

Psychological Perspectives on Physically Disabled Children and Adolescents

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This article briefly surveys the research literature describing the social environment experienced by physically disabled youth and that concerned with the relation between personality variables and disability among children and adolescents. Clinical considerations relevant to counseling disabled persons and their families as well as changing attitudes among the nondisabled are discussed. It is concluded that future work in these areas needs to be more systematic, based more on direct observational methods rather than self-report, and more directed toward clinical utility. With the advent of mainstreaming, issues of the adjustment and social interpretation of the young physically disabled individual have become more crucial than ever.

Research on psychological aspects of physical disability has been concerned with two major topics: attitudes and behaviors of the nondisabled toward the disabled and psychological characteristics of disabled individuals. Within both realms, studies using children and adolescents as subjects have been limited in quantity and depth. Professionals in the applied setting still look mainly to the clinical literature and to their own experiences for guidance in working with disabled youth and their families. The present discussion will include a brief review of each research area as an introduction to consideration of counseling approaches with disabled and nondisabled children and adolescents.

ATTITUDES TOWARD THE DISABLED

Psychological research of the past decades has only begun to address some of the obstacles encountered by the physically disabled in society. The most current research conducted with children and adolescents suggests some avenues for new investigation as well as possible counseling techniques to aid in ameliorating difficulties faced by the disabled persons.

Although research conducted with children is replete with methodological

problems, implications for new approaches can be gained by a review of the current literature on attitudes toward the disabled. Richardson and colleagues, in a series of studies, have attempted to delineate nondisabled children's attitudes toward their disabled peers (Richardson, Goodman, Hastorf, & Dornbusch, 1961; Goodman, Richardson, Dornbusch, & Hastorf, 1963; Richardson & Royce, 1968; Richardson, 1969, 1971). In response to the question, "Who do you like best?", children were asked to rank in order of preference drawings of children with various disabilities. Richardson and colleagues contended that performance on this picture-ranking task was a means of assessing children's attitudes toward the disabled as well as attitudes toward various types of disabilities. Consistent findings across age and cultural groups led the authors to conclude that both disabled and nondisabled children prefer nondisabled peers, that there is considerable agreement among children as to their preference for particular types of disabilities over others, and that different disabilities connote different degrees of stigma. Children from the ages of 8-10 years were in a high degree of agreement as to which handicaps they preferred over others. The order from most to least liked was: leg brace and crutches, wheelchair, amputation of the forearm, facial disfigurement, and obesity. In an extension of the research on children's preferences, Richardson (1971); Richardson, Ronald, and Kleck (1974); and Kleck, Richardson, and Ronald (1974) assessed possible changes in attitudes of nondisabled children toward disabled peers as a result of exposure to each other in a supervised camp experience. Again, employing the picture preference hierarchy, the authors obtained subjects' rankings of disabled and nondisabled children on the initial day of the camp experience as well as a few weeks later. Semi-structured interviews were also conducted to elicit information about children's acquaintances and friendships with other campers. No change was found in overall preference rankings across testing sessions. Some evidence did indicate, however, that children's friendship choices changed after a period of exposure to the disabled. The authors postulated that personal cues other than the disability became more relevant later in the camping experience. Generally, disabled campers had lower status than their nondisabled counterparts even after considerable interaction in sharing a living area and participating in joint activities. The authors concluded that exposure to disabled persons does not necessarily alter attitudes expressed toward them and that cues of physical appearance continue to be important even after significant periods of interaction. It was further suggested that other factors such as a disabled child's functional limitations and possibly limited social skills complicate the formation of social relationships.

Methodological problems inherent in this research restrict the conclusiveness of findings. The major questionable assumption behind this approach to viewing children's attitudes is that the expression of preference

for a drawing or a picture of a child is an expression of a child's "value" and that these "values" are determinants of behavior. The fact that the majority of the research on children's attitudes is dependent solely on self-report without behavioral measures lends question to its validity. Clearly, research with children in the area of attitudes and behavior toward the physically disabled remains inconclusive. What is needed is more direct observational work with disabled and nondisabled children interacting in naturalistic settings.

In one of the few studies to date of children's behavioral responses toward a child in a wheelchair, Perlman (1978) attempted to evaluate a number of behaviors involved in the interaction: looking, staring, eye contact, cooperative play, movement, helping behavior, and talking to the disabled child or talking about the wheelchair. Perlman's results indicated that nondisabled children evidence signs of greater discomfort, greater avoidance, and generally less interaction with a disabled child. Children in her study also verbalized a preference for the nondisabled child. Although one of the few studies conducted with children looking at behavioral cues during an interaction, Perlman's results closely parallel the adult literature on interpersonal interactions between disabled and nondisabled persons.

A series of studies in the area of social psychology has assessed the behavior and attitudes of nondisabled adults expressed toward a disabled confederate (Davis, 1961; Kleck, 1966; Kleck, Ono & Hastorf, 1966; Kleck, 1968, 1969). Research has primarily focused on the overt physical behavior expressed in brief, initial interactions. Results have been consistent as well as disturbing in their implications for the development of social relationships between disabled and nondisabled adults. Considerable evidence suggests that a nondisabled person's initial response on first meeting a disabled person is less favorable, more uncomfortable, and evokes greater anxiety than interactions with the nondisabled. Research indicates that nondisabled subjects interacting with a physically disabled confederate are generally more inhibited verbally, gesture less, come less close physically, terminate an interaction sooner, and tend to distort their opinions in ways they feel would be more acceptable to the disabled person. Disabled people frequently do not get accurate feedback regarding their performance from the nondisabled. Studies viewing the type of evaluative feedback the disabled receive from the nondisabled in the performance of a task have indicated that subjects interacted less with the disabled, did not get as close physically, and tended to give higher ratings to the disabled person's performance when it was actually controlled to be similar to the nondisabled person's performance (Kleck, 1969; Hastorf, Northcraft & Picciotto, 1979). Snyder, Kleck, Strenta, and Mentzer (1979) found that although most subjects wished to avoid the disabled, they were likely to ascribe their avoidance to other motives. The authors suggested the disabled person may be repeatedly rebuffed in social encounters by people who give them realistic excuses which do not reflect

their true feelings.

Some evidence suggests disabled persons also experience discomfort in interactions with the nondisabled. In an interesting reversal of previous social psychological research, Comer and Piliavin (1972) studied the behavioral output of physically disabled persons in interpersonal interactions. Consistent with their expectations, it was found that disabled people exhibit similar behaviors of greater motoric inhibition, less eye contact, termination of an interaction sooner, and admission to feelings of uncomfortableness when initially interacting with a nondisabled peer. Comer and Piliavin concluded that not only nondisabled individuals but the disabled individuals as well contribute significantly to the "pathology" of the interaction between disabled and nondisabled.

To summarize, research relating to children in the area of attitudes and behavior toward the physically disabled has been limited by a restricted experimental methodology which has attempted to predict behavior on the basis of self report of reactions to pictures. Few direct observational studies of children have been conducted. On the other hand, social psychological research with adults has tended to focus primarily on initial interactions between a disabled confederate and nondisabled peers and has not as yet addressed the issues of prolonged social interactions between disabled and nondisabled. The use of a confederate simulating a handicap has seriously restricted the types of disability which have been portrayed as well as effectively eliminated any opportunity to study characteristics of the disabled individual in the interaction. Evidence suggests that the physically disabled may have fewer and less frequent social experiences and, consequently, less social competence. Research is needed comparing the behavioral characteristics of disabled and nondisabled children interacting in naturalistic settings as well as viewing the behavior of individuals who are physically disabled interacting with their nondisabled peers.

PERSONALITY AND DISABILITY

Investigations of personality and adjustment of physically disabled individuals have asked two broad, related questions: Do disabled persons resemble each other psychologically? Is psychopathological responding inevitable? Adler (1930), one of the earliest commentators, wrote that, "Physical defects, whether congenital or acquired, invariably cause feelings of inferiority." Data have not always supported this position. The lack of coherence of findings and inconsistency of methods used have pointed to a need to redefine the questions. A brief overview of the literature dealing with physical disability and personality in children and adolescents should illustrate this need.

Considering the ubiquity of the assumption that physical disability leads to psychological problems, there is a paucity of experimental evidence to sup-

port it. Richardson, Hastorf, and Dornbusch (1964) found that 9 to 11-year-old disabled children made more negative statements about themselves than did nondisabled children. Observably disabled children have been found to show greater inhibition of impulse and lower educational achievement than controls (Richman & Harper, 1978). Employing a sentence completion measure, Cruikshank (1951) found that disabled adolescents expressed more feelings of guilt and fear than did their nondisabled peers. Results of two MMPI studies (Harper, 1978; Harper & Richman, 1978) tentatively supported the hypothesis that physically impaired adolescents are more vulnerable to adjustment problems and that they tend towards an inhibited, rather pessimistic personality style.

These comprise some of the few controlled demonstrations of consistent psychological differences between disabled and nondisabled youths. The clinical literature abounds with descriptions of the adjustment difficulties experienced by these children and their families. Yet, on the other hand, the bulk of the available evidence suggests that such difficulties are not inevitable and that disabled people do not necessarily resemble each other in personality or self-concept (e.g., Allen & Pearson, 1928; Levi & Michelson, 1952; Barker, Wright, Myerson & Gonick, 1953; Pringle, 1964; Cameron, Van Hoeck, Weiss & Kostin, 1971; Schontz, 1971, 1975; Clifford, 1973; Hewett, 1976; Rosher & Howell, 1978). Hewett (1976, p. 41) summarized aptly:

If casework studies alone are considered, the reader will tend to be convinced that all families with handicapped children are overwhelmed by emotional problems. The studies which have attempted to use rigorous scientific method in applying scales and controlling variables will leave the impression that the extent to which problems exist is not reliably measurable.

While physical impairment may be a most salient characteristic to an observer, then there is little reason at present to assume that it need dominate the disabled individual's self-concept or dictate a particular coping style.

Looking beyond the general questions of personality and psychopathology, researchers have attempted to identify specific factors which might affect adjustment to disability. The ancient idea that one's behavior is related to physical character has inspired consideration of disability type as a predictor. Again, consistent differences have not been found (e.g., Cameron et al., 1971; Schontz, 1971; Harper, 1978), and the search for homogeneity within, say, orthopedically impaired, auditorily impaired or cleft palate groups has diminished.

Severity and visibility of the physical impairment have been more fruitful predictors, yet findings have been somewhat contradictory. A study of high school juniors using paper-and-pencil measures of self-concept and social desirability (Meissner, Thoresen, & Butler, 1967) found no main effects of reported obviousness or impact of disability. Smits (1965) found that high school students with mild disabilities self-reported more positive self-

concepts than did those with severe impairments. Dorner's (1975, 1976) interviews with adolescents with spina bifida and their families indicated that depression was not directly related to severity, although social isolation did correlate negatively with degree of mobility. On the other side of the issue, some authors have noted that the mildly disabled often have more adjustment difficulties than those whose disability is more visible and severe (the marginality or role-conflict hypothesis). Support for this idea has been found among different subject groups, including cerebral palsied adults (Glick, 1953), adolescents with visual and auditory impairments (Cowen & Bobrove, 1966), and adult hospitalized patients (Colman, 1971).

Clearly, no simple correspondence exists between personality and type, severity, or obviousness of disability. Those who advocate the marginality hypothesis point out that the mildly or marginally disabled individual is in a more ambiguous role socially and hence subject to the stress of being deprived of a well-defined niche in relation to others. However, marginality itself may be situation-specific, depending upon whether the presence of the disability is highly salient within a given setting. Furthermore, ability level and social awareness may interact with these variables to make prediction more complicated.

Amount of time since onset of the disability is another possibly important factor. It seems probable that a person disabled since birth or early childhood would have an easier time than would the recently disabled individual, but once again, clinical observation is more available than data. A study of orthopedically disabled children (Seidl, Chadwick, & Rutter, 1975) failed to find the predicted effect, but time since onset did not vary greatly. Results of three other studies supported the hypothesis. A report of a counseling group for adolescent boys (Levi & Michelson, 1952) stated that those with disabilities of longer duration had more realistic goals and expressed less self-consciousness and less worry about dating than did recently injured boys. Bell (1967) based part of his argument for the validity of his Disability Scale of Adjustment on the finding that adults who had been disabled for longer obtained scores indicating greater acceptance than did those with a shorter time since onset. Using Linowski's (1971) scale, Boone, Roessler and Cooper (1978) found that acceptance of disability among 18 to 20-year-old clients was predictable by a combination of three independently functioning variables: hope, anxiety, and time since disabled.

As one can see, few unqualified generalizations can be made concerning factors which influence personality, adjustment and self-concept among physically disabled individuals, particularly if one considers only the research literature dealing with children and adolescents. Studies are few, and those few do not share a consensus concerning how to measure relevant psychological variables. "Adjustment" is an imprecise term requiring different criteria for different populations. Similar theoretical and methodological

problems surround terms such as "self-concept" and "personality." The former has generally been viewed only in terms of a simplistic evaluative (positive to negative) dimension, even though children do not necessarily focus on this in spontaneous self-descriptions (McGuire & Padawer-Singer, 1976). General personality tests such as the MMPI measure psychopathological aspects of responding without giving information about the individual's relative strengths. Clinical descriptions of disabled youth have also tended to emphasize the negative. In the future, studies of personality and disability need to reflect a greater interest in positive coping skills and need to be tied to clearer conceptions of the meaning of self-concept and adjustment within the context of prevailing social conditions.

COUNSELING CONSIDERATIONS

The Disabled Population

In considering counseling approaches with the families of physically disabled children and adolescents, we are forced to rely mostly upon our own and others' clinical views and observations. It is hoped that the discussion may stimulate further inquiry into promising ways to assist this challenging population.

Our first assumption is that physical disability occurs in a developmental context. There is no evidence to suggest that children with disabilities meet stages or crises which are fundamentally different from those encountered by nondisabled children, although there may be reliable differences of degree or timing. In fact it has been noted that disabled children frequently lag behind their nondisabled peers in affective or social development (e.g., Norris & Cruikshank, 1955; Strax, 1976), but this does not lessen the importance of taking the total developmental status of the child into account in the clinical situation.

As with nondisabled children, the clinician's work in the early years involves the parents centrally. There is near-universal agreement that parental behaviors and attitudes affect the child's present and future methods of coping with the disability. This point was made strongly in the classic paper by Allen and Pearson more than fifty years ago:

It is as essential to treat the relationship between the child and his parents and the attitude of the latter towards the disability at the time of its occurrence, in order that the personality may not be crippled, as it is to treat the disease itself. Such a crippling of the personality is probably a more serious menace to the future happiness of the individual than a very marked physical disability (1928, p. 235).

Parents of disabled children face a variety of tasks not demanded of other parents. They are expected, for example, (a) to care for the greater physical needs of the child, yet not overprotect; (b) to allow themselves to grieve about

the disability without rejecting the child; (c) to treat the child as normal, yet not deny the disability; (d) to exert greater effort, often for less reward, than with other children; and (e) to adjust expectations such that joy in the child's growth can be experienced even in the face of diminishing hopes. Not surprisingly, parents have been found to be imperfect at accomplishing these delicate adjustments; in addition, professionals have not always proven themselves useful in helping parents through the difficult first years of raising a disabled child. A study of mothers' interactions with their severely disabled cerebral palsied children (Shere & Kastenbaum, 1966) found that psychological needs were often neglected in favor of an exclusive concentration on the child's physical requirements. Mothers anticipated little gratification from interacting with their children, found them unappealing, and often reported having no time to play with them. Another negative factor was the shame felt at having a disabled child and the guilt at having such feelings, which seemed to lead to a reticence to discuss concerns openly with professionals. According to these authors, the professionals themselves tended to reinforce the preoccupation with the child's physical needs. Mothers reported that professionals contacted within the first few months of the child's life failed to provide either emotional support or practical suggestions which would enable them to face problems with a reasonably firm sense of direction.

Another descriptive study (Minde, Hackett, Killou, & Silver, 1972) involved following the development of 41 severely disabled (by cerebral palsy, polio, hydrocephalus, and other disorders) children from ages five to nine years. These authors observed that parents frequently seemed unable to help their children incorporate knowledge of their disabilities into their lives and future plans. Problems which arose tended to be dealt with as crises rather than as predictable developmental changes. Like Shere and Kastenbaum (1966), Minde and colleagues interpreted what they saw as reflecting parents' needs to categorize children as either totally deviant or totally normal without being able to adopt a more encompassing perspective. While these authors placed the burden of blame on societal values, it may be that professionals more often reflect than challenge these values and hence fail to provide parents with psychological alternatives. Without question, however, some parents do find alternatives. For example, Mallinson (1956), who examined case histories of 36 disabled children in Europe, concluded that those who were best adjusted had parents who recognized that they were "normal within the limitations imposed upon them by their handicaps"—i.e., that they need neither retreat to a "sick" role nor pretend that the disability did not exist.

Clinical experience confirms the occurrence of parental reactions to disability which may call for professional involvement: overprotection, denial, guilt, depression, detachment, neglect of psychological needs, placing the child in the "deviant" role, etc., (c.f., Schechter, 1961; McDermott &

Akina, 1974). Parents need reassurance that their efforts and attitudes make a difference in the child's life and that they can have a rewarding relationship with even a severely disabled child. In particular, during the first few months of the child's life, families need psychological support as much as they need other practical help. At the same time it should be noted that most parents develop positive relationships with their disabled children with little or no professional assistance. Clinicians can fall into the trap of assuming problems are present simply because the child is disabled and offer unneeded advice and interpretations. Unfortunately, we sometimes cultivate overdependence by teaching the children that their every move needs to be scrutinized and by encouraging parents to involve us in every decision concerning the child. In this sense we are in danger of reinforcing the idea that disabled children are assumed hopelessly deviant until proven otherwise.

As time goes by, the counselor's focus begins to move toward a more primary involvement with the disabled client. Many school-age children are articulate and psychologically minded enough to express a need for help coping with social situations. Others are anxious to discuss future educational or vocational plans, family problems, feelings of loneliness, etc. Often the clinician who has gained the child's trust can act as a mediator in decisions calling for parent-child negotiation. Although counseling is not qualitatively different for disabled than for nondisabled children, the clinician must be sensitive to the special life situation of the disabled child, which may have resulted in a prolonged period of dependence on parents and to deficits in self-evaluative ability, social skills, and social awareness. A normally intelligent child as young as eight or nine years can benefit from direct intervention in these areas.

With the coming of adolescence, the disabled youth is faced with new stresses even more potent than those encountered by nonhandicapped peers. S/he now has the sophistication to be aware of the lower social status accorded the physically disabled; fantasies about the future may start to give way to more realistic assessment; physical attractiveness becomes more important to the peer group; and being accepted by this group often becomes more crucial and less likely. According to clinicians, social isolation increases even for individuals who had been part of the social and academic mainstream during childhood (e.g., Fulthorpe, 1974; Strax, 1976; Chess, Fernandez, & Korn, 1980). Strax (1976) pointed out that adolescence is the time when the disabled person is most likely to accept society's image of the ideal body and, thus, to reject her/himself and reject identification with other disabled people. The effect of this denial, impoverished social situation and scarcity of role models, may be that the individual drops further behind maturationally, sometimes also becoming depressed, self-pitying, egocentric. Dorner's (1975, 1976) studies of teenagers with spina bifida supported Strax' conclusions: mothers told of a dwindling away of their children's nondisabled

friends with the onset of adolescence, and the subjects themselves reported depression and anxiety about the future.

Counseling approaches for adolescents follow from a consideration of these stressful changes. The clinician may work with an individual or group, but in either case the parental involvement in counseling is absent or greatly lessened. First, it is often essential to help the young person define realistic goals for the future. Often clients have never come to grips with their strengths or limitations, even after years of involvement with professionals of various disciplines. Looking ahead is fraught with more uncertainty for the disabled individual than for others. Supportive and informative discussion of options is important. A related concern is the adolescent's need for a fresh understanding of the disability and its implications. Freeman (1970) noted that new feelings and fears arise in the light of the adolescent's "changed self-awareness." On a simpler level we have found that often teenagers have unsophisticated, out-of-date notions of the facts about their disability and prognosis; e.g., most of Dorner's (1976) 46 subjects said that they would like to know more about spina bifida but were inhibited about asking.

A third emphasis for the clinician should be the promotion of independence in the adolescent. S/he should be given a voice in any decisions which are made. Here the counselor may intervene with families or other professionals as an advocate for the client's right to participate in his or her own management. In inpatient settings, efforts should be made to extricate adolescents from "child" status by providing more choices, responsibilities, and privacy. The counselor may be up against a lifelong history of dependence which the client along with parents, institutions, and professionals have collaborated in building.

Fourth, the client may need guidance in learning to value her/his own assets rather than striving vainly in realms where competition is futile. A quadriplegic young man attending a high school where membership on the football team is the highest-valued achievement will undoubtedly have a difficult time. The counselor cannot provide a substitute for peer acceptance. However, one can help the adolescent work toward more autonomous standards (c.f., Barker et al., 1953; Wright, 1960).

Finally, the counselor can work with the client on improving social skills and awareness. There is evidence that some disabled young adults tend to be less perceptive than their nondisabled counterparts (Ingwell, Thoreson & Smits, 1967), and certainly this would seem logical in light of the social psychological literature indicating that the disabled receive inaccurate feedback about themselves. The counselor can render a valuable service in providing the young adult with honest assessments of his/her social behaviors.

Groups are also an effective vehicle for feedback regarding how one appears to others and what actions might result in increased social opportunities. The group approach seems a particularly appropriate one for

disabled adolescents especially given the phenomenon of rejection of identification with disabled peers. It is not uncommon to hear a wheelchair-bound teenager express a preference for having only nondisabled friends. If an atmosphere of support and acceptance is established within a group, such denial becomes more difficult to maintain as well as less necessary for self-defense. Participants can use the safe setting of the group to try out new ways of coping with the social environment. The solidarity created may come to be political also as members share feelings and experiences of stigma. Depending upon the setting and purpose of the group, energy may be directed toward personal change and/or political activism. In either case, social skills and perception can be enhanced as group identification helps members build greater self-respect.

The Nondisabled Population

Unfortunately, the burden of coping with social barriers encountered by the disabled rests on disabled individuals and their families. It has been clearly established that negative attitudes and behaviors are directed toward the disabled by nondisabled peers. These behaviors contribute to "pathological" interactions, limit the social experiences available to the disabled, and possibly inhibit subsequent social adjustment. Yet, little in the way of research on intervention programs has been conducted to investigate techniques for modifying others' attitudes and behavior toward the disabled.

Those studies which have reported significant results in improving children's attitudes toward the disabled have focused primarily on employing different techniques of exposure to the disabled in controlled settings and assessing attitudes pre- and post-treatment. Generally, treatment has consisted of either controlled personal encounters with disabled individuals and/or an educational program focusing on teaching an orientation to certain disabilities. Rapier, Adelson, Carey, and Croke (1972) viewed changes in children's attitudes as a result of integration of the orthopedically impaired in an elementary school setting. The authors found that nondisabled children saw their disabled peers more positively and capable of greater independence after one year's exposure and interaction in a classroom setting. Children also viewed the disabled as less weak and less in need of attention and help than previously. Significant sex differences seen before integration, with boys judging the disabled more negatively, decreased to nonsignificance. Another study (Lazar, Gensley, & Orpet, 1971) indicated that after exposure to a special instructional program which included disabled guest speakers and subsequent group discussion, children's attitudes toward the disabled changed in a positive direction. Similarly, Rusalem (1967) reported positive changes on an attitude measure after subjects received brief exposure to a deaf-blind individual, instructions in how to communicate using the manual alphabet, and information regarding the deaf-blind. Donaldson and Martin-

son (1977) found that both live and videotaped discussion by a panel of physically disabled individuals were effective in modifying stereotyped attitudes toward the disabled. The authors suggested that not only the panel discussion itself but also the credibility of statements made by the panel members and the personal images they projected aided in modifying stereotyped attitudes. Clore and Jeffrey (1972) attempted to assess the effects of role playing and vicarious role playing on attitudes. The authors found that brief adoption of either the role of the disabled (by traveling around campus in a wheelchair) or vicariously experiencing the role of the disabled (by observing the person in the wheelchair) had significant positive effects on subjects' interactions with a disabled experimenter in response to a series of topical issues related to the disabled in general and to a disguised attitudinal measure four months later.

The importance of adequate supervision and control in any treatment procedure is illustrated in a study by Titley and Viney (1969). After exposure to a videotaped interaction of a disabled and a nondisabled child, children were allowed unsupervised discussion of the interaction. Contrary to expectations, it was found that those children with strong negative attitudes toward the disabled influenced children with more positive attitudes to alter their opinions to a more negative evaluation of the disabled.

Although most of these studies are subject to the same methodological criticism mentioned previously using attitude measures, some general trends in research findings became apparent. Clearly, attitudinal and behavioral changes toward the disabled cannot be accomplished by exposure to disabled individuals alone. Limited research indicated interactions need to be positive and well controlled and perhaps can be detrimental to the disabled if they are not. Significant evidence suggests disabled individuals have limited social relationships due to their functional impairments and also to limited and constrained interpersonal interactions available to them. It is further implied that, by virtue of these limitations, the disabled possess less social competence than their nondisabled counterparts.

With the current trend away from segregated classrooms and toward mainstreaming physically disabled students, a number of issues need to be addressed in order to facilitate their incorporation and acceptance into society. For example, given evidence that disabled people are socially stigmatized, what are the implications for mainstreaming? Can methods of self-presentation be identified which would heighten the attractiveness and social acceptability of disabled youth? Do the social limitations imposed on disabled persons lead to generally insufficient social skills, or are deficits more interactive and situation-specific? What techniques might be effective in changing attitudes in the young nondisabled population? Further systematic investigation of these and related issues holds promise for enhancing the lives of both disabled and nondisabled individuals.

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