It has already been discussed in the foregoing chapter as to how the handicapped child affects the family members and the family setting. Before dealing with the methodological or technical aspects of the study, it would be desirable if one arrives at semantic clarification of the concepts involved in the study, viz., physical and mental handicap, parental attitudes, marital adjustment, social burden, and temperament.

Physical and Mental Handicap

A disabled child is an individual having a restriction or lack (resulting from impairment at organ level) of ability to perform an activity within the normal considered range. The word "Disabled" implies the loss, to some degree, of power of body or mind. A disabled person is any person unable to ensure by himself or herself a normal life, as a result of a deficiency in his or her physical or mental capability (U.N. General Assembly Resolution, 3447 (XXX), 1975 cf. Tehal Kohli, 1981). This suffering is at a personal level. In case, this is not reversible or becomes chronic, it gives rise to "Handicap" interfering with the ability to interact with the surroundings for life's adaptation and is largely felt at the social level (Trivedi & Puri, 1981).

A more inclusive term "impairment" has been used by Sussman (1977). Impairment is defined as any deviation from
In late 1980, the WHO advocated the following definition of a handicap: A disadvantage for a given individual, resulting from an impairment or disability that limits or prevents the fulfillment of a role that is normal for that individual. WHO also differentiated the terms handicap, disability, and impairment. Impairment is defined as any loss or abnormality of psychological, physiological or anatomical structure and function and Disability refers to any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being.

The meaning of the word "Handicap" has changed through the years reflecting the society's changing attitude towards handicapped people. In the past, a handicapped person meant a person with permanent bodily injury, and was looked upon as deviant from an accepted norm. Such persons were generally cured of by special institutions and organisations. In the 1960's, the mentally retarded were included among the handicapped. Today, "a handicap" is a relative and dynamic concept which varies from individual to individual depending on their resources and special situations. Consequently, the handicapped person is not primarily an abnormal person but an ordinary person with special needs (Kohler, 1984).

Disability conditions may be found among children or adults everywhere in the world. The disabled may be severely mentally impaired, deficient, retarded, or handicapped. Some
children may be slow in learning while others may have speech or language defects. Individuals may be partially or totally deaf or blind or partially sighted. Still some may be orthopaedically handicapped who cannot move about normally. Children may have specific types of learning disabilities or some may have behaviour problems. Individuals may be affected with various combinations of such conditions as accidents, infectious diseases, defective genes, etc.

Handicaps in childhood fall into two basic categories 1) Physical Handicap (ii) Mental Handicap. A physical handicap affects the child's physical functions and general mobility and a mental handicap affects intelligence and ability to learn new skills.

Orthopaedic handicaps are considered to be one of the major physical handicaps. Persons disabled because of defects in bones, joints, muscles, tendons, ligament of spine and the limbs fall in the category of orthopaedically handicapped. Orthopaedically handicapped are those whose physical capacity is impaired by the loss, deformity, or paralysis of one or more limbs. They are the victims of diseases or injuries which leave behind a certain disability that is permanent and life long (GOI Planning Commission, 1951–61). Louttit (1957) has used the term orthopaedic impairment to cover the neuromuscular disabilities including cerebral palsy and poliomyelitis. The Association of Physically Handicapped, Bangalore, (1966) has further explained that the orthopaedically handicapped are persons who have defects which cause deformity or an interference
with normal functions of the bones, muscles, or joints.

A similar definition states that the category of the orthopaedically handicapped includes all those who have a condition which prevents them from having complete control of their muscles and the nerves which, in turn, control their ability to move about and use their limbs in a normal way. This includes polio effect, cerebral palsy, amputations resulting from accident or disease, birth anomalies, hemiplegia, muscular dystrophy, and spina bifida (Nimbkar, 1965).

The same definitions have been used in the description of the eligibility requirements for the scholarships provided for physically handicapped students by the Government of India, Department of Social Welfare (1970) and also for the purposes of reservation in employment for group "C" and "D" posts in Central Government (GOI, 1980). Although in this particular case of reservation and for scholarships, the term "Physically Handicapped" includes the blind, deaf, and orthopaedically handicapped, it is more frequently used to connote only the orthopaedically handicapped or those with neuromuscular disabilities.

As regards mental handicaps, mental retardation is a multidimensional phenomenon that involves overlapping physiological, educational, and social aspects of human functioning and behaviour. Historically, there are few mentions of mental retardation in earlier texts of human societies. However, the beginning of the 20th Century witnessed several magnificent medical discoveries which
suddenly opened for the medical researcher and the clinician new exciting vistas in the field of mental retardation. Definitions and classifications arose to aid in diagnosis. Tredgold (1932) defined mental retardation as a state of kind and degree that individual was incapable of adapting himself to the normal environment of his fellows in such a way as to maintain existence independent of supervision, control, or external support. Heber (1961) viewed that mental retardation referred to the subaverage general intellectual functioning which originated during developmental period and was associated with impairment in one or more of the following: 1) Maturation, 2) Learning, and 3) Social adjustment. Nanda and Shukla (1978) defined mental retardation or mental subnormality as a condition of arrested or incomplete development of intellectual capacity. The most comprehensive definition of mental retardation today is that by Grossman (1977) who defined it as significantly subaverage general intellectual functioning, existing concurrently with deficits in adaptive behaviour and manifested during the developmental period.

The levels of mental retardation are expressed in various terms. The international classification of diseases (WHO, 1978) classified the mentally retarded into four different categories taking into consideration the I.Q and development.

1) Mild retardation (I.Q 50-70): the development of an individual in this category is slow; he can be educated to some extent and with training he would be capable for earning, at least partially, his livelihood living an undue
II) Moderate retardation (I.Q. 35-49): Individuals in this category are slow in their development but are capable of learning to look after their personal needs. They can be trained to some extent to work in sheltered workshop and to live in protected environment.

III) Severe retardation (I.Q. 20-35): Individuals in this category are often unable to manage their own affairs, and their motor development, as well as speech and language may also be affected in many cases.

IV) Profound retardation (I.Q. 19 and below): The degree of defectiveness of the individuals in this category is of very serious nature rendering them unable to guard themselves even against common physical danger. Most often they are also physically handicapped and need constant custodial care for survival.

In 1973, the American Association of Mental Deficiency (AAMD) adopted the terms mild (I.Q. 52-68), moderate (I.Q. 36-51) severe (I.Q. 20-35) and profound (I.Q. 19 and below).

The third edition of the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-III, 1980) basically followed the AAMD and ICD-9 categories listed above but it added a new category, i.e., borderline intellectual functioning (I.Q. 70-85) classified as one of the conditions not attributable to a mental disorder. Eventually, these terms deal with the developmental characteristics, potential for education and training, and
Prevalence studies of mental retardation all over the world indicate that 2.5% to 3% of the general population is affected by it (WHO, 1968).

The overwhelming majority 87% of the mentally retarded fall into the mild mental retardation category, and the remaining 13% belong to the moderate, severe, and profound groups. In India, prevalence figures vary a great deal. Prabhu (1975), summarising ten surveys of mental retardation, reported an overall rate of 2.5%.

The boundary between physical and mental handicap is not necessarily clear cut. Many physically handicapped persons may also be mentally handicapped and many of them have severe problems in conceptualising and usually beyond the reach of formal education. On the other hand, many physically disabled children and adults do not necessarily lack intelligence or other mental faculties and cognitive functioning, and with appropriate help, education and training may be imparted to many of them.

Parental Attitudes

Parents have a profound influence on the growing child. Both parents attempt to shape their children's behaviours. Baumrind (1966, 1971, 1973) and Baumrind and Black (1967) emphasized the importance of different approaches to child rearing. Every parent has his or her own attitude towards each child in the family and towards child rearing methods. During every stage of childhood, certain aspects of
youngsters, innate temperament and their rate of maturation interact with their rearing style (Freedman, 1968; Komer, 1971, 1974; Osofsky, and Connell, 1972; and Buss and Flomln, 1975). The child rearing practices and attitudes of parents may range from accepting to rejecting, democratic to autocratic, and permissive to punitive (or restrictive). Whatever child rearing practice is being considered (such as, feeding, providing stimulation, disciplining) and whatever child rearing goal is intended (such as, helping children feel secure, enabling them to be loving and affectionate, promoting their independence strivings), the most beneficial and effective way of caring for them will vary according to the child's basic temperament. Hence, a good "fit' between an infant's temperament and the child rearing style of the parents is the key to positive personality development.

Many forces may affect the parent-child relationships. The parent's health and attitudes, inconsistencies, and possible immaturity or psychological disorders, tensions and quarrels between them, the birth of a younger sibling, and many other influences enter into the dynamics of parental relations and attitudes. There are certain attitudes which are fairly universal. These are the product of tradition, parental teachings, and experience in living with children.

Over Possessive Parents:

Possessive parents combine over affection with the tendency to overprotect and, maybe overindulgence in their children. Studies have shown that possessive parents have had some such experience as the following: the baby came
after many years during which time it seemed that they would never have one; as a baby the child suffered an illness or defect and for some time there were doubts whether or not it would survive; often they have only one child. Such circumstances as these make a child more precious and parents so anxious for his welfare and his safety that they overprotect him. Many of these parents had an unhappy childhood and, in reflecting upon this, say that they had been deprived of parental affection or not been given the opportunity to develop because of household and family responsibilities imposed upon them too early. In their determination that the same would not happen to their own children, they become over affectionate or overindulgent (Levy, 1943; Strang, 1959).

Parents may not be consciously aware of this fierce involvement. They do, however, reveal it by excessive fondling and a general anxiety about the child's safety that prevents them from allowing him to be independent, to explore alone, and adventure with other children. Overprotective parents allow no competing interest to interfere with their parental duties; they reduce their other interests in life to a minimum (Bakwin, 1948). Children of possessive parents are generally apprehensive, as if the world were a dangerous place. They show less originality and less desire to explore new situations/places (Baldwin, 1948, 1949). The anxiety which these children have acquired from their parents and the confusion they feel make them unable to do this. Children of overprotective parents find difficulty in making friends and in participating in regular social activities with other
children. They may have tantrums and be disobedient, imprudent, and demanding, and are often quarrelsome and troublemakers.

Over Permissive Parents:

These parents allow a child to do more or less exactly as he wishes. Usually, they are over indulgent so that the child is given far more possession than he reasonably needs. The permissive parents make few demands. They consider themselves to be resources but not standard bearers. The permissive parent attempts, "to behave in a nonpunitive acceptant and affirmative manner towards the child's impulses, desires and actions. She presents herself to the child as a resource for him to use as he wishes, not as an active agent responsible for shaping or altering his ongoing or future behaviour... She attempts to use reason but not over power to accomplish her ends" (Baumrind, 1968, p256). Children of permissive parents tend to be unstable and to show swings of mood and of behaviour from confidence to lack of confidence, from independence to dependence, from control to lack of control, from friendliness and sociability to hostility and aggression (Levy, 1943). Children of overpermissive parents present the picture of the typically 'spoilt' child: disobedient, rebellious, given to frequent temper tantrums, excessive in their demands on other people, and domineering over other children (Symonds, 1939). They misbehave in these ways partly because they have no external control to protect them from their own impulsiveness. Such behaviour may also be an implicit plea to their parents to take a stand, not to give way to their every whim and so to set limits to what they, the children, are allowed to do.
These children may show the same kind of inconsistency as do the children of possessive parents, being model children at outside and terrors at home.

Watson (1957) conducted a study which compared teachers' and psychologists' ratings of a sample of children from permissive homes with a sample from strict homes. An analysis of ratings showed that those from the permissive homes tended to score higher in persistence, independence, creativity (including spontaneity, originality, and the use of imagination) and friendliness. The children from the strict homes were rated higher on independence, negativism, energy level, conformity, and hostility. There was no difference between the groups with respect to self control during frustration, passivity, or anxiety.

Authoritarian Parents

Parents who are authoritarian combine over control with lack of warm affection. The control may be obtained through moral precepts with little or no physical punishment. Authoritarian parents, themselves, are convinced of the value of obedience, orderliness and control, seek to imbue their children with similar virtues. They adopt a philosophy of strict upbringing, involving mandatory routines and unquestioning obedience which they may justify as a determination not to spoil their children. Often they are themselves overcontrolled and their control of their children is a reflection of this.

Baumrind (1968) reported, "the authoritarian parent values obedience as a virtue and favours punitive, forceful
measures to curb self will at points where the child's actions or beliefs conflict with what she thinks is right conduct. She believes in inculcating such instrumental values as for authority, respect for work, and respect for the preservation of order and traditional structure" (pp. 261).

Sears et al. (1957) found that authoritative mother imposes high standards in table manners, care of household furniture, neatness (not getting dirty) tidiness (not leaving clothes or books lying around), orderly and quiet behaviour, and that she expresses little warmth towards the children, her husband, or towards herself. The standards she imposes on them, she also imposes on herself. She is particularly intolerant of any sex play or of any display of aggression by her children. She may sometimes use physical punishment but with her kind of personality, this is rarely necessary. She looks and that is all.

Children of parents whose chief mode of control is through moral precepts are less curious, explore and play less and are less sociable than the average child (Baldwin, 1948). The over control and the demands for absolute obedience seem to suppress children's spontaneity, originality, creativity, and the growth of social skills. The parents are so concerned with conformity that else is sacrificed to this end. Outside the home, the children are generally obedient, submissive, polite and dependable, but somewhat inhibited and unable, for example, to be expansive in their play or to answer in class. They tend to be somewhat withdrawn from other children (Symonds, 1939; Levy, 1943).
When the environment is unequivocally cold, hostile and punitive, a child tends to be obedient, submissive, polite, and so on. At school he tends to be unruly, coldly aggressive and sadistic towards his companions, to have frequent temper tantrums and to be little rebel, refusing to accept the restrictions necessary in such a social environment (Baldwin, 1945). He may use dictatorial methods to control and dominate other children (Henry, 1957).

Eron et al. (1963) found that more the punishment at home, more the aggression at school. The results held true for boys and girls alike, and it did not matter whether the father or mother was the punisher. Similar findings have been reported by Badyal (1988).

Democratic Parents

Baldwin (1948, 1949) made a distinction between the cold democratic and the warm democratic parent. Cold democratic parents do not express warm affection, they are direct, rational, unemotional. The child is given reason why he should do this and should not do that. He is given freedom to express his own ideas; he is given materials and is encouraged to develop his maturing skills. But above it all, there is lack of warmth, a scientific detachment from the child. He is not cuddled when he comes crying to his mother because he has been hurt. Instead the wound is attended to in a precise, medically prescribed way and that is the end of the matter. Such parents suppress expression of spontaneous affection. Behaviour is controlled and rational. There is a taboo on tenderness (Anderson, 1940, p. 184). Such parents may show
over concern with the child's progress and attempt to accelerate this. This persistent dependence and mastery, imbue the child with a sense of the importance of scholastic achievement (Winterbottom, 1958; Rosen and Andrade, 1959).

The warm democratic parents have many characteristics of the cold democratic parents, such as giving the child freedom to express his own ideas, material opportunities, and encouragement to develop skills. These parents are, however, warm. They are able to be tender or sympathetic as occasion demands, and to be affectionate without the excess of fondling which confuses and embarrasses a child. They are able to view their children objectively, to assess their good and not-so-good qualities. Such parents are not obsessed with their children's progress, although they are happy to have them succeed and encourage them to do so.

Radke (1946) presented an idealised picture of the behaviour of children of democratic parents by reporting them as being emotionally stable, popular, sensitive to the opinions of others, and less quarrelsome than other children. Baldwin (1945) reported that the children of democratic parents were sociable, not in dominant, but in a good-natured way. They are often precocious and able to converse with grown-ups on a surprisingly adult level.

Children of cold democratic and warm democratic parents show many similar characteristics. They are active, curious, and original. Children of cold democratic parents show the same precociousness when conversing with adults as do the children of warm democratic parents, but that is due to the continued...
Acceptance and Rejection

Another important dimension of parent-child relation is acceptance rejection empirically identified by Baldwin, Kalhorn and Breese (1945) as a principal dimension. Acceptance is often called nurturance, i.e. an attitude on the part of the parents, of warmth and helpful assistance towards the child. It is an attitude on the part of the parents which is characterized by a keen interest in and love for the child. The accepted child is generally social, cooperative, friendly, loyal, emotionally stable and cheerful. He accepts responsibilities and cares for his own property as well as that of others (Sears et al., 1957 and Milton, 1958 cf. Tiwary and Pal, 1986). Symonds (1938, 1949) pointed out that good citizens, good scholars, good workers, good husbands, good wives and good parents come from homes in which children are wanted and accepted.

Rejection is just the reverse, manifesting itself in hostility, crossness or indifference. Rejecting parents show a general indifference to their children's safety, and a lack of real concern for their personal and social development. Children of rejecting parents show characteristics similar to those who are brought up in an institution where the staff is too small to give individual and personal care and encouragement (Baldwin, 1945). Thus,
the children tend to be retarded in the development of their bodily, language and social skills, and often show an inordinate desire for affection and approval. The signs of rejection include nagging, spanking, paying no attention to the child, failing to provide him with money, toys or advantages, comparing him unfavourably with others, etc. A rejected child is exposed to hostility. At school age, rejected children are less physically active, sometimes clinging to the teacher. They often sit and do nothing and are less curious about the many activities going on around them. When they do start an activity of their own, they lack the tenacity to continue at the task for any appreciable length of time (Baldwin, 1948).

Parent-child relationships are complex. These relationships are different in the case of normal children as compared to the handicapped children. Parental attitudes towards a handicapped child are of paramount importance, not only because majority of such children are looked after at their homes but also because on these depend the efficiency and adequacy of the training measures to be adopted by the parents.

The parental attitudes undertaken in the present investigation are orientation towards child rearing, knowledge of the handicap of the child, attitude towards the handicap, and attitude towards management of the handicapped child.

Marital Adjustment

Marital adjustment is related to the institution of
marriage where two persons are living together and sharing all their experiences. Marriage denotes those unequivocally sanctioned unions which persist beyond sensuous satisfaction and thus come to undermine family life. Actually, marriage is nothing more than a more or less durable connection between the male and female, lasting beyond the mere act of propagation till after the birth of offspring. To Landis (1977), marriage is like any other type of contractual relationship; it involves obligations and difficulties.

No two human beings regardless of how intimately they live together can avoid obligations or evade all problems of adjustment. Marital adjustment has been described as a state in which the individual or the pair has a good arrangement with reality, adulthood and the expectations of others (Waller and Hill, 1951). Marital adjustment almost always means that one or both partners give up something in one area in order to satisfy a need in another area. A good adjustment is one in which each derives more satisfaction than deprivation and in which interlocking needs of each are usually met. It is the satisfaction of the marital partners themselves that determines the relative success of their adjusting efforts.

Adjustment in marriage is a continuous process (Klemer and Smith, 1970); specific adjustments are required at different stages of marriage. As the complexion of marriage changes, the two partners must resynchronize their ideas, values, desires, and goals if the marriage is to run smoothly. At the outset, newly weds face a multitude of adjustments. Sexual relationships, spending the family income, keeping in-laws happy, relating to new friends and a
new pattern of social life, and adjusting to the personal habits and hygiene of the new mate, are all important. However, initial adjustments are only the beginning. Even after the interaction between the marriage partners has been successfully established, new and changing situations like child birth together with the inevitable personality changes that result from aging and maturing make further adjustments necessary and inevitable.

The arrival of the first child in the family signals the beginning of a whole new era in the relationship of the husband and the wife. Some marriage partners who have made every other adjustment easily have trouble at this point; one partner or the other becomes jealous of the attention given to the child. The need for disciplining the child as he grows up necessitates another revaluation of the partner's attitudes towards each other, towards the child, and towards the complete living experience. The arrival of the second child calls for further adjustment, not only on the part of the marriage partners but also on the part of the first born.

Attempts at adjustment may be either defense oriented or reality oriented (Sexton, 1968). Defense oriented behaviour aims to reduce tension rather than seeking to fulfill a more basic need. Reality oriented adjustable behaviour is directed at the conflicting needs of the partners. Each partner recognizes his own and his partner's abilities and limitations and attempts to work within these limits. The most successful patterns of adjustment in marriages are those in which each spouse is equally emotionally dependent on the other (Peterson, 1964) and in which each is equally dominant in the relationship
Fullerton (1977) described that the good marriage is one in which there is no conflict; only minor differences that can be talked out in an earnest manner, are there. The happy marriage is assumed to be one of the eternal tranquility (as befitting a marriage made in heaven). A closer relationship inevitably generates both positive and negative emotions. Where there is contact, there is friction.

Hobbs (1956) opined that success or failure of marital relationship, is judged in terms of the adjustment of two personalities, a completely individualistic and secular yardstick. If the personalities fail to adjust, the marital conflict begins. This conflict means that one partner's behaviour has, in some way, violated the other partner's hopes and expectations (Patterson, Hops, and Weiss, 1975).

Kephart (1961) conceived of marriage in terms of personality fulfilment, the satisfaction of emotional needs and the attainment of overall happiness; to the degree that these goals are not achieved, man and wife are likely to feel that their marriage is unsuccessful.

For some, the adjustments are so easy that they are not even aware that they are adjusting. For others, adjusting is conscious and deliberate process of learning to understand to accept and to change (Klemer and Smith, 1970). In the early marriage, the most important factors to a couple are love and affection, satisfactory sexual relations, emotional interdependence, and temperamental interaction (Burgess and Wallin, 1953). Later in marriage, the factors that are most
important may change. Companionship becomes of primary importance to wives (Blood and Wolfe, 1960; Bell, 1971), and the husband's expression of love and affection may be of less importance than his understanding of her problems and feelings (Blood and Wolfe, 1960).

The traditional criteria of marital success are i) permanence ii) children iii) respect of community, and iv) economic well being (Truxall and Merrill, 1953). Researchers have looked beyond the traditional criteria and have sought to establish typologies of marital adjustment based on such factors as mutual personality development, sexual compatibility, common interests, and affectional relationships. Commenting on the problem of traditional and changing criteria of marital adjustment, Truxall and Merrill (1953) put it as follows: "In addition to these traditional criteria, marriage may mean happiness, the growth of personality and the enlargement of emotional experience. When there is no consensus of the goals of marriage, agreement is difficult on the degree to which these goals are or can be realised. Hence, no discussion of marital success can satisfy every one" (p. 253).

Marriages are an old mixture of delight and disillusionment. Countless studies have shown that quarrelling in marriage is inevitable. In fact, people who stay married and regard themselves as extremely happy together are not very different from most of those who wind up so unhappy that they get divorced (Bernard, 1970). Both kinds of couples may face much the same kinds of clashes. Some couples manage to work through the problems, surmount them and even profit.
from them while others throw up their hands and call it quit.

Fullerton (1977) commented that a marriage without conflict was not necessarily a happy marriage. A couple who is preoccupied with maintaining harmony and consensus may in fact have a "rubber fence" marriage when persons with low system marry, the marriage may be more a flight from self than a fulfillment.

Social Burden

Burden refers to the presence of problems, difficulties, or adverse events which affect the life (lives) of patients' significant others, e.g., members of the household and/or the family. The experience of the burden is a very personal matter. Each person has developed his or her own characteristic ways of handling threats, his or her routine for getting through life successfully and it has been identified with a variety of feelings and reactions, such as anxiety, intense emotional and physiological arousal, and frustration. Burden may be caused by any unpleasant, painful, dangerous, embarrassing, or otherwise aversive event. The response to events or changes that alter an individual's social setting, may consist of one or more physiological and psychological reactions that can be immediate or delayed. Thus, a number of responses such as increased financial difficulties, marital problems, depression and isolation, among others, have been considered indicators of being socially burdened.

Many researchers, such as Grad and Sainsbury (1963), made a
headway in assessing the burden felt by families on a three point scale. Hoeing and Hamilton (1966) added another dimension to this assessment by trying to differentiate between the objective and the subjective burden felt by family members. The economic and cultural conditions in India, being vastly different, may reveal a different pattern of stress on the families.

Typically, burden scales have tended to rate only those problems which are deemed to be "related to" or "due to" or "caused by" the patient's illness behaviour (e.g., Creer and Wing, 1974; Grad and Sainsbury, 1963; Stevens, 1973; Hoeing and Hamilton, 1967 and Pai and Kapur, 1981). Thus numerous definitions of "burden" exist in the literature; they share a common underlining frame of reference: "the effect of the patient upon the family" (Goldberg and Huxley, 1980; p. 127), or "the impact of living with a patient on the way of life and health of family members" (Brown, 1967, p. 53), or the "difficulties felt by the family of a patient" (Pai and Kapur, 1981, p. 334). Recently, however, there have also been attempts to distinguish between the occurrence of a problem, etiology, i.e., the extent to which it is "caused by" the patient's behaviour—its patient-relatedness (e.g., Spitzer et al., 1971; Platt et al., 1983). Gibbons et al. (1984) reserve the term "hardship" to signify the prevalence of predefined household problems, while burden is taken to refer to "that element of hardship explicitly attributed to the patient" (p. 77).

The main area of burden which have been investigated over the last twenty years are listed as effect on work employment,
social life and leisure, physical health, emotional/mental health, finances/income, household routine, family/household interaction, schooling/educational interaction with others outside household/family, and patient's behaviour.

The major dimensions of burden are "objective" (meaning any disruption to family/household life which is potentially verifiable and observable) and "subjective" (i.e., personal feelings of carrying a burden; being distressed, unhappy, upset, etc). Although, most scales tend to rate objective burden, only if (probably) related to the patient's behaviour, there are grounds for recommending that the occurrence of an event and its alleged "patient relatedness" should be assessed separately.

The present study has included six categories of objective burden, measured in a semistructured interview schedule. The schedule measures the effect of the presence of the handicapped child on family leisure, family interaction, physical and mental health of others, and financial burden. Subjective burden is assessed by asking one standard question, "How much would you say you have suffered owing to the child's illness?".

Temperament

'Temperament is an ancient concept. However, it is only recently that the scientific research in temperament has begun to act as a dominant force in developmental psychology. Gessell's (1937) analysis of the film records of children to assess characteristics such as activity level or energy output, adaptability, and liveliness of emotional expression
constituted one of the earliest studies. He concluded that certain fundamental traits of individuality, whatever their origin, existed early, persisted late, and asserted themselves under varying environmental conditions. Several theories of development have described the concept of temperament. Developmental theories like psychoanalytic theory of Freud, learning theories of Pavlov, Hull and Skinner, and sociological theories have agreed that individual differences in personality development result from differences in the environmental stimuli and life experiences.

Orlansky (1949), Klatskin et al. (1956), Bieser (1964), and Schaffer and Emerson (1964) were not in favour of environmentalists' view. Temperament theory of development differs from other developmental theories in many ways. Firstly, it emphasizes on the individuality of human behaviour rather than its universality. Secondly, it focuses on the genetic constitutional factors contributing to the normal and deviant development which is different from the theory of environmental causation of behaviour disorders. Thirdly, temperament is relatively stable and it implies continuity that disagrees from the point of view of development.

When psychologists started focussing on the dynamic aspects of activity and regularity functions of behaviour, the phase of traditional psychology of the temperament, e.g., of Kretschmer and Sheldon, with its static description of the innate properties of behaviour came almost to a complete halt.

Temperament is considered to be separate from personality. Personality is a product of sociocultural historical
conditions which is formed in the interaction between the human being and his or her social environment. On the other hand, temperament refers to the characteristic phenomenon of individual's nature including his susceptibilities to emotional stimulation, his customary strength and speed of response, the quality of his prevailing mood, and all the peculiarities of fluctuation and intensity of mood phenomenon regarded as dependent on constitutional make up and therefore largely hereditary in origin (Allport, 1961a).

Temperament is concerned with broad, innate personality dispositions that are hereditary in origin, stylistic in nature, related more with expressive behaviour rather than the content or instrumental (coping) behaviour. The inborn dispositions ostensibly underlie a variety of personality traits, determine to some extent many individual differences in personality and are expected to differentiate during development through complex interaction with the environment.

Such a model of temperament assumes that children start life with certain inherited personality dispositions manifesting in the form of individual differences in infancy. According to John Strelau (1983), "Temperament is a result of biological evolution and has innate anatomical and physiological substrate. Therefore, an individual possesses definite temperament as feature from the moment he or she is born".

Recent interest in temperament stems from the pioneering work of Thomas and Chess (1963, 1968 and 1977) who in their New York longitudinal study closely followed up a group of
children from birth through adolescence and early adulthood. They derived nine dimensions as activity level, rhythmicity, approach-withdrawal, adaptability, mood, intensity of reaction, threshold of responsiveness, distractability and persistence.

Temperament attributes play an important role in the development of psychological problems of various kinds. Children who are ill or handicapped become thermostats for the family mood and we can find their symptoms changing in relation to that as much as to anything "physiological" or "pathological" going on inside the body (Kraemer, 1982). Temperament is the best predictor of the child's adjustment with family members and society. It has been seen that it is not simply the family members who influence children but it is also the children who influence them as much. Whether an environment event is perceived as stressful or not is determined by the temperamental characteristics of the child e.g., a child who is withdrawing and poorly adaptable will find it stressful to cope with the frequent changes in the environment.

Temperament of the handicapped children has been studied in the present investigation. Four characteristics of temperament as suggested by Malhotra (1984) have been taken. These are:

I) Sociability: it describes the child's initial reaction to new stimuli; the ease or difficulty with which the initial pattern of response can be modified in the direction desired by the parents or others and the level of extrinsic stimulation that is necessary to evoke a discernible response.

II) Emotionality: it describes the amount of pleasant,
joyful, friendly behaviour as contrasted with unpleasant, crying, unfriendly behaviour and child's maintaining of activity in the face of obstacles to its continuation.

III) Energy: it describes the level, tempo and frequency with which a motor component is present in the child's functioning and the quantum of energy channelised into response.

IV) Distractability: it means effectiveness of extraneous environmental stimuli in interfering with or altering the direction of ongoing behaviour.