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Volume 16

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Contents

EDITORIAL BOARD.....	ii
INSTRUCTIONS TO CONTRIBUTORS.....	iii
SUBSCRIPTION RATES.....	vi
Contents.....	vii
Understanding Relationship Management in Pre-colonial Yorubaland: A Perspective on Strategies of the Akoko Communities <i>Okajare, Solomon Tai</i>	1-18
The Practice of Human Capital Management among Small Scale Entrepreneurs: An Empirical Overview <i>Olatunji Abdulganiy</i>	19-40
Uncensor the Minstrel, Uncage Human Rights- A Case for the Actualization of Human Rights through Music Genre in Igboland - Nigeria <i>Onuora-Oguno, Nnamdi Chiedu & Onuora-Oguno, Azubike</i>	41-60
Gender Differences and Work Commitment in Selected Federal Universities in Nigeria <i>Adekeye, D. S.</i>	61-78
Counselling Strategy for Effective Rehabilitation of Physically and Health Disabled <i>Bolanle, Segun Olakitan & Ajokpaniovo, Michael</i>	79-98
Perception of Factors Responsible for Failure in WAEC Examinations by Secondary School Students in Kwara State, Nigeria <i>Bolu-Steve, Foluke Nike, Alfred A. Adegoke & Biobaku, Emmanuel Temitayo</i>	99-114
External Intrusion and the Failed State Question: Is Nigeria Really a Failed State? <i>Akume, Albert. T & Philip, Dahida</i>	115-144

In Quest of the Authentic Image of Islam in the 21st Century
M.A. Bidmos

145-158

Quality and Organizational Performance of Small Business
Enterprises in Niger State
Mohammed Abubakar, Mawoli

159-178

The Contribution of Nigerian Scholars to Arabic Language and
Literature: A Case Study of *Al-Hifridul-Farid* of Shaykh Alikinla
Kamil Adeleke Adeyemi

179-189

Counselling Strategy for Effective Rehabilitation of Physically and Health Disabled

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Abstract

Disability is a functional disablement that results from impairment and consequently restricts an individual from performing their day-to-day activities. Therefore, a person is said to be disabled if he has had impairment in the past and this impairment may be physical, cognitive or developmental. Psychiatric and other types of chronic diseases are also regarded as disabilities. Thus, the physical and health disabled are described as persons with a condition that makes it difficult for them to perform some or all of the basic tasks of daily life. As a result, these categories of people need assistance in form of counselling and effective rehabilitation. Effective rehabilitation and counselling largely depend on counselling theories, which could be used to handle their emotional concerns such as depression, isolation and frustration among others, that might be the attendant consequences of their impairment. Changes may occur structurally and functionally because of these disabilities in the affected individuals, hence, counsellors need to be aware of these factors in the process of rehabilitation. Thus, one of the effective counselling strategies in handling the physical and health disabled is the Rational Emotive Behaviour Therapy (REBT) of Albert Ellis.

Key words: Physically and Health Impairment, Disability, Counselling, Rehabilitation, Rational Emotive Behaviour Therapy.

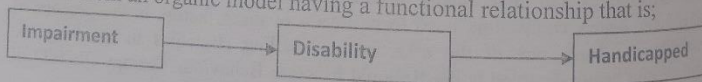
Introduction

Counselling and rehabilitation of people living with disabilities is a challenging field and an important area in the guidance and counselling profession. People living with disabilities are members of the larger society

though their disabilities may have incapacitated them to be adequately efficient and effective in their day-to-day activities. People living with disabilities are therefore impaired in one form or the other. They are called the disabled because their disabilities do not restrict them totally from social, emotional, intellectual, moral and physical activities within their environment. Hull (2008) described people with disabilities as persons with physical, sensory or mental impairment that can make performing an everyday task more difficult. Disabilities can be congenital, that is, someone is born with the handicap and it could be acquired soon after birth or at any stage of life. It could result from disease or infections, and could result from an accident. This is called adventitious disabilities and sometimes the cause may not be known (Obani, 2004).

Panda (2007) defined the disabled as people who differ from the average to such a degree in physical and psychological characteristics that the traditional school programme does not allow all round development and progress for them. They therefore need special ancillary services to develop or progress according to their abilities. Adima (1981) noted that the disabled person constantly experiences deterioration of his basic skills and a loss of self-confidence, resulting in despondency, inability to participate in normal life of the family and the community, maladjustment because of feeling of inequality, lack of prestige and other concomitants of "not belonging". Despite this seemingly gloomy existence of people with disabilities, they can be rehabilitated through counselling.

The meaning of disability is obvious, yet, it has lent itself to controversy because it connotes different meanings and has various synonyms such as impairment, exceptionality, handicapped, subnormal and special which have been used to describe it. However, the World Health Organization (1980) opined that these terms- impairment, disability and handicapped are derived from an organic model having a functional relationship that is;



Panda (2007) stated that due to widespread debate, discussion and research for many years, it has been concluded that the use of these three terms would be adequate – disability, impairment and handicapped.

Impairment is a change in normal structure or function resulting from a disease, disorder or injury. It includes any loss or abnormality of a psychological, physiological or anatomical structure or function, the

disturbance is at the level of organs such as loss of sight, hearing or a limb. Thus by implication, the result is a structural disablement.

Disability is any restriction or lack (resulting from an impairment) of the ability to perform an activity. For example, climbing stairs, operating machinery in the manner or within the range considered normal for a human being. It reflects disturbance at person's level such as behaviour, performance, mobility, communication and memory. As a functional disablement, it should be seen as a continuum in terms of severity, ranging from very slight to severe. This has importance in relationship to employment as progression of the disability may require further modification and adaptation of the workplace to show continuing employment.

Handicap is a disadvantage for a given individual resulting from an impairment or disability that limits or prevents the fulfillment of a normal role for that individual. That role may be in relation to a particular environment for example work, and the consequences may be cultural, social, economic and environmental. They may be manifested as physical in relation to self-sufficiency. Therefore, handicap is a restrictive disablement (Agius, 2007).

Current issues and debates surrounding disability include social and political rights, social inclusion and citizenship. In developed countries, the debate has shifted beyond a concern about the perceived cost of maintaining a dependent people with disabilities to an effort of finding effective ways to ensure that people with disabilities can participate in and contribute to, society in all spheres of life. Nevertheless, the greatest need is in the developing nations – where the vast bulk of the estimated 650 million people with disabilities reside. Hence, a great deal of work is needed to address concerns ranging from accessibility and education to self-empowerment and self-supporting employment and beyond.

There are still obstacles in some countries in getting full employment. In addition, the perception of people with disabilities may vary from country to country. The International Classification of Functioning, Disabilities and Health (ICFDH) produced by World Health Organization (2004) listed nine broad areas of functioning, which can be affected by disability:

- Learning and applying knowledge
- General tasks and demands
- Communication
- Mobility
- Self care
- Domestic life
- Interpersonal interactions and relationship

- Major life areas
- Community, social and civic life

The Disabled

The term 'disabled' is sometimes used interchangeably with handicapped, though handicapped is old-fashioned and offensive that it is now being rejected. 'Disabled' is generally viewed as a term to describe people with a permanent illness or injury that makes it difficult for them to use part of their body completely or easily (Oxford Advance Learner Dictionary, 2007). They are unable to learn easily; therefore, they are qualified to be assisted. People with disabilities are persons who may have problems in thinking, remembering, seeing, speaking, socializing or moving such that they require special education and related services for them to realize their full potentials. This description does not exclude the physically and health disabled.

Adima (1981) noted that people with disabilities are diverse in population within our society and vary in characteristics largely as the non-disabled. Thus, he described them as those who are "incapacitated or crippled" by multitude of factors such as, congenital defects, hereditary influences, accidents, infectious diseases and other environmental factors. For someone to be qualified as a person with disability there must be a manifestation of certain characteristics that limit the activity of such individual. It must be noted that people with disabilities do not include those who have itches or any skin illnesses such as eczema and pimples among others, because these are temporary conditions that will go in a short time.

However, many books on disability rightly describe the "disabled" as an identity that one is not necessarily born with, as disabilities are more often acquired than congenital. Based on this premise, some disability-right activists use an acronym TAB "*Temporarily Able Bodied*" as a reminder that many people will develop disabilities at some point in their lives from accidents, illnesses (physical, mental or emotional) or late emerging effects of genetics.

The Physically and Health Disabled

Physically and health disabled have been described in many literature as physically disabled, crippled, orthopedically impaired or health-impaired. Abba and Aduwo (1985) described the physically and health-impaired individuals as those who are crippled, deformed and or neurologically disordered. In the same vein, Ogbue, Obani and Abosi (1987) defined physical impairments as a malformation or abnormality of body parts and or ill health conditions that results in restrictions of normal movement and limitations of energy in an individual. These restrictions (crippling) and limitations (special

health problems) cause the handicaps (impairments) that the person experiences. For the purpose of special education, physical impairment can be divided into two types; orthopedical and health impairment (Birge & Sirvis, 1986, Ogbue, Obani & Abosi, 1987).

Orthopedical impairment is a severe disability that affects an individual's educational performance. It includes congenital impairment such as clubfoot, absence of some organs, impairment caused by disease such as poliomyelitis, bone tuberculosis and impairment caused by some other factors or causes such as cerebral palsy, amputation and fractures or burns that cause contractures (Panda, 2007). The legal definition of other health impairment is having an acute condition that manifests in severe communication and other developmental and educational problems or having limited strength, vitality or alertness because of acute health problems, such as heart disease tuberculosis, rheumatic fever, nephritis, epilepsy, hemophilia and diabetes, among others that adversely affect an individual's educational performance (Venn, 2010; Panda, 2007).

From the foregoing, it then can be deduced that people with physical impairments are susceptible to a myriad of mobility-related problems in architectural designing of buildings and infrastructure. Architectural designing include that of steps, staircases, heavy doors, narrow lifts and high window levels among others. These restrict the movement of the physically handicapped as well as their rehabilitation, employment, educational, vocational, cultural and recreational opportunities (Olawale, 2000). In fact, there are some neurological problems, which are not categorized as crippling, or a special health problem such as aphasia – inability to produce speech due to brain damage. Hence, they are classified as non-sensory physical impairments which may be classified as crippling and chronic health ailments. The crippled have obvious muscular and skeletal deformities as a result of which they wear braces, prosthetic devices such as artificial limbs, and sometimes move with crutches or wheel chairs. The crippled individual is referred to as orthopedically or motor impaired while those with health-related problems are referred to, and known, as people with special health problems (Panda, 2007).

Causes and Characteristics of Physically and Health Impairment

There are various causes of physical and health impairment and these include brain damage, brain fever, brain anoxia, Rh-incompatibility, intoxication, viral infection for the expectant mother, prolonged labour, lead poisoning, accident, polio, burns and injuries. These causes are either

congenital or adventitious (Panda, 2007). Panda further noted that physically-impaired individuals are passive, less persistent, exhibit shorter attention span, engage in less exploration and are not motivated to do anything. Furthermore, they depend more on adults and isolate themselves from peers. They have poor body image, high anxiety and frustration levels. They are usually quiet, conforming, tender minded and tense. The crippled individual's social relationship is another major problem for a physical disabled person. Their capacity for frustration and tolerance are lower compared with the normal children (Olawale, 2000). Ogbue, Obani and Abosi (1981) equally listed some of the observed characteristics among which are as follows:

- Loss of consciousness or seizures as in epilepsy, twitching and deep sleep.
- Pain in the spinal column and limbs.
- Stiffness in the neck and rigidity of the spinal cord followed by paralysis which leads to engagement in self pity.
- Restricted movement and very limited growth as in dwarfs.
- Agraphia (inability to write independently).
- Disorder of movement and posture.
- Absence of some body parts from birth, cancer of the blood.

Rehabilitation

Rehabilitation is a gradual process aimed at restoring a person's ability to live and work as normal as possible after a disabling injury or illness. It is aimed at assisting the individual to achieve maximum possible physical and psychological fitness as well as regain the ability for self care. Rehabilitation also helps individuals to learn and relearn skills of everyday activities with occupational training and guidance and with psychological readjustment (Stewart, 2010).

This definition has its shortcomings because of the word "*restore*". It pre-supposes that the individual at some time in his life had lived and worked normally, hence, many people. Microsoft Encarta (2009) described rehabilitation as any programmed ameliorative exercise, guidance or instruction afforded to those with a particular disability whether physical, psychological or social. The term rehabilitation is also applied to the economic help or relief given to refugees or victims of natural disasters and sometimes to urban reconstruction programmes. Therefore, including the social aspects of disability means that the person is identified as a client or patient on one hand and a member of the society on the other. The individual societal needs and his rehabilitation needs impinge upon and influence each

other. The counsellor or therapist who concentrates on the physical and mental aspects of the treatment and ignores the social, treats only part of the problems and does not meet fully the clients or patient's needs. In a related view, Hirschberg, Lewis and Thomas (1964) defined rehabilitation as the total process by which someone is restored to a state of optimal effectiveness and given an opportunity to enjoy a meaningful life.

From the foregoing, it is evident that rehabilitation is all encompassing – physical, emotional, social, medical, vocational and of course economic. The person who is skilled in providing these services is the counsellor who through his wealth of experience and training, employs the element of teaching, training and retraining, advising and consultation and even environmental manipulation such that it involves extensive work with many persons in addition to persons with disability (Daramola 1995). Reasons have been advanced as to why persons with disabilities would require rehabilitation. These include accidents, congenital defects and maladjustment of social origin among others. Rehabilitation counselling is to help persons with disabilities to achieve optimal functioning. Hence it implies that:

- (a) Rehabilitation counsellors should set target or goals to be achieved and put aside all their pre-conceived ideas. That is, the counsellor must help the disabled on his or her own level of functioning but it is better to allow the disabled to determine the level of functioning he/she is aiming at.
- (b) Rehabilitation counsellors should give a direction about how to achieve the goals set by the disabled. This process implies that the counsellor should know where to refer the client for different kinds of services that he or she may not be competent to offer such as job placements and medical treatment. The counsellor should also provide the emotional and therapeutic atmosphere necessary to put the disabled in shape. This includes as the required interventions to help the client overcome anxieties and doubts about his/her abilities.
- (c) Rehabilitation counsellors should provide follow up service because it is not enough to see that the clients get started. He should also ensure that it is a good start on something and that the goals of the process are attained as fully as possible.

However, it must be noted that rehabilitation is both preventive and restorative, directed towards improvement of function. While it may not be possible to "restore" the physically and health impaired to their former states of wholeness, rehabilitation counsellors are active in working with them. If it is not possible to "rehabilitate" it is very possible to "habilitate" (Stewart,

2010). This is to enable the physically- and health-impaired people to strive toward that which they and other people would accept without prejudice.

Rehabilitation of the Physically and Health Disabled

Physical and health impairment imposes limitations on the orderliness of life and the expectations of others; such understanding becomes the underlying attitude for helping to rehabilitate them. People with physical and health impairment are psychologically imbalanced whether they are congenital or adventitious-disabled. Hopkins (1971) and Lynch and Arndt (1973) opined that the physical and health impaired are usually depressed and have some difficulty in dealing with the inflexible frustration caused by their disability and this forms the basis of counselling and rehabilitation. Because of the social problems imposed upon the individual physical and health disabled, their socialization process varies with the time of onset of the disability.

Lynch and Arndt (1973) stated that when physical disability is identified at birth or thereafter, the parent's initial attention or reaction to the bodily appearance and functioning is greatly intensified and this intensification depends on the parents' specific attitudes. Also, research has shown that the physically disabled has to learn how to accept the disability and this process of acceptance may take a long time and this in itself may alter socialization patterns. In addition, in the areas of vocational and sexual relations they experienced serious problems. Genrich (1975) stated that people with physical disabilities have vocational aspiration problems hence they lack an understanding of their physical, intellectual and emotional limitation as well as capabilities and demonstrate more inappropriate job choices than non-disabled youth due to their narrow exposure to the world of work and their limited understanding of the possibilities open to them. Hence, vocational rehabilitation should be encouraged so that the physically disabled would be able to "test out" their abilities in the real world of work; they should be placed in jobs and helped them to cope effectively with their environment in order to function as independently as possible. In the areas of sexual functioning and sexual relationship, most people with physical disabilities shy away, although this is not only peculiar with them as it also manifests in the non-disabled individuals.

Rehabilitation is generally synonymous with therapy. Besides the convalescents, deaf-mute or blind people, amputees or paralytics and other person with physical and health impairment, people with emotional disturbance, criminals and juvenile delinquents can also profit from rehabilitation programmes. Since the programme is aimed at instilling or

restituting positive skills or attitudes in individuals with a more contributive and fulfilling role in society, rehabilitation begins with intervention and appropriate medical services.

Counselling Theories

In special education context, people with physical and health disabilities include those with severe disabilities that adversely affect educational performance and behaviour. Livneh and Sherwood (2001) stated that several counselling approaches could be used to counsel people with physical and health impairment to enable them gain insight into the psychosocial impact of, and personal adjustment to, the disability. In this regard, Counsellors must be familiar with theories specific to rehabilitation and follow guidelines for assessing therapeutic changes. This implies that Counsellors ought to choose those interventions most congruent with their own theoretical orientation, academic training, work setting and nature of the disability conditions.

However, Counselling strategies emanate from counselling theories. Egbochuku (2008) described counselling theories as provisional explanatory propositions made about certain human behaviour. It means that counselling theories are identified by the description what they do and their importance in the advancement of knowledge, research and professional practice. Hence, these theories are grouped into three broad categories based on their underlying assumptions about human nature, the origin and determination of human behaviour. This is diagrammatically shown below:

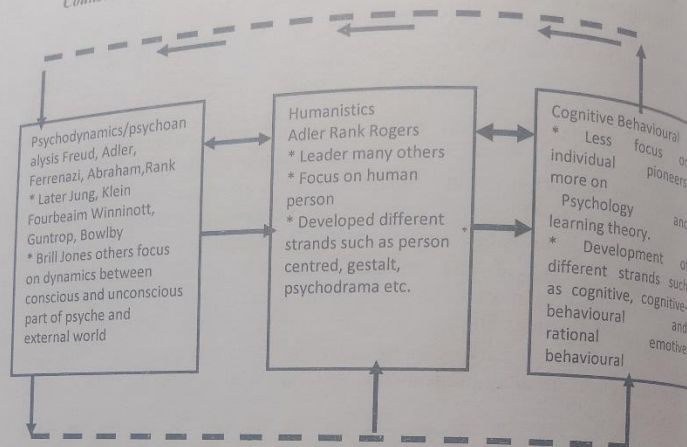


Fig 1: Diagram Showing Counselling Theories
Adapted from Egbochuku, (2008)

This classification will assist the counsellor to understand and utilize the theories. However, each classification has its aims and objectives, strengths and weaknesses that dictate its uses. For instance, the psychoanalytic theory focuses on the client's unconscious state (Egbochuku, 2008). Besides, Livneh and Sherwood (2001) asserted that the application of psychoanalytic intervention to rehabilitation and counselling of the Disabled is nonexistent because of the long duration of the treatment required, the necessity for advanced professional training and the financial training involved.

The psychodynamic approach is also called social psychological, Neo-Freudian or Neo analytic approach and their proponents are sometimes referred to as egopsychologists (Oyewo & Abiola, 2009). This approach according to Livneh and Sherwood (2001) is affected to some extent by the same limitations of the psychoanalytic methods of Sigmund Freud. The Humanistic approach includes the existential approach of May, Maslow, Frankl, Jourad, Person-centered theory of Carl Rogers and the Gestalt theory of Fritz Pearls. These groups of theories place emphasis on the attitude of the therapist and maintain that the quality of the client/therapist relationship is the prime determinants of the outcomes of the therapeutic process. (Oyewo & Abiola, 2009).

Livneh and Sherwood (2001) also stated that the need for a more active and direct approach in the later phase of the counselling process seems to limit the applicability of the person-centered approach to rehabilitation settings. Cook (1987) and Thomas, Butler and Parker (1987) listed some of the limitations of the use of this approach in rehabilitation settings as follows:

- reluctance to set specific goals apart from self actualization,
- aversion to diagnosis and evaluation, questions concerning the value of advice giving,
- lack of concern with the external environment,
- nature of being process-oriented rather than being outcome oriented
- tendencies not to focus on client's behaviour or skills development.

The Behavioural approach also known as cognitive oriented and Behaviour-oriented Action Therapies includes Transactional Analysis of Eric Berne, Behaviour Therapy of Bandura, Wolpe, Meichembain, Lazarus, Reality Therapy of Williams Glasser and the Rational Emotive Therapy of Albert Ellis among others. The major strength of this therapy is that it gives priority to the client's feelings, thinking and doing (Oyewo & Abiola, 2009). For instance, the goal of reality therapy is to teach clients to accept the real world, and assume responsibility for who they are and what they do and develop realistic acceptable and responsible plans and behaviour that will enable them to achieve and maintain a successful identity (Ososkie & Turpin, 1985; Walker, 1987). They further stated that clients are required to learn and face the reality of the disability and are guided on how to live within this framework. Disabilities are not allowed to be used as an excuse for personal failures and dependency.

Counselling Strategies

Based on the strengths and weaknesses of counselling theories therefore, Rational Emotive Behaviour Therapy (REBT) is being considered in this paper as the most congruent and closely-allied to the practice of counselling clients who are physically and health disabled. This is achieved through structural re-educative-relearning approach where by the client is taught how to dispute irrational beliefs, eliminate them and finally replace them with a rational belief system. Frustration and unhappiness associated with disability are considered irrational because they stem from a belief system that wrongly equates impairment and disability with terrible catastrophic events.

Rational Emotive Therapist regards people as having the inherent capacity to think and act rational and irrationally. Rational thinking is seen as

leading to appropriate emotion and adaptive behaviours resulting in healthy functioning. Irrationality, on the other hand, results in inappropriate emotions and imperfective behaviours. Such cognitions are the culprit of unhealthy or self-defeating functioning. Ellis (1973) and Ipietofesa (1978) identified such self-defeating functioning as anger, depression, guilt and anxiety. People with physical and health impairment experience such irrational thoughts beliefs and philosophies which eventually are cosigns of their sorrow affecting their efficiency in life, school and at work. Ellis (1982) stated that emotions are inseparable from thinking, hence individual thoughts are bolstered up by emotional outburst and in resolving this idea, individuals should depend on their intellectual endowment in order to erase or cure themselves from emotional upset.

Rational Emotive Therapist believes that on individual should be held responsible for his or her behaviour and they should not be blamed for their doings because blame and anger are irrational feelings that must be eliminated if a person must enjoy the benefit of rational existence.

Rational emotive therapist also believes that one's emotional response is dependent on "self talk" and self talk is a product of repeated ideas or thinking which is traceable to one's entrenched belief system. Essentially what the individual tell themselves become their thoughts and emotions. It is what an individual tells himself or herself that gives rise to calm thinking or excited emotions.

People with physical and health impairment should be taught by a rational emotive therapist on how not to think irrationally and not to engage in false sentences such as "since I lost my ability to walk, I must be helpless and therefore, my future is hopeless". It is these negative feelings about oneself which is consequent upon cognition, and self-verbalizations, that constitute lowered self-esteem. Ellis, (1973) said that affection and behaviour are largely determined by cognitive perception. Thus, REBT is an effective counselling intervention therapy for behavioural change and emotional balance for the physical and health impaired individual to live a sustainable life considering his/her their cognition and self verbalization. REBT entails digging deep into the activating event as if one has a camera in order to be sure of objectivity (Adewuyi, 2006).

Disputing self-verbalization in the physical and health-impaired individual is in form of a debate, which is based on the following:

- Is my thinking based on obvious fact?
- Will my thinking help me to achieve my short and long term goals?

- Will my thinking here best help me avoid my most unwanted conflicts with others?
- Will my thinking here best help me habitually feel the emotions I want to feel?

All these and many more are expressed by the physically and health impaired disabled and the REBT counsellors should be aware and thus, the process of effective counselling should be based on these premises. The REBT counselors will employ various counselling techniques such as teaching, confrontation, cognitive and restructuring among others.

REBT counsellors assist the depressed physical and health impaired individuals to erase their negative beliefs and expectations concerning the disability and its implications, thus eventually eliminating the illogical beliefs (Becks, 1967, Ellis, 1973, Halligan, 1983).

REBT counsellor following the A B C principle declared that it is not the antecedent event (A) such as losing a leg that causes the consequence (C) negative emotion or reaction such as depression; rather, it is the persons belief system (B). The belief system comprises those self evaluation meanings or self verbalization that negatively magnify the persons attitude toward the event – being rejected by others, because the physical and health impaired suffer, physical, psychological and social imbalance hence, they are usually depressed.

In correcting the identified cause of the disturbed condition, the REBT counsellor shows them that it is the illogical thinking that is the cause of their sorrow and unhappiness hence the counsellor will assist by helping them to change the irrational beliefs to a rational one through the elongation of the ABC theory into A – B – C – D – E – F. At point D the REBT therapist teaches the client how to dispute his irrational beliefs he acquired at point (B) such as why should I be a physical or health impaired person, what are the evidence that I am worthless. What is the evidence that I cannot make it? Ellis and Bernard (1986) described the disputing process as having three components:

- (a) Detecting- clients learn how to detect their irrational beliefs such as the “should”, “musts” the awfulising and their self-downing.
- (b) debating – clients debate their dysfunctional beliefs by learning how to logically and empirically question them and vigorously argue themselves out of, and act against, behaving them.
- (c) Discriminating – clients learn how to discriminate irrational beliefs from rational ones. The REBT counsellor employs behavioural, cognitive and emotive methods to assist clients to surrender their

irrational beliefs either during counselling session or outside counselling sessions. The persistent and forceful dispute of these irrational beliefs with the physical and health impaired individual by the counsellor will eventually lead to a new cognitive affect at point E leading to the belief that he is not worthless or hopeless and that despite his disability there is ability. Finally the last stage, which is point (F), implies that the counsellor is successful at point E and the physical and health impaired individual at this stage would have developed a new set of feelings which is rational and effective in his day-to-day activities; the feeling of depression or anxiousness will totally be rejected. The interaction process is diagrammatically shown below:

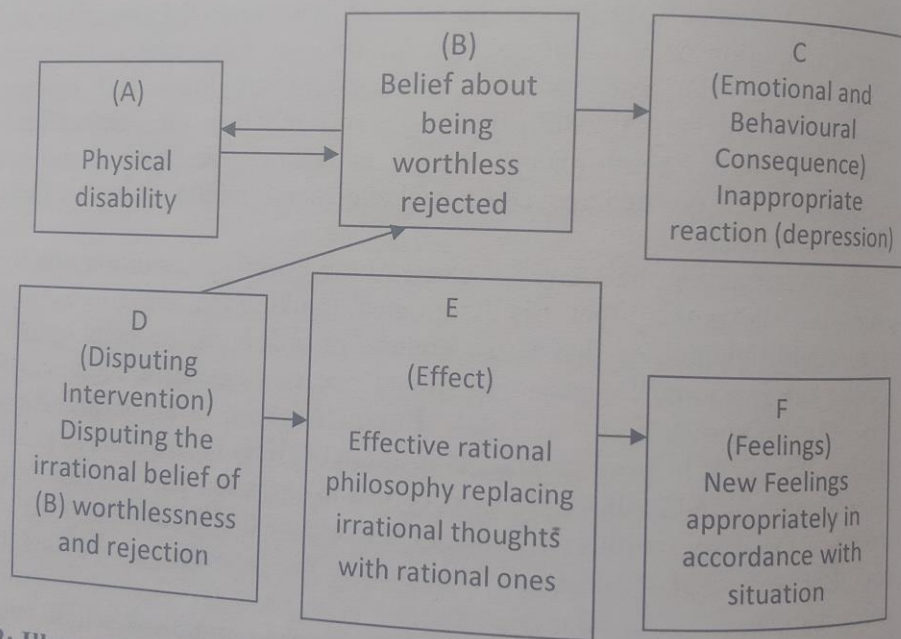


Fig 2: Illustration of the A-B-C Theory of Personality
Adapted from Azekhueme, (2007)

However, it must be noted that during the counselling session the REBT counsellor subscribes to various techniques such as teaching the clients to examine and modify the irrational perceptions and beliefs and teaching how to end the disability-associated frustration by either modifying their

environment or by learning to accept their existing life limitations when circumstances cannot be altered (Ard, 1968).

Clients are assisted in setting short-term and specific goals such as manouvering the wheelchair around the physically-disabled person's living quarters and applying for a seeing eye-dog permit among others. The problems the physically disabled encounter their disability are broken down into smaller components through graded assignments, while the activities schedules are developed to decrease or reduce the disabled person's ruminations about the disability and increase motivation (Bowers, 1988).

The physical disabled are also assigned homework exercises and written or practiced homework are subsequently brought to be discussed during counselling sessions. Ostby (1985) stated that physically and health disabled people are trained in skill acquisition to compensate for social, vocational, sexual and marital deficits.

REBT counsellors also confront the clients who are depressed especially the physical and health impaired because of their negative beliefs and expectations concerning the disability and its implication and proceed to assist the client in cognitive restructuring and eventually eliminate their illogical belief (Halligan, 1983; Ellis; 1973, Beck, 1967).

Conclusion

Physical and health impairment is a complex phenomenon, it includes sensory impairment, such as, visual, hearing and or loss of limbs and defects in other organs of the body and other related health problems, which may be mild or chronic. In view of this, all disabilities could as well be subsumed under physical and health impairment. Counselling and rehabilitation must be total social, physical, emotional, cultural, vocational and physical for them to be meaningful and effective. Counselling must aim at gaining in-sight into the psychological effects of the physical disability, for personal adjustment to the disability while the rehabilitation counsellor must be familiar with theory i.e. specific guidelines for assessing therapeutic change. Among the best counselling therapies are the (REBT) Rational Emotive Behaviour Therapy and the Cognitive Theory of Aaron Becks, although the two theories fall under the Cognitive Behaviour Therapy. However the two theories are not exclusive, hence a combination of theories may be more efficient – that is elective approach. This depends on the counsellor and the client level of cognition (Ellis, 1973; Becks, 1976). In most cases the counsellor who serves clients with disabilities is expected to choose any counselling intervention that is most appropriate and congruent with their own theoretical orientation,

academic training, work setting and the nature of their disability conditions. However, counsellor's observation of change in the client should adopt subjective measures such as evaluation of illogical and logical thinking ratio, client's proficiency in analyzing his or her self talk and the ability to teach REBT to others.

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