ATTITUDES TO DISABILITY

(OUTLOOK AND BEHAVIOUR OF PHYSICALLY HANDICAPPED (AND NON-HANDICAPPED) PEOPLE IN RELATION TO DISABILITY)

VOLUME ONE

A Thesis submitted for the Degree

of

Doctor of Philosophy

at

the University of Newcastle upon Tyne

1980

by

EDWARD HENRY FLYNN

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Abstract

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(Outlook and Behaviour of Physically Handicapped (and Non-Handicapped) People in Relation to Disability)

The thesis reviews literature concerned with attitudes toward physical handicap and investigates the view that the attitudes of society, in general, are influenced by exposure to physical handicap.

Four "matched" groups, disabled, those who cared for the disabled, and two groups of able-bodied people, active participants and passive observers, respectively, were interviewed and through the completion of attitude scales and discussions were found to have different responses and characteristics in areas indicated by the study. Each group contained 192 respondents. In the two able-bodied groups, the respondents were "matched" to the handicapped respondents by area of residence, sex, age-range, marital status, employment and educational level consistent with the handicapped persons at the time of known onset or occurrence of disability. The handicapped were persons who had received between the age of 18 years and 60 years some permanent physical handicap and had experienced the condition for a period of more than two years. They were also free from residential treatment and care at a hospital or similar institution.

The thesis records the differences between the different groups and indicates some of the reasons given by the respondents for the different situations.

Conclusions are drawn from the findings as to how the overall position may be improved and ways in which physically handicapped people

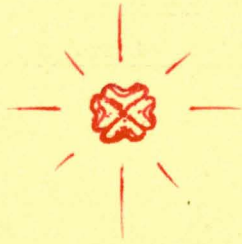
can be helped socially. Some possible outcomes are also indicated. In particular, it was found that the principal social barriers influencing the integration of physically handicapped people in community life were:-

(a) negative attitudes toward the handicapped which seemed to arise from the belief that they were fundamentally different from the able-bodied,

(b) discriminatory behaviour which revealed itself in either individual, institutional or ideological discrimination, and

(c) issues involved with the socio-economic conditions of the community.

- - - - - - -



God grant me the Serenity to accept

the things I cannot change,

Courage to change the things I can

and

Wisdom to know the difference.

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Attitudes to Disability

(Outlook and Behaviour of Physically Handicapped (and Non-Handicapped) People in Relation to Disability)

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I freely admit to the profundity of my debt to disabled and able-bodied people from all walks of life for their contributions to the study. To a countless number of people who have assisted me in different ways and by different measures, directly and indirectly, an expression of "sincere thanks" seems to me to be wholly insufficient.

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1. The disabled and able-bodied people who participated in numerous discussions concerning different aspects of the subject and, especially, to those who were involved in the attitude questionnaires,
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2. the late Mr. S. H. Hockey, a former tutor, whose philosophical outlook, understanding and faith in human relationships remain outstanding in the memory.

To these persons I sincerely trust that my endeavour is worthy of their contributions.

I have endeavoured to acknowledge the source of all quotations and illustrations. Where this has not been possible, I am indebted to those authors and illustrators whose authorship I have not been able to confirm.

The responsibility for the contents and associated elements of the study are entirely mine.

Synopsis

Although a greater understanding exists now than ever before about the need of disabled people to be able to realise their potential, physical disability continues to present tremendous problems to the individual who wishes to achieve social independence and acceptance. The inability of countless numbers of disabled people to reach their desired goals has been attributed to many reasons involving such issues as asocial personality, lack of motivation, inadequate opportunities and limited acceptance by significant others within the supporting services and outer community; all of which are primarily influenced by environmental forces.

The problems encountered by the disabled are not so much associated with physical neglect or inadequate medical treatment but much more deep-rooted in the negative attitudes and behavioural reaction of society toward its members.

Although the consequences of disability often cause people to behave differently in different environmental situations, the effects seem to produce a core which constitutes a common problem to those who attempt to attain a level of function as self-sustaining and contributory members of society. Disability frequently poses analytic problems as it juxtaposes social stigma with socially legitimate but permanently inadequate ability and the handicapped person tends to be stereo-typed despite the fact that he is totally motivated to overcome his handicap.

Personal handicaps such as restricted mobility and limited opportunities for employment, and social attitudes involving bias and prejudice frequently tend to deny many disabled a personally satisfactory place in the community.

Related to the need for participation is that of the opportunity for making a social contribution. To become maximally functional, the socially or physically disabled person must have the support of society and opportunities for meaningful involvement.

The magnitude of the problem makes it untenable to adopt a defeatist proposition that nothing can be done to improve the attitudes and outlook of people toward physical disability. There is a responsibility for constant evaluation of the outlooks and behavioural reaction of both disabled and able-bodied and the effectiveness of various services and programmes established to assist the disabled. The need emphasises the necessity to study disability on a multi-dimensional scale in order to tap the various issues involved with the affective domains of participative integration.

It seems paradoxical that compared with the astounding achievements made in other spheres of life, relatively little has been accomplished in changing public attitudes toward its disabled members. Many people involved with the consequences of disability have indicated that there is a dearth of study of attitude change and social interaction concerning the disabled in normal naturalistic settings.

Traditional disease orientated approaches to understanding disability have often failed to reveal the underlying social aspects of physical handicap; a short-coming which this study attempts to adjust by offering an integrated picture of the social characteristics of disability as perceived from within the outer community by the disabled (active participants), those who care for the disabled (active observers) and two groups of able-bodied people (active participants and passive observers, respectively).

Progress discernible in the study indicates ways of easing the relationship between the handicapped and the non-handicapped. The work describes the different views of the group participants and, in the final analysis, implies that the nature and degree of physical handicap tends to be largely founded on the cultural definitions and social perceptions interpreted to the handicapped by the non-handicapped.

The study does not attempt to cover every aspect of social psychology but it does point to many central issues and directions in which further study may be stimulated and profitably fulfilled in relation to human relationships.

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Explanatory Notes

1. Except where specifically stated, the words, "handicap", "disability", "handicapped" and "disabled" are used interchangeably in this study since they appear in United Nations resolutions with about the same connotation.

2. Although comments made by the disabled and caring about relationships and attitudes of significant others and various supporting services were "consumer-orientated", no obvious indication appeared during the interviews to infer that the respondents lacked respect for and appreciation of the care, work and services generally carried out on behalf of disabled people, in toto.

3. The phrasing of the different statements in the attitude scales was kept as near as possible to the phrasing used by disabled and able-bodied people when they openly discussed issues associated with disability before the formation of the questionnaire.

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11 (2) - (7)	Adapting to handicap
16 (2) - (8)	Changed attitudes
21 (2)	Available leisure time
27 (2) - (7)	Education and employment
33 (2) - (5)	Benefit of moral support
40 (2) - (5)	Nuisance in Society
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42 (2) - (3)	Importance of self-discipline
43 (2) - (3)	Loss incurring friendships
44 (2) - (5)	Understanding human behaviour
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46 (2) - (5)	Optimism
48 (2) - (7)	Influence of disability on marital status
Supporting Services	
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07 (2) - (9)	Treated as a "number" - Social Services Personnel
09 (2) - (5)	Interest in Church
10 (2) - (7)	Financial anxiety
18 (2) - (5)	Unrealistic
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25 (2) - (4)	Acceptance of assistance
30 (2) - (16)	Opportunities provided by Education Authorities
36 (2) - (6)	Provision of physical aids
37 (2) - (5)	Difficult roles in society
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41 (2) - (3)	Disablement Income
General Society (Outer Community)	
02 (2) - (6)	Physical and mental abilities - relationship
03 (2) - (6)	Friendship
15 (2) - (5)	Importance of knowledge and understanding
20 (2) - (3)	Integration of differently coloured people
23 (2) - (5)	Views concerning behavioural agreement
24 (2) - (3)	Influence of financial reward as a motivating "drive"
28 (2) - (5)	Co-operation from Public Services
29 (2) - (7)	Influence of moral and materialistic values
31 (2) - (5)	Understanding basic needs of disabled person
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CHAPTER I

General Introduction and Outline of Study

CHAPTER I

General Introduction and Outline of Study

Genetic inheritance, pre-natal or natal processes, infection, disease, accidents and injuries are among the variety of causes producing sometimes the same, sometimes different physical conditions. The origin of the condition, however, may affect the impact. Fortuitously derived conditions may be seen to differ from those induced by carelessness or those resulting from "heroic" circumstances. Reaction of the able-bodied are similarly complex. Some feel at ease in their encounter with disablement while in others it elicits anxiety and even aversion (Yuker, Block & Younng, 1966; Siller, Ferguson, Chipman & Vann, 1967 (a); Siller, 1976).

For the physically handicapped, problems vary according to age, clinical condition, social relationships and environmental circumstances. Thus onset around adolescence involves the modification of a projected role and, if permanent, the disability may necessitate a total re-adjustment in relation to the self and others. As is evident from many of the ensuing clinical, autobiographical or impressionistic accounts this adjustment is markedly affected if the environment is non-supportive or hostile. Fears associated with integration, association, disengagement, segregation and the imputation of functional, emotional and characterological qualities need study (Barker, Wright, Meyerson & Gonick, 1953; Wright, 1960; Cumming & Henry, 1961; Sussman, 1966 (a); Safilios-Rothschild, 1970; Townsend, 1973). The inter-relationship of these different issues and their involvement with an environment which has been developed and is being continually adjusted by non-handicapped people ensure that any study relating to disability will be complicated.

Important clinical studies of the effects of physical handicap (Davis, 1960; Susser, 1962; Mechanic, 1968; Balint, 1972; Jones & Jones, 1975) are often inadequate in dealing with the social consequences associated with disability (Hunt, 1966; Townsend, 1965; 1970). Indeed, until recently, much official writing about the behaviour and outlook of the disabled outside the captive province of hospitals, other similar institutions and homes, has been fairly limited (Boswell & Wingrove (eds.), 1974; Snowdon, 1976).

Attitudes became a focal problem in experimental research even from the beginning of this century and Thurstone & Chave (1929), Likert (1932) and Thorndike (1935) are among the early pioneers who attempted to develop scientific attitude assessment instruments. Murphy, Murphy & Newcomb, (1937) believed that no single concept within the realm of social psychology occupied a more central position than that of attitudes. Psychologists, educators, sociologists and anthropologists have since focussed their attention on the importance of attitudes and the consequential effects within the social concept (Sherif & Cantril, 1947; Allport, 1954; Warren & Jahoda, 1973).

Attitudes have been described as ideas charged with emotions which predispose a class of actions to a particular class of social situations (Rosenberg, Hovland, Abelson & Brehm, 1960; Triandis, 1971). They are inferred from the way one responds to particular stimuli - predisposition to action (behavioural component) emanating from the relationship of the cognitive and affective components. The components of an attitude need not be equally weighted and action-orientated attitudes may be produced with very little feeling or belief if a need can be satisfied simply and directly. When specific feelings and

reactions become consistently associated with a particular person or event, they do so because the components have become sufficiently inter-related to form an attitude. In this way, the individual develops "value-systems" which in turn enable him to interpret and evaluate situations. In a sense, they are used to perceive.

We shall use the term "attitude" in this study in a fairly general sense to include expressions of cognitive, conative and affective tendency, comprising the summation of a person's feelings and inclinations, prejudice and bias, pre-conceived motives, ideas, fears and convictions about a specific topic. This generalisation derives from a series of readings including Adorno, Frenkel-Brunswik, Levinson & Sanford, 1950; Festinger, 1957; Rokeach, 1960; Fishbein, 1967; Thorndike & Hagen, 1969; and Reich & Adcock, 1976.

Attitude studies may be classified in terms of the relative frequency of occurrence in the literature as indicated by Psychological Abstracts over a period of time. For example, over a ten year period, 1957 to 1967, investigations of attitudes toward specific disability groups made up about 5% of the total whilst attitude studies toward the disabled in general consisted of less than 1.5% of the total. This study may be justified in part by the paucity of knowledge relating to the disabled in general and the apparent lack of agreement of results in the few studies which are available on the subject (Yuker, et al, 1966).

The theory of attitude measurement is based on the assumption that the subject's attitudes may be measured by his expression of acceptance or rejection of opinions and that the subject's expressions may be quantified and weighted (Thurstone & Chave, 1929). A further assumption

is that the attitude assessor is used in situations in which one may reasonably expect people to tell the truth about their convictions and opinions. Attitude measurement is concerned with locating individuals along an attitude continuum on the basis of the opinions that they accept or reject.

An awareness of the inherent limitations in attitude measurement is important. For example, measurement deals mainly with attitudes which are common; in adjusting attitudes to a scale, restructuring may be done to the thought process; attitude scales are an approximation of the individual; rationalisation and deception may occur, particularly when the attitudes studied pertain to moral or social values.

The beliefs and attitudes of the caring and able-bodied sections of the community have invariably provided the fundamental concepts which have influenced policies and decided the provision and services to the disabled. Goffman (1968(a)) draws a distinction between the "own" - similarly impaired people and the "wise", - people who are privy to disability such as professional workers and other non-handicapped persons associated with disability. He indicates that the "wise" inevitably determine the ways in which handicaps and disability are viewed and assessed and the ways that services and assistance are allocated to the "own". The endeavours of many disabled to weave a "cloak of competence" within the community in order to cover potential stigma and lowered self-esteem are illustrated by Edgerton (1967 - pp. 144-204).

The handicapped, themselves, make an ever-increasing contribution to the associated supporting services. Voluntary organisations such as the Disablement Income Group (D.I.G.) and the Association of Disabled

Professionals (A.D.P.) have by campaigning as disabled people for disabled people altered the once popular conception that disabled people were a passive, accepting group unlike the non-handicapped.

During recent years official discussions have been held and reports issued in an endeavour to resolve some of the implications of disability (Piercy Report, 1955-56; Seebohm Report, 1972; Tunbridge Report, 1972; Vernon Report, 1972; "Care with Dignity" Report, 1974; Snowdon Report, 1976), whilst the Chronically Sick and Disabled Persons Act of 1970 has given formal recognition to the problems associated with integration of the disabled. This statutory document also forms a basis upon which some essential facilities may be provided for the good of the disabled by different agencies such as the Department of Health and Social Services, and the Education Authorities.

The theories associated with physical handicap and disability can be investigated in a number of different ways, as for example, by examining the behavioural profiles or case histories of individually handicapped people and comparing them with a "norm", or by examining the structure of attitudes and contemporary relationships between physically handicapped and non-handicapped people.

This study concerns itself with an examination of attitudes involved with selected social issues which help to determine the behavioural reactions of people encountering disability or handicap. It is based on the assumption that disabled or handicapped people are observed as people either "different from" or "essentially the same" as non-handicapped or able-bodied people. The research involved people within the age range of 18 years to 60 years who were either free of permanent physical handicap or were permanently physically handicapped but clinically free of the captive status of hospital, institution or home confinement. As subsequently described (pp. 118-119),

the disabled respondents participating in the study were persons who had experienced, and were experiencing, severe permanent physical handicap (disability) for a period of more than two (2) years.

In particular, the issues of interest were primarily focussed on examining:-

(1) the generality of attitudes and the reaction of physically handicapped people and non-handicapped people to physical handicap and disability, and

(2) the generality of attitudes associated with physical handicap to be found in connection with issues relating to the:-

  (a) physically handicapped person (i.e. self),

  (b) family and immediate environment of the handicapped person (i.e. family and close friends),

  (c) supporting services (i.e. Health and Social Services, Education, employment, Church etc.), and

  (d) society in general (i.e. outer community)

Referring to the first objective, it was hypothesised that the general attitudes of physically handicapped and non-handicapped people are at variance in many areas of social interaction.

In pursuing the second goal, it is suggested that although certain physical disabilities may possess primary connotations which have an adverse effect on behavioural reaction in the community, the main problems confronting the handicapped person are involved in fulfilling a role acceptable to the physically able-bodied. For example, whilst deafness and blindness produce impaired communication, paralysis gives rise to impaired mobility and greater dependency, and multiple sclerosis may lead to an attitude of hopelessness, an examination of the general

issues may indicate that divergent relationships in the different categories of handicap are still involved with general attitudinal problems emanating from the outer community.

Four different groups of respondents were involved in the research, namely:-

(1) Physically handicapped people (active participants),

(a) Non-handicapped (able-bodied) people (active participants),

(3) People who cared for the physically handicapped respondents within the home environment (active observers), and

(4) Able-bodied people (passive observers).

The able-bodied respondents in groups (2) and (4) were "matched" with the physically handicapped according to sex, age group, marital status, area of residence, education standard and category of employment as estimated at the time of occurrence of the disablement to the disabled respondents.

A series of statements were collected from the disabled and able-bodied people in various sectors of society before the interview stage commenced with the respondents involved in the study. Each statement indicated that the handicapped were either "different from" or "similar to" physically able-bodied people. Some of the statements referred to the characteristics of the handicapped whilst others were associated with the behaviour of handicapped people.

Initially, 50 respondents in each of the four specified groups completed a "150 Statements" questionnaire by personal interview. The questionnaire was designed on Thurstone & Chave and Likert techniques and adjusted, where appropriate, to conform to the role of the respondents in each of the four main groups. The questionnaire was subsequently

reduced to a more significant level by computer analysis to produce a shorter questionnaire consisting of 50 statements. This latter questionnaire was administered to a further 142 respondents in each of the four groups. In addition to completing both the "150" and "50" statements questionnaires, the active participants in the disabled and able-bodied[1] groups completed Cattell's "16 P.F. Test".

Apart from information yielded about the differences in attitudes between the membership reference group and the comparative reference groups, an attempt is made to identify the sectors and issues in which and where those differences occur, respectively, and to examine the differences in outlook and behaviour between the disabled and able-bodied.

Material in the remaining sections of the study is presented as follows:-

Chapter II provides a general review of the literature concerned with physical handicap and endeavours to examine a wide number of associated issues which have received attention by different writers and investigators throughout the last few years.

Chapter III deals with the formulation of hypotheses for the study and furnishes some of the basic concepts which contribute toward the format.

Chapter IV describes the methodology adopted for the research and refers to some of the problems and other related issues involved with the study. The statistical analyses of results are also reported.

Chapter V examines the results of the responses from each of the four different groups of people interviewed. Graphical illustrations,

"Outlook and Behaviour of Physically Handicapped (and Non-Handicapped) People in Relation to Physical Disability."

No. 1	No. 2	No. 3	No. 4	No. 5	No. 6	No. 7	No. 8
Review of Literature	Structure of "150 Statements" Questionnaire. Statements classified into 4 categories relating to the Self, Family, Supporting Services and General Society (i.e. Outer Community). Questionnaire issued to 50 "matched" respondents in each of 4 main groups involving disabled people, those who cared primarily for them, and 2 different groups of able-bodied people (i.e. active participants - A.B.(1) group, and passive observers - A.B.(2) group). The disabled and A.B.(1) groups also completed Cattell's "16 P.F." Test. Within 4 weeks of initial interview, 18 respondents in the disabled and A.B.(1) groups responded again to part of the original questionnaire.	"150 Statements" Questionnaire reduced to "50 Statements" Questionnaire. This shortened questionnaire issued to 142 "matched" respondents in each of the 4 groups mentioned previously. The disabled and A.B.(1) groups also completed Cattell's "16 P.F." Test. Within 8 weeks of initial interview, 24 respondents in the disabled and A.B.(1) groups responded again to part of the "50 Statements" Questionnaire.	Examination of responses between different groups (i.e. Disabled, Caring, A.B.(1) and A.B.(2) groups), and reasons submitted for differences between the categories involving the Self, Family, Supporting Services and General Society (i.e. Outer Community).	Statements in the "50 Statements" Questionnaire re-classified into 11 subjects which frequently determine the attitude and behavioural reaction of people toward disability. Subjects included:- Personal and Social Relationships, Disability Effects, Rehabilitation, Education, Motivation, Employment, Finance, Social Services, Medical, Legislation and the Church.	Examination of responses between different groups in relation to specific subjects mentioned previously and reasons submitted for differences.	"50 Statements" Questionnaire issued to 21 persons who had become disabled after having completed a questionnaire as an able-bodied respondent. Examination of differences between pre-disability and post-disability responses, and reasons given by respondents for such differences.	Main Conclusions and possible outcomes.

Fig. 1. Main Steps in Research

tabular statements and results, and descriptive accounts and comments are given about the differences in behavioural reactions.

Chapter VI investigates the differences in responses from 21 people who were interviewed initially as able-bodied respondents and subsequently as physically disabled respondents.

Chapter VII reconstructs the various issues, topics and areas of social interaction which appear as a result of the research to be of significance to the disabled and concludes with an overall summary of the results.

Chapter VIII summarises the main conclusions and possible outcomes.

The main steps of the research are illustrated in Figure 1 (opposite page).

CHAPTER II

Review of Literature

Chapter II

Review of Literature

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CHAPTER II

Review of Literature

1. Introduction

The literature has been reviewed and selected with an understanding that the clinical aspects, personal attitudes and behavioural reaction of both non-handicapped and handicapped people are all contributory factors towards improving the quality of life for the disabled. Information has been gathered not only from the reading of several reports and other literary studies in this country but also from sources in the U.S.A.

Much of the information has arisen from experiences, descriptive reports and studies relating to individual cases and captive groups (Brown, 1954 (a); Carroll, 1961; Townsend, 1962; Hunt, 1966; Keller, 1970; King, 1971; Lancaster-Gaye, 1972; Miller & Gwynne, 1972; Ashley, 1973; Bleackley, 1974; etc.). This is indicative of the width rather than the depth of the subject since it involves psychology, physiology, sociology, medicine and other related sciences, each of which has its own conceptual framework and which cumulatively form the complex matrix recognised as "behavioural science".

Disability may occur at any time during the passage of life and, from a clinical view, it may incorporate either single or multiple handicaps. However, the handicapped person suffers not just from a clinical condition but also from social problems involving the family, home, education, employment, marriage, finance, mobility and other essential vocational pursuits. His inability to cope with environmental problems often prevents a satisfying and a healthy

contribution to society (Becker, 1963; Freidson, 1966; Freeman, 1967; Brattgard, 1974; Blaxter, 1976).

To focus the term "disability" more clearly, it is necessary to consider "normality" in its social and psychological contents and to distinguish normality as a statistical concept from normality as a moral concept. Applied to handicapped people, normality is often used in the moral sense with the result that their aspirations and activities are assessed according to a behavioural pattern seldom achieved by most people. In asking, "What is meant by normal relationship for the disabled person?" we may imply an ideal which is beyond that achieved by most able-bodied people or which involves the disabled person over-riding the disability at too high a cost in physical and mental pain and stress. It may mean for either the able-bodied person or the disabled person a requirement to adjust their behavioural relationship to some artificial and unnatural level in the physical and social environment (Edgerton, 1967; Douglas, 1970).

As illustrated by Rosser & Harris (1965), the life cycle of the individual person is enveloped in an extremely complicated mosaic of activities. Society in general appears to demand that the individual should reach an established standard of self-care, communication and social integration. Apart from the natural phases of early youth and old age where assistance tends to derive from consanguinal relations or affines, the disabled person is frequently expected to fulfil the same social obligations as those of the physically able-bodied.

Whereas every person is in some way deviant from the statistical and moral norms, the person with a physical disability is by lack of choice in a distinctively more disadvantageous position. Nevertheless,

although deviance from the norm may be significant for the physically disabled person, it does not necessarily infer failure to perform every activity in one's life cycle. Goffman (1968 (a)) considered unusual behaviour or stigma to be a factor which united criminals, the aged, etc., as well as the physically disabled.

Whilst adapted environments and increased financial benefits undoubtedly reduce the indignities and apparent civil disabilities experienced by many physically disabled people, easier opportunities to achieve autonomy and social integration do not remove the traumatic impact of being different and being treated as such. Extended periods of disablement, impairment or handicap that make caustic in-roads into social intercourse are often sufficient to provide descriptions as "peculiar", "different", "tragic", "heroic", etc., to be applied to disabled persons (Hunt, 1966; Minton, 1974; Braddick, 1976).

Battye (1966) analyses the public response to the profound incompleteness of a physically handicapped and sexually impotent man, while Chalmers (1966) describes her experiences as a "victim" and what it meant to her husband and family. She states:-

> "In my husband's case, he had lost his wife, but she was not conveniently dead and buried....." (p. 22)

Disability and handicap have for long been primarily associated with the province of "medicine" and less attention appears to have been given to the equally important areas associated with remedial rehabilitation, education, employment and social integration. Furthermore, as the power to deploy services and make decisions relating to priorities must flow from the "wise" to the "own", professional trained personnel tend to formalise the concepts of

disability and handicap and to determine the ways in which the disabled and handicapped people are viewed and assessed.

The value of cross fertilisation is recognised in the words of Mr. Alf. Morris, (Minister for the Disabled) who, in 1975, stated:-

> "..... the biggest problem of all in the future is that of changing public attitudes; making all people recognise that it is not a "them and us" attitude or situation; in fact, "them", in the future are "us". Potentially everyone is disabled ..... The general public should realise that they themselves will be involved ..... if they want society to be better - and more humane - they had better start now."

2. Inter-Relationship of Disability and Handicap

To define disability and handicap requires consideration of the social processes of recognition and legitimation of incapacity for socially expected performance. As a socially defined facet of behaviour the question, "Who are the disabled or handicapped?" must be accompanied by the inter-related question, "In what situation are they disabled or handicapped?" To a large degree, it would appear that any explanation of the respective terms must incorporate medical, economical, environmental and social issues as well as the attitude and behavioural reaction of the individual person.

Traditionally, as indicated through the services of voluntary organisations and other sources, there was a tendency to consider the handicapped as a depressed minority, to treat them as a series of tragic cases and to isolate them from the remainder of the community. Hence, the passing of the Chronically Sick and Disabled Persons Act, 1970, has statutorily directed the focus of those who seek to further social integration, environmental normalisation and community care

towards the goal of active participation by handicapped people in the general activity of society.

Difficulties of definition derive not only from the nature of the personal handicap of the individual but also from the situational environment in which the individual finds himself. Words such as "cripple" and "incurable", often perpetuated in the names of individual institutions and in common usage some years ago have been replaced by other words such as "sickness", "impairment", "disability", and "handicap". These words frequently take different meanings according to the wish of the person who desires to use them.

Although "Chronic Sick" and "Disabled Person" are categories perpetuated in the Chronically Sick and Disabled Persons Act, 1970, it is significant that no attempt was made to define either term in the Act. Indeed, as far as Section 17 of the Act is concerned, the "young chronic sick" are people below the age of 65 years whilst in Section 28 provision is made for the use of powers to:-

> "..... make provisions as to the interpretation ..... of any of the following expressions ..... "chronically sick", "chronic illness", "disabled" and "disability".

The introduction of an "invalidity" pension for a number of handicapped people seems to suggest official recognition that some further state of disablement exists in the "disability" continuum.

Almost any definition of a disabled or handicapped person appears to be open to debate. Professional people tend to define their clients according to the terms of their professional language whilst the client or handicapped person's own definition is often influenced by his self-perceptions, attitudes and motivation. Confusion frequently

arises as a result of professional isolation and the objects or aims of different bodies and organisations. For example, the report on "Social Security Programmes Throughout the World" (1971) lists about 100 different criteria for invalidity benefits alone. Kitsuse & Circourel (1963) suggested that data on related social problems are often more revealing about the nature of an organisation than that indicated by related administrative and curricular content of the organisation. A report by the World Health Organisation (1966) listed no less than 65 definitions of blindness with definitions of "economic" and "social" blindness varying considerably ("economic" blindness relating essentially to capacity to work and "social" blindness referring mainly to educational requirements or the ability to take care of personal needs or to maintain social relations) - (World Health International Year Book, 1972).

"Disablement" and "handicap" are frequently seen to be used interchangeably. The Department of Employment has a register for disabled persons; local authorities are charged to keep a register for the substantially and permanently handicapped whilst the major statutory instrument was christened, "The Chronically Sick and Disabled Persons Act, 1970".

In recent years, the writings of Wright, 1960; Daitz, 1965; Ruesch & Brodsky, 1968; Haber & Smith, 1971; Harris, Cox & Smith, 1971; and others, have revealed increasing interest in the conceptualisation of "disability" and "handicap" and in the data derived from the basic parameters of the respective terms.

Neff (1971) refers to disability as a scientifically defined limitation of impairment and handicap as a social disadvantage (p. 110).

Duthie & Nichols (1968) defined physical disability as:-

> ".... a condition causing impairment of function through reduced motor power, or loss of co-ordination, or reduced endurance of deformity. If the impairment encroaches upon the individual's ability to live a normal life, then it constitutes a handicap." (p. 11)

Research by Jefferys, Millard, Hyman & Warren (1969) and the Bedford Research Unit formed the basis for the first major survey of handicapped persons over the age of 16 years living in private households to be carried out in Great Britain. In the ensuing survey, Harris et al, (1971) exemplified the differences and use of the terms, "impairment", "disablement", and "handicap", and pointed to the difficulties created by the lack of a suitable definition of such terms.

The Association of Disabled Professionals (1975) recommended the classification of intrinsic handicaps formed by Dr. M. Agerholm (1975 - Appendix IX). In this case, Dr. Agerholm described handicap as a long term disadvantage which adversely affects the individual's capacity to achieve the personal and economic independence which is considered normal for his peers. Inside this concept and definition of handicap, two broad divisions of handicap were made - extrinsic and intrinsic. The former was described as a disadvantage arising from the individual's environment whilst the latter, intrinsic, referred to the disadvantage arising from the individual's own characteristics from which he could not be separated.

In the Report of the Committee on the Assessment of Disablement (1965), reference is frequently made to the principle that assessment should be determined by:-

> "..... means of a comparison between the condition of the disabled person and that of a normal healthy person of the same age." (p. 4)

and then added:-

> "Loss of faculty may be defined as the loss of physical or mental capacity to lead a normally occupied life ..... A normally occupied life includes work as well as household and social activities and leisure pursuits". (p. 4)

However, there is no apparent evidence in the report that the committee made any attempt to obtain information systematically about disabled people and normally healthy people or to verify the psychological and social effects of disablement or handicap.

Sainsbury (1970; 1974) piloted a method for the functional assessment of handicap and the "patterns" of disabled people.

The Declaration of Rights of Disabled Persons (Annex IV - United Nations, General Assembly Resolution, 3447 (XXX), 1975) proclaims that a "disabled person" was:-

> "..... any person unable to ensure by himself or herself, wholly or partly, the necessities of a normal individual and/or social life, as a result of a deficiency, either congenital or not, in his or her physical or mental capabilities."

The Assembly also recorded that disabled persons:-

> "..... have the same fundamental rights as their fellow citizens of the same age, which implies first and foremost the right to enjoy a decent life, as normal and as full as possible." (Appendix X)

Note:- The term, "disabled person", as used in this study, is defined in Chapter IV., p. 119.

TABLE 1

Prevalence of Disability, Handicap, Limitation or Impairment in Five Countries

Study Population	Per Cent of Specified Population
U.S.A. 1966 (age 18 - 64) Haber (1968;1971)	
Disabled	17.2
Severe	5.9
Occupational	4.9
Secondary	6.4
Australia 1968 (Age 15 - 64) Ehrlich, et al, (1969)	
Chronic limiting condition	8.4
Denmark 1961 - 62 (Age 15 - 61) Anderson, (1964(a); 1964 (b); 1966)	
Physically handicapped	6.5
Great Britain 1968 - 69 (Age 16 - 64) Harris et al, (1971) and Buckle (1971)	
Impaired	3.9
Handicapped	1.2
Israel 1965 - 66 (age, men 14 - 64; women 14 - 59) Nizan and Avidor (1969)	
Vocationally handicapped	2.9

Source: Haber (1973)

Social conditions and values are inevitably associated with organic and clinical features in the definition of disability and handicap and this makes it difficult to obtain an accurate census or assessment of the disabled and handicapped population at a specific period of time.

Harris et al, (1971) and Buckle (1971) estimated that about 3 million people over the age of 16 years and living in private households in Great Britain were impaired (i.e. lacking part or all of a limb, or having a defective limb, organ or mechanism of the body). Table I (see opposite page) illustrates some of the findings of their survey. About 60% of the sample were estimated to be over the age of 65 years whilst a little more than 1¼ million people were considered impaired between the age of 16 and 65 years. According to their definition some 350 000 were classified as being handicapped (i.e. could not attend to matters of self-care). Reference to the limitations of this investigation have been made by the researchers, themselves, Topliss (1975), the Office of Health Economics (O.H.E. - 1977) and others, particularly in connection with the under-estimation of the prevalence of certain types of disability. The types of activity restriction surveyed were largely related to impaired peoples' capacities to care for themselves in their domestic environments. Children and people in institutions were excluded.

The significance of the Harris survey's focus on domestic self-care is demonstrated in Table I, which shows their figures for people of working age against those of other countries (Haber, 1973 (a)).

Terminology of Physical Limitation

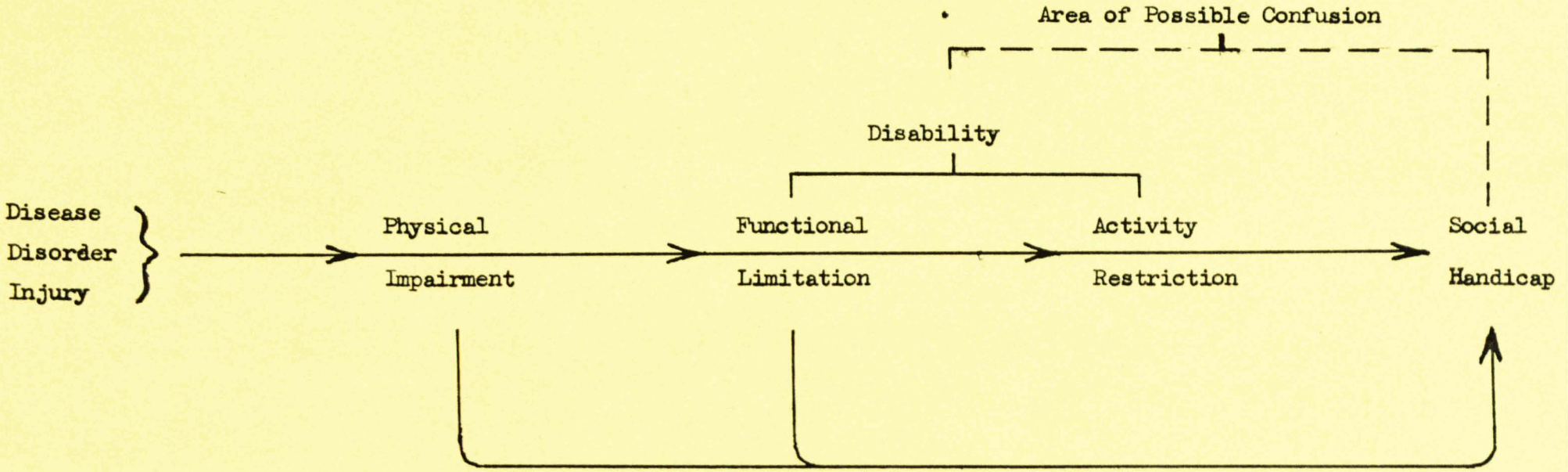


Fig. 2

Source Office Health Economics, 1977

Haber, indicating the British estimates to be relatively low, also suggested a strong positive link between the degree of occupational handicap experienced by people of a given level of disability and factors like low social status and poor educational background (pp. 328-33). This correlation does not appear to be so clearly indicated in the reports of Harris et al.

An examination of some official estimates of the disabled population by different sources frequently reveals different results even when they refer to the same period or within close proximity (Office of Population Censuses and Survey; O.P.S.C., - Harris et al, 1971); (Office of Health Economics (O.H.E.) - Pamphlet No. 38, 1971); (Department of Health and Social Security, D.H.S.S., Statistics of the Registered Blind and Partially Sighted Persons, 1972); (Topliss, 1975).

Standardisation in assessment and registration which would permit national comparison is suggested in the report, "The Missing Million - Have They Been Found?" (1975). This examined progress in searching out people who were eligible for services under the terms of the Chronically Sick and Disabled Persons Act, 1970.

The terminology of physical limitations has been graphically illustrated in the O.H.E. (1977) and reproduced in Fig. 2 (see opposite page). This attempts to connect the ideas of disease, impairment, disability and handicap into a continuum which extends from an individual physical event to a socially defined result. It assumes that the state of handicap is a behavioural consequence of disability and affects the individual's capacity to participate in an acceptable social role although other factors, such as the degree to which the individual is perceived as impaired or handicapped by others, may

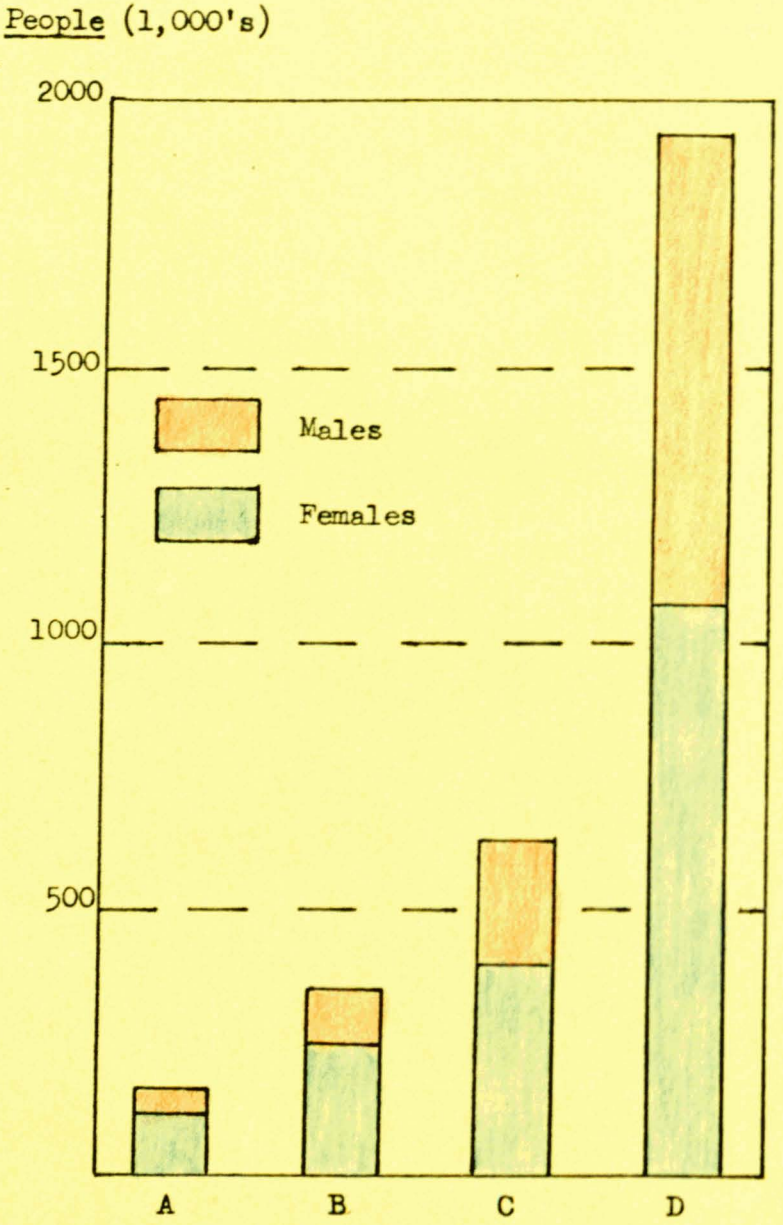
influence the overall process. Other relevant illustrations are shown on the ensuing pages, Figs. 3, 4 and 5, respectively.

Although illness, injury or functional limitations constitute necessary pre-requisites in the development of disability they do not always identify accurately either performance requirements or the adaptive potential of the individual. For this reason studies of disability have become more concerned with the interaction between restricted ability and the expected behavioural performance of the individual person.

As pointed out by Haber & Smith (1971), recognition of incapacity provides a basis for modification of role requirements and of behavioural alternatives. The duration of time is seen to be critical in the process of behaviour modification. Adjustments and intervention techniques appropriate to severe disability or handicap tend to focus on medical treatment whilst, in contrast, adaptations required to normalise role relationships and activities that are responsive to capacity limitations demand continuous attention and frequently absorb mental and physical energies. Similarly the extent of the overlap between individual and the organisational responses to incapacity may seriously restrict the adaptive opportunities of the functionally disabled or handicapped.

In summarising, it would appear that rational approaches to problems associated with the explanations of "disability" and "handicap" require some common agreement in both their conceptual interpretation and their form of measurement in order to provide a proper basis for understanding and coping with them.

Fig. 3 Handicapped and Impaired Adults in the Community



Note The Harris criteria of "handicap" were:-

A	Very severe	In need of permanent special care. For example, bedfast or chairbound, unable to feed or use the lavatory independently.
B	Severe	Finds most activities in daily living difficult, some impossible.
C	Appreciable	Can do a fair amount independently but some tasks difficult and help needed in a few areas.
D	Impairment	Either no difficulty in self-care or only minor problems.

Source Harris, 1971

3 Some Personal Aspects Influencing Disability Patterns

3.1 Age

Many studies of attitude have indicated that attitude formation and change are more related to experiences encountered than to age, per se (Barker et al, 1953; Wright, 1960).

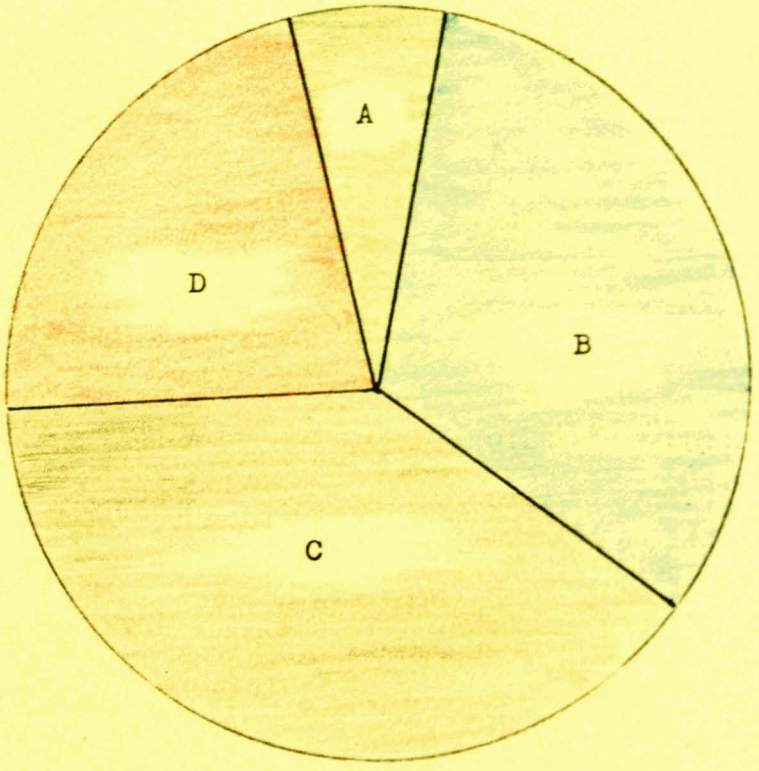
Yuker et al, (1966) pointed out that a number of findings about the relationship of age to attitudes of able-bodied people toward the disabled are contradictory. It was noted, however, that in terms of significant relationships, the younger age group of the able-bodied showed more favourable attitudes toward disabled people.

Siller, (1963; 1964) found that college students were significantly more favourable in their "Attitude Toward Disability Persons" scores than junior or senior high school students although Siller & Chipman (1964) did not report these differences when the sample was increased to include additional college students and some female adults.

An investigation concerning attitudes and information about deafness as a function of increasing maturity was carried out by Horowitz, Rees & Horowitz, (1965). Their findings revealed that, in general, a continuum existed with respect to age, education and achievement; the college students having significantly more favourable attitudes than either high school students or sixth grade students.

In connection with experimental studies carried out with people handicapped by impaired hearing, Barker et al, (1953) found no significant correlation between age at loss of hearing and adjustment whilst Bauman (1958) reported no significant correlation between the age and attitude of more than 2,000 blind adults towards their blindness.

Fig. 4 Number of Physically Handicapped People in Britain



Legend			N
	A	Children under 16 years	100 000
	B	Adults 16 and over in the community - severely and very severely handicapped	512 000
	C	Adults 16 and over in the community - appreciably handicapped	616 000
	D	Handicapped in institutions	350 000
			1 578 000

Source Office Health Economics estimates based on various sources, 1977

Studies carried out by Potter & Fiedler (1958) indicated that people with longstanding handicap tended to be more satisfied with themselves and more similar sociometrically to the non-handicapped.

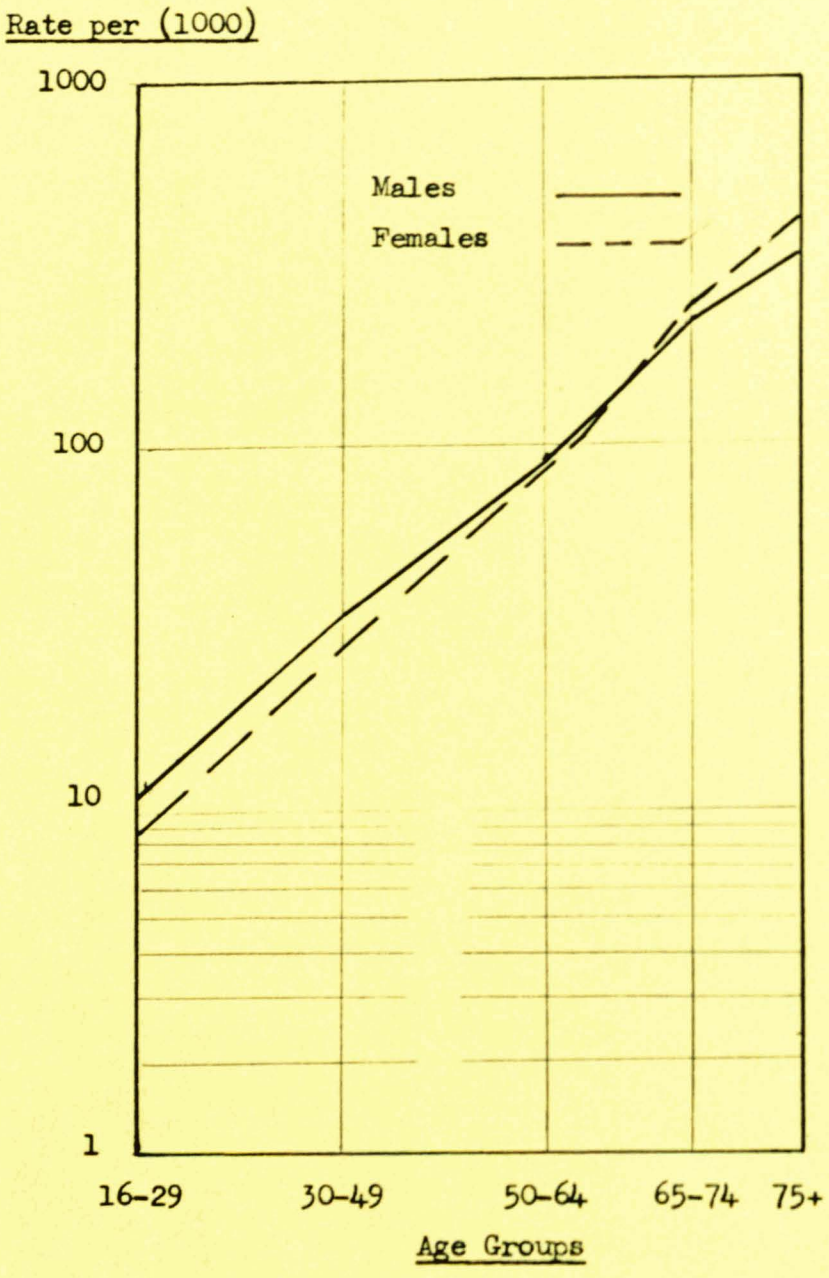
In a series of relevant studies, Yuker et al, (1966) did not find any significant relationship between attitude and age at onset of disability but the findings of Wada (1964), as reported by Yuker (p.57), revealed that attitudes were significantly related to acquired disability as compared to congenital disability. Greater acceptance was associated with acquired disability. An investigation by Arnholter (1963) involving 79 persons indicated no significant difference between workers whose abilities were acquired and those whose disabilities were congenital. Nevertheless, in the light of their survey of the evidence, Yuker et al, tentatively concluded that general attitude toward disability was unrelated to age at onset of disability.

3.2 Sex

Attitudinal differences between the sexes appear to have been examined in many studies and relevant data is readily available.

In the majority of studies reviewed by Yuker, Block & Campbell, (1960) in connection with the relationship between sex and "Attitude Toward Disabled Persons" (A.T.D.A.) scores, significant differences between males and females were reported with the females scoring significantly higher (i.e. greater acceptance of physical disability) than males. This view was shared by Chesler (1965), who, like Siller (1963), also reported that women tend to show a more positive attitude and acceptance of the physically disabled than do men. In offering a possible explanation for the behavioural pattern, Siller reasoned

Fig 5 Age specific impairment rates per 1000 people in the community



Note In the population aged 16 to 50 approximately 49% of the total are females.

In the population aged over 75, 69% are females.

Source Harris, 1971

that the underlying feelings are similar but that women are more subject to social pressures to compensate for this attitude (p.14).

A study by Baskin & Herman (1951) showed that female students tended to react more favourably to persons with disability than did male students whilst Gowman (1957) indicated that there were no sex differences when high school seniors ranked disabilities in terms of severity. Larkin (1962) pronounced that female adolescents tended to show better adjustment following blindness than male adolescents and Blanton & Nunnally (1964) found that deaf girls rated blind people and deaf people significantly more favourably than deaf boys did.

It would appear from the studies examined that females have a greater acceptance of physical disability than males not only as it affects themselves but also as it affects others.

3.3 Marital Status

Studies relating to the marital situation associated with attitudes to handicapped people appear to be more limited than one might have anticipated.

Bell (1962) conducted a survey involving non-handicapped married and unmarried hospital employees and found no significant differences. A similar result was produced from the investigation carried out by Yuker et al, (1960) concerning married and unmarried employees.

A perceptive account of how people felt when disability affected their relationships with spouses, parents and children is given by Sainsbury (1970). She found that marriages were at a greater risk of failure if the wife became handicapped than they were if disability primarily affected the husband. Marriages were also believed to be

at greater risk of failure soon after the onset of handicap than they were following a long period.

A similar survey was carried out by Blaxter (1976). Although it was a different geographical area and the subjects were less severely handicapped than those involved with Sainsbury's study, Blaxter considered that wives were more likely than husbands to leave the disabled spouse.

Safilios-Rothschild (1970) signified that married or unmarried women held a better chance following the onset of disability or handicap of being accepted in the family than male members of society. The role of breadwinner implies a more profoundly disturbing influence on the acceptance of disability it seems than the role of mother or wife. Gavron (1968) reported, in the married situation, a great deal of conflict and ambivalence (pp. 129 - 34). No incidence of husbands leaving their wives was reported by Deutsch & Goldston (1960). In a study of disabled husbands, Marra & Novis (1959) found that disability created a great degree of disruption in the marital situation. Wives were seen to take a greater responsibility for home management, to seek and accept employment outside the home, to experience an increase in marital discord and suffer a reduction in social and recreational activities.

Family situations especially high expectations from other members of the family, have been found to be conducive to the successful rehabilitation of the disabled person (Gibson & Ludwig, 1968 (a)). Litman (1962; 1966) found no appreciable relationship between the degree of family solidarity and the rehabilitation response of the handicapped person. However, the aims of therapeutic staff were

observed to be at great risk when the family failed to provide moral and physical support or failed to accept the performance or limitations of the handicap of the individual.

Sainsbury (1970) and Blaxter (1976) indicated that attitudes towards marriage were frequently affected by the degree of incapacity. Those who were severely incapacitated seemed to feel that they were unlikely to get married and tended to rationalise their disappointment by distinguishing the care required of a spouse from the outset of marriage from that demanded by the onset of handicap during the course of marriage.

A review of literature involving the sexual and emotional needs of the handicapped appears to suggest that many families, professional personnel, supporting services and people in the outer community cannot cope with the idea of the handicapped having the same emotional needs and desires as the remainder of the population. For example, in intermarriage between handicapped and non-handicapped, which is one of the best indices of social integration, negative attitudes and reaction of a large proportion of society to those issues seems to emphasise the "inferiority" status of the handicapped (Morgan, 1969; Shearer, 1972; Stewart, 1975; Greengross, 1976).

Opinions relating to relationships of love, sex and companionship, and a general description of the emotional needs of handicapped people are presented by Lancaster-Gaye (1972) from papers given at the First International Seminar of the International Cerebral Palsy Society.

The importance of sexual functioning is frequently seen to be a critical issue in the behavioural reaction of many handicapped people, particularly those disabled by paraplegia or tetraplegia. Indeed, until fairly recently, the view held by many medical consultants was

that the less said about the subject the better and many paraplegics and tetraplegics were encouraged to substitute other interests for their sexual desires (Colbert, 1969). Commenting about the lack of research on this subject before the Second World War, Gebhard (1968) noted a stigma associated with the topic which discouraged research relating to sexual behaviour and tended to prevent the publication of work already completed.

The sexual limitation of a spinal cord injured person is often considered the most frustrating and serious of all his disabilities (Medical World News, 1972), whilst Guttmann(1964),Guttmann & Walsh (1971), Chigier (1972), Hohmann (1972) and others have pointed to the serious consequences that lack of adequate knowledge about the subject can have on the self-concept and body-image of the handicapped. Mueller (1962) believed that one is impressed less often with his depression than with his own inability to understand what his disability is about.

Singh & Magner (1975) emphasised further that adjustment to sexual functioning is an essential part in the total adjustment process of the handicapped person. They believed that the topic was a vital part of the counselling relationship with the disabled and it called for frank and dignified treatment by all concerned.

3.4 Area of Residence

In 1966, Yuker et al (p. 50-51) stated that Roeher (1959) had reported that in a sample of over 300 Canadian adults, urban residents had exhibited more favourable attitudes toward disabled people than did rural residents. Results similar to those found by Roeher were found by Bateman (1962) in a group of 92 sighted children who had never known blind children; the urban children being significantly

more positive in their attitude toward the disabled. However, Yuker et al, (1966 - p. 51) recorded that an unpublished thesis by Lamers (1965) had shown contradictory results. In this survey, high school students in a city of population under 2,500 had revealed more favourable attitudes than high school students in a city with a population above 200,000.

3.5 Socio-Economic Status

Relatively limited information is available about the relationship of socio-economic factors and attitudes toward the disabled. Gowman (1957) found that lower class high school students tended to portray the blind with more stress on limitations and stereotyped concepts than middle class high school students. Yuker et al, (1962) reported on the relationship of property ownership and attitudes toward the disabled. Their results indicated that persons with favourable attitudes toward the handicapped were less likely to own houses or cars than persons who possessed such items. In a subsequent study, Yuker et al, (1966 - p. 53) reported that Felty (1965) had found in a sample of non-handicapped workers some correlation between persons in a low income bracket and positive attitudes toward the handicapped. Consideration of social class and reaction to physical handicap received attention from Dow (1965). Although it was predicted that owing to a relative emphasis attached to physique varying inversely with social class, reactions to physical handicap would be more severe at lower socio-economic levels, no difference was observed between a sample of middle and lower class families.

3.6 Disability Group Characteristics

In an endeavour to identify distinguishing personality traits for various disability groups, Barker et al, (1953), Dembo, Leviton &

Wright (1956 (a)) and Myerson (1957) believed generally that there was no clear evidence of an association between types of physical handicap and particular personality characteristics. Cohen (1962) reviewed personality aspects associated with multiple sclerosis; Tizard (1962) investigated personality aspects of epileptics; Moos (1964) reviewed personality data on over 5,000 sufferers from rheumatoid arthritis and all appeared to concur generally with the view of the previous writers.

Following studies with paraplegics, Hohmann (1966; 1972) found that emotional feelings of "sentimentality" increased subsequent to the onset of handicap whilst the levels of anger, sexual excitement and fear exhibited were reduced. An investigation carried out by Smits (1965) into reactions to the obviousness and degree of severity of physically handicapped people signified that persons with severe handicaps had much less favourable self-concepts than people with relatively minor handicaps.

Gray, Reinhardt & Ward (1969) found that persons with cardio-vascular diseases were generally less willing or able to accept their impairment realistically than other categories of handicapped people while Sanua (1960) suggested that cultural differences could have important determining influences on the behaviour of persons encountering stressful situations.

A study by Larkin (1962) involving blind adolescents implied that the extent of blindness is not influential in determining attitudes of the handicapped. The suddenness or gradualness of the onset of visual handicap was not significant in the findings of Bauman (1954) who also reported that little or no difference existed

between comparison groups in reported initial reactions to visual loss. Some support for the findings of Bauman is evident in those of Greenberg & Jordan (1957) who indicated that the degree of visual loss has no particular significance in relation to emotional adjustment although Myklebust (1964) considered that a relationship existed between sensory deprivation and emotional adjustment in connection with people handicapped by hearing loss. Rusalem (1950) believed that definite patterns of characteristics emerged from public attitudes toward blind people which implied that blindness was associated with specific "hallmarks". It was pointed out by Wright (1960) that visible handicap was particularly potent because it presented the person to others first in terms of physique and, consequently, tended to condition subsequent impressions. Barron (1955), Lukoff & Whiteman (1964) and Whiteman & Lukoff (1965) are other investigators who have examined the social consequences of visual loss.

Whilst Gowman (1957) found that blindness was chosen as a more serious handicap either foroneself or for a prospective spouse than either amputations, deafness or burns, MacDonald & Hall (1969) found that emotional handicap was more serious than those connected primarily with either internal, sensory or cosmetic features. In his study relating to the reactions to physical handicap, Siller (1963) found that people having the least cosmetic and functional implications were also those who received most favourable reactions from others.

Whilst recognising the possible psychosomatic effects of arthritis and rheumatism, Seidenfeld (1962) asserted that psychological treatment be directed toward individual situations and reactions rather than towards situations presumed to be constant with every person

within the same disability group. Diller (1962) recommended that people handicapped by hemiplegia but without perceptual or cognitive disorders be treated like any other group of disabled people. Schoenberg & Carr (1970) described reactions to loss of external organs, Blacher (1970) examined reactions to loss of internal organs and to chronic illness, Altshuler (1970) investigated reactions to sensory losses and Orfirer (1970) examined reactions to sexual loss. Although these writers referred to the psychological effects that accompany physical handicap, none described any feature that might have been recognised as a disability-specific personality. In their general opinions, the behavioural reactions of the disabled are determined primarily by pre-disability personality structure and by environmental conditions and experience.

The classification of disabilities by the able-bodied in terms of their seriousness imposed on the individual has received attention although the results of the investigations have not been uniform (Murphy, 1960; Rickard, Triandis & Patterson, 1963; Barsch, 1964).

In summarising, it seems that personal intervening variables can be of importance in the attitude of the physically handicapped and that it is important to consider them, irrespective of whether the study or examination deals with an individual person or a group. However, it would also appear that a cursory examination of existing research indicates that investigators are some way from establishing the presence of dependable correlations between disability and personality.

3.7 Stress and Denial of Disability

Denial of handicap has been known and studied for many years (Adler, 1927; Weber, 1942) and is seen as an important factor in the behavioural pattern of many handicapped people. The recordings of Wapner & Werner (1952), Werner & Wapner (1952) and Goffman (1968 (b)) indicate that attitudes and denials concerning the body are often the result of inter-personal relationships. Frequently cited concepts relating to inter-personal theory are those arising from the work of Barker and his colleagues, particularly his 1948 and 1953 monographs, and the treatise by Dembo et al, (1956 (a)), on adjustment to misfortune. Overlapping psychological situations involving mourning, succumbing, "spread", etc., are further illustrated by Wright, (1960).

The concept of denial seems to infer a negative effect as a necessary concomitant of disease or disability and one that is intrinsically disruptive. However, a study by Rosillo & Fagel (1970) indicated that persons with disabilities generally assessed their situations realistically. Neff (1971 - p. 46) reported that Dunn (1967) found that men and women college students with severe disabilities obtained greater satisfaction with social relationships than did those without disabilities.

Lederer (1952) regarded denial as the first stage of reaction to illness or disability. Resistance to taking the disabled role was considered by Phillips (1965) to be involved with assertions of the disabled person's autonomy while Goldstein & Eichhorn (1961) related such resistance to an individual's perception of the "good life" as determined by individualism and devotion to work. Denial of disability is seen by other writers to derive not only from the handicapped person's own behaviour but also from that exhibited by

his associates who often "minimise" the effects of the handicap or "normalise" the behaviour of the individual (Schwartz, 1957; Yarrow, 1960).

Weinstein and Kahn (1953) investigated the premorbid personalities of people who explicitly denied illness and found that explicitly verbal denial occurred only in persons with compulsive drives, a strong need for prestige and the esteem of others, and a record of always having denied felt inadequacies. Life experiences seem to have been valued not for their intrinsic satisfaction but as a means of maintaining prestige and "security". The same writers in 1955 reported ways in which major incapacities are denied, less threatening aspects of illness are stressed, and minimisation of disability, which is attributed to some benign cause.

The experiences of Warfield (1948), Hunt (1966) and others indicate that the concealment of handicap often creates emotional problems and examples of partial denial of blindness and prolonged false hopes for recovery by people associated with different handicaps are frequent in many writings including Garrett (1953), Gowman (1957), Carroll (1961), Garrett & Levine (1962), and Guttmann(1962; 1964). Denial of disability does not always imply personal depreciation of the "self". As suggested by Goffman (1968 (a)) it is often adopted for the purpose of maintaining social relationships if it is reasoned that the "truth" will not be acceptable. An illustration of the degree to which some persons will react to deny their handicap when devaluative attitudes are expressed about the disadvantages of the handicap is seen by the following comment by Warfield (1948):

> "I mustn't let on I couldn't hear perfectly.
> People didn't like it .... I must listen hard ....
> I must never say "What?" "What?" was perilous.
> "What?" would give away my secret and I'd be
> exposed to deadly danger." (pp. 4-5)

Further illustrations describing the humiliating and discrediting experiences of handicapped people are seen in the work of Edgerton and Sabagh (1962 - p. 267).

White, Wright & Dembo (1948) concluded that a visibly injured man might be reluctant to talk about the injury because of the fear of being "hurt". He might also feel that communication reminded him of painful implications of his injury or the situation in which the injury was received and these tended to promote denial responses. Here we see again the importance of the "social interaction" and "self-esteem" aspects of the problem. As shown by Barker, et al (1953) and Goffman (1968 (a) and (b);1971) a tendency to deny incapacity is common in the able-bodied as well as in the handicapped population.

Dembo et al, (1956) reported that individuals who have placed great value on bodily integrity, strength and attractive appearance and who consequently view physical handicap as a misfortune, tend to deny the existence of the handicap. They desperately endeavour to remain "normal" and attempt to prove themselves so by trying to retain pre-disability activities unchanged. Although these people are frequently admired for their behaviour, there is danger in their not being able to adjust with certain interactions (Litman, 1962;1966).

Weiss & English (1957) intimated that discontinuity in identity from "normal" to "handicapped" is sometimes used in a desirable manner since it provides the individual with a way to reconcile himself with negative, unacceptable life experiences or socially undesirable needs or wishes. This reaction is frequently seen among those over 45 years

of age, especially if they are unskilled or semi-skilled workers (Safilios-Rothschild, 1970).

Cowen (1960) seemed to indicate that research on psychological stress might provide information about the behavioural reaction of disabled people more clearly but attention to the subject by Lazarus (1966) and by Appley & Trumbull (1967) did not suggest much headway. A number of authors, including Blank (1957) and Carroll (1961) believed that persistent denial tends to be maladaptive.

3.8 Deviance

Disability and handicap tend to lend themselves to sociological analysis when conceptualised as deviance and Freidson (1966) presented a perceptive account of disability with imputed prognosis, responsibility and stigma being considered crucial aspects. Cohen (1959) refers to deviance as "behaviour which violates institutionalised expectations" whilst Lemert (1951) made distinction between primary and secondary deviations. Merton (1957), Cumming & Cumming (1957), Parsons (1958), Becker (1963) and Goffman (1968; 1971) discuss the imputations of social deviance.

It frequently seems that the key to remaining "normal" (i.e. pre-disability occupancy) for the handicapped is the non-possession of a societal label of deviance. Josephson's (1968) and Scott's (1969) studies inferred that people with the same degree of visible impairment may be labelled blind or not blind according to whether or not they have come to the attention of an organisation for the blind.

Passing as "normal" is seen as a stressful and complicated procedure for many disabled (Hunt, 1966; Edgerton, 1967; Goffman, 1968).

People who cannot "pass" because of the visible nature of the handicap seem to resort to the use of suitable ego defence mechanisms and Allport (1954) and Harbauer (1967) give descriptive accounts of this process.

Although labelling tends to be applied following the observation of deviant behaviour, Akers (1968) and Haber & Smith (1969) have indicated that it is the inappropriateness of responses to the disability rather than the labelling per se that leads to over-active negative feelings. This may suggest that the effects of stereotyping are as prevalent in attitudes toward the handicapped as they are toward ethnic minorities and they also tend to be as resistant to change. Literature by the handicapped themselves suggests that deviance may take various forms ranging from physical abnormality to discredited lineage or social class (Brown, 1954 (a); Hunt, 1966; Minton, 1974).

3.9 Body-Image and Self-Concept

Schilder (1935; 1953) seems to be largely responsible for the formulation of the concept of body-image as it is currently known and as used subsequently in the writings of Fisher & Cleveland (1968) and Fisher (1970). The body-image is often considered as a base for ego formation and frequently the terms are used interchangeably. As indicated by Schilder perception and disturbance of the body-image has an important influence on the behavioural reaction of the handicapped person. Apart from congenital handicaps or those occurring in the early stages of life, the onset of physical handicap requires change or modification to the pre-disability body-image. Fisher & Cleveland considered body-image to be a summary in body terms of a great many experiences the individual has had in the course of defining his

identity in the community. Hence, the body-image is a sensitive indicator which registers many of the person's social relationships, particularly those involved in the development of the identity.

Boulding (1956) proposed the establishment of a science devoted to the study of images while Scott (1965) and Deutsch & Merrit (1965) made further contributions to this aspect of handicap. The importance of "image" is also seen in Braydon's (1957) study of the problems of physically handicapped adolescents.

Shontz (1964) carried out an extensive review of the research in relation to bodily perceptions and described many approaches and methods used. The work of Rogers (1951; 1967) indicates that although the process of body-image development is subjected to other pressures and strains, the body-image and self-concept relationship is very close. According to Shibutani (1961), a person's body-image including physical appearance, bodily sensations, beliefs and emotions makes up part of the self-concept. Its importance within the self-concept varies with the nature and intensity of values and emotions invested in it. A similar view was seen by Wright (1960) who stated that the person's self-image is made up of the variety of personal characteristics that define for the person his psychological identity (p. 138). As explained by Kinch (1968), self-concept is the emergence from social interaction of the individual's conception of himself which, in turn, generates or influences the behaviour of that individual.

Machover (1949) examined the projections of personality in the drawing of the human figure and elucidated its value in personality evaluations. It was believed that the drawing of a person involved a projection of the body-image and provided a natural vehicle for the

expression of one's need and conflicts. One might suspect that the sudden loss of lower limb functions, bladder, bowel and sexual functions could be anticipated, as in the case of persons handicapped by paraplegia, to call for profound adjustment in the individual's conception of his whole body. Thom, Von Salzen & Fromme, (1946) stated that the paraplegic's ego suffers a great deal at the time of injury. In their opinion, the paraplegic's realisation of loss of normal sexual, bowel and bladder functions caused profound ego disturbance and tended to make the handicapped person depressed, over-dependent and unrealistic about the future. Nagler (1950) considered that a paraplegic suffers loss of prestige and, where loss is only functional, has greater difficulty in facing reality than a person who has suffered from an amputation where the loss is primarily of a structural nature.

An investigation of body-image in men with spinal cord injury was carried out by Wachs & Zaks (1960). In a "Draw-a-Person" test, members of a control group of chronically ill people were paired with an experimental group for age, education and length of illness. No significant differences were found between the groups. Studies carried out by Bors (1951) and Evans (1962) failed to produce any significant distortions in body-part size perceptions in paraplegics, whilst Mosak (1951) and Seymour (1955) indicated that spinal cord lesions tend to undermine self-esteem and self-concept and so cause considerable psychological disturbance. Some persons with amputations seem to experience a "real" and not an imagined "phantom limb" because of the need to keep the body-image and bodily sensations intact even after significant changes have arisen (Sanua, 1960; Simnel, 1962; 1967).

Other studies, including Petrus & Balaban (1953), have found no increased incidence of psychosis among paraplegics and that neuroses

were uncommon. Menninger (1953) pointed to the importance of body-image in connection with rehabilitation; Frank (1959) related body-image to feelings of guilt and shame; and Shontz (1969) indicated that the concept of body-image served as a rational basis for making practical decisions about remedial treatment.

In comparing non-handicapped wheel-chair restricted, and hemiplegic persons, Fink & Shontz (1960) reported that the physically healthy tend to over-estimate body-part sizes whilst the handicapped tend to under-estimate such aspects. Data obtained by Epstein & Shontz (1962) suggested that persons with low body satisfaction avoid the handicapped whilst those with high body satisfaction were more accepting.

MacGregor, Abel, Bryt, Lauer & Weissman, (1953) indicated that individuals with facial disfigurements who had adequately incorporated their disability in their self-concept were satisfied with improvement achieved through plastic surgery. The opposite reaction took place for those who had never accepted their disability and had not incorporated it into their self-concept. Secord & Jourard (1953) found women more likely to develop anxiety in relation to bodily processes than men; an observation contrary to those of Yuker et al, (1960) and Chesler, (1965). Cormack (1967) attempted to examine body relationships in the context of Festinger's (1957) theory of cognitive dissonance and found that those persons who experienced minimal discomfort in relation to their bodies tended to express more positive attitudes toward those who were visibly handicapped than people who experienced extreme discomfort.

Self-image is frequently associated with personal worth and values and, as indicated in the writings of Smith, 1958; Hartman, 1959;

Wylie, 1961, and Geis, 1972, the relationship and complexities of personal worth and values to the disabled can cause much stress. Whilst the physical and social realities are often constant reminders to the individual that he may never be able to fulfil his pre-disability role or ambitions, it seems that he, as the disabled person, must acknowledge that he is the arbiter of his level of satisfaction and determines this level by the way he defines or conceives of himself. Referring to the human capacity for evaluation, Smith (1958) states:-

> "..... the ability to respond .... in a critical way ..... is at the basis of all discussion concerning what has come to be called value." (p. 8)

3.10 Depression (Mourning)

The clinical manifestations of depression outlined by Cleghorn & Curtis (1959) were similar to those postulated by Wright (1955) who also considered that "mourning" implied a realisation of loss and the beginning of new coping mechanisms for the acquisitions of new motivations and for changes in values. Grief and related mourning have been identified by Rochlin (1965) and Blank (1971) as crucial phenomena in any kind of severe disability whilst Siller (1969; 1976) has indicated the importance of the mourning stage in the process of rehabilitation. Studies by Moos & Solomon (1965) and others have indicated that depression or "mourning" following the onset of handicap tend to aggravate the adverse effects of disability. About 50% of Sainsbury's (1970) sample thought that they got more depressed than the non-handicapped. Contributory factors given were lack of social contact, the insecurity for normal activities, inability to integrate into the community and lack of occupation.

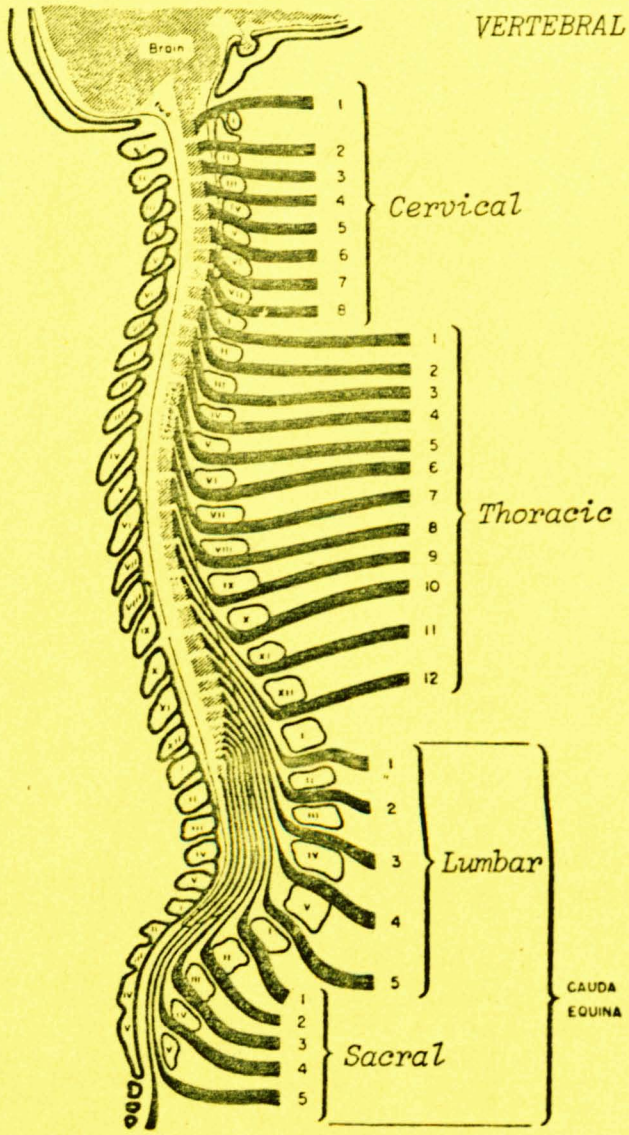
Fig. 6 Illustrated Definition of Paraplegic

(Person disabled by paraplegia)

A Paraplegic is a person whose lower extremities and part of the torso are paralysed as a result of injury or disease of the spinal cord.

A Tetraplegic has in addition a paralysis of the hands and a partial paralysis of the arms.

Most paraplegics and Tetraplegics have loss of sensation below the level of injury and loss of controlled function of the bladder and bowel.



VERTEBRAL COLUMN AND NERVE SUPPLY

C4 Diaphragm
C5 Deltoid and Biceps
C6 Wrist Extensors
C7 Triceps
C8 Hand

T2 - T7 Chest Muscles

T9 to T12 Abdominal Muscles

L1 - L5 Leg Muscles

S2 and Below - Bowel and Bladder

Kerr & Thompson (1972) believed that grief and mourning are inevitable and, in the case of paraplegics, emphasise the despair at the loss of physical ability, sexual potency and the loss of their former place in society. The authors state that the first questions usually asked following the onset of paraplegia are:-

> ""Will I be able to walk again?" and "Will I be able to work again?" The third question is there but suppressed; "Will I be able to have sex again?"" (p. 95)

3.11 Pain

The presence and perception of pain are important factors which contribute to the adjusted behavioural pattern of handicapped people. Investigations by Melzack (1961), Melzack & Wall (1965), Melzack & Torgerson (1971) and Lewis (1975) leads to the conclusion that the diversity of pain experiences probably explains why it is so difficult to define it satisfactorily.

The findings of Melzack (1973) supported the belief that pain was a:-

> ".....perceptual experience whose quality and intensity are influenced by the unique history of the individual and the meaning he gives to the pain-producing situation and by his "state of mind" at the moment." (p. 48)

The three pain syndromes, phantom limb or "absent limb" pain (Cronholm, 1951), causalgia or "burning" pain (Echlin; Owens & Wells, 1949) and neuralgia or "nerve" pain (White & Sweet, 1969) seem to indicate unusual features which frequently become maladies in their own right with the pain becoming far worse than that associated with the original injury. The high incidence of perception of phantom limbs and phantom pain, particularly in connection with people suffering from amputations and spinal cord lesions, and the frequency

with which the experience is associated with emotional distress, makes this area of study of importance, psychologically, as an element in an adjusted behavioural pattern for the handicapped person (Simnel, 1956).

Pain and its relief were considered by White & Sweet (1955) to constitute one of the great problems of medicine while Schilder (1964) reported that pain and motor control over the limbs played a special part in the creation of body-image.

3.12 Sensory Defects and Handicap

Vision and hearing are probably the most important of man's senses as they give him information of objects and events at some distance away from him. Whilst vision is directional, hearing is multi-directional. Both are complementary interactional agents which stimulate the network of communication and information to man.

In dealing with auditory handicap, Lane (1953) found greater emotional instability amongst the hard of hearing than among persons with normal hearing but qualified this finding by drawing attention to the marked differences of individuals. This finding appeared to be substantially corroborated by Levine (1953) who, subsequently (1962), recorded that the type of adjustment adopted by a person with auditory loss varied according to type and degree of handicap. Myklebust & Brutten (1953) found that when hearing is impaired in early life, visual perception is also disturbed. In their respective samples relating to hearing losses, Talkington & Reed (1969) and Talkington & Hall (1969) found few personality differences although subjects with hearing impairments tended to be more self-destructive than those without such handicaps. Results arising from an investigation carried

out by Rainer, Altshuler, Kallman & Demming (1963) emphasised the effects of acute isolation on people handicapped by hearing losses and Conrad (1970) found that students often memorised in a code quite different from that used by their teachers.

The reactions of people who sustain visual loss was investigated by Fitzgerald (1970). It was found that there was a need for prompt support on those who encountered blindness as a permanent handicap as it is a profoundly traumatic experience. Raskin (1962) indicated that although blindness imposed many practical problems it did not seem to produce maladjustment; an observation previously interpreted without general dissent by Lowenfeld (1953). In comparing cane users, guide dog users and those who did not use either aid, Bauman (1954) found that the persons who used guide dogs were more positive in their attitude toward blindness, possessed greater social competency and had less feelings of inadequacy.

An investigation by Cowen & Bobrove (1966) involving visually and auditory impaired subjects seemed to suggest that total disability tends to be less productive of personality disturbances than partial or marginal disability whilst studies by Myklebust (1964) and Sterritt, Camp & Litman (1966) indicated that the elimination of a sensory system disrupts the integration of residual sensory functioning.

Cowen, Underberg & Verillo (1958) established that anti-minority group attitudes were highly correlated with antipathy toward the blind, Handel (1960) and Himes (1960) concluded that attitudes toward the blind revealed evidence of stereo-typing and aversiveness to social closeness, and Noonan, Barry & Davis (1970) attempted to evaluate five theoretical approaches to the problems of aversion toward visible disability. These included cultural conformity, low

ego strength, authoritarianism, field dependence and unconscious concern. Authoritarianism was found to be the most valid predictor of negative attitudes toward the disabled.

3.15 Reactions and Adjustment

The behavioural reaction of people to handicap not only frequently depends upon the personal adjustment of the handicap but also is an important factor in that adjustment. Although as indicated by Wright (1960) and McDaniel (1969) there is no clear evidence of an association between types of physical handicap and particular personality characteristics, most writers agree that physical handicap increases difficulties with personal adjustment. Disablement suffered in adolescence or later years tends to be a period of shock, regret and frustration arising out of the inability of achievement of what were previously quite simple goals. A new body-image has to be realistically developed and accepted involving the formation of new relationships and a modification of his role in society.

Taylor (1960) indicates that the handicapped individual is deflected from the "norm", not in his "human substance", but in his physical and emotional efficiency and thus, emotionally shorn, tends to become abnormal in his attitude to himself and the outer world. Davis (1951), Sainsbury (1970), Townsend (1973) and others have indicated that handicapped people are frequently in a state of conflict from the occurrence of their handicap, the magnitude of which depends upon the nature and intensity of the disabling element. Contact with fewer people, restricted needs and fewer opportunities for communication tend to retard potential growth of the disabled person. His "closeted" surroundings tend to make interests in the self seem over-important, so that with narrower and fewer stimuli

his awareness and appreciation of the needs of others often decrease (Herron, 1966; Safilios-Rothschild, 1968; Blaxter, 1976). Frequently, as Shontz, Fink & Hallenbeck (1960) found, the handicapped person's energy is redistributed into channels more concerned with physical functioning whilst other values are rated less significant. The classical work of Maslow (1948; 1954) on the "Hierarchy of Needs" indicated that the higher order needs cannot become potent until the basic physiological and safety needs have been satisfied.

Increased physical symptoms and complaints, greater depression and apathy, and increased neurotic tendencies toward isolation, anxiety, dependency and lack of behavioural control were diagnosed by Moos & Solomon (1965) to be associated with people having greater degrees of functional incapacity. The principal findings of Wallen, Samuelson, Brewer, Gerber & Woolaver, (1964) revealed that the mildly handicapped tended to direct their guilt and hostility outward against the environment and seemed to have higher anxiety levels, whereas the severely handicapped tended to internalise their feelings.

It might have been thought that a marriage of the profiles of an emotionally mature person (Saul, 1947) and a self-accepting person (Berger, 1952) would reveal the kind of behaviour desired from a physically handicapped person. However, the work of many writers including Barker et al, (1953), Yuker, et al (1966), Siller et al, (1967), Edgerton (1967), McDaniel (1969), Saunders (1970), Scott (1970) and Blaxter (1976) indicates that a difference exists between someone accepting himself as a person with a handicap and someone accepting himself as a "whole" person.

In attempting to explain inconsistencies in relationships between degree of disability and adjustment, Wright (1960) postulated

that a person with a mild disability may have a greater push to hide and deny his handicap than a person whose handicap is so severe that it is undeniable and allows him no recourse but to grapple with the problem of accepting himself as a person with a handicap. On the other hand, it was believed that a mild form of handicap, by imposing fewer physical limitations, makes adjustment easier (Davis, 1961; 1965).

Physiological threat has always been of major concern to many handicapped people (Rosenzweig, 1944). With this in mind, Shontz, et al, (1960) indicated that items which were more highly valued by the chronically ill groups than the able-bodied groups were use of the body from the neck down, control of the bladder and the ability to walk. The items found to be more highly valued by the physically healthy groups included education, ability to love, children, religion and sexual capacities.

Although many observations have indicated that paraplegics often show evidence of depression because of their handicap, Nagler (1950) believed that the depressive reactions were seldom prolonged and, indeed, the initial presence was frequently taken as a good prognostic sign of adjustment as it tended to indicate a realistic recognition of loss. Mitchell (1970) found no difference of any magnitude between paraplegics and tetraplegics on adjustment scores from a variety of tests. Following their investigation into the vocational interests of paraplegics and tetraplegics and comparing them with other people of a disability group, Kunce & Worley (1956) contended that personality differences existed before the onset of disability and did not necessarily arise from the consequences of disability. Factors in the adjustment of paraplegics have been examined by several other writers including Grayson (1950), Manson (1951), Seymour (1955) and Guttmann (1962; 1964; 1965).

In their general conclusions, many investigators emphasised that appeals to the handicapped person's desire to get well were frequently short-sighted as getting well was only a part of the patient's "total structure". They believed that it was the entire "total structure", not his body alone, which determined the individual's attitude toward full recovery and his potential role in the community.

3.14 Other Issues Influencing the Personal Perspective of Physical Handicap

Differences between the way difficulties and problems are perceived by both the physically handicapped person (active participant) and the observer (active or passive) seem to have an implicit significance for the behaviour reaction of the handicapped (Dembo, 1964; 1970; Jones & Nisbett, 1971). Among these appear to be:-

3.14.1 Familiarity - The person who has been physically handicapped for a relatively long time seems to get used to it and, in many cases, seems to become more tolerant and accepting of its consequences. The work of Zajonc (1968 (a) and (b)) and Bandura (1969) support the importance of familiarity in reducing aversion and inducing liking.

3.14.2 Ownership - Physical handicap seems to become part of the self and, as seen by Heider (1958) tends to cause a positive sentiment as the individual becomes accepting of his own handicap.

3.14.3 Identity - "The boy in the wheel-chair", "The lady with the crutches", or "The man who uses hooks for arms" contribute significantly to the personality factors of the individual and his behavioural reactions to the observers (Wright, 1960; McGregor, 1951).

3.14.4 "Spread" - In contrast to "coping behaviour" when the handicapped person (active participant) reduces the adverse effects, circumventing

or overcoming them, the able-bodied (active or passive observer) frequently focuses attention and behaviour on the negative aspects of the handicap. As indicated by Dembo et al, (1956 (a)) there seem to be few positive aspects preventing a "negative spread" with its consequential effects.

3.14.5 Attribution - There is a basic difference in the perception of the cause or source of problem and difficulties as experienced by the handicapped person (active participant) and the perceptions made by the active or passive observer. As suggested by Valins & Nisbett (1971), the handicapped tend to attribute their difficulties primarily to environmental issues whereas the observers seem to focus their attention much more on the handicap and associated personal problems.

3.14.6 Span of Realities - The attitude and behavioural reaction of the handicapped seem to be frequently at variance with the able-bodied as their experiences in contact with various physical and environmental situations differ. They have a different "span of realities" because what is perceived and how well it is perceived are often seen to be very different (Willems, 1965; Mitchell, 1970).

3.14.7 Crisis - Observers agree that traumatic disability creates a crisis situation (Cohn, 1961; Davis, 1963). The adjustment process described by Shontz (1965) consists of a succession of approach-avoidance cycles with the frequency and amplitude diminishing with time. Blank (1971) observed a series of stages in an individual's reactions to blindness which contributed to the success or failure of the adjusted self whilst a four stage process involving shock, defensive retreat, acknowledgement and adaptation was characterised by Fink (1967) to be the primary reaction to traumatic disability.

3.14.8 Cosmetic - The importance of the cosmetic aspect of disability as an influential issue in personal relationships and social integration was seen by Dembo & Tane-Baskin (1956 (b)) and Siller & Silverman (1958) to be largely dependent upon the "intensity" of the social situation. It is also seen as an issue that frequently encroaches insiduously into the family sector.

4. Situational and Environmental Aspects of Disability Behaviour

4.1 Attitudes

The problems and difficulties experienced by many disabled people seem to have their origin in negative attitudes and emotional reactions of the non-handicapped members of society towards them rather than in physical neglect of inadequate medical treatment and caring. Professional literature contains many comments dealing with the negative feelings of the physically non-handicapped toward the physically handicapped (Gellman, 1959; 1960; Du Brow, 1965; Hilbourne, 1973; Snowdon, 1976) and frequently either state explicitly or imply a lack of social acceptance. As pointed out by Wright (1960; 1974) and others, positive coping aspects by the physically handicapped are frequently ignored whilst the negative features are emphasised. Rickard et al, (1963) and Jaffe (1967) have indicated that the dispensation of negative "labels" is conducive to positive behavioural reaction in the disabled. The effects of "social distance" are seen in the works of Merton (1957), Clinard (1964), Freidson (1966) and Scott (1970).

Social interaction between able-bodied and the handicapped has been approached from the viewpoints of social psychology, sociology and anthropology (Meyerson, 1948). Important theoretical and

descriptive analyses have been presented in terms of stigma and deviance (Davis, 1961; Goffman, 1968), experience and subjective sentiments (Hunt, 1966; Keller, 1970; Morris & Butler, 1972; Ashley, 1973; Bleackley, 1974), value systems (Dembo et al, 1956) and other similar works. Siller, Ferguson, Chipman & Vann, (1967 (a) - p.1) however, regret that many social psychological analyses have failed to consider certain fundamental implications of physical handicap as, for example, issues involving the body-image and self-image processes.

Scott (1970) has indicated that the existence of traits or qualities that stigmatise can be perceived as the product of ordinary genetic, psychological, social and economic processes that operate in all societies.

Despite the passage of time and the attention given to relevant issues concerned with disability, much recent literature infers that the status of the disabled continues to be ambivalent, even when essentially negative (Blaxter, 1976, and others). Disability is seldom seen as a status symbol (Wright, 1960; Neff, 1971) and frequently the individual finds himself in a "double bind" position, where on the one hand, he is expected to behave dependently, uncomplainingly and unostentatiously, whilst on the other, he is expected to accept and overcome or react as if he had no physical handicap (Sussman, 1966 (a)).

The writings of Dembo et al, (1956 (a)) and the earlier research of Ladieu, Haufmann & Dembo (1947) and White et al (1948) highlight the social consequences emanating from adjustment to misfortune.

Cowen (1960) investigated the paradoxical position posed by the severe maladjustment reaction experienced by some people with relatively slight handicap and the good adjustment made by others with

severe handicap. It was thought that the problem of maladjustment tended to arise from a perceptual disturbance or an internal change in organisation involving social relations.

Comer & Piliavin (1972) presented their ideas of the effects of physical deviance upon face-to-face interaction from experimental testing of hypotheses derived from Goffman's (1968 (a)) analysis. The findings appeared to demonstrate the significant contribution of the handicapped to the "pathology" of the interaction between the handicapped and physically non-handicapped. The importance of face-to-face interaction in the formulation of attitudes concerning handicapped people was also highlighted by Kleck (1966); Kleck, Ono & Hastorf, (1966); Campbell, (1967); Kleck, Buck, Goller, London, Pfeiffer & Vukcevic, (1968).

The work of Yuker et al, (1966), in their "Attitude Toward Disabled People" (A.T.D.P.) Scales; Goffman, (1968 (a) and (b); Wright, (1973) and others have indicated that attitudes towards the handicapped are multi-dimensional variables and that prejudices toward the handicapped may be better understood and conceptualised as a continuum.

Safilios-Rothschild (1968) illustrates the complexity of "hard core" areas of discrimination found even in "enlightened" people. Support for this observation is also seen in writings relating to the more fundamental areas of education (Snowdon Report, 1976), rehabilitation (Sussman, 1966), employment (Proceedings of Tenth World Congress of the ISRD, 1967) and mobility (Sharp Report, 1974).

It is also perceived that the handicapped, themselves, and particularly those who are able to pass generally as "normals",

frequently discriminate against the disabled. The motivation to interact socially, become close friends, fall in love or marry another disabled person, appear to be significant features (Hunt, 1966).

Other irrational factors are also seen to interfere as, for example, facial disfigurements which although not necessarily impairing people functionally, frequently set them apart socially and may have a much greater discriminating influence than that imposed on those more functionally handicapped, as in the case of, say, amputees (Macgregor, 1951; Macgregor et al, 1953; Whiteman & Lukoff, 1965).

Many negative attitudes towards handicap appear to develop from "prejudice" or "minority" views. Best (1967) believed that the disabled suffered the indignities of other "minority" groups in terms of discrimination and prejudice, an opinion endorsed by other investigators (Granofsky, 1956; Roeher, 1961; Sussman, 1969).

The prejudice approach includes what has been described by Wright (1960) as the "devaluation" aspect. Comparing attitudes exhibited toward ethnic groups and others in under-privileged social positions, Wright (p. 51) referred to Ray's investigation in which high school students showed that when the stimulus subject was presented as handicapped he was rated as feeling more inferior than when he was presented as non-handicapped.

The early writings of Barker (1948), Meyerson (1948) and Chevigny & Braverman (1950) suggested that a large proportion of people believed that "minority groups" have much in common and, by implication, may transfer findings from one group readily to another group.

Jordan (1963) commented upon the practice in literature to compare the handicapped with minority groups (Barker et al, 1953;

Wright, 1960; Lukoff & Whiteman, 1961; 1963), and contended that adherence to the premise that the physically handicapped could be equated to minority groups caused conceptual confusion and impeded heuristic goals. The findings of Jordan showed that there was adequate basis for regarding the handicapped with separate concepts from those applicable to minority groups.

The question that appears to emerge in these writings is whether the handicapped can be considered as a minority group, particularly when discussing attitudinal traits, a situation which seems much in evidence in Gowman's (1957) treatise concerning blind people.

Safilios-Rothschild (1970) gives a perceptual account of many deep-seated fears and aversions in the non-handicapped about most disabilities - visible and non-visible, stigmatised and non-stigmatised.

It seems that it is not always the handicapped people who can define whether they are socially or psychologically adjusted; this is often decided by the non-handicapped whose policy frequently appears to be based on their socio-psychological interpretations of what the handicapped, as a stereo-typed group, are expected to be and how they should perform. The complex problem of attitude definition and measurement is referred to again and the literature of it supplemented at the beginning of Chapter III (Formulation of Hypothesis - pp.107-114).

4.2 Role Behaviour

Basic to a study of physical handicap is an understanding of the social meaning of its consequences for the individual. Handicap inevitably changes fundamentally the individual's role. Apart from external behavioural changes there are changes in the way the individual perceives himself and his role, and the way he is perceived by others.

Parson's (1951) formulation of the role of the sick appears to have been widely quoted. Expectations defining this role include exemptions from normal roles, viewing sickness as an undesirable state of affairs to be relinquished as soon as possible, seeking competent help, and co-operating with such help. This conceptualisation seems to have been the subject of a number of criticisms in that it places much emphasis on motivation, does not account for normative differences in society, and does not account for differences between short-term acute sickness and long-term chronic illness (Freidson, 1966; pp. 71-99).

The problem of the role of the handicapped has wide implications not only for the individual but also for his family and other sectors within the community and the importance of role discontinuity, role strain and role asynchrony can be observed in the writings of Thomas (1966), Christopherson (1968), Starkey (1968), Cogswell (1968) and Ludwig & Colette (1969).

According to Haber & Smith (1969), success in the disabled role was achieved when adaptive responses were resolved into adaptations of the disabled role, itself. The disabled role was observed as a normalisation process in which the residue of the pre-disability role was utilised to develop and establish a pattern of behaviour which was considered acceptable to the family, supporting services and outer community.

Gross and his associates (1958) distinguish three categories of role definition which, in turn, were constructively criticised by Nagi (1966) who believed the categories to be better defined as conditions. Nagi drew particular attention to those categories which referred to societal ascription and expectations ("normative cultural patterns") and those which focussed on the reciprocal nature of behaviour ("interaction").

Conflict of roles frequently arises if role expectations are ambiguous and uncertain as behaviour becomes unpredictable. They appear to become more complicated when the implications are involved with the caring aspects of the wider medico-psycho-social field.

Non-facilitative relationships with others appear to act as a deviation from the pre-disability behaviour pattern learned by many handicapped and consequently impedes the positive qualities derived from cultural values.

As implied by Goffman (1956; 1968) and Wright (1960), handicap tends to cause a fragmentary effect on the behaviour pattern and produces a poignant "hurt" to many physically handicapped people when they realise that they must frequently accept assistance which cannot be repaid.

The impact of interaction with physical handicap seems to involve time and capacity as a consequence of restricted mobility, ability and other related features. These have an important influence on the behavioural repertoire and resultant interplay with the handicapped person's performance in both his major role and associated complementary roles.

Adjustment seems to derive from the nature and extent of the personal handicap and the role of interaction in four main areas consisting of the self, family, supporting services and the outer community. Apart from adjustment, many handicapped people are called upon to deal with the discontinuity of a previously occupied role in both daily living activity and social integration.

Perceptions made by Younghusband, Birchall, Davie & Kelmer Pringle, (1970), Miller & Gwynne (1972), Townsend (1973) and other principal workers involved with the handicapped, and the personal experiences of Keller (1970), Battye (1966), Boydell (1974) and others who have personally occupied the position of handicap, indicate that the role of the handicapped is intricate and closely interwoven with the issues of expectancy and acceptance.

It also seems that because they are frequently in confined roles of occupancy, many handicapped people find that they have to explain their function. Their particular condition and the apparent lack of knowledge about the condition by the non-handicapped appears to place a burden of explanation upon the handicapped over and above that which the non-handicapped carry.

The expectations of the handicapped by the able-bodied appear to be frequently determined by the goals or objectives which groups or sub-groups pursue in accordance with their personal interests (King, 1962; Hunt, 1966; Thomas, 1966; 1967; Jaco, 1972).

Briefly, such expectations are associated with dependence, conforming, withdrawal of prestige and power, dignified suffering, an inherent intuition of the course of events which the handicap will follow, and an expectation that the disabled will achieve maximum potential.

Discrepancies arising from behaviour at variance with role expectations have drawn the attention of many writers including Block (1952) and Gross & Stone (1964). Tension and embarrassment for both handicapped and non-handicapped appears to be frequently followed by attempts to relieve the situation by behaviour which illustrates an

apparent lack of understanding of the position (Goffman, 1956; 1971). These writers imply that embarrassment incapacitates persons for continued role performance and when identity, poise and confidence are disturbed role performance cannot continue.

Similar discrepancies occur, of course, outside the area of physical handicap. Flynn (1967; 1970), for example, reported wide discrepancies in the role conception between workmen, supervisors and other officials despite close legislative control in the operation of their various duties within the coal-mining industry.

In the area of acceptancy, the handicapped person seems to find himself in occupancy of at least four roles, namely, the person with a handicap (as his "self"), a person requiring assistance, a co-operative performer, and a person endeavouring to identify his individual role (Goffman, 1968; Thomas, 1967).

Important elements in these areas of acceptance include:-

4.2.1 a sense of healing and security which appear to be derived from the bond of love and companionship necessary to combat the feelings of depression, shock, guilt, anxiety and frustration (Hunt, 1966; Brattgard, 1972; Lancaster-Gaye, 1972; Braddick, 1976).

4.2.2 the presence of opportunity - permitted by the knowledge that the disabled person will be received, respected and accepted as an individual with equal rather than a superficial equality (Keller, 1970; Younghusband, 1970; Bleackley, 1974).

4.2.3 the freedom of participation - provided by the absence of psychological, physiological and sociological barriers (Carroll, 1961; Sainsbury, 1970, Morris & Butler, 1972; Ashley, 1973).

4.3 Rehabilitation

Bedbrook (1972) indicated that rehabilitation was one of the greatest challenges that medicine had to face and stressed the importance of understanding thoroughly a subject which appeared to have limitless horizons.

Rehabilitation is seen as a compendium of many components such as medical treatment, physical treatment, functional assessment, re-training and resettlement with each component consisting of many integral elements.

Although the term, "rehabilitation", was interpreted by Whitehouse (1956) as the "cultivation, restoration and conservation of human resources", (p. 56), Bermingham (1972) perceived a subtle distinction to exist between "rehabilitation" and "habilitation". The former was referred to as the "restoration or conservation of human resources" and the latter to the "cultivation of human resources".

As seen by Straus (1966) and Gellman (1974), rehabilitation comprised the total adaptation of the handicapped - physical, psychological, social, vocational and recreational, whilst Bloom (1966) viewed the term as a socialisation process, the purpose of which was to prepare the handicapped person to adapt to a type of deviant role.

The Tunbridge Committee (1972) Report, which coincided with the publication of the relevant Mair Report (1972) deliberately omitted to re-define "rehabilitation" and preferred to adopt the statement used by the World Health Organisation (1958):-

> "Medical rehabilitation has the fundamental objective not only of restoring the disabled person to his previous condition, but also of developing to the maximum extent his physical and mental functions. It aims not only as "physical cure" but also at "social cure". (para. 86)

According to Sussman (1966), rehabilitation is determined not by objective and scientific analysis of the individual's medical needs, as in the case of illness, but by evaluation of characteristics found in multiple social systems. Benefits, imputed stigma, reaction of families, peers and reaction from other sectors of society are some of the factors used in assessing rehabilitation potential and in effecting a regimen.

In advocating the need for a common terminology, Nagi (1966) differentiated among a number of phenomena including such aspects as traumatic injury (active pathology), anatomical abnormalities (impairments) and functional limitations. Myers (1966) also raised the problems of inconsistency in definitions of disability and potential for rehabilitation purposes.

Inconsistency among organisations in definitions of rehabilitation seems to limit or restrict the prospects of effective progress.

Ability of the handicapped to obtain some measure of independence was seen by many writers, including Sainsbury (1970; 1974), Townsend (1973), Topliss (1975) and Blaxter (1976) to be a good indicator of successful rehabilitation although such success frequently appeared to be greatly affected by existing economic and political issues. Pinker (1971) noted, with some relevance to this particular aspect, that the development of welfare legislation was greatly influenced by social and political theory; the personal element being often the secondary factor. A further illustration seems to be made by Sleeman (1973) who points out that most forms of social service expenditure provides not only consumer goods but also investment goods.

The ethics of an effective economical contribution to the health and welfare of the handicapped appears to have been borne in mind by

the Minister of Disabled, Mr. Alf. Morris, when in 1972 he stated:-

> "No one is saving money by refusing to provide services for disabled people. In fact, they are wasting money." (Medical World, 1972 - p.8)

4.4 Development of Handicapped People during the Rehabilitation Process

Probably the most critical event in the life of a handicapped person is the point at which the handicap is diagnosed with consequent implications for the caring person and other members of the family.

Some guidance of how the handicapped person may think of himself might be inferred from the findings of Richardson, Goodman, Hastorf & Dornbusch, (1961) and Richardson, Hastorf & Dornbusch, (1964), which indicated that although the respondents were realistic in the perception of their own situation, they exhibited limited appreciation of the nuances of interpersonal relationships. This was attributed to limited social involvement and experiences.

Studies by Taylor (1968) and Robinson (1971) indicate that decisions made by a large proportion of people to make appointments to have medical treatment with their doctors were determined more by social and psychological factors than on the basis of medical symptoms. Support for this finding appears evident in the operational roles of the general practitioner (Kessel & Shepherd, 1965), and the priest (Melinsky, 1970).

Morgan (1974) and others have focussed attention on the importance of needs and drives of the handicapped in the development stage of rehabilitation and particularly to the recognition and understanding of effective guidance and counselling.

Services for Disabled People - General Pattern in England Source:- Office Health Economics.

Fig. 7 (a)

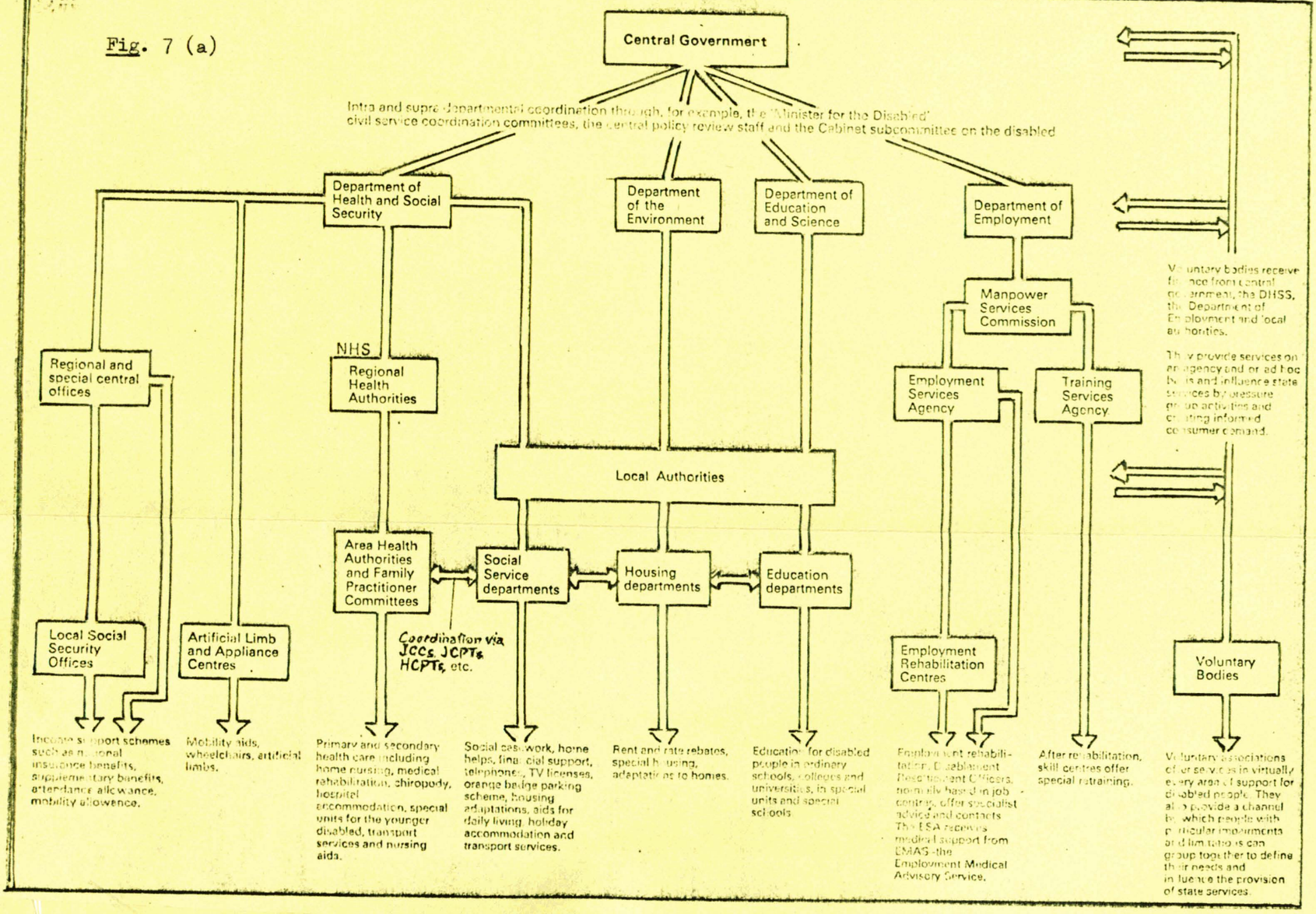
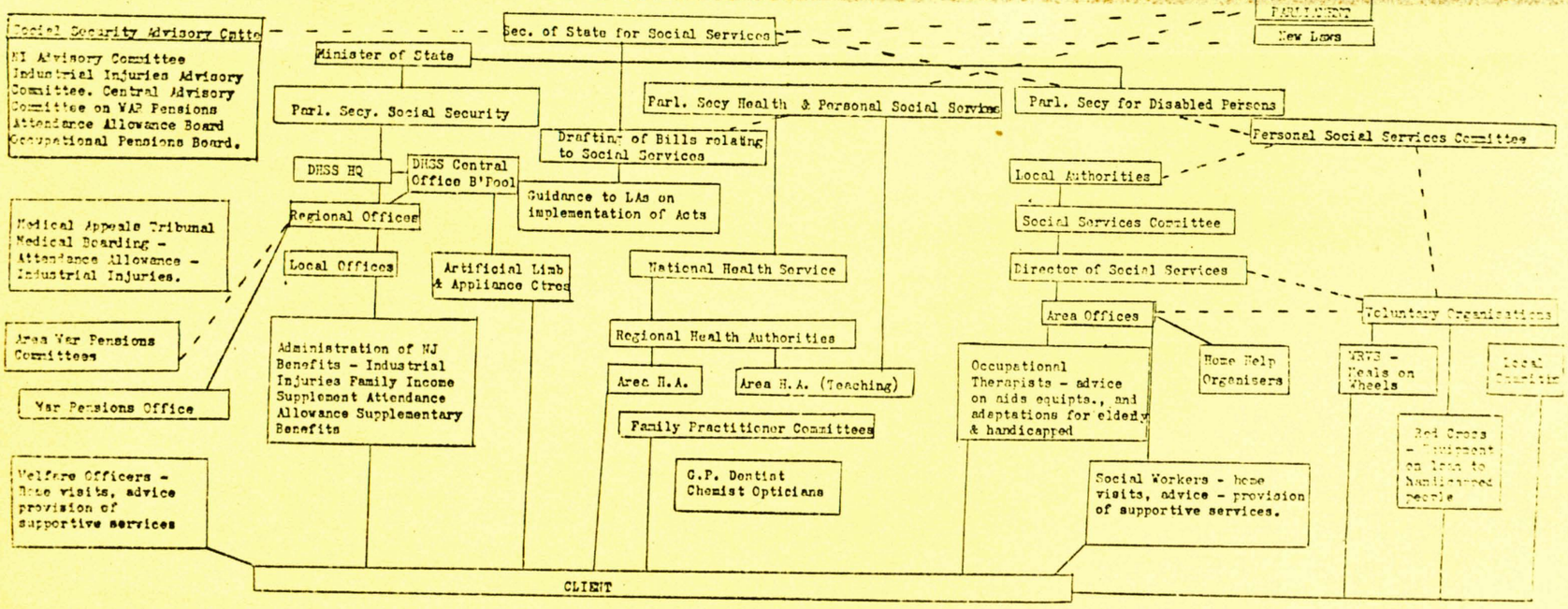


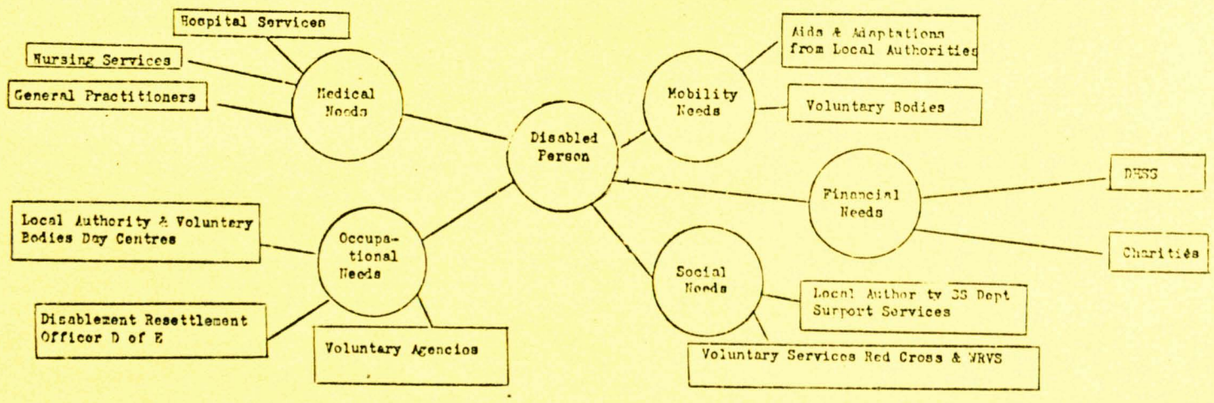
Fig. 7 Services for Disabled People - General Pattern in England

Source: Office Health Economics, 1977

Fig. 7 (b)

STRUCTURE OF D.H.S.S.





The association of certain personality characteristics during the early stages of rehabilitation received consideration from Goldsmith (1956) who claimed that personality structure was important in predicting the feasibility for rehabilitation. Positive need to recover strong aggressive feelings and optimistic attitudes facilitate the rehabilitation process whilst internalised aggressive dependency, need for self-punishment and pessimistic attitudes adversely interfered with progress.

DeWolfe, Barrell & Cummings, (1966) reported that patients who preferred authoritarian control and were negative in their approach toward other patients exhibited less emotional discomfort than patients who sought information about their condition and were somewhat critical of staff performance. The findings of Krause (1964) who investigated crisis situations in a rehabilitation centre indicated that crises encountered by the handicapped were associated with peaks of emotional adjustment at stages where personal activity was high.

The personal experiences of a number of severely handicapped people enabled Bleackley (1974) to present a clear recognition of individuality, a great awareness of capabilities and a deep understanding of the importance of development needs in respect of the handicapped.

4.5 Rehabilitation Services

Although the need for clear objectives is evident in many writings on the subject of rehabilitative treatment, Blaxter (1970) refers to the intricate network through which the process of rehabilitation takes place and the difficulties which many people inevitably find themselves. (See Fig. 7 - opposite page).

The Tunbridge Committee (1972) were critical in their report about the rehabilitation services and their lack of development following the recommendations made by the Piercy Committee Report (1956). It was pointed out that apart from restoring the individual to the highest level of functional activity, both mental and physical and in the shortest possible time, it was necessary to consider the programme in terms of the individual's morale, motivation and relationship to the community in which he lived and to which he would return. Reference was also made to the need for the general practitioner responsible for care to keep in mind the concept of total patient care and the need to initiate rehabilitation procedures and, where necessary, to seek the advice of those more experienced in the problems that may be encountered in the rehabilitation of his patient. The Committee concluded that the end result of the weaknesses and unevenness of the rehabilitation services was further suffering to the handicapped person and his family and the production of social and economic problems which were not only wasteful but, more significantly, were destructive of the quality of people's lives.

Minton (1974) takes the official blind welfare andrehabilitation services in Britain to task; aspects which were also considered of importance in the work by Carroll (1961) and Chevigny (1962).

Freidson (1970) uses the medical profession to highlight the tendency of some organisations to maximise control over the functional operations of their work. In the medical organisation, the medical profession appears to be dominant.

Forder, Reti & Silver, (1969) demonstrate a need for professional care-groups to create not only an effective system of communication but also to have a realistic concept of their roles. Misunderstanding

and a general lack of co-ordination of the various services seemed evident in respect of continuing care of paraplegic patients when discharged. Johnson & Johnson (1973) show the extent to which the services were failing paraplegics in Scotland and this particular work had an important influence in the introduction of the Chronically Sick and Disabled Persons (Scotland) Act, 1972.

Rehabilitation seems to imply more than therapeutic supervision and the application of physical methods and needs. It is seen as an intricately inter-related system involving the larger economic, social, welfare and political systems of society and appears to need dynamic leadership for success.

4.6 Communication

Problems of co-ordination and communication with the National Health Service seem to have been recognised for some time. Revans (1964) examined communications inside hospitals whilst Rodgers & Dixon (1960) and Jefferys (1965) have drawn attention to the lack of contact between general practitioners and other services.

Effective communications and planning services have also received consideration from Bermingham (1972) and Gedye (1973). A systems analysis of the services is offered by Bermingham as an operational solution whilst Gedye believes that obsolete modes of thought should not be applied to an environmental situation which is essentially dynamic.

The importance and effectiveness of communications systems in other large organisations may be seen in the writings of Katz & Kahn (1966), Leavitt (1969), Hughes (1970) and Vroom & Deci (1973) and in many ways these systems may be relevant to those within the National Health Services.

The interaction of the communication process and its perceived values are also seen in the works of Davis (1960), Roth (1962), Thoreson (1964), Glaser & Strauss (1965; 1968), Jones & Willis (1972) and Rosenblatt (1975), whilst Muthard & Salomone (1969) records the importance attached by rehabilitation counsellors to effective counselling, vocational counselling and placement duties.

4.7 Professional Attitudes

The approach by professional and associated personnel appears to provide a strong influence on the lives and personal attitudes of many handicapped people. Jones & Jones (1975) have highlighted the importance of sociology and its application to the various aspects of medicine. Although perhaps writing primarily for doctors and nurses, they also deal with the influence of rehabilitative relationships.

The task involved in the care and rehabilitation of the handicapped is seen to be both complicated and demanding but one must question the value of many formal and stereotyped attitudes adopted by professionals toward the handicapped. Although it may be generally assumed that the stereotyping of the disabled is not prevalent among those professionally engaged with the disabled, the work of Barker et al, (1953) and Scott (1965) have inferred that in many cases the attitudes of rehabilitative staff have shown little differences when they were compared with the attitudes revealed by many people within the outer community. Margolin, Goldin & Stotsky, (1969) found that a considerable amount of pessimism occurred among physicians and believed that the source could be traced to personal attitudes toward disability and toward specific conditions.

McDaniel (1969) believes that the attitudes of professionals toward their clients have not been subjected to sufficient

investigation, experimental or administrative. He also refers to the common usage of such terms as "quads" and "paras" (shortened terms for quadraplegics and paraplegics) which tend to segregate the "own" from the "wise" and provides a precedent frequently emulated by the non-handicapped when describing handicapped people. (pp. 41-42). A similar thought was expressed by DuBrow (1965) when he stated:-

> "..... Lumped into a group by his peers by appellations such as "C.P.", "M.S.", "C.V.A.", etc., one is prone to wonder if this kind of wastebasket labelling does not manifest a disregard for individuality, a sort of clubhouse disdain for the inferior by members of the "pro" team." (p. 25)

The findings of Ford, Liske & Ort, (1962) indicate that the reaction of physicians and medical students had tendencies towards avoiding persons who were severely disabled, demanding or seriously ill.

Research by Ferguson & Rayport (1965) illustrated that the removal of the clinical cause of handicap did not necessarily alleviate the overall handicapping condition. It would appear that response to change is governed by the nature, extent and kind of social concepts which demand modification in order to produce acceptance and constructive adaptation. Roith (1963) illustrates that events in the "career" of handicapped people are frequently used to establish a timetable of "norms" and although developed differently by the professional and the layman, serve to provide a guide to progress and act as a useful bargaining relationship between the interested parties.

Scheff (1966) considered the need for researches on what were implied to be standard stereotypes of an agency and their validity as measured by precision in diagnosis, treatment, training and placement of the handicapped.

Balint (1972) concluded that the role of doctors contained an apostolic function in the way they acted as apostles, seeking to proselytise their patients into having the kinds of diseases that the doctor thinks were conceivable in their particular cases and stated:-

> "It was almost as if every doctor had revealed knowledge of what was right and what was wrong for patients to expect and to endure, and further, as if he had a sacred duty to convert to his faith all the ignorant and unbelieving among his patients". (p. 216)

The total functioning of a handicapped person in the community appears to be much more difficult to measure than the personal functioning of clinical assessment.

4.8 Family

Telling commentaries on the predicament of families involved with handicap are frequently observed in the works of many writers including Hewitt (1970). In some respects, this work is an extension of the analysis of the stigmatised; people to whom Goffman refers to as "the own".

MacKeith (1973) itemises the probable reaction of parents and their professional advisers when they encounter handicap within the family and the main points of crisis in the life-cycle of a handicapped person in a domestic group. Bentovim (1972) adopts a different prescriptive tone in postulating the problems incurred by the family.

The unacceptable polarities of either giving up or being permanently dissatisfied with one's performance and handicap are illustrated by Chalmers (1956) and King (1971), who were required to adopt different roles to cope with the individual demands of their environmental situation. Disruption of the family life is also evident in the survey involving disabled housewives in the Merseyside

Area (Earnshaw, 1973), whilst divergent views of the situation and role of families in modern urban industrial life are illustrated by Parsons & Fox (1952) and Bott (1971) in connection with sickness and other relevant domestic crises.

Close kinship ties are frequently seen to be strengthened by the presence of handicapped members in those families that can care for the handicapped within the community although their contacts in the outer community are often restricted and curtailed (Townsend & Wedderburn, 1965; Bott, 1971; Bayley, 1973). In some ways, this behavioural reaction is similar to the contraction of social networks which appear to be the general experience of many aged people.

Nagi & Clark (1964) found that high rates of separation and divorce are characteristic of spouses afflicted by disability at early ages (37% of the divorced in the sample were less than 25 years of age). Separation and divorce occurred most frequently within a period of five years following the onset of disability.

Although involved with relatively minor handicapped people, Fielding (1950) found that women who engage most actively in social relations had the least negative attitudes toward their disabilities and revealed better all-round adjustment than women not so actively engaged.

In some ways, marital status seems to be related to the handicapped person's rate of recovery and subsequent roles in the family and the community. Haber (1964), Gibson & Ludwig (1968) and Rogoff, Cooney & Kutner, (1964) suggest that the need to use all one's residual abilities tend to produce greater performance from the self and more independence in the family, supporting and community roles.

The work of Skipper, Fink & Hallenbeck (1968) indicated that the greater the physical mobility of the handicapped woman the greater was her need for safety satisfaction.

Following an investigation into the rehabilitation of physically handicapped women in a family-orientated programme, Schwab (1975) considered that changes in attitudes were not adequately reflected in statistical data.

Sainsbury (1970) noted the strain imposed on many elderly parents of physically handicapped adults who were denied the prospect of reduced parental responsibility.

Although family relationships, in general, suffered when a member became disabled it seemed particularly difficult for disabled men, who when no longer the "breadwinners", lose their status as head of the household and frequently find that their authority is also undermined. Rubeck (1971) reported that families with a handicapped father frequently experienced disciplinary problems with their children. Strain on the relationship between spouses often produced conflicting emotional problems, such as protection and rejection, love and revulsion, and problems associated with coping with an altered relationship (pp. 28-37).

The experiences of Sainsbury and Rubeck underline the difficulties that many handicapped persons encounter in their relationships with the family and others. It is frequently seen that the handicapped person may experience ambivalence because he can empathise with the problems of others and yet apply to them the standards of the majority. As seen by Goffman (1968 (a)):-

> ".... he supports the norms of the wider society, but his social and psychological identification with these offenders holds him to what repels him, transforming repulsion into shame and then transforming ashamedness into something of which he is ashamed. In brief, he can neither embrace his group nor let it go." (pp. 131-32)

The importance of professional assistance to families with a handicapped member has been emphasised by many writers, including Goffman and Rubeck, and it would appear that social and psychiatric casework with physically handicapped people and their families could be supplemented by drawing on the resources of the local community.

In general, it seems that the greater the necessity to perform tasks and roles, the greater the probability that the handicapped will use their residual abilities to do so.

4.9 Employment

As stated by Brown (1954 (b))

> "Work is an essential part of man's life, since it is that aspect of his life which gives him status and binds him to society". (p. 187)

Other writers including Herzberg (1966), Fraser (1968), Warr (1971) and Argyle (1972) have examined the various concepts associated with the employment situation and it would appear that work may be seen as the touchstone of society's acceptance of the handicapped person as a full member of the community.

In expressing an ideology of work, Carroll (1965) believed that the concept was associated with the enlargement of human personality and the realisation of human potential. However, the values of an acquisitive society were seen to have imposed themselves upon the

concept with adverse effects. This appeared to be particularly so in connection with handicapped people.

The present employment policy towards handicapped people seems to be based upon the Report of the Tomlinson Committee (1943) and the Disabled Persons (Employment) Act, 1944. Previous to this Act, attempts to gain employment for the handicapped appear to have been primarily concerned with war-disabled, particularly those who were handicapped by blindness.

The Tomlinson Report took the view that the only really satisfactory form of resettlement for a handicapped person was employment which he could accept and retain on his merits as a worker in normal competition with fellow workmen, whilst the Act was a comprehensive measure to promote employment of disabled people irrespective of the cause or category of their handicap. This rubric was subsequently endorsed by the Piercy Committee Report (1956) on the Training and Resettlement of Disabled Persons, and the Disabled Persons (Employment) Act, 1958, and seems to have established the guiding principle for the disablement resettlement service of the current Employment Services Agency.

In an endeavour to assist handicapped people to gain employment, the Disabled Persons (Employment)Act, 1944, included the following measures:-

(a) the introduction of a Quota System which requires employers of 20 or more employees to have 3% of their normal work force enrolled as registered disabled people,

(b) a system of "designated employment" which requires all employers to offer certain jobs to handicapped people, and

(c) the establishment of various levels of sheltered employment schemes, subsidised workshops, training centres and home-employment schemes, for those people whose handicaps prevented them from participating in more "open" employment.

Each of the above measures has come under the scrutiny of different writers and authorities including Gretton (1972), Wiseman & Cullis (1975), Golding (1976) and Brewerton & Nichols (1977).

Although the 1944 Act contained some provisions for penalties and prosecutions, Gretton perceived it to be unenforceable. He points out that an employer who has refused a handicapped person employment may not employ a non-handicapped from the employment exchange unless he has filled his quota but this does not prevent him from employing someone from a place other than the employment exchange.

In many instances it would appear that there is an undue risk of too great an emphasis on the symptoms of disability and the unity - or segregation - of physically handicapped people in the employment situation and too little attention to the positive aspects of disability. Large (1973) discusses this point with feeling in response to the Consultative Document on the Quota Scheme for Disabled People.

The maintenance of a Register of Disabled Persons, a duty laid upon the Secretary of State by the Disabled Persons (Employment) Act, 1944, is carried out locally and its provisions fulfilled by the Disablement Resettlement Officer (DRO).

Registration incurs classification into one of a number of different broad medical categories. Some critics, such as the Association of Disabled Professionals, contend that this procedure tends to conceal the nature and degree of impairment likely to affect job prospects.

A detailed review of the Department of Employment's policies and services for the handicapped was undertaken by their Research and Planning Division in 1970. Information arising from the findings and subsequent discussions with relevant bodies concerned with the employment of handicapped people were published as Consultative Documents and made available from the Department of Employment (which subsequently became the Manpower Services Commission) and included:-

(a) Resettlement Policy and Services for Disabled People (1972),

(b) The Quota Scheme for Disabled People (1973),

(c) Sheltered Employment for Disabled People (1973),

(d) Industrial Rehabilitation for Disabled People (1973), and

(e) Vocational Training for Disabled People (1974)

Under the terms of the Employment and Training Act, 1973, responsibility for the provision of the public employment and training services, including the special services for handicapped people, all previously administered by the Department of Employment, passed to the Manpower Services Commission which consists of representatives of employers, trade unions, local government and education interests. The Commission was established in January, 1974, and together with its two executive arms, the Employment Services Division (ESD) and the Training Services Division (TSD), exists to help people to obtain jobs which satisfy their aptitudes and abilities and to assist employers to find suitable employees.

Facilities provided by the ESD for disabled people include a Disablement Resettlement Service (more than 500 Disablement Resettlement Officers (DROs) are based at Job Centres and local employment offices); a specialist service for blind people provided by more than

30 Blind Persons Resettlement Officers and about 12 Blind Persons Training Officers; and a national network of 26 Employment Rehabilitation Centres.

Expanded vocational training facilities are made available by the TSD at approved residential training colleges for disabled people whilst training provisions are provided for the disabled in Skill-Centres, Colleges of Further Education and Commercial Colleges, as for example Training Opportunities Scheme Courses (TOPS), and with employers.

Disablement Resettlement Officers normally work at the Job Centres and local employment offices. The importance of the role of the DRO was recognised by Greaves (1969) who attempted to provide a profile of the ideal DRO (pp. 52-54) and by Mattingly (1973) who has described more fully the role of the practising DRO.

At this stage of the review it might be relevant to recognise the importance of an effective bridge between school and a satisfactory occupation for the handicapped school leaver. Younghusband et al, (1971), Anderson (1973), Kershaw (1973), Tuckey, Parfit & Tuckey, (1973), as well as the Department of Employment (1972), the British Deaf Association (1974), and the National Innovations Centre Survey (1974), have made particular reference to this aspect of handicap. North Nottinghamshire College of Further Education has since 1969 successfully operated a Work Orientation Unit which fulfils the role of providing further education facilities for the handicapped school leaver within a college of further education catchment area.

The Provisions of the Employment and Training Act, 1973, require all local education authorities to provide a careers service and this enables careers officers to assist younger handicapped people within

the general framework of the services to concentrate more on abilities than the limitations imposed by their handicaps. The Careers Officers are assisted by confidential reports from headmasters, psychologists and school doctors, and they may also call on other medical advice in respect of the handicapped persons. In some areas specialist Careers Officers for the Handicapped are appointed.

The Health and Safety Commission (HSC), and its operational arm, the Health and Safety Executive (HSE), were established to administer the Health and Safety at Work etc. Act, 1974, and to provide a general focus of initiative for all matters relating to health and safety at work. The Employment Medical Advisory Service (EMAS), the medical arm of the HSE, provides advice to the ESA, TSA, employers and others about medical aspects of employment and rehabilitation in accordance with the terms of the Employment Medical Advisory Service Act, 1972.

The National Advisory Council on Employment of Disabled People (NACEDP) has the duty of advising the Secretary of State for Employment and the Manpower Services Commission on matters related to the employment and training of disabled people. This Council has representatives from each side of industry whilst independent members are drawn from the medical and social work professions and also from the voluntary field.

Dubot, Mirot & Salmon, (1971) present a descriptive account of the different forms of handicap and resettlement policies in operation for handicapped workers at the Renault establishment in France, whilst a short report of how Ford Motor Company (Britain) regards disabled workers and re-integrates their own handicapped has been given by Roots & Channing (1977). The National Coal Board has operated their occupational rehabilitation and training schemes

successfully since the commencement of nationalisation (1947).

Literature about the policy of treatment of handicapped people frequently implies that a large measure of discrimination against them is not only simply accepted but is claimed as a positive virtue. Referring to the rehabilitation of the disabled in Poland, Lidke (1968) indicated that the disabled workers must reach an optimum level of productivity. Failure to do so invites dismissal as the business or undertaking is not considered a social institution or a charitable organisation. (p. 577).

Haber (1973 (b)), in dealing with social planning for disabled people in the United States, perceives the primary institutional response, to social planning for the disabled to be concerned mostly with either the provision of income maintenance or adapting people to impairment rather than adapting the environment to suit the people.

In some respects the views of Bosanquet & Standing (1972) in connection with their analysis of favourable and unfavourable types of employment structure seem relevant to this aspect of disability.

Wiseman & Cullis (1975) discuss the disability policy in practice in this country and indicate that there is ample evidence to believe that a similar philosophy exists to that implied by Lidke and Haber. They examine critically the effects of the quota system, designated employment, sheltered employment and other associated elements involving employment of handicapped people and propound the needs for the creation of a competitive labour market in which the handicapped are permitted to compete in an equitable manner. It is argued that the handicapped might receive aid or assistance in kind rather than money but this would be on the basis of equity or distributional justice rather than output-maximisation.

Other writers including Hughes (1958), Townsend (1967), Sainsbury (1970), Rubeck (1971), Johnson & Johnson (1972), Topliss (1975) and Hill (1978) have examined and given descriptive accounts of some of the general problems encountered by the handicapped as a result of adverse employment situations.

Statistical returns by relevant surveys and the Register of Disabled Persons are seen to rely a great deal upon people's willingness to identify themselves as impaired. The readings of Taylor & Fisher (1968) and Hill, Harrison, Sergeant & Talbot (1973) suggest that there are at least as many non-registered disabled as registered disabled actually working.

According to the estimates provided in the Government Survey, 1969, some 697,000 impaired men and women were in the work force or temporarily sick or actively seeking work. About 176,000 of these people were classified as substantially handicapped by their impairments (Buckle, 1971).

In 1973, some 597,000 names were recorded on the Disabled Persons Employment Register (Department of Employment, Gazette, 1974) and it was thought that about half of those eligible to register actually did so. This seems to suggest that there are substantially more than the estimated 697,000 impaired people in the working population. Although this discrepancy may be partially caused by the use of different definitions of disability there may be other more influential reasons such as that associated with the implementation of the quota scheme for disabled people. In practice, the scheme appears to have created a situation in which registration is seen as a sign of social stigma and segregated activities (Wiseman & Cullis, 1975; Gretton, 1972).

Perusal of the general literature indicates that one of the main factors affecting unemployment of handicapped people is the national employment situation.

A written answer in the House of Commons (May, 1976) revealed that there were some 543,000 people registered as disabled with the Manpower Services Commission. The number of unemployed was estimated to be about 76,000 (i.e. 13.6%) as compared with the national average of 5.4%.

The corresponding figures given in the House for the ensuing year were 78,000 (i.e. 14.4%) people registered disabled and unemployed, as compared with the national average of 5.9%. (Department of Employment Gazette, 1977).

In July, 1976, 49.5% of the number of people who had been registered as unemployed had been out of work for more than one year (House of Commons 18.10.76).

Despite the many different factors involved with the employment of disabled people, one of the most important, particularly from an employer's point of view, is that associated with "work adjustment". Dawis, England & Lofquist (1964) described work adjustment as the outcome of the interaction between an individual and his work environment.

In their research, Carlson, Dawis, England & Lofquist, (1963) measured the performance of nearly 500 physically disabled workers and compared the results with about the same proportion of able-bodied workers at both skilled and unskilled jobs. They found that the disabled group did not compare favourably with the able-bodied

group in terms of overall performance rating or the quality of work although group results were similar for other indices of work performance.

On the contrary, a much earlier investigation reported by the U.S. Department of Labour (1948) involved some 11,000 physically impaired and 18,000 non-impaired people. The investigators found that the physically impaired people were not necessarily handicapped workers and that when given reasonable job placement the physically impaired workers, as a group, were fully able to compete successfully with non-impaired workers similarly placed.

Commenting upon the employment situation for the handicapped, the "Snowdon Report" Committee (1976) indicated that there was considerable unemployment, mis-employment and over-employment of handicapped people. Existing legislation and provisions for the handicapped appeared inadequate and there was a clear need for supporting services and the outer community to realise that employment was crucial to the integration of handicapped people of employable age within the life of the community. It was recommended that, so far as was practicable, employment for the handicapped should be as similar as possible to that of the able-bodied in respect of conditions of work, status and pay (p. 28).

It seems that the contribution from education, training, innate ability, skills, personal attitude, attitudes of potential employers and colleagues, and environmental conditions are all important factors in determining the opportunities for handicapped people in the employment situation.

Although there appears to be a profusion of statutory documents associated with handicap and employment for the disabled, few, apart from the quota scheme, contribute anything towards provisions for employment for the handicapped.

A large proportion are mainly concerned with general facilities at public places and appear to be orientated toward the industrial environment.

Statutory instruments are not seen as measures to enforce attitudes. Understanding and an appreciative reaction to disability is seen to arise only by the means of education in its widest context.

While successful management must attain its own specific objectives (Brech, 1967; Drucker, 1973) it appears from much of the overall literature that success for the disabled can be achieved only by the maximisation of the handicapped person's potential and the opportunities provided for him by the supporting services and the community. Both are vital.

4.10 Church and Religion

In this study, Church and religion were accepted as involving a general belief in a supreme being incorporating attitudes of devotion, reverence and gratitude along with a desire to obey and serve.

The emotional reaction of an individual to disability and handicap frequently depends upon the attitude held as an individual person and in this respect it seems important to consider the role of the Church and religion in the area of disability and handicap (Balint, 1957; Melinsky, 1970; Wright, 1973).

Religious beliefs have invited interpretations because of their relationships with experience on the one hand and with tradition on the other (Leuba, 1912; Brown, 1973). As noted by the writings of James, 1926; Welford, 1947; Brown, 1962; Goldman, 1964; Stanley, 1964; Moberg, 1965; Martin, 1976; and others, general views and beliefs associated with the teachings of the Church may vary in strength and magnitude with the passing of time and the necessity to adjust to many constantly changing needs. Some people hold rigid views and beliefs which have a significant bearing on their reactions to handicap and occasionally, handicapped and able-bodied are brought into deep conflict with opposing thoughts. The diversity of such beliefs may be illustrated by a cross section of replies given by almost any group of disabled people in response to the question, "Why do you think that you should suffer as you do with your disability?" Answers such as, "God expects some people to carry a cross - this is mine" - "It is the luck of the draw - God has nothing to do with it" - "It is a preparation for the real life of man", etc., indicate the different views reflected within the area of disability.

Forster (1954) considered that the teachings of many Churches had neglected the needs of handicapped people. Neglect had included a lack of understanding of the person behind the handicap and his need for what the Church was able to give. It was thought that the biggest handicap encountered by many disabled people was the spiritual and social starvation imposed by the community.

In discussing the needs of the handicapped, Howard (1954) stated:-

> "Many of them (disabled) are among the "unreached" - not because of their indifference, but because of ours - not because they do not want the Church, but because the Church has not made it clear that it wants them." (p. 7)

Apart from offering spiritual guidance, Jacobs (1954) believed that the role of the Church was important to the handicapped and their associates for the purpose of developing and maintaining vital elements in the rehabilitation process. The experience of Keller (1970) has indicated that the "religion of love" is the most soul-satisfying concept in all aspects of religion and forms of worship.

Peele (1966) believed that it was wrong for people to depend on faith alone to heal a physical ailment; medical science and the science of faith were the two essential elements.

From a medical point of view, Kerr & Thompson (1972) indicated that a feeling of support through religious belief was of value to the handicapped person in assisting him through emotional stages associated with the re-identification process but added:-

> " ..... when belief becomes delusion this can lead to failure ..... one of the patients ..... is still lying in bed, at home, waiting for the miracle that he is still convinced will occur enabling him to pick up his bed and walk." (p. 99).

Covalt (1958; 1960) observed little or no relationship between religion and good adjustment to illness or rehabilitation. Persons who were seen to be interested in the Bible were also frequently seen to be the most troublesome, unco-operative and insecure. However, contradictory evidence is seen in some of the studies reviewed by Moberg (1965), whilst DiMichael (1960) and Trevethan (1960) expressed positive opinions about the role of the clergyman in assisting the handicapped to live a life of quality.

A number of writers including Whitehouse (1961) and Palmer (1962) generally agree that the religious teaching of Christianity and other similar denominations provide the basic motivating force towards restoring the severely handicapped person back into society.

In his study concerning religious beliefs and attitudes, Knight (1961) reported significant differences from the responses of 67 students from church related colleges. Knight's findings included:-

(a) Most Jews within the group felt that physicians had no special role in relation to religion whereas most Christians felt that the physicians did have a special role,

(b) Methodists and Presbyterians believed that the patient's faith was of primary importance whilst the Catholics and Baptists tended to feel that their own faith was more important, and

(c) The group generally considered that the physician and the clergyman should work closely together.

Whilst examining the role of religion in the rehabilitation process, Palmer (1962) personally corresponded with thirty-one (31) authoritative respondents about the subject. Two persons replied in the negative stating that they did not believe that religion was associated with rehabilitation; two thought that religion had no "special message" for the disabled but offered the same spiritual resources to all people; whilst the others considered religion to have an important contributory part in the success of rehabilitation and enumerated ways in which it and the Churches functioned positively toward its success.

Palmer discussed religion as a motivating force, its relationship with the therapist and the handicapped person, respectively, and the role of the clergy and the church. It was concluded that the depth of conviction and the nature of religious beliefs of a disabled person were important factors in determining not only the degree to which as a patient he participates in the rehabilitative process but also the

extent to which he is likely to successfully adjust himself. Despite its stressing of the importance of realising the need of conserving and restoring the whole man, Palmer's detailed survey left the impression that much more research was required in this particular field.

The fading contribution of the Church was seen by the Office of Health Economics (1972) as one of the major factors which added to the burden of the Health Services. Departure from the ethic of self-sufficiency seemed to coincide with exposure to greater stresses and anxieties for an increasing number of people. Comfort (1972) also implied that the role of doctors tended to include an ever increasing proportion of spiritual counselling and guidance as a result of the diminishing role of the Church.

4.11 Motivation

The writings of different theorists such as Herzberg, Mausner & Snyderman (1959), Maslow (1962), Belcher (1962), Cofer & Appleby (1964) and Herzberg (1966) appear to suggest that motivation may be described generally as an organismic state which mobilises activity and integrates a person's behaviour. In this sense, reflex activities such as hiccoughing are excluded.

Nevertheless, Jones (1962) and Kelly (1962) considered the term to have specific meanings in dealing with people in hospital and other rehabilitation settings and so implied that it indicated particular patient behaviours.

For use at a symposium on the Motivation of the Physically Disabled (1968) (Nichols & Bradley (eds.)), motivation was defined as:-

> ".... the expression of personality in a situation of striving to overcome or adversity". (p. 11)

In a review of motivation research, Barry and Malinovsky (1965) stated:-

> "A major impression .... is that the concept of motivation is almost too broad, too complex, and too inclusive to usefully stimulate and aid in the improvement of rehabilitation practice and research". (p. 51)

Dealing with the subject subsequently, Barry (1968) assumed that a patient's behaviour at any given time was determined by three influential areas - the external situation; the patient's abilities, skills and knowledge; and the inner personality variables. The complexity of these factors and their contribution to successful performance and satisfaction were also examined by Pervin (1968).

Barry (1968) believed that the past history of a person becoming disabled was the best predictor of motivation for rehabilitation and his return to work; a view supported by many other writers including Meyerson, Kerr & Michael, (1967) and Nichols (1971).

Attention was drawn by Cotton (1970) to the importance of motivation in conductive education (unity of disciplines) and the success of Professor Peto's work with disabled people. This work indicated that lack of motivation was one of the greatest handicaps that confronted most people in overcoming physical handicap.

Lindsley (1964) referred to the significance of motivational aspects in the success of correlating positively the functional relationship between a disabled person and his specific environment (free operant conditioning). It was indicated by Belcher (1962 - p. 9) that motivation to participate in an organisation was more important than motivation to produce.

Goldstein (1959) stressed the importance of the unitary drive on the part of the person with a physical handicap to realise his capacities as fully as possible and Patterson (1964) propounded the need for a unitary theory of motivation in the counselling situation. The unitary motive, in Patterson's opinion, was also in accord with self-actualisation. Keith (1968) called for greater emphasis on autonomous behaviour in theories of motivation in the field of rehabilitation and objected to the assumption that the proper role for the person with a disability is the sick role (Parsons & Fox, 1952) in which dependency and childlike behaviour are required by the environment. The importance of the coercive effects of the environment forces on social behaviour is prominent in the writings of Goffman (1968), Roth & Eddy (1967), Shontz (1964; 1965) and Neff (1971).

Zane & Lowenthal (1960) indicated that "good" and "poor" motivation assessment was generally derived from a patient's co-operation and participation, and success or failure in a rehabilitation programme. They perceived motivation as a complex of forces - some interfering with and some disposing toward effort and learning. Thus negative and positive motivational factors exist. The implications suggested that stress and depression and other common emotional responses are important factors which can condition a person's motivation for a prescribed task performance whilst a minimisation or removal of such disturbance is a basic step toward successful rehabilitation.

Subsequently, Zane (1961) found that it was more productive to manipulate and change therapeutic conditions than to attempt to modify the disabled person's motivating reactions to stress.

According to Zane, the continued failure of a disabled person to achieve his goal creates a state of increasing stress and disorganisation with concomitant deterioration of mental and physical functions and of effective learning (p. 321). The study seemed to emphasise the importance of realistic goal-setting within the concept of successful rehabilitation.

In the opinion of Schlesinger (1963 (a) (b)), many motivational problems are caused by the environmental climate in which the handicapped person finds himself and immediate relationships within that setting. Whilst agreeing that complete control over the behaviour of the handicapped person is important in the very early stages following the onset of disability, Schlesinger (1963 (a)) questions its justification and merits over longer periods.

Schlesinger recommends the gradual increase in the responsibility and decision-making participation of handicapped people in the early stages of rehabilitation and underlines the obligatory need to improve physical, personal and social skills.

In a subsequent paper, Schlesinger (1963 (b)) pointed out that not only was patient depersonalisation and standardisation at odds with the requirement of "good motivation" but also staff and patient expectations and goals were frequently at variance. It was advocated that the primary test of the caring persons was to induce changes in the content, direction or frequency of the behaviour of the disabled person. Whilst admitting that change is often resisted by both caring and handicapped, changes were often perceived in a different light by the handicapped person.

Malmo (1965) interpreted the results of many studies reviewed by him to indicate that increasing physiological activities are

required to sustain performance but these do not necessarily reflect increased motivation during performance. The findings of Loeb, Beck, Diggory & Tuthill (1967) suggest that depression can condition a patient's motivation for prescribed task performances whilst success can be used to enhance performance. Vroom (1964) and Atkinson & Feather (1966) have applied more specific methods in their approaches to explain motivational reaction whilst others such as Kasl & Cobb (1964) and Hirschfeld & Behan (1966) have investigated specific behavioural issues between groups of handicapped people.

The need for clear and positive objectives in the process of rehabilitation is made by Kushlick (1972) and Rosen (1972). Referring to the importance of client involvement, Blaxter (1970) stated:-

> "The ideal client ..... is co-operative, motivated to using his residual capacities to the full, has acknowledged his disability and had it legitimated. This man is fighting for legitimation." (pp. 19-20)

4.12 Education

It is now commonly accepted that education is a continuing process and should not be concentrated wholly within a single period (Open University, 1970). Indeed, the Education Act, 1944, refers to the education of the people and the provision of a varied and comprehensive service in every area. It would appear that the contribution of education toward the development of attitudes associated with handicapped people is of essential importance. In this respect it would also appear that the integration of the handicapped, irrespective of age, with the able-bodied is as important to them as the benefits they accrue from academic achievement. This was implied by the 1970 Education (Handicapped Children) Act which made universal education compulsory for the first time in this century.

The Department of Education and Science, 1974, describes as an "article of faith" the idea that:-

> "If the handicapped and the normal are to understand one another and live together in the adult world, they should not be separated during their more formative years." (p. 4)

Confirming and expanding previous work by Siller (1964) and Horowitz, et al, (1965), Yuker et al, (1966) found that attitudes toward handicapped students were less favourable with increasing level through the elementary grades but that the trend reverses at the high school and college level so that increasing grade levels are related to more favourable attitudes. Although only limited information appears to be available about the relationship of educational level to attitudes toward disability, both Simmons (1949) and Lukoff & Whiteman (1963) found that the level of education correlated with positive attitudes toward the integration of blind people in sighted activities and settings. This agrees with the more generalised findings of Roeher (1959) who reported a positive correlation between higher educational levels and "acceptance" of disability.

Although it would appear from some literature that a relationship does exist between academic achievement and attitudes toward handicapped people, research in connection with Further or Higher Education of adult handicapped people seems to be fairly recent and relatively limited. For example, the Vernon Report (Education of the Visually Handicapped) appeared in 1972; the National Innovations Centre (1974) made a survey of the academic arrangements for disabled students in universities and polytechnics in 1973/74; and the National Union of Students sponsored a survey of admission policies in 1976.

The importance of an educational concept within the therapeutic measures of rehabilitation has been stressed by Friedland & Margolin (1969) and Rudd & Margolin (1970). They emphasised the importance of education as a prime mover in solving social and health problems. Berenberg (1969) assumed that it was not so much whether the medical field should have a responsible role in the education of the disabled but rather how they might contribute. Earlier work by Rudd (1952) implied that total education for the disabled person was conceived in daily living, daily learning and daily working. Sensenbaugh (1969) indicated that the ageing process could be most effectively controlled by an educational therapeutic approach. The loss of learning potential was not considered an inevitable concomitant of ageing as many elderly persons possess considerable capacities for learning.

Nichols (1971) referred to the importance of education in the assessment of severely disabled persons and stated:-

> "The correlation between educational levels and achievement is definite. Patients who have had a higher education are predominant among those who achieve maximal activity in spite of severe disability." (p. 30)

Although the provisions of education for handicapped people appear to have constantly lagged behind the facilities offered to able-bodied people, the last decade has probably yielded more research and investigation into problems and difficulties encountered by the handicapped than any relative period since 1944 - the inception of the Education Act and the Disabled Persons (Employment) Act.

The "Vernon Report" (1972), which appears to be of some relevance here, pointed out the importance of an educational stimulus to the mental and physical development of visually handicapped children in

preparation for subsequent life although it somewhat failed to satisfy the aspiration of other bodies who considered integration with the able-bodied to be an issue which demanded much more positive action than revealed by the report. In particular, it failed to satisfy a critique of the report produced jointly by the National Federation of the Blind of the United Kingdom and the Association of Blind and Partially Sighted Teachers and Students (1973).

In addition, the National Children's Bureau (1973) investigated the problems that occur when handicapped young persons reached school leaving age. Information gained from some 400 schools and covering 7,000 subjects indicated that the disabled school leaver was at a very large disadvantage in comparison with his able-bodied colleague and so generally confirmed a widely held suspicion. Excluding the mentally handicapped, the report indicated that only about 1% of the handicapped school leavers proceeded to Higher Education. The results also implied that a considerable lack of unity and cohesion existed between the various agencies concerned with further education and training. The Bureau requested greater flexibility and co-ordination between various departments and stressed the need for identification of responsibility in the advisory "counselling" relationship with disabled students.

Despite the recommendations and other useful information made by the National Children's Bureau, a follow-up sample survey made by the Disabled Student Research Unit (1975) to some local Education Authorities about the provisions and facilities for disabled students in Further and Higher Education, produced the following observation:-

> "... over 50% of them were lacking any significant information regarding services or provisions for handicapped people. The response from ..... authorities was entirely unhelpful and displayed the same lack of concern ...." (p. 25)

A survey undertaken by the National Innovations Centre (1974) was primarily concerned with the examination of the academic and social environment of handicapped students who were involved with full time courses in Higher Education. Although there were about 9 disabled people per 1,000 in the population as a whole of student age, there were only 2 disabled students per 1,000 students of comparable status at universities and polytechnics. The N.I.C. commented:-

> "This striking imbalance must surely indicate that disabled boys and girls face formidable barriers to Higher Education and that more must be done to bring down these barriers." (p. 26)

The authors recommended the needs for Universities and Polytechnics to institute procedures for dealing with disabled students on a systematic basis from the admissions stage through to assistance with gaining employment, and for further research to be carried out into a wide range of aspects of Higher Education for the disabled. Referring to the study, Dame Elizabeth Ackroyd stated:-

> "... the aim .... must be to integrate disabled students into the community of students at large.... Perhaps the greatest injury - and insult - which society inflicts upon the handicapped is that too often the disability overshadows everything else in the eyes of the able-bodied people." (N.I.C. Press Release - 29.3.74).

The Warnock Committee of Enquiry into Special Education (1978) reviewed the whole spectrum of education for handicapped children from pre to post school, including the tertiary sector. The committee proposed a new conceptual framework within which special educational provision should be made. This entailed a continuum of special educational needs rather than discreet categories of handicap. One

of the important themes within the report was the ending of the sharp distinction between the handicapped and the non-handicapped. In concluding their report (para. 19.35) the committee recorded:-

> "... organisational changes will not be sufficient in themselves to achieve our aims. They must be accompanied by changes in attitudes .... Nor will it be enough if these changes in attitude are confined to people engaged in special education. Changes in attitude are also necessary on the part of the public at large .... We believe that it (the report) not only ..... but will also, in itself, contribute to those changes in attitude which are essential if our aims are to be fully realised." (pp. 334-335).

Attempts to provide for the needs of any disabled person must encounter the problems posited by segregationist and integrationist lobbies, a situation which has been frequently observed since the introduction of the Elementary Education (Defective and Epileptic Children) Act, 1899, and indeed earlier years. It was noted that one headline in "The Teacher" (1974) read:-

"Don't segregate blind children. Pleas to Minister".

whilst on a subsequent page, readers observed:-

"Don't integrate mentally handicapped children".

The Department of Education and Science (1971) referred to the unfortunate practice of placing young or probationary teachers in charge of the weakest pupils and the difficulties that many schools experienced in securing suitably qualified and experienced teachers. Evidence was given that teaching handicapped persons required experience and qualifications additional to that acquired by the initial stage of professional education.

King (1965) examined the effects of physical handicap in specific teaching tasks and found that careers for the disabled or handicapped in teaching were needlessly restricted.

Overcoming the feelings of being different and of being helpless were in the opinion of Barron (1967) the two most important tasks to improving the attitudes of the handicapped person toward himself. Barron believed that a major contribution to the achievement of these goals was the employment of a physically disabled or handicapped teacher whose attitude toward his own disability and handicap and his appraisal of his limitation could provide the basis of dignity and potential worth to other people.

The National Foundation for Educational Research (1973) emphasised the importance of teachers possessing a sound knowledge of the formation of human relationships, the working of groups and the influence of social forces where their work was involved with disabled people.

According to the Department of Education and Science (1973/74), proportionately very few handicapped young people receive their education through the ordinary schools system despite the recommendations of the Ministry of Education (1954) that no handicapped child should be sent to a special school who can be satisfactorily educated in an ordinary school. Anderson (1973) gives fairly wide coverage on a number of issues relating to integration of the disabled young person, Topliss (1975) deals with some other relevant important issues and much of the content of Clegg's (1973) treatise on "How Equal is Opportunity?" could be related effectively to the position of handicapped people.

Relatively smaller studies associated with educational aspects of provisions for the disabled person have been carried out by the Central Council of Disabled (1972), the North East London Polytechnic (1973), the Association of Teachers in Technical Institutions (1974) and the Manchester Education Committee (1976).

An individual investigation by Dr. A.D.G. Gunn (1976) dealt with opportunities of the physically disabled patient for a University Education. Dr. Gunn pointed out that the opportunity for disabled students to obtain a University Education was not equal throughout the United Kingdom, that there were serious gaps in the process of communication and guidance, and there was an urgent need for authoritative bodies to provide facilities to overcome - not merely reduce - the handicaps of disabled students.

The National Union of Student and Action Research for the Crippled Child jointly established the Disabled Research Unit in 1974 to examine the problem of disabled students. Their investigation primarily concerned admission procedures in the tertiary sector, the role of the special school, and the functioning of local education authorities. The investigation revealed that many disabled students suffered acutely from a lack of suitable access to buildings designed for the provision of education; access to suitable equipment and furnishings for their needs; and the provision of adequate information and guidance about suitable opportunities for further education and training. The authors recommended that procedures and facilities should also be provided to permit disabled students to have more active participation and involvement with staff and able-bodied colleagues. An extract from the foreword summarises the findings of the Report (1976) as follows:-

> "The Disabled Student (i.e. the Report) makes uncomfortable reading. The history of well-intentioned neglect, the lack of positive policy, the inadequate provision in most universities, colleges and polytechnics - all must be changed." (p. v)

However, one exception which has permitted disabled students to continue education without fear of not having necessary pre-entry

qualifications, an educational institute which will accept them, and a place which provides them freedom from stress as a result of difficult access, is the Open University.

Since its inception in 1970, the policy of continuing education for all persons has been supported by a positive discrimination in favour of involvement for disabled students. The establishment of a full-time Senior Counsellor and a committee which is actively engaged and provides some justification for their concept:-

> ".... continuing education .... assumes the equal necessity for education to foster personal growth and fulfilment." Interim Report (1976 - p. 7).

4.13 Socio-Economic Status

Literature frequently indicates that the major problems and difficulties encountered by handicapped people are much more likely to emanate from their endeavours to maximise their roles within the community than from the medical aspects of their individual disabilities (Wright, 1960; Yuker et al, 1966; Siller et al, 1967; Snowdon, 1976).

The complexity of the concept "community" is evident by the various uses to which the term has been subjected and to which many writers have made reference (Tonnies, 1955: 1957; Cumming & Cumming, 1957; Dennis, 1958; Stacey, 1969; Frankenberg, 1970).

The Seebohm Report (1968) in recognising the importance of explaining the term "community" stated:-

> "The term "community" is usually understood to cover both the physical location and the common activity of a group of people. The definition of a community, however, or even of a neighbourhood, is increasingly difficult as Society becomes more mobile and people belong to "communities" of common interest, influenced by their work, education or social activities, as well as where they live. Thus although traditionally the idea of a community has rested upon geographical locality, and this remains an important aspect of many communities, today different members of a family may belong to different communities of interest as well as the same local neighbourhood. The notion of a community implies the existence of a network of reciprocal social relations, which among other things ensure mutual aid and give those who experience it a sense of well being." (para. 476)

This explanation appears to include the basic elements which tend to formulate the "community" concept. Whilst the geographical notion or physical location is implied within the meaning of "community", the core of the concept seems to be the feeling of identity which membership of a community bestows and which seems to derive primarily from shared values, attitudes and behavioural reactions that form the rules which guide the socialbehaviour within the community.

Consequent upon the findings of the Seebohm Report, Bayley (1973) focussed attention on the difference between care in the community and care by the community. Emphasis was laid upon the importance of the relationship between the social service department and the community (as indicated in the Seebohm Report - paras 475 - 478) and the need to go beyond care <u>in</u> the community and, if applicable, beyond care <u>by</u> the community. It was pointed out that it was not a question of the social services plugging the gaps but rather of their working with society (community) to enable society (community) to close the gaps.

The importance of living within the community may be illustrated from some of the studies which have been conducted in connection with life in institutions.

Bowlby (1953) has referred to the development of the "affectionless" personality whilst Freud & Burlingham (1965) drew attention to retarded intellectual, emotional and physical development.

Barton (1966) reviewed a number of studies of various kinds, including life in prisons, and found factors common in the different enclosed environments which tended to produce institutional neurosis. These included the loss of personal friends, possessions and personal events, loss of contact with the outside world, enforced idleness, and loss of prospects outside the institutional environment.

In many respects, Barton's findings were similar to those recorded by Goffman (1968 (b)) who indicated that the loss of support of friends and relatives in the outer community is not satisfactorily compensated in institutional life. Hunt (1970) believed that people in institutions tended to lose touch with their friends and relatives and formed only superficial relationships with other inmates or staff. The prevalence of apathy, depression and lack of interest were characteristic in all aspects apart from those which were immediately personal.

The findings of Miller & Gwynne (1972) who examined life in residential institutions for the physically handicapped and younger chronic sick, were also seen to be consistent with those of the previous writers.

The importance of living within the community is also seen in the work of Townsend & Wedderburn (1965), Sainsbury (1970),

Blaxter (1975) and others who found that despite the difficulties experienced by the physically handicapped in social relationships and interaction in the community, there was comparatively little demand by them for places in residential institutions.

Substantial support for the quality of living for the physically handicapped seems to emanate from active interaction within the community and this, at least, appears to be as essential to their fullness of life as specialised medical attention.

Townsend (1967) and Skinner (1969) found that in many cases handicapped people lived in housing more lacking in basic facilities than the rest of the community.

The National Government Survey (Buckle, 1971) gives some indication of the disturbing state of housing for disabled people with 60% of the total sample having no indoor lavatory (Table 116 - p. 119). The table indicates that the position is more than a question of physical comfort - it frequently has a major influence on the physically handicapped person's life style.

As indicated by Goldsmith (1967), the physical surroundings are of particular importance to the physically handicapped as independence develops not only from the capacities of the individual but also from the relationship between him and his environment. Goldsmith (1967; 1973) aptly illustrates the needs and concepts for designing suitable accommodation for the handicapped whilst Lancaster-Gaye (1972) directs attention to the Fokus (Sweden), Het Dorp (Holland) and the Danish Kollektivhus housing systems for handicapped people. The underlying concept associated with the needs of the handicapped as seen by the National Swedish Institute of Building Research (1972) is that

handicap is a combination of physical disability and deficiencies of the environment.

It would appear that independence is seen not only as a direct attribute from the capacities of the individual but also from the relationship between him and his environment. In this respect, the importance of facilities and amenities for daily living seem to determine to a large degree the extent of independence or dependence of the handicapped person, particularly in performing the basic functions associated with personal hygiene and mobility and, in some acute cases, sustenance. Failure to provide suitable amenities and facilities can seriously undermine the handicapped person's confidence and, even more crucial, his human dignity and respect. Skinner (1967) states:-

> "Any degree of personal independence exercised by a physically handicapped person represents a victory over adversity which can have a most significant psychological value for the individual concerned". (p. 62)

Jeffrey (1973) examined the living environment of physically handicapped people and perceived the importance of housing extending beyond the provision of a roof to providing the handicapped person with a social balance, security and an "awareness" of being a responsible and independent person.

Poverty and low income arising either directly or indirectly from disability appears to be a social problem that may be regarded in a fairly wide and generalised context. Furthermore, the work of Buckle (1971), Harris, Smith & Head (1972), Sainsbury (1970) and Blaxter (1975) indicates that a large proportion of handicapped people who live in the community depend to varying degrees on either direct or indirect financial aid from one or more statutory sources which exist for the handicapped.

Since the 1950s, several studies have revealed that extensive "pockets" of poverty prevail in Britain among the aged, low wage earner, one parent families and the unemployed (Abel-Smith & Townsend, 1965; Coates & Silburn, 1970; Townsend (ed.) 1970; Earnshaw, 1973). Disability, however, frequently encroaches upon these areas and exacerbates the situations by the extra expenses that occur as a direct result of the handicap (Morris & Butler, 1972).

For the physically handicapped individual the critical pressures are the extra costs and demands of the handicap and the earnings loss or reduction frequently associated with the onset of disability.

Any consideration of the "cost" of care seems to embrace many different aspects, such as additional costs arising from the disability, loss of potential earnings of the individual, loss of individual's output to society, cost of overall support of the handicapped and losses incurred by social attitudes.

Relevant information about the Health Services and associated cost of care involving handicapped people are shown in the works of Castles, Murray & Potter (1966), Forsyth (1966), Willcocks (1967), Titmuss (1968), Grosse (1971), Boswell (1972) and the European Economic Community Report (1974). More specific information is supplied by the Office of Health Economics (1975) and Buxton & West (1975).

A comprehensive investigation carried out by the Economist Intelligence Unit (1974) demonstrated that, apart from humanitarian aspects of caring for the handicapped in their own homes, considerable savings to the community could be achieved by keeping people living within the community than caring for them in residential units.

This report also serves as an illustration of how analytical techniques can assist rational decision-making; an aspect which received the attention of Turvey (1968).

Gedye (1973) discusses the "university contribution" to the definition of objectives for the disabled and makes the point that many problems for the handicapped would be solved if there was a general appreciation of how we all "fitted in" to the community in which we live.

Blaxter (1975) found that the people most likely to have money problems seemed to be those who found themselves in equivocal positions (e.g. severely disabled and working) or those who could not reconcile their definition of their needs with their definition of their rights. Discretionary benefits were more likely to be received if they represented a medically rather than a socially defined need and were exclusively for the sick or disabled person himself rather than his family.

Sainsbury (1970) describes in some detail the extra costs that disability can add to the family budget whilst Harris et al, (1972) in the National Government Survey, found that almost one in three disabled persons has at least one source of extra expenses as a result of their handicap and that a higher proportion of very severely handicapped person is in financial need than occurs in those with less severe handicaps.

Hyman (1977) investigated systematically the extra costs incurred in the daily living activities of 56 wheel-chair users and their social service needs. The findings indicated that not only were the community failing to help the handicapped but that in doing

so the community were failing to provide the handicapped with the means to help themselves.

Other sources which have stressed the economic problem of handicapped people include the Disablement Income Group (DIG) with their publications, "The Disability Trap" and "Realising a National Disability Income", and the Association of Disabled Professionals.

As indicated by Titmuss (1968), financial deprivation is frequently seen to be concomitant with handicap and, in the opinion of many others, selective discrimination is necessary to combat some of the worst areas of deprivation.

Whilst many provisions appear on the statute book, it is noted that a fair proportion seem to be restrictive in operation.

(The DHSS (1972) booklet, "HB 1 - Help for Handicapped People" and the Family Welfare Association's "Guide to the Social Services" (1975) give general guidance, subject to amendments, about available financial, medical and social service help for handicapped people).

It seems from the relevant literature that one of the major tasks of a civilised society is to respond to the welfare needs of those minority groups which lack political influence or economic power. The needs of the disabled are complex and varied and the problems of identification and measurement are difficult. Consequently, it would appear that within the constraints of their particular responsibilities, authority and accountability, everyone has a particular role to play to ameliorate the situation, including the disabled themselves.

4.14 Aids and Adaptations

Assistance required with hygiene factors and other personal activities such as getting in and out of wheel-chairs and the daily fitting of protheses can generally be provided by the family, relatives, close friends or staff of statutory or voluntary services. Whilst family members and close relatives are nearly always available, emotional ties can make it difficult for them to obtain relief, even temporary, for their responsibilities. Occasionally, crisis situations may arise when outside support is required.

Blaxter (1975) found that many self-perceived problems of housing and daily living in her sample went unsolved primarily due to ignorance, organisational factors and the difficulties of defining "need". In some respects the problems could also be traced to find that their origin were due to the loose formulation of major relevant legislation, as for example, the Chronically Sick and Disabled Persons Act, 1970. Whilst many people were much happier to be defined on "medical" rather than "social" grounds, this became difficult owing to the different services and categorisations involved.

The various types of aids, alterations and architecture required by the handicapped are noted in Jay (1974), Mattingly (1977), in the Reports of the Office of Population Censuses and Surveys (Harris, 1971; Buckle, 1971) and in Earnshaw (1973) which, through case studies, illustrates inter-relations between the handicapped person, adaptation, alteration, aid, human help and personal roles. The British Medical Association Planning Unit's Working Party Report, No. 2, (1968) authenticated many criticisms relating to aids for the disabled. Particularly important issues which caused grave concern to the Working Party in respect of the disabled were associated with

artificial limbs, appliances, specialised aids, wheel-chairs and vehicles organisation, research and development, and education and information.

The National Health Service is responsible for issuing such aids as wheel-chairs and artificial limbs; local authorities are responsible for certain aids in the home, such as hoists, and for architectural adaptations.

The difficulties and problems noted in the Tunbridge Report (1972) imply that aid and architecture should match. Lack of co-ordination in this requirement has been seen to be the cause of much frustration and unnecessary anxiety to the handicapped person.

Apart from the physical barriers which confront many handicapped when they attempt to enter offices, educational establishments, places of employment, shops, telephone booths, places of recreation, etc., (despite the introduction of the Chronically Sick and Disabled Persons Act, 1970) additional restrictions are frequently imposed upon them by the provisions of the Fire Precautions Act, 1971, and the Health and Safety at Work etc. Act, 1974. These provisions often create interpretation differences and conflict between users' interests (i.e. between the handicapped and the non-handicapped) and the creation of subjective judgements which seem to be frequently based on apathy and a lack of understanding of the situation.

It would appear from much of the relevant literature that if the disabled are not to be handicapped in activities such as living in a house, fulfilling a social role, earning a living or pursuing education or pleasure, then action cannot be limited to any one specific area such as housing, public transport, architecture or

city planning. Radical changes in one area may not be very effective unless accompanied by similar improvements in the other areas.

4.15 Sport for the Disabled

Guttmann(1968), founder member of sports for the disabled including the Olympic Games for the Disabled, discusses the development of the sports movement for handicapped people and its rehabilitative role. Apart from its importance for their physical and psychological development, Guttmann points out its value to social re-integration. Much publicity has been given to the increasing success of the "Disabled Olympics" whilst Croucher (1974) has supplied useful information on outdoor pursuits for handicapped people.

Indoor sport for the handicapped has also proved invaluable to the physical and social development of the handicapped and relevant information is obtainable from the relevant organisations concerned with Sport for the Disabled.

CHAPTER III

Formulation of Hypothesis

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Formulation of Hypothesis

The actual relevance of attitudes to behaviour has been questioned by Kutner, Wilkins & Yarrow, (1952), Wicker, (1969), Calder & Ross (1973) and Kelman (1974). These writers indicated that the relationship between attitudes and behaviour are only partially determinants of behaviour along with norms, habits and expectations, and negative attitudes or deep-rooted prejudices by able-bodied people towards the physically handicapped were not always accurate indicators of how people would react in situation.

Nevertheless, it would appear from the work of Chesler (1965), Siller (1966), Yuker et al, (1966) and many other writers that a strong relationship exists between attitudes and behavioural reaction. Literature on deviance, marginality status, exceptionality and stigma suggests that atypicality frequently causes adverse social consequences. As seen by Moriarity (1974), it is not difference per se which defines a person's psychological position but the treatment of the difference by society or the community, in general.

Whilst attitude formation, structure and change may have been anticipated to follow the paths normally predicted from general attitude theory (Allport, 1935: 1954; Fishbein, 1967; Warren & Jahoda, 1973; Reich & Adcock, 1976), it is interesting to note that Straus (1966), from a historical perspective, indicated that stigmatisation and aversion of the disabled had persisted throughout the decades. Prejudices appear to have become more subtle with the passing of time (Barker, et al, 1953) but deviance and relevant differences seem to

continue to find the positive and negative extremes with regularity (Edgerton, 1967; Goffman, 1968).

The idea that attitudes of others affect attitudes toward the "self" was expressed by Siller et al, (1967 (a)):-

> "A person with a handicap reflects prevalent social attitudes of self-depreciation and self-hate. In the newly disabled, on the other hand, negative attitudes previously focussed on members of a devalued out-group may re-focus on the self with devastating results." (p. 1)

In a subsequent study, Shontz (1971) indicated that attitudes toward the self are crucial and are frequently developed by attitudes revealed by others.

Davis (1961) analyses certain facets of coping behaviour as it relates to the generalised imputations of deviance that visibly handicapped people encounter in general society and elicits the dangers that arise from strained interaction. The underlying problem of the disabled person was perceived by Davis to be primarily sociological - arising from the attribution of deviance towards him - how to escape from the situation and to normalise social relationships.

The importance of a positive social influence within the functional relationships between the handicapped and supporting services agencies is outlined by Parsons & Fox (1952) and Younghusband et al, (1971). Gellman (1959) and English (1971) provide information about the anatomy of prejudice towards the physically disabled; Cogswell (1968) and Morgan, Hohmann & Davis (1974) feel that many disabled must cope fundamentally with a new concept of "resocialisation"; Chaiklin & Warfield (1973) indicate that the way the disabled manage "devaluation" has implications on their post-disability roles; whilst Skipper et al, (1968), Malone (1969)

and Nigro (1975) examine the impact of disability on marital and family relationships. All are involved with fundamental problems of the disabled as a function of society.

Apart from studies associated with physical handicap, the importance of behaviour as a function of both personality and environment has been demonstrated by many psychologists with studies in other areas of human behaviour (Maslow, 1954; McGregor, 1960; Lemert, 1967; Goldthorpe, Lockwood, Bechhofer & Platt, 1968; Mittler, 1970).

Bloom (1965) believed that much of what has been termed individual variation may be explained in terms of environmental variation whilst Cattell (1965) concluded that lack of allowance for the situation is one of the main causes for misjudging personality.

Environmental stimulation, however, does not exclude other people and evidence indicating interaction effects between people in therapy situation is reviewed by writers including Moos & Clemes (1967). Social and experimental situations have also been demonstrated to indicate that behavioural effects do occur during social interaction between the disabled and able-bodied (Kleck et al, 1966; Farina, Sherman & Allen, 1968; Comer & Piliavin, 1972).

Techniques used to measure attitudes toward disability and disabled persons have included theoretical discussions based on subjective personal experiences and collections of the considered experiences of people associated with the handicapped. These subjective evaluations have frequently provided hypotheses for more evaluative studies and also provided statements which have been developed for evaluating attitudes by objective methods, scoring and non-scoring techniques.

Important theoretical-descriptive analyses have been presented in terms of value-systems (Dembo et al, 1956), deviance (Davis, 1961), stigma (Goffman, 1968) and other sociological characteristics. These writers have tended to emphasise conscious processes and the psychological situation.

It has been pointed out that methodogical approaches exist that can provide tests of hypothesis in individual cases (Bakan, 1956; Eddington, 1967) but these tend to be more suited to captive populations.

Ranking procedures have been used to elicit preferences among professionals or employers for working with various types of handicapped people (Gowman, 1957; Rickard, Triandis & Patterson, 1963).

Rusalem (1950; 1965) used a type of check list to identify traits which were felt to be characteristic of the blind.

Non-scoring instruments have also been used with success. Jennings (1951) interviewed employers about the perceived needs for special provisions for disabled people on the job and other factors such as degree of acceptance of the disabled as a working member of a team.

As reported by Barker et al, 1953 (p. 71), Ray conducted a non-scorable pictorial projective technique in rank order according to several behaviour and personality characteristics.

Baxt, David, Jaffe & Wang, (1959), used a structured interview in their study of employers' preference for employing disabled people whilst a scale of item statements, divided into four different categories, was developed by Horowitz et al, (1965) for use with deaf people.

The development of early attitude scaling techniques by sociologists such as Thurstone and Likert have enabled the contemporary use of more

sophisticated scales, as for example those used by Lukoff and Whiteman (1959; 1961), Yuker et al, (1966) and Siller et al, (1967, (a) and (b).

Barker et al, (1953), examined a number of studies involving attitudes toward physically disabled people and contained in some of their conclusions:-

1. "Public, verbalised attitudes toward disabled persons are on the average mildly favourable; an appreciable minority openly express negative attitudes.

2. Indirect evidence suggest that deeper unverbalised attitudes are frequently hostile. This point requires further investigation.

3. The attitudes of disabled persons and of their physical normal associates are frequently in conflict with respect to the meaning of help, curiosity, sympathy and misfortune.

4. The attitudes of both the disabled person and his associates are influenced by the larger social situation in which interactions occur." (pp. 84-85)

From a multi-disciplinary approach, Siller et al, (1967 (a)) considered that the study of basic psychological issues pertaining to disability had been neglected and stated:-

> "..... the relationships between disability and such areas as self-concept, prejudice, body-image, etc., have not been bolstered by adequate empirical tests." (p. 1)

In a subsequent investigation (1967, (b)), Siller et al, strongly recommended the use of multi-dimensional measures in the structure of attitude scales involving the physically disabled; a view reiterated by Siller (1976). Unidimensional approaches described only limited aspects and these were not considered conducive to constructive results. Rawson (1973) indicated the need to take into account the different disciplines associated with care and treatment when pursuing any study involving physical disability.

Himes (1958) noted that disabled people could be perceived as "different" from the physically normal and reacted to in much the same manner as members of a minority group.

Whiteman & Lukoff (1963; 1964(a); 1964 (b); 1965), as reported in Siller, et al, 1967 (a) (p.4) identified five major components of attitudes toward blindness and compared them with the general category of physical disability. They found that the relationships between components of attitudes to one disability related closely to the same attitudinal component of another disability. The relationships between different attitudinal components were not so close.

The research of Yuker et al, (1966) suggested that although people with different disabilities could be viewed as different from one another, there were many similarities. It was pointed out by them that:-

> ".... The crucial determinant of a disabled person's attitudes (both towards himself and towards other disabled persons) is his perception of his disability, and not the objective nature of the disability." (p. 54)

They considered that focus on the general concept of disability was a most fruitful area for further research.

Wright (1960) believes that there is no substantial indication that persons with an impaired physique differ as a group in their general or overall adjustment. People with physical deviations are not a homogeneous group psychologically, and physical disability is a surface (phenotypic) classification. She emphasised the necessity of:-

> ".... getting below the surface, of leaving the non-psychological realm of physique and of seeking its underlying psychological significance." (p. 377)

McDaniel (1969) writes:-

> ".... I do not find it inconceivable, as Wright (1960) apparently does, that attitudes toward physical disability and towards disabled persons can be distinguished just the same as most people deplore poverty as a condition, or alcoholism, or homosexuality, but do not necessarily have the same attitude toward their "victims". (p. 28)

The survey by Shontz (1970) which dealt with literature relating to physical disability and personality factors disclosed no evidence to support the hypotheses that many forms of somatic disability are associated with particular forms of personality or that the extent of the effects of disability on personality is proportional to the severity of disability.

After reviewing literature about the measurement of attitudes toward disabled people, Yuker et al, (1956) concluded:-

> ".... few instruments have been devised which could be used in investigations of attitudes toward the disabled in general .... None of the instruments reviewed were designed for use with both the non-disabled and the disabled." (p. 16)

Other studies examined with a view to seeing how concepts were developed, hypotheses tested and perceptions exemplified included surveys by Gavron (1968), Sainsbury (1970) and Harris et al, (1971).

The readings cited in the foregoing literature and in other literature to which reference was made in the general review (Chapter II.) indicated that the outlook and behaviour of physically handicapped people might be perceived by both the handicapped and non-handicapped as either different from the physically "normal" or essentially the same and that the reaction of people to physical handicap was largely the product of the cultural milieu of the nature of social psychological man.

The readings also reveal that despite the use of many different techniques for measuring attitudes towards disabled persons and disability, most of the measures which have been designed for use with the handicapped have been directed towards persons with specific disabilities, particularly the visually handicapped. Few attempts appeared to have been made to design instruments which could have been used by people with different disabilities or by people free of handicap.

It also seemed that most of the real difficulties and problems encountered by a physically handicapped person are experienced in their endeavours to obtain a measure of independence, social integration and recognition as an accepted member of the community. Even the provision of adapted environments and increased income which assisted to reduce the indignities and apparent civil disabilities experienced by many handicapped are not always sufficient to permit easier opportunities for social integration and interaction. The normal flow of social interaction upon which social relationships are based was frequently perceived in the literature to be disrupted to the extent that the basis of communication itself had been undermined and normal interaction terminated.

These cumulative observations led to the posing of problems concerned with the measure of generalised beliefs and values associated with various aspects of disability. It was considered that a study of these reflections might provide a means for assessing the outlook and behavioural reaction of handicapped and non-handicapped people in relation to physical disability.

The following study is primarily sociological in content and is more concerned with an examination of attitudes and relationships involved with some of the substantive issues which determine the

behavioural reactions of persons encountering physical handicap than with attitudinal theory. It attempts to obtain information from both the membership reference group (active participants) and the comparative reference group (active and passive observers). The membership group consists of people with different permanent physical handicaps and a sample of "matched" non-handicapped people. In the comparative reference group the respondents are drawn from people who cared for the handicapped (active observers) and a sample of able-bodied who are "matched" as passive observers to the handicapped respondents.

A series of statements were collected from physically handicapped and non-handicapped people. Each statement indicated that handicapped people were either "different from" or "similar to" non-handicapped people. Some of the statements referred to characteristics that some handicapped people held or were thought to hold whilst other statements referred to how the handicapped should behave or be treated in social interaction.

It was decided that the attitudinal statements be used in relation to the four specified groups and examined to see whether they discriminated between the groups of individuals with physical handicaps, groups with intimate knowledge and responsibility for caring for the handicapped respondents, and the "matched" samples of able-bodied individuals.

It was anticipated that comparative information would emerge from the personal experiences and outlooks of the respondents from their involvement with the processes of adaptation, integration, engagement or disengagement in the various sectors of society. These sectors consisted of the self, family, supporting services and general society (or outer community).

Information obtained in this way from the handicapped and non-handicapped would seem to offer something of value towards the examination of questions such as the following:-

1. "To what degree and in what way are the outlooks or attitudes and behaviour of disabled or handicapped people patterned either by the handicap, family, supporting services and/or outer community?"

2. "To what degree and in what ways, if at all, do the outlooks or attitudes and behaviours of handicapped people differ from those of non-handicapped people, or vice versa?"

3. "If such patterning is in evidence, to what extent may this be explained and understood?"

It was recognised that verbalised attitudes could be measured on an attitudinal scale modelled on that by Thurstone & Chave and it was believed that this type of instrument would be valuable to the research in the study being contemplated.

The hypotheses to be tested therefore are:-

1. distribution of responses to the attitude scale would be different in the case of the handicapped and non-handicapped and that some areas where differences were most marked would form pointers to further investigation in more specific sectors involving the behaviour of handicapped and non-handicapped people,

2. the attitudes of those who cared for the handicapped would be closer to the handicapped than the attitudes of the non-handicapped, and

3. handicapped people generally have a desire for social relationships and aspirations similar to the non-handicapped.

Hence it was hoped that the results of the study would serve as a contribution to a fuller understanding of the personal and social consequences of physical handicap. For some limited purposes these hypotheses were, of course, recast into the null mode with reference to statistical significances.

CHAPTER IV

METHODOLOGY

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CHAPTER IV

Methodology

This chapter is in two sections. The first section 'A', deals with some of the issues considered in defining "physical handicap" and other matters involved with the premise, nature and scope of the interviewing process, the construction of the questionnaire and the actual interviewing procedure.

The latter section, 'B', deals more specifically with statistical information and the results arising from the different tests.

Section 'A'

1. Introduction

Several desiderata arise when consideration is given to the measurement of attitudinal components and the reactions and relationships with physical handicap. In the first place there is the need to operate a method which will obtain the requisite information and permit it to be identified and measured in accordance with approved procedures.

The readings of the various authors cited in the previous chapters and others including Fichter & Kolb (1953), Rosenthal & Rosenow (1970), Cohen & Taylor (1972) and Carver & Rodda (1978) have pointed to the importance of establishing a language which could be identified, recognised and recorded in terms acceptable to all people associated with the research, either directly or indirectly. Consequently, it was essential to provide a definition of "physical handicap" that was considered suitable and acceptable to those people involved in the study for identification, recognition and participation purposes.

2. Definition

Characteristics taken into consideration in formulating an acceptable definition of "physical handicap" for use in this study included:-

2.1 Physical handicap was seen as a permanent disadvantage or restriction of activity caused by a severe loss or reduction of a person's functional ability.

2.2 The degree of physical handicap was recognised as the extent to which the activity is restricted and impedes the person's interaction with others and his ability to achieve some measure of self-dependence and self-esteem.

2.3 The loss or reduction of functional ability depended not only on the extent of the impairment, injury, disease or illness, but on the individual's ability to adapt to, to minimise or to extend the effect of impairment.

2.4 Impairment referred to physical defect and the loss of normal bodily mechanical function/s.

2.5 Disablement or disability was accepted as a consequence of impairment and referred to the loss or reduction of functional ability.

2.6 Ability to adapt to the situation may be related to personality, intelligence, education, employment, moral beliefs, attitudes and environmental features; support of the home and family; and contact and interaction with the supporting services and the community.

2.7 Influences of various personal, moral and environmental characteristics and features can lead to positive or negative reactions with respect to the presence of physical handicap.

2.8 The "community" (or general society) provided the geographical location from which the handicapped in the wider network of free and reciprocal relationships and activities with physically non-handicapped people derived shared values, attitudes and behavioural reactions in accordance with mutually accepted social standards.

2.9 An age range of 18 years to 60 years used in the study was considered to be the span of life which permitted most people, directly or indirectly, to share a common objective and relationship with people outside the family unit for the good of themselves as individuals and of the community in general.

2.10 The disabled respondent participating in the study to be a person who had experienced, and was experiencing, severe permanent physical handicap (disability) for a period of more than two (2) years.

2.11 It was understood that the physical and mental processes used in the various inter-related areas were essential in part to the fulfilment of some measure of self-dependence, self-esteem and human dignity in respect of physically handicapped people.

An inter-relationship of the above factors suggested that "physical handicap" be used in this study as:-

> "A social term applicable to a person who because of some severe physical injury, illness or disease received between the age of 18 years and 60 years was experiencing and had experienced severe permanent physical disadvantage or restriction for a period of more than 2 years. The physical injury, illness or disease should have been thought generally to have been a handicap to the individual's pre-disability capacity to achieve within the community a measure of personal fulfilment, social interaction, self-dependence and self-esteem compared with his pre-disability potential. The handicapped person to be free from residential treatment and care at a hospital or other similar place of care."

It was also considered important that there was an awareness that the areas of belief, opinion and attitudes were relevant to the "disabled" situation as, only then, in contemplating the inter-relatedness of changes in these areas would it be possible to detect some meaningful patterns of association.

3. Premise

The real essence of the quality of any survey examining beliefs and attitudes seem to be obtained only by carrying out the survey in the natural habitat of its subjects. Myers (1958), Cicourel (1964), Suchman (1965), Yuker et al, (1966), Siller et al, (1966), and others have stressed the importance and value of examining the consequences of physical handicap within the fulness of the community; the area where the real consequences of physical handicap are experienced and where it was essential to consider the effects of physical handicap in their inter-relatedness on the behaviour of the individual.

As indicated by Wilber (1967), hospital and physicians' records seem to lack uniformity and are restricted to specifically treated cases; laboratory screening methods are incomplete diagnostically; whilst health interview surveys tend to underestimate the prevalence of physical handicap and are somewhat influenced by respondent recall, administrative aspects and legislative content.

Judgements made for studying physical handicap were seen to emanate from a large repertoire of factors associated with the personality, family, supporting services, community, environment and other inter-related areas.

Young & Willmott (1957) and Grebenik & Moser (1962) have pointed to the quality and richness of information obtained from good interviewing techniques; Jennings (1962) referred to the benefits of experiencing the personal situation; Cannell & Kahn (1954) perceived the accrued advantages from the communication process and personal relationship; whilst Simmons (1962) and Haber (1973) implied that the interview approach is frequently the only method of establishing depth to any study involved with physical handicap.

In attempting to fulfil the different criteria, it was decided to examine by personal interview and with suitable attitudinal questionnaires the various outlooks and behavioural reactions to physical handicap of a reasonable number of people handicapped by different physical disabilities and a comparable number of non-handicapped people within the community.

4. The Interview

Choice between alternative techniques for interviewing raises important issues of methodology with final selection often being determined by the type of information required and the kind of analysis to which that information is processed. Whilst the validity of responses and reliability of results are important components in the interviewing situation the decision as to whether the data obtained should be presented in a qualitative or quantitative form is often dependent upon the situational needs.

Whilst the complexity of the relationships studied in most kinds of social research makes it important for appropriate statistical methods to be used, it appears important with studies concerning physical handicap to realise, as indicated by Grebenik & Moser (1962), that:-

> ".... verbal descriptions of individual cases, institutions, and the like can often give a more vivid, richer and, in a sense, deeper picture of life than the statistical tables found in conventional reports. The two ways are .... complementary." (p. 21)

In a similar vein, Jennings (1962) writes:-

> ".... the main object was to see the situation from the point of view of the person interviewed .... the fact that, in a few cases, the narratives were highly charged with emotion....did not seem to us to diminish their value .... Indeed, means of communication and opportunities for the expression of feeling are obviously important factors in the social bond ...." (p. 12)

Two further issues to which due attention must be given in the interviewing process are those which concern bias and motivation to talk.

Sellitz, Jahoda, Deutsch & Cook (1962) discussed the problem of bias and concluded that much of what is called "interview bias" could more correctly be described as "interviewer differences." Referring to the provisions of a motivational basis for the respondent to communicate the information sought, Cannell & Kahn (1954) considered that it derived mainly from the respondent when:-

> ".... he sees the information-giving process as a means of attaining some goal which he considered desirable. .... attaining some satisfaction out of relationship with the interviewer .... communicating in the interview situation only in the absence of certain specific barriers ...." (p. 354)

In order to achieve the objective of this study it was therefore clear that considerable degrees of closeness in terms of understanding and acceptance with the respondents were necessary although, at the same time, it was essential to retain an appropriate measure of "distance" or "detachment" to provide objectivity and research fulfilment.

The choice of interview methodology for the study was made with these various points serving as guidelines. To discover and gain the respondents' personal perceptions and views of the various issues were the all-important objectives.

5. Scope

An endeavour to obtain in the sample physically handicapped people who proportionately represented valid personal and environmental characteristics by random selection through appropriate official channels proved unsuccessful. Problems centred around:-

Fig. 8 Boundary of Residence of Respondents associated with the Survey



Boundary of Residence of Respondents overmarked in Red

5.1 Confidentiality,

5.2 Lack of specific and adequate information about all physically handicapped people within the area desired to be surveyed, and

5.3 Extra work involved by the administrative staff.

Consequently, contact with the physically handicapped people was made following personal approach to officials and members of various supporting services, social and voluntary organisation operating within the geographical area surveyed. An indication of the organisations used as sources of information for obtaining the names of potential respondents is shown at appendix I. Individual names of the organisations and individuals have been omitted to preserve anonymity.

Selection of the handicapped respondents was made to be as consistent as possible with those who were (or might be) considered as severely disabled or handicapped in accordance with the definition of "physical handicap" described previously on p. 119.

6. Construction of Questionnaire

One hundred and seventy-five (175) different statements relating to the outlook and behaviour of physically handicapped people were collected within nine months from discussions by people residing in Northumberland and County Durham. Eight county districts (Fig. 8 - opposite page) were involved and information relevant to these districts is shown at appendix XI.

All the discussions took place in an informal atmosphere and were conducted with minimal participation by the author. In an attempt to minimise bias and gain complete frankness, the participants were unaware that specific statements made during the discussions were likely to be considered for use in a survey to be carried out in relation to the

outlook and behaviour of physically handicapped people. About half the discussions took place without any initial prompting by the author.

The total number of people in any single discussion did not exceed five (5) and the total involved in all discussions was 606, consisting of 275 physically disabled and 331 non-handicapped persons. No attempt was made to obtain personal information about the participants.

One hundred and fifty (150) most frequently recurring statements arising from the discussions were selected in the belief that they indicated generally a cross section of the outlooks and views on social consequences of many people following the onset of physical disability.

Confirmation of the suitability of the statements for this purpose was sought and obtained from ten (10) persons who did not participate in the discussions. These people consisted of:-

Doctor
Health Nurse
Social Worker
Training Centre Manager (Industry)
Personnel Officer (Industry)
College Lecturer
2 physically handicapped persons, and
2 non-handicapped persons

The statements were subsequently selected at random and presented in the form of a "150 Statements" Attitude Questionnaire designed on an eleven (11) point rating scale similar to the Thurstone & Chave (1929) attitude technique.

The questionnaire was then submitted to 16 people (8 physically handicapped and 8 non-handicapped) as a pilot test for comprehension and interpretation of the statements and suitability of design. Four

respondents (one handicapped, one caring and two non-handicapped) submitted their answers in writing. Copies of their answers are shown at appendix III.

The pilot test revealed a reasonably good understanding of the statements and the answers suggested that the questionnaire could be used with a wider and more representative population. The responses of the people who participated in this pilot test were not used in any part of the subsequent investigations.

A "panel" of twelve persons was then selected for the purpose of allocating the statements (150) into four (4) main categories within the questionnaire. These categories were considered particularly relevant to people following the onset of physical handicap and related to the:-

6.1 Self,

6.2 Family and immediate environment,

6.3 Supporting Services (i.e. Health Services, Education, Employment, Church, etc.), and

6.4 General Society (Outer Community)

The panel consisted of:-

Doctor	Male
Health Nurse	Female
Physiotherapist	Female
Production Foreman (Industry)	Male
Teacher (Disabled)	Female
Church Minister	Male
Administrative Officer (Disabled)	Male
Employment Officer (Disabled)	Female
2 Disabled persons (Unemployed)	Female and Male
2 Caring persons	Female and Male

Each member of the panel was given a complete set of the statements (150) and asked to place each statement individually into one of the four categories which was considered to be most appropriate. Members of the panel were not asked to register personal opinions about the strength of their agreement or disagreement with the individual statements.

The results of the panel's opinions were tabulated to show the category in which each member had allocated the various statements. A summary of the results indicating the majority judgement of the panel for each category is shown as follows:-

	Total
Self	43
Family	26
Supporting Services	48
General Society (Outer Community)	32
Total	149

The panel agreed that Statement No. 150 be omitted from the questionnaire and left in abeyance owing to the individual nature of the information required. Statistical information about the panel's findings is shown at appendix XII.

It was decided to submit the "150 Statements" Attitude Questionnaire to fifty (50) persons between the age of 18 years and 60 years in each of the following groups:-

(a) Physically handicapped (Disabled) - active participants,

(b) Non-handicapped (Able-Bodied[1]) - active participants,

(c) Caring (Persons responsible mainly for the care of the handicapped respondent outside hospital or similar residential institution) - active observers, and

(d) Non-handicapped (Able-Bodied[2]) - passive observers.

An attitude questionnaire was used for each respondent in the four (4) different groups and the statements adapted and adjusted where

necessary to accommodate the roles of the respondents in each group (i.e. disabled - active participants; able-bodied(1) - active participants; caring - active observers; and able-bodied(2) - passive observers). Copies of each questionnaire are shown in appendix II. A copy of a Reference Number Code used with each questionnaire appears at appendix XIV.

To supplement the attitudinal questionnaire, each respondent in the physically handicapped and able-bodied(1) groups was invited to complete Cattell's "16 Personality Factor" - Form 'C' Test. This psychological test permits comprehensive personality measurement in broad areas of functioning.

7. Group Selection

7.1 Physically Handicapped (Disabled Group) - Active Participants

Selection of the physically handicapped people was made in accordance with the description used for "physical handicap" and explained previously on p. 119. Other issues which determined or influenced the choice of the respondents were:-

7.1.1 Nature of handicap or disability
7.1.2 Area of residence
7.1.3 Sex
7.1.4 Age group
7.1.5 Marital status

The handicapped people were selected from within the following groups of disablement:-

7.1.6 Arthritis
7.1.7 Blind
7.1.8 Deaf
7.1.9 Amputees
7.1.10 Multiple Sclerosis
7.1.11 Polio
7.1.12 Stroke
7.1.13 Heart
7.1.14 Paraplegic

An endeavour was made to obtain a fairly reasonable representation of the different categories of disablement, each of which is described briefly in appendix VIII. Most interviewees were unknown to the author previous to the interviews.

Active participants in this group were recognised as being disabled. They were asked to view the role of the disabled in relation to the self, family, supporting services and outer community from a personally active and participative role.

7.2 Physically Non-Handicapped (Able-Bodied[1] Group) - Active Participants

The physically able-bodied[1] group was "matched" with respondents in the disabled group according to the following conditions:-

7.2.1 Area of residence

7.2.2 Sex

7.2.3 Age group

7.2.4 Marital status

7.2.5 Educational level consistent with that of the handicapped respondent at the time of known onset or occurrence of disability, and

7.2.6 Employment consistent with the handicapped respondent at the time of known onset or occurrence of disability.

Identification of respondents in the group was frequently made by "trial and error" although exploratory talks with the disabled and caring respondents often produced sufficient information to make an appropriate selection at the initial attempt. Most interviewees were unknown to the author previous to the interviews.

Active participants in this group were recognised as being able-bodied. They were asked to view the role of the able-bodied in relation to the self, family, supporting services and outer community from a personally active and participative role.

7.3 Caring Group - Active Observers

This group consisted of people who in a non-professional capacity were most closely involved with assisting the disabled person to fulfil his basic needs. The caring person was most frequently the spouse of the disabled person and was "matched" only by area of residence.

When a disabled person was living alone, the "caring" person was replaced by someone who had intimate knowledge of the role for caring for a person with a handicap similar to that of the disabled person. This procedure was also adopted for a small minority (3) of potential caring respondents who did not desire to complete the questionnaire.

Selection of the respondents in the caring group originated from information given by the handicapped person. Most interviewees were unknown to the author previous to the interviews.

Active observers in this group were recognised as those who were primarily engaged in caring for the disabled person. They were asked to view the role of the caring in relation to the self, family, supporting services and outer community from a personally active and participative role.

7.4 Physically Non-Handicapped (Able-Bodied[2] Group) - Passive Observers

In this group, the respondents were able-bodied people who expressed their opinion about physically handicapped people in the category to which they were "matched". The respondents were "matched" to the handicapped according to the following conditions:-

7.4.1 Area of residence
7.4.2 Sex
7.4.3 Age group
7.4.4 Marital status

7.4.5 Educational level consistent with that of the handicapped person at the time of known onset or occurrence of disablement, and

7.4.6 Employment consistent with the handicapped person at the time of known onset or occurrence of disability.

Identification of respondents in this group was frequently made by "trial and error" although exploratory talks about persons in one group often produced information which could be considered for "matching" potential respondents in another group.

Passive observers in this group were recognised as those able-bodied who held no special responsibility towards a particular disabled person but were aware of people within the category of disablement in which they were "matched". They were asked to view the role of the disabled in relation to people within the category of disablement in which they were "matched" from a personally "spectatorial" role.

8. Issue of Questionnaire and Tests

A personal approach to fifty (50)* people in each of the four groups was made for completion of the "150 Statements" Questionnaire. Their own approval was initially sought and their suitability to participate as potential respondents was confirmed. This established, it was found that all people in the handicapped (disabled) and non-handicapped (able-bodied(1) and (2)) groups agreed unhesitatingly to complete the questionnaire. Five (5) people in the caring group declined to complete the questionnaire but were replaced by other suitable persons. Co-operation from all the people approached in connection with the questionnaire was excellent.

The numbers associated with the different categories of disablement were as follows:-

---

* Three (3) other people were interviewed but their responses were not used because of unsuitable "matching".

9.1	Arthritis	5
9.2	Blind	6
9.3	Deaf	6
9.4	Amputees	3
9.5	Multiple Sclerosis	6
9.6	Polio	5
9.7	Stroke	4
9.8	Heart	5
9.9	Paraplegic	10
	Total	50

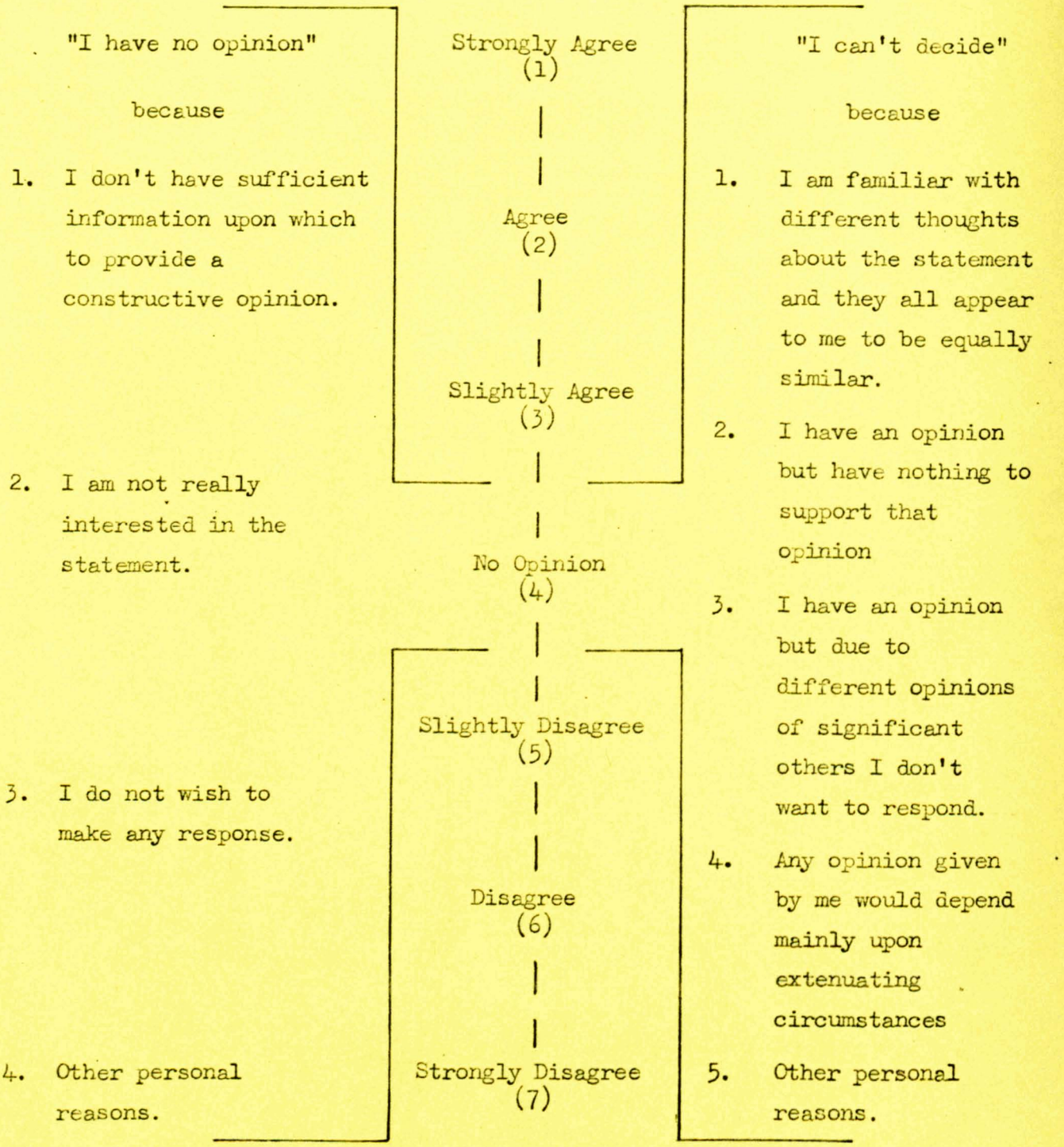
Respondents in the handicapped and able-bodied[1] groups were also given Cattell's "16 Personality Factor" test to complete.

9. Interviewing Procedure

The interviewing process relating to respondents completing the "150 Statements" Attitude Questionnaire in respect of the four groups extended over a period of some 20 weeks. A large majority of the respondents in each of the respective groups personally completed their own questionnaire; in other cases the responses of the respondents were recorded on to the questionnaires by the author. The disabled and A.B.[1] group respondents also completed the "16 P.F." Test. Raw scores and relevant data were subsequently classified and transferred on to prepared sheets for further processing. Recording tapes were not used during any of the interviews although much information in answer to supplementary questions was recorded by the use of shorthand notes. An elementary knowledge of the "Finger Alphabet" was sufficient to interview successfully two hard-of-hearing respondents but professional assistance was available and freely given in connection with one other person handicapped by deafness and with one person who communicated mainly by braille.

The names and addresses (or other suitable location) of the respondents were recorded only for the purpose of the possibility of a subsequent interview (e.g. reliability test) or a need to gain some

Fig. 9 Features of "No Opinion" Response in Questionnaire Design



Note:-

1. "No Opinion" did not necessarily mean no agreement or disagreement with one belief or some other.
2. Strength of response did not necessarily indicate flexibility or inflexibility to change.
3. Time involved in reaching a decision did not always indicate the "strength" or "support" of a response.

specific information. All information given by the respondents and others who assisted in providing assistance about potential respondents was regarded as strictly confidential and to be used only for the purpose of statements applicable to the main "150 Statements" Attitude Questionnaire.

Before commencing to answer the relevant questionnaires or tests, each respondent was carefully told about the purpose of the survey, the method used for the completion of the questionnaires and the tests and the need for an honest response to the various statements. (An interpretation of the "no opinion" response was given to the respondents in accordance with the illustration shown on opposite page). Otherwise, the completion of the questionnaires and tests were in accordance with generally approved standards.

Some 80% of the disabled and caring respondents completed their respective questionnaires and tests within their homes at the same time although the respondents completed each questionnaire independently.

About 80% of the A.B.(1) group and 40% of the A.B.(2) group respondents completed questionnaires and tests at their respective homes. Locations used for completing questionnaires and tests outside the home environment included offices, libraries, etc., and these premises frequently enabled two or three respondents to complete their questionnaires at the same time although independently of each other.

Within four (4) weeks of the initial interview, 18 respondents in each of the disabled and able-bodied(1) groups (every third (3rd) respondent) were invited to complete every third (3rd) question in the original "150 Statements" Questionnaire. The results indicated close agreement with the initial responses of the respective respondents and made a further contribution toward the satisfactoriness of the method or research.

The results of the "150 Statements" Attitude Questionnaire and the "16 P.F." Test were compared and analysed using an S.P.S.S. Programme on the Northumbrian Multiple Access Computer at the University of Newcastle.

It must be recorded that all the respondents received the author, irrespective of whether it was in their own home or elsewhere, with utmost respect, kindness and co-operation, and for this he was exceedingly grateful.

The individual responses from the "150 Statements" Questionnaire were compared with the total responses of each category (i.e. self, family, supporting services and society) within the questionnaire and the fifty (50) most significantly discriminating statements extracted. These statements were used to formulate a "50 Statements" Attitude Questionnaire. Copies of this shorter "50 Statements" Questionnaire as issued to each of the four groups (i.e. Disabled, A.B.(1), Caring and A.B.(2) are shown in appendix IV.

Each of the selected statements was reduced from the eleven (11) point rating scale (used in the "150 Statements" Questionnaire) to a seven (7) point scale. The "50 Statements" Attitude Questionnaires were issued to one hundred and forty-two (142) respondents in each of the four primary groups (i.e. 568* respondents from all four groups. The subsequent addition of 200 respondents who had completed the "150 Statements" Questionnaire provided a cumulative total of 768 respondents - pp. 134-135).

Method of approach to and identification of the respondents followed the same pattern as had been adopted for those respondents who had participated in the "150 Statements" interviews. Names and addresses of respondents were again recorded only for the purpose of the

---

* Ten (10) other persons were interviewed but their responses were not used because of unsuitable "matching".

possibility of a subsequent interview or in the event of desiring some specific details. Information obtained from the respondents in answer to supplementary questions was recorded by the use of shorthand notes. Examples of supplementary questions to the respondents and answers received are shown at appendix VII as an illustration. The interviewing process relating to the "50 Statements" questionnaire and relevant tests extended over a period of some 40 weeks. About 80% of the disabled and caring, 50% of the A.B.(1) group and 50% of the A.B.(2) group were interviewed at their respective homes. Suitable locations outside the home frequently enabled more than one respondent to be interviewed on the same occasion although independently of each other.

The categories of disablement and numbers of respondents who participated in the interviews with this shorter questionnaire were as follows:-

Arthritis	17
Blind	14
Deaf	8
Amputees	21
Multiple Sclerosis	10
Heart	37
Paraplegic	35
Total	142

Categories relating to persons handicapped by "polio" and "stroke", which had been included in the longer "150 Statements" Questionnaire, were omitted from the shorter "50 Statements" Questionnaire because of administrative difficulties.

The results of the 50 respondents who had completed the "150 Statements" Questionnaire and which had been reduced from the eleven (11) point rating scale to a seven (7) point rating were incorporated with the results of those respondents (142) who had completed the

"50 Statements" Questionnaire. This provided an overall total of one hundred and ninety-two (192) respondents from each of the four primary groups. The final numbers and different categories of disablement involved in the overall survey were:-

Arthritis	22
Blind	20
Deaf	14
Amputees	24
Multiple Sclerosis	16
Polio	5
Stroke	4
Heart	42
Paraplegic	45
Total	192

The "50 Statements" Attitude Questionnaire was repeated with twenty-four (24) respondents (every 6th respondent responding again to all statements in the Questionnaire) from each of the disabled and able-bodied[(1)] groups within eight (8) weeks of their initial interviews.

Relevant statistical information and results produced by the various tests are shown on the ensuing pages.

10. Classification of Behavioural Reactions

Each statement in the questionnaire suggested a response to a specific issue involved with behavioural reaction. Members of a "panel" were invited individually to examine each statement and indicate the issue that they thought had the most influence on the behavioural reaction of physically handicapped people within the social context of each of the fifty (50) statements used in the shorter questionnaire. The "panel" consisted of a:-

Doctor	Male
Health Nurse	Female
Physiotherapist	Female
Unemployed disabled person	Female
Unemployed able-bodied person	Female
Teacher	Female
Church Minister	Male
Industrial Production Foreman	Male
Industrial Training Officer	Male
Armed Forces Officer	Male
Voluntary Service Officer, and	Female
Self-employed Craftsman	Male

The issues selected by the "panel" to be of most influence enabled the statements to be classified into the following eleven (11) categories:-

Personal and Social Relationships
Disability Effects
Rehabilitation
Education
Motivation
Finance
Employment
Medical
Legislation
Health and Social Services, and
Church

Results and general summaries of these relationships with the respective statements are discussed in Chapter VII.

The "panel" was also invited to signify which statements they thought in the questionnaire to be either positively or negatively constructed. A summary of their findings are shown at appendix XIII.

The development of a fairly close relationship with a large proportion of respondents in the overall survey enabled subsequent contact to be made with twenty-one (21) persons who had participated as non-handicapped respondents and, following the onset of disability were willing to be interviewed again as respondents in a category of disablement. The results of these interviews are described in detail in Chapter VI (pp. 505 - 556).

Section 'B'

11. Statistical Results

One of the primary purposes of this part of the investigation was to reduce the "150 Statements" Attitude Questionnaire to a more significant level by computer analysis and so produce a shorter questionnaire consisting of fifty (50) statements which would yield as much information as the longer questionnaire and without sustaining any loss in quality.

11.1 Disabled Respondents (Active Participants) - Fifty (50) Cases

11.1.1 "150 Statements" Questionnaire (N = 50)

Computer analysis provided the mean and standard deviation for each of the relevant statements in connection with the disabled respondents. The scores of each statement were also correlated with the total response score of each of the four (4) categories (i.e. self, family, supporting services and general society) as previously outlined, and the overall total. For example:-

Variable	Correlation	Significance
Statement No. 001 with "self" score	0.3741	0.004
" " " "family"	0.4778	0.001
" " " "supporting services"	0.1968	0.085
" " " "society"	0.1621	0.130
" " " "overall total"	0.4711	0.001
Statement No. 002 with "self" score	0.0481	0.370
" " " "family" score	-0.1761	0.111
" " " "supporting services"	-0.1135	0.216
" " " "society" score	-0.1121	0.219
" " " "overall total" score	-0.0199	0.445

A correlation significant at the 0.05 level was considered to be worthwhile discussing; one at 0.01 level was clearly significant. The indications were, therefore, in the two above illustrations that

Statement No. 001 was reasonably placed in the "self" category but might be better placed in the "family" category. Statement No. 002 was not particularly well placed in any of the categories.

Scores in the four (4) categories correlated to a moderately acceptable degree.

The totals for the different categories were also correlated with each other and with the total for all categories. Results of these inter-category relationships were as follows:-

Variable	Correlation	Significance
Self with family	0.3092	0.014
" " supporting services	0.4816	0.001
" " society	0.0636	0.330
" " all groups (total)	0.7030	0.001
Family with supporting services	0.3405	0.008
" " society	0.3263	0.010
" " all groups (total)	0.7141	0.001
Supporting Services with society	0.1608	0.132
" " " all groups (total)	0.7727	0.001
Society with all groups (total)	0.5166	0.001

Each statement in the "150 Statements"Questionnaire was also correlated with two "paired" categories. For example:-

Variable	Correlation	Significance
Statement No. 001 with self & family	0.5251	0.001
" " supporting services & society	0.2902	0.020
Statement No. 002 with self & family	-0.0762	0.299
" " supporting services & society	0.0438	0.381

In addition, each category was correlated with two "paired" categories added together, and each "paired" category with the total group. The results of these inter-category relationships (omitting those involving the same scores) were as follows:-

Variable	Correlation	Significance
Self with supporting services & society	0.3974	0.002
Family with supporting services & society	0.4352	0.001
Supporting Services with self & family	0.5098	0.001
Society with self & family	0.2376	0.048
Self & Family with supporting services & society	0.5140	0.001

Consequently, on the basis of these item and group analyses the selection of items and groupings for the shorter version ("50 Statements" Attitude Scale) of the "150 Statements" Questionnaire was based.

11.1.2 "16 P.F." Test (N = 50)

Computer analysis provided the mean and standard deviation for each personality factor in respect of the disabled respondents. Each item was also correlated with the different categories (i.e. self, family, supporting services and society (i.e. outer community)) of the "150 Statements" Questionnaire. For example:-

Variable		Correlation	Significance
Personality Factor 'A'	with self	0.0469	0.373
" "	" family	0.1002	0.244
" "	supporting services	0.0250	0.431
" "	society	0.0843	0.280
" "	all groups (total)	0.0895	0.268
Personality Factor 'B'	with self	0.2007	0.093
" "	" family	0.4627	0.001
" "	supporting services	0.1050	0.246
" "	society	0.1168	0.222
" "	all groups (total)	0.3174	0.017

In the above illustrations, only Factor 'B' correlated significantly and that was connected with the family category.

The responses of the disabled in respect of each item in the "16 P.F." Test were correlated with two "paired" categories of the "150 Statements" Questionnaire. For example:-

Variable	Correlation	Significance
Personality Factor 'A' with self & family	0.0902	0.267
" " supporting services & society	0.0651	0.327
Personality Factor 'B' with self & family	0.4053	0.003
" " supporting services & society	0.1425	0.175

In the two above illustrations, only Factor 'B' correlated significantly with a "paired" category used and that attitude was in connection with the self and family.

The factors identified as correlating significantly with categories of the attitude scale for disabled respondents were:-

Variable	Correlation	Significance
Personality Factor 'B' with family	0.4627	0.001
" " " total	0.3174	0.017
Personality Factor 'C' with family	0.4624	0.001
Personality Factor 'E' with family	0.3008	0.017
" " " supporting services	0.4624	0.001
" " " total	0.3480	0.007
Personality Factor 'F' with family	0.3360	0.009
" " " society	0.2604	0.035
Personality Factor 'H' with family	0.2509	0.039
" " " supporting services	0.2770	0.026
Personality Factor 'M' with family	-0.2375	0.048
Personality Factor 'N' with supporting services	-0.2783	0.025
Personality Factor 'O' with family	-0.2956	0.019
" " " supporting services	-0.2459	0.043
" " " total	-0.2899	0.021
Personality Factor '$Q^{(1)}$' with self	-0.2936	0.019
" " " family	0.2695	0.029
Personality Factor '$Q^{(2)}$' with society	0.3436	0.007
Personality Factor '$Q^{(4)}$' with family	-0.3996	0.002

The results seemed to suggest that factors associated with the "16 P.F." Test and statements associated with the "150 Statements" Attitude Questionnaire for the disabled were related closely more with issues involving the family than they were with issues connecting the self,

supporting services and society, respectively.

11.2 Able-Bodied[1] Respondents (Active Participants) - Fifty Cases

11.2.1 "150 Statements" Questionnaire (N = 50)

Computer analysis provided the mean and standard deviation for each of the relevant statements in respect of the able-bodied[1] group respondents. Each statement was also correlated, as before, with the four (4) different categories (i.e. self, family, supporting services and society (outer community)), two "paired" categories (self & family and supporting services & society), and the overall total. For example:-

Variable	Correlation	Significance
Statement No. 001 with "self" score	0.0996	0.246
" " " "family"	-0.0844	0.280
" " " "supporting services"	-0.2523	0.039
" " " "society"	-0.2997	0.017
Statement No. 001 with self & family	0.0423	0.385
" " " support. ser. & society	-0.3351	0.009
Statement No. 001 with all groups (total)	-0.2129	0.069
Statement No. 002 with "self" score	-0.1042	0.236
" " " "family"	-0.1209	0.201
" " " "supporting services"	0.2597	0.034
" " " "society"	0.1325	0.180
Statement No. 002 with self & family	-0.1571	0.138
" " " support. ser. & society	0.2458	0.043
Statement No. 002 with all groups (total)	0.0766	0.298

In the above illustrations, Statement No. 001 seemed to correlate significantly with the supporting services and society, respectively, whilst Statement No. 002 seemed to correlate significantly only with the supporting services category.

In addition, each category was correlated with the different categories, the overall total, and two "paired" categories. The results of these inter-related findings were as follows:-

Variable	Correlation	Significance
Self with family	-0.0725	0.309
" " supporting services	0.0391	0.394
" " society	-0.0215	0.441
" " all groups (total)	0.5411	0.001
Self with self & family	0.8426	0.001
" " supporting services & society	0.0137	0.462
Family with supporting services	0.1352	0.175
" " society	0.1367	0.172
" " all groups (total)	0.4190	0.001
Family with self & family	0.4760	0.001
" " supporting services & society	0.1661	0.124
Supporting Services with society	0.3346	0.009
" " " all groups (total)	0.6736	0.001
Supporting Services with self & family	0.1074	0.229
" " " supporting services & society	0.8476	0.001
Society with all groups (total)	0.5950	0.001
Society with self & family	0.0549	0.353
" " supporting services & society	0.7838	0.001
All Groups (Total) with self & family	0.7033	0.001
" " " supporting services & society	0.7785	0.001
Self & Family with supporting services & society	0.1017	0.241

Again these analyses were used in the selection of items for the "50 Statements" version of the attitude scale.

11.2.2 "16 P.F." Test (N = 50)

Computer analysis provided the mean and standard deviation for each of the personality factors in respect of the able-bodied[1] group.. Each item was also correlated with the different categories (i.e. self, family, supporting services and society) of the "150 Statements" Questionnaire, the overall total, the two "paired" categories. For example:-

Variable	Correlation	Significance
Personality Factor 'A' with "self" score	-0.0570	0.347
" " " "family"	-0.1291	0.186
" " "supporting services"	-0.1492	0.151
" " "society"	-0.0554	0.351
" " "all groups" (total)	-0.1683	0.121
Personality Factor 'A' with self & family	-0.1200	0.203
" " supporting services & society	-0.1295	0.185
Personality Factor 'B' with self score	-0.0082	0.478
" " family	-0.2389	0.053
" " supporting services	0.2806	0.028
" " society	0.1273	0.197
" " all groups (total)	0.2460	0.048
Personality Factor 'B' with self & family	-0.1360	0.181
" supporting services & society	0.2460	0.048

In the above illustrations only Factor 'B' correlated significantly and that was in connection with individual categories relating to the family, supporting services and overall totals, and the "paired" supporting services & society categories.

The factors identified as correlating with categories of the "150 Statements" Questionnaire attitude scale for able-bodied[1] group respondents were:-

Variable	Correlation	Significance
Personality Factor 'B' with family	-0.2389	0.053
" " " supporting services	0.2806	0.028
" " supporting services & society	0.2460	0.048
Personality Factor 'F' with family	0.2883	0.022
" " all groups (total)	0.2734	0.029
" " self & family	0.2995	0.018
Personality Factor 'H' with supporting services	0.2818	0.024
" " " society	0.2890	0.021
" " " all groups (total)	0.3331	0.009
" " supporting services & society	0.3485	0.007
Personality Factor 'I' with self	-0.2994	0.017
" " " supporting services	0.3293	0.010
" " " society	0.2622	0.033
" " supporting services & society	0.3647	0.005
Personality Factor 'N' with society	0.2577	0.035
" " supporting services & society	0.2343	0.051
Personality Factor '$Q^{(2)}$' with self	-0.2733	0.027
Personality Factor '$Q^{(3)}$' with society	0.2293	0.055
" " " all groups (total)	0.3054	0.015
" " " self & family	0.2649	0.032

The results seemed to suggest that factors associated with the "16 P.F." Test and statements associated with the "150 Statements" Questionnaire involving the able-bodied[1] group respondents were closely related more with issues connecting the supporting services and society than with issues connecting the self and family categories.

The mean scores and standard deviations of the disabled and able-bodied[1] groups in relation to the "16 P.F." Test are shown as follows:-

16 P.F. Test

	Disabled Group (N = 50)		Able-bodied[1] Group (N = 50)	
Item	Mean	Standard Deviation	Mean	Standard Deviation
A	6.3000	1.4743	6.1000	2.1783
B	3.3333	1.6096	4.0851	2.0724
C	5.7800	1.9303	5.6400	2.7162
E	5.1600	1.7304	5.5000	2.0000
F	4.8367	2.2028	5.4490	2.0723
G	6.3800	2.1275	5.5102	2.3728
H	6.5600	2.0016	6.2200	2.0533
I	6.2000	1.7843	5.6000	2.0404
L	6.1200	1.9758	5.7600	2.0260
M	5.8000	1.7496	5.8800	2.0468
N	6.5400	1.7637	5.7200	1.9064
O	5.7000	1.8434	5.8600	2.5325
Q_1	5.9600	1.6157	5.7400	1.8385
Q_2	6.2600	1.9039	5.5600	1.7162
Q_3	6.5600	1.8201	5.7600	2.1529
Q_4	6.2400	2.4542	5.2000	2.4159

Profiles showing the raw mean scores in respect of the two groups are presented later - opposite p. 163.

11.3 Significant Differences in Relationships between Disabled and Able-Bodied[1] Groups in respect of "150 Statements" Attitude Scales and Cattell's Personality Factor Test ("16 P.F." - Form "C") - (N = 50)

11.3.1 Personality Factor 'B' showed a positive correlation with attitudes to the family and overall total for the disabled but produced a negative correlation with the family and a positive correlation with the supporting services, and "paired" supporting services and society category in respect of the able-bodied.

11.3.2 Personality Factor 'C' correlated positively for the disabled with the family but not at all for the able-bodied.

11.3.3 Personality Factor 'E' correlated positively with the family, supporting services and overall total for the disabled but not at all for the able-bodied.

11.3.4 Personality Factor 'F' showed a positive correlation for the disabled with the family and society and positive correlations for the able-bodied with the family, overall group and "paired" self and family category.

11.3.5 Personality Factor 'H' obtained a significant positive correlation for the disabled with the family and supporting services and positive correlations for the able-bodied with the supporting services, society, overall group and "paired" supporting services and society category.

11.3.6 Personality Factor 'I' produced a negative correlation for the able-bodied with the self and a positive correlation with the supporting services, society and "paired" supporting services and society category. No significant correlation was produced for the disabled.

11.3.7 Personality Factor 'M' showed a negative correlation for the disabled with the family but no correlation for the able-bodied.

11.3.8 Personality Factor 'N' obtained a negative correlation for the disabled with the supporting services and a positive correlation for the able-bodied with society and the "paired" supporting services and society category.

11.3.9 Personality Factor 'O' correlated negatively for the disabled with the family, supporting services and overall total but not at all for the able-bodied.

11.3.10 Personality Factor '$Q^{(1)}$' correlated negatively for the disabled with the self and positively with the family. No significant correlation was produced for the able-bodied.

11.3.11 Personality Factor '$Q^{(2)}$' correlated positively for the disabled with society and negatively for the able-bodied with the self.

11.3.12 Personality Factor '$Q^{(3)}$' correlated positively for the able-bodied with society, overall total and the "paired" self and family category but yielded no significant correlation for the disabled.

11.3.13 Personality Factor '$Q^{(4)}$' correlated negatively for the disabled with the family but not at all for the able-bodied.

It is interesting to note that nine (9) Cattell's Personality Factors correlated significantly for attitudes of the disabled to the family. These factors were:-

'B'	-	Intelligence
'C'	-	Emotional Stability
'E'	-	Independent
'F'	-	Enthusiasm

'H'	-	Spontaneous
'M'	-	Conventional
'O'	-	Confident
'$Q^{(1)}$'	-	*Group Dependency*
'$Q^{(4)}$'	-	*Relaxed*

Personality Factors correlating significantly for the able-bodied with the family were seen on two (2) occasions - Factors, 'B' and 'F', respectively. Personality Factors 'I' (Dependency) and '$Q^{(3)}$' (Self-control) produced significant correlations only for the able-bodied whilst Personality Factors 'A' (Participation), 'G' (Conscientiousness) and 'L' (Trustworthiness) did not yield significant correlations for either group.

It would seem primarily from these results that Cattell's Personality Factors are related much more to the family in respect of the disabled than with the able-bodied.

11.4 Caring Group (Active Observers) - Fifty (50) Cases

11.4.1 "150 Statements" Questionnaire (N = 50)

Computer analysis provided the mean and standard deviation for each of the relevant statements of the "150 Statements" Questionnaire in respect of the caring group respondents. Each statement was also correlated with the four (4) categories of the group as described previously in connection with the disabled and able-bodied[(1)] groups. In addition, each statement was correlated with the "paired" categories (self & family and supporting services & society) and total groups.

The results of these inter-category relationships are shown as follows:-

	Correlation	Significance
Self with family	-0.0069	0.481
" supporting services	0.1864	0.097
" society	0.1244	0.195
" self & family	0.7157	0.001
" supporting services & society	0.2108	0.071
" Overall Total	0.6195	0.001
Family with supporting services	-0.0170	0.453
" " society	0.1141	0.215
" " self & family	0.6934	0.001
" " supporting services & society	0.0527	0.358
" " Overall Total	0.5078	0.001
Supporting Services with society	0.1295	0.185
" " " self & family	0.1224	0.199
" supporting services & society	0.8224	0.001
" " Overall Total	0.5858	0.001
Society with self & family	0.1693	0.120
" " supporting services & society	0.6706	0.001
" " Overall Total	0.5254	0.001
Self & Family with supporting services	0.1887	0.095
Total with self & family	0.8010	0.001
Total with supporting services & society	0.7396	0.001

Significant positive correlations are evident in the different inter-category and overall total relationships.

11.5 Able-Bodied[2] Group (Passive Observers) - Fifty (50) Cases

11.5.1 "150 Statements" Questionnaire (N = 50)

Computer analysis provided the mean and standard deviation for each of the relevant statements in the "150 Statements" Questionnaire in respect of the able-bodied[2] respondents. Each statement was also correlated with the four (4) categories of the group as described previously in connection with the disabled and able-bodied[1] groups. In addition, each statement was correlated with the "paired" categories (self & family and supporting services & society) and total groups.

The results of these inter-category relationships are shown as follows:-

	Correlation	Significance
Self with family	-0.4257	0.001
" " supporting services	0.5895	0.001
" " society	0.3729	0.004
" " self & family	0.6435	0.001
" " supporting services & society	0.5880	0.001
" " Overall total	0.6994	0.001
Family with supporting services	-0.4996	0.001
" " society	-0.2415	0.046
" " self & family	0.4186	0.001
" " supporting services & society	-0.4775	0.001
" " Overall total	-0.3426	0.007
Supporting Services with society	0.5576	0.001
" self & family	0.1716	0.117
" supporting services & society	0.9790	0.001
" Overall total	0.9491	0.001
Society with self & family	0.1699	0.119
" " supporting services & society	0.7151	0.001
" " Overall total	0.7040	0.001
Self & Family with Supporting Services	0.1863	0.098
Total with Self & Family	0.4122	0.001
Total with Supporting Services & Society	0.9721	0.001

Significant correlations are evident in the different inter-category relationships.

Compared with the results of the caring group it would appear that the able-bodied[2] (passive observers) responses are closely related more with issues involving the supporting services and society (outer community).

11.6 Reduction of Original "150 Statements" Attitude Questionnaire

An examination of the significance of the various results of the disabled respondents' response scores to the "150 Statements" Attitude Questionnaire suggested that the number of statements could be reduced to fifty (50) without yielding any significant loss of material information. Consequently, it was decided to extract 50 statements from the disabled response scores which revealed a relatively high coefficient significance and might be statements which could be considered suitable for descriptive information about the category in which the respective statements were placed. Other information available for contribution toward the selection emanated from the response scores of the disabled in the "paired" categories. For example:-

(a) An item considered "borderline"

Variable	Correlation	Significance
Statement No. 001 with "self" score	0.3741	0.004
" " "family"	0.4778	0.001
" supporting services	0.1968	0.085
" society	0.1621	0.130
" all groups (total)	0.4711	0.001
" with "self & family"	0.5251	0.001
" "supporting services & society"	0.2902	0.020

The above illustration suggests that although Statement No. 001 was clearly significant in the "family" category, its placing in the "self" category was reasonable and its position in the "self" was considered to have a good potential for producing important information toward the overall objective of the research. The statement was

selected for inclusion in the "50 Statements" Questionnaire within the category of the "self".

(b) An Item Excluded

	Correlation	Significance
Statement No. 004 with "self" score	0.0335	0.409
" " "family"	-0.4736	0.001
" " "supporting services"	-0.1092	0.225
" " "society"	-0.1972	0.085
" " "all groups" (total)	-0.2174	0.065
" " "self & family"	-0.2655	0.031
" "supporting services & society"	-0.1097	0.224

In this illustration Statement No. 004 might have been considered both significant and reasonably suitable in the "family" category. However, it was excluded because of the presence of other statements with highly significant correlations and which were considered to provide greater potential for producing important information.

(c) An Item Included

	Correlation	Significance
Statement No. 044 with "self" score	0.2582	0.035
" " "family"	0.5668	0.001
" " "supporting services"	-0.0003	0.499
" " "society"	0.0295	0.419
" " "all groups" (total)	0.4880	0.001
" " "self & family"	0.5259	0.001
" "supporting services & society"	0.3402	0.008

In this case, Statement No. 044 was clearly significant in the "family" category and as it was also considered to be a statement which might produce important information was selected for inclusion within the "family" category of the "50 Statements" Questionnaire.

Initially, the original "150 Statements" were reduced to seventy-four (74) statements before progressing to the final fifty (50) statements.

It was also decided that the rating scale could be reduced with advantage from the original 1 to 11 point scale to a 1 to 7 point scale. An examination of the various groupings within the former scale indicated that the following method of adjustment was most appropriate:-

	Strongly Agree			No Opinion			Strongly Disagree
Original	1 - 2 -	3 - 4 -		5 - 6 - 7 -		8 - 9 -	10 - 11
Revised	1 - 2 -	3	-	4	-	5	- 6 - 7

These adjustments influenced the totals for the different categories (i.e. self, family, supporting services, society and overall total).

The personality factors of the "16 P.F." Test were correlated with two adjusted "paired" categories of the attitudinal scale (i.e. "new" self & family and "new" supporting services & society) and significant correlations arising from these relationships noted.

Each statement in the "150 Statements" Attitudinal Questionnaire was correlated with the two adjusted category "pairings" in respect of the disabled respondents. The original categories of the self, family, supporting services and society were also correlated with each adjusted "pairing" - the original "pairings" with the adjusted "pairings" - the original total with each adjusted "pairing" - each adjusted category with each adjusted "pairing" - and the "new" totals with each adjusted "pairing". The results of these inter-category relationships are shown as follows:-

	Disabled	
	Correlation	Significance
Self with new Self & Family	0.6182	0.001
" " Supp. Serv. & society	0.2390	0.047
Family with new Self & Family	0.8050	0.001
" " Supp. Serv. & Society	0.6785	0.001
Supp. Serv. with new Self & Family	0.5013	0.001
" " " Supp. Serv. & Society	0.5425	0.001
Society with new Self & Family	0.3190	0.012
" " Supp. Serv. & Society	0.7196	0.001
Total with new Self & Family	0.8250	0.001
" " Supp. Serv. & Society	0.7815	0.001
Supp. Serv. & Society with new self & family	0.3190	0.012
" " " new Supp.Serv. & society	0.7196	0.001
New Self with new Self & Family	0.9310	0.001
" " Supp. Serv. & Society	0.5773	0.001
New Family with new Self & Family	0.9137	0.001
" " Supp. Serv. & Society	0.7608	0.001
New Supp. Serv. with new Self & Family	0.7009	0.001
" " Supp. Serv. & Society	0.8628	0.001
New Society with new Self & Family	0.5568	0.001
" " Supp. Serv. & Family	0.8787	0.001
New Supp. Serv. & Society with new Self & family	0.7196	0.001
New Total with new Self & Family	0.9448	0.001
" " Supp. Serv. & Society	0.9074	0.001

An examination of these results and the significance of their values confirmed that the original "150 Statements" Questionnaire could be reduced to fifty (50) statements without any considerable loss of information.

The selected statements, their relationships and significant values with the different "paired" categories both before and after adjustment are shown as follows:-

DISABLED RESPONDENTS (N = 50)

Variable	Original Responses Correlation	Original Responses Significance	Adjusted Responses Correlation	Adjusted Responses Significance
Statement No 001 with Self & Fam.	0.5251	0.001	0.6082	0.001
" 010 " "	0.4787	0.001	0.5222	0.001
" 013 " "	0.3517	0.006	0.4258	0.001
" 016 " "	0.2698	0.029	0.3361	0.009
" 017 " "	0.5935	0.001	0.7185	0.001
" 021 " "	0.5169	0.001	0.5419	0.001
" 024 " "	0.3747	0.004	0.3689	0.004
" 034 " "	0.6044	0.001	0.5894	0.001
" 037 " "	0.6399	0.001	0.6358	0.001
" 039 " "	0.2886	0.021	0.3194	0.012
" 042 " "	0.5111	0.001	0.5948	0.001
" 071 " "	0.4112	0.002	0.3736	0.004
Statement No 035 with Self & Fam.	0.4257	0.001	0.5683	0.001
" 044 " "	0.5059	0.001	0.5822	0.001
" 047 " "	-0.3243	0.011	-0.4629	0.001
" 051 " "	0.4649	0.001	0.6189	0.001
" 052 " "	0.2656	0.031	0.4721	0.001
" 055 " "	0.3799	0.003	0.4166	0.001
" 056 " "	0.4744	0.001	0.6256	0.001
" 058 " "	0.3930	0.002	0.5564	0.001
" 060 " "	0.3109	0.014	0.3908	0.003
" 062 " "	0.4568	0.001	0.5544	0.001
" 064 " "	0.4784	0.001	0.5294	0.001
" 065 " "	0.5347	0.001	0.5249	0.001
" 067 " "	0.3712	0.004	0.3750	0.004
" 145 " "	0.3950	0.002	-0.3881	0.003
Statement No 030 with Supp.Serv.& Society	-0.2858	0.022	-0.3945	0.002
" 074 " "	0.3390	0.008	0.4827	0.001
" 076 " "	0.3603	0.005	0.5609	0.001
" 077 " "	0.2518	0.029	0.3094	0.014
" 085 " "	0.2731	0.027	0.2565	0.036
" 086 " "	0.5928	0.001	0.5399	0.001
" 092 " "	0.4555	0.001	0.6394	0.001
" 097 " "	0.3654	0.005	0.3487	0.007
" 099 " "	0.2850	0.022	0.4975	0.001
" 103 " "	0.2645	0.032	0.2235	0.054
" 106 " "	0.4019	0.002	0.3507	0.006
" 122 " "	0.2921	0.020	0.3515	0.006
Statement No 090 with Supp.Serv.& Society	0.3892	0.003	0.4877	0.001
" 094 " "	0.2245	0.059	0.1040	0.236
" 102 " "	0.5694	0.001	0.4716	0.001
" 118 " "	0.3290	0.010	0.5015	0.001
" 119 " "	0.2798	0.025	0.6092	0.001
" 127 " "	-0.3004	0.017	-0.5754	0.001
" 128 " "	0.4177	0.001	0.5692	0.001
" 131 " "	0.2295	0.054	0.4118	0.001
" 135 " "	0.2613	0.033	0.4869	0.001
" 136 " "	0.2419	0.045	0.3864	0.003
" 138 " "	0.2626	0.033	0.4544	0.001
" 139 " "	0.4989	0.001	0.5080	0.001

11.7 Completion of Remaining Interviews in the Survey

An additional 142 respondents were interviewed in each of the four (4) groups. Cattell's "16 P.F." Test and the shortened version of the "150 Statements" Questionnaire (i.e. 50 statements) were issued to each respondent in both the disabled (active participants) and able-bodied[1] (active participants) groups. Computer analysis provided the mean and standard deviation for each of the relevant statements for these two latter groups; the results being as follows:-

	Disabled Group (N = 142)		Able-Bodied[1] Group (N = 142)	
	SELF		SELF	
	Mean	St.Dev.	Mean	St. Dev.
Statement No. 001	5.9507	1.3957	5.5423	1.5918
" 002	4.0775	1.9207	3.6268	1.8929
" 003	4.3803	1.9524	3.2817	1.8503
" 004	3.0563	1.7043	3.0211	1.7644
" 005	3.4225	1.9798	4.6831	1.8995
" 006	4.9296	1.7367	4.9437	1.8171
" 007	3.2042	1.7965	4.3944	1.9532
" 008	3.4930	1.9669	3.1690	1.8139
" 009	3.7254	2.0217	4.7887	1.9491
" 010	3.9225	2.0109	3.8803	1.9332
" 011	3.4366	1.9659	4.3662	1.9295
" 012	4.5775	1.8806	3.5423	2.0338
Total Self	48.1549	5.6698	49.2394	6.2513
	FAMILY		FAMILY	
Statement No. 013	4.5563	1.8700	3.7254	1.9647
" 014	2.9225	1.7221	4.5141	1.9083
" 015	4.4930	2.0273	3.5000	1.9561
" 016	4.5775	1.8993	3.4577	1.9987
" 017	4.9296	1.8321	3.1792	1.9102
" 018	4.7183	1.9727	4.0563	2.0204
" 019	4.4296	2.0435	3.7042	1.9453
" 020	3.4648	1.9155	4.4577	1.9116
" 021	4.4859	1.9524	3.1901	1.9238
" 022	3.3592	1.9437	4.3099	1.9577
" 023	3.3944	1.8333	3.9930	1.9222
" 024	3.8239	2.0011	4.2676	1.9997
" 025	3.7958	1.9334	3.9296	1.9988
" 026	3.8451	2.0081	3.3803	1.8821
Total family	56.7958	7.4564	53.7042	7.2619

	Disabled Group (N = 142)		Able Bodied[1] Group (N = 142)	
	SUPPORTING SERVICES		SUPPORTING SERVICES	
	Mean	St. Dev.	Mean	St. Dev.
Statement No. 027	3.4648	1.9702	3.9225	1.9967
" 028	3.5775	1.9905	3.7465	1.9183
" 029	4.9437	1.8014	3.1268	1.8291
" 030	3.3451	1.9644	4.5000	2.0343
" 031	3.8944	1.9811	3.9930	1.9804
" 032	3.8944	1.9847	4.4930	1.9452
" 033	4.2535	2.0051	3.3944	1.9496
" 034	3.2817	1.6900	4.3310	1.9740
" 035	4.1690	1.9387	3.1408	1.7568
" 036	3.2113	1.8095	4.3239	2.0371
" 037	3.5352	1.9666	4.7535	1.9137
" 038	2.3592	1.5590	3.4859	1.9194
Total Supp. Serv.	43.9225	7.4901	47.2113	7.6751
	GENERAL SOCIETY		GENERAL SOCIETY	
Statement No. 039	3.9648	1.9837	4.9507	1.7354
" 040	4.3318	1.8783	4.6268	1.8854
" 041	3.2676	1.8677	3.0282	1.7420
" 042	4.2606	1.9739	3.4789	1.8971
" 043	4.0775	1.9645	4.5845	1.9433
" 044	4.1549	1.9178	3.3310	1.9341
" 045	3.7535	1.9504	3.6056	2.0385
" 046	4.2465	1.9063	3.2606	1.9376
" 047	4.4155	1.9028	3.1831	1.8817
" 048	4.4155	1.9542	4.3310	2.0026
" 049	3.7606	2.0139	3.1972	1.9213
" 050	3.3169	1.7519	3.9930	1.9875
Total Society	46.9648	6.8948	45.6056	6.7046

The shortened version of the "150 Statements" Questionnaire was also given to each respondent in the caring (active observers) and able-bodied[2] (passive observers) groups.

Subsequently, the responses in each group were added to those of the respondents in the previous groups to give an overall total of 192 respondents for each group.

12 General Overall Results for Disabled and Able-Bodied[1] Groups

12.1 "50 Statements" Attitude Questionnaire

12.1.1 Disabled Group Respondents (N = 192)

Computer analysis provided the mean and standard deviation for each of the relevant statements for the disabled respondents.

Each statement was also correlated with the four (4) categories (i.e. self, family, supporting services and society) of the group and the overall group total. Results of these inter-category relationships are shown as follows:-

	Correlation	Significance
Self with family	0.2882	0.001
" " supporting services	0.2876	0.001
" " society	0.1253	0.042
" " Overall Total	0.6364	0.001
Family with supporting services	0.2246	0.001
" " society	0.2808	0.001
" " Overall Total	0.6957	0.001
Supporting Services with society	0.2684	0.001
" " " " Overall Total	0.6759	0.001
Society with Overall Total	0.6275	0.001

It will be noted that the effects of the item analysis and the subsequent pruning of the longer "150 Statements" Questionnaire have been to "sharpen" the categories and make them more effectively individual. As seen later this procedure had also the effect of reducing the size of the correlations with personality factors.

12.1.2 Able-Bodied[1] Group Respondents (N = 192)

Computer analysis provided the mean and standard deviation for each of the relevant statements in respect of the able-bodied[1] group respondents.

Each statement was also correlated with the different group categories and results of these inter-category relationships were as follows:-

	Correlation	Significance
Self with family	0.1048	0.074
" " supporting services	0.1056	0.072
" " society	0.1132	0.059
" " Overall Total	0.5896	0.001
Family with supporting services	-0.0298	0.341
" " society	0.0360	0.310
" " Overall Total	0.5152	0.001
Supporting Services with society	0.1125	0.060
" " " Overall Total	0.5578	0.001
Society with Overall Total	0.5436	0.001

A comparison of the mean and standard deviation values for the full disabled and able-bodied[1] groups are shown as follows:-

FULL GROUPS

	Disabled (N=192)		Able-bodied[1] Group (N=192)	
	SELF		SELF	
Var.	Mean	St. Dev.	Mean	St. Dev.
001	5.8281	1.4350	5.6406	1.6215
002	4.1354	1.8680	3.7865	1.9338
003	4.5156	1.9116	3.7708	2.0025
004	3.0417	1.6012	2.8542	1.8475
005	3.2240	1.8970	4.1406	2.0016
006	4.9740	1.6577	4.8854	1.9327
007	3.2240	1.8776	4.8646	1.9449
008	3.4323	1.8661	2.8333	1.7675
009	3.7708	2.0413	4.9896	1.8840
010	3.9531	1.9744	4.2031	2.0734
011	3.2396	1.9075	4.3125	1.9297
012	4.6302	1.7764	3.9844	2.1182
Self	47.9531	7.3001	50.2552	6.9714

FULL GROUPS (TOTAL)

	(Disabled N=192) FAMILY		Able-Bodied[1] Group (N=192) FAMILY	
Var.	Mean	St. Dev.	Mean	St. Dev.
013	4.5885	1.7761	4.0573	1.9979
014	3.0104	1.6308	4.0260	2.0142
015	4.4531	1.9138	3.5104	1.9006
016	4.7448	1.7731	3.4479	1.8972
017	4.9896	1.7092	3.6458	1.9868
018	4.6562	1.8887	3.9427	2.0265
019	4.5052	1.9034	3.8125	1.9567
020	3.5521	1.8638	4.4896	1.8276
021	4.2760	1.8707	3.3229	1.8673
022	3.6927	2.0142	4.4896	2.0156
023	3.4375	1.7772	3.4427	1.9702
024	4.0208	1.9709	4.1823	2.0525
025	3.7969	1.8716	4.0625	1.9324
026	4.0156	1.9669	3.5885	1.8483
Family	57.7396	8.0441	54.0469	7.4019

FULL GROUPS (TOTAL)

	Disabled (N=192) SUPPORTING SERVICES		Able-bodied[1] Group (N=192) SUPPORTING SERVICES	
Var.	Mean	St. Dev.	Mean	St. Dev.
027	3.4844	1.9034	4.0052	1.9020
028	3.7500	1.9389	3.9010	1.7711
029	5.0937	1.8195	3.4479	1.8694
030	3.1823	1.8626	4.3646	2.0032
031	4.0260	1.8601	4.2500	1.9630
032	3.8906	1.8823	4.5208	1.9143
033	4.1875	1.8996	3.1823	1.9015
034	3.2292	1.7122	4.0625	1.9806
035	4.3698	1.8740	3.3021	1.7463
036	3.0000	1.7123	3.9948	2.1452
037	3.5625	1.9832	4.4948	1.8701
038	2.2448	1.4642	3.3750	1.8405
Supp. Serv.	44.0156	7.6573	46.8854	7.4242
	GENERAL SOCIETY		GENERAL SOCIETY	
039	4.1823	1.9824	4.6719	1.8166
040	4.4427	1.8636	4.7969	1.8632
041	3.1458	1.7840	3.2083	1.7270
042	4.4740	1.9441	3.4635	1.9358
043	4.1250	1.8603	4.5573	1.9353
044	4.1302	1.8416	3.2760	1.9067
045	3.7083	1.7600	3.5365	1.8754
046	4.4010	1.8787	3.3594	1.8760
047	4.5469	1.8470	3.1146	1.7863
048	3.6927	1.8853	4.5937	1.9312
049	3.7500	1.9630	3.0729	1.8433
050	3.2292	1.7752	3.8542	2.0051
Society	47.8542	7.3343	45.5313	6.6545

12.2 "16 P.F." Test

12.2.1 Disabled and Able-Bodied[1] Groups (N = 192 for each group)

Computer analysis provided the mean and standard deviation for each of the relevant items relating to both groups of respondents. The results are shown as follows:-

16 P.F. Test

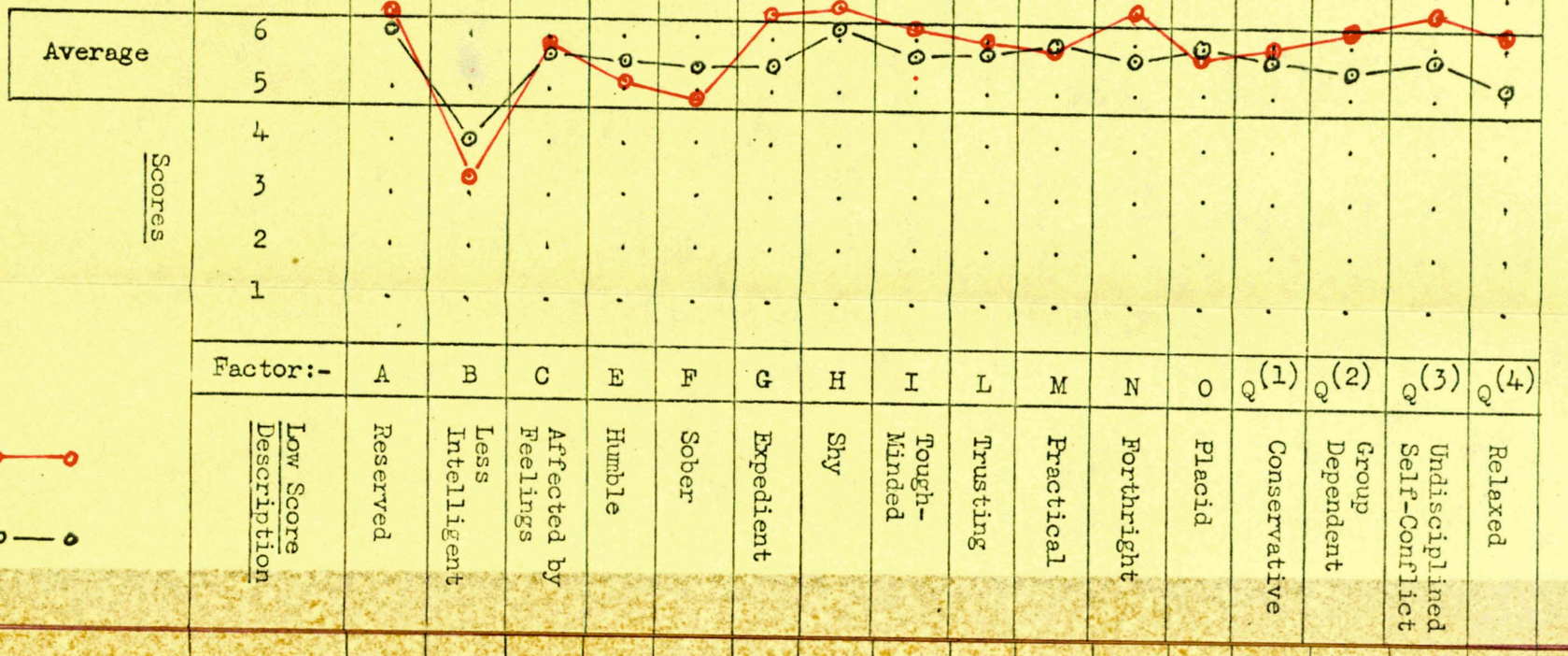
	Disabled Group (N=192)		Able-bodied[1] Group (N=192)	
Item	Mean	St. Dev.	Mean	St. Dev.
MD	6.5312	2.0894	6.2760	1.9501
A	5.7448	1.7313	5.9844	1.9723
B	3.5573	1.7891	3.8958	2.0025
C	4.9219	1.9998	6.0104	2.0770
E	4.9531	1.7673	5.9687	1.8699
F	5.0781	1.9548	5.6667	1.9344
G	6.1406	1.9133	6.0677	2.0313
H	5.4635	2.0231	6.3021	2.0952
I	5.7865	1.8677	5.6042	1.8728
L	5.7760	1.7832	5.6406	1.9633
M	5.4479	1.6236	5.8437	1.7978
N	5.9375	1.8663	5.8437	1.8914
O	6.0625	1.8747	5.8594	2.2033
Q1	5.6927	1.6609	6.0000	1.7988
Q2	5.5885	1.5992	5.2552	1.7642
Q3	5.9375	1.7505	5.7919	1.7954
Q4	5.9583	1.6902	4.7917	1.8864

It was noted that Personality Factors, 'C', 'E', 'H' and 'Q[4]', were not significantly, but interestingly different for these two groups.

Fig. 10 (a)

"16 P.F." Test Profile

"150 Statements" Questionnaire



Legend:

Disabled

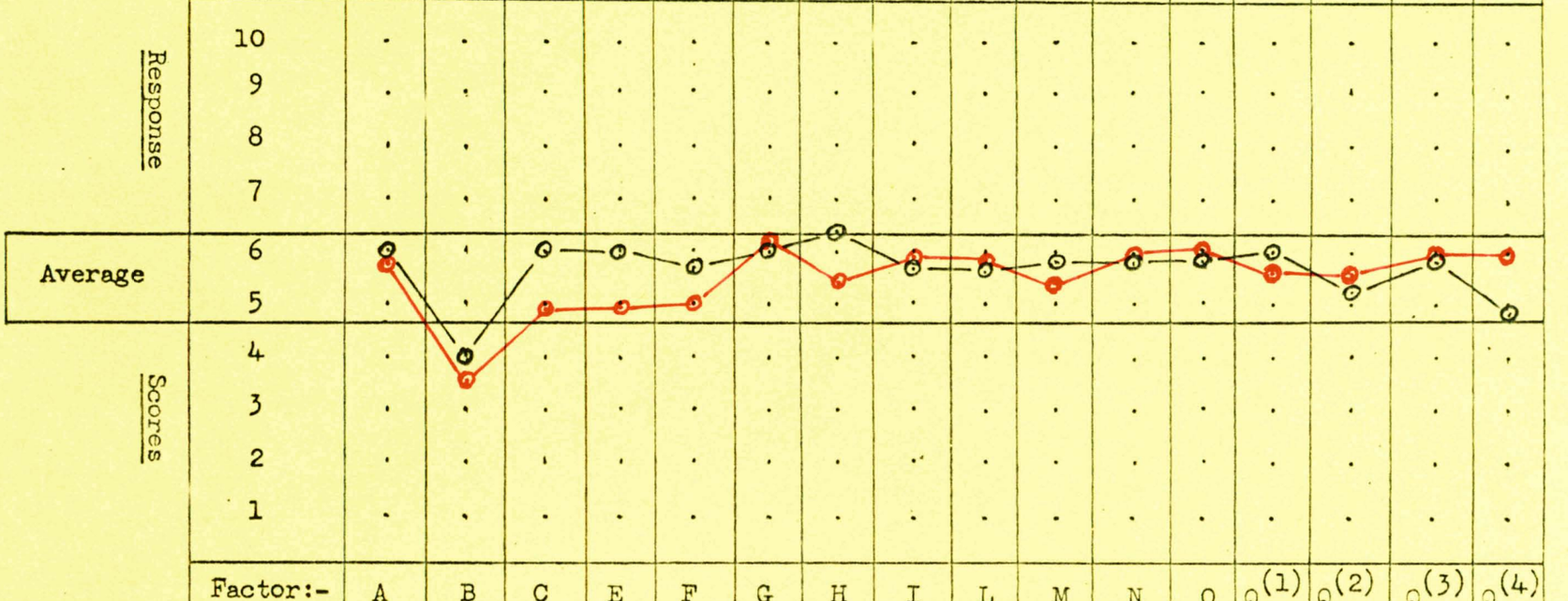
Able-Bodied(1)

(N = 50)

Fig. 10 (b)

"16 P.F." Test Profile

"50 Statements" Questionnaire



Legend:

Disabled

Able-Bodied(1)

(N = 192)

The mean raw scores of the primary factors from Cattell's "16 P.F." Test are presented on the opposite page (Figs. 10 (a) and (b)) for both the initial groups of 50 disabled and able-bodied[1] respondents and the overall groups of 192 disabled and able-bodied[1] respondents. Profiles of the disabled and able-bodied[1] respondents for the two groups were close.

The overall group responses appear to indicate that the disabled were slightly more affected by feelings, more humble, more serious, more restrained and more tense than the able-bodied - but not significantly so.

A general examination of the results suggests that:-

(1) personality characteristics of the disabled and able-bodied are not significantly or characteristically different, and

(2) that the relationships (see later) between factors associated with the attitude scales and the "16 P.F." tests were in respect of the:-

(a) Disabled related closely more with issues involving the family than with issues involving the self, supporting services and outer community, and

(b) Able-Bodied[1] related closely more with issues connecting the supporting services and outer community than with issues associated with the self and family categories.

13. Investigation into Reliability of Tests involving the "150 Statements" Attitude Scale Questionnaire and Cattell's "16 P.F." Test with the Disabled and Able-Bodied[1] Groups

The purpose of this part of the investigation was to:-

13.1 assess the reliability of both the longer and shorter attitudinal scales used in the survey,

/The longer attitude questionnaire was subjected to a re-test in an extended period of three (3) to four (4) weeks. Eighteen (18) respondents (every 3rd respondent within the group of 50 respondents being re-tested on 50 statements - every 3rd statement from the original "150 Statements" Questionnaire). Each statement was also reduced for this purpose from the eleven (11) point rating to a segen (7) point rating scale.

The shorter attitude questionnaire was subjected to a re-test in an extended period of four (4) to eight (8) weeks. Twenty-four (24) respondents (every 6th respondent within the group of 142 respondents) again completed the full "50 Statements" Questionnaire/.

13.2 gain a measure of the reliability of the personality factor scales (Cattell's "16 P.F." - Form 'C' - Test) used in the enquiry,

13.3 obtain comprehensive sets of comparable means and standard deviations for the four (4) sample groups,

13.4 check the sub-sample statistics against those for the main samples, (The hypothesis used in this case being that there would be a significant difference between the sub-sample and main samples) and

13.5 measure, with some stringency, the relationships between the personality factors and attitude ratios - four (4) separate estimates of correlations being available for each of the two (2) sub-samples.

13.6 The two (2) null hypotheses to be tested were:-

(a) "that there would be no consistent significant relationships between attitude and personality factors", and

(b) "that there would be no difference in the relationships concerning attitudes and personality factors between the disabled and able-bodied groups".

For these to be disproved, significant relationships at the 5% level would be expected in at least 50% of the possible cases.

14. Significant Relationships produced from Reliability Tests

The ensuing pages show:-

14.1 the inter-category relationships of the short and long attitudinal scales with the disabled and able-bodied[1] groups,

14.2 a comparison of the general means and standard deviations for the disabled and able-bodied[1] groups for the short and long attitude scales, and

14.3 the means and standard deviations for the disabled and able-bodied[1] groups for the 1st and 2nd "16 P.F." Tests.

15. Relationships between Attitude and Personality Factor Tests

15.1 significant correlations arising from the relationships of the 1st and 2nd attitude scales of each group category (i.e. self, family, supporting services, society and overall total) and the response scores produced from the 1st and 2nd interviews involving Cattell's "16 P.F." Tests, and

15.2 issues arising from the reliability tests.

15.3 general observations and conclusion.

14.1

Reliability of Attitude Scale - Inter-category Relationships of Short and Long Attitudinal Scales with Disabled and Able-Bodied[1] Groups - Response scores of 1st interview (F) presented with those of 2nd interview (S)

Short Questionnaire (N = 24) - Interviews extended over an interval of up to eight (8) weeks

	Self (S)		Family (S)		S.Serv.(S)		Soc'ty(S)		Total (S)	
	Corr.	Sig.	Corr.	Sig.	Corr.	Sig.	Corr.	Sig.	Corr.	Sig.
Dis. Self (F)	0.8984	0.000							0.3419	0.051
A.B. "	0.8248	0.000							0.5407	0.003
Dis. Fam. (F)			0.8542	0.000						
A.B. "			0.8872	0.000					0.4914	0.007
Dis.S.Ser. (F)					0.8628	0.000			0.5360	0.003
A.B. "					0.9424	0.000	0.4030	0.025		
Dis.Soc'ty (F)							0.8319	0.000	0.4934	0.007
A.B. "							0.9154	0.000		
Dis.Total (F)			0.5044	0.006	0.4434	0.015	0.6126	0.001	0.9095	0.000
A.B. "	0.4850	0.008	0.4514	0.013	0.5083	0.006			0.9023	0.000

The correlations ranging from 0.82 to 0.94, above, show the really quite remarkable high level of reliability in the final form of the attitude scale with the relatively independent categories.

The results shown below for the long questionnaire indicate that in its un-modified form the attitude scale was less consistently reliable.

Long Questionnaire (N = 18) - Interviews extended over an interval of up to 4 week

	Self (S)		Family (S)		S.Serv.(S)		Soc'ty(S)		Total (S)	
	Corr.	Sig.	Corr.	Sig.	Corr.	Sig.	Corr.	Sig.	Corr.	Sig.
Dis. Self(F)	0.9872	0.000	0.6056	0.004	0.6100	0.004				
A.B. "	0.9217	0.000			0.4958	0.018	0.5430	0.000		
Dis.Fam.(F)	0.6487	0.002	0.9828	0.000						
A.B. "			0.7681	0.000						
Dis.S.S. (F)	0.5647	0.007	0.4478	0.031	0.9322	0.000				
A.B. "	0.5138	0.015			0.8292	0.000				
Dis. Soc. (F)							0.9298	0.000		
A.B. "							0.6984	0.001		
Dis. Tot. (F)					0.6471	0.002	0.5261	0.012	0.9867	0.000
A.B. "			0.4112	0.045	0.5964	0.004			0.8903	0.000

14.2

(1)

Comparison of General Mean and Standard Deviations for the Disabled and Able-Bodied Groups following the 1st and 2nd Interviews

Short Questionnaire ("50 Statements" Questionnaire)

(a) Results for Full Group (N = 192)

	Disabled		Able-Bodied	
	Mean	St. Dev.	Mean	St. Dev.
Self	47.9531	7.3001	50.2552	6.9714
Family	57.7396	8.8441	54.0469	7.4019
Supporting Services	44.0156	7.6573	46.8854	7.4242
Society	47.8542	7.3343	45.5313	6.6546
Total Group	197.5625	20.0196	196.7708	15.6552

(b) Results for 1st Interview (N = 24)

	Disabled		Able-Bodied	
	Mean	St. Dev.	Mean	St. Dev.
Self	46.7917	5.7859	49.1250	6.6680
Family	58.0417	6.0540	55.0417	6.0998
Supporting Services	44.7917	7.3187	48.8750	8.5583
Society	47.9583	7.1474	44.0000	7.0834
Total Group	197.5833	12.4199	195.5417	20.6503

(c) Results for 2nd Interview (N = 24)

	Disabled		Able-Bodied	
	Mean	St. Dev.	Mean	St. Dev.
Self	47.0417	5.1540	48.4167	4.9862
Family	56.0417	4.7501	54.0000	5.9050
Supporting Services	44.8333	6.0193	47.5000	7.0649
Society	46.5000	5.8458	44.3333	6.6179
Total Group	194.4167	10.5085	194.2500	14.5580

The sample selected for full correlation analysis is shown in this comparison to have had means, although not always standard deviations, which are very close to those of the full groups. It is reasonable therefore to assume that the results from the sub-groups will be representative of those from the full sample.

This information was not available for those disabled and able-bodied respondents who used the long form of the attitude questionnaire but means in respect of their responses for the 1st and 2nd interviews are given as follows:-

Long Questionnaire ("150 Statements" Questionnaire)

(a) Results for 1st Interview (N - 18)

	Disabled		Able-Bodied	
	Mean	St.Dev.	Mean	St. Dev.
Self	45.3333	9.7014	52.4444	8.4382
Family	55.5000	8.4384	51.7778	8.2144
Supporting Services	42.5000	7.0898	44.7778	7.7956
Society	49.1667	7.5010	45.4444	6.0801
Total Group	196.5000	24.5794	194.5556	18.9123

(b) Results for 2nd Interview (N = 18)

	Disabled		Able-Bodied	
	Mean	St. Dev.	Mean	St. Dev.
Self	44.3889	8.1612	49.5566	6.2893
Family	57.8889	7.3556	50.2778	6.3783
Supporting Services	43.9444	6.2259	46.0556	5.7443
Society	48.3889	6.3072	47.1667	5.4250
Total Group	194.6111	20.6459	193.0556	17.1171

14.3 Means and Standard Deviations of Disabled and Able-Bodied[1] Groups following "16 P.F." Tests

(a) Short Questionnaire (N = 24)

Personality Factors	Disabled		Able-Bodied	
	Mean	St. Dev.	Mean	St. Dev.
A (First Interview)	5.542	1.351	6.375	1.439
B "	4.458	1.719	2.542	1.841
C "	5.042	1.944	5.750	1.327
E "	5.666	1.949	6.583	1.613
F "	4.833	1.880	6.125	1.849
G "	6.167	2.057	5.583	1.998
H "	5.292	1.944	6.208	1.587
I "	5.833	1.579	5.417	1.380
L "	5.625	1.377	5.083	1.717
M "	5.250	1.775	6.000	1.794
N "	5.875	1.676	5.708	1.681
O "	5.458	1.318	5.708	2.032
$Q^{(1)}$ "	5.583	1.472	6.167	1.341
$Q^{(2)}$ "	4.708	1.488	5.083	1.018
$Q^{(3)}$ "	5.958	1.876	5.750	1.511
$Q^{(4)}$ "	6.000	1.504	4.333	1.404

Personality Factors	Disabled		Able-Bodied	
	Mean	St. Dev.	Mean	St. Dev.
A (Second Interview)	5.292	1.334	7.167	1.465
B "	5.625	1.312	4.708	1.488
C "	5.167	1.239	5.875	1.296
E "	5.375	1.929	6.417	1.412
F "	5.167	1.606	6.333	1.927
G "	6.458	1.141	5.458	1.474
H "	5.292	1.681	6.292	1.334
I "	5.792	1.351	5.000	1.421
L "	5.208	1.503	5.250	1.032
M "	5.375	1.209	5.708	1.517
N "	5.625	1.408	5.500	1.642
O "	5.500	1.383	5.792	1.793
$Q^{(1)}$ "	5.792	1.503	6.333	1.274
$Q^{(2)}$ "	4.583	1.213	5.458	1.318
$Q^{(3)}$ "	5.833	1.551	5.667	1.129
$Q^{(4)}$ "	5.167	1.761	4.792	1.615

Mean and Standard Deviations of Disabled and Able-Bodied Groups following "16 P.F. - form C - Tests"

(b) Long Questionnaire (N = 18)

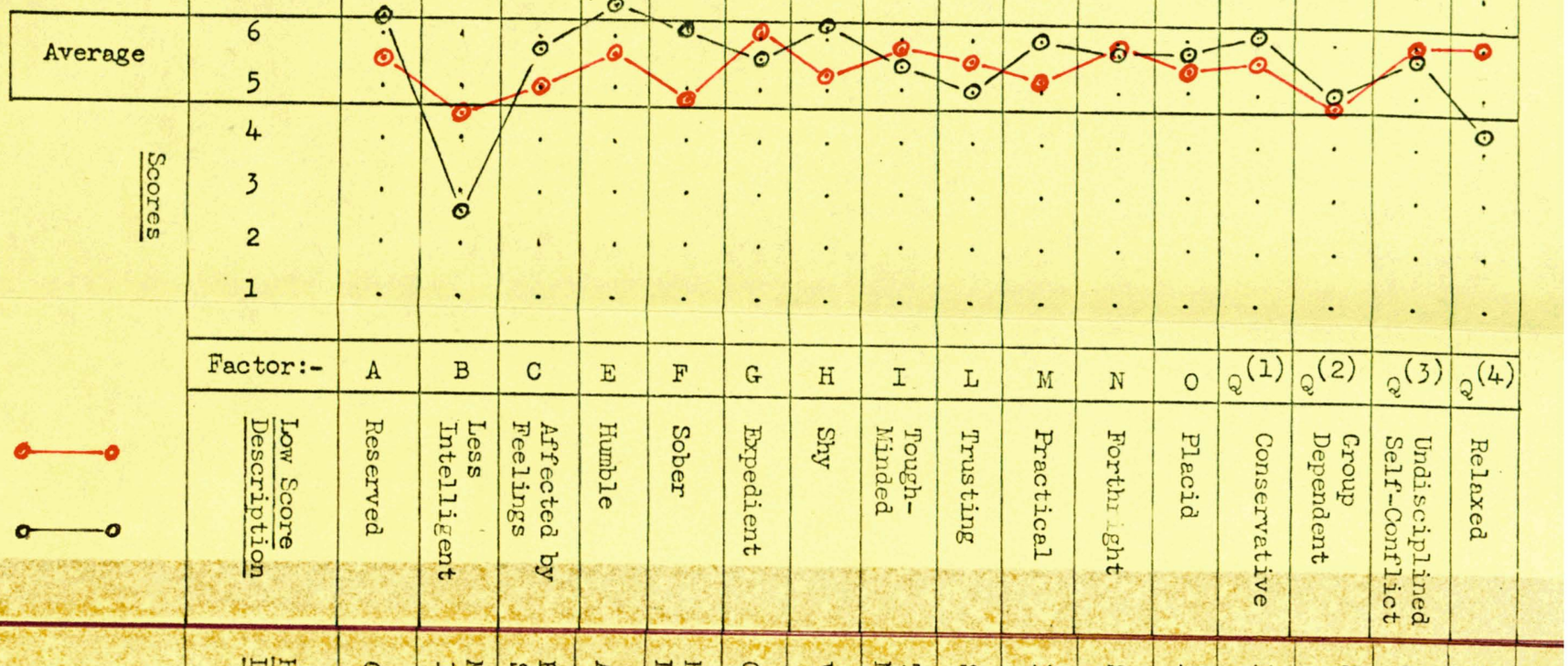
Personality Factors	Disabled		Able-Bodied	
	Mean	St. Dev.	Mean	St. Dev.
A (First Interview)	6.444	1.542	5.222	2.315
B "	2.833	1.886	3.000	2.196
C "	5.667	2.196	4.556	2.854
E "	4.833	1.723	5.222	2.211
F "	4.389	2.500	4.000	2.000
G "	5.722	2.444	4.833	2.618
H "	5.722	2.468	5.944	2.209
I "	5.889	1.605	5.222	2.102
L "	5.555	2.255	6.000	2.656
M "	6.000	2.142	6.389	2.659
N "	6.833	2.065	5.667	1.878
O "	6.055	1.862	5.000	2.849
$Q^{(1)}$ "	6.000	1.645	5.111	1.529
$Q^{(2)}$ "	6.611	2.033	5.668	2.000
$Q^{(3)}$ "	6.222	1.833	5.222	2.237
$Q^{(4)}$ "	7.000	1.909	5.778	2.129

Fig. 12 (a)

"16 P.F." Test Profile

Short Questionnaire
(50 Statements)

First Interview



Legend:

Disabled

Able-Bodied(1)

(N = 24)

Fig. 12 (b)

"16 P.F." Test Profile

Short Questionnaire
(50 Statements)

Second Interview

Legend:

Disabled

Able-Bodied(1)

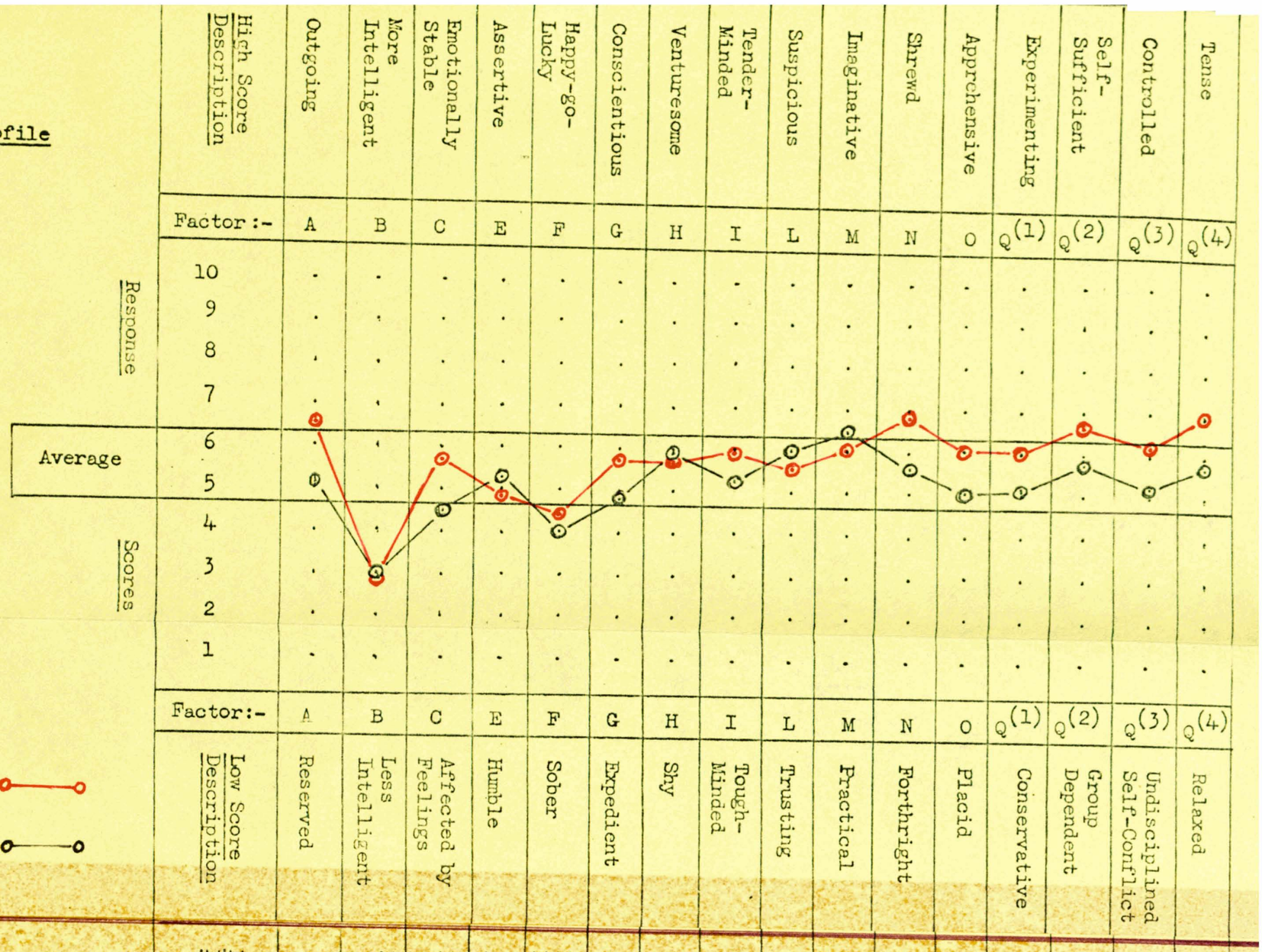
(N = 24)

Fig. 11 (a)

"16 P.F." Test Profile

Long Questionnaire
(150 Statements)

First Interview



Legend:

Disabled

Able-Bodied(1)

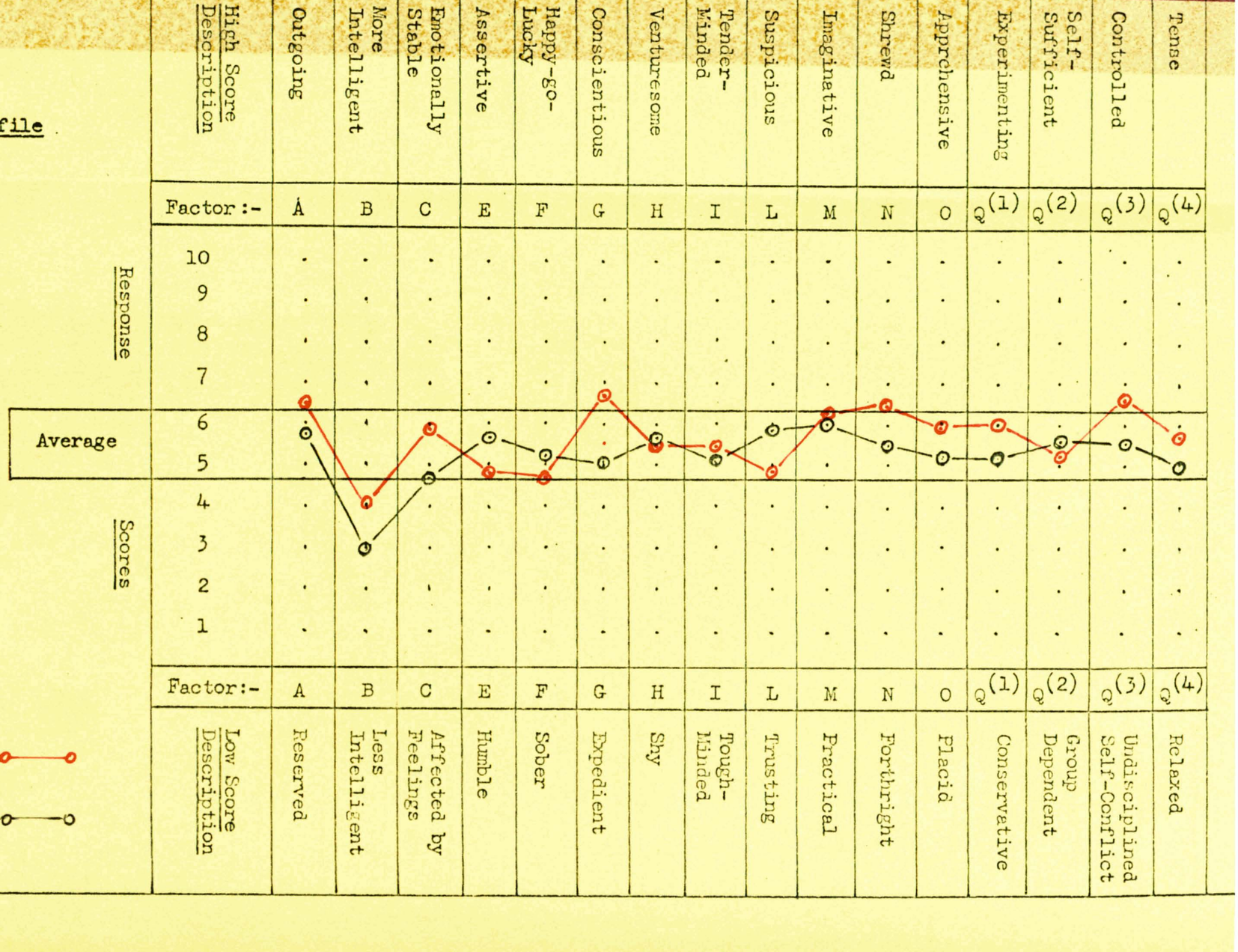
(N = 18)

Fig. 11 (b)

"16 P.F." Test Profile

Long Questionnaire
(150 Statements)

Second Interview



Legend:

Disabled

Able-Bodied(1)

(N = 18)

Personality Factors	Disabled Mean	Disabled St. Dev.	Able-Bodied Mean	Able-Bodied St. Dev.
A (Second Interview)	6.444	1.504	5.722	2.217
B "	4.111	1.605	2.944	2.099
C "	5.889	1.967	4.611	2.279
E "	4.722	1.809	5.611	2.146
F "	4.667	1.645	5.222	2.315
G "	6.667	2.000	5.167	2.149
H "	5.500	1.543	5.611	2.253
I "	5.556	1.617	5.111	2.111
L "	4.944	1.924	5.833	2.149
M "	6.222	1.987	6.000	1.910
N "	6.389	1.614	5.500	2.333
O "	5.889	1.745	5.222	2.102
$Q^{(1)}$ "	6.000	1.645	5.222	1.699
$Q^{(2)}$ "	5.389	1.420	5.611	1.420
$Q^{(3)}$ "	6.556	1.886	5.555	2.229
$Q^{(4)}$ "	5.722	2.052	4.944	2.338

Profiles of the disabled and able-bodied[(1)] respondents in each of these two groups are shown on the opposite page.

15. Relationships between Attitude and Personality Factor Tests

15.1 Significant Correlations arising from the Relationship of the 1st and 2nd Attitude Scales of each Group Category and the Response Scores of the 1st and 2nd Interviews involving Cattell's "16 P.F." Tests

15.1.1 Personality Factor 'A'

Short Questionnaire (N = 24)

	Corr.	Sig.
Supp. Serv. (F) A-Bodied with personality factor 'A'(F)	0.2758	0.056
" " (F) " " " " 'A'(S)	0.5845	0.001
" " (S) " " " " 'A'(S)	0.5631	0.002

Long Questionnaire (N = 18)

Society (S) Disabled with personality factor 'A' (F)	-0.3756	0.052

15.1.2 Personality Factor 'B'

	Corr.	Sig.
Short Questionnaire (N = 24)		
Family (F) Disabled with personality factor 'B' (F)	0.3699	0.038
" (F) " " " " 'B' (S)	0.3577	0.043
" (S) " " " " 'B' (S)	0.3513	0.046
Long Questionnaire (N = 18)		
Family (F) A-Bodied with personality factor 'B' (F)	-0.3976	0.051
Short Questionnaire (N = 24)		
Supp. Serv. (S) Disabled with personality factor 'B' (F)	-0.3889	0.040
Long Questionnaire (N = 18)		
Supp. Serv. (F) A-Bodied with personality factor 'B' (F)	0.6013	0.004
" (S) " " " " 'B' (S)	0.4942	0.019
Short Questionnaire (N = 24)		
Society (F) Disabled with personality factor 'B' (F)	-0.3346	0.053
" (F) A-Bodied " " " 'B' (S)	-0.4041	0.025
" (S) " " " " 'B' (S)	-0.3163	0.050

15.1.3 Personality Factor 'C'

Short Questionnaire (N = 24)		
Supp. Serv. (F) Disabled with personality factor 'C' (F)	-0.4240	0.019
Short Questionnaire (N = 24)		
Society (F) A-Bodied with personality factor 'C' (F)	-0.3562	0.044

15.1.4 Personality Factor 'E'

Short Questionnaire (N = 24)		
Supp. Serv. (S) A-Bodied with personality factor 'E' (S)	0.3819	0.033
Long Questionnaire (N = 18)		
Supp. Serv. (F) Disabled with personality factor 'E' (F)	0.4790	0.022
" " (S) " " " " 'E' (F)	0.4047	0.048
Long Questionnaire (N = 18)		
Society (S) Disabled with personality factor 'E' (S)	-0.4128	0.044

15.1.5 Personality Factor 'F'

	Corr.	Sig.
Long Questionnaire (N = 18)		
Self (F) Disabled with personality factor 'F' (S)	0.4202	0.041
" (S) " " " " 'F' (S)	0.4265	0.039
Short Questionnaire (N = 24)		
Family (F) Disabled with personality factor 'F' (S)	0.3659	0.039
" (S) " " " " 'F' (S)	0.3296	0.050
Short Questionnaire (N = 24)		
Supp. Serv. (F) A-Bodied with personality factor 'F' (F)	-0.3507	0.046
" " (F) " " " " 'F' (S)	-0.3640	0.040
" " (S) " " " " 'F' (F)	-0.3212	0.053
Long Questionnaire (N = 18)		
Supp. Serv. (F) Disabled with personality factor 'F' (S)	0.4388	0.034
" " (S) " " " " 'F' (S)	0.4518	0.030
Short Questionnaire (N = 24)		
Society (F) A-Bodied with personality factor 'F' (F)	-0.4714	0.010
" (F) " " " " 'F' (S)	-0.3951	0.026
" (S) " " " " 'F' (F)	-0.4300	0.018
" (S) " " " " 'F' (S)	-0.4354	0.017
Short Questionnaire (N = 24)		
Total Group (S) A-Bodied with personality factor 'F' (F)	-0.3743	0.036
" " (S) " " " " 'F' (S)	-0.3504	0.047
Long Questionnaire (N = 18)		
Total Group (F) Disabled with personality factor 'F' (S)	0.4219	0.041
" " (S) " " " " 'F' (S)	0.4134	0.044

15.1.6 Personality Factor 'G'

Short Questionnaire (N = 24)		
Supp. Serv. (F) Disabled with personality factor 'G' (S)	-0.5971	0.001
" " (S) " " " " 'G' (S)	-0.5010	0.006
Long Questionnaire (N = 18)		
Supp. Serv. (F) Disabled with personality factor 'G' (S)	0.3775	0.051
" " (S) " " " " 'G' (S)	0.4425	0.033
Long Questionnaire (N = 18)		
Society (F) A-Bodied with personality factor 'G' (S)	0.4262	0.039
Short Questionnaire (N = 24)		
Total Group (F) Disabled with personality factor 'G' (S)	-0.4767	0.009
" " (S) " " " " 'G' (S)	-0.3973	0.027
Long Questionnaire (N = 18)		
Total Group (F) Disabled with personality factor 'G' (S)	0.3781	0.051
" " (S) " " " " 'G' (S)	0.3970	0.051

15.1.7 Personality Factor 'H'

	Corr.	Sig.
Long Questionnaire (N = 18)		
Self (F) Disabled with personality factor 'H' (S)	0.4989	0.018
" (S) " " " " 'H' (S)	0.4273	0.038
" (F) A-Bodied " " " 'H' (F)	0.3864	0.057
" (F) " " " " 'H' (S)	0.4336	0.036
" (S) " " " " 'H' (F)	0.5655	0.007
" (S) " " " " 'H' (S)	0.5559	0.008
Long Questionnaire (N = 18)		
Family (S) A-Bodied with personality factor 'H' (F)	0.4771	0.023
" (S) " " " " 'H' (S)	0.5197	0.014
Long Questionnaire (N = 18)		
Supp. Serv. (F) Disabled with personality factor 'H' (F)	0.5092	0.015
" " (F) " " " " 'H' (S)	0.6531	0.002
" " (S) " " " " 'H' (F)	0.4046	0.048
" " (S) " " " " 'H' (S)	0.7193	0.000
" " (F) A-Bodied " " " 'H' (F)	0.5219	0.013
" " (F) " " " " 'H' (S)	0.4135	0.044
" " (S) " " " " 'H' (F)	0.4082	0.046
" " (S) " " " " 'H' (S)	0.4336	0.036
Short Questionnaire (N = 18)		
Society (S) Disabled with personality factor 'H' (F)	-0.3691	0.036
" (S) A-Bodied " " " 'H' (F)	-0.3795	0.034
Long Questionnaire (N = 18)		
Society (F) A-Bodied with personality factor 'H' (F)	0.4706	0.024
" (F) " " " " 'H' (S)	0.3990	0.050
" (S) " " " " 'H' (F)	0.4278	0.038
" (S) " " " " 'H' (S)	0.4868	0.020
Long Questionnaire (N = 18)		
Total Group (F) Disabled with personality factor 'H' (S)	0.4318	0.037
" " (S) " " " " 'H' (S)	0.4783	0.023
" " (F) A-Bodied " " " 'H' (F)	0.6288	0.003
" " (F) " " " " 'H' (S)	0.5645	0.007
" " (S) " " " " 'H' (F)	0.6582	0.001
" " (S) " " " " 'H' (S)	0.6977	0.001

15.1.8 Personality Factor 'I'

Long Questionnaire (N = 18)		
Self (F) Disabled with personality factor 'I' (S)	-0.4437	0.033
" (S) " " " " 'I' (S)	-0.4096	0.046

	Corr.	Sig.
Short Questionnaire (N = 24)		
Supp. Serv. (F) A-Bodied with personality factor 'I' (S)	-0.3692	0.038
" " (S) " " " " 'I' (S)	-0.3503	0.047
Long Questionnaire (N = 18)		
Supp. Serv. (F) Disabled with personality factor 'I' (S)	-0.5080	0.016
" " (S) " " " " 'I' (S)	-0.5402	0.010
" " (F) A-Bodied " " " 'I' (F)	0.4412	0.033
" " (S) " " " " 'I' (F)	0.6517	0.002
" " (S) " " " " 'I' (S)	0.4990	0.018
Short Questionnaire (N = 24)		
Society (F) Disabled with personality factor 'I' (F)	0.4076	0.024
" (S) " " " " 'I' (F)	0.3957	0.028
" (F) A-Bodied " " " 'I' (F)	-0.3913	0.029
" (S) " " " " 'I' (F)	-0.3442	0.050
Short Questionnaire (N = 24)		
Total Group (F) Disabled with personality factor 'I' (F)	0.3666	0.039
" " (F) " " " " 'I' (S)	0.3575	0.043
Long Questionnaire (N = 18)		
Total Group (F) Disabled with personality factor 'I' (S)	-0.4514	0.019
" " (S) " " " " 'I' (S)	-0.5006	0.017
" " (F) " " " " 'I' (F)	0.4125	0.044
" " (S) " " " " 'I' (F)	0.3724	0.064

15.1.9 Personality Factor 'L'

Short Questionnaire (N = 24)		
Family (F) Disabled with personality factor 'L' (F)	-0.4256	0.019
" (S) " " " " 'L' (F)	-0.4428	0.015
" (F) A-Bodied " " " 'L' (F)	0.3561	0.044
" (F) " " " " 'L' (S)	0.4148	0.022
" (S) " " " " 'L' (S)	0.3353	0.055
Long Questionnaire (N = 18)		
Family (S) A-Bodied with personality factor 'L' (S)	0.3898	0.055
Long Questionnaire (N = 18)		
Supp. Serv. (F) A-Bodied with personality factor 'L' (F)	-0.4090	0.046
" " (F) " " " " 'L' (S)	-0.4483	0.031
" " (S) " " " " 'L' (F)	-0.4587	0.028
" " (S) " " " " 'L' (S)	-0.6140	0.003
Short Questionnaire (N = 24)		
Total Group (F) A-Bodied with personality factor 'L' (F)	0.3885	0.030
" " (S) " " " " 'L' (F)	0.4078	0.024

15.1.10 Personality Factor 'M'

	Corr.	Sig.
Short Questionnaire (N = 24)		
Family (F) A-Bodied with personality factor 'M' (F)	-0.3501	0.047
Long Questionnaire (N = 18)		
Family (S) A-Bodied with personality factor 'M' (F)	0.4405	0.034
Short Questionnaire (N = 24)		
Supp. Serv. (F) A-Bodied with personality factor 'M' (S)	-0.3879	0.031
" " (S) " " " " 'M' (S)	-0.3143	0.057
Long Questionnaire (N = 18)		
Supp. Serv. (F) Disabled with personality factor 'M' (S)	0.3758	0.052
Short Questionnaire (N = 24)		
Society (F) A-Bodied with personality factor 'M' (S)	-0.3317	0.057
" (S) " " " " 'M' (S)	-0.4488	0.014
Short Questionnaire (N = 24)		
Total Group (F) A-Bodied with personality factor 'M' (F)	-0.3486	0.048
" " (F) " " " " 'M' (S)	-0.4512	0.013
" " (S) " " " " 'M' (F)	-0.3996	0.027
" " (S) " " " " 'M' (S)	-0.4492	0.014

15.1.11 Personality Factor 'N'

Long Questionnaire (N = 18)		
Self (F) A-Bodied with personality factor 'N' (F)	0.3364	0.056
" (S) " " " " 'N' (F)	0.4597	0.027
Long Questionnaire (N = 18)		
Family (S) A-Bodied with personality factor 'N' (S)	0.4250	0.039
Long Questionnaire (N = 18)		
Supp. Serv. (S) Disabled with personality factor 'N' (S)	-0.5071	0.016
" " (F) A-Bodied with " " 'N' (F)	0.5208	0.013
" " (S) " " " " 'N' (F)	0.5087	0.016
Short Questionnaire (N = 24)		
Society (F) Disabled with personality factor 'N' (F)	-0.3634	0.040
" (S) " " " " 'N' (F)	-0.4282	0.018

Long Questionnaire (N = 18)	Corr.	Sig.
Society (F) A-Bodied with personality factor 'N' (E)	0.5802	0.006
" (S) " " " " 'N' (F)	0.5020	0.017
Long Questionnaire (N = 18)		
Total Group (F) A-Bodied with personality factor 'N' (F)	0.6529	0.002
" " (S) " " " " 'N' (F)	0.6299	0.003

15.1.12 Personality Factor 'O'

Short Questionnaire (N = 24)		
Family (F) Disabled with personality factor 'O' (S)	-0.3765	0.035
" (S) " " " " 'O' (S)	-0.5658	0.002
Long Questionnaire (N = 18)		
Supp. Serv. (S) Disabled with personality factor 'O' (S)	-0.4391	0.034
Short Questionnaire (N = 24)		
Society (F) Disabled with personality factor 'C' (S)	-0.3452	0.049
Long Questionnaire (N = 18)		
Society (F) Disabled with personality factor 'O' (F)	-0.3829	0.053
" (S) " " " " 'O' (F)	-0.3726	0.054
" (F) A-Bodied " " " 'O' (F)	0.4346	0.036
" (S) " " " " 'O' (S)	0.6224	0.003
Long Questionnaire (N = 18)		
Total Group (S) Disabled with personality factor 'O' (F)	-0.3712	0.055

15.1.13 Personality Factor '$Q^{(1)}$'

Short Questionnaire (N = 24)		
Self (F) A-Bodied with personality factor '$Q^{(1)}$' (S)	-0.3890	0.030
Long Questionnaire (N = 18)		
Self (F) Disabled with personality factor '$Q^{(1)}$' (F)	-0.3907	0.054
" (S) " " " " '$Q^{(1)}$' (F)	-0.3505	0.057
Short Questionnaire (N = 24)		
Family (F) Disabled with personality factor '$Q^{(1)}$' (S)	-0.3287	0.053
" (S) " " " " '$Q^{(1)}$' (S)	-0.4068	0.024
Short Questionnaire (N = 24)		
Society (F) Disabled with personality factor '$Q^{(1)}$' (S)	-0.2842	0.059
" (S) " " " " '$Q^{(1)}$' (S)	-0.5023	0.024

	Corr.	Sig.
Short Questionnaire (N = 24)		
Total Group (F) Disabled with personality factor 'Q(1)' (S)	-0.3635	0.040
" " (S) " " " " 'Q(1)' (S)	-0.3824	0.033

15.1.14 Personality Factor 'Q(2)'

Short Questionnaire (N = 24)		
Self (F) Disabled with personality factor 'Q(2)' (S)	-0.4528	0.013
" (S) " " " " 'Q(2)' (S)	-0.4909	0.007
Long Questionnaire (N = 18)		
Self (F) Disabled with personality factor 'Q(2)' (S)	-0.4156	0.043
" (S) " " " " 'Q(2)' (S)	-0.4097	0.045
Long Questionnaire (N = 18)		
Society (F) Disabled with personality factor 'Q(2)' (F)	0.4673	0.025
" (S) " " " " 'Q(2)' (F)	0.3611	0.050

15.1.15 Personality Factor 'Q(3)'

Long Questionnaire (N = 18)		
Family (F) Disabled with personality factor 'Q(3)' (F)	0.4792	0.023
" (S) " " " " 'Q(3)' (F)	0.4644	0.026
Short Questionnaire (N = 24)		
Society (F) Disabled with personality factor 'Q(3)' (S)	0.5171	0.014
" (S) " " " " 'Q(3)' (S)	0.4605	0.027
Long Questionnaire (N = 18)		
Total Group (S) A-Bodied with personality factor 'Q(3)' (F)	0.3437	0.051

15.1.16 Personality Factor 'Q(4)'

Short Questionnaire (N = 24)		
Self (F) A-Bodied with personality factor 'Q(4)' (F)	0.3994	0.027
Long Questionnaire (N = 18)		
Self (F) A-Bodied with personality factor 'Q(4)' (F)	0.3734	0.036
Long Questionnaire (N = 18)		
Family (F) Disabled with personality factor 'Q(4)' (S)	0.4466	0.032
" (S) " " " " 'Q(4)' (S)	0.4225	0.040
Long Questionnaire (N = 18)		
Supp. Serv. (F) A-Bodied with personality factor 'Q(4)' (F)	-0.4673	0.025
" " (S) " " " " 'Q(4)' (F)	-0.5036	0.017

Long Questionnaire (N = 18)	Corr.	Sig.
Society (F) Disabled with personality factor '$Q^{(4)}$' (F)	-0.4065	0.047
Long Questionnaire (N = 18)		
Total Group (F) Disabled with personality factor '$Q^{(4)}$' (S)	0.4472	0.031
" " (S) " " " " '$Q^{(4)}$' (S)	0.4554	0.029

15.2 Issues arising from the Tests

15.2.1 Personality Factor 'A'

In the short questionnaire, significant positive correlations for the able-bodied were produced by the 1st attitude scale and the 1st and 2nd personality factor (P.F.) tests in connection with the supporting services. A significant positive correlation for the able-bodied in the short questionnaire was also produced by the 2nd attitude scale and the 2nd P.F. test with the supporting services.

15.2.2 Personality Factor 'B'

Significant positive correlations in respect of the family were shown for the disabled in the short questionnaire by the 1st attitude scale and the 1st and 2nd P.F. tests and by the 2nd attitude scale and the 2nd P.F. test.

The 1st and 2nd attitude scales and the 1st P.F. tests for the able-bodied in the long questionnaire showed significant positive correlations with the supporting services whilst the 1st and 2nd attitude scales and the 2nd P.F. test for the able-bodied in the short questionnaire produced significant negative correlations with society.

15.2.3 Personality Factor 'E'

Significant positive correlations in respect of the supporting services were obtained for the disabled by the 1st and 2nd attitude scales and the 1st P.F. tests in the long questionnaire.

15.2.4 Personality Factor 'F'

In the long questionnaire, significant positive correlations for the disabled were produced by the 1st and 2nd attitude scales and the 2nd P.F. tests in connection with the self and the family, respectively.

Significant negative correlations for the able-bodied were obtained by the 1st attitude scale and the 1st and 2nd P.F. tests in the short questionnaire in relation to the supporting services and, in the same sector, by the 2nd attitude scale and the 1st P.F. test. In the long questionnaire, significant positive correlations for the disabled were produced by the 1st and 2nd attitude scales and the 2nd P.F. tests.

In the short questionnaire, significant negative correlations for the able-bodied were obtained from both the 1st and 2nd attitude scales and the 1st and 2nd P.F. tests in relation to society.

Significant negative correlations for the able-bodied were produced in the short questionnaire by the 2nd attitude scale and the 1st and 2nd P.F. tests in respect of the overall group whilst in the long questionnaire significant positive correlations were obtained for the disabled by the 1st and 2nd attitude scales and the 2nd P.F. test in connection with the overall group.

15.2.5 Personality Factor 'G'

Significant negative correlations for the disabled in relation with the supporting services were obtained by the 1st and 2nd attitude scales and the 2nd P.F. tests in the short questionnaire and, in the long questionnaire for the same sector, significant positive correlations were produced for the disabled by the 1st and 2nd attitude scales and the 1st and 2nd P.F. tests.

In connection with the overall total, significant negative correlations for the disabled were produced in the short questionnaire by the 1st and 2nd attitude scales and the 2nd P.F. tests whilst in the long questionnaire significant positive correlations were obtained for the disabled by the 1st and 2nd attitude scales and the 2nd P.F. tests in respect of the overall total.

15.2.6 Personality Factor 'H'

Significant positive correlations for the disabled were produced in the long questionnaire by the 1st and 2nd attitude scales and the 2nd P.F. tests in connection with the self and, for the able-bodied in the same sector, by the 1st and 2nd attitude scales and the 1st and 2nd P.F. tests, respectively.

In relation to the supporting services in the long questionnaire, significant positive correlations were produced by the 1st and 2nd attitude scales and the 1st and 2nd P.F. tests for both the disabled and the able-bodied, respectively.

Significant positive correlations for the able-bodied with society were produced by the 1st and 2nd attitude scales and the 1st and 2nd P.F. tests, respectively.

Significant positive correlations for the disabled with the overall group were shown in the long questionnaire by the 1st and 2nd attitude scales and the 2nd P.F. tests and, in connection with the able-bodied in the same sector, by the 1st and 2nd attitude scales and the 1st and 2nd P.F. tests, respectively.

15.2.7 Personality Factor 'I'

In the long questionnaire involving the self, significant negative correlations for the disabled were produced by the 1st and 2nd attitude scales and the 2nd P.F. tests. Similar results were obtained in the short questionnaire for the able-bodied with the supporting services.

In the long questionnaire for the disabled with the supporting services, significant negative correlations were produced by the 1st and 2nd attitude scales and the 2nd P.F. tests. Significant positive correlations for the able-bodied with the supporting services were shown by the 1st attitude scale and the 1st P.F. test in the long questionnaire and also by the 2nd attitude scale and the 1st and 2nd P.F. tests.

Significant positive correlations for the disabled with society were revealed by the 1st and 2nd attitude scales and the 1st P.F. tests in the short questionnaire whilst, in the same sector, significant negative correlations for the able-bodied were produced by the 1st and 2nd attitude scales and the 1st P.F. tests.

Significant negative correlations for the disabled were revealed in the long questionnaire for the overall group by the 1st and 2nd attitude scale and the 2nd P.F. tests, respectively, whilst significant positive correlations were shown by the 1st and 2nd attitude scales and the 1st P.F. tests in respect of the able-bodied with the same sector.

15.2.8 Personality Factor 'L'

Significant negative correlations for the disabled were shown by the 1st and 2nd attitude scale and the 1st P.F. tests in the short

questionnaire relating to the family. In the same sector, the 1st attitude scale and the 1st and 2nd P.F. tests revealed significant positive correlations in respect of the able-bodied and also by the 2nd attitude scale and 2nd P.F. test.

Significant negative correlations in the long questionnaire for the able-bodied with the supporting services were produced by the 1st and 2nd attitude scales and the 1st and 2nd P.F. tests, respectively.

In the short questionnaire for the able-bodied with the overall group, significant positive correlations were obtained by the 1st and 2nd attitude scales and the 1st P.F. tests, respectively.

15.2.9 Personality Factor 'M'

Significant negative correlations were shown for the able-bodied in the short questionnaire by the 1st and 2nd attitude scales and the 2nd P.F. tests in respect of the supporting services whilst in the short questionnaire for the able-bodied with society significant negative correlations were produced by the 1st and 2nd attitude scales and the 2nd P.F. tests.

In the short questionnaire for the able-bodied in society, significant negative correlations were shown by the 1st and 2nd attitude scales and the 1st and 2nd P.F. tests, respectively.

15.2.10 Personality Factor 'N'

In the long questionnaire for the able-bodied with the self, significant positive correlations were produced by the 1st and 2nd attitude scales and the 1st P.F. tests.

Significant positive correlations in the long questionnaire for the able-bodied with the supporting services were shown by the 1st and 2nd attitude scales and the 1st P.F. tests whilst significant negative correlations in the short questionnaire for the disabled with society were obtained by the 1st and 2nd attitude scales and the 1st P.F. tests.

Significant positive correlations in the long questionnaire for the able-bodied with society were revealed by the 1st and 2nd attitude scales and the 1st P.F. tests and, in the long questionnaire for the able-bodied with the overall group, significant positive correlations were shown by the 1st and 2nd attitude scales and the 1st P.F. tests.

15.2.11 Personality Factor 'O'

Significant negative correlations in the short questionnaire for the disabled were produced by the 1st and 2nd attitude scales and the 2nd P.F. tests. In the long questionnaire for the disabled with society, significant negative correlations were obtained by the 1st and 2nd attitude scales and the 1st P.F. tests whilst, in the same sector, a significant positive correlation was produced for the able-bodied by the 1st attitude scale and the 1st P.F. test.

15.2.12 Personality Factor '$Q^{(1)}$'

In the long questionnaire involving the disabled with the self, significant negative correlations were shown by the 1st and 2nd attitude scales and the 1st P.F. tests.

In the short questionnaire concerning the family, significant negative correlations for the disabled were shown by the 1st and 2nd attitude scales and 2nd P.F. tests.

Significant negative correlations in respect of the disabled in the short questionnaires relating with society and the overall group,

respectively, were also produced by the 1st and 2nd attitude scales and 2nd P.F. tests.

15.2.13 Personality Factor 'Q(2)'

In the short and long questionnaires involving the disabled with the self, significant negative correlations were produced by the 1st and 2nd attitude scales and the 2nd P.F. tests, respectively. Significant positive correlations in the long questionnaire for the disabled with society were shown by the 1st and 2nd attitude scales and the 1st P.F. tests.

15.2.14 Personality Factor 'Q(3)'

In the long questionnaire for the disabled with the family, significant positive correlations were produced by the 1st and 2nd attitude scales and the 1st P.F. tests, whilst in the short questionnaire for the disabled with society, significant positive correlations were shown by the 1st and 2nd attitude scales and the 2nd P.F. tests.

15.2.15 Personality Factor 'Q(4)'

Significant positive correlations in the long questionnaire for the disabled with the family were produced by the 1st and 2nd attitude scales and the 2nd P.F. tests. Significant negative correlations in the long questionnaire for the able-bodied with the supporting services were shown by the 1st and 2nd attitude scales and the 1st P.F. tests. In the long questionnaire for the disabled with the overall group, significant positive correlations were obtained by the 1st and 2nd attitude scales and the 2nd P.F. tests.

15.3 General Observations and Conclusion

Four (4) significant correlations in respect of specific categories were produced on 6 occasions for the able-bodied by the inter-relationship of the 1st and 2nd attitude scales with the 1st and 2nd P.F. tests (Self - 1; Supporting Services - 2; Society - 2; and Overall Group - 1). A similar result was obtained on one occasion for the disabled and that was in connection with the Self.

Three (3) significant correlations in respect of specific categories were shown on 3 occasions for the able-bodied by the inter-relationship of the 1st and 2nd attitude scales with the 1st and 2nd P.F. Tests (Family - 1; Supporting Services - 3). A similar result occurred on one occasion for the disabled and that concerned the Family.

Two (2) significant correlations in connection with a specific category were produced on 30 occasions for the disabled by the inter-relationship of the 1st and 2nd attitude scales with the 1st and 2nd P.F. Tests (Self - 6; Family - 6; Supporting Services - 5; Society - 6; and Overall Group - 7). Similar results were shown on 12 occasions for the able-bodied (Self - 1; Supporting Services - 5; Society - 3; and Overall Group - 3).

In conclusion, an examination of the overall results indicated that the relationships between the attitude and 16 "P.F." Tests were not strong. There were no firm and repeated significant relationships which might have disproved the original null hypothesis, "that there would be no consistent significant relationships between attitude and personality factors" or the other hypothesis, "that there would be no difference in the relationships concerning attitude and personality factors between the disabled and able-bodied groups."

The only really interesting relationships emerging from the results concerned individual category relationships between the attitude scale and personality factor 'H' (spontaneity), particularly in connection with the supporting services where significant positive correlations were produced by the 1st and 2nd attitude scales and the 1st and 2nd P.F. tests for both the disabled and able-bodied, respectively.

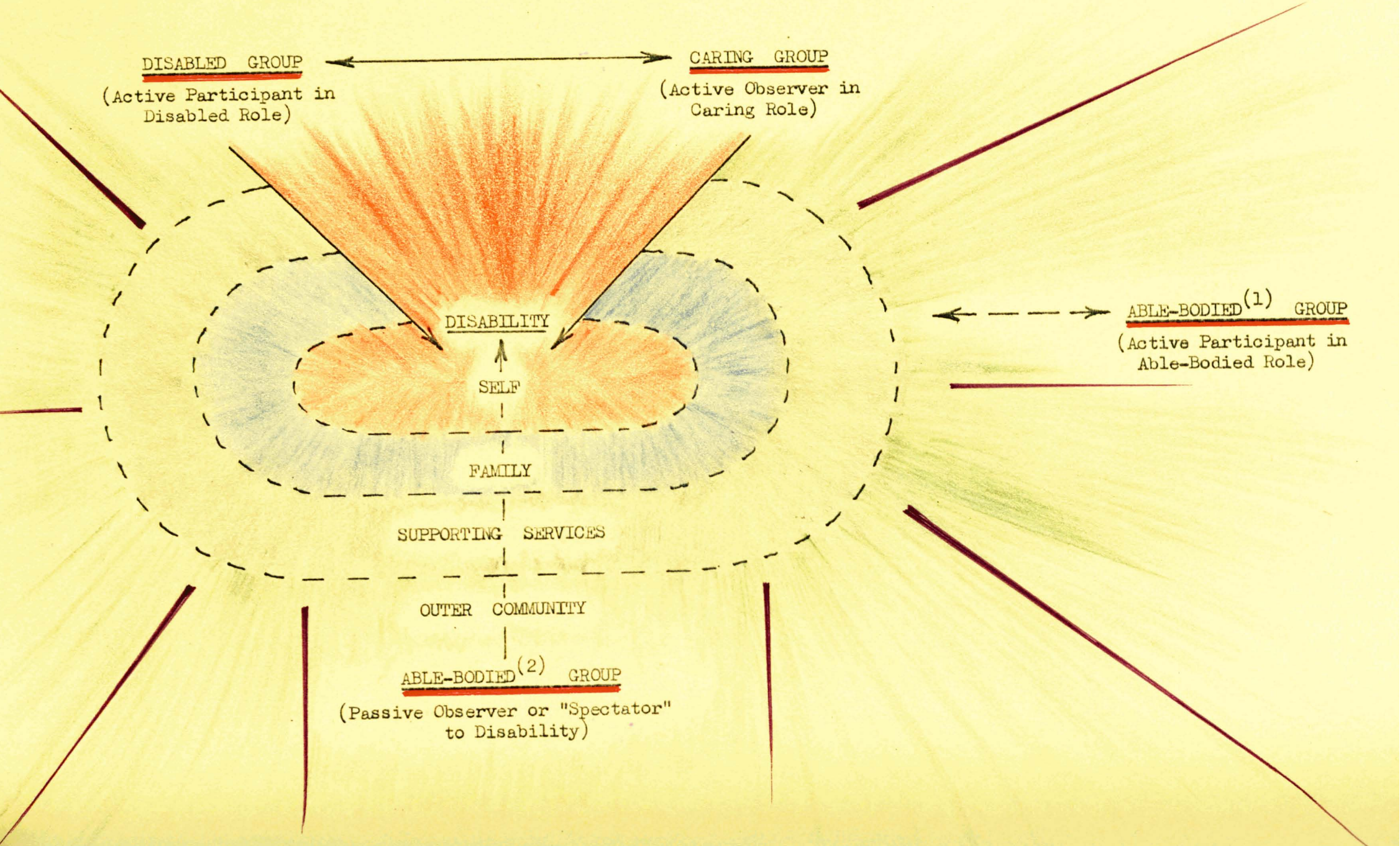
CHAPTER V

(Parts 'A' & 'B')

Outlook of Physically Handicapped and Non-Handicapped (Able-Bodied) People as Indicated by the Results of the Study

Fig. 13

Observing Disability from Four (4) Different Roles



CHAPTER V

This chapter deals with responses to statements from the four (4) main groups (i.e. Disabled, Able-Bodied[1], Caring and Able-Bodied[2]) and are shown in four (4) sub-chapters relating to:-

Sub-chapter "A" - Self, ... 12 statements
" " "B" - Family, ... 14 "
" " "C" - Supporting Services, and ... ... 12 "
" " "D" - General Society (Outer Community)... 12 "

The statements relevant to each different group of respondents (i.e. disabled (active participants), able-bodied[1] (active participants), those who cared for the disabled (active observers) and the able-bodied[2] (passive observers)) are shown for each main group and numbered in accordance with their particular sub-chapter. An index of lack of comprehension is subsequently revealed by noting the responses of the disabled and caring groups and those of the able-bodied[2] group (passive observers or "spectators" to the disability role) and, additionally, the responses of the able-bodied[1] group (active participants in the able-bodied role). An illustration of this perception is shown on the opposite page (Fig. 13).

The responses of the different main groups to each statement and the cumulative total for the groups are shown initially in graphical form. Comments following this graphical illustration are then made within three (3) different sub-sections in respect of the specific statement.

In the first sub-section, the comments relate to the responses from each of the four (4) main groups. The leading comments refer generally to the responses of the disabled and caring respondents and

these are followed by those of the A.B.(2) group respondents - as each group was exhibiting some form of attitude associated with the disability role. Ensuing comments concern responses of the A.B.(1) group respondents - those who were expressing an attitude involving the role of the able-bodied person.

The second sub-section deals with the responses of the different groups in answer to supplementary questions to the main group statement. Again, the leading paragraph tends to confine itself to comments from the disabled and caring respondents and those of the A.B.(2) group. This is followed by related comments from respondents within the A.B.(1) group.

The third sub-section is concerned with comments made about the comparative agreements between the responses of the different disability sub-groups and the responses of their "matched" respondents in each of the caring and A.B.(2) groups. No comments are made in this sub-section about responses from the A.B.(1) group as these respondents were concerned primarily with the able-bodied role.

A short general summary is submitted about information obtained from responses to the main statement and from the supplementary questions connected with each statement. This is followed by the presentation of statistical information relating to the means and standard deviation values of the respective groups, a graphical illustration of the group differences in scale values at 50% levels and between quartile levels, and a graphical illustration of comparative agreements between the different disability sub-groups as classified in accordance with the different disability categories.

Tables showing responses to the supplementary questions appear at appendix V.

Tables showing responses concerning comparative agreements between different categories of disability groups and histograms showing comparative agreement between different primary groups are provided at appendix VI.

Sub-chapter "A" - Self

Statement Nos:-

01
04
08
11
16
21
27
33
40
47
49
50

Statement No. 01

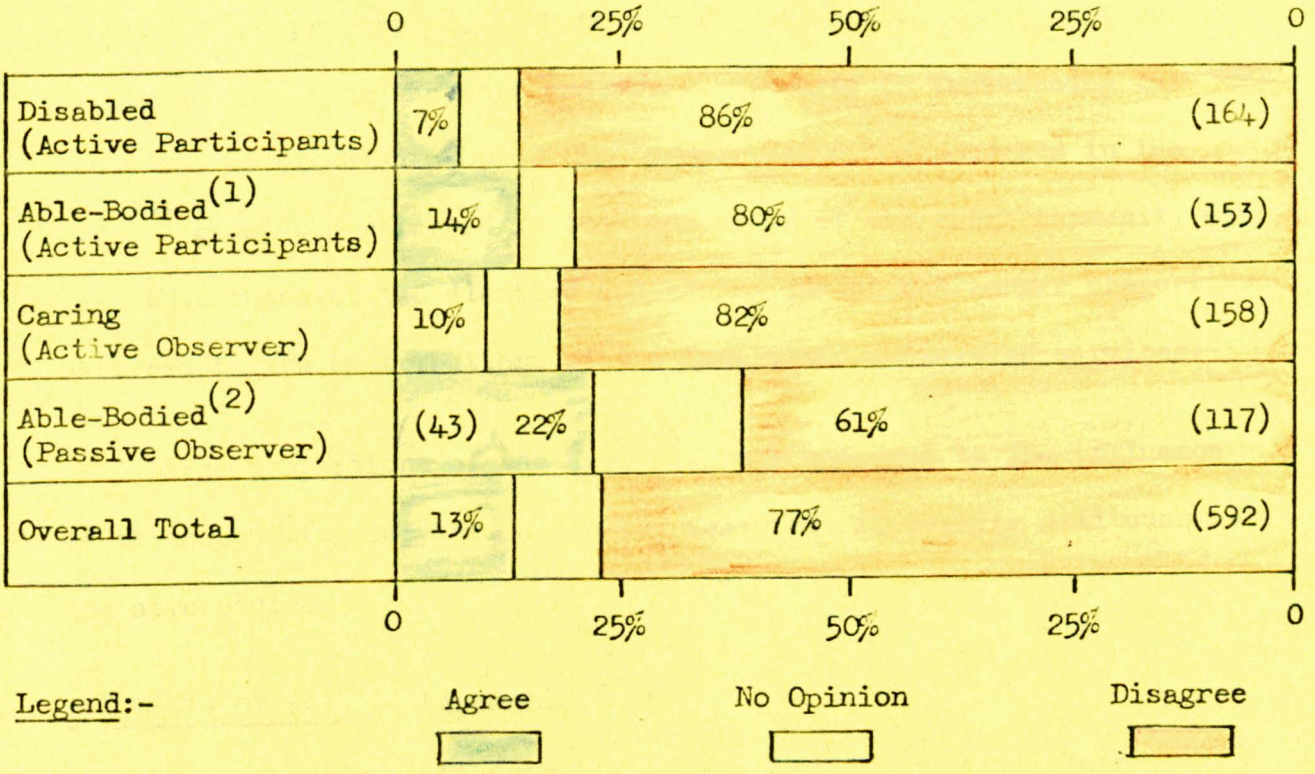
Disabled — Since I became disabled, I feel that I am living a life which has little purpose for me.

Able-Bodied(1) — I feel that I am living a life which has little purpose for me.

Caring — The disabled person is living a life which has little purpose for him.

Able-Bodied(2) — Persons who are disabled live a life which has little purpose for them.

Table No. 01 (1) — Group Responses to Statement (where each Group Total N = 192 = 100% and Overall Total N = 768 = 100%)



Statistical information and graphical representations illustrating the different responses of these main groups are shown after the summary and in Appendix Nos. V and VI.

Statement No. 01

1. Group Responses to Main Statement

See Table 01 (1)

Compared with the responses of the disabled (active participants), the results show that a higher proportion of the A.B.(2) group (passive observers) perceived the disabled as having little purpose in life. The disabled also appeared to have more purpose in their lives than some respondents in the A.B.(1) group (active participants). The responses of those who cared (active observers) for the disabled were seen to be relatively close to the responses of the disabled group.

2. Answers to Supplementary Questions

See Tables 01 (2) and (3) - (Appendix V)

The pattern of responses of the disabled and caring groups were close. Large proportions of both groups referred to the importance of attitudes involving the self and outer community in influencing the behaviour of disabled people. The proportion of respondents in the A.B.(2) group who referred to the importance of the outer community was less than those of the disabled and caring groups but larger proportions referred to the contributions of the family and supporting services.

Large proportions of the A.B.(1) group referred to the influence of the supporting services and outer community in forming attitudes of the able-bodied.

See Table 01 (4) - (Appendix V)

When asked to state specific issues which determined their responses to the main statement, large proportions of the disabled and caring groups referred to the influence of self-dependence and the

need to do "one's best". Large proportions of the A.B.(2) group believed that encouragement and assistance given to the disabled by people within the outer community were important contributory issues toward the development of positive attitudes.

The influence of self-dependence and "inner-self" perception were influential issues which determined the responses of the A.B.(1) group in respect of the able-bodied.

3. Comparative Agreements between Different Secondary Groups

See Table 01 (5) - (Appendix VI)

The responses of the disabled seem to suggest that those handicapped by multiple sclerosis or paraplegia tended to be less positive about their outlook than those who were handicapped by other categories of disability such as blindness or deafness. Agreement with the opinions of the disabled was evident in the responses of those who cared for them.

A relatively large proportion of the A.B.(2) group believed that people handicapped by arthritis, blindness or multiple sclerosis had little purpose in life.

The overall results seemed to suggest that the effects of a progressive disability or of greatly restricted mobility influenced considerably the outlook of the handicapped. Presentation of the physical image seemed to have some strong influence on the judgements made by the able-bodied about handicapped people.

4. Summary

The overall results seem to indicate an area of mutal incomprehension between the respective groups. Exposure to disability appears to provide

a challenge which if accepted tends to develop an attitude more positive and single-minded than that of many able-bodied people.

It seemed from statements frequently given during tne interviews that the development of a positive attitude for many disabled originated within the self and family domains and reached towards the outer community for fulfilment.

Statement No. 01 Main Group Statistical Information

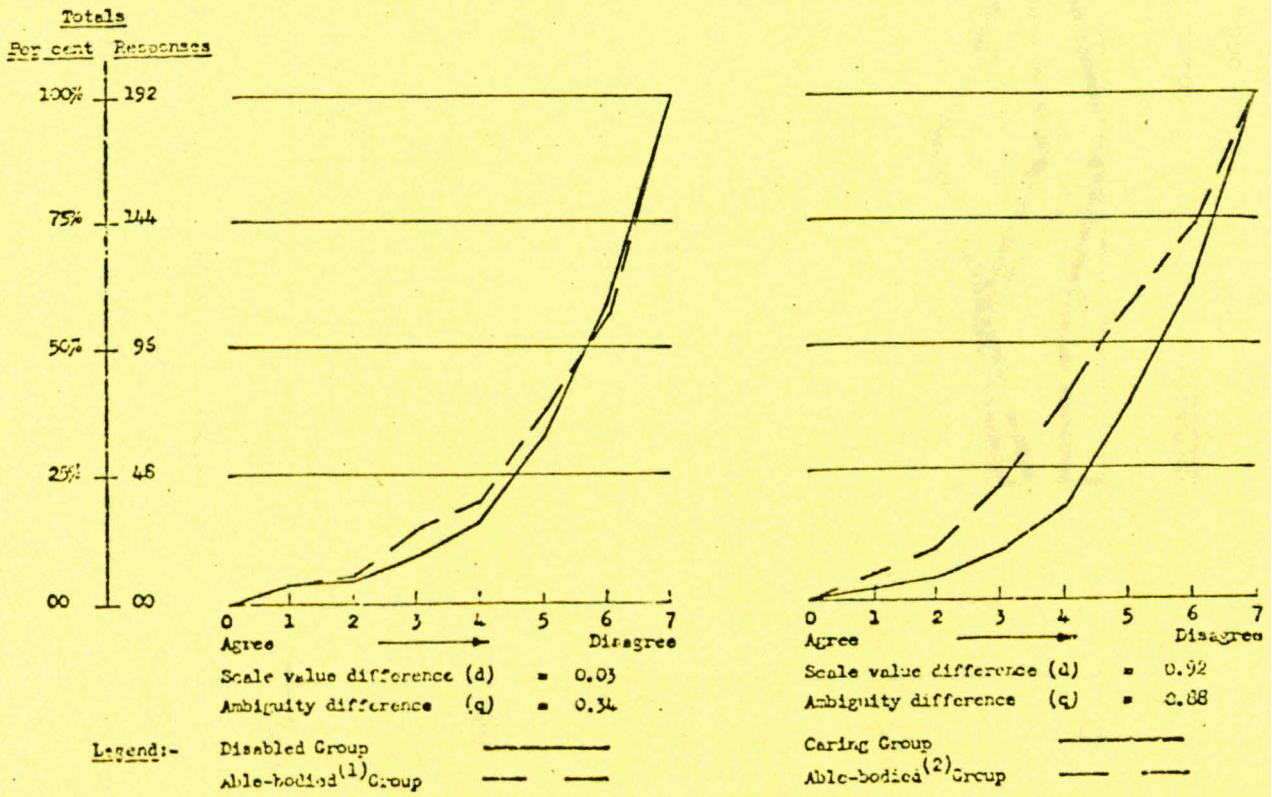
The mean and standard deviation values of the respective groups were:-

	Mean	Standard Deviation
Disabled	5.828	1.435
Able-Bodied(1)	5.641	1.622
Caring	5.656	1.463
Able-Bodied(2)	5.927	1.773

The distribution of the respective groups gave:-

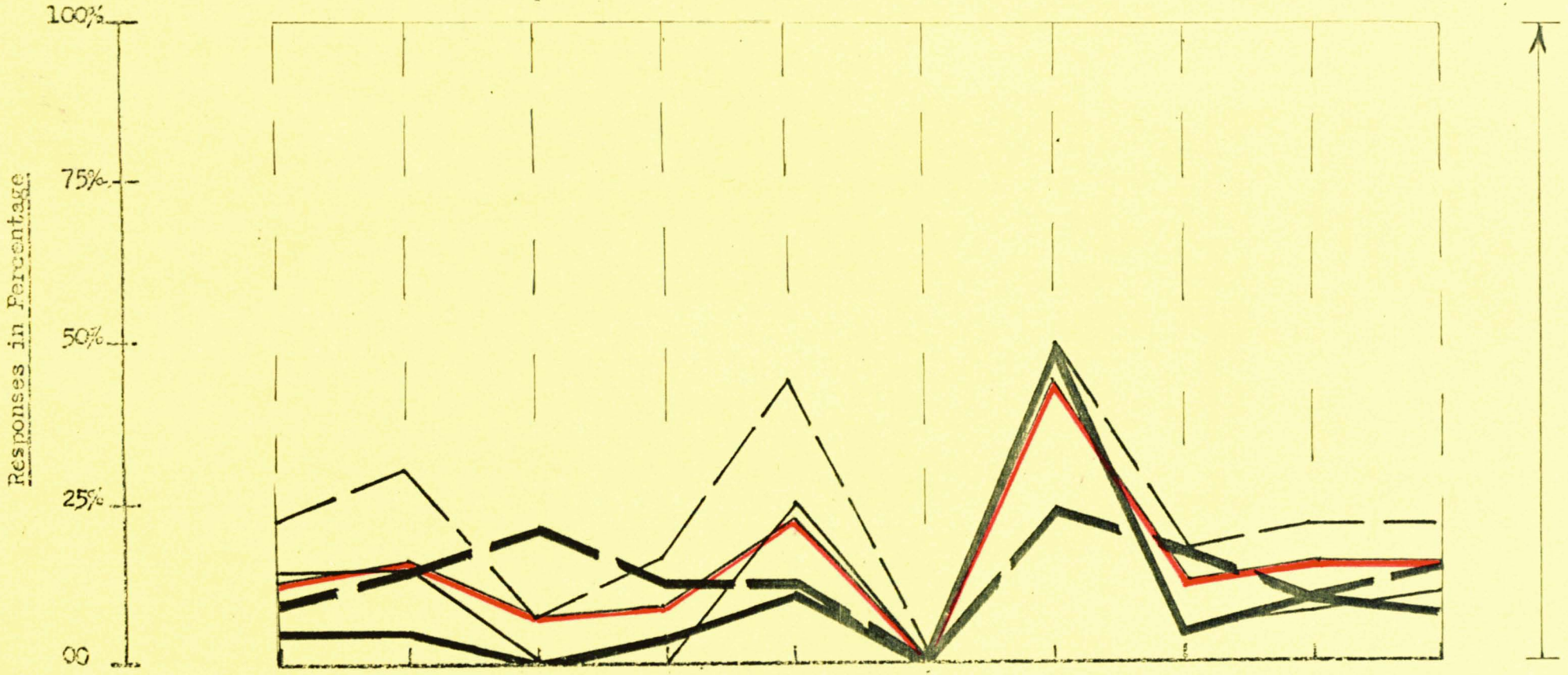
	Scale Value (S) (i.e. 50% level)		Ambiguity (Q) (i.e. Diff. between quartile levels)
Disabled	5.69	Disabled	-1.81
Able-Bodied(1)	5.66	Able-Bodied(1)	-2.15
Group Diff. (d)	0.03	Group Diff (d)	0.34
Caring	5.50	Caring	-1.99
Able-Bodied(2)	4.58	Able-Bodied(2)	-2.87
Group Diff. (d)	0.92	Group Diff. (d)	0.88

Statement No:- 01 Graphical Illustration of Group Differences in Scale Values at 50% Levels and Ambiguity between Quartile Levels



Statement No:- 01 Comparative Agreement between Different Secondary Groups of People

Arthritis	Blind	Deaf	Amputees	M.Sclerosis	Polio	Stroke	Heart	Paraplegic	TOTAL
N=22 =100%	N=20 =100%	N=14 =100%	N=24 =100%	N=16 =100%	N=5 =100%	N=4 =100%	N=42 =100%	N=45 =100%	N=192 =100%



Legend:-

Disabled Group

Able-bodied(1) Group

Overall

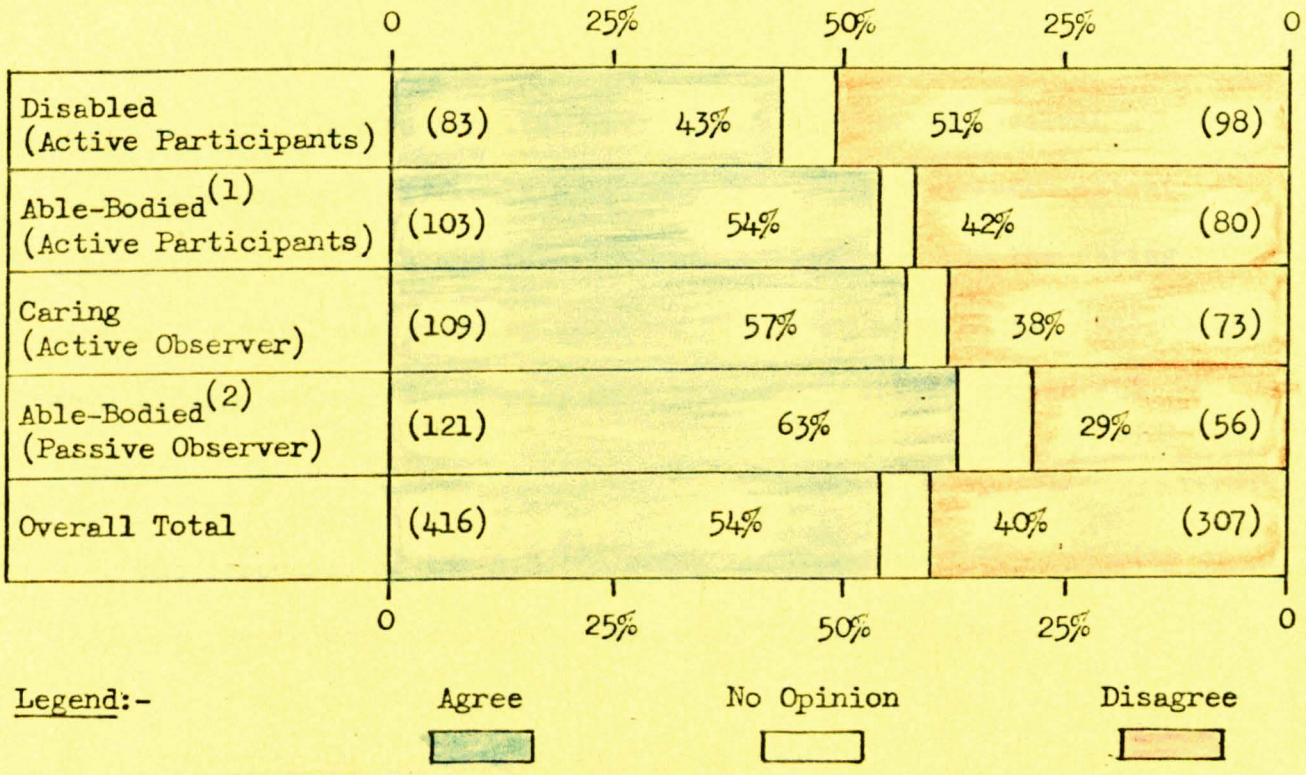
Caring Group

Able-bodied(2) Group

Statement No. 04

Disabled	The Medical Personnel with whom I have made contact since I became disabled have treated me more as a "number" than as an individual person.
Able-Bodied(1)	The Medical Personnel with whom I have made contact during the last few years have treated me more as a "number" than as an individual person.
Caring	The Medical Personnel with whom the disabled has made contact have treated him more as a "number" than as an individual person.
Able-Bodied(2)	Medical Personnel treat disabled persons more as "numbers" than as individual persons.

Table No. 04 (1) — Group Responses to Statement (where each Group Total N = 192 = 100% and Overall Total N = 768 = 100%)



Legend:- Agree | No Opinion | Disagree

Statistical information and graphical representations illustrating the different responses of these main groups are shown after the summary and in Appendix Nos. V and VI.

Statement No. 04

1. Group Responses to Main Statement

See Table 04 (1)

The responses of the disabled group seem to suggest that Medical Staff (i.e. Hospital Doctors and General Practitioners) treated handicapped people with more understanding than was thought by a large proportion of the caring and A.B.(2) group respondents.

One may suspect a little bias contributed to the difference in the general opinions of the disabled and caring respondents. In the early stages of disability, the disabled are frequently in contact with medical staff whose objectives are often concerned primarily with treatment to the function of the body rather than the behavioural adjustment of the disabled individual in the environment of the outer community. The results of clinical treatment and care are frequently assessed positively by the disabled in the early stages of recovery. Adjustment outside the hospital environment inevitably involves a relatively long and difficult programme depending to a large extent upon personal attitude and behaviour and assistance from the caring person and family, supporting services and outer community. Success in this wider domain is frequently much more difficult to assess and measure.

The responses of the A.B.(1) group indicated that the majority of the respondents were treated as "numbers" by medical staff.

2. Answers to Supplementary Questions

See Table 04 (2) and (3) - (Appendix V)

The results show that counselling and guidance on issues involving disability were particularly important to the disabled.

A stereo-typed approach by medical staff to the disabled was seen by the disabled and caring respondents to be less important than was indicated by a large proportion of the A.B.(2) group. Differences of opinions between the same two groupings were also seen in connection with issues relating to administration/organisation and physical aids/ adaptations. A large proportion of the A.B.(2) group thought that disabled people were more concerned with remedial attention to the self than with issues affecting social adjustment and integration.

Respondents in the A.B.(1) group who thought that they were treated as "numbers" by medical staff seemed to dislike particularly the stereo-typed manner by which they were given attention. Those who thought otherwise indicated the importance of counselling, display of initiative and individual attention.

See Tables 04 (4) and (5) - (Appendix V)

The responses of the disabled and caring groups were closely related with large proportions of each group referring to continuous assessment and the giving of frank opinions by medical staff as influential issues within the counselling and guidance situation. These issues were not seen to be so important to the disabled by the A.B.(2) group respondents.

As indicated by the responses of the A.B.(1) group, continuous assessment did not appear important to the able-bodied.

See Tables 04 (6) and (7) - (Appendix V)

The responses of the disabled and caring groups were close in connection with issues of importance within the administrative and physical aids sections, respectively. A large proportion of the A.B.(2) group believed that lack of administrative attention to the disabled was a more influential issue than indicated by the responses of the disabled and caring groups.

The responses of the A.B.(1) group were fairly close to those of the disabled and caring groups.

3. Comparative Agreement between Different Secondary Groups

See Table 04 (8) - (Appendix VI)

The results indicate that those who were handicapped by deafness were more satisfied with their relationships involving medical personnel than those who were handicapped by either multiple sclerosis or arthritis.

A large proportion of respondents in the caring group expressed disagreement with the responses made by those for whom they cared, as for example, those handicapped by arthritis, deafness, heart trouble and paraplegia. In many cases, it appeared during the interview that the caring persons had a "vested" interest in the welfare of those people who were subject to the stress of "pain".

A large proportion of the A.B.(2) group believed that those who were visually handicapped or suffered from deafness, heart trouble or paraplegia were the most likely to be treated as "numbers" amongst the disabled population.

The presence of pain and difficulties with mobility seemed to influence the outlook of some handicapped people in their attitude toward medical staff.

4. Summary

Independent of medical knowledge and skills, it seemed clear that a large proportion of all the groups looked to the general practitioner as a guide, philosopher and counsellor. Nevertheless, it was in this role that many respondents considered that general practitioners and supporting medical staff failed to appreciate the needs of disabled people.

Relatively large proportions of the disabled and able-bodied referred to "distant" relationships with their general practitioners, lack of receiving fundamental knowledge about the prognosis of their disabilities, inadequate information about personal assessments and examinations, and the absence of constructive contact with other supporting service agencies. Many doctors appeared to confine their treatment of disability to strictly clinical conditions. It was believed by many respondents during the interviews that in addition to clinical assessment and treatment, doctors should attempt to "educate" both disabled and able-bodied to mature responsibility and co-operative participation. This belief seems to be particularly relevant as the attitude of a person toward his disability is of considerable importance. Although some disabled appeared to have a "pride" only in their clinical condition, it was often in this situation that the general practitioner was thought to be able to offer much towards successful social interaction and the welfare of the individual.

It was evident that a large proportion of the disabled and caring respondents considered "success" in the disability role as the measure of the disabled person's self-independence and perceived place of recognition and acceptance in the outer community.

The essence of the doctor-disabled person relationship was seen to be its continuity and good counselling, as well as treatment, and it was this feature which appeared to strengthen the bond of mutual trust and improve the understanding and quality of living for many disabled people.

Statement No. 04 Main Group Statistical Information

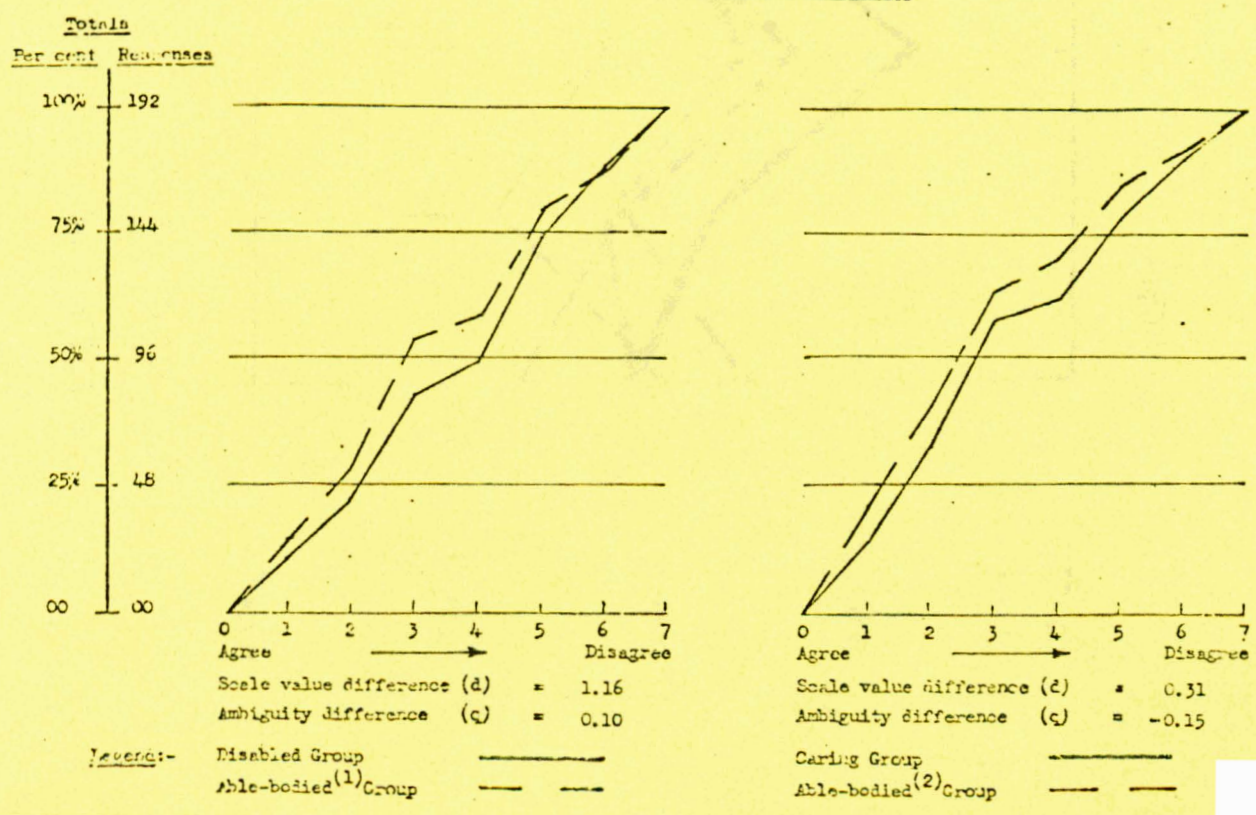
The mean and standard deviation values of the respective groups were:-

	Mean	Standard Deviation
Disabled	4.135	1.868
Able-Bodied(1)	3.787	1.934
Caring	3.692	1.942
Able-Bodied(2)	3.291	1.908

The distribution of the respective groups were:-

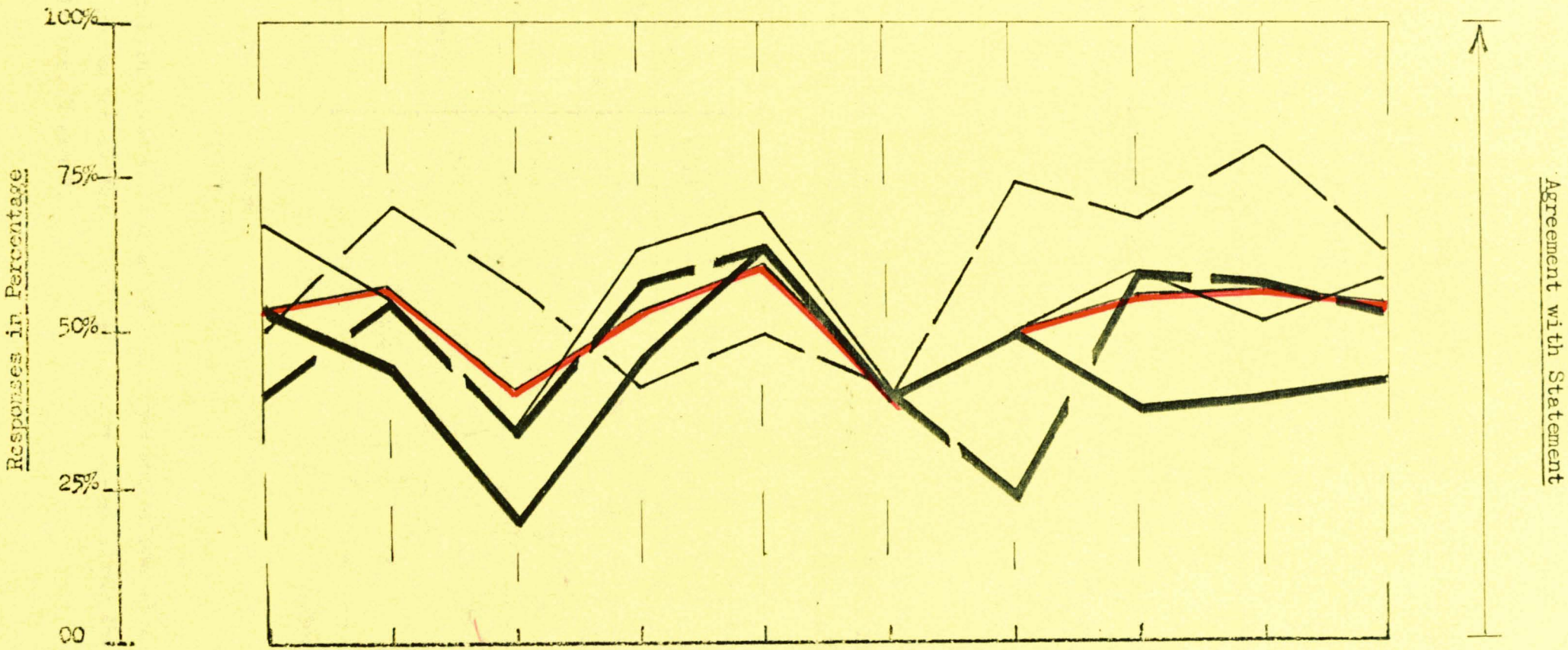
	Scale Value (S) (i.e. 50% level)		Ambiguity (Q) (i.e. Diff. between quartile levels)
Disabled	4.04	Disabled	-2.93
Able-Bodied(1)	2.88	Able-Bodied(1)	-3.03
Group Diff. (d)	1.16	Group Diff. (d)	0.10
Caring	2.72	Caring	-3.26
Able-Bodied(2)	2.41	Able-Bodied(2)	-3.11
Group Diff. (d)	0.31	Group Diff. (d)	-0.15

Statement No:- 04 Graphical Illustration of Group Differences in Scale Values at 50% Levels and Ambiguity between Quartile Levels



Statement No:- 04 Comparative Agreement between Different Secondary Groups of People

Arthritis	Blind	Deaf	Amputees	M.Sclerosis	Polio	Stroke	Heart	Paraplegic	TOTAL
N=22 =100%	N=20 =100%	N=14 =100%	N=24 =100%	N=16 =100%	N=5 =100%	N=4 =100%	N=42 =100%	N=45 =100%	N=192 =100%

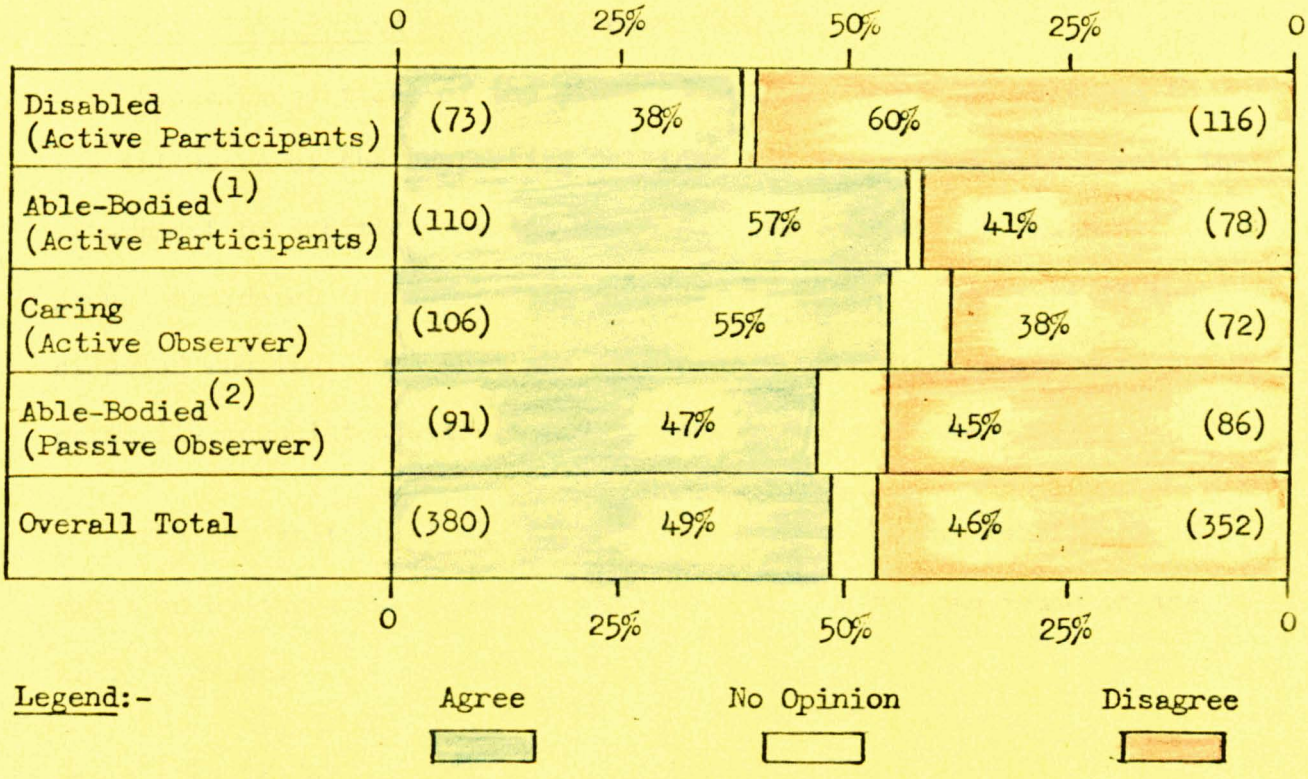


Legend:- Disabled Group; Able-bodied(1) Group; Overall; Caring Group; Able-bodied(2) Group

Statement No. 08

Disabled	Since I became disabled, I hope to fulfil my ambitions.
Able-Bodied(1)	I hope to fulfil my ambitions.
Caring	The disabled person hopes to fulfil his ambitions.
Able-Bodied(2)	Disabled people hope to fulfil their ambitions.

Table No. 08 (1) — Group Responses to Statement (where each Group Total N = 192 = 100% and Overall Total N = 768 = 100%)



Legend:- Agree | No Opinion | Disagree

Statistical information and graphical representations illustrating the different responses of these main groups are shown after the summary and in Appendix Nos. V and VI.

Statement No. 08

1. Group Responses to Main Statement

See Table 08 (1)

The disabled in this sample tend to have a lower expectancy of fulfilling their ambitions than indicated by a large proportion of respondents in the caring and A.B.(2) groups. This appeared to have been due to a display of caution, if not realism, which might not have been readily discerned by some respondents in the caring and A.B.(2) groups.

A large proportion of the respondents in the A.B.(1) group were seen to be more optimistic in their general outlook than the disabled.

2. Answers to Supplementary Questions

See Tables 08 (2) and (3) - (Appendix V)

Large proportions of the disabled and caring groups referred to the influence of the supporting services and outer community toward the attainment of ambition for the disabled. Respondents in the A.B.(2) group considered the supporting services to be less important to the disabled and indicated that the ambitions of disabled people were primarily associated with issues involving the self and family.

The recognition of the supporting services in the fulfilment of ambition by the able-bodied was more evident in the responses of the A.B.(1) group.

See Tables 08 (4) and (5) - (Appendix V)

Large proportions of the disabled and caring groups referred to employment as an issue of considerable importance in contributing to

the fulfilment of ambitions within the supporting services for the disabled. This issue was recognised similarly by a large proportion of respondents in the A.B.(2) group.

The responses of a large proportion of the A.B.(1) group indicated that the contribution of education to the fulfilment of ambitions relating to the able-bodied was less important than it was to the disabled.

3. Comparative Agreements between Different Secondary Groups

See Table 08 (6) - (Appendix VI)

The results indicate that those who were handicapped by either arthritis or blindness held a lower expectancy of fulfilling their ambitions than many people handicapped by other disabilities. The responses of the caring were frequently different from those of the disabled, particularly those who cared for people handicapped by blindness, heart trouble or paraplegia.

A large proportion of the A.B.(2) group believed that people handicapped by multiple sclerosis were more unlikely to fulfil their ambitions than people handicapped by other disabilities.

It appeared that personal reaction to disability and the degree of social activity experienced by the disabled person were influential issues contributing toward the potential fulfilment of ambition.

4. Summary

Ambition to most people disabled in their productive years was seen to be associated with employment, responsibility and recognition as an accepted member of society. In most cases, the disabled were required to make an almost complete readjustment in their vocational

pursuits following the onset of disability, and such an adjustment was not seen to be easy.

Apart from the positive application of personal attributes to acquire new abilities and skills, the disabled and caring respondents considered that successful re-orientation demanded understanding and co-operative assistance from tne supporting services and the outer community in order that the disabled could develop active-participative roles and intellectual-spectator recreational pursuits. Failure to obtain such assistance was often alleged to have been the reason why some disabled segregated themselves and developed feelings of "inferiority" and "stigma".

Statements from a number of able-bodied respondents tended to infer that they perceived disabled people living in a confined environment without real motive for identifying themselves with the activities of outer society.

Statement No. 08 Main Group Statistical Information

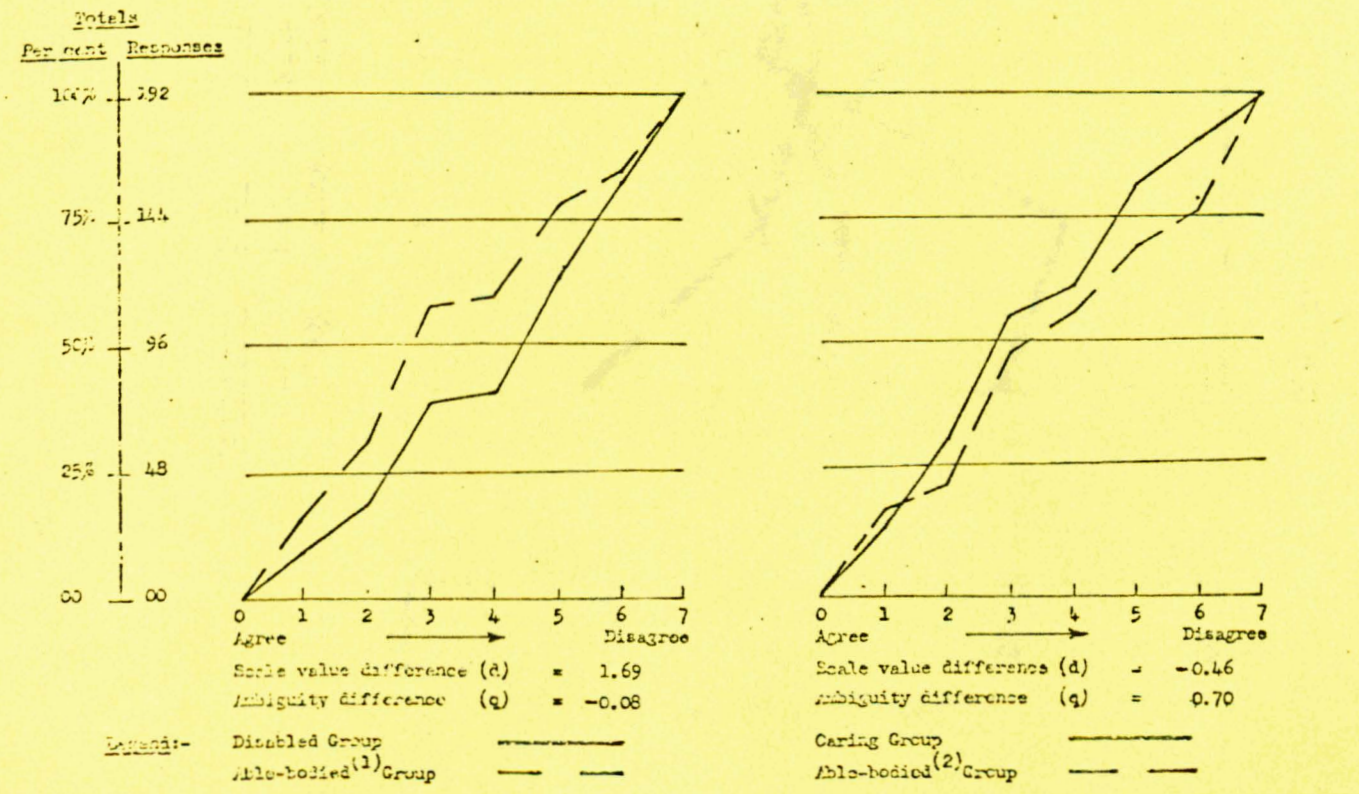
The mean and standard deviation values of the respective groups were:-

	Mean	Standard Deviation
Disabled	4.516	1.912
Able-Bodied(1)	3.771	2.003
Caring	3.651	1.835
Able-Bodied(2)	4.156	2.108

The distribution of the respective groups gave:-

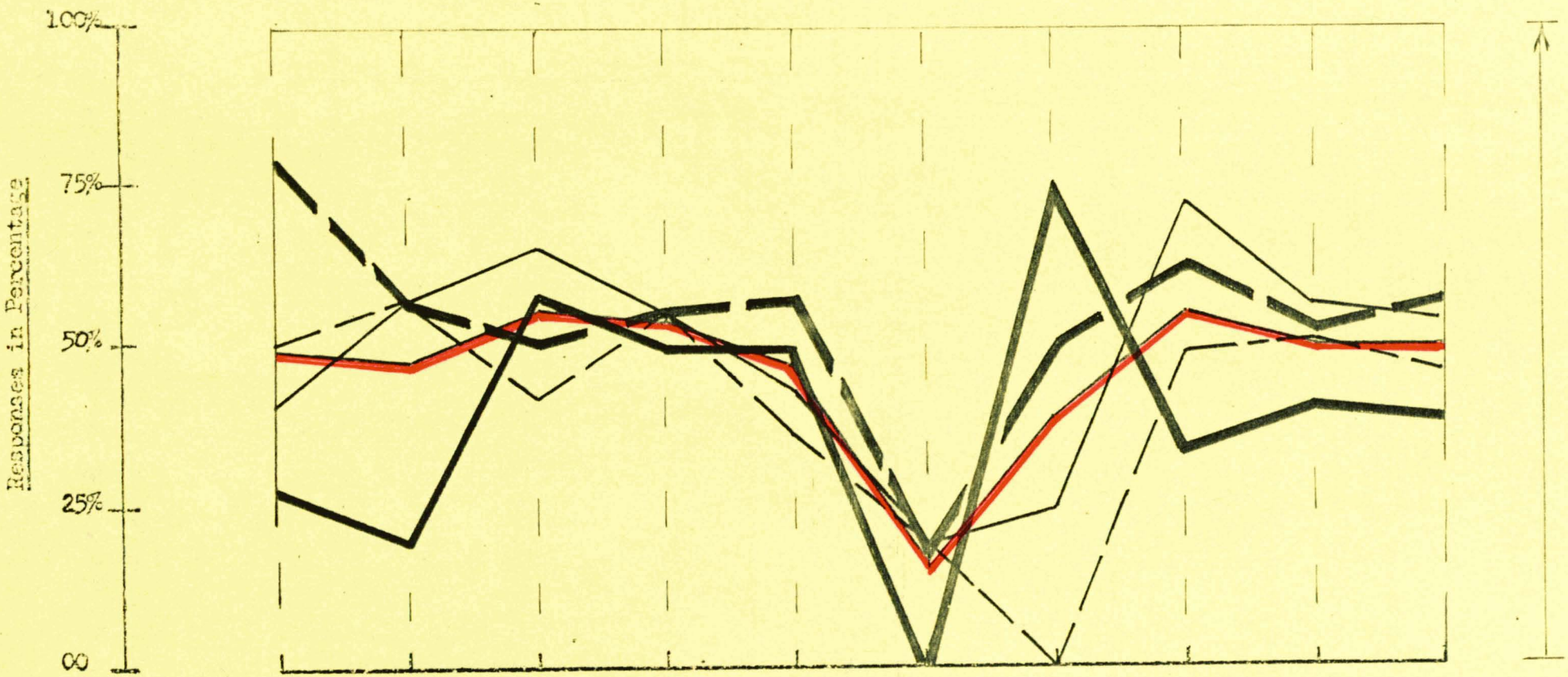
	Scale Value (S) (i.e. 50% level)		Ambiguity (Q) (i.e. Diff. between quartile levels)
Disabled	4.43	Disabled	-3.28
Able-Bodied(1)	2.74	Able-Bodied(1)	-3.20
Group Diff. (d)	1.69	Group Diff. (d)	-0.08
Caring	2.79	Caring	-3.01
Able-Bodied(2)	3.25	Able-Bodied(2)	-3.71
Group Diff. (d)	-0.46	Group Diff. (d)	0.70

Statement No:- 08 Graphical Illustration of Group Differences in Scale Values at 50% Levels and Ambiguity between Quartile Levels



Statement No:- 08 Comparative Agreement between Different Secondary Groups of People

Arthritis	Blind	Deaf	Amputees	M.Sclerosis	Polio	Stroke	Heart	Paraplegic	TOTAL
N=22 =100%	N=20 =100%	N=14 =100%	N=24 =100%	N=16 =100%	N=5 =100%	N=4 =100%	N=42 =100%	N=45 =100%	N=192 =100%



Legend:-

Disabled Group

Able-bodied(1) Group

Overall

Caring Group

Able-bodied(2) Group

Statement No. 11

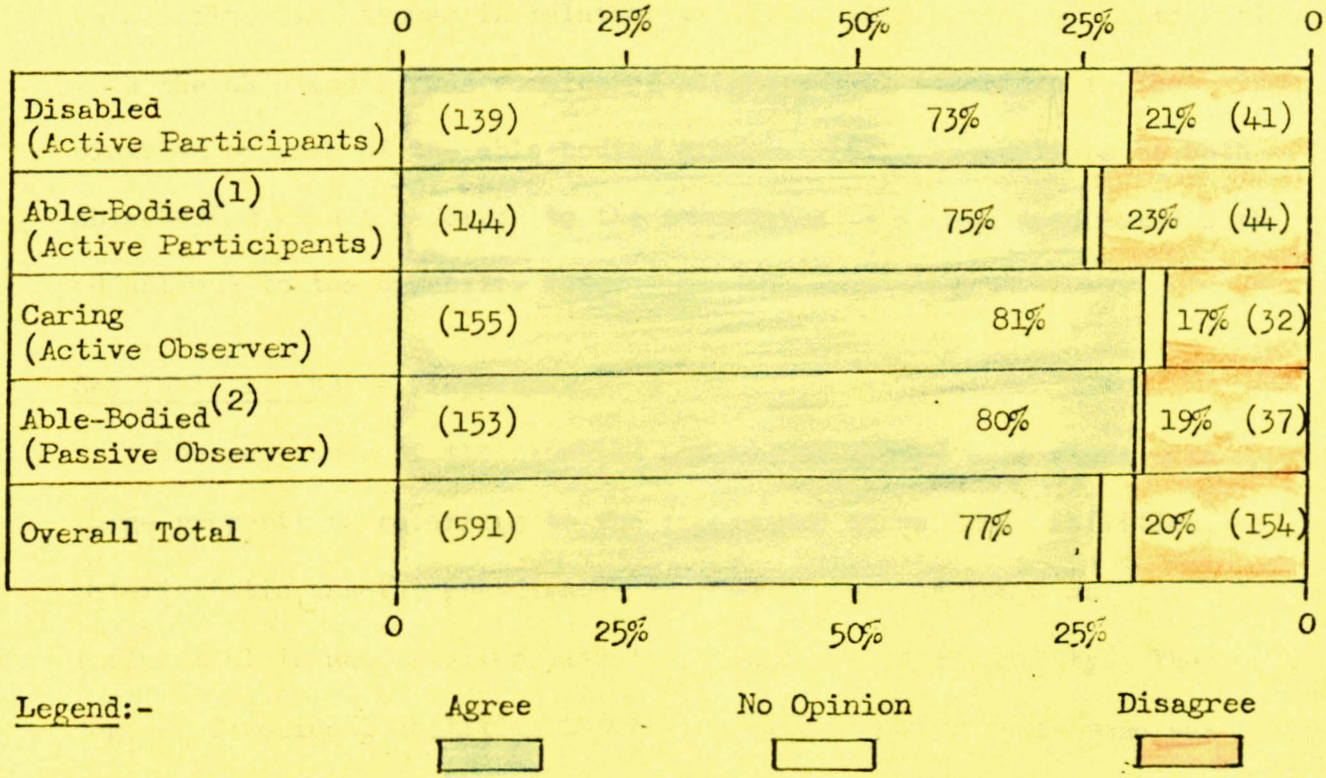
Disabled — I think that a disabled person should live with his handicap as early as possible.

Able-Bodied(1) — I think that a disabled person should live with his handicap as early as possible.

Caring — I think that a disabled person should live with his handicap as early as possible.

Able-Bodied(2) — Disabled persons should live with their handicaps as early as possible.

Table No. 11 (1) — Group Responses to Statement (where each Group Total N = 192 = 100% and Overall Total N = 768 = 100%)



Legend:- Agree — No Opinion — Disagree

Statistical information and graphical representations illustrating the different responses of these main groups are shown after the summary and in Appendix Nos. V and VI

Statement No. 11

1. Group Responses to Main Statement

See Table 11 (1)

Whilst all the groups considered that it was important for disabled people to live with their handicaps as early as possible, the proportion of disabled respondents who contributed to this belief was slightly smaller than those registered by the other groups.

2. Answers to Supplementary Questions

See Tables 11 (2) and (3) - (Appendix V)

The responses of the disabled and caring groups indicated that large proportions of the respondents believed that adjustment to disability, adjustment within the outer community, integration with the able-bodied and the maintenance of pre-disability friends and contacts were influential issues in relation to living with handicap. Integration with the able-bodied was considered slightly less important to the disabled by each of the able-bodied groups. Large proportions of both able-bodied groups referred to the importance of issues associated with adjustment to the disability role.

See Table 11 (4) - (Appendix V)

The responses of the disabled and caring groups were close with large proportions referring to the importance of residual abilities, materialistic assets, pre-disability status and self-image as influential issues involved with the acceptance of disability. The degree of residual abilities and the influence of the self-image was not seen by the able-bodied groups to be so important to the disabled.

See Tables 11 (5) and (6) - (Appendix V)

Reformulating a "new" self predicated on worth and value was seen by a large proportion of the disabled and caring groups to be an issue of primary importance in the rehabilitation of the disabled. The responses of the two able-bodied groups indicated that the respondents believed this issue to be of little importance to disabled people. Large proportions of both groups thought that restoration of the individual to his "pre-disability" role was of primary importance to the disabled.

See Table 11 (7) - (Appendix V)

A large proportion of the disabled and caring referred to the influence of the outer community in assisting the disabled to adjust readily to their handicaps. Smaller proportions of the able-bodied groups expressed similar opinions. Living with handicap was perceived by large proportions of the able-bodied groups to be predominantly influenced by the personality and attitude of the individual.

3. Comparative Agreements between Different Secondary Groups

See Table 11 (8) - (Appendix VI)

A large proportion of those who were handicapped by blindness, amputations or paraplegia indicated tnat the disabled should live with their handicap as early as possible. In general, tneir opinions were largely supported by those who cared for them and by respondents in the A.B.(2) group. The responses of those who were handicapped by deafness suggested that they needed more "time" than other disabled to adjust to their handicap.

It appeared from many of the responses that people who sustained handicaps as a result of accidents whilst they were relatively young

tended to adjust more readily to changed conditions and environment than older persons, particularly those who had been involved in "risk taking" activities.

4. Summary

Many disabled appeared to see early adjustment to their handicap as a function of social relationships, including their pre-disability friendships and contacts. Such relationships were perceived by both the disabled and caring people during the interviews as a "bridge" between the self and society. This feature was not recognised by the able-bodied who seemed to believe that it was relatively easy for the disabled to adjust to life in society. Their responses suggested that they were unaware of other areas involved in the process of re-orientation and many tended to see living with a handicap as a simple adjustment from one role to another.

It was apparent that the disabled and caring people considered that the realities and consequential effects of disability should be discussed with the disabled as early as possible. This may involve shock and grief but the respondents believed that it was more helpful than prolonging false expectations as an escape from reality. This effect of disability was not too clearly seen by the able-bodied.

Many disabled and caring people believed that there was an optimum period at which it was important for the disabled to accept the limitations of disability and commence the development of an adjusted role in society. Failure to do so at the appropriate time produced problems both with the self-concept and with adjustment to social pressures.

Statement No. 11 Main Group Statistical Information

The mean and standard deviation values of the respective groups were:-

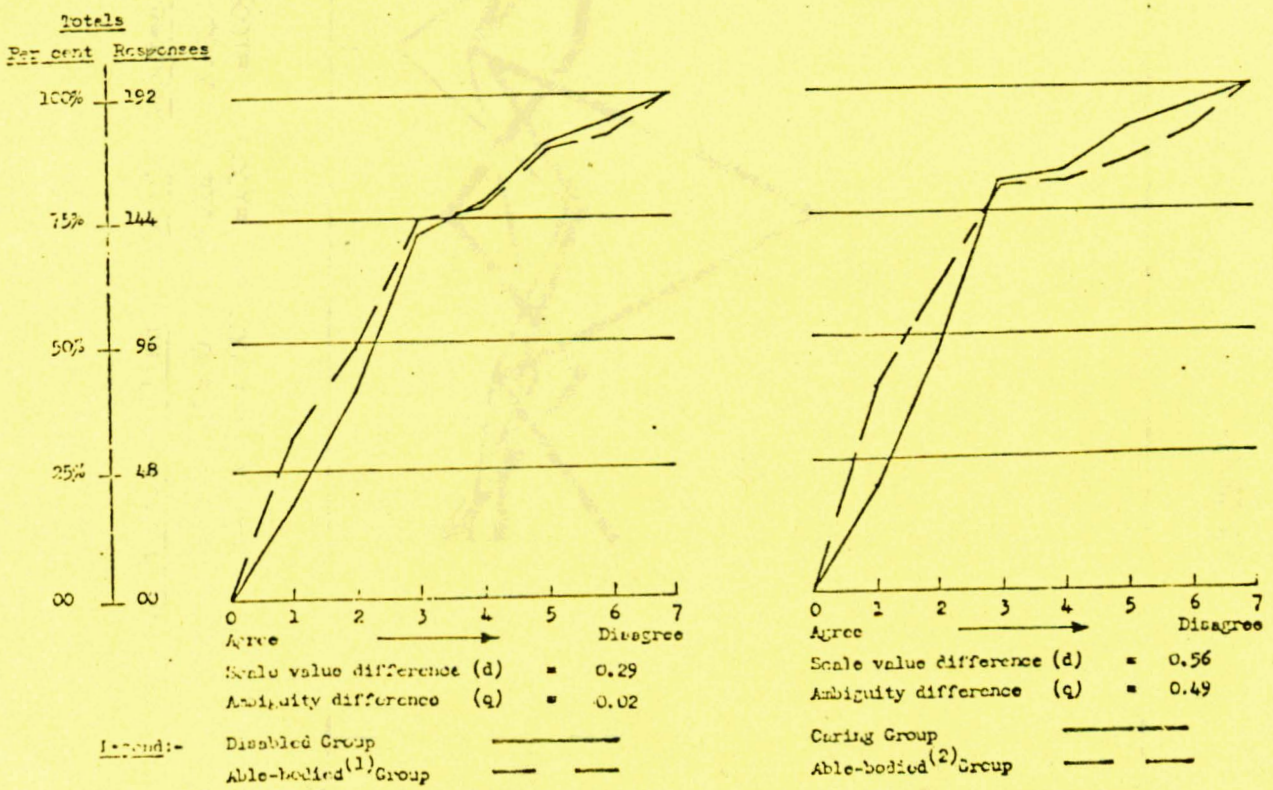
	Mean	Standard Deviation
Disabled	3.042	1.601
Able-Bodied(1)	2.854	1.848
Caring	2.817	1.552
Able-Bodied(2)	2.630	1.929

The distribution of the respective groups gave:-

	Scale Value (S) (i.e. 50% level)		Ambiguity (Q) (I.e. Diff. between quartile levels)
Disabled	2.33	Disabled	-2.17
Able-Bodied(1)	2.04	Able-Bodied(1)	-2.19
Group Diff. (d)	0.29	Group Diff. (d)	0.02
Caring	2.09	Caring	-1.64
Able-Bodied(2)	1.53	Able-Bodied(2)	-2.13
Group Diff. (d)	0.56	Group Diff. (d)	0.49

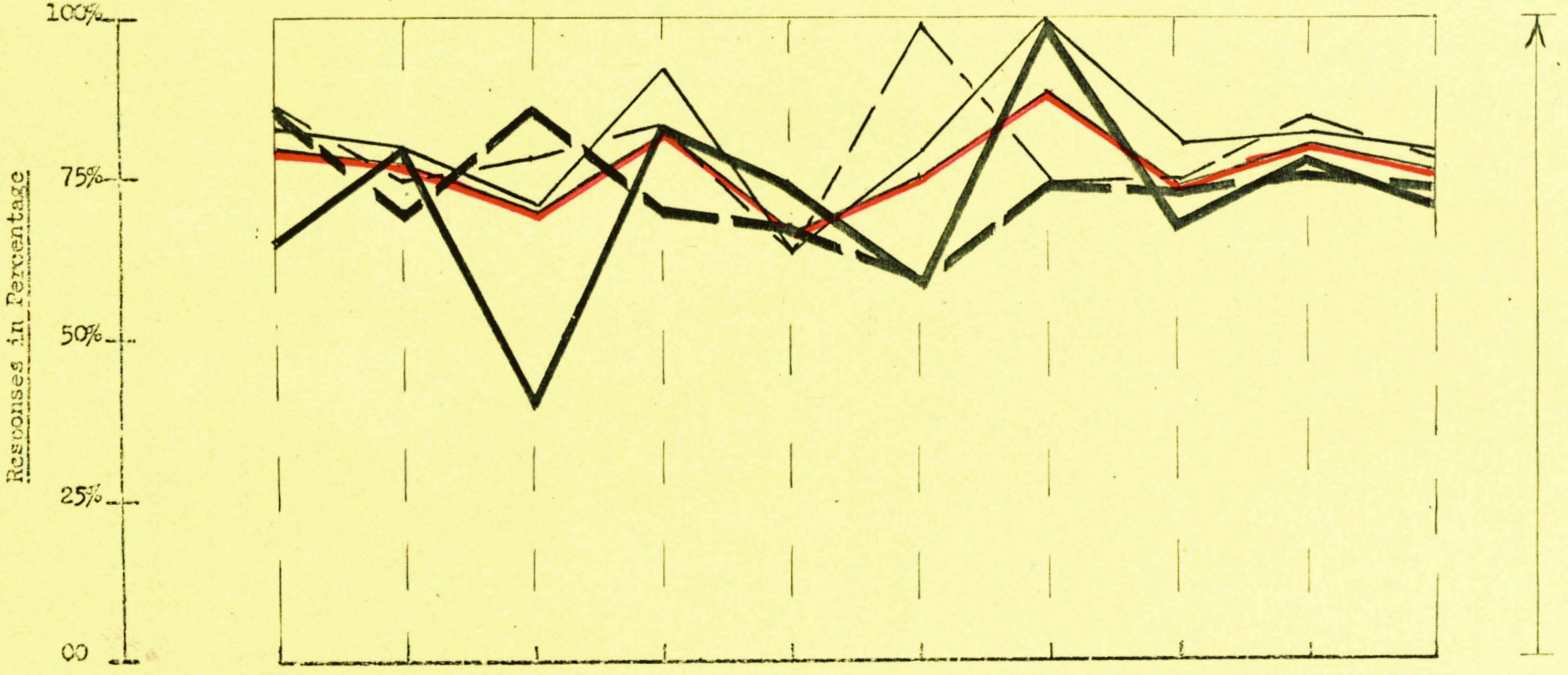
Statement No:- 11

Graphical Illustration of Group Differences in Scale Values at 50% Levels and Ambiguity between Quartile Levels



Statement No:- 11 Comparative Agreement between Different Secondary Groups of People

Arthritis	Blind	Deaf	Amputees	M.Sclerosis	Polio	Stroke	Heart	Paraplegic	TOTAL
N=22 =100%	N=20 =100%	N=14 =100%	N=24 =100%	N=16 =100%	N=5 =100%	N=4 =100%	N=42 =100%	N=45 =100%	N=192 =100%



Legend:-

Disabled Group

Able-bodied(1) Group

Overall

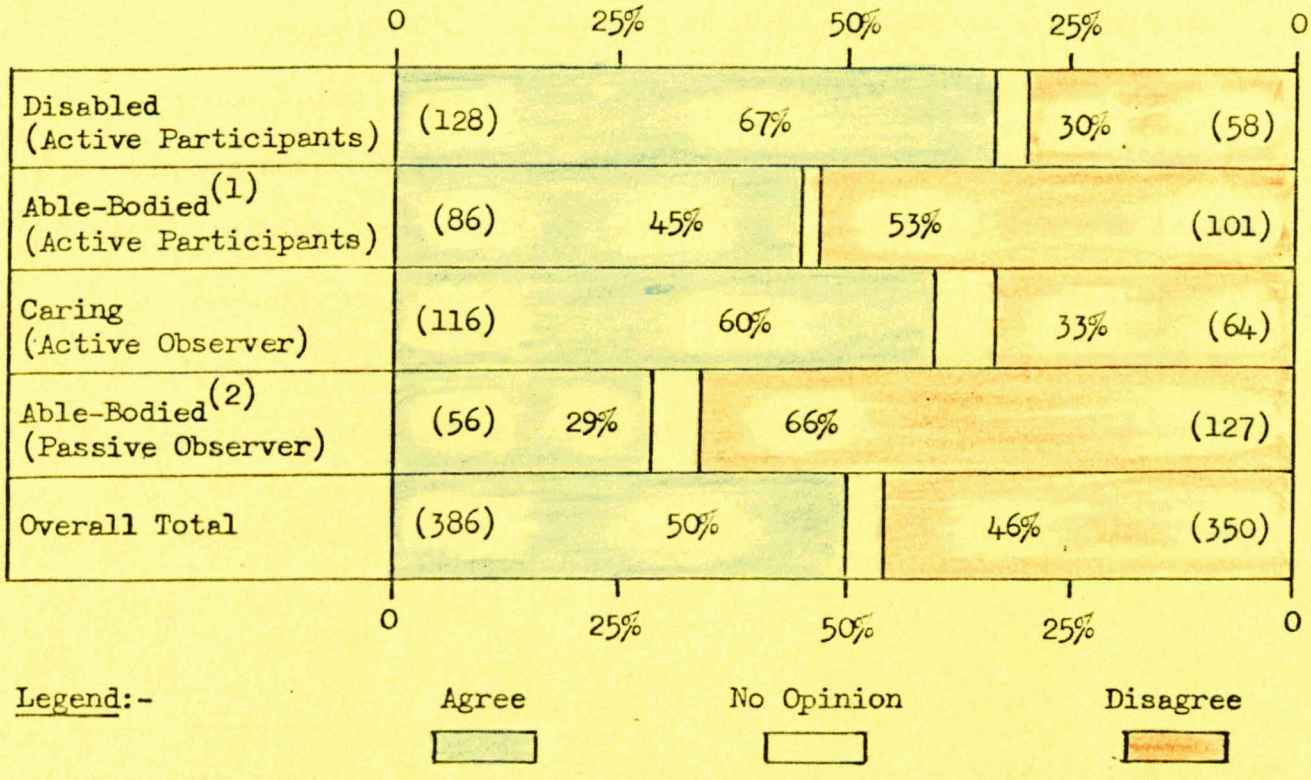
Caring Group

Able-bodied(2) Group

Statement No. 16

Disabled	Many able-bodied persons who knew me well before I became disabled have since altered their attitude towards me.
Able-Bodied(1)	Many able-bodied persons who knew me well a few years ago have since altered their attitude towards me.
Caring	Many able-bodied persons who knew the disabled person well before he became disabled have since altered their attitude towards him.
Able-Bodied(2)	People alter their attitudes towards a person when he becomes disabled.

Table No. 16 (1) — Group Responses to Statement (where each Group Total N = 192 = 100% and Overall Total N = 768 = 100%)



Legend:- Agree | No Opinion | Disagree

Statistical information and graphical representations illustrating the different responses of these main groups are shown after the summary and in Appendix Nos. V and VI.

Statement No. 16

1. Group Responses to Main Statement

See Table 16 (1)

The results show that about two-thirds of the disabled and caring groups indicated that the attitude of people changed toward the disabled following the onset of disability. Less than one-third of the A.B.(2) group agreed with this opinion.

A large proportion of the A.B.(1) group indicated that they had not experienced a change of attitude toward them (as able-bodied people) during the previous few years.

2. Answers to Supplementary Questions

See Tables 16 (2) and (3) - (Appendix V)

The responses of the disabled and caring groups were close with large proportions of each group referring to the influence of the supporting services and outer community in connection with attitude changes following the onset of disability. Changes of attitude in the outer community was not considered so influential to the disabled by respondents in the A.B.(2) group where a large proportion referred to the importance of attitudes associated with the self and family sectors.

The responses of the A.B.(1) group were seen to be near to those of the disabled and caring groups.

See Table 16 (4) - (Appendix V)

More than two-thirds of the respondents in the disabled and caring groups who indicated that disability changed attitudes following the onset of disability revealed that such changes were associated with

negative features; most of which were seen to occur in the supporting services and outer community domains. These areas did not appear so influential with those disabled and caring respondents who indicated that they had experienced a positive change in attitude following the onset of disability. In this latter case, the influence of the family was seen to be of some importance.

Relatively large proportions of the respondents in the A.B.(2) group believed that the self and family domains were influential to the disabled in those cases where the negative aspects of disability had been experienced. In those cases where a positive change of attitude was believed to have occurred, the supporting services and outer community sectors were seen by large proportions of the A.B.(2) group to be particularly influential.

The responses of the A.B.(1) group were near to those of the A.B.(2) group.

See Tables 16 (5) and (6) - (Appendix V)

These tables focus on important elements within the coping and succumbing framework.

In relation to the coping aspects, a large proportion of the disabled and caring appeared to be concerned mainly with the fulfilment of personal abilities; an aspect considered important by a smaller proportion of respondents in the A.B.(2) group. A similar pattern seemed to develop with the respective groups in connection with the succumbing features of disability.

A relatively large proportion of the A.B.(1) group referred to the influence of recognition of abilities and accomplishments in both the coping and succumbing elements of attitude change.

See Table 16 (7) - (Appendix V)

The human tendency to draw inferences about a person upon the basis of a single characteristic of the individual appears to be emphasised by large proportions of the disabled and caring groups. Cognitive expressions which were conducive to psychological "spread" were seen by many disabled and caring respondents to be an issue of great influence in promoting negative behavioural reaction toward the disabled. A much smaller proportion of the A.B.(2) group respondents referred to the importance of this characteristic.

The pattern of responses for the A.B.(1) group tended to be similar to those of the disabled and caring groups.

See Table 16 (8) - (Appendix V)

Affective expressions of "pity" or "shame" were seen by large proportions of the disabled and caring groups to be influential factors in contributing to a negative behavioural reaction toward the disabled. This issue did not appear to the A.B.(2) group to be of much importance to the disabled.

Expressions of "pity" or "shame" were seen to be of considerable importance to a large proportion of the A.B.(1) group.

An important positive contribution to the behavioural reaction of a large proportion of disabled and caring respondents was seen to be associated with inspiration; an issue which was recognised in respect of the disabled by a small proportion of the A.B.(2) group.

Expressions of sympathy, respect and warm relationship were seen to be important by large proportions of the A.B.(1) group.

3. Comparative Agreements between Different Secondary Groups

See Table 16 (9) - (Appendix VI)

The table reveals that those who were handicapped by deafness or multiple sclerosis appeared to be particularly affected by the change of attitudes toward them by others following the onset of disability. Problems associated with communication seemed to have a disturbing influence on the behavioural reaction of many disabled people. Apart from those who cared for persons handicapped by multiple sclerosis and heart trouble, the responses of the caring group were fairly close to those of the handicapped.

The responses of the A.B.(2) group were frequently different from those of the disabled and caring, particularly in connection with respondents who were visually handicapped.

4. Summary

Although the disabled perceived attitudes to change toward them following the onset of disability more in the supporting services and outer community sectors than elsewhere, a large proportion of the able-bodied considered the self and family to be more influential sectors. Losses involving psychological security, personality, basic skills, communication, appreciation, occupational and financial status were frequently analysed differently by the disabled and able-bodied. Many disabled and caring respondents believed that attitudinal loss toward the disabled would be decreased only by the exhibition of a greater understanding and an awareness of the needs of the disabled by many supporting service agencies and others in the outer community. The disabled considered themselves as people with abilities and differences. It seemed evident during the interviews that an individual's reaction

to disability was frequently dependent upon his pre-disability concept and social position and upon the reaction toward his disability and inherent handicaps by others during social interaction.

Whilst it often appeared that some disabled had difficulties in adapting themselves to social interaction with the able-bodied, it was also apparent that many able-bodied encountered problems in ascertaining whether they should ignore the handicap completely or treat the disabled person as if he was completely handicapped. It was because of these problems in interpreting each other's role that "asynchronies" frequently seemed to develop and to tend to produce negative results. Conflicting forces seemed to abound in the cognitive and affective domains of the disabled and able-bodied roles with both cognitive and affective components, such as "psychological spread" and "pity" being perceived as influential determinants in attitudinal change.

The essence of providing opportunities and the need to participate in an active and supporting role in society were apparent during the interviews in the coping and succumbing behavioural reactions of a large proportion of the disabled.

It also appeared evident from the interviews that there was a need for more education of the general public about the realisation and consequences of disability, particularly concerning the need for social integration, constructive and positive support policies in the supporting services and a greater understanding of the contributory role of the disabled person in society.

Statement No. 16 Main Group Statistical Information

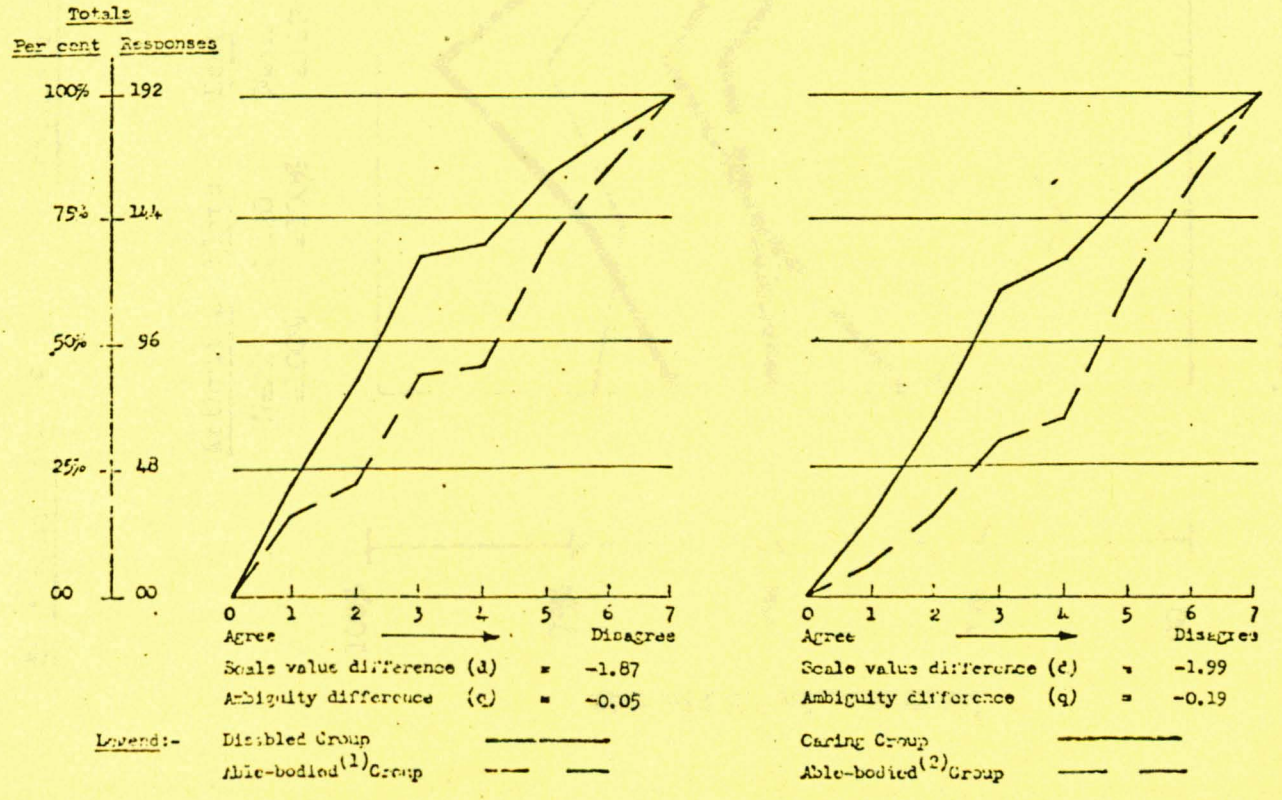
The mean and standard deviation values of the respective groups were:-

	Mean	Standard Deviation
Disabled	3.224	1.897
Able-Bodied(1)	4.141	2.002
Caring	3.494	1.865
Able-Bodied(2)	4.703	1.804

The distribution of the respective groups gave:-

	Scale Value (S) (i.e. 50% level)		Ambiguity (Q) (i.e. Diff. between quartile levels)
Disabled	2.29	Disabled	-3.24
Able-Bodied(1)	4.16	Able-Bodied(1)	-3.19
Group Diff. (d)	-1.87	Group Diff. (d)	-0.05
Caring	2.58	Caring	-3.10
Able-Bodied(2)	4.57	Able-Bodied(2)	-2.91
Group Diff. (d)	-1.99	Group Diff. (d)	-0.19

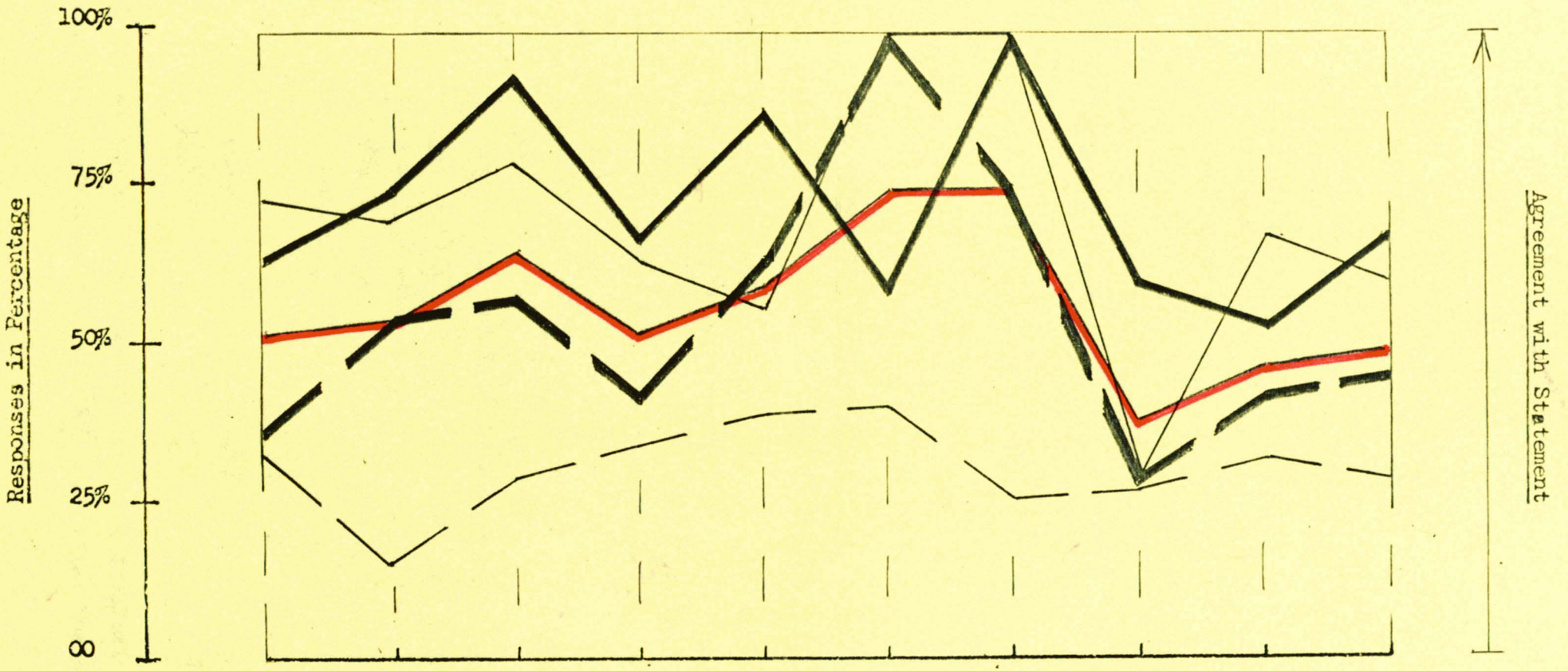
Statement No:- 16 Graphical Illustration of Group Differences in Scale Values at 50% Levels and Ambiguity between Quartile Levels



Statement No:- 16

Comparative Agreement between Different Secondary Groups of People

Arthritis	Blind	Deaf	Amputees	M.Sclerosis	Polio	Stroke	Heart	Paraplegic	TOTAL
N=22 =100%	N=20 =100%	N=14 =100%	N=24 =100%	N=16 =100%	N=5 =100%	N=4 =100%	N=42 =100%	N=45 =100%	N=192 =100%



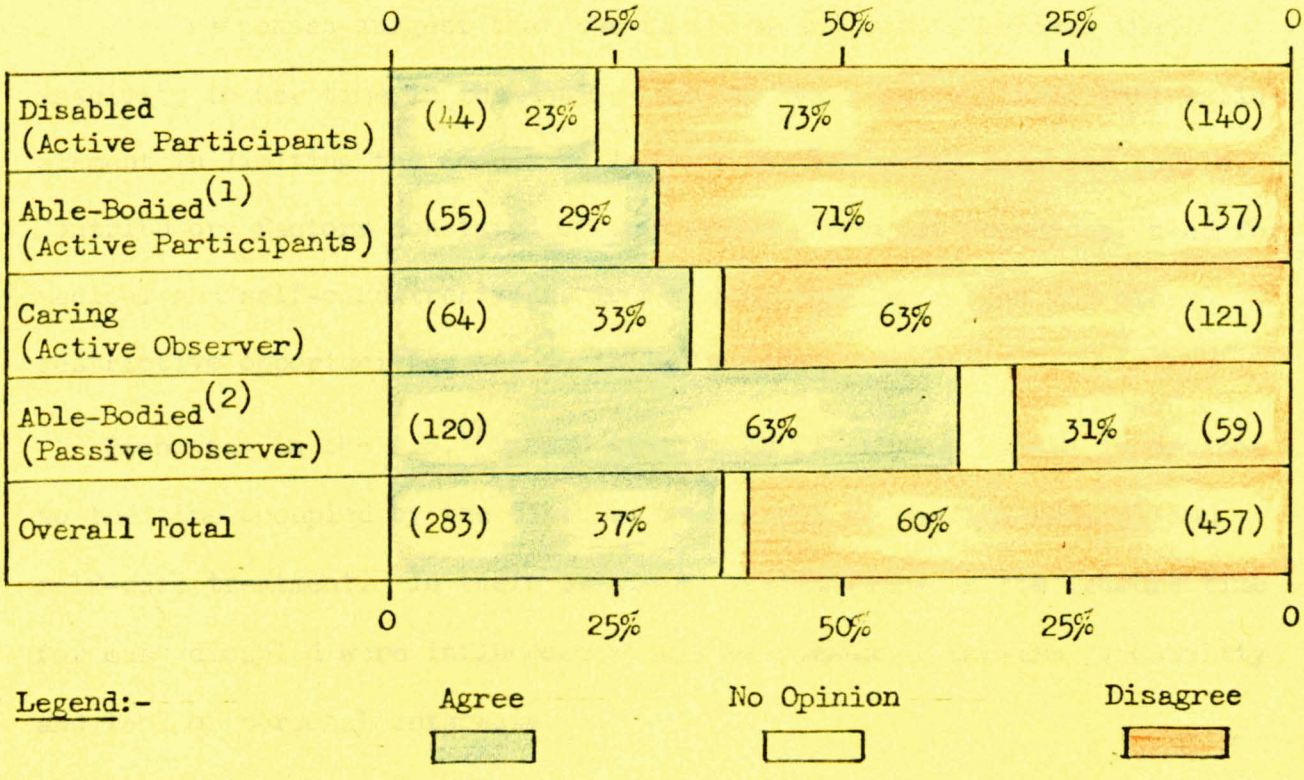
Legend:-

- Disabled Group
- Able-bodied(1) Group
- Overall
- Caring Group
- Able-bodied(2) Group

Statement No. 21

Disabled	Since I became disabled, I have more leisure time than able-bodied persons.
Able-Bodied(1)	I have more leisure time than disabled persons.
Caring	The disabled person has more leisure time than able-bodied persons.
Able-Bodied(2)	Disabled persons have more leisure time than able-bodied persons.

Table No. 21 (1) — Group Responses to Statement (where each Group Total N = 192 = 100% and Overall Total N = 768 = 100%)



Legend:- Agree | No Opinion | Disagree

Statistical information and graphical representations illustrating the different responses of these main groups are shown after the summary and in Appendix Nos. V and VI.

Statement No. 21

1. Group Responses to Main Statement

See Table 21 (1)

A very large proportion of the disabled group considered that they had less leisure time than able-bodied people and support for this view was evident by the responses of those who cared for them.

In contrast, about two-thirds of the A.B.(2) group believed that the disabled had more leisure time than able-bodied people.

Nearly three-quarters of the A.B.(1) group indicated that the disabled had more lesiure time than able-bodied people.

2. Answers to Supplementary Questions

See Table (2) - (Appendix V)

The responses suggest that the disabled and caring believe that inability to use time in the desired manner was a particularly influential element in limiting the amount of leisure available for disabled people. Contributory factors consisted of inadequate financial resources, need for medical and self-care treatment, immobility, limited access and other restrictive opportunities and social activities.

Responses in the A.B.(2) group attributed relatively little importance to the time occupied by the disabled on matters concerning medical and self-care treatment. In their opinions, restrictions on the leisure time for many disabled were influenced mainly by financial matters, immobility and lack of personal interests.

Financial matters were seen to be a restrictive factor on the leisure time activities of a large proportion of respondents in the A.B.(1) group.

3. Comparative Agreements between Different Secondary Groups

See Table 21 (3) - (Appendix VI)

The table indicates that those who were handicapped by arthritis, deafness, multiple sclerosis or paraplegia had less leisure time than many people handicapped by other disabilities.

The caring people agreed with those who were handicapped by arthritis, multiple sclerosis or paraplegia but a large proportion disagreed with the opinions expressed by those handicapped by deafness.

It was frequently evident during the interviews that apart from generally visible restrictions, such as limited mobility which directly tends to impede social integration, other more personal features associated with self-care greatly influenced both the amount and quality of leisure experienced by many disabled.

4. Summary

The overall results indicate that potential leisure for many disabled was much less than that for able-bodied people.

Despite the variability of many issues involved with leisure, it was apparent that the loss of a role as a contributory member of society following the onset of disability adversely affected the amount of "leisure" for many disabled. It was frequently stated by the disabled and caring respondents during the interviews that the quality of leisure for the individual was often determined by the "usefulness" of the person's contributory role in the community.

A large proportion of the able-bodied perceived leisure for the disabled as time unoccupied in the productive area of society.

The apparent absence of many disabled in general social interaction was seen by some of the able-bodied respondents as being largely of personal choice or lack of interest by the disabled. On the other hand, the disabled indicated that restrictive mobility, limited facilities and lack of suitable opportunities imposed upon them by some supporting service agencies frequently prevented their full participation in outer community activities.

Medical and self-care treatment, immobility and access difficulties which restricted social activities were seldom recognised by the able-bodied as important influences on the leisure time for disabled people.

Statement No. 21 Main Group Statistical Information

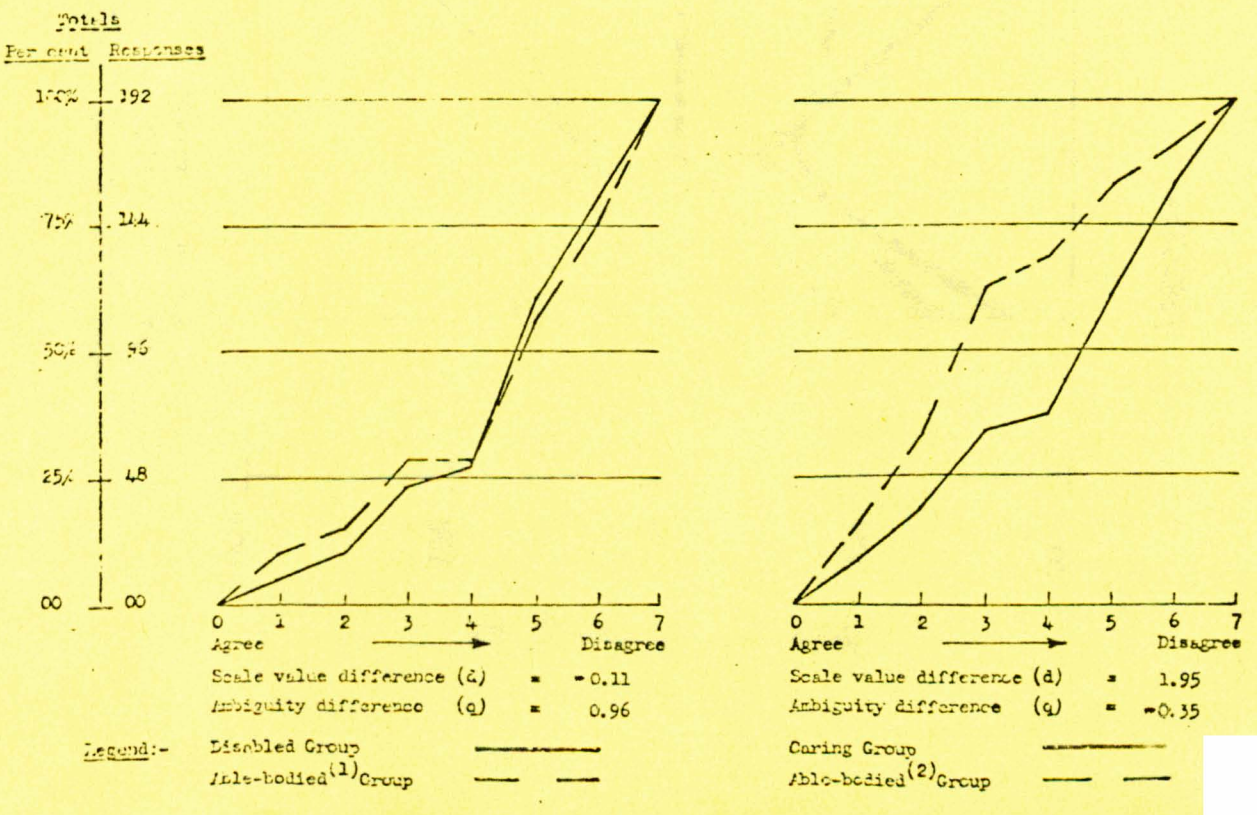
The mean and standard deviation values of the respective groups were:-

	Mean	Standard Deviation
Disabled	4.974	1.658
Able-Bodied(1)	4.885	1.933
Caring	4.593	1.915
Able-Bodied(2)	3.479	1.875

The distribution of the respective groups gave:-

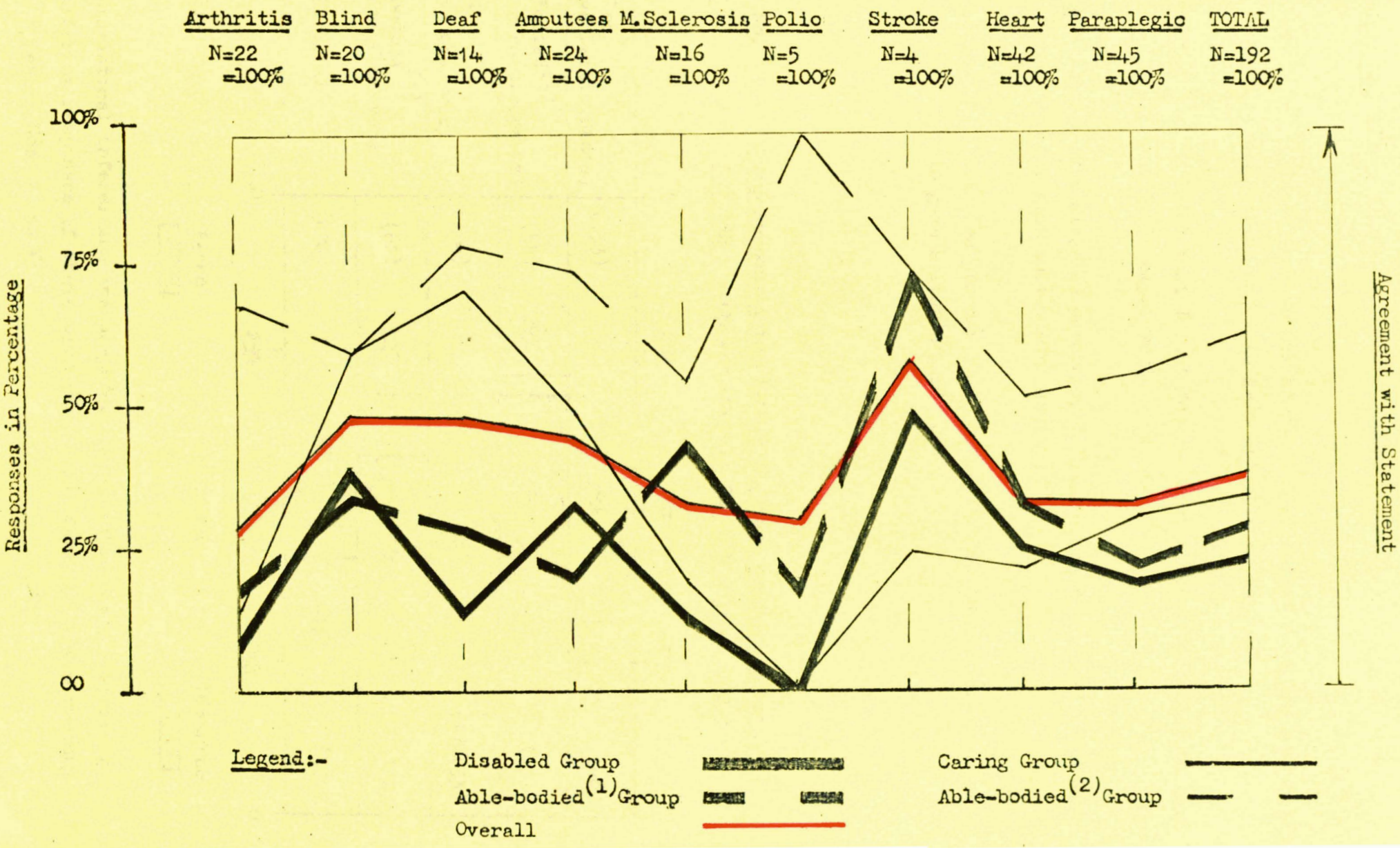
	Scale Value (S) (i.e. 50% level)		Ambiguity (Q) (i.e. Diff. between quartile levels)
Disabled	4.70	Disabled	-2.25
Able-Bodied(1)	4.81	Able-Bodied(1)	-3.21
Group Diff. (d)	-0.11	Group Diff. (d)	0.96
Caring	4.54	Caring	-3.22
Able-Bodied(2)	2.59	Able-Bodied(2)	-2.87
Group Diff. (d)	1.95	Group Diff. (d)	-0.35

Statement No:- 21 Graphical Illustration of Group Differences in Scale Values at 50% Levels and Ambiguity between Quartile Levels



Statement No:- 21

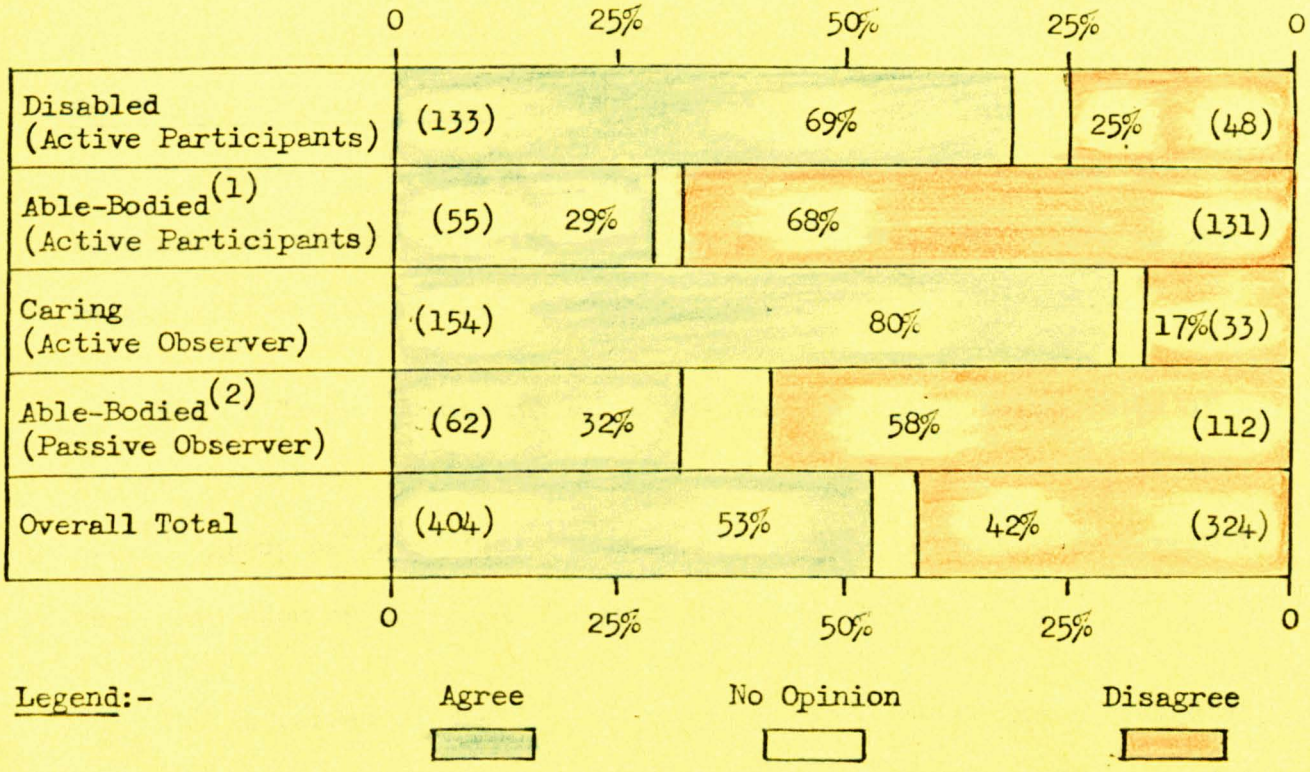
Comparative Agreement between Different Secondary Groups of People



Statement No. 27

Disabled	Since I became disabled, I think that I must "over-educate" myself in order to gain suitable employment.
Able-Bodied(1)	I think that I must "over-educate" myself in order to gain suitable employment.
Caring	The disabled person must "over-educate" himself in order to gain suitable employment.
Able-Bodied(2)	Disabled persons must "over-educate" themselves in order to gain suitable employment.

Table No. 27 (1) — Group Responses to Statement (where each Group Total N = 192 = 100% and Overall Total N = 768 = 100%)



Legend:- Agree | No Opinion | Disagree

Statistical information and graphical representations illustrating the different responses of these main groups are shown after the summary and in Appendix Nos. V and VI.

Statement No. 27

1. Group Responses to Main Statement

See Table 27 (1)

Compared with the able-bodied, the results indicate that a large proportion of the disabled people enjoy fewer equitable opportunities to gain suitable employment. The general view of the disabled concerning the importance of education in enhancing their prospects for gaining employment was endorsed by a larger proportion of those who cared for them but not by the A.B.(2) group whose general opinion was in sharp contrast to the disabled and caring respondents.

A relatively large proportion of the A.B.(1) group indicated that they did not have to "over-educate" themselves in order to gain suitable employment.

2. Answers to Supplementary Questions

See Tables 27 (2) and (3) - (Appendix V)

The table shows that a close relationship existed between the responses of the disabled and caring groups in connection with issues relating to education and employment.

Whilst "over education" was considered by the disabled to be of primary importance to initially obtain a job, many respondents in the A.B.(2) group believed that its main use to the disabled was to permit them a freedom of choice or to gain job satisfaction.

The responses of the A.B.(1) group, in respect of the able-bodied, recognised the importance of education for the purpose of freedom of choice or job satisfaction.

See Tables 27 (4) and (5) - (Appendix V)

Values associated with employment and considered to derive from education were seen by many disabled and caring respondents to be important for personal security and well-being, personal usefulness, social (core) identity and social satisfaction. Values associated with social usefulness and social identity were not seen by the A.B.(2) group to be particularly important to the disabled. A large proportion of the group indicated that personal security and well-being were the most valuable assets provided by education for the disabled in the "work" situation.

The responses of the A.B. (1) group were near to those of the disabled and caring groups.

See Tables 27 (6) and (7) - (Appendix V)

The importance of social identity and social usefulness within the different domains are revealed by the responses of the respective groups. Large proportions of the disabled and caring respondents referred to values associated within the supporting services and outer community. This observation was not reflected by the A.B.(2) group where a large proportion of the respondents believed that values arising from the "education-employment" relationship were primarily concerned within the area of the self.

The responses of the A.B.(1) group were near to those of the disabled and caring groups.

3. Comparative Agreements between Different Secondary Groups

See Table 27 (8) - (Appendix VI)

The table reveals that those who were handicapped by either blindness or multiple sclerosis were particularly concerned about the

need to "over-educate" themselves for employment. Agreement with the opinions of the disabled was evident by the responses of those who cared for them. In some cases, the caring respondents appeared to show a greater awareness of the need for education, particularly those who cared for people handicapped by paraplegia.

The responses of the A.B.(2) group indicated some disagreement with the opinions of the disabled and caring respondents.

Apart from personality factors and environmental conditions, it appeared that the more restrictive the consequences of one's handicap, the more concerned was the individual to "over-educate" himself in order to gain some measure of independence and to compensate for loss of functional abilities within the field of employment, other supporting service and outer community domains.

4. Summary

A very large proportion of the able-bodied seemed unaware of the importance of academic attainment for disabled people. Many did not see that the disabled had few alternatives in employment but with suitable opportunities could substitute mental abilities for restrictive physical skills.

To a large proportion of the disabled and caring groups, work appeared to be valued for personal well-being, personal usefulness, core identity and its intrinsic importance. Apart from the direct benefits for employment, education was also perceived to assist the disabled to adjust more readily to disability.

Objective training and an opportunity to prepare the disabled for potential employment were frequently seen by disabled and caring respondents during the interviews to be an important feature, particularly when inferior self-concepts and restrictive social structure conditions contributed to high unemployment.

Statement No. 27 Main Group Statistical Information

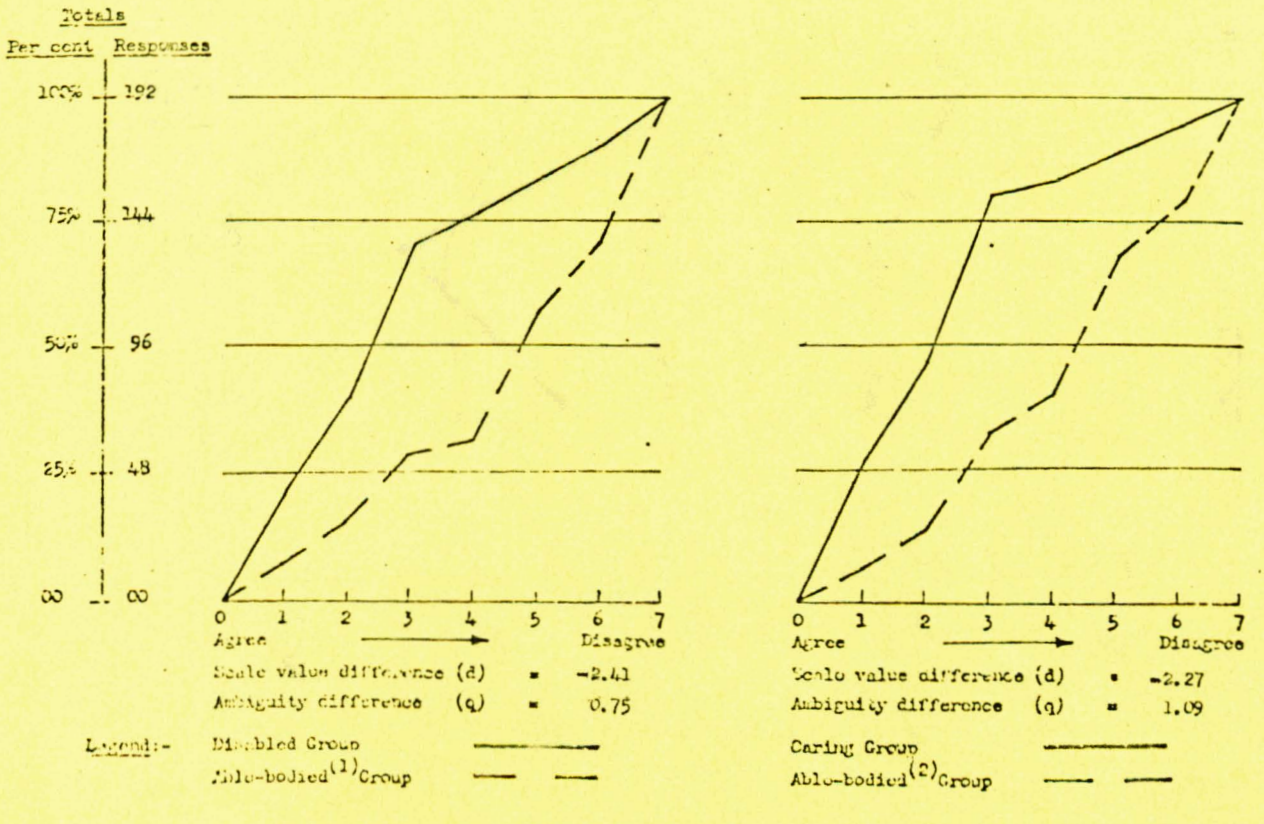
The mean and standard deviation values of the respective groups were:-

	Mean	Standard Deviation
Disabled	3.224	1.878
Able-Bodied(1)	4.865	1.945
Caring	2.807	1.712
Able-Bodied(2)	4.606	1.799

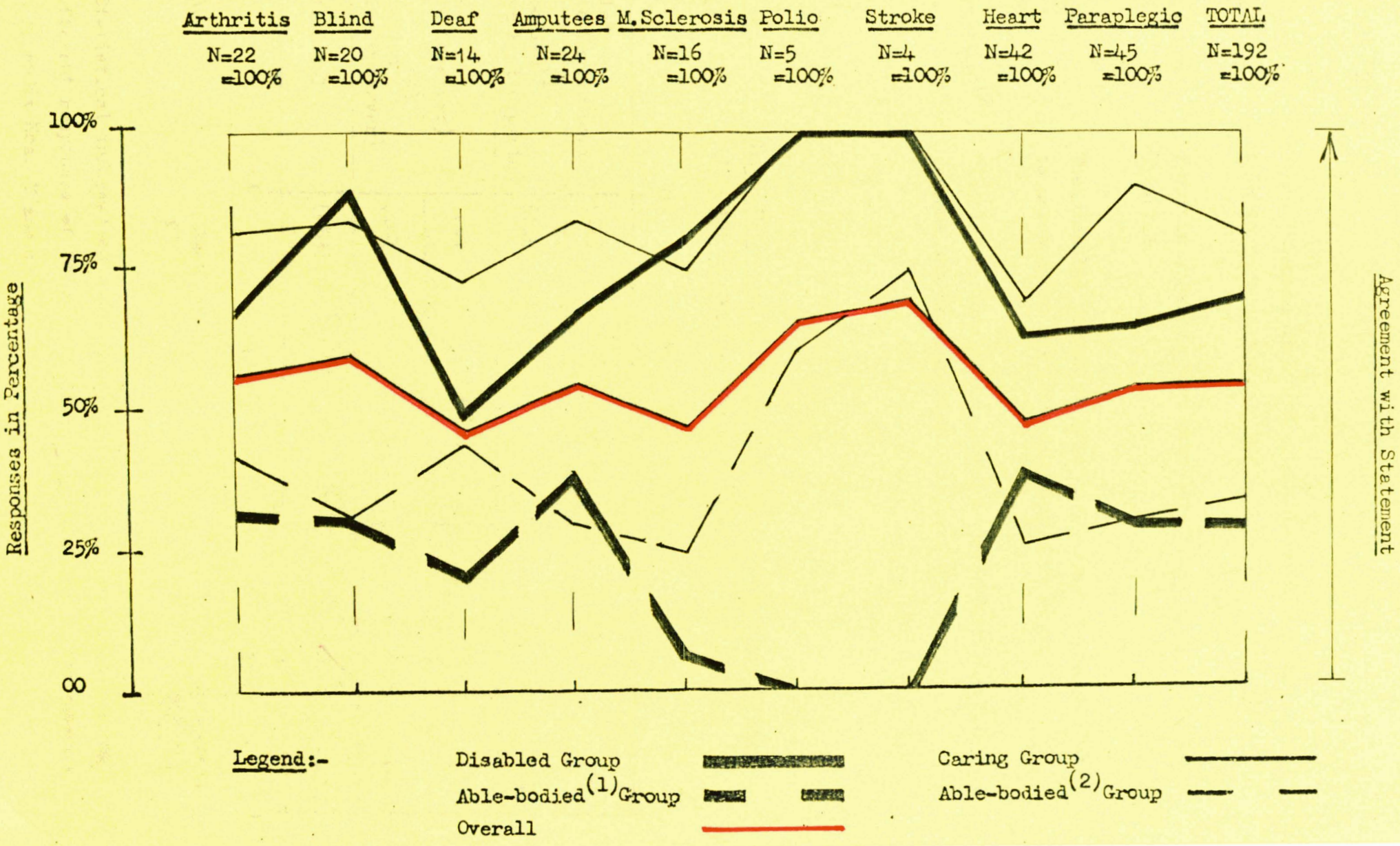
The distribution of the respective groups gave:-

	Scale Value (S) (i.e. 50% level)		Ambiguity (Q) (i.e. Diff. between quartile levels)
Disabled	2.35	Disabled	-2.61
Able-Bodied(1)	4.76	Able-Bodied(1)	-3.36
Group Diff. (d)	-2.41	Group Diff. (d)	0.75
Caring	2.06	Caring	-1.92
Able-Bodied(2)	4.33	Able-Bodied(2)	-3.01
Group Diff. (d)	-2.27	Group Diff. (d)	1.09

Statement No:- 27 Graphical Illustration of Group Differences in Scale Values at 50% Levels and Ambiguity between Quartile Levels



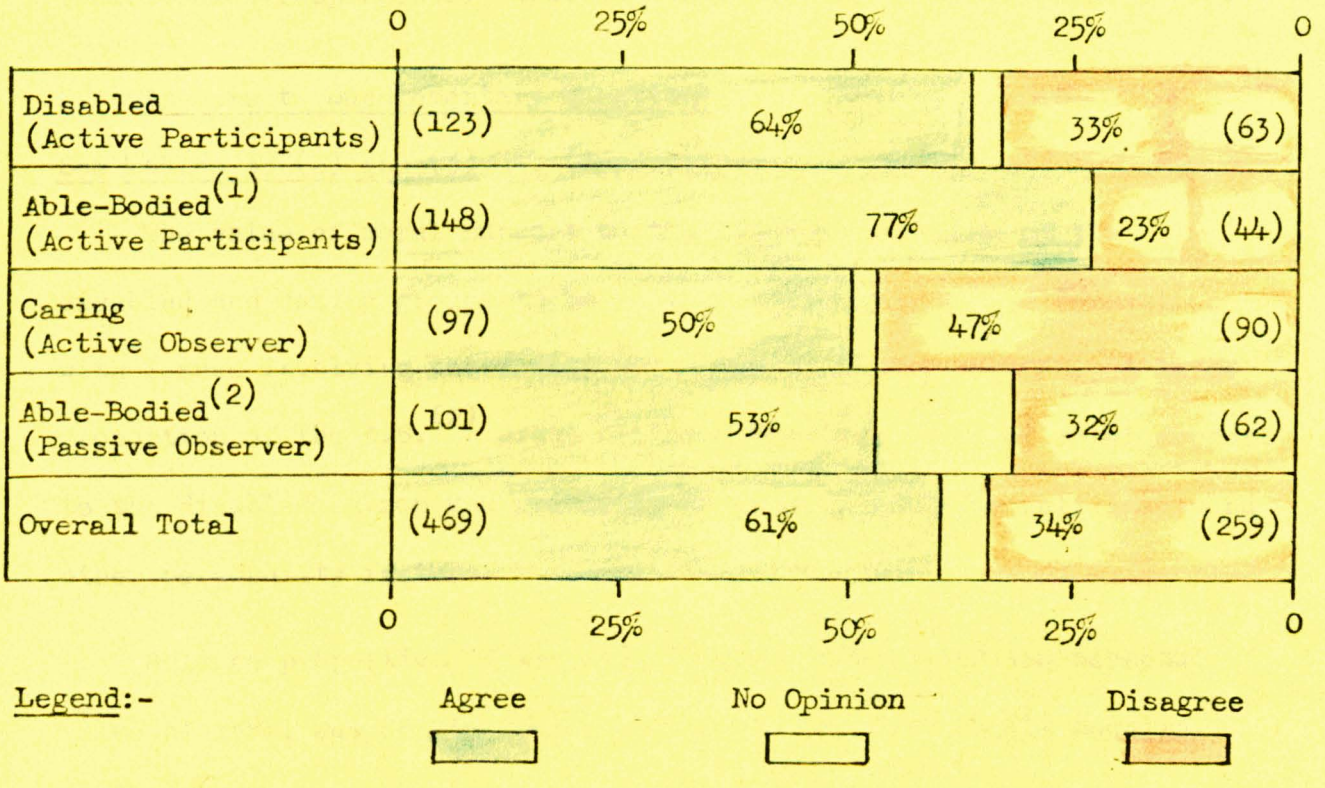
Statement No:- 27 Comparative Agreement between Different Secondary Groups of People



Statement No. 33

Disabled	Since I became disabled, I obtain moral support when I talk to persons who are more disabled than myself.
Able-Bodied(1)	I obtain moral support when I talk to persons who are disabled.
Caring	The disabled person obtains moral support when he talks to persons who are more disabled than himself.
Able-Bodied(2)	Disabled persons obtain moral support when they talk to persons who are more disabled than themselves.

Table No. 33 (1) — Group Responses to Statement (where each Group Total N = 192 = 100% and Overall Total N = 768 = 100%)



Legend:- Agree | No Opinion | Disagree

Statistical information and graphical representations illustrating the different responses of these main groups are shown after the summary and in Appendix Nos. V and VI.

Statement No. 33

1. Group Responses to Main Statement

See Table 33 (1)

The table shows that the majority of respondents obtained some moral support from talking to persons more disabled than themselves. Although about two-thirds of the disabled group considered that they received moral support from people more disabled than themselves, a smaller proportion of those who cared for them agreed with their opinion. One may speculate that the difference in proportions was caused by the caring respondents anticipating to be recognised by the disabled as prime contributors to moral support.

A large proportion of the A.B.(2) group believed that disabled people gained moral support from those more disabled than themselves.

More than three-quarters of the A.B.(1) group indicated that they (able-bodied respondents) received moral support from disabled people.

2. Answers to Supplementary Questions

See Tables 33 (2) and (3) - (Appendix V)

The value of moral support to the disabled was seen by the disabled and caring groups to be particularly important in connection with issues involving the family and outer community sectors. A large proportion of the A.B.(2) group believed that the value of moral support to the disabled person was primarily associated with the self-image and other personality factors.

A large proportion of the A.B.(1) group attributed the personal value of moral support to issues within the self and family domains.

See Tables 33 (4) and (5) - (Appendix V)

These tables refer to issues of importance in relation to the valuation of the individual.

The responses of the disabled and caring groups are seen to be closely related. Large proportions of each group referred to the influence of acceptance of disability by the individual, the family and close friends, and the degree of valuation focussed upon the disabled by the supporting services and outer community. The value of the supporting services and outer community to the disabled did not appear so influential to the A.B.(2) group wherein a very large proportion of the respondents believed that personal acceptance of disability was of primary importance to the disabled.

The responses of the A.B.(1) group in respect of able-bodied people were seen to be near to those of the disabled and caring groups.

3. Comparative Agreements between Different Secondary Groups

See Table 33 (6) - (Appendix VI)

The table indicates that people handicapped by deafness did not obtain the same degree of moral benefit as many people handicapped by other disabilities.

Agreement with those who were handicapped by deafness was particularly evident by the responses of those who cared for them. A large proportion of the caring group indicated that people handicapped by heart troubles gained less moral support from other people than many differently handicapped persons.

Apart from deafness, the responses of the A.B.(2) group indicated a fair measure of agreement with the opinions of the caring respondents.

The overall results seemed to suggest that a greater proportion of people handicapped by progressive disabilities gained more moral support from other disabled than people handicapped by stabilised disabilities. Problems associated with communication were also seen during the interviews to have some considerable influence on the outlook of many disabled.

4. Summary

It frequently appeared during the interviews that following the onset of disability, many disabled and caring respondents were involved with a loss of values which, in turn, were associated primarily with a "mourning" period. During this period, the disabled appeared to concentrate on "loss aspects" which seemed to continue until they reacted positively to re-orientated feelings and to the positive attitude and behaviour of other people.

An influential contributory factor to the re-orientation of feelings and behaviour by the disabled appeared to be the conceptual differences they perceived from other disabled as they realised the potential of their own abilities and assets. This situation tended to be recognised as "consolation by comparison."

It was also noted that in many cases the disabled attributed most of their problems and difficulties to environmental factors whereas respondents in the A.B.(2) group tended to ascribe such problems to the personality of the individual. In coping with disability, the handicapped person appears to become environmentally orientated as he strives to focus and modify his "outer world" more adequately to meet his physical and social needs. On the other hand, the able-bodied person tends to focus on the personality factors of the disabled and their behavioural reaction to the various situations in which they find themselves.

Whilst some handicapped people tended to look at the positive features of their own situation and focus on the negatives of alternative solutions, it was interesting to note during the interviews that a large proportion of the disabled indicated that they did so by believing that their handicap was less serious rather than by an expression of "superiority" over the other disabled person.

Statement No. 33 Main Group Statistical Information

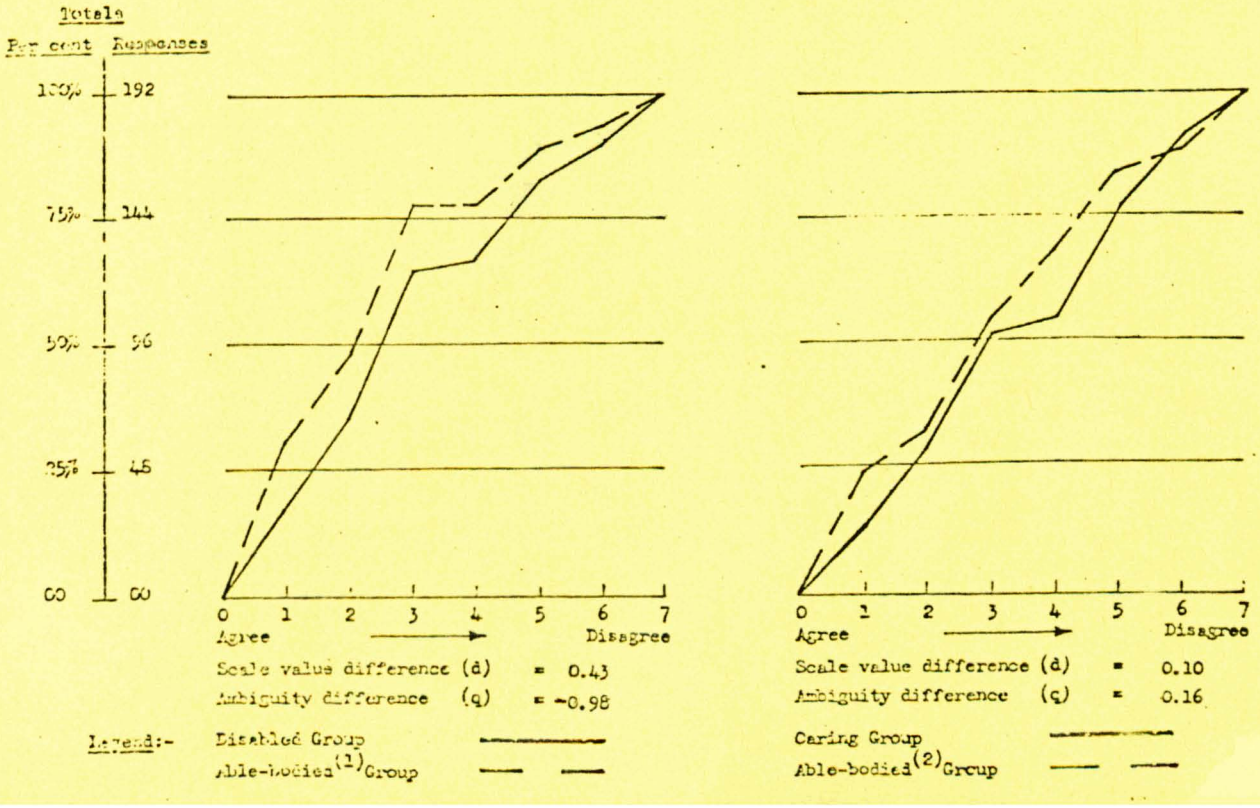
The mean and standard deviation values of the respective groups were:-

	Mean	Standard Deviation
Disabled	3.432	1.866
Able-Bodied(1)	2.833	1.768
Caring	3.890	1.901
Able-Bodied(2)	3.520	1.970

The distribution of the respective groups gave:-

	Scale Value (S) (i.e. 50% level)		Ambiguity (Q) (i.e. Diff. between quartile levels)
Disabled	2.50	Disabled	-3.08
Able-Bodied(1)	2.07	Able-Bodied(1)	-2.10
Group Diff. (d)	0.43	Group Diff. (d)	-0.98
Caring	2.96	Caring	-3.15
Able-Bodied(2)	2.86	Able-Bodied(2)	-3.31
Group Diff. (d)	0.10	Group Diff. (d)	0.16

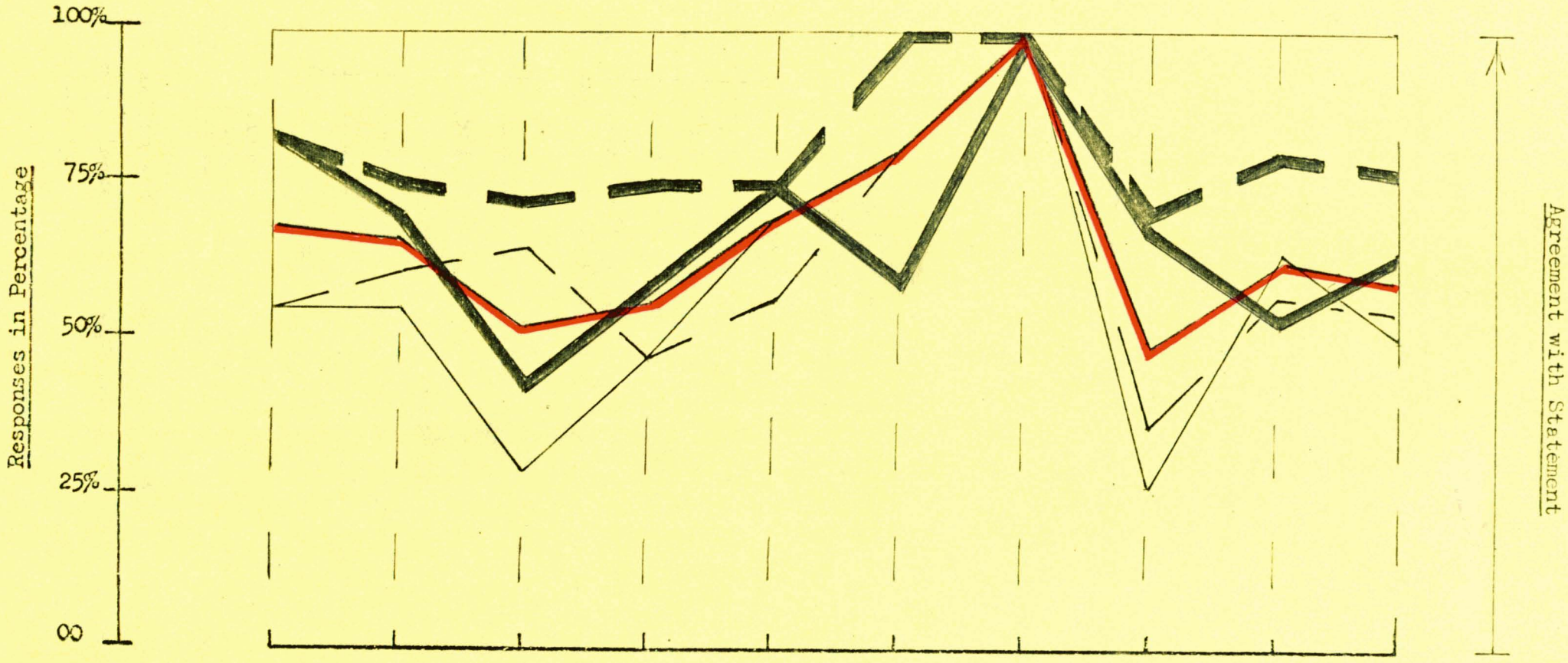
Statement No:- 33 Graphical Illustration of Group Differences in Scale Values at 50% Levels and Ambiguity between Quartile Levels



Statement No:- 33

Comparative Agreement between Different Secondary Groups of People

Arthritis	Blind	Deaf	Amputees	M.Sclerosis	Polio	Stroke	Heart	Paraplegic	TOTAL
N=22 =100%	N=20 =100%	N=14 =100%	N=24 =100%	N=16 =100%	N=5 =100%	N=4 =100%	N=42 =100%	N=45 =100%	N=192 =100%



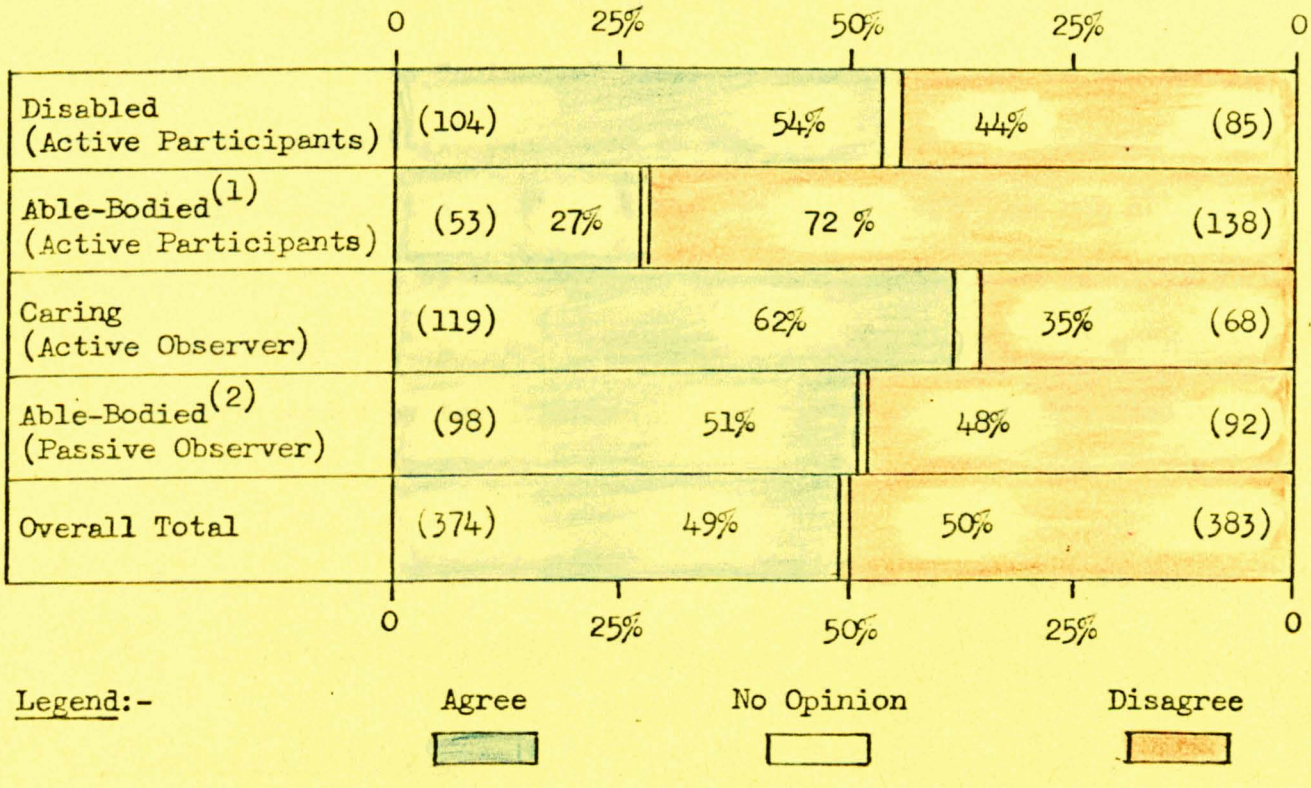
Legend:-

- Disabled Group
- Able-bodied (1) Group
- Overall
- Caring Group
- Able-bodied (2) Group

Statement No. 40

Disabled	Since I became disabled, I often feel that I am considered a nuisance when I participate in society.
Able-Bodied(1)	I often feel that I am considered a nuisance when I participate in society.
Caring	The disabled person is often considered a nuisance when he participates in society.
Able-Bodied(2)	Disabled persons are often considered a nuisance when they participate in society.

Table No. 40 (1) — Group Responses to Statement (where each Group Total N = 192 = 100% and Overall Total N = 768 = 100%)



Legend:- Agree | No Opinion | Disagree

Statistical information and graphical representations illustrating the different responses of these main groups are shown after the summary and in Appendix Nos. V and VI.

Statement No. 40

1. Group Responses to Main Statement

See Table 40 (1)

More than one-half of the disabled group indicated that they often felt that they were considered a nuisance in society. A large proportion of the caring respondents expressed agreement with the disabled. About one-half of the A.B.(2) group agreed with the opinions of the disabled and caring groups.

Responses from the A.B.(1) group indicated clearly that these respondents seldom felt that they were considered a nuisance in society.

2. Answers to Supplementary Questions

See Tables 40 (2) and (3) - (Appendix V)

Large proportions of the disabled and caring groups referred to the prevalence of the "nuisance" label to disabled people in the domain of the outer community. Responses in the A.B.(2) group indicated that social behaviour to the disabledin the outer community was not as stressful as implied by the disabled and caring groups. A relatively large proportion of the A.B.(2) group believed that much of the "nuisance" factor experienced by the disabled was encountered within the family sector.

The responses of the A.B.(1) group were seen to be near to those of the disabled and caring respondents.

See Tables 40 (4) and (5) - (Appendix V)

The reaction of the disabled and caring respondents pointed to the importance of the able-bodied to have a good understanding of the needs of the disabled in relation to social problems and to treat the disabled

as responsible persons. A large proportion of the A.B.(2) group thought that issues associated with access and general mobility problems were the primary causes of the "nuisance" label often attached to disabled people.

In connection with the able-bodied, a large proportion of respondents in the A.B.(1) group referred to the influence of issues involved with social problems.

3. Comparative Agreements between Different Secondary Groups

See Table 40 (6) - (Appendix VI)

The responses indicated that those who suffered from deafness, multiple sclerosis or paraplegia tended to feel that they were a bigger nuisance in society than those who were handicapped by other disabilities.

The responses of those who cared for people handicapped by arthritis, blindness, multiple sclerosis or paraplegia indicated particularly that disabled people were often considered a nuisance in society. The responses of the A.B.(2) group were frequently different from those of the disabled and caring groups.

Apart from issues concerned with co-operative assistance and personal involvement within society, it appeared that the physical attraction and personality of many disabled people were also influential factors in determining the reaction of able-bodied people.

4. Summary

The results indicate that any major physical disability is accompanied by a multitude of problems for the disabled person.

Apart from medical aspects of the disability, the disabled person must also cope with social problems arising from endeavours made to integrate into the outer community.

It was evident that problems involving the loss of psychological security, abilities and skills, communication and information, occupational and financial status, and personality organisation, absorbed time, money, space and labour.

Differences between corresponding views of the disabled and caring groups in relation to social behaviour seemed in some cases to arise because the caring person, as an active observer, frequently possessed a greater opportunity to perceive social reaction on a broader front than many disabled people who, as active participants, were more involved in face-to-face contacts and situations.

Statement No. 40 Main Group Statistical Information

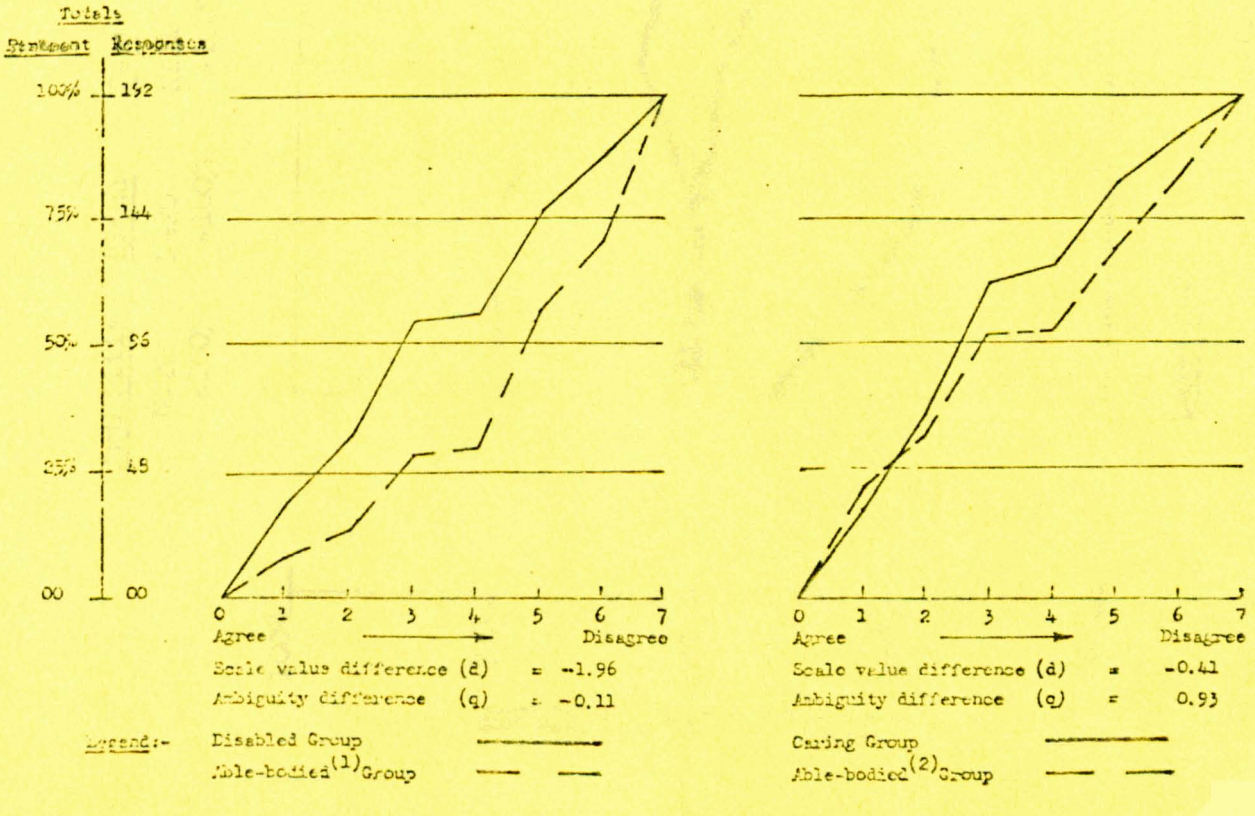
The mean and standard deviation values of the respective groups were:-

	Mean	Standard Deviation
Disabled	3.771	2.041
Able-Bodied(1)	4.990	1.884
Caring	3.453	1.886
Able-Bodied(2)	3.932	2.192

The distribution of the respective groups gave:-

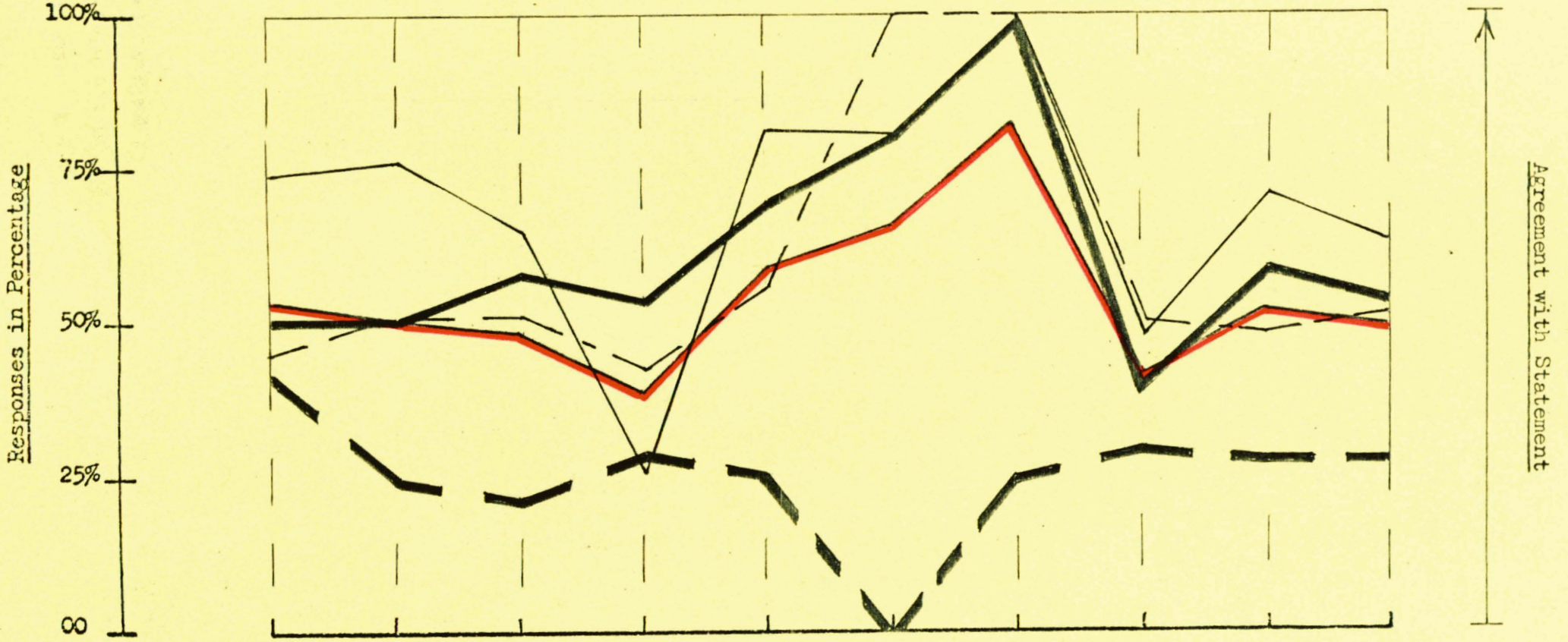
	Scale Value (S) (i.e. 50% levels)		Ambiguity (Q) (i.e. Diff. between quartile levels)
Disabled	2.82	Disabled	-3.45
Able-Bodied(1)	4.78	Able-Bodied(1)	-3.34
Group Diff. (d)	-1.96	Group Diff. (d)	-0.11
Caring	2.54	Caring	-3.17
Able-Bodied(2)	2.95	Able-Bodied(2)	-4.10
Group Diff. (d)	-0.41	Group Diff. (d)	0.93

Statement No:- 40 Graphical Illustration of Group Differences in Scale Values at 50% Levels and Ambiguity between Quartile Levels



Statement No:- 40 Comparative Agreement between Different Secondary Groups of People

Arthritis	Blind	Deaf	Amputees	M.Sclerosis	Polio	Stroke	Heart	Paraplegic	TOTAL
N=22 =100%	N=20 =100%	N=14 =100%	N=24 =100%	N=16 =100%	N=5 =100%	N=4 =100%	N=42 =100%	N=45 =100%	N=192 =100%



Legend:-

Disabled Group

Able-bodied(1) Group

Overall

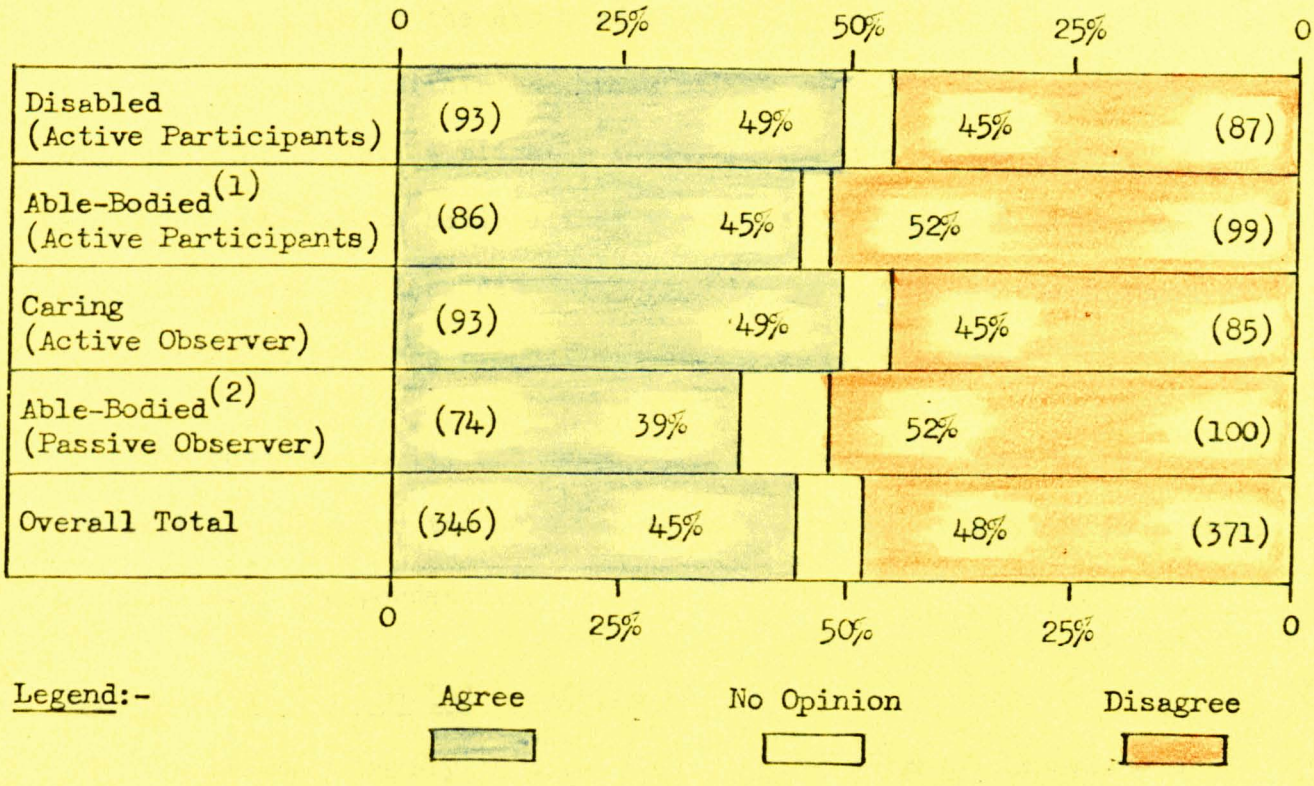
Caring Group

Able-bodied(2) Group

Statement No. 47

Disabled	My family and close friends would describe me as a demanding type of person since I became disabled.
Able-Bodied(1)	My family and close friends would describe me as a demanding type of person.
Caring	The family and close friends of the disabled person would describe him as a demanding type of person since he became disabled.
Able-Bodied(2)	Disabled persons are of a demanding nature.

Table No. 47 (1) — Group Responses to Statement (where each Group Total N = 192 = 100% and Overall Total N = 768 = 100%)



Legend:- Agree | No Opinion | Disagree

Statistical information and graphical representations illustrating the different responses of these main groups are shown after the summary and in Appendix Nos. V and VI.

Statement No. 47

1. Group Responses to Main Statement

See Table 47 (1)

The table indicates that a slightly larger proportion of each of the disabled and caring groups considered that the disabled were demanding in their nature. The responses of the A.B.(2) group suggested that the disabled were less demanding than indicated by the disabled and caring respondents.

In connection with able-bodied people, the responses of the A.B.(1) group were seen to be near to those of the A.B.(2) group.

2. Answers to Supplementary Questions

See Tables 47 (2) and (3) - (Appendix V)

The responses of the disabled group indicated that the disabled were more demanding within the areas of the self and outer community than in other areas. A slightly larger proportion of the caring respondents tended to believe that the disabled were more demanding in the family area and less demanding upon the self; issues which appeared to be endorsed by large proportions of the A.B.(2) group.

The outer community and supporting services were seen to be influential areas for the able-bodied as indicated by a large proportion of the A.B.(1) respondents.

See Tables 47 (4) and (5) - (Appendix V)

Issues which mainly contributed to the "demanding" reactions of the disabled were seen by large proportions of the disabled and caring respondents to be involved with social relations and integration.

A smaller proportion of the A.B.(2) group referred to the influence of these issues in the behaviour of the disabled whilst a larger proportion pointed to the provision of personal needs and aids for the disabled.

The responses of the A.B.(1) group were relatively near to those of the disabled group.

3. Comparative Agreements between Different Secondary Groups

See Table 47 (6) - (Appendix VI)

The results show that those who were handicapped by blindness or multiple sclerosis tended to be more demanding than people handicapped by other disabilities, particularly those who were handicapped by deafness. The people who cared for those handicapped by blindness or multiple sclerosis expressed similar opinions.

The responses of the A.B.(2) group were seen to differ frequently from those of the disabled and caring groups.

It appeared that the restrictive nature of certain disabilities contributed to the demanding behavioural reaction of many disabled people.

4. Summary

The results appeared to indicate that much of the demanding nature of many disabled people arises from their endeavours to solve problems emanating from physical handicap, particularly those associated with social integration. A mutual understanding of the difficulties and circumstances involved with the individual roles of both the disabled and able-bodied seemed to many respondents during the interview to be an essential factor in preventing situations which tend to lead

to adverse consequences in the social relationships. It was also apparent during the interviews that the more intimate a person was with his social environment, the greater was his opportunity for self expression and the less his need for "role playing" attributes; issues which frequently appeared to interfere with the integrity of a social relationship.

Some evidence during the interviews indicated that many disabled are more tolerant of the short-comings of society than many able-bodied. Although familiarity may have tended to reduce aversion and induce liking, the occupation of "time", "space" and problems involved with communication seemed to have serious consequences for many handicapped people.

Statement No. 47 Main Group Statistical Information

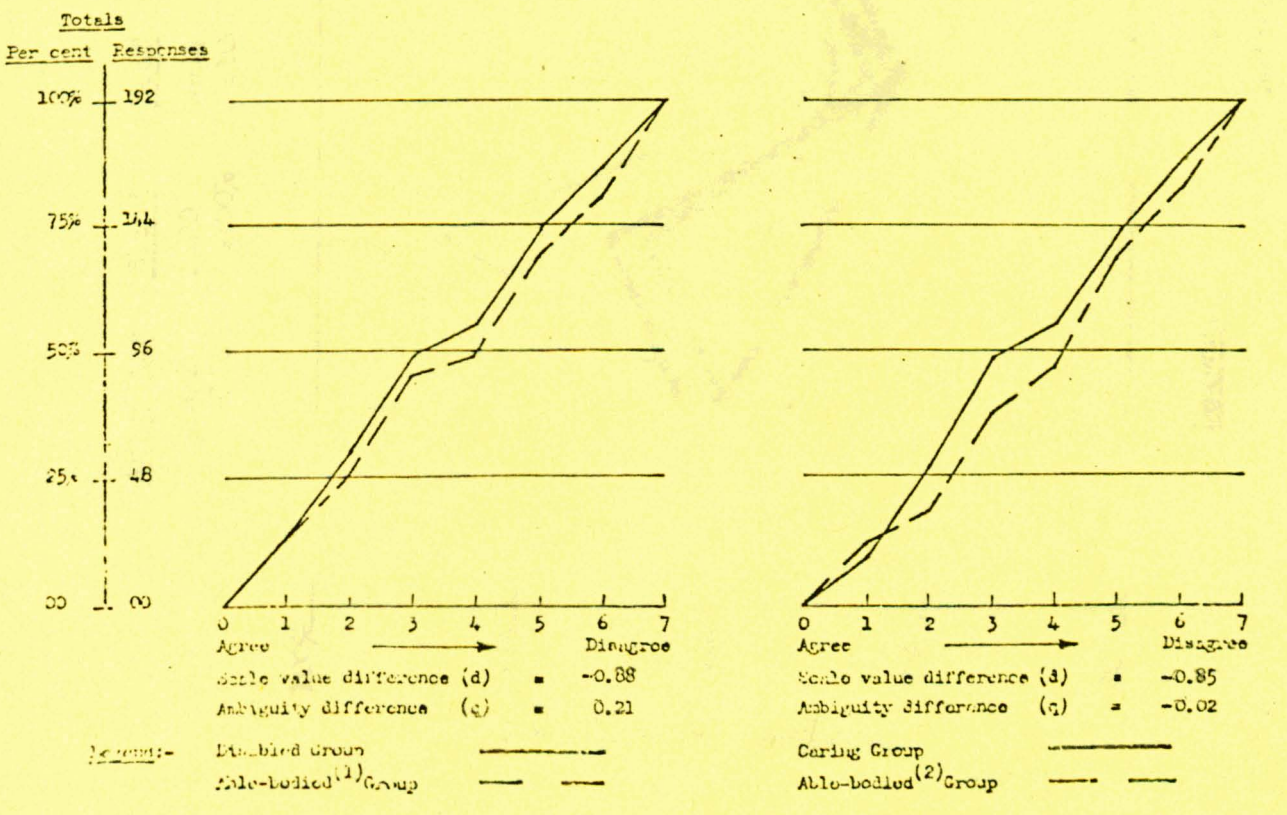
The mean and standard deviation values of the respective groups were:-

	Mean	Standard Deviation
Disabled	3.953	1.974
Able-Bodied(1)	4.203	2.073
Caring	3.958	1.878
Able-Bodied(2)	4.276	1.955

The distribution of the respective groups gave:-

	Scale Value (S) (i.e. 50% levels)		Ambiguity (Q) (i.e. Diff. between quartile levels)
Disabled	3.17	Disabled	-3.33
Able-Bodied(1)	4.05	Able-Bodied(1)	-3.54
Group Diff. (d)	-0.88	Group Diff. (d)	0.21
Caring	3.29	Caring	-3.13
Able-Bodied(2)	4.14	Able-Bodied(2)	-3.11
Group Diff. (d)	-0.85	Group Diff. (d)	-0.02

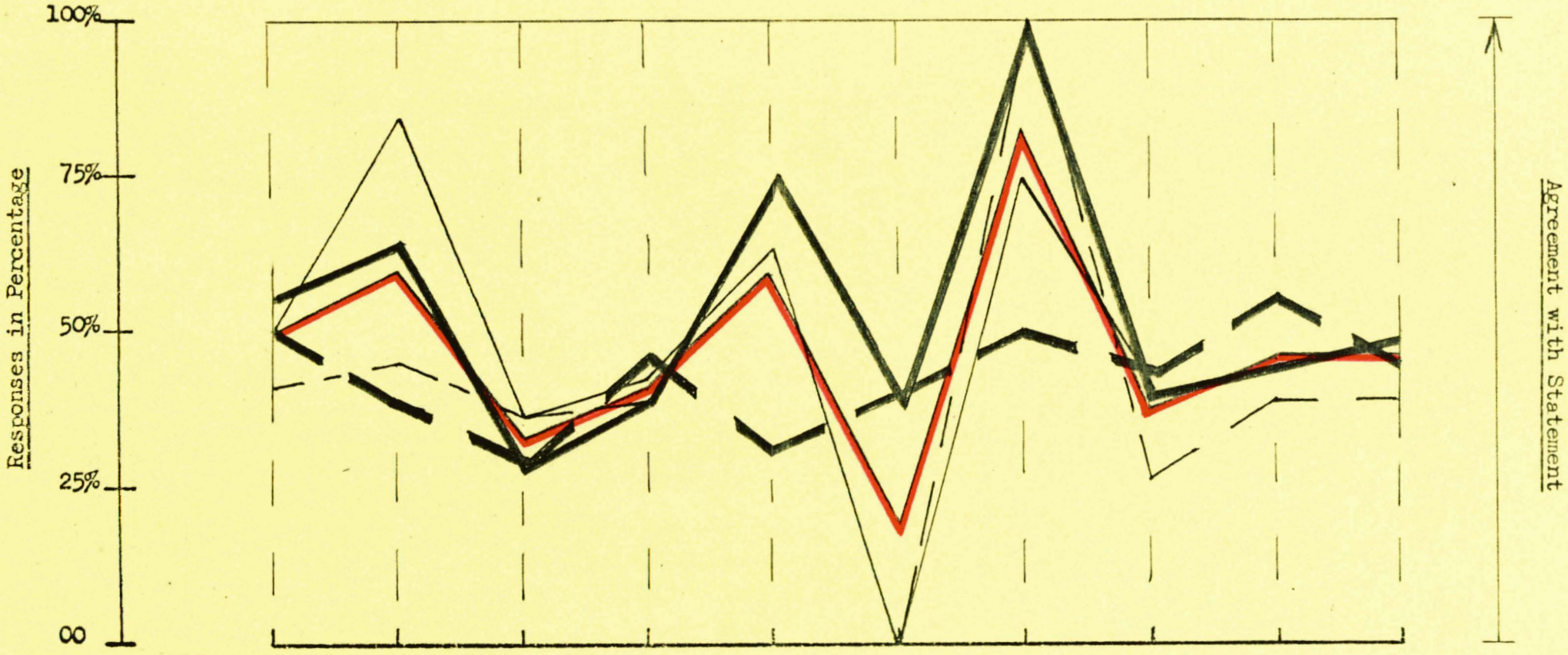
Statement No:- 47 Graphical Illustration of Group Differences in Scale Values at 50% Levels and Ambiguity between Quartile Levels



Statement No:- 47

Comparative Agreement between Different Secondary Groups of People

Arthritis	Blind	Deaf	Amputees	M.Sclerosis	Polio	Stroke	Heart	Paraplegic	TOTAL
N=22 =100%	N=20 =100%	N=14 =100%	N=24 =100%	N=16 =100%	N=5 =100%	N=4 =100%	N=42 =100%	N=45 =100%	N=192 =100%



Legend:-

Disabled Group

Able-bodied (1) Group

Overall

Caring Group

Able-bodied (2) Group

Statement No. 49

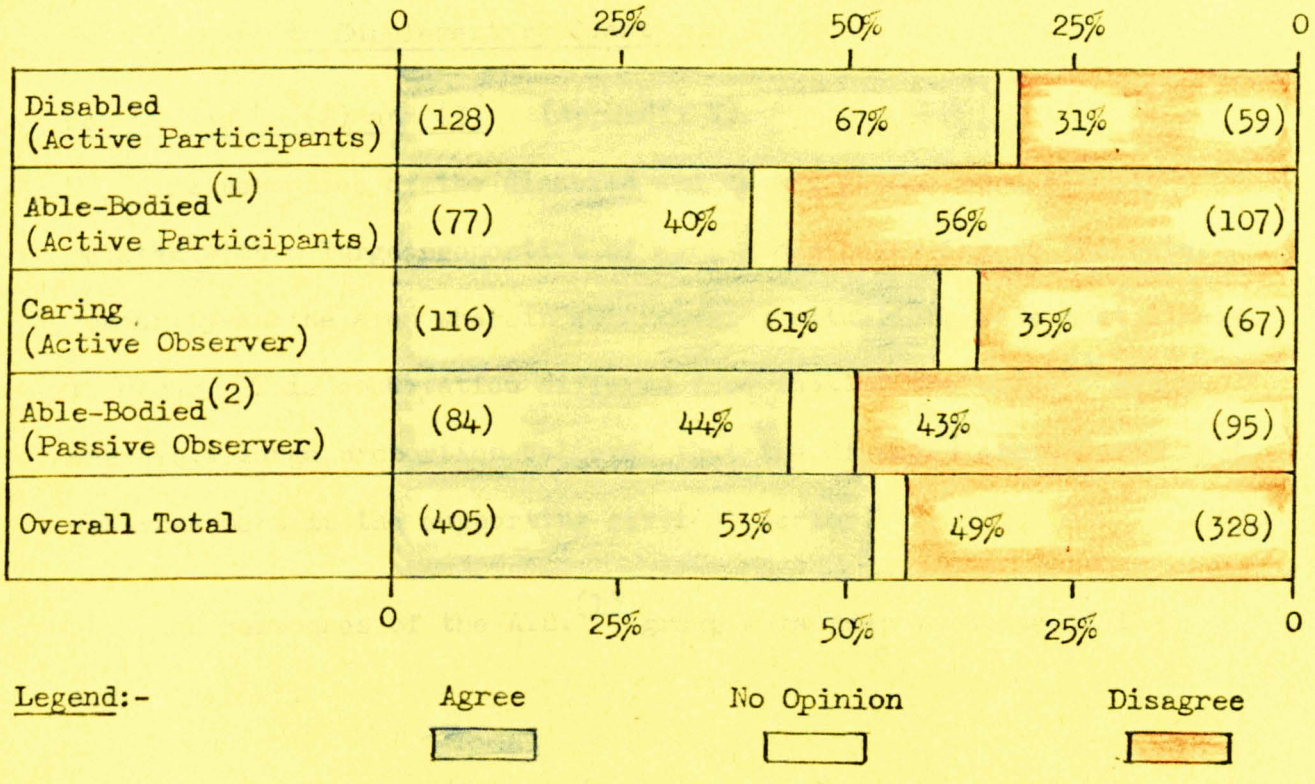
Disabled — When I am questioned about the effects of my disability, I seldom tell the truth if I feel that it might cause embarrassment.

Able-Bodied(1) — When I am questioned about the effects of my physical limitations, I seldom tell the truth if I feel that it might cause embarrassment.

Caring — When questioned about the effects of his disability, the disabled person seldom tells the truth if he feels that it might cause embarrassment.

Able-Bodied(2) — When questioned about the effects of their disability, disabled persons seldom tell the truth.

Table No. 49 (1) — Group Responses to Statement (where each Group Total N = 192 = 100% and Overall Total N = 768 = 100%)



Legend:- Agree — No Opinion — Disagree

Statistical information and graphical representations illustrating the different responses of these main groups are shown after the summary and in Appendix Nos. V and VI.

Statement No. 49

1. Group Responses to Main Statement

See Table 49 (1)

The table indicates that the behaviour of the disabled and able-bodied differed when communicating about their personal limitations. According to the responses of the disabled and caring groups, the presence of embarrassment has a deterring effect on a large proportion of disabled people when they are questioned about their disabilities. This general view is not seen to have been perceived by a large proportion of the A.B.(2) group.

Respondents in the A.B.(1) group did not appear to be so concerned about the effects of their personal limitations.

2. Answers to Supplementary Questions

See Tables 49 (2) and (3) - (Appendix V)

The responses of the disabled and caring groups were closely related with a large proportion of each group referring to the outer community as the area wherein embarrassing situations were most likely to occur. This observation differed from that of the A.B.(2) group wherein a large proportion believed that the disabled encountered most embarrassment in the supporting services sector.

The responses of the A.B.(1) group were near to those of the A.B.(2) group.

See Tables 49 (4) and (5) - (Appendix V)

The table indicates that a close relationship occurred between the disabled and caring groups in connection with issues which were considered to have an important influence in the embarrassment situation.

Respondents in the A.B.(2) group generally viewed these factors with different degrees of importance. It appeared from the relevant responses that the disabled were more understanding and generous in their approach to the effects of disability than recognised by a large proportion of respondents in the A.B.(2) group.

The responses of the A.B.(1) group indicated that sincerity and honesty were particularly influential aspects in their personal reaction to the situation.

3. Comparative Agreements between Different Secondary Groups

See Table 49 (6) - (Appendix VI)

The responses in the table indicate that those who were handicapped by arthritis or multiple sclerosis were more likely to avoid the truth about their disabilities than those people who were handicapped by deafness or visual handicap. Full agreement with these opinions was not evident in the responses of those who cared for them. The visually handicapped and those handicapped by paraplegia were, in the opinions of the caring, more likely to avoid the truth than those handicapped by other disabilities.

The responses of the A.B.(2) group were seen frequently to be different from those of the disabled and caring groups.

Physical perception and a person's attitude toward his disability appeared to be important factors in influencing the behavioural response of both disabled and able-bodied in the "disabled" situation.

4. Summary

The overall results suggest that when people deviate from what is generally perceived to be the "norm", they tend to protect

themselves by dissociating themselves from the difference. Behavioural reaction in such situations appears to be primarily concerned with ensuring that the focus of objectivity is moved away from the self.

Compared with pre-disability views, disability was seen during the interviews to have had an adverse effect on the self-esteem, particularly in relation to the objective self-image. Good adjustment appeared to depend largely upon the disabled person's realistic evaluation of the disability and his potential assets, and the attitudes and behavioural reaction of people within the family, supporting services and outer community domains.

It was also noted during the interviews that a large proportion of the disabled who held social responsibilities tended to "define away" any symptom which could be interpreted as a deterioration of their self-concept or responsibilities.

Statement No. 49 Main Group Statistical Information

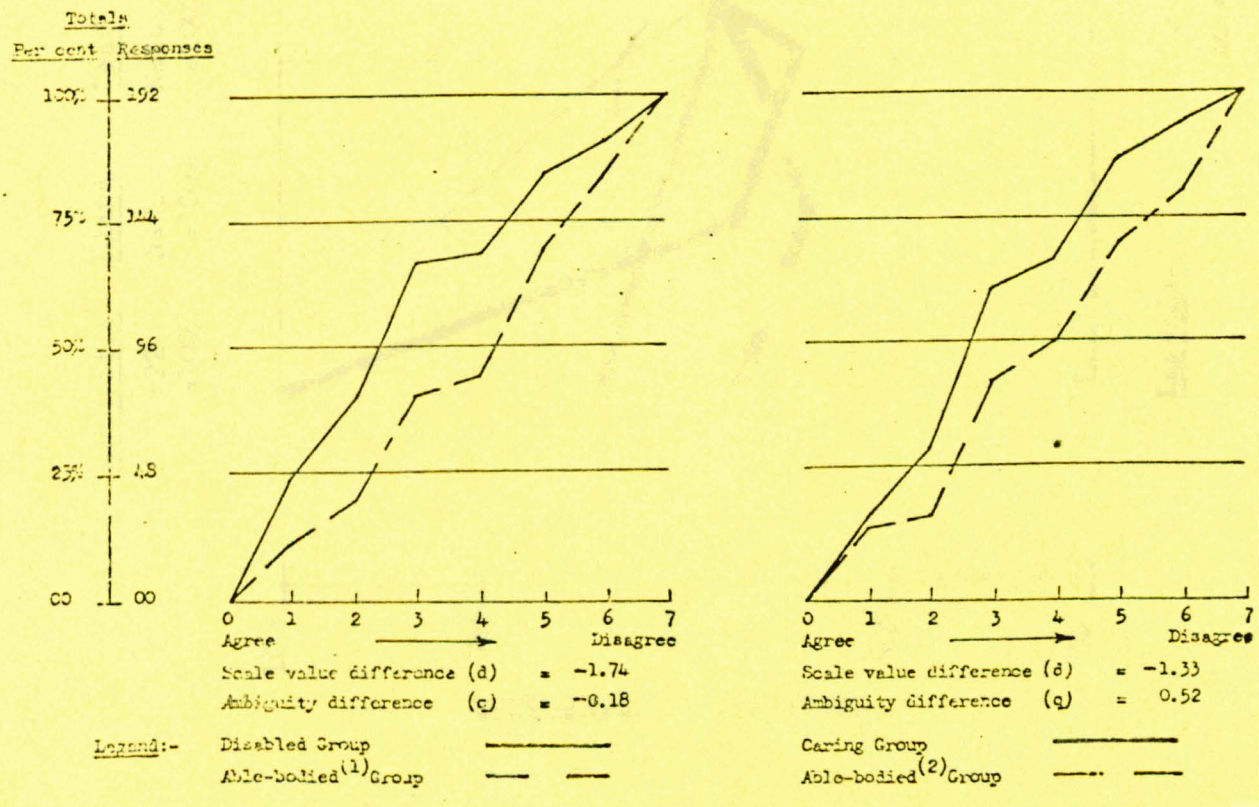
The mean and standard deviation values of the respective groups were:-

	Mean	Standard Deviation
Disabled	3.240	1.908
Able-Bodied(1)	4.313	1.930
Caring	3.515	1.712
Able-Bodied(2)	4.239	1.990

The distribution of the respective groups gave:-

	Scale Value (S) (i.e. 50% levels)		Ambiguity (Q) (i.e. Diff. between quartile levels)
Disabled	2.35	Disabled	-3.29
Able-Bodied(1)	4.09	Able-Bodied(1)	-3.11
Group Diff. (d)	-1.74	Group Diff. (d)	-0.18
Caring	2.67	Caring	-2.65
Able-Bodied(2)	4.00	Able-Bodied(2)	-3.17
Group Diff. (d)	-1.33	Group Diff. (d)	0.52

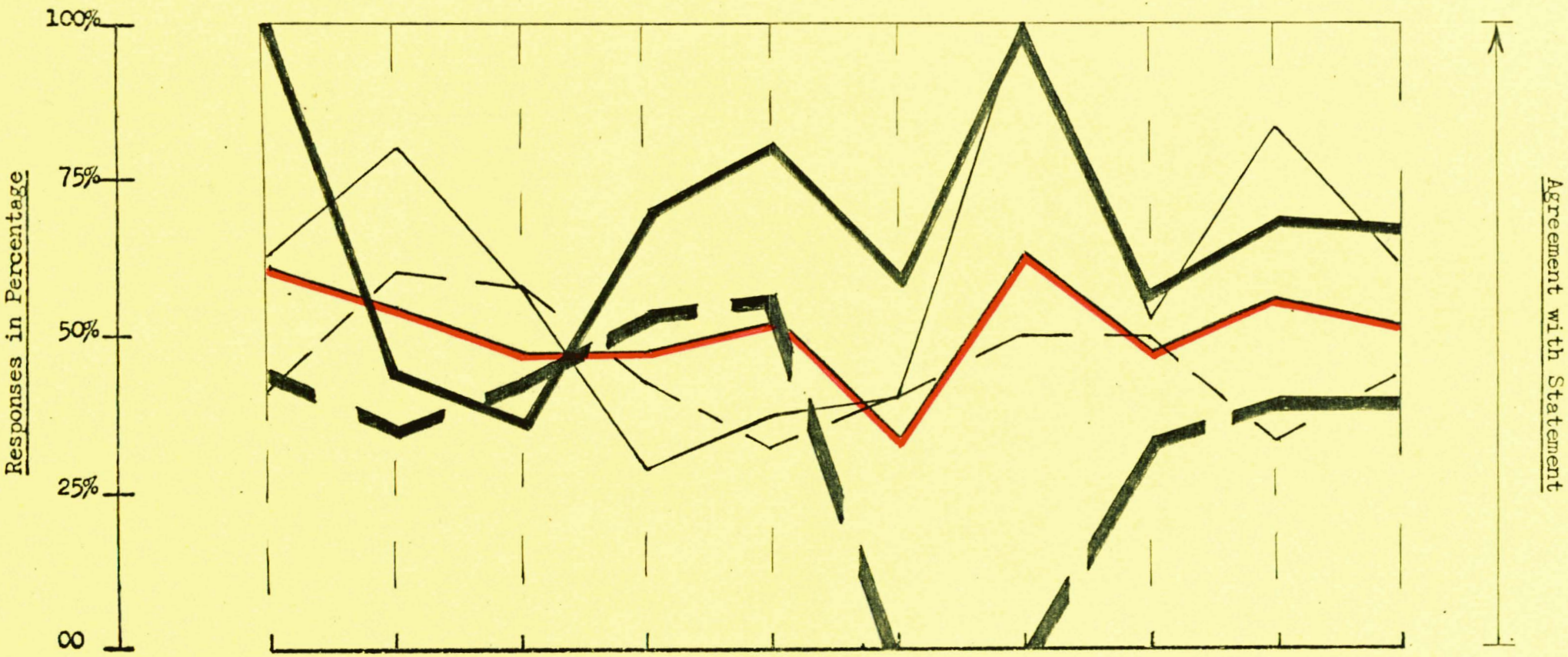
Statement No:- 49 Graphical Illustration of Group Differences in Scale Values at 50% Levels and Ambiguity between Quartile Levels



Statement No:- 49

Comparative Agreement between Different Secondary Groups of People

Arthritis	Blind	Deaf	Amputees	M.Sclerosis	Polio	Stroke	Heart	Paraplegic	TOTAL
N=22 =100%	N=20 =100%	N=14 =100%	N=24 =100%	N=16 =100%	N=5 =100%	N=4 =100%	N=42 =100%	N=45 =100%	N=192 =100%



Statement No. 50

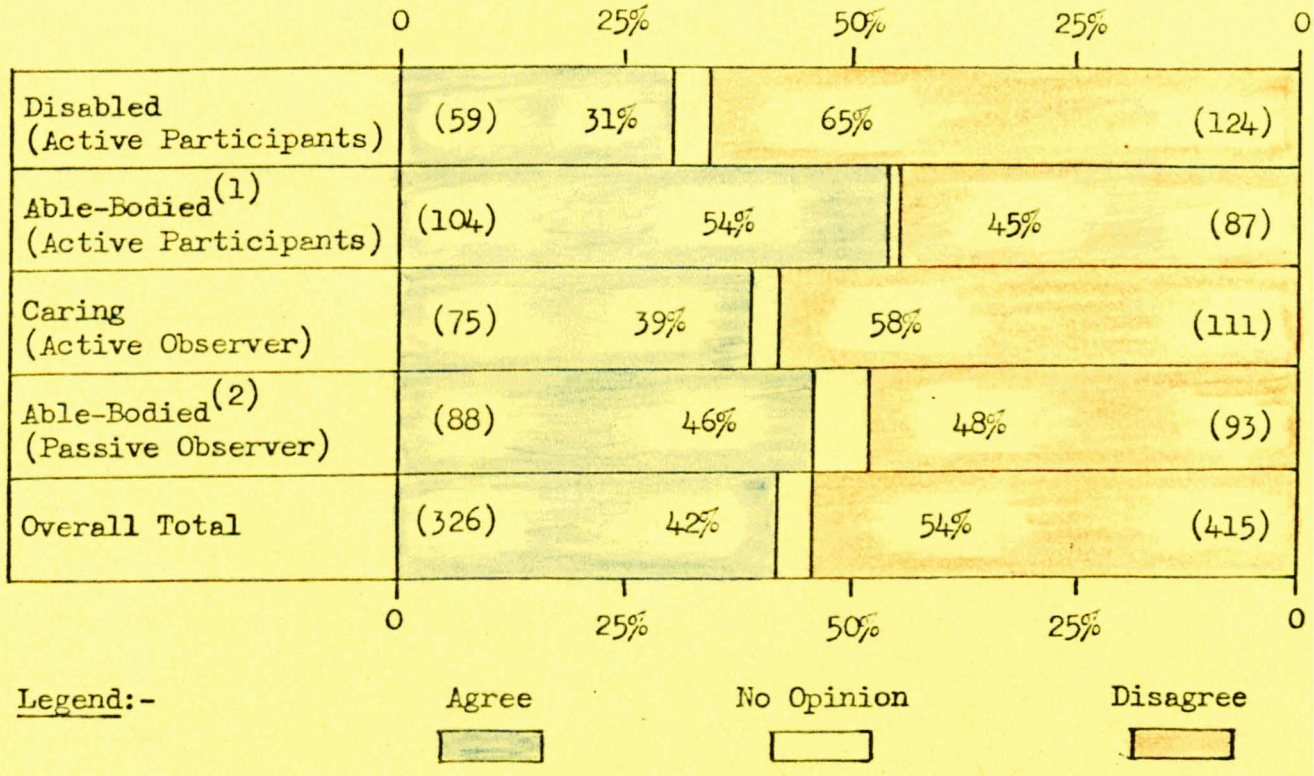
Disabled — Since I became disabled, I seldom make an attempt to do something when I think that success is unlikely.

Able-Bodied(1) — I seldom make an attempt to do something when I think that success is unlikely.

Caring — The disabled person seldom makes an attempt to do something when he thinks that success is unlikely.

Able-Bodied(2) — Disabled persons seldom make an attempt to do something when they think that success is unlikely.

Table No. 50 (1) — Group Responses to Statement (where each Group Total N = 192 = 100% and Overall Total N = 768 = 100%)



Legend:- Agree — No Opinion — Disagree

Statistical information and graphical representations illustrating the different responses of these main groups are shown after the summary and in Appendix Nos. V and VI.

Statement No. 50

1. Responses to Main Statement

See Table 50 (1)

About two-thirds of the disabled group considered that they often attempted to do something despite the probability of failure. Although agreement with this general view was provided by a large proportion of caring respondents, the number of respondents in the A.B.(2) group who subscribed to the view was much smaller.

The majority of respondents in the A.B.(1) group indicated that they seldom attempted to do something when success was unlikely.

2. Answers to Supplementary Questions

See Tables 50 (2) and (3) - (Appendix V)

The responses of the disabled and caring groups were closely related with a relatively large proportion of each group referring to the importance of the self in dealing with unknown situations. In the general opinion of the A.B.(2) group respondents, the self was the least influential area in respect of the disabled; large proportions of the group referring to the importance of the supporting services and family sectors.

The responses of the A.B.(1) group were seen to be relatively close to those of the disabled and caring groups.

See Tables 50 (4) and (5) - (Appendix V)

The table indicates that large proportions of the disabled and caring groups considered issues involving self-devaluation and social values were of considerable influence on the disabled when they were

confronted with unknown situations. A large proportion of the A.B.(2) group believed that materialistic values were more important to the disabled.

A large proportion of the respondents in the A.B.(1) group indicated that materialistic values were more important to them than other values associated with the self and society.

3. Comparative Agreements between Different Secondary Groups

See Table 50 (6) - (Appendix VI)

The table indicates that those who were handicapped by deafness were less likely to attempt something when there was a probability of failure than those who were handicapped by either blindness or amputations. Agreement with the opinions of the deaf was indicated by a large proportion of those who cared for them.

Responses of the A.B.(2) group frequently differed from those of the disabled and caring respondents.

Limitations in the freedom of choice seemed to produce a more positive reaction from many people. It also seemed that there were differences not only between individuals but also between the ways in which disabled people reacted to disabling functions and abilities.

4. Summary

The responses of the disabled and able-bodied indicated that when confronted with a small number of options, people tend to accept a challenge more positively. The predominating environmental and cultural values were seen by many respondents to be an important influential factor in making decisions.

Beliefs about the behavioural reaction of people were seen during the interview to have a tendency to change as a result of personal experiences. Consequently, it sometimes appeared that some people who enjoy many alternatives tend to mis-judge the reaction to challenge of people whose choice is limited.

Although it was evident from the responses of the disabled and caring respondents during the interview that physical restrictions often cause a feeling of personal inferiority, it was apparent that the disabled adjusted more easily when they were well motivated and expected to succeed or were positively supported by the supporting services and the outer community in their expectancy.

Statement No. 50 Main Group Statistical Information

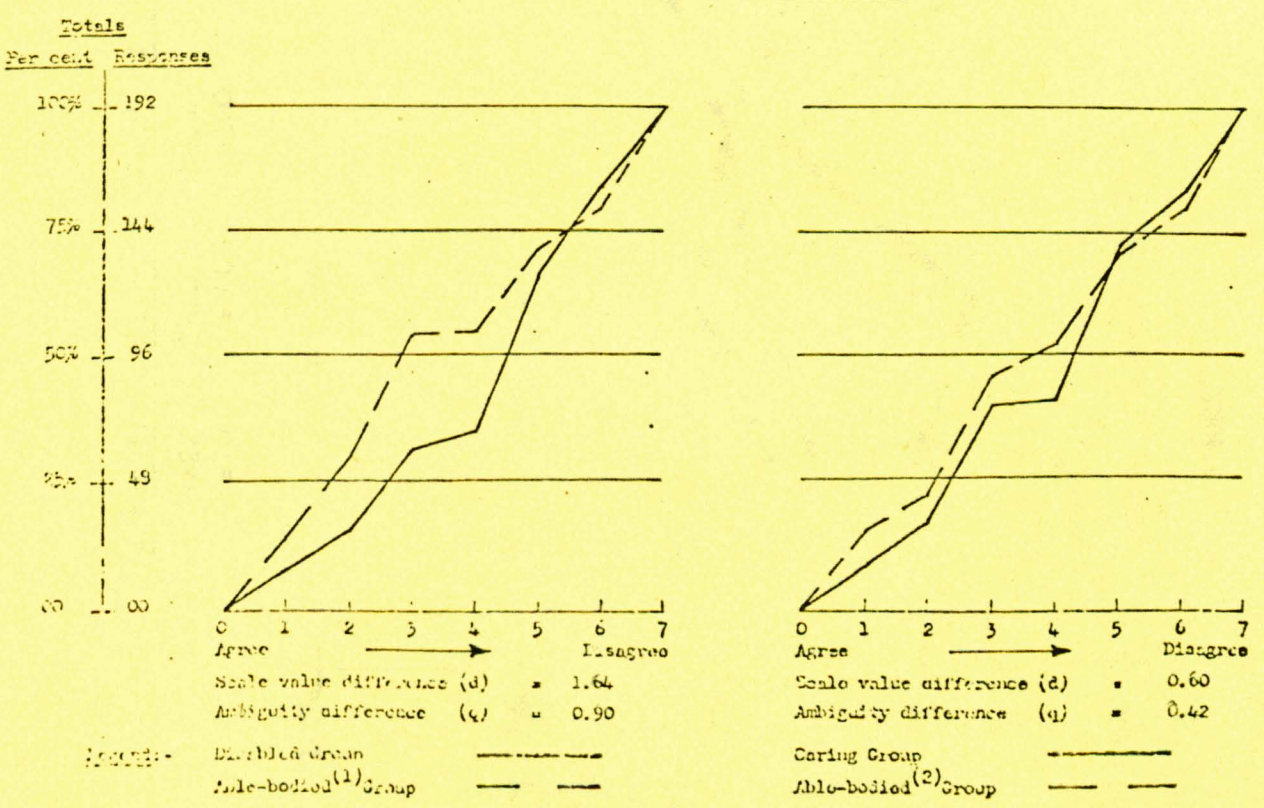
The mean and standard deviation values of the respective groups were:-

	Mean	Standard Deviation
Disabled	4.630	1.777
Able-Bodied(1)	3.984	2.118
Caring	4.371	1.818
Able-Bodied(2)	4.140	2.055

The distribution of the respective groups gave:-

	Scale Value (S) (i.e. 50% levels)		Ambiguity (Q) (i.e. Diff. between quartile levels)
Disabled	4.48	Disabled	-2.85
Able-Bodied(1)	2.84	Able-Bodied(1)	-3.75
Group Diff. (d)	1.64	Group Diff. (d)	0.90
Caring	4.27	Caring	-2.89
Able-Bodied(2)	3.67	Able-Bodied(2)	-3.31
Group Diff. (d)	0.60	Group Diff. (d)	0.42

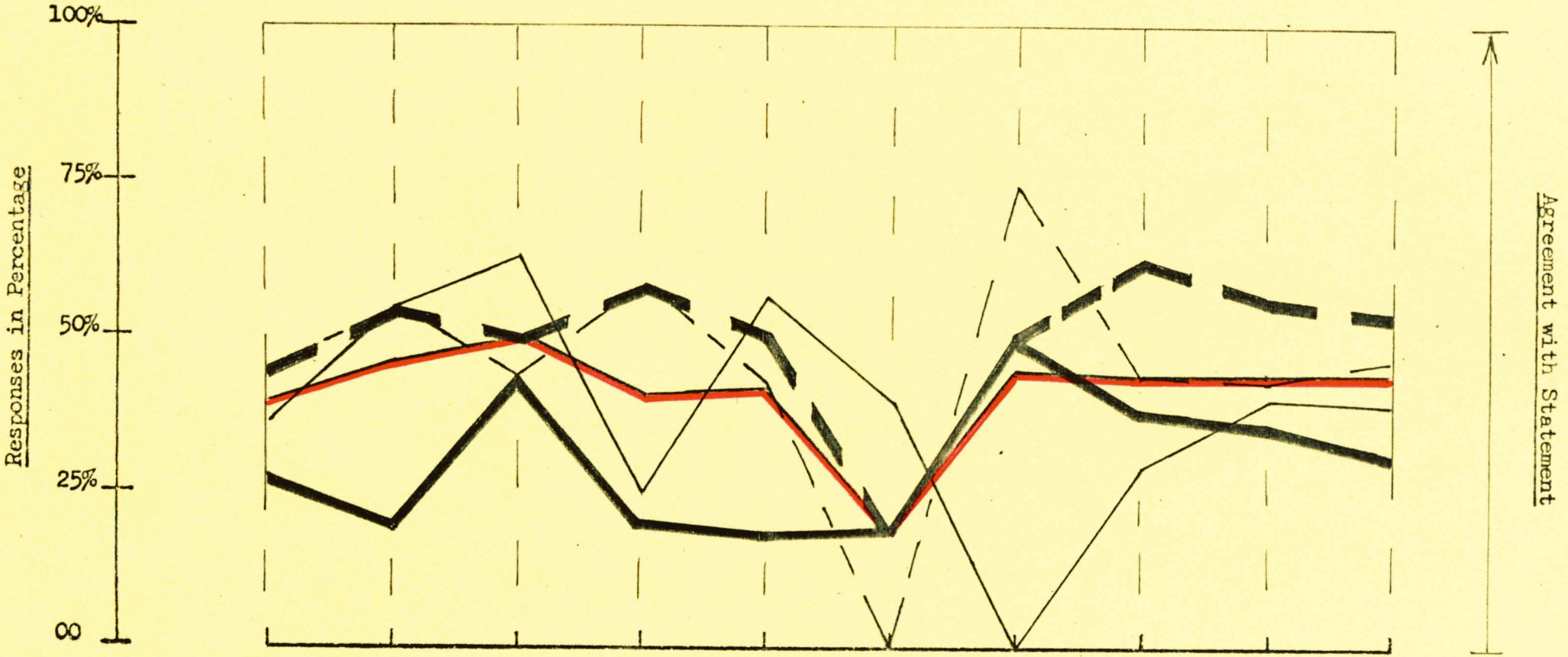
Statement No:- 50 Graphical Illustration of Group Differences in Scale Values at 50% Levels and Ambiguity between Quartile Levels



Statement No:- 50

Comparative Agreement between Different Secondary Groups of People

Arthritis	Blind	Deaf	Amputees	M.Sclerosis	Polio	Stroke	Heart	Paraplegic	TOTAL
N=22 =100%	N=20 =100%	N=14 =100%	N=24 =100%	N=16 =100%	N=5 =100%	N=4 =100%	N=42 =100%	N=45 =100%	N=192 =100%



Legend:-

Disabled Group

Able-bodied(1) Group

Overall

Caring Group

Able-bodied(2) Group

pp. 266 - 349

Sub-chapter "B" - Family

Statement Nos.

06
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Statement No. 06

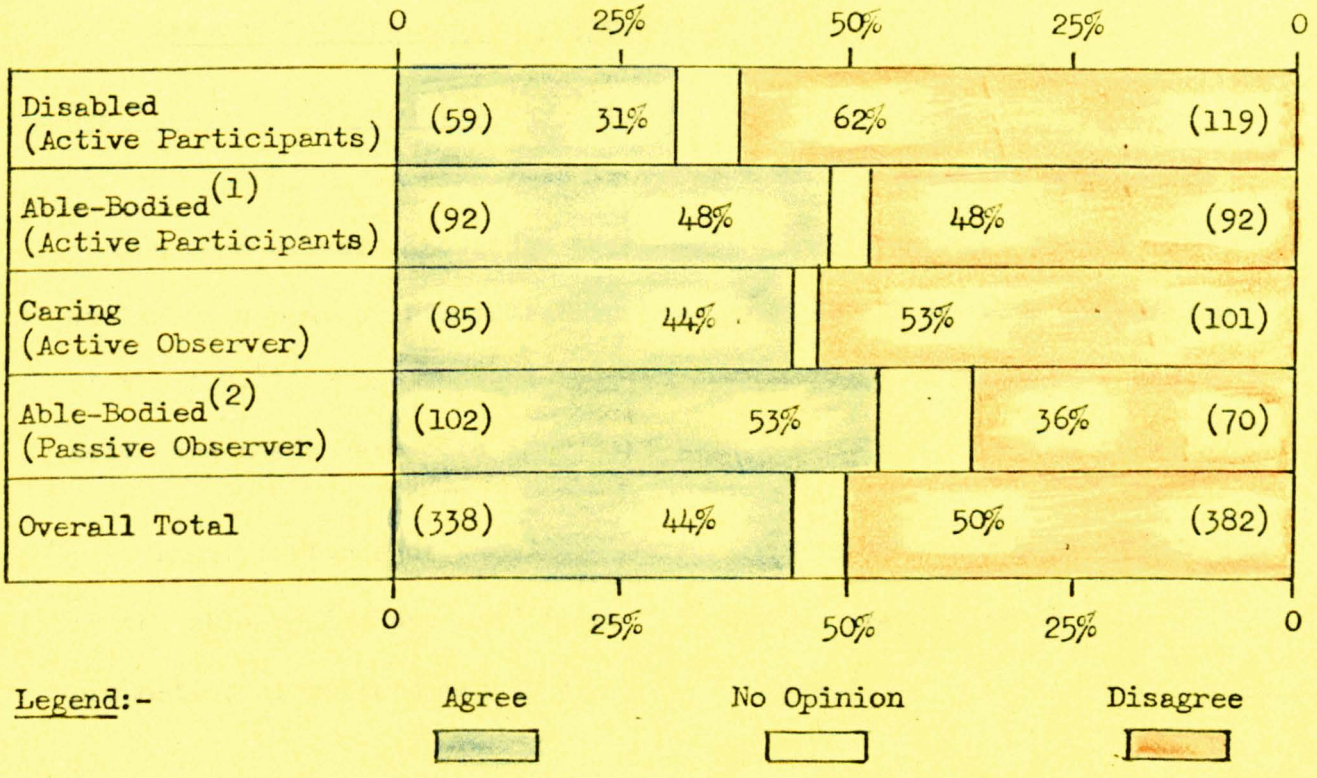
Disabled — Since I became disabled, I think that the person who mainly cares for me understands more than I do about my personal needs.

Able-Bodied(1) — I think that the person who mainly cares for me understands more than I do about my personal needs.

Caring — I understand more about the personal needs of the disabled person than he does.

Able-Bodied(2) — Persons who mainly care for the disabled understand more about the personal needs of the disabled than the disabled, themselves.

Table No. 06 (1) — Group Responses to Statement (where each Group Total N = 192 = 100% and Overall Total N = 768 = 100%)



Legend:- Agree — No Opinion — Disagree

Statistical information and graphical representations illustrating the different responses of these main groups are shown after the summary and in Appendix Nos. V and VI.

Statement No. 06

1. Group Responses to Main Statement

See Table 06 (1)

The results signify that a large proportion of the disabled group believed that they understood more about their personal needs than those who cared for them. However, the proportion of caring respondents who agreed with this opinion was less. The majority of respondents in the A.B.(2) group indicated that caring people knew more about the personal needs of the disabled.

The responses of the A.B.(1) group did not produce any clear indication about the specific reaction of able-bodied people to the statement.

2. Answers to Supplementary Questions

See Tables 06 (2) and (3) - (Appendix V)

The patterns of responses in respect of the disabled and caring groups were close. Knowledge about self-development and social attitudes appeared influential to the disabled but a large proportion of the A.B.(2) group thought that knowledge about socio-medico and self-care needs were more important issues within the caring role.

The importance of knowledge about socio-medico and self-care needs to the able-bodied appeared to be influential issues with a large proportion of respondents in the A.B.(1) group.

See Tables 06 (4) and (5) - (Appendix V)

The results indicate that large proportions of the respondents in the disabled and caring groups were primarily concerned with the

personal and social consequences of disability whilst a large proportion of the A.B.(2) group believed that the physical consequences of disability were more important to the disabled.

Large proportions of the A.B.(1) group referred to the importance of personal assets (values) in respect of the able-bodied.

3. Comparative Agreements between Different Secondary Groups

See Table 06 (6) - (Appendix VI)

The responses of those who were visually handicapped suggested that they relied more upon assistance from others than many people handicapped by different disabilities. Some agreement with this opinion was evident by the responses of those who cared for them although people handicapped by multiple sclerosis appeared to be particularly dependent upon the help of the caring person.

A large proportion of the A.B.(2) group thought that it was those who were handicapped by paraplegia who were mostly in need of assistance from the caring persons.

In many cases it seemed that what could be perceived as physical disability had a greater influence on people than those disabilities which were not so readily observed.

4. Summary

Physical handicap was seen by many respondents to handicap those who entered into social relationship with the disabled. In particular, those who cared for the disabled were frequently seen to be involved with the physical and social limitations and constraints imposed by handicap.

Nevertheless, although there was evidence to indicate that in some cases the family's physical and social integrity had been eroded, it seemed clear during the interviews that it was within the family unit that the disabled person generally found adjustment, security and social integrity more readily and easily. This appeared important for the restoration and development of personal values and social adequacy. It was through this kind of experience that many caring people indicated that they possessed a greater awareness than many disabled about the consequences of disability.

However, despite the importance of knowledge about disability, self-care and special needs to deal with the personal problems of impairment and self-management, the results indicate that issues causing frequent disruption within the individual roles of many disabled people were involved with development and expression of the self in the outer community. Many problems encountered by the disabled in the community seemed to be completely beyond their control, as for example, those associated with physical access, mobility, education, employment and social integration. It was these situations which appeared to indicate to many disabled and caring respondents that society did not recognise fully the problems of the disabled and that an uninitiated majority had established and were controlling "superior norms."

A large proportion of disabled and caring respondents thought that development of quality living for many disabled depended to a large extent upon the understanding shown and practical assistance given to them by the able-bodied. They seemed to believe that it was the duty of social justice to ensure that this objective was always in focus.

Statement No. 06 Main Group Statistical Information

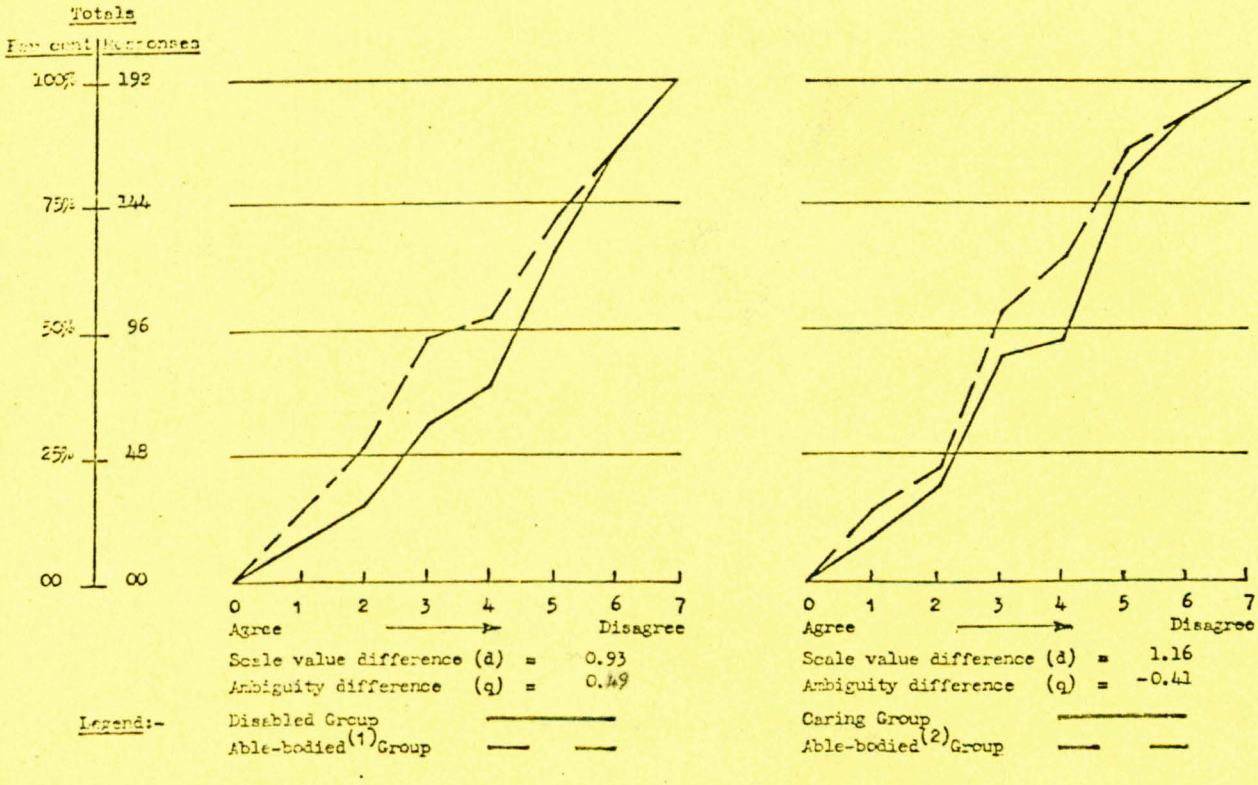
The mean and standard deviation values of the respective groups were:-

	Mean	Standard Deviation
Disabled	4.589	1.776
Able-Bodied(1)	4.057	1.998
Caring	4.083	1.704
Able-Bodied(2)	3.680	1.712

The distribution of the respective groups gave:-

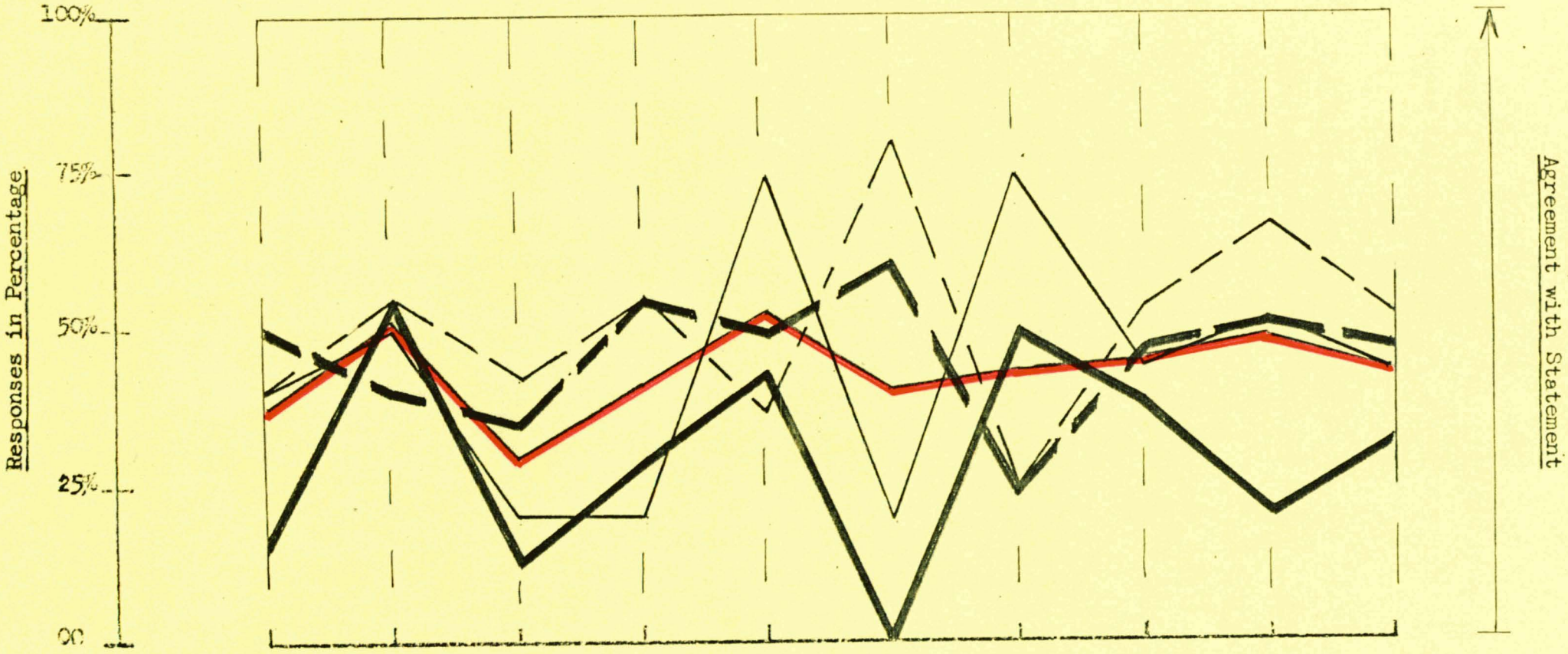
	Scale Value (S) (i.e. 50% levels)		Ambiguity (Q) (i.e. Diff. between quartile levels)
Disabled	4.43	Disabled	-2.82
Able-Bodied(1)	3.50	Able-Bodied(1)	-3.31
Group Diff. (d)	0.93	Group Diff. (d)	0.49
Caring	4.06	Caring	-2.82
Able-Bodied(2)	2.90	Able-Bodied(2)	-2.41
Group Diff. (d)	1.16	Group Diff. (d)	-0.41

Statement No:- 06 Graphical Illustration of Group Difference in Scale Values at 50% Levels and Ambiguity between Quartile Levels



Statement No:- 06 Comparative Agreement between Different Secondary Groups of People

Arthritis	Blind	Deaf	Amputees	M.Sclerosis	Polio	Stroke	Heart	Paraplegic	TOTAL
N=22 =100%	N=20 =100%	N=14 =100%	N=24 =100%	N=16 =100%	N=5 =100%	N=4 =100%	N=42 =100%	N=45 =100%	N=192 =100%



Statement No. 12

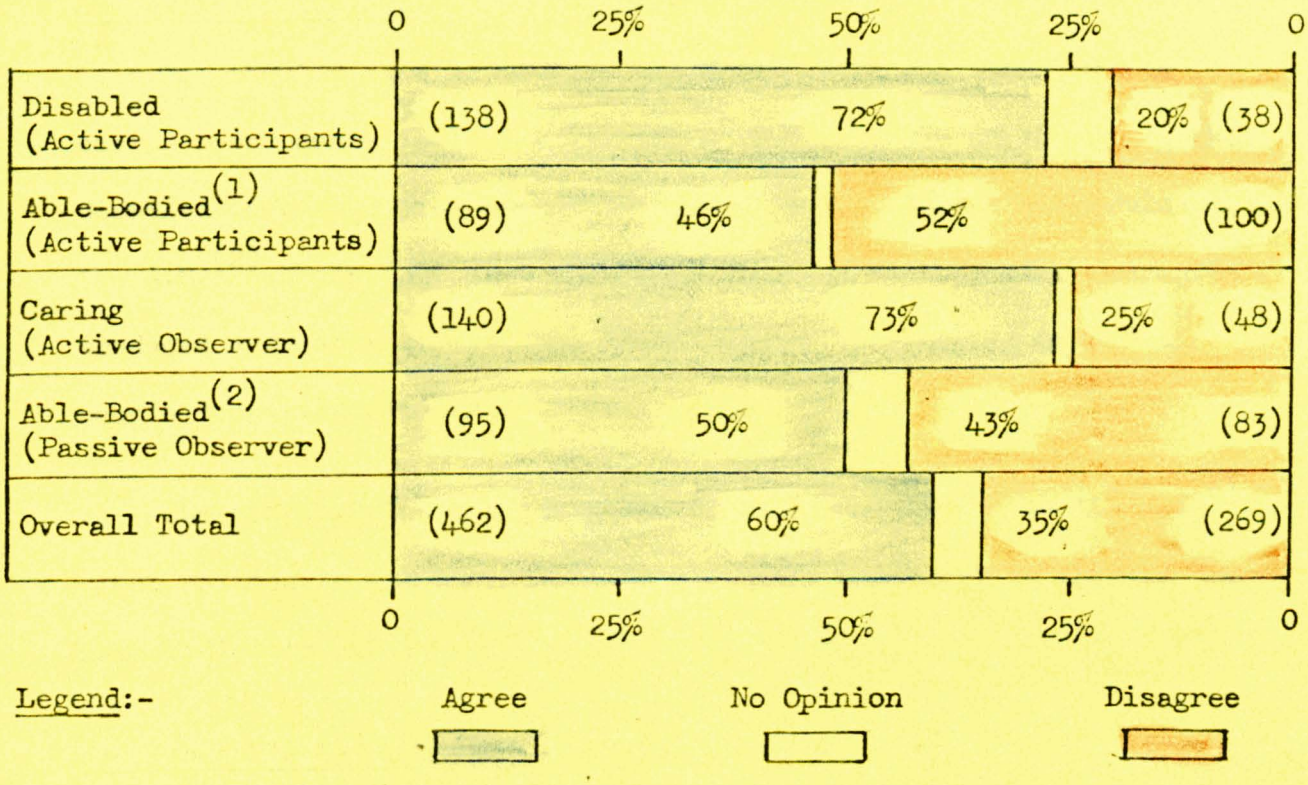
Disabled — Since I became disabled, the attitude of my family and close friends has been an important factor in assisting me to take part in outdoor activities.

Able-Bodied(1) — The attitude of my family and close friends has been an important factor in assisting me to take part in outdoor activities.

Caring — The attitude of the disabled person's family and close friends has been an important factor in assisting him to take part in outdoor activities.

Able-Bodied(2) — The attitude of the family and close friends of disabled persons is an important factor in assisting them to take part in outdoor activities.

Table No. 12 (1) — Group Responses to Statement (where each Group Total N = 192 = 100% and Overall Total N = 768 = 100%)



Legend:- Agree — No Opinion — Disagree

Statistical information and graphical representations illustrating the different responses of these main groups are shown after the summary and in Appendix Nos. V and VI.

Statement No. 12

1. Group Responses to Main Statement

See Table 12 (1)

It appeared clear from the responses of the disabled and caring respondents that the attitude of the family and close friends of the disabled was influential in helping them to participate in outdoor activities. This general view was not so readily discerned by the responses of the A.B.(2) group.

A relatively small proportion of the A.B.(1) group thought that the attitude of their families and close friends had been important to them in developing their outdoor interests.

2. Answers to Supplementary Questions

See Tables 12 (2) and (3) - (Appendix V)

The results seem to confirm the opinions of the disabled and caring respondents about the influence of the family in assisting the disabled to participate in outdoor activities. A large proportion of the A.B.(2) group indicated that the influence of the outer community produced a greater effect than other domains in inducing disabled people to participate in outdoor activities.

The responses of a large proportion of respondents in the A.B.(1) group pointed to the importance of the outer community in helping the able-bodied to participate in outdoor activities.

See Tables 12 (4) and (5) - (Appendix V)

The responses of the disabled and caring groups were fairly close. Whilst adjustment and development of the self and maximisation of potential ability appeared to be important to a large proportion of the

disabled and caring respondents, a large proportion of the A.B.(2) group thought that the development of social interests and abilities were the greatest benefits to accrue for the disabled from their participation in outdoor activities.

As indicated by a large proportion of the A.B.(1) group respondents, development of social interests and the restoration of personal values seemed important to able-bodied people.

3. Comparative Agreements between Different Secondary Groups

See Table 12 (6) - (Appendix VI)

The responses of the disabled indicated that the attitudes of the family and close friends were important in assisting persons in all categories of disablement to participate in outdoor activities. Agreement with this opinion was evident by the responses of those who cared for the disabled, especially those who cared for persons handicapped by deafness or paraplegia.

A relatively large proportion of the A.B.(2) group thought that the attitude of the family and close friends was not so important with people handicapped by blindness or multiple sclerosis as with those handicapped by other disabilities.

An influential issue in the overall responses appeared to be the way by which people perceived differently the various effects of either a progressive or stabilised disability and the presentation of the "self" by the disabled.

4. Summary

The disabled and caring people perceived disability as a multi-handicap which necessitated adjustment as an integrated part of the

whole person. Apart from the medical aspects of the disability, the restoration and adjustment of personal values in the supporting services and outer community were considered vital to the disabled. Restoration of confidence and social adequacy were frequently seen to originate from the family unity and progress to maturity through the supporting services and outer community. In many cases, the family unit seemed to serve as a bridging concept between the self and the community.

Whilst a large proportion of the able-bodied appeared to see the need for disabled people to participate in outdoor activities, many failed to recognise its importance to the promotion of self-development and to the maximisation of potential ability and independence for the disabled. Several able-bodied indicated during the interviews that they were prepared to interact with disabled people as long as the parties paid only perfunctory attention to each other; the dispensation of many customary social graces seemed to suggest undesirable relationships.

In general, the overall results suggest that participation in outdoor activities by the disabled produced a much more positive influence upon their personalities than realised by the able-bodied.

Statement No. 12 Main Group Statistical Information

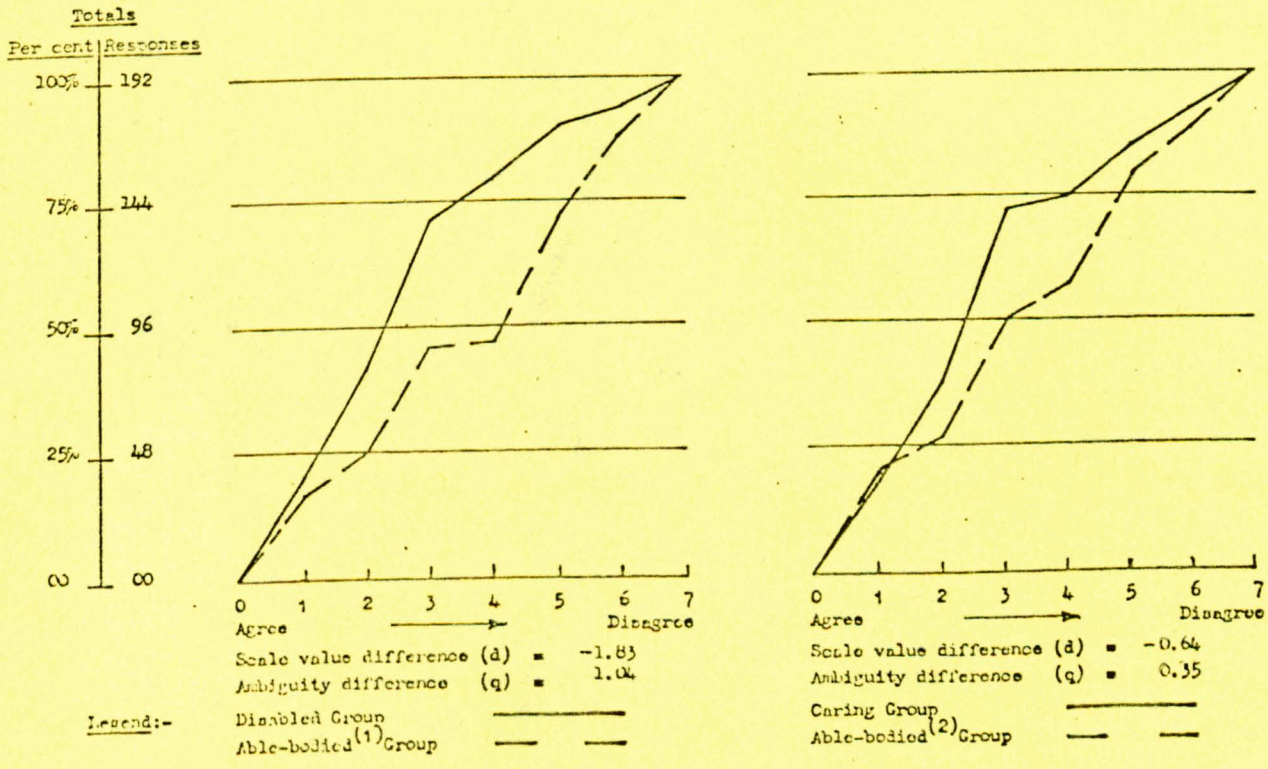
The mean and standard deviation values of the respective groups were:-

	Mean	Standard Deviation
Disabled	3.010	1.631
Able-Bodied(1)	4.026	2.014
Caring	3.182	1.766
Able-Bodied(2)	3.817	1.974

The distribution of the respective groups gave:-

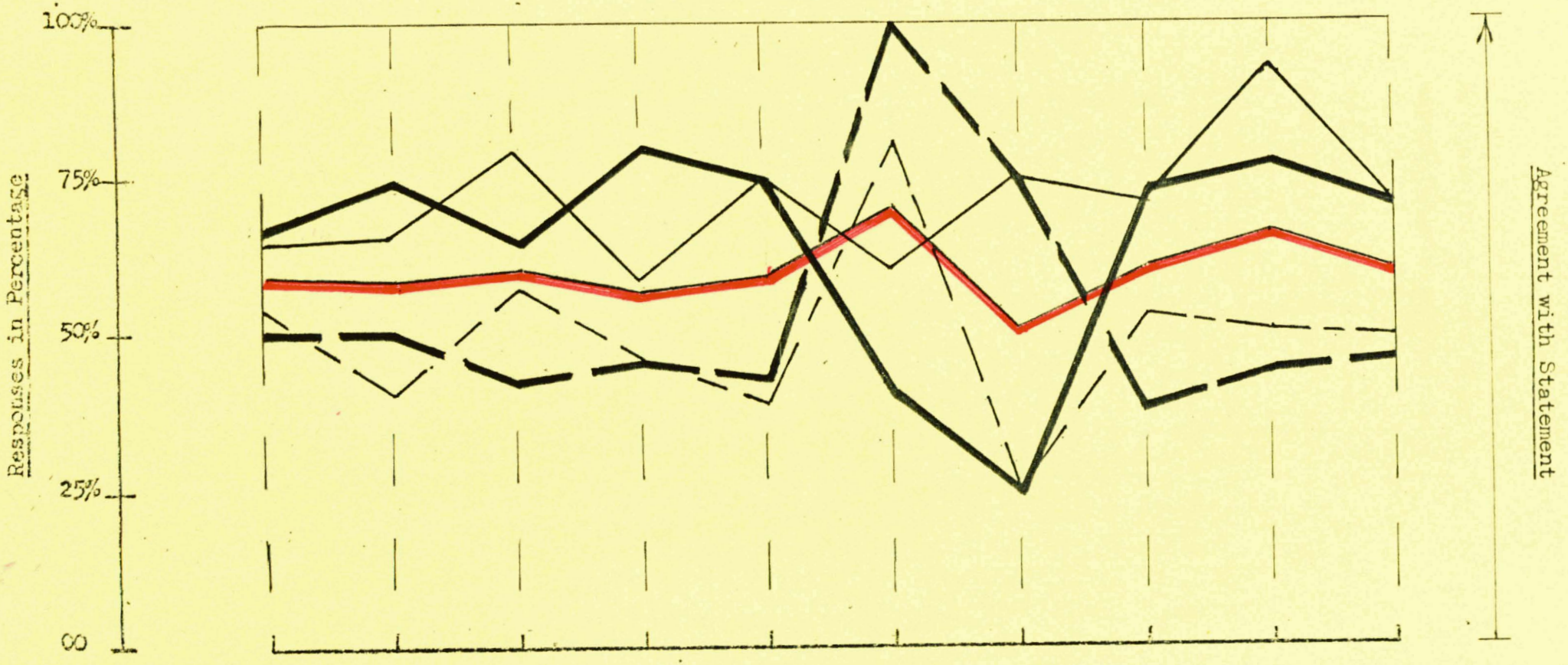
	Scale Value (S) (i.e. 50% levels)		Ambiguity (Q) (i.e. Diff. between quartile levels)
Disabled	2.29	Disabled	-2.14
Able-Bodied(1)	4.12	Able-Bodied(1)	-3.18
Group Diff. (d)	-1.83	Group Diff. (d)	1.04
Caring	2.36	Caring	-2.64
Able-Bodied(2)	3.00	Able-Bodied(2)	-2.99
Group Diff. (d)	-0.64	Group Diff. (d)	0.35

Statement No:- 12 Graphical Illustration of Group Difference in Scale Values at 50% Levels and Ambiguity between Quartile Levels



Statement No:- 12 Comparative Agreement between Different Secondary Groups of People

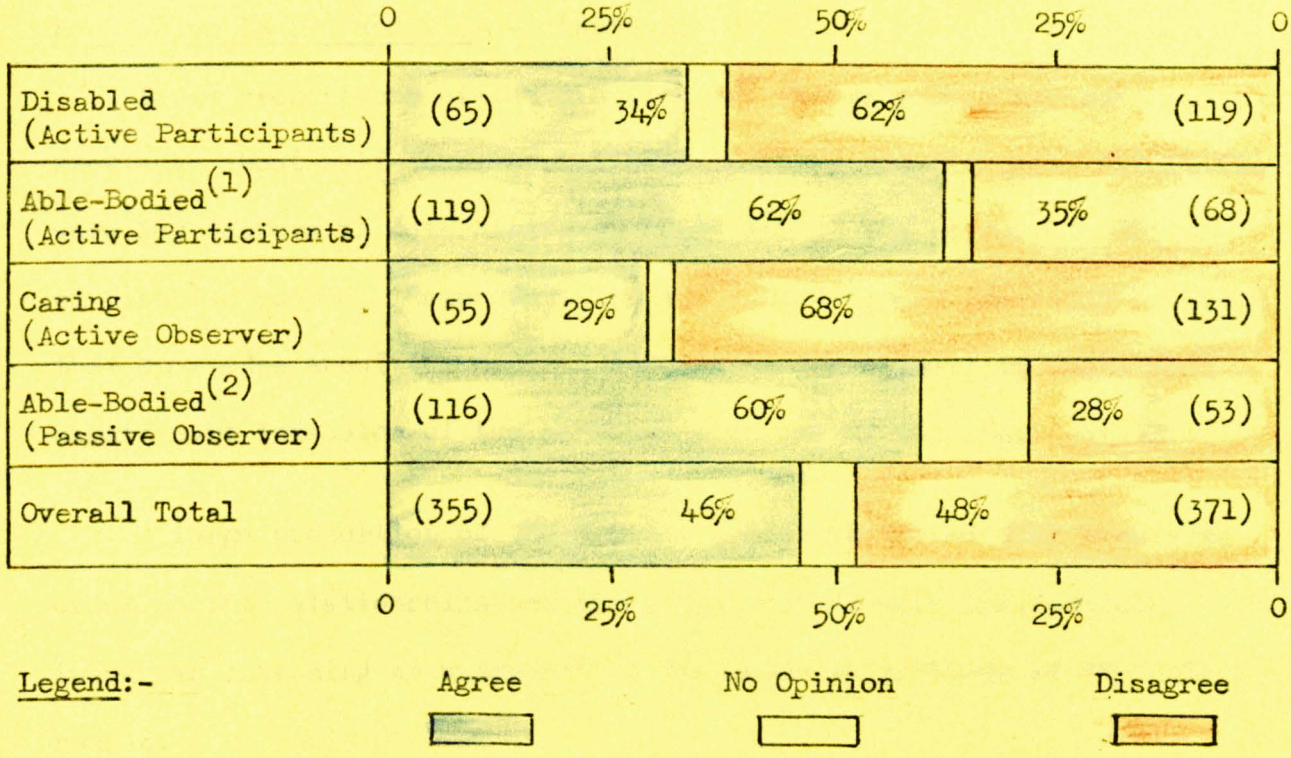
Arthritis	Blind	Deaf	Amputees	M.Sclerosis	Polio	Stroke	Heart	Paraplegic	TOTAL
N=22 =100%	N=20 =100%	N=14 =100%	N=24 =100%	N=16 =100%	N=5 =100%	N=4 =100%	N=42 =100%	N=45 =100%	N=192 =100%



Statement No. 13

Disabled	My close friends are aware of the personal problems associated with my disability.
Able-Bodied(1)	My close friends are aware of the personal problems associated with my physical limitations.
Caring	The disabled person's close friends are aware of the personal problems associated with his disability.
Able-Bodied(2)	The close friends of disabled persons are aware of the personal problems associated with their disability.

Table No. 13 (1) — Group Responses to Statement (where each Group Total N = 192 = 100% and Overall Total N = 768 = 100%)



Legend:- Agree | No Opinion | Disagree

Statistical information and graphical representations illustrating the different responses of these main groups are shown after the summary and in Appendix Nos. V and VI.

Statement No. 13

1. Group Responses to Main Statement

See Table 13 (1)

The table reveals that large proportions of the disabled and caring groups indicated that close friends of the disabled were not fully aware of the problems associated with the consequences of their disabilities. A large proportion of the A.B.(2) group disagreed with the opinions of the disabled and caring respondents.

The majority of respondents in the A.B.(1) group indicated that close friends were aware of the personal problems associated with their physical limitations.

2. Answers to Supplementary Questions

See Tables 13 (2) and (3) - (Appendix V)

Large proportions of the disabled and caring groups indicated that knowledge about self-care, social relationships and financial situations were key factors in determining an awareness of the personal problems of disabled people. Respondents in the A.B.(2) group generally believed that knowledge about the medical aspects of the disability was a most significant indicator of the personal problems of the individual.

A large proportion of the A.B.(2) group considered that knowledge about social relationships and financial matters were influential issues in assessing an awareness of the personal problems of the able-bodied.

3. Comparative Agreements between Different Secondary Groups

See Table 13 (4) - (Appendix VI)

The responses of the disabled and caring groups indicated that friends of those who were handicapped by deafness or multiple sclerosis were less likely to be aware of the disabled person's problems than friends of people who were handicapped by other disabilities.

The responses of the A.B.(2) group were seen to differ considerably with those of the disabled and caring groups.

It was apparent that many able-bodied people did not perceive disability as a multi-disciplinary handicap whilst others appeared unable to recognise that severe physical disability did not mean total disability.

4. Summary

Disability was seen as a dominant feature for the disabled in many situations. It frequently seemed to produce depreciatory feelings about the disabled person's own contribution within the supporting services and outer community. Consequently, the preservation of social adequacy and independence were considered by a large proportion of the disabled and caring to be an indispensable asset.

It was apparent that many able-bodied assessed the problems of the disabled only in terms of the outward and physical aspects of handicap. On the other hand, many disabled and caring respondents continually referred to the real problems of the disabled as being much deeper than those exposed at the surface. In particular, reference was regularly made by the disabled and caring to the belief that the disabled were often expected to conform to a "norm" established by

able-bodied people. However, despite being frequently the chief architects of many social problems and physical barriers encountered by the disabled, the able-bodied failed to recognise their existence.

During the interviews, it often appeared that a lack of understanding and an appreciation of the importance of social relationships in respect of the disabled were contributory factors to some of the "falseness" often associated with anormalisation and salutary aspects of disability.

Statement No. 13 Main Group Statistical Information

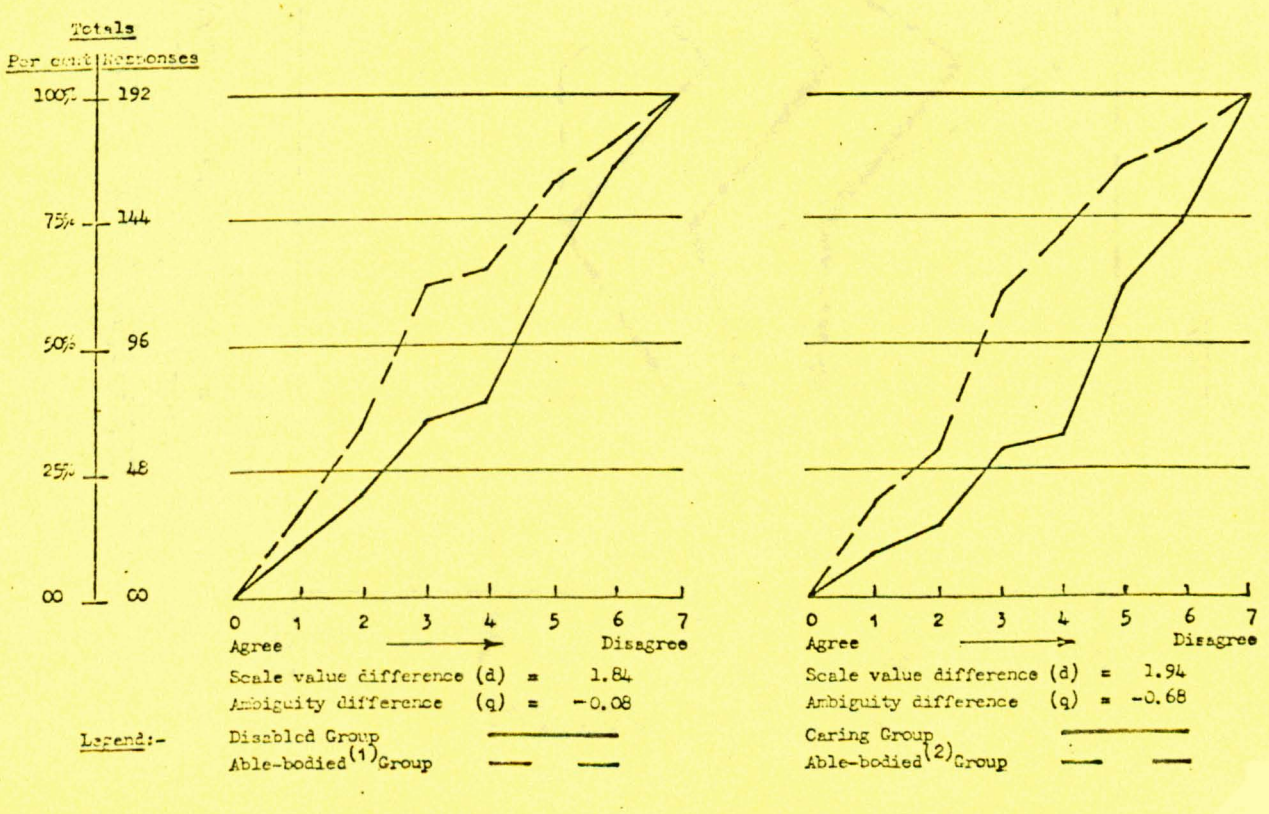
The mean and standard deviation values of the respective groups were:-

	Mean	Standard Deviation
Disabled	4.453	1.914
Able-Bodied(1)	3.510	1.901
Caring	4.812	1.894
Able-Bodied(2)	3.437	1.800

The distribution of the respective groups gave:-

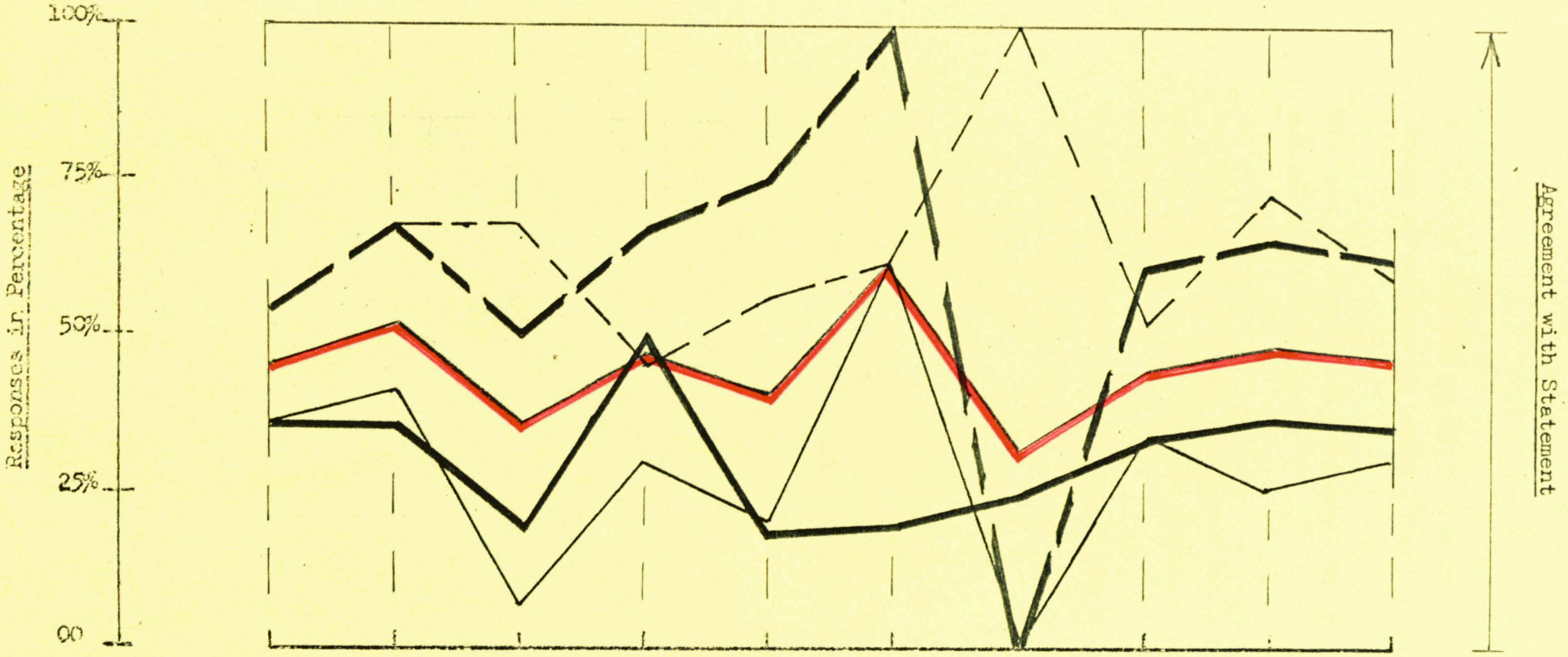
	Scale Value (S) (i.e. 50% levels)		Ambiguity (Q) (i.e. Diff. between quartile levels)
Disabled	4.43	Disabled	-3.16
Able-Bodied(1)	2.59	Able-Bodied(1)	-3.08
Group Diff. (d)	1.84	Group Diff. (d)	-0.08
Caring	4.63	Caring	-3.24
Able-Bodied(2)	2.69	Able-Bodied(2)	-2.56
Group Diff. (d)	1.94	Group Diff. (d)	-0.68

Statement No:- 13 Graphical Illustration of Group Difference in Scale Values at 50% Levels and Ambiguity between Quartile Levels



Statement No:- 13 Comparative Agreement between Different Secondary Groups of People

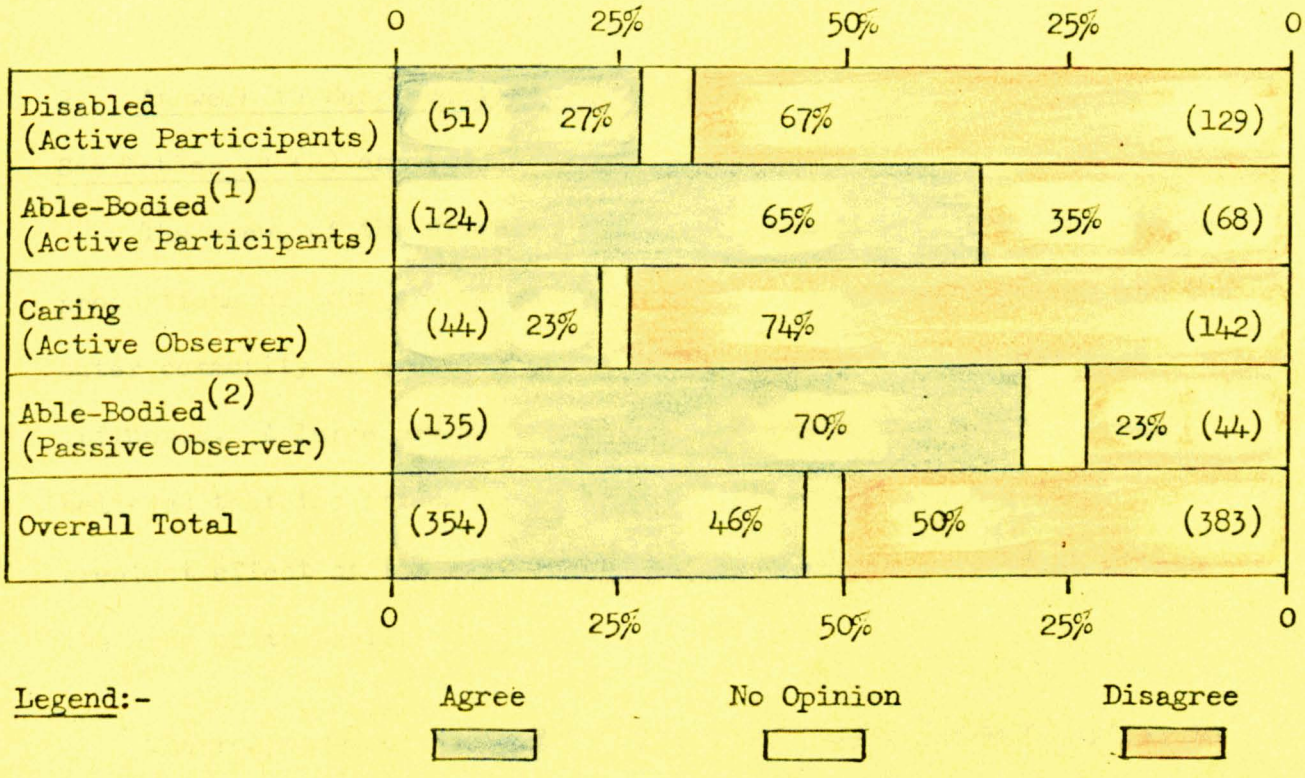
Arthritis	Blind	Deaf	Amputees	M.Sclerosis	Polio	Stroke	Heart	Paraplegic	TOTAL
N=22 =100%	N=20 =100%	N=14 =100%	N=24 =100%	N=16 =100%	N=5 =100%	N=4 =100%	N=42 =100%	N=45 =100%	N=192 =100%



Statement No. 14

Disabled	The lack of educational attainment has not had an adverse effect upon me since I became disabled.
Able-Bodied(1)	The lack of educational attainment has not had an adverse effect upon me.
Caring	The lack of educational attainment has not had an adverse effect on the disabled person.
Able-Bodied(2)	The lack of educational attainment has no adverse effect on disabled persons.

Table No. 14 (1) — Group Responses to Statement (where each Group Total N = 192 = 100% and Overall Total N = 768 = 100%)



Legend:- Agree | No Opinion | Disagree

Statistical information and graphical representations illustrating the different responses of these main groups are shown after the summary and in Appendix Nos. V and VI.

Statement No. 14

1. Group Responses to Main Statement

See Table 14 (1)

The table shows that a wide divergence of opinions occurred between the disabled and able-bodied respondents. Responses of the disabled and caring groups were close with very large proportions of each group indicating that the lack of educational attainment had adversely affected the quality of living for the disabled. In contrast, a large proportion of the A.B.(2) group believed that disabled people did not experience adverse effects as a result of low educational attainment.

A large proportion of the A.B.(1) group indicated that the able-bodied seldom experienced serious adverse effects due to low educational achievement.

2. Answers to Supplementary Questions

See Tables 14 (2) and (3) - (Appendix V)

The views of the disabled and caring groups were similar. Large proportions of both groups referred to the supporting services and the outer community as areas in which educational attainment had most influence. A large proportion of respondents in the A.B.(2) group believed that the influence of educational attainment had its greatest effect on the personality of the disabled individual within the area of the self.

The responses of the A.B.(1) group followed a pattern similar to that of the disabled group.

See Tables 14 (4) and (5) - (Appendix V)

The responses of the disabled and caring groups suggested that educational attainment produced its greatest benefits from issues involving employment and social integration. A large proportion of the A.B.(2) group thought that the disabled received their greatest benefits from educational attainment from matters involving status, self-esteem, leisure, recreation and other associated issues.

As evident from a large proportion of responses in the A.B.(1) group, educational attainment was important to the able-bodied in the employment sector.

3. Comparative Agreements between Different Secondary Groups

See Table 14 (6) - (Appendix VI)

The responses of the disabled and caring groups indicated that low educational attainment aggravated the adverse consequences of most people in different categories of disablement. This view was in contrast to that perceived by the A.B.(2) group from wherein a large proportion of the respondents indicated that educational attainment provided little influence upon the quality of living of disabled people.

It was apparent that a large proportion of the able-bodied respondents viewed disability only in its negative aspects and failed to see that education assisted with the development of potential and with opportunities which provided recognition as a fully respected member of the community.

4. Summary

Education was considered by a large proportion of the disabled and caring people to be important to the disabled for the purpose of

assisting them to be accepted as contributory members of society. During the interviews, many of these respondents believed that the higher the disabled person's educational standards, the better were his prospects for employment, social integration and "status".

A large proportion of the able-bodied did not perceive educational attainment to be of great value to the disabled as the physical limitations and the restrictions of disability appeared to them to be dominant in any situation.

It frequently appeared that disabled people needed discrimination in their favour if they were to have opportunities comparable with their able-bodied contemporaries to become full contributory members of society. Comparable opportunities to those of the able-bodied often seemed to necessitate a higher standard of education for the disabled.

Education was seen by many disabled and caring respondents to be an important element within a life of fulfilment. To the disabled and caring, the higher levels of human needs, such as respect, "status", potential development and accomplishment emanated from the lower needs such as friendship, recognition and employment. This view was not always seen clearly in the responses of the able-bodied respondents, particularly the A.B.(2) group (passive observers).

Statement No. 14 Main Group Statistical Information

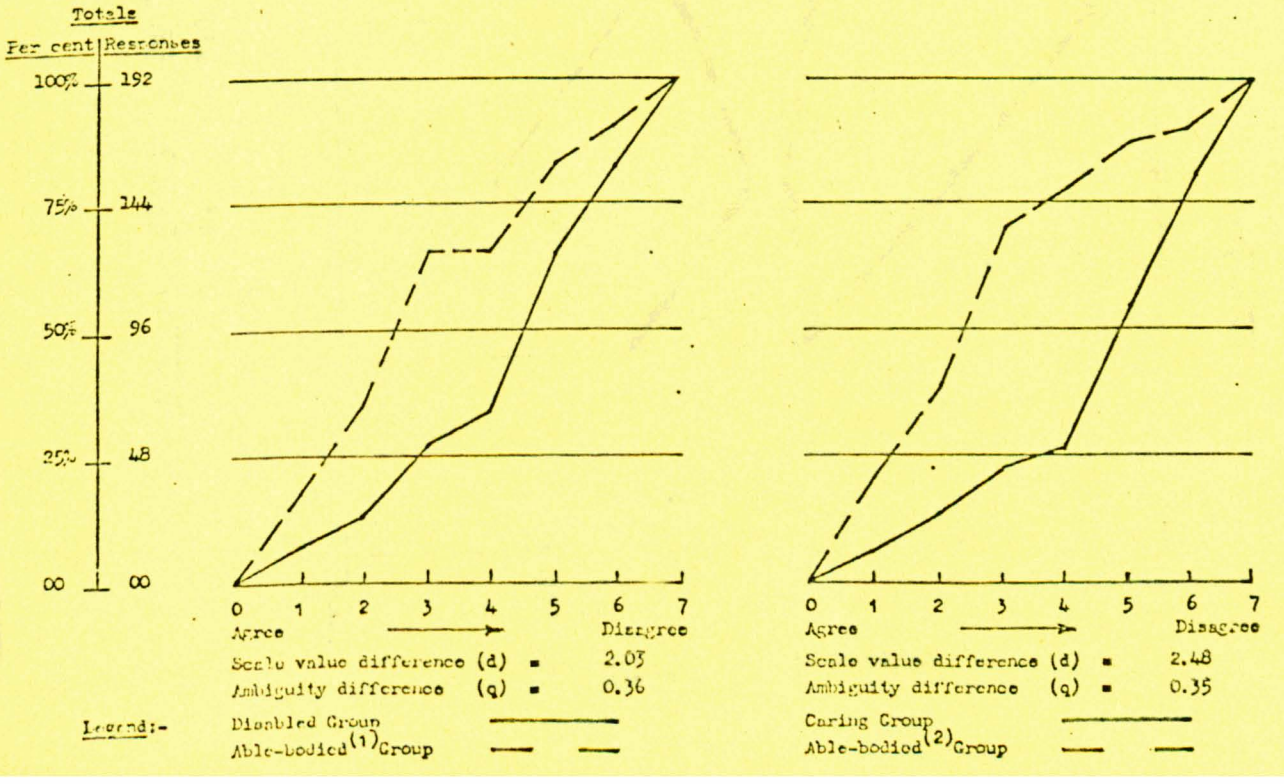
The mean and standard deviation values of the respective groups were:-

	Mean	Standard Deviation
Disabled	4.749	1.773
Able-Bodied(1)	3.448	1.897
Caring	4.984	1.753
Able-Bodied(2)	3.166	1.814

The distribution of the respective groups gave:-

	Scale Value (S) (i.e. 50% levels)		Ambiguity (Q) (i.e. Diff. between quartile levels)
Disabled	4.55	Disabled	-2.75
Able-Bodied(1)	2.52	Able-Bodied(1)	-3.11
Group Diff. (d)	2.03	Group Diff. (d)	0.36
Caring	4.85	Caring	-2.13
Able-Bodied(2)	2.37	Able-Bodied(2)	-2.48
Group Diff. (d)	2.48	Group Diff. (d)	0.35

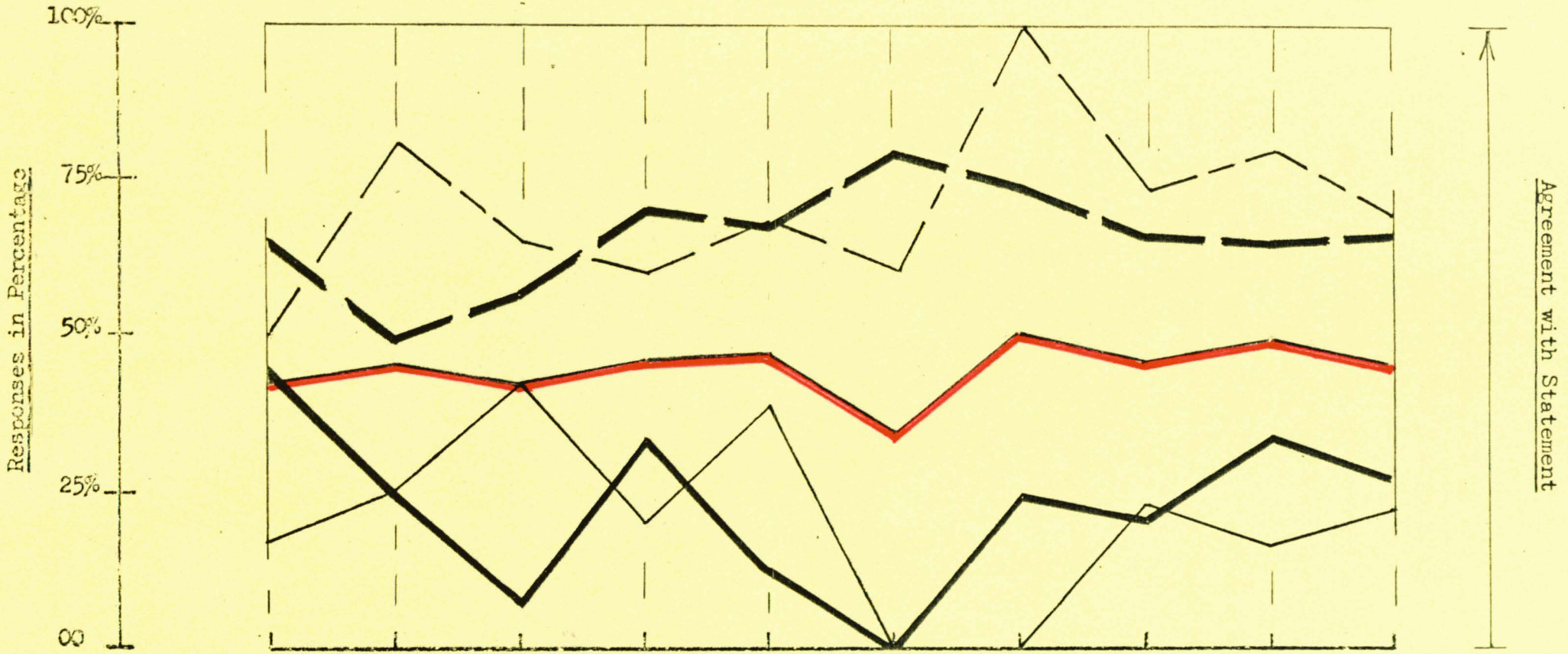
Statement No:- 14 Graphical Illustration of Group Difference in Scale Values at 50% Levels and Ambiguity between Quartile Levels



Statement No:- 14

Comparative Agreement between Different Secondary Groups of People

Arthritis	Blind	Deaf	Amputees	M.Sclerosis	Polio	Stroke	Heart	Paraplegic	TOTAL
N=22 =100%	N=20 =100%	N=14 =100%	N=24 =100%	N=16 =100%	N=5 =100%	N=4 =100%	N=42 =100%	N=45 =100%	N=192 =100%



Statement No. 17

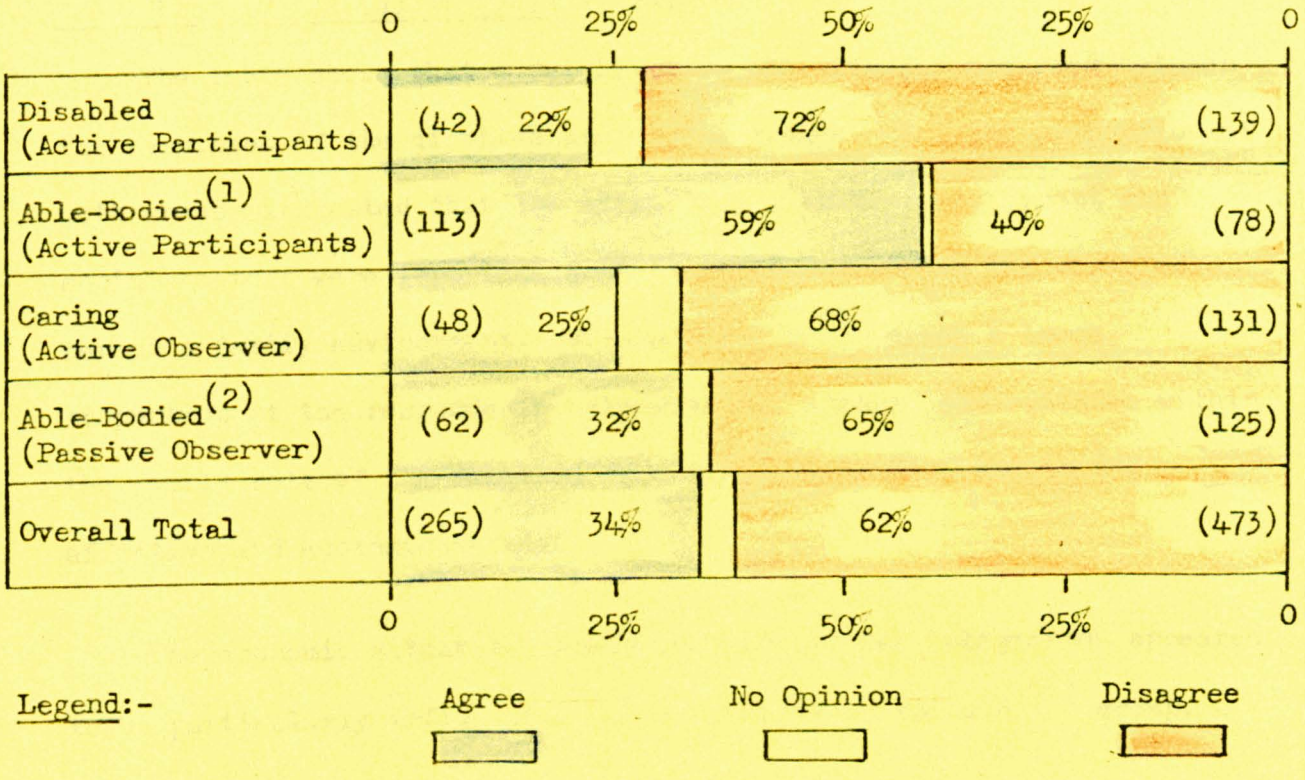
Disabled — My disability has seldom had an adverse effect on my role as a responsible member of my family.

Able-Bodied(1) — My physical limitations have seldom had an adverse effect on my role as a responsible member of my family.

Caring — The disability has seldom had an adverse effect on the disabled person's role as a responsible member of his family.

Able-Bodied(2) — Disability has seldom an adverse effect on the role of disabled persons as responsible members of their families.

Table No. 17 (1) — Group Responses to Statement (where each Group Total N = 192 = 100% and Overall Total N = 768 = 100%)



Legend:- Agree | No Opinion | Disagree

Statistical information and graphical representations illustrating the different responses of these main groups are shown after the summary and in Appendix Nos. V and VI.

Statement No. 17

1. Group Responses to Main Statement

See Table 17 (1)

Large proportions of the disabled and caring groups indicated that disability caused an adverse effect on the role of the disabled person as a responsible member of the family. Although smaller in number, the table shows that a large proportion of the A.B.(2) group expressed opinions similar to those of the disabled.

The responses of the A.B.(1) group showed that the physical limitations of a large proportion of the group seldom had an adverse effect on their family responsibilities.

2. Answers to Supplementary Questions

See Tables 17 (2) (a) and (b) - (Appendix V)

The table shows that a fairly close relationship occurred between the responses of the disabled and caring groups. A large proportion of both groups indicated that the affective, economic, employment and social sectors were important factors which influenced the disabled person's family environment. Within the A.B.(2) group a large proportion of the respondents believed that adverse consequences within the family role of the disabled were most likely to occur in the affective and economic sectors.

The economic situation, employment and social integration appeared to be particularly influential to respondents in the A.B.(1) group.

See Table 17 (3) (a) and (b) - (See Appendix V)

The responses of a large proportion of the married respondents in the disabled, caring and A.B.(1) groups seem to indicate that the primary

effects of physical handicap upon the disabled spouse are concerned with family integrity, employment & education, the financial position of the family, and the fear of loss of social acceptance.

Respondents in the A.B.(2) group did not appear to consider the loss of social acceptance to be of primary importance to the disabled spouse although, unlike the A.B.(1) group, a large proportion of the respondents appeared to express agreement with the disabled and caring groups about the importance of the contribution of the disabled spouse in the family management role.

More secondary effects which, in some cases, seemed to have pervaded the personality of the handicapped person, related to concern about the family's health & welfare, loss of the self-image, loss of affection, family shame and the presence of depression, anxiety & aggression.

See Tables 17 (3) (c) (d) and (e) - (See Appendix V)

These tables indicate the responses of the married male and female respondents, respectively, in connection with the personal effects of disability. The responses of the females who indicated that they were concerned about the family's financial situation, family integrity, employment and education were seen to be larger in proportion than those recorded by the males. It was noted that the respondents in the A.B.(1) group seemed to express more concern about these issues in relation to able-bodied people than respondents in the other groups about the disabled.

The male respondents in all groups appeared to be more concerned generally than the females about the fear of loss of social acceptance and their contribution to the family management role. It may be that

the difference in the "normal" role of the "confined" housewife and the "outside" breadwinner had some influence on the fear of loss of social acceptance and the perception of one's own contribution to the family management role.

See Tables 17 (4) (a) and (b) - (Appendix V)

The tables show that a large proportion of each of the four groups seem to consider that the primary effects of the spouse's disability on the family unit involve altered functions and responsibilities in home management, reduced social and recreational activities, marital distress and financial embarrassment.

It seemed to some respondents that certain issues, such as marital distress, are not only sensitive and crucial areas in family relationships but have also persuasive and long range effects upon the outlook and behavioural role of the handicapped individual and the family unit.

See Tables 17 (4) (c) (d) and (e) - (Appendix V)

These tables indicate the responses of the married male and female respondents, respectively, in connection with the effects of disability on the family unit. The results appear to suggest that the effects of a wife's disability tend to cause the need for a greater adjustment in functional activities and responsibilities in home management than in the case when the husband becomes disabled and the wife occupies the conventional role of the male partner.

The adverse effects of some of the primary aspects of disability upon the family unit, including those involved with marital distress and the need to seek financial assistance, seemed to be recognised by a relatively large proportion of respondents in each group.

Compared with the responses of the disabled and caring groups, it was noted that a slightly larger proportion of respondents in the A.B.(1) and (2) groups referred to the effects of reduced social and recreational activities.

3. Comparative Agreement between Different Secondary Groups

See Table 17 (5) - (Appendix VI)

The cumulative responses of the disabled and caring respondents indicated that the pre-disability role of the disabled person as a responsible and contributory member of the family was adversely affected by the onset of disability. The responses of the disabled suggested that the disabled roles of those handicapped by amputations or heart trouble were slightly less affected than those handicapped by other disabilities. Those who cared for persons handicapped by heart trouble showed evidence of some agreement with the disabled.

Many respondents in the A.B.(2) group did not appear to recognise readily the multiple handicapping effects of disability.

In some cases it seemed that the able-bodied failed to realise that disability encroaches upon all facets of a person's pre-disability role, particularly those persons involved with responsible and contributory roles in society.

4. Summary

The effect of disability on the family appeared to depend a great deal upon the disabled person's contribution to the family needs.

It was indicated that when the woman's role was primarily that of "wife and mother" or the man's role involved "husband, father and breadwinner", there was inevitably some disturbance of the respective contributions to the family following the onset of disability.

During some interviews the consequences of disability were seen to have had an adverse effect on marital and other family relationships.

Although there was evidence to indicate that marital and family responsibilities assisted some disabled to adjust and achieve a measure of self-esteem fairly readily, there were other cases where similar achievement was fulfilled without the presence of marital and family responsibilities. Tension within the marital partnership, financial problems, restrictive social activities and lack of opportunities to achieve one's aspirations tended to be destructive elements arising from the onset of disability. The able-bodied appeared to be unable to recognise many of these problems.

It was also apparent during the interviews that the "spread" phenomenon and the generalisation of physical impairments as symptoms of negative personality or psychological characteristics encroached upon the family unit and frequently produced aversive behaviour. Although this feature appeared to be a common experience with many disabled and caring respondents, a relatively small proportion of the able-bodied commented on similar personal behavioural reactions.

Statement No. 17 Main Group Statistical Information

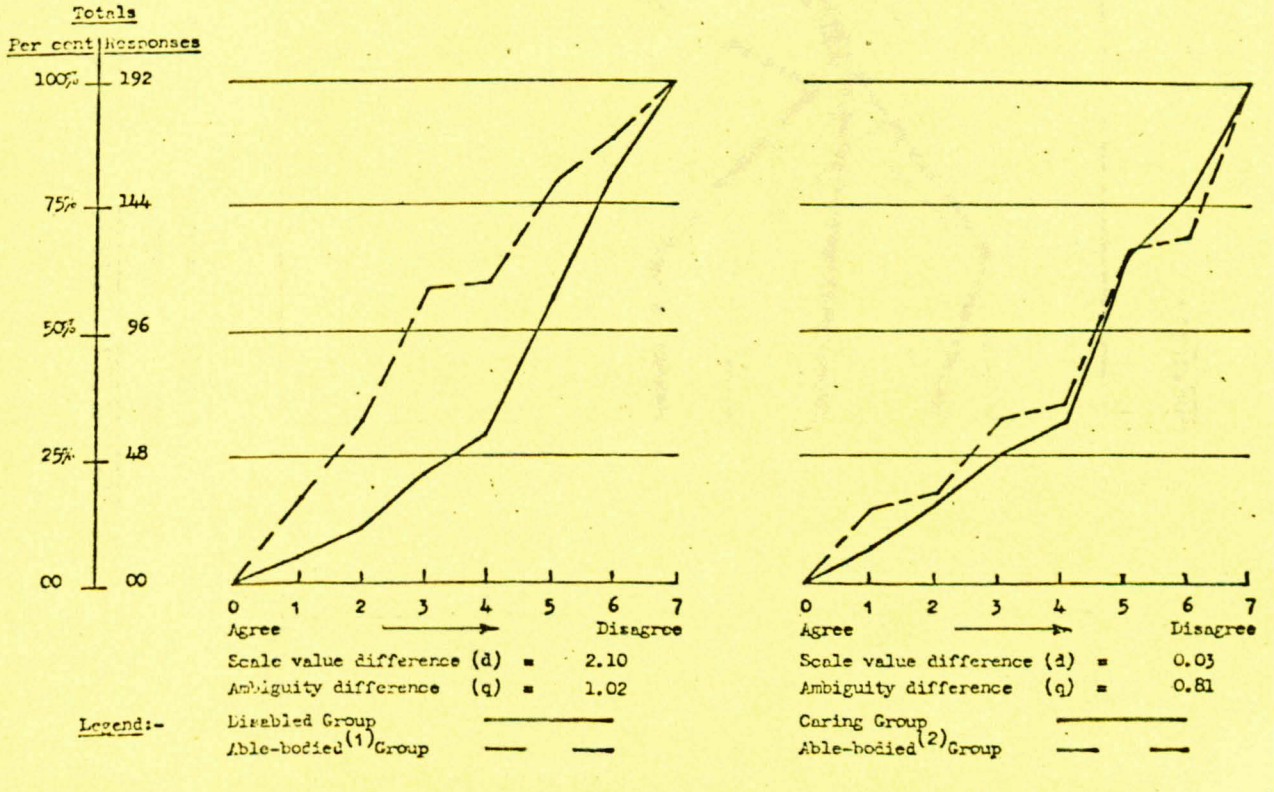
The mean and standard deviation values of the respective groups were:-

	Mean	Standard Deviation
Disabled	4.990	1.709
Able-Bodied(1)	3.646	1.987
Caring	4.785	1.835
Able-Bodied(2)	4.687	2.113

The distribution of the respective groups gave:-

	Scale Value (S) (i.e. 50% level)		Ambiguity (Q) (i.e. Diff. between quartile levels)
Disabled	4.80	Disabled	-2.22
Able-Bodied(1)	2.70	Able-Bodied(1)	-3.24
Group Diff. (d)	2.10	Group Diff. (d)	1.02
Caring	4.54	Caring	-2.90
Able-Bodied(2)	4.51	Able-Bodied(2)	-3.71
Group Diff. (d)	0.03	Group Diff. (d)	0.81

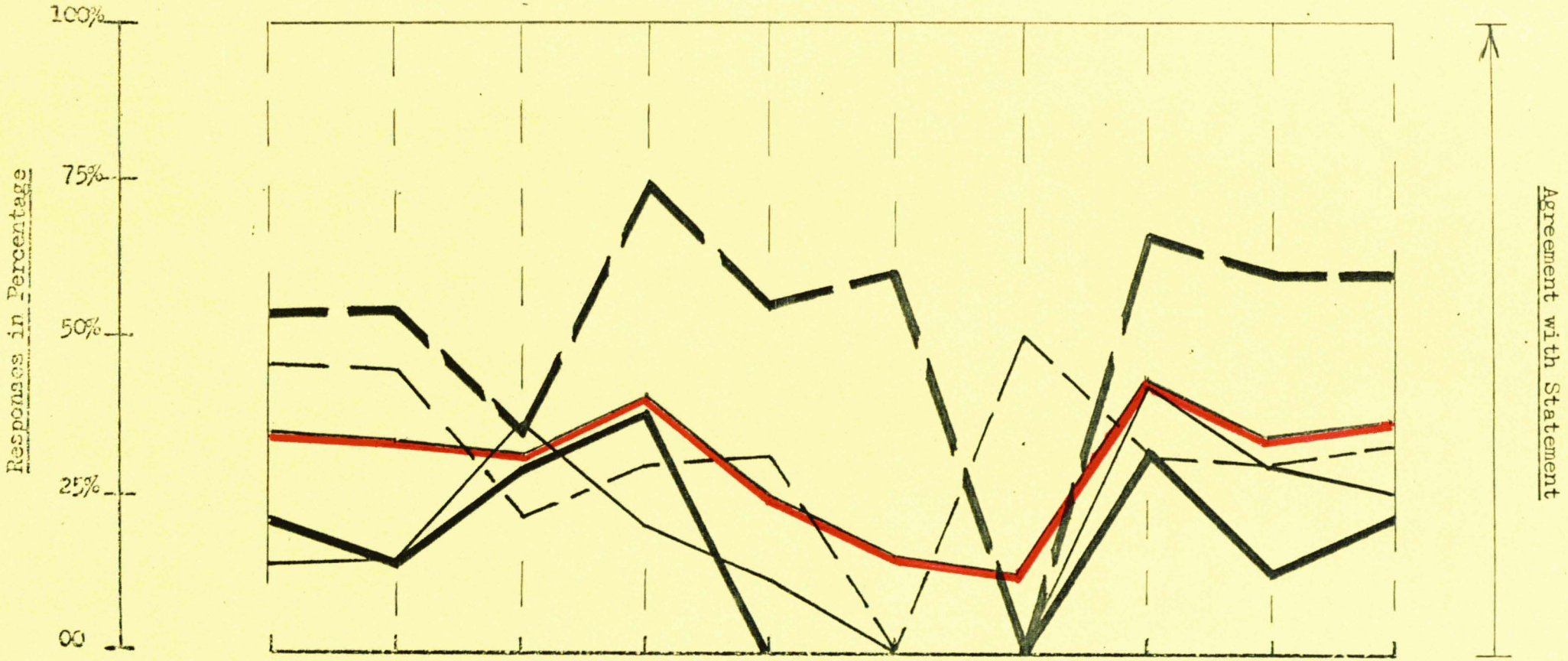
Statement No:- 17 Graphical Illustration of Group Difference in Scale Values at 50% Levels and Ambiguity between Quartile Levels



Statement No:- 17

Comparative Agreement between Different Secondary Groups of People

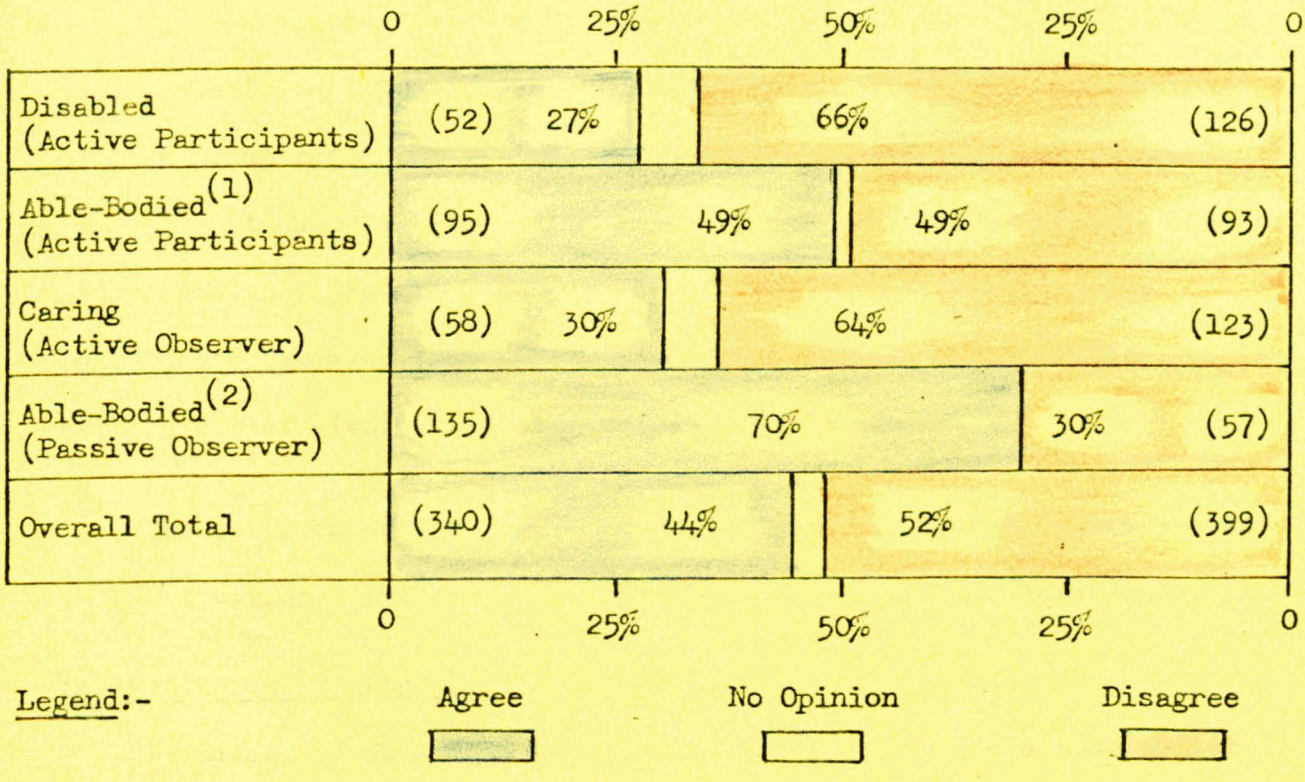
Arthritis	Blind	Deaf	Amputees	M.Sclerosis	Polio	Stroke	Heart	Paraplegic	TOTAL
N=22 =100%	N=20 =100%	N=14 =100%	N=24 =100%	N=16 =100%	N=5 =100%	N=4 =100%	N=42 =100%	N=45 =100%	N=192 =100%



Statement No. 22

Disabled	Since I became disabled, I have been well informed about matters relating to my disability.
Able-Bodied(1)	I have been well informed about matters relating to my physical limitations.
Caring	The disabled person has been well informed about matters relating to his disability.
Able-Bodied(2)	Disabled persons are well informed about matters relating to their disabilities.

Table No. 22 (1) — Group Responses to Statement (where each Group Total N = 192 = 100% and Overall Total N = 768 = 100%)



Statistical information and graphical representations illustrating the different responses of these main groups are shown after the summary and in Appendix Nos. V and VI.

Statement No. 22

1. Group Responses to Main Statement

See Table 22 (1)

The table reveals that large proportions of the disabled and caring groups considered that disabled people were not well informed about matters relating to their disabilities. In contrast, nearly three-quarters of the A.B.(2) group believed that disabled people were well informed about matters applicable to their disabilities.

The responses of the A.B.(1) group did not indicate any specific opinion about the reaction of able-bodied people to the statement.

2. Answers to Supplementary Questions

See Tables 22 (2) and (3) - (Appendix V)

The responses in the table show that a fairly close relationship occurred between the disabled and caring groups with large proportions of each group referring to the importance of information about social issues, particularly those which involved the supporting services and outer community sectors. A large proportion of the A.B.(2) group respondents believed that information about medical and self-care matters was of significant importance to the disabled.

The opinions of the A.B.(1) group respondents were frequently seen to be at variance with those of the disabled and caring respondents.

See Tables 22 (4) and (5) - (Appendix V)

Provision of an effective information service and the application of positive attitudes are seen by the responses of a large proportion of the disabled and caring respondents to be particularly influential issues in conveying information to the disabled. Emphasis on the

effectiveness of an information service are apparent by the responses of the A.B.(2) group.

A large proportion of the A.B.(1) group thought that the application of positive attitudes was an extremely important issue within the organisation of an effective communications system.

3. Comparative Agreements between Different Secondary Groups

See Table 22 (6) - (Appendix VI)

The table indicates that those people who were handicapped by deafness, multiple sclerosis or paraplegia were less well informed about matters relating to their disabilities than many people handicapped by other disabilities. Agreement with the opinions of the disabled was evident by the responses of those who cared for them.

In contrast, a large proportion of the A.B.(2) group thought that disabled people were generally well informed about matters affecting their disabilities.

It seemed clear from the comments of a large proportion of the disabled and caring respondents that an effective communications system was of paramount importance to disabled people.

4. Summary

Situations arising from organisational failure, mismanagement, misinterpretation of information, apathetic attitudes, and ignorance of various aspects of disability were perceived by a large proportion of the disabled and caring people as additional handicaps of the disabled. It was thought that all supporting service agencies need to have a general understanding of the relationships of services dealing with self-care, financial benefits, education, employment and

social integration in order that they could maximise their help to the disabled.

Although a large proportion of the able-bodied believed that the disabled were kept well informed by different communications media about matters affecting their disabilities, it was noted that when a number of respondents were asked during the interviews to give information about a specific item concerning disability, many were unable to do so.

A large proportion of the responses during the interviews seemed to point to the need for more education amongst the general public about different handicapping conditions in order to obviate misconceptions leading to discrimination.

Statement No. 22 Main Group Statistical Information

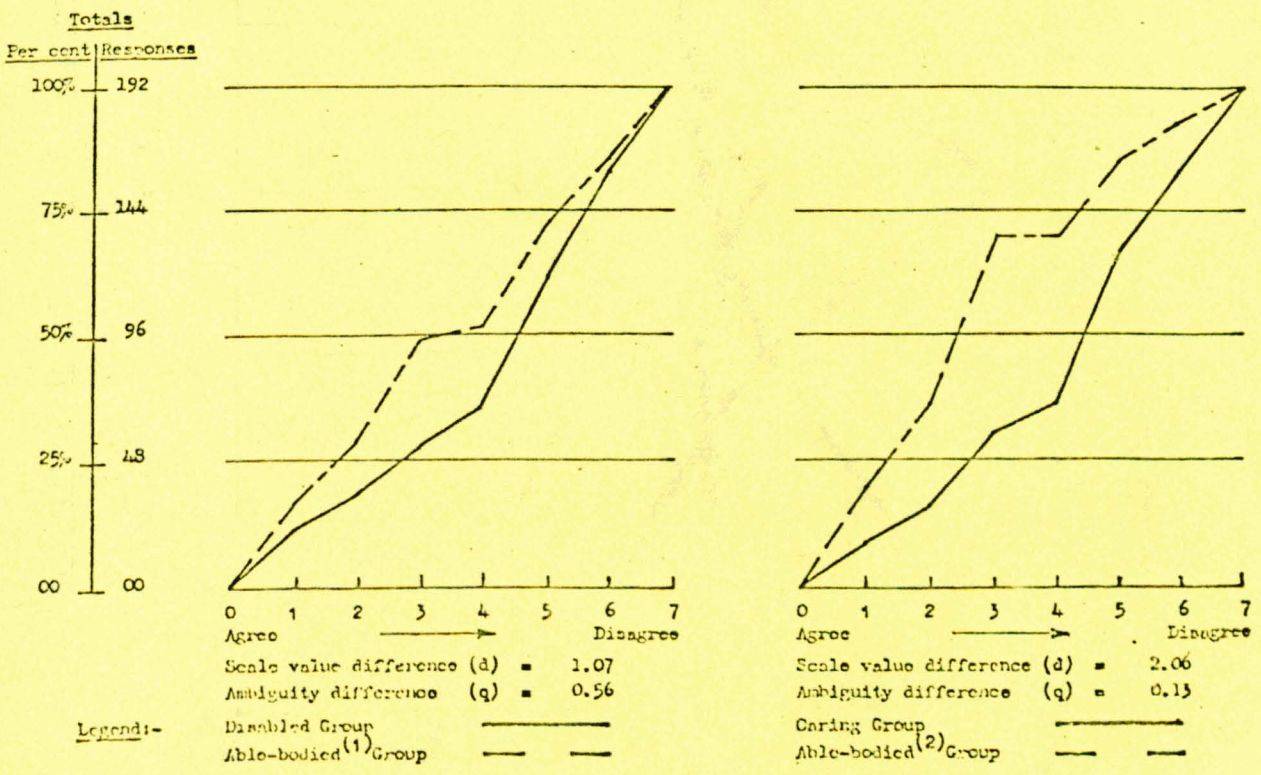
The mean and standard deviation values of the respective groups were:-

	Mean	Standard Deviation
Disabled	4.656	1.889
Able-Bodied(1)	3.943	2.027
Caring	4.614	1.838
Able-Bodied(2)	3.265	1.852

The distribution of the respective groups gave:-

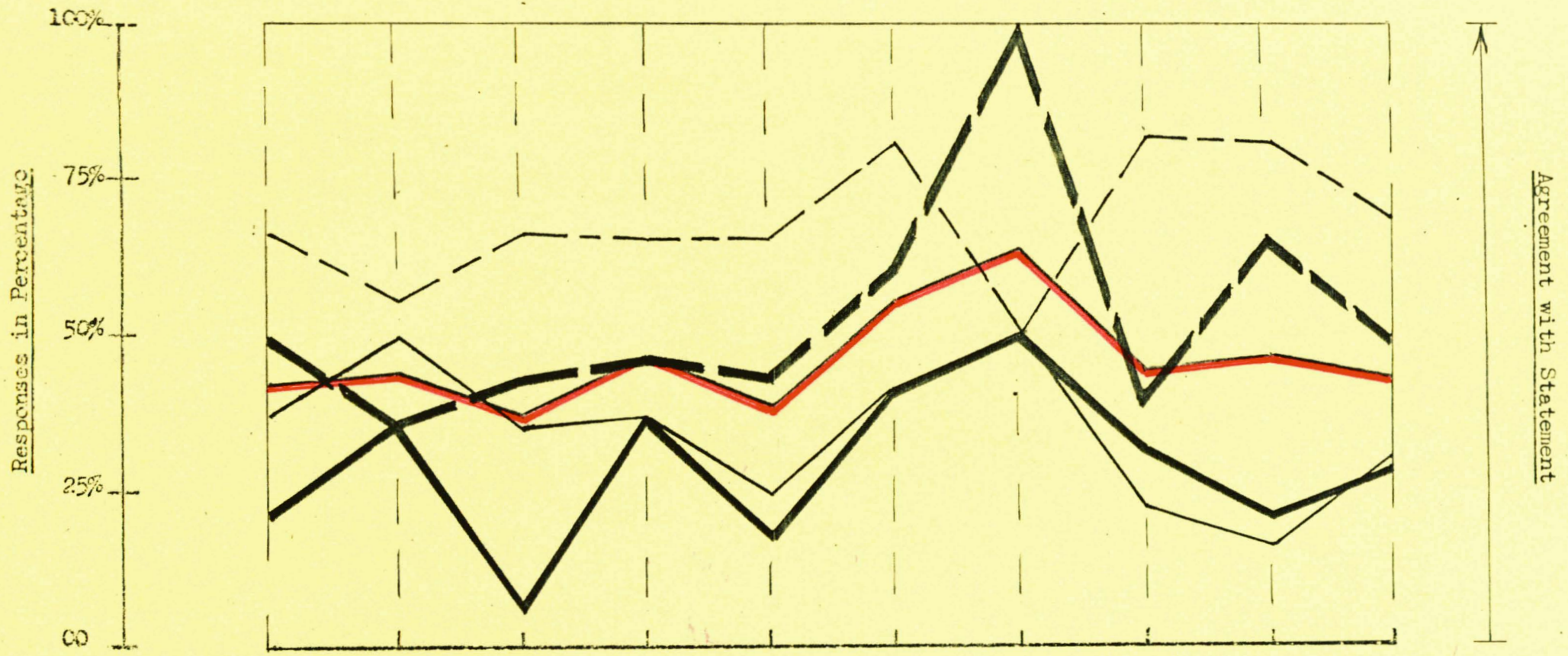
	Scale Value (S) (i.e. 50% levels)		Ambiguity (Q) (i.e. Diff. between quartile levels)
Disabled	4.57	Disabled	-2.84
Able-Bodied(1)	3.50	Able-Bodied(1)	-3.40
Group Diff. (d)	1.07	Group Diff. (d)	0.56
Caring	4.47	Caring	-2.89
Able-Bodied(2)	2.41	Able-Bodied(2)	-3.02
Group Diff. (d)	2.06	Group Diff. (d)	0.13

Statement No:- 22 Graphical Illustration of Group Difference in Scale Values at 50% Levels and Ambiguity between Quartile Levels



Statement No:- 22 Comparative Agreement between Different Secondary Groups of People

Arthritis	Blind	Deaf	Amputees	M.Sclerosis	Polio	Stroke	Heart	Paraplegic	TOTAL
N=22 =100%	N=20 =100%	N=14 =100%	N=24 =100%	N=16 =100%	N=5 =100%	N=4 =100%	N=42 =100%	N=45 =100%	N=192 =100%



Legend:-

Disabled Group

Able-bodied(1) Group

Overall

Caring Group

Able-bodied(2) Group

Statement No. 26

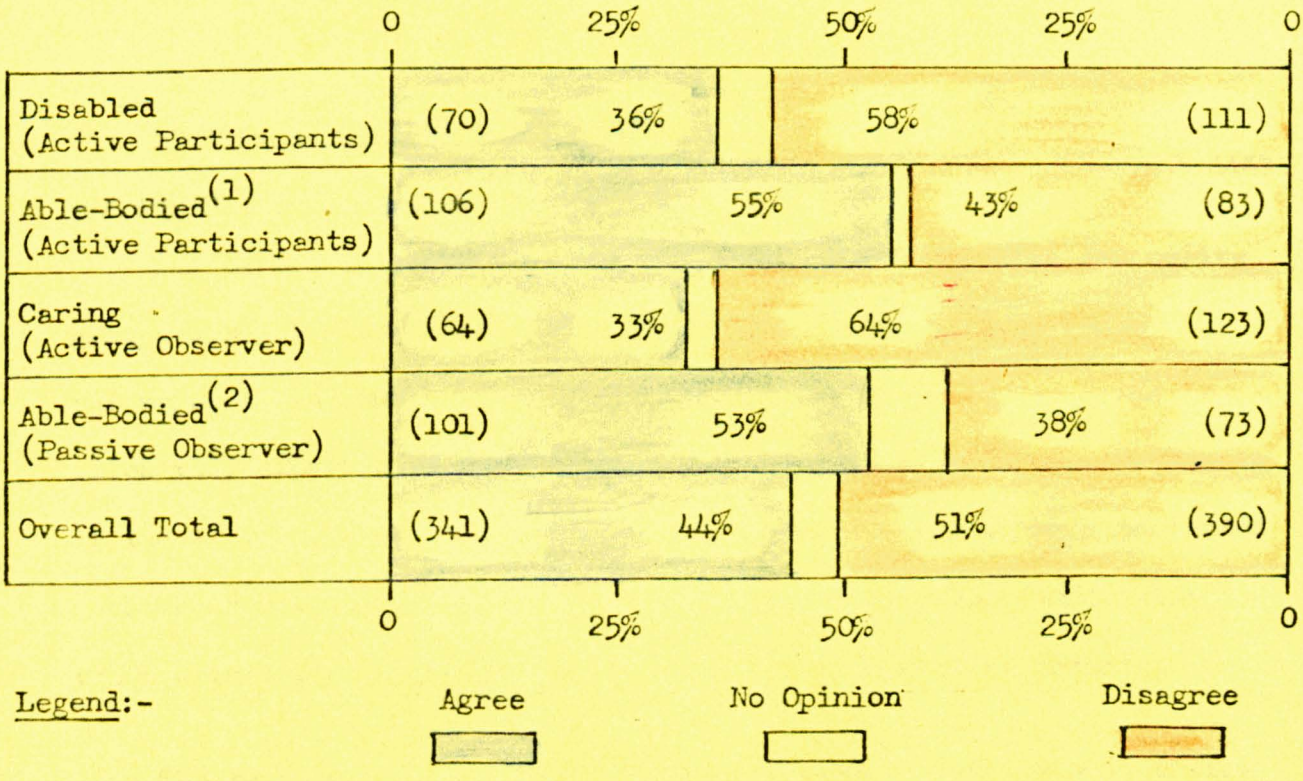
Disabled — Since I became disabled, I seldom worry when I have said to close friends something which should have been left unsaid.

Able-Bodied(1) — I seldom worry when I have said to close friends something which should have been left unsaid.

Caring — The disabled person seldom worries when he has said something to close friends which should have been left unsaid.

Able-Bodied(2) — Disabled persons seldom worry when they have said something to close friends which should have been left unsaid.

Table No. 26 (1) — Group Responses to Statement (where each Group Total N = 192 = 100% and Overall Total N = 768 = 100%)



Legend:- Agree — No Opinion — Disagree

Statistical information and graphical representations illustrating the different responses of these main groups are shown after the summary and in Appendix Nos. V and VI.

Statement No. 26

1. Group Responses to Main Statement

See Table 26 (1)

The table reveals that a large proportion of the disabled group were sensitive about saying something to close friends which should have been left unsaid. A larger proportion of the caring group expressed agreement with the general feeling of the disabled. The observations of the disabled and caring groups were not perceived similarly by the A.B.(2) group wherein a large proportion of the respondents believed that disabled people were not inclined to sensitiveness about the feelings of others.

The majority of respondents in the A.B.(1) group indicated that they did not worry after saying something to close friends which should have been left unsaid.

2. Answers to Supplementary Questions

See Tables 26 (2) and (3) - (Appendix V)

The tables indicate that the responses of the disabled and caring groups were closely related with large proportions of each group referring to the supporting services and outer community as areas in which they experienced much concern. A large proportion of respondents in the A.B.(2) group believed that the disabled would be more concerned with the behavioural reaction of individuals within the family than those within the supporting services and outer community sectors.

The responses of the A.B.(1) group suggested that the able-bodied were more sensitive to behavioural reactions of people within the supporting services than elsewhere.

See Tables 26 (4) and (5) - (Appendix V)

The responses show that the disabled and caring respondents thought that the fear of loss of social values tended to produce more anxiety for the disabled than the fear of self-devaluation. On the contrary, respondents in the A.B.(2) group generally thought that the disabled were more concerned with self-devaluation.

The majority of respondents in the A.B.(1) group seemed to be more sensitive to the effects of self-devaluation than with the loss of social values.

3. Comparative Agreement between Different Secondary Groups

See Table 26 (6) - (Appendix VI)

The table reveals that people who were handicapped by deafness or heart troubles tended to be more sensitive to the behavioural reaction of other people than those handicapped by other disabilities. The responses of the caring group indicated general agreement with the opinions of the disabled.

In contrast, a large proportion of the respondents in the A.B.(2) group considered that those who were handicapped by deafness were the least likely to worry about something said to friends which should have been left unsaid.

The importance of social relationships did not, in many cases, appear to be fully appreciated by the able-bodied, particularly in relation to those people whose social activities and environment were restricted.

4. Summary

Social interaction and relationships with the family were seen by the disabled and caring respondents to be much more

realistic than those with the supporting services and the outer community.

A large proportion of the disabled believed that "normal" relationships within the supporting services and outer community were of vital importance as it provided them with confirmation of social acceptance. The greater the number of social relationships, the more assured did the disabled feel of the acceptance of their position in outer society.

The discontinuance of a personal relationship with able-bodied people was frequently interpreted by the disabled during the interviews as indicative of a reaction to "social deviance". This appeared less important to the able-bodied because their social relationships were usually much wider and more varied than those of the disabled.

Ambivalent attitudes, representing a mixture of ignorance, fear and overprotection, were perceived during the course of the interviews to frequently constitute an important social barrier to the integration of many disabled. In a number of cases, it seemed as if the family of the disabled person had found difficulties in finding an appropriate balance between support and encouragement for independence and social integration.

Statement No. 26 Main Group Statistical Information

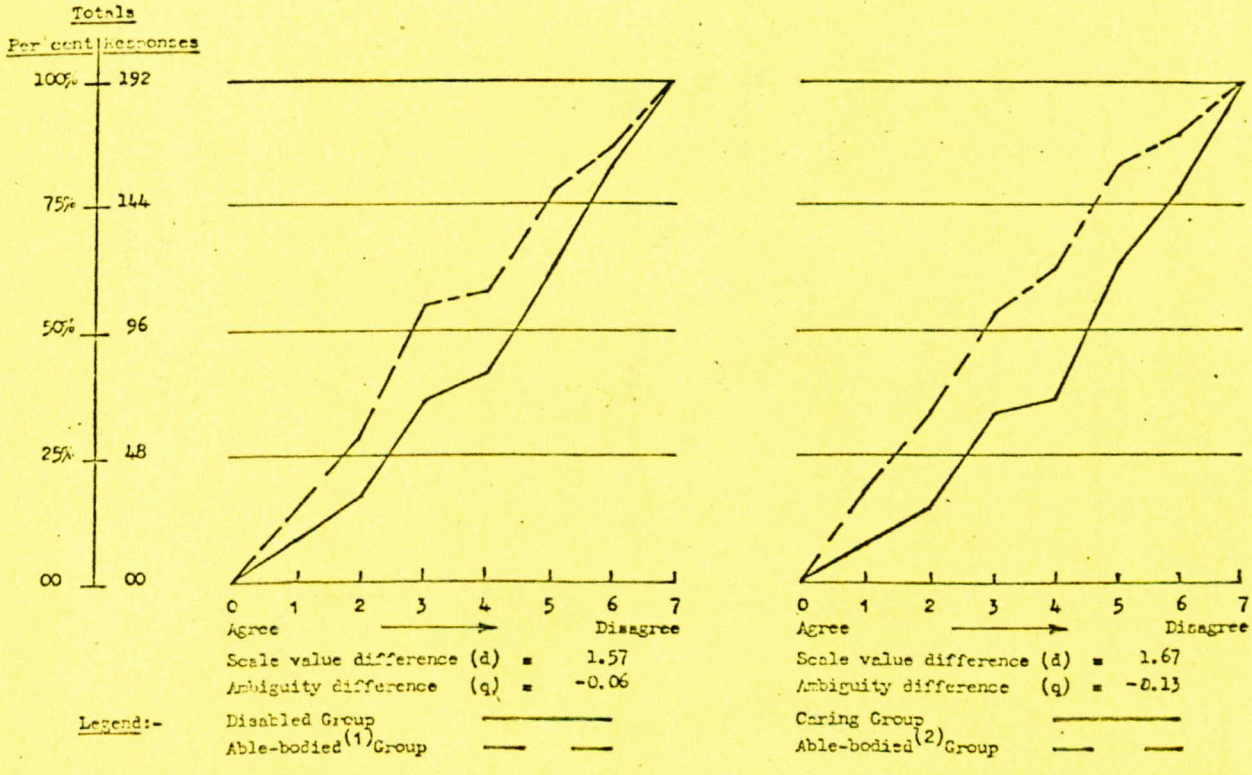
The mean and standard deviation values of the respective groups were:-

	Mean	Standard Deviation
Disabled	4.510	1.903
Able-Bodied(1)	3.813	1.957
Caring	4.703	1.898
Able-Bodied(2)	3.635	1.915

The distribution of the respective groups gave:-

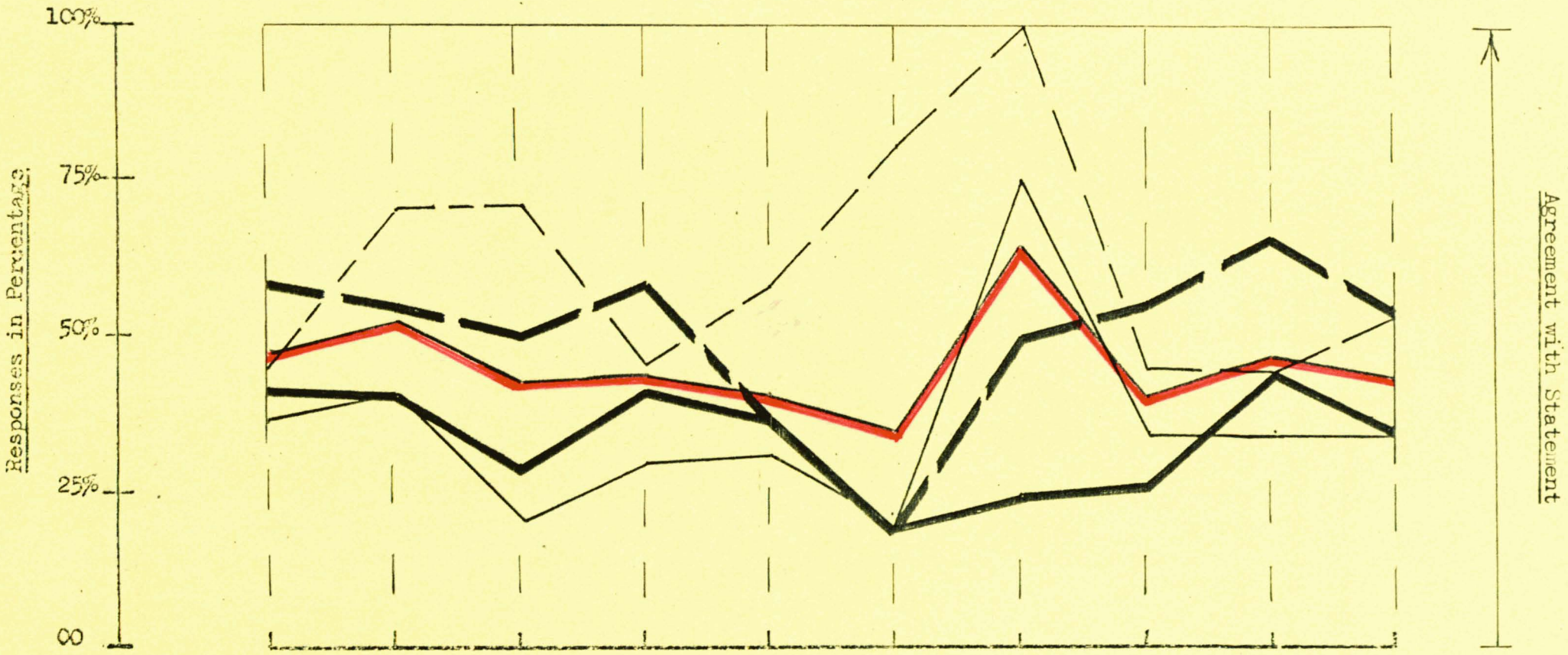
	Scale Value (S) (i.e. 50% levels)		Ambiguity (Q) (i.e. Diff. between quartile levels)
Disabled	4.38	Disabled	-3.18
Able-Bodied(1)	2.81	Able-Bodied(1)	-3.12
Group Diff. (d)	1.57	Group Diff. (d)	-0.06
Caring	4.52	Caring	-3.28
Able-Bodied(2)	2.85	Able-Bodied(2)	-3.15
Group Diff. (d)	1.67	Group Diff. (d)	-0.13

Statement No:- 26 Graphical Illustration of Group Difference in Scale Values at 50% Levels and Ambiguity between Quartile Levels



Statement No:- 26 Comparative Agreement between Different Secondary Groups of People

Arthritis	Blind	Deaf	Amputees	M.Sclerosis	Polio	Stroke	Heart	Paraplegic	TOTAL
N=22 =100%	N=20 =100%	N=14 =100%	N=24 =100%	N=16 =100%	N=5 =100%	N=4 =100%	N=42 =100%	N=45 =100%	N=192 =100%



Legend:-

Disabled Group

Able-bodied(1) Group

Overall

Caring Group

Able-bodied(2) Group

Statement No. 32

Disabled

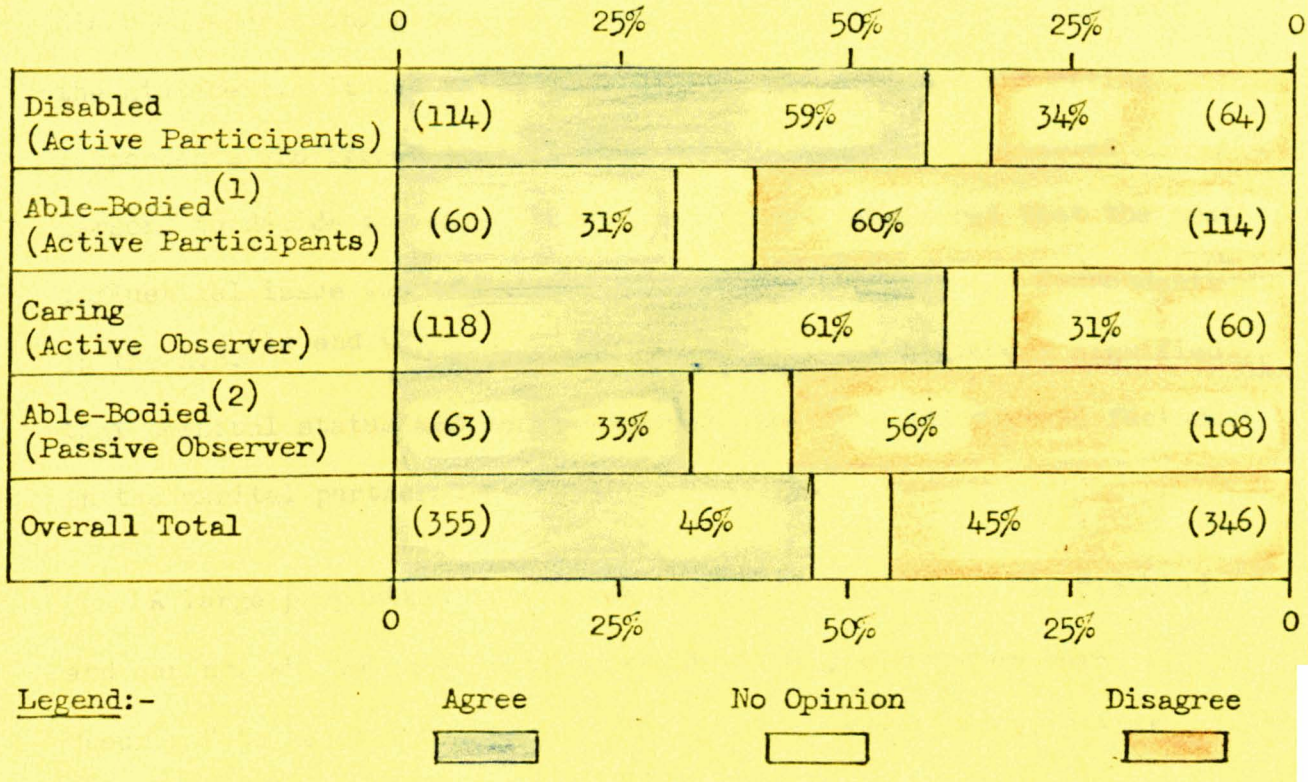
Able-Bodied(1)

Caring

Able-Bodied(2)

I think that it takes more "courage" for a disabled person to decide to marry an able-bodied person than it takes for an able-bodied person to decide to marry a disabled person.

Table No. 32 (1) — Group Responses to Statement (where each Group Total N = 192 = 100% and Overall Total N = 768 = 100%)



Legend:- Agree | No Opinion | Disagree

Statistical information and graphical representations illustrating the different responses of these main groups are shown after the summary and in Appendix Nos. V and VI.

Statement No. 32

1. Group Responses to Main Statement

See Table 32 (1)

The table shows that a large majority of the disabled indicated that it takes more "courage" for a disabled person to decide to marry an able-bodied person than it takes for an able-bodied person to decide to marry a disabled person. A large proportion of those who cared for the disabled expressed agreement with the responses of the disabled but the majority of respondents in the A.B.(1) and (2) groups indicated that it was the able-bodied who required more "courage".

2. Answers to Supplementary Questions

See Tables 32 (2), (3), (4) and (5) - (Appendix V)

The tables reveal a close agreement of opinions between the disabled and caring groups about the various factors associated with the statement. It was noted that amongst the disabled and caring respondents who agreed that it took more "courage" for disabled persons to decide to marry, large proportions considered that the most influential issue was associated with social acceptance. Respondents in the A.B.(1) and (2) groups who agreed with the statement signified that personal status and marital stress were also influential factors in the marital partnership.

A large proportion of all the groups, particularly the disabled and caring, who believed that able-bodied people required more "courage" to decide to marry disabled people, also indicated that social status was the dominant factor. The influence of marital stress and stress within the family and home was evident by relatively large proportions of all the groups.

It was noted that larger proportions of single respondents in the disabled and caring groups seemed to give more emphasis to adverse consequences experienced in areas of the self and family sectors than revealed by the married respondents.

See Tables 32 (6), (7), (8) and (9) - (Appendix V)

Whilst the sense of love, belonging and "togetherness" were seen by a large proportion of each group to be important factors within the marital relationships, the various tables indicate that the disabled considered integration and acceptance of their general situation by the outer community to be of greater importance to them than indicated by the responses of the able-bodied groups. On the other hand, shared interests, companionship and dependency did not appear to be so important to many respondents in the disabled and caring groups as indicated generally by the able-bodied.

3. Comparative Agreements between Different Secondary Groups

See Table 32 (10) - (Appendix VI)

Responses of the disabled group suggested that the risk of marriage was greater to those people who were handicapped by multiple sclerosis than it was to people handicapped by other disabilities. The responses of the caring group showed general agreement with those of the disabled.

The responses of the A.B.(2) group differed considerably from those of the disabled and caring groups.

It was apparent during the interviews that a large proportion of the able-bodied failed to recognise the importance of many basic qualities associated with the marital partnership in respect of disabled people.

4. Summary

It would appear that marriage between the disabled and able-bodied provides a good indicator of social integration. Responses from the disabled and caring respondents suggested that the greatest problems encountered by the marital partnership were most likely to originate from the social sector. During the interviews many disabled indicated that lack of social acceptance and involvement and limited opportunities for education and employment were particularly important issues to be considered by the disabled when making marital decisions.

The able-bodied, in general, believed that disability imposed stress upon the marital partnership but they viewed such stress as occurring primarily within the confined areas of the self and family. It seemed from the different responses that the able-bodied observed disabled people living a life which was confined in a restrictive environment whereas the disabled seemed to look to full participation in an integrated society.

The traditional definitions of masculinity and feminity were frequently seen during the interviews to minimise the degree of flexibility that disabled husbands and/or wives have in alternately occupying roles labelled "masculine" or "feminine". Traditional expectations about the appropriate roles of men and women seemed in some cases to constitute not only a social barrier but also to impede the familial integration of the disabled whenever their disability affects the "core" of the masculine or feminine familial roles.

Problems in deciding which role should be fulfilled by the disabled person to meet with the approval of the family and other significant individuals were frequently seen during the interviews to be stressful, particularly when examined in the view of potential marriage.

A number of disabled respondents seemed to accept a model of conformity by their declaration of "no marriage", whilst others were observed to have rebelled against the labelling process by participating in the marriage partnership. Many able-bodied during the interviews looked generally at disability and marriage as an acceptable situation provided that an element of "invalidism" prevailed in the partnership.

The responses of many respondents indicated that the characteristics of disability frequently posed moral problems that were often severe and somewhat poignant in the marital and family relationship. It also seemed evident that the effects of disability and consequential adjustment had a major influence on the success of the marriage partnership.

The social stigmatisation of disability by some people was seen in the "spread of the stigma" to close relatives. In a few cases close relatives and spouses had dissociated themselves from the disabled person despite the fact that the latter had been rehabilitated and occupied a responsible role as a working member of society.

It appears that disability frequently tests the basic concepts of a marital partnership and the various issues which are entwined within the partnership from the supporting services and outer community. In many cases the stress imposed upon the partnership by the various issues did not appear to be recognised by the able-bodied.

Statement No. 32 Main Group Statistical Information

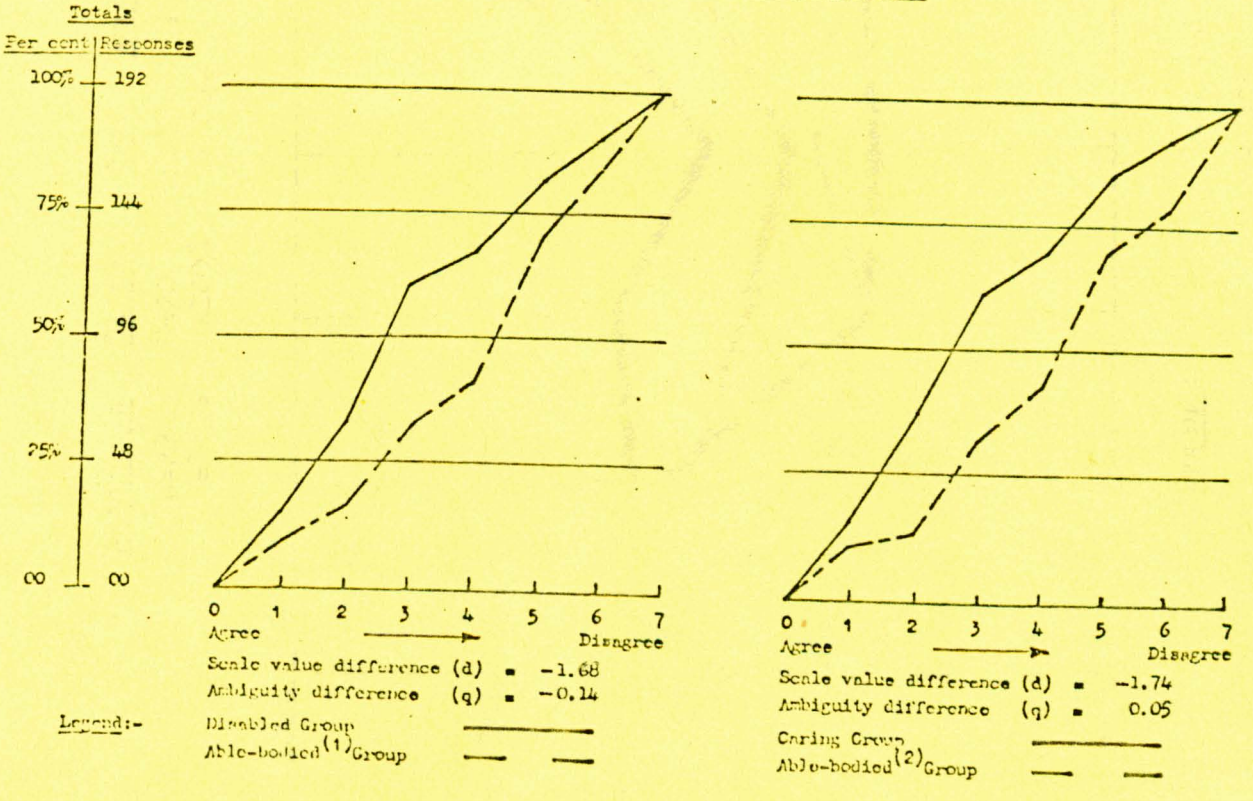
The mean and standard deviation values of the respective groups were:-

	Mean	Standard Deviation
Disabled	3.552	1.864
Able-Bodied(1)	4.490	1.828
Caring	3.395	1.816
Able-Bodied(2)	4.453	1.875

The distribution of the respective groups gave:-

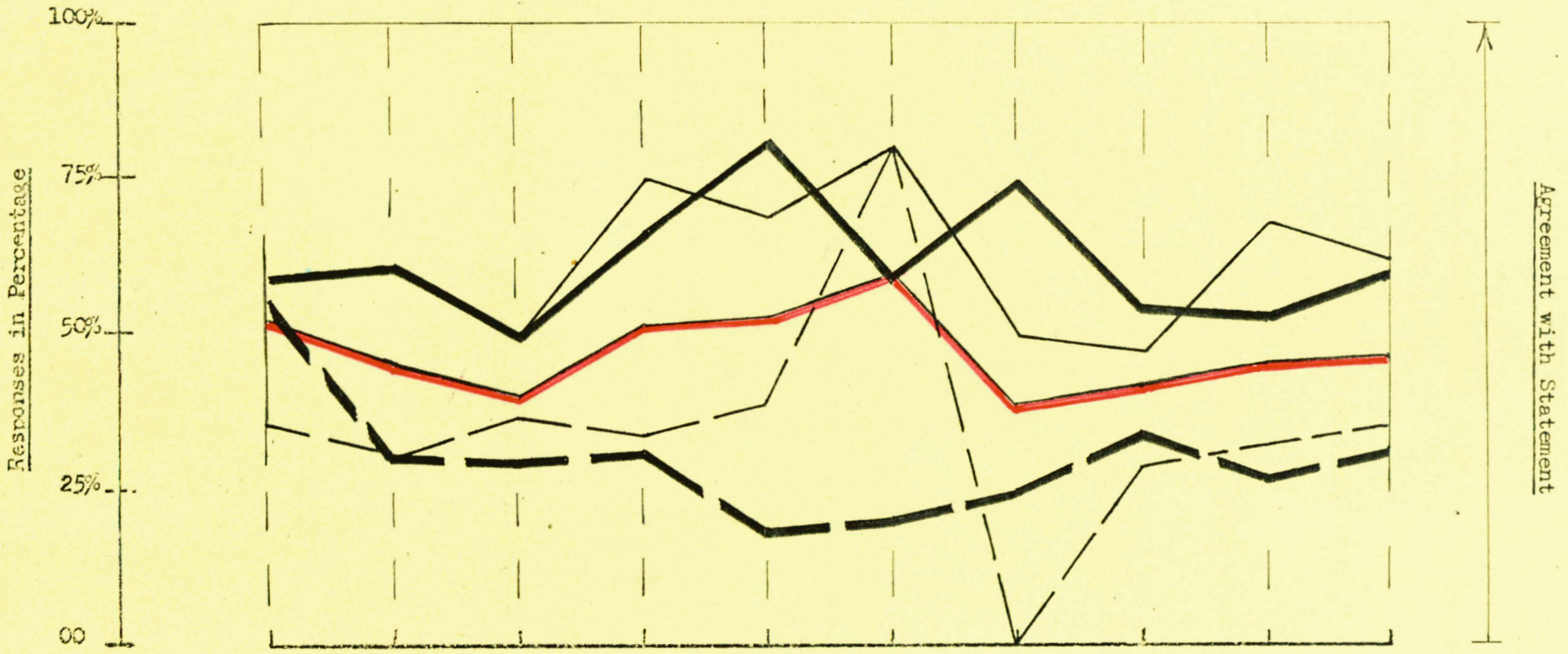
	Scale Value (S) (i.e. 50% levels)		Ambiguity (Q) (i.e. Diff. between quartile levels)
Disabled	2.63	Disabled	-2.97
Able-Bodied(1)	4.31	Able-Bodied(1)	-2.83
Group Diff. (d)	-1.68	Group Diff. (d)	-0.14
Caring	2.52	Caring	-2.94
Able-Bodied(2)	4.26	Able-Bodied(2)	-2.99
Group Diff. (d)	-1.74	Group Diff. (d)	0.05

Statement No:- 32 Graphical Illustration of Group Difference in Scale Values at 50% Levels and Ambiguity between Quartile Levels



Statement No:- 32 Comparative Agreement between Different Secondary Groups of People

Arthritis	Blind	Deaf	Amputees	M.Sclerosis	Polio	Stroke	Heart	Paraplegic	TOTAL
N=22 =100%	N=20 =100%	N=14 =100%	N=24 =100%	N=16 =100%	N=5 =100%	N=4 =100%	N=42 =100%	N=45 =100%	N=192 =100%



Legend:-

Disabled Group

Able-bodied(1) Group

Overall

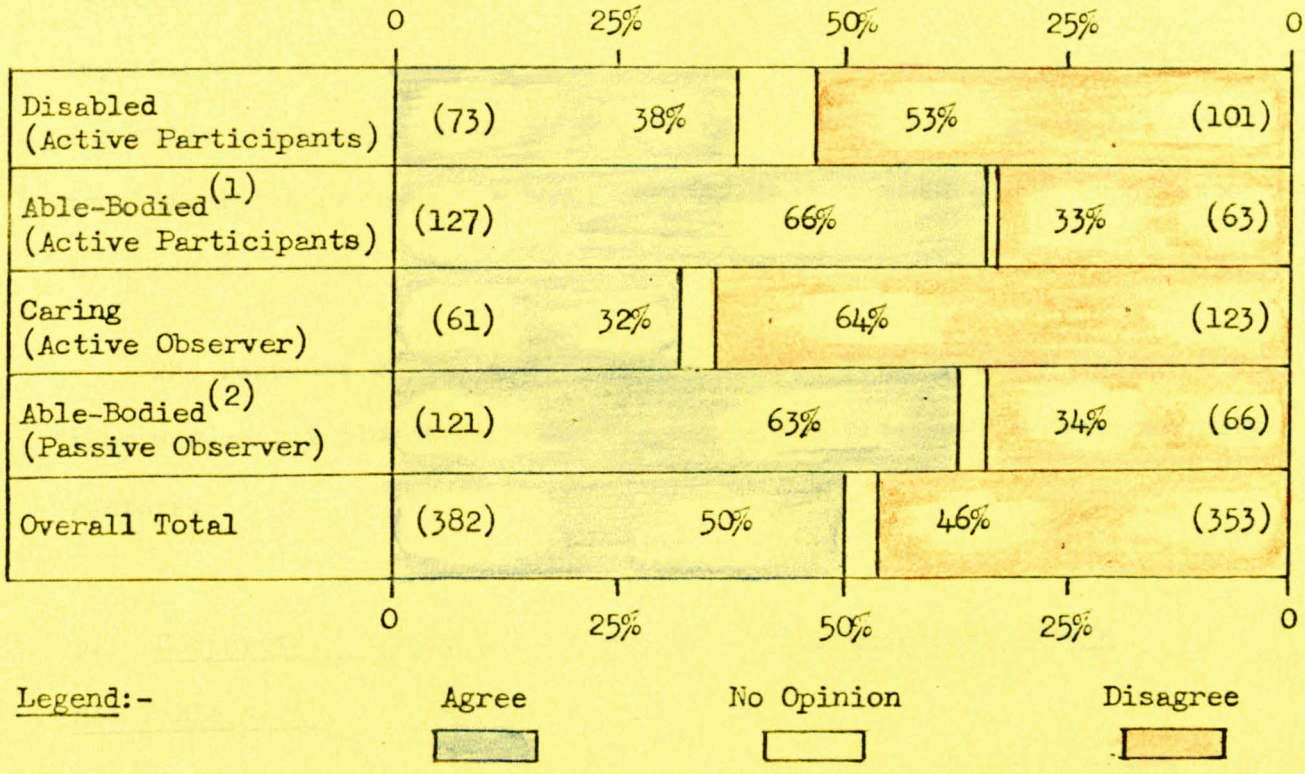
Caring Group

Able-bodied(2) Group

Statement No. 42

Disabled	Since I became disabled, self-discipline has not been important to me.
Able-Bodied(1)	Self-discipline has not been important to me during the last few years.
Caring	Self-discipline has not been important to the disabled person.
Able-Bodied(2)	Self-discipline is not important to disabled persons.

Table No. 42 (1) — Group Responses to Statement (where each Group Total N = 192 = 100% and Overall Total N = 768 = 100%)



Statistical information and graphical representations illustrating the different responses of these main groups are shown after the summary and in Appendix Nos. V and VI.

Statement No. 42

1. Group Responses to Main Statement

See Table 42 (1)

The majority of the disabled considered that self-discipline was important to them and agreement with this opinion was evident by a large proportion of the caring group. About two-thirds of the A.B.(2) group believed that self-discipline was not important to the disabled.

About two-thirds of the A.B.(1) group respondents indicated that self-discipline was not important to them.

2. Answers to Supplementary Questions

See Tables 42 (2) and (3) - (Appendix V)

The responses of the disabled and caring groups were closely related with large proportions of each group referring to the importance of discipline in sectors involving the supporting services and outer community. A large proportion of the A.B.(2) group believed that disciplinary measures involving the self were of great importance to disabled people.

The response of the A.B.(1) group showed that self-discipline for them was most influential in the supporting services and outer community sectors.

3. Comparative Agreements between Different Secondary Groups

See Table 42 (4) - (Appendix VI)

The responses of the disabled group indicate that self-discipline was most important to those people who were handicapped by amputations. Agreement with this opinion was evident by the responses of those who cared for the amputees.

The responses of the A.B.(2) group were frequently seen to differ from the disabled and caring groups.

The importance of self discipline to the disabled did not appear to be fully appreciated by a large proportion of the able-bodied.

4. Summary

Self-discipline was seen by the disabled to be more influential as a contributory factor toward social integration and achieving a successful role in society than was indicated by the able-bodied.

It was also indicated by a large proportion of the disabled that self-discipline was an important motivational issue in the restoration of physical integrity, personal independence and social adequacy. These aspects were not readily identified by the able-bodied who indicated that the attributes of self-discipline were more involved with the self and family roles.

Statement No. 42 Main Group Statistical Information

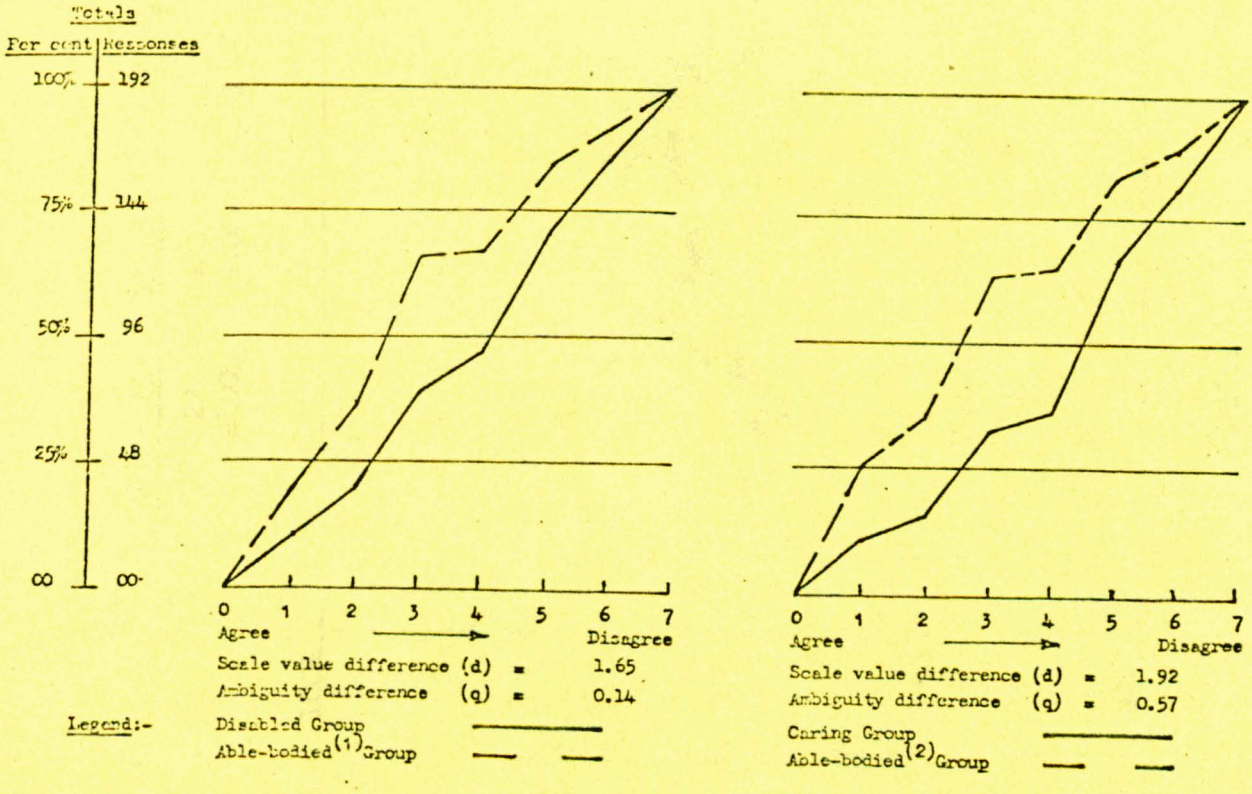
The mean and standard deviation values of the respective groups were:-

	Mean	Standard Deviation
Disabled	4.276	1.872
Able-Bodied(1)	3.323	1.867
Caring	4.588	1.876
Able-Bodied(2)	3.401	2.007

The distribution of the respective groups gave:-

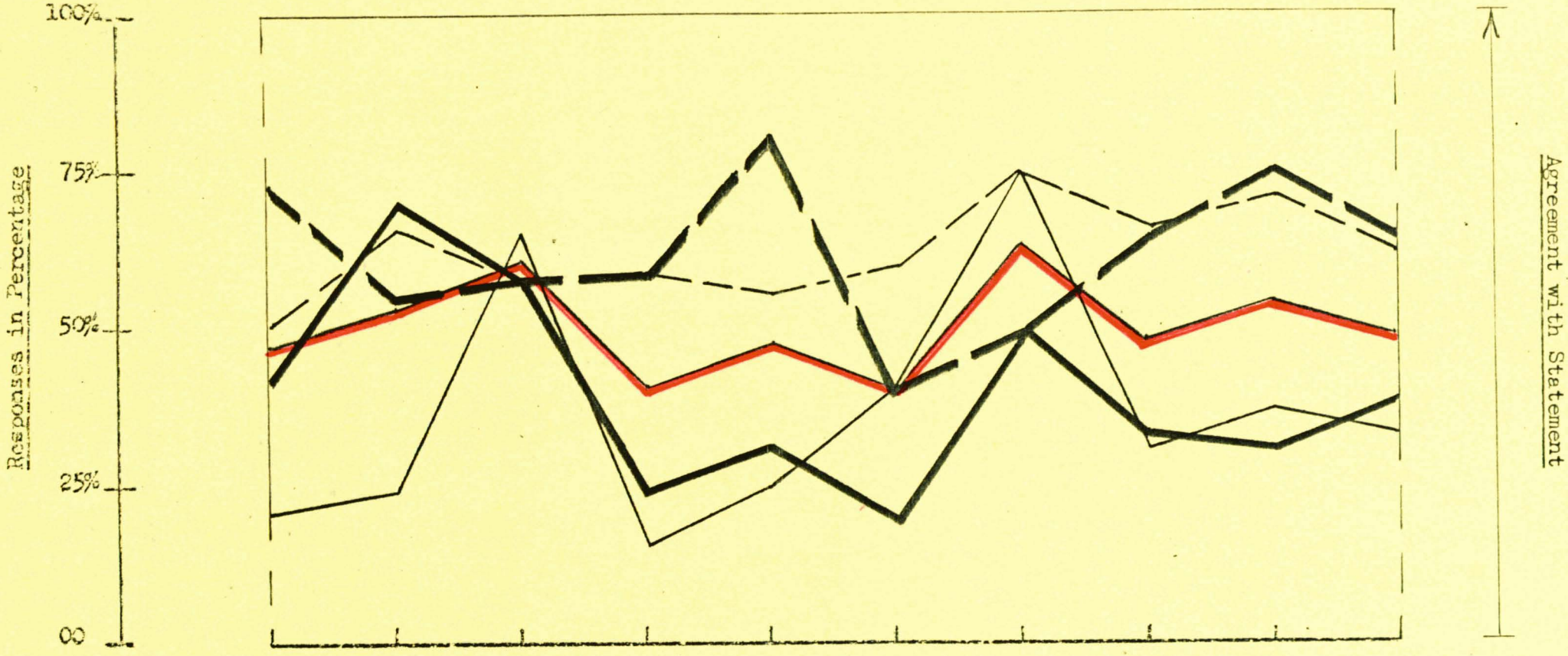
	Scale Value (S) (i.e. 50% levels)		Ambiguity (Q) (i.e. Diff. between quartile levels)
Disabled	4.12	Disabled	-2.99
Able-Bodied(1)	2.47	Able-Bodied(1)	-3.13
Group Diff. (d)	1.65	Group Diff. (d)	0.14
Caring	4.45	Caring	-2.98
Able-Bodied(2)	2.53	Able-Bodied(2)	-3.55
Group Diff. (d)	1.92	Group Diff. (d)	0.57

Statement No:- 42 Graphical Illustration of Group Difference in Scale Values at 50% Levels and Ambiguity between Quartile Levels



Statement No:- 42 Comparative Agreement between Different Secondary Groups of People

Arthritis	Blind	Deaf	Amputees	M.Sclerosis	Polio	Stroke	Heart	Paraplegic	TOTAL
N=22 =100%	N=20 =100%	N=14 =100%	N=24 =100%	N=16 =100%	N=5 =100%	N=4 =100%	N=42 =100%	N=45 =100%	N=192 =100%



Legend:-

Disabled Group

Able-bodied(1) Group

Overall

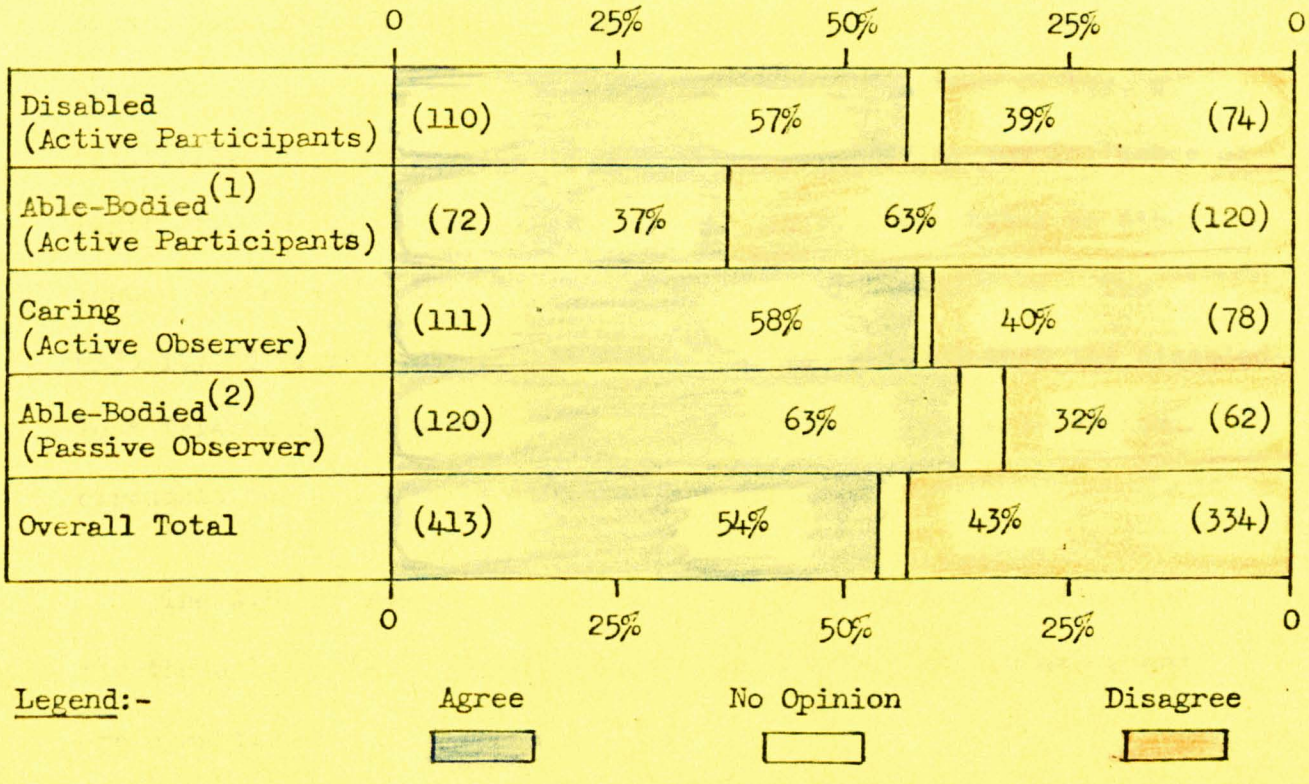
Caring Group

Able-bodied(2) Group

Statement No. 43

Disabled	Since I became disabled, I have lost contact with many of my former close friends.
Able-Bodied(1)	I have lost contact with many of my former close friends.
Caring	The disabled person has lost contact with many of his former close friends since he became disabled.
Able-Bodied(2)	The disabled person loses contact with many of his former close friends after he becomes disabled.

Table No. 43 (1) — Group Responses to Statement (where each Group Total N = 192 = 100% and Overall Total N = 768 = 100%)



Statistical information and graphical representations illustrating the different responses of these main groups are shown after the summary and in Appendix Nos. V and VI.

Statement No. 43

1. Group Responses to Main Statement

See Table 43 (1)

The table shows that large proportions of the disabled and caring groups agreed that the occurrence of disability tended to terminate many pre-disability friendships. A slightly larger proportion of the A.B.(2) group expressed agreement with the opinions of the disabled and caring respondents.

In contrast, a large proportion of the A.B.(1) group indicated that the friendships of the able-bodied did not terminate so quickly.

2. Answers to Supplementary Questions

See Tables 43 (2) and (3) - (Appendix V)

A fairly close relationship was seen to occur between the responses of the disabled and caring groups. Apart from the importance of economics and activities within the supporting services sector, a relatively large proportion of each group referred to the influence of restrictive daily living activities and the loss of status as other issues contributing towards the termination of friendships. The majority of respondents in the A.B.(2) group believed that the disabled lost friendships as a result of inheriting less favourable economic circumstances and adverse employment situations.

The A.B.(1) group believed that a continuation of friendships for the able-bodied centred around issues related to economics and employment.

3. Comparative Agreements between Different Secondary Groups

See Table 43 (4) - (Appendix VI)

The responses indicated that those people who were handicapped by multiple sclerosis tended to lose friends following the onset of disability more quickly than people handicapped by other disabilities.

Agreement with the opinions of the disabled was evident by the responses of large proportions of both the caring and A.B.(2) groups.

Loss of contacts with friends appeared to many respondents to be one of the adverse consequences of restrictive social activity and environment; factors usually allied with disability.

4. Summary

Values associated with pre-disability roles were frequently seen during the interviews to have depreciated considerably following the onset of disability, particularly those associated with self-esteem, personal integrity and social adequacy. Consequently, post-disability relationships had often been affected adversely.

It seemed clear that contact and participation with the supporting services and outer community were of great importance to a large proportion of the disabled. Any termination of personal relationships was thought to have a greater adverse effect upon the disabled than upon the able-bodied because of limited opportunities to substitute the losses with new friendships.

For the disabled and caring people, friendships with people in the supporting services and outer community was seen to provide stability of orientation and security.

It often appeared during the interviews that irrational fears and conscious and unconscious reactions to disability had formed a prohibitive social barrier to the ability of the disabled person to develop and establish intimate relationships with the able-bodied.

The segregation of the disabled in education and employment appeared to be an important social handicap; a position often more seriously affected if the disabled were unable to participate in club, sports and leisure activities. In a few cases it seemed that segregation from such social activities had been intentionally instituted by the disabled themselves and, occasionally, this was perceived to have led to the exclusion of relationships with the able-bodied.

Statement No. 43 Main Group Statistical Information

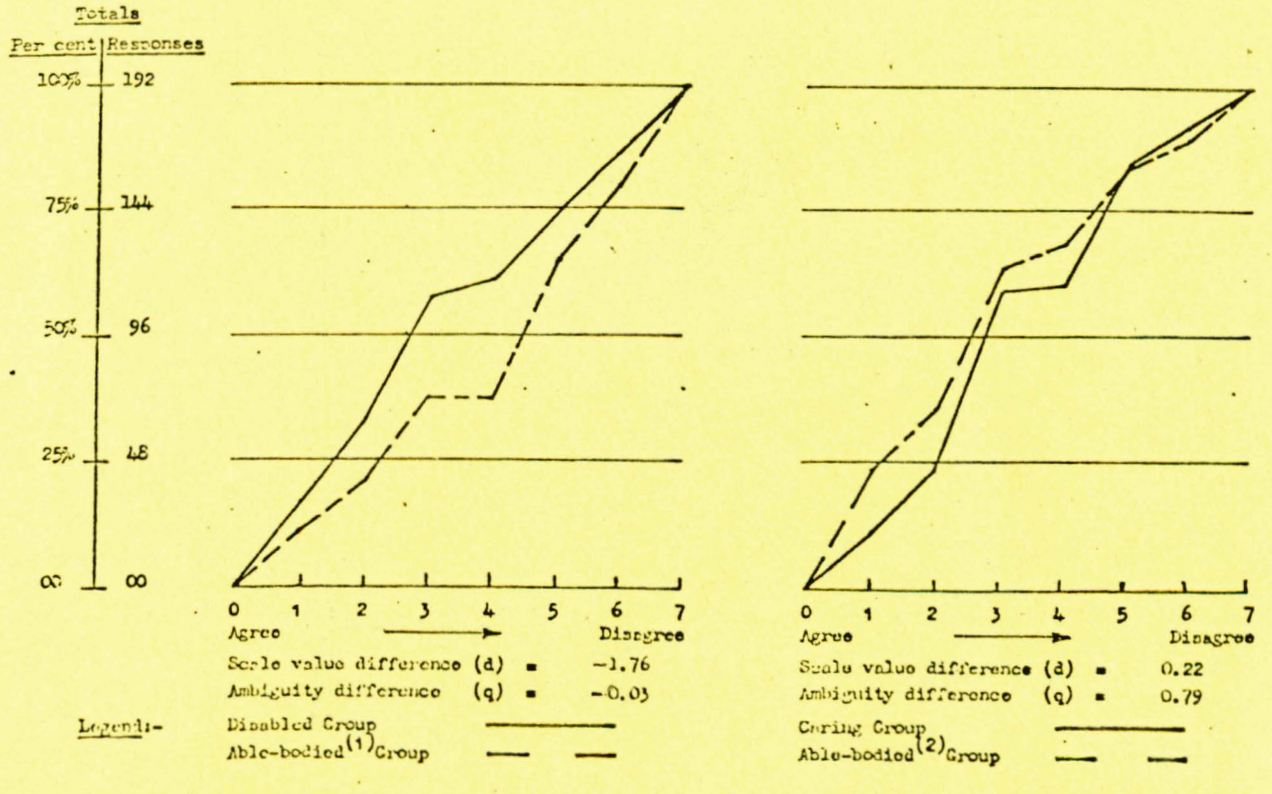
The mean and standard deviation values of the respective groups were:-

	Mean	Standard Deviation
Disabled	3.693	2.014
Able-Bodied(1)	4.490	2.016
Caring	3.734	1.738
Able-Bodied(2)	3.369	1.934

The distribution of the respective groups gave:-

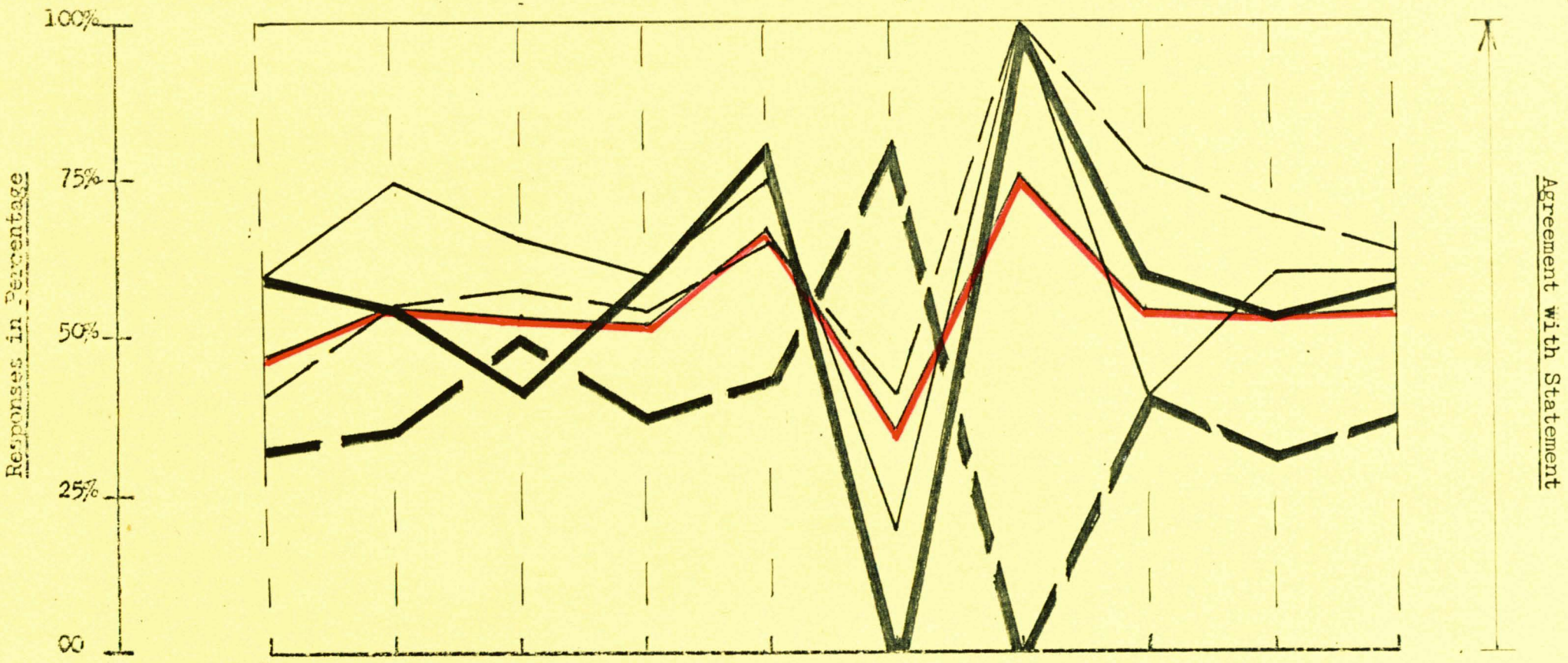
	Scale Value (S) (i.e. 50% levels)		Ambiguity (Q) (i.e. Diff. between quartile levels)
Disabled	2.72	Disabled	-3.47
Able-Bodied(1)	4.48	Able-Bodied(1)	-3.44
Group Diff. (d)	-1.76	Group Diff. (d)	-0.03
Caring	2.74	Caring	-1.57
Able-Bodied(2)	2.52	Able-Bodied(2)	-2.36
Group Diff. (d)	0.22	Group Diff. (d)	0.79

Statement No:- 43 Graphical Illustration of Group Difference in Scale Values at 50% Levels and Ambiguity between Quartile Levels



Statement No:- 43 Comparative Agreement between Different Secondary Groups of People

Arthritis	Blind	Deaf	Amputees	M.Sclerosis	Polio	Stroke	Heart	Paraplegic	TOTAL
N=22 =100%	N=20 =100%	N=14 =100%	N=24 =100%	N=16 =100%	N=5 =100%	N=4 =100%	N=42 =100%	N=45 =100%	N=192 =100%



Legend:-

Disabled Group

Able-bodied(1) Group

Overall

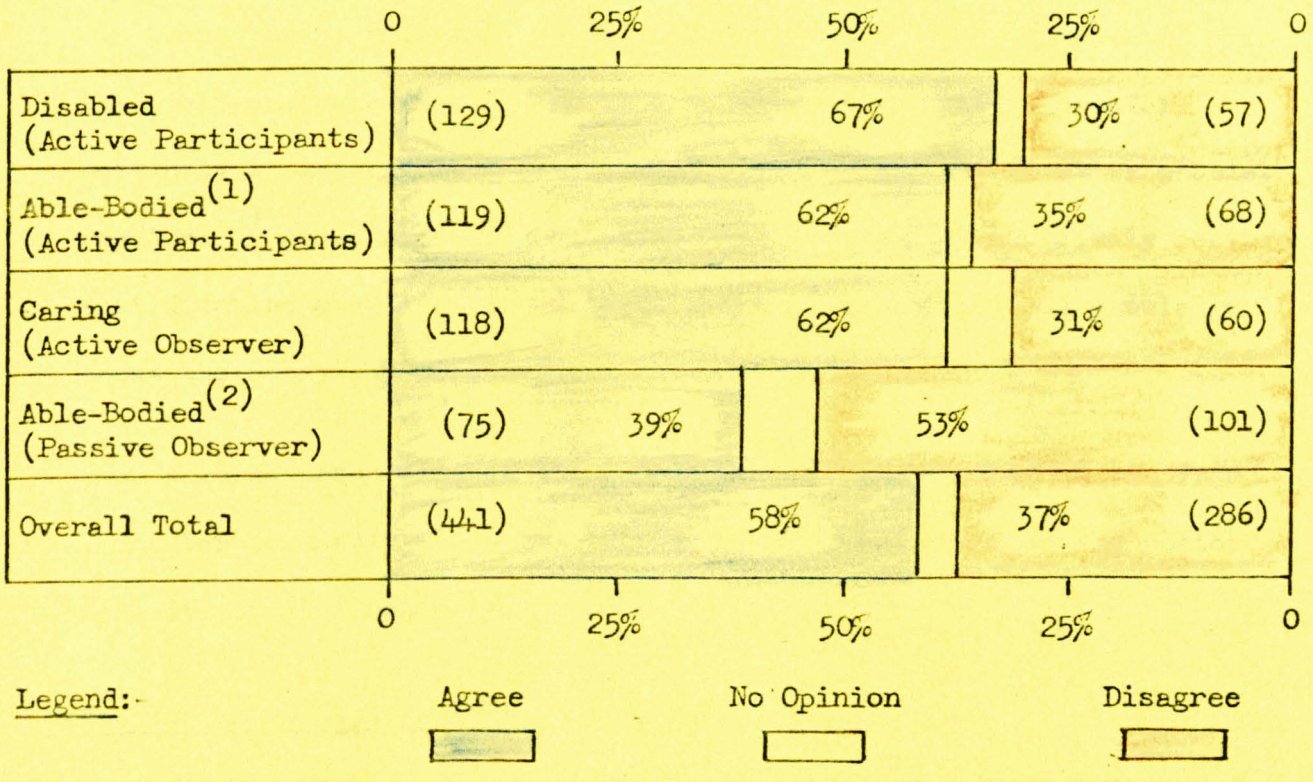
Caring Group

Able-bodied(2) Group

Statement No. 44

Disabled	As a result of my disability, I have a good understanding of the behaviour of other persons.
Able-Bodied(1)	I have a good understanding of the behaviour of other persons.
Caring	The disabled person has a good understanding of the behaviour of other persons.
Able-Bodied(2)	As a result of their disability, disabled persons have a good understanding of the behaviour of other persons.

Table No. 44 (1) — Group Responses to Statement (where each Group Total N = 192 = 100% and Overall Total N = 768 = 100%)



Legend:- Agree | No Opinion | Disagree

Statistical information and graphical representations illustrating the different responses of these main groups are shown after the summary and in Appendix Nos. V and VI.

Statement No. 44

1. Group Responses to Main Statement

See Table 44 (1)

The table reveals that a large proportion of the disabled group indicated that they had obtained a good understanding of the behaviour of other people since the onset of their disabilities. Agreement with this opinion was evident by the responses of a large proportion of those who cared for them. The majority of respondents in the A.B.(2) group did not subscribe to the opinions of the disabled and caring.

A large proportion of the A.B.(1) group indicated that the able-bodied possessed a good understanding of the behaviour of other people.

2. Answers to Supplementary Questions

See Tables 44 (2) and (3) - (Appendix V)

Large proportions of the disabled and caring groups indicated that self-analysis was as important as interaction with the outer community in gaining an understanding of the behaviour of other people. The A.B.(2) group generally believed that it was from the family sector that disabled people obtained their greatest experience and knowledge about the behaviour of others.

A large proportion of the A.B.(1) group thought that it was from the outer community where the able-bodied derived a deeper and better understanding of other people.

See Tables 44 (4) and (5) - (Appendix V)

The responses of the disabled and caring groups were closely related in connection with issues considered important in helping the disabled to understand the behaviour of other people. Large proportions of each group referred to the importance of the attitudes of individua-

people and the influence of values and "norms" established by the supporting services, outer community and the general communications media. These issues did not seem to be so important to the disabled as indicated by the responses of the A.B.(2) group. A large proportion of this group referred to the influence of legislation and the national political and economic situations in determining attitudes and behavioural reaction of different services toward the disabled.

The responses of the A.B.(1) group were near to those of the A.B.(2) group.

3. Comparative Agreements between Different Secondary Groups

See Table 44 (6) - (Appendix VI)

The results indicate that those who were handicapped by arthritis or blindness believed that they possessed a good knowledge of the behaviour of other people. Those who were disabled by heart troubles or hearing difficulties were more conservative in their assessments. The responses of the caring group showed evidence of general agreement with those of the disabled.

The responses of the A.B.(2) group frequently differed from those of the disabled and caring groups.

Restrictive choice of social opportunities appeared in some cases to have offered a greater opportunity for self-analysis and behavioural reaction which otherwise the respondents might not have experienced.

4. Summary

The social behaviour of other people was seen by the disabled and caring respondents to be particularly important. They frequently

referred to misconceptions, prejudices, stereo-typing and patronising attitudes exhibited by the able-bodied during social interaction. These aspects appeared unimportant to a large proportion of the able-bodied.

Most disabled seemed to give a clear indication that an honest confrontation with their associated problems and facing disability in its totality assisted them to react positively to an adjusted role. They believed that this attitude was a product of self-analysis, education and accurate information. The importance of the concept seemed to be particularly pertinent to many able-bodied in order that the abolishment of negative attitudes toward the disabled could take place.

It was evident that individual attitudes and prejudices which produce discriminatory behaviour often have a direct relationship to broad social issues. The comments of many respondents during the interviews seemed to suggest, in many ways, that political systems reflect the philosophy of, and approach to, social behaviour. Legislation seems to provide the "norms" for such reaction and where the political views and systems consciously seek to make changes in society, they tend to provide opportunities to re-assess social attitudes towards the disabled and influence the attitude and behavioural reaction of the supporting services.

Statement No. 44 Main Group Statistical Information

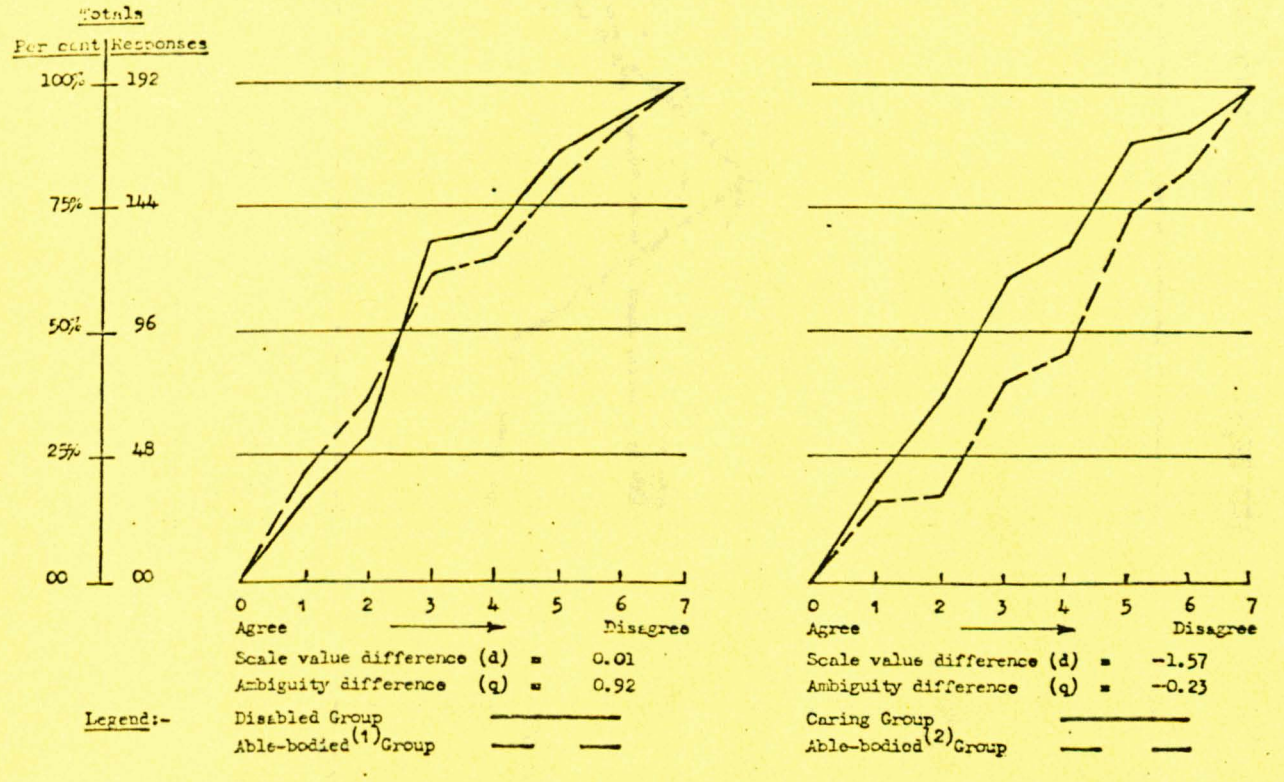
The mean and standard deviation values of the respective groups were:-

	Mean	Standard Deviation
Disabled	3.438	1.777
Able-Bodied(1)	3.443	1.970
Caring	3.328	1.833
Able-Bodied(2)	4.208	1.978

The distribution of the respective groups gave:-

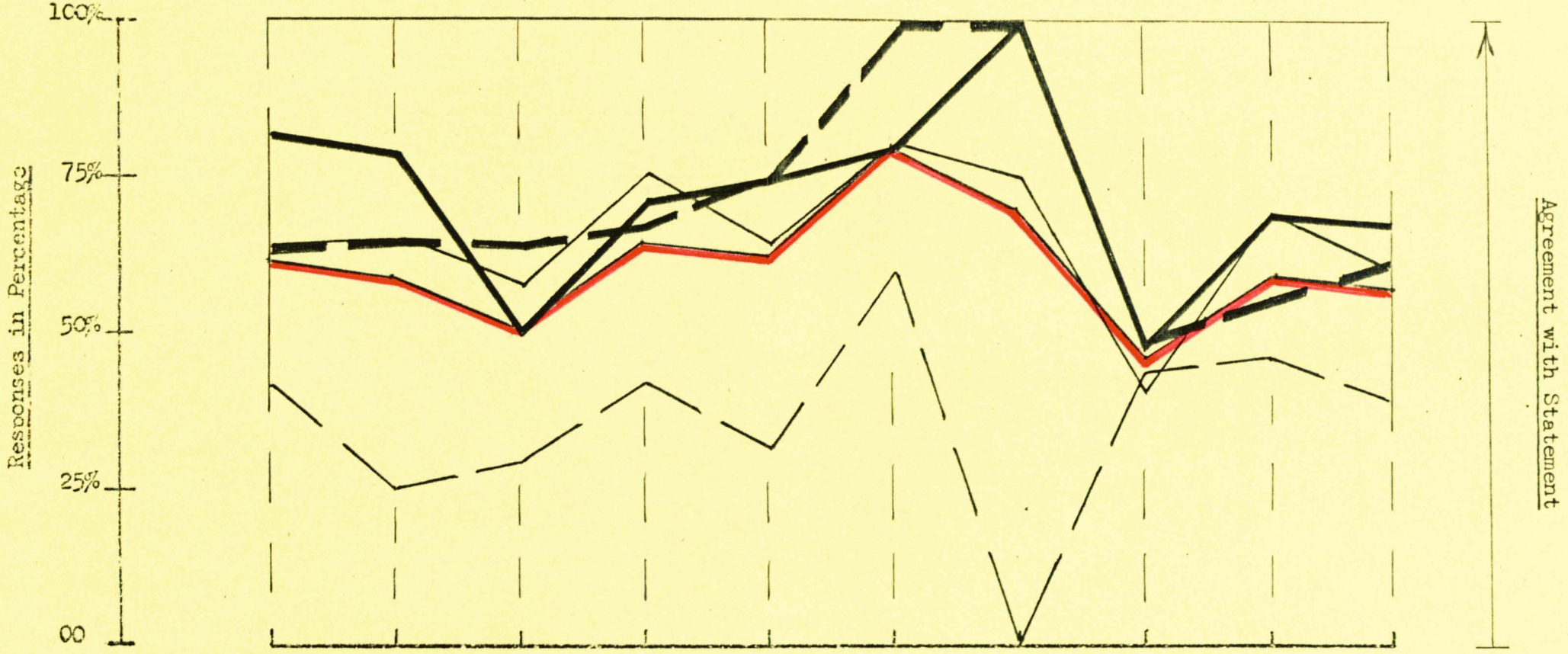
	Scale Value (S) (i.e. 50% levels)		Ambiguity (Q) (i.e. Diff. between quartile levels)
Disabled	2.55	Disabled	-2.50
Able-Bodied(1)	2.54	Able-Bodied(1)	-3.42
Group Diff. (d)	0.01	Group Diff. (d)	0.92
Caring	2.54	Caring	-3.06
Able-Bodied(2)	4.11	Able-Bodied(2)	-2.83
Group Diff. (d)	-1.57	Group Diff. (d)	-0.23

Statement No:- 44 Graphical Illustration of Group Difference in Scale Values at 50% Levels and Ambiguity between Quartile Levels



Statement No:- 44 Comparative Agreement between Different Secondary Groups of People

Arthritis	Blind	Deaf	Amputees	M.Sclerosis	Polio	Stroke	Heart	Paraplegic	TOTAL
N=22 =100%	N=20 =100%	N=14 =100%	N=24 =100%	N=16 =100%	N=5 =100%	N=4 =100%	N=42 =100%	N=45 =100%	N=192 =100%



Legend:-

Disabled Group

Able-bodied(1) Group

Overall

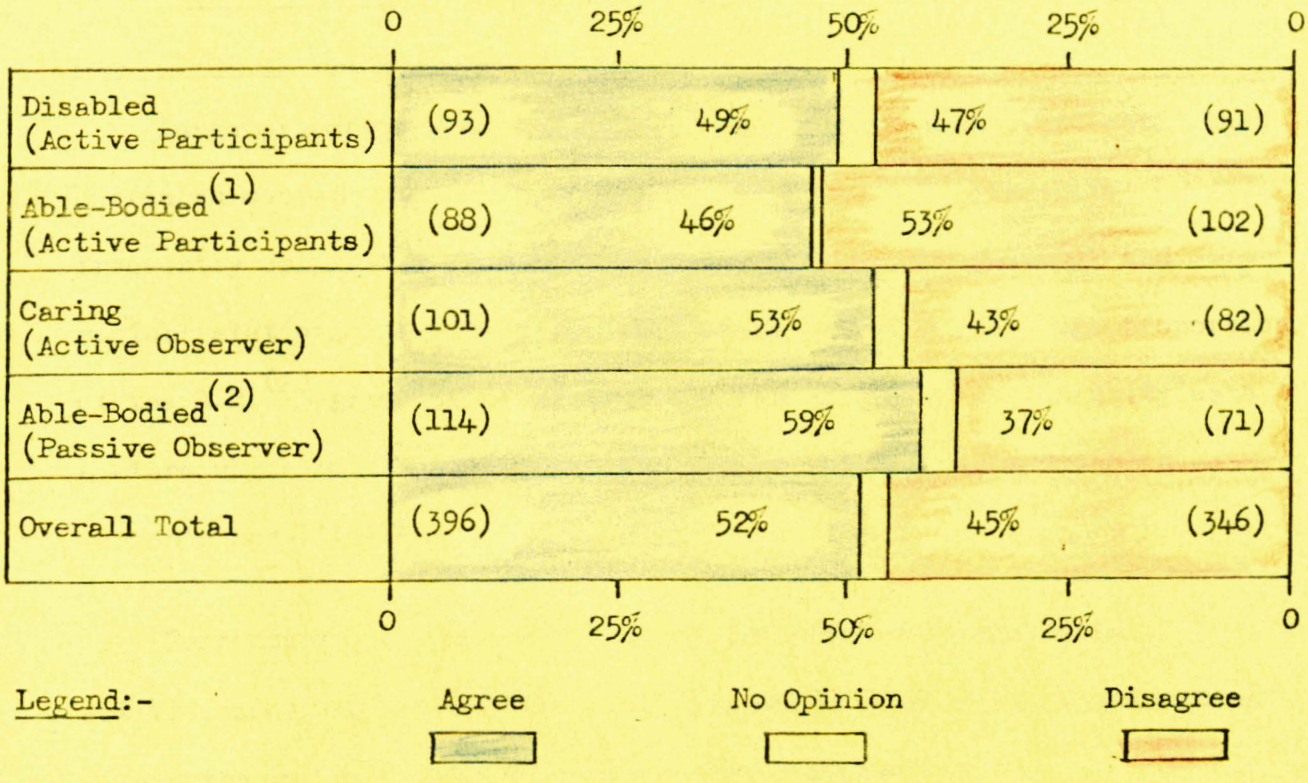
Caring Group

Able-bodied(2) Group

Statement No. 45

Disabled	Since I became disabled, the social activity of my home-life has decreased.
Able-Bodied(1)	The social activity of my home-life has decreased during the last few years.
Caring	The social activity of the disabled person's home-life has decreased since he became disabled.
Able-Bodied(2)	The social activity of a family's home-life decreases when a member becomes disabled.

Table No. 45 (1) — Group Responses to Statement (where each Group Total N = 192 = 100% and Overall Total N = 768 = 100%)



Legend:- Agree | No Opinion | Disagree

Statistical information and graphical representations illustrating the different responses of these main groups are shown after the summary and in Appendix Nos. V and VI.

Statement No. 45

1. Group Responses to Main Statement

See Table 45 (1)

The table reveals that the disabled were almost undecided in their group opinion about the statement although the majority of those who cared for them indicated that the social activities of the disabled person's home life had decreased following the onset of disability. A large proportion of the A.B.(2) group agreed with the opinion of the caring group.

The responses of the A.B.(1) group generally indicated that the social activity of the able-bodied did not decrease as quickly as that experienced by disabled people.

2. Answers to Supplementary Questions

See Tables 45 (2) and (3) - (Appendix V)

Large proportions of the disabled and caring groups indicated that decreased social activities of the disabled person's home-life frequently originated from limited opportunities for personal and social relationships within the supporting services. A large proportion of the A.B.(2) group believed that the family and outer community were sectors which mainly influenced the social activity of a disabled person's home-life.

Respondents in the A.B.(1) group indicated that the social activities of their home-life were determined largely by relationships within the supporting services and outer community.

See Tables 45 (4) and (5) - (Appendix V)

Whilst the tables reveal much agreement by the different group respondents concerning issues which influence social activity within

the disabled person's home life, it was noted that large proportions of the disabled and caring respondents referred to the adverse consequences of stigmatisation.

3. Comparative Agreements between Different Secondary Groups

See Table 45 (6) - (Appendix VI)

The table indicates that those people who were handicapped by heart troubles seemed to have greater restrictions imposed on the social activities of their home-life than those who were handicapped by deafness.

The responses of the A.B.(2) group indicated that those who were handicapped by paraplegia were more likely to experience restrictive social activities in their home-life than many other differently handicapped people.

Statements from some of the respondents suggested that the adverse effects of social stigmatisation often encroached upon the family unit.

4. Summary

The social activities of a disabled person's home-life was seen to depend among many variables of his attitude, his acceptance of the disability, the role of other members of his family, the reaction of the family to disability, living accommodation and the disabled person's social and recreational contacts and activities. Absence of occupational and creative interests in home often appeared to originate from a social problem.

It was apparent that the environment of each respondent influenced his attitude and behaviour and knowledge of those issues which were associated with the family and supporting services seemed to be particularly important to the disabled respondents.

The influence of social barriers seemed to produce a greater effect on the attitude and behaviour of the family of the disabled person than was recognised by many able-bodied. The spread of stigmatisation was perceived frequently to have encroached upon the family sector.

Statement No. 45 Main Group Statistical Information

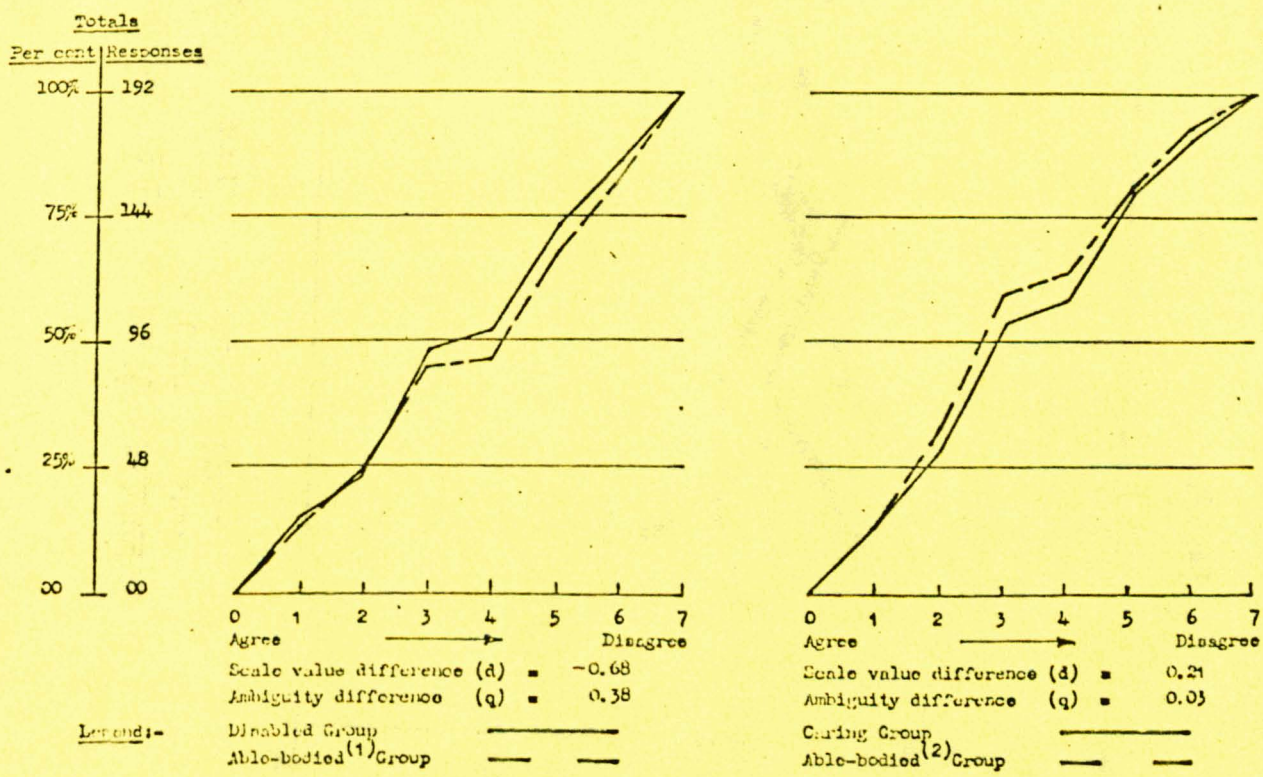
The mean and standard deviation values of the respective groups were:-

	Mean	Standard Deviation
Disabled	4.021	1.971
Able-Bodied(1)	4.182	2.053
Caring	3.786	1.887
Able-Bodied(2)	3.593	1.813

The distribution of the respective groups gave:-

	Scale Value (S) (i.e. 50% levels)		Ambiguity (Q) (i.e. Diff. between quartile levels)
Disabled	3.50	Disabled	-3.07
Able-Bodied(1)	4.18	Able-Bodied(1)	-3.45
Group Diff. (d)	-0.68	Group Diff. (d)	0.38
Caring	2.88	Caring	-3.01
Able-Bodied(2)	2.67	Able-Bodied(2)	-3.04
Group Diff. (d)	0.21	Group Diff. (d)	0.03

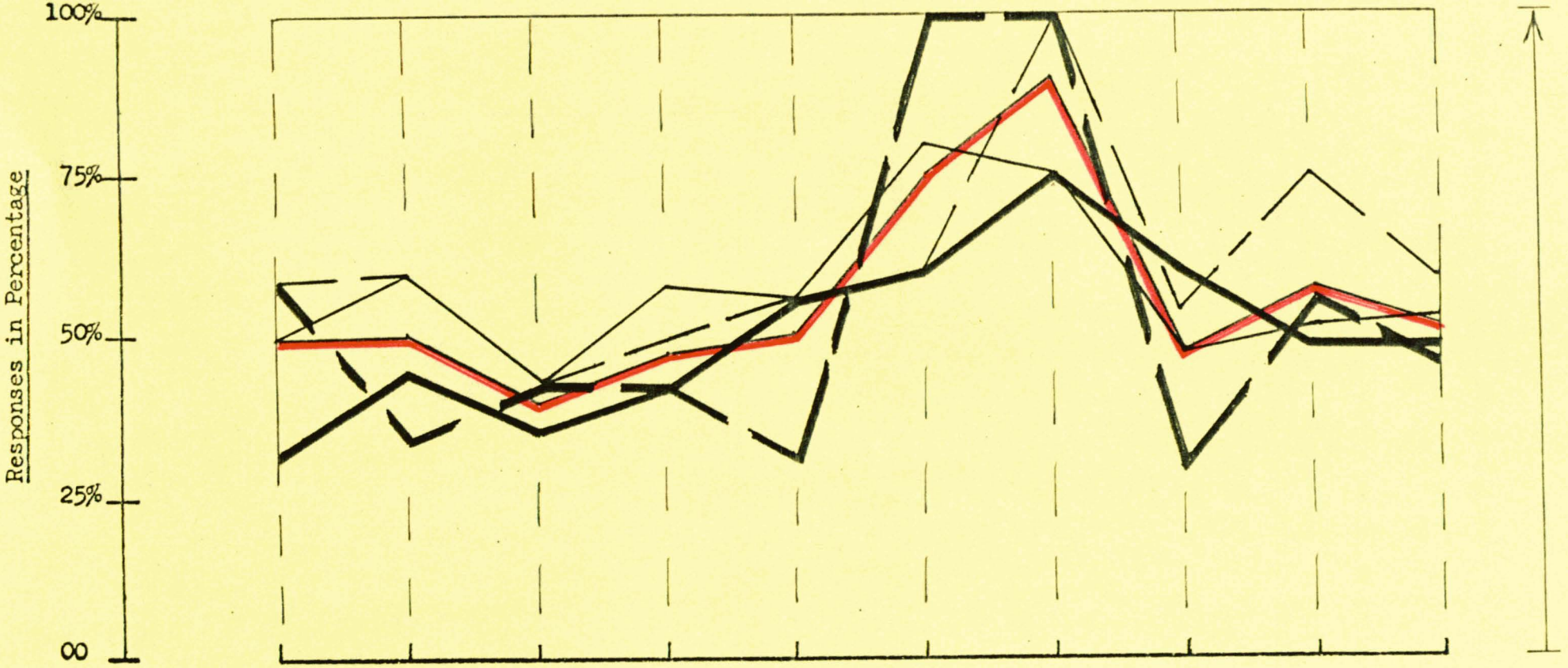
Statement No:- 45 Graphical Illustration of Group Difference in Scale Values at 50% Levels and Ambiguity between Quartile Levels



Statement No:- 45

Comparative Agreement between Different Secondary Groups of People

Arthritis	Blind	Deaf	Amputees	M.Sclerosis	Polio	Stroke	Heart	Paraplegic	TOTAL
N=22 =100%	N=20 =100%	N=14 =100%	N=24 =100%	N=16 =100%	N=5 =100%	N=4 =100%	N=42 =100%	N=45 =100%	N=192 =100%



Legend:-

Disabled Group

Able-bodied (1) Group

Overall

Caring Group

Able-bodied (2) Group

Statement No. 46

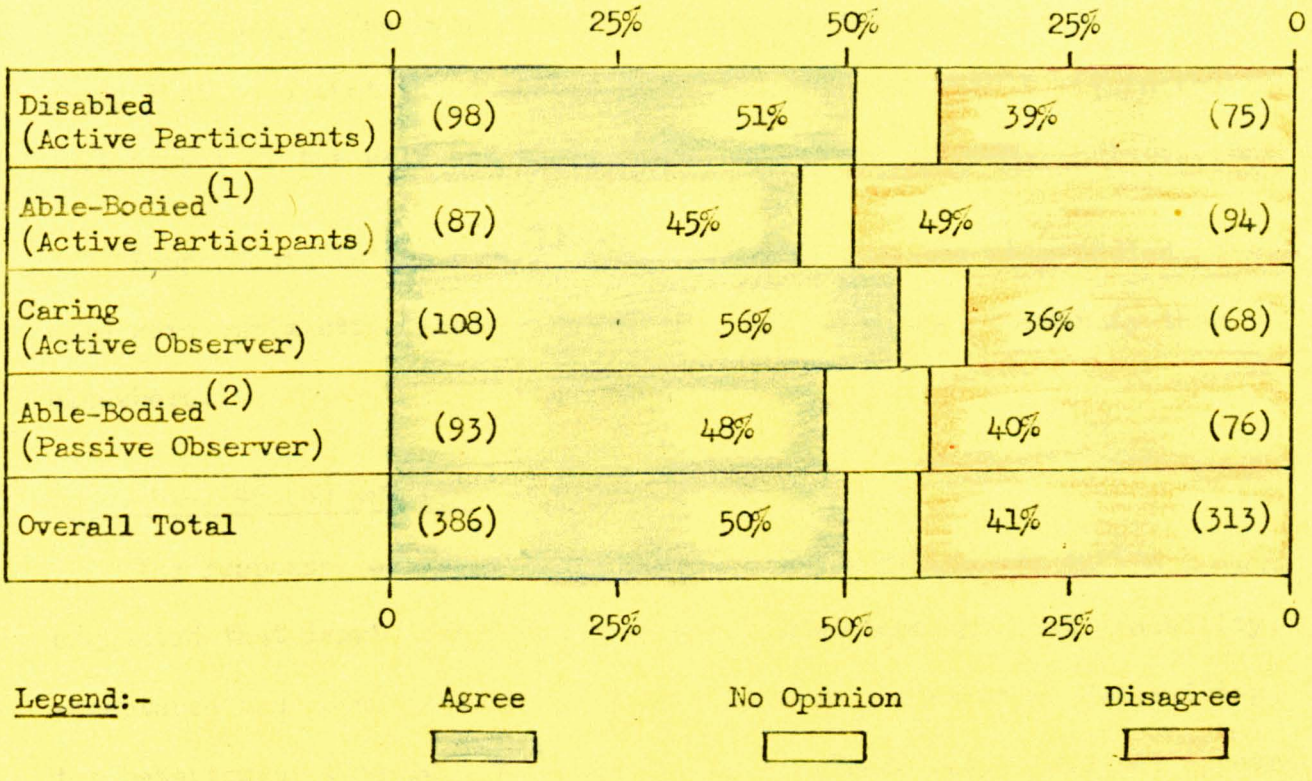
Disabled — People who know me since I became disabled would describe me as an optimist.

Able-Bodied(1) — People who know me would describe me as an optimist.

Caring — People who know the disabled person would describe him as an optimist.

Able-Bodied(2) — Disabled people are optimists.

Table No. 46 (1) — Group Responses to Statement (where each Group Total N = 192 = 100% and Overall Total N = 768 = 100%)



Legend:- Agree — No Opinion — Disagree

Statistical information and graphical representations illustrating the different responses of these main groups are shown after the summary and in Appendix Nos. V and VI.

Statement No. 46

1. Group Responses to Main Statement

See Table 46 (1)

A large proportion of the disabled group respondents believed that they reflected an outlook of optimism to other people. Agreement with this opinion was evident by the responses of a slightly larger proportion of the caring group. About one-half of the A.B.(2) group believed that disabled people were optimistic in their outlook.

A large proportion of the A.B.(1) group indicated a less optimistic outlook in respect of the able-bodied.

2. Answers to Supplementary Questions

See Tables 46 (2) and (3) - (Appendix V)

Large proportions of the disabled and caring groups indicated that optimistic behaviour by the disabled was most frequently seen in the outer community. The responses of a large proportion of the A.B.(2) group indicated that the disabled exhibited optimism mainly within the environment of the self and their family and close friends.

Respondents in the A.B.(1) group believed that the able-bodied were more optimistic within areas of the self and outer community than elsewhere.

See Tables 46 (4) and (5) - (Appendix V)

The responses of large proportions of the disabled and caring suggested that issues involving a general understanding about disability, acceptance and communicative participation were important in determining the behavioural attitude of disabled people. These issues did not appear so important to the A.B.(2) group wherein a large proportion of the respondents thought that achievement produced a more optimistic outlook and incentive for the disabled.

The responses of the A.B.(1) group were near to those of the A.B.(2) group.

3. Comparative Agreements between Different Secondary Groups

See Table 46-(6) – (Appendix VI)

The responses of the disabled group indicated that those who were handicapped by amputations were more optimistic than those who were handicapped by multiple sclerosis, heart trouble or blindness. General agreement with the disabled was evident by the responses of those who cared for them, particularly by those who cared for the respondents handicapped by paraplegia. Agreement with this latter observation was also seen by the responses of the A.B.(2) group.

The extent of the handicapping features of the disability and the individual's own attitude to the disabling functions were frequently seen to be most influential issues in determining the behavioural reaction of different respondents.

4. Summary

Whilst a large proportion of the disabled and caring people indicated during the interview that the disabled frequently made use of denial and an unrealistic mode of optimism in social interaction with the able-bodied, the disabled were seen in the family environment to be free of inhibitions or "unnatural" characteristics. It was frequently observed that the disabled developed confidence and a positive attitude within the family atmosphere in order to enable them to interact with the supporting services and outer community.

Apart from the value of achievement as a positive factor, the need for understanding, acceptance and communication were seen to be other extremely important issues concerning the behavioural reaction of the disabled.

Statement No. 46 Main Group Statistical Information

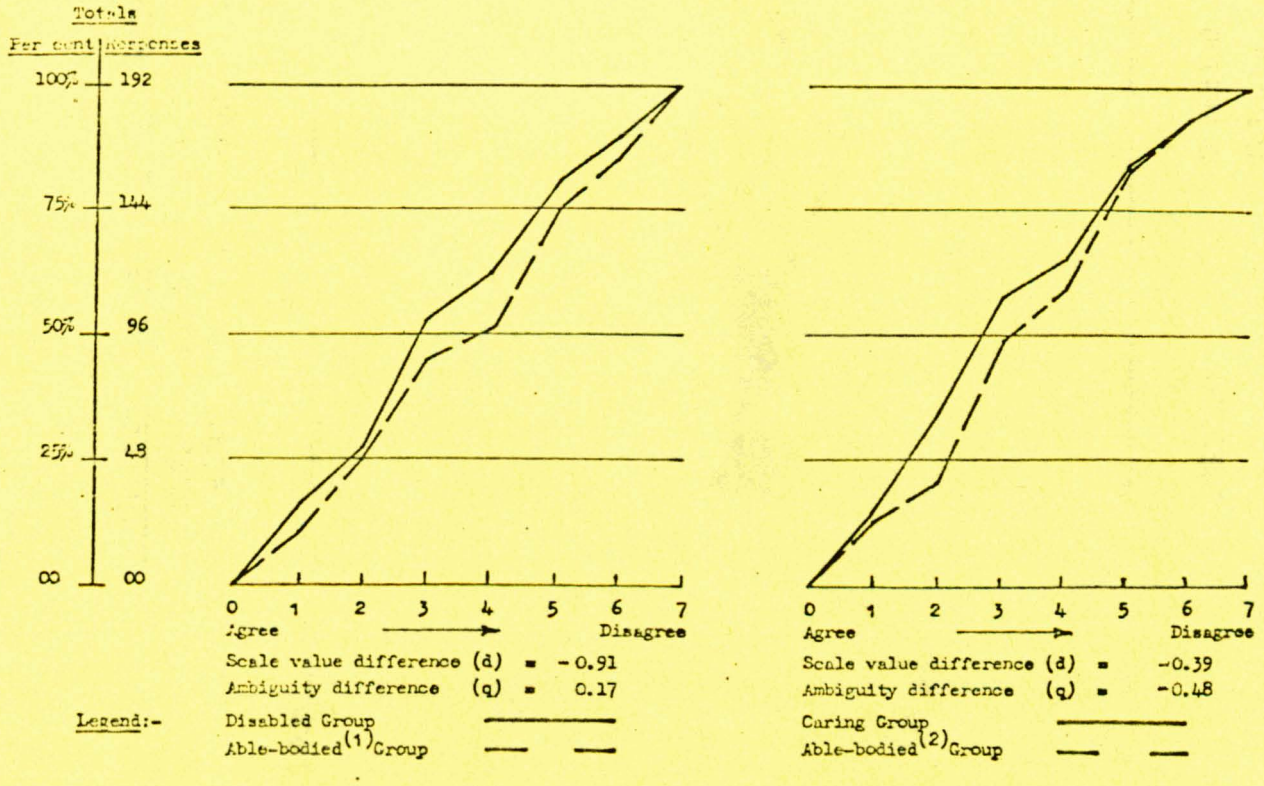
The mean and standard deviation values of the respective groups were:-

	Mean	Standard Deviation
Disabled	3.797	1.872
Able-Bodied(1)	4.063	1.932
Caring	3.546	1.771
Able-Bodied(2)	3.812	1.699

The distribution of the respective groups gave:-

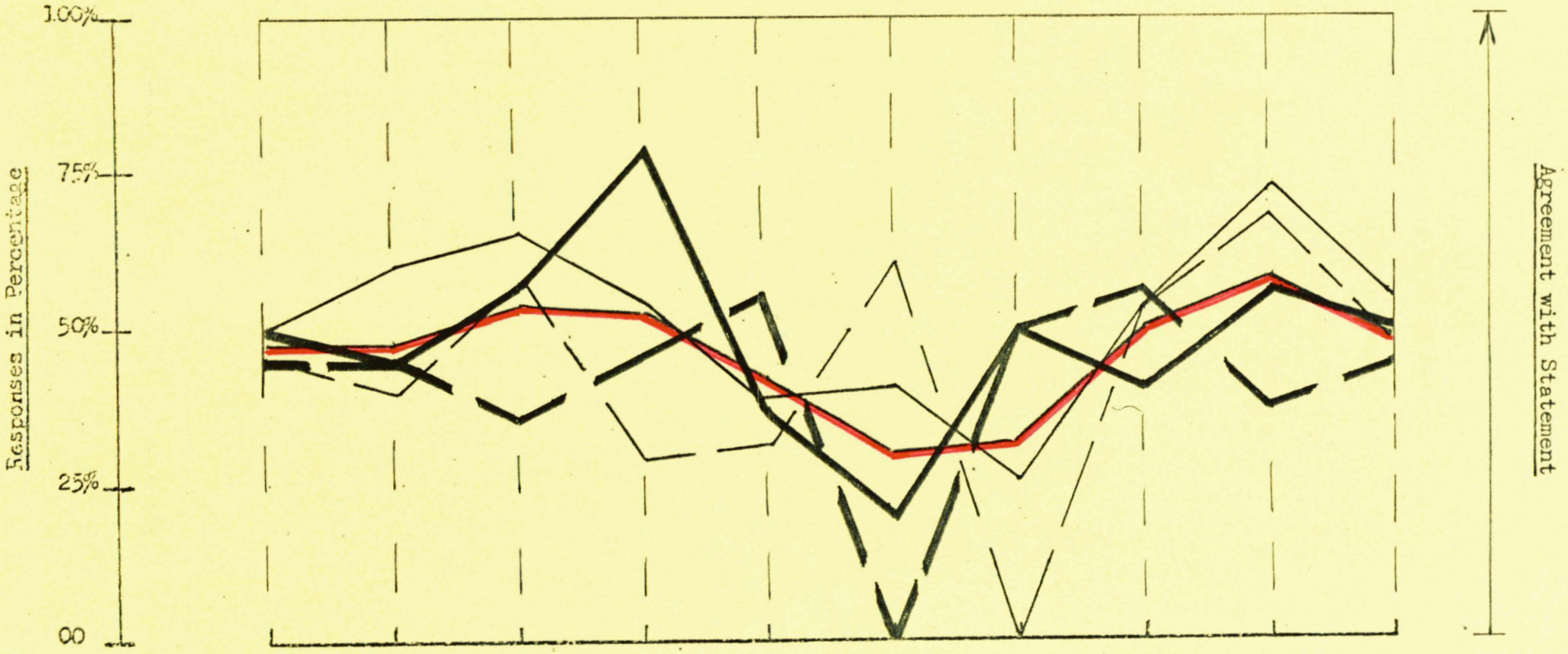
	Scale Value (S) (i.e. 50% levels)		Ambiguity (Q) (i.e. Diff. between quartile levels)
Disabled	2.92	Disabled	-2.83
Able-Bodied(1)	3.83	Able-Bodied(1)	-3.00
Group Diff. (d)	-0.91	Group Diff. (d)	0.17
Caring	2.69	Caring	-2.98
Able-Bodied(2)	3.08	Able-Bodied(2)	-2.50
Group Diff. (d)	-0.39	Group Diff. (d)	-0.48

Statement No:- 46 Graphical Illustration of Group Difference in Scale Values at 50% Levels and Ambiguity between Quartile Levels



Statement No:- 46 Comparative Agreement between Different Secondary Groups of People

Arthritis	Blind	Deaf	Amputees	M.Sclerosis	Polio	Stroke	Heart	Paraplegic	TOTAL
N=22 =100%	N=20 =100%	N=14 =100%	N=24 =100%	N=16 =100%	N=5 =100%	N=4 =100%	N=42 =100%	N=45 =100%	N=192 =100%



Legend:-

Disabled Group

Able-bodied(1) Group

Overall

Caring Group

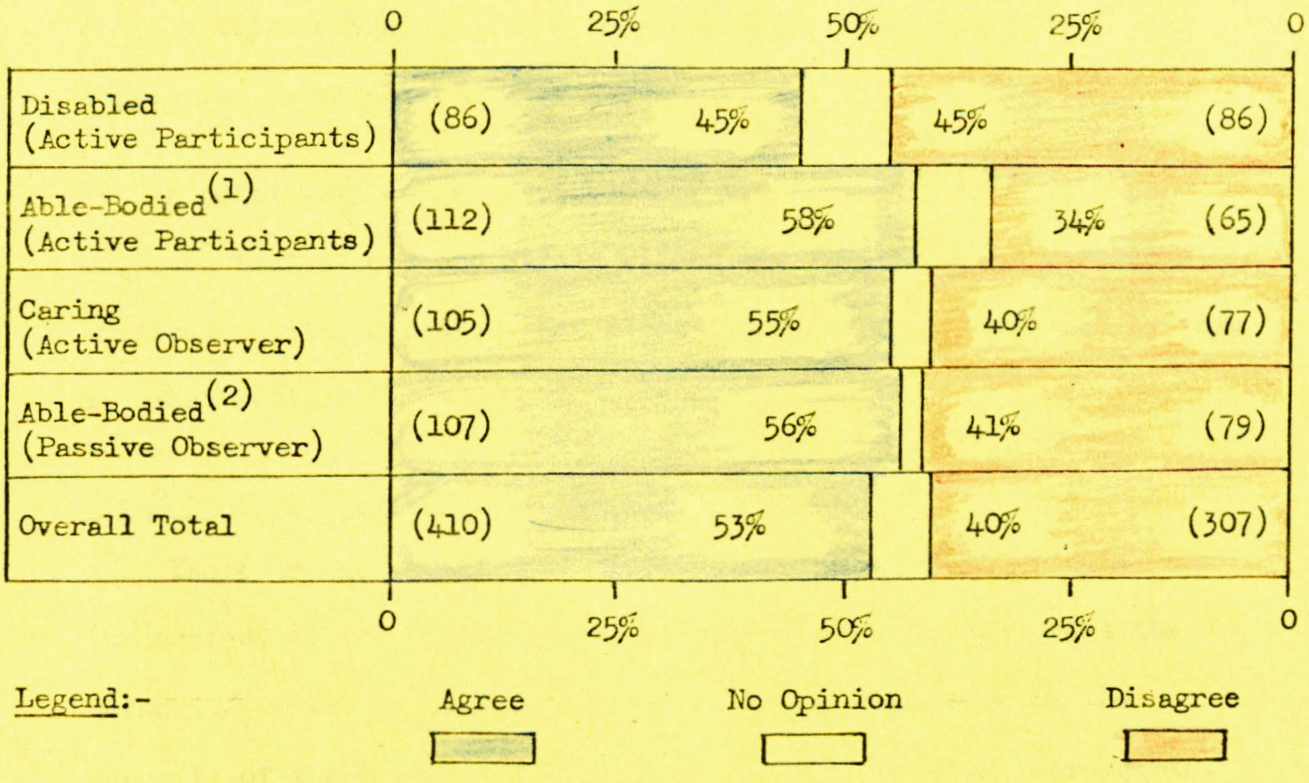
Able-bodied(2) Group

Statement No. 48

Disabled
Able-Bodied(1)
Caring
Able-Bodied(2)

The bond of love which is associated with marriage is weakened if one of the partners sustains a serious physical disability.

Table No. 48 (1) — Group Responses to Statement (where each Group Total N = 192 = 100% and Overall Total N = 768 = 100%)



Legend:- Agree | No Opinion | Disagree

Statistical information and graphical representations illustrating the different responses of these main groups are shown after the summary and in Appendix Nos. V and VI.

Statement No. 48

1. Group Responses to Main Statement

See Table 48 (1)

Although the results indicate that the disabled held an open opinion about the statement, a large proportion of those who cared for them indicated that the bond of love which is associated with marriage is weakened if one of the partners sustains a serious physical disability. The majority of respondents in the A.B.(1) and (2) groups held opinions similar to those of the caring group.

2. Answers to Supplementary Questions

See Tables 48 (2) and (3) - (Appendix V)

A large proportion of the disabled and caring groups who agreed that disability weakened marriage believed that the areas from wherein most contributory stress occurred were those which involved the supporting services and outer community.

A relatively large proportion of the A.B.(1) and (2) groups believed that stress and strain within the family sector were more critical for the disabled than stressful features encountered by them in other sectors.

See Tables 48 (4), (5), (6) and (7) - (Appendix V)

These tables reveal that larger proportions of the single (unmarried) disabled and able-bodied respondents thought that the personal/marital relationships held a greater influence on the security of the marriage than indicated by the married respondents. The single disabled respondents also appeared to indicate greater importance than the caring and able-bodied respondents on the influence of outer community relationships in the marital partnership.

The caring respondents emphasised the contribution of the supporting services sector.

3. Comparative Agreement between Different Secondary Groups

See Table 48 (8) - (Appendix VI).

The responses of the disabled group indicate that those who were handicapped by amputations were more likely to believe that disability weakened the marriage relationship than those people who were handicapped by blindness or hearing difficulties. Some agreement with this general opinion was evident by the responses of those who cared for them.

Overall, it appeared that the caring and able-bodied (1) and (2) groups tended to believe that disability produced a more negative aspect on the marital relationship than indicated by the disabled group.

4. Summary

The extent of strain which disability imposes upon marital relationships appears to depend primarily upon acceptance of the disabled role by both partners. Concomitant factors such as the intensity and stability of the pre-disability relationship, physical integrity, occupation of time and space, social relationships with other members of the family, the supporting services and outer community were seen to be influential variables.

As indicated by the interviews, instability of a marriage appears to be more apparent soon after the onset of disability when the process of "disabling the normal" is much in evidence. When a strong and stable relationship existed, re-defined role in the marital partnership usually took place readily and smoothly. Moral and practical assistance from the supporting services and the outer community were frequently considered vital for preventing crisis situations.

Most disabled were aware of the limitations of "social distance" but found their attempts to reduce it to be hindered by the failure of many able-bodied to understand the consequences of social disability and other associated with life situations, as in the case of love and marriage.

Communication was considered important to allow mutual decisions on such topics as sexual relationship, family and home responsibilities and social integration.

The able-bodied seemed to look at the external aspects of marriage whereas the disabled looked at the deeper and more basic issues as, for example, the implications of emotional maturity and progressive establishment of the marriage partnership.

Statement No. 48 Main Group Statistical Information

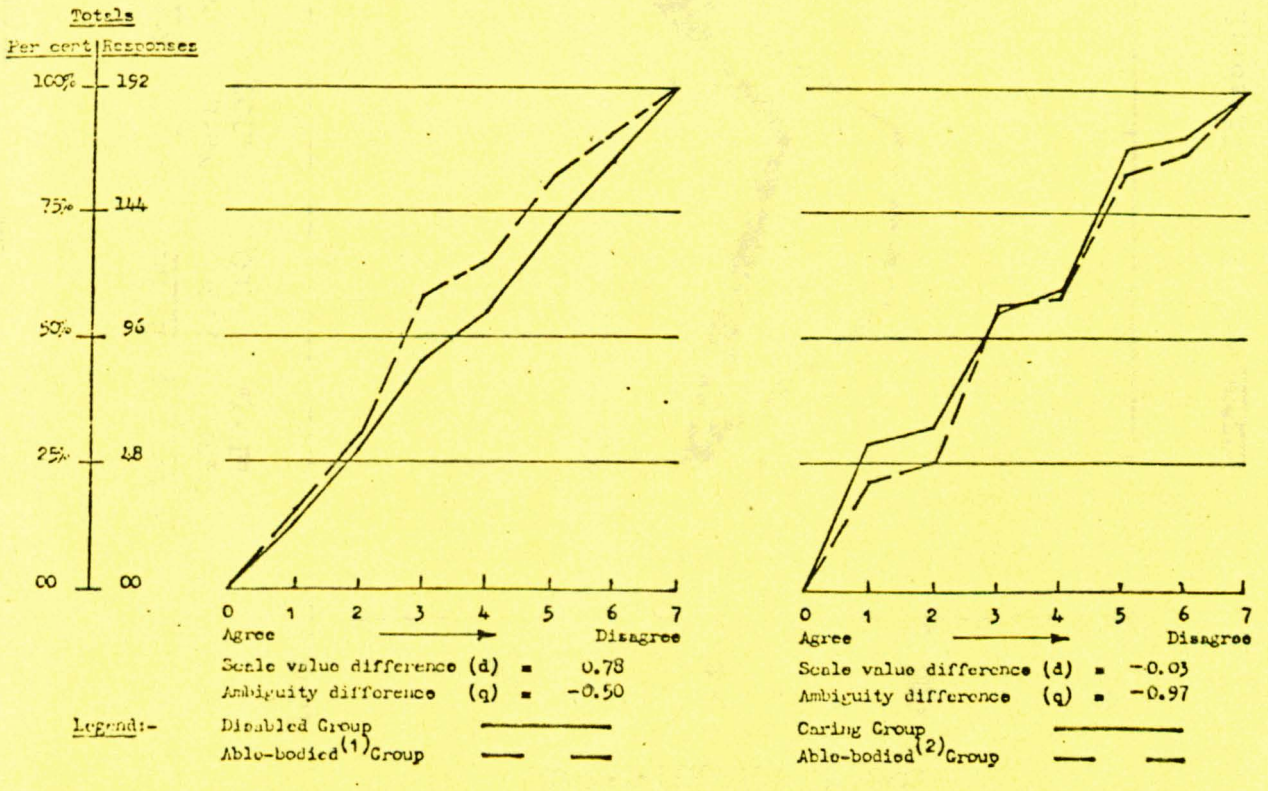
The mean and standard deviation values of the respective groups were:-

	Mean	Standard Deviation
Disabled	4.016	1.967
Able-Bodied(1)	3.589	1.848
Caring	3.458	1.962
Able-Bodied(2)	3.682	1.989

The distribution of the respective groups gave:-

	Scale Value (S) (i.e. 50% levels)		Ambiguity (Q) (i.e. Diff. between quartile levels)
Disabled	3.50	Disabled	-3.35
Able-Bodied(1)	2.72	Able-Bodied(1)	-2.85
Group Diff. (d)	0.78	Group Diff. (d)	-0.50
Caring	2.78	Caring	-3.64
Able-Bodied(2)	2.81	Able-Bodied(2)	-2.67
Group Diff. (d)	-0.03	Group Diff. (d)	-0.97

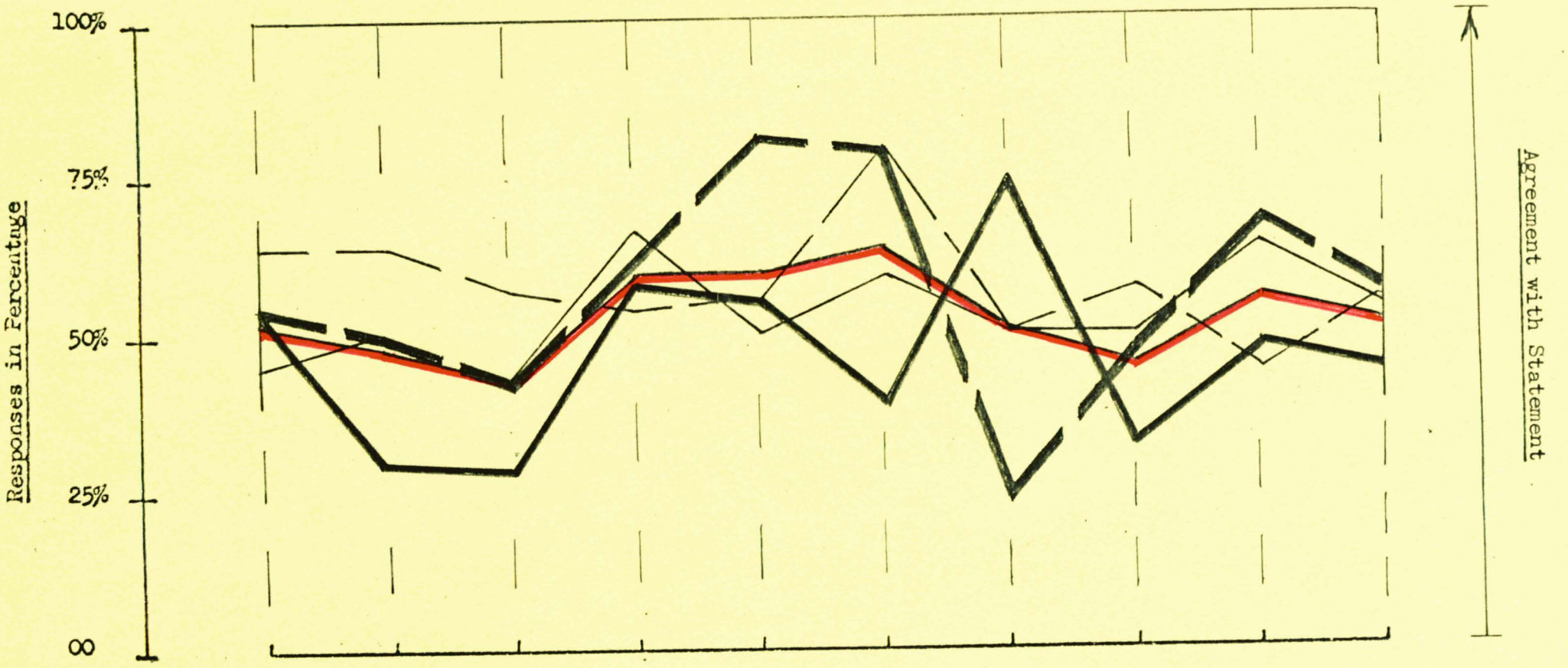
Statement No:- 48 Graphical Illustration of Group Difference in Scale Values at 50% Levels and Ambiguity between Quartile Levels



Statement No:- 48

Comparative Agreement between Different Secondary Groups of People

Arthritis	Blind	Deaf	Amputees	M.Sclerosis	Polio	Stroke	Heart	Paraplegic	TOTAL
N=22 =100%	N=20 =100%	N=14 =100%	N=24 =100%	N=16 =100%	N=5 =100%	N=4 =100%	N=42 =100%	N=45 =100%	N=192 =100%



Legend:-

- Disabled Group
- Able-bodied(1) Group
- Overall
- Caring Group
- Able-bodied(2) Group