CHAPTER III
REVIEW OF RELATED LITERATURE

A review of related literature pertaining to the theory as well as empirical findings related to the problem is prerequisite for the formulation of the hypotheses in any research. A brief review of literature regarding the nature of the concepts of parental attitudes, marital adjustment, social burden and temperament has already been given in Chapter II. Empirical studies related to the present problem are being discussed in this chapter.

Parental Attitudes

The attitudes of parents of handicapped children have received a fair amount of research attention. Much of the attitudinal research has been focused on the dimensional structure of child rearing philosophies, i.e., warmth-hostility and restrictiveness-permissiveness which provides varying results.

Kanner (1961), a leading child psychiatrist, described parents' reactions to the child's handicap as of three specific types: a) Mature acknowledgement of the actuality and acceptance of the child, b) disguising of reality with search for either scapegoats upon which to blame the handicap or the seeking of magic cures, c) complete denial of the existence of any handicap. Kanner further emphasizes that these basic attitudes colour all aspects of the care and management of the retarded child.

Boggs (1961) reported that parents interpreted the birth
of a retarded child differently. Parents from rural areas had poor understanding, considered it as a short lasting and temporary problem, and were not sure of the nature of the problem. Educated parents and those from urban background definitely had a more scientific perception of the condition and its cause. In accordance with the prevailing belief systems, parents from rural background usually tended to implicate the rôle of dietary deficiency, supernatural forces and neglect during pregnancy as causative or contributory factors. Their unrealistic expectation that sooner or later the child would start functioning like any other person of normal intelligence probably arises from their excessive hopefulness and a conscious or unconscious wish that the child be perfect. Similar data have been reported by Chaturvedi and Malhotra (1983).

Caldwell and Guze (1960) found no difference between mothers with severity of the child's retardation. Dingman et al. (1963) found that difference on the Parental Attitude Research Instrument were related primarily to maternal education.

In contrast to this, while investigating the parental attitudes towards the retarded children, Condell (1966) found that parents had much concern and anxiety about their child's future and seemed to have a more abstract need system, such as, the happiness of the child. Mothers of mildly and severely retarded children have been found to be rejecting and punitive (Cook, 1963; Ricci, 1970).

Bhatt (1963), while studying physical, psychological,
social, educational, and vocational aspects of physically handicapped, interviewed 600 handicapped persons in Bombay, Pune, and Ahmedabad. Regarding family and social life, he found that about 74% of the handicapped were accepted by the family, while 12% felt rejected occasionally, and the remaining 14% were both rejected and deserted.

Several interactional studies measuring responsiveness and communication have reported meaningful differences between groups of mothers with retarded and non-retarded children. In a pioneering study, Kogan et al. (1969) compared a group of 6 retarded children and their mothers with a control group of 10 pairs of mothers and their non-retarded children on parameters of relative status, affection, and involvement. Mothers of retarded children displayed extreme degree of warmth and friendliness less frequently. The retarded children generally displayed a more neutral status (neither dominant nor submissive). Arya (1970) has described that parents' overattentiveness or negligence may increase the level of retardation. Faulty parental attitudes interfere with the child's learning. Unrealistic and self-defeating attitudes lead to distorted family interactions which greatly hamper the already slow learning processes of the child and may at times precipitate severe emotional problems in both the parties (Akhtar and Verma, 1972).

Fletcher (1974) reported that women have been found to be more accepting of handicapped children than men. Baliga (1975) has referred to the counselling of parents of handicapped children because they "have a guilt complex" about the handicapped child which leads them to be either
Srivastava et al. (1978) carried out a study on the attitudes of mothers of the retarded children towards child rearing practices. They analysed the child rearing attitudes of mothers of mentally retarded as compared to those of the normal children. Out of 23 areas of the Parent Attitude Research Instrument (Hindi adaptation) the two groups were found to be significantly different on 11. The mothers of mentally retarded children believed more in the seclusion of the mother, reported more marital conflict, were more strict, got easily irritated on the children, suppressed aggression and believed in ascendency of the mother. On the other hand, the mothers of normal children did not show any such attitudes and believed more in the dependency of the mother.

Nanda and Shukla (1978) reported that the parents who had just been told that their child was handicapped had the feelings of guilt and shame with the result that they started either rejecting or overprotecting the child. Landman (1979) found a significant negative correlation between overprotective attitude of the parents of the retarded children and developmental skill as measured by an applied performance test. Pillai (1979) reported that the parents having lack of understanding or shame/guilt feelings either rejected or overprotected the child. Feelings of guilt and rejecting attitudes have also been reported by other investigators (e.g., Zuk, 1959; Worchel and Worchel, 1963; Walsh, 1968; Harper, 1968 and Rastogi, 1981). Condell (1966), Harper (1968), Rastogi (1981) also found that these feelings could be...
arising out of their poor perception of illness, poor social, and academic performance by the child, or as a psychological reaction but this would eventually hamper the proper handling of the child.

Several investigators (Terdal, Jackson and Garner, 1976; Weitze et al., 1978, Thoman et al., 1978; Eheart, 1982; and Breiner and Forehand, 1982) have found that the mothers of retarded children tended to be more active and directive with their children.

Seth (1979) studied 30 mothers of handicapped children and compared them with those of a control group of 30 normal children. She found that mothers of handicapped children had more maternal dominant and rejectant attitudes and less maternal possessive attitudes. Waisbren (1980) found in her study of parental attitudes that the parents of very young developmentally delayed children were more angry and rejecting.

Ferrara (1979) studied the attitudes of the parents of mentally retarded children towards normalization activities and concluded that parents of trainable mentally retarded children displayed the most positive attitude. Rastogi (1981) reported considerable amount of favourable parental attitudes accompanied with feelings of guilt, pessimism, and sometimes hostility, and observed that the mothers as compared to the fathers, showed more negative attitude towards their retarded child; and both the parents of severely retarded children had more negative attitudes as compared to those of mildly retarded children.
Parents cannot be properly understood in isolation from their social context. Brim (1975), Bronfenbrenner (1976) and Gorden (1980) have stressed the importance of many ecological variables that affect parents in general. These parents are "normal" individuals subject to the same forces and changes in modern life that influence all families. The impact of a disability, whether mental or physical, on the attitude of the family or individual is determined by its meaning within an ecological context (Macgregor et al. 1953; Wright, 1960; Myerson, 1963; and Grossman, 1972). The significance of various factors like socio-cultural attitudes (Maisel, 1953, cf., Wright, 1960; Lussier, 1960; Roskies, 1972; Sarason and Doris, 1979; Edgerton, 1970, 1981, and Glinther, 1980), socio-economic status (Singh and Bargar, 1982; Sen, 1986), and mother's education (Seshadri, 1983) as mediators of parental attitudes require attention. Surprisingly, unhealthy and negative attitudes have more often been reported in educated, urbanites, and those belonging to higher socio-economic status. This is probably due to the failure of their child to perform as well as other children in the modern competitive society. Chaturvedi and Malhotra (1984) reported that of the rejection manifestations, commonest were over hostility and neglect of the child; Eighty Six percent got irritated over trivial issues and the parents who would punish frequently were 63%. It was found that only a few tried to avoid their child or send him away from home. They further reported that the perfectionistic attitudes were also common. About ninety percent parents used excessive strictness and persuasion while dealing with the retarded child. Seventy percent parents were nagging and found faults with whatever the child did.
Compensatory overprotection and increased attention were observed in most of the parents. Parents would not allow the children to do anything on their own and supervised them continuously. These parents felt let down by their retarded child and they took it as a personal defeat. Therefore, despite their better understanding of the illness, they tended to reject the disadvantaged child. Younger parents had more negative attitudes probably due to increased burden so early in life or due to their limited experience.

Narayanan (1984) revealed that a few parents approached the institutions to escape from the drudgery sorrowing the case of the handicapped which was a form of escapism on the part of such parents. Some parents looked upon the residential special institutions as a panacea to all the maladies surrounding the handicapped. They wished and hoped that the institutions would use some magic formula to offset the organ inferiority of the child and translated it into a normal human being.

Sen (1986) compared two different dimensions of parenting (negative and positive) between the two groups, i.e., normal and retarded groups, through multidimensional parenting scale. Normal children were found to be significantly better off in terms of positive parenting, such as love, encouragement, acceptance progressism, democratisation and independence. An opposite trend (though not significant), such as autocracy, discouragement, and dependence was noticed for the retarded group. The same author (1988) stated, "Parents sometimes make provisions for gifts and toys for their handicapped child, even though they may not accept
him emotionally. There are other instances where parents never allow their poor miserable handicapped child to grow up, as they never let him feel independent."(p.54).

A society's negative evaluation of a child placed severe strain on the child's parents. Parental aspirations for the child and the realisation of cherished goals could be thwarted by social obstacles as well as by the disability itself. Parents are forced into conflicting roles as providers who desired the best for their children and as members of a society that viewed the child as socially unworthy (Seligman,1983).

The impact of positive and negative factors on the personality and attitude formation of the disabled child and his family has been illustrated by Ramchandran et al. (1981) on the basis of Kurt Lewins' Force Field theory. The disabled person and his family members with negative psycho-social factors believed that disability was due to sin and there was no remedy for disability. Hence, both the disabled person and his family members felt mentally disturbed and disappointed in life and even acquired an inferiority complex. On the other hand, a disabled person with positive psycho-social factors and compensatory defence mechanisms to display and aspirations coming up in life. His family members also tried to share his sufferings, secured some treatment, and gave right type of care, love, and affection.

Faulty patterns of child rearing like infantalising and over protective attitudes of mothers, extreme Parental criticism, rejection, and hostility cause emotional problems in children (Glueck and Glueck, 1950; Bandura and Walters, 1959;
The extent of negative parental attitudes, erroneous perception and unrealistic expectations is such that it necessitates specialised handling by those who use psychotherapeutic and counselling measures. It is essential to handle these in order to improve upon the disabled child's functioning and reducing the stressful family situation.

Marital Adjustment of Parents of Handicapped Children.

Marital relationships in the families of handicapped children have been a subject of much clinical concern but relatively not much direct research has been initiated in this area.

Farber (1959) studied the effects of having a retarded child on marital integration in 240 families, finding that although marital integration declined with the presence of retarded child, outcome was more strongly related to the marital integration of the parents prior to the presence of such child.

Reports of unhappy marriages and frequent parental quarrelling in families with handicapped children (Holt, 1957; Schonell and Walts, 1957; Farber, 1959; Farber and Jenne, 1963; Tew, Pyne and Lawrance, 1974) are at variance with the finding from other studies (Fowle, 1969; Howett, 1970; Kellmer, Pringle and Fiddes, 1970; Roskies, 1972 and Martin, 1975).

Both parents, of course, react adversely to the birth of
retarded children. However, the fathers' reactions may serve to exacerbate the situation. Instead of increasing their level of involvement, many fathers seem to become less involved in their families, thus leaving their wives to cope alone with the emotionally and physically draining task of raising retarded children. Fathers may thus bear a greater responsibility for allowing the birth of a retarded child to have adverse effects on their marriages, even though, ironically, fathers report more family and marital discord than mothers do (Schonnell and Watts, 1956).

Kagan and Moss (1959) and Amesure (1962) found that mental retardation is associated with broken homes though social and economic conditions were also reported to be important.

Farber (1962) reported that parents of retarded boys had a lower degree of marital integration than did parents of retarded girls. Presumably, this was because parents had higher expectations about boys than about girls; therefore, their expectations were most seriously violated when sons were retarded.

Gath (1973, 1974) found a low rate of broken homes among the families of mongol children living at home but it was balanced by increased incidence of divorce and separation in families of similar children in institution. The same author (1977) also found that severe dissatisfaction was more common among parents of mongol babies and it was found that mothers attributed the sexual problems to distaste for intercourse after the birth of an imperfect child. Two fathers out of 26, complained of importance and said that they felt "less of a man" not producing a normal child.
Several reports confirm Gath's and Farber's findings that retardation has an adverse effect on marital integration and satisfaction (Schipper, 1959; Lonsdale, 1978), with these effects being reflected in higher rate of divorce (Love, 1973), suicide (Love, 1973), and desertion (Reed & Reed, 1965). The birth of a retarded child tends to inhibit future child bearing (Carver and Carver, 1972; Chigier, 1972) that ultimately affects marital relationships.

Tew et al. (1977) observed that the physical and emotional strains of caring for a disabled child cause significantly more separation or divorce than occurs in general population.

Ishtiaq (1977) too found that 72.04% respondents (mentally retarded children) reported that their parents quarrelled among themselves while only 27.96% reported that their parents did not quarrel.

Friedrich (1979) reported that marital satisfaction of the mother was the best overall predictor of her coping ability with the child's handicap. In addition, a positive relationship existed between the child's residence (mothers of an institutionalised child reporting more stress) and sex (mothers of female child reporting more stress) and coping behaviour that confirms Farber's (1962) findings that sex of the child is important to marital integration as retarded male than female children had a more significant negative impact on the marriage. Murthy (1980) too reported that mental retardation had an affect on the parents' adjustment.

Hare et al. (1966), Freeston (1971), Field (1972) Bagleiter
et al. (1976), Cyner (1980) and Green (1981) have reported that marital dysfunction is frequently mentioned in dealing with a chronically ill or handicapped child that can destroy family life.

Friedrich and Friedrich (1981), comparing matched groups of mothers of handicapped and non handicapped children, found a significant difference between groups on the Locke Wallace, a marital adjustment inventory, with the former group reporting lower satisfaction.

Cooke et al. (1986) found in their study that the families into which disabled were born were more likely to dissolve once in their first ten years. Also the one parent spells were longer for the more severely disabled, whose families were unlikely to be reconstituted following a break down. Marital problems brought about by the presence of the retarded children may also be exacerbated by the fact that families with retarded children become socially isolated (Schonell and Watts, 1956; Farber, 1962; Legeay and Keogh, 1966; Meyerowitz and Farber, 1966; Illing Worth, 1967 and Carver and Carver, 1972). This seems to occur for a number of reasons ranging from the lack of time to socialise and the parents' own unhappiness about their children's condition to the lack of acceptance and understanding by others.

On the other hand, despite their grief, parents of 50% mongol children in Gath's (1977) study felt drawn closer together and reported that marriage was rather strengthened than weakened by their shared tragedy, a view similar to that expressed by parents of older mongol children (Gath, 1973; 1974; Burton, 1975). Similar results of other studies indicate
that the likelihood of family disruption is not significantly greater in these families (Hewett, 1970; Freeston, 1971 and Martin, 1975; Waisbren, 1980); the caring may bring the parents closer together (Hare et al, 1966), and that the presence of a disabled child can have both positive and negative effects on family relationships (Walker et al, 1971; Mc Andrew, 1976; and Gath, 1977, 1978).

The variability in the findings on marital satisfaction in parents of handicapped children suggests that the marital response is not uniform and may depend on factors aside from the presence of a handicapped child. Such factors would include the type and severity of handicap, age and sex of the child and the quality of the marital relationship prior to the presence of a disabled child.

The Impact of Handicapped Children on Family Members

In recent years, researchers and interventionists have become increasingly interested in the parents and families of handicapped children. Although, the focus of this interest has varied, one body of literature suggests that families of handicapped children often experience added stress (Farber, 1959; Cummings, Baylay and Rie, 1966; Fartheringham and Creal, 1974; Cummings, 1976; Beckman Bell, 1981).

Weber (1963) has described that "the child who is slow in his physical development responds slowly to parental demands and is unable to compete successfully with the children of his own age, is apt to provoke a feeling of anxiety and frustration. In such cases, the parents are very likely to
have feeling of guilt and self doubt. The result is intra familial tensions" (pp.73-74).

Farthingham et al. (1972) conducted a study in Toronto, dealing with the issue of home care versus institutional care for the retarded children. Their study did not indicate any significant differences between the families of retarded children in the group staying at home and the institutionalised group, but the families of the group remaining at home showed a significant deterioration. The retarded child remaining at home obviously presented increasing stress to the parents and siblings.

Baliga (1975) reported that the parents had the emotional disturbance for having a handicapped child when they faced the problem of insecurity after their death. Besides the evidence that stress may be a crucial factor in the lives of many families of handicapped children, variations in the amount of stress have been reported as a function of the child's diagnosis (Cummings, et al.1966; Cummings, 1976; Holroyd and Mc Arthur,1976). Puri (1975) found that the parents were shocked when they were told that their child was not able to grow intellectually and there was no medicine to cure it. This happens because besides being an object of love and affection, a child serves as an extension of parents' self for the fulfilment of certain type of desires and the whole structure of psychological satisfaction is shocked by the rude shock. Holroyd and Mc Arthur (1976) found differences in the amount of stress reported by families of children who were autistic, had Down's Syndrome, and were out patients in a psychiatric clinic.
Dodge (1976) examined the impact of cerebral palsy child on the family and described the results of these multiple stresses as "Stir Crazy Syndrome". Ranade (1977) reported that the parents of the mentally retarded had the problem of not accepting the fact that their child was mentally retarded. They considered it to be a stigma, had a feeling of guilt and shame and they were also blamed by the relatives as well as by themselves for having a retarded child and had a financial problem.

Shastri (1978) stated that due to a mentally retarded child in the family, the parents faced many problems, such as emotional, psychological and financial. They struggled with their emotions and reactions of the other children which disrupt the atmosphere of the home, damage both retardates and siblings, and even, at times, endanger the marital relationships. Retardation may inflict heavy financial expense, and it may pose difficulty and problems in planning for future pregnancies.

Nanda and Shukla (1978) also reported the emotional impact on the parents who had just been told that they had a "handicapped child". It is beyond the comprehension of an individual who has never thought of it and faced such a problem. So much so that the parents start feeling guilty, experience anxiety, and have the feelings of hostility or rejection towards the child.

Plumber (1979) from her experiences in child guidance clinic reported that the handicapped children with the habits of aggressiveness, stubbornness and destructiveness adversely
affect the family setting. Other studies suggest that more family stress tends to occur in families of older handicapped children and that the boys' handicapped tends to be more stressful than that of girls (Farber, 1959; and Bristol, 1979, cf. Paula Beckman, 1983).

The handicapped child also affects the family economically, especially when the parents find it difficult to accept the diagnosis. They spend a sizeable amount of money (regardless of their economic status) going from one treatment centre to another until their financial situation becomes critical. Not only this but their health and general efficiency also get impaired. Chronically ill children present a set of practical care problems, e.g., sleeping, washing, dressing, feeding, and toileting. The extra demands on parental time often result in physical exhaustion as well as psychological and interpersonal strain. Several investigators (Grossman, 1953; Marra & Novis, 1959; Litman, 1966; Steinhaeur et al., 1974; Fox, 1977) have examined the social and familial problems associated with the presence of a handicapped child. Oster et al. (1975) and Dupont et al. (1978) reported that the temporal, financial and mental stress as well as social isolation is considerable. In 80% of the cases, the parents' sleep was disturbed by the child, 59% of the mothers had given up or limited their cultural activities, 77% had limited contact with friends, 49% had limited contact with relatives, and 59% had stopped going on vacation. Sixty Seven percent of the families stated that the circumstances altered.

Many parents, in their overwhelming anxiety for the welfare of the child, loose their sense of perspective and
decide that money is of no consequence where the needs of the child are concerned. In cases where this happens, the results are almost disastrous to the home situation because added to the terrible emotional strain through which the family members pass in the additional burden of anxiety over the critical financial situation. Such parents may be viewed as "patients" who are in need of treatment (Turnbell and Turnbell, 1978 and Seligman, 1979).

However, Pidd (1977), Reynolds (1979) and Wishart et al. (1981) reported that the parents of handicapped children were not found to suffer from significantly greater ill health than those of normals. They further reported that presence of the retarded child does not appear to change the family routine to any large extent; it did not affect their friendships and social activity. There were very little attempt to camouflage the child's condition from friends and neighbours.

Levenstein (1981), on the other hand, described the chronic illness/handicap as not merely an isolated event in the chronic life of the individual but a situation which alters the entire fabric of family life. Johnson and Price (1980), supporting Levenstein, reported that disorders which cripple young adults are "family diseases"—in the sense that they cause emotional and financial disruption in families.

Sharma and Mukerji (1981) in a study of 150 handicapped children reported severe frustration, feeling of inferiority complex, guilt, and shame in more than 90% of parents.
Rastogi (1984) reported that both the parents of mildly retarded children obtained higher score on anxiety, phobia, and depression. Analysis of different factors when compared for fathers and mothers revealed a higher degree of neurotic traits in mothers.

Sharma and Gupta (1985) revealed in their study that the parents of physically handicapped children were more often the victims of mental ill health as compared to those of controls. Other investigators (Pershad et al, 1979 and Miller, 1978) have reported greater magnitude of neuroticism, depressive and dyspnoeic effect in mothers of handicapped or emotionally disturbed children.

With the presence of a handicapped child in the family, another problem that haunts most parents is the question of whether to have another child or not, not only does this strain the minds of the parents, it also inhibits future child bearing (Carver and Carver, 1972).

Siblings, particularly at risk for maladaptive responses, undergo concurrent stress, have poor relationships with the parents and/or with the ill child, poor support system and limited communication skills (Taylor, 1980). They themselves develop physical symptoms, social problems, antisocial behaviour, change in mood, or anxiety related habits of self esteem (Valman, 1981). The other studies reported that they have caused the patient's condition (Rothstein, 1980). On other hand, Teja, Verma and Shah (1971) concluded on the basis of their studies that mental retardation was associated with sibling rivalry.
The conflicting situation of parents vis-a-vis society is unresolveable. Family members pay a cost for society's attitude toward the disabled child. The parents are unable to find a babysitter because their child is handicapped, the family whose offsprings are teased by other children may find its ties to the community diminished because of the handicapped child. The interests of the child and those of the parents are thus placed in a partial conflict (Roskies, 1972). This fact may be partly responsible for the higher than average risk of child abuse faced by handicapped children (Seligman, 1983).

As in many other developing countries, facilities for caring for handicapped children are grossly inadequate in India. Invariably, therefore, the burden of bringing up a handicapped child is borne fully by the parents as assistance from the Government or other agencies is minimal. As a result, the families with a handicapped child (physical and/or mental) have to bear the social and economic burden of bringing up such a child.

Gandhi and Aggarwal (1969) concluded in their study of 100 handicapped children that they could be trained and made useful. They should be employed so that they are not a burden on the family.

Rehabilitation of handicapped child means that beside providing medical/physical care to the child, the whole family of the child is actively involved in the programme in the order to lighten the social burden of parents and siblings.
Characteristics of Handicapped Children

Human growth is a physiological process in which psychological and physical development are interdependent. Any derangement of the patterns of normal physical growth will have serious repercussions upon a child's intellectual and emotional growth.

The stress associated with the presence of a disabled child, no doubt, is an important consideration for the family but this deeply shocking event will occupy these children forever during their lives. Depression, rage, anxiety and despair are ever present threats, straining the coping capacities of these children (Lazarus et al., 1980). The crippled child is unable to satisfy the human desire to explore the unknown. He is deprived of the experience of wider external world as well as self knowledge and sense of security. The handicapped child thus restricts his experiences and, therefore, shapes his own mental, emotional, educational and social growth accordingly.

The development of a handicap as the onset of a chronic disease profoundly alters the life of the afflicted child. The threat to life, the loss of function, and the change in appearance call forth intense reactions of anxiety, grief, rage and despair (Edward, 1981). Becoming less physically attractive or less able causes profound feelings of becoming less worth.

A realistic look in to the problems a disabled individual is likely to face would certainly suggest maladaptive
personality patterns. These are liable to become tumbstone of his developments, thereby, perhaps, leading to further frustrations and helplessness. Two major viewpoints are found to exist regarding the effects of disability on personality. One viewpoint emphasizes that physically handicapped are helped rather than hindered by the disabilities. Adler (1926) in his theory of compensation advocated this viewpoint. Crippling, in that case becomes, in fact, a source of strength. He proposed a relationship between bodily defects and behaviour, suggesting that the driving in human nature is the experience of a need to excel and to overcome any handicap.

The other point of view which is rather a common belief insists that all mental, moral, and spiritual disorders are linked with physical affliction. According to Allport (1961 b) physical is associated directly with personality. Strong bodies, well formed and socially approved statures, predispose people to develop extraverted, and realistic and social traits. Conversely, malformed or markedly atypical physiques tend (in relation to social and environmental standards) to produce introverted, intellectual, or artistic personalities. Kammerer (1940), supporting this view, reported that certain attitudes were prevalent among many handicapped children. The child often was timid socially, felt inferior because he considered himself to be defective and because he repeatedly experienced isolation from peers and failure to compete adequately with them. Broida et al. (1950) differentiated the crippled children in the context of feeling of fear by using Symond's Picture Story Test. He reported that such children experienced conflict because their needs
for increased social integration were assumed to be counterbalanced by fear of entering social situation.

Using a "Sentence Completion" test, with crippled junior and senior high school children, Cruickshank (1952) found that these children wanted their peers and other adults to overlook their disabilities, inspite of the fact that they often lacked some of the social attributes necessary for this and they desired to be treated as individuals and not as handicapped people. As a group, they were less able bodied control subjects, to evaluate interpersonal relationships. They had a tendency to withdraw from social contacts, and they also showed relatively fewer "normal" adolescent interests.

Using the Rozenweig Picture Frustration Test, Smock and Cruickshank (1952) found that the level of frustration tolerance of physically handicapped children was lower than that of normal children. Similarly, Linde and Patterson (1958) used the Minnesota Multi phasic Personality Inventory (MMPI) with handicapped college students and noted that the cerebral palsied subjects tended to show emotional maladjustment.

However, no specific patterns of personality types as such, appeared to differentiate the disabled from the control group. Some of the difference were attributed to the anxiety generated by the disability and the concomitant tendency of the disabled to withdraw from social contacts.

Johnson (1958) and Mussen (1958) also reported the frustration and isolation in handicapped children more than in the normal children due to restricted choices and activities and impaired independence and social acceptability.
Schecter (1961), working with orthopaedically handicapped children, assessed the same emotional reactions and reported that the contributing factors appeared to be poor physical health, a lack of social acceptance, and consequent paucity of contacts outside the home.

Impressionistic assessments have been made in the field of mentally retarded children's behaviour. Some of the most frequently remarked aspects of the behaviour of the mentally retarded are distractibility in attention and hyperactivity (Tredgold, 1949; Gallagher, 1957; House and Zeaman, 1960 and Longnecker and Person, 1961). However, the belief that the brain injured group of mentally deficient would be more distractable than the familiar type (Strauss and Lehtinen, 1947; Strauss and Kephart, 1955; and Cruickshank et al., 1961) has received support in many studies (Golden, 1956; Schlanger, 1958; Foschee, 1958; Gardner et al., 1959; Spradlin et al., 1959; Cromwell and Foschee, 1960; Ellis et al., 1963; Girardeau and Ellis, 1964; and Brown, 1965).

Some of these studies (Foschee, 1958; and Cromwell and Foschee, 1960), however, were carried out from the stand point of activity and hyperactivity was assumed to be another concomitant of brain injured retardates. The investigators reported that regardless of classification of subjects, all groups showed significantly less activity with increased visual stimulation.

Hutt and Gibby (1965) stated that mentally retarded children can have the reactions of (a) excessive aggression, (b) excessive timidity, (c) Enuresis, and (d) eating
problems. They further stated that mental retardation affects the entire child's daily routine activities when he is not permitted even to do the many things that he could do. He functions below the level of his already limited abilities. It happens when the parents overprotect the child. Mental retardation affects the entire life activities of the retarded such as academic work, play activities, physical and emotional development. The retarded child, according to the authors, is denied the usual childhood experiences; what other children casually accept is not for him. Not for him are close childhood friendships, group activities for which he can be praised. Rather his childhood is one in which he is constantly reminded of his worthlessness and weaknesses; it is full of feelings of futility and rejection. He is truly a Johan, a social outcast, and hardly has any feelings of belongingness to a social group.

The behaviour of the retarded reflects more than the cognitive processes. Therefore, the personality factors are as important as intellectual.

Sen and Sen (1967) demonstrated that the mentally retarded, who were more excitable (measured on an "Excitability Rating Scale" developed by Claridge and O'Connor), were found to show trace inaccessible behaviour. If memory fails even when the trace contains the stimulus in formation, the trace is described as inaccessible. The trace inaccessibility in memory was demonstrated to be present in some of the subjects of a group severely subnormal, alike intellectually normal persons. The subjects who showed this type of behaviour made comparatively more intrusion errors in
a serial recall task than the control group. This study thus suggested that this behaviour characteristic observed in the retarded individuals was related to the type of personality such as excitability.

Deb (1967) studied the personality pattern of crippled boys aged above ten years by using Murray's Thematic Apperception Test (TAT). The results suggested the unconscious guilt feelings and severe superego pressure. As a result of their guilt feelings for their oedipus wishes, the weak ego accepts castration due to pressure of severe super ego. Thus physiologically affected body parts had psychological impact on the victim.

Raimbault and Royer (1969) examined the handicapped children and found that the higher feelings of guilt contributed to anxiety, shame, deviance, sense of doom and failure, a sense of badness, fear of death, denial, and anger like their parents that ultimately affected the adjustment.

Sternlicht and Deutsch (1972) and Intagliata and Willer (1982) reported behaviour problems of these children to be the main cause of failure to adjust in community.

Bose and Banerjee's (1969) results revealed that the presence of some covert determinants in the physically handicapped children structured an active inner life, the negative pull of theirs made them withdrawn and passive, resulting in crippling their spontaneous liveliness. Passivity and withdrawal became compensatory mechanisms magnifying their invalid condition and sustaining the same. Their failure in acquiring social skills was also supposed to
be related to these tendencies.

Mukherjee (1970) found the retardates to be very rigid both physiologically and in their personality make up. In a study by Bentovim (1972), it was found that often physically handicapped girls thought they would never be a mother and this thought was seen to result in social rejection and devaluation of the self. The author explained, on the basis of these results, that girls tend to value close personal relations more than handicapped boys so that any condition that interferes with social relationships affects the girls' happiness and may arouse anxiety. The sex differences in anxiety and obsessiveness may be concerned with physical appearance. It was concluded that the adjustment problems among the handicapped were greater among girls than boys.

Mathew (1974) observed that persons with body defect showed more inferiority feelings than those without body defect.

Jones (1974) studied the school achievement and interpersonal relationships of orthopaedically handicapped and found that the performance of normals was better than the handicapped which might be due to lack of concentration in class room and also frustration and maladjustment caused due to unwell treatment by teachers classmates and peer groups.

Shukla and Khoche (1974) studied male mental retardates and compared them with 50 normal adolescents matched for chronological age and socioeconomic status. The results of the Bell's Adjustment Inventory revealed that mentally retarded adolescents were severely maladjusted in the home.
health, social, and emotional areas in particular, and overall adjustment in general. Shastri and Mishra (1979) assessed the social functioning of the retarded on the basis of certain criteria, such as interaction, communication, self responsibility and level of impairment.

Sircar (1975) carried out a comparative study of hostility between mentally retarded and normal children. The Holtman inkblot test was administered to 30 institutionalised retarded boys and 30 normal boys belonging to the same socio economic group and in the age range of 8-12 years. The results indicated that as compared to the normal group, the retarded group was significantly more hostile.

Kishwar and Chandra (1975), in one study, attempted to highlight the sociological factors associated with mental retardation on a sample of 93 moderately mentally retarded and 107 normal children between ages 6-10 years. Results indicated that the intellectual handicap, lack of proper motivation and emotional disturbance are associated with mental retardation.

Kiswar (1977) reported 87.10% retarded children to be submissive, and about 72.04% to be characterized by self consciousness, 59.14% were found to be vagrant, and 75.3% withdrawing. Similar characteristics of the mentally retarded have been reported by Sarason and Goldwin (1959), Robinson and Robinson (1965), Philips (1965), Marfatia (1968) Malin (1969 a), Sethi (1971), and Hussain (1975).

Dembo's (1975) study demonstrated that the child born with disabilities differs from that with acquired disability. For
the child with a congenital disability watching life go by was not enough for the development of sensitivity and skills in human relationships. To the child with acquired disability, socio-psychological adjustment appeared to be a matter of revaluation where bodily loss was reluctantly accepted and physical integrity played a more essential role in judgement of self and others.

Lynch and Arnott (1976) found that physically handicapped children did not often show an external expression of aggressive reactions. There was no doubt that these unexpressed feelings not only influence their attitudes towards the world around them, but also interfere with the emotional and social adjustment processes.

James and Snaith (1979) found that between 20 and 60% of mentally handicapped children had moderate to severe behavioural disorders.

Plumber (1979), from her experiences in the child guidance clinic, reported that the "aggressiveness, stubbornness and destructiveness" were commonly associated with psychological problems in the mentally retarded children. The characteristics like withdrawal and extreme shyness of the retarded child would interfere with his utilisation of his potentialities.

A normal child generally grows up with a balance of security and independence whereas this is not the case with the handicapped child. He, therefore, feels frustrated and inferior. Insecurity is, thus, experienced in all spheres of physical, emotional and social life (Prasad and Salich, 1980).
In a comparative study of personality patterns, life satisfaction and problem patterns of orthopaedically impaired and normals, Ghai and Ittyerah (1980) found that the handicapped were less independent, less well adjusted, but more satisfied than the able bodied normals. They were also found to have confronted with significantly higher number of problems in the domain of home and psychological and social adjustments.

Murthy et al. (1980) studied 108 retarded children. They reported that 8% of children were having associated behaviour problems with mental retardation.

Sethi and Sen (1981) made an attempt to examine the level of intelligence, creativity, self concept, and frustrations of orthopaedically handicapped children. The sample consisted of a group of 20 orthopaedically impaired of 8-12 years. The self concept of the handicapped was found to be significantly better than that of normal. The results indicated that the handicapped children did not view themselves as inferior to others; and they were found to hold a firm belief that they were as capable as anyone else, in the private and social sphere. The same author reported that the handicapped were not found to differ significantly from the normals on frustration level except for two factors, namely, need persistence and ego_defensive impunitiveness.

Rao (1981) reported studies on the orthopaedically handicapped children who were compared with normal children on some psychological variables. The handicapped group was found to exhibit low self appraisal, passivity, low ego strength
and projected agressiveness. They were found to be more worrying type, exhibiting self condemning attitudes and submissive reactions. However, they took a more realistic approach toward their frustrations. The same author reported in one study, using picture frustration test, that handicapped individuals were quite ego defensive. Those who were rehabilitated by providing them with artificial limbs and were able to move about freely, showed remarkable change in attitude. They were almost comparable to normals and they did not suffer from inferiority feelings and any undue ego defensiveness, at least apparently.

Motivation becomes an important variable when the retarded is compared with the nonretarded. Research evidence suggests that many of the reported differences between retarded and normal children of the same mental age are a result of motivational and emotional differences. Andreanska and Andreanska (1981) summarized findings of a series of studies on the motivation of handicapped children. It was reported that i) contrary to the normal population, for most of the subjects, the sequence of their motivational responses was contingent upon the type of activity to be performed and ii) there were differences in the motivational behaviour of individuals with different handicaps. In the mentally retarded, for example, external stimuli were more effective source of motivation rather than internal stimuli.

Mohan et al. (1981) selected 51 mentally retarded boys from regular and special schools and compared their scores on the Eysenck's Personality Inventory with that of a control group of normal boys. They found that the mentally retarded
scored higher on neuroticism indicating social isolation, rejections, stigma, and rebellion. The authors also maintained that family stress increased with repeated failure and frustration. They reported extraversion in the retarded to be higher as compared to the normals. Earlier, Mohan & Sethi (1968) found that the retarded scored higher on extraversion and lower on neuroticism scales.

Gordon et al. (1982) conducted a computer search of the records of 114 mentally retarded children and adolescents and reported that 25% of the subjects showed behavioural and emotional problems. He also found that prevalence was related to the degree of retardation and age.

Gunthey and Upadhayaya (1982) studied adaptive behaviour in retarded and nonretarded children of 7 to 13 years of age. Mentally retarded subjects had significantly lower adaptive and higher maladaptive behaviour scores than the subjects of other groups.

Koller (1983) examined the retarded children and reported that hyperactive behaviour was most frequent among children with lower IQs. Aggressive conduct disorders in childhood were most frequent among females and antisocial behaviour was more frequent among males.

Handicaps can seriously disturb the personality development of a child. Many children develop symptoms of depression. According to Bicknell (1983) "Mentally handicapped people seem to have little desire to communicate, they do not develop a social conscience, nor imaginative skills and they have extreme difficulty with one to one relationships. They are
liable to profound depressive illnesses when their sexuality develops" (p. 176).

Harvey et al. (1984) concluded that physically handicapped and their sibs have lower self esteem as compared to the controls. Prakash et al. (1985) studied the personality disposition of mentally retarded children in detail. Two groups of 50 normal and 50 retarded children in the age range of 10 to 12 years matched as far as possible with regard to socio economic strata of parents, comprised the sample of the study. Personality dispositions were measured by the Personality Assessment Questionnaire (PAQ). The dispositions assessed by PAQ are dependency, instability, world view, hostility self esteem, and emotional responsiveness. The results showed that the scores of mentally retarded children in all the six personality variables were poorer than the normal subjects.

There is ample evidence supporting the assertion that the low self evaluation impairs social and emotional adjustment (Blaxter, 1976). Low evaluation by a disabled child will be associated to resistance of association with other persons which could consequently impair social and emotional adjustment.

Husain pointed out, on the basis of Wenar (1956), that handicapped children did not have the type of self control which enabled them to hold negative feelings in check and function more objectively and on realistic basis.

On the other hand, Sahasbudhe et al. (1980) reported in their study that physical disability had minimal affliction on
the educational career of the handicapped child. Hobbies of handicapped children were found to be same as of the controls but extra curricular activities of handicapped group were significantly affected. More than 70% of these children were cooperative, inquisitive, and of mixing nature. He, therefore, concluded that much could be achieved provided a therapeutic community was created for the rehabilitation of such children.

In our community, the handicapped are treated as low grade citizens because they are dependent and are not productive themselves. Due to a lack of confidence and courage, they are not able to lead the life of a normal person and in due course they develop psychosocial frustration. There is a need to understand such children, experience their feelings, and give them chance to live like a normal human being in the atmosphere of love and acceptance. Those, involved in the intervention and rehabilitation programmes need to keep in mind the characteristics of the handicapped children.

PRESENT HYPOTHESES

On the basis of the theoretical orientation in Chapter II and the studies reported above in Chapter III, the following hypotheses were formulated.

i) Mothers of normal children will have more positive orientation towards child rearing than those of physically handicapped children followed by the mothers of mentally handicapped children.

ii) Mothers of physically handicapped children will have more knowledge of the handicap than the mothers of mentally
handicapped children.

iii) Mothers of physically handicapped children will have more favourable attitude towards the handicap and the management of the handicap than the mothers of mentally handicapped children.

iv) Parents of normal children will have better marital adjustment than the parents of handicapped children.

v) Mothers of mentally handicapped children will report higher social burden than the mothers of physically handicapped children.

vi) Normal children will be more sociable than the handicapped children.

vii) Physically handicapped children will be higher on emotionality than the mentally handicapped children, with the normal children falling between the two.

viii) Mentally handicapped children will show more energy followed by normal children and then the physically handicapped children.

ix) Mentally handicapped children will be more distractable than the physically handicapped and normal children.