THE SOCIAL AND EMOTIONAL ADJUSTMENT OF PHYSICALLY DISABLED LUSAKA PRIMARY SCHOOL CHILDREN

BY

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ABSTRACT

The social and emotional adjustment of physically disabled, Lusaka primary school children was compared with the adjustment of their non-disabled counterparts. The main purpose of the study was to see if the disabled sample manifested significantly more rejection, over-protection and a lower mental health status than their non-disabled counterparts.

Three instruments were used to try and detect these differences between the two groups of children. They were the Parental Acceptance Rejection Questionnaire and the Personality Assessment Questionnaire, both devised by Rohner and his associates for their "Parental Acceptance - Rejection Theory -"PART ", and the "Over-Protection" Questionnaire devised by myself.

The findings, contrary to much of the literature on the disabled, revealed no significant differences between the two groups in terms of rejection, over-protection or mental health status. The only significant difference was in negative self-esteem (a scale of the Personality Assessment Questionnaire), with the disabled sample manifesting significantly lower self-esteems than their non-disabled counterparts. The results thus revealed an overall positive picture of social and emotional adjustment for the disabled sample concerned, contrary to much of the existing literature on the disabled.

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CHAPTER 1

THEORETICAL INTRODUCTION AND DEVELOPMENT OF HYPOTHESES

Rationale.

In this study I decided to concern myself with some specific social and emotional aspects of physically disabled primary school children in Lusaka, since it has been the Zambian Government's desire through the Ministry of Education to encourage their full participation in the field of Education. This goal is manifest in the Ministry's "Statement on Educational Reform", (1976) which states that "whenever possible, handicapped citizens will enrol in the same educational institutions and follow the same programmes as others". We see from previous research that it is indeed advantageous to integrate the physically disabled with the able-bodied from as early on as the pre-school level upwards. (Weinberg, 1978; Fox, 1976; Vogel, 1974; Kushman, 1976; Thomas 1978 and Phiri, (Zambia) 1979).

With the ever increasing integration of disabled children into mainstream schools in our country, it seems increasingly important that we have a better understanding of their social and emotional adjustment to both their and our advantages, whether we be parents, teachers, siblings or whatever our relationships to them may be.

It was with this aim in view that I decided to look at the social and emotional adjustment of physically disabled, Lusaka primary school children in terms of parental acceptance - rejection along with seven personality dispositions that are thought to be an expectable outcome of parental aggression or neglect everywhere (Rohner, 1980 p.2), as well as in terms of parental over-protection.

My decision to look at rejection and overprotection in particular was strengthened after I had reviewed the literature available on the social and emotional or "psychological" adjustment of the disabled. As Thomas (1978 p.100) points out, these two extreme attitudes are among the distinguishing features of the culture of handicap.

An introduction of the instruments I used to look at rejection and overprotection and the theory from which they have emerged will follow my literature review which deals mainly with the social psychology of childhood disability, and how the concepts of rejection and over - protection fit into this context.

Literature Review.

Defining disability and handicap.

A disability is the lack or loss of a function or a capacity. As Thomas (1978 p.4) states, "in a sence it is an objective limitation imposed by disease or accident (of life or birth)." He further notes that the term "handicap" is sometimes synonymous with disability but that the former has certain psychological overtones. Whether a disability becomes a handicap depends on its nature and severity, its prognosis and favourable reaction to treatment, the extent to which it interferes with everyday life, and the attitudes of other people to it. The extent to which a disability is a handicap also depends on the personal meaning the loss of function has for an individual.

We therefore see that while the distinction between disability and handicap is noteworthy, in practice the terms have become interchangeable and will be used in this way throughout this paper.

Social psychology and disability.

As we know, the disabled population is wide in age range, and in the severity, causes and kinds of disability. From a social psychological perspective, the precise medical category of disability is not particularly relevant, except where it tends to carry a particular social stigma with it.

According to Thomas (1978) "severity" of disability is a far more useful approach for this perspective as it indicates the likely degree to which the disabled person will be able to cope with the problems of everyday living, and we see in fact that this approach is there throughout the literature on rehabilitation.

Because we are concerned with the disabled in a social context in this paper, a useful categorisation of disability-handicap is that of Thomas (1978, p.5) which distinguishes five psychosocial categories:

1. This category is based on the degree to which the disability prevades the perceptual field. It is highly visible and provides early information which acts as an anticipatory signal to others. These signals convey cues about the social identity of the disabled person.
2. In this category the dominant theme is difficulty in effective interpersonal communication. Distant cues may be absent or minimal but problems of reception or expression occur early in any social encounter; deafness and speech impediments are typical examples.
3. Here the person appears normal both from a distance and during social encounters. His disability is episodic or phasic as with asthma, epilepsy, haemophilia and maladjustment.
4. This category relates to the connotation carried by the label: the disability is associated with social stigma, as in severe retardation and educational subnormality.
5. A combination of the above - for example Down's Syndrome (mongolism) with its physical aspect and its social stigma.

The categories can be used as discrete entities but also as dimensions, so that category (1) visible handicaps, may be considered as a range or continuum from highly visible to almost undetectable and so forth. Thomas (1978) notes that if recent research into childhood handicaps is a guide, then most of disabled persons cannot be adequately embraced by just one of these categories.

The categories are derived from observations of disabled persons' reception in society and of attitudes towards them. We know from the work of Cook (1971) and Argyle (1975) that the process of forming impressions of others is a complicated affair involving static elements - the face in repose, physique, voice, clothes, hairstyle etc. - and dynamic aspects such as orientation, distance, posture, gesture, body movement, facial expression, gaze direction, tone of voice, rate and fluency of speech.

We see that physique and appearance are important criteria in impressionistic social classification. Adams and Cohen (1974) have shown that teachers are influenced by their pupils' appearance, though only for a short while, after which other characteristics such as learning and behaviour become more important. Nevertheless, physique and appearance are not unimportant in the forming of impressions and we learn (and so must the visibly handicapped), the specific positive and negative cultural values attached to variations in physique and appearance. These values are not simply applied to others but also by the self to the self. Their acquisition is a long process begun in childhood, continued through a host of social encounters and powerfully reinforced by the medias' projection of what is beautiful and desirable and what is not. Often we see the attribution of other personal qualities and characteristics which follow the value direction of the physical variation.

How we come to attach visual, social and moral meanings to physical variations is a process not clearly understood, but chance meetings with the disabled vividly illustrate for each of us the lesson we unconsciously learned in childhood; that the disability or disfigurement seems to dominate the perceptual field for both participants, so that what is central is the disability and not the disabled person. (Thomas, 1978 p.7). An additional hinderance to smooth interaction will be the experience of the one and the unexperience of the other. The normal person's limited experience with the handicapped may make him uncertain and insecure, while the disabled person, from previous experiences, may expect the situation to be strained.

As we probally all know, disability can mean different things to different people, evoking a sympathetic response in some, a negative hostile reaction in others, while others again may wish simply to avoid such an encounter. Consequently, in terms of social psychology, we see that initial encounters between the disabled and others do not start from a neutral point, but the disabled person has to deal with definitions of himself and his disability previously and independently conceived by others.

The above points along with Thomas' categories illustrate some of the psycho-social dimensions of the problem of the disabled person as a social being. As Meyerson (1955) p.12) has put it, disability is not an "objective thing in a person but a social value judgement" or as Thomas (1978 p.9) says, "disability may be evaluated objectively, in the sense that constraints on mobility, manipulatory skills, hearing, etc., can be quantified, but that the handicapping nature of the disability cannot be so accurately assessed". The handicap is both a social value judgement as well as a personal one, the latter being powerfully affected by the attitudes of, and interaction with others, but not totally conditioned by them. As Thomas (1978) adds, any loss of physical function is likely to be viewed negatively with the negative values deriving from three sources: the nature of the disability, negative values imposed by the self, and negative ones imposed by the society.

We see that other people's attitudes to disability are the social and psychological "matrix" in which the disabled live. It is fundamental to their socialisation and is influential both in their interpersonal behaviour and in the more organized ways in which society provides for them. It includes the everyday sanction imposed by normals; differing socio-personal distances in interactions, and the laws and institutions through which public attitudes are conveyed. These all create a climate in which the disabled "see how they are seen". (Thomas '78 p.11).

General attitudes to disability.

In realising the importance of attitudes, we see that the social psychological approach suggests that the behaviour, self-image and socialization of the disabled are conditioned by society's attitudes and the values that underpin them.

Some writers (Berreman, 1954; Tenny, 1953) have suggested that the prevailing social attitudes to disablement have led to the creation for the disabled of a social status somewhat like that given to ethnic minority groups. Both have a status subordinate to majority interests and suffer restrictions on entry into certain roles. Both appear to experience difficulties in employment and education. However, the disabled person is not usually a member of a group. He is often isolated and must meet the privations of his low status without the morale of group membership. And while belonging to an ethnic minority group allows a person to attribute his low status to the oppressive attitude of the dominant majority, the disabled are more likely to put their equivalent status down to personal inadequacy.

Thomas (1978) finds likening the social status of the disabled to that of adolescents making the transition from childhood to adulthood, more accurate. He maintains that adolescents' status is marginal between the two - and the disabled are similarly marginal people as they occupy a position along the contimum from physically capable to physically helpless. The sence of marginality is intensified by the indefinite boundary between physical normality and physical disability, and the characteristic psychological state that results is anxiety and insecurity. For the adolescent the pressing question is: "Shall I be expected to behave as an adult or a child?" For the disabled the equivalent question is: "Which part of me is to be emphasized, the disabled or the non-disabled aspect?"

The difference between them is that the marginality for the adolescent is temporary, while that of the disabled may well be life-long.

Levine (1970) is inclined to the opinion that society perceives the disabled in terms of categories and attributes. Those aspects of the disabled person, especially those physical ones which society regards as differentiating him most from others, Levine calls the "defining" attributes. But the disabled person also has his own perception of which aspects of his body, skills and limitations actually distinguish him from the non-handicapped Those which the disabled himself regards as critical in separating him off, Levine calls the "critical" attributes and further states that there can be discrepancies between defining and critical attributes. When these discrepancies are large, personal insecurity is potentially maximised as the individual perception of self conflicts with stereotype expectations. The processs of "getting the handicapped to accept their handicap" is one which attempts to narrow the gap between defining and critical attributes. That the disabled are antagonistic to the way society defines them is shown by the presence within the traditional voluntary organization of radical group who are attempting to obtain self determanation in the management of their affairs A good example is the "National Federation of the Blind" run <u>by</u> the blind <u>for</u> the blind in America.

Levine suggests that attitudes to the handicapped are not static but evolve through at least five stages.

1. All persons with a particular disability are held to possess certain characteristics.

2. While general belief are held about a category of disability, an individual is seen as transcending the popular view: he is untypical of his category and this is explained by special circumstances such as intense motivation or exceptional compensating gifts.

3. With sufficient examples of exceptional behaviour that portion of the defining attribute is dropped from the stereotype.

4. Through medical and technical skills the disabled person is largely indistinguishable from the rest of his social group ("you'd never guess he was handicapped").
5. By their skills, achievements anddiversity of social roles, the collection of defining attributes vanishes, the true extent of individual differences is revealed and stereotyping does not take place.

Naturally, Levine's described process is open to investigation but the notion that we use convenient conceptual packages when thinking about others is not new. Stereotypes of national characteristics, racial groups and other 'outsider' minorities are part of our social education and thus built-in elements of our socialisation. To be "like us" is natural and normal, to be "not like us" is foreign, unusual and abnormal, thus physical disability is seen as a violation of physical normality that easily extends to social abnormality.

Attitudes and Culture.

The belief that attitudes towards handicap can be "built" into a culture receives support from a number of sources. One is the examination by Haffter (1968) of the history of attitudes to childhood disability in Western Europe based on folktales from as early as the Middle Ages. Haffter suggests that a residue of these earlier belief actually influences present-day attitudes through a societal "collective unconscious".

For insight into the development of attitudes in our immediate past, we may turn to Anthropology. Hanks and Hanks (1948) examining attitudes to disability in non-Western cultures, found that Western concepts of disabilit could not easily be used as ethnological data since what was seen as a handicap in one non-Western culture was not in another. When the social status of the afflicted was at its lowest, they called this as "pariah status", the afflicted having no rights to seek or claim help and being seen by the majority as a threat. In cultures where disability reduces people's capacity to hunt or gather food, stringent measures may be taken to remove 'economic liability,' as among the Eskimos. An improved status was enjoyed by the disabled in cultures which practiced a "tolerant utilization", where the person was expected to contribute to the group insofar as he was able, and his involvement in social life was limited only by his ability and inclination - this was apparently the case among certain North American Indian tribes. Other cultures allowed the disabled a strictly "limited participation", and clearly defined the rights and obligations of the disabled that were more circumscribed than those of the active majority. Finally, Hanks and Hanks noted that in parts of East Africa the handicapped enjoyed a "laissez - faire" social status. Here they were given shelter and protection and their was no obligation or pressure on them to contribute to the group; the definition of achievement was broad and it was possible for the handicapped to gain a measure of prestige and status by exercising such abilities as they had, though there was no pressure on them to do so.

From their work, the authors saw a connection between prevailing attitudes and social and economic factors, and concluded that,

> "protection of the physically handicapped and social participation for them is increased where: (1) the level of productivity is higher in proportion to the population and its distribution more nearly equal; (2) competitive factors in individual or group achievement are minimized; (3) the criteria of achievement are less formally absolute as in hierarchical social structures and more weighted with concern for individual capacity, as in democratic social structures." (Hanks and Hanks, 1948, p.20).

The relationship between attitudes to disability and a society's economic wealth has been confirmed by Jordan and Friesen (1969). They examined attitudes and socio-economic development in Columbia, Peru and the United States and found progressively more positive attitudes to disability as the economic status of the country improved.

In a series of researches by Richardson et. al. (1961) it was apparently revealed that within a culture, uniform attitudes towards handicap exist, indicating that there is a "set" of attitudes towards disability rather than attitudes being a matter of individual preference and experience. It should be noted though, that Richardson's procedures have been questioned by other researchers.

Disability seen as deviance.

Sufficient empirical evidence is available showing that the physically disabled are given a socially constructed deviant status which can be placed within the "misfit" model. (e.g. Wright, 1960; Scott, 1969; Brown, 1954; Minton, 1974). The major positions supporting the model are predominantly interaction theories which, as Thomas (1978) indicates, suggest three views of man and his social behaviour. Firstly, individual behaviour is a response to the behaviour of others - a reciprocal influencing of people and social forces. Secondly, this reciprocal process implies the use of symbols as mediators, the chief of them being language, so that the influence is seldom direct, but by and through language. Thirdly, the self is part of the interaction matrix and is affected by the activities and outcomes of the process. The deviance of the handicapped arises from their apparently negligible potential for interaction. e.g. failure of the handicapped to provide selectively the non-verbal companions of speech (Richardson, 1968); the inability of the blind to use the 'unique sociological functions of the eye' (G ffman, 1969); and, failure of the disabled to supply such accessories of conventional communication as a glance or gaze (Argyle, 1973).

Deviance not only stigmatizes the deviant, but those in regular association with him. This phenomenon is described by G ffman (1968, p.43) as a "tendency for stigma to spread from the stigmatized individual to his close connections," from which it follows that such "courtesy stigma" is generally avoided rather than sought. The concept of stigma is closely allied to the process of labelling described by Pearson (1975).

Whether a physical or mental deviation is regarded as stigmatizing depends on how people respond to the particular label. For Goffman, stigma meant the imputation to a person of attributes that are deeply discrediting. Despite changes in attitudes, the disabled are still treated as having a stigma, although perhaps, the more blatant forms of prejudice are camouflaged. When confronted by discrimination, hostility, indifference or simply awkwardness, the disabled person will naturally tend to withdraw from interpersonal or community transactions, thereby "lesse the possibilities of understanding his interests, asperations and the ways of dealing with society's perception of his deviance." (Levine, 1970, p.45).

The distinction developed by Lemert (1967), between primary and secondary deviances is also of interest here. The primary deviance is the disability itself, while the secondary deviance is an adaptive pattern of behaviour for coping with the social responses to the primary one. The work of Scott (1969, 1970) on the socialization of the blind illustrates this dual nature of disability as deviance. Visual handicap is the primary deviance, while the secondary one is the behaviour which develops as a result of blind people's day-to-day encounters with the sighted community, and the attitudes and the expectations of professional agencies and "blindness workers".

As Thomas (1978) notes, misfit sociology has been criticized for its theoretical vagueness and its reliance on inside accounts, while Goffman's stance has been challenged for its unattractive view of man- as always attempting to win support for the presented self. More serious, is the charge that it has failed to provide a commanding view of society and has instead concentrated on what its critics termed the trivia of interpersonal behaviour. Among its positive contributions are its power to illumunate our own part and that of professional caring persons in creating deviance, as well as providing a platform for views from the "other side". As regards disability it allows the use of personal accounts as well as traditional modes of investigation and a range of theoretical positions. All this is an advantage given the absence of a single comprehensive theory of the social psychology of disability. The misfit model is thus admirably suited for explaining people accorded deviant status, but amongst the handicapped there are some who appear to avoid the stigma attached to others with the same affliction.

Personality and the disabled.

The study of the personality of handicapped children has been somewhat sparse. Pringle (1964) noted that there were few studies of the emotional development of blind children; Reed (1970) made a similar comment about deaf children, Ziegler (1966) about retarded children and Pilling (1973) about children with chronic illnesses. One reason for the comparative neglect of personality studies is the technical difficulty of assessing handicapped children, and although braille versions of popular personality tests are available, the standardisation problems are formidable.

As Thomas (1978) notes, the scarcity of objective data has not prevented beliefs and opinions emerging about the personality of the handicapped, operating to fill the empirical vacuum.

There is a long history in philosophy, literature and psychology of concern with the relationship between psyche and soma, so that it is hardly suprising that the handicapped should be seen as proving ground for speculation and study. The attempts to link appearance and physique with behaviour identified with the work of Kretschmer (1926) and Sheldon (1942) have failed to show substantive evidence of a strong correlation at both group and individual levels. There have, however, been several attempts to show on theoretical grounds that extreme physical variations will influence personal development. We now turn to these theories (McDaniel, 1969) and their relative potentialities as explanatory devices (English, 1971.)

Some theoretical positions.

(a) Individual Psychology. Among Adler's (1927) propositions was that each individual personality is unique and develops in response to certain social impulses which include a sence of inferiority, the striving for superiority and intervening compensatory behaviour. Such feeling are not abnormal but present in everyone. The disabled person has a special type of inferiority, "organ inferiority", and thus an enhanced drive to establish his superiority. McDaniel notes that this concept of inferiority and its accompanying compensatory behaviour has been applied indiscriminately to the handicapped. Thomas (1978) argues that although compensatory behaviour can be observed in many disabled persons, this is different from a compensatory lifestyle. He notes further that although there is case evidence of the disabled using their disabilities as instruments of social control, the non-disabled probably use their appearance and physique just as much for the same purpose but it only becomes "pathological" when practiced by those with a stigmatized physical deviation.

As Thomas concludes, concepts of inferiority and compensation cannot cover the wide range of responses of disabled persons to their disability. While they may be useful at the clinical level, they are too restricting for rehabilitation psychology.

(b) Body image. Attitudes to self and others are thought to be affected by perceptions of values attributed to appearance and physique. Persons place themselves on a continuum from those with a positively valued body image to those with a negatively valued one. For Schilder (1 body image was closely identified with self-image. Body image is constructed from postural cues, tactile impressions, visual appearance, degree of functional effectiveness and from social reinforcement. The disabled person receives negative feedback from his body and via the responses of others during his formative years, while his body image is being constructed. Richardson's work (1968) suggests that disabled children share the value system of . non-handicapped peers, and we may assume that perception by the handicapped of the high value placed on normal phisique provides a tension between actual and ideal body images. This tension is sometimes revealed in handicapped children's self-portraits where the area of physical deviation is either exaggerated or disregarded. For Thomas, this view of personal or self-image is most valuable when there are marked abnormalities of physique or appearance, and also where chronic illness deprives the child of former physical skills or capacities i.e. acquired disabilities.

c) Somatopsychology. This is the study of 'variations in physique that affect the psychological situation of a person by influencing the effectiveness of his body as a tool for action or by serving as a stimulus to himself or others' (McDaniel, 1969, p.11). Behaviour and physique are seen as interrelated and interactive. Thus, according to this position, the visibly disabled are given a subordinate social role and those with milder disabilities will suffer greater anxiety and frustration than the grossly handicapped, since the latter experience lower expectations or have more allowances made for them. This contridicts an often expressed view that poorer adjustment is associated with more severe handicap.

Three concepts derived from somatopsychology are valuable for understanding the emotional development of children: they are mourning, devaluation and spread. Mourning, as applied to the disabled, refers to sadness and regret at the lack or loss of functional skills. Mourning is seen not only as a psychological state but also a social obligation, so the loss of a limb or function may depress a person who is then expected to conduct himself appropriately for the degree of loss and to go through a period of readjustment. At an individual level the period of mourning and its intensity of feelings will vary considerably, but it will not be expected to continue indefinitely - this is what is meant by 'coming to terms with the handicap,' (Thomas, 1978 p.72).

"Devaluation" and "spread" are closely related concepts. Devaluation is the process by which the disabled person is seen as more handicapped than he actually is, because of attitudes from others as well as his own lowered self esteem. This is shown in various ways; by prejudice against the disabled similar to that shown to other minorities, by prejuged helplessn and dependency, and by attitudes of overprotection and rejection. (Wright, 1960). The disabled person's own attitude may reflect 'devaluation' of his own position which may also include the phenomenon of 'spread'. By this is meant that the disability may not remain confined to the actual limits of the impairment, instead, the individual may come to view himself as being incapacitated in additional ways. In other words, he may become excessively disabled, with the disability expanding from its original source to encompass the whole body or the whole personality.

As Wright (1960) pointed out, somatopsychology has failed to show a consistent relationship between personality and disability, but its subordinate concepts have great potential for gaining an understanding of the effects of disability on the individual.

(d) Social role. Illness or disability is not only a physical phenomenon with accompanying psychological features, it prevents the person from performing a range of customary social roles. Illness grants a legitimate exemption from customary requirements which continues as long as the patient performs adequately in the new "sick" role. The "sick role" involves presenting ones' self for treatment, an acknowledgement that one is sick, a striving for recovery and active cooperation with those who are seeking to return one to optimum role capacity (Gordon, 1966.).

Handicapped children can be seen as "sick" for some are, whilst others may be considered metaphorically so, and treated as if they were, though not all of them will be able to perform every aspect of the sick role, such as striving to get well or cooperating with healing agencies. One danger of perceiving handicapped children as sick is that like sick persons, they will have things done for them and to them and will largely be at the mercy of the professional healers and helpers, with the consequent loss of human dignity and independence (Thomas, 1978).

In order to gauge their relative power as explanatory tools, English (1971) examined the theories in the context of the behaviour of the disabled and the reactions of normals to disability, especially in connection with th effect of handicaps and early experiences, the psychological impact of disablement, the sociological aspects of prognosis for rehabilitation and attitude change. He developed twelve propositions (e.g. the stigmatisation of the disabled can be reduced) and then considered which theories seemed to offer support for them. The theories he used were individual-psychology, psychoanalytic, body-image and social-role theories. Theoretical support, or lack of it, for a proposition was judged on a five point scale.

English concluded that no single theory was sufficient to encompass our present knowledge of the psychological and sociological impact of handica In his view the effects of disability in childhood are best explained by reference to psychoanalytic theory and individual psychology; rehabilitation processes are best analysed with a combination of individual psychology and body-image theory, while sociological aspects are probably best derived from social-role theory. He found that the reactions of the disabled and of other people important to them could not be explained by any one theoretical stance, that there was a need for an eclectic approach to theoretical concepts and that attempts to understand the personality of the handicapped offered a major challenge since a unifying theory was a necessary, but as yet distant, goal.

Summarizing 30 studies on the personality of medically labelled disabled group e.g. Down's syndrome, epilepsy, cerebral palsy, blindness, deafness etc. , Thomas (1978) notes that the authors all appear to have gone through several stages. At the start there was usually an attempt to unveil the common personality characteristics on which stereotyped views were based. The second stage was often the breaking-down of the stereotype into patterns of behaviour and reaction associated with clinical sub-categories. Finally the view that the latter had common personality characteristics collapsed as the true extent of individual differences among children with a common handicap became apparent. Thomas adds that we are left with the more difficult though essentially more humane, task of reflecting on the children and their experiences as individuals, and not as a medically labelled group. After all, regularities in behaviour might just as easily be the result of being treated, taught or institutional in a more or less uniform manner.

Role theory.

Some writers have found it unrewarding to approach the handicapped child's behaviour through the primary medical categories of conditions, and have discovered a more fruitful frame of reference in role theory, which is not anchored to specific medical labels.

Role theory has been most consistently applied to handicapped children in the case of those who are chronically ill. The person who becomes sick has to deal with the new role of the sick person, with its inbuilt tension between past and present. Role is defined as "the set of prescriptions defining the behaviour of an occupant of one (social) position towards other related positions "(Johnson, 1970 p.44). In the "sick" role the "prescriptions" involve an exemption from some of the responsibilites associated with position; but there must be shown a desire to get well and to cooperate with those attempting to heal.

Gordon (1966) suggested three significant role relationships: doctor-patient; family - patient; and self (ego) - patient. Each could be examined in terms of 4 possible reactions to illness; dependence (a tendency to give up some areas of responsibility); normal independence (retaining the responsibilities inherent in the status "well"); over-independence (demanding more independence when sick than when well); and self-pity (rejecting the possibilities of self help).

Fishler et. al.(1972) studied a group of 45 children with a rare condition, galactosemia requiring a special diet. They followed this group from early childhood to adulthood, using various tests, appropriate to the state of development, such as draw-a-person, sentence completion, Rorschach ink-blot and Thematic Apperception Tests. Their results showed that there were definite changes according to age. The pre-school child was seen as excessively shy and fearful in terms of personal contacts, in the school-age period there were many signs of anxiety such as nail biting, and at adolescence there were a few children with serious problems of adjustment. There was "little doubt that their poor self-image was related to their dietary restrictions which clearly set them apart from other persons. These feelings of inadequacy were further compounded by learning problems at school". (Fishler et. al., 1972, p.416).

Olch (1971) investigated 45 children with haemophilia, a condition characterised by recurrent haemorrhages which may be spontaneous or caused by even a minor injury, making hospitalization usual. Olch gave her subjects draw-a-person, and Rorschach tests, and need-achievement measures. In the 5-7 age group she found a common anxiety, intense feelings of inadequacy and social unease. The 8-12 group were passive, lacked spontaneity and were keenly aware of the difference between themselves and others. The young adolescents showed the greatest activity, resistance and independence, while the older ones "exhibited the greatest constriction of personality. They relied heavily upon intellectualization, compulsivity and avoidance of spontaneity".

These two studies both cover the child's developmental period. They both give some support to somatopsychological theories and to role theory. Olch suggests that in haemophilia patients, limited activity produces a restricted thought process. Neither produces any evidence for a distinctive personality type, but both indicate a pattern of adaptation to prescribed roles.

Pinkerton and Weaver (1970) noted the similarity of their asthmatic patients to other sick children, with anxiety, dependency and neuroticism influencing their immediate interpersonal milieu. Swift, Seidman and Stein (1967) found that children with diabetes had a poor self-image and showed dependence, anxiety, oral preoccupations and depression.

Broadly speaking, these studies all show a degree of adaptive response which cannot solely be explained by their illness. According to Thomas (1978p.86), what gives the developing picture some coherence is that the adaptive pattern emerges from role expectation. The experience of limited everyday activities and the anxiety caused by illness and its treatment appear to produce, in Gordon's terms, a role behaviour consonant with dependence and self-pity. The particular value of the Fishler and Olch studies is that they show the role not to be consonant over the developmental period. In the early period there is unsettledness, giving way to passivity in the latency period, challenged by resistance and independence in pre-adolescence and followed by rigidity and compulsion later on. (Unresolved questions about these studies are the sample size used, the particular environments in which the children developed and the under-use of other possible explanatory variables such as parental attitudes, Thomas (1978 p.86).

An extension of this view of the significance of the role is found in the work of Minde et. al. (1972), who examined the psycho-social development of a group of physically handicapped children. The youngest appeared to regard themselves as non-handicapped but having a functional disability that would be made good in time. When placed in residential school this response underwent a significant change with many of the children going through a period of profound melancholy due to separation from home and the realization that miraculous cures were unlikely. Eventually, on coming through this depressed phase, they made statements showing a view of the self that included their disablement. Minde comments on the gradual and sometimes painful process by which these children made the transition from one status to another.

Self-image.

How a person percieves and appraises himself can be described and interpreted in a number of ways. Self-appraisal or self-concept has a devel
mental component in the child, refering to the extent and manner in whic

innate predispositions, biological growth and maturation affect his view of himself, along with a social component - a view of the self derived from interactions with others, especially family and those close to the child. Self-concept develops out of the organisms' interaction with the environment and the value systems of others, and out of the need to have a consistent view of the self, and is subject to modification through learning. Argyle (1973) provides a concise view of self-concept as consisting of self-image i.e. how the person sees himself, and self-esteem-the value he places on himself.

Both self-image and self-esteem will be influenced by perceptions of the attitudes of others, especially of those whose opinion is most prized. Thomas (1971) showed that among ten-year-olds the influence of the family on the formation of self-concepts was more significant than that of peer groups, though we would expect changes in adolescence.

Most studies of handicapped children on measuring self-concept have used self-report rather than observational measures, with both the retarded and physically handicapped being studied. As Lawrence and Winschel (1973) have pointed out, findings with the retarded children are, at best, inconclusive because of the technical problems of the validity and reliability of self-concept measures when used with them.

The studies of the physically handicapped appear to be more consisten Nussbaum (1962) studied a group of adolescents with cerebral palsy in order to determine their self-concepts, and the concepts held of them by their mothers about capacity to perform tasks, social relationships, vocational potential and intelligence. He found significant correlations between the adolescents' own self-concepts and their mothers' concepts in the areas of tasks, social relationships and vocational potential, and concluded that mothers appear to influence the self-concepts of their children.

Smits (1964) studied the influence of the obviousness and severity of disability on adolescents' self-concepts, using a self-concept and self-acceptance measure. Those with milder disabilities had higher self-concept scores than those with severe ones; severely disabled girls had the lowest self-acceptance scores, and the more obviously disabled adolescents received more extreme ratings from classmates than did the others.

Kinn (1964) examined differences in the self-reports of 72 physically handicapped and non-handicapped children, as well as discrepancies between actual and ideal self. The handicaps included sensory, orthopaedic, circulatory and metabolic disorders. The results showed that the handicapped children saw themselves as less physically adequate than the non-handicapped; they had fewer close relationships and fewer opporturnities for social participation, and though they had similar life-goals to the non-handicapped, they felt less able to achieve them. The visibly handicapped showed greater non-correspondence between self-concept and ideal self than did the non-handicapped.

Grinter (1974) studied the self-concepts and ideal selves of visually handicapped adolescents and found that they did not have a lower self-concept score than did a control group. They did, however, show a greater discrepancy between perceived and ideal self, and there was an association between low self-concept scores and ratings of social adjustment.

Other studies of the self-concept of disabled persons that have found evidence of a lowered self concept in disabled persons compared with their non-disabled counterparts are those by Speck, 1975; Katz and Florian, 1978; and Hartung, 1975.

Socialization of the disabled.

Direct and indirect effects of disability on socialization practices.

We see that socialisation practices in the disabled may be influenced by the direct effects of the disability itself. This is most obvious in the case of children with profound sensory disabilities such as the deaf who are slow to acquire social concepts which are heavily dependent upon language (Kates and Kates, 1965). Children with severe physical handicaps may be effectively cut off from the crucial adjustive experiences of the peer group, unless very special efforts are made to provide those experiences.

Where parents see that their child and his disability are likely to meet rejection or indifference, the socialization process can be constrained to the social learning programme the parents prefer. Such indirect effects can be seen in the case of children with severe facial deformities, with the family forming a "protective capsulé" for the child concerned. (Goffman, 1968).

The subculture of handicap.

Blyth (1968) suggests that the "cultural contexts" for the child include nationality, rural or urban setting, social class, neighbourhood, sex-role divisions, peer group, the common experience of schooling and the specific culture of the child's family. Some handicapped children are not able to participate in these cultural contexts and their experiences differ from their age-mates because of prolonged periods in hospital, separate forms of schooling, institutionalization, restriction on mobility or over-protection. (Thomas, 1978).

If successful socialization partly depends on a body of shared experiences, those who fail to acquire this, find it more difficult to secure a rightful place in their culture. The more successfully the handicapped person adjusts to the culture of handicap, the harder will be the task of participating in the full range of conventional social roles. Among the distinquishing features of the culture of handicap are:

exposure to extreme attitudes - either over-protection or rejection; involuntary association with others similarly handicapped; frequency of hospitalization; special education; restrictions on the full range of adult roles; awkwardness in social interaction; and lifelong bureaucratic structures-sheltered workshops, colonies, total institutions. In some cases these may be summarised as resulting in a subordinate social status and a role of dependence. (Thomas, 1978, p.100).

The socialization of the physically handicapped.

Physical handicap, particularly in those forms which seriously restrict mobility, is a variable limitation which prevents or inhibits the acquiring of developmental skills at the appropriate ages. Such children may grow up in a resticted environment with isolation and prolonged hospital treatment, and thus may develop a preoccupation with the self. (Thomas, 1978 p.102). One overriding issue that seems to be true for all kinds of physical handicap is that of dependence. Disability may imply an unchanging dependence on adults in many areas of personal life. As Thomas (1978, p.103) cautions, "The task for socializers is to confine their care strictly to the disability while maximizing the child's independence in every other way".

The family of the handicapped child.

Stereotypes.

Research on families of the disabled suffers from the same effect that Staples (1971) noted in his review of research on black families. People studying the latter tended to be white sociologists, with little or no intimate knowledge of the families in question and little or no experience of black culture. Further, they examined their evidence in the light of the predominant Anglo-Saxon, middle class model of family life. (Thomas, 1978 p.108).

Many studies of families with handicapped children produce over-negative or over-positive evidence based on limited interviews or highly selective samples. If we look at the representative sampling of Hewett (1970) and Gegory (1976), we see that they reveal a diversity of parental attitudes.

The literature on parental problems has two main approaches; the practical one which usually involves facts about family difficulties and the psychological one which tends to emphasise the emotional reactions of the parents and siblings.

Thomas (1975) points out that among recent developments in the literature is a recognition of the dynamic change in parental attitudes and reactions in which the child is seen as an active agent. Parallel with this, there has been a growing sensitivity to the social forces which impinge on the family, particularly about how attitudes are shaped and maintained by the reactions of others (Voysey, 1975).

Thomas has noted a striking aspect of families with a handicapped child, it is about how vulnerable they are with their behaviour and attitudes often being interpreted somewhat flexibly according to the stance of the research worker. A good example is emotional stress. Ross (1964) suggests that few controlled studies imply that most parents of the handicapped are under severe emotional stress and so does Roith (1963), but Love (1970) reports parents as suffering shock, refusal, quiet, bitterness, envy and rejection.

Initial parental reactions.

With all the disagreements about family reactions (rejecting, heroic or matter-of-fact), Thomas (1978) notes that there is wide agreement that the birth of a handicapped child or the discovery of a defect causes a period of profound stress and goes on to add that the connection between initial reaction and subsequent attitudes is rather uncertain.

Types of attitudes

As Thomas (1978) notes, it has been usual to label parental attitudes in terms of broad types which appear to have originated with Somers (1944), studying the personality of the blind adolescent. The classification includes: acceptance, perfectionism, over-protection, and disguised and open rejection.

Acceptance usually refers to the full psychological and social incorporation of the child into the family. Dale (1967) suggested that acceptance ideally involves both parents. Lowenfeld (1974) found that, while no family was immune to the effects of having a blind child, many parents were able to accept the child fully. For Lowenfeld, acceptance was more likely when the parents had other, non-handicapped children; when the handicapped child was the first one, acceptance was more difficult.

Perfectionism, or denial, implies an urge to eradicate the disability, expressed in demanding from the child the full range of normal behaviour. Lowenfeld (1971, p.108) describes perfectionism as the response of parents who love their child but cannot face the reality of his handicap. Ross (1964) suggests that where denial takes the form of undue pressure for the achievement of high and unrealistic goals, this leads to frustration, regression and other forms of maladjustment which, while secondary to the main handicap, can have greater impact on the development of the child's personality.

Those who over-protect are in effect concentrating on the handicap and not on the child. According to Poznanski (1973) this attitude is common among parents. While "over-protection" cannot be objectively estimated, for Poznanski it means that the handicapped children receive more attention than their disabilities require, and much more than any siblings receive.

Over-protection limits the child's opportunities for learning independence in habits and ways of thinking, restricts his social interactions and leaves **him** with little or no chance of coping with feelings of failure. Boone and Hartman (1972) found that over 60 per cent of parents in their samples displayed this "benevolent-over-reaction". In extreme cases the child's psychological health can only be restored by a period of separation from the family. As Thomas (1978) points out, the use of such broad terms as "over-protection" to describe parental attitudes is not without danger as it tends to imply that attitudes are constant and held equally by both parents. As Thomas indicates, it is more probable that partners do not always have the same attitudes as each other, that attitudes change over the developmental period and are as likely to result from interaction with the child as to be responses to disability per se.

Related to over-protection is the evidence of the existence of a "special" mother-child relationship between a mother and her disabled child as opposed to a mother and her normal child. (Sequin, 1976). The literature indicates that this relationship is usually one of over-protection and/or rejection on the part of the mother (Barker, 1953; **Wright**, 1960), with over-protection and overpossessiveness by the mother being most characteristic (Koudekova, 1975; Bolstad, 1974; Oettinger, 1938; Boone and Hartman, 1972).

Thomas (1978) notes that rejection may be conceded by parents who display all the signs of care and concern; in such parents there may be conflict between intellectual and emotional acceptance. Refering to open rejection, Sheridan (1973) notes that is usually occurs in two groups of parents - those who are immature and incapable of assuming their responsibility and those who are mentally disordered, although both groups are thought to be small in number.

Parental attitudes are the product of many forces and like us they are subject to the process of social learning which creates a set of beliefs about disability. But as Thomas (1978 p.113) indicates, perhaps the greatest common source of attitudes is parent's self-blame for their child's condition.

Interaction between parents', and handicapped childrens' attitudes.

Mannoni (1973) showed that attitudes and values of parents before the birth of a handicapped child do influence the way the child is perceived and treated. There has been a tendency to ascribe the adjustment of handicapped children to their parents' attitudes, with disturbed children said to come from families where they were over-protected or rejected. Walters and Stinnett (1971) suggest that this influence is not a one-way street but that parental attitudes do change as the child gets older, partly because of the nature of the interaction between them and their children.

In looking at the relationship between parental attitudes and the adjustment of children, we may consider the study of Neuhaus (1969), who examined the social and emotional adjustment of deaf children. He found that positive attitudes from the mothers coincided with emotional and social stability for all the children. The fathers' expressed attitudes did not correlate with the adjustment of the younger children. In some cases it was found that both parents had the same positive or negative attitudes whilst in others each parent held directly opposite attitudes. Positive attitudes in both parents were associated with superior adjustment, positive maternal and negative paternal attitudes were associated with better adjustment than negative maternal and positive paternal ones. So with this sample and for this disability, maternal attitudes appear to be the more crucial ones for the emotional well-being of the children.

In explaining parental attitudes from a social psychological perspective, Voysey (1972) contends that two factors, power and responsibility, significantly modify parent's behaviour. By responsibility she means the extent to which parents, and others, perceive the handicap as being caused by the parents (neglect, inadequate care, genetic factors etc.) Power refers to the extent to which others consider the parent capable of ameliorating the disability or behaviour of the child. As Voysey puts it, these factors are subjective "actors' definitions" and liable to change. She advances 4 types and their parental behaviour.

1. Not responsible-with power. Where the Child is "ill" from a non-hereditary complaint, the parents are able to follow the given medical advice and the predominant interpersonal style is "coping splendidly".

2. Responsible-with power. Whatever the objective facts the mother blames herself but is determined to secure the best available treatment. Interpersonal style - "making amends".

3. Not responsible - no power. As in some cases of congenital abnormality nothing can change the tragic situation for the parents. They have to manage the expressions of sympathy from others. Interpersonal style - "stoic acceptance".

4. Responsible - no power. Where no cause of the handicap can be determined, parents may create their own - as from the mismanagement of the child - but in the case of undifferentiated mental handicap the condition is not remediable. Interpersonal style - "restricted social interaction".

The management of social interactions involves the growth of sensitivity to others' responses, and skills in handling potentially ambiguous or threatening situations. These skills, (refered to by Voysey as "competence") include developing an ability to manage events which would ordinarily be seen as threatening to parental identity: learning to avoid situations where reactions might be uncertain; coping with the "first time" to school, a party etc.,; and becoming more resilient to rebuffs, insults and false sympathy.

Thomas (1978 p.124) concludes that the literature on parents' attitudes to the handicapped child is incomplete and perhaps misleading since it lacks the dimension of experience. He maintains that detailed interviews, completion of attitude scales and observation itself cannot fully admit the investigator to the central experience of living and loving a child with a disability of body or mind, and that experience could be critical for reducing simplistic (and often negative) stereotypes of parental attitudes.

Schools and handicapped children. Acceptance at school.

Obviously, the effects of dislike and rejection are the first to come to mind in the school context. Anderson (1973) noted that many mildly handicapped pupils in primary schools experienced few overt expressions of dislike and that in general disabled children were well accepted by their peers.

The teacher's role in helping the disabled child to adjust is of great importance. Marge (1966) discovered that pupils' and teachers' attitudes to the speech - handicapped were similar, both expressing a strong preference for the non-handicapped. Thomas (1978) explains that children are such acute observers of their teachers that it would be surprising if there were not a link between their attitudes.

Obtaining accurate information about the acceptance of the disabled at school has been done mainly through sociometric studies. Rucker, Howe and Snider, (1969) found that slow-learning children in integrated classes have a lower social status and are less well accepted than other children.

Among the factors which might influence acceptance is how visible the disability is. Adams and Cohen (1974) found that at first, teachers were influenced by pupils appearance and physique, but that these soon became less and less significant in their evaluations. Richardson, Ronald and Kleck (1974) found that their disabled sample were inadequately equipped in interpersonal relationship skills which contributed to their low social status. Thomas lists the factors likely to influence acceptance of the handicapped schoolchild as practical communication difficulties, episodic conditions, competence, atypical behaviour, frequency of contact and level of interpersonal skills. Anderson (1973) and Jacobs and Pierce (1968) found that children with neurological abnormalities such as cerebral palsy (i.e atypical behaviour) had a somewhat lower sociometric status than their retarded counterparts without these and than their non-handicapped peers. In a study to show that acceptance is influenced by perceptions of competence, Gottlieb and Davies (1973) found that children of average mental ability selected significantly fewer retarded children as partners for a skilled motor task. Willey and McCandless (1973) used checklists of adjectives to study the reciprocal perceptions of groups of normal, retarded and orthopaedically handicapped children, and discovered that both the normal and the retarded ascribed more positive terms to their own group than to the other group, though some retarded pupils expressed somewhat more positive attitudes towards normal peers than were reciprocated. Perceptions of the orthopaedically handicapped were almost wholly positive. This study occured in school settings which encouraged a good deal of contact between groups, and proximity has long been thought to be an important factor in the forming of friendship since it fosters initial acquaintance. (Thomas, 1978, p.135.)

Types of schooling for handicapped children.

Educational provision for the handicapped is a contimum extending from acceptance and integration within an ordinary school at one pole to institutionalization at the other, with special classes, day special schools and residential special schools lying in between. As Thomas (1978) points out, this variety illustrates in concrete terms the duality of attitudes to handicap - the desire to create some positive means of assistance and the willingness to separate and confine.

Since the sample for my research came from the "positive" end of this continuum, I will only briefly summarise the effects of segregated schooling on the handicapped, so as to highlight the pros and cons of this type of education.

According to Thomas (1978) p.137-138) the effects of segregated schooling on handicapped children are:

1. It places them in a social system largely composed of others similarly handicapped, so that they take the others as their reference group.
2. Particularly when it is residential, it means a loss of contact with normal peer groups and all that this implies for psychological and social development.
3. The children lose friendships in their home neighbourhood.
4. There is the sense of stigma.
5. A too-protective environment is dangerous because of the effect of the loss of protection when they have to leave it.
6. There are the consequences of a school environment which is uncertain whether it is a branch of the social services, a para-medical aid centre or a teaching institution.

However there are also positive features:

1. A high ratio of adults to children and the greater attention which individual children can then receive.

2. The efficiency of special instructional methods.
3. The concentrated availability of medical and therapy services.
4. The reduction of pressure on children which gives them opportunity and time to cope with physical self-care and the psychological opportunity to build up worthwhile levels of self-esteem.
5. The living in a community where needs are acknowledged and catered for.

As far as help for handicapped children is concerned, Thomas aptly concludes that "the most significant and enduring advances are likely to be achieved through the accelerating trend of educating more and more handicapped children together with their non-handicapped peers". (Thomas, 1978, p.147).

Aims and Objectives.

Origins and Development of the aims and objectives of the study.

Initially, as already indicated, the main aim of my study was to look at two specific aspects of the "special" mother-child relationship, namely rejection and overprotection. Thomas (1978) has pointed out that these two attitudes are among the distinguishing features of the culture of the handicap, and a good deal of the literature supports their existence. (Barker, 1953; Wright, 1960; Koudekoca, 1975; Bolstad 1974; Kammarer; 1940; Oettinger, 1938; Boone and Hartman, 1972, Sheridan 1973; Love, 1970; and others.).

My initial two aims were to find out if i) there is evidence of significantly more "rejection" by the mothers of the disabled than by the mothers of their non-disabled counterparts, and 2) if there is evidence of significantly more "overprotection" by the mothers of the disabled than by the mothers of their non-disabled counterparts. I decided to limit my study to the mother-child(rather than the parent-child)interaction because of the evidence of the"special" mother-child relationship shown by Sequin (1976), Koudekova(1975) and others, and also because of the importance of maternal over paternal or parental attitudes for the emotional and social stability of the disabled child found by Neuhaus (1969).

<u>Rejection</u>.

In searching for an appropriate instrument for the measurement of "rejection", I came across Rohner's "Parental Acceptance-Rejection Theory" - PART; a socialization theory developed since 1973 which has a whole range of instruments to measure acceptance - rejection in children, parents and adults. What further attracted me to this theory and its instruments were the thorough standardization of the instruments on different cultures and the fact that behavioural and personality (rather than attitudinal) dispositions were used, which are predicted by the theory to be associated universally with parental acceptance-rejection. (Rohner, 1980). These dispositions are as follows: 1) hostitity/aggression, 2) dependence, 3) negative self-esteem, 4) negative self-adequancy 5) emotional unresponsiveness, 6) emotional instability, and 7) negative world view.

In looking at these dispositions, we see that evidence for four of them can be found in the literature reviewed. For dependence-Pinkerton and Weaver, 1970; and Swift, Seidman and Stein 1967.For negative self-image in terms of negative self-esteem and negative self-adequacy - Fishler et. al., 197 Olch, 1971; Swift, Seidmann and Stein, 1967; Nussbaum, 1962; Smits, 1964; Kinn 1964; Speck 1975; Katz and Florian, 1978; and Hartung, 1975; and for emotional instability - Neuhaus, 1969. This fact further persuaded me and I finally decided to make use of two of Rohner's instruments:

1) The child version of the Personality Assessment Questionnaire and
2) The child version of the Parental Acceptance-Rejection Questionnaire.

At this stage, I would like to introduce Rohner's "Parental-Acceptance Rejection Theory "-PART on which the instruments, the PAQ and PARQ, are founded.

PART is a theory of socialization which attempts to explain and predict major consequences of parental acceptance and rejection for behavioural, cognitive and emotional development of children and for personality functioning of adults everywhere. The theory also attempts to explain why some children are better able than others to cope with the corrosive effects of parental rejection and emotional abuse. These are 2 classes of outcome variables of primary interest to PART. In addition to these outcomes, PART attempts to predict major psychological, environmental and maintenance systems, antecedents to parental acceptance-rejection. The theory is also concerned with the relationship between parental acceptance-rejection and expressive behaviours in society.

Defining PART.

Conceptually, parental acceptance and rejection together form the warmth dimession of parenting. Parental warmth is construed as a bipolar dimension where rejection, or the absence of parental warmth and affection, stands at one pole of the scale in opposition to acceptance at the other pole. Accepting parents are defined in PART as those who show their love or affection toward children either physically or verbally, using forms of behaviour which jointly and individually are likely to induce a child to _feel_ loved or accepted.

Rejecting parents are defined in PART as those who dislike, disapprove of, or resent their children. In many cases they view the child as a burden and they sometimes compare him unfavorably with other children. Rejection is manifest around the world in two principal ways, namely, in the form of parental hostility and aggression on the one hand,

and in the form of parental indifference and neglect on the other (Rohner, 1975b). Both forms of parental rejection - that is, rejection revealed as hostility aggression and rejection revealed as indifference/neglect-express an impaired (or even the absence of a) bond of parental attachment and both forms of rejection in their concrete mainfestations are likely to induce children to feel unloved or rejected.

Parental acceptance-rejection may be viewed from two perspectives; as subjectively experienced by the child (or subjectively reported by the parent); and as externally measured by an outside observer. The extent to which self-perceived versus objectively determined acceptance-rejection are coincident is problematic in any given case. Ultimately, PART takes as self-evident that parental rejection has its most consistent and predictable effects on children primarily insofar as the child perceives the parent's behaviour as being rejecting. This view is shared by others such as Kagan (1978) who states: "parental rejection is not a specific set of actions by parents but a belief held by the child."

Behavioural outcomes of PART.

As noted before, PART predicts that acceptance and rejection have consistent effects on the behavioural and personality dispositions of children everywhere, as well as on the personality functioning of adults who recall being rejected as children. PART to date has therefore been concerned with a limited constellation of personality dispositions, dispositions that are thought to be an expectable outcome of parental aggression or neglect everywhere. They in no way represent a complete list of the consequences of parental rejection but are the primary ones included at this time in PART. The dispositions are hostility, dependence, negative self-esteem, negative self-adequacy, emotional instability, emotional unresponsiveness and a negative world view. The dispositions were based on the results of a research by Rohner (1975 b) using a sample of 101 societies which showed that rejected children throughout the world are significantly more hostile, aggressive or passive aggressive than are accepted children, and that rejected children tend to evaluate themselves more negatively, and to be more dependent than accepted children.

As Rohner (1980) points out, (and which is especially significant for my sample of disabled children) there seems to be little doubt in the study of parental acceptance-rejection-as in the study of other forms of parenting - that one should take into account the personal and behavioural characteristics of the child as an instigator of parental action, just as one takes into account the personal characteristics of the parent(s), or of the salient characteristics of the situation where the parents and children interact (Rohner and Rohner, 1979 a, 1979 b).

From Rohner's work on PART, I decided to make use of the following two questionnaires:

1) The Personality Assessment Questionnaire for the Child - PAQ.
2) The Parental Acceptance-Rejection Questionnaire - PARQ.

A detailed discussion of these two complimentary self-report instruments will follow in the method, but it may be noted at this stage that the hypotheses I put forward were related to the total scores of each questionnaire as well as to the 4 composite scales of the PARQ and the 7 composite scales of the PAQ.

The hypotheses from the PAQ and PARQ will be listed at the end of the chapter.

Over-protection.

As we have already seen from the literature, over-protection has been com found among parents of the disabled, with the parents in effect concentrating on the handicap, and not on the child. (Thomas 1980, p.112). According to Poznanski (1973), while "overprotection" cannot be objectively estimated, for him it occurs when the handicapped child receives more tention than the disability requires and much more than any siblings ceive. As Thomas (1978) points out, the use of such a broad term as ver-protection" to describe parents' attitudes is not without danger it tends to imply that the attitudes are constant and held equally by th parents.

Taking Thomas' caution into account, I decided to limit the scope my "overpretection" questionnaire to overprotection by the mother only, which also refered to as "over-mothering". The term comes from Wiggins et. al. 971, p.173) who were commenting on the "over-mothered", sometimes called nothered" person who, they conclude, is not free to acquire the instrumental ills which provide a substitute for the security of the mother.

As far as my "over-mothering" questionnaire was concerned, I based on behavioural manifestations of overprotection by mothers as perceived my sample of disabled and non-disabled children. The behavioural nifestations (or tendencies) of overprotection I chose to use, don't any way represent a complete list of the behavioural manifestations of erprotection. The questions of my questionnaire could be divided into ree basic behavioural tendencies:

. Tendency to try and limit child's time spent away from mother and home.

. Tendency to be much involved in child's affairs.

. Tendency not to be too demanding on child in terms of household help and cooperation.

The reason for my explaining and listing these tendencies is that hypotheses on over-protection are derived from them.

With this brief introduction to my instuments (details in Chapter 2) will now list my aims and hypotheses. (It may be noted that all the potheses are tested by either a total test score or a total scale score).

Objectives and Hypotheses

The three main objectives of the study were,

1). To find out if there is evidence of significantly more rejection by the mothers of the disabled, than by the mothers of their non-disabled counterparts.

2). To find out if there is evidence of significantly more overprotection (or "over-mothering") of the disabled by their mothers, than by the mothers of their non-disabled counterparts.

3). To find out if there is evidence of a significantly lower "partial mental health status" for the disabled children, compared to their non-disabled counterparts.

The following are the hypotheses I tested in relation to these aims:

Using the PARQ:

1. Disabled children perceive significantly more rejection from their mothers than do their non-disabled counterparts. (Using the total, composite score.)

   Using the 4 scales of the PARQ:

   a) Disabled children perceive significantly less parental warmth/affectio than do their non-disabled counterparts.

   b) Disabled children perceive significantly more parental aggression/hostility than do their non-disabled counterparts.

   c) Disabled children perceive significantly more neglect/indifference than do their non-disabled counterparts.

   d) Disabled children perceive significantly more undifferentiated rejection than do their non-disabled counterparts.

Using the PAQ:

2. The partial "mental health" status of disabled children is significantly lower than that of their non-disabled counterparts. (Using total, composite score).

a) Disabled children report significantly more hostility/aggression than do their non-disabled counterparts.

b) Disabled children report significantly more dependence than do their non-disabled counterparts.

c) Disabled children report significantly more negative self-esteem than do their non-disabled counterparts.

d) Disabled children report significantly more negative self-adequacy than do their non-disabled counterparts.

e) Disabled children report significantly more emotional unresponsiveness than do their non-disabled counterparts.

f) Disabled children report significantly more emotional instability than do their non-disabled counterparts.

g) Disabled children report significantly more of a negative world view than do their non-disabled counterparts.

(Using the 7 scales of the PAQ.)

Using the over-preotection/over-mothering questionnaire: (O-PQ)

3. Disabled children report significantly more overpretection by their mothers than do their non-disabled counterparts. (Using the total score.)

a) Mothers of disabled children tend to limit their children's time spent away from mother and home significantly more than the mothers of their non-disabled counterparts.

b) Mothers of disabled children tend to be significantly more involved in their childrens' affairs than the mothers of their non-disabled counterparts.

c) Mothers of disabled children tend to be significantly less demanding on their children in terms of household help and cooperation, compared with the mothers of their non-disabled counterparts.

d) Mothers of disabled children tend to be significantly more overprotecting (without also being rejecting) to their children, than do their non-disabled counterparts.

At this point it should be noted that although the above stated hypotheses are all directional in terms of the disabled being more rejected, overprotected and having a lower "mental health status" than their non-disabled counterparts, this is not necessarily what I expected from my sample.

These hypotheses were basically formulated from the findings from Western literature as already indicated, although Thomas (1978) has pointed out that the literature to date, (particularly on parental attitudes) is incomplete and perhaps misleading as it lacks the dimension of actual experience. Other authors such as Hewett (1970) and Gregory (1976) have also stressed the diversity of results so far obtained.

What struck me particularly about the literature on rejection and over-protection in the disabled was that although these were frequently noted as characteristics of the disabled, actual research evidence for them was never presented. They seemed rather to be concluding sympathies voiced by the authors concerned, with their actual definitions and measurement not being consistent or even available in some cases.

Having worked personally with the disabled on a number of occasions, (although only in Zambia), I did not get the picture of their social situation being one of rejection and over-protection in most cases, although, I admit, I did harbour these ideas to some extent before my work with them.

What I was after in this research was the actual social and emotional situation for the disabled schoolchild in Zambia today, in terms of acceptance/rejection, over-protection and emotional adjustment. These seemed to be the pertinent issues for me, and were, at the same time, ambiguous as far as the literature was concerned.

As far as acceptance-rejection and emotional adjustment were concerned, Rohner's PARQ and PAQ qualified very well for my use as they have been developed and tested over many years. For the"over-protection" aspect, I developed my own questionnaire and, as Rohner did, I concerned myself with actual behaviours rather than "attitudes", the latter which has largely been the case in past researches.

Using the above listed hypothesesderived from the three mentioned questionnaires, I wanted to find out the existing social situation (or milieu) for the disabled Zambian schoolchild in terms of acceptance/rejection and over-protection, as well as the existing emotional adjustment in terms of the partial mental health status of the children concerned, compared with their non-disabled counterparts.

Details of the three instruments used and their development follow in Chapter 2.

CHAPTER 2

METHOD

This Chapter will describe the subjects of the study along with the 3 questionnaires used to measure (1) the over-mothering aspect of over-protection, (2) rejection-acceptance, and (3) the seven personality dispositions predicted by PART to be expectable outcomes of parental aggression or neglect everywhere, giving a partial "mental health" status of my respondents. A description of ,the pilot studies and final procedure will be included with each instrument description.

Subjects

As indicated in the introduction, it was my intention in this study to compare two groups of subjects; physically disabled school children with their non-disabled school-going counterparts.

The reason I chose to limit the disabled sample to visible physical disability was not because I expected them to have the same "personality" because of the similarity of their disabilities as has been done for the blind, deaf, epileptic and other disabling conditions described in Thomas, 1978 (p.74-84). My reason for restricting the subjects to those with visible, physical disabilities was basically methodological, as I wanted subjects who has no problems with reading, hearing and writing to answer my questionnaires efficiently.

I further decided to exclude subjects with episodic physical disabilities such as epilepsy and sickle-cell anaemia because of the inconsistency of their debilitating episodic conditions. After making inquiries into the frequency and length of these debilitating episodes from the teachers and children themselves, I discovered that the episodes varied tremendously, depending on the child concerned, with some being severely debilitated for long periods, and others being slightly debilitated very rarely. I therefore decided to restrict my sample to children with permanent, visible defects of the limbs, i.e. those with orthopaedic impairments. As this paper deals mainly with the social psychological aspects of disability, I did not find it useful to go into the different medical classifications of the orthopaedic disfunctions of my sample, but noted instead which limb(s) was affected and if this had a mild, serious or severe disabling effect on the child concerned. My operational definitions were as follows:

1. <u>Mild visible disability</u>.

   a) Of the leg-child has use of both legs but walks with slight difficulty due to "thin" leg from polio, or deformed foot, or one leg shorter than the other. <u>No aids needed for walking</u>.

   b) Of the arm-child has both arms but has lost full use of one hand due to finger deformities or finger loss etc. Partial use of disabled arm and hand.

   c) Of combination of limbs-child has all 4 limbs but has restricted use of an arm and leg due to congenital malformations or partial paralysis etc.

2. <u>Serious visible disability</u>.

   a) Of the leg-child has to make use of calipers or crutches but is able to <u>walk with the help of these aids.</u> Could include limb loss.

   b) Of the arm-child has both arms but loss of a hand, further limiting use of disabled arm.

   c) Of comination of limbs-child is able to walk but only with the help of aids e.g. calipers on arms and legs.

3. Severe visible disability.

   a) Of the leg(s) -child is unable to walk and is dependent on a wheel-chair or being carried about. Could include paralysis or loss of both legs.

   b) Of the arm(s)-child has total loss of use of arm or arms due to paralysis or limb loss.

   c) Of comination of limbs-child is unable to move about on its own due to loss or paralysis of limbs.

At this point it may be noted that disabled children who are able to attend regular schools are probably thought to be the mildly rather than the severely disabled. This is true to some extent, although as we will see from my sample, a fair number of children using calipers, crutches and wheelchairs are found in regular schools. Further, I would like to put forward a point from somatopsychology which contradicts an often expressed view that poorer adjustment is associated with more severe handicap. According to this position, the visibly disabled are given a subordinate social role and those with milder disabilities will suffer greater anxiety and frustration than the grossly handicapped, since the latter experience lower expectations or have more allowances made for them. In this light, I have assumed that my subjects with mild disabilities will have about the same problems with adjustment as those with severe visible disabilities (using my definitions), and have thus included them together in my sample of disabled children.

Sample selection.

For my sample, I had a group of visibly disabled school-going children together with a matched group of non-disabled school-going children. As far as the randomness of my sample was concerned, I assumed that the occurence of a disability is usually random in itself, so I chose as my sample, all the visibly disabled children I came across in nine Lusaka Government Primary schools. I found a total of 25 visibly disabled children in seven of these, who served as my sample. As far as choosing matched, non-disabled controls was concerned, I chose a child of the same age, grade and sex as the disabled child, sitting nearest the disabled child in class.

It may be noted that the question was raised as to why I did not choose my matched subjects from amongst the siblings of the disabled sample. Besides the obvious reasons of possibly not being able to match age and sex, there is evidence from the literature that if a disabled child is present, this will naturally have an effect on the role patterns of the family and each member thereof, (Parsons, 1958). Taking this into account, I naturally excluded from my sample of non-disabled children, any who had a disabled sibling or parent at home as well.

The following is a summary of the description of my sample of 25 visibly physically disabled and 25 matching non-disabled children:

1. Sex

Sex	Male	Female
Disabled	13	12
Non-disabled	13	12

2. Age

Age	10	11	12	13	14	15	16
Disabled	2	1	5	10	5	1	1
Non-disabled	2	1	5	10	5	2	

Grade at school

3.

Grade	5	6	7
Disabled	7	5	13
Non-disabled	7	5	13

4. Classification of disability (for disabled only).

Classification	No. of subjects
Mild	21
Serious	3
Severe	1
	25

(15 polio cases included).

5. Age of onset of disability (disabled group only)

Age	Number
since birth	4
6 months to 3 yrs	19
8 yrs	1
9 yrs	1

6. Ordinal position in the family

Position	1st born	2nd	3rd	4th+
disabled	6	8	6	5
Non-disabled	4	8	4	9

7. Number of siblings

No. of siblings	only child	1-3	4-6	7-9	Over 9
disabled	0	3	10	12	0
Non-disabled	0	6	8	9	2

Mothers' occupation

Occupation	housewife	office worker	Other
disabled	15	6	4 (2 teachers, 1 nurse, 1 air-hostess.)
Non-disabled	16	7	2 (1 Minister, 1 business-woman).

Instrument Number 1:

The Parental Acceptance-Rejection Questionnaire (PARQ).

The PARQ is a self-report instrument designed by Rohner, Saavedra and Granum (1979) to measure individuals' perceptions of parental acceptance and rejection (i.e. the warmth dimension). Parental acceptance-rejection is a bipolar dimension of parental behaviour with acceptance defining one end of the continuum and parental rejection defining the other end.

Parental rejection seems to be expressed the world over in three different ways (see Rohner, 1975), namely in the form of aggression/hostility, neglect/indifference, and in an "undifferentiated" form where the expression of rejection is neither clearly aggressive/hostile now neglecting/indifferent.

There are 3 versions of the PARQ, the Adult, Child and Mother PARQs. The one I chose to use is the Child PARQ which asks children to respond about the way they feel their mothers treat them. The instrument thus measures an individual's perception of the warmth and affection or rejection he receives in his family. Most of the items in the questionnaire refer to maternal <u>behaviour</u> rather than to maternal attitudes, thus avoiding some of the difficulties commonly found when one has to demonstrate that a link exists between the attitudes expressed by a person and behaviour engaged in by the person.

Definitions.

The Child PARQ consists of four scales:

1) perceived parental warmth/affection.
2) perceived parental aggression/hostility
3) perceived parental neglect/indifference, and
4) perceived parental rejection (undifferentiated).

The perceived parental warmth/affection scale refers to parent-child relationships where parents are perceived to give love or affection without qualification, but not necessarily with great demonstration. Accepting parents are generally seen as liking their child, they are seen as approving of his personality and they seem to take an interest in his activities and well-being. Warmth and affection may be manifested by showing approval of the child, playing with him, enjoying him, fondling him, comforting or consoling him, praising him, or demonstrating love in words or other actions. Routine caretaking and amusing the child as part of a schedule, or as a matter of felt duty or responsibility do not automatically indicate emotional warmth and affection. Signs of spontaneous warmth and affection are more revealing than warmth and affection which are solicited by the child.

Perceived parental aggression/hostility, perceived neglect/indifference, and perceived undifferentiated rejection are all forms of behaviour falling at the "negative" (i.e rejecting) end of the warmth dimension. Perceived parental rejection refers to the perceived absence or significant withdrawal of warmth and affection. Parents who are perceived to be rejecting, seem not to like their child, they seem to disapprove of him or resent him, and they are often seen as viewing him as a burden rather than a pleasure. Many rejecting parents are seen to be cold and unsympathetic, and they are seen as comparing their child unfavorably with other children.

The scale "perceived undifferentiated rejection" refers to conditions where the child sees his parents as withdrawing warmth from him (i.e. they are seen as rejecting him), but where such rejection does not clearly reflect either perceived aggression/hostility or perceived neglect/indifference, per se. To illustrate, question 4 in the Child PARQ states, "My mother does not really love me."

The scale "perceived aggression/hostility refers (a) to conditions where the child believes his parents are angry, bitter, or resentful of him (i.e. perceived hostility), or (b) conditions where the child believes his parents intend to hurt him, physically or verbally (i.e. perceived aggression). Parents who are seen as being "aggressive" are often viewed as being critically impatient, irritable, or antagonistic toward the child. Such parents may be seen to make disapproving or derogatory remarks to and about the child. Apparently aggressive, hostile parents may be viewed as nagging, scolding, and ridiculing their child, and they may say how the child gets on their nerves or express their frustration and **irritation** at the child's behaviour in other ways. Other expressions may include abrupt and rough handling of the child, hitting the child, cursing the child, and speaking to him in what is perceived as a harsh, depreciating tone of voice.

The scale "perceived neglect/indifference" refers to conditions where the child sees his parents as unconcerned or uninterested in him. Such parents are seen by the child as paying little attention to him, and they are apt to be viewed as spending a minimum amount of time with him. When such parents are together with their children they may be perceived to ignore the child's requests for help, attention or comfort. They may be seen as forgetting promises made to him, and they are often regarded as failing to attend to other details or needs important to the child's happiness or well-being. Neglecting or indifferent parents are not necessarily seen to be hostile, however; they simply may be viewed as cold, distant, or unconcerned about their child.

PARQ Format:

There are a total of 60 items in the questionnaire: the warmth/affection scale has 20 items, the aggression/hostility and neglect/indifference scales each contain 15 items and the undifferentiated scale contains 10 items.

Modifications

In addition to the 18 items reworded by Rohner et. al, in the Child version to make them more understandable to young children, I reworded a further 11 questions after pre-testing the qustionnaire. The pretest was carried out on a sample of 20 Grade 5 to 7 pupils at Lusaka Boys School to make sure that the children could understand the questions as well as the questionnaire procedure.

Although Rohner et. al. recommend the questionnaire to be used on respondents from 7 to 12 years of age, after two pre-tests of the CPARQ, I found it necessary to start my sampling at the Grade 5 level because of the difficulties the respondents had in understanding the questionnaire which was in a second language for all of them.

In addition to the 11 question modifications (incidentally, in which I tried to keep as close to the meaning of the original questions as possible), and the modified age range from 10 to 15 years of age, I also modified the instructions and procedure of the questionnaire. I summarised the written instructions and instead spent more time explaining them verbally. Rohner et. al. indicate that the entire questionnaire may have to be read to poor readers, which was the case for most of the Grade 5 respondents. For those who completed the questionnaire by themselves, I instructed them in the beginning to raise their hands if at all there was any word they did not understand, stressing that the exercise was not a "test" and that they were free to ask about the meanings of as many questions as they liked.

In the verbal instructions, respondents were asked not to dwell too long on each item. They were reminded that there were no right or wrong answers to the items and were encouraged to respond rapidly and the way they really feel, and not the way they might like their mother to be. As recommended, the questionnaires were completed in a single sitting and without distraction. In most cases the respondents took about 5 minutes longer than the 20 minutes typically taken to complete the CPARQ.

Scoring System:

In the CPARQ respondents were instructed to ask themselves if an item is basically true or untrue about the way their mothers treat them. If the statement is basically true, they are instructed to ask themselves, "Is it almost always true?" or " Is it only sometimes true?" Or, if an item is basically untrue, they are instructed to ask: "Is it rarely true?" or, "Is it almost never true?".

The items are scored as follows:

True of my mother		Not true of my mother	
Almost always true	Sometimes true	Rarely true	Almost never true
4	3	2	1

Seven items in the neglect/indifference are reverse scored, and all the items in the warmth/affection scale are reverse scored so that a high score indicates maximum perceived rejection or minimum perceived warmth /affection. For those items that are reverse scored, the scoring changes as follows:

4 becomes 1

3 becomes 2

2 becomes 3

1 becomes 4

As indicated by Rohner et. al., the mean and standard deviations of the 4 scales will probably be somewhat different within most samples. They recommend therefore, that each of the 4 scales be converted to a Z-score before summing the scores to form a total (composite) test score, and before performing any subsequent statistical operations.

Interpretation of the PARQ.

As indicated in the hypotheses in Chapter One, part of my aim was to compare my disabled with a matching non-disabled sample on the 4 PARQ scales as well as the total (composite) PARQ score.

T-tests **were used to compare the** two matched groups for each scale as well as for the total score, giving a total of 5 t-tests **for the PARQ.**

In addition to the testing for significance of these hypotheses, I compared the descriptive data obtained (i.e. mean, standard deviation, midpoint, maximum and minimum for each scale) with the responses of a sample of 220 children tested by Rohner et. al. (1980).

Development of the PARQ.

It is important to note that the CPARQ was constructed to be usable cross-culturally, and thus three additional considerations guided the development of the instrument. First, that the scales chould have universal applicability; second, that the terms within each scale should have common international referents; and third, that the phraseology of the items should be decentred from standard, idiomatic American English.

These conditions were approximately satisfied through the following procedures. Prior work on a cross-cultural survey using a sample of 101 societies showed that verbal and physical forms of the 4 scales are the principal manifestations of the rejection-acceptance process the world over (see Rohner, 1975). Also, the same study was helpful in clarifying specific classes of items that have common international referents. The test items were screened and decentred from idiomatic American-English in 1971 with the help of two Turkish anthropologists in collaboration with three American-English speakers. Subsequently over the next 2 years the instrument was piloted on a small sample of English-speaking children in

New England to detect any further problems with the test items, response format, and so forth. Since 1973, continual pre-testing has helped detect items containing words that are troublesome, especially for young children. Standardized substitutions for these words or phrases are described in the "Handbook", (1980), some of which I made use of.

The most intensive formal, statistical analysis of the validity and reliability of the instrument was initiated starting 1975. This analysis is described in detail in the "Handbook," (1980, p.30-39).

Final Procedure and Administration of the CPARQ.

The final administration of the CPARQ on the 50 subjects took place at 7 Lusaka primary schools over a period of 2 months. The location of subjects was made, in most cases, a week or two before the final test administration. In all cases, the CPARQ was administered to the subjects on the same day as the other 2 instruments of my study, with a break of 10 minutes between the administration of each questionnaire. The CFAQ was administered first, followed by the CPARQ and lastly by the "over-mothering" questionnaire.

In most cases, the test administration took place in the school staff rooms and twice in a senior teachers office, as the schools do not usually have an empty classroom to spare. The average class size from which the subjects came was from 45 to 63 pupils per class.

As there were only a few disabled subjects from each school, each test sitting usually consisted of 2 disabled with 2 non-disabled children. In the cases where 3 to 5 disabled pupils were found in one school, I usually had 2 sittings on different days in the same school. The reason for this was that I had noticed during my pre-testing that the younger pupils (Grade 5) had problems with some items and I wanted to be able to read out the items for them if necessary. I gave the subjects the option to read the questionnaires themselves or to ask me to read to them if they wished. I found that 10 of the 14 Grade 5 subjects asked me to read the questionnaires for them. The others completed the questionnaires on their own, only asking me to read or explain items they did not understand.

The child version of the Parental Acceptance-Rejection Questionnaire is presented in the Appendix in full.

Instrument Number 2:

The Personality Assessment Questionnaire (PAQ)

The PAQ is a self-report instrument designed to assess an individual's perception of him/herself with respect to seven behavioural dispositions:

1) hostility and aggression, including physical aggression, verbal aggression, passive aggression, and problems with the management of hostility and aggression
2) dependency,
3) self-esteem,
4) self-adequeacy,
5) emotional responsiveness,
6) emotional stability, and
7) world view.

(Evidence is presented regarding the internal consistency as well as the concurrent, convergent, discriminant, and construct validities of these scales in the Handbook,(1980, p.66-86).

The PAQ was developed as a complement to the PARQ. That is, as predicted by parental acceptance-rejection theory, parental warmth/affection, hostility/aggression, indifference/neglect, and undifferentiated rejection (as measured by the PARQ) are related to the personality and behavioural constructs measured by the PAQ (Rohner 1975, 1980). The PAQ may be used in other contexts as well, such as making an overall assessment of the (partial)" "mental health" status of respondents concerned. (Handbook, 1980, P.64).

Three versions of the PAQ have been developed as with the PARQ, a Mother, Adult and Child version, the latter which I have used. This Child PAQ was designed to be used on children from about seven through twelve years of age. The PAQ asks children to reflect on their behavioural dispositions. It is written in the present tense and asks respondents to reflect on their true, not ideal or wished-for, feelings about themselves.

Definitions

It should be noted that the continuum-like quality of the behavioural and personality dispositions is not emphasized in the following definitions, although it is implied by PART.

Hostility, Aggression, or Passive Aggression, and Problems with the Management of Hostility and Aggression.

Hostility and Aggression. Hostility is an emotional (internal) reaction or feeling of anger, enmity or resentment directed toward another person, situation or oneself. Hostility is expressed behaviourally (externally) in the form of aggression, an act which is intended to hurt someone or something, usually another person, but sometimes oneself. Active aggression may be manifested verbally in such forms as bickering, quarreling, telling someone off, sarcasm, or by making fun of someone, criticizing him, humiliating him, cursing him or saying thoughtless, unkind or cruel things. Aggression may be revealed physically by fighting, hitting, kicking, biting, scratching, pinching, throwing things or by other forms of destructiveness.

Passive Aggression. This is a less direct expression of aggression in such forms as pouting, sulking, procrastination, stubbornness, passive obstructionism, bitterness, vindictiveness, irritability, and temper tantrums.

Problems with the Management of Hostility and Aggression

This refers to the expression of these feelings in disguised or symbolic form such as worried preoccupation about aggression, aggressive fantasies or dreams, anxiety over one's own real or fantasied aggression, unusual interest in hearing or talking about violent incidents, or by an unusual concern about the real or threatened aggression of others. These feelings may be conscious (recognized) or unconscious (unrecognised) by the individual. In either case the person has difficulty coping with or expressing hostility or aggression.

Dependence. This is the emotional reliance of one person on another for comfort, approval, guidance, support, reassurance or decision making. Independence is essential freedom from such emotional reliance. The goal of dependency behaviour among children is usually the elicitation of warm, affectionate attention from an adult. Indicators of dependency among children include clinging to their parent, attention seeking, becoming anxious, insecure, unhappy, weepy or whiney when they are separated from their parent, or waiting for or demanding the nurturant response of someone else (i.e. succorance).

The dependence scale of the PAQ emphasizes items dealing with individuals' desire to have sympathy or encouragement from persons close to them when they are sick or having troubles. None of the items deals with two forms of behaviour sometimes associated with dependency, viz. (a) proximity seeking - the desire to be near or in physical contact with another person - or, (b) approval seeking.

Self Evaluation (Self-Esteem and Self-Adequacy).

Self-evaluation consists of feelings about, attitudes toward, and perceptions of oneself, falling on a continuum from positive to negative. Self-evaluation consists of two related dimensions, self-esteem and self-adequacy:

Self-Esteem.

This is a global, emotional evaluation of oneself in terms of worth. Positive feelings of self-esteem imply that a person likes or approves of himself, accepts himself, is confortable with himself, is rarely disappointed in himself, and perceives himself as being a person of worth, or worthy of respect. Negative self-esteem, on the other hand, implies that a person dislikes or disapproves of himself, is uncomfortable with himself, is disappointed in himself, devaluates himself, perhaps feels inferior to others, and perceives himself as being essentially a worthless person or as being worth of condemnation.

Self-Adequacy.

This is an overall self-evaluation of one's competence to perform daily tasks adequately, to cope satisfactorily with daily problems, and to satisfy one's own needs. Positive feelings of self-adequacy imply that a person views himself as being a capable person, able to satisfactorily deal with his daily problems, feels that he is a success or capable of success in the things he sets out to do; he is self-assured or self-confident and feels socially adequate.

Negative feelings of self-adequacy, on the other hand, imply that a person feels he is an incompetent person, unable to successfully meet or cope with the demands of day-to-day living. He lacks confident self-assurance, often feeling inept; and he sees himself as a failure and as being unable to successfully compete for the things he wants.

Emotional Responsiveness.

This refers to a person's ability to freely and openly express his emotions, for example, feelings of warmth and affection. Emotional responsiveness is revealed by the spontaneity and ease with which a person is able to respond emotionally to another person. That is, emotionally responsive people have little difficulty forming warm, intimate, involved and lasting attachments. Their attachments are not troubled by emotional constriction or defensiveness. They are able to easily act out their sympathy and other feelings on appropriate occasions. Interpersonal relations of emotionally responsive people tend to be close and personal, and such persons have little trouble responding emotionally to the friendship advances of others.

Emotionally unresponsive or insulated people, on the other hand, are subject to fairly wide, frequent and unpredictable mood shifts which swing from such poles as cheerful to gloomy, happy to unhappy, contented to dissatisfied, or friendly to hostile. Such persons are often upset easily by small setbacks or difficulties, and they tend to lose composure under minor stress. Oftentimes emotionally unstable people also tend to be excitable or to get angry easily and quickly.

Evaluation of the World (World View).

This is a person's often unverbalized, global or overall evaluation of life and the universe as being essentially a positive or negative place, that is as being basically a good, secure, friendly, happy, unthreatening place having few dangers (positive world view), or as being a bad, insecure, threatening, unpleasant and hostile, or uncertain place full of dangers (negative world view). World view refers to one's conceptions of and feelings about the basic nature of the cosmos and of life itself; it does not refer to a person's empirically derived knowledge of the economic, political, social or natural environment in which he lives.

Structure of the PAQ.

The child version of the PAQ contains seven scales designed to measure the seven behavioural characteristics described before. Each scale contains 6 items giving a total of 42 items. It should be noted that the vocabulary in the child version is simplified and therefore more generalized than the adult version.

Essentially, the structure of the PAQ is very much the same as the PARQ, with the main difference being that the PARQ asks respondents to answer about their mothers while the PAQ asks them to respond about themselves. Since this is the case, the procedure will not be repeated except to say that the PAQ was administered to the same subjects under the same conditions as the PARQ, with a ten minute break in-between, the PAQ being administered first.

The PAQ was pre-tested on the same sample as the PARQ and 7 vocabulary changes were made (e.g. stupid for dumb, cross for grouchy. cheerful for cheery, angry for mad.) The instructions were also modified as with the PARQ; the writtten instructions were summarised and the verbal explanation ellaborated instead, The PAQ was read out loud to the same respondents that requested the PARQ to be read to them,

The response options and scoring system of the PAQ are the same as for the PARQ. 31% (13 items) in the PAQ are reverse scored. All scales are designed so that a high score indicates a maximum of the behaviour that is predicted to be associated with parental rejection, namely high hostility, dependence (vs, independence), negative self-adequacy, emotional unresponsiveness, emotional instability, and negative world view.

All items in the PAQ are constructed to reveal at face value relevant behaviours in each of the seven scales defined and operationalized earlier. That is, no indirect indicators are employed.

Total (Composite) PAQ Score.

As indicated earlier, the PAQ was designed originally to measure seven personality/behavioural dispositions which are predicted in PART to be associated universally with parental acceptance-rejection. Parental rejection tends to impair healthy emotional and behavioural functioning. That is, rejection affects one's "mental health". Thus individuals who achieve a high score on the PAQ may be regarded as having a "poorer" mental health status than persons who achieve low scores. Thus, researchers may find it useful to make an overall assessment of the (partial) "mental health" status of respondents by summing the seven scale-scores to form an overall or composite test-score.

Because the mean and standard deviation of the seven scale scores are likely to be somewhat different within most samples, Rohner advises researchers to convert scale scores to Z scores prior to summing the scale scores.

Interpretation of the PAQ.

As can be seen from the hypotheses in Chapter 1, my main aim was to compare my disabled with a non-disabled sample for the 7 PAQ scales as well as the total (composite) PAQ score. I used t-tests to compare the two groups for each scale as well as for the total score, giving a total of 8 t-tests for the PAQ.

In addition to the testing of hypotheses, I compared my descriptive data (i.e. mean, standard deviation, and midpoint for each scale) with the responses of a sample of 220 children tested by Rohner et. al. (1973).

Development of the PAQ.

As with the PARQ, the 3 versions of the PAQ were constructed on a rational-theoretical basis (Goldberg, 1972) in 1971. The same cross-cultural considerations guided the development of the PAQ as did the PARQ. The PAQ developed along with the PARQ and was subject to the same screening, piloting and pre-testing as described for the latter.

Guided by the standards outlined in the American Psychological Association's "Standards for Educational and Psychological Tests" (1974), the PAQ was subjected to an intensive analysis of its validity and reliability described in the "Handbook" (1980, p.66-86).

The Child Personality Assessment Questionnaire is presented in the Appendix in full.

Instrument Number Three:

The Over-mothering (over-protection) Questionnaire. (O-PQ).

Development of the O-PQ .

In the initial stages of trying to define "over-protection" operationally and hence develop my questionnaire, I came across Thomas' (1978) warning of the use of such a broad term as "over-protection" which tends to imply that attitudes are constant and held equally by both parents. I also came across Poznanski's (1973) definition of over-protection among parents of the disabled which for him means that (1) the handicapped child receives more attention than the disability requires and (2) much more than any siblings receive. The term "over-mothered" also came to my attention through the work of Wiggins et. al. (1971 p.173) who commented on the "over-mothered" sometimes called "smothered" person.

Taking the above stated into account, I decided to limit my definition of over-protection to one of the partial, behavioural manifestations of over-protection by the mother only. It should be noted that the behavioural manifestations I chose to include in my definition don't in any way represent a complete list of behavioural manifestations of over-protection possible by the mother. Instead, they are the ones I chose to be as some of the most common and obvious behavioural manifestations of over-protection. Although I had originally decided (because of Poznanski's definition) to use a comparative definition comparing my subjects with their siblings, I decided to abandon this idea for two reasons. Firstly, what about those only children in my sample, secondly, which sibling; the older or younger one, and thirdly, I would not be able to find siblings of the same age and sex except for identical twins.

My definition of over-mothering was as follows:

(1) Tendency of mother to restrict child's time spent away from home and herself.

(2) Tendency of mother to be much involved in child's affairs.

(3) Tendency of mother not to be too demanding on child in terms of help and cooperation.

From these tendencies which had been compressed from an original list of 7, I devised a questionnaire of 14 questions to be administered to the mothers of my sample. On pre-testing this questionnaire on the mothers of the same sample I used for pre-testing the PAQ and PARQ, I had problems, with only 60% of my sample being able to answer the questionnaires due to language and literacy problems. I therefore decided to rephrase my questions to be answered by the children, as was the PAQ and PARQ. I also expected less stereotyped and thus more truthful answers from the children.

The first child O-PQ (Over-protection questionnaire) consisted of 12 questions as I had delected two ambiguous questions. The questionnaire was a multiple-choice type with each question having 4 alternatives (a, b, c, d) from which to choose. On pre-testing the Child O-PQ I discovered that 3 questions had ceilings that were too high, so I rephrased the alternatives to adjust the ceilings.

For each over-mothering tendency, I had the following number of questions:

Tendency 1 : 5 questions (Numbers 2, 4, 5, 7, 10)
Tendency 2 : 5 questions (Numbers 6, 8, 9, 11, 12)
Tendency 3 : 2 questions (Numbers 1, 3)

The Thurstone scale was used to grade the answers. Depending on the question, the alternatives in the answer were scored as follows:

For questions 1, 2, 4, 8, 9, 10 and 11 the key was: a scores 4
b scores 3
c scores 2
d scores 1

For questions 3, 5, 6, 7 and 12 the key was: a scores 1
b scores 2
c scores 3
d scores 4

For all the questions, the highest score (4) stood for maximum over-mothering and the lowest score (1) stood for minimum over-mothering. The alternatives therefore lay on a continuum with 4 points, score 4 being the highest and score 1 the lowest, with scores 2 and 3 in between.

The instructions for the O-P Q were very brief asking the respondents to tick the one best answer that "shows how your mother is to you" for each of the twelve questions. (See appendix for questionnaire.).

Final Administration and Procedure.

The O-PQ was administered on the same sample of 25 disabled and matching 25 non-disabled children as was the PARQ and PAQ. The O-PQ was the last questionnaire to be administered after a 10 minute break after the PARQ. The instructions were read out loud in all cases, and for the ases who had the other two questionnaires read to them, so was the PQ.

The questionnaire took at most 10 minutes to complete and the nswers were checked to see if only one answer had been ticked and that ll 12 questions had been answered.

nterpretation of the (Over-mothering) Over-protection Questionnaire.

As indicated in Chapter 1, the aim of constructing the O-PQ n this study was to test 4 hypotheses related to over-protection by he mothers of my sample. The main aim (and hypothesis) was to see if he disabled sample admitted to significantly more over-protective ehaviour from their mothers than did their matched non-disabled ounterparts (i.e. using total O-PQ)

The three subordinate hypotheses were related to each "behavioural endency" investigated to see if there was a significant difference etween the tendency scores of the disabled-compared to the non-disabled roup.

CHAPTER 3

RESULTS

Introduction:

Before describing the results of the analysis of the data obtained in the study, I will briefly indicate why I chose to use "one-tailed t-tests for independent samples" to analyse the data obtained.

Firstly, due to the use of a Lickert and interval scaling in the response formats, it was clear that I had to use a parametric test for analysing the data, thus the t-test.

Secondly, it may be noted from the previous chapters that I referred to the two samples concerned as "the disabled and their non-disabled counterparts", rather than "the disabled and a "matched" non-disabled sample." The reason for the word "matched" only being used in parenthesis was that I did not have a "matched subjects design", but rather an "independent groups design." The two samples concerned were not matched in the statistically necessary way as it was not possible to ensure that they were "very similar on the variables that influence the behaviour(s) of the study," (Miller, 1975, p.19). In my case I was only looking at one variable (physical disability) that may contribute to overprotection and rejection, leaving out many other possible contributing variables. For this reason, I considered the two groups as "independent samples", although I did control for age, sex and grade to make sure that I was dealing with two groups of "primary school-going children", rather than perhaps children who do not attend school and fall outside the age range for children.

Thirdly, it may be noted from the hypotheses presented in Chapter One that they were all directional, predicting that the disabled sample would show more rejection, overprotection and their composite traits than he non-disabled sample. This factor pointed to the use of one-tailed ather than two-tailed t-tests on the data obtained.

Over-all, it was thus decided to use""one-tailed t-tests for ndependent samples" to analyse the data obtained.

esults of data analysis.

In the statistical analysis of the data obtained, I will be resenting each hypothesis previously indicated in Chapter One together ith the t-test results and additional descriptive statistics obtained ith the help of the social science package of the University computer. lso presented will be some basic descriptive statistics obtained by ohner et. al. (1976) testing 220 Washington D.C. primary school espondents, for the PAQ and PARQ, which I will compare with results obtained.

Finally, a written resume' of the findings in order of their tatistical significance will be presented.

-test results.

(Critical values of t given for .05 level of significance).

1. The Parental Acceptance-Rejection Questionnaire (PARQ).

Hypothesis 1:

Disabled children perceive significantly more rejection from their mothers than do their non-disabled counterparts.
(Using total, composite Z scores).

	No. of cases	Mean	Standard dev.	t-value	degrees-freedom	critical value of t
Disabled	25	.0004	3.303	-0.19	48	1.684
on-disabled	25	0.1752	3.158			

The t value obtained indicates accepting the null-hypothesis of significant difference in perceived rejection between the disabled and -disabled groups.

othesis 1 (a):

Disabled children perceive significantly <u>less warmth/affection</u> n do their non-disabled counterparts.

	No. of cases	Mean	S.D.	t-value	deg.freedom	crit.val. of t
Disabled	25	39.4	9.138	-0.23	48	1.684
on-disabled	25	40.08	11.503			

The t-value obtained indicates accepting the null-hypothesis of significant difference of perceived <u>warmth/affection</u> between the abled and non-disabled groups.

othesis 1 (b):

Disabled children perceive significantly <u>more aggression/hostility</u> n do their non-disabled counterparts.

	No. of cases	Mean	S.D.	t-value	deg.freedom	crit. val. of t
Disabled	25	33.64	7.488	-1.22	48	1.684
Non-Disabled	25	36.16	7.051			

The t-value obtained indicates accepting the null hypothesis of significant difference of perceived <u>aggression/hostility</u> between the abled and non-disabled groups.

othesis 1 (c):

Disabled children perceive significantly more <u>neglect/indifference</u> n do their non-disabled counterparts.

	No. of cases	Mean	S.D.	t-value	deg.freedom	crit. Val. of t.
Disabled	25	32.32	6.575	0.07	48	1.684
on-disabled	25	32.2	5.708			

The t-value obtained indicates accepting the null hypothesis of o significant difference of perceived neglect/indifference between the isabled and non-disabled groups.

pothesis 1 (d):

Disabled children perceive significantly more undifferentiated ejection than do their non-disabled counterparts.

	No. of cases	Mean	S.D.	t-value	deg.freedom	crit. t val
Disabled	25	22.88	5.94	-0.5	48	1.684
on-disabled	25	23.64	4.83			

The t-value obtained indicates accepting the null hypothesis of significant difference of perceived undifferentiated rejection tween the disabled and non-disabled groups.

e Personality Assessment Questionnaire (PAQ).

pothesis 2:

The partial "mental health" status of disabled children is gnificantly lower than that of their non-disabled counterparts. sing total, composite Z scores).

	No. of cases	Mean	S.D.	t-value	deg.freedom	crit.t value
Disabled	25	-0.158	2.85	0.27	48	1.684
Non-disabled	25	-0.416	3.52			

The t-value obtained indicates accepting the null hypothesis of significant difference between the partial "mental health" statuses the disabled and non-disabled groups.

pothesis 2 (a):

Disabled children report significantly more hostility/aggression an do their non-disabled counterparts.

	No. of cases	Mean	S.D.	t-value	deg.freedom	crit. t value.
Disabled	25	14.28	2.98	-0.19	48	1.684
Non-disabled	25	14.44	3.04			

The t-value obtained indicates accepting the null hypothesis of o significant difference of hostility/aggression manifestations between he disabled and non-disabled groups.

ypothesis 2 (b):

Disabled children report significantly more dependence than do heir non-disable counterparts.

	No. of cases	Mean	S.D.	t-Value	deg.freedom	crit. t valu
Disabled	25	18.0	2.56	0.65	48	1.684
Non-disabled	25	17.48	3.07			

The t-value obtained indicates accepting the null hypothesis of o significant difference of dependence manifestations between the disabled nd non-disabled groups.

ypothesis 2 (c):

Disabled children report significantly more negative self-esteem han do their non-disabled counterparts.

	No. of cases	Mean	S.D.	t-value	deg.freedom	crit. t va
Disabled	25	14.72	3.29	1.96	48	1.684
Non-disabled	25	12.96	3.06			

The t-value obtained indicates accepting the alternate hypothesis hat there is a significant difference between the negative self-esteem cores for the disabled and non-disabled groups. The disabled group howed significantly more negative self-esteem than their non-disabled ounterparts.

pothesis 2 (d):

Disabled children report significantly more negative self-adequacy an do their non-disabled counterparts.

	No. of cases	Mean	S.D.	t-value	deg.freedom	crit. t value
Disabled	25	15.56	3.46	0.38	48	1.684
n-disabled	25	15.24	2.29			

The t-value obtained indicates accepting the null hypothesis of significant difference of negative self-adequeacy manifestations tween the disabled and non-disabled groups.

pothesis 2 (e):

Disabled children report significantly more emotional unresponsivenes an do their non-disabled counterparts.

	No. of cases	Mean	S.D.	t-value	deg.freedom	crit.t value.
Disabled	25	14.32	1.79	0.13	48	1.684
n-disabled	25	14.24	2.52			

The t-value obtained indicates accepting the null hypothesis of significant difference of emotional unresponsiveness between the sabled and non-disabled groups.

pothesis 2 (f):

Disabled children report significantly more emotional instability an do their non-disabled counterparts.

	No. of cases	Mean	S.D.	t-value	deg.freedom	crit.t value.
Disabled	25	16.68	2.44	0.91	48	1.684
n-disabled	25	15.96	3.10			

The t-value obtained indicates accepting the null hypothesis of significant difference in emotional instability between the disabled and n-disabled groups.

ypothesis 2 (g):

Disabled children report significantly more of a negative world iew thain do their non-disabled counterparts.

	No. of cases	Mean	S.D.	t-value	deg.freedom	crit. t-value.
Disabled	25	13.84	3.3	0.08	48	1.684
on-disabled	25	13.76	3.8			

The t-value obtained indicates accepting the null hypothesis of o significant difference in negative world view between the disabled and on-disabled groups.

he Overprotection/over-mothering questionnaire

ypothesis 3:

Disabled children report significantly more overprotection y their mothers than do their non-disabled counterparts.

	No. of cases	Mean	S.D.	t-value	deg. freedom	crit. t-value
Disabled	25	34.24	3.14	0.72	48	1.684
on-disabled	25	33.48	4.26			

The t-value obtained indicates accepting the null hypothesis of o significant difference in overprotection by mothers between the he disabled and non-disabled groups.

ypothesis 3 (a):

Mothers of disabled children tend to limit their children's time pent away from mother and home significantly more than mothers of their on-disabled counterparts.

	No. of cases	Mean	S.D.	t-value	deg. freedom	crit. t-v
Disabled	25	14.72	1.97	0.0.5	48	1.684
on-disabled.	25	13.68	2.44			

The t-value obtained indicates accepting the null hypothesis no significant difference in mothers limiting the time their children pend away from mother and home between the disabled and non-disabled oups.

pothesis 3 (b):

Mothers of disabled children tend to be significantly more volved in their children's affairs than the mothers of their n-disabled counterparts.

	No. of cases	Mean	S.D.	t-value	deg.freedom	crit t-valu
Disabled	25	13.68	2.053	-0.0057	48	1.684
n-disabled	25	14.22	2.53			

The t-value obtained indicates accepting the null hypothesis of significant difference in the mothers' involvement in their childrens' fairs between the disabled and non-disabled groups.

pothesis 3 (c):

Mothers of disabled children tend to be significantly less manding on their children in terms of household help and cooperation, an the mothers of their non-disabled counterparts.

	No. of cases	Mean	S.D.	t-value	deg.freedom	crit. t-va
Disabled	25	5.84	1.189	0.0074	48	1.684
n-disabled	25	5.68	1.256			

pothesis 3 (d):

Mothers of disabled children tend to be significantly more over-otecting (wihout also being rejecting) to their children, than do their n-disabled counterparts.

	No. of cases	Mean	S.D.	t-value	deg.freedom	crit. t-va
Disabled	25	9.96	1.77	0.31	48	1.684
n-disabled	25	9.8	1.92			

The t-value obtained indicates accepting the null hypothesis of significant difference in mothers over-protecting (without also jecting) their children, between the disabled and non-disabled groups.

TABLE ONE

NS AND STANDARD DEVIATIONS OBTAINED WITH ROHNER'S (1976) COMPARISONS.

The Parental Acceptance Rejection Questionnaire (PARQ)

SCALE	Mean for disabled.	Mean for non-disabled.	Rohner's Mean.	s.d. for disabled.	s.d. for non-disabled.	Rohn s.d.
warmth/affection	39.4	40.08	31.26	9.14	11.50	9.2
aggression/hostility	33.64	36.16	29.00	7.48	7.05	8.7
neglect/indifference	32.32	32.20	27.04	6.57	5.71	6.7
undifference/[illegible] rejection	22.88	23.64	19.11	5.94	4.83	5.1

The Child Personality Assessment Questionnaire (PAQ)

hostility/aggression	14.28	14.44	13.37	2.98	3.04	3.5
dependence	18.00	17.48	16.77	2.56	3.07	2.9
negative self-esteem	14.72	12.96	12.23	3.28	3.06	3.3
negative self-adequacy	15.56	15.24	13.34	3.47	2.29	3.3
unresponsiveness	14.32	14.24	12.98	1.80	2.52	2.1
emotional/instability	16.68	15.96	16.01	2.45	3.10	3.0
negative world view	13.84	13.76	11.34	3.30	3.83	3.8

The Over-protection/Over-mothering Questionnaire (O-PQ) (No comparisons).

over-protection	34.24	33.48		3.14	4.26	
limiting time away	14.72	13.68		1.97	2.44	
Mother's involvement	13.68	14.12		2.05	2.53	
less demanding help	5.84	5.68		1.19	1.26	
overprot. without rejection	9.96	9.80		1.77	1.92	

TABLE TWO

HIGHEST AND LOWEST SCORES OBTAINED WITH ROHNER'S (1976) COMPARISONS.

SCALE	highest possible Score	lowest possible score	disabled highest	non-disabled highest	disabled lowest	non-disabled lowest	Rohner's highest
The PARQ							
warmth/affection	80	20	58	65	20	22	65
aggression/ hostility	60	15	47	48	20	19	50
neglect/ indifference	60	15	42	42	20	18	45
undifferentiated/ rejection	40	10	33	31	10	15	36
The PAQ							
ostility/ ggression	24	6	19	21	7	6	23
ependence	24	6	23	24	14	13	23
egative self-esteem	24	6	24	19	6	7	24
egative self-adequacy	24	6	21	19	7	11	21
nresponsiveness	24	6	17	21	11	11	21
motional/ instability	24	6	21	21	10	10	24
egative world view	24	6	19	23	8	8	24
he O-PQ.							
ver-protection	48	12	41	41	26	24	(no compa
imiting time away	20	15	18	19	10	11	
other's involvement	20	15	19	20	9	9	
ess demanding for help	8	2	8	8	4	3	
ver-protection ithout rejection ejection	16	4	12	14	6	7	

Summary of Results.

In looking at the t-tests and means obtained, we see that the only statistically significant result (at the 0.05 level) was from a PAQ scale showing that the disabled sample reported significantly more negative self-esteem than their non-disabled counterparts.

The next most notable difference was that the disabled showed a greater (but not statistically significant) tendency towards being more over-protected or over-mothered (O-PQ) than their non-disabled counterparts.

Another notable difference was that the disabled showed a greater (but not statistically significant) tendency towards dependence than their non-disabled counterparts.

We see that the statistically significant result and those results with strong tendencies towards significance all came from the Child Personality Assessment Questionnaire (PAQ) and the Over-protection/ Over-mothering Questionnaire (O-PQ).

As far as the Parental Acceptance-Rejection Questionnaire (PARQ) was concerned, there were no significant or nearly significant differences between the disabled and non-disabled groups. It is of interest to note that the non-disabled, rather than the disabled sample had higher mean "rejection" scores for 3 of the 4 PARQ scales, as well as for the total PARQ score.

The following are a list of scales and total scores that all had higher means for the disabled over the non-disabled group. They are presented in order of magnitude of difference between the two groups with the scale with the biggest difference between means being presented first:

Scale or test total	Hypothesis number and t-value	
1. More negative self-esteem	2 (c)	1.96
2. More emotional instability	2 (f)	0.91
3. More over-protection/Over-mothering by mother	3 (total)	0.72
4. More dependence	2 (b)	0.65
5. More negative self adequacy	2 (d)	0.38
6. More over-protection (without rejection) from mother	3 (d)	0.31
7. Partial "mental health" score (Total PAQ score)	3 (total)	0.27
8. More emotional unresponsiveness	2 (e)	0.13
9. More of a negative world view	2 (g)	0.08
10. More neglect/indifference from mother	1 (c)	0.07
11. More limits by mother on time spent away from home	3 (a)	0.015
12. Mother less demanding for household help and cooperation.	3 (c)	0.0074

To the contrary, the following list of scales and score totals all had higher means for the non-disabled, over the disabled group. They are presented in order of magnitude of difference between the two groups with the scale with the biggest difference between means being presented first:

Scale or test total	Hypothesis number	t value
1. More aggression/hostility from mother	1 (b)	-1.22
2. More undifferentiated rejection from mother	1 (d)	-0.5
3. Less warmth/affection from mother	1 (a)	-0.23
4. More total rejection from mother	1 (total)	-0.19
5. More hostility/aggression felt	2 (a)	-0.19
6. More involvement by mother in child's affairs.	3 (b)	-0.005

Comparison of PARQ and PAQ results with Rohner's (1976) sample.

For all the PARQ and PAQ scales, the mean scores for both the disabled and non-disabled groups were slightly higher than those obtained by Rohner (1976) on a sample of 220 Washington D.C. elementary school children. (See Table One).

Additionally, the lowest scores obtained for both the disabled and non-disabled groups on both the PAQ and PARQ scales were all slightly higher than those Rohner (1976) obtained on his sample. (See Table Two). At the same time, the highest scores for both groups, for both instruments, were either slightly lower (16 out of 22 cases) or the same as (5 out of 22 cases) the highest scores for Rohner's (1976) sample. (See Table Two).

CHAPTER 4

DISCUSSION

From the results obtained, (using the PARQ, the PAQ and the O-PQ as instruments), we see that there were no significant differences in perceived rejection, over-protection and mental health status between the disabled sample and their non-disabled counterparts. The only significant difference between the groups was in "negative self-esteem", with the disabled group manifesting a significantly lower self-esteem than their non-disabled counterparts.

Of particular importance to note is the "consistent picture" obtained, with the social situations at home (represented by the mothers' behaviours in the PARQ and the O-PQ) and the children's emotional adjustment (represented by their responses in the PAQ), both indicating that there were no major differences in the social and emotional adjustment of the two groups of children concerned. The importance of the family's influence over that of peer groups on the self-concept formation of ten-year-olds has been shown by Thomas (1971).

Previous studies on the disabled have found "rejection" to be one of the distinguishing characteristics of disabled persons. (Barker, 1953; Somers, 1944; Wright, 1960; etc.). My results seem not to concur with these previous findings as far as "rejection" (defined and measured using Rohner's PARQ) by the mothers of my disabled was concerned. The rejection tendency seemed to be stronger, in fact, in the mothers of the non-disabled group, with 3 out of 4 PARQ scales leaning in this direction.

As indicated in Chapter One, although rejection is frequently noted as a characteristic of the disabled (Thomas, 1978. p.100), from the literature I reviewed, most of the evidence supporting "rejection" came from clinical studies (Barker, 1953; Wright, 1960) and seemed rather to be an expression of the authors' sympathies, rather than concrete evidence obtained by defining, operationalizing and measuring "rejection" as such. In commenting further on the previous literature on rejection, I can only echo the warning made by Thomas (1978) on the over-use of simplistic (and often negative) stereotypes of parental attitudes towards the disabled.

In attempting to explain my results, I concluded (together, perhaps, with the majority of my sample being only mildly, physically disabled) that the socio-cultural context of my disabled sample seemed neither to be condusive for any significant "rejecting" behaviours by the mothers concerned, nor for "perceived rejection" by the disabled children themselves. The specific socio-cultural context of the sample, condusive to this result of acceptance rather than rejection will be discussed further on. This finding of acceptance concurs with that of Lowenfeld (1974) who found that parents of disabled children were able to accept the child fully, although acceptance was more difficult if the disabled child was the first or the only child.

"Over-protection" has also been found to be one of the main characteristics of the disabled (Barker, 1953; Bolstad, 1974; Boone and Hartman, 1972; Kondekova, 1975; Oettinger, 1938 and Wright, 1960), as well as being a distinguishing feature of the culture of handicap (Thomas, 1978 p.100). The results of this study indicated a slight (but not significant) tendency toward increased "over-protection" by the mothers of the disabled group, compared with those of the non-disabled group. Considering that the various physical limitations of the disabled sample did in fact limit their mobility or dexterity in varying degrees, it is not suprising that "over-protection" was found to a limited extent by the mothers of the disabled children. The fact that the disabled sample all attended regular schools was in itself a sign that this "over-protection" was perhaps not excessive. Other possible explanations for the mild degree of "over-protection" will come to light in the description of the socio-cultural context of the sample described further on.

As noted in Chapter One, "dependence" has also been assumed, pronounced and found to be one of the major characteristics of the disabled (Gordon, 1966; Pinkerton and Weaver, 1970; Swift, Seidman and Stein, 1967 and others). Although a slightly larger tendency towards dependence was found in the disabled group compared to their non-disabled counterparts, no significant difference was found between the two groups.

As far as the partial "mental health status" of the subjects was concerned, the disabled group tended to have slightly (but not significantly) higher scores than their non-disabled counterparts, indicating a slightly worse mental health status for the disabled group. If we look at the component scales of the PAQ, we see that the only significant difference between the groups was for the negative self-esteem scale, with the disabled group showing significantly more negative self-esteem than their non-disabled counterparts.

From Chapter Two we see that Rohner regards "self-evaluation" to be made up of "self-esteem" and "self-adequacy". Self-esteem is the emotional evaluation of oneself in terms of one's worth and self-adequacy is the self-evaluation of one's competence to perform tasks and to cope. These concepts of self-evaluation are similar to those of self-image and self-esteem found in self-image theory described by Argyle, 1973.

Of interest is the significantly lower self-esteem scores compared to the "average" self-adequacy scores of the disabled sample. These results seem to imply that although the disabled sample did not seem to lack confidence in their own competence to perform tasks and to cope, their emotional evaluation of themselves in terms of their worth was, never-the-le low.

A possible explanation for these results is that whereas self-adequacy by Rohner's definition is dependent on the individual's own assessment of himself, self-esteem tends rather to be dependent on a "social" judgement, since one's worth tends to be determined socially rather than by oneself.

In trying to explain this lower self-esteem for the disable group from a somatopsychological point of view, we see that the concepts of "devaluation" and "spread" are useful. "Devaluation" is the process by which the disabled person is seen as more disabled than he actually is because of attitudes from others as well as his own lowered self-esteem. "Spread" describes the expansion of the disability from its original source to encompass the whole body or the whole personality. (Wright, 1960).

Body image theory also has an explanation for the significantly lower self-esteem found in the disabled sample. Richardson's (1968) work suggests that the disabled share the value system of their non-disabled peers, and thus a tension exists for them between their actual and ideal body images. For our particular disabled sample, the lowered self-esteem together with the average self-adequacy may be seen as manifestations of the actual versus the ideal body image.

Social-role theory (Parsons, 1951) also refers to the "inbuilt tension" the disabled or sick person may feel between the new role of being sick or disabled, and the old, "normal" role. It should be noted that persons with a disability from birth have not experienced the old, "normal" role as such, but are familiar with it through the socialization process.

The "prescriptions" for the disabled role include exemptions from some responsibilities, leading to a lowered self-esteem for the disabled person concerned. Role relationships with others may also contribute to a lowered self-esteem for the disabled, especially if only the "self (ego)-disabled person" relationship is positive, while the other (e.g. "family-disabled person") relationships are negative.

As noted by English (1971), the reactions of the disabled and of the people important to them cannot only be explained by one theoretical stance as has been shown with the example of significantly lower self-esteem for the disabled sample concerned. He goes on to recommend an eclectic approach since a unifying theory is a necessary but distant goal.

The lowered self-esteem found for the disabled group concurs with the work of Grinter (1974) who found that his group of visibly disabled adolescents did not have lower self-concepts than a control group but however, showed a greater discrepancy between perceived and ideal self.

The classification of the majority of the disabled group as "mild" fits in with the work of Smits (1964) who found that adolescents with milder disabilities had higher self-concept scores that those with severer disabilities. Overall low self-concept (or self-evaluation) scores were not expected or found for the disabled sample concerned, although many studies on the self-concept of disabled persons have found evidence of a lowered self-concept (Hartung, 1975; Katz and Florian, 1978; Speck, 1975).

From the results discussed above, we see that the picture of the social and emotional adjustment of disabled, Lusaka primary school children is much the same as for their non-disabled counterparts.

An important contribution to the explanation of these findings is the cultural context of the sample concerned. Children, we know, develop in a series of interlocking cultural contexts. As Blyth (1968, p.39) suggests, these include nationality, rural or urban setting, social class, neighbourhood, peer group, schooling experience as well as the specific culture of the child's family. Each context has its roles, rules, norms and other ingredients such as language, attitudes and values. The significance of these contexts is that they involve groups, the members of which are mostly around the same age. As a result, individuals acquire the values, attitudes, language and images of the group, and the totality of shared experiences provides the basis of "belonging" (Bettelheim, 1971). This "belonging" is the foundation for identity formation and secure membership of the social order.

Some disabled children are not able to participate fully in these cultural contexts as their cultural experiences differ from those of others in their age group because of separate forms of schooling, restriction on mobility, prolonged periods in hospital or over-protection.

If successful socialization partly depends on a body of shared experiences, then an individual who fails to acquire such a common stock will find it difficult to secure a rightful place in his culture. As Thomas (1978, p.100) notes, the more distinctive the "culture of handicap" the more difficult the integration into the large community and the harder the task of participating in the full range of conventional social roles.

Among the distinguishing features of the culture of handicap are: exposure to extreme attitudes of either over-protection or rejection; involuntary association with others similarly handicapped; frequency of hospitalization; special education; restrictions on the full range of adult roles; awkwardness in social interaction and a lifelong association with "sheltered" workshops and institutions.

If we look at the particular socio-cultural contexts of the disabled group of this study, we see no significant difference in their exposure to extreme attitudes of either over-protection or rejection by their mothers compared with the non-disabled group. The fact that this particular disabled group all attend regular Government primary schools also largely excludes the distinguishing "culture of handicap" features of special education, a lifelong association with "sheltered" workshops and institutions, and involuntary association with others similarly handicapped. "Frequency of hospitalization" was also excluded for this particular group of visibly physically disabled children, although I did come across a number of school children with sickle-cell anaemia, asthma and other "non-visible" physical disabilities who were frequently hospitalized. Since most of this particular disabled sample were classified as mildly physically disabled, they did not seem to have much awkwardness in social interaction unlike say, some of the deaf. Most of this disabled sample can also look forward to participating in the full range of adult roles, except perhaps, with limited participation in games and sports.

Although the "good" social and emotional adjustment of this disabled sample may be partially attributable to the "mild" nature of their disabilities and the consequent social implications listed above, other social and cultural factors could also be playing their part.

As noted by Rohner and Rohner (1979a), other social factors that may affect adjustment are: the personal and behavioural characteristics of the child as an active agent or instigator of parental action (also noted by Thomas, 1978 and Walters and Stinnett, 1971); personal characteristi of parent(s); or the pertinent characteristics of the situation where parents and child interact.

In Chapter One we have also seen evidence that one's particular "culture" affects attitudes towards disability and therefore the social and emotional adjustment of the disabled as well (Haffter, 1968; Hanks and Hanks 1948; Jordan and Friesen, 1969).

Of particular interest to this study is the work of Hanks and Hanks (1948) who noted a "laissez - faire" social status enjoyed by the disabled in parts of East Africa, as opposed to more subordinate social statuses found elsewhere. In East Africa, the disabled were given shelter and protection and there was no obligation or pressure on them to contribute to the group. Also, the definition of achievement was broad, allowing the disabled to gain a measure of prestige and status by exercising such abilities as they had, though there was no pressure on them to do so.

Although no actual research evidence is known to me, it is my contention that much the same "cultural" situation prevails in the Zambian context. This, I concluded after noting further from Hanks and Hanks (1948, p.20) that the protection of the disabled and social participation for them is increased where "competitive factors in individual or group achievement are minimized" and "the criteria of achievement are less formally absolute as in hierchical social structures, but more weighted with concern for individual capacity, as in democratic social structures." These characteristics serve well to describe the prevailing "Zambian culture" or way of life with its stress on the importance of the extended family structure, and the "humanistic" approach based on traditional "Zambian" culture.

Another interesting finding of the study was that the average scores for both the disabled and non-disabled groups were found to be slightly higher than the results Rohner obtained on his American sample of 220 childre

Before interpreting these results, we may look at a study by Rohner, Roll and Rohner (1980) working in Mexico with a sample of 175 Mexican children. They found that Mexican children perceived themselves to be significantly more rejected than the American children, and also scored significantly higher on all the personality PAQ scales, except for dependence which was significantly lower. The results imply that the Mexican children were significantly more "independent", and Rohner et. al. theorise that this independence together with the high scores on hostility and aggression as well as emotional unresponsiveness, make it likely that these children were expressing "defensive independence", described by Parental Acceptance - Rejection Theory as a probable outcome of extreme rejection.

In this study, all the scale scores for both groups were slightly higher than Rohner's American scores, including the dependence score, so the "defensive independence" does not seem to hold in this case.

I am more inclined to believe that the greater "perceived rejection" for the total sample could have something to do with the large family sizes of the subjects, with most of them having between 4 and 9 siblings each.

Another possible explanation could have to do with the questionnaire interpretation. Besides possible problems with items that were possibly not properly understood, I noted that "Sometimes true", the alternative which scored 3 points in most cases, was far more popular than "Rarely true", the alternative which scored 2 points in most cases. It seemed to me that the subjects in both groups preferred the "sometimes tru alternative to the others, probably because its meaning was better understood by them. In a number of cases, the alternative "rarely true" had to be explained to the subjects with the alternative "hardly true" often being presented as well. The "sometimes true" alternative also seems to me to be the most ambiguous of the alternatives, and perphaps the popularity of its choice could have been due to the subjects trying to avoid the more clear answers. The "forced choice" format of answering probably also contributed to the popularity of the "Sometimes true" alternative.

For the particular disabled sample of this study we see that their social and emotional adjustment was found to be much the same as for their non-disabled counterparts, contrary to the implications and findings of the majority of previous studies on the disabled. These findings bring us back to a caution by Thomas (1978, p.124) about the literature available on attitudes to the disabled which he describes as being incomplete and perhaps misleading since it lacks the dimension of experience. He maintains that studying the central experience of living and loving a child with a disability of body or mind could be critical for reducing simplistic (and often negative) stereotypes of parental attitudes. He concludes that the courage of parents and children in the face of common stress may contain an element of mystery, not ultimately reducible to psychological or sociological theory [as yet] my addition in parenthesis).

As far as the implications of this study for the integration of the disabled into "normal" school situations is concerned, we may note that the disabled sample seemed to be well adjusted, both socially and emotionally, contrary, probably, to the expectations of many of us. It seems to me that this negative "social" judgement is probably one of the root causes for the lowered self-esteem held by this particular disabled who seem well adjusted otherwise in terms of their emotional and family situations.

BIBLIOGRAPHY

ADAMS, G.R. and COHEN, A.S. (1974) Children's physical and interpersonal characteristics that effect student - teacher interactions Journal of Experimental Education, 43, 1-5.

ADLER, A. (1927) The Practice and Theory of Individual Psychology. New York, Harcourt Brace Jovanovich.

ANDERSON, E.M. (1973) The Disabled Schoolchild. London, Methuen.

American Psychological Association. (1974) Standards for Educational and Psychological Tests. Washington, D.C. American Psychological Association Inc.

ARGYLE, M. (ed.) (1973) Social Encounters. Harmondsworth, Penquin Books.

ARGYLE, M. (1975) Bodily Communication. London, Methuen.

BARKER, R.G., Wright, B.A., Meyerson, L. and Gonick, M.R. (1953) Adjustment to Physical Handicap and Illness: A Survey of the Social Psychology of Physique and Disability,, New York, Social Science Research Council.

BERREMAN, J.V. (1954) Some implications of research in the social psychology of disability. Exceptional Children, 20, 347-50.

BETTELHEIM, B. (1971). The Children of the Dream. St. Albans, Paladin.

BOLSTAD, C.H. (1974). A Behavioural Comparison of Handicapped and Normal Children within the Family., Ph.d. Thesis, University of Oregon.

BOONE, D.R. and Hartman, H. (1972). The benevolent over-reaction. Clinical Pediatrics, 11, 268-271.

BROWN, C. (1974) My Left Foot. London, Secker and Warburg.

COOK, M. (1971). Interpersonal Perceptions. Harmondsworth, Penguin Books.

DALE, D.M.C. (1967) Deaf Children at Home and at School. University of London Press.

ENGLISH, R.W. (1971). The application of personality theory to explain psychological reactions to physical disability. Rehabilitation Research and Practice Review, 3, 35-47.

FISHLER, K.L., Donnell, G.N., Bergen, W.R. and Koch, R. (1972) Intellectual and personality development in children with galactosemia. Pediatrics, 50, 412-9.

FOX, A.M. (1976) Review; The special education needs of physically handicapped children. Child Care, Health and Development, 2 (1), 45-71.

GOFFMAN, E. (1968) Stigma. Harmondsworth, Penguin Books.

GOFFMAN, E. (1969). Behaviour in Public Places. New York, Free Press.

GOLDBERG, L.R. (1972). Parameters of personality inventory construction and utilization: a comparison of prediction strategies and tactics. Multivariate Behavioural Research Monograph, 72 (2).

GORDON, G. (1966). Role Theory and Illness. New Haven, College and University Press.

GOTTLIEB, J. AND DAVIES, J.E. (1973). Social acceptability of E.M.R. Children during overt behaviour interactions. American Journal of Mental Deficiency, 78, 141-3.

GREGORY, S. (1976). The Deaf Child and His Family. London, Allen and Unwin.

GRINTER, E.A. (1974). A study of self-concepts and self-acceptance of visually handicapped adolescents. Diploma Dissertation, University College of Swansea.

HAFFTER, C. (1968). The changeling: history and psychodynamics of attitudes to handicapped children in European folk-lore. Journal of History of Behavioural Sciences, 4, 55-61.

HANKS, J.R. and Hanks, L.M. (1948). The physically handicapped in certain non-occidental societies. Journal of Social Issues, 4, 11-20.

HARTUNG, J.R. (1974). Psychosocial and Behavioural Consequences of a Change in Lower Extremity Orthosis. Ph.D. Thesis, University of Texas, Houston.

HEWETT, S. (1970). The Family and the Handicapped Child. London, Allen and Unwin.

JACOBS, J.F. and Pierce, M.L. (1968). The social position of retardates with brain-damage associated characteristics. Exceptional Children, 34, 677-81.

JORDAN, J.E. and Friesen, E.W. (1969). Attitudes of rehabilitation personnel towards physically disabled persons in Colombia, Peru, and in the United States. Journal of Social Psychology, 78, 151-61.

KAGAN, J. (1978). The growth of the child: Reflections on human development. New York, W.W. Norton and Co.

KATES, S.L. and Kates, F.F. (1965) . Social and non-social concepts of deaf and hearing pupils. Journal of Abnormal Psychology, 70, 214-7.

KATZ, S., Shurka, E. and Florian, V. (1978). The relationship between physical disability, social perception and psychological stress. Scandinavian Journal of Rehabilitation Medicine, 10 (3), 109-113.

KINN, W.T. (1964). Self-report of physically handicapped and non-handicapped children. *Dissertation Abstracts*, 24, 12, 5196-7.

KONDEKOVA, A. (1975). *Ceskoslovenska Psychiatrie*, 71 (1), 68-72.

KRETSCHMER, E. (1926). *Physique and Character*. New York, Harcourt, Brace Jovanovich.

KUSHMAN, K.A. (1976). A comparison of the effects of integrated and non-integrated preschool experience on degrees of social participation among able-bodied and multiple physically handicapped children. Ph.D. Thesis, University of Boston.

LAWRENCE, E.A. and Winschel, J.A. (1973). Self-concept and the retarded - research and issues. *Exceptional Children*, 39, 310-7.

LEMERT, E.M. (1967). *Human Deviance, Social Problems and Social Control.* Englewood Cliffs, New Jersey, Prentice-Hall.

LEVINE, S. (1970). A proposed conceptual framework for special education. In Meisgeier, C.H. and King, J.D. (ed.) *The Process of Special Education Administration*. Scranton, Pennsylvania, National Text Book Co.

LOVE, H.D. (1970). *Parental Attitudes towards Exceptional Children*. Springfield, Illinois, Thomas.

LOWENFELD, B. (1974). *Our Blind Children*. 3rd ed., Springfield, Illinois, Thomas.

MANNONI, M. (1973). *The Retarded Child and the Mother*. London, Tavistock.

McDANIEL, J.W. (1969). *Physical Disability and Human Behaviour*. New York, Pergamon.

MARGE, D.K. (1966). The social status of speech handicapped children. *Journal of Speech and Hearing Research*, 9, 165-77.

MEYERSON, L. (1955). Somatopsychology of Physical Disability. In W.M. Cruickshank (ed.) *Psychology of Exceptional Children and Youth*. Englewood Cliffs, New Jersey, Prentice-Hall.

MINDE, K.K., Hackett, J.D., Killon, D. and Silver, S. (1972) How they grow up: 41 physically handicapped children and their families. *American Journal of Psychiatry*, 128, 1554-60.

Ministry of Education (1976). *Education for Development, Draft Statement on Educational Reform*, Lusaka, Ministry of Education.

MILLER, S. (1975). *Experimental Design and Statistics*. London, Methuen.

MINTON, H.G. (1974). Blind Man's Buff. London, Elek.

NEUHAUS, M. (1969). Parental attitudes and the emotional adjustment of deaf children. Exceptional Children, 35, 721-7.

NUSSBAUM, J. (1962). An investigation of the relationship between self-concept, mothers concept and the reality orientation of adolescents with cerebral palsy. Dissertation Abstracts, 22, 12, 4410-1.

OETTINGER, K.B. (1938). An experiment in teaching physically handicapped children at home. Mental Hygiene, 22, 245-64.

OLCH, D. (1971). Personality characteristics of haemophiliacs. Journal of Personality Assessment, 35, 72-9.

PEARSON, G. (1975). The Deviant Imagination. London, Macmillan.

PHIRI, L.N. (1979). Problems of the Handicapped. Unpublished. Lusaka, University of Zambia.

PILLING, D. (1973). The Child with a Chronic Medical Problem. National Children's Bureau, National Foundation for Educational Research.

PINKERTON, P. AND WEAVER, C.M. (1970). Childhood asthma. In O.W. Hill (ed.), Modern Trends in Psychosomatic Medicine, Vol. 2, London, Butterworths.

POZNANSKI, E.O. (1973) Emotional issues in raising handicapped children. Rehabilitation Literature, 34, 322-6.

PRINGLE, M.L.K. (1964). The Emotional and Social Adjustment of Blind Children. National Foundation for Educational Research.

REED, M. (1970). Deaf and partially hearing children. In P. Mittler (ed.) The Psychological Assessment of Mental and Psysical Handicaps. London, Methuen.

RICHARDSON, S.A. (1968). The effects of physical disability on the socialization of a child. In D.A. Goslin (ed.), Handbook of Socialization Theory and Research. Chicago, Rand McNally.

RICHARDSON, S.A, Goodman, N., Hastorf, A. and Dombusch, S.M. (1961). Cultural uniformity in reactions to physical disabilities American Sociological Review, 26, 241-7.

RICHARDSON, S.A. RONALD, L. AND KLECK, R.E. (1974). The social status of handicapped and non-handicapped boys in a camp setting. Journal of Special Education, 8, 143-52.

ROHNER, R.P., DEWALT, B.R., and Ness, R.C. (1973). Ethnographer bias in cross-cultural research: An empirical study. Behaviour Science Notes, 8, 275-317.

ROHNER, R.P. (1975 b). *They love me, they love me not: A worldivide study of the effects of parental acceptance and rejection*. New Haven, HRAF Press,

ROHNER, R.P., and Rohner, E.C. (1979 a). A multivariate strategy for the study of child abuse. *Journal of the Division for Early Childhood*, 1, 108-114.

ROHNER, R.P. AND ROHNER, E.C. (1979 b). Coping with perceived parental rejection: Correlates of social cognition. In L.H. Eckensburger, Y.H. Poortinga and W.J. Lonner, (eds.) *Cross-cultural contributions to psychology*. Amsterdam, The Netherlands, Swets and Zeitlinger.

ROHNER, R.P. (1980). *Handbook for the study of parental acceptance and rejection*. Storrs, Cornecticut, University of Connecticut.

ROITH, A.I. (1963). The myth of parental attitudes. *Journal of Mental Subnormality*, 9, 51-4.

ROSS, A.O. (1964). *The Exceptional Child in the Family*. New York, Grune and Stratton.

RUCKER, C.N., Howe, C.E. and Snider, B. (1969). The participation of retarded children in junior high academic and non-academic regular classes. *Exceptional Children*, 36, 617-23.

SCOTT, R.A. (1969). *The Making of Blind Men.* New York, Russell Sage Foundation.

SCOTT, R.A. (1970). The construction of conceptions of stigma by professional experts. In J.D. Douglas (ed.). *Deviancy and Respectability*. New York, Basic Books.

SEQUIN, J.A. (1976). The social perceptions of the physically handicapped child, a comparison with the non-disabled. Ph.D. Thesis, Ohio State University.

SHELDON, W.H. AND STEVENS, S.S. (1942). *Varieties of Temperament*. New York, Harper and Row.

SHERIDAN, M. (1973). *The Handicapped Child and His Home*. National Children's Home.

MITS, S.J. (1964). Reactions of the self and others to the obviousness and severity of physical disability. *Dissertation Abstracts*, 25, 2, 1324-5.

OMERS, V.C. (1944). *The Influence of Parental Attitudes on the Personality Development of the Adolescent Blind*. American Foundation for the Blind.

PECK, O. (1975). The handicapped individual and his social interactions. *Heilpadagogik*, 44 (3), 199-204.

TAPLES, R. (1971). Towards a sociology of the black family. *Journal of Marriage and Family*, 35, 119-38.

WIFT, C.R., SEIDMAN, F. AND STEIN, H. (1967). Adjustment problems of juivenile diabetics. Psychosomatic Medicine, 29, 555-71.

ENNEY, J. (1953). The minority status of the handicapped. Exceptional Children, 19, 260-4.

HOMAS, J.B. (1971). A study of the self-concepts of pupils in their final year at a streamed junior school. M. Ed. Thesis, University of Wales.

HOMAS, D.T. (1978). *The Social Psychology of Childhood Disability*. London, Methuen.

OGEL, H.D. (1974). A follow-up study of former student - patients at the Crippled Childrens Hospital and School, Sioux Falls, South Dakota. Ph.D. Thesis, University of South Dakota.

OYSEY, M. (1975). *A Constant Burden.* London, Routledge.

ALTERS, J. and Stinnett, N. (1971). Parent-child relationships: a decade review of research. *Journal of Marriage and the Family,* 31, 70-111.

EINBERG, N. (1978) Modifying social stereotypes of the physically disabled. *Rehabilitation Counseling Bulletin*, 22 (2), 114-24.

IGGINS, J.S., RENNER, K.E., CLARE, G.L. and Rose, R.J. (1971). *The Psychology of Personality*. Reading, Massachusetts, Addison-Wesley.

ILLEY, N.R. AND McCANDLESS, B.R. (1973). Social stereotypes of normal, E.M.R. and orthopaedically handicapped children. *Journal of Special Education*, 7, 283-8

RIGHT, B.A. (1960). *Physical Disability: a Psychological Approach*. New York, Harper.

IGLER, E. (1966). Mental Retardation: Current Issues and Approaches. In L. and M. Hoffman (eds.), *Review of Child Development Research*. New York, Russell Sage Foundation.

APPENDIX I

(PARQ)

NAME: ______________________________

<u>Instructions</u>: Here are some statements about the way mothers act toward their children. I want you to think about how each one of these fits the way your mother treats you. After this, choose only <u>one</u> answer and tick the space of your choice. Remember, there is no right or wrong answer to any statement, so be as honest as you can. Answer each statement the way you feel your mother really is rather than the way you might like her to be.

	TRUE OF MY MOTHER		NOT TRUE OF MOTHER	
	Almost Always True.	Sometimes true.	Rarely True.	Almost never true.
MY MOTHER				
1. Says nice things about me..........	____	____	____	____
2. Scolds or shouts at me when I am bad	____	____	____	____
3. Totally ignores me................	____	____	____	____
4. Does not really love me............	____	____	____	____
5. Talks to me about our plans and listens to what I have to say......	____	____	____	____
6. Complains about me to others when I do not listen to her..............	____	____	____	____
7. Is often interested in what I do...	____	____	____	____
8. Likes me to bring my friends home, and tries to make things nice for them....................	____	____	____	____
9. Ridicules and makes fun of me......	____	____	____	____
. Ignores me as long as I do not do anything to bother ther...........	____	____	____	____
. Shouts at me when she is angry.....	____	____	____	____
. Makes it easy for me to tell her things that are important to me....	____	____	____	____
. Is hard and rough to me...........	____	____	____	____
. Enjoys having me around her........	____	____	____	____
. Makes me feel proud when I do well.	____	____	____	____
. Hits me when I do not deserve it...	____	____	____	____
. Forgets things she is supposed to do for me.......................	____	____	____	____

		TRUE OF MOTHER		NOT TRUE OF MOTHER	
	My Mother	ALMOST always true.	Sometimes true.	Tarely true.	Almost never true.
18.	Sees me as a big bother or nuisance				
19.	Praises me to others				
20.	Punishes me severely when she is angry				
21.	Makes sure I have the right kind of food to eat				
22.	Talks to me in a warm and loving way				
23.	Gets angry at me easily				
24.	Is too busy to answer my questions				
25.	Seems to dislike me				
26.	Says nice things to me when I deserve it				
27.	Gets mad or cross quickly and picks on me				
28.	Is concerned who my friends are				
29.	Is really interested in what I do				
30.	Says many unkind things to me				
31.	Pays no attention when I ask for help				
32.	Thinks it is my own fault when I am having trouble				
33.	Makes me feel wanted and needed				
34.	Tells me that I make her cross				
35.	Pays a lot of attention to me				
36.	Tells me how proud she is of me when I am good				
37.	Makes sure that she hurts my feelings				
38.	Forgets important things I think she should remember				

(PARQ)

My Mother	TRUE OF MOTHER		NOT TRUE OF MOTHER	
	Almost always true.	Sometimes true.	Tarely true.	Almost never true.
39. Makes me feel I am not loved any more if I misbehave	____	____	____	____
40. Makes me feel what I do is important.	____	____	____	____
41. Frightens or threatens me when I do something wrong	____	____	____	____
42. Likes to spend time with me	____	____	____	____
43. Tries to help me when I am scared or upset	____	____	____	____
44. Shames me in front of my playmates when I misbehave	____	____	____	____
45. Tries ot stay away from me	____	____	____	____
46. Complains about me	____	____	____	____
47. Cares about what I think and likes me to talk about it	____	____	____	____
48. Feels other children are better than I am no matter what I do	____	____	____	____
49. Cares about what I would like when she makes plans	____	____	____	____
50. Lets me do things I think are important even if it is out of the way for her	____	____	____	____
51. Thinks other children behave better than I do	____	____	____	____
52. Makes other people take care of me, for example, a relative or neighbour.	____	____	____	____
53. Lets me know I am not wanted	____	____	____	____
54. Is interested in the things I do	____	____	____	____
55. Tries to make me feel better when I am hurt or sick	____	____	____	____
56. Tells me how ashamed she is when I misbehave	____	____	____	____
57. Lets me know she loves me	____	____	____	____
58. Treats me gently and with kindness	____	____	____	____
59. Makes me feel ashamed or guilty when I misbehave	____	____	____	____
60. Tries to make me happy	____	____	____	____

THE END

APPENDIX 2

(CPAQ)

NAME: ____________

AGE: ____________

GRADE: ____________

INSTRUCTIONS

These statements are about you. Answer them as truthfully as possible. Choose only ONE answer for each statement and tick (✓) in the box of your choice. There is no right or wrong answer to any sentence, so be as honest as you can and answer each statement the way you think you really are rather than the way you would like to be.

	TRUE OF ME		NOT TRUE OF ME	
	Almost Always True	Sometimes True	Rarely True	Almost Never True
1. I think about fighting or being mean				
2. I like my mother to feel sorry for for me when I am sick				
3. I like myself				
4. I feel I can do the things that I want as well as most people				
5. I have trouble showing people how I feel				
6. I feel bad or get angry when I try to do something and I cannot do it				
7. I feel that life is nice				
8. I want to hit something or someone				
9. I like my parents to show a lot of love for me				
10. I feel that I am no good and never will be any good				
11. I feel I cannot do things well				
12. It is easy for me to be loving with my parents				
13. I am in a bad mood and cross without any good reason				
14. I see life as full of dangers				

	TRUE OF ME		NOT TRUE OF ME	
	Almost Always True	Sometimes True	Rarely True	Almost Never True
15. I get so mad I throw and break things	_____	_____	_____	_____
16. When I am unhappy I like to work out my problems by myself...........	_____	_____	_____	_____
17. When I meet someone I do not know, I think he is better than I am.......	_____	_____	_____	_____
18. I can compete successfully for the things I want.................	_____	_____	_____	_____
19. I feel I have trouble making and keeping good friends................	_____	_____	_____	_____
20. I get upset when things go wrong.....	_____	_____	_____	_____
21. I think the world is a good, happy place..............................	_____	_____	_____	_____
22. I make fun of people who do stupid things.............................	_____	_____	_____	_____
23. I like my mother to give me a lot of attention.......................	_____	_____	_____	_____
24. I think I am a good person and other people should think so too.....	_____	_____	_____	_____
25. I think I am no good at doing things.............................	_____	_____	_____	_____
26. It is easy for me to show my family that I love them.........	_____	_____	_____	_____
27. I am cheerful and happy one minute and gloomy or unhappy the next.......	_____	_____	_____	_____
28. For me the world is an unhappy place..............................	_____	_____	_____	_____
29. I sulk and refuse to talk when I get cross..............................	_____	_____	_____	_____
30. I like to be given encouragement when I am having trouble with something.......................	_____	_____	_____	_____

		TRUE OF ME		NOT TRUE OF ME	
		Almost Always True	Sometimes True	Rarely True	Almost Never True
31.	I feel pretty good about myself.......................				
32.	I feel I cannot do many of the things I try to do.............				
33.	It is hard for me when I try to show the way I really feel to someone I like.............				
34.	It is unusual for me to get angry or upset................				
35.	I see the world as a dangerous place.......................				
36.	I have trouble controlling my temper.......................				
37.	I like my parents to give a lot of attention to me when I am hurt or sick............				
38.	I get unhappy with myself......				
39.	I feel I am a success in the things I do..................				
40.	It is easy for me to show my friends that I really like them.......................				
41.	I get upset easily when I meet hard problems................				
42.	Life for me is a good thing....				

APPENDIX 3

Questionnaire for Children (O-PQ)

Name: ____________________

Age: ____________________

Grade: ____________________

Instructions:

Please tick the answer that BEST shows how your mother is to you. Make sure you answer all the questions; thank you.

1. Does your mother expect you to do what she says...........

   (a) yes, always.

   (b) yes, most times.

   (c) yes, if I feel like it.

   (d) no, not always.

2. When your mother leaves you alone at home does she.....

   (a) always make sure to come back as soon as possible.

   (b) usually try to be back soon

   (c) usually try to be back soon but does not seem to worry much.

   (d) do so without any problem and comes back when she feels like it.

3. Does your mother expect help in the house and garden from you.......

   (a) yes, often.

   (b) yes, sometimes when she asks.

   (c) yes, sometimes if I feel like it.

   (d) yes, but hardly ever.

4. Where does your mother mostly allow you to play.......

   (a) At home, either alone or with brothers, sisters or relatives.

   (b) at home, with friends.

   (c) at home, but now and then at the homes of friends.

5. Does your mother allow you to do things such as scouts, guides, sport end other activities after classes.......

   (a) yes, always.

   (b) yes, sometimes.

   (c) yes, but not often.

   (d) no, not usually.

6. How much spare or free time does your mother have for you......

   (a) hardly any.

   (b) a little.

   (c) a lot.

   (d) very much.

7. Has your mother left you in the care of others, sleeping away from home in the past..........

   (a) yes, quite often.

   (b) yes, a few times.

   (c) yes, but very rarely.

   (d) no, never.

8. Does your mother often give you help and advice...

   (a) yes, all the time.

   (b) yes, very often.

   (c) yes, sometimes.

   (d) yes, but only from time to time.

9. Does your mother help, or make sure that you get help with homework.....

   (a) yes, every day.

   (b) yes, quite often.

   (c) yes, but only if I ask.

   (d) no.

10. If you are a bit sick with a cold or headache, does your mother.......

    (a) usually stop you from going to school.

    (b) sometimes stop you from going to school.

    (c) allow you to go if you want to.

    (d) make sure that you go.

11. Has your mother known your teachers at school.......

    (a) yes, she always has.

    (b) yes, quite a few.

    (c) yes, but very few.

    (d) no.

12. When you have a small fight with another child and come home sad and tell your mother, does she...........

    (a) not pay much attention to you.

    (b) talk to you about it.

    (c) talk to both you and the other child about it.

    (d) talk to both of you about it as well as the other child's mother or your teacher.