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1. Introduction:

Most parents look forward to the birth of a new child with excitement and with dreams of the happiness their new offspring will bring to the family. Although most mothers and fathers have some moments of worry during pregnancy. The belief that bad things happen to other people prevails and parents develop a picture in their minds of beautiful, bright and clever child to come, the child who will have a better life than the parents, the child who will be a helpmate and who will bring parents nothing but pride, joy and success. When at birth or at some later time, the parents realize or are told that their child will be disabled, will not be “normal” may need lifelong output, the disappointment and sense of loss they experience is immense and may resemble that of the sudden death of a loved one, and they may indeed experience what amounts to the death of a child they had imagined and expected.

The parents of disabled children face many problems. Many fear they will never be able with, adapt to, or “cope with” being the parents of a disabled child. It is remarkable that almost always parents make excellent adaptation to what has happened to them and become their child’s most important support. Often the birth of a disabled child uncovers in the parents reserves of personal strength and courage which they did not believe they possessed. These adaptations are rarely made aloe; husbands and wives must support each other, the extended families of each must go through their own processes of adaptation and learn how best to support the parents, spiritual of religious faith will assist some, and friends and community of the parents all have a crucial part to play. Professional can also have a powerful influence on the way parent adapt to their disabled child. Professional may be a part of the problem or part of the solution. Many families of the disabled children have found that physicians and other
health care professional with whom they have a meet generally unhelpful and poorly informed, as well as all too often arrogant and seemingly unfeeling or unsympathetic.

With the birth of a disable child, parents were reported to experience complex feeling that include the feeling of loosing someone beloved. The reaction to a loss has patterns of shock, denial, deal, depression, and acceptance adjustment in adults. Guilty feeling, depression, and anxiety were part of this process and it takes more than a couple of months to reach the acceptance adjustment phase in some parents and they developed more severe symptoms than others. Daily care routine; economic problems, received appropriate help and education are the basic hardship of the parents of a disabled child. Diagnostic confusions, behavioral and health problems, and feeling of loneliness in parents also add to these hardships. The increase in the severity of the disability results in a more dependent child, more responsibility for the parents, and therefore more anxiety in the parents.

Studies showed that the parents of an autistic child experience over anxiety due to social relatedness, delay or absence of speech development, stereotypic movement, hyperactivity and lack of eye contact. The mothers of autistic children were reported to be more introverted and neurotic than the normal control group and parents of child with autism and Down syndrome were reported to be overanxious, oversensitive, stern in manner, and sensitive to be frustrated with criticism.
2. Well-Being:-

2.1. Meaning of Well-Being:-

The concept of well-being originated from Positive Psychology. The shift from negative to positive psychology is a welcome change in the discipline. The focus positive psychology is to study the improvement in the lives of individuals. Positive Psychology has emerged from the problem of the west. Thus it may be inferred that knowledge is culturally conditioned.

Well-being is often defined as a sound economic disposition. An eastern Study of relationship between having money. And life satisfaction revealed that between 1940’s and the year 2000 people needed more money to maintain, the same level of satisfaction. In other words one needed more money to stay happy in 2000 than in 1940’s with the requirement of money steadily increasing over the years. Another study proved that while the richest American measured 5.8 on satisfaction while the Slum dwellers of Kolkata measured 2.9 indicating again that satisfaction is not directly related to money.
per se. However, up to the income level of $ 10,000 a correlation between money and satisfaction was found, beyond which addition in income did not contribute to Well-Being. Thus an economic criterion was found to have a limitation in predicting Well-Being.

2.2. New Model of Well-Being:

A good life involves engagement, satisfaction and purpose. According to the new model, concept of well-being refers to health, vitality, creativity, fulfillment and resilience. It refers to thriving and flourishing that involves mind, body, society and environment in general. Well-being refers to a harmonious interplay of cognitive and affective process rather than subjugating to them. In term of Indian terminology it refers to harmony of Indriyas, Chetta and Atma.

Pleasure relates to one aspect of well-being. Sukah, as is called in Sanskrit refers to ‘Agreeable feelings’ based on mind, self, sense organ objects and perception. According to Indian perceptive ‘Mindedness' is the cause of ‘Dukha’. The Hedonic perspective of well-being is ‘Preyas’ while the Eudemonic perspective refers to 'Shreyas' True happiness lies in expression of virtue.

The question that logically follows from the above two perceptive is whether pursuit of a goal per se is related to well-being? It has been found that pursuit of goal and the resultant success per se does not ensure happiness. On the other hand, a general, happy disposition leads to success.

Exploring into the causes of unhappiness it was found that, negative social comparison, inequitable reaction to equal losses and gain are some of the main causes.
When the reasons for unhappiness are identified, how do we mitigate them to reach well-being? What are the identified challenges to well-being?

Among the many, following are the few challenges:

- Imbalance of work and leisure
- Life style related problem
- The very approach of measuring development in terms of consumption.
- Competition, promoting individualism and egoism.
- Technology generated problems.
- Modern medicine and health intervention and
- Lack of health related support system.
- The mainstream psychology identifies four dimensions well-being
  - Evolutionary
  - Affective
  - Motivation and Developmental

The Indian perspective identities four aspects, viz. the five elements. The person or Jeeva, the life or Ayu, and the health or Arogya. Well-being as per Indian perspective relates to well-being on physical, psychological and spiritual planes. The Indian approach to well-being refers to Maitri, Karuna, Mudita and Upeksha meaning Relatedness, compassion, Pleasant disposition and avoidance of conflict in other words well-being refers to uniting self with self by negating the ego. This in turn indicates that well-being is a combination of survival, Well-Being, freedom and identity.
2.3. Subjective Well-Being:

Subjective Well-Being has been studied in a larger number of disciplines over many centuries and has been defined in ethical, theological, political, economic and psychological terms (Diener, 1984; Veenhoven, 1984). In psychology subjective Well-Being is defined as people’s assessment of their lives. People evaluate their lives in several ways. First, people make their judgment about their lives whether their lives are fulfilling, satisfying and meaningful. People also evaluate specific aspect of their lives such as their marriages, health, and work and leisure time. In addition, people react to events with affect (moods and emotion); positive of pleasant affect, when things are going well and negative or unpleasant affect, when things are going badly. Thus the affect system provides an “online” evaluation of life. The more a person experiences pleasant emotion and less him or her experiences unpleasant emotion, the individual’s affect system is evaluating life in positive term. Thus subjective well-being in an umbrella term that refers to these different forms of evaluations of one’s life and quality called happiness as well as psychological well-being.

Studies of happiness show that the following things all enhance our well-being:

- A good marriage
- The company of friends
- Rewarding work
- Sufficient money
- A good diet and physical activity
- Sound sleep
- Engaging leisure
• Religious or spiritual belief and practice.

2.4. Well-Being More than Feeling Good:-

We often measure well-being as happiness or satisfaction with life. The search for happiness confused with the pursuit of pleasure, but well-being is about more than living the good having meaning in life about fulfilling our potential and feeling that lives are worthy.

Well-being is powerfully influenced by perceptions and expectations. Adaptation and so are especially important. We tend to adapt to changes in our situation, whether it’s gain losing it (although losses—of a job or partner, for example—are hard to take). Our others count a great deal; comparing favorably elevates us, comparing poorly dimming between our aspirations and achievements also matters.

All in all, well-being comes from being connected and engaged, from being relationships and interests. These give meaning to our lives.

We are deeply social intimacy, belonging and support provided by close. Personal relationship seems and isolation exacts the highest price.

2.5. Causes of Well-Being:-

There are several important points to make about the causes of well-being. The relation is not always reciprocal. In other happier people are more likely to be married, have done more interesting work or earn higher incomes.

Many of the factors are interrelated. For example, the costs of being unemployed go of income; work also offers Purpose in life, belonging and friendship. The benefits of the social connections, spiritual support, sense of
purpose, coherent belief system that religion provides; all these things can be found in other ways (although perhaps) Finally, we need to beware that in our eagerness to be happy we don‘t make the pursuit another personal goal that is self-focused and self-defeating, a source of stress and because of unrealistic or inappropriate expectations. As the Chinese sage Lao-Tzu and happiness too greedily, and be not fearful of unhappiness.

2.6. Well-Being and Quality of Life:-

Before the 1970s, quality of life received little attention in the medical or public health literature, but since then the situation has been reversed. Despite its widespread use, the term "quality of Life" has different meanings to different people. For some researchers and clinicians, quality of life means almost anything beyond information about death and death rates. For others quality of life is an umbrella concept that refers to all aspects of person’s life, including physical health, psychological well-being, social well-being, financial well-being, family relationships, friendships, work, leisure and the like. In contrast, some approaches to quality of life emphasize the social and psychological aspects of life, and contrast quality of life with quality of care.

Variation is also found in measurement strategies. Some scholars believe that quality of life can be measured by objective parameter. For example, the quality Of life in a city is sometimes measured by a summary of characteristics such as the schools, the cultural offerings, the aesthetic properties, the climate, the health care system, the employment possibilities, and so on. By the same token, characteristics of a person, such as income, health status, mental health status, disease profiles, educational level, and housing situation can be summed to create an overall quality-of-life measure. Others view the objective
parameters that are often associated with quality of life to be indicators, whereas the actual quality of life can only be measured by a subjective appraisal made by the individual living the life. If one believes that quality of life is inherently subjective, it is then possible to test indicators by the extent to which they predict the quality of life reported by groups of people.

Why is quality of life of interest for public health? First, a good or a poor quality of life is, in some ways, the ultimate marker of the success of preventive health practices and of health care. Second, many health care regimens often seem to detract from quality of life, at least in the short run. As individuals, with the help of their physicians, make decisions about treatment choices, they may take quality of life into account and may seek information about the likely effects on the quality of their life. Third and related to the previous point recent rhetoric pits quantity of life against of life, especially in terms of end-of-life treatments; the argument is sometimes made that some treatments are inadvisable because the quality of life likely to result for the extra time gained is too poor. Thus, quality of life has come to be seen as a gold standard for weighing the benefits and costs of life extending treatments. Finally, in some circumstances, people are asked to change their life circumstances, perhaps forever, for the sake of their health status and care. Relocation to a nursing home would be an example of such a dramatic change. In that situation, it is incumbent on those who plan, fund and license nursing homes to have some way of assuring that the quality of life, in so far as it is influenced by the facility, is of an acceptable standard.

In health care, the term "health-related quality of life" (HRQL) is often used. This approach narrows consideration to those aspects of quality of life that are deemed to be affected positively or negatively by medical or health
care Intervention. Another important distinction is between a general HRQL measures (e.g. one that asks about quality of life affected by health) in contrast to a disease-specific HEQL measure. A disease-specific approach may pose questions in relation to the effects of a particular disease (e.g., cancer, arthritis, heart disease) and its treatment with items such as “have you experienced reduction in social activities because of your condition.” Other tools are comprised of objective items (for example, agree-disagree items) that are thought to be particularly relevant to the particular disease. A generic HRQL measure may simply be a general measure that attempts to tap health status using the full range of the World Health Organization's definition of health: "physical, psychological, and social well-being."

Subjective judgments of quality of life, though logically the best single source of information, are prone to be influenced by a number of factors. First, expectations influence appraised quality of life, so that an individual may become used to circumstances that could objectively be considered substandard. (This criticism also applies to measures of satisfaction.) Second, individuals may feel constrained because of courtesy or intimidation from actually expressing their views. The intimidation is more likely if the person is in vulnerable health and perceives himself or herself as dependent on care providers, a circumstance that is common for nursing home residents. Finally, lifelong personality traits may influence perceived quality of life.

Personality is generally classified according to five traits (each of which can be seen in their expression or their opposites): neuroticism, extroversion, agreeableness, conscientiousness, and openness. Although little large-scale psychological or sociological research has been done to link subjective quality-of-life results to personality, anthropologists have observed patterns that
suggest underlying Personality is very much related to how individuals view the quality of their life.

Examples of some general HRQL measures in widespread use include the Sickness Impact Pronle (SIP) which was developed by Bergner and colleagues in the 1970s, and the Medical Outcomes Studies (MOS) Short Form. Known as the SF - 36, developed by John Ware and colleagues. The SIP, which was developed in the 1970s, contains 136 items that tap twelve categories of wellbeing: sleep and rest, eating, work, home management, recreation and pastimes, ambulation, mobility, body care and movement, social interaction, alertness behavior, emotional behavior, an communication. As its name suggests the SF - 36 contains thirty - six questions and generates scores in eight categories: physical functioning, role limitations due to physical problems, social functioning, bodily pain, general mental health, role limitations due to emotional problems, vitality, and general health perceptions; an SF-12 is also available that provides summary scores for physical and mental functioning.

The best known approach specifically for elderly people is the Multi-level Assessment Instrument (MIA), Developed by Lawton and colleagues; this is 152-item battery that generates scores in seven areas; physical health, cognition, activities of daily living, time use, social relations and interactions, personal adjustment, and perceived environment. More recently, Kane and colleagues have been conducting research to develop a self-report measure of the psychological aspects of quality of life for nursing home residents; their eleven domains include comfort, functional competence, autonomy, dignity, individuality, privacy, relationships, meaningful activity, sense of security and safety. Enjoyment and spiritual well-being.
The Quality of Well-being (QWB) Scale, developed by Kaplan and colleagues, differs from the approaches so far described because it defines quality on twenty-four functional states on a scale ranging from 0 for death to 1 for perfect health. The scoring weights were developed based on preferences that individuals assign to the various states.

2.7. Psychological Well-Being and Meditation:

The great tragedy of the civilization is that it has improved the circumstances of man (living standard) but not man himself. The value systems are rapidly on decline and human life has already become so invaluable that ordinary deaths go unreported and catastrophes involving may be million people could just be considered as a matter of chance. It signifies a spell of horror to peace lovers. Will there be any virtues left? Will there be any joy, compassion, love or concern? Or is it going to be a just task oriented world? (Nathawat 1975) There is no doubt that a new world is unfolding its different & never-ending layers of Change, me full magnitude of which is Impossible for us to comprehend (Toffier 1970). It seems that most of us are in a state of Suffering, a little more or a little less. Depending on our circumstances, only the free-being is exempt from this suffering.

In recent years, psychological or subjective Well-Being (SWB) is the focus of intense research attention (Diener & Diener 1995). Psychological well-being resides within the experience of the individual (Campbell et.al. 1976). It is person’s evaluative reaction to his or her life either in terms of life satisfaction (Cognitive evaluations) or affect (on going emotional reaction). (Diener & Diener 1995), however, held that little attention has been paid to whether the predictor of psychological well-being differs in various cultures.
They further added, that variables that influence peoples’ evaluations of their do vary across culture.

While working in the area of psychological well-being in our country the author has pointed out the role of personality (particularly hard lines) and social support in psychological well-being (Nathawat 1988, Nathawat & Rathore 1996, Whereas, Diener et.al. 1989) held that people who are successful at attending frequent positive affect will be happy.

The main issue of concern for clinical and health psychologist is whether meditation is a useful procedure for enhancing happiness or psychological well-being. Many people believe that meditation enable the Person to reach a state of profound rest, as claimed popular self-help books (Foreman, 1974). (Bhaskarn 1991), observed that meditation would appear tp have prevention potential, though it’s relaxing effects in stress-included psychological disorders and in what frankly calls, “Noogenic Neuroses” characterized by dissatisfaction with living in spite of having all the material satisfaction, a sense of meaninglessness in living, a sense of alienation from on e self and one’s environment. Meditation would also seem to have potential for enhancing psychological Well-being, especially if we include the spiritual dimension in our concept of happiness. The author has personal experience of effects of meditation in enhancement of his subjective Well-Being by participating in 10 days Vipassana camp at Galta, Jaipur. Meditation may promote the “Being” mode of living postulated by (Fromm 1976), against the “Having” mode.

Above views are understandable in the light of observation, that affluence may not necessarily be related with happiness. (Campbell et.al.
1976), for example, disclosed that during period 197-1972, when most of economic & social indicators were moving rapidly upward, the proportion of population of U.S.A. who was described as “very happy”, declined steadily. They further reevaluated that 17% of life satisfaction or happiness is predictable from 10 demographic indicators in national probability sample.

There is vast panorama of ancient literature from our country to suggest various ways of enhancing happiness & subjective well-being. Meditation figures as one of the important technique in this direction (Carrigton & Phron, 1975; Vahla et.al., 1975; Vigne, 1995).

3. Life Satisfaction:-

3.1. Concept of Life Satisfaction:-

Satisfaction is a state of mind. It is an evaluative appraisal of something. The term refers to both ‘contentment’ and ‘enjoyment’. As such it covers cognitive- as well as affective-appraisals. Satisfaction can be both evanescent and stable through time.

Life satisfaction is the way a person evaluates his or her life and how he or she feels about where it is going in the future. It is a measure of well-being and may be assessed in terms of mood, satisfaction with relations with others and with achieved goals, self-concepts, and self-perceived ability to cope with daily life. It is having a favorable attitude of one's life as a whole rather than an assessment of current feelings. Life satisfaction has been measured in relation to economic standing, amount of education, experiences, and residence, as well as many other topics.
Human is an objective creature always evaluating his life situation. He will feel no satisfaction until he gains his goals. Perhaps, it can be said that the final aspiration of every human being is to attain his goals and desires and this attainment leads to life satisfaction. Therefore, Life Satisfaction is the central aspect of human welfare. It is ultimate goal and every human being strives to achieve this goal throughout the life. Life satisfaction is a multidimensional concept related to psychological and environmental life conditions. The term life satisfaction can be split into two words-life and satisfaction.

Life - Life is the state of functional activity peculiar to organized matter and especially to the portion of it such as, constituting on animal or plant before death (Oxford Dictionary 1990). Life is what one's thinking makes it, one makes it human or hell through one's thinking (Baltes 1986). Life is on object to which the effect or ambition is directed. In fact, no life can be without a goal. Satisfaction- Satisfaction is a Latin word that means to make or do enough. Satisfaction is a word difficult to define.

Webster's Encyclopedic Dictionary of English Language (1977) defines it as an "act of satisfying or state of being satisfied, contentment in possession and enjoyment; and to satisfy is to gratify fully the wants, wishes or desires of any to supply to the full extent, with what is wished for". In general, the word satisfaction is defined as fulfillment or gratification of desires, feelings or expressing pleasures, happiness, contentment and optimism. It is the knack of finding a positive for every negative. Satisfaction wholly depends upon the individuals' environment, caliber, behavior and nature. It is more concerned with mind than the material world.
Life satisfaction is attainment of a desired end and fulfillment of essential conditions (Wolman, 1973). Satisfaction in life does not lie in the length of days, but in the use we make of them. A man may live long yet may get little from life. Thus satisfaction in life does not depend on number of years, but on will (Baltes 1977). It is a degree of contentment with one's own life style. (Goldenson 1984) psychologically speaking satisfaction may occur on a conscious, preconscious and unconscious level and brings an organism to a balanced state. Satisfaction with one's life implies a contentment with 'or' acceptance of one's life circumstances, or the fulfillment of one's wants and needs for one's life as a whole.

Life satisfaction is the conscious and cognitive judgment of one's life in which the criteria of judgment are up to the person (Pavot & Diener, 1993). It is frequently uttered that the persons sharing the view that life has a meaning, goal and direction, are the ones having optimal life satisfaction.

Life satisfaction is defined as a perception of being happy with one’s own life and a belief that one’s life is on the right track. To date, our understanding of how life satisfaction relates to youth outcomes is limited, however a recent pilot study on a nationally representative sample of adolescents found that it is negatively related to outcomes such as substance use, depression, getting in fights, and delinquency and positively related to good grades (Lippman et al., 2012). Satisfaction is the only parameter with which one can make out if the concerned individual is happy or otherwise in his/her life. It is not merely u judgment about one’s life. In fact it is the central part of all human activity. A human being does each and every activity for one and only one sale reason well that is to be satisfied in life or we can put it as Life Satisfaction.

According to (Beutell 2006) it is believed that life satisfaction is related to better physical, and mental health, longevity, and other outcomes that are considered positive in nature. In addition, (Chow 2009) argues that improved levels of life satisfaction might give rise to better health in the future and that this can already be identified within a three year time frame.

Although there is a lack of congruence regarding the definition of life satisfaction (Iverson and Maguire, 2000), this thesis will adopt the definition as described by Veenhaven (1991, p.3) “life satisfaction is conceived as the degree to which an individual judges overall quality of his life as a whole favorably.

Life Satisfaction means sores how people evaluate their life as a whole rather than their current feelings.

1. Fulfillment of a need or want
2. the feeling experienced when one’s wishes are met
3.2. Definition of Life Satisfaction:

Life satisfaction defined in a very simple and clear way, is not seen as this much easily understandable concept in reality. For this reason, many different definitions can be encountered.

Life satisfaction for Sumner (1966) is "A positive evaluation of the conditions of your life, a judgment that at least on balance, it measures up favorably against your standards or expectations." According to Andrew (1974) life satisfaction represents an overarching criterion or ultimate outcome of human experience.

According to Hamilton (1995) in the Dictionary of Developmental Psychology, life satisfaction is the degree of contentment with one's own life style. Life satisfaction is referred as an assessment of the overall conditions of existence as derived from a comparison of one's aspiration to one's actual achievement (Cribb 2000). Life Satisfaction generally implies the pleasure that a person gets from his/her life (Telman and Unsal 2004).

In Indian Philosophy, satisfaction includes the capacity for enjoyment i.e. more enjoyment leads to more happiness. A satisfied and meaningful life involves both subjective thinking and objective component.

3.3. Importance of Life Satisfaction:

Need of L.S. Life satisfaction involves generally the whole life of a person and all the aspects of life. Life satisfaction is the dominance of positive feelings to the negative ones in the daily life and means to be good in different views such as happiness and moral (Avsaroglu, Deniz & Kahraman, 2005). Life satisfaction is the need of the hour. It is of much importance in today's
stressful life. Without satisfaction man cannot lead a peaceful and prosperous life. So one must learn to break tensions, worries and anxieties of daily life. Otherwise these all will break him. Life satisfaction refers to an individual's well-being, quality of life and happiness (Noone, 1998).

It is a state of feeling pleasure in an organism, which is ultimate goal that human beings are thriving to achieve in entire lives. Without life satisfaction, there is disharmony in the inner & outer self. It gives rise to feeling of emptiness, uneasiness and meaninglessness in life. This paradoxical situation leads to crisis of character, values and working efficiency. Life satisfaction includes the capacity for enjoyment. The more we can enjoy what we have, the happier we are. A person having high life satisfaction is expected to have happy/higher adjustment with life and vice-versa.

When we refer to life satisfaction, we can assess the extent to which individual feel that they are leading a meaningful life. It can help us in assessing social problems thereby, helping us in the formation of policies to overcome such problems. By the study of life satisfaction, we can monitor social progress. Life satisfaction of individual in a group indicates the meaningfulness of life but when satisfaction declines, this indicates possible problems. We can also know about certain factors which play a positive role in maximizing life satisfaction and their crucial role in reducing the dissatisfaction.

3.4. Factors Affecting Life Satisfaction:-

Wilson (1968) is of the view that a man would be completely happy if he is satisfied in all aspects of life. A life that involves the satisfaction of simple desires, gives many pleasures. These desires arise due to a number of
behavioural actions that are related to overt or covert behaviour of the concerned individual or these may be environmental i.e. related to social, mental and physical environment.

3.4.1. Personal Factors:-

Satisfaction of needs - our needs or urges always creates tensions and worries in our mind. As result, we become restless and dissatisfied. The various needs are as follows:

- Physiological - needs includes food, clothing, dwelling & sex.
- Psychological - needs include self-esteem, attitude, social intelligence, mental health, anxiety, frustration, life skills, and emotional stability.
- Social - needs include strong family support (satisfaction with spouse, with children and with rest of family), social participation, social support social cognitive skills, family relationships, social status and other social outlets and affiliations.
- Education - It has been realized that education plays a pivotal role in the life satisfaction of an individual. Education is very much important for everyone. It dispels mental illusions and its place cultivates good thinking, knowledge, attitudes, values etc, which helps in bringing life satisfaction.
- Nature of Job - Life satisfaction also depends on an individual's Job nature and job satisfaction in which he is engaged (Singh & Mulay, 1982). Man, being a social animal needs social recognition which is marked by his status and position in the society. Job is an important factor to upgrade the social status and position of a man. Hence, suitable job gives satisfaction in life.
■ Economic Status - Satisfaction with housing and living conditions, with income's purchasing power and with financial solvency.
■ Leisure Activities
■ Marital Status
■ Sports Participation
■ Mental and Physical Health
■ Positivity of Emotions
■ Coping Abilities
■ Ego Identity

Above all the needs also affect our life satisfaction.

3.4.2. Environmental Factors:-

Environment includes everything that surrounds us. It is one of the important factors which influence not only the various psychological traits but also our good social behavior. It the environment is peaceful and congenial it helps to facilitate balanced life. Good social relationships with neighbors, colleagues and participation in social activities also provide life satisfaction.

■ Social Circle/Friendship - satisfaction with friends and with availability of time to spend with them.
■ Occupational Facilities - such as promotion, recognition, freedom, salary, job - security, work itself, job status, and friendliness of head, relationship with employees, achievement and working conditions enhances the life satisfaction.
■ Community Environment - satisfaction with community services such as trash collection, public transport, road conditions, public lights, neighborhood safety and trust in local authorities.
- Physical/Geographical Environment
- Good Residential Facilities

**Duffy (2004)** conducted a study using data from British Household Panel Survey with aim to identify factors which are most and least associated with life satisfaction. These are called positive and negative drivers respectively.

- Positive Drivers - comfortable finances, retired life, talk to neighbors, agree with ordinary people, share wealth and participation in sports.
- Negative Drivers - Long-term illness, want to move home, single, non-retired house hold, number of visits to general practitioner, cannot afford visits.

4. Stress:-

4.1. What is STRESS? :-

It is a word derived from the Latin word ‘stringere,’ meaning to draw tight. One concept on stress says that, external forces (load) exerting pressure upon an individual, producing stain and we can measure the stress to individual in the same way, that we can measure physical stress on a machine (**Hinkle, 1973**).

Cannon observed that when subjects experienced situations of cold, lack of oxygen, and excitement, physiological changes such as emergency adrenalin secretions were produced. Cannon described these individuals as being; under stress’.

One of the first scientific attempts to explain the process of stress-related illness was made by the physician and scholar, (**Hans Selye 1946**), who described three stages an individual encounters in stressful situations.
“As stress begins to take its toll on the body and mind, a variety of symptoms can result. Doctors have identified the physical and behavioral symptoms of stress that occur before the onset of serious stress-related illness. They have also identified those ailments that have a stress background, meaning that they may be brought on or aggravated by stress.”

**Definitions of stress fall into three categories (Bartlett, 1998; Goetsch & Fuller 1995):**

(A) Stress as a stimulus;

(B) Stress as a response;

(C) Stress as an interaction between an organism and its environment.

This view of stress was given by Selye’s (1956), that, ‘stress is the non-specific response to any demand made upon it’. While medical students, noticed a general malaise or syndrome associated with ‘ill’, regardless of the particular illness. The syndrome is characterized by;

(A) a loss of appetite;

(B) an associated loss of weight and strength;

(C) loss of ambition;

(D) A typical facial expression associated with illness.

Stress is the reaction people have to excessive pressures or other types of demand placed upon them. It arises when they worry that they can’t cope. Stress is often termed as a twentieth century. Syndrome born out of man’s race towards modern progress and its ensuing complexities.

**4.2. Meaning of Stress? :-**

Stress is a general term applied to various psychological (mental) and physiological (bodily) pressures experienced or felt by people throughout their
lives. Stress can have a big impact on your body, in ways that are felt by just you, and in way that the world can see. One of the more visible potential by products of stress is weight gain many people find themselves to be “emotional eaters” who react to stress by reaching for something often the wrong thing.

4.3. Definitions of Stress:-

An understanding of stress is in terms of an interactive process model dynamic process in which time plays a vital role. It is thus, very apparent that simple dictionary definitions of stress are inadequate when seeking to define and conceptualise psycho – social and occupational stress. However, it is observed that dictionary definitions have evolved to embrace changes in the use of the expression.

Steadman’s Medical Dictionary (1982, 24 Edn.) defines stress as:

1. The reactions of the animal body to forces of a deleterious nature, infectious, and various abnormal states that tend to disturb its normal physiological equilibrium.
2. The resisting force set up in a body as a result of an externally applied force.
3. In psychology, a physical or psychological stimulus which, when impinging upon an individual produces strain or disequilibrium.
4.4. The Nature of Stress:

Although the contemporary approach to understanding stress embraces an interactive viewpoint (i.e. stress is in the eye of the beholder), it is necessary to be aware of potential stressors in the environment. Thus, the aim of this chapter is to assess the nature of stress. Evidence from a growing body of research suggests that six major categories of stress may be identified. Since, a high proportion of the populations are engaged in paid employment outside the home and most research tends to focus to on occupational stress, five of these categories are concerned with work stress.

**These include:**

1. Stress in the job itself; stressors intrinsic to the job include workload, poor physical conditions, low decision making attitude, etc;
2. Role-based stress; associated with role conflict, role ambiguity and responsibility;
3. Relationships with others (i.e. superior, colleagues and subordinates); interpersonal demands are potential stressors;
4. Career development; including under of over promotion and lack of job security;

5. Organizational structure and climate; this includes restrictions on behavior and the politics and culture of the organization as sources of stress.

4.5. Symptoms of Stress:

(1) Physical Symptoms:-
- Sleep pattern changes
- Fatigue
- Digestion changes
- Loss of sexual drive
- Headaches
- Aches and pains
- Infections
- Indigestion
- Dizziness
- Fainting
- Sweating and trembling
- Tingling hands & feet
- Breathlessness
- Palpitations
- Missed heartbeats

(2) Mental Symptoms:-
- Lack of concentration
- Difficulty in making decisions
- Confusion
- Insomnia
- Disorientation
- Panic attacks

(3) Behavioral Symptoms:-
- Appetite changes – too much or too little
- Eating disorders – anorexia, bulimia
- Increased intake of alcohol & other drugs
- Increased smoking
- Restlessness
- Fidgeting
- Nail biting
- Hypochondria
- Decrease in job satisfaction

(4) Emotional Symptoms:-
- Bouts of depression
- Impatience
- Fits of rage
- Tearfulness
- Deterioration of personal hygiene and appearance

(5) Physiological Symptoms:-
- Headache
- Heart disease
- High BP
- Back problems
- Migraine

4.6. Types of Stress:-

(1) Positive Stress:-

Stress can also have a positive effect spurring motivation and awareness providing the stimulation to cope with challenging situations. Stress also provides the sense of urgency and alertness needed for survival when confronting threatening situations.

Ex.
- Mental Alertness
- Motivation
- High efficiency

(2) Negative Stress:-

It is a contributory factor in minor conditions, such as headaches digestive problems, skin complaints, insomnia and ulcers.

Excessive prolonged and unrelieved stress can have a harmful effect on mental, physical and spiritual health.

Ex.
- Acute stress
- Chronic stress
(3) The Individual Stress:-

Everyone is different with unique perceptions of and reactions to events. There is no single level of stress that is optimal for all people. Some are more sensitive owing to experiences in childhood, the influence of teachers, parents, and religion etc.

Most of the stress we experience is self-generated. How we perceive life weather an event makes us feel threatened or stimulated, encouraged or discouraged, happy or sad depends to a large extent on how we perceive ourselves.

Self-generated stress is something of a paradox, because so many people think of external causes when they are upset.

Recognizing that we create most of our own upsets is an important first step towards coping with them.

Other Types of Stress:-

(1) General Stress:-
   - Everyone has this stress
   - Resolve in a day or two
   - No intervention
(2) Cumulative Stress:-
   - Builds up in your body
   - Become more difficult to alleviate your symptom.
   - More serious psychological problems
(3) Acute Traumatic Stress:-
   - Critical incident stress
- Produce psychological distress
- Abnormal reaction to normal situation

(4) Post Stress Traumatic Stress:
- Severe stress produces severe psychological trauma
- Produce lasting change.

4.7. Source of Stress:

![Diagram of stress sources](image)

(1) Environmental Factors:
- Economic uncertainly
- Political uncertainly
- Technological change

(2) Organization Factors:
- Task demands
- Roll demands
- Interpersonal demands

(3) Personal Factors:
- Family problems
- Economic problems
- Personality
4.8. What Causes Stress?:-

The causes of stress don’t exist objectively, and individuals differ in what they see as a stressor in the first place (Lazarus, 1966).

(1) Divorce or separation
(2) Death of a loved one
(3) The birth of a child
(4) Lack of sleep
(5) Physical injury
(6) Working overtime
(7) Major financial setback
(8) Personal conflict
(9) Employment changes
(10) Becoming the victim of a crime
(11) Natural disaster
(12) Traffic congestion

4.9. Stress Related illness?:-

Stress is not the same as ill-health but has been related to such illnesses as:

- Cardiovascular disease
- Immune system disease
- Asthma
- Diabetes
- Digestive disorders
- Ulcers
- Skin complaints – Psoriasis
- Headaches and migraines
- Pre – menstrual syndrome
- Depression
4.10. What are the Effects of Stress?:

The general adaptation syndrome, (GAS) according to Selye (1956), GAS represents the body’s defense against stress. The body responds in the same way to any stressor, whether it’s environmental or arises from within the body itself. He initially observed that injecting extract of ovary tissue into rats produced enlargement of the adrenal glands, shrinkage of the thymus gland, and bleeding ulcers. When he used extract of other organs (pituitary, kidney, spleen, etc.), as well as substances not derived from bodily tissue, the same responses were produced. He eventually found that this same ‘triad’ of ‘non-specific’ responses could be produced by such different stimuli x-rays, sleep and water deprivation and electric shock. Selye (1956) defined stress as: The individual’s psycho-physiological response, mediated largely by the automatic nervous system and the endocrine system, to any demands made on the individual’.

GAS comprises three stages: the alarm reaction, resistance and exhaustion.

4.10.1 Alarm Reaction:

When Stimulus is perceived as a Stressor, there is a brief shock phase. Resistance to the stressor is lowered. But this is quickly followed by the counter –shock phase. The sympathetic branch of the ANS is activated, which
in turn, stimulates adrenal medulla to secrete increased levels of adrenaline noradrenalin (catecholamine). These are associated with sympathetic changes which are commonly referred to as fight and flight syndrome. The catecholamine mimic sympathetic arousal, (and so are ‘sympatiomimetics’) noradrenalin is the transmitter at the synapses of the sympathetic branch of the ANS. Consequently, noradrenalin from adrenals prolongs the action of noradrenalin released at synapses in the ANS. This prolongs sympathetic arousal after stressor’s removal. This is referred to as the adrenal-medulla system (or sympatho-adrenomedullary axis).

4.10.2. Resistance:-

The stressor is not removed, there’s a decrease in sympathetic activity, but an increase in output from the other part of the gland, the adrenal cortex. Adrenocorticotrophic hormone (ACTH) is released from the anterior pituitary (the ‘masendocrine gland), upon instruction from the hypothalamus. The adrenal cortex is essential for the maintenance of life and its removal results in death.

The effect of ACTH is to stimulate the adrenal cortex to release corticosteroids (or adrenocorticoid hormones), one of which are the glucocorticoids hormones (chiefly, corcosterone, cortisol and hydrocortisone). These control and conserve the amount of glucose in the blood (glucogenesis) high, help to resist stress of all kinds. The glucocorticoids invert protein into glucose; make fats available for energy responsiveness. In this way, the anterior pituitary axis contributes to the fight or flight syndrome.
4.10.3. Exhaustion:-

Once ACTH and corticosteroids are circulating in the blood stream, they tend to inhibit the further release of ACTH from the pituitary. If the stressor is removed during the resistance stage, blood sugar levels will gradually return to normal. However, when the stress situation continues, the pituitary-adrenal excitation will continue.

The body’s resources are now becoming depleted, the adrenal can no longer function properly, blood glucose levels drop and, in extreme cases, hypoglycemia could result in death.

It is at this stage that psycho-physiological disorders develop, including high blood pressure (hypertension), heart disease, coronary artery disease, (CAD), coronary heart disease (CHD), asthma and peptic (stomach) ulcers. Selye called these the diseases of adaptation.

4.10.4. Evaluation of GAS:-

Lazarus (1999) cites a study of patients dying from injury or disease. Postmortem examination showed that those who remained unconscious had normal levels of corticosteroids, while the opposite was true for those who were conscious (and therefore presumably aware they were dying). Lazarus infers from this that: ‘…some psychological awareness akin to a conscious perception or appraisal of the psychological significance of what is happening may be necessary to produce the adrenal cortial changes of the GAS’.

While Selye helped us understand how stressors affect the body. In order to understand what makes a psychological event stressful, we must put a
person into the equation. In effect, says Lazarus: ‘it takes both the stressful stimulus conditions and a vulnerable person to generate a stress reaction.’

4.11. Techniques for Reduce the Stress:-

(1) Take sufficient rest
(2) Do daily exerceses
(3) Talk to people friends
(4) Organise your life
(5) Manage your anger
(6) Be flexible
(7) Take charge of your life
(8) Do things which you love to do
(9) Overcome ego / jealousy
(10) Take sufficient sleep
(11) Increased effective communication skills
(12) Connect in to creative activities
(13) Increased self-esteem
(14) Increased self-concepts
(15) Increased self-confidence
(16) Improve overall health
(17) Improve attitude

5. Disabilities:-

In India, the broad definitions of different categories of disabilities have been adopted in the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995 as well as under the Rehabilitation Council of India Act, 1992.
“Person with Disability” refers that a person suffering from not less than forty percent of any disability certified by a medical authority.

The National Policy for Persons with Disability, announced in February 2006, attempts to clarify the framework under which the state, civil society and private sector must operate in order to ensure a dignified life for persons with disability and support for their caregivers.

WHO has adopted a sequence underlying illness - related phenomenon as; Disease Impairment Disability Handicap

**Explanation of Various Terms as Adopted by WHO (1992)**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Concerned with</th>
<th>Represent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impairment</td>
<td>Abnormalities of body structure and appearance; organs or system functioning</td>
<td>Disturbances at organ Level</td>
</tr>
<tr>
<td>Disabilities</td>
<td>Impairment in terms of functional performance and activities</td>
<td>Disturbances at personal Level</td>
</tr>
<tr>
<td>Handicaps</td>
<td>Disadvantages resulted from impairment and disabilities</td>
<td>Interaction with and adaptation to individual’s surroundings</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>S No.</th>
<th>Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Blindness</td>
</tr>
<tr>
<td>2.</td>
<td>Low Vision</td>
</tr>
<tr>
<td>3.</td>
<td>Hearing Impairment</td>
</tr>
<tr>
<td>4.</td>
<td>Loco motor disability</td>
</tr>
<tr>
<td>5.</td>
<td>Mental retardation</td>
</tr>
<tr>
<td>6.</td>
<td>Mental illness</td>
</tr>
</tbody>
</table>

The Persons with Disabilities-Equal opportunities, protection of Rights and full participation Act, 1995 defines disability means that “A person suffering from not less than forty percent of disability as certified by a medical authority. The Act classifies the disability as follows;

1. **Blindness/Visual Impairment:**

   As per PWD Act 1995, blindness refers to a condition where a person suffers from any of the following conditions, namely:
   - Total absence of sight or
   - Visual acuity not exceeding 6/60 meter or 20/200 feet (Snellan) in the better eye with correcting lenses; or
   - Limitation of the field of vision subtending an angle of 20 degree or Worse

The term visual impairment is used to describe those who are permanently handicapped by defective vision, caused by congenital defect, illness or injury (Evan, 1995).
The definition of blindness is used to describe individuals who are totally blind and unable to perform any work for which eyesight is essential (Khaw, 1994).

2. Low Vision:-

The WHO working definition of Low Vision (WHO, 1992) is as follows:

“A person with low vision is one who has impairment of visual functioning even after treatment and/or standard refractive correction and has a visual acuity of less than 6/18 to light perception or a visual field of less than 10 degrees from the point of fixation, but who uses, or is potentially able to use vision for the planning and/or execution of a task”.

The Department for Education and Skills, (DFES, 2001), defines that those with relatively minor visual difficulties are sometimes described as having low vision.

3. Hearing impairment:-

The PWD Act, 1995, defines hearing impairment as loss of sixty decibels or more in the better ear in the conventional range of frequencies.

Jangira and Mukhopadhyay (1986) defines that hearing impaired persons have hearing loss one or both ears due to impairment in the auditory mechanism. The hearing loss is a continuum ranging from mild to severe and profound loss. Deaf persons on this continuum are those whose auditory channel fails to serve as a means of processing speech.
4. Loco motor Disability:-

“Loco motor Disability” as defined in the Act is the disability of bones, joints or muscles leading to substantial restriction of movement or any form of cerebral palsy.

5. Mental Retardation:-

“Mental Retardation” as defined in the Act as a condition of arrested or incomplete development of mind of persons which is specially characterized by sub-normality of intelligence.

❖ Defining mental retardation:-

“Mental retardation refers to substantial limitations in present functioning. It is characterized by significantly sub-average intellectual functioning, existing concurrently with related limitations in two or more of the following applicable adaptive skill areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure and work. Mental retardation manifests before are 18”.

❖ Characteristics of children with mental retardation:-

There is a great deal of variability of retarded students. We must, therefore, consider each retarded person as a unique and separate individual. The most obvious characteristics of MR children are discussed hereunder.

(A) Cognitive Characteristics:-

Retarded children exhibit cognitive problems. Research has documented that retarded children are likely to have difficulties in the areas related to cognition, namely, attention, memory, language and academics. Many of the
cognitive problems of retarded individuals are due to attention problems (Brooks and McCauley, 1984). Many MR children often attend to wrong things. They have difficulty in allocating their attention properly. Attention is crucial at various stages of information processing in the properly processing the information. In other words the more complicated the memory task, the more likely it is that a retarded individual will have difficulties with it.

Many of the retarded children have language and speech problems, particularly, articulation errors. Normally, their language development progresses at a slower rate. When the degree of retardation is greater, the language and speech difficulties are more severe.

**(B) Social Characteristics:**

Mentally retardation individuals are candidates for candidates for a variety of social and emotional problems. (Luftig 1998) reported that MR individuals have problems in making friends. (Leahy et al. 1982) found them to be poor in self-concepts. Since most of them have speech problems, they find it difficult to communicate with others properly. Mildly retarded individuals often avoid associating with other retarded persons for fear of emphasizing their own stigma.

**Causes of mental retardation:**

Mental retardation is associated with hundreds of specific medical and genetic conditions as well as with psychosocial disadvantage. Even then, causation is not clearly identified in an estimated 20 to 30 per cent of cases of severe retardation and in 50 to 60 per cent of mild retardation (Gilberg, 1997). However, it is often reported that both biological factors and psychosocial factors contribute to MR (Luckasson et. al 1992).
(A) **Organic Risk Factors:**

Mental retardation is attributed to organic risk factors. This implies that biological conditions account for disordered brain function and intellectual deficiency. A variety of genetic aberrations, both inherited and none inherited, are associated with specific syndromes of mental retardation. Particularly the syndromes such as Down syndrome, Fragile X syndrome, and Williams syndrome are very closely associated with MR. Simonaff et al. (1996) suggested that aberrations in the number and structure of chromosomes are single most common cause of severe Retardation. Down syndrome, the most common single disorder of mental retardation, occurs in approximately one in a thousand forth (Thapar et al., 1994). This condition accounts for an estimated 5 per cent of mild retardation and 30 per cent of more severe cases (Gilberg, 1997). Down syndrome is mainly formed due to trisomy condition of 21st chromosome.

The trisomy condition is said to occur due to non-disjunction of chromosome 21 during meiosis. Down syndrome was formerly called ‘mangolism’ and persons with this defect were called ‘mangoloid idiots’. They also have multiple malformations like flattened face with fissures and increased space between the eyes’. Nose is also flattened and the ears are malformed.

Fragile X syndrome is another condition associated with mental retardation. It affects about 5 per cent of cases of more severe retardation and 5 per cent of cases of mild retardation (Gilberg, 1997). It acquired its name from an abnormal ‘fragile’ site on the X chromosome. The Fragile X syndrome involves defective metabolism, which means the inability of the body to convert a common dietary substance.
Brain damage can also result from infections that may lead to mental retardation. Infections can occur in the expectant mother or the infant or the young child after birth.

(B) Polygenic Factors:–

Polygenic influences are non-pathological and derive from multiple genes whose effects combine to produce variation in intelligence in normal individuals, resulting in mental retardation in limited number of cases. Few studies on individual with retardation bear implication for polygenic inheritance (Thompson. 1997). We have also research evidences for the fact that polygenic influences vary with the level of retardation. A family study revealed that the IQ of sibling of children with severe retardation averaged 103, hinting that severe retardation did not ‘run in families’ and that some specific organic factor caused retardation in the affected child. On the contrary, the IQ of siblings of children with mild retardation averaged 85, suggesting general family influence, particularly, polygenic inheritance (Scott, 1994).

(C) Psychosocial/Cultural Factors:–

There are quite number of mentally retarded children who usually appear normal and have no identifiable organic etiology. Their IQ scores happen to be within the range between 50 and 70 and they possess relatively good adaptive skills. They are often first identified at the time of entering school. Such cases are associated with cultural-familiar retardation (Crnic, 1988) for which psychosocial and cultural factors is identified as causes.

Mild retardation seems to occur among the lower economic classes as well as in some minority groups.
6. What is Mental illness?

A mental illness is a disease that causes mild to severe disturbances in thought and/or behavior, resulting in an inability to cope with life’s ordinary demands and routines.

5.1. Person with Multiple Disabilities:-

The PWD Act (1995) defines “person with severe disability means a person with eighty percent, or more of one or more disabilities. It, however, does not clearly define persons with multiple disabilities.

Definition by the National Trust: As per the National Trust for Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act, 1999, multiple disabilities means a combination of two or more disabilities as defined in clause (1) of Section (2) of the Persons with Disabilities Act, 1995. In addition to the above, multiple disabilities include individuals who are Deaf blind, autistic, cerebral palsied, neurologically impaired. These disabilities may either be congenital or acquired.

5.2. Education of the Disabled in India - A Historical Perspective:-

According to Miles (2000), rudimentary attempts to educate students with disabilities were made in India long before such attempts were made in Europe. The formal education of children with disabilities began in India in 1869 when Jane Leupot, with the support of the Church Missionary Society, started a school for “blind students” in Benares (Miles, 1997). Miles also reported that the first formal school for children with intellectual and physical disabilities was established in the eastern part of India in Kurseong in 1918.

The education of children with disabilities in segregated settings continued well after India gained independence from Great Britain in 1947,
with various non-government organizations assuming increasing responsibility for their education. By 1966 there were 115 schools for students with a visual impairment, 70 schools for students with a hearing impairment, 25 schools for students with an orthopedic disability and 27 schools for students with an intellectual disability (Aggarwal, 1994). According to Pandey & Advani (1997), by 1991 there were about 1,200 special schools for students with arousing types of disabilities in India. In 1974, the Ministry of Welfare, Government of India, initiated the Integrated Education of Disabled Children (IEDC) program to promote the integration of students with mild to moderate disabilities into regular schools. The program was also designed to promote the retention of children with disabilities in the regular school system. However, the program met with little success. Rane (1983), in his evaluation of this program in the State of Maharashtra, reported that (a) the non-availability of trained and experienced teachers, (b) lack of orientation among regular school staff about the problems of disabled children and their educational needs, and (c) the non-availability of equipment and educational materials were major factors in the failure of the program. Also, a lack of coordination among the various departments to implement the scheme was another major factor in the failure of the IEDC plan (Azad, 1996; Pandey & Advani, 1997).

Due to its shortcomings, the IEDC program was revised in 1992. Under the revised scheme, 100 percent assistance became available to schools involved in the “integration” of students with disabilities. Various nongovernment organizations are now fully funded to implement the program. According to the most recent estimates, the IEDC is being implemented in 26 States and Union Territories, serving more than 53,000 students enrolled in 14,905 schools (Ministry of Information and Broadcasting, 2000). In 1987,
the Ministry of Human Resource Development (MHRD), in association with UNICEF and the National Council of Educational Research and Training (NCERT) developed the Project for Integrated Education for the Disabled (PIED). This project produced several positive results. Jangira and Ahuja (1993) reported that as a result of improved program planning and better management skills now made available to the teachers, the capacity of various states to implement integration programs was enhanced. Both regular school teachers and students became more receptive toward students with disabilities (Azad, 1996). The success of the PIED project led to an increased commitment by the Department of Education to integrate students with disabilities (Jangira & Ahuja, 1993).

In 1996, the Government of India enacted the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act (PWD Act) of 1995 (Ministry of Law Justice and Company Affairs, 1996). The Act provided for both preventive and promotional aspects of rehabilitation. It covered such aspects as education, employment, non-discrimination, prevention and early detection, social security, research and manpower development, and affirmative action. Seven categories of disability were covered in the legislation, namely “blindness,” “low vision,” “leprosy cured,” “hearing impairment,” “locomotors disability,” “mental retardation” and “mental illness.”

The PWD Act required the Central, State, and Union Territory Governments to ensure that all children with disabilities had access to a “free and appropriate” education until the age of 18 years. In order to expand educational opportunities for children with disabilities, the Central Government, in its Five-Year Plan (1997-2002), set aside 1,000 million rupees
specifically for the provision of integrated education (Ministry of Welfare, 1997; Ministry of Information and Broadcasting, 2000).

The Government of India’s policies were based on the principle of Universal Elementary Education (UEE) which resonated with the ‘education for all’ mantra adopted by several western democracies after its launch at the UN World Conference in 2000.

In the year 2002, the elementary education, i.e. education for children within the age group of 4 to 14 years, was made a ‘fundamental right of every child’ in India under the 86th Constitutional Amendment. As a result, the thrust was increased to promote the education of the disabled also along with the out of - school children.

The influential National Policy on Education of 1986 stated that the education of children with special needs was an ‘inseparable part’ of the mainstream education system and thus, endorsed the expansion of elementary education to achieve this aim (MHRD, 1986).

The centrally sponsored government scheme - the Integrated Education for Disabled Children (IEDC) scheme - was launched by the Ministry of Social Welfare in 1974 (Rane 1983). The Right of Children to Free and Compulsory Education Act, 2009 leads the way by offering every child the right to education in their neighborhood school and giving the National Commission for Protection of Child Rights (NCPCR) with a mandate to monitor the implementation this Act. In addition, the Persons with Disability (Equal Opportunities, Protection of Rights and Full Participation) Act 1995, together with the Rehabilitation Council of India Act 1992 (amended in 2000) and the National Trust for Welfare of Persons with Autism, Cerebral Palsy, Mental
Retardation and Multiple Disabilities Act, 1999 provide the legislative backbone to the national policies surrounding disability and education of children with special needs. The PWD Act 1995, for instance, affirms the central government’s commitment to ensure full participation of people with disabilities in the society including education, public sector employment and health.

The government scheme Sarva Shiksha Abhiyan (SSA) Programme launched in 2002 based on the principles of ‘education for all’. The World Bank alone invested $500 million in Phase I (2003-2007) to expand facilities and improve infrastructure in order to get children to access learning in their neighborhood school. In Phase II (2007-2012) the Bank further committed to provide $1.35 billion for specific targets such as, to expand access to schools, Increase retention, raise learning levels and improve inclusive education for Children with special needs (Sankar, D. 2007).

5.3. Role of Parents of Disabled Children:-

The true sufferers are the parents of disabled children. The parents having the female disabled child suffer with more stress, emotional problems and neurotic problems. Likewise the parents’ with mentally retarded child also face intensive problem of stress. Sometimes the parents have to take the advice of their physician or counselor to give some basic training. In Western countries many social issues are advantage to the parents in Government side also. In Indian context the social situations are more pathetic because of the financial problems of the parents and also lack of proper education. In this juncture the researcher focused his direction to verify the stress levels,
emotional maturity levels and personality of the parents in different variables, with the relationships and differences between them.

5.4. Disability in India:-

Over the last fifty years, right to education has evolved in India inspired by a host of factors including judicial interpretations, enactment of special laws and amendment to the constitution. The constitution of India has made education a fundamental right for all children including the children with disabilities in the age group of 6-14 years. Section 26 of Persons with Disabilities Act (1995) affirms the capacity of Indian State to afford free education beyond 14 years of age, particularly in the context of children with disabilities.

According to the Census (2001) there are 2.19 crores people with disabilities in India who constitute 2.13 per cent of the total population. This includes persons with visual, hearing, speech, loco motor and mental disabilities. Seventy five per cent of persons with disabilities live in rural areas, 49 per cent of disabled population is literate and only 34 per cent are employed. The earlier emphasis on medical rehabilitation has now been replaced by an emphasis on social rehabilitation.

In India different definitions of disability conditions have been introduced for various purposes, essentially following the medical model and, as such, they have been based on various criteria of ascertaining abnormality or pathologic conditions of persons. In absence of a conceptual framework based on the social model in the Indian context, no standardization for evaluating disability across methods has been achieved. In common parlance, different
terms such as disabled, handicapped, crippled, physically challenged, are used inter-changeably, indicating noticeably the emphasis on pathologic conditions.

Persons with Disability Act, 1995 Through the Act is built upon the premise of equal opportunity, protection of rights and full participation, it provides definitions of disabled person by following the medical model. According to the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995, "Person with disability" means a person suffering from not less than (40%) forty percent of any disability as certified by a medical authority (any hospital or institution, specified for the purposes of this Act by notification by the appropriate Government). As per the act "Various types of Disability" are, (i) Blindness; (ii) Low vision; (iii) Leprosy-cured; (iv) Hearing impairment; (v) Loco motor disability; (vi) Mental retardation; (vii) Mental illness, which were defined as below. "Blindness" refers to a condition where a person suffers from any of the following conditions, (i) Total absence of sight. (ii) Visual acuity not exceeding 6/60 or 20/200 (snellen) in the better eye with correcting lenses; (iii) Limitation of the field of vision subtending an angle of 20 degree or worse;

"Person with low vision" means a person with impairment of visual functioning even after treatment or standard refractive correction but who uses or is potentially capable of using vision for the planning or execution of a task with appropriate assistive device; "Leprosy cured person" means any person who has been cured of leprosy but is suffering from- (i) Loss of sensation in hands or feet as well as loss of sensation and paresis in the eye and eye-lid but with no manifests deformity; (ii) Manifest deformity and paresis; but having sufficient mobility in their hands and feet to enable them to engage in normal economic activity; (iii) Extreme physical deformity as well as advanced age
which prevents him from undertaking any gainful occupation, and the expression "leprosy cured" shall be construed accordingly; "Hearing impairment" means loss of sixty decibels or more in the better ear in the conversational range of frequencies; "Loco motor disability" means disability of the bones, joints muscles leading to substantial restriction of the movement of the limbs or any form of cerebral palsy; "Mental retardation" means a condition of arrested or incomplete development of mind of a person which is specially characterized by sub normality of intelligence; "Mental illness" means any mental disorder other than mental retardation; Initially parental response may be a form of emotional disintegration. This may evolve into a period of families’ adjustment and later into reorganization of the families daily day to day life situations. Some of the parents cannot cope up beyond certain level of stress due to the emotional disintegration. So they decide to give their child for adoptions or to aboard or to place the child in any institutions. These decisions are not easy and it is so stressful to the families especially to the parents. Government of India Schemes and Benefits for the Disabled Assistance to Disabled Persons for Purchase/ Fitting of Aids and

- Appliances (ADIP Scheme) National Scholarship for Disabled
- Railway Concession including Escort
- Income Tax Exemption for Parents
- National Awards
- Age Relaxation for Employment
- 3% Reservation in govt. employment
- NHFDC Loan Schemes
- Union Territory of Pondicherry Schemes and Benefits of Disabled Disability Pension
• Scholarship
• Marriage Assistance
• Loan Assistance for Self employment
• Group Insurance
• Special school scheme
• Aids and Appliances
• Vocational training
• Transport Allowance

6. Conclusion of the Chapter:-

    In this chapter one the researcher tells how he became aware of the study concept of the psychological well-being, life satisfaction and stress of the parents from all this concepts have been clarified the reader is how referrers to chapter two for the literature study on psychological well-being, life satisfaction and stress.