1997

The Empirical Development of an Instructional Product Designed to Enhance the Cognitive Awareness of and the Modification of Affect Toward the Disability Condition

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Andrews University

School of Education

THE EMPIRICAL DEVELOPMENT OF AN INSTRUCTIONAL
PRODUCT DESIGNED TO ENHANCE THE COGNITIVE
AWARENESS OF AND THE MODIFICATION OF
AFFECT TOWARD THE DISABILITY
CONDITION

A Dissertation

Presented in Partial Fulfillment

of the Requirements for the Degree

Doctor of Philosophy

by

Rikard Ashmore Bailey

June 1997

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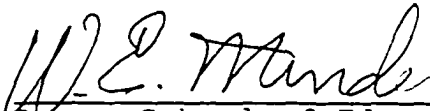
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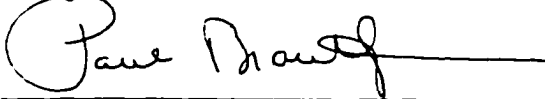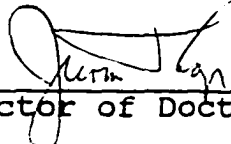
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ABSTRACT

THE EMPIRICAL DEVELOPMENT OF AN INSTRUCTIONAL
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ABSTRACT OF GRADUATE STUDENT RESEARCH

Dissertation

Andrews University

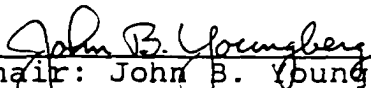School of Education

Title: THE EMPIRICAL DEVELOPMENT OF AN INSTRUCTIONAL
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          OF AND THE MODIFICATION OF AFFECT TOWARD THE
          DISABILITY CONDITION

Name of researcher: Rikard Ashmore Bailey

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Date completed: June 1997

Problem

The Seventh-day Adventist church had no empirically
developed instructional product in the form of an
educational curriculum designed to enhance the cognitive
awareness of and the modification of affect toward the
disability condition. The purpose of this project was to
develop empirically an instructional product in disability
awareness training for Seventh-day Adventist church members
and their guests so to better build an interactive,
empowered, and inclusive sense of community.

Method

The developmental process of Baker and Schutz (1971)

was used to produce and validate the instructional product. First, the content of the curriculum to train Seventh-day Adventist church members and their guests was identified through an examination of disability and disability awareness training literature.

The developing materials were divided into instructional units, arranged into a logical sequence, and introduced with behavioral objectives. It was established that the product would be successful only when at least 80% of the attending learners achieved at least 80% on each objective.

In the developmental process, the instructional product was revised numerous times. Some of the learning units were streamlined, while others were expanded. Specific weaknesses, exposed during the tryout stages, were appropriately corrected and a participants' and instructor's manual were prepared. At the conclusion of the final presentation, the required standard for mastery was attained on all objectives.

Results

The instructional product, called the D.A.R.T. Seminar or Disability Awareness Reality Training Seminar, includes the instructor's manual with textual information covering each of the 20 points of the disability training seminar divided into four sections in combination with a separate participant's manual inclusive of review questions, pictorial representations of textual examples, and the

general outline in progressive detail of each of the 20 disability training points.

This instructional product met an arbitrarily established criteria that held true to the researcher's chosen methodology and represented a realistic majority of a convenient sample: 80% of the subjects on the final presentation reached each objective at or above the 80% arbitrarily chosen mastery level. The modification of affect was considered significant when the difference between the affective post-test and pre-test scores reached the 15.35% difference level. A $\underline{t}$-test for dependent means, significant at the .05 level, was utilized.

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CHAPTER 1

INTRODUCTION

Background of the Problem

"Most disabled people strive for normalization and integration. However they often encounter social, economic, psychological and political barriers in attempting to achieve this goal" (Nagler, 1990, p. 1). The majority of individuals with a disability desire and endeavor to achieve a social and personal integration with, and a full participation with, their able-bodied counterparts (Nagler, 1990). However, "some segments of our society cannot and will not accept the limitations imposed by disabilities" (Nagler, 1990, p. 1).

The problem of the disability condition rests in the myths and distorted knowledge that is directly associated with the disability condition. The non-acceptance of this condition and its limitations by certain segments of the society, as M. Nagler stated above, must be attributed to the general lack of awareness of the facts and exposure to the reality that is disability. "It is important to remember that people with a disability condition are still people; people with needs, characteristics and lifestyles,

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people who for one reason or another are called exceptional as a result of their disability condition" (Hardman, Drew, Egan, & Wolf, 1990, p. 1).

Awareness of the disability condition is the first step toward achieving change in attitude (National Easter Seal Society, 1994). This change in attitude can possibly bring to life in society's perception a shared trust for the sacredness of life as a whole.

The disability condition is a complex array of a multitude of different aspects associated with the human adventure (McDevitt & McDevitt, 1979). Since the disability condition affects over 34 million Americans (Graves, McLaughlin, Davis, & Reswick, 1992), it is important that we--for the sake of community building (Ross, 1981) and support for and encouragement to this large American minority (Hale, 1979)--be aware of their limitations. This awareness is to better allow a natural integration of acceptance and inclusion into the dreams and possibilities of society so the necessity of opting for only secondary gains will not be the only dream available (Nagler, 1990).

It then is vital, in the awareness process, to understand the general condition of disability.

> There are four basic types of disabilities. The first type of disability prevents the disabled person from ever having the opportunity to experience a normal life. Such people are afflicted with congenital disorders. The second type of disability status is developmental: those who are burdened with hypertension, arthritis and other related conditions. These individuals must often limit their activities as

a consequence of their disabilities. The third
category of disability is instantaneous impediments
which are usually quite sudden and extremely
restrictive. The final disability status is
psychological; this group includes those people with
mental disorders. (Nagler, 1990, p. 1)

The disability condition poses a fivefold challenge.

"The stress of these four types of disability conditions can

range from mild to severe. In some cases, members of the

disabled are unable to adjust to their handicap and in other

cases they can overcome them completely" (Nagler, 1990, p.

1). However, the process of successfully overcoming the

physical challenges of a disability is but just the first

part of the fivefold challenge that is associated with the

disability condition. Overcoming the physical challenge of

a disability, to the point of successfully integrating into

a practical community involvement, is a partial victory.

Many individuals with a disability condition discover that

they are severely impeded by the other four challenges, a

multitude of social, economic, political, and psychological

barriers (Nagler, 1990).

It seems appropriate, when studying the disability

condition, to become aware of certain basic feelings and

perceptions that are associated with this condition so to

keep the condition in a personal realm, yet separate and

distinct from the individuals themselves (National Easter

Seal Society, 1994). "The disabled often believe that they

are members of a victimized minority, who are prevented by

the attitudes of society from enjoying the quality of life

they deserve" (Nagler, 1990, p. 1). Being society's victims

of uneducated prejudice and unaware discrimination,

individuals with a disability often feel and experience and

consequently suffer similar isolation and alienation

experienced by racial, religious, ethnic, and other minority

groups (Nagler, 1990).

> Over 30 million people with disabilities accept
> responsibility for their work, family and individual
> lives. Their substantial contribution to society can
> be contributed both to personal competence and to the
> strengths of those communities that foster and support
> attempts to live independently. (Suarez De Balcazar,
> Bradford, & Fawcett, 1988, p. 17)

There remains, even in these communities, a multitude

of physical and social barriers that limit good jobs,

acceptable housing, accessible transportation, and other

very needed services (Suarez De Balcazar et al., 1988).

"Handicapped individuals are increasingly being thought of

as a classification of citizens whose civil rights are being

abridged by the presence of barriers" (Kliment, 1985, p. 4).

These barriers are physical, social, political, economic,

and psychological, and can be greatly frustrating,

unsettling, and causes of immense anxiety and fear (Wright,

1983, pp. 95-115). "These community problems thwart even

the most heroic, personal attempts to pursue a full life"

(Nagler, 1990, p. 3).

The major anxieties of individuals with disabilities in

contemporary society rest in the threat of attack on

personal independence. These major anxieties cause the

problems that create the barriers that limit and constrain
this segment of the population. The major issues identified
by disabled Americans that cause the most difficult physical
problems are 18 by category: (1) Affordability and
availability of assistance devices, (2/3) Accessibility and
affordability of commercial services, (4) Community support
and responsiveness, (5) Awareness and involvement with
disability rights and advocacy, (6) Employment
accommodations, disincentives, and training, (7) Employment
discrimination, (8) Employment opportunities, (9)
Availability and enforcement of handicapped parking, (10)
Affordability and availability of health care, (11) Housing
affordability, availability, and accessibility, (12)
Insurance affordability for health care, (13) Negative media
portrayal and lack of public information, (14) Public access
unavailability, (15) Social services, lack of information,
(16/17) Availability and affordability of transportation,
(18) Consumer-identified dimensions of affordability of
utility bills (Suarez De Balcazar et al., 1988).

> People with disabilities were socially invisible,
> powerless people. Their rise to social visibility,
> social consideration, a modicum of power and increasing
> acknowledgement of their rights to equal opportunity
> has vastly exceeded the wildest hopes of social
> psychologists and others who were concerned with this
> issue. (Myerson, 1988, p. 178)

Society in general has progressed a long way in its
recognition, acknowledgment, and support of the disability
condition and the specific issues and problems that are

associated with the personal anxieties that accompany a loss of independent living ability. Society has moved past the time when little babies with disabilities were monsters and adults with deviant physiques or unfunctioning body parts were freaks. In this moving-past process of adjustment and acceptance, much about physique-behavior relationships and disability awareness has been learned, but there is still a long way to go toward reaching complete acceptance and total integration (Myerson, 1988).

"From a theoretical point of view, it is possible to integrate a physical disability within a healthy, well-rounded personality. However, clinically, a personality so constructed is rarely if ever encountered" (Cutsforth, 1948, p. 3). In the individual with a disability, severe enough to cause limitation and lack of ability, the incapacitation of personality is often times disproportionate to the degree of physical incapacitation. The feelings of inadequacy in the personality are poured into the disability, which is made the emotional causal factor for their existence. The acceptance of all the inadequacies of the personality, in terms of the disability, causes the individual to adapt an overwhelmed attitude toward the world, the required responsibilities, and most all activities in the daily life. This overwhelmed attitude and reaction serves only to heighten the feelings of disability, dependence, and inadequacy (Cutsforth, 1948). "The attempt to compensate

for the feelings of inadequacy drives the individual to successes, but never to personality adjustment" (Cutsforth, 1948, p. 2).

Adjustment to the disability condition is not a state of permanence. Adjustment is a developing process, an on-going process that requires community support and encouragement, mental and physical therapy, and a physically possible avenue toward adjustment to an altered lifestyle (Nagler, 1990). Sociologically, disability may be conceptualized as a social process (Haber, 1967; Haber & Smith, 1971; Nagi, 1965; 1969). The adjustment process is ongoing simply because of society's constant need to be made aware of and to accept individual differences in people with disabilities (Gartner & Joe, 1987). "Disability produces alienation from society" (Romeis, 1983, p. 5). This alienation is the creator of the disabling effects on the individuals of the particular conditions.

> Being disabled means many things not only to the disabled person, but also to their associates. The rejection, isolation, and alienation in traditional patterns of treatment have given way to a mainstream orientation. According to the mainstream philosophy, the disabled are to be integrated as much as possible in order to maximize their habilitative potential, thereby ensuring that these individuals will enjoy the highest quality of life achievable for them. However, there are still many citizens in the disabled community who continue to undergo varying degrees of negativism, prejudice, and disassociation because they have been stigmatized and forced into the role of an involuntary deviant. (Nagler, 1990, p. 2)

Statement of the Problem

The disability condition is a complex array of physical, social, political, economic, and psychological limitations in life activities (Graves et al., 1992). Individuals with disabilities must struggle with and through each of these characteristics daily in an attempt to meet their limitations through successful adaptation. People with disabilities face isolation, alienation, prejudice, distorted knowledge, fear, insecurity, forced dependence and avoidance by their acting society (Nagler, 1990).

People with disabilities need society's encouragement and support in their attempts to independently engage in life's activities. If the disabled person's present society can act as an enlightened disability therapist and begin to understand and even expect that, with time, a person with a disability can embrace the disability, then the energies of the rehabilitation process can be directed toward moving away from compensating for the disability (Vash, 1981). These rehabilitation energies "can be directed toward more joyous aspects of life, such as experiencing, learning, producing, loving and knowing, thereby transcending the effects of the disability" (Vash, 1981, p. 9).

The local church congregation has a fortunate representation in the living process of a community. In fields of education, health, and social provision, as well as spiritual direction, the church family is socially

recognized as viable (Belben, 1986). "The church has been pictured thus far as a caring community and laypersons as people who care" (Brister, 1978, p. 46).

This caring, socially viable source of community provision could, through the proper awareness training, be a support and encouragement to the personal and social rehabilitation process of members with disabilities. A church congregation could, if properly trained in the awareness of the disability condition itself, be helpful in the process of transcending the isolating, alienating, and avoiding effects of the disability condition and instrumental in the direction of personal energies toward independence, self-expression, community involvement, and personal and social fellowship.

> Fellowship is an over-used and under-valued word in the church vocabulary. It is often offered at a very superficial level in the life of a congregation. Opportunities to experience it at deeper levels need to be offered. Fellowship--sharing at the heart level as well as at the head level, needs to grow until we discover how it is that we can begin to relate to each other openly, honestly and caringly, learning to drop our masks, barriers and inhibitions. (Matthew & Lawson, 1989, p. 112)

Church congregations could be more instrumental in the mastery of each of these aspects, with the appropriate education and awareness training in the disability condition.

Purpose of the Study

The purpose of this study was to empirically develop an instructional product for Seventh-day Adventist church members, designed to train and enhance the awareness of and the positive affect toward the disability condition.

The instructional product development method of Baker and Schutz (1971) was followed in this process. The instructional product was designed to be in the form of an intensive, 5-hour disability awareness training seminar. It was hypothesized that 80% of the participating members and their guests attending the specific church congregation would master 80% of the criteria of each behavioral objective during the seminar. It was further hypothesized that positive modification of affect toward the disability condition would take place during the seminar.

Significance of the Study

The significance of this study can be measured in two ways. First, this study demonstrates the value of the empirical development model. This holds significant value historically, since a very small percentage of curriculums have been actually empirically developed. Second, the content itself equips the learning audience to understand the disability condition more fully and thus individuals interact with acceptance rather than react out of fear. In this interaction there will come the impetus toward more comprehensive social inclusion.

Theoretical Framework of the Study

The Baker and Schutz (1971) methodology of instructional product development is over 25 years old. It is a behavioral, technical production model in the empirical/analytical type of inquiry. This researcher interprets the Baker and Schutz (1971) methodology of instructional product development as being influenced by the theoretical foundations of a progression of four historical curriculum development methodologies.

The first foundational methodology is the scientific management theory of Franklin Bobbit (1918), which focused on development of specific objectives based upon scientific methods for the establishment of a curriculum. This first foundational theory relates to the Baker and Schutz (1971) methodology of instructional product development by establishing the concept of a testable or scientific method of developing specific objectives for use in the learning process.

The Baker and Schutz (1971) methodology incorporates this scientific method into its development by using a pre-test to determine what is known about the subject and a subject presentation with sensitivity to all questions raised, to determine what is necessary, according to the researcher, to be learned and formed as a learning objective.

The second foundational methodology deals with certain objectives, experiences, and the organization of John Tyler (1975), all associated with learning and the learning process. The portion of the Tyler theory that relates to the Baker and Schutz (1971) instructional product development methodology centers around the concept of learning as a production system and individual learning outcomes as the principle product of such a system. This theory relates to the Baker and Schutz (1971) methodology through the measureable results of a pre-test/post-test system as the learning outcome.

The pattern of research and design as structure of Fredrick Shaw (1966) is the third foundational methodology this researcher interprets as integral to the Baker and Schutz (1971) method of research. This educational concept deals with the structure of learning through specific teaching strategies. This relates to the Baker and Schutz (1971) methodology through its suggested prescriptions for content presentations.

The fourth foundational methodology comprising the Baker and Schutz (1971) research method seems to be associated with the theoretical and practical regard for individual understanding and personal interests as the essence of education of Charles Silberman (1970). Baker and Schutz (1971) utilize this learner's theory in their situational implementation of needs-specific instructional products.

I chose this research methodology because of its possible potential to facilitate learning and behavior modification.

This particular model of curriculum development, in its behavioral theory, addresses what this researcher believes are the most significant perspectives associated with the educational process, those being: What has the learner realized and what now can the learner do with these new realizations?

Definition of Terms

The following terms are defined as used in this study:

Disability: Refers to "any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner, or in the range, considered normal" (World Health Organization, 1980).

Condition: Refers to any one of the four bodily situations that result in a limitation and/or lack of life activity (Graves et al., 1992): (1) Congenital disorders; (2) developmental disorders; (3) instantaneous impediments; and (4) psychological disorders (mental disorder included) (Nagler, 1990).

Behavioral Objective: A precise description of a learner's post-instruction behavior. This description includes four criteria: (1) the specified learner; (2) a measurable verb describing the learner's post-instructional performance; (3) the given conditions in which the behavior

occurs; and (4) a precise standard of acceptable performance (Baker & Schutz, 1971).

Community: A body of individuals in active process of acceptance and inclusion of each other's differences for the purpose of personal and corporate support.

Support: The offering and the receiving of encouragement, motivation, and inspiration.

Cognitive Awareness: The exposure to and realization of certain presented concepts associated with the disability condition whose percentage of comprehension can be determined by a post-presentation testing situation.

Modification of affect: The measurable change of perceptions held toward the disability condition by individuals attending the D.A.R.T. Seminar. This change of perceptions can be determined by a post-presentation testing situation.

Mastery: The pre-established level of post-instructional behavior. In this study, the acceptable level of performance on the post-test was set at 80/80. At least 80% of the participants were required to score 80% or higher on each presented objective in order to achieve mastery.

Empirical Instructional Product Development: A process in which instructional materials are developed according to measurable objectives, using members of the target audience for feedback and testing.

The D.A.R.T. Seminar: The 5-hour intensive instructional product representing disability awareness reality training designed for the Seventh-day Adventist church to build community among its members and guests.

Assumptions

It is assumed that mastery of the material presented is accomplished at the 80% level of testing achievement and that complete comprehension of the presented concepts is not permanent. It is assumed that the 80% level of achievement on the post-/pre-test comparisons represent the achievement of a realistic majority of a convenient sample. It is assumed that human memory is flawed. It is assumed that awareness of certain aspects of the presented concepts associated with the disability condition is permanent. It is assumed that behavior change accompanies tested modification of affect associated with the disability condition. It is assumed that the D.A.R.T. Seminar is limited in its scope of the disability subject and that the 20 points that compose the Seminar are limited in their treatment of the disability condition.

It is assumed that Seventh-day Adventist church members, as well as their guests, have a basic understanding of the Seventh-day Adventist mission of service, are willing to commit to helping better serve their communities, and are willing to become more aware of, and active in, the needs of their neighbors with disabilities.

Delimitations of the Study

1. This study was developed with the intention of instructing young adults and adults of both genders who regularly attend the Seventh-day Adventist church.

2. This instructional product is introductory in nature only, not an exhaustive curriculum on the study of disability and disability awareness.

3. The instructional product was designed to increase cognitive awareness of the disability condition in general and to positively modify affect associated with the disability condition in general. Therefore, it covers the general definitions of only 16 disabling conditions--those 16 definitions that are represented by the Easter Seal Society.

4. The instructional product was designed for English readers only. Therefore, references associated with the disability condition in other languages were not included.

Limitations of the Study

1. The Seventh-day Adventist church members who composed the majority of each seminar sample were considered as one homogenous group. The sample did not represent the entire Seventh-day Adventist church population.

2. The sample of participants was not randomly chosen, but conveniently arranged.

3. The sample included only those church members and their guests who were willing to participate in the training seminar.

4. The memory of the participating individuals was limited to their personal development.

5. The ability to comprehend the presented material was also limited to personal development and by past awareness of the disability condition and the researcher's clarity and development of presentation.

6. The depth of presentation and number of questions directly addressed in the presentation were limited by the time allotted for each presentation.

7. The results of the seminar were a product of a study based on near-immediate recall and a need for an honest willingness to disclose personally held attitudes.

8. The statistical success of the finished product was limited by the rate of forgetfulness exhibited by each individual on each specific question.

Outline of the Study

This study is divided into five chapters. Chapter 1 is an introductory chapter. Chapter 2 reviews related literature associated with the disability condition. It is outlined according to the approach to the disability condition used in this study and organized under six main headings: development of programs, development of a working definition, development of awareness through social

evaluations, development of social attitudes and social responsiveness, and the historical development of the instructional product.

Chapter 3 explains the methodology used in this study—a seven-step process based on Baker and Schutz (1971). It includes a list of the instructional objectives used in the study, and a description of the statistical analysis used to measure cognitive modification and modification of affect.

Chapter 4 presents the results of the empirical development of the instructional product, the tests, and the statistical analysis.

Chapter 5 provides the summary, conclusions, implications, and recommendations for further research.

The appendices contain the cognitive instruments (pre- and post-tests), the criteria for each objective, a diary of the developmental process, the participants' manual, and the instructor's manual.

CHAPTER 2

REVIEW OF LITERATURE

Overview

According to the President's Committee on Employment of
People with Disabilities, chaired by Tony Coelho in 1995,
over 49 million Americans experience some sort of disability
condition. "More than 14 percent of the civilian, non-
institutionalized population, are limited in their activity
due to long term disability" (Adams & Benson, 1990, p. 11).
This staggering number of individuals represents a very
large segment of the general population and a segment that
often lives in a shadow of mystery.

> Physically disabled people, men, women and children who
> were born with a physical impairment or who have a
> physical impairment as a result of illness, injury,
> accident or age, represent the largest, although often
> most hidden minority in the whole world (Hale, 1979, p.
> 6).

With these figures at hand, there still remains a great
inaccuracy in complete data collection. "These figures only
begin to convey information about the number and condition
of persons with disabilities, given the myriad, often
conflicting, array of information available on this segment
of the population" (Graves et al., 1992, p. 17).

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This study delves into the awareness and knowledge of different yet general disability conditions more completely. It examines the problems and needs of persons with disabilities and how attitudes toward these persons are developed and how they can be enhanced through simple awareness, exposure, and contact, for the sake of establishing an inclusive sense of community.

The World Health Organization defines disability as: "any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner, or in the range considered normal" (World Health Organization, 1980). Through the process of this instructional product development and each participant's response associated with the continual review of current literature on the topic, the definition of a disability condition continued to expand into the following conceptual framework of any condition in life that creates an interruption, restriction or inability to perform a life-activity in a socially and personally acceptable manner and range.

This research study, through the process of instructional product development, involves the general term called disability and refers to its perceived reality as a disability condition. Disability as a condition "involves many areas of functioning, such as physical (e.g. walking), emotional (e.g. personal relationships) and mental (e.g. problem-solving)" (Bennefield & McNeil, 1989, p. 3).

Following the data and definitions in the related literature, this study examines seven basic areas of awareness. The first area is an examination of the development of the concept and action of disability awareness training. The second area of review is the development of an understanding of the disability condition itself through a developed working definition. The third basic area of awareness in this study is the examination of the development of existing sociological aspects associated with personal and public evaluation of human differences. The fourth area of review is the development of the origin of attitudes toward persons with disabilities and when and where such attitudes may be formed. The fifth area of development is the formulation of a social and personal responsiveness toward the disability condition and the practical role society can play in accepting and integrating persons with disabilities. The sixth area of study is the historical development of curriculum formation and the empirical process within this formation. The final area deals with the spiritual formation of disability awareness according to this researcher.

This study is an attempt designed to increase awareness of the disability condition. This study is also designed to be instrumental in the enhancement of general affect toward the disability condition for the sake of strengthening

community relationships and for the inclusion and reverence toward the diversity of humanity.

The Development of Programs in
Disability Awareness Training

Introduction

"In 1995, nearly all agencies and associations that help disabled persons have disability awareness programs" (Daley, 1995). The concept of disability awareness and the training in the different fields of disabilities for the purpose of the enhancement of publicly held attitudes is a concept that is steadily gaining a foothold within the public consciousness of our society, yet still faces grand human obstacles toward progression of full integration in work and life in general.

> As we move forward in our quest for full and total inclusion not only in the employment arena but in all aspects of life, we must not forget the many gains we have made. Equally important, we cannot lose sight of the long road we have yet to travel, and must continually remind ourselves and those around us of the importance of our rights and our responsibilities as American citizens. (Coelho, 1995, p. 1)

Historical Development

The actual development of disability awareness programs and training procedures for employment-related industry and public edification began in earnest as a change in perception was evolving around the nation as a result of an important work of research. In 1984, a reference bibliography, entitled Attitudes Toward Disabled People,

Past and Present," was published by the National Library Service for the Blind and Physically Handicapped in Washington, DC, for general public awareness. From this date in 1984, the emphasis in the related literature on the disability condition has shifted away from a focus on difference and limitation and more to a focus on abilities and potential. This national shift of focus made evident the beginning development of a social attitude enhancement and acted as a catalyst for continual public awareness through the formation of different disability awareness training programs.

Since this date in 1984, individuals with disability conditions began actively participating more fully in the mainstream of society, advocating for full social and personal acceptance. These actions were wonderful benefits to the development of nationwide awareness programs and to the continual change of attitudes that were forming. This active, progressive approach on the part of the individuals with disability conditions and those in support of national human rights eventually led to the passage in Congress of the Americans With Disabilities Act in July of 1990. From this time on, public attitudes, through varied awareness training programs, have been slowly but steadily changing (Strauss, 1991).

Public policies created toward people with disabilities in the areas of education, employment, and daily living are

influenced widely by the four different formats of media in modern society. Western literature, television, motion pictures, and print journalism create images of the disability condition that negatively affect national policy and therefore naturally influence personal and public attitudes toward this condition. Any awareness program must therefore take into serious consideration the media as a potential harm to the enhancement of inclusive and integrative public attitudes. The media is simply an extension of the human thought process with grand potential for positive or negative influence (Gartner & Joe, 1987).

Public Involvement

In a research study performed in Canada in search of better public awareness of disabled persons, the effectiveness of a Canadian advertising campaign with the theme "Your Attitude Toward the Disabled Can Be Their Biggest Handicap" was examined. "The campaign appeared moderately successful in terms of its visibility, but ineffective in changing attitudes toward disabled persons or in eliminating prejudices" (Fichten, Hines, & Amsel, 1985, p. 410). This study simply cast more light upon the deep-seated human attitudes that exist within society and suggested that the media, in all of its potential influence for hindering or helping the progression of the disabled person within society, can only work as an assistant alongside the existing influence base of an individual's

beliefs and expectations. Although media holds a grand potential for a large part of these social expectations, "the most effective means of changing attitudes toward people with disabilities is through frequent equal-status contact" (Fichten et al., 1985, p. 411). This Canadian media study demonstrated the social need of "frequent equal-status contact" with people with disability conditions, thus continuing the social progression and development of just such awareness programs throughout the country that promoted and encouraged educative awareness, exposure to, and contact with, disabled individuals.

Rhonda Amsel and C. S. Fichten studied the effects of actual contact on the thoughts about interaction with students who had a disability condition. The literature on this research study suggested that volunteer college students who had experienced previous contact with individuals of a disability condition were more at ease with their disabled peers than those who had no previous contact. This study further suggests that contact may alter the pattern of thoughts concerning interaction with people who have a disability condition (Amsel & Fichten, 1988).

It seems that human contact with the actual disability condition through contact with the actual person involved creates an awareness and exposure that forms a belief and expectation that makes it possible to transcend the persuasive social stigma of media-induced public attitudes

and prejudices. The literature suggests that the contact made needs to be complete and of enough length to receive accurate information.

Carl Augusta and Jane McGraw concluded from their study on the specific impairment of blindness that such a disability, and disability in general, can and needs to be "humanized" through extensive public education. This study suggests that "the public forms images of blind people on the basis of brief contacts" (Augusta & McGraw, 1990, p. 397). The images formed by the public concerning any disability condition are based on too brief a contact or no contact or exposure at all, only stories in the media magnified by personal beliefs and fears.

> This limited exposure may convey inaccurate information
> about blindness and visual impairment and any
> disability condition in general. This could be changed
> through educational efforts by consumer groups and
> service organizations, public service announcements,
> printed materials, local television and radio programs,
> school curricula on disabilities, and work with leaders
> in the community. (Augusta & McGraw, 1990, pp. 397-398)

The work of Carl Augusta and Jane McGraw in October of 1990 is a primary example of the extensive modification of affect and effort in the attempt to represent all people equally, stemming from the shift in attitudes and educated awareness after the 1984 publishing of the historically held public perceptions of disabled people and especially in relation to and associated with the congressional declaration of The Americans With Disabilities Act of July 1990. The avenue of education through different disability

awareness training programs for community service was, by October of 1990, wide open and becoming more fully acknowledged and socially possible. By this time, the shift in attitudes from helpless to able was an acting benefit to the progression of continual education, although the actual integration in public of what these attitudes represented was hardly ever socially practiced.

Training Programs in Awareness

One of the first actual training programs in disability awareness using a specific curriculum was designed for presentation to pre-school children by Carol Wells and Dale Baum in the summer of 1985. It was patterned after the 1983 research study by Mara Sapon-Shevin, which discovered the effectiveness of training children at an early age in human differences through age-related curricula, guides, and specific books (Sapon-Shevin, 1983). This new study presented ways to "integrate information about disabling conditions as story time, art, science, dramatic play, language and snack time" (Baum & Wells, 1985, p. 283). Baum and Wells acted on the idea that children at a very young age begin to form their social expectations about their surrounding world and the beliefs and actions that serve to maintain those socially prescribed notions of personal defense and subjective safety.

Joan Kilburn, in 1984, 1 year prior to the development of the pre-school disability curriculum, presented a study

on education and exceptional children that considered a very
similar community education program for young children,
developed in 1980 and sponsored by the Easter Seal Society
of Marin County, California. Kilburn noted that "this
Better Understanding Of Handicapped Children program helped
school children and adults become more aware of the needs
and capabilities of persons who have disabilities through a
variety of activities" (Kilburn, 1984).

Acting on this same theme, Betty Binkard, the founder
of the Count Me In (C.M.I.) Educational Program, a
successful handicap awareness program presented to the
different schools in that state by parents of disabled
children, indicates in the literature that such a program is
effective in the task of changing and building positive
attitudes toward people and especially children, because as
a child, "the formation of certain social images are not yet
complicated by adult perceptions of struggle, survival and
suspicions, the adult fears that often develop a sense of
social prejudice" (Binkard, 1989).

Binkard, Baum, Wells, and Kilburn all believed that
promoting disability awareness at an early age was
beneficial for the establishment of certain social
acceptance patterns that would later come into focus as the
children matured and became an active part of society's
functioning. The research literature presented by different
studies from Binkard, Baum, and Wells is in agreement with

earlier literature and established foundational frameworks for later studies that awareness of human differences, in specific, the disability condition, was most beneficial to young children only if the necessary exposure and contact was available and made possible in the educational and training programs.

Attitudes and Awareness Training

Joy Donaldson, in 1980, presented an early research finding of one of her studies on changing attitudes toward disabled people. She presented an analysis of research associated with methods of modification of affect and discovered the classic six procedures, all centered around the all-important availability of physical and emotional contact, later to be stressed in the rehabilitation and special education literature. Joy Donaldson suggested that the greatest modification of affect was a result of educational awareness, exposure, persuasive messages, analysis of personal prejudices; not inferring negative suggestions, rather understanding basic human nature and perceived personal protection, disability simulation, group discussions, and always an actual amount of proper contact (Donaldson, 1980).

With these six methods of modification of affect concerning the disability condition analyzed as effective through many research studies, beginning in 1980, the development of disability awareness training programs for

the public, coupled with the change of public attitudes toward disability in 1984, continued to progress in development and social perception of need.

Community Service and Disability Awareness

Lindsey Gething, Rosemary Leonard, and Kate O'Loughlin, in their 1986 study of disability, were pioneers in the concept of community awareness for the sake of community unity and community service, both for the impaired and by the impaired. "In disability there are definite social and emotional aspects of concern, certain family reactions of complicated array, attitudes of others and personal responses. These all require adjustments that can be made" (Gething, Leonard, & O'Loughlin, 1986).

In this study the community is viewed as a whole, with the role of family that both gives and receives. The individual with a disability condition needs to receive from the "family" emotional support and opportunity to serve as well as give to the "family" the wealth of humanness that each individual, regardless of his or her condition, possesses through applied service and acceptance. This study by Gething et al. was one of the forerunners of the dual acceptance necessity that is part of any disability. The healthy community must accept its members with disabilities in conjunction with the individuals with disability conditions accepting their communities and the people comprising them.

This integrative idea of community as it relates to
service and the human right to live freely and completely
alongside one another was dealt with by Harlan Hahn in 1988,
through a study addressing the disability condition and the
social politics of human differences. "The definition of
disability has shifted from a medical approach or an
economic approach to a new socio-political approach that
proposes a new conceptual framework for an appraisal of
attitudes toward persons with disabilities" (Hahn, 1988).
This attitude shift has widened the possible exposure to and
contact with the disability community, making available
again an educational platform for community awareness
through training programs, which resist the existence of the
disability community within a non-disabled community and
attempts to create, through awareness and integration, one
world community accepting of human diversity.

Using the concept of physical and emotional contact as
the vital ingredient in disability awareness education and
modification of affect for the public, Joanne Milner, in the
rehabilitation literature during the fall of 1988, presented
the Metro Toronto (Canada) School Board's Disability
Awareness Program as a combined effective effort of
exposure, awareness, and contact at the same time. "This
program was effective because people with disabilities
actually spoke to their fellow students about their
abilities and limitations, seeking direct questions from

their peers about their perceived unknown" (Milner, 1988, p. 6). The students in this Canadian school district were given full contact with a disability condition, both emotionally and physically. As a result, Milner notes in her review, "this awareness program was extremely successful in changing attitudes toward disability from negative to positive" (Milner, 1989, p. 8).

Cinnie Noble, in 1989, researched the Canadian Council for the Disabled and presented to the rehabilitation literature in the spring of that year a study on the Sensitivity-Awareness Training Program sponsored by this specific Council for all service-industry personnel. It was designed by this Canadian Council to teach personnel how to serve persons with sensory and ambulatory disabilities. The results of this study were similar to the results associated with school settings, in that children as well as working adults possess fears of the disability condition that present themselves as specific prejudices if awareness of the reality is not made available (Noble, 1989). Noble believes in the educational effort and the effective resulting process for all ages, in schools and industry.

"It is important to help make employers feel more comfortable about the possibility of hiring people with disabilities or making certain modifications to meet the needs of customers who are disabled" (Rebillot, 1980, p. 30). Kris Rebillot notes in his research of the Better

Understanding Program in Northern California that attitudes can be changed through proper awareness education and that these enhanced attitudes "can lead to service opportunities for the person with a disability as well as business opportunities for the company, which translated into benefits for the betterment of the community as a whole" (Rebillot, 1980, p. 32). It appeared, in the disability and rehabilitation literature, that by the fall of 1989 disability awareness training had formed a complete enough development through the process of attitude shift and perception change to offer a beginning public acceptance and a practical social necessity that could possibly unite in community awareness and service, pending an act of Congress.

The Development of a Working Definition of the Disability Condition

Defining Disability

"The word disability in society is often associated with fear of the unknown, inadequate experience, incorrect and distorted information and simply a lack of knowledge" (National Easter Seal Society, 1994). Disability happens as a result of a natural function of the human body that has been insulted in some real and explainable manner. Disability occurs in three different categories: physical disability, mental disability, and emotional disability. The emotional disability is associated with the mental disorder segment of this particular impairment, yet

independent and separate from mental retardation. "Mental disorder is a comprehensive term that describes forms of mental illness or emotional disorders" (National Easter Seal Society, 1994). Individuals may rest in one, two, or all three of the categories, depending upon the type of insult to the body that has occurred.

Disabling Life Occurrences and Disability Types

This insult that causes the impairment that leads to the disability can be a result of four different events or occurrences. The first is birth. The process of birth is a complex assembly of progressions and developments. Defects can happen at any stage during this lengthy process; defects that lead to impairments can later develop into disabilities of all combinations of the three categories.

> Assembling a human being from a single fertilized egg is a formidable task. Nature does not always do the job perfectly, and the result is that 2% to 3% of all babies born in the United States have a major malformation. Some defects, moreover, become apparent later in childhood, as they evolve. (Edelson, 1992, p. 13)

Birth can carry with it genetic defects and chromosome problems that can develop into disabilities. Lifestyle affects the birth development through its association with any incorrect exposure to medicines, chemicals, toxins, and radiation. The possibility of affecting the abilities of the next generation is great.

> Few people are sufficiently aware of the continuous rise in the incidence of congenital malformation or birth defects. Apparently this increased incidence is

associated with the increasing longevity of man and the increasing possibility of carrying on into the next generation the inherited defects of a previous generation. (Fishbein, 1963, p. 5)

The second event and/or occurrence that can lead to

disability is disease.

The concept of disease refers to objective phenomena. The human body is composed of cells, tissues and organs that must function adequately to ensure biological continuity. Disease denotes a state of unhealth, or a state in which the body is suffering from a malfunctioning of one or more parts. (Diamond & Jones, 1983, p. 3)

Disease can insult the human body at any time, any

place, and at any age, leaving an impairment that is

disabling in a physical way, a mental manner, or an

emotional trauma, and also any combination of the three

categories.

When individuals are diagnosed as having a chronic, disabling illness, they go through a process of adapting to a disease that can be fraught with unpredictability, remissions and exacerbations. Adaptation is a complex process varying from one illness to another and is influenced by both internal and external factors ranging across the biologic, psychologic, interpersonal and sociocultural spheres of life. (Miller, 1983, p. 218)

The third event or occurrence that can lead to

disability is an accident or injury. This occurrence can

happen to any person at any time and cause an insult to the

body that can leave that person impaired and disabled. The

accident and injury disability very commonly happens in the

home (Breckon, 1978). The industrial accident and the

environmental accident can and do cause personal injury and

open the door for public responsibility and involvement

(Gaskins, 1989). The most evident and usual accident that causes disability comes from the automobile (Fletcher, 1964). The accident/injury segment of that which causes disability is a wide and varied collection of events and occurrences that are constantly being corporately and privately monitored for more preventive education and practiced precautions.

The fourth event and occurrence that can disable is the process of aging.

> In the year 2020, the percentage of the population age 65 and over could reach 30 percent. In addition, health care needs of the elderly make the older person a major consumer of the various forms of health care. For example, elderly persons have twice as many hospital stays and the stays last twice as long. In addition, people over age 65 visit the doctor 43 percent more often that those under age 65. Also, the variety of health care settings currently available and needed are much greater for the elderly than for other segments of the population; for example, elderly people use hospitals, long-term care settings, rehabilitation facilities, out-patient clinics, respite centers, home care, hospices and day care centers. (Lewis, 1985, p. 2)

This is the time when the body structure and processes transform to a different rate and strength in regard to function and movement. An aging individual's heredity is vulnerable to any number of impairments at this time, impairments that can lead to disabling disease, and impairments that are disabling in themselves. "When illness is superimposed on normal age-related changes, the classic parallel lines of normal human biology and disease converge

in the elderly patient, causing the physician confusion and concern" (Eisdorfer, 1980, p. 140).

The aging process is a constant study and practice, and a human development that is extremely vulnerable to external forces. "Aging alters the response to disease. The aging process and the stress of previous diseases cause the body to respond to the same noxious stimulus in ever changing ways" (Steinberg, 1983, p. 42).

Aging is the process where a person continues to live his or her life in the throws of a decreasing (slightly) body function. This aspect of the cause of disability is always creating a presence through its natural effects on style of living.

"In answer to the question, In the last four weeks, did anything like sickness, or any old injury or any health problem bother you, half of all older people, (50 percent) named one or more illness" (Shanas, 1962, p. 7).

The disability condition, then, can be caused through four events or occurrences: birth, accident and/or injury, disease, and age. These four events and occurrences are categorized into three different areas of the living experience: physical disability, mental disability, and emotional disability. This study now examines each category separately.

The Disability Conditions

The National Easter Seal Society, based in Chicago, Illinois, has established a program of disability awareness entitled: The First Step Campaign. "This program sets out to change some of the misconceptions that get in the way of acceptance" (National Easter Seal Society, 1994).

In this national campaign, the Easter Seal Society has established 16 general categories within the three possible avenues (physical, mental, and emotional) allowing for the presence of a disability condition. These 16 categories are briefly defined in the glossary section of the campaign curriculum. In this section of the study, each of these 16 categories describing a different disability condition is examined in more extensive detail.

The disability condition is what causes the impairment to the individual person's functional ability. "People are not conditions" (National Easter Seal Society, 1994). An awareness of the different conditions that cause an individual to live with a disability might allow a separation of the actual person from the actual condition in the mind of society, which, if successful, would be an accomplished goal of this research study.

The following 16 conditions represent disability in general. Awareness of these conditions is the progression toward the separation of fear from perception, thus allowing for possible acceptance, both personally and socially.

1. "Amputation is the surgery resulting in a missing body part such as an arm, leg or hand" (National Easter Seal Society, 1994). "Industrial and road accidents are major causes of severe damage, but the necessity for amputation may also arise as the result of such diseases and conditions as gangrene, cancer, frostbite and hardening arteries" (Hale, 1979, p. 258).

2. "Blindness refers to total loss of vision. Not to be used when referring to partial vision which may also be correctly called partial sight or visual impairment" (National Easter Seal Society, 1994). "Blindness is the inability to perform any work for which eyesight is essential" (Hale, 1979, p. 258). Blindness may result from injury to the eye itself or from some abnormality or lesion in the brain or optic nerve. "Blindness is sometimes due to a systemic disorder such as diabetes. Other causes include cataracts, glaucoma, birth defects, detached retina, keratitis, iritis, ophthalmia and various forms of trachoma" (Hale, 1979, p. 258).

> Loss of vision, of any degree, is clearly a subjective, personal, internal experience calling potentially for major life changes. Loss of vision impinges on every facet of daily living affecting self-image, social relationships, status, practical "taken for granted" capabilities and skills, potentially undermining confidence and previously established self-perceptions and patterns of behavior, life-style, occupation, etc. (Conyers, 1992, p. 9)

> Cerebral palsy is the umbrella term for a group of disabling conditions resulting from central nervous system damage. It is inappropriate to assume that a person with cerebral palsy also has mental retardation;

the two disabilities do not necessarily or typically occur together. (National Easter Seal Society, 1994)

3. "Cerebral palsy is a group of medical conditions characterized by nerve and muscle dysfunction caused by damage to the brain which controls and coordinates muscular action" (Hale, 1979, p. 259). "According to the location of the damage, varying disabilities occur. The most common are spasticity, athetosis and flaccidity and sometimes difficulty with speech" (Hale, 1979, p. 259).

4. "Communicative disorder is another umbrella term for speech, hearing and learning disabilities" (National Easter Seal Society, 1994). Communicative disorders represent a very complex integration of many basic avenues of social stigmas demonstrated through social interruptions, perceptions, and judgments. These socially stigmatized frustrations are derived from personal difficulties with different aspects associated with speech, hearing, and learning, the three venues of social interaction.

> The degree to which a speaker has an accurate understanding of the quality of his speech product influences how the reactions of others are interpreted. Unless the person with the disability has an opportunity to learn that his speech is distorted or otherwise inaccurate, he assumes that the acoustic patterns he produces while speaking conform to the patterns of the mental model he employs when he encodes the message. (Hartbauer, 1978, p. 283).

5. "Deafness refers to total loss of hearing. Deafness is not the appropriate term to be used when referring to partial hearing loss, this would be hearing impairment" (National Easter Seal Society, 1994). "Deafness

is of either two types. In the conductive type, something
interferes with the passage of sound to the inner ear. In
perceptive deafness there is damage or defective development
of the inner ear" (Hale, 1979, p. 260). "The terms 'deaf-
mute' and 'deaf and dumb,' are inaccurate descriptions.
Most people who are deaf have nothing wrong with their vocal
cords. They cannot speak because they cannot hear" (Hale,
1979, p. 260).

> 6. Developmental disability is any mental and/or
> physical disability manifested before the age of 22
> that may continue indefinitely and result in
> substantial limitation in one, two, three or more of
> the following life activities: self-care, receptive
> and expressive language, learning, mobility, self-
> direction, independent living and economic sufficiency.
> (National Easter Seal Society, 1994)

This developmental disability definition is another
huge umbrella term that represents a defined interruption,
restriction, or inability in one's life activity.
Developmental disability, according to the National Easter
Seal Society, is manifested before a certain age, yet does
not exclude those individuals who develop similar physical
and/or mental disability symptoms later in their life
experience from this same category.

7. "Epilepsy is an umbrella term for various disorders
marked by disturbed electric rhythms of the central nervous
system and typically manifested by seizures--involuntary
muscular contractions" (National Easter Seal Society, 1994).
"Epilepsy is a nervous disorder due to a sudden unusual
release of energy in the brain. The severe form is known as

grand mal, and the less severe form is known as petit mal"
(Hale, 1979, p. 260).

8. "Hearing impairment is a term for a range of
hearing disabilities from slight to severe" (National
Eastern Seal Society, 1994). "Hearing loss is organic or
functional. An organic hearing loss has a physical basis,
whereas a functional hearing loss is psychological in
origin" (Berg, Blair, Viehweg, & Wilson-Vlotman, 1986, p.
4). "Organic hearing loss constitutes nearly all hearing
loss among children" (Newby, 1979, p. 62). The hearing
impairment itself results from a wide range of occurrences,
such as various genetic defects, varied mild to severe
diseases, a multiplicity of drugs, and different variations
of traumas (Berg et al., 1986). It is important to the
individual involved with the impairment that society in
general understand that hearing impairment and deafness are
completely different, although they are almost always
associated with speech difficulties. "One of the most
recognized but probably least understood concomitants of
deafness (and hearing impairment) is a deficit of oral
communication skills" (Sims, Walter, & Whitehead, 1982, p.
75).

This deficit of oral communication skills is a complex
biological result of the affected physiological process that
creates the hearing impairment itself. "The deaf and
hearing impaired individual's speech errors can be related

to abnormal respiratory, laryngeal, and articulatory activities. By virtue of this physiological complexity, accurate surface level descriptions of the deaf's speech errors are frequently precluded" (Sims et al., 1982, p. 75).

9. "Hemiplegia is full or partial paralysis of one side of the body, caused by brain damage due to disease, trauma or stroke" (National Easter Seal Society, 1994). This impairment usually occurs in older persons, but is possible at any age, and at any age this impairment is severely disabling. Oftentimes in the course of a person's physiological processes, the disease, trauma, and stroke are interrelated, where the disease causes the stroke, the trauma causes the hemiplegia, and the trauma again causes the disease, which leads again to the stroke.

> The treatment and rehabilitation of the adult patient with hemiplegia has become an important medical and social problem. The latest estimate is that there are approximately 100,000 severely handicapped patients with this condition living in this country, that cerebrovascular accident patients occupy daily 18,000 hospital beds, and that there are about 55,000 new patients every year. Physiotherapists spend 10% of their time working with adult stroke patients, and speech therapists up to 80% of their time. The main causes of the condition are haemorrhage, thrombosis and embolism, road accidents and tumors. (Bobath, 1989, p. 1)

This disability presents itself in many varied conditions that usually are associated with some degree and distribution of spasticity and sensory disturbance. The conditions of hemiplegia can be treated and the recovery can be spontaneous or through extensive therapy. This

disability and its presenting conditions are no respecter of age, race, or sex (Bobath, 1989).

> The increase in this impairment is largely due to the higher average age of the population, to the greater stress of life in our cities giving rise to a larger number of younger stroke patients and to the increase in the accident rate. (Bobath, 1989, p. 1)

10. "Learning disability is a disorder affecting the understanding or use of spoken and/or written language" (National Easter Seal Society, 1994). The term learning disability is again a grand umbrella term for many communicative disorders. The National Easter Seal Society, in the First Step Campaign, refers to this particular disability as that specific disorder that affects reading, speaking, and expressing in a written form what one has read or heard.

Learning disabilities are a continuing, dynamic discipline for constant study in education and society. It is, like so many, a very misunderstood and distorted disability. "Children and youth who are destined to become educational discards unless their learning disabilities are recognized and treated, are likely to be found in any classroom" (Lerner, 1993, p. 5).

Learning disabilities are so varied and complex that the federal government established a summary definition in the Federal Public Law 101-476, the Individuals With Disabilities Education Act (IDEA) (1990), which built upon an earlier version of this legislation, Public Law 94-142,

Education for All Handicapped Children Act (1975). This federal definition of the complexities of learning disabilities has become the federal-, state-, and county-accepted program definition (Lerner, 1993).

This federal definition of learning disabilities is established in two separate parts. The first part is definitional and the second part is operational. The definitional part was adopted from a 1968 report to Congress and the National Advisory Committee on the Handicapped. It is taken from the Public Law 101-476 as stated in the Individuals With Disabilities Education Act, 1968.

> The term, children with specific learning disabilities, means those children who have a disorder in one or more of the basic psychological processes involved in understanding, or is using language, spoken or written, which disorder may manifest itself in imperfect ability to listen, think, speak, read, write, spell or do mathematical calculations. Such disorders include such conditions as perceptual handicaps, brain injury, minimal brain dysfunction, dyslexia and developmental aphasia. Such a term does not include children who have learning, hearing, or motor handicaps, of mental retardation, of emotional disturbance, or of environmental, cultural, or economic disadvantage. (Lerner, 1993, p. 9)

The second part of the federal definition of learning disabilities is the operational segment. It first appeared in a separate set of regulations for children with learning disabilities that was established through the U.S. Office of Education in 1977.

The regulation states that a learning disability exists if the following characteristics are present:

(1) The student does not achieve at the proper age and
ability levels in one or more of several specific areas
when provided with appropriate learning experiences.
(2) The student has a severe discrepancy between
achievement and intellectual ability in one or more of
these seven areas: (a) oral expression, (b) listening
comprehension, (c) written expression, (d) basic
reading skills, (e) reading comprehension, (f)
mathematical calculation, and (g) mathematical
reasoning. (Lerner, 1993, p. 9)

The learning disabled child: (a) has academic
retardation, (b) has an uneven pattern of development,
(c) may or may not have central nervous system
dysfunctioning, (d) does not owe his learning problems
to environmental disadvantage, and (e) does not owe
learning problems to mental retardation or emotional
disturbance. (Hallahan & Kauffman, 1976, p. 20)

Learning disability is an extensive disorder that

affects so many individuals in so many different ways and in

different and varied forms and degrees. Learning disability

is an important disorder to be aware of and understand

socially as well as from a personal standpoint, for it is so

often mistaken for mental disorders and even retardation.

The learning disability presents a disorder that, when

distorted through unaware and uneducated assumption,

inappropriately leads to possible devastating personal

labeling that is completely untrue and unnecessary.

Mental illness and mental disorder is a loss of social
and/or vocational skills necessary to function
independently. Terms such as mentally deranged,
deviant and crazy are not appropriate. Mental disorder
is a more comprehensive term that describes any of the
recognized forms of mental illness or severe emotional
disorder. Terms such as neurotic, psychopathic and
schizophrenic are libelous labels. (National Easter
Seal Society, 1994)

The disorder associated with mental illness and mental difficulties is a very debated and misunderstood subject of constant practice and research.

> After nearly 90 years, the psychiatric concept of mental disorder as reaction remains nebulous, and its value in classification uncertain. Leaving aside the question of obscure terminology ("exogenous" meaning exopathic, "endogenous" for cryptogenic, "stress" instead of strain, etc.), ambiguity can be detected in four areas: (1) the concept of illness; (2) the concept of aetiology; (3) the basis of classification; (4) the strategy and methods of investigation. (Katschnig, 1986, p. 24)

11. Mental illness is then, through much constant debate, continuous research, and clinical practice, defined as the loss of necessary abilities to function in a socially acceptable, independent manner. Mental disorder is a wide, encompassing term used to cover any and all of the different aspects of mental illness and severe emotional problems. Each one is a vast, wide, umbrella term housing a myriad of different aspects of disorders associated with the mind and the mind's creation of felt and perceived emotions. Every person is a different creature and every disorder associated with the mind and emotion is a different and separate difficulty. Understanding this vast difference in presenting symptoms associated with mental illness and mental disorders is again the first step in becoming aware of the real life struggle that is personally and socially involved with this disability. Awareness of this disability also increases the community responsiveness toward the person involved, and socially desensitizes the stereotyped

fear, and possibly replaces it with a working understanding and awareness of this very real life occurrence (Katschnig, 1986).

"Mental retardation is the condition causing a person to have significantly below-average general intellectual functioning. Labels such as moron, mentally deficient/ defective and feebleminded are not acceptable" (National Easter Seal Society, 1994).

This condition is yet another disabling impairment that is complex and often misunderstood by society. It is becoming more studied, researched, and understood, yet it still holds a sense of confusion and assumed distortion.

> The concept of mental retardation is made more complex because the varying disciplines that deal with it hold widely divergent viewpoints. Definitions of mental retardation have changed over the years as behavioral science has grown, become more complex, and included attention to broader aspects of the environment. Parameters or bases of classification for mental retardation have differed a great deal over time and are often fluid and in some cases implicit, rather than explicit and well thought through. (Drew, Logan, & Hardman, 1988, p. 4)

12. "Paraplegia is the paralysis of the lower half of the body involving the partial or total loss of function of both legs" (National Easter Seal Society, 1994). This disability is extensively studied and researched. The therapy management of patients' spines and spinal cords is an ongoing, thorough, and complete area of research and study.

> Thousands of individuals fracture their spines every year and as a result remain totally or partially

> paralysed for the rest of their lives. In addition to
> these, there are victims of spinal cord injury or
> disease from many other causes. Forty years ago such
> people died from the resulting complications. Today a
> normal life expectancy can be anticipated, providing
> the correct treatment is given and the complications
> thus avoided. (Bromley, 1985, p. 3)

Paraplegia is a disability that results from severe

damage to certain areas of the spinal cord and associated

areas of the body. It is a specific impairment that results

in an exact and predictable manner. It is a complex

impairment due to the complexity of the area of the body

affected, yet a very clear and precise impairment when

speaking of effects upon mobility and life functioning.

"Paraplegia is partial or complete paralysis of both

lower limbs and all or part of the trunk as a result of

damage to the thoracic or lumbar spinal cord or to the

sacral roots" (Bromley, 1985, p. 3).

The facts of the personal cases of individuals admitted

to hospitals for paraplegia-related incidences are varied.

The percentages of those admitted are highest concerning

trauma.

> Of the cases admitted to spinal units, approximately
> 70% are traumatic, and approximately 50% of these
> involve the cervical spine. The majority of the
> traumatic cases, approximately 50%, are the result of
> road traffic accidents. Industrial accidents account
> for approximately 26%, sporting injuries, 10%, and
> accidents in the home approximately 10%. The non
> traumatic cases are mainly the result of transverse
> myelitis, tumors and vascular accidents. Spinal cord
> damage resulting from either injury or disease may
> produce quadriplegia or paraplegia. (Bromley, 1985, p.
> 3)

13. "Quadriplegia is the paralysis of the body involving partial or total loss of function in both arms and both legs" (National Easter Seal Society, 1994). Paul R. Cooper (1986) concludes the following:

> Few diseases or injuries have the potential for producing the devastating effects on survival and quality of life that cervical spinal cord trauma does. Despite the vast amount of research, there is currently no medical treatment that has been proven effective in ameliorating the effects of mechanical injury to the spinal cord. (cited in Berczeller & Bezkor, 1986, p. 8)

A spinal cord injury is clearly a major trauma, and the treatment of such trauma requires specific care strategies. This medical treatment should be immediate and complete, remembering that the emotional impact of such a trauma cannot be forgotten. Angelo R. Canedo's research (1986) parallels the dependance upon specific medical care with the psychological needs of eventual adjustment for the sake of maintaining life.

> As the aspects of acute medical care retreat into the background, the emotional reactions often become more pronounced and begin to assume more obvious importance to all parties concerned. Psychological reactions, frequently described as stages of adjustment, at times seem to parallel the process of medical care and can support the primary objective of preserving life. (cited in Berczeller & Bezkor, 1986, p. 11)

Spinal cord injuries are infrequent disabilities compared to other major disability conditions, yet they are severely debilitating and extremely costly (Berczeller & Bezkor, 1986). Awareness of the full extent of the medical and emotional (psychological) aspects of quadriplegia and

paraplegia allows proper understanding and undistorted views

of this condition.

> Nearly all quadriplegic patients have periods of
> depression before they can start to accept their
> disabilities. These may be manifest in many ways, such
> as apathy, aggression, overcheerfulness, or unrealism.
> Patients may not be able to apply themselves fully to
> rehabilitation until they have at least partially
> accepted their disabilities. (Ford & Duckworth, 1987,
> p. 1)

With an understanding and general awareness of the

quadriplegia condition and the social, personal, and

emotional extent of such a disability, a first step has been

taken toward clarifying the misconceptions and enhancing the

community involvement and acceptance.

14. "Spasticity is having sudden, abnormal involuntary

muscle spasms. Muscles are spastic, people are not"

(National Easter Seal Society, 1994). Bruce M. Gans and Mel

B. Glenn (1990) give the following definition:

> Spasticity is one of the most common features of the
> motor deficits associated with the upper motor neuron
> syndrome. It spans a variety of diagnoses and ages,
> and is one of the most common problems dealt with by
> physicians and therapists caring for patients with
> neurologic diseases. (cited in Glenn & Whyte, 1990, p.
> 1)

Some of the effects of the disability associated with

spasticity are explained by Gans and Glenn as weakness

through a lower muscle strength contraction, paralysis as an

inability to activate muscle activity voluntarily, and

fatigue as an inability to sustain a work performance level

of voluntary muscle contractile activity. Gans and Glenn

(1990) conclude with the effects of spasticity on basic

movements. They write of an incoordination as a decrease in the skilled sequential control of muscle activation resulting in lower fine motor accuracy and diminished reflex as an involuntary motor response of the body or limb segment to a physical agent (cited in Glenn & Whyte, 1990).

Spasticity is a disability that affects the useful work capacity of an individual. Gans and Glenn continue to describe the functional consequences of spasticity.

> A principal consequence of spasticity is diminished capacity of the patient to accomplish useful work with the motor system. This is usually thought of as an exaggerated array of spontaneous motor activity that distorts or precludes useful motor function. (cited in Glenn & Whyte, 1990, p. 5)

15. "Speech impairment is having a limited or difficult speech pattern or patterns" (National Easter Seal Society, 1994). Speech is a major part of any association with other people. Speech is the communicative, working tool of relating, feeling, sensing, and being a part of the world. According to Arthur Boothroyd, the word speech is used in many different ways, by different people, in many different situations. Boothroyd (1983) proposes a definition for speech to aid in establishing a basis for understanding complexities of the word when referring to certain clinical evaluations. He refers to speech as the flowing of designed sounds.

> Speech is a system of movements that generate patterns of sound. These movements, and the resulting sounds, represent linguistic structures that in turn represent conceptually organized thoughts. Speech is used for communication between human beings. The linguistic

structures fulfill their purpose when they permit a
listener to generate the same thoughts as exist in the
minds of the talker. The speech patterns fulfill their
purpose when they permit a listener to generate the
same linguistic structures as exist in the mind of the
talker. (cited in Hochberg, Levitt, & Osberger, 1983,
p. 182)

Verbal communication is complicated. Boothroyd

explains that the complexity of speech involves the

consideration of its acoustic aspects, its motor aspects,

its linguistic aspects all in coordination with the active

role of the listener in the communication process (cited in

Hochberg et al., 1983).

Speech impairments are existent through the great

complexity of speech and all the possible segments of the

communication process that could create vulnerable patterns

of structural disorders.

Carol Westby (1994) speaks about the importance that

communicative skills hold in mainstream cultures and the

disability that results from poor linguistic abilities and

communication skills. Westby states:

Mainstream culture places a high value on communication
skills. Adults encourage children to ask and answer
questions and tell stories. Once a child walks,
parents focus on a child's talking. If a mainstream
child is not talking by age 18 months or 2 years,
parents express concern. (cited in Tomblin, Morris, &
Spriestersbach, 1994, p. 32)

The disability that results from a speech impairment,

whether severe of mild, is always a noticeable and serious

barrier to social acceptance and self-identity. "Inability

to communicate, at a fundamental level, presents a vivid

picture, whenever it is encountered. But it has always been disability in speech, the primary index of language ability, which has attracted most attention since the earliest of times" (Crystal & Varley, 1993, p. 11).

This impairment is a disability that affects a person's relation to every aspect of human connection, self, family, and society. Awareness from concerned friends of the condition and its effects can possibly enhance the understanding and responsiveness offered.

These 16 conditions are by no means a complete list of possible impairments leading to disability. These 16 conditions are, according to the National Easter Seal Society, the commonly seen, most frequently encountered and, oftentimes most misunderstood and feared impairments and disorders leading to specific and separate disabilities. Awareness of these 16 conditions will hopefully begin a more accepting understanding of specific disabilities and differences in general. Once the impairment can be more readily understood as a condition resulting from a human biological function common to all humankind through birth, disease, accident, or age, the person with the disability can be more readily accepted for his or her similarity and less feared for his or her difference.

The problems that are born from lack of ability and restriction naturally then would encompass medical care and treatment, emotional care and support, and legal freedoms

(Hale, 1979). These very problems that confront a person with a disability establish the corresponding needs of that person in a series of equal, parallel issues. The needs echo the problems in the areas of social, behavioral, physical, and intellectual capabilities which differ from the normative (Ross, 1981).

Individuals with disabilities and differences, whatever the impairment and disorder, have medical problems and need medical treatment. Individuals with disabilities have emotional issues and need emotional support and encouragement. Individuals with disabilities, as Ted Kennedy, Jr., proclaimed in his 1989 article in Parade Magazine, entitled "They'll Astonish You," need the empowerment of opportunity. "We [people living with disabilities] face social barriers and need the freedom of opportunity to participate fully in society, to be regarded by others as an equal and have equal access to working hard and living independently" (cited in Hardman et al., 1990, p. 34).

The Development of Disability Awareness Through Social Aspects of Evaluation

Social Evaluation and Social Disintegration

The social atmosphere of the world surrounding the individual with a disability is constantly revolving around the disability condition. Personal interactions with other individuals, both with a disability and without, become

difficult and non-existent. Robert Marinelli and Arthur

Dell Orto (1984) speak on the interpersonal impact of

disability and agree that, in many instances, common

interactions between people with a disability and people

with a fully able body are not always constructive.

Personal tensions and attitudal barriers are potential

stressors in this situation. The individuals with the

disability are faced with a potential practice of social

skills they have never had the opportunity to learn and use

in public. Therefore, the interactions have a possible

negative result for both parties involved.

> These interactions may be described as strained or
> anxiety-provoking for both participants. In some
> cases, the persons who have disabilities are excluded
> socially from others. In other cases, they may be
> intruded upon through stares or questioned out of
> curiosity. (Marinelli & Dell Orto, 1984, p. 137)

The social sphere of the individual with the disability

condition seems to always be in a state of stress when

involved in any way with the social sphere of the individual

with the non-disability condition. Elaine Makas (1985)

reviews some empirical research that states the reality of

existence of stressful situations concerning interactions

with people of a disability condition. "Empirical research

suggests that both disabled people and nondisabled people

experience a great deal of stress when interacting with one

another" (cited in Nagler, 1990, p. 25).

One such empirical research study showed that these

stresses are at a very high level of interaction.

Studies by Kleck and his colleagues (Kleck, 1966, 1968; Kleck, Ono & Hastorf, 1966) demonstrated that nondisabled subjects report greater emotional distress, exhibit higher physiological arousal, show less motoric activity, display less variability in their verbal behavior, express opinions that are less representative of their previously reported beliefs, and terminate interactions sooner when interacting with a confederate who appears disabled than when interacting with a nondisabled confederate. (Nagler, 1990, p. 25)

Kelley, Hastorf, Jones, Thibaut, and Usdane (1960) and Goffman (1963) have suggested, as a result of their studies, that this tension that exists between the individuals with the disabilities and the individuals without the disabilities may be a result of neither person knowing what the other expects. Jones et al. (1984) recommended that clear communication between the two parties could reduce interaction strain.

Hastorf, Wildfogel, and Cassman (1979) and Belgrave and Mills (1981) have found that very simple acknowledgment of the disability by the person with the disability can reduce the nondisabled person's discomfort (Nagler, 1990).

An intensive study by Cook and Makas (1979), employing both participant observation and interviews over a two-month period, emphasized the importance of direct communication of expectations in the development of successful relationships between a disabled person and a non-disabled one. (Nagler, 1990, p. 25)

Another study performed by Comer and Piliavin (1972) found similar indications of discomfort among disabled individuals when interacting with nondisabled individuals, as opposed to individuals who appeared disabled (Nagler, 1990). This discomfort of interaction between the

individual with a disability and the individual of able body may be due to lack of communication skills on both sides of the discomfort. "Persons with disabilities sometimes lack the social skills necessary to communicate successfully with nondisabled people in the community, particularly about the stigmatizing effects of their disability; furthermore, they are not taught these skills" (Marinelli & Dell Orto, 1984, p. 137).

These studies have shown that the best approach to lessening the tension and stress in interpersonal relationships between the person with the disability and the person without the disability is to be honest and expressive of natural expectations and attempt to develop clear and direct communication, remembering that neither party can possibly know what the other party expects, and each needs to be told so they can know.

Disability and Non-Acceptance

The social problems and needs of individuals with different disabilities seem to rest in acceptance. Acceptance may be slow in coming, possibly in part due to presumed expectations and lack of direct communication and distorted information and knowledge (Nagler, 1990). Acceptance and non-acceptance and the integration into society's mind-set and social interactions with individuals with disabilities are major concerns of sociologists researching the disability condition. Ladieu-Leviton,

Adler, and Dembo (1948), in their research into adjustment

and social acceptance, examined possible reasons for non-

acceptance of the person with the disability by the person

without the disability.

> The injured and disabled feel that they cannot be
> expected to shift their attitudes concerning their
> physical limitations in order to narrow this margin,
> since they feel that they are the ones who really know
> the actual reality limitations in their own cases.
> They feel that it is the non-injured and non-disabled
> who have to reexamine their attitudes for possible
> misconceptions, biases, and mistaken beliefs in order
> to reduce the discrepancy. (cited in Marinelli & Dell
> Orto, 1984, p. 150)

The first reason for social non-acceptance of the

person with the disability by the person without the

disability, presented by Ladieu-Leviton et al. (1947), is

said to center around physical limitation. A far-reaching

misconception is a general tendency on the part of the non-

disabled to overestimate physical limitations imposed by a

disability or injury (cited in Marinelli & Dell Orto, 1984).

> Since the non-disabled cannot readily acquire
> information as to the variable capacities of the
> disabled person, they may indicate their willingness to
> have him participate, and leave to him the judgment of
> whether or not he will be able to do so. The non-
> disabled may feel that in the event that participation
> is impossible, it will seem inconsiderate to have even
> suggested it. The danger of hurting the feelings of
> the disabled, however, will be no greater than in other
> non-participation situations. At the same time the
> additional distress of apparent rejection will be
> avoided. (cited in Marinelli & Dell Orto, 1984, p. 151)

The second aspect of the reasons for non-acceptance

toward people with disabilities is the appearance of the

disability. "The discrepancy between the beliefs of the

non-disabled, and the facts as they exist, operates relative to the appearance of the disability just as it does relative to disability-imposed limitations" (cited in Marinelli & Dell Orto, 1984, p. 152).

Limiting the social interaction of the disabled by the non-disabled, because of the presumed expectations of aversion toward the appearance of the disability to society, stops the educative process of adaptation for the person with the disability and unnecessarily isolates them (cited in Marinelli & Dell Orto, 1984).

The third aspect of the reasons for non-acceptance of the disability condition by the non-disabled is believed by Ladieu-Leviton et al (1948) to center around personal evaluation. According to this study, the person with the disability tends to militate against their social acceptance.

> They believe that they [the disabled] are evaluated by the non-disabled not only in terms of the physical aspects of their disability, but in terms of presumed psychological concomitants as well. There appears to be a spread of evaluation from characteristics actually affected by the disability, to other characteristics not necessarily so affected. This "halo" phenomenon is considered as generally devaluative or negative. (cited in Marinelli & Dell Orto, 1984, p. 153)

Personal evaluation of the disability condition by the non-disabled, whether the occurrence of the impairment was from birth, disease, injury, or age, can be a devastating reality, when its effects are felt by the person with the disability through isolation and rejection. This isolation

and rejection is an evaluative product of non-acceptance, which in turn is a result of misinformation and distorted knowledge. With correct knowledge and awareness, people become people in relationship to other people, innocent of concerns about physical limitations, general appearance, and personal evaluations.

> When the disabled do not feel seclusive, or know that, aside from the disability, they are not "handicapped," it is the non-disabled person who must shift preconceived and erroneous attitudes. It is they who can best obviate the accusation of "wilful" non-acceptance. (Marinelli & Dell Orto, 1984, p. 153)

In the light of the non-acceptance potential toward the individuals with disabilities that rests in the non-disabled social climate of interaction, the idea of identity and presentation comes into focus. "In the usual scheme of things, we evaluate strangers by the identities which they present to us. Thus, individuals establish their identities by conveying a series of attributes which they believe legitimately convey their personalities and identity" (Nagler, 1990, p. 178).

Disability: The Social Effects and Responses

The individuals who present a visible disability to society have these positive attributes that have been developed and established through a personal belief system of acceptance. These positive attributes are present and presented, although usually overridden by the fact of the obvious, visible disability. The disability condition is

prone to having two effects on society at large. Disability

is persuasive and stigmatizing. Because of these two

effects, two associated actions are performed by society to

individuals with disabilities. These actions tend to be the

act of isolation and the act of ignoring both creators of

social stigmatization and perceived deviance (Nagler, 1990,

pp. 178-182).

> Because of visibly handicapped do not comprise a
> distinct minority group or subculture, the imputation
> of generalized deviance that they elicit from many
> normals are more nearly genuine interactional emergents
> that conventionalized sequelae to intergroup
> stereotyping as for example, might obtain between a
> Negro and a white. It is appropriate to consider the
> general nature of the threat posed to the interactional
> situation per se as a result of the disabled being
> perceived routinely as different or odd, estranged from
> the common run of humanity; in short, other than
> normal. (Davis, 1961, p. 122)

Disability and Social Deviance

The perspective of the disability condition as deviant,

or as different and socially set apart in a negative way,

seems to be as old as human nature itself. A window into

this continuous perspective from this past half-century can

be traced to certain aspects of a labeling theory proposed

by E. M. Lemert in 1951.

According to the definition in Lemert's theory, "the

Negro, the career woman, the criminal, the Communist, the

physically handicapped, the mentally-ill, the homosexual, to

mention but a few, are all deviants, albeit in different

ways and with markedly different consequences for their life careers" (Lemert, 1951, p. 121).

E. J. Thomas (1966) also proposed a deviant social role for those individuals in society who have a disability. Thomas viewed disability as requiring "resocialization into a deviant social category" (Thomas, 1966, p. 7). J. Lorber (1975) also associated the disability condition with a social deviance. Lorber indicates that "some familiar kinds of deviance are socially defined as accidental or illness, foreignness, crippling or inherited defects" (Lorber, 1975, p. 278). W. R. Gove (1976) summarized the social deviance association and its position in the labeling theory as the social system oppressing the underdog through developed procedures for people with disabilities that create and stabilize social deviant behavior.

"The disabled are typically stigmatized, and their stigma often appears to act as a master status which determines the nature of their interaction with others" (Gove, 1976, p. 60).

The labeling theory approach to the analysis and examination of deviant behavior and the behavior that society perceives as deviant has been widely used. This labeling theory argues that much of what is seen and perceived as deviant is a result of society's reaction to labeled deviance (Nagler, 1990).

"When individuals are labeled deviant, for whatever reason, the societal reaction to this label reinforces the image of oneself as being odd, different or deviant. At this point, one's deviance may become stabilized" (Nagler, 1990, p. 180).

R. P. Lowry (1973) reacts to the labeling theory by presenting the practical aspects of its effects on the target population. "If someone is continually treated as inferior, dangerous, and deviant, the chances are great that he will come to see himself in this way and act accordingly" (Lowry, 1973, p. 118).

Society plays a very large part in the rehabilitation process of persons with disabilities as they attempt to integrate into a workable, social lifestyle and live a workable, fulfilling life, alongside their non-disabled peers (DeLoach & Greer, 1981).

S. A. Richardson (1969) presents the essential value of the family and its extended parts as the nuclear society which is invaluable to the personal support and encouragement of the person with a disability. If the family is capable of showing positive support in the face of society's negative evaluations, the reactions of other people may become inconsequential. The family needs to be supportive amidst negative evaluations. These negative evaluations are real (Richardson, 1969).

It is unlikely that the child born with a handicap will have parents, neighbors, sibs and peers who have the

same handicap and from whom he can gain experience in
dealing with others. Generally, he will be surrounded
by non-handicapped people who share the general
negative values of the culture toward the handicap.
(Richardson, 1969, p. 1059)

The family may be motivated to provide support and

encouragement to the member with a disability, yet they may

be lacking, as a unit and in person, the proper family

skills, personal insight, and proper, undistorted

information that is required and necessary to do so

therapeutically (Nagler, 1990; Richardson, 1969). The

negative evaluations are present and forthcoming. The

social stigma is real. The person with a disability is

personally alone in a way that society seldom perceives

(DeLoach & Greer, 1981; Nagler, 1990; Vash, 1981).

Sociological research pertaining to disabling
conditions in our society has most often focused on
nondisabled rather than disabled persons. Most
typically, these studies have involved the
investigation of public reactions to persons with
varying types of disabilities. This research generally
shows that physical disability is a non-accepted and
ignored state. (Nagler, 1990, p. 186)

Underlying the motive and design of sociological

research concerning the disability condition and the self-

concept, academic, occupational performance, and

interpersonal relationships of the individuals with

disabilities, rests the general assumption that efforts

directed toward integrating people with disabilities into

the mainstream of society would be benefitted from an

understanding of those socially induced conditions that aid

or hinder the person with a disability in the adjustment

process of meeting the social demands of performance in a non-disabled world (Nagler, 1990).

The Development of Disability Awareness and the Origin of Social Attitudes

"It has been discovered by social scientists that many groups are not treated in terms of what they are, but in terms of their social images" (Nagler, 1990, p. 137). Historically and in tradition, individuals with disabilities have been separated, alienated, and isolated from the society-at-large through institutionalization, shunning, and ignorance. Persons with disabilities have been purposefully forgotten. "Their humanity, identity and abilities have been overlooked and ignored in light of their differences" (Nagler, 1990, p. 137).

Persons with disabilities are often viewed as sickly and inept. The most common image of a person with a disability is usually associated with charity and dependence (Ruffner, 1984). Society views disability as an illness that carries great negative social weight. "A stigmatizing illness, be it mental illness, leprosy, cancer, epilepsy and or stomage status, tends to be an individualizing and privatizing experience" (Morrison & Ursprung, 1987, p. 2). There is no illness subculture and, as a result, the persons who are experiencing an illness that presents itself in social stigma can often feel isolated and alienated from

themselves as well as from society. Illness conveys

negative public images (Nagler, 1990).

Conceptualizing the Disability Condition
Through Stereotyped Images

Attitudes toward the disability condition are

influenced by mass media, most specifically movies,

television, and newspapers. This influence is usually

negative and distorted through limited exposure and unaware

assumptions (Bogdan, Biklen, Shapiro, & Spelkoman, 1982).

The horror film, first appearing at the turn of the

century, is an example of media's vast negative influence

toward the disability condition. "MGM's 1932 film 'Freaks'

capitalized on the horror film/freak show link in order to

promote the fear of deformity" (Bogdan et al., 1982, p. 3).

> From the first horror films to modern-day renderings,
> physical and mental disabilities have been shown to
> connote murder, violence and danger. Whether from the
> effect of a full moon or a secret potion, an attractive
> actor changes before our eyes, from a harmless, good
> citizen, to a killer monster. (Bogdan et al., 1982, p.
> 3)

The disability condition has a history of being

represented in the movies, a very influential segment of

society's media education, as negative, dangerous, evil, and

frightening.

This negative portrayal of the disability condition

seen in the horror, gangster, and adventure films of this

century has made its way into the television, comic, and

newspaper media as well. John Townsend, an anthropologist

who has studied images of the mentally ill on television, discovered that "one-quarter of all shows depicting mentally-ill people, cast them as violent" (cited in Bogdan et al., 1982, p. 4).

The comic strip produces a view of deformity and disability as glaringly evil and sinister. In this dangerous portrayal of disability comes the opposing force of the super hero as serenely perfect and incapable of any human mistake. Together, these two forces, the evil disabled and the super-perfect hero, do daily battle, with the disabled villain always being destroyed and the dangerous evil being extinguished. This contrasting scenario creates attitudes associated with heroes versus villains, disabled, bad people versus super-abled, good people, and casts a continuous shadow of fear, danger, and evil upon the representation of the people with disabilities (Bogdan et al., 1982).

The media is a powerful source of suggestion and influence in the present advancements associated with social expectations and demands.

> Television, radio, newspapers, books and magazines are part of most people's daily experience. Few would question the power exerted by the media over their lives as a continuing source of information, entertainment and education and as a molder of public opinion. (Hale, 1979, p. 46)

For the most part, individuals with disabilities are portrayed as sickly or sick, for disability is associated with being a medical issue. People with disabilities are

then represented as dependent on society, for sick people are in need of expert help and care; or the persons with disabilities are viewed as special overachievers who accomplish great feats of personal conquests. The media cast a definite persuasive influence upon society concerning oftentimes distorted awareness, associated with the disability condition (Ruffner, 1984).

A few sociological authors and researchers suggest a common psychological concept concerning the persons with disabilities. The suggestion is that people with disabilities remind the able-bodied and healthy of death, animal ancestry, or their own imperfections.

> Such purely psychological explanations, which deny cultural and political contexts, serve no purpose other than to reify further prejudicial associations of disability with evil and fear. The association of monsters and disabilities is a social creation. (Bogdan et al., 1982, p. 4)

The Disability Condition: Aversive Behavior and Children

Researchers who deal with the sociological issues of the disability condition have consistently documented the existence of negative attitudes toward people with disabilities and have also claimed that these attitudes have developed during childhood (Ryan, 1981; Weinberg, 1978; Wilkins & Velicer, 1980). K. Ryan (1981) suggested that there is enough hard, consistent research to carefully assume that an age-related acceptance sequence exists in

association with people with physical disabilities and disabilities in general.

> Small children may be particularly rejecting (of people with disabilities) because of their subjective, role-taking ability. Very young children (4 to 6 years of age) are generally egocentric; they cannot determine another individual's internal state. They may reject people with disabilities because they do not understand their subjective perspectives, and may assume that their own aversive reactions are shared by others and caused by the person with the disability. Also, for very young children, physical attractiveness has been found to be a large component of social judgment. (Ryan, 1981, p. 244)

This reaction might explain some children's aversive behavior toward individuals who have an obvious disability. Young children may assume that a negative physical trait, which might induce an uncomfortable, negative state within themselves, means that a person is a bad person (Morrison & Ursprung, 1987).

The Disability Condition: A Social Acceptance Pattern

M. O'Moore (1980) studied the different social acceptance patterns of non-disabled children to disabled children in a school setting. The discovery was that there may be inappropriate times for social integration. O'Moore found in her study that young children in the 9 to 11 age group were not as socially accepting of children with disabilities as they were with other children of a non-disabled control group (O'Moore, 1980).

The studies of O'Moore also showed that the sex of the subject was an influencing factor in the children's

acceptance of the disability condition. "Boys, whether
disabled or not, achieved greater social acceptance with
their peers than did girls" (O'Moore, 1980, p. 321). Even
with this acceptance, the age group of children from 9 to 11
showed fewer relationships established among disabled
children when in comparison with non-disabled children of
the same age group, social status, and belief systems
(O'Moore, 1980). "This suggests that a disability can be a
powerful component in determining children's preferences.
It may cover up a child's better known pattern of social
acceptability" (O'Moore, 1980, p. 325).

In a group of disabled and non-disabled young children,
"students evaluated themselves most favorably, non-disabled
children as a group less favorably, and disabled children as
a group least favorably" (Parish, Baker, Arheart, &
Adamchak, 1980, p. 251). This same evaluation occurred in
both the children with disabilities as well as in the
children without visible disabilities. In this study, the
authors also noted that the self-evaluation or rating of
young, non-disabled males was consistently at a higher level
than the ratings of disabled children by both the disabled
and non-disabled young females. "The non-disabled females
rated both self and non-disabled children significantly
higher than non-disabled males rated disabled children"
(Parish et al., 1980, p. 250). Both the children with
disabilities and non-disabled children perceived themselves

in a positive light. "Disabled children though, tended to evaluate other disabled children quite negatively" (Parish et al., 1980, p. 252).

> Since this data was collected from mainstreamed classrooms, it may be that mainstreaming has a negative stigma associated with it for both disabled and non-disabled children. It may be that mainstreaming, in its present form, may enhance the social-emotional difficulties encountered by disabled children. (Parish et al., 1980, p. 253)

J. Wilkins and W. Velicer (1980) performed a study on the attitudes of children toward various stigmatized social groups. The basic hypothesis of this research rested in the assumption that negative attitudes and feelings for these social groups are learned in early childhood. Four semantic, differential scales were employed in this study to assess children's basic attitudes toward four different social groups. These groups included non-disabled individuals, physically disabled individuals, people with mental retardation, and mentally ill individuals. This research employed a sample and population of males and females in the third and sixth grades.

> People with mental illness were rated most negatively on the evaluation and understandability scales. Both the retarded and the physically disabled were rated less positively than the non-disabled on the evaluation scale, but not as negatively as the mentally ill. (Wilkins & Velicer, 1980, p. 365)

The results from this research study concur with the results of a similar study performed by S. Wisely and D. Morgan (1981). In this research study, individuals who were either mentally retarded or physically disabled were

evaluated and rated by a mature audience as less active and less potent than those individuals who were either non-disabled and/or mentally ill (Wisely & Morgan, 1981). There was no measurable difference found in held attitudes of the third- and sixth-grade students toward the other three stigmatized groups (Wilkins & Velicer, 1980). "This information shows that attitudes toward mentally-ill individuals are distinct from attitudes toward non-disabled people, and also distinct from the attitudes toward the other disability groups in the study" (Wilkins & Velicer, 1980, p. 370).

Wilkins and Velicer (1980) claim, as a result of their research study, that children's attitudes differ from the attitudes of adults. They make this claim on the basis that individuals with mental illness were not viewed by the child population in their study as less active or less potent than normal people (Wilkins & Velicer, 1980).

N. Weinberg (1978) performed another disability research study involving young children, this time between the ages of 3 and 5. Weinberg desired to determine whether young children understood the factual meaning of physical impairment and whether their studied attitudes differed between children of disabilities and able-bodied children. The study included two separate experiments in which the children in the study responded to certain questions associated with pictures. "The data from the two studies

indicated that a shift does occur between ages three and four, from a lack of knowledge to an understanding about disability, when depicted as an orthopedic impairment" (Weinberg, 1978, p. 49).

This study also showed that when a child is forced to make a choice between a child with a disability and a child without a disability as a playmate, the 4- and 5-year-olds preferred a non-disabled child. These discriminatory attitudes tended to follow the developmental understanding of disability as a condition. "Older children who knew about the impairment were less likely to play with the child with the disability, than the younger children who lacked a working knowledge of disability" (Weinberg, 1978, p. 55).

In the research study performed by M. Horne (1982), many different previous studies on attitudes and learning disabilities were reviewed and studied. Horne discovered through the review of past research that social peers in an academic setting exhibited more general acceptance toward their normal-achieving fellow students. Horne also found that these same students

> assigned rejectee status to those who had a speech impairment, and amputation and physical disability, or who were low achievers, retarded and disturbed. This sequence of acceptance was also found among teachers and that, perhaps, students actually learned their biases from their instructors. (Horne, 1982, p. 81)

Horne, then, needless to say, believes that any developed modification-of-affect project should involve not

only the students but be directed toward each of the acting teachers as well (Horne, 1982).

From the research performed upon young children in the school setting, it would appear that the working attitudes of these young people toward individuals with disabilities are quite flexible and impressionable (Morrison & Ursprung, 1987). "Perhaps programs designed to improve attitudes toward people with disabilities will have the most impact when directed toward children who are just beginning to form their perceptions of the disabled" (Morrison & Ursprung, 1987, p. 4).

The research on the origin of negative attitudes toward persons with disabilities presents a definite need for educational programs directed toward young children.

> There is considerable evidence suggesting that such an undertaking would be beneficial. Classroom teachers, counselors, and other people working to implement such projects know these endeavors must be based on the assumption that the dissemination of accurate information about disabilities will lead to increased positive attitudes and reduction of social rejection, stigmatization and prejudice. (Nagler, 1990, p. 163)

The Development of a Social Responsiveness Toward the Disability Condition

The Disability Condition and the Actions of Realistic Acceptance

Fear of the unknown. Inadequate experience. Incorrect or distorted information. Lack of knowledge. These shape some of the attitudal barriers that people with disabilities face as they try to gain access and acceptance in their communities. People in society can exert a powerful influence over the way people with disabilities are perceived. It is important to the more than 43 million Americans with disabilities that

they be portrayed realistically and accurately. (National Easter Seal Society, 1994)

Society can be an important part of the realistic and accurate portrayal of people with disabilities if people are aware of the lifestyle aspects of disabilities and responsive to the known needs and adjustments that are associated with this condition. "I believe most people are well-meaning. They simply lack the good information they need to be able to deal realistically with physical impairments" (Maloff & Wood, 1988, p. ix).

Responsiveness toward the disability condition and realistic acceptance of the individuals in this condition must first come through a change of attitude, where the attitudal barriers are lowered if not removed through awareness, exposure, personal analysis, and personal contact (Nagler, 1990).

Young children are a very important target population for disability awareness training, for in young childhood events have a lasting impact. Positive experiences and events, introduced at an early age, should be effective in overcoming and preventing further association to negative stereotypes dealing with disabilities (Morrison & Ursprung, 1987).

The Disability Condition: Attitude-Enhancing Experiences

J. Donaldson (1980) suggested six different ways and methods of positively enhancing the experience of disability

into the lives of young children, therefore creating a

fearless and an aware responsiveness to the disability

condition. Donaldson (1980) categorized these methods of

disability enhancement as follows: "direct or indirect

contact with, or exposure to, disabled persons; information

about disabilities; persuasive messages; analysis of the

dynamics of prejudice; disability simulation and group

discussions" (Donaldson, 1980, p. 506).

The first suggested method presented by Donaldson

(1980) of direct contact with and exposure to persons with

disabilities is the primary objective of the study and text

of K. Ross (1981). Ross presents the following rebuttal

toward traditional isolation of persons with disabilities.

> Among the pressures helping to bring about today's
> changes in the education of handicapped people have
> been the discoveries that they do a better job of
> achieving, both academically and socially when their
> isolation ends, and that a regular school setting helps
> them to adjust and cope with the real world. (Ross,
> 1981, p. 2)

Putting an end to the isolation and exposing children

and adults who have disabilities to other persons without

disabilities in a school setting and a work setting can

serve as a positive attitude-enhancing experience for the

non-disabled as well as an isolation-ending, socially

accepting experience for the person with the disability.

> As the handicapped are integrated, now and in the
> future, exposure to their particular needs will help
> normal children understand the similarities and
> differences among people. This exposure will also help
> diminish the stereotyping of the handicapped, which is
> most likely to happen if normal children are sensitized

to these needs beginning in the early years. (Ross, 1981, p. 2)

The second method of attitude enhancement--information about disabilities--presented by Donaldson (1980) is the whole key purpose behind the National Easter Seal Society, First Step Campaign. This campaign "sets out to change, through information, some of the misconceptions that get in the way of employment, community mobility, and personal acceptance from society" (National Easter Seal Society, 1994). Information about the reality of disability is the first step in the attitudal modification and then resulting responsiveness.

The third method of Donaldson's (1980) persuasive message can be illustrated by the portrayal of complete and in-depth development and growth of persons with disabilities, through the same stages of life as non-disabled persons. The persuasion comes from the association of the person with the disability to the real-life reality of a person without a disability. The stages of development are experienced by both the disabled and the non-disabled. The stages of individual autonomy, intimacy, early parenthood, middle parenting, late parenting, and aging are the phases of adulthood and human life shared by human beings, with disabilities or without disabilities (Rule, 1984, pp. 105-114).

The fourth, fifth and sixth methods of attitude modification by Donaldson (1980) were prejudice analysis,

disability simulation, and group discussions. These three
are of a personal note and require an in-depth examination
of one's assumed perceptions of the disability condition
compared honestly to the reality of the disability
condition. These last three methods also require the
following of "a model which incorporates the ideas that
attitude modification be perceived as a result of either the
reduction in restraining forces or an increase in driving
forces surrounding an opinion or a behavior" (Donaldson,
1980, p. 510).

Responsiveness toward the disability condition, then,
is a major result of personally held attitudes toward the
disability condition (Vash, 1981). Attitudes form the
extent and availability of responsiveness.

L. M. Voeltz (1982) performed a research study
pertaining to the primary method of a young child's affect
modification suggested by Donaldson in 1980. Voeltz (1982)
examined the different effects of structured interactions of
non-disabled children with their disabled fellow student
peers in the attempt to discover how to better socially
respond to the needs of the disability condition.

The research study involved students in grades 4, 5,
and 6. The study lasted for two academic semesters. The
study program consisted of a series of orientation
activities and exercises. These activities and exercises
were conducted at the recess period and at other social

events. The goal of these exercises was to develop a peer relationship that resembled a friendship relationship over and above a helping-obligatory relationship.

The non-disabled students, in addition to the request of interacting, were asked to write essays and draw pictures of their experiences. An attitude survey was administered to measure the effects of the program (Voeltz, 1982).

> Results over the two semesters revealed significantly higher acceptance of individual differences on various attitudal dimensions by children in the experimental group. The highest acceptance was with the individuals in the high-contact level group, followed by the low-contact level group and finally by the no-contact group, which was associated with the lowest responses in relationship to acceptance. (Voeltz, 1982, p. 385)

This study also presented data that represented consistent sex differences in acceptance of persons with disabilities. Girls in the study were significantly more accepting than the boys in the study. "These results provide support for the use of structured social interactions for promoting acceptance of disabled individuals by their non-disabled peers" (Voeltz, 1982, p. 390).

This structured, social interaction promotes acceptance and positive attitudes that fuel an appropriate responsiveness toward the disability condition. This appropriate responsiveness is the acceptance that a person with a disability longs for, deserves, and personally needs (Vash, 1981).

The Disability Condition:
Myth Rebuttal

The practice of isolating persons with disabilities by grouping them together has incorrectly spawned the social myth of people with disabilities are more comfortable only with other people with disabilities.

> Years of grouping people together with disabilities in separate schools and institutions has reinforced this misconception. Today, more and more people are taking advantage of new opportunities to join the mainstream of our society. (National Easter Seal Society, 1994, myth #6)

This myth can be laid to rest by community awareness of the need for individuals with disabilities to integrate into and be an active part of everyday, non-disabled life, interacting with people with disabilities and people without disabilities alike (Rule, 1984).

The social myth exists that people without a disability are morally obligated to care for their fellow citizens who have disabilities. This social myth is presented by the National Easter Seal Society as a major reason for negative attitudes toward this segment of the population. Society feels unnecessarily burdened with this perceived assumption of forced responsibility (Maloff & Wood, 1988). The unfortunate aspect of this social fact is that it rests upon a false assumption. "People may offer assistance to whom ever they choose, but most people with disabilities prefer to be responsible for themselves" (National Easter Seal Society, 1994), myth #7).

The learning of and maintenance of personal independence are vital aspects of the rehabilitation process for any individual with a disability. Independence of a personal nature is the first realization of loss associated with an acquired disability. Self-responsibility and personal independence are the two primary goals of rehabilitation behind personal acceptance, which is an on-going process and a working social integration (Caplan, 1987; DeLoach & Greer, 1981; Hirschberg, Lewis, & Thomas, 1964).

Much fear and anxiety in the social eye concerning the disability condition stems from an uneducated expectation of the great difference that makes up the world of the disabled person. The misconceived assumption is that the lives of people with disabilities are totally different from the lives of the non-disabled people (National Easter Seal Society, 1994, myth #9).

The fact is that "people with disabilities go to school, get married, work, have families, do laundry, grocery shop, laugh, cry, pay taxes, get angry, have prejudices, vote, plan, and dream like everyone else" (National Easter Seal Society, 1994). The lives of persons with disabilities are similar to the lives of the persons without disabilities. This realization can begin to calm the fears of society concerning such an unreachable difference, and thus create a responsiveness through

awareness, rather than an isolation through uneducated assumptions (Maloff & Wood, 1988).

The most harmful myth that society assumes as a group concerning the disability condition and the individuals in this condition is one that belittles the person with the disability, as well as creates a sense of personal defense within the non-disabled person's mind-set. This is the assumption that all people with disabilities always need help (National Easter Seal Society, 1994, myth #12).

"Many people with disabilities are quite independent and capable of giving help. But if you want to give help to someone with a disability, ask first if they need it" (National Easter Seal Society, 1994). The giving of help or the lending of aid to a person with a disability is sometimes a socially misconceived conceptual act of threatening that person's independence.

> How much help a person chooses to accept is a matter of
> personal preference. Some disabled people enjoy
> assistance any time it makes things go more smoothly or
> more quickly. Others prefer to receive help only when
> it is truly necessary. Offering help is never the
> wrong thing to do. It can always be declined if not
> wanted. (Maloff & Wood, 1988, p. 7)

The appropriate, social responsiveness of a non-disabled person towards a person with a disability is a vital link to the disabled person's personal acceptance of and adjustment to his/her own disabled condition (DeLoach & Greer, 1981; Maloff & Wood, 1988; Rule, 1984). This social

responsiveness then is simply a matter of educated awareness and good practice.

Personal and Social Awareness and the Friendship Skills Used When Interacting With a Disability Condition: Disabled vs. Handicapped

When speaking to a person with a disability, or about a person with a certain disability, use the word disability, not the word handicapped. "A disabling condition may or may not be handicapping. Someone who uses a wheelchair has a physical disability. This person is handicapped when faced with a set of stairs where there is no ramp alongside" (National Easter Seal Society, 1994).

When speaking to a person with a disability, or about a person with a disability, always attempt to emphasize the person, innocent of the disabling condition. When the person is valued for him/herself, a personal success is experienced and the effects of the disability are transcended to a point of social integration and personal fulfillment (Vash, 1981). This personal fulfillment is the driving force behind the adjustment process (DeLoach & Greer, 1981). "The disability experience can be a powerful stimulant to developing a coherent philosophy of life that imparts meaning to a source of considerable pain" (Vash, 1981, p. 193). Responsiveness to the disability condition first and foremost means to be attentive to the person

involved through an educated awareness of the disability
condition.

A major aspect of appropriate responsiveness toward
persons with disabilities is the conscious absence of
labeling. "Because people are not conditions, don't label
individuals as the disabled, the epileptics, the post-polios
or with other names of conditions. Refer instead to people
with cerebral palsy or someone who has epilepsy" (National
Easter Seal Society, 1994).

When speaking to or about a person with a certain
disability, omit entirely, if possible, any mention about
the disability condition, the effects of the condition or
the origin of the disability, if it is not a vital and
important part of the necessary flow of the conversation.
In so doing, this conscious act of personal attentiveness
toward the person as an individual, the disability and its
effects have permission to dissolve to the background of the
living experience, making room for more important issues
such as loving, knowing, learning and experiencing (Caplan,
1987; Maloff & Wood, 1988; Vash, 1981).

Personal etiquette and its practice toward the person
with a disability are part of the integration process for
the non-disabled as well as part of the acceptance and
adjustment process for the person with the disability (Rule,
1984). Awareness of the considerations of personal and
social etiquette associated with the disability condition is

the beginning of the end of fear of the unknown, inadequate experience, incorrect or distorted information, and lack of knowledge, those barriers that create the negative attitudes that distill distorted and assumed perceptions (National Easter Seal Society, 1994).

The Disability Condition and a Social Etiquette

The first practice of appropriate etiquette toward a person with a disability is to always shake hands when introduced. "People with limited hand use or who wear an artificial limb do shake hands" (National Easter Seal Society, 1994).

The second practice of appropriate etiquette is to treat adults as adults. "Address people who have disabilities by their first names only when calling everyone present by his or her first name" (National Easter Seal Society, 1994).

The third practice of appropriate etiquette is to speak directly to the person with the disability. "When speaking to a person with a disability, speak directly to that person, rather than through a companion who may be along" (National Easter Seal Society, 1994).

The fourth practice of appropriate etiquette toward a person with a disability is to speak naturally and freely, unembarrassed about using common, everyday speech such as: see you soon, got to be running, or walk this way. People who are unsighted, orthopedically impaired, and

communicatively impaired use these same common terms to mean

the same thing (National Easter Seal Society, 1994).

> Do not be overly sensitive regarding the
> inappropriateness of every day expressions. When
> interacting with persons of disability, many persons
> feel they are committing a faux pas if they slip and
> use such expressions as: see what I mean, with someone
> who may be blind. (DeLoach & Greer, 1981, p. 56)

The fifth major practice of appropriate etiquette

toward the disability condition is the art of lending

assistance. "If you offer to help a person with a

disability, wait until the offer is accepted, then carefully

listen for specific, personal instructions" (National Easter

Seal Society, 1994). Lending aid is a very personal and

sensitive act one person can share with another. "Even with

no special skills, you can be helpful, simply by virtue of

being available when the need arises. The need for

assistance frequently occurs" (Maloff & Wood, 1988, p. 119).

A very common reason for any reluctance on the part of

the non-disabled person to offer assistance to the person

with a disability stems from a fear of making the situation

worse, or as Maloff and Wood suggest, "bungling the job."

This fear comes from past experiences and poses a

possibility that is not unrealistic.

> It is definitely possible for a well-meaning helper to
> do more harm than good. But a positive outcome can be
> almost assured if certain procedures are followed. The
> first aspect of the procedure is to ask whether help is
> wanted before beginning to assist. Even if you feel
> certain that your assistance would be welcome, do not
> begin helping without his o.k. The second aspect of
> this procedure is to be prepared to take no for an
> answer. The third and final aspect is to find out

specifically what needs to be done. After hearing the instructions, proceed only if you are sure you understand what needs to be done and feel capable of doing it. (Maloff & Wood, 1988, p. 8)

A Model of Restrictive Conditions in Social Exposures--A Summary of the Related Literature

In summary of the related literature associated with the different aspects of definition, social evaluation, origin of attitude, and social responsiveness toward the disability condition, a theoretical construct is in order. The formation or comparison of some sort of constructed theory associated with an established explanation relating to the specific actions, reactions, and responses of individuals in society, and society in general, toward people experiencing a disability condition becomes a necessary requirement for a sense of completion concerning both the review of literature and a cognitive-emotional closure.

There seems to exist in the disability-related literature nothing expressly stated or scientifically established that is associated with a theoretical statement claimed as theory. There seems to exist no statements concerning certain humanly restrictive conditions in a social setting in relation to certain humanly non-restrictive conditions in the same social setting recognized as a "theory of disability." What does clearly exist in the related literature, as discovered throughout this review, is

a social and personal observation and orientation that closely follows a predictable behavioral trend.

In the absence of such a "theory of disability," then, I refer to this observed trend in behavior as a model of restrictive conditions in social exposures. This model of orientation, as reviewed in the literature and expressed through the development of the D.A.R.T. Seminar, suggests that the personal and social responses and reactions toward the disability condition are associated with personally held attitudes formed through social and personal expectations. These expectations, it seems, are composed of socially conditioned and individually produced responses to the differences that are represented by a disability condition.

Disability awareness training as seen through the intent of the D.A.R.T. Seminar addresses these held attitudes through an educational modification of personal and social expectations. This is done by integrating the behavioral aspects of an empirically developed presentation and technical response analysis with the subjective incorporation of an inclusive empowerment of each seminar participant through the subject matter content that is centered around acceptance through awareness.

This research project adds to the specific body of knowledge associated with the disability condition, the related orientation of expectation toward disability in social exposures, and associated disability awareness

training programs. This addition is accomplished in part by statistically demonstrating that through the provisional reliability and content validity of the developed cognitive and affectual testing instruments used as part of the D.A.R.T. Seminar formation, the personal and social response to disability, in general, by members of different church congregations and specific community-service professionals is, in part, a l earned reaction evolving from certain expectations into held attitudes that can be positively modified through education.

The Historical Overview of the Development of Instructional Product

The Curriculum: An Academic Teaching Tool

Academic curriculum as a specialized field of study and the practiced use of such a pre-formed and regulated instructional format as an academic teaching tool is believed to have begun in earnest in the early 20th century, immediately following World War I. This was a period in American history that experienced great national progress in technological and industrial endeavors (Molnar & Zaharik, 1977). The field of education, with its possibilities of furthering practical knowledge in the workplace, was viewed as a means of advancing this national progress whereby academic developers and administrators involved in curriculum production and selection were persuaded to act in

a more systematic and utilitarian manner concerning the
development of their craft.

The appearance of the book entitled The Curriculum
(1918), written by Franklin Bobbit, was instrumental in
establishing a basis upon which the popular, scientific,
factory-management methodology of the day was transferred to
the development of a curriculum theory for education in
specific for the continuation and management of national
progress in industry and technology (Molnar & Zaharik,
1977).

> If schools were to become as efficient and effective as
> factories, waste in the curriculum needed to be
> eliminated. This process resulted in the
> identification of numerous, discreet skills and other
> learnings, and the emergence of specific, detailed
> objectives as the first and most important decision in
> curriculum development. (Molnar & Zaharik, 1977, p. 2)

Ralph W. Tyler's classic book entitled Basic Principles
of Curriculum and Instruction (1949), was based upon the
earlier work and theories of Franklin Bobbit. Tyler
expounded on a specific model of curriculum planning which
he had personally developed and used in his academic
practice since the 1930s. Tyler's theory of curriculum
planning addressed four basic and essential questions,
questions that Tyler believed to be fundamental: (1) What
should be the educational objectives in the curriculum? (2)
What learning experiences should be developed to enable the
students to obtain the objectives? (3) How should the
learning experience be organized to increase their

cumulative effect? (4) How should the effectiveness of the curriculum be evaluated? (Tyler, 1949, p. 1). This Tyler approach to curriculum planning and decision-making offered an innovative, effective, and efficient method of selecting objectives for the progression of learning. This methodology came into design for the purpose of making education more systematic and the selection of educational objectives more utilitarian.

Tyler suggested that a first, experimental step in this process that tentative, general educational objectives should be developed from such sources as students' needs and interests as are associated with the present society at large. This would include the scope of family, health, vocation and career, religion and recreational pursuits, as well as needs and interests from subject specialists and selective, available resources.

These tentative, general educational objectives, then, after this developmental process, should be subjected to a finely meshed filtering procedure through the specific educator's personal philosophy and values concerning education and the psychological/emotional factors of the learning method which determine the possibility and suitability of the learning material according to established developmental factors. Tyler stated, then, as a systematic consequence of this methodology, precise instructional objectives can be developed.

Since the published introduction of R. W. Tyler's model of curriculum planning in 1949, there have been many attempts by curriculum theorists and developers to make improvements in clarity and design, most specifically, Robert Glasser (1962), Hilda Taba (1962), Popham and Baker (1970), Baker and Schutz (1971), and R. M. Gagne and Briggs (1974).

Curriculum as a theory, as it has been applied in the classroom, has suffered severe and intensely negative criticism through the developing years of its formation. Frederick Shaw (1966), a concerned curriculum developer, reviewed the broad scope of the future direction and usefulness of the present curriculum theory design and predicted that the present curriculum theory failed to adapt to a certain necessary structure of pattern that would encourage and enable beneficial change to freely occur (Shaw, 1966). The problem rests, Shaw said, in that "curriculum theory has not played a decisive role in influencing curriculum change" (Shaw, 1966, p. 349). The structure that was missing from the theory was a pattern or foundation that supported and directed both curriculum research and its design of practice.

The Curriculum: Concept and Design as Methods of Learning

The National Committee of the National Educational Association Project on Instruction (1963, p. 190) came to

the necessary conclusion that the present curriculum organization suffered from an ineffective and hindering dualism of design and basic concept. The disunified dualism rested in the cognitive ordering of knowledge and the psychological characteristics and effects of the actual learner as a recipient of that pre-designed knowledge schedule.

Charles E. Silberman (1970) performed a massive study of the American public school system for 3 1/2 years. It was a research study commissioned by the Carnegie Corporation that brought to existence his book Crisis in the Classroom (1970). He observed six different educational directions led by the present curriculum that represented a crisis situation in American public schools:

1. A preoccupation with order, control and routine, for the sake of routine

2. Subjugation of the student by the school

3. A practice of systematic repression creating their own discipline problems

4. The promotion of docility, passivity, and conformity in discouraging students to learn for themselves

5. Uniform method of education, disregarding the student's individuality, understanding, and interests

6. Despite attempts at true reform, the practiced curriculum remains trivial and banal (Silberman, 1970).

Alwin Toffler's (1974) book, Future Shock, voiced insightful criticisms concerning the academic and realistic condition of education and its practiced curriculum in American schools. His perceived observations were that much of the contemporary curriculum consisted of mindless, unnecessary aspects of past importance. He believed that the presently used curriculum was an obsolete misunderstanding of present and future human needs. Toffler strongly believed and accurately suggested that a school curriculum be a true education for the student, an education that prepares students for the cognitive and effectual skills required of the specialized and individualized job markets of the future, and for life in an ever-increasing complex and heterogenous society (Toffler, 1974).

During this period of criticism of education and its present curriculum development and frustration with how to accomplish desired educational outcomes consistent with proposed theory and necessary goals, came a body of literature describing an "educational technology" defined by Baker and Elam (1978).

> During the past decade, much has occurred to move educational technology from a primitive status to an increasing differentiated technology capable of integrating visions, realities, educational characteristics and organizational characteristics in accomplishing social objectives. (Baker & Elam, 1978, p. 6)

James W. Popham (1967), in an article on instructional product development, listed the fundamental forces that were

behind this educational technology movement. He believed the forces to be social trends and social needs, separate technology, and private foundations involved in curriculum development. Popham also believed that the government had a great investment in educational research and development.

Popham continued his perceptions of the forces behind this movement as being continually outside of the educational arena, as in behavioral psychology and the modification of human behavior. In this area rested his commitment to the production of pre-specified behavioral changes in learner's theory, creating a responsibility on the educator's part to share with the student in the learning process. This new attitude and practice supported a feeling of impatience among researchers and educators concerning their contributions to their fields, which grew to be a driving force behind the support of educational technology (Popham, 1967, pp. 403, 404).

Norman Gronlund (1973) described, in his book on the preparation of criterion-referenced texts for use in the classroom, a system of measurement with consideration to the developmental levels of the learner. Rather than the mastery of basic steps of knowledge, this developmental criterion-referenced procedure allows the student to aim toward a level of achievement to which he/she is able, comfortable, and desirous.

This systematic procedure, which identifies a learner's mastery of specific behaviors, seemed to evolve from the norm-referenced measurement practices which were designed to ascertain a learner's relative performance in reference to a group of learners having taken the same test. This brought about a behavioral objective concern and established an educational movement in its honor. This behavioral objective concern for educational product development demanded educational materials and tests which would suitably fit into the specific expectations implied by the new behavioral objectives (Gronlund, 1973).

John McNeil (1969) summarized this behavioral objective shift in attitude among curriculum developers, researchers, and those in the practice of curriculum as a realization of the ultimate importance of the tested desired changes in the learner, and the lesser importance of the methods and sequence of instruction used to produce those desired changes (McNeil, 1969). As a result of this realization, a change began to take place whereby the developers of the instructional materials seemed fit and willing to begin to accept some of the responsibility and accountability to the proposed learners' failure to master the intended behavioral objectives (McNeil, 1969).

William Deterline (1971) sensed this feeling of responsibility to the learner from the educator and claimed that this blossoming sense of accountability that evolved

into an actual educational movement was not at all a new theory of education, but rather an empirical method of planning, maintaining, and developing instruction, with a new mission of becoming results oriented (Deterline, 1971).

In this same article, entitled "Applied Accountability," Deterline (1971) made further suggestions concerning the direction of education while under this accountability sensitivity. The first directive of this realized movement was the production of a specified performance capability. The second directive was that certain instructional components must produce the desired results. The third directive was that an empirical development process must be employed. Deterline maintained his sensitive nurture of all learners in the empirical process by further suggesting that through evaluative data collection the accountability meaning must be maintained by identifying possible weakness and providing for those weaknesses by established corrective changes and backup educational materials so to meet the different kinds of learning methods and student needs (Deterline, 1971).

A System of Accountability: Need, Objective and Task-Effectiveness

To further develop this accountability movement to the improvement of education, Roger Kaufman (1971) suggested that accountability be applied through a systems approach. A systems approach has been defined as "a point of view and

a set of procedures which enable decision-makers and developers to examine carefully and systematically the way in which an attack on a social or educational problem might be made" (Carter, 1969, p. 31). Kaufman, taking this systems approach quite literally, suggested that the accountability method in education borrow tools from the field of management, tools such as auditing, systems analysis, needs assessment, behavioral objectives or measurable performance objectives, planning, programming, budgeting systems, methods means, selection techniques, program evaluation review techniques, and other such business management tools.

Kaufman continues this thoughtful suggestion by stating:

> If we educators then, are going to be accountable, it would be well if we had tools by which we could determine our accountability, our predictable results, our alternatives, our control of educational operations, our methods for ascertaining the meeting of needs and associated objectives. (Kaufman, 1971, p. 21)

Launor Carter (1969) developed an educational process of curriculum development that would hold true to the demands of the accountability movement. Carter suggested an eight-step systems approach to the development of an educational curriculum. The systems approach was as follows: (1) statement of the need for such a curriculum, (2) a clear definition of the desired objectives which will satisfy the proven need for the curriculum, (3) a definition of real limiting constraints which all systems must satisfy,

(4) the generation of alternative systems, (5) the selection of the best possible alternatives, (6) the implementation of the selected alternatives for testing, (7) performing a thorough evaluation of the experimental system, and (8) feedback of the required modifications until the objectives are met. Carter suggested such a systems approach to the educational process of curriculum development because it placed necessary emphasis upon the problems that are so present in educational product development and curriculum planning such as implementation, evaluation, feedback, and revision (Carter, 1969).

Baker and Schutz (1971) suggested an even more systematic approach to the development of curriculum planning, placing an even more focused emphasis upon the revision and feedback aspects accompanying evaluation and implementation suggested by Carter (1969). The Baker and Schutz (1971) methodology focused upon the learner as architect for the planning of the learning objectives and the learning presentation. Through sought feedback and suggestion, the learner's experience and the learner's individual need-to-know concept were the foundation for the formation of this methodology.

The Baker and Schutz (1971) methodology encompasses the educational successes gleaned from the scientific management theory of Franklin Bobbit, the objectives, experiences, and organizational theory of Ralph Tyler, the disapproval of a

dualism of design and concept of The National Committee of the National Educational Project on Instruction, the foundational pattern of research and design as structure of Fredrick Shaw, the accountability according to a systems approach theory of Launor Carter, and the regard for individual understanding and interests of Charles Silverman. From this combination of progressive developmental theory evolved the behavioral, technical, production model of curriculum development in the empirical/analytical type of inquiry developed for use by Baker and Schutz (1971).

This methodology represents seven main stages of development involving the collection of data for pre- and post-test cognitive and affective comparisons. The seven stages of development are as follows: (1) formulation of a new educational product through justifiable need, (2) establishment of behavioral objectives coupled to methods that promote positive affect stated in measurable terms, (3) formation of the cognitive pre-test/post-test instrument based upon the need-driven behavioral objectives, (4) initial development of the instrument and its exposure to a small group representing the target population, (5) product tryout with a larger group of individuals of the target population, (6) product revision where a still larger group is exposed to the entire educational product and pre-/post-test comparisons are made for a pre-established significant level of mastery, and (7) operational analysis where a still

larger group (25 or more) is exposed to the instructional product presentation for mastery and completion of the empirical development process (Baker & Schutz, 1971).

With all this attention to the development of educational curriculum through a systems approach and a new sensitivity to the educator's part responsibility to the learner's success in learning and the continuous idea of education as technology, certain goals were established during the 1960s and early 70s to pertain to educational research dedicated to the development of comprehensive instructional systems. These goals were to produce improved instructional outcomes by developing research-based, quality-verified instructional systems and support systems to be used in the nation's schools. The other goal is to produce a specific technology providing replicable systematic procedures for effecting improvement in all fields of education (Baker & Elam, 1978).

A leading force in the developmental process of instructional technology has been the Southwest Laboratory for Education and Development. Baker and Elam (1978) describe three major factors which have been used and are of common importance and effectiveness to the efforts of instructional product development. These are: (1) the definitions of instructional systems which have led to the educational outcomes of the learner, teaching manuals and teacher's manuals and student activity manuals, program

implementation and monitoring systems; (2) stages of program
development which have defined the cycle of development in
terms of specified functions and which have promoted the
whole sequence and overall integrity of the program; (3) the
systematic sequencing of task elements which have stressed
the interdependent nature of the smaller systems within the
larger systems and the stages of development (Baker & Elam,
1978, p. 6).

Dean Spitzer and Kerry Kennedy (1980) took this
technology of education to the most specific point and spoke
then on the differences between the newly realized
instructional development and the traditional concept of
curriculum development. They defined these differences
through the comparison of different designs,
implementations, and specific evaluation procedures.
Spitzer and Kennedy (1980) define the traditional
development of curriculum as being more general in scope of
aims and goals with an undefined and unlimited target
audience. In this curriculum development, these aims and
goals are based upon perceived needs and further evaluated,
usually, by general acceptance or other similar general
criteria.

On the other hand of educational technology and
awareness, instructional development, according to Spitzer
and Kennedy (1980), is defined as being more specific in its
performance objectives, more specific in its directly

targeted audience, and much more direct and specific in its statement of assessed needs. In an instructional development process, the methods and procedures tend to be more highly systematic, structured, and empirical in orientation. The learning activities are closely related to defined outcomes and the evaluation procedures show the direct emphasis this instructional methodology has upon results and outcomes (Spitzer & Kennedy, 1980).

In summary, the expansion of the educational movement towards the rigorously structured, systematic, and now empirically validated instructional product development has been influenced by many different social changes, industrial and governmental involvements, as well as great technological advances. Through all this change and association with different needs and desires of the educational curriculum, the most influential factor that arose from this educational technology and applied-results orientation from the actual developers of the curriculum plan was the realization from strong evidence that the effectiveness of any given instructional product is derived from the testing of the given product with a representative sample of learner-subjects, representing the willingness and effective necessity on the part of the curriculum developers to expose their entire program to the process of empirical validation.

The Curriculum as Process: Paradigms,
Models, Analysis, and Perspectives

The completion of a review of the literature relating

to the history and formation of curriculum development and

product formation must further examine the paradigms and

perspectives that create the models of development mentioned

earlier in this review, beginning with the four traditional

procedural questions of Ralph Tyler's (1949) Basic

Principles of Curriculum and Instruction. "Tyler identified

four questions that should provide the parameters for

curriculum study" (Schubert, 1986, p. 171). These

identified questions are as follows: What educational

purposes should the school seek to attain? How can learning

experiences be selected which are likely to be useful in

attaining these objectives? How can learning experiences be

organized for effective instruction? How can the

effectiveness of learning experiences be evaluated? "Tyler

suggested a set of inescapable questions that must be asked

of any curriculum" (Posner, 1995, p. 20). With this set of

established questions acting as the format of the beginning

of further development in all curriculum studies, many

conceptual models began to evolve. One that needs to be

mentioned in a review of this nature is the Johnson Model.

Mauritz Johnson's conceptual model of curriculum study and

purposes evolved over a period of 10 years, from 1967 to

1977 (Posner, 1995). Johnson stipulated a definition of

curriculum as "a structured series of intended learning

outcomes" (Johnson, 1967, p. 130). Following this working

definition of curriculum came the aspect of distinguishing

between the often confused term of instruction.

Instruction, according to Johnson, is the process by which

what is to be learned is taught to students (Posner, 1995).

Through these definitions came an important conclusion that

further established the concept and purpose of curriculum

study. According to the Johnson Model, the curriculum

itself is not a process, but the curriculum development is.

This conceptual idea holds the intent behind the selecting

and structuring of the intended learning outcomes from the

cultural source of the curriculum for the purpose of

achieving educational goals (Posner, 1995).

These educational goals set the framework for the

outline of the Johnson Model (1967) in general. This model

begins its formation of a curriculum and a purpose for its

formation with specific goal setting which reaches into the

aspects of curriculum selection and curriculum structuring.

From this planned format comes, in conclusion, a technical

evaluation possibly influenced by theory and research but

not by ideology (Posner, 1995). As can be seen, Johnson,

like Tyler before him, "disavows a linear planning approach,

but assumed a means-end logic underlying rational planning"

(Posner, 1995, p. 20).

Building on the four curriculum questions of the Tyler

Model, then, Johnson simply refines these same questions

into a workable model appropriate for the particular

analysis of formal presented curricula. The Tyler rationale

and the Johnson Model, when combined together, form a guide

to specific curriculum analysis of component parts.

Using these two frameworks, a learner may be guided

toward perceived educational goals and specific aims,

intended learning outcomes, and other aspects of a

curriculum's implicit or explicit purpose (Posner, 1995).

Although these considerations of a curriculum's anatomy are

important dimensions in the scheme of educational purpose,

there rests a danger in the Tyler Model of curriculum

formation that represents conciliatory eclecticism as

warring conceptions of the curriculum in general (McNeil,

1996).

> The learner as a source is consistent with the
> humanistic conception, especially when data regarding
> the learner's own psyche needs and interests are
> considered. Society as a source is in keeping with
> social adaptive and some reconstruction orientations,
> while the subject matter specialist as a source tends
> to recognize the academic conception of curriculum.
> (McNeil, 1996, p. 131)

The true danger rests in knowing or not knowing, as the

case may be, regarding the Tyler model, which source needs

more attention and which source seems most important and

worthy of more assigned educational weight in regard to

order of emphasis. In spite of these dangers, the

"possibility of treating learners, society and subject

matter as part of a comprehensive process" (McNeil, 1996, p.

131) shields the treatment of the same subjects as separate,
isolated entities apart from the whole (McNeil, 1996).

Other difficulties with the Tyler Model of curriculum,
especially when combined with the perceived refinements of
the Johnson Model of "intended learning outcomes," surround
the idea of control. It is vital to be aware of the
specific criticisms that surround this model in order to
understand its inner form and be educated as to the analysis
of its theory and its social and personal purpose and
necessity.

The control of the Tyler Model comes from the idea that
stems from a tradition of pre-determined purposes and
functions that "narrow an institution's goals and
objectives, which in turn narrows the possible instruction"
(McNeil, 1996, p. 131). This tradition has been likened to
a production model. "The input is the student, the process
is the learning experience and the output is the pre-
specified objective or product" (McNeil, 1996, p. 131). The
other criticisms of this model rest in the areas of the time
needed to implement the data process and the disagreement
over values. The solution, or at least a working
resolution, to such criticized problems necessitates a
decision-making procedure coupled alongside a belief system
and a base of held values gleaned from interviews,
presentational feedback, and discussion groups associated
with the population sample's verified need and desire of

specific educational enlightenment (McNeil, 1996, pp. 132-133).

From these criticisms came different models for curriculum development as specialists in this field attempted to improve upon the Tyler Model by reversing the order of procedures used. The statements of educational values were placed as the first step and then refined through information of the learners and their social conditions in regard to knowledge of the subject matter, their realized needs, and desires to learn (McNeil, 1996, pp. 130-133).

From these attempts to improve an existing model evolved different rational and technical models in curriculum decision making. The needs-assessment model for determining curriculum is seen as a popular method of establishing and restoring confidence in specific educational institutions as well as an accepted way of advancing interests in "previously ignored groups when it allows clients to determine what they want to learn and not merely to select from a list of meaningless choices" (McNeil, 1996, p. 143). Building on the conceptual framework of the needs-assessment ideology is the futuristic model. This model places emphasis on specific future conditions more than an existing, present status, where future needs are anticipated in light of an agreed upon future that is desired by the student in the student's

cultural and social possibilities and realities. Building upon the futuristic model even more is the vocational training model. This model is most appropriate "in institutions claiming to prepare students for specific jobs" (McNeil, 1996, p. 143).

The rational model is an idealistic and comprehensive form of curriculum formation, giving attention to the interests and concerns of the learner, the learner's society, and the fields of knowledge associated with the specific cultural environments. It has received specific criticisms for its ideological stance on specialization of subject matter. This model desires to create a relevance between actual education in a classroom with perceived social needs. With this format as the highest function, this model would tend to "respond to generalizations about society to the exclusion of other considerations" (McNeil, 1996, p. 143). These models of orientation are resulting attempts to refine and reorganize the criticisms that plagued and educated the Tyler Model and rationale.

Tyler's model incorporated certain purposes, learning experiences, organization, and evaluations that composed four beginning questions that aided in the evolution of an empirical-analytic method or mode of inquiry referred to as "the paradigm of perennial analytic categories" (Schubert, 1986, p. 183). From this evolved combination of inquiry and the educational attempts to reorganize the dominant,

technical curriculum formation of the day, two more
alternative paradigms rose into existence in the recent
literature: the "paradigm of practical inquiry" and the
"paradigm of critical praxis" (Schubert, 1986, pp. 182-183).

The paradigm of practical inquiry serves more of an
interest related to the practical aspects of curriculum
formation and its communication through understanding
opposed to the interests of more technical principles of
control and certainty in a perceived static, social reality.
This paradigm of practical inquiry serves society best
through the organization of social interaction as a method
of rationality. It perceives individuals in society as
active and capable of creating knowledge for themselves
through personal assumptions and the associated meaning that
is the existence of everyday life. The paradigm of
practical inquiry, opposed to the more rigid empirical-
analytical mode of technical, value-free, and objectified
knowledge, perceives the reality base of knowledge as
intersubjectively constituted, sharing its presence within a
whole social context, rather than a forced, value-efficient
and testable system of principles and certainty. The
paradigm of practical inquiry in curriculum development
further focuses on the questions associated with meaning in
the specific social culture and its related expression,
opposed to the technical/analytical mode of inquiry that

simply accepts specific social culture as reality attempts to accept its expression as further sources of meaning.

The other alternative paradigm that appears in recent literature as an attempt to reorganize the once dominant empirical-based, principle- and control-oriented technical model of inquiry into curriculum formation is the paradigm of critical praxis. This mode of inquiry possesses elements that seem to be created into the educational buzzwords of modern curriculum instruction. This mode of inquiry seems to serve the interest of emancipatory desires through the social organization of power and individual empowerment, giving the impression of true inclusion within a social and political context. This mode of curriculum development associates itself with the necessity of ideology through the rationality of critique and action. The desire for emancipatory power drives this mode of inquiry to seek out anything oppressive and dominating through a sensitivity to any false consciousness. Unlike the empirical-analytic paradigm that accepts without question the social reality that surrounds it, and unlike the practical-orientated paradigm that more closely focuses on the sensitivity to life's meaning through an awareness of social culture, the critical paradigm examines different value systems and conceptual aspects of perceived justice upon the specific basis for inquiry pertaining to the desire to offer an

inclusive method of learning to every individual (Schubert, 1986).

The models of curriculum development from Tyler and Johnson brought the empirical-analytical mode of inquiry into an accepted and respected form of educational research and teaching methodology until the realization of and/or the critique of the resulting product formation innocent of a non-technical sensitivity to value systems in association with social and cultural contexts. From these critiques and perceived insights into better modes of inquiry came four modern models for determining curriculum. The models are as follows: the needs-assessment model where clients have a say in the choice of educational goals; the futuristic model where needs are anticipated in light of a desirable future perception; the vocational training model with its claims to prepare students for jobs; and finally the idealistic rational model that gives attention to the interests and needs of the learner, the learner's society, and cultural context alongside the desired fields of knowledge.

In conjunction with these four models came two alternative paradigms to educationally counter the dominant technical framework of perennial analytic categories, or the basic empirical-analytic mode of inquiry. These modern curriculum studies are: the paradigm of practical inquiry, working with social interaction through communication and understanding and the paradigm of critical praxis, dealing

with emancipatory social action and the necessity of individual empowerment through inclusion. These models and modes of inquiry into the educational aspects of curriculum development, combined with the social data and history of the section leading into this component of the review of literature, compose a more complete picture of the process involved with the development and formation of the curriculum as a continuous learning tool and model of learning.

The Curriculum Development Methodology
of Baker and Schutz as
Significant in 1997

The Baker and Schutz (1971) methodology of curriculum development represents a significant contribution to the progression of theory and practice associated with the educational process. This particular theory of methodology utilizes Franklin Bobbit's general basis for the transfer of a scientific factory-management methodology into a curriculum theory for educational purposes through the use of information associated with problem-specific responses to the curriculum development process. This is significant in the educational process of 1997 for it sheds light upon the specific problems to which a curriculum was responding.

The Baker and Schutz (1971) methodology also gleaned the theoretical perspectives of Ralph Tyler associated with the statement of specific objectives, the development of learning experiences, the experiential organization, and the

concept of evaluated effectiveness through the clearly presented idea of what students are expected to learn. This conceptual theory is significant, for it establishes learning objectives, teaching content, order, and sequence.

Baker and Schutz (1971) established a curriculum development methodology that agreed with the National Committee of the National Educational Project on Instruction (1963) in denouncing the dualism of design and concept and attempted to establish a unification of theory through clearly stated rationale. Baker and Schutz (1971) present a significant methodology for 1997 through their required presentation of why certain learning objectives and lesson content are important for those individuals whose perceived needs are addressed by the objectives design and development.

This same methodology incorporated the conceptual framework of Fredrick Shaw's foundational patterns of research and design as a structure of enabled, beneficial change, through the use of educational guidance and teaching strategies. Baker and Schutz (1971) suggested specific prescriptions for content presentation. This concept is a very significant one in 1997, for it requires a description of how to teach the desired objectives.

Baker and Schutz (1971) also utilize Launor Carter's theory of accountability in a systems approach through their use of explanation and indication of how the specific

curriculum and the students learning the curriculum should be represented. This concept is very significant for education in 1997 for it establishes an evaluation for the learning process and the results of that evaluation.

The regard for a student's creativity, their understanding, and their basic interests as the essence of education was foremost in the theory of Charles Silberman. Baker and Schutz (1971) utilize this student theory in the implementation of its curriculum. Again, this is significant for education in 1997 for this conceptual process represents an appropriateness and an integration of a specific curriculum coupled to a findings report of what actually happened as a result of its implementation.

The Baker and Schutz (1971) methodology, according to this researcher, is significant in 1997 as an educational tool because it addresses the problems to which the curriculum was designed, it presents a clear idea of what the students are expected to learn, it speaks of why certain learning objectives and content are important, it suggests how to teach the objectives, it presents an indication of how the curriculum was evaluated and gives the results and, finally, it presents indications of whether the curriculum has been implemented, in what situations, and the results of the appropriate implementation.

The D.A.R.T. Seminar: Using the
Baker and Schutz Methodology

I used the Baker and Schutz (1971) methodology to
increase awareness associated with the disability condition
and to modify affect associated with the same condition.
The observation of specific objectives in terms of the
student learner's pre-instructional behavior provided
helpful specifications in the development of the
instructional stages and presented a clear statement as the
student learner's possible behavior after the presented
instruction.

The prototype tryout stages of the presentation, called
the D.A.R.T. Seminar or the Disability Awareness Reality
Training Seminar, provided the necessary data to modify the
identified specifications and product curriculum on the
basis of the desired level of mastery. The development of
this disability awareness instructional product followed the
seven steps as outlined in the book Instructional Product
Development (Baker & Schutz, 1971).

In the formation and development of the D.A.R.T.
Seminar, the empirical process outlined by Baker and Schutz
(1971) was followed. This process is an empirical-analytic
mode of inquiry serving the technical interests of a social
concern. To address the criticisms associated with this
particular mode of educational inquiry, those criticisms
that speak of its insensitivity to social context and need
of control through testable certainty and factory-like

objectified knowledge, is to promote the D.A.R.T. Seminar through a comprehensive understanding of its purpose coupled to its subject matter. I agree that the danger of acting out all that which is correctly brought to criticism rests in those two aspects of the study: purpose and subject matter. If the behavioral objectives planned for the study are not empirically designed and developed by the people who comprise the population of the research study through extensive interviews, questions, observations, direct conversations, specific visitations, and numerous developmental presentations on the proposed topic, with extreme sensitivity to what the people profess they need to know and desire to know about the proposed subject matter, then I agree that the empirical-analytical method of inquiry would deserve every technical critique and criticism. If the purpose of the empirical study was unclear or designed to operate in the interests of law-like propositions that are empirically testable, assuming knowledge to be value-free and only objectified, then the only interest served would be a technical one through the extremely limited social organization of work or vocation. This would suggest an acceptance of a present social reality. This conceptual framework is worthy of criticism.

The D.A.R.T. Seminar holds a proposed and designed purpose for the building of community interaction for the sake of emancipatory empowerment of each person in the

community. The research methodology follows an empirical-
analytical mode of technical inquiry, yet it is closely
coupled to the purpose of social interaction and social
inclusion through the social-awareness-oriented subject
matter.

The D.A.R.T. Seminar resulted from a research
methodology that was empirically developed and designed.
The objectives, testing instruments, criteria, outline, and
complete curriculum were based on information and data
carefully gathered from 18 months of interviews,
discussions, questions, visitations, observations, and topic
presentations. The development was always extremely
sensitive to what the people said they needed to know and
desired to know in order to reduce their fear and prejudice
and to give to each participant desired personal power
through the act of practical inclusion. The D.A.R.T.
Seminar methodology used a technical mode of curriculum
inquiry to suggest a practical, interactive educational
product produced for and by the people, for the expressed
purpose of building acceptance and inclusion within the
people's specific community, and in so doing empowering the
individuals experiencing a disability condition through
inclusion and empowering all individuals through awareness
and the related act of acceptance.

A Spiritual Foundation for a Divine
Example of Community Associated
With the Disability Condition

I believe in an inclusive and accepting God of encouragement, motivation, and inspiration based on love (1 John 4:8). I assume, through a personal belief, that God accepts and includes every human individual into His presence out of love and desire for that person's relationship and life happiness (John 14:1-3). This spiritual base establishes the divine foundation for this study. Scripture seems to express an example of divinity actively pursuing the well-being of humanity (Luke 1:79). This divine example demonstrates a supportive relationship involved in community building as it is associated with an active process of acceptance and inclusion (1 John 4:16-19).

Support is a human need (Mehr, 1992). Every individual needs to be encouraged, motivated, and inspired in order to live as fully and as completely as was designed (Whittington, 1990). The concept of relationship pertaining to oneself, others, and one's higher power represents a sense of spirituality and establishes a conceptual model to actively follow based upon the divine example of God and His personal and social interactions.

God, then, accepts and includes every human being willingly into His presence because He loves each individual. It is part of His divine nature, thus His desire to establish an active community and partake of an

active relationship with every human being. God in His divine nature desires to relate to all individuals in their human nature. Human nature is flawed and incomplete. Divine nature is perfect and complete. God's desire and action, then, is to accept and include each individual into His presence and in so doing offer to meet that individual's need of support and completeness (Whittington, 1990).

In this conceptual model rests the outline proposed for the interaction of each individual towards another. The human condition naturally seems to be characterized by a state of disability (Mehr, 1992). Every individual has an interruption, restriction, or inability in his or her life pattern in some form. God, in His divine nature, accepts, includes, and thus offers divine support for any and every degree of wounded humanity.

This God of community, for support of each individual, represents a divine love that is filled with the freedom of choice and purpose. Community in this sense, then, is an active process of free will directed toward becoming more complete in the divine example.

The divine aspects of wisdom and knowledge concerning disabling conditions can be experienced more fully by individuals who act in acceptance and inclusion of this condition. The joy of imagination and creativity can be exercised by individuals who include the disability condition into their community life and look for new and

fulfilling ways to meet specific needs that arise (Webb-Mitchell, 1994).

The divine virtues of patience and long-suffering can be learned and lived by individuals in a community that is practicing the acceptance of others with visible and detectable differences (Mehr, 1992). The individuals who participate in the living process of others with disability conditions may experience the intimacy that arises from realizing and acting upon basic human needs through a caring, self-understanding.

The protective and strengthening virtues of flexibility and resiliency developing through the process of self-discovery and social acceptance of others' differences as represented by the disability condition can only create a personal and corporate closeness to each individual in the community process and security in the unity that arises from each other's differences (Webb-Mitchell, 1994). The empathy of individuals for other individuals establishes a maturity within the corporate body or community that offers both support for and freedom of self-expression and perception (Fewell & Vadasy, 1986).

These attributes of personal and corporate integration that arise from the acceptance and inclusion of individuals with disabling conditions into a community setting can present a more realistic picture of the divine condition. From this picture, individuals can possibly perceive, amidst

humanity, a God who desires community and acts from a complete nature of supportive love (Whittington, 1990).

Individuals who live with a detectable disability condition, just as all individuals in the human condition, need a community of care and support to absorb the pain of social perception and expectation (Webb-Mitchell, 1994). All individuals are children of God and therefore are essential elements in the fabric of the reflection of the divine image. They are all desired, chosen, and precious to the source of that image.

To accept and include individuals with disabilities into an active community is to model the relationship that God desires with each human being. To actively accept and include each individual into the family of God (Whittington, 1990) as well as into a personal family of care (Mehr, 1992) is to offer a relationship with that individual that is the spiritual base for the divine example of community (Fewell & Vadasy, 1986).

CHAPTER 3

METHODOLOGY

Population and Sample

The development of this disability awareness training

seminar followed the seven specific steps as outlined in the

book entitled Instructional Product Development (Baker &

Schutz, 1971).

The target audience for this study was Seventh-day

Adventist church members and their guests of both genders,

and were in or had completed high school. They were of a

variety of ethnic cultures and familiar with the American

culture. They were both single and married, age 16 years

and older.

Students enrolled at Andrews University in the Master

of Divinity program, specifically studying Pastoral

Counseling, were the first group invited to participate in

the development of this disability awareness training

curriculum. The second group was comprised of students

enrolled in the Master of Divinity program, specifically

studying Pastoral Psychology. Each group was exposed to an

hour-long interactive learning experience for a 2-day

period.

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The third group invited to participate in the development of this curriculum was comprised of individuals able to attend a community seminar in the city of South Haven, Michigan. This community seminar was held in the South Haven Memorial Library for 11, 90-minute, evening sessions. This group consisted of Seventh-day Adventist church members and their guests from within the South Haven community.

These developmental seminars were used in the continual formation of the instructional product. As the knowledge and experience of each presentation began to solidify through feedback and responses, coupled with the questions and suggestions of each of the participant's interest in the topic, the seminar seemed to take on a form that was both presentationally practical and communally responsible.

The fourth group of individuals to experience the budding seminar in its developing state was the afternoon personnel pool of the Human Services Department of a community retirement and rehabilitation center in Milton-Freewater, Oregon. This group consisted of Seventh-day Adventist church members employed by the health center. This single session lasted 1 hour. These beginning seminars and interactive presentations were used to deem the instructional product appropriate for further exposure to larger groups. During the process of these initial 16 developmental sessions and the accompanying participant

responses, reactions, and feedback, carefully acknowledged by the researcher, the fundamental outline and structure for the proposed 20 behavioral objectives of the seminar, the cognitive and affectual testing instruments proposed to be used, and the testing criteria were composed.

Steps in Empirical Product Development

Baker and Schutz (1971) identify seven steps for the empirical development of an instructional product. These seven steps represent the present accepted methodology for the empirical development of instructional products. These steps were followed as an outline for this research study.

The first step is called formulation. Formulation addresses the question of whether a new or improved product is justifiable in terms of its need. Baker and Schutz (1971) point out that the value of developing an instructional product is in direct proportion to its need.

The audience that this research study claims as its specific population and sample were SDA church members and their guests. There appeared to be no empirically developed instructional product, offered through an SDA church educational department, dealing with awareness training of the disability condition for its members as they strive to build emotional community among themselves and the physical community surrounding them. There appeared to be no empirically developed curriculum to instruct the awareness of the disability condition as a condition, separate from a

person or to teach an awareness of the practical
sociological issues faced by individuals with disabilities.
There seemed to be no curriculum available to teach an
awareness of the origin of attitudes held by society toward
the disability condition or finally to teach an awareness of
the possible responsiveness by society toward individuals
with the disability condition. This instructional product
is an attempt to fill that absence in the community
education and training of Seventh-day Adventist church
congregations.

The second step in developing an instructional product
is the formulation of instructional specifications. These
include the establishment of non-ambiguous behavioral
objectives and methods that promote positive affect stated
in measurable terms. Acceptable levels of performance and
any criteria-qualifying objectives must be specified (Baker
& Schutz, 1971).

Minimum acceptable performance is set at 80/80; that
is, mastery of the behavioral objective will be achieved
when 80% of the attending learners master at least 80% of
the criteria on each objective. The following 20 behavioral
objectives, established through an extensive initial process
of 16 developmental, presentational question-and-answer
sessions (averaging 14 participants per session) in two
separate states, are proposed:

Section One: The Disability Condition-- Four Behavioral Objectives

1. The learner will demonstrate a conceptual understanding of the disability condition by responding correctly to a multiple-choice question concerning the definition of disability.

2. The learner will demonstrate a conceptual understanding of the disability condition by listing correctly two of the four possible life occurrences that enable a disability to happen.

3. The learner will demonstrate a conceptual understanding of the disability condition by correctly naming one of the four types of disability and explaining in eight words or less how understanding could make a difference in personal acceptance.

4. The learner will demonstrate a conceptual understanding of the disability condition by correctly listing one of the 16 disability conditions presented by the National Easter Seal Society (1994) and explaining in 10 words or less how that condition would have a personal restriction in life performance.

Section Two: Sociological Issues of the Disability Condition-- Seven Behavioral Objectives

5. The learner will demonstrate a conceptual understanding of certain sociological aspects of the disability condition by correctly responding to a multiple-

choice question concerning how society evaluates strangers (Nagler, 1990).

6. The learner will demonstrate a conceptual understanding of certain sociological aspects of the disability condition by listing Mark Nagler's (1990) three-point process of social evaluation.

7. The learner will recall from memory the two-characteristic effect that disabilities have upon the public and society, by correctly responding to a multiple-choice question concerning these two characteristics.

8. The learner will demonstrate a conceptual understanding of certain sociological aspects of the disability condition by naming the two actions performed by society toward people with disabilities as a result of the above two-characteristic effect and explain in 10 words or less a more personal manner of interactive action.

9. The learner will demonstrate an understanding of the sociological issues involved in the disability condition by naming one of the three reasons that Ladieu-Leviton et al. (1948) give for non-acceptance of the disability condition and explain in 10 words or less why this reason exists.

10. The learner will demonstrate a conceptual understanding of certain sociological aspects of the disability condition by naming one of the two points of social disintegration of people with disabilities and

explain in 10 words or less how to personally advance a social integration.

11. The learner will demonstrate a conceptual understanding of certain sociological aspects of the disability condition by explaining in 10 words or less how disability historically became linked with social deviance.

Section Three: Attitudes Toward the Disability Condition--Four Behavioral Objectives

12. The learner will demonstrate an understanding of the age-related acceptance sequence with respect to the disability condition suggested by K. Ryan (1981) by matching the three possible reasons for children's aversive behavior toward the disability condition to six associated statements.

13. The learner will demonstrate an understanding of the disability condition by explaining in 10 words or less how society conceptualizes the disability condition through pre-existing stereotyped images and through the three media formats.

14. The learner will demonstrate an understanding of the disability condition by listing from memory two of the six attitude-enhancing experiences presented by J. Donaldson (1980) and explaining in 15 words or less how they might enhance personal attitudes toward the disability condition.

15. The learner will demonstrate an understanding of the disability condition in regard to social acceptance

patterns by listing and briefly explaining, in 10 words or less, one of the four suggested points that create the pattern of acceptance in young children and what this point means personally as a member of society.

Section Four: Responsiveness to the Disability Condition--Five Behavioral Objectives

16. The learner will demonstrate an understanding of the disability condition by correctly responding, through rebuttal, in five words or less to a series of four common myths about disability.

17. The learner will demonstrate an understanding of the disability condition by explaining, in 10 words or less, two of the four points of personal and social exchange when talking to and associating with a person with a disability condition.

18. The learner will demonstrate an understanding of the disability condition in regard to realistic acceptance by correctly naming two of the four specific methods of action suggested by M. Nagler (1990).

19. The learner will demonstrate an understanding of the disability condition in regard to realistic acceptance, by correctly naming two of the four specific methods of action suggested by M. Nagler (1990).

20. The learner will demonstrate an understanding of the disability condition by listing two of the five general considerations for disability etiquette and explaining in

eight words or less how these points could make a person with a disability condition feel more accepted.

Baker and Schutz (1971) indicated that positive affect promotes mastery of behavioral objectives. To promote as positive an affect as possible, the following strategies are proposed:

1. The seminar, if possible, will be held in the largest, most well lighted and most open space of the available physical plant.

2. The seminar will utilize sufficient instructional equipment and large, open work areas for any demonstrations, discussions, and necessary review sessions.

3. A variety of community-building activities, such as sharing experiences, small group presentations, and team-teaching will be utilized to generate enthusiasm, develop encouragement, and establish support and comradarie.

4. A learner's or participant's manual will be given to each attending church member to enhance learning and provide for note-taking.

5. Presentations will include a variety of instructional aids such as overhead transparencies, slides, and, where possible, a public address system.

6. The format of the seminar incorporates a 2 1/2 hour session, a break, and another 2 1/2 hour session. Each 2 1/2 hour session will include a 10-minute break every hour. The extended break between the first 2 1/2 hour session and

the final 2 1/2 hour session will be 30 minutes in length, where a light meal will be served.

7. Time will be allotted for discussions and questions at strategic intervals throughout each unit of instruction.

Cognitive Awareness: The
Testing Instruments

The third step in the development of an instructional product, according to the process of Baker and Schutz (1971), is the prototype cognitive pre-test and post-test with criteria for evaluation. This pre-test/post-test instrument is based upon the behavioral objectives to evaluate mastery. The criteria for the questions are based upon the stated behavioral objectives and the information gathered from the review of literature. To ensure that some of the higher levels of cognition were integrated into the evaluation instrument, an attempt was made to be in association with Bloom's Taxonomy (Bloom, Engelhart, Furst, Walker, & Krathwohl, 1956). Bloom explains that the primary purpose for the establishment of a taxonomy process of educational objectives is to facilitate communication. This communication in the educational model can be accomplished, according to Bloom, by "selecting appropriate symbols, giving them precise and usable definitions, and securing a consensus from the group which is to use them" (Bloom et al., 1956, p. 11).

The research that Bloom and his associates performed identified six major classes of learning that should be considered when attempting to increase higher levels of cognition: (1) knowledge, (2) comprehension, (3) application, (4) analysis, (5) synthesis, and (6) evaluation (Bloom et al., 1956, p. 18). Each of the areas is arranged in a hierarchical manner, 1.00 being assigned to knowledge, which is considered to be the basic foundation, and 6.00 being assigned to evaluation, which is considered the highest level of cognition and learning (Bloom et al., 1956, pp. 201-207). The questions and criteria of this instructional instrument established the outline of the instructional product.

The fourth step in the development of the instructional product is called the initial development of the instrument and its exposure to a small group of two or three individuals of the target population. The information of the seminar is presented in a positive manner, while seeking suggestions for improvement. In this step, the instructional product is reviewed and modified in accordance with the suggestions and feedback received and a comparison of the pre- and post-test scores. After appropriate modification, a complete draft of the instructor's manual is assembled for further testing on larger groups.

The fifth step is called the product tryout with a larger group of four to six individuals of the target

population. During this phase of the developmental process, a word-for-word presentation is made. This is part of the instructor's manual mentioned above in the fourth step. During this particular tryout step, special attention is given to the aspects of clarity, content, and ability to communicate the intended instructional information that comprises the seminar. Again, evaluative comments are encouraged from each of the attending individuals, and modifications and revisions are made on the product where needed.

The sixth step is called product revision. Eight to 10 individuals from the target population are selected to be exposed to the seminar in complete form and mastery of the material through pre-test and post-text comparisons. With this information on record, modifications and revisions of the product are again made where appropriate.

The seventh step is operations analysis. A group of 25 individuals is used to conduct this final phase of the instructional product development. Mastery is again set at 80/80 and, as for each previous presentation, achievement at this level for each behavioral objective is the target proposal. Achievement at this level is the indicator that the empirical development process is complete.

Modification of Affect: The
Testing Instruments

This research study is the development of an instructional product designed to enhance general awareness of the disability condition. An important part of this research study is the enhancement of positive attitudes toward the disability condition or the modification of affect. This modification of affect in the attending learner was measured through a Likert-type instrument. This Likert-type instrument was in addition to the cognitive measuring instrument (pre-/post-test), both making up the complete testing instrument for general awareness of the disability condition.

The developed items in the Likert-type scale instrument, as well as the cognitive testing instrument, were presented to a panel of experts consisting of five individuals in professional practice of, and with specific expertise in, fields relating to the subject matter of disability, such as education, sociology, and psychology in association with community and human services. These five professionals reviewed the testing instruments for content validity and determined if the questions and statements were appropriately relational and if they were being asked with the proper orientation toward the seminar subject matter and if the purpose of their relation is directed toward modification of affect.

The criteria for selecting these individuals were based on experience and expertise. These five experienced and expert individuals were asked to determine whether or not each item should be included in the test instrument, both cognitive and affectual, as a viable aspect of awareness training and probable modification of affect. After this process was complete, the affectual statement items were randomly arranged to form an intended instrument with a numerical value assigned from 1 (strongly disagree) to 5 (strongly agree) to each statement item. The cognitive testing items were carefully arranged to harmonize with the empirical development of the curriculum as it flowed from the responses, interviews, and feedback of the seminar participants.

Both testing instruments were then exposed for study and approval to the panel of experts mentioned above. This panel was comprised of a Doctor of Osteopathy specializing in Physical Medicine and Rehabilitation, a Doctor of Philosophy specializing in Social Work and Mental Health Counseling, a Doctor of Ministry, specializing in Human Service Administration and Education, a Doctor of Philosophy specializing in the education, administration, and practice of Social Work and, finally, a Doctor of Philosophy specializing in Educational and Psychological Statistical Analysis. These five experienced experts studied and reviewed the testing instruments and passed them as

correctly reflecting the orientation of the behavioral objectives and as appropriately demonstrating a naturally assumed, provisional degree of consistency when dealing with specific results across repeated measurements. These instruments were then passed as valid for content. At this point in the developmental process, these testing instruments were ready for the process of data collection.

Statistical Analysis

Modification of affect was measured by comparing the pre- and post-test scores obtained in the affective exams from the various groups involved in the developmental process (Andrews, Klein, Davidson, O'Malley, & Rogers, 1981; Ferguson & Takane, 1989). A t-test for dependent means, significant at the .05 level, was utilized. This statistical procedure occurred during each of the presented developmental phases of this product.

Summary

The population desired for this study consisted of Seventh-day Adventist church members and their guests located in communities in Michigan, California, Oregon, and Washington.

The minimum acceptable performance on the cognitive pre-/post-tests was set at the 80/80 level. Twenty behavioral objectives with their criteria and a set of specific strategies to promote a successful mastery of

general awareness of the disability condition and a positive

modification of affect toward this disability condition were

established. To measure the attending learner's

modification of affect, a Likert-type scale instrument was

developed. The statistical procedure selected to measure

the modification of affect, at the .05 level of

significance, was a t-test for dependent means.

CHAPTER 4

FINDINGS

This chapter is a report of the results obtained
through the process of the development of an instructional
product: The D.A.R.T. Seminar--Building Community One
Difference at a Time. The steps used in this research
project are the seven steps of instructional product
development outlined by Baker and Schutz (1971).

Step 1: Formulation

It became evident from the review of literature and
personal exposure to different agencies of social service
that training in disability awareness was becoming a popular
subject of research and action in the growing social
sensitivity of life and work in the United States. Agencies
that specifically offer services to people with a disability
condition are proving to be more and more socially active in
the process of developing an awareness concept and an
awareness program presentation available both within their
agency and to the public.

Ellen Daley (1995), member of the President's Committee
on Employment of People with Disabilities, says that nearly
all agencies and associations that help people who have a

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who have a disability condition now offer some sort of disability awareness program. She suggested three large agencies as the nation's models for conceptual development of a general awareness and program creation for in-service agency education. The first was the California Governor's Committee for the Employment of Disabled Persons located in Sacramento, California. The second model association was the Regional Disability and Business Technical Assistance Centers, located in Washington, D.C. The third model agency was the National Rehabilitation Information Center, located in Nevada. These agencies and hundreds like them around the nation are becoming increasingly sensitive to the social need of awareness of the disability condition, both for the society at large as well as for the population of people with disabilities, for the sake of increased workforce efficiency and workforce possibility.

Throughout the literature search of disability awareness programs, there appeared many cognitively educational presentations, but no empirically developed training programs involving disability awareness, affectual modification, and social service. There was absolutely nothing available concerning an empirically developed disability awareness training program for the specific social services associated with a parish congregation. There did not exist an empirically developed awareness training seminar on the reality of the disability condition

and social attitudes, to which Seventh-day Adventist congregation members could be directed to, or personally referred to, for help and assistance in this area of acceptance and inclusion of the disability condition. This lack led to the conclusion of need and the empirical development of such a product: The D.A.R.T. Seminar-- Building Community One Difference at a Time.

Step 2: Instructional Specifications

Throughout a process series of 16, 1-to-2 hour, interactive, university-based and community-based, presentation/discussion sessions, a set of 20 behavioral objectives was formulated and then stated in measurable terms. These 20 behavioral objectives were interactively developed in joint response to unanimously expressed, personally and socially felt needs and represented the most asked questions concerning disability.

The minimum acceptable level of performance for the learner's response was set at an 80/80 level; that is, when 80% of the learners present mastered at least 80% of the criteria presented on each objective, it would be considered that mastery had been accomplished.

Positive affect promoted the mastery of the behavioral objective (Baker & Schutz, 1971). To accomplish this task, seven specific comfort and promotional strategies were attempted, adapted, and modified, then adopted and

implemented into the presentational completion of the development of the product.

Step 3: Item Tryout

A cognitive pre- and post-test instrument (Appendix A) and specific criteria for evaluating mastery (Appendix B) were designed through the same 16 interactive, university and community discussion/presentation sessions that communally developed the 20 behavioral objectives. The criteria for the questions were based on the specifically stated behavioral objectives and the information obtained from the review of literature, personal interviews, and counseling sessions involving realistic acceptance of a disability condition. To ensure that some of the higher levels of cognition would be included, the evaluation instrument was designed in accordance with Bloom's Taxonomy of learning and included all six categories.

The criteria for eight of the questions (1, 2, 3, 5, 7, 8, 19, 20) were based on knowledge, ranging from a level of 1.10 (knowledge of specifics) to a 1.24 (knowledge of the criteria by which facts, principles, opinions, and conduct are tested and judged). Five of the questions (4, 6, 9, 10, 11) were based on a 2.20 (interpretation) comprehension level. Question 12 was based on the application at the 3.00 level (the use of abstractions in particular and concrete situations). Questions 13, 16, and 18 were based on analyses ranging in level from 4.20 (analysis of

relationships) to 4.30 (analysis of organizational principles). Question 14 was based on synthesis at the 5.00 level (putting together of elements and parts so as to form a whole). The last two questions (15 and 17) were based on evaluation at the 6.10 (judgments in terms of internal evidence) and the 6.20 level (judgments in terms of external evidence).

To measure the learner's modification of affect, a 20-item Likert-type instrument (Oppenheim, 1966) was designed. The 20 items were developed through the integration of the understanding gleaned from the review of literature on disability awareness training and personal attitudes toward disability associated with the questions, answers, responses, reactions, and shared feelings of the above-mentioned 16 presentation and discussion sessions dealing with personal and social awareness and the disability condition (see Appendix F).

Step 4: Product Development

Based on the 20 behavioral objectives and the pre- and post-test criteria, the outline for The D.A.R.T. Seminar--Building Community One Difference at a Time was organized into six stages. Stage 1 was entitled "Taking the Pre-Test Inventory" and was designed to be incorporated into the instructional information as an integral part of the established curriculum. Included under this heading were three items: a personal information sheet (for the purposes

of identification), the affective Likert-type exam, and the cognitive-educational exam. These materials, with the appropriate instructions, were to be dispersed to each seminar participant prior to being exposed to the instructional material in the seminar.

Stage 2 was the establishment of the beginning of the educational instruction. This was entitled "Section One--Understanding the Disability Condition." This section was subdivided into the following four learning components: (1) Defining Disability, (2) Understanding the Disabling Life Occurrences, (3) Becoming Aware of the Types of Disability, and (4) General Awareness of the Disability Conditions. These four areas of learning were formulated based on the behavioral objectives 1 through 4 respectively, and the criteria-based test instrument.

Stage 3 was the establishment of the beginning of the in-depth social awareness section. It was entitled "Section Two--General Sociological Issues Associated With the Disability Condition." This section was subdivided into seven separate subheadings. Each of these headings is an educational entity unto itself, yet arranged in a progressive manner, where each point builds a learner's awareness for the upcoming insight.

The social awareness subheadings of Stage 3 are as follows: (1) The Social Evaluation Point, (2) The Social Evaluation Process, (3) Disability and the Two-

Characteristic Effect Upon Society, (4) Disability and
Society's Double Action Response, (5) Disability and Non-
Acceptance, (6) Disability and Social Dis-Integration, (7)
Disability and Social Deviance. Subheading 1 was
established based on behavioral objective 5 and the
criteria-based test instrument. Subheading 2, dealing with
belief systems and social expectations was based on
behavioral objective 6 and its criteria. Behavioral
objective 7 and its criteria provided the necessary insight
for designing and producing subheading 3, dealing with the
persuasive and stigmatizing effects of the disability
condition upon society at large. Subheading 4, Disability
and Society's Double-Action Response, was established based
on the concepts derived from behavioral objective 8 and its
criteria. Behavioral objective 9 and its criteria provided
the spark and guidelines for creation of subheading 5, which
dealt with the social non-acceptance of the disability
condition. The sixth subheading, dealing with the
disability condition and social dis-integration, derived its
present formation from behavioral objective 10 and its
criteria. The final subheading of step 3, dealing
historically with the disability condition and social
deviance, was established based on behavioral objective 11
and its criteria.

Stage 4, entitled "Section Three--Origin of Attitudes
Toward the Disability Condition," was subdivided into four

stages. The first-stage subheading, (1) Aversive Behavior in Children Toward the Disability Condition, was completely formed and produced from behavioral objective 12 and its measuring criteria. The second subheading, (2) Conceptualizing the Disability Condition Through Stereotyped Images, was developed through behavioral objective 13 and its criteria. The third subheading, (3) Disability and Attitude-Enhancing Experiences, was created by behavioral objective 14 and its accompanying criteria. The fourth and final subheading in this section, (4) Disability and Social Acceptance Patterns, was formulated based on behavioral objective 15 and its criteria.

Stage 5 was entitled "Section Four--Responsiveness Toward the Disability Condition." This step was subdivided into five subheadings that represented five basic needs: (1) Disability Myth Rebuttal, (2) Personal and Social Awareness When Speaking to or About a Person With a Disability, (3) Disability vs. Handicap, The Big Difference, (4) Actions of Realistic Acceptance of the Disability Condition, and the final subheading, (5) Becoming Aware of General Disability Etiquette. These final five needs were formulated based on behavioral objectives 16, 17, 18, 19, and 20 respectively and their criteria.

Stage 6 was entitled "Taking the Post-Training Examination," and was the final step in the product-development outline. Because this educational product, The

D.A.R.T. Seminar--Building Community One Difference at a Time, was a program designed for Seventh-day Adventist church members living, working, and serving in a community setting and not specifically for administration in an academic school setting, such academic practices as listening for and writing an actual exam might be a practice long forgotten or happily denied. To aid in preparation for taking the final cognitive post-test, then, special provision was made to provide each seminar participant opportunity to practice the test-taking art by engaging in a mini-practice exam after the completion of each step or stage in the outline that was similar in form and comparable in content to the criteria-based final exam, only much shorter and covering only that finished step or section. The taking of each mini-practice exam (four in number, one after each section) was part of the incorporated curriculum as was the obtaining of instant feedback of the correct response. Because enjoyment always enhances learning and thus hopefully mastery of the presented material, special effort was made to promote each participant's interest in the educational product by incorporating humor with real life experience as well as tactful, open sharing and group involvement through interactive discussions.

Step 5:   Product Tryout

This instructional product in an advanced outline form, as a result of a developmental process of 16 shared 1-to-2 hour presentations, was now becoming ready for presentation and tryout, this as a result of constant development, perception of responsive reactions, and continual revision of curriculum, presentation, and testing instruments. The first two presentations, over a year earlier, were 1 hour each and held in the Pastoral Counseling class in the Seventh-day Adventist Theological Seminary, with 19 students. These first two sessions, accompanied by helpful feedback and personal responses and shared reactions, were instrumental in the beginning development of the behavioral objectives 1-4 and 18-20 and the criteria dealing with the disability condition and practical responsiveness to this condition. It was in this theological, academic setting that I first answered completely my personal questions about product need in the church congregation community education program, as well as understanding the necessity of a testing instrument that was a practical extension of life in a congregation that is interested in serving its surrounding community.

The next two developmental sessions were again held in the same theological seminary, this time in the Pastoral Psychology class, with 23 students. This session was instrumental in the beginning development of behavioral

objectives 7-12 and 14, 15, and 16 and the criteria dealing with sociology, attitudes, and personal evaluation.

Through much revision and continual development of the disability theme in relation to community service and a more educated perception of a church congregation's felt needs, a more extensively developed outline of presentations was presented to the community at the South Haven Memorial Library, in the resort town of South Haven, Michigan. Eleven 2-hour presentations were presented, discussed, and pre- and post-tested, with an average nightly attendance of 24 people. These 11 sessions with the tests and responses provided the insight and awareness for the foundational building blocks of the progressively developing educational curriculum, and the modification of affect measuring tool as well as the beginning aspects of behavioral objectives 5-16, the social impact (effect and action) of disability on society, and social attitudes concerning the disability condition as well as acting instrumentally in the continual formation of the cognitive testing instrument.

The final presentation/discussion in the development of the outline was given to a group of 10 social service professionals in the field of geriatric health care and health maintenance at the El Zora Community Living Center and Rehabilitation Facility located in Milton-Freewater, Oregon.

This presentation/discussion was a 50-minute, in-service educational session on the disability condition and general awareness of personal and social responsiveness toward this condition. This session, although brief in time, was an exercise in the continued formulation of the behavioral objectives 5, 6, 7, and 8 and their criteria, dealing with social evaluation of perceived difference and social response to effects and actions.

Through these 16 interactive presentations/discussions and all the feedback, reactions, responses, shared needs and experiences, coupled with the continual review of disability awareness literature, the 20 behavioral objectives making up the 20-point process of awareness training (D.A.R.T.) was becoming more defined and practical. The cognitive and affectual testing instruments, in association with a criteria in continual development, were beginning to take the form and shape of an outline ready for a product tryout.

Group of 13

This instructional product, now in an advanced outline form, was presented to a group of 13 professional community service caregivers, all members of local church congregations; 10 individuals (77%) were Seventh-day Adventists and 3 individuals (23%) attended other local church congregations. This seminar was presented as an afternoon continuing education, in-service program sponsored by the Social Work Department of Walla Walla College in

Walla Walla, Washington. The group consisted of 13 individuals: 2 office managers from the Department of Social Work on the college campus, 2 state facilitators from the City Department of Disability Services, 1 retired registered nurse (R.N.), 1 retired minister in mission consulting services for the Washington Conference of the Seventh-day Adventist Church, 1 director of nursing education at Walla Walla College, 1 retired cardiac surgeon and medical consultant, 1 chief executive officer (C.E.O.) of The Shipley Foundation of Southern California and executive finance committee board member of Loma Linda University, 1 professor of Human Development and family therapist, 1 director of the Equal Opportunity Employment Department of the U.S. Army Corps of Engineers in Washington State, 1 medical director (D.O.) for an Oregon-based convalescent and retirement center, 1 professor of Social Work and director of graduate studies at Walla Walla College, and 1 geriatric social worker from an Oregon-based rehabilitation facility. The time spent sharing and learning with this group marked the first "official" presentation of this curriculum. These 13 individuals represented a total of over 200 years of experience in community social service of assisting the human condition. Each of the participants received the seminar information in its advanced outline form, and all were very active in

providing the feedback and reactions necessary for the developmental process to continue.

These 13 professional members of a community and in service to a community represented in part the desired population chosen for this study. They represented a cross-section of professional services and educations, and possessed a vast collection of experience in community service to their fellowman. Each one of these participants also demonstrated a large amount of courage coupled with a strong desire to learn and become more sensitive to disability issues, for this specific seminar was forced to move to another, less advantageous location for learning, due to a bomb threat in the very room and at the very time of the originally-scheduled seminar. The room that was finally discovered and settled upon was smaller, darker, innocent of tables, desks, and chalk or writing boards, and lacked any "academic feeling." I wonder how much the "settled upon" atmosphere of the seminar room and the possible, pending explosion of the bomb threat affected the learning, sharing, discussing, and feeling of the presented curriculum.

However, every facet of the program was presented to this group, from the developed curriculum with all 20 developed behavioral objectives to the cognitive and affectual pre- and post-test exams. I made a special effort to be sensitive to any questions, comments, explanations,

suggestions, and needs that were expressed in the hope of learning more effective ways to improve the general comprehension of the curriculum to further general awareness of the disability condition and continue to build community through the enhancement of attitudes.

One initial reaction to the pre-test was that it scared the learners and made them feel they knew very little. Part of the curriculum, then, must be to instructionally soothe each seminar participant by explaining the purpose of the pre-test--that being only to test the curriculum and gauge the specific awareness on the subject, thus creating the need for continual learning. The curriculum should point out that one can never become too aware or learn too much about other people and the human condition; therefore, one need not be afraid of the pre-test, but rather embrace the adventure of learning and becoming more aware.

The questions on the cognitive pre- and post-tests were of such construction that guessing (except on question 12, behavioral objective 12, the age-related acceptance sequence, matching exercise) would be a difficult task without having experienced the seminar. The need for becoming aware of this disability condition material in such a way as to personally respond to the cognitive pre-test questions in a reasonable fashion was evident from the 13 scores of zero on the pre-test exam. From the group feedback, the 13 scores of zero represented a strong desire

on the part of each participant to learn new material and become more aware of the human condition by way of the disability condition through direct exposure to this seminar. The score of zero in this group setting was their expressed desire to forfeit a guess and concentrate on the correct answer in order to learn and become more aware. Therefore, the set required level of proposed mastery (80/80) was not attained on any of the 20 behavioral objectives (see Tables 1 and 2).

After the D.A.R.T. Seminar was presented and properly discussed, the post-test exam was given and the results were attained. Mastery (80/80) was attained on two of the presented objectives, behavioral objective 12, dealing with aversive behavior toward disability. The percentage of 92 of the group of 13 (12 learners) received a score of 90 or better concerning this objective. The other mastered objective was number 16, dealing with the rebuttal of disability myths. The percentage of 84 of the group of 13 (11 learners) received a score of 80 or better. This was very encouraging. The required level of mastery was not obtained on objectives 1-11, 13, 14, 15, 17, 18, 19, and 20. These objectives dealt with the basic understanding of the disability condition, social evaluation process, reasons for non-acceptance of the disability conditions, attitude enhancing experiences, social acceptance patterns in young children, proper ways to interact with a person with a

TABLE 1

COGNITIVE PRE- AND POST-TEST RESULTS OF 13 PARTICIPANTS' LEVELS OF ACHIEVEMENT (ROUNDED)

OBJECTIVES SUBJECTS		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	MEAN (SUBJECT)
1	POST	0	75	25	0	0	0	100	0	33	0	0	100	80	0	0	100	0	33	0	80	31
	PRE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2	POST	0	100	25	100	0	0	0	0	33	0	33	0	33	0	33	100	0	0	0	0	26
	PRE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
3	POST	0	75	75	100	100	33	100	100	0	0	33	100	0	33	0	100	0	33	0	40	56
	PRE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
4	POST	100	100	75	100	100	100	100	0	33	100	0	100	100	33	0	100	25	0	0	80	64
	PRE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
5	POST	100	100	25	100	100	100	100	100	0	25	100	100	100	0	25	100	0	100	25	80	68
	PRE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6	POST	100	100	25	100	100	100	100	100	33	0	0	100	100	0	0	100	0	66	0	80	64
	PRE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
7	POST	100	75	50	100	100	100	0	0	0	0	0	100	0	0	25	75	0	0	0	60	26
	PRE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
8	POST	100	75	0	0	100	0	100	0	0	0	0	100	0	0	0	0	0	0	0	0	26
	PRE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
9	POST	100	75	0	50	100	33	100	0	0	100	100	100	66	66	25	100	80	100	75	0	65
	PRE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
10	POST	100	100	0	100	100	25	0	25	0	0	0	80	100	0	25	100	25	66	0	0	32
	PRE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
11	POST	100	100	100	100	100	0	100	100	0	0	100	100	50	0	50	100	33	66	25	80	68
	PRE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
12	POST	0	50	25	50	100	33	100	0	0	50	0	100	33	33	25	100	0	0	0	0	35
	PRE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
13	POST	100	50	50	100	100	100	100	100	66	100	33	100	33	33	25	100	25	100	75	40	68
	PRE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MEAN (OBJECTIVE)		69	88	36	77	69	38	69	46	15	29	31	91	51	20	12	98	14	43	15	43	

TABLE 2

COGNITIVE PRE-TEST RESULTS OF 13 PARTICIPANTS'
LEVELS OF ACHIEVEMENT
(ROUNDED)

Objective Number	% 0–19	% 20–39	% 40–59	% 60–79	% 80–100
1	100	0	0	0	0
2	100	0	0	0	0
3	100	0	0	0	0
4	100	0	0	0	0
5	100	0	0	0	0
6	100	0	0	0	0
7	100	0	0	0	0
8	100	0	0	0	0
9	100	0	0	0	0
10	100	0	0	0	0
11	100	0	0	0	0
12	100	0	0	0	0
13	100	0	0	0	0
14	100	0	0	0	0
15	100	0	0	0	0
16	100	0	0	0	0
17	100	0	0	0	0
18	100	0	0	0	0
19	100	0	0	0	0
20	100	0	0	0	0

disability condition, methods of realistic acceptance, and disability etiquette, respectively.

Table 3 presents the collected data of the seminar in the group of 13 during the cognitive post-test exam (Table 1 shows the results of the collected data of this group's cognitive pre- and post-test exams). Table 3 is in an organized, easy-to-read layout form that shows what percentage of the group of 13 participants learned what percentage of the material in that specific, presented objective. For example, concerning objective 1, 31% of the 13 learners received a score of 0-19%, while 69% of the learners received a mastery score of 80-100% on that same first objective. For another example from Table 3, the most difficult objective to master in the curriculum seemed to be objective 19, where 69% of the 13 learners received a score of 0-19. Only 15% of the learners received a score from 20-39%, and 15% received a score from 60-79%, while 0%, none of the 13 learners, received a score from 40-59%, or mastery at 80-100%. Beside the two mastered objectives, 12 and 15, objectives 1, 4, 5, 7 were nearly mastered with 69% of the 13 learners receiving a score of 80-100%.

Objectives 9, 15, and 19 were seemingly the three most difficult to master, with objective 19 causing the most confusion. On each of these objectives, 0% of the 13 learners scored in the 80-100% range, while 61% of the learners scored 0-19% on objectives 9 and 15 and, as

TABLE 3

COGNITIVE POST-TEST RESULTS OF 13 PARTICIPANTS' LEVELS OF ACHIEVEMENT (ROUNDED)

Objective Number	% 0-19	% 20-39	% 40-59	% 60-79	% 80-100
1	31	0	0	0	69
2	0	0	8	31	61
3	23	38	15	15	8
4	15	0	15	0	69
5	31	0	0	0	69
6	46	23	0	0	31
7	31	0	0	0	69
8	54	0	0	0	46
9	61	31	0	8	0
10	61	8	8	0	23
11	54	23	0	0	23
12	8	0	0	0	92
13	31	15	8	8	38
14	61	23	0	8	8
15	61	31	8	0	0
16	8	0	0	8	84
17	61	31	0	0	8
18	38	15	0	23	23
19	69	15	0	15	0
20	31	0	23	15	30

mentioned earlier, 69 percent of the learners scored in the 0-19 percentage range for objective 19. As a result of this painful, yet necessary and extremely helpful process of data analysis, I simplified, streamlined, and focused the criteria for all of the objectives with special emphasis on the presented material of these three objectives.

Based on an analysis of each objective and its criteria and the feedback and reactions obtained from this group, it became apparent that the particular problem areas failed because of ambiguous statements and unclear explanations, insufficient practice opportunities for the learner, too brief a time allocation for too much covered material (too much, too fast), and a decline of necessary learner's attention due to fatigue. Appropriate modifications and necessary revisions were made to correct these weaknesses.

The ambiguous statements were made more clear by covering the exact points that were to be tested, speaking about the extra research only after the primary points were understood. The presentation was made more focused and precise in order to magnify exactly what was required to understand for the purpose of becoming aware and sensitive to the addressed topic. Proper practice time and exercises were devised and implemented to give more direct focus to each learner, which would also address the need for more time to understand fewer yet more carefully presented points. The presentation of these now proven, difficult

objective points was now a more sensitive issue of increased awareness. And finally, brief and more frequent breaks were introduced in more strategic places in the seminar in order to reduce the participants' natural fatigue and keep a more focused interest on the task at hand.

This first "official" presentation of the D.A.R.T. Seminar at Walla Walla College was a success, not in terms of cognitive mastery, but in terms of data collection showing the need for learning on this topic and awareness concerning this sensitive social issue as well as the need for a general social attitude awareness and enhancement. I was able to pinpoint strategic areas within the curriculum presentation, the post-test exam, and the criteria base, needy of extra focus, clarity, and concentration and also realize anew the personal nature of the disability condition and how much it affects all of us living together in a community and in a common society.

The main intent behind the effort and concentration on the cognitive presentation of the curriculum and the following cognitive pre- and post-test exams is the focus on affectual modification and the belief that cognitive knowledge elicits an awareness that can be instrumental in the facilitation of enhanced attitudes. My goal was ultimately to positively enhance attitudes concerning the disability condition through educated cognitive awareness.

Modification of Affect--Group of 13

This same group also participated in the pre- and post-test affectual modification exams. Out of the 13 seminar participants, only 11 were able to complete the affectual modification exam at the end of the seminar due to time restraints and prior engagements.

The modification of affect for this group of 13, with only 11 taking the pre- and post-test affect exam, was determined by a t-test comparing the pre- and post-test scores of the affectual instrument (see Appendix F). The attained t score value of this first group of 11 individuals was 3.48, which was significant at the .05 level. The difference between the post- and pre-test scores was 8.45%, indicating a small modification of affect. Table 4 shows the scores of the pre- and post-test exams and their differences.

Group of 28

Another D.A.R.T. Seminar in its complete form was presented and discussed, this time at the West Covina Hills Seventh-day Adventist Church in southern California. This particular presentation was shared with 28 congregation members after a potluck supper, in an airy, large, well-lighted and air-conditioned room, with long tables to write on and take notes. This interactive presentation of the D.A.R.T. Seminar tested, as far as data collection, only modification of affect. I wanted to experience a

TABLE 4

AFFECTIVE TEST SCORES OF 11 PARTICIPANTS

SUBJECTS	Pre-Test	Post-Test	Post-Test Pre-Test Difference
1	75	77	2
2	67	79	12
3	64	77	13
4	53	79	26
5	88	89	1
6	71	78	7
7	74	77	3
8	74	88	14
9	81	79	-2
10	77	81	4
11	56	69	13
Mean	70.91	79.36	8.45*

* $p = .006$.

concentrated focus on the attitudes and awareness of attitudes among each of the congregation members, so only the pre- and post-test exam of the affectual modification instrument was used.

Every facet of the curriculum was presented to this church.

Modification of Affect--Group of 28

The modification of affect for this group of 28 was determined by a $\underline{t}$-test comparing the pre- and post-test scores of the affective instrument given to each participant at the beginning and conclusion of the seminar. Table 5 shows these scores and their differences. The attained $\underline{t}$-score value for this group of 28 participants was 5.92, which was significant at the .05 level. The difference between the post- and pre-test scores was 6.61%, indicating a slight modification of affect.

The learners in this group seemed motivated to vocally participate in the D.A.R.T. Seminar and learn and share all they could with each other through lengthy interactive discussions. It is hypothesized that the presented enthusiasm for more community awareness and a realized method of building that community was a contributing factor for the group's significant modification of affect. I congratulated the group for their help in making the seminar a success and extended my appreciation to each one for methodically going through the entire curriculum with such

TABLE 5

AFFECTIVE TEST SCORES OF 28 PARTICIPANTS

SUBJECTS	Pre-Test	Post-Test	Post-Test Pre-Test Difference
1	88	88	0
2	75	85	10
3	74	72	-2
4	74	83	9
5	79	84	5
6	80	89	9
7	75	88	13
8	78	87	9
9	85	85	0
10	76	79	3
11	70	78	8
12	72	76	4
13	74	69	-5
14	61	72	11
15	64	69	5
16	69	78	9
17	56	76	20
18	68	77	9
19	77	75	2
20	59	67	8

Table 5--Continued.

SUBJECTS	Pre-Test	Post-Test	Difference
21	72	78	6
22	74	82	8
23	64	68	4
24	80	90	10
25	69	75	6
26	52	72	20
27	79	88	9
28	75	74	-1
Mean	72.11	78.71	*6.61

*p = .000.

enthusiasm and shared insight. This group of 28 learners was then eliminated from the sampling of the target population.

Throughout the entire developmental process, every effort was made to be sensitive, open, and flexible to the task of product formation. During the process of the first 16 presentations in Michigan and Oregon, as well as during the first complete, "official" seminar presentation in Washington state, at Walla Walla College, and then again in West Covina Hills Seventh-day Adventist Church in Los Angeles, California, every conscious effort was made to prepare the materials for duplicate learning experiences by others in the future.

After the appropriate changes were made in the presentation format and the simplification and clarification of the developed criteria and all 20 behavioral objectives were complete, emphasis was placed on completing the instructor's manual curriculum and the developmentally realized, all-important participant's learning workbook or learner's manual.

The learner's workbook or participant's manual was developed into an integral part of the curriculum through the continual process of the first 18 presentations. After each of the first 16 sessions presented to different populations, the presentation of the seminar was more closely focused and linked with more simple clarity to each

of the 20 developed behavioral objectives. More emphasis
was placed on the simplification and explanation of only the
necessary points of awareness that would enhance a general
sensitivity to the subject matter as well as more
efficiently prepare the learner for the post-test
instructional exam. This focusing and simplification
formation was attempted through the addition of visual aids
as both learner's workbook inserts and presentational
curriculum transparencies, both used in conjunction with the
presented behavioral objectives. These learner's workbook
inserts were designed to connect the presented concept of
the disability condition to the reality of life as we all
live it together in a community setting. From the feedback,
responses, and questions received from the different
participants after each seminar, it appears that the visual
effect, from both the insert and the identical matching
overhead transparencies, in magnification of the auditory
presentation, was a successful aid in the understanding,
remembering, and learning of the concepts presented through
each behavioral objective. The inserts proved to add a
sense of reality to the presented objectives.

Introductory comments and instructions, learning
activities, practice exams, and review sheets were completed
and strategically inserted in each unit of the instructional
materials. Each workbook contained a learning review, a
sort of mini-exam and combination review sheet that provided

the participant the opportunity to practice and discuss the presented concepts after the completion of each unit, in preparation for the final post-instructional exam. The questions asked in these mini-tests (4 in number, 1 per learning unit) were similar in form and content to the questions asked in the final post-instructional instrument. With the illustrated visual aids strategically located in association with certain objectives proven to be difficult to understand and the single mini-tests and review sheets located after each divided unit in preparation for the post-instruction final test, and each behavioral objective in prepared sequence, the learner's workbook seemed fully prepared for the next D.A.R.T. Seminar.

The allocation of time for each of the six stages of Step 4: Product Development (4 learning units, 2 testing units) of interactive instruction in the D.A.R.T. Seminar was based on the importance of that section as it related to the other units as a whole in the awareness experience. Following the complete assembly of each unit into a formulated learning program, the developed materials were delivered to the services of Andrews University Lithotech Printing Works to be copied and bound with a plastic spine. The product of instruction, complete with teacher's curriculum manual and participant's learning workbook and testing instruments, both cognitive and affective, now appeared ready to be presented as a whole to a larger group.

Step 6: Product Revision

With the experience, knowledge, corrective feedback, and continual reality-based revisions of the 16 developmental traits of the D.A.R.T. Seminar community service curriculum in Michigan and Oregon incorporated within the two complete, full presentations of the seminar in Washington and California, the D.A.R.T. Seminar was fully prepared to be presented to a statistically significant number of participants in a church congregational setting.

Arrangements were made through the Seventh-day Adventist Theological Seminary of Andrews University, Department of Intern Education, to become involved with the Felt-Need, Community Outreach Program through the Intern Services of the Chikaming Seventh-day Adventist Church in Sawyer, Michigan. A community seminar was planned for the Sabbath afternoon of November 11, 1995, through the acting pastor and one church intern from the Seminary. The D.A.R.T. Seminar at this time was planned as an in-service congregational education as well as a sponsored community outreach program designed to better acquaint the community with the Chikaming Church and together become more aware and accepting of each other's diversity and more sensitive to the complexity of disabling conditions in the shared lives of each community member.

Group of 17

A complete trial presentation of the newly revised D.A.R.T. Seminar--Building Community One Difference at a Time community curriculum was conducted under replicable conditions with a group of 21 individuals from the desired population pool. This group of 21 individuals consisted of local Chikaming church members and assigned pastoral interns, as well as friends of local members from other surrounding churches.

Because of afternoon conflicts, church and family duties, and cold, snowy, wintery weather, only 17 out of the attending 21 Chikaming Church members actually participated completely in the D.A.R.T. Seminar presentation. These 17 participants were tested both cognitively and affectually during the course of the seminar.

On the cognitive pre-test instructional inventory, the scores on all 20 behavioral objectives fell below the pre-stated (80/80) level of mastery. On each of the 20 behavioral objectives, all 17 attending participants scored 0% (see Tables 6 and 7).

On the cognitive post-test instructional inventory, the scores showed an encouraging increase from all 17 attending participants. The range of achieved scores, in comparison to the pre-test scores (0%), showed a significant increase with 12 of the attending 17 participants (71%) reaching the mastery level of 80% or more on the overall seminar of 20

TABLE 6

COGNITIVE PRE- AND POST-TEST RESULTS OF 17 PARTICIPANTS' LEVELS OF ACHIEVEMENT (ROUNDED)

OBJECTIVES	SUBJECTS	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	MEAN (SUBJECT)
1	POST	100	100	60	100	100	100	100	100	100	100	100	67	57	100	100	100	33	100	100	100	91
	PRE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2	POST	100	100	100	100	100	100	100	100	100	100	33	100	43	100	100	100	67	100	100	100	92
	PRE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
3	POST	100	100	100	100	100	100	100	100	100	100	100	67	100	100	37	100	0	100	100	100	90
	PRE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
4	POST	100	100	100	100	100	100	100	50	100	100	100	67	100	100	100	100	67	100	100	100	93
	PRE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
5	POST	100	100	100	100	100	100	100	100	100	100	67	67	100	50	60	100	67	100	100	100	92
	PRE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6	POST	100	100	100	100	100	100	100	100	100	0	67	100	100	100	50	100	50	50	100	100	81
	PRE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
7	POST	100	100	100	100	100	100	100	100	33	100	100	67	57	75	50	100	33	75	100	55	69
	PRE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
8	POST	100	100	100	100	100	100	100	100	100	0	0	67	43	100	50	100	16	100	100	44	67
	PRE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
9	POST	100	100	0	100	100	0	100	100	0	0	0	67	100	0	37	100	16	25	100	0	45
	PRE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
10	POST	100	100	100	100	100	100	100	100	100	100	100	33	100	100	100	100	67	100	100	100	85
	PRE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
11	POST	100	100	100	100	100	100	100	100	100	0	0	67	43	100	0	100	0	0	100	0	33
	PRE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
12	POST	100	100	100	100	100	100	100	100	100	100	100	67	100	100	100	100	67	100	100	100	91
	PRE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
13	POST	100	100	100	100	100	100	100	100	100	100	100	100	57	100	100	100	67	100	100	100	96
	PRE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
14	POST	100	100	40	100	100	0	100	0	0	0	0	100	100	100	37	100	67	100	100	55	65
	PRE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Table 6--Continued.

OBJECTIVES		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	MEAN (SUBJECT)
SUBJECTS																						
15	POST	100	100	100	100	100	100	100	100	100	100	100	71	28	100	12	100	67	100	100	100	84
	PRE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
16	POST	100	100	100	100	100	100	100	100	100	100	100	67	57	100	0	100	33	100	100	100	85
	PRE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
17	POST	100	100	40	100	100	100	100	100	33	33	100	100	100	100	0	100	50	50	100	100	80
	PRE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MEAN (OBJECTIVE)		100	100	74	94	83	88	100	82	62	61	67	71	81	82	54	100	43	82	82	80	

TABLE 7

COGNITIVE PRE-TEST RESULTS OF 17 PARTICIPANTS' LEVELS OF ACHIEVEMENT (ROUNDED)

Objective Number	% 0–19	% 20–39	% 40–59	% 60–79	% 80–100
1	100	0	0	0	0
2	100	0	0	0	0
3	100	0	0	0	0
4	100	0	0	0	0
5	100	0	0	0	0
6	100	0	0	0	0
7	100	0	0	0	0
8	100	0	0	0	0
9	100	0	0	0	0
10	100	0	0	0	0
11	100	0	0	0	0
12	100	0	0	0	0
13	100	0	0	0	0
14	100	0	0	0	0
15	100	0	0	0	0
16	100	0	0	0	0
17	100	0	0	0	0
18	100	0	0	0	0
19	100	0	0	0	0
20	100	0	0	0	0

objectives as a mean whole. All 17 participants scored 100%
on objectives 1, 2, 7, and 16 with 4 additional participants
reaching mastery, 80% or more, on objectives 4, 5, 6, and
19, with scores of 94%, 82%, 88%, and 82% respectively.
Four more participants scored highly, almost reaching
mastery on objectives 8, 14, 18, and 20, with respective
scores of 76%, 71%, 71%, and 71%. No participant of this
particular seminar reached mastery on each and every
objective (see Table 8).

With a minimum standard of 80% of the participants
achieving at least 80% mastery on each objective, at least
14 participants (.80 x 17 = 14) needed to score 80% or
higher on each objective to achieve mastery and complete
empirical development of this curriculum. On 12 of the
objectives (3, 8, 9, 10, 11, 12, 13, 14, 15, 17, 18, and 20)
however, the participants did not reach this standard.
Thus, the revised edition of the D.A.R.T. Seminar was
considered unsatisfactory and in need of more empirical
development at this point.

Modification of Affect--Group of 17

This group of 17 also participated in the modification
of affect exercise. Each of the 17 participants was given
the modification of affect testing instrument upon entering
the room prior to the presented seminar. Each participant
filled out the test instrument, and those 17 instruments
were collected. The D.A.R.T. Seminar was presented in full

TABLE 8

COGNITIVE POST-TEST RESULTS OF 17 PARTICIPANTS'
LEVELS OF ACHIEVEMENT
(ROUNDED)

Objective Number	% 0–19	% 20–39	% 40–59	% 60–79	% 80–100
1	0	0	0	0	100
2	0	0	0	0	100
3	12	6	12	6	65
4	6	0	0	0	94
5	18	0	0	0	82
6	12	0	0	0	88
7	0	0	0	0	100
8	12	0	12	0	76
9	35	6	0	0	59
10	35	6	0	0	59
11	24	12	0	6	59
12	0	6	0	76	18
13	6	0	41	0	53
14	12	0	6	12	71
15	24	24	12	6	35
16	0	0	0	0	100
17	24	30	0	47	0
18	6	6	12	6	71
19	18	0	0	0	82
20	12	0	18	0	71

with as much question-and-answer time as possible. The same modification of affect testing instrument was again given to each participant upon closing the presentation time together. The scores of each before-and-after testing instrument were then compared to measure any modification of affect.

Table 9 shows the pre-test scores, the post-test scores, and their differences. The attained t score value for this group of 17 individuals was 5.45, which was significant at the .05 level. The difference between the post- and pre-test scores was 15.35 percent, indicating a significant modification of affect.

I congratulated the group on a job well done and extended my sincerest gratitude for their participation. This group of 17 was then eliminated from the sampling of the target population.

Based on the feedback, responses, and suggestions obtained from this group of the Chikaming Church community, appropriate modifications were made concerning the correct, desired responses associated with the pre-formed criteria. It was noted that a community seminar cannot resemble a college subject course. The information presented would be lost in frustration and confusion over perceived attempts by the community members to take notes, comprehend, and respond correctly in a formal educational manner. It became apparent that formal learning, as in a classroom setting, is

TABLE 9

AFFECTIVE TEST SCORES OF 17 PARTICIPANTS

SUBJECTS	Pre-Test	Post-Test	Post-Test Pre-Test Difference
1	76	100	24
2	77	89	12
3	67	96	29
4	63	75	12
5	55	77	22
6	89	96	7
7	46	91	45
8	77	85	8
9	57	77	20
10	68	87	19
11	77	95	18
12	62	82	20
13	76	69	-7
14	88	95	7
15	56	70	14
16	78	84	6
17	81	86	5
Mean	70.17	85.53	15.35*

*$p = .000$.

not the present major experience of most community members. The need for additional activities and methods to enhance motivation and general opportunity for obtaining knowledge was realized. The importance of engaging the learners in active participation early in the presentations of the instructional materials became obvious.

The review of presented material must also be a constant activity in the role of the instructor. Coupled with plain and simple review sheets at the end of each presented learning unit, the answers and explanatory responses that meet the pre-planned criteria for each unit must be presented in a clear manner. The most important observation and realization that evolved from this particular presentation of the D.A.R.T. Seminar was that an overload of information presented is not as beneficial to the learning process as the direct teaching of what is required for successful completion of the seminar. Through the process of multiple seminar presentations at this point, I finally realized that to have the seminar participants walk away from the presentation with the 20-point process for a working knowledge and awareness of the disability condition secure in their minds, the certain points of awareness must be presented, innocent of any and all associated research findings. Just the points being tested are to be just the points presented, so they may become just the points learned.

Group of 20

Armed with this new experiential knowledge and specific realizations, another D.A.R.T. Seminar presentation was planned. A full seminar was incorporated into the fall quarter teaching schedule of the Andrews University Social Work program as a professional development seminar for class credit. The classes of EDS114 General Issues in Social Work and EDS231 Social Policies for Social Workers were the two classes that combined their sponsorship of the D.A.R.T. Seminar to create the offered presentation.

The date was set for early Sunday morning, December 3, 1995, in classroom 108 of the Andrews University School of Business. Lunch and class credit were provided. Room 108 was chosen for its comfort, large overhead projection screen and brightly lighted atmosphere. A total of 20 social work majors from both classes participated in the presentation.

The cognitive pre-test results of the 20 seminar participants fell below the pre-stated (80/80) level of mastery. The obtained overall scores on each objective ranged from 0-100%, with overall scores ranging from 3-48% (see Table 10). On one of the objectives (objective 2) 80% of the participants, 16 out of 20, scored 80% or above. This indicated that 80% of the participants were knowledgeable regarding the disabling life occurrences. On 19 objectives (1, 3, 4-20) no participant reached the mastery level. On objective 12, 75% of the participants, 15

TABLE 10

COGNITIVE PRE- AND POST-TEST RESULTS OF 20 PARTICIPANTS' LEVELS OF ACHIEVEMENT (ROUNDED)

OBJECTIVES SUBJECTS		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	MEAN (SUBJECT)
1	POST	100	100	100	100	100	33	100	100	67	100	33	100	100	100	37	100	100	100	100	100	88
	PRE	0	100	0	100	0	0	0	0	0	0	0	100	0	0	0	0	0	0	0	0	15
2	POST	100	100	100	100	100	100	100	100	100	100	22	100	57	100	0	100	100	100	100	100	84
	PRE	100	100	0	0	0	0	100	0	0	0	0	83	28	0	0	0	0	0	0	0	21
3	POST	80	100	80	100	100	100	100	75	100	22	100	100	100	100	100	100	50	100	100	100	80
	PRE	0	100	40	100	0	33	100	75	100	0	33	100	43	0	0	0	0	0	0	0	41
4	POST	90	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	67	100	75	78	90
	PRE	18	100	0	0	0	0	0	0	0	0	0	100	43	0	0	50	0	0	0	0	18
5	POST	84	100	60	60	0	100	100	50	100	100	100	100	100	63	63	100	0	100	0	56	84
	PRE	15	50	40	0	0	0	0	0	0	0	0	100	0	0	0	0	0	0	0	0	15
6	POST	84	100	100	100	100	100	100	63	100	100	100	100	85	87	100	100	100	100	100	100	84
	PRE	17	100	40	50	0	41	0	0	67	67	56	17	0	0	0	0	0	0	0	0	17
7	POST	92	100	100	100	100	67	100	100	100	100	100	100	100	100	100	100	83	100	75	89	92
	PRE	17	100	40	0	0	0	0	75	0	0	0	100	14	37	25	0	0	51	50	0	17
8	POST	97	100	60	100	100	67	100	63	100	100	78	100	57	50	50	75	50	75	25	67	97
	PRE	48	100	60	0	0	67	0	0	0	0	0	100	0	0	0	0	17	0	0	0	48
9	POST	84	100	80	100	100	100	100	100	100	100	100	100	86	100	0	100	50	0	50	78	84
	PRE	10	100	40	0	0	22	0	38	50	50	11	100	14	0	0	0	0	0	0	0	10
10	POST	85	100	60	100	100	67	100	100	100	100	100	100	100	100	88	100	67	75	100	100	85
	PRE	11	100	60	0	0	22	0	25	67	50	33	100	0	0	0	0	0	0	0	0	11
11	POST	74	100	80	100	100	67	100	50	83	87	100	100	100	100	38	100	100	100	100	100	74
	PRE	10	100	40	0	0	0	0	0	0	0	0	100	0	0	0	0	0	0	0	0	10
12	POST	80	100	60	100	100	100	100	100	100	100	100	100	100	100	100	100	67	100	50	100	80
	PRE	26	100	60	0	0	0	0	0	0	0	33	100	0	0	0	0	0	0	0	0	26
13	POST	96	100	80	100	100	100	100	100	100	100	100	100	100	100	88	100	100	100	100	100	96
	PRE	33	100	0	0	0	0	0	25	67	50	33	100	0	0	0	0	0	0	0	0	33
14	POST	80	100	60	100	100	100	100	50	83	87	100	100	100	100	38	100	100	50	50	56	80
	PRE	20	100	0	0	0	0	0	0	0	0	0	100	0	0	0	0	0	0	0	0	20

Table 10--Continued.

OBJECTIVES		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	MEAN (SUBJECT)
SUBJECTS																						
15	POST	100	100	80	100	100	100	0	12	33	100	67	100	43	0	0	100	33	0	0	44	53
	PRE	0	100	0	0	0	0	0	0	0	0	0	50	0	0	0	0	0	0	0	0	8
16	POST	100	100	100	100	100	100	100	100	100	100	100	83	43	50	100	100	83	100	100	100	93
	PRE	0	100	0	0	0	0	0	0	0	0	0	100	14	0	0	75	17	0	0	0	15
17	POST	100	100	20	100	0	67	100	88	50	0	67	100	100	25	25	100	33	50	50	0	59
	PRE	0	50	0	0	0	0	0	0	0	0	0	100	28	0	0	0	0	0	0	0	9
18	POST	100	100	100	100	100	67	0	100	0	33	0	33	43	25	0	100	50	50	50	0	38
	PRE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5
19	POST	100	100	100	100	100	33	0	50	75	100	33	100	100	100	38	100	67	100	100	100	80
	PRE	0	0	0	0	0	0	0	0	0	0	0	100	0	0	12	50	0	0	0	0	8
20	POST	100	100	100	0	100	44	100	75	50	100	100	100	71	50	100	100	100	100	100	100	80
	PRE	0	100	40	0	0	0	100	25	33	0	0	0	0	0	0	0	0	0	0	0	15
MEAN (OBJECTIVE)		85	100	87	91	85	85	85	79	83	79	73	76	77	58	52	98	68	78	78	77	

out of 20, reached a score of 80% or better, coming close to mastery. On objective 7, 40% of the participants, 8 out of 20, reached mastery. The majority of the participants' levels of achievement fell between the 0-19% range (see Table 11).

On the cognitive post-test scores, an extremely encouraging increase occurred. The range of achieved scores, in comparison to the pre-test scores (3-48%), showed a significant increase (38-97%). Twenty participants (the whole class) reached the 100% mastery level on objective 2. Nineteen participants reached the 95% mastery level on objectives 12 and 16. Seventeen participants reached the 85% mastery level on objectives 1, 4, 5, and 7, and 16 seminar participants reached the 80% mastery level on objective 3. Fifteen seminar participants (75%) scored in the mastery range of 80% or more on objective 10, narrowly missing the mastery level of 80/80. Sixteen out of the 20 participants scored 55-100% on each objective on their post-test, making the level of achievement at this point 80/55 (80% of the learners scoring 55% or more on each objective).

As it stands at this point in the development of the curriculum, 8 of the 20 participants (40%) scored 80% or better on each objective of their post-test (see Table 12). For mastery to occur regarding this curriculum, 16 of the 20 participants (80%) must have reached a final score of 80% or better. The participants did not reach this standard, thus

TABLE 11

COGNITIVE PRE-TEST RESULTS OF 20 PARTICIPANTS'
LEVELS OF ACHIEVEMENT
(ROUNDED)

Objective Number	% 0-19	% 20-39	% 40-59	% 60-79	% 80-100
1	86	0	0	0	14
2	10	0	10	0	80
3	65	0	20	10	5
4	70	0	5	0	25
5	95	0	0	0	5
6	85	10	5	0	0
7	60	0	0	0	40
8	75	15	0	10	0
9	75	5	5	10	5
10	85	5	5	5	0
11	85	10	5	0	0
12	20	0	5	0	75
13	85	10	5	0	0
14	95	5	0	0	0
15	95	5	0	0	0
16	80	0	10	5	5
17	95	5	0	0	0
18	95	0	5	0	0
19	95	0	5	0	0
20	95	5	0	0	0

TABLE 12

COGNITIVE POST-TEST RESULTS OF 20 PARTICIPANTS'
LEVELS OF ACHIEVEMENT
(ROUNDED)

Objective Number	% 0–19	% 20–39	% 40–59	% 60–79	% 80–100
1	15	0	0	0	85
2	0	0	0	0	100
3	0	5	0	15	80
4	10	0	0	5	85
5	15	0	0	0	85
6	0	10	5	15	70
7	15	0	0	0	85
8	5	0	20	20	55
9	5	5	10	10	70
10	10	15	0	0	75
11	10	15	5	15	55
12	0	5	0	0	95
13	0	0	35	10	55
14	15	20	20	5	40
15	25	25	10	0	35
16	0	0	0	5	95
17	5	10	20	25	40
18	10	0	20	10	60
19	10	5	25	10	50
20	10	0	15	20	55

this edition of the D.A.R.T. Seminar was deemed
unsatisfactory at this developmental point and another
seminar was planned.

Modification of Affect--Group of 20

This group of 20 participants from the Social Work
Department of Andrews University did partake of the
modification of affect instructional pre- and post-tests,
and although the cognitive aspect of the learning process
was deemed unsatisfactory as far as reaching a pre-planned
level of achievement was concerned, the modification of
affect was accomplished in a satisfactory manner.

The procedure for modification of affect was identical
to the previous ones in each seminar presentation. The
participants were given a pre-instruction modification of
affect test to fill out and hand in when completed. Then
the seminar was presented in its full form with both pre-
and post-cognitive tests as part of the curriculum. At the
end of the seminar presentation, the same post-instruction
modification of affect test was given to each attending
participant, then collected and compared to the first test
prior to the instruction. The scores of the pre-test and
the post-test and their differences can be found in Table
13.

The attained t score value of this group of 20
individuals was 5.96, which was significant at the .05
level. The difference between the post- and pre-test scores

TABLE 13

AFFECTIVE TEST SCORES OF 20 PARTICIPANTS

SUBJECTS	Pre-Test	Post-Test	Post-Test Pre-Test Difference
1	60	76	16
2	81	86	5
3	67	74	7
4	78	86	8
5	82	84	2
6	72	84	12
7	89	89	2
8	74	80	6
9	97	98	1
10	77	94	17
11	70	82	12
12	55	80	25
13	70	80	10
14	82	89	7
15	78	79	1
16	73	81	8
17	71	77	6
18	87	89	2
19	85	94	9
20	72	85	13
Mean	76.00	84.35	8.35*

*$p = .000$.

was 8.35 percent, indicating a small modification of affect for this group of 20 seminar participants. All participants were congratulated for their endurance and fine performance during the presentation, and sincere gratitude was extended to the group for their willingness to develop themselves personally and professionally through awareness and increased tolerance of others' differences. This group of 20 was then eliminated from the sampling of the target population.

The developmental process of the D.A.R.T. Seminar curriculum, as public service through awareness, continued in the organization of another presentation. This time a new format was implemented to increase the likelihood of an 80/80 mastery level during the entire presentation. The new format was implemented into the instructional inventory pre- and post-test instruments. The new format centered around the timing problems associated with the large amount of material presented in the seminar. Through the feedback and suggestions offered from the last seminar attendees, the presented materials were formulated into a more practical and workable format for learning the desired objectives.

The pre- and post-test instructional inventory, with no change to the questions themselves, was organized into a more simple, streamlined, and effective means of learning, simply by pre-testing the whole seminar group at one time, together and completely, involving all four learning units,

then post-testing the seminar participants immediately after each learning unit was discussed and fully presented. This simple procedure involved four separate post-test inventory situations, yet associated less information to learn into each test. The review sheets following each learning unit in the participant's manual were also revised to include each test question asked in that particular unit and the correct answers to each question based upon the pre-researched criteria for all 20 questions, which represent the 20 behavioral objectives forming the whole seminar composition.

This newly organized presentation of the D.A.R.T. Seminar was prepared to be given to the employees of Andrews University Adventist Information Ministries Department (A.I.M.) as well as to the Youth Sabbath School of the All Nations Church, as an afternoon Adventist youth program at the All Nations SDA Church in Berrien Springs, Michigan. It was planned for December 18 and 19, from 3:00 p.m. to 5:00 p.m. on both afternoons, and February 3 from 3:30 p.m. to 8:30 p.m. in the youth meeting room off the main sanctuary, which serves as the recreational community center after regular church service hours. This location was chosen for its light and airy atmosphere, its comfort and convenience, and its open environment conducive to listening, writing, responding, and learning. This setting would also serve as a familiar atmosphere of known comfort for this seminar

audience, innocent of outside distractions, for maximum presentation, learning, and modification of affect possibilities throughout the seminar experience.

The last group to attend the D.A.R.T. Seminar, the 20 social work majors of Andrews University, achieved a successful level of mastery on the overall test, or at least 80% or more on the 20 objectives as a whole, but not on each separate objective. This was encouraging and educational. The developmental process of empirical research associated with curriculum development continued throughout this entire project. From the feedback of the social work majors, Learning Unit II needed to be arranged differently with more strategic timeframe concerns. This was arranged simply by separating Learning Unit II into two separate presentations with two associated testing experiences matching each presentation. The first section of Learning Unit II was divided into a set of four objectives and four test questions. The second section of Learning Unit II included the last three objectives with associated test questions. With this new development, the practice and experience of the previous seminar presentations and a completed mastery of the 20 behavioral objectives on the testing inventories as a whole, this new arrangement of the D.A.R.T. Seminar at the All Nations Seventh-day Adventist Church was prepared for presentation.

Group of 30

For the next step in the process of instructional development, 30 participants completed the 5-hour D.A.R.T. Seminar--Building Community One Difference at a Time instruction at the All Nations Church. The participants of this particular seminar presentation included 11 employees of the Adventist Information Ministry at Andrews University, 2 adult All Nations Church youth division leaders, 2 adult Sabbath School teachers and deaconesses of the All Nations Church, 3 adult parents of children in the youth division of the church, and 12 young adults from the combined youth division classes. The seminar was conducted in the youth division classroom at the church around tables placed to give maximum room to write and take notes. A vespers service was presented at sundown in association with the young adults concerning the spiritual aspects of acceptance and awareness of others' differences. At the completion of the entire seminar, a meal of pizza, chips, and cold soda was served.

Preparation for the seminar began an hour before the actual presentation. The room was cleared from any distractions and tables and chairs were thoughtfully placed in a horseshoe-shape arrangement, giving the learners opportunity to see the presenter at all times during the presentation, as well as allowing ample room for each participant to have personal note-taking space for better

learning. The appropriate supplies, participant's manuals, pens and pencils, extra writing paper, instructor's manual, visual aids, and blackboard with chalk and erasers were brought in the room and set up for handout and ease of presentation and learning.

As the participants began to arrive, I made a conscious effort to welcome each one and thank them for their planned efforts in attending the awareness training seminar. Finally, all 30 of the seminar participants were greeted with an enthusiastic welcome. Following the explanation and intent of the seminar, all the materials for Stage 1, Taking the Pre-Training Inventory, were examined. Included in the material (which makes up the introduction in the participant's manual) was the personal information sheet, the affective pre-test, and the complete four-unit cognitive pre-test.

The affective pre-test was administered to all 30 participants to measure specific existing attitudes toward the disability condition. It was then collected and stored away for later analysis. Then the cognitive pre-test was administered to the group of 30 participants to determine if they had a mastery of the material to be presented. The results of this test, shown in Table 15, indicate that all 20 of the behavioral objectives fell far below the pre-stated standard (80/80) for mastery. Though the obtained scores ranged from 0-100% per objective, the mean scores

showed a need for learning in the field of disability awareness. This need translates into an unreached level of mastery. The level of achievement per participant for all 20 objectives ranged from 0-24%, indicating that all 30 participants fell below the level of mastery.

On six of the objectives (2, 3, 4, 5, 12, 16) a score of 80% or more was achieved. Forty-three percent of the participants reached the 80% or more level on objective 2, dealing with disabling life conditions, while 7% of the group reached this level on objective 3, dealing with the different types of disability conditions. Three percent of the group reached the 80% or more level on objective 4, dealing with explaining the disability conditions, while 3% again reached this level on objective 5, associated with the sociology of evaluation. Twenty percent of the 30 participants reached 80% or more on objective 12, dealing with aversive behavior in children toward the disability condition, and 13% of the group achieved this level on objective 16, dealing with the rebuttal of social myths and the origin of attitudes.

Objectives 1, 7, 9, 10, 11, 13, 14, 15, 18, 19, and 20 are the questions where 100% of the 30 participants fell into the 0-19% range of achievement. There was a small smattering of scores falling between the 20-39% range, the 40-59% range, and the 60-79% range of achievement (see Tables 14 and 15).

TABLE 14

COGNITIVE PRE- AND POST-TEST RESULTS OF 30 PARTICIPANTS'
LEVELS OF ACHIEVEMENT (ROUNDED)

OBJECTIVES SUBJECTS		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	MEAN (SUBJECT)
1	POST-	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
	PRE-	0	0	100	0	0	67	0	0	0	0	0	100	0	0	0	100	0	0	0	0	10
2	POST-	100	100	0	100	100	100	100	100	100	100	89	83	100	100	37	100	83	100	75	89	85
	PRE-	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
3	POST-	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
	PRE-	0	0	0	0	0	0	0	85	0	0	85	67	0	0	0	100	83	0	87	0	10
4	POST-	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	95
	PRE-	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5
5	POST-	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
	PRE-	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5
6	POST-	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
	PRE-	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5
7	POST-	100	100	100	100	100	100	100	100	100	100	100	100	85	100	100	100	100	100	100	100	98
	PRE-	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	15
8	POST-	100	100	100	100	100	100	100	100	100	100	80	100	100	100	100	100	100	100	100	100	100
	PRE-	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	15
9	POST-	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
	PRE-	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5
10	POST-	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	95
	PRE-	0	0	0	0	0	0	0	75	0	0	0	0	0	0	37	0	0	0	0	0	0
11	POST-	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
	PRE-	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
12	POST-	80	100	100	80	100	100	80	100	83	100	100	100	100	100	100	100	100	100	100	100	99
	PRE-	0	0	50	0	0	0	0	0	0	83	0	0	0	0	0	0	0	0	0	0	14
13	POST-	80	100	100	80	100	100	80	100	100	100	100	100	100	100	80	100	100	100	100	100	92
	PRE-	0	100	50	75	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
14	POST-	100	100	100	100	100	100	100	100	100	100	100	100	100	100	87	100	100	100	100	100	98
	PRE-	0	100	50	100	100	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	11
15	POST-	80	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	99
	PRE-	0	100	100	100	100	33	0	0	0	0	0	0	0	0	0	50	0	0	0	0	24

Table 14--continued.

OBJECTIVES SUBJECTS		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	MEAN (SUBJECT)
16	POST- PRE-	100 0	100 0	100 0	100 0	100 0	100 0	100 0	100 0	100 0	100 0	100 0	100 0	100 0	100 0	100 0	100 0	100 0	100 0	100 0	100 0	100 0
17	POST- PRE-	80 0	100 100	0 0	100 0	100 0	100 0	100 0	100 0	100 0	100 0	100 0	100 0	100 0	100 0	100 0	100 0	100 0	100 0	100 0	100 0	98 5
18	POST- PRE-	100 0	100 67	100 0	100 0	100 0	100 0	85 0	100 0	100 0	100 0	100 0	85 0	100 0	100 0	100 0	100 100	100 0	100 0	100 0	100 0	98 10
19	POST- PRE-	100 0	100 100	100 0	100 0	100 0	100 0	100 0	100 50	100 67	100 0	100 0	100 62	100 0	100 0	100 0	100 0	83 0	100 0	100 0	100 0	99 14
20	POST- PRE-	100 0	100 100	100 0	80 0	80 0	100 0	100 0	100 0	100 0	100 0	100 0	100 0	100 0	100 0	100 0	100 0	100 0	100 0	100 0	100 0	97 5
21	POST- PRE-	100 0	100 100	100 0	80 0	100 0	100 0	100 0	100 0	100 0	100 0	100 0	100 0	100 0	100 0	100 0	100 0	100 0	100 0	100 0	100 0	99 6
22	POST- PRE-	100 0	100 75	100 60	100 0	100 0	100 0	100 0	100 0	100 0	100 0	100 0	100 100	100 0	100 0	100 0	100 62	100 0	100 0	100 0	100 0	98 3
23	POST- PRE-	83 0	100 100	80 0	100 0	100 0	100 33	100 0	100 37	83 0	80 0	83 0	100 0	100 0	80 0	80 0	100 0	100 0	80 0	80 0	80 0	91 8
24	POST- PRE-	80 0	80 100	80 0	100 0	80 0	100 0	100 0	80 0	83 0	80 0	80 0	80 0	80 0	80 0	87 0	80 0	80 0	80 0	80 0	80 0	84 8
25	POST- PRE-	80 0	100 0	80 40	100 60	80 0	100 0	100 0	100 0	83 0	80 0	100 0	100 0	80 0	80 0	80 0	80 0	100 0	80 0	80 0	100 0	93 2
26	POST- PRE-	100 0	100 0	100 0	100 0	100 0	100 0	100 0	100 0	100 0	80 0	100 0	100 0	80 0	80 0	100 0	100 0	100 0	80 0	100 0	100 0	95 2
27	POST- PRE-	80 0	100 50	80 0	100 0	100 0	100 0	100 0	100 0	100 0	80 0	80 0	80 0	80 0	80 0	80 0	100 0	100 0	80 0	100 0	80 0	94 0
28	POST- PRE-	0 0	100 0	0 0	80 0	100 0	0 0	100 0	0 0	80 0	0 0	0 0	80 0	80 0	80 0	80 0	100 0	75 0	75 0	100 0	80 0	87 5
29	POST- PRE-	80 0	100 100	80 0	80 0	80 0	100 0	80 0	80 0	80 0	80 0	100 0	100 0	80 0	80 0	80 0	80 0	80 0	83 0	80 0	100 0	43 5
30	POST- PRE-	80 0	100 100	80 0	80 0	80 0	100 0	80 0	80 0	80 0	80 0	100 0	100 0	80 0	80 0	80 0	80 0	83 0	83 0	80 0	100 0	86 5
MEAN (OBJECTIVE)		90	96	88	92	97	95	93	93	93	92	94	93	95	95	90	98	93	96	97	96	

TABLE 15

COGNITIVE PRE-TEST RESULTS OF 30 PARTICIPANTS'
LEVELS OF ACHIEVEMENT
(ROUNDED)

Objective Number	% 0–19	% 20–39	% 40–59	% 60–79	% 80–100
1	100	0	0	0	0
2	47	0	3	6	43
3	83	0	7	3	7
4	90	0	0	7	3
5	97	0	0	0	3
6	93	7	0	0	0
7	100	0	0	0	0
8	87	3	7	3	0
9	100	0	0	0	0
10	100	0	0	0	0
11	100	0	0	0	0
12	73	0	0	7	20
13	100	0	0	0	0
14	100	0	0	0	0
15	100	0	0	0	0
16	80	0	3	3	13
17	97	0	0	0	3
18	100	0	0	0	0
19	100	0	0	0	0
20	100	0	0	0	0

Mastery in this research had been established at 80/80; that is, 80% of the participants needed to score at least 80%, not on the test as a whole, but rather on each behavioral objective presented. On the basis of these results, it was concluded that all 30 participants lacked the majority of the information contained in the D.A.R.T. Seminar, thus exhibiting an educational need.

For the cognitive post-test, the standard for mastery was maintained at 80% of the participants scoring at least 80% on each objective. Tables 14 and 16 show the results of the cognitive post-test.

With the minimum standard for mastery set at 80/80, at least 24 participants (.80 x 30 - 24) needed to score 80% or more on each objective. Table 14 shows that the post-test scores for each objective ranged from 80-100%, indicating that the 80% level of mastery for each objective was attained. The scores for 27 out of 30 participants ranged from 80%-100%. Participants 2 and 10 scored 85% and 95% respectively, yet without achieving mastery. For participant 2, objective 6 was 67%, objective 15 was 37%, and objective 19 was 75%, representing a level below mastery on each objective. Participant 10 scored 37% on objective 15 also representing a total level below mastery on each objective. Participant 29 achieved only a 43% mean total on all 20 behavioral objectives due to 10 unanswered questions

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TABLE 16

COGNITIVE POST-TEST RESULTS OF 30 PARTICIPANTS' LEVELS OF ACHIEVEMENT (ROUNDED)

Objective Number	% 0–19	% 20–39	% 40–59	% 60–79	% 80–100
1	3	0	0	0	97
2	3	0	3	0	97
3	7	0	0	0	93
4	3	0	0	0	97
5	0	0	0	0	100
6	3	0	0	3	93
7	3	0	0	0	97
8	3	0	0	0	97
9	3	0	0	0	97
10	3	0	0	0	97
11	3	0	0	0	97
12	0	0	0	0	100
13	0	0	0	0	100
14	0	0	0	0	100
15	0	7	0	0	93
16	0	0	0	0	100
17	0	0	0	3	97
18	0	0	0	3	97
19	0	0	0	3	97
20	0	0	0	0	100

(0% on objectives 1, 2, 3, 4, 6, 7, 8, 9, 19, 11) and 75% on objectives 17 and 18.

Table 16 shows that 29 (97%) of the 30 participants achieved mastery on objectives 1, 2, 4, 7, 8, 9, 10, 11, 17, 18, 19; 28 (93%) achieved mastery on objectives 3, 6, and 15; and 30 (100%) of the 30 participants achieved mastery on objectives 5, 12, 13, 14, 16, and 20.

The developed curriculum was considered to be satisfactory based on the achieved mastery above the pre-determined 80/80 standard with 30 participants. The curriculum can now wear the hard-earned title of empirically developed. The instructional product or instructor's manual and the participant's manual can both be found in the Appendix section of the dissertation.

Modification of Affect--Group of 30

The modification of affect for the group of 30 was determined by a t-test comparing the pre- and post-test scores. Table 17 shows these scores and their differences. The attained t score value of this group of 30 was 9.09, which was significant at the .05 level. The difference between the post- and pre-tests was 15.13%, indicating a significant modification of affect.

Satisfactory modification of affect had been attained for the group of 30. The participants voiced a significant motivation toward becoming more aware of others' differences and more specifically aware and sensitive to the disability

TABLE 17

AFFECTIVE TEST SCORES OF 30 PARTICIPANTS

SUBJECTS	Pre-Test	Post-Test	Post-Test Pre-Test Difference
1	57	91	34
2	73	88	15
3	69	92	23
4	96	96	0
5	52	61	9
6	77	94	17
7	70	93	23
8	89	99	10
9	83	88	5
10	77	97	20
11	63	79	16
12	93	97	4
13	50	61	11
14	62	81	19
15	62	79	17
16	75	96	21
17	80	98	18
18	60	70	10
19	71	89	18
20	70	92	22

Table 17--Continued.

SUBJECTS	Pre-Test	Post-Test	Post-Test Pre-Test Difference
21	62	83	21
22	76	85	9
23	67	74	7
24	53	57	4
25	50	87	37
26	58	60	2
27	50	78	28
28	63	78	15
29	48	64	16
30	73	76	3
Mean	67.63	82.76	15.13*

*p = .000.

condition after their participation in the seminar. It is hypothesized that the significant modification of affect contributed to the participant's cognitive mastery of the D.A.R.T. Seminar--Building Community One Difference at a Time curriculum as shown on the post-test results.

Step 7: Operations Analysis

This section of the developmental process is dedicated to the noted strengths and weaknesses of the instructional product formation. One encouraging strength was noted when one of the seminar participants, who served his community through law enforcement, humorously stated, "If I had but half as much energy as you, I could be happy." This response indicated to me that enthusiasm is an important and vital component to learning as well as to teaching.

A second strength was noted when another seminar participant, this time a retired but active minister and missions consultant, stated after the presentation that, "This information is so valuable, it needs to be in Reader's Digest to reach the masses." This response affirmed the researcher and indicated that the seminar topic on disability awareness is an important subject in need of general clarification and that this instructional product supplies a certain need.

Another strength was acknowledged from a notation made by a seminar participant on an optional response page attached to the back of the affective post-test. It read,

"The D.A.R.T. Seminar has helped me become more accepting of others around me. Thank-you for this awareness." This response indicated that the product curriculum had awakened an awareness in the differences of other people and that this awareness was becoming instrumental in facilitating a general acceptance.

Another strength was noted after the completion of the seminar in Washington state, when an attending employee of the U.S. Army Corps of Engineers, Department of Labor Relations, commented on how much she had learned from and enjoyed participating in the seminar. This employee stated, "This is the kind of education we need for my workers and the public we deal with on a daily basis." This comment indicated that there existed not only a general need for this education, but even a more specific, public need outside the proposed study population of church congregations. This comment indicated to me that this seminar curriculum was a necessary education for public and private concerns.

Another useful strength was acknowledged on the Saturday evening of the last presented seminar due to the achieved level of mastery attained by the participants. After the completion of the third learning unit, the hour was such that the delicious planned supper was being served. Instead of promptly leaving the seminar for the tempting smells and inviting tastes of the wafting pizza aroma, all

30 participants stayed in their seats and wished to finish the final learning unit and complete the awareness training without an extended break, then have supper. This participatory action indicated the need and desire of the participants for the continuity and flow of the presented material. The seminar was developed to flow from one objective to the next logically and purposefully within each learning unit. This desire by the seminar participants to complete what was started in terms of educated awareness places an affirmation upon the overall design of the seminar and stresses the importance for the presentation to always flow with the design for maximum efficiency of learning.

A weakness was noted in the timeframe format of the seminar. Continual feedback and response from different participants in almost every seminar presentation centered around the time issue. There seemed to always be a need to rush the presentation in order to cover completely each and every behavioral objective, allowing enough time for discussion and sharing of concepts. This continual feedback from the concerned participants indicated that the instructional materials must either be more streamlined with less demands and exposure of research, or a reassessment of time allocations for each unit of instruction should be made, thus expanding the length of time required for the whole seminar.

A second weakness was noted concerning the limited age group to which this awareness seminar was designed. The researcher, being a doctoral student and making the disability awareness training seminar--the D.A.R.T. Seminar--the final dissertation project for the degree, certain requirements for research kept the length and scope of the presentation at a rather lengthy and advanced level. This required level of understanding limited the presentation and mastery of the objectives to an almost completely adult audience. Even with this adult or near-adult prerequisite, many comments and responses from the adults centered around "not understanding half the words used." These comments and responses indicate a need for a simplification of the instructional product, the testing instruments, and the learning aids such as the overhead transparencies. With a general simplification of materials, even a younger, less specific audience could be eventually reached.

Summary

Thirty participants completed the 5-hour D.A.R.T. Seminar--Building Community One Difference at a Time training program. The participants included 11 employees of Andrews University Information Ministry representing five different local church congregations, as well as 19 adults and young adults representing the church in which the seminar was held.

On the cognitive post-test, mastery was attained on all 20 behavioral objectives. Twenty-nine (97%) of the 30 participants achieved mastery on objectives 1, 2, 4, 7, 8, 9, 10, 11, 17, 18, and 19; 28 participants (93%) achieved mastery on objectives 3, 6, and 15; and 30 participants (100%) achieved mastery on objectives 5, 12, 13, 14, 16, and 20 (see Table 16). The empirically developed curriculum was considered to be satisfactory based on mastery above the pre-determined 80/80 standard with 30 participants.

The modification of affect for the group of 30 was determined by a t-test comparing the pre- and post-test scores. The critical value of t with 29 degrees of freedom at the .05 level of significance is 2.04. The obtained t score was 9.08. This showed a statistical significance. It was concluded that satisfactory modification of affect had been attained and that the participants were significantly motivated toward becoming more aware and accepting of the disability condition upon completion of the seminar.

It was encouraging to note the degree to which the instructional materials for the D.A.R.T. Seminar impacted the participants. The verbal and written responses after most of the presentations indicated that the participants had not only been influenced in a positive way toward an educated awareness of differences in the form of disabilities, but had also had an enjoyable time during the learning process.

CHAPTER 5

SUMMARY, IMPLICATIONS, CONCLUSIONS,

AND RECOMMENDATIONS

Statement of the Problem

The social problem that this study addresses is the absence, in the SDA Church community service education, of an empirically developed instructional product designed and tested for affect modification and enhanced awareness of the disability condition.

Through the process of social awareness, a general sensitivity to the human condition can begin to establish a foundation for essential community outreach and a fulfillment of personal and public needs. In the formation of the D.A.R.T. Seminar, with the presented case study subject being the disability condition, this personal condition, which presents itself as a human difference, represents a social mind-set that is in need of an encouraged enhancement through educated awareness. This community service education serves the mission and purpose of community interaction and individual empowerment through inclusion.

Most individuals with a disability condition seek for a personal and social sense of normalization and integration within their lives through their work and home life. The problem begins in the encountered social, economic, political, and psychological barriers that are constant threats to the achievements of such a goal. The problem of the disability condition, then, is continued through the myths and distorted knowledge that is directly associated with disability, and finalized through the social and personal non-acceptance of this human condition and its associated limitations. The answer to this disability condition problem rests in general awareness education, straightforward facts, and direct exposure to the reality that is disability so that an enhancement of attitudes toward this condition can naturally occur. The general attitude can be the biggest barrier of all.

The Easter Seal Society suggests that awareness of the disability condition is the primary step in the social direction of achieving change in general attitudes. J. Donaldson in 1980 suggested a six-point experience of attitude enhancement, the first being contact through exposure and awareness, then information through persuasive messages, analysis of personal prejudice and judgments, simulation, and group discussion. Mark Nagler suggested four points of general acceptance and attitude change toward disability in general. He suggested awareness, exposure,

contact, and personal analysis of responses, reactions, and feelings.

This curriculum, the associated workbook, the testing instruments (both cognitive and affectual), and the general criteria were all designed in conjunction with the social and personal needs associated with the problem of the disability condition and the socially formulated answers to this problem. Based on these stated needs and the basic problems associated with personal and social barriers, the purpose of this study was to develop, empirically, a curriculum to assist Seventh-day Adventist Church congregations and their guests in the process of becoming more socially and personally sensitive and aware of the disability condition, thus human differences in general. This awareness training had the designed mission of reducing personal fear and prejudice through the enhancement of social attitudes for the sake of community acceptance, effective interaction, and general inclusion. This mission was completed successfully through this study. There now exists an empirically developed instructional product that has been shown to positively modify affect and positively enhance cognitive awareness of the disability condition. It is the D.A.R.T. Seminar.

Review of Literature

The Seventh-day Adventist Church had no empirically developed curriculum on disability awareness training for the general education, sensitization, and attitude enhancement of its church members concerning the disability condition and human differences in general. This need was met by the creation, formation, and empirical development of the D.A.R.T. Seminar.

The church is quickly realizing the need to be aware and sensitive to the disability condition and the need to be more respectful, tolerant, and accepting of the human condition as it, the church body, reaches out into the community to build, strengthen, empower, and include each individual as worthy of acceptance and validation. The disability condition represents the presented human condition. Awareness and enhanced attitudes toward this aspect of humanity is the church congregation's special privilege, worthy of an in-depth, advanced, group learning activity requiring specialized instruction and intense training.

Historically, disability awareness education and related training, through seminars, workshops, and lecture series, have been associated with general agencies that offer services directly to the individuals with a disability condition. Through telephone interviews, service-agency spokespersons stated that they were familiar with the

concept of disability awareness training and most were even aware of actual programs available. These training programs were available to both the employees of the service agencies as well as to the families and friends associated with service toward the disability condition. Occasionally there would be a program developed and researched and presentationally geared for the public's interest and edification. These rare training workshops and seminars usually came from larger, more general service agencies, such as The National Easter Seal Society, The President's Committee on Employment of People With Disabilities, The California Governor's Committee for the Employment of Disabled Persons, The Regional Disability and Business Technical Assistance Centers, and the National Rehabilitation Information Center. These training programs were general in nature and limited in availability, due simply to the size of the sponsoring agency and the induced public interest of a blandly developed program.

The intentions were valid and efforts were sincere in each of these offered training programs, yet there were certain fundamental elements absent. The elements of a personally integrated curriculum, empirically developed through social focus, personal contact, and group response, with a community-service intentionality, were needed for any hope of affect modification. With this focus on human services, and a design for public presentation and large

group interaction through common human difficulties and differences, the felt-need, interactive D.A.R.T. Seminar came into formation.

The D.A.R.T. Seminar, to aid in the process of development, was separated and prepared into six learning units, each one an integral part of the general awareness training expectation. These six learning units were the pre-instructional learning exam and pre-affectual standardization instrument and general introduction and instruction preparation, coupled with the four learning units of instruction including definitions, sociology, attitudes, and responsiveness, finalized by step 6, the post-instructional learning exam and post-modification of affect learning instrument. Common to each of the six learning units were the models of awareness, exposure, contact, and personal analysis of feelings and responses in conjunction with the shared human need of expressed and felt acceptance and acting tolerance for all human differences.

From the review of literature, it became apparent that each of the learning units created and developed by the D.A.R.T. Seminar--definitions, sociological aspects, origin of attitudes, and responsiveness--represented extensively researched and studied facts, yet nothing compiled into any user-friendly format for public presentational purposes concerning the enhancement and modification of general attitudes. The sources were mainly found in

representational books and periodical articles from psychological, rehabilitation, educational, social-science, and religious journals.

Public attitudes toward disability and individuals with a disability condition were found to be oftentimes the greatest barrier in this segment of the population's search for normalization and accepted integration within their communities and personal lives. Since the publication of the reference bibliography entitled "Attitudes Toward Handicapped People, Past and Present" in 1984, through the National Library Service for the Blind and Physically Handicapped, in the Library of Congress in Washington, DC, the emphasis in the literature on disability and the awareness of its condition has been shifting from a focus on differences and limitations to a new, constructive focus on abilities and potential. Individuals with disability conditions are participating more completely and fully in the main flow of social activity and are advocating for full acceptance.

This daring, socially and personally necessary approach to life led to the passage in Congress of the Americans With Disabilities Act in July of 1990, signed by the President of the United States of America, George Bush. This act of Congress was extremely influential in helping to change public attitudes toward the positive, and the real beginning of the drive to enhance and modify public affect associated

with the disability condition in hopes of integrating and
normalizing, thus accepting a very large, persuasive,
isolated, ignored, and stigmatized segment of the
population.

Methodology

Baker and Schutz (1971) identify seven steps or process
stages for the empirical development of an instructional
product. These seven steps were followed as a general guide
and outline and then interpreted and enlarged upon to
appropriately verify and develop the needs presented by a
seminar style format designed for shared interaction with
large groups of individuals. The chosen research
methodology for the development of this instructional
product entitled The D.A.R.T. Seminar--Building Community
One Difference at a Time, was the instructional product
formation of Baker and Schutz (1971) interpreted by this
researcher. This methodology was chosen and interpreted to
meet the specific needs of this research study. The seven
steps or process stages include: formulation, instructional
specifications, item tryout, product development, product
tryout, product revision and, finally, operations analysis.

Step 1 began by first reviewing the literature and
questioning directors of service agencies, church conference
employees, and individuals of disability associated with the
topic of research. Through this extensive review, the
question was addressed, "Is a new or improved product, such

as a disability awareness training curriculum designed for enhanced human services, justifiable in terms of its needs?" The answer, stated in response, by individuals in varied human and community services, was a unanimous "yes, the need justifies the new product proposed." During this initial phase of the development, the target population for the study (SDA church congregations and human service personnel) was selected.

Step 2 included the development of the instructional specifications which involved establishing 20 behavioral objectives, or a 20-point training process empirically developed through careful attention to the personal and social problems, fears, anxieties, questions, reactions, and desires to understand better the disability condition shared with the researcher throughout the course of 16 developmental presentations on disability in two different states. These behavioral objectives, stated in measurable terms, formulated through the extensive review of individual and group testimony, were the basis for the criterion-based testing instrument (pre-/post-cognitive instructional exam). This testing instrument was empirically designed to measure a pre-established level of mastery. The minimum acceptable level of performance was set at 80/80; that is, when 80% of the learners mastered at least 80% of the criteria on each objective, mastery would be considered accomplished.

Specific strategies to promote positive affect were also established.

A Likert-type affectual testing instrument was also formulated in conjunction with the cognitive instructional exam. This affectual instrument measured the learners' pre- and post-seminar affect and any modification thereof concerning people with a disability condition. The statements on the modification of affect exam and its complete formation, just like the cognitive testing exam, were a researched result of literature reviewed in conjunction with questions, responses, and suggestions acknowledged through a personal and social desire-to-know basis, derived from the same process of disability discussions presented in a series of 16 meetings in Michigan and Oregon. These testing instruments, both cognitive and affectual, were then examined and reviewed by a carefully chosen panel of five experts representing careers of professional human service that I wanted exposure and access to on each behavioral objective and affectual statement. This panel of five experts agreed on the content validity and the assumed, provisional reliability of the testing instruments associated with appropriate and limited data collection.

Step 3 of the product development was the item tryout in which the prototype pre- and post-tests with the criteria for evaluation were tested on a small sample group (13

learners). Step 4 was the initial development of the actual instructional instrument and its exposure to two larger groups of the target population (28 and 17 learners respectively). Then, based on the developed behavioral objectives and the specifically formulated criteria, the materials were organized into the following six stages: Taking the Pre-Training Inventory, Defining the Disability Condition, Sociological Aspects of Evaluation and the Disability Condition, Origin of Attitudes Associated with the Disability Condition, Responsiveness Toward the Disability Condition, and Taking the Post-Training Instructional Exams. These six stages of step 4, along with their respective subheadings, provided the outline for the development of the instructional product.

Step 5 was the product tryout with a larger group. In this step, the product was tested on a group of 20 individuals, and in step 6 revisions were made based on the test results. This revised product was then presented to the largest group of 30 individuals for the possible final testing. The scores on the pre-test validated the need for the product, and the post-test scores indicated that they had reached the required 80/80 mastery level, with a significant modification of affect. Following the seminar, as was done in each of the numerous previous presentations, observed strengths and weaknesses were noted, completing

Step 7, operations analysis, in the final developmental process.

Results

The instructional product, in brief outline form, was presented to a group of 13 community service agency professionals, after a series of 16 developmental presentations were completed and a series of 20 objectives were formulated into a 20-point disability awareness training process. Based on the pre-test scores, there appeared to be a need for the knowledge and awareness of the presented curriculum, as no participant reached the mastery level of 80/80. However, the post-test also showed that this group failed to reach the required level of mastery on the areas dealing with disability definitions, sociological aspects of social evaluation, effects and actions of social judgments, social acceptance patterns, disability and deviance, personal responsiveness, and social etiquette toward the disability condition. Mastery (80/80) was not reached on a total test basis or a per-objective basis on the post-test. However, this group, in failing to reach cognitive mastery, did show encouraging enthusiasm and a slight enhancement of presented attitude concerning the disability condition in general as shown by the t-test comparisons of the pre- and post-test Likert-type exams given as part of the instructional instrument. The group

expressed a sincere interest in their experience of awareness throughout the seminar in general.

Modifications were made to the instructional materials to simplify many of the presentations and expectations, to add practical, useful, and meaningful test practice opportunities, and to include group interaction activities to promote involvement. The participant's manual was further modified to include example-rich visual aids and lead-in quotes to introduce each section or learning unit. The most helpful modifications were the practice exams at the completion of each learning section. The pre- and post-test questions acted as models for the formulation and customization of the specific unit practice tests.

The instructional product, inclusive of the teaching manual or presentational curriculum, participant's workbook, instructional instruments, both cognitive and affectual, and the associated behavioral-objective driven criteria, was then presented to a group of 28 individuals comprising a single SDA congregation. This group represented the research target population. For this group of 28, only the affectual modification exam was pre- and post-tested. This group demonstrated a significant modification of affect after the results were calculated through a t-test comparison. This group of 28 individuals was also very vocal in its interaction with each behavioral objective, which was encouraging, and was the hypothesized reason for

the large modification of affect concerning the disability condition in this group.

The curriculum, in its now more developed state, was then presented to a smaller group of 17 individuals, all members of a small SDA church congregation. This group of 17 individuals was selected from the target population. This group demonstrated a lack of mastery of the materials on the cognitive pre-test inventory exam. This is always expected and showed again the need for the materials. This group of individuals did not reach mastery on the post-test exam, where 80% or more of the group failed to master at least 80% on the post-test as a whole as well as 80% or more on each presented behavioral objective. It was becoming apparent that this presented curriculum was developing into, through extensive presentational practice and revision, an effective educational product. It was also apparent that much more practice was needed for even more effective presentations.

A group of 20 individuals was then selected from Andrews University's Social Work Department to officially test the effectiveness of the curriculum and the entire educational product as a whole. The scores of the pre-test fell below the mastery level as expected. This group of 20 did achieve mastery on the post-test as a whole, but failed to reach the mastery standard (80/80) on each behavioral objective. It appeared that the improved instructional

methods as well as additional practice materials and practice tests with the immediate provided feedback had enhanced the learning process. The modification of affect for this group was significant, again adding more evidence to the idea that through gained cognitive awareness comes an enhancement of attitude.

Finally, the curriculum as a complete educational product was tested on a group of 30 individuals. As expected, the scores on the pre-test instrument indicated a need for the curriculum. The post-test instrument showed mastery had been achieved. Practice exercises, immediate feedback of correct answers to the presented behavioral objectives, additional visual aids, constant group review, and a specific teaching aim focusing upon only the required criteria for each behavioral objective were utilized to create a more effective presentation. Both in cognitive and affectual testing situations the results showed a very significant modification of affect to be associated with this newly revised educational product. The interactive presentational format seemed to increase motivation and enthusiasm within the group as well as act toward the maintenance of interest and personal focus. The size of the group also was observed to aid in the enhancement and involvement through shared interaction throughout the entire presentation of the curriculum.

Summary

Throughout the empirical developmental process of this educational product, the D.A.R.T. Seminar, it became evident that certain, specific activities promoted mastery-level learning and played an important role in promoting and maintaining a high level of enthusiasm and motivation toward the presented topic and its social and personal meaning. These activities included adequate practice on comparable test questions, with constant review and personal integration, in preparation for the post-instruction inventory, the opportunity for immediate feedback and clarification of expressed ideas and testable expectations and a constant atmosphere of enjoyment through the interactive expression of shared cognitive and affectual integrations of personal and social meaning.

The pre-instruction inventory (pre-test) tended to create a need for the material and helped to motivate participation. The teaching to specific objectives and the constant group review aided in focusing the presented material, for the sake of learning, attitude change, and data collection. Limiting the actual time of the seminar also assisted in focusing the presentations specifically on the designed objectives.

One of the purest teaching examples of the developmental progression involving the empirical process of this instructional product was the use of the pre-

instruction inventory (pre-test). The pre-instruction inventory was designed to be difficult or impossible to answer correctly prior to experiencing the actual seminar, yet after the seminar, the post-instruction inventory (post-test) was easily understood. This experience presented the need for such a seminar. When something new is not understood and there appears no immediate workable answers to satisfy natural confusions, a frustration sets in and immediate prejudice and dislike appear. This event happened on each of the pre-test exams during every seminar. No one enjoyed not knowing the answers. The participants voiced their prejudice over the pre-test. Prejudice seemed to evolve around the confusion and frustration of not knowing all the answers.

The post-test was a different experience. Everyone knew the answers and understood the examples and showed no confusion or fearful frustration. Most everyone enjoyed the post-test.

The purpose of the D.A.R.T. Seminar is to reduce prejudice and fear (enhance positive attitudes) and allow individuals to know and understand the answers (enhance cognitive awareness) associated with the disability condition, representing the differences in general of the human condition. There existed no empirically developed instructional product designed for this purpose of changing attitudes and increasing awareness of the disability

condition for church congregations until the production of the D.A.R.T. Seminar was completed. This particular problem has been shown, through this research study, to now be solved.

Recommendations

To meet the continual social and personal need for both the integration of cognitive awareness and modification of affect in the areas of prejudice and human differences—most specifically the differences associated with the disability condition—the following recommendations are suggested:

1. Make this instructional product available for use in all community and human service agencies.

2. Make this instructional product available to all church congregations.

3. Make this instructional product available to all undergraduate Religion and Theology majors and graduate Seminary students.

4. Make this instructional product available to all undergraduate and graduate students in programs of pre-professional and professional human services (social work, counseling, education, psychology, dentistry, medicine, nursing, public health, allied health fields, etc.).

5. Consider this instructional product for presentation by a city council to the community in National Disability Employment Awareness Month.

6. Make this instructional product available for presentation to personnel of corporations and small and large business owners through the President's Committee on Employment of People With Disabilities.

7. Explore the possibility of developing an informational videocassette of the curriculum.

8. Make the instructional product, through the seminar format, a yearly, or bi-yearly or more, networking forum for employers and service providers as job support for successful employment of persons with disabilities as well as positive basic business contacts.

9. Andrews University might consider evaluating its offered courses of study in terms of their possible contributions to social exposure, personal differences, and disability awareness associated with community, national, and world public service.

10. Explore the possibility of converting an unused corner of the Andrews University campus into a social awareness center that would make available, present honestly and teach responsibly, through different controlled exposures, the human diversity (case study--the disability condition) that is everyone's community.

11. Determine the validity of the instructional product beyond established content validity.

12. Create a theoretical model associated with the disability condition incorporating this instructional product.

13.   Reduce the content of the instructional product. Possibly address 10-12 objectives in an 1-1 1/2-hour time span.

14.   Study the long-term effects of the cognitive and affective objectives.

15.   Study the effects a presenter with a disability condition might have compared to a presenter without a disability.

16.   Establish a new course in the University curriculum dealing with the sociology of the disability condition.

Further Study

1.   Track each seminar participant through an essay inventory to determine the value of the learned curriculum in his or her personal life.

2.   Follow each seminar participant through a planned questionnaire procedure to determine the social and personal benefits of the curriculum to his or her career.

3.   Determine the impact of the curriculum on participants of the seminar who lived personally with a disability condition.

4.   Determine the impact of the curriculum on participants of the seminar who worked professionally with individuals with disabilities.

5.   Determine the understanding of the disability condition in the setting of human prejudice by full-time parish pastors.

6.   Integrate the complete instructional product into

the overall academic curriculum of a Pastoral Psychology

course, both undergraduate and graduate.

7. Expose an evangelistic team to the complete

curriculum materials and study the effect it might have on

the acceptance patterns of the visitation calls, methods of

sermon presentation, and neighborhoods visited.

8. Determine how different cultures react and respond to

the disability condition and exposure to this curriculum in

their education.

9. Determine the difference in attitude, if any,

between male post-test results and female post-test results

coupled with the age of the participant when exposed to this

curriculum together.

10. Develop a self-evaluating test instrument capable

of assisting pastors and pastoral staffs in determining the

degree to which their programs are promoting a personal and

social acceptance of human diversity, inclusive of disability

and difference in general.

11. Develop a study that would question individuals

with a disability condition on their personal acceptance and

satisfaction before working at a chosen job and then during

meaningful employment, and come to a shown conclusion

concerning the aspects of vocational involvement, disability,

and self-esteem.

12. Determine the motivational elements that best

inspire an individual with a disability condition to seek an

education and career training and compare them with determined elements that inspire able-bodied individuals to seek the same.   Through this comparison then develop a community-based program that will meet these discovered needs.

13. Develop a questionnaire designed to discover social fears associated with public interaction.   Present this questionnaire to individuals with a physical disability condition and to able-bodied individuals.   Then compare and contrast the results and present a conclusion that would enable specific training and counseling to be offered so to open the doors of an integrated lifestyle to more individuals with a physical disability condition.

14. Interview numerous individuals with a disability condition who hold personally satisfying careers and ask them to list 10 personal obstacles that they had to overcome and how they accomplished each victory.   Then assemble all the data and develop a motivational training curriculum in career satisfaction designed for college career service centers in conjunction with college student disability services.

15. Interview and present a developed questionnaire to college students with a disability condition on making friends and maintaining friendships.   Offer the same questionnaire and interview time to non-disabled college students.   Compare the resulting data and develop a theory of friendships based upon body image, body function, and personal/social acceptance.

APPENDICES

APPENDIX A

COGNITIVE INSTRUMENT

COGNITIVE EDUCATIONAL INSTRUMENT
Pre-instruction/Post-instruction
Inventory

The Disability Condition

Based on the twenty behavioral objectives that compose

the twenty-point process of Disability Awareness Reality

Testing (D.A.R.T.)

SECTION I

Learning Unit One - DEFINING THE DISABILITY CONDITION

(1) Disability is defined by the World Health Organization
     in Geneva as:

     a.   all limitations associated with vocational
          endeavors
     b.   **any restrictions or lack of ability to perform an
          activity in an acceptably normal manner**
     c.   any lack of ability to perform certain activities
          accepted as normal in an experimentally tested
          time frame
     d.   any impairment that restricts vocational and
          social performance and interactions

                                                  3 pts. total:

(2) List two (2) of the four possible life occurrences that
     enable a disability to happen.   (Any two)

     a.

     b.

                                                  4 pts. total:

(3) Identify one (1) of the four specific types of
     disability and explain, in 8 words or less, how
     understanding this type of disability could make you
     more accepting of the human condition.

     a.

     b. (explain)

                                                  5 pts. total:

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(4) Choose any <u>one (1)</u> of the sixteen foundational disability conditions, and explain, in 10 words or less, <u>how</u> that condition would cause you an interruption, restriction, or inability in your life performance.

a.

b. (explain)

5 pts. total:

SECTION II

Learning Unit Two - SOCIOLOGICAL ISSUES ASSOCIATED WITH EVALUATION AND THE DISABILITY CONDITION

(5) Society evaluates perceived strangers by: (S.E.P.)

a. the different attitudes that are presented
b. carefully examining their motives for entry into specific social circles
c. routinely asking questions of a personal nature
d. **the specific identities that are presented**

3 pts. total:

(6) List the <u>three (3)</u>-point process of social evaluation inspired by Dr. Nagler.

a.

b.

c.

9 pts. total:

(7) Disability is prone to having a two-characteristic effect upon society. These two characteristics are:

a. inclusive and traumatizing
b. **persuasive and stigmatizing**
c. exclusive and tranquilizing
d. conclusive and discouraging

3 pts. total:

(8) This two-characteristic effect causes society to perform two actions toward individuals with disabilities. List these two (2) actions and explain, in 10 words or less, how you might act in a more integrative manner.

a.

b.

c. (explain)

8 pts. total:

(9) Identify one (1) of the three possible reasons for non-acceptance of the disability condition and briefly explain, in 10 words or less, why this reason exists.

a.

b. (explain)

6 pts. total:

(10) Discuss, in 10 words or less, how you could use just one (1) of the two points of possible social dis-integration to advance a social integration among people with disabilities.

a. (list one point)

b. (explain)

6 pts. total:

(11) In 10 words or less, briefly explain historically, how disability became linked with social deviance.

a.

b.

c.

9 pts. total:

SECTION III

Learning Unit Three - ORIGIN OF ATTITUDES TOWARD THE DISABILITY CONDITION

(12) To the left of each statement, place the letter representing <u>one</u> of the three reasons below (a, b, c) for possible negative behavior toward the disability condition.

    a.   subjective role-taking ability
    b.   egocentric developmental stage
    c.   physical attraction, social judgment

___ ___   I am present

___ ___   I choose to stand near her but not you

___ ___   Accepts one world

___ ___   Not easily persuaded to another view

___ ___   I play only with him

___ ___   The only approach is . . .

            6 pts. total:

(13) Explain, in 10 words or less, <u>how</u> society is familiar with conceptualizing the disability condition through pre-existing, stereo-typed images.
(Use the Batman example and the 3 media formats)

a. (good)

b. (bad)

c. (3 media formats)

            7 pts. total:

(14) There exists, in disability awareness training (Donaldson, 1980), six suggested attitude enhancing experiences. Choose two (2) of these experiences and explain, in 15 words or less, how they might be useful in enhancing your attitudes toward the disability condition.

a.

b.

c. (explain)

8 pts. total:

(15) List one (1) of the four points associated with Dr. Nagler's specific social acceptance pattern and explain, in 10 words or less, what this point means to you as a member of society.

a.

b. (explain)

8 pts. total:

SECTION IV

Learning Unit Four - RESPONSIVENESS TOWARD
THE DISABILITY CONDITION

(16) The following four statements, according to the National Easter Seal Society, are commonly held misconceptions concerning persons with disabilities. Respond, in rebuttal form, to each statement using 5 words or less.

a.   People with physical disabilities are more comfortable with "their own kind."

b.   Non-disabled people are obligated to take care of their fellow citizens with disabilities.

c.   The lives of people with disabilities are completely different than those of non-disabled people.

d.   People with disabilities always need help.

8 pts. total:

(17) You are at a social gathering with a large group of people. The host of the event has a disability condition. Mention how you would talk and mingle with the host demonstrating your specific friendship skills. (Use 10 words or less and two (2) of the 4 suggested skills)

a.

b.

6 pts. total:

(18) Explain, in 10 words or less, how a person with a disability condition (or anyone) becomes handicapped (use the three points of human need--I.A.M.).

4 pts. total:

(19) There seems to be four specific methods, according to Dr. Mark Nagler, of action that aid in the realistic acceptance of the disability condition. Identify two (2) of the four methods of action (any two).

a.

b.

4 pts. total:

(20) Disability etiquette involves the manner in which an individual or group positively interacts with a person of disability. Name two (2) of the five points discussed, associated with a disability etiquette and explain, in 8 words or less, how each point could make a person with a disability feel more accepted.

a-1 (name the point)

a-2 (explain the point)

b-1 (name the point)

b-2 (explain the point)

                                          9 pts. total:

Complete cognitive test total _____ 121 points

APPENDIX B

CRITERIA FOR COGNITIVE INSTRUMENT

COGNITIVE EDUCATIONAL INSTRUMENT

Pre-instruction/Post-instruction
Inventory

CRITERIA FOR COGNITIVE INSTRUMENT

SECTION I
Learning Unit One - DEFINING THE DISABILITY CONDITION

(1) Disability is defined by the World Health Organization in Geneva as: (choose only one)

    a.   all limitations associated with vocational endeavors
    b.   any restrictions or lack of ability to perform an activity in an acceptably normal manner
    c.   any lack of ability to perform certain activities accepted as normal in an experimentally tested time frame
    d.   any impairment that restricts vocational and social performance and interactions

                                 3 pts. total:

(2) List <u>two (2)</u> of the four possible life occurrences that enable a disability to happen.

    2 pts.   a. **Birth**   **Accident/Injury**

                      (any two)

    2 pts.   b. **Disease**   Aging

                                4 pts. total:

(3) Identify <u>one (1)</u> of the four <u>types</u> of disability and explain, in 8 words or less, <u>how understanding</u> this type of disability could make <u>you</u> more accepting of the human condition.

    2 pts.   a. **Congenital, Developmental, Instant-Impediment, Psychological**

    3 pts.   b. (explain): **Differences are seldom one's choice, but one's reality.**

                                 5 pts. total:

(4) Choose any <u>one (1)</u> of the sixteen foundational disability conditions, and explain, in 10 words or less, <u>how</u> that condition would cause <u>you</u> an interruption, restriction or inability in your life performance.

2 pts.   a.   Example: **Paraplegia**

3 pts.   b. (explain):   **A loss of leg movement would mean redefining perceived identity.**

5 pts. total:

SECTION II
Learning Unit Two - SOCIOLOGICAL ISSUES ASSOCIATED WITH THE DISABILITY CONDITION

(5) Society evaluates perceived strangers by: (S.E.P.)

a.   the different attitudes that are presented
b.   carefully examining their motives for entry into specific social circles
c.   routinely asking questions of a personal nature
d.   **the specific identities that are presented**

3 pts. total:

(6) List the <u>three (3)</u>-point process of social evaluation inspired by Dr. Nagler.

3 pts.   a.   **View**

3 pts.   b.   **Acknowledge**

3 pts.   c.   **Accept**

9 pts. total:

(7) Disability is prone to having a two-characteristic effect upon society.   These two characteristic effects are:

a.   inclusive and traumatizing
b.   persuasive and stigmatizing
c.   exclusive and tranquilizing
d.   conclusive and discouraging

3 pts. total:

(8) This two-characteristic effect causes society to perform two <u>actions</u> toward individuals with disabilities. List these <u>two (2)</u> actions and <u>explain</u>, in 10 words or less, how <u>you</u> might act in a more integrative manner.

2 pts.   a.   **Isolate**

2 pts.   b.   **Ignore**

4 pts.   c.   (explain): **Allow disabilities into your life-schedule by examining personal fears**

8 pts. total:

(9) Identify <u>one (1)</u> of the three reasons for possible non-acceptance of the disability condition and briefly explain, in 10 words or less, why this reason exists.

2 pts.   a.   **Appearance, Limitations, Judgments (any one)**

4 pts.   b.   (explain): **The human condition prefers "similar" and "pleasant"**

6 pts. total:

(10) Discuss, in 10 words or less, how you could use just <u>one (1)</u> of the two possible points of social dis-integration to advance a social integration among people with disabilities.

2 pts.   a.   (List one point): **Unpracticed Social Skills**
    (any one)   **Lack of Communication**

4 pts.   b.   (explain): **Express your needs concerning disability anxiety, listen in response.**

6 pts. total:

(11) In 10 words or less, briefly explain historically <u>how</u> disability became linked with social deviance.

3 pts.   a.   **Labeled and associated as bad - 50s**

3 pts.   b.   **Isolated - 60s**

3 pts.   c.   **Ignored - 70s**

SECTION III

Learning Unit Three - ORIGIN OF ATTITUDES TOWARD
THE DISABILITY CONDITION

(12) To the left of each statement, place the letter
representing one of the three reasons below (a, b, c)
for possible negative behavior toward the disability
condition.

a.   subjective role-taking ability **(only mine)**
b.   egocentric developmental stage **(me only)**
c.   physical attraction, social judgment **(me and mine)**

___b___   I am present

___c___   I choose to stand near her but not you

___a___   Accepts one world

___b___   Not easily persuaded to another view

___c___   I play only with him

___a___   The only approach is . . .

6 pts. total:

(13) Explain, in 10 words or less, how society is used to
conceptualizing the disability condition through pre-
existing stereo-typed images.   (Use the Batman example
and the 3 media formats)

2 pts. **(good)**   a.   **Good winners are perfect**

2 pts. **(bad)**   b.   **Bad losers are impaired**

3 pts. **(3 media formats)**   T.V., Movies and Print

7 pts. total:

(14) Choose two (2) of the six attitude-enhancing
experiences and explain, in 15 words or less, how they
might be useful in enhancing your attitudes toward the
disability condition.

2 pts. each   a.   **Contact, Exposure, Judgments,
                    Simulation, Group Discussion**
              b.   **Awareness**

(any two)

4 pts. (explain): **Through awareness I learn, through exposure, I experience, through contact, I acknowledge and accept.**

8 pts. total:

(15) List <u>one (1)</u> of the four points associated with Dr. Nagler's specific social acceptance pattern and explain, in 10 words or less, what this point means to you as a member of society.

3 pts. a.1. **Children esteem themselves highest and others with visible differences the least**
2. **Children with identical disabilities reject the other**
3. **Social acceptance/integration may be age-related**
4. **Social treatment occurs in association with social image**

(any one)

5 pts. b. (explain): **The human condition is defensive and needs assurance through awareness.**

8 pts. total:

SECTION IV

Learning Unit Four - RESPONSIVENESS TOWARD
THE DISABILITY CONDITION

(16) The following four statements are commonly held misconceptions concerning persons with disabilities. Respond, in rebuttal form, to each statement, using 5 words or less.

a. People with disabilities are more comfortable with "their own kind."
2 pts. **We are all one kind**
b. Non-disabled people are obligated to take care of their fellow citizens with disabilities.
2 pts. **We enjoy caring for ourselves**
c. The lives of people with disabilities are completely different than those of non-disabled people.
2 pts. **Life offers similar experiences**
d. People with disabilities always need help
2 pts. **Usually not more than others**

8 pts. total:

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(17) You are at a social gathering with a large group of people. The host of the event has a disability condition. Mention <u>how</u> you would talk and mingle with your host, demonstrating your specific friendship skills. (Use 10 words or less and two <u>(2)</u> of the 4 suggested skills.)

3 pts. each   a.   **emphasize ability in action**   (any two)

            b.   **emphasize ability in conversation**

            c.   **use the word disability, not handicap**

            d.   **try not to label as "lesser"**

6 pts. total:

(18) Explain, in 10 words or less, <u>how</u> a person with a disability condition (or anyone) becomes handicapped. (Use the three points of human need, I.A.M.)

4 pts. (explain: **Remove independence, access and movement and a handicap is formed.**

4 pts. total:

(19) There seems to be four specific methods, according to Dr. Mark Nagler, of action that aid in the realistic acceptance of the disability condition. Identify <u>two</u> <u>(2)</u> of the four methods of action (any two).

2 pts.   a.   **Awareness**   **Exposure**

2 pts.   b.   **Contact**   **Personal judgments**

4 pts. total:

(20) Disability etiquette involves the manner in which an individual or group positively interacts with a person of disability. Name <u>two (2)</u> of the five points associated with a possible disability etiquette and explain, in 8 words or less, <u>how</u> each point could make a person with a disability feel more accepted.

2 pts.   a - 1.   **Always shake hands, or treat adults as adults, or speak directly to the person** (choose any one)

2 pts.   a - 2.   **Show respect, through acceptance, by granting equal status**

2 pts.   b - 1. **Don't be afraid of everyday language**
or ask once, listen twice (choose any one)

3 pts.   b - 2. **Validate each personhood by
integrating existence with service**

9 pts. total:

Complete cognitive test total: _____ 121 pts.

APPENDIX C

INSTRUMENT FOR MODIFICATION OF AFFECT

ATTITUDES HELD TOWARD PEOPLE EXPERIENCING
A DISABILITY CONDITION

Measuring Instrument for Modification of Affect

Read each statement carefully. Indicate, by circling your answer, whether you strongly agree (**SA**), agree (**A**), are undecided (**U**), disagree (**D**), or strongly disagree (**SD**) with each statement.

1. The disability condition makes me uncomfortable.

    SA **A** **U** **D** **SD**

    1   2   3   4   5

2. People with disabilities are usually pre-occupied with themselves and their conditions.

    SA **A** **U** **D** **SD**

    1   2   3   4   5

3. Individuals with disabilities should always expect to live their lives in a completely different manner than their non-disabled friends and relatives.

    SA **A** **U** **D** **SD**

    1   2   3   4   5

4. Society is seldom proud of its fellow members with disabilities.

    SA **A** **U** **D** **SD**

    1   2   3   4   5

5. Ignoring a person with a disability is the safest way to avoid a social disaster.

    SA **A** **U** **D** **SD**

    1   2   3   4   5

6. People with physical disabilities always feel more at ease associating with other individuals with similar disabilities.

    SA **A** **U** **D** **SD**

    1   2   3   4   5

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7. People with disabilities are more excitable than able-bodied people.

       SA   **A**   **U**   **D**   **SD**

        1   2   3   4   5

8. People with disabilities require constant attention.

       SA   **A**   **U**   **D**   **SD**

        1   2   3   4   5

9. I will attempt to absent myself from a person with a disability condition.

       SA   **A**   **U**   **D**   **SD**

        1   2   3   4   5

10. People with disabilities seldom strive very hard toward personal accomplishments.

       SA   **A**   **U**   **D**   **SD**

        1   2   3   4   5

11. People with disabilities always need extra help.

       SA   **A**   **U**   **D**   **SD**

        1   2   3   4   5

12. I am uncomfortable with the way a person with a disability condition may react to me if I offer any assistance.

       SA   **A**   **U**   **D**   **SD**

        1   2   3   4   5

13. People with disabilities publicly hide more than non-disabled people.

       SA   **A**   **U**   **D**   **SD**

        1   2   3   4   5

14. People with disabilities are usually sickly.

   SA   A   U   D   SD

   1   2   3   4   5

15. I am afraid of people with disabilities.

   SA   A   U   D   SD

   1   2   3   4   5

16. People with disabilities are more submissive than non-disabled people.

   SA   A   U   D   SD

   1   2   3   4   5

17. I am uncomfortable in formally greeting a person with a disability condition.

   SA   A   U   D   SD

   1   2   3   4   5

18. It is difficult for me not to be embarrassed when around a person with a disability condition.

   SA   A   U   D   SD

   1   2   3   4   5

19. People with disabilities are seldom able to be of assistance to others.

   SA   A   U   D   SD

   1   2   3   4   5

20. I have fear in attempting to communicate with a person that has a disability condition.

   SA   A   U   D   SD

   1   2   3   4   5

APPENDIX D

DIARY OF PRODUCT DEVELOPMENT

DIARY OF PRODUCT DEVELOPMENT

The instructional product development of an educational curriculum is a process of continual revision, requested feedback, and perceptive need fulfillment, all focused upon a specific community integration. This instructional product was developed through the Baker and Schutz (1971) methodology of empirical revision and community need perception as the basic guideline, coupled with an enlarged testing schedule and group-sensitive, felt-need formation and verification of product objectives associated with the researcher Bailey's (1996) interpretation. The D.A.R.T. Seminar - Building Community One Difference At A Time, was developed empirically over a two-year time span (94-95), and encompassed four states (MI, CA, OR, WA) in its developmental and target population presentations. Empirical revisions were continually analyzed and formed after presentations of the developing curriculum were presented to a learner's audience as small as 13 participants and as large as 30 participants. The development of this curriculum was designed through the exposure to varied aspects of a community existence. The audience base consisted of university students, community residents, rehabilitation hospital employees, community service professionals, university professors, and in completion, all aspects of a specific community population

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that comprise different Seventh-day Adventist church congregations.

The broad exposure to different community populations in different parts of the nation that the D.A.R.T. Seminar Curriculum - Building Community One Difference At A Time, received through its extensive developmental process can account for its direct and focused emphasis on the community needs of awareness, sensitivity, and acceptance of community diversity and stressed sensitive tolerance toward the human condition.

The first group of participants that were instrumental in the ground-breaking formation of a concept of disability awareness education, were the men and women of the course CHMN555 Pastoral Counseling, offered through the Seventh-day Adventist Theological Seminary at Andrews University. The idea of an empirically developed curriculum for a church congregation on disability awareness and human diversity was born in this series of Seminary presentations. The confirmed need for such a developed program in a church setting was encouraged by the series participants who were mature, acting pastors, teachers, and administrators who expressed a personal as well as a corporate hunger for more educated awareness concerning disability and sensitivity to human differences.

This first Seminary series was extremely productive in its cognitive contribution to the facts of disability's

definition as it relates to a social acceptance pattern as well as expressing an appropriate social responsiveness to the disability condition in general. Pastors and teachers, professionals in the field of human interactions, were seeking and sharing both personal experiences and felt needs in a way that developed a coupling effect of the cognitive need to know with the emotional need to feel accepted and integrated into the social processes of a specific community life. This coupling effect of the cognitive aspects of any awareness education and the affective realm that supported the need to cognitively achieve more awareness formed the concept of a curriculum combining the cognitive and affectual aspects of human sensitivity toward the disability condition. The participants of this pastoral counseling class contributed the understanding of the need for a church-designed curriculum and presented an informative approach to make this concept an effective reality.

The next developmental presentation series building upon the knowledge of the previous combined format was again set in the Andrews University Theological Seminary. This second series of presentations were set in the course named CHMN550 Pastoral Psychology. The students in this class were younger and less experience professionally, yet very anxious to learn and contribute to the development of a church congregational curriculum. It was in this second series that the realization of the important need for

presentational flow and practical knowledge presented in a non-academic, community-minded fashion was made clear.

The attention span of the students in this class was shorter than the more mature members of the previous class. This second series of presentations aided the formation of a more concise, clear and shorter combination of facts and effectual experiences to present information in appropriate harmony with the realistic expectations of the audience pool. This concept became a very important factor in the final formation of a realistic community-oriented seminar in presentational design for a church congregation. The academic endurance of a student-based audience pool is very much different than a community-based audience pool, unpracticed in the cognitive disciplines of reading, memorizing, and questioning. This second series of developmental presentations created in the forming curriculum a sensitivity to the community members and their need to process the presented information in as simple and practical and personally relevant manner as possible.

With the experience and knowledge from the feedback and responses from both two-day presentational series on disability awareness in the Theological Seminary, the design of the curriculum was becoming tuned to the needs of a community-based audience pool which was represented by the target population of this research study, that being the church congregation.

Arrangements were then made to present this newly formed and highly focused curriculum on disability awareness to a community audience in an interactive presentational series of 11 weeks through the public library of South Haven, Michigan, sponsored by the Harbor Lights District of the Lake Union Conference of the Seventh-day Adventist Church. Posters and flyers were made and sent out to the district churches and community members. The presentations were planned for the evenings and the community education room in the library was prepared to welcome the community-based audience pool.

The community participants of this seminar presented a very different response to the shared concepts of disability awareness than did the Seminary students. The feedback and reactions and shared experiences of the community participants reflected the day-to-day struggles of personal survival in a working world and acceptance of a disability condition was treated as a practical problem in need of a workable solution, opposed to an academic exercise in problem-solving. Both cases were necessary for the establishment of a meaningful curriculum for use in community service. The process of empirical development was occurring and each stage was adding to the fullness of the instructional product.

The 11 weeks of community presentations in the public library, with all of the practical questions and shared real

life experiences of fear, anxiety and prejudice, combined
with the academic feedback and conceptual responses of an
idealistic approach to acceptance of human differences, were
instrumental in developing the outline of the modification
of affect, Likert-type instructional inventory as a working
part of the instructional product. The community need to
become aware of the disability condition as it relates to
the human condition and then be exposed to individualistic
conditions of disability and come into actual contact with
these differences is a need that was portrayed as evident
and lacking in both the academic and community workplace
environments.

The outline of the cognitive awareness instrument was
developed through these 11 weeks of shared, interactive
presentations and revised continually through the common
feedback of necessary simplification and clarity of fact and
concept. The link was realized through the usual community
questions and shared experiences of confusion and concern
that the questions that comprise the cognitive testing
instrument need to address the practical awareness needs of
the community for the purpose of emotionally and mentally
exposing each participant to the real-life disabling
conditions and through that exposure making emotional
contact with the human differences that comprise the world
around each one of the seminar participants.

The perceived and stated revisions were made to the existing curriculum with the directed focus of necessary simplification and practical community application. The accompanying participant's manual was outlined and drawn up for further testing and empirical feedback. The introduction was completed and instructional and inspirational quotes were added and strategically placed throughout the 20 behavioral objectives to introduce and make emotional contact with each new learning unit of the curriculum. The behavioral objectives were organized into a thoughtful flow following the empirically developed design of the basic curriculum format. Visual aids or line drawings were added to the participant's manual, representing specific points of awareness necessary for test mastery and modification of affect concerning the disability condition. Overhead transparencies duplicating each conceptual visual aid were developed and used in the oral presentation of each seminar, attempting to add more strength to the development of the awareness process by incorporating into the cognitive education, each individual participant's emotion through the combination of shared sense perception.

The completion of the four presentations in the academic environment of a theological seminary coupled with the eleven presentations in the working, practical, necessary environment of a public community library brought

the need for a concentrated focus on the reality of the
disability condition and the reality of the disabling
conditions in general of the human state. The development
of this curriculum was directed toward the community
awareness and modification of affect of the disability
condition and the reality of the necessity of building a
stronger, more sensitive, accepting and tolerant community
together. The official name of the seminar was then born
upon this developed realization of the reality of disability
and the reality of life and the losses, interruptions,
restrictions, and inabilities that are a part of living.
The name of the seminar as a whole, inclusive of the
curriculum, the participant's manual and the testing
instruments, both cognitive and affectual, was called the
D.A.R.T. Seminar, representing Disability Awareness Reality
Training.

The newly-born, continually-revised, and empirically-
developed D.A.R.T. Seminar was then taken to Milton-
Freewater, Oregon, and presented in a condensed form to the
hospital employees of El Zora Rehabilitation, Retirement and
Convalescent Medical Treatment Center. The participants of
this Oregon D.A.R.T Seminar were professionals in the field
of disability and the treatment of disabling conditions
through a variety of working disciplines. The response to
the conceptual ideas and the reactions to the interactive,
shared experiences and day-to-day approaches to a practical,

realistic acceptance of the disability condition were ones
of enthusiasm, interest, and associated desire to become
more aware and thus more effective in their specific fields
of providing health care to this specific segment of the
community population.

The feedback and helpful and correction suggestions
from these working disability health-care professionals were
a continual, educational progression from the community-
based seminar participant's feedback and suggestions, yet
each one from each group was vital and instrumental in the
seminar's purpose of reaching the awareness of a community
and in that awareness changing attitudes toward human
differences. The primary contribution made to the D.A.R.T.
Seminar from the disability health-care providers in the
Oregon seminar was the knowledge of and responsiveness
toward the emotions of the individuals with specific
disabilities and how social prejudice toward disability in
general can be fueled by the misconceptions of these very
real and present emotions. This presentation clarified that
emotions of one segment of the population evoke and are a
part of the emotions of the associated segment of the
population and each are able to fuel and direct the other
through their interconnectedness. This important knowledge
and these shared experiences were immediately incorporated
into the second section and the fourth learning unit of the

participant's manual and curriculum dealing with social responsiveness toward the disability condition.

With this newly revised and more fully adapted and developed D.A.R.T. Seminar, arrangements were made for another presentation to be given at Walla Walla College in Washington state through the Social Work Department of that college's community service education. The date was set and the advertisements were sent out to the community and the room was prepared for speaking, sharing, note-taking, and questioning, with lunch and refreshments served as part of the seminar program. The presentation of the seminar was postponed then by the announcements of a bomb threat in the very room and at the very time of the scheduled presentation. The college very apologetically and gently moved the place of presentation to the other side of the campus away from the pending explosion, sacrificing the wonderful scheduled learning environment for a dimly lighted lobby filled with overstuffed chairs and an atmosphere of expectation. The seminar was presented and completed in this atmosphere. The researcher wonders how much the results of the testing instrument were affected by the anxiety over the pending explosion and the poor learning environment.

The cognitive testing inventory for this presentation of the D.A.R.T. Seminar was very informative and revealing of the need to simplify and clarify each of the required

points of information in the empirically developed criteria

for the inventory (pre- and post-tests). The data results

of the seminar were not high and certainly not 80 percent of

the material, yet the participants actively participated and

openly voiced their responses, reactions, experiences, and

suggestions for more effective learning and teaching

possibilities.

The encouraging aspect of this bomb-threat shadowed

seminar presentation was the calculated data results of the

group modification of affect testing inventory. It showed

that attitudes did indeed change from before the seminar, to

after the seminar, although very little. This was

encouraging to the researcher and was contributable in

hypothesis to the fact that the entire population of the

Washington state, Social Work Department sponsored D.A.R.T.

Seminar was attended by very aware, very well-educated

professionals in the fields of community service, from

college professors to physicians and nurses to conference

ministers. Through this presentational experience it became

evident that more educated awareness of the cognitive

aspects of the disability condition was needed and it seemed

that this awareness was able to enhance attitudes toward

this condition.

After the noted revisions were implemented and the

format and presentation of the D.A.R.T. Seminar was applied

and focused upon the community needs expressed through the

corporate responses and reactions of the previous presentations, further arrangements were made to present the seminar directly to the research project target population, the church congregation. The D.A.R.T. Seminar was then scheduled for presentation at the West Covina Hills Seventh-day Adventist Church in Los Angeles, California. Because the measured modification of affect was so slight after the seminar in Washington and because the presentational time limit was tight in California, the seminar was presented in full form, yet only the modification of affect testing instrument was utilized. Each point was presented, shared, questioned, and responded to in full fashion and given full attention. The seminar was an interactive festival, with the church congregation participants sharing and responding with a great fervor and interest in becoming more accepting and aware and educated toward an appropriate responsiveness.

The calculated results of the modification of affect testing instrument were very encouraging. It seemed that attitudes were greatly modified after exposure to the empirically developed behavioral objectives in a group-interactive setting. The church members were very vocal and expressed very personal and private fears and anxieties concerning their own disabling conditions. The church members expressed their enjoyment of the seminar in its effects upon a more finely tuned sensitivity and general awareness of the disability condition and what this

condition represents in one's daily interaction with human differences. After this California church presentation, it seemed that the D.A.R.T. Seminar curriculum was beginning to fulfill its created purpose, that being to form an awareness of the reality of the disability condition and enhance general attitudes held concerning its place in the human condition.

The general affect of a church congregation concerning the disability condition seemed to be enhanceable when exposed to the curriculum based on the twenty empirically developed behavioral objectives. The next presentation of the D.A.R.T. Seminar was again scheduled for a church congregation, this time preparations were made to allow enough time for the testing inventory of both the cognitive awareness and the modification of affect.

Arrangements were made through the Pastoral Internship Program of the Seventh-day Adventist Theological Seminary at Andrews University to present the D.A.R.T. Seminar at the Chikaming Seventh-day Adventist Church in Sawyer, Michigan, as a congregational in-service education as well as a community outreach program through the church pastor and the pastoral interns in service at the church. It was planned for November 11, 1995, on a Saturday afternoon following a scheduled potluck supper. It was held in the educational wing of the church, utilizing the ample table space and light, airy atmosphere of that section of the parish. The

refreshments provided by the researcher (hot apple cider and oatmeal cookies) served as fine, healthy snacks to enhance attention levels, community morale, cognitive functioning, and modification of affect during and after the seminar presentation.

The D.A.R.T. Seminar was presented in its full, complete format of 20 participants that Sabbath afternoon. The timing of the seminar was monitored and strictly adhered to for the purposes of individual sensitivity and learning effectiveness. The D.A.R.T. Seminar is a community-based project that must cater to the individual schedules of a busy community both as church members and non-church members. The D.A.R.T. Seminar is also a general awareness training program attempting to free itself from the structures and demands of a college course or an academic exercise.

The timing of the complete seminar is a crucial aspect of the entire format. The seminar is designed in one-hour segments with a 10-minute break after each hour, a meal break after the second hour, and four hours in all. Time is crucial to every individual attending a community seminar, so as much awareness as possible needs to be artfully packed into as short a time span as can be arranged and successfully managed.

The D.A.R.T. Seminar presented at the Chikaming church was a timing success. The first section inclusive of both

units was presented and tested with an hour and a half. A
break was taken with hot cider, oatmeal cookies, and
fellowship, and the last section was then presented and
tested both cognitively and affectually within a second 90-
minute period including the closing remarks and expressed
gratitude. Under different conditions, the D.A.R.T. Seminar
could be extended into more lengthy sessions of shared
interaction and communion. In the academic setting, the
D.A.R.T. Seminar could be utilized into a four or five-day
academic exercise, taking a whole class period for each
learning unit. In the parish setting, time is of the truest
essence, so the seminar was presented as an afternoon
community outreach program. It worked well, with fine
audience participation and group interaction.

The D.A.R.T. Seminar was presented in its complete form
with its complete instructional instrument in full use. The
time it took to pre- and post-test every one of the seminar
participants was time well spent in the learning process,
for each question asked on the instructional instrument was
an objective point of awareness in the presented seminar.

Because of the individual needs and busy schedules of
each of the seminar participants, many individuals were
pulled away from the seminar by prior engagements, allowing
the data collected to be from a significantly smaller group
than originally planned. This occurrence seemed to be the
norm for each of the prior seminars presented. It seems to

be a fact of life in a community-based seminar, where the individuals in attendance have a busy life outside of the seminar setting. The data then must be carefully analyzed and the seminars must be very carefully planned and aggressively promoted and endorsed.

Learning the art of a seminar presentation is a life-long process and with this learning schedule comes the many developmental experiences that hone, polish, and refine the instructional product in harmony with one's own style and presentational manner.

After the Chikaming Church presentation and the realization that the timing and the seminar format must work in association with each other, another seminar presentation was organized. This seminar was arranged through the Andrews University Social Work Department and was designed to be a part of the existing curriculum as required in-service education towards community awareness and continuing education in-service to diversity, differences, and disability.

This presentation of the D.A.R.T. Seminar was planned for Dec. 3, on Sunday morning from 9:00 a.m. until 2:30 p.m. with lunch and refreshments served at strategic intervals during the presentation. It was held in the Chan Shun Hall, School of Business Amphitheater on the campus of Andrews University. A sign-up sheet was passed around in both the social work classes on theory and practice and twenty social

work majors signed the sheet and participated in the
D.A.R.T. Seminar.

The Chan Shun Hall Amphitheater in the Andrews
University School of Business was again chosen for the
seminar site for its level of comfort, lightness, airy and
academic feel. The segment of the population that was
interacting this time was a group familiar with the academic
setting, being that they were still in school and still
fresh in their listening and responding responses. This
social work group of twenty participants all showed up on
time and began the seminar with related and practical
questions concerning the different aspects of the disability
condition.

The D.A.R.T. Seminar was presented in its full form
inclusive of all pre- and post-tests, both cognitive and
affectual. The timing of each learning unit was watched
carefully and attempts were made to apply the principles of
timing and curriculum amount to the theories of learning in
association with presentational format, all of which were
part of each D.A.R.T. Seminar presented in the past.

This attentive group of twenty participants, all of
which were social work or closely related majors, scored
very high on their pre-tests, both cognitively and
affectually. The reason for this was hypothesized to be
directly related to the amount of exposure and learning
received concerning community service and the trained mind

set of accepting differences and helping the needs that arise from these differences in a generally subjective role-taking society.

The post-tests given to these same social workers received high scores. Testing was an accepted and familiar method of learning for these participants, being that they were still in school, and it's showed through their test scores. This group of twenty social work majors performed well and interacted as if they were in a classroom which delighted the researcher the entire time of the seminar presentation.

This group was the first gathering of participants that were exposed to the new format of breaking the tests into two separate testing experiences. It seemed to work well. The tests were given after the presentation of only two learning units. This new format then allowed for two post-testing experiences, instead of only one large one at the end. This enabled less information at one time to be tested, which was a positive addition to the learning process of the seminar.

The seminar was a success, not in terms of mastery but in terms of timing and presentation. The social work majors responded well to the participant's manual and to the questions and suggestions of the seminar. There was an 80 percent or better score on the complete testing instrument (both experiences) by 100 percent or all 20 of the seminar

participants. This was an encouraging breakthrough for the D.A.R.T. Seminar as an instructional instrument. It meant that the format and the presentation in conjunction with the 20 behavioral objectives was nearing a point of public mastery, or a point where community service would become a possibility.

There were 8 of the 20 participants (40 percent) that received a score of 80 percent or more on each objective in the instructional product. 60 percent of the 20 participants (12 participants) did not reach mastery (80 percent of the audience scoring 80 percent on each objective). The feedback and suggestions were helpful and meaningfully applied to the instructional product as a whole, as yet another presentation of the D.A.R.T. Seminar was organized in search of the elusive 80/80 mastery level of achievement. Mastery was reached on the testing instrument as a whole for the first time, but not yet on each objective. The mastery level of achievement was becoming a score of possibility now and not a hopeless nightmare.

With the success of this last seminar presented to the social work majors of Andrews University, another seminar was organized for complete presentation to the employees of the Andrews University Information Ministries Services (AIM). The dates were set for December 18 and 19, from 3:00 p.m. to 5:00 p.m., again in the comfortable, academic luxury

of the Chan Shun Hall, room 108. The complete form of the
D.A.R.T. Seminar, using the new method of testing after each
presented learning unit, was given to 10 participants over
the two scheduled days. The results of this seminar were
most encouraging to the researcher, for this group of
participants reached master (80/80). Eight of the ten
seminar participants (80 percent) scored 80 percent or
better on each presented objective. Two of the participants
scored 85 percent and 95 percent on the overall test score,
yet were lacking mastery on objectives 6 (67 percent) and 15
(37 percent) respectively. Six of the participants (60
percent) scored 100 percent on each of the 20 objectives,
and eight participants (80 percent) then scored the required
80 percent or better on each objective, presenting, for the
first time, cognitive mastery of the material.

The testing inventories were identical to each of the
previous pre- and post-tests given, the curriculum
information was identical to the previous seminars
presented, although much smoother and more complete in
stressing each necessary objective. Every aspect of the
seminar was identical to the ones in the past, except for
more experience in the presentation process and the newly
applied testing format, which was now broken up into four
separate tests (exact same questions), immediately following
each of the four presented learning units. This new format,
coupled with the experience of many previous seminar

presentations, is the method for complete mastery of the material as empirically proven by this last presentation.

The fourth learning unit of the D.A.R.T. Seminar curriculum, Responsiveness Toward the Disability Condition, was next presented to the Andrews University Theological Seminary Winter Colloquium as part of the Human Relations segment of the two-day series of practical seminars for pastors and religious education teachers. This learning unit of the D.A.R.T. Seminar was presented in partial form as a presentational topic with no collection of data involved. It was presented to 43 men and 2 women, all enrolled in the Theological Seminary and all attending this colloquium to learn how to better relate to the human condition. The length of the presentation was 60 minutes. The suggestions, questions, and comments offered by the participants were insightful and practical and very beneficial to the future presentations of this segment of the seminar as well as to the complete seminar as a whole. Each of the suggestions and practical comments offered by this group of theological students were incorporated into the presentational format and objective teaching of each learning unit for future benefit and success toward the goal of achieved mastery on each presented objective by a statistically significant number of participants.

The D.A.R.T. Seminar was again organized to be presented as a continuing education in-service training

session for the Berrien Springs Police and Fire Departments.
The dates were set for January 9 and 16, 1996, at 6:30 p.m.
to 8:30 p.m. again in Chan Shun Hall of the Andrews
University School of Business.

With the success of the last presentation, and the
suggestions and comments carefully recorded and purposefully
applied to the instructional product in each specific case,
the same, new testing format was used. The questions
remained the same on the testing instrument, the behavioral
objectives remained the same on the instructional product.
The only change rested in the format of the test. The
purpose of the change, dictated by the testing results of
the previous 21 seminar presentations was to decrease the
amount of information to learn at any one particular time
and increase the amount of time to learn the lesser amount
of material. This goal was accomplished by breaking the
testing inventories down even farther into four separate
testing experiences, one after each presented learning unit.
The pre-test would be given as a whole, all four units at
once, at the beginning of each seminar in order to detect
the awareness need of the proposed material. Then each
learning unit would be tested separately after each unit
presentation was completed. It was a success. This was the
key ingredient to reaching mastery on each objective, for it
worked perfectly for one of the six attending law

enforcement officers, and possibly all six if only they had
answered each question.

One of the six police officers scored 100 percent on
each of the 20 behavioral objectives comprising the
presented curriculum, while the other five officers scored
100 percent on the questions they took the effort to
complete, and zero percent on those questions they either
did not answer or did answer but not seriously.

This group of police officers from Berrien Springs
presented a vastly different assembly of individuals from
the other organized presentations, being uninvolved directly
with an academic setting in any fashion. It was an
excellent opportunity to interact with the community and the
people involved with direct, non-academic community service.
The affective difference between the pre- and post-tests
offered was not large, signifying to the researcher that the
general acceptance and sensitivity to differences and
especially disability differences, was intact and in-
practice. There was a slight modification of affect for
each inventory taken, showing that the curriculum and the
event of learning a specific topic on disability awareness
can contribute to a positive modification of affect overall.
The data gathered from the Police Department was not
included in the data section of chapter 4 of the
dissertation, however, the knowledge, practice, and
awareness gathered from the presentation was extremely

valuable and thus implemented into the next organized presentation of the D.A.R.T. Seminar in hopes of continually developing a more effective, efficient, and useful instructional product for the sake of disability awareness training.

In an attempt to reach mastery with a significant number of learners (25 or more), another group was organized. This time the D.A.R.T. Seminar presentation, in workshop form, was organized for the entire youth group associated with the All Nations Church in Berrien Springs, Michigan, led by Dr. Walter B. T. Douglas of the Theological Seminary and Lloyd Hamilton of the School of Education. A Saturday afternoon presentation was planned, with sundown vespers and evening refreshments for February 3, 1996, in the church recreational area. This area was chosen for its large, well-lighted space, ease of movement, and availability of long, sturdy tables upon which to take notes and take the necessary tests used in the collection of data. Another reason that the church recreational center was chosen was for its familiarity to the audience participating in the seminar presentation. This familiarity concept has proven very beneficial in past seminars to the task of group, positive modification of affect. The time was planned for the whole presentation in one time frame, from 3:30 p.m. to 8:30 p.m., including the social time at the conclusion of the seminar presentation. Upon announcing the

D.A.R.T. Seminar to the youth, eager excitement for the
opportunity to socialize and be a helpful part of a project
designed to help other people was shown.

Preparations were made for the success of the seminar
by arriving an hour early at the church and setting up
tables, chairs, and desks and arranging the "classroom"
where the seminar was to be held into the most efficient and
productive arrangement possible. After arriving early at
the church and examining all the possibilities of learning
arrangements and set-ups, the decision was made by the
researcher to present the seminar in the large, well-lighted
young adult Sabbath School room, just off the main sanctuary
floor. This decision was made for the purpose of greater
learning possibilities, from a more intimate gathering space
with fewer possible distractions, opposed to the larger,
more wide-open space of the main sanctuary floor.

An enthusiastic welcome was offered to all the
participants as they slowly arrived around the starting time
of 3:30 p.m. Once the room was filled with 19 individuals,
the seminar was begun. (These 19 individuals were combined
in the data collection and analysis process with the 11
individuals from the previous seminar to the AIM employees
of Andrews University to form a collective group of 30
seminar participants.) The first stage of step 4 in the
developmental process, Taking the Pre-Instruction Inventory,
was completed by filling out the personal information sheet

and the taking of the cognitive and affectual pre-tests. Stages 2, 3, and 4 of the process were then completed utilizing frequent small breaks and much time for questions and clarification of concerns and testing procedures. During the seminar, the researcher attempted to remain open and sensitive to suggestions, comments, and questions for the sake of assisting in the learning process.

At sundown that evening, which was 6:00 p.m., a brief vespers service was held in the main sanctuary for all the seminar participants. Following the worship service, the last learning unit, stage 5 of the process, was presented. Immediately following the completion of the fourth learning unit, the last stage of the process, stage 6, was completed by having the entire seminar group take the cognitive and affectual post-tests. Having finished the complete presentation of the D.A.R.T. Seminar, a delicious supper was served.

This group of 19 participants all scored below the mastery standard of 80/80 on the cognitive pre-test prior to the seminar presentation. This was expected. Yet, following the seminar presentation, with all of its newly revised teaching methods and testing objectives in place, 18 of the 19 seminar participants reached the mastery level of achievement on each objective of the post-test. Mastery had finally been achieved. The researcher was overjoyed. In combination with the 11 previous seminar participants, where

9 of the 11 individuals scored mastery on each objective, a total of 27 participants out of a group of 30 had reached the mastery level. This 27 out of 30 number is 90 percent of the participants who achieved mastery, or a score of 80 percent or more on the post-test for each objective.

Concerning the pre-test, with all 30 participants, the compared results of the pre- and post-tests were wonderfully revealing. On the pre-test for the 30 participants, concerning objectives 1, 7, 9, 10, 11, 13, 14, 15, 18, 19, and 20, 100 percent of the participants, all 30, scored in the 0-19 percent range. On objective 2, 43 percent or 13 participants scored in the 80-100 percent range, while only 7 percent or 2 participants scored in this same range for objective 3. On objective 12, 20 percent or 6 participants scored in the mastery range and on objectives 16 and 17, only 13 percent or 4 participants and 3 percent or 1 participant, respectively, scored in the mastery range of 80 percent or more.

The cognitive post-test results showed much higher scores in comparison. This was encouraging and joyful to the researcher. On objectives 1, 2, 4, 7, 8, 9, 10, 11, 17, 18, and 19, 97 percent or 20 of the 30 participants scored in the mastery range. On objectives 3, 6, and 15, 93 percent or 28 of the 30 participants scored in the 80-100 percent range. Finally, on objectives 5, 12, 13, 14, 16, and 20, 100 percent of the 30 participants scored in the 80-

100 percent mastery range. The post-test results showed that mastery had been achieved by this last group of 30 participants.

All the participants were congratulated and thanked for their hard work and fine efforts in making this research study a success. Many of the participants returned after the supper and thanked the researcher for the awareness that was gained that evening and voiced sincere gratitude for aiding in their acceptance process of the disability condition. These words of acceptance were treasured by the researcher as words of a mission successfully begun.

Mastery was achieved with this last group of 30 seminar participants and a true, practical, interactive seminar representing individual inclusion and personal emancipatory empowerment was born. From this birth came an invitation to present the newly completed, statistically significant and fully mastered D.A.R.T. Seminar in Winona, Minnesota. The seminar was scheduled for March 22 and 23, through the Alpine Meadows Health and Education Institution, located in Fountain Valley, Wisconsin, just over the Mississippi River from Winona, Minnesota.

The actual seminar was planned for the evening hours on Friday and Saturday, from 7:00 p.m. to 9:00 p.m., with a Sabbath morning sermon on acceptance and inclusion in between. It was to be held in the town of Winona, at the lecture hall adjoining the medical clinic and the health

food store. It was advertised on the two local radio
stations and in print form in the counseling centers,
schools, colleges, universities, and churches surrounding
the area.

It went very well. It was well attended and met with
great enthusiasm and interest. The researcher was very
thankful for the opportunity to share the D.A.R.T. Seminar
with the wonderful people in Winona, and for the opportunity
to continually learn from the discussions, comments,
questions, and insights brought into focus through the
presentation process. The goal of practical, social
interaction combined with individual empowerment leading to
a personal and social inclusion was reached according to the
feedback and group response after the seminar. This group
reaction made the researcher very happy and grateful and
hopeful for a continued awareness and associated action,
within the group and personally, of one of the grandest of
all human needs, the need to belong.

Another opportunity to share the formulated and
empirically developed D.A.R.T. Seminar presented itself
through an invitation by an Andrews University Seminar
student to be the featured speaker for a young adult series
of meetings on community involvement and service through
acceptance. There were two evenings planned, April 1 and 8,
1996, in the Berrien Springs Community Resource Center.
Each evening meeting was to involve two learning units of

the D.A.R.T. Seminar as the focus of sharing and interaction.

Each session was well attended and met with extreme responsiveness and enthusiasm over the concept of human service through acceptance of differences, most notably, the differences represented by the disability condition. The audience consisted of Berrien Springs High School students, led by the pastoral staff for youth ministry from the Village SDA Church in Berrien Springs, and the Seminar at Andrews University.

The young people were very vocal in their questions and responses and very open in sharing their fears and expectations associated with disability and the social stigma that it carries. The whole D.A.R.T. Seminar was presented, though in shorter versions than previously experienced. This allowed the presentations to be extremely focused upon the audience and the topic of choice, being community and human service through acceptance.

The responses of the young people during both evening sessions were the education and enjoyment for this researcher. Each question was met with a response that represented a personal hurt or feeling of shared hurt for another person of a disability condition somewhere in their past. The feeling of sympathy for the reality of life's darker experiences shared these two nights was of an immense depth, but at no time did the essence of pity or negative

judgment come into focus. Instead of pity, these young people asked for education for better understanding and awareness of the condition for better ability to serve, integrate, incorporate, and accept each person and personhood into their community of shared friendships. These two evenings represented what the D.A.R.T. Seminar holds as its primary goal and purpose: the empowerment of all people inclusive of their individual differences through the community act of interaction by acceptance.

APPENDIX E

THE D.A.R.T. SEMINAR - BUILDING
COMMUNITY ONE DIFFERENCE
AT A TIME
(PARTICIPANT'S MANUAL)

DISABILITY AWARENESS REALITY TRAINING

Building Community

The D.A.R.T. Seminar

One Difference At A Time

Participant's Manual

By

Rikard Ashmore Bailey

1996

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D.A.R.T.

REALITY · REALITY · REALITY · REALITY

AWARENESS · AWARENESS

SEMINAR

Building Community One Difference At A Time

The D.A.R.T. Seminar

Building Community One Difference At A Time

"Our only hope will lie in the frail web of understanding

of one person for the pain of another"

- John Dos Passos

Participant's Manual

Name _____   Date _____

Community Service _____

The following materials represent the learning outline for the D.A.R.T. Seminar empirically developed, 20-point process of disability awareness reality training: the conceptual behavioral objectives 1 - 20 presented in sections 1 - 4.

Section 1: Defining the Disability Condition

1. The learner will demonstrate a conceptual understanding of the disability condition by becoming aware of the expressed definition of disability.

2. The learner will demonstrate a conceptual understanding of the disability condition by understanding the life occurrences that enable a disability to happen.

3. The learner will demonstrate a conceptual understanding of the disability condition by becoming aware of the types of disability and aware of how understanding these types could aid in more tolerance and acceptance of the human condition in general.

4. The learner will demonstrate a conceptual understanding of disability by becoming aware of the different disability conditions and their effects on daily life activity.

The D.A.R.T. Seminar

Section 1: The Disability Condition

Objective 1: Defining Disability

Objective 2: Understanding the Disabling Life Occurrences

Birth

Disabling
Life Occurances

Sickness

Aging
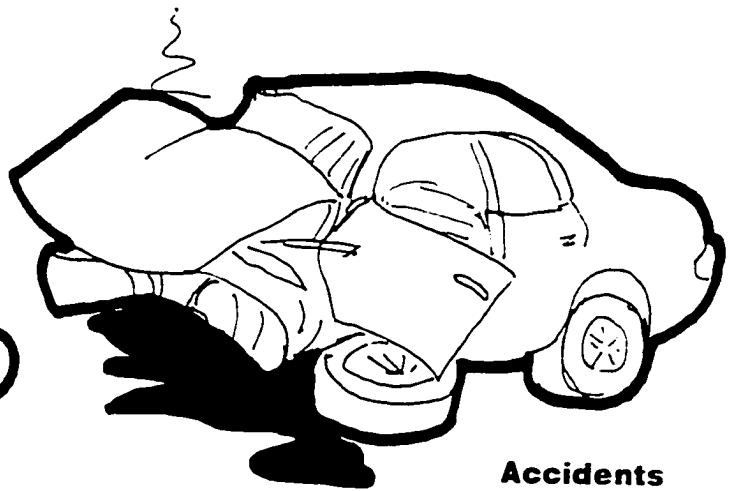
Accidents

The D.A.R.T. Seminar

Objective 3: Becoming Aware of the Types of Disability

Objective 4: Becoming Aware of Different Disability
Conditions

#4   The disabling conditions

*Amputation - body-part removal

*Blindness - vision loss

*Cerebral Palsy - umbrella - nerve/muscle dysfunction caused by brain damage

*Communicative Disorders - umbrella - speech/hearing and learning disabilities that affect communication

*Deafness - hearing loss

*Developmental Disability - umbrella - mental/physical disability manifested before age 22 and continues limiting indefinitely

*Epilepsy - umbrella - disturbed electrical rhythms of central nervous system manifested by seizures

*Hearing Impairment - hearing disabilities (slight-severe)

*Hemiplegia - full/partial paralysis of one side of the body caused by brain damage

*Learning Disability - umbrella - reading/speaking and writing (written expression) impairment

*Mental Illness and Mental Disorder - loss of social/ vocational skills necessary to function independently

*Mental Retardation - condition of below-average intellectual functioning

*Paraplegia - partial/total loss of function of both legs

*Quadriplegia - partial/total loss of function in both arms, both legs

*Spasticity - sudden, involuntary muscle spasms

*Speech Impairment - limited or difficulty pattern(s)

The D.A.R.T. Seminar review questions for **Section 1:** Conceptual Behavioral Objectives 1 - 4.

1. What is a definition of the disability condition?

2. What are the life occurrences that enable a disability to happen?

3. What are the types of disability?

4. Name one disability condition that would cause you the most fear and explain why.

Modern man is educated to understand foreign

languages and misunderstand foreigners.

- G. K. Chesterson

Section 2: Sociological Issues Associated with Evaluation and the Disability Condition

5. The learner will demonstrate a conceptual understanding of certain sociological aspects associated with the disability condition by becoming aware of how society may evaluate "strangers."

6. The learner will demonstrate a conceptual understanding of certain sociological aspects of the disability condition by becoming aware of the Nagler 3-point process of social evaluation.

7. The learner will demonstrate a conceptual understanding of the disability condition by becoming aware of the two-characteristic effect disability has upon the public and society.

8. The learner will demonstrate a conceptual understanding of certain sociological aspects of the disability condition by becoming aware of the two actions performed by society toward people with disabilities as a result of the pre-mentioned two characteristic effect. The learner will be able to discuss more integrative social actions.

9. The learner will demonstrate an understanding of the sociological issues involved in the disability condition by becoming aware of familiar reasons for non-acceptance of the disability condition and why these reasons exist.

10. The learner will demonstrate a conceptual understanding of the disability condition by becoming aware of common points of social disintegration and a method to advance a social integration among people with disabilities.

11. The learner will demonstrate a conceptual understanding of certain sociological aspects of the disability condition by understanding how disability continued historically to be linked with social deviance.

The D.A.R.T. Seminar

Section 2: **Sociological Issues and Evaluations**

Associated with the Disability Condition

Objective 5:   The Social Evaluation Point

Objective 6:   Social Evaluation Process
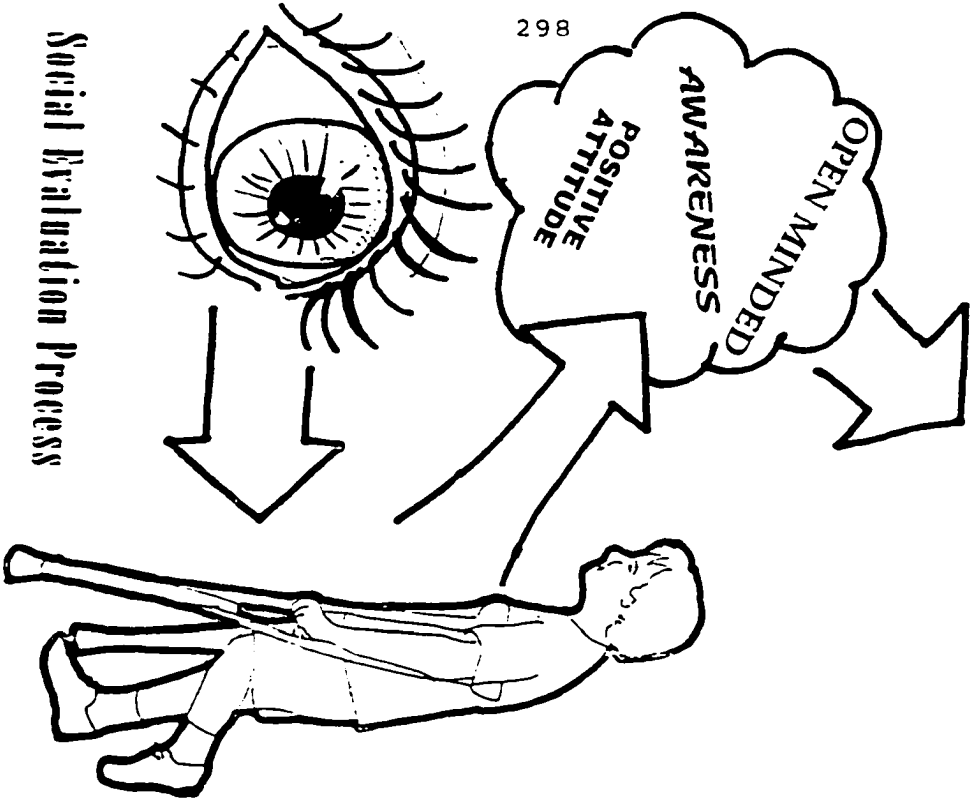
298

Social Evaluation Process

POSITIVE ATTITUDE

AWARENESS

OPEN MINDED

ACCEPTANCE

Social Evaluation Process

FEAR

IGNORANCE

PREDJUDICE
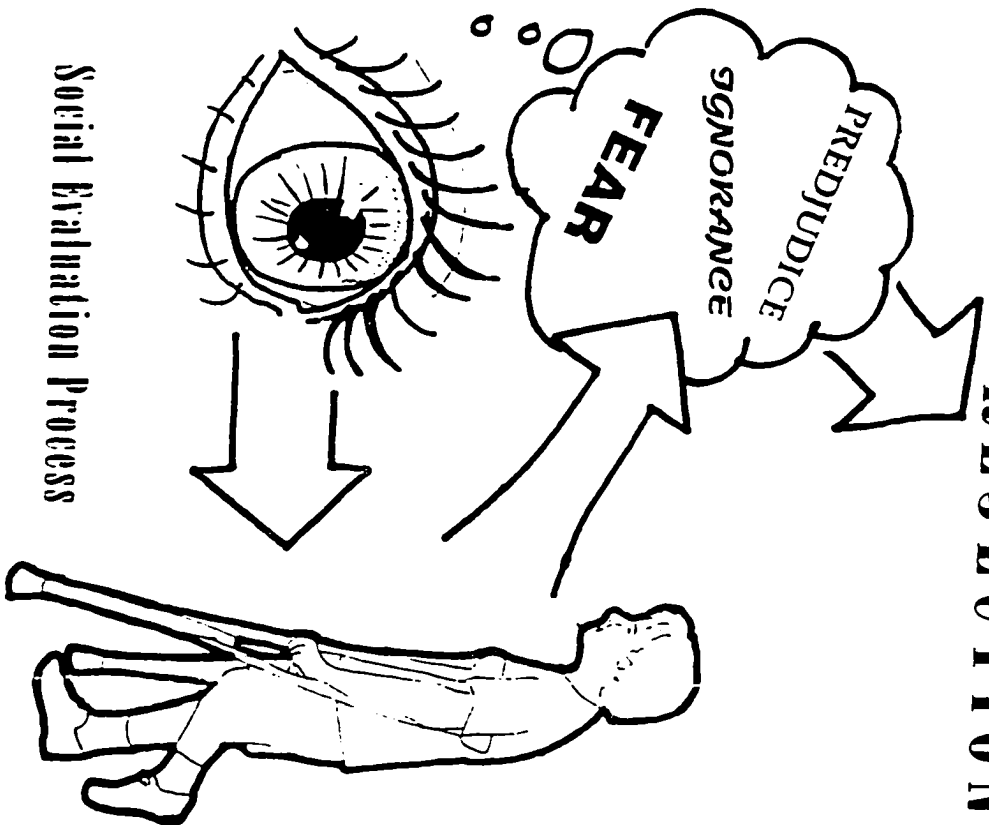
REJECTION

The D.A.R.T. Seminar

Objective 7:   Disability and the Two-Characteristic

Effect Upon Society

Objective 8:   Disability and Society's Double

Action Response

SOCIAL PERCEPTION~PREJUDICE
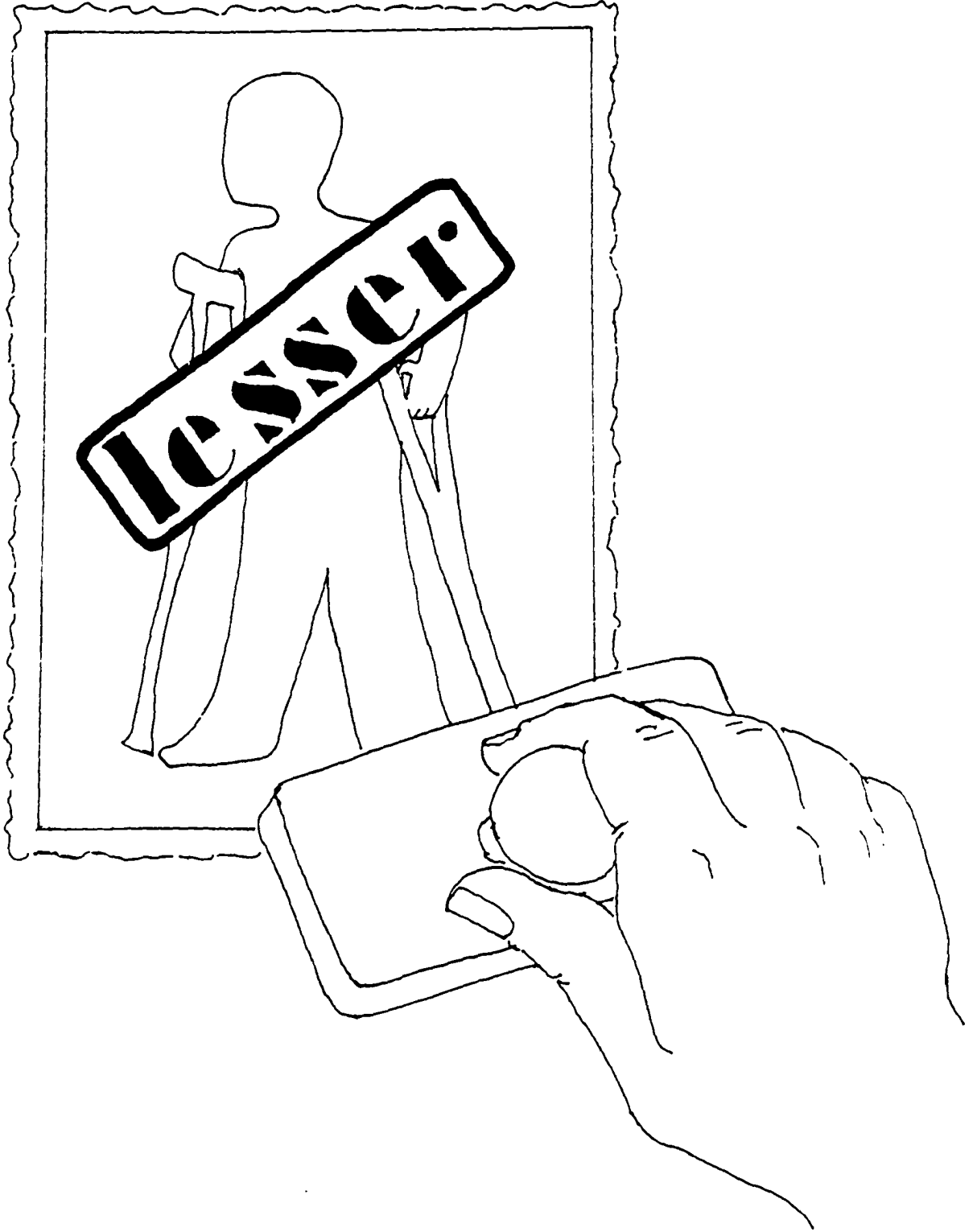
The D.A.R.T. Seminar

Objective 9:   Disability and Non-Acceptance

Objective 10: Disability and Social Disintegration

The D.A.R.T. Seminar

Objective 11: Disability and Social Deviance
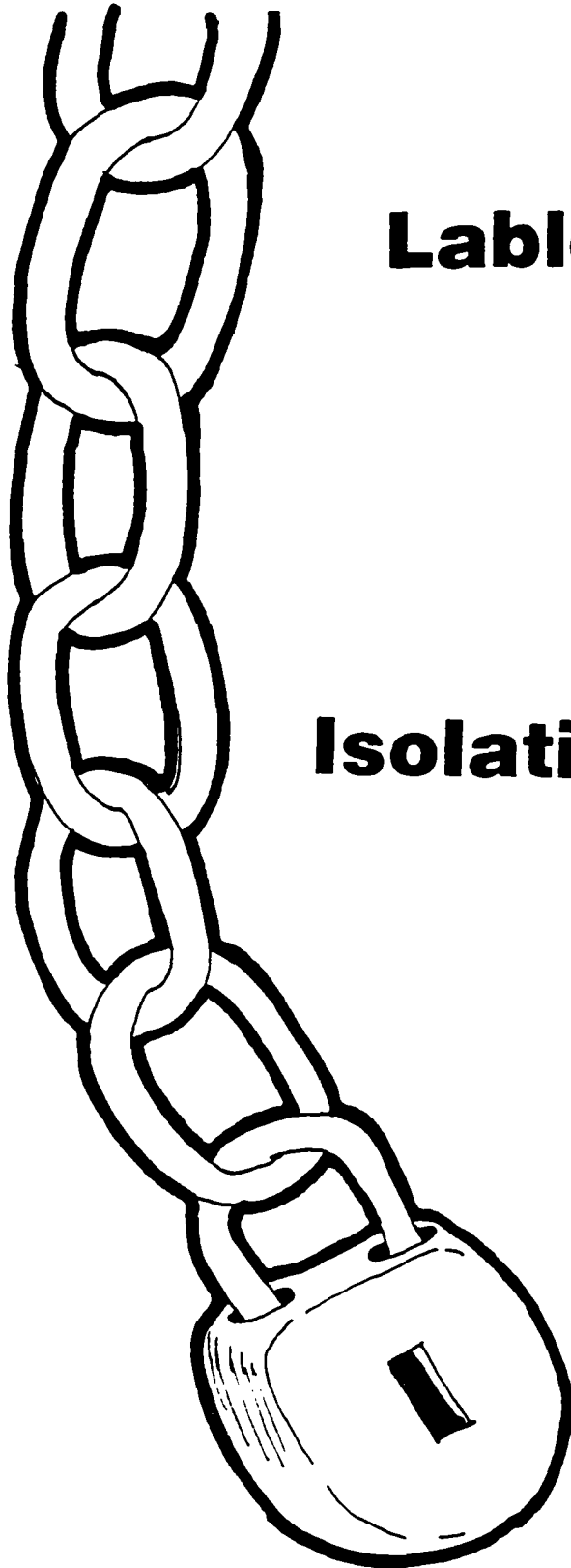
Labled "Deviant"

1951

Isolation Promoted

1966

Ignored

1976

The D.A.R.T. Seminar review questions for **Section 2:**
Conceptual Behavioral Objectives 5 - 11.

5. How does society evaluation strangers?

6. What is the 3-point process of social evaluation?

7. Name the two-characteristic effect disability has upon society.

8. Name the two actions performed by society toward people with disabilities.

9. What are the reasons for non-acceptance of the disability condition and why do these reasons exist?

10. Name the points of social disintegration.

11. How does disability continually become linked with social deviance?

Lots of folks confuse bad management with destiny

- Kin Hubbard

Section 3: An Origin of Attitudes Toward the Disability Condition

12. The learner will demonstrate an understanding of an origin of attitudes with respect to the disability condition by becoming aware of possible reasons for certain aversive behavior in children exhibited toward the disability condition.

13. The learner will demonstrate an understanding of certain attitudes toward disability by becoming aware of how society is used to conceptualizing the disability condition through pre-existing stereotyped images.

14. The learner will demonstrate an understanding of certain attitudes toward disability by becoming aware of Donaldson's attitude enhancing experiences and how they might enhance any personal attitude.

15. The learner will demonstrate an understanding of the disability condition and certain held attitudes in regards to a social acceptance pattern by becoming aware of a four-point pattern of acceptance and a personal meaning extracted from this pattern.

The D.A.R.T. Seminar

Section 3:   Origin of Attitudes Toward the Disability

Condition

Objective 12:   Aversive Behavior Toward the Disability

Condition

Objective 13:   Conceptualizing the Disability Condition

Through Stereotyped Images

The D.A.R.T. Seminar

Objective 14: Disability and Certain Attitude Enhancing

Experiences

Objective 15: Disability and a Social Acceptance Pattern
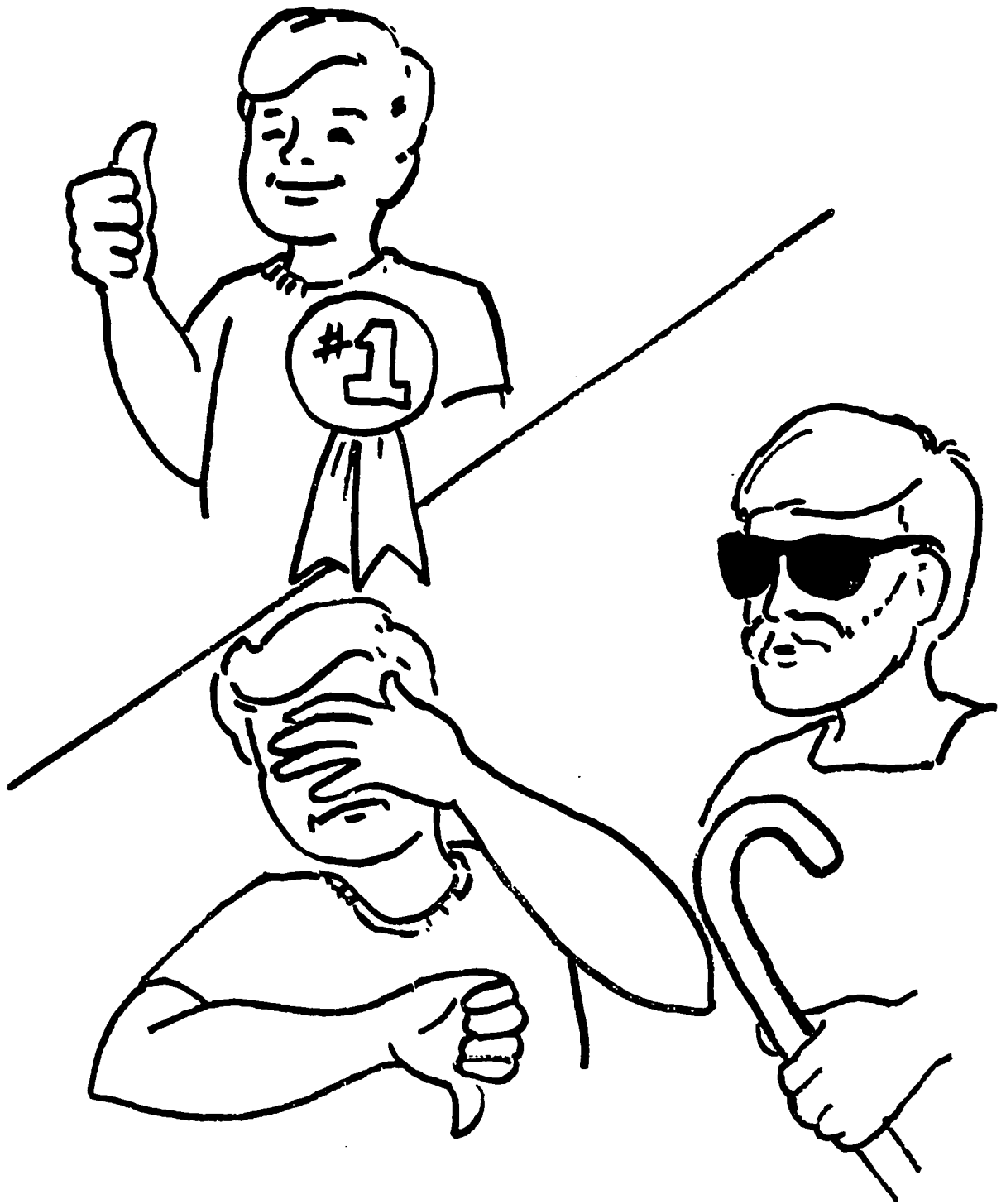
The D.A.R.T. Seminar review questions for **Section 3:**
Conceptual Behavioral Objectives 12 - 15.

12. What are 3 common reasons for a child's aversive
behavior toward a person with a disability?

13. How does society conceptualize the disability condition
through stereotyped images?

14. What are Donaldson's attitude enhancing experiences and
how could they enhance a personal attitude toward the
disability condition?

15. What is the Nagler social acceptance pattern and how
could understanding its structure and concept add personal
meaning to one's life as a member of society?

"It usually takes more than three weeks to prepare

a good impromptu speech"

- Mark Twain

Section 4: Responsiveness Toward the Disability Condition

16. The learner will demonstrate an understanding of a responsiveness toward the disability condition by becoming aware of the four social myths associated with disability.

17. The learner will demonstrate an understanding of a responsiveness toward the disability condition by becoming aware of the friendship skills associated with an interaction with a person of disability.

18. The learner will demonstrate a conceptual understanding of a responsiveness toward the disability condition by becoming aware of how a person with a disability can become handicapped.

19. The learner will demonstrate an understanding of a responsiveness toward the disability condition by becoming aware of the Nagler methods of realistic acceptance of a disability condition.

20. The learner will demonstrate an understanding of a responsiveness toward the disability condition by becoming aware of a basic disability etiquette and how such a practiced etiquette could make a person with a disability feel more accepted.

The D.A.R.T. Seminar

Section 4: **Responsiveness Toward the Disability Condition**

Objective 16:   Social Myth Rebuttal

    a.   "their own kind"

    b.   obligation to "take care of"

    c.   live different lives

    d.   always needs help

The D.A.R.T. Seminar

Objective 17:   Personal and Social Awareness When
Speaking To or About a Person With a Disability Condition
(Friendship Skills)

Objective 18:   Disabled vs. Handicapped: The Big Difference

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Objective 19:   Certain Actions Associated With a Realistic

Acceptance of the Disability Condition

Objective 20:   Becoming Aware of a General Disability

Etiquette

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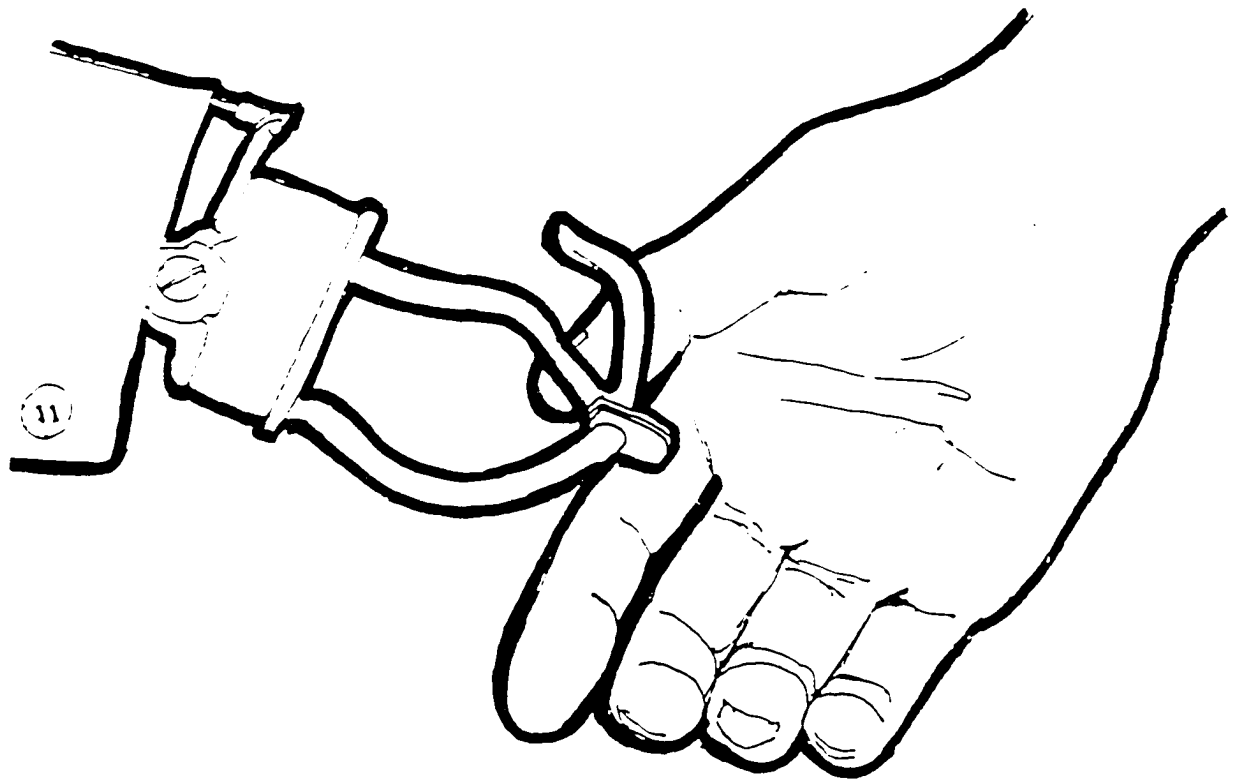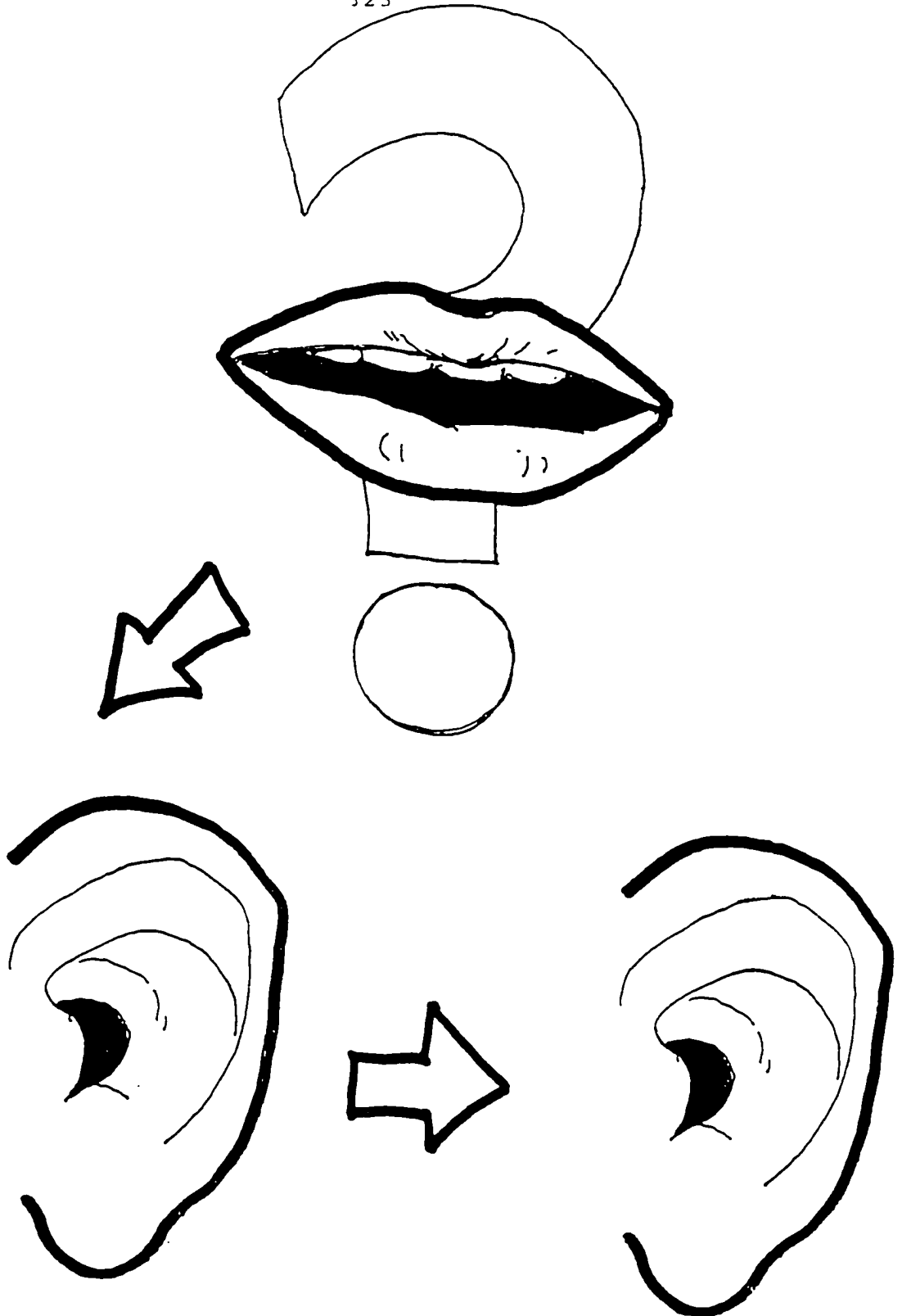
The D.A.R.T. Seminar review questions for **Section 4:**
Conceptual Behavioral Objectives 16 - 20

16. What are some common myths and associated rebuttals
relating to the disability condition?

17. What are the friendship skills associated with personal
awareness and social exchange, used when interacting with a
person of disability?

18. How does a person with a disability become handicapped?

19. Name the Nagler methods of realistic acceptance
associated with the disability condition?

20. What are the points of disability etiquette according to
the D.A.R.T. Seminar and how could they make a person with a
disability feel more accepted?

BUILDING COMMUNITY ONE DIFFERENCE AT A TIME . . .

APPENDIX F

THE D.A.R.T. SEMINAR - BUILDING COMMUNITY ONE

DIFFERENCE AT A TIME

(INSTRUCTOR'S MANUAL)

DISABILITY AWARENESS REALITY TRAINING

Building Community

THE D.A.R.T. SEMINAR

One Difference At A Time

INSTRUCTOR'S MANUAL

By

Rikard Ashmore Bailey

1996

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Defining the Disability Condition

The disability condition is represented by: "any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner, or in the range considered normal" (World Health Organization, Geneva, 1980).

The disability condition can further be represented by: "any condition in life that creates an interruption of, a restriction in, or an inability to, perform a life-activity in a socially and personally acceptable manner and range" (The D.A.R.T. Seminar, 1996).

PREFACE

The materials in this Instructor's Manual are designed primarily to educate and assist Seventh-day Adventist church members, other interested church members, and social service personnel in the awareness and practice of certain concepts and friendship skills necessary for the inclusion and empowerment, into everyday social activity, that segment of the population that is experiencing a disability condition. This task can be attempted and completed as a result of the related dissertational study showing that specific cognitive awareness gained associated with the disability condition can positively modify associated affect relating to the same disability condition. This research finding leads to the researcher's presupposition that a more positive attitude toward the disability condition can be more instrumental in the facilitation of an equal status inclusion and integrative acceptance toward human differences in general.

The ideas, concepts, and practical suggestions presented in this manual were derived from an extensive search of associated literature both historical and contemporary, personal interviews with patients, survivors and care-giving personnel in their homes, offices, clinics, individual churches, rehabilitation facilities, general care hospitals and geriatric health-care and wellness centers

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located in four different states. Over twenty-four developmental topic presentations and seminar workshops relating to disability awareness training were presented throughout five different states and over three decades of personal experience dealing with my own disability, all combined to form the D.A.R.T. Seminar.

I would like to express to you my sincere appreciation for making the commitment to participate in this special awareness training seminar. I have researched and assembled what I consider to be the basic essentials instrumental to the facilitation of a conceptual, cognitive awareness of the disability condition and an associated, enhanced modification of affect. This program has been extensively tested and re-tested, showing results demonstrating that specific knowledge gained can be a positive influence in the modification of associated affect.

It will take a full five hours to complete this training program. The commitment you show here at this seminar will benefit you personally through the process of becoming more aware, and possibly more interested, in building an inclusive community through personally enhanced attitudes toward the disability condition.

The D.A.R.T. Seminar, or Disability Awareness Reality Training, represents a twenty-point process of educational progression through four different subjects of awareness associated with the disability condition. The twenty points

are composed of the twenty empirically developed behavioral objectives that create the seminar's educational purposes. The four different subjects of awareness associated with the disability condition are the empirically developed studies of definition, evaluation, attitudal origins and social responsiveness.

The D.A.R.T. Seminar follows a presentation and open discussion format where acceptance, inclusion, and personal empowerment are the structural goals supporting the purposes of enhanced cognitive awareness, positive modification of affect, and comfortable personal and social integration. This seminar curriculum, its learning objectives, its outlines, testing instruments, both cognitive and affectual, its participant's manual, as well as this instructor's manual are all a result of intense empirically developed testing and re-testing, questioning, observing, interviewing, teaching, and presenting topic discussions, partial workshops and complete seminars to the target populations of church members and social service personnel.

The D.A.R.T. Seminar represents an empirical-analytical mode of technical inquiry. The specific methodology follows a seven-step empirical process for instructional product formation developed by Baker and Schutz (1971) and interpreted by Bailey (1996). The steps are as follows: Formulation, Instructional Specifications, Item Tryout, Product Development, Product Tryout, Product Revision, and

Operations Analysis. These seven steps are representative
of an empirical development of a curriculum, yet through
this technical mode of analytic inquiry lies a practical
interaction with society that purposes an emancipatory
empowerment of each individual through the socially
formulated learning objectives and behavioral modifications.

The presentation of the seminar is designed to not play
an adversarial role with the subject matter content, but
rather work in harmony with its purpose and claim verifiable
results that demonstrate a need for its existence and an
accomplishment of its mission. The D.A.R.T. Seminar uses an
empirical-analytical mode of technical inquiry into the
social science of curriculum development that incorporates
the interactive and emancipatory goals of the subject
content into a practical mission of knowledge and acceptance
for the purpose of individual and community inclusion. This
seminar has been proven successful in enhancing cognitive
awareness of and a positive modification of affect toward
the disability condition.

The methodology used to demonstrate the goals and
purposes of the D.A.R.T. Seminar, mentioned earlier as the
method following Baker and Schutz (1971), used a pre-test/
post-test instructional format. Each behavioral objective
and affectual response-option associated with this seminar,
40 in all, was empirically formulated and then pre-tested
for need verification and attitude reference and then post-

tested for goal attainment and attitude modification. This extremely lengthy process was performed over months of time and increasingly larger groups of seminar participants each presentation. This was done until a cognitive and affectual pre-established statistical standard was attained with a pre-established, statistically significant number of attending individuals.

With the data from each of these progressive seminar presentations, coupled with the final statistically significant data base, came the analysis of each response both cognitive and affectual, signifying that the seminar was empirically developed and able to achieve, to a pre-established statistical standard, the goal of positively enhancing both cognitive awareness and modification of affect toward the disability condition.

Instructor's Manual Table of Contents

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The following materials represent the teaching outline and cognitive information for the D.A.R.T. Seminar empirically developed, 20-point process of disability awareness reality training: the conceptual behavioral objectives 1 - 20 presented in sections 1 - 4.

20 LEARNING OBJECTIVES

The 20-point process of Disability Awareness Reality Training that form the purpose and structure of the D.A.R.T. Seminar

Section 1: Defining the Disability Condition

1. The learner will demonstrate a conceptual understanding of the disability condition by becoming aware of the expressed definition of disability.

2. The learner will demonstrate a conceptual understanding of the disability condition by understanding the life occurrences that enable a disability to happen.

3. The learner will demonstrate a conceptual understanding of the disability condition by becoming aware of the types of disability and aware of how understanding these types could aid in more tolerance and acceptance of the human condition in general.

4. The learner will demonstrate a conceptual understanding of disability by becoming aware of the different disability conditions and their effects on daily life activity.

Section 2: Sociological Issues Associated with Evaluation and the Disability Condition

5. The learner will demonstrate a conceptual understanding of certain sociological aspects associated with the disability condition by becoming aware of how society may evaluate "strangers."

6. The learner will demonstrate a conceptual understanding of certain sociological aspects of the disability condition by becoming aware of the Nagler 3-point process of social evaluation.

7. The learner will demonstrate a conceptual understanding of the disability condition by becoming aware of the two-characteristic effect disability has upon the public and society.

8. The learner will demonstrate a conceptual understanding of certain sociological aspects of the disability condition by becoming aware of the two actions performed by society toward people with disabilities as a result of the pre-mentioned two-characteristic effect. The learner will be able to discuss more integrative social actions.

9. The learner will demonstrate an understanding of the sociological issues involved in the disability condition by becoming aware of familiar reasons for non-acceptance of the disability condition and why these reasons exist.

10. The learner will demonstrate a conceptual understanding of the disability condition by becoming aware of common points of social disintegration and a method to advance a social integration among people with disabilities.

11. The learner will demonstrate a conceptual understanding of certain sociological aspects of the disability condition by understanding how disability continued historically to be linked with social deviance.

Section 3: An Origin of Attitudes Toward the Disability Condition

12. The learner will demonstrate an understanding of an origin of attitudes with respect to the disability condition by becoming aware of possible reasons for certain aversive behavior in children exhibited toward the disability condition.

13. The learner will demonstrate an understanding of certain attitudes toward disability by becoming aware of how society is used to conceptualizing the disability condition through pre-existing stereotyped images.

14. The learner will demonstrate an understanding of certain attitudes toward disability by becoming aware of Donaldson's attitude enhancing experiences and how they might enhance any personal attitude.

15. The learner will demonstrate an understanding of the disability condition and certain held attitudes in regards to a social acceptance pattern by becoming aware of a four-point pattern of acceptance and a personal meaning extracted from this pattern.

Section 4: Responsiveness Toward the Disability Condition

16. The learner will demonstrate an understanding of a responsiveness toward the disability condition by becoming aware of the four social myths associated with disability.

17. The learner will demonstrate an understanding of a responsiveness toward the disability condition by becoming aware of the friendship skills associated with an interaction with a person of disability.

18. The learner will demonstrate a conceptual understanding of a responsiveness toward the disability condition by becoming aware of how a person with a disability can become handicapped.

19. The learner will demonstrate an understanding of a responsiveness toward the disability condition by becoming aware of the Nagler methods of realistic acceptance of a disability condition.

20. The learner will demonstrate an understanding of a responsiveness toward the disability condition by becoming aware of a basic disability etiquette and how such a practiced etiquette could make a person with a disability feel more accepted.

The Development of a Working Definition of the Disability Condition

Defining Disability

"The word disability in society is often associated with fear of the unknown, inadequate experience, incorrect and distorted information and simply lack of knowledge" (National Easter Seal Society, First Step Campaign, 1994). Disability happens as a result of a natural function of the human body that has been insulted in some real and explainable manner. Disability occurs in three different

categories: physical disability, mental disability, and emotional disability. The emotional disability is associated with the mental disorder segment of this particular impairment, yet independent and separate from mental retardation. "Mental disorder is a comprehensive term that describes forms of mental illness or emotional disorders" (First Step Campaign, 1994). Individuals may rest in one, two, or all three of the categories, depending upon the type of insult to the body that has occurred.

Disabling Life Occurrences and Disability Types

This insult that causes the impairment that leads to the disability can be a result of four different events or occurrences. The first is birth. The process of birth is a complex assembly of progressions and developments. Defects can happen at any stage during this lengthy process; defects that lead to impairments, that can later develop into disabilities of all combinations of the three categories.

> Assembling a human being from a single fertilized egg is a formidable task. Nature does not always do the job perfectly, and the result is that 2% to 3% of all babies born in the United States have a major malformation. Some defects, moreover, become apparent later in childhood, as they evolve (Edelson, 1992, p. 13).

Birth can carry with it genetic defects and chromosome problems that can develop into disabilities. Lifestyle affects the birth development through its association with any incorrect exposure to medicines, chemicals, toxins, and

radiation. The possibility of affecting the abilities of the next generation is great.

> Few people are sufficiently aware of the continuous rise in the incidence of congenital malformation or birth defects. Apparently this increased incidence is associated with the increasing longevity of man and the increasing possibility of carrying on into the next generation the inherited defects of a previous generation (Fishbein, ed., 1963, p. 5).

The second event and/or occurrence that can lead to disability is disease.

> The concept of disease refers to objective phenomena. The human body is composed of cells, tissues and organs that must function adequately to ensure biological continuity. Disease denotes a state of unhealth, or a state in which the body is suffering from a malfunctioning of one or more parts (Dimond, Jones, 1983, p. 3).

Disease can insult the human body at any time, any place, and at any age, leaving an impairment that is disabling in a physical way, a mental manner, or an emotional trauma, and also any combination of the three categories.

> When individuals are diagnosed as having a chronic, disabling illness, they go through a process of adapting to a disease that can be fraught with unpredictability, remissions and exacerbations. Adaptation is a complex process varying from one illness to another and is influenced by both internal and external factors ranging across the biologic, psychologic, interpersonal and sociocultural spheres of life (Miller, 1992, p. 218).

The third event or occurrence that can lead to disability is an accident or injury. This occurrence can happen to any person at any time and cause an insult to the body that can leave that person impaired and disabled. The

accident and injury disability very commonly happens in the
home (Breckon, ed., 1978). The industrial accident and the
environmental accident can and does cause personal injury
and opens the doors for public responsibility and
involvement (Gaskins, 1989). The most evident and usual
accident and injury-causing disability comes from the
automobile (Fletcher, 1964). The accident/injury segment of
that which causes disability is a wide and varied collection
of events and occurrences that are constantly being
corporately and privately monitored for more preventive
education and practiced precautions.

The fourth event and occurrence that can disable is the
process of aging.

> In the year 2020, the percentage of the population age
> 65 and over could reach 30 percent. In addition,
> health care needs of the elderly make the older person
> a major consumer of the various forms of health care.
> For example, elderly persons have twice as many
> hospital stays and the stays last twice as long. In
> addition, people over age 65 visit the doctor 43
> percent more often than those under age 65. Also, the
> variety of health care settings currently available and
> needed are much greater for the elderly than for other
> segments of the population; for example, elderly people
> use hospitals, long-term care settings, rehabilitation
> facilities, out-patient clinics, respite centers, home
> care, hospices and day care centers (Lewis, 1985, p.
> 2).

This is the time when the body structure and processes
transform to a different rate and strength in regard to
function and movement. An aging individual's heredity is
vulnerable to any number of impairments at this time,
impairments that can lead to disabling disease, and

impairments that are disabling in themselves. "When illness is superimposed on normal age-related changes, the classic parallel lines of normal human biology and disease converge in the elderly patient, causing the physician confusion and concern" (Eisdorfer, ed., 1980, p. 140).

The aging process is a constant study and practice and a human development that is extremely vulnerable to external forces. "Aging alters the response to disease. The aging process and the stress of previous diseases cause the body to respond to the same noxious stimulus in ever changing ways" (Steinberg, ed., 1983).

Aging is the process where a person continues to live his or her life in the throws of a decreasing (slightly) body function. This aspect of the cause of disability is always creating a presence through its natural effects on style of living.

"In answer to the question, In the last four weeks, did anything like sickness, or any old injury or any health problem bother you, half of all older people (50 percent) named one or more illnesses" (Shanas, 1962, p. 7).

The disability condition, then, can be caused through four events or occurrences: birth, accident and/or injury, disease, and age. These four events and occurrences are categorized into three different areas of the living experience: physical disability, mental disability, and

emotional disability. This study will examine each category separately.

The Disability Conditions

The National Easter Seal Society based in Chicago, Illinois, has established a program of disability awareness entitled: The First Step Campaign. "This program sets out to change some of the misconceptions that get in the way of acceptance" (National Easter Seal Society, First Step Campaign, 1994).

In this national campaign, the Easter Seal Society has established sixteen general categories within the three possible avenues (physical, mental, and emotional) allowing for the presence of a disability condition. These sixteen categories are briefly defined in the glossary section of the campaign curriculum. In this section of the study, each of these sixteen categories describing a different disability condition will be examined in more extensive detail.

The disability condition is what causes the impairment to the individual person's functional ability. "People are not conditions" (First Step Campaign, 1994). An awareness of the different conditions that cause an individual to live with a disability might allow a separation of the actual person from the actual condition in the mind of society, which, if successful, would be an accomplished goal of this research study.

The following sixteen conditions represent disability in general. Awareness of these conditions is the progression toward the separation of fear from perception thus allowing for possible acceptance, both personally and socially.

"Amputation is the surgery resulting in a missing body part such as an arm, leg or hand" (First Step Campaign, 1994). "Industrial and road accidents are major causes of severe damage, but the necessity for amputation may also arise as the result of such diseases and conditions as gangrene, cancer, frostbite and hardening arteries" (Hale, 1979, p. 258).

"Blindness refers to total loss of vision. Not to be used when referring to partial vision which may also be correctly called partial sight or visual impairment" (First Step Campaign, 1994). "Blindness is the inability to perform any work for which eyesight is essential" (Hale, ed., 1979, p. 258) Blindness may result from injury to the eye itself or from some abnormality or lesion in the brain or the optic nerve. "Blindness is sometimes due to a systematic disorder such as diabetes. Other causes include cataracts, glaucoma, birth defects, detached retina, keratitis, iritis, ophthalmia and various forms of trachoma (Hale, ed., 1979, p. 258).

> Loss of vision, of any degree, is clearly a subjective personal, internal experience calling potentially for major life changes. Loss of vision impinges on every facet of daily living affecting self-image, social

relationships, status, practical "taken for granted" capabilities and skills, potentially undermining confidence and previously established self-perceptions and patterns of behavior, life-style, occupation, etc. (Canyers, 1988, p. 9).

"Cerebral Palsy is the umbrella term for a group of disabling conditions resulting from central nervous system damage. It is inappropriate to assume that a person with cerebral palsy also has mental retardation; the two disabilities do not necessarily or typically occur together" (First Step Campaign, 1994). "Cerebral Palsy is a group of medical conditions characterized by nerve and muscle dysfunction caused by damage to the brain which controls and coordinates muscular action" (Hale, ed., 1979, p. 259). "According to the location of the damage, varying disabilities occur. The most common are spasticity, athetosis and flaccidity and sometimes difficulty with speech" (Hale, ed., 1979, p. 259).

"Communicative Disorder is another umbrella term for speech, hearing and learning disabilities" (First Step Campaign, 1994). Communicative disorders represent a very complex integration of many basic avenues of social stigmas demonstrated through social interruptions, perceptions, and judgments. These socially stigmatized frustrations are derived from personal difficulties with different aspects associated with speech, hearing and learning, the three venues of social interaction.

The degree to which a speaker has an accurate understanding of the quality of his speech product

influences how the reactions of others are interpreted. Unless the person with the disability has an opportunity to learn that his speech is distorted or otherwise inaccurate, he assumes that the acoustic patterns he produces while speaking conform to the patterns of the mental model he employs when he encodes the message (Hartbauer, ed., 1978, p. 283).

"Deafness refers to total loss of hearing. Deafness is not the appropriate term to be used when referring to partial hearing loss, this would be hearing impairment" (First Step Campaign, 1994). "Deafness is of either two types. In the conductive type, something interferes with the passage of sound to the inner ear. In perceptive deafness there is damage or defective development of the inner ear" (Hale, ed., 1979, p. 260). "The terms 'deaf-mute' and 'deaf and dumb' are inaccurate descriptions. Most people who are deaf have nothing wrong with their vocal chords. They cannot speak because they cannot hear" (Hale, ed., 1979, p. 260).

> Developmental Disability is any mental and/or physical disability manifested before the age of 22 that may continue indefinitely and result in substantial limitation in one, two, three or more of the following life activities: self-care, receptive and expressive language, learning, mobility, self-direction, independent living and economic sufficiency (First Step Campaign, 1994).

This developmental disability definition is another huge umbrella term that represents a defined interruption, restriction or inability in one's life activity. Developmental disability, according to the National Easter Seal Society, is manifested before a certain age, yet does not exclude those individuals who develop similar physical

and/or mental disability symptoms later in their life experience from this same category.

"Epilepsy is an umbrella term for various disorders marked by disturbed electric rhythms of the central nervous system and typically manifested by seizures - involuntary muscular contractions" (First Step Campaign, 1994). "Epilepsy is a nervous disorder due to a sudden unusual release of energy in the brain. The severe form is known as grand mal, and the less severe form is know as petit mal" (Hale, ed., 1979, p. 260).

"Hearing impairment is a term for a range of hearing disabilities from slight to severe" (First Step Campaign, 1994). "Hearing loss is organic or functional. An organic hearing loss has a physical basis, whereas a functional hearing loss is psychological in origin" (Berg, Blair, Viehweg & Wilson-Vlotman, 1986, p. 4). "Organic hearing loss constitutes nearly all hearing loss among children" (Newby, 1979, p. 62). The hearing impairment itself results from a wide range of occurrences, such as various genetic defects, varied mild to severe diseases, a multiplicity of drugs and different variations of traumas (Berg et al., 1986). It is important to the individual involved with the impairment that society in general understand that hearing impairment, as well as deafness, is completely different, although almost always associated with speech difficulties. "One of the most recognized but probably least understood

comcomitants of deafness (and hearing impairment) is a
deficit of oral communication skills" (Sims, Walter &
Whitehead, 1982, p. 75).

This deficit of oral communication skills is a complex
biological result of the affected physiological process that
creates the hearing impairment itself. "The deaf and
hearing impaired individual speech errors can be related to
abnormal respiratory, laryngeal, and articulatory
activities. By virtue of this physiological complexity,
accurate surface level descriptions of the deaf's speech
errors are frequently precluded" (Sims et al., 1982, p. 75).

"Hemiplegia is full or partial paralysis of one side of
the body, caused by brain damage due to disease, trauma or
stroke" (First Step Campaign, 1994). This impairment
usually occurs in older persons, but is possible at any age,
and at any age this impairment is severely disabling.
Oftentimes in the course of a person's physiological
processes, the disease, trauma and stroke are interrelated,
where the disease causes the stroke, the trauma causes the
hemiplegia, and the trauma again causes the disease which
leads again to the stroke.

> This treatment and rehabilitation of the adult patient
> with hemiplegia has become an important medical and
> social problem. The latest estimate is that there are
> approximately 100,000 severely handicapped patients
> with this condition living in this country, that
> cerebrovascular accident patients occupy daily 18,000
> hospital beds, and that there are about 55,000 new
> patients every year. Physiotherapists spend 10% of
> their time working with adult stroke patients, and
> speech therapists up to 80% of their time. The main

causes of the condition are haemorrhage, thrombosis and embolism, road accidents and tumors (Bobath, 1989, p. 1).

This disability presents itself in many varied conditions that usually are associated with some degree and distribution of spasticity and sensory disturbance. The conditions of hemiplegia can be treated and the recovery can be spontaneous or through extensive therapy. This disability and its presenting conditions is no respecter of age, race, or sex (Bobath, 1989).

> The increase in this impairment is largely due to the higher average age of the population, to the greater stress of life in our cities giving rise to a larger number of younger stroke patients and to the increase in the accident rate (Bobath, 1989, p. 1).

"Learning disability is a disorder affecting the understanding or use of spoken and/or written language" (First Step Campaign, 1994). The term learning disability is again a grand umbrella term for many communicative disorders. The National Easter Seal Society, in the First Step Campaign, refers to this particular disability as that specific disorder that affects reading, speaking, and expressing in a written form, what one has read or heard.

Learning disabilities are a continuing, dynamic discipline for constant study in education and society. It is, like so many, a very misunderstood and distorted disability. "Children and youth who are destined to become educational discards unless their learning disabilities are

recognized and treated, are likely to be found in any classroom" (Lerner, 1993, p. 5).

Learning disabilities are so varied and complex that the federal government established a summary definition in the Federal Public Law 101-476, the Individuals With Disabilities Education Act (IDEA) (1990), that build upon an earlier version of this legislation, Public Law 94-142, Education for All Handicapped Children Act (1975). This federal definition of the complexities of learning disabilities has become the federal, state, and county accepted program definition (Lerner, 1993).

This federal definition of learning disabilities is established in two separate parts. The first part is definitional and the second part is operational. The first definitional part was adopted from a 1968 report to Congress and the National Advisory Committee on the Handicapped. It is taken from the Public Law 101-476 (Individuals With Disabilities Education Act).

> The term, children with specific learning disabilities, means those children who have a disorder in one or more of the basic psychological processes involved in understanding, or in using language, spoken or written, which disorder may manifest itself in imperfect ability to listen, think, speak, read, write, spell or do mathematical calculations. Such disorders include such conditions as perceptual handicaps, brain injury, minimal brain dysfunction, dyslexia and developmental aphasia. Such a term does not include children who have learning, hearing, or motor handicaps, of mental retardation, of emotional disturbance, or of environmental, cultural, or economic disadvantage (Lerner, 1993, p. 9).

The second part of the federal definition of learning disabilities is the operational segment. It first appeared in a separate set of regulations for children with learning disabilities (U.S. Office of Education, December 29, 1977).

The regulation states that a learning disability exists if the following characteristics are present:

> (1) The student does not achieve at the proper age and ability levels in one or more of several specific areas when provided with appropriate learning experiences. (2) The student has a severe discrepancy between achievement and intellectual ability in one or more of these seven areas: (a) oral expression, (b) listening comprehension, (c) written expression, (d) basic reading skills, (e) reading comprehension, (f) mathematical calculation, and (g) mathematical reasoning (Lerner, 1993, p. 9).

> The learning disabled child: (a) has academic retardation, (b) has an uneven pattern of development (c) may or may not have central nervous system dysfunctioning (d) does not owe his learning problems to environmental disadvantage, and (e) does not owe learning problems to mental retardation or emotional disturbance (Hallahan, Kauffman, 1976, p. 20).

Learning disability is an extensive disorder which affects so many individuals in so many different ways and in different and varied forms and degrees. Learning disability is an important disorder to be aware of and understand socially as well as from a personal standpoint, for it is so often mistaken for mental disorders and even retardation. The learning disability presents a disorder that, when distorted through unaware and uneducated assumption, inappropriately leads to possible devastating personal labeling, which is completely untrue and unnecessary.

Mental illness and mental disorder is a loss of social and/or vocational skills necessary to function independently. Terms such as mentally deranged, deviant and crazy are not appropriate. Mental disorder is a more comprehensive term that describes any of the recognized forms of mental illness or severe emotional disorder. Terms such as neurotic, psychopathic and schizophrenic are libelous labels (First Step Campaign, 1994).

The disorder associated with mental illness and mental difficulties is a very debated and misunderstood subject of constant practice and research.

After nearly 90 years, the psychiatric concept of mental disorder as reaction remains nebulous, and its value in classification uncertain. Leaving aside the question of obscure terminology ("exogenous" meaning exopathic, "endogenous" for cryptogenic, "stress" instead of strain, etc.), ambiguity can be detected in four areas: (1) the concept of illness; (2) the concept of aetiology; (3) the basis of classification; (4) the strategy and methods of investigation (Hatschnig, ed., 1986, p. 24).

Mental illness is then, through much constant debate, continuous research, and clinical practice, defined as the loss of necessary abilities to function in a socially acceptable, independent manner. Mental disorder is a wide, encompassing term used to cover any and all of the different aspects of mental illness and severe emotional problems. Each one if a vast, wide, umbrella term housing a myriad of different aspects of disorders associated with the mind and the mind's creation of felt and perceived emotions. Every person is a different creature and every disorder associated with the mind and emotion is a different and separate difficulty. Understanding this vast difference in persons and presenting symptoms associated with mental illness and

mental disorder is again the first step in becoming aware of the real life struggle that is personally and socially involved with this disability. Awareness of this disability also increases the community responsiveness toward the person involved, and socially desensitizes the stereotyped fear, and possibly replaces it with a working understanding and awareness of this very real life occurrence (Katschnig, ed., 1986).

"Mental retardation is the condition causing a person to have significantly below-average general intellectual functioning. Labels such as moron, mentally deficient/defective and feebleminded are not acceptable" (First Step Campaign, 1994).

This condition is yet another disabling impairment that is complex and often misunderstood by society. It is becoming more studied, researched, and understood, yet it still holds a sense of confusion and assumed distortion.

> The concept of mental retardation is made more complex because the varying disciplines that deal with it hold widely divergent viewpoints. Definitions of mental retardation have changed over the years as behavioral science has grown, become more complex, and included attention to broader aspects of the environment. Parameters or bases of classification for mental retardation have differed a great deal over time and are often fluid and in some cases implicit, rather than explicit and well thought through (Drew, Logan & Hardman, 1988, p. 4).

"Paraplegia is the paralysis of the lower half of the body involving the partial or total loss of function of both legs" (First Step Campaign, 1994). This disability is

extensively studied and researched. The therapy management of patients' spines and spinal cords is an on-going, thorough, and complete area of research and study.

> Thousands of individuals fracture their spines every year and as a result remain totally or partially paralysed for the rest of their lives. In addition to these, there are victims of spinal cord injury or disease from many other causes. Forty years ago such people died from the resulting complications. Today a normal life expectancy can be anticipated, providing the correct treatment is given and the complications thus avoided (Bromley, 1985, p. 3).

Paraplegia is a disability that results from severe damage to certain areas of the spinal cord and associated areas of the body. It is a specific impairment that results in an exact and predictable manner. It is a complex impairment, due to the complexity of the area of the body affected, yet a very clear and precise impairment when speaking of effects upon mobility and life functioning.

"Paraplegia is partial or complete paralysis of both lower limbs and all or part of the trunk as a result of damage to the thoracic or lumbar spinal cord or to the sacral roots" (Bromley, 1985, p. 3).

The facts of the personal cases of individuals admitted to hospitals for paraplegia-related incidences are varied. The percentages of those admitted are highest concerning trauma.

> Of the cases admitted to spinal units, approximately 70% are traumatic, and approximately 50% of these involve the cervical spine. The majority of the traumatic cases, approximately 50% are the result of road traffic accidents. Industrial accidents account for approximately 26%, sporting injuries, 10%, and

accidents in the home approximately 10%. The non
traumatic cases are mainly the result of transverse
myelitis, tumors and vascular accidents. Spinal cord
damage resulting from either injury or disease may
produce quadriplegia or paraplegia (Bromley, 1985, p.
3).

"Quadriplegia is the paralysis of the body involving
partial or total loss of function in both arms and both
legs" (First Step Campaign, 1994). Paul R. Cooper, in his
1986 article entitled "Initial Clinical Evaluation,"
appearing in the text Medical Complications of Quadriplegia,
concludes the following:

> Few diseases or injuries have the potential for
> producing the devastating effects on survival and
> quality of life that cervical spinal cord trauma does.
> Despite the vast amount of research, there is currently
> no medical treatment that has been proven effective in
> ameliorating the effects of mechanical injury to the
> spinal cord (Berczeller, Bezkor, 1986, p. 8).

A spinal cord injury is clearly a major trauma, and the
treatment of such trauma requires specific care strategies.
This medical treatment should be immediate and complete,
remembering that the emotional impact of such a trauma
cannot be forgotten. Angelo R. Canedo wrote an article
entitled "The Psychological Impact of Spinal Cord Injury" in
the text entitled Medical Complications of Quadriplegia.
Canedo's research parallels the dependence upon specific
medical care with the psychological needs of eventual
adjustment for the sake of maintaining life.

> As the aspects of acute medical care retreat into the
> background, the emotional reactions often become more
> pronounced and begin to assume more obvious importance
> to all parties concerned. Psychological reactions,
> frequently described as stages of adjustment, at times

seem to parallel the process of medical care and can
support the primary objective of preserving life
(Berczeller, Bezkor, 1986, p. 11).

Spinal cord injuries are infrequent disabilities

compared to other major disability conditions, yet they are

severely debilitating and extremely costly (Berczeller,

Bezkor, 1986). Awareness of the full extent of the medical

and emotional (psychological) aspects of quadriplegia and

paraplegia allows proper understanding and undistorted views

of this condition.

> Nearly all quadriplegic patients have periods of
> depression before they can start to accept their
> disabilities. These may be manifest in many ways, such
> as apathy, aggression, overcheerfulness, or unrealism.
> Patients may not be able to apply themselves fully to
> rehabilitation until they have at least partially
> accepted their disabilities (Ford, Duckworth, 1987, p.
> 1).

With an understanding and general awareness of the

quadriplegia condition and the social, personal, and

emotional extent of such a disability, a first step has

begun toward clarifying the misconceptions and enhancing the

community involvement and acceptance.

"Spasticity is having sudden, abnormal involuntary

muscle spasms. Muscles are spastic, people are not" (First

Step Campaign, 1994). Bruce M. Gans and Mel B. Glenn wrote,

in the introduction of the text entitled Practical

Management of Spasticity in Children and Adults, the

following definition:

> Spasticity is one of the most common features of the
> motor deficits associated with the upper motor neuron
> syndrome. It spans a variety of diagnoses and ages,

and is one of the most common problems dealt with by physicians and therapists caring for patients with neurologic diseases (Glenn, Whyte, 1990, p. 1).

Some of the effects of the disability associated with spasticity are explained by Bruce Gans and Mel Glenn as weakness through a lower strength muscle contraction, paralysis as an inability to sustain a work performance level of voluntary muscle contractile activity. Gans and Glenn conclude with the effects of spasticity on basic movements. They write of an incoordination as a decrease in the skilled sequential control of muscle activation resulting in lower fine motor accuracy and diminished reflex as an involuntary motor response of the body or limb segment to a physical agent (Glenn, Whyte, 1990).

Spasticity is a disability that affects the useful work capacity of an individual. Gans and Glenn continue to describe the functional consequences of spasticity.

A principal consequence of spasticity is diminished capacity of the patient to accomplish useful work with the motor system. This is usually thought of as an exaggerated array of spontaneous motor activity that distorts or precludes useful motor function (Glenn, Whyte, 1990, p. 5).

"Speech impairment is having a limited or difficult speech pattern or patterns" (First Step Campaign, 1994). Speech is a major part of any association with other people. Speech is the communicative, working tool of relating, feeling, sensing, and being a part of the world. According to Arthur Boothroyd in the chapter entitled "Evaluation of Speech" from the text entitled Speech of the Hearing

Impaired, the word speech is used in many different ways, by

different people in many different situations. Boothroyd

proposes a definition for speech in his chapter on

evaluations to aid in establishing a basis for understanding

the complexities of the word when referring to certain

clinical evaluations. He refers to speech as the flowing of

designed sounds.

> Speech is a system of movements that generate patterns
> of sound. These movements, and the resulting sounds,
> represent linguistic structures that in turn represent
> conceptually organized thoughts. Speech is used for
> communication between human beings. The linguistic
> structures fulfill their purpose when they permit a
> listener to generate the same thoughts as exist in the
> minds of the talker. The speech patterns fulfill their
> purpose when they permit a listener to generate the
> same linguistic structures as exist in the mind of the
> talker (Hochberg, Levitt & Osberger, 1983, p. 182).

Verbal communication is complicated. Arthur Boothroyd,

again in the article "Evaluation of Speech," explains that

the complexity of speech involves the consideration of its

acoustic aspects, its motor aspects, its linguistic aspects

all in coordination with the active role of the listener in

the communication process (Hochberg, Levitt, Osberger,

1983).

Speech impairments are existent through the great

complexity of speech and all the possible segments of the

communication process that could create vulnerable patterns

of structural disorders.

Carol Westby, in her article "Multicultural Issues"

that appears in the text entitled Diagnosis in Speech-

<u>Language Pathology</u>, speaks about the importance that communicative skills hold in mainstream cultures, and the disability that results from poor linguistic abilities and communication skills. Carol Westby states:

> Mainstream culture places a high value on communication skills. Adults encourage children to ask and answer questions and tell stories. Once a child walks, parents focus on a child's talking. If a mainstream child is not talking by age 18 months or 2 years, parents express concern (Tomblin, Morris & Spriestersbach, 1994, p. 32).

The disability that results from a speech impairment, whether severe or mild, is always a noticeable and serious barrier to social acceptance and self identity. "Inability to communicate, at a fundamental level, presents a vivid picture, whenever it is encountered. But it has always been disability in speech, the primary index of language ability, which has attracted most attention since the earliest of times" (Crystal, Varley, 1993, p. 11).

This impairment is a disability that affects a person's relation to every aspect of human connection, self, family, and society. Awareness, from concerned friends, of the condition and its effects can possibly enhance the understanding and responsiveness offered.

These sixteen conditions are by no means a complete list of possible impairments leading to disability. These sixteen conditions are, according to the National Easter Seal Society, the commonly seen, most frequently encountered, and oftentimes most misunderstood and feared

impairments and disorders leading to specific and separate disabilities. Awareness of these sixteen conditions will hopefully begin a more accepting understanding of disability in specific and differences in general. Once the impairment can be more readily understood as a condition resulting from a human biological function common to all of mankind through birth, disease, accident, or age, the person with the disability can be more readily accepted for his or her similarity and less feared for his or her difference.

The problems that are born from lack of ability and restriction naturally then would encompass medical care and treatment, emotional care and support and legal freedoms (Hale, 1979). These very problems that confront a person with a disability establish the corresponding needs of that person in a series of equal, parallel issues. The needs echo the problems in the areas of social, behavioral, physical, and intellectual capabilities which differ from the normative (Ross, 1981).

Individuals with disabilities and differences, whatever the impairment and disorder, have medical problems and need medical treatment. Individuals with disabilities have emotional issues and need emotional support and encouragement. Individuals with disabilities, as Ted Kennedy, Jr. proclaimed in his 1989 article in Parade Magazine entitled "They'll Astonish You," need the empowerment of opportunity. "We (people living with

disabilities) face social barriers and need the freedom of opportunity to participate fully in society, to be regarded by others as an equal and have equal access to working hard and living independently" (Hardman, Drew, Egan & Wolf, 1990, p. 34).

The Development of Disability Awareness
Through Social Aspects of Evaluation

Social Evaluation and Social Disintegration

The social atmosphere of the world surrounding the individual with a disability is constantly revolving around the disability condition. Personal interactions with other individuals, both with a disability and without, becomes difficult and non-existent. The authors Robert Marinelli and Arthur Dell Orto, both editors of the text entitled The Psychological and Social Impact of Physical Disability, speak on the interpersonal impact of disability and agree that in many instances, common interactions between people with a disability and people with a fully able body are not always constructive. Personal tensions and attitudal barriers are potential stressors in this situation. The individuals with the disability are faced with a potential practice of social skills they have never had the opportunity to learn and use in public. Therefore, the interactions have a possible negative result for both parties involved.

These interactions may be described as strained or anxiety-provoking for both participants. In some cases, the persons who have disabilities are excluded socially from others. In other cases, they may be intruded upon through stares or questioned out of curiosity (Marinelli, Dell Orto, 1984, p. 137).

The social sphere of the individual with the disability condition seems to always be in a state of stress when involved in any way with the social sphere of the individual with the non-disability condition. Elaine Makas, in her article entitled "Positive Attitudes Toward Disabled People: Disabled and Nondisabled Persons' Perspective" that appears in the text Perspectives On Disability, reviews some empirical research that states the reality of existence of stressful situations concerning interactions with people of a disability condition. "Empirical research suggests that both disabled people and nondisabled people experience a great deal of stress when interacting with one another" (Nagler, 1990, p. 25).

One such empirical research study showed that these stresses are at a very high level of interaction.

Studies by Kleck and his colleagues (Kleck, 1966, 1968; Kleck, Ono & Hastorf, 1966) demonstrated that nondisabled subjects report greater emotional distress, exhibit higher physiological arousal, show less motoric activity, display less variability in their verbal behavior, express opinions that are less representative of their previously reported beliefs, and terminate interactions sooner when interacting with a confederate who appears disabled than when interacting with a nondisabled confederate (Nagler, 1990, p. 25).

Kelley, Hastorf, Jones, Thibaut, and Usdane (1960) and Goffman (1963) have suggested, as a result of their studies,

that this tension that exists between the individuals with the disabilities and the individuals without the disabilities, may be a result of neither person knowing what the other expects. Jones et al (1984) recommended that clear communication between the two parties could reduce interaction strain.

Hastorf, Wildfogel, and Cassman (1979) and Belgrave and Mills (1981) have found that very simple acknowledgement of the disability by the person with the disability can reduce the nondisabled person's discomfort (Nagler, 1990).

> An intensive study by Cook and Makas (1979), employing both participant observation and interviews over a two-month period, emphasized the importance of direct communication of expectations in the development of successful relationships between a disabled person and a non-disabled one (Nagler, 1990, p. 25).

Another study performed by Comer and Piliavin (1972) found similar indications of discomfort among disabled individuals when interacting with nondisabled individuals, as opposed to individuals who appeared disabled (Nagler, 1990). This discomfort of interaction between the individual with a disability and the individual of able body may be due to lack of communication skills on both sides of the discomfort. "Persons with disabilities sometimes lack the social skills necessary to communicate successfully with nondisabled people in the community, particularly about the stigmatizing effects of their disability; furthermore, they are not taught these skills" (Marinelli, Dell Orto, 1983, p. 137).

These studies have shown that the best approach to lessening the tension and stress in interpersonal relationships between the person with the disability and the person without the disability is to be honest and expressive of natural expectations and attempt to develop clear and direct communication, remembering that neither party can possibly know what the other party expects, and each needs to be told, so they can know.

Disability and Non-Acceptance

The social problems and needs of individuals with different disabilities seems to rest in acceptance. Acceptance may be slow in coming, possibly in part due to presumed expectations and lack of direct communication and distorted information and knowledge (Nagler, 1990). Acceptance and non-acceptance and the integration into society's mind-set and social interactions with individuals with disabilities is a major concern of sociologists researching the disability condition. Ladieu-Leviton, Adler and Dembo (1947), in their research into adjustment and social acceptance examine possible reasons for non-acceptance of the person with the disability by the person without the disability.

> The injured and disabled feel that they cannot be expected to shift their attitudes concerning their physical limitations in order to narrow this margin, since they feel that they are the ones who really know the actual reality limitations in their own cases. They feel that it is the non-injured and non-disabled who have to reexamine their attitudes for possible

misconceptions, biases, and mistaken beliefs in order to reduce the discrepancy (Marinelli, Dell Orto, 1984, p. 150).

The first reason for social non-acceptance of the person with the disability by the person without the disability, presented by Ladieu-Leviton, Adler and Dembo (1947), is said to center around physical limitation. A far-reaching misconception is a general tendency on the par of the non-disabled to overestimate physical limitations imposed by a disability or injury (Marinelli, Dell Orto, 1984).

> Since the non-disabled cannot readily acquire information as to the variable capacities of the disabled person, they may indicate their willingness to have him participate, and leave to him the judgment of whether or not he will be able to do so. The non-disabled may feel that in the event that participation is impossible, it will seem inconsiderate to have even suggested it. The danger of hurting the feelings of the disabled, however, will be no greater than in other non-participation situations. At the same time the additional distress of apparent rejection will be avoided (Marinelli, Dell Orto, 1984, p. 151).

The second aspect of the reasons for non-acceptance toward the people with disabilities is the appearance of the disability. "The discrepancy between the beliefs of the non-disabled, and the facts as they exist, operates relative to the appearance of the disability just as it does relative to disability-imposed limitations" (Marinelli, Dell Orto, 1984, p. 152).

Limiting the social interaction of the disabled by the non-disabled because of the presumed expectations of aversion toward the appearance of the disability to society

stops the educative process of adaptation for the person

with the disability and unnecessarily isolates them

(Marinelli, Dell Orto, 1984).

The third aspect of the reasons for non-acceptance of

the disability condition by the non-disabled is believed, by

Ladieu-Leviton, Adler and Dembo (1947), to center around

personal evaluation. According to this study, the person

with the disability tends to militate against their social

acceptance.

> They believe that they (the disabled) are evaluated by
> the non-disabled not only in terms of the physical
> aspects of their disability, but in terms of presumed
> psychological concomitants as well. There appears to
> be a spread of evaluation from characteristics actually
> affected by the disability, to other characteristics
> not necessarily so affected. This 'halo' phenomenon is
> considered as generally devaluative or negative
> (Marinelli, Dell Orto, 1984, p. 153).

Personal evaluation of the disability condition by the

non-disabled, whether the occurrence of the impairment was

from birth, disease, injury, or age, can be a devastating

reality when its effects are felt by the person with the

disability through isolation and rejection. This isolation

and rejection is an evaluative product of non-acceptance,

which in turn is a result of misinformation and distorted

knowledge. With the correct knowledge and awareness, people

become people in relationship to other people, innocent of

concern with physical limitations, general appearance, and

personal evaluations.

> When the disabled do not feel seclusive, or know that,
> aside from the disability, they are not 'handicapped,'

it is the non-disabled person who must shift preconceived and erroneous attitudes. It is they who can best obviate the accusation of "wilful' non-acceptance (Marinelli, Dell Orto, 1984, p. 153).

In the light of the non-acceptance potential toward the individuals with disabilities that rests in the non-disabled social climate of interaction, the idea of identity and presentation comes into focus. "In the usual scheme of things, we evaluate strangers by the identities which they present to us. Thus, individuals establish their identities by conveying a series of attributes which they believe legitimately convey their personalities and identity" (Nagler, 1990, p. 178).

Disability: The Social Effects and Responses

The individuals that present a visible disability to society have these positive attributes that have been developed and established through personal belief system acceptance. These positive attributes are present and presented, though usually overridden by the fact of the obvious, visible disability. The disability condition is prone to having two effects on society at large. Disability is persuasive and stigmatizing. Because of these two effects, two associated actions are performed by society to individuals with disabilities. These actions tend to be the act of isolation and the act of ignoring, both creators of social stigmatization and perceived deviance (Nagler, 1990, pp. 178-182).

Because the visibly handicapped do not comprise a distinct minority group or subculture, the imputation of generalized deviance that they elicit from many normals are more nearly genuine interactional emergents that conventionalized sequels to intergroup stereotyping as for example, might obtain between a Negro and a white. It is appropriate to consider the general nature of the threat posed to the interactional situation per se as a result of the disabled being perceived routinely as different or odd, estranged from the common run of humanity; in short, other than normal (Davis, 1961, p. 122).

Disability and Social Deviance

This perspective of the disability condition as deviant, or as different and socially set apart in a negative way, seems to be as old as human nature itself. A window into this continuous perspective from this past half-century can be traced to certain aspects of a labeling theory proposed by E. M. Lemer in 1951.

According to the definition in Lemert's theory, "the Negro, the career woman, the criminal, the Communist, the physically handicapped, the mentally-ill, the homosexual, to mention but a few, are all deviants, albeit in different ways and with markedly different consequences for their life careers" (Lemert, 1961, p. 121).

E. J. Thomas (1966) also proposed a deviant social role for the individuals in society who have a disability. Thomas viewed disability as requiring "resocialization into a deviant social category" (Thomas, 1966, p. 7). J. Lorber (1975) also associated the disability condition with a social deviance. Lorber indicates that "some familiar kinds

of deviance are socially defined as accidental or illness, foreignness, crippling or inherited defects" (Lorber, 1975, p. 278). W. R. Gove (1976) summarized the social deviance association and its position in the labeling theory as the social system oppressing the underdog through developed procedures for people with disabilities that create and stabilize social deviant behavior.

"The disabled are typically stigmatized, and their stigma often appears to act as a master status which determines the nature of their interaction with others" (Gove, 1976, p. 60).

The labeling theory approach to the analysis and examination of deviant behavior and the behavior that society perceives as deviant has been widely used. This labeling theory argues that much of what is seen and perceived as deviant is a result of society's reaction to labeled deviance (Nagler, 1990).

"When individuals are labeled deviant, for whatever reason, the societal reaction to this label reinforces the image of oneself as being odd, different or deviant. At this point, one's deviance may become stabilized" (Nagler, 1990, p. 180).

R. P. Lowry (1973) reacts to the labeling theory by presenting the practical aspects of its effects on the target population. "If someone is continually treated as inferior, dangerous, and deviant, the chances are great that

he will come to see himself in this way and act accordingly"
(Lowry, 1973, p. 118).

Society plays a very large part in the rehabilitation
process of persons with disabilities as they attempt to
integrate into a workable, social lifestyle and live a
workable, fulfilling life alongside their non-disabled peers
(DeLoach, Greer, 1981).

S. A. Richardson (1969) presents the essential value of
the family and its extended parts as the nuclear society
which is invaluable to the personal support and
encouragement of the person with a disability. If the
family is capable of showing positive support in the face of
society's negative evaluations, the reactions of other
people may become inconsequential. The family needs to be
supportive amidst negative evaluations. These negative
evaluations are real (Richardson, 1969).

> It is unlikely that the child born with a handicap will
> have parents, neighbors, sibs and peers who have the
> same handicap and from whom he can gain experience in
> dealing with others. Generally, he will be surrounded
> by non-handicapped people who share the general
> negative values of the culture toward the handicap
> (Richardson, 1969, p. 1059).

The family may be motivated to provide support and
encouragement to the member with a disability, yet they may
be lacking, as a unit and in person, the proper family
skills, personal insight and proper, undistorted information
that is required and necessary to do so therapeutically
(Nagler, 1990; Richardson 1969). The negative evaluations

are present and forthcoming. The social stigma is real.

The person with a disability is personally alone in a way

that society seldom perceives (Vash, 1981; DeLoach, Greer,

1980; Nagler, 1990).

> Sociological research pertaining to disabling
> conditions in our society has most often focused on
> nondisabled rather than disabled persons. Most
> typically, these studies have involved the
> investigation of public reactions to persons with
> varying types of disabilities. This research generally
> shows that physical disability is a non-accepted and
> ignored state (Nagler, 1980, p. 186).

Underlying the motive and design of sociological

research concerning the disability condition and the self-

concept, academic, occupational performance, and

interpersonal relationships of the individuals with

disabilities, rests the general assumption that efforts

directed toward integrating people with disabilities into

the mainstream of society would be benefitted from an

understanding of those socially induced conditions that aid

or hinder the person with a disability in the adjustment

process of meeting the social demands of performance in a

non-disabled world (Nagler, 1990).

The Development of Disability Awareness
and the Origin of Social Attitudes

"It has been discovered by social scientists that many

groups are not treated in terms of what they are, but in

terms of their social images" (Nagler, 1990, p. 137).

Historically and in tradition, individuals with disabilities

have been separated, alienated, and isolated from the

society at large through institutionalization, shunning, and ignorance. Persons with disabilities have been purposefully forgotten. "Their humanity, identity and abilities have been overlooked and ignored in light of their differences" (Nagler, 1990, p. 137).

Persons with disabilities are often viewed as sickly and inept. The most common image of a person with a disability is usually associated with charity and dependence (Ruffner, 1984). Society views disability as an illness that carries great negative social weight. "A stigmatizing illness, be it mental illness, leprosy, cancer, epilepsy and/or stomate status, tends to be an individualizing and privatizing experience" (Morrison, Ursprung, 1987, vol. 1, p. 2). There is no illness subculture and as a result, the persons who are experiencing an illness that presents itself in social stigma, can often feel isolated and alienated from themselves as well as from society. Illness conveys negative public images (Nagler, 1990).

Conceptualizing the Disability Condition Through Stereotyped Images

Attitudes toward the disability condition are influenced by mass media, most specifically movies, television, and newspapers. This influence is usually negative and distorted through limited exposure and unaware assumptions (Bogdan, Biklen, Shapiro & Spelkoman, 1982).

The horror film, first appearing at the turn of the century, is an example of media's vast negative influence toward the disability condition. "MGM's 1932 film "Freaks" capitalized on the horror film/freak show link in order to promote the fear of deformity" (Bogdan et al., 1982, p. 3).

> From the first horror films to modern-day renderings, physical and mental disabilities have been shown to connote murder, violence and danger. Whether from the effect of a full moon or a secret potion, an attractive actor changes before our eyes, from a harmless, good citizen, to a killer monster (Bogdan et al., 1982, p. 3).

The disability condition has a history of being represented in the movies, a very influential segment of society's media education, as negative, dangerous, evil, and frightening.

This negative portrayal of the disability condition seen in the horror, gangster, and adventure films of this century have made their way into the television, comic, and newspaper media as well. John Townsend, an anthropologist who has studied images of the mentally ill on television, discovered that "one-quarter of all shows depicting mentally-ill people, cast them as violent" (Bogdan et al., 1982, p. 4).

The comic strip produces a view of deformity and disability as glaringly evil and sinister. In this dangerous portrayal of disability comes the opposing force of the super hero as serenely perfect and incapable of any human mistake. Together these two forces, the evil disabled

and the super-perfect hero, do daily battle, with the disabled villain always being destroyed and the dangerous evil being extinguished. This contrasting scenario creates attitudes associated with heroes versus villains, disabled, bad people versus super-abled, good people, and casts a continuous shadow of fear, danger, and evil upon the representation of the people with disabilities (Bogdan et al., 1982).

The media is a powerful source of suggestion and influence in the present advancements associated with social expectations and demands.

> Television, radio, newspapers, books, and magazines are part of most people's daily experience. Few would question the power exerted by the media over their lives as a continuing source of information, entertainment and education and as a molder of public opinion (Hale, 1979, p. 46).

For the most part, individuals with disabilities are portrayed as sickly or sick, for disability is associated with being a medical issue. People with disabilities are then represented as dependent on society, for sick people are in need of expert help and care; or the persons with disabilities are viewed as special over-achievers who accomplish great feats of personal conquests. The media casts a definite persuasive influence upon society concerning oftentimes distorted awareness associated with the disability condition (Ruffner, 1984).

A few sociological authors and researchers suggest a common psychological concept concerning the persons with

disabilities. The suggestion is that people with
disabilities remind the able-bodied and healthy of death,
animal ancestry, or their own imperfections. "Such purely
psychological explanations, which deny cultural and
political contexts, serve no purpose other than to reify
further prejudicial associations of disability with evil and
fear. The association of monsters and disabilities is a
social creation" (Bogdan, et al., 1982, p. 4).

The Disability Condition: Aversive Behavior and Children

The researchers that deal with the sociological issues
of the disability condition have consistently documented the
existence of negative attitudes toward people with
disabilities and have also claimed that these attitudes have
developed during childhood (Ryan, 1981; Weinberg, 1978;
Wilkins and Velicer, 1980). K. Ryan (1981) suggested that
there is enough hard, consistent research to carefully
assume that an age-related acceptance sequence exists in
association with people with physical disabilities and
disabilities in general.

> Small children may be particularly rejecting (of people
> with disabilities) because of their subjective, role-
> taking ability. Very young children (4 to 6 years of
> age) are generally egocentric; they cannot determine
> another individual's internal state. They may reject
> people with disabilities because they do not understand
> their subjective perspectives, and may assume that
> their own aversive reactions are shared by others and
> caused by the person with the disability. Also, for
> very young children, physical attractiveness has been
> found to be a large component of social judgment (Ryan,
> 1981, p. 244).

This reaction might explain some children's aversive behavior toward individuals who have an obvious disability. Young children may assume that a negative physical trait which might induce an uncomfortable, negative state within themselves means that a person is a bad person (Morrison, Ursprung, 1987).

The Disability Condition: A Social Acceptance Pattern

M. O'Moore (1980) studied the different social acceptance patterns of non-disabled children to disabled children in a school setting. The discovery was that there may be inappropriate times for social integration. M. O'Moore found in her study that young children in the 9 to 11 age group were not as socially accepting of children with disabilities as they were with other children of a non-disabled control group (O'Moore, 1980).

The studies of M. O'Moore also showed that the sex of the subject was in influencing factor in the children's acceptance of the disability condition. "Boys, whether disabled or not, achieved greater social acceptance with their peers than did girls" (O'Moore, 1980, p. 321). Even with this acceptance, the age group of children from 9 to 11 showed fewer relationships established among disabled children when in comparison with non-disabled children of the same age group, social status and belief systems (O'Moore, 1980). "This suggests that a disability can be a powerful component in determining children's preferences.

It may cover up a child's better known pattern of social acceptability" (O'Moore, 1980, p. 325).

In a group of disabled and non-disabled young children, "students evaluated themselves most favorably, non-disabled children as a group less favorably, and disabled children as a group least favorably" (Parish, Baker, Arheart & Adamchak, 1980, p. 251). This same evaluation occurred in both the children with disabilities as well as in the children without visible disabilities. In this study, the author also noted that the self-evaluation or rating of young, non-disabled males was consistently at a higher level than the ratings of disabled children by both the disabled and non-disabled young females. "The non-disabled females rated both self and non-disabled children significantly higher than non-disabled males rated disabled children" (Parish, et al., 1980, p. 250). Both the children with disabilities and non-disabled children perceived themselves in a positive light. "Disabled children though, tended to evaluate other disabled children quite negatively" (Parish, et al., 1980, p. 252).

> Since this data was collected from mainstreamed classrooms, it may be that mainstreaming has a negative stigma associated with it for both disabled and non-disabled children. It may be that mainstreaming, in its present form, may enhance the social-emotional difficulties encountered by disabled children (Parish, et al., 1980, p. 253).

J. Wilkins and W. Velicer (1980) performed a study on the attitudes of children toward various stigmatized social

groups. The basic hypothesis of this research rested in the assumption that negative attitudes and feeling for these social groups are learned in early childhood. Four semantic, differential scales were employed in this study to access children's basic attitudes toward four different social groups. These groups included non-disabled individuals, physically disabled individuals, people with mental retardation, and mentally ill individuals. This research employed a sample and population of males and females in the third and sixth grades.

> People with mental illness were rated most negatively
> on the evaluation and understandability scales. Both
> the retarded and the physically disabled were rated
> less positively than the non-disabled on the evaluation
> scale, but not as negatively as the mentally ill
> (Wilkins & Velicer, 1980, p. 365).

The results from this research study concur with the results of a similar study performed by D. Morgan and S. Wisely (1981). In this research study, individuals who were either mentally retarded or physically disabled were evaluated and rated by a mature audience as less active and less potent than those individuals who were either non-disabled and/or mentally ill (Morgan, Wisely, 1981). There was no measurable difference found in held attitudes of the third and sixth grade students toward the other three stigmatized groups (Wilkins, Velicer, 1980). "This information shows that attitudes toward mentally-ill individuals are distinct from attitudes toward non-disabled people, and also distinct from the attitudes toward the

other disability groups in the study" (Wilkins, Velicer, 1980, p. 370).

Wilkins and Velicer (1980) claim, as a result of their research study, that children's attitudes differ from the attitudes of adults. They make this claim on the basis that individuals with mental illness were not viewed by the child population in their study, as less active or less potent than normal people (Wilkins, Velicer, 1980).

N. Weinberg (1978) performed another disability research study involving young children, this time between the ages of three and five. Weinberg desired to determine whether young children understood the factual meaning of physical impairment and whether their studied attitudes differed between children of disabilities and able-bodied children. The study included two separate experiments in which the children in the study responded to certain questions associated with pictures. "The data from the two studies indicated that a shift does occur between ages three and four, from a lack of knowledge to an understanding about disability, when depicted as an orthopedic impairment" (Weinberg, 1979, p. 49).

This study also showed that when a child is forced to make a choice between a child with a disability and a child without a disability as a playmate, the four and five-year-olds preferred a non-disabled child. These discriminatory attitudes tended to follow the developmental understanding

of disability as a condition. "Older children who knew about the impairment were less likely to play with the child with the disability, than the younger children who lacked a working knowledge of disability" (Weinberg, 1978, p. 55).

In the research study performed by M. Horne (1982), many different previous studies on attitudes and learning disabilities were reviewed and studied. Horne discovered, through the review of the past research, that social peers in an academic setting exhibited more general acceptance toward their normal achieving fellow students. Horne also found that these same students

> assigned rejectee status to those who had a speech
> impairment, and amputation and physical disability, or
> who were low achievers, retarded and disturbed. This
> sequence of acceptance was also found among teachers
> and that, perhaps, students actually learned their
> biases from their instructors (Horne, 1982, p. 81).

Horne then, needless to say, believes that any developed modification of affect project should involve not only the students but be directed toward each of the acting teachers as well (Horne, 1982).

From the research performed upon young children in the school setting, it would appear that the working attitudes of these young people toward individuals with disabilities are quite flexible and impressionable (Morrison, Ursprung, 1987). "Perhaps programs designed to improve attitudes toward people with disabilities will have the most impact when directed toward children who are just beginning to form

their perceptions of the disabled" (Morrison, Ursprung, 1987, p. 4).

The research on the origin of negative attitudes toward persons with disabilities presents a definite need for educational programs directed toward young children.

> There is considerable evidence suggesting that such an undertaking would be beneficial. Classroom teachers, counselors, and other people working to implement such projects know these endeavors must be based on the assumption that the dissemination of accurate information about disabilities will lead to increased positive attitudes and reduction of social rejection, stigmatization and prejudice (Nagler, 1990).

The Development of a Social Responsiveness Toward the Disability Condition

The Disability Condition and the Actions of Realistic Acceptance

> Fear of the unknown. Inadequate experience. Incorrect or distorted information. Lack of knowledge. These shape some of the attitudal barriers that people with disabilities face as they try to gain access and acceptance in their communities. People in society can exert a powerful influence over the way people with disabilities are perceived. It is important to the more than 43 million Americans with disabilities that they be portrayed realistically and accurately (National Easter Seal Society, First Step Campaign, 1994).

Society can be an important part of the realistic and accurate portrayal of people with disabilities if society as people were aware of the lifestyle aspects of disabilities and responsive to the known needs and adjustments that are associated with this condition. "I believe most people are well-meaning. They simply lack the good information they

need to be able to deal realistically with physical impairments" (Maloff, Wood, 1988, p. IV).

Responsiveness toward the disability condition and realistic acceptance of the individuals in this condition must first come through a change of attitude, where the attitudal barriers are lowered, if not removed through awareness, exposure, personal analysis, and personal contact (Nagler, 1990).

Young children are a very important target population for disability awareness training, for in young childhood, events have a lasting impact. Positive experiences and events, introduced at an early age, should be effective in overcoming and preventing further association to negative stereotypes dealing with disabilities (Morrison, Ursprung, 1987).

The Disability Condition: Attitude Enhancing Experiences

J. Donaldson (1980) suggested six different ways and methods of positively enhancing the experience of disability into the lives of young children, therefore creating a fearless and an aware responsiveness to the disability condition. J. Donaldson (1980) categorized these methods of disability enhancement as follows: "direct or indirect contact with, or exposure to, disabled persons; information about disabilities; persuasive messages; analysis of the

dynamics of prejudice; disability simulation and group

discussions" (J. Donaldson, 1980, p. 506).

The first suggested method presented by J. Donaldson

(1980) of direct contact with and exposure to, persons with

disabilities is the primary objective of the study and text

of K. Ross (1981). Ross presents the following rebuttal

toward traditional isolation of persons with disabilities.

> Among the pressures helping to bring about today's
> changes in the education of handicapped people have
> been the discoveries that they do a better job of
> achieving, both academically and socially when their
> isolation ends, and that a regular school setting helps
> them to adjust and cope with the real world (Ross,
> 1981, p. 2).

Putting an end to the isolation and exposing children

and adults who have disabilities to other persons without

disabilities in a school setting and a work setting, can

serve as a positive attitude enhancing experience for the

non-disabled as well as an isolation-ending, socially-

accepting experience for the person with the disability.

> As the handicapped are integrated, now and in the
> future, exposure to their particular needs will help
> normal children understand the similarities and
> differences among people. This exposure will also help
> diminish the stereotyping of the handicapped, which is
> most likely to happen if normal children are sensitized
> to these needs beginning in the early years (Ross,
> 1981, p. 2).

The second method of attitude enhancement information

about disabilities presented by J. Donaldson (1980) is the

whole key purpose behind the National Easter Seal Society,

First Step Campaign. This campaign, "sets out to change,

through information, some of the misconceptions that get in

the way of employment, community mobility, and personal acceptance from society" (<u>First Step Campaign</u>, 1994). Information about the reality of disability is the first step in the attitudal modification and then resulting responsiveness.

The third method of J. Donaldson's (1980) persuasive messages can be illustrated by the portrayal of complete and in-depth development and growth of persons with disabilities, through the same stages of life as non-disabled persons. The persuasion comes from the association of the person with the disability to the real life reality of a person without a disability. The stages of development are experienced by both the disabled and the non-disabled. The stages of individual autonomy, intimacy, early parenthood, middle parenting, late parenting, and aging are the phases of adulthood and human life shared by human beings, with disabilities or without disabilities (Rule, ed., 1984, pp. 105-114).

The fourth, fifth, and sixth methods of attitude modification by J. Donaldson (1980) were prejudice analysis, disability simulation, and group discussions. These three are of a personal note and require an in-depth examination of one's assumed perceptions of the disability condition compared honestly to the reality of the disability condition. These last three methods also require the following of "a model which incorporates the ideas that

attitude modification be perceived as a result of either the reduction in restraining forces or an increase in driving forces surrounding an opinion or a behavior" (J. Donaldson, 1980, p. 510).

Responsiveness toward the disability condition, then, is a major result of personally held attitudes toward the disability condition (Vash, 1981). Attitudes form the extent and availability of responsiveness.

L. M. Voeltz (1982) performed a research study pertaining to the primary method of a young child's affect modification suggested by J. Donaldson in 1980. Voeltz (1982) examined the different effects of structured interactions of non-disabled children with their disabled fellow student peers in the attempt to discover how to better socially respond to the needs of the disability condition.

The research study involved students in grade four, five, and six. The study lasted for two academic semesters. The study program consisted of a series of orientation activities and exercises. These activities and exercises were conducted at the recess period and at other social event periods. The goal of these exercises was to develop a peer relationship that resembled a friendship relationship over and above a helping-obligatory relationship.

The non-disabled students beside the request of interacting, were asked to write essays and draw pictures of

their experiences. An attitude survey was administered to measure the effects of the program (Voeltz, 1982).

> Results over the two semesters revealed significantly higher acceptance of individual differences on various attitudal dimensions by children in the experimental group. The highest acceptance was with the individuals in the high-contact level group, followed by the low-contact level group and finally by the no-contact group, which was associated with the lowest responses in relationship to acceptance (Voeltz, 1982, p. 385).

This study also presented data that represented consistent sex differences in acceptance of persons with disabilities. Girls in the study showed to be significantly more accepting than the boys in the study. "These results provide support for the use of structured social interactions for promoting acceptance of disabled individuals by their non-disabled peers" (Voeltz, 1982, p. 390).

This structures, social interaction promotes acceptance and held positive attitudes that fuel an appropriate responsiveness toward the disability condition. This appropriate responsiveness is the acceptance that a person with a disability longs for, deserves and personally needs (Vash, 1981).

<u>The Disability Condition: True Myth</u>
<u>Myth Rebuttal - Dis-Abled vs. Handicapped</u>

The practice of isolating the persons with disabilities by grouping them together has incorrectly spawned the social myth of people with disabilities are more comfortable only with other people with disabilities. "Years of grouping

people together with disabilities in separate schools and institutions has reinforced this misconception. Today, more and more people are taking advantage of new opportunities to join the mainstream of our society" (First Step Campaign, 1994, myth #6). This myth can be laid to rest by community awareness of the need for the individuals with disabilities to integrate into and be an active part of everyday, non-disabled life, interacting with people with disabilities and people without disabilities alike (Rule, ed., 1984).

People without a disability are morally obligated to care for their fellow citizens who have disabilities. This is a social myth presented by the National Easter Seal Society as a major reason for negative attitudes toward this segment of the population. Society feels unnecessarily burdened with this perceived assumption of forced responsibility (Maloff, Wood, 1988). The unfortunate aspect of this social fact is that it rests upon a false assumption. "People may offer assistance to whom ever they choose, but most people with disabilities prefer to be responsible for themselves" (First Step Campaign, 1994, myth #7).

The learning of and maintenance of personal independence is a vital aspect of the rehabilitation process for any individual with a disability. Independence of a personal nature is the first realization of loss associated with an acquired disability. Self-responsibility and

personal independence are the two primary goals of
rehabilitation behind personal acceptance, which is an on-
going process and a working social integration (Caplan,
1987; DeLoach, Greer, 1981; Hirschberg, Lewis & Thomas,
1964).

Much fear and anxiety in the social eye concerning the
disability condition stems from an uneducated expectation of
the great difference that makes up the world of the disabled
person compared to the world of the non-disabled person.
The misconceived assumption is that the lives of the people
with disabilities are totally different than the lives of
the non-disabled people (First Step Campaign, 1994, myth
#9).

The fact is that "people with disabilities go to
school, get married, work, have families, do laundry,
grocery shop, laugh, cry, pay taxes, get angry, have
prejudices, vote, plan and dream like everyone else" (First
Step Campaign, 1994). The lives of the persons with
disabilities are similar to the lives of the persons without
disabilities. This realization can begin to calm the fears
of society concerning such an unreachable difference, and
thus create a responsiveness through awareness, rather than
an isolation through uneducated assumptions (Maloff, Wood,
1988).

The most harmful myth that society assumes as a group
concerning the disability condition and the individuals in

this condition, is one that belittles the person with the disability, as well as creates a sense of personal defense within the non-disabled person's mindset. This is the assumption that all people with disabilities always need help (First Step Campaign, 1994, myth #12).

"Many people with disabilities are quite independent and capable of giving help. But if you want to give help to someone with a disability, ask first they need it" (First Step Campaign, 1994). The giving of help or the lending of aid to a person with a disability is sometimes a socially misconceived conceptual act of threatening that person's independence.

> How much help a person chooses to accept is a matter of personal preference. Some disabled people enjoy assistance any time it makes things go more smoothly or more quickly. Others prefer to receive help only when it is truly necessary. Offering help is never the wrong thing to do. It is always be declined if not wanted (Maloff, Wood, 1988, p. 7).

The appropriate social responsiveness of a non-disabled person towards a person with a disability is a vital link to the disabled person's personal acceptance of and adjustment to his/her own disabled condition (DeLoach, Greer, 1981; Maloff, Wood, 1988; Rule, ed., 1984). This social responsiveness, then, is simply a matter of educated awareness and good practice.

Personal and Social Awareness and the Friendship Skills Used When Interacting With a Disability Condition

When speaking to a person with a disability or about a person with a certain disability, use the word disability, not the word handicapped. "A disabling condition may or may not be handicapping. Someone who uses a wheelchair has a physical disability. This person is handicapped when faced with a set of stairs where there is no ramp alongside" (National Easter Seal Society, First Step Campaign, 1994).

When speaking to a person with a disability, or about a person with a disability, always attempt to emphasize the person, innocent of the disabling condition. When the person is valued for him/herself, a personal success is experienced and the effects of the disability are transcended to a point of social integration and personal fulfillment (Vash, 1981). This personal fulfillment is the driving force behind the adjustment process (DeLoach, Greer, 1981). "The disability experience can be a powerful stimulant to developing a coherent philosophy of life that imparts meaning to a source of considerable pain" (Vash, 1981, p. 193). Responsiveness to the disability condition first and foremost means to be attentive to the person involved through an educated awareness of the disability condition.

A major aspect of appropriate responsiveness toward persons with disabilities is the conscious absence of

labeling. "Because people are not conditions, don't label individuals as the disabled, the epileptics, the post-polios or with other names of conditions. Refer instead to people with cerebral palsy or someone who has epilepsy" (First Step Campaign, 1994).

When speaking to or about a person with a certain disability, omit entirely, if possible, any mention about the disability condition, the effects of the condition or the origin of the disability, if it is not a vital and important part of the necessary flow of the conversation. In so doing this conscious act of personal attentiveness toward the person as him or herself, the disability and its effects have permission to dissolve to the background of the living experience, making room for more important issues such as loving, knowing, learning and experiencing (Vash, 1981; Caplan, 1987; Maloff, Wood, 1988).

Personal etiquette and its practice toward the person with a disability is part of the integration process for the non-disabled as well as part of the acceptance and adjustment process for the person with the disability (Rule, ed., 1984). Awareness of the considerations of personal and social etiquette associated with the disability condition is the beginning of the end of fear of the unknown, inadequate experience, incorrect or distorted information and lack of knowledge, those barriers that create the negative attitudes

that distill distorted and assumed perceptions (<u>First Step</u> <u>Campaign</u>, 1994).

<u>The Disability Condition and a</u> <u>Social Etiquette</u>

The first practice of appropriate etiquette toward a person with a disability is to always shake hands when introduced. "People with limited hand use or who wear an artificial limb do shake hands" (<u>First Step Campaign</u>, 1994).

The second practice of appropriate etiquette is to treat adults as adults. "Address people who have disabilities by their first names only when calling everyone present by his or her first name" (<u>First Step Campaign</u>, 1994).

The third practice of appropriate etiquette is to speak directly to the person with the disability. "When speaking to a person with a disability, speak directly to that person, rather than through a companion who may be along" (<u>First Step Campaign</u>, 1994).

The fourth practice of appropriate etiquette toward a person with a disability is to speak naturally and freely, unembarrassed about using common, everyday expressions such as: see you soon, got to be running along, or walk this way. People who are unsighted, orthopedically impaired and communicatively impaired use these same common terms to mean the same thing (<u>First Step Campaign</u>, 1994).

> Do not be overly sensitive regarding the inappropriateness of every day expressions. When

interacting with persons of disability, many persons feel they are committing a faux pas if they slip and use such expressions as: see what I mean, with someone who may be blind (DeLoach, Greer, 1981, p. 56).

The fifth major practice of appropriate etiquette toward the disability condition is the art of lending assistance. "If you offer to help a person with a disability, wait until the offer is accepted, then carefully listen for specific, personal instructions" (First Step Campaign, 1994). Lending aid is a very personal and sensitive act one person can share with another. "Even with no special skills, you can be helpful, simply by virtue of being available when the need arises. The need for assistance frequently occurs" (Maloff, Wood, 1988, p. 119).

A very common reason for any reluctance on the part of the non-disabled person to offer assistance to the person with a disability stems from a fear of making the situation worse, or as Maloff and Wood suggest, "bungling the job." This fear comes from past experience and poses a possibility that is not unrealistic.

It is definitely possible for a well-meaning helper to do more harm than good. But a positive outcome can be almost assured if certain procedures are followed. The first aspect of the procedure is to ask whether help is wanted before beginning to assist. Even if you feel certain that your assistance would be welcome, do not begin helping without his o.k. The second aspect of this procedure is to be prepared to take no for an answer. The third and final aspect is to find out specifically what needs to be done. After hearing the instructions, proceed only if you are sure you understand what needs to be done and feel capable of doing it (Maloff, Wood, 1988, p. 8).

A Model of Restrictive Conditions
in Social Exposures

In summary conclusion of the related literature
associated with the different aspects of definition, social
evaluation, origin of attitude and social responsiveness
toward the disability condition, a theoretical construct is
in order. The formation or comparison some sort of
constructed theory associated with an established
explanation relating to the specific actions, reactions and
responses of individuals in society and society in general
toward people experiencing a disability condition becomes a
necessary requirement for a sense of completion concerning
both the review of literature and a cognitive-emotional
closure.

There seems to exist in the disability related
literature nothing expressly stated or scientifically
established, associated with a theoretical statement claimed
as theory. There seems to exist no statements concerning
certain humanly restrictive conditions in a social setting
in relation to certain humanly non-restrictive conditions in
the same social setting recognized as a "theory of
disability." What does clearly exist in the related
literature, as discovered throughout this review, is a
social and personal observation and orientation that closely
follows a predictable behavioral trend.

In the absence of such a "theory of disability," then,
this researcher refers to this observed trend in behavior as

a model of restrictive conditions in social exposures. This model of orientation as reviewed in the literature and expressed through the development of the D.A.R.T. Seminar, suggests that the personal and social responses and reactions toward the disability condition are associated with personally held attitudes formed through social and personal expectations. These expectations, it seems, are composed of socially conditioned and individually produced responses to the differences that are represented by a disability condition.

Disability awareness training as seen through the intent of the D.A.R.T. Seminar addresses these held attitudes through an educational modification of personal and social expectations. This is done by integrating the behavioral aspects of an empirically developed presentation and technical response analysis with the subjective incorporation of an inclusive empowerment of each seminar participant through the subject matter content that is centered around acceptance through awareness.

This research project adds to the specific body of knowledge associated with the disability condition, the related orientation of expectation toward disability in social exposures and associated disability awareness training programs. This addition is accomplished in part by statistically demonstrating that through the provisional reliability and content validity of the empirically

developed cognitive and affectual testing instruments used as part of the D.A.R.T. Seminar formation, the personal and social response to disability in general, by members of different church congregations, and specific community-service professionals is, in part, a learned reaction evolving from certain expectations into held attitudes that can be positively modified through education.

APPENDIX G

NATIONAL EASTER SEAL SOCIETY PAMPHLET

In conversation...

- When talking with someone who has a disability, speak directly to that person rather than through a companion who may be along.
- Relax. Don't be embarrassed if you happen to use accepted, common expressions, such as "See you later" or "Got to be running along," that seems to relate to the person's disability.
- To get the attention of a person who has a hearing disability, tap the person on the shoulder or wave your hand. Look directly at the person and speak clearly, slowly, and expressively to establish if the person can read your lips. Not all persons with hearing impairments can lip-read. Those who do will rely on facial expressions and other body language to help in understanding. Show consideration by placing yourself facing the light source and keeping your hands and food away from your mouth when speaking. Keep mustaches well-trimmed. Shouting won't help. Written notes will.
- When talking with a person in a wheelchair for more than a few minutes, place yourself at the wheelchair user's eye level to spare both of you a stiff neck.

- When greeting a person with a severe loss of vision, always identify yourself and others who may be with you. Say, for example, "On my right is Penelope Potts." When conversing in a group, remember to say the name of the person to whom you are speaking to give vocal cue. Speak in a normal tone of voice, indicate when you move from one place to another, and let it be known when the conversation is at an end.
- Give whole, unhurried attention when you're talking to a person who has difficulty speaking. Keep your manner encouraging rather than correcting, be patient rather than speak for the person. When necessary, ask short questions that require short answers or a nod or shake of the head. Never pretend to understand if you are having difficulty doing so. Repeat what you understand. The person's reaction will clue you in and guide you to understanding.

Some common courtesies...

- Offer assistance to a person with a disability if you feel like it, but wait until your offer is accepted BEFORE you help, and listen to any instructions the person may want to give.
- When giving directions to a person in a wheelchair, consider distance, weather conditions, and physical obstacles such as stairs, curbs, and steep hills.
- Use specifics such as "left a hundred feet" or "right two yards" when directing a person with a visual impairment.
- Be considerate of the extra time it might take for a person with a disability to get things done or said. Let the person set the pace in walking and talking.
- When planning events involving persons with disabilities, consider their needs ahead of time. If an insurmountable barrier exists, let them know about it prior to the event.

the first step

Awareness is the First Step Towards Change:

Tips for Disability Awareness

400

Jim Byrnes, star of WISEGUY and spokesperson for "The First Step" campaign.

Everybody's fighting some kind of stereotype. People with disabilities are no exception. The difference is that the barriers we face begin with people's attitudes about us. And these attitudes are often rooted in misinformation and misunderstandings about who we are and how we became disabled.

Easter Seals' **The First Step** campaign sets out to change some of the misconceptions that get in our way—when we're looking for a job, trying to get around in our communities, and working to become accepted for who we are.

Awareness is the first step towards change.

Some myths and facts about people with disabilities...

Myth 1 People with disabilities are brave and courageous

Fact Adjusting to a disability actually requires adapting to a lifestyle, not bravery and courage

Myth 2 All persons who use wheelchairs are chronically ill or sickly

Fact The association between wheelchair use and illness has probably evolved through hospitals using wheelchairs to transport sick people. A person may use a wheelchair for a variety of reasons, none of which may have anything to do with lingering illness

Myth 3 Wheelchair use is confining, users of wheelchairs are "wheelchair-bound"

Fact A wheelchair, like a bicycle or an automobile, is a personal assistive device that enables someone to get around

Myth 4 All persons with hearing disabilities can read lips

Fact Lip-reading skill varies greatly among people who use it and is never wholly reliable

Myth 5 People who are blind acquire a sixth sense

Fact Although most people who are blind develop their remaining senses more fully, they do not have a sixth sense

Myth 6 People with disabilities are more comfortable "with their own kind"

Fact Years of grouping people with disabilities in separate schools and institutions has reinforced this misconception. Today, more and more people are taking advantage of new opportunities to join the mainstream of our society

Myth 7 Nondisabled people are obligated to "take care of" their fellow citizens with disabilities

Fact People may offer assistance to whomever they choose, but most disabled persons prefer to be responsible for themselves

Myth 8 Curious children should never be allowed to ask people about their disabilities

Fact Many children have a natural, uninhibited curiousity and ask questions that some adults might find embarrassing. But scolding children for asking questions may make them think there is something "bad" about having a disability. Most people with disabilities won't mind answering a child's question

Myth 9 The lives of people with disabilities are totally different than those of nondisabled people

Fact People with disabilities go to school, get married, work, have families, do laundry, grocery shop, laugh, cry, pay taxes, get angry, have prejudices, vote, plan, and dream like everyone else

Myth 10 It's all right for nondisabled people to park in accessible parking spaces for a short time

Fact Because accessible parking spaces are designed and situated to meet the needs of persons who have disabilities, these spaces should only be used by people who need them

Myth 11 Most people with disabilities are unable to have sexual relationships

Fact Any person can have a sexual relationship by adapting the sexual activity. People with disabilities can have children naturally as well as adopt them. People with disabilities, like other people, are sexual beings

Myth 12 People with disabilities always need help

Fact Many people with disabilities are quite independent and capable of giving help. But if you want to help someone with a disability, ask first if they need it

Myth 13 There's nothing one person can do to help eliminate the barriers confronting people with disabilities

Fact Everyone can contribute to change. You can help remove barriers by:

- understanding the need for accessible parking and leaving it for those who need it
- encouraging participation of people with disabilities in community activities by making sure that meeting and event sites are accessible
- understanding children's curiosity about disabilities and people who have them
- advocating for a barrier-free environment
- speaking up when negative words or phrases are used in connection with disability
- writing producers and editors a note of support when they portray people with disabilities as they do others in the media
- accepting people with disabilities as individual human beings with the same needs and feelings you might have
- hiring qualified disabled persons whenever possible

Some general considerations for disability etiquette...

- People with disabilities are entitled to the courtesies that you extend to anyone. This includes their personal privacy. If you don't generally ask people about their sex lives, or their complexions, or their incomes, then don't ask people with disabilities about theirs.
- If you don't make a habit of leaning or hanging on to people you're with, then don't lean or hang on someone's wheelchair. Wheelchairs are an extension of personal space for people who use them
- When you offer to assist someone with a vision impairment, allow the person to take your arm. This will help you to guide, rather than propel or lead this person
- Treat adults as adults. Call a person by his or her first name only when you're extending this familiarity to everyone present. Don't patronize people who use wheelchairs by patting them on the head. Reserve this sign of affection for children, even if a wheelchair user's head rests temptingly at about the same height as a child's

A glossary of terms . . .

Amputation - Surgery resulting in a missing body part such as an arm, leg or hand.

Blindness - Refers to total loss of vision. Not to be used when referring to partial vision which may also be correctly called *partial sight* or *visual impairment.*

Cerebral Palsy - An umbrella term for a group of disabling conditions resulting from central nervous system damage. It is inappropriate to assume that a person with cerebral palsy also has mental retardation; the two disabilities do NOT necessarily or typically occur together.

Communicative Disorder - Another umbrella term for speech, hearing and learning disabilities that affect one's ability to communicate.

Deafness - Refers to total loss of hearing. Not appropriate when referring to partial hearing loss. Use *hearing impairment.*

Developmental Disability - Any mental and/or physical disability manifested before the age of 22 that may continue indefinitely and result in substantial limitation in three or more of the following life activities:

☐ Self care
☐ Receptive and expressive language
☐ Learning
☐ Mobility
☐ Self-direction
☐ Independent living
☐ Economic sufficiency

Epilepsy - An umbrella term for various disorders marked by disturbed electrical rhythms of the central nervous system and typically manifested by seizures-involuntary muscular contractions.

Hearing Impairment - Term for a range of hearing disabilities from slight to severe.

Hemiplegia - Full or partial paralysis of one side of the body, caused by brain damage due to disease, trauma or stroke.

Learning Disability - A disorder affecting the understanding or use of spoken and/or written language.

Mental Illness/Mental Disorder - Loss of social and/or vocational skills necessary to function independently. Terms such as *mentally deranged, deviant* and *crazy* are not appropriate. *Mental disorder* is a more comprehensive term that describes any of the recognized forms of mental illness or severe emotional disorder. Terms such as *neurotic, psychopathic* and *schizophrenic* are libelous labels.

Mental Retardation - A condition causing a person to have significantly below-average general intellectual functioning. Labels such as *moron, mentally deficient/defective* and *feebleminded* are not acceptable.

Paraplegia - Paralysis of the lower half of the body involving the partial or total loss of function of both legs.

Quadriplegia - Paralysis of the body involving partial or total loss of function in both arms and both legs.

Spasticity - Having sudden, abnormal involuntary muscle spasms. Muscles are spastic, people are not.

Speech Impairment - Limited or difficult speech patterns.

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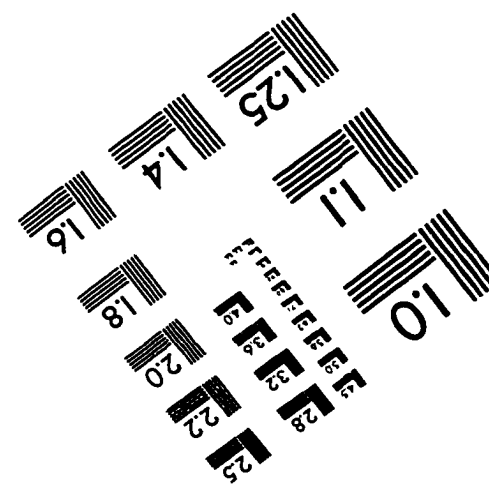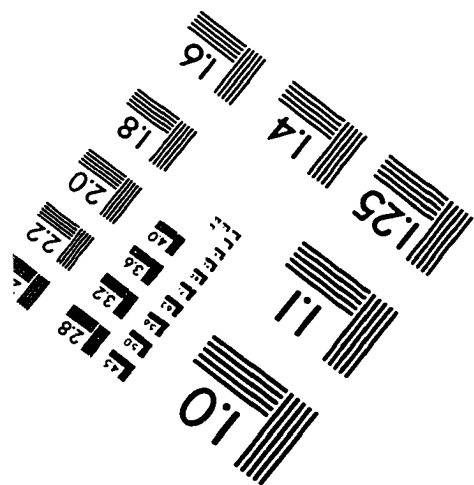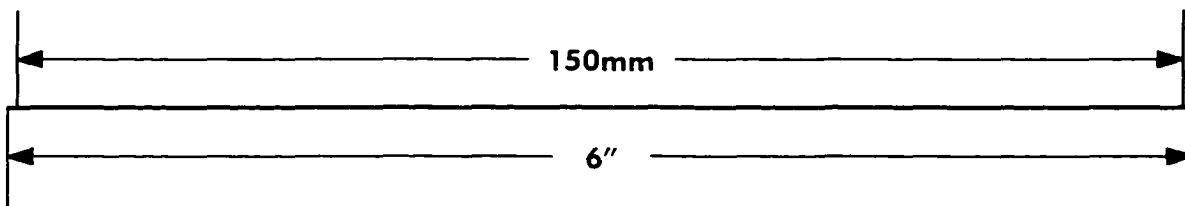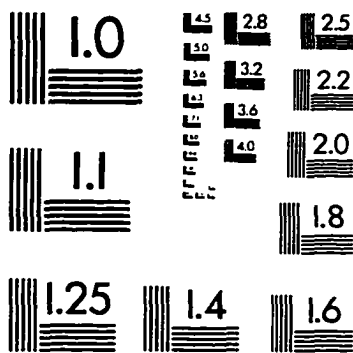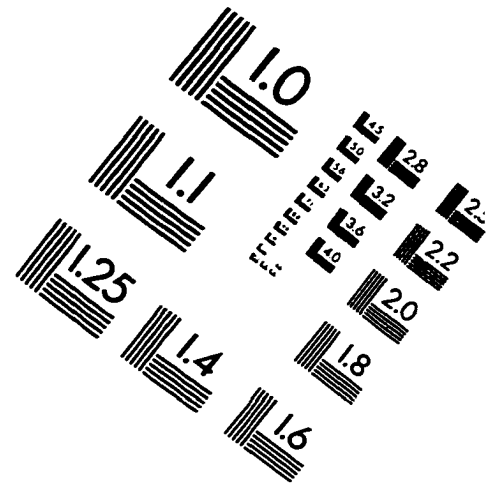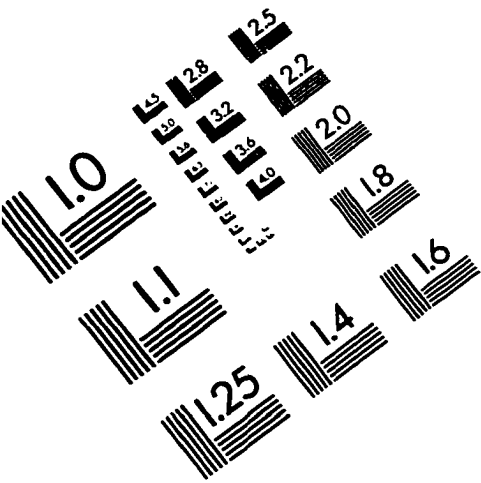
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IMAGE EVALUATION
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