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PSYCHOSOCIALISSUES IN LEARNING DISABILITIES

Dr.Mala kumari
M.A.(Ph.d)
(Psychology),LNMU Darbhanga

ABSTRACT

In this study, psychosocial functioning of different groups of young children with learning problems was investigated using a diverse set of psychosocial variables (including behaviour problems, academic motivation, social preference, and self-concept). Children with learning disabilities experience almost everyday situations such as shame, anxiety, frustration, social isolation, melancholy and lack of self-confidence . Such situations have serious psychological effects on a primary child and contribute to creating a negative self-image and low self-esteem. Generally, these children are hardly motivated to learn because they do not praise very often because of their low performance, and are not internally satisfied for the same reason.Where learning disabilities coexist with hyperactivity, pupils with learning disabilities receive unfavorable criticism of both their performance and their behavior. Of course, such a treatment has negative effects on learning and shaping the personality of the child. With early diagnosis and early intervention, dyslexia can be addressed and the difficulties faced by a dyslexic child are minimized. The assessment of co-morbidity and the psychosocial complications of dyslexia is an essential part of the evaluation and therapeutic intervention . Proper parenting and teacher briefing and their willingness to collaborate with experts is the key to addressing learning difficulties as well as all the consequences they have on a child's life.

Keywords: Specific learning disability; Challenges; Inclusive Education

SOME WARNING SIGNS OF PSYCHOLOGICAL DIFFICULTIES

Low self-esteem is a common issue for kids with LD. Dr. Robert Brooks, a psychologist, Harvard Medical School professor, and expert on self-esteem, categorizes the signs of low self-esteem in kids as either “direct” or “indirect.” Direct indicators include words or actions that suggest that a child lacks self-confidence, is overwhelmed by challenges facing him, or has little hope for future success. At times, however, according to Dr. Brooks, signs of low self-esteem may be masked by a variety of self-defeating coping strategies, such as:

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- **Quitting**, when tasks become difficult or frustrating;
- **Avoiding** a task or activity for fear of failing;
- **Clowning**, to hide lack of confidence or to relieve pressure;
- **Controlling**, to counteract a sense of helplessness;
- **Being aggressive and bullying**, to fend off feelings of vulnerability;
- **Denying**, in order to manage the pain they would feel if insecurities were acknowledged;
- **Being impulsive**, finishing tasks as quickly as possible "just to get it over with."

Occasional and short-term use of these unproductive coping strategies is probably not a cause for concern. But when they become the habitual way a child approaches daily tasks, interfering with learning, growing, and enjoying life, it's time to look at the feelings behind the behavior.

Some kids with learning difficulties may become either anxious or depressed as a result of ongoing academic and non-academic struggles related to their LD. According to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)*, which is used by physicians to diagnose psychological problems, a child who is anxious may seem worried most of the time; may act nervous in certain settings, such as in crowds of people, at school, or when expected to perform; or may fear being separated from home or from parents or other adults to whom he's attached.A child who is depressed, according to criteria, seems sad or irritable most of the time; loses interest and pleasure in many activities she used to enjoy; over-eats or loses her appetite; feels inappropriate guilt; has trouble thinking, concentrating, and making decisions; feels worthless or hopeless. If you are worried that your child may be experiencing psychological difficulties, discuss your concerns right away with your pediatrician, family physician, or a mental health professional. As an expert on your child's personality and typical behavior, you play a critical role in identifying early signs of possible problems. By taking action when you first notice that your child is having problems, you can begin to support her to regain her self-esteem, motivation, and the pleasure she gets from friends, family, and daily activities.In the next few months, upcoming articles in this series will focus on particular psychological difficulties that can affect children with LD, such as anxiety, depression, or loneliness, and what research shows about effective approaches for coping with these challenges.

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DISTINCTION BETWEEN TERMINOLOGIES – DISORDER, DISABILITY, DIFFICULTY, AND SLOW LEARNER

The terms learning disorders, learning disability (LD), and learning difficulty are often used interchangeably but differ in many ways. Disorder refers to significant problems faced by children in academic areas, but this is not sufficient to warrant an official diagnosis. The word "disorder" is a medical term as mentioned in the Diagnostic and Statistical Manual of Mental Disorders,and International Statistical Classification of Diseases and Related Health Problems, both of which are considered authoritative guides for mental health professionals.

. To receive special disability certificates and services under these acts, a student must be a "child with a disability."SLD is an official clinical diagnosis where the individual meets certain criteria as assessed by a professional (psychologist, pediatrician, etc.).Children with "learning difficulties" underachieve academically for a wide range of reasons, including factors such as behavioral, psychological, and emotional issues; English being their second language and not their mother tongue; ineffective instruction; high absenteeism; or inadequate curricula. These children have the potential to achieve age-appropriate levels once they are provided support and evidence-based instruction.Students with below average cognitive abilities whom we cannot term as disabled are called "slow learners." The slow learning child is not considered mentally retarded because he is capable of achieving a moderate degree of academic success even though at a slower rate than the average child.

TYPES OF LEARNING DISABILITIES

Reading disability (also known as dyslexia) is the most common LD, accounting for at least 80% of all LDs. Reading should be taught; it is not an innate entity. Reading requires the ability to understand the relationship between letters and the associated sound, which is known as phonetics. Dyslexia reflects a specific problem in processing individual speech sounds (e.g., the ssss sound, the mmm sound) in words (phonemes). There can also be problems with holding sounds in sequence in short-term memory (e.g., holding the sequence of sounds in a new word in mind long enough to recognize it). Children with a reading disability may also have difficulties with reading fluency, resulting in reading skills that are accurate but effortful and slow.*Dyscalculia* is generally characterized by difficulty in learning or understanding mathematical operations. A student with arithmetic disorder might have difficulty organizing problems on the page; following through on multiple step calculations such as long division; transposing numbers accurately on paper or on to a calculator, such as turning 89 into 98;

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distinguishing right from left; and using mathematical calculation signs. They may also be confused about basic operations and facts.

Dysgraphia is generally characterized by distorted writing despite thorough instruction. A student with dysgraphia exhibits inconsistent and illegible writing, mixing upper and lowercase letters, and writing on a line and inside margins. He or she might have fine motor difficulties such as trouble holding the pencil correctly, inability to use scissors well, or coloring inside the lines. Overall writing does not communicate at the same level as his or her other language skills.LDs are associated with psychological comorbidities.Approximately 30% of children have behavioral and emotional problems.Children with SLD are at an increased risk of hyperactivity. There is a strong relationship between inattentiveness and reading disabilities. The comorbidity of attention deficit hyperactivity disorder (ADHD) in children with LD varies from about 10% to as high as 60% depending on the sample taken.Co-occurrence of major depressive disorder (MDD) and LDs was studied in 100 children age 9–12 years. It was seen that 62% of children with MDD had LD, whereas only 22% of children without depression had LD. The comorbidity of LD with both internalizing and externalizing disorders implicates the need for cognitive and behavioral approaches in the remediation programs offered to dyslexic children. Diagnosis at an early age results in boosting self-confidence and social competency.

LDs do not become evident till the child starts going to school. Many children do not exhibit any signs until they engage in tasks which require certain kind of cognitive processing which becomes apparent then.A lot of research and efforts are being done in the field of LDs in the western world. However, in India, the experience and research are limited. The government and educational authorities are also progressing toward the betterment of education system. There are many gray areas in this field which need more efforts, clarity, understanding, and discussion.

PSYCHOLOGICAL PROBLEMS IN SCHOOL CHILDREN

Problems at school can show up as poor academic performance, lack of motivation in school, loss of interest in school work, or poor relationships with peers or teachers. Teachers are expert observers, and after proper training they can recognize the early warning signs of psychological problems. Their observation of students and judgment on the characteristics of their cognitive and emotional behaviours can provide vital insight for preparing prevention and intervention programmes for children and their problems. Common psychological problems we face in school children are as follows –

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ANXIETY DISORDERS

Children experience a range of anxiety disorders, including generalised anxiety, panic, phobias and obsessive-compulsive disorder. These disorders are characterised by significant fear and uneasiness that lasts for a month or longer and affects the child's quality of life manifesting in school refusal, distress when separated from parent, social withdrawal and timidity, pervasive worry and fearfulness and restless sleep and nightmares. Often these anxieties can be easily dealt with counselling; a long delay requires initial medication as well.

LEARNING DISORDERS

Some children have difficulty in learning at the same level as their peers. It may help to determine how the child learns best. For some children, reading is easy, while other children benefit from a visual demonstration. Still others work best by having hands-on learning. Testing is required to determine the specifics of the disorder and develop a specialised learning plan. Learning disabilities are characterised by a significant difference in the child's achievement in some areas, as compared to his or her overall intelligence. The student may have some of these difficulties in problems with reading comprehension, delays in speaking and listening, difficulty performing arithmetic functions and understanding basic concepts, difficulty with reading writing and spelling, difficulty organising and integrating thought and poor organisation skills. These problems can be dealt by simple to complex learning and teaching interventions by multi professional approach.

CONDUCT DISORDER

This serious disorder requires treatment that may include medication, counselling and behavioural management. Some of the easy identifiable symptoms include easily angered, annoyed or irritated, frequent temper tantrums, argues with adults / teachers, aggressive towards animals and other people, low self-esteem, blames others for misdeeds, refusal to obey parents/teachers, lack of empathy, frequent lying, difficulty concentrating/forgets things, never completes a task and restlessness and fidgeting. These problems require multi pronged approach, sometimes medication, and intense individual counselling along with family intervention for good outcomes.

EATING DISORDERS

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Some children fall victim to eating disorders, including anorexia nervosa and bulimia. Typical symptoms are being underweight, feeling she is fat even when she is thin, obsession with counting calories, and frequent excuses for not eating. Currently, we are seeing obesity on the rise in Indian children. These children will become victims of bullying and lose self esteem and confidence resulting in being physically inactive or lethargic leading to excessive eating and depression which is the beginning of acute health related problems in the future.

ATTENTION-DEFICIT HYPERACTIVITY DISORDER

ADHD is suspected when a school-aged child has difficulty focusing on homework, does not give close attention to details or makes careless mistakes in schoolwork, work, or other activities, has trouble keeping attention on tasks or play activities, does not seem to listen when spoken to directly, does not follow instructions and fails to finish schoolwork, chores, or duties in the workplace, has trouble organising activities, avoids, dislikes, or doesn't want to do things that take a lot of mental effort for a long period of time (such as schoolwork or homework), loses things needed for tasks and activities (such as toys, school assignments, pencils, books, or tools), easily distracted, forgetful in daily activities. Some of the common Symptoms for Hyperactivity/Impulsivity may include – often fidgets with hands or feet or squirms in seat, gets up from seat when remaining in seat is expected, runs about or climbs when and where it is not appropriate, has trouble playing or enjoying leisure activities quietly, "On the go" or often acts as if "driven by a motor", talks excessively, blurts out answers before questions have been finished, has trouble waiting one's turn and interrupts or intrudes on others. Most often these children can be treated with medication and intensive behaviour modification to manage adequate behaviours in the class.

AUTISM

Autism is a pervasive disorder in which the child does not communicate at the same level as his/her peers and may show little interest in contact with others. S/he may have learning difficulties and become focused on rigid routine and particular objects instead of showing interest in new things. Autistic children often have particular mannerisms, such as flapping their hands and an exaggerated startle response. Some of the observable behaviour in the class is that the child has difficulty with communication, delayed developmental milestones, particularly speech, difficulty making or maintaining friendships, difficulty in understanding how others feel/empathy, isolated or indulges in repetitive play, takes language literally, having obsessional behaviour and rituals, tantrums, extreme sensory sensitivity and sometimes flapping arms or toe

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walking. While no medication directly treats autism, behaviour modification treatment and a specialised learning environment can maximise the child's potential.

SUBSTANCE ADDICTION

Older children may fall into substance abuse and addiction. Substances commonly abused include alcohol, marijuana and prescription drugs, among other drugs. Inhalants such as gasoline, paint, glue and solvents are also used for getting 'high'. There is a rise in our school children getting addicted to inhalants; we have come across students who keep their solvents in the wash rooms and in their bags. They do inhale when no one around them. We have witnessed children as young as in 6th standard getting addicted and these children sometimes become psychologically or physically addicted to substances and require treatment for recovery. Parents must become familiar with signs of substance abuse. These children like to stay away from people, stay in their rooms behind closed doors, argue vehemently for pocket money, frequently become sick with fevers, colds/chills, etc decreased appetite, excessive sleeping at odd times and sudden behavioural changes.

Common treatments include intensive individual counselling, family intervention and sometimes inpatient hospitalisation. Depression and Bipolar Disorder Depression may begin in childhood, particularly if the child has close biological relatives who suffer from depression. Depression is often marked by a lack of interest in activities, sadness and exhibition of poor self-esteem. Bipolar disorder is a disorder in which a child suffers from periods of depression cycle with periods of mania; it can also become apparent by late childhood. Some of the observable symptoms include ongoing sadness, irritability, loss of interest in friends, toys and activities, loss of energy and concentration, loss of weight or appetite, deterioration in school work and thoughts of suicide or self-harming. Depression and bipolar disorder occasionally lead to suicide attempts, and parents must monitor the child as well as seek appropriate treatment. Therapeutic techniques for these disorders involve medication and intensive individual counselling along with family intervention.

COMPLEXITY OF GRADATION IN LEARNING DIFFICULTY AND DISABILITY

According to standard assessment procedure for learning disorders, one class is taken as one standard deviation. So if a child is performing two classes below his actual standard/class, then he or she is diagnosed as LD, and if the performance is one class below, then it is diagnosed as learning difficulty not amounting to disability. Now, various education boards, including CBSE.The Indian Certificate of Secondary Education ICSE, Kerala Board, and Maharashtra

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Board, provide various concessions for students with LD; but there are no facilities for students with learning difficulty. The awareness among policy makers regarding this point of differentiation is limited. There is no provision for students with difficulties. Lack of support from school authorities and parents worsen the situation. Students are not able to avail relaxations and suffer silently. Pediatricians and psychiatrists rely on clinical psychologists to distinguish students with learning difficulty and disability. This confusion creates problems for the process of certification and intervention. The problems of students with learning difficulty not amounting to disability needs to be dealt with specialized techniques of intervention at early stages by a special educator and a parent together.

STIGMA AND LABELING

In India, acceptance of children suffering from LDs in schools largely depends on the capability of the schools to provide necessary services to the children and the attitude of the teachers to put some sincere efforts to help these children. Inclusion, therefore, has rather become selective inclusion of children with disabilities in the mainstream, especially in private schools. These children suffer from many behavioral problems and certain comorbid conditions such as ADHD which is again not known to many. They are labeled as dull, lazy, mischievous, troublesome, and so on without knowing the actual reason behind this. Social attributes play a very important role in the overall course of illness. Acceptance from society, peers, teachers, and so on affect their successful inclusion.The label of LD carries its own burden, baggage, and complications.

OVERLAP WITH SCHOOL DROPOUT

It is difficult to treat various students who drop out from the school as a homogeneous group. Dropping out from the school can be attributed to factors such as low socioeconomic status, behavioral issues, LDs, or intellectual disability. There is a lot of overlap between these categories. There are students who are first-generation learners. According to the National Policy on Education, 1986, these students should be allowed to set their own pace of learning and should be given remedial supplementary instructions. Their slow pace of acquiring information may be due to their background which is not stimulating enough to induce learning, but these children can often be diagnosed with SLDs. This again creates confusion.

GOVERNMENT POLICIES AND APPLICABILITY

Sarva Shiksha Abhiyaan aimed at universalization of elementary education “in a time bound manner,” as mandated by the 86th Amendment to the Constitution of India, making free and

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compulsory education to children between the ages of 6 and 14 years a fundamental right. It was decided under this scheme that no student shall be failed and will be promoted to the next class. This is very important and necessary initiative; but because of this, LD remains undiagnosed and untreated for a longer period of time. Child's problems aggravate because parents do not bother until the child fails, and school authorities do not bother till the school result is affected. Since a child is promoted to next class without the need of minimum passing marks, parents and teachers become complacent and wake up only at secondary levels, and the child's problem remains unnoticed. Some parents try to get away with their child's problem by availing certificates of disability without any extra efforts which are actually required to be invested in. Accommodations which are now being given to students with LDs in the classrooms are sometimes regarded as unfair by parents of students without SLD. It is important to make the parents aware of the fact that these concessions and accommodations are not unfair advantages to students. In fact, if appropriate and timely concessions are not used, students could be branded as having LDs, creating serious negative impact to their achievement and self-concept. The parents can be sensitized on the above issues through parent–teacher meetings and other awareness programs conducted in the school.

CONCLUSION

Just as adults, children too suffer from psychological problems. These may be simple behavioural, emotional or learning problems to complex psychological problems. Treatment exists for all types of problems and Clinical Psychologists can determine if the child has a problem. Many problems cycle with periods of worsening followed by periods of improvement. Some issues resolve with a little help while others persist through adulthood. Prompt diagnosis and appropriate treatment increases the likelihood of successful management of these problems and help children live their lives without breakdowns.These may be simple behavioural, emotional or learning problems to complex psychological problems. Treatment exists for all types of problems and Clinical Psychologists can determine if the child has a problem. Many problems cycle with periods of worsening followed by periods of improvement. Some issues resolve with a little help while others persist through adulthood. Prompt diagnosis and appropriate treatment increases the likelihood of successful management of these problems and help children live their lives without breakdowns. Problems range from school refusal, difficulty with concentration and learning, disruptive behaviour, eating and sleeping problems. Some are transitory, mild and moderate, others serious causing distress, confusion, lack of control, become unmanageable.

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