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Patronising Communication toward Pupils with Down Syndrome.
Case Study: Care Givers in the Psycho-pedagogical Centre of Children
with Special Needs in Tiaret

A Dissertation Submitted in Partial Fulfillment of the Requirement for the
Degree of M.A in Linguistics

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Dedication

*To all **Down syndrome** people around the world, this work is a token of love
and respect for you*

*In the memory of my **Mom** may her soul rest in peace*

*To my spiritual ideal who lighted a candle for me, the source of inspiration,
love, and affection: beloved **Dad***

*To my second mom: **Fadila** whom her continued support and encouragements
brought its fruit*

*To all my friends, relatives, lovely brother, and dearest sisters specially
Khadidja and Fatima*

I dedicate this work

Amina BENMIHOUB

Dedication

*First and foremost, I would like to dedicate this humble work to the most precious blessings I have ever got from Allah, my lovely **MOTHER** and amazing **FATHER** for always being there for me, raising me to become who I am now and for the unconditional love and endless support. **MOM, DAD** I love you to the moon and back.*

To:

*My big sister **IKRAM**, my soulmate whom I share secrets and enjoy every single moment.*

To:

*My brother **MOHAMED** for supporting and helping me during this year*

To:

*The apple of my eye, my source of inspiration, handsome little brother **IMAD***

To:

*My dearest friend **HANANE** with whom I share the most beautiful and precious memories of my life, you have special place in my heart, thank you for being my sister*

To:

*My precious friends **WISSAM** and **CHAIMA**, thank you for letting me take a part in such a wonderful, entertaining and unforgettable journey throughout the three years that we spent together.*

To:

*My friend **KHALDIA**, thank you from the bottom of my heart for your precious efforts and time you devoted for me*

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Table of Contents

Dedication	II
Acknowledgments	IV
Table of Contents	V
List of Figures and Tables.....	VIII
List of Graphs	IX
List of Abbreviations and Acronyms	X
Key to Phonemic Transcription	XI
abstract	XII
ملخص.....	XI
General Introduction	1

Chapter One: Down Syndrome Background Information

1.1. Introduction.....	6
1.2. Disability.....	6
1.2.1 Physical Disability	7
1.2.2 Cognitive Disability.....	8
1.2.2.1 Functional Cognitive Disability	9
1.2.2.2 Clinical Cognitive Disability.....	9
1.2.2.2.1 Traumatic Brain Injury	9
1.2.2.2.2 Dementia.....	9
1.2.2.2.3 Autism Spectrum Disorder (ASD).....	9
1.2.2.2.4 Down syndrome (DS) as a Focus of Study.....	10
1.3. Diagnosis and Treatment of Down syndrome	12
1.4. Down syndrome Physical Phenotype.....	12
1.5. Down syndrome Behavioural Phenotype.....	13
1.5.1 Cognitive Phenotype.....	13
1.5.2 Social-Emotional Phenotype	15
1.5.3 The Linguistic Phenotypes.....	15
1.5.3.1 Phonology	15
1.5.3.2 Morphology.....	16
1.5.3.3 Syntax	16
1.5.3.4 Semantics	17

1.5.3.5 Pragmatics.....	17
1.6. The Integration of Children with Disabilities within Centres.....	17
1.7. Conclusion	19

**Chapter Two: Conceptual Frameworks and Theoretical Perspectives
on Patronisation**

2.1 Introduction.....	21
2.2. Conceptual Framework.....	21
2.3 Speech Accommodation Theory (SAT).....	21
2.3.1. Speech Accommodation Theory (SAT)'s ideas origins.....	22
2.3.1.1 Similarity Attraction Theory	22
2.3.1.2 Social Identity Theory (SIT)	23
2.3.1.3. Self Categorisation Theory (SCT).....	25
2.3.1.4 Attribution Theory.....	27
2.4. Communication Accommodation Theory (CAT).....	27
2.5. Communication Accommodation Theory Development	29
2.5.1. Foundational phase (1969).....	29
2.5.2. Intergroup/Contextual Phase (1977)	30
2.5.3. Subjective Phase (1982).....	30
2.5.4. The Fourth Phase (1986).....	30
2.5.5. Communicative Breadth Phase (1988)	30
2.5.6. Mediating Mechanism Phase (2006)	31
2.6. Accommodative Strategies	31
2.6.1. Convergence.....	31
2.6.2. Divergence	33
2.6.3. Maintenance	34
2.7. Non-accommodation.....	35
2.8. Patronisation	37
2.8.1 Patronising Speech in Intergenerational Communication.....	39
2.8.1 Communication Predicament of Aging (CPA)	41
2.8.3 Communication Enhancement Model.....	43
2.9. Inter-ability Communication.....	43
2.9.1. Patronising Speech toward People with Physical Disabilities	44
2.9.2. Patronising Speech toward People with Cognitive Disability	46
2.9.3.-Patronising Speech toward People with Down syndrome	47

2.10. Conclusion	48
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Chapter three: Data Collection, Findings and Discussion

3.1 Introduction.....	50
3.2 Methodology	50
3.3 The Population	51
3.4 The Sample	51
3.5The Research Instruments.....	51
3.6 Piloting Stage.....	52
3.7 The Description of the Questionnaire	52
3.8 Description of the Interview	53
3.9 Analysis of Carers' Questionnaire	53
3.9.1 Carers' Personal Information	53
3.9.2 Carers' Attitudes toward Down syndrome Individuals	54
3.9.3 Carers' Verbal Communicative Behaviour.....	58
3.9.4 Carers' Nonverbal Communicative Behaviour.....	66
3.9.5 The Impact of Carers' Communicative Behaviour on DS Pupils.....	70
3.10 Analysis of Clinical Psychologists' Interviews	73
3.10.1Clinical Psychologists' Professional Data	74
3.10.2 Clinical Psychologists' Attitudes and Communicative Behaviour Addressed toward Down syndrome Category and its Impact on them.....	75
3.11 Discussion of Findings.....	78
3.12 Conclusion	81
General Conclusion.....	82
Bibliography	84
Appendices.....	92

List of Figures and Tables

Figure 1.1. Trisomy 21	11
Figure 1.2. Mosaicism.....	11
Figure 2.1. CAT's Principles	29
Figure 2.2. Cognitive Function of Convergence, Divergence/Maintenance.....	35
Figure 2.3. Affective Function of Convergence, Divergence/Maintenance	35
Figure 2.4. Communication Predicament of Aging Modal.....	42
Table 2.1. Convergent Features and Selected Source	32
Table 2.2. The Features of Patronising Communication.....	38
Table 3.1 Carers' Motives for Sympathising with DS Children	55
Table 3.2 Carers' Reasons for Assisting DS Pupils	56

List of Graphs

Graph 3.1: Carers' Working Experience	54
Graph 3.2: Carers' Treatment of DS Pupils	57
Graph 3.3: The Effect of People's View of Disability on Speech Choice	57
Graph 3.4: Carers' Manner of Addressing DS Pupils	58
Graph 3.5: Carers' Use of Spoiling Terms	59
Graph 3.6: The Spoiling Terms Used by Carers	59
Graph 3.7: The Nature of Vocabulary Used with DS Pupils	60
Graph 3.8: The Nature of Sentences Used with DS Pupils	61
Graph 3.9: The Frequency of DS Pupils' Failure in Tasks Understanding.....	62
Graph 3.10: Number of Repetition Times for DS Pupils by Carers.....	62
Graph 3.11: Carers' Praise of DS Pupils	63
Graph 3.12: Vocabulary Used for Praising	64
Graph 3.13: Carers' Repose Prompts with DS Pupils	65
Graph 3.14: Limited Topics Selection	65
Graph 3.15: Carers' Position	66
Graph 3.16: Carers' Pitch Voice while Interacting with DS Pupils	67
Graph 3.17: Carers' Manner of Rewarding DS Pupils.....	67
Graph 3.18: Carers' Pronunciation.....	68
Graph 3.19: Carers' Speech Pace	69
Graph 3.20: Carers' Speech Pace Adjustme.....	69
Graph 3.21: Carers' Facial Expression.....	70
Graph 3.22: Carers' Speech Style Adjustment with DS Pupils	71
Graph 3.23: Speech Style Adjustments Impact on DS Pupils.....	71
Graph 3.24: The Importance of Simplified Speech Use with DS	72
Graph 3.25: The Importance of Support on DS Learning Process.....	72
Graph 3.26: Facial Expression Impacts on Communication Process with DS	73
Graph 3.27: Clinical Psychologists' Working Experience.....	74

List of Abbreviations and Acronyms

CAT: Communication Accommodation Theory

DS : Down syndrome

SAT: Speech Accommodation Theory

SCT: Self Categorising Theory

SIT: Social Identity Theory

Key to Phonemic Transcription

Consonants/ letters/ numbers			Examples		
Letters/ Numbers	Phonemic Symbols	Arabic equivalents	Arabic Meanings	Phonemic transcriptions	Meanings in English
A	/ʌ/	أ	أضواء	/ʌdwaʌ/	Lights
B	/b/	ب	بلد	/balʌd/	Country
C	/s/	س	سيارة	/sajara/	Car
Sh	/ʃ/	ش	شرق	/ʃark/	East
Ch	/tʃ/				
D	/d/	د	دب	/dob/	Bear
Dh	/d/	ض	فرض	/fard/	Test
Ḍ	ð	ذ	ذهب	/ðahab/	Gold
Th	e	ث	ثلج	/θaldj/	Snow
F	/f/	ف	فيل	/fi:l/	An elephant
H=(7)	/h/	ه	هرب	/harʌb/	Escape
/	/h/	ح	حرب	/harʌb/	War
Gh	/	غ	غرب	/gharʌb/	West
J	/dʒ/	ج	جمل	/dʒamal/	Camel
K /C/	/k/	ك	كهف	/kahf/	Cave
Kh= 5	/	خ	خمسة	/kham.s/	Five (5)
L	/l/	ل	ليل	/leil/	Night
M	/m/	م	مدينة	/madina/	City
N	/n/	ن	نهر	/nar/	River
Q	/k/	ق	قلم	/qalam/	Pen
G	/g/	ف	السوق	/su:qa/	Sougueur
R	/r/ /a:/, /r/	ر	رسم	/rasm/	Drawing
S	/s/	ص	صبي	/sabee/	Baby
T	/t/	ت	تلميذ	/tilmi:ʌ/	Pupil
6	/	ط	طائر	/ba:ir /	Bird
U	/ju:/	ي	ياسين	/jasin/	Yassine
W	/w/	و	ولد	/walʌd/	Boy
Z	/z/	ز	زميل	/zamil/	Mate
3	3	ع	عمل	/ʒamel/	Job

Abstract

This study attempted to describe the communicative behaviour of care givers when interacting with Down syndrome pupils inside the Psycho-pedagogical Centre of Children with Special Needs in Tiaret. It focused mainly on revealing the verbal and nonverbal patronising features that characterise care givers communicative behavior, in addition to unveiling the factors behind their adaptation of such speech style, and its possible impacts on Down syndrome pupils. The study type is descriptive and it followed a mixed-method approach of gathering data in which both detailed questionnaire and semi-structured interview were adopted as research tools. After analysing the obtained data, the results showed that the mental state of Down syndrome pupils is the leading force behind care givers' adaptation of a patronising communication. In addition, findings indicated that both verbal and nonverbal patronising features characterise the care givers' communicative behaviour, and they have a positive impact on Down syndrome pupils serving as a tool to aid communication, facilitate comprehension, and reinforce their learning process.

Key Words: Care givers, Communicative behaviour, Down syndrome, Patronising communication, the Psycho-pedagogical Centre of Children with Special Needs

المخلص

حاولت هذه الدراسة أن تصف السلوك التواصلي لمقدمي الرعاية أثناء التفاعل مع فئة متلازمة داون داخل المركز النفسي البيداغوجي للأطفال ذوي الاحتياجات الخاصة في ولاية تيارت. وقد ركزت بشكل أساسي على كشف الخصائص اللفظية والجسدية التي تميز السلوك التواصلي لمقدمي الرعاية، بالإضافة إلى الكشف عن الاسباب الرئيسية وراء تبني أسلوب خطاب الرعاية وتأثيره المحتمل على تلامذة متلازمة داون. اتبع البحث منهجا مختلطا لجمع البيانات حيث أن استبياننا مفصلا و مقابلة شفوية استخدمت كأدوات بحث. بعد تحليل البيانات التي تم جمعها أظهرت النتائج ان الحالة الذهنية لتلاميذ المتلازمة هي السبب الرئيسي وراء تبني أسلوب خطاب الرعاية بالإضافة إلى ذلك أشارت النتائج الى ان كل الخصائص اللفظية والجسدية لهذا الأسلوب قد ميزت السلوك التواصلي لمقدمي الرعاية، كما أن له تأثيرا ايجابيا على فئة المتلازمة حيث يعتبر أداة للمساعدة على التواصل وتسهيل الفهم وتعزيز عملية التعلم.

الكلمات المفتاحية: مقدمي الرعاية ، السلوك التواصلي ، فئة متلازمة داون , خطاب الرعاية,المركز النفسي البيداغوجي للأطفال ذوي الاحتياجات الخاصة.

General Introduction

Since human beings do not live in isolation and are always in contact with one another, communication is a fundamental process to socialise, express one's ideas and emotions, exchange information, and reach the mutual understanding that builds better relationships and tightens social bonds. Communication can be achieved either verbally using a language or nonverbally using signs and body language in general involving a sender, message, channel, and recipient for the success of the process.

One thing is known about the communicative behaviour is that it can never be stable, but continuously changes with changing situations, contexts, and participants. In other words, people are continuously altering their speech style resulting in what is known as linguistic accommodation. Linguistic accommodation is extracted from Howard Giles theory in 1970 "Speech Accommodation Theory" where the major focus then was on the verbal shifts adopted by speakers during social encounters, their motives for doing so, and its evaluation from the reception side

Speech Accommodation Theory (SAT) blossomed to Communication Accommodation Theory (CAT) in the eighties when extended to cover the whole communication process including verbal and nonverbal behaviour of interactants, and it was implied to study communication between different social groups such as gender, generations (intergenerational communication), cultures (intercultural communication), and abilities (inter-ability communication). Our study will shed the light on inter-ability communication namely, communication between disabled people and non-disabled specifically Down syndrome (DS) category with care givers inside centre. CAT believes that non-disabled people accommodate their communicative behavior when initiating conversation with disabled people resulting in a new speech style called "Patronising Speech".

Patronising speech was most tackled in intergenerational communication; however, little is known about the same phenomenon in inter-ability communication where there are two influential works in the same arena of inquiry; the first is that of Anne Sussan Fox and Howard Giles (1996) with physically disabled people and the second of Morris (2007) with cognitively disabled people where the major focus was on the evaluation of patronising behaviour in normal settings putting aside both its features and impact where both studies adopted a written vignette accompanied with a detailed questionnaire as research tools . However, our study tackles patronising communication in institutionalised settings where

General Introduction

care givers inside centres are believed to make certain adjustments in their communicative behaviour when initiating conversation with DS pupils which may result in certain patronising features and may affect DS pupils.

In fact, what grew our enthusiasm to tackle such topic is the personal and close relationship we have with DS category in addition to the few published works on the phenomenon of patronising speech addressed towards these people and its impact on them which caused lack of interest among Algerian scholars and linguists on that topic.

Our work will be of great value to those who endeavour to conduct such topic serving as a source due to its originality. Moreover, the topic followed a different path from the previous studies where it was conducted in institutional settings and with a specific anomaly known as DS which make the results more specific to this category. Also, the findings of the study may provide insights about how to deal and communicate with DS individuals in a way that best suits their needs.

The current study endeavours to describe the communicative behaviour of care givers verbally and nonverbally when communicating with DS pupils in addition to unveiling the factors behind their adaptation of patronising speech, and its possible impacts on these pupils. In addition, it aims to shed the light on patronising communication, thus raising people awareness toward this style of communication by outlining the main verbal and nonverbal features of patronisation addressed toward DS pupils inside the centre by care givers.

For the sake of reaching the aforementioned objectives, the following questions have been raised:

1. How can care givers' mental representations of DS individuals affect their communicative behaviour while interacting with them inside the centre?
2. What are the verbal and nonverbal patronising features that are adopted by care givers during interactions with DS pupils?
3. What are the nonverbal features of patronisation that can be reflected in the care givers' communicative behaviour while interacting with DS pupils?
4. What is the impact of patronising communication on DS pupils inside the centre?

To answer the aforementioned questions, the following hypotheses have been formulated:

1. It is assumed that care givers hold certain mental representations about DS pupils such as needy, dependent, and different leading them to shift to a patronising form of addressing.

General Introduction

2. It is hypothesised that the verbal patronising feature adopted by care givers can be detected through the use of clarification strategies such as speaking more slowly and clearly, and simplification strategies such as the use of simple vocabulary, simple short sentences, in addition to the use of endearment terms, nickname and first name of addressing, exaggerated repetition, exaggerated interruption, limited topic selection, and exaggerated praise for minor accomplishments.
3. It is claimed that the nonverbal patronising features that can be reflected in care givers' communicative behaviour are the use of very high loud pitch of voice with exaggerated pronunciation, exaggerated smile, standing too close while interacting with DS pupils and patting on their heads.
4. It is believed that patronising communication adopted by care givers toward DS pupils has a positive impact on them serving as a helpful strategy to aid communication, facilitate comprehension, encouraging and reinforcing their learning process inside the centre.

For the sake of answering the research questions and reaching our objectives, we adopted the mixed-method approach for gathering both quantitative and qualitative data using both questionnaire and semi-structured interview as research tools. The questionnaire was handed to 20 carers consisting of 31 close-ended questions namely yes/no, questions, and multiple choices, in addition to one open-ended question. On the other hand, the semi-structured interview was set up with three clinical psychologists who work inside the Psychopedagogical Centre of Children with Special Needs in Tiaret.

This master dissertation consists mainly of three chapters; the first chapter has been dedicated to provide in-depth insights about disability, its definition from both the medical and social perspective, and its types physical and cognitive putting much emphases on the cognitive one specifically DS. In addition, it provides detailed background information about DS category including the definition, diagnosis, the different phenotypes, and the integration of disabled people in educational settings.

The second chapter is devoted to the review of the related literature where we first define all the conceptual frameworks that correlate to the study then we refer to the theory that guided our study namely, CAT theory, and its related theories including social identity theory (SIT), similarity attraction theory, self-categorising theory (SCT) , attribution theory, in addition the implication of such theories in different works including patronising speech in different contexts mainly the intergenerational and inter-ability one.

General Introduction

The last chapter presents the practical side of our investigation. It deals with the representation of the research methodology, research tools, the analysis of data accompanied with its graphical representations, and a detailed discussion of the findings.

Research Limitations

The majority of scientific studies faced a set of limitations either during the data collection phase or the analysis process, and our study is not an exception. First and foremost, due to covid-19 pandemic we were obliged to investigate only in one centre for people with special needs and this might affect the process of over generalisation since the corpus is limited to one centre in Tiaret. The second main limitation is the lack of literature devoted for our topic which proves to be an original in our region. Moreover, not all participants were cooperative since they took a long time to hand over the online questionnaires and that hindered us from starting the analysis earlier.

Research Recommendations

This study paves the way to other researchers who might be interested in conducting a research on this topic. Since the context of our study is a Centre for Children with Special Needs, one might investigate inside public educational settings, especially after the integration of DS children within special classes inside primary schools. Another one may use Critical Discourse Analysis (CDA) to analyse care givers discourse taking into account different variables such as, kinship, distance, and gender. It is also possible to make a comparative study to test similarities and disparities between the speech style addressed to able bodied pupils and the one adopted towards disabled ones inside classrooms, besides analysing patronising speech effects during inter-ability encounters, taken into account parents' opinions about the efficiency of using this speech on DS children abilities and skills.

Chapter One:

Down Syndrome Background Information

1.1. Introduction.....	6
1.2. Disability.....	6
1.2.1 Physical Disability.....	7
1.2.2 Cognitive Disability.....	8
1.2.2.1 Functional Cognitive Disability.....	9
1.2.2.2 Clinical Cognitive Disability.....	9
1.2.2.2.1 Traumatic Brain Injury.....	9
1.2.2.2.2 Dementia.....	9
1.2.2.2.3 Autism Spectrum Disorder (ASD).....	9
1.2.2.2.4 Down syndrome (DS) as a Focus of Study.....	10
1.3. Diagnosis and Treatment of Down syndrome.....	12
1.4. Down syndrome Physical Phenotype.....	12
1.5. Down syndrome Behavioural Phenotype.....	13
1.5.1 Cognitive Phenotype.....	13
1.5.2 Social-Emotional Phenotype.....	15
1.5.3 The Linguistic Phenotypes.....	15
1.5.3.6 Phonology.....	15
1.5.3.7 Morphology.....	16
1.5.3.8 Syntax.....	16
1.5.3.9 Semantics.....	17
1.5.3.10 Pragmatics.....	17
1.6. The Integration of Children with Disabilities within Centres.....	17
1.7. Conclusion.....	19

1.1 Introduction

Apart of being different in personality, traits, and behaviour, people are also different in terms of capacities and abilities whether those related to able-bodiedness including physical tasks and skills in general, or those related to able-mindedness such as level of intelligence, speech competency, speech production and learning. In general, individuals who experience certain limitation and constraints when performing a cognitive or a physical task, which is regarded as normal or natural by convention, are considered cognitively or physically disabled with varying degrees. This chapter will be dedicated to provide insights and a clear view of disability from two different perspectives, the medical and the social one, and its both types physical and cognitive in addition to the integration of disabled people within public and private centres. Moreover, the current chapter will shed much more light on the cognitive disability specifically the category of DS providing detailed background information about it including the definition, diagnosis, and its different phenotypes.

1.2 Disability

The number of disabled people has been estimated one billion in the entire universe including both types, physical and cognitive disability (World Bank Organisation, 2020). Disability, handicap, impairment, are different terminologies to refer to the same issue which may touch any category be it young, old, male or female, and which may have a severe emotional impact on the disabled people themselves and people around them too. A disability can be diagnosed since birth, or can be acquired through external factors such as injuries and accidents which lead to the loss of any part of the body resulting in a physical disability or damages in the brain resulting in a cognitive one.

The terminologies used to describe and label those people vary. People generally call them either “People with disability ” reinforcing the emphases on the person rather than the disability which might be quite offensive, or might call them “Disabled people ” putting the emphases on the disability rather than the person (Jaeger & Bowman, 2005, p.04).

For children and youths, the term special health care and needs is used more often than a disability; it includes children who experience functional limitation and “who have or are in an increased risk for a chronic physical, developmental, behavioural, or emotional condition, and who also require health and related services of a type or amount beyond that required by children generally ” (Mc pherson, Arango, & Fox, as cited in Krahn, Walker, & Araujo, 2015, p.199).

The definition of disability is a complex process since it varies from one perspective to another. The two main important perspectives and models for defining a disability is the medical and the social one. Starting with the medical model, a disability is defined as “an identifiable medical impairment or condition that impacts the daily life ” (Jaeger & Bowman, 2005, p.06). According to this model, a disability is a biological and a physiological problem within the person removed from external factors (Sihers, 1998, as cited in Jaeger & Bownan, 2005, p.14). The focus remains on diagnosis through medical insight with the goal of striving to eliminate the impairment or disability, and find the appropriate cure (Thomas & Woods, 2003, p.17) with the help of medical materials and advanced technology. Some of the developed medical treatments might include metal knees, plastic hearts, motorised elbows, electronic ears, and artificial lamb.

While the medical model views disability as a biological and a physiological problem, the social model focused on external factors and social barriers that contribute in the construction of a disability and the restriction of disabled people. Thomas and Woods (2003) explained: “if society did not meet the needs of all the people in it irrespective of their physical ability and their mental intellect, then it is society that is causing the disablement, not the medical condition used to explain the function of the person’s mind or body ” (p.16). That is to say, environment creates disability by certain barriers for example, a building without elevator creates an obstacle for the wheelchair users to get access to the building, another example might include a deaf person without a sign language interpreter.

In addition, this model requires advances in social justice rather than in medicine(Siebers, 2001,as cited in Jaeger & Bowman, 2005,p.15). It seeks to guarantee equality between disabled people and their counterpart normal people in terms of their rights, inclusion within society, and working opportunities.

In general, one can say that a disability is not restricted only to the medical condition of the person, but it extends to the social and environmental arrangements and conditions that create barriers in the way of people with impairments and restrict their daily life activities.

1.2.1 Physical Disability

A physically disabled person is the one who experiences certain limitations, difficulties, restrictions and constraints when performing certain motor activities in the daily life including walking, moving, eating alone which requires him/her assistance from others. This disability is either a congenital (since birth), or acquired.

A physical disability can be classified into two major categories; a musculoskeletal disability which is, “the inability to carry out distinctive activities associated with movement of the body parts due to muscular or bone deformities, diseases, or degeneration”, the neuromuscular disability on the other and is defined as “the inability to perform controlled movements of affected body parts due to diseases or disorder of the nervous system (Handicaps Welfare Association, 2020).

1.2.2 Cognitive Disability

Human cognition refers to a broad range of invisible activities and tasks carried out by the human brain such as learning, reasoning, thinking, creating, perceiving (Borson, 2010, p.375). Performing the aforementioned cognitive tasks differ from one person to another; some people might exhibit extraordinary capabilities; however, others might face difficulties with one or more types of mental tasks due to their mental limitation or cognitive disability.

According to the American Association of Mental Retardation (AAMR), individuals with cognitive disability are those who can be described as having mental retardation, and who display intellectual, maladaptive behaviour and social skills (as cited in Thomas & Woods, 2003, p.150).

Heber (1961) classified mental retardation into five cases according to the level of intelligence of the person:

- المتخلف عقليا على الحدود Borderline mental retardation with 83-68% level of intelligence.
- حالات التخلف البسيطة Mild mental retardation with 67-52% level of intelligence.
- حالات التخلف المتوسطة Moderate mental retardation 51-36%.
- حالات التخلف الشديد Severe mental retardation 35 -20%
- حالات التخلف البالغ العميق Profound mental retardation with less than 19% level of intelligence. (as cited in El-faramaoui & El-nasadje, 2010, p.29).

Three years later, Scherenberger classified mental retardation according to the learning expectancy of the person

- قابلين للتعليم Educable person 75-50%.
- قابلين للتدريب Trainable person 49-20%.
- اعتماديون شديد الإعاقة Dependable person with severe handicap less than 19%.(ibid).

It is hard to identify the causes of a cognitive disability; however, there are certain factors that are believed to contribute in the construction of a cognitive disability such as

genetic and chromosomal disorders including DS and Edward syndrome, damages in all or some areas in the brain caused by injuries, drugs and alcohol overconsumption, developmental disorders such as Autism.

1.2.2.1 Functional Cognitive Disability

This type includes people who have problems with memory, math comprehension, verbal and visual comprehension, problem solving, attention, etc, with varying degrees of severity (Cogn, 2018). Functional cognitive disability focuses on the abilities of the users' cognition and the challenges he or she might face irrespective of their medical or behavioural causes. (ibid)

1.2.2.2 Clinical Cognitive Disability

This type includes cognitive conditions such as Attention Deficit Disorder (ADD), dyslexia (difficulty reading), and learning disabilities in general (Cogn, 2018). Clinical cognitive disability might be caused by Traumatic Brain Injury (TBI), Dementia, developmental disorder like Autism, chromosomal disorder like Down syndrome (cog, 2018).

1.2.2.2.1 Traumatic Brain Injury (TBI)

TBI is a sudden damage to the brain caused by any external force like falls, collisions, crashes affecting a person's cognitive abilities, skills and brain functioning in general. It ranges from mild to severe and maybe permanent or temporal depending on the severity of the struck. TBI may result in problems hearing, talking, speaking, remembering and is considered as the leading force behind Alzheimer and Dementia.

1.2.2.2.2 Dementia

According to world health organisation (2019) Dementia is a syndrome that affects memory, thinking, comprehension, learning capacity, and language leading to a cognitive impairment. One of the most common forms of Dementia is Alzheimer. Dementia threatens generally people aging from 30 to 60 years old where the first syndrome that patients may suffer from is the loss of the memory.

1.2.2.2.3 Autism Spectrum Disorder (ASD)

ASD is a set of neurodevelopment disorders characterised by a deficit in social behaviour and nonverbal interactions such as reduced eye contact, facial expressions, and body gestures that can be noticed in the early three years of life (Park et al., 2016, p.01).

Studies of Autism and related conditions showed that most autistic children suffer from mental retardation and poor comprehension of meaning (Brask, 1972, as cited in Gillberg, 1989, p.13).

The most useful and satisfactory approach to the diagnosis of ASD is through the assessment and monitoring of behaviour and the development of the child in order to identify any impairment or abnormality and their degree of severity since there is no medical test for the disease. The Centre of Disease Control and Prevention identified certain signs and symptoms that indicate the probability of having ASD:

1. An autistic child might have problems with social, emotional, and communication skills.
2. He/she avoids eye contact with people.
3. Autistic child enjoys staying alone instead of being in touch with others.
4. They cannot express their feelings and needs.
5. Autistic children have problems with getting adapted to new things (changing routine for example).
6. They are known for their repetition of certain actions and behaviours without getting bored.
7. They may lose the skills they once learnt like words and expressions.

1.2.2.2.4 Down Syndrome (DS) as a Focus of Study

DS is one of the most common genetic diseases caused by chromosomal abnormality or disorder. It was named after the English doctor John Langdon Down who first recognised the syndrome in 1866, and called children with DS as Mongoloids because they resembled people from Mongolia. It may affect one in 400-1500 new born in the whole universe (Kazemi, Salehi, & Kheirollahi, 2016, p.126). As for Algeria, one out of 700 children is born with DS (Makhlof, Chedani, & Jewahra, 2019, p.110).

The normal people's cells contain forty- six (46) chromosomes; however, people with DS cells contain forty -seven (47) chromosomes. The French Jerome Lejeune and the American Patricia Jacobs were the first who identified the extra chromosome in 1959, and called it chromosome 21 (Kazemi et al. 2016, p.127).

Studies and researches in the medical field identified mainly three types of DS. The most common and widely spread type of DS accounting for 95% of cases is called Trisomy 21. It is caused by an error in cell division named "non-disjunction " that leads to an embryo with three copies of chromosome 21 instead of the usual two (ibid).

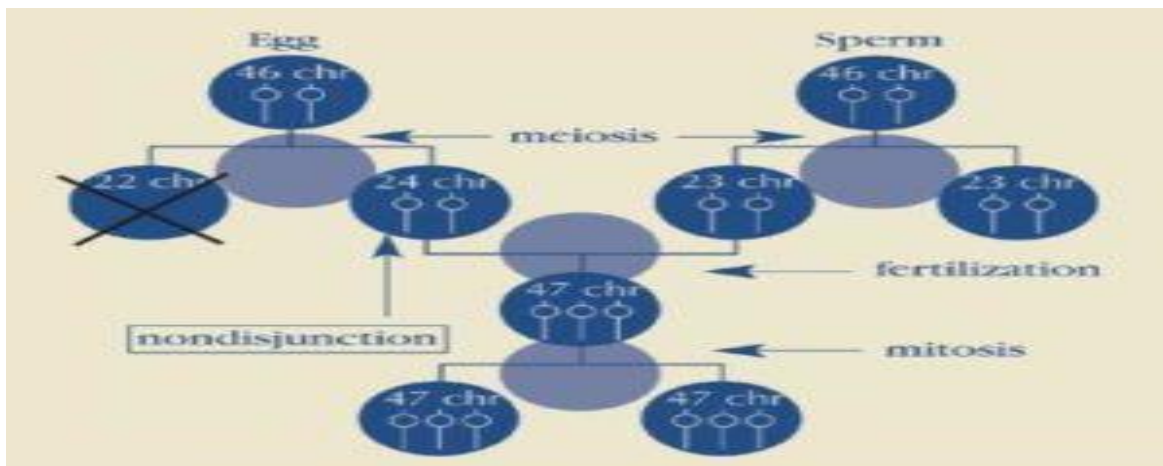


Figure 1.1 Trisomy 21, Adopted from Central Mississippi Down syndrome Society (CMDSS).

The second type was determined by Fracaro and Bolani (1960) in which they have found that it may affect 3 to 4 % of cases (Nmiri, 2011, p.58). It is called Translocation where part of chromosome 21 breaks off during cell division and attaches to another chromosome usually 14 or 15 (Kazemi et al. 2016, p.127). Mosaicism is the third type of DS affecting only 1% of cases. It is similar to Trisomy 21 in the sense that both are caused by abnormal cell division after fertilisation; however, in Mosaicism the third copy of chromosome 21 is present in some, but not all cells. (ibid)

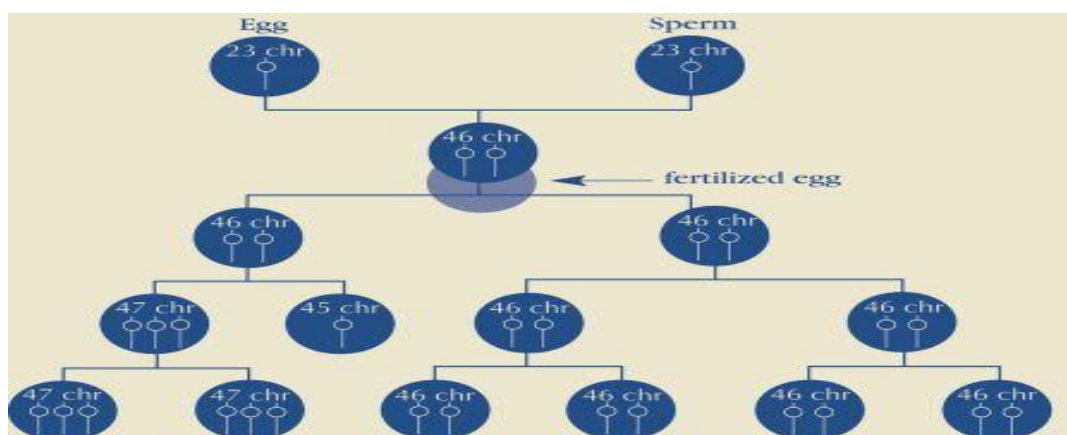


Figure 1.2. Mosaicism Adopted from CMDSS

According to National Down syndrome Society (NDSS) once a woman gives birth to a baby with DS, it is estimated that the risk of having a second child with DS is about 1 in 100. In addition, the age of the mother (more than thirty-five years old) can be a contributing factor in having a child with DS (n.d, p.05).

DS is the leading force behind intellectual disability, mental retardation, in addition to

being exposed to many health issues including Congenital Heart Diseases (CHD), Alzheimer, leukemia, cancers (Asim, Kumar, Muthuswamy, Jain, & Agarwal, 2015, p.01).

1.3 Diagnosis and Treatment of Down Syndrome

Detecting DS disease can be either during the pregnancy period, or after giving birth. One of the latest and most accurate innovations for detecting DS during pregnancy is called “Non-invasive prenatal testing NIPT ” which is a blood test of the pregnant woman to look at the DNA (Deoxyribonucleic acid) of the baby to figure out whether there is a chromosomal problem with the baby (Taylor, 2014). Diagnosing DS after giving birth is much easier with the help of appearance and the physical characteristics of the new born. In case the facial traits of the baby matches the one identified by doctors for children with DS, then a “Karyotype” procedure is carried which is a “visual display of the chromosomes grouped by number, size, and shape”(NDSS,n.d, p.02) to confirm the case.

There is no medical cure for DS; however, children who suffer from this disease are more in need to receive special education, assistance and care in schools in addition to benefiting from speech and physical therapy (Kazemi et al.2016, 130).

1.4 Down Syndrome Physical Phenotype

Identifying a person with DS is not a difficult task for people especially with the help of their physical characteristics and facial traits that they share in common. NDSS identified the most common traits of DS that characterise most of them with varying degrees; some of them have all the traits and the others might have only some

- Low muscle tone.
- Flattened facial profile, a somewhat depressed nasal bridge and small nose.
- Hyper- flexibility.
- A single deep crease across the center of the palm.
- A small skin folds on the inner corner of the eyes.
- Excessive space between the first and second toe.
- Large tongue in relation to the size of the mouth.
- Upward slanting eyes.
- A silky thick hair.
- Shortness.
- Curvature of the fifth finger caused by under development of the middle phalanx (bone).

- An abnormal shape of ear. (n.d, p.11)

1.5 Down Syndrome Behavioural Phenotype

Nyhan (1972) has introduced a description for the “behavioural phenotype” which is a set of external observable behaviour of children with genetic disorders that its presence caused a set of genetic conditions (as cited in Bhattacharyya, Sanyle, Roy & Saha, 2009, p. 63). DS is the most type of intellectual disability that has been researched among more than 1000 genetic disorders, one area of interest that caught scholars’ attention is the behavioural profile which is specific to DS individuals that has been described from different areas including cognitive, social-emotional and the linguistic one (its discussion in the following section). The studies conducted in these areas have helped in understanding both the weaknesses and strengths of this category of people (Fidler, Most & Philofsky, 2009, p. 38).

For DS individuals whom are not diagnosed with ASD, their social development is their strongest point (ibid), in the sense that they are perceived as “delightful”, “loving”, “ bright”, “sociable”, “funny” and “kind” (Down, 1866 as cited in Grieco, Pulsifer, Seligohn, Skotko & Schwartz, 2015, p. 140). This personality description is an outcome of what has been stated by Gibbs and Thorp as being “positive Down syndrome stereotype” (as cited in Bhattacharyya et al., 2009, p. 59).

There have been many studies conducted on the strongest points of DS individuals at the level of the behavioural phenotype. For instance, Freeman and Kasari (2002) have found that the majority of children with this disability have proved their possession of the greatest quality in peer-relationships, which is friendship (as cited in Fidler et al., 2009, p.38). However, a common difficulty for all individuals is in speech and language in which scholars have focused on deficits in the verbal memory, articulation and its outcomes on their expressive language (Paterson, 2001 as cited in Dix, 2016, p. 52). According to Wishart (2001), although DS children are well-known of their cheerful character, they can be stubborn, hyperactive, impulsive, trouble maker and hyper-sensitive during their childhood in addition to their laziness during tasks that require persistence refusing to put efforts in problem solving tasks (as cited in Dix, 2016, p. 52).

In conclusion, the social understanding and awareness are the powerful points of DS individuals, while their motivational deficits in addition to the obstacle of speech and language or the linguistic profile are the major challenges for this category of people.

1.5.1 Cognitive Phenotype

Generally speaking, cognition includes thinking skills and information processing, but according to Byrne et al. (2019) it is extended to cover “all activities and processes concerned with the acquisition, storage retrieved and processing of information regardless of whether these processes are explicit or conscious” (para 8). However, these processes can be damaged depending on individuals’ mental state, like the case of DS people. About 80% of individuals with DS have moderate intellectual disability, even though some have average range of IQ scores and others have severe intellectual disability (Roizen, 2007 as cited in Martin, Klusek, Estigarribia & Roberts, 2009, p. 114). The latter led to the appearance of strengths and weaknesses within the different cognitive domains, especially the executive functions (EF). It can be defined as a specific set of attention regulation skills including cognitive flexibility, working memory, inhibition in addition to the planning process (Alvarez & Emory, 2006; Blair & Diamond, 2008;). Older studies on EF have demonstrated that DS people have deficits on tasks of attention, perceptual speed, reaction time and motor control (Berkson, 1960 as cited in Grieco et al., 2015, p. 137).

First, the skill of cognitive flexibility is considered challenging for children and adults with DS, specifically on verbal-mediated tasks (Hippolyte, Iglesias & Barisnikov, 2009). As for the second skill of the working memory of DS which is known with its poor performance in comparison to normal individuals (Makenzie & Hulme, 1987 as cited in Broadley, MacDonald & Buckley, 1995, p. 4). According to Marcell and Armstrong (1982), people with DS have poor auditory memory compared with the visual one, in addition to their deficit in articulation namely, the weak verbal memory (ibid). Some examples are provided by Fidler and Daunhauer (2013) during their presentation to demonstrate the nature of DS persons’ working memory, like “ when given two things to do, remembers only the first or the last one, has a short attention span and forget what he/she is doing mid-task” (slide 30). The following cognitive process is inhibition where individuals with this disability faced a great difficulty on verbally mediated inhibition tasks , a lack of inhibit control (Munir et al. as cited in Grieco et al., 2015, p. 138). Finally, the central part in cognitive functioning, planning which means “generating appropriate steps needed to reach a goal” (Fidler & Daunhauer, 2013, slide 12). However, as Lanfranci (2010) have stated that the process of execution of such problem solving strategies to reach a goal is much hard for DS children to handle (ibid)

From what have been mentioned above; one might notice the different deficiencies that DS people may have concerning the different neuro-cognitive skills of shifting, working memory, inhibition and planning. However, their cognitive profile has strengths too such as

the strong receptive language they have. This cognitive phenotype is one component of the general behavioural profile of DS individuals.

1.5.2 Social-Emotional Phenotype

Unlike the cognitive functioning and development which showed significant weakness and impairment in individuals with DS, social functioning showed relative strength as Guralinck, Connor and Johnson (2011) have explained, “available evidences suggest that in comparison to many aspects of cognition and language the social development of children with Down syndrome appears to be relative strength ” (p.64).

In terms of socialisation, people with DS are characterised as highly sociable, engaging, and affectionate (Martin et al., 2009, p.03). They are very competent in forming interpersonal relationships like friends, and initiating interactions with others. They like approaching and integrating with adults, shaking hands with everyone they meet, and imitating others (Morssi 1999 as cited in Nmiri, 2011, p. 65). They have also been described as “charming, outgoing, cheerful, and happy ” (Fidler & Philofsky, 2005, p. 38).

Although most people with DS are described as sociable and pacific, some of them might be diagnosed with Autism which deprive them from integrating with people and forming relation, and may exhibit some stubbornness and aggressive behaviour (Shamari, 2007, p.24).

1.5.3 The Linguistic Phenotypes

For normal individuals, the complete expression of speech and language requires people’s desire to interact with one another, an appreciation of what is being understood by the participants and their reactions to what is being communicated. After the formulation of intent or a goal in communication, speech requires a mental representation of the message, next, a realisation of these messages into words and, finally, an articulation of the mental words as physical sounds. This long process results in the smallest aspects of language including phonetics and phonology; morphology and syntax; semantics and pragmatics. However, things are different for individuals with DS, in the sense that they possess a special characteristic profile of language and communicative strengths and weaknesses that can be analysed via the aforementioned interrelated systems of linguistic communication.

1.5.3.1 Phonology

Phonology refers to the study of how speech sounds form patterns and overlap with

phonetics which refers to the production and the articulation of speech sounds. However, this speech production has been noticed as a significant difficulty for DS individuals, as Down (1867) has stated “they are usually able to speak; the speech is thick and indistinct, but may be improved greatly by a well-directed scheme of tongue gymnastics” (260). The phonological impairment that DS individuals have can be seen in the errors they made during articulation in addition to the limited sounds they produce. The latter has been proved by Robert and colleagues (2005) that boys with DS produce fewer consonants correctly in comparison to their peers with other intellectual disabilities (as cited in Martin et al., 2009). Another point is their poor speech intelligibility due to many reasons like the omission of certain sound, and the physical properties DS people have such as: small oral cavity, large extended tongue, large tonsils and poor muscles tone (Chapmen, 1997 as cited in Dix, p.69)

1.5.3.2 Morphology

Morphology, the grammar of words, can be defined as the study of development and understanding of linguistic units, especially morphemes and how they are combined to form words. For DS case, the morphological impairments can be summarised in the way these individuals use morphemes with its two types the inflectional and bound morphemes. For instance, the use of cases and content words (such as, nouns and verbs) in addition to the lack of using function words like prepositions, conjunctions and personal pronouns (Diez-Itza & Marainda, 2007 as cited in Arias-Trejo & Barrón-Martínez, 2017, p. 3). Another study which is conducted by Lazaro, Garayzabal and Moraleada (2014) on DS children has examined the morphological skills of how to pluralise nouns, but these children had lower performance, which means they lack skills in this area (as cited in Arias-Trejo & Barrón-Martínez, 2017, p.6).

1.5.3.3 Syntax

Syntax, the grammar of sentences, studies how words are combined to form phrases, clauses and sentences. It is considered as a big obstacle for individuals with DS which was the concern of many scholars. For example, Price and colleagues (2007) have pointed out that a group of boys with DS scored lower on syntax, especially the active and passive voice, direct and indirect speech than their peers with similar mental age (as cited in Martin et al., 2009, pp. 5-6). Another example to illustrate the problems that DS individuals face at the syntactic level would be the common committed errors in gender, number and tense agreement (Arias-Trejo & Barrón-Martínez, 2017, p. 3).

1.5.3.4 Semantics

Semantics is the study of the relationship between words and their meanings. Putting aside individuals' variability, it is an area of deficit for DS individuals, in the sense that they face great difficulties with regard to language comprehension. As Chapman, Hesketh and Kistler (2002) have said that this process of comprehension may grow weaker as these individuals turn to adults (as cited in Andreou & Katsaron, 2016, p. 60). Moreover, recent study done by Nash and Smouling (2008) on semantic capacities of people with DS has shown that children face difficulties in generating many words out of the different parts of speech, especially verbs (ibid). So, it is clear that the area of semantics is a region of deficit for DS people.

1.5.3.5 Pragmatics

Pragmatics is the study of how language is used in its social context that is to say, language in use. It is considered as an area of strengths in children with DS in comparison to other genetic disorders (Roberts, Price & Malkin, 2007). For example, due to the long period of time DS children have spent using gestures as a way of communication, they can interpret the non-verbal gestures addressed to them and react accordingly (Kumin, 1996 as cited in Compton, 2013, p. 13). In addition, they use different types of sentences such as imperatives, declaratives and interrogatives which are types of illocutionary acts during their speech (Randal, 1993 as cited in Tsakiridou, 2006, p. 02). However, they have many deficits at the level of this area as Martin et al (2009). have stated that “challenges may include imitation and elaboration of topics, initiation of communicative repairs and some linguistic aspects of narratives” (p. 7). In summary, young individuals with DS own a complex profile of strengths and weaknesses in the sub-field of linguistics, pragmatics.

1.6 The Integration of Children with Disabilities within Centres

Each and every individual has the right to be fully integrated within his/her environment. The latter is supported by the publications of reports from UNESCO which supported the right of people with special needs to take an active role in society. As a result, many countries around the world have promoted the inclusion of this category in social life specifically centres to cater the leaning of children with disabilities. For instance, in Uganda several laws and acts were made, such documents include Constitution of Republic of Uganda (1995) and the person with disability act (2006). In the U.S the rights of persons with disabilities are reserved in legislation like Education for all Handicapped Children Act, 1975;

Individuals with Disabilities Education Act, 1990. (as cited in Adie, 2018). As far as the Algerian context is concerned, a law has been enacted following the publication of UNESCO as Berkail and Ben Mustepha (2018) have said:

حقق المعاقون أهم مكاسبهم التشريعية بعد نضال طويل من خلال صدور القانون رقم 09/02 المؤرخ في 05/08/2002 المتعلق بحماية المعاقين وترقيتهم [1]، الذي كان تجسيداً لنص الإعلان الذي أقرته الجمعية العامة للأمم المتحدة في 19/12/1975 حول حماية المعاقين،

[People with disabilities have achieved their most important legislative gains after a long struggle through the promulgation of Law No. 02/09 of 08/05/2002 on the protection and promotion of the Disabled (1)], which was the embodiment of the text of the Declaration adopted by the United Nations General Assembly on 19/12/1975 on the Protection of Disabled Persons (our translation)].

In the same line of work, it has been stated that a lot of special educational institutions for children with different types of disabilities were built, in which Berkail and Ben Mustepha (2018) have stated that:

في سنة 2010 أكثر من 441 مركز يهتم بتأهيل مختلف أصناف الإعاقات إضافة إلى المدارس الخاصة بتربية وتعليم المعاقين والمقدرة 146 مدرسة، منها 93 لتعليم المعاقين ذهنيا و 23 مدرسة لتعليم الصم والبكم و 21 مدرسة للمكفوفين.

[In 2010, more than 441 centres for the rehabilitation of various types of disabilities, as well as special schools for the education of disabled persons, 146 schools, including 93 for the education of the mentally handicapped, 23 schools for the education of deaf mute, and 21 schools for the blind (our translation)].

The Ministry of Education have made efforts concerning the integration of children with special needs, especially the deaf-mute individuals, in which they have built specific classrooms at the level of centres all around the country. The latter was confirmed via the joint ministerial decree issued in 2014. 13th March:

تطبيقاً للقرار الوزاري المشترك المؤرخ في 10 ديسمبر 1998، المتعلق بفتح الأقسام الخاصة للأطفال ذوي الإعاقات الحسية الخفيفة (ضعيفي السمع والمكفوفين) في المؤسسات التعليمية التابعة لقطاع التربية الوطنية وضعت الدولة الجزائرية عدة صيغ لضمان التمدرس بالأطفال ذوي الاحتياجات الخاصة و هذا حسب طبيعة إعاقاتهم و درجاتها حيث يتم التكفل بهم في مؤسسات متخصصة تابعة لوزارة التضامن والأسرة وقضايا المرأة.

[In accordance with the Joint Ministerial decision of 10 December 1998, concerning the opening of special sections for children with minor sensory disabilities (hearing impaired and blind) in educational institutions of the national education sector, Algeria has developed several formulas to ensure that children with special needs

are studied according to the nature and degrees of their disability they are provided in specialised institutions held by the ministry of solidarity, family and women's issues. (Our translation)]

Accordingly, this law that has been enacted for the sake of children with disabilities, in fact has neglected other types of impairments, such as cognitive and intellectual disabilities. However, the efforts of integrating the other types of disabilities that was done either fully or partially should never be forgotten. For instance, in Algeria DS category has received much support by the ministry via devoting private and public centres to reinforce and cater the learning abilities of individuals who suffer from this anomaly.

1.6 Conclusion

To sum up, this chapter provides background information about disability in general and DS disorder in particular. The detailed description provided about DS aetiology, treatment and the behavioural phenotype have clearly proved the special condition these people have, thus having a special care and treatment in each stage during their lifespan, especially education. In this respect, Algeria has put much effort to provide a suitable leaning atmosphere for DS children by building many centres all over the country to work on their deficits and improve their strengths for the sake of taking a part within society in the future. The next chapter, we try to give a detailed explanation of patronising communication during both intergenerational and inter-ability encounters, taking CAT as a foundation stone to explain this phenomenon.

Chapter Two:

Conceptual Frameworks and Theoretical Perspectives on Patronisation

2.1 Introduction.....	21
2.2. Conceptual Framework.....	21
2.3 Speech Accommodation Theory (SAT).....	21
2.3.1. Speech Accommodation Theory (SAT)'s ideas origins.....	22
2.3.1.1 Similarity Attraction Theory	22
2.3.1.2 Social Identity Theory (SIT)	23
2.3.1.3. Self Categorisation Theory (SCT).....	25
2.3.1.4 Attribution Theory.....	27
2.4. Communication Accommodation Theory (CAT).....	27
2.5. Communication Accommodation Theory Development	29
2.5.1. Foundational phase (1969).....	29
2.5.2. Intergroup/Contextual Phase (1977)	30
2.5.3. Subjective Phase (1982).....	30
2.5.4. The Fourth Phase (1986).....	30
2.5.5. Communicative Breadth Phase (1988)	30
2.5.6. Mediating Mechanism Phase (2006)	31
2.6. Accommodative Strategies	31
2.6.1. Convergence.....	31
2.6.2. Divergence	33
2.6.3. Maintenance	34
2.7. Non-accommodation.....	35
2.8. Patronisation	37
2.8.1 Patronising Speech in Intergenerational Communication.....	39
2.8.1 Communication Predicament of Aging (CPA)	41
2.8.3 Communication Enhancement Model.....	43
2.9. Inter-ability Communication.....	43
2.9.1. Patronising Speech toward People with Physical Disabilities	44
2.9.2. Patronising Speech toward People with Cognitive Disability	46
2.9.3.-Patronising Speech toward People with Down syndrome	47
2.10. Conclusion	48

2.1 Introduction

Communication takes place all the time, in different forms (verbal or nonverbal), in a variety of contexts, and it is up to interactants to decide which interactive mode or style to adopt influenced by their understanding of individuals' needs and styles of communication, stereotypical images they shape about their interlocutors, and the socio-historical context of the interaction. Due to the various communicative styles used by interactants, Communication Accommodation Theory (CAT) has emerged in the early 1976 "to explore the different ways in which we accommodate our communication, our motives for doing so, and the consequences" (Giles & Ogay 2007, as cited in Bomfiglo, 2013, p.05). Since its emergence, CAT was implied as a framework to study communication between different social groups in different contexts such as intercultural communication, intergeneration communication, inter-ability communication namely, communication between non-disabled people and disabled people where people adjust their communicative behaviour to a one that differs notably from inter-ability communication and tend to adopt a patronising communicative style with those who are labeled as disabled physically or cognitively. Thus, this chapter will be dedicated to the theoretical perspectives on patronising communication that is cited in literature, and making sense of all the conceptual frameworks related to the study. Furthermore, it provides a clear picture on the basis or the framework that guides this study which is CAT theory.

2.2 Conceptual Framework

In this part, we will focus mainly on the different concepts that are strongly related to the current study including, Speech Accommodation Theory (SAT), CAT, divergence, maintenance, over-accommodation, and particularly patronising speech where it is used in both intergenerational and inter-ability communication. In doing so, we will consider our context where patronising communication is addressed towards people with cognitive disabilities in general and people with DS disability in particular. In addition to unveiling the different verbal and nonverbal features that are present during this process of accommodation. Consequently, this stage will bridge the gap between both the theoretical and the practical parts.

2.3 Speech Accommodation Theory (SAT)

During the 1970s, SAT emerged to analyse the language behaviour and the linguistic features that characterise people's speech during a social encounter. SAT developed mainly by

Chapter Two Conceptual Frameworks and Theoretical Perspectives on Patronisation

the socio-psychologists Giles, Tylor, and Bourhis to “Explore the socio-psychological parameters underlying the moves speakers make in their speech behaviour ” (Galloise, Ogay & Giles, 2005, p.07). It focused mainly on the accommodative strategies of convergence, divergence, and maintenance from both the production and reception side that is to say what are the motives behind the speakers' use of these strategies and how the listeners perceive and evaluate them.

SAT explained the occurrence of convergence strategy during social encounters from the framework of Similarity Attraction Theory that is to say, we converge to look similar to our interlocutor and thus gaining approval, and explained both divergence and maintenance from SIT perspective in other words, we diverge to disassociate self from other and maintain both social and personal identity. Furthermore, other theories including Attribution Theory and Self-categorising Theory (SCT) were integrated in SAT elucidation of speech shifting occurrence.

SAT assumes that interactants make certain adjustments in their linguistic behaviour known as accommodation, and that accommodation is a fundamental process in any human interaction. These adjustments can be reflected in the speech of the speakers through the use of accommodative strategies

2.4 Speech Accommodation Theory (SAT)’s Ideas Origins

SAT was set to examine the motives behind people’s style shifting on the production side, in addition to how the different accommodative strategies are being evaluated from the reception side (Galloise, Ogay, & Giles, 2006). SAT relied on the following theories to explain logically the aforementioned goals and they are Similarity Attraction Theory (1971), SIT (1979), SCT, and Attribution Theory (1958; 1973).

2.4.1 Similarity Attraction Theory

This theory has provided a predictive framework to examine how and why people are attracted to one another influenced by their surroundings in their social context. The most studied form of attraction by Similarity Attraction theory is the similarity of individuals’ attitudes; in this regard Berscheid and Walster (1983) concluded that “ people are attracted to those who share their attitudes”(as cited in Sunnafrank, 1991,pp,451-452).

A large body of literature has investigated the role that similarity of attitudes play in interaction; we consider two major explanations which have been suggested in this regard.

Chapter Two Conceptual Frameworks and Theoretical Perspectives on Patronisation

First the Newcomb view to balance which is derived from Hieder (1958) perspective that assumes that people prefer to balance between attitudes and perceptions towards peoples' attitudes about the same object and their attraction towards these people. For this process to succeed, the aforementioned objects must be both crucial and mutually relevant to the participants in such interaction. Consequently, the similarity in attitudes is strongly associated with interaction when relationships develop (as cited in Sunnafrank, 1991, pp. 453-454). Second, Byrne (1971) explanation that was formulated after a great number of studies conducted about similarity attraction in social interactions. The results have shown that people react positively with those who share the same attitudes to their own, in the sense that they are viewed as individuals who possess positive qualities (as cited in Broome, 1983, p.138).

In the view of the above state of affairs, one might say that this theory suggests that the more our beliefs and attitudes are alike to those around us, the more likely it is for us to be attracted to them. However, one should note that in some situations dissimilarity is the key success to a better understanding of human liking.

SAT was in part derived from Similarity Attraction Theory, which posits that “an increase in interpersonal similarity results in an increase in interpersonal attraction” (Gallois et al., 2005, p.123). In other terms, the idea held by this theory was given a different name by Giles and his colleagues as being convergence as a strategy adopted by people to sound more similar to others.

2.4.2 Social Identity Theory (SIT)

SIT is a social psychological theory that was first introduced by Tajfel in 1978 and later by both Tajfel and Turner in 1979 to explain, “What occurs when individuals socially categorize themselves and other individuals into social groups ” (Tajfel, 1974, as cited in Morris, 2007, p.05).

SIT as a whole is based on four main principles that were outlined by Tajfel. The first principle is named social categorisation which allows people to categorise themselves and others into groups in this regard Tajfel and Turner (1979) have said "social categorization is conceived as cognitive tools that segment, classify, and order the social environment ” (as cited in Trept, 2002, p.257). People generally categorise themselves as in-group, "a collective of similar persons all of whom identify with each other, see themselves and each other in similar ways and hold similar view, all in contrast to members of out-group ”(Stets & Bunk,

Chapter Two Conceptual Frameworks and Theoretical Perspectives on Patronisation

2000,p.13), and categorise others as out-group.

In-group and out-group belongingness is not only a matter of sharing or differing in nationality, culture, or ethnicity, but it extends to encompass other categories since people belong to a complex society which allows a multiplicity of choices (Holliday, Hyde, & Kullman, 2004, p.49). They could define themselves as members of age group, religion, a school class, or a football team group. This categorisation of groups is used to stereotype people in out-group as being different and separate them from ones in-group (Morris, 2007, p.05). This group categorisation leads to specific adjustments and shifts in one's communicative behaviour during interaction triggered by stereotypes associated with certain or other groups. Taking the example of age group accommodation an adult may accommodate his speech to a more childish and a simplified one when interacting with a child due to his perception of the child as being needy and incompetent.

The second principle of SIT is the social comparison where we evaluate and compare our group with other groups to "get an idea of the superiority or inferiority of our group " (Trept, 2006, p.258). We see our groups in comparison to others to get a clear view of it and define its place and position.

The third principle is the social identity which is the person's knowledge of his/her membership to a particular social group or category that is to say he/she defines him/herself as a member of a particular group and be part of it (in-group). An individual's social identity may be demonstrated through his/her linguistic and non-linguistic behaviour.

The last principle is self-esteem which goes hand in hand with the positive evaluation of the person's group as Turner, Brown, and Tajfel explained "the need for a positive self-esteem is satisfied by the positive evaluation of one's group " (as cited in Trept, 2006, p. 259) that is to say self-worth and value enhance as long as our group gains positive distinctiveness when compared with other groups. This positive distinctiveness is achieved through the in-group and out-group competition to reach a positive social identity.

The in-group and out-group competition to gain a positive evaluation and thus maintain a positive identity may result in-group bias, in this regard Tajfel and Turner (1979) used "A Minimal Group Paradigm " to test people bias to their in-group. They chose the participants randomly and based on no specific criteria, and then they divided them into two groups and asked them to allocate points for any group. The results showed that each member of the group gave more points to his or her group, and biased in favour of their groups.

Chapter Two Conceptual Frameworks and Theoretical Perspectives on Patronisation

SIT has been integrated into so many studies including intercultural and cross-cultural communication, interethnic and intergroup communication to explain the occurrence of accommodation during interactions. It views accommodation as "a result of intergroup process wherein communicators do not interact based on individual, personal identities [...], but, rather, based on their membership in and affiliation with assorted social categories (Giles, 2016, p.123). In addition, SIT was adopted as a framework for interability interaction in the sense that "disability is an identity that is most easily activated in encounters involving an individual with a disability, which leads to an intergroup orientation toward the interaction" (Palomares, Giles, Solize, & Galloise, 2016, p.138). Saying that the interaction drift to an intergroup orientation means communication is influenced by the social identity of the interactants and group membership, that is to say, people with no disability identify themselves within the category of normal people (in-group), and identify people with disabilities within the category of disabled people and thus being the out-group.

2.4.3 Self-Categorisation Theory (SCT)

SCT as the second component of Social Identity approach was elaborated after the death of Tadjfel, in 1982, by Turner and colleagues in which they aimed to shift from the intergroup focus to the intra-group one. This elaboration was clearly explained in the book entitled *Rediscovering the Social Group: a Self Categorising Theory* (1987). They have relied on the concept of categorising process that was crucial to SIT. The development of the SCT can be summarised into three main steps. First, the distinction between both personal and social identities in which both form what is called the self-concept. This difference is mentioned by Tajfel and Wilkers (1963) in the sense that personal identity is the set of attitudes, memories, emotions and behaviours that comprise a part of people's self-concept and that differentiate them from others, while social identity is a set of individuals' features of the self-image which are derived from their belongings to a specific social category (as cited in Hornsey, 2008, p.206). The second step is the elaboration of the personal- social identity distinction to levels of categorisation; these levels of abstraction are clearly stated by Turner and Oakes (1986):

In the social self-concept, there are three important levels of abstraction: self-categorization as a human being (the super-ordinate category) based on the differentiation between species, in-group out-group categorizations (the self as a social category) based on the differentiation between groups of people (class, race, nationality, occupation, etc.) and personal self categorizations (the subordinate

Chapter Two Conceptual Frameworks and Theoretical Perspectives on Patronisation

level) based on the differentiation between oneself as a unique individual and other (relevant) in-group members. (p.241)

Accordingly, the concept of identity is characterised as being dynamic and operates at different levels of inclusiveness depending on salience which has been defined by Turner and Reynolds (2012) as being “a function of an interaction between the perceiver's readiness to use a self-category in a given instance and the fit of that self-category to the apprehended stimulus reality” (p.08). This means that salience is activated whenever there is an interaction between people, but it is context-bound.

The final step is the detailed understanding of self-concept alongside with stereotyping; how in-group members build preconceived attitudes towards themselves and others who belong to the out-group, as Turner (1999) has proposed that individuals stereotype out-groups as being the other and increasing their intra-group similarities by stereotyping their own in groups to look more similar than they are. (as cited in Morris, 2007, p.09). Thus, creating one of the fundamental ideas of SCT known as depersonalisation of the self, which is not a loss of identity but rather a change from personal to the social level of identity (Turner, 1987). The latter has created the notion us vs. them and the creation of in-group biases. This is why SCT was chosen as a framework to study inter-ability communication in the sense that when individuals without disabilities categorise individuals with cognitive disabilities into one out-group, the individuals with cognitive disabilities lose their diverse characteristics (Morris, 2007, p. 10).

Tajfel (1969) has claimed that self-categories are constructed based on the accentuation of the perceived similarities between the self and other in-group members, and the accentuation of perceived differences between distinct social groups(as cited in Turner, & Oakes,1986,p.241). The latter has been stated by SCT that the social categories are formed based on perceived similarities among the members of the in-group, and the disparities between the self and the out-group members.

From what has been mentioned above; the reason why SAT relied on SCT besides SIT as a foundation stone is to understand the motives behind both divergence and maintenance. People strive to maintain their positive social identity by increasing social distance with others. In this respect, Gallois et al., (2005) have stated: "SIT explains the adoption of these strategies through the desire to signal a salient group distinctiveness so as to reinforce a social identity" (p.08).

2.4.4 Attribution Theory

Attribution theory can be traced back to the publication of the book entitled *The Psychology of Interpersonal Relations* (Heider,1958) where the author dealt with how one person thinks, perceives, and feels about the other part during interpersonal relation or encounter, and how s/he reacts to the other part's behaviour and interprets it.

Heider believes that we see people with their psychological processes such as needs, intentions and that these psychological processes cannot be measured by a ruler or weighed by a scale, but they are mentalist concepts that are mediated and observed by others (1958,p.10).

According to Attribution Theory, our psychological state can be reflected in a variety of ways which allows people to grasp it and ascribe it to a particular reason "one might say psychological processes such as motives, intentions, sentiments are the core process which manifests themselves in overt behaviour and expression in many variable ways " (Heider, 1958, p.15).

Attribution Theory penetrated many fields especially the psychological ones and laid the foundation for the conduction of many studies. A vivid example is CAT theory where attribution theory was adopted to explain and analyse how are accommodative strategies perceived and evaluated by interlocutors (the reception side), and what are the internal causes and intentions (Psychological reasons) that lead the speaker to adopt a particular communicative behaviour. Moreover, the theory attempted to elucidate what does a particular communicative behaviour tells about the speaker "perceptions and evaluations of behaviours are theorized to result in attributions about the speakers (e.g. politeness, competence, empathy, and the speaker's group "(Giles,2016,p.29).

2.5 Communication Accommodation Theory (CAT)

CAT as being the latest presentation of the SAT has highlighted how much the vision of the theory has been widened over the years; this development is exemplified via the shift from "Speech" to "Communication Accommodation Theory". In this respect, Gallois et al., (2005) have said that this remarkable change is marked with the notion of CAT to cover the entire process of communication, and not just the linguistic behaviours" (as cited in Bonfiglio,2013,p.04). In this respect Giles, Coupland and Coupland (1991) have argued that "the focus has broadened from exploring specific linguistic variables to encompass nonverbal

Chapter Two Conceptual Frameworks and Theoretical Perspectives on Patronisation

and discursive dimensions of social interaction; hence the wider notion of CAT (communication accommodation theory)” (p.07).

This significant development of CAT was a result of the integration of four theories that are mentioned previously including Similarity Attraction Theory, SIT, SCT and Attribution Theory for the sake of explaining the factors that influence communicators' interactions. As a result, the theory implication has expanded to prove that communication can take place in many intergroup contexts. In other terms, CAT has been chosen as a foundation stone for many scopes, Giles (2016) has mentioned that “satellite models [of CAT] in other intergroup contexts emerged, such as language contact between speakers of different age groups; people with different physical abilities; the genders miscommunication in the workplace and police-civilian interactions" (p.04). In other terms, these theoretical explanations of the different types of interaction among different social groups were to understand it when it happened at the intergroup level and not the interpersonal one.

However, as Giles and Ogay (2007) have said that the most studied context by CAT is the intercultural one (p.300). In this respect, there have been multiple studies to illustrate the importance of this context, for example, the work of Bouhris (1984) which discussed the use of the different accommodative strategies in Canadian intergroup context. He has asked the Francophone and Anglophone Canadians in Montreal about directions. Similar work has been conducted in Tunisia by Lawson and Sachdev (2000), following the same procedures of the previous study the results have shown that even though Tunisians converge most of the time to the researcher language, they diverge when addressed in French. This strategy was adopted by them to signal their group distinctiveness from the colonisers. (ibid)

According to Giles and Ogay (2007, p.294), there are four principles that were adopted by CAT (see the figure below):

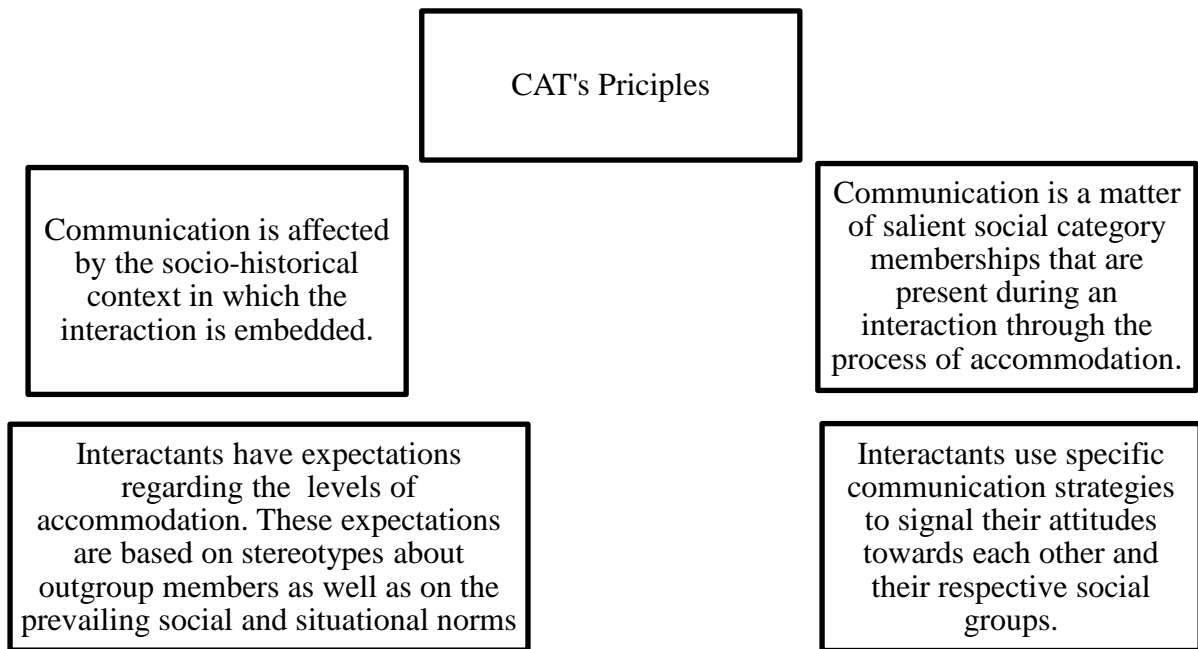


Figure2.1. CAT’s Principles

From what has been mentioned above; one can assume the intention behind opting for CAT as a foundation stone for our study which can be summarised into two main points. First, the remarkable shift of SAT which focuses on the verbal form of speech to CAT which covers the verbal, non-verbal and paralinguistic features of individuals 'communicative features. Second, it has become an interdisciplinary scope of interest in the sense that it has been applied to study communication within different social contexts (culture, genders, generations and abilities). Thus the latest version of SAT proves to be the right option to take to achieve one scope of interest of the present study.

2.6 Communication Accommodation Theory Development

“Theories are not only about life, they also have their own lives ” (Gallois, et al., 2006, p.04). Like any other theory, CAT underwent many stages, phases, and refinements to finally reach what is widely known as CAT. In this regard, Giles (2016) identified a conceptual map of CAT history and development that included the following phases:

2.6.1 Foundational Phase (1969)

This phase witnessed the birth of speech accommodation theory when Giles started noticing not only himself, but also people around him shifting their dialects, and bilinguals switching their languages continuously. Giles noticed that his Cardiff accent changes constantly to a more Standard English when interacting with his peers at college which grew

Chapter Two Conceptual Frameworks and Theoretical Perspectives on Patronisation

his enthusiasm to wonder why and what are the reasons behind this shift. Giles found in the work of Labov (1966) an inspiring source to begin his journey of inquiry since Labov tackled style shifting from a colloquial to a more prestigious one by New York citizens influenced by the formality and informality of context. However, Giles reinterpreted this kind of style-shifting in terms of interpersonal influence between speakers instead of context. Giles (1991) argued, "The presumed role of formality- informality of context, and the criterion of attention to a speech that was seminally associated with the prestigiousness of speech styles by Labov could be reinterpreted, at least in part, as having been mediated by interpersonal accommodation processes " (p.05). In addition, Giles first years of research included issues like accent and speech convergence, speech accommodation, and explained them in interpersonal interaction that is people interact as individuals with no awareness of social categories (Hornsey, 2008, p .206).

2.6.2 Intergroup/Contextual Phase (1977)

While the first phase focused on interpersonal interaction, this phase put much emphasis on intergroup interaction where people relate entirely as representative of their groups (ibid). It analysed the linguistic moves such as divergence and non-accommodation strategies that the speakers make as forms of social differentiation between them, drawing on SIT (Giles, 2016, p.04).

2.6.3 Subjective Phase (1982)

In this phase, explanations of accommodation and non-accommodation strategies was based and influenced by stereotypes conceived about interlocutors, "the prime insight here was that speakers accommodate not to where others are in any objectively measurable sense, but rather, to where they are believed or biasedly heard " (Thakerer, Giles, & Cheshire, 1982 as cited in Giles, 2016, p.04).

2.6.4 The Fourth Phase (1986)

This phase witnessed studies on intergenerational communication in other terms, communication between young and elder people where young people tend to over accommodate elder one through the use of a speech style known as patronising speech. It also witnessed the emergence of the communicative predicament of ageing modal by Ryan 1986.

2.6.5 Communicative Breadth Phase (1988)

It is called the blossom phase because it knew an extension from the analyses of

Chapter Two Conceptual Frameworks and Theoretical Perspectives on Patronisation

accommodation in speech only to encompass the whole communication process including the non-verbal practices such as dress style and body language.

2.6.6 Mediating Mechanism Phase (2006)

In this phase, the theory shed the light on “how accommodation could trigger various emotions like irritation, pride, and joy which then dictate particular evaluative and behavioural reaction from others” (Dorjee, Giles, & Barker, 2011 as cited in Giles, 2016, p.06). It focused mainly on the reception side and the attributive motives for accommodation.

2.7 Accommodative Strategies

During social encounters people may adjust their adopted speech to either gain interlocutors’ approval or to distinct themselves from others; however, sometimes they stick to their style without any modifications made. In fact, these communicative strategies are the core of SAT in which they are labelled as being accommodative strategies including convergence, divergence/maintenance.

2.7.1 Convergence

Because SAT has witnessed huge changes, concepts, such as convergence has been developed during this process. According to Giles (1973) “if a sender in a dyadic situation wishes to gain the receiver’s approval, then he may adapt his accent patterns towards that of this person that is to say reducing pronunciation dissimilarities” (as cited in Trudgill, 1987, p. 02). In other words, convergence definition was only limited to the linguistic features of interaction since it was labelled as being 'accent convergence', therefore emphasise the interlocutors' speech as a whole and their accent in particular. After the shift from SAT to CAT, the definition of convergence has widened to cover the linguistic, paralinguistic and the non-verbal features of communication, as Giles et al., (1991) have defined this concept as being “a strategy whereby individuals adapt to each other's communicative behaviour in terms of a wide range of linguistic-prosodic-nonverbal features including speech rate, pausal phenomena and utterance length, phonological variants, smiling, gaze, and so on" (p.07). The latter was accompanied by a detailed table to illustrate how convergence can take both the verbal and nonverbal forms (see the table below):

Features converged	Selected sources
Utterance length	Matarazzo et al. (1968)
Speech rate	Street (1983)
Information density	Aronsson et al. (1987)
Vocal intensity	Natale (1975a)
Pausing frequencies and lengths	Jaffe and Feldstein (1970)
Response latency	Cappella and Planalp (1981)
Self-disclosure	Ehrlich and Graeven (1971)
Jokes, expressing solidarity-opinions orientations	Bales (1950)
Gesture	Mauer and Tindall (1983)
Head nodding and facial affect	Hale and Burgoon (1984)
Posture	Condon and Ogston (1967)

Table 2.1. Convergent Features and Selected Source

Convergence has been most of the time used to reflect individual’s or group’s need for social approval, in this respect Butler and Aune (1992) have suggested that communicators alter their communicative behaviour to be similar to those they interact with (as cited in Bonfiglio,2013,p.7). Following the same path, Soliz and Giles (2014) have clearly stated that “convergence is understood as a strategy aimed at becoming similar to interlocutors, for the purpose of approval, affiliation, and the reduction of social distance” (as cited in Bielenia-Grajewska, 2015, p.5). In other words, what urge communicators to use convergence is to minimise the social distance with others by fostering the similarities. However, the most important motive is the cognitive Function of convergence which is to facilitate comprehension. The latter is clearly stated by Bielenia-Grajewska (2015) as “consciously and subconsciously people imitate interlocutors since similarities in verbal and nonverbal behaviour stimulate effective communication” (p.03).

Convergence maybe either upward or downward, in which Giles et al., (1991) have defined them in which former refers to a shift toward a more prestigious variety and the latter refers to accommodating toward more stigmatised or less standard forms in context, for instance, adopting the prestigious dialect of an interviewer is an example of upward

Chapter Two Conceptual Frameworks and Theoretical Perspectives on Patronisation

convergence and shifting to street language in certain minority communities is an example of downward convergence.

According to Bourhis, Giles, and Lambert (1975), convergence is evaluated positively by the recipients (as cited in Giles & Ogay, 2007, p.297). However, Simard, Taylor, and Giles (1976) have proposed three crucial factors that play a role in deciding the ultimate evaluation including the other's language competence, the effort he or she made, and the external pressures pushing the speaker to act in a particular way.

2.7.2 Divergence

During the interaction, one speaker may alter or shift his/her speech away from his/her communicator displaying instances of divergence. Giles (2016) has claimed that divergence occurs when adjusting one's communicative behaviour to be more dissimilar to the listener (p.37) to emphasis differences and distinctiveness between self and other. Divergence may include alternation in the linguistic behaviour of the speaker such as speech rate or code choice, or non-linguistic behaviour like the way of dressing, gestures, etc. that contrast with the listener.

The speaker adopts a divergent communicative behaviour for either a cognitive or an affective motive. The cognitive motive for divergence is to facilitate comprehension and enhance communication efficiency as Street and Giles (1982) have explained, "Comprehension can also be facilitated through divergent shifts " (as cited in Giles, 2016, p.43); however, the affective motive is to show dislike and disinterest to the speaker, in addition to displaying national, cultural, and group differences and distinctiveness, thus reinforcing one's own personal and social identity, "divergence can be a tactic of intergroup distinctiveness of individuals in search of a positive social identity "(Giles et al., 1991,p.23).

Divergence might take different forms with varying degrees; it can be upward/downward or full/partial divergence. Upward divergence occurs when speakers shift toward a prestigious or standard variety while downward divergence takes place when shifting toward a stigmatised and less prestigious variety. Full divergence happens when the speaker adopts completely different communicative behaviour from the interlocutor; however, partial divergence presents instances like code switching from few words, but not fully shifting away from your interlocutor.

Most of the time Recipients evaluate divergence negatively and less favourable in the sense that it is a non-cooperative strategy that is used by speakers who refuse to integrate

Chapter Two Conceptual Frameworks and Theoretical Perspectives on Patronisation

with their interlocutors and prefer to disassociate themselves from them to indicate social distance. However, Giles (2016) argued that the accommodation strategies be it convergence, divergence, or maintenance are evaluated based on the attributions recipients make about these strategies that is to say the motives that they think gave raise to it(p.50).

2.7.3 Maintenance

While interactants are provided with the option of either converging to their interlocutors' communicative behaviour or diverging from them they may also choose to persist their original style regardless of the style of their interlocutor (Gasiore & Giles, 2012, as cited in Bonfiglo, 2013, p.07). Maintenance is strongly related to divergence since both of them are used for reinforcing one's social and personal identity and evaluated negatively by the recipients.

From what has been said before, one can deduce that speakers are provided with multiple options and strategies when interacting with each other; they can converge, diverge, or even maintain their communicative behaviour for different functions that are summarised by Giles, Scherer , and Taylor (1979) (as cited in Galloise et al., 2005, p.126). See the figures below:

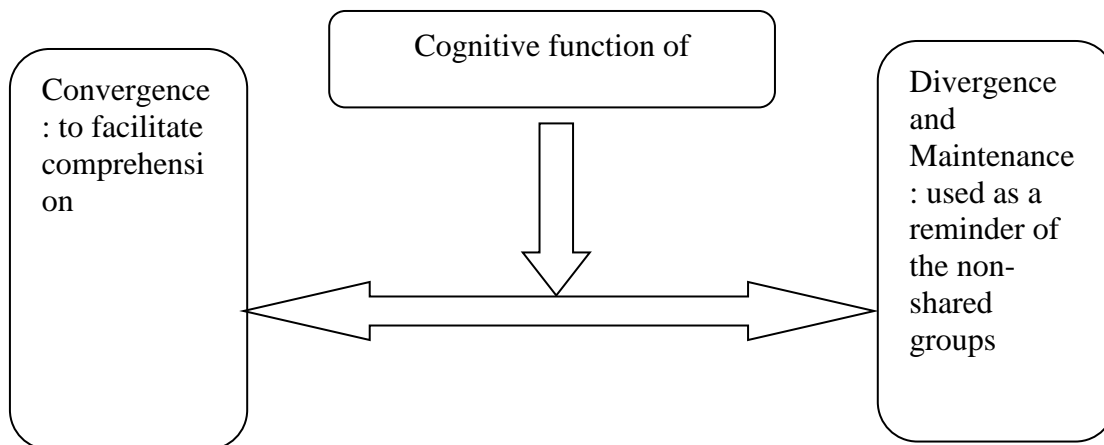


Figure 2.2 Cognitive Function of Convergence, Divergence/Maintenance

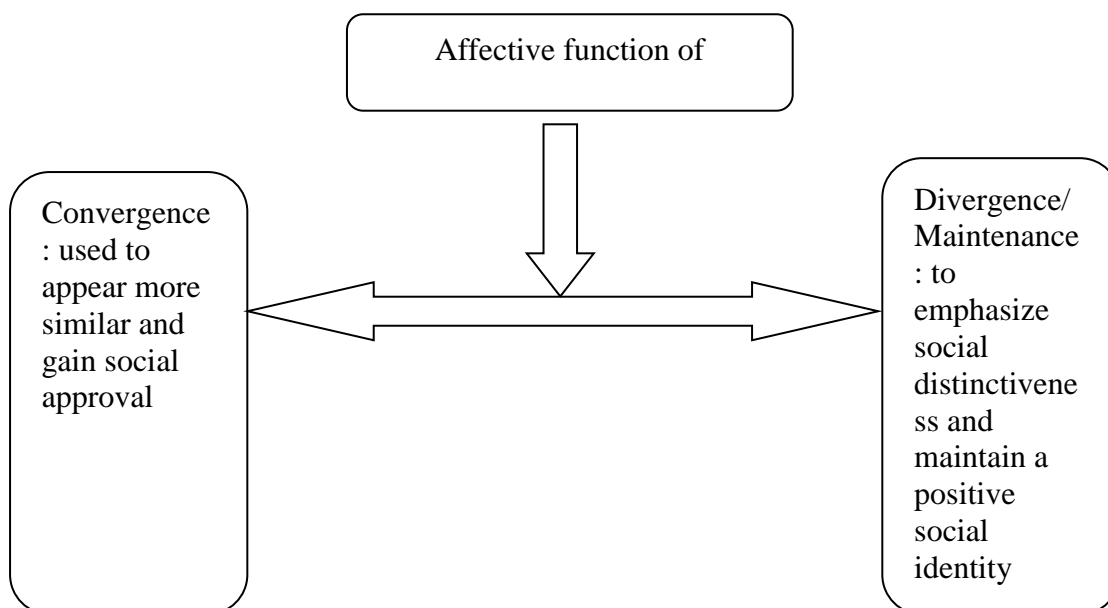


Figure 2.3 Affective Function of Convergence, Divergence/Maintenance

2.8 Non-accommodation

Generally speaking, the process of accommodation or non-accommodation may be present in any conversation depending on the participants' perceptions of the adjustments made. If these modifications are perceived as being positive and appropriate, then one can assume that accommodation has happened. If not, then non-accommodation has happened (Giles & Gasoirek, 2014). The latter means that non-accommodation occurs whenever the

Chapter Two Conceptual Frameworks and Theoretical Perspectives on Patronisation

interlocutors inappropriately move towards the needs of their partner, however during this process they may use different strategies. According to Giles, accommodation includes strategies of non-accommodation such as under-accommodation and over-accommodation. (Gallois et al., 2005)

First, according to Giles and Powesland (1975), under-accommodation happens when interlocutors maintain or accentuate differences either verbally or nonverbally with insufficient movements towards the communicative needs of others. (As cited in Ishak & Rafik-Galea, 2015) Accordingly, this strategy can be seen as an extension of maintenance in the sense that individuals refrain themselves from modifying their communicative style despite other's behaviour and needs.

Second, over-accommodation which has been defined by Coupland, Coupland, Giles and Henwood (1988) as being “the perception that a speaker is exceeding or overshooting the level of a given behaviour necessary for a successful interaction” (p.7), the sender is extending the needed accommodation in such situations. What one should note is the considerable scholarly attention given to this strategy, in which it has been defined by Griffin (2012) as patronising talk, the result of the oversimplification of the message and its content. It can lead to the support of negative stereotypes and minimising the interactions between communicators or even whole groups (as cited in Fisk & Vaarala, 2017). This new vision of the concept of over-accommodation has led to the notion of patronising speech that is used to explain many types of communication, such as intergenerational and interability communication.

Gasoirek and Giles (2014) have mentioned that both aforementioned strategies are subjective phenomena because they rely on the recipient's interpretations and perceptions of interlocutors' behaviours and not objective qualities of the behaviour itself. In other words, they both focus on the perceived motives and their own decisions regarding people and not the behaviour performed by them verbally or nonverbally.

From what has been mentioned above; it seems that these non-accommodative strategies are used in different situations depending on the senders' evaluation of the recipients' verbal and non-verbal behaviours, which is why they are considered to be subjective rather than objective. However, what is important in our study is the concept of over-accommodation, patronising speech, which will be discussed in the upcoming paragraph.

2.9 Patronisation

Giles and Gasoirek (2011) have pointed out that in communication accommodation framework, patronising speech is known as over-accommodation (as cited in Cavallaro, Seilhamer, Chee & Chin, 2016, p.02). Thus, the notion of over-accommodation is synonymously used with patronising speech in addition to other concepts and a variety of definitions has been provided by different scholars including; Ashburn and Gorden (1981), Caporeal, Lukaszewski, and Culbertson (1983), Harwood, Giles, Fox, Ryan and Williams (1993), Ryan, Hummert, and Boich (1995) and Grainger (1993, 1995). First, Ashburn and Gorden (1981) have defined patronising speech as a simplified speech in terms of the number of imperatives and interrogatives, repetition, speech rate, complexity, length of utterance and pronominal substitution(as cited in La Tourette,1999, p.11), in which they have labelled it as baby talk. In the same vein, Copereal et al. (1983) have given another notion which is secondary baby talk as a speech characterised with an exaggerated intonation and a higher pitch of voice. Harwood et al. (1993) have defined it as "inappropriate modifications based on stereotypes of incompetence and dependence" (p.212). In this view, Ryan et al. (1995) have used the patronising speech to describe speech addressed to older adults based on stereotyped expectations (as cited in Ryan, Shumovich, Kennaley & Pratt, 2000, p. 273)

However, to Grainger (1993, 1995) patronising verbal behaviour should not be seen as a “distinct category of speech style, but rather as a communicative style that is used depending on characteristics of the situation, the participants and the environment” (as cited in Thimm, Rademacher & Kruse, 1998, p.79)

From what has been stated above; it is clear that all definitions have focused superficially on interlocutors' verbal and nonverbal behaviours without digging deeper, except for Ryan et al. (1995, p.154) who have provided a detailed verbal, nonverbal and paralinguistic features of patronising communication as the following table indicates :

Chapter Two Conceptual Frameworks and Theoretical Perspectives on Patronisation

Verbal	Non-verbal
<p>A. Vocabulary</p> <p>Simple</p> <p>Few multisyllabic words</p> <p>Childish terms</p> <p>Minimizing words (e.g. just, little, short)</p> <p>Pronoun modifications (e.g. over inclusive we, exclusive we, avoidance of me/you in favour of name substitutions)</p> <p>B. Grammar</p> <p>Simple clauses and sentences</p> <p>Repetitions</p> <p>Tag questions</p> <p>Imperatives</p> <p>Fillers</p> <p>Fragments</p> <p>C. Forms of address</p> <p>First names and nicknames</p> <p>Terms of endearment (e.g. sweetie, dear, honey)</p> <p>child-like terms (e.g. good girl, naughty boy, cute little man) Third-person reference</p> <p>D. Topic Management</p> <p>Limited topic selection and topic reinforcement (e.g. focus on past, shallow, task oriented, or overly personal/intimate)</p> <p>Interruptions dismissive of other-generated topics, exaggerated praise for minor accomplishments</p>	<p>A. Voice</p> <p>High pitch</p> <p>Exaggerated intonation</p> <p>Loud</p> <p>Slow</p> <p>Exaggerated pronunciation</p> <p>B. Gaze</p> <p>Low eye contact</p> <p>Staring</p> <p>Roll eyes</p> <p>Wink</p> <p>C. Proxemics</p> <p>Stand too close</p> <p>Stand over a person seated or in bed</p> <p>Stand too far off</p> <p>D. Facial expression</p> <p>Frown</p> <p>Exaggerated smile</p> <p>Raised eyebrows</p> <p>E. Gestures</p> <p>Shake head</p> <p>Shrug shoulders</p> <p>Hands on hips</p> <p>Cross arms</p> <p>Abrupt movements</p> <p>F. Touch</p> <p>Pat on head</p> <p>Pat on hand, arm, shoulder</p>

Table 2.2 The Features of Patronising Communication

In the view of the above state of affairs, one might say that over-accommodation or patronisation can be used and defined differently according to the aims and the objectives of the research, sometimes it is strongly linked to the notion of stereotype, and in other cases, it

Chapter Two Conceptual Frameworks and Theoretical Perspectives on Patronisation

is just a style used to refer to adjustments made depending on context and its elements including the participants. Consequently, giving an exact definition for the term patronisation is difficult due to its relative nature.

2.10 Patronising Speech in Intergenerational Communication

A considerable amount of literature has been conducted on intergenerational communication i.e. communication between young and elderly adults (Ryan & Bourhis 1991; Ryan, Hummert & Boich 1995; Harwood, Ryan, Giles, & Tysoski 1997; Thimm, Rademacher, & Kruse 1998; Bugental 2012; Lowery 2013; Cavallaro et al., 2016) in different contexts (in a normal setting like community or institutional settings like healthcare institutions) to explore how this type of communication is characterised, what might hinder its effectiveness, how do different generations feel when coming into contact with each other, and how do they evaluate each other's communicative behaviour.

CAT theory made a significant contribution to intergenerational communication studies serving as a helpful framework and a fertile soil for conducting such studies. According to CAT theory younger adults adjust their communicative behaviour when initiating a conversation with elderly adults resulting in an over-accommodation talk, elder speak, baby talk, or patronising speech.

Ryan, Giles, Bartolucci and Henwood (1986) proposed four types of accommodation strategies in young old talk. The first strategy is called over-accommodation that takes place when the young adults notice a physical handicap or impairment in the elderly adult such as hearing impairment which urges the young speaker to make certain adjustments in his speech. This strategy is characterised by an exaggerated carefulness to one's speech and the use of baby talk that resembles speech used with children as Caporal (1986) has explained that "There is no evidence that baby talk to children and baby talk to elderly adults are para-linguistically distinguishable(as cited in Cavallaro et al., 2016, p.02).

The second strategy is dependency-related over- accommodation which involves the use of patronising speech especially by care providers in institutional settings with elderly residents assuming that old people are dependent, weak, and cannot take care of themselves.

Intergroup over-accommodation, on the other hand, involves an adjustment in young adults speech based on group categorisation (being elderly), and triggered by certain stereotypes about elderly such as being incompetent, needy, slow moving and thinking, fragile, and rambling of speech (Hummert ,Garaska, Shaner & Strahn,1994, p.147).The last

Chapter Two Conceptual Frameworks and Theoretical Perspectives on Patronisation

strategy is known as age-related divergence which is mainly used by younger adults to disassociate themselves from the elderly interlocutors by speaking young like using fast speech and discussing youth topics (Ryan & Bourhis, 1991, p.443).

Intergenerational communication is generally affected by the stereotypes and the wrong perceptions that young adults hold about the elderly one which drift the speech to a more patronising one. Patronising speech directed to elderly is characterised by simplified grammar and vocabulary, variable speaking pitch, louder talk, and the use of endearment terms like honey and sweetie (Harwood, Ryan, Giles, & Tysosky, 1997, p.171).

Patronising speech is produced from a well-intentioned meaning and for a cognitive function like facilitating comprehension and improving communication efficiency as Ryan et al. (1997) argued " in a certain context, the speech adaptation associated with patronising style may be functional and correctly attuned to the needs of the recipients "(p.171); however, Kuper and Harden (1999) claimed that it does not help improve comprehension and cause communication problems, and it may hinder the communication itself (as cited in Lowery, 2013, p.08). In addition, it might be evaluated negatively by elderly recipients.

The evaluation of patronising speech earned the lion portion in intergenerational communication studies. Ryan and Giles (1991) conducted a study in this regard and found that participants rated the young patroniser as less respectful, less nurturing, and the patronisee as being frustrated which reinforces the idea that over-accommodation has negative consequences on the recipients such as becoming more isolated and avoid interactions with younger adults (Ryan et al. 1986, as cited in Lowery, 2013, p.08). However, the evaluation of the patronising speech directed to elderly adults depends on the subjective interpretation of the recipients and the context. For example, patronising speech and over-accommodation are evaluated positively and more acceptable by elderly in healthcare institutions and faculties than in normal context as Meeks (2000) explained, " institutionalized elderly responding more favourably to over-accommodation than their community dwelling counterparts "(as cited in Cavallaro et al., 2016, p.03)

Responses to a patronising speech by the elderly have also grasped researchers' intention in intergenerational communication. Harwood, et al. (1997) conducted a study to measure an elderly adult (75 years old) response to a patronising speech directed to him by a bystander in an auto accident setting. The researchers used a written vignette with related questions to collect data about how participants perceive the responses of the elderly to the

Chapter Two Conceptual Frameworks and Theoretical Perspectives on Patronisation

patronising speech used with him. Participants rated the old men who responded assertively as non-competent, but less benevolent and less respectful than the nonassertive or neutral responder. Moreover, a non-relevant response i.e. neglecting the patronising speech was perceived by participants as less competent than the assertive response. A more recent study by Pierquet (2006) dealt with the same issue; however, this time the elderly people were participants themselves. They reported that they ignored the patronising speech most of the time which allows the continuity of using it by younger adults and that they felt worthless and disrespected.

While most studies put only the elderly adults on the spot neglecting the other part (the younger adults) and their feeling when involving in intergenerational encounters, McCann, Cargile, Giles, and Bui (2004) shed the light on this issue when investigated how young adults felt when initiating in intergenerational communication compared with intergenerational one to put it differently, communication between people from the same generation. Participants reported that they felt more obliged to be respectful and avoidant and that their interaction with the elderly was more problematic and pleasing than with the same age interaction.

Further researches and studies can be conducted in intergenerational communication and the use of patronising speech from different perspectives and insights taking into consideration the gender of the interactants, distance and kinship, frequency of the interaction (how often does the interaction take place).

2.10.1 Communication Predicament of Aging (CPA)

Old people, who are repeatedly experiencing demeaning communication because of their age are subjected to negative communication patterns that have a huge impact on them, either positively or negatively. Scholars working on CAT framework have suggested that older adults have always faced a communication predicament, especially in intergenerational encounters, as Ryan, Meredith, MacLean, and Orange (1995) have defined this predicament as an extra obstacle made by interlocutors that must be overcome by older adults(as cited in Draper, 2005,p.276)

Ryan, Giles, Bartolucci and Henwood (1986) have suggested a framework to study both the emergence and the effects of this negative communication, in which they have labelled it as being the Communication Predicament of Aging (CPA) (as cited in Ryan, et al., 2000, p. 272). This model suggests that individuals often modify their speech based on their

Chapter Two Conceptual Frameworks and Theoretical Perspectives on Patronisation

perceived stereotypes of ageing, resulting in over-accommodation or patronisation toward them. In other terms, as Shadden and Toner (2011) have claimed that the adjustments happened during conversational encounters are due to interlocutors' perceptions of elders and not their actual capacities (as cited in Lowery, 2013,p. 4)

In CPA model the features of ageing, such as physical appearance, slow movements, and voice quality provide cues that create a mental representation in younger adults' minds often called ageing stereotypes. Consequently, they made modifications in their speech known as elderspeak, which means the role of stereotype is the production of patronising speech, as Hummert and Shaner (1994) have shown that ageing stereotype that is activated by younger adults determines the extent to which a patronised message is produced by them (as cited in Harwood et al.,1997,p. 271)

However, these negative stereotypes have a negative impact on both communication and identity, which has been conceptualised by Ryan et al. (1986) within the CPA model as it is shown in the following model that has explained how elders respond cooperatively or assertively depending on their evaluation of the speech style:

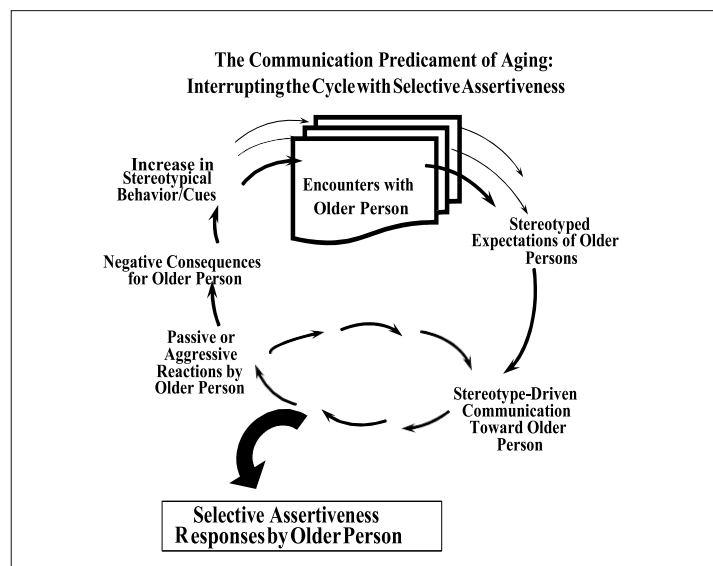


Figure 2.4 Communication Predicament of Aging Modal

These responses as stated by Harwood, Giles, Fox, Ryan and Williams (1993) in their elaboration of the model that the cooperative response has led to the reinforcement of age stereotype resulting in an unsuccessful communication. Conversely, the assertive response that showed rejection of such communicative behaviours may lead to effective

Chapter Two Conceptual Frameworks and Theoretical Perspectives on Patronisation

communication (as cited in La Tourette, 1999, p. 4)

From the above state of affairs; one might say that CPA model has come to explain two points that can be summarised as follow. First, the difficulties that elders faced in conversations with older adults due to the negative stereotype held about them resulting in patronisation or elder speak. Second, the cooperative and the assertive responses of older adults due to the over-accommodative behaviour addressed to them during intergenerational encounters.

2.10.2 Communication Enhancement Model

While communication predicament of ageing focused on stereotypes as the major force behind adapting certain communicative behaviour by younger adults when interacting with elderly adults, communication enhancement model depends on the assessment of the needs of the elderly adults in terms of competency, physical or cognitive impairment to adopt the appropriate adjustment by health providers when involving in intergenerational interactions. This model endeavours to promote and improve the communication efficiency which guarantees the well-being and satisfaction of both parts involved in the communication process. According to this model, health providers should undergo certain training and practices to be acquainted with the styles of communications that suits their interlocutors and do not demean, underestimate or affect their self-esteem in any sense.

2.11 Inter-ability Communication

There have been many approaches provided to explain and understand inter-ability communication. However, the most recent one among them is the intergroup perspective to inter-ability situations, where theories like SIT (Tajfel 1978) and CAT (Giles, Mulac, Brade & Jhonson 1987) were highlighted (Makkawy, 2016, p.17). Following Tajfel's claim (1978) that interpersonal interactions can turn out to be intergroup ones. The same goes for interability encounters due to the salience of disability, as Strena and Kleck (1985) have claimed that there is a huge impact on social interactions between people with disabilities and people without disabilities appeared due to that salience (as cited in Fan Lung, 2007, p.8). Thus, Fox and Giles (1996a) have given a name to the process that involves communication between able-bodied individuals and people with disabilities, as being inter-ability communication.

Another crucial factor that may influence and mediate the communicative patterns

Chapter Two Conceptual Frameworks and Theoretical Perspectives on Patronisation

during inter-ability encounters is the attitudes held towards disability, which is discussed in most of the studies conducted in this area of research (Braithwaite in press as cited in Fox & Giles, 1996a, p.222). It has been found by Wright (1989) that people with disabilities are often viewed negatively by those without disabilities, describing them as being socially introverted, defensive and easily excluded from the society (ibid). In the same vein, Fitchen, Robillard, Judd and Amsel (1989) have made a comparison between able-bodied college students and their disabled peers. The results have shown that the attitudes held toward students with disability were indeed negative, in which they believed that they were more socially anxious and were likely to date a disabled partner. As for Morris (2005) who has stated that people with disability are considered to be dependent and heteronomous individuals. Emry and Wiseman (1987) have linked these negative attitudes and the concept of stereotype, saying that this latter is a form of these beliefs held toward disability (as cited in Fox & Giles, 1995a).

However, it has been proved by some scholars that people with disability may be viewed positively and that people without a disability can have lower levels of prejudice, as Yazbeck, McVilly and Permenter (2004) have found that highly educated people and those who are in continuous contact with people with intellectual disabilities tend to have more positive attitudes towards them. In another study where a sample of high school pupils was chosen has found that children with an orthopaedic disability were surprisingly rated higher than their counterparts without disability (de Approcada, Waston, Mueller & Isaacson-Kulles, 1985, as cited in Fox & Giles, 1996a, p.222).

From what has been mentioned above; one might say during inter-ability encounters, attitudes held towards disability can be either positive or negative. Although these attitudes are positive, there might be a difference between a disabled person's perception of positivity and the way it is perceived by an individual without disability. For instance, a person without disability conceptualised positive attitudes as being nice or helpful; however, it can be perceived by a disabled individual as being patronisation and prefer to avoid the disability category entirely (Makas, Finnerty-Fried, Sugafoss & Rees, 1988, as cited in Yazbeck, et al., 2004, p.03).

2.11.1 Patronising Speech toward People with Physical Disabilities

According to Hammert (1994), individuals with obvious physical and mental disabilities are more likely to receive patronising talk (as cited in Williams, Kenper &

Chapter Two Conceptual Frameworks and Theoretical Perspectives on Patronisation

Hammert, 2005, p.01). This patronisation which was mainly studied within intergenerational settings has been labelled by Fox (1995) as the most dominant communicative feature in inter-ability situations (as cited in Lung, 2007, p.9). However, there have been few studies that tackled patronising speech in inter-ability situations either towards people with physical or cognitive disabilities, as Fox and Giles (1996a) have stated "little is known about the communicative behaviour occurring in inter-ability situations" (p.225). Consequently, most studies addressed people with physical disabilities were conducted on attitudes held toward them and how people without disabilities address them differently due to their perceived negative stereotypes.

Fitchen and Bourdon's (1986) study has pointed out that there was inappropriate communicative behaviour occurred during inter-ability encounters known as patronisation, as the following example has indicated " by asking the wheelchair user to do an unnecessary task to make him or her feel useful in a group insisting that socialisation is good for the wheelchair user"(p.330). In another work, Fox and Giles (1996b) research participants have commented "the only time she was addressed was when she was one of the people in wheelchair", "she did not seem to address her as a normal person", and "the waitress's comment generalized the disabled", which means that they have believed that stereotype held toward this category is the foundation for in inter-ability communication. Fox and Giles (1996a) have listed the three forms of patronising speech:

- a) baby talk, such as "poor little dear" or "honey" spoken in a condescending tone;
- b) depersonalizing language, such as "it's nice that you people get out of the house";
- and (c) third-party talk, where a nondisabled person directs communication not at the person with a disability, but at a non-disabled person who is with them, for example, "Does he take cream in his coffee?" (p. 267).

Accordingly, these aforementioned forms can only be addressed towards people with physical disabilities in which they were stated to give an overview of the participants' evaluations of patronising speech addressed toward this category of people.

In the same line of work, they have used two written vignettes one is patronising, while the other is not in addition to a questionnaire to answer questions about "rating the perceived feelings, personality, motivation, and future behaviour of interactants" (p.272). The results have revealed that patronising speech has an impact on the rating of feelings and personality of interlocutors, i.e. it can cause changes on how people feel and act.

Even though this study has added insights into the field of inter-ability communication,

Chapter Two Conceptual Frameworks and Theoretical Perspectives on Patronisation

its concern was only for physical disabilities. This missing gap was later studied by Lung (2007) in which he has said "not much of the studies are on the basis of [...] types of disability of persons with disabilities"(p.12). He has conducted a study which consists of two parts: the first study aimed at examining the relationship between types of disability and the stereotypes of communicative competence. The research tool adopted was a survey addressed to sixty-two people at the campus of City University of Hong Kong to know the rating of nine types of disabilities that differ in three dimensions including the cognitive orientation, visibility and context-specificity. The results have shown that each type of disability has a specific rate of communicative competence which is different from others. The second study objective was to test if the perception of patronising speech can be affected by changes in stereotypical communicative competence towards people with disabilities. His sample was a group of forty students of City University put under experimental condition (public relations vs. Computer science) to evaluate the patronising speech. The results have revealed that accommodation can happen in the form of perceptive of a third party.

From the above discussion; one should note that the previous studies done on inter-ability communication were only limited to attitudes besides the non-verbal features of patronising speech, leaving an inadequate explanation for patronising speech including its: verbal, non-verbal and paralinguistic features.

2.11.2 Patronising Speech toward People with Cognitive Disability

While patronising speech in intergenerational communication earned the lion portion of literature and grasped the intention of many researchers, patronising speech in inter-ability communication did not. There are only two published works concerning patronising speech in inter-ability contexts. Fox and Giles conducted the first study in 1996 to explore the evaluation of patronising speech directed to people with physical disabilities, and Morris (2007) has tackled the same topic but with people with cognitive disabilities. Since then, there are no other studies concerning the topic.

Morris's study sought to examine the perception and evaluation of nondisabled people concerning the use of patronising speech with people with cognitive disabilities. Adapting written vignettes accompanied by a detailed questionnaire as tools for conducting data, the participants were asked to read one of the two vignettes. Both vignettes contained a verbal interaction between a cashier in a grocery store with no disability and a customer who was described as having a cognitive disability; however, one of the vignettes contained a

Chapter Two Conceptual Frameworks and Theoretical Perspectives on Patronisation

patronising speech toward the customer and the other one contained a neutral speech.

Participants of the study were asked to rate the verbal interaction in both cases, to describe the feeling of the cashier and the customer in both cases, and whether or not they would have spoken differently than the cashier did. The results showed that the participants evaluated the patronising speech as being less professional, appropriate, and common than the non-patronising speech. They rated the cashier as feeling warmer, supportive, and nurturing when using a patronising speech and the customer as feeling less respected. In addition, most participants reported that they would have spoken differently than the cashier when used a patronising speech.

Although the study is considered as the first tackling patronising speech with people with cognitive disabilities and serves as a basis upon which other studies can build up their researches, it still contains certain gaps that were not covered in the study. First, the study did not identify what kind of a cognitive disability the customer is suffering from. Second, the study focused on the verbal features only neglecting the non-verbal features of patronising speech. In addition, further studies should include the patroniser or the patronisee as participants in the study to gather more reliable data about their feelings and perceptions about patronising speech.

2.11.3 Patronising Speech towards People with Down Syndrome

Though there are many influential works conducted on patronising speech during inter-ability encounters, there are few published works that tackled this phenomenon taking into account the following points. First, the specificity and uniqueness of each type of disability that requires distinct communicative behaviours and a specific treatment, i.e. avoiding generalisation which is labelled under the title “people with cognitive disabilities” instead of choosing one kind of disability, such as DS. Thus, the study might end up with a set of features of patronisation that can be addressed only to one particular anomaly. Second, covering the whole definition of CAT perspective of patronising speech addressed towards disabled people and not just the part that deals with the perception and evaluation of nondisabled individuals concerning the use of this specialised speech.

Our topic, indeed, has covered these gaps in which we have chosen one specific disability which is DS opting for CAT framework to unveil the verbal and nonverbal patronising features since this approach covers the whole process of communication and not just the linguistic behaviour. Moreover, taking into account the second part of CAT definition

Chapter Two Conceptual Frameworks and Theoretical Perspectives on Patronisation

that was set to examine people's motives behind this style shifting and its possible effect on the reception side.

2.12 Conclusion

Throughout this chapter, we tried to study the phenomenon of patronising communication from different angles; mainly the inter-group perspective using both SIT and SCT and from CAT perspective referring to the different accommodative and non-accommodative strategies including convergence, divergence, maintenance and over-accommodation which is synonymously used with patronising speech. Furthermore, we tried to shed light on the previous studies conducted in this arena of research. First, how patronising speech in intergenerational communication is strongly linked to perceived negative stereotypes held towards older adults and its impact on them. Second, patronising speech in inter-ability communication that has a small amount of literature devoted only to the relationship between the types of disability whether physical or cognitive and non-disabled people's attitudes towards it, putting aside the analysis of the speech occurred during these encounters. In the next chapter, we will focus on the practical side of the research, in which we will discuss the methodology followed to conduct such study referring to our population, the sample selected and the tools used to obtain valid data accompanied with an objective analysis of the results found.

Chapter Three:

Data Collection, Findings and Discussion

3.1 Introduction.....	50
3.2 Methodology.....	50
3.3 The Population.....	51
3.4 The Sample.....	51
3.5The Research Instruments.....	51
3.6 Piloting Stage.....	52
3.7 The Description of the Questionnaire.....	52
3.8 Description of the Interview.....	53
3.9 Analysis of Carers' Questionnaire.....	53
3.9.1 Carers' Personal Information.....	53
3.9.2 Carers' Attitudes toward Down syndrome Individuals.....	54
3.9.3 Carers' Verbal Communicative Behaviour.....	58
3.9.4 Carers' Nonverbal Communicative Behaviour.....	66
3.9.5 The Impact of Carers' Communicative Behaviour on DS Pupils.....	70
3.10 Analysis of Clinical Psychologists' Interviews.....	73
3.10.1Clinical Psychologists' Professional Data.....	74
3.10.2 Clinical Psychologists' Attitudes and Communicative Behaviour Addressed toward Down syndrome Category and its Impact on them.....	75
3.11 Discussion of Findings.....	78
3.12 Conclusion.....	81
General Conclusion.....	82
Bibliography.....	84
Appendices.....	92

3.1 Introduction

In the previous chapter, we intended to provide in-depth insights about the different possible situations where patronising speech might occur during both intergenerational and inter-ability encounters that have been analysed from an inter-group perspective taking CAT as a foundation stone for this analysis. However, the current chapter is devoted for the practical part of our investigation attempting to explain the research methodology; the sample selected the research type, approaches and instruments used for gathering data. Finally, it gives an objective analysis and interpretation of the major results to answer our research questions and to confirm or refute the hypotheses being formulated.

3.2 Methodology

Any research inquiry depends on certain data to reach the ultimate goal of either confirming or disconfirming the hypotheses that have been already formulated, thus the researcher is provided with either the qualitative approach of gathering data, the quantitative, or the mixed method approach to select the one that best serves his/her objectives. Creswell (2014) has stated that the qualitative approach of gathering data is an approach “for exploring and understanding the meaning individuals or groups ascribe to a social or human problem. Data is gathered in the participants’ setting then analysed through making interpretation of the meaning of the data ” (Para 03). The quantitative approach on the other hand is used for “ testing objective theories by examining the relationship among variables these variables can be measured on instruments so that numbered data can be analysed using statistical procedures ” (Creswell, 2014, Para 04).

However, our research opts for the mixed method approach which allows us to diverse the type of data gathered (both quantitative and qualitative data) to provide adequate and reliable information to best describe the phenomena under investigation. The mixed method approach as Creswell (2014) put it “ is an approach to inquiry involving collecting both quantitative and qualitative data, integrating the two forms of data [...] to provide a more complete understanding of research problem than either approach alone ” (Para 05). In addition, the research is purely descriptive trying to objectively describe the communicative behaviours of carers inside centre when interacting with people with DS, According to Kothari and Garg (2019) “the main characteristics of it is that the researcher [...] can only report what has happened or what is happening ” (p.20).

3.3 The Population

Since we are conducting our study inside centres for mentally disabled people in Tiaret, we must first give a brief description of the chosen centre in Tiaret City centre as being our case study. The Psycho-pedagogical Centre of Children with Special Needs which accepts under its surveillance 78 children from six to 18 years of age who possess a disability of various degrees (from mild to moderate) as well as those diagnosed with DS. It has a pedagogical department where there is a specialised team of clinical psychologists, carers, educators and one speech therapist.

3.4 The sample

There are mainly two types of sample designs which are non-probability and probability sampling; however, according to what has been mentioned by Kothari and Garg (2019) the second type proves to be the best technique for the selection of a representative sample due to one major reason “random sampling ensures the law of Statistical Regularity which states that if on an average the sample chosen is a random one, the sample will have the same composition and characteristics as the universe.” (p.60). Consequently, we have chosen our participants randomly so this sample that contains 20 specialised educators and three clinical psychologists can be a best version of the whole population which is the pedagogical team that works inside the centre. However, due to covid-19 pandemic and the lockdown of all public and private institutions, participants’ number decreased to only 23 who accept to take a part in our study. In other terms, this unpredictable situation affects in a way or another, the type of sampling chosen during this research.

3.5 The Research Instruments

It is known that opting for specific instruments is not done randomly but it is based on several factors including the study objectives, time and the population size in order to achieve adequate and accurate data collection phase. Therefore, our study is based on two main methods including a questionnaire and an interview. Our aim behind this selection is to unveil the different patronising features addressed towards DS children, besides shedding light on the driving force behind care givers’ communicative behaviours and its effects on this category.

The first instrument, the questionnaire as being the most common tool used among researcher was administered to specialised educators (carers) inside centres for people with

special needs. Our sample consisted of 20 carers in which they work in the centre located in Tiaret Road of Bouchekif. However, the second tool i.e. the interview was directed to three clinical psychologists selected randomly to collect more detailed information and not just superficial knowledge, as Kothari and Garg (2019) have stated that “the chief merits of the interview method are: more information and that too in greater depth can be obtained [...], the interviewer may catch the information off guard and thus having spontaneous reactions [...]” (p.99).

3.6 Piloting Stage

Before handing the questionnaire to the chosen sample population, it is advisable to conduct a piloting study to test if there are some ambiguities to be clarified; some items must be deleted or reformulated. In other terms, spotting weaknesses and thus preparing the final draft to be handed to the respondents. In this respect Kothari and Garg (2019) have said that “the pilot survey is in fact the replica and rehearsal of the main survey [...] it brings to light weaknesses (if any) of the Questionnaire and also of the survey techniques” (p.101).

Therefore, we have decided to conduct a pilot study via handing six copies to teachers and specialised educators to test the methodology adopted and the wording of the questions whether they are clear or not. Hence, based on their feedback some questions were amended while others were completely omitted. Since the first draft contains a lot of open-ended questions, we have reformulated them to multiple choice questions and we have deleted one section. Consequently, this stage proves to be helpful and useful to design a final draft with clear questions and multiple options.

3.7 The Description of the Questionnaire

This method of data collection is widely used among researchers in which it consists of set of questions addressed to a specific sample population. This selection is due to different reasons, most importantly for the freedom it gives to respondents and the time given for them to reflect on their ideas in addition to revealing statistical facts of the data collected.

It is administered to 20 specialised educators who work inside the Psycho-pedagogical Centre for Children with Special Needs. It is made up of 30 questions, with 29 close-ended questions where respondents are required to answer by “yes” or “no” or either choosing the appropriate box from set of options, and one open-ended question. The questionnaire was translated to Arabic since our informants were not familiar with the English language. The

questions were classified into five sections as follow:

Section one (QQ 1) dealt with carers' personal information and involved only the working experience.

Section two (QQ 2-7) this section had to do with carers' attitudes towards pupils diagnosed with DS

Section three (QQ 8-18) this section highlighted the carers' verbal communicative behaviour towards DS pupils inside centres.

Section four (QQ 19-25) this section shed the light on the carers' nonverbal communicative behaviour towards pupils with DS inside centres.

Section five (QQ 26-30) this section dealt with the impact of carers' communicative behaviours on DS pupils.

3.8 Description of the Interview

The interview is the most well-known and widely implemented tool for gathering qualitative data and exploring others' views, perspectives, stands. It can be structured, semi-structured, or unstructured, face to face or telephonic. For our research, we opt for the semi-structured type of the interview to better gain insights and elaborations about our research topic and to reach answers for our research questions in much more details. The semi-structured interview allows the researcher to pursue the questions in a flexible way and to involve from time to time supportive tools to further elicit ideas and probe for clarifications; it also allows you to rephrase or reword your questions in a way that suits the situation and not to respect the order of the few determined questions in your schedule. Our interview was set up with three clinical psychologists using the telephone as a helpful tool due to the pandemic situation which made it impossible to meet them. All the participants were asked seven predetermined questions (**see appendix 3**) in addition to some alternations and probe questions for each. Each question of the interview aimed at answering inquiries that correlate to our research topic.

3.9 Analysis of Carers' Questionnaire

This part deals with the graphical presentation of data collected from the first research tool, the questionnaire.

3.9.1 Carers' Personal Information

This section deals with the background information of our respondents

QQ1: Working Experience



Graph 3.1 Carers' Working Experience

It has been observed from Graph 3.1 that our respondents are divided into three groups in terms of their working experience. The first group represents the least experienced one with 60 % (4 males and 8 females), while the second group of 4 females corresponds to 20% work between 5 to 10 years. The last group that gathered the most experienced carers represents 4 females with 20 percentages. However, none of them achieves more than 15 years in his/her career. From what has been mentioned, one can deduce that our sample lacks experience which might affect the quality of data collected.

3.9.2 Carers' Attitudes towards Down syndrome Individuals

This section of the questionnaire is designed to reflect and reveal the carers' mental representation and attitude toward DS pupils inside the centre.

QQ 2: Do you feel sympathy towards Down syndrome people?

QQ 3: Why? Because they are?

Choices			
Yes	19 (95%)	Motives	Number/ percentage
		Needy	16 (80%)
		Weak	0
		Other	4 (20%)
No	1 (5%)	/	
The total		20	100%

Table 3.1 Carers' Motives for Sympathising with DS Children

80% (3 males and 13 females) view individuals with DS as being needy which is the reason why they feel pity towards them, while 20% (one male and 3 females) choose other including the mental state of DS pupils that makes them chained and dependent people and the latter triggers certain feelings of sympathy toward them. However, the one who claimed that they have no pity for them(1 female) back up their stand stating that they are like their normal peers and there is no need neither to feel sympathy towards them nor to show it. In addition, as the table shows no one considers weakness as a motive for sympathy.

QQ 4: Do you aid them in accomplishing their intellectual and physical tasks?

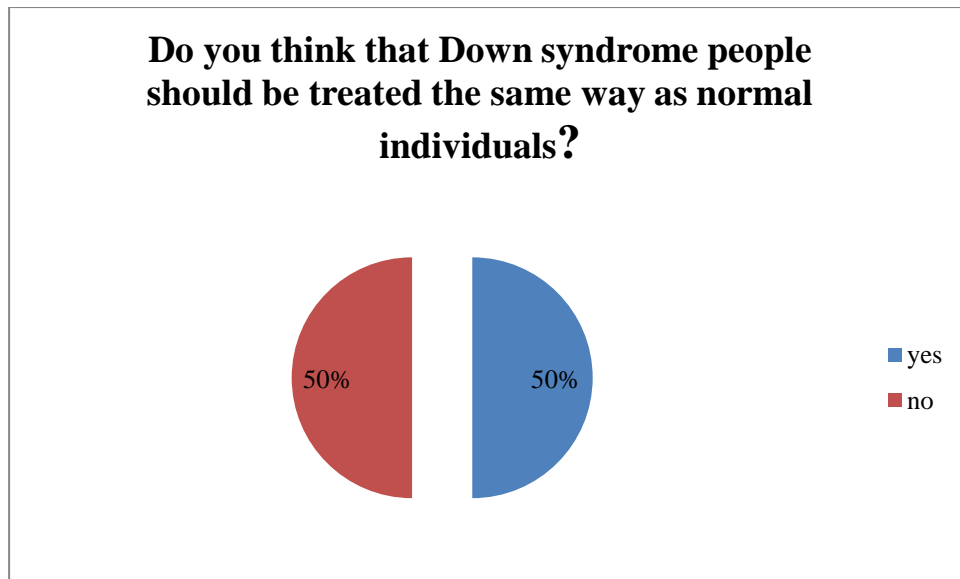
QQ 5: Why? Because they?

Choices			
Yes	20 (100%)	Reasons	Number/ Percentage
		Cannot do it alone	5(25%)
		Cannot do it appropriately	9(45%)
		Incompetent	3(15%)
		Other	3(15%)
No	0	/	
The total		Other	100%

Table 3.2 Carers' Reasons for Assisting DS Pupil

This question highlights why carers aid their DS pupils in doing almost every task handed for them. 25% (5 females) help them because they think that they cannot do it alone, while 45% (2 males and 7 females) assume that they cannot do it appropriately which urges their interference for help and that confirms that they are dependent and needy in their view. 15% (1 male and 2 females) consider them as incompetent and that is why they assist them; however, 15% (one male and 2 females) help them due to other reasons including their mental state giving the example of poor memory and assimilation issues. The above table sums up the images and views that carers shape and hold about DS pupils in a way or another.

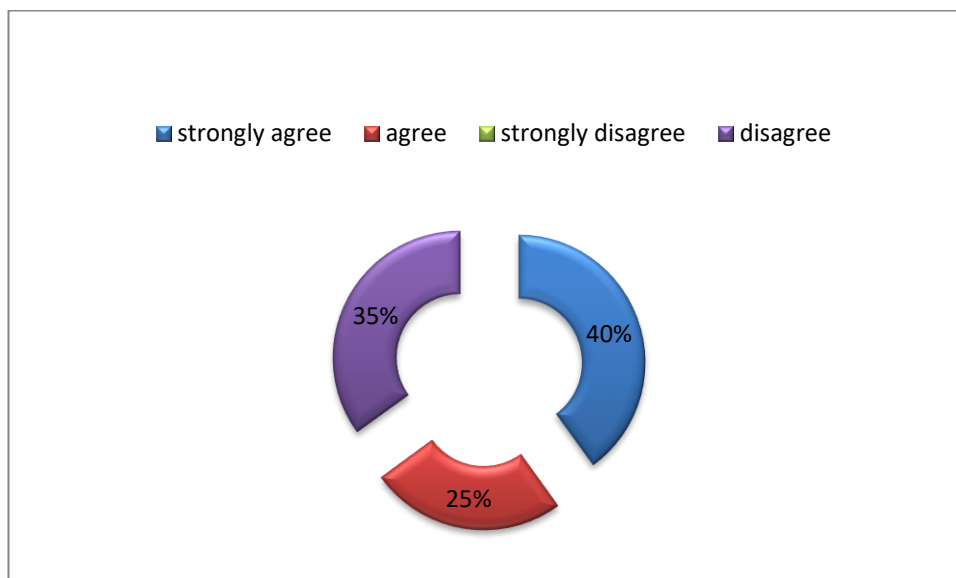
QQ 6: Do you think that Down syndrome people should be treated the same way as normal individuals?



Graph 3.2 Carers 'Treatment of DS Pupils

This question is designed to explore whether carers are in-grouping or out-grouping DS people. The results as the graph shows was equal 50% (3 males and 7 females) of them say that they should be treated the same way as normal people which means they are in-grouping them; however, the other 50% (one male and 9 females) view that they should be treated differently than normal people which reinforces that they are out-grouping them and labelling them in the category of “disabled group”.

QQ 7: People's view of disability affects the way they address Down syndrome people



Graph 3.3 The Effect of People's View of Disability on Speech Choice

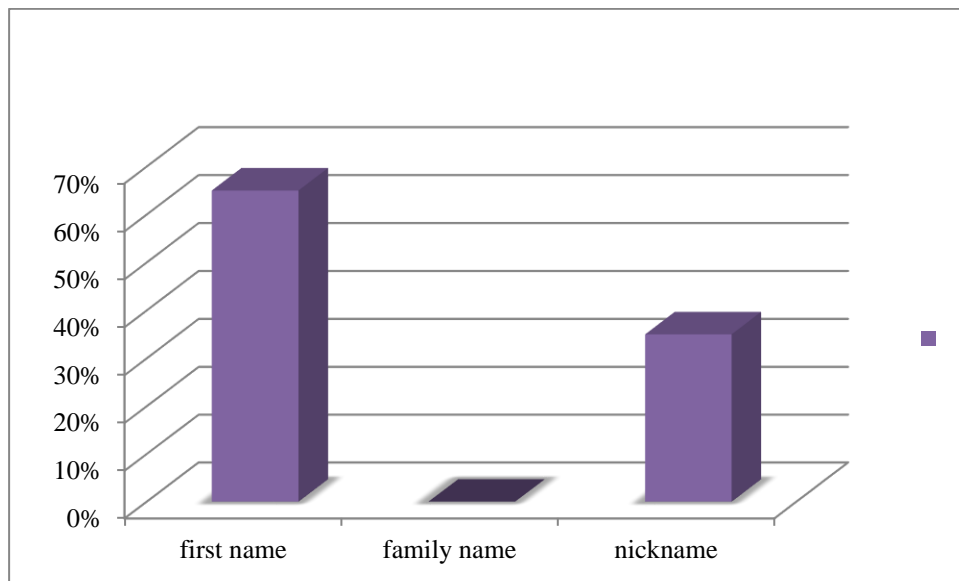
40% (2 males and 6 females) strongly agree with the fact that people's view of

disability affects in a way or another the speech addressed to them, while 25% (one male and 4 females) agree with this view. However, 35% (one male and 6 females) disagree with this statement as it is shown in the above graph.

3.9.3 Carers' Verbal Communicative Behaviour

This section had to do with the main verbal communicative features addressed towards pupils diagnosed with DS

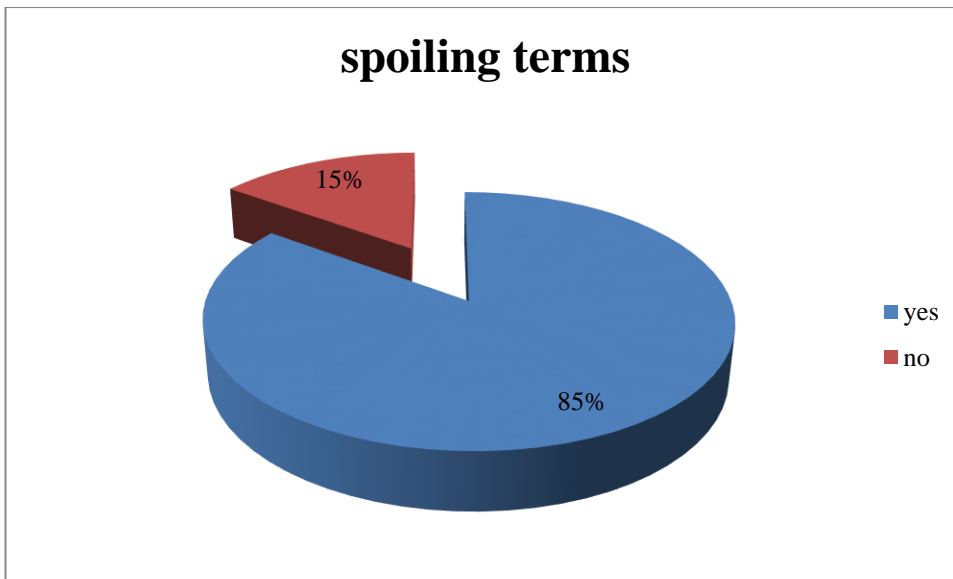
QQ 8: Do you address Down syndrome children using?



Graph3.4 Carers' Manner of Addressing DS Pupils

Graph 3.4 identifies the different ways carers address their DS pupils inside centre. 65% (9 females and 4 males) addressed their pupils using first names; however, 35% (7 females) chose calling them using nicknames while none addressed them using their family names. From the data presented above one can claim that carers address their pupils using only first names and nicknames as a manner of addressing neglecting the family name way of addressing.

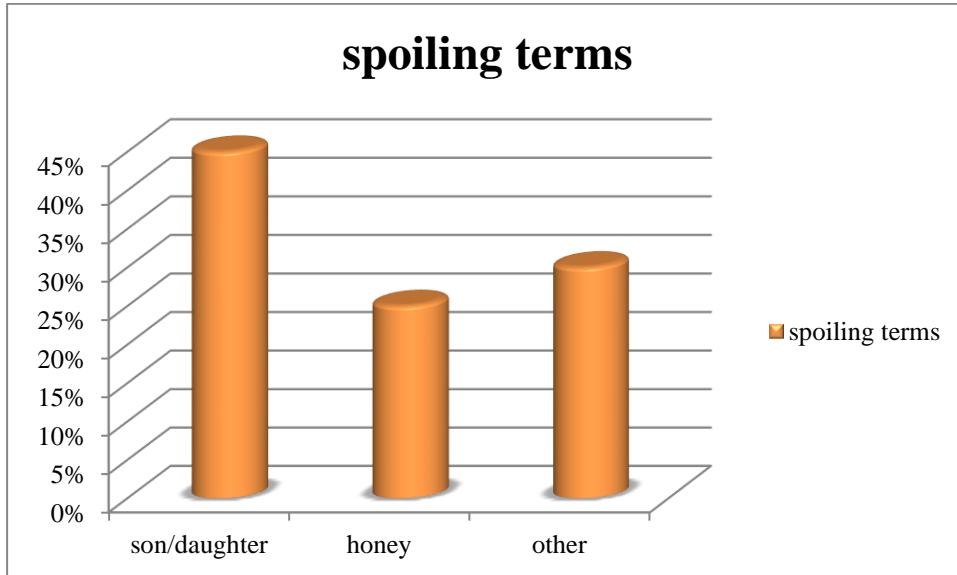
QQ 9: Do you usually use spoiling terms with them?



Graph 3.5 Carers’ Use of Spoiling Terms

Graph 3.5 shows that 95% (3 males and 16 females) of the participants adopt the spoiling terms with DS pupils; however, 5% (one males) claim that they do not use these terms with them.

QQ 10: What do you usually use with your pupils?

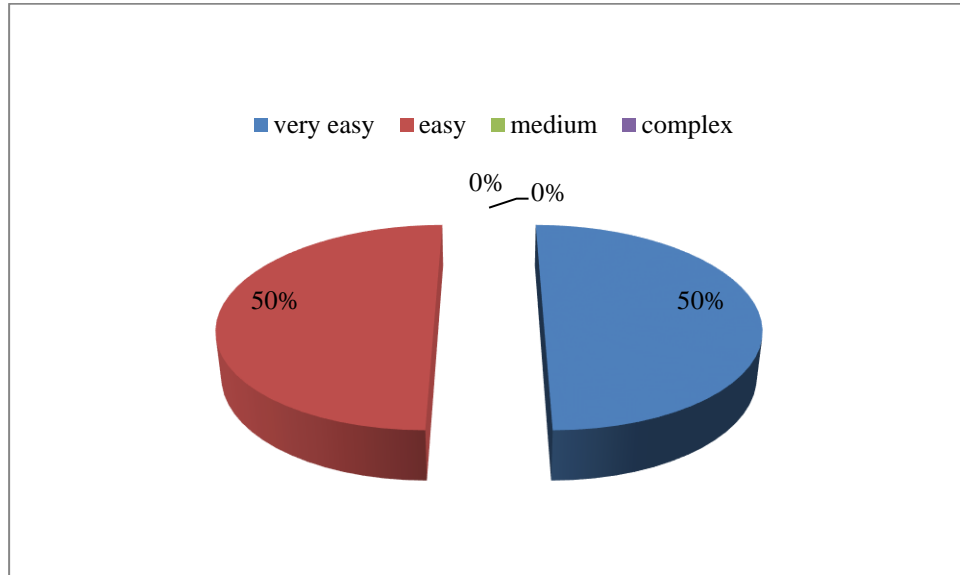


Graph 3.6 The Spoiling Terms Used by Carers

Graph 3.6 is a complement to the previous graph for the sake of determining the type of spoiling terms adopted by carers while addressing DS pupils inside the centre. As the graph clearly shows, 45% (3 males and 6 females) choose son/daughter بنتي/benti/, ولدي/weldi/. 25% (4 females) opt for the second option which is honey حبييتي/hbi: bti/

حبيبي/hbibbi/. While 30 % (1 male and 5 females) choose other including شاطر /ʃʌ6ʌr/, ساجي/sʌdʒi/ courageous, بطل/bʌ6ʌl/ hero, الشابة/ʃʌba/ beautiful, حلوة/hʌlwa/.

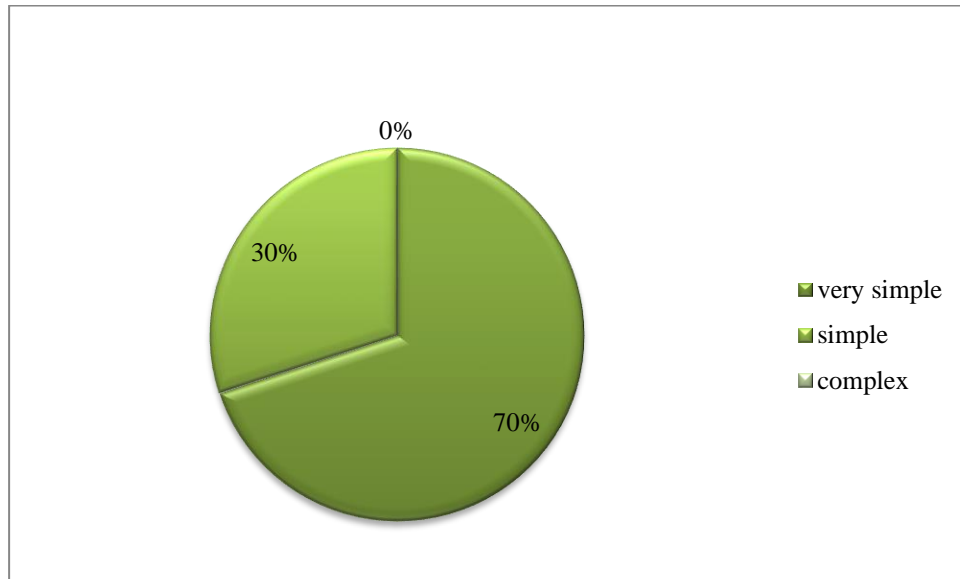
QQ 11: What is the nature of vocabulary you use with Down syndrome children?



Graph 3.7 The Nature of Vocabulary Used with DS Pupils

Graph 3.7 reflects the nature of vocabulary used by carers while dealing with DS pupils. The results indicate that carers vocabulary swing between very easy with 50% (9 females and one male) of the answers, and easy with equivalent percentage 50% (3 males and 7 females) while none chose medium or complex vocabulary.

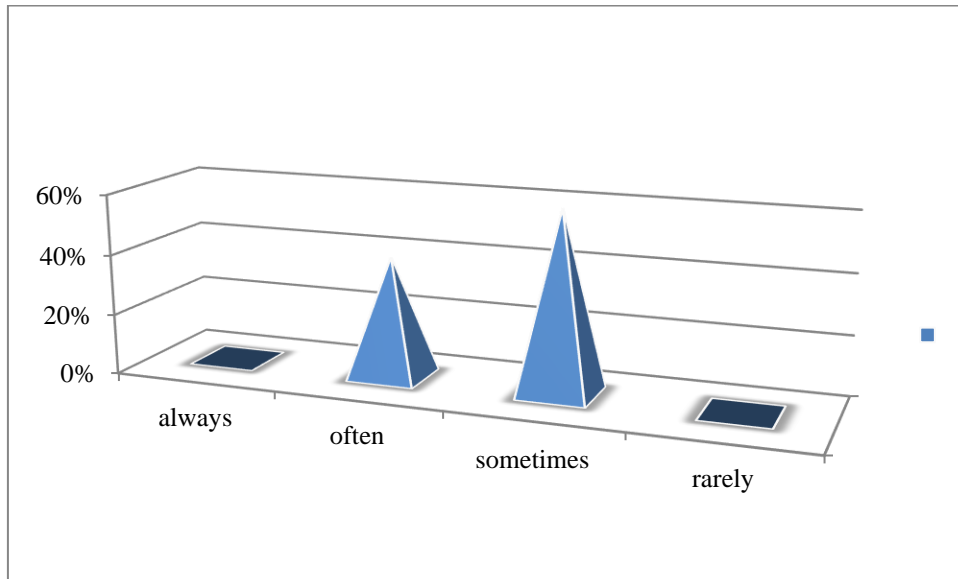
QQ 12: What are the most common types of sentences you use while explaining to them?



Graph 3.8 The Nature of Sentences Used with DS Pupils

Graph 3.8 provides a clear picture on the nature of sentences adopted by carers when explaining or communicating with DS pupils. As the graph shows carers use a very simple vocabulary with 70% of answers (3 males and 11 females), and 30% (1 male and 5 female) opt for simple vocabulary. It is worth mentioning here that none of the carers adopt a complex type of sentences with DS pupils.

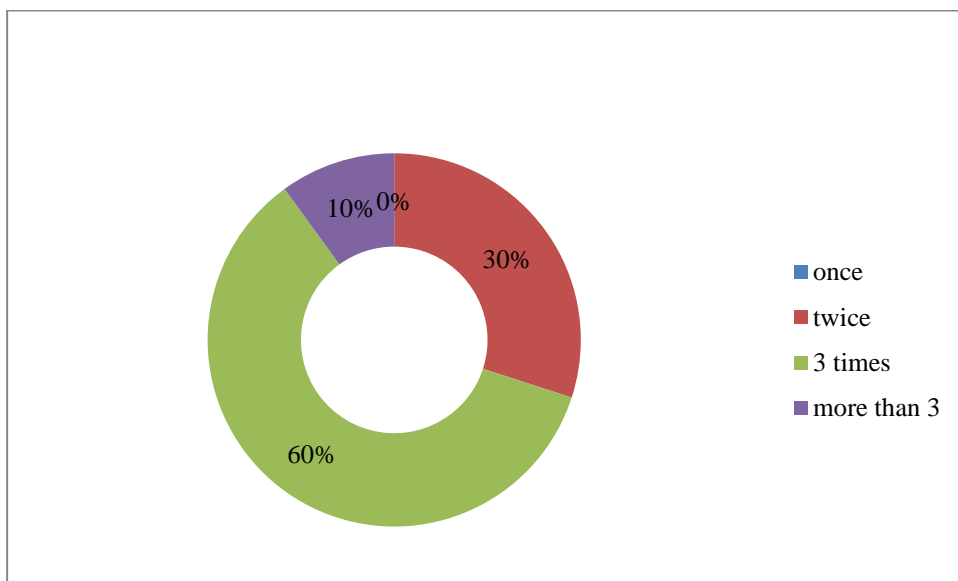
QQ 13: How often do Down syndrome children fail to understand the task handed to them?



Graph 3.9 The Frequency of DS Pupils’ Failure in Tasks Understanding

Graph 3.9 seeks to reveal the number of times DS pupils fail to understand or grasp the task handed to them by carers. 40% of the total number of carers specifically 2 males and 6 females state that their pupils often fail to understand the tasks handed to them; however, 60% (2 males and 10 females) claim that it sometimes happens with them.

QQ 14: How often do you repeat for them?

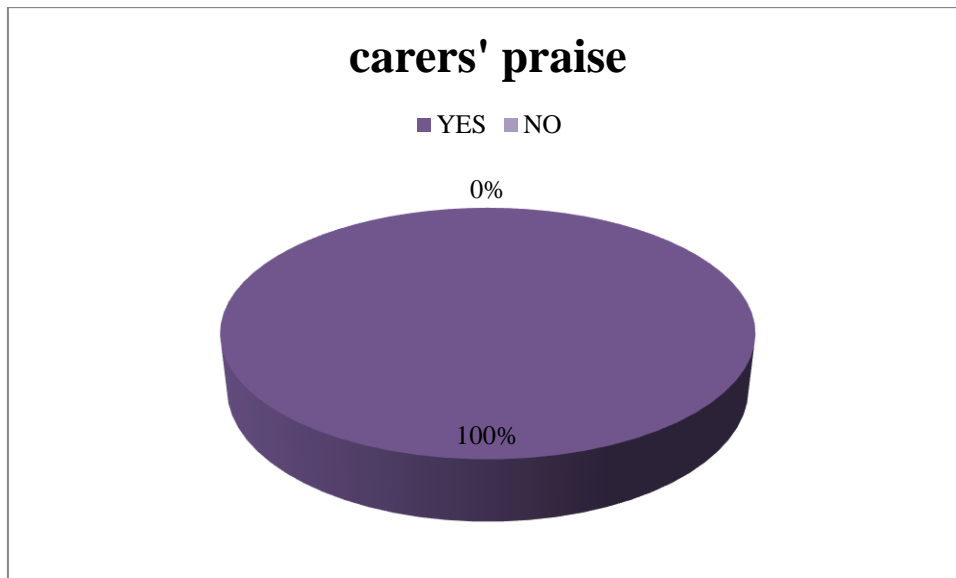


Graph 3.10 Number of Repetition Times for DS pupils by carers

Graph 3.10 represents the number of times carers are obliged to repeat explanation for

their DS pupils for the sake of clarifying and delivering the message after their failure of understanding. The answers ranged between 60% opting for three times corresponding to 2 males and 10 females, 30% (2 males and 4 females) opting for twice, and 10% (2 females) opting for more than three times.

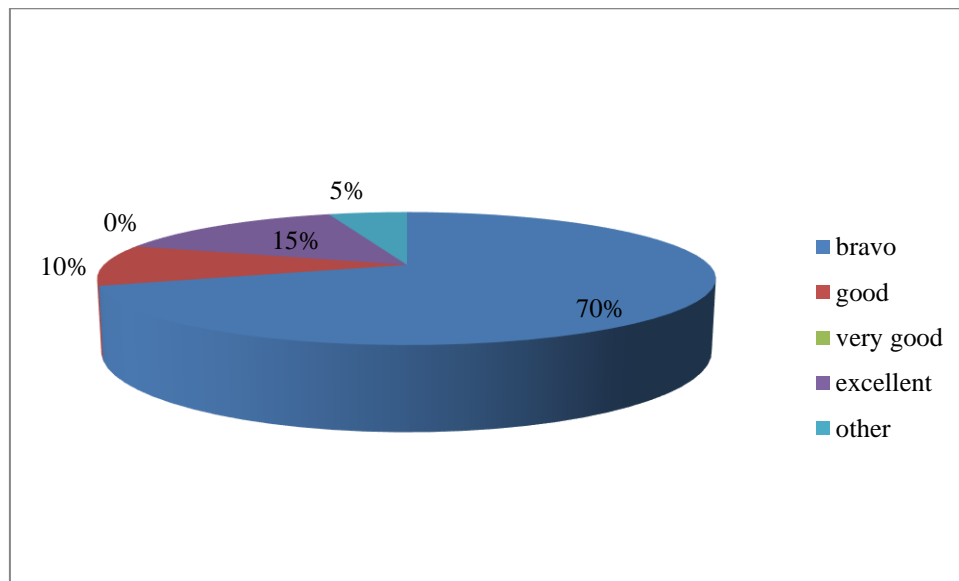
QQ 15: Do you usually praise Down syndrome children for minor accomplishment?



Graph 3.11 Carers' Praise of DS Pupils

As the pie chart above shows, all carers (100%) praise their DS pupils inside the centre even for the minor accomplishments they made as a way to motivate them since a DS pupil needs more encouragements and positive feedback to achieve excellent results.

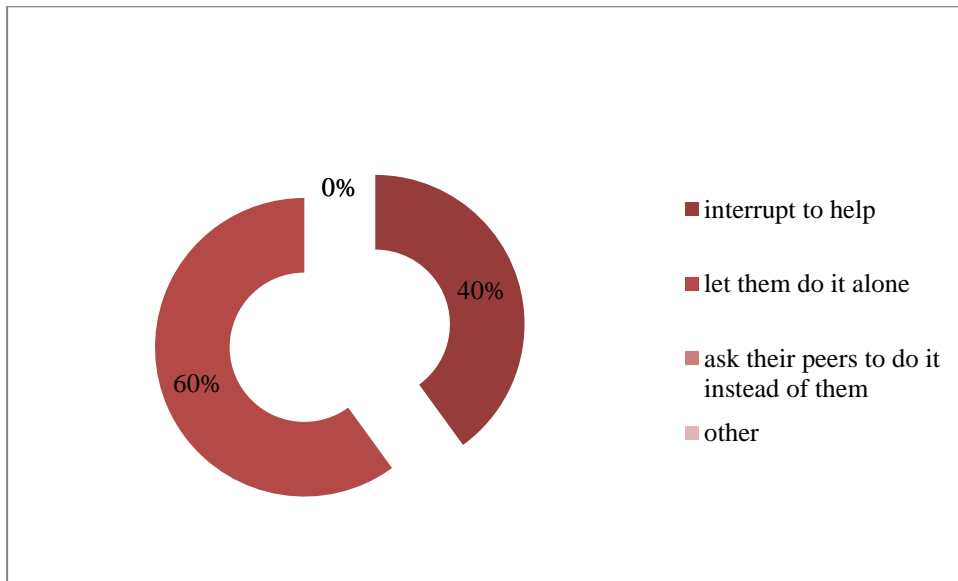
QQ 16: What are the words that you use while doing so?



Graph 3.12 Vocabulary Used for Praising

The above question seeks to reveal how carers praise their pupils verbally using specific vocabulary when their pupils achieve certain tasks or activities no matter how simple they are. As we take a closer look at the graph 3.12 we can see that most of the carers use “bravo” as a praising word with 70% of the total number (2 males and 12 females), while 15% (1 male and 2 females) choose excellent ,and 10% (2 females) prefer to say good. The other 5% (1 male) opt for other including praising terms like شطور /ʃabu:r/ and ساجي /sɑdʒi/ on the other hand none choose very good as a way of a verbal complimentary with DS pupils. Here, one can claim that in spite of the different lexis and words adopted by carers as way of complementary with DS pupils, they all praise them in a way or another.

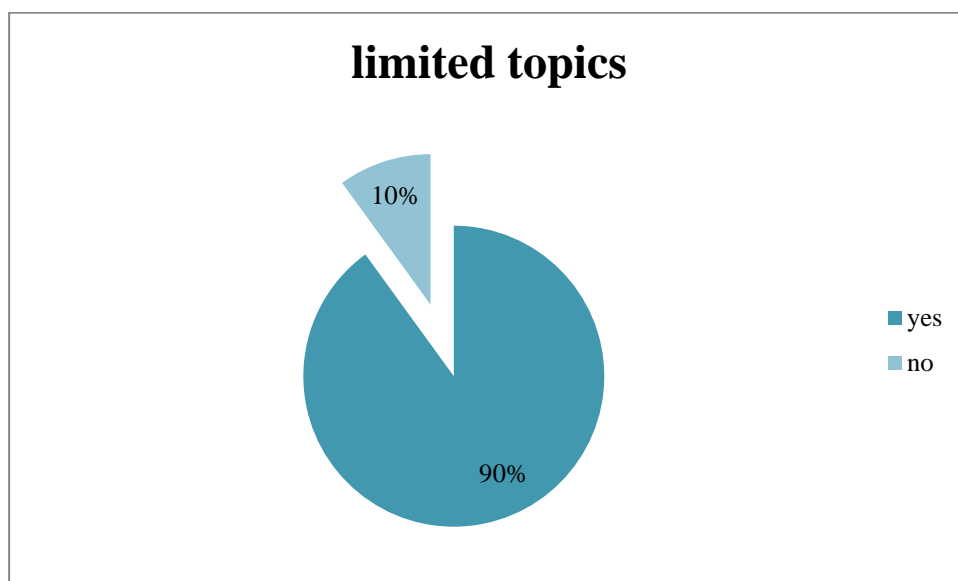
QQ 17: While Down syndrome children start answering your question, do you?



Graph 3.13 Carers Repose Prompts with DS Pupils

Graph 3.13 targets to identify the response prompts adopted by carers as a way of interference to help pupils with DS while answering. 40% (2 males and 6 females) interrupt to help a DS child while answering their questions, while 60% (2 males and 10 females) let them do the task handed alone without any interruption for the sake of fostering independence and self-reliance of DS pupils. As for the 2 last options as the graph indicates none has chosen it.

QQ 18: Are you limited in the choice of topics handed to Down syndrome children?



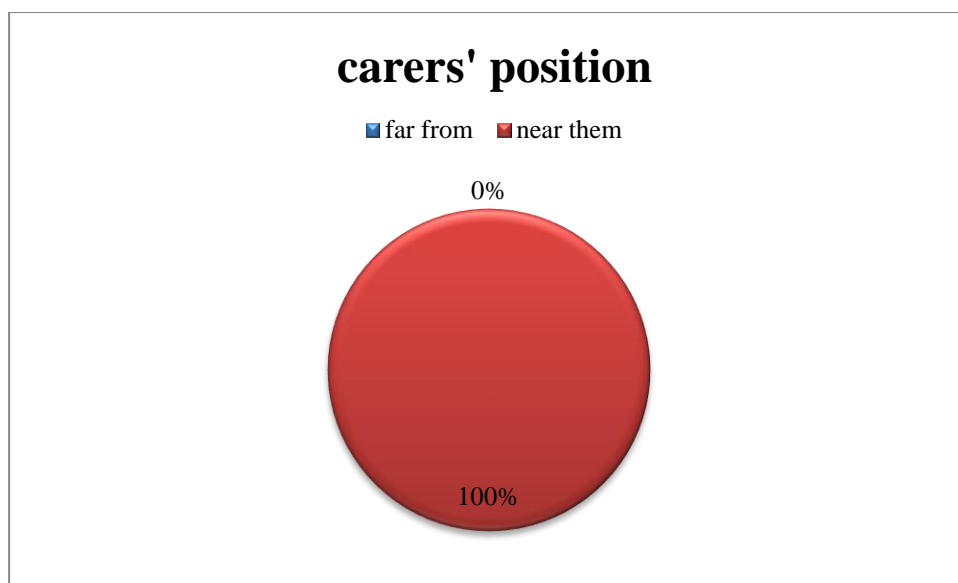
Graph 3.14 Limited Topics Selection

Graph 3.14 seeks to explore whether DS pupils are opened to every kind of topics, or there is kind of limitation in topics chosen and handed to them by carers. 90 % (4 males and 14 females) say that they are limited in the choice of topics handed to DS children; while 2 females corresponds to 10% say the opposite.

3.9.4 Carers' Nonverbal Communicative Behaviour

This section shed the light on the carers' nonverbal communicative behaviour towards pupils with DS inside centres.

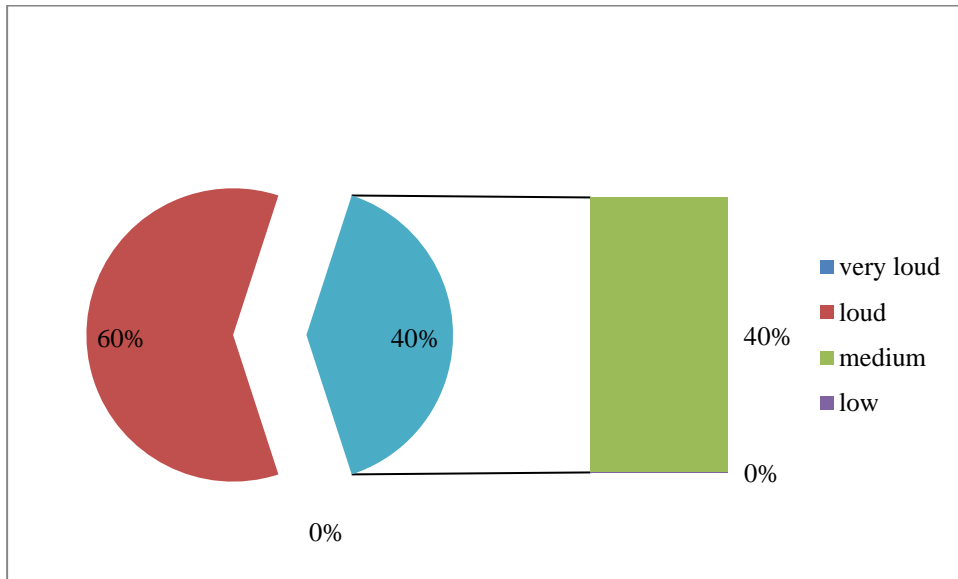
QQ 19: While explaining a task, do you stay?



Graph 3.15 Carers' Position

Graph 3.15 shows that all carers (100%) sit near their DS pupils while explaining tasks which reinforces the crucial role that distances plays when communicating with DS pupils who have motor problems, especially the difficulties of performing multi-tasks, to assure the appropriate understanding.

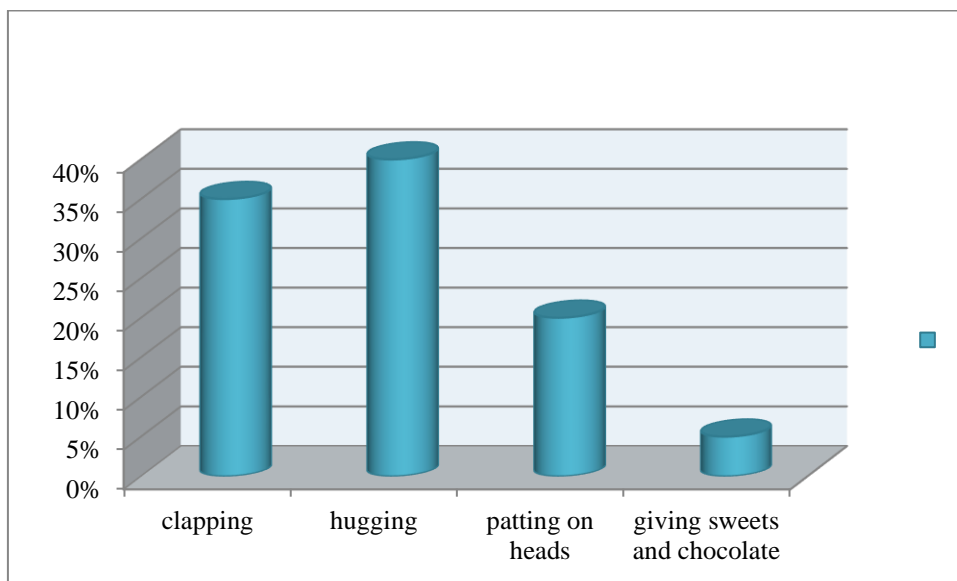
QQ 20: How do you rate you pitch of voice while interacting with Down syndrome individuals?



Graph 3.16 Carers Pitch Voice while Interacting with DS Pupils

60% (12 females) use a high pitch of voice while interacting with DS pupils, however 40% corresponds to 4 males and 4 females use a medium pitch voice. As we can notice from the graph, the largest percentage swings for high pitch voice use due to the learners hearing problems (physical state).

QQ 21: How do you reward your pupils after each accomplishment made?

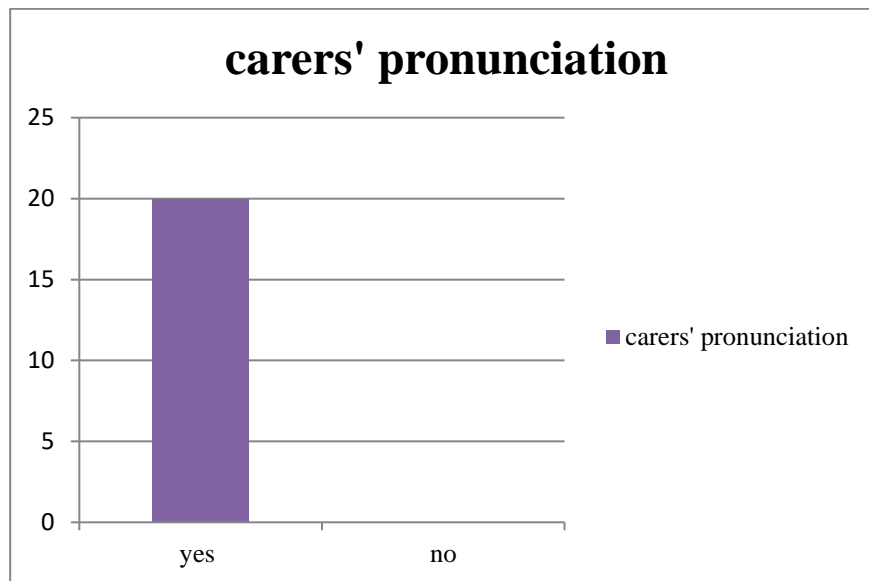


Graph 3.17 Carers’ Manner of Rewarding DS Pupils

Graph 3.17 represents the carers’ manners or ways of rewarding their DS pupils

nonverbally. It indicates that 35% (4 males and 3 females) clap for their DS pupils after each accomplishment made, 40% (8 females) choose to hug them, and 20% (4 females) pat on their heads, while 5% (1 female) grants them sweets and chocolate as a reward. It is worth mentioning here that ways or manners of rewarding are a personality bound behaviour that depends on the choices and personal preference of carers, but it exists and characterise all the carers' communicative behaviour

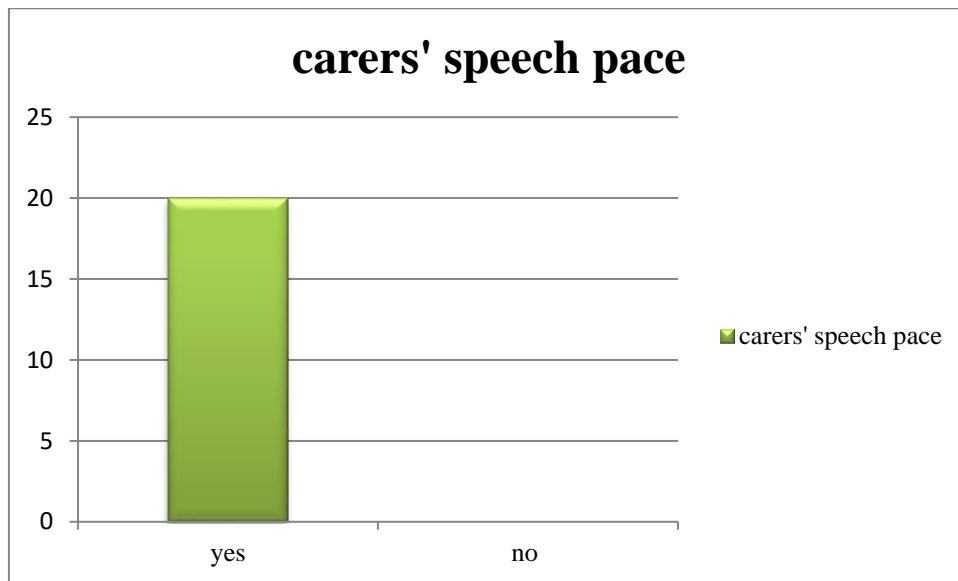
QQ 22: Do you consider the correct pronunciation while interacting with Down syndrome individuals?



Graph 3.18 Carers' Pronunciation

As graph 3.18 represents, all carers consider and ensure the correct pronunciation of words and expressions when interacting with DS pupils a sway to guarantee the correct assimilation and to avoid any sort of confusion.

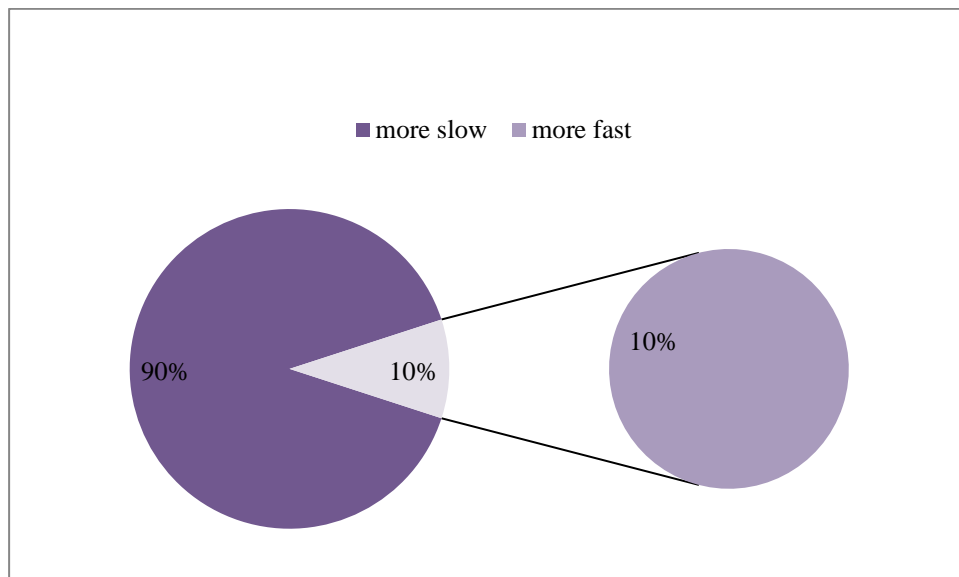
QQ 23: Does your speech pace change while interacting with Down syndrome children?



Graph 3.19 Carers' Speech Pace

100% (4 males and 16 females) change their speech pace while interacting with DS children as the graph clearly represents.

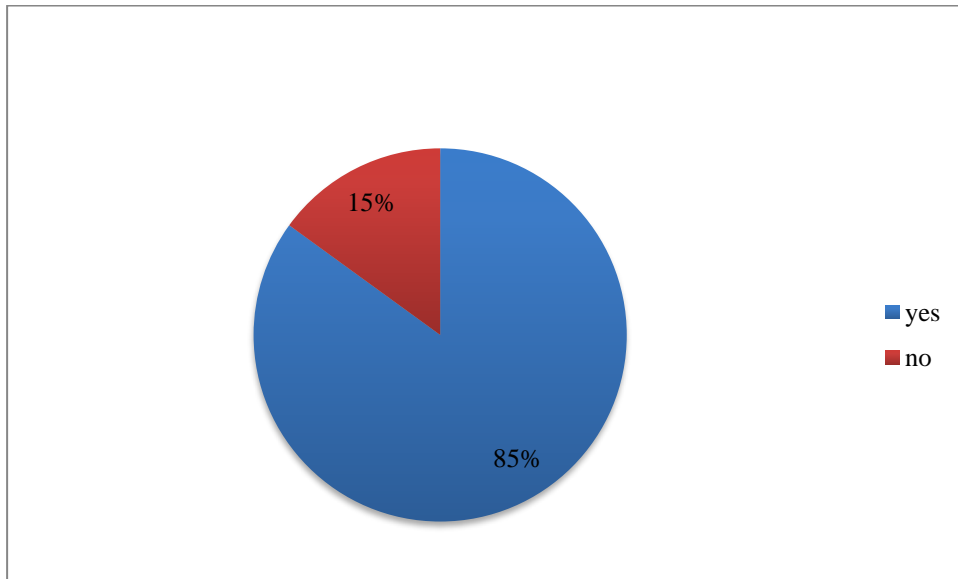
QQ 24: If yes, how does it become?



Graph 3.20 Carers' Speech Pace Adjustment

90% (4 males and 14 females) change their pace to become slower because DS pupils need time to process the information addressed to them besides achieving language intelligibility between both carers and their pupils, unlike 2 females which correspond to 10% change it to become more fast.

QQ 25: Do you find yourself smiling more than the usual while interacting with Down syndrome children?



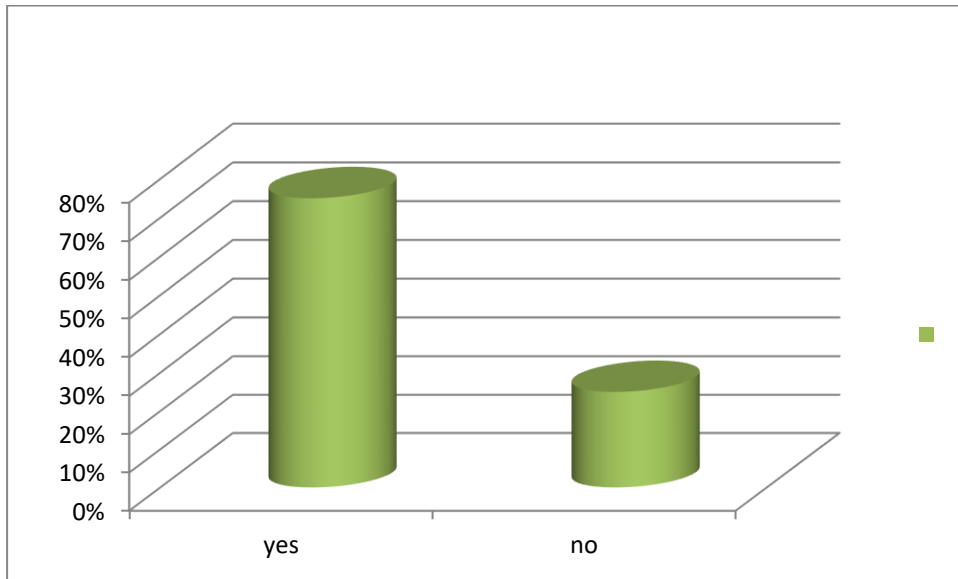
Graph 3.21 Carers' Facial Expression

85% (3 males and 14 females) observe that they smile more than the usual while talking to DS children and that is mainly due to the nature of these children who possess exquisite charming abilities besides their energetic aura. However, 15% (1 male and 2 female) say the opposite.

3.9.5 The Impact of Carers' Communicative Behaviour on DS Pupils

This section of the questionnaire reveals the possible results and impact of the carers' communicative behaviour on DS pupils' learning process and mental evolution.

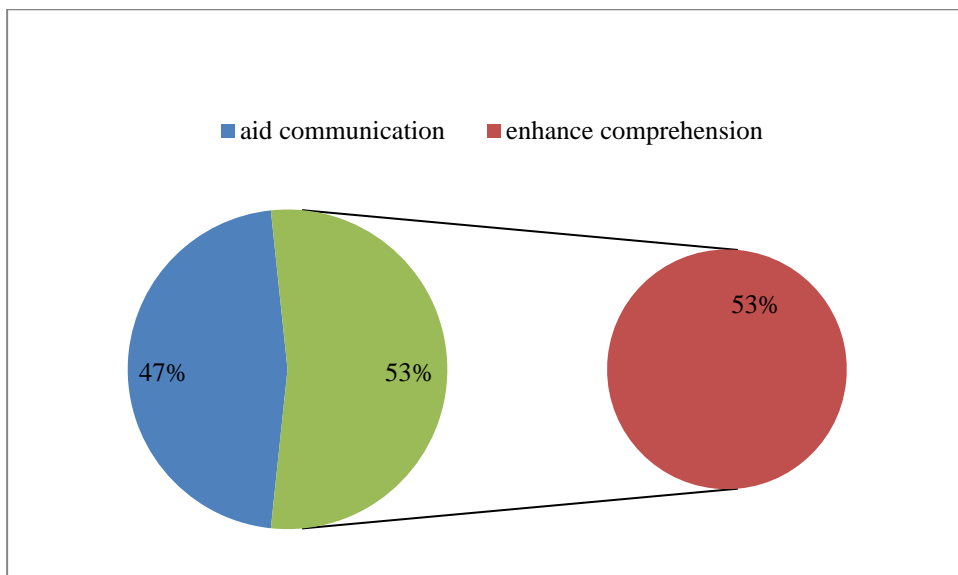
QQ 26: Is it necessary to change your style of speech once you interact with Down syndrome individuals?



Graph 3.22 Carers’ Speech Style Adjustment with DS Pupils

As the graph 3.22 indicates 75% (3 males and 12 females) say that it is necessary to adopt a different style with DS individuals, while 25% (one male and 4 females) say the opposite.

QQ 27: If it is yes, how can that be helpful?

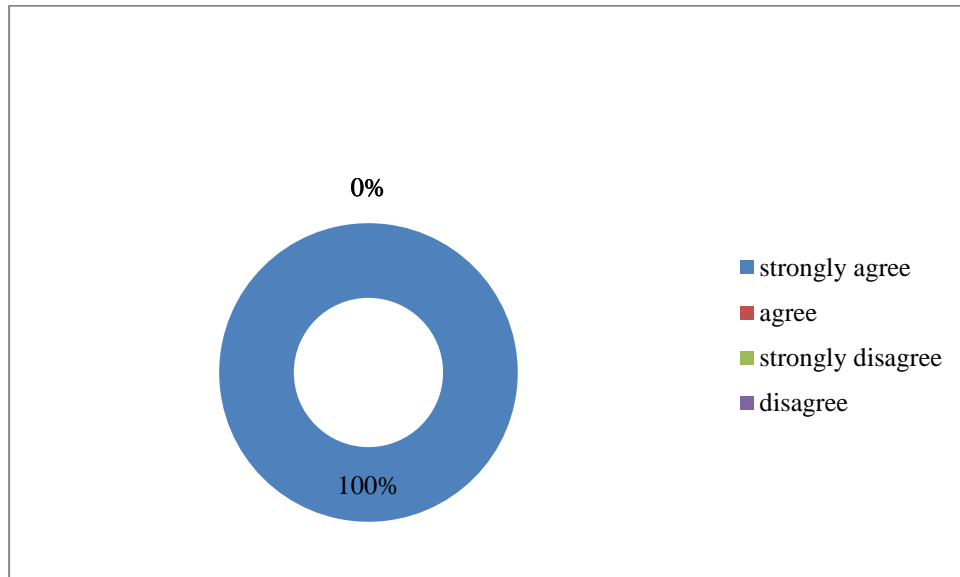


Graph 3.23 Speech style Adjustments Impact on DS Pupils

35% (7 females) of those who answered yes back up their claim saying that this shift aid communication in between them which helps reaching mutual intelligibility , while 40%

(3 males and 5 females) say that this shift enhances DS individuals' comprehension.

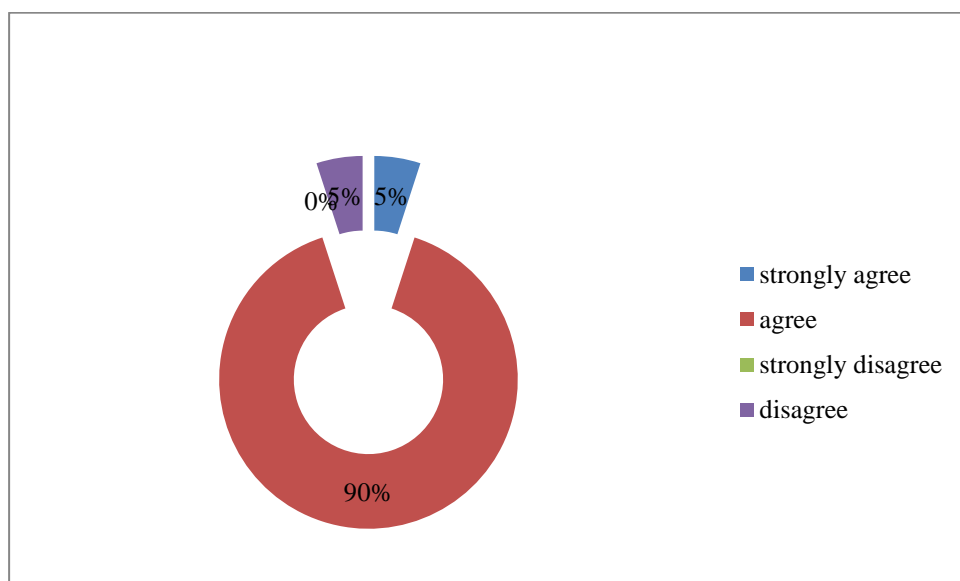
QQ 28: It is necessary to use a simplified form of speech to guarantee proper understanding of Down syndrome children



Graph 3.24 The Importance of Simplified Speech Use with DS

As graph 3.24 shows 100% (4 males and 16 females) strongly agree with the fact that a simplified form of speech is a must to guarantee proper understanding of DS children which indicates that it has a positive impact and brings benefit to them.

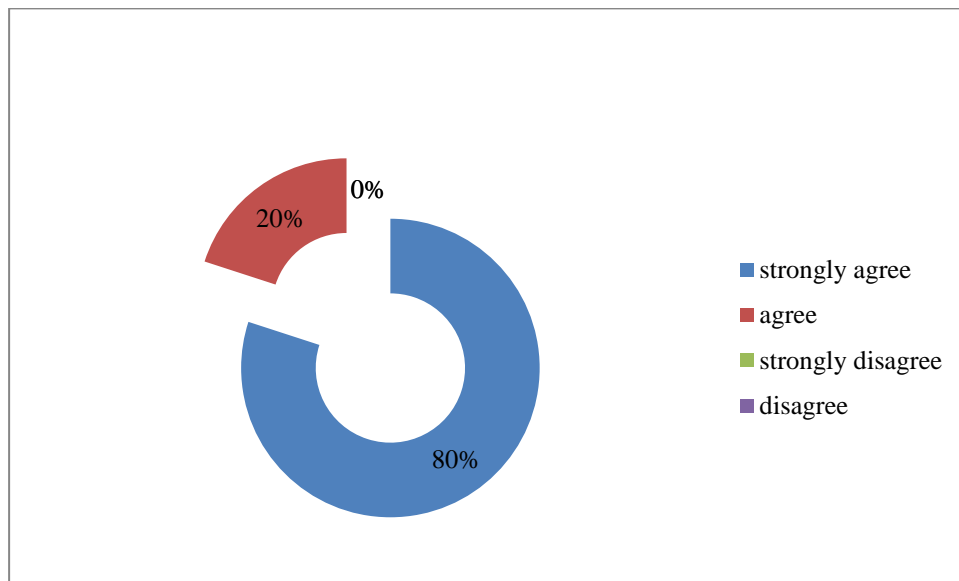
QQ 29: This category of people needs a continuous support to reinforce their learning skills



Graph 3.25 The Importance of Support on DS Learning Process

5% (one male) strongly agree with the statement, while 90% (2 males and 16 females) agree; however, one male (5%) disagree with this statement. From the above we can deduce that positive feedback including rewarding and praising provided by carers to DS pupils reinforce their learning abilities.

QQ 30: Carers' relaxing facial expressions (smiley faces) help in building strong relationships and aid communication with them



Graph 3.26 Facial Expression Impacts on Communication Process with DS

As graph 3.26 shows, 80% corresponding to 16 female of the carers strongly agree with statement, and 20% corresponding to 4 males agree with the statement. The graph confirms the importance and benefit of smiley relaxing face expressions in tightening relationships with DS pupils and thus facilitating the communicative process with them.

3.10 Analysis of Clinical Psychologists' Interviews

Since the major focus and interest of this study is to highlight the verbal and the non-verbal patronising features addressed towards DS pupils, the reasons behind caregivers adoption of patronisation and its impact on this category; choosing the clinical psychologists helps us getting more reliable and accurate data that make our research sounds more credible.

During the semi-structured interview, clinical psychologists are asked to answer seven questions. There are three psychologists from The Psycho-Pedagogical Centre of Children with Special Needs. Theses interviews consist of two sections including:

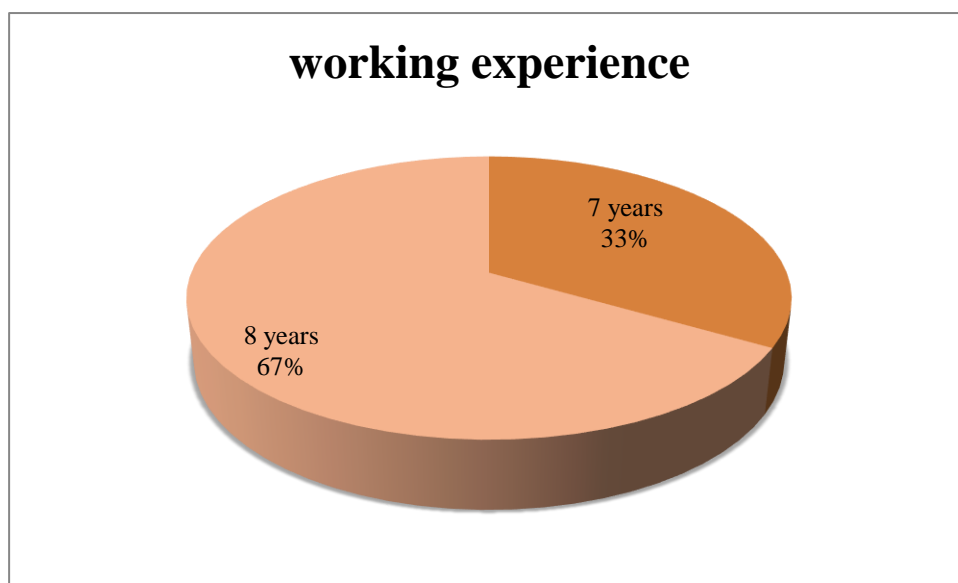
Section one (Q1-Q2): it deals with clinical psychologists' professional data

Section two (Q3-Q5): it highlights the clinical psychologists' verbal and nonverbal behaviour towards DS pupils and its impact on them besides the attitudes they hold about DS individuals

This interview will reveal the verbal and the nonverbal patronising features addressed to DS pupils besides knowing its effects on them as well as the attitudes they held towards this category of people.

3.10.1 Clinical Psychologists' Professional Data

QQ 1 : Working Experience



Graph 3.27 Clinical Psychologists' Working Experience

It has been noticed in graph 3.27 that our participants have a long experience gained during their professional carrier, in which one male has been working for about 7 years, while 2 females have spent 8 years working as clinical psychologists.

In fact interviewing such informants who have a long experience may help us in collecting more reliable data that enrich our understating of the topic under investigation.

QQ 2: have you ever worked in other centres?

It has been noticed from our participants' responses is that all of them have worked in private associations that care for people with special needs, mainly autistic and DS individuals and not public centres. The fact that they have experience in other places earned them more qualifications and that is a gaining point in our side to obtain reliable data from

professionals.

3.10.2 Clinical Psychologists' Attitudes and Communicative Behaviour Addressed toward Down syndrome Category and its Impact on them

This section includes a set of questions to reveal clinical psychologists' attitudes besides the verbal and nonverbal communicative behaviour addressed to DS pupils and how this category can be affected by it.

QQ 3: When first mentioning Down syndrome category, what is the first impression that pops up to your mind about them?

It is observed in our interviewees' responses that all informants provide the same answer in which three of them have positive impressions on DS category; however, they have stated a set of negative representations that are the results of DS individuals' delayed mental state.

To start with, all clinical psychologists say that DS who are developmentally delayed are in fact competent individuals; they have weaknesses and strengths like anyone else in the population. They are sensitive and can respond to positive expressions of friendships and get hurt or upset by inconsiderate behaviours. Moreover, they say that despite their delayed physical, intellectual and language development, they possess extraordinary abilities if we compare it to the fact of being disabled. That is why being a clinical psychologist obliged them to have faith and believe that they can achieve better results if they receive the suitable treatment.

However, they note that they cannot deny the fact that these individuals are dependent and need a continuous support and care more than any other typically developing peers, but they can grow up to live independently with varying degrees of support and accommodations. In other terms, they have clearly pointed out that DS people are not different but unique creatures who own features that should be respected.

QQ 4: How does that affect your communicative behaviour toward them?

As for the second questions in this interview; participants are asked to identify how their views towards DS individuals have an impact on the way they address them in which the three of them propose one main effect which is the adjustments they made in their speech in a way that suit DS pupils deficits. According to them, these modifications can be summarised in two major points. First, the use of a simplified language and vocabulary

chosen to avoid any sort of misunderstanding, as for the second one they say that they have to be very careful in the choice of word used they use while interacting with these individuals due to the impressive imitation abilities they have. In other words, the shift in their communicative behaviour was due to DS pupils' cognitive state and not the attitudes they held towards this category whether positive or negative.

QQ 5: Do you adopt the same communicative behaviour whether with Down syndrome category or with other people? Why? And how your verbal and nonverbal communicative behaviour becomes?

Furthermore, we have asked clinical psychologists about the difference between treating a DS child and a normal one, their reasons behind this treatment and how the communication (verbally and nonverbally) operates between them. This question helps us in revealing the patronising features addressed towards DS pupils. Nearly all psychologists state that the treatment of typically developing children is totally different from their counterparts who have DS, except for one who stresses the importance of treating them as normal individuals. Their reasons were mainly the specificity of DS abnormality, they state that this category belongs to people with special needs, they need a special treatment. As for the one who refuses to treat the differently backed this claim saying that a psychologist duty is to make a DS individual feel acceptance as being a normal person and not odd, but this is bounded with limits in which its borders are set according to their weaknesses and the uniqueness of their case.

Moreover, they state the different examples and illustrations about their verbal and non-verbal communicative behaviour addressed towards DS pupils. First of all, they opt for a simple language and avoid any use of complex vocabulary to suit DS pupils' mental age, besides repeating themselves to avoid any sort of confusion. In addition, they say that they often change their speech pace in order to achieve language intelligibility. However, sometimes they use a very childish tone with them but this later happened unconsciously. Second, they say that they interact nonverbally with DS children very often, especially if they asked them to perform tasks that need a higher level of concentration, and they maintain an eye contact and sit near every single child to assess him/her and give immediate feedback and praise to ensure that these pupils associate rewards with their efforts, which take different forms depending on their preferences. Finally, they all concluded that the degree of disability from mild to moderate has a huge impact on the way they address this category of people.

QQ 6: What are the strategies you personally adopt to facilitate comprehension, communication, and to reinforce the learning abilities of Down syndrome category?

In fact all respondents have provided similar tactics adopted with DS pupils. First, they say that building strong bond based on care, trust, faith, love and acceptance that creates an appropriate motivation and tell that all communication matters, are the keys success for aiding communication with DS pupils.

As for the strategies to facilitate comprehension, they say that they opt for simple directions for activities which must be highly structured and sequenced. Moreover, they provide a small amount and over-repeated information presented at a time, that is to say for them repetition is the key to learning. This choice is due to the weak short-term and long-term memories that a DS child have. Another strategy is the slow speech pace they adopt to enhance language intelligibility. Finally, the necessity of interruption to guide DS pupils throughout exercises accompanied with corrective feedback when needed.

Finally, all clinical psychologists agreed upon the fact that both reinforcements and punishments are the best ways to cater the learning of DS pupils. They claim that positive language and praise that can be social and nonverbal like giving sweets and chocolate, hugging and kissing them are powerful tools to motivate them to improve their skills and abilities. They say that knowing the “right” from the “wrong” is the first thing to practice with DS child and punishment is the best way to achieve this goal. For instance, their faces become frown and use a slightly harsh pitch whenever DS children misbehave.

Moreover, they say that they try their best to make the lessons as realistic as possible by presenting pair of pictures with shiny bright colours, since DS pupils are visual learners who believe in the concrete and put aside the abstract things.

QQ 7: Do you think that your communicative behaviour meets the needs of Down syndrome pupils? How is that?

Finally, we have asked them to assess their treatment of DS pupils and see if it does suit them or not. They emphasise that the way they treat DS pupils is the best option to take to achieve better results. They backed up their claim saying that they are very careful in the choice of words and expressions just to facilitate for DS individuals and to meet their needs. The over repetition they do due to DS individuals possession of weak memory meets their need to enhance comprehension. The way they reward and sit behind them aid communication with these pupils. In other terms this special treatment is the best way to cater

the learning abilities DS children so that they become autonomous individuals in the future and they conclude saying that treating them in a different way is the worst crime has ever been committed against them.

3.11 Discussion of Findings

Carers and Psychologists' Attitude toward DS Pupils and their Motives behind Adopting Patronisation

Taking CAT as a foundation for our study to analyse the different verbal and non-verbal modifications made by both carers and psychologists (patronisers) during inter-ability encounters and their motives behind these adjustments besides its impact on DS pupils (patronises) has led to significant, valuable yet unexpected findings. Therefore, this concluding section in chapter three will summarise the results gathered from both the questionnaire and the interview to end up with some final comments.

Starting with the attitudes held towards DS individuals by carers and psychologists, data gathered clearly show that our participants hold both negative and positive attitudes respectively. They have characterised them as being dependent and needy as well as viewing them as unique, lovable, charming, competent and can grow up to become independent individuals if they receive the suitable treatment that fits their needs and deficits.

Reflecting on what has been mentioned above; our findings go hand in hand with previous research studies. For instance, the study conducted by Wright (1983) where he found that people with disabilities are often viewed negatively by those without disability. In addition to what has been mentioned by Morris (2005) saying that people with disability are considered to be dependent and heteronymous individuals. Then, what has been stated by Yazbeck et al. (2004) who have found that highly educated people and those who are in a continuous contact with people with intellectual disabilities tend to have positive attitudes towards them strongly supports our findings that carers who are in a contact with DS pupils view them positively.

Moving to the relationship between the attitudes held towards DS individuals and the communicative behaviour adopted by both carers and psychologists towards this category of pupils, our findings clearly deny any sort of relation between both of them and that the core reason behind these modifications is DS individuals' delayed intellectual and language development and not the attitudes held towards them whether positive or negative. However, there is a fine line between these attitudes and DS deficits because the former causes the latter

to occur. In other words, patronising communication resulted from recipients' mental state and not due to the perceived negative attitudes.

The results obtained from the close-ended question: "people's view of disability affects the way they address DS individuals" which shows that 65% of our respondents agree with this statement supports the Self-Categorising Theory (SCT) since the majority categorise DS individuals into out-group due to the salience of disability which is DS in our case, and that this categorisation results in special manner of treatment and addressing not for the sake of enhancing ones social identity but for the recipients own benefits which contradicts with the principle of Social Identity Theory (SIT). As a result, our findings contradict what has been defined as being patronising speech by Harwood et al. (1993) in which they have stated that it is "inappropriate modifications based on stereotypes of incompetence and dependence" (p.212). In other words, they clearly associated the occurrence of patronising speech with the negative attitudes held towards the patronisees. Thus, we might suggest an extra definition for the term patronising speech as being appropriate adjustments made due to patronisees' actual abilities. Therefore, our hypothesis is partially confirmed.

The Verbal Patronising Features in Carers' Communicative Behaviour

Since there are no previous studies that tackled patronising speech features addressed to people with cognitive disabilities specifically DS category, we were obliged to take the work of Ryan et al. (1995) on intergenerational communication as a guiding theory to our work to highlight the patronising features within inter-ability communication due to the similarities found in between their study and ours. The verbal and non-verbal patronising features determined by Ryan et al are found in institutional settings and adopted by health providers inside these centers due to their notice of a physical impairment in the elderly which it is a common point with our study.

After analysing and digging deeper into the answers provided either by carers or clinical psychologists in both research tools questionnaire and semi-structured interview we found out that their communicative behaviour with DS pupils inside the center contains verbal features of patronization including exaggerated praise for minor accomplishments, the use of simple vocabulary and sentences, interruption, repetition, the use of nick names and first name for addressing, endearment terms, childish tone, limited topic selection and these verbal features correspond with the one predetermined by Ryan et al. (1995) in the intergenerational context, thus supported the second hypotheses of our study.

The Nonverbal Patronising Features in Carers's Communicative Behaviour

The nonverbal communicative behaviour of both carers and psychologists is also characterised by its patronising features as data clearly indicate. These features can be summarised in the use of slow speech pace, high loud pitch voice, exaggerated smile, frown faces to show dissatisfaction, standing near or beside the DS pupils, pat on head. These findings match Ryan et al. 1995 nonverbal patronising features in the intergenerational context, and that supported our third hypotheses. Our study coincidentally revealed other nonverbal features including hugging with the highest percentage of answers, maintain eye contact with DS pupils, using coloured pictures for illustrations.

The impact of Patronising Speech Adopted by both Carers and Psychologists on DS Pupils:

Our results indicate that both carers and psychologists make certain adjustments in their communicative behaviour resulting in certain verbal and nonverbal patronising features that are addressed toward DS pupils. In fact these features proved to be beneficial and of a great importance to the success and efficiency of the communicative process with DS pupils.

To begin with the consequences of the verbal patronising features where our participants confirmed that adopting a simplified easy language with a continuous repetition to avoid any sort of confusion and guarantees proper understanding because simple language suits their mental state. Besides, they insisted that interruption, praising for the simplest achievements, and rewarding are powerful tools to reinforce their learning skills. In addition, they all agreed on the fact that adjusting their speech style helps aiding communication and facilitate comprehension (see **questionnaire question 28**). Moving to the nonverbal patronising features consequences on DS pupils where our participants provided satisfactory and positive comment on it. Starting with the analysis of question 31 of the questionnaire where all participants agreed upon the idea that smiling tightens relationships with DS pupils which helps in the communication process. in addition, carers emphasised on the importance of adopting high loud pitch voice due to their hearing deficit and sitting beside them to provide them with instant feedback which insures proper understanding. Finally, when our participants were asked in the interview whether their communicative behaviour meets the needs of DS pupils they assured us that their communicative behaviour is the best option to achieve better results.

What has been mentioned above clearly proves that our participants are converging

towards DS pupils for a cognitive function which is to facilitate comprehension, thus improving communication efficiency, and that patronising speech adopted by both carers and psychologists is not done randomly or based on character bias or negative stereotypes held toward DS people, but a result of specialised training based on objective description and evaluation of DS needs, weakness, and strengths which foster the idea that Communication Enhancement Model can also be implemented in inter-ability communication and not only intergenerational contexts. Finally, we can say that all patronising features found in our study has a positive impact on DS pupils serving as a bridge to reach proper understanding, effective communication, and improving DS learning abilities and that clearly supported our fourth hypotheses. Our results go hand with hand with Ryan et al. (1997) statement that “in certain context, the speech adaptation associated with patronising speech maybe functional and correctly attuned to the needs of the recipients”, and contrast with Pirquet (2006) findings in the intergenerational context where patronising speech had negative impact on the self-esteem of elderly feeling worthless and disrespected. It also contrast with Ryan et al. (1986) where patronising communication has negative consequences on elderly such as becoming more isolated and avoid interaction with young adults. Therefore, our hypothesis is confirmed.

3.12 Conclusion

This chapter portrays the practical part of our research work about the different features of patronising communication addressed towards DS pupils and its impact on them besides reflecting the relationship between care givers’(carers and clinical psychologists) attitudes and the adjustments made during inter-ability encounters. To make our study sounds more reliable and credible, two main research instruments were chosen which are, a detailed questionnaire and a semi-structured interview to get an adequate understanding of this phenomenon. The statistical data presented via tables and figures denied any relationship between patronisers’ attitudes and their patronising speech adopted while interacting with DS pupils. Moreover, it highlighted the different verbal and nonverbal patronising features adopted by care givers inside Centres of Children with Special Needs and proved that the impact of this speech can only be beneficial for these individuals and have a positive impact on both communication efficiency and the learning process of DS pupils.

General Conclusion

This study aimed at highlighting the different patronising communicative features adopted by caregivers and its impact on the reception side, DS pupils during inter-ability encounters. Moreover, discovering the link between patronisers' attitudes held towards this category and their adopted communicative behaviour. In other words, discovering the driving force behind the occurrence of patronising speech during interactions between caregivers and DS pupils inside the centre.

To go over the main points, then, it has been obviously noticed that care givers including both carers and clinical psychologists hold certain positive attitudes towards DS pupils in which they describe them as being, charming, lovely and competent as well as viewing them negatively such as being disabled, needy, dependent individuals who have sympathy towards them. Unexpectedly, these aforementioned views whether positive or negative have no relation with the communicative behaviour adopted by our participants. In fact the adjustments they made during inter-ability interactions were due to DS special case that obliged carers and psychologists to shift their style to suit DS pupils' needs besides reaching better results concerning their learning process. In other words, care givers mental representations of DS pupils have nothing to do with the speech style addressed to this category.

Strangely enough, the stereotypes that led researchers to define patronising speech as being a result of such false impressions and the leading force behind the emergence of this speech is absent in this study simply because care givers insist on improving DS capacities and abilities putting aside any negative ideas that may hinder them from achieving their goal.

Moving deeply in the analysis, these modifications are performed verbally and non-verbally by our participants, in which a variety of patronising features were detected while interacting with DS pupils inside Centre of Children with Special Needs. In fact opting for Ryan et al. (1995) features as being our core theory to shed light on how communication between care givers ad DS pupils operates was due to the similarities in between their study and our topic. Consequently, identical findings were found but with additional patronising features due to the uniqueness of DS anomaly.

Interestingly, the verbal and nonverbal patronisation has positive impacts on DS pupils in which each feature is used for a given reason to achieve a specific goal. It is clear

Bibliography and Appendices

from the obtained data that using a simplified language guarantees proper understanding of DS pupils, the over repetition they do due to DS pupils' weak working and short-term memories proves to be helpful in reaching language intelligibility. Moreover, the perfect reward system that care givers opt for like, hugging, clapping, patting besides the social reinforcements is the best way to cater DS pupils learning process. In other terms, patronising communication has proved to be of a great help to DS pupils via aiding communication, enhancing comprehension and improving their learning process.

To cut a long story short, the adjustments observed in care givers interactions with DS pupils are a clear proof that there is a certain categorisation in between two social groups of typically developing people and developmentally delayed individuals; however, the patronisers as being our participants are using patronising speech with good intention which is to improve DS performance and to make them independent individuals who can grow up to participate and serve the society and not for the sake of enhancing a positive social identity or to prove anything to anyone . So, patronising speech is a strategy used by care givers done with good intentions resulted from an urgent need to help DS individuals and proves to be suitable, useful and beneficial for this category.

BIBLIOGRAPHY

I. Books

- Arias-Trejo, N., & Barrón-Martínez, J. B. (2016). "Language skills in Down syndrome". In A. Auza Benavides & R., G. Schwartz (Eds). *Language Development and Disorders in Spanish-speaking Children* (pp.329-341). Mexico. doi: 10.1007/978-3-319-53646-0_16
- Bielenia-Grajewska, M. (2015).Linguistic Convergence. *Handbook of Science and Technology Convergence*, 1–12. doi: 10.1007/978-3-319-04033-2_84-1
- Creswell,J.W.(2014). Research design: Qualitative, quantitative, & mixed methods approach (4thed).Los Angeles, London, New Delhi, Singapore, Washington Dc. Sage
- Fox, S.A., & Giles, H. (1996b).“Let the wheelchair through!”: An intergroup approach to Interability communication. In W.P. Robinson (ED.), *Social groups and identity: The developing legacy of Henri Tajfel* (pp.215-248). Amsterdam: Elsevier.
- Gallois, C., Ogay, T., & Giles, H. (2005). Communication accommodation theory.In W. B. Gudykunst (Ed.), *Theorizing about intercultural communication* (pp. 121-148). Thousand Oaks, CA: Sage Publications, Inc.
- Giles, H. [ED]. (2016). *Communication accommodation theory: negotiating personal relationships and social identities across contexts*. Cambridge: Cambridge university press.
- Giles, H., & Gasiorek, J. (2014). “Parameters of nonaccommodation: Refining and elaborating communication accommodation theory”. In J. P. Forgas, O. Vincze, & J. László (Eds.), *Sydney symposium of social psychology. Social cognition and communication* (p. 155–172). Psychology Press. New York.
- Giles, H., & Ogay, T.(2007). Communication Accommodation Theory. In B.B. Whaley & W. Samter (Eds.), *Explaining communication: Contemporary theories and exemplars* (pp.293-310). Mahwah, NJ: Lawrence Erlbaum
- Giles, H., Coupland, J. & Coupland, N. (1991). Accommodation theory: Communication,context, and consequence. In Giles, H., Coupland, J., & Coupland, N. (Eds.), *Contextsof Accommodation Developments in Applied Sociolinguistics* (pp. 1-68). New York:Cambridge University Press.

Bibliography and Appendices

- Gillberg, C. [ED]. (1989). *Diagnosis and Treatment of Autism*. Boston. Springer.
- Heider, F. (1958). *The psychology of interpersonal relations*. Lawrence Erlbaum Association. New Jersey . U.S.A. ISBN: 0-89859-282-8.
- Holliday, A., Hyde, M., & Kullman, J. (2004). *Intercultural communication : an advanced resource book*. London: Routledge.
- Jaeger, P.T & Bowman, C.A., (2005). *Understanding Disability: Inclusion, Access, Diversity, and Civil Rights*. U.S.A. Praeger publishers.
- Kothari, C. R., & Garg, G. (2019). *Research methodology: Methods and techniques*. New Delhi: New Age International (P) Limited.
- Sunnafrank, M. J. (1991). Interpersonal attraction and attitude similarity: A communication-based assessment. In J. Anderson (Ed.), *Communication Yearbook* (pp.451-483). Newbury Park, CA: Sage
- Thomas, D., & Woods, M. (2003). *Working with people with learning disabilities: theory and practice*. London and New York. Jessica King Shepp Publishers.
- Trudgill, P. (1986). *Dialect in contact*. Blackwell, Oxford. UK
- Turner, C. & Reynolds, J. (2012). Self-categorisation theory. In A. M. Van Lange, W. Kruglanski & E. Higgins (Eds). *Handbook of Theories of Social Psychology*, (pp.1-23). London: SAGE Publications Ltd. doi: <http://dx.doi.org/10.4135/9781446249222.n46>

II. Articles

- Adie, E., U. (2018). Towards improved inclusion of women and girls with disabilities in the development agenda of Nigeria. *International Journal of Integrative Humanism*, 10(1), 1-15
- Alvarez, J. A., & Emory, E. (2006). Executive function and the frontal lobes: A meta-analytic review. *Neuropsychology Review*, 16(1), 17-42. doi:10.1007/s11065-006-9002-x
- Andreou, G. & Katsaron, D. (2016). Semantic processing in children with Down Syndrome. *Selected Papers of the 21st International Symposium on Theoretical and Applied Linguistics*, 21, 59-66.
- Asim, A., Kumar, A., Muthuswamy, S., & Jain, S., Agarwal, S. (2015). Down syndrome: An insight of the disease. *Journal of Biomedical Science* 22(1), 1-41. doi:

Bibliography and Appendices

10.1186/s12929.015-0138vy.

Bayne, T., et al. (2019). What it cognition. *Current Biology*, 29(13), 6-23. doi: 10.1016/j.cub.2019.05.044

Bhattacharyya, R., Sanyal, d., Roy, K. & Saha, S. (2009). A study of cluster behavioural abnormalities in Down syndrome. *Indian Journal of Medical Scinece*, 63(2), 58-65

Blair, C., & Diamond, A. (2008). Biological Processes in Prevention and Intervention: Promotion of Self-Regulation and the Prevention of Early School Failure. *Development and Psychopathology*, 20(3), 899-911. doi: 10.1017/S0954579408000436

Bonfiglio, L. C. (2013). Accommodation theory and its application to health communication. *Encyclopaedia of Health Communication*. Doi: 10.4135/97811483346427.n77.

Broadley, I., MacDonald, J., & Buckley, S. (1995) Working memory in children with Down syndrome. *Down Syndrome Research and Practice*, 3(1), 3-8. doi:10.3104/reports.44

Broome, J. (1983). The attraction paradigm revisited responses to dissimilar others. *Human communication research*.10 (1), pp. 137-151

Caporael, L. R., Lukaszewski, M. P., & Culbertson, G. H. (1983). Secondary baby talk: Judgments by institutionalized elderly and their caregivers. *Journal of Personality and Social Psychology*, 44(4), 746–754. <https://doi.org/10.1037/0022-3514.44.4.746>

Cavallaro,F., Seilhamer, M.F, Chee, Y.T.F & Chin,B.(2016). Overaccommodation in a Singapore eldercare facility, *Journal of Multilingual and Multicultural Development*.doi: 10.1080/01434632.2016.1142553

Compton, R., L. (2013). Pragmatics in children with Down syndrome: How can strengths and challenges impact therapy. *Research Papers*. Paper 341. Retrieved from: http://opensiuc.lib.siu.edu/g_s_rp/341

Coupland, N., Coupland, J., Giles, H., & Henwood, K. (1988). Accommodating the elderly: Invoking and extending a theory. *Language in Society*, 17(1), 1–41.

Down, J. L. H. (1867). Observations on an ethnic classification of idiots.*Journal of mental science*, 13, 121-123

Draper, P.(2005). Patronizing speech to older patients: a literature review. *Reviews in Clinical Gerontology*, 15, pp 273-279. doi:10.1017/S0959259806001869

Bibliography and Appendices

- Fichten, C.S., & Bourdon, C.V. (1986). Social skill deficit or response inhibition: Interaction between disabled and nondisabled college students. *Journal of College Student Personnel, 27*, 326-333.
- Fichten, C.S., Robillard, K., Judd, D., & Amsel, R. (1989). College students with physical disabilities: Myths and realities. *Rehabilitation Psychology, 34*(4), 243-257.
- Fidler, D., J., Most, D., E., & Philofsky, A., D. (2009). The Down syndrome behavioural phenotype: Taking a developmental approach. *Down Syndrome Research and Practice 12*(3), 37-44. doi : 10.3104/reviews/2069
- Fox, S.A., & Giles, H. (1996a). Interability communication Evaluating patronizing encounters. *Journal of Language and Social Psychology, 15*(3), 265-290.
- Grieco, J., Pulsifer, M., Seligsohn, K., Skotko, B.& Schwartz, A.(2015). Down syndrome: Cognitive and behavioural functioning across the lifespan. *American Journal of Medical Genetics Part C Seminars in Medical Genetics, 169*(2), 135-149. doi: 10.1002/ajmg.c.31439
- Guralnick, M.J.(2011). The Peer-related Competence of US Young Children with DS. *Amj Intellect Dev Disabili, 116*(1). 48-64. doi:10.1352/1944-7558-116.1.48.
- Harwood, J , Ryan, E.B , Giles, H & Tysoski, S. (1997). Evaluations of patronizing speech and three response styles in a non-service-providing context, *Journal of Applied Communication Research, 25*(3), 170-195.doi: 10.1080/00909889709365475
- Harwood, J., Giles, H., Fox, S., Ryan, E.B., & Williams, A. (1993). Patronizing young and elderly adults: Response strategies in a community setting. *Journal of Applied Communication, 21*, 211-226.
- Helman, J. A., Bugental, D., Corpuz. R. (2012). Patronising speech to older adults. *Journal of Non-verbal Behaviour 36*(4). 249-261. DOI: 10.1007/S 10919-012-0135-8.
- Hippolyte, L., Iglesias, K., Barisnikov, K. 2009. A new emotional Stroop-like task: Application to the Down syndrome population. *Archives of Clinical Neuropsychology, 24*, 293–300. doi: 10.1093/arclin/acp036
- Hornsey, J. (2008). Social identity theory and self-categorising theory: A historical review. *Social and personality psychology compass. 2*(1), pp 204-222
- Hummert, M.L., Garastka, T.A., Shanner, J.L., & Strahm,S.(1994). Stereotypes of the Elderly

Bibliography and Appendices

- Held by Young, Middle-aged, and Elderly Adults. *Journal of Gerontology*,49(5), pp 240-249. doi: 10.1093/geronj/49-5.p240source Pub Med.
- Ishak, W. I. & Rafik-Galea, S. (2015).Speech accommodation strategies in the selling of life insurance.*Pertanika J. Social Sciences & Humanities*, 23, 143-157
<http://www.pertanika.upm.edu.my/>
- Kazemi, M., Salehi, M., & Keirollahi,M.(2016). Down syndrome current Status, Challenges and Future Perspectives. *Int JmoL Cell Med Summer*,5(3). 125-133. doi: 10.22088/acadpub.BUMS.
- Martin, G., Klusek, J., Estigarribia, B. & Roberts, J.(2009). Language characteristics of individuals with Down syndrome.*Topics in Language Disorders*,29(2), 112-132. doi: 10.1097/TLD.0b013e3181a71fe1
- McCann,R.M.,Cargile,A.C.,Giles,H. & Bui,C.T.(2004).Communication Ambivalence toward Elders: Data from North Vietnam,South Vietnam,and the USA. *Journal of Cross Cultural Gerontology*,19(4),275-297.doi:10.1023/B:JCCG.0000044685.45304.ca.
- Park. M., R., Lee, J., M, Hoon, M., E, Lee, D. S, Kim,B. N, Kim,J,... Pack. (2016). A short Review on the Current Understanding of Autism Spectrum Disorders. *Experimental Neurobiology*.25(1), 1-13. doi: 10.5607/en.2016.25.1.1.
- Pierquet,J, & Dickmeyer, L.,(2006). Making Sense of Patronising Speech: Examining Elderly Perceptions of Intergenerational Communication. *Journal of Undergraduate Research* ix,1-12.
- Roberts, J. E., Price, J., & Malkin, C. (2007).Language and communication development in Down syndrome.*Mental Retardation &Developmenta Disabilities Research Reviews*, 13, 26-35. doi: 10.1002/mrdd.20136
- Ryan, E. B., Bourhis,R. Y.,& Knops,U.(1991).Evaluative Perceptions of Patronising Speech Adressed to Elders. *Psychology and Aging*,6(3),442-450.doi:10.1037/0882-7974.6.3.442.
- Ryan, E. B., M. L. Hummert, & L. H. Boich. (1995). “Communication Predicaments of Aging: Patronizing Behavior Toward Older Adults.” *Journal of Language and Social Psychology*, 14 (1–2), 144–166.
- Ryan, E.B., Kennaley, D.E., Pratt, M.W., & Shumovich, M.A. (2000). Evaluations by staff, residents, and community seniors of patronizing speech in the nursing home: Impact

Bibliography and Appendices

- of passive, assertive, or humorous responses. *Psychology and Aging*, 15(2), 272-285.
- Ryan,E.B., Giles, H., Bartolucci,G.G.,& Henwood, K.(1986). Psycholinguistic and social psychological components of communication by and with the elderly. *Language and Communication*,6,1-24
- Ryan,E.B.,Hummert,M.L.,& Boich,L.M.(1991).Communication Predicament of Aging:Patronising Behaviour toward Older Adults. *Journal of Language and Social Psychology*,14(1-2),144-166.doi:10.1177/0261927x9514.1008.
- Simard, L. M., Taylor, D. M., & Giles, H. (1976). Attribution Processes and Interpersonal Accommodation in a Bilingual Setting. *Language and Speech*, 19(4), 374–387. doi: 10.1177/002383097601900408
- Simard, Lise M., Taylor, D.M & Giles,H.(1976). Attribution Processes and Interpersonal Accommodation in a Bilingual Setting. *Language and Speech*. 19(4), pp. 374–387. doi:10.1177/002383097601900408.
- Stets,J., & Bunke,P.(2000).Identity Theory and Social Identity Theory. *Social Psychology Quarterly*, 63(3), 224-237.
- Thimm ,C, Rademacher, U & Kruse, L. (1998). Age stereotypes and patronizing messages: Features of age-adapted speech in technical instructions to the elderly, *Journal of Applied Communication Research*, 26(1), 66-82. doi: 10.1080/00909889809365492
- Tsakiridou, M. (2006). The linguistic profile of Down’s syndrome subjects: evidence from wh-movement construction. *SOAS Working Papers in Linguistics*, 14, 227-248.
- Turner, C. & Oakes, J. (1986).The significance of the social identity concept for social psychology with reference to individualism, interactionism and social influence. *British journal of social psychology*, 25, pp. 237-252
- Williams,K., Kenper,S. & Hammert,M.L.(2005). Enhancing communication with older adults: Overcoming elderspeak. *Journal of Psychosocial Nursing and Mental Health Services*,43(5),12-6. doi: 10.3928/0098-9134-20041001-08
- Yazbeck, M.,McVilly, K. & Parmenter, T.R. (2004). Attitudes.toward people with intellectual disability: An Australian. perspective. *Journal of Disability Policy Studies*, 15(2), 97-111. doi: [10.1177/10442073040150020401](https://doi.org/10.1177/10442073040150020401)

III. Theses

- Dix, L., E. (2016). *Exploring The Development of Theory of Mind in Children with Down's syndrome* (Doctoral Thesis), University of Leeds, U,K
- Fisk, M & Vaarala, S, (2017). *The use of communication accommodation strategies: A case study of four meetings* (Master's thesis).University of Jyväskylä, Finland
- La Tourette, T.R.(1999). *Elderly respondents' perceptions of patronizing speech by service providers toward elderly adults* (Master thesis). University of Louisville, KY, U.S
- Lowery, M.L. (2013). *Elderspeak: Helpful or harmful? A systematic review of speech to elderly adults*. (Master dissertation). Auburn University, Alabama, U.S
- Lung, H.F.(2007). *Communicating with types of disability: Communicative competence and patronizing speech*. City University of Hong Kong, Hong Kong, China
- Makkawy. A.(2016). *Workplace accommodations and people with disability: The dilemmatic communicative process of requesting access technology* (Doctoral dissertation). University of North Carolina, North Carolina, U.S

IV. Seminars

- Morris, J. (2005, March). Citizenship and disabled people: A scoping paper prepared for the Disability Rights Commission. Seminar presented at the disability rights commission (DRC). Britain

V. PowerPoint Presentation

- Fidler, D., J. & Daunhaueur, L., A. (2013). Executive functioning in Down syndrome: Implications for education and intervention [PowerPoint slides]. Retrieved from <https://genetics.emory.edu/documents/resources/>

VI. You tube

- Tylor, B.,(2014, November 11th). Understanding non-invasive prenatal testing (NIPT) prenatal diagnosis & screening. Retrieved from <http://www.youtube.com> (2020, July 12th, at 2.00 pm).

Webography

[http:// www.cmdss.org/parentguid/about-down-syndrome/type-syndrome.](http://www.cmdss.org/parentguid/about-down-syndrome/type-syndrome)

[https://www.cdc.gov/ncbddd/autism/facts-html.](https://www.cdc.gov/ncbddd/autism/facts-html)

[https://www.hwa.org.sg/general-information-on-physicaldisabilities/.](https://www.hwa.org.sg/general-information-on-physicaldisabilities/)

[https://www.ndss.org/about-down-syndrome/downsyndrome.](https://www.ndss.org/about-down-syndrome/downsyndrome)

[https://www.nimh.nih.gov/health/topics/autism-spectrumdisorders-asd/index.shtml.](https://www.nimh.nih.gov/health/topics/autism-spectrumdisorders-asd/index.shtml)

[https://www.webaim.org/articles/cognitive.](https://www.webaim.org/articles/cognitive)

[https://www.who.int/news-room/fact-sheets/detail/dementia.](https://www.who.int/news-room/fact-sheets/detail/dementia)

[https://www.worldbank.org/en/topic/disability.](https://www.worldbank.org/en/topic/disability)

المراجع بالعربية

حمد محمد ظاهر واوان الشمري (2007). الفروق في السلوك العدواني و المهارات الاجتماعية لدى اطفال متلازمة داون طبقا لفترة الالتحاق ببرامج التدخل المبكر. الكويت: جامعة الخليج العربي.

رضية بركايل ، عبدالله بن مصطفى ، حقوق ذوي الاحتياجات الخاصة في النظام القانوني الجزائري، مجلة جيل حقوق الانسان، ع 25، 2018، ص 27

علي حمدي الفرماوي وليد رضوان النساج (2010). الإعاقة العقلية: الاضطرابات المعرفية و الانفعالية . (ط1). عمان: دار صفاء للنشر والتوزيع

مخلوف بالقرين، عمر شراني ، عزيزة جواهره (2019). علوم الطبيعية و الحياة. الجزائر: دار القصة للنشر.

نجية نميري (2011). القلق لدى ام الطفل المصاب بمتلازمة داون.(مذكرة ماستر) البويرة: جامعة العقيد اكلي محند او الحاج.

وزارة التربية الوطنية، فتح اقسام خاصة للأطفال ذوي الاحتياجات الخاصة ضمن مؤسسات التربية و التعليم العمومية التابعة لقطاع التربية الوطنية، 2014، منشور ضمن الرابط

<http://www.education.gov.dz>

Appendices

Appendix 01

The questionnaire in English

Dear carers:

We would like you to answer the following questions concerning the carers' communicative behaviours towards Down syndrome children inside centres. This research is conducted by master two English students of the University of Tiaret. This is not a test so there is no "wrong" or "right" answer and you do not even have to write your names. Please give your answers sincerely as only this will guarantee the success of the investigation. Thank you very much for your help.

N.B: You are kindly invited to cross (X) the best choice that seems true for you.

❖ Section One: Personal Information

1. Working Experience:

0-5 5-10 10-15 more than 15

❖ Section two: Carers' Attitudes towards Down Syndrome Individuals

1. Do you feel sympathy towards Down syndrome people?

Yes no

2. Why? Because they are?

Needy

Weak

Others (specify).....

3. Do you aid them in accomplishing their intellectual and physical tasks?

Yes no

4. Why? Because they?

Cannot do it alone

Cannot do it appropriately

Are incompetent

Others (specify).....

5. Do you think that Down syndrome people should be treated the same way as normal

individuals?

Yes no

6. People's view to disability affects the way they address Down syndrome people

Strongly disagree disagree agree strongly agree

❖ **Section Three: carers' verbal communicative behaviour**

1. Do you address Down syndrome children using?

First name Family name Nickname

2. Do you usually use spoiling terms with them? Yes no

3. What do you usually use with your pupils?

Son/Daughter Honey

Others (specify).....

4. What is the nature of vocabulary you use with Down syndrome children?

Very easy easy medium complex

5. What are the most common types of sentences you use while explaining to them?

Very simple simple complex

6. How often Down syndrome children fail to understand the task handed to them?

Always often sometimes rarely

7. How often do you repeat for them?

Once twice Three times more than three times

8. Do you usually praise Down syndrome children for minor accomplishment?

Yes No

9. What are the words that you use while doing so?

Bravo good Very good excellent

Others (specify).....

10. While Down syndrome children start answering your question, do you?

Interrupt to help

Bibliography and Appendices

Let them do it alone

Ask their peers to answer instead of them

Others (specify).....

11. Are you limited in the choice of topics handed to Down syndrome children?

Yes no

❖ Section Four: Carers' Nonverbal Communicative Behaviour

1. While explaining a task, do you stay?

far from them near them

2. How do you rate you pitch of voice while interacting with Down syndrome individuals?

Very loud loud medium low

3. How do you reward your pupils after each accomplishment made?

Clapping hugging patting on head

Giving sweets and chocolate

Others (specify).....

4. Do you consider the correct pronunciation while interacting with Down syndrome individuals?

Yes no

5. Does your speech pace change while interacting with Down syndrome children?

Yes no

6. If yes, how is becomes?

More slow

More fast

7. Do you find yourself smiling more than the usual while interacting with Down syndrome children?

Yes no

Bibliography and Appendices

❖ Section Five: carers' communicative behaviour effects on Down syndrome children

1. Is it necessary to change your style of speech once you interact with Down syndrome individuals?

Yes no

2. If it is yes, why you do so?

.....
.....

3. It is necessary to use a simplified form of speech to guarantee proper understanding of Down syndrome children

Strongly disagree disagree agree strongly agree

4. This category of people needs a continuous support to reinforce their learning skills

Strongly disagree disagree agree strongly agree

5. Carers' relaxing facial expressions (smiley faces) help in building strong relationships and aid communication with them

Strongly disagree disagree agree strongly agree

Thank you very much for your cooperation...

Appendix 02

The Questionnaire in Arabic

استبيان

نود منكم الإجابة على الأسئلة التالية المتعلقة بالسلوكيات التواصلية للمربين المختصين تجاه أطفال متلازمة داون داخل المراكز. يتم إجراء هذا البحث من قبل طالبتين من جامعة تيارت شعبة اللغة الإنجليزية . هذا ليس اختبارًا لذا لا توجد إجابة "خاطئة" أو "صحيحة" وليس عليكم حتى كتابة أسماءكم. يرجى تقديم إجاباتكم بصدق لأن هذا فقط سيضمن نجاح بحثنا و شكرًا

ملاحظة : ضع علامة في الخانة المناسبة لاختيارك

❖ المرحلة الأولى: معلومات شخصية

1. الخبرة: 0-5 5-10 10-15 أكثر من 15

❖ المرحلة الثانية: مواقف المربين من متلازمة داون

1. هل تشعر بالتعاطف تجاه أناس المصابين بمتلازمة داون؟ نعم لا

2. لماذا؟ لأنهم؟

يحتاجون المساعدة

ضعفاء

أخرى (أذكرها).....

3. هل تساعدهم على إنجاز مهامهم الفكرية والبدنية؟ نعم لا

4. لماذا؟ لأنهم؟

لا يستطيعون فعلها بأنفسهم

لا يقدرّون على فعلها بشكل صحيح

غير أكفاء

أخرى (أذكرها).....

5. هل تعتقد أنه يجب معاملة الأشخاص المصابين بمتلازمة داون بنفس الطريقة التي يعامل بها الأفراد العاديون؟

نعم لا

6. ان نظرة الناس للاعاقة تؤثر على طريقة التعامل مع فئة متلازمة داون

موافق غير موافق

❖ المرحلة الثالثة: السلوك التواصلي اللفظي للمربين

1. هل تخاطب اطفال متلازمة داون مستعملا ؟

الاسم اللقب اسم دلح

2. هل تستخدم كلمات دلح معهم؟ نعم لا

3. ماذا تستعمل بالتحديد ؟

بنتي/ولدي حبيبي/حبيبتي

أخرى(أذكرها).....

4. ما طبيعة المصطلحات التي تستخدمها مع أطفال متلازمة داون ؟

سهلة جدا سهلة متوسطة الصعوبة معقدة

5. ما نوع الجمل المستعملة أثناء الشرح لهم ؟

بسيطة جدا بسيطة مركبة

6. ما هو عدد المرات التي يخفق فيها أطفال متلازمة داون في استيعاب كلامك ؟

دائما غالبا أحيانا نادرا

7. كم مرة تعيد الشرح لهم ؟

مرة واحدة مرتان ثلاث مرات أكثر

8. هل عادة ما تمدحون أطفال متلازمة داون حتي لو كان انجازهم بسيطا؟ نعم لا

9. ماهي كلمات الإطراء الموجهة لهم ؟

برافو جيد جيد جدا ممتاز

أخرى(أذكرها).....

10. أثناء إجابة أطفال متلازمة داون على سؤالك ، هل ؟

تقاطع للمساعدة

تدعمهم يفعلون ذلك بمفردهم

تطلب من زملائهم الإجابة بدلا عنهم

أخرى(أذكرها).....

11. هل أنت ملزم باختيار مواضيع معينة لأطفال متلازمة داون ؟ نعم لا

❖ المرحلة الرابعة: السلوك التواصلي الغير اللفظي للمربين

1. أثناء شرح النشاط الموكل له، هل تجلس ؟

قربيا من الطفل بعيدا عن الطفل

2. كيف تصف نبرة صوتك أثناء التفاعل مع أطفال متلازمة داون ؟

عالية جدا عالية عادية منخفضة

3. كيف تكافؤهم بعد كل انجاز ؟

التصفيق العناق المسح على الرأس تقديم حلوى أو شوكولاتة

أخرى (أذكرها).....

4. هل عادة ما تحرص على النطق الصحيح للكلمات و التركيز على مخارج الحروف أثناء الحديث مع أطفال متلازمة

داون نعم لا

6. هل تغير من وتيرة كلامك أثناء التفاعل مع أطفال التريزوميا؟ نعم لا

7. إن أجبت بنعم فكيف تصبح ؟ أبطأ أسرع

8. أثناء تواصلك مع أطفال التريزوميا، هل تجد نفسك تبتسم بشكل مختلف عن طبيعتك؟

نعم لا

❖ المرحلة الخامسة: آثار السلوك التواصلي للمربين علىأطفال متلازمة داون

1. هل من الضروري تغيير طريقة الكلام أثناء التفاعل مع هذه الفئة ؟ نعم لا

2. لماذا تعتقد ذلك ؟

.....
.....

3. من الضروري استعمال لغة مبسطة لضمان الفهم السليم لأطفال متلازمة داون

موافق غير موافق

4. إن فئة متلازمة داون بحاجة إلى دعم مستمر خاصة اللفظي لتعزيز مهاراتهم التعليمية

موافق غير موافق

5. تساعد تعابير الوجه الهادئة(الوجه المبتسم) لمقدمي الرعاية في بناء علاقات قوية مع أطفال التريزوميا وتساعد

على التواصل معهم

موافق غير موافق شكرا جزيلاً على تعاونكم

Appendix 03

Clinical Psychologists' Interview in English

Section One: Professional Data

1. For how many years have you been working as a clinical psychologist?
2. Have you ever worked in other centers?

Section Two: Clinical Psychologists' Communicative Behaviour and Attitude toward Down syndrome Category

1. When first mentioning Down syndrome category, what is the first impression that pops up to your mind about them?
2. How does that affect your communicative behaviour toward them?
3. Do you adopt the same communicative behaviour whether with Down syndrome category or with other people? Why? And how your verbal and non-verbal communicative behaviour becomes?
4. What are the possible ways and strategies that you personally adopt to facilitate comprehension, communication, and to reinforce the learning abilities of Down syndrome category?
5. Do you think that your communicative behaviour meet the needs of Down syndrome pupils? How is that?

Clinical Psychologists' Interview in Arabic

مقابلة شفوية مع أطباء النفس العيادي

المرحلة الأولى: المعطيات الوظيفية:

1. منذ متى وان تمتهن الطب النفسي العيادي؟
 2. هل سبق و عملت في مراكز أخرى غير هذا المركز؟
- المرحلة الثانية: السلوك التواصلى لأطباء النفس العيادي وموقفهم من فئة التريزوميا :
1. عند ذكر فئة المتلازمة ما هو الانطباع الأول أو الصورة التي تتبادر إلى ذهنك عنهم؟
 2. كيف يؤثر انطباعك على سلوكك التواصلى اتجاههم؟
 3. هل تعتمد نفس السلوك التواصلى سواء مع الأشخاص العاديين أو مع ذوي المتلازمة؟ لماذا؟ وكيف يصبح سلوكك التواصلى سواء اللفظي أم الجسدي؟
 4. ما هي الطرق أو الاستراتيجيات التي تعتمد عليها أنت شخصيا لتسهيل الفهم والتواصل وتعزيز القدرات التعليمية لدى فئة التريزوميا؟
 5. هل تعتقد أن طريقة تواصلك مع ذوي المتلازمة تلبي احتياجاتهم؟ كيف ذلك؟

Appendix 5

**مدينة النشاط الاجتماعي
المركز النفسي البيداغوجي للأطفال
المعوقين ذهنيا
نيرانت**




من قنع من الدنيا باليسير هان عليه كل عسير



المركز النفسي البيداغوجي للأطفال المعوقين ذهنيا نيرانت
العنوان: طريق بوشيف - نيرانت -
الهاتف: 040 - 77 - 71 - 72
الفاكس: 046 - 41 - 54 - 70
البريد الإلكتروني: Cppehm14@yahoo.fr



22/10/2014 12:15

الالتصام كلمة طيبة بغير حروف

ياكل المركز

- الجناح الإداري :
- الإمامة
- مكتب المدير
- مكتب المقتصد
- مصلحة المستخدمين
- المخزني
- قاعة الاجتماعات
- الحراسة
- الجناح البيداغوجي :
- المكتب البيداغوجي
- مكتب الأخصائي النفسي
- مكتب الأخصائي الأطفوني
- مكتب المساعدة الاجتماعية
- العيادة
- الأفواج
- القاعة النفسية الحركية
- النادي
- المرافد
- الساحة

ت شافية كافية دين غنى علم مروءة وعفو وعافية

مراحل التكفل بالطفل

مصلحة الفحص والمتابعة الخارجية

تضم هذه المصلحة للكشف عن درجة الإعاقة وإمكانية التكفل بالطفل الحامل لها، توجيه أولياء الأطفال فيما يخص حقوق أبنائهم، المتابعة العيادية والأرطوقية للأطفال الذين يعانون من إضطرابات مصاحبة، تحضير الأطفال المعنيين بالإلتحاق بالمركز.

قسم الملاحظة

عند قبول الأطفال المتخلفين ذهنيا للإلتحاق بالمركز يخضع هؤلاء لفترة الملاحظة وذلك من أجل تقييم إمكانياتهم وقدراتهم ومن ثم توجيههم إلى المستوى الذي يناسبهم.

قسم الإثارة

موجه خصيصا للأطفال الذين يحملون درجة عميقة من التخلف الذهني أو الذين يعانون من إضطرابات مصاحبة تؤثر على أداؤهم التربوي .

قسم التفصيلين

مصنفة من 01 إلى 05 ، مخصصة لفئة المتخلفين ذهنيا درجة متوسطة ، تضم هذه الأقسام تقديم تربية مناسبة للطفل حسب قدراته كما تضمن له رعاية و تدريب على الحياة العملية باستغلال إمكانياته وقدراته لأقصى حد ممكن.

قسم ما قبل التمدرس

يشمل هذا المستوى خاصة فئات الأطفال المتخلفين ذهنيا درجة خفيفة ، يستفيد هؤلاء من متابعة تربوية من خلال برنامج مستوى السنة الثانية من التعليم الابتدائي.

قسم ما قبل التمهين

بعد المرور على المستويات السالفة بضمن هذا المستوى للطفل تدريب مهني وفقا لقدراته وتحضيره للإعتماد على نفسه وعلى الاندماج في الحياة العملية.

مهام المركز

- ❖ التكفل بفئة الأطفال المعوقين ذهنيا
- ❖ مساعدة الطفل على الاندماج في الوسط الاجتماعي
- ❖ تنمية القدرات الحركية ، الاجتماعية ، الفكرية والمعرفية
- ❖ تهيئة الطفل لإدماجه في الحياة

شروط الإلتحاق بالمركز

يستقبل المركز النفسي البيداغوجي للأطفال المعوقين ذهنيا أطفال ذوي الإعاقة الذهنية العميقة ، المتوسطة والخفيفة والأطفال ذوي الإضطرابات النفسية اللغوية للإستفادة من التكفل التربوي المخصص و براوح السن ما بين 06 و 18 سنة حيث يتم الإلتحاق الطفل بالمركز بطلب من والديه أو بتوجيه من جهات مختصة يخضع بعدها إلى الفحص النفسي العيادي لتحديد توفير الشروط اللازمة للتكفل به داخل المركز

ملف القبول على مستوى المركز

- ❖ طلب خطي
- ❖ شهادة طبية لمخصص في الأمراض العقلية
- ❖ شهادة إقامة للطفل
- ❖ شهادة ميلاد
- ❖ شهادة عقلية
- ❖ 04 صور شمسية
- ❖ بطاقة التنليح
- ❖ بطاقة الزمرة الديموية.



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بطاقة فنية

التسمية المركز النفسي البيداغوجي للأطفال المعوقين ذهنيا.

انشأ المركز النفسي البيداغوجي للأطفال المعوقين ذهنيا بتيارت بموجب المرسوم الرئاسي 2599/87 حيث افتتح رسميا من قبل التضامن الوطني والأسرة بتاريخ 29 سبتمبر 2010

الهيئة الوصية

-وزارة التضامن الوطني والأسرة وقضايا المرأة

Technical Sheet of the Psycho-pedagogical Center of Children with Special Needs