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Maternal Reactions to Children with Visible and Non-Visible Handicaps

Doral R. Olsen
Utah State University

MATERNAL REACTIONS TO CHILDREN WITH VISIBLE AND NON-VISIBLE HANDICAPS

by

Doral R. Olson

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Approved:

_____
Major Professor

_____
Committee Member

_____
Committee Member

_____
Dean of Graduate School

UTAH STATE UNIVERSITY
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ABSTRACT

MATERNAL REACTIONS TO CHILDREN WITH
VISIBLE AND NON-VISIBLE HANDICAPS

by

Doral R. Olson
Master of Science

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Major Professor: Dr. Don C. Carter
Department: Family and Human Development

The purpose of this study was to investigate the reactions of mothers to their handicapped child to determine if there is an association between visible and non-visible handicaps, and the mother's reaction to the handicapped child.

A null hypothesis was employed which asserted that the mother's reaction to the handicapped child would not be related to the visible nature of the handicap. It was further hypothesized that the variables of mother's age at the birth of the handicapped child, education, and rigidity, child's birth order and the husband's occupation would be unrelated to the mother's reaction to her child

The population consisted of 18 mothers of deaf children and 17 mothers of children with visible physical handicaps. The data were collected by use of a questionnaire administered to the mothers in their homes.

Using a chi-square analysis the findings reject the null hypothesis and show that mothers of children with a visible handicap are more accepting of their children than are mothers of children with non-visible handicaps. Of the other variables only the husband's occupation showed a statistically significant relationship to the mother's acceptance of her handicapped child.

(83 pages)

INTRODUCTION

Theories of how children develop tend to fit into either the nature or nurture category; that is, children develop primarily according to their genetic makeup, or they are most strongly influenced by environment and social interaction. Most theories recognize that the developmental process involves some pattern of interaction between the child and the environment. It is difficult to separate the biologic being and environmental being. This is the case with the handicapped child, as well as with all other persons.

Among children there is a wide range in which normal development occurs. However, there are many children who, because of genetic problems, delivery traumas, pre-natal or post-natal injuries, never develop in a completely normal pattern. As is true of the normal child, the handicapped child does not fit into a specific pattern of development. Each handicapped child is unique and an individual, just as is each normal child.

In many ways the handicapped child is like any other child--he has feelings and needs, is part of a family, and is an individual worthy of receiving the best his parents

can provide. True, he has some special needs created by his handicapped condition, but it is important to bear in mind that overall he is a child first, and a child with a special problem or problems second.

A child is highly dependent on others for the first twelve to fifteen months of his life. The emotional survival of the infant hinges on the quality and quantity of the interaction he experiences with every facet of his milieu. These are the months when the foundations are laid, not only for future emotional stability, but for basic global character traits and for intellectual development. The relationship with his mother, or the mothering person, is especially important so as to develop trust as a component in his developing personality. The literature emphasizes that during infancy the most significant human relationship is between mother and child.

Kagan (1971) says that the mother's attitude toward the child and the kinds of social interaction that occur during feeding are more crucial than whether the baby is nursed or bottle-fed. He goes on to say that there seems to be an association between the mother's practices and the child's behavior. These ideas are not new but they illustrate the kind of references frequently encountered

in literature related to the parent-child relationship. Merriel (1946) states:

> The child's relationship with his parents is a significant factor in the development of his personality. During his earliest years the parents constitute the chief social influence which the child experiences. Later, the determining nature of their interaction with the child is supplemented by forces from other parts of the environment. Nevertheless, all through the dependent years, the particular quality of the parents' role in the parent-child relationship is one of paramount importance in the establishment of permanent motivational and personality attributes. (p. 91)

There has been a great deal of literature written on the reaction of families to various handicapping circumstances but none has dealt with the parental reactions to the various visible and non-visible types of handicapping conditions. The literature, which has dealt most often with the mother, has examined only one type of reaction--usually feelings of guilt and non-belief--and has not dealt with all the varying reactions and degrees of acceptance or non-acceptance of the child by the mother or others in the family.

The relationship between the handicapped child and his mother is as important as that of the normal child to his and, possibly, may be more important. The mother's

attitude toward the child is of vital importance to his total social, emotional, and intellectual development, and therefore to his total personality. The mothering process is important, but not all mothers respond favorably to their child. Some find it difficult to be as accepting of the child or of their own role as mother as they would like to be. It may be that the fact of a child having a handicap makes it more difficult for some mothers to accept and function as effectively in the parental role as they might otherwise be able to do. For some mothers, faced with this complication of parenthood, it may be several months or years before they become fully and honestly accepting of the handicapped child.

There are a variety of reasons for a mother's lack of acceptance of her handicapped child, some of which might be guilt, disappointment or failure. The physical attractiveness of the child may be an important factor in the mother's acceptance or rejection. In a recent review Berscheid and Walster (1973) concluded that people who vary in physical attractiveness receive different responses and this response pervades all facets of life including childhood. If this is true, one would assume mothers would have varying responses to their children depending on their

physical attractiveness. It would be important to note that the physically handicapped child, especially one whose handicap was visible, would evoke a reaction quite different from a child who was just not very attractive. This reaction of the parent would have a real impact on the child and his eventual self-image.

Some mothers might respond to a handicapping condition with added nurture and compensatory attention, but for others it would seem likely the handicap might constitute an unattractive element in the child which would generate a less positive response. The child's reaction to such a response might stimulate a circular reaction of negative consequences to the child.

The purpose of this study was to investigate the reaction of a group of mothers to their handicapped children. The mother of a handicapped child has feelings of anxiety over raising her child, as does the mother of a normal child. She also has fears, hopes, expectations, and goals for her child. She may, however, have more than her share of anxiety, frustration, guilt and feeling of hopelessness because of the child's handicap. As children are unique, so are mothers, differing greatly in their patterns of mothering and their attitudes toward their children.

There does however, seem to be ways of grouping mothers of handicapped children, either on the basis of characteristics of the mothers or of the children. One possible grouping within the group of mothers of handicapped children would be to separate mothers of children with a visible handicap into one group for comparison with the mothers of children with a non-visible handicap.

It seems reasonable to expect that the type of handicap the child has can influence the mother's attitude. If the child appears to be normal it might be easier for the mother to deny to herself and others that her child has a problem. This would be in sharp contrast with the mother whose child has a handicap that is visible everytime she looks at her child.

Problem

All parents experience some kind of stress when dealing with a new child in the family. However, little is known about particular problems that are encountered by the mothers of handicapped children. A child's total development depends in part on the degree to which he or she is accepted and rejected by the mother. Mothers are likely to have different types of reactions to a handicapped child than they do to a normal child. Different types of

handicaps will present contrasting kinds of problems and challenges which, in turn, will result in various types of reactions on the part of the mother. The visibility of a handicap can create different reactions on the part of the mother in that if the handicap is not visible it probably would be easier for the mother to deny there is anything wrong with her baby. However, if the handicap is of a visible nature it would be more difficult for the mother outwardly to deny that her child has a handicap.

Purpose

The purpose of this study has been to investigate the reactions of mothers to their handicapped child to determine if there is an association between visible (physical) and non-visible (deaf) handicaps, and the mother's reaction to her handicapped child. Included was a secondary effort to determine if such characteristics of the mother as her age, education, and rigidity as a personality characteristic, or the child's birth order or husband's occupation served as intervening variables associated with the mother's reaction to the child.

Hypothesis

The null hypothesis asserted that the mother's reaction to her handicapped child would not be related to the nature of the child's handicap, whether visible or non-visible. It was further hypothesized that the variables of mothers' age at the birth of the child, education, rigidity as a personality characteristic, the child's birth order and the husband's occupation would be unrelated to the mother's reaction to her handicapped child.

LITERATURE REVIEW

Parent-Child Interaction

In a review of parent-child relationship literature, Walters and Stinnet (1971), concluded that parental acceptance, warmth and support are positively related to favorable emotional, social and intellectual development of children. They point out that there has been little research done in the area of the influence the child has on parental interaction, and suggest the need for research in this specific area during various stages of the family cycle. They further suggest that there is a distrust of simplistic explanations concerning the direction of causality in explaining the nature of parent-child relationships. They feel the era of viewing children solely as products of their parents' influence is past, for it is now recognized that children themselves exert a powerful influence upon the parent-child relationship. Their feeling is that few generalizations can be made concerning directional causality and even these must be qualified by a list of contingent conditions. Walters and Stinnet also feel that in many studies it has been difficult to determine which is the dependent and independent variable.

In studies where emotional distress and impaired functioning are found in parents of disturbed children, it has been traditionally assumed that the direction of causation is from parent to child. However, as Kyser (1968) suggests, there is little evidence to support such a view, and the direction of causation may well be the reverse. Schvaneveldt (1968) reports "mother-child interaction as a unit of study is of great importance, and has subsequent social consequences about which society and families are deeply concerned," (p. 255). Kendall (1970) in reviewing McCarthy's work says:

> It is not just the amount of contact with the mother that is important, but the quality of that contact. After reviewing the research on the subject, McCarthy concluded that in ordinary homes the quality of the mother-child relationship has an important bearing on the acquistion of language. The quality most helpful to the child is difficult to describe or to measure scientifically, but it is made up of many things. It may be that the mother did not want to have the child. She may not feel she is competent to take care of him. The quality depends upon the extent to which she talks with him, or, on the other hand, is silent and preoccupied while giving physical care. It also depends greatly upon the extent to which she develops a truly close relationship with him. (p. 4)

Laresen and Leigh (1975) suggest that the view one has of himself is influenced by many factors in his environment, such as physical appearance, social competence and

others. Research has been conducted on the correlation of many of these types of variables with self-esteem. Even though most researchers agree that self-esteem does not develop until the child begins using rudimentary language, the feelings of love, trust, and acceptance of the mother begin emerging in the first few weeks of the infant's life. Maier (1969) states,

> The mother, or caring person, brings the social world to the infant. The environment epxresses itself through the mother's breast, or the bottle substitute. Love and the pleasure of dependency, which is so important in this phase are conveyed to him by the mother's embrace, her comforting warmth, her smile and the way she talks to him. (p. 35)

According to Papalia & Olds (1975) the mother-child relationship is one of the greatest and long-lasting influences on the child's emotional and social development.

All of the above mentioned studies focus on the importance of a good mother-child relationship during the early weeks of the child's life for good social, emotional and intellectual development throughout the remainder of his life. If this is needed for the normal child we would assume it to be of even more importance to the handicapped children looked at in this study, because of their added dependence on their mothers as a result of

limited abilities in one or more areas of physical development.

Acceptance-rejection The acceptance of a child by his parents is considered the foundation of child development by many researchers. Hurley (1965) describes acceptance and rejection as follows:

> Acceptance is conceptualized as representing one extreme of a bipolar continuum, epitomized by parental behaviors oriented toward encouraging the child to interact fully and freely with the environment...Rejection, representing the opposite pole, is viewed as parental behavior oriented toward constricting and limiting the child's inclinations to freely explore the physical, interpersonal, and ideational aspects of the environment... (p. 20)

He goes on to say that even though the parental rejection may be subtle or indirect it would seem to carry a common core of unpleasant affective experience for the child. Kagan (1971), in discussing a mother's attitude toward her child, concludes it is not always possible to determine what attitudes lie behind her rejecting behavior. He defines parental rejection as a dislike and resentment of the child.

In the case of a handicapped child acceptance by his parents would be imperative. The review of literature in this area show that acceptance is one of the most

difficult of parental responsibilities. Mecham, Berki and Berko, (1960) and Denhoff and Holden (1954) say that acceptance of the child as well as of the handicapping condition is often clouded by parental overprotection, and a feeling of restriction by the mother, which will often turn into rejection of the child. The child who feels this rejection may then try to gain acceptance and rewards without earning them.

Rheingold (1945), in discussing initial interviews with parents of the handicapped, suggests that the parents need to be guided towards an emotional acceptance of the child and his mental defects, since wise planning for such a child is impossible if the parents do not accept his retardation. There is little likelihood that they will act upon the advice given them until this goal is attained. Emotional acceptance in this sense may be defined as: sufficient agreement between the subjective fact (the parents' feelings) and the objective fact (the reality situation) to make wise handling and planning possible. Later in the same article Rheingold says: "...Their (the parents) objective discussion of the child seems to suggest their rejection of him" (p. 147). In talking with parents

of deaf children Cole (1959) found the parents repeatedly related the difficulty they had in initially accepting both the child and the handicap.

He sums up the literature by pointing out that:

> Very few things are more important to the child than the attitudes which the mother expresses toward him. Bennett (1959) called attention to the fact that some parents found it impossible to accept the child's handicap and continued to submit him to tests in the hope of finding a cause and a cure. This attitude might mean that even the good achievements of a child are rejected and he would not be accepted within his own limits, but would be compared to an arbitrary standard. He also found in this study that learning and emotional problems were reported as arising from parents rejection in connection with a sense of personal or social stigma, perfectionist standards, driving the child to achieve results. (p. 15)

Effects of Handicapped Children on Families

Assuming the parents of a handicapped child have feelings of frustration different from those of parents with normal children, it seems appropriate to look at some quotations from the parents themselves. Cole (1959) has reported a variety of comments from parents including the following: Some parents are ashamed of the child and want to send him away from home. Some cannot let the child go. Some parents are eager to learn, grasping for any source of information. Some are so stunned at having a handicapped child they cannot even ask questions.

> Following my hearing, 'your child is deaf', I now knew for certain what I had only suspected and feared. I looked at my child, Stevie, sixteen months old. He was no longer a baby I could sing and talk to, eagerly awaiting his first words. Instead he had become someone strange and rather frightening. Many questions arose in my mind as my heart cried for help. How could I talk to Stevie so that he would understand, how could I know of his needs and wants--when he was hungry, hurt, wanted a toy or love? I began to draw away from him, to lose patience and finally to ignore his eager hands pulling my skirt, his frustrations coming out as temper tantrums, his smiles and the child himself as much as possible. What was I to do with him?...I felt I was the only person in the world with a deaf child. I was blinded by the deafness. Then I took a long look at him...he was a sweet adorable boy. (p. 360)

Moustakas, (1969) related the following discussion with a mother after her giving birth to a deformed child.

> For three days I was numb with grief and shock, with disbelief and pain. I thought I would turn my face to the wall until it was all over and maybe I would never need to look straight into the face of my grief and disappointment. We wanted her, and longed to keep her. Then that feeling of shame and mortification crept in. We, Clarence and I, had a child that was deformed, was not normal, could we face our relatives and our friends now? What had we done to deserve this kind of punishment? If we had done wrong why should Elizabeth be the one to pay for it? I searched my soul for the meaning of life and for the meaning of Elizabeth's being. (p. 10)

Spock (1965) related the findings of a study by the Bureau of Educational Research of the New York Board of Education that found, after interviewing sixty-four parents of disabled children of the fifth and eighth grade, the great majority of them had mixed feelings of love and strong feelings of irritation and resentment for their children. They emphasized the intense emotional costs their marriage had suffered because of the child's disability, and expressed fears that they had neglected their other children. To many the worst despair came from the loss of hope that their child would continue to grow mentally and physically. They felt alone and isolated from parents of non-handicapped

children. Parents of a noticeably handicapped child felt sensitive about his appearance and would resist taking the child out in public.

There has been considerable research on the effects of mental retardation on families, and retardation has enough characteristics that are similar to other handicaps that the findings from this research seem relevant. Rosen (1955) has demonstrated that the family's adjustment to retardation moves through five successive stages. The first stage is an awareness that a serious problem exists. The second is a recognition of the problem for what it is. Third, there is a search for the reason or cause of the problem. Fourth, there is an attempt to find a solution; and fifth, there is an attempt to accept and adjust to the problem, a goal which is frequently very difficult to attain. Rheingold (1945) describes similar stages of response in her description of a method used to interpret a diagnosis of retardation to families.

There are several problems that are associated with each of these stages. By the time the parents of the retarded child reach the physician's office they are aware that something is wrong, and they are usually very anxious. Frequently their worry and concern lead them to a temporary

denial of the problem when they are first informed of the diagnosis (Michaels and Schsuman, 1962; Mayo, et. al., 1962). This type of defense against the crisis illustrates the need for professional help in adjusting to their situation (Robinson, 1965).

As the parents gradually recognize the true nature of the problem, they usually experience a combination of several reactions such as shock, fear, anxiety, grief and even withdrawal. Mayo, et. al. (1962) points out that the reaction to the diagnosis of retardation is frequently so great that days or even weeks may pass before the parents can ask or face their questions. As the implications are fairly similar with a diagnosis of any handicap it seems defensible to assume similar responses on the part of parents of most handicapped children. Robinson and Robinson (1965) point out that after parents recognize the problem they usually search for its cause. These authors identify two motives that seem to underlie this quest for causes. First, the parents hope that by finding the etiology they may find a cure and/or prevent a future occurrence. Second, there is frequently a desire for an escape from feelings of guilt and responsibility.

An understanding of the cause is usually followed by

a search for a cure. As Robinson and Robinson (1965) point out, rapid advances in medical science lead many to feel that if only the right specialist or the right new treatment were found a miraculous cure might be found. At present, however, no such miracle cure is known for any of the handicapping conditions.

The last stage in adjusting to retardation is an acceptance of both the problem and the child. The research indicates that most parents are able eventually to become relatively comfortable with the situation, but the greater the retardation, the more difficult it is to do so (Farber, 1959, 1960: Michaels and Schucman, 1962). A good summary on the handicapped child was written by Landau (1972).

> All Children need attention, understanding and patience, but handicapped children need more of it more often. The advent of a handicapped child into any family constellation draws the entire family into a relationship of heightened intra-family dynamics. Parents typically experience grief and conflict regarding the etiology of the child's problem. Two kinds of reactions to a child's physical handicap are evident. Roger Barker (1948) says: "By virtue of the fact of being different and requiring an unusual amount of help and attention he is ineveitably a person of unusual importance." Parental reaction to children thus handicapped can result in either rejection of the child because of parental guilt or recompense to the child for his unfortunate condition. In either case, feelings of guilt and resentment may develop in parent and child. It is usual for a parent of a handicapped child to experience

> guilt as well as pain as a result to bringing a less-than-perfect child into the world. Mothers especially often blame themselves for the child's handicapping condition, viewing the child as a reflection of imperfection in themselves. These feelings are usually strongest immediately after the child's birth or in his earliest years. (p. 299-301)

Family Crisis Literature

The impact of stress on families has been reviewed by many people over the years. Hansen and Hill's (1964) review and Burr's (1973b) discussion of theory in this literature have identified a number of factors that are related to the vulnerability of families when stress occurs and to the ability of families to recover from the disruptive effects of stress when they are vulnerable. These reviews argue that the factors most closely related to vulnerability are the family's definition of the seriousness of the event, the amount of family adaptability, the amount of time the event is anticipated, the externalization of blame for the event and the amount of integration of the family. Burr (1973a) states:

> The factors that are related to the ability to recover from crisis are the amount of resources in the community, the amount of the wife's external social activity, the amount of marital adjustment, the amount of intergration, the amount of adaptability, and the ratio of personal and positional influence in the family. (p. 14)

LeMasters (1957) reported that when a mother had professional training and enjoyed her work outside the home before she became a parent it was much more difficult for her to adjust to the parental role with the advent of a first child than if she had not been so previously employed. Hobbs (1965) found very different results than did LeMasters but reasoned that one explanation of this might be that parents of very young children, as used in his study, had not yet recognized or admitted the existance of the crisis situation.

Miller (1974) in reviewing a study by Feldman quotes him as saying:

> It is hypothesized a "baby honeymoon" phenomena occurs during which couples are initially elated with their experiences as parents, but over time they gradually admit to being bothered and experiencing more stress. He reasoned that it may be easier for parents to acknowledge negative feelings about their child in retrospect than during the time they are actually experiencing these feelings. (p. 9)

Later in Miller's (1974) review he discusses findings from various studies regarding social class and husbands occupations as having an effect on the family crisis situation. He concludes that although Hobbs (1965) and Russel (1974) found class to be related to the extent of the crisis reported by the family, it also appears that income and the husband's occupational prestige have been

found to be inversely related to the extent of the crisis experienced.

According to Miller (1974) the conclusion of the family crisis literature is that:

> All evidences reviewed indicated that first parenthood is a moderately stressful experience for most young couples. The studies all agree that there is a noticeable amount of disruption and reorganization associated with the transition into parenthood. Characteristics of the husband and wife and qualities of their relationship before parenthood, situational characteristics of the pregnancy and childbirth experience, and characteristics of the first born child are all important contingency factors which can reduce or add to the strains accompanying transition into parenthood. There is some evidence that becoming a parent may also bring personal rewards and fullfillment, particularly for women. (p. 28)

Assuming that the information the above researchers have done on the crisis of transition into parenthood is accurate the implications this information has for the transition into parenthood would have for the couple who has a handicapped child would be tremendous. Because the advent of a handicapped child into a family is in itself a critical event of varying intensity, the family crisis literature can help explain some of the possible causes of severe stress encountered by the family of the handicapped child.

Summary

The literature on parent-child interaction has pointed to the importance of a good mother-child relationship during the early weeks of the child's life to provide maximum development of the child's social, emotional and intellectual growth throughout his life.

The acceptance-rejection literature points out that there are few things more important to the child than the attitudes which his mother has and expresses toward him. The acceptance of the child by his parents is the foundation of child development. That many parents have difficulty accepting their children when they are normal children points to the possibility of a more difficult task in accepting the handicapped child. The importance of acceptance of the handicapped child would be paramount, as he would have a greater number of obstacles to overcome than the normal child. However, it was pointed out that most often parents have a great deal of trouble accepting the handicapped child.

The transition into parenthood and the crisis effect on the family was reviewed. This literature suggests that parenthood is a stressful time for most couples under the best conditions, and any added stress such as the birth

of a handicapped child would significantly add to the family stress. This literature mentioned the importance of family social status and the husband's occupation as variables in the amount of stress experienced. Parents vulnerability at the time of the birth of the child was also discussed and the implication this has for the family of the handicapped in regard to the amount of resources available to the parents to acquire help for their child.

The effects of the handicapped child on the family included a review of statements from parents of handicapped children which provided a picture of the frustrations, anxiety, pain, and resentment the parents felt when they realized their child was not normal. Many of the parents discussed their feelings regarding neglect of other children in the family, the emotional costs to their marriage, and the feelings of isolation they felt because they thought no one understood what they were thinking and feeling. The steps a parent must work through in accepting his handicapped child were outlined, and it seems that most parents are eventually able to become relatively comfortable with the child in their care.

The literature suggests in general that anxiety, insecurity and many other emotional problems can increase

in the child because of parental reactions to the child, and to the various handicapping conditions that are often diagnosed at birth or soon after. This in turn would have an important effect on the child's total developmental process.

Berschied and Walster's (1973) idea of a childs physical attractiveness affecting the parents reaction to the child coupled with Spock's (1965) suggestion that a mother whose child has a more visible handicap resists social contacts for her child served as springboards for this study. In reviewing the literature further and finding varying ideas on maternal reactions to handicapped children it was decided that this study would explore the effect which the nature of the handicap, visible or non-visible, has on the mothers acceptance or rejection of her child.

The mothers of children with visible handicaps were chosen from a list provided to the researcher by the Developmental Disabilities Clinic at the Primary Children's Hospital in Salt Lake City, Utah. From this list of sixty-two names the secretary of the program checked the names of twenty families whom she knew had children four years old or under and who were not mentally retarded. From this list two of the mothers indicated they did not wish to participate in the study and following the interviews the researcher discarded one of the questionnaires because she did not feel the mother had understood what she was to have done with the questionnaire. This left the study with a total of thirty-five participants.

Operational Definitions

Visible handicap is defined as an abnormal condition of the physical development of the child that is apparent to anyone looking at the child, i.e. cerebral palsy. A non-visible handicap is defined as an abnormal condition of physical development that is not apparent to a person when he looks at the child, e.g., deafness.

Instrument

Parts one and two of the questionnaire were adapted

from one prepared by Dennis Kendall (1970) for a study which he conducted to investigate the reaction of a group of mothers when they received word they had a deaf child. The first section of the questionnaire is composed of twenty statements from the Parent Attitude Research Instrument (PARI) which were designed to determine acceptance-rejection, overprotection and guilt. These questions were the same ones selected and used by Kendall in his study. The mothers were asked to respond to this part of the questionnaire by indicating their agreement or disagreement on a four point Likert type scale. The second section of this questionnaire is composed of twenty words from which the mothers were asked to select seven which they felt best described their initial reaction to their child's handicap. Half of the twenty words reflect positive feelings, and half of them reflect feelings which are negative. These same twenty words were used in the Kendall study.

Part three of the questionnaire consists of thirty-nine items from the Wesley Rigidity Scale (Robinson and Shaver, 1972). The scale is composed of sixty-seven items, fifty of which are used to measure rigidity. The subject responds "true" or "false" to each item indicating whether or not the statement applies to himself or herself.

One point is given for each rigid answer. The fifty rigidity items were selected from a pool of ninety which Wesley drew from various personality tests or constructed herself. Five clinical psychologists rated each item in the pool on the degree of rigidity it expressed. The fifty items selected were judged by all five judges to express a high degree of rigidity. No other measure of the reliability of this test was available. As to validity, it seems that rigidity, as measured by this scale, seems to be related to a behavioral measure of this concept as defined by Wesley as follows: Rigidity is defined as "the tendency to persist in responses that may previously have been suitable in some situation or other but that no longer appear adequate to achieve current goals or to solve current problems." (p. 313)

Robinson and Shaver (1972) published 41 of the 50 items in the Wesley Scale, and their items were selected for use in this study. However, in the process of preparation of the questionnaire two items were omitted and this omission was not discovered until after the data had been collected.

Part four of the questionnaire was a personal data sheet asking for information about the mother, including her own age, her age when her handicapped child was born,

years of mother's education, the child's birth order and the occupation of the father.

The study was almost a replication of the Kendall (1970) study in which he investigated mother's reactions to learning their child was deaf. Most of the questionnaire was adapted from his study in the sense that the questions which he used to explore parental reactions comparable to those being explored in this study were used without modification. The Wesley Rigidity Scale was not used by Kendall, but was included in this study as an exploratory inquiry into the area of personality as a possible characteristic of the mothers which might be associated with their parental behavior, or response to their handicapped child.

The questionnaire was not tested prior to collection of the data, primarily because the major part, as related to the hypothesis, was essentially the utilization of an instrument previously used to study a similar problem.

Method

The researcher contacted Mr. Thomas Clark (Director of the Parent-Infant Program) and Mr. Dennis Gehring (Director of the Developmental Disabilities Clinic) and asked their assistance in the project and for permission

to use parents in their respective programs for the study. Both were agreeable to the idea. They provided a list of persons enrolled in the programs from which the researcher chose twenty names from each list as project participants. The researcher prepared a letter which was sent to each mother asking her cooperation in the study. The letters were sent on letterhead stationery from the two projects over the signatures of the two directors (See appendix). A follow-up telephone call was made to each of those who received letters asking if they were willing to participate in the study.

An appointment was made with each mother for the researcher to come to her home for an interview. When the researcher arrived at the home she introduced herself and informally visited with the mothers for a few minutes to establish a rapport with them. The questionnaire was then given to the mothers and they were asked to complete them and to mark them according to their feelings about their handicapped child only. If the mothers had questions about the questionnaire the researcher told them she would not be able to answer their questions at that time but would be happy to discuss it with them when they had completed the form.

When the questionnaire was completed and any questions answered the researcher asked the mothers if they would

verbally respond to some questions while she tape recorded the answers. There were four general questions asked (See appendix) covering the mothers feelings about her relationships with her husband, handicapped child, other children in the family and how she felt about herself. At times it was not necessary to ask all of the questions as the mothers would volunteer the information when answering one of the previous questions. However, questions were asked until all desired information was received.

At times it was not feasible to tape record the mothers because of interruptions by children, neighbors and television. Standardization of the questioning was not possible because of the various situations in each household and with each mother. Following the interview the researcher visited with the mothers for three or four minutes and then would leave. When the researcher returned to her car she would often jot down comments the mothers had made during the informal visiting, which the researcher felt were ideas and feelings not covered in the formal interview questioning. At times the comments were contradictory to those the mothers made during the formal questioning.

ANALYSIS OF DATA

The questionnaire was composed of four parts. Part one consisted of twenty statements that were rated on a four-point scale ranging from strongly agree to strongly disagree. This section was scored by assigning a numerical value of 1, 2, 3, or 4 to each of the possible responses. Some of the statements were judged to be accepting if the mother strongly disagreed. A score of four was the numerical value of the most acceptable response. The most desirable response for each item was decided by the researcher, another graduate student and the research director based on general child development principles. The scores for the twenty statements were totaled for each of the mothers.

Part two of the questionnaire consisted of twenty words representing both positive and negative feeling. Each word was assigned a numerical value of ten. The mothers were asked to choose seven of the words that best described their initial reactions to the child and the handicap. The negative and positive scores were added separately and then subtracted from one another to leave a potential score ranging from +70 to -70. The scores from part two were then added to or subtracted from the

scores from part one resulting in a total acceptance score for each mother.

The rigidity scale was scored by adding the total number of non-rigid answers and subtracting that score from the total possible of thirty-nine. There were thirty-nine questions in this section for which the mothers could choose a rigid or a non-rigid response. This resulted in a rigidity score that could range from thirty-nine to zero.

The occupation of the husband was included as an intervening variable. Women without husbands, were not included in this tabulation. There was only one in this category. Occupations of the husbands included in this study were categorized into the following groups: professional, blue collar, sales/clerical and the three women whose husbands were self-employed or unemployed were classified as other.

Child's birth order, mother's age at the birth of the child, and level of mother's education were listed numerically as reported by each mother. The child's birth order was listed as first child, second child and third or more child, making three groupings for this category. Mother's age at the birth of the child was rank ordered from highest to lowest and the median was calculated which

became the division for two groupings, high/low, in this category. The level of the mother's education was calculated in the same manner as the mother's age, making two groupings in this category.

Mothers' acceptance scores, reflecting the dependent variable of the mother's reaction to the child and his handicap, were arranged in rank order from 122 to -5. A constant of five was added to each making the range from 127 to 0, and the scores were divided into three groups representing a high, medium and low grouping. The highest score, 127, was divided by 3 with a quotient of 42, which was subtracted from 127 for a remainder of 85, which became the cutoff point for the high group. Forty-two was then added to 0 making 42 the cutoff point for the low group. The middle range then became the scores from 43-84.

Acceptance scores were first divided into two categories of high and low using the median as the division point. It was apparent by looking at the tables there could be no reliable analysis of the data by using this type of distribution. The researchers original idea of setting up the high/low categories was that high scores would be indicative of positive attitudes toward the child and his handicap. However, as the researcher contemplated the distribution and reflected on the comments of individual

mothers during and after the interviews, she came to realize that a three-way categorization was needed, based on the rank order distribution. The high scores would then reflect the mothers who seemed to be unrealistic in their acceptance of their child. These mothers seemed not to have confronted the reality of the problem and were thought to be trying to gloss over the entire situation. Following the discussions with the mothers it seemed to the researcher that mothers with the healthiest attitudes about their child were the ones who had and could express both positive and negative feelings about their child and the handicap. Therefore, by dividing the mothers into three categories, the high scoring mothers were felt to be unrealistic, the middle range of mothers to be accepting and the low scoring mothers more rejecting.

A 3x2 design was used to determine the degree of association between the mothers acceptance scores and the high/low visibility of the handicap. The data were analyzed by the sum of chi square based on the .05 level of confidence.

The influence of the intervening variables mother's age at the birth of the handicapped child, mother's education, mother's rigidity and husband's occupation were studied by categorizing the mothers into three groups of

high, medium and low acceptance of the child and his handicap within each of the variables, and then using a 3x2 design for the mother's education and age. A high/low categorization was used for age and education because there was not enough difference in scores to justify more categories. The range of mother's ages was from 39 to 20 with a medium of 25.5. The high range was above 25 and a low age was below 25. The range of mother's education was from 17 to 12 years with a medium of 13. The high range was above 13 and the low range was below 13.

A 3x3 design was used to determine the association between acceptance and mother's rigidity because there was a large range of rigidity scores, twenty-nine to three, and between acceptance and child's birth order. Birth order classifications were made as to first child, second child, and third and more. The husband's occupation was originally divided into three categories: blue collar, professional and sales/clerical thus making the use of a 3x3 design possible, inasmuch as all but four cases fit these categories.

The data collected from the recordings and the informal interviews were tabulated in seven categories; (1) feelings of guilt and punishment of self, (2) feelings

of guilt and punishment of the child, (3) denial by both self and husband, (4) feelings of isolation, (5) feelings of self pity, (6) feelings of resentment, pain, frustration and anxiety, (7) feeling the child to be a special child. The number of mothers who expressed feelings that fell into these categories was tabulated and the total number was recorded for each of the seven categories. The data were categorized separately for mothers who had a child with a visible handicap in contrast to those whose child's handicap was of a non-visible nature.

In the final tabulation of scores there were 18 mothers of children with non-visible handicaps and 17 mothers of children with visible handicaps, leaving the study with a total of 35 mothers.

FINDINGS

Hypothesis

A null hypothesis was employed which asserted that a mother's reaction to her handicapped child would not be associated with the visible nature of the child's handicap.

The data from the questionnaire, using medium scores only, indicate that mothers of children with a visible handicap appear to be more accepting of their children and their handicaps than are the mothers of children with a non-visible handicap (See Table I) Ten mothers, of 59%, of the mothers of children with visible handicaps had acceptance scores within the middle range in comparison to four mothers, or 22%, of the mothers of children with non-visible handicaps.

The data also indicated that mothers of children with either type of handicap, when added together, had more high acceptance scores than low acceptance scores. Also mothers of the children with non-visible handicaps had more low scores than did the mothers of the children with visible handicaps.

The null hypothesis was rejected because the data show that the visible nature of the child's handicap affects the mothers reaction to the child.

TABLE 1. Chi-square analysis for degree of maternal acceptance of a handicapped child as influenced by the nature of the handicap.

MOTHER'S ACCEPTANCE SCORES	NATURE OF THE HANDICAP		
	VISIBLE	NON-VISIBLE	TOTAL
HIGH	6	8	14
MEDIUM	10	4	14
LOW	1	6	7
TOTAL	17	18	35

Degrees of freedom = 2 Chi square = 6.40523 ($P < .05$)

Other Variables

The hypothesis predicted such variables as husband's occupation, child's birth order, mother's education, age and rigidity would be unrelated to the mother's reaction to her handicapped child

The association between the husband's occupation and the mother's acceptance of her handicapped child, in terms of visibility or non-visibility of the handicap is indicated in Table 2. Eight mothers or 73% of those whose husbands were professionals had acceptance scores within the middle category. Five, or 71% of the mothers whose husbands are in the sales/clerical field had acceptance scores within the middle range. Only two of 15% of the mothers whose husbands are blue collar workers had acceptance scores within the middle range. More mothers were found in the medium or positive category than was true for either the high or low acceptance group, indicating that overall, the total group of mothers in this study were more accepting than rejecting in response to their handicapped children. The mothers within the blue collar category tend to be either over accepting or rejecting in comparison with the mothers in the other two categories. It is interesting to note that the father's occupation has a more powerful influence on the mothers acceptance of the child and the handicap than does the mother's education.

Because there is a significant association between the socio-economic status of the family and the mother's acceptance of the handicapped child, the influence of the visibility of the child's handicap on this association was

TABLE 2. Chi-square analysis for mother's acceptance of their handicapped child compared with husband's occupation.

MOTHER'S ACCEPTANCE SCORES	FAMILY SOCIO-ECONOMIC STATUS			
	BLUE COLLAR	PROFESS-IONAL	SALES/ CLERICAL	TOTAL
HIGH	7	2	1	10
MEDIUM	2	8	5	15
LOW	4	1	1	6
TOTAL	13	11	7	31

Degrees of freedom = 4 Chi square = 9.8626 ($P < .05$)

explored. (See Table 3) It appears that visibility of the handicap has its greatest impact among the mothers in families with a professional orientation. Seven of the eight mothers who indicated a positive (middle range) acceptance score were mothers of children with a visible handicap.

The mothers' education did not appear to be associated with her acceptance of her child. (See Table 4) Mothers with more education did tend to fall more frequently in the middle range of acceptance than was true of those with less education. Those with more education seem to be more unaccepting rather than highly unrealistic, a four to six comparison. The differences among the mothers in their responses, when categorized by high or low education, were such as to suggest a positive influence from education, but the differences were too small to be significant. The wives of the professional husbands did not have as much education as did the fathers.

The mother's age at the birth of the handicapped child was not associated with her acceptance of the child and the handicap at a significant level. (See Table 5) It appears the younger mother adjusts to her child as well as the older mother.

TABLE 3. Husband's occupation as compared with the mother's acceptance scores.

MOTHER'S ACCEPTANCE	HUSBAND'S OCCUPATION						
	BLUE COLLAR		PROFES-SIONAL		SALES/ CLERICAL		TOTAL
	V	N-V.	V	N-V.	V	N-V.	
H	3	4	1	1	1	0	10
M	1	1	7	1	3	2	15
L	1	3	0	1	0	1	6
SUB-TOTALS	5	8	8	3	4	3	
TOTAL	13		11		7		

TABLE 4. Chi-square analysis for mother's acceptance of their handicapped child compared with the mother's education.

MOTHER'S ACCEPTANCE SCORES	MOTHER'S EDUCATION		
	HIGH	LOW	TOTAL
HIGH	4	8	12
MEDIUM	9	6	15
LOW	6	2	8
TOTAL	19	16	35

Degrees of freedom = 2 Chi square = 3.7034 (P .20)

TABLE 5. Chi-square analysis for mother's acceptance of their handicapped child by the mother's age at child's birth.

MOTHER'S ACCEPTANCE SCORES	MOTHER'S AGE		
	HIGH	LOW	TOTAL
HIGH	6	5	11
MEDIUM	8	8	16
LOW	4	4	8
TOTAL	18	17	35

Degrees of freedom = 2 Chi square - .0623886 ($P > .98$)

Rigidity as a personality characteristic of the mother was not significantly associated with her acceptance of her child and his/her handicap. (See Table 6) However, there were more mothers who fell within the middle range of acceptance than either the high or low categories. It is also interesting that there were more mothers within the middle range of acceptance with a medium rigidity score than with either a high or low rigidity score. Table 6 does show that the mothers tend to be in the medium range of rigidity, 21 of 35, but there are 11 in the high range in comparison to three in the low range of rigidity.

The child's birth order appears not to be associated with the mother's acceptance of the child. (See Table 7) This was interesting to the researcher because many of the mothers verbally stated that they could not have coped with the child and the accompanying problems if the child had been their first child. The findings show, however, that the mothers are able to respond to the challenge of their child's problems when the need arises so it may be that it only seems to the mother that she would not have been able to cope. The acceptance scores of the mothers of first children were not significantly different from those of mothers of second, third, etc., children. There is some slight suggestion in the data that mothers are able to be

TABLE 6. Chi-square analysis for mother's acceptance of their handicapped child compared with mother's rigidity.

MOTHER'S ACCEPTANCE SCORES	MOTHER'S RIGIDITY			
	HIGH	MEDIUM	LOW	TOTAL
HIGH	4	7	1	12
MEDIUM	5	9	1	15
LOW	2	5	1	8
TOTAL	11	21	3	35

Degrees of freedom = 4 Chi square = .358586 (P .99)

TABLE 7. Chi-square analysis for mother's acceptance of their handicapped child compared with child's birth order.

MOTHER'S ACCEPTANCE SCORES	CHILD'S BIRTH ORDER			
	3RD+	2ND	1ST	TOTAL
HIGH	3	5	4	12
MEDIUM	6	4	5	15
LOW	2	3	3	8
TOTAL	11	12	12	35

Degrees of freedom = 4 Chi-square = 1.11364 (P .90)

more accepting with the third child than earlier was true, as indicated by the finding that six of eleven mothers in the third child category were in the positive, or medium, acceptance group. Again, however, this is not a significant difference, possibly due to the small number of mothers in the study.

Occupation of the husband was the only one of the supplemental variables which was found to be associated with the mother's acceptance of her child at the 5% level of significance, when treated as an independent variable. Therefore, it is the only one of the supplemental independent variables which was treated as an intervening variable.

Qualitative Data

The tape recorded information provided by the mothers was generally very limited. It appeared that the mothers were hesitant to reveal many of their feelings when they were being recorded, but after the recorder was turned off they seemed to feel more free to volunteer more and sometimes contradictory information. (See appendix for questions asked furing the taped part of the interview)

Three of the tape recorded questions related to the mother's relationship with her husband and her other

children after learning of her child's handicap and the fourth related to her feelings about herself. The general tone of the answers was that the child had brought the husband and wife closer together because they had a serious problem to face and they had to work together to make the best adjustment for the child and the family. Seven of the mothers stated that for the first week or more they withdrew from their husbands. They felt that each needed to work out the problem alone and then they were able to work together to help the rest of the family. In only three or four instances did the mothers say that they felt the child had created a sustained barrier between her and her husband. All of the mothers reported they felt good about the way they had handled the child and the rest of the family. Four or five said if they had it to do over, knowing what they now know, they would do things differently; but at the time they felt they did the best they could. Approximately three fourths of the mothers reported that extended family members and friends had helped greatly by offering faith and prayers in behalf of the child and the family, and indicated they they did not know if they could have endured without this kind of help from others.

It is interesting to note from Table 8 that guilt and punishment of self, resentment, pain, frustration and anxiety were reported by over half of the mothers in the study. These are the topics the mothers discussed most freely with the researcher during the informal discussion after the interview.

After the pencils, papers, and tape recorded had been put away there was a different tone to the mother's conversation. After the eleventh or twelfth interview, on returning to her car the researcher began a procedure of recording her impressions as to what had been said during the informal discussion so as to be able to compare these feelings with what the mothers had said during the formal questioning and on the questionnaire. These statements were then broken down into seven categories and an attempt was made to quantify the number of statements which fell into each. (See Table 8) When informally discussing their problems the mother said such things as: "Sometimes I really resent this having happened to me;" "I don't know what I did to deserve having this happen to our family or child;" "What did my child do to deserve having to put up with this handicap for life?" "Sometimes I still cry at night because I feel so frustrated in thinking I am not doing what I should for my child;" "My husband

TABLE 8

Qualitative data from tape recordings and informal interviews

MOTHER'S FEELINGS	NUMBER OF MOTHERS RESPONDING
Guilt and punishment of self	20
Guilt and punishment of child	6
Denial by both self and husband	15
Isolation	16
Self-pity	19
Resentment, pain, frustration, anxiety	27
Child is a special child	18

refuses to accept the fact that our child is different than other children." "It has caused some problems in our family;" "The other children in the family resent the time I have to spend with our handicapped child and this causes some problems for me;" "I feel guilty:" "I am frustrated;" "I feel like no one understands." There seems to be no pattern to these feelings according to the variables examined in this study. (See Tables 9 and 10)

TABLE 9. Qualitative data from tape recordings and informal interviews

MOTHER'S FEELINGS	BLUE COLLAR		PROFES-SIONAL		SALES/ CLERICAL		TOTAL
	V	N	V	N	V	N	V&N
Feelings of guilt and punishment of self	3	5	5	3	2	1	19
Feelings of guilt and punishment of child	2	2	0	2	0	0	6
Denial by both self and husband	2	4	4	3	1	1	15
Feelings of isolation	2	3	4	2	2	2	15
Feelings of self pity	3	5	4	3	2	1	18
Feelings of pain, resent-ment, anxiety, frustration	4	5	8	3	3	3	26
Child is a special child	0	6	5	2	4	1	18

TABLE 10

MOTHER'S FEELINGS	NUMBER OF MOTHERS RESPONDING		
	VISIBLE HANDICAP	NON-VISIBLE HANDICAP	TOTAL
Feelings of guilt and punishment of self	11	9	20
Feelings of guilt and punishment of child	2	4	6
Denial by both self and husband	7	8	15
Feelings of isolation	9	7	16
Feelings of self-pity	10	9	19
Feelings of pain, resentment, frustration, anxiety	16	11	27
Child is a special child	9	9	18

In some categories under visible there is one more mother reporting than appears above, husband unemployed.

Discussion

It is interesting that the literature on physical attractiveness suggests that people who are more physically attractive are apt to be better received by others in their environment. This study, however, indicated that the opposite is true in relation to the handicapped child and his acceptance by his mother. Based on the preceding data it appears that it may be easier for the mother of the child with a non-visible handicap to deny there is anything wrong with her child, thus making the acceptance of the child and the handicap more difficult. It may be that mothers compensate for their handicapped childs physical appearance by more nurturance and acceptance than the mothers of children whose handicaps and not visible.

There were several interesting factors that arose in the discussions with the mothers which emerge as impressions rather than in the form of specific data.

No attempt was made to determine the religiosity of the family, but in almost every home the mother mentioned how faith and prayers had played a big part in helping her and the family adjust to and accept the child and the handicap. Eighteen of the mothers expressed the opinion that their children were special children, and they felt that they were privileged to have them in their homes. The researcher feels many of these expressions are a result of the

religious beliefs of the family, but at times wondered if they were indications of what the mother thought they should be feeling rather than true feelings. From the discussions with the mothers the researcher was able to ascertain that most of them belong to the Church of Jesus Christ of Latter-Day Saints, the predominant church of the area. The church teaches its members that handicapped children are special spirits and that the homes to which they come are special; this feeling was reflected in the discussions.

The researcher noted in the interviews with the mothers of the physically handicapped children that the mothers often would say, "I am glad my child is not one of the bad ones at the school." In talking with the director of the nursery school for the physically handicapped, the researcher asked if by chance all of the mothers chosen for the study were mothers of children with mild handicaps. The director's reply was that he thought the mothers were really saying, "I have learned to cope with my problems and any other problems look worse than mine." This seems to be saying that which is familiar is less threatening than the unknown, which is true in most dimensions of life. Also the process of learning to love a child changes many feelings the mother might have if she were to think of a child with whom she had not had many hours of interaction.

Nine of the mothers were concerned that something they had or had not done during pregnancy had caused the child's handicap. Some of the mothers stated that other children in the family had difficulty accepting the child handicap. Some children had asked the parents to get rid of the handicapped child. On the other hand, other parents said that the older children in the family had grown and developed in their understanding of people because of the handicapped child in their home.

A predominant statement from the mothers of both the deaf and the physically handicapped children was that for sometime after the birth of the child the mother had thought that there was something wrong with the baby, but she could not convince the doctor of this. Very often the mothers were told that their fears were all imagined. They were told to stop worrying because the child would be normal. Then in a few months the doctors might say, "You were right, I do think there is something wrong." When the diagnosis finally came the mothers were relieved, not to know that there was a problem, but to finally know for sure what was wrong. At this stage they could then begin to cope with the problem.

The mothers of both the deaf and physically handicapped children expressed their gratitude for the help both they

and their children received from the respective programs in which their children are enrolled. They feel that the training the children are getting is of very high quality. The feeling was often expressed by the mothers that the professionals working with their children are very interested in helping the children but they are not realistic as to the amount of time the mothers have to spend with their handicapped child. They report that sometimes the professionals make them feel more guilty because they are not doing all they should for their children, when in reality the mothers are spending more time with the handicapped child than they feel is fair to the rest of the family. Sometimes they say the professionals act as if they "know it all" and have little compassion or understanding of what the mothers have to face during a twentyfour hour day. Some of the parents asked that the professionals give them some kind of hope--if only to say that the child can be normal in at least one aspect of life.

When two mothers were told by a psychiatrist, at one of the parent meetings, that it was normal for them to feel frustrated, angry, etc., when everyone else was telling them they should be grateful that their child wasn't more severally handicapped, it greatly helped with their

emotional adjustment. They said from then on they were able to go on with the healing process and were able to stop feeling guilty that they were not more grateful. Most of the mothers reported they still have periods of depression, but they now know how to cope with them; and they last only a short time and then the mother is able to be on with the business of the day.

The researcher felt that most of the mothers were able to discuss their true feelings with her in the informal situation and they are most happy to do whatever they can to help others who have children with handicaps and to help the general public gain a better understanding of handicapped children.

It may be of interest to the reader to know that two of the children with physical handicaps are adopted children. The parents were told by the adoption agencies, when the handicapping condition was discovered, that they could give the children back to the agency if they wished The parents of both children said they had no inclination to give the children back. One father's reaction was, "Of course not! If we had given birth to him we could not give him back." Here again we see the effect of the strength of parental love and the force of this love in response to the child.

SUMMARY AND CONCLUSIONS

Summary

All parents experience some kind of stress when dealing with a new child in the family. However, little is known about particular problems that are encountered by the mothers of handicapped children. Because a child's total development depends, in part, on the degree to which he or she is accepted or rejected by the mother, this study attempted to determine if the nature of the handicap was associated with the mother's acceptance of her child. Rather than study each handicapping condition separately, the researcher chose to classify handicapping conditions into two categories--visible and non-visible--for examination.

A null hypothesis was employed stating that the mother's reaction to her handicapped child would not be associated with the visible or non-visible nature of the handicap and that variables such as mother's age, education, rigidity as a personality characteristic, child's birth order and the husband's occupation would be unrelated to her acceptance of the child.

Literature on parent-child interaction was reviewed which indicated that during the early weeks of the child's life a good interaction was necessary for the future positive social, emotional and intellectual development of the child. Rheingold (1945) suggests that parents need to be guided towards an emotional acceptance of the child since wise planning for a child is impossible if the parents are not able to accept his handicap. Kendall (1970) sums up the literature by saying:

> Very few things are more important to the child than the attitudes which the mother expresses toward him...learning and emotional problems arise from parental rejection in connection with a sense of personal or social stigma, perfectionist standards, driving the child to achieve results. (p. 15)

The transition into parenthood and the crisis effect on the family was reviewed. This literature suggested that parenthood is a stressful time for any couple and any added stress such as the birth of a handicapped child would add to the stress in the family significantly. The literature mentioned the family social status and the husband's occupation as one important variable in the amount of stress experienced.

The literature on the effects of the handicapped child on the family suggested in general that the child may experience anxiety, insecurity, and other emotional

problems because of parental reactions to the child, and to the various handicapping conditions that are often diagnosed at birth or soon after. These in turn would have an important effect on the child's total developmental process.

The sample for the study included 20 mothers of children with a hearing handicap, who were chosen from the Parent-Infant Project of Utah, and 20 mothers of children with physical handicaps chosen from the Developmental Disabilities Clinic in Salt Lake City, Utah. All of the mothers had children four years of age or younger. The directors provided the researcher with a list of children in their programs. The mothers of these children were then sent a letter asking if they would participate in the project. The response from the parents was generally positive; however, because some of the parents declined or moved away, the project was left with 35 participants.

A questionnaire based on the Parent Attitude Research Instrument (PARI) prepared by Dennis Kendall (1970) was adopted for use in this study. To this was added the Wesley Rigidty Scale. The study was almost a replication of the Kendall (1970) study in the sense that the questions which he used to explore parental reactions, which were similarly being explored in this study, were used without

modification. The Rigidity Scale was included in this study as an exploratory inquiry into the area of personality as a possible characteristic of the mothers which might be associated with their response to their handicapped child.

Following the mailing of the letters to the parents asking their participation in the program the researcher contacted each of them by telephone and set up an appointment to meet with them in their home. During the home visit the questionnaire was administered and four or five questions concerning the mother's relationship with her family were asked and the responses tape recorded. The mothers were all cooperative with the researcher and at times volunteered information that revealed interesting insights into their true feelings and frustrations with having a handicapped child.

The questionnaire was scored numerically and the scores were rank ordered from high to low in the various categories of the test, using the original author's scoring system. A 3x2 design was used to determine the degree of association between the mother's acceptance scores and the high/low visibility of the handicap. The data were analyzed by the sum of chi square based on the .05 level of confidence. A 3x2 design was used for the variables of mother's education and age. A 3x3 design was used with the

variables of child's birth order, mother's rigidity as a personality characteristic, and husband's occupation. The data collected from the recordings were tabulated in seven categories with a division between mothers of children with a visible handicap and mothers of children with a non-visible handicap.

A null hypothesis was employed. However, the data indicate mothers of children with visible handicaps appear to be more accepting of their children than are mothers of children with a non-visible handicap. The hypothesis asserted other variables as being unrelated to the mother's reactions to the nature of the handicap. The variables were husband's occupation, mother's education, age at the birth of the handicapped child, rigidity of the mother and the child's birth order. Occupation of the husband was the only one of the supplemental variables which was found to be associated with the mothers acceptance of her child at the 5% level of significance, when treated as an independent variable. Therefore, it was the only one of the supplemental independent variables which was treated as an intervening variable.

The tape recorded material revealed that most of the mothers felt their handicapped child had brought her and her husband closer together because they had a serious

problem to face and they had to work together to make the best adjustment for the child and the family. In general the mothers stated they felt good about the way they had handled their handicapped child with the limited knowledge they had available to them when the diagnosis was initially made. The mothers also reported that family and friends supplied a tremendous support system to them during the initial weeks of frustration.

Conclusion

The findings suggest that mothers of children with a visible handicap appear to be more accepting of their child, and the handicap, than is true of mothers whose child has a non-visible handicap. This is particularly true for mothers in professional families as contrasted to those in blue collar or clerical occupations.

Research in the area of physical attractiveness (Berscheid & Walsters, 1973, and Spock, 1965) has indicated that attractive persons generate positive responses from others, in contrast to the less favorable responses generated by those who are physically unattractive. The findings of this study do not support the findings of physical attractiveness research, but there may be an acceptable explanation for this variance. It may be noted

that previous studies have not dealt with the mother-child relationship in a direct way.

The mother-child relationship is often characterized in protective terms. It seems quite possible that mothers respond quite differently to their own handicapped child than may be true of their reactions to the physical characteristics of other persons.

It is recognized that mothers are individuals, among whom there is more than one style with which they attempt to cope with the problems associated with their having a handicapped child. The findings, however, appear to provide support for the conclusion that mothers tend, with variance among them by occupational groupings, to respond protectively, by providing compensatory acceptance of the child with a visible handicap.

Suggestions for Further Study

1. Because the present researcher felt the instrument she used to obtain information of the mother's acceptance of her handicapped child was not adequate to explore fully the mother's true feelings, it would be interesting to work on constructing an instrument that would circumvent this problem, and give this kind of study more validity.

2. It would be of great interest to do this same type of study, investigating the father's reactions to handicapped children. Many of the mothers in the present study indicated they did not feel their husbands had fully accepted the child or the handicapping condition.

3. This same type of study would be beneficial if done using a larger sample from a more varied population than is found in the Wasatch front area of Utah.

4. Because of the many references made to religious ideas and values by the mothers in the present study, it would be of interest to investigate how religion affects a mother's reactions to her handicapped child.

5. Knowing there are many similarities to the acceptance patterns of mothers of both handicapped and normal children it would be interesting to do a study and see if there are also similarities in acceptance for these two groups in relation to the independent variables used in this study.

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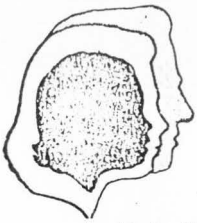
APPENDIX



parent-infant program

A State-Wide Infant Program for the Hearing Impaired

April 8, 1976

Dear Mrs.

During the next three to four weeks Miss Doral Olson will be conducting a research project dealing with maternal reactions to handicapped children. I have given her permission to contact you requesting your cooperation and participation in this research. The results of this research will be of assistance to the Parent-Infant Program, and for this reason I encourage you to participate with Miss Olson.

She will contact you by telephone within the next week asking your participation and will also answer any questions you might have. Those participating will receive a personal visit by Miss Olson at which time she will have you complete a questionnaire and will ask you to answer four or five questions that will be tape recorded. The information gathered from each individual will be combined into a cumlative total of all responses. You can be assured no individual names or personal confidences will be revealed in anyway.

Thank you for your consideration and participation.

Sincerely,

Thomas C. Clark

UTAH SCHOOL FOR THE DEAF | 846 Twentieth Street | Ogden, Utah 84401 | Phone (801) 399-2907

Robt. W. Tegeder, Superintendent
Tony Christopulos, Principal

Thomas C. Clark, M.S.
Program Director

E. Rosalie Reese, M.S.
Parent Supervisor

Susan Watkins, M.S.
Education Audiologist

DEVELOPMENTAL DISABILITIES, INC.

A Non-profit Organization - *A Stimulation Program for Neurologically Disabled Infants and Children*

Primary Children's Hospital Annex - 363 Twelfth Ave., Rm. 107 - Salt Lake City, Utah 84103 - 328-1601 Ext. 351

9061

- A UNITED WAY AGENCY -

April 20, 1976

Dear Mrs.

During the next three to four weeks Miss Doral Olson will be conducting a research project dealing with maternal reactions to handicapped children. I have given her permission to contact you requesting your cooperation and participation in this research. The results of this research will be of assistance to the Developmental Disabilities Program, and for this reason I encourage you to participate with Miss Olson.

She will contact you by telephone within the next week, asking your participation and will also answer any questions you might have.

Those participating will receive a personal visit by Miss Olson at which time she will have you complete a questionnaire and will ask you to answer four or five questions that will be tape recorded.

The information gathered from each individual will be combined into a cumulative total of all responses. You can be assured no individual names or personal confidences will be revealed in any way.

Thank you for your consideration and participation.

Sincerely,

Dennis F. Gehring

Dennis F. Gehring
Director

DFG/lac

QUESTIONNAIRE

PART I

READ EACH STATEMENT BELOW AND THEN RATE THEM AS FOLLOWS:

A	a	d	D
Strongly Agree	Mildly Agree	Mildly Disagree	Strongly Disagree

Indicate your opinion by drawing a circle around the "A" if you strongly agree, around the "a" if you mildly agree, around the "d" if you mildly disagree, and around the "D" if you strongly disagree.

There are no right or wrong answers, just answer according to the way you feel. Remember to answer all questions as they would apply to your handicapped child or your relations with him.

	Strongly Agree	Mildly Agree	Mildly Disagree	Strongly Disagree
1. A mother should do her best to avoid disappointment for her handicapped child.	A	a	d	D
2. A young mother of a handicapped child feels "held down" because there are lots of things she wants to do while she is young.	A	a	d	D
3. A mother has a right to know everything going on in her child's life because her child is part of her.	A	a	d	D
4. A mother must expect to give up her own happiness for that of her handicapped child.	A	a	d	D
5. A good way to discipline a child is to let him know that his parents won't love him if he is bad.	A	a	d	D
6. A mother's greatest fear is that in a forgetful moment she might let something bad happen to her child.	A	a	d	D

	Strongly Agree	Mildly Agree	Mildly Disagree	Strongly Disagree
7. A handicapped child would get on any womans nerves if she had to be with him all day.	A	a	d	D
8. Mothers should know better than to allow their handicapped child to be exposed to a difficult situation.	A	a	d	D
9. Mothers sacrifice almost all their own fun for their handicapped child.	A	a	d	D
10. Mothers very often feel that they can't stand their child a minute longer.	A	a	d	D
11. Children should be "babied" until they are several years old.	A	a	d	D
12. The most important consideration in planning the activities of the home should be the needs and interests of the child.	A	a	d	D
13. Having to be with the handicapped child all the time makes a woman feel that her wings have been clipped.	A	a	d	D
14. I didn't fully please my husband because I gave birth to a handicapped child.	A	a	d	D
15. Handicapped children should be kept away from all hard jobs which might be discouraging.	A	a	d	D
16. I experienced great anxicty in not being given anthing to do when I found out our baby was handicapped.	A	a	d	D
17. Children and husbands do better when the mother is strong enough to settle most of the problems.	A	a	d	D
18. It isn't fair that a woman has to bear just about all of the burden of raising children by herself.	A	a	d	D
19. When I knew that my child had a handicap I wanted someone to tell me what to do for him, not just that he had a handicap.	A	a	d	D
20. One thing about having a handicapped child is that you are not free enough to do things you like.	A	a	d	D

QUESTIONNAIRE

PART II

From the following list of words check seven of those which you think might best describe your initial reactions to your child's handicap.

contentment	compassion
adjustment	confusion
anxiety	bitterness
self-pity	eagerness to learn
relief	rejection
frustration	faith
understanding	guilt
disbelief	shame
hope	acceptance
despair	calmness

QUESTIONNAIRE

PART III

Read each statement. Circle TRUE if you feel the statement is true and FALSE if you think the statement is false. There are no right or wrong answers.

TRUE FALSE I am often the last one to give up trying to do a thing.

TRUE FALSE There is usually only one best way to solve most problems.

TRUE FALSE I prefer work that requires a great deal of attention to detail.

TRUE FALSE I often become so wrapped up in something I am doing that I find it difficult to turn my attention to other matters.

TRUE FALSE I prefer doing one thing at a time to keeping several projects going.

TRUE FALSE I dislike to change my plans in the midst of an undertaking.

TRUE FALSE I never miss going to church.

TRUE FALSE I would like a position which requires frequent changes from one kind of task to another.

TRUE FALSE I usually maintain my own opinions even though many other people may have a different point of view.

TRUE FALSE I find it easy to stick to a certain schedule, once I have started it.

TRUE FALSE I believe women ought to have as much sexual freedom as men.

TRUE FALSE I do not enjoy having to adapt myself to new and unusual situations.

TRUE FALSE I prefer to stop and think before I act even on trifling matters.

TRUE FALSE I would not like the kind of work which involves a large number of different activities.

TRUE FALSE I try to follow a program of life based on duty.

TRUE FALSE I have kept a careful diary over a period of years.

TRUE FALSE My interests tend to change quickly.

TRUE FALSE I usually find that my own way of attacking a problem is best, even though it doesn't always seem to work in the beginning.

TRUE FALSE I dislike having a learn new ways of doing things.

TRUE FALSE I like a great deal of variety in my work.

TRUE	FALSE	I am a methodical person in whatever I do.
TRUE	FALSE	I am usually able to keep at a job longer than most people.
TRUE	FALSE	I always finish tasks I start, even if they are not very important.
TRUE	FALSE	People who go about their work methodically are almost always the most successful.
TRUE	FALSE	When I have undertaken a task, I find it difficult to set it aside, even for a short time.
TRUE	FLASE	I have a work and study schedule which I follow carefully.
TRUE	FALSE	I usually check more than once to be sure that I have locked a door, put out the light, or something of the sort.
TRUE	FALSE	I have never done anything dangerous for the thrill of it.
TRUE	FALSE	It is always a good thing to be frank.
TRUE	FALSE	I have a habit of collecting various kinds of objects.
TRUE	FALSE	I have taken a good many courses on the spur of the moment.
TRUE	FALSE	I believe that promptness is a very important personality characteristic.
TRUE	FALSE	My interests change very quickly.
TRUE	FALSE	It is the slow, steady worker who usually accomplishes the most in the end.
TRUE	FALSE	I am always careful about my manner of dress.
TRUE	FALSE	I usually dislike to set aside a task that I have undertaken to finish.
TRUE	FALSE	I am inclined to go from one activity to another without continuing with any one for too long a time.
TRUE	FALSE	I prefer to do things according to a routine which I plan myself.
TRUE	FALSE	I always put on and take off my clothes in the same order.

QUESTIONNAIRE

PART IV

CIRCLE THE APPROPRIATE NUMBER.

1. Marital status?

   1. Married (living together)
   2. Separated
   3. Divorced
   4. Remarried

2. Are you employed?

   1. yes
   2. no

3. Circle the last grade in school you completed.

   High School: 8 9 10 11 12 — College: 13 14 15 16 17 or more

4. Child's sex.

   1. Male
   2. Female

5. How old were you when this child was born? _____

6. How many other children do you have? _____

7. Was this child born first, second, third, etc.?

   1 2 3 4 5 6 7 8 9 10

8. Husband's occupation? _____

9. Would you like to know the results of this study?

   1. yes
   2. no

Questions Used for Tape Recording

1. What were your feelings when you heard or knew your child was handicapped?
2. How have you changed since you first knew and when you accepted the fact of the handicapping condition?

   If there is a difference in interaction with handicapped child and normal child it may well be saying they haven't yet accepted--may pull out suggestions of overprotection.
3. What are your feelings now concerning your relationship with your spouse--since recognition of the handicapped child?
4. What would you do differently in relation to:
   a) handicapped child
   b) husband
   c) your other children
5. How do you feel about your role as wife and mother since having a handicapped child?
6. What did you think when you were told your child was handicapped?