CHAPTER I

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The present investigation aims at exploring the impact of parental acceptance, reaction of siblings and the peer-group on certain important psychological dimensions amongst handicapped persons. We have selected for study three dimensions — depression, anxiety and self-confidence — all three providing an index of a sense of well-being. Our focal concern is with handicapped persons. The susceptibility of the handicapped, who have to cope with greater number of stresses and strains, to have a higher degree of depression and anxiety and a lowered self-confidence, led us to explore these variables. By elucidating the extent to which depression, anxiety and self-confidence are predicted by or dependent on parental acceptance, sibling-reaction and peer-group acceptance, we should be able to contemplate intervention strategies.

The word handicap is used to describe the disadvantages imposed by an impairment or disability upon the individual in the context of his cultural milieu, or in his psychological, physical, vocational and community activities (Sen, A., 1988). The degree to which he is handicapped depends on his physical, psychological and mental capability and the social attitude imposed upon his specific impairment. Thus, handicap
may be conceived as a social condition imposed on the disabled individual. This imposition has its roots in the negative value emanating from different sources such as those imposed by the society, imposed by the person himself and imposed by a value system that has important repercussion on the personality of the handicapped individual.

A handicap is a phenomenon experienced by each of us, for at some level of functioning and in the context of some behaviours, we are bound to fall below the desired level. So, as in the vocabulary of golf, every player has his own handicap, each of us plays the game of life with our handicaps very much in evidence.

So, usage of the term handicap carries a subtle and implicit connotation of viewing the handicapped merely as a group with some special problems and not in terms of a qualitative continuum of abled versus disabled; advantaged versus disadvantaged. Sussman (1977) defined handicap as any deviation from the normal, which results in defective structure, function, organisation or development of the whole, or any part of the individual's faculties. In fact, handicap can not be described in totally absolute terms, since the issue is related in part to the manner in which the person perceives himself and in which society deals with him.
Both are inextricably related and it is within this relationship that the psychologist intervenes.

There may be various ways of classifying the handicapped person. DuBose (1978) has suggested that mentally handicapped may be classified according to the AAMD (American Association of Mental Deficiency's) manual and terminology as border-line, mild, moderate, severe and profound retardation. All other forms of handicap are suggested to be brought under the category of moderately or severely "handicapped". It has been generally recognized by the professional community, that individual possessing severe, profound, or multiple handicaps can be grouped under the umbrella of severely handicapped.

Whitten (1974) define disabled or handicapped person as "a handicapped individual who has a severe physical or mental disability which seriously limits his functional capacities (mobility, communication, self-care, self-direction, work tolerance or work skills) in terms of employability".

English & English (1958) defines handicap in term of reduced "aptitude" in performing the ordinary tasks of life or a particular vocation, thus distinguishing a handicap from a crippling condition which they associate with inability to perform a certain kind of task. Their distinction (which
they correctly state is not always observed) is in the same
direction as ours but is somewhat less comprehensive.

We observe a welcome change in attitude towards
handicap in the fact that definitions are moving toward focus
on interventions rather than mere classification. Thus Paul
Thompson (1974) Director of programmes for severely
handicapped children and youth, Bureau for the Education of
the handicapped, defines the severely handicapped child as
.... "one who, because of his physical, mental or emotional
problems or a combination of such problems; needs
educational, social, psychological and medical services
beyond those which have been offered by traditional
programmes, to maximize his full potential for useful and
meaningful participation in society and for self-fulfilment".

Understanding the behaviour and problems of the
handicapped is an important area of human concern. The
handicapped do not have to be merely tolerated or looked
after, but problems distinctive to them must be clearly
appreciated. It must be also understood that handicap in one
area does not mean handicap in all areas. Thus a person with
inability to reach optimal targets in one field may have
potential for excellence in some other. Not only from the
point of view of the individuals themselves, but also in view
of the social benefits, this is an important point. More important, even if no benefit is to accrue to society, it is in the interest of humanism and compassion to study our less privileged brethren, for handicapped individuals too have the right to live happy and decent lives.

A handicapped person should be guided to develop his dormant abilities and to integrate in the mainstream of the country. To attain "full participation and equality" in society for a disabled person, it is imperative to have guarantee for means of livelihood. Severely handicapped children sometimes are unable to use the common learning experiences of every day living which form the basis for intellectual development in an non-handicapped children, so the environment must be adopted to meet their development needs. Special programmes which appreciate their problem, but at the same time do not detach them from the mainstream must be contemplated. Care should be taken to make these programmes comprehensive. An immobile child who spends all his time lying as his back may be considered by his parents to be intelligent because he can repeat nursery rhymes and count-up to ten, but if this detached verbal skill is fed at the expense of all sensorimotor learning and he has little chance of linking verbal learning to an understanding of the material world, it would serve no end.
It is necessary that the individual having handicaps be encouraged and taught to become independent in all vital spheres. If some special ability exists, it should be fostered as it may become the backbone of his adjustment as well as livelihood.

A very pertinent question is - what are the major forces that can exert a beneficial and constructive influence in this quest for optimal adjustment. How do the normal and natural social forces which each child faces during the developmental process reflect on the adjustment of the handicapped child?

Experiences relating to parents, siblings and peer-group may have important implications for the child with handicap since a sense of acceptance - rejection by the above-forces may determine his own self-acceptance, self-alienation and attitudes. The role of sibling reaction and peer-group acceptance on acceptance of the self (that is, absence of alienation with the self) have been clearly brought out in various studies, Tabassum (1989), (That a high degree of a self-acceptance is observed when both sibling-relations and peer-acceptance are positive. Low self-acceptance seems to go hand in hand with poor siblings relations and low peer-group acceptance).
Since an important concern of the psychologist is the investigate phenomena with a view the highlight aspects of behaviour that can alleviate human suffering and improve quality of life, the present investigation has this focus in mind. The manifestation of negative attitudes and percepts among the handicapped may be in the form of a high sense of depression elevated anxiety level and empirical evidence to show that handicapped persons have greater problems in this sphere (Maslow 1954, Mathew 1974, Ghai and Ittyerah, 1980).

If dimensions like parental attitude, attitude of sibling and peers is found to influence behaviour related to anxiety, depression and a general sense of confidence, it will be an important base for constructive intervention. In the forthcoming paragraphs, we will discuss the concepts of parental acceptance, sibling-reaction and peer-group acceptance and show how they effect the handicapped person.

PARENTAL ACCEPTANCE

Parents relationship with the child is the key influence is guiding the personality development. No doubt siblings, peers, neighbours and teachers play an important role as time goes by, but during the earliest, most formative years of the individuals, parents exert the greatest influence.
Research has shown that the early months of life are tremendously important in starting the infant on the pathway of healthy or unhealthy development. Particularly significant during this period is "mothering" - the subtle factor of maternal love and stimulation (Ribble, 1944; Bowlby, 1951, Fischer, 1952, Rudenesco, 1952). Freud described the mother-child relationship as anaclitic (literally, "leaning on") to denote child's dependence on his or her mother's subsistence (Ainsworth and Bill 1969). In her capacity to arouse both pleasurable and unpleasurable sensations in the infant the mother becomes, "... unique without parallel, established unalterably, for a whole life time as the first and strongest love object as the prototype of all later love relations for both sexes" (Freud, 1949).

Allport (1961) is also concerned with the parent-child relationship in the development of personality but he too emphasized the role of infant-mother interaction in it, especially with the amount of security and affection she provides to the child. If the infant receives sufficient security and affection positive psychological growth will ensue through the seven stages of the self-emergence. The child will form an identity and self-image and the self will extend beyond the person. During adolescence, appropriate strivings will form to provide a frame of reference and
motivation for future growth. With all aspects of the self in place, a healthy, mature adult will almost inevitably emerge.

Obviously, then the role of the mother is of great importance, what happens if she does not supply sufficient security and affection to the infant? A child raised under these conditions becomes insecure, aggressive, demanding, jealous, and self-centered and physiological growth is minimized. As an adult the person will be controlled by childhood motivations and by infantile drives and conflicts, and is likely to develop some form of mental illness.

Psychologists on the basis of the information gathered through interviews, questionnaires, and ratings of parents and children suggest the importance of two dimensions of parental behaviour: acceptance-rejection and permissiveness – restrictiveness (Backer, 1964, Martin, 1975, Sears, Maccoby and Lewin, 1957, Symonds, 1939). These dimensions have undergone the most intensive examination.

Acceptance-rejection refers to the respect and love or lack of both – that parents feel for their children. At the extreme, accepting parents show warmth, affection, approval and understanding. Rejecting parents on the other hand, are
cold, disapproving, and punitive. They do not enjoy their children nor are they sensitive to their needs.

Schaefer (1959) on the basis of his observations of mothers interactions with the children from one month to three years of age has arranged maternal behaviours in a circular order around the two dimensions of love hostility (acceptance-rejection) and autonomy control (permissiveness-restrictiveness). This model indicates a range of parental behaviour and also shows that both permissive and restrictive parents can be either accepting or rejecting. Very different environments are provided for the child, depending on the parents position on these dimensions.

Some studies provide the evidence that the manner in which a child is treated affects his or her behaviour. For example, Robert Sears, Eleanor Maccoby and Horry JLevin (1957) sought to discover parental antecedents of various behaviours in young children. They found that highly permissive parents tended to have highly aggressive children. For when children got their way by being aggressive, their behaviour was reinforced. But parents who physically punished aggression also had aggressive children, apparently because punishment increased the children frustration and thus incited more aggression (Dollard et al 1939).
In some other studies (Becker, 1964, Bronson, 1972, Kagan and Moss, 1962; Schaefer, 1959) it has been found that restrictive parents have children who are obedient, polite and generally conforming, permissive parents have children who are more disorderly aggressive, expressive and uninhibited. When permissiveness is carried to an extreme (to the point where parents exert little or no control), or when parents are markedly inconsistent in their disciplining then their children are likely to become delinquent or emotionally disturbed. On the other hand, when discipline is overly strict and children are denied any expression of themselves, then they may be outwardly submissive while harboring resentment and frustration. Growing up in an atmosphere of restrictiveness combined with frequent punishment may also lead to aggression against oneself.

If the parents are responsive to the infant when he is hungry or cries, protect him from excessive cold and light, and provide him with love and stimulation, the infant normally gets off to a good start. The infant who is rejected, treated harshly or simply ignored on the other hand, tends to show symptoms of developmental difficulty almost at once.
The impact of close and intimate relationship between the child and his parents has always been emphasized in human societies. The child comes to look upon the parents as the sources of all his satisfaction, and as the person who are to supply all the basic needs that he, as a child, experiences. At the same time the child may look upon the parents as the source of his handicap, which causes hate, sometimes he may perceive the parents as the source of the solution of his disability (Sen, A. 1988).

The attitude of the members of the family towards the handicapped is a very important consideration. Acceptance of the handicapped child goes a long way towards the adjustments of his problem.

A handicapped child may sense very easily the emotions of his parents. If the parents consider his disability a calamity which has made his life good for nothing, the handicapped child would also think likewise. If they feel bitter against an unjust fate, he would also start thinking the same. If the parents make his handicap the pivot of their exisstance, he is liable to use it with self-centered to extract sympathy from others. However, if they accept his limitations in an objective manner, he is likely to think and act in the same manner (Sen, 1988).
Every child yearns affection from his parents; he needs to be assured that he is wanted in the family. Parents sometimes make provisions for gifts and toys for their handicapped child, even though parents have accepted him emotionally some parents never allow the handicapped child to grow-up, as they never let him feel independent. They want to do everything for their handicapped child.

Sometimes he (handicapped) is poured with excess love, care, protection and security. Because he has been considered as a 'failure', so the child (handicapped) unusually develops a sense of insecurity, helplessness, alienation, frustration, depressive and resentment. If the handicapped person is not able to participate in normal play activities he would have little contact with society. He must have to actualize himself, to realise his potentialities. The family (parents) need to encourage the handicapped person to attain the social acceptance, self-acceptance and independence. William James (1890), the great psychologist remarked, "the world is a big blooming buzzing confusion". If it is more so for the handicapped one. He is combatting the sense of mistrust arising from his ignorance of the environment.
The parents will need to overcome their feeling of frustration, guilt, confusion, despair, contradictions, helplessness and segregation.

The concept of parental acceptance means that the child be accepted physically, mentally, emotionally and psychologically by his parents. Whether the child particularly the handicapped child, feels happy or unhappy, depends a lot upon his emotional health, and emotional health is determined mainly by the environment in which the child grows up and the relationships he has with the people in his environment. It is the environment particularly the parents that produce the basic personality structure. Being liked, loved, accepted, identified and appreciated by his parents, the handicapped child feel secure, happy and confident. He needs a reasonable degree of acceptance in order to lead him a healthy, happy and decent life.

According to Symonds (1939), "that accepted are more cooperative, socialized, friendly, have highly valued personal characteristics and are happier and more stable than the rejected group of children".

If the child lacks love, affection, care and recognition he would not be an emotionally secure child. Hirkle and Wickers (1974) describe, "the absence of love and
affection of parents in childrens life caused great hardships and adversely affected their personality".

In a study of two groups of persons coming from favourable and unfavourable environments of home respectively. Powers and Witmers (1974) found that all the boys "who turned out well" had parents whose attitudes towards them were rated "favourable" and all most all who were neuratic and delinquent had parents whose relationships with them were distinctively "unfavourable".

By and large, parents are very keen to provide their handicapped children appropriate upbringing. However, the presence of a particular child in the family give rise to numerous additional problems. During pregnancy, mothers often worry about the possibility of having a defective child. They want to have a normal child; but when the fear of deformed baby becomes a reality, a sense of guilt, feeling of rejection, helplessness, disappointment, the parents. It is not easy for parents to accept the reality that thier child is different, but they should try to show acceptance without being overwhelmingly emotionally upset about it. Parental warmth is indispensable for every young child, but it assumes much greater importance for the handicapped child.
The concept of acceptance would mean the fostering of the sense of sharing among all members of the family, including the handicapped child. This experience builds up his personality. Play is a fruitful avenue of giving the children a sense of achievement, sense of success. Hertha (1962) suggests that a person strives to gradually define his or her identity with increasing consciousness. Further, "children are aware of everything that goes on between the parents like the lack of love and lack of acceptance. When people are closely bound together in space. Their frictions are produced by mere proximity". Thus the family and close social circle hold the key to the individual's self-image.

Role of Siblings

The child interacts in the family (home) not only with parents but in most cases with siblings. What effect this interaction has on him depends in Adlerian terms on his position in the family constellation, his age at the time of birth of other children and his relationship with his parents'. If a child is an infant when a sibling is born, he will have too little perception of the situation to be jealous. However, if he is old enough to recognize that he is sharing his mother's affection or more concretely her attention - with some one new he is almost sure to be jealous. Aggression and hostility to the new born is a
possible outcome but in emotionally insecure children, regressive behaviour like bed-wetting, thumb-sucking may occur (Baller, W.R.).

Hurlock (1943) suggests that sibling relationships have normal phases of ups and downs. For example, the pleasant relationship between babies and their siblings start to deteriorate during the secondary years of life, and by the time babies become young children, the relationship is often frictional. Not all sibling relationship is frictional all of the time but at every point of time some favourable as well unfavourable sibling relationships exist. Whether the siblings are older or younger, they contribute emotional security and teach young children how to show affection for others. Further more, all children learn in a family where there are siblings, to play certain roles depending on their sex, their ordinal position in the family and the age differences between them and their siblings (Hurlock 1943).

Nuttal and Nuttal (1971) point out that as family size increases the mother exhibits not only less attention but also less warmth toward individual children. Frequently older siblings are assigned the supervisory and disciplinary roles maintained by parents in smaller families. The eldest child is the only one who, until he is dethroned by the birth
of a subsequent child, does not have to share his parents love and attention with other siblings, Tayler & Kagam (1973).

Another study (Lamb and Smucks 1977) points out that every infant and youngster tends to watch, follow and imitate older siblings, so older siblings play an important role in facilitating the younger child's mastery over the inanimate environment. Some times the seriousness of unfavourable sibling relationship is that they effect the relationship of all family members and even relationship with other (outsiders).

The sibling relationship to child development is more applicable if the children are close in age. They play together, work together, eat together, share the same rooms, toys, clothes and have similar interests because of similar maturational phases. Close age sibling can form a sort of union against parental management, they save each other from being with adults too much and treat themselves as equals.

The factor of siblings and relationship with them becomes a matter of great concern for the handicapped child. Over and above factors of rivalry and competition for parental love, the presence of the handicapped child may create pressing situations. Caring for the handicapped off-
spring may take the attention of the mother so overwhelmingly that the siblings may resent this. They may also be called upon to share responsibility and involve their sibling in activities of games and leisure. Whether they perform this task with compassion and pleasure or they do so with resentment and anger is the result of value systems and attitudes inculcated in them. Whatever the attitude is, it will nevertheless exert a drastic influence on the handicapped child's self-acceptance.

Turnbull (1977), has pointed out that brothers and sisters of handicapped individuals, often need special help in understanding their handicapped sibling. Brothers or sisters may have concerns related to the cause of their handicapped sibling's problems, whether their friends will understand, the educational and vocational potential of the sibling, the likelihood of producing a handicapped child themselves, and whether they will have responsibility for their handicapped sibling after their parents die. Brestan, Naomi, Prabucki, Kenneth (1987) have pointed out that Siblings at the worst extreme, together with manifesting an excess in depressive affect and social isolation. In an other study Breslain, Naomi, Wetzman, Michal and Messenger & Katherin (1982) have suggested that birth order in relation
to disabled sibling and sex had a significant interactive effect.

It is clear that siblings have an important role to play in the behaviour dynamics of the handicapped. Hoyer, Paulette Joyee Perrone (1984) have gone so far as to suggest on the basis of studies conducted that the degree to which security attachment and participation is encouraged between pre-school and new born sibling determines the quality of sibling interaction over time.

Peer Group Acceptance:

In peer—group acceptance physique is supposed to be one of the important factors. Even normal variation in physique such as being strong or weak, tall or short, handsome or ugly, are important factors in forming the peer-group.

The "peer-group" has been described as an "aggregation of people of approximately the same age who feel and act together the term peer usually refers to children who are social equals and who are similar on characteristics such as age. However, recently it has been suggested that classifying children who interact at about the same level of behaviour complexity as peer might be more appropriate than just focussing on equal ages (Lewis & Rosenblum, 1975).
The relationship with peer is qualitatively different from that with family members. Havighurst (1953) considers the peer-group as a play group which furnishes companions who, unlike adults are of approximately equal skill and strength and who provide outside the family, his relationship with people outside the family becomes increasingly important in his development. The child who is intimidated and bullied by other children, for example may lose his self-confidence and come to feel that his only "safe" role is a submissive one. This in turn may lead to problems in holding hostility.

Bruner (1965) points out that peer-group is a significant source of social control in human beings. Being accepted by the peer-group is an important source of happiness and self-confidence for the child. To ensure his acceptance by the peer-group, the child learns that he must accept the groups interests and values, and in the process of accepting peer-group may be an important face enhancing adjustment in school. According to Hurlock (1932) handicapped children find themselves left out of many activities which their class-mates enjoy, the few extra curricular activities they can participate in generally have a low prestige value. Children who deviate markedly from the norm in mental ability likewise enjoy poor social acceptance. Dull children dislike
the school, because of peer-rejection and because they are made to feel inadequate both in class-room and in play.

Peers are a source of information about social-interaction rules and about how well the child is playing the game, from a different perspective than that of the family. It is the perspective of equals with common problems, goals, status and abilities.

According to Cowarding, Nancy, Whelan (1984) a number of studies have indicated that mainstreamed handicapped students are not generally accepted by their non-handicapped peers. Whatever the degree of acceptance observed, it appeared to vary according to certain physical, social, and psychological characteristics of the evaluating peer. In an extremely significant study conducted by them, sixty nine non-handicapped and eleven learning handicapped students were studied. Sociometric data were obtained, including gender, chronological age, ethnicity, school placement, socio-economic status, school achievement and physical education ability. Results indicate that:

1. The learning handicapped group were rated lower in social status than their non-handicapped classmates.
2. More popular students were more accepting of their handicapped peers than were less popular.
3. High moral maturity displayed more accepting than lower moral development.
4. Girls were more accepting of their handicapped-peers than boys.
5. Older students were more accepting than younger students in class.
6. Individuals with social status comparable to the learning handicapped were found to exist within the non-handicapped population. These students were similar to the learning handicapped-group in social skill, moral development and physical education ability.

Although the sample was limited these findings have important implications, social status was affected by the handicap, moral maturity, sex, age and social popularity influenced attitude towards handicap. The most illuminating finding is that within the group labelled as non-handicapped, and living a normal life as such, were many individuals similar to the learning handicapped-group in social skill, moral development and physical education ability. This strengthens our attitudes of viewing the handicapped as a group with certain special problems, but remembering that there is no barrier of qualitative difference between the two groups.
The conclusion that more popular students were more accepting of their handicapped peers than were less popular was also indicated by the study conducted by Hampson (1984). He demonstrated that subjects rated as unpopular were not behaviourally helpful in the helping tasks that formed part of the experimental situation.

Cornsweetcaral (1985) is of the view that since a large body of the previous researches on peer-group acceptance had found link between problems in peer relationships during childhood and subsequent psychopathology, this link needed to be explored in more detail, in order to delineate what kinds of problems in, peer relationships are associated with what specific kinds of adjustment problems. It was found that social skill factors were consistently associated will all adjustment measures, and within social skills, the factor of social comfort was associated with all but one adjustment measure. The factor that topped namely knowledge of appropriate social responses was found related to popularity as well as to teacher and peer-rated measures of adjustment.

As increasing proportion of physically disabled children participate in classes with the non-disabled peers, the quality of their relationships with such children is being studied. As a result of using incomplete sentences with physically limited and non-disabled children,
Cruickshank (1952) reported that handicapped children reveal insecurity relative to the negative feelings expressed about them by their non-disabled peer. Despite this, however, the relationships between the two groups are, in most instances, favourable.

Further, Cruickshank (1952) defined that, Guilt, frustration, and fear were found to be more common among physically disabled than non-disabled children and play a part in peer-group in determining their social adjustment. Richardson, Hastorf, and Dornbuser (1964) discovered that a group of physically disabled. Compares on peer physical activities, a higher score of negative statements about themselves than did non-disabled children. Realistic in their self-descriptions, the handicapped children were aware of their shortcomings in the physical area, a condition reflected in comparative lack of social experience and greater concern for the past.

According to Hartup (1976) peer-group is an essential arena for interpersonal learning especially in the area of sociability, socialization of aggression, moral development, and personal adjustment, peers are viewed as primary socializing agents for children.
The child’s first social-group is his family. He learns to live first as a member of his own family, and later on as a member of the peer, neighbour and school. If he is accepted by his family, sibling and parents, he would experience more reward and success in his endeavours outside home as well. Particularly the handicapped child, with the increasing awareness and feeling of belongingness to the family. He starts to participate in every activity in home and outside the home. Yuker (1965) noted non-disabled individuals with negative attitudes toward disability tended to avoid interactions with members of this group and that even if such non-disabled individuals were helped to accept their disabled peers, the quality of the acceptance was superficial. Consistent with the finding that these who held negative attitudes toward the exceptional have similar feelings toward certain ethnic groups. Yuker observed a tendency for such persons to assign the disabled to a class and to attribute to them presumed class characteristics.

In peer-group one finds the development of friendship and co-operation, or dominance and leadership.

As pointed out earlier, situations arising out of the handicap increase chances for the individual being exposed to conditions which promote depression, alleviate anxiety and
reduce self-confidence. There may be other dimensions of personality which the handicap may doubtless be affecting, but we have selected for study the above mentioned aspects because of their fundamental importance for the individual, as well as their relevance for intervention and management.

Grinker and Coworkers (1961) described the "characteristics of hopelessness, helplessness, failure, sadness, unworthiness, guilt internal suffering" as the essence of depression.

Melges and Bawly (1969) also characterize depressed patients in this way and Bibring (1953) defines depression "as the emotional expression (indicative) of a state of helplessness and powerlessness of the ego".

In (1974) on the basis of experiments conducted, Seligman proposed a learned helplessness model of depression. He suggests that although anxiety is the initial response to a stressful situation, anxiety is replaced by depression if the person comes to believe that control is unattainable and that their actions make no difference in bringing about either pleasure or pain. Depression is caused by the expectation of future helplessness.

A depressed person expects bad events to occur and believes that there is nothing he or she can do to prevent
them from happening. In some ways this model is similar to ego analytic view of Bibring, who proposed that depression follows ".... the ego’s shocking awareness if its helplessness in regard to its aspiration".

Inherited physiological characteristics may predispose an individual to extreme mood changes. Early experiences (the loss of parental affection or the inability to gain gratification through one’s own efforts) may also make a person vulnerable to depression in later life. Negative viewing of one’s world, one’s self, and one’s future places a person at risk of depression. Pyszczynski and Greenberg (1989) have built on the psycho-analytic idea that, depression occurs to the extent that the individual who experiences the loss of a person or goal and fails to disengage the cycle and continues to self-focus in the absence of any way to regain what was lost.

Beck (1976) Kulper, MacDonald, and Derry (1983) suggest that information network linked to the self-provide the best memory access and that depressive individual's possess negatively toned network that are associated with self-esteem.

Ingram (1984b) draws on four concepts; network theories, affect nodes, depth of processing and cognitive
capacity. Ingram assumed that depressive individuals possess extensive negative network and that, as a result, negative information will be most elaborated and will occupy the greater proportion of cognitive capacity.

Beck (1984) described that depressed individuals are particularly prone to recognize negative words and scenes, where non-depressed individuals have a positive bias.

Sharp and Tennen (1983) found that depressed subjects selectivity emphasized negative attributional cues in accounting for failure, similar findings were reported by Dunber and Lishman (1984), Powell and Helmsley (1984).

The handicapped individual is in greater danger of falling victim to a sense of depression as a feeling of hopelessness, helplessness, failure, sadness, suffering are the natural outcome of realization of deficit together with irrevocability of deficit. Further, since depression or "paralysis of the will" (Beck, 1967) is the outcome of learned helplessness (Seligman 1974) or of a particular cognitive framework resulting in processing of information in a particular manner (Beck, 1976, Kulper, MeDonald, and Derry 1983), there is reason to believe that exposure to certain experiences can reduce vulnerability to depression. These experiences will probably be related to parental attitudes
and attitudes of siblings and peers, and this is what the present investigator desires to investigate.

The second dimension which the investigation wishes to probe in relation to parental, sibling and peer acceptance of the handicapped is anxiety.

Anxiety is considered to originate as an inborn response to excessive stimulation. It is being accompanied by tension and rigidity. Excessive anxiety is also known to be the source of many behavioural disorders (Sullivan, 1948).

Anxiety is a complex of many emotions as distinguished from a passing experience of anger, fear or grief. Anxiety is defined by Drever (1955), "as a chronic complex emotional state with apprehension or dread as its most prominent component, characteristic of various nervous and mental disorders".

To Ausubel (1954) anxiety is an internal subjective state originating in an internal subjective fashion related to threat to the self-esteem of the individuals. According to Freud (1949), "anxiety is a specific state of unpleasure accompanied by motor discharge along definite path ways. It is an unpleasant subjective feeling involving expectations indefiniteness and a sense of helplessness". He further
added that, "anxiety is the crucial problem in emotional and behavioural disorders".

Freud, Bronteen, Thompson. Gershman, Erikson, May, Almy, Reichman and White relates the concept of anxiety with fear. According to Reichman, "anxiety is concerned with anticipated fear of punishment and disapproval withdrawal of love disruption of interpersonal relationship and isolation or separation".

Anxiety may be defined as a cognitive affective syndrome that is characterized by physiological arousal (indicative of sympathetic nervous system arousal) and apprehension or dread regarding an impending, potentially negative outcome that the person believes he or she is unable to avert (Cf. Dixon et al., 1957; Paul & Brenstein, 1973; Schlenker & Leary 1982).

It was Freud who first described the situational that becomes the cause of anxiety. He draws our attention toward anxiety which he calls "separation anxiety" which arises when the young child feels himself helpless, and deprived of love and care of his parents.

Freud speaks of anxiety arising in a child situation of being left alone, being in the dark and finding himself with a stranger, instead of the person to whom he clings.
According to Horney's theory a chronic condition of anxiety develops when the individual finds himself in an environment that is unreliable, unjust and harsh, an environment he does not have the power of change, which undermines his ability to grow and interferes with his opportunity to develop his potentialities as a person.

Anxiety may be viewed as an out growth of particular kinds of parent child relationships. In a study (Carter and Chess 1951) of factors influencing the adjustment of organically handicapped children, the most prominent single factor in determining whether anxiety would become an important seemed to be parental-attitude. It was found that the amount of anxiety is related to the parents. Carrol (1955), "Every person posseses a drive for growth and if this drive is rewarded by a number of successes he can tolerate a few failures. But if he failed repeatedly the anxiety which is created to hold him back".

Thus, if the child has problems, he is anxious, the mother may feel she is responsible, or that she herself also has "problems", such feelings may produce considerable anxiety and guilt along with varying degree of denial, projection, or repression.
Brown et al. (1947), "children who are permitted opportunities for democratic participation in the home and who are given the measure of support and confidence by the parents are honest, friendly and responsible.

There is ample evidence found in literature that authoritative parents produce mal-adjusted children. The prediction that authoritarian attitudes would make a child submissive, lacking in security and independence who would, therefore be less popular with his companions. Read (1945), Radka (1946) and Miles (1946).

Sarason et al (1960) states, "It is only realistic that children need help with problems, but help with every problem, could lead to the child feeling anxious about his adequacy in solving them himself. A child may feel he will fail when he does not have help even when the solution is otherwise within his group".

For the handicapped child, this fear of failure, apprehensions, dread regarding potentially negative outcomes are a more overwhelming reality than for the non-handicapped child. Mature parents, who appreciate the problems of their handicapped offspring and help to lessen them with their warmth, appreciation and acceptance may do a lot to reduce their child's anxieties. The same is true of siblings who
can give support to their sister/brother by accepting his presence on equal terms, without condescension or resentment.

Peer, on their part by accepting the handicapped child within their social circle can help to reduce anxiety arising out of a sense of isolation and social non-belongingness.

Thus, studying the role of parental acceptance, sibling reaction and peer acceptance in determining anxiety amongst handicapped children will be an area with studying.

SELF CONFIDENCE

The self is evaluated as well as perceived. Some Judge themselves as being large, strong good, and worthy (Maslow and Mittelman 1951). Self-confidence has many synonyms: self regard, self-satisfaction, self-respect, self-esteem, self-acceptance, etc. All refer to a person's evaluation of his own worth, adequacy, and competence. The self is evaluated as well as Kelly (1955) has found that scores in self-confidence and self-evaluation are more closely related to each other than scores on any other personality trait.

Those with a low opinion of themselves generally feel that people are constantly observing and criticizing them. Those who feel inferior do not trust or accept themselves. Self-acceptant people have personal values which they trust
to guide their behaviour. Hoffeditz (1934) compared the self-confidence of men of low, medium, and high economic status; the higher the economic status, the higher their confidence. Stagner (1948) has given the same definition. However, we must bear in mind that probably it is not economic status per se that is influencing, but situational and experience created by a higher and better income level. According to Mckee and Sherriffs, (1957) men consistently obtain higher self-confidence scores than women. Homa watt and Richardson, (1944) found that supervisor are considered more valuable and more self-confident than non-supervisor. If others value us, we value ourselves, we value others, (Phillip 1951).

Rogers (1951) suggests that maladjusted person needs to gain confidence in himself and confidence in other people. Is a person with high self-confidence, better adjusted than a person with low self-confidence? Friedman (1955) answers in the affirmative, but with reservations. He used 16 normal, 16 neuratic and 16 psychotic subjects to measure good, fair, and poor an adjustment. The correlation between the ideal-self sorting and the perceived - self sorting was used as a measure of self-confidence. The normal subjects did have greater confidence than the other two groups, but ‘...were seriously maladjusted. Psychotic subjects had greater self-confidence than the neurotic subjects.
Butler and Haigh (1954) also used the correlation between ideal and perceived-self sortings as a measure of self-confidence. He used normal subjects and maladjusted subjects, measuring the maladjusted group both before and after therapy. The results showed, the normal group showed much less discrepancy between their ideal and perceived selves (Friedman 1955 is also in the same opinion).

Very low self-confidence is always associated with maladjustment. Consequently, the desire to maintain and enhance self-confidence is a universal and powerful motive.

We have some evidence of parent-child relationships that produce competent and self-confident youngsters. In a series of studies, three and four-year-old children were observed at home and in nursery school and rated on five measures of competency: (1) self-control, (2) the tendency to approach new or unexpected situations with curiosity and enthusiasm (3) vitality, (4) self-reliance, and (5) the ability to express warmth toward playmates. On the basis of Baumrind's (1967) study, when the parents are very controlling and more concerned with their own needs than with those of their children, their offspring may be fairly self-controlled but not very secure or confident in their approach to new situations or other people. Very permissive
parents, who neither reward responsible behaviour nor discourage immature behaviour, produce youngsters with the least self-reliance and self-control.

Again Baumrind (1972) studied that self-confidence in young children seem best fostered by a warm and nurturant home where parents reward responsible behaviour but also encourage independent actions and decision making.

According to Allport (1954) that "early self" is composed of a sense of bodily self, a sense of personal identity, and a feeling of self-esteem.

The trait of self-esteem appears to be a result of early success in setting and accomplishing goals, an accomplishment which elicits recognition and praise from parents, sibling and peers. Behaviour psychologists believed that the self-confidence is directly related to the feed-back, we receive regarding how others view our appearance and behaviour. Agnihotry (1987) Gupta (1987) stated that high self-confidence has been found among the accepted children and low confidence among those, who are alienated, withdrawal, rejected, inconsistent, descriptive, instelling and hostile detachment.
Another dimension of importance, when discussing the phenomenon of handicap is the dimension whether in handicap stayed at home or institutions the child's relationship with others and impact of this on the child's self/concept may require special attention. By developing an increased sensitivity to their special needs, parents can create a home environment conducive of encouragement and assurance which would help them to face the outside world which is not necessarily always so friendly.

In general, a child's development at home is generally better than in an institution. But in case of handicapped an optimistic developmental model is capable of growth, development and learning. To institutionalize him would be to help him to develop as a person, so that he can manage his daily personal affairs and can get job etc. according to his abilities. The particular person may be given special training leading to practical help in their day to day life, such as dressing, independent movement, handling of money matters, main training personal hygiene, learning to communicate about their needs, self help etc.

To institutionalize a handicap child it is difficult time for the parents, especially the mother. The first reaction of the mother is the fact that she produced a
defective child, and she thought herself a responsible for all happenings too. Casler (1961) and Yarrow (1964), have suggested that the devastating effects of institutions on infants and young children are not caused by the infants' separation from the mother perse, but by the deprivation of all the stimulation that she provides and mediates. Children who are adequately stimulated, whether by one or several caretakers, do not show symptoms of institutionalization.

The institutionalized child has a different psychological situation; he has a family, parents, an illness, (Bowlby 1952). Further his point of view is that maternal separation experiences during institutionalization were pathogenic. Robertson (1959, 56) states that when institute admission deprives a child of a warm, intimate, and continuing relationship with his mother, the reaction has three Phases (1) to protest which the child. Strongly and consciously demonstrates his grief. (2) child is less active in showing a conscious need of his mother but experiences an increasing hopelessness. He may become withdrawn, apathetic, and may make no demands and in the third phase, denial, the child shows more interest in his surroundings. He may appear stable and sociable.

Another study was conducted by Prugh and his associates, (1953, 1954, 1955). The purpose of the study was
to investigate the nature of the effects of brief institutionalization upon both children and parents the results indicate that children under three years of age are the most susceptible to the negative aspects surrounding institute care. Separation from the mother is often interpreted as a punishment or desertion. This reaction, separation anxiety was found among the younger children. Depression and various disturbances were noted among the older age groups, withdrawing behaviour became common. But all children was the reaction to treatment and diagnostic procedure as punishment. In those who seemed to have a positive reaction towards institution were those who seemed to have the most satisfying relationship with their parents, especially the mother.

Many people have been convinced that any care other than that given by the mother is detrimental to a child's emotional development. Research evidence is beginning to demonstrate that group care for infants and young children can be designed to be as effective - and some times better than that given by mother.

According to Spitz (1945) Rutter (1972), early prolonged institutionalization may produce different consequences, like inadequate social, tactile, and perceptual
stimulation. Goldfarb showed children who remain in institutions lacked guilt, were unable to keep rules, and were unable to make lasting relationship. Colvin (1958) showed that children in a residential treatment setting who had experienced early care in institutions had very low impulse control, high dependence, and unrealistically high self-evaluation and ego-deficit.

The institutionalized subject must be paid serious attention on both physical and mental health (Kosberg, 1973). There has been found a high incidence of depression among the children separated from their mothers. (Spitz and Wolf, 1946). Depression can be lifted if the institution provides a substitute mother in the form of a care taker who spends a great deal of time interacting with the infants (Bowlby, 1952). Institutionalized children scored lower in IQ, reading and speaking ability, and social maturity, they were also more likely to be hyperactives unable to concentrate, craving of affection and unable to keep rules (and lacking in guilt over breaking them) (Goldfarb, 1945).
AIMS AND OBJECTIVES OF THE PRESENT INVESTIGATION

More than any other discipline, the social sciences are anchored most clearly within the actual life situations and social milieu. The social scientist draws inspiration from experiences and occurrences within the social context. His studies and his researches must therefore relate to people, their concerns, fears and problems. The psychologist being a social scientist concerned not with the peripheral ranges of the environment, but with the most central aspect, namely the behaviour of human beings, is vested with greater responsibility towards solving and alleviation of human problems. The Indian psychologist is also appreciating that researches must be geared towards national goals and social needs, therefore we are observing that in recent years the Indian psychologist, instead of replicating foreign researches is gradually moving towards conducting studies which have real meaning and application value in the Indian context. Since psychological factors operate within the social framework and dynamic forces existing in unique cultural contexts, researches on the handicapped conducted in other countries have a limited value for us. Thus within the Indian psychological perspective researches on socially relevant issues such as on socio-economically deprived, women,
handicapped persons are coming up. Further more, with the progress of civilization the human society marks for itself goals higher and higher on the hierarchy of human needs. Just as the individual functions from the lowest order physiological as safety needs and comes up through various experiences ultimately towards the higher goals of self-actualization, within human societies and culture too we observe that civilization and progress has taken us to a situation where the higher order needs of altruism and compassion are considered important and viable. Inspite of the rise in violence and terrorism which may appear to be contrary to what we are saying, at the level of agreed upon universal values receiving unanimous consensus from human kind, it is values of altruism and compassion that are favored. We are rejecting all values related with narrow barriers or walls, either geographical or historical but are progressing towards cosmopolitan goals of human welfare brotherhood. Thus one of the accepted human values is to subscribe towards uplift and gradual development of sections of society, that have been deprived in one way or the other. We find that in all countries of the world, concerted effort is being made towards helping the handicapped individuals to lead normal meaningful lives. In our own country we find this concern in the form of political manifestos, government
politics, television and other mass media programmes, social welfare organizations and voluntary agencies working for rehabilitation of the handicapped.

However, a large no. of these programmes have not been able to achieve the desired objective, because the information base regarding psychological dynamics of the handicapped has not been fully provided. If knowledge and appreciation of the problems of the handicapped vis-a-vis psychological processes, and social interactions is provided, it will help us to translate into action; many of the aims and objectives which are being laid down by social as well as national organizations. The aim of our present study is to focus on certain crucial parameters which are related to well-being and high quality of life and adjustment for handicapped persons.

Feelings of depression and feelings of anxiety deprive the individual of positive experiences, whereas a feeling of self-confidence is an attribute which helps the individual in coping with life and its problems in a positive way. By trying to highlight what important factors within the individual's primary social groups give rise to these conditions, the investigator has tried to present a picture in which clear directions can be understood as to how depression, anxiety and self-confidence occur amongst the handicapped, what factors are responsible for them, and
therefore how the applied psychologist can intervene to achieve some positive desired ends.

In reality, a multitude of factors are possibly responsible for giving rise to the experience of depression, anxiety and self-confidence. It is not humanly possible for an investigator to create such a wide canvas which will cover all possible factors. But from amongst the factors that operate, those that seem to be most relevant and meaningful are selected. The investigator feels that in order to clarify and bring out the dynamics through which depression, anxiety and self-confidence go through in the handicapped, the most meaningful aspect which can be taken up for the study relates to those forces and those interactions, which occur through individuals emotionally and psychologically close. Parents and siblings constitute the outside world for the child and his first contact with society is through them. The manner in which parents view the deficit possessed by the handicapped child, the manner in which siblings react to it becomes an important index about what the deficit means. In the individual who is born handicapped, the qualitative evaluation given to the handicap emerges not so much from the actual inconvenience suffered by the individual but from the societal reaction, particularly that of parents and sisters and brothers. The peer-group, though not the part of the
family is also one of the most crucial agencies of socialization for the young child. It is the adjustment of the individual with peers which forms the basis of his reactions and dealings with the world in general. We have therefore, selected these three factors, namely parental-acceptance, sibling-reaction and peer-group acceptance for study in terms of their prediction of depression, their prediction of anxiety and their prediction of self-confidence. The aims and objectives of the study may therefore be summarized as:

1. To study the extent to which parental acceptance, sibling-reaction and peer-group acceptance predict the experience of depression.

2. To study the extent to which parental acceptance sibling reaction and peer-group acceptance predict the experience of anxiety.

3. To study the extent to which parental-acceptance sibling reaction and peer-group acceptance predict the experience of self-confidence.

Furthermore, since the investigator has also selected for study the variables of sex, nature of handicap, as well as the factor of being institutionalised and non-institutionalised; these three predictor variables were studied in terms of their relationship with depression,
anxiety and self-confidence in these three conditions. Thus, we aim to explore:


5. Prediction of depression, anxiety and self-confidence in the orthopaedically handicapped sample and sensory handicapped sample.


It was necessary to study these sub-groups as this should provide in-depth information that would clarify how different life situations may give rise to different dynamics. Through the study the investigator aims at helping to create an information base relating to certain basic issues regarding the handicapped, so that meaningful psychological realities of the handicapped, his perception of things, his world view is understood. Analysis would reveal the position of the three predictor variables with regard to each of the three dependent variables. We would get a fairly holistic picture of the phenomena and would be able to help in arriving at meaningful and relevant interventions and strategies which would help the handicapped persons and which would help us in helping the handicapped.