THE CARE GIVEN TO THE DIFFERENTLY-ABLED CHILDREN AND THEIR PSYCHOLOGICAL WELLBEING IN RUNYENJES CONSTITUENCY, EMBU COUNTY, KENYA

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A Thesis Submitted to the Faculty of Arts and Social Sciences in Partial Fulfilment of the Requirements for the Award of the Master's Degree in Counselling Psychology at the Catholic University of Eastern Africa

NAIROBI, KENYA

OCTOBER, 2021

DECLARATION

I the undersigned declare that this thesis is my original work and has never been presented to any other university or institution of learning for academic credit. I have acknowledged all the information from other sources including those whom I have worked with.

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ACKNOWLEDGEMENTS

I owe my sincere thanks and gratitude to Almighty GOD for my life and for many other blessings. I acknowledge the Bishop of the diocese of Embu, Rt. Rev. Paul Kariuki Njiru for giving me a chance to pursue my studies at The Catholic University of Eastern Africa. My regards also go to brother priests in Kevote parish, family members and all the friends who have assisted me in various ways in developing this thesis.

I am greatly indebted to my supervisors Dr. Stephen Asatsa and Dr. Elijah M. Ndung'u for their support and guidance in developing this study, without which this study would not have been successfully developed. I also wish to acknowledge Dr. Muriithi and Dr. Githuthu, from the department of Psychology in Catholic University of Eastern Africa, and Dr. Amissah for their criticism and corrections as I was developing this study. I acknowledge Mr. Mugambi Fredrick of St. Paul's Kevote for taking time to read my work for grammatical corrections.

ABSTRACT

Children with motor impairments are a global concern. Their psychological wellbeing is of great concern for those living with them. This research was aimed at investigating the care given to these differently-abled children and their psychological wellbeing in Runyenjes Constituency, Embu County in Kenya. The study was guided by the following four research objectives; to investigate the influence of family care on the psychological wellbeing of the differently-abled children, to establish the relationship between residential institutionalized care and the psychological wellbeing of the differently-abled children, to assess the implications of educational care on the psychological wellbeing of the differently-abled children and to evaluate the psychological care offered to the differently-abled children and their psychological wellbeing in Runyenjes Constituency, Embu County, Kenya. The study was anchored on Maslow's theory of hierarchy of needs and The Medical theory of disability. The study adopted Descriptive research design applying cross sectional method to collect data at one point in time. The study also applied a mixed methods approach involving both qualitative and quantitative approaches. The target population of the study was 80 children with motor impairments living in the families and institutions in Runyenjes Constituency, ten key informers that comprised of five chaplains and five guidance and counselling teachers of the institutions where these children are found. The study conducted a census study that involved all the participants in the target population. The study used purposeful sampling method to get vital information from the target population. The research tools were questionnaires for the differently-abled children and an in-depth interview guide for the key informers. The questionnaires had section A and B having five-point Likert scale questions designed by the researcher as per the objectives and standardized 42 PWB Ryff tools. The analysis of quantitative data was done using correlation analysis using SPSS Version 21. Data was presented in tables using descriptive statistics in the form of frequencies and percentages for quantitative variables. The data collected from the interview guide was analysed thematically. The study found out that family care, residential institutionalized care and educational care influenced personal growth more than any other domain of psychological wellbeing of the differently-abled children. The male gender was also found to show higher scores in psychological wellbeing than the female gender. The interviews revealed that Mass and pastoral activities, occasional guidance and counselling and visits by well-wishers were some of the attempts to offer psychological care to the differently-abled children. The study recommended training, assignment of specialists, extra time and resources, and frequent interactions of the differently-abled children with other people for promoting their psychological wellbeing. Following its findings, the research recommended further assessment on the extent to which care should be given to the differently-abled children such that it doesn't become excess to the point of decreasing their psychological wellbeing. The study also recommended further research on the psychological wellbeing in relation to gender.

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ABBREVIATIONS

BPS	Bio-Psychosocial model
DAC	Differently-abled children
KNCHR	Kenya National Commission for Human Rights
PW	Psychological wellbeing
SEN	Special Education Needs
SPSS	Statistical Package for Social Sciences
UNICEF	United Nations Children Fund
WHO	World Health Organization

DEFINITIONS OF TERMS

Able bodied children:	refers to the children who have no motor impairments and are able to coordinate their limbs properly.
Care:	refers to the provisional of the basic needs to the DAC and addressing their developmental changes as they mature at homes, educational and residential institutions
Differently-abled children:	Refers to the children who have motor impairments making them slow to do physical activities due to the effects it has on the limbs.
Educational Institutional care:	Refers to the care given to the differently-abled children in the schools where they undertake their formal education.
Inclusion:	Refers to the provision of health, participation in social activities by differently-abled children especially in education and other programs.
Inclusive Education:	Refers to the system of education that is open to all children including those with special needs like disabilities
Family:	Refers to the place where the differently-abled children are brought up either by the biological parents, guardian or through adoption
Family care:	Refers to the care given to the differently-abled children in the families where they were born and live with their biological parents, guardians or through adoption.

Parent:	Refers to an adult who takes care of the differently-abled child being a biological parent, a guardian or who has adopted the differently-abled child
Psychological wellbeing:	refers to how the differently-abled children are able to exploit their abilities, have healthy relationships with others and have positive thinking in their lives.
Psychological Care:	refers to the provision of support in terms of psychological, social and spiritual needs aiming at modifying behaviour, emotional state, or feelings of the differently-abled children.
Residential Institutional care:	Refers to the care given to the differently-abled children in the small homes which does not pertain to education.
Small home:	Refers to a centre where the children with disabilities are brought together for specialized care and attention as they attend school together with their able bodied peers.

CHAPTER ONE

INTRODUCTION

1.1 Introduction

Disability has been a global concern in all the ages. The World Report on Disability attests that more than a billion people of the world's population live with some form of disability (WHO, 2014). This concern is based on the rise on the number of cases of people either born with disability or becoming so after birth. The disabled are perceived differently and this perception determines the care they are given (WHO, 2014). The term "differently-abled children" as applied in the study was used to refer to children with motor impairments. This implied that despite these children having limited use of limbs they have different abilities in their own various ways (UNICEF, 2013). These abilities include home chores, academic and co-curricular activities at school, relationships with other people and having positive thinking in life. These abilities together with the care these children receive in their families, residential and educational institutions form part of their psychological wellbeing. The study sought to investigate the care given to the differently-abled children and their psychological wellbeing in Runyenjes Constituency, Embu County, Kenya.

1.2 Background to the study

People with different impairments are usually received with mixed feelings by different people in the world. They live with their families, in special homes or in educational institutions (Batya, 2017). Impairments are visual if associated with sight, audio if associated with hearing, cognitive if associated with mental functioning and motor if associated with limited or no use of limbs (Orr, 2015). This study specifically focused on the children with motor impairments. UNICEF (2013) gave a report on the state of the world's children with disabilities stating that these children have additional challenges and barriers and generally suffer exclusion in many occasions (Misauri, 2019). This basically would raise psychological issues to these children.

Grant, Ramcharan & Flynn (2007) did a study in Europe. The title of the study was "Participation and Quality of Life of Children with Disabilities Living in Europe". This was to investigate the influence of the environment on the participation and quality of life of disabled children aged 8-12 years. It was conducted in seven EU countries i.e., Denmark, France, Germany, Ireland (North and South), Italy, Sweden and England. It was found that the participation and quality of life of disabled children and adolescents was lower compared to those without disabilities. This was in terms of social support and peer relationships. The participation and quality of life for the children with motor impairment depended on the environment where they lived. This environment which would be at the families of the disabled children, children's homes and educational institutions determined their psychological wellbeing (Batya, 2017). This was from the care they received in the environment they were found.

A study done in Zimbabwe by Janet and Lazowski in 2012 focused on children with physical impairment. The title was 'The psychological well-being of adolescents with physical disabilities in inclusive community settings'.

The findings indicated that the adolescents with disabilities and living in such inclusive communities had high levels of autonomy and choice, purpose in life, positive relations with others and good personal growth and self-acceptance. The study also found that the adolescents with disabilities ended up being rejected and stigmatized across many cultures by some discrediting and dehumanizing statements made about their attributes. This was seen to have impacts on their psychological wellbeing since at times they were also considered as lesser humans thus minimizing the care they received from the care givers (Lazowski, 2012).

In Kenya a survey entitled “Kenya National Survey for Persons with Disabilities” was done and a report written in 2008. The report indicated that the establishment and emergence of many small homes for disabled children in the country would create concern about the care given in these institutions. This was in comparison to the care given in the families. The concern was to establish whether the institutionalized children had any psychological developmental difference from those living in their families. It was found out that 65% of children with disabilities regarded the environment as major problem in their daily lives as later established by KNCHR (2014). These findings pointed to the fact that the environment where these disabled children live in may have effects to their psychological wellbeing.

In Runyenjes Constituency in Embu County it was revealed that some parents were tethering the disabled children with ropes to avoid the alleged shame of siring such children as reported by *The Star newspaper* (6/4/2019). This forms the basis of the common practice of taking the differently-abled children “out there” to the rehabilitation units as posited by Nyakiamo, (2019). The indication is that the family members would prefer the disabled children to be in a different environment rather than in their families. This is from the fact that in the institutions the disabled children would meet with others who have similar conditions and they live together for some time. They would also receive educational care and frequent visits by well-wishers and at times their relatives (Nyakiamo, 2019). The revelations from the studies indicated the effects of the environment where the differently-abled children live. This is because it is in these environments of family, residential and educational institutions that the differently-abled children receive care. This care determines their psychological wellbeing.

The general understanding of psychological wellbeing consists of the domains of positive relationships with others, personal growth, autonomy, environmental mastery, purpose of life and self-acceptance (Ryff, 2017). Specifically, the psychological wellbeing of children is based on provision of their rights and addressing their developmental transitional issues (Arieh, 2007). This means that the care given to the children and their psychological wellbeing involves providing the basic rights for them and addressing their developmental changes as they mature. This study sought to examine how the care the differently-abled children received determined their psychological wellbeing.

The concept of disability has a general meaning of the various types of disabilities. The term “disabled” has been used generally together with words like “physically challenged”, “handicapped’’ and “less fortunate” (Badu, 2016). These terms indicate the motor type of impairment. The motor impairment is characterized by the limited use of limbs due to various causes (Rowland, 2014). The reason for the choice of this type of impairment in the study was that it fitted very well with the concept of different abilities. The study used “differently-abled” (DAC) to imply that these children have their own abilities in their own ways besides their motor limitations. Though the children have motor impairments, they have other functional faculties like sight, hearing and intellectual abilities among others (Batya, 2017). These children only lack the limbs coordination and movements and therefore they are termed as differently-abled. The term was first proposed in the 1980s as an alternative to disabled, handicapped, challenged or having special needs (Twain, 2006). It gave a more positive message and avoided discrimination towards people with disabilities. The changed perceptions towards these people determine greatly the care they would receive in the family or in the institutions and generally in the society. This care has great implications to their psychological wellbeing. (Nurius, 2015)

The concept of care generally refers to the provision of what is necessary for health, wellbeing and protection of a person. The study considered four types of care for the differently-abled children. These are the family care, residential institutional care, educational institutional care and the psychological care. This is because the children with motor impairments live in the families, residential and educational institutions (Batya, 2017). They also require psychological care just like any other human being (Kendra, 2019). Family care is provided at home by the parents, siblings and other relatives. Residential institutional care is given in small homes, orphanages and charitable institutions by some designated staff. Educational institutional care is given at the places where these children undergo formal training. The psychological care is given by the chaplains and the counsellors within the reach of these children.

All children whether disabled or able bodied require family care (Government of Kenya, 2001). This family care entails provision of food, clothing, shelter, protection from abuse and general support as they mature (Chernego, 2016). In some families, children with motor impairments are viewed as a source of strength, hope, joy, love and pride (Mulheir, 2012). However, in many families these children are neglected and many family members are not willing to expose them due to cultural, parenting or family patterns of secrecy (Kett and Ommeren, 2009). There have been cases of children being hidden from the public for a long time in Runyenjes Constituency.

The Star Newspaper (6/4/2019) reported that many children with disabilities are tied with ropes inside dark rooms where they live in deplorable conditions. These few reported cases indicate that the children with motor impairments are not only hidden but also receive little or no family care (Misauri, 2019). This has great impact on their psychological wellbeing as they are subjected to such dehumanizing conditions.

There are many other families with children with motor impairments who find it challenging to care for them in their families due to various factors (Misauri, 2019). They therefore end up taking them to residential institutions where these children can receive the care that may not be available at home (Naomi, 2016). This residential institutional care revolves around feeding, sleeping, moving around, challenging behaviour, communication and connecting them with others. In some cases, family members occasionally visit these children while most don't. Still many charitable organizations and individuals visit these institutions and deliver material things to them. Helen (2019) says that many people who visit these children are driven by pity rather than respect. Because of pity, people visiting concentrate on the ordinary needs of these children and fail to recognize their uniqueness and other psychological elements (Batya, 2017). Though there is provision of the basic needs and some other requirements at residential institutions in Runyenjes Constituency, there are some incidents of continuous withdrawal of differently-abled children from these institutions over the last four years (Gender and Social Services, Embu West Sub-county, 2019). This necessitates the study to find out the amount of care at the residential institutions and the reason for preference by many families to take their differently-abled children out of these residential institutions.

A most recent practical program on inclusion is in the area of education that sees the differently-abled children schooling together with the able-bodied children (Dreyer, 2017). This involves accommodating the physically challenged children into the system of formal education. The differently-abled children who attend educational institutions come from their families or from their residential institutions. Here, they are able to learn how to read, write, communicate, concentrate and develop their personal abilities (Malinda, 2005). Runyenjes Constituency has three schools that were involved in this study. This is because they are attached to residential institutions where the differently-abled children are able to operate from. Each of these schools has a special needs teacher assigned by the government to ensure that these children's educational needs are met (Ministry of Education, 2009). There has been a decline in the enrolment of differently-abled children in these schools for the last four years (Sub-county Director of Education Embu East, 2019). Still the reports from the three schools reveal a significant drop on the performance of the differently-abled children compared to the performance of the differently-abled children who were enrolled in these schools many years ago (Orr, 2015). This calls for an investigation on the amount of educational institutional care offered to the differently-abled children in the area of study and the possible causes of the decline of enrolment and academic performance of the DAC owing to the fact that they only have motor impairments and possess other functional abilities.

The differently-abled children require psychological care just like their able-bodied peers (Misauri, 2019). This psychological care is given to them in their families, in the residential institutions or in the educational institutions. Generally, the psychological care means any activities used to modify behaviour, emotional state, or feelings of the differently-abled children as they cope with the situations of life (Ncube, 2014). They are assisted to develop emotional wellbeing and individual's capacity to live a full and creative life and the flexibility to deal with life's inevitable challenges (Ministry of Labour, 2015). The psychological care also helps the differently-abled children to know and to manage themselves, be in touch with their situation and embrace a sense of self-worth, control over behaviour, realistic beliefs, spiritual appreciation or belief in purpose, independence, feeling safe and happy, appreciation of others and hope for the future (Ministry of Labour, 2015). This necessitates the study that seeks to investigate the amount of psychological care offered to the DAC in Runyenjes Constituency since there is a drop in the academic performance of those in schools while some have been withdrawn from the residential institutions. An assessment on psychological care is also required for those at their families since many live in deplorable conditions.

The care given to the differently-abled children has a great impact on the psychological wellbeing of these children. Many studies have only been done on one environment where this care is offered. Other studies only evaluate the statistical facts about where the DAC are found without going further to probe the type and amount of care in these environments. Still other studies focus more on the people who take care of the DAC finding out the resilience of these care givers and their psychological wellbeing. There has been little concern for the psychological wellbeing of the differently-abled children since much concern has been on the environment they live in, their numbers and the people who take care of them.

The uniqueness of this study was that it went further to investigate the amount of care in all the possible environments where the DAC live without being limited to the numbers of the DAC, merely identifying the environments or singling only one environment. It focused on the psychological wellbeing of the DAC which had been left out by many studies. The study raised a question about the care given at all the environments and the need to see the status of this care in relation to the psychological wellbeing of the recipients of this care, the differently-abled children. In Runyenjes Constituency there are DAC who are not taken to school, others perform low at school, others are withdrawn from the residential institutions while others are hidden and alienated from the general public. The care given to these children at whatever the environment raises issues on their psychological wellbeing hence the need for this study. The study was therefore concerned with the care given to the children with motor impairments and how this care influenced the psychological wellbeing these children.

1.3 Statement of the Problem

The realities in many parts of the world reveal that many of the differently-abled children undergo the unfortunate dehumanizing mistreatments. In the family environment some are hidden, isolated, bullied and even in some cases being treated as outsiders due to the shame and taboos associated with disabilities. Other differently-abled children are taken to institutions like small homes, children’s centres or even rehabilitation units where they are provided with material things by the well-wishers, relatives and charitable organizations. The provision of material requirements at times is over emphasized as a result of too much pity to the differently-abled children. There are many incidents of differently-abled children having been sexually abused, bullied and even tortured in these residential institutions. The current trend of inclusive education has seen some incidents of exclusion, rejection, discrimination, bullying and even torture of the differently-abled children. The educational facilities at times are limiting to the differently-abled children. In some incidents the able- bodied children are taught to excessively pity the differently-abled children eliciting some psychological issues to the differently-abled children. In other incidents the differently-abled children are not placed in leadership positions for doubts of their performance and in many occasions they are left out in the daily activities of the school like sports and other motor involving activities.

In Runyenjes Constituency the differently-abled children are found in their families while others are found in residential and educational institutions. They are able to receive care from their family members and from the staffs at the residential and educational institutions. Much of this care is led by pity and focused majorly on material provisions. This has seen withdrawal of some differently-abled children from the residential institutions and low performance for those who go to school. Others have been removed from their families and taken to the residential institutions all with an aim of providing the material requirements needed for them.

The study explored the psychological wellbeing of the children with motor impairments and focused on how the care offered in the environments of family, residential and educational institutions influenced their psychological wellbeing. The study considered this population as highly neglected in terms of their psychological wellbeing as the care givers were only concerned with provision of material requirements without taking into account the personal abilities, healthy relationships, positive thinking and other elements that entail to the psychological wellbeing of the differently-abled children. The study therefore related the care given to the children with motor impairments to their psychological wellbeing.

1.4 Objectives of the Research

The study had the following objectives:

i. To investigate the influence of family care on the psychological wellbeing of differently-abled children in Runyenjes Constituency, Embu County, Kenya.
ii. To establish the relationship between residential institutionalized care and the psychological wellbeing of differently-abled children in Runyenjes Constituency, Embu County, Kenya.
iii. To assess the implications of educational care on the psychological wellbeing of differently-abled children in Runyenjes Constituency, Embu County, Kenya.
iv. To evaluate the psychological care offered to the differently-abled children and their psychological wellbeing in Runyenjes Constituency, Embu County, Kenya.

1.5 Research Questions

i. What is the influence of natural family care on the psychological wellbeing of differently-abled children in Runyenjes Constituency, Embu County, Kenya?
ii. What is the relationship between residential institutionalized care and the psychological wellbeing of the differently-abled children in Runyenjes Constituency, Embu County, Kenya?
iii. What is the implication of educational care on the psychological wellbeing of differently-abled children in Runyenjes Constituency, Embu County, Kenya?

iv. What psychological care is offered to the differently-abled children and their psychological wellbeing in Runyenjes Constituency, Embu County, Kenya?

1.6 Significance of the Study

The research aimed at looking at the psychological elements that touch differently-abled children and how these elements are addressed by the care given in the families and in the educational and residential institutions. This would be significant in promoting the psychological wellbeing of these children. The knowledge on the elements of the psychological wellbeing of the differently-abled children could enable the caregivers to promote it to the DAC. This would therefore help those interacting frequently with the differently-abled children in the environments they live in. The findings of the study may assist those planning and managing the institutions where these children stay. It would be useful to the government as it rolls out the programs of the differently-abled children.

The research also aimed at probing into the perception of people towards differently-abled children as evidenced by the children's homes in Runyenjes Constituency. This is because many disabled people are perceived as recipients of charity and with imminent disadvantages and thereby pitied to the point of being avoided (UNICEF, 2013). The findings of the study would be significant in changing some of the inappropriate perceptions towards the differently-abled children by the society and the general public.

The findings of the study could be significant to the implementers of the current trends of inclusions. This would help the policy makers involved in the implementation of inclusive education since there will be a further concern for these implementers to go beyond the institutions of learning. These implementers include the teachers, the fellow learners, the managers of education and even the parents or guardians of these children. This is because the implementation is faced by confusion, misunderstandings and different opinions leaving many unanswered questions in the theory and practice of inclusive education (Dunn, 2015).

1.7 Theoretical Framework

This is concise explanation of the theoretical framework or line of inquiry adopted in the study. The study reviewed the Maslow’s Theory of Hierarchy of needs and the Medical Theory of disability. This was applied in terms of the proponents of the theories, their key concepts, how they related to the study, their strengths and weaknesses and their justification in the study.

1.7.1 Abraham Maslow; The Theory of Hierarchy of needs.

Abraham Maslow an American Psychologist created the theory of Hierarchy of needs in 1934. This was a theory of psychological health predicated on fulfilling innate human needs. He held that there are five major categories of basic needs common to all people. These needs are as a hierarchy in the shape of a pyramid from lowest to highest. Individuals must meet the needs at the lower levels of the pyramid before they can successfully be motivated to tackle the next levels. The lowest two levels represent deficiency needs, and the upper three levels represent growth needs (Maslow 1968).

The physiological needs are the first and most basic needs of the people for survival. These are food, air, water, sleep, shelter and warmth. People must have food to eat, water to drink, and a place to call home before they can think about anything else. If any of these physiological necessities is missing, people are motivated above all else to meet the missing need. The second set was the safety and security needs. Safety is the feeling people get when they know no harm will befall them, physically, mentally, or emotionally. Security is also the feeling people get when their fears and anxieties are low (Maslow 1968).

The third level of the pyramid has the needs associated with love and belonging. These needs are met through satisfactory relationships with family members, friends, peers, classmates, teachers, and other people with whom individuals interact (Maslow 1968). Satisfactory relationships imply acceptance by others. Having satisfied their physiological and security needs, people can venture out and seek relationships from which their need for love and belonging can be met. The fourth level of needs involve self-worth and self-esteem needs. Once individuals have satisfactorily met their need for love and belonging, they can begin to develop positive feelings of self-worth and self-esteem, and act to foster pride in their work and in themselves as people. The fifth level of Maslow's pyramid is the need for self-actualization. This is a person's desire to become everything he or she is capable of becoming. It also involves the desire to realize and use his or her full potential, capacities, and talents. This need can be addressed only when the previous four have been satisfied. It is rarely met completely. Maslow (1968) estimated that less than 1% of adults achieve total self-actualization.

Strengths and weaknesses of the theory

The theory has strengths in that it addresses many of the needs of a human person in all the levels. In the environment of natural family or institutions there are various needs for the DAC. This means that these needs have to be met in their hierarchy. Starting from the physiological, to safety, to love and belongingness, to esteem and to self-actualization, these needs form part of the psychological wellbeing of the DAC. The theory was applicable in the study. This is because the provision of the needs in their hierarchy is recommended in the environments of family, residential and educational institutions. This would form a significant element of the care given to the DAC in these environments. The theory also applied in the study since it gives a progression of hierarchy of needs from one level to the other. This would form a transition in the wellbeing of the DAC at all the levels of provision for these needs. This would open up other elements of the psychological wellbeing of the DAC without limiting only to the physiological needs, but incorporating other elements that constitute the wellbeing of these children.

The major weaknesses of the theory are that it lacks scientific elements of definitions and empirical evidence and may also not be generalized due to differences in cultures. It also assumes that all people experience the needs in the same order without recognizing the cultural and individual differences. It also fails to give the indicators of the satisfaction of the needs of one level before one would go to the next level. The study was not influenced by these weaknesses since it assessed the care given to DAC which comprises of the provision of the human needs in all the levels. The study did not therefore purpose to measure the satisfaction and empirical evidence of satisfaction. It instead focused on the care in the environments of family and the institutions to the DAC assuming that just like all the human beings the DAC require provision of these needs for their proper psychological wellbeing without necessarily following the sequence in the hierarchy.

1.7.2 The Medical Theory of Disability

This theory was developed from the mid-1800s by Medical professionals who treated people as problems to be solved, often failing to take into account the various aspects related to the person’s life as a whole. It also referred to as the ‘personal tragedy’ model because it defines disability in a fundamentally negative way. It sees disability as something that is ‘wrong’ with a person’s body or mind (Garthwaite, Bambra , Warren , Kasim , Greig, 2014). Disability is seen as a medical problem that resides in the individual. It is a defect in or failure of a bodily system and as such is inherently abnormal and pathological. The goals of intervention are cure and rehabilitation that aims at adjusting the disabled person to their condition and to the environment.

The people with disabilities deviate from what is normal and thus referred with terms such as ‘invalid’, ‘cripple’, ‘spastic’, ‘handicapped’ and ‘retarded’ (Garthwaite et al 2014). They are not comparable with their able-bodied counterparts. These people depend solely on experts who aim at restoring them to normalcy. The disabled children have problems that may make it difficult for them to make good decisions about their own life. They are likely to need professionals to look after them and if the problem cannot be fixed, they will never be equal to other young people (Garthwaite et al, 2014). The theory also states that the people with disabilities should play the ‘sick role’ properly if they desire to receive continued help and support. They have very little they can do for they are mere victims (Greig, 2014).

Strengths and weaknesses of the theory

The strength of the medical theory is that it views disability as a feature of the person, directly caused by the disease, trauma or other health condition. This requires medical care provided in the form of individual treatment by professionals, either medical or other treatment and intervention, to ‘correct’ the problem with the individual (Dressman, 2008). This explains some interventions to the DAC especially where it applies to the corrective surgeries.

The major weakness of the theory is that it looks at the disabled people as mere victims of physical disadvantages and therefore they have to depend solely on the professionals even for their decision making (Dressman, 2008). This has been the attitude towards the DAC for a long time where they have been viewed as people to be pitied all the time and depending solely on the able-bodied people.

This theory relates perfectly to the study because many people have similar conceptions towards the differently-abled children as those of the proponents of the theory. The differently-abled children are seen as victims of physical conditions that require professional interventions. For this reason, the differently-abled children are usually taken out there for these professionals who are trained to care for them. In other cases, the DAC are viewed as abnormal and being tied to their physical conditions that are inherent in them. Likewise, some people tend to take these children with so much pity that they exaggerate the care they accord them. They treat them as disadvantaged people in the society thus requiring interventions in greater parts of their lives. All these elicit some psychological issues to the differently-bled children since it is projected to them by the people who take care of them. This study aimed at assessing the care at natural families, educational and residential institutions which greatly is determined by the attitude that people have towards the differently-abled children. This care influences significantly the psychological wellbeing of these children.

1.8 Scope and Delimitation of the Study

The research was narrowed to the differently-abled children in the institutions in Runyenjes Constituency as well as those in the families in the same area. This is because the attention of the researcher was caught by the residential and educational institutions that work very well together. The focus was on the children who have motor impairments that affect the general coordination of limbs. The time of research was the month July 2021. This is because during this time the children were both in the schools and in their homes during the short holiday.

The study reviewed the literature dealing with psychological wellbeing, reports about children with disabilities, concepts of disability with its types, inclusive education, the establishment of the institutions in Runyenjes Constituency and their managements. This was because such literature was directly related to the topic. The study used a cross-sectional research design to collect data from the target population at one time and place. The target population was the differently-abled children in the area of study and the key informers who were the chaplains and the guidance and counselling teachers in the area of study.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This is the analysis of the existing literature on the topic under study. The study reviewed the theories that explain disabilities and how they related to the topic. The study also identified the gaps left by the theories and how it would fill these gaps. In this review the study also considered the related empirical studies done on the topic of research. These are the studies done globally, regionally and locally. The objectives of the study guided the review of empirical studies. The author, the study title, the findings, the methods of sampling, the tools and the design used in the studies were reviewed. At the summary level there was an examination of the gaps left out and how the study filled these gaps.

2.2 Review of Concepts of Disability

The concept of disability is broadly applied and therefore needs a proper explanation and review. The study reviewed two major schools of thought that have attempted to define disability and its related concepts. These are the Saad Nagi (1965) in his Disablement theory and the International Classifications of Impairments, Disabilities and Handicaps (ICIDH). These theories appropriately explained the concept of disability (WHO, 1980).

2.2.1 The Nagi Concept of Disability

Saad Nagi (1965) defines disability as the gap between a person's capabilities and the demands created by the social and physical environments. Disability is a limitation in performing socially defined roles and tasks expected of an individual within a social-cultural and physical environment. These limitations apply to the family, work, education, recreation and self-care. Here the disabled individual cannot function as expected by the society. One is viewed as tied by the disabilities. The other people in the society term the disabled as not able to meet their expectations. The disabled here are termed as impaired and with functional limitations as viewed by the able bodied in the society (Nagi, 1991). The disabled have to depend on those that are able bodied people and in many cases they are locked out of the common opportunities in the society that include work, recreation, employment and family participation.

2.2.2 The International Classifications of Impairments, Disabilities and Handicaps

This school of thought abbreviated (ICIDH) was developed in Europe in the early 1970's. It describes disability as a term that summarizes different functional limitations occurring in any population in any country of the world (WHO, 1980). It further says that people may be disabled by physical, intellectual or sensory impairment, medical condition or mental illness (WHO, 1980). Such impairments, conditions or illnesses may be permanent or transitory in nature. The ICIDH first component of disability is impairment, which is defined as any loss or abnormality of psychological or anatomical structure of function (WHO 1980). These impairments represent a functional limitation that restricts the person's performance.

The World Health Organization (1980) introduces the term handicap to this concept. This denotes the loss or limitation of opportunities to take part in the life of the person with a disability and shortcomings in the environment and in many organized activities in the society, for example information, communication and education. This prevents persons with disabilities from participating on equal terms. This puts the disabled at a disadvantaged position and they are locked out from various opportunities due to their disabilities (WHO 1980).

2.3 Review of the Theories of Disability

This is the review of the theories applicable to the study. The study considered the background and the proponents of the theory, the key concepts, the criticism by other scholars, the strengths and the weaknesses of the theory and its application to the study. The study reviewed the Social Model of Disability and the Bio-psychosocial Model of Disability. The term model here was applied interchangeably to refer to the theory.

2.3.1 The Social Model of Disability

The origins of the social model of disability can be traced to an essay by Paul Hunt, a disabled Briton which was published in 1966. Hunt argued that people with impairments are viewed as unfortunate, useless, different, oppressed and sick because they are unable to enjoy material and social benefits of modern society (Dressman, 2008). According to Hunt the disabled people encounter prejudice which expresses itself in discrimination and oppression (Dressman, 2008). Disability was seen as the disadvantage or restriction of activity caused by a contemporary social organization which did not consider the people with physical impairments and thus excluding them from participation in the mainstream social activities (Maroto and Pettinicchio, 2014). The Social model of disability pointed out that the society had created key disabling barriers that excluded the people with impairments. These were attitudinal barriers, physical barriers and information and communication barriers (Ferrie and Watson, 2015).

The attitudinal barriers are social and cultural attitudes and assumptions about people with impairments that explain, justify and perpetuate prejudice, discrimination and exclusion in society. Such people were seen to be in need of protection for they can’t work, can’t be independent, can’t have sex, shouldn’t have children, and they are “child-like (Ferrie and Watson, 2015). The physical barriers were linked to the physical and built environment that prevents the people with impairments from equal access to facilities such as stairs, steps, narrow corridors and doorways, toilets among many other public spaces. The information and communication are barriers linked to lack of sign language interpreters for the deaf people, lack of provision of hearing induction loops, lack of information in different accessible formats such as easily read formats and inability to have inclusive education.

These barriers identified by the social model of disability disable the people with impairments by creating exclusion, discrimination and disadvantage for them. The model proposed some solutions which mainly included provisions of whatever is disabling to the impaired people. The model likewise proposed some pillars of independent living to enable the people with impairments live well in the society. These were appropriate and accessible information, an adequate income, appropriate and accessible health and social care provision, a fully accessible transport system, full access to the environment, adequate provision of technical aids and equipment, availability of accessible and adapted housing, adequate provision of personal assistance, availability of inclusive education and training, equal opportunities for employment, availability of independent advocacy and self-advocacy and availability of peer counselling (Ferrie and Watson, 2015).

This theory has been criticized by subsequent scholars; the creation and promotion of a Bio-psychosocial Model of Disability and by the disabled people themselves. Many scholars argued that the theory was not exhaustive in addressing the issues of disability. This led some scholars like Oliver (1983) to claim that the social theory only applied to wheel chair users. The other scholars included all the disabled people (Dressman, 2008). The physically challenged people themselves held that the social model did not explain or address the specific experiences and needs of certain groups of disabled people like the mental health system survivors and people with long term health conditions. The model did little in recognizing, understanding and responding to the specific and diverse range of experiences, barriers and needs of all people with impairments. The development of the bio-psychosocial model criticized the social model as leaving out the medical and the psychological elements of disability and therefore lacking a lot of issues.

However, the social model of disability has some strengths. The model is dynamic and effective in that it focuses the social barriers and solutions to such barriers. This is a great advantage in dealing with people with impairments since the model maps out an approach to inclusion and equality that is of benefit to society as a whole, not just disabled people (Ferrie and Watson, 2015). The model also distinguished impairment from disability. Impairment is an individual’s physical, sensory or cognitive difference, for example, being blind or having dysfunctional limbs, while disability is the social consequences of having impairment (Ferrie and Watson, 2015). People with impairments are disabled by society. The model held that disability is therefore a social construct that can be changed and removed. This brought an advantage to the incorporation of the people with impairments to the society once the barriers were removed.

The theory is considered to have weaknesses in that it ignored the other elements of disability like the biological elements as well as the psychological elements. This could have led the disabled to react inappropriately to a society that was seen to be disabling them other than looking at the proper ways to adjust in their conditions in the society. The theory being concerned majorly on the physical disabilities was locking out the considerations of other forms of disability (Ferrie and Watson, 2015).

The theory was very much applicable to this study on the psychological wellbeing of the differently-abled children in Runyenjes Constituency in Embu County, Kenya. Many proponents of this theory were institutionalized people. The study aimed at finding out the way the residential care influenced the psychological wellbeing of the children under the study. The theory proposed a very positive way of referring to the disabled and this was applied directly to the study since the way the other people term them forms part of the psychological wellbeing. The theory opposed the mere reduction of disability to medical needs that can be rectified medically and to the charitable attitudes towards the disabled as people to be pitied all the time. This applied to the study that sought to find out how the differently-abled children were treated in their families, at the educational and residential places without eliciting excess care effects. The social model proposed the interventions that it referred to as the pillars of independent living. These applied to the study as it sought the interventions offered to the differently-abled children as they receive family care, the educational and the residential care and the psychological care. Finally, the key point of eradicating the social barriers applied in the study that sought how the presence of any barrier could affect the psychological wellbeing of the differently-abled children under the study.

2.3.2 The Bio-psychosocial Theory of Disability

The bio-psychosocial model was proposed by George Engel in 1977. He famously argued that medicine in general and psychiatry in particular ought to shift from a bio-medical perspective of disease to a bio-psychosocial (BPS) perspective on health. He claimed that health, wellness, and disease are dependent upon the interaction between three factors: biological or physiological factors, psychological or mental factors, and social factors. According to this model, no disease or even good health can be the manifestation of a physiological condition alone (Cromby, 2013). The wellness or the diseases of a person significantly have other determiners besides the biological element. Well-being is thus defined as an overall state of health and happiness at the biological, psychological and social levels.

The Bio-psychosocial model looks at health and disease in a variety of contexts and examines how the interaction of different factors leads to specific issues for an individual. The 'bio' component of this theory examines aspects of biology that influence health which would include things like brain changes, genetics, or functioning of major body organs, such as the liver, the kidneys, or even the motor system. The 'psycho' component of the theory examines psychological components like thoughts, emotions, or behaviours. The 'social' component of the model examines the social factors that might influence the health of an individual like our interactions with others, our culture, or our economic status (Oudenhove and Cuypers 2014). All these elements are connected. This means that biology can affect psychology, which can affect social well-being, which can further affect biology, and so on.

The theory also addresses the term disability as including impairments in body functions and structures, activity limitations and participation restrictions. These elements have negative aspects of the interactions between the biological, psychological and the sociological elements of the disabled people. Bodily impairments are problems in body function or structure such as a significant deviation or loss of a body part or a biological system (Oudenhove and Cuypers 2014). The activity limitations are difficulties an individual may have in executing or implementing activities in the society and in a social system. Participation restrictions are problems an individual may experience in involvement in life situations that require the disabled to deal with some elements of life.

There have been very many criticisms towards the theory over time. The greatest criticizers of this model are the practitioners of medicine, sociology and psychiatry. Many of the medical scholars who advocate this model argue that it shifted from the limited approaches of the past and went broader. With the three factors of physiological, psychological, and social influence to health, healthcare, and disease, the model considers the smaller picture of any biological problems at an individual level, as well as the bigger picture of psychological issues together with the effect that the society at large with its systems has on that individual in their situation.

Another positive outlook of the model is that cure, recovery, and good health are not completely in the hands of medical experts, but are also partly in control of the patients themselves. Along with medical experts taking care of the biological treatment, patients and their families can maintain a demeanour that will result in quick psychological and social recovery, which will ultimately help better and faster physiological recovery. Similarly, it advocates social support, leading to a promotion of community-based living in society (Oudenhove and Cuypers 2014). This in turn affects the general well-being of society at large for the better.

Negatively the model has been described as an inappropriate approach both in the practice of medicine as well as the training of the medical practitioners. This is because the model assumes that all mental illnesses are, in fact, bio-psychosocial. Critics feel that this would actually increase the stigma that is attached to these disorders, instead of reducing it (Oudenhove and Cuypers 2014). This assumption can also lead to confused treatment which may have grave consequences. Other critics hold that despite intensive efforts, it is very difficult to teach this model to psychiatry students in an academic setting. Not all students are convinced by the three-fold approach of the model, and are not convinced about its credibility or usefulness. Critics feel that the vagueness of the model, and giving equal importance to all three factors in every situation, can discourage prospective psychiatry students from the very beginning, thus compromising on the number of students who wish to become psychiatrists. The model would also not fit in the training of medical students since it can be confusing and misleading to the trainees who may not understand what symptom of a patient is to be categorized in which factor.

The strength of the model is that the model approaches the human issues of wellbeing holistically. This means that the disabled have physiological, psychological and social elements that need to be addressed. The model also gives the disabled an impetus for positive incentive and attitude towards themselves. The theory by describing the social aspects of disability demonstrates the role of the society in promoting the wellbeing of the disabled. Without limiting to the physiological elements only, the theory outlines other important considerations in the lives of the disabled who should not only be viewed physically but also socially and psychologically.

The weakness of the theory is that basically it was developed in the contexts of mental illnesses and diseases which may not necessarily affect the disabled. It also considered and focused on the disabled workers thus leaving out the aspects of age and capacity. This is seen to strip the disabled people generally of rights and support. This is from what the model argues as the elements that make the disabled people have fewer incentives and stop them from being self-reliant. The model also makes the disabled people develop a denial of disability as a social construct, and ultimately they end up placing the blame and responsibility for exclusion, discrimination, poverty and all that flows from this back onto them as individuals. This appears to be a way of telling the disabled that they can affirm themselves at whatever the cost which at times may not be practical.

The theory was very much applicable to the study. Firstly, the theory has a holistic approach. This study sought to find out the psychological wellbeing of the differently-abled children which constitutes of the biological, social and psychological elements. The family care, the educational and residential care and the psychological care given to the differently-abled children in Runyenjes Constituency was assumed to be revolving around the three elements of a person alluded by the theory. These are the biological, the psychological and the social. The study was evaluating whether the care given to these children was able to meet the demands of the three elements. Though the study was limited to the psychological wellbeing, the theory applied to relating the study with its other elements of social and biological as parts of the holistic wellbeing of a person. The theory also applied in this study since the psychological wellbeing of differently-bled children was seen to greatly depend on the social and biological elements.

2.4 Review of Empirical Studies

This is the review of the studies that have been done in other areas and are related to the topic of the research. The approach in this study was global, regional then local. The global approach reviewed the studies done in Europe; the regional will review those done in Africa while the local ones will be those done in Kenya. The empirical studies were guided by the research's specific objectives. The review was on the author, study title, methodology and the findings of the studies. At the end of every study there was a gap identified and how the study addressed the gap identified.

2.4.1 The Influence of Family Care on the Psychological Wellbeing of Differently-abled Children

The family care refers to the care given to the children in the homes they were born in. This care is given by the immediate relatives of the child who can include parents and siblings, as well as members of the extended family. The psychological wellbeing of these children depends on whether they receive the care or not.

A study was done in Europe and Eurasia and a report given in 2014. The countries studied were Armenia, Azerbaijan, Georgia, Herzegovina, Ukraine, Russia, Serbia and Kosovo. The title of the study was 'Towards Deinstitutionalization.' The study was done among the children and adults with motor impairments in this region. The major objective of the study was to establish the situation of legal status and policy frameworks that supported deinstitutionalization, and the transition from institutional care to family support in the region of study (Chernego, 2016).

The study methodology was a review of desktop research conducted by the authors using a wide range of resources, including information from interviews with representatives of non-governmental organizations (NGOs) working in the region. There was no direct interaction with the disabled people at all and there was no definite sample for the representatives of the people working with the disabled people. These representatives of the people working with the disabled were asked questions about the legal status and policies that would govern the process of deinstitutionalization.

The findings of the study indicated that the family stood better placed to promote the wellbeing of disabled people (Chernego, 2016). This was because most people with disabilities whether due to stigma, inaccessibility of places, technologies, services and social structures, or lack of support within the community had been isolated and segregated from their communities. They were therefore confined to institutions where they were at risk of exploitation, violence and abuse. They were also barred from meaningful participation in the life of their communities because either services were not available or communities were organized in ways that excluded them from participation. The family care was therefore to be made an alternative to institutional care. The families would provide child protection, social care, health care, and educational care to the disabled children. The other elements of the family care included feeding, sleeping, toilet training, addressing challenging behaviours, communication skills, housing, and transport among others. All these would promote the wellbeing of the disabled people in their families.

Other findings indicated that previously the family care was lacking leading to institutionalization. There was lack of specialized services for children and adults with disabilities, as well as inaccessibility of mainstream services such as education, health care, transport and childcare contributes to institutionalization (Chernego, 2016). Families lacked formal support on medical, social, and psychological services and this led many parents in the Russian Federation to place their child in an institution (Rogers, 2014).

There was also lack of a personal life, lack of autonomy and a lack of respect for one’s personal integrity which could hamper an individual’s emotional and social development (Mulheir, 2014). The findings also noted some social deprivation and taught helplessness which was described as the psychological effects of living in deplorable family situations. Language and intellectual development were also seen to be affected since some disabled children received meagre care in their families. This could also lead to various mental health problems, including aggressiveness and depression (Mulheir, 2014).

This study had various gaps as it advocated for family care. The study majorly focused on deinstitutionalization which advocated for a return to the family care system for the disabled. It was therefore evaluating the inadequacy of the institutions to care for the disabled people. There was no direct study of the families where these disabled people lived. Rather the study depended on the views of the interviewees about the ideal conditions in the families that would care for the disabled people. Though the study found out the reasons leading to disabled people being taken away from their families, it did not concern itself deeply with the care in the families and how this care would relate to the psychological wellbeing of the disabled people. There was a methodological gap where the study did not have a specific research design, methods of sampling, direct target population and primary data sources. This is because the study reviewed desktop research reports conducted by the authors using a wide range of resources like information from interviews done to representatives of the people working with disabled people.

This study filled these gaps in that it sought to establish the family care already being given to the DAC rather than give the ideal conditions of family care. There was a direct contact to the DAC living in their natural families as well as the care givers in these families. The study filled the methodological gap by applying cross-sectional research design. This had a direct contact with the target population who provided crucial information. There was also purposeful sampling of the relevant target population which provided relevant data.

There was an empirical study on family care that was conducted in Nigeria. The study was entitled 'The burden experienced by family caregivers of patients with mental disorders at selected hospitals in Ekiti state, Nigeria' in 2014. This was done by several scholars like Ajibade B., Ajao O., Fabiyi B, Olabisi O. Akinpelu A. among others. The Methodology employed was descriptive design using 138 respondents as sample size using Leshie Kish formula. The study was delimited to the family caregivers of mentally ill patients attending psychiatric outpatient clinics of two tertiary hospitals in Ekiti State. The target population for this study was family caregivers of patients with mental disorders in the psychiatric outpatient departments.

The findings of the study indicated that caring for the disabled people was a high burden. This was associated with the amount of time spent caring for them, lack of finance and trying to meet other responsibilities (Fabiyi, 2014). With the advent of deinstitutionalization of the disabled people globally there had been an increased burden on the patients' closest relatives in many countries. The caregiver was usually found to be responsible for providing assistance to the patients in performing their activities of daily living which included; bathing, eating, cooking, dressing; taking medications, and hospital follow-up attendance (Ajao, 2014). This burden was seen as a multi-dimensional concept reflecting physical, psycho-emotional, social and financial consequences arising from caring for an impaired family member (Sahoo, 2014). This implied that the care given to the disabled people in the family lacked in many elements.

The study in Nigeria had some gaps. Methodologically the study employed a descriptive design which may have left out important data. The study also targeted only the parents who were taking care of the people with mental disorders. It focused on the caregivers and had little or no focus on the recipients of the care given in the family. The study was also conducted in selected hospitals where the scholars encountered the patients who were brought on some days for check-up. This means that the scholars did not encounter the patients in their real setting at their families. The researchers gave the recommendations of home care for the patients without going deep into the situations at the families.

This study filled the gaps by focusing on the family members who offer family care to the DAC as well as the differently-abled children in their families. Unlike the study in Nigeria the proposed study used cross-sectional research design which was aimed at giving more comprehensive data in the area of study. This research studied the care given to the DAC in their families and their psychological wellbeing. This therefore related the family care to the psychological wellbeing of the DAC. This element was lacking in the study in Nigeria since the outcome of the care given in the family was not found out as the study focused only on the caregivers and not on the recipients of the care.

In South Africa a study entitled ‘Breaking the curse of disabled children in South Africa’ was done. This was by Natasha Ghoneim in 2015. It was a case study of Lesley Mashimbye, a 13-year-old boy suffering from cerebral palsy and spinal bifida. The findings of the study indicated that in South Africa children with disabilities were often viewed as a curse by their families. This led to the conclusion that the family care would not be offered properly to the disabled children due to the negative mentalities towards them by the family members.

This case study had a methodological gap in that it lacked vital information from a larger target population. It also did not specify the outcome of the family care given or not given to the disabled children. The study also concluded that there were possibilities that the family care was not offered at all to the disabled children due to the negative mentalities towards them.

This study filled this gap by getting information from a target population of the DAC who provided comprehensive information on the family care given to the DAC in Runyenjes Constituency. The study also focused on the outcome of the family care given to the DAC by assessing their psychological wellbeing after receiving or not receiving the natural family care.

In Ghana there was a study entitled ‘The Family and Disability in Ghana: Highlighting Gaps in Achieving Social Inclusion’. This was done by Maxwell Peprah Opoku, Beatrice Atim Alupo, Naomi Gyamfi, Lois Odame, Wisdom Kwadwo Mprah, Eric Lawer Torgbenu and Eric Badu. It was done in 2012. This study aimed at examining the family support and its impact on the lives of persons with disabilities in Ghana. The study participants were 48 persons with physical, hearing and visual disabilities. These were purposefully sampled from the members of Disabled Peoples’ Organizations. They were conveniently drawn from 4 districts in the Northern region of Ghana. All participants were interviewed using a structured interview guide which was developed from the literature (Aldersey, 2012. The researchers performed content analysis, following O’Leary’s (2010) six steps in analysing qualitative data.

The findings of the study indicated that most participants lacked the support and provision of basic needs from their families. Some participants bemoaned rejection by their families, where they were hidden and deprived of very basic needs. On the other hand, a few participants (7) mentioned that their families were willing to help them, but poverty was a barrier to giving assistance. This denied them the opportunity to access productive activities that could improve their living conditions. Others indicated that they lacked education and educating them was regarded as a waste of resources (Opoku, 2015). Other families were found to delegate their care giving responsibility to care takers or even keep their children with disabilities in respite homes (Nakade, 2017; Sauer and Lalvani, 2017). Other revelations of the studies indicated that siblings were unable to support each other or grow up together and develop a strong relationship (Jacobs and MacMahon, 2017). The effect of this was that persons with disabilities could grow up with low self-esteem, perceiving themselves as dependents on others in the society.

The study also found that the family is yet to come to terms with the capabilities of persons with disabilities without viewing them from the medical perspective, that is, as individuals with defects. Families seemed uninterested in the well-being of the study participants, which had put them at a disadvantage in the society. Persons with disabilities were consistently seen as liabilities, and this explains why families denied them the chance to have access to necessities of life such as education (Aldersey, 2012). The social order was usually against the education of persons with disabilities who were seen as individuals who needed to be supported to live, rather than be empowered to be independent (Baffoe, 2013).

The study in Ghana had some gaps. Methodologically it only applied qualitative approach which left out the crucial quantitative information. It also applied only structured interview guide which was based on existent literature. This may have limited the participants in their participation for they were led to fit in the structure of the researcher. It also focused only on the recipients of the family care leaving out the caregivers in the family setup who would have vital information as well.

This study filled these gaps by using other instruments like questionnaires and in-depth interview guide. The study also targeted the chaplains and the guidance and counselling teachers together with the DAC who are the recipients of the family care. This enriched the data on family care and the psychological wellbeing of the DAC.

In Kenya, there was a study done in Turkana. It was entitled ‘Childhood disability in Turkana, Kenya: Understanding how care takers cope in a complex humanitarian setting’. This was done by Maria Zuurmond, Velma Nyapera, Victoria Mwenda, James Kisia, Hilary Rono and Jennifer Palmer. This study was conducted in September 2012 and May 2013. The study was based on in-depth interviews with 31 families, key informants and focus group discussions in Turkana, Kenya. It explored the lives of families caring for children with a range of impairments. The study employed four qualitative interviews to the children with disabilities, the care takers of these children, their parents and key informants including village elders, hospital and clinic-based staff, community health workers and teachers. Two focus groups were also conducted and detailed notes were taken appropriately.

The findings of the study revealed that having a child with disability impacted the whole family, generating specific challenges related to caring, income generation and the psychosocial health of the care takers especially the women (Kisia, 2012). The stigma and shame associated with having a disabled child was pervasive and influenced how children were cared for. It also affected the wider support like provision of assistive devices as well as the difficult terrain for a wheelchair, toileting and the personal care of children, and limited access to water. The children with disabilities were more likely to be malnourished than their able-bodied peers and even their siblings (Kuper, 2015).

The study in Kenya had some gaps. It only applied qualitative in-depth interviews which may have led to concealing of some vital information since the respondent would not like to expose themselves fully. The study did not show the implications of the family care to the psychological wellbeing of the children with disabilities but was concerned basically on how the caregivers coped with their situation.

This study applied other tools for data collection like standardized questionnaires that enriched data on family care to the DAC. This study also focused on the outcome of the family care to the DAC which is their psychological wellbeing rather than being stuck only at the caregivers.

All the findings of the studies on the family care given to the DAC indicated that the psychological wellbeing of the differently-abled children in the region of study was at stake. The care at their families was affected by the poverty of the family, the stigmatization by the community, the lack of basic care practices and the difficulties the caregivers had in caring for them.

2.4.2 The Relationship between Residential Institutionalized Care and the Psychological Wellbeing of Differently-abled Children

Residential institutional care is the care given in the small homes, orphanages, charitable institutions to the differently-bled children (Browne, 2009). This is different from the family care in that the differently-abled children do not live with their biological or adoptive relatives. Institutionalization of children with disabilities is the placement of children, who have been abandoned or whose parents cannot support them, into a facility which can be similar to an orphanage. Mostly the children are many in number unlike in a family set up where the differently-abled child may be only one or just a few.

There was a study done on residential care in England by Sir Martin Narey. It was entitled "Independent review of children's residential care". It was conducted in July 2016. The study method was just interview and focus group discussion. The study applied a sample of 158 children out of a total of 376 children who were living in and with experience of living in a residential care. All these children were not necessarily disabled.

The findings of the study indicated that there may be more than one reason for a child being placed in a residential institution, but the primary reason is their abuse or neglect followed by family dysfunction (Narey, 2016). This abuse caused the placement of the children whether they were disabled or not. According to the study three quarters of residential institutions were good or better with some genuinely outstanding. This therefore implies that the care taken on the children in the residential centres was promoting the psychological wellbeing of the children in those centres and therefore attracting many children.

This study had gaps in that it lacked a defined research design. It also focused only on the children in the institutions without considering the caregivers who provided the care. It also did not specify the elements of the care given to the children in the residential centres. The study also focused on disabled and able-bodied children ignoring the fact that they have different needs and psychological orientations. This study filled these gaps in that it applied a cross-sectional research design in the residential institutions in Runyenjes Constituency. This study also looked at some elements of residential care like provision of basic needs, integration in the institution, protection from abuse and fair treatment. It also involved the caregivers in the residential institutions. This study purely focused on the DAC in the residential institutions examining the implications of the care they receive to their psychological wellbeing.

Another study was conducted in western and central European countries of the European Union (EU) by Kevin Browne together with some other researchers in 2015. It was entitled ‘The effects of institutionalization and living outside of family care on children's early development’. The study focused on behavioural consequences of institutionalization compared to family-based care. The methodology applied by the study was a review of the previous reports and studies done on the effects of institutionalization of the children.

The findings showed that institutions negatively affected the child's social behaviour and interaction with others, as well as negatively affecting the formation of emotional attachments. Additionally, institutionalization was linked to poor cognitive performance and language deficits (Browne and Chou, 2015). Institutionalization of children was also found to have led to developmental delays due to the absence of physical stimulation and presence of daily neglect, motor skill delay, inadequate brain development, impairment in social and cognitive skills, and speech impediments (Browne, 2015). Attachment disorders were also found leading to harmful self-inflicting actions, anxiety disorders, eating disorders, as well as difficulty in forming healthy relationships (Browne, 2015).

The study had some gaps as it only reviewed the previous reports on institutionalization without going to a specific locale. It only depended on the secondary data from the reports of other studies done elsewhere. It left out the elements of the care in these institutions and focused directly on the effects of the care.

This study had a specific area of study, that is, Runyenjes Constituency in Embu County Kenya. This allowed collection of primary data with application of cross-sectional research design. The study also looked at the elements of the care given to the DAC in residential institutions like provision of basic needs, integration in the institution, protection from abuse and fair treatment assessing how these elements influenced the psychological wellbeing of the DAC in the residential institutions.

Another study was done in Zimbabwe. It was entitled ‘Psychosocial challenges faced by children in residential care facilities’. This was conducted by J. C. Makhubele, A. T. Mukushi, V. Mabvurira, F. K. Matlakala in 2017. This study sought to examine the psychosocial challenges facing children in residential childcare facilities in the Mashonaland Central province, Zimbabwe. In the methodology the study adopted a qualitative approach and used a case study design. The study used a sample of 44 children from a children’s home in Bindura town, Mashonaland Central province and 3 key informants who were caregivers participated in the study. The study used purposive sampling in identifying participants for interviews and focus group discussions. Data were analysed using a thematic content analysis.

The findings of the study indicated that the children in residential care facilities face a myriad of challenges that range from a lack of attachment with caregivers, peer relationships to a lack of proper adult guidance, identity, and a family with shared values. This is because these children are affected by peer pressure, discriminated against by society, and also face challenges in adapting to the institutional life (Matlakala, 2017). These psychosocial challenges that the children faced were seen to affect their confidence and self-esteem. This subsequently caused a wide range of problems for their development, well-being and longer-term outcomes. Institutional care was also found not to adequately provide the level of positive individual attention from consistent caregivers which is essential for successful emotional, physical, mental, and social development of children (Makhubele, 2017). The other common issues for children in institutional care were a significantly increased risk of sexual and physical abuse, a lack of stimulation, and harsh discipline. Children in institutions were less likely to attend school, and were frequently isolated from their traditional communities. Long periods in an institution made it harder for a child to assimilate back into a family and community, and denied them access to the life-long attachments and community support systems that family relationships and communities can provide (Makhubele, 2017).

The study in Zimbabwe had some gaps. Methodologically it only used interviews which would limit the information given. As it focused on the psychological challenges of the children in residential facilities it left out the elements of the care given to these children. It also focused on all the children in the residential facilities without considering whether they were disabled or able bodied.

This study together with interview used standardized questionnaires on psychological wellbeing so as to get comprehensive data. The study also studied three residential institutions in the area of study and thus obtained a wide range of information rather than one case study. The study focused on the DAC in the residential institutions focusing on the elements of the care given to the DAC in these institutions and the implications of this care to the psychological wellbeing of the DAC.

In Kenya there was a study done entitled ‘Institutionalization of children in Kenya: A child rights perspective’. The aim was to find out whether institutionalization of children in Kenya neglect a child rights based approach. This was done by Stephen Ucembe in June 2015. The methodology used was a review of the available materials on institutionalization.

The findings of the study revealed that the general wellbeing of the disabled children was at stake with institutionalization. The core indicators for this were abuse, exploitation and neglect within the institutions, as well as, a litany of long term social, psychological and emotional damage associated with institutionalization (Ucembe, 2015). The findings also agreed with those of Browne (2009) that children in institutional have reduced intellectual, social and behavioural abilities compared with those growing up in a family home. In most of the circumstances these children are disempowered, and cannot influence the process of placement, or consulted to determine their wishes before placement to institutions. The findings also indicated that in the institutions the children ended up with inadequate or no individualized care that is pertinent to survival and development (Ucembe, 2015).

The study in Kenya had some gaps. It lacked primary source of information since it was a review of the secondary data from the reports of studies done elsewhere. It also concluded that the care in the residential institutions negatively affected the children in those institutions. Its focus was on able bodied children who have different orientations from the differently-abled children. The study also did not point out the elements of residential care that would influence the children in them.

This study was conducted in a locale with DAC and people who interact with them. This provided primary data by applying cross-sectional design with purposeful sampling method. The study focused on particular elements of residential care like provision of basic needs, integration in the institution, protection from abuse and fair treatment and the implications of these elements to the psychological wellbeing of the DAC in them. This study also focused on the differently-abled children who have different psychological orientation from the able bodied children.

2.4.3 The Implications of Educational Care on the Psychological Wellbeing of Differently-abled Children

Educational care involves the care given to the differently-abled children in the learning institutions as they go through formal education programs. The differently-abled children mostly come from their families or from the residential institutions as they undergo formal education. Educational care is implicated in the inclusive education which is a new approach towards educating the children with diverse abilities and learning difficulties with that of normal ones within the same manner (Dreyer, 2017). The educational care has great influence on the psychological wellbeing of differently-abled children as indicated by various studies.

A study was done in the United Kingdom in 2016 by the Institute of Education. The methodology applied was a review of various reports on special needs. The findings of the study indicated that not all children and young people with special education needs had a learning disability. For this reason, educational care was deemed very vital to the children with special needs. Other revelations of the study indicated that the children with special needs were likely as other children to be bullied regularly (Institute of Education, 2014). This was seen to hurt the disabled children both physically and emotionally more than those without a learning disability

(Chatzitheochari, 2016). This had a lot of psychological implications to the wellbeing of these children due to lack of educational care in these schools.

The study in United Kingdom had some gaps. It only reviewed the previous reports on children with special needs. Its findings also revealed bullying of the children with special needs as the great call for educational care. Though it admitted that not all children with special needs had learning disabilities, it did not specify the elements of educational care.

This study applied cross-sectional research design on a specific locale of Runyenjes Constituency to obtain primary data. It also had a definite target population of the DAC in educational institution as well as the guidance and counselling teachers in these institutions. The study assessed the elements of educational care like availability of facilities, co-curricular activities and staffing and their implications on the psychological wellbeing of the DAC.

Another study was done in Mauritius University in 2016. The title of the study was "Forgotten, excluded or included? A case study of students with disabilities at the University of Mauritius". The study was done by Sameerchand Pudaruth, Rajendra P., Gunputh Upasana and G. Singh. The aim of the study was to find out whether the University of Mauritius had sufficient facilities to support disabled students and whether there were additional structures for the students with disabilities. The research design and methodology applied was the use of an online self-administered or self-completion questionnaire which included a mixture of open-ended and closed questions to collect the data. The population for this study was only 500 students, which represented about 4% of the total student population of the University of Mauritius. The sample selected adopted a combination of convenience and purposive sampling of students of university of Mauritius. The quantitative responses were analysed using simple data analysis techniques, while the qualitative data were extracted into themes for discussion

The Findings of the study indicated that despite being aware of the fact that there are students with disabilities at the University of Mauritius, 80 respondents (65.6%) mentioned that they were unaware of the amount of funds that are injected by the University of Mauritius in order to provide the necessary facilities and support structures for students with disabilities (Sameerch, 2016). This according to the study indicated the lack of some support structures, such as student liaison officers, appropriate recreational and sport facilities and special access features for students with disabilities.

The study in Mauritius had some gaps. Methodologically as it applied a case study design, it only used online questionnaires which may have left out some vital information about the facilities in the university. It also limited educational care to provision of facilities of learning and sports since it aimed at assessing the amount of funds set for such facilities in the university. It was also concerned with university education undertaken by disabled people who may have adjusted to their disabled situations over time.

This study used cross-sectional design to study three educational institutions in Runyenjes Constituency. It also used Ryff's standardized questionnaires and in-depth interview so as to get comprehensive data. The study assessed the elements of educational care like availability of facilities, co-curricular activities and staffing and assessed the implications of these elements to the psychological wellbeing of the DAC. The study focused on children in primary schools who were at their formative ages and requiring special attention for their psychological wellbeing.

Another study entitled 'Inclusive education in Tigray province Ethiopia' was conducted by Franck and Joshi in 2017. The aim was to examine how inclusive education was being implemented at rural and urban schools in Tigray province. The research design was cross-sectional design that used interviews, participant observation, and focus groups as instruments of data collection. The findings were given as a report with little scientific implications.

The findings of the study that teachers and school administrators were generally in favour of mainstreaming children with disabilities into normal schools. Many participants mentioned the physical presence of children with disabilities interacting with classmates at school could facilitate attitudinal change in the community (Franck and Joshi, 2017). Changing attitudes and community outreach helped to expand enrolment of children with disabilities. However, insufficient training of teachers and itinerant teachers along with shortages of teaching materials and resources presented major challenges to addressing special education needs.

The study in Tigray had some gaps. It did not seek specifically the elements of educational care and the implications of this care to the psychological wellbeing of the DAC. This study assessed the elements of educational care and assessed how these elements influenced the psychological wellbeing of the DAC. This study did not be merely aim at writing a report on inclusive education but went further to look at the implications of educational care to the DAC who go through it.

In Kenya there was a study done by Boit Chepkirui Joyce in 2016. The title of the study was ‘Extent of Success in Implementation of Inclusion of Special Needs Children’s Access and Participation in Pre-Schools, in Kericho County’. The study sought to find out the extent to which children with special educational needs were enrolled in preschools of study, the available facilities needed in the inclusive schools and the training of teachers to handle children with special educational need. The methodology used was a qualitative case study of two public pre- schools that practiced inclusion in Kericho County. The case study employed purposive sampling of two public preschools administrators and teachers for the purpose of comparison although the study itself was not comparative. The target population was school administrators, regular schools teachers and education assessment resource centre officers in Kericho County. The study employed interviews, questionnaires and observations schedules in data collection.

The findings of the study revealed that all schools in the area of study reported inadequate facilities and resources as well as irrelevance of the available ones. It was also revealed that general curriculum teachers lacked basic skills in handling learners with special educational needs. The two schools studied experienced shortage of teachers trained in special educational needs and those present were unable to handle individual educational needs of the disabled children making inclusion an illusion. The implication from the study was that there was hardly any educational care offered to the differently-abled children in the region under study.

The study in Kericho had a gap in the target population. It focused mainly on school administrators, regular teachers and education assessment officers. This left out the pupils who are the direct beneficiaries of inclusive education. This study included the differently-abled children who learnt in the schools in Runyenjes Constituency. This l enriched the data from the chaplains and guidance and counselling teachers from these schools. The DAC also gave first-hand information and experience about the educational care they receive in relation to their psychological wellbeing.

Another study was done by Esther M. Mwangi in 2014. The title of the study was 'Challenges Facing Implementation of Inclusive Education in Public Primary Schools in Nyeri Town, Nyeri County, Kenya'. The study sought to find out the status of implementation of inclusive education in Nyeri town and the factors hindering this implementation. The study adopted a descriptive survey design. The target population of the study was all the 42 head teachers of the public primary schools in study locale, 538 primary school teachers and 40 ministry officials. The research instruments used to collect data included an observation checklist, a questionnaire, and an interview schedule. Data analysis was done using the statistical package for social sciences (SPSS) to generate descriptive statistics.

The study revealed that there were inadequate teaching and learning materials such as a favourable curriculum, equipment and other facilities which had the greatest representation cited by 40% of the total number of respondents. This was closely followed by insufficient teacher training and experience cited by 32.5 % of the total number of respondents. The study also revealed that there were several socio-economic and cultural factors that constraint effective teaching and learning in most sampled schools. The main factors that hindered inclusive education were stigmatization, negative attitudes from members of the society and parental ignorance. Geographical distance between schools and homes forced the concerned parents to take their disabled children to school daily and to pick them up after school which proved cumbersome to the parents and as a result, most parents opted to keep their children with learning disabilities permanently at home to avoid such inconveniences.

The study in Nyeri had a gap on the target population. It completely left out the learners who are direct beneficiaries of inclusive education. This study involved the differently-abled children who undergo formal education in the three schools in Runyenjes Constituency that offer education to the DAC. This gave first-hand information and experience about the educational care they receive in relation to their psychological wellbeing.

A study was done in Embu County in 2012 by Njiru Onesmas. The study was entitled 'Constraints Facing Inclusive Education for Children with Special Needs in Public Primary Schools in Embu East District, Embu County, Kenya'. The focus of the study was on the resources provided for inclusive education, factors enhancing it and the difficulties faced by children who go through inclusive education.

The study adopted descriptive survey research design and targeted all the head teachers and teachers in the 70 public primary schools in the district. Interval sampling technique was adopted to select the 12 participating schools and purposive sampling to select the participants.

Data were collected using questionnaires and observation checklist which were validated through piloting. The presentation used percentages and frequency distribution tables.

The findings indicated that the schools in the area of the study were not well equipped with physical and teaching/learning resources to support inclusive education. The financial support from the government was inadequate with delayed remittances. Moreover, few severe cases of learners with special needs enrolled requiring support from their parents, siblings and peers were reported (Njiru, 2012).

The study in Embu had a gap in that it left out the learners and other providers of care to the DAC. As it focused on the head teachers and the regular teachers it did not include the direct beneficiaries of inclusive education who are the learners. This study included the differently-abled children who undergo formal education in the three schools in Runyenjes Constituency that offer education to the DAC. This provided first-hand information and experience about the educational care they receive in relation to their psychological wellbeing. The study in Embu also focused only on material provision and left out other elements of the psychological wellbeing of the disabled children. This study focused on other elements of educational care like facilities, staffing and co-curricular activities. This enriched the information about the educational care of the DAC in the schools and how this care related to the psychological wellbeing of the differently-abled children.

2.4.4 The Psychological Care Offered to Differently-abled Children on their psychological wellbeing

Psychological care refers to the provision of support in terms of psychological, social and spiritual needs (Legg, 2010). It involves helping the individuals to deal with how they view themselves as individuals, what is important to them and how their relationship with others may affect their decisions in their lives (Hodgkinson, 2008). The differently-abled children in their families, residential and educational institutions require some specialized psychological support interventions in terms of general counselling and pastoral care. Generally, the psychological support interventions would mean any activities used to modify behaviour, emotional state, or feelings of the differently-abled children.

There was a study done in Ireland. It was entitled ‘Social Factors Associated with Family Resilience’. This was by Choi and Yoo in 2015. The aim was evaluate the resilience of the families of disabled children and how this resilience would help them assist their disabled children. They undertook a survey of 175 parents of children with autism. The sampling was purposively done so as to select only the families that had autism. They used questionnaires and in-depth interviews.

The findings of the study indicated that social factors associated with family resilience included family cohesion, close family relationships, social competence and social support. These factors helped the families to be integrated even as they were caring for the disabled children. Having strong supportive relationships within families caring for a person with intellectual disability was considered to be a protective factor associated with resilience (Choi and Yoo, 2015). The findings also indicated that the family’s ability to pool resources together and to stay connected as they cared for the disabled children was a sign of resilience. This also enabled proper communication skills to the disabled children (Choi and Yoo, 2015). The cohesiveness and resilience of the family members of the children with disabilities promoted the wellbeing of the children since they remained better placed in their families.

The study in Ireland had some gaps. It focused only on the parents of the disabled children and the support they would get so as to care for their disabled children. There was little or no attention to the children themselves. This study assessed the impact of counselling and pastoral attention to the DAC. This provided sufficient information about how the differently-abled children were assisted to live in their states by counsellors and chaplains who aimed at promoting the psychological wellbeing of the DAC.

Another study was done on the psychological interventions in the learning institutions in Rwanda. The study title was ‘Strategies of Early Interventions on Academic Performance of Learners with Physical Disabilities in Primary and Secondary Schools in Two Selected Districts, Rwanda’. This was done by Jean Twagirimana in 2016. The purpose of this study was to determine the strategies of early intervention on academic performance of learners with physical disabilities in special primary and secondary schools. The study used a descriptive survey research to find out teacher professional education level and the materials involved in providing early interventions in special needs education. The target population of parents, learners and teachers was 1,673. In the study purposive and simple sampling techniques were used to select teachers and parents while stratified sampling was used in selecting learners. The study used questionnaires, interview guide, focus group discussion and observation checklists as the instruments to collect data. Descriptive statistics was used to present and analyse the results of the study.

The findings of the study showed that educational programs were not delivered as effectively as expected because of the big number of teachers not qualified in the area of special needs education. It was also noted that early interventions were not provided as well due to the lack of experts in that area. The materials used by teachers in delivering early interventions were inadequate despite the fact that regular education teachers improvised materials, models and adaptations to enhance academic performance of learners.

The study in Rwanda had some gaps. It purposed to merely examine the professional preparation of the teachers who provide early interventions and the materials used for early interventions. It left out the other practical activities of psychological support to the disabled children. This study examined the psychological care offered to the DAC in Runyenjes

Constituency and how this care influenced directly the psychological wellbeing of the differently-abled children. This study examined how general counselling and pastoral care impacted the psychological wellbeing of the DAC in the area of study.

The study in Rwanda also limited itself to the disabled children in schools. This left out those others not in schools who also required psychological support. This study examined how general care and pastoral care was provided to all the DAC in the area of study whether at families or in residential and educational institutions. This study provided the information about the psychological care offered to the DAC wherever they were found and examined the impact of this care to the psychological wellbeing of the DAC in Runyenjes Constituency.

In Kenya there was a document in October 2015 from the Ministry Of Labour Social Security And Services; Department Of Children Services. The title was ‘National Psychosocial Support Guidelines for Orphans and Vulnerable Children in Kenya’. These were basically guidelines to streamline and operationalize the psychosocial support services for orphans and vulnerable children in the country by families and the community at large. The methodology for this was an assessment of other researches done on psychological interventions to the children with disability in institutions both residential and educational internationally. The report indicated that the psychological care comprised of the interventions like problem solving, planning and decision making, stress management, negotiation, assertiveness, using culturally appropriate coping mechanisms, and ability to assess strengths in relation to needs (Ministry of Labour, 2015). The disabled children would also be assisted to develop emotional wellbeing which was described as an individual’s capacity to live a full and creative life and the flexibility to deal with life’s inevitable challenges (Ministry of Labour, 2015). The interventions were also to lead the disabled children to the intrapersonal area that concerned the individual’s ability to know and to manage him or herself, be in touch with one’s life and embrace a sense of self-worth, control over behaviour, realistic beliefs, spiritual appreciation or belief in purpose, independence, feeling safe and happy, appreciation of others and hope for the future (Ministry of Labor, 2015).

This report had a methodological gap. It did not have a specific target population, research design, sample size, area of study and findings. It was merely a guideline based on other researches. This study was conducted in Runyenjes Constituency and targeted the differently-abled children in the families and in the residential and educational institutions in that area. This gave first-hand information about the psychological care offered by the guidance and counselling teachers and the chaplains practically. This study further examined the impact of this psychological care on the psychological wellbeing of the DAC in Runyenjes Constituency.

2.5 Summary of Literature Review and Identification of the Research Gap

In all the study reviews done there were identified gaps that made this study relevant. Methodologically the specific research design was lacking especially where the reviews were reports of previous researches. Other studies lacked sample sizes and sampling procedures and techniques. There was also a gap on the target population whereby many studies focused on the children with intellectual disability, children with autism, the caregivers who attended to the disabled children and only the disabled children who were in the institutions. Although many studies reviewed used questionnaires, focus group discussion and interview guides, many directed these instruments to other target population who were not the disabled children thus not getting first-hand information and experience about the care the DAC received.

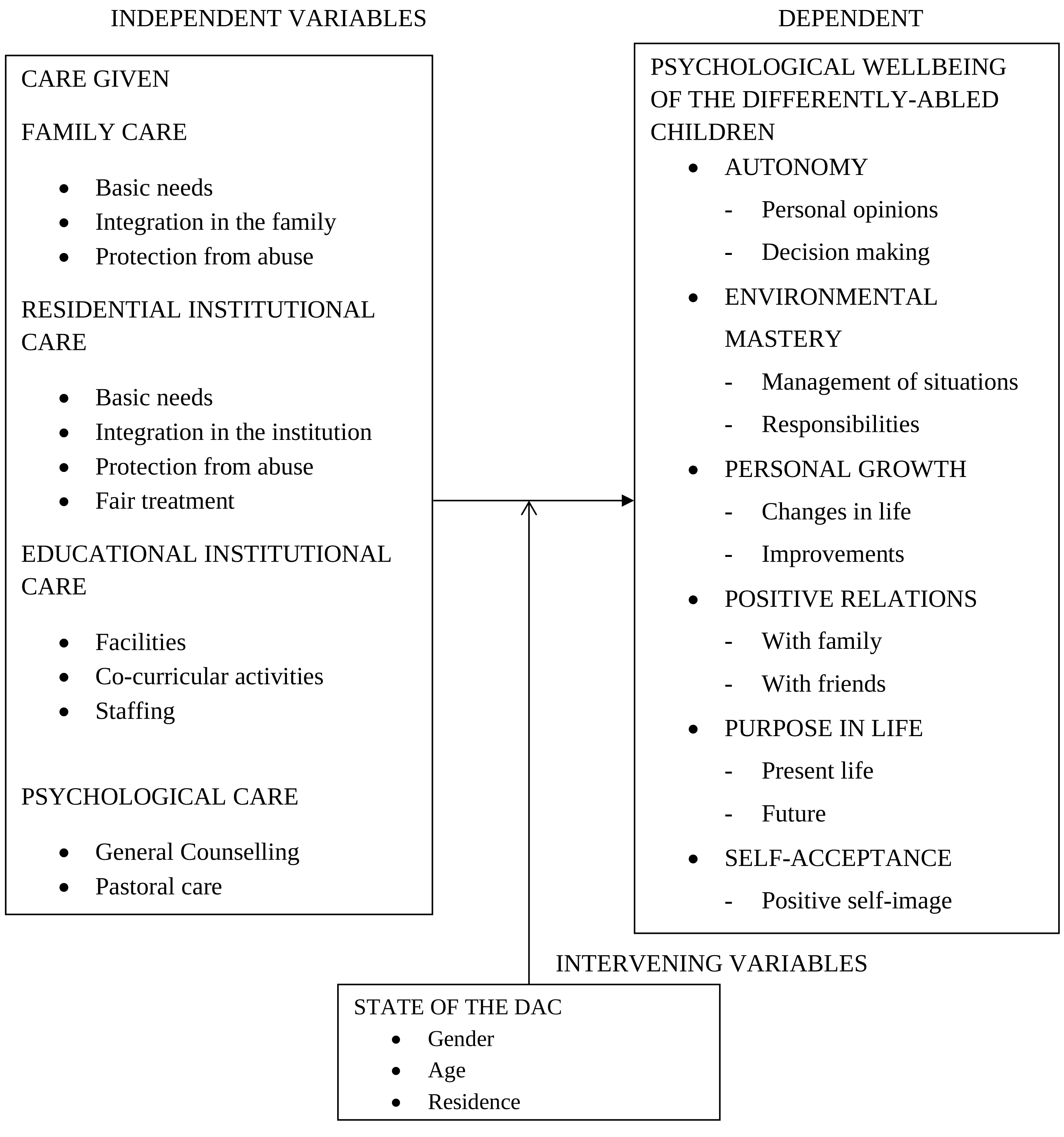
The other gaps from the reviewed studies were on the findings. There was generalization of the information about the care the disabled children receive at homes and in the institutions. The findings on family care indicated that poverty, stigmatization and negligence were the key barriers to caring for the disabled children. The residential institutions were also found to be avenues for abuse and molestation of the disabled children. The educational care was based merely on the teachers' qualifications and material provisions which were found out to be lacking. The findings in general ruled out possibilities of care to the disabled children in families and institutions based on the fact that the caregivers were poor, untrained and overburdened.

This study addressed these gaps by having a cross-sectional research design done in Runyenjes Constituency. The study also targeted the DAC in families, residential and educational institutions, guidance and counselling teachers and the chaplains. These were purposefully sampled since they would provide vital information. The study focused on the three residential and educational institutions where the DAC were found. This area was specifically chosen for proper assessment of the care at the families and residential and educational institutions. Unlike the reviewed studies that advocated for where the disabled children are to be placed, this study examined the care in families and residential and educational institutions and assessed how this care influenced the psychological wellbeing of the DAC. This is because the DAC were in the three environments of families, residential and educational institutions. Following from the findings the study gave recommendations on the care in the three environments based on the promotion of the psychological wellbeing of the differently-abled children in Runyenjes Constituency.

2.6 Conceptual Framework

Maxwell (2004) and Hurberman (1994) defined a conceptual framework as a visual or written product that explains either graphically or in narrative form, the main themes to be studied, the key factors, variables and their presumed relationships. The independent variables in this study were the types of care given to the differently-abled children in the families, at the residential institution and at the educational institution and the psychological care. The dependent variable was the psychological wellbeing of these children once they receive the care in the family or in the residential and educational institutions. The indicators of the psychological wellbeing included autonomy, environmental mastery, positive relations, personal growth, purpose in life and self-acceptance.

Figure 1: Conceptual Framework



INDEPENDENT VARIABLES

CARE GIVEN

FAMILY CARE

- Basic needs
- Integration in the family
- Protection from abuse

RESIDENTIAL INSTITUTIONAL CARE

- Basic needs
- Integration in the institution
- Protection from abuse
- Fair treatment

EDUCATIONAL INSTITUTIONAL CARE

- Facilities
- Co-curricular activities
- Staffing

PSYCHOLOGICAL CARE

- General Counselling
- Pastoral care

DEPENDENT

PSYCHOLOGICAL WELLBEING OF THE DIFFERENTLY-ABLED CHILDREN

- AUTONOMY
  - Personal opinions
  - Decision making
- ENVIRONMENTAL MASTERY
  - Management of situations
  - Responsibilities
- PERSONAL GROWTH
  - Changes in life
  - Improvements
- POSITIVE RELATIONS
  - With family
  - With friends
- PURPOSE IN LIFE
  - Present life
  - Future
- SELF-ACCEPTANCE
  - Positive self-image

INTERVENING VARIABLES

STATE OF THE DAC

- Gender
- Age
- Residence

The dependent variable and the independent variables related to the study. The care given to the DAC in the family, residential and educational institutions would influence their psychological wellbeing. The elements of the psychological wellbeing would be traced to the care given in these environments. The intervening variables were gender, age and the environment or the residence of the DAC. Being a male or a female of a certain age combined with the care given at family, residential and educational institutions would add up to the psychological wellbeing of the DAC. The study aimed at finding out whether the care is provided or not and how this influences the psychological wellbeing of the DAC.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter covered the locale of the study, the research design, the target population of the study, the description of the sample and sampling procedures, the research instruments, data collection procedures and the data analysis procedures.

3.2 Locale of the Study

This study was conducted in Runyenjes Constituency, Embu County, Kenya. It is on the upper part of Embu County comprising of Embu West, Embu East and part of Embu North sub-counties. It has an estimated population of 160,000 people out of which an estimation of 300 have motor impairments (Embu County Integrated Development Plan 2020). This area has three residential institutions attached to three public primary schools bearing similar names. They are Kivuria, Kevote and Nthagaiya rehabilitation units and primary schools. These institutions take care of differently-abled children. The differently-abled children are placed in these institutions by their relatives while other differently-abled children live in their families. The differently-abled children are provided with family care, residential and educational institutional care as well as psychological care.

3.3 Research Design

A research design is a strategy for planning and conducting a research study (Kombo& Tromp, 2006). The choice of a good research is based on the fact that the design is able to provide optimal results of the study (Severani and Bougie, 2009). This study adopted a descriptive research design. This design aims at accurately and systematically describing a population, situation or phenomenon using a wide variety of research methods to investigate one or more variables. (Oso, 2016). The approach was that of mixed methods that involved quantitative and qualitative data collection. The quantitative used the questionnaires while the qualitative used the interview guides as the tools for the data collection. Under the descriptive design the study applied the cross-sectional survey design is a design which collects data from a target population at one point in time (Oso, 2016). The data is collected from various cases of the population and then makes a report based on the data collected at once with no intention of going back to the same population to collect the same data for the same study. The aim of cross-sectional studies is to obtain reliable data that make possible to generate, robust conclusions, and create new hypotheses that can be investigated with new research as it investigates causal and effect relationships. This makes cross-sectional studies particularly useful for studying a particular phenomenon, whether it is assumed to be the cause or the consequence, or both in a defined population (Zangirolami, Echeimberg & Leone, 2018).

3.4 Target Population of the Study

The target population of a research is the larger population from which a sample is drawn and to which the researcher intends to generalize his or her findings (Oso, 2016). The target population of this study was 80 differently abled children living in their families and in residential institutions in the area of study (Data from County Social Services Department, Embu County). These were the DAC who lived together with their family members as well as in the 3 institutions in Runyenjes Constituency in Embu County in Kenya from where they receive care. The study also targeted 5 chaplains who work with the differently-abled children and 5 guidance and counselling teachers working with the differently-abled children. This is because they were considered to be the overseers of the spiritual and psychological care of the DAC in the institutions and in the families in the area of study. The population is shown in Table 1

Table 1: Target Population

Category of Respondents	Number Available
Differently-abled children in natural families and in residential and educational institutions	80
Guidance and Counseling teachers in public primary schools	5
Chaplains in the area of study	5
Total	**90**

3.5 Description of Sample and Sampling Procedures

3.5.1 The Sample Size

Creswell (2000) describes sample as a number of individuals for study in such a way that the characters selected represent the large group from which they were selected. This research conducted a census study. A census study, also called complete enumeration is the one that involves the study of every unit, everyone or everything in a population (Oso, 2016). This means that the target population was taken as the sample size. Oso (2016) further posits that where the subjects under investigation are few and well defined, they can be studied all of them. The sample size therefore comprised of the 80 DAC, 5 chaplains and 5 guidance and counselling teachers in the area of study. The reason for the census study was that all the members of the target population were reachable and would provide vital information related to the study. For this reason, the researcher found no reason to exclude some members of the target population through getting a sample. The sample size table is as follows:

Table 2: Sample Size

Category of Respondent	**Number available**	**Percentage**
Differently-abled children	80	88.8
Chaplains	5	5.6
Guidance and Counselling teachers	5	5.6
Total	**90**	**100**

3.5.2 The Sampling Procedure

Sampling procedure is purposely targeting a group of people believed to be reliable for the study (Gerring, 2007). This study applied purposeful sampling procedure. This is the sampling procedure used to select the respondents with the required information (Mugenda and Mugenda, 2003). It also ensures that focused information is collected and saves time and cost since it selects typical and useful cases only (Oso, 2016). This study by applying purposeful sampling ensured that the DAC, the chaplains and the guidance and counselling teachers were contacted and provided vital information about the care given to the DAC in the natural families as well as in the residential and educational institutions.

3.6 Description of Research Instruments

The instruments used in the study were questionnaires with questions on family, residential and educational care and standardized Ryff questionnaires on psychological wellbeing (Appendices I) and in-depth interview guide (Appendix II).

3.6.1 Questionnaires

A questionnaire is a research instrument consisting of a set of questions for the purpose of gathering information from respondents (McLeods, 2018). The items in the questionnaires seeking information on family, residential and educational institutional cares were designed by the researcher. The questions were based on a 5-point Likert scale where the respondents specified their extent of agreement to a statement in five points with **1**= Strongly Disagree, **2**= Disagree, **3**= Neutral, **4**= Agree, **5**= Strongly Agree as described by Jovanic (2019). The questionnaire had the other part measuring the psychological wellbeing. These were 42 Ryff's standardized items with the extent of agreement of1= Strongly Disagree, 2= Disagree Somewhat, 3= Disagree Slightly, 4= Agree Slightly, 5= Agree Somewhat and 5= Strongly Agree.

Appendix I was a questionnaire to collect the data on the family care, residential institutionalized care and educational institutional care from the DAC. It had sections A, B and C. Section A was on demographic information of the respondents. Section B contained 11 items. Items i-iii collected data on family care regarding the provision of basic needs to the DAC, involvement in the family matters and protection from abuse. Items iv-vii collected data on the residential institutionalized care regarding provision of basic needs, involvement in matters of the institution, protection from abuse and fair treatment. Items viii-xi collected educational institutional care regarding availability of ramps and special toilets, participation in games and special teachers and other staff in the educational institution. Section C contained 42 Ryff's standardized items measuring the psychological wellbeing of the DAC.

3.6.2 In-depth Interview Guide

An in-depth interview guide is a qualitative research technique that involves conducting intensive individual interviews with small number of respondents to explore their perspectives on a particular idea, program or situation (Boyce, 2006). Appendix II was an in-depth interview guide which collected the data from the chaplains and guidance and counselling teachers in the area of the study. The focus was on the ways through which the chaplains and guidance and counselling teachers offer psychological care that promotes the psychological wellbeing of the DAC. The key concerns were on the activities of chaplaincy, guidance and counselling, motivation speaking and spiritual growth as ways of offering psychological help to the DAC.

3.6.3 Scoring of Questionnaires

Once the questionnaires were filled and collected they were scored in relation to the half of the score. For the type of the care given to the DAC the maximum possible score was 5. Where there was a score of 2.5 and above it implied high quality of the care given while a score of below 2.5 would mean poor quality of care. For the psychological wellbeing of the DAC the maximum possible score was 6. Where there was a score of 3 and above it implied high quality of the care given while a score of below 3 would mean poor quality of care.

3.7 Description of Data Collection Procedures

Before field work, the researcher obtained an introduction letter from the university in order to seek research license from the National Commission for Science and Technology and Innovation (NACOSTI). The researcher obtained via an email the permission to use the 43 Ryff’s items. The researcher bought and produced the research materials before the actual data collection guided by the research budget. The date and time for collecting data was planned in advance. A schedule of timelines to achieve particular stages of writing was strictly followed to ensure completion of the study on time.

The researcher reported to the residential and educational institutions for identification and assistance on mobilizing the DAC and the staff targeted in this study. The researcher briefed the institutional authorities on the purpose of the visit and produced the letters of identification from the university and research license from NACOSTI. The researcher then proceeded to the participants guided by the institutional staffs and after the introductions there was the issuing of questionnaires to the participants. The questionnaires were self-administered where the participants were asked to fill in personally and return to the researcher. The researcher explained and made clear to the participants all the items in the questionnaires one by one in some incidents using the vernacular. This was to ensure that the participants understood all the questions and responded accordingly. The researcher then collected the filled in questionnaires as a way of attaching importance to the exercise and to assure confidentiality to the respondents.

The in-depth interview guides was conducted in a friendly manner and the responses were recorded appropriately on a notebook. The researcher allowed the respondents to express their views freely about what they were asked. This was by ensuring that the researcher did not direct the respondent on what to say. The researcher retained copies of the questionnaires and interview guides in soft copy and hard copy form as a backup in case the first ones were lost.

3.7.1 Operationalization and Measurement of Variables

The independent and the dependent variables were measured with the indicators for each variable. The independent variables were family care, residential institutional care, educational institutional care and the psychological care offered to the DAC in Runyenjes Constituency, Embu County, Kenya. The dependent variable was the psychological wellbeing of the differently-abled children who received the family, residential institution, educational institution and psychological care. The independent variables were measured by the use of 5-point Likert Scale while the dependent variable will be measured by the use of 6-point Likert Scale and in-depth interview guide.

The family care had the indicators of provision of basic needs, involvement in the family matters and protection from abuse. The basic needs were meant to be food, shelter and clothing. Involvement in the family referred to the inclusion in family activities and being treated fairly. Protection from abuse referred to prevention from physical, psychological and sexual abuse.

The residential care had the indicators of provision of basic needs, involvement in the public matters of the institution, prevention from any form of abuse and fair treatment. The basic needs were meant to be food, shelter and clothing. Involvement in the public matters of the residence meant being included and informed about some if not all, but important matters of what went on in the residential institution. Prevention from abuse meant protection from physical, emotional or sexual abuse. Fair treatment implied no discrimination and equal treatment and appreciation in the residential institution.

The educational care had the indicators of having ramps, special toilets for the DAC, participation in various games and special teachers assigned to take care of the DAC. Ramps and special toilets were those meant to ensure the convenience of the DAC and the suitability as well as the ease of use. Various games meant the ones that were accommodative to the DAC. Special teachers meant the teachers placed and assigned the care of the DAC.

The psychological care had the indicators of general counselling and pastoral care. General counselling was operationalised by its frequency, relevance and impact on the behaviour of the DAC in the institutions. Pastoral care was operationalized by its frequency, promotion of self-acceptance and value system to the DAC and how it assisted the DAC to participate in spiritual activities.

The psychological wellbeing had the indicators of autonomy, personal growth, positive relations, environmental mastery, self-acceptance and purpose in life. These were operationalized as per the guidance of Ryff's explanation.

3.8 Validity of the Study Instruments

Mugenda and Mugenda (2011) describes validity as the statistical measure of a test's ability to measure what it intends to measure. The validity of the instruments is very critical in ensuring proper conclusions based on the information obtained from the instruments (Creswell, 2014). This study used three types of validity to assure the quality of the data collection instruments namely face validity, content validity and concurrent validity. Face validity is concerned with the extent to which the research instrument is subjectively viewed to measure what it purports to measure. It may be influenced by the appropriateness of the language used in the test items. In this study the face validity was determined by the guidance of the supervisors and examiners as well as using the Ryff's standardized questionnaires.

Content validity examines if a research instrument captures the sample behaviour it purports to measure. The study used Ryff's instruments assuming that during the standardization and licensing process, the tools were subjected to expert critique thus enhancing validity. For the concurrent validity of the Ryff's tools it was assumed to have been determined during the standardization process and that they had been replicated in other parts of the world.

3.8.1 Reliability of the Research Instruments

Reliability means the likelihood of obtaining the same results when the researcher measures the same variable more than once, or when more than one person measures the same variable (Oso, 2016). Reliability therefore, relates to the measurement accuracy of the data collection instrument. An instrument can be said to be reliable if its measurement accurately reflects the true scores of the attribute under investigation (Creswell, 2004). In this study the researcher explained one item at a time to the participants. This is because of the age of the participants who required even a mother tongue translation.

3.9 Description of Data Analysis Procedures

The researcher was guided by the research questions to analyse the data. The analysis of quantitative data was done using correlation analysis using SPSS Version 21. Data was presented in tables using descriptive statistics in the form of frequencies and percentages for quantitative variables. The data collected from the interview guide was analysed thematically as per the research questions. Inferences were done appropriately out of the findings.

3.10 Ethical Consideration

Before collecting data, the researcher acquired permission from the University and a research permit from the National Commission for Science and Technology (NACOSTI) confirming that the researcher had the approval to carry out this study in Runyenjes Constituency. The researcher fully explained the research to the participants in advance in order to obtain their informed consent. The researcher then obtained consent from the participants and ensured that they participated voluntarily. The researcher adhered to the confidentiality and privacy of respondents. The researcher explained to the participants that their replies were to be used for the purposes of research only. Anonymity of participants was adhered to by not letting them indicate their names on the questionnaires and interviews.

The researcher ensured that the research would not so much elicit psychological issues by offering psychological debriefing to the participants after data collection. This was done by the researcher taking more time at the end of data collection in order to help participants return to normalcy and therefore preventing the study from causing harm to the participants. The researcher also kept all the recorded research data and filled questionnaires in safe custody after which they would be destroyed once this thesis has been approved by the University. The researcher was also at all times sensitive to human dignity and meant well in the intentions of the study since a breach of this would be quite sensitive.

3.11 Conclusion

In this chapter the research design, target population, samples and sampling procedures, the data collection instruments and analysis and the ethical considerations of the study were described. The data organization and the analysis of the findings formed chapter four.

CHAPTER FOUR

DATA ANALYSIS, PRESENTATION AND DISCUSSION OF FINDINGS

4.1 Introduction

This chapter presents the findings and analysis of the study which sets to examine the care given to the differently-abled children and their psychological wellbeing in Runyenjes Constituency, Embu County, Kenya. The chapter starts by presenting the response rate, and the demographic details of the study participants. Then the results are presented in line with the study's objectives.

4.2 Response Rate

The researcher had targeted a population of 80 differently-abled children out of which 70 participated. The researcher also targeted 5 chaplains who work with the differently-abled children and 5 guidance and counselling teachers working with the differently-abled children. The 5 chaplains and the 5 guidance and counselling teachers participated in the study. The respondents were to come from the residential institutions and from the families where the differently-abled children lived. However, due to Covid-19 pandemic challenges the researcher managed to issue the questionnaires to 70 respondents out of which 69 returned the filled questionnaire. After cleaning the data, all the questionnaires were fit for data processing. This response made 98.57% of the intended sample size. This response rate from the target population was good since it provided vital information to the study.

Table 3: Response Rate among Participants

Instrument		Returned Questionnaire	Achieved Response Rate
Questionnaire	70	69	98.57%

4.3 Demographic Analysis

The demographic analysis of the participants was done so as to analyse the psychological wellbeing of the differently-abled children in terms of their age, gender and the type of residence they are found in.

4.3.1 Age of Participants

The study sought to find out the age of participants. The results are presented in Table 2

Table 4: Age distribution of the participants

		Frequency	Percent
Valid	5 to 10 Years	35	50.7
	Above 10 Years	34	49.3
	Total	**69**	**100.0**

The findings indicated that 50.7% of participants were between ages 5 to 10 years while 49.3% were above ages 10.

4.3.2 Gender of Participants

The study sought to find out the gender of participants. The results are presented in Table

Table 5: Gender of participants

		Frequency	Percent
	Male	31	44.9
	Female	38	55.1
	Total	**69**	**100.0**

The findings indicated that 44.9% of participants were male while 55.1% were female.

4.3.3 Type of Residence of Participants

The study sought to find out the type of residence of participant as presented in Table 3

Table 6: Type of Residence for Participants

		Frequency	Percent
	Family of Origin	16	23.2
	Residential Institution	53	76.8
	Total	**69**	**100.0**

The findings indicated that 23.2% of participants were living in their family of origin while 76.8% were living in the residential institution. This means that many families prefer to take their DAC to the institutions where they can live with other differently-abled children.

4.4 Descriptive Analysis

The study sought to find out the care given to the differently-abled children and their psychological wellbeing.

4.4.1 Care Given to Differently-abled Children in Runyenjes

The study sought to examine the quality of type of care given to differently abled children in Runyenjes constituency. The care was assessed on three sub domains namely family care, residential institutional care and educational institutional care using the mean. The maximum possible score was 5. Where there was a score of 2.5 and above implied high quality of the care given while a score of below 2.5 would mean poor quality of care.

Table 7: Type of Care

	N	Minimum	Maximum	Mean	Std. Deviation
Family Care	69	2.3	5.0	4.459	.5335
Residential Institutional Care	69	2.3	5.0	4.377	.5066
Educational Institution Care	69	2.0	5.0	4.533	.5143

The findings indicated that the quality of care given to differently abled children in Runyenjes constituency was high with educational institutional care leading with mean= 4.533, SD 0.5143, followed by family care with mean= 4.459, SD 0.5335. The residential institutional care had a mean of 4.377, SD 0.5066. The findings indicated an above average care.

The high educational care could be attributed to the fact that the government of Kenya supports many programs for the differently-abled children through funding and quality assurance assessments. The residential institutional care was lower than the family care since the institutions depend on well-wishers who may not be available at all time thus limiting the resources required to offer care to the children in these institutions.

The findings of the study were in opposition to studies done by Chepkirui (2016) and Chatzitheochari (2016) that indicated that there was no educational care at all to the differently-abled children in the educational institutions. However, the findings agreed with the study done on family care by Chernego (2016) that indicated that the family care promoted the wellbeing of the DAC by providing basic needs and protection from abuse and exploitation.

4.4.2 Psychological Well Being of Differently Abled Children

The study sought to examine the psychological wellbeing of differently abled children in Runyenjes constituency. It was assessed on six domains namely autonomy, environmental mastery, personal growth, positive relations, purpose in life and self-acceptance. The maximum possible score was 6. Where there was a score of 3 and above it implied high quality of the care given while a score of below 3 would mean poor quality of care.

Table 8: Psychological Wellbeing Levels

	N	**Minimum**	**Maximum**	**Mean**	**Std. Deviation**
Autonomy	69	2.4	6.0	3.783	.6841
Environmental Mastery	69	2.6	5.1	3.789	.4977
Personal Growth	69	2.6	5.9	3.617	.5733
Purpose in Life	68	2.4	4.6	3.326	.4543
Self-Acceptance	69	3.3	6.0	4.145	.4741
Positive Relations	69	2.4	5.0	3.843	.4833

The results indicated that participants' psychological wellbeing was just slightly above average though around the borderline. The highest domain was self-acceptance (mean=4.145, SD= 0.4741) followed by positive relations (mean= 3.843, SD= 0.4833), environmental mastery (mean= 3.789, SD= 0.4977), autonomy (mean= 3.783, SD= 0.6841), personal growth (mean= 3.617, SD=0.5733). The lowest domain was purpose in life (mean= 3.326, SD= 0.4543).

Self-acceptance to the DAC could be attributed to the fact that these children had been informed well about their status and how they could develop in other areas despite having motor impairments. Purpose in life scored low and this could be attributed to the fact that the children are still growing and dependants who have not yet made up their minds on what they want to become and achieve in life. Generally, the psychological wellbeing of the children was average which means there was room for making it better.

4.5 Demographic Differences in Psychological Well Being of Differently Abled Children in Runyenjes Constituency, Embu County, Kenya.

The study sought to identify the demographic differences in psychological wellbeing in order understand how various demographic variables affected the wellbeing of the differently abled children. These demographic differences were the age, gender and the environment where the DAC lived. The elements of the demographic differences were seen to have some influence on the psychological wellbeing of the DAC.

4.5.1 Gender Difference in Psychological Wellbeing of Differently Abled Children in Runyenjes

Gender differences in psychological wellbeing of participants was examined. The results are shown in table 9.

Table 9: Gender Differences in Psychological Wellbeing of Differently Abled Children in Runjenyes

Gender Of Participant		Autonomy	Environmental Mastery	Personal Growth	Purpose in Life	Self-Acceptance	Positive Relations
Male	Mean	3.866	3.945	3.747	3.310	4.194	3.825
	N	31	31	31	30	31	31
	Std. Deviation	.8123	.5770	.5554	.5131	.5365	.4748
Female	Mean	3.714	3.662	3.511	3.338	4.105	3.857
	N	38	38	38	38	38	38
	Std. Deviation	.5607	.3851	.5730	.4087	.4197	.4960

The results indicated that males reported higher well-being compared to females. Males reported higher scores on autonomy (mean= 3.86, SD= 0.813), compared to female who scored mean= 3.714, SD= 0.5607. This could be attributed to the patristic mentality in the society that promotes the domineering nature in the male gender than in the female gender. Males also reported higher scores on environmental mastery (mean= 3.945. SD=0.5770) compared to females mean= 3.662, SD= 0.3851), personal growth (mean=3.747, SD= 0.554) compared to female mean 3.511, SD=0.5730) and self-acceptance (mean= 4.194, SD= 4.105) compared to female mean= 4.105, SD 0.4197). Female on the other hand scored higher on purpose of life (mean= 3.338, SD= 0.4087) compared to males mean= 3.310, SD= 0.5131) and positive relations (mean= 3.857, SD= 0.4960) compared to males 3.825, SD= 0.4748). This is attributed to the fact that females appeal to emotions more than males and thus tend to relate more to themselves and to others.

The findings agreed with the study on gender and psychological wellbeing by Matud, Marisela &Fortes (2019). The findings here indicated that males scored higher on autonomy and self-acceptance than females. This was attributed to the masculinity of males.

4.5.2 Age Difference in Psychological Wellbeing of Differently Abled Children in Runjenyes

Age differences in psychological wellbeing of participants were examined. The results are shown in table 10:

Table 10: Age Difference in Psychological Wellbeing of Differently Abled Children in Runjenyes

Age of Participants		Personal Growth	Purpose in Life	Self-Acceptance	Positive Relations	Autonomy	Environmental Mastery
5 to 10 Years	Mean	3.608	3.363	4.069	3.886	3.804	3.718
	N	35	35	35	35	35	35
	Std. Deviation	.5612	.5084	.3540	.4823	.7235	.4320
Above 10 Years	Mean	3.626	3.286	4.223	3.798	3.761	3.861
	N	34	33	34	34	34	34
	Std. Deviation	.5937	.3929	.5673	.4875	.6511	.5544

The results indicated that the participants of the ages above 10 years reported higher well-being compared to the participants of the age of 5 to 10 years on self-acceptance (mean= 4.223, SD= 0.5673), compared to participants of the age of 5 to 10 years who scored mean= 4.069, SD= 0.3540, environmental mastery (mean= 3.861 SD=0.5544) compared to participants of the age of 5 to 10 years (mean= 3.718, SD= 0.4320) and personal growth (mean=3.626, SD= 0.5937) compared to participants of the age of 5 to 10 years mean (3.608, SD=0.5612). This could be attributed to the fact that the children above 10 years have been made more aware of themselves and their developmental changes than the children below 10 years. The participants of the age of 5 to 10 years on the other hand scored higher on purpose of life (mean= 3.363, SD= 0.5084) compared to participants above 10 years (mean= 3.28, SD= 0.3929), positive relations (mean= 3.886, SD= 0.4823) compared to participants above 10 years mean (3.798, SD= 0.4875) and autonomy (mean =3.804, SD= O.7235) compared to participants above 10 years (mean= 3.761, SD= 0.6511). This could be from the fact that children between 5 to 10 years tend to trust more, relate more and are less influenced by others compared to the children above 10 years.

The findings of this study were in agreement with the findings of the studies done previously on psychological wellbeing in relation to age. Bluth (2017) found that as children enters into adolescence their wellbeing in purpose of life, autonomy and positive relations decrease due to the changes they experience than during pre-adolescence stage. However, with time they accept the changes and develop themselves more and master their environment as they transit to adulthood (Bluth, 2017).

4.5.3 Difference in Psychological Wellbeing of Differently Abled Children According to their Residence in Runyenjes

Differences in residence and the psychological wellbeing of participants was examined. The results are shown in table 11:

Table 11: Residence Difference in Psychological Wellbeing of Differently-abled Children in Runyenjes

Residence of Participants		Personal Growth	Purpose in Life	Self-Acceptance	Positive Relations	Autonomy	Environmental Mastery
Family of Origin	Mean	3.464	3.268	3.884	3.696	3.571	3.848
	N	16	16	16	16	16	16
	Std. Deviation	.3670	.4777	.3267	.3494	.2904	.4650
Residential Institution	Mean	3.663	3.343	4.224	3.887	3.846	3.771
	N	53	52	53	53	53	53
	Std. Deviation	.6177	.4502	.4857	.5115	.7548	.5100

The results indicated that the participants in residential institutions reported higher well-being compared to the participants in the family of origin on personal growth (mean= 3.663, SD= 0.6177), compared to participants in the family of origin (mean= 3.464, SD= 0.3670), purpose in life (mean= 3.343 SD=0.4502) compared to participants in the family of origin (mean= 3.268, SD= 0.4777), self-acceptance (mean= 4.224 SD= 0.4857) compared to participants in the family of origin mean (3.8848, SD=0.3267), positive relations (mean= 3.887, SD= 0.5115) compared to participants in the family of origin (mean= 3.696, SD= 0.3494) and autonomy (mean= 3.846, SD= 0.7546) compared to participants in the family of origin (mean= 3.571, SD= 0.2904). The participants in the family of origin however scored higher on environmental mastery (mean= 3.848, SD= 0.4650) compared to participants in residential institutions (mean= 3.771, SD= 0.5100).

The participants in the residential institutions showed higher psychological wellbeing attributed to the fact that they live together with children who share common conditions and thus accept themselves, relate well with them and develop personally. Still at the institutions they stood better chances of motivational speaking and guidance and counselling than at their families.

The study findings opposed the study towards institutionalization of DAC done by Browne in 2015. The study indicated that institutions affected the social behavior, cognitive and emotional development of the DAC since the children have no direct interaction with the family members. These family members were the ones to provide wellbeing for the children as found out by Chernego (2016).

4.6 The Influence of Family Care on the Psychological Wellbeing of Differently-abled Children in Runyenjes Constituency, Embu County, Kenya.

The study sought to investigate how family care influenced the psychological wellbeing of differently-abled children in Runyenjes Constituency, Embu County, Kenya. The results are presented in the table 12:

Table 12: The Influence of Family Care on the Psychological Wellbeing of Differently-abled Children in Runyenjes Constituency, Embu County, Kenya.

		Family Care
Family Care	Pearson Correlation	1
	Sig. (2-tailed)	
	N	69
Autonomy	Pearson Correlation	.201
	Sig. (2-tailed)	.098
	N	69
Environmental Mastery	Pearson Correlation	-.054
	Sig. (2-tailed)	.658
	N	69
Personal Growth	Pearson Correlation	.320**
	Sig. (2-tailed)	.007
	N	69
Purpose in Life	Pearson Correlation	-.202
	Sig. (2-tailed)	.099
	N	68
Self-Acceptance	Pearson Correlation	.204
	Sig. (2-tailed)	.093
	N	69
Positive Relations	Pearson Correlation	.203
	Sig. (2-tailed)	.095
	N	69

The study indicated that there was a weak positive significant correlation between the family care and personal growth ($r= 0.320$, $p< 0.05$). This means that an increase in family care would mean an increase in personal growth. This could be attributed to the affection and concern that the family members have towards the DAC thus boosting the psychological wellbeing of the DAC. The study also indicated a very weak positive insignificant correlation between family care and self-acceptance ($r= 0.204$, $p> 0.05$), positive relations ($r= 0.203$, $p> 0.05$) and autonomy ($r= 0.201$, $p>0.05$). The study also indicated that family care had very weak negative insignificant correlation with purpose in life ($r= -0.202$, $p> 0.05$) and environmental mastery ($r= -0.054$, p>

0.05). This means that an increase in family care would decrease purpose in life and environmental mastery. This could be attributed to the fact that excess care to the DAC would lead to overdependence on their family members denying them a chance to do some of the activities on their own.

The findings of this study agreed with those of Mulheir (2014) that indicated that the family care was insignificant in prooting autonomy, personal growth and purpose in life. Fabiyi (2014) and Sahoo (2014) too agreed that the family care due to lack of finances and negative mentalities was unable to positively and significantly promote the psychological wellbeing of the DAC.

The results of the study on the other hand contradicted the findings of Chernego (2016) that positively and significantly attributed high psychological wellbeing to family care. In the family there was no abuse or exploitation and the family provided child protection, social care, health care and all basic needs. This indicated a strong correlation between family care and psychological wellbeing.

4.7 The Relationship between Residential Institutionalized Care and the Psychological Wellbeing of Differently-abled Children in Runyenjes Constituency, Embu County, Kenya.

The study sought to establish how residential institutional care related to the psychological wellbeing of differently-abled children in Runyenjes Constituency, Embu County, Kenya. The results are presented in the table 13.

Table 13: The Relationship between Residential Institutionalized Care and the Psychological Wellbeing of Differently-abled Children in Runyenjes

		Residential Institutional Care
Autonomy	Pearson Correlation	.132
	Sig. (2-tailed)	.279
	N	69
Environmental Mastery	Pearson Correlation	.037
	Sig. (2-tailed)	.763
	N	69
Personal Growth	Pearson Correlation	$.329^{**}$
	Sig. (2-tailed)	.006
	N	69
Purpose in Life	Pearson Correlation	-.074
	Sig. (2-tailed)	.547
	N	68
Self-Acceptance	Pearson Correlation	.154
	Sig. (2-tailed)	.206
	N	69
Positive Relations	Pearson Correlation	.044
	Sig. (2-tailed)	.719
	N	69
Residential Institutional Care	Pearson Correlation	1
	Sig. (2-tailed)	
	N	69

The study indicated that there was a weak positive significant correlation between residential institutionalized care and personal growth ($r= 0.329$, $p< 0.05$). This means that an increase in residential institutionalized care would increase personal growth for the DAC. This could be attributed to motivational speeches and guidance and counselling sessions offered to the DAC in the institutions since they are together sharing common challenges. The study also indicated that there was very weak insignificant positive correlation with self-acceptance ($r= 0.154$, $p> 0.05$), autonomy ($r= 0.132$, $p> 0.05$), positive relations ($r= 0.044$, $p> 0.05$) and environmental mastery ($r= 0.037$, $p> 0.05$). The residential institutional care as per the study had very weak negative insignificant correlation with purpose in life (r= -0.074, p> 0.05). This means that an increase in residential institutionalized would decrease the environmental mastery. This could be attributed to excess care and attention offered to the DAC in the institutions by the care takers and the people who visit them. This would lead the DAC to be over dependent on these people in a way that they are not able to do some things on their own.

The findings of this study generally agreed with the findings of other studies done previously in that the residential institutionalized care had weak positive insignificant correlation with the majority of the elements of psychological wellbeing. Browne (2015) and Makhubele et al (2017) found that the residential institutions affected the social, emotional, intellectual and behavioral development for the DAC and thus put their psychological wellbeing at stake due to the exposure to neglect, exploitation, abuse and lack of individual care.

4.8 The Implications of Educational Care on the Psychological Wellbeing of Differently-abled Children in Runyenjes Constituency, Embu County, Kenya.

The study sought to assess the implications of educational care on the psychological wellbeing of the DAC in Runyenjes Constituency. The results are presented in the table 14:

Table 14: The Implications of Educational Care on the Psychological Wellbeing of Differently-abled Children in Runyenjes

		Educational Institution Care
Autonomy	Pearson Correlation	.210
	Sig. (2-tailed)	.083
	N	69
Environmental Mastery	Pearson Correlation	-.110
	Sig. (2-tailed)	.367
	N	69
Personal Growth	Pearson Correlation	$.449^{**}$
	Sig. (2-tailed)	.000
	N	69
Purpose in Life	Pearson Correlation	.073
	Sig. (2-tailed)	.554
	N	68
Self-Acceptance	Pearson Correlation	-.082
	Sig. (2-tailed)	.502
	N	69
Positive Relations	Pearson Correlation	-.021
	Sig. (2-tailed)	.862
	N	69
Educational Institution Care	Pearson Correlation	1
	Sig. (2-tailed)	
	N	69

The study indicated that there was a moderate positive significant correlation between educational care and personal growth ($r= 0.449$, $p< 0.05$). This means that an increase in educational care would increase personal growth of the DAC. This can be attributed to the support by the government in education system and academic elements that boost the personal growth of the DAC. Still the educational care emphasizes greatly on academic achievements where the DAC excel since they have only motor impairments. The study also found a weak positive insignificant correlation between educational care and autonomy ($r= 0.210$, $p> 0.05$) and purpose of life ($r= 0.073$, $p> 0.05$). The educational care as per the study had very weak negative insignificant correlation with positive relations (r= -0.021, p> 0.05), self-acceptance (r= -0.082, p. 0.05) and environmental mastery (r= -0.110, p. 0.05). This means that increasing educational care would probably decrease positive relations, self-acceptance and environmental mastery. This could be attributed to the fact that in the educational institutions there are incidents of over emphasis on academic excellence at the expense of other areas of life.

The findings of this study agree with those of other studies done previously in that the educational care may not positively and significantly influence many elements of the psychological wellbeing of the DAC. Pudaruth (2016) and Chepkirui (2016) affirmed that the educational institutions lacked structural support, adequate facilities and the facilities available were irrelevant for the promotion of the psychological wellbeing of the DAC.

4.9 The Psychological Care Offered to the Differently-abled Children and their Psychological Wellbeing in Runyenjes Constituency, Embu County, Kenya.

The study sought to evaluate the psychological care offered to the differently-abled children and their psychological wellbeing in Runyenjes Constituency. This was done by conducting in-depth interviews to the key informers who were the chaplains and the guidance and counselling teachers from the institutions where the DAC are found. The participants were allowed to narrate their views on what is missing and what is existing regarding the psychological care offered to the DAC in the area of study. Their responses were presented thematically.

4.9.1 The Missing Elements in the Provision of Psychological Care

The responses from the interviewees revealed that there was inadequacy in time, resources, and availability of trained personnel. This meant that the providers of the psychological care to the DAC faced some challenges regarding time, resources and training of personnel. This would have implications to the psychological wellbeing of the DAC.

4.9.1.1 Time

The study established that adequate time to meet the DAC and attend to them either at families, residential or educational institutions was lacking as one teacher narrated thus:

When the children come here in school, there is the school program that has to be followed leaving very little time to attend to the children outside the academic program. This would deny the DCA lots of opportunities to be attended to.

4.9.1.2 Resources

It was also revealed from the interviewees that the resources that can help the psychological care providers were inadequate. These resources ranged from material to human resources. Getting some specialized personnel was found to be difficult since the family or the residential and educational institutions were basically concerned about how to avail the mere basic needs to the DAC. A teacher held that, *getting a person specialized to attend to these children requires money which we don't have: still we don't have many specialized people like motivational speakers and counsellors around who can frequently come and address some areas of psychological wellbeing for these children.*

4.9.1.3 Trained Personnel

The responses also indicated that there lacked chaplains specifically assigned to serve the DAC. Those that attended the DAC were not very frequent to the institutions. This was attributed to the fact the chaplains are also allocated other duties which they have to attend to, leaving very little time to be with the DAC. There also lacked a consistent and definite program to attend to the DAC as one teacher said that *on guidance and counseling occasionally the special needs education teacher hold counseling sessions with those children in the small home* (residential institution). Still on motivational speaking the same teacher held that *we have had occasions when catholic* *women leadership visit the small home and talk to the children.* Other areas that needed attention were the diet which ought to be balanced all the time, comfortable sitting places and adequate water for the use by the children.

The findings from the interviewees agreed with the finding of the study by Twagirimana (2016). This was on the aspect of missing elements that would promote the psychological wellbeing for the DAC. There was lack of trained and enough personnel to handle the differently-abled children. There was also lack of resources that would be used in handling the DAC and this reduced the provision of psychological care to these children.

The lack of ways to provide psychological care to the differently-abled children may be attributed to the fact that these children require special attention different in some ways from that given to the able-bodied children. Many people find it easier to work with able-bodied children than the DAC. From the homes where they were born, to schools where they learn and to the residential institutions where they reside, the DAC have some special demands that have been neglected or people generally feel unable to provide. This has led to lack of provision of psychological care to these children. Many people have mixed emotions whenever they come across differently-abled children and this creates a bigger barrier towards assisting the children psychologically. Still very many people go up to the level of providing material needs to these children and lack the extra engagements to cater for psychological needs.

4.10 The Existing Elements in the Provision of Psychological Care

The responses from the interviewees indicated that there were some attempts to provide psychological care to the differently-abled children in the area of study. These were:

4.10.1 Mass and Pastoral Activities

The findings revealed that there were Masses celebrated to the DAC by the chaplains in a month or in a term. These according to one chaplain *are very helpful to the children as noted in the general appreciation and feedback from stakeholders. This has gone a long way into helping these children towards self-acceptance*. The pastoral support from the chaplains and nuns was also noted to have greatly built the psychological wellbeing of the DAC.

4.10.2 Guidance and Counselling and Motivational Speaking

Frequent visits from charitable groups and well-wishers were also noted to be part of provision of psychological wellbeing for the differently-abled children since they were encouraged by the visitors. One teacher held that *the occasional motivational speaking and guidance and counselling are a source of hope, sense of life and acceptance for these children. Still these children interact with other children like them and this boosts their self-acceptance.*

4.10.3 Visits by Doctors and other Specialists

This study also found that there is an existing program by doctors who do monthly assessment to these children and if need be they are taken for corrective surgery. This is done in agreement between the institution and the parents or the guardians of the differently-abled child. One teacher said that *after this surgery is done the child improves greatly in terms of physical activities and this has led to further growth in other areas.*

The existing elements of the provision of psychological care to the differently-abled children agree with the findings of the Ministry of Labor, Kenya (2015). The agreement was on the fact that the psychological wellbeing of the DAC includes guidance and counseling as well as spiritual attention and appreciation. This brings about realistic beliefs about oneself, purpose in life and hope for future.

4.10.4 Suggestions for Future Intervention

Following the current trends of inclusion and appreciation of the dignity of human persons it is possible to care for the DAC psychologically through some interventions. This would be through provision of the elements that were found to be missing in the provision of the psychological care to the DAC.

4.10.5 Frequent Interactions

Having frequent interactions with the DAC and understanding them in their situation opens many chances for all the people to assist them psychologically. When the DAC are exposed to many people they are able to create positive relations, accept themselves and above all realize that they have very much other potential in their lives. This will boost their psychological wellbeing.

4.10.6 Training of Personnel

Proper training and preparation of personnel regarding the psychological issues of the DAC would give one a stronger platform to offer psychological care to them. This means that the people handling them will understand a greater part of what the DAC go through and how to address their issues thus ensuring psychological wellbeing. The chaplains, teachers and care givers to the DAC need to be specifically trained on the areas touching the psychological wellbeing of the DAC.

4.10.7 Creating Enough Time

Having enough time for the DAC and having organized programs and allocating resources are ways that would assist in providing psychological care to the DAC hence promoting their psychological wellbeing. This helps the chaplains, guidance and counseling teachers, motivational speakers, health practitioners and all other related service providers to contribute greatly to the psychological wellbeing of the DAC.

4.10.8 Assigning Human and Material Resources

Besides training the personnel the church being on the frontline needs to assign chaplaincy services, pastoral care and spiritual nourishment that would promote the psychological wellbeing of the DAC. The government allocating resources and training professional counselors would address the needs that are vital in promoting the wellbeing of the DAC. The community, well-wishers and charitable groups and organizations would also form part of the team that in their own ways would promote the psychological wellbeing of the DAC. Encouraging the interaction of the DAC in various activities and incorporating them minding their abilities and situation would play a great role in promoting the psychological wellbeing of the differently-abled children.

4.11 Conclusion

This chapter presented the findings of the study from the quantitative and qualitative data. In every analysis there was a comparison to a study done previously on the area being analysed. There was a researcher’s voice after every analysis.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter presented the summary, conclusions and recommendations based on the findings of the research. The summary of the main findings of the four objectives of the study was presented then followed by the recommendations of the study. Finally, there were suggestions for further study based on the findings of the study.

5.2 Summary of the Findings

This section presented a summary of the findings of the four objectives of the study.

5.2.1 The Influence of Family Care on the Psychological Wellbeing of Differently-abled Children in Runyenjes

The study sought to investigate how family care influenced the psychological wellbeing of differently-abled children in Runyenjes. This was the care given to the DAC in their families. The findings of the study from the descriptive statistics indicated that there was a weak positive significant correlation between the family care and personal growth ($r= 0.320$, $p< 0.05$). This meant that with an increase in family care there would be an increase in personal growth. This could be attributed to the affection and concern that the family members have towards the DAC thus boosting the psychological wellbeing of the DAC. The study also indicated that family care had very weak negative insignificant correlation with purpose in life ($r= -0.202$, $p> 0.05$) and environmental mastery ($r= -0.054$, $p> 0.05$). This meant that an increase in family care would decrease purpose in life and environmental mastery. This could be attributed to the fact that excess care to the DAC would lead to overdependence on their family members denying them a chance to do some of the activities on their own.

5.2.2 The Relationship between Residential Institutionalized Care and the Psychological Wellbeing of Differently-abled Children in Runyenjes

The study sought to establish how residential institutional care related to the psychological wellbeing of differently-abled children. This was the care offered to the DAC in the residential institutions. The findings of the study indicated that there was a weak positive significant correlation between residential institutionalized care and personal growth ($r= 0.329$, $p< 0.05$). This means that an increase in residential institutionalized care would increase personal growth for the DAC. This could be attributed to motivational speeches and guidance and counseling sessions offered to the DAC in the institutions since they were together sharing common challenges. The findings also indicated that residential institutional care had very weak negative insignificant correlation with purpose in life ($r= -0.074$, $p> 0.05$). This means that an increase in residential institutionalized would decrease the environmental mastery. This could be attributed to excess care and attention offered to the DAC in the institutions by the care takers and the people who visit them. This would lead the DAC to be over dependent on these people in a way that they are not able to do some things on their own.

5.2.3 The Implications of Educational Care on the Psychological Wellbeing of Differently-abled Children in Runyenjes

The study sought to assess the implications of educational care on the psychological wellbeing of the DAC in Runyenjes Constituency. This was the care offered to the DAC in the educational institutions mainly the schools. The findings of the study from the descriptive statistics indicated that there was a moderate positive significant correlation between educational care and personal growth ($r= 0.449$, $p< 0.05$). This means that an increase in educational care would increase personal growth of the DAC. This can be attributed to the support by the government in education system and academic elements that boost the personal growth of the DAC. Still the educational care emphasizes greatly on academic achievements where the DAC excel since they have only motor impairments and are in the school going age. The findings also indicated that the educational care had a very weak negative insignificant correlation with positive relations ($r= -0.021$, $p> 0.05$), self-acceptance ($r= -0.082$, p. 0.05) and environmental mastery ($r= -0.110$, p. 0.05). This means that increasing educational care would probably decrease positive relations, self-acceptance and environmental mastery. This could be attributed to the fact that in the educational institutions there are incidents of over emphasis on academic excellence and competition at the expense of other areas of life.

5.2.4 The Psychological Care Offered to the Differently-abled Children and their Psychological Wellbeing in Runyenjes

The study sought to evaluate the psychological care offered to the differently-abled children and their psychological wellbeing in Runyenjes. This was done by conducting in-depth interviews to the key informers who were the chaplains and the guidance and counseling teachers in the institutions where the DAC are found. They gave their views on what was missing and what was put in place regarding the psychological care offered to the DAC. The findings indicated that adequate time to meet the DAC and attend to them either at families, residential or educational institutions was lacking since there was no time allocated for attending to the DAC. The findings also indicated that human resources like specialized and trained chaplains, counselors and motivational speakers to attend to the DAC were lacking. Material resources like funds and proper facilities were also found to be lacking.

The responses from the interviewees also indicated that there were some attempts to provide psychological care to the differently-abled children in the area of study. The existing elements were Masses and pastoral activities offered frequently. These were found to have greatly built the psychological wellbeing of the DAC. Another existing element was the occasional motivational speaking and guidance and counselling which brought hope, sense of life and self-acceptance for the DAC. The findings also revealed that there is an existing program by doctors who do monthly assessment to these children and if need be they are taken for corrective surgery. This led to further growth in other areas thus promoting the psychological wellbeing of the DAC.

5.3. Conclusion

The purpose of the study was to investigate the care given to the differently-abled children and their psychological wellbeing in Runyenjes Constituency, Embu County, Kenya. The type of care was divided into family care, residential institutionalized care, educational institutional care and the psychological care. The psychological wellbeing was viewed from its six domains of autonomy, self-acceptance, environmental mastery, personal growth, purpose in life and positive relations. The findings of the study indicated that educational institutional care was leading with mean= 4.533, SD 0.5143, followed by family care with mean= 4.459, SD 0.5335 and then the residential institutional care with a mean= 4.377, SD 0.5066. This was attributed to the great support and monitoring of the education system by the government that assures high quality. Still, this was attributed to the fact that the DAC are in school going age and therefore very receptive to the educational care.

Generally, the family care, residential institutionalized care and the educational institutional care had a weak positive significant correlation with personal growth as a domain of psychological wellbeing. This meant that increasing the care would increase the personal growth of the DAC. There were existing elements in offering psychological care based on pastoral and spiritual care and guidance and counselling. The interventions by doctors was also found to have boosted greatly the psychological wellbeing of the DAC especially after corrective surgeries

5.4. Recommendations

The study found missing elements that were a challenge to offering psychological care and eventually not promoting the psychological wellbeing of the DAC. Recommendations were made to five stakeholders who would be vital in the implementation of the findings of this study. These were the parents or the guardians of the DAC, the government, the church, the managers of the institutions and the general community.

To the parents or the guardians of the DAC and the community this study recommended frequent interactions and exposure of the DAC to many people while understanding them in their situation. This would create positive relations, help them accept themselves and above all realize that they have very much other potential in their lives. The research recommended the involvement of the community, well-wishers and charitable groups and to promote the psychological wellbeing of the DAC.

To the government this research recommended allocation of resources like funds and other required facilities in the institutions where the DAC live. The research recommended training of the persons handling the DAC like the teachers and counselors who would assist greatly in the promotion of the psychological wellbeing of the DAC. The government would also assign to specific teachers the duties of handling the DAC.

To the managers of the institutions the research recommended allocation of enough time in the programs for the DAC to interact with chaplains, counsellors and motivational speakers. To the church the research recommended assigning chaplaincy services, pastoral care and spiritual nourishment to a specific chaplain who would plan and come up with a way of promoting the psychological wellbeing of the DAC. This would ensure the availability of the chaplains to the DAC thus playing a key role in the promotion of their psychological wellbeing.

5.5. Recommendation for Further Study

As revealed by the findings of this study the excess care would lead to decreased psychological wellbeing of the DAC. Many people often believe that the DAC require much care. The study therefore recommended a further study on the extent of the care the DAC need to receive in relation to their own space that they require for their psychological wellbeing.

On gender differences in psychological wellbeing of differently abled children the results indicated that males reported higher well-being compared to females. Males reported higher scores than females on autonomy, environmental mastery, personal growth and self-acceptance. On the other hand, the females scored higher than males on purpose of life and personal relations. With such notable differences this research recommended a further study on psychological wellbeing in relation to gender.

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APPENDICES

1. RESEARCH TOOLS

APPENDIX I: QUESTIONNAIRES FOR THE DIFFERENTLY-ABLED CHILDREN

Instructions

I am a student at The Catholic University of Eastern Africa. I am currently conducting a study on '**The Care Given to Differently-abled Children and their Psychological Wellbeing in Runyenjes Constituency, Embu County, Kenya'.** I kindly request you to assist me collect the information about the psychological wellbeing of children with motor impairments. You are assured that your responses will be treated with strict confidence and the information you give will be used for this research only. There is no right or wrong answers. Do not write your name and you are requested to respond to all questions in each section.

Thank you.

SECTION A: DEMOGAPHIC INFORMATION

Tick your answers where necessary

1. Gender Male ( ) Female ( )
2. Please tick appropriately your age

   Below 5 years ( ) 5-10 years ( ) above 10 years ( )

3. Tick where you live: In the family where you were born ( )

   In the residential institution ( )

4. Tick the people you live with

   Nuclear family members ( ) Extended family members ( )

SECTION B: THE CARE GIVEN AND THE PSYCHOLOGICAL WELLBEING OF DIFFERENTLY-ABLED CHILDREN

5. Kindly respond by ticking **(√)** accordingly the extent to which you agree with the following statements on a scale of **1-5** where **1**= Strongly Disagree, **2**= Disagree,

3= Neutral, **4**= Agree, **5**= Strongly Agree

FAMILY CARE

S/No	**Statement**	**1**	**2**	**3**	**4**	**5**
i.	My family provides me with enough basic needs					
ii.	I am well involved in the family matters of our family					
iii.	My family has put ways to prevent me from any form of abuse					

RESIDENTIAL INSTITUTIONAL CARE

S/No	**Statement**	**1**	**2**	**3**	**4**	**5**
iv.	This residential institution provides me with enough basic needs					
v.	I am well involved in the public matters in this residential institution					
vi.	This residential institution has put ways to prevent me from any form of abuse					
vii.	In this residential institution I am treated fairly					

EDUCATIONAL INSTITUTIONAL CARE

S/No	Statement	1	2	3	4	5
viii.	My school has ramps in most of the buildings					
ix.	My school has enough special toilets for use by the differently-abled children					
x.	My school helps the differently-abled children to participate in a special way in various games					
xi.	My school has special teachers and other staffs assigned to take care of the differently-abled children					

SECTION C: THE PSYCHOLOGICAL WELLBEING OF DIFFERENTLY-ABLED CHILDREN

The following set of questions deals with how you feel about yourself and your life. Please remember that there is no right or wrong answers.

Circle the number that best describes your present agreement or disagreement with each statement.	Strongly Disagree	Disagree Somewhat	Disagree Slightly	Agree Slightly	Agree Somewhat	Strongly Agree
1. I am not afraid to voice my opinions, even when they are in opposition to the opinions of most people.	1	2	3	4	5	6

Circle the number that best describes your present agreement or disagreement with each statement.	**Strongly Disagree**	**Disagree Somewhat**	**Disagree Slightly**	**Agree Slightly**	**Agree Somewhat**	**Strongly Agree**
2. In general, I feel I am in charge of the situation in which I live.	1	2	3	4	5	6
3. I am not interested in activities that will expand my horizons.	1	2	3	4	5	6
4. Most people see me as loving and affectionate.	1	2	3	4	5	6
5. I live life one day at a time and don't really think about the future.	1	2	3	4	5	6
6. When I look at the story of my life, I am pleased with how things have turned out.	1	2	3	4	5	6
7. My decisions are not usually influenced by what everyone else is doing.	1	2	3	4	5	6
8. The demands of everyday life often get me down.	1	2	3	4	5	6
9. I think it is important to have new experiences that challenge how you think about yourself and the world.	1	2	3	4	5	6

Circle the number that best describes your present agreement or disagreement with each statement.	**Strongly Disagree**	**Disagree Somewhat**	**Disagree Slightly**	**Agree Slightly**	**Agree Somewhat**	**Strongly Agree**
10. Maintaining close relationships has been difficult and frustrating for me.	1	2	3	4	5	6
11. I have a sense of direction and purpose in life.	1	2	3	4	5	6
12. In general, I feel confident and positive about myself.	1	2	3	4	5	6
13. I tend to worry about what other people think of me.	1	2	3	4	5	6
14. I do not fit very well with the people and the community around me.	1	2	3	4	5	6
15. When I think about it, I haven’t really improved much as a person over the years.	1	2	3	4	5	6
16. I often feel lonely because I have few close friends with whom to share my concerns.	1	2	3	4	5	6
17. My daily activities often seem trivial and unimportant to me.	1	2	3	4	5	6

Circle the number that best describes your present agreement or disagreement with each statement.	**Strongly Disagree**	**Disagree Somewhat**	**Disagree Slightly**	**Agree Slightly**	**Agree Somewhat**	**Strongly Agree**
18. I feel like many of the people I know have gotten more out of life than I have.	1	2	3	4	5	6
19. I tend to be influenced by people with strong opinions.	1	2	3	4	5	6
20. I am quite good at managing the many responsibilities of my daily life.	1	2	3	4	5	6
21. I have a sense that I have developed a lot as a person over time.	1	2	3	4	5	6
22. I enjoy personal and mutual conversations with family members or friends.	1	2	3	4	5	6
23. I don’t have a good sense of what it is I’m trying to accomplish in life.	1	2	3	4	5	6
24. I like most aspects of my personality.	1	2	3	4	5	6
25. I have confidence in my opinions, even if they are contrary to the general consensus.	1	2	3	4	5	6

Circle the number that best describes your present agreement or disagreement with each statement.	**Strongly Disagree**	**Disagree Somewhat**	**Disagree Slightly**	**Agree Slightly**	**Agree Somewhat**	**Strongly Agree**
26. I often feel overwhelmed by my responsibilities.	1	2	3	4	5	6
27. I do not enjoy being in new situations that require me to change my old familiar ways of doing things.	1	2	3	4	5	6
28. People would describe me as a giving person, willing to share my time with others.	1	2	3	4	5	6
29. I enjoy making plans for the future and working to make them a reality.	1	2	3	4	5	6
30. In many ways, I feel disappointed about my achievements in life.	1	2	3	4	5	6
31. It’s difficult for me to voice my own opinions on controversial matters.	1	2	3	4	5	6
32. I have difficulty arranging my life in a way that is satisfying to me.	1	2	3	4	5	6

Circle the number that best describes your present agreement or disagreement with each statement.	**Strongly Disagree**	**Disagree Somewhat**	**Disagree Slightly**	**Agree Slightly**	**Agree Somewhat**	**Strongly Agree**
33. For me, life has been a continuous process of learning, changing, and growth.	1	2	3	4	5	6
34. I have not experienced many warm and trusting relationships with others.	1	2	3	4	5	6
35. Some people wander aimlessly through life, but I am not one of them.	1	2	3	4	5	6
36. My attitude about myself is probably not as positive as most people feel about themselves.	1	2	3	4	5	6
37. I judge myself by what I think is important, not by the values of what others think is important.	1	2	3	4	5	6
38. I have been able to build a home and a lifestyle for myself that is much to my liking.	1	2	3	4	5	6
39. I gave up trying to make big improvements or changes in my life a long time ago.	1	2	3	4	5	6

Circle the number that best describes your present agreement or disagreement with each statement.	**Strongly Disagree**	**Disagree Somewhat**	**Disagree Slightly**	**Agree Slightly**	**Agree Somewhat**	**Strongly Agree**
40. I know that I can trust my friends, and they know they can trust me.	1	2	3	4	5	6
41. I sometimes feel as if I've done all there is to do in life.	1	2	3	4	5	6
42. When I compare myself to friends and acquaintances, it makes me feel good about who I am.	1	2	3	4	5	6

Thank you for your participation.

APPENDIX II: INTERVIEW GUIDE FOR CHAPLAINS AND TEACHERS

Instructions

I am a student at The Catholic University of Eastern Africa. I am currently conducting a study on '**The Care Given to Differently-abled Children and their Psychological Wellbeing in Runyenjes Constituency, Embu County, Kenya'.** I kindly request you to assist me collect the information about the psychological wellbeing of children with motor impairments. You are assured that your responses will be treated with strict confidence and the information you give will be used for this research only. There is no right or wrong answers. Do not write your name and you are requested to respond to all questions in each section.

Thank you.

SECTION A: DEMOGAPHIC INFORMATION

Tick your answers where necessary

1. Gender

   a) Male ( ) b) Female ( )

2. Please tick appropriately your highest level of education

   Primary ( ) Secondary ( ) Tertiary ( )

3. For how long have you been in this school?

   Less than 5 years ( ) 5 – 10 years ( ) above 10 years ( )

SECTION C: THE PSYCHOLOGICAL CARE GIVEN TO THE DIFFERENTLY-ABLED CHILDREN AND THEIR PSYCHOLOGICAL WELLBEING

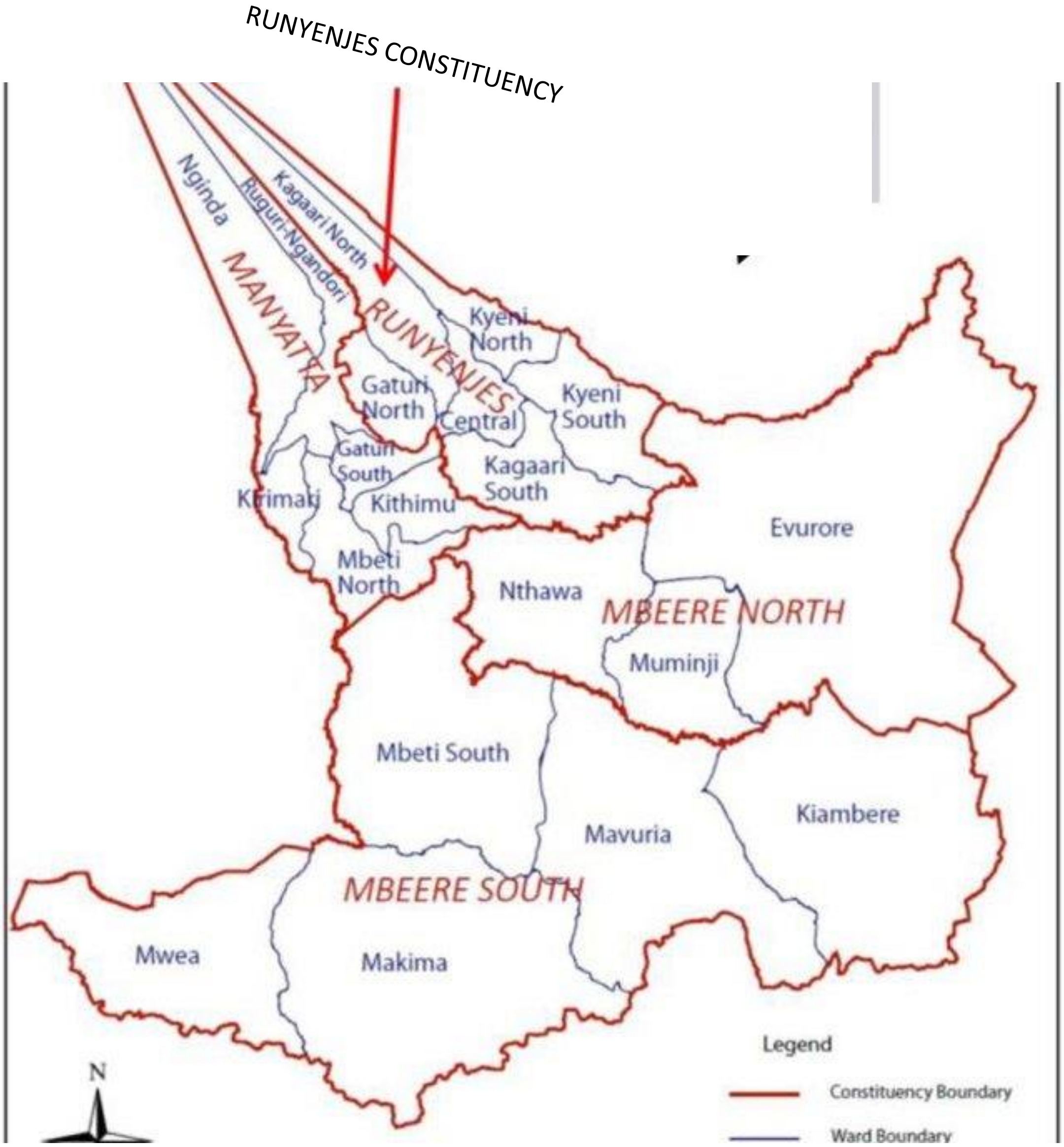
GENERAL COUNSELLING

4. What has been put in place to address the psychological wellbeing of the differently-abled children in terms of Chaplaincy, Guidance and counseling, Motivational speaking and Spiritual growth this area?

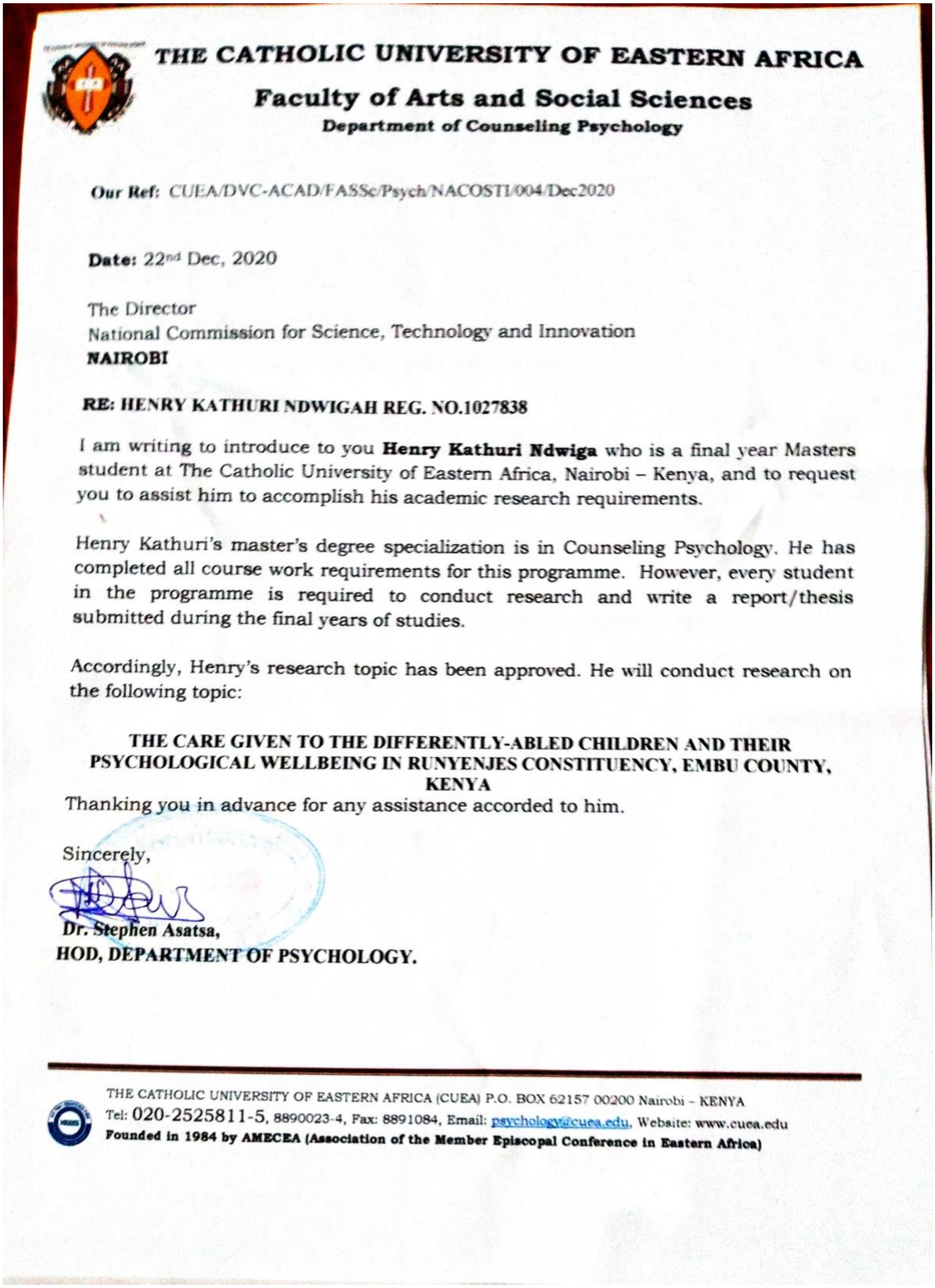
5. How do you rate the quality of services provided by what has been done in the question 4 above?

6. In which areas should the school or the residential institution improve so as to improve the psychological wellbeing of the differently-abled children?

APPENDIX III: MAP OF THE STUDY AREA



APPENDIX IV: LETTER FROM THE UNIVERSITY



THE CATHOLIC UNIVERSITY OF EASTERN AFRICA

Faculty of Arts and Social Sciences

Department of Counseling Psychology

Our Ref: CUEA/DVC-ACAD/FASSc/Psych/NACOSTI/004/Dec2020

Date: 22nd Dec, 2020

The Director
National Commission for Science, Technology and Innovation
NAIROBI

RE: HENRY KATHURI NDWIGAH REG. NO.1027838

I am writing to introduce to you **Henry Kathuri Ndwiga** who is a final year Masters student at The Catholic University of Eastern Africa, Nairobi – Kenya, and to request you to assist him to accomplish his academic research requirements.

Henry Kathuri's master's degree specialization is in Counseling Psychology. He has completed all course work requirements for this programme. However, every student in the programme is required to conduct research and write a report/thesis submitted during the final years of studies.

Accordingly, Henry's research topic has been approved. He will conduct research on the following topic:

THE CARE GIVEN TO THE DIFFERENTLY-ABLED CHILDREN AND THEIR PSYCHOLOGICAL WELLBEING IN RUNYENJES CONSTITUENCY, EMBU COUNTY, KENYA

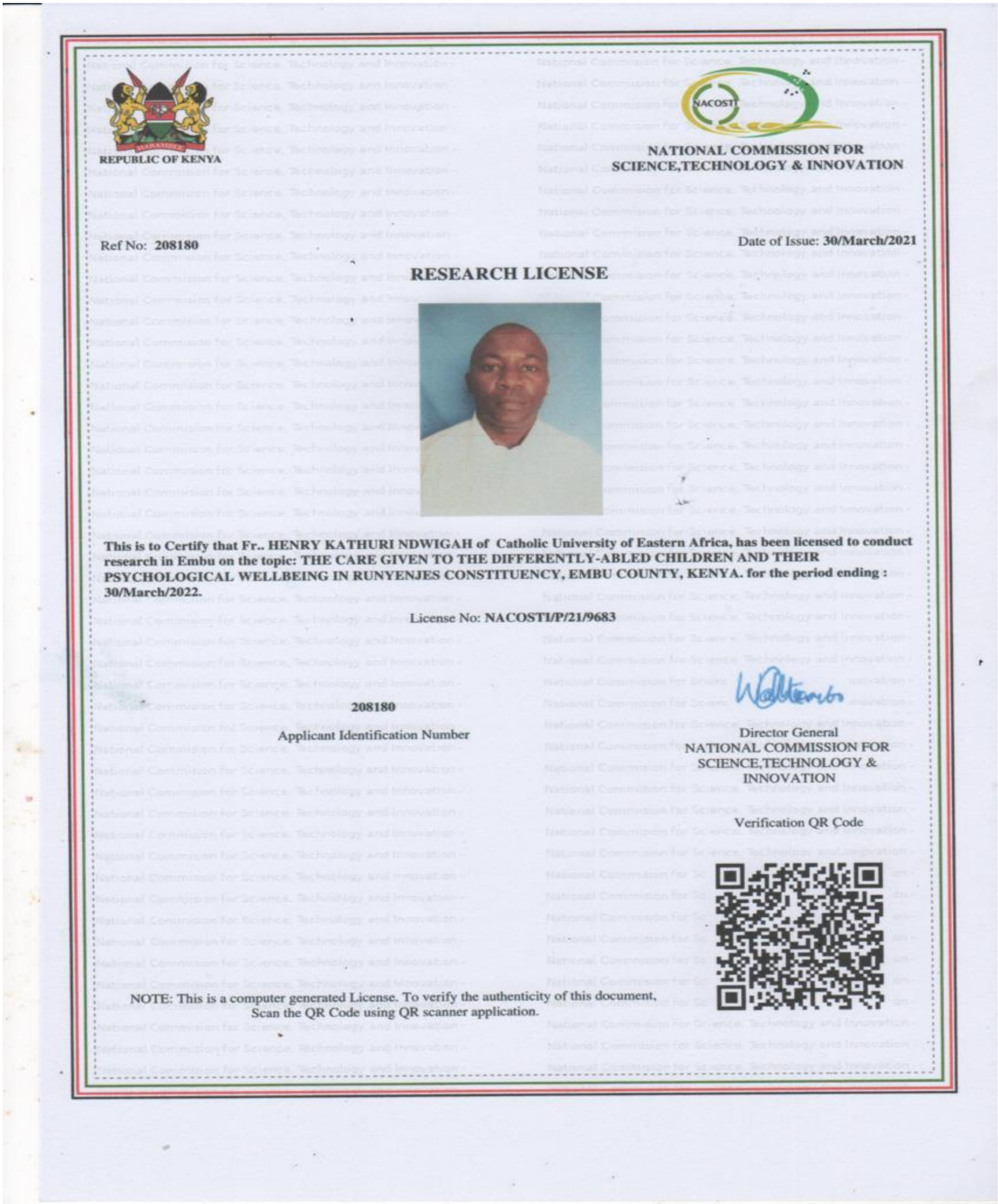
Thanking you in advance for any assistance accorded to him.

Sincerely,

Dr. Stephen Asatsa,
HOD, DEPARTMENT OF PSYCHOLOGY.

THE CATHOLIC UNIVERSITY OF EASTERN AFRICA (CUEA) P.O. BOX 62157 00200 Nairobi – KENYA
Tel: 020-2525811-5, 8890023-4, Fax: 8891084, Email: psychology@cuea.edu, Website: www.cuea.edu
Founded in 1984 by AMECEA (Association of the Member Episcopal Conference in Eastern Africa)

APPENDIX V: RESEARCH PERMIT FROM NACOSTI



REPUBLIC OF KENYA

NATIONAL COMMISSION FOR
SCIENCE,TECHNOLOGY & INNOVATION

Ref No: **208180**

Date of Issue: **30/March/2021**

RESEARCH LICENSE

This is to Certify that Fr.. HENRY KATHURI NDWIGAH of Catholic University of Eastern Africa, has been licensed to conduct research in Embu on the topic: THE CARE GIVEN TO THE DIFFERENTLY-ABLED CHILDREN AND THEIR PSYCHOLOGICAL WELLBEING IN RUNYENJES CONSTITUENCY, EMBU COUNTY, KENYA. for the period ending : 30/March/2022.

License No: **NACOSTI/P/21/9683**

208180
Applicant Identification Number

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NATIONAL COMMISSION FOR
SCIENCE,TECHNOLOGY &
INNOVATION

Verification QR Code

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Scan the QR Code using QR scanner application.

APPENDIX VI: RESEARCH BUDGET FOR THE STUDY

The following is the budget for the proposed study.

ITEM	COST IN KSHS.
Printing of all the drafts	9,500
Binding of all the drafts	3,500
Data collection procedures	30,000
SPSS and data analysis procedures	4,500
Hard cover binding of the final submission (5 pieces @ 2,500)	12,500
Miscellaneous	3,000
Total	**63,000**

APPENDIX VII: RESEARCH SCHEDULE

The work plan for the proposed study is as follows

ACTIVITY	TIME
Defence of the topic	November 2018
Drafting of the proposal	January to May 2019
Submission of first draft to supervisors	December 2019
Departmental Defense of the Proposal	February 2020
Faculty Defense of the Proposal	June 2020
Data collection	July 2021
Data Analysis	July 202
Writing Chapters four and five	August 2021
Faculty Defense of First Draft	August 2021
Final Submission of hard cover Thesis	September 2021

APPENDIX VIII: CONSENT FORM FOR RESPONDENTS

The Catholic University of Eastern Africa

P.O. Box 62157- 00200

Nairobi, Kenya

Dear Respondent,

Fr. Henry Kathuri Ndwigah is a post graduate student at the Catholic University of Eastern Africa, pursuing Master's Degree in Counselling Psychology. He is carrying out a study on **The Care Given to Differently-abled Children and their Psychological Wellbeing in Embu West Sub-County, Embu County, Kenya.** You are kindly requested to participate in this research by filling the attached questionnaire. The shared information shared will be treated confidentially and anonymity will be ensured. You have the freedom to accept or decline to participate in the research or withdraw at any point during the process. If you voluntarily accept to participate in the study, kindly append your signature.

Participants Signature _________________________Date__________________________

Researcher's Signature________________________Date____________________________

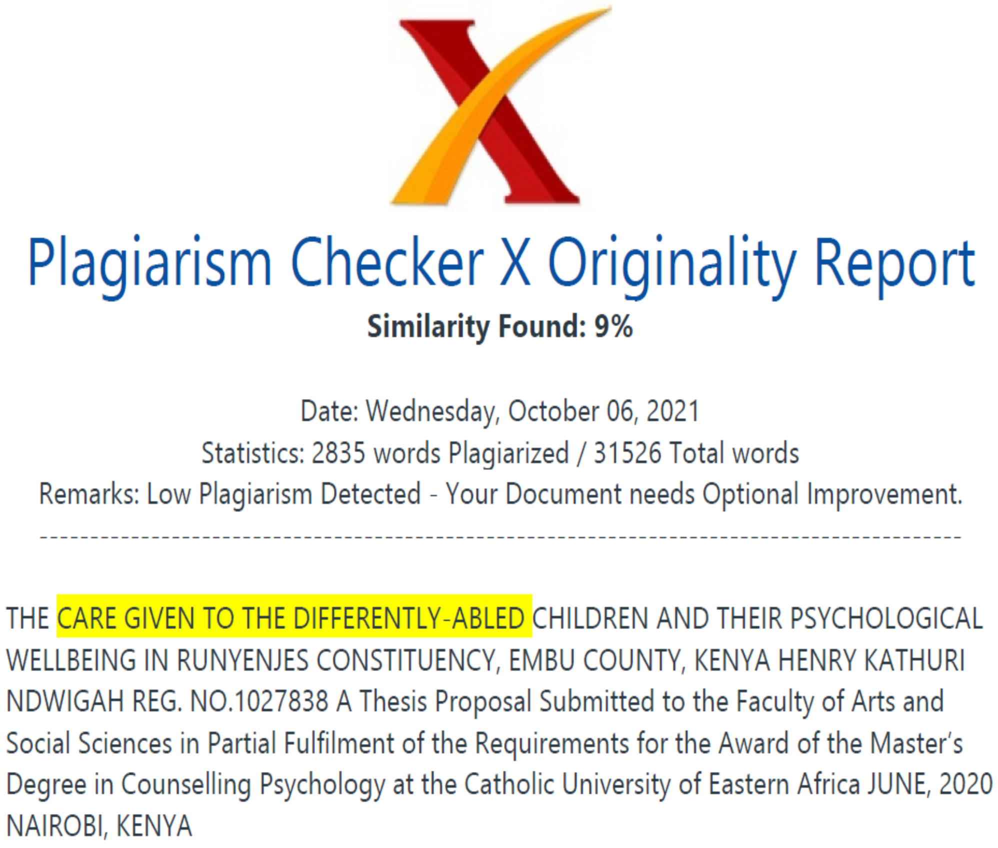
Thank you for your availability to participate in this study.

Fr. Henry Kathuri Ndwigah

Email henkan08@gmail.com

Cell Phone 0720736099

APPENDIX IX: ANTIPLAGIARISM CERTIFICATE



Plagiarism Checker X Originality Report

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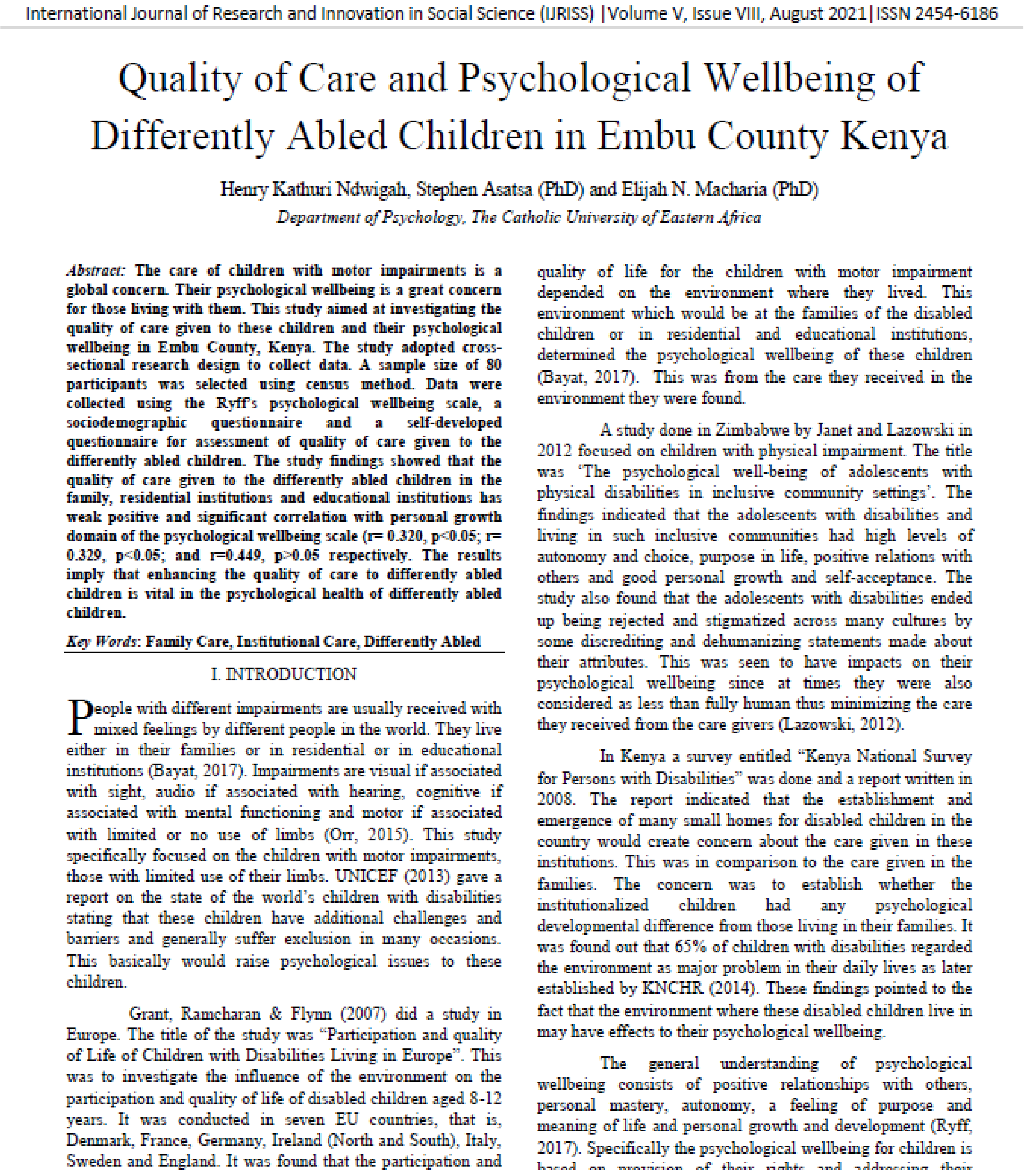
Remarks: Low Plagiarism Detected - Your Document needs Optional Improvement.

THE CARE GIVEN TO THE DIFFERENTLY-ABLED CHILDREN AND THEIR PSYCHOLOGICAL WELLBEING IN RUNYENJES CONSTITUENCY, EMBU COUNTY, KENYA HENRY KATHURI NDWIGAH REG. NO.1027838 A Thesis Proposal Submitted to the Faculty of Arts and Social Sciences in Partial Fulfilment of the Requirements for the Award of the Master's Degree in Counselling Psychology at the Catholic University of Eastern Africa JUNE, 2020 NAIROBI, KENYA

APPENDIX X: PUBLICATION



International Journal of Research and Innovation in Social Science (IJRISS) |Volume V, Issue VIII, August 2021|ISSN 2454-6186

Quality of Care and Psychological Wellbeing of Differently Abled Children in Embu County Kenya

Henry Kathuri Ndwigah, Stephen Asatsa (PhD) and Elijah N. Macharia (PhD)
Department of Psychology, The Catholic University of Eastern Africa

Abstract: **The care of children with motor impairments is a global concern. Their psychological wellbeing is a great concern for those living with them. This study aimed at investigating the quality of care given to these children and their psychological wellbeing in Embu County, Kenya. The study adopted cross-sectional research design to collect data. A sample size of 80 participants was selected using census method. Data were collected using the Ryff's psychological wellbeing scale, a sociodemographic questionnaire and a self-developed questionnaire for assessment of quality of care given to the differently abled children. The study findings showed that the quality of care given to the differently abled children in the family, residential institutions and educational institutions has weak positive and significant correlation with personal growth domain of the psychological wellbeing scale ($r= 0.320$, $p<0.05$; $r= 0.329$, $p<0.05$; and $r=0.449$, $p>0.05$ respectively. The results imply that enhancing the quality of care to differently abled children is vital in the psychological health of differently abled children.**

Key Words: **Family Care, Institutional Care, Differently Abled**

I. INTRODUCTION

People with different impairments are usually received with mixed feelings by different people in the world. They live either in their families or in residential or in educational institutions (Bayat, 2017). Impairments are visual if associated with sight, audio if associated with hearing, cognitive if associated with mental functioning and motor if associated with limited or no use of limbs (Orr, 2015). This study specifically focused on the children with motor impairments, those with limited use of their limbs. UNICEF (2013) gave a report on the state of the world's children with disabilities stating that these children have additional challenges and barriers and generally suffer exclusion in many occasions. This basically would raise psychological issues to these children.

Grant, Ramcharan & Flynn (2007) did a study in Europe. The title of the study was "Participation and quality of Life of Children with Disabilities Living in Europe". This was to investigate the influence of the environment on the participation and quality of life of disabled children aged 8-12 years. It was conducted in seven EU countries, that is, Denmark, France, Germany, Ireland (North and South), Italy, Sweden and England. It was found that the participation and quality of life for the children with motor impairment depended on the environment where they lived. This environment which would be at the families of the disabled children or in residential and educational institutions, determined the psychological wellbeing of these children (Bayat, 2017). This was from the care they received in the environment they were found.

A study done in Zimbabwe by Janet and Lazowski in 2012 focused on children with physical impairment. The title was 'The psychological well-being of adolescents with physical disabilities in inclusive community settings'. The findings indicated that the adolescents with disabilities and living in such inclusive communities had high levels of autonomy and choice, purpose in life, positive relations with others and good personal growth and self-acceptance. The study also found that the adolescents with disabilities ended up being rejected and stigmatized across many cultures by some discrediting and dehumanizing statements made about their attributes. This was seen to have impacts on their psychological wellbeing since at times they were also considered as less than fully human thus minimizing the care they received from the care givers (Lazowski, 2012).

In Kenya a survey entitled "Kenya National Survey for Persons with Disabilities" was done and a report written in 2008. The report indicated that the establishment and emergence of many small homes for disabled children in the country would create concern about the care given in these institutions. This was in comparison to the care given in the families. The concern was to establish whether the institutionalized children had any psychological developmental difference from those living in their families. It was found out that 65% of children with disabilities regarded the environment as major problem in their daily lives as later established by KNCHR (2014). These findings pointed to the fact that the environment where these disabled children live in may have effects to their psychological wellbeing.

The general understanding of psychological wellbeing consists of positive relationships with others, personal mastery, autonomy, a feeling of purpose and meaning of life and personal growth and development (Ryff, 2017). Specifically the psychological wellbeing for children is based on provision of their rights and addressing their