CHAPTER II

REVIEW OF LITERATURE

The review of literature relevant to the present study is presented under following headings : disabled person -defined, nature, cause and type of disability and rehabilitation of disabled persons. Review of relevant researches on problems faced by the disabled person, and their families were also included. Researches on management problems and practices of homemakers were also part of the review of literature conducted for the purpose of the present study.

Disabled Person - Defined

The disabled have been defined differently by various authorities because there is no clear cut demarcation between the "able bodied" and the "disabled". There are things which a physically disabled persons can do and cannot do. Therefore they are said to be as persons with physical disability and not "physically disabled persons" (Wright, 1960).

The disabled are defined differently for different purposes too (Bhatt, U.1963).

a) Medical - Whatever may be the cause, physical disability will lead to a limitation of physical function, whether locomotor, sensory or affecting special organs.

b) Vocational - The vocational rehabilitation Act, 1954 USA, defines a physically handicapped individual as :

> "One who is under a physical or mental disability which constitutes a substantial handicap to employment, but which is of such a nature that vocational rehabilitation services may reasonably expect to render him fit to engage in a remunerative occupation".

c) Sociological - The dictionary of sociology, defines, a handicapped person as,

> "possessing a physical defect which reduces one's efficiency in performing one's personal and social obligations according to a socially determined standard. Since the degree of defect and the test of social adequacy vary with the individual and the community, no hard and fast definition of handicapped is possible".

d) Educational - The child may be considered handicapped,

> "If his physical condition prevents full participation in childhood activities of a social, recreational, educational and vocational nature".

The terms disabled and the "handicapped" are often used synonymously. Hamilton (1960) however makes a slight distinction between the two. Disability is defined more particularly as a medical condition and refers to impairment of physical or mental nature. While handicap refers to somatopsychological relationship. Handicap is the cumulative result of obstacles which disability interposes between the individual and his maximum functional level. It adds to the difficulty of the growing process (Barker, et al 1960).

The common feature between disability and handicap is however that they both are used to describe "a characteristic which is limiting" (Patty and Johnson, 1967).

For the purpose of the present study the "disabled person" is defined as "one who has limitation of physical and mental function, whether locomotor, sensory or affecting special organs".

Nature, Types and Causes of Disability

Nature of Disability.

The physical and mental condition of an individual is undeniably a part of his personality structure. Body size, malformation, musculature difficulties, neurological conditions, sensory limitations and limitation of special organs such as brain, heart cannot be overlooked in personality evaluation.

Physical difficulties run into a gamut from the obvious to the subtle. Certain are noticeable in some environments and not in others. Some curtail behaviour markedly, others operate only at certain intervals or under specialized condition. Some are permanent with no hope for improvement, others only temporary with good chance for diminishment. Sometimes a disability is a part of a whole situation otherwise favourable for personality growth while at other times it may prove to be the last straw in an environment that is already burdensome from all points of view.

If the disability is present at birth, it is immediately part of the factors influencing the moulding of the personality. It will affect both parental and peer relationship. It may necessitate additional parental care and economic strain. The extra attention required may make individual very dependent upon his family. Sometimes it may lead to a guilt feeling in the parents and therefore it may take form of antagonism or over-indulgence.

If handicap comes into picture later in the process of personality development, it may have a very different effect. If it is imposed on a fully developed personality, still other

problems arise. Individuals who have tasted an unhampered life find it hard to accept these limitations on their freedom. Like all new experiences the disability may be assimilated, resisted and reconstructed.

Types of Disability.

The problem of disability and handicap can be divided into five sections : physical, mental, emotional, social and aging. These groupings are very broad and are made for sake of clarity. In real life situation however one may find a combination of different areas of disability in one individual.

A. Physical Disability - The physical disability can also be further classified as cosmetic handicaps, orthopaedic handicaps, cerebral palsy, epilepsy, heart difficulties, visual disability and acoustal disability.

Cosmetic Handicaps are thought in terms of their definitions by various cultures. These handicaps includes, cross-eyedness, marks on body, constrict growth of head, feet or any other part of the body by binding them.

Body size or proportion also becomes handicap. Thinness or obesity is considered a handicap in certain countries; extreme shortness or tallness in some people also becomes a handicap. Specific irregularities such as buck-teeth, big ears, large nose, thick glasses, baldness or any other bodily disproportions or discoloration can be interpreted as handicap.

Orthopaedic Handicaps are defects of limb or body musculature. These disabilities are visible and people are prepared to make allownces. Much can be done to help these

individuals to restrict their lives and build up their physical resources.

Cerebral Palsy - It is a condition in which there is difficulty with control of muscles or joints. It is frequently called spastic paralysis; 'cerebral' means anything connected with the brain, whereas the word 'palsy' indicates lack of control of muscles and joints. Cerebral palsy is a term used to designate any paralysis, weakness, incoordination or functional aberration of the motor system resulting from brain pathology. It is, perhaps, unique among crippling conditions because, it may include all the functions of the brain. It may not only represent a motor handicap but may also include sensory and mental deviations as well. Visual, auditory and speech defects and epilepsy are some of the other accompaniments of this brain disorder. In many ways, cerebral palsy is just an opposite of poliomyelitis. It denotes lack of control over movements because the muscles are too strong in wrong places, whereas in poliomyelitis the weakness of movements is due to tender muscles. Children often make fun of these people because they cannot understand why anyone should be so chaotic and jerky in coordination. Severe cases of cerebral palsy make the person totally dependent on the family and from psychological point of view it is a more difficult handicap.

Epilepsy is convulsive disorder. It is a condition which causes a person to suffer from fits characterized by abnormal movements. Such fits are described as "grand mal" when there is loss of consciousness and convulsions or "petit mal" when there is only momentary loss of consciousness and no convulsions.

Heart Difficulties - The hidden character of cardiac trouble makes it difficult for some sensitive sufferer to limit their activities as they should. Inspite of the problems many cardiac cases make a favourable adjustment to their limited roles.

Visual disability - When sense organs are affected, part of the world is closed off. Blindness shuts off visual stimuli. If an individual has this condition from infancy, he has no orientation from which to draw important perceptions based upon seeing. This handicap make for a limited use of the common mechanism of identification; renders testing of visual reality impossible, throws the slightless person on his own world both mentally and emotionally. If blindness occurs later in life some of these orientations of mind pictures, as it were, can be used for building concepts. The effects of the lack of sight are especially noticeable in emotional and social phases of life.

Acoustal Disability - To persons suffering from such a disability an important part of the world is also lacking. To them life is silent film. One of the avenues of communication is missing. This handicap is greatest if it occurs before the child has had an opportunity to develop language habits. With neither hearing to understand what is said to him nor speech to express himself, the deaf-mute must necessarily be devoid of many common concepts and ideas.

Socially, he is largely unconscious of refinements of behaviour. He suffers from mental isolation, which lessens his social competence. He may imagine others are talking about him and may build up a feeling if insecurity and an attitude of distrust of people.

B. Mental Disability. The mental disability can also vary from slight retardness in learning ability to a state of mental imbalance. Mental retardation by definition is exactly what the term itself describes. The mentally retarded are individuals who are retarded and inadequate in their intellectual development and ability. The modern concepts however defines them as non-normal persons. Their intellectual development and ability has not normally developed. Mentally deranged or imbalanced persons include those who have lost control over their mental faculty upto various degree.

Causes of Disability.

A thorough knowledge of causes of disability would be helpful in planning programmes for individual concerned and also in preventing the conditions which could be avoided. The chief causes of physical and mental disabilities are : Hereditary, Congenital, Acquired and other causes. Each of the above mentioned causes are again attributable to a number of contributory causes.

Hereditary - A Hereditary defect is one that passes down from generation to generation because of some sort of disturbance in the working of inherent gene mechanism. It is, however, important to realize that this condition may or may not manifest itself at birth or might not have appeared before in the individual's immediate family.

The incidence of hereditary defects in India are not yet ascertained but it might be less because among Hindus, who form the major population of India, practice exogamy, which debars an

individual from marrying within his immediate circle of kith and kin - Sagotra and Sapinda (Bhatt, U. 1963).

Congenital Defects - They are those that are present at birth. All congenital defects may not be due to heredity most of them are the result of infections, nutritional deficiencies, chemical factors and other environmental conditions. The causes of congenital deformities are :

1) Maternal malnourishment.
2) Maternal infection.
3) The incompatibility of R.H.factor in parental blood.
4) Chronic diseases (diabetes).
5) X-ray also have adverese effect on embryo.
6) Chemical agents.
7) Glandular disorders of the mother.
8) Mechanical factors such abnormal blood pressure, position of foetus.

Acquired Defects - The term acquired defects includes many conditions. The defects may be acquired due to :

1) Birth Injuries. Many brain injuries are due to this.
2) Pathological Conditions and Diseases. Infectious diseases like whooping cough, measles, scarlet fever meningitis, hemiplegia, paraplegia, tuberculosis of bones and joints and poliomyelitis may lead to physical defect in the child. Multiple sclerosis which is a neurological disease and muscular dystrophy which means that the muscles are not nourished properly or have some impairment of the nerve supply that causes weakness and disability.

3) Accidents may be a result of industrial or road accidents. Amputation also may have to be done in some cases to save the person.
4) Nutritional Deficiencies lead to low resistence against diseases and ultimately result in disablement.
5) Postures. The commonest of all defects associated with poor posture is curvature of the spine.
6) Consequence of War. The hazards of war lead to permanent disablement not only to military personnel but also to civilians.
7) Poverty with ignorance and disease results in disablement.

Other Causes - Causes other than those mentioned above which are in some way or the other responsible for the aggravation of physical disabilities, are illiteracy, shortage of medical personnel, want of requisite institutions, traditional fatalism in Indian people and fear of the Surgeon's knife.

Rehabilitation of Disabled Person

The term rehabilitation itself is used at times, in very limited way. According to definition adopted by the International Labour Conference (1955), rehabilitation means "the restoring of handicapped persons to the fullest possible physical, mental, social, vocational and economic usefulness of which they are capable". It has been estimated by the experts, that with proper treatment rehabilitation and training 90 percent of disabled people can be made secure and independent. The process of rehabilitation is composed of five parts.

1) Physical.

2) Social.

3) Psychological.

4) Educational.

5) Vocational.

All the above mentioned aspects are closely related but for purpose of understanding, it is essential to consider them seperately.

Physical Aspect of Rehabilitation.

Rehabilitation when applied to physical disability includes prevention, cure and rehabilitation. Measures should be taken to prevent defects due to heredity, congenital causes and acquired defects. The curative measures include early detection and recognition and proper treatment both in and out of hospital.

Physical restoration of disabled person is also essential. Physical restoration is defined as "the system of treatment that employ every device and measure to expedite recovery, shorten the period of convalescence and secure for the patient the maximum development of his physical and mental capacities" (Bhatt, U.1963).

It includes adequate diagnosis, appraisal of individuals working capacity, surgery, convalescent care, physio-therapy, physical conditioning, occupational therapy, remedial gymnastics and protehtics, which means artificial substitute for the lost limb.

Social Aspect of Rehabilitation.

The attitude of the society in which the disabled person lives influences to a very great extent his social rehabilitation. The social attitudes towards the handicapped have been through four distinct stages.

Exposure and Destruction. The early man eliminated the handicapped or destroyed them as "survival of the fittest" was the law of those days.

Care and Protection. With spread of Christian ideals in West and Buddhist doctrines in the East, the care and protection of the handicapped was emphasized.

Training and Education. With the advent of 18th century the ideas of liberty, equality and fraternity helped the handicapped gain their rights as individual member of the society.

Social Absorption. Towards the end of 19th century vocational problems of the handicapped started to attract attention.

Thus the attitude of society has been changing from time to time. Some of the common attitudes are curiosity, pity, over solicitude, dislike, embarrassment, repugnance, indifference, fear and sympathy.

Among all social institutions the family's attitude plays a very significant role in rehabilitation of the disabled person. Parental reactions generally fall into three categories.

1) Those who refuse to face reality.

2) Those who acknowledge disability on its surface but cannot reconcile themselves to its far reaching effects.

3) Those who accept the disabled child as he is.

Very few families react according to the last category. Therefore, changing of the negative attitudes towards disabled people is a big task before our social worker, educators, planners of social rehabilitation.

Psychological Aspect of Rehabilitation.

The disability may influence the personality in two ways, firstly by handicapping the individual in ordinary tasks and secondly by prejudicing the opinion of others against him. The areas in which the disabled persons are usually maladjusted are : Body image, self-evaluation, security - both physical and emotional and level of achievement.

The factors which may influence the adjustment of the individuals are severity or extent of disability, type of disability, cause of disability, age at the onset of disability, level of intelligence, attitude of the family and the society.

The factors mentioned above were the external factors which influenced personality development. The intrinsic factors such as, the previous personality of the individual and acceptance of the disability by the person himself are equally important in his rehabilitation.

Educational Aspect of Rehabilitation.

Education forms the link between medical and vocational rehabilitation of the handicapped. It is a valuable tool with

which the disabled person can conquer his disability. Special education, like normal education, should be based on taking into consideration the whole child. Education must develop his talent, abilities, whether physical, mental or moral. It should concern itself not only with the development of mind but with the whole life of the pupil. Types of special education facilities include :

Hospital Schools. They are hospital wards organized into classes for bed-ridden children and mostly cover pre-primary or primary education.

Home Teaching. For those who cannot attend schools permanently or for sometime after their discharge from hospital.

Day and Boarding Special Schools for severely handicapped students who cannot benefit from normal education.

Special Arrangement in Ordinary Schools for those who suffer from minor disability.

Correspondence School Arrangements for those who are severely disabled.

Components of special education are remedial treatment, that is, physio therapy, special housing and equipment, special curriculam, transportation and counselling, education of parents, recreational facilities and specially trained teachers to teach the disabled are also necessary.

Vocational Aspect of Rehabilitation.

A job for the disabled ensures him security and independence to counteract the feelings of insecurity and dependence that are commonly caused by his physical disability. Vocational rehabilitation includes, expert counselling and guidance; vocational training and judicious placement.

The various careers open to the disabled are professional or intellectual careers, technical career, commercial career, poultry farming, handicrafts, household work, unskilled manual labour and special sheltered employment suitable for their handicap.

Rehabilitation Programmes in India

Since independence the services for the disabled have steadily improved. The emphasis has shifted from charity to rehabilitation. Attempts are made for education, employment and provision of vocational training to the disabled people in the various plans prepared by the government. The projects for the benefit of disabled persons are finalised in one of the following ways :

1) Projects run by Central Government.
2) Projects run by State Government.
3) Projects run by voluntary organization with the help of government aid.
4) Projects run by voluntary society without government help.
5) Projects financed by Municipality.

The rehabilitation facilities provided in India at various hospitals institutions and centres include medical care, education, vocational training, job placement, pensions and allowmces, and social services, such as, welfare assistance. Better coordination of the services on the state and national levels is still needed. Efficiency of services of course, depends on other factors as well, such as, the number of professional personnel, the nature of their training, and the

financial resources available, but coordination of services would make possible more efficient use of whatever facilities are currently available.

Within the framework of the general objectives declared by the United Nations, the National Plan of Action for IYDP year 1981 in India was framed. The focus of the action programme was on education of child under 14 years of age, employment schemes, disability prevention programmes, vocational training in all centres and rural oriented programmes. Setting up of National Council to advise government, conduct national surveys, award distinguished disabled, encourage research, frame legislation and give publicity to the various facilities were also some of the suggested areas of action.

Facilities and Programmes for the Disabled in Gujarat State

Research and development in medical science, social sciences and technology have made it possible to educate and prepare the disabled people to be productive members of the society. The disabled people include, deaf-mute, blind, orthopaedically handicapped and mentally retarded. No scientific study has been made to assess the number of disabled in India. A rough estimate made by social welfare department, Gujarat State, however indicates that there are 2.5 lakhs blind, 1.5 lakh deaf-mute, 3.5 lakh orthopaedically handicapped. In India, it is estimated to be 45 lakhs blind, 15 lakh deaf-mute, 40 lakhs orthopaedically handicapped and mentally retarded are estimated to be 2-4 percent of the total population.

The year 1981 was declared as International Year for the Disabled Persons so that education, training and rehabilitation programmes could help maximum number of disabled persons to be self-reliant.

Since 1960 when Gujarat became a separate state, the facilities provided for the benefit of disabled have increased. The various programmes include :

Development of Educational and Training Institution. These institutions have increased from 11 to 62 during the past twenty years.

Institutions for Education and Training for Disabled in Gujarat State, 1981

S.No.	Type of institution.	Govern-ment.	Volun-tary.	Total
1.	Institutions for blind.	3	19	22
2.	Institutions for deaf-mute.	2	18	20
3.	Orthopaedically handicapped.	2	5	7
4.	Mentally retarded.	2	11	13
	Total :	9	53	62

The above table shows that voluntary organizations still play a major part in education and training of disabled in India. The institutions however receive grants from the government. There are more institutions for training blind, and deaf-mute but comparatively very few for mentally retarded.

Other facilities include Integrated educational scheme which extends grants to normal schools who admit disabled persons. Central government also provides aid to voluntary organizations

catering to the needs of the disabled. Vocational cum production centres and self-employment and rehabilitation centres for disabled have also been started in the state.

Financial sid schemes are of three types : cash benefits, loan facilities and concession. The cash benefits are provided in form of scholorships to children for education, unemployment benefit for the educated, oldage and disabled pension scheme. Vehicle allowance and cash grant for purchase of artificial limbs and equipment. Government gives loans for self-employment of disabled through nationalized banks.

The financial aid in form of concessions include travelling in bus and trains at concession rates, for blind and orthopaedically handicapped, free postage of braille literature and relief on radio licence, 50 percent concession in petrol and diesel prices, and customs duty concession for institutions who receive gifts of educational and training materials and equipments from other countries. Parents of mentally retarded children are given income tax relief upto Rs. 2400 for education and training of their children.

For employment of disabled the schemes include separate employment exchange and reservation of four percent clerical posts in office, half percent in industries and employment in telephone booths. Relaxation in age for employment is given upto 10 years.

Awards to employed disabled, their employers and best disabled teacher are given by the state government every year.

Evaluation of Services for Handicapped in Gujarat

A series of articles was published in "The Times of India", Ahmedabad, on the services offered for handicapped in various districts of Gujarat. A critical review of the services was made by the correspondents in each district. A summary of this review is presented below ;

On the whole it was found that there are number of institutions for rehabilitation of the disabled in Gujarat State, but not enough to cater to the needs of the population. The accurate figures of disabled population are not available. In Baroda it is estimated to be four to six percent(Sawhney,1981). Misra, (1981) feels that for all the tree-top-trumpeting by the government about benefits given to the disabled, the fact is that very little has been done to make the life better for the disabled, especially in Saurashtra. There are about 77,000 disabled in Saurashtra and only 10 institutions to cater to their needs. Sopariwala, (1981) from Broach and Bhatt,N.(1981) from Bulsar district reports that nothing much has been done in these two districts to educate and train disabled people and make them self-reliant.

Rao,(1981) points out that Surat district lags behind in facilities for early detection of disabilities, occupational therapy, recreational activities and job placement services for the handicapped. Doshi (1981) writes that rehabilitation work for disabled started in Banaskantha district only after 1963 and Bhatt,D.(1981) reports that in Porbandar, the welfare activities are improving in all areas. In Baroda, Sawhney,(1981) feels

economic resettlement is in sheer neglect. He found that inspite of four percent vacancies especially reserved for the disabled; whether blind, orthopaedically handicapped or deaf; the government offices do not employ disabled. The private organizations have stolen a march in employing the handicapped. Out of 150 employed disabled, 90 are employed by Jyoti limited alone, followed by IPCL having 18, GSFC 15, Hindustan Brown Boveri 11 and Gujarat Refinery five.

Among the institutions for blind, the complex at Vastrapur, Ahmedabad is one of the biggest in State (Menon, 1981). It houses a secondary school, a technical school and various workshops for blind. The blind are taught to be self-reliant in day to day activities, play games, gets formal education upto 10th class and are given a course in technical education. It has biggest braille library, an excellent recording studio where lectures are taped on various topics. Another institute only of its kind for blind is found in Jamnagar. It has a multi category workshop. The handicapped workers are given a stipend according to their output (Kantharia, 1981). Other institutions are Blind School at Palanpur; Bhavnagar, Phansa village in Bulsar district, Porbandar, Baroda and Rajkot.

The institutions for deaf-mute are being improved. At present the institute at Mandvi, in Kutch is one of the institutes which caters to the needs of the disabled (Puri,1981). The deaf-mute are given sense training through simple and vibratory touch and lip-reading (Puri,1981). The institute at Bhavnagar provides educational training with modern electronic equipment and operates and underground workshop for vocational training (Trivedi,1981).

Other deaf-mute schools are to be found at Banaskantha, Baroda, Kancholi in Bulsar district, Jamnagar, Rajkot and Surat.

There are very few institutes for orthopaedically handicapped. In Nadiad, under the auspicious of Kaira Development Board, an Apang Manav Rojgar Talim Kendra is being planned to train the disabled in taking up home industries like preparing carpets, cane chairs, incense sticks, chalk sticks, sewing and knitting, leather work, book binding, typing and bidi-making (Barot, 1981).

There are some institutions for academic training of the orthopaedically handicapped at Baroda, Porbandar, Rajkot and Mandvi in Kutch. In Surat, as pointed out by Rao (1981), there are some surgeons who perform reconstructive surgery on partially functioning polio affected limbs and physio-therapy in hospitals run by government, municipal corporation and private specialists. For mentally retarded children there are three main institutions one at Baroda, other at Rajkot and third called 'Ankur' at Bhavnagar.

There are several voluntary organizations which take interest in the rehabilitation of the disabled, to name a few are, Lions Club, Rotary Club, V-one Society and the Society for the Physically Handicapped also, at Baroda.

The future plans reveal that the projects to be undertaken at Palanpur are : a pre-primary school for the deaf, a rural integration programme for the blind, a rehabilitation and orientation mobility training course for blind and the first school in Gujarat for spastic children, that is, those suffering from cerebral palsy (Doshi,1981). In Rajkot plans are underway to

start a clinic for mentally retarded girls. The Vastrapur complex at Ahmedabad is planning to start some more vocational courses at Ahmedabad and the Surat Municipal Corporation is planning to start a workshop and dormitary making artificial limbs.

Review of Related Researches

The researches conducted could be broadly classified into those related to :

I. Problems faced by the disabled and their families in India.

II. Management problems and practices followed by the homemakers in India.

III. Problems and practices of families with disabled person carried out abroad.

Research Studies on Problems of Disabled Person and their Families

The related researches are reviewed as follows :

Disabled Persons and their Problems.

The various problems faced by the disabled persons have been studied by some of the research workers. Efforts were made to estimate the number of disabled persons according to their nature of disability, causes and treatment given to them, their age and sex distribution, extent of dependence, literacy level, employment and marital status. The psycho-social and the economic problems faced by the disabled were also, the aspects of some of the studies. A few attitude studies, especially related to mentally retarded children, were also the point of emphasis of some of the researches.

The method used to select the sample, of most of the survey type researches, was stratified random sampling or purposive sampling from a known population. The data were collected in almost all studies by interview method.

Number, Age and Sex of the Disabled. Information was sought to discover trends in assessment of disabled population, their age and sex distribution. Very few localized studies were found and the findings were varying so that it was difficult to make generalizations.

Causes of Disability. The causes identified were congenital, sickness and accident in the survey conducted in Madras (1963). Saksena (1962) found blindness was mainly due to illness. Blindness (85 percent), deaf and muteness was due to congenital defects (77 percent) and more than half of the orthopaedically handicaps were due to illness and specially polio myelitis found Shivadey (1973). Blindness due to cataract was twice more frequent in rural than in urban areas. The sample survey in Madras revealed that 76 percent were handicapped since birth. Most of the people treated preferred allopathic, non-surgical treatments (84 percent). Shivadey (1973) found most of them started treatment immediately and this was more in case of low income group and illiterate group.

Saksena (1962) found that 91 percent blind had incurable blindness, 60 percent deaf were totally deaf and Gupta (1972) found that majority of the mentally retarded children needed treatment for speech defects, followed by poor understanding, temper tantrums, poor concentration, memory, enuresis, school backwardness, abnormal behaviour and lack of socialization.

Orthopaedically 60 percent had one handicap while 12 percent had two or three handicaps. Gupta (1970) found that among mentally retarded 64 percent suffered from speech defects. Dubey and Khanna (1972) found maximum number of mentally retarded children had Dyslalia (functional articulation disorder). They also found that 50 percent had conductive hearing defect, 30 percent senso-neural hearing loss and 25 percent central hearing loss. The causes of disability reported in most studies were congenital, sickness and accident. In most cases blindness and deafness were attributed to congenital defects while orthopaedic defects to sickness.

Personal Grooming. Vadhyar (1975) found that 98 percent of blind and orthopaedically handicapped adults did not need any help in personal grooming. Bhatt,U.(1963) found that only 19 percent of physically handicapped who were severely disabled needed help in daily routine activities. Aggrawal (1979) found that mentally retarded children also needed help in looking after themselves. Ishtiaq (1977) also reported similar findings. Kanwar (1960) found that the extent of dependence reduced with the increase in age of the physically handicapped children. Gokhale (1977) found that among those who were fitted with artificial limbs needed help in fitting prothesis, braces and also in bathing, dressing and feeding in most cases. It was found that disabled persons needed help in personal grooming although some needed more than the others.

Education. The literacy level was found to be low in the earlier studies. Agnihotri (1955) reported two percent literacy level among blind in Kanpur while Saksena in 1965 found that

61 percent males and 69 percent females were illiterate and found that younger children were better off with regards to education, probably because special schools were started for education of blind. Chopra (1977) also found that handicapped possessed considerably higher level of education than their father, brothers or sisters. Vadhyar (1975) found more male than female students studying in colleges in Bombay. Shivadey(1973) found that majority of the disabled fitted with braces, were studying and used them for minimum five hours in the younger age group. They went to normal schools in majority of cases and only in seven percent of cases they went to special schools. However, it was found that once the appliances became short, as they outgrew the old size fitted at an early age, they did not acquire the new one in exchange.

Bhatt, U (1963) found that 57 percent experienced hardships in continuing studies after disability and that disablement affected their extra curricular activities in 47 percent of cases. Ambani (1976) found that problems of mobility, prolonged medical treatment and negative reactions of the teachers and classmates were the reasons for not studying further. Vadhyar (1975) found that blind and orthopaedically handicapped college students were interested in higher studies for better future and keeping themselves occupied. But only 34 percent wanted to pursue studies after graduation while remaining 66 percent wanted to take up job. Ishtiaq (1977) found that mentally retarded children did not have favourable attitude towards school and teachers found that 76 percent of them were truant or irregular in attending classes. Gandhi and Aggrawal (1969) found that parents felt that mentally retarded child

cannot be benefited by schooling.

The educational status of the disabled improved over the period of years. In some studies they were found to have more education than their father, brothers or sisters. Mentally retarded children however did not have positive attitude towards schooling.

Employment. Majority of the disabled were looked after by their families and the incidence of employment was less among these people said Bhatt,U.(1963). Agnihotri (1955) found only five percent of the blind in Kanpur worked as weavers, book-binders, toy makers, basket makers and a few as music teachers. Among physically handicapped in Madras (1961) it was found that 50 percent males and 54 percent females were unemployed and those employed were engaged in occupations such as domestic servants, coolies and traders. Saksena (1962) found that handicapped were working and 16.4 percent were unpaid workers in family enterprises. More number of blind and deaf-mute were trained than orthopaedically handicapped.

The number of male employed was found to be more than female in a study conducted by Vadhyar (1975). Ambani (1976) found that 50 percent of the respondents were unemployed and the reasons were low education, lack of vocational training, problem of mobility, non-cooperative and unhelpful attitude of employers and co-workers. Chopra (1977) found that orthopaedically handicapped formed 5.4 percent of the universe of the employment exchange register. Shivadey (1973) found among those who are fitted with artificial limbs and of age for employment, only five

percent were unemployed and only 14 percent neither worked nor wanted to work.

With regards to training, it was found that 62 percent had no training while remaining had some training in tailoring, carpentary, cane-work, printing, electrical wiring, painting and telephone operating. Vyas (1979) too felt that vocational training was a must for blind. In a study conducted by Department of Physical Medicine and Rehabilitation Medical College, Trivandrum (1975) it was found that 69 percent of the disabled were unemployed or under employed but satisfied in their jobs. Few people left jobs because of maladjustments and found workshop methods not suitable and felt need for sheltered workshop.

In a study on beggars Chaukar (1976) found that they were willing to work and they resorted to begging because they did not have any job.

Shivadey found that out of 96 respondents who were working 62 were handicapped after they started working and 22 could not work after being disabled. Bhatt, U.(1963) found on the other hand that majority of the employed were thrown out of job on account of disability and 45 percent needed vocational training or placement services.

Among those who were working 73 percent felt their capacity to work was not affected by disability and all except 11 percent were content and happy in their jobs. Shivadey (1973) too reported similar findings, that majority of these employed were satisfied with their work and found the attitude of the co-workers satisfactory.

Vadhyar (1975) found that blind preferred telephone operator's job while orthopaedically handicapped prefered clerical. Chaukar (1975) found that employers were willing to give jobs to the handicapped in their industries and among those who had already employed handicapped found, that although the disabled took a little time to adjust, they were accepted by other workers. They can work regularly on machines and are not usually slow in work.

Samant (1977) reported that none of the companies were ready to employ epileptic persons because they may have to pay heavy compensation if accident occured.

A study undertaken by V-one Society, Baroda (1981) shed light on many aspects of the work and personal life of employed disabled people which would prove to be of use to employers, organizations working for handicapped people, the community and the disabled persons themselves. Interviews of 207 people with help of structured questionaire was done.

Important facts which emerged out of the survey were : Most of the employed disabled people were found to be orthopaedically handicapped. More job openings for persons with other types of disabilities particularly mentally retarded, need to be explored.

According to the opinion of the supervisors, the disabled subjects put up a highly satisfactory job performance and behaviour. Besides this, they were managing on their own and had established excellent safety records. This information needs to be spread amongst the employers in a more concerted manner.

Remuneration earned by self-employed subjects was closer to that earned by employed subjects. In view of this and considering that it may not be possible for all the handicapped persons to find employment in organised sectors of economy some of the disabled people, if found to possess the minimum skills and interests, can be given initial financial and material support to set up self-employment activities.

At present a sizeable number of disabled persons (127) are satisfactorily performing skilled/technical jobs in industries. The employers should therefore feel confident at offering blue collar jobs to the handicapped persons.

Although a lot has already been done by way of vocational rehabilitation of handicapped persons, a lot more needs to be done before the disabled people can take their rightful place in the work force and become self-supporting member of the society. The incidence of unemployment was more in those who were cared for by their families. The number of male employed were more than female. The problem of underemployment was also found but the disabled were satisfied with jobs. Low education, lack of vocational training, problem of mobility and non-cooperative and unhelpful attitude of employers and co-workers were some of the problems. More number of blind and deaf-mute were found to be trained than orthopaedically handicapped.

Marriage. The prospects of marriage of disabled were limited in earlier times; but now with increased opportunity for education, training and employment of disabled the prospects

have improved. Agnihotri (1955) found that only six percent out of 3600 blind in Kanpur were married, in survey of physically handicapped in Madras (1961) it was found that 40 percent males and 69 percent females were married. Bhatt,U.(1963) found that handicap and financial status came in way of marriage of 55 percent of disabled person but among those who were married, 73 percent had happy married life. Vyas (1979) found that majority of the blind were unmarried because of unemployment and physical disability. According to Gandhi and Aggrawal (1969) the people felt that mentally retarded children cannot look after their family. Some felt they made faithful spouse while others considered them loose charactered. The employed disabled had better prospectous of marriage than the unemployed. The marriage of mentally retarded children did not meet with favourable response.

Psycho-Social. The effects of disability are not restricted to physical condition only. They affect the psycho-social aspects of the disabled person's personality too.

Bhatt,U.(1963) found that, the first reaction to the disability was fear panic and anxiety in 70 percent of cases and in the rest feelings of inferiority, shame and guilt. Kanwar (1960) used the case study method to find out emotional implications, of a handicapped child, the manifestations that the child builds up and the degree of success with which he makes use of services offered to him. It was found that the attitudes of the parents towards children changed after they acquired handicap; it was inconsistent, one of rejection rather than acceptance or over protection.

Of the three types of handicapped children studied the orthopaedically handicapped were found to be best adjusted followed by deaf-mute and blind respectively. In large majority of the children the degree of depression and dependence reduced as they grew older. When they were not supported adequately by parents or institutions some became reserved, some talkative, some turned religious and to some music and painting helped. On the whole girls seemed more cheerful in their outlook. Handicap meant more to those who acquired it after birth than those who are born with it.

Gandhi and Aggrawal (1969) report that in the opinion of people mentally retarded people were restless, uncomfortable and unhappy lot and do not have sound mind. Ishtiaq (1977) found that parents of mentally retarded children found them submissive, self-conscious and vagarant. They found their child interested in sitting idle and failing to understand.

Social. The reactions of parents, siblings, friends and society play a major role in socialization of the disabled person. Bhatt, U.(1963) found that majority of the parents accepted the disabled person although some rejected them emotionally or deserted them. Ambani (1976) found that parents showed affection to the child and some even tried to over protect their children. It was found that employed disabled persons had better response from family members. Orthodox attitude of parents and community was responsible for discontinuation of medical treatment in case of blind. Parents of mentally retarded children felt that their child was inferior (Ishtiaq, 1977). With regards to siblings attitude, it was found that the disabled were treated nicely by

them, in a study conducted by Ambani (1976). Ishtiaq (1977) found the attitude of majority of the siblings unfavourable towards mentally retarded children. Vyas (1979) reported that family members, neighbours and friends treated blind people in very good manner. Bhatt,U.(1963) in her study also found that the attitude of friends, neighbours and caste people was positive towards disabled but at the same time she found that more than half of them were not good at making friends. Ambani (1976) found that 30 percent respondents found it difficult to make friends.

Parikh, N.(1973) found that social problems were not very significant when compared with economic and emotional problems. The attitude of teachers was found to be positive in 75 percent of cases by Bhatt,U.(1963), but the majority of classmates treated them as inferior, pitied them or joked about their disability.

Gandhi and Aggrawal (1969) sought opinions of the educated middle class people regarding mentally retarded people. They found that most people felt that the mentally retarded have less energy, poor memory, are unable to progress at school, cannot run a family, cannot lookafter themselves, cannot benefit from schooling, can be useful if trained properly and they should be employed. They felt that retardness was burden on society and some felt they did not have moral sense while other felt that they did have.

Majority of the disabled in the study conducted by Bhatt,U.(1963) were not member of any association for the disabled. Vadhyar (1975) found that there was greater awareness

among males than females regarding welfare organizations.

Financial Problems. Lack of funds at times comes in way of proper treatment and rehabilitation of disabled persons. Agnihotri (1955) and Chauker (1976) found that in very low income groups the children were sent for begging to add to family income and in some cases they were auctioned to others for same purpose. The survey conducted in Madras (1961) revealed that majority of the disabled had household income less than Rs.1500 per year. Saksena (1962) found 21 percent of the handicapped were permanently disabled and were completely dependent on the family financially.

Bhatt,U.(1963) reported that lower financial status came in the way of marriage of disabled persons in more than half of the cases.

Vadhyar (1975) found that about 30 percent of the disabled college students were employed; earning Rs.251 - 500; in order to meet their personal expenditure. It was also found that blind received more exemptions for tution fees and other financial facilities than orthopaedically handicapped. The blind received assistance from Central and State government welfare boards, National Association for the Blind and the Lions Club. Other facilities such as readers and writers also were provided to the blind. Most of the respondents felt that financial assistance was inadequate.

The study conducted by Department of Physical Medicine and Rehabilitation, Trivandrum (1975) revealed that disabled people were economically dependent on parents and siblings in 46 percent of cases, 15 percent were self-supporting, 17 percent on spouse

and 19 percent on children.

Gokhale (1977) found that 64 percent of the respondents did not feel that they were burden on the family while remaining felt that they were economic burden on the family.

Vyas (1975) in his study on blind people found that poverty was the cause in majority of the cases for discontinuation of medical treatment for cure of blindness and it also came in way of their marriage prospects.

The financial problems were the characteristic feature of majority of the families with disabled and most of them had to depend on parents, spouse or siblings for financial help. Lack of funds deprived them of medical treatment and marriage prospects. The financial assistance from social welfare agencies was found to be more for blind people than orthopaedic but it was however not adequate.

Somatopsychological Aspect of Disabilities. Wright,(1960) reported some generalizations based on the researches conducted abroad on the somatopsychological aspect of disability. The generalization in some broad areas are summarized as follows :

1) There is no substantial indication that persons with an impaired physique differ as a group in their general or overall adjustment as well as between types of physical disability and particular personality characteristics.
2) Although personality patterns have not been found consistently to distinguish disability group as a whole, certain behaviour, rather directly connected with the limitations have. For example, the greater

ease with which the able bodied get about as compared with the paraplegic.

3) Although consistent group trends with respect to personality and adjustment have not been found, studies of individuals convincingly indicate that physical disability has a profound effect on the person's life.

4) Public, verbalized attitudes towards persons with disabilities are on the average mildly favourable. An appreciable minority openly express negative attitudes though these are more frequently revealed indirectly.

5) The evidence is rather clear that the attitudes of parents toward their children who have disability tend to the extreme more often than toward their non-disabled children, centering about the following patterns :

> Over solicitude, accomplishments beyond the child's abilities, inconsistent attitude. Over protection appears to occur more frequently than rejection.

6) The attitudes of person themselves also vary. They have little relation to degree of disability in massed data; are related to personality characteristics existing prior to the disability and are influencial in the direction of acceptance via change in the person's value system. (pp 373 - 380)

Thus the review of research study revealed that a lot of studies have been done to identify problems faced by the disabled and their psycho-social, somotopsychological and economic

implications.

Problems Faced by the Families.

Disability of a person is not only his individual concern. His family also suffers with him and faces a number of psychological, social and economic problems. They also face the problem of finding suitable place to provide education, training and employment to the person and get him married and settled in life.

Very few researches have been conducted on assessing the problems faced by the families of disabled only with mentally retarded or non-normal children. The design of these studies was exploratory survey and in couple of cases supplemented with experimental design with aim to develop and test need based programmes to help the parents. Interview and observations were the tools used for data collection.

Parikh, N.(1973) conducted a study of psychological, social and educational problems faced by families with mentally deficient child. She found that psychological problems centered mainly around parent-child relationship. Parents were worried about the future of the child and felt frustrated in life.

Supathanki (1956) also found that the family relationships were affected by having mentally retarded child in the family. Some parents over-protected, some rejected the child and some treated him equally. Majority of parents were grieved on realising that their child was mentally deficient. A few had a feeling of shame, anger or guilt. On realizing the defect, a majority took immediate actions and consulted physicians or psychiatrists.

The result of the study conducted by Parikh, J. (1978) indicated that majority of the parents/guardians expressed their anxiety concerning adjustment problems; care and attention in future life; marriage and employment of the subjects. Parents faced maximum difficulties in providing education, and vocational training for their children. They found medical and psychological treatment for their children very expensive. The parents were however very much interested in understanding the problem, its effect and the measures to be adopted to help the child. Majority of the parents wanted to help the handicapped child in improving manners, academic skills and providing vocational training. They needed guidance to reduce their tensions and anxiety regarding their children.

Results of the study conducted by Lakhani (1975) revealed that inspite of economic backwardness, majority of the families spent money specifically on education and treatment of child. Almost all the parents suffered from many psychological problems due to presence of their child. They faced difficulty in accepting the fact that the child was retarded because most of the parents did not even understand properly what was meant by "mental retardation". Educational backwardness of the mentally retarded children was another severe problem which worried the parents a great deal.

In the study conducted by Yadav (1980), the common needs felt by the parents were identified as follows :

1) Need guidance to increase their strength in terms of controlling their anger, increasing their confidence and developing coping skills to deal with the child.

2) Need for outlet of anxiety, to develop awareness regarding its causes and effects on the child and self.

3) Need help in understanding their daily problems and handling them effectively.

4) Expressed desire for developing good health habits in the child and making him independent in routine tasks.

5) Need understanding regarding nature of handicap, its causes, medical treatment, training and prognosis.

6) Need guidance to perceive special needs of these children by understanding their behaviour.

7) Expressed desire to know what and how much learning can be expected from their child.

8) Want to understand their role in helping the community to understand and accept their child.

9) Showed curiosity to know diagnostic evaluation services, training facilities, rehabilitation centres and employment opportunities for these children in the city of Baroda and other parts of the country.

Based on the above needs assessed, a framework of parent education programme was prepared and implemented. The results revealed that after receiving the programme there was an increase in majority of the parent's understanding regarding themselves and their child. It helped them to accept the handicap of the child, improve skills to help their child and to develop coping skills in them. It also helped them to modify their behaviour in a manner which helped their child. The results revealed that mothers gained more from parent education programme than fathers. The reason for this might be that the mothers had higher motivation to learn than fathers as they have to deal with the child for most of the time and/or it might be that they were

given more intensive programme useful in terms of acceptance of handicap, understanding his limitations and giving play and activity experiences to enhance their learning.

Supathanki (1956) found that the parents looked upon the problem mentally retarded children with different degrees of seriousness depending upon their culture, educational background, the family set up and the child's position in the family. Mental deficiency of the child became a problem to the parents soon after birth, or at the schooling age or when the child did not show social adjustment.

Parikh, N.(1973) also found that the efforts made for the retarded child's treatment by parents were greatly dependent on the education and income of the parents. Social problems were not found to be very significant when compared to edonomic and emotional problems yet they contributed to aggravating the existing situation. The findings revealed that low income and large size of the families were responsible for bringing about economic distress for many families and many times aggravated the situation because mentally retarded child demands more expenditure than other children.

Parents resorted to borrowing every month to overcome their financial difficulties, especially in low income groups. The problems in the families of disabled centered around parent-child relationship. Lack of understanding of the disability on the part of parents and educational backwardness of mentally retarded child were major problems.

The educational programme to train the parents of disabled would prove helpful, revealed one of the studies. The social

problems were found to be less significant than economic and emotional problems. The families in some cases had to borrow money every month to meet financial difficulties.

The factors which influenced parent's attitude were culture, educational background, income, size of the family, the family set up and child's position in the family.

Research Studies on Rehabilitation of Disabled Person.

The objective of some of the researches was to find out the extent of rehabilitation of disabled persons. Some wanted to know the extent of use of artificial limbs by the disabled while others centered around the experimentation of the usefulness of vocational training under controlled circumstances.

The findings of the study conducted by Shivadey (1973) revealed that 78 percent used appliances and those did not use gave the reason that they outgrew them. Eighty-nine percent used them for a minimum of five hours. Nearly 68 percent did not change when they outgrew appliances. Out of 91 percent who changed 63 percent received financial help from social welfare organizations. Help in fitting appliance at home was given by father and mother, 31 percent required help in bathing, 25 percent in dressing and nine percent while eating and the mother helped them.

Gokhale (1977) studied the social and vocational rehabilitation of the orthopaedically handicapped who were fitted with artificial limb at the AIIPMR Bombay. Findings revealed 78 percent used the appliances provided to them while 22 percent did not use them. The reasons quoted were that prothesis/brace became short,

were unsuitable to environmental conditions, parental neglect and poor economic conditions.

Adiseshiah (1972) investigated rehabilitation programme for handicapped people in Madras. A total of 75 persons fitted with artificial limbs were tested for vocational evaluation. More than half the number tested for basic intelligence fell below normal level. The psycho-motor tests and aptitude tests had been accepted by the vocational counseller as a useful indicator of potentiality for vocational training. Vocational counselling had been quite helpful in rehabilitation.

Department of Physical Medicine and Rehabilitation, Medical College, Trivandrum (1975) conducted a research to develop practical methods for the total rehabilitation of orthopaedically handicapped and person with neurological disorders.

Few people who were helped under project to get job in industries left it because of maladjustments. The workshop methods were not suitable to the physically handicapped. This pointed to the necessity to provide for adaptation of equipment in the workshop or have sheltered workshops specially for physically handicapped.

Department of Health, Education and Welfare, Washington, D.C., U.S.A. and the Government of Maharashtra and Bombay Municipal Corporation (1969) planned a study to find out employment problems and opportunities for blind in the industries. It was proved that blind should be encouraged to take sheltered employment because they were reluctant to compete for fear of being laid off. It was found that there were not enough aids, appliances, instruments and machines to be used to train blind in India. Accomodation

posed main problem for blind workers in open industries.

Ramachandra and Pandiarajan (1971) conducted a feasibility survey of training visually handicapped as physiotherapist. It was found that seventy five percent of the treatment can be done by the blind, and 25 percent provided certain preconditions are fulfilled. Sixtyfour percent of exercise treatment can be done by the blind and remaining needed adaptation. Fifty percent of electro-therapy treatment can also be done by blind, but the presence of one sighted person is essential. All aspects of hydrotherapy treatment can be given by the blind but it is not a commonly used treatment.

Chaukar (1976) found that 36 percent started begging after onset of disability and 64 percent because they had no job. Those who did not admit to begging wanted to work and out of those who admitted to begging 69 percent were willing to work.

Need for education and rehabilitation of handicapped was felt. Need to educate the community about the usefulness of the handicapped member was also felt. Those fitted with artificial limbs never bothered to replace them when they outgrew them. The sheltered workshop were preferred more than regular workshops. Special appliances and instruments were needed to train the disabled.

Effects of Disability on Family and Independent Living.

In conclusion one can say that the effect of disability, especially that of the breadearner, on the family is devastating. It affects each family member economically, socially, emotionally and mentally. It threatens their cohesion. Family reactions to

a disability will vary from family to family, depending on various factors such as (i) the meaning of disability to the family, (ii) how the family has dealt with previous crisis, (iii) life style, (iv) its coping resources, (v) the role and status of the disabled member, (vi) the combination, size and responsibilities of the family, (vii) last but not the least socio-cultural orientation. Effects of disability on and reactions of each member including the victim himself are inter-dependent. The family rather than the individual should be considered as a rehabilitation client. Family can be a source of motivation, and it can also induce depression. "Nau (1973) reviewed family rehabilitation programs in which the family in toto, was treated as the rehabilitation client and concluded that family rehabilitation is a viable approach to resolving many different issues associated with severe cases of disability" (Motwani, 1981).

Research Studies on Management

Management means the way families or individuals use the resources available to them to gain maximum satisfaction in achieving their goals and realize their values. To manage well one does not have to know about the elements of management and the steps involved in its process. But the knowledge about the management concepts, problems and practices does help in analyzing one's own quality of management as well as understand how others manage in similar situation or under circumstances which demand a complete re-organization of family's resource pattern such as disability of a family member.

The researches conducted in India, on managerial behaviour of the homemakers from normal families centre around three broad categories, namely, awareness of management concepts, the managerial problems faced by them and practices followed by them under different circumstances, such as rural or urban backgrounds, employed or non-employed homemakers; the type and stage of family cycle, the income level, educational status and so on. There are no studies that directly deal with problems and practices of homemakers with disabled family member. Therefore an attempt is made to review general practices and problems faced by homemakers and some of the factors which affect them for the purpose of understanding how families manage in a given situation.

Research on Management Concepts.

The researches dealing with different aspects of management have been conducted from time to time. The aspect under consideration have been management process, goals and decision making. The results revealed that the families did not recognize the need for training for successful home management (Shakuntala 1960) but needed to be instructed in the area of planning and managerial process (Thomas, S.1966). Later the studies revealed that homemaker were aware of the steps of managerial process to some extent (Saikia, 1979). The low income families made budget but did not keep any records and mental plans were used by all families (Lata Kumari, 1974). Organization techniques were used by homemakers in management of household tasks (Kulkarni, 1975) and verbal medium followed by audio visual medium and/or a combination of both were used for proper communication (Vaish,1976).

The knowledge of and implementation of management process are more crucial to families with disabled than normal families because of the tremendous demand such a situation places on the family's scare resources.

The studies on goals and values reveal that families set specific goals for future of their children and education of child was one of the strongly held values (Thomas, M.1979). The same could be true of families with disabled child as the educational needs, need not be any different from that of normal child. The extent of goal attainment increased with planning found Aggrawal (1979). The families with disabled member have to be very careful in planning the use of their resources in order to achieve the goals for rehabilitation of their disabled family member.

In India the decisions regarding expenditures are made by the male head of family (Puri,1968., Firebaugh and Wellington, 1971). Although the joint pattern of decisions making was prevalent in nuclear families (Narsimha Char, 1977), (Latakumari, 1974) with regards to major expenditures. The wives in nuclear families if they were earning members made more independent decisions (Narsimha Char, 1977., Yamdagni, 1972) than those in joint families. The educated children had their voice in making decisions too found Thomas, M. (1979).

The pattern of decision making concerning families with disabled child should follow similar course. The disability being a major crisis need to be the joint concern of the parents and if the disabled person is afflicted with the handicap later in life he should naturally have say in his treatment, education and training.

The study conducted by Pabha, (1977) on values in relation to decisions revealed that rank ordering of values changed but the values held themselves did not change. Thus the values held by families would not be subjected the change but their ranking may definitely show a different order when they have a disabled person as a family member.

Researches on Management Problems and Practices.

Management problems and practices refer to the problems faced by the homemaker and the practices they follow in allocation of resources available to the family in a manner which satisfies the family goals. A number of researches studies have been conducted to identify problems faced and practices followed in utilization of resources by the homemakers. The two most widely explored areas are money management and time management.

The lack of funds is experienced by majority of the families for various purposes and they try to meet this situation by diverting resources to meet most important needs of the family, improve their income, borrow money to tide over crisis or save money to meet future needs. Economic pressures lead women to seek employment (Mukherjee, 1965). Spending money cautiously and planning future expenditure were of concern in low income families (Desai,1965., Shakuntala, 1966). Food of course was found to be the major item of expenditure (Desai,1965., Rajeswari, 1968., Saikia, 1979). The educational expenses in rural families were lower than clothing expenses (Rajeswari, 1968) but in the urban families the educational expenses were found to be more than that of on clothing (Saikia, 1979). The normal families

spent about two percent on health of the family. It would be interesting to know how the expenditure pattern of families with disabled differed from that of normal families.

The need for saving was felt by majority of the families and they did set aside some portion of their income for some or the other purposes (Desai,1965., Dhingra, 1967., Saikia, 1979., Thomas, M.1979). The common purposes for which they saved were, higher education of children, future emergencies, marriage, oldage and financial security (Dhingra,1967., Saikia,1979). The families with disabled have an additional motive of planning financial security of their disabled person who may or may not be able to support himself/herself on his/her own effort. The family's savings help in meeting the unexpected and emergency expenditure on immediate treatment, care and rehabilitation of disabled family member.

The forms of saving commonly used by the families are compulsory deposits, insurance, provident fund, post office saving account and cash (Dhingra, 1967., Thomas,M. 1979). Economic handling of resources was practiced by all families and middle income group did more long term planning (Aggrawal, 1979). Families with disabled need to follow this practice more religiously than normal families as the costs of rehabilitation of the disabled person have to be met over and above normal household expenses.

The demands on the time of homemakers becomes a problem in some families. The problem aggravates if homemaker is working (Saraswathi, 1962; Remabhai, 1963) does not have help

from either family members or from hired person, and had no time and labour saving devices (Kurien, 1965; Adaviyappa,1976; Saikia,1979). The homemakers who had young children to care for also faced time problems (Harode, 1964). Age and education of homemaker and income of the family were some other factors influencing time management (Kurien, 1965). The homemaker with disabled family member would also face extra demands on her time and would need help of other family members, labour saving devices and hired help to solve her problems.

The amount of leisure time available also depends on age of homemaker, her employment status, presence of children in family, amount of help received and use of labour saving equipment (Leelavati,1965; Ranawat,1972; Nimkar and Jategaonkar, 1978; Saikia, 1979). To this list of factors one can add the extent of time demanded by the disabled family member. The leisure time is the most likely time used to meet the extra time demands of homemakers. The moment the demands increase the first cut is made on leisure time because the time spent in homemaking activities would not reduce considerably without external help and a minimum of sleep and rest are must for a hardworking housewife.

The homemaker is however the main person who carries out household activities but she needs help of other family members too in some of the activities because the amount of time and energy she has are limited (Prafullakumari, 1963). When a homemaker had additional responsibility of working outside the home or special care of a disabled or an old invalid person in the family; the demands on her time and energy increase to some

extent. She has to seek help of other family members or hire help to ease her burden. Some researches studies have been conducted to review this aspect of management too.

The adolescent or adult daughter in the family is the person next to homemaker who is involved in homemaking activities (Prafullakumari, 1963; Thomas, S. 1966). The family type, size, income, occupation of mother, ordinal position of girls and time available influenced the participation while paid help did not (Thomas, S., 1964).

In some of the activities husband also help and the employment status of wife, size of family, socio-economic status, amount of hired help available and the amount of time available to them affected their participation (Bhandari, 1974).

The participation of other family members both in care of the disabled family member and/or in the household activities would be of great help to the homemaker with disabled family member. The presence of grown up daughter would definitely help and the interest and help from husband would reduce the pressure on her time.

Housing conditions also play an important role in the health of the family member and may reduce or aggravate the chances of disability through disease. Poor housing conditions increased the incidence of illness in slum dweller (Sethna, 1967) and in low income groups (Qureshi, 1968). Problems faced by homemakers increase with badly planned kitchens (Kurien, 1965).

None of the researches however described the difficulties which a disabled person feels with regards to space, structural features, planning of the bathrooms, and bed rooms as well as

adequate lighting for the disabled.

Rehabilitation of Homemaker in Household Task.

The disabled homemaker needs rehabilitative services to adjust herself in carrying out the household tasks. The investigator came across only one such study in India, although a lot has been done in other countries to help disabled homemaker.

Chhabria (1974) made an attempt to study the adjustment of disabled women in their home task. All women rehabilitated at the All India Institute of Physical Medicine and Rehabilitators were interviewed. Of 35 women thus interviewed 11 were below 20-25 years of age. The findings revealed that the handicapped women could be easily rehabilitated with electrical equipments, but these were out of reach of most of the patients. Another very interesting finding was that handicapped women were adjusted mainly because of the other women in joint family who helped them. Rehabilitation programme at the institute had helped the respondents in gaining independence and confidence to some extent.

Researches Abroad.

The researches conducted abroad deal with the problem of disabled with greater specificity and a brief review is reported on the following pages.

The health of the family member is important in home management. When the health of even one of the family members is affected due to extended illness or disability it puts constraints on the financial resources and also affects the

operation of the households. Disabled face a lot of problems in independent living and the families have to make a lot of adjustments.

Effect on Financial Management.

In a study carried out by U.S. Department of Health Education and Welfare (1971) it was found that families who have members with illness or chronic conditions often experience a strain on financial resources. The economic impact of illness on family is related both to the family's earning ability and to its demands on income. In 1963, more than two fifths of the household units with a disabled member had income under $ 3000.

Duff and Hollinghead (1975) reported that families with a member hospitalized in semi-private and ward accomodations had more severe economic hardships than those with patients in private rooms. The medium income of the families with a member in a private room was twice that of families with patients in semi-private accomodation.

The way the Saxon family met the expenses (1975) were that the son got a part-time job, and the 12 year old daughter did most of the household chores because Mrs. Saxon had a series of illness and was hospitalized for extended period.

Effects on Operation of Household. Plott (1973) in the study conducted on time spent in homemaking by families with handicapped and non-handicapped members found that, presence of a handicapped person increases total time given to household tasks. If the handicapped person required physical care and/or special bed and personal linen the additional time may be upto

six hours per day.

Manning (1975), in another such study found that with the homemaker disabled, a total of 3.7 hours more was spent on household tasks than if she was not. The homemakers themselves spent 2.7 hours less but received 6.7 hours more help. They spent less time in physical care of others or in financial management than did well homemakers.

Schawb (1973), estimated that nearly 12 percent of the homemakers in U.S. have a physical disability which interferes with their performance of the household tasks..

They have physical handicaps which are hidden, as in case of heart disease or tuberculosis, or visible, as in case of paralysis, amputation and similar disability. The principles of work simplications are the same for the handicapped, as well persons, but their need is greater. Special attention must be paid to adapting the household environment to their limitations, or to special ways in which they must use their bodies.

Three barriers encountered by the woman in her home can at least partially be overcome by work simplications. Limitations in the functioning of her body, physical obstacles in her environment and change of standards for household procedures and products.

The potential effect of a chronic disease or disability on operation of household is the manner in which the input to the managerial system can differ from other households. A study by Crain (1975), and others on effects of a diabetic child on Marital Integration and Related Measures of Family functioning revealed that parents of diabetic child have lower goal agreement and greater parental role tension than parents of non diabetic children.

Deacon and Firebaugh (1975) state that, less agreement between the parents on the goals that enter the managerial system can increase the difficulty of managing a home in a manner consistent with the family goals.

Rolthschild (1975) pointed out, another effect that appears to be both task and role related in the differences among families in their acceptance of a disabled person into the family and the rehabilitation of that person. The acceptance of a disabled person into the family, varies too, among disabled persons. Acceptance of disability of a mother is often easier than of a disabled father since her role and the tasks involve the home, and remaining at home is more compatible with social expectations. Men who can no longer fill the role of main wage earner often have a more difficult time in rehabilitative efforts.

Deacon, Maloch and Bradwell (1975) found that children in particular give help to chronically ill or disabled mothers. They found that almost no physical or structural changes were made to accomodate the ill or disabled mother. Compared to 'normal' families decision-making patterns differ little in families with a chronically ill or disabled mother.

Deacon and Firebaugh (1975) in another study on components of Home Management in relation to selected variables found that middle income families with children under 18 years of age, the health of the homemaker contributed to differences in home management. For a household task, homemakers with poorer health were less realistic in their standards and sequences of tasks were less flexible and the standards were more complex (involved more persons and tasks) than those of homemakers with better health.

Stresses related to role may occur with disability. In a study conducted by Ludwig and Collette (1975), it was found that disabled husbands dependent on wives for personal care were less involved in making decisions - such as those involved in car repairs, or car purchase or computation of income tax - than were husbands who were disabled but not dependent for personal care.

The concept of rehabilitation for the homemaker has been enlarged to include the reclaiming of the whole person as pointed out by Whitten (1969). It is now also centered upon the family said Fisher (1969).

May, E.E. (1969) feels that performing household skills may be used as therapy. Performing them also has immediate value in enabling handicapped homemakers to carry on the long-time value in making it possible for orthopaedically and otherwise handicapped children to live independent lives in their own homes.

From the begining of the rehabilitation movement, the American Heart Association has had a place in it. The U.S. Vocational Rehabilitation Services Administration (1973) recognized homemaking as an occupation and this provided rehabilitation services to enable the handicapped homemaker to perform household activities. Work simplication of the household task has been a fundamental part of this aspect of rehabilitation.

The school of Home Economics at University of Nebraska developed a mobile coach, "Homemaking unlimited" as a means of taking rehabilitation instruction out into state. It shows specific ways in which to overcome the various barriers to performance of household tasks (1967).

A longnitudinal study for approximately three months on one case was done by Bryce (1967), for the purpose of the Rehabilitation of the homemaker. The subject selected was disabled, unemployed and living with her mother in a large old fashioned city house. She was 32 years of age and had no rehabilitation programme for past 13 years.

Procedure followed was related to, physical findings, medical history, evaluation of physical therapist and coordination tests, history of case i.e. when the defect started and reason, evaluation of physical function, testing programme in which the subject was encouraged to carry out various household activities with equipment in the house and some provided by investigator for experimentation and daily record was made soon after teaching and testing session about subject's self-evaluation.

The psychological evaluation was carried out with the help of subject's self-evaluation - daily record of mood, energy and any extra or unusual activity in which she engaged. Mother's evaluation of subject - regarding mood, energy and extra or unusual activity. The other observers - three close friends were requested to evaluate.

No demonstrable result took place in either muscle strength or co-ordination - although there was some functional improvement. Daily record showed improvement in physical function. All observers agreed that the greatest barrier to independent living was psychological rather than physical.

The study by Oyer and Paolucci (1970) was designed to answer basic questions regarding the relationships of homemakers hearing losses to selected aspects of family integration; goal concensus,

marital tension, rejection of homemaking role, power in decision making, family task performances and management of children's behaviour.

A sample of 30 families with homemakers who had hearing losses were compared with 30 families with homemakers who had normal hearing. A non-probability purposive sample was selected to conform to the following criteria : Intact family, presence in the home of a child of 18 years or younger, no person other than the immediate family residing within the home and agreement of husbands and wives to participate in the study.

Audiograms were obtained for determining hearing threshold of hard of hearing homemakers. The homemakers with hearing loss were divided into further two groups according to severity of hearing losses. Group one with severe hearing losses, group two with lesser hearing loss.

Aspects of homemaker's roles as wife, mother and housekeeper were examined. Interviews were held in the houses of the families. Couples were first asked to supply demographic data needed for matching groups and factors related to hearing loss and each husband and wife was asked to complete the data collection instruments.

Each subjects were asked to complete following data collection instruments :

1) Western Reserve University Goal concensus scale, which measured couples agreement on family goals.

2) Marital conflict scale which measured marital conflict and tension.

3) Rejection of the homemaking role scale which measured homemaker's dissatisfaction with homemaking role.

4) Task performance instrument which measured family members participation in family tasks or activities as well as members decision making power.

5) Parental acceptance scale which measured parental acceptance of certain behaviour of children.

Data were analyzed by non-parametric differences tests and within the confines of the study, following conclusions were drawn.

1) Goal concensus between groups of families did not differ significantly. Homemakers with hearing losses attributed greater importance to family goal that designed the home as a place where family members feel they belong. Normal hearing homemakers attributed greater importance as a place for entertainment of friends.

2) Father's marital tension or conflict increased with the severity of mother's hearing losses.

3) Mother's rejection of homemaking role did not differ between groups.

4) Although mother's power in decision-making did not differ significantly between groups, there was a tendency for hard of hearing mothers to have more decision making power.

5) Hard-of hearing mothers received significantly more help from other family members in performance of family tasks.

6) Family groups did not differ as to their agreement on the management of children's behaviour.

The research project undertaken by Hewett and Newsons (1970) was designed to do three things. One to discover what practical problems face mothers who bring up handicapped children in their own homes, secondly to find out from the mothers themselves how well the various social services which are intended to help them and their children work in practice, and finally to attempt an objective comparison between the family lives of normal children

and handicapped children. The method used was descriptive survey method. Interview schedule was used as a guide for collecting information.

A total of 180 interviews were included in the final study. It was not randomly drawn sample from known population because there might be other children who were not registered with the society. Using handicap score as guide it was found that there were equal number of very mildly handicapped and very severely handicapped children in sample.

Sixtyone percent of mothers had no complaints about housing conditions. The remaining found awkward stairs, bathroom too cold and too small, toilets being upstairs, outside and not flush, dampness; awkward steps, sloping yard, narrow doorways. Only five out of seventy found it to be totally unsuitable. Twentyfive fathers had either made alterations to their home themselves or had them done privately. Many of them were minor such as putting hand rails where necessary, making barricades for staircases and putting up extra fences in the garden. Two had added rooms on the ground floor. Five had put in toilets or bathroom downstairs. In five instances help was given by local authority for alterations in home. One fourth of children presented management problem of not being able to sit without support. Thirtysix mothers had found difficulty in lifting and carrying heavy children and was their greatest problem.

Almost half of the sample had no special equipment for children. Out of the 96 who had equipment, 50 had no difficulty and 46 had some problems - wheelchairs, Amesbury chair (for indoor use chairs to fit needs of individual children taking into account different needs for support and control) large size prams moved

on wheels, titled back walking aids.

Other gadgets and modification to ordinary household equipment to ease the problems faced by mothers were also found. Several fathers had modified spoons and forks. Help of other children were also sought. To get proper sleep mother tried to keep child awake, till all went to bed and used various ways to soothe or amuse child to sleep. The extra cost of special foods was sometimes mentioned as a problem - more often the problem was extra time taken by children to eat.

The problems which mother found most difficult to cope were carrying and lifting 20 percent, in continence, four percent, feeding 12 percent, communicating with child nine percent and only three percent difficulties related to mental handicap. Several mothers stressed child's total helplessness and dependence.

About half of the sample considered themselves in good health. They felt depressed because they had no relief from the handicapped child's care. Day centres for all children would help. These working out found that it improved their morale as they were not constantly reminded of their trouble. Fortyone percent accepted outside help. Mothers of highly handicapped felt no need for relief and help. In case of emergency, majority of them were cared by father or relatives. Help of institutions was also sought. Seven percent wanted financial help but extra expenses were mentioned for shoes, clothes, napkins, special foods, travelling expenses, buying pushchairs etc.

Thirty-three percent mothers felt other children were jealous of disabled person. Resentments towards extra attention was not problem but sibling found it irksome if certain restrictions were placed on them or distrubance caused by the handicapped child.

Temper tantrum became a problem sometimes. Father found it difficult to overcome the grief of having handicapped child. There was high degree of agreement between parents of the handicapped children on the question of strict enforcement of discipline. Fathers were sharing task of bringing up the handicapped child.

Twentyone percent of the mothers felt a sense of isolation but they were not very much out of touch from all social contacts. The mothers received support and comfort from friends and relatives. Maternal grandmother were tower of strength for their daughters. More than seventy percent of the mothers said they welcomed interest of people other than friends and relatives. Genuine, sensible and non-advisory approaches are likely to be welcomed. They were only too anxious to have their children accepted as members of the community.

There was no evidence to suggest the presence of a handicapped child radically altered normal patterns of joint activity for the parents as 59 percent went out, the parents did not leave children because they were in doubt about the competence of baby - sitters. Some felt it was good to leave child so he does not became dependent on them.

The problem of company for their children was difficult to solve if the family was small and child was not going to day-care centre. Out of 125 children of school going age, 26 did not go, 19 attended for one or two days. Sixtytwo percent had no nursery day-care centres. Twentysix percent attended ordinary schools. Only 10 percent were waiting to put child in residential school. The existence of waiting list indicated that the residential care was not adequate to meet demands.

Three kinds of decision which seemed to arise from presence of handicapped were; whether to have more children, find other treatment, if present one is inadequate and the future of child as he grows. Fifty percent felt their feeling of having more children were not changed. Eighty percent did not use private treatment. Majority of mothers were realistic only two out of 180 gave unrealistic reply. Fiftyfour percent faced each day as it came, 10 percent tried not to look ahead but wondering about future.

The individuality of the problems seemed to be stressed by mothers, they felt, they had unique problems. Mothers in the sample came to gradual realization that something was wrong with their babies. Once they accepted the fact, they could adjust to expectations of child and his handling, to suit the disability.

There is evidence that no specific kind of handicap brings unique problems to the family. Far more difficulties are shared by all families with handicapped child. The problems have more similarities with those with normal child than differences.

It does not mean that there were no problems dependent upon handicap. Their existence is undeniable. The struggle to lead the kind of life desirable and normal entailed varying degree of effort. Some had little difficulty, other had to summon all of their physical and emotional resources to meet the challenge and in some circumstances or ill-health of the parents threaten the well being of the family members. The stresses of having handicapped child increased their problems.

One of the mothers said, "you naturally wish they were normal", which expresses precisely the first and final dilemma of the mother of the disabled child - the acceptance of the unacceptable.

Housing for the Disabled.

We are all influenced by our environments. In fact, our immediate surroundings have a great deal to do with our everyday comfort, our security and our sense of well being. For persons who are handicapped, restrictive housing environments may seriously limit total life space.

The result may be withdrawl from active participation in what more able bodied persons consider routine daily activities. How easy it is to see why the handicapped may suffer daily losses to their sense of self-worth. Following are some suggestions for housing adaptations that would go a long way, we think, to improve the daily lives of countless numbers of persons. Agan, et. al(1977) offered various suggestions for planning houses suitable to the needs of the disabled.

Entrances.

For persons with limited mobility, single-story or ground floor residences are most desirable. Where inclines are necessary, at least one should be ramped - with no steeper than a 30 centimeter rise for every 3.6 meters of ramp length (one foot for every four yards). Handrails should be mounted at a height of approximately 80 centimeters (about 32 inches) on at least one side of the ramp; and there should be an open space adjacent to the door that is at least 1.1/2 square meters wide (approximately 5 square feet).

General Structural Features.

Doors should be carefully designed for disabled persons, who often lack strength, grasp, coordination, or visual acuity. Doorways and trafficed areas should be at least 90 centimeters

wide (three feet) and uncluttered; doors should be relatively light weight. Doorknobs must be reachable by persons confined to wheelchairs; knobs or levers at approximately 90 centimeters (36 inches) from the floor will enable such persons to work them with comparative ease. Knurled knobs or door handles can be used to warn persons with visual impairments of steps or other potentially dangerous areas.

Raised thresholds constitute a hazard, both to persons in wheelchairs and to the ambulant disabled, who risk tripping over the raised area. If the threshold must be raised (to provide a watertight closing, for example), it should be raised no more than one centimeter (one-half inch) and should be made of a material that depresses under pressure. Painting the raised threshold in a contrasting color may lessen the potential for accidents.

Floors should be covered in nonslip yet easy-to-manoeuvre surfaces. Floor coverings, however, will probably have to vary for persons with different disabilities. For the visually impaired, floor surfaces should be sufficiently hard to create an echo, but persons with hearing impairments may prefer that flooring muffle extraneous sounds.

Walls should be smooth (to prevent abrasion). Unnecessary projections and unusual angles create hazards for the disabled and should be avoided wherever possible.

Kitchens.

Storage facilities in the kitchens of homes designed for handicapped or elderly persons should allow easy retrieval of items. Shelves should be placed at heights reachable by those

in wheelchairs; to avoid hazards, cabinets should not be installed over appliances.

Open storage shelves, revolving and pull-out shelves, pegboards, and magnetic catches are other features that may allow ease of access to needed items. Persons with visual impairments will benefit by having a generous amount of storage space so that similar items can easily be stored together, without crowding.

Kitchen counters should be low and have recess that permit persons confined to wheelchairs to work comfortably. Pull out boards will work when it is not possible to lower an entire counter. Sinks should also be placed so that they accommodate persons in wheelchairs; garbage disposals - where possible - will be valuable, especially in cold thermostatic regulators may help paraplegics who are often insensitive to temperature changes.

Appliances - dishwashers, washers, dryers, and ovens - in general should be front-opening. All controls should be reachable and easily manipulated. For persons with visual handicaps, control knobs should be identifiable by touch.

Bathrooms.

One of the first requirements for bathrooms designed to meet the needs of the elderly and handicapped is that they be larger than is customarily the case in new homes - large enough to allow manoeuverability with a wheelchair or walker.

Grab bars, should be positioned near tub, shower, sink, and toilet. These handrails should have a nonskid surface and be capable of supporting 113 to 137 kilograms (approximately 250-300 pounds).

Transfer to a bathtub is often difficult and hazardous for the handicapped; showers are less dangerous. In either case, a seat is an important safety device. Nonslip floors, in both bathtubs and showers, and easily accessible soap dishes are essential for the comfort and safety of the user. The shower floor should be flush with the floor outside, with a slight slope toward the drain.

Toilet seats are often lower than wheelchair seats, creating transfer problems. A wall hung toilet placed between 45 and 50 centimeters (18-20 inches) from the floor would help correct this problem.

Other fixtures - mirrors, towel racks, cabinets, and so forth - should be low enough to permit comfortable use by persons with limited mobility.

Additional suggestions that would be of immense value in bathrooms designed to meet the needs of elderly and handicapped persons are call or "help" buttons, nonscald controls on mixing faucets, warm air dryers, counters on either side of the lavatory for care of dentures and medications, and sinks positioned for ease of access.

Bedrooms.

As is the case for bathrooms, bedrooms should be large enough to permit elderly and handicapped persons to move about with ease. When possible, in fact, there should be space enough for minor nursing care. And bedrooms in close proximity to bathrooms are essential.

Mattresses should be level with wheelchair seat height for

ease of transfer. Telephones, light switches, and alarm units should be located near the head of the bed.

Closets with sliding or swing-out doors and at least one rod no higher than 120 centimeters (4 feet) will be more easily used by handicapped persons, and dressing tables with recesses wide enough to accommodate wheelchairs are a great help.

Lighting.

Light switches should be 90 centimeters (three feet) from the floor; outlets should be 45 to 60 centimeters (18-24 inches) high. In bedrooms and bathrooms, two or three-way light switches eliminate the need to cross darkened areas of a room. And lights must be placed near bed, bath, and medicine cabinet. For persons with impairments to their hands, rocker-type light switches are especially advantageous. Pull-down fixures and large windowed areas may be added conveniences.

Clothing for the Disabled.

Clothing is one element in everyday living many people take for granted. But for a person with physical disability, putting on clothing may be an impossible, or at best, a very frustrating experience. Unsuitable clothing can restrict movement, produce discomfort, make the wearer feel unattractive and thus influence the wearer's self-image and morale (Phipps,1977).

The major problems related to clothing for disabled are centred around :

a) Clothes that are not fitting their body size and shape.

b) Materials and construction of clothes which can withstand abrassion from mechanical aids.

c) Large enough in size to allow free movement for person in wheel chair.

d) Openings which can be easy to reach and operate.

e) Attractive fashion.

A dress easy to put on and take off makes it possible to dress or be dressed within a reasonable length of time and minimised the strain of dressing(Phipps, 1977). Some of the functional features of the dresses should thus be as follows:

Neck Lines. Too close or too deep necklines are not suitable. The 'V' neck and round neck are suitable for individuals who are unable to reach at closures next to neck. Collar styles too close to neck should be avoided such as polo neck, Chinese collar, and ruffles.

Sleeve Patterns. Kimono sleeves, raglan sleeves, short sleeves with deep armsye, puff sleeves can be used but sleeveless dress, fitted and full length sleeves should be avoided.

Closures. Full-length or 3/4th length openings should be used.

Fastners. Fastners could be just a belt, buttons larger than usual sizes, zipper and velcro fastners.

Skirt. Fullness in skirt, wrap around skirts and pleated skirts are suitable for physically handicapped. Elasticized waist and length below knee should be made.

A review of related researches thus revealed that a lot has been done to identify the problems of the disabled people in India and abroad. The practices which the families follow in meeting the situation was however not explored in India but a few studies abroad deal with how families handled the situation. Hence the present study is probably the first attempt in assessing the management problems faced by the families with disabled member and the practices they follow in solving them.