Table 2) demonstrated that a higher %age of disabled respondents had low level of social adjustment even with provision of both more (82.98%) and less (92.44%) health structure support. On the other hand, respondents had varying level of social adjustment with no health structure support. Chi-square value (χ^2 = 121.90) showed a highly significant association between variables. Likewise, Gamma value (0.763) showed a strong positive and significant relationship between health structure support (independent variable) and social adjustment (dependent variable) of disabled persons.

Table 2. Relationship between health structure support and social adjustment of disabled persons.

Health Structure Support	Social Adjustment			Total
	Low	Moderate	High	
To great extent	39 (82.98%)	03 (06.38%)	05 (10.64%)	47 (11.75%)
To some extent	110 (92.44%)	06 (05.04%)	03 (02.52%)	119 (29.75%)
Not at all	82 (35.04%)	105 (44.87%)	47 (20.09%)	234 (58.50%)
Total	231 (57.75%)	114 (28.50%)	55 (13.75%)	400 (100.00%)

Chi-square = 121.90 (P-value = 0.000**), Gamma = 0.763 (P-value = 0.000**)
** = Highly significant

Bivariate analysis regarding social adjustment (Table 3) demonstrated that a higher %age of disabled respondents had low level of social adjustment even with greater community support (87.55%). On the other hand, a higher %age of disabled respondents had moderate level of social adjustment even with community support to some extent (87.30%) and more respondents had higher social adjustment with no community support (71.90%). Chi-square value (χ^2 =423.42) and Gamma value (0.860) showed a significant relationship between health structure support and social adjustment of disabled persons.

Bivariate analysis regarding social adjustment (Table 4) demonstrated that a higher %age of disabled respondents had low level of social adjustment even with more (89.82%) and less (72.22%) family support. On the other hand, more respondents had moderate social adjustment with no family support (57.34%). Chi-square value (χ^2 =211.09) and Gamma value (0.842) showed a significant relationship between family support and social adjustment of disabled persons.

Table 3. Relationship between community support and social adjustment of disabled persons.

Community Support	Social Adjustment			Total
	Low	Moderate	High	
To great extent	211 (87.55%)	20 (08.30%)	10 (04.10%)	241 (60.25%)
To some extent	09 (08.82%)	89 (87.30%)	04 (03.90%)	102 (25.50%)
Not at all	11 (19.30%)	05 (08.80%)	41 (71.90%)	57 (14.25%)
Total	231 (57.75%)	114 (28.50%)	55 (13.75%)	400 (100.0%)

Chi-square = 423.42 (P-value = 0.000**), Gamma = 0.860 (P-value = 0.000**)
** = Highly significant

Table 4. Relationship between family support and social adjustment of disabled persons.

Family Support	Social Adjustment			Total
	Low	Moderate	High	
To great extent	150 (89.82%)	09 (05.39%)	08 (04.79%)	167 (41.75%)
To some extent	65 (72.22%)	23 (25.56%)	02 (02.22%)	90 (22.50%)
Not at all	16 (11.19%)	82 (57.34%)	45 (31.47%)	143 (35.75%)
Total	231 (57.75%)	114 (28.50%)	55 (13.75%)	400 (100.0%)

Chi-square = 211.09 (P-value = 0.000**), Gamma = 0.842 (P-value = 0.000**)
** = Highly significant

Bivariate analysis regarding social adjustment (Table 5) demonstrated that a higher %age of disabled respondents had low level of social adjustment even with greater emotional support (90.39%). On the other hand, a higher %age of disabled respondents had moderate level of social adjustment even with lesser emotional support (85.96%) and more respondents had higher social adjustment with no emotional support (70.69%). Chi-square value (χ^2 =435.74) and Gamma value (0.860) showed a significant relationship between emotional support and social adjustment of disabled persons.

Table 5. Relationship between emotional support by non-disabled persons and social adjustment of disabled persons.

Emotional Support	Social Adjustment			Total
	Low	Moderate	High	
To great extent	207 (90.39%)	12 (05.24%)	10 (04.37%)	229 (100.0%)
To some extent	13 (11.50%)	96 (85.96%)	04 (03.54%)	113 (100.0%)
Not at all	11 (18.97%)	06 (10.34%)	41 (70.69%)	58 (100.0%)
Total	231 (57.75%)	114 (28.50%)	55 (13.75%)	400 (100.0%)

Chi-square = 435.74 (P-value = 0.000**), Gamma = 0.860 (P-value = 0.000**)
** = Highly significant

DISCUSSION

Mean value for age (34.4 years) was in middle of ages of respondents. Furthermore, values of mean (34.4), median (34.3) and mode (35.05) for age groups were almost comparable (Table 6). This revealed that the data were nearly symmetrical. 12.10 of deviation from mean value (34.4), on the average, was observed for age of respondents. High coefficient of variation (35.16%) revealed a wide range of ages of respondents chosen for this study along with majority of young persons (around mean value of 34.4 years). Below 3% value of kurtosis (2.27%) disclosed that distribution was platykurtic i.e., flattop. 0.05 value of skewness revealed that distribution was symmetrical. Large number of persons in Punjab having age ranging from 15 to 65 years was reported by Pakistan Bureau of Statistics (PBS, 2015).

Regarding household income of respondents, values of mean, median and mode were not alike (Table 6), while mean value (21250) was higher than median (19539) and mode (16439). On the average, Rs. 10580 of deviation

from mean value (Rs. 21250) was found for household income of respondents. High coefficient of variation (49.79%) displayed a wider range of annual household income of respondents. More than 3% value of kurtosis (3.03%) showed that distribution was mesokurtic i.e., nearly symmetrical, while 0.48 value of skewness showed that distribution was nearly positively skewed.

Table 6. Estimates of mean, median, mode, standard deviation, coefficient of variance, kurtosis and skewness of age and monthly household income.

Estimates	Age	Monthly income
$\bar{X} \pm SD$	34.4±12.10	21250±10580
Median	34.30	19540
Mode	35.05	16440
CV (%)	35.16	49.79
Kurtosis	2.27	3.03
Skewness	0.05	0.48

The socio-economic background as a whole revealed that majorities of the respondents were male by gender from lower class with secondary and higher secondary school education but dependent on others to fulfil their financial requirements. More than 50% of the respondents (58.6%) were matriculate, intermediate and graduate (Fig. 5) showing thereby higher qualification among disables of the area. It is interesting to notes that some respondents had higher degree i.e., masters (3.5%) and M.Phil./ Ph.D. (1.3%) degree.

Only 13.75% respondents were enjoying high level of social adjustment. It was notable that 35.75% of respondents found support from family to some extent for social adjustment. 14.5% respondents did not acquire any emotional support from non-disabled people showing thereby that they suffered emotionally due to the ill-behaviour of non-disabled persons regarding their disability. It is an alarming situation for social adjustment disabled persons living in rural area, which needs attention to society as well as family to change their attitude and treat them equally to those of non-disabled people. Our results showed that health structure support was a key and significant factor for the social adjustment of disabled persons where with the increase of health structure support, there would be easier social adjustment of disabled persons. Furthermore, the increased support from community and family for disabled person would lead to a better social adjustment of the disabled persons. It was also observed that more emotional support would lead to easier social adjustment of disabled persons in the society.

Likewise, Miles and Hossain (1999) narrated that Pakistani individual of rural community were not fully aware of the social adjustment of disabled persons. The community as well as family members do not try to adjust them according to their strengths and talent, however, they point out as economic and social burden. Disparity in subjective well-being of persons with disability was described mostly by socio-economic status, personal resources or level of participation in work, and not by the level of disability, narrated by vanCampen and vanSantvoort (2013). Similarly, Aslam *et al*. (2011) argued that co-operation and support of the community were compulsory for the social adjustment but the persons with disabilities faced many challenges to live a healthy social life. The community members neglect, discriminate and criticize them, which are creating disapproving effects on the social adjustment of disabled persons. Beresford (1994) acknowledged parents of the disabled persons who devoted themselves for their take care, pay attention and brought up. There are many clinicians works for the development of techniques and strategies for the treatment and adjustment of the disabled persons, and it is only parents who apply these techniques for the training and self-help skills of the disabled persons. There is a dire need to highlight the essential requirements and improvement of health facilities for the persons with disabilities. Shaffer *et al. (*2009) described interaction of disabled individuals with other members of the society as more vital element. They narrated that lack of social support and emotional mistreatment from public had adverse impact on disabled persons. These people are facing disapproval and social antagonism within the social setup of rural community.

The emotional disturbance results in aggression and social extraction during childhood, middle childhood and adolescence. These factors are more significant for males rather than females.

CONCLUSION

In the light of above findings, it is concluded that family support, community support, emotional support by non-disabled persons and health structure support are utmost important factors for social adjustment of disabled persons in rural community. To provide education and increased the level of awareness regarding needs of disabled persons is highly recommended for the non-disabled persons of the community. Disabled persons may be provided with trainings and some professional skills to live an independent life in the community. The aforementioned determinants can integrate the disabled persons in rural community with social structure and can make possible for them to be a productive part of the society. To cope with these hindering factors of shifting disabled persons as marginalized part of the society, proper policies may be implemented by the government.

AUTHORS' CONTRIBUTION

Dr. Muhammad Musa analyzed data and wrote the manuscript. Fazeelat Naz designed and conducted the research study. Dr. Falak Sher supervised the research and edited the manuscript. All authors read and approved the final draft for publication.

CONFLICT OF INTEREST

The authors declare that there is no conflict of interests regarding the publication of this manuscript.

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