UNIVERSITY OF CAPE COAST

COMMUNITY LIVING AND PARTICIPATION OF PEOPLE WITH DISABILITIES: A CASE STUDY OF THE CAPE COAST METROPOLIS

BY

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DECLARATION

Candidate's Declaration

I hereby declare that this thesis is the result of my own original work and that no part of it has been presented for another degree in this university or elsewhere.

Candidate's Signature: ……………………… Date: ……………………….

Name: ……………………………………………………………………………..

Supervisors' Declaration

We hereby declare that the preparation and presentation of the thesis were Supervised in accordance with the guidelines on supervision of thesis laid down by the University of Cape Coast.

Principal Supervisor's Signature: …………….............. Date…………………

Name: ……………………………………………………………………….

Co-Supervisor's Signature: ………………..................... Date…………………

Name: ……………………………………………………………………………..

ABSTRACT

The purpose of the study was to examine the community livving and participation of people with disabilities with their sighted counterparts. The case study design was used for the study. The sample size was 16. These comprised 12 people with disabilities and 4 non-disabled peers. The method for data collection was interviews. The purposive sampling technique was used to select the sample size. Data was analysed thematically. Results from the study showed that most people with disabilities do not participate fully in the community. The study concluded that community living and participation of people with disabilities was partial due to some environmental, policies and self-perceptions of people with disabilities and the non-disabled in the community. It was recommended that the self-perceptions of people with disabilities need to be improved upon through counselling during their associations meeting and also through active participation in community activities whenever possible. Also playing and working together on activities in the community should be adopted by the non-disabled to boost the nature of friendships in the community, since such activities proved to be effective in predicting friendships in the community. It was also recommended that regular advocacy be done to educated community members on disability issues to minimize prejudice and misconceptions.

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DEDICATION

To my mother, Hawa Bukari, and in memory of my late former Principal Supervisor, Professor Prosper Deku.

KEYWORDS

Disabilities

Community living

Hearing impaired

Intellectual and Developmental Disabilities

Impairment

Participation

Physically challenged

Visually impaired

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LIST OF ABBREVIATIONS

GFD:	Ghana Federation for Disabled
HI:	Hearing Impaired
IDD	Intellectual and Developmental Disabilities
ICF:	International Classification Functioning
KEEA:	Komenda Edina Eguafo Abrim
NGOs:	Non-Governmental Organisations
PC:	Physically Challenged
PWDs:	Persons with Disabilities / People with Disabilities
VI	Visually Impaired
W.H.O.:	World Health Organisation

CHAPTER ONE

INTRODUCTION

Disability is part of the human condition (WHO, 2015). Almost everyone will temporarily or permanently be impaired at some point in life, and those who survive to old age will experience increasing difficulties in functioning (WHO, 2015). Most extended families have a disabled member, and many non-disabled people take responsibility for supporting and caring for their relatives and friends with disabilities. Every epoch has faced the moral and political issue of how best to include and support people with disabilities (World Bank, 2011).

Community livving and participation of people with disabilities has been referred to as the involvement of an individual in social, cultural and economic activities that is appropriate for the person (Mansell & Ericsson, 1996). In a study conducted by Dijkers (2010), researchers described participation as a complex and multidimensional construct, and concluded that there are no set standards for defining and measuring participation.

Participation of individual with disability in the communities has become crucial for social inclusion agenda in recent times. Community living and participation of people with disabilities cannot be overlooked in Ghana. since it facilitates their overall socialization in the mainstream of society.

Background to the Study

Historically, people with disabilities are often regarded as unproductive and incapable of contributing in a positive way to society and are rather seen as constituting an economic burden on the family and the society (WHO, 2015). The functional limitations typically associated with ageing are not simply related to a person's chronological age. Capacities and health needs of people with disabilities living in communities are indeed very diverse. Opportunities for an ageing population to remain active and to continue to participate in society are dependent on one main factor: their health. Good health fosters activity and participation. At the same time; the experience of limitations and restrictions –that is, disability – has negative implications for health. Sudden deterioration in health, or a chronic or lifelong illness, may influence activities and participation even early on in life. Therefore, young people are a non-negligible group among those facing disability in their own homes and immediate surroundings (WHO, 2015).

The global prevalence of moderate or severe disability is estimated to be 15% of the general population and 50% among those aged 60 years and older (World Health Organization, 2015). This means that up to 190 million adults experience significant difficulties in functioning, and as many as 1 billion people are estimated to be living with some kind of disability. While some disabilities result in extensive health care needs, others may affect everyday life without requiring frequent contact with health care or social services. Disability is therefore an extremely diverse topic. Nevertheless, common denominators are limitations on activity and restrictions on participation for the individual. The World Health Organization (WHO) and the World Bank have stated that specific attention should be paid to promoting participation among people with disabilities (WHO, 2011).

Avoke and Avoke (2004) stated that, throughout history, there has existed a belief, that individuals with disabilities could “pollute” the society. Stereotyping and prejudice have become the tools utilized to marginalize individuals with disabilities. They argue that in the past, the communities within which they lived justified the manner in which people with disabilities were treated. This was because disabilities were attributed to the visitation of evil on an individual from the “gods”. Children with disabilities were therefore `viewed as being less than human and were subsequently vulnerable to less than human treatment`.

Currently, Ghana has a total of 737,743 persons with some form of disability (Ghana Statistical Service, 2013). According to the Ghana Federation of Persons with Disabilities (GFD, 2016), people with disabilities in Ghana are often regarded as unproductive and incapable of contributing in a positive way to society, but rather seen as constituting an economic burden on the family and the society at large, which leaves them in vicious cycle of poverty. In developing countries such as Ghana, there are rarely strong disabilities movements actively working to improve the living conditions for people with disabilities.

Several visits to some people with disabilities by the researcher on normal day to day activities in the metropolis showed how people with disabilities live in the communities. A case in point was a physically challenged boy who was carried in a washing bowl because his parents could not afford a wheel chair to facilitate his movement. Awini (2015) noted that, social inclusion goes far beyond one’s simple presence in the community. He stressed that it is about how we play, the roles we take in civic life, who we love, how we connect with faith, and how we build fulfilling relationships and manage the various barriers within and outside the communities.

The nature of participation that exists in the communities may influence their active roles in all spheres of life. Participation is a highly valued rehabilitation outcome for people with disabilities, their caregivers and society at large, because it is related to a person's ability to be an active and contributing member of society (Whiteneck, 2015). Community living and participation includes both personal relationships and community belonging (Simplican, Kosciulek & Leahy, 2015).

Community living and participation in this study have been conceptualized in a number of ways. These ways are categorised into positive relationships or friendships, social contact or interactions, peer acceptance, "friendship" or "relationship" focuse on companionship and membership in networks of the whole community. "Contacts" or "interactions" focus on playing, working and having fun together, and being included in or excluded from activities, while "people' social self-perceptions" in principle involves their own feelings, such as belonging to the group and loneliness. "Acceptance" by the non-disabled on the other hand focus on other community members taking into account the possibilities willingness to assist or to stand up for those with disabilities and the benefits they derive from their community living and participation. Given the importance of participation for rehabilitation policy and practice and the participation challenges and vulnerabilities observed by the researcher working with people with disabilities, it is imperative that the researcher explores further how persons with disabilities live and participate in the everyday community lives.

According to the United Nations (United National\Enable, 2006) "evidence and experience show that when barriers to people with disabilities are removed and persons with disabilities are empowered to participate fully in social life, the entire community benefits. Barriers faced by persons with disabilities are therefore a detriment to society as a whole, and accessibility is to achieve progress and development for all" (p 1).

Hart (2013) noted that, the nature of community living and participation may influence their performances in all spheres of life. Maximizing community living and participation between people with disabilities and those without disabilities may generally be considered an important aspect of placing them in the communities' life as well as school, job, transportation, recreation and congregation (Petry, Maes, & Vlaskamp, 2005).

Cultural perspectives on disabilities involve the idea that people with disabilities are objects of pity who exist to be taken care of. However, this perspective needs to move toward the perception to see people with disabilities merely as people who, in superficial ways, are different from people without disabilities. It is important to recognize that people with disabilities are, like everyone else, striving to get by, to live, to have jobs, to have homes, to have fun, and to lead fulfilling lives. People without disabilities often experience unconscious and automatic feelings such as pity, fear, and revulsion. Although rooted in superstition or lack of knowledge, the bias against people with disabilities is generally not meant to be malicious or to segregate the population into a caste system (Abbott & McConkey, 2006). Regardless of the intentions, many people without disabilities exhibit feelings of frustration or uncertainty when encountering a person with a disabilities. These attitudes serve to separate the "nondisabled" from the "disabled", which further isolates people with disabilities.

Gadagbui (2004) opined that the inhuman treatments were not only unique to the Greeks, Athens and Romans, but was also common to other ethnic groups in our local communities in Ghana. She noted that in our local communities, people with disabilities have different defamatory names and labels such as “Neawanyinagyan`adwene ho in Twi, meaning one who has grown but left his mind”. Gonjas call them “Esalbato”. The Gas call them”buulu” especially persons with intellectual disabilities. The visually impaired are called “onifuraeni” in Akan, Zooma in Mamprulli and so on. There are treated in similar terms in the past, even now in certain communities. In some communities in Ghana people with disabilities are believed to have wrong the gods for taboo-breaking and are punished for their crimes committed. Others beliefs people with disabilities are evil spirits and witchcraft. Such children are seen as a curse and are treated with dislike.

Gadagbui (2004) again noted that due to superstitions and beliefs, children born with defects were murdered in various ways such as dipping the child`s head in water meant for bath to prevent the mother from giving birth to additional defective child. However, if the defect is not detected early and the child survived, he/she is subjected to severe beatings or cruel treatment at the least provocation. She noted that, infants or children were given “mercy” killing or euthanasia through certain rituals whereby mashed yam mixed up with eggs believed to be the dish to be served to the river babies called “nsuba” in Akan.

A study conducted by Slikker (2009) on the attitudes towards persons with disabilities in Ghana noted that people with disabilities in Ghana are vulnerable and disadvantaged group in the country and for their exclusion in society. The study also revealed that most respondents feels ashamed when meeting people with disabilities and do not want to associate themselves to them. It further state that respondents are unhappy having brother or sister as a disabled and are often excluded from participation in social and household activities. Parents of people with disabilities are often afraid of the behaviour of the community towards their children, as such some parents with children with disabilities often hides them from the society which usually leads to some maltreatments are left to their own fate, which forces some of them to become beggars in the community which needs to be researched into.

In the past, people with disabilities were segregated from society, and parents of children born with disabilities were expected to institutionalize their children. Routines and living conditions in institutions were a far cry from what ordinary people would consider minimally acceptable. Over-crowding, lack of privacy, inhumane treatment, and abuse were everyday realities in institutions. Customary justifications for keeping children with disabilities out of society have centered on their impairments. Social isolation was inevitable with institutionalized practices; however, society, people's attitudes, and the resulting discrimination need to be observed. (Amado, 2013). Although people with disabilities make use of the ordinary places that define community life such as going to restaurants, shopping, and movies, the current disability services system design still results in people with a disability being socially isolated from the community members without a disabilities.

It is important to differentiate between community presence and community living and participation. Community presence refers to the sharing of ordinary places that define community life and involvement in everyday settings, activities, and schedules (Clement & Bigby, 2007). Community living and participation refers to the experience of being part of a growing network of person relationships including close friends (Clement & Bigby, 2007). Community participation moves beyond impersonal and temporary community interactions. While people with disabilities may experience physical integration, they often do not experience social integration (Amado, 2013).

Statement of the Problem

With these superstitions and beliefs about persons with disabilities, it is important to research into the establishment of friendships between people with disabilities and their typical peers as it is a major issue for inclusive community living and participation. Very little is known about the community living and participation of people with mild intellectual and developmental disabilities, the hearing impaired, the blind and the physically challenged in Ghana.

Even though, community living is to bring people with disabilities and those without disabilities together, it appears the nature of the relationships that exist among them in the community have not been considered or researched into adequately to enhance the knowledge and advocacy for policy makers and other practitioners.

In addition, it appears very little is known about the social interaction patterns engaged in by people with mild intellectual disabilities, the hearing impaired and the visually impaired and their non-disabled counterparts in the community. It also seems that people with mild intellectual and developmental disabilities, the hearing impaired, the visually impaired and the physically challenged experience some difficulties in being accepted by their peers without disabilities in the community. Various literature reviewed mostly centred their research on the educational institutions, they also based their research on one or two disabilities without adequate attention to how these individuals live and participate in the various communities in Ghana.

Authors focusing on community living for persons with disabilities have explored different aspects of community living such as community integration, cost factors, staff-client interaction, and service models that are offered in different living arrangements for persons with disabilities (Heller, Miller, & Factor, 1999; Kozma et al., 2009; McConkey, 2007; McConkey & Collins, 2010). Thus, there are varying factors within different living arrangements that affect the participation of perrsons with disabilities in community. However, the results from all the studies on various types of community living do not provide a clear picture regarding the role of social interaction patterns, social self perception and the nature of friendship in affecting participation of persons with disabilities in community. The conceptual value of community living is limited and the true meaning of full participation of persons with disabilities in social and community life still requires. This study seeks to research into.

The defining variables of social participation; nature of friendship or relationship, patterns of social interaction, social self-perception of people with mild intellectual disabilities, the hearing impaired, the visually impaired and the physically challenged and their acceptance by other community members remain elusive and therefore explored in this study.

Purpose of the study

The purpose of this research was to gain a better understanding of community living and participation of people with disabilities in the Cape Coast Metropolis of the Central Region of Ghana.

Specifically, the study sought to:

1. Assess the social interaction patterns that exist between people with disabilities in their communities.
2. Examine the nature of friendships that exists among people with disabilities and their non-disabled counterparts.
3. Explore how social self-perceptions of people with disabilities influence their acceptance by others without disabilities
4. Determine the social and emotional benefits people with disabilities derives from their communities living and participation.

Research Questions

The following research questions were raised to guide the study:

1. What social interaction patterns exist between people with disabilities and their non-disabled peers in their communities?
2. What is the nature of friendships that exist among people with disabilities and their non-disabled counterparts?
3. How do the social self-perceptions of people with disabilities influence their acceptance in the communities?
4. What benefits do people with disabilities derive from participation in the community?

Significance of the Study

The study was significant for five reasons:

There were little or no much existing studies on community living and participation of people with mild intellectual and developmental disabilities, with visual impairment, hearing impairment and the physically challenged especially in Ghana. This study gave people with these disabilities in the community the unique opportunity to participate actively in the community

It also revealed the social self-perceptions of people with mild intellectual and developmental disabilities, the visually impaired, the hearing impaired and the physically challenged in the area of the study. This would enable stakeholders to adopt strategies that would promote self-esteem and self-acceptance by assisting people with various disabilities to develop positive self-referent statements to shape self-reinforcing behaviours necessary in ensuring their social participation in the community.

Also, it helped to find out the pattern of social interactions among people with disabilities and the non-disabled for the benefit of people with disabilities. It would enable stakeholders in disabilities issues to adopt or otherwise find out appropriate means of ensuring positive patterns for interactions among people with disabilities in the community.

Lastly, the outcomes of this study aimed to add to literature, as well as revealed crucial mandates for social services and policies that would be geared towards the well-being of people with disabilities with regards to community living and participation. Policy makers, Non-Governmental Organizations (NGOs) as well as all disabilities interest groups are the likely beneficiaries of this study.

Delimitation

My interest in the study aroused as a result of working with people with disabilities for a number of years in the Cape Coast Metropolis. My work involved offering advocacy for children with special educational needs. The choice of Cape Coast Metropolitan area of the Central Region of Ghana was due to its proximity to the researcher.

Even though, there are many forms or categories of disabilities across the various communities in Cape Coast, the study focuses only on the hearing impaired, the visually impaired (blind), the physically challenged and the mild intellectually and developmentally disabled in the Cape Cost Metropolitan area of the Central Region of Ghana. This was so because these groups have the highest numbers of registered members at the Social Welfare Department of the Cape Coast Metropolis. This study was delimited to the nature of social interactions, patterns of friendship that exist between people with disabilities and those without disabilities, emotional benefits and self-perceptions with much attention on mild intellectually disabled, hearing impaired, visually impaired and the physically challenged.

Limitations

The study was performed on a small scale with only sixteen (16) participants that might have limited our knowledge about PWIDs and their opinions on community living and participation. Important selection criteria for this study were that participants were only registered members of people with disabilities at the Social Welfare Department of the Cape Coast Metropolis which could have not given the actual picture of other forms of disabilities.

Consequently, transferability of the results may be limited. A longer study period, with more participants and sites could have increased the depth of collected data and thereby could have influenced the results by providing more detailed and elaborated understanding of community living and participation of people with disabilities.

Definition of Terms

Disabilities: refer to any restriction or lack of the ability to perform an activity in the manner or within the range considered typical for a human being, as a result of impairment.

Community living: a group of interdependent people inhabiting in an environment by sharing a common understanding, having certain attitudes and interests in common through social interactions and other purposes.

Intellectual and Developmental Disabilities: is a disability characterized by significant limitations in both intellectual functioning and in adaptive behaviour, which covers many everyday social and practical skills.

Participation: active involvement of an individual, group or organization consulted in all activities of interest.

Physically Challenged: an umbrella or genetic terminology referring to many other conditions such as amputation, poliomyelitis, spinal cord injury, muscular dystrophy, limb deficiencies, bone tuberculosis, orthopedic, cerebral palsy, spinal bifida, and many others which affects the person`s ability to move about, use the arms and legs effectively, to swallow food and to breathe independently.

Visual Impairments: Visual (Vision) Impairment is a reduction in vision – usually associated with age – that cannot be corrected by prescription glasses, contact lenses, medicine or even surgery.

Organisation of the Study

The study is presented in five chapters. Chapter one is the introduction which covers the background of the study, statement of the problem, purpose of the study, and research questions. Other aspects of the chapter are the significance, delimitations, operational definition of terms and organization of the study.

Chapter two deals with the review of related literature. It covers the theoretical framework, the conceptual framework and the review on the key themes raised in the research questions. Chapter three focuses on the methodology and covers the research approach, design, the population, sample size, sampling procedures, instrumentation; trustworthiness, data collection procedures and data analysis. Chapter four covers the results of the study and discussion of the findings. Finally, the summary of findings, conclusions, recommendations and suggestions for further research forms the concluding chapter of the report.

CHAPTER TWO

LITEREATURE REVIEW

Introduction

This chapter presents the literature review for the study. The following sub-headings are covered: Theoretical review, Conceptual framework, Nature of relationships/friendships that exist among people with disabilities and those without disabilities, Social interaction patterns that exist between people with disabilities and those without disabilities, Social self-perception of people with disabilities and its influence on their acceptance by others without disabilities.

Finally the benefits people with disabilities derive from community living and participation of the individual and the summary of literature reviewed.

Theoretical review

The theories that guided this study were the normalization theory of Wolfensberger and Nirje (1982) and Allport contact theory (1954). The contact theory, also known as intergroup contact theory, asserts that direct contact between groups of individuals with different backgrounds or characteristics, serves to promote positive intergroup relationships, especially when interactions are frequent, meaningful, and of long duration. Contact theory is rightly associated with the study of community living and participation of people with disabilities and those without disabilities in the community.

The normalisation theory

"Normalisation refers to utilization of means which are as culturally normative as possible in order to establish or maintain personal behaviour and characteristics which are as culturally normative as possible" (Wolfensberger, 1972). Nirje (1983) defined the normalisation principle as "… making available to all people with disabilities patterns of life and conditions of everyday living which are as close as possible to the regular circumstances and ways of life or society"(Nirje,1983 p. 1).

Normalisation principle required that services be organised to maximise opportunities for the people with disabilities using them to function with the greatest level of autonomy possible and to have ordinary relationships with the rest of society. The principle of normalisation is concerned with normalising the living conditions, experiences, expectations and aspirations of people at risk of being devalued, and not forcing people into an arbitrary stereotype of being normal. In 1983 Wolfensberger and colleagues adopted the term social role valorisation. The label social role valorisation clearly describes the normalisation goal of supporting people (who are at risk of being devalued) to create and maintain a range of valued social roles. In fact Wolfensberger's (1983) last definition of the normalisation principle was as "the enablement, establishment, enhancement, maintenance, and/or defence of valued roles" (p. 125). These two definitions suit perfectly into this research as I try to find the community living and participation of people with disabilities by examining their social interaction patterns, social self-perceptions, nature of friendships and the social and emotional benefits of people with disabilities. Since they are expected to live a normal life in the community they live in by participation in its activities.

The contact theory

The Contact theory of Allport (1954) also called intergroup contact theory, asserts that direct contact between groups of individuals with different backgrounds or characteristics, serves to promote positive intergroup relationships, especially when interactions are frequent, meaningful, and of long duration. Thus, a key modern theory of prejudice reduction is the Common In-group Identity theory which helped found out the social self-perceptions of people with disabilities influence their acceptance by others without disabilities in the community. It emphasizes re-categorization through identity with larger groups that include the original groups (Awini, 2015). Allport had advocated precisely for the same mechanism. Drawing concentric circles with family in the centre and humankind at the periphery, Allport (1954) maintained that "concentric loyalties need not clash" and that prejudice is minimized by inclusive group membership.

Contact theory of Allport, is a "pattern of hostility in interpersonal relations which is directed against an entire group or against its individual members" (Allport, 1979 p.12). Although, originally developed with interracial interactions in mind, researchers have extended the contact theory to mean the understanding and promoting of relations between people with disabilities and the nature of friendship that exists among people with disabilities and their non-disabled counterparts.

These assertions go well for with this study as it seeks to find out the interaction patterns, friendship, self-perceptions and the emotional and economic benefits of people with disability in the Cape Coast Metropolis. Stacy, Geraldine, John and Michael (2015) opined that, the major obstacle for achieving the goal of social inclusion for people with disabilities is that the concept of community participation remains unclear. They noted that the lack of clarity results from the numerous definitions of social inclusion, which can make the concept interchangeable with social integration, social network, social inclusion, and social capital. Hence, this research may use such words interchangeably. This study used the theories to explore the community living and participation of people with disabilities.

Rydell, Hagekull and Bohlin (1997) noted that social participation involves nature of friendships, patterns of interactions which collectively is influenced by the social self-perceptions held by an individual. These may affect pro-social behaviours (i.e. the ability and willingness to help, share and cooperate among others) Also, in the views of De Winter, Baerveldt, and Kooistra (2002), self-perceived social competency is therefore, an essential aspect of psychological health that may be facilitated through social participation.

Participation is a valued and ultimate goal of people with disabilities, disabilities organizations, policy makers, rehabilitation workers and other stakeholders (Hammel, Magasi, Heinemann, Whiteneck, Bogner, & Rodriguez, 2008). Participation, as defined in the International Classification of Functioning (ICF) Disability and Health refers to the "involvement in a life situation" (WHO, 2001). International Classification of Functioning states that participation in communal life is influenced by environmental factors as well as personal factors. Environmental factors include the physical, social and attitudinal environment in which people live (WHO, 2001). Personal factors include personal freedom, choice, satisfaction and values.

The International Classification of Functioning briefly describes a person's ability and disability, including the barriers and facilitators as environmental factors that influence functioning and participation of the person (Schneider, Hurst, Miller, & Üstün, 2003). The environmental factors component of the ICF model aligns with the social model of disability, which determines disability as a socially created issue as opposed to a problem with the individual (Oliver & Bochel, 1991). The social model also proposes that disability is a socially created problem and not an attribute of the person. According to social model of disability, barriers to participation are due to inflexible and inaccessible physical and social environmental issues that require political response or solutions (Albrecht, Selman, & Bury, 2001). Thus, from the views of the ICF and social model of disability, it can be concluded that environmental factors play a key role in defining the participation and disabling barriers of a person in the community. Participation of PWDs is thus influenced by their living place, services available, access to those services and the attitude of society. Participation is a complex and multidimensional construct and there are no set standards for defining and measuring participation (Dijkers, 2010).

The classification and conceptualization of participation has been done in a variety of ways. The ICF classification system measures level of participation using scales and questionnaires to describe what an individual can do in a standardized environment and what an individual does in their daily life activity, which is influenced by environmental and personal factors (World Health Organization, 2001). The classification does not place much emphasis on self-perception and deriving meaning of participation from participant's views and experiences.

Furthermore, it is essential to determine what level of choice, assistance and involvement that person defines as full participation (Badley, 2008). Thus, there are a number of considerations specific to people with disabilities that need to be appreciated before considering ways to determine and measure participation of people with disabilities in community. Self-perceived participation is a recent concept in the area of disability to measure and conceptualize participation. There were only 6 studies found (Abbott & McConkey, 2006; Beadle, Brown, Hutchinson, & Whelton, 2012; Cocks & Boaden, 2011; Deguara, Jelassi, Micallef, & Callus, 2012; Kjellberg, 2002; Stancliffe, Lakin, Larson, Engler, Taub & Fortune, 2011) that included the people's perspective in defining participation. These studies attempted to include insider's perspective in defining the meaning and ways ofcommunity living and participation.

One study that explored insider's perspectives of people with disabilities is by Hammel et al (2008). They conducted a focus group with sixty three people with diverse disabilities to self-identify the meaning of participation. The study tried to gain insider's perspectives from people with disabilities to understand the meaning of participation, how participation could be characterized, and what are the barriers and support needed for participation. They concluded that, participants conceptualized participation as a cluster of values that included active and meaningful engagement/being a part of, choice and control, access and opportunity/enfranchisement, personal and societal responsibilities, having an impact and supporting others, and social connection, inclusion and membership.

Participation does not only include engagement in community and society but also the approach to personal meaning and satisfaction (Hammel et al., 2008). Considering the importance of perceived level of participation, Abbott & McConkey (2006) conducted a qualitative study to gather the information about perceived barriers to social inclusion and what could be the possible solutions to overcome social isolation of people with disabilities. They identified four main barriers: lack of necessary knowledge and skills; role of support staff and service managers; location of house; and community factors such as lack of amenities and attitudes.

Friendships/Relationships that Exist Between People with Disabilities and the Non-disabled Peers

Community living and participation with friends foster the formation of meaningful relationships, social competence and psychosocial well-being (King, Law, King, Rosenbaum, Kertoy & Young, 2003). People with disabilities have a sense of belonging and believed by others as key factors associated with success in life (King, Chaters, Miller, MacKinnon & Havens, 2000).

A research conducted by Robinson and Truscott (2013) in Australia on young people with disabilities, especially people with physical disabilities revealed that one-third reported happy and positive friendship networks during the transition from primary to high school in the community. However, a further one-third of the participants did not have a single friend at school or in the community. Importantly, for children with friends, they felt these relationships helped them to be more mentally resilient to bullying and teasing, even if their friend was not physically present at the time (McMaugh, 2011). Another study in Australia on young people with physical disabilities (De Vet, Waitt & Gorman-Murray, 2012) revealed that having both friends and an accessible territory in which to hang out together at school, was important in building both social and spatial connections.

Salmon (2012) completed a study with teenagers with disabilities and their close friends about how they negotiated their friendship and their feelings about belongings. The results revealed that while all of these young people were engaged in rich and fulfilling relationships, they had all been through a period where segregation was imposed on them by their nondisabled peers. Each of the teens described ways that they challenged the often stigmatising expectations that the wider community had on their friendships. This included the expectation that their non or less-disabled friends had caring responsibilities; resisting stereotypes (such as being sacrificing of their own needs by being friends with persons with disabilities); and developing friendships with other young people with disabilities and choosing to self-exclude from more public spaces, which felt self-affirming.

Anderson, Balandin and Clendon (2011) interviewed 49 students of disabilities and the non-disabled friends of children, to find out about their experience of friendship. The children described mutually beneficial friendships, through language such as ‘he cares about me and I care about him’ (p.82). Although, the friendships had arisen spontaneously between the people through common interests, altruism, recognition and positive feedback were motivators for the people without disabilities to maintain their relationship.

Youth with disabilities face unique challenges in establishing social networks and fulfilment with adult social roles as a spouse, co-worker or neighbour (Poulsen, Ziviani, Cuskelly & Smith, 2007). Difficulties in mobility, communication, socialization, and dependency on family members for self-care and transportation often limit the social opportunities of youth with disabilities (McGavin, 1998). For youth with visual impairments in particular, sports and physical function, communication ability and access to desired community recreational activities have been found to be associated with higher participation with friends. Adolescent females with physical disabilities have reported lower social acceptance compared with females without disabilities; while males with physical disabilities did not differ from males without disabilities (Shields, Loy, Murdoch, Taylor & Dodd, 2007). It is noteworthy that children and adolescents with disabilities do not report lower overall self-worth compared with peers with typical development (Shields, et al., 2007).

Nind, Rix, Sheehy and Simmons (2003) noted that friendships matter to children, their parents and their teachers, because they provide children with the opportunities to develop important skills and attitudes, and perhaps most importantly, they enhance quality of life for children and their families. Friendships serve a wide array of purposes that include social and academic enhancement and they improve lives in families and thus, the wider community (Lehohla & Hlalele, 2012).

Researchers generally emphasised that the most important of all peer social relationships is friendship (Bukowski, Newcomb & Hartup, 1996; Newcomb & Bagwell, 1996).

Friendships play a central role in children's relationships, and are characterized by high levels of reciprocity, mutuality, affect, and provide a context that supports numerous aspects of a child's social participation (Rubin, Coplan, Chen, Buskirk & Wojslawowicz, 2005). The influence of friendship on young children's emerging socially competent behaviour patterns has produced particularly consistent findings. Specifically, friend versus non-friend play comparisons have indicated that social play with friends is characterized by more positive affect, higher levels of social interactions, and more effective forms of conflict management (Ladd, Kochenderfer & Coleman, 1996; Newcomb & Bagwell, 1996).

Concept of friendship

Friendship has multiple meanings in our culture and varies across cultures, though with some common dimensions (Keller, 2004). The many dimensions of friendship commonly reported in the literature and used in everyday understanding include similarity, proximity, transcending context, companionship, reciprocity, mutuality, help/support, conflict management, stability, trust/loyalty, and intimacy/disclosure (Bukowski, Newcomb & Hartup, 1996).

People with disabilities often appeared to have success in making friendships with typical peers. According to Hunt, Staub, Alwell, and Goetz (1994), Fryxell and Kennedy (1995), people with disabilities spent more time participating in activities with their typical peers, received higher proportions of social initiations, and had richer friendship network. Friendship plays an important role in children's social participation and well-being (Siperstein, Leffert, & Wenz-Gross, 1997). In addition, people exhibit predominantly same-sex of friendship formation (Hartup, 1992). Prior to adolescence, children's social relationships, especially, their friendships with peers are important in their life.

Friendship is described as reciprocal liking and behavioural involvement between people (Hall & McGregor, 2000). In order to determine if a friendship exists, several researchers have suggested use of multiple measures such as socio-metric measures, observations of social interaction and interviews (Hunt, Alwell, Farron-Davis & Goetz, 1996). Reciprocal liking is typically measured by socio-metric instruments. From a socio-metric perspective, reciprocal liking is seen as two or more individuals nominating each other as friends. Hall and McGregor (2000) insisted that mutual nominations are clear indicators of friendships.

Companionship, or doing things together, is another feature of friendship that emerges early and remains important (Berndt, 1996). Companionship helps to maintain the relationship and is a way to assess its strength and closeness (Aboud & Mendelson, 1996). Once companionship has been established, the friendship tends to move deeper into a reciprocal and mutual relationship. Piaget (1965) noted the importance of reciprocity or a give-and-take relationship between two people and suggested that friendships without this were lower in quality. Van der Klift and Kunc (1994) warned that one-sided ‘‘help is not and can never be the basis for friendship’’ (p. 393–394) because it then loses the reciprocity that is essential in maintaining a balanced friendship.

Aspects of friendship that show increases from middle childhood to early adolescence include conflict management and stability. Friends will disagree and argue, but a sign of a deeper relationship is that they are able to manage conflicts and resolve their differences (Berndt, 1996). If the friends are able to maintain a fairly conflict free relationship, then stability will develop. Stability, consistency, and reliability are all important in maintaining friendship (Turnbull, Blue-Banning, & Pereira, 2000).

Typically developing teens expect that friends will not leave or betray each other (Bukowski, Newcomb & Hartup, 1996b) and can trust each other with intimate details without being judgmental. During adolescence, close friends disclose personal information and feel an emotional bond to each other. Intimacy through personal disclosure is a step beyond mutuality that deepens the relationship (Wiener & Sunohara, 1998). Overall, doing things together, having similar behaviours and preferences, and liking and being liked develop earlier; expectations of trust, disclosure, mutual respect, dealing with conflicts, being able to count on the other person, and intimacy come later. These are the normative expectations for a fully realized friendship and for competent friends.

A number of studies have been focused on relationships between children with disabilities and their typically developing peers (Turnbull et al., 2000). These studies have provided rich detail on the qualities, benefits, and limitations of this type of friendship. Increased parental facilitation usually is involved in establishing and maintaining these friendships (Turnbull, Pereira & Blue-Banning, 1999). There is less information on friendships when both friends are disabled.

Social network of friendship

Much of the research on children's social networks has been influenced by research in sociology. This is evident not only in the emphasis on the group as the construct of interest but also in the more basic premise that individuals cannot be understood outside of the social contexts in which they exist (Cairns, Xie & Leung, 1998). Also important is the view of the peer group as dynamic rather than static entity, an idea that has its roots in the work of Moreno (1934). Thus, while both socio-metric status and social network analysis have a common origin in Moreno's theories, the aspects of his theories considered most critical have been shaped in important ways by the larger academic traditions (psychology and sociology) within which the two research literatures have developed.

Kinderman (1993) outlined several key assumptions underlying social network analysis. Kinderman, assumed that people develop within a peer context that has a certain structure, that this structure is perceived similarly by man, and that this structure has important implications for individual development. Thus, a primary goal of social network analysis is to identify the patterns of children's affiliation within the peer group. Cairns, Leung, Buchanan, and Cairns (1995), this includes both the subsets of individuals within the group (i.e., cliques or clusters), as well as the relations among these groups within the broader network.

A growing number of studies revealed that children with mutual friends are generally better adjusted and more socially competent than children without friends. They are more sociable and pro-social, have higher self-esteem, and are less likely to be lonely (Newcomb & Bagwell, 1995). They manage difficult transitions more smoothly, and their self-esteem increases following such transitions if they have mutual friends (Ladd, 1990; Berndt et al., 1999). For children who find themselves victimized by some of their peers, having friends can reduce the incidence of victimization and friends can provide support and advice about how to manage the problem (Hodges, Malone & Perry, 1997; Hodges et al., 1999). In one particularly well-controlled study, children with a greater number of mutual friends were found to be more pro-social and good-humoured, and less likely to tease others or boss them around, even after taking into account their group acceptance and peer network centrality (Gest, Graham-Bermann & Hartup, 2001).

It should be noted, however, that the univariate view that characterizes most of the work on children's friendships may over-estimate the importance of friendships in children's development. First, the role of friendship in children's social development is likely to depend on the nature and quality of the child's other close relationships, the number and kinds of stresses the child confronts, and the child's own temperament and interaction skills. For example, having friends is more important for children whose family relationships are less satisfying, supportive, and positive than it is for children in higher-functioning families, and families contribute more heavily to children's adjustment when they do not have close friends (Gauze, Bukowski, Aquan Assee & Sippola, 1996).

Second, friendships may be more important at some points in development than at others (Hartup & Stevens, 1997). Third, having friends may be less important than other aspects of the child's social behaviour in contributing to the development of social competence. In particular, children's aggression or their likeability and acceptance in their peer group are sometimes better predictors of social competence than how many friends they have (Gest et al., 2001). Finally, the association between friendships and other aspects of social competence may be driven by features of the person`s social competence rather than vice versa (Hartup, 1996). That is, children who possess the social, communicative and self-regulatory skills to establish and maintain mutual friendships are also likely to be more sociable and cooperative, better at managing conflict and disagreement, have higher self-esteem, and endorse the peer group’s norms.

Mutual relationships

A substantial amount of research has been conducted to investigate and conceptually model the aspects of friendship among typically developing children (Parker & Asher, 1993; Bukowski, Hoza & Boivin, 1994). Researchers working within developmental theoretical frameworks have found out that children develop different priorities for friendship as they mature, with intimacy becoming much more important in adolescence than in early childhood where shared activities are the focus of most friendships (Ladd, 1988; Newcomb & Bagwell, 1996). Freeman and Kasari (1998) reported that companionship, stability, and emotional support are more often used in definitions of friendship than affection and intimacy.

Much research has focused on establishing the presence of friendships between people with disabilities and peers in different settings. Many of these studies have reported on friendships, but have actually utilized socio-metric analysis to measure the peer status or acceptance of children with disabilities in inclusive settings (Hall & McGregor, 2000; DiGenaro Reed, McIntyre, Dusek & Quintero, 2011). Peer status measures, however, may not relate to actual shared activities or to friendship (Hall & McGregor, 2000) to those between typically developing children.

Examination of friendships in typically developing children and people with disabilities has often involved nomination of a "friend" and the subsequent examination of characteristics of the relationship on the assumption that nomination reflects an actual friendship. Researchers examining people with disabilities have used a variety of methods to infer the existence or non-existence of friendships, often consisting of a direct question as to whether a peer is a friend (Lee, Yoo & Bak, 2003; Locke, Ishijima, Kasari & London, 2010; Kuo, et al., 2011) and have often assumed a pre-existing friendship when examining features or interactions between the individuals involved in the relationship (Freeman & Kasari, 2002; Matheson, Olsen & Weisner, 2007; Morrison & Burgman, 2009). Researchers, however, have not typically attempted to determine the extent to which these relationships actually met the criteria of friendship as it has traditionally been defined and the correspondence between nominations of friends and the expected features of friendship.

Although, the study did utilize specific criteria to examine friendships between people with disabilities and peers, it was extremely limited by its artificial setting, narrow age range, and primary focus on children with emotional disabilities. In contrast, Harry, Park, and Day (1998) found out that individual features (reciprocity, liking, affection, and having fun), as identified by Bukowski et al. (1996), as important in the friendships of typically developing children were also present in the relationship of two girls with visual disabilities.

Freeman and Kasari (2002) utilized systematic criteria from research on friendship of typically developing children (i.e. stability, parent nomination and reciprocal nomination) to examine the friendships of children with Down

Syndrome and their peers. After examination of information provided by target children, peers, and parents, the researchers discovered that at least 30% of all the dyads did not meet the stated criteria for friendship. More recently a small number of studies (Bauminger, Solomon, Aviezer, Heung, Brown, Gazit, & Rogers, 2008; Bauminger, Solomon & Rogers, 2009; Rossetti, 2011) have used predefined criteria to select friend, but relied on the perceptions of individual person or parents to determine these friendships rather than confirming them through specific criteria traditionally used to define friendships.

Berndt (2002) indicated that the quality of their friendships varies considerably both across children and across different friendships of the same child. Generally, friendship quality has been described in terms of particular resources or provisions that the friendship offers and the affective dimensions of the relationship. Friendships have been distinguished in terms of the amount of support, intimacy, and interdependence versus coercion, emotional distance, and disengagement, as well as differences in power, status, exclusivity, conflict, warmth, validation and caring, companionship, commitment, and conflict resolution (Bukowski, Newcomb & Hartup, 1996).

Berndt (2002) has shown that children who rate their friendships positively on one feature tend to rate them highly on other positive features as well. For example, at second, fourth and sixth grades, the features of intimacy, loyalty, pro-social behaviour, conflict, play, and self-esteem-support loaded on one primary factor (Berndt & Perry, 1986). This has led Berndt to argue that the various positive features of friendship quality actually constitute a single dimension from high to low positivity (Berndt, 2002). Likewise, Berndt notes that negative features occur even in good friendships-conflict, rivalry, inequality, and dominance attempts occur in all friendships. These features, too, appear to comprise a single dimension of negative quality from high to low, and this dimension is relatively independent of positive friendship quality (Berndt, 2002). Whether it is more informative to characterize friendship quality in a more differentiated or more global manner remains an issue in this area of study.

With regard to reciprocation of friendship nomination, only a handful of researchers (Freeman & Kasari, 2002; Wiener & Schneider, 2002; Chamberlain, Kasari & Rotherham-Fuller, 2007) have utilized nomination by target students as well as reciprocation of nomination by peers to examine the friendships of children with disabilities. All of these researchers found out that their chosen peers did not necessarily reciprocate the nominations of friends by target people. Although, reciprocity of nominations and mutuality of behaviours have been reported between people with disabilities and typically developing peers, researchers have found out that, in some cases, reciprocal friendships are more likely between children with disabilities (Cuckle & Wilson, 2002).

Social Interaction Patterns that Exist between People with Disabilities and the Non-Disabled

People living with disabilities have been found to have a variety of social deficits, including limited participation in active and social play and increased dependence on others to make social arrangements (Hooyman, & Kiyak, 2008), poor social skills, limited intrinsic motivation, lack of drive, and decreased concentration. Disability has been associated with lower levels of social interaction (Perrin, Bloom, & Gortmaker, 2007). They have shown a significantly restricted ability to initiate and direct social interactions with siblings and a tendency to engage in rigidly hierarchical relationships where they assume the role of the younger child (Fonagy, Gergely, & Target, 2007)). At school, children with disabilities participate in less cooperative play, more solitary play, and more play with teachers than typically developing peers (Anderson, Moore, Godfrey, & Fletcher-Flynn, 2004).

Another measure of social interaction is the frequency of getting outside the home. Home confinement among community dwelling disabled older persons is common and has been associated with nutritional deficiencies, reduced access to medical care, and depressive symptomatology (Perrin, Bloom, & Gortmaker, 2007; Locher, Ritchie, Robinson, Roth, Smith West, & Burgio, 2008).

Extreme social isolation, represented by near or complete absence of contact with other people, is rare (Stokoe Jr, 2005). It is especially unlikely for disabled older women living in the community, for who continued community residence depends largely on the availability of help from others. Nevertheless, relative social isolation may exist in the form of limited interaction with friends and other valued members of one's social network.

The deprivation caused by lack of environmental engagement can result in secondary social, emotional, and psychological disabilities that persist into adulthood (Patel, Flisher, Hetrick, & McGorry, 2007). These secondary disabilities can include isolation, poor self-esteem, poor social adjustment, and unemployment (Stokoe Jr, 2005). Lack of mobility, overprotection by parents, and lack of opportunities for peer interaction have been cited as contributing factors to the poor social adjustment of many young adults with disabilities (Lightfoot et al., 1999; Stevens et al., 1996; Strax, 1991).

Voluntary community associations are wide-spread in Ghana as well as in other countries. They intersect with major societal institutions such as the family, education, the economy, religion and government. Babchuck and Booth (1969) stated that such groups "are a vital part of the fabric of society and play a crucial mediating role in the relations between the institutions of the society as well as providing a link between the individual and institutions." (p. 44) People join groups to "find meaning in life, to express their social identity, to contribute to the well-being of others, and to improve their chances in the labour market" (Bekkers, 2005, p. 439).

Community associations and groups provide the opportunity for both participation and civic engagement, which have many benefits, both for those individuals involved and for the overall welfare of the community. Research studies in such fields as education, urban poverty, unemployment, the control of crime and drug abuse have discovered that successful outcomes are more likely in engaged communities (Coleman & Hoffer, 1987; Sampson & Morenoff, 1997). Civic engagement and social connectedness have also shown to produce such results as better schools, faster economic development, lower crime, and more effective government, and communities with high rates of citizen participation experience a heightened sense of trust and higher levels of communication and coordination (Putnam, 2000).

Interaction and proximal processes

Bronfenbrenner (1999) opined that most factors related to the social interaction of a person occur within proximal processes, that is, within the interaction between the person, objects in the environment and information in the form of symbol messages. The effect of such enduring proximal processes on a child varies as a function of the child's characteristics and previous experiences of the child within the environment (Bronfenbrenner, 1999; Wachs, 2000). In two domains of research, social interaction has been found to be related to proximal processes: (a) research about interaction and social competence (Kontos & Wilcox-Herzog, 1997; Bronfenbrenner, 1999), and (b) research about school success and motivation in schoolwork (Skinner, Zimmer-Gembick & Connell, 1998).

Studies by Almqvist and Granlund (2005) on the interaction between people with and without disabilities report few instances of interaction on equal terms. Often, children without disabilities have a dominating role with the children with disabilities acting more passively in a responding discourse role (Tamm & Skär, 2000; Nordström, 2002). In terms of proximal processes this fact leads to a lack of reciprocity in the interaction (Tamm & Skär, 2000; Wachs, 2000), which also affect the quality and rate of the children's development in different areas, such as socially and academically.

Social Self-perception of people with disabilities and its influence on their acceptance by the non-disabled

Perception regarding disability is a multifaceted concept. As Olney and Brockelman (2003) wrote, ''People with disabilities adapt their mode of self-perception to specific situations. They might choose to embrace, reject, conceal or reveal a disability for a number of reasons'' (p. 35). Some persons may choose to reject a perception of disability because of the negative stereotypes that are associated with such a label (Goffman, 1983), while others may feel positively about such a perception.

Self-perceived participation is a recent concept in the area of disability to measure and conceptualize participation. There were 6 studies found (Abbott & McConkey, 2006; Beadle Brown, Hutchinson, & Whelton, 2012; Cocks & Boaden, 2011; Deguara, Jelassi, Micallef, & Callus, 2012; Kjellberg, 2002; Stancliffe, Lakin, Larson, Engler, Taub and Fortune, 2011) that included the people's perspective in defining participation.

Participation is a valued and ultimate goal of people with disabilities, disability organizations, policy makers, rehabilitation workers and other stakeholders (Hammel et al., 2008). Participation, as defined in the International Classification of Functioning, Disability and Health refers to the "involvement in a life situation" (WHO, 2001). International Classification of Functioning states that participation in communal life is influenced by environmental factors as well as personal factors. Environmental factors include the physical, social and attitudinal environment in which people live (WHO, 2001). Personal factors include personal freedom, choice, satisfaction and values.

Many studies have addressed how people perceive themselves and believe that others perceive them in terms of disability, and have been nearly unanimous in their identification of social factors in compensating for the more direct physical limitations. Watson (2009) conducted interviews with 14 persons who conventionally would be defined as having disabilities. However, while each acknowledged the severity of their physical limitations, many did not adopt a self-perception of having a disability.

Many items factored into one’s rejection of having a disability. For one, it was the roles and relationships that the individuals took within their families that caused them to perceive themselves as not having a disability. For others, it was the ability to hold jobs, to socialize, and to interact with members of the opposite sex that were cited as reasons for not thinking of themselves as having a disability. Still for others, simply the ability to ‘‘lead a normal life’’ was cited as a reason to not construct their identity as an individual with a disability. Camilleri (1999) took a similar view. He argued that common assumptions about disability focus on the lack of abilities, but more progressive movements (e.g., United Nations, 1993, 1998) have sought to understand the phenomenon of disability from a more social standpoint.

Studies that address how others perceive individuals with disabilities have arrived at similar conclusions. Tregaskis (2000) sought to uncover differences in attitudes about wheelchair users among nondisabled workers at two leisure centres: one in which only persons without disabilities attended, and one in which both those with and without disabilities attended. While still a work in progress at the time of its publication, the question is valid: Do others whose perceptions of persons with disabilities as active, engaged community participants differ from those who may not perceive them as such? In addition, integration with others in occupational settings may cause persons with disabling conditions to feel as though they are looked at less as having a disability (Riches & Green, 2003). It is possible that the more individuals come in contact with persons with disabling conditions in social settings, their perceptions of disability may change (Roper, 1990). Quantitative analyses, while often studying participants across different populations, have arrived at many of the same conclusions. Daltroy et al. (1995) employed a randomized cross-sectional study of 289 community dwelling elderly persons to explore the influence of social, psychological, and health factors on self-report of function.

Factors such as having face-to-face social contact, living in a more integrated community, and being able to participate in community life by engaging in such factors as shopping were found to have significant effects on one's self-perception of disability.

Similarly, Zunzunegui, et tal (2004) found that elderly persons with greater social networks perceived themselves to have greater health status. While undertaking studies among elderly persons is fundamentally different than studies that focus on persons of disabilities of all ages, the central finding remains: Those more socially involved in their community are less likely to identify themselves as having a disability. A path analysis conducted by Nosek, Hughes, Swedlund, Taylor, and Swank (2003) indicated that factors such as social isolation impacted levels of social cognition and self-esteem among women with disabilities, which ultimately led to negative self-evaluations and perceived negative evaluations by others.

Given the review of perceptions of disability arising out of the social model of disability, this three things in the social lives of persons with a disability may lead them to perceive themselves as not having a disability: the degree to which they are integrated into their community, the degree to which they are able to hold jobs, and whether or not they are married. The perceptions of disability regarding the medical model are more obvious and may form the baseline for how individuals perceive themselves in regard to disability: having specific disabling conditions, and having activity limitations.

Acceptance

Acceptance is defined as the willingness to experience thoughts and feelings without letting them determine one's action. In the context of disability, it emphasizes the importance of accepting oneself as a capable person despite having a disability in psychological adjustment (Darlene, 2007). As acceptance of disability is related to psychological adjustment, studies on acceptance of disability are often explored in the medical and psychological field for developing successful rehabilitation strategy. In relation to this, acceptance of disability has been examined in the context of its association with demographic factors.

Studies on personal acceptance of disability were diverse as each study examined different types of disability which are then related to personal acceptance of disability. Bowling (2014) in a study on persons with disabilities (PWDs) envisage that acceptance of disability occurs in the context of personal and public. Bowling found that there is a significant association between personal acceptance of disability and selected demographic factors: age, income, marital status, congenital disability and self-esteem.

Study done by Woodrich and Patterson (1983) on disability caused by spinal cord injuries found that gender, education and age had a significant association with the level of personal acceptance of disability. Their study showed that the relationship between age and acceptance of disability is inversely related. Besides this, the study indicated that PWDs with higher education are more versatile, motivated and able to control and integrate their disability into their life.

Public acceptance can be defined as accepting the relationship between persons with disabilities and able-bodied. Public acceptance of disability has been explored in various dimensions. Previous studies on public acceptance of disability have shown that the public has a low acceptance of disability. Hosain, Atkinson, and Underwood (2002) found that public viewed persons with disabilities differently from able-bodied. They were teased, hated, viewed negatively and overly-sympathized. Another study by Kaur, Leong, Yusof, and Singh (2015) found that neighbours opposed to having people with severe intellectual disability living next to them as they felt the PWDs were a threat to their security.

Interactions

Anderson, (2011) examined interaction between PWDs and the able-bodied based on developing friendship and relationship of equal status and found that PWD`s friendship with able-bodied was facilitated by mutuality and acceptance, however, development of friendship is influenced by public transport and physical support. In the case of acceptance of disability at the workplace, employing PWD is seen as challenging. Study done by Shigaki, Anderson, Howald, Henson and Gregg (2012) indicated how people with disabilities are treated unfairly, harassed and discriminated at work even though there is evidence that people with disabilities are more committed, and their performance is comparable to able-bodied co-workers. The stigma of unattractiveness, origin and course which is related to disability has a negative impact on people with disabilities. Beside this, employers are reluctant to employ people with disabilities as they do not want to lose valuable organization employees because of lack of acceptance of disability.

As such, many people with disabilities conceal their disabilities to protect their image of competency at work. The unfavourable attitude towards people with disabilities by co-workers and employers make people with disabilities difficult to adjust at the workplace or are being excluded from the labour-market opportunities.

The concept of social stigma can be applied to a variety of groups, including those with disabilities. Social stigmatization and discrimination can cause a person with a disability to withdraw their participation in social life and ultimately lead to poor life satisfaction. In other words, the way in which society perceives such individuals affects their well-being and state of mind. This approach to stigma is called the socio-cognitive model. The model states that when compared to people with emotional or social disabilities, attitudes toward individuals with physical disabilities are more favourable (Murphy & Carbone, 2008). The socio-cognitive model reinforces previous findings of several studies using American participants. Harasymiw, Horne, & Lewis (1976a) coined the term stigma hierarchy to refer to the order of preference of certain disability groups over others. Harasymiw *et al.* (1976b) and others (e.g., Abroms & Kodera, 1979) found that less visible disabilities (e.g., diabetes) are the most accepted, followed by visible disabilities (e.g., visual impairment) and disabilities involving mental functioning (e.g. depression), and that disabilities for which a person is perceived to be responsible (e.g., alcoholism) are the most stigmatized.

Recent research supports earlier findings that community attitudes toward inclusion of people with disabilities are generally positive, but tend to be paternalistic. When disabilities are perceived as more severe, stigmatising attitudes, anxiety and discomfort are also more likely to emerge. Research identifies more negative attitudes toward individuals with mental illness (particularly schizophrenia) than toward individuals with other intellectual or developmental disabilities, and that people with physical disabilities experience the least stigma. This is hypothesised to be due to common perceptions that people with mental illnesses are unpredictable and potentially dangerous. People with an intellectual disability are also often perceived as less capable than they actually are. Thus, increasing knowledge of intellectual disabilities is likely to help to allay any anxiety and discomfort caused by high levels of general ignorance within the community.

Socio-demographic characteristics are also associated with more positive or negative attitudes toward inclusion of people with disabilities. More negative attitudes tend to be held by males, older people and those with lower levels of education. Personal contact with people who have disabilities is consistently highlighted as an important catalyst for positive attitude change. Importantly, this contact must be positive, because negative experiences (particularly in childhood) contribute to more negative attitudes in adults. The positive effect of contact is more likely when the person with a disability is perceived by the audience as credible and relatable, and of equal or higher status to themselves.

Social self-concept of people with disabilities

Social self-concept is a system of beliefs and attitudes that individuals have about themselves (Francis, 1996). The *extrospective approach* by Sullivan (1953) cited in Lifshitz, Hen and Weisse (2007) viewed self-concept as a product of a person’s social interactions and society’s reactions to that person. The *introspective approach by* Fitts (1965); Rogers (1951) cited in Lifshitz, et al. (2007) focused on the consciousness that underlies the self-image, and is defined as a consistent cognitive model of a person’s perception of his or her attributes, values, and interpersonal relations. Some studies by Beaty (1992); Lopez-Justicia, Pichardo, Amezcua and Fernandez (2001) have found out that adolescents with visual impairments may feel inadequate and inferior because of their lack of social acceptance, academic underachievement, and physical disability (Hatlen, 2004).

Individuals appraise their interpersonal relationships, while the appraisal of a relationship reflects what it means to the individual and whether it is good or bad (Leary, 2000; Fincham, 2003; Fitness et al., 2005; Trope & Gaunt, 2005). An interpersonal relationship could be ascribed to infinite number of causes but self, other person, situation, environment; self-other person interaction and relationship itself are the most prominent causes in describing positive and negative relationships (Erber & Gilmour, 1995; Planalp & Rivers, 1996; Argyle, 2001).

Also, partners tend to attribute their positive interpersonal relationships to themselves and their negative interpersonal relationships to the other person and situational factors (Fitness et al., 2005; Stephanou, 2005, 2007; Weiner, 2001, 2002). Furthermore, the more negative the interpersonal relationship, the more the attributions to the other person's constant negative properties (Argyle, 2001; Hewstone & Antaki, 2001; Fincham, 2003; Williams & Gilmore, 2008).

Attributing good friendship to stable factors enhances friendship expectations, and facilitates relationship engagement, while attributing negative friendship to unstable is likely to improve friendship and minimize the feeling of hopelessness. In contrast, attributing negative friendship to stable factors reduces positive expectations, produces the feeling of hopelessness and can lead to learned helplessness, a sense that none effort can lead to good friendship

(Weiner, 2001; Seligman, 2002; Fitness et al., 2005; Peterson & Steen, 2005; Stephanou, 2010). Guilt and anger are elicited by controllable causes, but guilt emerges from internal, whereas anger is typically elicited by external factors (Stephanou, 2007). Hate results from appraisals of relative powerlessness and a perceived lack of control (Fitness et al., 2005). Also, stable causes maximize feelings of pity, given uncontrollable causes, and feelings of anger, given controllable causes (Graham & Hoehn, 1995).

Social competence as a factor for social participation

Nyberga, Henricssonb and Rydella (2008) noted that considerable research effort has been devoted to identifying risk factors for different aspects of low social participation. In contrast, not much is known about buffering factors, although the last decades have seen a growing interest in protective factors in children's social participation (e.g. Buchanan & Flouri, 2001). Adolescents' social competence has been linked to higher participation in sports and extracurricular activities (Donaldson & Ronan, 2006). Participation in groups and social activities predicts adolescents' peer attachment and self-perceived strengths, such as 'friendly', 'humorous', and 'outgoing' (McGee, Williams, Howden-Chapman, Martin & Kawachi, 2006).).

Children with developmental coordination disorders who perceive themselves as more physically competent have been found to participate in more community recreational and physical activities than those who are less competent (Hay & Missiuna, 1998). Children with physical disabilities who reported higher perceived social competence have been found to report higher preferences for social activities, participate in these activities more intensively, and have more enjoyment (King et al., 2006).

Low levels of pro-social behaviour as well as social initiative have been linked to peer rejection in population samples (Parkhurst & Asher, 1992; Newcomb et al., 1993; Rydell et al., 1997). Social competence in relation to loneliness has rarely been investigated, but there are reports of negative relationship between perceived competence/pro-social behaviour and loneliness in pre-schoolers (Coplan, Findlay & Nelson, 2004). In the adult literature, there has consistently been a negative relationship between social skills and loneliness (Riggio, Watring & Throckmorton, 1993; Segrin, 1993). From the point of view of problem behaviours, low social competence has been associated with internalizing problems as well as externalizing problem behaviours (Henricsson & Rydell, 2006).

Given the above relations, it would be of interest to see to what extent social competence contributes to social participation, and further, it seems possible that social competence could serve as a moderator of problem behaviours with respect to peer relations. Moderation could take different forms: in line with the reasoning above about protective factors, good social skills could temper the negative effect on peer relations for children with high levels of problem behaviour.

Second, high levels of social competence could further boost the peer relations of children with low levels of problem behaviours. Third, poor social competence could exacerbate the poor peer relations of children with high problem levels, and finally, poor social competence could jeopardize the normally good peer relations of children with low problem levels. Somewhat surprisingly, the question of the combined effects of problem behaviour and social competence on peer relations has barely been investigated.

In a study by Henricsson and Rydell (2006), high pro-social skills buffered the negative effects on later peer acceptance for children with early internalizing problems, but there was no such effect with regard to externalizing problems. In addition, social initiative further boosted later low problem levels of children who were non-problematic in first grade. Studying the same sample, meagre buffering effects of social competence were found with regard to teacher–child relationship for children with problem behaviours (Henricsson & Rydell, 2004). Both conceptually and empirically, a close association exists between children's social competence and friendships across the life span (Howes, 1988; Hartup & Stevens, 1997). Having at least one reciprocal friend is positively associated with social competence. Children with more reciprocal friends have higher levels of social competence, and friendship dyads are characterized by more socially competent play than non-friend dyads (Vaughn et al., 2000; Vaughn, Colvin, Azria, Caya & Krzysik, 2001; Lindsay, 2002). It is likely that this association reflects a complex process that evolves over time in which children's competence supports friendship development which, in turn, supports the further development of competence (Newcomb & Bagwell, 1996).

Social competence and peer relationships

Ladd (1996) noted that peers are generally characterized as individuals who are similar to the child in age and/or developmental level. Peer relationships may refer to children's efforts to interact with age mates, their positions or role in same age group or cliques, and their participation in various forms of relationships (Ladd, 1989). Research on peer relationships suggests the need to distinguish between friendship, which refers to a specific relationship between two individuals, and peer acceptance, which is an index of child social status among playmates and peers. According to this distinction, peer acceptance is a general group-oriented, unilateral construct that represents the view of the group toward an individual, whereas friendship is a bilateral construct that refers to a reciprocal relationship between two people with both affirming it (Bukowski & Hoza, 1989). The mutuality or reciprocity of affection is crucial as this distinguishes friendship from one child's desire to be liked by a peer, when that other child does not return the preference (Dunn, 2004).

The task of defining social competence has been approached in two ways (Hubbard & Coie, 2006). In the first; it has been defined solely in terms of social skills, whereas in the second, more emphasis has been placed on the social outcomes that children achieve (Hubbard & Coie, 2006). These outcomes include having friends, engaging in effective social interaction with peers, and being popular or liked by peers. Drawing on the latter approach, this study adopts social success as a criterion for defining competence.

Research has paid growing attention to children's peer interactions, social relationships and social competence. Peer interactions and friendships have been found to play an important role in facilitating the personal, social and moral development of individuals (Hall & McGregor, 2000). Social interactions have also been considered important for cognitive development (Vygotsky, 1978) and academic performance (Welsh, Parke, Widaman & O'Neil, 2001). Having friends and being accepted as part of a peer group is not only highly valued by most children, it is also essential for their social, emotional and academic development.

Social and Emotional Benefit of Community Living and Participation for People with Disabilities

Benefits from a service provider`s perspective

There are several reasons why service providers regard general community living and participation as beneficial for people with disability, but they are all contestable. These presumed benefits are as follows:

The theory of normalization decrees community living and participation to be beneficial. However, this reason has little contemporary relevance in western nations. The issue at hand is not whether people should be accommodated in institutions. The question now is how to optimize the life quality of people living in community settings, and normalization is silent on the issue of people's individual needs and desires. There are considerable dangers in using deinstitutionalisation as a basis for quality of life evaluations when the social consequences are ignored.

- Community resources are more likely to flow to groups that are publicly visible. Perhaps this is so, and perhaps it is not; but there are other ways to achieve government funding than through physical integration. Advocate groups and service providers can achieve appropriate funding by lobbying.
- Community living and participation is good for future generation people who are disabled. That is, community exposure changes public attitudes for the better and this will enhance community acceptance as a long-term strategy. Even if it were so, and even if the evidence is weak and equivocal (Krajewski & Flaherty 2000), ethical considerations demand

that any imposed activity, such as community exposure, must be beneficial to the participants, not just to other people.

- Community living and participation necessarily confers some tangible benefit to the participant. In summary, none of the reasons (1) to (3) provides a justification for enforced integration with the general community.

So it is time to examine the evidence for (4), that community living and participation necessarily confers benefit to the participant. One source of data comes from an examination of how other population groups choose to integrate with people who are non-family.

The fact is, when people are given free choice they evidence a preference for integrating with their own kind, not with the community in general (Katz, Lazarsfeld, & Roper, 2017). Thus, people who are rich congregate in exclusive and expensive suburbs, new migrants live close to others who share their culture and language, people who are elderly congregate in retirement villages, and people with particular medical conditions seek social affiliation with others who share their diagnosis (Lipsitz, 2006). So, how would such people define their ‘community’? Would the rich banker regard the unskilled, newly arrived migrant as part of her community, and with whom she should ‘integrate’ to achieve an improved life quality? Would the elderly residents of a retirement village regard integration with the adolescent youth who surround their enclave as enhancing their sense of community? Perhaps not, yet the philosophy of community living and participation is so entrenched that writers on service policy simply assume that people with disability are somehow different from other groups in society, such that integrated rather than segregated experience is necessarily of benefit to them (Giddens, 2013). Authors do not usually explain why this should be the case. Especially they do not explain why such people should regard community living and participation with the general community as being more desirable than community living and participation within the community of people with an intellectual disability.

So, what is the evidence for direct personal benefit derived from general community living and participation? The evidence for tangible, objective benefit will be examined first, followed by an examination of benefit at the level of personal experience.

Starting with the youngest groups, over the preschool to adolescent years, the effects of community living and participation, compared with segregated classroom environments, have been commonly researched. While results generally favour community living and participation, the differences are often small and not evident in all measured variables. A few examples will suffice to make this point. Advantages have been reported in pro-social behaviour (Eime, Young, Harvey, Charity, & Payne, 2013). On the other hand, no changes or differences have been reported on verbally or physically hostile behaviour or general developmental skills (Chasiotis, 2011).

In terms of adults, again the results are neither clear-cut nor dramatic. Certainly, some researchers are successful in demonstrating that more community living and participation conditions provide modest benefits to the recipients (Iyengar & Kinder, 2010). It is noteworthy, however, that there appears to be a bias operating in the reporting of many studies, such that the benefits of integrated living are emphasized while the areas of non-benefit or even disadvantage, are de-emphasized.

In terms of living environment, observers rated the community homes as homelier and the social climate as less institutional. However, in terms of staff work practices, while the community homes rated higher in terms of procedural matters (activity planning and training/ supervision of staff) and staff support to residents, this did not simply translate into direct benefits to the residents. Thus, there was no difference between the two living environments in terms of person-centred planning, assessment and teaching, or the frequency of resident contact by staff. This is particularly surprising as the community homes had a much higher staffing ratio (2.8) than the cluster housing (1.3).

They also reported the community homes to generate greater exercise of choice, social network size (including staff), less stereotypic behaviour, and more community exposure. Additionally, however, they found more disengaged activity within the community homes, no differences in network size after staff had been accounted for, and no differences in family contact or engaged activity. These seem rather flimsy grounds to support the authors' conclusion regarding overall life quality. Moreover, and as noted by the authors, the benefits that were evident to the community home residents were probably attributable to the greater staffing ratio rather than to the living environments per se.

Another example of exaggerated claimed benefits is provided by Iyengar and Kinder (2010). They compared 20 people (IQ 24–61) who had moved from segregated to competitive employment with a matched control group who remained in the segregated setting. Their measures included adaptive behaviour, physical health, and personal performance. Both groups were assessed at baseline, and again at a 6- and 12-month follow-up. The authors claim their study provides ‘an encouraging picture of the positive effects of competitive employment on the quality of life of persons with physical impairment.’ (p. 97).

In fact, their analysis is severely flawed. They used a multivariate analysis of variance with participant numbers insufficient to support such a statistical approach, they failed to use a Bonferroni correction for significance levels following multiple paired comparisons and they failed to adequately acknowledge that many of their significant differences were influenced by the control group scores decreasing over time, and finally they found no significant main effects. The only convincing parameter of change was in terms of increased weekly income.

As has been argued by Cummins and Lau (2003), the most crucial measure of community living and participation success is how people feel about themselves and their lives. One approach to such assessment is to ask people what factors contribute most to their life quality, and the fact is, when such questions are asked, very few people regard integration with the general community as either a desirable or personally relevant form of activity. For examples:

Kahneman and Krueger (2006) conducted a research in disability services by using 14 focus group discussions and 444 personal interviews to discover the aspirations of people with a disability. What they found at the top of their list was not community integration but having an intimate friend.

The Comprehensive Quality of Life Scale (Cummins & Lau, 2003) has been extensively used with both general population samples and people with an intellectual disability. The scale asks people to rate a set of seven domains on importance and satisfaction, and the rank order is highly predictable. Practically everybody regards the domain of ‘relationships’ at the top of their list, and the domain of ‘community’ at the bottom. So there is substantial evidence that people regard connection to their community as one of the least relevant areas of their lives.

Another approach to judging the personal benefit of community living and participation is to compare the subjective well-being of people living in different types of accommodation. Eight studies have been reviewed by Cummins and Lau, (2003) and the findings were as follows:

1. One study involved people with an intellectual disability living in a nursing home (Heller et al. 1998). Their subjective well-being averaged 57%SM, which is way below the normal range of 70–80%SM for group means (Cummins & Lau 2003; Percentage of scale maximum, %SM, projects Likert scale data onto a standard 0–100 scale). However, two years after moving to a shared house in the community the score rose to 70%SM, which is the lowest margin of the normal range.
2. In relation to the other studies, four of the groups living in institutions/cluster housing averaged 78%SM. In contrast, the six groups living in group homes average 81%SM, while the two groups living with their families had scores that differed markedly from one another (70 and 83%SM).

The conclusion that may be drawn from these studies is assisted by the Theory of Subjective Well-being Homeostasis (Cummins & Lau 2003). This proposes that subjective well-being is held for each individual within a narrow positive range by a combination of personality and cognitive devices. These act to defend against the influence of negative external forces, thereby allowing the well-being of normative groups to remain within a 70–80%SM range.

An implication of homeostatic theory is that people adapt to a wide range of living circumstances and thereby maintain their well-being within the normal range. Thus, while group mean scores that lie below 70%SM are indicative of a highly negative environment that has defeated homeostasis, group mean scores that lie within the 70–80%SM range yield little information about the circumstances of living.

This understanding can be used to interpret the aforementioned data as follows. While the nursing home environment in Cummins and Lau (2003) study exerted a sufficiently negative influence to defeat the homeostatic system, the other living environments did not. Thus, from these data on subjective well-being, no clear indication can be obtained as to the personal benefits of living in institutions/cluster housing, group homes, or within the family environment.

The work environment is another source of differentiation with respect to the degree of integration, and one relevant study has been located that measured subjective well-being. Costanza, Fisher, Ali, Beer, Bond, Boumans, and Gayer (2007) claimed to have demonstrated higher subjective quality of life among people in supported employment within a general community work situation, compared with others in sheltered employment.

For many reasons, however, this study cannot be regarded as providing reliable evidence for such a conclusion. Briefly, the workshop participants were drawn from a single location, the number of participants in each group were small (N¼10), no Bonferroni correction was made for multiple tests of significance, and some of the items were so complex and ambiguous that it is uncertain what meaning can be derived from the data (e.g. 'Do you feel within the past year your ability to make independent decision is: worse, a little worse, about the same, better, much better').

In conclusion, while the nursing home environment of Heller and Eisenberg (1998) was clearly associated with a lower than normal level of subjective well-being, no clear discrimination is apparent within the other living or work environments that have been cited. This seems surprising given the enormous concentration of effort to create integrated living and working environments. Why are the benefits of integration not more clear-cut? Perhaps the level of physical integration needs to be increased for determined benefit to emerge.

Challenges/Barriers to Community Living and Participation

Persons with disabilities are confronted with numerous barriers to community integration as they move from the dependence of childhood and early adolescence to the autonomy and independence of adulthood. The most obvious of all barriers is lack of access to community living environments. Deinstitutionalisation has resulted in a large increase in the number of persons with intellectual disability living in community settings. For young adults with disability to experience the many benefits of community inclusion, they must first live in settings that provide access to a wide range of employment, recreational, and self-enrichment activities.

A second obstacle to full inclusion within the community stems from the rather restrictive attitudes of parents and family members. Many parents express concern about impending moves from institutions to small community facilities. Reasons for apprehension include fears about the appropriateness of available community settings, anxiety that the move will have a negative impact on the family, and concerns that the individual does not possess necessary skills to function adequately within the community. Discussions with parents following moves of their young adults to community settings revealed more positive feelings about these placements, as 80% of the parents reported satisfaction with the deinstitutionalisation process (Havlicek, McMillen, Fedoravicius, McNelly, & Robinson, 2012).

A third major barrier to community inclusion results from opposition on the part of community members. Some community members resist development of group homes in their neighbourhoods (Adamson, 2010). Reasons for such opposition include concerns about negative influences on property values, neighbourhoods' character, and neighbourhoods' children (Cheshire, & Sheppard, 2004). However, follow-up studies have demonstrated indifferent or accepting attitudes by community members and no decreases in property values (Abramsky, et al, 2014) following the opening of small community residences.

A fourth and equally critical barrier to community inclusion has resulted from lack of funding necessary to provide quality services in small community-based settings (Braun, Catalani, Wimbush, & Israelski, 2013). While the majority of people are typically able to find enough resources to move from parental homes within a year or two of leaving school, general lack of financial resources prevents many young adults with mental retardation from moving into supported community residential settings during the same developmental period.

Full access to all aspects of community living is the principal goal of most inclusion programmes. The general barriers discussed here significantly limit such access. However, more specific obstacles to integration within the community also exist. These barriers limit access of persons with disability to programmes, environments, and services that have the potential to substantially enhance the quality of living. Specific barriers of special relevance to the therapeutic recreation specialist include those limiting access to recreational leisure programmes, hindering development of social networks, impeding economic self-reliance, and obstructing the young adult from obtaining needed support services.

Challenges/Barriers to Recreational/Leisure Integration

One-third of all persons with disabilities have a reported need for recreational/leisure services but are unable to obtain them (Guernsey, Nicoli, & Ninio, 2007). This staggering figure indicates that numerous barriers to participation in recreational/leisure activities need to be addressed. The most frequently reported barrier to participation in social and leisure activities was the lack of a companion, friend, or advocate with whom to share the experience. Other barriers included lack of finances and lack of transportation to leisure activities. It is clear from these studies that more work is needed to facilitate development of social relationships that enable young adults with disability to experience full inclusion within recreational/leisure settings.

A second major barrier to full integration within recreational/leisure settings is the lack of practical, widely available guidelines for planning and implementation of integrated programs. While a few excellent guides in this area exist (Glaser & Strauss, 2017), this type of information is either not generally available or frequently used by professionals in the field. However, one such programme, Unified Sports of Special Olympics, has set forth published guidelines to assist programme leaders with provision of opportunities for shared participation in sports for persons with and without mental retardation. Guidelines of this formally integrated, national programme have explicitly stated goals that have enabled both participants and the Unified Sports programme itself to overcome barriers of recognition and acceptance and, thereby gained increased support and popularity among the sporting public.

A third barrier to integration within recreation/leisure settings stems from lack of skills persons with disabilities have available to take advantage of these programmes. Unless participation is initiated by a family member or professional support is available for programme participation, many persons with disabilities are not able to take part in these activities. Failure of families and service providers to provide sufficient opportunities for persons with disabilities to develop physical and self-determination skills necessary for independent access to programmes greatly restricts opportunities for participation.

Challenges/Barriers to Social Integration

Persons with disabilities face numerous barriers to developing integrated social networks. One barrier faced by young adults stems from difficulty in asserting control and choice over important aspects of daily living. In recent years, several researchers emphasized developmental transition from dependence to self-determination as an important outcome of early adulthood for persons with disabilities (Geenen & Powers, 2007). Barriers to self-determination may be raised when parents ignore preparation for independent living, resist or prevent their young adults from participating in normal developmental activities (e.g., spending the night with a friend, or participating in adult-oriented recreational/leisure activities), or advocate for maintaining solely asexual relationships (Powers, et al, 2012).

Bolton (2010) identified rights of making choices and risk-taking as fundamental prerogatives of adolescent and early adult development. Interference with these rights constitutes a barrier to development of a supportive social network of friends and significant others. For example, if persons with disabilities are not allowed to choose age appropriate recreational/leisure activities, it significantly decreases the likelihood they will meet same-aged peers with similar interests. One major factor that influences formation of social relationships is similarity of interests (Kreijns, Kirschner, & Jochems, 2003). Attitudes and expectations of parents, residential staff, and other professionals often result in persons with disabilities having little input into leisure and recreational activities in which they participate.

This places such individuals at risk for having social networks that neither meet basic support needs nor enhance quality of life. Numerous specific barriers also limit development of rich social networks for persons with disabilities. The first of these entails lack of access to reliable transportation (WHO, 2015). Individuals with disabilities living in rural settings typically have limited options as to how they can get together with friends and acquaintances. Young adults in urban areas also find access to transportation services difficult. Identified transportation barriers include prohibitive costs, complicated routes and procedures, stringent eligibility requirements, lack of reliability, and physical and psychological vulnerability of using such services.

Another specific barrier to development of social relationships is lack of safe, accessible, age-appropriate situations within which to meet others

(Lindsay, Sussner, Greaney, & Peterson, 2009). In many areas, young adult hangouts are unsafe for persons with disabilities. Park and recreation professionals often concentrate efforts on providing programming opportunities to children with few non-competitive programmes for young adults. Without support, many persons with disabilities are unable or unwelcome to participate in any leisure-time activities (e.g., health clubs, concerts, theatre).

Hesitancy on the part of recreational staff is one of the major reasons such activities are often inaccessible. Recreational/leisure professionals will likely remain anxious about integrating persons with disabilities into programmes until their knowledge about disabilities and disability-related issues is increased.

Additional barriers to social integration include insufficient support provided to general recreational/leisure professionals once persons with disabilities are integrated into existing activities, and general lack of knowledge of existing programmes. Many recreational professionals report receiving inadequate support when persons with disabilities are integrated into their programmes or activities. This includes lack of time to prepare necessary adaptations, as well as difficulty accessing and efficiently using the time of therapeutic recreation specialists (Downing, & Peckham-Hardin, 2007). In addition, many parents, professionals, and young adults with mental retardation are completely unaware of recreational/ leisure programmes that exist within their communities. Inadequate outreach by sponsoring organizations and poor interagency communication are two factors that contribute to this state of affairs.

Barriers to Economic Integration

When compared with individuals without disabilities, types and levels of employment available to persons with disabilities are restricted. These differences are symptomatic of barriers affecting economic integration of all young adults with disabilities.

Specific barriers to employment of persons with disabilities include limited employment options, a shortage of support services to enhance productivity, low pay, lack of integrated opportunities for work, exclusion from vocational services due to eligibility requirements, insufficient staff, and lack of funding resources (Lysaght, Ouellette-Kuntz, & Morrison, 2009). Although barriers to employment have been well studied in recent years, less well studied is the level of control persons with disabilities have over expenditure of personal income. In an economy in which spending patterns influence fashions as much as social norms, young adulthood is a time in which individuality is asserted through dress, hobbies, friends, gifts, and even diet. These activities and material goods are obtainable only through disbursement of income.

As suggested by O'connor (2017), persons with disabilities often do not have control over how their funds are spent. This often results in an inability to purchase desired goods and services. Participation in recreational/leisure programme is often overlooked by professionals and families when decisions are made regarding disbursement of income earned by persons with disabilities. Whether decisions made by others prevent these people from taking part in integrated recreational/leisure programmes altogether, or channel them into participation in programmes not of their own choosing, basic rights of the individual are often ignored.

Barriers to Obtaining Needed Support Services

To participate fully in community life, many young adults with mental retardation require support services. This includes assistance in the form of recreational/leisure services, friend-advocate programes, transportation, in-home respite care, self-help/support groups, vocational training, and case management. While a wide variety of support services is needed by young adults with mental retardation, many of these types of assistance are not available to individuals (Gulliver, Griffiths, & Christensen, 2010). Unavailability of and lack of access to these services constitute barriers to full inclusion within the community.

A second barrier limiting access to integrated community living is shortage of financial resources to support specific needs of persons with disabilities. This includes general lack of resources to deal with specific needs such as challenging behaviours; physical and/or sensory impairments; extensive care needs in eating, dressing, or toileting; and exceptional medical needs. Persons with disabilities, extensive medical needs, or challenging behaviours are less likely to move from institutions to integrated community settings and are more likely to be admitted or readmitted to institutions than counterparts who do not possess these characteristics (Petry, & Maes, 2007).

These individuals participate less frequently in typical community activities whether they live in urban or rural settings or in large or small residences (Bovaird, 2007). In addition, young adults with exceptional needs rarely work within integrated community settings (Gerhardt, & Lainer, 2011). Despite these barriers, however, persons with disabilities, including those with challenging medical needs, challenging behaviours, or severe disabilities can and do live successfully in community settings (Resch, Mireles, Benz, Grenwelge, Peterson & Zhang, 2010). The challenge for all service providers is to identify resources and supports that enable all such persons to be fully included in community settings.

Ways of Improving Community Living and Participation

Knoll (1990) identified 11 characteristics of environments that support a high quality of life for persons with disabilities. These include real choices in all aspects of daily life, instruction to develop functional skills, opportunities for interaction with a variety of people, use of generic services, access to community resources, age-appropriate settings and materials, entrance to a wide range of community environments, living in a typical neighbourhood, meaningful daily activities, use of non-aversive interventions, and opportunities to develop friendships. The therapeutic recreation specialist is in an excellent position to insure that environments of young adults with mental retardation are characterized by most, if not all, of these qualities.

Enhancing quality of life for persons with disability is a difficult and complex task. One must not only facilitate development of social ties between young adults with disabilities and the rest of the community but also create and strengthen relationships among organizations that serve such individuals. In designing and overseeing implementation and evaluation of community programmes, the specialist is in a position to promote development of lasting social relationships among persons with and without disabilities, change societal attitudes and expectations about persons with disability, and provide persons with disabilities access to a wide range of environments in which they can choose and initiate social relationships. Program design must not only draw upon content of recreation and a knowledge base of developmental, social, and economic characteristics of persons with disabilities, but on support systems available and necessary to meet specific needs. Based upon this assumption, several recommendations are made, some recommendations include;

Respect Independence and Self-determination of Persons with Disabilities

Far too often professionals working to enhance the lives of persons with disabilities assume the care-provider knows best. Persons with disabilities are placed into programmes without ever inquiring as to their levels of interest or providing those opportunities to make informed choices about participation. All young adults, including those with disabilities, are entitled to exercise control over basic aspects of their lives as part of the developmental process (Havinghurst, 1972). It must be ensured that persons with disability have opportunities to exercise self-determination by making them integral parts of the planning team, encouraging their participation in program design and content, and valuing their contributions. Allowing a young person with a disability to shape at least some activities that compose daily life also provides a powerful message to parents and other professionals as to age-appropriate expectations in this area.

Emphasize Strengths and Contributions of the Individual

All individuals have strengths and weaknesses. However, for far too long service providers have used a deficit-based model to design programmes for persons with disabilities. That is, emphasis has traditionally been on what one could not do rather than what one could do. While it would be inappropriate to ignore limitations of a disability, programming is likely to be significantly more effective if based upon skills an individual possesses rather than on skills he/she lacks. As persons with disabilities move into more normative settings, the heterogeneity of skills and abilities will evolve, just as they do for young adults without disabilities. Allowing the person with disabilities, rather than others, to identify well-developed skills and abilities is a second strategy that has proven to be of value. Focused programming on selection and planning of social activities rather than task accomplishments is one way to accomplish this.

Acknowledge Developmental Status

If community living and participation is to become a reality, persons with disabilities need to have access to the same age-appropriate community experiences as peers without disabilities. Opportunities to access the same community experiences as individuals without disabilities play a crucial role in friendship development. Without such access, it is unlikely that persons with disabilities will share common interests with peers, develop similar belief systems, or be perceived by peers as similar in other respects. In developing inclusive recreation and leisure programs, the developmental status of the persons with disabilities must be acknowledged.

This means focusing inclusion efforts on programs or activities socially valued by other people. Integrating a person with disability into a football league, for example, would be more appropriate than facilitating inclusion in a shuffle-board or croquet association.

Include Systematic Programming to Stimulate Social Interaction

One benefit of participation in recreational/leisure programs is that an individual has opportunities to interact socially with others with similar interests. Taking part in joint activities can lead to the development of friendships. However, physical integration is not synonymous with community living and participation. Because of limited opportunities for integrated social interactions, many people with disabilities may remain anxious or reluctant to engage in such activities. Incorporating systematic programming to stimulate social interactions (e.g., cooperative learning) into recreational/leisure activities is one avenue through which to make participation a more effective learning and social experience.

Few young adults with or without disabilities can live high-quality lives without the aid of community resources. Fewer still take full advantage of available resources. Much of this is due to lack of communication and coordination between existing programmes and agencies. Many people with disabilities and their families are unaware of existing resources within communities. This state of affairs is also often true for professionals within disability-related fields. There must be information exchange and creation of more effective linkages among organizations that serve persons with disabilities and between these young adults and organizations themselves. Effective coordination of services and programs offered, recreational programmes, community education programmes, can do much to remove barriers effectively limiting inclusion of persons with disabilities.

Due to support needs of persons with disabilities, there must be development of resources beyond those currently available to insure that full inclusion becomes a reality. These resources can be obtained if community and service organizations, corporations and small businesses are recruited to join in the pursuit of full community living and participation. The most valuable resource that can be obtained from such organizations is not money, but, rather, involvement of members of the community. Use of such individuals as volunteer support staff, integration facilitators, and mentors will increase accessibility of programmes to persons with disabilities while also serving as vehicles through which to change community attitudes toward persons with disabilities.

Community living and participation of people with disability

Conceptual Framework

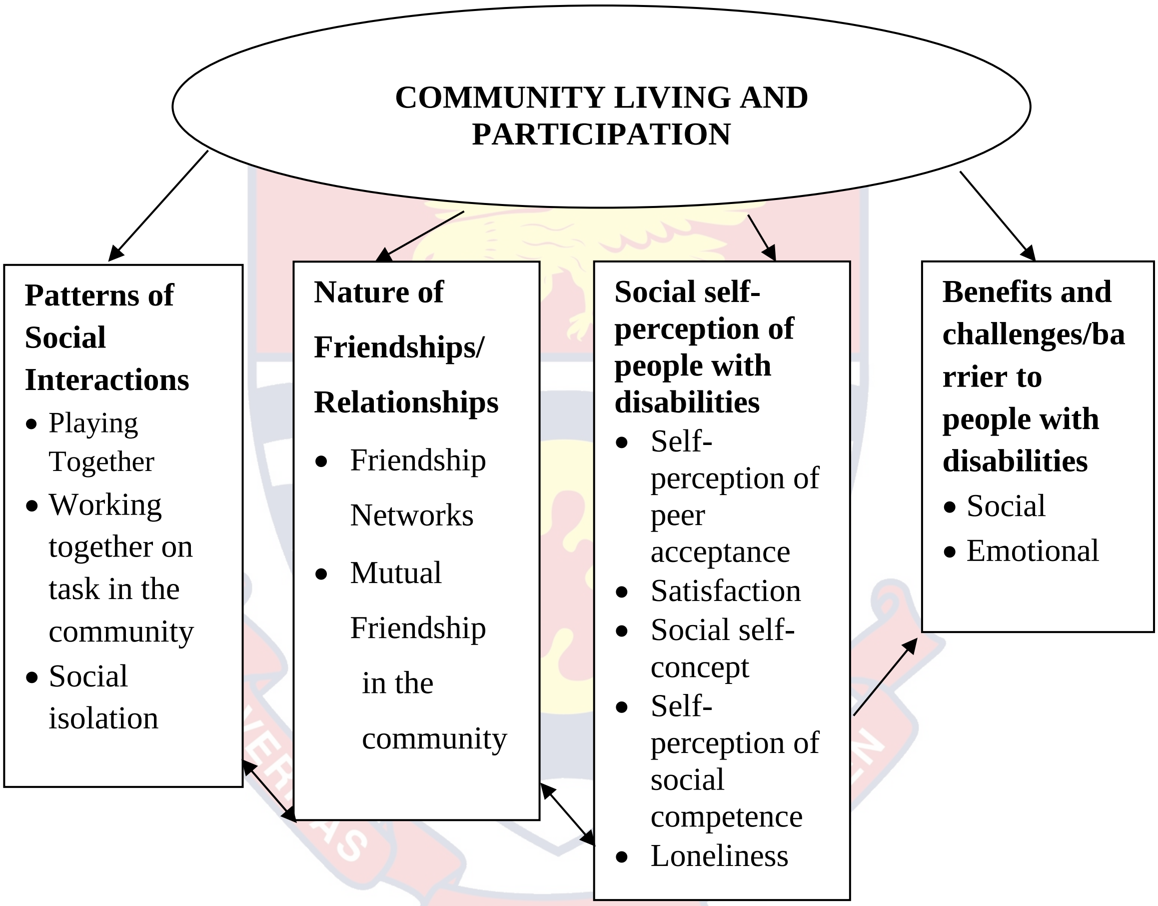


Figure 1: Conceptual Framework.

Within the framework, community living and participation is an issue in the generality of the individual wellbeing in the environment. The participation in the community reflects on the type of relationships or the nature which leads to the patterns of social interactions which can involve playing together, working together on tasks or in an unusual case, social isolation. The patterns of social interactions have a link with social self-perceptions of people with disabilities and in this case, those with mild intellectual and developmental disabilities, visual impairments, hearing impaired and the physically challenged. Their own self-perceptions can influence their acceptance and socialisation with others without disabilities. Negative or positive social self-perceptions can either lead finally to acceptance or non- acceptance by people without disabilities in the communities.

Within the framework, community participation is a key issue in an inclusive environment in the community. The community participation reflects on the type of relationships or the nature which leads to the patterns of social interactions which can involve playing together, working together in the community or in unusual cases, social isolation. The patterns of social interactions have a link with social self-perceptions of people with disabilities. Their own self-perceptions because of the disability can influence their acceptance and socialisation with peers that are not having any disabilities. Negative or positive social self-perceptions can either lead finally to acceptance or non-acceptance by peers without disabilities in the communities.

Summary of Literature Review

The literature has elaborated the interaction patterns between people with disabilities with varying diversity. The literature has also chronicled the social self-perception of people with disabilities and how that boosted their interpersonal relationships in the communities. These included their social competence and loneliness among others. The literature also highlighted the acceptance of people with disabilities and focused on the social preference, social support behaviours and rejection.

Although different stages and aspects of friendship have been well documented in studies of typically people with disabilities, less research has been conducted in which practitioners and people own experiences have been applied to examine the nature of friendships and social interaction patterns existing between people with disabilities and their peers in the various communities in Ghana. Also, although people`s social self-perception for their social participation reflect and influence the quality of the friendship, only a limited number of studies have focused on these concepts, and on how they interactively influence friendship expectations especially in Ghana.

In addition, evidence from the literature indicated no report on how the social self-perceptions of people with disabilities may influence their acceptance in their communities. Overall, the empirical evidence suggests the necessity of examining the community living and participation through their own experiences. consequently, this study was based on the connection between the friendships network, social interaction patterns, peer acceptance and social self-perception, social and emotional benefits of people with disabilities as being influenced by their participation in the community in Ghana.

CHAPTER THREE

RESEARCH METHODS

Introduction

This chapter presents an overview of the methods used in the study. Areas covered include the research design, population, sampling procedure, sample size, data collection instrument, data collection procedure, data processing and analysis and ethical consideration.

Research Design

This study adopted a qualitative case study research design. Case study research design is the investigation of the one or more specific 'instances of' something that comprises the cases in the study. The case study approach is widely used in the social sciences, and there is a growing confidence in its applicability as "a rigorous research strategy in its own right" (Hartley, 2004, p. 323). Yin (2003) explained that it as an empirical inquiry that investigates a contemporary phenomenon within its real-life context. A case can be something relatively concrete such as an organization, a group or an individual, or something more abstract such as an event, a management decision or a change programme.

Qualitative investigation is the collection, analysis, and interpretation of comprehensive narrative and visual; that is, non-numerical data to gain insights into a particular phenomenon of interest **(**Hayford, 2007; Gay. Mills & Airasian, 2009). Qualitative researchers are interested in understanding the meaning people have constructed, that is, how people make sense of their world and the experiences they have in the world (Merrian, 2009).

According to Denzin and Lincoln (2005), qualitative research is a situated activity that locates the observer in the world. Theses practices transform the world. They turn the world into a series of representations, including field notes, interviews, conversations, photogragraphs, recordings and memos to the self. At this poit, qualitative research involves an interpretative, naturalistic approach to the world. Qualitative researchers are interested in understanding the meaning people have constructed, that is, how people make sense of their world and the experiences they have in the world (Merriam, 2009). As such, the study delved into the community living and participation of people with disabilities. This enabled dialogue and listening to capture the essence of what is perceivved by the subjects (vander, 1999).

Creswell (2007) gives the concept of case study that, it is a qualitative approach in which the researcher explores a case or cases over time, through detailed, in-depth data collection. For example, the sources of information can be observation, interview, audio-visual material and documents and reports. In this case the researcher used interview. Gall, Gall, and Borg (2007) give the meaning of case study as "an in depth investigation of two or more phenomena in natural settings considering the perspectives of the participants involved in the phenomena" page 447.

Choosing case study design helped the researcher to investigate deeply the community living and participation of people with disabilities in terms of their positive relationships or friendships, social contact or interactions, peer acceptance. "Friendship" or "relationship" focuses on companionship and membership in networks of the whole community. “Contacts” or “interactions” focuses on playing, working and having fun together, and being included in or excluded from activities, while “people’ social self-perceptions”. “Acceptance” by the non-disabled on the other hand focuses on other community members taking into account the possibilities willingness to assist or to stand up for those with disabilities in the Cape Coast Metropolis. With this approach I could better appriaciate their point of view on the issue off community living and participation of people with disabilities.

Population

A population in a research refers to the large group of people with common observable features to which one hopes to apply the research results (Fankiel & Wallen, 2003). Nnuman (2007) noted that, population is the unit being sampled, the geographical location, and the temporal boundaries. It can be a person, organization, a written document or a social action.

Creswell (2005), states that a population refers to group of humans selected for a study. The population of this study was people with disabilities, which comprised the mild intellectually disabled, visually impaired, hearing impaired and physically challenged. According to the Population and Housing Census report conducted in 2010 by the Ghana Statistical Service, these four categories formed the top four categories of disabilities recorded. The total population consisted of all 590 registered people with disabilities at the Social Welfare Department of the Cape Coast Metropolitan Assembly. This comprised of 109 persons with mild intellectual disability, 219 physical challenged, 165 hearing/speech impaired and 97 visual impairments. Proximity and easy access to the selected associations, also informed my choice of these four groups.

Sample and Sampling Procedure

Purposive sampling procedure was used to select 16 adult (18 years and above who are and can engage in productive activities in the community) respondents which comprised 12 persons with disabilities and 4 persons without disabilities. Thus, 3 mild intellectual and developmental disabilities, 3 hearing impaired, 3 physically challenged, 3 visual impairments (blind) and 4 non-disabled (who are closely related to persons with disabilities) in the community with much experience and knowledge in the study area. Purposive sampling is the type of samping in which the researcher uses his/her on judgement regarding the seection of participants from whom required information is colected (Amin, 2005). The selection of the participants was purposevily done to ensure that rich information about the community living and participation of people with disabilities was obtained and also to get a deeperr understanding of the phenomenon.

Table 1-*Number of participants selected from the various disabilities groups and the non-disabled*

Type of disability	Number of participants	Male	Female
Visual impaired	3	2	1
Hearing impaired	3	2	1
Physically challenged	3	1	2
Mild intellectually and developmentally disabled	3	2	1
Non-disabled	4	3	1
Total	16	10	6

Source: Field Data, 2019

Data Collection Instrument

Avoke (2005) noted that interviews are ways of verbally interacting with participants or respondents in conducting research. The main instrument for the study was an interview guide (Appendix D and E). The interview guide was divided five parts. Part one elicited information on demographic data of respondents. Part two elicited information on social interaction pattern that exist between persons with disabilities and the nondisabed. Part three elicited information on the nature of friendships/relationships among persons with disabilities and the nondisabled. Also, part four elicited information on the social self perceptions of persons with disabilities. Finaly, part five elicited information on the benefits of community livving and participation of persons with disabilities. Similarly, there was an interview guide for the non-disabled. These were special individuals in the community who attend to the immediate needs of persons with disabilities. The interview guide for the non disabled elicited information on the community living and participation of people with disabilities in their respective locations.

Data Collection Procedures

The data collection was preceded by an introduction letter from the Head of Department of Education and Psychology, University of Cape Coast (see Appendix B). This letter was sent to the Department of Social Welfare, Cape Coast to seek permission and the appropriate days, date and time to conduct the interview through the Ghana Federation for Disabled. All the four disabilities groups presidents were informed about the research during their executives meeting at the assembly. Appropriate dates, days and time were given to me by the (GFD).

Interviews were conducted at the convenience places of the respondents to avoid disturbances by others for a period of three weeks. The intention was to maintain privacy and confidentiality of participants. Rights of participants to participate, decline or withdraw from the study were clearly explained to them. Interviews were conducted after participants had consented into written and orally aggreements depending on participant`s ability to read and write. Participants who could not read and write were made to thump-print the consent form after all the necessary information regarding the study was provided in the local language (Fante).

Interview sessions were one-on-one between the researcher and the respondents using interview guide. Each respondent was interviewed separately and each interview time lasted for thirty (30) minutes and was tape recorded and notes taken. Breakwell, Hammond, Fife-Schaw and Smith (2006) noted that spending an equal amount of interview time with interviewee ensures consistency which contributes to trustworthiness of the study. Deem (2002) opined that, in interview, it is important for the researcher to record as much detail as possible. Therefore, to capture detailed sets of information during interviews, an audio recording device was used to enhance the accuracy of the data collected.

In the case of participants who were hearing impaired, the researcher used an experienced sign language interpreter during the interviews as the researcher has no expertise in that area. All participants were told that the interview would be audio recorded before the start of the interview as agreed on in the consent form earlier. Participants were again told that the interview was being recorded for academic purposes only which was agreed and consented to.

Ethical Considerations

According to Saunders, Lewis and Thornbill (2012), research ethics relates to questions about how to formulate and clarify a research topic, design a research and gain access, collect data, process and store data, analyse data and write up research findings in a moral and responsible way. An ethical consideration in the field is inevitable when the work involves others, whether they are colleagues, respondents, assistants or people in position of authority (Pereceman & Curran, 2006).

Ethical issues are highly relevant and requires due consideration. Babbie and Mouton (2006), opined that ethical standard requires that researchers do not put participants in a situation where they might be at risk of harm as a result of their participation. Trustworthiness of qualitative study is judged by whether the researcher conforms to standards for acceptable and competent practice and whether they meet the standard for ethical conduct (Rossman & Rallis, 2003). It is as a result of this that necessitated my consideration for ethical approval for the study. Kara (2015) emphasized that, it is important to ensure that the way in which the research is designed is methodologically sound and morally defensible to all those who are involved in it. In order to deal with this ethical issues in this study, I first applied and obtained ethical clearance from Institutional Review Board, University of Cape Coast (see Appendix A).

After this, an introductory letter was also collected from the Department of Education and Psychology introducing me to the gatekeepers of the participants. Gatekeepers have a key role to ensure that researchers gain access to intended participants and sites for research (McFadyen & Rankin, 2016). According to Saunders (2006), gatekeepers refers to the adult who controls or limits researcher`s access to participant. For example, the top manager or senior executive in an organisation or the person within a group or community who makes the final decision as to whether to allow the researcher access to collect data from respondents or not.

In view of this, permission was sought from the Department of Social Welfare and the Ghana Federation of the Disabled (GFD) in the Cape Coast Metropolis of the Central Region. Permission was also sought from GFD to interview some selected members of their association in the Metropolis. Participants were assured of confidentiality, anonymity and that names and identifying information would not be collected during and after the study (Sommers & Sommers, 2002). Finally, the interviews were conducted after respondents had consented to in writing and orally depending on the participants` ability to read and write.

Participants who could not read or write were made to thump-print the consent form after all the necessary information regarding the study was provided in the local language. Additionally, interview guide excluded any identification details such as names and addresses of the participants (Creswell; 2009, Sommers & Sommers, 2002).

Data Analysis Procedure

Thematic analysis was used for the analysis of the data as it dealt with the naturally events and it provided vivid descriptions and inforrmationthat led to answers (Miles & Huberson, 1994). Thematic analysis helped produce categories from the data, unlike qualitative strategies which predetermined categories. To this effect thematic approach to qualitative data analysis by Braun and Clarke, (2006) was adapted for the study. According to Braun and

Clarke (2006), thematic analysis is the method for identifying, analyzing and reporting themes within the data. The following steps using an iterative process were used for the analysis of collected data. Thematic analysis by Braun and Clarke (2006) has six phases which have been stated and described.

1. *Data cleaning and familiarization with the data*

To familiarize myself with the data, the audio recorded interview were listen to several times (Gay, Mills & Airasian, 2009). Each interviewee was given a numeric code based on the order in which they were interviewed for easy referencing (Sommers & Sommers, 2002). Each interviewee was given an assigned specific number (code) (IDD 1-3) for people with mild intellectual and developmental disabilities according to the sequence in which participants were interviewed. People with visual impairment were also given code/number (VI 1-3), people with hearing impaired (HI 1-3) and finally, those with physical challenge (PC 1-3). People without disabilities were given codes/numbers (ND 1-4). The field notes and reflections were also named according to the number assigned to each participant. Separate files were prepared for information collected from each participant that included transcribed interview sheets, field notes, and reflections of participants during the interviews. Through this way, each participant's file was identifiable through the number assigned to each participant and ensuring privacy at the same time.

Verbatim transcription of the audio interview were done and hesitations and pauses were also noted (McClellan, Macqueen & Neidig, 2003). Each interview was transcribed in the same week that the participant was interviewed. Notes were taken after each reading of the transcription that guided the interview of next participant. Concurrent data collection and transcription helped and guided the interview session with the next participant.

After all interviews were completed and transcribed, the whole data set was read carefully prior to forming the codes. During this phase, notes were taken to identify any patterns to determine if any formative codes were visible. This was done to preserve originality and ensure that no information was misinterpreted or lost. The transcribed data was read through while listening to the audio tape in order to ensure there were no omissions. Each interview was summarized. This helped to conceptualize what the interviewees said and identified any similarities and differences in their statements (Vanderpuye, 2013).

After the transcription process, the primary researcher went through the data in depth, to get familiar with the depth and breadth of the content. It involved 'repeated reading' of the data in an active way that guided the primary researcher to search the context and patterns of what has been shared. Each interview was transcribed in the same week that the participant was interviewed. Notes were taken after each reading of the transcription that guided the interview of next participant. Concurrent data collection and transcription helped and guided the interview session with the next participant.

After all interviews were completed and transcribed, whole data set was read carefully prior to forming the codes. During this phase, notes were taken to identify any patterns and determine if any formative codes were visible

2. *Generating initial codes*

Coding is the process of examining the data for themes, ideas and categories and making similar passages of text with a code label so that it can easily be retrieved at a later stage for further comparison and analysis (Taylor & Gibbs, 2010). After initial familiarization with data and generation of few ideas, initial coding begun. In the process of coding, data was organized into meaningful groups. The coding process included word-for-word reading of the interview transcripts, labeling of words or parts of sentences with pencil. Each sentence was read carefully and significant words were marked. In the coding process, parts of sentences or words were coded and un-coded multiple times during the process. The labels or codes represented important pieces of information that was needed for this study. I also maintained memo notes in the process of coding. I had two people involved helped me in the process by enduring nothing is missed during the tedious task of coding.

3. *Searching for themes*

All the relevant categories were considered together to identify potential themes. An analysis chart was developed to form a relationship between codes, sub-categories and categories so as to develop themes. Some of the sub-categories were used in final theme generation and some of them formed categories. In the end, four themes were developed from the organization of the existing data.

4. *Reviewing themes*

This stage included refinement of initial identifiable themes. Some of the initial themes merged or separated into different themes as the analysis process went further. The principles of internal homogeneity and external heterogeneity (Pattons, 1990) were used as principals in identifying final themes. (Braun & Clarke, 2006) this is the stage of generating a thematic `map` of the analysis if the themes work in relation to the coded extracts (phase 1) and the entire data set (phase 2).

Themes were developed through reviewing and refining initial categories and making changes if they did not fit together. I reviewed the major themes and sub themes to ensure that the themes could not be discussed alone were collapsed and added to one that was similar. It was also taken in consideration that the themes made connection with the broader picture and research objectives.

5. *Defining and naming themes*

This phase of analysis is to refine the specifics of each theme, and the overall story of analysis tells, generrating clear definitions and names of each theme (Braun & Clarke, 2006). I made sure that the names that were given to the subthemes were catchy and immediately give the reader a sense of what the theme is about. In all, 4 major themes and 24 subthemes were defined and refined by the essence of what each theme is about and determing what aspect of the data each theme captures. An example of themes and subthees can be seen in Appendix E.

6. *Producing the report*

At this stage, final analysis was done that guided towards writing a report. The report was the description of all the themes with valid and reasonable story from the raw data. It helped in understanding the results and how themes were developed. The discussion involved description of generated themes as well as arguments related to research questions.

The themes developed during the process were linked to each other and the research questions. The process of analysis from coding to themes to interpretation was iterative. Notes were kept that were used to make an audit trail of the findings and representations of final data. Throughout the process of data analysis, during codes and themes development from raw data, the study supervisor was contacted and periodical discussions were held to ensure guided progression of the data analysis. In addition, the study results were sent to the study supervisors to ensure that the process followed and associated outcomes made logical sense from the collected data.

Trustworthiness of the data

To maintain the trustworthiness of this study, the researcher engaged in various strategies so as to logically represent the findings. This study attempted to establish its trustworthiness by maintaining the credibility, transferability and dependability of the results. Credibility is related to presenting the true picture of the participants' experiences. The focus of the study was to gain peoples' perspective on community participation and how their living arrangements impact their participation in community. To address this goal, persons with disabilities's were asked about their experiences and views instead of relying solely on proxies or other people in close association. Including persons with disabilities's to define their own participation in community increased the credibility of the findings, as it was coming directly from people who have challenges to participate in community.

The continuous guidance from research supervisors gave a supervised and logical direction. The primary researcher sought agreement from research supervisors at various stages of data collection and data analysis. The inclusion criteria of people having experience of living in the community helped in identifying study participants. This process helped in gathering information from participants who could provide maximum information about living community and were able to tell their levels of participation in community.

To facilitate transferability in this study, participant's characteristics such as level of participation, ability to interact and make friends in their life experiences played an important role in determining where and under what conditions the study findings were transferable. It was assumed that each person has his or her unique perspective about living and participation in community. However, it was hoped that the study can give a good picture about what is important for persons with disabilities while participating in community and how this population describe their participation while living in the community, foster independent and inclusiveness.

Using content and thematic analysis approach with an iterative process in data collection and analysis provided an opportunity to cover both depth and breadth of the study objectives. In addition, the use of participants' quotes in presenting the results also added to the study dependability. It allowed the consistency between raw data coding and development of categories or themes from it.

CHAPTER FOUR

RESULTS AND DISCUSSION

Introduction

This chapter presents the results and discussion of findings. The analysis are presented in two sections: Section one presents the demographic data of respondents. It analyses the transcriptions of data generated from the interview conducted with the people with disabilities and those without disabilities. The analysis reflected on the themes that emerged from the data collected. Data from the interview were analysed in relation to the research questions and findings presented based on the following major themes.

a. Assess the social interactions patterns that exist between people with mild intellectual and developmental disability, the visually impaired, the hearing impaired and the physically challenged in their various communities.

b. Examine the nature of friendships that exist among people with mild Intellectual and developmental disabilities, the visually impaired, the hearing impaired, the physically challenged and their non-disabled counterparts.

c. Explore how social self-perceptions of people with mild intellectual developmental disabilities, the visually impaired, the hearing impairment and the physically challenged influence their acceptance by others without disabilities

d. Determine the social and emotional benefits people with mild intellectual and developmental disabilities, the visual impaired, the hearing impaired and the physically challenged derive from their communities living and participation.

Prior to the analysis of the presentation of results in relation to the research questions and objectives formulated to guide the study, it is apparent to take notice of the demographic data of the respondents who were interviewed. In all 12 people with disabilities and 4 non-disabled were interviewed.

Demographic Data of Respondents

Results in Table 2 illustrate the gender distribution of the respondents.

Table 2-*Gender of the Respondents*

Disability type	Male	Percentage (%)	Female	Percentage (%)
Mild intellectual and developmental disabilities	2	12.5	1	6.25
Visually impaired	2	12.5	1	6.25
Hearing Impaired	2	12.5	1	6.25
Physically Challenged	1	6.25	2	12.5
Non-disabled	3	18.75	1	6.25
Total	10	62.5	6	37.5
TOTAL				100

Source: Field Data, 2019.

The results indicate that female respondents were (37.5%) while majority of the respondents were male with (62.5%). This means that the male respondents dominated in the study.

Table 3-*Age Distribution of Respondents*

Age Range	Male	Female	Total	Percentage (%)
18 – 23	1	1	1	6.25
24 – 29	1	2	3	18.75
30 – 35	4	1	5	31.25
36 –41.	2	1	3	18.75
41 and above	3	1	4	25.00
Total	10	6	16	100

Source: Field Data, 2019.

Majority of the respondents were 30 - 35 years and could have thus used their experiences in age to share their community living and participation of with disabilities in the community.

Social Interactions Patterns Engaged in by People with Disabilities in the Community

Social Interactions Patterns

The people`s responses were categorised on the various social interactions patterns. In relation to this and in one of the interview sessions, a person who was visually impaired stated that:

> *The social interaction is very good, but it varies from person to person and how you approach. I don't know if it's because of my status in the community .but I do have good interactions with most members of this community* (Verbatim response from a person with VI - 1).

Another respondent during the interview remarked that:

> *I interact with them and go with them during certain activities, play times and during some occasions in the community* (Verbatim response from a person with PC - 1).

One respondent noted that:

> *My interactions with the nondisabled peers has been a challenge. Some misunderstood the sign language and do otherwise which may not be exactly what I really wanted to communicate to them (*Verbatim expression from a person with HI - 1).

However, their non-disabled peers seem to suggest that their interactions with people with disabilities is quite good except that of the people with intellectual disability as one non-disabled person remarked:

> *I interact with most people with disabilities like the blind, the physically challenged and the hearing impaired. However, I have difficulty interacting with those with intellectual disabilities as some of their react violently sometimes*
>
> (Verbatim response from a non- disabled person ND-4).

Another non-disabled peer described social interaction pattern with people with disabilities as very *swift* (verbatim response from a non-disabled person ND-1).

It was evident from the analysis that the social interaction patterns with the non-disabled people were fairly good. It was also evident from the people who are visually impaired and the physically challenged that some of the non-disabled people often assisted when they were in difficulties despite a few isolated cases of the unhelpful attitudes from other non-disabled peers were also noted. Being in a position to help people with disabilities when necessary can be a facilitating factor in enhancing their community living and participation of people with disabilities for strong relationships.

Another sub-theme under social interaction pattern was playing together.

Playing together

In terms of playing together, the people interviewed expressed mixed feelings. One person acknowledged that:

> *For games, I have experienced that by participating before at primary and my secondary school day. When I used to run 100 meters for my house. But for now, not. I only play games with my disabled peers during our lesser time* (Verbatim expression from VI-1).

Another respondent remarked this way:

> *For me and others we don't play with them because they won't even agree. Play what game with them? What? If we say we are playing, it is just for saying sake. Normally we feel exempted from sports and games in the community. Apart from us organizing our own disability games* (Verbatim expression from VI 2). When asked what play activity exist between you and your non-disabled counterparts? The answer was "*None"* It seems clear that there was mixed opinions regarding playing together but by large, the people with disabilities did not think that they were being successfully embraced and involved in playing activities with the nondisabled in the community. These are clear indications that people with disabilities did not participate with the nondisabled peers in interaction in terms of playing together in the community.

Working together

On working together, people with disabilities were able to mention various elements that defined the pattern of interactions as they worked together with their non-disabled peers in given tasks in the community. One person noted that:

I work with them every day. I have employed five non-disabled persons who are currently working with as you can see them working. I do the supervisions every day. You remember I told you earlier on that, even with my blindness, I rose to become a director of the department I was working till I voluntarily resigned to do my own business (Verbatim response from VI -1).

Another respondent remarked that:

> *Working together, normally we feel exempted from sports and games. But we sometimes go for meetings, and others* (Verbatim response from PC 2).

One other respondent had this to say:

> *When am called to take part in a meeting I see that am also of importance. Especially community meeting and church activities. I go there to also make some input into whatever decisions the community want to engage in. Working with the non-disabled people depends on the individual. If you are kind, capable and opened you can work with them else……* (Verbatim response from PC 2).

Another respondent noted that:

> *For me, I will say working together with people with disabilities must be hand in hand. There is the need for collaboration at*

> *every work place no matter your ability or disability* (Verbatim response from ND 1)

Also, another non-disabled respondent that:

> *I would have loved working together with the non-disabled people. However, I do not get the opportunity to do so* (Verbatim response from ND 2).

Willing to cooperate, sit together, and work together and taking part in community activities were key in explaining whether they worked together with the nondisabled and the vice versa in the community. The views expressed by some of the people with disabilities showed they were not spontaneously involved in works of the community. Working together on giving task enhance the interaction level of people and thus promote social participation. Similarly, associative interaction pattern also surfaced.

If people with varying needs are involved in a wide range of social activities such as working on difficult tasks together, it can promote more effective problem-solving and resolution of such 'conflicts', build stronger ties and enhances acceptance of all. However, the comments of the people further revealed another pattern of interaction known as social isolation.

Social isolation

During the interview, it became apparently clear that the people who were blind and physically challenged were isolated from games and other activities that their nondisabled counterparts felt they could not perform. For instance, people in the interview noted that:

> *For the games, they do not organize any game that will encourage us to participate. But they rather use foul means to*

> *drop us. We are only included in only disability games. They do not even know what activities we can take part in the community* (Verbatim response from PC 2).

Another respondent noted that:

> *It does not occurs. For the games, they do not organize any game that will encourage us to participate. But they rather use foul means to drop us. We are only included in only disability games. They do not even know what activities we can take part even about* (Verbatim response from VI 2).

Another respondent had this to say:

> *I don't feel accepted. In that the stigmatization and perceptions are too high. It demoralizes me* (Verbatim response from IDD 1)

Also, a respondent noted that:

> *People cannot associate themselves with PWDs; they do not feel fine in their presence. During social gatherings people are surprised that you are there because you are blind. They discourage you and you do not feel comfortable. You do not enjoy attendance any more. People think we cannot do anything to help them in the society and within the family* (Verbatim response from VI - 3).

It would seem that when games are organised in the community, people with disabilities were often not encouraged to participate and this was attributed to the attitudes of their non-disabled peers. What seems to emerge from the assertions is isolation of people with disabilities from interactive activities.

Playing, working together and social isolation issues were the focal domains identified from interactions. Initiating and responding to interactions, participating in conversations, and working collaboratively were key in describing the pattern of interactions existed between people with disabilities and their non-disabled counterparts.

Social Self-Perception of People with Disabilities

The interaction with the people with disabilities in the interview in the community revealed varied experiences as far as their self-perception of peer acceptance, satisfaction or non-satisfaction social self-concept, self-perception of social competence and loneliness were concerned. In describing their experience or what they went through in the community, a respondent noted that:

It's terrible sometimes. Several open gutters, some drivers doesn't respect the road signs and it usually take the sighted people sometime to help me cross the road. People with disabilities are not really considered when putting up certain structures for public use as such some of us have difficulty in moving freely in the community (Verbatim response from VI 2)

One respondent remarked this way:

> *It is very stigmatizing living in this community. Some people who hearing make fun with me because I cannot speak. The sometimes laugh at me* (Verbatim response from HI - 1)

Another respondent noted her concern this way:

> *It is very normal and I always participate in all aspects when with them because they tend to seek for my ideas about issues pertaining to my disability. I always feel satisfied and included* (Verbatim response from IDD - 2).

In the view of another person with disability, this is what is expressed:

> *I will say it is normal for me. My only challenge is the language barrier with the hearing in the community* (Verbatim response from HI - 2).

However, in the view point of a non-disabled peer, this is what is said:

> *I feel uncomfortable because they are different. It is a taboo to be like them. Person will be depending on me, needs help from me* (Verbatim response from ND - 3)

When a respondent with a physical disability was asked how she would feel about having a neighbour who also has a physical disability, she answered:

> *I do not want to have a neighbour with a physical disability. The person will be a burden to me and I will have to do things for him/her, like carrying water and all that stuffs* (ND - 4).

Respondents who have a disability themselves are often critical about other people with disabilities who do not behave well or who are begging, because it has an influence on the perception of society about all people with disabilities: It is apparent from the analysis of the viewpoints of the people with disability that, they personally experienced some level of acceptance by the non-disabled peers. The comments indicate their own experience of care and concern being exhibited by the nondisabled towards them in the community. The analysis above represent a mixed picture as far as their own perception and description of peer acceptance is concern. However, some non-disabled persons had different view to what people with disabilities expressed. Interactions with others in the in the community can provide a basis from which people with disabilities learn to view the world. Social self-perception of peer acceptance can be vital to the well-being of people with disabilities in the community. The extent to which they feel accepted and involved in various social activities go a long way to enhance their community participation.

Satisfaction in the community

When asked about satisfaction or otherwise in the community, the respondents shared their experience in varied ways:

One respondent said:

> *I feel satisfactory when I am with both the disabled and the non-disable together doing things in the interest of the community.* (Verbatim response from VI - 1).

Another stated his concern this way:

> *I feel no satisfactory because of the stigmatization in the community.* (Verbatim response from VI - 2).

Another respondent acknowledged that:

> *My satisfaction is average because I get some support from some people but not always.* (Verbatim expression from HI - 1).

It would be seen from the comments of the pupils that myriad of reasons could be associated to the feelings of satisfaction in the in community, having fun, interacting together and been able to forget of personal problems can be positive indicators of satisfaction in the community as expressed above by the respondents during the interview.

However, people with disabilities expressed diverse feelings so far as being in the community was concerned: *I feel non satisfactory because of the discrimination and the negative attitudes towards me in the community.*(Verbatim response from IDD 2).

On the centrally, the non-disabled expressed satisfaction in the community

> *I feel satisfied in the community because I have being to school, got employed, have time for recreational activities and married with children. So I am okay in the community* (Verbatim expression from ND - 2).

Though some people with disabilities expressed some sort of dissatisfaction in the community, it can be conclusively noted that the people had an interesting experience in the community as expressed during the interview. Another sub-theme was social self-concept.

Social self-concept

In expressing their self-concept in the community varied dimensions, the people with disabilities in the interviews noted, as far as their community living and participation was concern.

A respondent noted that:

> *Very frustrating. There are several stumbling blocks in the community, especially the open gutters and many others* (Verbatim response from VI – 2).

Another respondent noted that:

> *I feel appreciative of my performance especially in school, I ask questions and also pose questions for response.* (Verbatim response from HI – 1).

A respondent acknowledged that:

> *In school during classes, I ask questions and teachers praise me and tells the sighted peers. I contribute during classes and the*

> *teachers motivate me. It is the same at home too. My parents and friends always encourages me.* (Verbatim response from a HI 2).

These experiences and views of a positive performance can be a prelude to their acceptance and general social participation in the community. This would give other non-disabled peers the confidence to interact with them and get involve them in wide ranging activities in the community. Another sub-theme that described the pupils' own self-perception was performance in social activities.

Nature of Friendship that existed between people with disabilities and their peers without disabilities

To answer this theme, the interview data collected from the people who were disabled were used. People responses were grouped according to the nature of friendship that existed between people with disabilities and those without disabilities.

Nature of Friendship

Interview interaction on the nature of friendship in the community with the people with disabilities revealed that the non-disabled population were friendly to them (especially, the visually impaired, the hearing impaired and the physically challenged) and gave them assistance when and as demanded. A remark made by a person who was visually impaired attested to this:

> *Am friendly to the sighted and some are also friendly to me* (Verbatim response from VI - 1).

However, same could not be said about the mild intellectual and developmental disabilities. As a remark by one of the respondents

> *They are not friendly to me at all. I go closer to them and they drives me away*

(Verbatim response from IDD - 3)

Another respondent said that:

> *The friendship is good in the sense that, sometimes we play together. Sometimes you may get assistance and may not get but others too would ask to help you when they see you coming particularly when it comes me having difficulty in moving to certain places in the community* (Verbatim response from a person with PC1).

It was evident from the analysis of the comments from the people that, the nature of friendship network among the people in the community centred on being assisted or helped by the sighted peers.

A visually impaired commented that the nature of friendship network with the sighted was cordial though it lacked intimacy:

> *The friendship* is *very cordial even as from primary level when I was then sighted and anywhere I go. But since I became blind at times, there are some people who may not be ready for me in terms of intimacy thus sharing our secrets but when they begin to talk too much when chatting I discard such friendship. I will say it's very cordial* (Verbatim response from a person with VI 3).

One other respondent remarked this way:

> *Initially, some people think disability is contagious and would not like to come closer to you. But as time went on they came closer and got to know how we got impaired and this made people draw closer to me and assist me in all things. Some will*

> *like to come closer but others do not want to come closer* (Verbatim response from a person with HI- 2).

It seemed clear that there existed some levels of friendship with the non-disabled peers in the community as depicted by the comments from the people with disabilities. These revelations are consistent with the "contact theory" as well as the "normalization theory" which noted that as mainstream people with disabilities in the community living and participation closer to their marginalized peers, their attitudes become more positive and they develop positive relationship with each other. Apart from those with intellectual disabilities.

Again, on friendship, a person with (VI - 3) however, indicated that the friendship system in the community did not favour him because, he only had his fellow blind as a friend though, and the non-disabled/ did not hate him as such. They treated them with bias and would not spend time with them. His comments went this way:

> *The sighted do not make friends with me. They take their fellow sighted as friends just as I do with the blind. Sometimes they shout on me and I don't like that. I want to play with them but they are not ready to accept me* (Verbatim response from a VI - 3).

Another person remarked this way:

> *They are not good, some of them. They are only friends with the non-disabled more than us. They treat their fellow non- disabled peers well but shun on us* (Verbatim response from IDD 2).

The comments from the people on nature of friendship revealed that there were mixed reactions on this issue. While others had and made friends with the non-disabled peers, others did not experience that. Having been living in this community from infancy, one would have expected that the nature of friendship network would favour all people with disabilities in the community but that does not exist. That is not to say that there is total absence of friendship network with the non-disable population since some of the people reported having positive experiences with the non-disabled peers.

Mutual Friendship in the community

Data analysis on mutual friendship/relationship in the community revealed events and elements that made significant impressions on the intimacy or quality of their friendship with the non-disabled counterparts. On this, a person commented that:

> *I experience very uncordial relationship, we don't chat with each other well. I don't also talk to each other about things we like or dislike in the community because they don't want me to get closer to them* (Verbatim response from a person with VI 2).

Also, another respondent stated that:

> *With others they shy away. I am very intimate, I visit them in the homes and various places. I discuss a lot on persons with disability. I try to explain to my nondisabled peers how we behave, and what we are capable of doing. When sometimes something is bothering me, I discuss with my friends* (Verbatim response from VI 3).

The analysis of the peoples' comments indicated that the some people with disabilities sometimes disclose their feelings with the nondisabled peers, the non-disabled did not disclose their intimate feelings to them. However, some people with disabilities acknowledged that the nondisabled sometimes discloses their intimate matters with them:

> *Some are very intimate to me. They advice and encourage me most at times* (Verbatim response from a person with PC 1).

Contrary to the majority views expressed by the disabled, other people expressed views that communicated positive and mutual relationship between them and the non-disabled peers in the community. For example, a visually impaired person noted that:

> *Some take me as their brother and treat me well and assist me and this has made me happy. The nature of friendship with the sighted peers is partly mutual. People want to know how I become impaired. i disclosed to them as I said earlier on that I became total blind at the latter part of my secondary education. When I told them all these and they become very close with me. We share things in common, jokes, play and discuss our problems* (Verbatim expression from VI - 1).

Similarly, a non-disabled person also described with passion, the kind of relationship that she experienced with the disabled peers in their community:

> *Some of the disabled peers are very mutual by nature of friendship, how they come near me so as to know what brought about things around. Sometimes they do admire everything I do*

> *as I move around with them and these friends will all move and play with me* (Verbatim remark from a non-disabled person in the community ND 2).

However, another respondent had this to say:

> *When a person with disabilities approach us, we do not want them to near us. We are ashamed to be with them. Especially a "mentally" disabled behaves abnormal, the person is fearful. People think it is a curse to see a disabled person in the morning, it is a bad omen. They try to segregate and ignore you. Some people do not like to see disabled. The way they talk and behave make them feel ashamed to be with them* (verbatim response from ND 1).
>
> The analysis of the viewpoints of the people living in the community revealed three things: mutual relations, partial mutual friendship and total absence of mutual relationship in some disabilities. While some of the people with disabilities noted that they were mutually in positive relationship with the non-disabled peers, some thought otherwise and yet others described it as only partial. Partial in the sense that it was one sided friendship.

Self-perception of social competence

On performance in social activities in the community, a respondent acknowledged that:

> *I will say yes and positive when giving the nod. I become elated with what I can do with my friends in social activities.. I like making friends and keeping friends and make fun of each other.* (Verbatim response from PC – 1).

Another respondent noted that:

> *As for me I don't know what to say. It is okay. I am able to be with my friends, but because some of them make fun of us, I don't like it.* (Verbatim response from HI 3)

Also, a respondent opined that:

> *I easily approach people, I don't fear initiating conversation. I always ask for clarification of things am not clear on. I don't fear approaching people, for example, if I need help l come out from the room and stand out to wait for anyone who comes by. Am good at keeping secret in my school and a lot of teachers call me advisor.* (Verbatim expression from VI – 3).

Another respondent stated that:

> *I don't easily get angered and don't let my friends know that I am angry so I become quiet and ignore certain comments from some people in the community* (Verbatim response from PC – 2).

A respondent again remarked this way:

> *I try to assist my disabled peers in various way. I have the ability to keep secrets and to show my love and care to them.* (Verbatim response from ND – 3).

From the analysis of the perspectives of the people with disabilities and the non-disabled, it is apparent that they have reasonable levels of social competence that could enable them to build stronger ties together in the community. The views expressed in these statements suggests that the people were able to initiate conversations, ability to keep secret, control temper, and ability to assist peers. These could be major elements in describing one's perceived competencies in building interpersonal relationship both in the house, in school and at work places in the community.

Another respondent stated that:

> *We assist each other when you have problem I make sure I touch the person in order to know the problem. By getting to know the problem, I make suggestion if possible* (Verbatim expression from PC – 2).

From the views expressed by the people, it could be gleaned that they were able exhibit qualities that marked their social competence. Form these expressions, it could be seen that social competence enables people with disabilities to establish and maintain good relationships with typical peers, and this could be predictor of acceptance by the non-disability. Another sub-theme that surfaced from the analysis of the interview comments was loneliness.

Loneliness

On loneliness during the interview, an interviewee reported the following.

A respondent stated that:

> *The environmental conditions makes me feel lonely. For instance, if I want to go to any of the public places around and there is no one around to guide me, I can't…* (Verbatim response from VI – 2).

Another respondent also noted that:

> *I don't feel lonely and feel accepted by my friends and other people. I normally share things and keep secrets so as to keep my friends intact. For social activities, they include me most often* (Verbatim response from HI – 1).

Again, a respondent also stated that:

> *I sometimes feel lonely in the sense that, when there is a gathering and no one is around to push me there, it becomes a problem for me. Having the interest to go but I can't go due to my disability*. (Verbatim response from PC – 2)

Another respondent stated that:

> *Actually, some of the disabled feel lonely because they are keep indoor, and has no contact with anybody to communicate with in the house. Those who are able to come out also have less people to talk with* (Verbatim response from ND – 3).

It seems clear that there was mixed views in terms of experiences of loneliness of people with disabilities in the community. Whiles others shared experiences of loneliness especially in terms of environmental challenges and material wise, others never did.

The analysis of the interview data revealed acceptance elements on these key issues:

Preferences in interactions

On the issue of preferences, their responses revealed the following: A respondent noted that:

> *Their general attitude is okay; for me it is very well. Generally, their attitude towards me is good. I feel good with everyone* (Verbatim response VI – 1).

Another respondent stated that:

> *It is okay because no one have ever spoken harshly to me. I normally ask the sighted peers what is happening in this or that*

> *area. When they are having conversation and I involve myself in it, they don't shut me down* (Verbatim response from VI – 2).

A respondent noted that:

> *It is positive because most non-disabled assist me during any work that am undertaking. It is positive because anything with advantage has disadvantage but normally the advantage outweigh the disadvantage. It is usually good to think positively always* (Verbatim response PC – 1).

A respondent stated this:

> *Positive because of our attributes that we have as individuals. Sometimes they do come to me and ask why I isolate myself. They share ideas with me and we interact a lot. So it's both sides of the coin* (Verbatim expression from IDD – 2).

From the analysis of the people's perspectives, it is conspicuous that the other people without disabilities exhibited positive attitudes and preferences towards them in different activities in the community, and this was usually in doing things together, having similar behaviours and preferences, and liking and being liked. Others elements such as expectations of trust, disclosure, mutual respect, dealing with conflicts, being able to count on the other person, and intimacy can actually be determinants of acceptance.

Social support in the community

On the social support issues that people with disabilities receive from their non-disabled in the community, their responses revealed the following during the interview:

A respondent said this:

> *The sighted peers walk, and chat with me when we are going to eat or work or play and others also share their things with me. When having games some of the non-disabled come for me, and during some meetings and district assembly meeting as I represent people with disabilities we are being assisted.* (Verbatim response from VI – 1).

Another respondent also noted that:

> *Social interaction is also good. Social support such as helping as go for meetings, to the hostel. Assisting me in school activities- I normally go with them to do homework, discussion, and entertainment show. Sometimes they don't allow others to maltreat us* (Verbatim expression HI – 1).

A respondent acknowledged that:

> *My sighted peers also assist me in various ways when you want to buy something and fetch water. I have a sighted peer who always support me during learning. They are my sighted peers who are my classmates. They help me solve my mobility problem, fetch water for me. Some want to do everything for me which I don't like that* (Verbatim response from HI – 3).

The main issues such as sharing things, walking together, and being assisted which emerged from the comments, explained the social support they received from the non-disabled peers in the community and in the schools. These are positive signs but as to whether they were lasting supports was something that some of the people could not clearly describe.

These comments from the respondents evidently indicated the level of support they received from their non-disabled peers. Supports that are based on the knowledge of the individual can facilitate the overall acceptance of the people with disabilities in a broad range of activities in the community. It could to a large extent also determine the level of acceptance.

Benefits and challenges to people with disabilities

It is important to establish the gains that people with disabilities will drive in their community living and participation. As such, the study tried to find out from the respondents what their thoughts are in terms of what they will benefit as long as their participations are concerned. One of the sub-themes was:

Social benefits

On social benefits, a respondent had this to say:

> *I experienced a sense of belonging when other members of a community valued what they had to say and expects us to contribute to the wellbeing of the community* (Verbatim response from IDD 2).

Another responded noted that:

> *My participation will improved feelings of well-being and self-esteem. Access to resources and activities not available at home. I also* feels *the excitement of being part of a community group* (Verbatim response from HI - 1).

Again, a respondent said

> *My participation will create an opportunities to make new friends and develop new and varied relationships. This will*

> *help me to learn appropriate social behaviour* (Verbatim response from VI - 3).

Also, another respondent said:

> *People with disabilities can pay taxes if they are employed and have jobs that can provide their daily bread. People with disabilities can also share their gifts and talents with the community* (Verbatim response from PC 2)

One of the respondents said:

> *I think they can benefit from their community participation if all abled people sees their disabilities as not inability. People with disabilities will feel proud and happy and contribute their quota to the development of in the community* (Verbatim response from ND 3).

Challenges to community living and participation

People with disabilities are likely to face some challenges in the community. However, how these barriers and challenges are managed to their benefits is key. In responding to what are some of the barriers or challenges faced by people with disabilities, this was what a respondent had to say:

> *Actually, in the first place, most structures in this community are not disability friendly. How can I fully participate in this community, whereby the main managers of this community is inaccessible? Just have a look at the Metropolitan Assembly building. It supposed to be the first point of call when a person with disability needs any support. Is this building disability friendly? Are they aware of the Disability Act 715 of 2006? In*

> *fact, people with disabilities are not well treated at all in Ghana not only in this community* (Verbatim response from PC 3).

Another respondent said:

> *I wonder really, if the non-disabled do understand disabilities issues. You are planning a community for every individual in the community to benefit, and you do not make provisions for people with disabilities. What kind of lives are we supposed to live? Open gutters everywhere, very bad attitudes towards us, most people are not willing to employ people with disabilities to work and earn something for their living. All that we hear now and then is that people with disabilities will have their share of whatever. It is very frustrating to say the least* (Verbatim response from VI -2).

Also, a respondent said:

> *There are so many recreation centres around this town, check for yourself how many of them are disability friendly? Luck of employment opportunities for us and no jobs. Few of us are engaged in our own mini trading to get some food at the end of the day. Most companies are not willing to employ qualified people with disabilities, simply because of the disability of the person, which does not means inability* (Verbatim response from HI- 2)

A respondent also noted that:

> *Disabled feel that they are cheated by nature so they are angry. If you want to help them, they think you look down upon them*

> *and tell you they can do it themselves* (Verbatim response from ND - 2).

Again, a respondent stated that:

> *Whenever a decision is made, people with disabilities are not involved. Nobody values their opinion* (Verbatim response from ND - 3).

These were some of the responses given by some people with disabilities during the interviews. Listening to all their responses, I could say that the principal barrier to the participation of people with disabilities in community activities and organizations is to a large extent a problem of attitude. Common attitudinal barriers that are assumed or faced when moving to real community participation opportunities. The community do not mostly welcome people with disabilities. They are fearful of them and think they have too many "problems" or needs to "fit in." Individual barriers to full community participation. Overcoming people’s barriers to participation and inclusion includes understanding and being able to describe and promote the person's gifts and strengths. These gifts and strengths can then be matched to needs of the community. This makes the process of participation and inclusion easier.

I must indicate that, most responses by the respondents expressed similar views in most of the interview guide questions. As such there was no need repeating same views expressed already by other respondents.

Discussions

Research Question 1: What social interactions patterns exist between people with disabilities and their non-disabled peers in their communities?

It was evident from the data analysis that the social interaction patterns with the non-disabled was fairly good. Those with disabilities stated that the non-disabled peers often assisted them when they were in difficulties even though a few isolated cases of the unhelpful attitudes from other non- disabled peers were also noted. The analysis of the data revealed themes that emerged from playing and working together with the non-disabled, and social isolation. The people with disabilities expressed varied views that highlighted the patterns of interactions existing in the community. In the data analyses, initiating and responding to interactions, participating in conversations, and working collaboratively were key in describing the pattern of interactions that existed between people with disabilities and the non-disabled in the community. Very few people with disabilities reported that some non-disabled peers take them as their brothers or sisters.

They approached their non-disabled peers when they needed help, and by so doing, interacted with them. They sometimes did call on the non-disabled when the need arose. However, most people with disabilities reported that they had difficulty initiating interactions among the non-disabled peers as reported by Perrin, Bloom and Gortmaker (2007) that disability has been associated with low levels of social interaction. Also, Fonagy, Gergely and Target (2007) that people with disability have shown a significant restricted ability to initiate and direct social interactions with siblings and a tendency to engage in rigidly hierarchical relationships where they assume the role of younger child. Hall and

McGregor (2000), have reported that people with typical abilities acted as helpers, caregivers or tutors of the children with disabilities. Similarly, Bergen (1993) have expressed concern that interaction between people with disabilities and their peers without disabilities may resemble care giving relationships rather than friendships. These are elements of relationships that can facilitate full acceptance of people with disabilities in the community in the community settings as identified by the contact theory.

Further analysis of the data revealed yet another interaction pattern that could be termed as "*associative interaction with typical peer*". As noted elsewhere in the literature and data analyses, it was often the case that reasonable levels of interactions took place with the other peers. Indeed, from the comments of the people with disabilities, the interactions even involved a broad range of social activities and these were critical for promoting inclusiveness of all. For instance, the findings indicated that as with them, they played with the sighted. They shared jokes and funny stories together, as well as socialised with them. These experiences describe an interaction pattern where both people with disabilities and non-disabled interact on regular basis and in a mutual manner.

Indeed, there is growing evidence that 'conflicts' between friends are likely to be constructively resolved (Hartup et al., 1988), if people with varying needs are involved in a wide range of social activities such as working on difficult tasks together. Such social activities may promote more effective problem-solving and resolution of such 'conflicts', build stronger ties and enhances acceptance of all. This is a clear proposition of the contact theory which states that bringing people together who are in "conflict" (or where one is isolated or ignored); the conflict will subside as they get to work together in various activities.

These findings were buttressed by the non-disabled who noted that the participation of the sighted with the blind in interaction activities. Indeed, there is growing evidence that 'conflicts' between friends are likely to be constructively resolved (Hartup et al., 1988), if people with varying needs are involved in a wide range of social activities such as working on difficult tasks together. Such social activities may promote more effective problem-solving and resolution of such 'conflicts', build stronger ties and enhances acceptance of all. This is a clear proposition of the contact theory which states that bringing people together who are in "conflict" (or where one is isolated or ignored); the conflict will subside as they get to work together in various activities.

As chronicled by the contact theory and noted elsewhere in the literature, creating an environment within which young people with blindness can interact meaningfully with others is pivotal to negating the poor self-concept and potential for social isolation from their sighted peers thus enhancing acceptance and socialization.

In terms of the interaction patterns that emerged between the people during given task, the analysis of data revealed a pattern that could be described as *cooperative*. The respondents noted that some of the sighted were willing to cooperate with them during group work. Willing to cooperate, sit together, and taking part in a group discussions were key in delineating the interactions patterns that occurred with the non-disabled in tasks. Consistent with the thinking of Anderson-Butcher et al. (2008), the ability and willingness to help, share and cooperate with others enhance the social participation of people with disabilities. Their judgment of their ability to successfully establish and maintain positive social relationships, and to support and help others is key to their social participation in the community. This, however, should be appreciated by the non-disabled peers. Also, playing together in the form of involvement in group activities has been described by researchers such as Power and Hyde (2002) as major aspects of social participation. It is therefore interesting to note the presence of such in the community.

Working together enhances the interaction level of people with disabilities and thus promoted social participation. Rogers (2000) have reported that young students with special needs engage in more cooperative play with typically developing peers than with other classmates with special needs. These findings dispute that of Pijl and Scheepstra (1996) who noted in a study that people with blindness were the least likely to be involved in small group work in the community. Indeed the contact theory has its basis on experiences as key to resolving differences between "factions", and on the evidence of cooperative interactions, reported by the people, it was clear that the nature of relationships would be boosted leading to meaningful inclusiveness.

Besides, the analyses of comments from the focus group interactions revealed what could be termed as *"parallel" or solitary atypical interactions*. As noted in the data analysis, the people with disabilities reported that the interaction pattern with the non-disabled in the community was not good at all. Most of the non-disabled peers did not want to come nearer to the people with disabilities or play with them. "*For me no, the non-disabled do not want to play any game with me"*. There was an isolated case in interactions where both categories of people interacted in terms of their typicality. In consonance with these findings, Gresham and MacMillan (1997) asserted that, in terms of actual interactions in inclusive settings between people with disabilities and the non-disabled in general, people with disabilities had lower social interaction than their typical peers. These experiences could impact negatively on the social participation of people with disabilities especially in environments where they are expected to form positive relations as per the contact theory (Allport, 1954) which states that the best place to resolve differences between the disable and non-disabled is a common environment for both groups of people.

It can be deduced from the discussions that, pattern of interactions that could be described as associative interaction with typical peers, cooperative interactions, and parallel" or solitary atypical interactions were revealed from the study.

Research Question 2: What is the nature of friendship/relationship that exists among people with disabilities and their non-disabled peers?

The analysis of the data revealed elements that described the nature of friendships/relationships that existed in the community. It was evident from the analysis of the comments of the respondents that, the friendship network in the community centred on being assisted or helped by the non-disabled.

The respondents' insightful descriptions showed the nature of friendship that existed in the community. The respondents noted that their relationship is *cordial and they played together* with the non-disabled counterparts as well as *got assistance* from them. Nind, Rix, Sheehy and Simmons (2003) noted that, having friends and being part of a group for most learner, is the most significant aspect of school. Soodak (2003) also stated that friendship matter to children, their parents and their teachers, because they provide children with the opportunity to develop important skills and attitudes, and perhaps most importantly, they enhance quality of life of children and their families.

Berndt (1996) also noted that doing things together, was another feature of friendship that emerges early and remains important. Doing things together helps to maintain relationships and is a way to assess its strength and closeness (Aboud & Mendelson, 1996). Once relation has been established, the friendship tends to move deeper into a reciprocal and mutual relationship. These kinds of friendship have the potential for promoting meaningful inclusiveness as embedded in the contact theory which stated that negative perceptions towards others with disabilities change when both parties work together and become familiar with each other's potentials and challenges.

Anderson, et al. (2011) interviewed students without disabilities to find out about their experience of friendship with students with disabilities. The children described mutually beneficial friendships, through language such as 'he cares about me and I care about him' (p. 82). The proposition of the contact theory by Allport is that knowledge of people with disabilities by the non-disabled is likely to change their negative attitudes towards them and thus promote acceptance.

It should be noted however, that some of the people with disabilities viewed their friendship experiences in the community as negative. For instance, the people noted that the non-disabled did not make friends with them and were not ready to accept them instead made friends with their typical peers. The respondents also buttressed that the non-disabled did not make friends with them but treated their fellow non-disabled peers cordially while shouted at them.

This means that people without disability cooperated and related among themselves more than they did with those who with disabilities. These could be negative experiences in an environment that they are expected to build positive relationship with peers and thus acquire social skills capable of living and participating in the community and the larger society. These experiences could be encapsulated into a friendship networked described by Evans and Meyer (2001) as “guest friend” where the non-disabled perceives people with disabilities as guest and would not play with them. These findings tend to contradict the contact theory which expects both categories of people to build on experiences that would change misconceptions and wrong perceptions in order to strengthen stronger relationships. As noted in the literature review. The foregoing discussions revealed experiences that were extremely varied and included both stories of positive relationships and experiences of social isolation or loneliness in the community.

The data revealed events and elements that made significant impressions on the intimacy or quality of their friendship with the non-disabled in the community. Three indicators of intimate relationships were revealed: mutual relations, friendship and total absence of friendship or relationship in the community. While some of the people noted cordially positive relationship with the non-disabled, some thought otherwise and yet others described it as quite good. It was evident from the analyses of the data that some of the non-disabled peers took the disabled as brother/sister and treated, as well as assisted them in activities that made them happy. Some people also asserted that they shared things in common, jokes, play and discussed their problems together. Brotherly or affectionate treatment, sharing and discussing problems together with the non-disabled were very key in explaining the mutual relationships that existed in the community.

These were the key defining events that could corroborate in facilitating participation in the community. These experiences support the contact theory and the normalisation theory since it has the potentials to promote acceptance of people with disabilities in the community. Wager and Bailey (2005) described mutual relationship as someone you have a significant relation with and someone you want to spend time and share experiences with. In a study with people with disabilities and their close friends about how they negotiated their friendship and their feelings about belonging, Salmon (2012) noted that all of these young people were engaged in rich and fulfilling relationships

As noted early on in the data analyses, the people also described elements of partial, cordial and mutual relationships in the community. A respondent noted that the nature of friendship with the non-disabled peers was very cordial in the sense that some of the friends did like to disclose their secrets with him but some did not but expected him to do. The people noted that non-disabled did not disclose their secrecy to them but want them (the disabled) to do.

The analysis of the data also revealed some level of absence of mutual relationship in the community. For instance, the people asserted they did not talk to the non-disabled other about things they liked or disliked in the community. These can be negative experiences but what should be examined is the level of social competence of the people with disabilities which are discussed later in the study. Allport (1954) warned in his contact theory that superficial contact between members of different groups can, in fact, have negative consequences on the socialization of people with disabilities who are being mainstreamed in the community.

It is evident from the discussions that, there existed some levels of friendship with the non-disabled in the community and this friendship network centred on being assisted, guided or helped by the non-disabled. The analysis of the data revealed mutual relations, cordial and partial mutual friendship and total absence of mutual relationship in the community. While some of the disabled noted that they totally have no positive relationship with the non-disabled, some thought otherwise and yet others described it as very cordial.

Research Question 3: How does the social self-perceptions of people with disabilities influence their acceptance in the community?

The interaction with the people with disabilities in the interview the revealed varied experiences as far as their own self-perceptions of peer acceptance, satisfaction at the community, social self-concept, self-perception of social competence and loneliness were concerned. Responding to questions during the interview, respondents expressed their experiences on the basis of their own self-perception of peer acceptance, some of the people with disabilities noted that the non-disabled initiated interactions with them in the church, community meetings them anywhere in the community.

The findings indicated that the non-disabled counterparts discriminates and stigmatizes some categories of people with disabilities especially, those with intellectual and developmental disabilities and the visually impaired in the community. These were discouraging statements made by some respondents concerning their perceptions of acceptance by their non-disabled peers. This confirms a study done by Shigaki, Anderson, Howald, Henson and Gregg

(2012) indicated that people with disabilities are treated unfairly, harassed and discriminated at work even though there is evidence that people with disabilities are committed, and their performance is comparable to the able-bodies co-workers. Also, a study by Geisthardt and Munsch (1996) reported findings confirms to what this study revealed; people with disabilities report greater levels of loneliness, isolation and interpersonal conflict. They rely less on peers for social support when dealing with interpersonal problem than people without disabilities.

Acceptance of people with disabilities by their peers without disabilities is considered to be of primary importance to their successful integration. Acceptance should not however, be seen on the basis of sympathetic expressions.

Describing whether their presence was been felt in their community was a motion determined by the people on the basis of their physical presence. However, the physical presence of people with disabilities does not by itself ensure full participation and development, unless functional and social participation are also provided (Schmidt & Čagran, 2008). Unfortunately, a research by Mpofu (2003), reported that people with visual impairment are half as likely to report a sense of belonging, feeling safe or accepted, than are pupils without disabilities thus confirming what emerged from the data. Whether or not a people feels truly included is reliant on their participation beyond physically being included in activity, community, work or relationships.

This viewpoint is consistent with the aspect of the contact theory, which was the theoretical underpinning of this study. Allport (1954) argued that the physical presence of the people with disabilities can enhance their acceptance by the non-disabled since they will live to gain full understanding and experiences of people with disabilities in the community.

As a basis for determining their acceptance by sighted peers in the community, the findings also indicated that the sighted sought the consent of the blind on issues pertaining to their learning and their impairments. The findings indicated that some categories of people with disabilities always participated in some aspects with the non-disabled because they sought their ideas.

Furthermore, in expressing their feelings of satisfaction or otherwise in community, the people with disabilities shared their experiences in varied ways. For example, while others felt satisfaction in community, some thought otherwise. For instance, some respondents felt unsatisfied in the community. As noted elsewhere in the data analyses, a myriad of reasons could be associated to the feelings of satisfaction or non-satisfaction in the community as described by the respondents. Playing together with the non-disabled and been able to forget of personal problems can be positive indicators of satisfaction in the community as depicted. They mentioned how much they enjoyed being without adult supervision and how sometimes adults interfere too much at home. These experiences also determined the people own self-perception of acceptance in the community. These experiences represent key issues that put the contact theory on the spotlight; experiences that have the potential of promoting acceptance.

Issues on name calling and activities that were not adapted to meet the demands placed on them because of their disabilities, might have triggered this feeling of dissatisfaction. These tendencies could adversely affect the self-concept of people with disabilities in the community. These can be isolated cases of experiences that might contradict the contact theory which notes that discriminations, stigmatization and bullying among others are likely to minimise when people with disabilities and the non-disabled in the same community.

Having the ability to interact confidently can thus boost one's self-concept. Feeling valued includes being appreciated for the qualities that one brings to both individual friendships and the wider community; having one's strengths and positive qualities recognized at multiple levels; and having a constructive rather than a deficit view of one's disability applied to both individual and whole community. Indeed, there were evidences that attest to the viability of the contact theory; being appreciated having one's strengths and positive qualities recognised, and having a constructive rather than a deficit view of one's disability promote and signify acceptance of people with disabilities.

It can be summed up from the discussions that, as a measure of personal feeling of acceptance, the non-disabled initiated interactions with the disabled on meeting them anywhere in the community. The people noted that their social performances were key in expressing their own social self-perception of acceptance by virtue of their self-concept. The social competence of people with disabilities further defined and influenced their own social self-perception of acceptance in the community.

Research Question 4: What benefits will people with disabilities derive from participation in the community?

The analysis of data from the interview, revealed issues that indicated the benefits for people with disabilities in the community participation. The findings revealed that, the general attitude poor planning of structure and other social amenities in the community which hinders the full benefits to people with disabilities. The non-inclusion of people with disabilities in policies decisions also came up very strongly. People with disabilities were mostly not catered for when it comes to leisure and recreational activities in the community and they could not fully involved themselves in leisure and recreational activities with the non-disabled. People with disabilities also observed that there are several destructions across community which hinders the free movement of some people with disabilities.

However, most respondents expressed the benefits they will derive in their community living and participation. Community living and participation is good for people who are disabled as expressed by some respondents *our full participation in the community will enable us to contribute to decision making to enhance our well-being* That is, community exposure changes public attitudes for the better and this will enhance community acceptance as a long-term strategy. As stated by one respondent *we will feel inclusive in the community.* Krajewski and Flaherty (2000), ethical considerations demand that any imposed activity, such as community exposure, must be beneficial to the participants, not just to other people. Community living and participation confers some tangible benefit to the participant. It provides a justification for enforced integration with the general community. .

The fact is, when people are given free choice they evidence a preference for integrating with their own kind, not with the community in general (Katz, Lazarsfeld, & Roper, 2017). Cummins and Lau (2003), the most crucial measure of community living and participation success is how people feel about themselves and their lives. As expulsed by one respondents *I feel good and inclusive, acceptance and part of the community*. One approach to such assessment is to ask people what factors contribute most to their life quality, and the fact is, when such questions are asked, very few people regard integration with the general community as either a desirable or personally relevant form of activity. For examples: a respondent stated that *I will make more friends and share my thoughts and feelings with other members of the community and also take part in most activities in the community.*

From the perspective of the normalisation theory, normalization principles required that services be organised to maximise opportunities for the people using them to function with the greatest level of autonomy possible and to have ordinary relationships with the rest of society. The principles of normalisation is concerned with normalising the living conditions, experiences, expectations and aspirations of people at risk of being devalued, and not forcing people into an arbitrary stereotype of being normal (Njiri,1982).

In a nutshell, as to whether, people with disabilities were benefiting from their community living and participation with their non-disabled peers, elements such as getting to involve themselves in community activities and the free movements of people with disabilities, sharing ideas and things in interactions with the non-disabled, walking together, and been assisted by the non-disabled persons determined their benefits in the community.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Introduction

The purpose of the study was to examine the community living and participation of people with disabilities: A case study of the Cape Coast Metropolis.

The study specifically sought to:

a. Assess the patterns of social interactions that exist between people with mild intellectually disabled, visual impairments, hearing impaired and the physically challenged in their various communities.

b. Examine the nature of friendships that exist among people with mild intellectually disabled, visual impairments, hearing impaired, physically challenged and their non-disabled counterparts.

c. Explore how social self-perceptions of people with mild intellectually disabled, visual impairments, hearing impaired and the physically challenged influence their acceptance by others without disabilities.

d. Determine the social and emotional benefits people with mild intellectually disabled, visual impairments, hearing impaired and the physically challenged derive from their communities living and participation.

Four research questions were deduced from the objectives to guide the data collection process of the study. The contact theory propounded by Allport and the normalisation theory of Njire were used to guide the study. The case study research design was used to assess the live experience of the people with disabilities as far as their community living participation were concerned. Twelve people with disabilities were interview for the study whereas 3 people without disabilities were also interview for the study. Data from the interviews were analysed using themes that emerged from the respondents' responses

Summary of Major Findings

The major findings are summarized according to the sub-themes that emerged from the research questions:

Patterns of social interactions

The study revealed pattern of interactions that could be described as *"cordial" or "mixed"* based interactions. For instance, some people with disabilities reported that they approached their non-disabled peers when they needed help, and by so doing, interacted with them. Whereas, others claimed they found it very difficult to interact with the non-disabled due to their negative attitudes towards them.

Besides, the findings revealed what could be termed as "*parallel*" *interactions.* For instance, a respondent noted that most of the non-disabled peers did not want to come nearer to them or play with them.

Further findings from the study revealed another interaction patterns that could be termed as "*associative interaction with typical peer*". Thus, an interaction pattern where both people with disabilities and the non-disabled interact on regular basis and in a mutual manner.

Nature of Friendship/Relationship

In terms of the nature of friendships that existed in the community. The findings were that some people with disabilities played together with the non-disabled as well as got assistance such as “guidance” from them. The non-disabled sometimes helped the disabled whenever they needed it.

It should be noted however, that some of the people viewed their friendship experiences in the community as *negative and frustration*. For instance, the findings revealed that the non-disabled did not make friends with some people with disabilities and were not ready to accept them in social activities in the community.

Three indicators of intimate relationships were revealed from the study: mutual relations, partial mutual friendship and total absence of mutual relationship in the community.

Social self-perception of people with disability

The findings revealed that the sighted initiated interactions with the blind on meeting them anywhere in the school. For instance, a pupil indicated that whenever the sighted met him outside the classroom, they tried to make enquiries from him, and sometimes had fun together.

As a basis for determining their acceptance by sighted peers in the community, the findings indicated that the *sighted sought the consent of the blind on issues* pertaining to their learning and impairment. The analysis of data showed that the blind always participated in all aspects with the sighted because they sought their ideas about his academic work.

Furthermore, in expressing their feelings of satisfaction or otherwise in the community, respondent shared their experience in varied ways. While others felt satisfaction in the community, some thought otherwise. For instance, *a respondent asserted that, he felt happy when he was enstooled as the development chief of the community despite his disability*.

In expressing their social self-perception by virtue of their self-concept, the findings showed that the social performances of people with disabilities were key. The findings revealed the ability of people with disabilities to contribute in the community and have confidence in social activities as very important in defining their attributes, values and interpersonal relations.

Further findings from this study revealed that the social competence of people with disabilities, defined and influenced their social self-perception in the community. The views expressed by respondents suggested that some were able to initiate conversations, ask for clarifications, kept secrets issues about their friends, controlled their temper, and assisted peers.

Acceptance

The findings revealed statements that indicated preference for people with disabilities in activities in the community. The mild intellectual disabilities were treated harshly and derogatory words were used on them and they did not involve themselves in interactions initiated by the non-disabled. The findings also showed that the non-disabled shared ideas in interactions with the visually impaired, the physically challenged and the hearing impaired. However, same could not be said for people with intellectual and developmental disabilities.

Key issues such as sharing things, walking together, and been assisted by the non-disables which emerged from the comments of the respondents, explained the social supports people with disabilities received from the non-disabled peers in the community and, thus were variables that the respondents used to explain the extent at which they were accepted or otherwise by the non-disabled.

Benefits

On the benefits of community living and participation of people with disabilities, the findings revealed that most people with disabilities do not really know the benefits of the social, emotional and political advantages available to them in the community.

Conclusion

Community participation is a valued and important construct in the life of people with disabilities. This study concluded that the interaction patterns in the community fairly favoured certain categories of people with disabilities like the visually impaired, the physically challenged in the community living and participation of people with disabilities. Whereas, the mild intellectual and developmental disabilities had poor interactions with the non-disabled. People with visual impairment played the role of receiver of an interaction exchange. It was either being a helper in a way of a guide, cooperative or associative patterns of interaction.

Also, nature of friendships in the community were partially one-sided. As stated earlier on, the non-disabled peers helped the visually impaired and the physically challenged whenever some of them were in need of help. But same could not be said for the hearing impaired and the mild intellectual and developmental dishabilles. While some of the sighted were mutually friendly to the visually impaired some were not, and yet others described their friendships as only partial. Again, the social self-perceptions of people with disabilities in the community were quite favourable to the visually impaired and the physically challenged.

Recommendations

Based on the findings, the following recommendations are made:

1. There should be more advocacy by the Department of Social Welfare in the communities that encourage frequent meaningful peer interactions with all people with disabilities and the non-disabled peers.
2. The National Commission for Civic Education should up their edudducation on disabilities issues in the communities to enable the non-disabled get insight knowledge to be able spport and assist all categories of people with disabilities to develop the capacity to make and maintain stable and satisfying friendships with the others.
3. GFD should organise regular capacity building for their members and aso put prressure on duty bearers to put the necessary structures in place or their wellbeing
4. Reguar counselling by GFD during their associations meeting to build their self perceptions and also through active participations in community activities whenever possible.

Suggestions for Further Research

Several limitations must be considered for this study. One issue is related to generalization of the findings. Results of this study might not be generalizable to all people with any other type or severe of disability condition. Participants included only four categories of people with disabilities and few non-disabled people within the study community. Additional research is necessary to establish the participation of people with disabilities to find out if similar findings could established for all other types of disabilities in Ghana.

REFERENCES

Abberley, P. (1987). The concept of oppression and the development of a social theory of disability. *Disability, Handicap & Society, 2*(1), 5-19.

Abbott, S., & McConkey, R. (2006). The barriers to social inclusion as perceived by people with intellectual disabilities. *Journal of intellectual disabilities*, *10*(3), 275-287.

Aboud, F., & Mendelson, M. (1996). Determinants of friendship selection and quality: Developmental perspectives. In W. Bukowski, A. Newcomb, & W. Hartup (Eds.). *The company they keep: Friendships in childhood and adolescence.* Cambridge studies in social and emotional development (pp. 87– 113). Cambridge, UK: Cambridge Univ. Press.

Abramsky, T., Devries, K., Kiss, L., Nakuti, J., Kyegombe, N., Starmann, E., & Michau, L. (2014). Findings from the SASA! Study: A cluster randomized controlled trial to assess the impact of a community mobilization intervention to prevent violence against women and reduce HIV risk in Kampala, Uganda. *BMC medicine*, *12*(1), 122-127.

Abroms, K. I., & Kodera, T. L. (1979). Acceptance hierarchy of handicaps: Validation of Kirk's statement, “special education often begins where medicine stops. *Journal of Learning Disabilities*, *12*(1), 15-20.

Adamson, D. (2010). Community empowerment: Identifying the barriers to “purposeful” citizen participation. *International Journal of Sociology and Social Policy*, *30*(3/4), 114-126.

Albrecht, G. L., Seelman, K. D. D., & Bury, M. (2001). *Handbook of disability studies.* Thousand Oaks, CA Sage Publications.

Almqvist, L., & Granlund, M. (2005). Participation in school environment of children and youth with disabilities: A person-oriented approach. *Scandinavian Journal of Psychology, 46*, 305–314.

Argyle, M. (2001). Social relationships. In M. Hewstone, W. Stroebe, J. P. Codol, & G. M. Stepheson (Eds.). *Introduction to social psychology*. Oxford; UK: Blackwell.

Allport, G. W. (1954). *The nature of prejudice*. Oxford; UK: Addison-Wesley.

Allport, G. W. (1979). *The nature of prejudice*. Reading, MA: Addison-Wesley Publishing Co.

Amado, A. N. (2013). Social inclusion and community participation of individuals with intellectual/developmental disabilities. *Intellectual and Developmental Disabilities*, *51*(5), 360-375.

Anaby, D., Miller, W. C., Eng, J. J., Jarus, T., Noreau, L., & PACC Research Group. (2009). Can personal and environmental factors explain participation of older adults? *Disability and Rehabilitation*, *31*(15), 1275-1282.

Anderson, K., Balandin, S., & Clendon, S. (2011). He cares about me and I care about him: Children's experiences of friendship with peers who use AAC. *Augmentative and Alternative Communication, 27*(2), 77–90.

Anderson, A. (2011). Hospitable classrooms: Biblical hospitality and inclusive education. *Journal of Education and Christian Belief*, *15*(1), 13-27.

Anderson, A., Moore, D. W., Godfrey, R., & Fletcher-Flinn, C. M. (2004). Social skills assessment of children with autism in free-play situations. *Autism*, *8*(4), 369-385.

Asher, S., Parker, J., & Walker, D. (1996). Distinguishing friendship from acceptance: Implications for intervention and assessment. In W. Bukowski, A. Newcomb, & W. Hartup (Eds.), *The company they keep: Friendships in childhood and adolescence. Cambridge studies in social and emotional development* (pp. 336– 405). Cambridge, UK: Cambridge Univ. Press.

Avoke M. K., & Avoke S. K. (2004). *Inclusion, rehabilitation and transition services in special education.* Department of Special Education, University of Education, Winneba, Ghana.

Avoke, M. (2005). *Special educational needs in Ghana: Policy, practice and research*. Winneba, Ghana: Special Educational Books.

Awini, A. (2015). *Social participation of pupils with visual impairment in school activities in selected regular basic schools in Ghana*. Unpublished doctoral thesis). University of Education, Winneba, Ghana.

Babbie, E., & Mouton, J. (2006). *The practice of social research*. Cape Town:, South Africa: Oxford Press.

Babchuck, N., & Booth, A. (1969). Voluntary association membership: A longitudinal study. *American Sociological Review*, *34*, 31-45.

Badley, E. M. (2008). Enhancing the conceptual clarity of the activity and participation components of the international classification of functioning, disability, and health. *Social Science & Medicine*, 66(11), 2335-2345.

Bagwell, C. L., Bender, S. E., Andreassi, C. L., Bigby, C., & Fyffe, C. (2006). Tensions between institutional closure and deinstitutionalisation: What can be learned from Victoria's institutional redevelopment? *Disability & Society*, *21*(6), 567-581.

Bauminger, N., Solomon, M., & Rogers, S. J. (2010). Predicting friendship quality in autism spectrum disorders and typical development. *Journal of Autism and Developmental Disorders, 40*, 751-761.

Bauminger, N., Solomon, M., Aviezer, A., Heung, K., Brown, J., Gazit, H., & Rogers, S. J. (2008). Friendship in high-functioning children with Autism Spectrum Disorder: Mixed and non-mixed dyads. *Journal of Autism and Developmental Disorders, 38*, 1211-1229.

Beadle- Brown, J., Hutchinson, A., & Whelton, B. (2012). Person centred active support increasing choice, promoting independence and reducing challenging behaviour. *Journal of Applied Research in Intellectual Disabilities*, 25(4), 291-307.

Berndt, T. J. (1996). Exploring the effects of friendship quality on social development. In W. Bukowski, A. Newcomb, & W. Hartup (Eds.). *The company they keep: Friendships in childhood and adolescence*; *Cambridge studies in social and emotional development* (pp. 346–365). Cambridge, UK: Cambridge Univ. Press.

Berndt, T. J. (2002). Friendship quality and social development. *Current Directions in Psychological Science, 11*, 7-10

Berndt, T. J. (2004). Children's friendships: Shifts over a half century in perspectives on their development and effects. *Merrill Palmer Quarterly*, *50*(3), 206-223.

Berndt, T., J., & Perry, T. B. (1986). Children’s perceptions of friendships as supportive relationships. *Developmental Psychology, 22,* 640–648.

Bolton, G. (2010). *Reflective practice: Writing and professional development*. New York; NY Sage publications.

Bouffioulx, E. Arnould, C., & Thonnard, J. L. (2011). Satisfaction with activity and participation and its relationships with body functions, activities, or environmental factors in stroke patients. *Archives of physical medicine and rehabilitation*, *92*(9), 1404-1410.

Bovaird, T. (2007). Beyond engagement and participation: User and community coproduction of public services. *Public administration review*, *67*(5), 846-860.

Bowling, A. (2014). *Research methods in health: investigating health and health services*. UK; Philadelphia: McGraw-Hill Education.

Braddock, D. L., & Parish, S. L. (2001). *History of disability*. London; UK: Sage

Braun, V., & Clark, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*, 77-101.

Braun, R., Catalani, C., Wimbush, J., & Israelski, D. (2013*). Community health workers and mobile technology: A Systematic Review of the Literature*. *PloS one*, *8*(6), 65-77.

Breakwell, G. M, Hammond, S, Fife-Schaw, C., & Smith, J. A. (2006*). Research methods in psychology* (3rd ed). London, UK: Sage Publication.

Bronfenbrenner, U. (1999). Environments in developmental perspective: Theoretical and operational models. In S. L. Friedman & T. Wachs (Eds.). *Measuring environments across the lifespan: Emerging methods and concepts* (pp.3–28). Washington DC: American Psychological Association.

Bukowski, W. M., Hoza, B., & Boivin, M. (1994). Measuring friendship quality during pre and early adolescence: The development and psychometric properties of the friendship qualities scale. *Journal of Social and Personal Relationships, 11*, 471-484.

Bukowski, W. M., Newcomb A. F., & Hartup W. W. (Eds.) (1996). *The company they keep: Friendship in childhood and adolescence.* Cambridge, UK: Cambridge Univ. Press.

Bukowski, W. M., Newcomb, A. F., & Hartup, W. W. (Eds.). (1996a). *The company they keep: Friendship in childhood and adolescence.* Cambridge, UK: Cambridge Univ. Press.

Bukowski, W. M., Newcomb, A. F., & Hartup, W. W. (1996b). Friendship and its significance in childhood and adolescence: Introduction and comment. In W. M. Bukowski, A. F. Newcomb, & W.W. Hartup (Eds.). *The Company they keep: Friendship in childhood and adolescence* (pp. 1–15). New York, NY: Cambridge University Press.

Burke, J., & Larry, C. (2000). *Educational research: quantitative and qualitative approaches.* Boston; MA: Pearson Educational Company.

Cairns, R., Xie, H., & Leung, M. (1998). The popularity of friendship and the neglect of social networks: Toward a new balance. In W. M. Bukowski, & A. H. Cillessen (Eds.), *Sociometry then and now: Building on six decades of measuring children's experiences with the peer group: No. 80. New directions for child development* (pp. 5 –24). San Francisco; CA: Jossey-Bass.

Cairns, R. B., Leung, M., Buchanan, L., & Cairns, B. D. (1995). *Child Development, 66,* 1330–1345.

Camilleri, J. (1999). Disability, Inclusion & Human Rights. Malta: KNDP. 322

Chamberlain, B., Kasari, C., & Rotherham-Fuller, E. (2007). Involvement or isolation? The social networks of children with autism in regular classrooms. *Journal of Autism and Developmental Disorders, 37*, 230-242.

Chase, B. W., Cornille, T.A., & English, R.W. (2000). Cord injuries. *The Journal of Rehabilitation,* 66, 14-22.

Chasiotis, A. (2011). An epigenetic view on culture: What evolutionary developmental psychology has to offer for cross-cultural psychology? *Fundamental questions in cross-cultural psychology*, (pp. 376-404).

Cheshire, P., & Sheppard, S. (2004). Capitalising the value of free schools: The impact of supply characteristics and uncertainty. *The Economic Journal, 114*(499), F397-F424.

Clement, T., & Bigby, C. (2010). *Group homes for people with intellectual disabilities: Encouraging inclusion and participation*. London; Jessica Kingsley Publishers.

Clement, T., Johnson, K., & Bigby, C. (2007). *Making life good in the community*. *The story so far*. London; Jessica Kingsley Publishers.

Cohen, A. P. (2013). *Symbolic construction of community*. New York; UK: Routledge.

Cohen, L., Manion, L., & Morrison, K. (2000*). Research methods in education* (5th ed). London; UK: Routledge Falmer.

Cohen, L. Manion, L., & Morrison, K. (2004). *Research methods in education*. (6th ed.) New York: NY: Routledge.

Cohen. L., Manion, E., & Morrison, K. (2003). *Research method in education*(5th ed.). New York; UK: Routledge Falmer – Taylor Group

Cohen, L., Manion, L., & Morrison, K. (2007). *Research methods in education* (6th ed.). London; UK: Routhledge.

Coplan, R. J., Findlay, L. C., & Nelson, L. J. (2004). Characteristics of preschoolers with lower perceived competence. *Journal of Abnormal Child Psychology, 32*(4), 399–408.

Costanza, R., Fisher, B., Ali, S., Beer, C., Bond, L., Boumans, R. & Gayer, D. E. (2007). Quality of life: An approach integrating opportunities, human needs, and subjective well-being. *Ecological Economics*, *61*(2-3), 267-276.

Creswell, J. W. (2005). *Educational research: Planning, conducting and evaluating quantitative and qualitative research* (2nded). New Jersey;NJ: Merrill Prentice Hall.

Creswell, J. W. (2007). *Qualitative inquiry and research design: Choosing among five approaches.* London; UK: Sages Publications.

Cuckle, P., & Wilson, J. (2002). Social relationships and friendships among young people with Down's syndrome in secondary schools. *British Journal of Special Education, 29*, 66-71.

Cummins, R. A., & Lau, A. L. (2003). Community integration or community exposure? A review and discussion in relation to people with an intellectual disability. *Journal of Applied Research in Intellectual Disabilities*, *16*(2), 145-157.

Darlene, A. G. (2007). Examining the structure of the revised acceptance disability scale. *Journal of Rehabilitation*, *73*(3), 3-9.

Deem, R. (2002). Talking to manage-academics: Methodological dilemmas and feminist research strategies. *Journal of the British Sociological Association, Sociology*, *36*, 835-855.

De Vet, E., Waitt, G., & Gorman-Murray, A. (2012). How dare you say that about my friend: Negotiating disability and identity within Australian high schools? *Australian Geographer*, *43*(4), 377–391.

De Winter, M., Baerveldt, C., & Kooistra, J. (2002). Enabling children: participation as a new perspective on child health promotion. *Child: Care, Health and Development*, *25*(1), 15-23.

Denzin, N., & Lincoln, Y. (2005). *Handbook of qualitative research* (3rded). Thousand Oaks, C A: Sage.

Denzin, N. K., & Lincoln, Y. S. (2000) *Handbook of qualitative* research. (2nd ed).Thousand Oaks, CA: Sage Publications Inc.

Department of Education and Skills (2001) *Special educational needs code of practice*. London; UK: DfES.

Dias, R. C., Freire, M. T., Santos, É. G., Vieira, R. A., Dias, J., & Perracini, M. R. (2011). Characteristics associated with activity restriction induced by fear of falling in community-dwelling elderly. *Brazilian Journal of Physical Therapy*, *15*(5), 406-413.

Dijkers, M. P. (2010). Issues in the conceptualization and measurement of participation: An overview. *Archives of Physical Medicine and Rehabilitation*, *91*(9), S5-S16.

Downing, J. E., & Peckham-Hardin, K. D. (2007). Inclusive education: What makes it a good education for students with moderate to severe disabilities? *Research and Practice for Persons with Severe Disabilities*, *32*(1), 16-30.

Dumay C. J (2013). *Qualitative research interview*. London: Sage.

Dunn, J. (2004). *Children's friendships: The beginnings of intimacy*. Oxford; UK: Blackwell.

Dusek, J., Quintero, N. Reed, F. D. D. & McIntyre, L. L. (2011). Preliminary assessment of friendship, problem behavior, and social adjustment in children with disabilities in an inclusive education setting. *Journal of Developmental and Physical Disabilities*, *23*(6), 477-489.

Eime, R. M., Young, J. A., Harvey, J. T., Charity, M. J., & Payne, W. R. (2013). A systematic review of the psychological and social benefits of participation in sport for children and adolescents: Informing development of a conceptual model of health through sport. *International Journal of Behavioral Nutrition and Physical Activity*, *10*(1), 98-109.

Emerson, E., & Hatton, C. (2014). The self-rated health of British adults with intellectual disability. *Research in Developmental Disabilities*, *35*(3), 591-596.

Eyssen, I. C., Steultjens, M. P., Dekker, J., & Terwee, C. B. (2011). A systematic review of instruments assessing participation: challenges in defining participation. *Archives of Physical Medicine and Rehabilitation, 92*(6), 983-997.

Fincham, F. D. (2003). Attributions in close relationships: From balkanization to integration. In G. J. O. Fletcher, & M. S. Clark (Eds.). *Handbook of social psychology: Interpersonal processes* (pp. 3-31). Oxford; UK: Blackwell.

Fitness, J., Fletcher, G. J. O., & Overall, N. (2005). Interpersonal attraction and intimate relationships. In M. A. Hogg, & J. Cooper (Eds.), *Handbook of social psychology* (pp. 258-278). London: Sage.

Francis, E. A. (1996). Self-concepts of children with visual impairments. *Review*, *28*, 35-43.

Frankel, J. R., & Wallen, N. E. (2003). *How to design and evaluate research in education* (2nd ed). New York; NY: McGraw Hill Inc

Freeman, S. F. N., & Kasari, C. (1998). Friendships in children with developmental disabilities. *Early Education and Development*, *9*, 341-355.

Freeman, S. F. N., & Kasari, C. (2002). Characteristics and qualities of the play dates of children with Down syndrome: Emerging or true friendships? *American Journal on Mental Retardation*, *107*, 16-31.

Fonagy, P., Gergely, G., & Target, M. (2007). The parent–infant dyad and the construction of the subjective self. *Journal of Child Psychology and Psychiatry*, *48*(3 - 4), 288-328.

Fryxell, D., & Kennedy, C. (1995). Placement along the continuum of services and its impact on students' social relationships. *Journal of the Association for Persons with Severe Handicaps, 20*, 259-269.

Gadagbui, G. Y (2004). *Education in Ghana and special needs children*. Accra-North, Ghana: City Publishers.

Gauze, C., Bukowski, W. M., Aquan Assee, J., & Sippola, L. K. (1996). Interactions between family environment and friendship and associations with self-perceived well-being during adolescence. *Child Development, 67*, 2201– 2216.

Gauthier, D. (1988). Hobbes's social contract. *Noûs, 22*, 71-82.

Gay, L. R., Mills, G. E., & Airasian, P. (2009). *Educational research: Competencies for analysis and applications*. Upper Saddle River, NJ: Person Education.

Geenen, S., & Powers, L. E. (2007). Tomorrow is another problem: The experiences of youth in foster care during their transition into adulthood. *Children and Youth Services Review, 29* (8), 1085-1101.

Gest, S. D., Graham-Bermann, S. A., & Hartup, W. W. (2001). Peer experience: Common and unique features of number of friendships, social network centrality, and sociometric status. *Social Development, 10,* 23– 40.

Gerhardt, P. F., & Lainer, I. (2011). Addressing the needs of adolescents and adults with autism: A crisis on the horizon. *Journal of Contemporary Psychotherapy*, *41*(1), 37-45.

Ghana Statistical Service (2012). 2010 population and housing census. Summary report of final results. Accra; Ghana: Sakoa Press Ltd.

Ghana Federation of the Disabled. (2016). *About GFD*. Retrieved from http://www.gfdgh.org/about%20us.html

Giddens, A. (2013). *The third way: The renewal of social democracy*. HobokEn; NJ John Wiley & Sons INC.

Gilmore, L., & Cuskelly, M. (2014). Vulnerability to loneliness in people with intellectual disability: An explanatory model. *Journal of Policy and Practice in Intellectual Disabilities, 11*(3), 192-199.

Gitlin, William, M., Machiko T., Marcus, L. (2001). Factors associated with home environmental problems among community-living older people. *Disability and rehabilitation, 23*(17), 777-787.

Glaser, B. G., & Strauss, A. L. (2017). *Discovery of grounded theory: Strategies for qualitative research*. UK; Oxford: Routledge.

Gottman, J. M. (1983). How children become friends. *Monographs of the Society for Research in Child Development, 48*(201), 86.

Grosvenor, I., & Ross, R. (2001). *Doing research in special education: Ideas into practice*. London: David Fulton.

Guernsey, K., Nicoli, M., & Ninio, A. (2007). *Convention on the rights of persons with disabilities: Its implementation and relevance for the World Bank*. Geneva; Swezerland: World Bank Social Protection.

Gulliver, A., Griffiths, K. M., & Christensen, H. (2010). Perceived barriers and facilitators to mental health help-seeking in young people: a systematic review. *BMC Psychiatry, 10*(1), 113.

Haak, M., Ivanoff, S., Fänge, A., & Iwarsson, S. (2007). The multiple meaning of home as experienced by very old Swedish people. *Scandinavian Journal of Occupational Therapy*, *14*(1), 25-32.

Hall, L. J., & McGregor, J. A. (2000). A follow-up study of the peer relationships of children with disabilities in an inclusive school. *The Journal of Special Education*, *34*(3), 114-126.

Harasymiw, S. J., Horne, M. D., & Lewis, S. C. (1976). A longitudinal study of disability group acceptance. *Rehabilitation Literature*. *37*(4), 98–102

Harry, B., Park, H.-S., & Day, M. (1998). Friendships of many kinds: Valuing the choices of children and youth with disabilities. In L. H. Meyer, H.S. Park, M. Grenot-Scheyer, I. S. Schwartz & B. Harry (Eds.). *Making friends: The influences of culture and development* (pp. 393-402). Baltimore; MD: Paul H. Brookes.

Hammel, J., Magasi, S., Heinemann, A., Whiteneck, G., Bogner, J., & Rodriguez, E. (2008). What does participation mean? An insider perspective from people with disabilities. *Disability and Rehabilitation*, *30*(19), 1445-1460.

Hart, R. A. (2013). *Children's participation: The theory and practice of involving young citizens in community development and environmental care*. Milton Park, Abingdon, Oxford shire Routledge.

Hartup, W. W., & Stevens, N. (1997). Friendships and adaptation in the life course. *Psychological Bulletin, 121*, 355–370.

Hartup, W. (1996). Cooperation, close relationships, and cognitive development. In W. Bukowski, A. Newcomb, & W. Hartup (Eds.), *The company they keep: Friendships in childhood and adolescence* (pp. 213– 236). Cambridge, UK: Cambridge Univ. Press.

Hayford, S. K. (2007). *Special educational needs and quality education for all*. University of Education, Winneba, Ghana: Special Education Department.

Havlicek, J., McMillen, J. C., Fedoravicius, N., McNelly, D., & Robinson, D. (2012). Conceptualizing the step-down for foster youth approaching adulthood: Perceptions of service providers, caseworkers, and foster parents. *Children and Youth Services Review, 34*(12), 2327-2336.

Heller, M. A., & Eisenberg, R. S. (1998). Can patents deter innovation? The anti-commons in biomedical research. *Science, 280*(5364), 698-701.

Heller, T., Miller, A. B., & Factor, A. (1999). Autonomy in residential facilities and community functioning of adults with mental retardation. *Mental Retardation, 37*(6), 449-457.

Henricsson, L., & Rydell, A-M. (2006). Children with behaviour problems: The influence of social competence and social relations on problem stability, school achievement and peer acceptance across the first six years of school. *Infant and Child Development, 15,* 347–366.

Hewstone, M., & Antaki, M. (2001). Attribution theory and social explanations. In M. Hewstone, W. Stroebe, J. P. Codol, & G. M. Stepheson (Eds.). *Introduction to social psychology* (p.111-141). Oxford: Basil Blackwell.

Hirsch, F. (2005). *Social limits to growth*. New York; NY: Routledge.

Hodges, E. V. E., Malone, M. J., & Perry, D. G. (1997). Individual risk and social risk as interacting determinants of victimization in the peer group. *Developmental Psychology*, 33(6) 1032– 1039.

Hodges, E., Boivin, M., Vitaro, F., & Bukowski, W. M. (1999). The power of friendship: Protection against an escalating cycle of peer victimization. *Developmental Psychology*, *35*(6) 94– 101.

Hooyman, N. R., & Kiyak, H. A. (2008). *Social gerontology: A multidisciplinary perspective*.New York; NY: Pearson Education.

Hosain, G. M., Atkinson, D., & Underwood, P. (2002). Impact of disability on quality of life of rural disabled people in Bangladesh. *Journal of Health, Population and Nutrition*, 20(297-305).

Howes, C. (1988). Peer interaction of young children. *Monographs of the Society for Research in Child Development*, *53*(1), 217-130.

Hooyman, N. R., & Kiyak, H. A. (2008). *Social gerontology: A multidisciplinary perspective*. New York: Pearson Education.

Hubbard, A. J., & Coie, D. (2006). Emotional correlates of social competence in children's peer relationships. Duke University, Retrieved from *www.udel.edu/psych/fingerle*, 1-19.

Hunt, P., Staub, D., Alwell, M., & Goetz, L. (1994). Achievement by all students with the context of cooperative learning groups. *Journal of the Association for Persons with Severe Handicaps*, *19*, 290–301.

Ichida, Y., Hirai, H., Kondo, K., Kawachi, I., Takeda, T., & Endo, H. (2013). Does social participation improve self-rated health in the older population? A quasi-experimental intervention study. *Social Science & Medicine*, *94*, 83-90.

Iyengar, S., & Kinder, D. R. (2010). *News that matters: Television and American opinion*. Chicago; University of Chicago Press.

Jahoda, A., Wilson, A., Stalker, K., & Cairney, A. (2010). Living with stigma and the self-perceptions of people with mild intellectual disabilities. *Journal of Social Issues*, *66*(3), 521-534.

Jellesmark, A., Herling, S. F., Egerod, I., & Beyer, N. (2012). Fear of falling and changed functional ability following hip fracture among community-dwelling elderly people: an explanatory sequential mixed method study. *Disability and Rehabilitation*, *34*(25), 2124- 2131.

Johnson, B., & Christiansen, B. (2012). *Educational Research: Quantitative, qualitative & mixed approaches.* Los Angeles; CA :Sage Publications.

Kahneman, D., & Krueger, A. B. (2006). Developments in the measurement of subjective well-being. *Journal of Economic perspectives*, *20*(1), 3-24.

Kahu, E. R. (2013). Framing student engagement in higher education. *Studies in Higher Education*, *38*(5), 758-773.

Kamstra, J. H., Aleström, P., Kooter, J. M., & Legler, J. (2015). Zebrafish as a model to study the role of DNA methylation in environmental toxicology. *Environmental Science and Pollution Research*, *22*(21), 16262-16276.

Kara, H. (2015). *Creative research methods in the social sciences: A practical guide*. London; UK: Policy Press

Katz, E., Lazarsfeld, P. F., & Roper, E. (2017). *Personal influence: The part played by people in the flow of mass communications*. London; UK: Routledge.

Kaur, G., Leong, T. P., Yusof, J. M., & Singh, D. (2015). Perception of people with disability in creating sustainable public policy. *Procedia-Social and Behavioural Sciences*, *168*, 145- 155.

Keller, M. (2004). A cross-cultural perspective on friendship research. *International Society for the Study of Behavioural Development Newsletter*. *46*(2), 10–14.

Kim, K., Park, Y. H., Lee, B. S., & Kim, J. Y. (2010). Comparison of the attitude towards and contact with disabled person among healthcare professionals, lay persons, and disabled persons. *The Korean Journal of Rehabilitation Nursing, 13(*1), 13-22.

Kimmel, A. J. (1996). *Ethical issues in behavioural research*. Cambridge; UK: Blackwell.

Kimberlin, C. L., & Winterstein, A. G. (2008). Validity and reliability of measurement instruments used in research. *American Journal of Health-System Pharmacy*, *65*(23), 2276-2284

King, G., Chaters, T., Miller P. J., MacKinnon, E., & Havens, L. (2000). Success in life of older adolescents with cerebral palsy. *Quantitative Health Research*, *10*, 734-739.

King, G., Law, M., King, S., Rosenbaum, P., Kertoy, M. K., & Young, N. L. (2003). A conceptual model of the factors affecting the recreation and leisure participation of children with disabilities. *Physical & Occupational Therapy in Paediatrics*, *23*(1), 63-90.

King, G., Law, M., King, S., Hurley, P., Hanna, S., Kertoy, M. (2006). Measuring children's participation in recreation and leisure activities: Construct validation of the CAPE and PAC. *Child: Care, Health and Development, 33*(1), 28-39.

Kinderman, T. A. (1993). Natural peer groups as contexts for individual development: The case of children's motivation in school. *Developmental Psychology, 29*, 970– 977.

Kinoshita, T. L., Montarello, S. A., & Muller, J. G. (2005). Friendship quality and perceived relationship changes predict psychosocial adjustment in early adulthood. *Journal of Social and Personal Relationships*, *22*(2), 235- 254.

Kuo, M. H., Orsmond, G. I., Cohn, E. S., & Coster, W. J. (2011). Friendship characteristics and activity patterns of adolescents with an autism spectrum disorder. *Autism*, 17(4): 481-500.

Kozma, A., Mansell, J., & Beadle-Brown, J. (2009). Outcomes in different residential settings for people with intellectual disability: A systematic review. *American Journal on Intellectual and Developmental isabilities*, *114*(3), 193-222.

Krajewski, J., & Flaherty, T. (2000). Attitudes of high school students toward individuals with mental retardation. *Mental Retardation*, *38*(2), 154-162.

Kreijns, K., Kirschner, P. A., & Jochems, W. (2003). Identifying thepitfalls for social interaction in computer-supported collaborative learning environments: A review of the research. *Computers in Human Behaviour*, *19*(3), 335-353.

Ladd, G. W., & Kochenderfer, B. J. (1996). Linkages between friendship and adjustment during early school transitions. In W. M. Bukowski, A. F. Newcomb, & W. W. Hartup (Eds.), *The company they keep: Friendship in childhood and adolescence* (pp. 322–345). Cambridge, UK: Cambridge Univ. Press.

Ladd, G. W., Kochenderfer, B. J., & Coleman, C. C. (1996). Friendship quality as a predictor of young children's early school adjustment. *Child Development, 67,* 1103– 1118.

Ladd, G., & Kochenderfer-Ladd, B. (2002). Identifying victims of peer aggression from early to middle childhood: Analysis of cross-informant data for concordance, estimation of relational adjustment, prevalence of victimization, and characteristics of identified victims. *Psychological Assessment, 14,* 74–96.

Leary, M. R. (2000). Affect, cognition and the social emotions. In J. P. Forgas (Ed.), *Feeling and thinking: The role of affect in social cognition* (pp. 331-356). Cambridge: University Press.

Lee, S. H., Yoo, S. Y., & Bak, S. H. (2003). Characteristics of friendships between children with and without mild disabilities. *Education and Training in Mental Retardation and Developmental Disabilities, 38,* 157-166.

Lehohla, M. & Hlalele, D. (2012). Inclusive classrooms: An eco systemic Perspective. *Journal of Human Ecology, 37*(3); 189-201.

Levitas, R. (2005). *The inclusive society? Social exclusion and new labour*. Springer.

Lightfoot J., & Sloper P (2002b) *Research works: Involving young people in health service development*. Social Policy Research Unit. The University of York.

Lindsey, E. W. (2002). Preschool children's friendships and peer acceptance: Links to social competence. *Child Study Journal*, 32(3), 145–156.

Lindsay, A. C., Sussner, K. M., Greaney, M. L., & Peterson, K. E. (2009). Influence of social context on eating, physical activity, and sedentary behaviors of Latina mothers and their preschool-age children. *Health Education & Behavior*, *36*(1), 81-96.

Lipsitz, G. (2006). *The possessive investment in whiteness: How white people profit from identity politics*. Temple University: Temple University Press.

Lifshitz, H., Hen, I., & Weisse, I. (2007). Self-concept, adjustment to Blindness, and quality of friendship among adolescents with visual impairments. *Journal of Visual Impairment & Blindness, 101*(2), 2-20.

Lopez-Justicia, M. D., Pichardo, M. C., Amezcua, J. A., & Fernandez, E. (2001). The self-concepts of Spanish children and adolescents with low vision and their sighted peers. *Journal of Visual Impairment & Blindness, 95*, 150-160.

Locher, J. L., Ritchie, C. S., Robinson, C. O., Roth, D. L., Smith West, D., & Burgio, K. L. (2008). A multidimensional approach to understanding under-eating in homebound older adults: The importance of social factors. *The Gerontologist*, *48*(2), 223-234.

Locke, J., Ishijima, E. H., Kasari, C., & London, N. (2010). Loneliness, friendship quality and the social networks of adolescents with high functioning autism in an inclusive school setting. *Journal of Research in Special Education Needs, 10*, 74-81.

Lysaght, R., Ouellette-Kuntz, H., & Morrison, C. (2009). Meaning and value of productivity to adults with intellectual disabilities. *Intellectual and Developmental Disabilities, 47*(6), 413-424.

Magasi, S., & Post, M. W. (2010). A comparative review of contemporary participation measures' psychometric properties and content coverage. *Archives of physical medicine and rehabilitation, 91*(9), S17-S28.

Magasi, S., Hammel, J., Heinemann, A., Whiteneck, G., Bogner, J., & Rodriguez, E. (2008). What does participation mean? An insider perspective from people with disabilities. *Disability and rehabilitation, 30*(19), 1445-1460.

Mansell, J., & Beadle-Brown, J. (2010). Deinstitutionalisation and community living: Position statement of the comparative policy and practice special interest research group of the international association for the scientific study of intellectual disabilities, *Journal of Intellectual Disability Research, 54*(2), 104-112.

Mansell, J., & Ericsson, K. (1996*). Deinstitutionalisation and community living intellectual disability services in Scandinavia*. Britain and the US.

Maree, K. (2007). *First steps in research*. Pretoria; South Africa: Van Schaik.

Marianne S. (2009). Understanding *the United Nation Convention on the Rights of Persons with Disabilities*. A handbook on the human rights of persons with disabilities. *Advocate, 1*, 1-4.

Matheson, C., Olsen, R. J., Weisner, T., & Dykens, E. (2007). A good friend is hard to find: Friendship among adolescents with disabilities. *American Journal on Mental Retardation, 112*(5), 319–329.

Merriam, S. (2009). *Qualitative research: A guide to design and implementation*. San Francisco; CA: Jossey-Bass.

McConkey, R. (2007). Variations in the social inclusion of people with intellectual disabilities in supported living schemes and residential settings. *Journal of Intellectual Disability Research*, *51*(3), 207-217.

McConkey, R., & Collins, S. (2010). The role of support staff in promoting the social inclusion of persons with an intellectual disability. *Journal of Intellectual Disability Research*, *54*(8), 691-700.

McFadyen, J., & Rankins, J. (2016). The role of goalkeepers in research. Learning from reflexivity and reflection. *Journal of Nursing and Health Care*, *4*(1), 82-88.

McGavin, H. (1998). Planning rehabilitation: A comparison of issues for parents and adolescents. *Physical & Occupational Therapy in Paediatrics*, *18*(1), 69-82.

McGee, R., Williams, S., Howden-Chapman, P., Martin, J., & Kawachi, I. (2006). Participation in clubs and groups from childhood to adolescence and its effects on attachment and self-esteem. *Journal of Adolescence, 29*(1), 1-17.

McLellan, E., Macqueen, M K & Neidig, I. J (2003). Beyond the qualitative interview: Data preparation and transcription. *Field Methods, 15*(1), 63-84.

McMaugh, A. (2011). Encountering disablement in school life in Australia: Children talk about peer relations and living with illness and disability. *Disability & Society, 26*(7), 853–866.

McVilly, K. R., Stancliffe, R. J., Parmenter, T. R., & Burton-Smith, R. M. (2006). ‘I get by with a little help from my friends’: Adults with Intellectual Disability Discuss Loneliness. *Journal of Applied Research in Intellectual Disabilities*, *19*(2), 191-203.

Mill, M. B., & Huberman, A. M. (2005). *Handbook of qualitative research* (3rd ed). Thousand Oaks, CA: Sage

Morrison, R., & Burgman, I. (2009). Friendship experiences among children with disabilities who attend mainstream Australian schools. *Canadian Journal of Occupational Therapy, 76*,(3) 145-152.

Morse, J. M., Barrett, M., Mayan, M., Olson, K., & Spiers, J. (2002). Verification strategies for establishing reliability and validity in qualitative research. *International Journal of Qualitative Methods*, *1*(2), 13-22.

Moreno, J. L. (1934). *A new approach to the problem of human interrelations*. Washington, DC: Nervous and Mental Disease Publishing.

Murphy, N. A., & Carbone, P. S. (2008). Promoting the participation of children with disabilities in sports, recreation, and physical activities. *Paediatrics*, *121*(5), 1057-1061.

Neuman, W. L. (2007). *Social research methods: Qualitative approaches* (4th ed). Boston; MA: Allyn Bacon.

Newcomb, A. F., & Bagwell, C. L. (1995). Children’s friendship relations: A meta-analytic review. *Psychological Bulletin, 117*, 306–347.

Newcomb, A. F., & Bagwell, C. L. (1996). The developmental significance of children's friendship relations. In W. Bukowski, W. Newcomb, & W. Hartup (Eds.), *The company they keep: Friendship in childhood and adolescence* (pp. 289–321). Cambridge, UK: Cambridge Univ. Press.

Nind, M., Rix, J., Sheehy, K., & Simmons, K. (2003). *Inclusive education: Diverse perspectives.* London; UK: David Fulton Press.

Nicholas, W. (2006). *Social research methods. London*: Sage Publications, Inc.

Nirje, B. (1969). *The normalisation principle and its human management implications.* In R. B. Kugel, & W. Wolfensberger (Eds.), *Changing patterns in residential services for the mentally retarded*. pp. 179-195 Washington, D.C.: President's Committee on Mental Retardation

Nirje, B. (1982). *The basis and logic of the normalization principle*. Sixth International Congress of IASSMD, Toronto.

Nyberga, L., Henricssonb, L. & Rydella, A. M. (2008). Low social inclusion in childhood: Adjustment and early predictors. *Infant and Child Development*, *17*, 639-656.

Noble H. & Smith J. (2015). Issues of validity and reliability in qualitative research. *Evidence Based Nursing*, 18, 34-35.

Noonan, V. K., Kopec, J. A., Noreau, L., Singer, J., Chan, A., Mâsse, L. C., & Dvorak, M. F. (2009). Comparing the content of participation instruments using the International Classification of Functioning, Disability and Health. *Health and quality of life outcomes*, *7*(1), 93.

Nordström, I. (2002). *Samspel på jämlika och ojämlika villkor: Om lindrigt utvecklingsstörda skolbarns samspel och relationer med kamrater.* [Interaction on equal and unequal terms: Conditions for the peer relations of school children with intellectual disabilities]. (Unpublished Doctoral dissertation), Stockholm University, Department of Education.

Nosek, M. A., Hughes, R. B., Swedlund, N., Taylor, H. B., & Swank. P. (2003). Self-esteem and women with disabilities. *Sciences and Medicine, 56*, 1737-1747.

O'connor, J. (2017). *The fiscal crisis of the state*. London:; UK: Routledge.

Oliver, M., & Bochel, H. M. (1991). The politics of disablement. *International Journal of Rehabilitation Research, 14*(2), 185.

Olney, M. F., & Brockelman, K. F. (2003). Out of the disability closet: Strategic use of perception management by select university students with disabilities. *Disability & Society, 18*(1), 35-50.

Patel, V., Flisher, A. J., Hetrick, S., & McGorry, P. (2007). Mental health of young people: A global public-health challenge. *The Lancet, 369*(9569), 1302-1313.

Patton, M. Q. (2001). *Qualitative research and evaluation methods*. London: Sage Publications Limited.

Patton, M. Q. (1990). *Qualitative evaluation and research methods*. London; SAGE Publications, Inc.

Perecman, E., & Curren, S. R. (2006). *A handbook for social science field research. Essays and bibliography sources design and methods*. Thousand Oaks, CA: Sage Publications.

Perenboom, R. J., Wijlhuizen, G. J., Garre, F. G., Heerkens, Y. F., & van Meeteren, N. L. (2012). An empirical exploration of the relations between the health components of the International Classification of Functioning, Disability and Health (ICF). *Disability and Rehabilitation*, *34*(18), 1556-1561.

Perrin, J. M., Bloom, S. R., & Gortmaker, S. L. (2007). The increase of childhood chronic conditions in the United States. *Jama*, *297*(24), 2755-2759.

Petry, K., & Maes, B. (2007). Description of the support needs of people with profound multiple disabilities using the 2002 AAMR system: An overview of literature. *Education and Training in Developmental Disabilities*, 42(2), 130-143.

Petry, K., Maes, B., & Vlaskamp, C. (2005). Domains of quality of life of people with profound multiple disabilities: The perspective of parents and direct support staff. *Journal of Applied Research in Intellectual Disabilities*, *18*(1), 35-46.

Pettigrew, T. F. (1998). Intergroup contact theory. *Annual Review of Psychology*, *49*(1), 65-85.

Pettigrew, T. F., & Tropp, L. R. (2005). Allport's intergroup contact hypothesis: Its history and influence. In J. F. Dovidio, P. Glick, and L. Rudman (Eds.). *On the nature of prejudice: Fifty years after Allport* (pp. 262-277). Malden, MA: Blackwell.

Piaget, J. (1965). *The moral judgment of the child.* New York; NY: Free Press.

Poulsen, A. A., Ziviani, J. M., Cuskelly, M., & Smith, R. (2007). Boys with developmental coordination disorder: Loneliness and team sports participation. *American Journal of Occupational Therapy, 61*(4), 451-462.

Powers, L. E., Geenen, S., Powers, J., Pommier-Satya, S., Turner, A., Dalton, L. D., & Swank, P. (2012). My life: Effects of a longitudinal, randomized study of self-determination enhancement on the transition outcomes of youth in foster care and special education. *Children and Youth Services Review, 34*(11), 2179-2187.

Putnam, R. (2000). *Bowling alone: The collapse and revival of American community*. New York; NY: Simon & Schuster.

Putnam, M. (2005). Conceptualizing disability: Developing a framework for political disability identity. *Journal of Disability Policy Studies*, *16*(3), 188-198.

Reidy, D. (1993). A comparison of methods of assessing adaptive behaviour in pre-school children with developmental disabilities. *Australia and New Zealand Journal of Developmental Disabilities*, *18*(4), 261-272.

Resch, J. A., Mireles, G., Benz, M. R., Grenwelge, C., Peterson, R., & Zhang, D. (2010). Giving parents a voice: A qualitative study of the challenges experienced by parents of children with disabilities. *Rehabilitation Psychology*, *55*(2), 139-150.

Riches, V. C., & Green, V. A. (2003). Social integration in the workplace for people with disabilities: An Australian perspective. *Journal of Vocational Rehabilitation*, *19*(3), 127-142.

Robinson, S., & Truscott, J. (2013). *Belonging and connection of school students with disability issues paper*. Sydney; Australia: Children with Disability Australia.

Rochette, A., Korner-Bitensky, N., & Levasseur, M. (2006). Optimal participation: A reflective look. *Disability and Rehabilitation*, *28*(19), 1231-1235.

Rossman, G, B., & Rallis, S. F (2003). *Learning in the field*: *An introduction to qualitative research*. Thousand Oaks, CA: Sage Publication

Rosso, A. L., Taylor, J. A., Tabb, L. P., & Michael, Y. L. (2013). Mobility, disability, and social engagement in older adults. *Journal of Aging and Health*, *25*(4), 617-637.

Rossetti, Z. (2011). That's how we do it? Friendship work between high school students with and without autism or developmental disability. *Research and Practice for Persons with Severe Disabilities*, *36*, 23-33.

Routledge. Gretz, S., & Ploof, D. (Eds.). (1999). *The common thread: A collection of writings about friendships, relationships and community life*. Pennsylvania Developmental Disabilities. *1*(2), 111-122.

Rubin, K. H., Coplan, R. J., Chen, X., Buskirk, A., & Wojslawowicz, J. (2005). Peer relationships in childhood. In M. Bornstein, M.; Lamb, M., (Eds.). *Developmental science: An advanced textbook*. 5. Hillsdale, N.J: Erlbaum. p. 469-512.

Rydell, A. M., Hagekull, B., & Bohlin, G. (1997). Measurement of two social competence aspects in middle childhood. *Developmental Psychology*, *33*, 824–833.

Salmon, N. (2012). ‘We just stick together’: How disabled teens negotiate stigma to create lasting friendship. *Journal of Intellectual Disability Research, Early View, 27,* 195–202.

Saunders, M. L. (2006). *Research methods for business students.* London; UK: Sage.

Saunders, M., Lewis, P.Thornhill, A. (2012). *Research methods for business students* (4th ed). Harlow FT Prentice Hall.

Segrin, C. (1993). Social skills deficits and psychosocial problems: Antecedent, concomitant, or consequent? *Journal of Social and Clinical Psychology, 12,* 336–353.

Schneidert, M., Hurst, R., Miller, J., Üstün, B. (2003). The role of environment in the international classification of functioning, disability and health (ICF). *Disability & Rehabilitation, 25*(11-12), 588-595.

Shields, N., Loy, Y., Murdoch, A., Taylor, N. F., & Dodd, K. J. (2007). Self-concept of children with cerebral palsy compared with that of children without impairment. *Developmental Medicine & Child Neurology, 49*(5), 350-354.

Shigaki, C. L., Anderson, K. M., Howald, C. L., Henson, L., Gregg, B. E. (2012). Disability on campus: A perspective from faculty and staff. *Work, 42*(4), 559-571.

Simplican, S. C., Leader, G., Kosciulek, J., & Leahy, M. (2015). Defining social inclusion of people with intellectual and developmental disabilities: An ecological model of social networks and community participation. *Research in Developmental Disabilities, 38*, 18-29.

Siperstein, G. N., Leffert, J. S., & Wenz-Gross, M. (1997). The quality of friendships between children with and without learning problems. *American Journal on Mental Retardation, 102,* 111–125.

Skiba, R. J., Poloni-Staudinger, L., Gallini, S., Simmons, A. B., & Feggins-Azziz, R. (2006). Disparate access: The disproportionality of African American students with disabilities across educational environments. *Exceptional Children*, *72*(4), 411-424.

Skinner, J., Zakus, D. H., Cowell, J. (2008). Development through sport: Building social capital in disadvantaged communities. *Sport anagement Review*, *11*(3), 253-275.

Slicker J. (2009). *Attitudes towards persons with disabilities in Ghana*. Accra; Ghana: VSO Ghana.

Sommers, R., & Sommers, B (2002). *A practical guide to behaviour research tools and techniques.* New York Oxford University Press.

Stainback, W., & Stainback, S. (1991). A rationale for integration and restructuring: A synopsis. *The regular education initiative: Alternative perspectives on concepts, issues, and models*, 225-239.

Stake, R. E. (1994*). Qualitative case study: Handbook of qualitative research*. Sage Publication, CA:

Stebnicki, M. A., & Marini, I. (Eds.). (2012). *The psychological and social impact of illness and disability*. NY; Springer Publishing Company.

Stephanou, G. (2005). Academic performance and interpersonal relationships (in Greek). In F. Vlachos, F. Bonoti, P. Metallidou, I. Dermitzaki, & A. Efklides (Eds.), *Human behavior and learning: Scientific annals of the psychological society of Northern Greece 3*(pp.201-228). Greece: Athens: Ellinika Grammata.

Stephanou, G. (2007). Students' appraisals and emotions for interpersonal relationships with teachers. In S. Vosniadou, D. Kayser, & A. Protopapas (Eds.), *Proceedings of the European Cognitive Science Conference* Canada: Lawrence Erlibaum Associates.

Stokoe Jr, W. C. (2005). Sign language structure: An outline of the visual communication systems of the American deaf. *Journal of Deaf Studies and Deaf Education*, *10*(1), 3-37.

Suleymanov, F. (2014). *Academic achievements of students with special needs in inclusive education: A case study of one primary school in Azerbaijan*. (Unpublished master's thesis), University of Oslo.

Tamm, M., & Skär, L. (2000). How I play: Roles and relations in the play situations of children with restricted mobility. *Scandinavian Journal of Occupational Therapy*, 7(4), 174–182.

Taylor, S. J., Bogdan, R., & Lutfiyya, Z. M. (Eds.). (1995). *The variety of Community experience: Qualitative studies of family and community life*. Paul H Brookes Publishing Company.

Tregaskis, C. (2000). Interviewing non-disabled people about their disability-related attitudes: Seeking methodologies. DOI: 10.1080/09687590025711.

Trope, Y., & Gaunt, R. (2005). Attribution and person perception. In M. A. Hogg, & J. Cooper (Eds.). *Handbook of social psychology* (pp. 190-208). London; UK: Sage.

Turnbull, A. P., Blue-Banning, M., & Pereira, L. (2000). Successful friendships of Hispanic children and youth with disabilities: An exploratory study. *Mental Retardation, 38,* 138– 153.

Turnbull, A. P., Pereira, L., & Blue-Banning, M. J. (1999). Parents' facilitation of friendships between their children with a disability and friends without a disability. *Research and Practice for Persons with Severe Disabilities, 24,* 85– 99.

United Nations (2006). *Convention on the rights ofpPersons with disabilities.* New York: UN Web Services Section, Department of Public Information.

Van der Klift, E., & Kunc, N. (1994). Beyond benevolence: Friendships and the politics of help. In J. S. Thousand, R. A. Villa, & A. I. Nevin (Eds.), *Creativity and collaborative learning: A practical guide for empowering students and teachers* (pp. 391–402). Baltimore; MD: Brookes.

Vanderpuye, I (2013). *Piloting inclusive education in Ghana: Parental perception, expectations and involvement.* Unpublished doctoral dissertation, School of Education, the University of Leeds.

Van Asselt-Goverts, A. E., Embregts, P. J. C. M., & Hendriks, A. H. C. (2015). Social networks of people with mild intellectual disabilities: Characteristics, satisfaction, wishes and quality of life. *Journal of Intellectual Disability Research*, *59*(5), 450-461.

Verdonschot, M. M. L., De Witte, L. P., Reichrath, E., Buntinx, W. H. E., &Curfs, L. M. G. (2009). Community participation of people with an intellectual disability: A review of empirical findings. *Journal of Intellectual Disability Research, 53*(4), 303-318.

Vygotsky, L. (1995). Fantasi och kreativitet i barndomen [Imagination and creativity during the childhood]. *K. Öberg Lindsten, översättning). Göteborg: Daidalos.(Original publicerat 1930).*

Wachs, T. D. (2000). *Necessary but not sufficient – the respective roles of single and multiple influences on individual development*. Washington, DC: American Psychological Association.

Walker, A. (1999). *Handbook on questioning children: A linguistic perspective.* London; UK: Sage.

Watson, S. F. (2009). Barriers to inclusive education in Ireland: The case for pupils with a diagnosis of intellectual and/or pervasive developmental disabilities. *British Journal of Learning Disabilities, 37*(4), 277-284.

Weiner, B. (2001). Intrapersonal and interpersonal theories of motivation from an attributional perspective. *Educational Psychology Review, 12,* 1-14.

Weiner, B. (2002). Social emotions and personality inferences: A scaffold for a new direction in the study of achievement motivation. *Key Speech at the 8th WATM & Motivation and Emotion Conference.* Moscow, Russia.

Wellman, B., & Leighton, B. (1979). Networks, neighbourhoods, and communities: Approaches to the study of the community question. *Urban Affairs Quarterly, 14*(3), 363-390.

Welsh, M., Parke, R. D., Widaman, K., & O'Neil, R. (2001). Linkages between children's social and academic competence: A longitudinal analysis. *Journal of School Psychology, 39*(6), 463-482.

Whiteneck, G. (2006). *Validated measures of participation and the environment from Craig hospital: CHART and CHIEF*. Paper presented at the United Nations International Seminar on Measurement of Disability, New York, 1-4 June 2001.

Whiteneck, G., & Dijkers, M. P. (2009). Difficult to measure constructs: conceptual and methodological issues concerning participation and environmental factors. *Archives of Physical Medicine and Rehabilitation, 90* (11), S22-S35.

Wilkie, R., Peat, G., Thomas, E., Croft, P. (2006). The prevalence of person-perceived participation restriction in community-dwelling older adults. *Quality of Life Research, 15*(9), 1471-1479.

Wiener, J., & Sunohara, G. (1998). Parents' perceptions of the quality of friendship of their children with learning disabilities. *Learning Disabilities Research & Practice, 13,* 242–257.

Williams, B., & Gilmore, J. (2008). Annotation: Sociometry and peer relationships. *Journal of Child Psychology and Psychiatric, 35,* 997-1013.

Wolfensberger, W. (1983). *Normalization: The principle of normalization in human services*. Toronto; Canada: National Institute of Mental Retardation, Leonard Crainford.

Woodrich, F., Patterson, J. B. (1983). Variables related to acceptance of disability in persons with spinal cord injuries. *Journal of Rehabilitation, 49*(3), 26-30.

World Bank (2012). *Internet User*. Retrieved fromhttp://www.data.worldbank.

World Health Organization (2001). *The UN Standard Rules on the Equalization of Opportunities for Persons with Disabilities.* II. Main Report. WHO/DAR/01.2. Geneva; Switzerland: WHO, 290.

World Health Organization. (2015). *World report on ageing and health*.

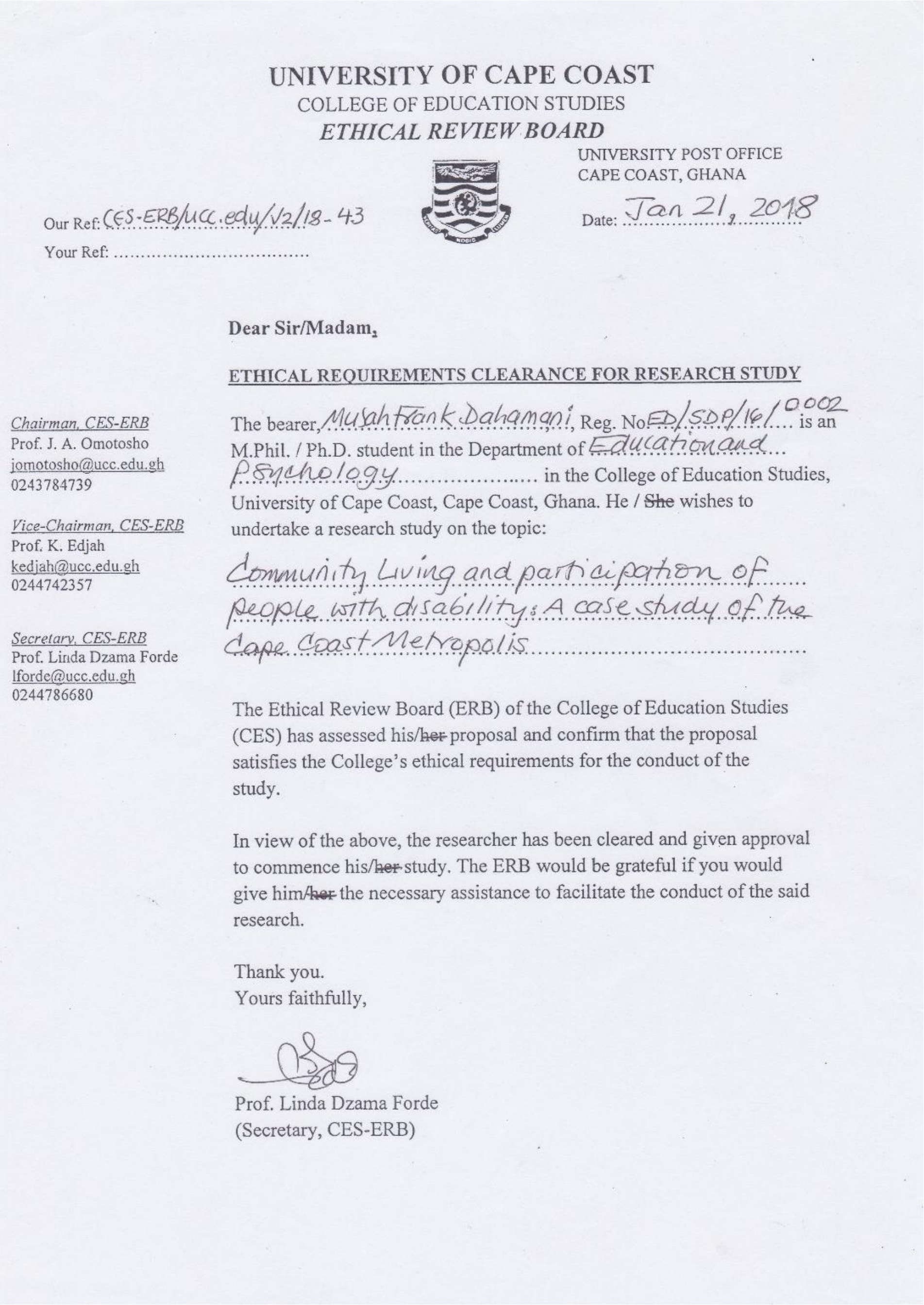
Yin, R. k. (2003). *Application of case study research* (2nd ed). London; UK: Sage.

Zunzunegui, M. V., Minicuci, N., Noale, M., Pluijm, S. M. F., Blumstein, T., Deeg, D. J. H., & CLESA Working Group. (2004). Disability-free life expectancy: a cross-national comparison of six studies on aging. The CLESA project. *European Journal of Ageing*, *1*(1), 37-44.

APPENDICES

APPENDIX A

ETHICAL CLEARANCE



UNIVERSITY OF CAPE COAST
COLLEGE OF EDUCATION STUDIES
ETHICAL REVIEW BOARD

UNIVERSITY POST OFFICE
CAPE COAST, GHANA

Our Ref: CES-ERB/ucc.edu/V2/18-43
Your Ref: ……………………………

Date: Jan 21, 2018

Chairman, CES-ERB
Prof. J. A. Omotosho
jomotosho@ucc.edu.gh
0243784739

Vice-Chairman, CES-ERB
Prof. K. Edjah
kedjah@ucc.edu.gh
0244742357

Secretary, CES-ERB
Prof. Linda Dzama Forde
lforde@ucc.edu.gh
0244786680

Dear Sir/Madam,

ETHICAL REQUIREMENTS CLEARANCE FOR RESEARCH STUDY

The bearer, Musah Frank Dahamani, Reg. No ED/SDP/16/0002 is an M.Phil. / Ph.D. student in the Department of Education and Psychology in the College of Education Studies, University of Cape Coast, Cape Coast, Ghana. He / ~~She~~ wishes to undertake a research study on the topic:

Community Living and participation of people with disability: A case study of the Cape Coast Metropolis

The Ethical Review Board (ERB) of the College of Education Studies (CES) has assessed his/~~her~~ proposal and confirm that the proposal satisfies the College's ethical requirements for the conduct of the study.

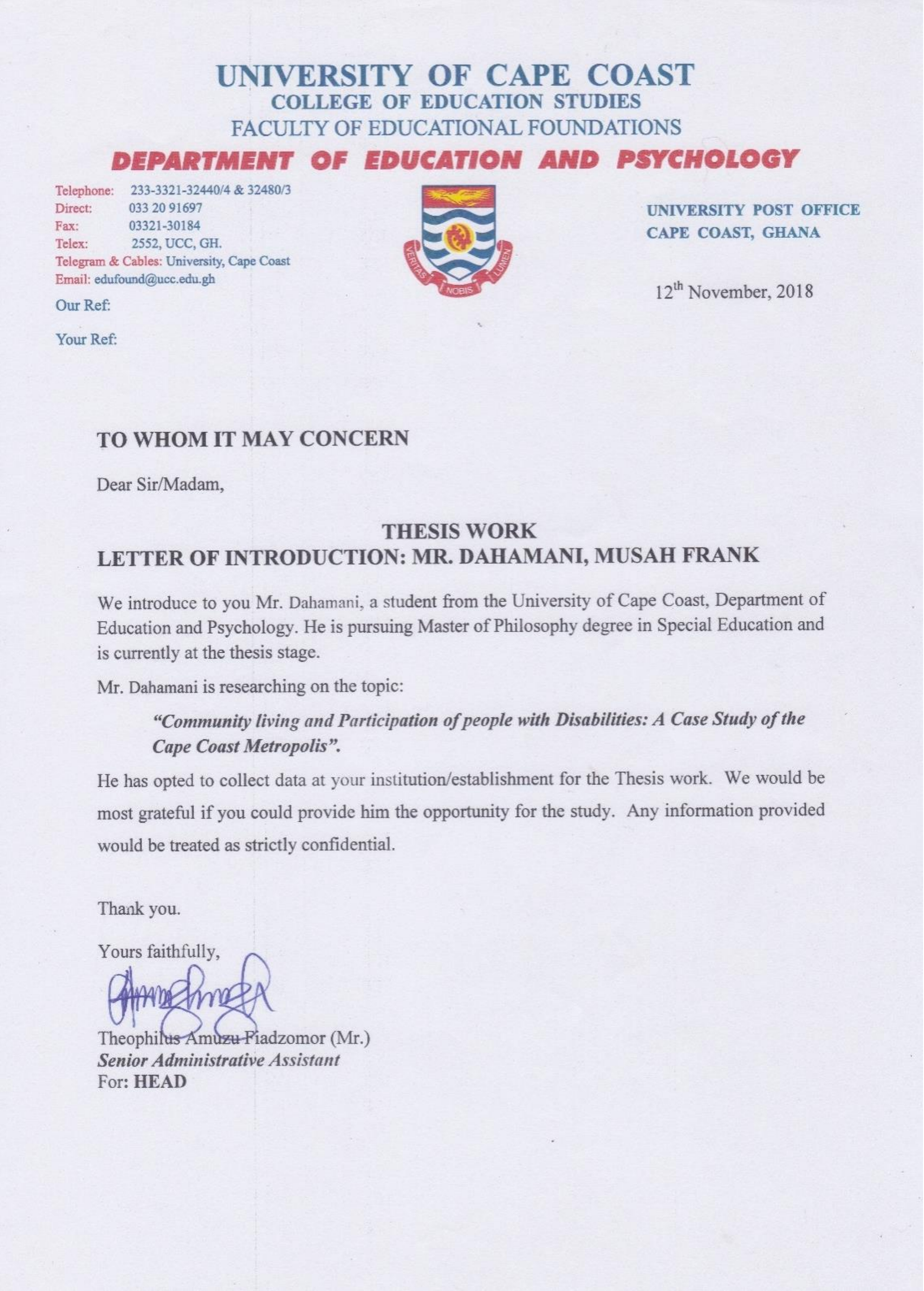
In view of the above, the researcher has been cleared and given approval to commence his/~~her~~ study. The ERB would be grateful if you would give him/~~her~~ the necessary assistance to facilitate the conduct of the said research.

Thank you.
Yours faithfully,

Prof. Linda Dzama Forde
(Secretary, CES-ERB)

APPENDIX B

INTRODUCTORY LETTER



UNIVERSITY OF CAPE COAST
COLLEGE OF EDUCATION STUDIES
FACULTY OF EDUCATIONAL FOUNDATIONS
DEPARTMENT OF EDUCATION AND PSYCHOLOGY

Telephone: 233-3321-32440/4 & 32480/3
Direct: 033 20 91697
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Telex: 2552, UCC, GH.
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Email: edufound@ucc.edu.gh

UNIVERSITY POST OFFICE
CAPE COAST, GHANA

Our Ref:

Your Ref:

12th November, 2018

TO WHOM IT MAY CONCERN

Dear Sir/Madam,

THESIS WORK
LETTER OF INTRODUCTION: MR. DAHAMANI, MUSAH FRANK

We introduce to you Mr. Dahamani, a student from the University of Cape Coast, Department of Education and Psychology. He is pursuing Master of Philosophy degree in Special Education and is currently at the thesis stage.

Mr. Dahamani is researching on the topic:

> ***"Community living and Participation of people with Disabilities: A Case Study of the Cape Coast Metropolis".***

He has opted to collect data at your institution/establishment for the Thesis work. We would be most grateful if you could provide him the opportunity for the study. Any information provided would be treated as strictly confidential.

Thank you.

Yours faithfully,

Theophilus Amuzu-Fiadzomor (Mr.)
Senior Administrative Assistant
For: **HEAD**

APPENDIX C

CONSENT FORM

You are invited to participate in a research study. Please, read this consent form so that you understand what your participation will involve. Before you consent to participate, please ask any questions to be sure that you understand what your participation will involve.

Research Topic: *“Community Living and Participation of People with Disabilities: A Case Study of the Cape Coast Metropolitan”*

Researcher’s Name: **Dahamani, Musah Frank**

Principal Supervisor: **Dr. Kofi Krafona**

Co Supervisor: **Dr. Edward Kofi Ntim**

Department of Education and Psychology, University of Cape Coast, Ghana.

General Information about the Research

This interview guide is intended to find out the community living and participation of people with disabilities in the Cape Coast Metropolitan of the Central Region of Ghana. Your response to this interview will be used for academic purposes only. You are therefore not to write your name anywhere on the question paper.

Possible Risks and Discomforts

The potential risks and discomforts to you in this study are low, but the nature of the questions asked might bring back unpleasant memories while responding to interview questions. If this happens you may skip answering a question or stop participating in the study entirely or permanently. Your participation is voluntary.

Possible Benefits

There are no direct benefits to you from the study participation. However, this research may provide you with the opportunity to reflect upon your experience in the community living and participation, gain insight in your participation and future interactions with the non-disabled. Also, the possible benefit may be indirect but the outcomes are likely to inform policy decision making that would shape the community living and participation of people with disabilities, issues which the respondents may be beneficiaries. This can help bring more stakeholders on board in the community living and participation of people with disabilities.

Confidentiality

Please be assured that no names or any other form of identity is required of you. Every effort will be made to ensure confidentiality for all information you supply during the research interview. As soon as the individual interviews are transcribed and accuracy checks completed, the audio files will be destroyed. Participants will be assigned study code and will be attached to the dataset stored as hard copy or soft file. Any information provided will be handled with care and used for academic purpose only.

Compensation

There will be no material or direct compensation for participation in the study since the study will not take so much time and does not pose any danger to the respondents.

Voluntary Participation and Right to Withdraw

Participation in this research is absolutely voluntary and you under no compulsion to take part. You may withdraw as you so with at any point in the study. You may also choose not to answer specific questions.

Contacts for Additional Information

In case of any doubt or/and for additional information concerning the study, you may contact the Principal Investigator, Dahamani, Musah Frank, University of Cape Coast, Ghana. Telephone: 0208283162 / 0244694300 or email address: frankdahamanie@gmail.com

Your rights as a Participant

This research has been reviewed and approved by the Institutional Review Board of the school of graduate studies, University of Cape Coast, Ghana. If you have any questions about your rights as a research participant you can contact the 1RB Office between the hours of 8am-5pm.

Volunteer agreement

The above document describing the benefits and procedures for the research titled: "Community Living and Participation of People with Disabilities: A Case Study of the Cape Coast Metropolitan" has been read and explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction. I agree to participate as a volunteer.

……………. ……………………………….

Date Name and signature or thumbprint

If volunteers cannot read the form themselves, a witness must sign here: I was present while the benefits, risks and procedures were read to the volunteer. All questions were answered and the volunteer has agreed to take part in the research.

………………. ……………………………

Date Signature or thumbprint.

I certify that the nature and purpose, the potential benefits, and possible low or no risks associated with participating in this research have been explained to the above individual.

…………………..   …………………………

Date   Signature of person who obtained consent

APPENDIX D

INTERVIEW GUIDE FOR PEOPLE WITH DISABILITY

Demographic Data of Respondents

Gender

Male ( ) Female ( )

Type of disability: HI, VI, IDD, PC

Age: 18- 23, 24-29, 30-35, 36-41, 42-47, 48+

Social Interactions Patterns

1. How would you describe the nature of interactions existing between you and the non-disabled in the community?
2. How does your participation in social activities occur in the community with peers who are not disabled?
3. How do you work together with the non-disabled in the community?
4. Do you play together?
5. What play activities exist between you and your non-disabled counterparts? How often?
6. How are you involved in other community activities?
7. How is it, working together with the non-disabled counterparts?
8. Do you usually need any support from them?

Nature of Friendship/Relationships

9. What is the nature of friendship between you and those without disabilities in the community?
10. Describe it.
11. What about the friendship network between you and the nondisabled?
12. How intimate is it?

Social Self-Perception of People with Disability

13. How will you describe what you go through in the community?
14. What makes you think you feel accepted in activities by your non-disabled counterparts?
15. How do you feel in the community?
16. What makes you experience a feeling of satisfaction in social activities in the community? Or non-satisfaction?

17. What abilities do you have to make and keep friendship with other community members who are non-disabled?

Acceptance of People with disability in the community

18. What is the general attitude of the non-disabled peers towards you in the community?
19. Describe it
20. Preference in interaction?
21. What social support is provided by you to your non-disabled friends?
22. How do you relate with your non-disabled friends in play, work, etc. activities in the community?

Benefits of community living and participation to people with disability

23. What benefits do you derive from participation in the community?
24. What are the social benefits to you in your community?
25. What emotional benefits do you get from your community living and participation?

Challenges/barriers of community living and participation

26. What are the challenges/ barriers you face in your community?

APPENDIX E

A SAMPLE TRANSCRIBED DATA OF A VISUALLY IMPAIRED (VI -1)

Demographic Data of Respondents

Gender: Male

Type of disability: VI

Age: 48+

Social Interactions Patterns

1. How would you describe your social interactions patterns existing between you and the non-disabled in the community? *The social interaction is very good, but it varies from person to person and how you approach. I don't know if it's because of my status in the community. but, I do have good interactions with most members of this community. The social interaction is very good, but it varies from person to person and how you approach. By approaching my sighted friends when I need help and so doing I interact with them and ask them their names. We sometimes go to them and also do call on them and they are good sometimes.*
2. How does your participation in social activities occur in the community with peers who are not disabled? *I used to go out.. sit outside… and do whatever.. sitting.. and roaming around with friends.. and …. they ask you go outside.... and we meet people.. and come back..".*
3. How do you work together with the non-disabled in the community? *I work with them every day. I have employed five non-disabled persons*

who are currently working with as you can see them working. I do the supervisions every day. You remember I told you earlier on that, even with my blindness, I rose to become a director of the department I was working till I voluntarily resigned to do my own business

4. Do you play together? *For games, I have experienced that by participating before at primary and my secondary school day. When I used to run 100 meters for my house. But for now, no, I am now grown.*
5. What play activities exist between you and your non-disabled counterparts? *Not at all for now, im very busy with my bussines as such I don't get time.*
6. How are you involved in other community activities? *Most often as and when i`m informed by the people arround me.*
7. How is it, working together with the non-disabled counterparts? *I work with them every day. I have employed five non-disabled persons who are currently working with as you can see them working. I do the supervisions every day. You remember I told you earlier on that, even with my blindness, I rose to become a director of the department I was working till I voluntarily resigned to do my own business*
8. Do you usually need any support from them? *Oh ya, when I am going to church and meetings, I usuall go with my guide who assists me. Almost, each and every one need support in one way or the other do persons with disabilities.*

Nature of Friendship/Relationships

9. What is the nature of friendship between you and those without disabilities in the community?

10. Describe it. *The friendship* is *very cordial even as from primary level when I was then sighted and anywhere I go. But since I became blind at times, there are some people who may not be ready for me in terms of intimacy thus sharing our secrets but when they begin to talk too much when chatting I discard such friendship. I will say it's very cordial*
11. What about the friendship network between you and the nondisabled? *Am friendly to the sighted and some are also friendly to me. With others they shy away. I am very intimate, I visit them at their various places. I discuss a lot on persons with disability. I try to explain to my sighted peers how we behave, and what we are capable of doing. When sometimes something is bothering me, I discuss with my friends. The only thing is that they don't disclose their secrecy to us but want us to do. That one we will not do*
12. How intimate is it? *Initially, some people think disability is contagious and would not like to come closer to you. But as time went on they came closer and got to know how we got impaired and this made people draw closer to me and assist me in all things. Some will like to come closer but others do not want to come closer*

Social Self-Perception of People with Disability

13. How will you describe what you go through in the community? *It's terrible sometimes. Several open gutters and it usually take the sighted people sometime to help me cross the road. People with disabilities are not really considered when putting up certain structures for public use as such some of us have difficulty in moving freely in the community*

14. What makes you think you feel accepted in activities by your non-disabled counterparts? *I think I have had enougth support from the people I stay and work with. I easily approach people, I don't fear initiating conversation. I always ask for clarification of things am not clear on. I don't fear approaching people, for example, if I need help l come out from the room and stand out to wait for anyone who comes by.*
15. How do you feel in the community? *I feel satisfactory when I am with both the disabled and the non-disable together doing things in the interest of the community.*
16. What makes you experience a feeling of satisfaction in social activities in the community? Or non-satisfaction? *I feel satisfactory when I am with both the disabled and the non-disable together doing things in the interest of the community.*
17. What abilities do you have to make and keep friendship with other community members who are non-disabled? *Am friendly to the sighted and some are also friendly to me*

Acceptance of People with disability in the community

18. What is the general attitude of the non-disabled peers towards you in the community?
19. Describe it. *It is okay because no one have ever spoken harshly to me. I normally ask the sighted peers what is happening in this or that area. When they are having conversation and I involve myself in it, they don't shut me down.*
20. Preference in interaction? *As for me I play with both. We share jokes and tell funny stories.*

21. What social support is provided by you to your non-disabled friends?

    My sighted peers also assist me in various ways when you want to buy something and fetch water. I have a sighted peer who always support me. They help me solve my mobility problem, fetch water for me. Some want to do everything for me which I don't like that.

22. How do you relate with your non-disabled friends in play, work, etc. activities in the community? *Look, they want to play with us but because of our impairment, they can't. I socialize with them. Me, I am funny and because of that many want to play with me and include me in their conversations.*

Benefits of community living and participation to people with disability

23. What benefits do you derive from participation in the community? *I engagement in activities, engagement with peers, support workers and family, and being a part of community. I will feel accepted and also contribute y part to the community development*. However, sometimes, *they ask me if I need support or stuff like that...like they can help in getting job or something…*

24. What are the social benefits to you in your community?

    My ability to participate with outside world and engagement in activities of my choice helped me. For social activities, they include me.

25. What emotional benefits do you get from your community living and participation? *I don't feel lonely and feel accepted by my friends and other people. I normally share things and keep secrets so as to keep my friends intact.*

Challenges/barriers of community living and participation

26. What are the challenges/ barriers you face in your community?

    Hmmm,I wonder really, if the non-disabled do understand disabilities issues. You are planning a community for every individual in the community to benefit, and you do not make provisions for people with disabilities. What kind of lives are we supposed to live? Open gutters everywhere, very bad attitudes towards us, most people are not willing to employ people with disabilities to work and earn something for their living. All that we hear now and then is that people with disabilities will have their share of whatever. It is very frustrating to say the least

APPENDIX F

INTERVIEW GUIDE FOR PEOPLE WITHOUT DISABILITY

Demographic Data of Respondents

Gender

Male () Female ()
Age: 18- 23, 24-29, 30-35, 36-41, 42-47, 48+

Social Interactions Patterns in the community

1. How would you describe the nature of interactions existing between you and the disabled in the community?
2. How does your participation in social activities occur in the community with peers who are disabled?
3. How do you work together with the disabled in the community?
4. Do you play together?
5. What play activities exist between you and your disabled counterparts?
6. How often?
7. How are you involved in other community activities?
8. How is it working together with the disabled?
9. Do you usually need any support from them?

Nature of Friendship/Relationships in the community

10. What is the nature of relationship between you and those with disabilities in the community?
11. Describe it.
12. What about the friendship network between you and the disabled?
13. How intimate is it?

Social Self-Perception of People without Disability

14. How will you describe what you go through in the community?

15. What makes you think you feel accepted in activities by your disabled counterparts?
16. How do you feel in the community?
17. What makes you experience a feeling of satisfaction in social activities in the community? Or non-satisfaction?
18. What abilities do you have to make and keep friendship with other community members who are disabled?

Acceptance of People with disability in the community

19. What is the general attitude of the disabled peers towards you in the community?
20. Describe it
21. Preference in interaction?
22. What social support is provided by you to your disabled friends?
23. How do you relate with your disabled friends in play activities in the community?

Benefits of community living and participation to people with disability

24. What benefits will the disabled derive from participation in the community?
25. What are the social benefits to you in your community?
26. What emotional benefits do you get from your community living and participation from people with disabilities?
27. How do you feel associating with people who are disabled in the community?

APPEDIX G

CODING SYSTEM

Main theme	Sub theme	Categories codes	Example of patterns of response
Patterns Of Social Interaction	Playing together	Exclusion and exemptions	For games, I have experienced that by participating before at primary and my secondary school day before becoming blind **VI-3**
			Normally we feel exempted from sports and games in the community **VI 2**
		Helper" or "carer" pattern of interactions	The social interaction is very good, but it varies from person to person and how you approach. I don't know if it's because of my status in the community .but I do have good interactions with most members of this community **VI-1**
	Working together	Cooperative interaction pattern	Working together, normally we feel exempted from sports and games. But we sometimes go for meetings, and others **PC 2**
		Collaborating with one another	For me, I will say working together with people with disabilities must be hand in hand. There is the need for collaboration at every work place no matter your ability or disability **ND 2**

	Social isolation	Interaction with other peers	I interact with them and go with them during certain activities, play times and during some occasions in the community **PC-1**
		Stigmatisation perceptions and ill treatment	I don't feel accepted. In that the stigmatization and perceptions are too high. It demoralizes me **IDD 1**
		Loneliness	I don't feel lonely and feel accepted by my friends and other people. I normally share things and keep secrets so as to keep my friends intact. For social activities, they include me **HI 3**
		Non-participation	It does not occurs. For the games, they do not organize any game that will encourage us to participate. **V 2**
Nature of Friendship/Relationship	Friendship network	Welcoming/cordiality relationship	The friendship is very cordial even as from primary level when I was then sighted and anywhere I go **VI 3**
		Parallel friendship	They are not good, some of them. They are only friends with the non-disabled more than us. They treat their fellow non- disabled peers well but shun on us **IDD 2.**
		Helping and playing with each other	The friendship is good in the sense that, sometimes we play together. Sometimes you may get assistance and may not get but others too would ask to help you when they see you coming **HI-3**
			Am friendly to the disabled and some are also friendly to me **ND 4**
	Mutual friendship	Intimacy	With others they shy away. I am very intimate, I visit them in the homes and various places. I discuss a lot on persons with disability……..**VI 3**.
		Mutual friendship in the community	Some take me as their brother and treat me well and assist me and this has made me happy. The nature of friendship with the sighted peers is partly mutual **PC3**
			Maintaining the friendship, when they come around and they meet their friends, they greet them, talk to them and the non-disabled don't avoid them

			although some of the persons with intellectual disabilities have a lot of problems. The friends sometimes come here to chat with them **ND- 4**.
			By nature of friendship, some of the non-disabled peers are very mutual, how they come near me so as to know what brought about my impairment especially they tend to do anything for me. Sometimes they do admire everything I do and these friends will always like to move and play with me **VI 1**
Social Self- Perceptions	Self-Perception of peers acceptance	Stigmatization	It is very stigmatizing living in this community. Some people who hearing make fun with me because I cannot speak. The sometimes laugh at m*e* **HI 1**
		No communication	I will say it is normal for me. My only challenge is the language barrier with the hearing in the community **HI - 2**.
		Negative perceptions	Initially, some people think disability is contagious and would not like to come nearer to them. But as time went on I went closer and got to know how they got impaired and this made me draw closer to them and assist in all things. Some will like to come closer but others do not want to come closer **ND-4**
		Burden	I do not want to have a neighbour with a physical disability. The person will be a burden to me and I will have to do things for him/her, like carrying water and all that stuffs **ND - 1**.
		General attitude	Their general attitude is okay; for me it is very well. Generally, their attitude towards me is good **VI 1**
		Taboos and misconceptions	I feel uncomfortable because they are different. It is a taboo to be like them. Person will be depending on me, needs help from me **ND – 3**