

**PERSONALITY, STRESS-TOLERANCE
AND WELL-BEING OF WOMEN WITH
PHYSICAL DISABILITIES**

Thesis submitted for the Degree of
DOCTOR OF PHILOSOPHY
in Psychology

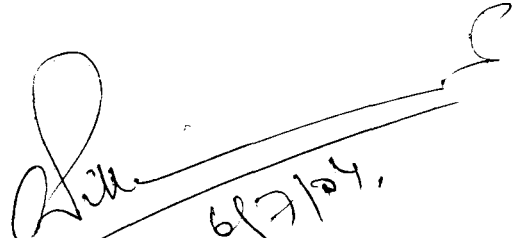
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2004**

CERTIFICATE

Certified that this report on 'PERSONALITY, STRESS-TOLERANCE AND WELL-BEING OF WOMEN WITH PHYSICAL DISABILITIES', is a record of bonafide study and research carried out by Mrs. Sareena N. P. under my supervision and guidance. The report has not been submitted by her for any award of degree or diploma in this or any other university.


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ABBREVIATIONS

- DCDR - District Centre of Disability Rehabilitation**
- OD - Orthopaedically Disabled Women**
- VD - Visually Disabled Women**
- ND - Non-disabled Women**
- DW - Disabled Women**

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INTRODUCTION

Sareena. N. P. "Personality, stress-tolerance and well-being of women with physical disabilities" Thesis. Department of Psychology, University of Calicut, 2004

INTRODUCTION

-
-
- *Disability*
 - *Personality*
 - *Stress*
 - *Well-being*
-
-

DISABILITY

No two human beings are exactly alike. Culture, religion, age gender, skin colour, are just a few of the infinite number of ways in which people differ. Another such dimension which causes diversity is 'Disability'.

Giving a clear, specific and scientific definition of disability has been found difficult by many. Like many concepts in applied fields, disability is also difficult to define.

According to Wendell (1996) the question of definitions of disability arise in countless practical situations, influence social policies and determine outcomes that profoundly affect the lives of people with disabilities. The United Nations definition of disability (Cited by Wendell) is widely used and tends to be favoured by disability activists and other advocates of greater opportunities for people with disabilities. It offers the following definitions of and distinctions among impairment, disability and handicap.

Impairment: Any loss or abnormality of psychological, physiological or anatomical structure or function.

Disability: Any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being.

Handicap: A disadvantage for a given individual resulting from an impairment or disability, that limits or prevents the fulfilment of role that is normal, depending on age, sex, social and cultural factors for that individual.

These definitions are widely criticised and a new classification of impairment disability and handicap is developed by WHO in 1997 and the proposed new classification again refers to three levels of disablement-

1. Losses or abnormalities of bodily functions and structure.
2. Limitation of activities.
3. Restriction in participation

(c.f. Graham and Martin, 2001)

A critical meaning of disability is understood when one looks at it from different perspectives. Many perspectives on the meaning of disability have been advanced, each founded on diverse and sometimes competing values and theoretical foundations. Depoy, Gilson and Cramer (2003) describe four models of disability:

1. Medical Model of Disability

The medical approach defines disability as permanent biological impediment and positions individuals with disabilities as less able than those who are non-disabled. As a form of biological determinism, the focus of disability is on physical, behavioural, psychological, cognitive and sensory tragedy and thus the problem to be addressed by disability services is situated within the disabled individual.

2. Political Model of Disability

In this model, disability is seen as a condition which interferes with one's capacity to work and make economic contributions to a social group.

Thus the privileges afforded to those who do contribute are withheld in part or in total from disabled individuals because they have nothing to exchange.

3. Cultural Model of Disability

Cultural views of disability suggest that all individuals who define themselves as disabled belong to a unique group which shares experiences, tacit rules, language and discourse. In this view, the notion of disability is about group belongingness and distinctions from others groups who do not share the disability identity.

4. Social Model of Disability

Social model of disability is a definition and analysis of disability initiated by the union of physically impaired against segregation in the 1970s and later developed by Vic Finkelstein and Mike Oliver. It is socially constructed and views the locus of the 'problem' to be addressed by services and supports within the social context in which individuals interact. The incapacity to function to a large extent is related to a disability-hostile environment in which barriers clash against personal choice.

Negative attitudes, limited physical access, limited access to communication and resource and to the rights and privileges of a social group are considered as some of the barriers that interfere with the disabled individual's potential to actualise his/her desired roles. Thus disability is seen as diversity of human condition and not a trait to be cured or fixed.

This model of disability which underlines the difference or diversity and social construction is supported by many personnel in this field from 1960s to the present. As cited by Weingberg, (1979) Goffman points out that physical disability is a stigma that marks the person as different and reduces him or her from a whole, usual person to a tainted or discounted one. The situation is more clarified by Yamamota (1979) when he says that deviance is not inherent in any particular pattern of behaviour or physical attribute. Society determines whether some individuals should be regarded as different by selecting certain facets of their being and then attaching to these facets, labels and interpretations.

Abberley in 1987 points out that the identification of disablism as a specific form of social oppression stems from the subordination of people because of their impairment. People categorized in this way are marked apart as a distinct social group on the grounds of their perceived bodily deficiency and treated differently (c. f. Barnes and Mercer, 2003).

The social construction of disability, like that of gender, underscores this fact, it is the attitudes and institutions of the non disabled even more than the biological characteristics of the disabled, that turn characteristics into handicaps (Fine and Asch, 1988).

Wendell (1996) further says that disability is socially constructed through the failure or unwillingness to create ability among people who do not fit the physical or mental profile of 'paradigm' citizens. Jenkins (1996) also emphasizes the social construction of disability while citing Oliver's opinions that disability is wholly the product of social exclusion and

marginalization and Swain's argument that the focus of attention should be upon built environments and the inadequate nature of the social response to impairment and not upon disabling conditions and people with disabilities.

Campbell and Oliver (1996) point out that this model fired up disabled people's hearts and minds by offering an alternative conceptualisation of the problem. Liberated, the direction of disabled people's personal energies turned outwards to building a force for changing societies. Ghai (2000) also challenges the premise that problems and solutions lie within disabled people rather than within society.

According to Mc. Kenna (2001) the new WHO definition for disability (Page 2) is also proposed within the context of the social model of disability.

Types of Disability

Depending upon the nature, disability can be categorised into various types such as locomotor disability, visual disability, hearing disability and mental retardation. Pandey and Advani (1995) cite a set of definitions provided in the Rehabilitation Council of India Act, 1992, for the above mentioned types of disability.

I. Visual Disability: Visually handicapped means a person who suffers from any of the following conditions, viz.,

1. Total absence of sight
2. Visual acuity not exceeding 6/60 or 20/200 (snellen) in the better eye with the correcting lenses.

3. Limitations of the field of vision subtending an angle of degree 20 or worse.

II. Hearing Disability: Hearing handicap means deafness with hearing impairment of 70 decibels and above in the better ear or total loss of hearing in both ears.

III. Locomotor Disability: Locomotor disability means a person's inability to execute distinctive activities associated with moving both himself and objects from place to place, and such inability resulting from affliction of either bones, joints muscles or nerves.

IV. Mental Retardation: Mental retardation means a condition of arrested or incomplete development of mind if a person who is specially characterised by sub-normality of intelligence.

Causes of Disability

There are several causes of disability. Iyer and Mukul (1990) broadly classify them as following:

Disabilities due to:

- a) diseases
- b) malnutrition and low-birth weight
- c) congenital anomalies
- d) socio-economic status

Sen (1988) classified the causes of disabilities linking it with the types of disabilities and grouped them as presented the Table 1.1.

Table 1.1
Causes of Disability

Types of Disability	Causes
Impaired Vision	Infectious diseases Injuries Poisoning Tumours Pre-natal influences
Auditory Impairment	Pre-natal influences Injuries Mental Retardation Physical handicap
Speech Defects	Organic Psychogenic Functional
Orthopaedic Handicap	Post-polio residual Paralysis Cerebral palsey Tuberculosis
Brain Injury	Circulatory disturbances Disturbed metabolism Growth and Nutrition Brain trauma Drug/ poison intoxication Epilepsy Infections Miscellaneous causes
Mental Retardation	Chromosomal Aberrations and other complexities Infections during pregnancy Medical complications Environmental deprivation Familial Mental Retardation Unknown causes

Disability and Adjustment

Sen (1988) states that the basic adjustment problems of the handicapped are not necessarily radically different from the non-handicapped of comparable chronological and mental age group. However, disability imposes an extra burden upon the person which consequently renders him/her more vulnerable to adjustment problems. There are mainly two domains of adjustments that a handicapped person has virtually to make.

- 1) He/she has to adjust himself/herself to his/her own specific disability
- 2) He/she has to adjust to the congenial social surroundings.

Bhatt (1963) points out that several factors affect the adjustment of the physically disabled to their disability.

They are:-

1. duration of disability
2. severity or extent of disability
3. type of disability
4. cause of disability
5. age of onset of disability
6. level of intelligence
7. attitude of the family
8. attitude of wider society

As cited by Agarwal and Pachal (1993), Verma divides the overall adjustments of the disabled into five areas: (1) physical (2) psychological (3) social (4) vocational and (5) economic. All these five areas overlap and are certainly not mutually exclusive. Acceptance of handicap, anxiety, motivation and aspirations and reaction sensitisation are included under psychological aspects and interpersonal relations, roles, the normative structures of various social institutions, family relations and marital relations are important aspects of social adjustment.

Whatever may be the type of disability or pattern of adjustment, the worst victims in the group are women with disabilities., and as Fine and Asch (1988) state, the disability and being female interact in a profoundly discriminatory and disadvantaging way.

WOMEN WITH DISABILITIES

In the world of gendered differences, another realm of women's exclusion and discrimination are observed in the lives of women with disabilities. The picture reveals the restricted boundaries and painful terrain which the disabled women have to traverse.

Hans and Patri (2003) believe that among the people of the world where women occupy a secondary or minority position, this is further entrenched among the disabled themselves, where women are secluded in another minority status. They also say that despite the prevalence of

disability in this society, disabled persons tend to be invisible and women with disabilities are more invisible. These women are overlooked, disregarded and neglected by the majority.

Lonsdale (1990) opines that disabled women and men all face oppression in the form of unmet material needs and negative social attitudes, though social responses to disabled women cause them special problems.

Lonsdale also stresses that women with disabilities are rendered invisible in a host of different ways. First they actually appear less and are literally seen, less often in public. Second, even when they are not physically out of sight, they are psychologically out of sight. Third as a minority group, they are often ignored and devalued by the majority.

Thomas and Thomas (2003) point out that these women face a triple handicap and discrimination due to their disability, gender and developing world status. Hands and Patri also talked about this triple discriminations.

As cited by Huggins (2003) Begum suggests that although disability may be the predominant characteristics by which a person is labelled, it is essential to recognize the gender influences which play an important role in determining how that person's disability is perceived and reacted to.

Fine and Asch (1988) suggest that a look at the literature on the views of the non-disabled toward person's with disabilities reveal that the attitudes of non-disabled women and men are overwhelmingly negative.

Pane (2003) joins them and went a step further by stating that if the individual is a woman with disability the negative attitude is deeper and these attitudes even though not verbal, underline people's actions and responses to the woman with disability.

Fine and Asch indicate also that for many years the thrust of rehabilitation and government study and policy was on the war-wounded, one who was invariably a male. "Having a disability was seen as synonymous with being dependent, child like and helpless- an image fundamentally challenging all that is embodied in the ideal male: virility, autonomy and independence. Yet this image is replicated, if in caricature, all that is embodied in the ideal female: emotionality, passivity and dependence". (p.3)

Huggins (2003) report that Esther Boylan explored the ways in which disability is gendered. All aspects of life for eg: employment, education, human sexuality and human rights are seen as being influenced by gender.

Darnbrough (2003) points out that disabled women are commonly devalued for two basic reasons: the emphasis on physical appearance found in every society and the importance placed on strength to carry out household duties as well as a work outside the home. On these grounds, the disabled women are made to feel less worthy.

In Walsh's (2000) opinion girls and women with disabilities especially physical disabilities often notice that they do not conform to dominant

cultural and commercial images of feminine beauty. Lonsdale (1990) says that a significant part of self-image or the internal conception people have of themselves is made up of their body image.

Lonsdale further reports Boyle and Shaul's explanation that four things contribute to a negative body image and are as follows:

1. negative reactions from outside
2. lack of control over bodily functions which is not usually associated with adulthood.
3. having to incorporate cold, hard, metallic appliances into the concept of warm, soft, lovable femininity.
4. fears of sexual and social rejection.

According to Wendell (1996) the body ideals include not only ideals of appearance, which are particularly influential for women but also ideals of strength, energy, movement function and proper control. The latter are unnoticed assumptions for most people who can meet them, but they leap to the foreground for those who are sick or disabled.

Many of the issues that are faced by women in general in a male dominated society also have an impact on women with disabilities (Thomas and Thomas, 2003).

Barnes and Mereer (2003); Hans and Patri (2003); Walsh (2000) Mainge and Dozier (2000); Lonsdale (1990); Fine and Asch (1988); and believed that disabled women experience disadvantages that set them apart

from both disabled men and non-disabled women-economically, socially and psychologically. The special issues concerning female population with disabilities are discussed as follows:

1. Attitude and prejudice of the public including family, community and even the government, which are stereotyped and negative towards, disability.
2. Lack of mobility, isolation and confinement to the house.
3. Lack of education and training
4. Economic dependence on the male members of the family
5. Lack of environmental adjustment
6. Lack of equipment necessary to cope with the disability.
7. Poor health due to malnutrition, lack of activity, poverty and ignorance.
8. Less likely to be married than non-disabled women but more likely to be abandoned with children facing social stigma, loneliness and poverty.
9. Not considered fit to look after children which naturally deprives her of a role important for her emotional satisfaction and personal dignity.
10. Severe frustrations and inferiority complex. Lack of opportunities and access to education and training for self-improvement and independence, destroys the self-confidence, self-image and self-

esteem due to the concept of her physical body image dominating the socio-cultural patterns.

11. Non-involvement in self-help movements at all levels.
12. Problems related with sexuality and reproduction.
13. Denial of human rights.
14. Protection against violence is not available

In short, as Boylan argues the opportunities and support afforded to disabled men, by which they are encouraged to become integrated into the mainstream of society are not available to disabled women or is available with tremendous difficulty. The experience of disabled women in underdeveloped and developing countries like India is much more severe. (c.f. Huggins, 2003).

Women with Disabilities in India

In a patriarchal society, like in India, there are different yardsticks of perceiving and judging disabled men and women and the treatment meted out to them is obviously different.

Through out the region in urban and rural communities alike, women with disabilities have to face certain unique disadvantages and discrimination. Among women, disabled women are seen as inferior and this results in their isolation and marginalisation (Bhambani, 2003).

Thomas and Thomas (2003) also mention that in the South Asian context, gender equity is an issue for a large majority of women, given the socio cultural practices and traditional attitudes of society. Therefore many of the issues that are faced by women in general in a male dominated society, also have an impact on women with disabilities. Although disability leads to inequality and marginalisation, disabled people are not a homogenous group. Women with disabilities from developing countries face certain unique disadvantages compared with disabled men, such as the difficulties in fulfilling traditionally expected gender roles, accessing rehabilitation services and participation in community life. These terms require a little more explanation which is made in the following sections.

Traditional Gender Roles

For men and women, the expectations of gender roles are different, especially in the Indian sub continent, where each sex is expected to perform different roles in society, according to different criteria. These roles are determined by historical, religious, ideological, ethnic, economic and cultural factors.

Although both men and women with disabilities face difficulties in fulfilling their expected gender roles as long as a disabled man earns a living, his chances of getting married and having a family are much more than those of a disabled woman. A disabled woman is perceived as one who

is unable to perform traditional roles of wife, mother and home-maker, because of her disability, even if she may be able to do them in reality.

Access to Rehabilitation Services

In accordance with the traditional, social and cultural norms in village societies, many women do not go out of their houses to seek help for health care, especially if the care provider is a male. Most rehabilitation personnel, including CBR workers in developing countries are men.

Participation in Community Life

Restricted mobility due to cultural reasons and absence of access provisions in the surrounding environment are hampering factors in the participation of women with disabilities in community life.

The families of disabled women tend to be over protective about them and prevent them from going out of the house, for fear that they be exploited in some way because of their disability. Although well-intended, these anxieties can lead to feelings of isolation, loneliness and low self esteem. Families in traditional societies are generally supportive in terms of physical assistance to their disabled women, but often fail in providing emotional support which is a more complex issue. Many families preferred to ignore the existence of feelings, emotions and the need for emotional support in women especially if they are also disabled.

The gender bias and discriminatory practices compounded with lack of economic status of disabled women aggravates their subjugation, segregation and misery. Such a picture in the gendered world of the disabled would definitely have its impact on the psychology of these women, which needs to be explored from psychological aspects of disability to its special reference to women with disabilities.

A PSYCHOLOGICAL APPROACH TO DISABILITY

Every physical disability is accompanied by some sort of psychological disturbance (Bhatt, 1963). But the psychology of a person with physical disability is not moulded only from his/her disability. Though it is affected by the emotional overtones of disability, it is linked with a lot of other factors. Thus a scientific view on this subject is to be much more broader.

The impact of disablement on disabled individual has not been an interesting topic to many psychologists. English (1977) tries to explain this using certain major theoretical principles of psychology. The theories examined are psychoanalytic theory, individual psychology, body image theory and social role theory.

Psychoanalytic Theory: Psychoanalytic theorists believed that disablement almost always have an adverse effect on personality, especially if it occurs in early childhood. They are likely to be immature and passive-aggressive

types. Persons disabled after school begins, probably would not experience any substantial change in personality, according to psychoanalytic thinking.

Individual Psychology: Proponents of Individual Psychology believe that physically disabled person attempted to compensate for a defective organ by strengthening it. In their view, physical or mental deformities are principal causes of a 'faulty' life style. They also believe that there is a higher incidence of emotional disturbance among the disabled than the non disabled.

Body Image Theory: Body image theorists believe that the attitudes individuals have towards themselves and others is viewed as being shaped substantially in terms of their perceptions about physique.

Social Role Theory: The basic notion underlying Role Theory is that people interact according to learned expectations of behaviour. In terms of disability, it has been hypothesized that persons primarily enact roles according to their expectations or role set, for and about the so called 'sick role'. It is also believed that illness or disability disrupts established role patterns and leads to a reorganisation of roles.

Though the author tried to apply these four major theories to the psychology of disability, they reflect the times in which they are written. But in this changing world, the background of disability has changed to the extent that their own attitudes toward themselves are changing and it would

definitely show its impact in their psychology. So an attempt has been made to understand the psychology of disabled by relating the concepts and ideas of existing theory of psychology, relevant in the context of physical disability.

According to Anastasi (1958) the relationship between physique and behaviour may be manifested in a variety of ways. Sometimes we find neural or glandular abnormalities which set rigid limits to behaviour development. Physique may effect behaviour through the operation of social stereotypes also. Whether a person is conspicuously tall or short, fat or thin, muscular or bony, blonde or brunette - these and many other characteristics serve as a stimuli for the responses of other people toward him. Woodworth and Marquis (1971) also agree that the individuals physique is certainly a factor in his personality.

Hurlock (1996) points out that the individual's 'personal world' is central in the development of his personality. And one subject which is ever present in this personal world is the body. (The theoretical approaches on the influences of body on personality will be elaborated in the latter part of this chapter).

As cited by Hurlock, Meyerson stresses this point of view when he claimed that the person's physique may influence behaviour by mediating the effectiveness of the body as a tool for action or by serving as a stimulus to the self and others.

Directly the body influences personality by determining what a person can do and cannot do. Indirectly a person's adjustments to life are influenced by the way he perceives his body in relation to the bodies of others, his ideal as well as culturally approved standards and by the evaluation of his physical abilities and disabilities by others. This perception shapes his adjustive experiences.

Our understanding of relationship between physique and personality led us to investigate the influence of physical disability on personality. Many scientific views confirm this influence.

Hurlock (1996) cites that the first scientific attention to the psychological affects of physical defects on personality came from Alfred Adler in the 1900s and in his theory of 'Organ Inferiority' Adler stated that neurosis and other manifestations of maladjustment are compensators of physical disabilities. A less direct influence of physique upon behaviour is discussed by Anastasi (1958) by illustrating severe sensory and motor handicaps which reduce normal social intercourse and interfere with education.

According to Lazarus (1976) physiological factors can affect behaviour either directly or indirectly. For direct influence, normal behaviour is altered by damage to tissues or by structural or functional conditions in the nervous system. Recently Edlen, Golanty and Brown (1998) opine that physical defects directly affect personality by placing limitations

on what the person can do and thus restricting the areas within which he can develop a positive and realistic self concept. Indirectly personality is affected by the way defects influence the attitude and treatment by significant people.

In Sen's (1988) opinion handicap may be conceived as a social condition imposed on the disabled individual. This imposition has its root in the negative value emanating from different sources such as imposed by the society, imposed by the person himself.

An overview of the above discussion revealed that personality is a factor which can get influenced by disability- be it due to biological reason or due to the social condition.

According to Agarwal and Pachal (1993) certain changes in the personality of the disabled are obvious due to various blocks and barriers put up by their disabled conditions. Even more important are the social reactions which are even harder on them in influencing the mental make up or personality of the disabled.

Thus it is recognised that disability, individual personality and social environment are closely inter-linked and as such, no single factor can account for the personality of the physically handicapped. In this respect Dr. Kessler says: "An organic disability becomes an actual disability only when the individual senses a defect and feels a consciousness of that defect reflected by his environment". (c.f. Bhatt, 1963. p. 123-124).

The influence of environment on the personality of an individual- be it disabled or non-disabled, is a much agreed view among the psychologists. The environment influences the development of the individual in many different ways. The habits and skills of the person depend upon the environmental situations permitting practices. The individual's knowledge depends on the teaching he has received and his social attitudes depend on the situation in which he has participated. While the environment does not force the individual into a mould as if he were passive in the process of development, it does provide opportunities and stimulation.

Kurt Lewin discusses this view in his Field Theory. Lewin proposes that behaviour is a function of both the person and the environment. His famous equation $B = F(P, E)$ reflects this belief. Lewin maintains that different people exposed to identical environmental situations might act differently. Although Lewin would agree with behaviourists that a person is a function of his environment, $P = F(E)$, he would also say that the environment is a function of the person, $E = F(P)$. The same environmental stimulus can be perceived differently by different people.

The environment, especially the human environment with all its perceptions and reactions obviously differ for the physically disabled and non-disabled.

The discussion on influence of environment on personality brings into picture the concept of adjustment. Adjustment refers to the

psychological processes through which people manage or cope with the demands and challenges of everyday life (Weiten and Lloyd, 2003). These demands or pressures represent the core of stressful experience. Thus a discussion on stress and its effects is demanded. And it is often noticed that our personality might influence how we interpret situations, thereby affecting how much stress we experience or personality might influence our responses and coping styles while under stress. The point is that there seems to be a relationship between personality and stress.

Vachon (1987) points out that within the Lazarus model, stress is viewed as an ongoing process, affected by individual personality factors and environmental variables.

In this context Vachon also cites Pearlin and Schooler who define psychological resources as the personality characteristics that people draw upon to help them withstand threats posed by events and objects in their environment and these resources residing within self, can be formidable barriers to the stressful consequences of social strain.

Bischof (1970) points out that a disturbance of physical and mental health as occurs in stress, affects the quality and quantity of the person's achievements and thus affects his self-concept. Since stress affects the quality of the person's behaviour it indirectly influences his personality through the reactions it calls forth from others.

The opinions reviewed so far confirm that personality and stress do have a relationship and so to understand persons with disabilities better, a discussion on this in the context of disability is significant.

Sen (1988) says that whatever may be the form of disability. It always has some social consequence. Physique is supposed to be one of the very crucial factors in the formation of personality; it is thus imperative that disability is almost invariably associated with a psychological problem. If normal variations in physique such as strong or weak, tall or short, handsome or ugly are important factors in peer group formation, evidently the pathological variations in the form of disability are quite potent factors in forming the negative body image of an individual. It has been reported that physical attractiveness is a basic determinant not only in terms of achievement but also in terms of development of self-concept which is derived through social interactions. Social interaction, on the other hand determines the adjustment pattern of an individual. Thus disability of any kind depending on its degree, is likely to have important repercussions on the adjustment of the disabled.

Every human being makes different types of adjustments in his/her life and the disabled person also is not an exception. It is generally assumed that the extra factor 'disability' colours all the zones of adjustment and creates more stress to the disabled. How a person with disability deals with the stressors and makes adjustments depends on the personality of the

individual, thus confirming the existence of a relationship between personality and stress among disabled also.

The very notion of stress cannot be understood without the specification of a particular organism involved in the supposedly stressful situation (Cooper, 1984). And here, the organism involved is a disabled person, who is often stigmatised by the society. So there is every chance for persons with disability experiencing more stress, since disability may become an extra demand to adjust with. But the chance for disability becoming a stressor depends on the individual involved as well as the situations he/she has to face. Thus the relationship between personality and stress becomes relevant for disabled in this context. That is, the disability with its physical or social consequence can influence the personality and this influence can show its impression in the stress-tolerance of disabled person.

How the disabled perceives his disability is the first and foremost in determining his/her personality and there by his/her stress-tolerance. Bischof (1970) states that a person's positive self-attitude and stress-tolerance are related. As cited by Vachon (1987) Pearlin and Schooler find that freedom from negative attitudes towards self (self denegeration), the possessions of a sense that one is in control of the forces impinging on one (mastery) and the presence of favourable attitudes towards oneself (self-esteem) were helpful in vitiating stress. Thus the personality characteristics like, sense of control, self-esteem and self-efficacy, which can get affected by

the disability of a person, determines how the person with disability deals with stress. The dimension of optimism-pessimism also can be related to explain the influence of disability on personality and stress.

Disability results in various limitations in social functioning. These limitations will be influenced by physical constraints in the environment by stigmatising reactions from others; and neglect or overprotection by family members. These could certainly enhance the stress experiences of a person with disability.

No one who suffers from emotional stress makes good personal and social adjustment nor is he happy, realizing how far short he falls of his capacities and of the expectations of the significant people in his life.

Much of human behaviour is motivated by basic human needs - when individuals succeed in meeting their needs, they experience pleasant emotions such as joy, pleasure, satisfaction and contentment. When they do not, they experience unpleasant emotions such as frustrations, anger, sadness, grief and shame. But our day-to-day life is full of stories of competition and resistance and we cope with these differently. Whatever be the techniques or strategies used, if we can effectively cope with stress, it will result in mental health and sense of well-being.

As cited by Scott (1976) Henry states that successful coping with the normal stressful situation is indicative of mental health and Jahoda proposes three basic features of mental health.

1. The person displays active adjustment or attempts at mastery of his environment in contrast to lack of adjustment or indiscriminate adjustment through passive acceptance of social condition.
2. The person manifests unity of personality - the maintenance of a stable integration which remains intact in spite of the flexibility of behaviour which derives from active adjustment.
3. The person perceives the world and himself correctly independent of his personal needs.

While discussing environmental influences of Mental health, Muchinsky (2000) cites Warr's nine environmental determinants of mental health which can be viewed as bases of psychological well-being

1. Opportunity for control
2. Opportunity for skill use
3. Externally generated goals
4. Environmental variety
5. Environmental clarity
6. Availability of money
7. Physical security
8. Opportunity for interpersonal contact.
9. Valued social position.

A reflection on the life of the disabled individual definitely forces to decide that these determinants of mental health are significantly relevant in his/her life. And as Sen (1988) has described, the experiences of the disabled

may give rise to feelings of inadequacy and frustration and these feelings are not conducive to mental health. But the well-being of a disabled person may not get badly affected if he/she has the determination to fight.

So in short, since a person with disability who is considered different and often inferior, has to face more resistance and more competitions, the chances for having a negative impact of disability on his/her well-being and stress-tolerance cannot be overruled.

Thus, this attempt to approach disability psychologically direct us to three major concepts of psychology, on which disability might infuse and influence. Those psychological variables are personality, stress-tolerance and well-being and hence a basic understanding of these 3 concepts is demanded in this investigation.

PERSONALITY

In popular usage, "Personality is the ability to elicit positive reactions from other people in one's typical dealings with them" (Mischel, 1984. p.1). In scientific studies, personality psychologists have disagreed about exactly how to define personality. According to Allport, "Personality is the dynamic organisation within the individuals of those psycho-physical systems that determine his characteristic behaviour and thought". In Guilford's view "personality is a person's unique pattern of traits". Mc. Clelland describes

personality as the most adequate conceptualisation of a person's behaviour in all its detail. (c.f. Mischel, 1984. p.2)

In short, personality is a complex hypothetical construct that has been defined in variety of ways (Weiten , 1998) and these different ways explain three basic features of personality.

1. The influence of psychophysical system in moulding personality.
2. The consistency of a person's behaviour over time and across situation.
3. The uniqueness of personality pattern.

The different ways of discussing personality led to the development of different approaches to personality. These approaches can be roughly grouped under various perspectives; namely,

- ❖ Psychoanalytic perspective
- ❖ Humanistic perspective
- ❖ Existential perspective
- ❖ Behaviouristic perspective
- ❖ Social learning perspective
- ❖ Biological perspective

Each school of thought has particular concepts and language to carve particular formulation of personality. The present study is primarily related to the biological and secondarily to interpersonal and social learning perspectives. So an elucidation on biological perspective is warranted.

BIOLOGICAL PERSPECTIVE

For Hall and Lindzey (1991) this perspective deals with the psychological aspects of human behaviour as they are related to the morphology and physiology of the body.

It has been recognized that important distinctions between person are inherent in body structure - its shape, appearance, strength, muscular development and similar features of morphology. These features are commonly grouped together under the term physique.

Popular efforts to judge abilities and personality from physical appearance probably dates back to the earliest social interaction among men. From time to time these attempts were formulated as systems such as phrenology and physiognomy based on head shapes and facial features respectively.

The biological approach to personality is based on the fact that personality, like behaviour, must have a physical habitat, a body. Whatever form the personality ultimately takes as we know it, it cannot be disembodied. Moreover, there is reason to believe that much of the sparkle of a personality can be taken away by factors affecting the body such as fatigue, nourishment or sickness. At a deeper level, there is evidence that many of the distinguishing features of personality such as degree of extraversion or introversion may ultimately rest upon characteristics of the functioning of the central nervous system; such as the balance of excitatory

and inhibitory potentials in the cerebral cortex (Cartwright, 1974).

The biological approach to personality had attracted many theorists and many had contracted their work exclusively in this area, but not every one's view is the same. Some stood alone, some confirmed others' views and concepts and some others worked out more expressions. Thus each theorist has something of his own to discuss and some of the major views are discussed in the forth coming pages.

Hippocrates, Galen and Others

A review of the related literature reveals that the individuals who is generally credited with having begun work in the area of constitutional psychology is Hippocrates who suggested not only a typology but also a temperament typology and a conception of humours that is highly congruent with the current emphasis up on the importance of endocrine secretions as determinants of behaviour.

Hippocrates suggested a twofold classification of physique, dividing the subjects into muscular, thickest, strong and short (*Habitus Apoplecticus*), or delicate, thin, weak and long (*Habitus Phthisicus*). Further Hippocrates explained that men could be divided into 4 basic temperament types corresponding to 4 basic elements -air, water, fire and earth and they are choleric (irritable), melancholic (depressed) sanguine (optimistic) and phlegmatic (calm, listless). He attributed each temperament to a

predominance of one of the bodily humours: yellow bile, black bile, blood and phlegm. (Hall and Lindzey, 1991; Mischel, 1984).

Following Hippocrates, many writers have attempted similar classifications, some introducing a third type of body-build and many trying to show how body-build is related to behavioural characteristics. Roston, for example writes about three types of body-builders, taking more into consideration, the developmental and functional aspects of physique than its anatomical aspect. His digestive type, muscular type and cerebral type are thus based on the hyper development or hyper functioning of these aspects of physique Viola's three types, *macroplanchnic*, the *microplanchnic* and the *normoplanchnic* are on the other hand, based on the ratio of limb development to trunk development.

Another Greek physician-Galen is usually given credit for systematising the previously vague notions of biological constitution and psychological character types into a coherent four fold typology of temperaments. Galen's typology is similar to Hippocrates.

Immanuel Kant: The German philosopher Immanuel Kant amplified the classical temperament theory by proposing separate groups of verbal trait descriptions for each of the four temperaments.

Wilhelm Wundt: According to Monte (1980) next major theorist who proposed dimensional modification is Wilhelm Wundt. The key to Wundt's scheme lay in his attempt to recognize the four types (described in the temperament theory) according to the degree to which each possessed two

variable characteristics- degree of emotionality and degree of changeableness.

Earnest Kretschmer : With Earnest Kretschmer constitutional psychology embarked upon its modern cause. He studied the relation between physique and mental disorder. The fundamental types of physiques described by Kretschmer are asthenic (Frail, linear physique) athletic (muscular vigorous physique) pyknic (plumpness) and dysplastic (with deviant aspects to the individual build).

William H. Sheldon: In the area of constitutional psychology, Sheldon's contribution is considered with more importance than the work of all others. Bischof (1970) reports that Sheldon was interested in studying the psychological aspects of human behaviour as they are related to the morphology and physiology of the body. In Sheldon's opinion there is a hypothetical biological structure (morphogenotype) that underlines the external observable physique (phenotype) and play not only an important role in determining physical development but also in moulding behaviour. Precisely Sheldon's theory deals primarily with five concepts viz., primary components, secondary components, Female somatotyping, constancy of the somato type and temperament.

1. **Primary Components :** The primary components consist of three types of body forms such as Endomorphy (rounded and spherical in

appearances) mesomorphy (upright, sturdy and rectangular) and ectomorphy (thin with long appendages and fine born structures).

2. *Secondary Components* : The three important secondary components are Dysplasia (any consistent or uneven mixture of the three primary components in different regions of the body), Gynadromorphy (physique possessing characteristics associated with the opposite sex) and 't' component (measure of aesthetic pleasingness).
3. *Female Somatotyping*: Sheldon's work in the area of female somatotyping suggests that endomorphy and endomorphy combined with ectomorphy are more common among women, while mesomorphy and mesomorphy combined with endomorphy are more common among men.
4. *Constancy of the Somato Type* : Sheldon is firm in his conviction that no nutritional change could cause the measurements of a person of one somato type to stimulate those of another somatotype.
5. *Temperament*: Sheldon assessed the behavioural characteristics of his subjects and he proposed three aspect of temperament. They are viscerotonia (typified by love of physical comfort and eating, love of being with other people and love of their approval and complacency) somatotonia (typified by assertiveness in posture, love of physical adventure and a love of power and domination and

combativeness) and cerebration (featured by love of privacy, emotional restraint and lack of self confidence).

Hans Eysenck: One of the first modern attempts to link personality to biological functions was a theory developed by Hans Eysenck. He studied inheritance in personality and has worked to understand how the nervous system related to personality. Eysenck saw personality as composed largely of two super traits: emotional stability (neuroticism) and extraversion.

Arnold Buss and Robert Plomin: Recently Arnold Buss and Robert Plomin argues that there are three normal personality dispositions that deserve to be called temperaments. They are activity level, sociability and emotionality. Buss and Plomin's view of emotionality is similar in many ways to Eysenck's supertrait of neuroticism or emotional instability. The three temperaments proposed by Buss and Plomin resemble Sheldon's ideas. (c.f. Carver and Scheier, 1996)

The above discussed scientific views on biological perspective show that biological approach to personality has widely varied in focus over the years. Although there have been criticism of various aspects on the biological perspective, it is not of insignificance and seems to be among the more active areas of contemporary psychology of personality.

SOCIAL LEARNING PERSPECTIVE

This approach to personality emphasis learning of behaviour via observation and direct reward in the course of interpersonal interaction and

is exemplified by theories. Albert Bandura, Walter Mischel and Iullian Rotter (Magill, 1996).

INTERPERSONAL THEORY OF PERSONALITY

According to Sullivan personality is the relatively enduring pattern of recurrent interpersonal situations which characterise human life (c.f. Pincus and Ansell, 2003). According to them Sullivan's concept of the interpersonal situation can be summarized as the experience of a pattern of relating self with other, associated with verifying levels of anxiety (or security) in which learning takes place that influences the development of self-concept and social behaviour.

STRESS

Just as the bodily mechanisms, stress is a fact of life. Many times it clings on us from all sides. Sometimes we choose events that bring us stress. Many other times stress is so typical in our society that we tend to take them for granted. We can never be completely free of stress. To say no to all stress is equivalent to saying no to life. We react to the stressful situations in various ways. Sometimes successfully, sometimes by becoming dependant or irritated and some other times by more deviant reactions. The varied responses of stress are of considerable interest in the field of psychology.

Historical Perspective:

Although stress is a concept that has interested psychologists for many years, early studies of stress were done within the field of medicine.

In the first decade of this century, for example, physicians described the relationship between certain personality patterns and subsequent diseases. Even earlier, was the work of Claude Bernard in the 1860s who proposed that an individual's internal system should ideally remain constant in spite of external changes, a concept that was developed into the notion of homeostasis by Walter Cannon in 1935.

The link between external factors and the body's internal responses was furthered by Wolf and Wolff's study of changes in stomach activity that accompanied various emotions. Much of their research was later developed into modern medicine's scientific study of psychosomatic diseases such as ulcers and asthma. (c.f. Ross and Altman, 2000)

Stress as a concept has been studied for almost 100 years. This history of research and theory has given us several different ways to think about stress.

The Concept of Stress:

Stress is a difficult term to define partly because it means different things to different people. Although the overall experiences of stress include both stimulus and response variables, most definitions tend to emphasize

one aspect of stress more than the other.

Webster's Ninth New Collegiate Dictionary defines stress as bodily or mental tension resulting from factors that tend to alter an existent equilibrium. (c.f. Lovallo, 1997).

Coleman, Morris and Glaros (1974) defined stress as 'any adjustive demand that includes a state of tension or threat and that requires change or adaptation if an individual is to meet his or her needs' (p. 146). According to Rathus and Nevid (1984) stress is a concept borrowed from physics which is defined as a pressure or force excited on a body. In psychology, stress is the demand made on an organism to adjust, to cope or to adapt. As cited by Baron (1996) Lazarus and Folkman in 1984 define stress as our response to events that disrupt or threaten to disrupt our physical or psychological functioning. According to Cooper (1984) stress is a non-specific response of the body to any demand. Zimbardo states that stress is the pattern of specific and non specific responses an organism makes to stimulus events that disturb its equilibrium and tax and exceed the ability to cope (c.f. Atwater, 1995). Mc. Ewen and Seeman (2003) define stress as a threat, real or implied to the psychological or physiological integrity of an individual. To state briefly the concept of stress can be understood within three models.

Stress as an Internal Response

The works of Hans Selye is generally considered the first major discussion of stress as a phenomenon in itself. Selye was interested in the

response of the body to demands made upon it and believed that this response was 'non-specific'. By this term, Selye meant that whatever the external or internal demands on the body, the person's response to stress followed a universal pattern. He termed this pattern, 'the General Adaptation Syndrome'.

Stress as External

Another way to think about stress is as engineers do. In engineering stress is defined as the total number of factors that strain a piece of equipment. Thus equipment breaks down when the stress accumulates past a key breaking point in it. This concept has been applied to the study of stress in humans beginning with the work of Adolf Meyer in 1930s. This concept was further developed by Holmes and Rahe in 1967. They defined stressful life events as those events which either signal or initiate significant life change in the individual who experiences them.

Stress as an Interaction

The above two models emphasized either processes internal to an individual or events outside the individual. The third model of stress, perhaps, the most widely regarded to-day is the transactional mode (or interactional mode) by Richard Lazarus. This model defined stress as occurring when there is an imbalance between demands and resources and emphasised the ongoing nature of the balance or imbalance. In addition, this

model believed that environments can influence people and that people can influence environments.

Types of Stress

Psychologists have come out with a few ways of classifying the various stressful experiences which can be mainly four categories.

Atwater (1995) cites Hans Seleye's description of two classifications of stress.

- i) *Distress and Eustress*: When events have harmful effect, the stress is labelled as distress and eustress is the stress which has a beneficial effect.
- ii) *Hypo Stress and Hyper Stress*: Hyperstress or excessive stress, usually occurs when events including positive ones, pile up and stretch the limits of our adaptability. Hypostress or insufficient stress is apt to occur when we are lacking adequate stimulation.

Lovallo (1997) adds the classification of physical and psychological stress as the third one.

- iii) *Physical Stress and Psychological Stress*: Psychological stressors are events which are challenges to well-being, not because they are physically threatening but because of how we perceive them. Physical stressors are events having a direct physical threat to one's well-being

Weiten and Lloyd (2003) cite yet another classification of stressors by Dougall and Baum.

- iv) *Acute Stressor and Chronic Stressor*: Acute stressors are threatening events that have a relatively short duration and a clear end point and chronic stressors are threatening events that have a relatively long duration and no readily apparent time limit.

Sources of Stress

A wide range of conditions and events are seen capable of generating experiences of stress and the literature reveals that there are two basic sources of stresses: situational and individual.

Situation Related Stress: The significant situation related factors are frustration, conflicts, pressure, major stressful life events, hassles of daily life and environmental conditions.

- a) *Frustration* : According to Weiten and Lloyd (2003) frustration occurs in any situation in which the pursuit of some goal is thwarted. Both external and internal barriers produce frustrations. Some external barriers such as floods, power failures and transportation breakdowns are non-social. Others are social, in the sense that they are placed in our way by other people. Internal barriers are personal limitations and disabilities which thwart one's aspirations (Munn, Fernald and Fernald, 1972).
- b) *Conflicts*: Carson and Butcher (1992) opine that in many instances stress results from the simultaneous occurrence of two or more compatible needs or motives.
- c) *Pressure*: Pressure is an adjustive demand that require and organism to speed up intensity or change behaviour. Weiten and Lloyd (2003)

say that pressure can be divided into 2 subtypes: the pressure to perform and the pressure to conform.

- d) *Stressful life events* : Weiten and Lloyd (2003) opine that life changes may represent a key type of stress. Life changes are any noticeable alteration to one's living circumstances that require adjustment. It is found that both positive and negative life events produce stress.
- e) *Hassles of Daily Life*: Daily life is filled with countless minor sources of stress that each seem to make up their relatively low intensity by their much higher frequency (Baron, 1996).
- f) *Environmental conditions*: According to a journalist, Alvin Toffler, the changes, in the society cause a psychological state called 'Future shock' Future shock is caused by the inability to adapt to the rapid change in the pace of life. It is the stress produced by rapid acculturating technological, social and cultural changes.

Hockenbury and Hockenbury (1998) opine that the social conditions can also be an important sources of stress. Reports reveal that crowding, crime, unemployment, poverty, racism, inadequate health care and substandard housing are all associated with stress. Stress can also result when cultures clash. Presence of pollutants too can produce stress. Noise is often mentioned as a pollutant related to the stressful affects of urban living.

Individual Related Stress: Individual related stress primarily focus on self-imposed stress. Coleman, Morris and Glaross (1974) reported that in some

cases we impose stress on ourselves and other people due to our irrational beliefs and expectations.

Factors Influencing the Severity of Stress

The severity of stress refers to the extent to which stressors require adjustment and adaptation by the individual and or the severity of stress as experienced by the individual determined primarily by two factors; person variables and situational variables.

Person Variables

Glimer (1970) says that even physiological reactions to the same emotion provoking situation will vary widely from individual to individual. Different psychologists accounted various factors for this difference. The discussions of Coleman, Morris and Glaross (1974), Lazarus (1976), Eisdorfer and Wilkei (1977), Newman and Newman (1983), Baron (1996) have identified the following factors:

1. Meaning of the situation for the individual
2. Prior experience
3. Sense of control: Lazarus (1976) opines that threat depends on the extent to which a person feels capable of mastering danger. When he or she feels fully capable of preventing harm, threat is absent or minimal. The importance of competence and its opposite, helplessness is widely observed in stress research. According to Rotter some people perceive themselves as having an external locus of control, which means they do not feel that they personally can

control events. On the other hand some people perceive themselves as having an internal locus of control, which means that they experience themselves as exerting personal control over events in their lives. It was concluded from a study by Suzanne Kobasa that past experience, sense of competence and a sense of control can be combined to increase a person's stress-tolerance.

4. **Developmental stages:** The broad array of problematic situations during various developmental stages become sources of stress.
5. **Type of personality:** The lives of personality have been consistently referred by stress researchers who differ in terms of their experience of stress or in terms of their susceptibility to stress and stress induced problems. Type A is characteristic of the individual who is rushed and hurried. The Type A person is competitive, hostile, aggressive, impatient with others , intolerant of slowness, hard driving, achievement oriented and status-conscious. The A behaviour seems to be related to stressful life style as well. In contrast the type B individual is easy, going, relaxed, patient and tolerant. Research on the topic of the Type A personality, spear headed by Friedman and Roseman has traditionally maintained that the Type A personality is associated with increased stress.
6. **Social support:** People who have close relationship with others seem to be able to withstand stressful events, better than those without social support.

7. Individual Differences: The dimension of optimism - pessimism is pointed out as one of the reasons for individual difference in their resistance to stress. Hardness is also taken as one of the characteristics which distinguishes stress-resistance people from those who are susceptible to its harmful effects.

Situations Variables

Many characteristic features of life events are important in pursuing a person to appraise a situation as threatening or harmful. The number, duration, predictability and imminence of the adjustive demands are a few that are considered influencing the severity of stress by Coleman, Morris and Glaross (1974).

Reactions to Stressors

The discussion on the sources of stress has shown that stress is created by any demand made on the individual which require some adjustive action, and during the process of adjustment or maladjustment the stressors affect the individual. This aspect of how individuals react to stressors has been an interesting area for the scientific world lately and they have come out with many views and we could conclude that reactions to stress spread in four levels, namely, physiological, behavioural, cognitive and emotional. They are summarised in Table 1.2.

Table 1.2
Reactions to Stressors

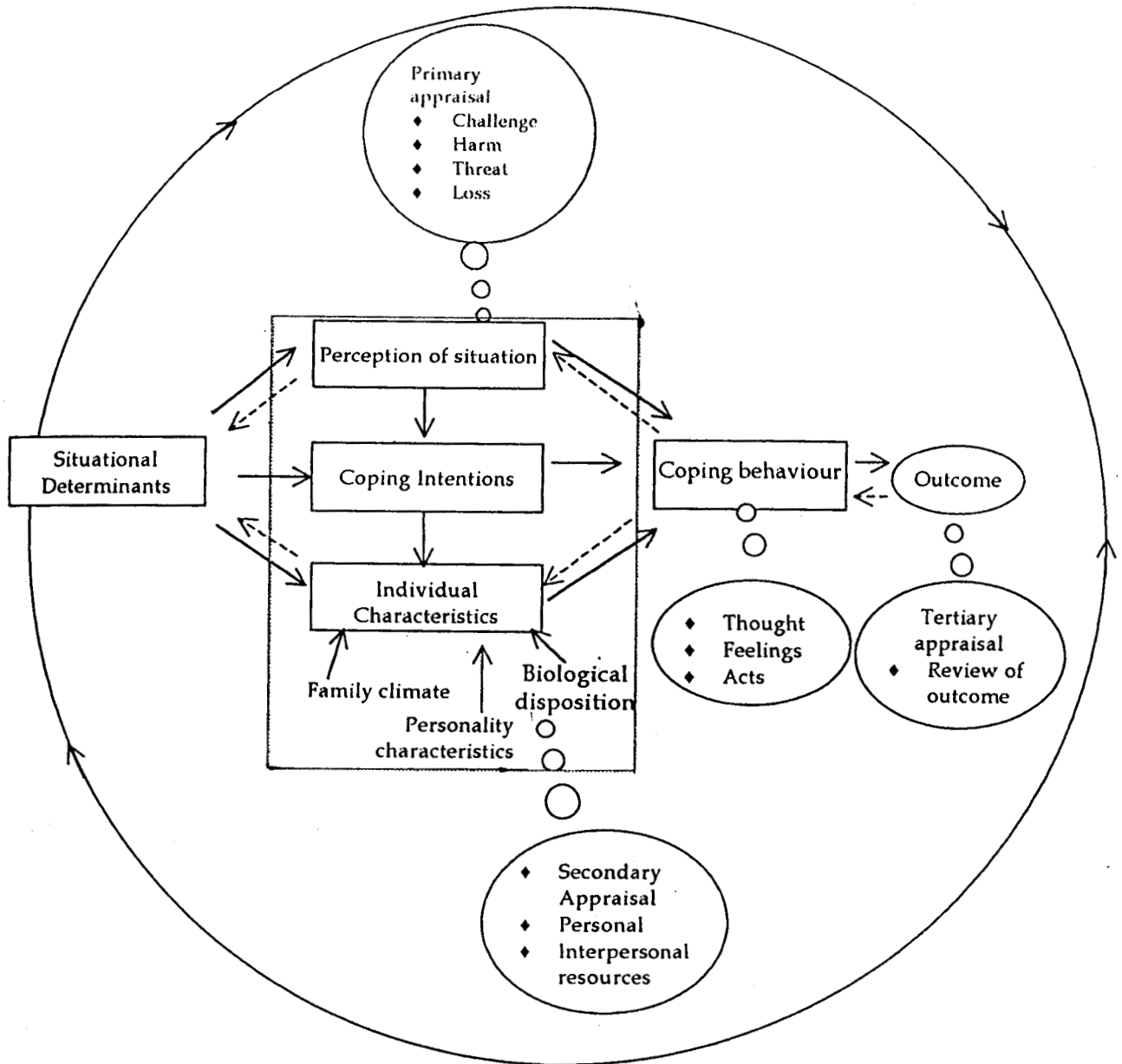
Sl. No.	Levels of Reaction	Modes of Reaction
1.	Physiological	<ul style="list-style-type: none"> ❖ Increased heart rate ❖ Elevated blood pressure ❖ Muscular tension ❖ Slowing down of digestive system ❖ Release of adrenaline and non adrenaline
2.	Behavioural	<ul style="list-style-type: none"> ❖ Decreased performance level ❖ Avoidance of stressful situations passivity/ inertia
3.	Cognitive	<ul style="list-style-type: none"> ❖ Distortion in thinking ❖ Lowered intellectual functioning ❖ Unproductive ❖ Anxiety generating pattern of thinking ❖ Indecisiveness
4.	Emotional	<ul style="list-style-type: none"> ❖ Fear and anxiety ❖ Anger and hostility ❖ Guilt and grief ❖ Loneliness ❖ Depression

Stress and Coping

Newman and Newman (1983) explain that coping refers to what a person does in an effort to reduce stress, or to solve difficult life challenges. People under stress have several options open to them and they cope with stress by choosing one or more of them.

Frydenberg (1997) has developed a model of coping process from research findings till date. The model posits that coping is a function of the situational determinants and the individual characteristics, perception of the situations and coping intentions, the individuals bring a host of biological, dispositions, personal and family history and family climate. A diagrammatic representation is shown in Fig 1.1.

Figure 1.1. Diagrammatic Representation of Coping



$C = F$ (situational determinants + individual characteristics)

$C = F (P + S + p^s)$

C = coping

P = personal characteristics

S = Situational

p^s = Perception of situation

(c.f. Frydenberg (1997), p. 37)

The different aspects of stress were thus reviewed by different theorists which also reveal how individuals vary in facing this stress of life. Some people handle stress very well. Other people are devastated by the slightest difficulties. Whatever be the way one approaches stress, effective coping will result in effective adjustment which in turn bring health and well-being in ones life.

WELL-BEING

Well-being is a relative term. For some people it may mean a sense of achievement at work, or a feeling of closeness to family, friends and community. For others it means material wealth and the goods it can purchase. And for many others, well-being might be a simple but nourishing meal or a day free of pain. But from the scientific point of view many philosophers and social scientists have been concerned themselves with defining well-being.

Sehgal and Sharma (1998) report that for more than 20 years, the study of psychological well-being has been guided by two primary conceptions of positive functioning. One formulation, traceable to Bradburn's seminal work, distinguished between positive and negative affects and defined happiness as the balance between the two. The second primary conception which has gained prominence among sociologists was by Cambell, Converse and Rodges who emphasised life satisfaction as the

key indicator of well-being. Viewed as a cognitive component, life satisfaction was seen to complement happiness, the more affective dimension of positive functioning. They have also cited Andrew's views that other studies passed well-being according to global questions about work,, income, social relationship and neighbourhood. Feldman (1998) defines well-being as "the sense of psychological and physical robustness" (p.153)

Diener (1984) says that definitions of well-being can be grouped into three categories. First, well-being has been defined by external criteria such as virtue or holiness. Second, social scientists have focussed on the questions of what leads people to evaluate their lives in positive terms. This definition of subjective well-being has come to be labelled as life satisfaction and relies on the standards of the respondent to determine what is good life. The third category of definitions of subjective well-being stresses pleasant emotional experience. This may mean that the person is experiencing mostly pleasant emotional experiences.

Bryant and Veroff (1982) scanning many studies on the perceived quality of life, cite Campbell's classification of three types of well-being affect, strain and satisfaction Campbell recognises that when people speak of satisfaction they cognitively focus on experience, but when people speak of affects and strains they focus more spontaneously on the flow of everyday life.

In his article on well-being, Diener (1984) explains that the area of subjective well-being has three hallmarks.

1. It is subjective: According to Campbell it resides within the experience of the individual. Kamman pointed out that concepts notably absent from definition of subjective well-being are the necessary objective conditions such as health, comfort, virtue or wealth. Although such conditions are seen as potential influences on subjective well-being, they are not seen as an inherent and necessary part of it.

The subjective well-being includes positive measures. It is not just the absence of negative factors; as is true of most measures of mental health.

The subjective well-being measures typically include a global assessment of all aspects of a person's life. Although affect or satisfaction within a certain domain may be assessed, the emphasis is usually placed on an integrated judgement of the person's life.

Components of Subjective Well-being

According to Diener, Suh and Oishi (1997) there are three primary components of subjective well-being: satisfaction, pleasant affect and low levels of unpleasant affect. Each of the major facets can in turn be broken into subdivision. Global satisfaction can be divided into satisfaction with the various domains of life such as recreation, love, marriage, friendship and so forth and these domains can in turn be divided into more facets. Pleasant affect can be divided into specific emotions such as joy, affection and pride.

Finally, unpleasant affect can be separated into specific emotions and moods such as shame, guilt, sadness, anger and anxiety.

Major Indicators of Well-being:

Penrod (1986) explains the major indicators of well-being as health, marriage, family life, confidence and satisfaction. Among these the most important indicators are health and marriage, the least important were financial circumstances and an involvement in community or professional organisation.

Factors Influencing Health and Well-being

Some people seem quicker than others to see the positive aspects of the worst experiences. They reassert their sense of control when they are buffeted by fate. They know when to deny and when to hope. Their coping skills seem to come in packages, one that resists stress and promotes well-being. The factors that lead to this conditions can be classified into two sections. The first section is the individual side of health and well-being which discusses what health and well-being are to an individual. The second section is the social side of health and well-being that depend on the people around an individual.

I. Individual Side of health and well-being

According to Wade and Tavris (1987) stress-resistant people have a sense of coherence, psychological hardiness, a sense of control and social interests.

II. Social side of health and well-being

The importance of social relationships to health have been studied by many and they found that social networks may influence health positively or negatively. Positively social networks such as friendships, family, acquaintances maintain physical health and emotional well-being. Social networks can also have negative effect. For eg: friends can also be stressful as a source of hassles, conflicts, burdens and betrayals (Wade and Tavriss)

Theoretical Approaches

While Penrod (1986) states health as the most important indicators of well-being, there are certain others who believe health is not an inherent and necessary part of well-being. But they also agree that health is a potential influence on well-being.

Various models have been developed to understand health and wellness. Edlen, Golanty and Brown (1998) discuss the medical model, the environmental model and the holistic or wellness model.

The Medical Model

Medical model is mainly a statistical account of diseases. It is excellent for gathering numerical data on the prevalence and incidence of diseases which is interpreted to measure health.

The Environmental Model

The environmental model of health emerged with modern analysts of ecosystem and environmental risks to human health. In this model, health is

defined in terms of the quality of person's adaptation to the environment as conditions change. This includes the effects of socio-economic status, education and multiple environmental factors on personal health. It focuses on conditions outside the individual that affect his or her health. These conditions include quality of air and water, living conditions, exposure to toxic substances, socio-economic conditions, social relationships and the health care system.

The Holistic Model

The Holistic or wellness model defines health in terms of the whole person, not in terms of the diseased part of the body. The holistic model encompasses the physiological, mental, emotional, social, spiritual and environmental aspects of individuals and communities. It proposes that health is a state of optimum or positive wellness. Wellness is thus much more than mere physical health

Related Concepts

Many social scientists explained that our overall sense of well-being is influenced as much by our everyday state of mind as it is by physiological factors. Social psychologists have examined the social and psychological components that determine the sense of well-being and they include discussions on how self influences our perception of willing, how a sense of helplessness may lead to depression and how attributional patterns affect

psychological health. They also discuss how certain kinds of illusion we mistakably hold may ultimately produce a sense of well being.

a) Self Complexity and Well-being

Citing social psychologists Lenville's description of self complexity is the phenomenon of viewing oneself as having many distinct facets, Feldman (1998) says that self-complexity seems to function as a barrier against illness and depression. Feldman also refers to a report by Kalthoff *et al.* which stated that people with higher self complexity show greater resistance to depression brought by stress and that their rate of physical stress related illness is lower. When a person with high self-complexity has difficulties on the job, she/he can turn for psychological compensation to successes that she/he is experiencing in other domains of his/her life.

b) Self-Discrepancy Theory

Despite our desire to be brilliant, likeable and terrific, the truth is that many of us see ourselves as quite different from our ideals. Many scientists worked in this area and have put forward many views on the concept of self. Carl Roger's extensive research on self concept in the 1950s, is considered a major attempt in this area.

Weiten and Lloyd (2003) states that mismatching of self perceptions is termed self-discrepancy. Citing Higgins, they state that individuals have several sets of self perspectives: the actual self (qualities that you or others

believe you actually possess); the ideal self (characteristics that you or others would like you to have); and the ought self (traits that you or others believe that you should possess). Higgins's self discrepancy theory argues that the discrepancy between self-concept and self guides (ideal self and the ought self) leads to negative emotions and ultimately to lower psychological well-being. At the same time, minor inconsistencies between the actual self and self guides can be helpful in sparking efforts to reduce the discrepancy (c.f. Feldman, 1998).

c) Self-Disclosure and Well-being

According to Weiten and Lloyd (2003) self disclosure is the act of sharing information about your self with another person.

Self disclosure is both a symptom of personality health and at the same time a means of ultimately achieving healthy personality. Withholding self disclosures seems to impose a certain stress on people. Feldman (1998) refers to certain studies related to with self disclosure and its influence on well-being. Cited studies of Jourandi, Derlega and Berg; Dealega, Metts, Pekroma and Margulis, Maonsour, Waring, Charfer and Freg; Rogers and Holloway, report that the one important consequence of self disclosure is an increase in the level of intimacy in social interactions. Another group of studies reported by Feldman reveals that the increased intimacy in social interactions may in turn provide social support that can also help to reduce

stress. In short, sharing fears and problems with others, who are trusting, worthy and supportive play a key role in mental health.

d) Self-Regulation Failure

The work of directing and controlling one's behaviour is termed self-regulation (Weiten and Lloyd, 2003) According to Bandura, the most central of all mechanism of self-regulation is self-efficacy which is referred as the belief that one has positive ability with ones actions, to bring about a certain outcome. Self-efficacy believes function as determinants of behaviour by influencing motivation, thought process and emotions in ways that may be self-aiding or self-hindering (Magill,1996)

When self-regulation failure is present, there are inadequacies in the control of one's behaviour and often might result in crime, teen pregnancy, drug abuse, gambling etc (Feldman, 1998).

e) Attributional Style and Well-being

Attributoinal style refers to the tendency to use similar causal explanations for a wide variety of events in one's life. According to Seligman, people tend to exhibit, to varying degrees, one or two attributional styles: an optimistic explanatory style or a pessimistic explanatory style. Pessimistic explanatory style can foster passive behaviour and make people more vulnerable to learned helplessness and depression (c.f. Weiten and Lloyd, 2003).

Learned helplessness is the belief that one can exert no control over one's environment. When people hold such a belief they feel unable to escape their environment and may simply give up leading in some cases to profound feeling of depression (c.f. Feldman, 1998). Feldman also referred to a report by Mckean which said that learned helplessness has proved to be a durable concept, relevant to both physical health and psychological well-being.

f) Illusion and Well-being

The peril of having an accurate view of the world and oneself seems too pronounced. According to Taylor and Brown (1988) certain types of inaccuracies about oneself and others may actually promote mental health. Considerable research evidence suggests that overly positive self evaluations, exaggerated perceptions of control or mastery, and unrealistic optimism are characteristics of normal human thought. Moreover, these illusions appear to promote other criteria of health, including the ability to care about others, the ability to be happy or contented and the ability to engage in productive and creative work. These strategies may succeed because both the social world and cognitive processing mechanisms impose filters on incoming information that distort it in a positive direction; negative information may be isolated and represented in as unthreatening a manner as possible. These positive illusions may be especially useful when

an individual receives negative feedback or is otherwise threatened and may be especially adaptive under these circumstances.

Feldman (1998) also emphasises that there are limits to how far people can twist reality and sometimes it is clearly maladaptive to ignore objective threats and to assume that one can always exert control over any situation.

Thus in brief, well-being is a broad concept of positive mental health and can be defined as the subjective feeling of contentment, happiness, satisfaction with life's experiences and of one's role in the world of work, sense of achievement, utility, belongingness and no distress, dissatisfaction or worry.

These three psychological concepts, which are being inferred though, namely personality, stress and well-being are inextricably interwoven aspects of an individual's life from birth to death. And detailed study of these variables in the context of disability would definitely widen our understanding of the psychology of disability.

In order to ensure incremental validity of present investigation effort was made to scan through the empirical literature on the topic.

REVIEW OF LITERATURE

Sareena. N. P. "Personality, stress-tolerance and well-being of women with physical disabilities" Thesis. Department of Psychology, University of Calicut, 2004

REVIEW OF LITERATURE

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- *Disability and Women*
 - *Disability and Personality*
 - *Disability and Stress*
 - *Disability Well-being*
 - *Disability and Certain Related Psychological Variables*
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Marginalisation experienced by disabled individuals in social world is reflected in the research field too. They as a group lack the drama of neurosis, psychosis or psychosomatic diseases. They are not interesting subjects to the exponents of systematic science very often. Thus it is not very surprising that the studies on disabled are very few and whatever is done is mainly in the background of medicine and its allied disciplines. But lately disabled themselves have succeeded in voicing their life and problems not only to the social world but also to Social Sciences. They have even succeeded in formulating a separate discipline exclusively concerned with persons with disabilities.

Davis (1997) opined that disability studies is a field, whose time has come. Twenty years ago there was no such thing as disability studies. However, there were a few stirrings of interest within the academic world. In 1975 the open university introduced an undergraduate course, entitled 'The Handicapped person in the community'. It continued in various guises for more than 15 years and the first post graduate programme emerged in 1979 at the university of Kent. Various other initiatives were established in 1980s but it was not until the 1990s that disability studies began to emerge with an academic identity of its own. The ideas about oppression, emancipation, representation, struggle, inclusion, independence, discrimination, rights, genocide and so on and the sociologists, educationalists, psychologists, linguists, historians, literary theorists, disabled people and others who have made a contribution to all this is

codified and encapsulated into a single discipline called disability studies (Oliver and Barton, 2000).

Almost all disabilities involve a functional limitation of some sort that the bearer must accommodate in one way or another and this results in creating a feeling of difference or deviation. Feelings of being different can cause sociological as well as psychological impact.

Social views and opinions regarding these impacts are almost alike. Scientific community too tried to understand this difference. Some findings were similar to social views while some others were different.

This study exclusively on women with disabilities was formulated after an indepth review of available empirical studies. The investigator did not limit her search only on the variables decided for the study for two reasons.

- 1) The investigator felt a need for interdisciplinary theoretical understanding of women with physical disabilities.
- 2) The variables decided for the present study namely personality, stress and well-being are significantly influenced by many other psychological and sociological variables.

In this chapter an attempt has been made to understand women with physical disabilities empirically as much as possible and also to review some related studies on personality, stress and well-being and studies on related psychological variables, inorder to formulate the problem of the present

study and propose some specific hypotheses. The collected literature related to the present study is classified into 5 categories.

1. Disability and Women
2. Disability and Personality
3. Disability and Stress
4. Disability and Well-being
5. Disability and Certain Related Psychological Variables

DISABILITY AND WOMEN

Women with physical disabilities face severe obstacles for leading a productive life. Social stigma, negative labels and social processes may be internalised and become intra psychic dimensions, both conscious and unconscious. The consequences of disability and disability as it interacts with gender will be understood only in the light of careful exploration of the interacting social, historical and psycho dynamic forces.

Since disability studies is an emerging academic field presently located largely within the disciplines of sociology, medical anthropology and medical rehabilitation, its focus on disability as a primary category of analysis and social identity obscures gender distinctions as a sub field. One of the least explored intersections of multiple identity discourse is feminism and disability studies. A brief review of feminist disability studies is included.

Following an impulse similar to the positive identity politics that yielded feminist consciousness raising and the radical reframing 'Black is

beautiful' academic theorists and activists such as Harlan Hahn, Rober Bogdan Marsha Saxton, Deborah A. Stone, Harlan Lane, Claire H. Wachowitz, Paul K. Longmore and Irving Kenneth Zola- as well as Fine and Asch are currently interrogating the prevailing interpretation of disability as corporeal inferiority, recasting it instead as another form of embodied difference which like race and gender has traditionally been interpreted as an inadequacy (c.f. Thomson, 1994).

Despite a growing awareness of disability status as a socially determined condition much like gender or race, only a few disability scholars who are also self-proclaimed feminists- such as literary critics Marilyn J. Phillips and Rosemarie Garland Thomson, Philosophers Susan Wendell and Anita Silvers or sociologists Asch and Fine have made indepth studies on the connection between sex-gender system and cultural category of disability.

Besides the feminist perspective women with physical disabilities are lately identified and explored in other areas of social sciences. Some of the studies on disabled women are discussed in the following section.

Skipper, Fink, Hallenbeck (1977) examined the effect of the wife's long-term disability on marital relationship. It focused on husbands and wives need satisfaction and marital satisfaction as each attempts to adapt to problems generated by the wife's impairment. The results indicated that the greater mobility did not automatically result in greater need satisfaction and the data revealed that little could be predicted about the disabled women's

marriage satisfaction from knowledge of their physical mobility.

Florian and Dangoor (1994) conducted a study to examine the personal and familial adaptation of women with physical disabilities when compared with women without such conditions. The findings indicated that a high level of stress and strain and a low level of individual resources contributed to a low personal and familial adaptation. The expected causal relationships among the model's variables of stress and adaptation were similar in the two cohorts. The principal difference between these two cohorts was in the magnitude of the relationships.

Morris (1995) examined disabled women's experience of receiving assistance with daily living activities. Help can be given within a personal relationship as an expression of love, but disabled women may also encounter abusive, restrictive or exploitative relationships. Public services do not usually provide help in a manner that enables a woman to have choice and control in her life or even to carry out child-caring or home making chores. Research on the different ways of receiving personal assistance indicates that those women who are able to pay for their own help were most likely to be living independently in the sense of exerting choice and control in their lives.

Tompkins (1996) used a critical ethnographic approach to explore how women with disabling conditions define themselves and their relationships within the social, political world. Through dialogic processes central to the critical ethnographic method, this study explicates how these

women have created their life meanings, have become aware of prevailing ideology and have interacted in their social worlds to bring about change. Three significant and related themes evidenced themselves within the texts of the women's stories. **Voice** included issues around the silencing of the women's voices and the denial of their individual and collective reality by others in interaction with their social environment. **Visibility** highlights how the reality of the women was altered to such an extent that they became invisible, even to themselves; how they engaged in games of 'hide and seek' with formal support networks; the processes through which they publicly identified themselves as women with disabilities; and their visions for creating new realities of disablement. **Virtue** reflects stories about value, worth, beauty, justice and morality.

Barron (1997) examined social constraints with regard to womanhood through interviews with 6 Swedish physically disabled females (17-22 years). The findings showed that the disabled women are subjected to stereotyped views on what having an impairment involves and have to deal with certain normative criteria of what constitutes womanhood. Despite being 'Children' of their time and culture (i.e., rejecting the traditional subservient role of 'the disabled' and of women generally), the subjects yearn to pursue tasks closely linked to the traditional role of (non disabled) women. It is argued that this can be understood as a means of counterbalancing an early acquired role of passive recipient. Alongside a passive identification with the group of 'the disabled' the subjects strive

toward being seen as something other than disabled.

Dangoor (1997) investigated the main variables which may explain the variation in long term psycho-social adaptation of women with physical disability. Findings indicated that socio-economic status (high rate of unemployment, low education and income level) plays the most important role in explaining the variation of the adaptational measures.

A study of six blind women aged 16-36 years from south Lebanon was undertaken by Fahd *et al.* (1997) to gain an objective and indepth understanding of life experiences of women, mitigating the effect of disabling environment. Oral histories from interviews, which consisted of open-ended questions dealing with the perceived role of parents and the discrimination between blind women and men in respect of education, work and social networks were collected. Findings confirmed that several discriminations against blind women exist in terms of education, employment, social life and marriage.

Ferri and Gregg (1998) analysed the manner in which disability informs and complicates gender identity for women with disabilities. The dual silence of women with disabilities who remain largely unheard of, both in feminist literature and in the disability movement is highlighted. Several strategies for change including stand point or minority models and strategies within feminist thinking that may be useful or emancipatory of women with disabilities are considered.

A community based study was conducted to investigate correlates of high overall level of emotional vitality by Pennix *et al.* (1998). Findings revealed that a substantial proportion of even the most disabled women can be described as emotionally vital. In addition, it was observed that emotional vitality is not solely a function of stable, enduring individual characteristic but that health status, disability and sociodemographic context also have an impact on emotional vitality.

Gold and Auslander (1999) discussed gender issues in newspaper coverage of people with disabilities in Canada and Israel. The comparison showed that in both countries there was significantly greater coverage of males than females. In addition, different (and stereotypical) types of details were used to describe the two groups, and females were associated with different kinds of problems than males, including a higher incidence of violence and victimization. This paper concludes with some ideas for altering the images of disabled women in the media.

Bandeen (2000) examined whether emotional vitality protects against progression of disability and mortality in disabled older women. It was concluded that emotional vitality in older disabled women reduce the risk for subsequent new disability and mortality. It is also suggested that positive emotions can protect older persons against adverse health outcomes.

Farber (2000) tried to understand the personal experience of women with disabilities engaged in the occupation of mothering and their perceptions of their interpersonal environment, including interaction with

family, professional caregivers and the community. The results explained that the quality of the participants experience varied with the degree of perceived similarity or dissimilarity with other mothers and acceptance of these differences. In addition, their perception of the supportive or non supportive nature of their interpersonal environment had an impact on their mothering experience.

Secondary conditions and their relationship to life satisfaction in women with physical disabilities were analysed by Coyle *et al.* (2000) and found that secondary conditions influence health status and quality of life. Despite differences among disability groups in terms of the type of secondary conditions. Common secondary conditions experienced by most women may be amenable to non-disability specific health promotion programs.

Lipson and Rogers (2000) examined pregnancy, birth and post partum experiences of 12 women with mobility limiting physical disabilities. Analysis of semi-structured interviews of one or two hours revealed that the women's experiences were influenced by their own perspectives and the characteristics of health care system within which they were treated. The women's experience included the effect of her disability, her resources and her personality and approach. Health care system factors included provider attitudes, knowledge about disability and structural and political factors.

Nosek *et al.* (2003) examined the sense of self of women with physical disabilities in terms of self-esteem, self-cognition and social isolation.

Correlation analysis indicated that the women with disabilities had significantly lower self-cognition and self-esteem and greater social isolation than the women without disabilities as well as significantly less education, more overprotection during childhood, poorer quality of intimate relationships and lower rates of salaried employment. Path analysis indicated that each of the sense of self mediators are significantly related to the outcome of intimacy, that both social isolation and self-esteem are significantly related to health promoting behaviour and that only self-esteem was significantly related to employment. Respondents who were older, less disabled, less educated, less over-protected, and had more affection shown in the home tended to feel that others saw them more positively. Women with positive school environments, less over-protection and more affection in the home experienced less social isolation; age, education and disability severity were not significantly related to social isolation.

Odette, Yoshida, Israel, Li, Ullman, Colontonio, Maclean and Locker (2003) examined internal and structural barriers to wellness activities experienced by women with disabilities. They also discussed women's actual and recommended strategies to address these barriers. The findings suggested that individual and structural barriers exist for the women, with structural barriers (physical, informational, and systematic access) being predominant. Barriers prevented women from engaging in desired wellness activities.

Reid, Angus, Mckeever and Miller (2003) examined the experiences of mothers who are wheelchair users in their roles of home making and parenting. Findings from this study showed that women did not have the freedom or economic resources to seek out new living arrangements or make modifications to existing environments. Lack of space, stairs, difficult to-reach spaces, poor transportation and limited community access were barriers that women experienced. The study also points to the importance of recognizing that the women used many strategies to regain control over aspects in their environment to enable greater autonomy and participation for themselves.

Tak and Laffrey (2003) attempted to identify the relationships among functional disability, chronic daily stress, coping strategies, beliefs about personal control, social support and life satisfaction in older women with Osteoarthritis. The findings showed that older women with poorer functional ability experienced greater chronic daily stress, reported more frequent use of emotion-focussed coping strategies and had a higher chance health locus of control. It is also revealed that the perceived social support and internal health locus of control significantly contributed to the prediction of life satisfaction after demographic, illness-related and stress-related variables were controlled.

The studies so far discussed delineates the picture of women with physical disabilities shot through the eyes of different branches of humanities. The factors of double handicap and discrimination were

highlighted. The different roles of a typical woman were analysed in the context of women with disabilities. The psychology of disabled women so far discussed reveal lower self-esteem, self cognition, life satisfaction and greater social isolation. But higher emotional vitality in physically disabled women was also noticed.

DISABILITY AND PERSONALITY

Physical disability is considered as an important factor influencing the behaviour and adjustment of a person. It may be in two ways. Firstly by means of the specific limitation on functions imposed directly by the impairment itself and secondly by an indirect effect through interaction of the physical disability with various psycho social dimensions. Personality development of the physically disabled tends to manifest the indirect effects more significantly. Studies dealing with the influence of disability on personality are discussed below:

In a study comparing the blind with the sighted ones, Singh and Akhtar (1971) had two matched groups of samples of 20 subjects from each and administered Singh's self concept scale to them to obtain measures of private self and social self in two separate forms. Differences between mean scores were not significant on the personal self. But the social self yielded significant mean differences; means scores on self-esteem of the two groups were also found to be significantly different. Non-handicapped group had

an advantage over the handicapped one with respect to scores on self-esteem as well as social esteem.

Singh and Pathak (1984) compared the blind with the sighted on four personality dimensions: Psychoticism (P), Extraversion (E), Neuroticism (N) and Lie score (L) as postulated by Eysenck and Eysenck. The groups did not differ significantly in any of the four scales, though there was some marginal difference in the lie scores between the two groups, the blind having the higher score. This perhaps suggested that the blind responded to the lie items in a more socially desirable manner.

Kapoor and Sen (1984) made a comparative study among congenitally blind, the adventitiously blind and their sighted peers on some personality and cognitive variables. It deemed to be appropriate to investigate into the intelligence level of the three groups and whether the intelligence level of the blind affects the personality factors considered. The results indicated that the congenitally and adventitiously blind groups do not differ significantly from each other or from their sighted peers on the personality variables.

Even though social attitude towards the blind is not generally unfavourable, social stereotyping conditions may not have favourable reactions toward the blind and may influence their own self concept and personality adjustment.

Banarjee (1984) conducted a study on psychic determination of some physically handicapped children. With the aim to picture the projective

patterns of physically handicapped children, Children's Apperception Test was administered. From the test findings which revealed the presence of some psychic-determinants in these physically handicapped children, it may be concluded that these children did not turn to be a neurotic as they required amount of ego strength to develop pathways to gratify their needs by a sort of activity or overt outlet directly involving the environment. On the other hand according to the super ego structure majority of the children were emotionally unstable in comparison to their ego and intelligence level. And by passivity and withdrawal, as compensatory behaviours, each of them magnified their invalidity and sustained the same. As a result their spontaneity and liveliness became crippled also.

Aplin and Rawson (1986) examined 30 children with hearing loss for psychological assessment and most of them had scored at normal limits on the Junior Eysenck Personality Inventory. Introversion alone or combined with neuroticism was the most important personality dimensions especially for girls.

As cited by Sen (1988) Kapoor has reported some studies using questionnaires and inventories. In an investigation by Griff, Bernreuter Personality Inventory and Laird Personality Inventory were used to investigate adjustment problems in the blind and the partially sighted adolescents. It was found that blind were less self-sufficient and less dominant than the sighted. Brown in another study reported that there were no significant differences between the blind and sighted groups on the

Neymann Kohlstedt performances, significant sex difference was however observed; the blind females were found to be more introvert than the sighted males. Hubbard also compared personality traits and found that the sighted subjects were found to be better adjusted but the two groups differed in sex, age, intelligence and academic achievement. In Hasting's study the blind were found to be more disturbed in self adjustment and had more mental health liabilities. Brieland and Barker found that there is significant relationship between blindness and personality adjustment.

Barker *et. al.*, commented that the slight personality disturbances observed may be presumed to be associated with the nature of sensory deprivation prevailing in this type of disability. Baumen commented that personality pattern of the handicapped groups is based largely on the social and economic consequences of their handicap rather than upon the direct impact of the physical defect upon the personality (c.f. Sen, 1988).

Using projective test Deb studied the personality pattern of the handicapped children in addition to the pattern of the ego of the hospitalised handicapped children. Murray's Thematic Apperception test was used to ascertain the personality pattern of the boys above 10 years and found that personality pattern becomes a contributory factor for remaining in the dependent (paralytic) stage. (c. f. Sen, 1988).

Bose and Banerjee studied 30 physically handicapped institutionalised children with the objective of understanding the masked inner life and drawing up their personality make up on the basis of test

findings. The results revealed the presence of some covert determinants in these physically handicapped children. It was argued that while these covert determinants structured an active inner life, the negative pull of the said marked inner life made them withdrawn and passive, resulting in crippling their spontaneous liveliness. Passivity and withdrawal became compensatory behaviour, magnifying their invalid condition and sustaining the same. Their failure in acquiring social skill was also supposed to be related with them. It was argued that they are victims of invalid condition that developed as a direct sequel to their original illness or trauma and due to the interaction between their developmental background and interpersonal relationships (c.f. Sen, 1988).

Prasad *et. al.*, as cited by Sen (1988) conducted a study with 20 subjects in the age range of 15 to 62 years. The various aspects studied covered personality characteristics, thought disturbances, personal and social relationships, attitudes toward self and others and phantom limb phenomenon. On personality dimensions - extroversion and introversion dimensions were also studied. The introversion features were more dominant between 26 to 40 years of age, who are interested mainly in social and outgoing activities. These activities were marked with personality characteristics such as frankfulness, sincerity, dominance and decent behaviour in dealing with others. On the other hand, the introverts were found to be withdrawn, sensitive, shy reserved, secretive and nervous in character.

Mathew observed that persons with body defect showed more inferiority feelings than those without any body defect. The feelings of incapacitation may result in lack of confidence in one's abilities and bring in a host of psychological barriers in personal and social adjustment (Sen, 1988).

In a comparative study of the personality patterns, life satisfaction and problem patterns of orthopaedically impaired and normal male adults, Ghai and Ittyerah found that the handicapped were less independent, less well adjusted, but more satisfied than the able bodied normals. They were also found to have confronted with significantly higher number of problems in the domains of home and psychological and social adjustment. In a comparative study of personality characteristics of the blind, the deaf and normal, Bhargava and Lina found that the sensory disabled were more reserved, emotionally unstable, shy, dependent than the control group (Sen, 1988).

Rao reported studies on the orthopaedically handicapped children who were compared with normal children on some psychological variables. The handicapped group was found to exhibit low self-appraisal, passivity, low ego strength and projected aggressiveness. They were found to be more worrying type, exhibiting self-condemning attitudes and submissive reactions. However, they took a more realistic approach toward their frustration (c.f. Sen, 1988).

Goel and Sen have reported a few studies on personality dimensions of the visually handicapped, by several students of psychology. The results on the 16 pf showed a large number of the subjects to have poor self concept and emotional instability, below average intelligence and physical dependence. They were found to be not fully cognizant of reality and possessed a sense of insecurity. They were rated by their teacher as aggressive, un-inhibited, generally group dependent, sociable, predictable and emotionally maladjusted (c.f. Sen, 1988).

Deshmukh (1988) tried to draw out personality profiles of physically disabled along certain personality characteristics. Indication of difference in the personality make up of the disabled and non disabled was obtained only in respect of manifest anxiety. The investigator pointed that while expecting a difference in personality characteristics of the disabled and the normals, the possibility of operation of the compensatory mechanism in the former is often overlooked.

As cited by Sen (1988) Lind and Patterson used the Minnesota Multiphasic Personality Inventory (MMPI) with handicapped college students and noted that the cerebral palsied subjects employed by them, tended to show emotional maladjustment. However, no specific patterns of personality type as such, appeared to differentiate the disabled from the control group. Some of the differences were attributed to the anxiety generated by the disability and the concomitant tendency of the disabled to withdraw from social contact.

Sen also cited Norris *et. al's* claim that it was possible for them to identify the conditions for optimal personal development of the blind child. The concept of optimal development involved the factors like acquisition of independence, responsibility, freedom of fractioning and a potential. Failure to provide the requisites for optimal development was considered to be the main hindrance in related functioning creating severe emotional problems.

Studies on social adjustment of the blind undertaken by Vasudeva and others as cited by Sen(1988) showed their difficulty of adjustment. The general conclusion was however, that lack of sight does not necessarily produce any personality change.

Lowenfeld observed that in the matter of personality and social factors, there were no basic differences between the blind and the normal sighted peers. It was asserted that any differences observed are unique to individuals and may result from situations similar to those faced by sighted persons (Sen, 1988).

Agarwal and Pachal (1993) explored the personality of the orthopaedically handicapped and deaf persons by using the Thematic Apperception Test. The sample consisted of 31 handicapped workers. The investigation revealed that an orthopaedically handicapped person has a model personality of a passive person with conflicts tensions and anxieties who has abasement but also has latent aggression. He also has nurturance and soccourance needs along with achievement and affiliation needs and no power need.

The findings of the study conducted by Kumar *et al.* (1994) revealed that the normal subjects manifested a high degree of extraversion as compared to the handicapped. Handicapped subjects manifested more neurotic and psychotic symptoms as compared to their normal counterparts.

Bharadwaj (1995) investigated the basic differences found among the handicapped and non-handicapped children, mainly who are congenital blind and cerebral palsied with reference to their personality orientations on a sample of 450 children ranging between the age of 8 to 16 years. It is discovered that the personality make up of the children is associated with sizothymia, low intelligence, ego weakness, excitability, low super-ego strength, threctia and shrewdness. The existing difference is only of degree and not of types. It is also discerned that the blind children are showing greater behavioural disharmonies in their personality make up, where as cerebral palsied children require more facilities for the proper development of personality.

Reddy (1997) attempted to find out the relationship between personality factors on the one hand and problems of coping behaviour on the other. The major findings are as follows. Insecurity and loneliness, depression, feelings of inferiority and emotional instability were the personality factors which registered negative responses from the subjects. Loneliness, depression, guilt proneness and emotional instability revealed significant relationship with maladjustment in the subjects. Visually

handicapped were found to be the most problematic group, both in coping as well as in negative personality tendencies. Boys and girls did not differ significantly on personality factors.

Gawali, Thacker and Kamble (1998) attempted to find out the level of manifest anxiety and extraversion/neuroticism among different category of handicapped male and female clients. The subjects were classified according to the types of handicap and sex differences. No significant difference was found in extroversion-neuroticism and level of anxiety between the different categories. No significant difference was found between males and females. However, deaf and orthopaedically handicapped differed significantly on neuroticism. It was observed that the deaf have more neurotic tendencies than the orthopaedically handicapped.

Santhosh (1999) assessed the personality make up of congenitally visually impaired children. It was found that congenitally visually impaired children were easy going imaginative and had normally developed ego strength. Both boys and girls showed poor intellectual development. Boys were easy going and shrewd while girls were shy conservative and dependent. The author argued that an understanding of the personality make up of the visually impaired children would help in integrating them in to the mainstream of the sighted world.

Jyothi and Reddy (2000) compared personality profiles of the hearing impaired and normal children. The results indicated that the groups differed significantly in the personality factors for intelligence, phlegmatic-excitabile

temperament, desurgency - surgency, restrained venturesome, vigorous-doubting nature, self assuredness, apprehensiveness and relaxed-tense temperament.

Personality of the physically disabled examined through the above studies tend to fall under two types. One showing similarities with non-disabled and the other revealing a few significant differences in personality of disabled and non-disabled.

DISABILITY AND STRESS

The sources of stress may be physical, psychological or social. The disability may cause stress in all these three areas. But whether disability becomes an ever existing stressor or it is accepted and well adjusted by the person considered determines how his/her life is. A few of the studies related to stress and coping with disability are examined below.

Jayasree (1982) conducted a comparative study of the manneristic behaviour of the blind and the sighted persons. Four kinds of mechanisms - head movement, eye poking, and rubbing, clapping and jumping-were found to exist only in the blind children. The sighted children showed 13 other types of mannerisms in higher percentage than that of the blind children. But blind girls showed more mannerisms in comparison to blind boys.

Agarval and Kaur (1988) administered psychometric measures of stress, strain and locus of control along with biographical data obtained

from the school records. In addition to these intelligence, educational achievement and teacher and peer acceptance were rated by the teachers and peers respectively. The results indicated that while health and emotional adjustment is the single best predictor of stress among the handicapped children, the level of home adjustment emerged as the predictor of strain. The child higher on stress is also older in age and had become handicapped at a later age. With visual-impairment being related to higher stress levels than hearing impairment.

Srivastava and Sinha (1989) confirmed that stressful events during life time were found to be related with the symptoms of physical as well as emotional distress. A more significant relationship between stressful events of past one year and symptoms of emotional distress was also found.

Hancock, Craig, Tennant and Chang (1993) investigated the effects of Spinal Cord Injury (SCI) on perceptions of control, self-esteem and coping styles over the first year of SCI. 41 acute spinal injured patients and 41 able-bodied controls matched for age, sex and education completed a variety of standardised questionnaires on three occasions over year. The instruments included the locus of control of behaviour scale, Rosenberg's Self-Esteem Scale and Adapted Mental Adjustment to Cancer (MAC) Scale which measures coping styles, including fighting spirit, helplessness, hopelessness and fatalism. The spinal cord injured group were found to be more external in their perceptions of control, lower in self esteem and more helpless /hopeless and fatalistic attitude than the controls. The majority of the SCI

group had scores reflecting adaptive coping styles and in fact levels of self esteem but there were still a substantial proportion who displayed maladaptive coping styles (E.g.: external locus of control, fatalism, helplessness).

Hancock, Craig and Chang (1994) conducted a two year follow up of above study. Persons with Spinal Cord Injury and a demographically matched able bodied control group completed same standardised questionnaire on four occasions over two years. Results obtained in the first year replicated in the two year data. Except for the Locus of control of Behaviour Scale. After one year, the SCI group were found to perceive their life to be externally controlled, to be lower in self-esteem and have more helpless/hopeless and fatalistic attitudes than the controls. There were no differences in self-esteem and coping styles after two years for the SCI group. However, locus of control fluctuated over the 2 years, though there was a trend for the SCI group to be more externally focussed.

Kumar *et al.* (1996) compared the adjustment patterns of 50 physical handicapped and 50 normal subjects of Patna town. Results indicated significant differences in the adjustment patterns of handicapped persons as compared to their normal counterparts. These differences could be attributed to the feelings of isolation, differentiation and negligence experienced by the handicapped which obstructed their proper adjustment in society.

Emmons (1997) in his work 'coping responses of the visually impaired' investigated the coping responses of individuals whose acuity was between 20/70 and 20/200 and less than 20/200. The results indicated that the visually impaired were coping well within the average range; regardless of the loss of sight. The visually impaired subjects were found to cope with their vision loss no differently than a sighted individual copes with a stressful situation.

Huurre (2000) investigated psychosocial development and social support among adolescents with visual impairment. Developmental differences and similarities between adolescents with visual impairment, without visual impairment and those with chronic conditions were investigated. Further, the role of social support in promoting psychological well-being was of interest. The results showed that the average size and composition of social networks among adolescents with and without visual impairment were quite similar. Adolescents with and without visual impairment turned to their parents (especially to mother) mainly for intimate interaction, material aid, physical assistance, guidance and feedback. Friends were an important source of social support in intimate and social interactions. However, adolescents without visual impairment (especially the girls) reported receiving support from friends more frequently than adolescents with visual impairment. There was, however a trend toward an excessive risk of depression and lower self-esteem among visually impaired girls compared to normally sighted girls. Among boys, visually impaired boys tended to score less often in the depressed range than boys without visual impairment. The prevalence of depression was higher

among girls than boys, whether they were visually impaired or not. The results indicated that most adolescents with visual impairment traverse this period of life without any significant psychological difficulties. However, it seems likely that in adolescence visual impairment causes stress, especially in girls.

Satapathy and Singhal (2001) attempted to find out the significant psychosocial (such as stress, self-esteem and behavioural problems) and background variables (such as age, age of onset, severity of impairment, parents, education and occupation, family income, parental impairment status and pre-school education) as correlates and predictors of socio-emotional adjustment of the visually and hearing-impaired adolescents. Results revealed behavioural problems, stress and academic performance as the common predictors of and contributed to social-emotional adjustment. Interestingly, no background variables contributed to the social-emotional adjustment of the visually and hearing impaired students, while family income and parents' deafness contributed positively in case of the hearing impaired.

Hopps *et al.* (2001) investigated the relationship between certain variables that are specific to people with physical disabilities and loneliness. The sample was made up of 39 adults with visible physical disabilities. The variables measured are physical independence, level of impairment, acceptance of disability, as well as social skills and anxiety related to handicap situations. Correlational analysis suggested that among the variables examined, physical independence, as well as social skills and social anxiety related to situations

where disability is involved, are associated with loneliness. These data might help identify people with physical disabilities who are at risk for experiencing loneliness, target more efficient intervention objectives and develop strategies for optimizing social integration.

Satapathy, and Singhal (2001) compared stress, self-esteem, adjustment level and academic performance of visually and hearing impaired students. Results revealed that visually impaired were less stressed, had higher self-esteem, higher level of adjustment and academic performance than the hearing impaired students. Hearing impaired adolescents also exhibited more number of behaviour problems.

Patrickka *et al.* (2002) investigated on the relationship between psychosocial support (social contact and emotional intimacy) and changes in health status (physical, psychosocial and emotional functioning) experienced by 583 adults age 45-75 year living at home with a pre-existing physical illness. Controlling for age, sex and initial level of health status, the analyses showed that a low level of social contact was associated significantly with deterioration in psychosocial and emotional functioning only in the presence of adverse life events. Confiding relationships did not appear important for adults with pre-existing illnesses who are not at significant risk of developing stress-related conditions. Social participation outside the home would help to reduce deterioration in psychosocial and emotional functioning, important outcomes for improving and maintaining quality of life.

Satapathy (2003) investigated the grade and gender difference on stress perception and behavioural problem of 79 visually impaired adolescents, examined the relationship between these two variables and also attempted to find out the familial correlates of stress and behavioural problems. Results revealed that the visually impaired females and the students in grade VIII were significantly more stressed than their counterparts. Findings on gender differences revealed that visually impaired females perceived life as more stressful than their main counterparts. Correlation between stress and behavioural problems were found inverse and significant irrespective of student's grade and gender. Stress had significant negative association with many of the family's socio-economic status variables.

The studies discussed here indicated that the best predictor of stress among disabled is health and emotional adjustment. No significant difference in coping styles between disabled and non-disabled were obtained.

DISABILITY AND WELL-BEING

Well-being is often considered to be an appropriate outcome measure indicating the way in which people perceive and react to their health and to other non-medical aspects of their lives. The effect of physical disability on well-being has given rise to a few studies and some of them are discussed in this section.

Schulz and Decker (1985) interviewed 100 middle aged and elderly spinal cord injured persons on perceived control, attributions to blame and the nature of social comparison they made using index of psychological well-being, life satisfaction index and the centre for Epidemiologic studies Depression scale. For all three outcome measures, respondents reported levels of well-being only slightly lower than population means of non-disabled persons of similar age. Controlling for health status and current income, they found that persons who have high levels of social support, who are satisfied with their social contacts and who feel they have high levels of perceived control report high levels of well-being.

Moore's (1998) findings highlighted several factors that may place some older women with severe visual deficits at an increased risk for lower levels of overall well-being and suggest nursing interventions that may be used to assist older women to integrate the visual loss experience into their lives.

Rea *et al.* (1999) in their study 'Employment Skills: Enhancing Quality of Life' found that unemployment is associated with feelings of loneliness, pessimism, morbid or gloomy thoughts, and self-pity in 74%-76% of unemployed disabled women. Employment is viewed as a productive use of time that improves outlook on life and augments contribution to society.

Dijkers (1999) analysed the correlates of life satisfaction for individuals with spinal cord injury. Life satisfaction is associated with several demographic, social functional and clinical characteristics. Females

reported slightly higher life satisfaction than males and highest life satisfaction was found for married persons, the lowest for those separated. Persons with spinal cord injury who resided in nursing home or long-stay hospital reported the lowest well-being. Students and home-makers expressed high life satisfaction, compared with those who reported that they were retired or unemployed; those competitively employed reported the highest levels. Current education level is related to satisfaction, with the least educated persons having the lower mean Satisfaction With Life Scale (SWLS) ratings. The number of years that someone has lived with spinal cord injury also appears to be a determinant of life satisfaction: mean SWLS scores increase by years. Of the disablement components, impairment (level of injury) contributed indirectly, through its impact on motor disability.

A recent meta analysis found that subjective well-being among persons with spinal cord injury was lower than in the population at large, but that the difference was not dramatic (c. f. Dijkers, 1999).

Elliot, Uswatte, Lewis and Palmatier (2000) examined psychoanalytic constructs in the adjustment of individuals with physical disability. According to Kohout optimal adjustment during life transitions is contingent on the individual's capacity for maintaining and pursuing meaningful goals, which reflects a stable sense of self. A series of studies was conducted to determine if goal instability would predict adjustment and health following disability. Goal instability was predictive of depressive behaviour and acceptance of disability among individual with recent onset

disability. Goal instability predicted subjective well-being one year later. Among community residents with a disability, goal instability was associated with life satisfaction; this relationship was not mediated by perceived stigma or community mobility. These findings indicated that a flexible yet durable goal orientation is associated with optimal psychological adjustment among individuals with a physical disability.

A study analyzed by Salkever (2000) on young adults with developmental disabilities to describe relationships between activity status and respondents' life satisfaction and self-perceived productivity. Results showed significantly lower life satisfaction ratings for persons who were idle or who only reported housework as an activity compared to respondents engaged in paid employment, schooling, and/or volunteer work.

Chase, Cornille and English (2000) examined the extent that the life satisfaction of persons with traumatic spinal cord injuries is linked to perceived control, verbal communication skills, satisfaction with personal assistance, marital status and handicap. A convenience sample of 158 individuals with such injuries responded to a self report questionnaire. Eighty-nine percent of the respondents chose to use a World Wide Web based form. Although bivariate analyses revealed life satisfaction was significantly related to perceived control, communication skills, satisfaction with personal assistance, marital status, and handicap; perceived control and marital status were the strongest predictors of life satisfaction.

The purposes of the study conducted by Hampton and Marshall (2000) were three fold. First, it examined value differences between Americans and

Chinese people with spinal cord injuries (SCI). Second, it assessed the impact of culture and gender on life satisfaction. Third, it explored patterns of correlates of life satisfaction in the two groups. The results indicated that Americans and Chinese people with SCI differed significantly in the values of family integrity and separation from ingroups. Although Americans were more satisfied with their lives than the Chinese, culture-related values did not appear to influence life satisfaction. Also, gender was not consistently related to life satisfaction in the two groups. In addition, Americans differed from the Chinese in the patterns of the correlates of life satisfaction. For the Americans, there were four variables (perceived health status, self-efficacy, self-reliance, and marital status) that significantly correlated with life satisfaction. However, for the Chinese, only self-efficacy and perceived health status were related to life satisfaction

Bloom *et al.*, (2001) indicated in their study on women with breast cancer that the size of the social network was related to greater emotional and instrumental support and greater emotional support was related to better mental well-being. Contrary to predictions, greater use of instrumental resources was related to poorer physical well-being. The results indicated the importance of social resources on well-being following life-threatening illness.

Modrego, Pina, Simon and Azuara (2001) analysed and correlated quality of life with neurologic impairment and disability in all patients with Multiple sclerosis from the geographic area of Bajo Arazon in the north eastern region of Spain. It was found that patients moderately or severely

disabled showed a significantly decreased satisfaction in comparison with the nondisabled or mildly disabled one. Disability and handicaps were significantly related to some items of Functional Assessment of Multiple sclerosis, mobility symptoms and emotional well-being, but not with the remaining items - general contentment, thinking and fatigue, family and social well-being and additional concerns. Although we globally observed poorer quality of life in more disabled patients, the perspectives of the patients did not necessarily agree with disability scales in some domains of health.

Ville *et al.*, (2001) described the effects of severe motor impairments on a person's well-being. They examined the relationship between overall assessment of well-being as expressed by the people interviewed and a range of clinical, social and psycho-social factors. They tried to identify certain confounding factors, and to analyse the respective effects of different types of variables studied. Thus current age, the age at which the impairment occurred and having or not having a professional activity do not have any direct links with the assessment of well-being, whereas the existence of pain and the subjective assessment of one's own independence and of the severity of one's disability are predictive factors. The functional independence indicators are only linked to well-being when they relate to situations in which the dependents create embarrassment due to socio-cultural taboos. The loss of autonomy only affects well-being in as much as it imposes limits to social activity, whether they be relational or occupational.

Living as a couple is a negative predictive factor if the couple were together prior to the impairment occurring. The overall results demonstrate the importance of moving beyond any conception of the impact of the impairments of well-being that is too exclusively focused on the individual and of integrating the socio-cultural meanings of handicap situations and the dynamics of the interactions which take place therein.

Parvez and Yagub (2001) examined general well-being sources of happiness and daily hassles among the blind male and female institutionalized children. The findings of the study were (i) male and female children did not differ significantly on general well-being, (ii) of different sources of happiness male and female subjects differed significantly on 'interesting work' and 'sports and exercise' and (iii) male and female blind institutionalized children expressed different daily hassles.

Hosain, Atkinson and Underwood (2002) examined the impact of disability on quality of life in rural Bangladesh. Information on disability and how it affected their life were obtained either from the disabled people or from their care givers by interviewing them. The study revealed that disability had a devastating effect with quality of life of the disabled people with a particularly negative effect on their marriage, educational attainment, employment and emotional state. Disability also jeopardized their personal, family and social life. More than half of the disabled people were looked at negatively by society. Disabled women and girl children suffered more from negative attitude than their male counterparts, resulting in critical adverse

effects on their psychological and social health.

Putnam *et al.* (2003) explored how people living with long-term disabilities defined and conceptualized health and wellness, and to discover what they perceived to be the major facilitators and barriers to health and wellness for themselves and other individuals living with disability. Results from focus groups indicated that health and wellness is perceived as distinct from disability as a multi-level phenomenon encompassing dimensions of the person, the community, and the systems that govern interactions within social and physical environments. Additionally, data suggested that appropriate interventions at each level are required to facilitate greater levels of health and wellness among persons living with disability.

Ville *et al.*, (2003) presented a study of the identity of persons with motor impairments with regard to the community of disabled persons. The authors used the Tetrafigap survey on the long term outcome of tetraplegic spinal-cord injured (TSCI) persons in France to study the sense of belonging to the community of disabled persons among 1356 TSCI persons in relation to factors of social participation (both sociological and disability -related) and subjective factors (subjective well-being, social perception of disability, perceived disability). The results show that 44% of TSCI persons felt that disabled persons do not constitute a community (no-community group). Of those who recognised the existence of such a community 34% said they belonged to it (the in-community group) and 22% declared they did not (the out-community group). Factors related to the sense of community belonging

were identified. Subjective well-being appeared to be independent of any sense of community belonging. However, the authors found a gender difference: women in the 'in community' group described themselves as having a poorer level of well-being than women in the other two groups.

The studies examined subjective well-being and related factors in the case of physically disabled. The studies revealed a low level of well-being in physically disabled, but not very dramatic. Reliance on devices, pain, subjective assessment of one's own independence, severity of disability are predictive factors of well-being. Satisfactory social contacts and high levels of perceived control report high levels of well-being.

DISABILITY AND CERTAIN PSYCHOLOGICAL VARIABLES

There are certain other psychological variables which were subjected to empirical analysis in terms of their influence and or interaction with disabilities. Thus an attempt is made to examine these variables in this section.

Smits (1979) investigated the effect of obviousness and severity of disability has on the way disabled adolescents feel about themselves, and in turn, on the way others feel about them. The results indicated that the mean self-concept score of these adolescents with mild physical disabilities was significantly higher than the mean self-concept score of those adolescents with severe physical disabilities. Severely disabled female adolescents had a significantly lower mean self-acceptance score than both severely disabled

male adolescents and mildly disabled female adolescents.

Weinberg (1979) attempted to answer two major questions of whether disabled persons see themselves differently from the way able bodied persons see themselves and whether sex influences the disabled person's self-perception in the same manner that it affects the able bodied persons' self-perception. With a few exception (3 out of 29 items) self-perceptions of disabled and able bodied were similar. On examining the sex effects, it was found that there were seven items on which males and females differed in their self-reports. Females perceived themselves as more emotional, more religious, more sensitive, more moral, more enjoyable to be with, less aggressive and less courageous than man. No significant interaction effects between sex and physical condition were found on any of the items.

Sethi and Sen (1981), in a comparative study of orthopaedically handicapped children and their normal peers found that the handicapped subjects held a better concept of themselves, but did not vary much on their reactions to frustrations as compared with normals. They also discussed that no significant relations were discovered between intelligence and self-concept or intelligence and creativity.

Agarwal and Dhar (1984) conducted a factorial study on disabled in the light of attributional theory, this study compared the structure of normal with that of disabled on life events attributions. Attributional component of key life events when subjected to factor analysis yielded nine factors in disabled sample and seven identifiable factors in normals. Both factor

solutions have some similarities as well as dissimilarities. Fame and self-control appear in both the sample. Somehow disabled sample has come out with a factor structure which appears to be oriented toward 'self- against society'. This is perhaps the situation in which the disabled find themselves.

Singh (1984) found that locus of control of visually handicapped and sighted subjects did not differ significantly. But it was also observed that non-congenitally blind were less internal and differed significantly from their sighted counterparts.

Bhargava and Seth (1990) investigated the self-concept of orthopaedically handicapped and how they differ with their counterparts. The results indicated significant differences in the five areas of self-concept between the groups. The five areas are behaviour, physical appearance and attributes, anxiety, popularity and happiness and satisfaction.

Magill-Evans and Restall (1991) attempted to study the self-esteem of person with cerebral palsey. The results revealed that as adolescents the girls scored significantly lower than the other groups on physical, social and personal self-esteem, however, as adults, these subjects were no longer significantly different from the other groups. Male subjects had self-esteem scores similar to those of the non-disabled groups in both adolescence and adulthood. The factors that the subjects identified as leading to changes in self-esteem were relationships and experiences.

Manickaraj and Karunanidhi (1992) in their study on locus of control assertiveness, vocational maturity and vocational preference between orthopaedically handicapped and normals also did not yield any difference.

Tabassum, Iqbal and Ahamed (1993) probed factors affecting self-acceptance amongst the handicapped. This investigation has tried to bring to light differences in self-acceptance among orthopaedically and sensory handicapped subjects. The factor of sex was also taken into consideration. The results indicated that the sensory handicapped are more self-accepting than orthopaedically handicapped. There is no significant difference in the self-acceptance of male and female handicapped.

Jyothi and Reddy (1996) examined the levels of adjustment and self-concept among 230 normal and 230 hearing impaired children. Results revealed that the hearing impaired children had a lower self-concept compared to normal subjects but they exhibited a higher quality of adjustment in the areas dealing with health, emotionality and masculinity-femininity.

Martinez and Sewell (1996) compared the self-concept scores of 19 visual impaired and 19 matched controls using the Tennessee Self Concept Scale. The results of the study suggested that the presence of a visual impairment does not necessitate a negative self-concept.

Rani (1997) investigated on aggressive reactions to frustration in the physically handicapped. The physically handicapped and non-handicapped children differed significantly on extra punitive and impunitive responses.

The predominance of intropunitive, impunitive and need persistence was found among physically handicapped subjects.

Bharadwaj (1999) conducted a study to assess the psychogenic needs of normal congenitally blind and cerebral palsied children. It is discerned that normal children show higher score for need for achievement, dominance and hetero sexuality as compared to congenitally blind and cerebral palsied children. The higher score on need for intraception in congenitally blind when compared with normal ones and higher score on need for order and succorance as compared to cerebral palsied ones need clinical attention. However, cerebral palsied children show higher score on need for achievement as compared to normal and congenitally blind children respectively.

Nosek and Hughes (2000) reviewed findings on sense of self and spirituality that have emerged in several of the studies conducted by the Center for Research on Women with Disabilities. It presented a review of literature on self-esteem, self in connection to others, and self-efficacy, and described findings from two qualitative and one quantitative study of these constructs in women with disabilities. Discussion led to the hypothesis that the sense of self in connection to others is a fundamental determinant of self-esteem, and that self-efficacy, when perceived as a power drawn from a divine source, is an important mechanism used to transcend the challenges to both that often accompany disability.

Ohja (2002) investigated social anxiety and various dimensions of mental health among orthopaedically handicapped youth. Social anxiety was observed significantly high in orthopaedically handicapped persons. Orthopaedically handicapped female, were found to be more socially anxious as compared to orthopaedically handicapped male. However, few dimensions of mental health viz. Group oriented attitude, integration of personality and positive self evaluation were significant on physically handicapped in general.

Eide and Roysamb (2002) studied the relationship between level of disability, psychological problems, social activity and social networks. The study confirms that activity limitations predict level of psychological problems. It appeared from the analysis that activity limitations increase with increasing psychological problems and although to a lesser extent, with increasing age. Women report somewhat higher activity limitation than men. The social variables correlate with activity limitation.

In the background of so far discussed theoretical and empirical understanding of disability, the structure and design of the present study is formulated.

PRESENT STUDY

Physical disability is often defined as a physical limitation in activity. But in the light of theoretical literature and empirical studies discussed so far, it is very clear that disability is not a mere functional limitation but is

inclusive of remarkable psychological and social implications. In other words, disability may be conceived as a social condition imposed on the disabled individual. This imposition has its roots in the negative values emanating from different sources such as stereotyped attitudes, discriminating social processes and disability hostile environment.

Any human being is identified primarily in terms of his/her unique behaviour characteristics, which is conceptualised by the term 'personality'. The actions and interactions of the person valued in terms of the adaptability or fitness to conditions result in the mental health and subjective well-being of the person. Similarly the potential to manage the different situations with adequate competency is partly a matter of earlier experience or exposure that is reflected in the experience of stress. Therefore, the conditions or impressions of the interactions of the person with the environment will obviously have a role in shaping the characteristic behaviour patterns, mental health and subjective experience of day to day interaction.

Psychological repercussions of socially enhanced disability are indicated by many scholars. Effects of disability on self-concept and self-esteem have been emphasized and all discussions on the psychological impact of physical disability refer to dimensions of personality and mental health. The review of empirical studies also support these inferences.

Thus almost all dimensions of an individual will be affected by his/her disability. These effects can be profound in women who are generally subjected to gender discrimination too.



Women with disabilities face discrimination even within the family to a greater extent than men with disabilities. Lack of mobility, isolation and confinement to the house are special issues concerning them. They encounter further discriminations as they are denied of their reproductive rights and opportunities to enter marital and family life. In a patriarchal society, like in India, the disadvantages will be more severe. This gender bias and discriminatory practices compounded with lack of economic resources would definitely influence the psychological realm of these women and this need to be explored.

Though attempts are made in India and abroad to study various dimensions of the problems faced by physically disabled, most of them are focussing on children or men. Thus, social invisibility felt by women with physical disabilities is reflected in research field too. So a proper understanding of the state, challenges, problems of women with disabilities and the psychological impacts of these are relevant and significant for improving the quality of life of women with physical disabilities. Therefore, this study is aimed at investigating personality, stress-tolerance and well-being of women with physical disabilities.

Objectives of the Study

- 1) To study the personality of women with physical disabilities
- 2) To study the stress-tolerance of women with physical disabilities
- 3) To study the well-being of women with physical disabilities

- 4) To study the relationship between personality, stress-tolerance and well-being in physically disabled women.

Hypotheses

A few hypotheses formulated to meet the objectives are:

- 1) a) Women with physical disabilities and non-disabled women differ in personality.
b) Women with orthopaedic disabilities and women with visual disabilities differ in personality.
- 2) a) Women with physical disabilities and non-disabled women differ in stress-tolerance.
b) Women with orthopaedic disabilities and women with visual disabilities differ in stress-tolerance.
- 3) a) Women with physical disabilities and non-disabled women differ in well-being.
b) Women with orthopaedic disabilities and women with visual disabilities differ in well-being.
- 4) Personality and stress-tolerance are related in women with physical disabilities.
- 5) Personality and well-being are related in women with physical disabilities.
- 6) Stress-tolerance and well-being are related in women with physical disabilities.

METHODOLOGY

Sareena. N. P . “Personality, stress-tolerance and well-being of women with physical disabilities ” Thesis. Department of Psychology , University of Calicut, 2004

METHODOLOGY

-
- *Design*
 - *Sample*
 - *Tools*
 - *Analysis of Data*
-

Women with physical disabilities is the focus of the present study. Present investigation aims to study the influence of disability on personality, stress-tolerance and well-being in these women and how these three factors are interrelated.

Research methodology is a way to systematically solve the research problem (Kothari, 1993). Cresswell (1994) stated that methodology is 'the entire process of a study' (p.7). In Breakwell's (1995) opinion, research methods can be differentiated according to whether data are submitted to a qualitative or quantitative treatment. According to Cresswell one approaches a quantitative methodology by using a deductive form of logic, wherein theories and hypotheses are tested in a cause and effect order. Concepts, variables and hypotheses are chosen before the study begins and remain fixed throughout the study (in a static design). The intent of the study is to develop generalisations that contribute to the theory and that enable one to better predict, explain and understand some phenomenon. These generalisations are enhanced if the information and instruments used are valid and reliable.

According to Ascher (1994) research design methodology in psychology follows the principles of research methodology in science, but there are also many special considerations in addition to the basic principle. Most of the variables are abstract and often have few direct referents to the biological or physical world. The very act of observing or measuring psychological variables can cause the subjects to react or change. Therefore, for obtaining a valid and

reliable result and for reaching a definite conclusion the method has to be properly planned and designed.

This chapter is devoted to the description of the methodology followed in this study, which contains details of design, sample, tools, method of administration, scoring and analysis of data.

Design

The design of the present study is a descriptive one which comes under passive Observation Research Design (Ascher, 1994). According to Wilkinson and Bhandarkar (1982) the purpose of a descriptive study is to portray accurately the characteristics of a particular situation or group or individual.

Sample

Sample is a group of elements selected from a larger, well-defined pool of elements (Magill, 1996). Krathwohl (1994) says that sampling procedure are ways of selecting a small number of units from a population to enable researchers to infer the nature of that population from the sample. The present investigation made use of two sampling techniques. The subjects of experimental group were selected using 'Disproportionate stratified sampling technique' According to Schofield (1996) to draw a stratified sample, the elements of a population are divided into non-overlapping groups-strata. Simple random samples are drawn from each of these and together they form

the total sample. In disproportionate sampling, strata are represented in the sample in unequal proportions in the population (Festinger and Katz, 1976).

Purposive sampling is used to select subjects of the control group. According to Kerlinger (1995) purposive sampling is a nonprobability sampling characterized by the use of judgement and a deliberate effort to obtain representative samples by including presumably typical areas or groups in the sample.

❖ **Inclusion-Exclusion Criteria**

Subjects of the experimental group and control group were included in the sample following certain inclusion-exclusion criteria.

Inclusion Criteria

a. Experimental Group

Selection of subjects in the experimental group was based on the following criteria.

- ❖ Women with orthopaedic disabilities or visual disabilities will only be selected.
- ❖ All subjects are to be registered either in special employment exchanges of Calicut district or District Centre for Disability Rehabilitation, Calicut.
- ❖ All subjects are to be aged between 18 and 50.

b. Control Group

The inclusion criteria decided for the control group were as follows:

- All subjects are to be women without any physical disability.
- All subjects are to be aged between 18 and 50.
- Family members of the subjects in the experimental group are only to be considered as subjects for the control group.

Exclusion-Criteria***a) Experimental Group***

1. The subjects are not a permanent resident of any institution for physically handicapped.
2. The subjects are to be without other physical or behavioural problems.

b) Control Group

1. Subjects are to be without any chronic physical or behavioural problems.

Thus a representative sample consisting of experimental group and control group was selected using the above discussed sampling techniques and inclusion-exclusion criterion. The two sub groups were thus matched for age, family status and family environment. The procedure involved in the selection of the sample is as follows:

Procedure for Selection of the Sample

In order to select representative group of physically disabled and non disabled the investigator approached various Panchayats, Municipalities, Corporation, Special Employment Exchanges and Calicut District Centre for Disability Rehabilitation. First the lists of physically disabled women who have registered in these centres were collected. The lists collected from Panchayats, Municipalities and Corporation were not included in the investigation because the office records did not specify either age or category of disability. The lists collected from Calicut District Centre for Disability Rehabilitation, aided by National Institute of Mental Retardation, Secunderabad and Special Employment Exchanges were included in the investigation since they specified all the personal details like age, sex, category of disability and home addresses.

Permission for reference of census records in District Centre for Disability Rehabilitation (DCDR) was sought through correspondence to National Institute of Mental Retardation. Thus the disabled population considered for the study included the physically disabled women registered in DCDR from 2000 March to December 2001 and the disabled who got either temporarily or permanently employed through special employment exchanges.

During the period from 2000 March to December 2001, the total number of individuals registered in DCDR was 8964, out of which 5832 were men and 3132 were women. The total number of persons with orthopaedic disabilities registered during this period was 4220, out of which 2960 were men and 1260

were women. The total number of persons with visual disabilities included in the list was 842, out of which 553 were men and 289 were women.

In the next step, first the women with orthopaedic disabilities and visual disabilities were separated from the main list. Secondly the women with orthopaedic disabilities and visual disabilities aged between 18 and 50 were identified and separated and thirdly stratification based on residential area was done. The final list consisted of 917 women with orthopaedic disabilities of which 156 residing in urban areas and 761 residing in rural areas, and 160 women with visual disabilities with 15 residing in urban areas and 145 residing in rural areas. Age-wise stratification of the sample was done in the next step. Four age-groups, namely 18-20 years, 21-30 years, 31-40 years and 41-50 years were used for this stratification. Finally the actual sample of the study was chosen using lottery method of sampling from the 4 age-groups in both urban and rural areas. However, women with visual disabilities residing in urban area were all contacted but few were excluded since they did not fulfill with the inclusion-exclusion criteria.

The total number of individuals included in the list taken from special employment exchanges was 69 and using lottery method equal number of subjects from both urban and rural areas were selected for final study.

Distribution of the Sample

The sample of the study consisted of two categories of population, namely the disabled women and non-disabled women and selection of sample

is limited to Calicut district. As many researchers in the field have rejected labels loaded with stereotype negativity, this study will refer the subjects of experimental group as women with disabilities or disabled women. The subjects of control group will be referred as 'non-disabled women and not as normals' for the same reason that the disabled may be treated at par with the non-disabled in all other respects, whereas the term 'normal' implies freedom from all possible psychological vulnerabilities. The total strength of the sample was 210. The experimental group consisted of 150 women with physical disabilities out of which 97 were women with orthopaedic disabilities (OD) and 53 were women with visual disabilities (VD). The control group consisted of 60 non disabled women (ND). The subjects of experimental group were selected from two centres namely, the special employment exchanges of Calicut and Calicut District Centre for Disability Rehabilitation. Table.3. 1 Shows the Institution Wise Distribution of the Experimental Group

Table 3.1

The Institution Wise Distribution of the Experimental Group

Sl. No	Institution	OD	VD	Total
1.	Special Employment Exchanges	17	3	20
2.	Calicut District Centre for Disability Rehabilitation	80	50	130
	Total	97	53	150

Care was taken to include both the urban and rural disabled population.

Table.3.2 shows the residential area wise distribution of the sample.

Table 3.2

Residential Area-wise Distribution of the Sample

Sl. No	Area of Residence	OD	VD	ND	Total
1.	Urban	50	10	30	90
2.	Rural	47	43	30	120
	Total	97	53	60	210

In order to represent an adult population, subjects between the age of 18 and 50 were only included. Age was also a base for stratification of the sample.

Table 3.3 shows the age-wise distribution of the sample.

Table 3.3

Age-wise Distribution of the Sample

Sl. No	Age-Group	OD	VD	ND	Total
1.	18-20 years	20	12	14	46
2.	21-30 years	26	13	25	64
3.	31-40 years	31	18	17	66
4.	41-50 years	20	10	4	34
	Total	97	53	60	210

Though religion as a variable was not controlled the sample included subjects of the three religions, which is given in table 3. 4.

Table 3.4**Religion-wise Distribution of the Sample**

Sl. No	Religion	OD	VD	ND	Total
1.	Hindu	50	34	39	123
2.	Muslim	43	16	21	80
3.	Christian	4	3	0	7
	Total	97	53	60	210

Economic status of the subjects in the sample is given in Table 3.5.

Table 3.5**Distribution of Economic Status in the Sample**

Sl. No	Economic Status	OD	VD	ND	Total
1.	Lower class	35	18	16	69
2.	Lower middle class	56	28	36	120
3.	Upper middle class	6	7	8	21
4.	Upper class	0	0	0	0
	Total	97	53	60	210

Employment provides security. So care was taken to include both employed and unemployed subjects in the sample.

Table 3.6

Employment-Wise Distribution of the Sample

Sl. No	Employment	OD	VD	ND	Total
1.	Employed	27	11	10	48
2.	Unemployed	70	42	50	162
	Total	97	53	60	210

Marriage is also considered to provide security and is reported as not easily possible in the case of women with physical disabilities Table.3.7 shows the distribution of marital status in the sample.

Table 3.7

Distribution of Marital Status in the Sample

Sl. No	Marital Status	OD	VD	ND	Total
1.	Unmarried	65	34	18	117
2.	Married	21	15	42	78
3.	Separated	7	2	0	9
4.	Divorced	0	2	0	2
5.	Widowed	4	0	0	4
	Total	97	53	60	210

Though the financial aid provided by the government is very minimal, it is often the only source of finance for the disabled, Table.3.8 shows the distribution of the disabled sample receiving financial assistance.

Table 3.8

Distribution of Financial Assistance

Sl. No	Financial Assistance	OD	VD	Total
1.	Receiving	40	28	68
2.	Not Receiving	40	22	62
	Total	80	50	130

Tools

For the present investigation which intends to study personality, stress-tolerance and well-being of women with physical disabilities three standardised self-report measures and an information schedule were used.

- 1) To study the personality dimensions a Malayalam adaptation of the 16 PF form C (Rema and Anita, 1989) was used.
- 2) A Malayalam adaptation of Life Change Events Inventory (Paul and Moorthy, 1992) was used to study the stress-tolerance of the entire sample.
- 3) A Malayalam adaptation of PGI General well-being measure (Anita and Sareena, 2000) was used to study the well-being.
- 4) An information schedule covering the general demographic factors and some relevant information regarding family and disability prepared by the investigator was also used.

Each measure is described briefly along with the pattern of administration and scoring followed

16 PF Form C

16 PF Test is a widely used personality test developed by R.B. Cattell. Cattell's conceptualisation of personality describes the basic structure of personality, its dynamics and the temporary and more permanent changes it can undergo. Cattell attempts to draw together all these separate influences bearing on behaviour in a single equation. Methodologically, Cattell favours an atheoretical approach, in which factor analysis is used as an explanatory way to discover personality factors.

16 PF test is a multidimensional set of 16 questionnaire scales arranged in omnibus form. It is designed to make available, in a practicable testing times, information about an individual's standing on the majority of primary personality factors and four secondary factors. Originally published in 1949, the 16 PF is designed for use with young adults (from age of 16 years or 17 years) to late maturity. The 16 PF is virtually self-administering and can be used with groups and individuals. It is applicable to a wide range of educational levels and is available in some 15 languages.

There are six forms of the 16 PF. All forms of 16 PF measure 16 dimensions of personality. Each dimension is identified as a factor and each factor is designated by an alphabet. Forms C and D are with somewhat less

demanding vocabulary and consisting of 105 items each intended for use with the educationally disadvantaged and are having a three choice response pattern which include an 'in-between' alternative other than Yes or No.

Four 'second-order' scores are also obtained from a combination of scores on specific sets of the 16 factors. The second order scores provide a convenient capsule description of personality. A brief description of the primary and secondary factors of the 16 PF questionnaire is shown in Table 3.9.

Table 3.9

The Primary and Secondary Source Traits on the 16 PF Test

Factor	I. Primaries	
	Low Sten Score Description	High Sten Score Description
A.	Reserved-Sizothymia	Outgoing-Affectothymia
B.	Dull- Low intelligence	Bright-High Intelligence
C.	Affected by feelings-Lower ego strength	Emotionally stable-Higher ego strength.
E.	Humble-Submissiveness	Assertive-Dominance
F.	Sober-Desurgency	Happy-Go-Lucky-Surgency
G.	Expedient- Weaker super ego strength	Conscientious- Stronger super ego strength
H.	Shy- Threctia	Venturesome - Parmia
I.	Tough- Minded- Harria	Tender minded- Premsia
L.	Trusting-Alaxia	Suspicious - Protension
M.	Practical- Praxernia	Imaginative-Autia
N.	Forthright - Artlessness	Astute - Shrewdness
O.	Self-assured - Untroubled adequacy	Apprehensive - Guilt proneness

Continued...

(Table 3.9 Continued...)		
Factor	I. Primaries	
	Low Sten Score Description	High Sten Score Description
Q ₁	Conservative-conservation temperament	Experimenting - Radicalism
Q ₂	Group dependent- Group adherence	Self-sufficient - Self-sufficiency
Q ₃	Undisciplined Self-conflict Low self-Sentiment integration	Controlled-High strength of Self-sentiment
Q ₄	Relaxed - Low Ergic Tension	Tense - High ergic tension
	II. Secondaries	
Symbo l	Technical Title	Popular Label
Q _I	Exvia Vs Invia	Extraversion Vs Introversion
Q _{II}	Adjustment Vs Anxiety	Low Anxiety Vs High Anxiety
Q _{III}	Pathemia Vs Cortertia	Sensitivity, Emotionalism Vs Tough poise
Q _{IV}	Subduedness Vs Independence	Dependence Vs Independence

Usha Seetharam in 1974 modified Form C of the 16 PF with the language made simpler than the original form to suit Indian population. Rema and Anita adapted this questionnaire into Malayalam in 1989. Instead of following a word to word translation each item was translated into simple Malayalam keeping the meaning and tone intact. The linguistic perfection was checked by academic and non academic language experts at three levels. Thus the final draft was prepared and reliability of items as well as the entire form was tested.

Reliability

Equivalent form reliability between English and Malayalam versions is reported by computing item-wise correlation coefficients and this ranged from 0.27 to 0.98 except for three items. Internal consistency was also worked out by item to factor correlations within the Malayalam form and the correlation coefficients are reported to be sufficiently high.

Validity

Validity of the Malayalam adaptation of 16 PF Form C was found by computing factorwise correlations between scores on the English and Malayalam forms and this ranged from 0.74 to 0.98. Validity was also estimated by calculating the mean of the correlations of all the items with the respective factor scores and this ranged from 0.58 to 0.90.

Administration and Scoring

The 16 PF Form C was administered on women with physical disabilities and non-disabled women individually. After seating the subject comfortably and establishing sufficient rapport, the question book along with answer sheet was given. Simple and clear instructions are printed on the booklet. Though the test was untimed, the investigator reminded the respondents that they should not dally and should give immediate answers and move along. Answers were always marked on a separate answer sheet.

Hand scoring method was used. Two cardboard stencil keys were used. One covered factors A, C, F, H, L, N, Q and Q₃ and the other covered factors B, E, G, I, M, O, Q₂ and Q₄. But before computing the ten scores of the factors, faking was handled. Since there was a chance of distortion in self-evaluative data the score on factor MD (Motivational Distortion) of each subject was found. Subjects' answer sheet was rejected if the score was 12 and above.

Each answer in the answer sheet scored 0, 1 or 2 point except for factor B, each single item contributed to only one factor. After fitting the stencil over the answer sheet the marks visible through the holes for each factor were counted and sum of the scores of each factor indicated the raw score of that factor. A sten score of 1 to 3 was considered low, score of 4 and 7 as slightly deviant, score of 5 and 6 as average and score of 8 to 10 as high.

Second order factors were analysed, which were derived from the sten scores on the primaries following the method shown in the manual. There is a slight variation in the procedures used for men and women.

2. Life Change Events Inventory

To study the impact of stress, it is necessary to have some yardstick to measure the intensity of life events. Pestonjee (1999) stated that life events stress are concerned with situational encounters and the meaning that a person may attach to such events.

As cited by Newman and Newman (1984) Meyer argued that both positive and negative life events produce stress. Building on this idea, Holmes and Rahe developed the Social Readjustment Rating Scale to measure the perceived stressfulness of 43 life events in 1976. By testing thousands of people, they were able to rank a series of life change events in order of their disruptive impact. Subjects were given the list of events and were told that event of marriage had a value of 50 life change units. They were then asked to score all the events on a scale from 0 to 100, using the scale value of 50 for marriage as reference. At the top was death of a spouse (100 LCUS) followed by divorce (73), imprisonment (63) and death of a close family member (63) and so on. Wade and Tavris (1987) have reported that among the people who become ill, the large majority had 300 LCUS or more in a single year.

Pestonjee (1999) also stated that most investigations in India in this area have made use of the Social Readjustment Rating Scale (SRRS) developed by Holmes and Rahe. A stressful life events scale for use in India was developed by Singh *et. al.*, in 1981. It is termed as Presumptive Stressful Events Scale (PSE Scale). There are 51 items in it, which range from death of spouse to family conflict to going to tour. There are 24 personal items like divorce, sexual difficulties etc and 27 impersonal items like theft. There are 10 desirable items like getting married; 32 undesirable items like crops damaged. There are 10 ambiguous events, as prophecy of palmist (c.f. Kuruvila, 1991).

The above scale, remodified to suit Indian culture by Radhakrishnan, Joseph and Varghese in 1984 added 14 new items. This was adapted in Malayalam by Paul and Moorthy in 1992. This life change events scale used in the present study consists of 67 items .

Reliability

The test-retest reliability of LCE scale on a population of 50 subjects was found to be 0.79. The time gap between the first administration and the second administration was one month.

Validity

The correlation coefficient obtained between the LCE scale in Malayalam and LCE scale in English was 0.71 on a population of 50 subjects.

Administration and Scoring

Life change events inventory was administered on women with physical disabilities and the matched control subjects individually. The subjects were told that the scale consists of 67 statements related to day-to-day life events. They were asked to mark their rating to each incident, when it occurred or if it occurs in their lives. The ratings were made on a 5 point scale. The total score indicates the stress-level of an individual. Therefore, it is inferred that a low stress score indicates more stress-tolerance and vice versa.

3. PGI General Well-being Measure

Many attempts have been made in the past to measure positive mental health, only one of which is the measure of subjective, general sense of psychological well-being. Verma and Verma (1989) developed one such

tool and is reported to be reliable and valid.

Verma and Verma reported that the development of a scale to measure the general well-being of an individual was made by Dr. H. Dupery in 1970 and this schedule was later used and modified by Edward and Fazio and many others in several large scale studies. This scale was a 25 item, 6 point scale with 33 scores measuring several aspects of adjustment like freedom, health concern, worry, distress, energy level, satisfaction, cheerfulness, relaxation, emotional behaviour control etc.

This scale was tried out, modified with certain items deleted, the format was completely changed and simplified to suit Indian conditions where majority of our clinical population is rural, illiterate and unsophisticated. A 20 point scale thus constructed was called PGI. General well-being scale. Hindi version of this scale is also made available by Moudgil *et. al.*, in 1986. As cited by Verma and Verma (1989) Moudgil stated that scale scores have been found to be independent of socio-economic status (-0.39) and education (0.12) when correlated with these variables but it showed correlation with age (0.52 $p < 0.01$).

Reliability

Verma and Verma (1989) have cited that reliability estimated by Kuder and Richardson Formula- 20 was 0.98 ($p < 0.01$) and for test retest reliability the coefficient was 0.91 ($p < 0.01$) for the English version.

Validity

The test was correlated with a number of tests in different studies. The scale showed significant correlations of 0.56 with Bradburn well-being scale and of 0.54 with PGI quality of life scale (Verma and Verma, 1989).

For the present study the PGI General Well Being Scale was adapted to suit the selected sample with lower education levels. A summary of the procedure of adaptation of PGI General well-being measure from English to Malayalam is as follows.

Translation

As the first step, the items of the English version of PGI General-being Measure (Verma and Verma; 1989) were translated into Malayalam to suit the local population. A word to word translation was not followed, but it was made in such a way that the meanings were conveyed in the local vernacular. The translation in Malayalam was made by the investigator with the help of academically competent persons and was checked by language experts before it was administered on a selected sample.

In order to establish efficiency of the Malayalam form, comparable to that of the English form and also for establishing reliability and validity, the English version and the translated Malayalam version were administered on a selected sample.

Sample of Standardisation

The sample for standardisation was drawn from a population of post graduate students studying in various departments of University of Calicut, including science, languages and humanities. Systematic random sampling technique was used for selecting the subjects.

It was made sure that all subjects had equal proficiency in Malayalam and English. The sample consisted of 50 men and 50 women. Age of the subjects ranged from 22 to 26 years with an average age of 24 years.

Administration: For estimating the efficiency of the Malayalam version individual administration of the test was done on the selected subjects. Both English and Malayalam version was administered on the two groups.

For the first half of the group, comprising of 25 men and 25 women, questionnaire in English was given first. After a two week interval, the translated Malayalam version of the test was given to the same subjects. To minimise the influence of priority for one language, the second half was given the Malayalam version first and two weeks later the English version was administered.

Reliability

For establishing the reliability of this test correlations between total scores on the English version and total score on the Malayalam version were computed. The values are given in Table 3.10.

Table 3.10
Correlation Coefficients Between Total Scores
on the English and Malayalam Versions of PGI Well-Being Scale

Sl. No.	Group	r	Level of Significance
1	Girls	0.9316	0.001
2.	Boys	0.9510	0.001
3.	Total	0.95440	0.001

All the correlation coefficients in Table 3.10 establish the reliability of the scale and hence was used for the final study.

Administration and Scoring for the Final Study

The Malayalam version of the PGI General well-being measure was administered on the experimental and control group individually. Care was

taken to establish a rapport with each subject and after making sure that they are ready and relaxed the simple instructions printed on the scale was read out to them. Then the respondents were asked to tick the statements applicable to them. Number of tick marks was counted and that constituted the well-being score of that particular individual at that time.

Subjects who got more than 10 points on this scale can be considered healthy (Rema, 1995).

Information Schedule

An information schedule was designed to collect details regarding age, education, marital status, family, nature of handicap etc. The schedule was prepared in English and administered individually by the investigator on both the groups.

Copies of the tools are given as Appendices.

Analysis of Data

The present investigation intended to study personality, stress-tolerance and well-being of women with physical disabilities had formulated a few hypotheses presented in the first chapter. After scoring the responses on each tool, tenability of hypotheses was tested statistically as follows.

- The first hypothesis that states personality of the disabled and non-disabled differs, was tested by
 - i) Computing percentage of subjects in experimental group scoring low and high on the factors of 16 PF.

- ii) One way ANOVA was computed for each factor between scores of the disabled and non-disabled groups.
 - iii) Inter-group differences were further clarified through Means and Standard Deviations. Further statistical computations are redundant as one way ANOVA deals with only two groups.
 - iv) MANOVA was used to estimate the influence of area of residence, marital status, economic status, employment status, religion and financial assistance on personality factors of experimental group.
- The second hypothesis that states stress-tolerance of disabled and non-disabled women differs was tested by
 - i) Overall stress score of each subject was estimated and significance of difference between means of scores of disabled and non disabled on Life Change Events Inventory was found using one-way analysis of variance(ANOVA).
 - ii) Inter-group differences were further clarified through Means and Standard Deviations.
 - iii) ANOVA, Means and Scheffe's method were used to analyse the influence of area of residence, marital status, economic status, employment status, education, religion and financial assistance on the stress-tolerance of experimental group.
 - The third hypothesis that states well-being of disabled and non-disabled women differs was tested by
 - i) Overall well-being score on P.G.I. well-being measure of each subject was estimated and percentage of subjects scoring above and below 10 points were found out.
 - ii) The significance of difference between mean scores of disabled and non-disabled women was computed using one-way analysis of

variance(ANOVA).

iii) Inter-group differences were further clarified through Means and Standard Deviations.

iv) ANOVA, Means and Scheffe's method were used to understand the influence of area of residence, marital status, employment status, economic status, education, religion and financial assistance on well-being of the experimental group.

- The fourth hypothesis studying the relationship between personality and stress-tolerance was tested by Stepwise Multiple Regression Method to compute regression coefficients between scores of subjects in the experimental group on all the factors of 16 PF and Life Change Events Inventory.
- The fifth hypothesis studying the relationship between personality and well-being was tested by Stepwise Multiple Regression method to compute regression coefficients between scores of subjects in the experimental group on all the factors of 16 PF and PGI General well-being measure.
- The sixth hypothesis that states the stress-tolerance and well-being are related was tested by
 - i) Pearson's product moment correlation to compute the correlation coefficients between the scores of subjects in the experimental group on Life Change Events Inventory and PGI General well-being measure.
 - ii) Partial correlations were computed to test the role of personality in the relation between the two.

Results and discussions are presented in the next chapter.

RESULTS AND DISCUSSION

Sareena. N. P . “Personality, stress-tolerance and well-being of women with physical disabilities ” Thesis. Department of Psychology , University of Calicut, 2004

CHAPTER IV

**RESULTS AND
DISCUSSION**

SECTION ONE

- *Hypothesis I*
- *Hypothesis II*
- *Hypothesis III*

SECTION TWO

- *Hypothesis IV*
 - *Hypothesis V*
 - *Hypothesis VI*
-
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It may be recalled that in the present study, an attempt has been made to understand the personality, stress-tolerance and well-being of women with physical disabilities. The results obtained in the study are divided into two sections. In the first section, results with regard to personality, stress-tolerance and well-being of women with physical disabilities in comparison with non-disabled women are presented. In the second section, results pertaining to the relationship between personality, stress-tolerance and well-being are described.

Section I

This section verifies the first three hypotheses of the present investigation.

HYPOTHESIS I

With respect to first hypothesis, the analysis of results is discussed in 2 subsections. Firstly, the personality of women with disabilities is analysed and secondly, comparisons of the personality of the disabled with non-disabled women and comparisons between the sub-groups of disabled are attempted.

At the outset the personality pattern of disabled women is analysed in terms of percentages of subjects scoring low (1-3) and scoring high (8-10) on the 16 PF variables. Factor wise analysis of the percentages of low scorers and high scorers is tabulated as shown in Table 4.1.

Table 4.1
Percentage of Low Scorers and
High Scorers in the Experimental Group on the 16 Personality Factors

Sl. No	Personality Factors	Percentage of Low Scorers	Percentage of High Scorers
1.	A	33%	5.3%
2.	B	83.3%	0%
3.	C	46%	6.6%
4.	E	56.6%	0%
5.	F	33.3%	16.6%
6.	G	4.6%	12%
7.	H	23.3%	10%
8.	I	1.3%	18.6%
9.	L	18%	16%
10.	M	42%	4%
11.	N	32%	11.3%
12.	O	5.3%	28%
13.	Q ₁	12.6%	5.3%
14.	Q ₂	33.3%	2%
15.	Q ₃	20.6%	5.3%
16.	Q ₄	29.3%	8.3%

An examination of percentages reveals that extreme and strongly deviant scores are not very frequent with reference to women with disabilities, though significant differences between low scorers and high scorers are obvious on certain factors of 16 PF. A factor wise description of the analysis is discussed in the following pages.

Factor A: Sizothymia Vs Affectothymia

With reference to factor A, the low scorers (A-) out do high scorers (A+) in the case of physically disabled women. The number of high scorers is almost negligible in the group.

The scores indicate that disabled women express behaviour more of low scorers than the behaviour of high scorers. A- persons are characterised by the flatness and dryness of the emotionality and A+ refers to the tendency to be appropriate but fulsome expression in affect feeling. So, from Table 4.1 it may be inferred that the disabled women have a temperamental inclination to be cautious in emotional expression, uncompromising and critical in outlook and are awkwardly aloof in manner.

This finding should be read considering the background situation of the disabled women in any society. The disabled, who are considered different, and often inferior, experiencing a lack of acceptance, feels the need to be guarded, both in emotion as well as in behaviour to avoid downfall. This view gets strengthened by the following suggestions, cited by Fine and Asch (1988).

Hanna and Rogovsky suggested that the disabled women might be negatively viewed by both women and men than the disabled men. The trend on factor A in the present study fits into the views of Chenoweth, Gilson *et al.*, and Sobsey who opined that when disabled women are taught

to comply with the requests and instructions of others, tacit cultural understanding silences these women from expressing their vivid experiences and perceived needs. This would definitely create a critical outlook, a self-restricted interaction and distrust in the minds of disabled women. Thus it can be concluded that society has an influencing role in moulding a cautious temperament in emotional expression and aloofness in manner in women with physical disabilities.

Factor B: Low Intelligence Vs High Intelligence

On this factor majority of the physically disabled women have scored low with none scoring high. This indicates that disabled women in the sample are of low intelligence. Lack of environmental stimulation may be accounted for this.

Factor C: Lower Ego Strength Vs Higher Ego Strength

Factor C is one of dynamic integration and maturity as opposed to uncontrolled disorganised general emotionality. The pattern in the table has shown that almost half of the members of the experimental group have scored low (C-) on Factor C and a similar number of them have scored within average range.

The C- person is characterised by emotional instability and ego weakness. He/she is affected by feelings, emotionally less stable, easily upset and changeable in attitudes and interests. He/she is easily perturbed,

evasive of responsibilities and gets into fights and problem situations. C- person who gets annoyed with things and people, is dissatisfied with the world situation, his/her family and his/her own health.

Deprivation of many things changeable and unchangeable can cause frustration and annoyance. Disabled are considered as persons with inadequate capacity to decide anything about his/her life. They are deprived of opportunities that would assist development of stable emotionality. They live in a society that gives prime-importance to non-disabled. The disabled women both at home and society experience the discriminations associated with disability and gender. This injustice unknowingly upsets the person making her sensitive and antagonistic in behaviour and manner. If the person has higher ego strength, she/he would face this injustice with maturity and calmness. But disabled woman is deprived of developing such a matured potential in her.

As opined by Hodapp (1998) successful adaptation to the personal predicament of being handicapped is dependent on the attitudes of family, professional staff and society in general. Misdirected kindness and failure to treat a handicapped person as a responsible and sensitive individual in his own right together encourage him to unnecessary dependence, adoption of the sick role and manipulative behaviour. Bharadwaj (1995) also found a similar trend of C- in visually impaired children and cerebral palsied

children. Parents and siblings of disabled women also pointed out this during data collection.

Factor E :Submissiveness Vs Dominance

On factor E, majority of disabled women scored low (E-) while none of them scored high (E+) on this factor. A E+ person characterises dominance and is assertive, aggressive, competitive and stubborn. So none of the disabled women in the sample are assertive, aggressive, competitive or stubborn. Their characteristic feature is submissiveness. They are obedient, mild, easily led, docile, accomodating, dependent, considerate, diplomatic, expressive, conventional, conforming, easily upset by authority and humble.

The reasons for the development of these features could easily be related to social interactions and expectations. Physically disabled may be more of the most severely stigmatised group. The degree of stigmatisation might depend on how undesired the difference is in a particular social group. Physical disabilities are physically salient and represent some deficiency or distortion in the bodily form, and in most cases are unalterable. According to Coleman (1997) in the case of stigma, role expectations are often the same as the stereotypes. Some stigmatised people become dependent, passive, helpless and childlike because that is what is expected of them.

In some way or other, every one is a product of environment and person who has impairment when brought into a family and society imbued with the prevailing negative attitudes is likely to view himself and his potential in the light of those attitudes. Therefore they tend to be less optimistic, less confident and submissive.

Factor F: Desurgency Vs Surgency

This is one of the most important components in extraversion. A low score on F denotes the desurgent characteristics. The individuals with F- are sober, taciturn, serious, silent, introspective, full of cares, concerned, reflective, incommunicative, stick to inner values, slow and cautious while surgent (F+) individuals have an easier, less punishing, more optimism creating environment or that they have a more happy-go-lucky nature through less exacting aspirations. Desurgency is 'soberness' and caution rather than depression.

The analysis of scores reveals that the group of disabled women has more low scorers than high scorers. The disability of an individual might diminish the feeling of outwardness. Future does not look bright to them. Their experiences in the world do not offer them a positive feeling.

This personality factor denotes some relationship with the factor A, which also indicates the cautious behaviour of disabled women. Women with disabilities, besides being faced with discriminations because of their

disabilities, are also caught up in the pervasive climate of being women. This double handicap provides a climate of segregation that in turn deprives them of an optimistic atmosphere. This imbues a feeling of sobriety and caution in disabled women.

Factor G: Weaker Super Ego Strength Vs Stronger Super Ego Strength

The scores of disabled women on Factor G reveal that they cannot be considered as low scorers or high scorers. But a closer look at the sten scores reveal that 40.6% of disabled women are strongly deviant with a sten of 7 towards high score and the percentage of high scorers is a little higher than low scorers. Therefore it can be assumed that they tend to show the characteristics of high scorers than that of low scorers.

A person scoring high on factor G is characterized by his/her super ego strength. They are persuing, determined, responsible, emotionally disciplined, consistently ordered, conscientious, dominated by sense of duty, and concerned about moral standards and rules. Many features of psychoanalytic concept of super ego strength seem to be embodied in this factor especially the features like dependency on social approval and conformity to the social group. Women with physical disabilities who are discriminated, would naturally like to be as the majority. They might not like to be considered as the other" . This is supported by Barron's (1997) view that along with a passive identification with the group of disabled,

they strive toward being seen as something other than disabled.

Factor H: Threctia Vs Parmia

Factor H is a strongly defined factor that appears with persistence even in rough factorings of ratings. The person who scores low on H (H-) reports himself to be intensely shy, tormented by an unreasonable sense of inferiority, slow and impeded in expressing himself, disliking occupations with personal contacts, preferring one or two close friends to large groups and not able to keep in contact with all that is going around him, while the H+ individual is adventurous, thick-skinned and socially bold.

The disabled group for the study consists of more (nearly 1/4th) low scorers than high scorers. This indicates that many of the disabled women feel shy, timid, restrained and threat sensitive.

Social environment, from immediate family to social institutions, plays major role in the personality formation. Disability creates a different situation that does have an impact. Women with disabilities, with lesser opportunities in this regard, as commented by Lonsdale (1990) are invisible in a host of different ways. They appear less, especially in public, are often ignored and devalued. They are psychologically out of the sight of common man as well as of policy makers and social scientists. This denial of opportunities disposes them of situations influencing positive characteristics of personality. Thus the hidden disabled women is compelled to become

shy, withdrawn, retiring in face of the opposite sex, apt to be embittered, restrained, rule bound, restricted interacts, careful, considerate, and quick to see dangers. Emotional caution spotted in this factor has also been reflected in some of the earlier factors.

Factor I: Harria Vs Premsia

The values in the table indicate that number of low scorers in the group is almost nil. Though the high scorers do not form a majority, the tendency is evident. Distribution of sten scores also reveals that 34.5% disabled women are deviant towards high scores.

A low scorer on factor I (I-) represents some sort of tough, masculine, practical, mature, group-solidarity generating and realistic temperamental dimension. While a high scorer on factor I (I+) is tenderminded, sensitive, dependent and overprotected. They express fidgety and expect affection and attention. They are clinging, insecure and they seek help and sympathy.

This inferred nature of disabled women may be attributed to two reasons: one in the physical inadequacy itself and the other in the upbringing. Disabled child in Indian families, especially in earlier joint families were overprotected. Neglected cases, depending on the situation at home were also rarely seen. In either case, the disabled child is never brought up to be an independent, self-reliant productive individual. Feelings of dependence are injected into him/her. He/she will never be considered

complete. His/her defects are magnified and protected making him/her more and more dependent, sensitive and insecure. Secondly the stereotyped feminine role in Indian societies more or less fits into the I+ characteristics.

According to Bhatt (1963) the attitude of society towards physically disabled has always been conflicting. The consequence of this ambiguity is that the disabled person feels insecure about his reception by others.

Factor L: Alaxia Vs Protension

The term protension, signifying 'projection and inner tension'- the essential of the pattern- is used to describe this factor.

The person with a low score on factor L (L-) is one of easy going, friendly, and relaxed. They express a lack of ambition and striving and L+ individual is suspecting, jealous, irritable and dwelling upon frustration.

The values in Table 4.1 on factor L indicate almost same percentage of low scorers and high scorers. So the disabled women are neither trusting nor suspecting. They are only cautious which could be seen as a positive quality that makes shaping of a healthy pattern possible by providing adequate environment.

Factor M :Praxernia vs Autia

Persons with low score on this factor M(M-) is practical and has down to earth concerns, while M+ persons are imaginative, bohemian and absent

minded. The scores in the table show a clear inclination as almost half of the disabled women in the sample have scored low and only a negligible number of disabled women scored high.

So the scores confirm that the disabled women rarely become imaginative, bohemian and absent minded. They tend to be more conventional, alert to practical needs, concerned with immediate interests and issues, prosaic, guided by practical realities, dependable in practical judgement, earnest and concerned or worried but steady.

Disabled women, who realize their difference or are being reminded constantly by others of their difference, from childhood onwards, cannot but be realistic and practical. They, who are being labelled by others as inferior, cannot but be down to earth which is also reflected in the data of this study.

As Sen (1988) reported a handicapped child encounters many problems. For eg: he/she may sense that people find him/her different, and he/she may realize that others find him/her unattractive. As Fine and Asch (1988) pointed out, the accounts of the lives of disabled women and men revealed that boys are often encouraged to meet the world, whereas girls are more often kept away from it. The disabled woman, who is made to feel ostracized cannot hide from the bare realities and avoids anything far-fetched. Future does not look bright for her, so they tries to be satisfied with immediate interests and issues. These views justify the responses of the

sample studied here.

Factor N: Artlessness Vs Shrewdness

A low score on factor N indicates that the person will be forthright and unpretentious. They are genuine, but socially clumsy. They have vague and injudicious mind. They get warmly emotionally involved and are gregarious, spontaneous and natural. They have simple tastes and lack self-insight. They are unskilled in analysing motives and are content with what comes, and have blind trust in human nature. A N+ person is shrewd, astute and worldly.

The group of disabled women studied consists more of low scorers than of high scorers. Personal observation and theoretical understanding reveal that every feature of N- could not be attributed to disabled women and may be that is the reason for not having a high percentage of low scorers. Still they show certain features of low N.

Factor N can more or less be considered a socially acquired pattern, stimulated by the environment. The upbringing and uncongenial social surroundings influence the social behaviour of the disabled, making them socially clumsy or active. As Sen (1988) pointed out the limited competence in the handicapped gives rise to feelings of inadequacy and frustration, thereby he is liable to develop inappropriate social behaviour.

Social interaction plays a major role in formulating behaviour

appropriate for strengthening social contact as well as for establishing one's place in the society and competence. But disabled woman who is often not allowed or if allowed, not entertained to be involved in social interactions, are thus deprived of nurturing opportunities.

Factor O: Untroubled Adequacy Vs Guilt Proneness

The data in Table 4.1 shows a dominance of O+ over O- though percentages for both are not too high. The O+ persons tend to be depressed, moody, worried, and are full of foreboding and brooding. He/she has childlike tendency to anxiety in difficulties. He /she does not feel acceptance or feel freedom to participate in groups. He/she is unstable, reports over fatigue from situations, feels inadequate to meet the rough daily demands of life, and is easily down hearted and remorseful. There are indications that a 'broken-down state' occurs sporadically with this pattern as a reaction to situations of repeated failure, transgression and inadequacy.

These characteristic features attributed to disabled through scoring high on O, is confirmed when we reflect on the living contexts of disabled women. And also some related features are already identified in them by scoring low on factor H. These findings are supported by Bhatt's (1963) argument. A physically disabled person cannot satisfy many of his emotional needs under normal circumstances. He/she therefore feels frustrated and inferior. Apart from many things a physically disabled person

has to fight yet another battle on the psychological front against insecurity. Disablement brings about a sort of uncertainty into many areas of his/her life. The three areas in which he/she encounters insecurity are physical, emotional and social.

Factor Q₁: Conservatism of Temperament Vs Radicalism

The percentages in Table 4.1 reveal that neither low scorers nor high scorers form a majority among disabled with the number of low scorers a few more than high scorers.

The person who scores low on Factor Q₁ is confident in what he has been taught to believe and accepts the 'tried and true' despite inconsistencies, when something else might be better. He is cautious and compromising in regard to new ideas. The person who scores high on Q₁ tends to be interested in intellectual matters and has doubts on fundamental issues. Although low score descriptions of Factor Q₁ fit well into the context of disability theoretically the data does not support this. The environment and normal social situations make the disabled woman feel uncomfortable and resistant to the system. She may be compelled to respect established ideas or be tolerant of traditional difficulties, especially because of other social and physical compulsions under which they cannot afford to be radical. Therefore they prefer to be average scorers.

Factor Q₂: Group Dependency Vs Self-Sufficiency

The results reveal that disabled women tend to be more group dependent. A person, who scores low on Factor Q₂, prefers to work and make decisions with other people, likes and depends on social approval and admiration. She/he tends to go along with the group and may be lacking in individual resolution.

As Coleman (1997) stated, many stigmatised people are not encouraged to develop or grow, to have aspirations or to be successful. Inclusion of disabled, especially women with disabilities in activities which maximise the potentials is rarely present in our society. Social exclusion experiences are apparent in their lives. Still they like and depend on social approval. They hate isolation and tend to go along with the group, since as per Maslow's Need-hierarchy theory, sense of belongingness is an innate need of every human being. Another probable reason may be that since they are physically dependent to some extent they fail to develop adequate independence and hence tend to develop a dependency on others especially when they are women. This accounts for the greater number of low scorers in the table.

Factor Q₃: Low Self-Sentiment Integration Vs High Strength of Self-Sentiment

Factor Q₃ represents the strength of the individual's concern about his self-concept and self-image. Q₃+ persons show socially approved character

responses, self-control, persistence, foresight, considerateness of others, conscientiousness and regard for etiquette and social reputation while Q₃- person will not be bothered with will control and regard for social demands. He is not overly considerate, careful or painstaking. He may feel maladjusted. The scores in the table indicate that there are more low scorers than high scorers in the disabled group.

In the development of personality body image plays a very important role, for it determines, to a great extent, an individual's idea of his own self and the ideas of others about his own self. Sprague and Hayes (2000) argued that social psychologists describe self as the human ability to think about, that is be aware of ourselves, to look at ourselves from the perspective of others, to know the kind of person we would like to be. A self is socially constructed. All of us infer and revise a sense of who we are and who we can and should be through our daily lives, particularly social interaction. So the woman with disability who is deprived of this social interaction develops a self described in Q₃-, probably with a lower sense of social responsibility and views herself as recipient only.

Factor Q₄. Low Ergic Tension Vs High Ergic Tension

The percentages reveal that almost one third of the disabled subjects are low scorers on this factor. This shows the tendency to be sedate, relaxed, composed and satisfied (not frustrated). In some situations, this over

satisfaction can lead to laziness and low performance in the sense that low motivation produces little effort on part of the self. The person who scores high on factor Q_4 tends to be tense, excitable, restless, fretful and impatient. He is often fatigued, but unable to remain inactive. His frustration represents an excess of stimulated, but undischarged drive. However, it also shows that majority of the subjects fall within the average and remains adequately reactive.

Thus an overall evaluation of the results in Table 4.1 suggests that physically disabled women tend to develop a personality characterised by low intelligence, lower ego strength, submissiveness, desurgency, practical, artlessness and group dependency.

Comparisons of subgroups on Personality

In this subsection, comparisons of personality pattern of women in the different subgroups of the sample are described mainly under four categories.

1. Personality of women with physical disabilities with that of non-disabled women.
2. Personality of women with orthopaedic disabilities with that of non-disabled women.
3. Personality of women with visual disabilities with that of non-disabled women.

4. Personality of women with orthopaedic disabilities with that of women with visual disabilities.

According to Moskowitz (2000) the important goal of personality research is to identify the ways to describe characteristic patterns. There are many influencing factors- temporary or permanent in the growth of these characteristic features. The present study that investigated the influence of disability on personality is based on two assumptions.

- a) The influence of physical aspects of disability on personality.
- b) The influence of social environment of disability on personality.

The experimental group of the study that consisted of women with disabilities has certain physical limitations due to their disabilities. The social environment magnifies these limitations. New approaches and theories support this social model of disability. Wendell (1996) said that disability is socially constructed through the failure or unwillingness to create ability among people who do not fit the physical or mental profile of 'paradigm' citizens. As Gleeson opined, the incapacity to function to a large extent is related to a disability hostile environment in which barriers clash against personal choice (c.f. Depoy, Gilson and Cramer, 2003).

The influencing factors of the social environment can be counted from parents, immediate family members, style of parenting, nature of

upbringing, schooling, peer group pattern and interactions and community services to social institutions. These factors being different for disabled and nondisabled do show their impact on their personalities along with gender related features.

When a non-disabled is provided with all the activities and opportunities for maximum development, disabled women are deprived of many of these opportunities. And whatever negligible opportunity provided is for temporary maintenance or survival. Future oriented activities are very meagre which develop doubts and worries about future. Moreover, reactions of others keep on reminding and reinforcing their sense of inadequacy or incompleteness.

In the so far discussed context of disability, the personality of disabled women was analysed and compared with that of non-disabled women. For this purpose, the scores on 16 PF were analysed computing one way ANOVA and intergroup differences were further clarified through Means and Standard Deviations. The results are presented in the tables 4.2 to 4.11.

Table 4.2 gives the factorwise 'F' values computed between scores of experimental (women with physical disabilities) group and control (non-disabled women) group.

Table 4.2

Factorwise 'F' Values of the Disabled Women and Non-Disabled Women

Sl No.	Personality Factors	Source	DF	SS	MSS	F
1	A	Between Group	1	2.137619	2.137619	0.6300687
		Within Group	208	705.6767	3.392676	
		Total	209	707.8143		
2	B	Between Group	1	4.480476	4.480476	2.4072196
		Within Group	208	387.1433	1.861266	
		Total	209	391.6238		
3	C	Between Group	1	0.321905	0.321905	0.070074
		Within Group	208	955.5066	4.593782	
		Total	209	955.8285		
4	E	Between Group	1	9.737619	9.737619	2.8127904
		Within Group	208	720.0767	3.461907	
		Total	209	729.8143		
5	F	Between Group	1	36.01191	36.01191	6.6940017**
		Within Group	208	1118.983	5.379727	
		Total	209	1154.995		
6	G	Between Group	1	6.407619	6.407619	2.9592888
		Within Group	208	450.3734	2.165257	
		Total	209	456.781		
7	H	Between Group	1	0.84	0.84	0.2011219
		Within Group	208	868.7266	4.17657	
		Total	209	869.5666		
8	I	Between Group	1	0.761905	0.761905	0.3881683
		Within Group	208	408.2667	1.962821	
		Total	209	409.0286		
9	L	Between Group	1	1.051905	1.051905	0.2760916
		Within Group	208	792.4767	3.809984	
		Total	209	793.5286		
10	M	Between Group	1	19.04762	19.04762	5.9826417*
		Within Group	208	662.2333	3.183814	
		Total	209	681.2809		

Continued...

(Table 4.2 continued...)

Sl No.	Personality Factors	Source	DF	SS	MSS	F
11	N	Between Group	1	0.004286	0.004286	0.001006
		Within Group	208	886.11	4.260144	
		Total	209	886.1143		
12	O	Between Group	1	4.207619	4.207619	1.1610715
		Within Group	208	753.7733	3.62391	
		Total	209	757.9809		
13	Q1	Between Group	1	0.617143	0.617143	0.3203217
		Within Group	208	400.74	1.926635	
		Total	209	401.3572		
14	Q2	Between Group	1	21.40191	21.40191	6.9917431**
		Within Group	208	636.6933	3.061026	
		Total	209	658.0952		
15	Q3	Between Group	1	4.480476	4.480476	1.2401987
		Within Group	208	751.4433	3.612708	
		Total	209	755.9238		
16	Q4	Between Group	1	2.750476	2.750476	0.6322421
		Within Group	208	904.8734	4.350353	
		Total	209	907.6239		

**p < .01 * p < 0.05

The F values in table 4.2 indicate that there is significant difference between the personality of the disabled women and the non-disabled women with respect to only three factors- F, M and Q₂.

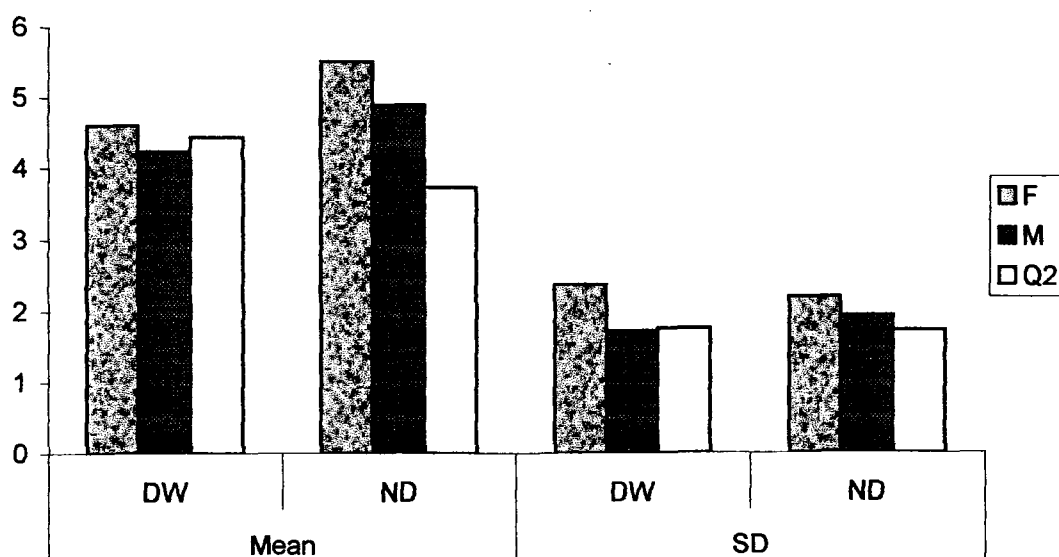
In order to specify the nature of difference on these variables - F, M and Q₂, the Means and Standard Deviations are given in Table 4.3.

Table 4.3
Means and Standard Deviations
of factors F, M & Q₂ of Disabled women and Non disabled women

Sl. No	Factors	Mean		SD	
		DW	ND	DW	ND
1	F	4.6	5.5166	2.3658	2.1977
2	M	4.233	4.9	1.72006	1.937
3	Q ₂	4.44	3.733	1.75889	1.72584

The significant values in Table 4.3 also indicate that the mean scores of disabled women on factors F and M are less than that of non-disabled women while the mean scores of disabled women on factor Q₂ is higher than that of non-disabled women. A graphical representation of the significant difference between the personality of the disabled women and non-disabled women is given in figure 4.1.

Figure 4.1: Means and Standard Deviations of factors F, M & Q₂ of Disabled women and Non disabled women



The implications of these results are to be looked into separately for each factor.

Factor F

Factor F attributes easier, optimism creating environment for high scorers and sober, cautious, pessimistic nature for low scorers. The mean values in Table 4.3 indicate that the disabled group has more low scorers, while majority of non-disabled women show a tendency towards average score. So while the disabled group shows more cautious and sober behaviours, the non-disabled do not feel the need to be cautious and sober. But at the same time disabled also do not exhibit optimism in all their dealings. Disabled women, who are entertained more with discouragement than encouragement, could not feel like painting their future dreams colourful. Even the present does not offer safety and security. Probably the past remind them to be cautious in every step. Thus caution, inhibition and failure feelings get manifested in their interactions as confirmed by the result of the present study indicated in the table 4.3. Lower mean score on F for disabled than non disabled in this study is also supported by the findings of Jyothi and Reddy (2000).

Factor M

As revealed by Table 4.3, the mean score of women with disabilities is lower than the mean score of non-disabled group. A closer look at the

percentages in Table 4.1 exposes that 42% of the disabled women are considered as low scorers, which confirms the attribution of characteristics of M- to women with disabilities.

M- characteristics include practical and down to earth concerns, while a high scorer on M is imaginative and unconventional. The mean score (4.9) as mentioned in Table 4.3 for the non-disabled suggests that they show a tendency towards average score. So it can be considered that majority of non-disabled women express neither praxernia nor autio, reflecting their objective attitude to life. The group of women with disabilities show a tendency towards low score as evinced in Table 4.3. So conventional and practical attitudes can be designated to them. They have down to earth concerns and are pertained with immediate interests and issues and avoid anything far-fetched.

In the present sample the physically disabled lives along with non-disabled in the same family as well as in the same society. The difference in appearance and the limitations in function label them as 'other'. This otherness is projected to them, by themselves and by others in everyday life. Adequate opportunities or training are not given to them to overcome the inferior feelings precipitated due to this diversity. The disabled here, being a woman has to face more stereotyped gender attitudes, in addition to negative attitudes to disability. As Wendell (1996) pointed out, most non-

disabled people cannot wrap their minds around the possibility that some can be disabled or ill and can also work productively, have intimate relationships or be happy. These situations and attitudes make them acquire the characteristics of low scorers on M. The non-disabled is not restricted in hopes and dreams by the limitations and stereotyped messages. So they can afford to be imaginative and fanciful.

Factor Q₂

Opposite to the trends shown in the case of factors F and M, women with disabilities have higher mean score (4.43) than the mean score of non-disabled women (3.73) as testified in Table 4.3. The percentages on factor Q₂ in Table 4.1 reveal that 33.3% of the disabled women are low scorers with only 2% high scorers. So it is very clear that majority of disabled are average scorers. This is testified by the mean score in Table 4.3 which shows a tendency towards average score. So while the non-disabled women clearly show the characteristics of low scorers, women with disabilities cannot be attributed neither with characteristics of low scorers or high scorers. A high score on factor Q₂ denotes self-sufficiency, the mean scores reveal that neither disabled nor non-disabled can be characterised with the feature of self-sufficiency. The gender related restrictions and limitations of low economic class that are common to all subjects of the study (Table 3.5) can be ascribed as the two major reasons for this.

The non-disabled women, who resemble the majority like to be identified with other non-disabled women. Association with others like them, does not bring any stigmatisation or degradation to them. So, naturally, they like to go with the group, they definitely depend on social approval more and tend to be conventional and fashionable. But woman with disability, if identified with non-disabled, will be constantly reminded of her limitations. And even if woman with disability tries to be conventional and depends on others, stigmatisation and isolation proceed and would not be able to receive mutual appreciation and approval in support. At the same time she cannot be temperamentally independent and is not accustomed to going her own way. Ghai and Ittyerah's finding as cited by Sen (1988) that the handicapped are less independent supports the finding of the present study.

To further clarify the nature of difference between disabled and non disabled women with regard to personality each category of disabled was taken separately and compared with the non disabled. Table 4.4 shows the comparison of Orthopaedically disabled and non disabled.

Table 4.4
Factor Wise F values of
Orthopaedically Disabled and Non-Disabled Women

Sl No.	Personality Factors	Source	DF	SS	MSS	F
1	A	Between Group	1	3.432531	3.432531	1.082072
		Within Group	155	491.6885	3.172184	
		Total	156	495.121		
2	B	Between Group	1	4.174283	4.174283	2.4295533
		Within Group	155	266.3098	1.718128	
		Total	156	270.4841		
3	C	Between Group	1	0.070607	0.070607	0.0150553
		Within Group	155	726.923	4.689826	
		Total	156	726.9936		
4	E	Between Group	1	10.97674	10.97674	3.1899896
		Within Group	155	533.3545	3.440997	
		Total	156	544.3312		
5	F	Between Group	1	41.89263	41.89263	8.2087936**
		Within Group	155	791.0246	5.103384	
		Total	156	832.9172		
6	G	Between Group	1	4.412704	4.412704	1.9928132
		Within Group	155	343.2179	2.214309	
		Total	156	347.6306		
7	H	Between Group	1	0.482518	0.482518	0.1095034
		Within Group	155	682.9952	4.406421	
		Total	156	683.4777		
8	I	Between Group	1	1.953396	1.953396	1.0076432
		Within Group	155	300.4797	1.938579	
		Total	156	302.4331		
9	L	Between Group	1	1.163308	1.163308	0.3130105
		Within Group	155	576.0596	3.716514	
		Total	156	577.2229		
10	M	Between Group	1	21.74991	21.74991	6.9273248**
		Within Group	155	486.6577	3.139727	
		Total	156	508.4077		

Conitunued...

(Table 4.4 Continued...)						
Sl No.	Personality Factors	Source	DF	SS	MSS	F
11	N	Between Group	1	0.158865	0.158865	0.0334077
		Within Group	155	737.0768	4.755334	
		Total	156	737.2357		
12	O	Between Group	1	9.784074	9.784074	2.5048995
		Within Group	155	605.4261	3.905975	
		Total	156	615.2102		
13	Q1	Between Group	1	0.898326	0.898326	0.4454563
		Within Group	155	312.5794	2.016641	
		Total	156	313.4777		
14	Q2	Between Group	1	4.255898	4.255898	1.5549748
		Within Group	155	424.2282	2.736956	
		Total	156	428.4841		
15	Q3	Between Group	1	2.997598	2.997598	0.8342909
		Within Group	155	556.9132	3.592988	
		Total	156	559.9108		
16	Q4	Between Group	1	0.000109	0.000109	0.0000265
		Within Group	155	639.6941	4.127059	
		Total	156	639.6943		

** p < 0.01

The 'F' values in Table 4.4 indicate that personality of orthopaedically disabled women and non-disabled women significantly differ with respect to factors, F and M. These factor scores that denoted significant difference between the groups were further clarified through Means and Standard Deviations. The details are given in Table 4.5

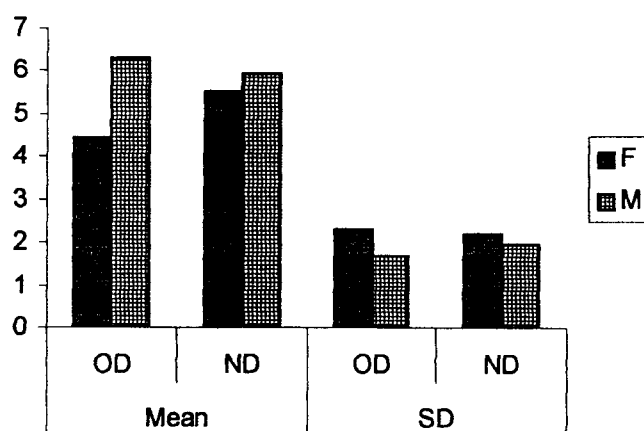
Table 4.5

**Means and Standard Deviations of factors
F and M of orthopaedically disabled women and non disabled women**

Sl. No	Factors	Mean		SD	
		OD	ND	OD	ND
1	F	4.45361	5.51667	2.29592	2.19778
2	M	6.27835	5.9333	1.66226	1.93715

A Graphical Representation of the above data is given in figure 4.2.

Figure 4.2: Means and Standard Deviations of factors F and M of orthopaedically disabled women and non disabled women



As indicated by values in Table 4.5 and in Figure 4.2, the mean scores of factors F and M show a significant difference between orthopaedically disabled and non-disabled with a higher score for non-disabled. Here it is also noted that disabled as a combined group differed from the non-disabled group in terms of the same factors (Table 4.2). So it is evinced that orthopaedically disabled represents the disabled group in terms of the factors F and M and it is also noted that orthopaedically disabled women do

not differ in terms of factor Q_2 , which is another significant factor that the disabled group in general differ from the non-disabled.

Physical disabilities are very obvious in orthopaedically disabled women, and that makes them constantly aware of their limitations. To add more, they are sensitive to the very subtle stigmatised expressions of the non-disabled population. This led them to be cautious and often sober. Their defects, in comparison with non-disabled, are magnified before them by themselves and others and diminish the future expectations and imbibe a pessimistic approach in them. Attribution of these characteristic features to orthopaedically disabled women is testified by their lower mean score 4.45 in Table 4.5.

The mean scores of factor, M in Table 4.5 also reveal that the mean score of orthopaedically disabled is lower than non-disabled and the mean score (4.9) of non disabled indicates a tendency towards average score.

Orthopaedically disabled, being isolated due to obvious physical differences could not but be practical and guided by objective realities. They are afraid to dream and be fanciful for fear of failure due to their limitations, which are magnified by the society. The attitude of others as well as being marginalized, enhance the severity of their functional limitations. And to add more, the attributed cautious behaviour indicated by factor F as given in Tables 4.1 and 4.5 compels them to give prime importance to the present situation and needs.

The second category of disabled group- visually disabled group included in the sample is also compared with non-disabled group in terms of 16 factors of personality and is given in Table 4.6

Table 4.6

Factor Wise 'F' Values of Visually Disabled and Non-Disabled Women

Sl No.	Personality Factors	Source	DF	SS	MSS	F
1	A	Between Group	1	0.158961	0.158961	0.0512372
		Within Group	111	344.372	3.102451	
		Total	112	344.531		
2	B	Between Group	1	2.548698	2.548698	1.2951028
		Within Group	111	218.4424	1.96795	
		Total	112	220.9911		
3	C	Between Group	1	0.769956	0.769956	0.191622
		Within Group	111	446.0088	4.018097	
		Total	112	446.7788		
4	E	Between Group	1	3.50957	3.50957	0.977682
		Within Group	111	398.455	3.589685	
		Total	112	401.9646		
5	F	Between Group	1	11.84385	11.84385	2.1656342
		Within Group	111	607.0588	5.468998	
		Total	112	618.9027		
6	G	Between Group	1	6.029899	6.029899	2.9303062
		Within Group	111	228.4126	2.057771	
		Total	112	234.4425		
7	H	Between Group	1	0.988523	0.988523	0.2491055
		Within Group	111	440.4805	3.968293	
		Total	112	441.469		
8	I	Between Group	1	0.051472	0.051472	0.0271836
		Within Group	111	210.1786	1.893501	
		Total	112	210.2301		
9	L	Between Group	1	0.399736	0.399736	0.1055225
		Within Group	111	420.4852	3.788155	
		Total	112	420.8849		

Continued...

(Table 4.6. Continued...)						
Sl No.	Personality Factors	Source	DF	SS	MSS	F
10	M	Between Group	1	6.617031	6.617031	1.8629222
		Within Group	111	394.2679	3.551963	
		Total	112	400.885		
11	N	Between Group	1	0.235657	0.235657	0.0658826
		Within Group	111	397.0387	3.576925	
		Total	112	397.2743		
12	O	Between Group	1	0.080425	0.080425	0.0256784
		Within Group	111	347.6541	3.132019	
		Total	112	347.7345		
13	Q1	Between Group	1	0.084254	0.084254	0.0496374
		Within Group	111	188.4113	1.697399	
		Total	112	188.4956		
14	Q2	Between Group	1	53.58308	53.58308	16.942467**
		Within Group	111	351.0541	3.162649	
		Total	112	404.6372		
15	Q3	Between Group	1	4.383105	4.383105	1.178892
		Within Group	111	412.6965	3.717987	
		Total	112	417.0796		
16	Q4	Between Group	1	14.5937	14.5937	3.2291188
		Within Group	111	501.6541	4.519406	
		Total	112	516.2478		

** p<0.01

The F values in the table indicate that there is significant difference in the mean scores of factor Q₂ between the visually disabled women and non-disabled women. Means and Standard Deviations of the respective groups are given in Table 4.7 to clarify the nature of difference.

Table 4.7
Means and Standard Deviations of factor
Q₂ of visually disabled women and non disabled women

Sl. No	Factors	Mean		SD	
		VD	ND	VD	ND
1	Q ₂	5.11321	3.7333	1.83618	1.72584

As indicated by Table 4.6, factor Q₂ has a distinctive influence on visually disabled. Factor Q₂ is testified also in Table 4.2 as a distinctive personality factor in the difference between disabled and non-disabled women but is not supported by values in Table 4.4. So it can be concluded that mostly visually disabled women have contributed to the combined disabled group to attain a significant difference on factor Q₂ in comparison to non-disabled women's group.

It is also noted that the factors F and M which are indicated significantly different in comparisons between combined disabled group and non-disabled group and between orthopaedically disabled women and non-disabled women have not emerged in the comparison between visually disabled women and non disabled women. So it can be inferred that visually disabled women express almost the same characteristics as non-disabled women with regard to factors F and M.

Non-disabled women express high group dependency with a low mean score (3.7) as indicated in Table 4.7. But visually disabled women share neither a high group dependency nor an independence from the group

with a mean score of 5.13, which is an average score.

Vision is a sensory modality, which contributes to almost all functions and interactions. Deprivation of this sensory modality duly shows its impact on the interaction of visually disabled. They being deprived of understanding the facial expressions and body language of others build up a self-imposed restriction in their minds and this inhibits them from becoming a joiner or a sound follower.

Since the mean score of visually disabled falls within the average score, it is very clear that they fail in attaining self-sufficiency attributed to high scorers. Though the visually disabled woman with training can overcome her disability, the attitude of society is often the reverse. Our society still cannot relate self-reliance and disability. This distrust and disbelief unconsciously blur the faith of visually disabled in themselves, making them less self-sufficient as testified by the mean score in the present study. Griff (cited by Sen, 1988) also found that the blind are less self-sufficient.

The results in the tables 4.4 and 4.6 suggest that each category of disabled differs with the non disabled on different personality factors. For verification of this trend it was also tried to find out whether the orthopaedically disabled and visually disabled differ on personality factors when compared separately. Table 4.8 gives 'F' values computed between factorwise mean scores of orthopaedically disabled women and visually

disabled women.

Table 4.8
Factor wise 'F' Values of
Orthopaedically Disabled and Visually Disabled Women

Sl No.	Personality Factors	Source	DF	SS	MSS	F
1	A	Between Group	1	1.799499	1.799499	0.4658541
		Within Group	148	571.6938	3.862796	
		Total	149	573.4933		
2	B	Between Group	1	0.041087	0.041087	0.0210081
		Within Group	148	289.4523	1.955758	
		Total	149	289.4933		
3	C	Between Group	1	0.508171	0.508171	0.1020389
		Within Group	148	737.0652	4.98017	
		Total	149	737.5734		
4	E	Between Group	1	1.250501	1.250501	0.3658729
		Within Group	148	505.8428	3.417857	
		Total	149	507.0933		
5	F	Between Group	1	5.883291	5.883291	1.0514545
		Within Group	148	828.1167	5.595383	
		Total	149	834		
6	G	Between Group	1	0.476219	0.476219	0.2147719
		Within Group	148	328.1638	2.217323	
		Total	149	328.64		
7	H	Between Group	1	0.184308	0.184308	0.0444543
		Within Group	148	613.609	4.146007	
		Total	149	613.7934		
8	I	Between Group	1	2.541659	2.541659	1.2505847
		Within Group	148	300.7917	2.032376	
		Total	149	303.3333		
9	L	Between Group	1	0.115158	0.115158	0.0289765
		Within Group	148	588.1782	3.974177	
		Total	149	588.2933		

Continued...

(Table 4.8 Continued...)

SI No.	Personality Factors	Source	DF	SS	MSS	F
10	M	Between Group	1	2.707677	2.707677	0.9146604
		Within Group	148	438.1257	2.960309	
		Total	149	440.8333		
11	N	Between Group	1	0.844517	0.844517	0.1963944
		Within Group	148	636.4155	4.300105	
		Total	149	637.26		
12	O	Between Group	1	11.02646	11.02646	3.0651293
		Within Group	148	532.4135	3.597389	
		Total	149	543.44		
13	Q ₁	Between Group	1	0.349298	0.349298	0.1724406
		Within Group	148	299.7907	2.025613	
		Total	149	300.14		
14	Q ₂	Between Group	1	37.1444	37.1444	12.971139**
		Within Group	148	423.8156	2.863619	
		Total	149	460.96		
15	Q ₃	Between Group	1	0.416896	0.416896	0.1158819
		Within Group	148	532.4431	3.597589	
		Total	149	532.86		
16	Q ₄	Between Group	1	17.85842	17.85842	4.17753*
		Within Group	148	632.6816	4.274876	
		Total	149	650.54		

** P < 0.01; * P < 0.05

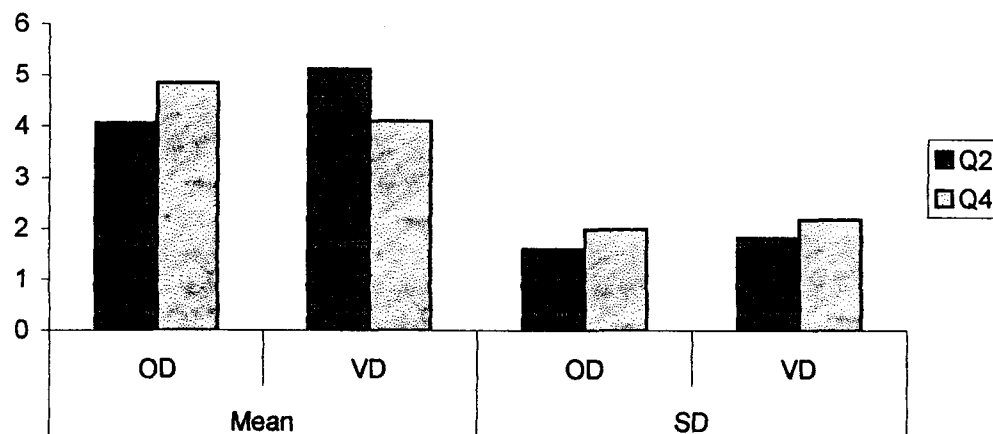
The 'F' values in the Table 4.8 clearly indicate that the orthopaedically disabled and visually disabled women significantly differ in the mean scores on factors Q₂ and Q₄. These significant factors were further clarified through Means and Standard Deviations. The details are given in Table 4.9.

Table 4.9
Means and Standard Deviations of Factors Q₂ and Q₄
of Orthopaedically disabled women and visually disabled women.

Sl. No	Factors	Mean		SD	
		OD	VD	OD	VD
1	Q ₂	4.07217	5.11321	1.60888	1.83618
2	Q ₄	4.83505	4.113207	2.003541	2.180864

A graphical representation of the above data is presented as figure 4.3.

Figure 4.3: Means and Standard Deviations of Factors Q₂ and Q₄ of Orthopaedically disabled women and visually disabled women.



As indicated by the values in Table 4.8 and Figure 4.3, the significance of the two factors Q₂ and Q₄ in differentiating the orthopaedically disabled women from visually disabled women is strengthened. The mean scores in Table 4.9 reveals that while visually disabled women have a higher mean score than orthopaedically disabled women on factor Q₂, a reverse trend is seen in the case of factor Q₄. It is also revealed that while visually disabled

acquires an average score on factor Q₂, the score of orthopaedically disabled on factor Q₄ shows a similar tendency on factor Q₄.

The deviant score towards low score on factor Q₂ of orthopaedically disabled indicates that they express group dependency and the deviant score towards low score on factor Q₄ of visually disabled indicates that low ergic tension and unfrustrated feelings can be attributed to them.

Disabled women face oppression in one way or another. Depending on the category of disability, their functional limitations will be different and this difference will create some sort of difference in their experiences, which in turn imposes difference in certain features of personality. The results of the present study reveal that disabled women as a group show some difference from non-disabled and each disability exhibits some difference too.

The experiences of visually impaired and orthopaedically disabled are not always similar. Functional limitation and visibility of functional limitation are different in these two groups. The fact that the impairment of orthopaedically disabled is more visible to others and to themselves and at the same time they are comparable with the nondisabled in many other ways, they are unable to experience a total segregation from the main stream. But they tend to develop feelings of in competency and inadequacy in comparison to the nondisabled which make them less independent. On the other hand the visually disabled women experience and sense more functional limitation and segregation, since one of the major sensory modalities is impaired.

In the development of personality, body image plays an important role. It determines individual's ideas of his/her self and ideas of others about him/her. The consequence of undesired body image has a serious impact on the social life of an individual. In the case of orthopaedically disabled women, they are constantly made conscious of their difference in every social interaction as they are exposed to all kinds of information and other's reactions. So unconsciously they develop emotions, attitude and behaviour to deal with these. Thus though they do not show always group dependence, they wish to go with the group and depends on social approval more, as testified by the tendency for a low score on factor Q_2 . While, visually disabled have a clear perception of their disability which differentiates them from others and hence do not wish to be identified with the non-disabled group. As Sen (1988) stated, it is mainly through visual modality that human beings receive accurate and gestalt impressions of the environment. So visual impairment often leads to frenzied confusion. She is confused about her social background; she is confused about the people around her. So she is unable to join them with full faith. So she tries to be moderate in her approach with regard to group dependency and self-sufficiency. This can be the reason for visually disabled women in the present study acquiring a mean score (5.113) for Q_2 which is considered as an average score.

With reference to factor Q_4 , the visually disabled are deviant towards low score as per the mean score presented in Table 4.9. Factor Q_4 , which deals with ergic tension reveals that the visually disabled women have lower ergic tension compared to the orthopaedically disabled who have a mean score showing the tendency for an average score.

Interestingly when the combined disabled group was compared with non disabled no significant difference on this factor was yielded as shown by Table 4.3. An evaluation of the results in Tables 4.3, 4.8 and 4.9 suggests mainly two aspects.

- i) Disabled and nondisabled women score in the same range for ergic tension.
- ii) Among the disabled the visually challenged have relatively lower ergic tension than OD and ND.

So it can be concluded that low ergic tension is pertaining particularly to the visually disabled women. Two reasons can be attributed for this.

The visually disabled usually do not face the ridiculing attitude of the society as the orthopaedically handicapped. Primarily, they are not aware of others attitudes towards them, as they cannot see. Secondly, visually disabled is treated by society with more sympathy, while, even the media presents orthopaedical disability as something to laugh at. This may be accounted for the unfrustrated composed feeling of visually disabled women.

Another reason may be that increase in aspirations lead to more frustrations. The orthopaedically disabled are aware of the ample opportunities and competitions involved in these opportunities. Being a disabled woman the road to success is longer than usually expected. They have to put forward a strong fight to attain success. These enhance the frustration level of orthopaedically disabled. But, as the visually disabled women are often not much aware of the opportunities provided to sighted individuals their aspirations will be reduced and thereby meet with lower frustration.

It was also attempted to compare the disabled women and non disabled women on the four second order factors derived from the scores on the primary factors. Details are shown in Table 4.10.

Table 4.10
F Values of Disabled Women and Non
Disabled Women for Second Order Personality Factors

Sl. No	Factors	Disabled Vs Non disabled	Orthopaedically disabled Vs Non disabled	Visually disabled Vs Non disabled	Orthopaedically disabled Vs Visually disabled
1.	Q _I	1.122937	0.164484	3.064485	2.610461
2.	Q _{II}	1.86 E-05	0.377428	1.239338	2.582165
3.	Q _{III}	0.346963	0.072254	0.773432	0.597686
4.	Q _{IV}	0.004062	0.67607	2.049658	5.772028*

* P < .05

The second order factors may be viewed as broader influences or organizers contributed by primaries. The chief primaries involved in the factors are as follows.

Q_I - A+, E+, F+, H+ and Q₂

Q_{II} - C-, H-, L+, Q₃- and Q₄+

Q_{III} - A-, I-, M-, E+ and L+. (different patterns for men and women)

Q_{IV} - E+, L+, M+, Q₁ + and Q₂+

The scores in the Table 4.10 indicate that significant difference exists only between visually disabled and orthopaedically disabled and the factor, which induces this difference, is Q_{IV}. This factor was further clarified through Means and Standard Deviations and the details are given in Table 4.11.

Table 4.11
Means and Standard Deviations of Factor Q_{IV} of
Visually Disabled Women and Orthopaedically Disabled Women

Sl. No	Factors	Mean		SD	
		OD	VD	OD	VD
1	Q _{IV}	3.87732	4.30566	1.031837	1.065439

The mean scores in Table 4.11 indicate that mean score of orthopaedically disabled is lesser than the mean score of visually disabled women.

Factor Q_{IV} represents subduedness Vs independence. As revealed by both, the mean scores express subduedness and a closer look at the values reveals that the orthopaedically disabled exhibits more subduedness than the visually disabled.

The experimental group, which includes both orthopaedically disabled and visually disabled, being characterized with subduedness can be a reflection of gender factors. Submissiveness is often considered as an important aspect of femininity. The difference in mean scores between the visually disabled women and orthopaedically disabled women can be attributed to the fact that they differ in terms of the awareness of their limitations and the competencies and opportunities of the non-disabled women.

Orthopaedically disabled women, though more apparent in differences, are intact with regard to sensory modalities. They face and sense more stigmatised attitudes and have more difficulty in being isolated. So, they feel safe to be submissive. The social attitudes take away the spirit to fight. But the visually disabled, though different from non-disabled, being ignorant of the competencies and opportunities of non-disabled women and the awareness of being visually

disabled are motivated to compensate for the disability and thus tend to be less submissive. The higher mean score of the visually disabled than that of orthopaedically disabled indicated in table 4.11 confirms this.

MANOVA was used to estimate the influence of area of residence, marital status, economic status, employment status, religion, education and financial assistance on personality factors. The results reveal that none of these factors influence the features of personality (The details of MANOVA are given as Appendix-I).

HYPOTHESIS II

With reference to the second hypothesis to test whether there exists any difference in stress-tolerance between women with physical disabilities as compared to the non-disabled women and also between the visually disabled and orthopaedically disabled women the mean scores of each group was computed after estimating the overall-stress score of each subject on Life Change Events Inventory. The differences in mean values were tested for significance by using ANOVA. Intergroup differences were further clarified through Means and Standard Deviations. ANOVA was used to estimate the influence of area of residence, employment, religion, education, financial assistance, economic status and marital status on stress. Means and Standard Deviations and Scheffe's test were used to further

clarify the status of influencing socio-economic factors. The results are given in tables from 4.12 to 4.17.

Table 4.12 gives the mean values of overall stress score of each sub group included in the sample.

Table 4.12
Mean Stress Scores of the Sub Groups

Sl. No	Group	Mean Score
1.	Women with physical disabilities	230.8333
2.	Non-disabled women	220.5833
3.	Women with orthopaedic disabilities	225.825
4.	Women with visual disabilities	240.00

The mean scores in the Table 4.12 reveal that the mean score of women with physical disabilities is higher than the mean score of non-disabled women. When each sub group in the experimental group is considered, the mean score of visually disabled women is higher than that of orthopaedically disabled women. A close examination reveals that both the disabled and non-disabled women could not score a very low stress-score which in turn indicates a lower stress-tolerance of the whole sample. The gender related factors can be accounted for this, since both experimental and control group included only female subjects.

The difference in mean values is tested for significance through ANOVA and results are given in Table 4.13.

Table 4.13
ANOVA of Stress Scores across the Sub Groups

SI No.		Source	DF	SS	MSS	F
1	Women with physical disabilities and Non-disabled Women	Between Group	1	4502.679	4502.679	2.222356
		Within Group	208	421425.4	2026.084	
		Total	209	425928.1		
2	Orthopaedically disabled women and Non-disabled women	Between Group	1	1018.402	1018.402	0.50072
		Within Group	155	315250.6	2033.875	
		Total	156	316269		
3	Visually disabled women and Non-disabled women	Between Group	1	10609.58	10609.58	5.675687*
		Within Group	111	207492.6	1869.303	
		Total	112	218102.2		
4	Orthopaedically disabled women and Visually disabled women	Between Group	1	6886.813	6886.813	3.327245
		Within Group	148	306334	2069.824	
		Total	149	313220.8		

* P < 0.05

The F values in the table indicate that although there is a significant difference between visually disabled women and non-disabled women in terms of stress, no significant difference is found between orthopaedically disabled women and non-disabled women, between combined group of disabled women and non-disabled and between orthopaedically disabled women and visually disabled women. But it is interesting to find that as in personality characteristics there is similarity between orthopaedically disabled and the non-disabled in stress scores also and the visually disabled women differ significantly from the non disabled.

Stress is part of every day life. Lack of accessibility, lack of support system, functional limitations etc add to the list of demands which might

increase the stress level of a physically disabled person. A close examination of reactions to the changes in environment-physical and emotional-pertaining to an ordinary person is essential to understand the stress-tolerance of the individual. And here the disabled being a woman, the gender related events also have to be considered to estimate the stress-tolerance. It was popularly believed that stress contributes more to problems of women with physical disabilities than to non-disabled women. The present investigation does not confirm this by a significant mean difference though the disabled women have a higher mean stress score, indicating only a tendency for less stress tolerance.

Many reasons can be attributed for the non-significant difference. Though the disabled definitely have more hassles in daily life than the non-disabled, they acquire competency to deal with them as if it is inevitable. Experiences might help them to win over their difficulties of routine life and many such things which are considered by others as difficult for the disabled are not really difficult for them. Thus, inspite of their impairment they acquire alternate ways to adapt to situations. Therefore, the disability, probably, does not make much difference in the amount of day to day stress they have to cope with.

A disabled woman with experience, knows when there is injustice, denial of protection and opportunities. Stated otherwise the disabled woman

knows when she is not being treated as others are treated and when the treatment is not fair. Thus her experiences in life make her capable of understanding the situation properly and anticipating the stressful situations promptly. As Coleman, Morris and Glaros (1974) opined, familiar situations and predictability reduce the severity of stress.

A woman has to play different roles in her life. Each role has its own hopes, stresses and strains. Physical disability does not reduce her right to perform these roles, though the social environment does not provide this. All experiences of disabled have confirmed the society's inhibition to offer different roles to the disabled individual, especially to a woman with physical disability. But interestingly the results of this investigation reveal that a disabled woman does not turn apathetic towards the roles of a woman, though she is deprived of these by the non-disabled population. So her reactions to the incidents related to these roles are the same as those of an ordinary woman. And this might be one of the major reasons for not having a significant difference between the mean scores of disabled women and non-disabled women.

King and Gomes (2000) stated that globally women face life stressors of parenting, marriage, divorce infertility, sexual abuse, pregnancy, violence, caring for the elderly, loss of loved ones etc. Reactions to these incidents will be stressful to disabled women as well as to non-disabled women. The

reactions of disabled men might differ in these matters, while support from society too can be anticipated by men both disabled as well as non-disabled.

Though women, both disabled and non-disabled express a similarity in the experience of stress, and thus denoting that the women with physical disabilities in this study feel and sense like non-disabled women, social and psychological implications of disability cannot be totally overruled. This is implied by the slight difference in the mean scores indicated in Table 4.12. Women with physical disabilities encounter physical, attitudinal and policy barriers in attempts to meet their needs, as well as goals. Carson and Butcher (1992) report that when a person's strivings are thwarted either by obstacles that block progress toward desired goal or by the absence of an appropriate goal, frustration occurs. According to Munn, Fernald and Fernald (1972) both external and internal barriers produce frustrations. In the context of disability, negative social attitudes, and limited opportunities form the external barriers and psychological reactions to these external barriers thwarting one's aspirations and meaning of life turn as internal barriers. These frustrations even though fail to be present as permanent emotions or personality features of a disabled woman as per the personality analysis, it is possible that they can infuse some amount of stress in a disabled woman. Lack of facilities for relaxation also can cause low stress-tolerance.

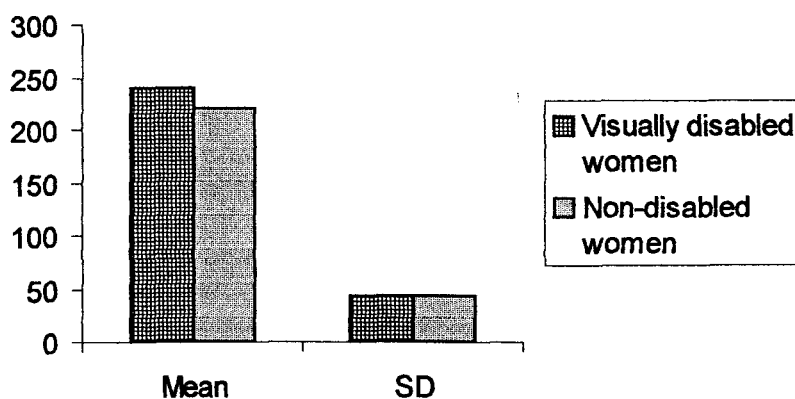
The significant difference between visually disabled women and non-disabled women as testified in the table 4.13 was further clarified through Means and Standard Deviations. The details are given in Table 4.14.

Table 4.14
Means and Standard Deviations
of Stress of Visually Disabled and Non Disabled Women

Sl. No	Group	Mean	SD
1.	Visually disabled women	240	43.69651
2.	Non-disabled women	220.5833	42.82495

A graphical representation of above data is presented in Figure 4.4

Figure 4.4: Means and Standard Deviations of Stress of Visually Disabled and Non Disabled Women



When each category of disabled women was compared with non-disabled separately, the visually disabled have a significantly higher mean score than that of the non-disabled women as confirmed in Table 4.14. This result confirms Karlon's statement that a number of researches in recent years observed positive relationship between visual impairment and psychological distress like depression, tension, loneliness and nervousness.

Blindness deprives the person of visual information which results in lowering the quality of awareness and confidence along with minimization of mobility in physical environments. The whole picture of the world is blurred to the visually disabled. This might turn to be an added demand to adjust with increase in stress.

It is often mentioned that the social connectedness reduces stress. If you have to be constantly alert to understand what people around you are discussing there is no chance for relaxation. And this is very relevant with reference to the visually disabled women. These sensory impaired women have to take extra strains to receive communications promptly. In the absence of eye contact, visually disabled use their tactual senses. This handiness has been accepted as a very important and accurate mode of communication. But the visually disabled individual, being a woman, experimentation of this technique is not socially accepted (Yaduvansh, 2004).

Lack of significant difference between orthopaedically disabled and non-disabled women as revealed in Table 4.13 is another dimension of the above view. Absence of sensory impairment in orthopaedically disabled imbibes almost the same pattern of stress experiences as that of non-disabled women.

The results of ANOVA estimating the influence of social factors like area of residence, education, employment, economic status, religion, marital

status and financial assistance on the experience of stress revealed that employment, religion and financial assistance influence the experience of stress. (Details of ANOVA are given as Appendix II). The influence of employment on stress experiences are further clarified through Means and Standard Deviations. Table 4.15 gives the values of Means and Standard Deviations of Employed and Unemployed disabled subjects.

Table 4.15
Means and Standard Deviations
of Stress of Employed and Unemployed Subjects

Sl. No	Group	Mean	SD
1	Employed	210.8944	50.41035
2	Unemployed	231.3802	45.6574

The values in Table 4.15 reveal that employment brought in a significant difference in stress tolerance of the disabled women. The mean values reveal that the stress score of unemployed disabled women is higher than that of employed disabled women. The findings of the study conducted by Rea *et. al* (1999) which indicated unemployment is associated with feelings of loneliness, pessimism, morbid and gloomy thoughts and self-pity support this result.

Disability brings about a sort of uncertainty and indefiniteness into many areas of disabled woman's life. Bhatt (1963) stated that areas in which the disabled individual encounters insecurity are physical, emotional and

social. Employment brings in differences in the subjective experience of a person. Financial independence provided through proper employment helps the individual to meet many of the physical needs. Better social acceptance is acquired through employment which induces self confidence in the disabled, who are otherwise imposed with inferiority feelings. Self reliance and self-esteem attained through economic independence develop healthy emotions and become more competent to meet the demands of day-to-day life.

The double handicap imposed by being disabled results in a lot of discriminations making her vulnerable. The result of this study emphasizes that employment duly helps the disabled in reducing stressful feelings. Even though the disabled women are low-paid, low-stated and with poor working conditions, it is found to be a major stress reducing factor in the life of a disabled woman.

Table 4.16 gives the values of Scheffe's test for stress between subjects of different religions.

Table 4.16
Scheffe's F for Stress Between Subjects of Different Religions

	Muslim	Hindu	Christian
Mean	242.322	222.011	239.8571
Muslim			
Hindu	7.048504*		
Christian	0.018657	1.014727	

* $p < 0.05$

The values in Table 4.16 reveal that the Muslim subjects differ significantly in their experience of stress in the experimental group. The mean scores indicate that the stress score of Muslim subjects is greater than that of Hindu subjects, suggesting that Muslim disabled women experience more stress than Hindu disabled women. This finding is very relevant, in the light of the fact that the study was conducted in a district where Muslims are relatively more conservative and less educated.

Education and employment of Muslim women are not often given importance in Muslim society. And if the woman is disabled, the neglect of these dimensions is more profound. Self-reliance inducing nurturing is also absent. These situations might fail to build up stress-tolerance in a disabled Muslim woman.

Moreover, Muslims are celebrating type, by nature. The social interactions through celebrations are very frequent among non-disabled Muslim women, where as, disabled Muslim women, who are often not entertained in these celebrations, are thus might become more deprived of social interaction opportunities.

Another social factor is marital status. The Muslim mind do not favour the unmarried status. That majority of the disabled Muslim women were unmarried might infuses inferiority feelings in them.

Helping the needy is a religious compulsion in the Muslim community. So when, they are helped, it being an act of charity, does not

induce feelings of self-reliance. It only emphasises their status of being 'the other' and this will induce more stress. The patriarchal Muslim society also denies them economic independence. The relation between physical and psychological dimensions with regard to financial status and stress is testified again when financial assistance out of charity is emerging as a stress producing factor as per Table 4.17.

Table 4.17 reveals that the values of Scheffe's F for stress between those receiving financial assistance, not receiving financial assistance and the employed.

Table 4.17
Scheffe's F for Stress Between Subjects not
Receiving Financial Assistance, Subjects Receiving
Financial Assistance and Employed Subjects of Experimental Group

	Subjects not receiving financial assistance	Subjects receiving financial assistance	Employed subject
Mean	225.000	243.7173	205.450
Subjects not receiving financial assistance			
Subjects receiving financial assistance	5.757526		
Employed subject	2.961671	11.53219**	

** P < 0.01

The values in the table indicate that significant difference is indicated between those receiving financial assistance and employed. The mean values in the table indicate that the least stressed among the group are employed

disabled women and the highly stressed are those receiving financial assistance.

Though both employed and subjects receiving financial assistance get monetary benefits, they differ significantly in terms of stress. Two reasons can be accounted for this. Though both are getting money, the employed disabled woman receives her salary with the pride and satisfaction of leading a rewarding productive life. Those receiving are beneficiaries and since the receiving hand of beneficiaries is always below, it indicates a low status and dependency. The second reason is that the amount of financial assistance being very less, (Rs. 110 per month) is not able to bring difference in the financial difficulties faced by disabled women.

HYPOTHESIS III

With reference to the third hypothesis which state that women with physical disabilities and non disabled women differ in terms of well-being, the scores were analysed in the following ways. Firstly, the over-all well-being score of each subject was estimated and the percentage of subjects scoring above 10 points and below 10 points on P.G.I. General well-being was found out. Further, the differences between mean scores of women with physical disabilities and non-disabled women and between women with orthopaedic disabilities and women with visual disabilities were assessed using one way ANOVA. Intergroup differences where further clarified through Means and Standard Deviations. ANOVA was used to estimate the

influence of area of residence, employment, religion, education, financial assistance, economic status and marital status on well-being. Means and Standard Deviations and Scheffe's test were used to further clarify the status of influencing social factors. The results are given in the tables from 4.18 to 4.23.

The percentages of subjects scoring above 10 points and below 10 points are tabulated in Table 4.18.

Table 4.18
Scatter of Well Being Scores Among Sub Groups

Sl. No.	Groups	Above 10	Below 10
1.	Women with visual disabilities	56.6%	43.3%
2.	Women with orthopaedic disabilities	55.6%	44.3%
3.	Women with physical disabilities	56%	44%
4.	Non disabled women	81.6%	18.3%

The scores in the Table 4.18 show that the control group has the highest percentage (81.6%) of subjects scoring above 10 points, while the disabled women's group has 56.6% of subjects scoring above 10 points. The table also reveals that women with visual disabilities and women with orthopaedic disabilities have almost same percentage of subjects scoring above 10 points. The individuals scoring above 10 points are considered healthy (Rema, 1995). So the results indicate that majority of non-disabled

women are healthy while approximately only half of the disabled women's group are healthy.

Further to study whether the difference between mean scores on PGI General well-being measure of women with physical disabilities and non-disabled women and between women with orthopaedic disabilities and women with visual disabilities is statistically significant, one way ANOVA was computed separately. The 'F' values are given in Table 4.19.

Table 4.19
ANOVA of Well-Being Scores across the Sub Groups

Sl No.		Source	DF	SS	MSS	F
1	Women with physical disabilities and Non-disabled Women	Between Group	1	471.4405	471.4405	31.08974**
		Within Group	208	3154.083	15.16386	
		Total	209	3625.524		
2	Orthopaedically disabled women and Non-disabled women	Between Group	1	467.3564	467.3564	30.59337**
		Within Group	155	2367.841	15.27639	
		Total	156	2835.197		
3	Visually disabled women and Non-disabled women	Between Group	1	234.7755	234.7755	16.26934**
		Within Group	111	1601.791	14.43055	
		Total	112	1836.566		
4	Orthopaedically disabled women and Visually disabled women	Between Group	1	15.03472	15.03472	0.963904
		Within Group	148	2308.465	15.59774	
		Total	149	2323.5		

** P < 0.01

Quite interestingly the 'F' values in Table 4.19 indicate that women with physical disabilities differ significantly from non-disabled women in terms of well-being. Moreover, women with orthopaedic disabilities and

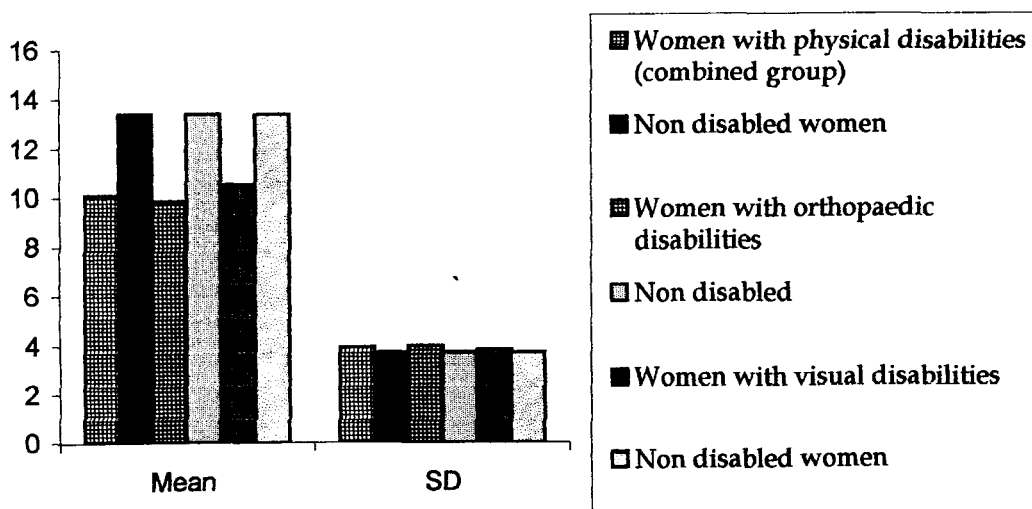
when compared separately with the control group. The 4th F value in the table indicates that women with orthopaedic disabilities and women with visual disabilities do not differ significantly as far as well-being is concerned. The Means and Standard Deviations of the respective groups given in Table 4.20 clarify the nature of difference.

Table 4.20
Means and Standard Deviations
of Well-Being of Disabled and Non Disabled Women

Sl. No.	Group	Mean	SD
1.	Women with physical disabilities (combined group)	10.1	3.94
	Non disabled women	13.416	3.75
2.	Women with orthopaedic disabilities	9.86577	4.0016
	Non disabled	13.41667	3.78
3.	Women with visual disabilities	10.52883	3.851093
	Non disabled women	13.41667	3.752024

A graphical representation of above data is depicted in Figure 4.5.

Figure 4.5: Means and Standard Deviations of Well-Being of Disabled and Non Disabled Women



The results in the table indicate that the mean score of non-disabled women is higher than women with disabilities. The same trend is expressed by non-disabled women when compared separately with women with orthopaedic disabilities and women with visual disabilities.

As indicated in the Table 4.18, while more than 80% of non-disabled women have a high sense of well-being with mean score well above 10 as per Table 4.20, women with physical disabilities have scored just 10, which is the cut off score for average psychological health. The women with orthopaedic disabilities could not attain the 10 points completely (9.86), where as the visually disabled could only score just above 10 points (10.52). In short, it is testified that women with physical disabilities in general do not enjoy a healthy state of well being. The physical, psychological and social aspects of disability, jointly or separately might have induced a decrease in the sense of well-being in these women.

As Sinha (1990) stated, well-being is related to all aspects of psychological growth of the individual-physical perception, language skills, intelligence, sociability and social sensitivity, emotional maturity, learning, enduring aspects of personality and cultural values. The discussions so far included in this study on physically disabled very duly indicate that these aspects of well-being can be influenced by disability whatever may be the category of functional limitations. The lesser mean score in the Table 4.20

denotes the influence as negative and answers for the low sense of well-being in women with physical disabilities.

Moreover, health, food consumption, education, occupation and work conditions, housing, social security, clothing, recreation and leisure and human rights are supposed to influence human well-being and many of these are diseased in the lives of the physically disabled, especially in women with physical disabilities.

Well-being is often viewed within the frame work of Maslow's theory of hierarchy of needs. Man's most vital needs are concerned with his survival. His social needs relate to his sense of security and the community comes in later, while the higher order ego-related needs concern his self-fulfilment designated as self-actualisation. A disabled women's life is full of struggles to acquire and attain the need mentioned in every stage of the hierarchy. The affluent ones might be lucky to satisfy the basic needs, but the needs mentioned in higher stages are often deprived in them also. Jacobs (2004) pointed out that disabled people lack the essentials and self-actualization has been denied to them because the foundations of Maslow's hierarchy of needs are not in place.

It was discussed by Diener, Suh, Lucas and Smith (1999) that discrepancy theories involving social comparison and aspirations are correlated with subjective well-being. These factors which are often present

in the life of a disabled women are relevant in the discussion of well-being of women with physical disabilities.

Social comparison, though it does not produce long term affects on subjective well-being, social information has its largest influence on well-being when it influences their goals. A disabled woman identified with an impacting body image is constantly exposed to social comparisons and this inturn affects her aims and goals. And the internalised negative message influences the sense of well-being.

Many contemporary theories suggest that discrepancy between one's aspirations and actual standing relates to subjective well-being. Either inappropriately high or low levels of aspiration can be detrimental to subjective well-being, leading to anxiety and boredom respectively. Apart from the functional limitations, the social stigma, negative labels and social processes too influence the level and achievement of aspirations, which in turn influence the sense of well-being.

Some of the concepts related to social and psychological components, namely self complexity, self-discrepancy, self disclosure and self-regulation, determining the sense of well-being referred in Chapter I studied in the context of disability also will enhance the causes for low sense of well-being in women with physical disabilities. The roles of these four factors can be clearly explained independently.

Self complexity, the phenomenon of viewing oneself as having many distinct facets, offers ways of satisfaction in other domains when he or she has difficulties in a particular area. The social set up and functional limitations might make it difficult for disabled women to attain complexity which in turn negatively affects the well-being.

According to Huggins self-discrepancy theory argues that the discrepancy between self-concept and self-guides leads to negative emotions and ultimately to lower psychological well-being. Self guides are the standards that people strive to attain and the disabled women experience more difficulties in this context than the non-disabled women (c.f. Weiten and Lloyd, 2003).

Self-disclosure has a positive influence on well-being. As referred by Feldman (1998) the important consequence of self-disclosure is an increase in the level of intimacy in social interactions and this in turn provides social support. The disabled woman who is considered as the 'other' enjoy very few interpersonal relationships. They being stigmatised, internalise a caution in them, which in turn might restrict the self-disclosing attitude of women with physical disabilities.

Self-efficacy belief, which has control over all mechanisms of self-regulation can be important for our health and well-being. Self-efficacy involves our confidence in our ability to achieve desired goals. The confidence as well as highly specified goals are often absent in the lives of

disabled women. The experiences in life often minimize their confidence and they often lead a passive and idle life which is revealed through their low sense of well-being.

Thus it can be concluded that it is not disability per se, but rather the contextual, social, physical and emotional dimensions of the impact of the disability that influence the sense of well-being in women with physical disabilities. A meta analysis reported by Dijkers (1998) also supports this finding.

The results of ANOVA estimating the influence of personal background like area of residence, religion, education, employment, economic status, marital status and financial assistance on well-being reveal that employment, economic status and financial assistance influence the sense of well-being (Details of ANOVA are given as Appendix III). The influence of employment on sense of well-being was further clarified through Means and Standard Deviations and is given in Table 4.21.

Table 4.21
Means and Standard Deviations
for Well-Being of Employed and Unemployed Women

Sl. No.	Group	Mean	SD
1.	Employed	12.36389	4.270082
2.	Unemployed	11.13217	4.106161

The Mean values indicate that the employed subjects experience significantly high sense of well-being than their unemployed counterparts

among the physically disabled. Employment is an important factor for staying psychologically healthy by having a structured day, staying mentally active and keeping themselves busy besides the economic independence. Otherwise, the life of a disabled woman is without an aim and full of uncertainties. Many a times they are not expected to be involved even in household chores. So it is almost an inactive life, which will certainly bring unhealthy emotions and feelings of meaninglessness in life. Moreover, the negative messages such as being a burden to the family inflict more pain. Instead, employment can bring a meaning to their life assuring at least a little financial independence and an activity to be involved in.

Employment also provides independence and ability to operate within social spheres. It yields social connectedness, social support and social integration to a certain extent and these are definitely associated with positive health outcomes for women with physical disabilities which is testified by the mean score in Table 4.21.

Social status is upgraded when one is employed. Social participation realised through employment might help to reduce deterioration in psycho social and emotional functioning and to increase outcomes for improving and maintaining a better quality of life. Thus the multidimensional potentials of employment can influence the acquisition of a higher sense of well-being, especially in women with physical disabilities who are doubly ignored.

The influence of economic status and financial assistance were further clarified using Scheffe's test.

Table 4.22 gives the values of Scheffe's test for well-being between different socio-economic classes.

Table 4.22
Scheffe's F for well-being between different economic classes

	Lower Class	Lower Middle Class	Upper Middle Class
Mean	8.88679	10.36905	13.30769
Lower Class			
Lower Middle Class	5.028466		
Upper Middle Class	14.2716**	6.769207*	

** p<0.01, * p < 0.05

The results in Table 4.22 suggest that economic status is a major influencing factor of the sense of well-being in women with physical disabilities.

The 'F' values also indicate that no significant difference is noted between lower class and lower middle class but significant difference is evident between lower class and upper middle class and lower middle class and upper middle class.

The mean values of well-being indicate that people of the lower class have lowest well-being score and those of the upper middle class have highest well-being score. It is also noted that lower class subjects fail to attain even an average psychological well being with scores below 10 points.

A reflection of Fine's and Asch's (1988) opinion regarding this is relevant in this context "social class can alleviate or exacerbate the impact of a disability, just as class and race influence access to decent housing, schooling, cultural activities and recreational opportunities for the non-disabled. For the educated and economically comfortable parent willing to assist a disabled youngster, these resources may reduce what could otherwise be serious deprivations". (p.9)

Yet another aspect of economic status of the disabled and its impact is indicated in Table 4.23 which shows the results of the Scheffe's test for well-being between those receiving financial assistance and those not receiving financial assistance and employed subjects.

Table 4.23

Scheffe's F for Well-Being Between Subjects Receiving and Not Receiving Financial Assistance and Employed Disabled Women

	Subjects without Financial Assistance	Subjects with Financial Assistance	Employed
Mean	10.35484	9.220589	12.3000
Subjects with out financial assistance			
Subjects with financial assistance	2.844509		
Employed	3.879706	9.877551**	

** p<0.01

Though significant difference between subjects receiving financial assistance and subjects not receiving financial assistance and between subjects not receiving financial assistance and employed subjects is not revealed, significant difference is expressed between employed and subjects receiving financial assistance.

Financial assistance provided through pensions for handicapped is only a monetary benefit. It fails to induce psychological satisfaction and sense of well-being in disabled. On the other hand social stigma is attached to it and that in turn causes inferiority feelings in disabled. According to one of the respondents as revealed during data collection, the attitude of non-disabled towards her was as follows "...you're disabled, so what ... you're eligible for financial assistance for disabled...". This type of attitudes is stress enhancing. In addition to this the amount of financial assistance is very small and that too at long intervals.

As far as the employed women is concerned the monetary benefits they attain as their salaries make them financially independent and gives a sense of self worth. Financial assistance often could not offer financial independence and a productive life to the unemployed. This might be the reason for finding significant difference between subjects receiving financial assistance and the employed disabled women.

Section II

Second major attempt in the study was to explore the nature of relationship between the three variables presented in the first section, viz.,

personality, stress tolerance and well-being.

HYPOTHESIS IV

The fourth hypothesis of the investigation was to study the relationship between personality and stress-tolerance in women with physical disabilities. This was estimated by computing stepwise multiple regression coefficients between the factor-wise scores of subjects in the experimental group on 16 PF Form C and total scores on Life Change Events Inventory. The values of regression analysis are given in the tables 4.24 to 4.26

Table 4.24 gives the results of regression analysis of stress-using the personality factors as the independent variables for women with physical disabilities.

Table 4.24
Regression Analysis of Stress
on Personality Factors for Women with Physical Disabilities

Sl. No.	Factors	R ²	B	F	p
1	L	0.065433	-7.600527	10.36214	0.0015**
2.	C	0.113626	-6.088039	7.992548	0.0053**
3.	G	0.13954	5.019557.	4.396909	0.0377*
4.	F	0.168694	3.811086	5.085289	0.0256*
5.	N	0.184227	-3.088023	2.741732	0.0999
6.	Q ₃	0.192103	-2.286091	1.394093	0.2396
7.	H	0.198687	1.90171	1.166755	0.2819

** p<0.01

*p<0.05

Results of regression analysis of stress on personality in table 4.24 reveal that the best predicting variables are L, C, G, F, N, Q₃ and H respectively and the significantly contributing personality factor to stress are factors L, C, G, and F.

The values of R² and B can be separately considered for prediction of stress. The values of R² reveal that factor L emerge as the best predictor of stress of women with physical disabilities, predicting nearly 6% of variance and value of B for this factor indicate that a change of 1 Standard Deviation on factor L will bring a change of 7.60527 Standard Deviation on stress. It has a negative contribution to the stress, indicating that when L⁺ features are high in a disabled women, her stress level will be low.

So, protension highly contributes to the stress-tolerance level of disabled women. There is some suggestion that protension is a preferred method of handling anxiety among intelligent and educated people (Cattell, Eber and Tatsuoka, 1976). The disabled women do not have high intelligence as per Table 4.1 and also are not highly educated, still L⁺ factor is testified as causing a reduction in the stress level of disabled women.

But as per Table 4.1 the experimental group does not consist of many low scorers or high scorers on factor L. Majority of them are average scorers. So it can be concluded that when the scores on Factor L are higher than that of a low scorer, it is causing positive influence on the stress-level of physically disabled women. So as found in the discussion of personality of

disabled women, their cautious nature which is neither trusting nor suspecting, help them to meet the stress of their life with tolerance.

The next predictor variable in the combined group is factor C. This predictor has accounted for an additional 4% of variance. Factor C also has a negative contribution with a variance of 6.088039 Standard Deviation, suggesting that highly stressful disabled women have features of low scorers on factor C.

Emotional stability, maturity, calmness, ability to show restraint in avoiding difficulties and adjustment to facts (features of C⁺) are related to stress-tolerance of an individual. The above features of factor C are related to good coping skills. Hence when these characteristics are less in an individual, he/she will be experiencing more stress. It is also noted that the person, who is dissatisfied with the world situation, his family and his own health, as indicated by a low scorer on factor C, is testified to have low stress-tolerance. This sort of feelings might be frequent in a disabled woman and correspondingly her stress level will be high. So it is well identified by the regression coefficients that factor C and stress are negatively influencing. The results in the Table 4.1 and Table 4.12 also support this finding, as almost half of the disabled women are low scorers with a not very low overall stress score.

Factor G is the next best predictor of stress-tolerance in disabled women, predicting nearly 2% of variance and a B of 5.0195. Factor G has a

positive contribution to the stress, indicating that persons with stronger super ego strength tend to be more stressful.

A G⁺ person views himself/herself as correct and a guardian of manners and morals, persevering and cautious in statements. This well-disciplined might get easily perturbed when they see injustice and wide differences in different sections of society. Though they are cautious, they might be disturbed. So when this is high in an individual, he/she will be highly stressful too.

The lesser number of low scorers among disabled women described in Table 4.1 and the high stress score of disabled women in Table 4.2 supports this finding. Though the high scorers are less in percentage, it is denoted in the discussion on factor G on page- that disabled women show a strong deviance towards high score and thus the finding is well supported. Next best predicting factor F with 2.9% variance, also indicates a positive relationship with stress and a B of 3.811086. A F-person is sober, taciturn, serious, silent, introspective, full of cares, sticks to inner values, slow and cautious. These features in the context of disabled women might help them to be very realistic and to deal with the discriminations and deprivations in a healthy manner, thus enhancing the stress-tolerance. As indicated by values in Table 4.1 though there are more low scorers than high scorers, they do not form the majority. So since the disabled women fail in acquiring the features of high scorers on factor F, their stress score also is not low, as indicated in the Table 4.12.

Though factors N, Q₃ and H do not significantly contribute to the stress of disabled women, the pattern of contributions is revealed in the Table 4.24. The factors N and Q₃ reveal a negative influence and factor H has a positive influence on the stress score.

As each type of disability is followed by particular demands the stress experienced might also differ. The difference between the different groups in the experimental group is indicated in the analysis of stress by personality factors for women with visual disabilities and for women with orthopaedic disabilities as shown in Table 4.25.

Table 4.25

Regression Analysis of Stress on 16 Personality Factors for Women with Visual Disabilities and Women with Orthopaedic Disabilities

Group	Factors	R ²	B	F	P
Women with Orthopaedic Disabilities	L	0.087966	-7.677719	9.162773	0.003**
	C	0.141201	-4.381211	5.826859	0.017*
	Q ₁	0.151653	-3.401276	1.145841	0.287
	F	0.161902	2.845855	1.125058	0.291
	G	0.17316	3.417002	1.238959	0.268
	B	0.184557	-3.811901	1.257962	0.265
Women with Visual Disabilities	N	0.102491	-11.18599	5.823931	0.020*
	L	0.171918	-9.819582	4.192064	0.046*
	G	0.263127	9.622794	6.065164	0.017*
	C	0.35182	-7.073659	6.567995	0.013**
	B	0.383266	8.010496	2.396449	0.128
	A	0.420682	5.085387	2.970936	0.091
	Q ₄	0.440647	4.425702	1.606198	0.211
	O	0.462094	-4.728679	1.75437	0.192
	E	0.475495	-2.993072	1.098591	0.300

** p < 0.01

* p < 0.05

A quick glance of the values in Table 4.25 suggest that the two subgroups differ in terms of the personality factors predicting the extent of stress experienced. The significantly contributing factors in the group of orthopaedically disabled women are L and C.

As in the combined group, factor L has emerged as the best predictor of stress among orthopaedically disabled women, predicting nearly 8% variance with a B of -7.67719 having a negative contribution as well, indicating that when L⁺ features are high in an orthopaedically disabled woman, her stress level will be low. So as with combined disabled group, in the orthopaedically disabled women's group also it is indicated that protensive feelings are capable of inducing stress-tolerance.

The next best predictor factor C, predicting a 6% variance, has a negative contribution and B of -4.381211 to stress. As in the combined group of disabled women, C⁺ features like high emotional stability, maturity, adjustment to facts bring a reduction in the level of stress in orthopaedically disabled women too.

The factors Q₁, F, G and B also contribute to stress-tolerance in orthopaedically disabled women though not at significant levels. The factor Q₁, and B present a negative contribution where as factors F and G induces a positive contribution to stress-tolerance.

In visually disabled women, the regression analysis shows that four factors have indicated predictability of stress tolerance at significant levels,

of which the two, L and C are common to the combined and orthopaedically disabled groups. N has emerged as the best predictor of stress with 10% variance. It has a negative contribution with B of -11.18599 indicating that when features of N+ are high in a visually disabled woman, her stress level will be low. That is when visually disabled women are socially aware, emotionally disciplined, insightful regarding self, insightful regarding others and has exact, calculating mind, they are highly stress-tolerant. This factor is non significantly predicted in combined disabled (Table 4.24) whereas it is not predicted in orthopaedically disabled women. This indicates that it is a special feature of visually disabled women.

As Sen (1988) pointed out, it is mainly through visual modality that human beings receive accurate and gestalt impressions of the environment assisting in orienting them toward the environment. So visual disability reduces the interactional opportunities. In the absence of accurate alternatives, visually disabled women are unable to become highly socially aware and could not acquire insight regarding others and this stress inducing personality factors might increase the stress level of the subjects.

Another predictor factor L, predicting a 6.9% variance, has a negative contribution (B = -9.819582) to stress, suggesting that when features of L+ are high in visually disabled women, they experience less stress. So as in orthopaedically disabled women, in visually disabled women also protensive feelings are capable of inducing high stress-tolerance level. Since,

disabled women combined as well as separate express this trend, it can be considered as a common trend in women with physical disabilities.

The next best predictor of stress is factor G. It is predicting a 9% variance and has a positive contribution with B of 9.622794 to stress. So when visually disabled women have higher super ego strength, their stress level is also high. The combined group of disabled women also express this trend as per Table 4.24, but orthopaedically disabled women fail to bring a significant contribution. So it can be concluded that visually disabled women offer a major contribution in this.

As in the other two groups, in visually disabled women also factor C is a good predictor effecting 8.8% of variance and has a negative contribution with B of -7.073659 suggesting the ability of higher ego strength to induce high stress-tolerance in visually disabled women. Interestingly this is very much in line with the Freudian view that ego strength is associated with adjusted behaviour and the dominance of super ego strength can induce mal adaptive tendencies.

The other factors which contribute to stress-tolerance in visually disabled women, though not at significant levels, are B, A, Q₄, O and E. Of these, factors B, A and Q₄ express positive contribution where as factor O and E express negative contribution.

Second Order Factors on 16 PF

It was also attempted to study the predictability of stress by second-order factors of personality on 16 PF in women with physical disabilities.

The details of regression analysis are shown in Table 4.26.

Table 4.26
Regression Analysis of Stress-Tolerance
on Second Order Factors Among Experimental Sub-Groups

Group	Second Order Factors	R ²	B	F	P
Women with orthopaedic disabilities	Q _{II}	0.026159	0.769308	2.5519	0.1135
Women with visual disabilities	Q _I	0.062066	15.29688	3.374823	0.072
	Q _{III}	0.142065	-10.8603	4.66228	0.035*
	Q _{IV}	0.177843	8.660029	2.132391	0.150
Women with physical disabilities	Q _{II}	0.01283193	0.65617	1.9238	0.1675

* p < 0.05

The values in the table 4.26 indicate that (i) only one second order personality factor (Q_{III}) shows predictability of stress. (ii) Only in the group of visually disabled women Q_{III} has influence on stress tolerance.

Factor Q_{III} denotes Emotionalism Vs Tough poise. It predicts 6% variance and the value of B is -10.8603 indicating a negative contribution. It suggests that when Q_{III} is low, the stress level will be high. When visually disabled women are very sensitive and emotional, they tend to experience higher stress. But when they have alertness and readiness to handle problems at a 'dry' cognitive and objective level it will give them high stress-tolerance. Cattell, Eber and Tatsuoka (1976) stated that low scoring individuals show a tendency to feel rather than think. So visually disabled

women who acquire a high stress-tolerance might be alert and act sensibly, not emotionally.

Factors Q_I and Q_{IV} also show a non-significant contribution to stress-tolerance in visually disabled women. Both present a positive contribution with variance of 7.9% and 3% respectively.

At the same time, factor Q_{II} (Low Anxiety Vs High Anxiety) is indicated as the best predictor of stress, though not at significant levels, both in orthopaedically disabled women and in the combined group of women with physical disabilities.

The best predicting factors relating personality and stress in non-disabled women are different from disabled women as revealed by the Table given as Appendix IV. The details of the control group is not included in the text as the primary focus of the study is only the disabled and is not intending a comparative analysis of the control and experimental groups. Factor I (Tough-Minded Vs Tender-Minded), which has not emerged as a contributor in any of the disabled women's group-separate or combined, has emerged as the best predictor stressinf non-disabled women. Factor I with 8% variance has predicted a positive contribution to stress. It is also noted that factor N (Naivete Vs Shrewdness) shows positive contribution to stress in non-disabled women, where as in disabled women factor N shows a negative contribution to stress. Thus it clearly indicates that while relating

stress-tolerance and personality factors non-disabled women differ from women with physical disabilities to a certain extent.

HYPOTHESIS V

With reference to the fifth hypothesis to study the relationship between personality and well-being in women with physical disabilities, step-wise multiple regression coefficients were computed between the factor-wise scores of the experimental subjects on 16 PF form C and total scores on P.G.I. General Well-being Scale. The values of regression analysis are given in the Tables 4.27 to 4.29.

Table 4.27
Regression Analysis on Well-Being
by Personality Factors for Women with Physical Disabilities

Sl. No.	Factors	R ²	B	F	P
1.	Q ₄	0.125015	-0.456333	21.14578	9.58E-06**
2.	H	0.177716	0.412804	9.42142	0.002586**
3.	F	0.212453	0.224837	6.439665	0.012279**
4.	Q ₁	0.229828	0.348641	3.271241	0.072697
5.	B	0.246263	0.355	3.139923	0.07862
6.	L	0.254913	0.268967	1.66001	0.199774
7.	A	0.261492	0.223064	1.264978	0.262678
8.	G	0.270049	-0.242576	1.6533001	0.20072
9.	N	0.2777182	0.24641	1.381443	0.241894
10.	E	0.284471	-0.200869	1.416099	0.236105
11.	O	0.291572	0.186021	1.383144	0.241606
12.	C	0.298915	0.171897	1.435013	0.233016

** p<0.01

Results of regression analysis of personality and well-being in Table 4.27 reveal that the personality factors significantly contributing to well-being are Q_4 and H. The values of R^2 and B when separately considered for prediction of well-being, the values of R^2 indicate that the best predicting factor is Q_4 with 12% variance. The value of B for this factor indicate that a change of one Standard Deviation on factor Q_4 will bring a change of 0.456333 Standard Deviation on well-being.

The B value for Q_4 denotes that it has a negative influence on well-being so it can be concluded that low ergic tension contributes to the better sense of well-being.

Ergic tension shows itself by the individual's being irrationally worried, tense, irritable, anxious and in turmoil, which are quite contrary to the features of high sense of well-being. In other words, the relaxed, tranquil, torpid, unfrustrated and composed nature expressed by Q_4 persons significantly contribute to the sense of well-being.

The figures in Table 4.1 indicate that only 29.3% of disabled women are low scorers on factor Q_4 . Majority of disabled women who do not have this personality feature might not be able to attain high sense of well-being. This is testified by Table 4.20 also indicating a border line mean score of 10.1 for disabled women.

The next predictor variable in the combined disabled group - factor H brings a 5% variance. It has a positive contribution to well-being and a B of

0.412804. So the features of H⁺ individuals help inducing a high sense of well-being. The H⁺ person shows little inhibition by environmental threat and incidentally, is rated 'lazy' in childhood and thick-skinned in social interaction. This constitutional susceptibility to inhibition in turn generates the boldness in social, sexual, emotional and physical danger situations which comes out in H⁺ individuals. The positive relation of these features with sense of well-being in disabled women should be interpreted with due reflection on social condition of disability.

The disabled women who are often marginalized, need extra courage and strength to come into mainstream and attain a productive life. So the above mentioned features of H⁺ are needed for disabled women to enjoy the status of a productive human being. As indicated in personality analysis in Table 4.1 only 10% of disabled women have emerged as high scorers. So it might be the reason for not having a very high sense of well-being in disabled women as denoted in Table 4.20.

The next predictor is factor F with 4% variance expressing a positive contribution with B of 0.224837. This suggests that the characteristics of surgency are capable of enhancing the sense of well-being in disabled women. Other personality factors contributing to the sense of well-being to some extent are Q₁, B, L, A, G, N, E, O, and C. Of these all factors except factors E and G express a positive influence on stress.

As functional limitations of each category of disability differs, its implications also vary. The analysis of hypotheses 1, 2 and 3 also testified this. The regression analysis of well-being on personality factors for women with visual disabilities and for women with orthopaedic disabilities is shown in Table 4.28.

Table 4.28
Regression Analysis of Well-being
on 16 Personality Factors For Women with Visual
Disabilities and Women with Orthopaedic Disabilities

Group	Factors	R ₂	B	F	P
Women with Visual Disabilities	H	0.185716	0.74496	11.63174	0.001**
	E	0.259232	-0.547022	4.962097	0.031*
	Q ₃	0.321996	-0.625648	4.536035	0.038*
	A	0.391033	0.548334	5.441679	0.024*
	I	0.441627	-0.600126	4.258606	0.049*
	C	0.460459	0.304369	1.605576	0.211
	G	0.474439	-0.369735	1.197035	0.279
	M	0.488872	0.278322	1.242453	0.271
Women with Orthopaedic Disabilities	Q ₄	0.175181	-0.598332	20.17677	2.14E-05**
	F	0.216832	0.25966	4.999186	0.027*
	Q ₁	0.244629	0.535083	3.422284	0.067
	Q ₂	0.266921	0.472997	2.797659	0.097
	H	0.288178	0.424241	2.717515	0.102
	L	0.320158	0.373457	4.233604	0.043*
	M	0.337889	-0.321344	2.383436	0.126
	B	0.353748	0.394595	2.159505	0.145

* p < 0.05 ** p < 0.01

Values in Table 4.28 suggest that the personality factors significantly contributing to the sense of well-being in the group of visually disabled women are H, E, Q₃, A and I. Factor H has emerged as the best predictor of well-being in visually disabled women and as the second best in the combined disabled group. Factor H predicting nearly 16% of variance has a positive contribution to well-being with B of 0.74496. This trend suggests that adventurous, active, friendly, emotional and artistic interests and social boldness of H⁺ persons increase the sense of well-being in visually impaired women.

The next predictor is factor E, which predicts nearly 7% variance. It has a negative contribution with B as -0.547022; suggesting that submissiveness, obedience, dependence, considerateness, diplomacy, conventionality, conformity etc. represented by E⁻ individuals might induce high sense of well-being.

Factor Q₃, the third predictor of well-being also has a negative contribution and a B of 0.625648 with 6% variance. This indicates that self-sentiment integration has high influence on the sense of well-being.

So self-sentiment integration is the extent to which the person has crystallised for himself/herself a clear, consistent, admired pattern of socially approved behaviour, to which she/he makes definite efforts to conform. The concern and regard for the standards might induce tension and anxiety in her. The visually disabled women, who could not be clear

about the pattern of socially approved behaviour, due to their visual impairment, might induce more strain in her life if she tries to conform to the common behaviour pattern which is only a blurred picture to her. So it is better to have low self-sentiment integration, which will in turn produce greater sense of well-being.

Factor A as a predictor has a positive contribution to the sense of well-being with a variance of 6.9% and a B of 0.548334. So when the visually disabled woman is warm hearted, easy going, ready to be compared and of adaptable nature, her level of well-being, also will be high.

The last significantly contributing factor is factor I. It predicts 5% variance and has a negative contribution with a B of -0.600126. So when features of I is present in a visually disabled woman, her sense of well-being will be high. That is, when visually disabled woman act on practical and logical evidence and takes responsibility, she might not dwell on her physical disabilities and this might enhance her level to well-being.

The factors C, G and M also contribute to the sense of well-being in visually disabled women though not at significant levels. Factor G presents a negative contribution where as factors C and M induces a positive contribution to well-being.

In orthopaedically disabled women, regression analysis shows that as in the combined disabled group (Table 4.27) factor Q₄ has emerged as the

best predictor. Factor Q_4 with 17% variance imbibes a negative contribution and a B of 0.598332. So low ergic tension influence the sense of well-being in orthopaedically disabled women too.

Factor F is the next best predictor of stress-tolerance in orthopaedically disabled women. It predicts nearly 4% variance and has a positive contribution with a B of 0.25966. The pattern of contribution suggests that when F^+ characteristics like enthusiasm, cheerfulness, happy-go-lucky attitude become their basic temperaments, they will experience high sense of well-being irrespective of their deformities.

Other personality factors predicting the sense of well-being, though not at significant levels, are Q_1 , Q_2 , H, L, M and B. All these factors except factor M, express a positive contribution to well-being. So radicalism, self-sufficiency, venturesome, protension, high intelligence and praxernia help to increase sense of well-being in orthopaedically disabled women.

Second Order Factors on 16 PF and Well-Being

It was also attempted to study the predictability of well-being on second order factors of personality in women with physical disabilities. The details of regression analysis are shown in Table 4.29.

Table 4.29
Regression Analysis of Well-Being on Second
Order Factors on 16 PF for Women with Physical Disabilities.

Group	Factors	R ²	B	F	p
Women with Physical Disabilities	Q _{II}	0.096004	-0.70087	15.71749	0.0001**
	Q _I	0.122309	0.470464	4.405655	0.037*
Women with Orthopaedic Disabilities	Q _{II}	0.12524146	-0.84099	13.601	0.0003**
Women with visual disabilities	Q _I	0.106195	1.032944	6.05943	0.01**
	Q _{III}	0.178605	-0.64316	4.40774	0.04*

* $p < 0.05$ ** $p < 0.01$

The results of regression analysis reveal that Q_I and Q_{II} are the two factors which tend to be good predictors of well-being. Factor Q_{II} has emerged as the best predictor of well-being in the combined group and in the orthopaedically disabled group. While Q_I holds the first position for the visually disabled group and the second predictor in combined disabled group and factor Q_{III} which comes as the second in visually disabled group is not expressed by combined disabled group as well as orthopaedically disabled group.

Factor Q_I denotes Introversion Vs Extraversion and factor Q_{II} indicates Low Anxiety Vs High Anxiety. So as per the results in Table 4.29. Extraversion and Adjustment (Low anxiety) help in enhancing the sense of well-being in physically disabled women. The influence of extraversion

characteristics on neurotic/psychotic symptoms indicated in the study conducted by Kumar *et. al.*, (1994) supports this finding.

Table 4.29 also reveals that Q_I infuses a positive contribution with 10% variance and B of 1.032945 to well-being and Q_{III} with 17% variance and a B of -0.6437 infuses a negative contribution in visually disabled women. Factor Q_{II} induces a negative contribution of B -0.84099 to well-being in orthopaedically disabled women. So it is revealed that Adjustment increase the sense of well-being in orthopaedically disabled women, where as extraversion infuses higher sense of well-being in visually disabled women. Visually disabled women have been showing the feeling of the 'other' through out the analysis and might internalise this otherness which tend to make them less socially active where as orthopaedically disabled women with all sensory modalities intact realising the challenges in competing with the non disabled tend to make them more anxious.

The best predicting personality factor of the sense of well-being in non-disabled women as revealed by the table given as Appendix No. V, is factor Q_4 . The other significantly predicted personality factors of the sense of well-being of non-disabled women are E and L respectively and the second order factor Q_{II} also has emerged as a predictor of sense of well-being in non-disabled women.

Role of factor Q_{IV} , representing ergic tension, in predicting sense of well-being is the same in both disabled and non-disabled. But the other two

significant predictors E and L reveal a different pattern of contribution. While factor E (submissiveness Vs Dominance) shows a negative contribution in visually disabled women, the non-disabled women expresses a positive contribution to the sense of well-being. The factor L (Alaxia Vs Protension) reveals a positive contribution to the sense of well-being in orthopaedically disabled women while a negative contribution is revealed in non-disabled women. Similar pattern of contribution to the sense well-being is expressed by both disabled women and non-disabled women with regard to the second order factor Q_{II} . These differences between disabled and non disabled may be because of the different levels of competencies within them which would make the probable rate of success that they may attain a little different. For example, a dominant non-disabled woman can afford to be successful in achieving what she wants and thus add to the sense of well-being whereas if a visually disabled woman is dominant she might not be able to achieve her goals successfully due to the physical dependence and hence meets with frustration, failure and lower sense of well-being.

Thus, the results of the analysis of V^{th} hypothesis reveal that the significantly contributing primary personality factors to the sense of well-being of disabled women are Q_4 , H and F and second order personality factors are Q_I and Q_{II} . Apart from the contribution of factors H and M as indicated in the Table 4.28 the roles differ in orthopedically disabled and visually disabled with regard to certain contributing personality factors.

When the personality factors Q₄, Q, Q₂, F, L and B are testified as significant predictors of sense of well-being in the orthopaedically disabled women, factors Q₃, A, E, I, C and G emerged as predictors of sense of well-being in the visually disabled women.

HYPOTHESIS VI

The sixth hypothesis of this investigation was to study the relationship between stress-tolerance and well-being of women with physical disabilities. This was estimated by computing correlation coefficients between the scores of the subjects in the experimental group on Life Change Events Inventory and P.G.I. General well-being measure as shown in Table 4.30.

Table 4.30
Correlation Coefficients Between
Stress and Well-Being for the Sub Groups

Sl. No.	Group	r	p
1.	Women with orthopaedic disabilities	-0.18958	0.0629
2.	Women with visual disabilities	-0.187760	0.1781
3.	Women with physical disabilities	-0.17435	0.0328*

* p < 0.05

The table values reveal that stress and well-being are correlated in the combined group of disabled women and the nature of correlation is negative. But when each category of disabled is taken separately, though the

nature of correlation is same, the level of correlation is not significant for separate groups independently.

The results in the Table 4.12 and 4.20 also partially support the results of the analysis of this hypothesis. Disabled as a combined group support this finding with a lesser-well-being score and higher stress-score. But when each sub group of the disabled group is considered, a slight variation is noticed. The visually disabled with higher stress score (Table 4.12) than orthopaedically disabled should have a well-being score lesser than that of women with orthopaedical disabilities, according to this hypothesis. But it is not so, which is testified with non significant 'r' value. Though the group of orthopaedically disabled too express the same non significant correlation, it shows a tendency towards significance, (0.06 level of confidence). The personality differences indicated in table 4.8 might be considered as contributing to this effect . As Mc Crace and Costa (1986) pointed out personality is causally prior to the stressors, coping efforts and well-being states.

Theoretically, as indicated in the definition of well-being - affect, strain and satisfaction are the three types of well-being that focus on experiences and flow of everyday life. Our day-to-day life, filled with competitive experiences, is capable of inducing stress. With impaired sense of vision, the visually disabled women have to deal with more demands and the impact of this is testified by highest stress score computed for visually

disabled women. Stress often pertains initially to specific things or events, slowly showing impact on all other dimensions. But the sense of well-being is more of a general feeling. The visually disabled women with personality features indicating between group dependency and self sufficiency and low ergic tension presents a character, which despite their greater stressful feelings is capable of maintaining the general psychological health intact, as testified by an average mean score of well-being in Table 4.20. This aspect of interrelationship existing among personality, stress and well-being can be accounted for the non-significant correlation between well-being and stress in visually disabled women.

In this context it also needs to be recalled that the stress score yielded on Life Change Events Inventory is based on the perception of imaginary life events i.e., the subject is instructed to rate the expected amount of stress if the event occurs in their lives. Therefore the self concept, self adequacy and independence becomes more significant in the perception of a life event as stressful. Since the perception of visually disabled and orthopaedically disabled might differ, the corresponding stress scores and well-being scores as well as their relationship might also differ. As revealed by the results earlier in this study, the orthopaedically disabled tend to have feelings of incompetency and negatively affected self concept which in turn influence their psychological health, that is reflected in their high stress and low well-being scores as indicated in Tables 4.12 and 4.20. But visually disabled who

are found to be alert, vigilant and less group dependent, imbibing a cautious nature and being self-dependent are able to maintain their state of mental health inspite of high stress score.

As per results in table attached as appendix VI the non-disabled women also express a non significant negative correlation between stress and well-being. This strengthens the inference that personality probably operates as a moderator of impact of stress on well-being. Inorder to verify this, partial correlation is computed to rule out the role of personality factors or to identify the role of personality in the relationship between stress and well-being in physically disabled women. The results of partial correlation are given in Table 4.31.

Table 4.31
Partial Correlation Coefficients
Between Stress and Well-Being for the Subgroups

Sl. No.	Group	$r_{1,23}$
1.	Women with orthopaedic disabilities	-0.139713
2.	Women with visual disabilities	-0.488636*
3.	Women with physical disabilities	-0.230472*

* $p < 0.05$

The results in Table 4.31 reveal that significant negative correlation between well-being and stress is expressed by women with visual disabilities and the combined group. The pattern of correlation is negative for all the three groups. The results reveal that women with visual disabilities, who have been expressing a variation from other group

throughout the discussion, showed a difference in earlier correlation (Table 4.30) too. Personality factors are attributed for this difference. When correlation between stress and well being is estimated, eliminating the personality factors, a significant relationship is yielded. Hence influence of the personality factors is confirmed. Personality is then testified as the centre or dominant factor that influences the nature and severity of experience of stress and well-being and their relationship.

Analysis of the data collected in the study gives some clear indications. With respect to the physically disabled women of Calicut district, the development of personality pattern differs from non-disabled women, irrespective of their socio-economic background. It is also suggested that there is a differential impact of the different disabilities on the development of personality characteristics.

In terms of the experience of stress or stress-tolerance, the visually disabled women show less stress-tolerance or experience more stress by interacting with the environment when compared to the non-disabled women while they do not differ significantly from orthopaedically disabled women. It is also revealed that employment, financial assistance and religion play a significant role in their experience of stress.

The results also indicate that the physically disabled women maintain a significantly lower sense of well-being as compared to non-disabled women, while the type of disability do not influence their well-being

significantly. With respect to socio-demographical factors employment, economic status and financial assistance have emerged as moderating factors in the experience of psychological well-being.

The three variables of the study, viz., personality characteristics, stress-tolerance and well-being are found to be significantly interrelated in physically disabled women in which personality characteristics have significantly emerged as a moderating factor in the relationship between stress-tolerance and well-being.

SCOPE OF THE STUDY

General attitude towards physically disabled is neglect or over protection or indifference. If ever a helping hand is offered, it is only an act of charity. But the disabled do not need our pity, what they demand is acceptance. For accepting them it definitely needs a better understanding of their physical and psychological states. This investigation is one such attempt. Women with physical disabilities are selected for investigation as they are the worst victims in the group. The findings of the present study have several implications for understanding the disabled from their perspective and to help them overcome the disadvantages faced by them. The most important among these are mentioned below:

1. To re-structure the social image of women with physical disabilities

The findings suggest certain negative implications of stigmatisation faced by the physically disabled, especially due to the double discrimination

imposed on physically disabled women. Public education and efforts for awareness building about the potential of women with physical disabilities would have a role to play in removing misconceptions and discrimination against them. The most prevalent strategy for attaining personal wellness among the disabled is increasing public awareness about viewing people with disabilities as whole persons. The fact that disability does not mean illness is an important concept that needs emphasis in both health care professionals and the general public.

2. To maximise the psychological health of women with physical disabilities.

The findings of the study regarding personality, stress and well-being indicate that personality has a significant role in the mental health of physically disabled women. The management of stress and well-being are dependent on personality pattern. Understanding the need for healthy personality in physically disabled women enabling them to strive for a rewarding life, the following ways are suggested to maximise their psychological health.

a) Changing the family environment:

Though not directly testified, the influence of childhood experiences and types of parenting on personality are inferred from the communications of the family members during data collection. Parental awareness regarding a supportive as well as confidence building interaction is demanded. Need

for caring the disabled child at par with non-disabled children in the family avoiding over protection or neglect is to be emphasised in parental counselling

b) Building positive self concept:

A positive self concept can be moulded in physically disabled women by introducing the following measures:

- ❖ Provision for treatment or training to overcome or to minimize the functional limitations occurred due to disability.
- ❖ Provision for accessibility to opportunities for self developments.
- ❖ Building up non-stigmatised attitude in non-disabled.
- ❖ Provision for psychological help at individual and group level for self awareness and independent thinking.
- ❖ Provision for assertiveness training and self-esteem building.

c) Creating social interaction opportunities:

Being a social animal, social interactions have determinant effects. Meaningful social interactions need to be introduced through policies and programmes as well as through imbining attitude change in the non-disabled. Meaningful involvement of the disabled women, which is an effective way of social and psychological well being, is to be assured through programmes introduced from school level to community level, among literates and illiterates, especially encouraging non-governmental organisations (NGOs) working in this field.

d) Changing the environment:

The added demands due to disability can have negative influence on the emotional well-being of the physically disabled women if the environment is hostile. By changing the physical as well as psychological dimensions of the disability-hostile environment into a friendly one the emotional well-being of women with physical disabilities can be ensured to a certain extent.

3. To develop physically disabled women as productive members of the society

Apart from inducing better psychological health in women with physical disabilities by the four ways they should also be helped to become a productive, active and contributing member of the society by:

- a) Mainstreaming of physically disabled women into the social life, not for the sake of reservations, but with due importance to them as members of this society.
- b) Provision for employment opportunities:

To estimate the sense of dependence and to boost up self-esteem, every disabled individual should be provided with chances to prove their meaningful contribution to the society. By empowering the disabled women psychologically and occupationally, the dependent status of women with physical disabilities can be changed to a productive one. The need for providing the disabled individual with employment opportunities is emphasised and recommended to

the governmental bodies, quasi governmental managements and private level institutions.

General Outcome

By easing out the stress and strains of the physically disabled and by making them equally healthy and productive the beneficiaries will not only be the disabled but the kith and kin and all those who interact with the disabled and who thereby will be also be released of their stress in managing the disabled. This will smoothen the relations between them.

Suggestions for Future Research

1. Investigation including subjects of all categories of disability will be relevant.
2. Considering the difference in socio-cultural constitution of the population of Kerala, a state-wise analysis, including subjects from all the districts of Kerala, is also suggested.

SUMMARY AND CONCLUSIONS

Sareena. N. P . “Personality, stress-tolerance and well-being of women with physical disabilities ” Thesis. Department of Psychology , University of Calicut, 2004

SUMMARY AND CONCLUSIONS

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- *Objectives*
 - *Hypotheses*
 - *Sample*
 - *Tools*
 - *Administration*
 - *Statistical Analysis of Data*
 - *Major Findings*
 - *Conclusion*
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A disability is a limitation of function because of an impairment (Lane, 2002). The existence of disabled members is not uncommon in any society. But physical disability is only a fragment of the total handicap against which a disabled person has to struggle. The disability in any person, of any kind- irrespective of its congenital or acquired nature - would also pose additional challenges in social and psychological contexts.

According to Barnes and Mercer (2003) the combination of material disadvantages, powerlessness and demeaning cultural stereotyping, marks out disabled people's experience of social oppression. Society is unable to see beyond disability. They fail to see them as whole persons as similar to them.

Sen (1988) stated that whatever may be the causes of disability and whatever may be its effects, it has a tremendous impact on the development of personality of the individual and his corresponding adjustment into society. Moreover, personality is a variable which can be moulded in a healthy way if care is given from childhood itself, especially in the context of disability. It is necessary to understand the personality and its specific details in relation with other psychological features to assure positive mental health in the disabled and thus to make possible for them to live a rewarding life inspite of all disabilities.

Another major factor that aggravate the disadvantages is gender discrimination which often goes unnoticed. Moreover, these images have

serious consequences in terms of education, employment, life styles, personal relationships, victimisation and abuse. There is ample evidence that women with disabilities experience psycho-social problems that remain largely neglected including depression, stress, low self-esteem and social isolation. (Meekosha, 2004). These features reflect in the personality and mental health.

Most of the studies on disabled is conducted on men who are relatively less socially ostracised. Some have started thinking of cultural and gender differences too. Although the idea of women empowerment is aired nothing much has been done for the physically disadvantaged, that too with scientific footing. Hence the present investigation is an attempt in this direction.

OBJECTIVES

The study is designed with four objectives:

- 1) To study the personality of women with physical disabilities
- 2) To study the stress-tolerance of women with physical disabilities
- 3) To study the well-being of women with physical disabilities
- 4) To study the relationship between personality, stress-tolerance and well-being in physically disabled women.

HYPOTHESES

A few hypotheses is framed to be tested in this study.

1. a) Women with physical disabilities and non-disabled women differ in personality
b) Women with orthopaedic disabilities and women with visual disabilities differ in personality.
2. a) Women with physical disabilities and non-disabled women differ in stress-tolerance.
b) Women with orthopaedic disabilities and women with visual disabilities differ in stress-tolerance.
3. a) Women with physical disabilities and non-disabled women differ in well-being
b) women with orthopaedic disabilities and women with visual disabilities differ in well-being.
4. Personality and stress-tolerance are related in women with physical disabilities.
5. Personality and well-being are related in women with physical disabilities.
6. Stress-tolerance and well-being are related in women with physical disabilities.

SAMPLE

The sample of the study consisted of two categories of population, namely the disabled women and the non-disabled women. The total

strength of the sample was 210. The experimental group consisted of 150 women with physical disabilities, out of which 97 are with orthopaedic disabilities and 53 are with visual disabilities. The control group consisted of 60 non-disabled women. Disproportionate stratified sampling technique was used to select the subjects of experimental group and purposive sampling was used to select subjects of control group in order to control the family background of all the subjects included in the study

TOOLS

Tools used in this study included three standardised self-report measures and an information schedule.

- (i) To study the personality characteristics of subjects a Malayalam adaptation of 16PF form C (Rema and Anita, 1989) was used that assess 16 primary factors and 4 second order factors.
- (ii) To study the stress-tolerance of the sample a Malayalam adaptation of Life Change Events Inventory (Paul and Moorthy, 1992) was used. The scale consists of 67 items related to day to day life events. The subjects were asked to mark their rating to each incident, when it occurred or if it occurred in their lives.
- (iii) A Malayalam adaptation of PGI. General Well-Being measure was prepared to study the well-being. The scale consists of 20 items and

the respondents were asked to tick the statements which are applicable to them.

- (iv) An information schedule was prepared to collect the general demographic details and some relevant information regarding the disability.

ADMINISTRATION

All the four measures were administered individually to all the subjects in the sample.

STATISTICAL ANALYSIS OF DATA

After scoring the responses of each test, as per the directions of the authors, the scores were tabulated and was analysed statistically. The first hypothesis was tested using One-Way ANOVA and MANOVA. Second and third hypotheses were tested using One-way ANOVA and Scheffe's test wherever necessary. The fourth and fifth hypotheses were tested using stepwise Multiple Regression Analysis method. The sixth hypothesis was analysed using Pearson's Product Moment Correlation and Partial Correlation.

MAJOR FINDINGS

Major findings of the present investigation are as follows:

1. Personality pattern of women with physical disabilities differ significantly from that of the non-disabled women with regard to

desurgency, praxernia and group dependency.

2. Personality of women with orthopaedic disabilities differ significantly from that of women with visual disabilities in terms of group dependency, ergic tension and independence
3. There is no significant difference in stress tolerance between disabled and non-disabled. Visually disabled women are significantly lower in stress tolerance than non-disabled, while the orthopaedically disabled and visually disabled do not differ significantly.
4. The women with physical disabilities differ significantly from non-disabled women in terms of well-being, but two experimental subgroups do not differ significantly as far as well-being is concerned.
5. Personality and stress-tolerance are related in women with physical disabilities in terms protention, ego-strength, superego-strength and surgency.
6. Personality and sense of well-being are related in women with physical disabilities in terms of threctia, ergic tension, extraversion and anxiety.
7. The stress and well-being are significantly correlated in disabled women.
8. Factors like area of residence, education, religion, economic status, marital status and financial assistance do not influence the personality of disabled women.

9. Social factors like religion, financial assistance and employment significantly influence the stress level of women with physical disabilities.
10. Social factors like economic-status, employment and financial assistance influence the sense of well-being of women with physical disabilities.

CONCLUSIONS

1. The first hypothesis framed in the study stands accepted indicating that the disabled and non-disabled women differ in personality.
2. The second and third hypotheses stand partially accepted.
3. The fourth, fifth and sixth hypotheses stand accepted by the findings of the present study revealing that personality, stress-tolerance and sense of well-being are interrelated in physically disabled women.
4. Personality has emerged as a predisposition for management of stress and sense of well-being in women with physical disabilities.

CONFIDENTIAL

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APPENDICES

APPENDIX I

MANOVA FOR SOCIAL FACTORS ON PERSONALITY

Factors	Rao's R	p-level
Area of residence	1.85109	0.120
Employment	1.628129	0.168
Marital status	0.392027	0.984
Education	0.912026	0.585
Religion	0.988114	0.445
Economic status	0.73612	0.659
Financial assistance	0.247008	0.981

APPENDIX II

ANOVA FOR SOCIAL FACTORS ON STRESS

Sl No.	Factor	F	P
1	Area of residence	1.515	0.22
2	Employment	5.942	0.016**
3	Religion	7.091522	0.0086**
4	Education	2.340497	0.05866
5	Financial Assistance	6.684077	0.00166**
6	Economic Status	2.143249	0.120924
7	Marital Status	2.02026	0.09464

* p < 0.05 ** p < 0.01

APPENDIX III

ANOVA FOR SOCIAL FACTORS ON WELL-BEING

SI No.	Factor	F	P
1	Area of residence	0.452	0.502
2	Employment	5.008	0.02*
3	Religion	0.217665	0.8046
4	Education	2.082047	0.058
5	Financial Assistance	5.196121	0.0066**
6	Economic Status	7.60431	0.0072**
7	Marital Status	1.370581	0.247024

* p < 0.05 ** p < 0.01

APPENDIX IV

REGRESSION ANALYSIS OF STRESS ON PERSONALITY FACTORS FOR NON-DISABLED WOMEN

Sl. No.	Factors	R ²	B	F	P
1	I	0.087486	5.604614	5.560699	0.022*
2	M	0.136908	-6.634748	3.26873	0.076
3	N	0.181424	5.243514	3.045398	0.086
4	C	0.22616	-4.642867	2.914374	0.093
5	Q _I	0.259611	-6.743225	2.698208	0.106
6	H	0.282863	3.300194	1.718447	0.195
Second order factors					
7	Q _{II}	0.042527	8.106162	2.57612	0.114
8	Q _I	0.0645988	5.316311	1.369272	0.246

* p < 0.05

APPENDIX V

REGRESSION ANALYSIS OF WELL-BEING ON PERSONALITY FACTORS FOR NON-DISABLED WOMEN

Sl. No.	Factors	R ²	B	F	p
1	Q ₄	0.380392	-0.748715	9.81229	0.002**
2	E	0.512071	0.615334	9.079298	0.003**
3	L	0.57808	-0.686413	6.052139	0.017*
4	Q ₂	0.597045	0.40059	1.904706	0.173
5	Q ₃	0.616637	-0.364694	2.071815	0.155
6	I	0.635481	0.46115	2.097683	0.153
Second order factors					
7	Q _{II}	0.074439	-0.93077	4.664704	0.035*
8	Q _I	0.092688	-0.54966	1.146438	0.288
9	Q _{IV}	0.121263	0.614092	1.821041	0.182

* p < 0.05 ** p < 0.01

APPENDIX VI

CORRELATION COEFFICIENT BETWEEN STRESS AND WELL-BEING OF NON-DISABLED WOMEN

Group	r	P
Non-disabled women	0.111241	0.397

INFORMATION SCHEDULE

1. Name :
2. Age :
3. Religion :
4. Marital Status : Unmarried/Married/Widow/
Separated/Divorce

5. Socio-Economic Status

- a) Financial status of the family depending on the style of living.
Lower/Lower Middle/Upper Middle/Upper
- b) Availability of food in the family - Adequate/Inadequate/Luxuries
- c) Availability of luxurious electrical appliances at home - Yes/No
- d) Adequate space and privacy at home - Yes / No.
- e) Availability of toys and books during childhood - Yes /No

6. Education

- a) Literate/ Illiterate
- b) Literate/ LP/UP/HS/Pre-degree/Degree/Others

7. Vocational Training: Received/ Not received

- a) Age of admission
- b) Type - Assembling/Screen printing/ weaving/candle making/
electronic works/ computer training/ carpentry/ other
cottage industrial works

8. Financial Assistance: Received/ Not received

- a) Source - Govt/ Non Govt orgns/ Private Person
- b) From - (Age at which the subject began to receive)
- c) Period

9. Employment - Yes / No

- a) Place - Govt/Non-govt.
- b) Salary - below Rs. 500/Rs. 500-1000/Rs. 1000-2000/ Above 2000

10. Family History of Disability

- a) Parental Level
- b) Close relatives
- c) Distant relation

16 PF Form C

നിർദ്ദേശങ്ങൾ

നിങ്ങളുടെ താൽപര്യങ്ങളേയും സമീപന രീതികളേയും കുറിച്ചറിയാനുള്ള ഏതാനും ചോദ്യങ്ങളാണ് ഈ ചോദ്യാവലിയിൽ കൊടുത്തിരിക്കുന്നത്. മനോഭാവങ്ങളിലും താൽപര്യങ്ങളിലും ഓരോ വ്യക്തിയും വ്യത്യസ്തനായിരിക്കുന്നുവെന്നതിനാൽ ശരിയോ തെറ്റോ ആയ ഉത്തരങ്ങളില്ല.

ഓരോ ചോദ്യത്തിനും മൂന്ന് സാധ്യതകൾ ഉത്തരങ്ങളായി കൊടുത്തിട്ടുണ്ട്. അവയിൽ നിങ്ങൾക്ക് യോജിക്കുന്നത് ഉത്തരക്കടലാസ്സിൽ നിർദ്ദിഷ്ട സ്ഥാനത്ത് (X) എന്ന് അടയാളപ്പെടുത്തി സൂചിപ്പിക്കുക. 'ബി' ഉത്തരങ്ങൾ കഴിയുന്നതും ഒഴിവാക്കുക.

ഉത്തരമെഴുതുമ്പോൾ താഴെ പറയുന്ന കാര്യങ്ങൾ ശ്രദ്ധിക്കുക.

1. സത്യസന്ധവും നിങ്ങളെ സംബന്ധിച്ച് ശരിയുമായ ഉത്തരങ്ങൾ മാത്രം നൽകുക.
2. ഇത് സമയപരിധി ഇല്ലാത്ത ഒരു ടെസ്റ്റാണെങ്കിലും കഴിയുന്നത്ര വേഗതയിൽ ചെയ്തു തീർക്കുവാൻ ശ്രമിക്കണം. ചോദ്യങ്ങളെക്കുറിച്ച് കൂടുതൽ ചിന്തിച്ച് സമയം കളയാതെ ഓരോ ചോദ്യവും വായിക്കുമ്പോൾ തോന്നുന്ന ആദ്യത്തെ പ്രതികരണം രേഖപ്പെടുത്തണം.
3. ഉണ്ട് (എ) അല്ലെങ്കിൽ ഇല്ല (സി) എന്ന ഉത്തരങ്ങൾ തെരഞ്ഞെടുക്കാൻ തീരെ നിർവ്വഹമില്ലെങ്കിൽ മാത്രമേ (ബി) ഉത്തരങ്ങൾ ഉപയോഗിക്കാവൂ.
4. എല്ലാ ചോദ്യങ്ങൾക്കും ഉത്തരമെഴുതാൻ പ്രത്യേകം ശ്രദ്ധിക്കുക. നിങ്ങളുടെ ഉത്തരങ്ങൾ പരമ രഹസ്യമായി സൂക്ഷിക്കുന്നതായിരിക്കും.

1. മുൻപുണ്ടായിരുന്നതിനേക്കാൾ കൂടുതൽ ഓർമ്മശക്തി ഇപ്പോൾ നിങ്ങൾക്കുണ്ടോ ?
(എ) ഉണ്ട് (ബി) കുറച്ച് (സി) ഇല്ല
2. മറ്റുള്ളവരിൽ നിന്നകന്നുമാറി ഒരു സന്യാസിയെപ്പോലെ ഒറ്റക്ക് ജീവിക്കുവാൻ നിങ്ങൾക്ക് സാധിക്കുമോ?
(എ) അതെ (ബി) ചിലപ്പോൾ (സി) ഇല്ല
3. ആകാശം താഴെയുണ്ടെന്നും മഞ്ഞുകാലത്ത് ചൂടാണെന്നും പറയുന്ന ഒരാൾ ഒരു കുറ്റവാളിയെ എന്തു വിളിക്കും ?
(എ) അക്രമി (ബി) പുണ്യവാളൻ (സി) മോലം
4. വ്യത്തിഹീനരായ ആളുകളെ കണ്ടാൽ നിങ്ങൾ സ്വീകരിക്കുമോ ?
(എ) സ്വീകരിക്കും (ബി) ചിലപ്പോൾ മാത്രം (സി) അവരോട് വെറുപ്പ് തോന്നും
5. പരിചാരകരുടെ ജീവിതം മെച്ചപ്പെടുമ്പോൾ കാണാൻ നിങ്ങൾ ഇഷ്ടപ്പെടുമോ ?
(എ) അതേ (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല
6. ആഘോഷാവസരങ്ങളിൽ തമാശയും കഥകളും മറ്റുള്ളവർ ആദ്യം പറയട്ടെ എന്നാണോ നിങ്ങൾ കരുതുക ?
(എ) അതെ (ബി) ചിലപ്പോഴൊക്കെ (സി) അല്ല
7. നിങ്ങളുടെ ദൈനംദിനാവശ്യം കഴിഞ്ഞു മിച്ചം പണമുണ്ടെങ്കിൽ മറ്റുള്ളവരെ സഹായിക്കുന്നതിനായി ഉപയോഗിക്കാറുണ്ടോ ?
(എ) അതെ (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല
8. എന്തെങ്കിലും ചടങ്ങിൽ നിങ്ങളെ കണ്ടുമുട്ടിയാൽ നിങ്ങളുടെ പരിചയക്കാരിൽ അത് വാസ്തവത്തിൽ സന്തോഷമുളവാക്കുമോ ?
(എ) അതെ (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല

9. താഴെ പറയുന്നതിലേതുവിധത്തിൽ വ്യായാമം ചെയ്യാൻ നിങ്ങൾ ഇഷ്ടപ്പെടും ?
(എ) സൈക്കിൾ സവാരിയും നീന്തലും (ബി) 'എ' യും 'സി' യും (സി) കളിയും ഗുസ്തിയും
10. ആളുകളുടെ പറച്ചിലും പ്രവൃത്തിയും തമ്മിലുള്ള പൊരുത്തക്കേട് കാണുമ്പോൾ നിങ്ങൾക്ക് പരിഹാസം തോന്നാറുണ്ടോ ?
(എ) ഉണ്ട് (ബി) വല്ലപ്പോഴും (സി) ഇല്ല
11. നിങ്ങളുടെ കുട്ടിക്കാലത്ത് ഓരോ ദിവസവും സ്കൂളിൽ പോകുമ്പോൾ വിഷമം തോന്നിയിട്ടുണ്ടോ ?
(എ) ഉണ്ട് (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല
12. നിങ്ങൾ പ്രകടിപ്പിക്കുന്ന ഒരഭിപ്രായം മറ്റുള്ളവർ ശ്രദ്ധിക്കാതെ പോയാൽ നിങ്ങൾ എന്തുചെയ്യും ?
(എ) സാരമില്ല എന്നുവയ്ക്കും (ബി) എ യ്ക്കും സി യ്ക്കും ഇടയ്ക്ക് (സി) മറ്റുള്ളവർ ശ്രദ്ധിക്കുന്നതുവരെ അതാവർത്തിക്കും.
13. ആരെങ്കിലും നിങ്ങളോട് മോശമായി പെരുമാറിയെന്നു തോന്നിയാൽ നിങ്ങൾ -
(എ) അതത്ര ഗൗരവമുള്ളതല്ലെന്നു കരുതി മിണ്ടാതിരിക്കും (ബി) 'എ'യ്ക്കും 'സി' യ്ക്കും ഇടക്ക് (സി) നിങ്ങളുടെ നിലപാട് (അഭിപ്രായം) അയാളെ വ്യക്തമായി ബോധ്യപ്പെടുത്തും.
14. ആരെയെങ്കിലും നിങ്ങൾ പരിചയപ്പെട്ടാൽ
(എ) അയാളോട് നിങ്ങൾ രാഷ്ട്രീയത്തെക്കുറിച്ചും സാമൂഹിക ചിന്താഗതിയെക്കുറിച്ചും സൗഹാർദ്ദത്തോടെ സംവാദം നടത്തും (ബി) 'എ'യ്ക്കും 'സി'യ്ക്കും ഇടയ്ക്ക് (സി) നിങ്ങളോട് തമാശ പറയാൻ അനുവദിക്കും
15. നിങ്ങൾ സ്വയം ചെയ്തുതീർക്കുമെന്ന് പ്രതിജ്ഞ ചെയ്ത ജോലികൾ പരസഹായം തേടാതെ സ്വയം ചെയ്തുതീർക്കുന്നതിൽ അഭിമാനം കൊള്ളാറുണ്ടോ ?
(എ) ഉണ്ട് (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല
16. ഭൂതകാലത്തെക്കുറിച്ചോർക്കുന്നത് സമയം പാഴാക്കലാണെന്ന് തോന്നുന്നുണ്ടോ ?
(എ) ഉണ്ട് (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല
17. ധാരാളം സമയമുണ്ടെന്നറിയാമെങ്കിൽ കൂടി ഒരു തീവണ്ടിയാത്രക്കൊരുങ്ങുമ്പോൾ നിങ്ങൾ തിരക്കിടുകയും അസ്വസ്തനാകുകയും ചെയ്യാറുണ്ടോ ?
(എ) ഉണ്ട് (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല
18. മാതാപിതാക്കളോട് നൈമിഷികമായിട്ടെങ്കിലും നിങ്ങൾക്ക് വെറുപ്പ് തോന്നിയിട്ടുണ്ടോ ?
(എ) ഉണ്ട് (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല
19. ജോലിക്കാരിൽ നിന്നോ ഉപഭോക്താക്കളിൽ നിന്നോ ദിവസം മുഴുവനും പരാതി കേൾക്കേണ്ടി വരുന്ന ഒരു ജോലി നിങ്ങൾ ഏറ്റെടുക്കുമോ ?
(എ) അതെ (ബി) ചിലപ്പോൾ (സി) ഇല്ല
20. താഴെ പറയുന്നവയിൽ 'ഏകദേശം' എന്ന പദത്തിന്റെ വിപരീതമായിട്ടുള്ളതേത് ?
(എ) യാദൃശ്ചികം (ബി) കൃത്യം (സി) ഏകദേശം
21. കൂടുതൽ ശക്തിയും ഊർജ്ജവും ആവശ്യമുള്ള സമയങ്ങളിൽ അവ ആവശ്യത്തിന് നിങ്ങൾക്കുണ്ടാകാറുണ്ടോ ?
(എ) ഉണ്ട് (ബി) കുറച്ച് (സി) ഇല്ല
22. കൂടുതൽ ലൈംഗികതയുള്ള ചലച്ചിത്രങ്ങൾ കണ്ടാൽ/കേട്ടാൽ നിങ്ങൾക്ക് ലജ്ജയും കുറ്റബോധവും തോന്നാറുണ്ടോ ?
(എ) ഉണ്ട് (ബി) കുറച്ച് (സി) ഇല്ല
23. ധാരാളം ആളുകൾ പങ്കെടുക്കുന്ന സൽക്കാരവേളകളിലോ ആഘോഷാവസരങ്ങളിലോ നിങ്ങൾ പോകാറുണ്ടോ ?
(എ) അതെ (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല

- 24. നിങ്ങളുടെ അഭിപ്രായം
(എ) ചില ജോലികൾ മറ്റു ജോലികളുടെയത്ര ശ്രദ്ധയോടെ ചെയ്യേണ്ട ആവശ്യമില്ല (ബി) 'എ'യ്ക്കും 'സി'യ്ക്കും ഇടയ്ക്ക് (സി) ഏതു ജോലിയും ചെയ്യുന്നെങ്കിൽ നന്നായി ചെയ്യണം.
- 25. തെരുവിലൂടെ നടക്കുമ്പോൾ മറ്റുള്ളവർ നിങ്ങളെ ശ്രദ്ധിക്കുന്നത് നിങ്ങൾക്കിഷ്ടമാണോ ?
(എ) അതെ (ബി) ചിലപ്പോഴൊക്കെ (സി) അല്ല
- 26. താഴെ പറയുന്നതിൽ ആരായിത്തീരാനാണ് നിങ്ങൾ ആഗ്രഹിക്കുന്നത് ?
(എ) പുരോഹിതൻ (ബി) 'എ' യോ 'സി' യോ (സി) ഉയർന്ന സൈനികോദ്യോഗസ്ഥൻ
- 27. ചില നിസ്സാര കാര്യങ്ങളിൽ ഒരു അയൽവാസി നിങ്ങളെ പറ്റിക്കുകയാണെങ്കിൽ അയാളെ കുറ്റപ്പെടുത്തുന്നതിനേക്കാൾ നല്ലത് അയാളുമായി ലോഹ്യത്തിൽ കഴിയുകയാണ്
(എ) അതെ (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല
- 28. താഴെ പറയുന്നവയിൽ നിങ്ങൾ കാണാനിഷ്ടപ്പെടുന്നതേത് ?
(എ) നല്ല പുരാണ സിനിമ (ബി) 'എ' യോ 'സി' യോ (സി) സാമൂഹ്യ പുരോഗതിയെ ലക്ഷ്യമാക്കുന്ന നല്ല സിനിമയോ നാടകമോ
- 29. നിങ്ങളെ ഒരു ജോലിയേൽപ്പിച്ചാൽ ഒന്നുകിൽ സ്വന്തം രീതിയിൽ തന്നെ അവ ചെയ്യും അല്ലെങ്കിൽ രാജി വയ്ക്കും എന്ന് ശഠിക്കുമോ ?
(എ) അതെ (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല
- 30. ക്ഷീണിച്ചുപോകുമെന്നു കരുതി നിങ്ങൾ ആവേശകരമായ കാര്യങ്ങളിൽനിന്നു അകന്നു നിൽക്കാനാഗ്രഹിക്കുമോ ?
(എ) അതെ (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല
- 31. താഴെ പറയുന്നവയിൽ ഏതു കളിയ്ക്കാനാണ് നിങ്ങൾ ഇഷ്ടപ്പെടുന്നത് ?
(എ) ചെസ് (ബി) 'എ' യോ 'സി' യോ (സി) ഫുട്ബോൾ
- 32. കുഞ്ഞുങ്ങളെ വാക്സിനേറ്റു ചെയ്യുന്നതു ക്രൂരതയാണെന്നും മാതാപിതാക്കൾക്ക് അത് തടയാനുള്ള അവകാശം ഉണ്ടാകണം എന്നും നിങ്ങൾ കരുതുന്നുവോ ?
(എ) അതെ (ബി) രണ്ടിനുമിടക്ക് (സി) ഇല്ല
- 33. താഴെ പറയുന്നവയിലേതിൽ വിശ്വസിക്കുന്നതാണ് കൂടുതൽ നല്ലത് ?
(എ) ഇൻഷുറൻസ് (ബി) രണ്ടിനുമിടക്ക് (സി) വ്യക്തിപരമായ ഭാഗ്യം
- 34. മനോവിഷമങ്ങൾ പെട്ടെന്ന് മറക്കുന്ന ആളാണോ നിങ്ങൾ ?
(എ) അതെ (ബി) ഇടത്തരം (സി) അല്ല
- 35. നിങ്ങൾ ചെയ്തത് തെറ്റാണെന്ന് ബോധ്യമായാൽ അത് ഏറ്റുപറയാൻ പ്രയാസം തോന്നാറുണ്ടോ ?
(എ) ഉണ്ട് (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല
- 36. ഒരു ഓഫീസിൽ നിങ്ങൾ പണിയെടുക്കാൻ ഇഷ്ടപ്പെടുന്നത് -
(എ) സാങ്കേതികവകുപ്പിൽ (ബി) രണ്ടിനുമിടയ്ക്ക് (സി) ഇന്റർവ്യൂ ചെയ്യുകയും ആളുകളെ ജോലിക്കെടുക്കുകയും ചെയ്യുന്ന ഭരണവകുപ്പിൽ
- 37. താഴെ പറയുന്നവയിൽ ഏതുവാക്ക് മറ്റു രണ്ടു വാക്കുകളോട് യോജിക്കുന്നില്ല
(എ) പുച്ഛ (ബി) അരികെ (സി) സൂര്യൻ
- 38. മോശമായ ആരോഗ്യം മൂലം നിങ്ങളുടെ പരിപാടികളിൽ പലപ്പോഴും മാറ്റങ്ങൾ വരുത്തേണ്ടിവരാറുണ്ടോ?
(എ) ഉണ്ട് (ബി) മിക്കപ്പോഴും (സി) ഇല്ല
- 39. വ്യക്തിപരമായ ആവശ്യങ്ങൾക്ക് ജോലിക്കാരെ വയ്ക്കുന്നത് നിങ്ങൾക്കിഷ്ടമാണോ ?
(എ) അതെ (ബി) ചിലപ്പോഴൊക്കെ (സി) അല്ല
- 40. നന്നായി പെരുമാറാൻ കഴിയാത്തതുമൂലം നിങ്ങൾ കൂട്ടുകാരിൽനിന്നും ഒറ്റപ്പെടാറുണ്ടോ ?
(എ) ഉണ്ട് (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല

- 41. സദാചാര നിയമങ്ങൾ മനുഷ്യൻ കൂടുതൽ കർശനമായി പാലിക്കണമെന്ന് നിങ്ങൾക്ക് തോന്നാറുണ്ടോ?
(എ) അതെ (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല
- 42. നിങ്ങൾ ചിലപ്പോഴൊക്കെ മിണ്ടാൻ കഴിയാത്തത്ര കോപിഷ്ഠനാകാറുണ്ടോ ?
(എ) ഉണ്ട് (ബി) രണ്ടിനുമിടയ്ക്ക് (സി) ഇല്ല
- 43. ശാരീരികാധ്വാനം അധികം ആവശ്യമുള്ള പ്രവൃത്തികൾ പെട്ടെന്ന് ക്ഷീണിക്കാതെ മറ്റുള്ളവരേക്കാൾ കൂടുതൽ ചെയ്യാൻ നിങ്ങൾക്ക് കഴിയുമോ ?
(എ) അതെ (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല
- 44. സാഹചര്യങ്ങൾ വളരെ പ്രതികൂലമാവുന്ന അവസ്ഥയിലും മിക്ക സാക്ഷികളും സത്യം പറയാൻ തയ്യാറാവുമെന്ന് നിങ്ങൾ കരുതുന്നുവോ ?
(എ) അതെ (ബി) കുറേയൊക്കെ (സി) ഇല്ല
- 45. ചിന്തിക്കുമ്പോൾ അങ്ങോട്ടുമിങ്ങോട്ടും നടക്കുന്നത് നിങ്ങളുടെ ചിന്തയെ സഹായിക്കുമെന്ന് തോന്നുന്നുവോ ?
(എ) അതെ (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല
- 46. താഴെ പറയുന്നവയിൽ ഏതുകാര്യത്തിലാണ് നമ്മുടെ രാഷ്ട്രം കൂടുതൽ ധനം വിനിയോഗിക്കേണ്ടത് ?
(എ) യുദ്ധോപകരണങ്ങൾക്കായി (ബി) രണ്ടിനും (സി) വിദ്യാഭ്യാസത്തിനായി
- 47. ഒരു സായാഹ്നം ചെലവഴിക്കാൻ താഴെ പറയുന്നവയിൽ ഏത് നിങ്ങൾ ഇഷ്ടപ്പെടും.
(എ) വാശിയേറിയ ചീട്ടുകളി (ബി) രണ്ടും (സി) കഴിഞ്ഞ അവധിക്കാല ചിത്രങ്ങൾ കാണുക
- 48. താഴെ പറയുന്നവയിൽ നിങ്ങൾ കൂടുതലായി വായിക്കാനിഷ്ടപ്പെടുന്നതേത് ?
(എ) ഒരു നല്ല ചരിത്ര നോവൽ (ബി) രണ്ടും ഒരുപോലെ (സി) ആഗോളവിഭവങ്ങൾ എങ്ങനെ ഉപയോഗിക്കുമെന്നതിനെക്കുറിച്ച് ഒരു ശാസ്ത്രജ്ഞന്റെ ലേഖനം
- 49. ഈ ലോകത്തിൽ നല്ല മനുഷ്യരാണ് വിസ്തൃതങ്ങളേക്കാൾ കൂടുതലെന്ന് നിങ്ങൾ വിശ്വസിക്കുന്നുവോ ?
(എ) അതെ (ബി) കുറേയൊക്കെ (സി) ഇല്ല
- 50. സ്വന്തം ജോലിയിൽ നിങ്ങൾ മറ്റുപലരേക്കാളും കൂടുതലായി കഴിവും സാമർത്ഥ്യവും പ്രകടിപ്പിക്കാറുണ്ടോ ?
(എ) അതെ (ബി) മിക്കപ്പോഴും (സി) ഇല്ല
- 51. മറ്റാരെയും കാണാൻ തോന്നാത്തവിധം ദുഃഖിതനും നിരുത്സാഹവാനുമായി ചിലപ്പോഴെങ്കിലും നിങ്ങൾക്ക് സ്വയം അനുഭവപ്പെടാറുണ്ടോ ?
(എ) വളരെ ചുരുക്കമായി (ബി) ചിലപ്പോഴൊക്കെ (സി) മിക്കപ്പോഴും
- 52. നിങ്ങൾ ചെയ്യുന്നത് പൂർണ്ണ ബോധ്യമുള്ളപ്പോഴൊക്കെ അത് എളുപ്പമായി ചെയ്യാൻ നിങ്ങൾക്ക് കഴിയുമോ ?
(എ) അതെ (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല
- 53. താഴെപ്പറയുന്നവയിൽ ഏതു ജോലി നിങ്ങൾ ഇഷ്ടപ്പെടുന്നു.
(എ) ഓഫീസിലെ മാനേജർ (ബി) 'എ' യ്ക്കും 'സി' ക്കും ഇടയ്ക്ക് (സി) കെട്ടിടങ്ങളുടെ പ്ലാൻ വരക്കുന്ന ആർക്കിടെക്റ്റ്
- 54. കറുപ്പ് ചാരനിറത്തിനോട് എന്നപോലെ വേദനയ്ക്ക്
(എ) മുറിവ് (ബി) രോഗം (സി) അസ്വസ്ഥത
- 55. ഉറക്കത്തിൽ സംസാരിക്കുകയോ നടക്കുകയോ ചെയ്യാതെ സുഖനിദ്രയുള്ള ആളാണോ നിങ്ങൾ
(എ) അതെ (ബി) ചിലപ്പോഴൊക്കെ (സി) അല്ല
- 56. സുഹൃത്തിനോട് മനഃപൂർവ്വം നൂണ പറഞ്ഞശേഷം നിങ്ങൾക്ക് അയാളെ ലജ്ജയില്ലാതെ അഭിമുഖീകരിക്കാൻ കഴിയുമോ ?
(എ) അതെ (ബി) ചിലപ്പോൾ (സി) ഇല്ല

- 57. സാമൂഹിക ചടങ്ങുകൾ സംഘടിപ്പിക്കുന്നതിന്നു നിങ്ങൾ എപ്പോഴെങ്കിലും ഊർജ്ജസ്വലമായി പങ്കെടുത്തിട്ടുണ്ടോ ?
(എ) ഉണ്ട് (ബി) വല്ലപ്പോഴും (സി) ഇല്ല
- 58. നിങ്ങൾ കൂടുതൽ ആരാധിക്കുന്നത് ?
(എ) ബുദ്ധിമാനായ വിശ്വസിക്കാനാവാത്ത ഒരാളെ (ബി) രണ്ടിനുമിടയ്ക്ക് (സി) പ്രലോഭനങ്ങളെ അതിജീവിക്കാനുള്ള മനഃശക്തിയുള്ള ഒരു സാധാരണക്കാരനെ
- 59. ന്യായമായ ഒരു പരാതി ഉന്നയിച്ചുകഴിഞ്ഞാൽ നിങ്ങൾക്ക് സാധാരണയായി സംതൃപ്തി തോന്നാറുണ്ടോ?
(എ) ഉണ്ട് (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല
- 60. നിരുത്സാഹപ്പെടുത്തുന്ന ചുറ്റുപാടുകൾ നിങ്ങളെ കരച്ചിലിന്റെ വക്കുവരെ എത്തിക്കാറുണ്ടോ?
(എ) ഉണ്ട് (ബി) വല്ലപ്പോഴും (സി) ഇല്ല
- 61. നമ്മൾ വിചാരിക്കുന്നതിലധികം സൗഹൃദം പല വിദേശരാജ്യങ്ങൾക്കും നമ്മോടുണ്ടെന്ന് നിങ്ങൾ കരുതുന്നുണ്ടോ ?
(എ) അതെ (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല
- 62. മറ്റുള്ളവരിൽ നിന്നകന്ന് സ്വന്തം ചിന്തകളിൽ മുഴുകാൻ ഇഷ്ടപ്പെടുന്ന അവസരങ്ങൾ എല്ലാ ദിവസവും ഉണ്ടാകാറുണ്ടോ?
(എ) ഉണ്ട് (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല
- 63. ശാന്തനായിരിക്കുന്ന സമയങ്ങളിൽ നിങ്ങൾ അംഗീകരിക്കുന്ന ചെറിയ നിയമങ്ങളും നിയന്ത്രണങ്ങളും മറ്റും ചിലപ്പോൾ നിങ്ങളെ അലട്ടാറുണ്ടോ?
(എ) ഉണ്ട് (ബി) കുറേയൊക്കെ (സി) ഇല്ല
- 64. ശിക്ഷക്കെതിരായുള്ള ആധുനിക രീതിയേക്കാൾ നല്ലതാണ് ശിക്ഷ നൽകിയുള്ള പഴയ വിദ്യാഭ്യാസ സമ്പ്രദായം എന്ന് നിങ്ങൾ കരുതുന്നുവോ?
(എ) അതെ (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല
- 65. നിങ്ങൾ സ്കൂൾ ജീവിതത്തിൽ കൂടുതലായി പഠിച്ചത്?
(എ) ക്ലാസിൽ പോയിട്ട് (ബി) രണ്ടിനുമിടയ്ക്ക് (സി) പുസ്തകം വായിച്ച്
- 66. ചെറിയ സാമൂഹിക ബാധ്യതകളിൽ നിന്നും കഴിയുന്നത്ര അകന്നുനിൽക്കാനാണോ നിങ്ങൾ ശ്രമിക്കുക?
(എ) അതെ (ബി) ചിലപ്പോഴൊക്കെ (സി) അല്ല
- 67. ഒരു പ്രശ്നം കൂടുതൽ പ്രയാസമുള്ളതായി തോന്നിയാൽ നിങ്ങൾ -
(എ) വേറൊരു പ്രശ്നമെടുക്കും (ബി) ഏ ക്കും സി ക്കും ഇടക്ക് (സി) അതേ പ്രശ്നത്തെ വേറൊരു രീതിയിൽ സമീപിക്കും.
- 68. വ്യക്തമായ കാരണങ്ങളില്ലാതെ തന്നെ നിങ്ങൾക്ക് അതിയായ ആധി, കോപം, ചിരി ഇവ ഉണ്ടാകാറുണ്ടോ?
(എ) ഉണ്ട് (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല
- 69. ചില സമയങ്ങളിൽ മറ്റു സന്ദർഭങ്ങളിലുള്ളത്ര നന്നായി ശ്രദ്ധ കേന്ദ്രീകരിക്കാൻ കഴിയാറില്ലെന്ന് നിങ്ങൾക്ക് തോന്നുന്നുണ്ടോ?
(എ) അതെ (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല
- 70. മറ്റുള്ളവരുടെ സൗകര്യം കണക്കിലെടുത്ത് നിങ്ങൾ പ്രവൃത്തികളുടെ സമയം ക്രമീകരിക്കുമോ?
(എ) അതെ (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല
- 71. ഈ സംഖ്യാശ്രേണി പൂർത്തിയാക്കാൻ നിങ്ങൾ ഏത് സംഖ്യകൾ കൂട്ടിച്ചേർക്കും? 1, 2, 3, 6, 5,
(എ) 10 (ബി) 5 (സി) 7
- 72. മറ്റുള്ളവരുടെ പ്രവൃത്തികളെ നിങ്ങൾ വിമർശിക്കാറുണ്ടോ?
(എ) ഉണ്ട് (ബി) വല്ലപ്പോഴും (സി) ഇല്ല
- 73. അഹംഭാവങ്ങളും ഡംഭേമാരുമായവരുടെ സാന്നിദ്ധ്യം നിങ്ങളെ അസന്ദമനാക്കാറുണ്ടോ?
(എ) ഉണ്ട് (ബി) വല്ലപ്പോഴും (സി) ഇല്ല

- 74. ഏതവസരത്തിലും യാത്ര ചെയ്യുവാൻ നിങ്ങൾ ഇഷ്ടപ്പെടുന്നുണ്ടോ?
(എ) അതെ (ബി) വല്ലപ്പോഴും (സി) ഇല്ല
- 75. പെട്ടെന്ന് ഉണ്ടായ വേദന കൊണ്ടോ രക്തം കണ്ടിട്ടോ എപ്പോഴെങ്കിലും നിങ്ങൾക്ക് മോഹാലസ്യം പോലെ വന്നിട്ടുണ്ടോ ?
(എ) ഉണ്ട് (ബി) ചിലപ്പോഴെല്ലാം (സി) ഇല്ല
- 76. ആനുകാലിക പ്രശ്നങ്ങളെക്കുറിച്ച് മറ്റുള്ളവരുമായി സംസാരിച്ചിരിക്കാൻ നിങ്ങൾക്കിഷ്ടമാണോ ?
(എ) അതേ (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല
- 77. താഴെ പറയുന്നവയിൽ ആരാകാൻ നിങ്ങൾ ഇഷ്ടപ്പെടുന്നു?
(എ) എഞ്ചിനീയർ (ബി) രണ്ടും ഒരുപോലെ (സി) സാമൂഹിക സിദ്ധാന്തങ്ങൾ പഠിപ്പിക്കുന്ന ടീച്ചർ
- 78. മറ്റുള്ളവരുടെ പ്രശ്നങ്ങളിൽ ഇടപെടുകയോ അതു പരിഹരിക്കാൻ ശ്രമിക്കുകയോ ചെയ്യാനുള്ള പ്രവണത നിങ്ങൾക്ക് സ്വയം നിയന്ത്രിക്കേണ്ടി വരാറുണ്ടോ ?
(എ) ഉണ്ട് (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല
- 79. നിങ്ങളുടെ അയൽക്കാരിൽ എത്ര പേരോട് സംസാരിക്കുന്നത് ബോറടിയാടി നിങ്ങൾക്കനുഭവപ്പെടാറുണ്ട് ?
(എ) എല്ലാവരോടും തന്നെ (ബി) ചിലരോട് (സി) ആരോടും ഇല്ല
- 80. നിങ്ങൾ വായിക്കുന്നതിൽ പ്രചരണത്തിന്റെ അംശങ്ങൾ ഉണ്ടെങ്കിൽ മറ്റുള്ളവർ ചൂണ്ടിക്കാണിച്ചുതരാതെ നിങ്ങളത് മനസ്സിലാക്കുമോ?
(എ) അതെ (ബി) ചിലപ്പോൾ (സി) ഇല്ല
- 81. ഏതു കഥയിലും ഒരു ഗുണപാഠമുണ്ടായിരിക്കണമെന്ന് നിങ്ങൾ കരുതുന്നുവോ?
(എ) അതെ (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല
- 82. ഏതു വ്യവസായത്തിലും കൂടുതൽ പ്രശ്നമുണ്ടാക്കുന്നത് താഴെ പറയുന്നവയിൽ ഏതു കൂട്ടരാണെന്നാണ് നിങ്ങളുടെ വിശ്വാസം ?
(എ) നിലവിലുള്ള രീതികളെ മാറ്റുകയും വ്യത്യാസപ്പെടുത്തുകയും ചെയ്യുന്നവർ (ബി) ഇരുതരക്കാരും (സി) പുതിയ രീതികൾ നടപ്പിലാക്കാൻ വിസമ്മതിക്കുന്നവർ
- 83. പ്രായോഗികമല്ലേ എന്ന സംശയം കാരണം സ്വന്തം അഭിപ്രായങ്ങളും ആശയങ്ങളും പ്രായോഗികമാക്കുവാൻ നിങ്ങൾ ചിലപ്പോൾ മടിക്കാറുണ്ടോ ?
(എ) ഉണ്ട് (ബി) കുറേയൊക്കെ (സി) ഇല്ല
- 84. നിങ്ങളെ കാണുന്നതുതന്നെ വെറുപ്പാണെന്ന മട്ടിൽ ചില അഹംഭാവികളായ ആളുകൾ പെരുമാറാറുണ്ടോ?
(എ) ഉണ്ട് (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല
- 85. മറ്റുള്ളവരുടെ മുമ്പിൽ നാണക്കേടുണ്ടാകാത്തവിധം വിശ്വസനീയമായ ഓർമ്മശക്തിയുടെ ഉടമയാണോ നിങ്ങൾ ?
(എ) അതെ (ബി) ഇടത്തരം (സി) ഇല്ല
- 86. മറ്റുള്ളവർ നിങ്ങളോട് പെരുമാറുന്നതിനേക്കാൾ മോശമായ രീതിയിലാണോ നിങ്ങൾ അവരെ കരുതുക
(എ) അതെ (ബി) ചിലപ്പോൾ (സി) അല്ല
- 87. സംസാരിക്കുമ്പോൾ മറ്റുള്ളവരേക്കാൾ സാവധാനത്തിലാണോ നിങ്ങൾ പ്രതികരിക്കുക ?
(എ) അതെ (ബി) ചിലപ്പോൾ (സി) അല്ല
- 88. ഒരു വാച്ചിന്റെ രണ്ടു സൂചികൾ 65 മിനുട്ട് കൂടുമ്പോൾ ഒരുമിക്കുന്നു എങ്കിൽ വാച്ച് ഓടുന്നത് ?
(എ) മെല്ലെയാണ് (ബി) കൃത്യമാണ് (സി) വേഗത്തിലാണ്
- 89. മറ്റുള്ളവർക്കുവേണ്ടി കാത്തുനിൽക്കേണ്ടി വന്നാൽ നിങ്ങൾക്ക് വല്ലാത്ത ക്ഷോഭം വരുമോ ?
(എ) അതെ (ബി) ചുരുക്കമായി (സി) ഇല്ല
- 90. നിങ്ങൾ അഹംഭാവിയും അൽപ്പനൂമാണെന്ന് മറ്റുള്ളവർ കരുതാറുണ്ടോ ?
(എ) ഉണ്ട് (ബി) വല്ലപ്പോഴും (സി) ഇല്ല

- 91. ജോലി ചെയ്യാനുള്ള ശരിയായ സാമഗ്രികൾ കിട്ടിയില്ലെങ്കിൽ പരാതി പറയണോ എന്ന് സാവധാനത്തിലാണോ നിങ്ങൾ തീരുമാനിക്കുക?
(എ) അതെ (ബി) ചിലപ്പോഴൊക്കെ (സി) അല്ല
- 92. വീട്ടിൽ നിങ്ങൾ -
(എ) വിശ്രമസമയം കൊച്ചുവർത്തമാനം പറഞ്ഞ് ഉല്ലസിക്കും (ബി) രണ്ടും (സി) പ്രത്യേക ജോലികൾ ചെയ്യുവാൻ ഉപയോഗിക്കും
- 93. മറ്റുള്ളവരുമായി സൗഹൃദം സ്ഥാപിക്കുന്നതിൽ നിങ്ങൾ മെല്ലെയാണോ ?
(എ) അതെ (ബി) വല്ലപ്പോഴും (സി) അല്ല
- 94. ആളുകൾ കവിതയിൽ പറയാൻ ശ്രമിക്കുന്ന കാര്യങ്ങൾ സാധാരണ ഗദ്യത്തിൽ നേരെ പറഞ്ഞാൽ പോരെ എന്നു നിങ്ങൾ ചിന്തിക്കാറുണ്ടോ ?
(എ) ഉണ്ട് (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല
- 95. സൗഹൃദം ഭാവിക്കുന്നവർ ചിലപ്പോൾ ചതിക്കുമെന്ന് നിങ്ങൾ സംശയിക്കാറുണ്ടോ ?
(എ) ഉണ്ട് (ബി) കുറേയൊക്കെ (സി) ഇല്ല
- 96. നിങ്ങളിൽ കാര്യമായ യാതൊരു മാറ്റവുമുണ്ടാക്കാതെയോണോ നിങ്ങളുടെ ഈ വർഷത്തെ ഏറ്റവും നാടകീയമായ അനുഭവങ്ങൾ കടന്നുപോകുന്നുത് ?
(എ) അതെ (ബി) ചിലപ്പോഴൊക്കെ (സി) അല്ല
- 97. നിങ്ങൾ സാവധാനമാണോ സംസാരിക്കുക ?
(എ) അതെ (ബി) ചിലപ്പോഴൊക്കെ (സി) അല്ല
- 98. നിങ്ങൾക്കു ചില കാര്യങ്ങളിൽ ഉള്ള ഭയമോ അനിഷ്ടമോ നിയന്ത്രിക്കാൻ കഴിയാതെ വരാറുണ്ടോ? ഉദാഹരണമായി ഒരു മൃഗം, ഒരു പ്രത്യേക സ്ഥലം മുതലായവ
(എ) അതെ (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല
- 99. ഒരു സംഘത്തിൽ താഴെപറയുന്നവയിലേതാകാൻ നിങ്ങൾ ഇഷ്ടപ്പെടും
(എ) സാങ്കേതിക പുരോഗതിക്കുവേണ്ടി പണിയെടുക്കുന്നയാൾ (ബി) രണ്ടിലേതെങ്കിലും (സി) റിക്കാർഡുകൾ സൂക്ഷിക്കുകയും നിയമങ്ങൾ പാലിക്കപ്പെടുന്നോ എന്ന് പരിശോധിക്കുകയും ചെയ്യുന്ന ആൾ
- 100. ഒരു സാമൂഹിക പ്രശ്നത്തെപ്പറ്റിയുള്ള വോട്ടെടുപ്പിൽ ഏതഭിപ്രായം രേഖപ്പെടുത്തണമെന്ന് തീരുമാനിക്കാൻ നിങ്ങൾ താഴെ പറയുന്നവയിൽ ഏതു വായിക്കും
(എ) അതേക്കുറിച്ചുള്ള ഒരു നല്ല നോവൽ വായിക്കും (ബി) രണ്ടിലേതെങ്കിലും (സി) സ്ഥിതി വിവരകണക്കുകളും മറ്റു വസ്തുതകളും അടങ്ങുന്ന ഒരു പുസ്തകം വായിക്കും.
- 101. രാത്രിയിൽ നിങ്ങൾ തികച്ചും അത്ഭുതകരവും അർത്ഥശൂന്യവും ആയ സ്വപ്നങ്ങൾ കാണാറുണ്ടോ ?
(എ) ഉണ്ട് (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല
- 102. വീട്ടിൽ തികച്ചും ഏകാകിയായി കുറച്ചു സമയം ചിലവഴിക്കേണ്ടി വന്നാൽ ആധിയും ഭയവുമുണ്ടാകുമോ?
(എ) അതെ (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല
- 103. തീരെ ഇഷ്ടമില്ലാത്ത ആളുകളോട് സൗഹൃദം ഭാവിച്ച് അവരെ നിങ്ങൾ വഞ്ചിക്കാൻ ശ്രമിക്കാറുണ്ടോ?
(എ) ഉണ്ട് (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല
- 104. ഏതാണ് മറ്റു രണ്ടിനോടും യോജിക്കാത്തത് ?
(എ) ഓടുക (ബി) കാണുക (സി) തൊടുക
- 105. സീതയുടെ അമ്മ മോഹന്റെ അച്ഛന്റെ പെങ്ങളായാൽ മോഹന് സീതയുടെ അച്ഛനോടുള്ള ബന്ധം
(എ) സഹോദരൻ (ബി) അനന്തിരവൻ (സി) അമ്മാവൻ/ചിറ്റപ്പൻ

Department of Psychology

CALICUT UNIVERSITY

LIFE-CHANGE EVENTS INVENTORY

നിർദ്ദേശങ്ങൾ:-

ദൈനംദിന ജീവിതവുമായി ബന്ധപ്പെട്ട ഏതാനും പ്രസ്താവനകൾ താഴെ കൊടുത്തിരിക്കുന്നു. കഴിഞ്ഞ ഒരു വർഷത്തെ നിങ്ങളുടെ അനുഭവം വെച്ച് നോക്കുമ്പോൾ സ്വീകാര്യമായി തോന്നുന്ന പ്രസ്താവനകളുടെ ക്രമനമ്പറിൽ ശരി അടയാളം രേഖപ്പെടുത്തുക. നിങ്ങൾക്ക് ഇല്ലാത്ത അനുഭവമായാൽ കൂടിയും അവ ഉണ്ടായാൽ ഉള്ള പ്രത്യാഘാതം രേഖപ്പെടുത്തുക. ഓരോ സംഭവവും നിങ്ങളിൽ ഉണ്ടാക്കിയേക്കാവുന്ന പ്രത്യാഘാതം 1 മുതൽ 5 വരെയുള്ള തോതിൽ അടയാളപ്പെടുത്തുക.

- 1- വളരെ കുറവ്
- 5- വളരെ കൂടുതൽ

- | | |
|---|-------------|
| 1. ഭാര്യയുടേയോ/ഭർത്താവിന്റെയോ മരണം |
1 |
| 2. താനോ അടുത്ത ബന്ധുവോ ജയിൽ ശിക്ഷയ്ക്കു വിധേയമായത്. |
2 |
| 3. വളരെ അടുത്ത ബന്ധുവിന്റെ മരണം. |
3 |
| 4. കുടുംബത്തിൽ ഒരാളുടെ ഗൗരവമേറിയ മാനസികരോഗം. |
4 |
| 5. ഉദ്യോഗത്തിൽനിന്ന് താൽക്കാലികമായോ സ്ഥിരമായോ പിരിച്ചുവിട്ടത്. |
5 |
| 6. വേർപെട്ടു താമസിക്കൽ/വിവാഹമോചനം. |
6 |
| 7. വ്യവസായത്തിലെ പരാജയം. |
7 |
| 8. മകനോ, മകളോ വീട് വിട്ട് പോയത്. |
8 |
| 9. ഗൗരവമേറിയ രോഗമോ, മുറിവോ മൂലം ആസ്പത്രിയിൽ കഴിയേണ്ടി വന്നത് അഥവാ ഒരു മാസത്തേക്ക് ഉദ്യോഗത്തിൽനിന്ന് വിട്ടു നിൽക്കേണ്ടിവന്നത്. |
9 |
| 10. കുടുംബത്തിൽ ഒരാളുടെ ഗുരുതരമായ രോഗം. |
10 |
| 11. സന്താനങ്ങൾ ഇല്ലായ്മ. |
11 |
| 12. ദാമ്പത്യ സംഘർഷങ്ങൾ. |
12 |
| 13. ഭാരിച്ച കടബാധ്യതയിൽപ്പെട്ടത്. |
13 |
| 14. സുഹൃത്തിന്റെ മരണം. |
14 |

- 15 15. ദാമ്പത്യപ്രശ്നങ്ങളല്ലാത്ത കാരണങ്ങളാൽ ഭാര്യയിൽ നിന്ന്/ഭർത്താവിൽ നിന്ന് വേർപെട്ടു ജീവിക്കേണ്ടി വന്നത്.
- 16 16. പരീക്ഷയിലെ തോൽവി.
- 17 17. ഭാര്യയുടെ/ഭർത്താവിന്റെ ദാമ്പത്യേതര ബന്ധങ്ങൾ.
- 18 18. ഉദ്യോഗം നിഷേധിക്കപ്പെട്ടത്.
- 19 19. കുടുംബാംഗം വീട് വിട്ട് പോയത്.
- 20 20. വസ്തുവകകൾ/വിളവ് നശിച്ചത്.
- 21 21. പോലീസ്/സർക്കാർ അധികൃതരുമായുള്ള ഗൗരവമായ പ്രശ്നം.
- 22 22. നിങ്ങളുടെ/കുടുംബത്തിലൊരാളുടെ തൊഴിലില്ലായ്മ.
- 23 23. അസാധാരണമായ പ്രസവം.
- 24 24. മോശമായ ഒരു പ്രദേശത്തേക്ക് താമസം മാറ്റിയത്.
- 25 25. ആഗ്രഹിക്കാത്ത ഗർഭധാരണം.
- 26 26. ഉദ്യോഗത്തിൽ നിന്ന് റിട്ടയർ ചെയ്തത്.
- 27 27. കുടുംബാംഗത്തിന്റെ മദ്യത്തിന്റെയോ, മയക്കുമരുന്നിന്റെയോ ഉപയോഗം.
- 28 28. സാമ്പത്തിക നഷ്ടമോ പ്രശ്നങ്ങളോ.
- 29 29. സന്താനത്തിന്റെയോ, ആശ്രിത സഹോദരിയുടെയോ വിവാഹം.
- 30 30. സ്വന്തം ദാമ്പത്യേതര ബന്ധങ്ങൾ.
- 31 31. കവർച്ചയോ കള്ളവോ സംഭവിച്ചത്.
- 32 32. കുടുംബപരമായ സംഘർഷം.
- 33 33. ഒരു മകനില്ലാത്ത അവസ്ഥ.
- 34 34. സ്ത്രീധനത്തെ സംബന്ധിച്ച പ്രശ്നം.
- 35 35. ലൈംഗിക പ്രശ്നങ്ങൾ.
- 36 36. ഭാര്യയുടെയോ/ഭർത്താവിന്റെയോ ബന്ധുക്കളുമായുള്ള സംഘർഷങ്ങൾ.
- 37 37. കുടുംബാംഗം ഉദ്യോഗം ഉപേക്ഷിച്ചത്.
- 38 38. പരീക്ഷക്കോ, ഇന്റർവ്യൂവിനോ ഹാജരായതോ അതിനായി തയ്യാറെടുപ്പ് നടത്തിയതോ.
- 39 39. തകർന്ന വിവാഹനിശ്ചയം/പ്രേമബന്ധം.

40. വ്യവസായം മാറുകയോ, വിപുലീകരിക്കുകയോ ചെയ്തത്.	40
41. ഒരു പ്രധാന സാധനം വാങ്ങിയത്/കെട്ടിടം പണിതത്.	41
42. ഭാര്യ/ഭർത്താവ് ഉദ്യോഗത്തിന് പോയിതുടങ്ങുകയോ ഉദ്യോഗം ഉപേക്ഷിക്കുകയോ ചെയ്തത്.	42
43. ജോലി സ്ഥലത്ത് സഹപ്രവർത്തകരുമായുണ്ടായ പ്രശ്നങ്ങൾ.	43
44. ഏറ്റെടുത്ത കാര്യം പൂർത്തിയാക്കാൻ കഴിയാതെ വന്നത്.	44
45. ഗർഭച്ഛിദ്രം നടത്തേണ്ടിവന്നത്.	45
46. വിവാഹം കഴിച്ചത്.	46
47. വീട്ടിൽ ഒരംഗം കൂടി വന്നുചേർന്നത്.	47
48. കുഞ്ഞിന്റെ ജനനം.	48
49. ഓമനിച്ചു വളർത്തിയ ജന്തുവിന്റെയോ, വീട്ടുമൃഗത്തിന്റെയോ മരണം.	49
50. സുഹൃത്തുമായി ബന്ധം വിടർത്തിയത്.	50
51. തൊഴിൽ സാഹചര്യത്തിലുണ്ടായ മാറ്റങ്ങൾ/സ്ഥലംമാറ്റം.	51
52. ഗർഭം അലസിപ്പോയത്	52
53. മകളുടെ ജനനം.	53
54. വന്ധ്യംകരണത്തിന് വിധേയമായത്.	54
55. പോലീസുമായോ സർക്കാർ അധികൃതരുമായുള്ള ചില്ലറ പ്രശ്നം.	55
56. സ്കൂൾ വിദ്യാഭ്യാസമോ മറ്റേതെങ്കിലും പുതിയ പഠനമോ ആരംഭിച്ചത്/അവസാനിപ്പിച്ചത്.	56
57. പ്രേമബന്ധത്തിൽപ്പെട്ടത്.	57
58. അയൽക്കാരുമായുള്ള പ്രശ്നം.	58
59. ആശിച്ച ഗർഭധാരണം.	59
60. വിവാഹം നിശ്ചയിച്ചത്.	60
61. ജ്യോത്സ്യപ്രവചനം.	61
62. സാമൂഹിക പ്രവർത്തനങ്ങളിലെ മാറ്റം.	62
63. കൂടുംബപരമായ ചടങ്ങുകളുടെ കുറവ്.	63
64. വ്യക്തിപരമായി വർന്നേട്ടം കൈവരിച്ചത്.	64

65

65. അവധിയിലോ, തീർത്ഥാടനത്തിനോ പോയത്.

66

66. ഉറക്കശീലത്തിൽ ഉണ്ടായ മാറ്റം.

67

67. ഭക്ഷണരീതിയിൽ വന്ന മാറ്റം.

Code.....

AGE :

RELIGION :

SEX :

MARITAL STATUS : M/UM

OCCUPATION : WORKING

EDUCATIONAL :

NON-WORKING

QUALIFICATION :

STUDENT

CODE NO. :

DOMICILE : URBAN/RURAL/SUB URBAN

PGI GENERAL WELLBEING MEASURE

പേര് :
 വയസ്സ് :
 സ്ത്രീ/പുരുഷൻ :
 വിലാസം :

നിർദ്ദേശം:- ദൈനംദിന ജീവിതത്തെ വിലയിരുത്താനുതകുന്ന ഏതാനും പ്രസ്താവനകൾ താഴെ കൊടുത്തിരിക്കുന്നു. കഴിഞ്ഞ ഒരു മാസത്തെ നിങ്ങളുടെ അനുഭവങ്ങളുടെ വെളിച്ചത്തിൽ സ്വീകാര്യമായി തോന്നുന്ന പ്രസ്താവങ്ങൾക്കു നേരെ () അടയാളം രേഖപ്പെടുത്തുക. നിങ്ങളുടെ അഭിപ്രായങ്ങൾ ഗവേഷണത്തിന് മാത്രമേ ഉപയോഗിക്കുകയുള്ളൂ.

- 1 ഓജസ്സോടുകൂടിയതായിരുന്നു.
- 2 വികാരങ്ങളും പെരുമാറ്റവും പരിപൂർണ്ണനിയന്ത്രണത്തിൽ ആയിരുന്നു.
- 3 സ്വകാര്യ ജീവിതത്തിൽ തീർത്തും സംതൃപ്തിയുണ്ട്.
- 4 ജീവിതത്തോടു ഏറെ പ്രതിപത്തിയുണ്ട്.
- 5 സുഖമായി ഉറങ്ങാറുണ്ട്.
- 6 പലപ്പോഴും വൈകാരികമായ പകപതയും സ്ഥിരതയുമുണ്ട്.
 മിക്കപ്പോഴും മാനസികസംഘർഷമില്ലാത്ത വിശ്രമാവസ്ഥ അനുഭവപ്പെടുന്നു.
 മിക്കപ്പോഴും ഊർജ്ജസ്വലനാണെന്ന് അനുഭവപ്പെടുന്നു.
- 9 മിക്കപ്പോഴും ഉത്സാഹവും സന്തോഷവും തോന്നുന്നു.
- 10 പരിഭ്രമമോ സങ്കോചമോ അലട്ടാറില്ല.
- 11 പുതംകണ്ഠയോ ആശങ്കയോ തോന്നാറില്ല.
- 12 ചഗം ക്ഷീണിക്കാറില്ല.
- 13 ദുഃഖം, രോഗം എന്നിവ വിഷമിപ്പിക്കാറില്ല.
- 14 ദുഃഖമോ സങ്കടമോ തോന്നാറില്ല.
- 15 ജീവിതം പൊതുവേ തൃപ്തികരമാണ്.
- 16 സ്മാരണയായി പെട്ടെന്ന് ശൂണ്ഠി പിടിക്കാറില്ല.
- 17 എഴുതുകയോ ആവശ്യമുണ്ട്, ഉപയോഗമുണ്ട് എന്നൊക്കെ തോന്നാറുണ്ട്.
- 18 ജീവനും ക്രിയാത്മകവും ഫലപ്രദവുമാണെന്നു തോന്നുന്നു.
- 19 ഞാനല്ലാറിന്റേയും ഒരു ഭാഗമാണെന്നു തോന്നുന്നു.
- 20 ആര്യേകരമായ സ്ഥിതിയിലാണ്.

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