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A Comparative Study of the Applicable Laws araelating to Educational Support of Exeptional Children and Adolescents of Iran and UNICEF International Organization

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Quantitative Study

Abstract

Background: The main goal of planning governments is to provide physical, mental, and social support to people by providing them with relevant facilities. The purpose of this study was to compare the implementation of the laws related to the educational support of exceptional children and adolescents in Iran and the United Nations International Children's Emergency Fund (UNICEF) international organization.

Methods: The research method was qualitative and adaptive. The sample included the documents and annual reports available in the Organization for Education of Exceptional Children and the Welfare Organization of Iran that were selected through available and targeted sampling from 2011 to 2020, and an international dimension, UNICEF annual reports on educational support for exceptional children and adolescents from 2011 to 2020. Some quantitative data were analyzed using descriptive methods, and content analysis was done in the documentation adaptation section. According to the findings, the number of exceptional children and adolescents covered by well-being has increased in recent years.

Results: The Phi correlation coefficient between families of exceptional children and adolescents and welfare authorities on the quantity and quality of educational support showed that the views of families and authorities were in harmony. According to a UNICEF study in 51 developing countries, 42% of female and 51% of male exceptional and disabled children (an average of about 47%) managed to attend primary school, while in Iran, the average was 62.5%.

Conclusion: It can be concluded that educational support in Iran is better than UNICEF reports from developing countries.

Keywords: Adolescent; Child; Iran; United Nations; Exceptional

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Introduction

Cancer is the name given to a set of diseases resulting from the uncontrolled proliferation of cells. Cancer cells are separated from the usual mechanisms of cell division and growth. The exact cause of this phenomenon remains unclear, but genetic factors or factors that disrupt cell function may play a role in cancer formation (Hopstaken et al., 2022). Prostate cancer (PC) is one of the men's most common cancers and is considered as one of the most important causes of mortality in adult men. In the United States (US), it is reported to be the second leading cause of death after lung cancer (among cancers). PC is the most common cancer in men, affecting about one in six men (Plym et al., 2022; Schmanke, Okut, & Ablah, 2021). The highest prevalence of PC is in Africa and the lowest in the Asian population. Several studies have shown familial accumulation of PC. The main reason for this accumulation is to inherit the genes involved (Dorff et al., 2022).

The prostate is one of the most important glands of the male reproductive system, located below the bladder and in front of the large intestine, and plays an essential role in reproduction. The gland is usually small in size, but over fifty, it gradually enlarges and sometimes causes problems for men. In general, the most common prostate diseases are inflammation of the prostate (prostatitis), enlarged prostate (benign prostatic hyperplasia) due to aging, and PC. The most worrying prostate disease is PC, which means forming cancer cells in the prostate tissue. Because this prostate cell deformity occurs slowly, it may not show symptoms for several years before severe malignancy. Late diagnosis can lead to malignancy as well as the spread of cancer cells to other tissues, including the bladder and colon (Alghamidi, Hussain, Alghamdi, & El-Sheemy, 2014; Orrason, Westerberg, Garmo, Lissbrant, Robinson, & Stattin, 2020). Studies show that cancer has several negative consequences in these patients, including decreased general health, reduced quality of life, and despair, among which anxiety, depression, and despair are more common. Cancer generally causes profound emotional problems in patients and their families, ranging from depression, anxiety, and maladaptation to emotional disorders and fear of relapse and death. The prevalence of psychological disorders in patients with cancer is high, and there is a high risk of depression and anxiety in these patients (Bastani et al., 2010; Choi, Rhee, & Flannery, 2022). Thus, if special measures are not considered to solve these problems, they will have destructive effects and adverse physical and psychological consequences.

The phenomenon of anxiety is one of the issues that human beings have always been involved with over time. This phenomenon is pervasive and universal, and it exists in all human beings, and even the most instrumental people have experienced it. Feeling anxiety occurs when a person perceives a danger beyond his ability to deal with it (Henriksson et al., 2022; Mayer, Craske, & Naliboff, 2001). Over the past decade, several psychological methods have been developed to improve the psychological status of people with cancer, like reality therapy and neurofeedback.

Reality therapy is a counseling and psychotherapy method founded by Glasser (2000). Reality therapy helps people explore wants, needs, behavioral values, and ways which help meet their needs. It is based on common sense and emotional conflicts, emphasizing reality, accepting responsibility, and recognizing right and wrong and their relationship to daily life. Glasser's approach is a unique blend of philosophy and existential and behavioral methods similar to the self-regulatory methods of therapists' behavior (Asadzadeh, Samad-Soltani, Salahzadeh, & Rezaei-

Hachesu, 2021; Glasser, 2000). Non-denial of reality, responsibility, and, accordingly, planning to achieve goals is one of the primary human needs in the process of life, which has been given importance in this therapeutic approach. This approach helps people control their behavior, take responsibility for their actions, and make better choices in their lives, emphasizing that access to a successful identity is achieved through successful work and the power to choose the agent. It is vital for his mental health (Chow, Hon, Chua, & Chuan, 2021). Researchers have examined and validated the effect of reality therapy on a wide range of psychological symptoms. Bhargava (2013) showed that reality therapy effectively reduced depression in deaf people. Lowe (2000) also found that reality therapy effectively reduced stress and anxiety in pregnant women.

The neurofeedback process involves training or learning to self-regulate brain activity. The brain controls blood flow through the dilation or contraction of blood vessels, and the blood flow in the brain is directed to specific areas. Neurofeedback works so that it has far fewer side effects than the drug. It is also a non-invasive method compared to other brain interventions, such as deep brain stimulation. It is a method of manipulating neuronal activity that allows researchers to evaluate changes in neuronal activity and gain important information about the relationship between brain activity and disease symptoms (Gruzelier, Egner, & Vernon, 2006; Munoz-Moldes & Cleeremans, 2020). Researchers have suggested that neurofeedback affects psychological disorders such as depression, anxiety, fatigue, stress, sleep problems, and pain in patients with cancer. In a study, Mennella et al. (2017) found that neurofeedback training reduced anxiety and negative emotion (depression) in women. Alino Costa et al. (2016) realized that neurofeedback training reduced anxiety.

The psychological consequences of cancer affect society, the individual, and the family. Therefore, the effective treatments for depression and anxiety in these patients must be identified to prevent the occurrence or exacerbation of their psychological problems. In this study, the researchers tried to answer the question of whether there is a difference in the effectiveness of reality therapy and neurofeedback training in reducing anxiety and depression in men with PC.

Methods

The method of the present study was quasi-experimental with a pretest-posttest, follow-up design with a control group. The statistical population of the study consisted of men with PC who were referred to Baghdad Teaching Hospital in Baghdad, Iraq, for treatment for six months (January to June, 2020). Using the G*Power software with effect size = 0.15 and $\alpha = 0.05$ and also the sample size of previous studies, the sample size of the present study was considered to be 60 (20 people for each group) (Garrett, Tao, Taverner, Cordingley, & Sun, 2020; Huang, Lin, Han, Peng, & Huang, 2021). Finally, three population groups of 20 people in each group were randomly divided. It should be mentioned that 20 people were in the reality therapy group, 20 in the neurofeedback group, and 20 in the control group. Individuals in the three groups were barred from meeting during research and discussing the content of their treatment.

Inclusion criteria were symptoms of depression and anxiety based on the doctor's diagnosis, being 35 to 60 years old, at least one month passed since the diagnosis of PC and surgery, no history of mental illness and hospitalization, not having another cancer, having a high school education or higher, ability to participate in group therapy sessions, and willingness to cooperate. Exclusion criteria of the study were

not attending meetings for more than three sessions, unwillingness to continue attending meetings, and using psychotropic drugs to reduce anxiety and depression during the study. Due to ethical considerations, prior to the plan's implementation, participants were promised that the information received from each member remained strictly secret and that each member could withdraw from the training at any time when they did not want to continue.

Each patient's files in the mentioned hospital were studied to accomplish the research. The patients who met the inclusion criteria were found. Individuals who wanted to participate in the study were asked to come to the center to answer Beck Depression Inventory (BDI) and the State-Trait Anxiety Inventory (STAI) questionnaires. A total of 184 patients agreed to attend the center. After answering the questions by the invited patients and according to the scores obtained by each patient, 60 patients were selected using the simple random sampling method and divided into three groups: reality therapy, neurofeedback, and control.

In each group, the initial scores of the selected individuals were recorded as a pretest for their STAI and BDI questionnaires. The reality therapy group received reality therapy training for 12 sessions, and the neurofeedback group received neurofeedback training for 18 sessions. The control group had simple appointments (10 sessions) with the therapist.

After this stage, the posttest stage began. The control group also completed the questionnaires again after 12 sessions with the therapist. Five months later, the follow-up stage started, the patients' questionnaires were again completed, and the data were extracted as a result. In short, the classes of the reality therapy group were held as follows: group formation and acquaintance, self-acknowledging to strengthen self-confidence, promoting responsibility and giving responsibility to group members, examining the level of responsibility by controlling what should be done, discussing the wrong choice, successful and unsuccessful communication, and their perceptions of themselves, and finally reviewing previous sessions.

Neurofeedback was treated three times a week for 15 sessions. The neurofeedback device used in the current investigation was a Canadian device made by Thought Technology, FlexComp Infiniti model with ten channels. In this paper, neurofeedback therapy was performed on the experimental neurofeedback group for six weeks and three 40-minute sessions per week. In neurofeedback, first, according to the international 10-20 system, the electrodes were installed in F4-PZ locations according to the treatment protocol.

This study measures anxiety using a state-trait anxiety questionnaire, including separate self-assessment scales to measure overt and covert anxiety. The STAI explicit anxiety scale (Form Y-1) consists of twenty sentences that assess a person's feelings at "the moment and the time to respond." The STAI hidden anxiety scale (Form Y-2) also includes twenty sentences that measure a person's general and normal emotions. The minimum score for the trait and state anxiety subscale is 20, and the maximum score is 80. The reliability of the STAI test was calculated by Quek et al. (2004).

The BDI consists of 21 questions designed to assess the feedback and symptoms of patients with depression, and its items are based on the observation and summary of shared attitudes and symptoms among depressed mental patients. The minimum score in this test is zero, and the maximum is 63. The score for every person is obtained directly by adding the individual scores in each item: 0 to 13: no or minimal depression, 14 to 19: mild depression, 20 to 28: moderate depression, and 29 to 63: severe depression. Findings showed that this questionnaire had a high

validity (Stefan-Dabson, Mohammadkhani, & Massah-Choulabi, 2007; Yang & Stewart, 2020).

Data were analyzed using a multivariate analysis of covariance (MANCOVA). To do this, SPSS software (version 16, SPSS Inc., Chicago, IL, USA) was used.

Results

In table 1, the number of disabled people covered by the Welfare Organization of the whole country from 2011 to 2019 is reported (since the statistical yearbook of 2010 has not yet been published, the information of this yearbook is not available).

In the statistical yearbooks of 2011 and 2012, the division and presentation of statistics based on disability severity have not been reported. As you can see, according to figure 1, the number of people with disabilities covered has increased over the past years, and more people with disabilities and their families are receiving support and well-being services. According to the country's Welfare Statistical Yearbook (2019), the severity of disability is the extent of "size and extent of harm" in the performance and social participation of a person determined by the outcome of the size and extent of the injury in "physiological function and anatomy of the body" on the one hand, and "limitation in capacity and ability to perform daily activities of life or social participation", on the other hand. Its degrees include mild, moderate, severe, and very severe. In the yearbooks studied, the number of disabled persons was not present by age and therefore, according to the records and documents in the organization, the number of exceptional children and adolescents was estimated as follows:

In 2021, 200000 disabled people under the age of 7 and about 500000 disabled people aged 7 to 20 were covered by welfare. The following results were obtained in a checklist completed by families with exceptional children and adolescents covered by welfare: 40 exceptional girls and adolescents and 60 exceptional children and adolescents participated in this study and answered a researcher-made questionnaire (families answered the questionnaire).

Table 1. The number of disabled people covered by well-being from 2011 to 2019 by the severity of disability in the whole country

Year	Mild	Medium	Severe	Very severe	Uncertain	Total
2011	-	-	-	-	-	851386
2012	-	-	-	-	-	1093855
2013	133793	292233	376024	226475	83169	1111694
	(12.03)	(26.38)	(33.82)	(20.37)	(7.48)	
2014	143225	311036	407222	234113	83429	1179005
	(12.14)	(26.38)	(34.53)	(19.85)	(7.07)	
2015	158121	331604	433404	220883	76755	1220767
	(12.95)	(27.16)	(35.50)	(18.09)	(6.28)	
2016	180692	361404	474921	226169	286574	1319430
	(13.69)	(27.39)	(35.99)	(17.14)	(21.71)	
2017	211194	399496	517249	217620	112255	1415710
	(14.91)	(28.21)	(36.53)	(15.37)	(8.63)	
2018	263461	462611	578511	221546	63798	1590113
	(16.58)	(29.09)	(36.38)	(13.93)	(4.01)	
2019	309395	503093	622086	219431	56470	1710475
	(18.08)	(29.41)	(36.36)	(12.82)	(3.36)	

Data are presented as number and percent.

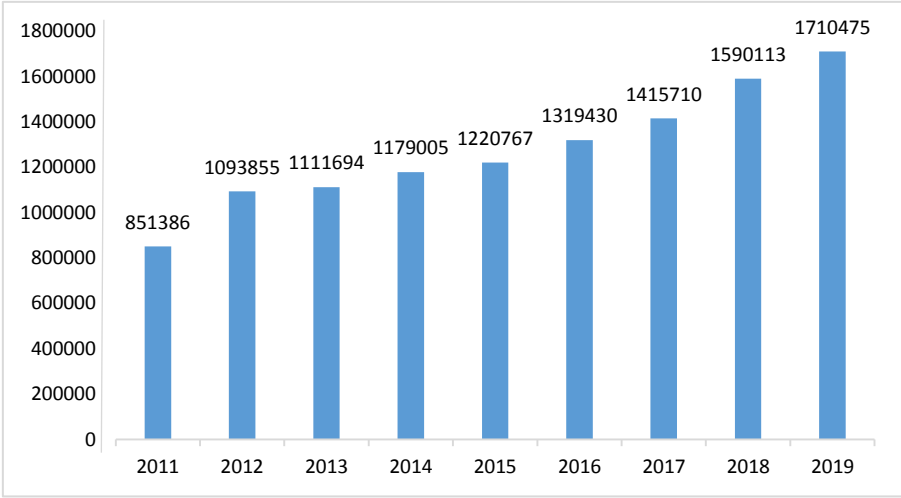

Figure 1. Number of disabled people covered by the Welfare Organization of the whole country from 2011 to 2019

The mean age of exceptional children and adolescents was 16.60, with a standard deviation (SD) of 3.21. Of these, 44% had physical and motor disability, 10% had multiple disabilities, 16% had intellectual disabilities, 13% had visual disabilities, 8% had mental disabilities, and 9% had hearing disabilities. The level of education of those who responded to the questionnaires was as follows: 25% of the subjects were illiterate, 61% had a diploma, and 14% had a diploma. Exceptional children and adolescents in this study were 28% only child, 40% two, 25% three, 4% four, and 3% five children. Fifty-two percent of these exceptional children and adolescents were first-born, 31 percent were second children, 15 percent were third children, and 2 percent were fourth children. In this study, 101 welfare officials had access to the files; 84 were women, and 17 were men, with an average of 19.49 years and a SD of 7.42 years.

As can be seen in table 2, in 2020, 90% of families reported that they did not receive services from rehabilitation centers, while 73.3% of welfare officials stated that disabled people did not benefit from rehabilitation assistance. Phi coefficient was used to investigate the correlation between families and welfare authorities, which in 2020 was very small at about 0.030.

Table 2. Percentage of rehabilitation assistance services received or not received by families of disabled persons and welfare authorities during 2011-2020

Group	Status	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Family	Yes*	7.0	8.0	8.0	9.0	10.0	10.0	11.0	10.0	10.0	10.0
	No**	93.0	92.0	92.0	91.0	90.0	90.0	89.0	90.0	90.0	90.0
Officials	Yes*	21.8	22.8	22.8	22.8	24.8	25.7	26.7	26.7	26.7	26.7
	No**	78.2	77.2	77.2	77.2	75.2	74.3	73.3	73.3	73.3	73.3
Phi coefficient		0.051	0.021	0.021	0.086	0.047	0.038	0.010	0.030	0.030	0.030
P-value		0.610	0.830	0.830	0.390	0.640	0.700	0.919	0.761	0.761	0.761

*Rehabilitation assistance services received or provided; **Received or not provided rehabilitation assistance services

Another critical point is that the opinion of families and authorities during the years 2011 to 2020 has been almost constant, and we are seeing a slight change in the status of receiving rehabilitation assistance services; therefore, according to the opinion of the authorities, the percentage of non-receiving rehabilitation assistance services has increased from 78% in 2011 to 73% in 2020, and only 5% improvement was seen. These figures were extracted from researcher-made questionnaires that families with exceptional children and adolescents and welfare officials responded to. The information in table 3 comes from articles, documents, and reports provided by the authorities.

In table 3, following the opinion of the authorities, in one place, exceptional children and adolescents (Seraj 2021), and in another place, 25% (website of disabled people, 2020) receive rehabilitation assistance, while UNICEF statistics are reported to be 5 to 15 percent.

Table 3. Comparison of United Nations International Children's Emergency Fund (UNICEF) comments and the relevant authorities of the country on rehabilitation assistance services

UNICEF (2015)	5% to 15% of children with disabilities and exceptional children in developing countries have access to rehabilitation aids.
Hemmat Mahmoudnejad (2020)	On behalf of the Planning and Budget Organization, for one million and 400 thousand disabled people in the country, 1300 billion tomans has been allocated, and this budget is 928 thousand tomans for each disabled per year and 80 thousand tomans for each disabled per month while 38 thousand billion tomans is needed.
Asadi (2021)	Thirty percent of the physically-disabled people with severe and severe mobility, 40 percent of moderate disabilities, 60 percent of hearing disabilities and deaf people, and 80 percent of disabled people in the field of severe blindness and severe visual impairment require rehabilitation assistance.
Nafarieh (2021)	One million five hundred fifty-three thousand nine hundred fifty-eight people cover people with disabilities. Healthcare provides 50% of the rehabilitation costs for these people.
Seraj (2013)	Of the 1.5 million people covered by welfare, 50% of disabled people receive rehabilitation aids, of which 240000 are children, 120000 of whom receive rehabilitation assistance; although this figure represents 50% of the cost efficiency, it does not include the quality of items and the quality of the needs (UNICEF figures were 5%-15%). Of course, the beneficiaries who help the Welfare Organization provide some of the costs. But if we consider one-third of the country's disabled population, which is three million people, half of them are not covered by welfare (i.e., children). Of a total of 480000 exceptional and disabled children in the country, 120000 benefit from rehabilitation assistance from Welfare Organization, and the rest, 360000, do not receive these facilities (equivalent to 25 percent). Of course, some people who are not covered come from families which use rehabilitation assistance facilities in the form of free shopping from the market, which is not an accurate statistics.

UNICEF: United Nations International Children's Emergency Fund

Discussion

This study showed that providing rehabilitation assistance services to exceptional children and adolescents in Iran was better than UNICEF statistics. According to the statistics obtained by a checklist of families with exceptional children and adolescents and welfare authorities, in 2020, according to the families, 10% and 26% of disabled people used rehabilitation assistance services. In explaining the disagreement between the welfare authorities and families of disabled children, it can be said that in completing questions and forms, considering the officers of the cases observing the papers to complete the form and answering the questions, they had a more objective and accurate opinion than the families who mentally completed the forms. In addition, due to the lack of meeting all needs and shortcomings, families usually reflect their complete dissatisfaction in their statements, comments, and answers to questions. However, the authorities' answer is based on the file and documentation and is more reliable.

Moreover, according to Yusuf, 5 to 15 percent of disabled and exceptional children in developing countries have access to rehabilitation aids, while according to the relevant authorities in Iran, 50 percent of these children have access to rehabilitation aids (Seraj, 2021). Although the statistics presented in the statements of the authorities and the documents and cases of disabled well-being have a significant difference (50% and 26%), it can be concluded that among developing countries, Iran has a better place in providing rehabilitation services to disabled people. He has (Bornstein, Davidson et al. 2003).

According to this research, Iran has a better position than UNICEF statistics in developing countries. One of the reasons is that, despite the economic problems in the country, due to religious and national culture and teachings, a significant part of the costs related to people in need are in the form of altruism, charity, charity, and charity vows. Participation is done with the country's support systems. In 2019, the statistics of public participation with well-being were generally 10512071593518 rials, 2759614968724 of which was cash and 6256881021088 of which was non-cash, and 1495575603706 rials of services (Hemmat Mahmoudnejad, 2020). A significant part of this assistance is allocated to exceptional children and young people, including providing rehabilitation aid.

The results of study by Shirmohammadi and Kelishadi (2018) showed that support for the rehabilitation of disabled children was one of the ordinary laws of Iran, the United States of America (USA), China, and India. According to Taheri's research (2012), one of the common laws between Germany, Sweden, and Iran is rehabilitation support for disabled children. Overall, the results of this study, in line with previous studies, show that Iran is advancing towards the rights of children with disabilities, and in this regard, it has successfully implemented the relevant laws.

Some limitations for the lack of rehabilitation assistance services for the disabled, high costs, inadequate government credits, cultural challenges, lack of adequate education, lack of proper accommodation and passageways for the presence and participation of disabled people, lack of fair executive laws, poverty, and livelihood problems of families (Iravani, Riahi, Abdi, & Tabibi, 2021).

This study has some limitations. In the statistics in the yearbook of welfare, the number of disabled people was not provided by age and therefore, access to the number of exceptional children and adolescents under welfare protection was limited. The statistics were reached based on the reports and opinions of the authorities. The lack of coordination of support devices in providing services was

another limitation in such a way that the services were done in the form of partisanship and the devices did not have complete and accurate knowledge of the services of other devices, which made it difficult for the researcher to collect information. Additionally, there was no strict executive policies in providing rehabilitation services to disabled and exceptional children and mastering organizational tastes in delivering services instead of a codified program. Therefore, the views of the authorities were different, setting up different systems to provide services and support devices to people with disabilities. This multiplicity of systems, on the one hand, leads to a lack of accurate information for the audience, and on the other hand, the researcher is confused (Rosenthal, 2009).

Considering the researcher's 30-year experience and expertise on exceptional and disabled children, and according to the research, which has been tried to be very accurate due to the existence of effective communication with authorities and support organizations, especially the Welfare Organization, suggestions are presented as follows: Prevent the distribution of credits for exceptional and disabled children and their families and the organization of the program and budget in a specific row and allocate to the custodian of this group for particular programs such as rehabilitation aids the welfare organization. International experiences have shown that establishing the Ministry of Family can be combined with scattered organizations, goals, programs, and human resources credits-command in one direction and centrally, avoiding leakage and waste of credits and human resources facilities. Monitoring in this mechanism will be more effective, and services will be given to individuals and families with greater quantity and quality. The Office of Studies and Research in Welfare must carefully examine services and activities. By establishing such an office, activities are monitored, and continuous improvement of the quality of services is achieved. In addition, this office can help researchers and students by providing more accurate and focused information. It is also suggested that other social welfare indicators be researched scientifically and compared with international standards and the country's position, and a more favorable service model for supporting devices should be designed.

Conclusion

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Conflict of Interests

Authors have no conflict of interests.

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