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Professional Section:

Feminism in context of women with disabilities and sterilization:

Feminism with its emphasis of multiple oppressions is key to guiding disability studies and research towards an understanding pluralities that characterize the experience of disability in India Feminism deals with the issues concerned about women and its limitations imposed by the patriarchal model of geo-religio-political influences. It fundamentally struggles for equality and opportunity in male dominated societies. As Chaman Nahal puts it "dependency syndrome", feminism is a struggle for freedom from dependency syndrome.

The intermingling of disablement and gender marks the reality of a woman with disability in India. Consequently, both congenital and acquired disabilities for the girl child are seen as additional rather than initial liabilities. A culture in which arranged marriages are the rule inherently puts disabled woman in a difficult position. Cultural stereotyping denies them the role of motherhood. Anita Ghai reminds Sudhir Kakar's (a psychoanalyst) statement: " whether a woman's family is poor or wealthy, whatever her caste, class, or religion, whether she is a fresh young bride or exhausted by many pregnancies and infants, an Indian woman knows that motherhood confers upon her a purpose and identity that nothing else in her culture can. Each infant borne and nurtured by her safely into childhood, especially if the child is a son, is both a certification and redemption of her ability, role, and status as a woman." Women with disability are, however, denied the possibility of this fulfillment, as marriage and consequent motherhood are both difficult achievements in a socially restrictive environment.

In many parts of the world, women rely on sterilization voluntarily as one of a range of methods for family planning. However, for other women, including women and girls with disabilities, sterilization is not a choice. The right to bodily integrity and the right of a woman to make her own reproductive choices are enshrined in many international human rights treaties. In particular, the Convention on the Rights of Persons with Disabilities reinforces the right to found and maintain a family and to retain fertility on an equal basis with others (Barriga, 2012).

Inspite of such clear directions, the forced sterilization of women with disabilities remains a global problem. Women with disabilities who elect to have a child are often criticized for their decision and face barriers in accessing adequate health care and other services for themselves and their children. Although society's fear that women with disabilities will produce so-called "defective" children is for the most part groundless, such erroneous concerns have resulted in discrimination against women with disabilities from having children. There is a dichotomy between the notions, on the one hand, that motherhood is expected of all women and, on the other, that women with disabilities are often discouraged, if not forced, to reject motherhood roles, despite their personal desires. Research shows that no group has ever been as severely restricted, or negatively treated, in respect of their reproductive rights, as women with disabilities.

Although women with disabilities experience many of the same forms of violence that all women experience — when gender, disability and other factors intersect — the violence against them takes on unique forms, has unique causes and results in unique consequences. Women with disabilities experience both the stereotypical attitudes towards women and towards persons with disabilities. The impact of stereotypical views of women with disabilities includes rolelessness, the absence of sanctioned social roles and/or institutional means to achieve these roles and can cultivate a psychological sense of

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invisibility, self-estrangement, and/or powerlessness (UN, 2012). Neither Indian feminism nor the Indian disability movement acknowledges that disabled women are doubly pinned by geo-religio-political restrictions. The feminists engaged with the issue of difference, united in their attempts to empower the powerless, and resolved to transform social inequalities have poorly addressed issues concerning the meaning of impairment for women with disability. It is observed that Indian feminist thought fails to recognize that the problematization of women's issues applies equally to disabled women's issues.

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Nutrition, immunity and Autism

Autism is second most prevalent neuro-developmental disorder after Attention Deficit Hyperactivity Disorder (ADHD). It is a complex developmental disorder but, unfortunately, it is not yet clear that what kind of mechanism is behind this disorder. More interest has been in some particular repetitive behaviour which look abnormal and some striking abnormality in immune-related molecules such as cytokines (physical process of cell division that divides the cytoplasm of the parent cell into daughter cell) in the brain and cerebral spinal fluid. There is an increasing evidence of immune involvement in Autism Spectrum Disorder (ASD). Some research results reveal that the deregulation of glutamatergic neurotransmission in the brain with enhancement of excitatory receptor functions by pro-inflammatory immune cytokines is the underlying mechanism. This immune deregulation may be a permanent state of the brain, which generally began during the early stage of development. Low immunity of the mother during pregnancy can also affect the foetus condition, which may result as infantile autism in the child.

The children with autism usually have a frequent complaint of gastrointestinal (GI) problems which may resolve by some dietary elimination. Research evidences indicate toward its direct relation with ASD. The intestine is the largest organ of the immune system and the other organs in this system are thymus, lymph nodes, bone marrow and spleen. These organs produce immune cells that defends the respiratory epithelia and the skin against bacterial and viral onslaughts. What we eat and drink goes through the intestinal tract, which contains bacteria called intestinal flora. These bacteria assist the body to digest food by producing special enzymes, which breakdown food into non-toxic absorbable substances. Immediately after birth the intestines of the infants are totally sterile and do not contain any bacteria, not even good bacteria. During the natural birth process, the infant receives some beneficial bacteria from the mother. The gift of organism immediately starts to multiply in the tiny GI tract of the infant and boosts its immunity. 'Bifidobacteria infantis' is the dominant bacteria in infants which prevents the growth of the rota-virus and thus helps in the prevention of lactose intolerance and increases the absorption of minerals and vitamin B. Thus, it is proved by researches that there is a relationship between relative metabolic disturbance and developmental disorder and, therefore, it is an emerging topic for the scientific research.

Vitamins, minerals and essential amino acids are essential for good human health. The studies on nutritional and metabolic status of children with autism mostly focus on only a few biomarkers. Some studies demonstrated that children with autism have impaired methylation, decreased glutathione, and oxidative stress and thus establish that nutritional supplementation with vitamin methyl- B 12, folic acid and trimethylglycine is beneficial. A study exhibited that the children with autism had higher levels of plasma having Vitamin B6 pre-supplementation, and which was confirmed in a follow-up study, suggest a metabolic imbalance in B6. Another study on dietary intake of 111 autistic children in China showed that most children with disorder had an inadequate intake of folic acid, vitamin B6, Vitamin A, Vitamin C and Zinc. In a study on vitamin D intake status in Egypt, it was found that young children with autism had lower levels of vitamin D in comparison to matched (controlled) group.

In Slovakia, another study found that children with autism had significantly higher levels of vitamin C and beta-carotene. A US study found that children with autism and their mother had usually low level of lithium compared to neurotypical children and their mothers; lithium is receiving increasing recognition as being an essential mineral. The increased or decreased level of amino acid in autism is the topic for deep research and discussion as in few researches it was found to be high, but in others it was low.

In conclusion, we can say that despite no single reason is available to say behind autism, it has been proven through many single-biomarker researches that the nutrients are as a strong mechanism behind the autism development which disturbs to the metabolic functions and effects to the immunity of a child who may develop a permanent abnormal state of the brain which is called as autism.

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Gabapentin

Uses

Gabapentin is approved as adjunctive therapy for partial seizures with or without secondary generalization in patients 12 years of age and older.

It does not prevent primary generalized seizures such as absence, myoclonic, or primary generalized tonic-clonic seizures. Gabapentin is usually used as an additional seizure medicine (add-on or adjunctive therapy) when another medicine has not been able to control all of a person's partial seizures. Sometimes gabapentin is also used alone to treat partial seizures.

Adverse effects

Most people who take gabapentin don't have too much trouble with side effects. The most common complaints (usually not too severe) are: tiredness, sleepiness, dizziness, weight gain and ankle swelling. People who have just started taking gabapentin (or who have just started taking a larger amount) should be careful during activities that might be dangerous, until they know whether they are having any side effects.

Serious side effects related to gabapentin include an increase in the number of seizures , or flu-like symptoms (including chills, fever or aches and pains), feeling disoriented or confused, rapid eye movement, feeling tremors or convulsions, or experiencing an increased number of easily attained bruises or skin discoloration.

Oxcarbamazepine:

Uses

Oxcarbazepine is used for partial-onset seizures—that is, seizures that begin in a limited area of the brain. Sometimes these seizures spread throughout the brain (generalize). It is either used by itself or added (add-on therapy) when another seizure medicine is not controlling all seizures. Oxcarbazepine is not effective against absence or myoclonic seizures

Adverse effects

Oxcarbazepine has now been in use since 1990, and it appears to be very safe. Some side effects of oxcarbazepine that have been reported include: dizziness, headache, tiredness, drowsiness, double vision, stomach upset and loss of coordination.

The occurance of these adverse effects can be managed by changing dosage or the way the drug is taken. These changes though should only be done under the guidance of the physician. Initiation on the drug and any changes in the dosage are times when one should be more careful of the adverse effects such as feeling sleepy, dizzy, or uncoordinated. Risky activities should be avoided during these periods. Alcohol will increase these adverse effects of oxcarbamazepine. Allergic reactions are an important reaction to the drug. A small percentage of people taking oxcarbazepine develop a rash within the first few weeks of taking it. The physician as well as the patient should be aware of the condition and should promply communicate. It's often necessary to switch to a different seizure medicine. Patients who have had reactions with carbamazepine may also have cross reactivity with oxcarbamazepine in 30% cases.

Long-term side effects of oxcarbamazepine especially those taking higher doses of oxcarbazepine, may include low sodium levels in the blood (hyponatremia). Usually this is not serious, but occasionally it may increase the number of seizures or cause other problems such as tiredness or dizziness. Sodium levels in the blood have to be checked especially if the patient is having nausea, a vaguely "unwell" feeling, headache, listlessness, or confusion.

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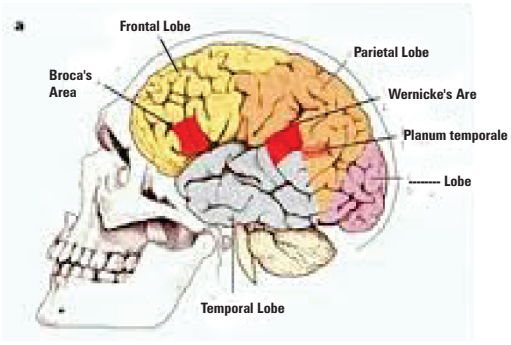
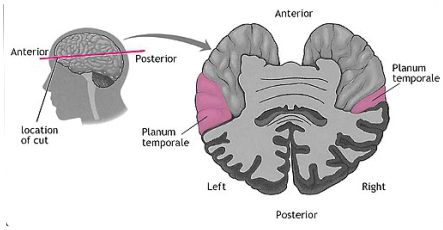
Specific Learning Disability and etiologies

The Learning disability was first used by Dr. Samuel Kirk, a Psychologist, in 1963 during an Education conference. Till then such children were labeled as having "minimal brain dysfunction" or "strephosymbolia" (writing letters reversed) .The specific learning disability (SLD) awareness movement is a recent origin in India. However, during the last decade there has been increasing interest there is no clear data about incident and prevalence of SLD in India. Most of the professionals working in the field of SLD Rehabilitation note that it is not an issue of Intellectual disability but information (cognitive) processing difficulties, hence can be unlearnt and relearnt with remedial training. A recent paper by Karande et al., (2011) note that SLD is 5-15% in school going children.

There are some theories which explains the anatomical cause for SLD. From a neurological point of view, the large prevalence of oral or written language deficits among these SLD children suggests a special vulnerability of the left hemisphere cortical systems subserving various aspects of language-related abilities to these aetiological factors. The basic postulate of current research in this field is that dyslexia and related disorders are fundamentally linked to a constitutional characteristic of the brain. Another line of neurological speculation has followed the initial observations that dyslexic children have poor or inadequate brain lateralization, especially for language. It is customary to cite the American neurologist Samuel Orton as the `founding father' of the now famous atypical lateralization theory of dyslexia. In particular, one idea proposed by Orton and later appropriated by Geschwind, was that the lateralization of language functions to the left hemisphere was delayed in dyslexics, so that the language prerequisites for learning to read could not develop normally. (For instance, the high incidence of

left-handers and the mirror-writing phenomenon were taken as evidence for abnormal lateralization in these children(Habib, 2011). Hinselwood theorized that the angular gyrus of the left hemisphere of the brain was responsible for reading disability. MRI scans of dyslexic and normal subjects were compared and found that 70% attention deficit disorder/ hyperactivity subjects had left>right pattern of asymmetry and 90% of dyslexic subjects had right> left planum/asymmetry. Post mortem studies were made to discover cortical layering, polimicrogyria in the left Planum temporale

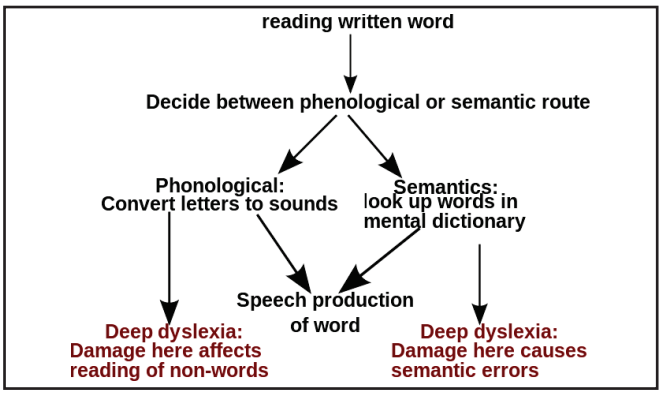




Galabandura and his colleages have reported at cytoarchetectonic level the presence of neumerous ectipias and displasias bilaterally in the inferior frontal gyrus of developmental adult dislexics,others using neuroimaging have shown macroscopic symmetry of anterior speech region . However Jernigan and colleages found a significant difference between language difference individuals and normal controls in the inferior frontal regions,with reversed direction of asymmetry. This has also been revealed in fMRI studies with an experiment in which a pattern of moving dots and stationary patterns were shown moving on a computer screen . An activity was recorded in the bilateral sides of inferior temporal region of normal individuals by moving pattern but not by stationary pattern but a no activity was seen in any pattern by dyslexics. More recently experiments have showed a relationship between the sulcal morphology of the inferior posterior frontal gyrus and family history of speech and language disorders, suggesting an increasing risk when extra sulci is present. Study made by Habib and Robicken on 16 Dislexics showed (i) the corpus callosum are more rounded and evenly thicker (ii) only right handed had larger mid colossal surface especially in the isthmus.

Perceptual disturbance is the major cause for learning disability. The intermediate effect brought about by brain dysfunction are visual perception disorder and language disorder.The final effect is hyperactivity and reading disability. Mykleburt used the term psychoneurological learning disability to indicate the disability is behavioural while the cause is neurological. He points out the levels in which the disability may occur and disturbance or obstruction at any of the stage will block the development in further stage. The information processing model given by Branerd and Ryna (1991) advocated that disturbance in any component during information processing will lead toLearning disability.

1.Structural component (anatomical)
2.Strategical (processing) component
3.Executive component.



Learning strategy deficits model presents that LD students may have the information but they cannot access it. It refers to application of techniques like acquisition, manifestation, integration, retention, recollection . Children with SLD have poor awareness about his knowledge concerning cognition process and products of anything related to it (Metacognition) is lacking.

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Feedback from our Readers:

"Thank you very much for detailed information about the role of rehab psychologist their role in SSA. The information provided was very useful and was eye opener for all here in Dahod (Gujarat). The SSA also can help a great deal to the society with a Rehab Pyschologist, The role of Rehab psychologist was explained very nicely."

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Note: Should you have write-ups or voice your concern, please correspond to:
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