EXPRESSED WILLINGNESS TO PARENT HANDICAPPER CHILDREN

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ABSTRACT

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By contrasting discussions of prejudice with current and historial conceptualizations of attitudes toward handicappers, the opening chapters presented fundamental paradoxes in determining the existance of negative valuation of handicappers. The purpose of this study was to demonstrate the negative valuation of handicapper children, the socially stereotyped manner in which such negative valuation occurred, and some factors that could tend to mask or mediate the expression of negative valuation. This was done by asking potential parents their willingness to parent various types of children.

Two hundred twenty college students who had expressed a desire to have children rated 11 descriptions of children (1 tab description and 10 handicapper descriptions) on four scales of expressed willingness to parent. Each scale represented a different parenting behavior or context suggesting progressively closer personal social distance, i.e. willingness to adopt,

to avoid conception, to abort, and to place for adoption. A fifth scale was used to assess attitudes toward each of the four parenting contexts.

Results indicated the existance of common preference hierarchies (stereotyped preference patterns) in each parenting context except place for adoption. In all four parenting contexts, however, the tab child was rated more positively than any of the handicapper children. More importantly, a correlational analysis suggested that in each parenting context the handicapper children were responded to as components of a common cluster distinct from the tab child. This was interpreted as additional evidence of socially stereotyped negative valuation of handicapper children.

Finally, the parenting contexts were shown to be significant factors in influencing ratings and in fact were proportionately more influential than the child descriptions. This was especially true of the place for adoption context, in which very little differentiation in ratings between tab and handicapper descriptions or among handicapper descriptions occurred. Although it was assumed that the mediation of ratings would be directly related to the personal social distance implied by the parenting context, this did not prove to be the case. In general, however, the context in which

attitudes toward handicapper children were ellicited did prove to have a significant masking or mediating effect. These results were discussed in the context of current conceptions of attitudes toward handicappers, with implications for future research, social programs, and social change.

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CHAPTER I

INTRODUCTION

Paradox: In the midst of national campaigns to promote positive attitudes towards individuals classified as defective (e.g. the White House Conference On Handicapped Individuals), there are concurrent national campaigns to "wipe out birth defects."

The ethics of eugenics and euthanasia are classical questions in our culture (Fletcher, 1973). Recent discussions, however, indicate a shift from whether-or-not questions to how-do-we-decide-who questions (Ausubal, Beckwith & Kaaren, 1974; Hall & Cameron, 1976). Relative to children defined in terms of physical and/or mental characteristics considered to be defective, the questions appear to be already answered.

Many people argue that all children have a right to be born normal (e.g. Katz, 1976). This "right" is predicated on the current social value structure which once it defines an individual as defective, 1) construes one's life to be a tragedy (Katz, 1976); 2) conceptualizes one's existance as a burden on society and the future of humankind (Etzioni, 1973); 3) sees one's presence as a negative influence on all family members

(Hilbourne, 1974); 4) defines one's body as defective (Irwin, 1976); 5) expects one's personality to invariably be thwarted (McFie & Robertsan, 1973); 6) views one's educational needs as creating special problems (Bartel & Guskin, 1971); 7) construes one's emotional needs for human love and contact to be higher than usual (Sheridan, 1975); 8) defines one's potential for meaningful humanhood to be especially low (Hall & Cameron, 1976); and 9) even before one is considered old enough to realize what it means to be classified defective, expects one's parents to experience a stereotyped constellation of negative affective and behavioral responses (Apgar, 1969; Battle, 1974; Erickson, 1974; Mercer, 1974; Pinkerton, 1970; Poznanski, 1973).

Although this area has been accused of excessive negative bias (Wershaw, 1963) and individuals considered to be defective have consistently reported life satisfaction equal to that of individuals who are not considered to be defective (Cameron, Hoeck, Weiss, & Kostin, 1971; Cameron, Titus, Kostin, & Kostin, 1973; Cameron, 1974), many people feel it is in the best interests of such children and society that they not be born, or if born, not be "forced" to live (e.g. The Hardest Choice, TIME, 1974; Shall This Child Die?, NEWSWEEK, 1973). However, those children who have apparently been denied this "right to be normal" are not necessarily ignored.

While other children are provided with supportive services including formal education to facilitate their adaptation, "defective" children are provided with supportive services including formal special education to facilitate their acceptance of and adjustment to their situation; to help compensate for their defects.

This difference in emphasis further examplifies the negative valuation of children classified as defective, and leads to the question of whether or not such children have a right to positive self-esteem or to positive self valuation. Note the paradox stated previously. If it was somehow better that one not be born, or not be forced to live, then what kind of attitudes toward that individual are justified?

It is the intent of this review to argue that the existing literature provides only confusing and biased answers to this question. In addition, I intend to demonstrate why this confusion and bias exists, and how it is manifested in expressed attitudes toward parenting children classified as defective.

CHAPTER II

TERMINOLOGY

Because of the vast literature and research in this area, the literature review will focus primarily on discussion relative to individuals with physical characteristics labeled as "defects," although it should be noted that much of the basic tenants of this dissertation are equally applicable to individuals with mental characteristics labeled as "defects."

Individuals with physical characteristics labeled defective are discussed in the psychological, sociological, rehabilitation, special education, and medical literatures under various headings. As a group, labeled defective individuals are referred to in three basic ways: (1) by using comparative adjectives as nouns (e.g., "the defective," "the disabled," "the handicapped"); (2) by using comparative adjectives as modifying or qualifying individuals (e.g., "defective individuals," "disabled individuals," "handicapped individuals"); and (3) by using comparative adjectives as modifying or qualifying characteristics of individuals (e.g., "individuals with a defect," "individuals with a

disability," "individuals with a handicap"). The following comparative adjectives are representative of those used in this manner: defective, disabled, handicapped, malformed, deformed, afflicted, impaired, imperfect, invalid, limited, anomolous, atypical and exceptional. (For additional discussion see Lacatis, 1976; Meyerson, 1971; Wright, 1960.)

Individuals not so classified are referred to in a somewhat different manner: (1) by using comparative adjectives as nouns (e.g., "the normals," "the able-bodied"); (2) by using comparative adjectives as modifying or qualifying individuals (e.g., "normal individuals," "able-bodied individuals"); and (3) by negating comparative adjectives, such as those listed above, with the prefix "non" (e.g., "the non-disabled," "non-handicapped individuals"). Three points need to be made here. First, rarely if ever is this group referred to by using comparative adjectives as modifying or qualifying characteristics of individuals, such as "individuals with a normal" or "individuals with an able-body." Second, with the exception of the use of the prefix "non," the number of comparative adjectives used is limited to two, i.e., "normal" and "able-bodied." Finally, to this author's knowledge, terminology conventions for this latter group have not been directly discussed in the literature.

A strict classification and terminology convention, usually referenced in part to Hamilton (1950), is cited in the literature (e.g., Battle, 1974; Hawke & Auerbach, 1975; Meyerson, 1971; Wright, 1960). This convention, known as the Medical Deficit Model, stresses the importance of making the following distinctions: (1) Defect--the actual characteristic or manifestation of abnormality, assumed to be detectable and definable by qualified physicians. (2) Disability--the actual functional impairments or limitations due to the defect, also assumed detectable and definable by physicians. (3) Handicap--the actual barriers imposed by the defect or disability relative to achieving self and/or social goals.

In fact, these terms typically are used interchangeably (especially "disability" and "handicap"), even by some authors who cite this convention and request precision in its use (e.g., Battle, 1974; Hawke & Auerbach, 1975). Stewart (1974) criticizes such interchangeability and lack of consistency. Because the "best diagnosticians" often disagree, Stewart especially criticizes research claiming distinctions between groups supposedly classified according to the Medical Deficit Model. Calling those who continue to misuse labeling the "worst enemies," Stewart, claims this practice is indicative of a pervasive lack of commitment on the part

of professionals to the real welfare of those being labeled. When classification is deemed necessary, as when determining needs for services, Stewart suggests it be based on relevant behaviors, not body types. (For an example of one such behavioral classification, see Carlson, 1976.)

Aside from criticisms of inconsistency and lack of objectivity, attention has been focused on the negative connotations of this terminology and resultant stigmatization. Jones (1972) makes two interesting observations with regard to stigmatization. First, few systematic inquiries have been made into how labeled children themselves perceive the labels. Jones notes that children are aware of the negative connotations, but often reject them as being descriptive of themselves. Second, while there is research evidence and widespread agreement (especially in special education) that deficit labeling can result in lowered self-esteem and lowered expectancies for labeled children, suprisingly few teachers actually attempt to help students deal with this negative influence, nor are they themselves professionally prepared to deal with it.

Though not cited by Jones or most others who have investigated this area, a potential solution to this problem appeared almost 30 years ago. Noting the

emphasis on psychological counseling to deal with low self-esteem, Brown (1948) reports that he and his colleagues found semantic training to be a highly effective therapy technique. Brown claims low self-esteem in most cases occurs because individuals confuse labels and terminology with the characteristics they are meant to signify and thus generalize the negative connotations to the actual characteristics. With appropriate semantic training, this problem, and thus low self-esteem, is avoided. Brown also suggests that professionals receive this training as they often make the same mistake. (See also Lilly White, 1958.)

Throughout the remainder of this dissertation I will use terminology developed and used in the State of Michigan by politically and socially active individuals with physical and/or mental characteristics labeled as defective by wider society. These individuals refer to themselves (when such classification is deemed necessary) as "handicappers." Most dictionaries define "handicapper" as one who determines or assigns advantages and disadvantages, consistent with this group's goal of not only labeling themselves, but defining themselves (Taylor & Gentile, 1976). As a noun, the term Handicapper denotes a social classification rather than a physiological evaluation and thus was chosen as the most

appropriate terminology for Michigan's Public Act 220, the "Handicapper Civil Rights Act" (effective April, 1977).

To maintain the integrity of this new terminology, the non-handicapper population will be referred to as "tabs" (temporarily able-bodied) indicating, in the spirit of the more classic terminology, their potential to become handicappers. (Logically, of course, all individuals, relative to their current styles and modes of functioning, are temporarily able-bodied.) Finally, those physical and/or mental characteristics labeled as defects by the tab majority and used to classify individuals as handicappers will be referred to as "characteristics" or as "defining characteristics."

CHAPTER III

A DISPARITY IN THE LITERATURE

The negative attitudes and discrimination faced by handicappers in our society are well documented (see Boyd & Hartnett, 1975; Horn, 1976; Johnson & Heal, 1976; Morgan, 1976; Parks, 1975). Given the amount of funding and the number of programs and professionals in the area (see Gellman, 1974), and the proportion of handicappers estimated in the population (25% of American adults and 15% of American children; Gliedman & Roth, 1976), one might expect the handicapper literature to indicate a fair understanding of both handicappers and attitudes toward handicappers. However, Gliedman and Roth (1976) contend that when the handicapper literature is compared to the mainstream of psychological and social psychological literature, this does not seem to be the case.

Gliedman and Roth claim that the handicapper area is forty years behind the times, dominated by "living fossils" of out-dated theories and methodologies. They suggest that the disparity between the handicapper and mainstream literatures can be understood in terms of prejudice toward the stigmatization of handicappers. Ironically, this point can be clarified by contrasting

discussions of the underlying dynamics of prejudice and stigmatization in the mainstream and in the handicapper literatures.

Mainstream Conceptualizations of Prejudice and Stigmatization

Stimulated by a desire to understand the elitist practices of facist Germany and Italy and to draw possible parallels with treatment of Jewish, Black, and other minority citizens in America, investigations of the underlying dynamics of prejudice and stigmatization significantly increased after World War II. Initially, Adorno and others focused on the authoritarian personality (e.g., Adorno, Fenkel-Brunswick, Levinson, & Sanferd, 1950), assuming that certain personality types embodied and embraced ethnocentrism and racism, or prejudice in general. Currently prejudice is veiwed as a product of socio-cultural factors that perhaps result in specific personality types.

Goffman (1963) provides a widely cited discussion of prejudice through the process of stigmatization. He contends that nearly everybody at some point has the experience of playing both the role of stigmatized individual (and/or group member) and the role of stigmatizing individual (and/or social agent). However, Goffman notes that people have a tendency to make either/or attributions concerning stigmas and stigmatization,

and thus a tendency to deny that their insight into this process is due to a commonality of experiences. For this reason, when he defines stigmas (i.e. defining characteristics) as attributes that are deeply discrediting, Goffman cautions that specific situations and related norms must be considered, i.e., "a language of relationships, not attributes, is needed" (p. 3). At best, one can only discuss how often an individual or an attribute will be stigmatized.

Although Goffman describes three different types of stigmas (body attributes, character attributes, and tribal attributes like race or religion), he explains that for each the same sociological features are found. "By definition, of course, we believe the person with a stigma is not quite human" (p. 5). Based on this assumption, a stigma-theory is constructed to explain the inferiority and thus justify discrimination and mistreatment. Goffman further notes that when a stigmatized individual defends against mistreatment, it may be seen as a direct expression of his or her defect, and therefore additional justification for the original mistreatment.

Prejudice through stigmatization is thus a social phenomenon, assumed to exist to the extent classification/justification norms are learned and applied. Such norms both encourage classification by

certain defining characteristics and justify attributions of inferiority and sub-humanhood based on these characteristics. Because of underlying similarities, these norms or stigma-theories can be reduced to a common structure composed of two paradoxical rules.

RULE ONE: It is abnormal for the abnormal to to be normal, i.e., it is normal for the abnormal to be abnormal. Using the concept of competency as an example, the stigmatized individual is expected to either be incompetent or over-competent, but never simply competent. Stereotypes of blacks often describe them as incompetent intellectually and over-competent sexually. Similarly behavior may be qualified in terms of defining characteristics such as "Amelia Erharts's transatlantic flight was an outstanding achievement, for a woman."

RULE TWO: It is abnormal for the abnormal to not want to be normal, i.e. it is normal for the abnormal to want to be normal. In direct contradiction to rule one, the stigmatized person is expected to have strong motivation to be normal. A classic example is Freudian sex role identification for women, where the young female is assumed to realize she is abnormal without a penis, and wanting to be normal, is motivated by penis envy to identify with her mother. Females who do not show penis envy (i.e., don't want to be normal) are

assumed to be maladjusted. Similar logic explains why blacks were expected to use skinlighteners, why tomboys are more acceptable than sissies, and why homosexuals who do not seek a cure are considered by many to have a double need for therapy.

Application of these rules occurs once the attribution of inferiority and sub-humanhood is justified by the presence or assumed presence of the defining characteristics in question (Hentig, 1948). The purpose is obvious; any behavior of a stigmatized person can be considered abnormal (Dunham, 1962). By extension, any attitude toward and/or treatment of such individuals can be justified (see Hoyt, 1973, for excellent examples in employment situations).

Defining characteristics, then, play a central role in the prejudice process. Allport (1957) also notes the tendency to justify prejudice on the "objective" basis of defining characteristics. Like Goffman, Allport cautions that identified defining characteristics provide a condensation point for negative attitudes and so aid, rather than account for prejudice. "The repugnance we feel is only slightly, if at all, traceable to the visible difference--our rationalizations to the contrary not-withstanding" (p. 137).

The Handicapper Literature Perspective

In discussing negative attitudes and behaviors in the handicapper literature, the role of defining characteristics is conceptualized differently. Wright (1960, 1974) among others (e.g., Davis, 1961; Dembo, et al., 1973), refers to the "spread phenomena." This assumes that negative attitudes toward the defining characteristic are themselves justified (i.e., the characteristics are objective manifestations of inferiority), but are inappropriately spread (or generalized) beyond it. Basically this means that negative attitudes do not simply arise from external sources and condense around defining characteristics; the process is assumed to work in reverse with appropriate negative attitudes arising from some intrinsically inferior quality of the defining characteristic and then spreading beyond it.

In a series of studies, Whiteman and Luckoff found that the defining characteristic "blindness" was rated significantly more negative than a person with the characteristic, "blind person" (Luckoff & Whiteman, 1961; Whiteman & Luckoff, 1960, 1962). Using "amputee" and "person missing a leg" Siller (1965) reported similar findings. In an expanded study, Whiteman and Luckoff (1965) reported similar findings with "physical handicap/physically handicapped person" and "blindness/blind person," and noted the characteristics alone were

significantly different from each other, but ratings of persons with the characteristics were not. These data have been used as indirect support for the spread phenomenon, indicating that a negative attitude toward a defining characteristic does not directly parallel negative attitudes toward a person with the characteristic.

Implications for Self Valuation

The implications of this difference in perceived role of defining characteristics for self valuation go beyond theory and so should be discussed. Using the spread model, an individual must accept a certain amount of inferiority. In addition the individual must accept that a certain amount of negative social reaction is appropriate, specifically when related to defining characteristics. The person need not accept total inferiority and so must guard against spread. Using the Goffman or prejudice model an individual need not accept any inferiority. The person need only accept, specifically relating to defining characteristics, difference from (not inferiority to) social norms.

These two orientations of self valuation relate to the history of various minority groups in this country. Premovement behaviors such as use of hair straighteners and skin lighteners by blacks, passive compliance to submissive roles by females, and extensive analysis and therapy by homosexuals are consistent with accepting a certain amount of self inferiority and

negative social treatment as justified. Movement behaviors such as Black Power, Women's Rights and Gay Pride are consistent with accepting difference from but not inferiority to social norms.

Clearly this later orientation is more conducive to development and maintanence of positive self-esteem. Those using the spread approach do not totally ignore this point; they often condone a practice of degradation and devaluation of others (usually other handicappers) as an alternative for developing and maintaining positive self-esteem (see Bettelhiem and Janowitz, 1950, for discussion of condoned prejudice as a homeostatic technique).

Claiming that everybody has defects of some sort, and "I'm not quite O.K., but then you're not quite O.K. either" orientation is prompted in the handicapper literature. Of course if everyone has a defect it would make no logical sense to bother classifying children or adults as defective in the first place. Because this orientation relies on the acceptance of self inferiority, it seems more likely to encourage prejudice than to build or maintain self-esteem.

Wright (1974) uses this self inferiority, other inferiority orientation to encourage integration of different handicappers in rehabilitation settings, but concedes that this is difficult to maintain outside the

rehabilitation setting. She claims that neither negative attitudes nor derogatory comparisons on physical bases can be totally eliminated because tabs invariably view handicappers from a "biologically advantaged" position. Handicapper children are similarly encouraged to use this self defeating orientation through comments like: "be thankful you are only (defining characteristic), and not worse off like children who are (different defining characteristic)."

While many lay individuals and professionals condone this derogation, it takes on special significance within and between handicapper sub-groups. Blind separatists claim "Blindness is a characteristic, thank God we're not crippled or deaf, etc." Deaf separatists claim "Deafness is a damn inconvenience, but thank God we're not blind or crippled, etc." Dwarf separatists claim "We're not crippled or handicapped, we're just little people." However, even among separatist leaders it is common knowledge that degradation of handicappers exists within sub-groups (Safilios-Rothschild, 1968), such as blind vs partially sighted; oralists vs manualists; and achondroplasts vs midgets.

CHAPTER IV

THE QUESTION OF APPROPRIATE NEGATIVE ATTITUDE

Underyling the different conceptualizations of the role of defining characteristics is the assumption of actual inferiority vs assumed or prescribed inferiority. The Goffman model assumes that negative attitudes (NA) are a function of prejudice and stigmatization (P,S), or NA = f (P,S). The Wright model assumes that negative attitudes are a function of appropriate negative attitudes (ANA) and a function of spread of appropriate negative attitudes, or NA = f (ANA) + s (ANA). The Wright model posses two unique constraints; how much negative attitude is appropriate and how is the appropriate negative attitude justified. The question of how much negative attitude is appropriate has been a point of contention since the beginning of the formal study of handicappers.

In 1940 Krammerer claimed to do the first empirical investigation of the psychology of "crippled" children. Reviewing the last twenty years of what he called the untested "Literature of Opinion," Krammerer noted general agreement that "crippling" resulted in

personality maladjustment. However, he noted a split over why it resulted. About half the authors reviewed used an Adlerian organic inferiority approach, assuming that any organic inferiority intrinsically caused maladjustment. The remaining authors assumed that maladjustment was in large caused by "unwise" social and familial influences. All the authors, including Kammerer, did agree on the need to cure patients of organic deficits, and the need to facilitate adjustment to those deficits that could not be cured.

The closing of World War II brought further establishment of a funded national policy concerning handicappers i.e., rehabilitation (Safilios-Rothschild, 1971). The goal of rehabilitation was to cure individuals of as much differentness as possible, then help develop salealbe work skills on the basis of what could not be cured. This further established medical professionals as the experts in the handicapper area, and clearly cast handicappers as "medical problems." In addition to providing the framework for more funded and formal study of handicappers, a major precedent of discrimination was established.

While thousands of jobs were created by the federal subsidies to the rehabilitation industries, these new jobs were ironically closed to handicapper applicants, especially at administrative levels. This

precedent was not significantly broken until 1975, when pressure from a group of radical handicappers at Berkley resulted in the appointment of Ed Roberts as California's Executive Director of Rehabilitation (Downey, 1975).

Early in 1948 the Journal of Social Issues devoted its entire fourth issue to an overview of the growing field of the psychology of handicappers, replete with the same theoretical split noted by Krammerer. As an addition, many of the non-Adlerian authors claimed to base their perspectives on the work of Kurt Lewin. As before, the disagreements were over the relative influence of social factors on the process of adjustment to biological deficits.

Because these early experts agreed on the essential organic inferiority of defining characteristics (as reflected in the early federal programs). they also agreed on the existance of appropriate negative attitudes. Their major difference was the amount of spread each side would allow. The Adlerian authors believed appropriate negative attitudes were strong enough to justify self-rejection and maladjustment. Therefore there was little justification for explaining negative attitudes and behaviors in terms of prejudice and stigmatization, or even spread; i.e., NA = f (ANA).

The social and Lewinian authors contended that the intrinsic impact of appropriate negative attitudes

did not account for everything. To these authors the Adlerian approach seemed to avoid social factors by allowing too much spread. As with Wright, however, the social and Lewinian authors assumed a significant amount of negative attitude as appropriate, given that their attention to social factors was primarily applied to facilitating the acceptance/adjustment process, rather than focusing on changing social values. (If NA = f (ANA) + s (ANA), then the relative emphasis on individual adjustment vs social change must depend on the amount of negative attitude assumed to be appropriate.)

There is ample evidence that this early theoretical disagreement is not yet resolved. Stappleworth (1974) accuses special education of a similar lack of emphasis on social influences as characterized by the Adlerian authors, suggesting it is past time to analyze the environment with the same intensity as deficits purportedly caused by internal factors. More importantly, medical rehabilitation facilities have been especially slow to consider social factors in early rehabilitation (Haber & Smith, 1971). Significant empirical investigations of such social influences are relatively recent (e.g., Bynder & New, 1976; Clum, 1975; Hawke & Auerbach, 1975; Hyman, 1975; Lane, Dorfman & Demopoulos, 1974; Wan, 1974). According to Jones (1972) at least special education teachers are cognizant

of the existance and impact of the stigma faced by their students, even if very few offer assistance with how to deal with it (see also Chaiklin & Warfield, 1973).

This historic emphasis on adjustment and its contemporary manifestations has also come under strong attack. Gliedman and Roth (1976) claim that "adjustment psycholgoists" in the name of helping handicappers, "systematically set out to mutilate the spirit of their clients" (p. 29. In particular, Gliedman and Roth contend that the authors claiming to base their adjustment approaches on Lewinian models are prime examples of the handicapper area being behind the times (i.e., Barker et al., 1953; Battle, 1974; Dembo et al., 1973; Kissin, 1971; Meyerson, 1948, 1971; Wright, 1960, 1974). Ironically, they note, the actual writings of Lewin clearly call for handicappers to fight for changes in the culture; not to adjust to the culture.

During the 1950's the question over the amount of negative attitude assumed to be appropriate took on an additional form centered around whether or not handicappers could be considered a true minority. Though this debate received increased attention throughout the 1960's due to increased attention to minorities in general, the issue still remains. One side of the debate contends that the noted similarities between handicappers and other minorities do not warrant

according handicappers real minority status (e.g., Alberecht, 1976; Barker et al., 1953; Davis, 1961; Dembo et al., 1973; Jordan, 1963; Kriegel, 1969; Langer, Fiske, Taylor, & Chanowitz, 1976; Meyerson, 1948; 1971; Roeher, 1961; Telford & Sawrey, 1967; Wright, 1960, 1974). The other side contends these similarities do warrant, with some qualifications, according handicappers minority status (e.g., Berreman, 1954; Cameron et al., 1971; Chesler, 1965; Conine, 1969; Downer, 1975; Fordyce, 1968; Gellman, 1959; Gliedman & Roth, 1976; Goffman, 1963; Yuker, Block, & Young, 1970; Zych & Bolton, 1972).

It is in fact this issue which underlies Gliedman and Roth's criticism of the handicapper area in general. Most programs, policies and professionals relating to handicappers reflect the classical Wright typological approach with a heavy emphasis on the need to facilitate the acceptance/adjustment process. With general recognition and acceptance of the minority status of handicappers, this heavy emphasis on adjustment would be seen as prejudicial. Specifically, the problems faced by handicappers would then be perceived as social problems to be ameliorated through social action; rather than medical and related problems which must be dealt with via the acceptance/adjustment process.

The essence of this 25-year-old controversy is well illustrated by contrasting the views of Gliedman and Roth with those of Alberecht (1976) and Langer et al. (1976). Because they believe attitudes toward true minorities are characterized by open hostility (explained by prejudice), Alberecht and Langer et al., like Wright, claim handicappers are not a true minority. These authors contend that attitudes toward handicappers are characterized by ambivalence and so are best explained by spread. Specifically, handicappers (or at least their defining characteristics) are novel stimuli; their presence causes a break in expectancies and thus increased orientation or emphasis on their differentness. This over-emphasis can result in inappropriate expectancies and behaviors (i.e., spread). However, underlying attitudes are assumed to be positive in general. Apparent negative attitudes and behaviors, such as complete avoidance, are merely the manifestations of this ambivalent approach/avoidance conflict.

This would explain, for example, why handicapper children are apparently treated more positively than handicapper adults; i.e., general expectancies relative to children are considerably less stringent and demanding than expectancies relative to adults. Supposedly, this discrepancy between treatment of handicapper adults and children does not exist relative to members of true

minorities, (Battle, 1974; Jordan, 1963; Roeher, 1961; Siller, 1975; Telford & Sawrey, 1967).

While many other differences have been noted, the apparent lack of open hostility and presence of ambivalent attitudes and behaviors represent the most consistent themes sited to reject handicapper minority status. Based on their own and other empirical observations (e.g., Comer & Piliavin, 1972; Kleck, 1968; Kleck & Horn, 1975; Kleck, Ono, & Hastorf, 1966; Luckoff & Whiteman, 1961; Whiteman & Luckoff, 1960, 1962, 1965), Alberecht and Langer et al. conclude that neither an Adlerian Type approach based on an intrinsic fear of becoming a handicapper (e.g., Novak & Lerner, 1968) nor a prejudice type approach based on learned hostility (e.g., Goffman, 1963) explain actual attitudes and behaviors as parsimoniously as a novelty/spread approach.

Predictably, these authors recommend that the public be educated to form more realistic expectancies. This they assume will reduce the novel stimulus value of handicappers and thus minimize spread of appropriate negative attitudes. In addition they recommend handicappers be educated to realize and accept that most apparent negative social responses are simply a function of their own novel stimulus value. By understanding the real reasons for apparent negative social reactions, personal adjustment will be enhanced and, by

controlling breaks in expectancies, the probability of positive social interactions will be increased.

Gliedman and Roth (1976) strongly support the minority status of handicappers, claiming that the pervasive prejudice toward handicappers is due to the paradoxical role of handicappers in the mainstream of society. Based on Talcott Parsons' description of the sick role in America, they contend that handicappers are cast in a variant sick role. Once classified as "sick," handicappers are relieved of all adult responsibilities and expectancies (i.e., a loss of power and control), as are all sick individuals. However, as other sick individuals are redefined as powerful in that they are expected to concentrate all their energies on "getting well," handicappers are not expected to have this power or control, i.e. they are defined as powerless all the way around.

The variant sick role is a stigma theory. Once the attribution of inferiority is made--once the handicapper is classified as "sick" or as having something medically "wrong,"--application of the two stigma rules becomes justifiable. Because the attribution of inferiority is based on a relatively stable characteristic, it is abnormal for the individual to become normal. By not expecting or allowing the individual to assume adult responsibilities (or child responsibilities related to

becoming an adult), the individual cannot be an adult (i.e., normal). This is stigma rule number one. Paradoxically, by attributing the responsbility of "getting well" to the individual, the variant sick role implies it is inappropriate for a handicapper to not want to get well (i.e., normal), which is rule two.

In view of this analysis, the apparent lack of hostility and presence of ambivalance may be due to social sanctions against open expressions of hostility and negative attitudes toward individuals who are sick and thus not responsible for their immediate behavior. Ferina et al. (1966) have noted that social constraints can significantly reduce such expressions in limited situations without actually changing underlying attitudes. As Goffman noted, "The attitudes we normals have toward a person with a stigma, and the actions we take in regard to him, are well known, since these responses are what benevolent social action is designed to soften and ameliorate" (p. 5).

Note for example unwritten rules like "don't hit kids with glasses," "don't fight with girls," and "don't make fun of crippled kids, they can't help it." DeBartolo (1975) humorously illustrates such a sanction in a recent satire. When a probing reporter asks if a scientist did indeed have the body of a fly, the scientist's brother responds, "Well, he wasn't exactly

Mr. America. But I don't think it's nice to point out defects in other people!" (emphasis added by DeBartolo). In this context the common advice to handicapper children that teasers are only showing their ignorance takes on a second meaning. Teasers are not ignorant because they treat handicappers as if they are inferior; teasers are ignorant because they apparently do not know that there is a social sanction against openly indicating the inferiority or defects of handicappers. Among others, activists in the women's movement claim that such covert hospitality can be more detrimental than overt hostility because it is harder to openly detect and thus harder to directly confront.

The sick role analysis also provides an alternate explanation for the noted disparity in treatment between handicapper children and adults. Given what Gliedman and Roth call the "myth of technology," children are perceived more positively because they are assumed to have greater potential for cure (i.e., more potential control) than adults. Berreman (1954) claimed charities are cognizant of this as indicated by fund raising techniques of focusing on the hopes the continued funding of research will ultimately uncover the miracle "cure" for countless handicapper children. The poster child used by Easter Seals Society for Crippled Children and Adults and the pleas to help "Jerry's Kids" indicates

this approach is still used today. While these funds are actually proported to be used for handicappers of all ages, these charities typically contend that the focus on children is the only way to raise the needed funds. It also should be noted that campaigns to raise funds for impoverished peoples' use a similar focus on children for similar reasons (Cahnman, 1969).

To summarize, only when the underlying dynamics of negative attitudes and behaviors are discussed relative to handicappers is there an assumption made about appropriate negative attitudes based on an assumption of the intrinsic or essential biological inferiority of defining characteristics. As suggested, the last 40 years of handicapper literature can be conceptualized in terms of these assumptions. It was shown that a Wright approach could be used to criticize an Adlerian approach for assuming too much appropriate negative attitude and allowing too much spread by not considering social factors as important influences on adjustment (adaptation). Similarly it was shown that a Gliedman and Roth approach could be used to criticize a Wright approach for assuming too much appropriate negative attitude and allowing too much spread by not considering prejudice and stigmatization important influences.

It is the contention of this author, however, that even the Gliedman and Roth approach does not fully

appreciate the disparity between the handicapper and mainstream literature. Specifically, it can be shown that a Goffman approach can be used to criticize the Gliedman and Roth approach for assuming appropriate negative attitude and allowing spread by not considering that the attribution of biological inferiority is itself prejudicial.

This is illustrated in the following quote from their discussion of the variant sick role, "Precisely because his biological deficit is not yet susceptible to cure, the handicapped person 'fails' to assert a similar mastery (succeeding at getting well) over his 'ailment' (Gliedman & Roth, 1976, p. 11)." By postulating that a handicapper defining characteristic is a "biological deficit," it is implied that it is normal for handicappers to be abnormal (biologically inferior), which is stigma theory rule one. By claiming that these assumed biological deficits are "not yet susceptible to cure," it is implied that it is normal for handicappers to want to be normal; i.e., handicappers would (should) become tabs if and when their particular defining characteristic becomes susceptible to "cure." This is stigma theory rule two.

In a very real sense, instead of providing a new approach to understanding prejudice toward handicappers, Gliedman and Roth simply assume significantly less

appropriate negative attitude than Wright, and call for significantly more stringent restrictions on allowing spread, or NA = f (ANA) + s(ANA) + SP. For these authors, and most others writing in this area, changing the conceptualization of "biologically inferior to . . ." to one of "biologically different from . . . " represents too large a cognitive step (see Dobzhansky, 1973).

CHAPTER V

THE QUESTION OF JUSTIFICATION OF APPROPRIATE NEGATIVE ATTITUDE

Unless there exists a clear and objective method for distinguishing appropriate negative attitude from inappropriate negative attitude, theoretically any attitude or behavior can be justified by assuming it is appropriate. However, if such a method did exist, the noted differences among those using Adlerian, Wright and Gliedman and Roth typological approaches could not, or at least should not exist. Perhaps understandably, of all those who assume some degree of biological inferiority and appropriate negative attitude, few discuss any such methodology.

The convention, it seems, is to use a personal application of the Medical Deficit Model (see p. 6). Wright, for example, explains that discrimination exists when behavior is not based on an objective analysis of actual limitations due to disability. Despite their criticisms of the Wright typological approach, Gliedman and Roth make a similar point.

In the mainstream, discrimination is assumed to exist when behavior is not based on an objective analysis

of actual ability. While this definition can be applied to all social out-groups, including handicappers, the Wright and Gliedman and Roth definitions, because they rely on the medical deficit model, seem only applicable to handicappers.

Use of the Medical Deficit Model is not limited to theory. The social institutions of special education and rehabilitation use this model to justify their existance and their treatment of handicappers. Though not directly attacking the medical deficit model, many have called this justification into question. Bartel and Guskin (1971) claim the special education and rehabilitation fields exist because society chooses to define handicapper children as creating problems.

When Congress investigated mislabeling of children in Head Start Programs (children were being mislabeled to meet a federally mandated 10% handicapper quota), they mandated stricter enforcement of diagnosis, so that no child would be forced to undergo stigmatization and discrimination by being mislabeled (LaVor & Harvey, 1976). Implicit here is the assumption that such stigmatization and discrimination is somehow justified for children appropriately diagnosed and labeled by qualified medical professionals.

While the objectivity of medical professionals in general has been questioned, very few have directly

questioned the objectivity of the medical deficit model as applied to handicappers. Etzioni (1976) for example, cites many cases of malpractice, including mis-diagnosis and needless surgery, to encourage his readers to not believe medical advice without, at the minimum, one outside opinion. However, in an earlier article, "Doctors Know More Than They're Telling You About Genetic Defects," Etzioni (1973) strongly argues that doctors should inform every expectant parent about genetic counseling and especially amniocentesis. This way, he claims, expectant parents can avoid further contamination of the gene pool and weakening of the species by avoiding conception when medical professionals indicate a high risk of birth defects, or by aborting any fetus diagnosed by medical professionals to be defective.

Meyerson (1971) provides what is perhaps the most direct analysis of the objectivity of the medical deficit model as applied to handicappers. He notes simply that "disability" and "handicap" are social value judgments. However, Meyerson implies that this absence of objectivity is of minor importance. Instead of focusing on changing cultural expectancies, he focuses on using a pseudo-Lewian model to assist <u>disabled</u> individuals with <u>adjustment</u> to minimize <u>handicaps</u>.

In summary, handicappers are not only defined and classified by a deficit model, they are also expected

to accept and adjust to a deficit model of themselves, as well as understand the history of negative social attitudes and discrimination through various applications of a deficit model. This deficit model is supported by socially designated experts in the area; by influential social institutions (e.g., special education, vocational rehabilitation, the Congress of the United States, etc.); and ultimately by the prestigious medical profession. Traditionally, the medical profession provides the agents (physicians and diagnosticians) granted the power to objectify attributions of biological inferiority to the individual, or at least to certain characteristics of the individual.

This cultural truism of intrinsic or essential inferiority is not unique to the handicapper area. Other out-groups in America have had to deal with attributions of inferiority, supported by social institutions and experts in the area. The Immigration laws of the early 1900's objectified by leading biologists and eugenicists who were funded by wealthy capitalists (e.g., Carnegie, Harriman, Kellog), marked a high point in the eugenics movement against assumed inferior genetic stock. Public outrage over the more direct eugenic efforts in Germany, however, forced this movement underground when America entered World War II (Ausubel, et al., 1974).

It is common knowledge that the I.Q. research by Jensen and others has been used, and in some cases is still being used, to justify attributions of biological inferiority to blacks. Perhaps not so common knowledge is that this same attribution resulted in 30 states passing "miscegenation" laws between 1915 and 1930; or that in 1971, 21 states had eugenic sterilization laws similar to the North Carolina law that resulted in the sterilization of 1,620 individuals, mostly young black females, between 1960 and 1968 (Ausubel, et al, 1974).

Duberman (1975) has noted that in our culture, where differences equal deficiencies, women and homosexuals, among other minorities, are especially vulnerable to victimization by attributions of biological inferiority objectified with research relating behavior and physiology. Duberman further observes that while the sciences have a history of finding differences to use as deficiencies, experts have a history of confirming, rather than challenging dominant social attitudes.

Dunham (1962) has noted that not only are major scientific theories (such as Darwin's theory of evolution) used extensively to objectify attributions of biological inferiority to justify subsequent prejudice, but major philosophical works have been used for similar ends. The Bible, for example, has been interpreted to objectify attributions of intrinsic inferiority of

females and homosexuals. In a tabloid publication, The Christian Vanguard (1976), Biblical references are used to objectify such attributions to blacks and Jews, so as to justify such practices as feeding these people diseased meats.

Obviously, deficit models are not only counter-productive to development and maintenance of positive self-esteem, they are also counter-productive to development and maintenance of positive group self concepts and positive social attitudes. The histories as well as the contemporary struggles of many out-groups in this country (e.g., Latino Americanos, Native Americans, Japanese Americans, Polish Americans, Afro Americans, Jewish Americans, Female Americans, Elder Americans, Gay Americans, etc.), suggest an inverse relationship between group acceptance of deficit model attributions and group behaviors consistent with positive self concept, such as group pride and open, occasionally violent, opposition to social mistreatment. Similarly, these groups begin to receive positive treatment in the literature when group members with positive group identity begin writing the literature and attacking the deficit model or models used to justify the oppression of their people.

CHAPTER VI

EMPIRICAL EVIDENCE OF STEREOTYPIC REJECTION OF HANDICAPPERS

General Classification Stereotypes

The existence of stereotyped reaction/rejection of handicappers has a long history of documentation. It was the postulation of a general stereotype that led to the development of the widely used Attitudes Toward Disabled Persons (ATDP) scale (Yuker, Block, & Campbell, 1960). Yuker, Block and Young (1970) provide an extensive review of the literature on attitudes toward handicappers, including over one hundred studies using various forms of the ATDP scale. Based on their reveiw, supplemented with additional studies of their own, they conclude that the existence of an inclusive general stereotype consistently is supported. [According to Yuker et al., (1960) the purpose of the original development of the ATDP, in the spirit of Wright, was to provide information to facilitate individual adjustment.]

In updating the Yuker et al. (1970) review, Block (1974) indicates continued evidence of this general stereotype. Based on findings that general classification terms suggest different definitions and referents to different people (e.g., Coet & Thorton, 1975; Coet &

Tindall, 1974; Jaffee, 1967), some have criticized the ATDP for using general classification terminology. However, Smits, Conine, and Edwards (1971) found that different conceptualizations of the general term "disability" did not contribute to any differences noted in ATDP scores.

Based on their data, Smits et al. conclude, as have many others using paper-pencil paradigms (e.g. Chesler, 1965; Conine, 1969; Jones, 1974) that handicappers are a generalized out-group (i.e. stigmatized minority). Evidence of stereotypical responding to handicappers has also been noted in studies using various physiological measures (e.g. Hess, 1965; Kleck, 1966; Kleck, Ono, & Hastorf, 1966; VanderKolk, 1976; Zych & Bolton, 1972). Still other studies indicate handicapper children learn the same stereotypes of handicappers as do other children (e.g. Richardson, 1960; Staffieri, 1968; Cohnman, 1969; Jones, 1972; Goldstein & Glackman, 1973).

Characteristic Specific Stereotypes

Studies using social distance rankings, while also indicating stereotyped rejection of handicappers, suggest specific defining characteristics play a role in determining the degree of rejection as evidenced by what have been called "hierarchies of preference." This

essentially means concordance across individuals on the degree of acceptance/rejection by defining characteristic descriptions in various social contexts, such as willingness to educate handicapper children (e.g. Badt, 1957; Murphy, 1960; Murphy, Dickstein, & Dripps, 1960). The long series of such studies by Richardson and associates, ranking pictures on the basis of friendship choices, provide an interesting sample of this approach. In addition to noting apparently learned preference hierarchies in Friendship choices by both handicapper and non-handicapper youths (e.g. Goodman, Dornbusch, Richardson, & Hastorf, 1963; Richardson, 1971; Richardson, Goodman, Hastorf, & Dornbusch, 1961), social sanction mediation of hierarchy expressions were also observed.

In addition to further documenting the existence of preference hierarchies, other studies also have noted the mediation of hierarchy expressions by various social sanctions. In an attempt to investigate the relationship between Richardson's paradigm and one of their own design, Matthews and Westie (1966) report that some of their 5th and 6th grade subjects were unwilling to rank handicapper children, expressing both moral and ethical reasons against such behavior, in the second phase of the study (but not in the first phase!). It is interesting to speculate that perhaps a process of

value clarification occurred between experimental encounters. Using the Richardson technique, Richardson and Royce (1968) and Richardson and Emerson (1970) found that stereotyped preference hierarchies of handicappers can strongly mediate and/or eliminate racial stereotype expression. Though this has been recently questioned by Katz, Katz, and Cohen (1976), Katz et al. used an actual physical encounter that added an adult/child interaction as a third and possibly intervening variable. Noting that preference hierarchies are a common characteristic of prejudice toward minorities, Tringo (1970) has revealed their existence in a significantly different paradigm.

Tringo had six subject groups (high school students, undergraduates in various majors, education undergraduates, physical therapy undergraduates, graduate students, and rehabilitation workers) rate 21 different defining characteristic descriptions on a nine-point social distance scale. Because of striking similarity of means, the last five samples were combined. But, while sample 1 means differed significantly from samples 2-6, the stability of the preference hierarchy was maintained. The same results were noted for sex differences. While females were significantly more accepting than males, a relatively common observation in this area (Yuker et al., 1970), the hierarchy was

maintained. Aside from claiming that this clear hierarchy of preference supported the existence of strong prejudice toward handicappers, Tringo expressed special concern that students and professionals in rehabilitation services did not differ significantly from the other samples tested.

General Classification Stereotypes vs Characteristic Specific Stereotypes

It should be noted that a rigorous application of the medical deficit model would demand that attitudes be a function of the specific defining characteristics in question. The literature reviews by Yuker et al., (1970) and Block (1974) would suggest that attitudes toward handicappers are relatively independent of specific defining characteristics. This is consistent with this author's contention that the medical deficit model is actually a stigma theory, and thus is actually incapable of a rigorous application. On the surface, however, the Richardson studies and the Tringo study may seem to indicate characteristic specific stereotypes.

Actually, in reference to the earlier discussion of Goffman, the question is not so much whether or not there are general classification stereotypes vs characteristic specific stereotypes. The real question is are the characteristic specific stereotypes in general a

function of the specific characteristic (as the medical deficit model would demand) or are the characteristic specific stereotype really a function of (i.e. symtomatic of) the general classification stereotypes. While Tringo at least concludes the latter, especially in view of the existence of preference hierarchies relative to other minorities, there are a series of studies that add insight to this question.

Summarizing the handicapper literature in general, Siller (1975) claims that regardless of affect, people apparently evaluate handicappers in a stereotyped framework. Based on a series of factor analytic studies (Siller, Ferguson, Chipman, & Vann, 1967; Siller, Ferguson, Vann, & Holland, 1967; Siller, Ferguson, Vann, & Holland, 1968; Siller, 1970; Bradley, 1970; Vann, 1970; Ferguson, 1970), Siller and his associates note that not only do responses to a wide-range of defining characteristic descriptions demonstrate similar underlying factors, but these underlying factors consistently provide a significantly better statistical "fit" to the data than analysis by defining characteristics. Further, over 50% of the variance in these studies was accounted for by one higher order factor called generalized rejection. Ironically, almost in the

spirit of Adler, Siller claims this evidence of stable, shared "intra-psychic" structure is not likely due to social learning.

CHAPTER VII

DEVELOPMENT OF HYPOTHESES

Noted earlier, few handicappers are given the opportunity to work in the handicapper area, or the sciences in general (e.g., Leonard, 1976). Growing militancy on the part of handicappers, however, is putting new pressures on those working in the handicapper area (e.g., Downey, 1975; Kellog & McGee, 1976). Invariably the call is made for attitude change. At the Michigan regional and state level White House Conferences on Handicapped Individuals, the sessions on Public Attitudes consistently drew the most participants. The irony, of course, is that no one seems to really know what positive attitudes toward handicappers are.

As long as people feel justified in believing there is something biologically "wrong" with handicappers, positive attitudes and behaviors toward handicappers are not likely to be adequately defined. Similarly, as long as a deficit model classification/justification norm relative to handicappers is socially condoned, handicappers can expect to face continued social mistreatment and stigmatization. In a recent controversial article, Sawisch & Fitzgerald (1976)

call for professionals working with handicapper children to begin to address this concern.

> Ultimately one must face the following questions: Is it ethical to "help" children . . . to develop physical and social skills when in adult life these children 1) will face employment discrimination in their efforts to find meaningful work; 2) will face social discrimination, especially when it comes to findings a mate, or even a date; 3) will face housing discrimination and enforced segregation from "public" buildings and transportation, often because these facilities are built for people with what is deemed "normal" bodies and abilities; 4) will be denied, or at least over-charged for insurance and other social amenities; 5) will be denied "equal protection under the law" and will likely not be expected to contribute in any meaningful way to society? . . . we do not mean to imply that helping children . . . is undesirable or unethical. Quite the contrary. The point simply put is that one is not helping children unless there is some concurrent effort to institute change in the hostile physical and social environment. If in the guise of helping, an individual or group tends to perpetuate demeaning attitudes toward those being "helped," one should not be so naive as to believe that that person or group is as humanistically concerned as is implied (p. 120).

The obvious omission in the Sawisch and Fitzgerald article was in not stressing that these negative stereotyped valuations may impact upon handicappers at the very youngest ages through the most intimate social contacts--parents. This potential impact can be demonstrated in a direct manner by asking potential parents their expressed attitudes toward parenting various handicapper children.

Such a parenthood related approach has not received significant discussion in the literature,

though Siller (1975) has used attitude scale items concerning willingness to parent. These items load heavily on a factor called rejection of intimacy, which is included in the higher-order factor of generalized rejection. Siller and his associates have found rejection of intimacy to be a significant factor relative to attitudes toward the following handicapper defining characteristic descriptions: obese, facial conditions (including facial disfigurement), blind, deaf, amputee, dwarf, hunchback, cerebral palsy, and paraplegic.

Within this expressed willingness to parent context, a number of related points can be addressed. First, as noted earlier, some authors feel there is a qualitative difference between attitudes toward handicapper children and attitudes toward handicapper adults. This author contends that expressed willingness to parent responses will suggest a general negative valuation of handicapper children, as compared to a non-handicapper or tab child. More importantly, this negative valuation and rejection, like the negative valuation and rejection of older handicappers, will be expressed in socially stereotyped patterns (i.e. preference hierarchies).

Assuming attitudes toward parenting handicapper children are expressed in a negatively stereotyped manner, how does one explain the contention that underlying attitudes toward handicappers are actually

positive (e.g. Albretcht, 1976)? As suggested earlier, social sanctions may actually mediate the expression of negative valuations. In fact, it is plausable to hypothesize that a social sanction is so powerful that it may completely mediate any influences of attitudes toward the objects in question. (Review discussion on pages 28 and 29.) Therefore, if attitudes toward parenting handicapper children are expressed in hierarchies of preference, then these hierarchies should show less differentiation as social sanctions against avoiding parenthood become stronger.

Consider the following parenthood related behaviors or contexts, arranged in what appears to be decreasing social distance, or increasing social sanctions against avoiding parenthood: (though not necessarily representing equal itervals) 1) adopting someone else's child; 2) avoiding the conception of one's own child; 3) aborting one's own child; and 4) placing one's own child up for adoption. Individuals who adopt children often receive social reinforcement, perhaps because they are seen as "rescuing" children from a life without parents. By the same token, individuals who place children up for adoption are not socially reinforced, perhaps because they are seen as "committing" children to a life without parents. Therefore, a refusal to place any child up for adoption might more

clearly represent a reaction to the behavior than a reflection of positive attitudes toward the children in question.

It makes sense then to investigate the mediating influences of relevent social sanctions when attempting to extrapolate underlying attitudes toward stimulus objects from actions or behaviors toward those objects. This has rarely been done in the handicapper literature. The Richardson studies for example use measures within only one behavioral context (friendship choices). The Siller studies use measures across many behavioral contexts. A more realistic approach would utilize measures within behavioral contexts and across behavioral contexts.

By asking potential parents to rate their willingness to adopt, avoid conception, abort, and place for adoption 11 child descriptions (1 tab and 10 handicapper descriptions), the following hypotheses were tested in the present study.

Hypothesis 1

> If the handicapper child descriptions do represent subgroups of the handicapper class, then the rankings of the child descriptions should show evidence of a preference hierarchy in each parenting context, as determined by Kendall's coefficient of concordance (W). A significant W can be interpreted as better than chance agreement in rank ordering among judges.

Hypothesis 2

a) The tab description should not be subject to rejection if it is not perceived as a representative of the handicapper class. Therefore, the tab description should be rated more positive in each parenting context than any other child description, as determined by Dunn's multiple comparison of mean differences.
b) In terms of a correlational analysis, the tab description should not be clustered with any handicapper descriptions. This can be shown by a low correlation between the tab ratings and a scale based upon the ratings of all the other descriptions combined (squared multiple correlation coefficient) for each parenting context.

Hypothesis 3

a) A major contention of this author is that an expressed attitude can be influenced by the context in which the attitude is ellicited. An analysis of variance across parenting contexts should indicate that context is a significant factor.
b) Because the idea of parenthood implies a high degree of intimacy, the parenting contexts should have a proportionately larger influence on ratings than the child descriptions, as determined by comparison of eta^2 scores.
c) A further, more detailed hypothesis is that the order of context influence should be related to the social distance or implied social sanctions associated with each parenting context. As discussed earlier, the order of influence (from least to most influence) should be (1) adoption, (2) avoid conception, (3) abortion, (4) place for adoption. This will be tested by means of analysis of mean inter-point differences across contexts, with less mean inter-description differentiation an indication of stronger context influence or mediation. Attitudes toward the parenting contexts themselves will be illustrated by a seperate rating scale.

In earlier discussions a question was raised as to the justification of negative attitudes. For example, how does one justify a greater willingness to abort a child who will be deaf than a child with no apparent physical differentness? The present study was not designed to answer this question, but rather, to demonstrate that this is a legitimate question to ask in the context of social prejudice.

CHAPTER VIII

METHOD

Subjects

Two hundred twenty volunteer subjects (110 females and 110 males) from introductory psychology classes participated in the study. All subjects were 18 or over and had expressed a desire to have children at some point in the future. Students who were parents or who were in the process of becoming parents were excluded.

Dependent Variables

Response booklets were prepared with a directions/cover page (described below), followed by five different attitude scales arranged in random order. Four of the scales deal with expressed willingness to parent: 1) Expressed Willingness to Adopt; 2) Expressed Willingness to Avoid Conception; 3) Expressed Willingness to Abort; and 4) Expressed Willingness to Place for Adoption.

For each of these scales, subjects were asked to rate 11 descriptions of children (randomized for each scale) on a nine point scale from "I definitely

would . . ." to "I definitely would not (adopt such a child; avoid the conception of such a child; abort such a child; or place such a child up for adoption)."

The 11 descriptions of children include common descriptions of 10 defining characteristics chosen two each from five higher-order classifications suggested in the literature: 1) Cosmetic (obese and facial disfigurement); 2) Asthetic (dwarf and hunchback); 3) Sensory (blind and deaf); 4) Amputee-functional (missing an arm and missing a leg); and 5) General-functional (confined to a wheelchair and crippled). Because this system of classification is based on a negative deficit model (review terminology section) a tab or control description was in terms of absence of handicapper defining characteristics (no apparent physical differentness). Pilot data using this description indicated a strong tabling effect at the positive end of all scales used.

One additional scale was used. The Expressed General Affective Reaction to Parenting Contexts scale required subjects to rate 24 parenthood related behaviors (of which 8 were used for this study) on a seven point scale from "I feel a strong negative reaction in general" to "I feel a strong positive reaction in general."

The direction of the rating scales were counterbalanced across all scales used to avoid response bias,

but are reported from low score - positive (e.g. would adopt; would not abort) to high score - negative (e.g. would place up for adoption; strong negative reaction). Samples of all scales are located in the Appendix.

Procedure

Subjects were run in groups of approximately 30 to 50 by one of two female experimenters. Subjects were first asked to read and sign experiment consent forms, which outlined their rights. Response booklets were then distributed. The experimenter asked subjects to read along as she read aloud the following directions from the first page of the response booklet.

> Some people begin having children in their late teens and early twenties. In order to provide appropriate services and programs for these new parents, we must have information about their general feelings toward a number of different issues related to having children. It is often difficult, however, to get objective information from individuals who are already parents or are in the immediate process of becoming parents.
>
> Because you have indicated intentions of someday having children, but are not currently parents nor in the immediate process of becoming parents, you can help us gain a more objective understanding of general feelings toward these potential issues of parenthood.
>
> This booklet contains six separate parts. For each part, you will be asked to indicate your own personal feelings on a seven or nine point scale. Please, this is not a test; there are no "right" answers other than what you personally feel is right! In order to preserve your anonymity and to assure confidentiality of your answers, Please Do Not Sign your booklet or give any identifying information other than your age and

> sex. If at any time, for any reason, you no longer wish to participate in this study, Please Stop! You will still receive complete credit for participation and the experimenter will destroy your booklet in your presence.
>
> The directions for each part of this study should be self-explanatory, but if you have any questions just raise your hand. Please read the directions and the scales carefully before completing each section. When you are finished, return your booklet to the experimenter and you will be given some parting information. Your experiment card will then be signed. If there are no questions, you may begin.

Upon returning response booklets, subjects were asked to leave their name and local address if they wished to have a summary of results sent directly to them. Subjects were given a card with the names, addresses, and phone numbers of the experimenters, the author, and the author's senior advisor; with directions on how any questions concerning the study could be answered and how copies of results could be obtained. Those individuals wishing to remain until all booklets were returned had an opportunity to speak with the experimenter and the author. After subjects were informed of these options, they were requested not to discuss the nature of the study with anyone for at least three weeks.

CHAPTER IX

RESULTS

Preference Hierarchies

The first hypothesis predicted a preference hierarchy in each parenting context for the child description rankings.

Kendall coefficients of concordance among judges were computed for each parenting context and are summarized in Table 1 with the average ranking of the child descriptions by parenting context. W was significant ($p < .05$) for the Adoption, Avoid Conception, and Abortion scales, but not for the Place for Adoption scale. Although this was a conservative test of concordance (11 descriptions were ranked on the basis of 9 point ratings), the magnitude of the W's were of the same order as those reported by Richardson et al. (1961). In the Richardson study, friendship choices were used to directly rank order 6 descriptions.

Based on these results, hypothesis one was marginally accepted. While there was evidence of a stereotypic preference or rejection hierarchy in three of the four parenting contexts, the similarities in the average rankings of many of the child descriptions

Table 1

Average Ranking of Child Descriptions
by Parenting Context with Kendall
Coefficients of Concordance (W)

Adoption		Avoid Conception		Abortion		Place for Adoption	
Tab	2.19	Tab	1.99	Tab	3.22	Tab	5.04
Obese	4.72	Obese	4.10	Obese	4.50	Obese	5.39
Deaf	5.75	Deaf	5.76	Deaf	5.54	Blind	5.79
Blind	5.86	Blind	6.31	Blind	5.88	Deaf	5.88
Face	6.07	Dwarf	6.39	Dwarf	6.12	Arm	5.94
Arm	6.44	Arm	6.58	Hunchback	6.44	Dwarf	6.07
Crippled	6.73	Face	6.69	Face	6.61	Leg	6.19
Dwarf	6.85	Leg	6.75	Arm	6.71	Crippled	6.19
Leg	6.88	Hunchback	6.76	Leg	6.82	Wheelchair	6.62
Wheelchair	6.90	Wheelchair	7.25	Wheelchair	7.12	Face	6.44
Hunchback	7.42	Crippled	7.30	Crippled	7.14	Hunchback	6.62
W = .20*		W = .23*		W = .13*		W = .02	

*p < .05

suggested that these descriptions were not well differentiated within the hierarchy. This observation, along with the lack of a significant W for the placement scale are discussed in relation to the remaining hypothesis.

Parenting Context

The second hypothesis predicted that the tab description would be rated more positive in each parenting context compared to any other child description, as determined by Dunn's multiple comparison of mean differences.

Mean description ratings for each context are given in Table 2. A subject by description analysis of variance was computed for each parenting context. The resulting F ratios were all significant ($p < .001$). Dunn's multiple comparison procedure was then used to compare the mean tab rating with the mean rating of each of the other child descriptions within each context. The mean tab rating was significantly more positive ($p < .01$) than the mean ratings of each of the other child descriptions in the adoption, avoid conception, and abortion contexts. In the place for adoption context, the mean tab rating was more positive than the mean ratings of each of the other descriptions, but the mean differences were only significant for the

Table 2

Mean Description Ratings by Context, Indicating Significant Mean Differences and F Ratios

Description	Context			
	Adoption	Avoid Conception	Abortion	Place for Adoption
Tab	2.14	1.96	1.91	2.08
Obese	4.32**	4.64**	3.09**	2.10
Face	5.12**	6.51**	4.48**	2.48**
Dwarf	5.33**	6.28**	4.08**	2.35*
Hunchback	5.63**	6.55**	4.37**	2.52**
Blind	4.82**	6.26**	4.01**	2.25
Deaf	4.77**	6.02**	3.85**	2.28
Arm	5.13**	6.41**	4.40**	2.28
Leg	5.34**	6.51**	4.63**	2.36*
Crippled	5.31**	6.85**	4.78**	2.39**
Wheelchair	5.35**	6.86**	4.75**	2.40**
F ratio	101.91†	279.02†	62.81†	5.52†

*significantly different from tab mean, $p < .05$
**significantly different from tab mean, $p < .01$
†$p < .001$

face, hunchback, crippled, and wheelchair descriptions ($p < .01$) and the dwarf and leg descriptions ($p < .05$).

As predicted, the tab description was rated significatnly more positive in each parenting context than any other child description, with the exception of the obese, blind, deaf, and arm descriptions in the place for adoption context. For these four exceptions however, the mean differences were in the predicted direction.

The hypothesized independence of tab and handicapper descriptions was supported by a low correlation between the tab ratings and a scale based upon the ratings of all the other descriptions (squared multiple correlation coefficient) for each parenting context.

An inter-description correlation matrix was computed for each parenting context (see Tables 3-6). On the whole, the correlations with the tab ratings were lower than any of the other correlations in each context. Squared multiple correlations (description - remaining descriptions) were computed for each description in each parenting context (see Table 7). The tab-scale correlations were quite low for the adoption (.12), the avoid conception (.07), and the abortion (.30) contexts, but was relatively high for the place for adoption context (.60). In comparison to the other squared multiple correlations in the place for adoption context (Table 7) however, it was clear that the tab

Table 3

Correlation Matrix For Adoption Scale

Tab											
Obese	.20										
Face	.23	.58									
Dwarf	.10	.61	.65								
Hunchback	.04	.58	.65	.81							
Blind	.17	.55	.53	.64	.60						
Deaf	.15	.60	.55	.68	.60	.84					
Arm	.13	.59	.65	.71	.72	.75	.73				
Leg	.13	.64	.65	.71	.73	.76	.77	.88			
Crippled	.11	.62	.64	.64	.61	.71	.71	.77	.78		
Wheelchair	.11	.54	.64	.64	.57	.74	.68	.72	.78	.81	
	T	O	F	Dw	H	B	Df	A	L	C	W

Standardized Item Alpha = .94

Table 4

Correlation Matrix For Avoid Conception Scale

Tab											
Obese	.23										
Face	.15	.64									
Dwarf	.16	.65	.80								
Hunchback	.14	.59	.81	.81							
Blind	.14	.61	.81	.81	.71						
Deaf	.15	.64	.77	.82	.76	.91					
Arm	.11	.64	.83	.82	.74	.85	.85				
Leg	.13	.63	.82	.85	.76	.87	.86	.93			
Crippled	.09	.56	.87	.75	.77	.81	.78	.85	.84		
Wheelchair	.08	.53	.79	.76	.77	.80	.81	.84	.86	.89	
	T	O	F	Dw	H	B	Df	A	L	C	W

Standardized Item Alpha = .96

Table 5

Correlation Matrix For Abortion Scale

Tab											
Face	.53										
Bace	.39	.67									
Dwarf	.39	.66	.81								
Hunchback	.38	.65	.87	.83							
Blind	.43	.71	.76	.81	.74						
Deaf	.44	.71	.81	.84	.80	.87					
Arm	.38	.70	.84	.84	.82	.82	.85				
Leg	.38	.70	.83	.84	.82	.82	.85	.99			
Crippled	.36	.65	.81	.82	.83	.82	.81	.88	.89		
Wheelchair	.37	.66	.82	.82	.80	.84	.81	.87	.87	.95	
	T	O	F	Dw	H	B	Df	A	L	C	W

Standardized Item Alpha = .97

Table 6

Correlation Matrix For Place For Adoption Scale

Tab											
Obese	.70										
Face	.67	.79									
Dwarf	.69	.87	.87								
Hunchback	.61	.87	.87	.91							
Blind	.61	.85	.77	.85	.84						
Deaf	.64	.88	.74	.85	.86	.88					
Arm	.70	.89	.89	.92	.90	.87	.86				
Leg	.67	.86	.89	.93	.90	.88	.85	.96			
Crippled	.54	.79	.80	.82	.84	.93	.80	.86	.86		
Wheelchair	.53	.80	.77	.80	.82	.86	.81	.87	.87	.85	
	T	O	F	Dw	H	B	Df	A	L	C	W

Standardized Item Alpha = .98

Table 7

Squared Multiple (item-scale) Correlations
For Each Description in Each
Parenting Context

	Adoption	Avoid Conception	Abortion	Place for Adoption
Tab	.12	.07	.30	.60
Obese	.52	.51	.62	.86
Face	.59	.84	.83	.86
Dwarf	.74	.81	.80	.91
Hunchback	.74	.77	.83	.90
Blind	.78	.88	.83	.94
Deaf	.77	.88	.85	.87
Arm	.82	.89	.98	.95
Leg	.85	.91	.98	.95
Crippled	.75	.88	.92	.91
Wheelchair	.75	.85	.92	.82

description was not clustered with any other description. In fact, for this context, only two clusters were evident; a single item tab cluster and a 10 item handicapper cluster. Careful review of Table 7, as well as Tables 3-6, indicates that these same two clusters occurred in each parenting context.

The tab description did not cluster with any of the handicapper descriptions in any parenting context. The tab squared multiple correlations were clearly lower than any of the other description squared multiple correlations. In addition to the evidence supporting a single item tab cluster in each parenting context, there was also strong evidence of a ten item handicapper cluster in each parenting context.

Figure one illustrates the mean ratings of the child descriptions by parenting context. A context by description analysis of variance was computed and is reported in Table 8. The context, description, and interaction F ratios were significant ($p < .001$). As indicated in Figure one, the interaction occurred in relation to the tab description. The mean tab ratings only ranged from 1.91 to 2.14 across the parenting contexts (see Table 2). The parenting contexts were a significant factor as predicted.

Eta^2 scores were computed and are reported in Table 8. A review of the eta^2 scores for context and

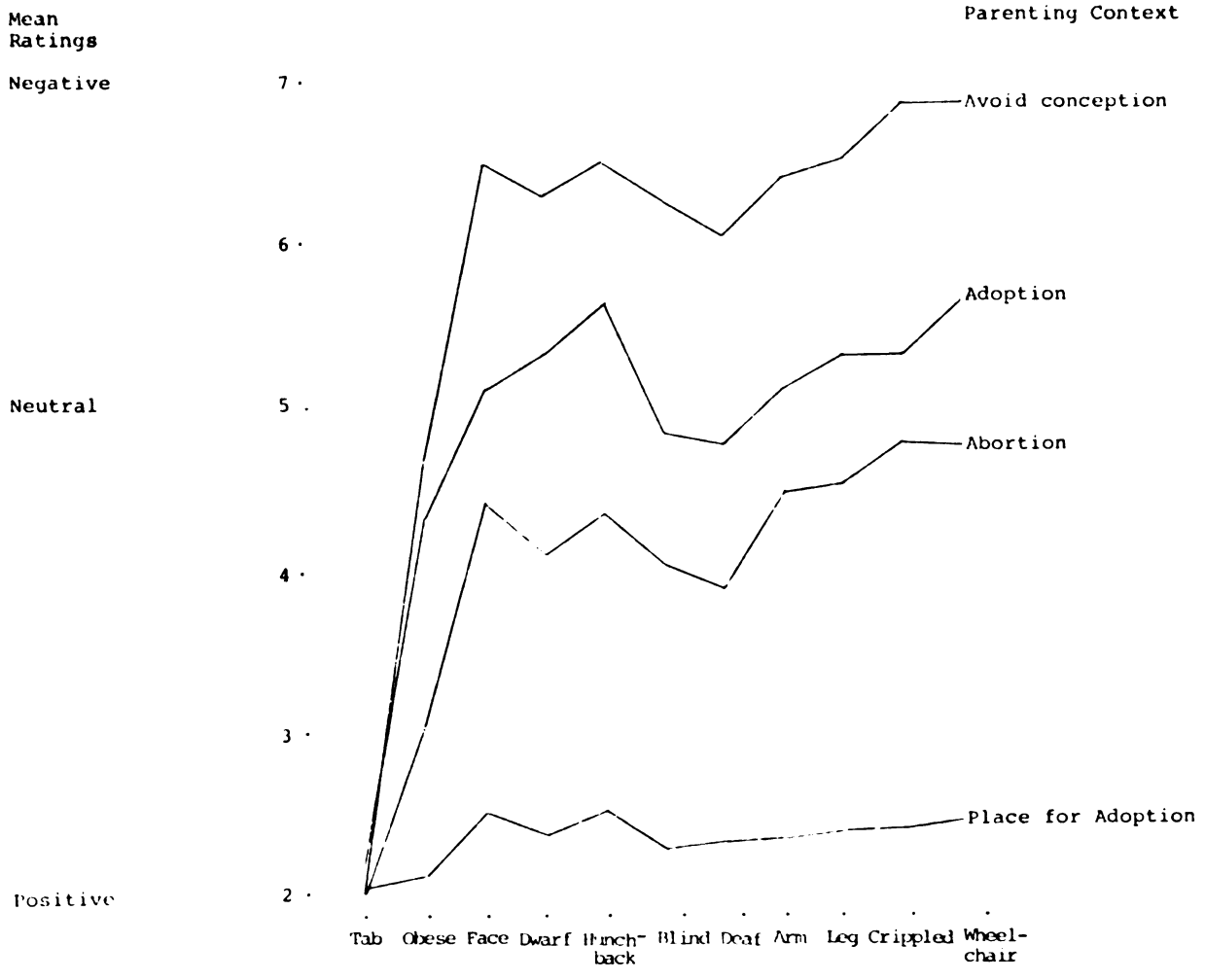

Figure 1.--Mean Ratings of Child Descriptions by Parenting Context

Table 8

Analysis of Variance Comparing Parenting Context and Child Descriptions

Source	SS	df	ms	F	N^2
1. Subjects	19025.77	219	86.88		22.6
2. Context	16606.44	3	5535.48	1290.32*	19.7
3. Description	6128.92	10	612.89	142.86*	7.3
4. Interaction	2077.05	30	69.24	16.14*	2.5
5. Residual	40393.84	9417	4.29		48.0
6. Total	84232.02	9679			

*$p < .001$

description indicates that the context sum of squares contributed 2.7 times as much to the total sum of squares as did the description sum of squares. As predicted, the parenting contexts had a proportionately larger influence on ratings than did the child descriptions.

It was predicted that the order of context influence (from least to most influence) would be (1) adoption, (2) avoid conception, (3) abortion, (4) place for adoption. This order was tested by an analysis of mean inter-point differences across contexts, with less mean inter-description differentiation an indication of stronger context influence or mediation. Attitudes toward the parenting contexts themselves were ellicited by a separate rating scale.

The mean ratings for each parenting context scale item are indicated in Table 9. The order of these means supported the predicted order. A mean inter-description difference analysis of variance was computed across parenting contexts (see Table 10) with the mean inter-description difference means. The context F ratio was significant ($p < .001$), but the mean ordering was not as predicted.

For clarification, a Tukey's HSD test was computed and indicated that all the means were significantly different from each other ($p < .05$). The most description differentiation or willingness to express a negative

Table 9

Mean Ratings for the Expressed General Affective Reaction to Parenting Context Scale

Context	Item	Mean Rating
Adoption	Adopting	2.11
	Parents adopting	1.47
Avoid Conception	Avoiding conception	3.13
	Parents avoiding conception	2.87
Abortion	Aborting	4.69
	Parents aborting	4.77
Place for Adoption	Placing for adoption	4.96
	Parents placing for adoption	4.80

Standardized Item Alpha = .71

Table 10

Mean Inter-description Difference Analysis of Variance with Mean Inter-description Means

Sources	SS	df	MS	F
Context	176.82	3	58.9400	103.6034*
Subjects	352.07	219	1.6076	
Residual	373.79	657	.5689	
Total	902.68	879		

*p < .001

Context	Mean
Adoption	1.57
Avoid Conception	1.74
Abortion	1.32
Place for Adoption	.57

valuation (i.e. least context influence) occurred in the avoid conception context, followed by the adoption, abortion, and place for adoption contexts. This variant ordering was consistent with the Kendal coefficients (Table 1) and the mean ratings, as illustrated in Figure one (see also Table 2).

An explanation for this variance from predicted order is suggested by the earlier discussion of eugenics. In hypothesizing the context order, it was assumed that social sanctions for or against a particular parenting behavior would be a simple function of the social distance implied by the behavior. However, eugenics in relation to handicapper children has long been viewed in a positive social light. Note for example the social acceptance and support of March of Dimes, as well as the proliferation of genetics counseling clinics and clinicians. Therefore, it may be more acceptable to express rejection in the context of avoiding conception of handicapper children than in the context of adopting such children, even though adoption in general has a stronger positive social valuation than does avoiding conception in general.

The mean inter-description difference mean for place for adoption indicated that very little differentiation between description ratings occurred. The mean ratings for this scale only ranged from 2.08 to 2.52

(see Table 2). The social sanctions against placing one's own child up for adoption were obviously so strong that they virtually eliminated the expression of rejection toward the handicapper descriptions, as noted under hypotheses one and two. Although the hypothesized order of influence was rejected, the assumption that the behavioral context in which an attitude is elicited can mediate the expression of that attitude was further supported.

CHAPTER X

DISCUSSION

The purpose of the present study was to verify the existence of stereotyped perceptions of and reactions to handicapper children from before conception to after birth. In the midst of national campaigns to promote positive attitudes toward individuals classified as defective, there are concurrent national campaigns to "wipe out birth defects." Does society in general have positive attitudes toward handicappers?

Are organizations that use "Pity Posters" to raise funds for handicapper children demonstrating positive attitudes toward those children (Stein, 1976)? Can one truly believe Baker (1975) when he claimed that managers actually have positive attitudes toward blind individuals; that managers simply refused to hire blind individuals because the managers had authoritarian personalities? How can anyone accept assumptions that in general underlying attitudes toward handicappers are positive in view of the historical and contemporary documentation of descrimination (Boyd & Hartnett, 1975; Horn, 1976; Johnson & Heal, 1976; Morgan, 1976; Parks,

1975), or in view of the demeaning terminology typically used to describe handicapper individuals and groups.

There is a disparity between mainstream conceptualizations of prejudice and stigmatization and conceptualizations expressed in the Handicapper literature. It was suggested that the isolation of the handicapper field has supported the lack of emphasis on the possibility that an apparently positive attitude may be masking a negative attitude, even though some authors have discussed this posibility (e.g. Doob & Ecker, 1970; Goffman, 1963; Lacatis, 1976; Titley & Viney, 1969).

Underlying the conceptualizations of prejudice and discrimination expressed in the Handicapper literature is the assumption of appropriate negative attitude. If a negative attitude is assumed to be appropriate, then one can claim that that attitude is not prejudicial or discriminatory. Many of the writers who criticized others for assuming too much appropriate negative attitude might themselves be subject to the same criticism.

In the absence of a logical means to justify the assumptions of appropriate negative attitude or the assumption of biological inferiority, such assumptions could be labeled prejudical. In an analysis of the medical deficit model, which appears to be the major referenced justification system, it was suggested that there was no logical means to justify the assumptions of

appropriate negative attitude. Further, it was suggested that the use of the medical deficit model paralleled the use of similar deficit models in attempts to justify prejudice and discrimination toward other minority groups.

Regardless of how one chooses to interpret the data, there is strong evidence in the literature of stereotyped perceptions of and reactions to handicappers. As Tringo (1970) noted, the existence of preference hierarchies are a common characteristic of prejudicial attitudes. Although in the present study the parenting contexts had a stronger influence on ratings than did the child descriptions, the evidence of preference hierarchies in the adoption, avoid conception, and abortion contexts are noteworthy. In addition to supporting the contention of stereotypic valuations of handicappers, even at the youngest ages, such hierarchies add fuel to the social friction among handicapper subgroups. This is especially true when various subgroups and their advocates compete for funds for social programs. Then each subgroup attempts to make a case for h o w it is viewed as the "worst off" group, how they receive the most social abuse, the least employment opportunities, etc.

While differences in stereotypes and attitudes among subgroups are interesting, it is imperative to view

these differences in a larger context. When comparing differences in attitudes toward the various handicapper subgroups with the differences between the handicapper class and the non-handicapper class, the subgroup distinctions seem of little significance. Relative to the tab child, all handicapper children are valued negatively, regardless of parenting context. Relative to the tab child, all handicapper children seem to be perceived as memebers of the same class.

This observation has two important practical implications. First, in view of the similarities in negative valuation, it is reasonable to assume that handicapper children, regardless of their characteristics, have the potential for shared negative social experiences (see Geis, 1972; Kleck et al., 1974). It is appalling, then, that no widespread attempts have been, or are being made to prepare handicapper children for these experiences (Jones, 1972). If the reluctance to prepare handicapper children for these experiences is a function of assuming that these children must learn to accept a certain amount of negative attitude as appropriate (e.g. Connors, 1976), then it is time to bring this assumption out in the open. The struggle against the development of prejudice will not be won until its roots have been explored in depth.

The second implication applies to handicapper adults, advocates, and programs aimed at changing attitudes. The strong commonalities in perceptions and valuations of the various handicapper subgroups suggests that handicappers may be losing the battle by fighting among themselves while wasting valuable time attempting to change attitudes toward one subgroup at a time rather than fighting the stereotype applied to handicappers collectively. Results of the present study suggest that the best that handicappers may hope to accomplish is to change the relative order within the handicapper class with a single subgroup approach. Regardless of what any single handicapper group thinks or wishes to believe, all handicappers are perceived as members of the same general social class. This is what handicappers have in common, and it is around this issue that they must unite if they truly hope to institute lasting social change.

Prejudice against handicappers is very real. The present study is but one additional piece of evidence in a long list of studies and personal experience. It is definitely time that those individuals involved in the handicapper area exercise extreme caution in what they choose to label positive attitudes. It should be evident for example that reluctance to place a handicapper child for adoption does not necessarily indicate a positive

attitude toward that child. As long as there are social sanctions against openly expressing rejection of handicappers in certain contexts (e.g. "Don't make fun of crippled people" or "Don't call them retarded if they can hear you") handicappers will face a difficult task in locating, isolating, and eradicating the roots of prejudice.

I do not mean to imply that prejudice against handicapper citizens reflects an organized master plan to make handicappers' lives miserable. Rather I wish to argue that the prejudice against handicappers reflects a learned or indemic prejudice. The major emphasis of this dissertation was to encourage critical investigation of the justification systems used to condone the continuation of prejudice toward handicappers. If we do not institute critical investigations, then we may well be responsible for perpetuating the status quo, where tab children grow up to discriminate against handicappers, and handicapper children grow up to devalue themselves.

Finally, I do not wish to assert that all parents should give birth to a handicapper child, or at least adopt one. No adult should be expected or forced to parent any child she or he does not wish to parent. However, as long as our culture supports a negative prejudice toward handicapper children, it is difficult for prospective parents to make such decisions without being

influenced by the pervasive cultural bias against handicappers. Freeing parents from this cultural influence would be a significant step toward freeing handicappers to determine their own personal value and their own value to society in general.

APPENDIX

PARENTHOOD

Some people begin having children in their late teens and early twenties. In order to provide appropriate services and programs for these new parents, we must have information about their general feelings toward a number of different issues related to having children. It is often difficult, however, to get objective information from individuals who are already parents or are in the immediate process of becoming parents. Because you have indicated intentions of someday having children, but are not currently parents nor in the immediate process of becoming parents, you can help us gain a more objective understanding of general feelings toward these potential issues of parenthood.

This booklet contains six separate parts. For each part, you will be asked to indicate your own personal feelings on a seven or nine point scale. Please, this is not a test; there are no "right" answers other than what you personally feel is right! In order to preserve your anonymity and to assure confidentiality of your answers, please do not sign the booklet or give any identifying information other than your age and sex. If at any time, for any reason, you no longer wish to participate in this study, Please Stop! You will still receive complete credit for participation and the experimenter will destroy your booklet in your presence.

The directions for each part of this study should be self explanatory, but if you have any questions, just raise your hand. Please read the directions and scales carefully before completing each section. When you are finished, return your booklet to the experimenter and you will be given some parting information. Your experiment card will then be signed. If there are no questions, you may begin.

Adoption Scale
Expressed Willingness to Adopt

Form LS753 Age_____Sex_____

Imagine you are going to adopt a child. Following is a list of descriptions of different children available for adoption. For each description, please indicate how you personally feel about adopting such a child. Use the nine (9) point scale given below. Write the number corresponding to your decision in the space provided after each description. Please rate all the descriptions given.

9. I definitely would adopt such a child.
8. I probably would adopt such a child.
7. I possibly would adopt such a child.
6. I might adopt such a child.
5. I am undecided.
4. I might not adopt such a child.
3. I possibly would not adopt such a child.
2. I probably would not adopt such a child.
1. I definitely would not adopt such a child.

A) A child who has no apparent physical differentness. _____

B) A child who has a facial disfigurement. _____

C) A child who is confined to a wheel chair. _____

D) A child who is obese. _____

E) A child who is crippled. _____

F) A child who is missing an arm. _____

G) A child who is deaf. _____

H) A child who is a dwarf. _____

I) A child who is a hunchback. _____

J) A child who is missing a leg. _____

K) A child who is blind. _____

Any comments?

Abortion Scale
Expressed Willingness to Abort

Form LS755 Age_____Sex_____

Imagine there is a method of determining physical chacteristics of your child before the child is born. Following is a list of descriptions of different children detectable by this method. For each description, please indicate how you personally feel about aborting such a child. Use the nine (9) point scale given below. Write the number corresponding to your decision in the space provided after each description. Please rate all the descriptions given.

9. I definitely would abort such a child.
8. I probably would abort such a child.
7. I possibly would abort such a child.
6. I might abort such a child.
5. I am undecided.
4. I might not abort such a child.
3. I possibly would not abort such a child.
2. I probably would not abort such a child.
1. I definitely would not abort such a child.

A) A child who will be blind. _____

B) A child who will be a dwarf. _____

C) A child who will be missing a leg. _____

D) A child who will be missing an arm. _____

E) A child who will be crippled. _____

F) A child who will be confined to a wheelchair. _____

G) A child who will have a facial disfigurement. _____

H) A child who will be deaf. _____

I) A child who will be a hunchback. _____

J) A child who will be obese. _____

K) A child who will have no apparent physical differentness. _____

Any comments?

Place for Adoption Scale
Expressed Willingness to Place for Adoption

Form LS756 Age_____Sex_____

Imagine you are going to have a child. Following is a list of descriptions of different children you could possibly have. For each description, please indicate how you personally fee about putting such a child up for adoption. Use the nine (9) scale given below. Write the number corresponding to your decision in the space provided after each description. Please rate all the descriptions given.

9. I definitely would not put such a child up for adoption.
8. I probably would not put such a child up for adoption.
7. I possibly would not put such a child up for adoption.
6. I might not put such a child up for adoption.
5. I am undecided.
4. I might put such a child up for adoption.
3. I possibly would put such a child up for adoption.
2. I probably would put such a child up for adoption.
1. I definitely would put such a child up for adoption.

A) A child who is deaf. _____

B) A child who is confined to a wheelchair. _____

C) A child who is obese. _____

D) A child who is a hunchback. _____

E) A child who is missing a leg. _____

F) A child who has a facial disfigurement. _____

G) A child who is missing an arm. _____

H) A child who has no apparent physical differentness. _____

I) A child who is a dwarf. _____

J) A child who is blind. _____

K) A child who is crippled. _____

Any comments?

Avoid Conception Scale
Expressed Willingness to Avoid Conceptions

Form LS764 Age_____Sex_____

Imagine there is a method of determining physical characteristics of your child before the child is conceived. Following is a list of descriptions of different children detectable by this method. For each description, please indicate how you personally feel about avoiding conception of such a child. Use the nine point scale given below. Write the number corresponding to your decision in the space provided after each description. Please rate all the descriptions given.

9. I definitely would not avoid conception of such a child.
8. I probably would not avoid conception of such a child.
7. I possibly would not avoid conception of such a child.
6. I might not avoid conception of such a child.
5. I am undecided.
4. I might avoid conception of such a child.
3. I possibly would avoid conception of such a child.
2. I probably would avoid conception of such a child.
1. I definitely would avoid conception of such a child.

A) A child who will be confined to a wheelchair. _____

B) A child who will have no apparent physical differentness. _____

C) A child who will be a hunchback. _____

D) A child who will be deaf. _____

E) A child who will be a dwarf. _____

F) A child who will be missing a leg. _____

G) A child who will be blind. _____

H) A child who will have a facial disfigurement. _____

I) A child who will be crippled. _____

J) A child who will be missing an arm. _____

K) A child who will be obese. _____

Any comments?

Parenting Context Scale
Expressed General Affective Reaction to

Form LS771 Age_____Sex_____

Following is a list of behaviors relating to parenthood. For each behavior please indicate how your personally feel about behavior. Use the seven (7) point scale given below. Write the number corresponding to your decision in the space provided after each behavior. Please rate all the behaviors given.

7. I feel a strong negative reaction toward this behavior.
6. I feel a moderate negative reaction toward this behavior.
5. I feel a slight negative reaction toward this behavior.
4. I am undecided.
3. I feel a slight positive reaction toward this behavior.
2. I feel a moderate positive reaction toward this behavior.
1. I feel a strong positive reaction toward this behavior.

A) Adopting children _____

B) Aborting children _____

C) Avoiding conception of children _____

D) Placing children up for adoption _____

E) Changing the characteristics of children before conception _____

F) Changing the characteristics of children before birth _____

G) Changing the characteristics of children after birth _____

H) Birth control _____

I) Planned parenthood _____

J) Parents adopting children _____

K) Parents aborting children _____

L) Parents avoiding conception of children _____

M) Parents placing children up for adoption _____

N) Parents changing the characteristics of children before conception _____

O) Parents changing the characteristics of children before birth _____

P) Parents changing the characteristics of children after birth _____

Q) Parents practicing birth control _____

R) Parents practicing planned parenthood _____

Any comments? (write on back, please)

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