A vast number of studies have been conducted to investigate the functioning of families having differently abled children. A good number of studies focused on the stress experienced by these families, particularly whether these families experience more stress than families of children with normal children. However, the effect of social support on families having disable children are less emphasized in the literature. Social support has shown to have a moderating effect on stress, and much research has been conducted to determine the extent of this effect with families with a disabled child. These problems are largely day to day issues, like the prolonged burden of caring and managing emotional or behavioral problems of children with disability.

Studies pertaining to disabled children have been primarily based on their emotional and adjustment problems as they tend to experience maladjustment and personality disorder due to their disability. In one such study, Kammerer (1940) states a handicap, severe or mild in itself is sufficient to arrest the normal development of the individual and to cause maladjustment and personality disorder, while reported that emotional difficulties such as hostile withdrawal, sense of insecurity, lack of self-confidence and extreme timidity were due to a disabled person’s unfortunate experience with siblings and parents. He found that the deformity not only places an individual at social and economic disadvantage but also plays a powerful role in determining the attitude of a disabled person towards oneself. Ringma and Brown (1991) also report that being disabled is not the sole cause of maladjustment, rather it seems dependent upon the number and severity of the problems which a disabled is confronted with.

A major portion of the research work is available on the visually impaired children, their parental care, care demand and support services. But not much of the work has been done on the cognitive, physical, hearing and speech impaired children and their various care demands and services. More so, only few works is available on the motor aspects of life. Besides personality and adjustment studies, a few researchers focus on the mental capabilities of the disabled. The study by Dial and Jack (2009) shows that sighted and blind children did not differ in their ability to think divergently. They also came to a similar conclusion that handicapped and normal children were equally creative in all factors of creativity test measures. Literature related to disability also gives
evidence of the impact of social and environmental forces on the development of intellectual and social competence of the disabled. It is reported that un-stimulating environment, cultural deprivation and poverty are the principal barriers which impede the proper growth and development of disabled persons.

Coming to the literature on specific disabilities, it is noted that with regard to blindness, voluminous work has been done about the cognitive characteristics of the blind. Likewise several comparative studies have also been made between the congenitally blind and accidentally blind persons. In Indian context, though studies are carried out in this aspect is not very exhaustive, including pertinent areas like, etiology of disability, socio-economic status, educational level, vocational problems, different aspects of prevention and rehabilitation, social adjustment of the disabled, their integration etc. Studies on social adjustment of the blind undertaken by Vasudeva (1979) and Sinha (1982) studied about personality adjustment of the blind children with regard to adjustment with sighted peers, while they reported emotional maladjustment among blind students are to „broken homes”.

Studies related to deaf people pertain mainly to their intelligence level. Vernon (1969) after reviewing a large number of studies concluded that those children, who are deaf and have hearing problem have essentially the same distribution of intelligence as the general population, even though the main score may be slightly less for the deaf children. Furth (1966) proposed that the deficiencies associated with the linguistic incompetence of the deaf could be overcome if non-verbal method of instruction and communication are more encouraged both at home in the earliest year and in formal school education. Studies further reveal that quality and quantity of the language and education that can be acquired by the deaf do not depend only on the intelligence level of the child but on many other factors such as early recognition of hearing loss, motivation of both the parents and the child towards learning.

In the field of orthopedically disabled empirical studies are much related to ascertain their intelligence and cognitive functioning. Some have even been directed on the effect of disability on personality development. Studies conducted by Kammerer (1940), Wright (1960) and Dembo (1975), among others touch on attitudinal problems of
the orthopedically disabled. In Indian context, Bhatt (1963) has undertaken an earnest effort to present the problem taking into consideration all the relevant facts and figures, reports and returns regarding the physical, psychological, social and vocational rehabilitation of the physically disabled. In the social and psychological fields, the study revealed that the attitudes of the members of the family towards the disabled individual were not in all cases desirable. Almost one-fourth of the total cases were either emotionally rejected or virtually deserted by their families on account of their disablement. Shankar (1976) in his work gives a detail account of different types of child disability, its causes and the need for facilities appropriate to their rehabilitation.

Studies show that birth of disabled child make parents hopeless and negative attitude developed towards their child (Ramaswamy, 1989). Speedwell et al. (2003), in their study, mentioned that parents of sick or disabled children are likely to be more stressed than parents of non-disabled children. They also mentioned that information regarding the welfare of children is beneficial for parents but sources of information have not given much importance in studies.

The birth of a child with disability causes lots of fundamental problems for parents. For some parents, these feelings of failure and loss of self-worth are temporary and for others, these emotions may last for a lifetime. What can be said with certainty is that the process of adjustment for parents is continuous and distinct (Hardman, Drew, Egan and Wolf, 1993). It indicated that parents may react very differently to the child and the mother sometimes took the role of physical protector and guardian for the child's needs, while the father mostly remain reserved in his role. He may cope by handling the situation carefully by internalizing his feelings.

Mehta (1983) in the book entitled “Handbook of disabled in India” surveyed the problems abroad and in the context of National scenario. The author also covered the categories of the disabled, specifically disabled groups, facilities and concessions available and allied matters in more elaborate way, which helps for the better understanding of disabled children.
Seiquira and associates (1990) marked that more than 50% of the mothers of mentally retarded children were having severe financial burden and also reported 61% of parents faced financial constraints while providing care to these disable children. Many earlier studies on mentally retarded children also reported rising financial burden because of two reasons, one is additional expenditure involved in caring for the mentally retarded children and the other is reduced sources of income because the parents had to spend extra time in parenting severely retarded children. (Mc Andrew, 1976; Seth, 1979; Veena, 1985).

**Theoretical Perspectives on Disability**

In recent years, the traditional medical model of disability has been challenged and alternative models emerged in various fields of humanities and social sciences, such as anthropology, political science, history, literary and cultural criticism, and disability studies (Barnes, Mercer and Shakespeare, 1999). The critical themes emanating from these arenas have examined the role of social and cultural factors in the development of the category of disability (Ingstad and Reynolds-Whyte, 1995; Priestley, 1999; Stiker, 1982); through the social model of disability. Marxist and political economy perspectives discuss the relationship between disability and the emergence of industrial society (Oliver, 1990, Stiker, 1982); the growing field of disability studies (Linton, 1998); professional domination experienced by people with disabilities (Foucault, 1973, 1977; Sapely and Hewitt, 1991); a critique of the discourse of normalcy (Amundson, 2000; Davis, 1997b) and the discourse of measurement (Cintron, 1997; Witkin, 2001); feminist theories (Garland-Thompson, 1997a; 1997b; Wendell, 1996; 1997); and disability arts and culture (Barnes, 2003; Oliver, 1996). It is noticed that the histories and experiences of people with different disabilities, such as physical disabilities, developmental disabilities, and mental health problems, are not homogeneous. However, once a human condition fits into disabled criteria many similarities emerge that comprise the overall experience of disability.
Social and cultural constructions of disability

Social constructionist framework to disability described constructionism as a theory that seeks to “elucidate the socio historical context and ongoing social dynamic of descriptions, explanations, and accountings of reality”. Rather than taking theory and the dominant forms of understanding as definite conclusions, implicit in social constructionism is the idea that knowledge is not an objective entity, but rather a social creation (Levine, 1997). Constructionism devotes particular attention to the ways in which knowledge is historically situated and embedded in cultural values and assumptions, socio-cultural norms, and language (Patterson, 1997). From the constructionist perspective, language serves as a method for producing meaning and generating knowledge rather than a representation of an objective “truth”. Constructionism as an epistemology, therefore, contributes a liberating quality to the social sciences by way of alteration to the monolithic landscape of positivism and scientific inquiry (Witkin, 1990).

Social constructionism can offer significant insight to contemporary conceptualizations of disability. Most individualistic (personal-tragedy) accounts of disability fail to recognize that even the most objective of disorders, such as visual impairment, do not exist independent of culture and society. The contemporary language of disability, with its individualistic representations of personal tragedy suggests that disability and impairment exist independent of cultural, historical, or other contexts (Brzuzy, 1997). While the emphasis on the influence of society and culture on human behavior has been widely accepted in several academic arenas (anthropology, cultural criticism, sociology etc), and the constructionist perspective asserts that a disability-related impairment comes from the relationship of the person with a disability to the socio-cultural environment; thereby the environment is seen as the primary target of intervention. (Gilson and DePoy, 2002).

Drawing from cultural studies, the cultural construction of disability questions the enlightenment idea of a rational, progressive human actor in society. It scrutinizes knowledge to deconstruct the unstated assumptions about disability and people with disabilities. The subjective experience of disability and both the explicit and implicit
assumptions that shape the disabled experience have been suggested by a large number of ethnographic studies undertaken by anthropologists (Groce and Scheer, 1990; Ingstad and Reynolds-Whyte, 1995; McDermott and Varenne, 1996). How disability is understood in different cultures. How are deficits of the body and mind interpreted and dealt with in different societies? How is an individual’s identity as a person affected by the cultural connotations of disability? How do processes of cultural transitions shape the local understanding of disability? Definitions of disability in terms of measurable functional limitations fail to recognize that culture permeates the variations of the human condition with consequences much deeper than the simple ability to perform a given task (Ingstad and Reynolds-Whyte, 1995). Objective criteria of functional limitations do not answer the question of how important is individual ability as a source of social identity in different cultures.

The experience of disability, too, varies across cultures. Edgerton (1985) studies showed societal attitudes toward people with impairments varied greatly in non-Western cultures, from negative discrimination, to acceptance, and to positive attribution of supernatural powers. Disability is, therefore, hardly a unitary concept. Understanding disability as a socially and culturally constructed phenomenon, rather than as an inherent objective “reality” calls into question the presuppositions of the medical model that form the foundation for agenda of human rights/social justice. In this regard, constructionism provides a theoretical framework to rethink disability in liberating and empowering terms.

A Social Model of Disability

The social model of disability was first put forth in the United Kingdom in a 1976 statement by the Union of the Physically Impaired Against Segregation (UPIAS, 1976). It was later discussed in detail by Corker (2000), Finkelstein (1980) and Oliver (1983, 1990, 1996). Instead of a narrow focus on functional limitations, the problem, according to the social model, is “society”s failure to provide appropriate services and adequately ensure the needs of disabled people are fully taken into account in its social organization” (Oliver, 1996). Disability, according to the social model, encompasses all factors that impose restrictions on people with disabilities, ranging from negative social attitudes to
institutional discrimination, from inaccessible public buildings to unusable transport systems, from segregated education to exclusion in work arrangements, and so on.

While it is acknowledged that the relationships of people with disabilities to their bodies involve elements of pain and struggle that perhaps cannot be eliminated or mitigated, yet many of the barriers that people with disabilities face are the consequences of having those physical impairments under existing social and economic arrangements, especially the means of industrial production. These social and economic systems could but do not accommodate disabled people’s physical conditions or integrate their struggles into the cultural concept of everyday life (Asch and Fine, 1988) and hence viewed as “oppressed” (Pfeiffer, 1996).

The social model of disability says that disability is caused by the way society is organised. The medical model of disability says people are disabled by their impairments or differences. The medical model looks at what is 'wrong' with the person, not what the person needs. It creates low expectations and leads to people losing independence, choice and control in their own lives.

**Social Comparison Theory**

Social comparison theory is a theoretical orientation that is now considered to have influence in the field of intellectual disabilities (Dagnan and Sandhu, 1999). According to this theory, one’s self-concept is largely determined by the ways in which one is treated by significant others. Social comparison research emphasizes that, in situations where the self concept is threatened, there are three possibilities: people may minimize comparisons (Brickman and Bulman, 1977), avoid upward comparisons (Steil and Hay 1997,) or try to self-enhance by making downward comparisons (Crocker, Thompson, McGraw and Ingerman, 1987). In the face of a threat to self-concept people may prefer to compare themselves with others they perceive as „worse off” than themselves. This can result in an increase in subjective well-being because downward comparisons appear to boost self-concept and reduce anxiety (Gibbons, 1986).
Social comparison theory (Gibbons, 1986; Szivos-Bach, 1993) predicts that comparisons with “normal” groups and as such their self-concept will decrease because of negative frame of reference effects (Wills, 1991; Buunk, Collins, Taylor, Van Yperen and Dakof, 1990) because participants may view context in different ways (Haslam and Taylor, 1992) and display “selective industry of the mind” (James, 1890). For example, people may choose to make either upward or downward comparisons and be quite selective as to which groups they use for comparison.

Leary, Tambor, Terdal and Downs (1995) found that rejected people, such as people with disabilities who have been institutionalized, showed greater negative feelings than a comparison group drawn from the normal population. Another study also showed that behaviours or situations associated with exclusion are also linked with decrements in self-concept (Suls and Wheeler, 2000). In a study that examined the relation between social comparison, self-concept and depression for people with intellectual disability, Dagnan and Sandhu (1999) concluded that social comparison self-concept and depression are interacting in the same way as they do for people without an intellectual disability.

Social Approaches to Disability

According to many disability scholars, individualistic approaches (especially the medical model) are biased and lead to practices and social arrangements that oppress disabled people. Interventions are aimed solely at the “abnormal” individual, whereas the surrounding community is left intact. Resources are not directed to changing the environment but to, for example, medical treatments with the aim to “improve” the impaired individual. This leads to a social and moral marginalization of disabled people and restricts them from full participation in society.

This criticism has been presented by a large number of theorists who take a social approach to defining disability. Some of them claim that disability is the result of oppressive material arrangements in society. This position is called the social creationist view of disability. In this perspective, it is essential to grasp the distinction between „physical impairments” and the social situation, called “disability,” of people with impairments. Impairment is defined as “lacking all or part of a limb, or having a defective
limb, organism, or mechanism of the body,” whereas disability is “the disadvantage or restriction of activity caused by a contemporary social organisation which takes little or no account of people who have physical impairments and thus excludes them from participation in the mainstream of social activities”. The core idea of the social creationist view is that disabled people are an oppressed social group. Their inferior status is not a natural effect of their impairment, but it is produced by unjust social arrangements. Disability is seen as the material product of socioeconomic relations developed within a specific historical context. In this approach, the main attention is directed to the disabling barriers and material relations of power.

Parenting Problems

Problems like Stress in families of differently abled children has been well recognized (Dyson, 1993; Krauss, 1993). Raising a child with disability is one of the strenuous jobs that any parents face. Disorders such as Autistic Spectrum Disorder (ASD) or Down syndrome leaves parents with little hope that their child will ever be able to live a normal life. However, Parents of children with ASD have been found to experience more stress and adjustment problems than the parents of children with Down syndrome, who in turn reported more stress and adjustment problems than parents of typically developing children (Sanders and Morgan, 1997). It is reported that, many parents are able to cope well with the demands and requirements of their child, however others will require supportive counseling by a professional who will able to help them to tackling the problems.

Raising a child with disability a profound impact on the family, firstly as parents come to acknowledge that the abnormality of child. Parents thus have to first deal with the fact that their child is different to other children, and will require special attention throughout their lives. Some of the problems that parents may face are the economic support for providing a disabled child, time demands of intervention therapies, possible social isolation due to a child’s mobility or behavioral problems and strained family relationships (Beckman, 1983).
Duis, Summers and Summers (1997) analyzed Parents versus child stress in diverse family”, and found that parents of children with Down syndrome or with developmental delays experienced more stress than the parents in families who did not have children with disabilities. Tannila et al. (1999) also attempts to clarify the coping mechanism of families with physically and/or intellectually disabled children. The parents of eight children (aged 8-10 years) with physical and intellectual disability were interviewed and analysed qualitatively using the grounded theory method. This study found that co-operation and social support as related to the coping strategies are most frequently used. Half of the families seemed to have found successful ways of coping, whereas another half had faced major problems regarding this. There were five main domains in which the high and low coping families differed from each other, such as parent’s initial experiences, personal characteristics, affects of the child disability on family life, acting in everyday life and social support. However the study concluded that development of supportive activities for families with disabled children provides a greater support to the parents. As the role of physicians, nursing staff and other professionals in this process is very important, more attention should be attached to the collaboration between these groups, to enable them to observe the situation from the perspective of the whole family.

Differently Abled Children and its Impact on Relationships among the Family Members

Associated stressors such as the child’s ability, age, and birth order or behavior problems can have an impact on relationships between other members in the family, and can affect the marital relationship. However, the effects may be ameliorated in the presence of certain factors. Firstly, the child’s characteristics can have important effects. Studies have shown that mothers are generally no more stressed than fathers, yet fathers are generally more distressed by their child’s inability to speak, whereas mothers are more distressed by more visible symptoms, such as inappropriate or stereotypical behaviors (Konstantareas and Homatidis, 1989; Ricci and Hodopp, 2003; Frey, K., Greenberg, M.T., and Fewell, R. R., 1989). Parents of children with less disability may thus experience less emotional distress as there are fewer characteristic or behavioral
factors to influence their coping abilities. Fathers may also be more affected by the
gender of their child than mothers, as fathers may be at greater risk of being unable to
develop affective ties to their child, particularly if the child with a disability is a son.
Main pressure for both mothers and fathers can include having a premature child, and
unable to look after the child and their development. In addition, mothers also feel
helpless and sometimes derived support from social support networks (Krauss, 1993).
While these factors can act as stressors for both mothers a fathers, for maternal
employment status can act as a buffer of stress (Warfield, 2001), as mothers have another
area to focus their attention and they are not solely spending time being a mother of a
disabled child. However, this may also be viewed as a strenuous job, if mothers are
working full-time and may be left with little energy to deal with their child at home.

Maclead and Williams (1992) look into factors influencing the functioning of
families with mentally retarded person. Results demonstrated that the importance of
characteristic of fathers to maternal coping skills in two parent”s families and also
maternal coping scores were not statistically different between both parents and single
parent”s households. Single parent”s mothers also appeared to be considerably more
dissatisfied with family functioning in study on stress in different types of family. In a
study examining the relationships between parenting stress and social support, they
interviewed 50 caregivers having children with mental handicaps and found that the
perceived availability of emotional support from spouses was the most effective way of
reducing parenting stress. Nevertheless, all caregivers were recruited by a convenience
sampling method that might have resulted in a biased sample. Moreover, the data was
collected through self-completed mailed questionnaires so the response rate,
understanding and thoroughness in answering the questions could not be controlled.

Singh et al. (2008) focused both positive and negative impact of disability on the
parents of disabled children. This study shows that it is not necessary that every family
of retarded children will have negative impact but in some families this problem can
create a positive impact, like “acceptance of situation realistically”, „standing right
behind the retarded child and provide support”. The study also highlights that most of the
parents of the selected retarded children viewed that they have more “positive impact”
than “negative impact”. To these parents having a mentally challenged child in a family is not a “burden like thing” but they accept the situation more positively and overcome the situation more gracefully. This study concluded that having an intellectually challenged child is not altogether a sign of so-called “bad fate or misfortune” to everyone, but it can also be a challenge which strengthens the parents of these children.

Parish et al. (2008) indicates the material hardship of families raising children with disabilities. Types of hardship include the following; food insecurity, housing instability, health care access. Result shows that families having disabled children experienced greater levels of material hardship. Further, it is also found that hardship declined significantly for families raising children with disabilities when income rose above the poverty level.

Wallander, Pitt, and Mellins (1990) have studied on maternal stress, child independence, and maternal adaptation. 119 mothers were intervened who have children with cerebral palsy, spina bifida, or hearing impairments between the ages of 2 and 18 years old. Wallander et al. (1990) showed that maternal stress was directly related to maternal mental health, and adaptation was not related to his/her child’s independence.

McDonald, Poertner, and Pierpont (1999) surveyed 259 families having children between the ages of 3 and 14, coping strategies of parents, perceptions of the child, and parenting stress. Findings revealed various patterns of care giving while, child, family, and environmental characteristics as predictors of parenting stress. Child characteristics, such as internalized and externalized behavioral problems contributed to stress, and in particular, the more severe internalized problems were associated with greater level of parenting stress.

**Differently Abled Children and Family Resilience**

Numerous studies suggest that these challenges may place additional pressure on family relationships. Studies by Dyson (1997) and Cohen (1999) indicate that those mothers and fathers of school-aged children with disabilities experience greater and more frequent stress because of their parenting demands than parents of children without disabilities. Others (Seltzer et al., 2001) found that parents of children with disabilities
report lower rates of social participation than parents of children without disabilities, perhaps due to increased financial problem and more demands for child care. Finally, result shows that having a child with poor health is negatively associated with the parental relationships.

Dyson (1997) found that parents of disabled children [children with mental retardation (13), physical/sensory impairments (11), speech disorder/learning disability (4), and developmental delay (2)] experienced similar levels of stress and that their stress was much higher than that of parents with non-disabled children. Keller and Honig (2004) also looked at stress from a gender standpoint and found that parents have similar level of stress overall but that the expression of that stress differs: fathers rated higher on child temperament, personal relationship and emotional attachment to their disabled child, while mothers experienced more stress in health, role restriction, and their spousal relationship.

Furthermore, the type of stress experienced by parents of a child’s disability is not same. Previous research suggests that mothers express more concern than fathers over the daily tasks related to the care of children with disabilities (Pelchat et al., 2003), which help to explain that why fathers are more likely to worry about emotional attachment with their children (Krauss 1993 and Cohen 1999). Compared to mothers, fathers also report financial stress. Gray’s (2003) research on gender differences in the parenting of children with autism found that fathers placed a higher level of importance on their „work role” and their corresponding ability to provide economically for their child’s medical care and future independence. Finally, in coping with these stress, it is also suggested that fathers are less likely seek social support for parenting a child with a disability than mothers because many of their male friends do not offer or know how to help them (Chesler and Parry 2001).

Several studies have been conducted on stress in families with differently abled child using the Parenting Stress Index. For example, Smith, Oliver, and Innocenti (2001) studied levels of parenting stress in families with a toddler with a developmental delay. Eight hundred families were assessed with the Parenting Stress Index to measure
perceived stress related to parenting, and the Family Support Scale and the Family Resource Scale to measure perceived support, time, and resources in the family. Smith et al. (2001) found that the more severe the child’s disability and little family’s resources, the greater the parent stress in the family.

Having a disabled child not only adds stress, but changes the nature of the stress experienced both financially and interpersonally. Part of the stress experienced by these families may be explained by the amount of time parents of disabled children spend in caring for their children and the potential of added financial burden related to their care (Curran et al. (2001) compared the time costs of caring for severely disabled children with that of caring for non-disabled children in the United Kingdom. Sixteen families with physically or mentally disabled children and thirty-one families of non-disabled children participated in the study. It was found that the disabled children required more care than normal children and the intensity of personal care did not decrease with age as it did for normal children. In addition, mothers from 12 of the 16 families with disabled children reported they were unable to return to work due to care of their disabled child, and the financial burden for caring differently abled child was great.

Hartshorne (2002) discussed family resiliency as a strong resource for parents when living with and caring for a severely disabled child. The paper notes that courageousness can be assisted by the parents” social support group and professionals. He suggests that parents will appraise their child’s disability through their lifestyle which can have a large effect on how they experience stress. Hartshorne encourages professionals to support family resilience through encouraging parents to find resources that are helpful to them and providing information adequate to their needs without overwhelming them with data, thereby running the risk of discouraging them. Parent networking through formalized support groups and less structured means, such as the internet; help provide emotional support and further access to resources (such as supplies related to their child’s care). This study looks at the strength and positive aspects of a parent”s courage and resiliency and provides suggestion to professionals in the medical and mental health field, in the interest of educating them as to the best way to assist them.
Gerstein et al. (2009) attempts to study the flexibility and the course of daily parenting stress in families of young children with mentally challenged. The background of the study shows parenting stresses have consistently been found to be higher in parents of children with mental disabilities, yet some families are able to be resilient and thrive in the face of these challenges, despite the considerable research on stress in families of mental disabilities, there is still dearth of research about the stability and compensatory factors associated with everyday parenting stresses.

**Problem Faced by the Family**

Reichman et al. (2008) review the impact of child disability on the family and suggest several ways to differentiate a child with a disability from parenting a child without a disability. Children with special health care needs often require additional primary care as well as more specialized and long-term medical care. Functional limitations may necessitate structural or technical medications in the physical home environment. A child”s disability may require parents to seek educational and recreational accommodations to ensure that the child has opportunities that are more equal to those of children without disabilities. Finally, as the child grows, specialized rehabilitation programs may be necessary to ensure a positive transition to adulthood. While there are numerous programs and organizations are there to provide parents of children with disabilities with social and financial support, navigating and coordinating these useful programs can be a challenge. Overall, the parents of a child with a disability may encounter a unique set of challenges that are not faced by parents of a child without a disability.

Families with a child of disability experience financial adjustments that make daily living very different from that of families with typically developing children (Parish and Cloud, 2006; Sen and Yurtsever, 2007). Financial stressors include medical insurance, child care, professional services, equipment, transportation, and work disruptions, depending on the severity and type of disability. Mothers of children with a disability reported having inadequate financial support. Additionally, research shows that families with differently abled children are at greater risk of living in poverty when compared to families with a child without a disability.
Social-emotional adjustments related to having disabled child include changes in hopes, dreams, expectations, anxiety, depression, distress, and both familial and nonfamilial relationships. The relationship between the child with a disability and his/her parents has been shown to be associated with behavioural and social-emotional qualities of the child. Children with more severe disabilities also were found to have more social-emotional and behavioural concerns than those with less severe disabilities. Marital strain has been found to be greater in families with disabled children. In one study, approximately 25% of the couples with a child with a disability reported distressed marital relationships (Kersh, Hedvat, Hauser-Cram and Warfield, 2006). In a study of 2,000 families with disabled children, almost half reported that they felt greater marital strain due to the disability. Approximately one-tenth of the couples were separated due to the stress on the family, and one-sixth of the couples had divorced. One factor that reportedly influences marital distress is severity of behaviour associated with a disability.

Research has also shown that mothers are more mostly affected by the challenges of raising differently abled child than are fathers. Research has demonstrated that parents of disable children not only report higher levels of stress, but also lower togetherness and poorer health than parents having normal children (Oelofsen and Richardson, 2006). In a comparison study of 104 families with a preschooler, half of whom had a disability and half of whom did not have any disability, parents completed a variety of questionnaires. Using the Sense of Coherence questionnaire, the Parenting Stress Index, the Health Perceptions Questionnaire, and the Family Support Scale examined coherence, stress, health, and support in families with disabilities including autism, cerebral palsy, muscular dystrophy, Down syndrome and developmental delays. It was revealed that mothers of differently abled children reported poorer health, lower coherence, and higher levels of parenting stress than fathers of children with a disability, but this was not the case parents of children without a disability. Parents of children without a disability reported no significant differences between their ratings of health, coherence, and stress.
Care Giving

Caring for a differently abled child forces a family to adjust, extraordinary physical, financial, and emotional stressors. These parents often reported lower scores on subjective wellbeing and higher scores on feelings of depression than parents of children without special needs (Oelofsen and Richardson, 2006). A number of studies have shown that much of the stress reported by mothers than fathers because of increasing responsibilities and demands in raising, caring for, and providing for their children due to the disability. Mothers of children with a disability report more psychological distress than others.

The siblings of differently abled children did more extracurricular activities to help and motivate them and are more responsible with regard to financial concern of the parents. Dyson (1988) examined co-existence of siblings of developmentally disabled children and siblings of non-disabled children. Adjustment was measured based on self-concept, behaviour problems, and social competence. Interestingly, brothers of disabled children showed less unusual and isolated behaviour and were less hostile, and had fewer external behaviour problems than siblings in the control group.

Tadema and Vlaskamp (2009) focuses on “The time and effort in taking care for children with profound intellectual and multiple disabilities: which indicate care load and support”. This study examines the type of basic needs caring tasks of parents in the Netherlands on a broad range related to health and basic needs. These perceptions of parents concerning to the care-load are emphasised. Furthermore, the relationship between the actual caring task and the subjective burden of parents is examined related to the child's age. Twenty five centres for special education throughout the Netherlands were asked to distribute the questionnaire among parents of children from 0-18 years with PIMD and still lived at home, in which parents of 133 children participated in the study. Their children had a mean age of 8.8 years. The caring task and subjective burden of parents was related to the child’s age, the sample was divided into two age groups. A questionnaire was developed to take into account the care-load, burden and support of parents. However, study focused on both burden and support of parents. Most children are dependent on them for fulfilling all their basic needs and have several health
problems. Significant relationships were found between the number of times parents have to get up at night and the level of burden at night and between the days a child stayed in hospital and the level of parental burden. In this study the results indicate that the caring task places heavy demands on parents in which professional support is extremely important for parents. The caring task is not necessarily indicative for the subjective burden of parent’s experience. Parents of young children express higher levels of burden than parents of older children. In this research both respite care and home support services are valued positively.

Gender differences in Caring of the differently abled children

With regard gender differences, in coping with the stress of parenting a child with a disability, several studies found serious gender differences in parenting behaviour. Co-resident fathers of a child with a disability are less likely to be primary care givers (Green 2003; Foster et al., 2004), have demonstrated greater engagement in social activities such as playing, nurturing, and discipline, as opposed to the instrumental activities of hygiene, teaching, therapy, and feeding (Simmerman and Blacher, 2001). Fathers are also less likely to be involved in a child’s treatment, and interact less with health care providers (Hauenstein, 1990). Pelchat et al. (2003) study of parents of children with Down syndrome suggests, this may be because fathers have difficulty in admitting that their child has limitations, and feel greater discomfort from the social stigma generated by their child’s disability.

Vidhya and Raju (2006) examined the level of adjustment and attitude of parents of disabled children. Sample consists of 50 parents (either mother or father) of mentally retarded children. Though many factors influence the well-being of a family, one factor is certainly the emotional and physical health of the parents. Parents are definitely the heart of the family. They are the ones who deal with the issues associated with their child’s disability and they are also required to maintain the household. Therefore, it is very important as parents to take some time to care for oneself as individuals.
Kersh, Hedvat, Hauser-Cram and Warfield (2006) found that parenting stress and depression for parents of developmentally disabled children was within the range of the normative sample, but that child behaviour problems predicted depressive symptoms in fathers, but not in mothers. Also, marital quality was a predictor of parenting value in mothers, but non-spousal social support was a predictor of parenting value in fathers. Child behaviour problems were linked with parental stress for both mothers and fathers. Both mothers and fathers experience stress, but the way the stress is expressed depends largely on the gender of the parent.

In another examination of psychological functioning in families of children with a disability, 48 mothers and 41 fathers of children with autism between the ages of 2 and 4 were assessed on child characteristics, parenting stress, and parent mental health. Mothers of children with autism had higher ratings of depression than fathers, but also more positive perceptions of their children than fathers of children with autism (Hastings, Kovshoff and Ward, 2005). Within each family, mothers and fathers respond differently to the outcomes associated with having a disabled child, but clearly both are affected in terms of psychological functioning, stress, and coping.

Breslau, Salkever and Staruch (1982) examined the effects of a disabled child’s in home residence status on the mothers labour force activity. They found that disabled children increase child care demands on families due to their extraordinary care taking needs and greater dependence on others for care and mobility. Their findings suggested that these increased childcare demands hinder the mother’s ability to hold full-time employment at any given time. Realizing that these stressors do not promote, get rid of replace other common every day stressors related to home and work might explain why the caretaker of a newly diagnosed child might report experiencing heightened levels of stress and anxiety.

Parent perceptions, stress, anxiety, and depression were also studied by Hastings (2003) in 18 parent dyads. He assessed stress and mental health in parents with children with autism between the ages of 8 and 17 years. Mothers in the study had higher levels of anxiety than fathers, and mother’s stress ratings were related to behavioural challenges.
associated with the child’s disability. However, mothers and fathers ratings were generally similar with regard to their perceptions of their child.

Keller and Honig (2004) examined child factors and stress in 30 families with a child with a disability between the ages of 7 and 12 years. The children in the study had disabilities including mental retardation, autism, learning disability, multiple disabilities, and sensory/physical conditions. They found higher levels of stress in mothers. The stress levels found in the mothers ratings were related to higher ratings of child demanding and need. Fathers stress was unrelated to child demand and need, but was related to child’s acceptability. Fathers had a more difficult time connecting and bonding with their child with a disability, which facilitates stress in the family. Family harmony and use of social support helped alleviate the stress that was found in both mothers and fathers. Positive coping was related to parent satisfaction with the family environment as well as stability of the marital system.

The various studies show that family characteristics, deficient knowledge about mental disability and lack of health care facilities and resources for caring children and adolescents with mental disability. The community and families of children with disability had poor knowledge on mental disability and appropriate care and about availability of resources and quality care. Families were not supported in the care of their children. Some children in consequence did not receive adequate health care. Some suffered from physical problems due to inadequate care; others were being locked in their room during periods when no-one was able to look after them. The factors such as were related to socio-economic characteristics of the families as well as to lacking service facilities. The support of care givers to children with mental disability has to be improved. Community and family based care in the study area would benefit families of children with mental disability.

Respite care is an important factor that acts to reduce parental stress and it lead to improvements in the quality of family life (Factor, Perry and Freeman, 1990). Much voluntary respite care comes from members of the immediate family such as
grandparents, aunts, uncles and siblings who are able to provide emotional or social support (Sharpley, Bitiska and Efremidis, 1997).

**Adaptive Social Behavior among the Differently Abled Children**

Matson et al. (2003) examine the adaptive and social behaviour of individuals with severe and profound mental retardation which mainly focuses on psychological disorder. These individuals were compared to a group of persons with similar intellectual level but no severe psychopathology. Participants were 36 individuals residing at a large developmental centre of Louisiana. It provides services to approximately 650 individuals, the majority of whom fall in the severe and propound ranges of mental retardation. This study examines with the groups on four factors such as age, gender, level of mental retardation and psychotrophic medication. Individuals in the psychiatric disorders group displayed significantly higher levels of some social and many adaptive skills than did individuals in both control groups, with psychiatric disorders and autism/PDD groups.

Levy and Katz (2004) examined the relationship between birth order, attachment style and adjustment in children with a sibling who has mental retardation. Research on the siblings of individuals with disabilities was guided by the assumption that siblings would automatically experience adjustment problems. But this study was referred to as the maladjustment views and focused on pathology in the families of individuals with disabilities without recognition or measurement of potential benefits. Fifty-two children ranging in age from 7-13 with a biological sibling who resided with them in the same household and who was from intact families were chosen for the study. Twenty five participants were in the experimental group with 13 born before and 12 after siblings with a moderate to severe mental retardation. The remaining 27 children had sibling’’s normal development and they served as a control group. The study results show that the presence of a child with MR in the family does not necessarily negatively affect either attachment style or adjustment of healthy siblings. Besides that it is found that siblings of a child with MR have more severe attachment styles than these in the control group.
Hastings (2003) describes the behavioural adjustment of siblings of children with autism in the United Kingdom and express that siblings of children with autism have more behavioural problems than normative samples and that the psychological stress of their mothers does not predict their behavioural adjustment. Eisenberg and Baker (1998) compared psychological adjustment and behavioural problems among siblings of children with retardation living at home, siblings of children with retardation in residential placement, and siblings of children without psychosocial problems of siblings of children with disabilities. Despite the different situations of these groups, they found that all three groups were highly similar on measures of psychological adjustment, self-esteem, and family environment. However, if the families of children with disabilities live in countries which provide only limited welfare services for disabled persons, and if the burden of care of the child with disabilities is thus left on the families, the pattern of psychosocial relationships among family members may be different from the results reported in their study.

**Communication Challenges Observed in Differently Abled Children**

In a study, Chan and May (1999) attempts to understand the impact of leisure options on the frequency and spontaneous communication production of a young child with multiple disabilities. The aim of the study was to investigate how the implementation of a multimodal communication system would influence the type and number of communicative attempts across leisure activities. Twelve intervention sessions were carried out over a three month period. The result of this descriptive study showed that with the introduction of leisure options as part of intervention, the child demonstrated increased vocalizations, words and word approximations, communicative gestures and use of signs an increased desire is shown among the communicate. The study findings indicate the usefulness and efficacy of leisure options as a potential intervention procedure in promoting the communication development of children with disabilities.

Communication deficits are seen across a range of verbal and nonverbal skills: gestures, intonation, melody, rhythm of utterance, facial expression and posture (Walenski et al., 2006). These children also face difficulties in using communication to
regulate social relations. Tomanik, Harris and Hawkins (2004) showed that in mothers of children with pervasive developmental disorders (mostly autism) aged 2-7 years, stress is associated with the child’s ability to participate in interactions and communicate. Mostly mothers of children with autism report higher stress when their children have poor communication skills (Konstantareas and Papageorgiu, 2006). It should also be mentioned that communication deficits are usually the primary reason why parents seek professional help (Charman and Baird, 2002).

Repercussions in social behavior of disabled children

Kanner (1943) documented a set of behaviours exhibited by 11 children that differentiated them from having any other psychiatric condition. These behaviours included an inability to develop relationships with people, delay in speech acquisition, lack of communicative use of speech after it was developed, delayed echolalia, pronoun reversal, repetitive and stereotyped play activities, an obsessive insistence on the maintenance of sameness, a lack of imagination, good rote memory, and normal physical appearance. He also recognized that these abnormalities were already present in infancy, which allowed for differentiation from childhood schizophrenia or psychosis. In his paper, he documented multiple reports from parents describing their children’s lack of interest in the activities of other adults and children they encountered at home or in their neighbourhoods. It is also found that these types of events focused exclusively on objects, completely ignoring the people in the room. In situations where they were forced to interact with other people, these children displayed annoyance, resentment, and anger.

Among the most important predictors of parent’s problems, the changing child’s behaviour is one of the important problems. Children with autism present a number of such problems, including aggression and self-injury (Matson and Rivet, 2008). Self-injury, aggressive and otherwise destructive behaviour are the strongest predictors of parental stress (Richman et al., 2009). The child’s stereotyped and self-stimulating behaviours are also a source of distress for parents. The actual degree to which specific behaviour problems contribute to parental stress depends on the child’s age. Parents of adolescents cite destructive behaviour and withdrawal from contact as the most
significant causes of concern, while self-stimulation and tantrums are mentioned primarily by parents of preschool children (Dunlap and Robbins, 1994).

Baker, Blacher and Olsson (2005) assessed depression, optimism, and behavioural problems in parents of 214 preschool-aged children between the ages of 3 and 5 who were classified as developmentally delayed, borderline, or non delayed. Children were administered the Bayley Scales of Infant Development, and parents completed the Child Behaviour Checklist, the Family Impact Questionnaire, the Center for Epidemiologic Studies Depression Scale, the Dyadic Adjustment Scale, and the Life Orientation Test. A negative relationship was found between child behaviour problems and mother’s well-being and optimism.

**Social skills of the differently abled children**

A number of studies conducted focusing on the parent and teacher expectations converge and diverge. Cai, Kaiser and Hancock (2004) demonstrate that if parents’ expectations of children’s behaviour converge with teachers’, children tend to have fewer behavioural adjustments when entering school for the first time. A longitudinal study of MacMillan (2005) examined differences between teacher and parent views of social skills taking 33 samples of adolescent students previously identified in the elementary grades as at risk for academic or behavioural concerns, or both. This study demonstrates that parents and teachers of adolescents with behavioural problems had different behavioural expectations. Whereas teachers primarily valued cooperation skills, rating skills that display assertion and self-control as less important for success in the classroom, parents valued the self-control, responsibility, and assertion skills. Lane, Stanton- Chapman, Jamison, and Phillips (2007) examined teachers’ and parents’ expectations of preschoolers’ behaviour to determine the extent to which teachers and parents converge and diverge in terms of social skills. Parents and teachers do not always hold similar expectations, and the divergence of behavioural expectations held by teachers and parents may pose difficulties for some young children with disabilities. Therefore, these expectations should be explicit and be compatible at home and school to lead children with disabilities to success in the classroom and to foster strong teacher-parent collaboration for satisfying the educational needs of children with disabilities.
Social Support Services

As the parenting stress of caregivers having children with disability is widely acknowledged, many previous studies tried to explore how the caregivers cope with these stresses. Social support is one of the most important coping factors examined. Social support is defined as information or social environmental conditions that enable an individual to feel loved and cared for, affirmed, or belonging to a group of persons with common goals and beliefs (Schaefer, Coyne and Lazarus, 2002). An individual’s perception of support is thought to be a characteristic related not only to the actual availability of support but also to the criteria that individuals use in interpreting behavior as either supportive or non-supportive.

By defining social support, Dunst, Trivette and Cross (1986a) mentioned it is a multidimensional construct that includes physical and instrumental assistance, sharing of information and resources, and as providing emotional and psychological support. The term may also refer to formal services received by professional organisations and less formal organisations, such as social clubs or churches, which the family feel is important to their lifestyle.

Cobb (1976) also defined social support as information belonging to one or more of three classes. Firstly, information which leads the person to believe that they are cared for and loved, secondly, information which leads to person to believe that they are esteemed and valued, and thirdly, information which leads the person to believe that they belong to a network of communication and mutual obligation. These definitions can be summed, to define social support as a network of individuals to provide information, resources, and emotional and psychological support through either formal, professional services, or through less formal mutual involvement within a family, friendship or social group.

Access to social support has been related to positive family and child outcomes in families of children with a disability (Rivers and Stoneman, 2003). Social support can come from various areas of society, for example from a spouse, grandparents, other family members, friends and professional agencies. Mothers tend to first seek support
from other family members, as informal sources of support are believed to be more effective at reducing stress than formal sources (Boyd, 2002). Family assistance can be one of the most useful sources of primary support, as families are more willing and able to provide instrumental and financial assistance. Family respite care and financial supports are some of the most frequently identified services that family support networks are able to provide (Herman and Thompson, 1995).

**Informal supports system**

Informal supports extend beyond government-sponsored programs and include the natural supports provided by the extended family e.g., grandparents), friends, and neighbors (McDonnell et al., 1995). Lehman, Ellard and Wortman (1986) suggested that natural supports are the most helpful to families under stress. Natural supports may include in-home assistance, house cleaning, and transportation from extended family members or friends. They suggested that "the nature and type of support will be unique to the individuals involved, and be dependent on a mutual level of comfort in both seeking and providing acceptance”.

The parents of children with disabilities, including those with mental retardation, may need a great deal of additional support from society, friends, and other family members to find the happiness that compensates for the frustrations and inconveniences of having a child (Knoll, 1992; Turnbull and Turnbull, 1985). The study focuses on the promotion of positive social environmental factors which may contribute to an increase of self-respect and independence. Informal support was studied by Benson (2006) in 68 parents of an elementary age child with autism spectrum disorder. He found that parent depression and the accumulated effects of stress were reduced with the provision of informal support for parents.

**Formal Support System**

Bristol and Schopler (1983) defined formal support as “assistance that is social, psychological, physical, or financial and is provided either for free or in exchange for a fee through an organized group or institution”. They defined informal support as “a network that may include the immediate and extended family, friends, neighbours, and
other parents”. Generally, informal support is the preferred mode of support over formal support (Boyd, 2002). Support from family, friends, and professionals has been shown to reduce stress and responses to stress.

House (1981) differentiated four different types of support such as emotional, instrumental, informational, and appraisal. Emotional support refers to non-tangible assistance, such as listening, sympathy, empathy, encouragement, and praise. Emotional support from extended family and self-esteem were found to be predictive of mother’s stress related to parenting (Trute, Worthington, and Hiebert-Murphy, 2008). Instrumental support refers to tangible assistance, such as childcare, housekeeping, transportation, or money. Informational support refers to the provision of information and resources, such as community agencies, professional advice, and online resources. Instrumental and informational support both provide non-emotional assistance and are often grouped together. Thus, across all studies social support is primarily characterized as emotional or instrumental.

Trute (1990) studied family adjustment in households containing young developmentally disabled children”. The study examined the importance of marital adjustment as a key predictor of family functioning in household’s containing young disabled children. This research selected a cross section survey and random sample of 88 families containing young developmentally disabled children by using in-home interviews of both mothers and fathers. It contains four factors, such as consensus, cohesion, satisfaction and affection. This study focused on the social network of fathers and mothers and included family, friends and human service professionals. Social network members who could be turned to in times of emergency and those who could be identified as confidents. Positive family adjustment is found to have little relationship to specific child attributes (gender, level of disability or temperament). This study concludes that the education level of a disabled child’s parents appears to facilitate overall family adjustment.
The Context and Dynamics of Social Support

Dunst et al. (2000) defined social support within the context of family level, in which the family’s social network system is instrumental in providing the resources needed for everyday living, in carrying out parenting responsibilities, and in supporting child learning and development. Support is often provided by family members, friends, and community agencies and organizations. These members of the family’s social network provided a range of environmental experiences that will ultimately influence the development and behavior of the child and the entire family. It has also been reported that these experiences strengthen the family by instilling feelings of competence and promoting new skills that are instrumental in helping families deal with disable children.

Support group may be a primary source of support for parents of disable children with complex needs. The goals of support group are, is to foster mutual aid, to help members cope with stressful life events, and to revitalise and enhance members, coping disabilities so they can affectively adapt and cope with future stressful events” (Toseland and Rivas 2008).

According to Narramore (2008), the most serious finding from the literature review is that lack of emotional support can affect a parent’s mental health. Health professionals need to understand the extent to which parent’s emotions are affected when a child is born with a disability and that the emotional stress is likely to increase, not decrease, as parents try to come to terms with a diagnosis and the impact that caring for such child will have on their lives. It is also clear that initially most of the emotional support comes from support groups.

Solomon et al. (2001) discussed the benefits of mutual support groups among parents of disabled children. Fifty-six parents who participated in mutual support groups were surveyed regarding overall helpfulness, satisfaction, group climate, and group impact. Overall, parents reported that the groups provided them with information about their unique problem and possible resources for help. They also valued the information about their child's specific disability; it helped reduce their feelings of insecurity. Parents also expressed the usual feeling of powerlessness in their relationships with professionals, but after being a part of the group and learning new ideas and information, they felt
empowered. Thus, support groups may provide a safe and supportive environment to help parents of children suffering from disabilities.

In another study, Baum (2004) also examined the benefits of parent support group for primary caregivers of a child with special health care needs among a sample of 114 primary caregivers. He found that 93% of caregivers were satisfied with the group and the strongest factors related to satisfaction were getting usable ideas, improved relationship with their child, and finding people to trust.

Horton and Wallander (2001) studied perceptions of hope and social support as resilience factors in 11 families with 5- to 18-year old children with cerebral palsy, spina bifida, or diabetes mellitus. Using a variety of questionnaires, they found no differences in agony among mothers and an inverse relationship with distress was found in mothers with regard to hope, social support, and distress, such that distress occurred with less hope and social support. “Perceptions of hope moderated the relationship between disability-related stress and maladjustment, suggesting a buffering effect when stress is high. However, hope did not appear to be a mediator of the relationship between social support and distress”.

Benson (2006) studied parent depression and the use of parent support, specifically informal and formal parent support, in 68 families with a child with special needs. The children were diagnosed with Autism, Pervasive Developmental Disorder an unspecified autism spectrum disorder, or developmental delay. He found that the use of informal social support was related to significantly fewer symptoms of parent depression, especially in families where the child’s disability symptoms were not severe. This is contradictory to the stress buffering hypothesis that suggests that support will buffer stress in more serious situations where coping resources are strained. That is to say that in the case of a child with a disability, the natural coping resources can sometimes be adequate in buffering the stress related to the disability.
Support Systems

Social support is calculated in a variety of ways, for example, in terms of the structure of support resources, by perceptions of the supportiveness of their relationships, by the number of individuals in the social support network, by the perceived quality of support, and by professional or nonprofessional categorization (Leavy, 1983). The most frequently used measure of social support is perceived quality of support received and satisfaction with it (Osseiran- Waines, Nahid, Elmacian and Sarkis, 1994).

The process by which support alleviates stress is not well understood or studied thoroughly. One theory that attempts to explain how social support alleviates stress is the “stress buffering hypothesis” (Cohen and Wills, 1985). Unlike the main effects hypothesis that states that social support has a positive effect on a family regardless of whether a family is experiencing stress, the buffering hypotheses states that social support has positive effects primarily for persons under stress (Cohen and Wills, 1985; Horton and Wallander, 2001). The stress buffering hypothesis affirms that when a person is in a great deal of stress, the benefits of social support is immense. It is presumed that when stress levels are low, coping skills are independent of social support and stress is thought to be more internally managed (Benson, 2006). Social support alone does not address all of the stressors in a family. It does, however, act as a buffering factor or moderator to the stress in a family. Other buffering factors include the repertoire and number of coping skills, parental or marital relations, stability of support, and problem-solving skill (Keller and Honig, 2004).

Several studies have looked at the relationship between the size of one’s social support network and level of stress in a family. Hodapp, Findler, and Smith (1998) found that the size of the social support network was directly related to the stressors and stress levels in a family with a child with a disability. That is to say that larger support networks were related to lower levels of stress. In a study of use of respite care by mothers of children with disabilities, Salisbury (1990) found that the size of the social support network was negatively correlated with reports of stress. Mothers of children with disabilities who had larger support networks had fewer reports of stress than mothers of children with disabilities who had smaller support networks.
Social support in this context has been studied as a buffering factor for families with a child with a disability (Boyd, 2002; Dunst, Trivette, and Cross, 1986; Troster, 2001). Being the parent of a child with a disability involves stress and disequilibrium in the family system. To cope with the stress and imbalance, a parent must find ways to alleviate the stress and bring about homeostasis. One way to adapt to stress is via social support. While social support can be a great source of coping in some families, mothers tend to use social support as a coping mechanism more so than fathers. Barnett et al. (1987) and Cutrona (1996) studied gender differences in seeking social support and found that mothers are more likely to ask for and receive help from both formal and informal social support networks. Fathers were found to rely on mothers or their internal coping skills to manage stress.

In a study of support as a buffer for stress, Wade, Taylor, Drotar, Stancin, Yeates, and Minich (2004) assessed psychological distress and adjustment in 189 parents of children with a disability. The children in the study had traumatic brain injuries and/or orthopedic impairments and ranged from 6 to 12 years of age. Wade et al. (2004) assessed resources, stressors, and psychological adjustment; they found that greater support and resources and fewer stressors were associated with less psychological distress.

Holahan and Moos (1985) studied factors that buffer the stress-based effect on physical health rather than mental health. They found that the members of the Stress Resistant Group had different stress adaptation skills than the members of the Distressed Group. Those in the Stress Resistant Group used more proactive coping techniques, had more self-confidence, and had better social support networks than those in the Distressed Group, and the members of the Distressed Group used more avoidance coping and had more physical illness than those in the Stress Resistant Group. Therefore, not only was stress related to psychological distress as previously stated, but stress and avoidance coping tactics negatively affected physical health, as well.
While some families have poor or negative coping strategies, many families use positive coping strategies to address stress in their system. Positive coping strategies may include acceptance of the child’s disability and feelings toward the child, obtaining help with routine care of the household and children, providing support and education to family members about the disability, maintaining an active social support system, utilizing resources in the community, and having faith (Kuster and Merkle, 2004).

**Social Network Theories**

A Social Network is defined as the number, frequently and linkages of contacts with other individuals or groups (Worcester, 1990). Social Network theories propose that social interaction between individuals lead to heterogeneous relationships that have different levels of supportiveness (Pierce, Sanason and Sanason, 1991). There are two main Network theories, task-specific theory and hierarchical compensatory theory which relate to care giving.

Task-specific theory categorizes social Network groups as primary, informational and formal groups. According to this theory each social network has different natures and because of these different natures of social networks, each network group can optimally manage different tasks (Litwak, 1985, Messeri, Silverstein and Litwak, 1993). This theory highlights the fact that people dependent on various needs have formal and informal groups to co-operate in most areas of life. In addition, the support provision varies across different relationships even within the primary groups. Hierarchical-Compensatory theory focuses on the importance of care recipients preferences. It relates to an ordered preference based on the primary relationship between care givers and care recipient (Messeri et al., 1993).

**Social Support Theories**

Uchino conceptualized social support as „the functions that are provided by social relationship” (Uchino, 2004). Social support theories have linked social support provided by social relationships to health outcomes, although each model emphasizes different processes.
The Functional Impact of Various Social Support Networks

Research shows that people who perceive a strong active social support network are healthier both physically and mentally (Dunst, Trivette and Hamby, 1994; Hodapp, Fidler and Smith, 1998). For example, social support from immediate and extended family, friends and professionals were found to ease the feelings of stress in families with a child with special needs (Hodapp et al., 1998). The most salient predictor of stress levels was the size of the support network of the family, wherein lower stress levels were related to a larger network, particularly the family network.

As shown, informal and formal social support is helpful to families of children with special needs. In a study of stress and coping in 47 families with children with visual impairments between the ages of 8 months and 7 years, Troster (2001) assessed the severity of the visual impairment, additional disabilities/illnesses, functional impairments, daily stress, parenting stress, and perceptions of social support. Social support was found to have a buffering effect on the stress that came from raising a child with a disability. However, parents of children with a disability perceived lower levels of both emotional and instrumental support.

A family’s need for support varies over time as they move through different phases of the life cycle. Eventually, a family may move from leaning on support from within the immediate family, to support from the extended family, to support from professional organizations, to support from the larger community, and even strangers (DeMarle and Le Roux, 2001). Two main reasons that mothers of children with autism seek social support are levels of stress and feelings of depression. Mothers stated that they first sought spousal support, then immediate and extended family support. Informal support was perceived as more valuable than formal support with relation to experiences of stress and depression. Of the formal supports assessed, parent support groups were rated most helpful, but were not used by all participants. Generally, mothers who had both informal and formal social support networks had more positive relationships with their children with special needs (Boyd, 2002).
Hassall and McDonald (2005) found that a mother’s decision to utilize social support was related to both child characteristics and parent characteristics. Child characteristics that influenced the attainment of social support were challenging behaviours and cognitive limitations. Mothers of children with severe impairments reportedly familiar with more stress than mothers of children with mild to moderate cognitive limitations. While the size of the support network was relatively comparable between groups, the perceived helpfulness of the support from the network directly related to stress levels in the groups. Behavioural challenges can impact the ability to obtain support, in that it may be difficult to find childcare while gaining formal support.

While support is one coping strategy to reduce stress, Taanila, Syrjala, Kokkonen, and Jarvelin (2002) examined the different coping strategies of families with a child with a disability. Eight families of children between 8 and 10 years old with physical and/or intellectual disabilities were interviewed twice. Three main coping strategies emerged from the interviews: gaining knowledge and acceptance, increasing family functioning (cohesion, flexibility, cooperation), and relying on social support from both formal and informal sources. As in previous studies, social support in any form was found to be a strong buffer to stress.

Parenting stress has been inversely associated with social support and cohesive family relationships. Specifically, support and relationships that have open communication and expression of feelings without judgment have been related to better family functioning. Social support in the form of friends, non-relatives, and professionals is also associated with better family functioning, especially for mothers (DeMarle and Le Roux, 2001). Caplan (1974) hypothesized that social support can enhance social-emotional functioning, attainment of information, and physical assistance when needed. Holahan and Moos (1985) found a negative relationship between parent social-emotional well-being and social support.

Seligman, Goodwin, Paschal, Applegate and Lehman (1997) examined perceptions of support from grandparents by mothers of a child with a disability. Seligman et al. (1997) found that grandmothers were rated as more supportive than
grandfathers, and mothers perceived their own mothers to be more helpful than their mother-in-laws. Both maternal and paternal grandparents were reported to provide more emotional support than instrumental support. Therefore, emotional support from maternal grandmothers seemed to be the most helpful of the supports studied.

Support in any form from a grandparent can also impact the parent’s psychological wellbeing. Trute (2003) conducted a study to explore parent’s perceptions of grandparents support and the impact of grandparent support on parent psychological adjustment in 59 mothers and 38 fathers of children with disabilities between the ages of 5 and 12 years old. The children in the study had a primary diagnosis of developmental delay, and many also had multiple handicaps and/or physical disabilities. He also found that the most important predictor of parenting stress and psychological well-being was perceived levels of emotional support and involvement of their own mothers rather than mothers-in-law. Parents agreed that maternal grandmothers tended to supply more positive support than grandfathers. Unexpectedly, practical or instrumental support from grandparents did not show any relationship with parent psychological health.

Schilmoeller and Baranowski (1998) investigated how helpful and supportive grandparents were to their family with a child with a disability, and how helpful their support was perceived to be. Seventy grandparents (93% grandmothers) of children with Cerebral Palsy between the ages of 1 and 19 were interviewed on their concerns and worries about their grandchild, parent and support group helpfulness, affection solidarity/proximity, and health status. They found that the grandparents in the study reported providing emotional support more frequently, including listening, talking, answering questions, encouraging, and accepting the disability. Grandparents also reported providing instrumental support in the form of financial help, babysitting, and providing respite for the parents.
Role of Mothers and Grandmothers in Social Support

Further research on grandparents as primary supports to families with a child with a disability was conducted by Baranowski and Schilmoeller (1999). One-hundred and five mothers of a child with a disability between the ages of 1 month and 11 years old were assessed on their views of support, helpfulness, and involvement from grandparents in their lives. Disabilities included in the study ranged from developmental delays to physical anomalies. The majority of mothers reported that maternal grandmothers were most supportive, helpful, and responsive to the needs of the mother. Support came in the forms of emotional support and instrumental support. Perceptions of support from paternal grandfathers were rated the least supportive and least involved.

With regard to types of involvement and support, Baranowski and Schilmoeller (1999) found that grandparent’s provision of time and emotional support were perceived to be the most helpful types of support reported. Support from grandparents was also related to geographical proximity and emotional closeness to grandparents prior to the child’s birth. They stated that “a grandparent was important mainly by virtue of being more than doing”. Emotional support was valued more so than instrumental support, even when instrumental support was high. In fact, both maternal and paternal grandfathers reportedly gave more instrumental support, but maternal and paternal grandmother’s support, which by nature was more emotional, was perceived as more helpful.

In a study of structural social support (size, range, and interconnectedness of contacts) and functional social support (emotional, instrumental, and informational) in 90 families with a child with Cerebral Palsy, Findler (2000) found that mothers of a child with Cerebral Palsy had higher professional support, but no such differences were found between the groups on measures of nonprofessional support. Maternal grandmothers were rated the most important support in both groups, even above spouse. Mothers perceived receiving more emotional support from either grandparent than instrumental or informational support. Maternal grandparents were also rated more supportive than paternal grandparents, with paternal grandfather least supportive.
Mitchell (2007) outlined grandparent support research in the United Kingdom, and, as in the United States, grandparent support served different functions depending on the presence of a disability. When there is no disability in any child in the family, grandparent support was positive and found in the forms of practical support, such as informal childcare, emotional support, and financial support, especially from grandmothers. Grandparent support was negative when conflict or inappropriate support was provided. In families where a grandchild had a disability, grandparent support had increased practical purposes, including informal childcare, respite care, and domestic help. Emotional support was described in more detail as nonjudgmental advice, listening, and being there. A hierarchy of support was noted wherein maternal grandmother was the most supportive member outside of the nuclear family. All support in families with a child with a disability reported a reduction of stress related to the grandparent support, unless there was a bad relationship between grandparents and their children prior to the birth of the grandchild with a disability.

Scherman and Shutter (1995) studied ways in which grandparents provided support to their grandchildren with a disability and their families. They interviewed 32 grandparents of children with disabilities, 63% of which were grandmothers. The grandchildren ranged in age from 20 months to 13 years and had disabilities such as mental retardation, metabolic/chromosomal disorders, autism, and severe attention deficit disorder. The study focused on assessing grandparent’s knowledge of the disability, effect on grandparent’s lives, and emotional response in the interview process. They found that “almost all the grandparents perceived their children as needing immediate support”, which they provided in several forms. Some grandparents provided direct relief to their children while others directed their support toward their grandchildren. Few grandparents also sought personal support. The majority of grandparents stated that they provided emotional, practical, and financial support, and the minority of grandparents stated that they provided help for the siblings in the family, help through prayer, or information gathering. Emotional support took form as encouragement, calling frequently, and being available. Practical support took form as babysitting, hospital and doctor stays, and chores.
Gardner, Scherman, Mobley and Brown (1994) interviewed 32 grandparents to assess their involvement with their grandchild with a disability. Grandchildren’s ages ranged from 20 months to 13 years and the majority of grandchildren had spina bifida. Gardner et al. (1994) looked at involvement, roles, and functions of grandparents, and conducted interviews in five areas: beliefs of role as a grandparent, grandparent/grandchild relationships, specific functions as grandparents, impact of roles on grandparent/grandchild relationship, and help in adjustment for family. Grandparent roles were reported to include twice as much direct contact with the grandchild (games, going for walks, love, encouragement, attention). Direct parent contact also was reported and included babysitting, respite, and financial help. Other roles were transportation to doctor’s appointments, school, parties, etc., medical and therapeutic interventions, and diet. The majority of grandparents reported emotional support as the strongest area (love, affection, and encouragement). However, one-fifth of the grandparents felt ineffective in providing support. Half of the grandparents in the study felt no change in the grandparent/grandchild relationship relative to the disability, yet half did feel a change in expectations (lowered) for the grandchild. Some grandparents “expressed concern or frustration that the nature of their grandchild’s disability created additional tensions and reduced their patience in interacting with their grandchild”.

The effect of various support systems

Majnemer et al. (2002) found in a study of early rehabilitation service utilization patterns of parents with developmentally disabled received occupational therapy, physical therapy was received by 24% of the families, and speech language pathologists provided services to 54% of the families. A small portion of the children saw a psychologist (17%) and then usually only for an evaluation (though the reason for the evaluation is not stated). Approximately half of the referrals for services come from physicians and the other half from other sources. The study found that lack of increased waiting times and lack of outside resources (such as rehabilitation centers) led to over utilization of acute care facility services. It can be inferred then that outside resources can be of help not only to parents, but to the healthcare system as well.
Llewellyn (1995) study on relationships and social support examined experiences of social support related to parenting. Parents reported mixed perceptions of the support they received from spouses, partners, family members. While serving as an important resource, support was also viewed as constraining. Social support has also been found to be an important component in therapeutic processes, as patients who receive special supportive care following an operation require less medication for pain and are able to be discharged earlier than patients who do not receive special care (Cobb, 1976).

The effectiveness of support networks has been found to be a more important factor for parental self-esteem than the size of the network (Seybold et al., 1991), thus a small, actively helpful group of friends or family is more effective at increasing a parent’s self-esteem than a larger, less active support group. Social support is able to mediate personal well-being and can improve parental attitudes towards their children (Dunst et al., 1986b). The presence of social support may lead to more positive perceptions of the family environment as it is linked to more stable functioning, a more positive perception of the child, and can enhance the parent-child relationship reported that parents with more supportive social networks were less protective of their child, regardless of the child’s diagnosis or severity of the disability, indicating that as levels of social support increase; parents feel less of a necessity to overcompensate by overprotecting their child. This study also found that children were more likely to make more developmental progress if their parents had supportive social networks. These findings suggest that not only does social support relieve some of the stress associated with raising a child with a disability, but it also gives them an opportunity to develop more positive relationships with their child. As parents are less protective they may be more willing to allow their child to experiment with their skills and provide them with more independence, which may explain why these children made greater developmental gains than children whose parents had less supportive social networks. However, the presence of more supportive social networks was related to children who had fewer physical limitations, were more socially acceptable to others, with fewer behaviour problems and with less difficult personality characteristics (Dunst et al., 1986b). This relation of child characteristics to the presence of social support suggests that the benefits
gained through having a supportive network may be limited to those families with a less physically disabled, more socially acceptable child.

While it is acknowledged that social support is an important factor in reducing the stress of parents with children with disabilities, research has found that such families have less social support available to them than families of typically developing children. There are various reasons why social support is often not readily available to families. Firstly, the perceived stigma associated with the child displaying characteristics that deviate from societal norms by displaying stereotypical or unacceptable behaviour may mean that parents are less likely to seek help, or that other people are less likely to be willing to help. Perceived stigma has been found to be consistently related to less perceived support from other family members and more negative interactions with family. The perceived stigma in this study related to the individual’s personal feelings about the stressor, for example, embarrassment or shame, and their projections of these feelings onto others, whether or not they accurately reflect support network members or society’s feelings about the stressor (Mickelson, 2001). Thus while parents may feel that their child’s characteristics will be rebuked by society and fewer people will be willing to help them, this may not actually be the case.

The stress involved in raising a child with a disability can be exacerbated by a lack of social support and can have effects on how the family is able to function and on the psychological adjustment of other children in the family. However, studies have shown that families who report higher levels of social support also report lower levels of stress (Beckman, 1991). This may be because families who have access to higher levels of social support may find that stress levels are ameliorated as the family has other people to turn to for respite care, someone to talk to or just the knowledge that someone else is willing to help. According to family systems theory, social networks and support provided to families both directly and indirectly influence the behaviour, attitudes, expectations and knowledge of parents and their offspring (Dunst, Trivette and Cross, 1986).
Social support has thus been shown to be an important factor in the functioning of families of children with disabilities. Families who have increased levels of support demonstrate less stress. The most effective support network is derived from help received by family and friends. However, the benefits of effective social support networks may be limited to families who have a less physically disabled, more socially acceptable child. In general, it is important for families to have an effective support system, regardless of the size of the network in order for them to be able to function effectively as a family.

In review of literature on the three major areas of parental problems, care demands and social support have indicated the need to conduct further study in this area, in spite of consistent relationships being observed. The line of action suggested that parents of children with disability in various dimensions like stress, care demands and social support factors may be analyzed and the present study makes an earnest attempt in this direction. The methodology adopted to conduct the study is presented in the next chapter.