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Sept.-Oct. 1981

VOLUME 42/NO. 9-10



*1981, The International Year
Of Disabled Persons*

Special issue devoted to Independent Living, IYDP



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REHABILITATION LITERATURE

Article of the Month

Personal Care Attendants: Key to Living Independently

NANCY K. SMITH and ANN B. MEYER, Ph.D.

For living human beings . . . whether acting alone or with the help of others . . . autonomy is an essential ingredient for further development. We surrender some of our autonomy when ill or crippled, but to surrender it every day on every occasion would be to turn life itself into a chronic illness. The best life possible . . . is one that calls for an ever greater degree of self-direction, self-expression, and self-realization.¹⁰

About the Authors . . .

Ms. Smith is currently coordinator of disabled student services at the University of Wisconsin in Madison. She formerly served as a counselor of students with special needs at the Waukesha County Technical Institute in Wisconsin. She recently obtained a master's degree from the University of Wisconsin-Milwaukee in rehabilitation counseling. Ms. Smith is a member of the American Personnel and Guidance Association and the American Rehabilitation Counseling Association.

Dr. Meyer developed the rehabilitation counselor education program at the University of Wisconsin-Milwaukee in 1965 and has served as the coordinator since that time. She completed her doctoral studies at the University of Wisconsin-Madison following two years of clinical experience as a rehabilitation counselor at the University of Washington. In recognition of outstanding contributions to rehabilitation psychology, Dr. Meyer was elected in 1977 to fellowship status in the American Psychological Association by Division 22. She has been actively involved in campus activities related to expanding services to persons with disabilities. Dr. Meyer is a certified rehabilitation counselor and licensed psychologist in the state of Wisconsin. Her special areas of interest include spinal cord injury and the rehabilitation of chemical abusers.

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CARL MAXWELL, a 19-year-old college student, broke his neck in a diving accident in 1960. The injury left him a quadriplegic, confined to a wheelchair and unable to take care of his essential daily needs. Because it did not seem realistic to believe that Carl would ever be able to work or attend school again, he had two options—to spend the rest of his life at home, placing the financial and emotional burden of his care on his family, or to spend the rest of his days in a nursing home, occupied mostly by senior citizens with whom he had little in common. Before the mid-1960's, the only real hope a severely physically disabled person had for returning to a productive and satisfying role in society was through vocational rehabilitation. Ironically, however, a person as severely disabled as Carl probably would not have been accepted as a vocational rehabilitation client, because there was not a reasonable expectation that he would ever become employable. In short, 20 years ago, someone as disabled as Carl would have been virtually "written off" by society. He probably would have been "sentenced" to a restricted family or institutional setting for the remainder of his life—to be unemployed, unsocialized, and unfulfilled.

Today, things would be different for Carl. In 1981, a person with a severe physical disability would no longer be written off, but instead, would be recognized for the valuable contribution that he or she could still make to society. Today, Carl probably would be able to finish his education, become employed, and live where he chooses. With the assistance of paid employees called personal care attendants (PCAs) to help with his daily activities, Carl could be in charge of his destiny and strive to achieve "the best life possible." This new, positive outlook for the severely disabled persons has grown and developed, especially during the past 15 years, as the concept of "independent living."

Independent Living and the Role of the Attendant

The [Wisconsin] task force [on Problems of People with Physical Handicaps] believes that social, psychological, and architectural barriers violate the fundamental human rights of people with physical disabilities. The basic issue is the right of people with physical disabilities to develop and exercise their talents fully in any way they choose. They seek the right to live independently, as fully competent adults, making their own choices about their lives and living with the consequences of those choices. They do not seek special privileges, protection from the world, or a subsidized existence.*

Independent living (IL) is basically the right to assume responsibility for directing one's own life, and for actively participating in the daily life of the community. It is living where one chooses and can afford, and includes managing one's own affairs, fulfilling many social roles, and making decisions that lead to less physical and psychological dependence upon others. It is the freedom to take risks and to make mistakes. In short, the independent living movement does not offer any quixotic goals to persons with severe disabilities—it simply postulates that the most effective way to learn how to live independently is by doing so.

Many disabled persons cannot live independently without assistance; hence, personal care attendants have been described as the key to successful independent living for people with severe physical disabilities.^{3,4} Of all the services and programs associated with the IL movement, attendant care has acquired the most symbolic significance, because the model incorporates many of the values and concepts cherished by IL advocates. Attendant care is viewed as a survival right, a benefit necessary to the physical existence of a disabled person, and as an alternative to institutionalization. Its indispensable nature gives attendant care the character of an inalienable right, with status comparable to a civil right.²

In spite of agreement that attendant care is probably the most crucial and most frustrating facet of independent living for persons with severe physical disabilities, little has been published on the subject. A review of the literature from the past 20 years revealed only one study in which the investigators directly solicited information from PCAs, and no research at all on the critical and extremely complex employer-attendant relationship. Much of what has been written on attendant care has consisted of either needs surveys or "how-to" handbooks for attendants.

Taking these factors into consideration, the follow-

ing literature review focuses on characteristics of PCAs, the needs for personal care as seen by consumers and rehabilitation program administrators, and modes of service delivery. Some of the personal factors that influence the delicate employer-attendant relationship, such as job satisfaction and personality characteristics, are examined. Finally, recommendations for facilitating the use of PCAs are formulated.

Job Description

A personal care attendant is a paid employee who provides regular in-home physical assistance with the essential activities of daily living to a severely disabled person who is unable to perform those activities alone. The position can be part-time or full-time, live-in or live-out. Duties include assisting the disabled employer with bathing, grooming, dressing, bowel and bladder programs, transferring between bed and wheelchair, light housekeeping, meal preparation, feeding, running errands, wheelchair maintenance, and laundering of clothes. PCAs provide an average of 4 hours of attendant care per day. A basic morning or evening routine takes about 45 minutes, excluding toileting and bathing. A full routine takes from 1½ to 3 hours.⁴ The daily time worked by a PCA depends primarily on the needs of the employer.

Model

When people are severely physically disabled, they are constantly being acted upon physically, their bodies being moved and positioned, and their surroundings being moved by others. In order to retain maximum independence and to control their lives and life-styles under those dependent conditions, people with disabilities must be able to direct their personal care and the running of their home, business, and social lives. The attendant care model assumes that persons with disabilities are not "sick"—that if they are well-versed in their own health care needs, they have the necessary ability and skill to direct and monitor their own personal care. The model recognizes that those with disabilities do not want to be exempted from responsibility, and do not want to be deprived of their "personhood."

The high degree of responsibility given to people with disabilities encourages them to be independent in other activities as well. Equally important, it provides the sole means of making the PCAs recognize that they are employees and that the affected individuals are their employers. When the hiring, training, and firing of attendants is left to disabled people, it makes them responsible for, and more motivated to try and find, PCAs with whom they can feel happy and physically secure.

*Wahner, J. W. *Final Report of Wisconsin's Task Force on Problems of People with Physical Handicaps*. Madison, Wis.: The Task Force, 1974.

Attendant care is more important to a person with severe physical disabilities than accessible housing, special parking, or affirmative action programs. Ramps, transportation, and even jobs are all useless to them if they do not have attendants to get them out of bed in the morning.

Problems of Attendant Care

It is safe to say that a personal care attendant easily can be the most important person in a severely disabled person's life. The need for attendant care, however, presents certain problems. The single most prevalent problem recognized by rehabilitation and IL leaders is the lack of money for attendant salaries, and the consequent high turnover rate.^{9,13,14} It is ironic that in a system with basically humanitarian goals, substandard wages are provided to care providers. A PCA position usually pays slightly more than minimum wage, and the average length of employment is six months. Unfortunately, the offer of a minimum wage attracts few people, many of whom may be marginal in mental or emotional stability, intelligence, or competence.¹²

Some applicants for PCA positions are public assistance recipients. Since additional income jeopardizes their continued standing, they do not like to work unless their employer agrees not to report their income. In most cases, the person who has a disability needs a PCA urgently, and will agree to almost any terms. The employer breaks the laws that require reporting employee salaries and thereby forfeits a sizable income tax deduction. The average short duration of an attendant's employment requires frequent advertising expenses. All of these costs are as permanent as one's disability, and can amount to a formidable sum over the years.⁹

In the only identified study of PCAs' attitudes,⁶ while only a few of the attendants actively complained about the inadequacy of their pay, the researchers were given the impression that low salaries and the almost total lack of fringe benefits contributed irrevocably to the low status and high turnover rate associated with the job. In another 1978 study, rehabilitation professionals agreed that higher salaries are necessary to attract potential attendants:

I cannot emphasize enough the fact that due to the traditionally low rate of pay and lack of recognition of attendants' need for emotional support, many people who would be potentially good attendants either never take this type of work or "burn out" quite soon.^{13, p. 151}

The life-threatening ramifications of PCAs leaving their jobs are obvious. Quite simply, if their disabled employers cannot find replacements, the employers may have to quit their jobs, sell their homes, give up

their independence, and move into nursing homes, just so that they can survive. The only way a participant-directed PCA system can be truly successful is if attendant wages are high enough to attract a stable labor force and maintain a decent level of social well-being.

Attendant Perspectives on Their Roles

In 1978, Hutchins and her co-workers⁶ undertook the only study that could be found to deal directly with attendants' needs and perspectives. The study was based on the assumption that to be successful, in-home attendant care must be a mutually beneficial enterprise that considers the needs of both attendant and employer. Unfortunately, the study had little external validity; the 21 PCAs who were personally interviewed as the sample were chosen because they were employed attendants known by the principal investigators. Nevertheless, because the study is unique, its results do at least suggest that various elements of the employer-attendant relationship deserve further study.

Briefly, the average monthly pay received by the 5 male and 16 female attendants was \$300; the average hourly pay was \$3.00. The tasks performed by the PCAs fell into two areas: personal care and housekeeping. Personal care activities most frequently performed included getting the employer in and out of bed, dressing, assisting with bowel and bladder programs, and bathing. The most frequent housekeeping activities reported were preparing and serving meals, and cleaning and straightening the employer's house. It was also common for attendants to accompany their employers on errands, to medical appointments, grocery shopping, and to provide transportation to jobs or schools.

Most of the subjects had held numerous previous jobs of a short-term nature. The majority of respondents reported "drifting into" attendant care work. All but five had had some past employment experience involving contact with disabled people. The PCAs' mean length of stay on attendant jobs was six months, with a range from three months to three years. The most frequent reason given for terminating their positions was the death of the employer or the employer's need for more intensive or skilled care, often in a hospital. Quitting because of personal conflicts with employers, dissatisfaction with the work, and inadequate pay also was reported. None of the PCAs reported ever having been fired from an attendant care position.

The majority of the sample had conditional feelings about attendant care work; about half regarded the work as simply a convenient way to make a living at the moment. The respondents stated that they would

continue with such work, or recommend it to others, only if nothing better were available, and they seemed emotionally neutral about both their work and their employees.

The most frequently reported intangible satisfaction with attendant work was a sense of personal reward in being of help and importance to another person. Other mentioned satisfactions with the job were its helping to meet the PCA's needs for companionship, security, food, and shelter. In general, there appeared to be a fairly consistent correlation between the PCA's degree of personal liking for the employer and job satisfaction. The attendants believed that interpersonal compatibility is a crucial component of a successful attendant-employer relationship.

A feeling that the work was tedious and boring was the most frequently reported intangible dissatisfaction. Also mentioned were dissatisfaction over inadequate pay, lack of relief and time off, and having to deal with DVR caseworkers. Also, tasks such as bowel and bladder work and housework were repeatedly mentioned as distasteful.

In discussing general qualifications for attendant care workers, the subjects emphasized the personal trait of a "sense of responsibility." The PCAs viewed their jobs as requiring a high degree of dependability. Always "being there" when expected and regularly following through with responsibilities were seen as crucial and sometimes life-saving matters. "Patience" also was stressed as important, particularly because the work can be monotonous, and because the lifestyle and routines of persons with disabilities are often much slower-paced than able-bodied persons are used to. Other personal characteristics viewed as desirable were "flexibility," a sense of humor, and "compassion not clouded with pity." Perhaps one of the most significant suggestions emerging from this study was the recommendation that employers, in many cases, could benefit from more guidance or training on how to work with their attendant-employees.

PCA Needs — Consumer Viewpoint

In 1977, the Levinson Policy Institute at Brandeis University studied the need for personal care attendants in Massachusetts.* Three groups of people were sampled: applicants who had not been accepted for Massachusetts Rehabilitation Commission (MRC) services, current MRC clients, and former MRC

clients. Two hundred interviews were conducted with a sample of 243 individuals, drawn from a known population of 325 people. A little less than half of the survey sample were evaluated as being moderately to totally dependent in self-care and mobility.

The researchers discovered many unmet personal care needs among MRC applicants and clients that could prevent clients from completing their vocational plans or accepting jobs at the completion of the rehabilitation process. Current MRC clients expressed the most unmet needs with respect to housekeeping activities such as meal preparation, housecleaning, and grocery shopping. These needs are often as important as personal care needs, because, if left unmet, they greatly increase the disabled person's risk of future institutionalization.

Most of the severely physically disabled citizens of Massachusetts had someone available to help them with personal care. However, that individual was usually another household member such as a spouse, parent, or adult child. A person who is severely dependent often becomes a tremendous burden on a household, and without some relief, family members must reluctantly turn to nursing home care for the dependent family member. In some cases, a care-providing parent becomes too old to continue taking care of an adult child. With no other helpers around, the person who is disabled may have no choice but to enter a long-term care facility at public expense.

A weighted total of 37 people living in institutions was included in the survey sample of MRC applicants and clients. They represented an estimated 42 people in the survey population. When the 37 were asked whether or not having a PCA would enable them to leave the institution in which they lived, about two-thirds responded that it would be "very likely" or "somewhat likely" that they could leave if they had a PCA. The researchers estimated that if all institutionalized persons surveyed were able to leave their institutions, the cost of their care and living expenses would have been reduced from approximately \$748,000 per year to \$164,300 per year, or a savings of \$583,700.

The researchers concluded that many MRC clients need personal care services if they are to attain their vocational rehabilitation goals. For those with the most severe disabilities, employment goals cannot be attained unless support services geared toward independent living also are available. Finally, and most importantly, the results emphasized the strong link between the twin goals of IL and employment. For those who are severely disabled, employment and independence are mutually reinforcing. When the subjects in this study were asked how a PCA might benefit them, they often mentioned the two goals concurrently.

*DeJong, Gerben. *Meeting the Personal Care Needs of Severely Physically Disabled Citizens in Massachusetts and The Need for Personal Care Services by Severely Physically Disabled Citizens of Massachusetts*. 1977. (Available from the Levinson Policy Institute, Brandeis University, Waltham, MA 02154)

PCA Needs — Rehabilitation Agency Viewpoint

How rehabilitation agencies perceive the attendant care issue with respect to their own clients was the focus of a 1978 study by Thornock and others. A questionnaire was mailed to 386 public and private rehabilitation agencies, institutions, and programs throughout the United States. The sample consisted of the 131 replies.

Over 85 percent of all respondents indicated that attendant care was extremely important to their clients in the following areas: promoting independence, maintaining higher morale, maintaining restored physical condition, decreasing hospitalization, and improving overall health. Other benefits included reducing the necessity of institutionalization and lessening the emotional and physical burden to families.

Over 90 percent of the subjects reported that among their client population were individuals who, in order to live independently, required attendant care. While only 20 percent of the rehabilitation professionals indicated that over half of their total clients needed full- or part-time PCA care, the majority of all respondents believed their estimates of clients' attendant needs were low, due to limitations of their own statistics and because families very often assume inestimable responsibilities when other resources were lacking.

Seventy-one percent of the respondents said that they had clients who were not living independently but who could if attendant care were available. More than two-thirds of the subjects indicated that clients who could not secure PCAs were often forced to live alone and manage as well as they could.

How to meet the financial cost of attendant service was the most-voiced concern of the respondents. Many respondents who raised the issue of financing attendant care expressed the belief that such services should be more broadly covered by all forms of public and private third-party payers (for example, insurance or Medicaid). They also pointed out that to make PCA work attractive, salaries must be higher.

Another group of the rehabilitation professionals suggested that the critical variables were being able to identify people who would, or could, do attendant work, and making sure they received adequate training. Several respondents suggested that likely candidates might be persons in groups with traditionally high unemployment rates, such as youth, older persons, those poorly educated, and minorities. They stressed that training must be followed by adequate salaries if the work was to be meaningful to prospective PCAs.

Numerous comments implied that attendant service was viewed as a low-prestige, unattractive form of employment. More psychological as well as material

rewards must be created to dignify and professionalize the PCA role.

The data from this study suggest that rehabilitation facilities are well aware that attendant care is a critical support for independent living among more severely disabled people. Respondents were concerned about the difficulties that people with disabilities experience in locating and maintaining adequate attendant services; yet, for the most part, these traditional rehabilitation providers did not involve themselves in providing any type of formalized access to PCAs for their clients.

Personal Qualities

In any interaction involving two or more people, there is always the chance of a personality conflict. Whether the interaction is in a social, business, or intimate setting, the way that the different individuals involved get along together has a direct influence on the results of the interaction. In the case of personal care attendant, the issue of possible attendant-employer personality conflicts is multiplied threefold, for their interaction involves all three settings - social, business, and intimate. In many cases, whether or not the two people involved successfully achieve the goals of their interaction has life-sustaining significance.

The only literature written exclusively on the subject of attendant care seems to be several attendant care handbooks^{5,7} usually designed for college campus attendants, which emphasize the practical realities of how to perform the basic tasks involved in the job. Little, if any, mention is made of the equally important factors involved in the attendant-employer relationship. One exception (DeGraff, 1979) is a guidebook on attendant care that places less emphasis on the tasks involved, choosing instead to offer hints to both PCAs and employers on how to develop a successful relationship.¹

DeGraff believes that there are four personal qualities that distinguish good attendants. First, attendants must be dependable and responsible in a very serious sense. When attendants are hired, they are agreeing to be responsible for helping to keep someone alive. Second, potential PCAs should be punctual, since delays in job performance could have serious or even fatal consequences. Third, being flexible is important, because some needs of the employer are unpredictable (such as the repair of mobility equipment or an "emergency" push through snow). Fourth, attendants must have at least some degree of interest in helping people. They should take pride in their work in detail, and in doing it well enough that they would be satisfied with the quality if the employer-employee positions were reversed.

Another coordinator of services for disabled col-

lege students also believes that a successful PCA must have an interest in the welfare of others. Simon¹¹ urges employers to look for attendants who are willing to provide assistance in a patient and understanding way, who have clean personal habits, and who are free of communicable diseases.

The attendant-employer relationship represents such a delicate balance between dependence and independence that Simon feels PCAs must understand the extent of their own responsibilities as well as those of the employer. To promote an effective attendant care relationship, Simon offers some guidelines for PCAs. First, employers, not their attendants, are most knowledgeable about their care needs. PCAs should not become overzealous in their need to "help" without discussing with the employer what procedures are necessary and how they should be performed. Second, providing physical assistance as well as the opportunity for employers to be as independent as possible are important elements of attendant care. In some situations, the individual may be capable of independence if they are given a little extra time to try new techniques. Third, PCAs are not hired to be friends, counselors, guardians, or parents. They are hired to provide a service in an efficient and hygienic manner. A close friendship can develop in the course of an attendant-employer relationship, but it is not necessary for effective attendant care. Whatever the relationship, open communication always is important. Fourth, PCAs should recognize the degree to which some employers rely on them for their personal well-being. Not taking the responsibility seriously, ignoring a schedule, or being careless in performing tasks could jeopardize the employer's health. The quality of attendant care should be consistent and not depend on the PCA's personal needs or moods. Finally, attendants should try to remember that they are being paid to do a job—they are not doing the person with a disability a "favor" by providing PCA care. High quality attendant care should be a right, not a privilege.

Job Satisfaction

The Boston Center for Independent Living's introductory literature* offers some hypotheses about factors contributing to a successful attendant-employer relationship, and job satisfaction for PCAs. How happy attendants are in their work seems to be partly a matter of how suited they are in character and temperament to the duties required of them and to their roles in general. PCAs should be able to cope with responsibility, be patient with routine, and be

able to accept physical differences and the less aesthetic tasks of personal care. They also must be able to accept the fact that, although their employers are physically dependent, they are completely in charge of their own lives and therefore the employers, not the attendants, should make all decisions regarding their own care.

Also bearing on attendants' attitudes toward their jobs is how appreciated they feel. Dependability, competence, and consideration should never be taken for granted; PCAs who have them deserve praise. The conviction that one is doing something worthwhile and important also contributes to job satisfaction. The degree to which PCAs like and respect their employers can have a profound effect on their job satisfaction. Employers can establish and maintain PCA respect in several ways: by functioning as independently as their disabilities allow; by being mature and knowledgeable about their own care; by being good household managers; by being engaged in some meaningful, socially useful activity, such as the pursuit of an education, vocation, or avocation; and by treating the attendants as the employers want and expect to be treated themselves—with honesty, fairness, kindness, patience, and respect.

Modes of Service Provision

In private, one-to-one PCA systems, persons with disabilities generally are responsible for hiring, supervising, and terminating their own attendants. Private PCA relationships usually occur in three settings: with people who live alone in apartment complexes or houses in residential neighborhoods; with people who live with their family or spouse and who have outside help for their activities of daily living; and in college dormitories, where attendants may also be the roommates of students who are disabled.

Another option that is becoming available is the shared attendant system in clustered living settings. In this type of arrangement, groups of people having disabilities and with similar attendant needs live near each other (as in the same apartment complex), and PCA services are contracted for the entire group. A person who is disabled might work with two or more attendants per day, and PCAs usually are available 24 hours per day. Most systems of this type maintain a full-time staff attendant manager who is responsible for scheduling and supervising the PCAs. Some clusters manage their attendant systems through a board of directors and/or a grievance committee. Shared attendant systems* imply that residents share responsi-

*Kahn, P. "Some Thoughts on Attitudes to Look For and Maintain in Your Personal Care Attendant." Unpublished introductory material, no date. (Available from the Boston Center for Independent Living, Inc., 50 New Edgerly Rd., Boston, MA 02115)

*Board, M. A.; Cole, J. A.; Frieden, L.; and Sperry, J. C. *Independent Living with Attendant Care: A Guide for the Person with a Disability*. 1980. (Available from the Institute for Rehabilitation and Research, 1333 Moursund, Houston, TX 77030)

bility for hiring, supervising, and terminating their PCAs. An advantage of the shared attendant system is that it may be very efficient and cost-effective.

The attendant care model is based on the combined philosophies of the consumer and self-help movements. According to the consumer movement, the consumers, not the providers, are best able to judge the adequacy of services and products. The self-help movement takes that assumption one step further in that it assumes that consumers are not only capable of evaluating service quality, but that they are also able to manage and direct the services they need. Thus, the attendant care model assumes that people with disabilities who are well versed in their own health care needs have the necessary ability and skill to direct and monitor their own personal care. These persons are not "sick," do not wish to be exempted from responsibility, and do not wish to be deprived of their personhood.

In contrast, in the home health model, disabled people do not direct their own care. Instead, care is provided by an agency-supervised home health aide. The disabled person is a passive recipient of services—in essence, a patient. Since Medicaid is the main source of reimbursement for home health services, most agencies shape their operating policies after those of the Medicaid program. Unfortunately, people's abilities to direct their own care are severely restricted by Medicaid requirements. For example, the Medicaid program requires that home health services be directed by a physician's plan of treatment, be supervised by a skilled nurse, and be reviewed every 60 days.

While the attendant care model with its consumer-directed services is the preferred model to provide ongoing, routine care as an alternative to long-term institutionalization, that is not to say that the home health model is unnecessary. The home health model is still needed to provide acute, restorative care during a period of illness or recuperation immediately following hospitalization.²

The Attendant-Employer Relationship

A PCA can encourage independence or foster dependence in an employer. Many PCAs have emotional needs that are met by their jobs. Depending on what these needs are, they may be helpful or detrimental to the employer. Many times, the person with a disability is acting as an employer for the first time, and lacks managerial knowledge and experience, which can weaken the relationship. Also, the employer is responsible for training the PCA to meet his

or her specific needs, even though the employer, personally, has had no experience or training.

In a successful attendant-employer relationship, there must be mutual respect and a willingness to make compromises. It is nearly impossible for a person with a disabling condition and a PCA who dislike each other to work together; the work is too intimate. A PCA who is reliable and considerate instills a feeling of security and confidence in the employer. In a sound attendant-employer relationship, the PCA's benefits can include the close, rewarding relationship with the employer itself, the satisfaction of doing personal/helping work with visible results, the importance of being needed, and sometimes, a home and acceptance into a family.

Socialization between PCAs and their employers varies according to the individuals involved. Some PCAs restrict themselves to coming in, doing their work, and leaving; others spend a lot of time talking and engaging in recreational activities with their employers. Close, personal relationships often develop between PCAs and their employers. Attendants who have become emotionally involved with their employers universally emphasize the importance of terminating the professional relationship if they wish to maintain the emotional one. The intensity of physically caring for someone has two features; it leads to the development of attractions and closeness, and then it destroys the same closeness when the caretaking is a necessity—neither a free choice made from love, nor a job that can be completed and left, both physically and emotionally.⁸

Recommendations

Since the personal care attendant plays such a major role in determining whether or not a person with a severe physical disability is able to live independently, it is critical that the attendant-employer relationship be as harmonious as possible. Little literature could be found on the subject, and only one study was directly addressed to attendants. Therefore, there seems to be an initial need to determine why the PCA turnover rate is so high and what can be done to make the job more appealing, by asking the people who do the work—the attendants themselves. Additional investigators might explore the role of the personal care attendant from both the employer's and the employee's perspectives, by including both PCAs and their employers as subjects.

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Value-Laden Beliefs and Principles for Rehabilitation

BEATRICE A. WRIGHT, Ph.D.

THE FOLLOWING makes explicit those "value-laden beliefs and principles" that have guided my work in rehabilitation as a field of study and service.* They are offered as possible guidelines to others with the intent that they be examined and improved, and then kept in the forefront to remind and to prompt, to check and to challenge, lest they remain inactivated and submerged by the weight of social, political, and personal pressures of all sorts.

1. *Every individual needs respect and encouragement; the presence of a disability, no matter how severe, does not alter these fundamental rights.*

A person is entitled to the enrichment of life and the development of his or her abilities, whether these be great or small and whether the person has a long or short time to live. The person must not be led to devalue the self or to give up hope. The person is not to remain neglected and deprived. Under no circumstance is the person to be treated as an "object" or "vegetable."

Biases that declare some groups to be more worthy or deserving of services than others lead to gross inequities and must be avoided. Life, increased mobility, and better communication skills are just as important to a 72-year-old as to a 12-year-old, to a mentally retarded person as to an average person, to a black person as to a white person, to a poor person as to a rich person.

The affirmation of human worth and dignity must not only be kept explicitly in the forefront when allocating limited resources. It should be reflected also in adequate case finding efforts so that no person who has a disability remains neglected.

2. *The severity of a handicap can be increased or diminished by environmental conditions.*

Although grammatical usage speaks of a "person's handicap," how handicapping a disability is depends to a great degree upon the characteristics of the person's environment. Thus, physical handicaps can be reduced by eliminating architectural barriers, interpersonal handicaps by overcoming devaluating social attitudes, educational handicaps by providing educational and training facilities, economic handicaps by

extending work opportunities, emotional handicaps by enhancing family and group support.

It should be stressed that the rehabilitation process itself carries an important environmental impact. Professionals and others must continuously question whether present methods or systems of operation are always or maximally helpful. They should seek ways to improve the rehabilitation process as well as to support environmental changes in the home and community that reduce the severity of handicapping conditions.

3. *Issues of coping and adjusting to a disability cannot be validly considered without examining reality problems in the social and physical environment.*

It is to be stressed that the personal-affective life of the individual generally can be most effectively strengthened within the context of dealing with reality problems that exist in the social and physical environment rather than by treating feelings in an environmental vacuum. Supportive attitudes of family,

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*Revised from the original 1972 version (Wright, B. A. Value-Laden Beliefs and Principles for Rehabilitation Psychology. *Rehab. Psychol.* 1972. 19:38-45).

friends, and professionals, as well as opportunities for satisfactory living offered by the community, facilitate the person's efforts to come to terms with the disability.

4. *The assets of the person must receive considerable attention in the rehabilitation effort.*

A person's healthy, physical, and mental attributes can become a basis for alleviating difficulties as well as for providing a source of gratification and enrichment of life. Special care must be taken to avoid overemphasis on the pathologic that leaves one inadequately sensitized to stabilizing and maturity inducing factors. Those attributes of the person that are healthy and promising must be supported and developed.

5. *The significance of a disability is affected by the person's feelings about the self and his or her situation.*

Feelings that often have to be worked through by a person who has incurred a disability are those of resentment, inferiority, guilt, loneliness, and being a burden; doubts about whether he or she will still be loved and accepted; worries about the future and how one will manage; and concern that one will be left behind. Such social-emotional concerns take time to resolve. When the person accepts the disability as personally nondevaluating and engages life positively, important rehabilitation goals have been reached.

6. *The active participation of the client in the planning and execution of the rehabilitation program is to be sought as fully as possible.*

Genuine respect for the client leads to the affirmation of the right, within very broad limits, to become actively engaged in the rehabilitation process and to make decisions that affect one's life. The client obviously also has information and ideas essential to rehabilitation progress that are not available to others.

Among the foremost consequences of active involvement on one's own behalf are the enhancing of the person's self-respect, initiative, and responsibility for carrying out decisions.

The principle requires that effort be made to determine the views of every client. Special effort will be necessary in those instances where a major problem of communication exists. Examples of such instances are deafness, aphasia, cerebral palsy, mental retardation, foreign speech, ghetto speech, and stuttering.

7. *The client is seen, not as an isolated individual, but as part of a larger group that includes other people, often the family.*

The problems of the client are intimately connected with those of the larger group of people whose welfare is shared. Therefore, early and active participation of such significant others as spouses, parents, siblings, and children are viewed as an important principle in the total rehabilitation process.

Where the client is in fact alone, or is resistant toward including other people, this principle may remain inactivated.

8. *Because each person has unique characteristics and each situation its own properties, variability is required in rehabilitation plans.*

Grouping persons according to a specific disability must not lead to stereotyped inferences about them. Differences in the needs, abilities, and circumstances of persons with the same or a similar disability require diverse approaches rather than the inflexible application of procedures.

Differences in problems that stem from particular characteristics of particular groups further serve to underscore the need for variability in the process of rehabilitation.

9. *Predictor variables, based on group outcomes in rehabilitation, should be applied with caution to the individual case.*

At the present stage of knowledge the individual, if given a chance, often becomes the exception which, instead of proving the rule, challenges it. Assessment data, therefore, generally can be used more appropriately as an indication of present status and as a *guide to remediation* than as a prognosticator of future performance.

The direct application of group based predictor variables is not questioned in regard to the behavior of groups *qua* groups, as in voting or consumer behavior, but is questioned in regard to long-range decisions about a particular individual. Moreover, prediction based on the response of the individual to the rehabilitation process rather than on "group variables" encourages treatment corrections in accordance with continuing evaluation.

10. *All phases of rehabilitation have psychological aspects.*

All human beings react cognitively and emotionally to events that involve them. These reactions in turn affect the further course of those events. One is compelled, therefore, to recognize that psychological factors are ever-present and often crucial in all aspects of rehabilitation—medical, surgical, educational, social, vocational, as well as primarily psychological.

The psychologist (as well as other psychosocially versed professionals) can offer help to other professions. For example, psychologists are able to describe principles and procedures that help to motivate a client, review body-mind relationships that are important in rehabilitation, assess client attributes, evaluate psychological and behavioral consequences of particular environmental situations, demonstrate ways to resolve intra- and inter-group conflicts, and sensitize personnel to social-emotional aspects of professional-client relations.

11. *Interdisciplinary and interagency collaboration and coordination of services are essential.*

The needs of individual clients are so diverse, encompassing all problems that one might expect to encounter in human affairs, that a variety of services is necessary. Comprehensive rehabilitation, therefore, requires the effort of many professions and close working relations among the various kinds of rehabilitation agencies.

There is the persistent danger that the pressure to meet agency and professional needs most efficiently and conveniently will become the principal basis for coordinating services. To guard against this danger a clear and explicit focus on meeting client needs most effectively is required.

Because of the complexities in the system of services, the client needs a specified person to serve as "coordinator" or "advocate" in providing information and otherwise acting on his or her behalf. Such a person may come from a self-help group or any of the helping disciplines as appropriate, rather than routinely from a single profession.

12. Self-help organizations are important allies in the rehabilitation effort.

Self-help groups provide important programs and mutual support to their members. They also can aid rehabilitation personnel in the understanding of significant problems and the development of new directions in the rehabilitation field. More extensive collaboration between professionals and self-help groups can be expected to further shared objectives.

13. In addition to the special problems of particular groups, rehabilitation clients commonly share certain problems by virtue of their disadvantaged and devalued position.

Devaluation and disadvantage are general life problems experienced by diverse groups: persons who have a physical, mental, or emotional disability; racial and religious minority groups; the poor, and so forth. These common problems give rise to important rehabilitation goals that are shared among socially and economically deprived groups.

Special problems stemming from the particular characteristics of particular groups are locomotion difficulties of persons with orthopedic disabilities, communication problems of those who have impaired hearing, addiction in the case of the drug user, malnutrition of the poor, intellectual deficits of the mentally retarded, and so on.

14. It is essential that society as a whole strive continuously and persistently to provide the basic means toward the fulfillment of the lives of all its inhabitants, including those with disabilities.

Among the obligations of society are the establishment of needed housing, schools, work opportunities, transportation, hospitals, recreational facilities, and other services. Professionals and others bear a responsibility in helping to meet these obligations by

initiating and supporting appropriate legislation and programs.

Where national and community resources are limited, ways to make more effective use of them or to expand them must be sought. Inertia and resistance to change lead to ignoring pressing problems and must be replaced by a determined effort to work toward better solutions.

Extending the goals of rehabilitation to their ultimate implications requires that effort be directed toward the prevention of handicapping conditions. Improvement of health care, reduction of accidents, control of pollution, overcoming of prejudice, diminution of poverty, are all major societal responsibilities. Professionals and others cannot remain indifferent to them.

15. Involvement of the client with the general life of the community is a fundamental principle guiding decisions concerning living arrangements and the use of resources.

Under special circumstances, where vital considerations indicate the advisability of some form of institutional living, every effort should be made to help the resident participate in community activities and services. Involvement with the community also can be served by sharing institutional resources and activities with the public. Periodic visits on the part of the resident with family, friends, or in foster homes, should become established procedure. The location of institutions, within rather than outside communities, facilitates such integration.

The development of halfway houses and other interim steps that encourage community involvement is imperative. Housing designed to meet special needs should be available in the community to persons with disabilities.

The client who chooses specialized living arrangements should continue to have the option and opportunity to move elsewhere as circumstances permit. In the interest of life enrichment, the space of free movement of a person should be enlarged rather than restricted.

16. People with disabilities, like all citizens, are entitled to participate in and contribute to the general life of the community.

This means that persons who have a disability fulfill not just the role of consumers; they also have abilities and talents offering a significant resource that should be utilized for the betterment of the community. The removal of attitudinal and environmental barriers preventing full participation in community life must be pursued on many fronts, including research, public education, legislation, and other forms of action.

17. Provision must be made for the effective dissemination of information concerning legislation and community offerings of potential benefit to persons with disabilities.

Large numbers of persons with disabilities remain

unaware of available services from which they could benefit. Professionals also are often unaware of them and thus do not serve adequately as sources for information and referral. Solution of the problem requires a variety of approaches by which both professionals and clients can be kept abreast of opportunities that might benefit clients should they choose to avail themselves of them.

18. *Basic research can profitably be guided by the question of usefulness in ameliorating problems, a vital consideration in rehabilitation fields.*

Basic research can be useful research in the sense of being oriented toward the alleviation and overcoming of problems faced in rehabilitation. The converse is also true: useful research can be basic research in the sense of advancing knowledge through the discovery of general principles that apply beyond the borders of the immediately presenting situation. It is misleading and stultifying to identify basic research with "pure" research, the unwitting assumption being that any guide to research other than that given by "knowledge for its own sake" renders it impure and somehow less basic.

It is, therefore, urged that the question of usefulness be regarded with favor as a guide to research. Basic research can profitably become real-life oriented in its conception and from its inception by considering usefulness as a value in the selection of problems, analysis of data, communication of results, and application of findings. In bridging the gap between theory and research, psychological concepts need to be examined and new ones introduced in the light of their usefulness in dealing with everyday life problems of persons who have disabilities.

19. *Persons with disabilities should be called upon to serve as co-planners, co-evaluators, and consultants to others, including professional persons.*

It is important that the rehabilitation field take ad-

vantage of the special knowledge and viewpoints of people who have disabilities. Such persons have had first-hand experience with the rehabilitation process and are directly involved with problems that personally affect them. Their ideas should be especially sought concerning ways in which rehabilitation services can be improved and the lives of people with disabilities enriched.

Organizations on behalf of persons having disabilities should make it a point to include representatives of client groups on their advisory boards. Examples of such organizations are rehabilitation centers, private and governmental health agencies, foundations, schools, and hospitals. Rehabilitation agencies should make certain that persons with disabilities serve in professional and nonprofessional capacities.

With respect to research on problems of rehabilitation, the special sensitivities and understandings of persons with disabilities can be utilized by having them serve as consultants and co-investigators.

20. *Continuing review of the contributions of those in rehabilitation within a framework of guiding principles that are themselves subject to review is an essential part of the self-correcting effort of science and the professions.*

The values and beliefs expressed in the foregoing set of principles need to be periodically reviewed for two main reasons. First, change in emphasis and content may be indicated by new knowledge and changing times. Secondly, specification as to how the principles can best be implemented requires constant examination and study if their effectiveness as guides in rehabilitation is to be increased.

In many cases, the sheer process of seriously examining a principle will reveal ways in which it is not being reflected in actual practice and also ways to improve the situation. Serious examination is directly available to everyone and when carried out in brainstorming group sessions can be especially productive.

PAPERS on development and progress in the field of rehabilitation will be welcomed for consideration as articles to be featured in future issues of *Rehabilitation Literature*.

Professional personnel should send their contributions or inquiries to the Editor at 2023 W. Ogden Ave., Chicago, Ill. 60612. An author's instruction sheet listing other specific requirements is also available—see page 292 of this issue.

Programming Strategies for Pupils with Disabilities Who Are Gifted

AUGUST J. MAUSER, Ed.D.

INDIVIDUALS with disabilities who are gifted are not a new phenomenon to our society. Numerous historical references may be cited of highly adept men and women who have transcended their disabilities and contributed to society in some unique and significant manner. Intellectually gifted and talented individuals who have had deafness, blindness, speech disorders, orthopedic disabilities, epilepsy, dyslexia, health impairments, behavior disorders, or combinations of these conditions are familiar to all occupations and careers, and to every conceivable life role.²

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Some of these persons and their talents are listed in Table 1. However, due to societal attitudes, past and contemporary, many gifted and talented persons with some form of disability have also succumbed to these disabilities and, in turn, deprived society and themselves of the many significant contributions that may have emerged.

A Definition

The "gifted" referred to in this article are those gifted and talented children and youth who will require *additional* special intervention to fully realize their potential in (a) general intellectual ability, (b) specific academic aptitude, (c) creative or productive thinking, (d) leadership ability, (e) visual and performing arts, and (f) psychomotor ability. In some cases,

early identification and intervention will significantly modify the effects of the disability. In other instances, a comprehensive life-long interdisciplinary treatment program will be required for optimum career development.^{9,10}

In essence, individuals with disabilities who are gifted constitute a minority group within a minority group. The types of disabilities experienced by this group are quite diverse and as such require the knowledge, commitment, and expertise of every conceivable talent within the field of regular education and special education for maximum progress and adjustment.

Concerns, Goals, and Priorities

The primary concerns in this area focus on the attitude of the general population toward children with disabilities who are gifted, as well as on the assurance that these children develop positive attitudes toward others and themselves. The positive developmental effects inherent in healthy home and family attitudes is another area of concern. These concerns have generated the following goals and priorities for educators of children with disabilities who are gifted: (a) to develop public awareness of these students; (b) to mobilize the efforts of the public and private sectors of the community, state, and nation to meet all the educational needs of gifted and talented children, including those with disabilities; (c) to promote total career education (differentiated in approach when needed); and (d) to tenaciously work toward non-segregation, whenever possible, and to minimize labeling and further stigma, which may impede or destroy the development of an adequate self-concept so necessary in all children.

Society as a Reducer of Handicapping Conditions

If society can be held responsible for creating handicapping conditions, it should be possible for society to reverse the process and reduce the effects of these conditions. Handicapping may be reduced by (a) minimizing the segregation of persons with disabilities or other problems, (b) eliminating any diagnostic procedures that do not facilitate or result in successful treatment attempts, and (c) eliminating

About the Article . . .

THOSE PUPILS who have been previously identified as "handicapped" under one or more of the traditional categories but who might also be gifted deserve specialized education not only in their areas of

disability, but also in their areas of strength. The need to modify societal attitudes and possible educational neglect is stressed and a comprehensive identification and treatment program is suggested.

treatment wherever the effectiveness of the treatment cannot be demonstrated. The suggested elimination of ineffective diagnostic and treatment procedures is based on the assumption that diagnosis and treatment may reduce normal progression through a life's career. A related implication is that necessary and useful treatment will carry less stigma when provided as invisibly as possible, thereby reducing the negative effects of the social condition associated with being "handicapped."

Much of what we have discussed has implied that labeling or handicapping individuals serves an important function for our society and that the society will resist the reduction of the labeling and handicapping process. Dentler and Erikson⁵ have clearly stated that by removing labeling within a group (and thereby improving the status of the labeled individual within that group), the effectiveness by which the group can motivate others to meet the norms of the group is reduced. Thus, it would seem easier to convince so-

Table 1.—Famous Gifted/Talented People* With Congenital or Acquired Disabling Conditions

NAME	TALENT	CONDITION
Bud Abbot	Comedian	Epilepsy
Brook Adams	Historian	Dyslexia
Jane Addams	Sociologist	Scoliosis
Hans Christian Anderson	Writer	Dyslexia
Ludwig von Beethoven	Musician	Hearing Impairment
Louis Braille	Educator	Visual Impairment
Larry Brown	Professional Football Player	Hearing Impairment
Miguel de Cervantes	Writer	Loss of Use of Arm (War injury)
Ray Charles	Singer	Visual Impairment
Winston Churchill	Politician	Speech Impairment
George S. Patton	U.S. General/World War II	Dyslexia
Charles Percy	Politician	Hearing Impairment
Joseph Pulitzer	Writer	Visual Impairment
Nelson Rockefeller	Politician	Childhood Dyslexia
Franklin Roosevelt	Politician	Paraplegia
Theodore Roosevelt	Politician	Asthma
Harold Russell	Actor, Academy Award Winner	Orthopedic Impairment
Tom Sullivan	Singer	Visual Impairment/Blind
Mel Tillis	Singer	Speech Impairment
Leonardo da Vinci	Painter	Dyslexia
Bill Veeck	Former Baseball Team Owner	Orthopedic Impairment
Charles Dickens	Writer	Emotional Instability
Sandy Duncan	Actress	Visual Impairment
Thomas Edison	Scientist/Inventor	Hearing Impairment/Dyslexia
Albert Einstein	Physicist	Dyslexia
Jose Feliciano	Singer	Visual Impairment
Aldous Huxley	Writer	Visual Impairment/Blind
Helen Keller	Sociologist	Hearing Impairment-Deaf/ Visual Impairment-Blind
Mary Tyler Moore	Actress	Diabetes
George Wallace	Politician	Paraplegia
George Washington	U.S. President	Dyslexia
Stevie Wonder	Singer	Visual Impairment-Blind
Emile Zola	Writer	Visual Impairment/ Speech Impairment Metabolic Disorder

*Baker² and Thompson¹⁸ were primary sources for noncontemporary individuals

cial groups to keep the members who have differences (and their labels) rather than to convince them not to differentially label and treat them equally within the group. Most importantly, it is necessary that in suggesting realistic change we consider the societal needs actually served by such treatment as the labeling process, rather than the humane rationale presented.

A "handicap" is a social condition; that is, a person's physical or behavioral condition becomes a handicap only to the extent that society, other people, or the person defines the condition as distinctive and undesirable. This definition may be manifested in verbal labeling, distinctive interpersonal reactions, and/or special treatment techniques, all of which imply unattractiveness, incompetence, or both. The result has been to remove the person further and further from standard life patterns, finally convincing the person that he or she is truly handicapped. Because most persons sense the serious consequences of being different, they exert great effort to avoid being seen as different by those whom they value. They may do this by drawing attention from their mode (or modes) of "distinctive" behavior. These attempts to "pass" or "cover" along with the societal apparatuses geared to cope with those who are different provide extensive evidence for the need to re-examine conditions. Finally, this approach suggests directions for prevention and treatment methods that are antithetical to the current approaches of our educational and rehabilitation agencies.

The School as a Significant Factor

The school has a two-fold function to perform with gifted children who are also disabled: (a) to provide cognitively meaningful experiences that allow the children to learn and achieve academically, and (b) to provide affectively meaningful experiences that allow them to learn and achieve an understanding of themselves as individuals and as social entities.

Performing one of these functions to the exclusion of the other, or single-mindedly pursuing one while assuming the other will naturally occur, leads to a fragmentary education. It must be recognized that the whole child, and the growth of the whole child, exceeds the sum of these two "parts." Perhaps one of the most serious charges leveled at education and educators is that we have too frequently refused to face or deal with this dictum—our protests of teaching the "whole" child notwithstanding.

Self-Concept

There are several reasons why educators should study self-concept and address concerted efforts toward including self-concept in the public school cur-

riculum for children with disabilities who are gifted. First, children who develop negative or weak self-concepts tend to demand an inordinate amount of teacher time in order to aid them in self and social management. Second, children who are poorly self-managed tend to invariably think poorly of themselves, perform poorly in academic areas, and cause disruption in the class—often triggering misbehavior by other children. Third, behavior problems in children are seldom identified until *after* they have become relatively stable and persistent classroom management problems. As a consequence, we don't work with potential problems, only with *existing* problems. It is obvious that we cannot afford to continue to work on a "remedial only" basis with children who have behavior disorientation. Finally, through conscious effort to work with the development of a healthy, positive self-concept in the classroom we may be able to appreciably reduce the number of children who later require additional special classes or services.

There are two issues concerning the study of self-concept that deserve to be mentioned as possible problem areas. First, unless the understanding of self-concept becomes a legitimate aspect in teacher preparation, it may well become a concept as poorly understood as intelligence. Equally as damaging is the ever-present danger that self-concept assessment or evaluation may be carried out as a means by which children can be labeled, rather than as an aid in providing instructional environment and program.

Definition of Self-Concept

Self-concept may be considered to be the sum total of those experiences, events, and interactions with significant others, which shape children's perceptions of their ability, and consequently their actual ability, to adequately and successfully interact with their environment.

The Impact of Self-Concept Formation

It has been said (in the Coleman report on education) that negative or poor self-concept is probably *the* most significant factor influencing a lack of achievement in schoolchildren (excluding, perhaps, intellectual or sensory impairments). Further research asserts that negative self-concept can also lead to hostility.¹⁴ Gallagher⁷ also adds that the negative self-concept may contribute to the stifling of creative instincts in gifted individuals. According to Gowan and Bruch,⁸ patterns of underachievement are to be modified and attempts must begin early in the child's life. Also, a study by Sisk¹⁵ indicated that the gifted child's self-concept of those who are gifted and who have disabilities thus evolves through a complex pattern

and can be extremely delicate. Unfortunately, a negative self-concept is not equivalent to a weak self-concept. The child with a negative concept of self will hold just as tenaciously to that concept as does the child with a positive self-concept. The reason for this is that people desire to be *something*—even if that identity has a negative valence for the significant others. The child who develops a *weak* self-concept is often extremely shy, withdrawn, frightened, and generally unhappy. These children are generally much more difficult to teach than are the more outgoing, aggressive children; they are afraid to try anything.

In summary, then, self-concept influences all behavior, including effective or negative behavior and cognitive or achievement behavior. Without an effective program to improve understanding of this self-concept process in parents and teachers and without adequate stress on the child's "gifts," the losses can be detrimental not only to the child but also to all of society.

Recommended Programs

The ideal program should include several components: referral system(s), diagnostic services, placement procedures, continuum of services, and follow-up system. The *referral system* should identify and refer for diagnostic services all gifted persons between the ages of 0 and 25 who are known to have or suspected of having disabilities. Referral procedures should be written and known to all potential sources of referral. Questions to be answered include: Does the referral system exist? Are referral procedures written? Where? Who has copies? and How many referrals have been made this month/semester/year?

Diagnostic services should include the educational, psychological, social, sensory, and medical components that are appropriate for assessing the needs of the individual, particularly the educational needs. Community resources, public and private, should be utilized wherever possible. Questions to be answered include: What type of diagnostic services are available? (medical, psychological, sensory, educational, etc.) and How often are they used? What criteria are employed to determine the selection of a particular diagnostic service?

Placement procedures should assure that persons be assigned to that program or service that will best meet their individual educational needs. A multidisciplinary educational planning and placement committee, which includes parents, should review all relevant data in arriving at a decision. An educational plan should be proposed by this committee. Such a plan should include a timetable for implementation and re-evaluation. Questions to be answered include: Who makes the placement decision? Is an educational

planning committee used? Who serves on the committee? and Are placement decisions written and communicated to the staff?

A *continuum of programs and services* can be viewed in two forms: (a) continuous from ages 0 to 25, and (b) intensive according to the segregation-integration continuum. Programs and services for gifted individuals with disabilities should be continuous from the preprimary level (including home training, parent counseling, and preschool classroom programs) through the elementary and secondary levels (including appropriate prevocational and vocational education providing skill entry into higher education or referral to another agency for postschool training).

The programming continuum must include provisions for all types of programs from residential to regular classroom placement with varying degrees of supportive services so that the educational needs at a particular stage of life may be met by the most appropriate program. Movement from one program to another must be possible and encouraged. Questions to be answered include: What unique sequence of experiences is provided to accomplish the stated outcomes? Is the sequence continuous from preschool through secondary level? and By what mechanism is articulation maintained between levels for the individual needing special service?

A *follow-up system* must include procedures for referral to other agencies for postschool placement or for monitoring placement. The following details also require consideration.

Qualified personnel must be provided in adequate numbers to conduct any special education programs and services needed. Provisions must be made for updating skills through inservice education so that children and youth with disabilities are provided services based on the latest methods and materials. Appropriate paraprofessionals should be provided for each program or service. Questions to be answered include: How many staff members conduct this program? What is their level of training? Is this level of training being changed? and What is the principal method used to upgrade personnel training? (recruitment, preservice training, summer at the university, scholarships, inservice training, etc.)

The *facilities* should provide sufficient classroom space to enable gifted students who have disabilities to participate in all educational activities appropriate for their growth and educational needs. Space for special-service personnel should be located such that students can speak openly and frankly, yet privately. Facilities should include adequate equipment, both regular and specialized to conduct the program or service. Housing for special education programs and services should facilitate maximum integration of the students with and without disabilities. Questions to

be answered include: Where are the special education facilities located? (in relation to other facilities) and Does the location promote integration of staff and students?

The *instructional content* of special education programs and services must be designed to obtain specific performance objectives for each student. The performance objectives must be consistent with the overall goal of enabling each person to reach maximum potential in the cognitive, effective, and perceptual motor areas and should include attention to needs for personal adjustment training as well as prevocational and vocational training. Wherever possible, parents should be involved in developing the curriculum plan for their child. Questions to be addressed include: What instructional materials and equipment are used? Are those materials relevant to the aims and to the most recent recommendations of authorities in this field? Are the resources of the school and community adequate to support this program? How are such resources utilized? and What instructional procedures are employed for students in this program? Are they relevant for the pupils enrolled in the program?

Leadership knowledgeable in the education of persons with disabilities is essential to ensure that comprehensive planning and evaluation of special education programs and services are ongoing. Leadership skills should include the ability to plan, execute, and evaluate special education programs and services; to supervise professional and paraprofessional staff; to plan and conduct appropriate inservice education programs; and to assume responsibility for the delivery of special education programs and services. Questions to be answered include: How often does the director (or supervisor) visit the program? Is the general education administration aware of special education programs and services? and How often do supervisors contact special education teachers? Who initiates the contact?

Opportunities for "appropriate" *integration* of gifted persons who have disabilities in the community help create acceptance for all people with disabilities. Not only does such integration prepare them for the future with the community, but it also helps the community to know, understand, and accept their human differences. Questions to be answered include: How many gifted persons with disabilities are integrated? How long? For what? Why? Who is responsible for the integration of students? Is the integration appropriate? Do transportation patterns affect student integration? How? and What evidence exists that shows that integration is helpful in the academic/social adjustment of the person having a disability?

Continuous and systematic program and service *evaluation* is needed to reveal the strengths and de-

ficiencies of the program or service and to suggest changes in the delivery system designed to meet performance objectives. Emphasis should be placed on the ability to adjust the programs and services to the needs of each individual. Questions to be answered include: Are there written procedures for systematic program evaluation? Who is responsible for program evaluation? and Are program goals and objectives clearly stated in measurable terms?

This proposed procedure should be helpful to local and intermediate districts in planning and evaluation of their special education programs and services for students with disabilities who are gifted. The school district personnel can adapt and modify the procedures—deleting and adding questions to fit their own particular situations.

This model can be employed in a variety of ways. The director, or comparable administrator, can assess the program alone, or with other administrators. Staff members in each program or service area can conduct a self-study to determine where improvement is needed; a group of parents may similarly assess the program. Still another procedure would be for a group of special educators, regular educators, parents, and community representatives to apply the model of each program or service that is adaptable and flexible for a variety of procedures. The essential ingredients in any evaluation are honesty, in looking for strengths and weaknesses in each element as it relates to the goals and objectives of the aforementioned programs and services, and an assessment of the extent to which each element meets the needs of the person involved.

People who have disabilities and are gifted are truly a paradox in society. Their extreme intellectual and special talents are often missed by society's sharp focus on physical or social variation. Through a broader interpretation and enforcement of PL 94-142, efforts should be made by national, state, and local agencies to ensure that this segment of the population is no longer ignored and given less than the finest educational treatment.

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Attention Subscribers

Due to the ever-increasing costs of paper, printing, and postage, effective immediately the price of a yearly subscription to *Rehabilitation Literature* will become \$18 for residents of the United States, and \$18 plus \$2 postage for residents of Canada and other countries. Single copies of the journal will remain at \$3 per issue.

The Editor

Alternative Concerns for Rehabilitation Professionals

BRIAN T. McMAHON, Ph.D., and LYNN TREW WESTERMAN

IT APPEARS that in anticipation of diminishing government funds for rehabilitation programs, rehabilitationists have manifested helplessness and insecurity as if this were the only rehabilitation issue. The profession has been mixed in an atmosphere of speculation, anxiety, and rumor about the probability of its own oblivion. While such trepidation is befitting a fledgling profession whose survival depends exclusively upon events in the political arena, this same posture is not appropriate for a rehabilitation profession whose development and range of legitimate concern exceeds the current problem of diminishing funds, and apparently exceeds the awareness of many of its own members.

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The purpose of this article is to recognize a variety of current social and political topics and propose that these be regarded heretofore as rehabilitation issues. The intention is to provide rehabilitationists with an awareness that the realm of their legitimate concern exceeds the current problem of diminishing government funds. Perhaps if rehabilitationists had concerned themselves earlier with such matters, and had openly articulated their interest in a public forum, the resulting recognition may have empowered them to more effectively represent and preserve their domain. But even at this late date the time has not passed to attend to what will be preferred as fundamental re-

habilitation issues. These topics have one common thread—all are related to the problem of human infirmity. It is proposed that any such issue is, in fact, a rehabilitation matter, as rehabilitationists are primary providers of service to the victims of these maladies. Thus each subject that follows is a rehabilitation matter as each relates to disability and contributes to the proliferation of persons with disabilities.

First, there is the issue of domestic violence or battering. Many rehabilitationists earn their living in part by administering to victims of domestic violence that results from an interaction between powerful and powerless family members. Today approximately 50 million Americans fall prey to physical abuse at the hands of a family member, including 6.5 million children. FBI estimates corroborate survey evidence by Straus¹¹ that in any one year approximately 1.8 million wives are beaten by their husbands. These instances of beating, bone fracture, burn, sexual molestation, food deprivation, and neglect have already affected over half of all American households. Each year as well there is a form of deferred retribution as 8 million of these children, now grown, assault their elderly parents.^{8, 12} While this problem is not completely understood, certainly rehabilitationists are entitled to a position, as they so frequently engage those who suffer this violence. Yet where is the position of this profession stated?

A related area of concern is media violence. The National Association for Better Radio and Television estimates that 75 percent of prime time television shows regularly present such violent acts as shootings and beatings. This organization claims that between the ages of five and 15 the average American child will witness the violent destruction of more than 13,000 people on television. After more than a decade of public clamor about television violence, the average number of violent incidents on weekend network children's programming has reached 25 per hour, placing cartoon watching among the most violent of media experiences.⁶ What is the stance of the rehabilitation profession on the issue of media violence? Where is it articulated?

Another aspect of violence is the matter of military conflict. Since the Soldiers Rehabilitation Act of 1917, which some commemorate as the birth of vocational rehabilitation, the profession has concerned itself with the restoration of disabled war veterans, and

rightly so. World War I produced 234,300 wounded Americans, while leaving 126,000 dead. World War II returned 670,846 maimed soldiers, while killing 406,781. The Korean "police action" generated 123,901 injured, while immolating 33,629 others. Finally (it is hoped) the Viet Nam "conflict" yielded 306,653 infirmed, while rendering 46,397 lifeless. In crass but real terms, these wars have furnished substantial amounts of raw material for the rehabilitation system in the form of 1,335,700 disabled returnees, but they have left 612,807 dead who would never avail themselves of rehabilitation assistance.⁵ Should rehabilitationists, entrusted with the recovery of these survivors, concern themselves only with the aftermath of war? Perhaps instead they should express their convictions on such issues as nuclear disarmament, American military intervention, exportation of military hardware and nuclear technology, truth in advertising in military recruitment, and the movement for improved treatment for Viet Nam War era veterans.

Perhaps a less intentional but more preventable area of violence is that of accidental death and injury. In this country alone there are over 26 million traffic accidents annually, which result in over 3 million injuries and 45,000 deaths.⁵ What is the rehabilitation position on the abolition of the 55 miles per hour speed limit as a federal requirement; requirements for mandatory airbags, automatic seatbelts, or collision bumpers; or drinking-driving reform legislation? Similarly in the workplace (ironically the preferred destination for most rehabilitation clients) there are over 2 million accidents each year resulting in 90,000 permanent impairments and 390,000 instances of occupationally induced disease.^{2, 4} Yet what is the rehabilitation position on the potential dismantling of OSHA regulations and worker compensation legislative reform? Perhaps instead this profession's attention will remain limited to the consequences of weakened workplace and highway safety regulations.

Another topic deserving the concern of rehabilitationists is the revitalized issue of handgun control. Civilian Americans are coveting some 55 million uncontrolled handguns. Another 2.2 million new guns are sold annually. These account for about two thirds of all murders, 90 percent of all robberies, and most fatal accidents and impulse killings.¹ In all we are losing about 32,000 lives each year to handguns, which have now killed more Americans since 1963 (over 400,000) than World War II did.³ After Kennedy, after King, after Wallace, after Lennon, after Reagan, and after Pope John Paul II, perhaps soon rehabilitationists will throw their political support against the single-issue gun lobbyists to replace the 25,000 ineffective local regulations with a single federal law.⁷

Beyond American borders there is other compel-

ling business that merits the special attention of rehabilitationists. In this International Year of Disabled Persons there are ambitious plans for the exportation of American rehabilitation technology and services abroad. When the rehabilitation profession seriously responds to the global need for its services, it will have to be prepared for a distribution of disabling conditions markedly different from earlier experience. For example, it may come face to face with the problem of world hunger. There are currently 400 to 700 million people whose health is persistently deteriorating due to inadequate diets. These are the permanently hungry, and their ranks include 12 million children under the age of five who die of starvation annually.⁹ Ironically this hunger exists in the face of abundance, as the most serious food crisis is not inadequate food production, but rather inefficient food distribution. This problem reaches the awareness of most Americans only when domestic food prices rise subsequent to increments in food exports. Indeed our record in relieving domestic hunger leaves much to be desired, and culturally different groups such as migrant farm workers and native Americans appear to have suffered most.¹⁰ Starvation is an extremely severe disability by any standard. Insufficient caloric intake slows the body down until at some point it begins devouring its own vital proteins as a source of energy. Most victims die of other diseases long before they have time to starve to death due to reduced biological defenses. While resolution of this problem may seem beyond the domain of rehabilitation, it is not premature for members of the profession to speak out on the abatement of the food stamp program at home, and the inclination to use food as "an economic weapon for peace" abroad. Food deprivation is not an economic attack; it is a physically and mentally disabling assault far more painful, far slower, and far more cruel than the deployment of conventional or even nuclear armaments.

The intention of this article is neither to overwhelm the reader with guilt nor to dissipate the attention and resources of the rehabilitation profession. The aim, rather, is to demonstrate that problems such as domestic violence, media violence, military conflict, industrial and highway safety, gun control, world hunger, and others are legitimate rehabilitation issues. This is so because each relates to the proliferation of persons with disabilities. Accordingly, for an individual to study, advocate, or intervene in any of these areas is not to abandon rehabilitation activity, but to exercise preventative measures that are long overdue in so mature a profession. Furthermore, the rehabilitation profession as a whole, through its lobbyists, professional associations, and consumer groups, should actively support the rehabilitation position (which is obvious in each instance) in legislative

and community organization efforts. To speak out loudly on these pertinent rehabilitation issues will not distract us from our course, but will result in more opportunities, more visibility, and ultimately more influence for the profession and its members.

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Editorial Advisory Board Expands to 15

The Editor and staff of *Rehabilitation Literature* are pleased to announce the appointments of three additional persons to serve on its Editorial Advisory Board. The newest members are **Carol Ann Peterson**, Ed.D., therapeutic recreation coordinator in the Department of Leisure Studies at the University of Illinois, Champaign, Ill.; **Naomi A. Reich**, Ph.D., chairman of the Division of Clothing, Textiles, and Interior Design at the University of Arizona, Tucson, Ariz.; and **Craig Mills**, former director of the Division of Vocational Rehabilitation in Tallahassee, Fla., and consultant in the area of rehabilitation legislation.

The Impact of IYDP: Some Capsule Commentaries

THE United Nations, honoring its commitment to human rights and dignity, in 1979 designated 1981 as the International Year of Disabled Persons (IYDP) with the theme of "Full Participation and Equality." It marks the beginning of an intensive effort by governments, the private sector, and persons with disabling conditions to improve the quality of life of the world's 450 million people who are disabled.

Sparked by the collective thinking of many concerned citizens, the U.S. Council for IYDP was formed as an independent organization to promote the UN observance in this country. The Council set out to build on the progress many individuals and organizations have made in helping persons with disabilities help themselves. As President, Jimmy Carter on June 22, 1979, pledged full cooperation of those agencies under his jurisdiction and commended the leadership and support of the many private organizations making plans for observance of this year. He emphasized that we must, "Increase public recognition of what remains to be done before handicapped persons are permitted full participation in

the life of their communities."

Subsequently, on February 6, 1981, President Ronald Reagan proclaimed the International Year of Disabled Persons in the United States. In his proclamation, President Reagan said, "Today there are 35 million disabled Americans who represent one of our most underutilized national resources. Their will, their spirit, and their hearts are not impaired, despite their limitations. All of us stand to gain when those who are disabled share in America's opportunities."

Some 300 national organizations, all 50 states, five U.S. territories, and more than 1,500 mayors and elected county officials have joined as partners to increase the nation's awareness of the independent living movement and the needs, problems, and capabilities of persons with varying degrees of disability.

The following "capsule commentaries" by members of *Rehabilitation Literature's* Editorial Advisory Board and other prominent rehabilitation professionals consider the impact of the International Year on independent living and on life for persons with disabilities in general.

DURING the past decade, independent living has developed as both a concept and a programmatic thrust affecting the lives of many severely disabled people. Conceptually, independent living asserts that all people can and should be encouraged to make important decisions which affect their own lives. The theory of independent living, however articulated, affirms every person's right to seek options and choose from among those options where they live, where they work, where they worship, what they eat, what they wear, who their friends are, and so forth. The theory also suggests that society has a responsibility to facilitate independence of its disabled members by providing physical access to the environment and needed supportive services.

Programmatically, independent living has experienced phenomenal growth during the past 10 years. Beginning with three programs in the early 1970s, there are now more than 170 independent living programs in the United States. These programs are providing vital services that disabled people need in order to move from institutions and other dependent settings into the mainstream of our communities. Independent living programs are helping people to realize goals which they were forbidden to express a few years earlier, and they are helping them to gain the confidence and experience necessary to be productive and contributing citizens.

As it is, the International Year of Disabled Persons marks a decade of progress in independent living. It may also mark the beginning of another decade of progress, or the end of independence as a realistic goal for disabled people.

At this point, thousands of people with many types of severe disabilities have proved that they can live comparatively independent lives. They have overcome the stigmatizing effects of segregation and specialized treatment to become ordinary people living in ordinary communities and doing ordinary things. People who were living in nursing homes or with their parents due to their disabilities a few years ago are now working as teachers, newscasters, mechanics, lawyers, and doctors. They are living in their own homes, raising their own families, and generally being responsible for their own care.

In spite of our accomplishments in independent living, many thousands of people remain institutionalized and overprotected. Some of these individuals have chosen the style of life they lead, but most have not. They are waiting for the opportunity to acquire the information and skills which they need in order to become independent. They are waiting for resources in their communities such as accessible housing, transportation, and attendant care. Independent living programs exist in relatively few communities today, and in these they have only begun to meet the potential need for their services. Thus, the future may be a bright one for the independent living movement.

On the other hand, it appears as though our policy makers and legislators are reacting to economic conditions in some ways which threaten the future of independent living. If federal support for independent living programs is withdrawn, if accessible public transportation is stopped, if housing subsidies are ended, if affirmative action is not required, if social security and veterans' benefits are cut, or if

IYDP COMMENTARY

other needed support programs are disbanded, independent living will become practically impossible for severely disabled people. In fact, most severely disabled people who are living independently today are doing so on a thread of security. If even minor changes occur in the independent living service support network, many people will be forced to return to their parents' homes, and to institutions. Thus, the future of independent living may be rather dark.

Regardless of what happens to independent living in the near term, the concept has had and will continue to have a profound effect on the lives of severely disabled people. Many people who dreamed of independent living a few years ago are doing it now, and many others have been inspired to dream. For this, we should celebrate. IYDP serves as a forum for our accomplishments and our expectations.

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FOR the federally funded independent living centers, the first six months of 1981 were charged with positive and negative forces. While the publicity generated by the International Year of Disabled Persons promoted the concept of independent living, the proposed federal budget reductions threatened the funding of the centers that provide the services which are essential to independent living.

A positive support of the independence and dignity of persons who are disabled is indicated by the phrase "of Disabled Persons," chosen to describe IYDP. If IYDP had been in 1950, it would have been *for the Crippled*; if 1960, *for the Handicapped*; if 1970, *for the Disabled*. There is also progress in the move from the words *crippled* to *handicapped* to *disabled*. There is even more progress in the move from the paternalistic preposition *for* to the equalizing preposition *of*.

IYDP has been the catalyst that triggered several centers around the country to arrange conferences specifically devoted to independent living. These conferences have attracted the attention of the media and have been the means of educating the general public to the value of independent living. Further, the IYDP connections with local governments and industry have resulted in interactions that might not have occurred for years and that have great potential for sustaining the centers in the years ahead that may be very lean years.

From all indications in 1981, the future does indeed look lean and wise centers are preparing to fight for their survival on many fronts:

- (1) by acquiring the techniques of political lobbying;
- (2) by forming coalitions with other local organizations of and for the disabled that are also facing life-threatening budget cuts to act as bulwarks against the proposed system of block grants, which may pit organization against organization in a general scramble for funding;
- (3) by using IYDP as an opening wedge to local industries as sources of support for voluntary contributions, for accessibility consultant fees, and for learning management skills;
- (4) by planning to become self-sufficient;
- (5) by becoming disabled-directed through the gradual replacement of nondisabled persons with qualified disabled persons, thus fulfilling the most basic concepts of independent living—peer models and direction by disabled persons;

(6) by proving the cost effectiveness of independent living by documenting the savings and making them more widely known; and

(7) by paring costs to the bare essentials.

In 1981, the International Year of Disabled Persons, the independent living centers are balanced on a precarious tightrope—threatened by the proposed budget reductions and supported by the favorable publicity of IYDP. To tip the balance toward survival, the centers are forming coalitions, lobbying, paring expenses, becoming more disabled-directed, marketing their services, doing overt fund raising, and becoming skilled managers.

Gini Laurie, Editor
REHABILITATION GAZETTE
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AS an initial sceptic, I could only see the importance of IYDP for the perennial congressional and professional "travelers," to the after-dinner speakers and to the headline hunters. As such, it could have remained just one of those attractively worded concepts on which to hang our conscience, but go no further. In contrast, years of rehabilitation program observation had taught me that an idea generated by research or innovative practice is only as valuable as the extent to which it is applied. So with my original set, I expected to see little application this year, but I was wrong. I and my other sceptical colleagues were forced to face international facts. It has been widely publicized this year, and must be accepted, that one out of ten persons on Spaceship Earth is disabled by physical, mental, emotional, or sensory impairment due to developmental hazards, disease, or trauma. Prevention and/or lifespan rehabilitation efforts have entered the domain of multinational global cooperation that now is registered in national and international information networks. These networks are visible and accessible, affording us an array of interdisciplinary approaches and a social options. Speaking of social options, it is noteworthy that this year has not been called the International Year *for* Disabled Persons. The very recognition that it is an International Year *of* Disabled Persons illustrates the growing worldwide interaction between consumer/self-help groups and professional efforts. Perhaps the greatest significance of this year is, after all, a public acknowledgment of the transition that has taken persons with disability out of the patronage of "patienthood" into the partnership of "personhood."

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THE International Year of Disabled Persons (IYDP) is a chronological designation that is long overdue. Yet, it is timely in its occurrence. The IYDP coincides with the decade of the '80s that is still in its infancy. It coincides, in our nation, with a government administration that is newly elected into power with a strong commitment to efficiency and waste reduction. The IYDP also interfaces with a public attitude that continues to develop in a positive direction toward insuring human dignity and protecting and promoting the human rights of all individuals. The disabled but able citizen is truly one of every country's available but untapped resources. Although every family, occupation or profession is in some way touched by the concept of disability, we must be sure that the awareness to the needs of

disabled persons develops to a total commitment to the prevention, education, and rehabilitation efforts that are needed. As we have, in the previous decade, made great progress in breaking architectural barriers, we must continue toward the elimination of the many other barriers (both visible and invisible) that interfere with the full development of those with disabilities.

The IYDP must have a specified mission to accomplish in a specified time frame. Definite goals and milestones must be set and reached by each discipline and each disabled individual that is associated with this truly multidisciplinary and heterogeneous group of professionals and clients. To me, the IYDP can be the beginning of a point of positive departure within the decade that will be more than a time in our history that will be forgotten and discarded like the page of a used calendar. The IYDP must serve as the catalyst for future professional cooperation and cohesiveness rather than provincialism. We have the opportunity to positively affect the attitude of both the public and private sectors of our nation and other nations to such a degree and intensity that we might truly witness the emergence of a stage in our history regarded as the *International Decade of Disabled Persons*.

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FULL PARTICIPATION in all aspects of life is an appropriate goal for rehabilitation. Likewise, it is the expressed desire of most disabled individuals. Major achievements have been made toward this important goal relative to such basics as employment, housing, transportation and education. However, several areas of the human experience have been slighted, or for the most part, ignored in the overall effort toward full participation. Opportunity for and facilitation of leisure and recreation participation is one such arena of concern. This aspect of full participation has continued to be an expressed need and interest of disabled individuals. Life in our society appears to take on dimensions of quality, self satisfaction, and enjoyment through the availability of opportunities to engage in self selected leisure experiences.

The International Year of Disabled Persons offers two unique contributions to the full participation concern. First, it provides large scale *public awareness* of disabled individuals and their abilities. The joining together of thousands of agencies and organizations to promote the concepts and goals of IYDP is an event that will continue to make an impact on citizens throughout the world. Likewise, the IYDP programs are directly and indirectly influencing all types of organizations in terms of awareness and possible program and service needs. A second major contribution of IYDP is the opportunity to focus on *specific abilities and needs* of disabled individuals.

Leisure and recreation participation of disabled individuals is one such area of specific focus that has benefited from the IYDP program. The National Therapeutic Recreation Society, the National Park and Recreation Association, and countless other organizations and agencies have utilized IYDP to bring attention to, demonstrate the abilities of, and promote the recreation and leisure concerns of disabled individuals. This is being accomplished through programs and promotional activities at the national, state, and local level. In addition, most of the efforts are cooperative, thus enhancing communication and understanding among and

between organizations and delivery systems. A few specific examples highlight these significant efforts to improve the quality of life through leisure opportunities:

- festival, celebration, or special events days focusing on sports, performing and expressive arts demonstrations
- leisure awareness and general recreation programs utilizing integrative and mainstreaming approaches
- special activity events, such as marathons, hot air ballooning, canoeing, and mountain climbing, which include or focus on disabled individuals
- the development of publications that address attitudinal, accessibility, and participation concerns
- conferences and workshops for leisure and recreation professionals to enhance and increase leisure involvement for disabled individuals

Many agencies have utilized the International Year of Disabled Persons to make a more lasting and permanent commitment. The following illustrates some of these projects:

- the construction of a recreation facility, park or special area (garden plots, playground, outdoor area) that is accessible
- conducting accessibility surveys of recreation areas to determine accessibility needs along with the development of plans of action to renovate
- long range plans for staff attitudinal awareness and accessibility of all leisure and recreation facilities and programs.

The specific activities of IYDP that target leisure and recreation for the disabled, as well as the long-range commitments of leisure agencies, appear to be positively influencing the full participation concept. These actions taken within the context of a wider awareness of all people regarding individuals with disabilities more than justifies the existence of the International Year of Disabled Persons. IYDP, however, is not a solution. The true measure of IYDP's impact cannot be determined in the current year. Its success will be dependent on activities, commitments, and progress made over time. Does the quality of life improve for disabled persons? Do attitudes of the general public change and facilitate full participation? Do human services take on a broader perspective? The answers to these questions will determine if IYDP was a promotional sham or an event of lasting significance.

Carol Ann Peterson, *Coordinator*
Department of Leisure Studies
University of Illinois
Champaign, Illinois

TODAY disabled children have greater opportunity to achieve independent living in their adult life than at any other time in history, and yet there continues to be much need for family education and guidance in this area. Families need support services which will enable them to reach the goal of providing optimal conditions for their children's growth and development toward physical and psychological independence.

The International Year of Disabled Persons can contribute to the attainment of this goal through the promotion of viable communication systems. It is apparent in working with disabled children and their families that the dissemination of ideas and problem solving techniques, the application of research findings, and the sharing of personal experiences and achievements have not reached many of the people who need them most urgently. If the International Year of Disabled Persons gives communication systems top priority, it can help to develop ongoing creative efforts

IYDP COMMENTARY

needed to reach a broader audience throughout the world. An inventive transmittal of information and an open-mindedness to receive such information are essential ingredients to improve the quality of life for many.

To nondisabled people, communication systems can stimulate awareness of the potential of persons with disabilities but more importantly, it can develop acceptance of disabled individuals and create a desire to act—to make a significant contribution. It can inspire action to make a contribution toward improving the environment in which a disabled person lives so that their chances for independent living continue to increase and remain feasible. It can inspire action to contribute to a family's acceptance and understanding of its disabled member and provide the support required for healthy interaction of all members and the community in which they live.

*Eleanor Boettke Hotte, Professor Emeritus
University of Connecticut
Storrs, Connecticut*

FULL PARTICIPATION for all disabled people within societies and communities worldwide requires meeting challenges and overcoming obstacles which have existed since the beginning of life on earth. The designation by the United Nations General Assembly of 1981 as the IYDP is but the first step in allowing and providing for such full participation in life by the most vulnerable of citizens, those with disabilities. The meaning and importance of the IYDP lies not only in those activities and actions that will take place during the year, but the realization that special attention needs to be directed to the problems of handicapped individuals to facilitate their maximal rehabilitation.

The 60-year history of rehabilitation in the United States sets an admirable example to be initially copied and subsequently expanded upon in an effort to aid people with disabilities. However, despite years of effort and involvement serious problems still exist. Handicapped people as a group still receive less schooling, work less, and have lower incomes than any other population. In the current international monetary crisis real concern exists that governments worldwide will reduce or cut back previous funding or assistance. Particularly in the United States human services and social science research are expected to suffer losses. Although proven time and time again that the rehabilitation of handicapped individuals is cost-effective, the economic crisis may well be of sufficient magnitude to cause the regression of needed and necessary services throughout the globe.

Fortunately, the IYDP comes at a time when it can best serve the needs of individuals with disabilities. The IYDP does this in two ways. The first involves organization. Because of the diversity of disabilities which are present, and the decentralization of involved agencies and organizations, handicapped persons as a group have never had a single organized lobby. The IYDP will help those with disabilities, and those interested in assisting them, to perhaps speak with a single voice focusing on the specific issue of full participation for all handicapped individuals in their respective societies and communities.

Secondly, the IYDP serves to integrate handicapped individuals into the mainstream through various stages. These stages, four in all, detail the process by which full participation in life may be assured for handicapped people. The stages include: 1) Awareness, 2) Contact, 3) Needs, and 4) Responsibility. The IYDP through its publicity and expo-

sure promotes public awareness of the plight of handicapped persons in the world today. Many people who do not generally come in contact with disabled individuals are unaware of their sometimes special needs. Awareness is the first step in understanding that problems may be present. Contact with those who are handicapped leads people to know that individuals with disabilities are the same as the rest of us. Only in the area of the disability does a possible difference exist. Contact through social interaction, cultural activities, or recreational and leisure time involvement quickly reveals that imagined, stereotypical differences simply are not real. Once aware that problems exist, and having had contact with disabled individuals, those special needs which are present can be examined. The most common needs revolve around education and employment. In these two areas considerable disparity in opportunity has been perpetuated. Lastly, responsibility is encountered. This responsibility evolves as a two-fold pattern. Handicapped people perhaps need to assert themselves to a greater degree and become more involved in social, political, and cultural activities that enhance, expand, or facilitate the first three stages detailed above. The responsibility of nonhandicapped people is to interact with disabled individuals relating or regarding the disability for what it is, not making assumptions about what the person cannot perform or accomplish. Following through these stages will more likely provide and enhance the potential of handicapped individuals for true full participation.

Understanding and utilizing these factors the IYDP has become a strong advocate of the valuable benefits which come from offering handicapped people equal opportunity. During this year many difficult choices will have to be made to meet the challenge of full participation and to overcome the obstacles still facing disabled persons. In every year, not just 1981, we should emphasize the rehabilitation of physically, mentally, social, and economically disabled people. Without such emphasis the world will never know true equality and freedom for all.

*Ted Riggat
Rehabilitation Institute
Southern Illinois University
Carbondale, Illinois*

THE only constant in life is change! In our personal and professional lives we are obligated to practice self evaluation, which is never an easy task. In 1981, we find ourselves in the United Nations International Year of Disabled Persons. This is perhaps the year for overt awakening of international awareness of the labors of thousands of individuals who have vociferously been the advocates for the disabled. These individuals, and the disabled themselves, must be heard worldwide in their stalwart efforts to improve the daily lives of disabled persons, and to ensure progressive and appropriate assistance, care, and opportunities, for this important population. This effort must not be encased in the International Year of Disabled Persons - 1981, but must be a perpetual effort, or until the word *disabled* is no longer used as an index related to the human race. Change doesn't come easily. It's inevitable, however. Let's not just assign 1981 as the International Year of Disabled Persons.

*Thomas B. Abbott, Chair/Professor
Department of Speech
University of Florida
Gainesville, Florida*

THE IYDP is an inspired idea whose time has come. The measure of its success will be the degree to which it is able to add impetus to the vast changes in attitudes and services for disabled persons now taking place throughout our society.

Architectural adaptations in all sectors, more educational and employment opportunities, independent living programs, and adapted housing have all made it possible for people with disabilities in the United States to live more independently than ever before. In particular, the field of rehabilitation engineering has developed rapidly. Advancements in computer design (reduction of size and cost, ease of operation, and increased capacity) is making exciting new developments possible, producing a first generation of electronic aids for people with speech impairments, blindness, and quadriplegia never before imagined. The need remains for the broad dissemination of information by means of international networking so that disabled people all over the world will be able to benefit from these new advances.

IYDP can best serve this need by utilizing its worldwide connections to bridge language and communication barriers among countries, to transmit knowledge by means of information packages and bibliographies in all areas of daily living. Data bases such as NARIC linked up with data bases in other countries with high technology will go a long way toward facilitating exchange of new research in technology, job opportunity, education, and what I choose to call *quality of life*.

Third world countries are still in need of very basic information. The emphasis here must be on reaching and beginning to serve the still unserved disabled population. A goal of parallel importance is the dissemination of medical information regarding new advances in research, early identification, and prevention of birth defects.

It is a tall order and an effort that must not end on December 31, 1981. IYDP must be looked upon as a beginning, a catalyst. Let us hope that the mechanisms for spreading information that are put into place this year will continue to affect the lives of disabled people for many years to come.

Ruth A. Velleman, *Director*
Human Resources School Library
Albertson, Long Island, New York

"The Reagan Budget is coming! The Reagan Budget is coming!" could be the cry of a present day Jack

Jouett (A Virginia counterpart to Paul Revere, who rode 200 years ago from the tavern in Cuckoo, Virginia, to Monticello, the home of Jefferson, president of a fledgling USA, to warn him of British troops seeking to capture him. Virginians are quick to explain, to those who don't know, that Jack rode farther and across more difficult terrain than Mr. Revere) riding to warn citizens that they will have to assume more responsibility for the social needs of themselves and their community.

Virginians often look to their history to recreate themes for modern concerns. Thomas Jefferson would have approved of the theme for the 1981 International Year of Disabled Persons—"Full Participation and Equality."

Virginia's Statewide Committee and the "Community Partners" have been busy in their efforts to create a program of independence and public awareness named "Endependence." Registration of disabled voters and accessibility of polling places comprise an objective. Among other objectives are Community Awareness Week planned for October 4-11 to coincide with "Hire the Handicapped Week." A main event for the Endependence program is scheduled for October 19, 1981, at the Yorktown Bicentennial celebration. A written Declaration of Endependence will be delivered to a proper recipient in Washington, D.C., through a relay by persons with disabilities.

In order for Americans with physical and mental disabilities to gain full participation in our national and community life, efforts must reach from highly visible activities to less publicized but equally significant efforts on the part in individuals in all communities. Full participation of disabled persons in the life of their society will be achieved when we each assume responsibility for ensuring that our communities are open to persons with disabilities. Programs for people with disabilities may disappear, but programs developed by individuals with disabilities and their neighbors to better serve themselves and their community should have the means to survive even the grimmest economic times.

The extent to which the activities initiated during this year are designed to continue of their own momentum will be the basis for ensuring that the IYDP was successful in seeking to gain full participation of disabled persons in the life of their society. History will tell if we were successful.

Roberta R. Sadler, *Director*
Research Utilization Services
Woodrow Wilson Rehabilitation Center
Fishersville, Virginia

Portraying Persons with Disabilities in Print

National Easter Seal Society Guidelines

The following guidelines, developed by the National Easter Seal Society in 1980, are reproduced here as part of the Society's observance of the International Year of Disabled Persons.

Words do matter. Although breakthroughs in technology, medical treatment, and legislation are opening doors to full and independent lives for persons with disabilities, our language persists in reinforcing other barriers. The words we use, often rooted in archaic concepts of dependency and helplessness, continue to perpetuate negative attitudes and corresponding patterns of response and expectation. Recognition of persons with disabilities as whole persons is long overdue. These guidelines are intended to help writers and speakers recognize instances where word choices may be negative, stereotyping, or demeaning and take constructive alternatives. The guidelines have been developed with the awareness that, because meanings change over time, periodic readaptation will be required.



1. Out of respect for the uniqueness and worth of the whole individual and because a disabling condition may or may not be handicapping, use the word *disability* rather than the word *handicap*, but give reference to the person first. Make it *person/individual* with a disability or *person/individual* who has a disability. In the plural case, *persons*, *individuals*, and *people* may all be used. Avoid using the derivative word *disabled* as a labeling adjective, which implies that the person as a person is disabled, as in the expression *disabled person* or *person who is disabled*. Also avoid using *disabled* as a noun, which implies a state of separateness or total disability, as in *the disabled*.

2. Because the person is not the condition, reference to the person in terms of the condition he or she has is inaccurate as well as demeaning. Avoid, then, reference to the person as *a postpolio*, *a c.p.*, *a stroke*, *an epileptic*, *a hemiplegic*, etc. Say, instead, the person who . . . *had/has polio*, *has cerebral palsy or c.p.*, *had/experienced a stroke*, *has epilepsy*, *has hemiplegia*, etc.

3. Some categorical terms are used correctly only when communicating technical information—for example, *hard of hearing*, *deaf*, *partially sighted*, and *blind*. More accurate choices when referring generally to persons who have disabilities of these kinds are *person/individual who has a partial hearing loss*, *person with a total/severe hearing loss*, *person who has limited/partial vision*, *person with total/severe loss of vision*.

In Overall Portrayal, Try To . . .

1. Emphasize the uniqueness and worth of all persons rather than differences between persons.
 2. Keep the individual in perspective; avoid emphasizing the disability to the exclusion of individual qualities and achievements.
 3. Show the individual with a disability doing something independently or for someone else—for example, as parents, community leaders, teachers, business owners, etc., and as participants and decision makers in their programs of rehabilitation.
 4. Show persons with disabilities in least restrictive environment, participating in activities in a manner that includes them as part of society and interacting with persons without disabilities in ways that are mutually beneficial rather than in those that foster the attitude of "one of them" vs. "one of us."
 5. Depict the *typical* achiever as well as the superachiever.
 6. Be consistent, but compliant when referencing titles retained by organizations such as Crippled Children's Services, Office for Handicapped Individuals, and Spastics Society.
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4. Avoid all terms carrying negative or judgmental connotations and replace them with objective descriptors. Some examples are:

AFFLICTED BY/AFFLICTED WITH—Say the person *has*.

CRIPPLE/CRIPPLED/THE CRIPPLED—Say the person *with a disability/individual with a disability caused by or resulting from/persons with disabilities*.

DRAIN/BURDEN—Say *condition requiring increased or additional responsibility/person whose condition requires intensive or additional care or adjustment*.

HOMEBOUND—Say *person whose ability to leave the home is limited*.

HOMEBOUND EMPLOYMENT—Say *employment in the home*.

INFLICTED—Say *caused by*.

INVALID (literally, not valid)—Say the person *who has a disability resulting from or caused by*.

LAME—Say *person with an orthopedic disability*.

RESTRICTED TO/CONFINED TO—Say *uses a wheelchair/walks with crutches*.

VICTIM—Say *person who has/person who experienced/person with*.

WHEELCHAIR BOUND—Say *uses a wheelchair*.

UNFORTUNATE, PITIFUL, POOR, and other such words carrying value judgments; **DEAF AND DUMB, BLIND AS A BAT, CRIP, FREAK, DEFORMED**, and other such cliches and terms that stereotype, disparage, or offend—*No replacements*.

5. Be careful with certain words that, if used incorrectly, can reinforce negative misconceptions of persons who have disabilities. These include:

DEFECT/DEFECTIVE—Acceptable for describing an object in error or at fault, such as a defective printout or a defective piece of equipment. Degrading and offensive when used in connection with human beings. Say *problem/condition*; some alternatives for *birth defect*—*difference in physical structure at birth, or lack of formation of (), or disability present at birth, or born with ()*.

DIAGNOSE—Accurate only when used in connection with a condition or a disease—for example, *The condition was diagnosed as osteomyelitis*. A person is never diagnosed, but may be *found to have* or *determined to have* whatever the condition or disease may be.

DISEASE—Acceptable when referring to or classifying some causes of some disabilities—for example, polio, Parkinson's disease, meningitis—which are diseases. Misleading and inaccurate to believe or imply that all disabilities are the result of diseases or that all persons who have disabilities are chronically ill or sick. Although a disability may be caused by a disease, the disability is not the disease itself and, therefore, can never be contagious (as is too often mistakenly thought).

NORMAL—Acceptable for referring to statistical norms and averages. Demeaning when used in reference to persons who have no disability. Say *persons without disabilities* instead.

PATIENT—Acceptable for referring to "an individual awaiting or under medical care and treatment," such as that administered in hospitals and doctors' offices. Although a few persons connected with Easter Seals may be patients, most are *clients* or *consumers*; none is ever a *case*.

These guidelines are available as a leaflet (A-290) from the National Easter Seal Society, 2023 West Ogden Avenue, Chicago, IL 60612. Requests should be accompanied by 35 cents, plus 25 cents postage and handling. Quantity rates are also available.

Events and Comments

ICD Rehabilitation and Research Center Becomes the International Center for the Disabled

THE ICD Rehabilitation and Research Center changed its name to the International Center for the Disabled during dockside ceremonies preceding the 52nd Annual Hudson River Cruise for the Disabled and ICD's Founder's Day Celebration.

In honor of the occasion, New York's Mayor Edward I. Koch addressed the more than 1,500 disabled people aboard and presented a replica of Marshall M. Fredericks' sculpture "Freedom of the Human Spirit," which stands on the site of the New York World's Fair, to ICD's Chairman Mrs. H. Lawrence Bogert and ICD's President Mr. Jeremiah Milbank, Jr.

Since its founding in 1917 by the late Jeremiah Milbank, the ICD has provided comprehensive rehabilitation services to thousands of disabled people. Known as the Institute for the Crippled and Disabled from 1920 - 1971, the agency changed its name to the ICD Rehabilitation and Research Center. According to ICD President Jeremiah Milbank, Jr., the new name the International Center for the Disabled "reflects our expanded mission to develop and exchange exemplary rehabilitation practices and to facilitate their adoption by the international rehabilitation community through demonstration and dissemination."

ICD is a comprehensive rehabilitation center. It provides patient/client services and conducts research and professional education programs. As a model agency, the ICD shares the programs it develops with all who seek to improve the condition of the disabled. ICD provides its patients and clients with services in the following areas: medical, psychological, vocational rehabilitation, speech and hearing evaluation and treatment, and rehabilitation of the confused and disoriented elderly.

For more information contact George Dannenberg, Assistant Director of the ICD Public Information Office at (212) 679-0100, or at ICD Headquarters, 340 E. 24th St., New York, NY 10010.

Mainstream Information Center in Operation

THE Mainstream Information Center (MIC), which has been in operation since March of this year, furnishes information on disability issues with emphasis on the employment of and health care for handicapped persons. The Center has a wide range of information and materials that can answer questions of particular interest to disabled adults, employers, educators, and rehabilitation professionals.

The MIC staff takes information calls on (202) 833-1162 (voice/TTY) between 9am-5pm EST, Monday-Friday. The Mainstream Information Center also houses a library of periodicals and books on disability. The Center features Mainstream's own comprehensive publications, which are available for distribution, including:

- *In The Mainstream*, a bimonthly newsletter on affirmative action issues in the employment of handicapped people.
- *Project HEALTH*, a quarterly newsletter on equal health care and employment for disabled persons in the health care sector.
- *Contract Compliance Guides*, a series of brochures on unions and affirmative action, medical standards in employment, recruiting, employing disabled veterans, and effects of handicapped employees on group insurance.
- *There Oughta Be a Law . . . There Is*, a consumer-oriented series on Section 503 of the Rehabilitation Act of 1973 and Section 402 of the Vietnam Era Veterans Readjustment Assistance Act.
- *The Federal Contractors Guide To . . .*, a series discussing Sections 503/402 designed for federal contractors.

To use any of Mainstream Information Center services, call (202) 833-1162 or write Mainstream Information Center, 1200 15th St., N.W., Washington, DC 20005.

Symposium on Careers for the Disabled To Be Held in Baltimore in December

THE National Careers for the Disabled Symposium, offering first-hand information to career-oriented disabled persons, will be sponsored by Commodore Business Machines, Inc., in association with Careers for Disabled, Inc., and be held at the Convention Center in Baltimore, Md., Dec. 4-6, 1981. The symposium will reach out to the many thousands of people who, because of their disabilities, and in some cases lack of skills, have been kept out of the mainstream of the work force.

Each workshop will include a special lecture on "how to" obtain training and then market new or existing skills in areas such as computer technology, starting one's own business, continuing one's education, sales, government and unions, finance, printing and graphic arts, clerical, travel and leisure, food services, communications, and repair trades.

In announcing that Commodore, an internationally known manufacturer of microcomputers, has agreed to sponsor the symposium, James Finke, president and chief operating officer of the company, said, "Today, business leaders must assume leadership rolls in helping assimilate millions of handicapped people into the work force. It is our

belief that their symposium will be an important first step in bringing about this reality. Commodore is especially pleased and excited to sponsor the symposium," Finke continued, "because we know how important the microcomputer can be for the handicapped; extending reach and multiplying capabilities."

According to Careers for the Disabled, Inc., a New York based nonprofit organization, a new age is dawning for those individuals generally classified as "handicapped" or "disabled." Federal laws, court decisions, changing public attitudes, and a growing assertiveness on the part of the 36 million handicapped themselves, are helping to rehabilitate the disabled into the mainstream of society. Through organizations like Careers for the Disabled, employable disabled persons are being encouraged to take their first steps into the world of work and financial and social independence.

Additional information and reservation forms for the National Careers for the Disabled Symposium are available by contacting Careers for the Disabled, 261 Madison Ave., Suite 1102, New York, NY 10016.

1982 International Ski for Light Scheduled

THE EIGHTH ANNUAL Ski for Light International will be held in the Black Hills of South Dakota, Feb. 7-14, 1982. Ski for Light International, sponsored by HEALTHsports, Inc., in cooperation with the Sons of Norway and the Black Hills Ski for Light Regional Committee, is a weeklong program designed to introduce visually impaired and physically disabled adults to cross-country skiing. In 1982, approximately 110 disabled individuals will take part. Many of these participants will have never experienced cross-country skiing before.

All instruction and skiing is done on a one-to-one basis, allowing each participant to proceed at his or her own pace. Each blind, visually impaired, or mobility impaired person is assigned an experienced, able-bodied cross-country skier, who will act as an instructor/guide for the entire week. In past years, participants have ranged in age from 18 to 67 with a nearly equal number of men and women.

If you are an experienced cross-country skier, and are able to devote one full week to X-C skiing with a disabled individual, HEALTHsports, Inc. invites your expertise. For an application write: Trygve Aarsheim, HEALTHsports, Inc., 1455 West Lake Street, Minneapolis, MN 55408.

If you are visually or mobility impaired, please contact for an application: Grethe Twiford, Screening Coordinator, P.O. Box 2971, Reston, VA 22091.

Photo Exhibition of Disabilities Opens At Kennedy Library

PRIOR to beginning a nationwide tour, a dramatic exhibition of 45 color photographs of disabled children and adults will be installed at the John F. Kennedy Library (Boston) from Sept. 28 to Oct. 25, 1981. Entitled *Ordinary Moments: Aspects of the Disabled Experience*, the photographic exhibition represents the work of Alan J. Brightman, 34, director of the Cambridge-based nonprofit organization, Educational Projects Incorporated, and a member of the Cambridge Commission on Handicapped Individuals. "These are quiet portraits," explains Brightman, "images and expressions of ordinariness among people generally regarded not to have much of it. Indeed, none of the special needs of disabled people is as pervasive, as persistent or as personal as the need to be perceived as ordinary by members of mainstream society."

The portraits included in *Ordinary Moments* span a wide variety of disabilities, including retardation, blindness, deafness, and, physical impairment. Individuals young and old, from a range of ethnic groups and lifestyles, are represented.

"So many public images of disability are designed to prove something or to teach something about being different," Brightman explains. "Too often, as a result, they're sensationalistic, too concerned with making a point to acknowledge the person. The photos in *Ordinary Moments* are like photos one might take of a friend; just a person in the world being who he or she likes to be."

Supported by grants from The Permanent Charity Fund of Boston and The F. W. Faxon Company (Westwood), *Ordinary Moments* is the latest in a series of disability-awareness activities undertaken by Brightman and his colleagues during the past 5 years. Brightman, who holds a doctorate in education from Harvard University, was responsible for the award-winning production of "Feeling Free," the first television series to feature a cast of disabled children. This critically acclaimed series was viewed weekly by more than 4 million people during its 1978 national premiere over PBS.

Brightman is also the author of numerous publications in the field of disabilities, including 5 books designed to acquaint children with their disabled peers. Most well known of these books are *Like Me* (Little, Brown and Co.) and *Feeling Free* (Addison-Wesley), each of which aims to increase children's understanding and acceptance of disabled peers. In addition, more than 400 of Brightman's photographs of disabled children and adults have been reproduced in 15 books and in periodicals as diverse as *The UNESCO Courier* and *T.V. Guide*.

The United Nations has designated 1981 as The International Year of Disabled Persons, and activities are presently being undertaken around the world to lessen the obstacles—interpersonal as well as physi-

cal—that handicap disabled individuals. "In a small, subtle way, I'm hopeful that *Ordinary Moments* will contribute to the urgent aims of the International Year," says Brightman, who began work on this project last February. Brightman adds, "The experience of being with disabled others is, for most people, infrequent, and when it occurs it is typically characterized by awkwardness; 'we' are not yet quite used to 'them' being too much around. *Ordinary Moments* will not replace the value of direct interaction in helping nondisabled and disabled folks get better acquainted; but, hopefully, it will create conditions in which such interactions are more likely to occur in the future."

Individuals and/or groups interested in acquiring *Ordinary Moments* for exhibition in appropriate sites throughout the U.S. are encouraged to call Dr. Brightman at (617) 661-7652. A limited number of sites will be made available through 1982. There are no rental fees for acquisition of the exhibition for periods of 2-4 weeks. Sponsors will, however, be expected to assume the costs of shipping and insurance.

HANDICAPPED CHILDREN ACHIEVE! Program Begins

DO YOU KNOW a disabled young person whose accomplishment deserves recognition? The Foundation for Exceptional Children has announced the beginning of its HANDICAPPED CHILDREN ACHIEVE! program, funded by a grant from the Shell Companies Foundation. Through HCA! a disabled child or youth can receive a personalized Certificate of Achievement attesting to accomplishment in any of seven categories. The achievements of all nominees will be considered for inclusion in materials describing the accomplishments of disabled children and youth. All applicants will also receive an announcement that can be used to publicize their award in the local community.

HCA! was established to recognize the capabilities of disabled children and youth to overcome barriers caused by disability or public misconceptions, to encourage them to seek their highest potential, and to increase public awareness of the abilities, aspirations, and normal personal qualities of disabled people.

To be eligible for an HCA! Certificate of Achievement, a disabled child or youth, through the age of 21, must be nominated by two other persons in any one of the following categories:

- Academics
- Arts
- Athletics
- Community Involvement
- Employment
- Extracurricular Activities
- Independent Living Skills

Children or youth for whom two nomination forms are completed and submitted will

receive a personalized HCA! Certificate of Achievement, a local publicity announcement, and consideration for inclusion in other published materials.

To receive nomination forms, send a self-addressed stamped envelope to: HANDICAPPED CHILDREN ACHIEVE! Foundation for Exceptional Children, 1920 Association Dr., Reston, VA 22091. All requests must state the achievement category for which nomination forms are requested. All nominations must be postmarked not later than January 15, 1982.

Disability Rights Training Offered in Workshops

Barrier Free Environments, Inc. (BFE) will hold a series of 10 four-day training and technical assistance workshops for disabled people residing in the Northeastern United States. The project will train approximately 800 disabled individuals in their rights under Section 504 of the Rehabilitation Act of 1973. Section 504 prohibits widespread discrimination by federally funded programs or agencies against disabled Americans.

The objective of the basic trainings is to develop a pool of disabled people with skills as negotiators and organizers who, in turn, will educate and support others in their rights, responsibilities, and remedies under Section 504. In addition to the six basic trainings, the program will offer four advanced trainings open to people who have received previous training in 504 or who have considerable experience with 504 issues. The objective of the advanced trainings is to give participants information on the latest developments in federal and state policy-making so that they may deal effectively with current 504 issues.

Applications for both trainings will be solicited from disabled people and parents of disabled children. Selection criteria include a demonstrated commitment to the rights of disabled people and the potential ability to train advocates and to negotiate effectively. The 504 Training and Technical Assistance Program is especially seeking applications from ethnic minorities, people with hidden disabilities (epilepsy, mental illness, diabetes, substance abuse, etc.), and older citizens with disabilities. There is no cost to participants. Hotel accommodations and some meals are provided. For more information on the Rights Training Workshops for Disabled People, contact Cindy Crouse, Logistics and Participant Selection Coordinator, Barrier Free Environments, Inc., Water Garden Hwy. 70 West, P.O. Box 30634, Raleigh, NC 27622; tel. (919) 787-8693.

The 504 Training and Technical Assistance Program is funded through a Department of Education contract awarded to Barrier Free Environments, Inc. The Raleigh, N.C. based firm is a first-time recipient of this contract.

EVENTS AND COMMENTS

The 10 Best Recent Rehab Films

by
John Moses, Director, Rehabfilm, RIUSA

(Reprinted with permission from *International Rehabilitation Review*, Second Quarter, 1981, p. 6)

(1) **Survival Run** — Winner of Grand Prize in the 1980 International Film Festival, New York. Two men, one blind and one sighted, participate as a team in a cross-country race in rural California, USA. It's as exciting as any film you've seen. 12 minutes long, distributed by Pyramid Films, Box 1048, Santa Monica, CA 90406.

(2) **Pins and Needles** — About a young woman who has learned recently that she has multiple sclerosis. She produced the film with her husband. This is an emotional, anxiety-ridden film about serious disability, the story of a woman who is vital, ambitious, and utterly frustrated by her forced immobility. Australian, 38 minutes long, just released in USA by Filmmakers' Library, 133 East 58th Street, Suite 703 A, New York, NY 10022.

(3) **Breaking Free** — (In Australia, this film is called *Stepping Out*) Opens with a performance of "Madame Butterfly" in the Sydney Opera House in November of 1979. The actors and dancers and mimes are mentally retarded men and women from Sydney, and it is their first public performance. Under the direction of a young Chilean arts therapist, the group from a residential home develop into a theater troupe, called "Naliandrah," the aboriginal word for butterfly. We see transformations: the troupe becomes more tightly knit, more magical, more caring. Many issues regarding the retarded person are addressed.

50 minutes long, the U.S. version will be available in 1981 from ABC Wide World of Learning, American Broadcasting Company, 1330 Avenue of the Americas, New York, NY 10019.

(4) **David** — Portrays the story of a young man with Down's syndrome. He also has a quick wit and a capacity to articulate which may astonish a good many viewers. David, giving a lecture to a group of special educators, humorously describes his condition. Through indomitable persistence and a home life obviously conducive to self-fulfillment, he has learned chess, ice skating, reading, and acting.

Distributed in the United States by Filmmakers Library, 133 East 58th Street, New York, NY 10022.

(5) **Best Boy** — Won the Academy Award for Best Documentary in 1980, produced and directed by Ira Wohl. Recounts the story of Wohl's retarded cousin, Philly, 52 years old, who has always lived with his parents. The film traces Philly's transition to an independent life and through the crises of

school and the death of his father. Available from International Film Exchange, 159 West 53rd Street, New York, NY 10019.

(6) **Board and Care** — Academy Award winner for Best Live Action Short Film in 1980. A bittersweet love story about two adolescents with Down's syndrome. The characters are well-meaning, but the film seems to demonstrate that the retarded do not yet govern their lives. 27 minutes long, produced by Sarah Pillsbury and Ron Ellis, and is distributed by Pyramid Films, Box 1048, Santa Monica, CA 90406.

(7) **Can't It Be Anyone Else?** — A film about three children who have leukemia. Diana is 12 and wants to know why she got leukemia instead of thieves and murderers.

Dnart, also 12 is black and lives with his mother in the inner city. Dnart wants to be an astronaut to get away from girls. His first wish is for all the money in the world, the second is to get over leukemia. Jim's 10 and wears a T-shirt that says "Bald is Beautiful."

The children are sages: living under the gun has made them wise before their time. Available in a 30-minute or a 50-minute version from Pyramid Films, Box 1048, Santa Monica, CA 90406.

(8) **Here's Looking at You, Kid** — Examines a boy's life after severe burn injuries from the viewpoints of the boy and his mother. Rob is charmingly hostile to the film interviewers — "When you look in the mirror what do you see?" (He knows why they ask.) "I see me." He insists obstinately, "What else should I see?" "Do you love your mother?" (Disbelief. He seems embarrassed for all mankind) "What a stupid question." Produced by Andrew McGuire of San Francisco Hospital Trauma Center, distributed by Biomed Arts Associates, 350 Parnassus Ave., Suite 905, San Francisco, CA 94117.

(9) **Back Wards to Back Streets** — This film is about going from "warehousing" to "dumping," from one inadequate response to the mentally ill to another. The reporter for this TV documentary visits a variety of urban locations in the USA. Although critical of most situations, the film does finally focus on some successful deinstitutionalization programs. 60-minute videotape, distributed by WNET Distribution and Sales, 356 W. 58th Street, New York, NY 10019.

(10) **Why Me?** — Nesbitt Spoon has just learned he has five minutes left to live in this uproarious cartoon from the National Film Board of Canada. Thematically serious, *Why Me?* contains countless comic flourishes. Spoon speedily passes through a variety of emotional responses to death: anger, bargaining, grief, and acceptance.

Disabled Child in Commercial

FOR THE FIRST TIME outside a television or fund-raising event, a child with a disability will appear on television in a com-

mercial. She is Rhonda Frost, an 11-year-old seasoned performer who has multiple sclerosis and gets around in a wheelchair. She was selected over more than 20 other children for a part in a new commercial for Mattel, Inc. In the commercial, Rhonda will be with a group of youngsters playing with the new Barbie Doll line.

1981 International Rehabilitation Film Festival Scheduled for November

THE Fifth Annual International Rehabilitation Film Festival will be presented in New York City on Nov. 4, 5, and 6, by Rehabfilm. The annual Festival is the only competition worldwide inviting entries from all nations of films and videotapes relating to every area of disability and rehabilitation. Programs will be entered into 14 categories, including physical disabilities, developmental disorders, mental retardation, and social issues involving disabled persons.

Persons interested in attending should contact Rehabfilm for audience registration information. The 1981 Festival will be an extraordinarily important one since 1981 is designated as International Year of Disabled Persons by the United Nations. Interested persons should write: Film Festival, Rehabfilm, 20 W. 40th St., New York, NY 10018 USA; tel. (212) 869-0460.

Portable Electronic Communication System Available

THE *Autocom*—a communication aid for nonoral, motor-impaired people—has been made available from Telesensory Systems, Inc. in Palo Alto, Calif. *Autocom* users can have complete freedom of mobility with their wheelchair-mounted communication board and they can communicate freely and spontaneously without the assistance or interpretation of others. The battery-powered *Autocom* will operate for eight hours of normal use before needing to be recharged from standard wall current. The *Autocom* can be personalized according to motor skills and offers message display flexibility, conversation viewing, correctability, continuous feedback systems, unlimited vocabulary, and personalized vocabulary overlays. Extensive research, development, and field testing of the *Autocom* have been conducted by its inventors at the Trace Research and Development Center for the Severely Communicatively Handicapped at the University of Wisconsin, with the support of the National Science Foundation and the Bureau of Education for the Handicapped (now the Office of Special Education), United States Office of Education.

A descriptive brochure and further information are available from Telesensory Systems, Inc., 3408 Hillview Ave., P.O. Box 10099, Palo Alto, CA 94304; tel. (415) 493-2626.

World War II Documentary Released After 35 Years

FOR THE FIRST TIME since 1946, John Huston's classic World War II documentary, "Let There Be Light," has been released by the U.S. Army for public viewing. It is now available from the National AudioVisual Center. The final part of a Huston war trilogy, including "Report from the Aleutians" and the "Battle of San Pietro," this moving film explores the effects of combat upon the minds and spirits of the men who fought in World War II. Cameras followed the rehabilitation of returning soldiers who had been victims of what was then conveniently labelled "shell shock" and "battle fatigue," as they underwent treatment at Mason General Hospital on Long Island in New York. Aiding the slow process of healing, doctors utilized a procedure known as narcosynthesis, whereby the soldiers remembered the moments and events underlying their physical and emotional disabilities—normal responses of minds that had experienced the unendurable. Viewers witness emotional dramatic scenes of men coping with great stress, reliving tragic experiences, and ultimately overcoming inability to walk, total amnesia, and stuttering. Copies of this lost "classic" are finally available through the National AudioVisual Center. Purchase prints have been made from the original 35mm. materials, ensuring the highest quality production standards. And, as a public service, prints of "Let There Be Light" are being offered to general audiences at a very reasonable cost.

For more information on "Let There Be Light," please contact: National AudioVisual Center, National Archives and Records Service, General Services Administration, Information Services Section SL, Washington, DC 20409; tel. (301) 763-1896.

Mr. Rogers Series Chosen by Public TV for "International Year of Disabled Persons"

"BEGINNING Saturday afternoon, Oct. 3, a new eight-week miniseries will be aired over the Public Broadcasting Service featuring the "I Am, I Can, I Will" programs produced by Fred Rogers and Family Communications, Inc.," Patrick E. McKeon, president of Hubbard, announced recently. McKeon further stated, "As exclusive publisher of the complete series, we are particularly honored the Public Broadcasting Service specially selected these programs for television viewing during the 'International Year of Disabled Persons.' The purpose of the eight half-hour programs is to help promote healthy attitudes in young children toward handicaps, whether their own or another's," he continued. "Although this is entirely new television broadcast material, it relies heavily on the style and great popularity of the long-running 'Mister Rogers' Neighborhood' programs. Fred Rogers is loved by children

everywhere. It is his unique, quiet presentation, which focuses on the individual child and nurtures his or her self-worth, that will provide a warm reception for this needed series," McKeon said.

Originally produced for school use under a grant from the Bureau of Education for the Handicapped, the complete "I Am, I Can, I Will" program includes films, books, and audiocassettes, all available from Hubbard. The film portion of the program has been specially edited for presentation on PBS on eight consecutive Saturdays, starting Oct. 3. The titles will be: Playing and Pretending, Talking About Feelings, You Are Special, Feeling Afraid, Helping, Waiting, Feeling Left Out, and Growing.

International Symposium on Designed Environments To Be Held in January, 1982

THE National Center for a Barrier Free Environment will sponsor an international symposium on "Designed Environments for All People" on Jan. 22-24, 1982, at the United Nations headquarters in New York. The project is being funded in part by the National Endowment for the Arts, and has the active support and participation of all major design societies, including the American Institute of Architects, The American Institute of Graphic Arts, the American Society of Interior Designers, the American Society of Landscape Architects, the Association of Collegiate Schools of Architecture, the Industrial Designers Society of America, and the Landscape Architecture Foundation. The gathering will represent the first time that all of the design professions have collaborated on one project.

The program, which will be aimed at design practitioners, educators, and students, will include a wide variety of plenary sessions, workshops, case studies, and panel discussions, to explore ways in which the built environment can be designed to ensure its accessibility to all people. An international interdisciplinary audience of at least 400 persons is expected.

For further information, write to the National Center for a Barrier Free Environment, Suite 1006, 1140 Connecticut Ave., N.W., Washington, DC 20036.

Regulations on Discrimination Available in Large Type

COPIES of federal regulations on racial, national origin, and handicap discrimination are now available in large size type editions for people with limited or impaired vision. The Office for Civil Rights has supplied copies of federal regulations for Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973 to all national libraries serving those who are blind and physically handicapped. Production of these regulations in 14-point

type will nearly double the average print size. Requests for free copies should be addressed to: Director, Office for Civil Rights, Department of Health and Human Services, 330 Independence Ave., S.W., Washington, DC 20201.

Golden Access Passport For Physically Disabled and Blind Persons

SECRETARY of the Interior James G. Watt has announced that people who are physically disabled or blind may now obtain free entry to national parks, monuments, historic sites, and recreation areas and receive 50 percent discounts on fees for recreational activities such as camping and boat launching. The disabled person already must be eligible to receive federal benefits for their disability under programs such as Disability Retirement (Office of Personnel Management); Compensation for Service-Connected Disability (Veterans Administration); Pension for Nonservice Connected Disability (Veterans Administration); Coal Mine Safety and Health Act (Department of Labor); Social Security Disability (Department of Health and Human Services); or any other of the disability programs.

The benefits are available under the new Golden Access Passport, which became available this summer. The new Golden Access Passport results from a 1980 amendment to the Land and Water Conservation Fund Act of 1965. Free lifetime entrance permits and discounts on fees are already available for people 62 and over under the Golden Age Passport. For people under 62, the Golden Eagle Passport provides unlimited entry for a \$10 annual fee. Golden Access and Golden Age Passports must be obtained in person, while the Golden Eagle may be obtained either in person or by mail.

For more information about the passports, contact: Division of Federal Lands Planning, U.S. Department of the Interior, 440 G Street, N.W., Room 236, Washington, DC 20243; tel. (202) 343-7665; or the National Park Service, 1013 Interior Building, 18th and C Streets, N.W., Washington, DC 20240; tel. (202) 343-4747.

Wanted: Humorous Experiences Related To Disability

"I am a graduate student at Arizona State University. I am working on a research project looking at the dynamics involved in humor and disability. I am seeking jokes, cartoons, and/or personal accounts about being disabled.

"I would like to invite the disabled or those who work closely with the disabled to send me anything they feel is appropriate. I have been a quadriplegic for 12 years and am familiar with the uses of humor from past experiences. I would appreciate any contributions." Please send to: John E. Bignall, P.O. Box 2306, Mesa, AZ 85203.

"Talking Book"—An Aid to Language Teaching

SOME CHILDREN find it difficult to pronounce a printed word without difficulty. This word blindness, or dyslexia, is an irritating impairment that necessitates individualized assistance. It requires specially trained teaching staff to give the children the attention they require. An aid has been developed at the Institute for Perception Research in Eindhoven (the Netherlands), which enables these children to practice individually during lessons. With this method, a special code is printed under each word. The child places a scanner with an optical element on this code and this information is converted into recognizable artificial sounds via a speech synthesizer. Thus, the child gains an idea of how a word must be pronounced from a "talking book" of this kind.

This direct association between the sound and the appearance of the word, which is still at the experimental stage, can be used in a large number of ways. The example given above illustrates only one of these. When a tape recorder is used, there is the problem that the pronunciation is not available for immediate recall. The talking book makes it possible to hear the pronunciation of any word at will, as often as is necessary and without reservation. In general, this new aid can be used for teaching foreign language; for example, as an aid to the pronunciation of words or characters (as found in Japanese). The usefulness of the system in an English course is currently being researched jointly by education experts from the Philips language laboratory and Tilburg University. The researchers emphasize that, while this method may indeed offer more scope in language teaching, expert guidance will always be essential.

The Institute, a collaboration between the Technical University in Eindhoven and Philips, has been performing fundamental research for years into the physical structure of human speech. The results of this research can be used, for example, in the automatic recognition of speech by computers or in the artificial reproduction of speech. Speech technology is now so advanced that a talking book is already a reality. To begin with, a number of characteristics of a given pronounced word are established; for example, amplitude, pitch, band-width and voicing. Indexes can be formulated for these which are reproduced in a binary code. A code of approximately 800 bits is needed to describe a word of average length. Each bit is represented by a black (or white) area, 160 μ m wide and 500 μ m high (1 μ m is a thousandth of a millimetre). The total code surface of the present version of the hardware is approximately 17 mm. $\times$ 8 mm. If this code were created with conventional digital techniques, a code length of 160 cm. would be necessary.

The student places the scanner on the code below the word during a reading les-

son. When a button fitted with six tiny lamps on the top of the scanner is pushed in, the lens moves down also and when the button is released, the lens is moved smoothly upwards by a spring. The code is scanned during this movement. The information is converted directly via a speech synthesizer into an artificial pronunciation of the word. However, the present system has a limited field of view. With the current construction a word lasting one second can be read (approximately three or four syllables). Even though the speech is coded as economically as possible (to prevent the code being too long), artificial speech of a reasonable quality is obtained.

For further information contact A. Rutten, North American Philips Co., 100 E. 42nd St., New York, NY 10017.

New Publication on Employment Examines Use of Disabled Self-Help Groups in Program Development and Implementation

"SELF-HELP ORGANIZATIONS of the disabled are rapidly growing in strength and numbers and should be used as a valuable resource by all employers who are committed to sound human resources management, in general, and to effective management of people with disabilities, in particular." This statement, recently made by Rami Rabby, serves as the theme for a useful "how-to" publication, which he has just released, entitled: *Employing The Disabled: What Are Self-Help Groups and What Assistance Can They Offer The Employer?*

Drawing on his past experience as director of Affirmative Action Programs for the Handicapped at Citibank, and on his present practice as a consultant on employment of the disabled and other aspects of institutional integration of the handicapped, Rabby develops a working definition of disabled advocacy groups and distinguishes between their role, on the one hand, and the role of other types of organizations and agencies in the field of disability, on the other. He offers concrete and practical examples and illustrations of how employers and disabled self-help groups can collaborate productively in outreach and recruitment, awareness training for supervisors and co-workers, removal of architectural barriers, and modification of discriminatory personnel practices.

The narrative text is followed by two appendixes listing over 100 disabled self-help organizations (complete with up-to-date addresses and telephone numbers), the vast majority of which are national in scope and have well-developed regional and local chapters. Since the organizations listed represent literally millions of people with disabilities, these appendixes should serve as a valuable resource, not only to employers of persons with disabilities, but also to all other organizations—federal and state government departments, colleges and universities, pub-

lic school systems, hospitals, nursing homes and other health care institutions, housing authorities, law enforcement agencies, museums, theatres, concert halls and other cultural facilities, zoos, parks and other recreation areas, transit systems, social service and rehabilitation agencies, and others who are legally obligated to make their premises and programs accessible to disabled persons or wish to publicize their services to the broad spectrum of the disabled community. Disabled individuals, their parents, and advocacy groups and self-help organizations should be well served by the listings, as they work to promote more effective programs of independent living and mutual assistance, increase and solidify their memberships, bring their organizations together within wider coalitions, and broaden their political base.

Employing The Disabled: What Are Self-Help Groups and What Assistance Can They Offer The Employer? costs \$5.00, plus 50¢ for postage and handling. Orders and checks (made payable to Rami Rabby) should be mailed to Rami Rabby, 136 E. 55th St., Suite 8E, New York, NY 10022. For further information, please write to the above address, or phone (212) 371-7766.

Information on Accessibility Available Through Toll-Free Number

AN architect has been commissioned to design a home for someone who uses a wheelchair, and wants to know the proper dimensions to make the house barrier free. A woman's husband recently had a stroke, and she wants information on how to ramp the steps leading up to their home. Both of these people were able to find answers to their questions by calling the National Center for a Barrier Free Environment's toll-free access information number: (800) 424-2809. The toll-free WATS line enables callers to discuss their information needs directly with design and information professionals. This person-to-person contact assists the National Center's staff to better understand the callers' needs, thereby providing more specific and thorough responses.

Founded in 1974, the National Center is a private, nonprofit organization which provides programs and services designed to assist in the creation of physical facilities that are accessible to disabled persons. In addition to the toll-free number, the Center's services include an information clearinghouse, a nationwide network of barrier-free design consultants, and a series of information bulletins and other publications addressing specific accessibility topics. Also available is a reference file on state building codes and standards relating to barrier-free design.

Information on these services can be obtained by calling the toll-free number or by writing: National Center for a Barrier Free Environment, Suite 1006, 1140 Connecticut Ave., Washington, DC 20036.

Life-Supporting System Developed for Deaf-Blind Persons

THE Helen Keller National Center for Deaf-Blind Youths and Adults in New York has designed and developed a special device with a life-supporting system for deaf-blind and deaf persons. The TACTILE COMMUNICATOR is basically a radio paging system that transmits lifeline information such as a doorbell ring, TTY or telephone ring, and fire alarm. It is comprised of two components—a transmitter housed in a 4" x 2 1/2" grey plastic case with 11" flexible antenna sheathed in a plastic case to prevent breaking and injury to the user, and a pocket-size receiver, which alerts the wearer to a signal being received by vibrating the receiver case.

The transmitter contains 6 inputs, 5 input terminals and a pushbutton. Three of the input terminals will produce separate coded signals. These signals are prioritized, with input 3 having the higher priority, and can be used for fire alarm. Input 2 has priority over input 1 and can be used for doorbell or phone. Two uncoded inputs are also available and are wired in parallel. These inputs are disabled when the fire alarm input is activated. The transmitter also contains a pushbutton which has priority over all other inputs, including number 3. This button permits personal communication in the house or out in the garden and can inform the receiver of an uncoded emergency in Morse Code. Since the transmitter is a conduit for information, it has enormous potential for tying in other options: an oven thermometer or boiling water detector, a smoke and fire alarm, the sound of a baby crying, or even a TTY to a hand held terminal with braille decoding.

The receiver contains a specially developed low power motor and cam assembly that produces the vibratory sensation the wearer feels. Another feature is a battery-saving circuit that turns the receiver on for 5 milliseconds to test for the presence of a signal. If no signal is detected, the receiver turns itself off for 100 milliseconds. This extends the life of the battery by 20 times, allowing a standard 9-volt alkaline battery to power the receiver for more than 75 hours continuously.

The Helen Keller National Center was instrumental in encouraging the F.C.C. to approve a new handicapped frequency at 43.64 megahertz and in April, 1981, the Center became the first organization to receive type acceptance for a receiver and transmitter on this handicapped frequency. The benefits were significant - a low traffic channel for communications, permitting the Helen Keller National Center to use less expensive, lower parts count circuitry and thus produce an affordable device.

The TACTILE COMMUNICATOR and additional literature is available at a cost of \$300, and may be ordered by contacting

Herb Cohen, Helen Keller National Center, Research Department, 111 Middle Neck Rd., Sands Point, NY 11050; tel. (516) 944-8900.

Max Cleland Receives National Courage Award

MAX CLELAND, former head of the Veteran's Administration, has won the second annual National Courage Award, presented by Courage Center in the Minneapolis suburb of Golden Valley, Minn. The National Courage Award honors individuals who have made a significant impact on a regional or national level in improving attitudes toward and services provided to individuals with physical disabilities. The award is a 15-inch replica of a bronze winged figure, "Spirit of Courage," by Minnesota sculptor Paul Granlund, which stands outside the lobby of Courage Center.

Cleland is himself disabled, a triple amputee as the result of a grenade explosion while he was serving as an Army paratrooper captain in Vietnam in 1968. Undaunted by his disability, he returned home to Georgia and, beginning in 1970, served two terms in the Georgia State Senate. President Jimmy Carter appointed him Administrator of the Veterans Administration in 1977. During his term Cleland strove to make the VA more responsive to the needs of Vietnam veterans and sought to develop younger VA management personnel through the Leadership VA program.

Cleland now tours the country lecturing about his past experiences and discussing issues affecting people with physical disabilities. He was honored at a public ceremony Oct. 16 at Courage Center along with the winners of the 1981 Rose and Jay Phillips Awards, presented annually to five men and women who have achieved outstanding success in their vocations despite severe disabilities.

RSA Commissioner Takes Office

GEORGE CONN, 48, was sworn in recently as U.S. Commissioner of the Rehabilitation Services Administration in the U.S. Department of Education. Secretary T. H. Bell administered the oath. Conn previously was the research and legislative director of the Paralyzed Veterans of America. He officially held that post from 1979 until his nomination. From 1975 to 1977 he was special assistant to the Executive Director, White House Conference on Handicapped Individuals, Washington, D.C., directing plans for both the national and 50-State conferences. From 1972 to 1975 he served as director, Office of Public Affairs, in the Rehabilitation Services Administration. From 1966 to 1972 he was executive director of the Governor's Committee on Employment

of the Handicapped for the State of Illinois. There he led a statewide effort that resulted in the first State Constitutional Article guaranteeing equal opportunities in employment, housing, and access to places of public accommodation for physically and mentally handicapped people.

A member of the United States Paralympic Teams in England, 1961-63, and Tokyo, 1964, Conn was awarded 17 gold medals in basketball, swimming, and the pentathlon. He was president of the National Wheelchair Basketball Association from 1966 to 1976 and also was the founder of the League of Disabled Voters in 1978, serving as its president in 1980.

Study Shows That Vocational Counseling Makes a Difference for Persons with Disabilities

EARLY vocational counseling may mean the difference between work and unemployment for persons having disabling injuries, according to a University of Wisconsin study. Dr. Richard Harvey, chairman of the Department of Rehabilitation Medicine at UW Hospital and Medical School, and Hollis Jellinek, rehabilitation psychologist, studied 86 patients with severe head and spinal cord injuries over a two-year period. Half of the patients received vocational/educational counseling while in the hospital; the other half were hospitalized before the hospital developed the counseling program. About 75 percent of those who received counseling in the hospital were employed three years later, compared to 19 percent of those who received no on-site counseling.

Vocational/educational counselors visited patients during the first week of hospitalization and throughout the rehabilitation process. Patients were taught to incorporate their disability into their old jobs or they were taught new skills. Instead of settling into a mindset of being disabled, patients were encouraged to function independently as students or workers.

Other studies have found that 33 to 62 percent of persons with spinal cord injuries were working or in school three years after their injury. These studies have demonstrated a link between successful employment and previous educational and vocational levels, in addition to age and sex of the patient. However, the UW study is the first to measure the effect of on-site counseling.

"Rehabilitation patients have been shown to benefit from a program that provides more than expert medical care," say the authors. "Effects of the total rehabilitation process have been major factors related to favorable experience of 'successfully' disabled persons."

Results of the study will be published later this year in the *Archives of Physical Medicine and Rehabilitation*.

Instructions to Authors of Articles for Rehabilitation Literature

As an interdisciplinary journal, *Rehabilitation Literature* is published for professional personnel and students concerned with the rehabilitation of the handicapped. It is intended to help the medical practitioner, therapist, or other personnel working with handicapped children and adults to keep up to date not only in his own professional field but also in other related fields. *Rehabilitation Literature* is in no sense the house organ of the National Easter Seal Society. Contributors of featured articles and book reviews are people outstanding in their own fields and give free expression to their own ideas and opinions.

In view of *The Copyright Revision Act of 1976*, effective Jan. 1, 1978, all transmittal letters to the editor should contain the following language before manuscripts can be reviewed for possible publication: "In consideration of the National Easter Seal Society taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to The Society in the event that such work is published by The Society." We regret that transmittal letters not containing the foregoing language signed by all authors will necessitate delay in review or return of the manuscript.

Kinds of Articles

The "Article of the Month," featured in each issue, is usually a review article in which the author will summarize current knowledge and recent developments in a specific subject field. The present status of the subject may best be documented by a review of the literature as well as by presenting the author's own experience and personal observations. In the course of his review of the subject the author should be able not only to report but also to evaluate and criticize what is being done and what is known. We hope that the author will be informed of current and recent research activities and will be able to discuss their implications in rehabilitation efforts. It is well for the author to keep in mind that although his reading audience is professional it is primarily an interdisciplinary one.

The "Special Article," which also appears in each issue, is appreciably shorter than the "Article of the Month," running 1,500 to 3,000 words in length. A special article may be an editorial expression of opinion held by the author, may be a report of a clinical experience or of a program or project, or may offer pragmatic observations and information in a problem area of concern to a particular segment of our readers.

Preparation of Manuscript

The space allotted to "Article of the Month" permits the use of one of 6,000 words, or approximately 17 typewritten pages, elite type, double spaced. The bibliography or list of references may be in addition to the pages of text. The author is asked to organize his article so that it will include section headings. The original and one carbon copy of the article, carefully typed and corrected, should be submitted to the Editor. The author should retain a copy. The Editor reserves the right to return for revision to the author a manuscript that does not meet the standards of a professional journal or the editorial requirements of *Rehabilitation Literature*. The Editor may be permitted to make minor editorial changes if they do not materially change the author's style or essential meaning.

Illustrations

Authors are asked to plan to write their articles so that illustrations are not essential. The physical and editorial format of *Rehabilitation Literature* will not permit usually the use of photographic illustrations or a substantial number of tables or charts. As soon as an author finds that illustrations are required for his paper he should consult the Editor immediately.

References and Footnotes

The author is asked to compile his references in a form that is consistent with a style to be found in the journals of his own profession. That the citations be complete and accurate is the responsibility of the author and is not one that the Editor can assume. The list of references should be typed as a separate section so that it may be published at the end of the article. On the other hand, footnotes, if any, should appear on the same page of the manuscript in which reference is made to them.

Information About the Author

When the manuscript is sent to the Editor, it should be accompanied by a biographical data sheet containing information about the author's education, professional work, and membership in professional organizations. This information will be used in the preparation of a short statement identifying the author.

Reprints

The publisher reserves the right to reprint the article for further distribution as part of the Society's education program. In such instances, authors will have the opportunity to purchase reprints at cost.

Whether or not the Society reprints the article, arrangements can be made with the Editor for ordering reprints at the author's expense.

STEPHEN J. REGNIER
Editor

A HANDBOOK ON STUTTERING

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The author's reference list now consists of nearly 1,500 articles and publications, all of which are cited in the text, in footnotes and in suggested reading lists at the end of each chapter.

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The Disabled Homemaker

By HOYT ANDERSON, illustrated by MORRIS GEE

Published by Charles C Thomas, Pub., 301-327 E. Lawrence Ave., Springfield, IL 62717. 1981. xi, 343 p. figs., tabs. \$19.50, cloth; \$12.75, paper.

Reviewed by ELEANOR BOETTKE HOTTE

About the Author . . .

Hoyt Anderson was born with cerebral palsy. In his teens, despite his disabilities and severe speech impediments, he began to work with other youngsters who were physically disabled in both educational and recreational programs. He later served as an aide in the Life Experience Program for the San Juan Unified School District in Sacramento, California, helping disabled adolescents learn independent living skills. Mr. Anderson currently is a graduate student in special education at California State University in Sacramento and lives independently in an apartment nearby.

About the Reviewer . . .

Ms. Hotte is professor emeritus, consultant, and lecturer in the School of Home Economics and Family Studies at the University of Connecticut, Storrs. She is co-author of *Independent Living for the Handicapped and Elderly* (Houghton Mifflin, 1974), and recently revised *Self Help Clothing for Children Who Have Physical Disabilities*, a publication of the National Easter Seal Society.

ALTHOUGH THE IMPORTANCE of independent living in the rehabilitation process is widely recognized by doctors, therapists, educators, counselors, parents, and individuals with disabilities, there is still a prodigious need to make the achievement of this goal possible for greater numbers of disabled people. Hoyt Anderson, by writing *The Disabled Homemaker*, is offering realistic encouragement to all who are living with a disability. He is not only a disabled person who has achieved independence himself, but is also willing to share with others ways in which they can help themselves become functioning and contributing members of society.

This valuable book presents "real life examples of disabled people" who have successfully accepted their disabilities and through determination and will power have attained varying degrees of independence. Anderson is quick to point out that there are risks and trade-offs along the way, but by acknowledging the risks and setting realistic expectations, a person can reap beneficial rewards. This constructive approach supports the prevailing theme throughout the book, which is to develop positive attitudes. All too frequently, family members or those who are working with a disabled person, in spite of good intentions, tend to emphasize the negative aspects by paying attention to what the individual cannot do. These negative attitudes can be counteracted if the individuals involved develop constructive views of their own life by accepting their disability and recognizing their own importance and worth as individuals. These feelings are vital elements in seeking solutions to problems and actively accomplishing the tasks involved with daily living.

The author also underlines creativity as an essential ingredient for working out ways to complete a task. He believes that disabled individuals must do things differently than others, and must find ways to minimize the time and effort it takes to complete a task. They must also learn to use their bodies to best advantage by strengthening those parts that can take over for impaired ones and contribute to mobility or increase the range of motion by developing grasping, pushing, and pulling movements.

An appealing chapter entitled "Anyone can Live Independently" speaks directly to the reader and exemplifies the personal approach used in this book. It suggests a range of alternative ways of doing things that cannot help but inspire someone struggling with a newly acquired disability or someone who has become discouraged with his or her inability to progress toward greater independence. It also helps individuals examine what they are doing at present and consider how they might change their ways to strive for more self-reliance.

Independent living can mean different things to different people, but to help understand the objectives of this book, *independent living* is explained with a personal definition attributed to a disabled students' program director who is confined to a wheelchair. His meaningful explanation is: "For me it really means autonomous living: someone having the ability to direct his own life even though he cannot perform all of the tasks himself. This involves taking responsibility and being able to plan your own life without supervision." Clearly stated, this concept is easy to adopt as a guiding factor in planning one's life because taking responsibility and being able to plan one's own life adds to the human dignity of the individual.

To expand on the idea that many severely disabled people can live in a home of their own and become more self-reliant, individual examples are used to show that independence also helps a person develop interpersonal relationships. Dependence can interfere with the way a person relates to others because it acts as a barrier between individuals and can be the cause of strained relationships. Dependent people do not always find it easy to communicate their true feelings and sometimes take the easy way out by withdrawing or avoiding situations that require them to interact with others. However, those individuals who are able to express themselves usually become more self-reliant, gain confidence in themselves, and develop the initiative to try more and more activities. Courage and determination are significant personal characteristics contributing to achievement.

A *Living Skills Profile Chart* allows the reader to assess whether he or she is ready for independent living. The chart includes a task analysis for eating, grooming, toileting, dressing, cleaning, cooking, serving meals, laundry, sewing, heavy household chores, marketing, financial management, and child care. For example, a task analysis of eating involves eight specific activities, while personal grooming has 17 and cooking has 38. By checking off what things "I can do" and when "I need help," the person is better able to describe individual capabilities and can determine what kind of help, if any, will be needed.

Using a classification system, the author discusses the effect of specific physical disabilities on managing

the essential tasks of keeping a home. This chapter explains that restrictions such as limited range of motion in fingers and wrists are generally associated with joint diseases, while lifting and carrying is often too strenuous for someone with upper extremity weakness. Wheelchair users have to consider heights of work surfaces, space for extended footrests, space for maneuvering their chairs, and ramps for access and mobility. Those with low energy levels probably should avoid tasks that require added strength and should consider using modifications or assistive devices to help them do the job with as little energy output as possible.

This chapter appears to offer more insight to the student therapist or counselor than to those with disabilities in that it defines the limitations and impairments in relation to the restrictions on the activities of daily life. Assuming that the disabled readers are already familiar with their limitations, I would expect them to be more interested in the more positive approach that is used throughout the remaining chapters.

In the ensuing chapters, many specific suggestions are presented about the basics of taking care of oneself and one's home. For each activity, usually more than one method is presented to demonstrate that there is no one way to accomplish a task. The chapter concerned with taking care of the body gives a candid discussion of urinary management and the use of a catheter. Bladder and bowel sections include a listing of equipment that is available, and procedures are explained with special emphasis given to the importance of cleanliness. In addition to bathing and grooming suggestions, wheelchair transfers are explained with step-by-step instructions for getting in and out of bed, getting on and off the toilet, and getting into a tub.

In the chapters devoted to household chores, the main focus is learning how to work with the least amount of effort. Two individuals—a person with paraplegia and a student with cerebral palsy—demonstrate the application of the seven principles of work simplification to various household chores. The first principle described is analyzing daily tasks. Not only is it important to know what you want to accomplish but also when or what time of day it is best for you to accomplish the specific task. Paying attention to your "own biological clock" means that a person does the most strenuous jobs when he or she is feeling best. The other work simplification principles discussed are: find an appropriate place, seek assistance if necessary, do it the easy way, do things simultaneously, change your work habits, and make your body work effectively.

The chapters devoted to cooking, cleaning, and laundry emphasize the importance of selecting the right equipment to make the tasks easier. Continuing

to promote task analysis, the author offers suggestions for methods of working to save energy and reduce the fatiguing aspects of these jobs. Although much of this information is available in other resources, the book does present some of the latest equipment offering greater safety and more efficient ways of working.

In recent years, much has been written about housing and interiors for the disabled, but this book's approach of relating housing to the activities that occur in daily living is a valuable aid in helping people with disabilities select suitable living space that will enable them to function. It brings together information about kitchen design, storage, structural modifications, and adaptations in areas within as well as outside the home. It also presents some of the contributions technology is making to the lives of disabled persons. Typically, most of the printed resource material on housing has been written for the designer, but Anderson tries to filter through this information and make it available for disabled individuals so that they can make wiser selections when looking for an apartment or house. The author recognizes that when an individual is renting a living space, whether it be a house or apartment, he or she may not be able to make structural modifications. In this case, there is greater need for careful analysis of the way an individual moves and acts before rental decisions are made.

A chapter on clothing reviews its functional aspects and gives guidelines to consider before buying clothes. My disappointment here is that the author

omitted a discussion of dressing techniques. There is less published information available on this phase of clothing, and Anderson had an opportunity to share individual ideas and hints with the many disabled people who have not yet found ways to facilitate getting in and out of a variety of clothing items.

Disabled mothers and fathers are in desperate need of special information and reinforcement on the handling of a child from infancy through the growth years. The final chapter is directed toward this group, and while it presents some very good material on child care equipment, it does not concentrate enough on the concerns of parents in handling their child.

At the end of each chapter appears a list of points to remember, an offering that is particularly helpful to student groups who might be using this as a text or reference book. The appendixes are another resource, for they include lists of clothing suppliers, manufacturers, and distributors of equipment and devices. If the reader is interested in additional information, a suggested reading list is organized according to the subject matter of each chapter.

I am convinced that *The Disabled Homemaker* has a wide audience to offer assistance to, much broader than is suggested by the use of "homemaker" in the title, which, unfortunately, continues to be limited in definition for most of the public. Anderson's book is an outstanding contribution to the literature in the field, and it offers many solutions to facilitate the prospects for greater independence for many more individuals.

Other Books Reviewed

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Care of the Older Adult

By: Joan Carson Breitung, R.N.

1981. 336 p. figs., photos. paper. Tiresias Press, 116 Pinehurst Ave., New York, NY 10033. \$9.90.

BY OVERCOMING PREJUDICE and patronizing attitudes toward elderly persons, health care professionals can learn to provide them with optimal physical and psychological care. Directed at practical nurses, this book presents a system of comprehensive care for elderly persons. Several sections of the text should also be helpful to elderly persons themselves, their families, the staff of treatment centers for this population, and instructors in geriatrics.

The concise text is divided into two main parts. The first part covers general aspects of geriatrics, beginning with a clarification of common misconceptions. Nursing homes are then discussed, including

selection of a home, types of care offered, alternative forms of care, counseling families who place relatives in these institutions, and patients' rights. This information is complemented by nine persons' viewpoints on nursing homes, including an administrator, a woman who placed her father in a home, and a resident. A section on mental disorders distinguishes between organic and functional problems and explains how nurses can orient confused patients; special attention is given to aphasia. The effects of aging on sexual function, attitudes toward sexuality, and recognizing elderly persons' sexual needs are addressed, and solutions are offered to common nutritional problems of this age group.

The main systems and sense organs of the body are the topics of the second part of the book. Emphasizing a personal approach to treatment, the author describes the anatomy of each system in straightforward terms, the changes that can occur in each system be-

Mainstreaming in Schools and Society

A CQUISITION of knowledge about disabilities and the problems they may present is only the first step young nonhandicapped people must take if societal integration of persons with disabilities is to be achieved. The authors of this curriculum recognize that appreciation of the similarities among all persons, development of accepting attitudes, and establishment of society's role in mainstreaming—within schools and society at large—are the ultimate objectives of educational efforts regarding disability.

Handicapped People In Society: Ideas and Activities for Teachers

By: Ruth-Ellen K. Ross and Teachers of the Howard County, Maryland, Public Schools

1981. 118 p., photos, paper. Silver Burdett Co., 250 James St., Morristown, NJ 07960. \$7.65 (plus \$.75 for shipping).

The programs in this guide are designed to achieve these objectives for youth at elementary, junior high, and high school levels. Each program can be used as a mini-course or a one- or two-week unit; individual program components can also be integrated into the existing curriculum. At the elementary and junior high levels, program sections are built around various conditions, such as physical, mental, visual, or hearing impairments. Each component lists cognitive and affective student objectives, describes a variety of activities, and suggests ways to evaluate progress. Active student involvement and the use of a variety of media characterize the learning environment envisioned by the creators of this curriculum. Selections of activities are usually sufficiently diverse to accommodate even those school systems with minimal resources, and the provision of master copies of

handout materials for some of the activities adds to the economic benefits of this package.

At the high school level, objectives focus on community awareness and affirmative action toward citizens with disabilities. Following participation in introductory group activities, students have an opportunity to display individual initiative by pursuing projects in the learning activity packet that is provided. If preferred, of course, activities can be performed by student groups.

Educators who are preparing to implement this curriculum will appreciate the background information provided in the book's introductory sections. A brief historical review of attitudes precedes a factual section on various handicaps. Definitions, categories, causes, and general characteristics are given for learning disorders, mental retardation, emotional disturbances, orthopedic handicaps, seizure disorders, and vision, hearing, and speech disorders. Professional resource materials are listed for various disabilities, vocational education, evaluation, and special education. Teachers are also provided with titles of audiovisual materials and supplementary student reading materials coded according to reading level.

An occasional problem may be encountered with regard to suggested materials; sources are not always easy to locate, and in one or two instances an activity requires use of a particular film rather than offering a choice. Despite these minor drawbacks, most educators will welcome the facility with which this curriculum can be implemented and adapted to their unique group of students, and the degree to which it can accomplish its goals. Mainstreaming will very likely become more than just a word to young people able to participate in this learning experience.

—Jan Bakker

cause of aging, and relevant nursing procedures. Illustrations clarify key concepts and review questions complete each chapter. The book also contains numerous references and addresses of pertinent organizations.

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Coordinating Services to Handicapped Children: A Handbook for Interagency Collaboration

Edited by: Jerry O. Elder and Phyllis R. Magrab, Ph.D.

1980. x, 250 p. paper. Paul H. Brookes, Pub., P.O. Box 10624, Baltimore, MD 21204. \$13.95.

NEITHER SCHOOL SYSTEMS nor individual agencies in human service delivery systems have sufficient resources to implement P.L. 94-142 effectively. To meet the varied needs of individual clients, interagency collaboration is essential. Before the process of collaboration can occur, however, a trusting attitude among agencies in the various service systems must be developed. Introductory chapters of

this handbook suggest ways to create a climate that nurtures trust among service providers in autonomous educational, social service, vocational rehabilitation, and health delivery systems. A rationale for initiating interagency planning at local levels is presented. The historical development of cooperative efforts among various service systems is traced, and the influence of decisions at the federal level is examined. Detailed in the guide's next major section are four operating models of service coordination for children and suggestions for avoiding some of the problems encountered. The concluding section presents necessary components of interagency service coordination derived from examination of operating models and current theory. Examples of interagency agreements are appended; several articles list references.

Partial contents are: Interdisciplinary Collaboration: A Prelude to Coordinated Service Delivery, by Phyllis R. Magrab and Laura M. Schmidt, p. 13-23.—The Intangible Human Factor: The Most Critical Coordination Variable, by Howard B. Hall, p. 45-62.—Development of a Community-Based Interagency Model, by Elynor Kazuk, p. 99-131.—Development of Preschool Interagency Teams, by Janelle Mulvenon, p. 133-162.—Planning Issues in Local Interagency Collaboration, by Denise Hummel-Delgado, p. 163-178.—Essential Components in Development of Interagency Collaboration, by Jerry O. Elder, p. 181-201.

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The Day Hospital: Organization and Management

Edited by: **Charlotte M. Hamill**

1981. xii, 177 p. tabs. Springer Publishing Co., 200 Park Ave. South, New York, NY 10003. \$23.50.

CERTIFIED under a general or rehabilitation hospital, a day hospital—which is also referred to as adult health services or the medical model of adult care—is a special type of outpatient setting that provides closely integrated diagnostic and treatment service (excluding surgery) for chronically ill and disabled persons. The patients' structured and individualized daily programs last from five to six hours, during which time they are closely observed and evaluated. Day hospitals emphasize rehabilitation, patient participation, and counseling services. This book discusses the components of this new form of care.

A definition and history of the day hospital are followed by a general approach to planning this type of hospital, including sponsorship, survey of community needs and resources, and designing facilities. Other sections on planning are devoted to staffing, admissions and discharge, patient transportation, and assessment and treatment. Examples of procedures used

at established day hospitals illustrate the major concepts, and the extensive appended material—such as a floor plan, time distributions, flowcharts of admissions and assessment processes, and hospital protocols—supplement these sections. Also described are the major services offered by a day hospital: medical and nursing services, speech and language therapy, physical therapy, occupational therapy, and social services. The physical layout for these services, team approach, family involvement, and staffing requirements are outlined. Also considered are financial management (feasibility as an option for health care, reimbursement, and cost effectiveness) and public relations (contacts with the media and community outreach). A bibliography is also supplied.

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Deinstitutionalization and Community Adjustment of Mentally Retarded People

Edited by: **Robert H. Bruininks** and others

1981. xvi, 428 p. figs. tabs. American Association on Mental Deficiency, 5101 Wisconsin Ave., N.W., Washington, DC 20016. \$24.75.

DEINSTITUTIONALIZATION promises to continue to be a major trend in services for mentally retarded persons. Yet as this form of care develops, there will be expanded efforts to evaluate and modify the new residential services. This book presents current research on the community adjustment of mentally retarded persons that will assist in evaluating and developing of public policy, understanding the quality of these persons' experiences, and increasing knowledge about the responses to them by agencies and other people. The articles are grouped into 4 major sections: an overview of deinstitutionalization and community adjustment, issues in research on these two areas, recent research on types of community placement, and research on providing and evaluating community placements. Also identified are areas for future research.

Partial contents are: Deinstitutionalization: Trends and Difficulties, by Richard C. Scheerenberger, p. 3-13.—A Conceptual Approach to Deinstitutionalization of the Mentally Retarded: A Perspective from the Experience of the Mentally Ill, by Leona L. Bachrach, p. 51-67.—A Qualitative Approach to the Study of Community Adjustment, by Steven J. Taylor and Robert Bogdan, p. 71-81.—Some Conceptual and Methodological Issues in Studying the Community Adjustment of Deinstitutionalized Mentally Retarded People, by Elinor Gollay, p. 89-106.—Issues in Interviewing Mentally Retarded Persons: An Empirical Study, by Carol K. Sigelman and others, p. 114-129.—Qualitative Methods and Cultural Perspectives in the Study of Deinstitutionalization, by Sylvia Ber-

Quality of Life and Spinal Cord Injury

STUDIES INDICATE that a considerable percentage of deaths among persons with spinal cord injury (SCI) are related to self-destructive behavior. Responding to this indication of psychological problems, the author analyzes the rehabilitation procedures used with this population "to determine how successful we have been at helping people achieve some degree of happiness in their lives." An important feature of this book, which has benefited from suggestions of a panel of persons with SCI, is the critical review of unsubstantiated theories about adjustment to SCI.

Spinal Cord Injuries: Psychological, Social and Vocational Adjustment

By: **Roberta B. Trieschmann**

1980. xiii, 234 p. figs. tabs. Pergamon Press, Maxwell House, Fairview Park, Elmsford, NY 10523. \$25.00.

Among these misconceptions are that patients experience shock and deny their disability during the acute state following injury and then adjust in distinct stages; that counseling enhances sexual functioning in persons with SCI and sexual attitude readjustment workshops change professionals' interactions with patients; and that group counseling is an effective therapeutic technique, particularly for improving self-esteem. In addressing these issues, the author specifies the depression and mourning that follow SCI, and recommends using behavioral techniques to improve sexual function and facilitating success in the community as a means of bolstering self-confidence.

This pioneering and optimistic work offers more than a critical review and alternative theories; it also describes several models and procedures that can help persons with SCI learn to live with their disability in their chosen environment. The learning model (as opposed to the medical model) is put forward as a method of teaching skills that will help persons with SCI compete in the community. This model views behavior as the result of variables in the person and the environment and arranges interactions to promote the desired behavioral goals. In this system, two overlooked aspects of motivation—"locus of control" and feelings of helplessness—are taken into account. A key area of instruction

in this model is social skills—the abilities to assert oneself, initiate contact, and make the other person feel comfortable.

New approaches to productivity and more inclusive research designs are also presented. Traditionally, discussions of productivity have been limited to employment, but the author stresses the value of educational and vocational activities, group membership, and participation in family and community. She also calls for closer scrutiny of employers' attitudes and prejudices, financial disincentives to productivity, and the procedures of the departments of rehabilitation, and suggests three strategies for vocational rehabilitation: identification of strengths, making them marketable, and placement in suitable jobs. The research designs commonly used in employment and other areas (including motivation) are criticized for focusing on personal characteristics that will lead to success and "screening out" persons who generally did not succeed even before injury. The author believes that research should increase opportunities for all persons with SCI.

Two additional variables that affect adjustment to SCI—the treatment environment and specific therapeutic techniques—are covered. Dispensing units of treatment and the physical design of most hospitals are said to inhibit patients' independence; greater use of behavior modification techniques and alternatives to the current rehabilitation center (self-management, transitional living, independent living, and tutorial models) are recommended. Also considered in the comprehensive sections on adjustment are demographic variables, perception of pain and body image, coping skills, and measurement of behavioral changes.

Besides the variables of adjustment, the text discusses the physical sequelae of SCI, management of acute injury, three major treatment systems, and statistics on incidence of SCI. Concluding sections are devoted to future research issues—including a new emphasis on behavior and descriptions of two approaches to measuring outcomes—and a three-stage rehabilitation program that utilizes psychologists and consists of the traditional rehabilitation center, a transitional living center, and follow-up in the community.

Throughout her extensive analysis, Ms. Trieschmann never loses sight of the goal of helping persons with SCI lead satisfying lives.

—S.J.T.

covici, p. 133-144.—Crime, Deviance and Normalization: Reconsidered, by Robert B. Edgerton, p. 145-166.—Residential Placement and Adaptation of Severely and Profoundly Retarded Individuals, by Sharon Landesman-Dwyer and Frederica MacI. Sulzbacher, p. 182-194.—Return of Retarded Adults of Natural Families: Issues and Results, by Barry Wil-ler, James Intagliata, and Nancy Wicks, p. 207-216.—Foster Family Care for Mentally Retarded People: A Qualitative Review, by James Intagliata, Nancy Crosby, and Linda Neider, p. 233-259.—Matching Developmentally Disabled Client Characteristics to Careprovider and Employer Preferences, by Patricia Sutter and Tadashi Mayeda, p. 260-264.—A Systems Approach to Community Living Skills Training, by Robert L. Schalock and Roger S. Harper, p. 316-336.—Placement Type and Client Functional Level as Factors in Provision of Services Aimed at Increasing Adjustment, by Arne T. Bjaanes, Edgar W. Butler, and Brendan R. Kelly, p. 337-350.—Service Paths Prior to Clinic Use by Mentally Retarded People: A Retrospective Study, by Louis Rowitz, p. 360-374.

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Early Management of Hearing Loss

Edited by: **George T. Mencher, Ph.D.**, and **Sanford E. Gerber, Ph.D.**

1980. xviii, 468 p. figs. tabs. Grune & Stratton, 111 Fifth Ave., New York, NY 10003. \$19.50.

THE Winnipeg Conference on Early Management of Hearing Loss was held in Manitoba, Canada, on April 26-29, 1980. This volume contains the recommendations and proceedings of the international conference. The development of speech and language in hearing impaired infants, a comparison of aural and total communication, services for families of these infants, and a model for promoting communication are addressed in the recommendations. The papers presented at the conference discussed medical management (from the pediatric, otologic, and multidisciplinary perspectives), audiological management, and evaluation—including the acoustic impedance battery and reflex testing procedures.

Partial contents are: The Team Approach to Congenital Deafness, by Marion P. Downs, p. 69-73.—The Hearing Impaired Infant: "Primary Care," by D. Robert Shea, p. 75-84.—Otological Care of the Hearing Impaired Child, by Robert J. Ruben and Gary Fishman, p. 105-119.—Impedance Measurements in Infants, by Jerry L. Northern, p. 131-149.—Hearing Aids for Infants, by Martha Rubin, p. 183-198.—Early Habilitation: A Blend of Counseling and Guidance, by Agnes H. Ling Phillips, p. 225-242.—The Mexican Approach to Early Management, by Enelda

Luttman, p. 279-292.—Acoupedics: An Approach to Early Management, by Doreen Pollack, p. 301-318.—Early Speech Development, by Daniel Ling, p. 319-333.—Management and Follow-up of Early Detected Hearing Impaired Children, by Lilly Tell, Moshe Feinmesser, and Chaya Levi, p. 355-368.—The Blind-Deaf Multiply Disabled Infant, by Kevin P. Murphy and David J. Byrne, p. 369-426.—The Effects of New United States Legislation on Services to Very Young Hearing-Impaired Children and Their Families, by Linda W. Nober, p. 427-440. The articles are thoroughly referenced.

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Educator's Resource Guide to Special Education: Terms-Laws-Tests-Organizations

By: **William E. Davis, Ph.D.**

1980. ix, 258 p. Longwood Div., Allyn and Bacon, Link Dr., Rockleigh, NJ 07647. \$17.95.

BECAUSE OF federal and state legislation on handicapped persons, the field of special education has broadened its scope recently. This sudden growth has resulted in unclear terminology in this field and a plethora of acronyms, abbreviations, tests, and references to legislation. This text is designed to clarify this situation for special educators and other persons working with children who are disabled.

The information and materials presented in this guide were gathered from four sources: the author's review of professional and lay literature, his own experience in special education, suggestions from professionals in special education and parents of handicapped children, and recommendations of instructors of special education courses. The book consists of five sections. The first and most comprehensive section defines seven types of terms, including categories of exceptional children, educational principles, psychological and medical terms, and commonly used medications. The definitions contain concrete examples, obsolete terms that some texts still employ, cross references, and alternative views on controversial terms (such as mainstreaming). The meaning of acronyms, abbreviations, and initials that are used in special education and related fields (such as rehabilitation) are supplied in the second section. Eight kinds of tests, surveys, and inventories are reviewed in the third section; suggested age ranges, purpose, use with specific populations, and date of publication or revision are indicated. Assessment of validity and reliability and discriminatory testing are discussed. The fourth section summarizes pertinent federal legislation and litigation (*Hobson v. Hansen*, *Mills v. Board of Education*, *Wyatt v. Stickney*). The last section consists of two parts: addresses of agencies and organizations concerned with disabled persons, and divisions of

special education within each state department of education.

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Ethical Decisions in Medicine. Second edition

By: **Howard Brody, M.D., Ph.D.**

1981. xvii, 421 p. figs., tabs. paper. Little, Brown & Co., 34 Beacon St., Boston, MA 02106. \$15.95.

AN ETHICAL PROBLEM arises when a person must choose one of several possible courses of action and place a different value on each action or its consequences. An introductory text for health care professionals, this book analyzes the complex considerations involved in making ethical decisions in contemporary health care. The volume features a programmed, self-instructional format.

Opening sections explain why an ethical system is important for medical professionals and presents a method of ethical reasoning that includes perception of a problem, consideration of alternatives and consistency, anticipating consequences of choices, and comparing consequences with personal values. Four major issues in modern medicine are then discussed: the doctor-patient relationship (confidentiality), informed consent (patient autonomy and respect), terminal care (quality of life), and participation in making ethical decisions (by patients and their families). The author applies ethical standards to specific cases in order to test their practicality and seeks general principles that can be universally applied.

The process of making ethical decisions is also demonstrated in eight common situations, including behavioral control (through drugs, conditioning, and psychosurgery), persons participating in research, use of limited resources (such as kidney machines), active and passive euthanasia, mass screening for genetic disorders, and social responsibilities of health care professionals. Concluding sections define health and disease in terms of ethical values and address the relationship between empirical facts and values. Among the nine appendixes are alternative ethical methods, a patients' bill of rights, and recommendations for physicians performing clinical research.

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Evaluation of Sensibility and Re-education of Sensation in the Hand

By: **A. Lee Dellon, M.D.**

1981. xiv, 263 p. figs. tabs. Williams & Wilkins Co., 428 E. Preston St., Baltimore, MD 21202. \$35.00.

IN RECENT YEARS neurophysiologists have used electron microscopy to understand the sensory receptors in the fingertip and to evaluate sensibility following nerve injury, while surgeons have acquired new knowledge about the function of the hand, such as

the different qualities of sensory function. Yet due to specialization there has been little contact between these two fields. The purpose of this text is to help hand surgeons, neuroscientists, and therapists to work cooperatively in the treatment of patients with injured peripheral nerves. The comprehensive review of the literature includes translations from foreign languages and unpublished scientific reports.

The three main sections of the text cover background information, evaluation of sensibility, and re-education of sensation. The source of current misconceptions about the morphology and physiology of sensory receptors is examined, and these inaccuracies are corrected through a contemporary model of the glabrous skin and an interpretive summary of modern neurophysiology. Sensory end organs after denervation and reinnervation are also discussed. The author then presents the evolution of his technique for evaluating sensibility, including a historical review of sensory testing and a comparison of alternative methods. Based on neurophysiology, this technique encompasses the pattern of sensory recovery following nerve repair, the use of vibratory stimuli administered by tuning forks for peripheral nerve problems, and the concepts of "moving-touch" and "constant-touch." The relevance of previous clinical tests is summarized and the use of the author's evaluative scheme in all potential clinical settings is described. The last section provides a method of sensory rehabilitation that is consistent with this evaluative technique. This method emphasizes specific sensory exercises at the appropriate time in the recovery process; the exercises stress finger movement and object recognition. Numerous vertical sections, models, and plates add to the value of this authoritative and well-referenced text.

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Golf God's Way

By: **Gus Bernardoni**

1978. 224 p. figs. photos. Creation House, 499 Gunderson Dr., Carol Stream, IL 60187. \$9.95.

AS A RESULT of a parachuting accident during World War II, Gus Bernardoni damaged his spinal column and lost the ability to move his right leg. After successful surgery for these problems a doctor recommended that he take up golf as a means of therapeutic exercise. Finding popular golfing techniques too painful for him, Bernardoni developed a personal approach to the game that did not aggravate his back problems and enabled him to become a professional golfer and respected instructor of both disabled and nondisabled persons. This book presents Bernardoni's method of "allowing the body to coordinate instinctively with the action of the golf club"

BOOK REVIEWS

and encourages handicapped persons to enjoy the benefits of golf according to their abilities.

Golfers are advised to avoid anxiety over their performance and the difficulties of a course, and instead focus their attention on natural, harmonized movements. They are also told to use a comfortable style suited to their level of skill rather than try to follow the complex instructions of others. Bernardoni emphasizes that "trying too hard often stimulates effort which impedes natural movement." In his golfing method, the lower portion of the body balances the leading motions of the upper body. The fundamentals of the game—grip, addressing the ball, stance, and swing—are clearly explained, and pitch shots, tap shots, and putting are discussed in detail. These techniques are depicted in numerous illustrations and photographs.

Specific adaptations of this method are described for persons with one arm, those with one leg, and blind persons (including determining the placement of the ball and use of an aide on the golf course). Suggestions are also offered for persons with heart or respiratory problems (moving hands and arms from the shoulder joints to avoid tension and strain), elderly persons (adjustment in use of clubs), persons with arthritis (a modified grip and pushing with the body), and those with back problems (avoiding shifting weight and initiating action with the hips). This book introduces handicapped persons to a challenging form of recreation.

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A Handbook on Stuttering. Third edition

By: Oliver Bloodstein, Ph.D.

1981. 477 p. paper. National Easter Seal Society, 2023 W. Ogden Ave., Chicago, IL 60612. \$10.00 (plus \$1.00 for mailing).

SINCE THE RESEARCH on stuttering is too vast for one volume to treat all aspects comprehensively, this book is intended as a guide to the literature for those who want to explore specific topics in depth. To this end citations to relevant publications and articles are comprehensive (nearly 1500) and encompass subjects that are only mentioned briefly. This revised and enlarged text also incorporates the findings of studies conducted since the publication of the 1975 edition (See *Rehab. Lit.*, Aug., 1975, #420), including investigations on symptomatology, the fluent speech of persons who stutter, the central processing of speech, voice-initiation time, the effects of contingent stimuli, and outcome of therapy.

Viewing stuttering as an "anticipatory struggle reaction," the book opens with sections on symptomatology—measurement of stuttering behavior, physiological and acoustic descriptions of this handicap, four

phases of its development—and theories of stuttering, including hypotheses about the moment of stuttering, etiology, and new theoretical frameworks. The validity of these theories is then assessed through consideration of studies on prevalence and incidence. A substantial section is devoted to characteristics of persons who stutter, such as physical health, lateral dominance, motor abilities, sensory and perceptual processes, and personality. Various abilities of persons who stutter are compared with those of persons without this disability, and areas for future research are identified. Another major area of research—the distribution and frequency of stuttering—is addressed, and the limited knowledge on early stuttering is reviewed to determine its possible relationship to normal disfluency (the avoidance and continuity hypotheses are considered here). This wide array of material is summarized succinctly, and interpretations and viewpoints are proposed. A concluding section provides a comprehensive discussion of treatment that emphasizes current practices (operant conditioning, use of speech patterns, programmed applications) and compares the results of numerous treatment methods. A snazzy new cover and evidence of scrupulous proofreading add to the value of this essential reference.

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Health Services Directory: A Topical Guide to Clinics, Treatment Centers, Rehabilitation Facilities, Counseling/Diagnostic Services, and Care Programs, with Descriptions of Related Human Service Institutions, Agencies, Associations, and Other Sources of Information for Each Topic. First edition

Compiled and edited by: Anthony T. Kruzas and others

1981. x, 620 p. Gale Research Co., Book Tower, Detroit, MI 48226. \$60.00.

A COMPANION VOLUME to Dr. Kruza's *Medical and Health Information Directory* (see *Rehab. Lit.*, June-July, 1978, #326), this directory covers services for both universal concerns—such as birth, aging, and hospice care—and specific handicapping conditions—including impaired vision, cystic fibrosis, and multiple sclerosis. Over 19,000 entries are grouped into 34 chapters, which describe organizations that address such problems as arthritis, burns, cancer, drug abuse, muscular dystrophy, chronic pain, and spinal cord injury. Separate sections are devoted to mental health centers, preventive medicine programs, genetic service centers, home care, and rehabilitation facilities. Most services are organized by state. The arrangement and scope of each chapter is explained in an introduction; pertinent federal agencies and national organizations, including their publications, are indi-

Independent Living as a Framework for Research

TWO KEY ASSUMPTIONS of the independent living (IL) movement are that the environment can limit disabled persons' participation in society and that, in addition to physical functioning and employment, measurements of rehabilitation outcome should consider quality of life. Demonstrating the importance of accessibility, this study presents a research model based on the theory and values implicit in the IL movement and employs the model as a means of determining the outcome of disability. The principal source of data was a computer file of 111 persons with spinal cord injury (SCI).

Environmental Accessibility and Independent Living Outcomes: Directions for Disability Policy and Research

By: Gerben DeJong, Ph.D.

1981. Publications, University Center for International Rehabilitation, D-201 W. Fee Hall, Michigan State Univ., East Lansing, MI 48824. \$8.00.

The opening section traces the development of the concept of IL from a social movement to an analytic paradigm. The constituency of the movement, relevant legislation, and IL's relation to other popular social movements (such as civil rights) are summarized. Two paradigms, or frameworks for identifying and solving problems, are then compared: the rehabilitation approach, in which professionals try to help disabled individuals become more motivated, perform the activities of daily living (ADL), and adjust psychologically; and the IL paradigm, in which disabled persons achieve greater control of their lives through peer counseling, advocacy, self-help activities, and removal of barriers and disincentives. Utilizing the IL paradigm, the study identifies and ranks variables reflecting IL values and specifies the outcomes consistent with the goals of the IL movement.

The extensive literature on SCI is interpreted in terms of the IL paradigm. Consideration of the prominent themes shows that the current emphasis on ADL and personal adjustment originated when persons with SCI had a much shorter life expectancy, that since their longevity has now increased productivity and unstructured environments should be studied, and that the value of

motivation and cooperation with professionals as predictors of outcome is questionable.

The theoretical background and literature review offer a context for the featured research model and methodology. In this model IL outcomes are defined as a function of four types of independent variables: socioeconomic characteristics (age, sex, education), disability-related variables (severity, duration), environmental variables, and assistive devices and aids. The analysis focuses on 6 environmental variables: attendant care, housing, transportation, economic disincentives, the patient role (degree of medical supervision), and services needed and received. Participating rehabilitation centers, selection of the study group, and the use of six analytic instruments are outlined, and the research's value judgements are clarified. An in-depth profile of the study group—including Barthel index scores, place of residence, and sources of income—indicates a high degree of medical instability and readmission to hospitals, which directly affect independence and suggest a need for further investigation of these problems.

Development of the study's measures of outcome (a complex system of ranking and weighting) and the degree of independence attained by the group members are then described. Living arrangement and productivity were found to be very different dimensions of independence, and variables predictive of one of these factors were not necessarily predictors of overall outcome. Multiple regression analysis was performed with living arrangement, productivity, and overall IL outcome as the dependent variables. Significant findings of regression analysis of the 6 environmental variables were: there was no clear relationship between home barriers and outcomes, transportation played a major role in promoting independent living, the disincentives variable was a strong predictor of productivity, persons with more severe disabilities were more likely to encounter environmental barriers, and there was a dynamic relationship between personal limitations and environmental barriers.

Also discussed are implications of the study's finding on "the important role of environmental support systems in fostering IL outcomes" for both disability policy and research; these implications involve specification of variables, other disability groups, and attendant care.

—S.J.T.

BOOK REVIEWS

cated at the conclusion of each chapter. Appended are descriptions of national associations providing information and services in areas not covered in the text, nonprofit voluntary agencies that can supplement the organizations described in the directory, and information and referral services in large metropolitan areas. This comprehensive reference also includes an index of organizations and key works.

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Leisure Programs for Handicapped Persons: Adaptations, Techniques, and Curriculum

By: Paul Wehman, Ph.D. and Stuart J. Schleien

1981. xi, 266 p. figs., tabs. paper. University Park Press, 300 N. Charles St., Baltimore, MD 21201. \$21.95.

SEVERELY DISABLED PERSONS who are returning to the community due to deinstitutionalization must learn new ways to use their increased leisure time, and those remaining in institutions can benefit from novel forms of activity. The value of therapeutic recreation is recognized in both P.L. 94-142 and recent federal regulations for rehabilitation services. Intended for teachers and therapists working with persons with all levels of mental retardation, serious emotional disturbances, and severe sensory impairments, this book explains how to implement leisure education programs for both children and adults. The sequenced, behavioral methods are designed to help disabled persons participate in regular and adapted activities.

In the opening section, Ronald P. Reynolds discusses the principle of normalization, its implications for leisure programs, and new roles of specialists in this field. Next considered are areas of competency that can be assessed in disabled persons—including proficiency in using objects or materials, length of self-initiated action, preferred materials, and frequency and duration of social interactions—and guidelines for selecting leisure skills to be taught—such as level of functioning, clients' interests, age appropriateness, and support of the home environment. The development of a recreational program, the goal of which is to facilitate self-initiated and independent use of leisure time, is described; the process of translating behavioral goals into instructional techniques is delineated. The rationale, historical background, and philosophies of adapting recreational activities are summarized, and five types of modifications—material, procedural, skill sequence, community-based facility, and lead-up activity—are presented, along with guidelines on the logistics of adapting activities.

A substantial portion of the text is devoted to numerous activities comprising a systematic recrea-

tional curriculum. Four categories of activities—object manipulation, games, hobbies, and sports—are provided in a standardized format consisting of the instructional objective, required materials, verbal cue, task analysis, and guidelines or special adaptations. These activities (using an instamatic camera, participation in major sports, musical games, using a telephone) were culled from a group of 600 that were field-tested by severely handicapped children in public schools, and are designed to develop 12 cores skills (head control, concentration, motor skills, unsupported standing). The authors' instructional methods are illustrated in 4 case studies of data-based behavioral programs in which students successfully acquired skills. This practical book emphasizes normalization, integration of handicapped and nonhandicapped students, participation by all disabled persons, and application of learning to community settings.

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Normal and Handicapped Children: A Growth and Development Primer for Parents and Professionals

By: Wilbur S. Thain, M.D., Glendon Casto, Ph.D., and Adrienne Peterson, R.P.T.

1980. vi, 258 p. figs. tabs. PSG Publishing Co., 545 Great St., Littleton, MA 01460. \$16.50.

CONCERNED PARENTS often ask their pediatricians if certain aspects of their children's development are "normal" or appropriate for their age level. This book assures parents that children have different rates of growth and development and discusses signs that indicate lack of progress or possible problems. The authors emphasize the value of early intervention programs when handicaps are detected.

The first part of the text begins with explanations of developmental norms, standard deviations, and the process of growth and differentiation. Six major areas of development are then explored: physical, intellectual, verbal, sensory and perceptual, self-care, and social-emotional. The major concepts in each area are explained. The average age at which children acquire specific skills is indicated, noting that individuals will vary from the mean and simultaneously develop several skills. This part presents guidelines for making decisions about assisting children and concise charts summarizing characteristics of developmental stages.

Handicapping conditions are the subject of the second and more comprehensive part of the book. Information on diagnostic procedures (such as amniocentesis), prevention, and developmental disabilities is followed by a discussion of genetics and genetic disorders. Separate sections are devoted to the major disabilities of mental retardation, Down's

syndrome, cerebral palsy, and epilepsy. Methods of prevention and treatment are cited in each of these sections. Miscellaneous medical syndromes (Trisomy-18, Turner syndrome, phenylketonuria), learning and behavioral disorders, and emotional disabilities are also addressed. Educational programs for handicapped children (including infant stimulation) and plans for future treatment are covered, and a method of documenting a child's growth and development is recommended. Appended are a glossary, a directory of services, and an annotated bibliography.

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Sexuality, Law, and The Developmentally Disabled Person: Legal and Clinical Aspects of Marriage, Parenthood, and Sterilization

By: Sara F. Haavik and Karl A. Menninger, II, J.D.
1981. xiii, 191 p. tabs. paper. Paul H. Brookes Publishing Co., P.O. Box 10624, Baltimore, MD 21204. \$13.95.

MAJOR clinical and legal issues have prompted a reexamination of laws requiring sterilization for developmentally disabled persons. Among these are the extension of rights of treatment and appropriate public education to these persons, the realization that the label of mentally retarded has been inappropriately applied to persons with diverse abilities, and the inequity of prohibiting developmentally disabled persons from having children while no such laws apply to others judged unfit for parenthood, such as alcoholics. Without drawing oversimplified conclusions about the complex and controversial topics that are addressed, this book surveys research studies and recent laws and cases on the sexual behavior, sterilization, and family status of mentally retarded persons. The emphasis is on developing guidelines for sexual behavior and nonpunitive responses to problems.

An overview of the sexual behavior of developmentally disabled persons gives a sample of the sexual attitudes of the staffs of institutions for these persons and recommends sexual education for these staffs, patients, and their parents. The inequities of laws restricting marriage among this population, which are termed "anachronistic and ineffective," are demonstrated by pointing out their violations of equal protection and due process. Cited are studies in this area showing that mentally retarded persons with higher IQ's married more frequently with a lower rate of divorce, and that many mentally retarded couples had financial problems, did not have many friends, and required the assistance of social service agencies.

Sections on parenthood state that there is no relationship between IQ and success as a parent, that many children of mentally retarded parents function in an average range of intelligence, and that there are

educational alternatives for these parents. The child-neglect laws are also examined, and recommendations are made regarding increased procedural safeguards, trying other solutions before termination is ordered, and more specific grounds for neglect and termination. In sections on sterilization, the history of this practice among mentally retarded persons is reviewed, the procedures and complications of vasectomy and tubal ligation are described, and the goals of counseling on this topic are indicated. Also considered are two major cases pertaining to sterilization (*Buck v. Bell* and *Stump v. Sparkman*), the elimination of eugenic prejudices from laws, and the trend toward deciding on sterilization on a case-by-case basis.

Since developmentally disabled persons are entitled to the same sexual experiences and information as others and since these persons are more vulnerable to exploitation when they are not informed, the authors strongly recommend sex education and premarital training programs for this population. The concluding section discusses these programs, including community support, use of birth control, behavioral approaches, training instructors, and policies and procedures for responding to inappropriate sexual behavior in community programs. Commercially available materials that can be used in these programs are appended. Providing thorough coverage of a timely subject, this book should be useful to legal advisors and the therapists of developmentally disabled persons.

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Stroke: How to Prevent It/How to Survive It

By: Gloria Jean Sessler

1981. 278 p. paper. Prentice-Hall, Englewood Cliffs, NJ 07632. \$6.95.

OVER THE PAST TWO DECADES significant progress has been made in understanding the causes of stroke, and new techniques for the treatment of persons who have had a stroke have been introduced. Optimistic about these new developments, the author discusses the prevention and treatment of stroke in a comprehensive and straightforward manner.

The classification of strokes and descriptions of brain anatomy and the circulatory system are followed by a discussion of transient ischemic attacks. The main portion of the text is devoted to factors that increase the risk of stroke and how they can be controlled. The effects of hypertension, atherosclerosis, hyperlipidemia, diabetes, smoking, oral contraceptives, and stress are explained for the understanding of the layman, as are the tests used to diagnose cerebrovascular disease. The neurological deficits and psychological problems that result from a stroke are addressed, and medical and surgical procedures used after a patient has stabilized are outlined (including

BOOK REVIEWS

endarectomy and cerebral bypass). Also covered are the process and goals of rehabilitation, the roles of the members of the rehabilitation team, the primary methods used in speech therapy and physical therapy, alternative forms of care, and assistive devices. The cases of famous persons who have had a stroke are summarized.

Featuring extensive information on prevention and concise explanations of diagnostic tests, Sessler's book is one of several texts on stroke that have been published recently. Jay's *Help Yourself: A Handbook for Hemiplegics and Their Families* (Rehab. Lit., Jan.-Feb., 1981, #5) offers useful advice on sexuality, developing occupational and recreational skills, and obtaining assistive devices. The focus and intended audience of Frees's *Stroke: The New Hope and the New Help* (R.L., Mar.-Apr., 1981, #97) are similar to that of Sessler's book; the former also contains a directory of relevant organizations. As its title suggests, *What Every Family Should Know About Strokes*, by Hess and Bahr, (R.L., July-Aug., 1981, #253) stresses the crucial role of the families of persons who have had a stroke. The value of this book lies in its coverage of the psychological effects of stroke and aspects of long-term rehabilitation, as well as the numerous additional resources that are listed.

331

Total Communication Used in Experience Based Speechreading and Auditory Training Lesson Plans: For Hard of Hearing and Deaf Individuals

By: Marta E. Baucom and Ralph E. Causby

1980. ix, 149 p. Charles C Thomas, Pub., 301-327 E. Lawrence Ave., Springfield, IL 62717. \$12.50, cloth; \$7.75, paper.

BETWEEN 1976 and 1979, students in aural rehabilitation classes at the University of North Carolina at Greensboro wrote speechreading lesson plans for deaf children and adults. Through observations and interviews the students were able to construct lesson plans based on the experiences, professions, and interests of the deaf persons. Intended for teachers of deaf students in residential and public schools, speech pathologists, and audiologists, the lesson plans presented in this volume are the results of the university students' efforts.

An introductory section reviews older literature (before 1945) on speechreading (including the Jena, Nitchie, and Bruhn methods) and auditory training (such as recommendations for individualized instruction), as well as recent material on these topics. The advantages of total communication are explained. The skills addressed by the four methods of speechreading instruction used in the lesson plans are then described: quick recognition exercises—visual percep-

tion; quick identification exercises—retention of visual imagery and association of a pattern with related words; sentence exercises—association and changes in conversation; and stories—use of contextual clues and short- and long-term memory. Auditory training in these lessons progresses from identifying one or more syllable individually and in sentences, to understanding words, to differentiation of words having minimal distinguishing features. The use of FM-type auditory trainers in instruction is considered. The standardized procedures for all the lesson plans are clearly outlined.

The major portion of the text consists of eight lesson plans for preschool children, 34 plans for school-age children, and 21 plans for adults. The lesson plans for each age group are focused on specific topics, such as a nursery rhyme, an easter egg hunt, and gardening. Recommendations are made for developing additional plans, and a form for collecting data is supplied. Interviews with hearing impaired persons in specific professions and descriptions of the visible components of speech are appended. A bibliography is also included.

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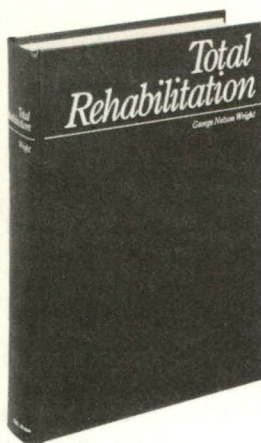
The Wheelchair Gourmet: A Cookbook for the Disabled

By: Mary Blakeslee

1981. 192 p. spiralbound. Beaufort Books, 9 E. 40th St., New York, NY 10016. \$8.95.

HUNDREDS of cookbooks are published each year, and bookstores prominently display a myriad of titles to tempt most every palate. However, a person with a physical disability, particularly one who uses a wheelchair, can find few cookbooks helpful in preparing meals. This book offers recipes of all kinds and methods for preparing food easily and efficiently. Many of the recipes have an international flavor, yet they are simple and well-organized with an emphasis on natural grains, low sugar, high protein, and high-bulk ingredients. Mary Blakeslee shares her cooking skill developed during 15 years of adapting techniques and recipes from her own vantage point in a wheelchair. She offers helpful hints and a selection of kitchen aids for preparation and cooking; the use of small appliances, such as a blender, food processor, and electric skillet, are advocated for specific recipes. Ranging from brown rice muffins to beer and gingersnaps beef to "Cheating Chocolate Mousse," the recipes have few ingredients and include easy-to-follow instructions that are spiced with light and humorous comment. This cookbook offers a helpful and exciting approach to mastering the art of cooking and managing in the kitchen. It should be enjoyed by a large audience.

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Total Rehabilitation

By George Nelson Wright, Ph.D.,
University of Wisconsin, Madison

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—Adrian Towne,
in *Rehabilitation Literature*

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By Thomas O. Mooney,
Theodore M. Cole, M.D., and
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By Norman R. Bernstein, M.D.

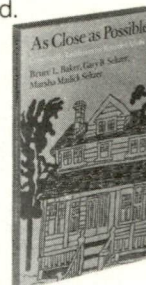


In this provocative and compassionate book, the author—an experienced psychiatrist at one of the country's foremost burn treatment centers—

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Abstracts of Current Literature

This section serves as an index to current publications reviewed, digested, or abstracted in this issue. The author index for each issue can be found on the inside back cover. The annual index, of authors only, is published at the end of the calendar year.

ACCESSIBILITY

See p. 303.

ACCESSIBILITY—BIBLIOGRAPHY

333. Project SHARE

Accessibility of human services. Rockville, Md., The Project, 1980. v, 46 p. paper.

The Project SHARE *Human Services Bibliography Series* consists of abstracts of documents from its collection on topics that reflect the current interests of the users of this information center. This publication is devoted to the literature on the informational, administrative, attitudinal, cultural, and physical barriers that limit access to human services. The review of the literature addressed the issues of approaching combinations of constraints in their entirety and tailoring solutions to specific environments. The purposes of this booklet are to provide an understanding of the relationship between variables that cause barriers and to indicate documents that should help practitioners make their services accessible. The format of the citations includes name and address of author, date of publication, number of pages, price and ordering information, and a thorough description of contents. An alphabetical list of authors and an index of titles complete the text.

Further information on this publication is available from Project SHARE, P.O. Box 2309, Rockville, MD 20852.

ADOPTION—PROGRAMS

334. U.S. Office of Human Development Services. Administration for Children, Youth and Families

Adoption project for handicapped children: Ohio District 11. Washington, D.C., The Admin., 1980. vi, 112 p. tabs. paper. (DHHS Pub. No. OHDS 80-30289)

The Ohio District 11 Adoption Project for Handicapped Children was a federally funded demonstration project designed to find families for children with physical, emotional, and developmental disabilities. The project, which was conducted jointly by 4 county agencies, showed that recruitment efforts and careful preparation of families can lead to successful adoption for these children and reduce the time they must spend in public care. The basic philosophy and specialized methods of the project, which resulted in the placement of 59 handicapped children, are described in this final report.

Agencies planning to replicate this model are advised to focus on prerequisite regional conditions, inter- and intraagency coordination, staffing patterns and costs, and practical aspects of programing (prepa-

ration of children for placement, communication between project staff and the foster care worker, emotional support for families, and involving foster parents). In addition to these topics, the report discusses staff education and training, post-placement services, disruption of adoption, communicating the project's goals, obtaining support from the community, and evaluation of the program. A substantial portion of the functional text consists of appended material, including administrative forms, outlines for group sessions, and a cost analysis of project placements. The comprehensive booklet should help simplify the adoption process for a greater number of disabled children.

Additional information on this publication is available from the Children's Bureau of the U.S. Office of Human Development Services, 200 Independence Ave., S.W., Washington, DC 20201.

AGING

335. U.S. Office of Human Development Services. The Federal Council on the Aging

The need for long term care: Information and issues. Washington, D.C., The Council, [1981]. v, 90 p. figs. paper. (DHHS Pub. No. OHDS 81-20704)

The third in a series of documents on long-term care of elderly persons issued by the Federal Council on the Aging, this booklet presents data on the key issues pertaining to the health of this population. Together the 3 documents provide preparatory information for the 1981 White House Conference on Aging. This chartbook reviews historical data, notes present trends, and makes projections for the future. Five categories of information are covered: base-line demographic material, health status, use of health services, informal support for elderly persons (spouses, children, other family members), and the impact of relevant federal policies. Important interrelationships are made between topics of investigation, such as age and disability, education and income, minority status and longevity, and living alone and being female.

Additional information on this publication is available from the Federal Council on Aging, Office of Human Development Services, 200 Independence Ave., S.W., Washington, DC 20201.

See also 316, 373.

AGING—INSTITUTIONS

336. Cohen, Jack C.

The new National Lutheran Home: A concept providing for the changing needs of the elderly. *Nursing Homes.* Jan.-Feb., 1981. 30:1:15-18.

A new residential center for elderly persons—the

National Lutheran Home for the Aged in central Maryland—is described. Housing elderly persons with a range of abilities, the center provides comprehensive services and activities in a campus atmosphere. The innovations in this center resulted from a 1972 study of the existing National Lutheran Home that accounted for changes in the elderly population. The right to privacy and accommodation of both dependent and active persons were key considerations in planning the facility, which consists of 8 small units and 3 unit villas for more independent residents. Special attention was given to making the center's corridors attractive because so many of the residents congregate in these areas. Also included in the center are day care for elderly persons in the community and specialized medical facilities for persons over 84 yrs. of age. Also described are details of the design, layout, furnishings, and color-coded decor. A photograph and a floor plan are included.

Nursing Homes is published by Heldref Publications, 400 Albemarle St., N.W., Washington, DC 20016.

ANIMAL TRAINING

337. Curtis, Patricia

Animals are good for the handicapped, perhaps all of us. *Smithsonian*. July, 1981. 12:4:49-52, 54-56.

Handicapped persons derive various benefits from the nonexploitative use of animals. This article describes programs that use animals in therapeutic recreation for disabled persons and summarizes recent theories on the value of animal companionship. The Cheff Center for the Handicapped in Augusta, Mich., offers horseback riding for children with physical and learning disabilities. In addition to giving children a sense of accomplishment, riding has helped to stretch the adductor muscles of children with cerebral palsy. Volunteers from the Anti-Cruelty Society in Chicago bring pets to elderly persons in a health center and hospitalized children. A puppy was instrumental in motivating one elderly woman who had a stroke to communicate with people again, and the confined children are said to enjoy the diversion that the pets provide. Pets are prevalent at Lima State Hospital for the Criminally Insane in Ohio, where they have been used to establish trust and communication between therapists and prisoners. Photographs of the animals being used in the programs are included. Also discussed is the Center for the Interaction of Animals and Society, where research suggests that the bond between humans and animals can be salubrious for all persons.

Smithsonian is published by Smithsonian Associates, 900 Jefferson Dr., Washington, DC 20560.

APHASIA

338. Blanchard, Sumner L. (Dept. of Communicative Disorders, Univ. of New Mexico, 608 Buena Vista, N.E., Albuquerque, NM 87131)

The effects of temporal expansion upon auditory comprehension in aphasic adults, by Sumner L. Blan-

chard and Thomas E. Prescott. *Brit. J. Disorders Communication*. Sept., 1980. 15:2:115-127.

The temporal expansion of speech is defined as the electronic replication of adjacent segments of a recorded speech signal, which extends that signal to a specified duration. This study investigated the effects of temporal expansion of verbal language on the auditory comprehension of adults with aphasia. Twenty-three persons with this disability and 23 non-handicapped persons received an unaltered and 3 temporally expanded versions of the Revised Token Test (RTT). Nonhandicapped participants responded to test stimuli under all conditions of temporal expansion with greater accuracy of performance and less latency of response than did the persons with aphasia. Although certain members of the latter group demonstrated significant improvement in their accuracy of performance on test stimuli, actual score differences from expanded conditions were insignificant. These same persons did not have characteristics that distinguished them from disabled participants whose performance did not improve. Also, neither group showed significant differences in their respective latency of response during the 4 experimental conditions. Manipulation of the signal-pause relationship is recommended as a focus for future research. Tabular data included. (36 refs).

ARCHITECTURE

See 357.

ATTITUDES

See 349.

BEHAVIOR MODIFICATION

339. Arkansas Rehabilitation Research and Training Center

Behavior management manual: Procedures for psychosocial problems in rehabilitation, by John N. Marr and Bob L. Means. Hot Springs, Ark., The Center, 1980. figs., tabs. paper.

Rehabilitation workers who spend the most time with clients (instructors, evaluators, recreational therapists, counselors) encounter numerous behavioral problems in the course of their work and are in an excellent position to help clients with these problems. This functional text provides professionals who do not have training in psychology with systematic methods of responding to clients' behavior in work and social settings. These methods are designed to help disabled persons obtain and hold jobs and participate in group activities.

Three aspects of bringing about behavioral change are emphasized: identification of problems in terms of observable behavior instead of labels, quantification that allows for the accurate estimate of the problem's severity and evaluation of assistance, and treatment based on social-learning theory and behavior modification. Suggestions are made for using the manual, including consultations with psychologists, experimenting with different procedures, recording success, demonstrating negative consequences of certain be-

haviors, and becoming aware of individual biases. The 7 major sections are devoted to the identification and measurement of problems, behavior that interferes with employment, 4 specific types of behavior (dependent, aggressive or hostile, withdrawn, and immature), and complaints about somatic conditions. The rationales for various behavioral techniques are discussed. This well-organized text is replete with examples of how to measure clients' behavior, procedures for observing and treating disabled persons, and alternative responses to problems.

Additional information on this publication is available from Arkansas Rehab. Research and Training Center, Hot Springs Rehab. Center, P.O. Box 1358, Hot Springs, AR 71901.

BRAIN INJURIES

340. Lynch, William J. (*Brain Injury Rehab. Unit (205B1), VA Medical Center (MPD), 3801 Miranda Ave., Palo Alto, CA 94304*)

Brain injury rehabilitation: Standard problem lists, by William J. Lynch and Nancy K. Mauss. *Arch. Phys. Med. & Rehab.* May, 1981. 62:5:223-227.

A variety of problem lists have been developed since the introduction 10 yrs. ago of the Problem-Oriented Medical Record (POMR), which has been found to be effective in general medical, surgical, psychiatric, and rehabilitation settings. This article describes the development of a standard problem list for use in brain injury rehabilitation and explains its application in a typical case. The list contains 5 categories of problems: cognitive, sensory motor, medical, emotional, and social. The standardized list is said to facilitate efficient identification of problems and specific plans and to offer a more uniform approach to evaluation of progress. The difficulties involved in formulating a problems list include evaluation of criteria for determining if a problem exists, the tendency to generate an unnecessarily lengthy list, and disagreement in terminology. (16 refs.)

BURNS

341. Stramba, Lorraine M.

Early motion and splinting of hands following burns: A literature review. *Can. J. Occupational Therapy.* Feb., 1981. 48:1:27-32.

Acute burns of the hand represent transient postural changes that can be readily corrected by early treatment techniques. After consideration of the features of exposure and contact burns and the prognosis for this disability, this article discusses the management of the burned hand in 2 phases: early—from time of injury to wound closure, and late—from wound closure to maximal return of function. The depth of burn to the hand, extent and location of burn, associated injuries, and age and cooperation of the patient determine the choice of management in the early phase. The goals of rehabilitation during this phase are to improve and maintain function and to prevent the development of anatomical deformities; these aims are accomplished through a program of

early motion (both passive and active) and proper positioning of the hand (usually with splints). The rationale and techniques of these 2 approaches are thoroughly described. Treatment of deep dorsal burns in the late phase consists of techniques that address the following pattern of deformity: metacarpophalangeal joint hyperextension, interphalangeal joint flexion, thumb adduction and extension, bunching of the metacarpal heads with loss of transverse palmar arch, and background displacement of the second and fifth metacarpals. Pressure and various types of splinting are recommended for these problems. A bibliography is included. (32 refs.)

Canadian Journal of Occupational Therapy is published at 641 Belmont Ave., Westmount, Quebec, H3Y 2W3 Canada.

BURNS—MENTAL HYGIENE

342. Davidson, Terrence N. (*4218 School of Education Bldg., Univ. of Michigan, Ann Arbor, MI 48104*)

Social support and post-burn adjustment, by Terrence N. Davidson and others. *Arch. Phys. Med. & Rehab.* June, 1981. 62:6:274-278.

To ascertain some of the physical and psychosocial adjustments of severely burned persons, interviews were conducted with 314 persons who had been treated for this injury at a major burn center between 1956 and 1976. The interviews focused on standard socioeconomic data and post-treatment life patterns, including employment and attendance in educational programs. The data show that social support is both directly and indirectly related to patients' post-burn adjustment. Measures of social support from family, friends, and peers were significantly related to several subjective assessments, including life satisfaction, self-esteem, and participation in social and recreational activities. Evidence was found suggesting that social support affects the rehabilitation process, independent of the severity of the burn. The findings challenge the commonly accepted theories about the relationship between psychosocial problems and severity of injury. Tabular data are included.

CEREBRAL PALSY

343. Bowen, J. Richard (*Alfred I. duPont Inst., The Nemours Foundation, P.O. Box 269, Wilmington, DE 19899*)

Treatment of extension contracture of the hip in cerebral palsy, by J. Richard Bowen, G. Dean MacEwen, and Pamela A. Mathews. *Developmental Medicine & Child Neurol.* Feb., 1981. 23:1:23-29.

Hip extension contracture is characterized by shortness of the hip extensor muscles, causing limited hip flexion. This study involved 20 persons with cerebral palsy who had a total of 35 extension contractures of the hip resulting from tightness of gluteus maximus or hamstring muscles, with associated quadriceps muscle spasticity. Associated problems included anteriorly dislocated hips, lumbar lordosis, thoracic kyphosis, and calcaneus feet. These persons' functioning was improved by active and passive exer-

cises, surgical release of contractures, and reduction of anteriorly dislocated hips. It is suggested that flexor or adductor tenotomies should be considered cautiously for persons with spastic hip extensor muscles because severe extension contracture may develop after these procedures. Included are photographs illustrating extension contracture of the hip and tabular data.

CEREBRAL PALSY—PARENT PARTICIPATION

344. Tarran, Elizabeth C. (*Senior Social Worker, Research, Social Services in Rural Areas Research Project, Dept. of Social Theory & Institutions, Univ. College of North Wales, Bangor LL57 2DG Wales*)

Parents' views of medical and social-work services for families with young cerebral-palsied children. *Developmental Medicine & Child Neurol.* Apr., 1981. 23:2:173-182.

Reported are the results of interviews with the parents of 67 children with cerebral palsy (CP) who received treatment at centers in Dundee and Glasgow in Scotland. Data were collected on the handicapped child's effects on family life, and on the parents' opinions of the services they received. Although half the mothers initially were unhappy about their child being away from home for part of the day at a preschool program, the majority soon found that the outside services (especially active therapy) made it easier to cope when the children were home. Almost half of the parents were dissatisfied with the way they were first told of their child's handicap, and most of them stated they had not been given enough support at this time. The following services are recommended for such families: 1) explanations of the diagnosis and information on prognosis, 2) practical assistance with daily management of the child with CP, 3) a home visitor to assist with household and emotional problems, and 4) programs for parents of handicapped children to get acquainted. Tabular data included.

CEREBRAL PALSY—PHYSICAL THERAPY

345. Sommerfeld, Donald (*5 Gallway Ct., Ann Arbor, MI 48104*)

Evaluation of physical therapy service for severely mentally impaired students with cerebral palsy, by Donald Sommerfeld and others. *Phys. Therapy.* Mar., 1981. 61:3:338-344.

The effects of 2 types of physical therapy service were studied over a 5-mo. period in 19 severely mentally impaired students with cerebral palsy, ages 3 to 22 yrs. The students were paired and assigned to either a direct therapy treatment group or a supervised therapy management group. The techniques used in each group are described. Also, 10 other students with these disabilities comprised a comparison group that did not receive physical therapy. The study found no significant differences in development of mature reflexes, improvement of gross motor skills, or increase of passive joint motion among the students in the direct, supervised, and comparison groups. This pilot study is not intended as a basis for

drawing conclusions on the value of physical therapy for persons with these handicaps. However, it does demonstrate that objective tests are reliable measurements of the 3 major areas of sensory motor development. More extensive and longer-term research is recommended to determine the best form of physical therapy for persons with both severe mental impairment and cerebral palsy. (17 refs.)

CHILDREN—GROWTH AND DEVELOPMENT

See 320, 328.

CHILDREN—GROWTH AND DEVELOPMENT—PROGRAMS

See 317.

CHILDREN'S HOSPITALS—OCCUPATIONAL THERAPY

346. Gallen, Debbi

Yes—occupational therapy can be dynamic in a chronic care setting, by Debbi Gallen and others. *Can. J. Occupational Therapy.* Feb., 1981. 48:1:19-26.

Bloorview Children's Hospital is a chronic care residential facility in Toronto, Canada, that primarily serves patients with cerebral palsy, spina bifida, and muscular dystrophy. This article describes the occupational therapy (OT) program in the hospital. The program takes place in 3 major treatment areas: an apartment fully equipped for activities of daily living, a large activity room, and a carpentry shop. Group activities are emphasized because the staff thinks that community living skills are learned best in these situations. The objectives and activities of 17 OT programs are presented, including a preschool summer program, a preschool therapy program, play groups for 3 levels of patients, 2 community living skills programs, a gross motor group, an avocational interest group, and a sex education class. The focus of these programs is continually evaluated and adapted in response to the changing needs of the population.

Canadian Journal of Occupational Therapy is published at 641 Belmont Ave., Westmount, Quebec H3Y 2W3, Canada.

CLEFT PALATE—SURVEYS

347. Geis, Nancy (*Fellow, Birth Defect Center, Tufts-New England Medical Center, 171 Harrison Ave., Boston, MA 02111*)

The prevalence of congenital heart disease among the population of a metropolitan cleft lip and palate clinic, by Nancy Geis and others. *Cleft Palate J.* Jan., 1981. 18:1:19-23.

A number of research studies have noted the increased prevalence of congenital heart disease among children with facial clefts. To further investigate the relationship between these 2 disabilities, the entire infant population (282 patients) of the Tufts-New England Medical Center Cleft Palate Clinic in Boston, Mass., was reviewed in order to calculate the prevalence rates of congenital cardiac anomalies. The over-

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all prevalence rate of congenital heart disease among the facial cleft clinic population was 6.7%. The prevalence rates for groups with the following specific disabilities were: submucous cleft palate—9.1%, congenital palato-pharyngeal incompetence—7.7%, cleft lip only—0%, unilateral cleft lip and palate—5.3%, bilateral cleft lip and palate—12.5%, cleft palate only—4.3%, Pierre Robin syndrome—13.6%, cleft lip and palate and a syndrome diagnosis—7.1%, and cleft lip and a syndrome diagnosis—16.7%. The clinic's data, which is limited to patients with potential for speech development, probably underestimate the true prevalence of congenital heart disease among unselected children with facial clefts. Another noteworthy finding was that 33% of the clinic population had isolated cleft of the palate. Tabular data are included. (15 refs.)

CLOTHING

348. Wilshire, E. R., comp.

Equipment for the disabled: Clothing & dressing for adults. Fifth edition. Oxford, England, Oxford Regional Health Authority, 1981. 44 p. photos. paper.

The latest in a series of catalogs on commercially available products from Great Britain, this booklet is focused on clothing for disabled adults. Since fashions in clothing change so frequently, the volume offers general information that will be helpful in choosing suitable, attractive styles at any time. An introductory section discusses metrification in fabrics and clothing, style, material, and care of clothes. Methods of dressing are suggested for persons with 9 types of disabilities, including hemiplegia, rheumatoid arthritis, and cerebral palsy. The clothing and aids are grouped into 11 categories, such as fastenings, underwear, nightwear, incontinence, shoes, and trouser adaptations. Each of these sections contains special considerations or recommendations for solving problems. Greater attention is devoted to women's clothing than to men's. Addresses of manufacturers, sizes and measurements, approximate prices, and photographs of the products are provided, and items that can be purchased outside of the United Kingdom are indicated.

Further information on this publication is available from *Equipment for the Disabled*, 2 Foredown Dr., Portslade, Brighton BN4 2BB, England.

COLLEGES AND UNIVERSITIES—DIRECTORIES

See 372.

CONSUMERS

349. University of Wisconsin-Stout. Stout Vocational Rehabilitation Institute and School of Education and Human Services

Courtesy needs of the disabled customer, by Sue A. Schmitt. Menomonie, Wis., Materials Development Center, 1980. iv, 107 p. paper.

As handicapped persons integrate into society, a greater number of them are using the services of hotels, restaurants, and other businesses in the hospitality industry. Developed as part of a training program for managers of these businesses, this manual explains the needs of disabled customers and presents techniques for serving them. The design of the training program included advice from handicapped persons, consumer groups, and professionals in vocational rehabilitation and the hospitality industry.

Statistics on the number of disabled persons and sensitivity exercises introduce managers to this potential sales market. The implications of visual and hearing impairments, epilepsy, and language problems are then described. The main section of the text focuses on the job responsibilities of a hostess, waitress, cashier, registration desk attendant, and bellhop, and offers specific suggestions on how these staff persons can best serve disabled customers. Role play situations, sighted guide techniques, and procedures to follow with a dog guide are included. Federal and Wisconsin state laws affecting the hospitality industry are also reviewed. Architectural barriers (in parking, entrances, interior access, restrooms, guestrooms, and housekeeping features) are illustrated in a slide/sound presentation (available from the publisher). Supplementary handouts on accessibility address problems, solutions, and costs. Among the 5 appendices are sources of additional information, suppliers of equipment, and the script of the training program's video cassette on service needs (also available).

Copies of the manual (\$10.00), the sound/slide presentation (\$30.00), and the video cassette (\$55.00) can be obtained from Materials Development Center, Stout Vocational Rehab. Inst., Univ. of Wisconsin-Stout, Menomonie, WI 54751.

CYSTIC FIBROSIS—NURSING CARE

350. Larter, Nanci (*Nurse Consultant in Pediatrics, Providence Hosp., Box 1067, Pacific & Nassau Sts., Everett, WA 98206*)

Cystic fibrosis. *Am. J. Nursing*. Mar., 1981. 81:3:527-532.

A nurse relates her clinical experiences with a 2½-yr.-old boy with cystic fibrosis (CF) and describes her interactions with the boy's family. The patient remained in the hospital for tests for 5 days, and during the year following discharge was readmitted once for pulmonary exacerbation. The article also discusses the 2 main characteristics of CF: chronic pulmonary disease marked by tachypnea, chronic cough with mucus production, barrel chest, clubbing of fingernails and toenails, cyanosis, and gastrointestinal problems (including obstruction of the ducts of the pancreas, anemia, and prolapse of the rectum). The sweat chloride test, the primary diagnostic procedure to confirm CF, is explained, and the nurse's efforts to help the boy's parents accommodate him at home are summarized. Featured are a chart of nursing care plans for the chief problems caused by CF (including family stress and the patient's psychological reactions to the disease) and an outline of the secretory and electrolytic abnormalities associated with this disease.

DEAF

See 320.

DEAF—LIP READING

See 331.

DEAF—MENTAL HYGIENE

351. Quedenfield, Carl (*Genesee County Community Mental Health Services, 420 W. Fifth Ave., Flint, MI 48503*)

Life style analysis: A method for assessing the deaf client, by Carl Quedenfield and Nyk Bartkiw. *J. Rehab. Deaf.* Oct., 1980. 14:2:8-14.

A theoretical paradigm from individual or Adlerian psychology is presented as a means of assessing the functioning of deaf persons. The major tenets that differentiate Adlerian psychology from other theories of personality are an emphasis on self-determination, a teleological view of behavior, and the theory that behavior is the result of "who that person believes himself to be." An integral concept of this theory of psychology is the person's life-style—"the totality of systems and principles which account for the consistency and directionality of an individual's life." Analysis of a deaf person's life-style can be used to help the therapist understand the client, establish rapport between client and therapist, formulate the course of treatment, and identify major skills and interests pertinent to vocational guidance.

Two types of information are elicited from deaf clients in determining their life-styles: responses to a family constellation questionnaire and early recollections. Suggestions are made for recording this information, and a life-style analysis questionnaire is provided. (14 refs.)

DECUBITIS ULCERS—PREVENTION

See 387.

DEVELOPMENTAL DISABILITIES—PROGRAMS

352. Sommers, David (*Psychologist, The Potomac Center, 1380 Marshall St., Hagerstown, MD 21740*)

A rapid method for describing the efficacy of early intervention programs for developmentally disabled children, by David Sommers and others. *Mental Retardation.* Dec., 1980. 18:6:275-278.

Although the rationale for early intervention programs (EIP) is generally understood, there is no established means of efficiently evaluating the effectiveness of these programs. Presented is a method of estimating EIP's influence on developmentally disabled children's rate of development. Based on the concept that pattern and rate of development follow a defined yet variable course, the simple graphic technique employs repeated assessments of observable skills and behaviors in 5 areas: gross motor, fine motor, adaptive behavior, personal and social behaviors, and speech and language. An initial evaluation shows the child's developmental rate on a graph

by plotting the number of skills exhibited against the child's chronological age. An individualized intervention program is then initiated, during which observers note the acquisition of new skills and behaviors. These are measured and plotted, and the difference between the slopes of the 2 lines yields an estimate of the effect of intervention. Examples of developmental rates plotted on graphs and the use of this method with 4 developmentally disabled children are provided. The clinical usefulness of this technique is considered to outweigh methodological problems in observer bias, reliability of scoring, and validity of the rate concept. The applicability and advantages of this measurement and areas for future research are also described.

DEVELOPMENTAL DISABILITIES—SEXUALITY

See 329.

DISABILITIES—FINANCE

353. Rehabilitation International and The United Nations

The economics of disability: International perspectives. New York, Rehab. Internatl., 1981. x, 238 p. figs., tabs, photos. paper.

The international rehabilitation community now realizes that the degree and consequences of disability vary according to the socio-economic conditions of each nation and the services it provides, and that disability generates costs to society other than the price of services. Presented as a contribution to the 1981 International Year of Disabled Persons, this publication consists of 3 main parts: the report of the United Nations (UN) Expert Group Meeting on the Socio-Economic Implications of Investments in Rehabilitation (held in Geneva, Switzerland, Dec. 1977), highlights of the UN study, *Rehabilitation for the Disabled: The Social and Economic Implications of Investments for this Purpose* (upon which the Expert Meeting was based), and case studies and empirical data from additional references that amplify many of the concepts and issues discussed in the UN documents. A conceptual framework for viewing disability and rehabilitation is followed by consideration of the full range of relevant economic issues: the relationship between economic and social costs, cost-benefit analysis, labor market and manpower policies, and social benefits systems. The implications of the substantial findings of the UN studies are addressed in a convenient summary. This informative and thorough text also contains a bibliography and numerous photographs of disabled persons from various countries.

Further information on this publication is available from Rehabilitation International, 432 Park Ave., South, New York, NY 10016.

DISABILITIES—STATISTICS

354. U.S. Public Health Service. Office of Health Research, Statistics, and Technology

Prevalence of selected impairments: United States—

ABSTRACTS

1977. Washington, D.C., The Office, 1981. iv, 70 p. tabs. paper. (DHHS Publ. PHS 81-1562)

Based on data collected by the 1977 Health Interview Survey, this booklet reports on the prevalence and effects of visual and hearing impairments, speech disorders, paralysis, absence of extremities, and 4 types of orthopedic disabilities. Tabular data indicate the number and rate per 1,000 persons for each type of impairment by selected socio-demographic characteristics, including age, sex, race, family income, place of residence, and geographic region. The implications of these disabilities—continual limitation of activity, number of days confined to bed or restricted in activities, frequency and degree of bother, and frequency of physician visits—are also discussed. Estimates obtained for number of persons with the following disabilities were: visual impairments—11.4 million, hearing impairments—16.2 million, speech impairments—2 million, complete or partial paralysis—1.5 million, amputation of major extremities—358,000, and amputation of minor extremities—1.9 million. Information on methods used in the survey is appended.

Further information on this publication is available from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402.

DRIVERS

355. University of Wisconsin-Stout. Driver Education for the Handicapped Safety Center

Driver education for the handicapped: A driving guide for behind the wheel instruction, by David G. Kraemer. Revised edition. Menomonie, Wis., Materials Development Center, 1980. xi, 63 p. figs., spiralbound.

A driver's license can greatly increase a handicapped person's independence and open new opportunities in employment, education, and recreation. The program of driver education presented in this manual was field-tested with persons with various disabilities at the Safety Center, University of Wisconsin-Stout. Five instructional forms—including those for a driver evaluation physical, selection of a training car, and final driving report—are provided. The major portion of the text consists of 16 structured lessons for disabled drivers, covering such skills as parking on uphill and downhill grades, changing lanes, and driving on a limited access roadway. The lessons contain behavioral objectives, reviews, new procedures, and assignments; a driver performance test makes up part of one lesson. Guidelines for teaching disabled drivers, prerequisites for students enrolling in this program, research on disabled drivers, and pertinent characteristics of mentally retarded students are also discussed. A glossary of medical terms and manufacturers of hand controls and other special automotive equipment complete this useful resource.

Copies of this publication are available for \$3.50 from Materials Development Center, Stout Vocational Rehab. Inst., Univ. of Wisconsin-Stout, Menomonie, WI 54751.

EMPLOYMENT

356. U.S. Equal Employment Opportunity Commission

Employment of handicapped individuals: Including disabled veterans in the federal government. Washington, D.C., The Commission, 1980. 85 p. tabs. paper.

Section 501 of the Rehabilitation Act of 1973 and Section 403 of the Vietnam Era Veterans' Readjustment Assistance Act of 1974 require all departments, agencies, and instrumentalities of the executive branch of the federal government to submit to the Equal Employment Opportunity Commission (EEOC) annual affirmative action plans for the hiring, placement, and advancement of handicapped persons, including disabled veterans. This booklet is the fifth such report from EEOC to the appropriate committees of Congress. Covering the period from Oct. 1978, through Sept. 30, 1980, the report contains an update of the progress that federal agencies have made in creating an equitable environment for handicapped applicants and employees, descriptions of new provisions for federal employment of these individuals, a summary of the activities of the Interagency Committee on Handicapped Employees (ICHE) and analysis of 102 recommendations adopted by the ICHE since 1975, and an explanation of the new "results-oriented approach" that EEOC has used to strengthen affirmative action programs for disabled persons. Both 1979 accomplishments and 1980 program plans are evaluated, and 1980 hiring goals are delineated. Included in the substantial appended material are data on employment by handicap status and agency and on employment of disabled veterans.

Additional information on this report is available from the Div. of Programs for Handicapped Individuals, Office of Government Employment Opportunity Commission, Attention Bailey's Crossroads, 2401 E St., N.W., Washington, DC 20506. Also available from this address are copies of EEOC's most recent affirmative action instructions to federal agencies (EEO-MD-708).

See also 391.

EMPLOYMENT—ACCESSIBILITY

357. George Washington University Rehab. Research and Training Center. Job Development Laboratory

Designing for functional limitations, by James Mueller. Washington, D.C., The Laboratory, 1979. 79 p. figs. spiralbound.

This design book is not directly concerned with architectural accessibility; instead it is focused on making work environments usable for persons with disabilities, presenting aids and modifications for this purpose. The unique format of the booklet consists of 2 sample worksites—an office and an industrial setting—that illustrate common adaptations for accommodating handicapped persons. Suggested additions to the standard designs are then recommended for 15 functional limitations, such as difficulty in interpreting information, vision and hearing impair-

ments, limited stamina, difficulty in sitting, and poor balance. Dimensions of equipment and work spaces are included in the drawings. The reverse sides of the sketches for each of these limitations list the disabilities with which they are associated and helpful aids. The use of this guidebook to determine room modifications for a man with cerebral palsy is demonstrated. Information on product suppliers and a bibliography are also provided.

Copies of this publication are available for \$10.00 from George Washington Univ. Rehab. Research and Training Center, Room 517, Ross Hall, 2300 Eye St., N.W., Washington, DC 20037.

EUTHANASIA

See 322.

HAND

See 323, 341.

HARD OF HEARING—EQUIPMENT

358. Donaldson, John D. (*Pediatric Otolaryngologist, Decatur Memorial Hosp., 2300 N. Edward St., Decatur, IL 62526*)

Hearing aids: A mystery to primary care physicians, by John D. Donaldson and Jerry L. Owens. *Illinois Med. J.* Dec., 1980. 158:6:392-394.

An introduction to amplification and a guide to helping hearing impaired persons receive satisfactory and economical fittings are provided. Questions that general practitioners can use to determine hearing acuity are enumerated, including inquiries about ringing in ears, level of noise in the working environment, and episodes of dizziness. The process of evaluation for a hearing aid—deciding which ear to amplify, manufacturing ear molds, fitting several alternative aids, instructing the patient in use and care of the instrument, and final evaluation—is discussed. The major components of a hearing aid—microphone, amplifier, and speaker—are explained and the available styles—ear level, body aid, eyeglass, and all-in-the-ear—are described. Also supplied are guidelines for selecting a dealer or dispenser of hearing aids.

HEALTH SERVICES—DIRECTORIES

See 326.

HEART DISEASE

See 347.

HIP

See 343, 385.

HIP—EQUIPMENT

359. Haworth, R. J.

Use of aids following total hip replacement, by R. J. Haworth and J. Hopkins. *Brit. J. Occupational Therapy.* Dec., 1980. 43:12:398-400.

Reported are data on the use of aids by 144 persons with total hip replacement. The participants were divided into 3 groups based on their symptoms and radiographic findings: unilateral osteoarthritis of the hip, bilateral osteoarthritis of the hip, and rheumatoid arthritis. The use of 4 types of aids (walking, bathing, toilet, and dressing) was studied. Results showed that the number of aids on loan to participants increased between admission and 3 mos. after operation (despite the fact that only 131 persons completed assessment at this time), 46% of the aids were unused 3 mos. after operation, and nearly half of the participants continued to use aids other than those for walking at 9 mos. after the operation. At 9-mos. follow-up, aids were used less by persons with unilateral hip disease (50%) than by those with bilateral hip disease (74%) or rheumatoid arthritis (87%). Also discussed are the advantages and disadvantages of an occupational therapy department's lending of portable aids to patients on discharge. Areas for further study are identified and tabular data are included.

British Journal of Occupational Therapy is published by the College of Occupational Therapists, 20 Rede Pl., Bayswater, London W2 4TU England.

HOME CARE

See 360.

HOME ECONOMICS

See p. 294; 332.

HOSPITALS

See 318.

HYDROCEPHALUS

See 384.

As part of our commemoration of the International Year of Disabled Persons, the following expanded section provides a comprehensive review of recent literature on independent living. Materials on attendant care, housing, conferences, and model programs in the U.S. and abroad are featured. Sources of additional information are also identified.

INDEPENDENT LIVING

360. Institute for Information Studies

Hiring and supervising personal service providers: A guide. Falls Church, Va., The Inst., 1980. ii, 39 p. paper.

Many severely disabled persons are capable of living independently with the assistance of a paid personal attendant, a service that is now funded by federal and state programs. This practical guide tells handicapped persons how to hire, train, supervise, and dismiss attendants and other personal service providers. The booklet also intends to improve the attendant-care profession by establishing standards and offering a better understanding of disabled persons as employers.

The text consists of 2 parts. The first part is focused on the personal service providers. Recruiting sources, conducting an interview, funding sources, and tax deductions for attendant care are covered. Other sections are devoted to notetakers and drivers and to model attendant care programs, including 2 programs funded by states, those organized by independent living centers, and a college-based service. The second part of the text presents over 100 community resource centers in the U.S. Organizations that offer services related to attendant care and assistance in activities of daily living are indicated.

Further information on this publication is available from the Inst. for Information Studies, 200 Little Falls St., Suite 104, Falls Church, VA 22046.

361. Norgard, Jim (*Communications Dept., Courage Center, 3915 Golden Valley Rd., Golden Valley, MN 55422*)

Accessible housing: Independent living. *Rehab. Digest*. 12:1:18.

Briefly described is the Courage Independent Living House in Golden Valley, Minn. The home is a working laboratory demonstrating how innovative structural designs and adapted household devices allow disabled persons to live in single-family units. Three young adults with physical disabilities and a personal care attendant live in the home. They are testing the practicality of a number of commercially available household devices, such as intercom, adapted switches on appliances, and automatic doors. Other features of the home are an accessible kitchen, a wheel-in shower, accessible sinks and toilets, and passive solar heating technology. Tours of the home, which includes educational displays on accessibility, are available to the public and can be arranged by contacting the Courage Center Tour Coordinator at the above address.

362. *Rehab. Gazette*. 1980. 23:16-29.

Special section on independent living.

The concept of independent living implies the rejection of the subservient roles traditionally assigned to disabled persons, their assumption of complete responsibility for their own lives, and the demand for human dignity and improved quality of life. The lead article in this special section addresses the philosophical underpinnings of the independent living move-

ment and the major challenges to the popular acceptance of these principles. Standards of success, funding and administrative problems, and advocacy are discussed. A shorter article suggests that disabled persons must use their creativity and ingenuity to live more independently.

Examples of disabled persons' initiative are then provided in a section on independent life-styles. Featured are biographical sketches of a man with arthritis who works as an insurance salesman and a music teacher; a printer with paralysis whose wife also has this disability; a 37-yr.-old woman with cerebral palsy who recently enrolled in college; an artist with quadriplegia who teaches ballet and choreographs dances; a director of an independent living center who has quadriplegia; a woman with this disability who works as a computer programmer and analyst; a filmmaker who has cerebral palsy; and another man with this disability who helped design a special typewriter that he could operate. These accounts emphasize the importance of determination to overcome obstacles and the benefits of family support. This section also contains recent developments and new resources in the areas of attendant care, accessibility, home adaptations, and relevant legislation.

Rehabilitation Gazette is published annually at 4502 Maryland Ave., St. Louis, MO 63108.

363. Rehabilitation International and Michigan State University. University Center for International Rehabilitation

Participation of people with disabilities: An international perspective: Selected papers from the 1980 World Congress of Rehabilitation International. Winnipeg, Canada, June 22-27, 1980. East Lansing, Mich., The Univ. Center, [1981]. viii, 157 p. photos. paper.

One of the main events at the 14th World Congress of Rehabilitation International was a workshop entitled "Participation of People with Disabilities in Rehabilitation." In this workshop, speakers discussed encouraging the full participation of disabled persons in decisions regarding their individual rehabilitation programs, the general design of programs, and pertinent legislative and administrative issues. Expressing the ideas of professionals from 10 countries, this volume contains selected papers from the workshop and other sessions of the 1980 Congress. The booklet presents an overview of the development and application of the concept of participation and raises questions about the sociological bases of this concept. The 22 articles are grouped into 5 sections: consumers, the organization and functions of consumer groups, the effects of consumer involvement in rehabilitation, the social implications of consumer participation, and a report on the 1980 World Congress.

Partial contents are: Self-Determination of Handicapped People, by Marianne Fritsch, p. 3-11.—The Right to All Types of Information, by Karl-Erik Karlsson, p. 14-16.—Consumer Groups: Their Organization and Function, by Allan Simpson, p. 21-38.—Organizing an Action Group, by John Simkins, p. 46-51.—Trade Union Participation, by Liam Maguire, p. 52-57.—Participation of Handicapped People in the Planning, Implementation and Man-

agement of Rehabilitation Services, by Pieter J. Blommestijn, p. 77-81.—Policy Issues in Independent Living Rehabilitation, by Donald E. Galvin, p. 82-85.—Higher Education Opportunities, by Kalle Könkkölä, p. 92-95.—The Disabled Consumer Movement: Policy Implications for Rehabilitation Service Provision, by Jim Derksen, p. 109-119.—From Charity to Integration: A New Future for Persons with Disabilities, by Edward V. Roberts, p. 120-125.—Towards Full Political Participation, by Barbro Carlsson, p. 129-134.

Copies of this publication are available for \$4.50 from Publications, University Center for International Rehab., Michigan State Univ., East Lansing, MI 48824.

See also p. 258, p. 294.

INDEPENDENT LIVING—EUROPE

364. Cole, Jean A., ed.

Living independently: Three views of the European experience with implications for the United States, by Lex and Joyce Frieden and Gini Laurie. New York, World Rehab. Fund, 1981. 63 p. paper.

The 2 articles in this monograph describe the experiences of severely disabled persons in several European countries, emphasizing opportunities for independent living (IL). Based on study tours of the countries described, the articles present rehabilitation systems and concepts that can be adapted in the U.S., the views of disabled persons in Europe, and the authors' assessments of the evolution of IL programs in Europe.

The first article offers opinions on the life-styles of handicapped persons in Sweden and the Netherlands. Among the conclusions drawn from the study of documents, visits to facilities, and personal interviews are that centralized provision of technical aids can be cost-effective, mass transportation systems can be economically adapted for disabled persons and these persons will use such systems, and the integration of handicapped children in regular classrooms can result in substantial benefits for them and for nondisabled students. The result of observations in 8 European countries (including France, Switzerland, Denmark, and England), the second article compares American and European concepts of IL. Attitudes toward handicapped persons, disseminating information, housing, home-care services, and nursing homes are addressed, and a number of specific programs are outlined. The author found that there is a significant difference between official descriptions of programs and the actual experiences of persons using them, innovative IL programs sometimes become more conservative and less effective, and the interpretation of IL varies in different countries.

Additional information on this publication is available from World Rehab. Fund, 400 E. 34th St., New York, NY 10016.

INDEPENDENT LIVING—PROGRAMS

365. Arkansas Rehabilitation Research and Training Center

Implementation of independent living programs in rehabilitation: Report from the Prime Study Group of the Seventh Institute on Rehabilitation Issues. Hot Springs, Ark., The Center, [1981]. iv, 211 p. paper.

Title VII, Part B of P.L. 95-602 gave state rehabilitation agencies the responsibility of providing independent living (IL) programs in addition to vocational rehabilitation. The work of a committee made up of professionals and disabled persons, this report is intended to assist agencies in initiating new IL programs for severely handicapped individuals with no vocational potential.

A review of the philosophical and historical development of IL and relevant terminology is followed by an analysis of current concepts of IL programs in terms of trends and implications for the future. The basic features of IL programs, variations of programs designs, and distinguishing characteristics (settings, goals, funding sources) are addressed. These programs' key services (information and referral, attendant care, housing referral, peer counseling) and staffing (including consumer involvement and work disincentives) are then addressed. Considerable attention is devoted to the use of the variety of funds and benefits available for severely handicapped persons receiving IL services; emphasis is placed on establishing a diverse and stable base of support for programs. Evaluating the extent to which IL programs help clients with physical, economic, psychosocial, educational, and vocational goals is discussed, and guidelines for training professionals on the implementation of IL programs are presented. This thorough and functional booklet also contains a bibliography, job descriptions for staff members, and sources of additional information.

Further information on this publication is available from Arkansas Rehab. Research and Training Center, Hot Springs Rehab. Center, 105 Reserve St., P.O. Box 1358, Hot Springs, AR 71901.

366. Brown, Dale

Independent living: Housing opportunities for persons who are both mentally and physically disabled. *Disabled USA*. 3:10:16-18.

Described is a unique project initiated by the Boston Center for Independent Living (BCIL) for persons who are both physically disabled and mentally retarded. The project consists of 3 types of living arrangements: 1) transitional living—residents living in an apartment learn such basic skills as supervising an attendant and budgeting money; 2) cluster living—several people living in adjoining apartments share attendant care, transportation, and other resources; and 3) independent living—clients live on their own and supervise personal attendants with BCIL providing services when needed. Services offered by BCIL, including negotiations with Medicaid, are indicated, and comments by staff members on the effectiveness of the program are included. Several clients describe the progress they have made at BCIL.

Disabled USA is published by The President's Committee on Employment of the Handicapped, Washington, DC 20210.

ABSTRACTS

367. Condey, Andrew

Rubicon Programs, Inc. independent living programs. *Am. Arch. Rehab. Therapy*. Winter, 1980. 28:3:11-13.

A private, nonprofit mental health corporation founded over 6 yrs. ago, Rubicon Programs has provided socialization, rehabilitation, and advocacy services to more than 600 mentally disabled adults in West Contra County, Calif. This article describes the corporation's programs that exemplify its commitment to the client's choice of treatment and the right to live and work in the least restrictive environment. Activities and services offered by the 4 programs are: 1) a community day center—group counseling, arts, sports, an independent living skills groups, and a prevocational training group; 2) a socialization center—support for integration into community recreational services, individual and group counseling, and advocacy services, 3) a garden center—horticultural therapy, in which participants engage in special projects (such as community gardening), and competitive employment, which offers work evaluation and work adjustment services as well as courses in skills related to operating a nursery; and 4) an independent living project—helps clients become integrated into a neighborhood. Also discussed are the types of persons who are eligible for each program. Sources of additional information are indicated.

American Archives of Rehabilitation Therapy is published by the Am. Assn. for Rehab. Therapy, W. 32 Ferndale Rd., Paramus, NJ 07652.

368. Kansas University Affiliated Facility

The CIL: Design for success, by Richard Royse. Lawrence, Kan., The Facility, 1980. 113 p. paper.

A center for independent living (CIL) provides direct and support services that enable disabled persons to control their lives as much as possible within their own communities. Synthesizing the innovative and successful components of a variety of established centers, this manual is intended for nonprofit organizations interested in developing CILs. Major emphasis is given to integrating with the existing service system while instituting services that ensure optimal independence.

A nonresidential resource center that offers residential support services, the model involves active participation by consumers in planning, directing, and providing the essential and interrelated services of housing, attendant care, employment, and transportation. Funding alternatives are considered in the discussion of each service option, and a form of combined funding is recommended. The housing alternatives of transitional living, clustered living, intermediate care facilities and nursing homes, and privately owned houses are described. Advocacy, counseling, referral, and evaluation are also covered. Sources of additional information complete this concise and useful booklet.

Additional information on this publication is available from Kansas Univ. Affiliated Facility, 348 Haworth Hall, Bureau of Child Research, Univ. of Kansas, Lawrence, KS 66045.

369. Stoddard, Susan

Evaluating California's independent living centers, by Susan Stoddard and Bruce Brown. *Am. Rehab.* Nov.-Dec., 1980. 6:2:18-23.

An evaluation of 11 state-funded independent living centers (ILCs) serving approximately 18,000 disabled persons in California is presented. Designed to assist in the rapid expansion of ILCs, the evaluation employed 4 sources of data: review and analysis of existing center and agency material, survey of clients, visits to each center, and interviews with community and state officials. The study focused on 8 issues identified by the state legislature: number and characteristics of clients, range of problems presented and services provided, number of persons who moved to an independent living setting, number who entered vocational rehabilitation and employment, impact on costs of medical and supportive services, effects on family and community activities, cost and savings to the state, and other sources of funding for the centers. The ILCs were found to assist disabled persons in obtaining more independent housing, relying less on hospitalization, and making greater use of attendant care. This study is said to demonstrate the utility of carrying out evaluations during program development rather than after services have been firmly established. Uses of the study are indicated.

Copies of the full evaluation are available from Research Section, Calif. Dept. of Rehab., 830 K St. Mall, Sacramento, CA 95814.

INDEPENDENT LIVING—RESEARCH

370. *Rehab Brief*. Mar. 11, 1981. 4:5.

Title: The influence of environmental barriers on independent living outcomes.

The Medical Rehabilitation Research and Training Center of Tufts-New England Medical Center in Boston, Mass., has undertaken a 3-phase study on the extent to which specific environmental factors and personal limitations contribute to the outcome of rehabilitation and what criteria are most valid for evaluating independent living (IL) programs. The results of Phase I of this study, which is focused on persons with spinal cord injury (SCI), are summarized in this report. Researchers interviewed 111 persons with SCI (characteristics of whom are provided), and 3 criteria of outcome were developed: 1) a measure of living arrangement, 2) a measure of productivity, and 3) an overall IL outcome measure representing a weighted average of the first 2 measures. The majority of study participants were living in unrestricted settings but were contributing little or nothing to community or family life. Multiple regression analysis found that the best variables for predicting a person's ability to live independently were transportation, economic disincentives, marital status, services received from agencies, education, and services received from vocational rehabilitation programs. Architectural barriers and the severity of disability did not prove to be important predictors of independence. Implications of this study for the national policy

on disability, research and evaluation in this area, and health policy are discussed, and the significance of the independent living movement is emphasized.

Rehab Brief is published by Rehab. Research Inst., College of Health Related Professions, Univ. of Florida, Gainesville, FL 32610.

SELECTED RESOURCES ON INDEPENDENT LIVING PROGRAMS AND CENTERS

Compiled by the Program Services Department, National Easter Seal Society

July, 1981

BOOKS/REPORTS

Attendant Care as an Independent Living Service, by Gerben DeJong and Teg Wenker. NATIONAL SPINAL CORD INJURY FOUNDATION CONVENTION JOURNAL, 1980, p. 37-51. No price given.

The distinguishing feature of this model is that the provision of care is directed by the consumer, not the provider. The three areas of human services affecting care—health care, income assistance, and social services—are addressed in this article.

The Convention journal is published annually by the National Spinal Cord Injury Foundation, 901 Arcola Ave., Wheaton, MD 20902.

The C.I.L. (Center for Independent Living): Design for Success, by Richard E. Royse. 1980. 113p., paper. Available from Affiliated Facility, 348 Haworth Hall, Bureau of Child Research, University of Kansas, Lawrence, KS 66045. No price given.

Synthesizing the innovative and successful components of a variety of established centers, this manual is intended for nonprofit organizations interested in developing CILs. Major emphasis is given to integrating with the existing service systems while instituting services that ensure optimal independence.

Community Resources for the Social Adjustment of Severely Disabled Persons: Options for Involvement, by Isabel P. Robinault and Caverlee Cary. 1980. iii, 136p. Available from Book Orders, Research Utilization Laboratory, ICD Rehabilitation and Research Center, 340 E. 24th St., New York, NY 10010. \$6.00.

A concise and heavily documented booklet to assist rehabilitation counselors and self-help groups in providing opportunities for self-fulfillment and the development of social skills for persons with disabilities. Examples of resources throughout the country focus on self-directed functioning grouped according to socialization and leisure, sexuality, hobbies and education, consumer advocacy and volunteer action, recreation, transportation, and travel.

Design for Independent Living: The Environment and Physically Disabled People, by Raymond Lifchez and Barbara Winslow. 1979. 209p., photos. Watson-Guption Pubs., 1 Astor Plaza, New York, NY 10036. \$25.00.

Developed from an architectural project of the C.I.L. and the University of California that included consultants who have disabilities and featured an investigation of the social and environmental factors enabling persons with disabilities to live independently in Berkeley, this book provides designers, architects, and city planners with methods of adapting the environment to meet special needs. Numerous photographs show practical design features and tools that were developed by persons with various physical limitations.

Environmental Accessibility and Independent Living Outcomes: Directions for Disability Policy and Research, by Gerben DeJong. 1981. Various paging. Available from Publications, University Center for International Rehabilitation, D-201 W. Fee Hall, Michigan State University, East Lansing, MI 48824. \$8.00 prepaid.

As a basis for setting policy on environmental barriers, this study presents a research model based on the theory and values implicit in the IL movement and employs the model as a means of determining the outcomes of disability emphasizing the role of accessibility.

How to Set Up an Independent Living Program: Twenty-Seven Questions and Answers and Independent Living and Deafness: Incorporating Deaf Clients into the Independent Living Network, by Independent Living Research Utilization Project. 1980. Various paging. Available from ILRU, Texas Institute for Rehabilitation and Research, 1333 Moursund Ave., Houston, TX 77030. \$3.00 each.

These two papers are the first available from a new technical report series being prepared by ILRU. The series, entitled *Issues in Independent Living*, will also include monographs on the relationship of independent living to evaluation, consumer involvement, clients with development disabilities, and elderly clients.

Hiring and Supervising Personal Service Providers: A Guide. 1980. ii, 39p., paper. Available from Institute for Information Studies, 200 Little Falls St., Suite 104, Falls Church, VA 22046. No price given.

The purpose of this guide is to give a wide range of readers the "know-how" to hire, train, supervise, and terminate, when necessary, the services of attendants or other personal service providers.

ABSTRACTS

Implementation of Independent Living Programs in Rehabilitation. 1980. 211p., paper. Available from Arkansas Rehabilitation Research and Training Center, University of Arkansas, Hot Springs Rehabilitation Center, P.O. Box 1358, Hot Springs, AR 71901. No price given.

A report from a committee including persons from the state rehabilitation agencies, the Rehabilitation Services Administration, two research and training centers, and individuals with severe disabilities. Chapters focus on models for IL programs, IL services, staffing IL programs, supporting these programs, program evaluation, and staff training.

Introduction to Independent Living Rehabilitation Services, by B. Douglas Rice and Richard T. Roessler. 1980. ix, 34p. Available from Arkansas Rehabilitation Research and Training Center, Hot Springs Rehabilitation Center, P.O. Box 1358, Hot Springs, AR 71901. \$3.00.

This booklet outlines some of the emerging issues and perspectives in independent living services.

Living Independently: Three Views of the European Experience with Implications for the United States, by Lex Frieden, Joyce Frieden, and Gini Laurie. 1981. 63p., paper. Monograph No. 10. Available from World Rehabilitation Fund, Inc., 400 E. 34th St., New York, NY 10016. No price given.

Section 1 provides observations of the life-style of persons with disabilities in Sweden and the Netherlands. Section II gives perspectives on the relationships between American and European concepts on independent living support services with emphasis on attendant care programs.

New Options and New Options Training Manual, by New Options Transitional Living Project, Jean A. Cole, Jane C. Sperry, Mary Ann Board, and Lex Frieden. 1979. 2 vols. Texas Institute for Rehabilitation and Research, Texas Medical Center, 1333 Moursund Ave., Houston, TX 77030. New Options, \$3.95; Training Manual, \$5.95.

Based on more than three years of successfully integrating persons with disabilities into the community, these two volumes offer valuable practical information on promoting independent living through a broad range of alternative methods.

ARTICLES

Accessible Housing: Independent Living, by Jim Norgard. REHABILITATION DIGEST, Jan.-Feb.-Mar., 1981, Vol. 12, No. 1, p. 18.

Development of an Independent Living Rehabilitation Program Curriculum. JOURNAL OF REHABILITATION, Apr.-May-June, 1980. Vol. 46, No. 2, p. 53-55.

European Concepts of Independent Living, by Gini Laurie. REHABILITATION WORLD, Spring-Summer, 1981. Vol. 6, No. 1 & 2, p. 24-26, 43-47.

Evaluating California's Independent Living Center, by Susan Stoddard and Bruce Brown. AMERICAN REHABILITATION, Nov.-Dec., 1980, Vol. 6, No. 2, p. 18-23.

Homemaker Rehabilitation in the Age of Accountability, by Joann L. Guthrie and others. REHABILITATION LITERATURE, Mar.-Apr., 1981, Vol. 42, No. 3-4, p. 90-91.

Independent Living Centers: An Idea Whose Time Has Come. THE EXCEPTIONAL PARENT, June, 1979, Vol. 9, No. 3, p. D-30-32.

Independent Living Concept Gaining National Attention, More Federal Support. Special section in PROGRAMS FOR THE HANDICAPPED, Office of Handicapped Individuals, Jan.-Feb., 1980, No. 1, p. 8-14.

Independent Living: Housing Opportunities for Persons Who Are Both Mentally and Physically Disabled and other articles. DISABLED USA issue on independent living, Vol. 3, No. 10, 1980.

Independent Living: Houston Experience, by Lex Frieden. AMERICAN REHABILITATION, July-Aug., 1979, Vol. 4, No. 6, p. 23-26.

Independent Living: How Do You Get a Good Attendant? by Elaine Hobson Miller. ACCENT ON LIVING, Fall, 1979, p. 52-55.

Independent Living: How Independent? by Alvin D. Puth. AMERICAN REHABILITATION, July-Aug., 1979, Vol. 4, No. 6, p. 28-29.

Independent Living Models, by Lex Frieden. REHABILITATION LITERATURE, July-Aug., 1980, Vol. 41, No. 7-8, p. 169-173. Available as reprint A-289, National Easter Seal Society, 2023 W. Ogden Ave., Chicago, IL 60612. \$.25 plus .25 postage. Quantity rates available.

The Influence of Environmental Barriers on Independent Living Outcomes. REHAB BRIEF, Mar. 11, 1981, Vol. 4, No. 5, 4 pages of issue.

Maintaining Personal Care Attendant Services, by Paul Kahn. AMERICAN REHABILITATION, Nov.-Dec., 1980, Vol. 6, No. 2, p. 24-26.

Rubicon Programs, Inc. Independent Living Programs, by Andrew Condey. AMERICAN ARCHIVES OF REHABILITATION THERAPY, Winter, 1980, Vol. 28, No. 3, p. 11-13.

Selected Factors Influencing Job Satisfaction of Attendants of Physically Disabled Adults, by Madelyn Stelmach and others. REHABILITATION LITERATURE, May-June, 1981, Vol. 42, No. 5-6, p. 130-137.

The Use of Paraprofessionals in Achieving Independent Living for Severely Handicapped Persons, by Greg H. Frith. REHABILITATION LITERATURE, Jan.-Feb., 1981, Vol. 42, No. 1-2, p. 18-20.

Special Issue on Independent Living (10 articles). ARCHIVES OF PHYSICAL MEDICINE AND REHABILITATION, Oct., 1979, Vol. 60, No. 10.

Special Section on Independent Living. REHABILITATION GAZETTE, 1980, Vol. 23, p. 16-29.

CURRICULAR MATERIALS

An Activities of Daily Living Curriculum for Handicapped Adults, by C. Tiller and C. Wyllie. Magic Valley Rehabilitation Services, Inc., 1978. Available from Materials Development Center, Stout Vocational Rehabilitation Institute, University of Wisconsin-Stout, Menomonie, WI 54751.

Looseleaf curriculum designed so that persons having no formal training in teaching skills can teach basic skills to adults in group and shelter homes.

The Independent Living Behavior Checklist and The Vocational Behavior Checklist, by Richard T. Walls and others. 1979. Various paging, paper. Available from West Virginia Division of Vocational Rehabilitation, Research and Training Center, 1 Dunbar Plaza, Suite E, Dunbar, WV 25064. \$10.00 (or \$5.00 per set).

Focused on defining independent living skills, these two checklists categorize skill objectives in terms of behaviors, standards, and conditions. Charts allow recording of skill achievement as well as dates that training is initiated and terminated for each objective.

Independent Living Checklist and Skill Charts and Vocational Behavior Checklist and Skill Charts, by West Virginia Rehabilitation Research and Training Center. Available from WVRR and TC, 1 Dunbar Plaza, Suite E, Dunbar, WV 25064. \$12.00 (or \$6.00 per set).

Clearly defined skills, methods of competency testing, and standards provide means for goal-setting and evaluation in writing individualized education or rehabilitation programs.

Instructional Materials in Independent Living: Resources in Personal, Social and Community Adjustment, by Bradley C. Smith. 1978. Available from Materials Development Center, Stout Vocational Rehabilitation Institute, University of Wisconsin-Stout, Menomonie, WI 54751. \$1.50.

BIBLIOGRAPHIES

A Bibliography of Selected Publications on Independent Living, with emphasis on housing, is available from the Clearinghouse on the Handicapped, Office of Special Education and Rehabilitation Services, U.S. Department of Education, Room 3106, Switzer Bldg., Washington, DC 20202. Also available from the Clearinghouse is a listing of Independent Living Programs.

Instructional Materials in Independent Living: Resources in Personal, Social and Community Adjustment, by Bradley C. Smith. 1978. 30p., paper. Available from the Materials Development Center, Stout Vocational Rehabilitation Institute, University of Wisconsin-Stout, Menomonie, WI 54751. \$1.50.

An annotated list of 103 entries and a subject index listing skills in 14 categories.

LEARNING DISABILITIES—RESEARCH

371. Torgesen, Joseph K. (*Dept. of Psychol., Florida State Univ., Tallahassee, FL 32306*)

Characteristics of research on learning disabilities, by Joseph K. Torgesen and Carl Dice. *J. Learning Disabilities*. Dec., 1980. 13:9:531-535.

Reported are the results of an analysis of research on learning disabilities performed by psychologists and educators and reported in 8 major education and psychology journals during a 3-yr. period (1976-78). Criteria used in selecting 105 articles and the journals included are identified. Findings regarding topics studied and methodology are compared to those of a research review of articles published before 1970.

An increase in the number of studies on memory skills and performance on tasks that test various supplementary reading skills was noted, as was a rising interest in social and affective development. Analysis of techniques used to select subjects revealed that few studies precisely reported data on number of subjects, IQ level, and age; small but consistent differences existed between intelligence levels of the samples with learning disabilities and control groups; operational definitions of learning disabilities differed among studies; and only half of the studies reported objective data about achievement of both groups. Regarding the design and execution of research, it was concluded that in nearly half of the cases research design failed to consider the heterogeneity of samples of learning disabilities in children and that many studies used measures that had questionable validity; in fact, concern for validity appeared to be absent. A positive trend mentioned is that 61% of the studies reviewed did involve manipulation of an experimental variable. Among the several recommendations for improvement in research is the development of systematic research programs on one topic as an alternative to the single, isolated studies that now prevail. (15 refs.)

LEARNING DISABILITIES—SPECIAL EDUCATION—DIRECTORIES

372. Ridenour, Dian M.

A guide to post-secondary education opportunities for the learning disabled, by Dian M. Ridenour and Jane Johnston. Oak Park, Ill., Time Out to Enjoy, 1981. 188 p. paper.

The results of a survey of 1,844 colleges, universities, technical schools, and other post-secondary institutions, this guide presents information on 155 institutions that offer educational opportunities for learning disabled (LD) students. The book consists of 3 main sections: programs that provide a full range of services for LD students, schools with learning labs and a full- or part-time specialist with a background in learning disabilities, and schools that do not have labs but have indicated a willingness to accommodate LD students. Each section contains a helpful introduction; the institutions are listed alphabetically by state. The format for describing schools includes admissions requirements and modifications, support services (diag-

nostic testing, tutoring, reader service), course modifications, graduation requirements, and additional comments. Filling a gap in reference resources, this guide also contains suggestions for using the listings and identifies limitations of the survey, a copy of which is appended.

Further information on this publication is available from Time Out to Enjoy, 113 Garfield St., Oak Park, IL 60304.

MEDICAL ETHICS

See 322.

MENTAL RETARDATION

373. Canadian Association for the Mentally Retarded. National Institute on Mental Retardation

Coping with Alzheimer's disease: A growing concern, by Ann Newroth and Stephen Newroth. Downsview, Ontario, The Inst., 1981. iv, 28 p. paper.

Characterized by premature physical and mental deterioration, Alzheimer's disease (AD) is of special interest to professionals concerned with mental retardation because people with certain forms of this disability (such as Down's syndrome) seem to be particularly susceptible to AD. Based on the programs used at a community-based residence for mentally retarded persons (a number of whom exhibited symptoms of AD), this booklet discusses the nature of the degenerative brain disease and practical methods of care. The opening sections cover the signs and diagnosis of AD, history of treatment, current research, and symptoms and stages of the disease (including changes in personality). The main section of the text is devoted to charts outlining symptoms, examples of behavior, implications, and management techniques. Grouped into 3 stages, the symptoms include impairment of memory, spatial disorientation, restricted blood circulation, and speech and language problems. Maintenance of morale, use of a team approach, counseling for patients and their families, and support for staff are considered to be important aspects of care. Concluding sections recommend alternatives to institutionalization for persons with AD, and sources of additional information are cited.

This publication is available for \$3.00 from the National Institute on Mental Retardation, Kinsmen NIMR Bldg., York Univ. Campus, 4700 Keele St., Downsview (Toronto) Ontario, M3J 1P3 Canada.

MENTAL RETARDATION—INSTITUTIONS

See 319.

MENTAL RETARDATION—PHYSICAL THERAPY

See 345.

MULTIPLE SCLEROSIS—SEXUALITY

374. Leyson, Jose Florantes (*Asst. Chief, SCI Service, V.A. Medical Center, Tremont Ave. & S. Centre St., East Orange, NJ 07019*)

The management of sexual dysfunctions in multiple sclerosis. *MS Quarterly*. Fall, 1980. 3:4:4-7.

To minimize problems of adjustment resulting from multiple sclerosis (MS), enhance the social and sexual contacts of persons with this disease, and improve their self-image and self-esteem, these persons and their sexual partners should be presented with pertinent facts, options, and treatments. This article discusses the importance of the accurate diagnosis of sexual dysfunctions associated with MS, as well as the variety of conditions that frequently cause problems during the course of MS. The status of reflexes, the function of the autonomic nervous system, perineal atony, monitoring the contractions of vaginal muscles, and cerebral lesions are addressed. The treatment and management of muscle spasms and related complications, anorgasmia, and dyspareunia are described, and the related topics of fertility, menstruation, contraception, and pregnancy are covered. Also considered are variables that determine the success of sex counseling and psychotherapy with this population, open sexual expression, sexual hygiene, and how to overcome lassitude and fatigue.

NUTRITION

375. Newmark, Stephen R. (*Div. of Clinical Nutrition, Scott and White Clinic, Temple, TX 76501*)

Nutritional assessment in a rehabilitation unit, by Stephen R. Newmark and others. *Arch. Phys. Med. & Rehab.* June, 1981. 62:6:279-282.

Recent evidence suggesting that protein-calorie malnutrition is a major cause of increased morbidity and mortality in the hospitalized population prompted a nutritional assessment of 49 consecutive admissions to a rehabilitation unit. Among the measured parameters were: serum albumin, height, weight, 24-hr. protein and calorie intake, and response to 4 antigens (purified protein derivative, streptokinase/streptodornase, trichophyton, candida) administered by intradermal injections. Patients were classified according to the following categories: normal—albumin $\geq 3.5\text{gm\%}$, positive skin tests, and normal weight; kwashiorkor—albumin $< 3.5\text{gm\%}$, anergic skin tests, and no weight loss; marasmus—albumin $\geq 3.5\text{ gm\%}$, anergic skin tests, and weight loss $> 10\text{lb}$ (4.54kg); or obesity—greater than 130% ideal body weight. Only 15 patients (33%) satisfied criteria for normal nutritional status at the time of admission. Protein-calorie malnutrition (marasmus or kwashiorkor) was found in 34 (67%) of the patients; four participants satisfied the criteria for both obesity and kwashiorkor. It is recommended that all patients admitted to a rehabilitation unit undergo a nutritional evaluation, and that if malnutrition is detected, a program of metabolic support should be initiated to increase protein levels and restore immunity. (11 refs.)

PARAPLEGIA—EQUIPMENT

376. O'Reagan, James R. (*Rehab. Engineering Center, P.O. Box 3348, Univ. Station, Charlottesville, VA 22903*)

Vacuum as a grasping force, by James R. O'Reagan, Mark Bresler, and Steven I. Reger. *Arch. Phys. Med. & Rehab.* May, 1981. 62:5:232-234.

Three systems for lifting small objects were designed using a vacuum as an artificial prehensile force. The first system, for persons with C4-5 quadriplegia, employed a vacuum pump, pneumatic tubing, and a customized wrist-hand orthosis.

This vacuum pick-up system was adapted for more severely disabled persons with C4 quadriplegia by substituting a lightweight, tubular aluminum mouthstick instead of the orthosis as the primary grasping utensil. A suction mouthstick, a variation for severely disabled persons without elbow function and forearm supination, lifted small objects and turned pages by using only the suction power generated by the person's own breathing without additional mechanical amplification. Also included are photographs and approximate costs of the devices and test data on performing tasks with them.

PUBLISHING

377. Ludlow, Norman H., comp.

Disabled people at work and play, illustrated by Sheila K. Devine. Rochester, N.Y., St. Vincent Press, 1981. 46 p. illus. paper.

Organizations that publish newsletters, brochures, or announcements can use art work to make these publications more attractive to readers and to illustrate central concepts. This booklet provides such groups with over 180 line drawings of disabled persons performing a wide range of activities, including sports, school lessons, crafts, and various jobs. Presented in 3 sizes, the drawings can be clipped or cropped to fit various spaces in publications. They can be used with spirit duplicators, mimeographs, office copiers, and offset duplicators. Depicted are persons confined to wheelchairs, persons using crutches and canes, blind persons, and those with prostheses.

Copies of this publication are available for \$15.95 (plus \$1.63 for shipping and handling) from Norman H. Ludlow, 516 Arnett Blvd., Rochester, NY 14619.

RECREATION

See 324, 327, 337.

REHABILITATION—PERSONNEL

378. Joe, Thomas (*Washington Office, The Center for the Study of Welfare Policy, University of Chicago, 236 Massachusetts Ave., N.E., Washington, DC 20002*)

Professionalism: A new challenge for rehabilitation. *Arch. Phys. Med. & Rehab.* June, 1981. 62:6:245-250.

By concentrating on the discrete problems of disabled persons that differentiate them from rest of society, professional specialization may reinforce social attitudes that lead to segregation of these persons and ultimately make them feel inferior. This article calls for greater collaboration among rehabilitation professionals that will extend services to greater numbers of handicapped persons and help them take control of their lives. To improve professional services, current

ABSTRACTS

trends and suggestions for action are presented in 3 areas: policy making, economics, and service delivery. Independent living and technology are said to be 2 areas in which professionals should focus their efforts. The professionals are urged to initiate a nonprofit corporation, bridging the public and private sectors, for fostering the independence of disabled persons. The corporation would have 2 major goals: strengthening local independent living organizations through funding, technical assistance, and evaluation; and identifying problems that could be solved through technology and promoting the development, production, and marketing of products.

REHABILITATION—PROGRAMS

379. United Nations Secretariat

Summary of information on projects and activities in the field of rehabilitation of the disabled during 1979. New York, The Secretariat, [1980]. ii, 146 p. paper.

The latest issue of this series presents rehabilitation activities that were undertaken by governments, agencies, and organizations throughout the world during 1979. Plans for future projects are also noted. The compilers have attempted to give a picture of the relevant developments in each principal geographical region of the world. The material in each section is grouped into 5 categories of contributors: United Nations and specialized agencies, regional inter-governmental organizations, bilateral government programs, international organizations, and other organizations. Included are sections on congresses, seminars, training courses and meetings; publications, studies, and films; and preparatory work for the 1981 International Year of Disabled Persons. Among the 4 appendixes are pertinent resolutions of the United Nations.

Additional information on this publication is available from the United Nations Secretariat, First Ave., New York, NY 10017.

REHABILITATION—PSYCHOLOGY

See p. 266; 339.

REHABILITATION—RESEARCH

380. Cardius, David (*Dept. of Rehab., Baylor College of Med., 1200 Moursund Ave., Houston, TX 77030*)

Quality of life in benefit-cost analyses of rehabilitation research, by David Cardius, Marcus J. Fuhrer, and Robert M. Thrall. *Arch. Phys. Med. & Rehab.* May, 1981. 62:5:209-212.

Benefit-cost (B-C) analyses traditionally have been limited to consideration of monetary benefits, largely because nonmaterial benefits are difficult to define and quantify. This article presents a model based on the general theory of B-C analysis that includes 7 dimensions of benefits. Identified by an analytic procedure administered to a broad representation of persons involved in rehabilitation, the dimensions include enhanced quality of services, improved individual client outcomes, improved administrative bases for service provision, and indirect benefits. It is pointed out that scales for measuring nonmaterial

benefits must be developed. Methods for estimating the value and the relative importance of the various benefits are analyzed, and a procedure for combining monetary and nonmaterial benefits is suggested. (10 refs.)

RIGHTS (LEGAL)

See 329.

SELF-CARE SKILLS—EQUIPMENT

See 348.

SPECIAL EDUCATION

See p. 297; 321.

SPECIAL EDUCATION—SEGREGATION AND NONSEGREGATION

381. Gillet, Pamela (*Northwest Suburban Special Education Org., 500 S. Plum Grove Rd., Palatine, IL 60067*)

Models for mainstreaming. *Education Unlimited.* Mar.-Apr., 1981. 3:2:6-11.

In same issue: Least restrictive environment programs: Why are some so successful? by Marsha A. Schubert and Harriet M. Glick, p. 11-13.

Adaptations made in the standard educational program can often accommodate the learning patterns of children with disabilities; several models of mainstreaming that demonstrate such adaptations are presented here. Twenty-five principles underlying effective models are listed initially. These focus around setting student goals with consideration of each individual's emotional and social needs, clarifying roles and utilizing skills of special and regular education personnel with support from the administration, adhering to the least restrictive environment concept while advocating alternative modes of instruction, pacing the integration rate in consideration of needs of everyone concerned, and melding special and regular program administration. The 18 models described are those used most widely and successfully as determined in a nationwide survey of special education administrators. Among those cited are: prescriptive instruction development, in which a multidisciplinary child study team formulates and monitors IEPs based on diagnostic classroom observation and experimental remediation; the resource plan, in which children are part of the regular classroom but receive needed assistance in a special education resource room (disadvantages of this most popular model are given); a materials retrieval resource center where materials can be matched to differences in styles and strengths of students; the primary level model, a natural process of mainstreaming in which teachers with both special and regular certification teach 18-20 children in one classroom; slip sessions, in which individual attention is facilitated by varying schedules to reduce class size for part of the day; team teaching, with the special education teacher as a resource within the classroom; diagnostic prescriptive teaching model, in which the prescriptive teacher assists classroom teachers with instruction and children's adjustment;

weighted formula for determining regular class size based on number of class members with disabilities; individually guided education by several staff members in a nongraded classroom of 100-150 children (unique benefits of this plan are given); teacher assistance teams, a peer-level-support and problem-solving system of fostering immediate results within the regular classroom; and consultation, an ongoing inservice approach in which consultants observe regular classes upon request and suggest special instructional techniques. Other models are mentioned. The article concludes with a list of elements viewed as most important for successful mainstreaming, regardless of the model used or adapted. These are: individualization in the regular classroom, acceptance of children with disabilities by teachers and classmates, cooperative relationships between regular and special staff, administrative support of mainstreaming, and related service support to regular classroom teachers.

In the second article, Schubert (*College of Educ., Wright State Univ., Colonel Glenn Hwy., Dayton, OH 45435*) and Glick also report results of a study attempting to determine reasons for differing levels of effectiveness of least restrictive environment (LRE) programs. Research teams visited 8 schools selected for their success with LRE programs and interviewed administrators, special and regular teachers, and, in some cases, students. General elements associated with the success of all the programs are given. Communication was a major factor—open, honest, and usually informal communication among all personnel made implementation smoother and more effective and was associated with supportive attitudes. Strong administrative support for the concept of mainstreaming was another shared attribute, as was the passage of time (problems and resistance decreased as mainstreaming became the norm). Teachers in each program also viewed flexibility in scheduling throughout the year as basic to success in programs where students had several teachers. A final factor was positive attitudes of all personnel, especially as reflected in a desire to work together. More specific elements viewed as vital to the efficacy of some of the programs included suitable placement criteria, availability of ongoing informal training of regular educators by special educators, and a commitment by all staff to continued program improvement.

382. Kehle, Thomas J. (*Chairman of School Psychol., 327 Minton Bennion Hall, Univ. of Utah, Salt Lake City, UT 84112*)

Do too many cooks spoil the broth?: Evaluation of team placement and individual educational plans on enhancing the social competence of handicapped students, by Thomas J. Kehle and John Guidubaldi. *J. Learning Disabilities*, Dec., 1980. 13:9:552-556.

The assumptions that mainstreaming enhances the personal adjustment of children with disabilities and fosters their acceptance by others lack an empirical data base. Reported here are results of a study designed to provide data on the specific assumption that formal team placement decisions (as required by P.L. 94-142) influence children's chances of successful social integration more positively than informal deci-

sions made by the school psychologist. An experimental group consisted of 24 EMR (educable mentally retarded) and 51 LD/BD (learning disabled/behavior disordered) children who were integrated into regular classrooms during the previous 2 academic years based on team decisions and for whom IEPs were developed. Regular education students from the same classrooms were also studied. A control group consisted of 33 EMR children and 15 LD/BD children placed in a regular classroom as a result of a decision by the school psychologist; no IEPs were developed for this group. Again, regular education students from these children's classrooms were included.

Selected components of the Barclay Classroom Climate Inventory were used to determine the effects that placement procedures and IEPs had on children's social and affective development. An analysis of the data revealed that only 2 significant contrasts among groups were accounted for by the treatment condition variable (experimental or control group), while 13 significant differences were related to other variables, such as type (normal, EMR, LD/BD) and sex. Details are provided in tables. It was determined that team placement decisions and use of IEPs were not superior to control procedures in enhancing special student's social integration into regular classrooms. Possible reasons for this unexpected result are explored, followed by an admonition that legislation not be passed without prior extensive research on the assumptions underlying the mandates.

SPEECH CORRECTION

383. Beveridge-Wavering, Agnes

Reinforcing home activities: Program for articulation improvement, by Agnes Beveridge-Wavering and Mavis Seibert-Shook. Second edition. Danville, Ill., Interstate Printers & Pubs., 1981. Unnumbered. figs. spiralbound.

Intended as a resource for speech therapists, this booklet presents sequential take-home assignments for children with articulatory problems. The activities focus on a variety of skills, including auditory discrimination of the defective sound, production of the sound in simple segments, and spontaneous articulation; most of the lessons can be adapted to any defective consonant sound. The principal goals of this program are the student's consistent use of the correct sound in conversation and the promotion of parent involvement in instruction. In this system, therapists can record children's progress in home assignments and parents can encourage their learning. Therapists are given guidelines for implementing the activities, such as arranging a conference with parents to discuss the program. Also included are suggestions for motivating children and for correlating home assignments with bulletin board displays. The individual pages can be easily removed from the 3-ring binder for duplication.

Additional information on this publication is available from Interstate Printers & Pubs., 19-27 N. Jackson St., Danville, IL 61832.

SPINA BIFIDA

384. Culatta, Barbara

Perceptual and linguistic performance of spina bifida hydrocephalic children. *Spina Bifida Therapy*. Jan., 1980. 2:3:235-247.

Children with spina bifida and hydrocephalus (SBH) often have learning disabilities that are not attributed to mental retardation, such as perceptual and language problems. To examine the relationship between these disabilities, this study investigated the perceptual and linguistic performance of children with SBH as compared to children in chronological age (CA) and mental age (MA) control groups. The linguistic variables assessed were vocabulary and measure of relevant language, and the perceptual variable was visual figure/ground perception. Results indicate that the SBH group performed significantly more poorly than both control groups on visual figure/ground perceptions and the measure of relevant language, but performed similarly to MA peers on the measure of vocabulary. A significant positive correlation was found between visual figure/ground performance and vocabulary in all 3 groups. For the CA and SBH groups, negative correlations were found between the measure of relevant language and visual figure/ground performance, as well as between the measure of relevant language and vocabulary. Thus, as the number of SBH children's irrelevant utterances increased, their performance on the figure/ground and vocabulary tasks was poorer. Additional research is recommended on the causes of irrelevant language in children with SBH. (38 refs.)

Spina Bifida Therapy is published by Spina Bifida Service, Loyola Univ. Medical Center, 2160 S. First Ave., Maywood, IL 60153.

SPINA BIFIDA—EQUIPMENT

385. Rose, G. K. (J. S., *Orthotic Research & Locomotor Unit, The Robert Jones & Agnes Hunt Orthopaedic Hosp., Oswestry, Shropshire SY10 7AG England*)

Clinical evaluation of spina bifida patients using hip guidance orthosis, by G. K. Rose, J. Stallard, and M. Sankarankutty. *Developmental Medicine & Child Neurol.* Feb., 1981. 23:1:30-40.

Described is a hip orthosis designed to provide the highest potential level of ambulation for children with myelomeningocele. The orthosis facilitates low energy-cost ambulation at a reasonable speed, as well as independent transfer from chairs to walking and vice versa. It has also enabled some users to ascend or descend stairs of up to 150 mm and gradients of up to 1:10. A review of 27 patients who had used the orthosis for periods of between 6 and 45 mos. was performed to determine the degree of benefit. Seventeen of the patients had no power in or below the hips, 10 patients had lumbar lesions, and the others had dorsol lesions. Evaluated by Hoffer's system of classification, 13 persons demonstrated improved ambulation when using the hip guidance orthosis, and most of the others showed some measurable improvement in ambulation. Testing of 14 patients before and after use of the orthosis revealed a mean

increase in speed of 87.3% with an accompanying decrease in heart rate, which clearly indicated improved efficiency. It is concluded that the hip guidance orthosis can provide low-energy ambulation for persons with spina bifida who have dorsal and high lumbar lesions. A photograph of the orthosis and tabular data are included. (16 refs.)

SPINAL CORD INJURIES

386. Gunby, Phil

New focus on spinal cord injury. *JAMA*. Mar. 27, 1981. 245:12:1201-1206.

Discussed are the intensive-care services for patients with acute spinal cord injury (SCI) offered by the Midwest Regional Spinal Cord Injury Care System in Chicago and 13 similar systems financed by the Rehabilitation Services Administration (RSA). Better clinical results at these centers are attributed to emergency treatment at the scene of the accident, including prompt recognition of actual or potential SC damage, swifter and safer transportation of injured persons to care facilities, and maintaining oxygen saturation of the cord area. Statistics on the incidence of complete and incomplete lesions and the costs of these injuries are provided, and the effects of different levels of SCI are summarized. Aspects of patient transport (administering drugs en route and protection of the injured cord area) and surgery (decompression of the cord and thoracolumbar procedures) are addressed. Also covered are rehabilitation services in the RSA system (including a model home for independent living) and prevention (including public education campaigns). In addition, the services offered by the Veterans Administration for persons with SCI are outlined.

JAMA is published by the American Medical Assn., 535 N. Dearborn St., Chicago, IL 60610.

See also p. 299.

SPINAL CORD INJURIES—NURSING CARE

387. Noble, Philip C.

The prevention of pressure sores in persons with spinal cord injuries. New York, World Rehab. Fund, 1981. 59 p. figs., tabs. paper.

A common complication among elderly persons, persons who are immobilized, and those with spinal cord injury (SCI), pressure sores or decubitus ulcers are defined as a "region of cellular necrosis of skin induced by external forces." Focusing on the incidence of this problem among persons with SCI, this monograph presents practical approaches to treating irritated skin or soft tissues.

Opening sections discuss the relationship between SCI and ulceration, multiple admissions among persons with SCI because of this problem, and factors that contribute to the development of pressure sores (the capacity of the body to support localized forces, manner of loading of body tissue, and general medical condition of the individual). Recommended measures for preventing pressure sores are: formation of pressure-management clinics, in which each patient's

risk for ulceration is assessed, suitable wheelchair cushions, postural supports, and other protective aids are prescribed, and patients are encouraged to take responsibility for care of their skin; and design and prescription of appropriate wheelchair cushions, considering the alternatives in flat pads and cushions with contoured surfaces. Also described are ways that patients can protect their skin during activities of daily living. The pressure sore prevention program at Royal Perth Rehabilitation Hospital in Western Australia is evaluated in terms of rates of readmission and costs of services, and ways of improving this program are suggested. A concluding section identifies areas for future research, such as determining which persons with SCI are most susceptible to decubiti and which activities are most directly responsible for skin breakdown. This comprehensive and pragmatic booklet also contains numerous references.

Additional information on this publication is available from World Rehab. Fund, 400 E. 34th St., New York, NY 10016.

SPORTS

See 324.

STROKE

See 330.

STROKE—SEXUALITY

388. Bray, Grady P. (Box 644, Univ. of Rochester, School of Medicine and Dentistry, Rochester, NY 14642)

Sexual function in stroke survivors, by Grady P. Bray, Richard S. DeFrank, and Terri L. Wolfe. *Arch. Phys. Med. & Rehab.* June, 1981. 62:6:286-288.

Although several authors have discussed the general topic of sexual function after stroke, there is a dearth of literature on the specific effects of this disability on sexuality. This comparative study of the sexual interest, function, and attitudes of 35 patients (24 men and 11 women) before and after stroke found no significant changes in the sexual interest or desire of either men or women. However, men reported a significant decrease in ability to achieve an erection and to ejaculate, and all of the 5 women who were premenopausal at the time of stroke indicated major alterations in menses. Only 1 woman reported orgasm following her stroke. Nineteen (79%) of the men and 8 (73%) of the women considered sexual function to be important to them, while all of the men and 8 (73%) of the women thought it was important to others of their age. The results from this small sample suggest that although the majority of persons who have a stroke continue to have sexual desires and believe that sexual function is important, most of them have problems with sexual dysfunction. These problems seem to be of sufficient seriousness and prevalence to require further study. Tabular data included.

STUTTERING

See 325.

TRANSPORTATION

389. *Rehab. Digest*. July-Aug.-Sept., 1981. 11:3:1-7, 15-19.

Series of articles devoted to transportation for handicapped persons.

Contents are: Transportation of the Handicapped: The Jurisdictional Maze, by Mary E. Allen, p. 2-3.—Transportation: Key to Integration, by David A. White, p. 4-5.—Equality for Handicapped: Can the Nation Afford It? by Harrison Donnelly, p. 6-7, 17.—Integrated Transportation Project: Victoria, B.C., by Harold Hawkins, p. 15.—Access to the Skies: A Rehabilitation International U.S.A. Program, p. 16-17.—Intra-Urban Public Transportation: For All or Some, by Robert F. Hunn, p. 18-19.

Rehabilitation Digest is published by the Canadian Rehab. Council for the Disabled, Suite 2110, One Yonge St., Toronto, Ontario M5E 1E5, Canada.

VISION—DIAGNOSIS

390. Bax, Martin (Thomas Coram Research Unit, 41 Brunswick Square, London WC1N 1AZ England)

Clinical testing of visual function of the young child, by Martin Bax, Hilary Hart, and Sue Jenkins. *Developmental Med. & Child Neurol.* Feb., 1981. 23:1:92-95.

Described are methods of testing the near and far vision of young children. For children aged 3 mos. to 2 yrs., a series of graded balls (from 61.5 cm to 3 mm) are recommended to test tracking ability and minimal observable distance. The balls are either rolled 10 ft. away from the child or attached to sticks and moved around a screen by the observer. Two-yr.-olds are asked to name 7 miniature toys at a distance of 3 m. The visual acuity of children over 3 yrs. of age can be evaluated with a series of letter-matching tasks performed at a distance of 3 m. Advantages over the standard Snellen vision test are pointed out, and results of these tests obtained from 300 nonhandicapped children are provided. Adaptations of the techniques for disabled children are suggested.

VOCATIONAL GUIDANCE

391. Clark, W. Dave

The role of job seeking and job development skills in successful placement. *Voc. Evaluation & Work Adjustment Bul.* Spring, 1981. 14:1:6-10.

The rehabilitation process is made up of various factors, among which are the job placement activities that should begin at the time of initial contact with clients. The extent of the counselor's involvement in these activities depends in part on the client's proficiency in job seeking and job development skills. This article reviews results from studies indicating that instruction in these skills contributes to faster job placement, higher starting salaries, and greater job satisfaction. Also presented is information on the basic aspects of successful job seeking and job development. Suggestions are provided for both counselors and clients on how to develop jobs, obtain in-

ABSTRACTS

formation before contacting an employer, and address relevant points while talking with an employer. (30 refs.)

Vocational Evaluation and Work Adjustment Bulletin is published by the Rehab. Inst., Southern Illinois Univ., Carbondale, IL 62901.

VOCATIONAL REHABILITATION—ADMINISTRATION

392. *Voc. Evaluation & Work Adjustment Bul.* Fall, 1980. 13:3:79, 81-102.

Series of articles on certification.

It is likely that the certification of vocational evaluators and adjustment specialists will be in effect by the end of this decade. One theme of this series of articles is that certification and competence in these fields must be considered as 2 separate issues. Certification insures that an individual meets at least the minimum standards of a profession in terms of work experience, education and training, and references; competence signifies the quality of the person's job performance. It is suggested that the concept and process of certification be used to stimulate the development of valuable educational opportunities, to attract talented persons to these professions, and to improve the status of practitioners and the delivery of services.

Contents are: The Certification Process: Friend or Foe, by Richard J. Baker, p. 79, 102.—VEWAA Certification: A Reality for the 1980's, by Walter A. Pruitt, p. 81-82.—Certification of Vocational Evaluators and Work Adjustment Specialists: Its History and its Future, by Darrell Coffey and Victoria Ann Mason, p. 83-85.—Proposal: VEWAA Certification Process, by the VEWAA Certification Committee, p. 86-91.—Certification for Vocational Evaluators: Results of the Survey, by Charles C. Coker, p. 92-97.

Vocational Evaluation and Work Adjustment Bulletin is published by the Rehab. Inst., Southern Illinois Univ., Carbondale, IL 62901.

VOCATIONAL REHABILITATION—PROGRAMS

393. Sawyer, Horace W. (*Rehab. Admin. and Services Program, Rehab. Inst., Southern Illinois Univ., Carbondale, IL 62901*)

Adjustment techniques in transition, by Horace W. Sawyer and Brenda G. Morgan. *Voc. Evaluation & Work Adjustment Bul.* Spring, 1981. 14:1:20-27.

The conceptualization of rehabilitation adjustment services has been broadened to include all activities that develop skills enabling individuals to live as independently as possible. This article discusses innovative trends and selected strategies in adjustment services. The following adjustment techniques, which are designed as part of comprehensive services, are described: individual counseling, assertiveness training, biofeedback, modeling, and "microtraining" (emphasizing single skills, presentation of relevant models, various forms of feedback to the individual, and positive supervision). For each technique, a review of the literature was conducted to determine new developments and related research that could be applied to rehabilitation settings. Also cited is the need for sound research on the effective application of adjustment techniques. (54 refs.)

WHEELCHAIRS

394. Garee, Betty, ed.

An Accent guide: Wheelchairs and accessories. Bloomington, Ill., Accent Press, 1981. x, 129 p. illus., photos. paper.

Persons who use wheelchairs often complain about the designs of this form of mobility and the maintenance of their chairs. Intended for persons buying their first wheelchair, experienced users of this aid, and professionals, this booklet addresses these 2 problems by presenting a wide variety of wheelchairs from which an appropriate design can be chosen, as well as comprehensive information on upkeep. Numerous photographs supplement the practical suggestions on selection, control systems, batteries and power units, the mechanics of wheels and tires, and accessories that can be added for comfort, safety, and convenience. Addresses of manufacturers of recommended products are included.

Copies of the publication are available for \$7.50 (plus \$.65 for shipping) from Accent Special Pubs., P.O. Box 700, Bloomington, IL 61701.

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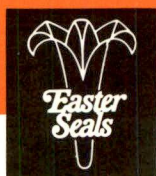
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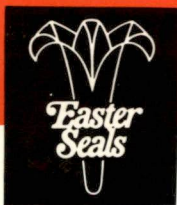
REHABILITATION LITERATURE

Nov.-Dec. 1981

VOLUME 42/NO. 11-12



*1981, The International Year
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In this issue: Adjustment to Disability;
Down's Syndrome; Spinal Cord Injury

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REHABILITATION LITERATURE

Article of the Month

Concepts of Adjustment to Disability: An Overview

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About the Author . . .

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ACCORDING to Lazarus,⁴⁴ the concept of adjustment may be traced to biology and Darwin's theory of evolution. Through the process of natural selection, species adjust to their environment in order to survive, and this is what constitutes evolution. Psychologists have come to apply this idea to psychological changes occurring within the person; psychological survival for the individual involves adjusting to meet threats imposed by internal and external demands.⁴⁴

Loss and change of sufficient magnitude produce crises threatening one's psychological equilibrium. Marris⁴⁷ studied various situations involving loss and change, and he observed that people tend to be conservative (to attempt to preserve the status quo) and that changes producing considerable disruption cannot be acknowledged without distress. Caplan⁸ has suggested that there are crisis situations that produce characteristic psychological responses to stress. Although these responses could be considered abnormal in the context of routine, daily life, they are deemed normal, because they are temporary and they are bound to the crisis situation. The distress that people feel at such times have come to be referred to as "transient situational disorders."¹⁰ The concept of adjustment has come to be applied to this context; it explains how and to what end a person deals with crises that threaten psychological functioning.

Among the threatening situations to which the concept of adjustment has been applied, physical disability ranks high. Holmes and Rahe³⁴ studied stressful life events, and they found there are many sorts of changes in life, both positive and negative, which are stressful; physical illness or disability ranked sixth from the top of the list of those events seen as most stressful. A physical disability presents the person with a crisis calling for adjustment, primarily because of the major physical losses and changes it produces.^{4,37}

A physical disability produces changes in one's psychological and behavioral functioning. There are changes—in how one physically gets around, in thoughts and feelings, in ways of finding satisfactions, and in role functioning within the context of family, friends, and society at large. Adjustment to a permanent physical disability involves integrating the reality of the disability within the person's cognitive, affective, and behavioral functioning.

Defining Adjustment

Arriving at a satisfactory and generally accepted way of defining adjustment is often difficult. First, there are multiple definitions possible, all of which vary according to their theoretical perspectives; from one theoretical stance adjustment is defined in terms of relative levels of behavioral functioning, while from another it is defined in terms of mental attitudes. The review of the literature that follows will discuss in much more detail the various theoretical approaches and the ways in which they define adjustment to disability.

A second problem concerns terminology. There are many terms used by different writers to identify what appear to be the same or highly similar forms of psychological phenomena. For example, *adaptation* is a term often used synonymously with adjustment. *Coping* and *mastery* are terms also used to label psychological phenomena that are either a part of adjustment or almost the same thing as adjustment. Finally, the term *rehabilitation* is often used in ways similar to adjustment. It may be possible to clear up this lexical difficulty by putting together some sort of logical hierarchy or structure for these terms, but that is not the objective here. For the purposes of this discussion, only one term will be used: *adjustment*.

Lazarus⁴⁴ states that those who address the concept of adjustment have seen it either as a process through which the person goes in psychologically dealing with life's demands, or as a psychological outcome that the person achieves. It is not that adjustment should logically be divided in this way, but this is how it has been approached by others. These are not unrelated ways of viewing adjustment; just as the process of learning the alphabet culminates in the outcome of having learned the alphabet, so does the process of adjusting to a disability lead to the outcome of being adjusted to a disability. The single term *adjustment* is often used for both the process and the outcome, and this is the third complication arising when defining adjustment; adjustment may be defined either in an outcome-oriented way or a process-oriented way.

Good and Bad Adjustment

It is difficult to talk about adjustment without ad-

ressing the fact that a person's adjustment may be deemed good or bad. The matter of abnormal adjustment or maladjustment is implied in any discussion of adjustment. Many who address adjustment to disability include discussions of what they consider to be abnormal, maladaptive, and self-destructive responses that obstruct adjustment and rehabilitation.^{11,20,33,35,51,62,72}

Values. Difficulties arise when it comes to asserting what optimal adjustment is or ought to be, because the criteria selected for distinguishing between good and bad adjustment will reflect personal values. It is thought that once value judgements enter the picture, adjustment becomes a culturally relative concept.⁴⁴ This becomes a problem, because we may wish to remain scientific and objective, and because there tends to be greater consensus about what is abnormal than what is normal.⁷⁰ For example, in a study of adjustment to physical disability, Bell⁵ found much more inter-rater agreement on "bad" adjustment than on "good" adjustment.

It appears impossible to avoid values, and we may best deal with them by accepting their presence, by attempting to regulate their point of impact, and by being clear about them and their influence. It has been noted that, contrary to previously held views, science is inescapably imbued with paradigmatic biases⁴¹ and is deeply informed by human values.⁷

Adjustment to Disability

Shontz⁶³ has traced the trends in theories of adjustment over the past 30 years. He notes that at first it was thought that the disability itself was the problem, rather than its psychological consequences, and it was expected that once the physical effects of the disability were reduced or counteracted, any psychological disturbances would subside. This rapidly proved to be an inadequate approach, because there were those who appeared unrehabilitated in spite of efforts to physically combat the handicapping consequences of the disability. Attention then moved from physical concerns to psychological concerns, and motivation came to be regarded as a major factor in rehabilitation; it was felt that lack of motivation led to failures in rehabilitation. Eventually, this too appeared to be an inadequate approach, because it was not an insufficiency of motivation but a blocking or misdirecting of it that obstructed rehabilitation efforts.⁶³

Later approaches focused increasingly upon the psychological adjustment of the person in response to the disability. For the purpose of discussion here, these may be divided into three categories: *a)* approaches that are more oriented to the person, *b)* approaches that are more oriented to the socio-

environmental context, and *c*) approaches that are integrative and view adjustment arising out of the interaction between the person and his or her social and physical environment.

Person-Oriented Approaches

Person-oriented approaches to adjustment to disability focus primarily upon what happens for the person in dealing with a disability. These approaches may be divided into those concerned with the behavioral aspects of adjustment and those concerned with the mental aspects of adjustment.

Behavioral Adjustment. Some explanations of adjustment to disability are drawn from behavior therapy. These are often the least complex explanations. Although many have contributed to the formulation of behavior theory, Pavlov's⁵⁴ principles of classical conditioning and Skinner's⁶⁶ principles of operant conditioning are basic to explanations of behavioral adjustment. Several researchers and theorists have applied this perspective in explaining rehabilitation and adjustment to disability.^{17,22,23,24,26}

From the behavioral viewpoint, adjustment involves the person's actual behavior, not how he or she thinks or feels. Behavior theory is concerned with how stimuli and responses go together such that certain stimuli come to elicit certain responses and cause them to persist. The onset of a permanent physical disability radically alters the person's ability to respond with behaviors that previously were physically possible; as a result, the conditioned and unconditioned responses and the reinforcers or stimulus consequences experienced by the person prior to disablement are no longer operative after the onset of the disability.

The behavioral approach is simple and direct. Adjustment involves dealing with the person's changed capability to physically behave as much or in the same ways as before. This requires finding new behaviors and reinforcers. The process of adjustment involves the learning, over time, of new reinforcers and behaviors. Adjustment is achieved when the person establishes new rewards and satisfactions, and when he or she returns to premorbid levels of behaving.

Mental Adjustment. The focus here is upon the internal psychological life of the disabled person, and there is complexity and variety to these explanations of psychological adjustment. The discussion below will first examine the origins of this approach and two early applications. Then there will be a section dealing with the process of mental adjustment followed by one addressing the outcome of mental adjustment.

Theories of mental adjustment are primarily psychodynamic in nature. This orientation may be traced to the work of Sigmund Freud and his con-

cepts of *a*) dynamic interaction between psychic forces or entities, and *b*) the process of psychological development taking place in stages. A major concern here is with how the person defends against and then comes to terms with objectionable internal and external events causing distress and psychic upset. The onset of a physical disability is a source of such psychologically objectionable material. In this regard, defensive reactions, such as denial and regression, are then seen as psychodynamic responses that occur during adjustment.²⁹

The works of two psychodynamic theorists, Adler² and Schilder,⁶⁰ were sources for early explanations of adjustment to disability.¹⁹ Adler was concerned with striving for superiority as a reaction against feelings of inferiority; his approach found application in the area of physical disability, because the experience of loss and devaluation produced by a disability was presumed to lead to feelings of inferiority. Schilder was concerned with body image and self-concept; changes in one's body caused by a disability were seen as having a direct bearing upon one's body image and self-concept.

Process of Mental Adjustment. The process of mental adjustment has most frequently been seen as taking place in stages. Although stages were initially used to explain the normal process of human development during childhood and adulthood, it came to have applications in other areas, such as crisis situations and transient situational disturbances. It has been used to explain the normal psychological responses to fatal illness,⁴⁰ and it has been used to describe the normal psychological responses to a permanent physical disability.^{9,13,20,21,29,32,33,38,39,55,62}

There are some common characteristics to the various stages of adjustment presented by those concerned with physical disability; indeed, there are more similarities than differences. In order of appearance, the stages often discussed include the following: *a*) initial shock, *b*) retreat or denial, *c*) grief, mourning, or depression, *d*) reactions against dependency, which include separation anxiety, assertion, and aggression, and *e*) eventual adjustment based largely upon acceptance of the disability and renewed life involvements.

Although many see the process of adjustment occurring in stages, this approach has been criticized, and its value may be primarily heuristic. Those who espouse it offer little support beyond personal experience or clinical impressions.⁶⁹ Also, some research into various responses to disability have failed to find evidence to support this approach, or have found evidence contradicting it. For example, denial and depression may not be necessary or beneficial, and they may not occur in distinct stages.^{16,43}

The major contribution of the stage-oriented ap-

proach to adjustment to disability may be the suggestion that this process involves moving from negative, rejecting responses to more positive and more accepting responses; at present this may be the best way to view the process of psychological adjustment to disability. There may be no distinct stages, and the sequence of psychological responses may not be the same for each person (they may occur in different orders, and some may be omitted), but the movement toward acceptance occurs nevertheless. This movement is manifested in terms of ongoing cognitive appraisal and reappraisal (recognizing and accepting the reality of the disability and changing values or attitudes about its meaning and consequences) and in terms of affective responses to it (feelings of helplessness, sorrow, despair, anger, and so on), which diminish over time.

Means and Akridge⁴⁸ have offered a concept of the process of mental adjustment that does not involve stages. Their approach contains a conception of what constitutes health, and this is manifested in what they call "healthy personing." For them, the healthy person appears to be an adequately adjusting person; that is, a person who, through a process that they outline, is continually acting constructively and maintaining open, facilitative relationships with others and the world around. For them, "the process of personal adjustment is the organization and disorganization of component processes such as the congruency of beliefs, values, and skills, or the integration of sensing, interpreting, feeling, intending and acting."^{48, p. 26} This approach may be seen as similar to that taken by the phenomenological/existential or humanistic theorists; instead of looking at "adjustment," they examine "adjusting."

For Means and Akridge, the process of adjusting is circular, and it has inputs occurring where persons interact with their social environment. They describe the nature of the adjusting person in the following way. First, the adjusting person is one who utilizes basic communication abilities, which include "the ability to attend, recognize, and report feelings and intellectual interpretations of self, world, and others." Second, the adjusting person is able to locate, experience, and communicate a purpose that includes a "persistent conceptualization of self, others, the world, and time"^{48, p. 26} and which has personal meaning. Third, the adjusting person possesses beliefs related to personal and social functioning; these include: *a*) belief in responsibility of each person for defining a purpose for being, *b*) belief in personal freedom and the responsibility for choosing, *c*) belief in the changing character of human existence, *d*) belief in one's self as a limitless resource to one's self, *e*) belief in the limited opportunities imposed upon life by mortality, *f*) belief in others as resources, *g*) belief

that each person is part of a whole that is presently defined as mankind, and *h*) belief in the earth's limited ability to be a resource. Fourth, the adjusting person possesses values that actualize his or her beliefs, especially as they "yield specific decision-making power for choosing." Fifth, the adjusting person possesses achievement skills enabling him or her to "convert problem statements or personal deficits into goal statement, identify, schedule and rank behaviors which lead to the desired goals, constructively act, and monitor and modify."^{48, p. 27} Sixth, the adjusting person possesses self-control skills in the areas of anxiety, concentration, and will power. And seventh, the adjusting person works toward an integration, which involves "continually converting one's belief system into behavior in more and more aspects one's life."

Outcome of Mental Adjustment. Seen as an outcome, mental adjustment involves the person's acceptance of the disability and self-concept. When adjustment is achieved, the person does not deny the fact and the difficulties it produces, and does not find his or her self-concept to be overly colored by the disability. Being adjusted to a disability means being able to obtain satisfactions within the limits imposed by the disability.⁵² As a result, being disabled is different but not "bad."⁹

Acceptance has been seen as crucial to the outcome of psychological adjustment. Wright⁷³ believes that the person who has come to accept a disability is well on the way to being adjusted to it. Vash⁷¹ similarly considers acceptance to be a fundamental aspect of dealing with a disability. Heijn³¹ notes that a major task of adjustment is recognizing the fact of the disability and the event or circumstance that caused it. Grayson²⁸ sees denial and acceptance as mutually exclusive opposites, and from his viewpoint denial must be overcome for the person to accept his or her disability. Kerr and Thompson³⁹ go further and speak of acceptance as not simply the opposite of denial, but as the very substance of adjustment that must be achieved bit by bit over time. Dembo, Leviton, and Wright¹⁵ insist that acceptance is more than simply becoming reconciled to one's fate; rather, it is a matter of arriving at a value change in which the disability is still seen as inconveniencing but not discrediting or overwhelming. Wright⁷³ describes what she feels are the four key aspects of acceptance of a disability: *a*) enlarging the scope of values, *b*) containing the disability effects, *c*) subordinating physique, and *d*) transforming values based upon comparisons between one's self and others into values based upon one's own assets and liabilities.

Acceptance of a disability has come to be viewed as related to one's overall self-concept. Research comparing responses on a self-concept scale to responses on an acceptance of disability scale indicates that ac-

ceptance is related to self-concept in general and that it is important to relate the value shifts occurring in acceptance with the broader perception of self.⁴⁶ Speaking from personal experience, Vash similarly relates acceptance to the larger issue of self when she states that "acceptance of disability was simply acceptance of myself; and there were parts of me that were harder to accept than my disability by far."^{71, p. 153}

Socio-Environmental Approaches

The socio-environmental approaches look primarily at the influence of external situations on the person with a disability. Theoretical explanations and research findings are expressed in terms of the social and physical situations confronting the person.

Social Construction of Reality. The idea that reality is socially constructed offers a basis for socio-environmental explanations for adjustment to disability. Attitudes, roles, social networks, labels, and so on are all part of human interaction, and they form the basis for day-to-day realities of life. Similarly, social interactions result in the physical objectifications of social realities.

It should be noted that this is not a discussion of ultimate or absolute reality. What is of concern here is the medium of social interaction whereby reality is constructed, perceived, communicated, and maintained.

Berger and Luckman⁶ point out that reality is sustained both within and by human perceptions and interactions. They suggest that, on one hand, people construct reality in the way in which they socially learn to perceive and communicate about the world around them, and that, on the other hand, they construct it behaviorally by ongoing social interactions (for example, through roles) and the manufacture of human artifacts (such as cities).

What is especially important about the social construction of reality is its dual impact upon the person with a disability. First, it is within the framework of existing social reality that the person comes to deal with his or her disability. Second, the fact that a physical limitation is disabling is partially a result of socially constructed realities, whether in the form of attitudes toward disability or architectural barriers. In the end, a person may be more disabled by social problems than medical conditions.⁶¹

Attitudes. Researchers concerned with sociopsychological aspects of physical disability have devised and employed scales to investigate the various forms and functions of attitudes held toward physical disabilities and persons who have them.^{64,65,74,75} Those who have reviewed research into attitudes toward disability and those with disabilities^{42,57,67} have noted that, either from the perspective of research or histor-

ical analysis, an impairment can evoke both negative and positive social responses. A person may experience difficulty in dealing with the stigma attached to a disability,²⁵ but at the same time a person may derive benefits from being in a marginal social status.⁵⁶ Wright⁷³ has discussed the ways in which a disability may result in both "inferior" status and a "salutary" status. Straus⁶⁷ has noted that, historically, those who have physical disabilities stand in the ambivalent positions of being deified or degraded. Conflicting expectations face the person with a physical disability.

Attitudes toward disability have a significant impact upon that part of adjustment involving acceptance. Within society at large, few people, if any, feel that "crippled is beautiful."⁴² As a result, there is a limit to how far a person can go in embracing or accepting disability; one is not supposed to accept it to the point of liking it. Acceptance then becomes a matter of "biting the bullet and smiling at the same time—and about equally easy."^{71, p. 151} The reason that crippled is not beautiful is that healthy is beautiful, and no one feels it is good or better to be disabled.⁴⁹

Labeling. To an extent, labeling creates and manages deviant status. Labeling theory offers a perspective on disability that reveals how social phenomena are created and sustained through language. From this point of view, disability is seen as deriving from an interaction in which it becomes experientially real through labeling either by one's self or by another person. A physical impairment is thus seen as a disability (and all that implies for social interactions) when it is so labeled. Just as we might say that beauty is in the eye of the beholder, so might we say that disability is in the labeling of it. Among those who have applied this approach to disability are Jones,³⁶ who found labeling to be fundamental in the social management of black children with mental retardation, and Scheff^{58,59} who found labeling to be central in identifying and managing disabled people who are receiving rehabilitation services.

Adjustment. Within the context of socio-environmental approaches to disability, adjustment may be viewed in terms of the individual, or in terms of society at large. In both cases, adjustment may be seen as occurring in terms of the physical situation or in terms of the social situation. In all cases, those writing in this area make little distinction between the process and outcome of adjustment.

1. *Physical situation in terms of the individual.*

It is the disability itself that constitutes the physical situation in terms of the individual person. The level or degree of impairment determines what sorts of physical adjustments should be made. The earliest approaches to adjustment focused upon physically compensating for the disability. These were attempts to change the person's environment at a very personal

level. Thus, for example, poor vision may be compensated for by use of eyeglasses; similarly, adjustment to paralysis in the legs may involve the use of braces and crutches.

2. *Physical situation in terms of society at large.*

Recent attention has moved to the societal level. There has been a shift from the immediate functioning of the person's body to the physical situation determined by the overall environment. Inasmuch as the physical environment we all share is to some degree a product of human interaction, this concern with the physical environment facing persons with disabilities is actually a concern with the social construction of the physical realities, which in part make a disability disabling. If the physical environment, particularly that which is man-made, presents barriers or obstacles, the impact of the disability is magnified. The issue is one of accessibility; architectural barriers obstruct the free movement and exacerbate the limitations imposed by the disability.³⁰ Such barriers are the product of socially constructed reality, and at the physical level, socio-environmental adjustment involves the removal of as many architectural barriers as possible.

3. *Social situation in terms of the individual.*

At the individual level, the person adjusts within the context of roles. The person with a disability occupies a deviant position in society, and his or her social career is managed through roles. In this way, the person may have deviant status but still have roles that normalize functioning. Among the roles identified by Parsons⁵³ is the *sick role*, which involves exemption from normal social role demands under the condition that the sick person wants to get well and seeks medical treatment. Gordon's²⁷ research indicates that there is also an *impaired role*, which involves those who are chronically ill or disabled and which functions to maintain normal activities and social involvements. The issue the person faces is being different (which arises from being physically impaired), not being sick.¹ During the early stages of disablement, particularly if the person is acutely ill at that time, the sick role is most relevant; later the impaired role becomes operative.

In addition to routine role functioning, the person must employ particular strategies for adjusting within the social context. Goffman²⁵ describes methods for *passing* or *covering* that are used to manage the stigma attached to a disability. Davis^{12,14} notes that deviance disavowal is a major means for normalization. As Albrecht puts it:

The disabled person redefines deviancy and values in terms of his resources, his own and others' expectations, and his reference group. What was "normal" for him yesterday is impossible or inappropriate for him today.^{3, p. 19}

It is not simply a matter of fitting into society, how-

ever. It is also a matter of utilizing social resources in adjusting, and friends or family may contribute a great deal in this area.

4. *Social situation in terms of society at large.*

Although it may seem somewhat strange to think of adjustment as occurring at the group level, this is a reasonable locus for adjustment. In this framework, it is not the individual who adjusts to disability but society as a whole which adjusts. Adjustment at the societal level would be in the area of commonly held attitudes toward disability. Toward this end, English¹⁸ suggests the use of a program he has designed to alleviate and combat stigma toward those with disabilities on the part of the general public and those who are directly involved in assisting these individuals.

Integrative Approach

Of all the perspectives on adjustment to permanent physical disability, the integrative approach appears to be the most comprehensive; it includes both personal factors and socio-environmental factors. Adjustment is seen as occurring through the interaction between the person and the environment. Personal and socio-environmental factors are integrated in this approach. The ways in which the person adjusts, the amount of adjustment required initially, and the type of adjustment achieved must be viewed in the context of the person's background and the situation.

Lewin's⁴⁵ work has been seminal in this area. Furthermore, his theoretical stance has influenced several who have been concerned with adjustment to disability.^{4,9,49} Lewin developed a field theory that integrates the person with his or her life space. The key principle in Lewin's theory is that behavior is a function of the interaction between the person and his or her environment.

A major feature of the integrative perspective is its attempt to view adjustment in relativistic terms. It has been noted that while we may wish to use a single scale for assessing adjustment to a disability, it should be a sliding scale, one taking into account variations between people.⁶⁸ Instead of limiting adjustment to some concrete state, process, or level of response, the integrative view takes into account the situation for the person and personality factors bearing upon how that person adjusts.

Moos and Tsu⁵⁰ have been among the most recent to elaborate a model of adjustment taking into account the integration of individuals with their environment. Although they intended it for use with respect to chronic illness, no disservice is performed by shifting it to physical disability. They see adjustment as taking place in the context of various background and personal factors, disability-related factors, and

physical and social-environmental factors. Adjustment is based upon an interaction between cognitive appraisal of the situation produced by the disability, adaptive tasks required by the disability, and the coping skills the person possesses. The sorts of background and personal characteristics that are relevant are "age, intelligence, cognitive and emotional development, philosophical or religious beliefs, and previous coping experience."⁵⁰, p. 15 The illness-related factors include the nature of the disability or illness and the consequences of it (for example, whether it is painful or disfiguring and whether the portions of the body affected is vested with particular physical or psychological importance). The nature of the physical setting (including possible barriers to mobility, novelty of settings, and aesthetic qualities) and the social context (including family, friends, and health professionals) comprise the factors determined by the physical and social environment. All of these interact with each other, and in combination they influence the ways in which the person perceives the meaning of disability, the sorts of adaptive tasks that arise, and the coping skills that are employed. Moos and Tsu identify seven adaptive tasks, which may be divided into two categories. The first are illness-related, and they include: dealing with the pain and incapacitation, dealing with the hospital environment and special treatment procedures, and developing adequate relationships with professional staff. The second is a general category, and it includes: preserving a reasonable

emotional balance, preserving a satisfactory self-image, preserving relationships with family and friends, and preparing for an uncertain future. There are also seven major types of coping skills, including the following: denying or minimizing the seriousness of a crisis, seeking relevant information, requesting reassurance and emotional support, learning specific illness-related procedures, setting concrete limited goals, rehearsing alternative outcomes, and finding a general purpose or pattern of meaning.

Summary and Conclusions

The intent here has been to review the various ways in which adjustment to permanent disability has been addressed. Some have viewed this topic primarily in terms of the individual; others have looked mostly at the person's social or physical situation; and finally, there have been those who see adjustment as involving both the person and his or her milieu. Although few would deny the need to take into account the overall situation for the person, it has been suggested here that those approaches that explicitly deal with the person's integration with their environment may be the most productive; in this way, our understanding of what it means to adjust to a disability will recognize multiple forms and levels of adjustment, which vary according to the person's psychological make-up and his or her social and physical situation.

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Physical Therapy and Infants with Down's Syndrome: The Effects of Early Intervention

SUSAN R. HARRIS, Ph.D., RPT

THE ROLE OF THE PHYSICAL THERAPIST as a member of the early intervention team has become particularly important when working with severely handicapped infants and young children. The therapist's role in both assessment and intervention usually encompasses the areas of gross and fine motor development, self-help skills, sensory integration, and the development of adaptive equipment.¹ Most therapists who work with severely handicapped infants and young children espouse a developmental approach to assessment and treatment in which the developmental motor level of the child is evaluated based on an assessment of gross and fine motor milestones, primitive and abnormal reflex patterns, and the presence or absence of age-appropriate automatic responses. Intervention is then directed at facilitating those motor activities that are *developmentally* appropriate for that particular child, regardless of current chronological age.

Because children with Down's syndrome (DS) have been viewed primarily as mentally retarded rather than as motor delayed, they have not frequently been considered as candidates for individualized physical therapy programs. In actuality, however, infants and very young children having Down's syndrome are generally more deficient in motor skills than in cognitive skills, as evidenced by a number of recent studies.^{2,3,4} Although most children with Down's syndrome eventually walk independently, they continue to evidence deficits in balance, coordination, and gait throughout childhood and adulthood.

To further expand upon this tentative rationale for including physical therapy as part of a Down's syndrome early intervention program, the following section will be directed toward a broader explanation of the delayed neuromotor development characteristic of Down's syndrome in infants and young children.

Neuromotor Development in Down's Syndrome

There are several facets of neuromotor development in Down's syndrome that will be discussed. The underlying neuropathology associated with Down's syndrome will be presented, followed by a discussion of the muscle tone abnormalities and reflex development characteristic of persons with this condition. Specific aspects of motor delay and their relationships to delays in other developmental domains will be presented at the end of this section.

In an attempt to understand the underlying neurological correlates of various neuromotor behaviors characteristic of Down's syndrome, extensive pathological studies have been carried out. Gross examination of the brains of individuals with Down's syndrome reveals both decreased brain mass and weight,⁵ smaller convolutions,⁶ and a more rounded shape.⁷ Whereas the overall brain weight of individuals with Down's syndrome averages 76 percent of the

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brain weight of normal individuals, the combined brainstem and cerebellum weight averages only 66 percent of normal.⁵ Examination of the brains of infants with DS indicates relative neurological immaturity, as evidenced by smaller convolutions than those of nonaffected infants of comparable age, as well as decreased myelination in the frontal lobes, precentral areas, and cerebella.⁶ Additional cytological differences include structural abnormalities in the dendritic spines of the pyramidal neurons of the motor cortex.⁸

A number of clinical neuromotor findings reflect these neuropathological differences. The most frequent neuromotor deficit noted among infants and young children with Down's syndrome is generalized hypotonia or decreased muscle tone.^{6,9} In a longitudinal study of 79 affected infants from birth to 10 months, Cowie¹⁰ administered comprehensive neurological examinations in which she demonstrated marked to extreme hypotonia in all the infants tested. The relatively decreased combined weight of the cerebellum and brainstem is thought to be one of the neurological correlates for the clinical phenomenon of generalized hypotonia.

Another frequent neurological finding demonstrated by the infants in Cowie's study was the retention of primitive reflexes past the time when they should normally disappear.¹⁰ Included among these retained reflexes were the palmar and plantar grasp reflexes, the stepping reflex, and the Moro reflex. Delay in the development of normal postural tone as evidenced by the severe head lag demonstrated during elicitation of the traction response and the lack of full antigravity extension when testing for the Landau response comprise the third major finding in Cowie's study. Possible neuropathological correlates for these deficiencies in reflex development include the delayed cerebellar maturation, the relatively small size of the cerebellum and brainstem, and the maturational delay of cortical pathways from the motor cortex.¹¹

In addition to these clinical neurological findings reflecting delay in the maturation of the central nervous system, infants with Down's syndrome also exhibit profound delays in achieving developmental motor milestones, as indicated in a number of studies. Whereas the mean age for achieving independent walking among nonaffected infants is 11.7 months according to Bayley,¹² the mean age of noninstitutionalized infants with Down's syndrome to achieve independent ambulation ranges from 22.3 months in a 1964 study by Fishler, Share, and Koch¹³ to 30 months in a 1970 report by Donoghue, Kirman, Bullmore, Laban, and Abbas.¹⁴ The average age for institutionalized children to achieve this major motor milestone has been reported to vary from 27 months¹⁵ to 4.2 years.¹⁴ In addition to a severe delay in the mean age of achieving all of the important developmental motor milestones, there is also a much broader age range for accomplishing each of these skills.

The generalized hypotonia characteristic of Down's syndrome has been implicated as a contributing factor in the delayed achievement of these developmental motor milestones by a number of researchers.^{11,15} In addition to being suggested as a factor contributing to overall motor delay, the generalized low muscle tone found in these youngsters has also been correlated with delayed speech acquisition,¹⁵ delayed affective and cognitive development,¹⁶ impaired stereognosis,¹⁷ slower reaction time, and decreased kinesthetic feedback.¹⁸

Although the deleterious effects of hypotonia on other areas of development have been broadly suggested by a number of researchers, there was not a single therapy program for Down's syndrome reported in the literature that advocated any therapeutic techniques for trying to increase muscle tone prior to a recent article published by the author.¹⁹ The following will provide an overview of physical therapy ap-

proaches for Down's syndrome that have been presented in the recent literature, as well as suggest the use of another therapeutic approach initially developed for use with children with cerebral palsy.

Current Physical Therapy Approaches

A review of the American and British literature on physical therapy during the past 15 years reveals only a handful of articles pertaining to physical therapy for Down's syndrome in children.^{19,20,21,22,23,24} Each of these programs will be briefly described, with reference to both its strengths and limitations for use with these individuals.

Kugel²³ described an 18-month pilot study conducted at the University of Nebraska Mental Retardation Clinical Research Center in which the motor skills of seven institutionalized infants with Down's syndrome, aged 4 to 17 months, were to be facilitated through the development of individualized management plans for physical and occupational therapy. General treatment goals included the improvement of head and neck control and the facilitation of developmentally appropriate motor skills such as sitting, creeping, standing, and walking. While these goals seem appropriate to the motor delays described in the preceding section, some of the activities designed to foster the achievement of these goals appear to be inappropriate and possibly contraindicated.

One such example is the repeated use of pull-to-sit activities without head support. The stated objective for this activity is to increase mobility of the head, an objective which appears entirely inappropriate in light of the fact that children with Down's syndrome are already hypermobile due to the decreased muscle tone and joint laxity characteristic of the syndrome.²⁵

A 1971 article by Hughes, an English physiotherapist, describes her 10 years of experience working with infants exhibiting Down's syndrome at Cheltenham Group Hospitals.²¹ While the author espouses a developmental approach to treatment with emphasis on proprioceptive and sensory stimulation, the only specific treatment strategies she mentions are the use of three basic postures: early prone-lying, side-sitting, and early weight-bearing in standing. Although the first two postures seem developmentally appropriate, the encouragement of early weight-bearing in standing must be criticized in light of the poor trunk control, hip instability, and knee hyperextension characteristic of the early standing posture of infants with Down's syndrome. It is hypothesized that the joint instability and hyperextension, which are secondary to the low muscle tone and lax ligaments, may actually be facilitated by encouragement of early weight-bearing in standing and for this reason such a static posture may actually be contraindicated.

A later descriptive report from the British physical therapy literature parallels the treatment approaches suggested by Hughes. York-Moore,²⁴ while also advocating early prone positioning and early weight-bearing in standing, further suggests the use of specific graded activities for strengthening the muscles of the lower extremities prior to the encouragement of weight-bearing. Although the author discussed the importance of attaining good sitting balance, she does not suggest any treatment techniques for facilitating balance or protective responses in sitting. Both York-Moore and Hughes suggest the use of developmentally appropriate, albeit static, postures with little mention of how to facilitate movement into and out of such postures.

In their description of an interdisciplinary program for 40 children with Down's syndrome, aged birth to 3 years, at the University of Tennessee Child Development Center, Connolly and Russell present a comprehensive physical therapy program that includes such activities as "muscle strengthening, range of motion, sensory and gross motor stimulation."²⁰ Stimulation of weak extensor muscles through the use of vibrators and facilitation of righting reflexes using large therapy balls were some of the other very appropriate therapeutic activities included. While the majority of these activities appear both developmentally sound and congruent with the amelioration of the motor deficits characteristic of these infants, the inclusion of range of motion activities seems to be unwarranted in light of the excessive range of motion and joint laxity that generally characterizes the young Down's syndrome population.

A report by Kantner, Clark, Allen, and Chase²² represents the only controlled study cited in the literature that was directed at examining the effects of physical therapy on the improvement of motor performance in Down's syndrome among infants. Due to the extremely small number of subjects used in this study ($n=4$), and the subsequent mortality of one of the subjects in the treatment group, the reported conclusions are extremely tenuous. The authors used vestibular stimulation as the intervention technique for the subjects in the experimental group. The dependent measure used to assess motor performance was an assessment scale developed by the authors. Since the lone surviving experimental subject gained 16 points on the motor scale and the two control subjects showed a mean gain of only 0.75 point, the authors concluded that vestibular stimulation was, in fact, a viable treatment strategy for improving motor performance among children with Down's syndrome. The lack of mention of random assignment to treatment groups raises further questions about the validity of the reported results.

While a number of the treatment techniques de-

scribed in the previous review of physical therapy programs for Down's syndrome are certainly appropriate in their attempts to remediate the motor delays associated with this population, there is yet another more global physical therapy approach that would appear to be even more congruent in its overall goals with the motor needs of this group.¹⁹ The neurodevelopmental treatment approach to physical therapy will now be described in detail.

Neurodevelopmental Treatment Approach

Although originally developed for use with children and adults having cerebral palsy, many of the goals of the neurodevelopmental treatment (NDT) approach seem particularly appropriate for use with children with Down's syndrome.^{26,27,28} One of the primary aims of treatment is the facilitation of normal muscle tone as a basis for more normal patterns of movement.²⁷ In light of the decreased muscle tone characteristic of these infants,¹⁰ the treatment aim of facilitating normal muscle tone is certainly appropriate. NDT techniques directed at increasing postural tone include joint approximation, tapping, and resistance.^{27,29} By increasing muscle tone, the therapist can provide the child with Down's syndrome with a more stable base of support from which to move.

A second goal of the NDT approach is the facilitation of righting, equilibrium, and protective responses as a foundation for normal patterns of movement.²⁸ The severe and persistent head lag noted by Cowie¹⁰ in testing for the traction response in infants with DS exemplifies a marked delay in the achievement of normal head righting and assists in justifying the inclusion of this second NDT goal in a physical therapy program for these infants. Ellis³⁰ has further stressed the importance of facilitating these automatic reactions in the treatment of the severely retarded child.

Since all NDT treatment involves handling of the child and is aimed at facilitating automatic movements rather than conscious, volitional responses, this approach represents an ideal physical therapy strategy for working with very young or retarded children.³⁰

Because the underlying theoretical rationale and goals of the NDT approach seem to correspond so closely to the neuromotor problems associated with Down's syndrome, a research project directed at examining the effects of NDT on improving the motor performance was carried out by the author.³¹ A brief description of this recently completed study is presented here.

Effects of NDT on Motor Performance in Infants with Down's Syndrome

Subjects

Participants in the study were 20 infants with

Down's syndrome enrolled in the Down's Syndrome Infant Learning Program at the Experimental Education Unit of the University of Washington's Child Development and Mental Retardation Center. The infants ranged in age from 2.7 months to 21.5 months at the outset of the research project. There were 11 female and 9 male participants, all of whom exhibited standard trisomy-21 Down's syndrome. Two additional infants were excluded from participation because of impending cardiac surgery, although several of the infants who did participate were those with moderate to severe congenital heart defects. A physician's referral was required for participation in the study as well as a signed parent consent form.

Method

All infants were pretested using two developmental assessment tools: the Bayley Scales of Infant Development¹² and the Peabody Developmental Motor Scales.³² Following assessment, a set of four individualized, behaviorally measurable therapy objectives was written for each infant. Subjects were blocked on three moderator variables (age, sex, and Peabody pretest score) and then randomly assigned to groups. The groups were then randomly assigned to treatment conditions: experimental and control.

The 10 subjects in the treatment group received individualized programs of neurodevelopmental therapy in their homes three times weekly for 40-minute sessions from a registered physical therapist. The intervention period lasted for nine weeks. All infants continued with their once-weekly participation in the Down's Syndrome Infant Learning Program. At the end of the intervention period, all 20 of the infants were posttested on the Bayley and the Peabody scales by a registered physical therapist who had conducted the pretesting and who was blind to the experimental group status of each infant. This same therapist evaluated the attainment of the individualized therapy objectives.

Results

A significant between-group difference in favor of the experimental group ($p < .05$) was demonstrated in evaluating the attainment of the individualized therapy objectives. The treatment group achieved 80 percent of their individualized objectives, whereas the control group achieved 57.5 percent of their

therapy goals. There were no significant differences between groups on either the Bayley or Peabody posttest measures, nor were there significant score differences.

Discussion

The achievement of a significant difference in the attainment of the individualized therapy objectives lends support to the hypothesis that neurodevelopmental therapy will improve motor performance in infants with Down's syndrome. The failure to find significant between-group differences on either the Bayley or the Peabody scales suggests several limitations, including the relatively small sample size, the brief length of the intervention period, and the lack of sensitivity of these tools to subtle neuromotor improvements.

Because this study represents one of the first carefully controlled group studies aimed at evaluating the efficacy of physical therapy on improving the motor performance of individuals affected by Down's syndrome, it is hoped that it will serve as a springboard for further research on the effects of early physical therapy intervention both with this group and with other specific disabled populations.

Summary

The purpose of this review has been to clarify the role of the physical therapist as part of the Down's syndrome early intervention team by first examining the neuromotor delays associated with Down's syndrome and then discussing some of the possible therapeutic approaches for remediating these delays. The theoretical rationale of the neurodevelopmental approach to treatment was presented in some detail for the purpose of serving as an introduction to the discussion of a research project that was directed at examining the effects of this approach to therapy on improving the motor performance of infants with Down's syndrome. The study described in this article represents an early attempt to evaluate the efficacy of physical therapy as an integral part of early intervention.

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Research Implications on Choosing a Program to Teach About Disabilities

BARBARA SHILLER HEINISCH

E DUCATORS who are concerned that children with disabilities be accepted by their peers in the mainstream are finding that it is necessary to teach specifically about children with differences. This is not a subject that is usually taught at home, and only recently has it begun to be addressed in the schools. Our society has isolated people with differences for so long that many people do not know how to relate

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to a person with a disability. Many peoples' insecurities on meeting a disabled person stem from a lack of knowledge about what the disability involves. It becomes hard to see where the disability ends and the person begins. The result is avoidance, which is interpreted by some researchers as a measure of negative attitudes.

There are many factors underlying these negative attitudes. Some feel that peoples' responses to the disabled minority are a form of prejudice, which differs from the prejudice felt toward any other minority group because of the personal threat involved. Most people have a very slim chance of suddenly joining any other minority group! Many who find the thought of becoming disabled unpleasant simply avoid people with disabilities.⁷ Another factor is negative spread,² in which persons with disabilities are perceived in terms of the negative affects of their disabilities. Being disabled is negative; thus the *person* is seen in a negative light. Unfortunately, people with disabilities are often grouped as if the disability were a personality factor. A disability, then, rather than being interpreted as an inconvenience, is seen as the salient characteristic of a person.

Gleidman and Roth⁴ describe an interesting phenomenon: It seems that when a member of the black minority, for example, becomes successful, he becomes the "Famous Black Baseball Player." He becomes a role model, living proof that a member of his

minority group can succeed. When a disabled person transcends the stereotyped dependent role to achieve success, the disability seems to recede into the background. Instead of adding status to the image of individuals with disabilities, the successful person's disability is rarely, if ever, mentioned.

Whose responsibility is it to tackle the problem of changing attitudes? Some qualified people have written books and curricula expressly for that purpose. Examining the plethora of new materials in this area, however, it becomes clear that in many cases some of them could negatively influence the attitudes of children. It is obvious that many of the authors of these new curricula and media programs never consulted the literature available on affecting positive attitude change. Although relatively few such studies exist, especially concerning attitude change in children, there is some information. Several studies have documented negative attitude changes resulting from activities being used in some of these programs.

The programs employ various techniques: simulations of disabilities; group discussion; the use of media, such as books, films, videotapes, and filmstrips; visits by disabled persons; direct teaching of information about disabilities; and, very rarely, analyzing the nature of prejudice.

Simulations are very popular. Typical activities might include the children taking turns using a wheelchair for part of the school day, or blindfolding children and letting them feel their way around. Children find this fun—it's a game. They also quickly learn exactly what they cannot do within the imposed disability. This can reinforce a negative stereotype. Only infrequently are they trained and prepared so that they see that they can still do most things, although inconvenienced by the disability. An example is teaching blindfolded children the proper sighted guide technique, and demonstrating possibilities for managing in the kitchen. Beatrice Wright¹⁰ refers to this as introducing a coping framework. Disability simulations should be structured so that rather than being a passive victim of circumstance, the disabled person is given the tools to actively cope with the problems and learn how to adapt and manage.

Interestingly, a study by Clore and Jeffreys¹ found positive attitude change in both those simulating a disability and others who merely observed. A signifi-

cant factor is being able to observe the reaction of nondisabled persons.

While it is difficult to study the effects of group discussion, some researchers have found negative attitude changes resulting from informal talks.⁸ Sometimes group discussions result in members of the group strengthening the opinion they held before the discussion took place.⁶ This information suggests that group discussion should be very carefully structured and based on fact, not emotion. The teacher or discussion leader must be comfortable enough with his or her own feelings so that children can be encouraged to ask what they really need to know, and receive concrete information. Many of the new programs contain little or no background information for the teacher who is uncomfortable with the facts about disabilities. Other programs not only present the facts clearly, but also offer resources for the teacher who wants more information.

The use of audiovisual materials can be very effective. Teachers are cautioned to choose carefully, however, as there are so many new films and media programs available. Some, of very questionable worth, are being heavily promoted by their publishers. Many of those aimed at very young children use cartoon drawings instead of photographs to depict the children with disabilities. While this may grab their attention, it denies the children the greatest benefit this medium can provide: the opportunity to stare. Donaldson³ points out that this "sanctioned staring" is an important part of reducing the discomfort many feel in the presence of those with disabilities. Our culture forbids such staring at an actual disabled person, although other studies have found that people do more staring at a disabled person when they think they are unobserved.⁵ The same researchers found that more opportunities for staring resulted in less avoidance of persons with disabilities. This information implies that sanctioned staring should be built into a program in its early stages; children should be given ample time to explore films, filmstrips, and children's books about disabilities. Some children will need more time than others to satisfy their curiosity. The research also implies that bringing disabled visitors into the classroom should not occur too early in the sequence of activities. The conflict between the desire to stare and the prohibition against it could create discomfort, resulting in a negative experience for the child, which will then be associated with the disability.

Visits to the classroom by people with disabilities can be valuable learning experiences. It is important that the visitors be chosen carefully and that they be capable of putting the children at ease. Also, they must be the kind of people who can contradict the stereotypes. An ideal situation is to have several dis-

abled visitors, which increases the information contradicting stereotypes. Donaldson³ stresses the value of the disabled visitors being of equal or valued status to the nondisabled hosts. Thus, children who are successfully mainstreamed can provide considerable positive information in terms of their experiences. This author's experience in introducing college freshmen to the needs of people with disabilities has shown that the learning activity praised by most students at semester's end is the one involving a panel of college students who are disabled, talking about themselves and candidly answering questions. A disabled peer is the best source of information about what it is like to be disabled, and how they want to be treated by those who are nondisabled.

About the Article . . .

ONE OF THE RESULTS of P.L. 94-142 was the appearance of numerous programs designed to help teachers educate their pupils about the disabled children being mainstreamed. The goal was to encourage acceptance. Unfortunately, using some of the new programs could result in children forming negative attitudes toward those who are "different." To aid teachers in planning appropriate activities and in choosing materials, the author reviews research on the efficacy of the techniques used in these programs, and presents suggestions for creating a program about differences which should result in producing positive attitudes toward those with disabilities.

A successful program to teach about differences should have some basic prerequisites: first, and most important, the idea of people being different from one another should be an ongoing one, with frequent emphasis on the uniqueness of each individual. Children need to know that it is OK to be different. The second prerequisite is some good, clear, basic background material for the teacher. Ideally, the teacher could attend a sensitizing workshop or course to be better prepared. If it is inconvenient or difficult to find a class, teachers might well consider organizing a group of interested professionals to follow the program outlined in the book published by the Council for Exceptional Children called *Everybody Counts! A Workshop Manual to Increase Awareness of Handicapped People*.⁹ It contains an interesting progression of activities and was written expressly for adults. A third point, discussed previously but not to be underrated, is that there be ample opportunity for staring, before children are expected to relate to people with disabling conditions. There are a lot of stereotypes to be unlearned; think of all the monster movies that had a character who walked very much like persons with hemiplegia, dragging one leg, and was perhaps facially

disfigured as well. Children need time to understand that a person without use of a body part is still just a person.

Once the prerequisites have been established, a teacher planning a unit to teach about disabilities might proceed in the following fashion:

1. A needs assessment will tell the teacher the children's level of understanding. This can take the form of a discussion with very young children, or a questionnaire with older ones. A good example appears in *What's the Difference?* by Barnes, Berrigan, and Biklen (see below).

2. Provide for plenty of sanctioned staring, either through the use of media or by visiting disabled people doing something successfully, such as a Very Special Arts Festival, or a wheelchair soccer game. Rehabilitation centers or sheltered workshops should be avoided; persons with disabilities in those settings will appear needy and segregated, which will reinforce negative stereotypes.

3. Concrete information should be taught. Children should be told just enough to dispel fears and promote understanding. There is no need to get bogged down in medical terminology. For example, small children need to know that disabilities are neither contagious nor the result of punishment.

4. Children should be given an opportunity to explore and experiment with the aids and devices used by those with disabilities. This will eventually help them to see a person with a disability more clearly as a person, rather than being distracted and curious about the strange things around them. Simulations can now take place, within the coping framework. Children should be taught appropriate skills, such as how to negotiate a step in a wheelchair, and should be encouraged to describe how they

would want to be treated by others were they actually to become disabled. It is most appropriate here to discuss the very nature of prejudice. Young children have a well developed sense of fairness, and can draw conclusions based on their experiences.

5. Guests can now be brought into the class. They should be of the same age or older, and should be approximately equal in social, educational, or vocational status. The guests should be able to field questions from the students. Children instinctively sense just how far they can go with their questions; if a guest seems flustered by the questions, the children will become uncomfortable, resulting in negative feelings.

6. The unit should be concluded with a discussion led by the teacher. Any final questions can be answered and conclusions drawn.

Once the climate has been created, there should be ongoing openness about differences in the classroom. Such an atmosphere benefits both students and teachers. The following books are offered as excellent resources for the teacher wishing to teach about differences. Each contains resource sections to aid the teacher in choosing supplementary materials.

- Barnes, Ellen; Berrigan, Carol; and Douglas Biklen. *What's the Difference? Teaching Positive Attitudes Toward People with Disabilities*. Syracuse, New York: Human Policy Pr., 1978. (This is part of the "Feeling Free" series. All of its components are excellent)
- Bookbinder, Susan. *Mainstreaming: What Every Child Needs to Know About Disabilities*. Boston, Mass.: The Exceptional Parent Pr., 1978.
- Cleary, Margaret. *Please Know Me As I Am*. Sudbury, Mass.: Jerry Cleary Co., no date. (Notable primarily for its annotated resource section)

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Sex, Spinal Cord Injury, and Staff Rapport

THOMAS D. STEWART, M.D.

My pilot light is out.

WITH THAT STATEMENT, a spinal cord injured man summed up his feelings about his post-injury sexual impairment. As a member of the rehabilitation team, how would you respond? What would you say?

There are superb articles discussing post-injury sexual reorientation programs.^{8,13,16,17} Initial inquiries about sex are often made to the staff members with whom the patients have their most trusting relationship. This person frequently is not a member of the medical-mental health team administering these programs, assuming one exists. A goal of this article is to help rehabilitation professionals manage these initial contacts that can lead to further sexual experiences and to participation in sexual counseling programs where available and when such programs are appropriate.

Affirmation of remaining possibilities and assistance in grieving losses are the core themes to be explored as they occur in the context of a one-to-one interaction in or out of a formal sex therapy program. I hope the following information will help professionals from varied backgrounds reach out to those persons with spinal cord injury with whom they have a special rapport. Many of the ideas developed here can be modified to apply to sexual dysfunction secondary to other disabilities. These concepts have also been helpful in my limited experience with homosexual patients. The suggestions to follow have been selected from nine years experience with this population on two spinal cord injury services and in the private practice of psychiatry.

After the cataclysm of spinal cord injury and the associated traumata of wheelchair confinement, leg bags, spasticity, and atrophy, can anything be affirmed regarding sexuality without one's seeming to be a Pollyanna? The answer is yes. Through asking the right questions and providing information with perspective, it is possible to affirm the following points: libido, hormonal intactness, functional possibilities, and technical developments.

Affirmations

Libido

Libido need not disappear forever with spinal cord injury. Men and women frequently feel castrated by

their injury. This feeling is revealed in comments such as, "I saw a nurse bend over to pick up a gauze today, and I didn't even care. I know a girl like her would have turned me on before this happened." This loss of interest leads patients to wonder how much else they have lost in addition to their extremity function.

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These patients need to be told in the acute post-injury phase that libido frequently returns after the passage of time and the return to familiar surroundings. Hospitals are hierarchical organizations filled with staff in white uniforms—a situation hardly conducive to lust. Furthermore, their emotional energy and attention are absorbed in the adjustment to the sudden change in themselves and they are therefore less free for response to outside interests.

Hormonal Intactness

The knowledge that hormonal intactness remains after injury is reassuring to many. Testosterone levels are not reduced in the injured cord, since the Leydig cells remain intact.^{2,4} Thus a low voice, beard, and libido (if circumstances permit) are physiologically supported. The situation for women is still more encouraging.⁶ Menstruation resumes usually two to three months after the accident, and as is the case with men, secondary sexual features remain. In addition women retain their fertility, as men usually do not. Women then can produce an "intact" person from their damaged bodies, a fact with considerable psychodynamic importance. A number of recent publications can help women understand their sexual situation after the injury.^{1,3}

Functional Possibilities

While both sexes retain sexual functional capabilities, women fare better than men. These capabilities are well covered in the literature and will be briefly reviewed.^{11,12} Women can have relations after injury unless there is a disruption due to adductor spasms. Water soluble lubricants are sometimes necessary. Orgasm is unlikely if the sacral area is totally devoid of sensation. Breast stimulation, however, may lead to a climax.

Following spinal injury, men have two types of erections, reflex and psychogenic. Reflex erections are associated with upper motor neuron, spastic injuries and occur in up to 90 percent of men with such lesions. Ejaculation is rare. Psychogenic erections occur with lower motor neuron, flaccid lesions. Approximately 30 percent of males with this impairment have erections. These erections are in response to cortical activity involving vision and fantasy, unlike the reflex type that requires local contact. Psychogenic erections are frequently discovered 1-2 years after injury under quiet conditions conducive to concentration. Some of these men have emissions of sperm. The following vignette is characteristic:

A 26-year-old man locked himself in his room and pulled the shades. Eighteen months before he had suffered an L3-4 complete flaccid injury. He began to read some pornography. A few minutes later to his surprise he saw that he had an erection that he could not feel. Following stimulation he experienced mild orgasmic sensations.

Clearly such a discovery would be unlikely in the chaos and clamor of an acute hospitalization. Possibly the most affirming act caring staff members can do is ask those individuals with spinal cord injury with whom they are close if they have made efforts to explore their sexuality. If not, the question itself affirms the feeling that such experiences are feasible for them. The importance of this questioning is underlined by evidence that many never attempt intercourse again after injury and that there is an average of two years post injury before sexual attempts are made. This two-year delay was the same for persons with paraplegia and quadriplegia.¹⁹

The disruptions and disfigurements associated with a disability need not destroy the heart of sexuality—the capacity to share pleasure and vulnerability with a loved one as demonstrated in the movie, "Coming Home." Those who experience the embarrassment and frustration of impotence can be reminded that this impairment need not become the visible symbol of the invisible. Impotence need not become a way of life.

Technical Developments

There are technical developments that can assist the sexual expression of those with spinal cord injury.

These include penile prostheses and electrostimulation. Two types of penile prostheses are available.¹⁵ The first is a silastic implant that is inserted into the corpora cavernosa, giving a permanent semi-erect state. The second is an inflatable device called the Scott prosthesis.¹⁸ Squeezing a bulb placed in the scrotum pumps fluid from a reservoir implanted in the abdominal wall into small balloons in the corpora cavernosa, producing an erection. Once the erection is no longer needed, a release valve allows return of the fluid to the reservoir. Care must be taken to assure that such devices are implanted in patients whose expectations are realistic. They are not a magical cure for a failing relationship nor a prop for poor self-esteem.²⁰

Another development is electrostimulation. This process involves the use of rectal probes to provoke the emission of sperm. It is doubtful that this process would have broad applicability, since poor sperm motility is common after spinal cord injury. Successful fertilization using this technique has been reported in persons with spinal cord injury.⁹

Practical Suggestions

Affirmation of remaining sexual possibilities will be to no avail if there are no attempts. There are a few practical suggestions that can help some people get started. The most important is making a comparison to the first pre-injury sexual effort. By alluding to how clumsy and unsure of themselves they might have been, I have often evoked a wry, "how did you know?" smile. They then reminisce about how their knowledge of themselves and their partner evolved to allow a richer experience. Spinal cord injury involves a starting over again in many areas of life, including sex. As before, their sexual experience may start again with fear, uncertainty, and failure, to be followed by enrichment—if they allow themselves to re-engage so they may enjoy their remaining capabilities. They need to become reacquainted with themselves and their partners.

A clinical example follows illustrating how sexual experience can evolve even when there has been a pre-injury sexual relationship to resume:

During psychotherapy a 32-year-old veteran with T7 complete paraplegia described the rebirth of his sex life that had been dormant for 8 years following his injury. He had been dating for four months when he and his girlfriend began to expand their physical intimacy. At first he was very uncomfortable being physically exposed with her. So much did not work and did not look quite right either. As contact with her increased he became more aware of both how much he could enjoy and of how much he had lost, as did she. "When I enjoy my thumb being inside her, I can just imagine how my penis would feel." He found satisfaction in both his pleasure and hers. Later they discovered their favorite position. With her on top he would insert his reflex erection. He would keep the back of his hand in contact with where they were joined so as

to have tactile input from their genital contact. Later he would pull his hand back and she would pin down his arms so he could resist her with his powerful biceps as they remained joined. This experience would leave them both sensually pleased and physically tired afterwards. He summed up his feelings, "It's certainly not as good as before, but," he continued with a smile, "I can't wait to do it again."

The other suggestions require a brief discussion. Before sexual stimulation, the bladder should be emptied. Reflex autonomic controls that would have prevented voiding during sex have been disrupted. By voiding first an embarrassing accident can be avoided. If lubricants are needed, they should be water soluble. Vaseline is an organic solvent that could dissolve a condom or diaphragm. It could also dry out after application into a hardened crust that could be difficult to remove. Thus, vaseline should not be used by women with spinal cord injury if lubrication is a problem.

Gynecological consultation before the resumption of sexual activity is a must for several reasons. A woman paralyzed from the waist down could easily reason quite incorrectly that she could not conceive. Birth control is a problem. Birth control pills might not be a good idea considering the increase in clotting factors associated with their use occurring in conjunction with the venous pooling in paralyzed legs. The I.U.D. is also fraught with risk. Pain from peritoneal inflammation is a warning of impending danger from this device, and sensory loss from spinal injury would hide this symptom. The diaphragm is safe, but would be difficult or impossible for a woman with quadriplegia to position.

Barriers

The affirmations and suggestions in this article will be of little value if the rehabilitation professionals and their patients encounter barriers that interfere with open discussions and discourage sexual experience after the injury. These barriers can also undermine the impact of well organized sexual counseling programs for individuals with spinal cord injury.^{5,14} Appreciation of these obstacles can reduce their detrimental effects, thus easing the flow toward resumption of sexual functioning.

For the disabled patient, the biggest wall involves the problem of vulnerability. Sex involves a shared vulnerability—a letting-in of past defensive barriers, both intra-psychic and spatial, which are designed to protect against the hurt of rejection. Sex involves shared exposure, both physical and emotional. This letting down of barriers becomes especially difficult when physical malfunction and deformity augment a feeling of vulnerability that existed before the injury. This sense of uncertainty about one's intactness reinforces pre-existent fears of rejection. Thus, reaching

out to concerned rehabilitation staff—let alone to available sexual partners—is undermined. As mentioned earlier, initial inquiries about sex will be made to those staff members with whom there is a special rapport and trust, which can offset this fear.

Barriers to this vital rapport, however, exist also within the professional staff. These often take the form of hidden assumptions. Some of these are revealed by open ended statements that can uncover these assumptions. The first is "If that'd happened to me, I'd . . ." Frequent completions are "kill myself," or "give up completely." These are hardly conducive to emotional growth. It is helpful to remind ourselves that we don't really know how we would respond and that it's the patients' answers to these questions that matter. A second statement is "Who would want to touch this person?" Again it's helpful to remind one's self that this is not our question to answer, but someone else's. The third is, "What will I say if he or she says . . ." Fear of patient's comments like, "I want to kill myself," or "I'm never again going to have an intimate relationship," can restrict staff openness and willingness to communicate. This staff discomfort can be eased by reminding one's self that it's what we *let* the patients say and not what we reply that matters most. The above can serve as an introduction to the self-analysis necessary to be of maximum assistance to patients having disabilities.

Grieving

Spinal cord injury ends many features of a person's life, such as a walk in the woods, a game of tennis, or an orgasm. These losses must be mourned. Grief is a healing reaction, like inflammation in a wound—both hurt. Both are necessary if a person is to remain intact. That which is no more must be given up so that remaining possibilities can be pursued. Without grief, unconscious pursuit of the unattainable (for example, walking) will continue and grinding depression will result.¹⁰

Rehabilitation professionals in every specialty can aid this process. The key is listening. Listening involves allowing others to say what they feel. Listening is doing something. Patience and compassion are required. Once the patient's feelings are shared they are no longer theirs alone to bear. Staff cannot share the patients' fates, but can share their anger and sadness.

Conclusion

By affirming remaining possibilities and allowing expression of feelings about permanent losses, we can help those with spinal cord injury, as well as those with other disabilities, live to the fullest extent possible. This requires an understanding of ourselves as

well as of our patients. Skilled use of rapport with patients by individuals on the rehabilitation team can help offset the impact of post-injury vulnerability.

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Educational Programming: A Seminar for Young Adults with Cleft Lip and/or Palate

MICHAEL IMHOFF, JOYCE LAASE PEACOCK, and PHILIP STARR

Introduction

THE IMPORTANCE AND VALUE of educational programming for persons with disabilities and their families is based on the premise that an understanding of the disability and its social and psychological ramifications facilitates better acceptance and coping with the disability or condition. Lamb⁴ describes how written information facilitates the acceptance of a sibling with a disability by helping the reader to gain insight and comprehension of the condition.

Other studies provide added support for the importance of information and understanding in adapting to a disability. Myers⁵ reports intellectual understanding is a factor associated with positive coping when wearing a brace for scoliosis (curvature of the spine). When an infant is born with cleft lip and/or palate (CL/P), Clifford and Crocker¹ state that the disappointment and shock of the parents is reduced when informed of the potential results of plastic surgery.

Although evidence demonstrates the value of information in the acceptance of a handicap, three studies suggest that persons with CL/P and their families are not receiving sufficient information regarding their condition. Walesky-Rainbow and Morris¹² report that children and teen-agers with CL/P are significantly less knowledgeable about clefting than their parents. Parents have identified their desire for more communication between patients, parents, and professionals.⁷ In addition, Starr, Ellis, and Oka¹⁰ report that parents and adult patients want more information, in nontechnical language, about treatment procedures.

Thus, recognizing the value and need for information concerning cleft lip and palate, the social service staff of the H. K. Cooper Clinic (Lancaster, Pa.) conducted a seminar for young adults with this condition and their families. The purpose of the seminar was to respond to questions and concerns that are common to teen-agers and young adults. This article will describe how the seminar was organized, its goals and content, and the overall response. Although this article describes an approach with persons with CL/P, the process employed could be adapted for other patient groups.

General Clinical Characteristics

A brief, general description of the clinical characteristics provides an understanding of the nature of CL/P and its treatment program. Cleft lip and palate can be described as a gap or opening in the upper lip and/or palate. It is due to a failure of fusion of the lip and/or roof of the mouth and occurs in the first trimester of pregnancy. The causes of oral-facial clefting lie in both genetic and environmental factors.⁶

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This article is based in part on experiences supported by the National Institute of Dental Research, NIH, DE 04779.

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The extent of the CL/P condition varies greatly.² There are three types of oral-facial clefts. They are cleft lip only (CLO), cleft lip and palate (CL&P), and cleft palate only (CPO). A child with CL&P is more likely to have feeding, surgical, dental, speech, and hearing difficulties than a child with CLO.

Like other rehabilitative services, the goal for a person with CL/P and the family is to assist in helping the person achieve full potential in all areas of human development.¹¹ As the child grows, physical, psychological, and social changes demand different types of treatment and counseling. These changes may require the services of various professionals—including the plastic surgeon, pediatrician, speech therapist, audiologist, dentist, orthodontist, prosthodontist, radiologist, geneticist, and social worker. Treatment for a CL/P begins as soon as possible after birth and may continue through adulthood.

Setting

The H. K. Cooper Clinic is the oldest, only full-time, fully staffed clinic in the United States that primarily serves persons with cleft lip and/or palate. Social service is one of several departments provided for the comprehensive treatment of patients and their families.

Social service uses a research-practitioner model to fulfill dual responsibilities of conducting research and implementing the findings in social work practice.⁸ Behavioral data is routinely collected at 2, 4, 6, 10, and 15 years of age. These findings form the basis for services to patients and their families, including educational programming. The social service staff relates to the progress of the clinic patients through the initial intake of socioeconomic and familial information, periodic monitoring, and, when needed, counseling.

Seminar

A. Age Stage Selected and Invitations Extended

The social service observed that many teen-agers and young adult patients, and their families, had common questions and concerns about the impact of CL/P in the areas of employment, social relations, and genetics. These concerns are similar to Havighurst's analyses of interpersonal relations, employment, and sexual interest as important issues for the adolescent.³

In reviewing the literature dealing with the impact of CL/P on social functioning, data suggest that problems may exist in certain areas. Starr⁹ presents studies that indicate teen-agers and adults with CL/P experience more difficulty in the areas of interpersonal relationships—specifically, dating and marriage.

In order to respond to these areas of concern and to facilitate better individual and social acceptance, a seminar was planned for young adults with CL/P and their families. A seminar format was chosen because it was seen as the most effective means of presenting such a wide range of topics and concerns to a group of people. It was also recognized that the group discussions occurring in the seminar would be a valuable experience.

All patients of the clinic between 12 and 25 years of age with a CL/P received an invitation by mail explaining the seminar. When these patients came to the clinic for appointments, they received a personal invitation and further explanation. In addition, a press release was issued informing the public of the seminar. Persons wishing to attend the seminar returned the registration form attached to the invitation. As the initial invitations were mailed four weeks prior to the seminar, a follow-up letter was mailed to those who registered to serve as a reminder.

B. Format

The seminar was held on a Saturday from 10:00

a.m. to 2:00 p.m. It was felt that four hours would be needed for people to have adequate time to actively participate in discussions of the speakers presentations through questions and responses, lunch, and informal conversations. This time schedule was based on the concept that learning is a process, and active participation is essential for the process to work. Active participation was stressed by creating a relaxed, friendly, and informal atmosphere and by encouraging comments, questions, or reactions at any time. The seating arrangement was designed so that active participation would not be hindered. People sat at small card tables arranged so that nearly each person was facing the others.

The group attending the seminar was composed of 26 people who came from the immediate locale, throughout Pennsylvania and three of the adjacent states. Of that group, 20 persons were patients or family members. There were four male patients (ages 12, 16, 22 and 24 years) and five female (ages 12, 17, 18, 21, and 24 years). The remaining six people consisted of the three speakers and members of the social service staff (four other patients registered for the seminar but did not attend).

The seminar presented speakers who had training and experience in the areas of concern. The speakers included a counselor from the Bureau of Vocational Rehabilitation, who spoke about "Employment and Educational Opportunities - How Does a CL/P Affect These Areas and What Can Be Done?" Another speaker, the clinic's geneticist, spoke about "The Genetics of Clefting," highlighting the risk rate for reoccurrence for the next generation. The third speaker was the former chief of social services of the Cooper Clinic, who had conducted research in the area of sociological functioning of adults with CL/P. He presented the results of his research in the areas of marriage, employment, education, and social integration; the title of the presentation was "How Does a CL/P Affect a Person Socially?"

C. Evaluation

At the end of the seminar the participants were asked to respond to an evaluation questionnaire. The questions were: "What important things did you learn today?" "What didn't you learn today that you would like to know more about?" and, "Do you feel the seminar was helpful? Why?"

The responses indicated that people gained information from the wide variety of topics discussed, but nearly everyone gave special mention to the value of the genetics presentation. For example, when asked, "What important things did you learn today?" one person responded, "That I didn't need to worry so much about future defects in my offspring."

In response to what they would like to know more about, two persons mentioned surgical methods of

repair. Another person wanted to know more about the problems of "peer group acceptance."

Several people requested more seminars in the future. As a result of these requests, seminars are being planned on topics relating to job readiness, surgical and dental means of repair, genetic information, highlights of social research, and speech development and therapy.

All participants felt the seminar was helpful. Examples of their comments include, "I feel it was very helpful. We need more programs like this"; "Thought

it was a terrific idea; only sorry there weren't any (seminars) while growing up"; and "A good idea that should continue, and attract more and more people year after year."

Appreciative comments were made concerning the cordial atmosphere and the chance to talk with people who have similar problems and experiences. Based on the participants' responses, the seminar was considered a valuable and positive experience in helping individuals gain a better understanding of themselves and cleft lip and palate.

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Events and Comments

IYDP Community, State Leaders Call for Continued Focus on Issues Related to Disability

MORE THAN 100 state and community leaders of the International Year of Disabled Persons called for a sustained focus on improving life for disabled Americans through the 1980's and beyond. Meeting in Washington, D.C., at a conference sponsored by the U.S. Council for IYDP, the participants also urged the continuance of federal support for disabled Americans through enforcement of existing legislation, specifically the civil rights provisions of the Rehabilitation Act of 1973 and the Education for All Handicapped Children Act of 1975.

The IYDP state liaisons and community partners concluded their two-day session with a unanimous resolution for the continuation of IYDP activities for an indefinite period beyond Dec. 31, 1981, when the IYDP is officially scheduled to complete its year-long program.

U.S. Council President Alan Reich noted that, "IYDP has underscored the importance of partnership and community-based participation. Our experience has demonstrated that, whatever their disability, disabled Americans can work together and that they want to reach solutions to their problems by working in full partnership with the larger community. Those problems are serious ones and they are not going to disappear overnight. This International Year for Disabled Persons has succeeded in promoting awareness of the problems facing 35 million Americans, but it will be truly successful only if it serves as the launching pad for the hard work that lies ahead."

In a separate resolution, program participants observed that "As the IYDP has progressed, certain ironies and contradictions have become readily apparent. Federal funding for important programs which promote 'full participation' (such as special education, vocational rehabilitation, independent living, transportation, employment, developmental disabilities) have been repeatedly threatened by proposals from the present administration. In addition, and perhaps more importantly," the resolution continues, "regulations which allow for equal opportunity and full participation are threatened by a review process, the intent of which is to remove government from the backs of states and local communities . . . although enforcement of these regulations has often left much to be desired, the fact that they are in place reaffirms the rights of persons with disabilities to the same opportunities afforded nonhandicapped persons. Without them, basic rights which nonhandicapped people take for granted, such as the right to an edu-

cation, to employment, and to access to community services will be denied persons with disabilities."

The United Nations General Assembly proclaimed 1981 as the International Year of Disabled Persons, issuing a global call for goals and programs for improving the lives of 450 million disabled persons worldwide. To date, 129 countries are participating in the program. The mission adopted by the U.S. Council for IYDP and the Federal Interagency Committee for IYDP encompassed the following nine points: expanded educational opportunity; improved access to housing, buildings and transportation; greater opportunity for employment; greater participation in recreational, social and cultural activities; expanded and strengthened rehabilitation programs and facilities; purposeful application of biomedical research aimed at conquering major disabling conditions; reduction in the incidence of disability through accident and disease prevention; increased application of technology to ameliorate the effects of disability; and expanded international exchange of information and experience to benefit all persons with disabilities.

New Brochure Highlights Building Access for Owners

A NEW RESOURCE for making buildings accessible is the result of a cooperative venture of the National Easter Seal Society and Building Owners and Managers Association International (BOMA). The resource, a leaflet called "Building Access," acquaints owners and managers of buildings with certain features that will make their facilities usable by persons with disabilities. The cooperation of the two organizations reflects the increased exchange by users and providers of building space to ensure an environment that enables everyone—including persons with disabilities—to function. "These exchanges," says Mr. Edward Carmody, Chairman of Codes and Regulations, BOMA International, "are the key to advancing the accessibility movement in this country."

As more job opportunities are opened to persons who are elderly or who have disabilities, owners and managers of office buildings look increasingly for ways to meet a variety of occupants' needs. "Building Access" offers a brief checklist to alert building management to some important features that help to make facilities accessible. It also suggests guidelines to help receptionists, security staff, and other frontline personnel respond to the special needs of their buildings' occupants and visitors. These guidelines, called "hospitality tips," include suggestions for communicating with persons who have a

hearing or visual impairment and point out that guide dogs, both "seeing eye" and "hearing ear" that accompany persons with disabilities should be admitted into buildings.

"Building Access" is one in a series of "Tips" brochures that the Easter Seal Society is producing for a variety of trade associations and other groups. Single copies of "Building Access" (Publication A-296) may be obtained by sending a self-addressed, stamped, business-sized envelope to the National Easter Seal Society, 2023 West Ogden Ave., Chicago, IL 60612.

Consumer Resource Materials Distributed by Boston Caption Center

THE WGBH Caption Center in Boston has produced a permanent reference collection of comprehensive and pertinent consumer-related information for schools, libraries, vocational rehabilitation programs, and other organizations serving deaf Americans. Resource materials derived from "Captioned Consumer"—a special feature on WGBH's nationally broadcast CAPTIONED ABC NEWS—have been updated and transformed into CAPTIONED CONSUMER SKILLS, a series of 15 videocassettes, now available for national distribution on a "free-rent" basis (borrower pays only return 4th class postage). The videocassettes are being distributed on $\frac{3}{4}$ " and $\frac{1}{2}$ " tape by Captioned Films for the Deaf, Indianapolis, Ind.

As surveys have indicated, "Captioned Consumer" has been a favorite of deaf audiences since its inception in 1975. The feature's success results from its in-depth research, clear writing, and attractive visual presentation. The captioned videocassette format, produced by the highly qualified Caption Center staff, combines crisp illustrations with easy to read captions. The CAPTIONED CONSUMER SKILLS videocassettes also provide an entertaining method for the nation's hearing-impaired individuals to learn and avoid the formal/academic look of print information.

CAPTIONED CONSUMER SKILLS—supported in whole by the Office of Consumer Education, U.S. Department of Education—will fill a void for desperately needed specialized consumer education resources for hearing-impaired persons, with a wide range of relevant consumer-oriented subject matter. Topics include: home safety instruction, personal health care information, financial guidance, shopping tips, and the accessibility of legal and social agency assistance. Further information may be obtained by contacting the Caption Center, WGBH TV, 125 Western Ave., Boston, MA 02134; tel. (617) 492-2777; TDD (617) 491-5724.

Films To Change Attitudes Toward Disability for Intermediate and Secondary Students Available

THREE FILMS being introduced by Lawren Productions, Inc., are designed to help change student attitudes toward handicapped persons, whether mainstreamed into their classrooms or encountered in the community.

The target grade levels are intermediate and secondary, 4 - 9, but school districts can also use them for teacher in-service and for motivating handicapped children to expand their skills and horizons. The films are:

(1) "The Able Disabled"

19 minutes - color - sound

purchase: film \$330; video \$270; rental: \$36/week.

"The Able Disabled" is composed of four short features, all relating to handicapped children or young adults who need wheelchairs or crutches to get about. It begins with AUGUSTUS, a talking wheelchair, proud of all that his young owner, Clay, can do with his help. Next, in DISABLED OLYMPICS, Wilma Rudolph, the sprinter who won three gold medals in the regular Olympics after overcoming childhood invalidism, narrates scenes from the Special Olympics with international handicapped competitors in wheelchair relays, slaloms, swimming, fencing, playing basketball. PICONIC is a musical and visual celebration of an outing of children with and without handicaps. The final feature is OUTWARD BOUND, a wilderness program where handicapped and nonhandicapped practice canoeing, climbing cliffs, and negotiating rope bridges—wilderness survival skills. The viewer gains a new perspective of the problems and the potential for achievement of persons with disabilities.

(2) "The Deaf Communicate"

12 minutes - color - sound

purchase: film \$220; video \$170; rental: \$28/week.

"The Deaf Communicate" starts with an explanation of HEARING AIDS by Larry Brown, a pro football star with impaired hearing. He shows the hearing aid built into his helmet and many other hearing aids that help those with partial hearing. SIGNING is demonstrated by Matt Hutton, a deaf teenager, who encourages the viewer to learn some signs. THE GALLAUDET DANCERS, three young female college students, dance to music they can't hear, and express their pleasure in this creative activity.

(3) "The Blind Participate"

20 minutes - color - sound

purchase: film \$330; video \$270; rental: \$36/week.

Audiences are stunned to see blind teen-agers and one-legged young men riding up on chairlifts and skiing down the mountain in a documentary on DISABLED SKIING. The skiers tell how they overcame their fears to participate in this sport. Next

HERBIE, the Braille Dot, explains how Braille and other techniques and devices help the blind and the partially sighted to read, write, and carry on many daily activities. Finally, JAMIE, the blind high school gymnast, helps us understand how important it is for persons with disabilities to be allowed to risk failure or a few lumps and bumps, just like their "normal" classmates. To grow and learn, they must be allowed to try.

The components of these three films/videoassettes are selected from SPECIAL DELIVERY - Lawren's five "show" series on mainstreaming. Information on both series are available from Lawren Productions, Inc., P.O. Box 666, Mendocino, CA 95460; tel. (707) 937-0536.

CEC Introduces New Multi-Media Training Kit on Gifted and Talented Children

THE Council for Exceptional Children has introduced the GIFTED AND TALENTED MULTI-MEDIA KIT. It is designed for preservice and inservice training as well as for use by parent groups and other community agencies. The kit contains six 10-minute sound/filmstrips that illustrate the experiences of gifted children, their teachers, families, and classmates. Supplementary materials are contained in an extensive workshop leader's manual. The manual includes suggestions on how to use the filmstrip series for inservice, preservice, and parent training. Full-length scripts, an extensive bibliography, a list of agencies concerned with the education of gifted and talented children, and masters for workshop material are included. Contents: Unit I: Identification of Gifted and Talented Students, Parts I and II; Unit II: Curriculum Alternatives for Gifted and Talented Students, Parts I and II; Unit III: Social and Emotional Development of Gifted and Talented Students, Parts I and II.

Price for individual units is \$60. The complete set of three units is \$165. Individual units or the complete set may be ordered from The Council for Exceptional Children, 1920 Association Dr., Reston, VA 22091.

Calendar Cites Birthdays of Famous Persons with Disabilities

A PERPETUAL CALENDAR marking the birthdates of numerous famous persons with disabling conditions has been developed by the Ohio Library Association in honor of the International Year of Disabled Persons. In addition to birthdays and other celebrations, the "Awareness Calendar" includes tips to librarians on special programs and outreach ideas, as well as appropriate reading lists. The calendars are available for \$1.50 from the Ohio Library Association, 40 S. Third St., Columbus, OH 43215.

Project Seeks Nonsexist Image of Disability in Child Education

THE Non-Sexist Child Development Project of the Women's Action Alliance, Inc., has completed the first year of ground-breaking research and development for Project R.E.E.D. (Resources on Educational Equity for the Disabled). Based on a review of the literature and first-hand observations in major centers across the country, some of the findings include:

- Books about those with disabilities written for parents, teachers, or other professionals convey the inaccurate message that most children with disabilities are white, male children.

- In children's books focusing on a major character with a disability, the disabled character is usually portrayed as a white child who has little or no contact with other children with disabilities and no contact with disabled adults.

- There is a decided absence of images of children and adults with disabilities in early childhood classrooms, even those that serve children with disabilities.

Project R.E.E.D. is a two-year project funded under a grant from the Women's Educational Equity Act Program, U.S. Department of Education, and sponsored by the Nonsexist Child Development Project of the Women's Action Alliance, Inc., in cooperation with New York University Office of Community Services. A major goal of Project R.E.E.D. is to incorporate images of children and adults with disabilities into the early childhood classroom, to make those images nonsexist as well as multicultural, and to integrate them with images of able-bodied people. Toward this end, the Project has developed prototype classroom materials (including puzzles, puppets, and block accessories) and has pilot-tested them in classrooms in the New York Metropolitan area. The materials will be nationally field tested during the second year of the project, which began in September of this year. A training guide, designed to help teachers and parents combat stereotyping on the basis of sex, race, or disabling condition, also is being field tested.

The first national conference on issues of educational equity for disabled women and girls will highlight the second year of Project R.E.E.D. The conference, cosponsored by Project R.E.E.D. and another WEBAP-funded program—the Disabled Women's Educational Equity Project in Berkeley, California—will take place in June, 1982. It will create a national focus on the past, present, and future of educating disabled women and girls for full, independent participation in society.

For additional information about Project R.E.E.D., contact Merle Froschl, Director, Nonsexist Child Development Project, Women's Action Alliance, Inc., 370 Lexington Ave., New York, NY 10017; tel. (212) 532-8330.

Handbook on Severe Disability Published

THE new *Handbook of Severe Disability* is now available from the Superintendent of Documents. This interesting text explains the various conditions underlying severe disability and is an invaluable resource text for rehabilitation counselors, other vocational practitioners, and allied health professionals.

Fully illustrated and written in layman's language, the *Handbook* provides detailed description of specific diseases known to cause severe disability, as well as information on psychosocial adjustment, sexual adjustment, consequences of bed rest, reconstructive surgery, and the normal function of the six body systems which, when affected by disease, result in severe disability. Each disease-oriented chapter provides a description of the disease and its functional disabilities, rehabilitation potential, standards of evaluation, total treatment, and vocational implications. An annotated bibliography follows each chapter, and a glossary of related terminology is included.

This clothbound volume is available from the Superintendent of Documents, Washington, DC 20402, for \$14.00. Payment by check, money order, Visa, or MasterCard must accompany each order, and the stock number 017-090-00054-2 should be included.

Guide for Work Measurement Available

Work Measurement: Stopwatch Time Study, (2nd edition) is a complete guide for the production manager and executive director for developing Engineered Time Standards according to the legal requirements of DOL Wage and Hour Division. Third text in the *Production Operations and Engineering* series, the book's nine chapters describe the linkage between methods study and time studies; time study equipment; responsibilities of supervisors; time study procedure; application of data; policy and implementation of a work measurement program. Step-by-step procedures are provided for identification of time study data; element description; number of cycles to study; conducting the study; recording regular and irregular elements; computation of elemental times; totalling observed times; allowed observations; calculating average times; check for statistical reliability; rating operator performance; determining normal times; establishing allowances; setting standard times; setting production standards; determining commensurate direct labor rates; and direct labor rates. The text offers a bibliography, available list of forms, and audiovisual aids. Attractive 3-ring binder. Cost: \$33.00 per copy, plus \$3.00 for shipping. Shipped UPS. Payment must accompany order. Write to: Vorac-Corrigan and Associates, 5913 Montana St., New Carrollton, MD 20784.

New OT, PT Journal Announced, Call for Papers

THE Haworth Press, Inc., has announced the publication of *Physical & Occupational Therapy in Geriatrics*, a new quarterly journal designed to provide a forum for allied health professionals to share information, clinical experience, research, and therapeutic practice in geriatrics. The journal focuses on current practice and emerging issues in the health care of the older client, including crisis intervention, long-term care in institutional and community settings, and innovative preventive programming. The journal now welcomes the submission of manuscripts dealing with such areas as:

- Functional Evaluation Tools Designed for Use With the Aged;
- Therapeutic Programming for Respite Care Programs for the Elderly;
- Working With Families of the Frail Elderly;
- Follow-Up of Nursing Home Discharge;
- PT/OT Discharge Planning in Acute Care for the Elderly;
- Working With the Hearing-Impaired and Vision-Impaired Elderly;
- Specialized Work With Older Clients With Particular Disabling Conditions, and Terminally Ill Individuals.

The journal will aim toward providing a forum for both physical therapy and occupational therapy services in health care institutions, with an aim to demonstrate the programs and clinical work that can be shared by professionals in an interdisciplinary fashion.

A complete "Instructions for Authors" brochure may be obtained from Jean Kiernat and Betty R. Hasselkus, Co-Editors, *Physical & Occupational Therapy in Geriatrics*, School of Allied Health Professions, 1300 University Ave., Room 2120, University of Wisconsin, Madison, WI 53706. Please include a stamped, self addressed envelope with all requests.

Subscriptions may be ordered from The Haworth Press, Inc., 149 Fifth Ave., New York, NY 10010. Prices: \$28 individuals; \$48 institutions; \$65 libraries. Individuals may deduct \$5.00 for a special introductory subscription rate. Postage and handling, add \$1.75 for USA orders and \$6.00 for Canadian orders. Orders outside the U.S. and Canada, add \$30.00.

Updated Bibliography on Attitudes and Disability Available

THE Regional Rehabilitation Research Institute on Attitudinal, Legal and Leisure Barriers at The George Washington University announces the availability of an updated, comprehensive edition of *Attitudes & Disability: An Annotated Bibliography 1975-1981*. Compiled and edited by Elaine Makas, this bibliography includes complete annotations on over 900 articles and publica-

tions, from 1975-1981, related to attitudes and disability. It is the most complete publication of its kind. Subject categories include: attitudes toward people with specific disabilities (e.g., attitudes related to mental retardation, attitudes related to visual impairment); attitudes of specific groups toward disabled people (e.g., attitudes of medical professionals, attitudes of educators); attitudes of disabled people toward themselves and others; strategies/programs for inducing attitudinal change; theories related to attitudinal change; and instrumentation for measuring attitudes. All annotations are cross-indexed for easy reference. This bibliography is specifically designed for use by researchers, students, disabled consumers, and social service professionals. Available, *prepaid* only, from: RRRI-ALLB Publications, 1828 L St., N.W., Suite 704, Washington, DC 20036. The cost of the bibliography is \$15.00. Checks should be made payable to George Washington University.

ABLEDATA System Receives Development Contract

THE National Rehabilitation Information Center (NARIC) has received from the California Department of Rehabilitation a \$73,467 contract to continue development work on the ABLEDATA System. The system consists of a national computerized database containing information about rehabilitation products, and a network of Information Brokers. This unique resource includes over 3,000 commercially available aids and equipment useful to disabled persons. Product data is delivered through information brokers who, in addition to providing access to the national database, also develop supplemental local information resources. Development work under the contract also includes increasing the database to more than 4,000 items by December, 1981; design of prototype training materials for Information Broker Workshops; testing of prototype materials; and design and distribution of public awareness brochures.

Film on Psychological Evaluation of Hearing Impaired Children and Adults For Loan

THE Boys Town Institute for Communication Disorders in Children has produced an award winning, 20-minute, 16mm color sound film on the psychological evaluation of deaf children and adults. The film and appropriate supplementary literature will be made available on loan, at no charge, to interested professionals and other parties. The film received the award for Creative Excellence in Medicine and Health at the U.S. Industrial Film Festival, 1981. Those desiring to borrow the film should contact Lori Smith, Film Distributions, Boys Town Institute, 555 N. 30th St., Omaha, NE 68131; tel. (402) 449-6511.

FEC Minigrant Applications Available for Educational Projects

APPLICATIONS are now available for approximately 30 minigrant awards from the Bill Geer Minigrant Award Fund of the Foundation for Exceptional Children. Proposed projects should take place during the summer of 1982 or the 1982-83 school year. Minigrant awards of up to \$500 each will be made for innovative education-related projects that directly benefit handicapped or gifted children and youth. For this series of awards the Foundation solicits project applications that address the following priority areas:

- Preschool programs for handicapped or gifted children
- Elementary or secondary level programs for handicapped or gifted students from rural areas
- Elementary level programs for culturally diverse handicapped or gifted children
- Programs that serve handicapped adolescents, particularly in career education or social living skills

Applications for projects in educational areas other than these will also be accepted. In addition, several Parent Workshop Minigrants of up to \$500 each will be made for projects fostering greater understanding between parents and their handicapped children. Project activities must include the participation of parents. Over the last two years the Foundation has made 56 minigrants throughout the United States, including several in Canada.

To receive application materials, send a self-addressed stamped envelope to: Foundation for Exceptional Children, 1920 Association Dr., Reston, VA 22091. All applications must be returned to the Foundation by February 1, 1982.

Organizations Foster Dental Health Programs for Disabled Individuals

DENTAL HEALTH is the most neglected health need of persons with disabilities. Working to change this situation is the sole concern of two affiliated, private, nonprofit organizations—the National Foundation of Dentistry for the Handicapped and the Academy of Dentistry for the Handicapped.

The Foundation has developed two unique programs to achieve this goal. One is called a "Campaign of Concern." The program is directed by dental hygienists who join the professional staff of special schools, sheltered workshops, and group homes to provide the following:

- (1) a curriculum for staff to use to teach daily oral hygiene and nutrition concepts,
- (2) routine checks of the effectiveness of the oral hygiene and suggestions to improve this skill,

- (3) annual oral exams to detect disease in its early stages, and
- (4) follow-up until needed care or treatment is completed. To help the hygienist complete a referral, the Foundation—through the local dental society—surveys dentists in the community who are involved in treating special patients and publishes a directory of these names. A Foundation treatment fund—generated in part by voluntary contributions—also is available to help needy persons pay for care.

Presently, "Campaign of Concern" programs are available in nine states: Colorado, Louisiana, Massachusetts, Michigan, New Jersey, New York, Minnesota, Pennsylvania, and Wisconsin.

"Dentistry for the Homebound" is the second Foundation program. A van, containing a laboratory and a portable dental operator, is the mainstay of the system. A dental assistant drives the van, sets up the equipment in the home or nursing home,

and provides chairside assistance to a dentist in the community who has scheduled time to use the service. Only four "Dentistry for the Homebound" programs are available so far to treat persons who are homebound—in Denver, Detroit, Newark, and Chicago. Several other metropolitan cities are considering the need for the program.

In contrast, the Academy of Dentistry for the Handicapped is a membership organization of dentists and hygienists who work to improve the education of dental professionals, research, and legislation to meet the needs of persons with handicaps. The Academy holds an annual scientific session, publishes a journal, makes their membership roster available to advocacy groups and consumers, and sensitizes the public to the need for this care.

Both organizations sponsor a clearinghouse on all aspects of dentistry for the handicapped. For more information, please contact either group at 1726 Champa, Suite 422, Denver, CO 80202; tel. (303) 573-0264.

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Internships in Vocational Rehabilitation Counseling

APPPLICATIONS are now available for graduate internships in vocational rehabilitation counseling offered at the suburban Philadelphia branch of the Devereux Foundation, a group of multidisciplinary residential treatment, special education, and rehabilitation centers. The Devereux Pennsylvania Branch is approved by the APA for pre-doctoral internships in counseling and clinical psychology. The Career House Unit is approved by the International Association of Counseling Services as an Accredited Counseling Center. The Vocational Rehabilitation Center is approved by CARF - The Commission on Accreditation of Rehabilitation Facilities.

The internships cover a full-time, 12-month program of training and experience in rehabilitation counseling with mentally retarded and emotionally disturbed adolescents and young adults presenting problems of learning and personal adjustment. Training and supervised experience in applied vocational rehabilitation counseling services may include: diagnostic vocational appraisals, individual and group counseling, prescriptive treatment planning, and sheltered workshop and selective job placement. Experience may also include participation in rehabilitation case conferences, milieu therapy and crisis intervention, residential treatment, and social rehabilitation.

Applicants must have a broad academic base of training and supervised practicum experience in vocational counseling and guidance. Experience in diagnostic vocational appraisals as well as a working knowledge of occupational information related to the current job market would be helpful. Preference will be given to applicants currently enrolled in, or graduated from, RSA-supported rehabilitation counseling training programs or APA-approved counseling psychology training programs. A combined stipend and housing allowance of \$466.66 monthly is available to qualified applicants who are U.S. citizens; the allowance and \$3,600 of the stipend are tax-exempt. Meals are provided when on duty. Group hospitalization and major medical insurance coverage is also provided. Early application is recommended as spaces are limited.

Information and applications are available from Dr. Henry Platt, Director, The Devereux Foundation, Institute of Clinical Training, Devon, PA 19333.

VA to Open New Centers

THE Veterans Administration will soon open 28 new Vet Centers around the U.S. in a major expansion of the readjustment counseling program for Vietnam veterans. Centers will be staffed by counselors, the majority of whom are themselves Vietnam era veterans, and will operate on an in-

formal basis. Most of the new centers will be located in counties having a veteran population of over 40,000, but some will be placed so as to serve more remote areas with sparse concentrations of veterans where there appears to be a need for these services. Further information is available from AMVETS (American Veterans of World War II, Korea, and Vietnam), 4647 Forbes Blvd., Lanham, MD 20801.

Journal Published for Rehabilitation Evaluators

THE PREMIER ISSUE of the *Journal of the Organization of Rehabilitation Evaluators* was recently published in Chicago, Ill. The Organization of Rehabilitation Evaluators (ORE) is sponsored by the Chicago Services for Work and Rehabilitation. The journal seeks to provide a forum for the exchange of information on the development, implementation, and utilization of program evaluation in rehabilitation. The publication will provide rehabilitation practitioners with practical information they can use to develop and/or improve their program evaluation systems.

Contents of the inaugural issue include: Managing Staff Resistance to Program Evaluation, by Cathy Lorber and James S. Lundstrom; Program Evaluation: An Educator's Dilemma, by Horace W. Sawyer; Quality and Success in a Charm? by Wendell H. Carter; An Inpatient Medical Facility's Use of Program Evaluation Information: The RIC Experience, by Edward A. Eckenhooff; Utilization of Data Generated from Program Evaluation, by Debra K. Gagliardo; The W. K. Kellogg Program Evaluation Project: A Follow-Up Survey, by W. C. Carter; and Determining the Cost of a Program Evaluation System, by Jeffrey C. Crumrine.

Membership in the Organization of Rehabilitation Evaluators is \$15.00 annually and includes 4 issues of the journal. Further information may be obtained from ORE at 4001 W. Devon Ave., Chicago, IL 60646; tel. (312) 736-9303.

New Magazine Focuses on Canada's Disabled Population

THE PREMIER ISSUE of a new monthly magazine was recently released, entitled *Perspectives: Canada's National Magazine on Disabilities*. "It is a news magazine with a particular interest in the issues of concern to the disabled community; but it will be informative, challenging, and entertaining for anybody and everybody," according to Editor Stephen Crozier. In addition to a full-time staff, the magazine utilizes a network of writers from agencies across the country to contribute to the publication's features. Further information is available by contacting Pedow Publishing, 632 Queen St. West, Toronto, Ontario M6J 1E4, Canada; tel. (416) 362-4561.

Ophthalmologic Organizations Consolidate

THE American Academy of Ophthalmology and the American Association of Ophthalmology have consolidated into an expanded and augmented American Academy of Ophthalmology. The Academy previously had a membership of 9,900 and the Association had 5,300 members, but there existed considerable overlap in membership between the two groups. The new Academy will establish a broadly based, representative body to deliberate issues and act in an advisory capacity to its board of directors. New membership categories will be created for noncertified ophthalmologists and ophthalmology residents. The organization is based at 1833 Fillmore St., P.O. Box 7424, San Francisco, CA 94120; tel. (415) 921-4700. The office for governmental relations is located at 1100 17th St., N.W., Washington, DC 20036.

Moss Hospital Art Show Marks Closing of International Year of Disabled Persons

AT 24, Janice Peroni is an aspiring artist and photographer with her own studio. Her paintings and photography have been shown nationally and she has won numerous awards. Several years ago, she was injured in an accident. She has quadriplegia.

Oils, watercolors, and ink drawings are among the repertoire of German mouth painter Erich Arnulf Stegmann. An accomplished portrait and landscape painter, he has traveled on all continents to paint on location and exhibit his works. His arms and hands are paralyzed from polio.

Joan Nixon was a commercial illustrator and layout designer. The onset of multiple sclerosis altered the direction of her career. Now she paints and sculptures from a wheelchair. Her work has been on exhibit around the world.

These artists are among 70 people whose work will be on display in Moss Rehabilitation Hospital's Third International Art Show for Artists with Physical Disabilities. The show, which is the closing event for the International Year of Disabled Persons, will be on exhibit Dec. 4, 1981 through Jan. 28, 1982 in the gallery of Provident National Bank, Broad and Chestnut Sts., Philadelphia, Pa. It is open to the public Monday through Friday during regular banking hours.

The show, which features the work of artists from 14 countries, will be judged and juried by a panel of prominent Philadelphia artists. Prizes will be awarded in three categories: oil or acrylic, watercolor or other aqueous medium, and drawings or graphics. Most of the paintings on exhibit are available for purchase. Last year more than \$10,000 of art was sold at the show. Support for the Moss art exhibit comes from both the art and rehabilitation communities, with distinguished leaders in both fields serving on an

advisory committee, including the deans of all the major Philadelphia art schools.

Moss Rehabilitation Hospital, long a leader in the field of rehabilitation medicine and research, is sponsoring the art exhibit to draw attention to the abilities, rather than the disabilities of handicapped people. In showcasing the creative talents of these professional artists, the hospital points to the resourcefulness and spirit of people who have triumphed over their physical limitations.

"Welcome Aboard" Tips for Youth Service Programs Available

A RECENT Easter Seal publication produced for national organizations with youth service programs reflects the new partnership that the National Easter Seal Society is developing to expand hospitable environments for persons with disabilities. The newest resource, called "Welcome Aboard," acquaints leaders of youth service agencies with tips for welcoming young people with disabilities into their programs. Joining Easter Seals in distributing the resource are: American Alliance for Health, Physical Education, Recreation and Dance; Big Brothers/Big Sisters of America; Boys Clubs of America; Boy Scouts of America; Camp Fire, Inc.; Girl Scouts of United States of America; Girls Clubs of America; National Recreation and Park Association; National Therapeutic Recreation Society; Young Men's Christian Association of the United States (YMCA); and Young Women's Christian Association (YWCA). The collaborative efforts of these organizations reflect the growing trend in which young people who have disabilities are participating actively in community youth programs across the country.

"Welcome Aboard" is designed to assist youth service agencies in expanding these opportunities by suggesting group techniques as well as accessibility features that provide a welcoming environment for everyone. "The shared concerns of the co-sponsoring organizations," says John Garrison, executive director of the National Easter Seal Society, "also offer new opportunities for strengthening voluntary efforts for better community services."

Single copies of "Welcome Aboard" (publication A-297) may be obtained by sending a self-addressed, stamped, business-sized envelope to the National Easter Seal Society, 2023 W. Ogden Ave., Chicago, IL 60612.

Volunteer Veterans Needed for MS Research Program

THE Department of Neurology at the VA Wadsworth Medical Center, Los Angeles, Calif., is engaged in an inpatient research program for multiple sclerosis using immunosuppressant drugs. They are looking for volunteer *veterans* with multiple sclerosis to help in this important research. Clinical summaries of potential candidates may be sent to Dr. Wallace W. Tourtellotte, M.D., Ph.D., Chief, Neurology Service (691/127), VA Wadsworth Medical Center, Wilshire and Sawtelle Blvds., Los Angeles, CA 90073. Further information may be obtained from Diana Keown, R.N., MS Clinical Nurse Specialist, at this number: (213) 824-4352.

Scholarships Available for Post-Secondary Study

Applications are now available for four \$1,000 scholarships to be made by the Foundation for Exceptional Children's Stanley E. Jackson Scholarship Program. These

awards are available for handicapped or gifted students who are pursuing post-secondary study in the 1982-83 school year. Students who are entering post-secondary study or those who are already enrolled in such an educational program are eligible. Two of the awards, one each for a handicapped and a gifted student, are reserved for ethnic minority applicants. To receive application materials, send a self-addressed stamped envelope to: Foundation for Exceptional Children, 1920 Association Dr., Reston, VA 22901. All applications must be returned to the Foundation by Feb. 1, 1982.

Film Explores Psychological Impact of Handicap on Family

"PART OF THIS WORLD," a sensitive film portrayal of how two parents learn to cope with, understand, and ultimately accept their child's deafness, is available from the Alexander Graham Bell Association for the Deaf for rent or purchase. The 28-minute color production features Ken Moses, a psychologist known nationwide for his counseling of parents of handicapped children. It is an excellent supplement to group parent counseling sessions and preservice and inservice teacher preparation programs. Although the specific handicap discussed is deafness, the film is actually an exploration of the psychological impact any handicap has on a family.

"Part of This World" is available in ¾ inch video cassette and 16mm film format for either rental (\$45/3 days) or purchase (\$400). Prepayment (make checks payable to A. G. Bell Association) or institutional purchase order required. Order from Transit Media, Inc., 779 Susquehanna Ave., Franklin Lakes, NJ 07417; tel. (201) 891-8240.

STATEMENT OF OWNERSHIP MANAGEMENT AND CIRCULATION

(Required by 39 U.S.C. 3685)

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11. I certify that the statements made by me above are correct and complete.

Stephen J. Regnier, Editor

Instructions to Authors of Articles for Rehabilitation Literature

As an interdisciplinary journal, *Rehabilitation Literature* is published for professional personnel and students concerned with the rehabilitation of the handicapped. It is intended to help the medical practitioner, therapist, or other personnel working with handicapped children and adults to keep up to date not only in his own professional field but also in other related fields. *Rehabilitation Literature* is in no sense the house organ of the National Easter Seal Society. Contributors of featured articles and book reviews are people outstanding in their own fields and give free expression to their own ideas and opinions.

In view of *The Copyright Revision Act of 1976*, effective Jan. 1, 1978, all transmittal letters to the editor should contain the following language before manuscripts can be reviewed for possible publication: "In consideration of the National Easter Seal Society taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to The Society in the event that such work is published by The Society." We regret that transmittal letters not containing the foregoing language signed by all authors will necessitate delay in review or return of the manuscript.

Kinds of Articles

The "Article of the Month," featured in each issue, is usually a review article in which the author will summarize current knowledge and recent developments in a specific subject field. The present status of the subject may best be documented by a review of the literature as well as by presenting the author's own experience and personal observations. In the course of his review of the subject the author should be able not only to report but also to evaluate and criticize what is being done and what is known. We hope that the author will be informed of current and recent research activities and will be able to discuss their implications in rehabilitation efforts. It is well for the author to keep in mind that although his reading audience is professional it is primarily an interdisciplinary one.

The "Special Article," which also appears in each issue, is appreciably shorter than the "Article of the Month," running 1,500 to 3,000 words in length. A special article may be an editorial expression of opinion held by the author, may be a report of a clinical experience or of a program or project, or may offer pragmatic observations and information in a problem area of concern to a particular segment of our readers.

Preparation of Manuscript

The space allotted to "Article of the Month" permits the use of one of 6,000 words, or approximately 17 typewritten pages, elite type, double spaced. The bibliography or list of references may be in addition to the pages of text. The author is asked to organize his article so that it will include section headings. The original and one carbon copy of the article, carefully typed and corrected, should be submitted to the Editor. The author should retain a copy. The Editor reserves the right to return for revision to the author a manuscript that does not meet the standards of a professional journal or the editorial requirements of *Rehabilitation Literature*. The Editor may be permitted to make minor editorial changes if they do not materially change the author's style or essential meaning.

Illustrations

Authors are asked to plan to write their articles so that illustrations are not essential. The physical and editorial format of *Rehabilitation Literature* will not permit usually the use of photographic illustrations or a substantial number of tables or charts. As soon as an author finds that illustrations are required for his paper he should consult the Editor immediately.

References and Footnotes

The author is asked to compile his references in a form that is consistent with a style to be found in the journals of his own profession. That the citations be complete and accurate is the responsibility of the author and is not one that the Editor can assume. The list of references should be typed as a separate section so that it may be published at the end of the article. On the other hand, footnotes, if any, should appear on the same page of the manuscript in which reference is made to them.

Information About the Author

When the manuscript is sent to the Editor, it should be accompanied by a biographical data sheet containing information about the author's education, professional work, and membership in professional organizations. This information will be used in the preparation of a short statement identifying the author.

Reprints

The publisher reserves the right to reprint the article for further distribution as part of the Society's education program. In such instances, authors will have the opportunity to purchase reprints at cost.

Whether or not the Society reprints the article, arrangements can be made with the Editor for ordering reprints at the author's expense.

STEPHEN J. REGNIER
Editor

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The author's reference list now consists of nearly 1,500 articles and publications, all of which are cited in the text, in footnotes and in suggested reading lists at the end of each chapter.

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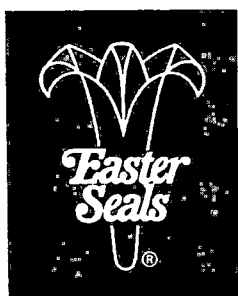
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Competitive Employment: New Horizons for Severely Disabled Individuals

By PAUL WEHMAN, Ph.D.

Published by Paul H. Brookes, Pub., P.O. Box 10624, Baltimore, MD 21204. 1980. xiv, 259 p. figs., tabs. paper. \$13.95.

Reviewed by FRANK R. RUSCH, Ph.D.

THE TREND to integrate individuals who are severely disabled into the mainstream of society has increased dramatically in recent years. The major philosophical impetus for this movement is embodied in the principle of normalization, which emphasizes the utilization of means that are as culturally normative as possible in order to establish, enable, or support behaviors, appearances, and interpretations that are as culturally normative as possible.³ A decade of litigation and legislation has also helped to speed the trends of expanded services to severely disabled persons. Unfortunately, increased awareness of the principle of normalization and recent litigation and legislation have yet to result in actual employment gains for this population. Instead, sheltered workshops, which are still the primary vehicle for providing rehabilitation services for handicapped adults, have been growing at an alarming rate. The Department of Labor projected that as many as 20,000 persons were being referred for sheltered workshop services at the end of the 1970's.

Traditionally, sheltered workshops offer three primary services: evaluation, extended sheltered employment, and employment transition services. Typically, employees of sheltered workshops make less than half the minimum wage, with the majority of the employees considered to be "inconsequential producers." Another study conducted by the Department of Labor (1977) suggested that the annual departure rate from sheltered workshops ranges from 12 percent to 15 percent and that 75 percent of these persons are placed (transitioned) into competitive employment within one year after entry into the workshop, with 33 percent placed after three months.² These data suggest that persons most frequently placed into competitive employment were generally *work ready* when they entered the workshop and training was not a significant factor to leading to employment.

Competitive Employment addresses the problem of stagnation within the continuum of rehabilitation services traditionally offered by sheltered workshop facilities. It focuses upon training severely

About the Reviewer . . .

Dr. Rusch is assistant professor in the Department of Special Education at the University of Illinois at Urbana-Champaign. He is co-author (with D. E. Mithaug) of *Vocational Training for Mentally Retarded Adults: A Behavior Analytic Approach* (Research Press, 1980). Dr. Rusch is a member of the Association for the Advancement of Behavior Therapy, American Association on Mental Deficiency, Council for Exceptional Children, and the Association for the Severely Handicapped.

Address: Department of Special Education, 288 Education Building, 1310 S. Sixth St., Champaign, IL 61820.

disabled persons for placement into the competitive labor market. The spirit of Paul Wehman's work with severely disabled adults is best captured by his belief that "all handicapped persons have a right to work at a competitive wage with non-handicapped co-workers and at a job that provides fulfillment and room for advancement."

This book offers a vocational training and placement model for severely disabled persons. The model is based upon a knowledge of jobs available in the community and an understanding of what these jobs require for entry. Wehman suggests that once job requisite skills are identified, each prospective employee's competence should be assessed with training provided to make up the difference between existing functioning levels and employer expectations. Following an introduction to competitive employment and a definition of those persons for whom this book is written, the next four chapters provide fairly detailed coverage of assessment, training, placement, and job retention procedures. Chapter 2, entitled "Assessment of Employability," introduces and defines several vocational, residential, and parental variables that may be related to job retention. A unique feature of this chapter is the inclusion of parents as valuable contributors to successful employment integration. Also included in this chapter are a fairly detailed job analysis survey and two examples of its use (dishwasher and groundsman).

Chapter 3 introduces a number of topics related to training, including: sequencing pre-employment skill training, industrial training, skill acquisition, and problems encountered when training on-the-job. Much of the information contained in this chapter and throughout *Competitive Employment* is based upon work conducted by Wehman over the past three years. These experiences have resulted in a great deal of knowledge based upon actual practice which, in turn, is presented to the reader in anecdotal fashion throughout the text and in actual case studies contained in many of the chapters. For example, the overwhelming majority of individuals who were trained and successfully placed into competitive employment by Wehman and his associates at Virginia Commonwealth University could not read. To alleviate the actual hardships of not reading, a card depicting tasks each employee must complete throughout the workday was designed and utilized. This example, and numerous others provided throughout the text, are conceptually sound and practically feasible.

The fourth chapter details the placement process. This chapter extends what is commonly thought to be important in the job placement process by including a detailed job analysis process that results in how to match a prospective employee to the demands of the

job. The strength of this chapter, however, lies in Wehman's overview of typical (and frequently, misunderstood) questions employers, parents, and others have when trying to ascertain how employment influences income maintenance programs (such as SSI) and what tax incentives exist for employers who hire persons with disabilities.

Chapters 5 and 6 overview the practices that should result in job retention and the perceptions employers, co-workers, and parents have regarding severely disabled workers, respectively. According to Wehman, job placement is not the final step in the vocational rehabilitation process; nor is the traditional two-month period of job retention an acceptable period for evaluating whether a placement is successful or not. This text suggests an interdependent train-place-train vocational trilogy, suggesting that omission of any one component would drastically reduce the likelihood of long-term employment. A major strength in Chapter 6 is the information offered on working with parents and how to improve parent perception of how competent their sons and daughters can be in non-sheltered employment settings.

In Chapter 7, Wehman briefly introduces several areas that "may" relate to overall success—for example, functional communication, travel training and mobility, social interaction skill training, and academic skill training. Each of these topics deserve much more coverage than offered. Some topics, such as social interaction skill training,¹ have received widespread attention in the existing rehabilitation literature and their value to the overall rehabilitation process is assumed.

A major strength and unique feature of this book is the invited chapter by Kochany and Keller entitled, "An Analysis and Evaluation of the Failures of Severely Disabled Individual in Competitive Employment." This chapter details several of the factors that have resulted in employment failure and several case studies documenting the deleterious effects parents, ancillary services, and work supervisors can have when each is not considered an integral part of the placement process.

The final chapter introduces Wehman's Project Employability and several other model programs in competitive employment that strongly suggest that competitive employment is a realistic option for severely disabled persons typically referred to sheltered workshops and/or typically thought of as "inconsequential producers." Much of *Competitive Employment* is based upon the actual experiences of Wehman's Project Employability. However, each of the programs presented in Chapter 9 follow very similar guidelines to integrate severely disabled persons into non-sheltered, competitive employment settings. Consequently, this book is believable and much of

what it offers is readily consumable by those that believe there are "new horizons for severely disabled individuals." I recommend this book as required reading for vocational special-needs personnel, rehabilitation specialists, and special education teachers and administrators interested in offering severely disabled adolescents and adults the opportunity to work in community integrated settings that include nonhandicapped persons. This book is also appropriate for parents. Although some readers may not find some topics sufficiently covered, *Competitive Employment* is adequately referenced, permitting readers to obtain similar philosophical and methodological approaches to diverse topics related to employment integration of severely disabled persons.

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3. Wolfensberger, W. The Definition of Normalization: Update, Problems, Disagreements, and Misunderstandings. In: R. J. Flynn and U. E. Nitsch (eds.). *Normalization, Social Integration, and Community Services*. Baltimore, Md.: University Park Pr., 1980.

Other Books Reviewed

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Basic Rehabilitation Techniques: A Self-Instructional Guide. Second edition

Edited by: **Robert D. Sine, M.D.,** and others

1981. xiii. 268 p. figs., photos. paper. Aspen Systems Corporation, 1600 Research Blvd., Rockville, MD 20850. \$18.95.

OPTIMAL CARE provided by a complete rehabilitation team of medical and allied health personnel is sometimes not available to hospital or long-term care facility patients with disabilities resulting from a stroke, spinal cord injury, or degenerative diseases. The responsibility for providing rehabilitation training often falls upon the general duty nurse. This guide is designed to help nurses in these settings obtain the information necessary to conduct individual rehabilitation programs prescribed by their patients' physicians. Incorporated in this updated edition are the areas of psychological responses to disability, management of pain, and techniques of patient education. Articles by experts in various fields supply professionals with cognitive information and also demonstrate—through description, diagrams, and photographs—methods to use in the rehabilitation of clients, including, where applicable, self-care. Each chapter opens with learning objectives for the professional, and chapter post-tests enable readers to evaluate mastery of objectives.

Partial contents are: Rehabilitation: A Nurse's Viewpoint, by Susan E. Dominguez, p. 1-6.—Common Disability Syndromes, by Robert D. Sine, p. 7-21.—The Psycho-Social Aspects of Rehabilitation, by Jerry W. Humble, p. 45-55.—Self-Care Training for Patients with Hemiplegia, Parkinsonism, and Arthritis, by Mahendra Shah, Ruth Avidan, and Robert D. Sine, p. 153-192.—Wheelchairs: Selection,

Uses, and Maintenance, by Georgianna B. Wilson and Virginia L. Kerr, p. 193-206.—Treatment of Chronic Pain, by David C. Bradshaw and Robert P. Carmignani, p. 207-219.—Identification and Management of Bladder Problems, by Shelly E. Liss, p. 227-235.—Teaching Rehabilitation Techniques, by Robert E. Rousch and J. David Holcomb, p. 249-257.

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Behavioral Weight Reduction Program for Mentally Handicapped Persons: A Self-Control Approach

By: **Anthony F. Rotatori, Ph.D.,** and **Robert Fox, Ph.D.**

1981. ix, 220 p. figs., tabs. paper. University Park Press, 300 N. Charles St., Baltimore, MD 21201. \$19.95.

FOR REASONS that have not been determined, many persons who are mentally retarded are also overweight. Assuming that the similarities between obese mentally retarded persons and obese nondisabled persons are greater than their differences, the authors have carefully made use of the research on dieting among nonhandicapped persons to formulate a weight-reducing program for mentally retarded persons. The result is a structured, empirical program that emphasizes observing behavior, recording data, and proceeding on the basis of the data.

Syndromes associated with obesity in mentally retarded persons, major causes of obesity, and popular treatments for this condition (psychotherapy, diet and exercise, medication, and surgery) are summarized in the first part of the text. Also presented in this preliminary section are a behavioral explanation for overeating among obese persons, a review of the effectiveness of behavior modification techniques for

limiting eating, and the main components of the self-control program—self-monitoring, stimulus control, and self-reinforcement.

The second part of the text consists of a training manual for implementing the self-control program with mentally retarded persons. Guidelines for selecting persons who will be most responsive to the program are established, and forms for compiling comprehensive information about each dieter are provided. An overview of the treatment procedures considered the role of the diet leader, the schedule of sessions during the 14-week training period, the use of a group weight chart and other reinforcers, effective teaching techniques, and communication with parents and caregivers (forms for which are appended). Lesson plans for teaching the following sequence of topics are then described: becoming aware of body weight and what one eats, controlling urges to overeat and snack, decreasing stimuli to overeat and snack, developing good eating habits, controlling overeating, exercising, and changing snack habits. The format for these sessions includes instruction in self-control techniques, criteria for mastering these techniques, evaluation of dieters' progress, and homework assignments. The concluding parts of this program entail maintenance of weight loss, in-service training on such topics as nutrition, and follow-up. This unique program—which features simplified instructions, functional charts and diagrams, and menus and recipes—has been validated by five studies of children and adults with mental retardation. Bibliographies on dieting and cooking are appended, and numerous references are supplied.

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Carolina Developmental Curriculum: Volume I—Activities in Gross Motor, Fine Motor, Visual Perception; Volume II—Activities in Reasoning, Receptive Language, Expressive Language

Edited by: Timothy M. Sturm

1980. 2 vols., figs., illus. paper. Walker Educational Book Corp., 720 Fifth Ave., New York, NY 10019. \$32.50 (Vol. I); \$29.50 (Vol. II).

ALL PRESCHOOL CHILDREN, including those with mild to moderate developmental delays, are intended to be served by programs that incorporate this two-volume developmental curriculum. Acquisition of a broad range of fundamental skills necessary for success in the mainstream of elementary education is its goal. The curriculum was developed as one component of a cycle of services employing continual evaluation as a means to program improvement. The 62-page Teacher's Guide (included in Volume I) explains the 10 steps of the cycle: 1) organizing the classroom to accommodate three or four groups of children working on various tasks, 2) assessing each

of the children using the Carolina Developmental Profile—a criterion-referenced tool measuring skills in seven areas (sample pages of the Profile are included), 3) devising annual objectives in various developmental areas on an individual basis (master copy of a yearly planning guide is provided), 4) grouping learners for instructional purposes according to assessed needs, 5) establishing a daily instructional schedule, 6) planning every month programs for each ability group, 7) providing instruction using the curriculum described below, 8) evaluating attainment of objectives on a monthly basis, 9) altering instructional plans as a result of assessment, and 10) post-testing, again using the Carolina Developmental Profile.

Curricular activities in areas of gross motor, fine motor, and visual perception are included in Volume I, while activities in reasoning, receptive language, and expressive language comprise Volume II; these correspond to the areas assessed by the Profile. For each of several progressively difficult tasks within each skill area, five sequenced acquisition activities are presented in terms of objectives, materials, and methods. Practice activities, enabling students to apply new skills to a wider range of tasks, are also suggested.

This program was created as a Project First Chance—Mainstreaming demonstration project and can serve as a model preschool program serving children with or without disabilities. It appears to be comprehensive in scope yet uncomplicated to implement.

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Communicative Abilities in Daily Living: A Test of Functional Communication for Aphasic Adults
By: Audrey L. Holland, Ph.D.

1980. Various pagination and cassette tape. figs., photos. paper. University Park Press, 300 N. Charles St., Baltimore, MD 21201. \$75.95.

TRADITIONAL EVALUATIONS of persons with aphasia do not measure "the large framework for specific language forms as supplemented by nonverbal behaviors" nor the ways that these persons use residual communicative skills in daily life. The Communicative Abilities in Daily Living (CADL) test is designed to assess these two significant aspects of aphasia.

The test manual describes research that was conducted to develop, validate, and revise the CADL. Also summarized are studies concerned with test norms and adaptations for mentally retarded and hearing impaired persons. Technical aspects of the test, underlying rationale, and administration in clinical practice are discussed. The validity of CADL was measured by comparison with conventional tests for aphasia and by observations of the communicative

behavior of persons with this disability in natural living environments. Norms have been established for the effect of aging and institutionalization on this population. Scoring of the CADL test employs a three-grade system (correct, adequate, incorrect), and administration time is usually less than 45 minutes. This manual also includes a test score booklet, a training test for clinicians learning how to administer the CADL, and two samples of completed tests. In addition to the manual, the complete CADL kit consists of photographs and illustrations that serve as test stimuli, 10 copies of the scoring booklet, prescription and appointment forms, and a cassette tape. The tape contains responses to the test questions by a person with aphasia and auditory test stimuli.

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Diabetes: A Guide to Self-Management for Patients and Their Families

By: Terri S. Kivelowitz and Laura Berenson

1981. xxii, 199 p. tabs., photos. paper. Prentice-Hall, Englewood Cliffs, NJ 07632. \$5.95.

MANY PERSONS WITH DIABETES quite understandably become tired of monitoring all the variables that affect their condition and coping with the disorder that this condition causes in their lives. This lucid and instructive book presents a program that enables individuals with this disability to manage these problems by developing a suitable life-style, using available community resources, and learning how to find and organize helpful services. Throughout the text the author cites pertinent advice and facts from other knowledgeable professionals.

The recommended means of managing diabetes is an "integrated, sustained program" formulated jointly by doctors and patients and consisting of medication (multiple-dose insulin or oral agent), exercise, diet and attention to body weight, and blood glucose management. A central goal of this program is the maintenance of control—keeping blood sugar levels close to normal (60-120 mg/dl); tests that can be used at home to determine glucose levels are described.

Opening sections encourage persons who have just learned that they have diabetes to restructure their lives and take responsibility for their treatment by directing their health care team. Pharmacists' central role in this team is then identified, and patients are told how to elicit information about medications and equipment from them. Carbohydrates, individualized meal plans, and exchange lists of foods of similar value are covered in a section on diet; exercise is said to supplement diets by lowering blood glucose and helping to prevent long-term complications. Ways of avoiding common complications of the foot, mouth, eyes, and skin through personal hygiene are also out-

lined. A discussion of reproduction points out that although impotence is higher for men with diabetes, this problem can be treated by therapy, and that women with this disability who control glucose are capable of a normal conception and pregnancy. A guide to hospital personnel and routines is supplied.

As preparation for obtaining support, new attitudes toward health care are explained, and the concepts of self-help, self-care, and self-management are defined. The author then relates the experiences of families she assisted as a field director for the American Diabetes Association, demonstrating how management techniques helped to reduce stress for persons of various ages. Adjusting to major changes and new situations, such as beginning school, career planning, and traveling, are considered. Special attention is devoted to the benefits of hospital-based diabetes clubs as a means of sharing information and solving problems. The procedures for instituting these clubs—including inpatient education, developing a membership, and structuring meetings—are detailed. Two handy features of this text are a glossary and an appended "diabetes directory," which contains supplementary information on the topics covered in the text, guidelines for recording medical history and use of medication and equipment, and numerous sources of assistance.

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A Guide for Helping the Child with Spina Bifida

Edited by: Gary J. Myers, M.D., Sharon Bidwell Cerone, R.N., and Ardis L. Olson, M.D.

1981. 307 p. figs., tabs., photos. Charles C Thomas, Pub., 301-327 E. Lawrence Ave., Springfield, IL 62717. \$19.75.

THE EDITORS of this comprehensive reference for parents of children with spina bifida hope that parents who are knowledgeable, understanding, and self-confident will also be more optimistic about their children's future and encourage them to become independent members of their community. Based on the editor's work with families at the Birth Defects Center at Strong Memorial Hospital in Rochester, N.Y., and containing contributions from colleagues in various health care professions, this text supplies practical information about the implications of spina bifida for the growing child.

The opening section of the book provides general information on spina bifida and the effects of this disability on family life. Causes and prevention of spina bifida, preparation for the disabled child in the home, the roles of health care professionals, and sources of assistance are among the topics covered. Special attention is given to physical and emotional development and the components of adequate educational

Disabled Persons' Views on Working

THE FRUSTRATING INEQUITIES of our employment system, which this collection of interviews with disabled persons hopes to help remedy, are dramatically illustrated by one young woman interviewed who has a collagen-vascular disorder that varies in intensity. When she experiences severe pain she must use a wheelchair, but during remission she can walk unaided. One employer interviewing her during a period of remission was reluctant to hire her because she might have to use her chair again; another, who served disabled persons, told her, "Gee, it's a shame you aren't more visibly disabled."

The Handicapped Speak

By: William Roth

1981. xi, 211 p. photos. McFarland & Co., Pub., Box 611, Jefferson, NC 28640. \$15.95.

Several of the 12 other persons interviewed related instances of discrimination in education and employment and criticized the environmental barriers that have limited their participation in society. Mr. Roth has compiled their opinions as a basis for formulating new policies in these areas, and his prefaces and concluding remarks place individual experiences in a broader context and explore the issues of adjustment, productivity, and availability of jobs. He urges that the emphasis on training disabled workers through rehabilitation programs "should be coupled with a policy to increase the economy's demand for disabled workers." The high percentage of adults interviewed who work with handicapped persons in some capacity (7 out of 10) may indicate that there is less demand for them in other areas, which would support the author's proposal.

These handicapped persons clearly demonstrate initiative and talents that should help them accomplish whatever goals they set for themselves. One is particularly impressed by the good judgment and maturity of the three adolescents who are included. These young persons already know how to cope with teasing, empathize with others, and plan careers: a 12-year-old girl with transverse myelitis who enjoys young children wants to be a pediatrician, and a young man with hemophilia hopes to become an architect. They

are also aware of the value of education, which the adults who are interviewed affirm.

Descriptions of adjustment to disability document the ways in which different people motivate themselves. A woman missing one hand and a man with paraplegia name acceptance of the handicap as the prerequisite for seeking new challenges. Some persons credit political action as a means of gaining perspective on their personal problems, and others express appreciation for their encouraging families. A psychotherapist who has polio explains how denial constrains constructive energy, gives examples of how he has helped disabled patients, and tells why he thinks disabled professionals are best qualified to serve others with handicaps. His theory should be considered in light of the fact that the services received by some of these persons in hospitals and other institutions were sometimes detrimental, particularly in the case of a young woman whose mother placed her in a state mental institution that lacked structured treatment.

Like other samples of disabled persons in recent literature, this group also values independent living. The young woman with the collagen-vascular disorder differentiates independence (accepting limitations) from solitude, and the psychotherapist spells out ways of expanding attendant and homemaker care and stresses the importance of choosing personal services. A woman confined to a wheelchair who works on implementing Section 504 offers an informative look at the regulation, including progress in implementation, federal support, and interpretation. Other articulate spokespersons discuss mainstreaming, attitudes, ways that blind children can become more independent, and disincentives for working.

The interviews prove that disabled persons can and want to work. In his epilogue, Mr. Roth identifies obstacles to employment—lack of transportation and discrimination by preference, process of selection, and inaccessibility—and suggests ways of restructuring production to accommodate this population, such as increased write-offs for architectural modifications. Although the interviewer's recommendations could be more concise and better organized, the disabled persons he has selected make a strong case for devising new systems of employment.

—S.J.T.

BOOK REVIEWS

programs from preschool through high school. The medical problems associated with spina bifida are then explained in layman's terms and illustrated with helpful diagrams. Questions regarding paralysis, surgery, hydrocephalus, eye problems, braces, casts, the urinary system, and skin care are answered succinctly, and the services offered by orthotists and post-surgical care are described in detail.

In the third section several parents from the Birth Defects Center relate ways in which they have assisted their children and offer advice about responding to the challenges these children present, and a young man with this disability credits his parents for helping him succeed. The concluding section of this book consists of a children's story about a girl with spina bifida who learns to play the guitar. Included in the useful appended material are a bibliography, relevant organizations, guidelines for building assistive equipment, and a glossary.

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Health Care and the Elderly

By: C. Carl Pegels

1981. x, 225 p. figs., tabs. Aspen Systems Corp., 1600 Research Blvd., Rockville, MD 20850. No price given.

ALTHOUGH NURSING HOMES have received a good deal of public attention and a large proportion of the funds allotted for elderly persons, the author points out that in the U.S. only about five percent of these persons actually reside in these homes. Proposing that "society at large should bear the burden of providing the resources that ensure personal health care" for elderly persons, this book attempts to devote equal attention to nursing homes and other forms of care. This inclusive survey of current and prospective health care services for elderly persons critically evaluates several trends and concepts in this field, such as the notion that greater expenditures ensure better care, the private ownership of nursing homes, the reimbursement systems of Medicare and Medicaid, and abuses in the sale of supplementary health insurance.

Based on statistical data obtained primarily from government sources, the text consists of three main parts. The first part relates the history of health care for elderly persons and how they became a separate demographic group, explains the relationship between the health care needs of this group and rising costs of care, and recommends preventive services (information, referral, and support). A section on the choice between institutionalization and home care emphasizes the need for controls in instituting the latter. The components of home care—diagnostic services, therapy, information on nutrition, transporta-

tion, and recreation—and day care, which is said to be the most desirable form of care, are then described. It is recommended that assessment and placement of elderly persons be performed by an unbiased organization; three such models are presented.

The nursing home industry is the focus of the second part. Sources of current problems in nursing homes are identified, a coherent, progressive policy is called for to assist the chronically ill persons who will remain in these homes despite deinstitutionalization, and the roles of certain professionals in these homes—medical director, physician's assistant, and nurse practitioner are defined. Another section reviews patients' rights and regulations pertaining to care, facilities, and professional competency in these institutions. It is proposed that the capital facilities of nursing homes should be owned by the government and managed by the private sector through competitive contracts. Community per capita reimbursement, direct and increasing payment with age, and institutional prepayment plans are explored as models for a national health policy.

The third part of the text covers specific aspects of health care for elderly persons, including the provision of hearing, vision, and dental care, limitations of Medicare, the advantages of Health Maintenance Organizations, the need for physicians specializing in geriatrics, and improved terminal care in home settings. A concluding section discusses factors that will affect the delivery and costs of health care for elderly persons in the future, such as the influence that these persons can exert.

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Hearing Loss. Second edition

By: Joseph Sataloff, M.D., Robert Thayer Sataloff, M.D., and Lawrence A. Vassallo

1980. xviii, 424 p. figs., tabs. J. B. Lippincott, E. Washington Sq., Philadelphia, PA 19105. \$30.00.

SINCE THE PUBLICATION of the first edition of this book in 1966, progress in otology and audiology has led to earlier and more accurate diagnoses in patients with hearing problems, including those related to the ototoxic effects of certain drugs, acoustic nerve tumors, and sudden, unilateral deafness. This second edition covers each of these areas and devotes special attention to occupational hearing loss and the implications of the 1971 Occupational Safety and Health Act. By presenting the principles and procedures for determining the causes of hearing loss in one comprehensive volume, the authors intend to help general practitioners and specialists respond to patients who want to know if their hearing can be restored.

Physicians are oriented to hearing loss through in-

troductory information on classification of problems and otologic history and examination. The various hearing tests are then discussed in detail; the uses and limits of the newest methods of diagnosis are indicated. Tuning forks, audiograms, testing for masking and bone conduction, and special hearing tests (for recruitment, auditory bone decay, and functional hearing loss) are among the specific techniques explained. Substantial treatment is given to the diagnostic criteria and causes of conductive hearing loss and sensorineural hearing loss. The differences between sensory and neural etiologies are pointed out; mixed, central, and functional hearing losses, tinnitus, and vertigo are also described. Typical and atypical cases in which these tests were used and seven tables that summarize differential diagnoses are noteworthy features of this text. Also addressed are hearing loss in children, hearing problems that are associated with diseases and syndromes, rehabilitative procedures, and the physics of sound.

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Human Sexuality and Rehabilitation Medicine: Sexual Functioning Following Spinal Cord Injury
 Edited by: Ami Sha'ked, Ph.D.

1981. xix, 210 p. figs., tabs. Williams & Wilkins, 428 E. Preston St., Baltimore, MD 21202. No price given.

THE SUBSTANTIAL PROGRESS that has been made during the last decade in the sexual functioning of disabled persons can be attributed in part to the new emphasis on normalization and comprehensive care that treats the patient in a holistic manner. The editor of this collection of articles points out that rehabilitation programs that promote sexual expression improve employability, familial and social readjustment, and self-concept. A major purpose of this book is to encourage rehabilitation personnel to facilitate the social integration of persons with spinal cord injury and other disabilities through sexual adjustment. Although the text is not primarily an instructional guide, some articles do address professional preparation for practice and actual sex therapy and counseling for handicapped persons. The 15 articles are thoroughly referenced.

Partial contents are: Sexual Aspects of Spinal Cord Injury: The State of the Art, by Susanne M. Bruyère, p. 1-25.—Normalization, Social Integration, and Sex Behavior: A Service Approach and Evaluation Method For Improving Rehabilitation Programs, by Robert J. Flynn, p. 37-66.—Anatomy and Physiology of Male Sexual Response and Fertility as Related to Spinal Cord Injury, by Laurence J. Gott, p. 67-73.—Neurophysiology of Female Sexual Response in Spinal Cord Injury, by Robert C. Geiger, p. 74-

79.—Sexual Attitude Reassessment Programs for Spinal Cord Injured Adults, Their Partners and Health Care Professionals, by Theodore M. Cole and Sandra S. Cole, p. 80-90.—Integrating Human Sexuality into Rehabilitation Practice, by Diane B. Brashear, p. 91-103.—Sexual Training of the Spinal Cord Injured Male and His Partner, by Ernest R. Griffith and Roberta B. Trieschmann, p. 119-133.—Group Sexual Counseling for the Physically Disabled Person, by M. G. Eisenberg, p. 134-143.—Sexuality and Social Rehabilitation in Women after Spinal Cord Injury, by Sue Bregman, p. 144-156.—The Role of the Rehabilitation Nurse in the Sexual Readjustment of Spinal Cord Injured Patients, by Margaret Walsh Rohme, p. 177-189.

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Language Intervention Strategies in Adult Aphasia

Edited by: Roberta Chapey, Ed.D.

1981. xviii, 383 p. figs., tabs. Williams & Wilkins, 428 E. Preston St., Baltimore, MD 21202. \$32.00.

A CONSIDERABLE NUMBER of approaches are currently available for the remediation of aphasia in adults. The purposes of this text are to compile these various remedial strategies and to promote their application and assessment in clinical settings.

The contributions from 19 authorities in the field are grouped into four major sections. The first section covers such basic topics as the role of the "aphasiologist," the meaning of language intervention, and the medical management of cerebrovascular accidents. Seven therapeutic approaches are presented in the second section; each of these is based on the reorganization of language through the stimulation of problem solving rather than on the teaching of specific responses to stimuli. Additional methods of therapy—including programmed instruction and melodic intonation therapy—are explained in the third section. The fourth section is devoted to the remediation of specific disorders (agnosia, apraxia, dysarthria) and therapies that employ alternative or augmentative methods of communication. An epilogue discusses the future of clinical aphasiology.

Partial contents are: The Assessment of Language Disorders in Adults, by Roberta Chapey, p. 31-84.—Issues, Prognosis, and Problems in the Rehabilitation of Language Disorders in Adults, by Jon Eisenson, p. 85-99.—Schuell's Stimulation Approach to Rehabilitation, by Joseph R. Duffy, p. 105-139.—Incorporating Parameters of Natural Conversation in Aphasia Treatment, by G. Albyn and M. Jeanne Wilcox, p. 169-193.—Environmental Language Intervention, by Rosemary Lubinski, p. 223-245.—Operant Conditioning and Programmed Instruction in Aphasia

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Rehabilitation, by Robert Goldfarb, p. 249-263.—Therapy Subsequent to the PICA, by Bruce E. Porch, p. 283-293.—Heightening Auditory Comprehension for Aphasic Patients, by Robert C. Marshall, p. 297-328.

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The Physical and Psychosocial Care of Children with Stomas: A Primer for Home and School

By: Sharlene Jackerson Hutchinson, R.N., and Ellen A. Shipes, R.N.

1981. ix, 85 p. figs. Charles C Thomas, Pub., 301-327 E. Lawrence Ave., Springfield, IL 62717. \$15.75.

HOSPITALS now offer increased services for children with stomas, including psychological counseling, but when these children are discharged they must come to terms with their new condition and the reactions of family and friends. Intended for parents of these children and for professionals who work with them after hospitalization, this succinct primer provides medical information on ostomies and suggests ways of helping children adjust following this operation.

An introductory section explains the purposes of stomas, differentiates between temporary and permanent stomas, describes stomal sites, and outlines the anatomy and physiology of the gastrointestinal and urinary systems. Pouching procedures, use of equipment (skin barriers, odor controls, cements and solvents), and diet are addressed. Illustrations supplement the text, and helpful suggestions are offered. Misconceptions about stomas—such as limitations of activities and dietary restrictions—are also considered. The phases of postoperative adjustment—emotional instability, anger, recognition, and reorganization—are defined in the context of general child development, and the effects of family attitudes and body image on adjustment are indicated.

Also discussed are the child's return to school, including information that teachers and classmates should know, provisions for special needs, and socialization with peers. Procedures for specific problems and emergencies, such as food blockage, water and electrolyte imbalance, and stomal bleeding are outlined, and school information forms, manufacturers of ostomy supplies, and a glossary are appended. This volume thoroughly covers a neglected topic.

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Preservation of Client Rights: A Handbook for Practitioners Providing Therapeutic, Educational, and Rehabilitative Services

Edited by: Gerald T. Hannah, Ph.D., Walter P. Christian, Ph.D., and Hewitt B. Clark, Ph.D.

1981. xxii, 412 p. figs. The Free Press, A Division of

Macmillan Publishing Co., 866 Third Ave., New York, NY 10022. \$25.00.

IN the human service professions, questions pertaining to the protection, care, and rights of clients must be addressed constantly. This handbook presents procedures, practices, and technologies that have proven to be effective in safeguarding patients' rights and resolving ethical issues. The 20 articles discuss such controversial topics as privacy, psychological autonomy, due process, protection against harm and involuntary servitude, informed consent, and the right to refuse treatment.

The text consists of four parts. The first part defines legal rights of patients and points out abuses that have occurred in the name of treatment. Current trends and established standards for humane care are also outlined. The protection and treatment of non-institutionalized clients are covered in the second part, while the rights of patients in institutions (group homes, hospitals, nursing homes) are discussed in the third. The final part is devoted to ensuring the rights of participants in applied research and evaluations. Court cases that set legal precedents regarding clients' rights are cited throughout the text.

Partial contents are: Legal Issues in Preserving Client Rights, by Reed Martin, p. 3-13.—Protecting the Educational Rights of the Handicapped Child, by Martin J. Pollack and Beth Sulzer-Azaroff, p. 61-82.—Accountability Systems for Protection of the Rights of Autistic Children and Youth, by Lynn E. McClannahan and Patricia J. Krantz, p. 83-106.—Client Rights in Clinical Counseling Services for Adults, by Gerald T. Hannah and Richard C. Surles, p. 107-121.—Client Rights of the Developmentally Disabled in Vocational Settings, by John P. Dineen and Jo-Ann Sowers, p. 225-245.—Safeguarding the Rights of Children and Youth in Group-Home Treatment Settings, by Gary D. Timbers, Robert J. Jones, and Jerry L. Davis, p. 246-277.—The Rights of Chronically Ill Children in Residential Programs, by Thomas L. Creer and Charles M. Renne, p. 278-300.—Patient Rights in Acute-Care Hospitals, by Michael F. Cataldo and Michael G. Ventura, p. 301-318.—Providing Nursing Home Residents' Rights, by K. Anthony Edwards and Jan Sheldon-Wildgen, p. 319-344.—A Quality-Assurance System for Ensuring Client Rights in Mental Retardation Facilities, by James E. Favell, Judith E. Favell, and Todd R. Risely, p. 345-364.

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Program Issues in Developmental Disabilities: A Resource Manual for Surveyors and Reviewers

Edited by: James F. Gardner, Ph.D., and others

1980. xi, 161 p. figs. paper. Paul H. Brookes Pub., P.O. Box 10624, Baltimore, MD 21204. \$12.95.

TITLE XIX (P.L. 92-223) calls for state facilities to provide individualized treatment for developmentally disabled persons that will teach them new skills and ways of behaving. This manual is intended for state surveyors and independent professional reviewers who must determine whether intermediate care facilities for these persons comply with federal regulations. Compiled with assistance from the Division of Long Term Care of the U.S. Dept. of Health and Human Services, the book does not give instructions to surveyors and reviewers or specify deficiencies, but instead highlights programs, policies, and practices that are effective in assisting this population.

The authors discuss the major themes pertaining to developmental disabilities—individual potential, active treatment, ethical issues—and their implications for intermediate care facilities. Violations of legal rights, simplifying individualized program planning, federal guidelines for developmental and behavioral programming, and the responsibilities of interdisciplinary teams are among the topics addressed. Featured throughout this functional text are criteria for evaluating the quality of services, question-and-answer sections, and cross references to Title XIX regulations. A glossary and recommended readings are included.

Contents are: Needs of Persons with Developmental Disabilities, by Karen Green and Linda Long, p. 1-9.—The Principle of Normalization: A Foundation for Effective Services, by John O'Brien, p. 11-32.—Legal Rights of Developmentally Disabled Persons, by Marcia Pearce Burgdorf, p. 33-61.—Implementing the Developmental Model, by Kenneth G. Crosby, p. 63-85.—A Behavioral Approach to Programming, by Wade Hitzing and Roann Nichols, p. 87-106.—Interdisciplinary Team Process and Individualized Program Planning, by James F. Gardner, p. 107-125.—Programming for the Severely/Profoundly Handicapped Person, by Philippa Campbell and William Bricker, p. 127-153.

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Room to Grow

By: Sylvia Gappa and Deirdre Glynn

1981. iv, 154 p. figs., photos. paper. Pitman Learning, 6 Davis Dr., Belmont, CA 94002.

THE AUTHORS began their primary school teaching careers in adjacent classrooms over 10 years ago, when learning disabilities were not generally recognized. After detecting a pattern in the problems of the slower learners, they decided to organize a self-contained classroom for all such students in their school and to obtain further training in special education. The instructional techniques and management

strategies presented in this book are drawn from their six years of team teaching in this special classroom.

Two case studies illustrate common problems of children who have trouble learning in a regular classroom—problems such as poor auditory memory, difficulty attending to tasks, low frustration tolerance, and disruptive behavior. Methods of assessing reading language skills, math, and perceptual motor skills are described (with sample tests appended), and the use of assessments to formulate a student's program is demonstrated. Because children with learning disabilities are often easily distracted and discouraged by minor failures, it is recommended that routines for group and independent projects be highly structured and that classrooms be functional and motivational. The daily time schedule for all major activities, including remedial instruction and physical education, is outlined; the benefits and logistics of course-related field trips are also discussed.

The goal of behavior management is to improve students' self-esteem so they can take responsibility for their behavior. The stages in accomplishing this goal and effective methods of improving behavior—personal notes to acknowledge an outstanding day, "time-out" for a child who loses control, and daily class meetings that stress problem solving, listening, and courtesy—are delineated. Formal orientation, a descriptive handbook (covering policies, services, and behavioral management), monthly group meetings, and individual conferences are suggested ways of communicating with parents. Integrating children from the special class into a regular classroom is considered to be a gradual process that involves communication between teachers, counseling children, and determination of the optimal time for changing rooms. Responsibilities and conditions of team teaching, which has enabled the authors "to accomplish more in less time, present fuller and more objective evaluations, and keep our energy and interest at high levels," are explained and supplemented with practical "survival tips"—such as holding a staff review at the end of each day. The assistance that other school professionals can offer is also indicated. A concluding section addresses the teacher's role in advocacy for learning disabled children and dealings with bureaucracies. Pertinent texts and audiovisual materials are cited throughout the text.

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Social Skills for Severely Retarded Adults: An Inventory and Training Program

By: Sandra E. McClennen, Ph.D., Ronald R. Hoekstra, and James E. Bryan

1980. xiii, 270 p. figs., spiralbound. Research Press, 2612 Mattis Ave., Champaign, IL 61820. \$34.95.

BEFORE mentally retarded persons can begin to live in communities, they must learn how to conduct themselves in social situations. However, most institutions that care for these persons do not teach social skills and tend to reinforce nonsocial behavior. Based on the assumptions that all ways of interacting with people are learned responses that are amenable to change and that every person is capable of learning, this educational resource offers a comprehensive inventory and individualized instructions for promoting culturally acceptable behaviors among this population. Designed to be implemented by direct-care staff, this program has been validated by the authors' research, which is summarized in an introductory section.

The program focuses on 10 areas of social behavior: physical interaction, touching and manipulating objects, reacting to one's name, smiling, eye contact, interacting with instructors, traveling with staff, group activities, recreation, and waiting for turns during activities and for other persons. Each social scale contains a series of increasingly complex objectives, which are accompanied by specific instructions for evaluation (inventory) and teaching. Also provided are adaptations for persons with visual, hearing, and motor impairments.

The procedure for instituting the program consists of assessing level of functioning with the inventory, formulating an individualized education plan, using the training section in conjunction with this plan, and maintaining acquired skills through modeling practice. Primary instructors are encouraged to establish trust with their students by using only positive reinforcements and avoiding punishment. Recommendations are made for performing both the inventory—timing and conditions of assessment, relevance of objectives, modeling—and the training sections—placing objectives in the context of the total program, varying the tasks and approaches, incorporating lessons into routine activities, and criterion testing. Detailed record keeping (forms for which are appended) is an essential aspect of both parts of this program. This systematic method of teaching socialization also includes an example of a training session and possible reasons for a student failing to acquire the new skills.

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Speech After Stroke. Second edition

By: **Stephanie Stryker**

1981. xvii, 427 p. figs., spiralbound. Charles C Thomas, Pub., 301-327 E. Lawrence Ave., Springfield, IL 62717. \$22.75.

A COMPILATION OF MATERIALS that the author has found to be effective in her work as a speech pathologist, this manual allows clinicians and family

members to use their creativity in helping persons with aphasia regain the use of speech. The manual can be used to design individualized treatment programs. Among the features of this second edition are a greater number of higher-level oral reading exercises, additional word recall drills, new sentences for practicing articulation, and expanded sections on math skills and the use of money.

As in the first edition (see *Rehab. Lit.*, Apr., 1976, #231), the text consists of drills in five major areas: comprehension of speech, imitation and articulation, recall of vocabulary and correct use of grammar and syntax, reading skills, and writing ability. The exercises in each section are arranged according to degree of complexity, and patients are encouraged to progress at their own rate of learning. Large print, activities that are appropriate for adults, and helpful suggestions for instructors are included. An introductory section discusses the types of speech and language disorders that result from stroke and evaluation of the extent of a patient's disorder. Also presented are 11 recommendations for administering speech therapy, such as explaining the reasons for difficulty in speaking, using concrete language, and beginning sessions at a level where the patient can succeed. Offering an ample amount of drills to choose from, this practical book also contains sources of further information.

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A Stutterer's Story

By: **Frederick Pemberton Murray, Ph.D.**

1980. xi, 168 p. paper. Interstate Printers & Pubs., 19-27 N. Jackson St., Danville, IL 61832. \$4.95 (2 or more copies \$3.96 each).

IN HIS PERSONAL ACCOUNT of the problem of stuttering, the author quotes Dr. Joseph Sheehan: "One of the troubles with being a stutterer is that nearly everything that anybody suggests will work temporarily, and nothing that anybody suggests will work permanently." Dr. Murray's unsatisfactory experiences with numerous speech therapies certainly bear out this opinion. Relating the frustrations of repeated relapses after attaining "fragile fluency," his book emphasizes that the goal of treatment is learning to accept oneself as a person who stutters.

The author's own path to self-acceptance encompassed some 30 years. He began stuttering quite suddenly when he was 2½ years old. In the opening sections of the book he describes the effects of his family and early schooling on his speech. Interspersed with autobiographical details, including the benefits Dr. Murray derived from psychoanalysis, are instructive sections containing advice for teachers and counselors, practical suggestions for persons who stutter

(such as developing personal interests), and summaries of the theories of authorities on stuttering, including Van Riper and Johnson. Learning that these men also stuttered encouraged the author to pursue a career as speech therapist; eventually, he became head of the stuttering program at the University of New Hampshire.

An unsuccessful search through 16 countries for an "ideal therapy" and a disastrous address before the American Speech and Hearing Association convention ultimately enabled Dr. Murray to stop trying to conceal his speech defect and to stutter openly without feeling guilty. He suggests that other persons with this disability can make substantial improvements in their speech by identifying situations that increase or decrease stuttering and trying to attain a sense of harmony in their lives. The concluding sections of the book comment on 14 recommendations of Van Riper, answer common questions (such as what happens to a person's stuttering as he gets older?), and outlines the available forms of treatment. This text offers a very readable blend of theory and practice.

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Voluntary Agencies in the Welfare State

By: **Ralph M. Kramer**

1981. xxvii, 334 p. figs., tabs. University of California Press, 2223 Fulton St., Berkeley, CA 94720. \$24.95.

IN WELFARE STATES in which "government-protected, minimum standards of income, health, nutrition, housing, and education" are the legal rights of all citizens, voluntary agencies strive to maintain their independence while receiving substantial governmental support. This study of 75 voluntary agencies for handicapped persons in four welfare democracies identifies the strengths and weaknesses of relationships between governments and agencies in providing

social services. Surprising findings of the study are: some of the largest and most bureaucratic agencies are also the most innovative, government funding does not necessarily limit agency autonomy, and giving voluntary agencies primary responsibility for social services can reduce citizen participation.

The United States, England, Israel, and the Netherlands were chosen for the study because they illustrate some of the major patterns of interaction between the government and voluntary sectors in different sociopolitical contexts and varying stages of development. These areas are covered in introductory case studies of each country. The second part of the text then compares the voluntary agencies on the basis of internal organization structures; size, formalization, and professionalization; and governance and financial systems. The four main traditional roles of these agencies—innovation (demonstrating new programs), promotion of volunteerism, advocacy for needed services, and provision of services—are discussed in the third part, and the ways they are performed in each country because of particular professional ideologies, executive leadership, public policy, and civil culture are described.

In the concluding part of the book, the four traditional roles of voluntary agencies are reformulated in light of the comparative analysis, and four characteristic vulnerabilities of these agencies—detrimental formalization, displacement of ends by means, minority rule, and ineffectuality—are explained. It is recommended that voluntary agencies seek broader and more diverse constituencies, become more accountable, and make better administrative decisions. Possible roles for these agencies in the 1980's are suggested, and the key issue of voluntary autonomy and public accountability is reconsidered in the context of the study's conclusions. A comprehensive bibliography completes this exploratory text, which should serve as a basis for further investigations in this area.

Abstracts of Current Literature

This section serves as an index to current publications reviewed, digested, or abstracted in this issue. The author index for each issue can be found on the inside back cover. The annual index, of authors only, is published at the end of the calendar year.

ACCESSIBILITY

See 472.

ACCESSIBILITY—BIBLIOGRAPHY

413. Architectural and Transportation Barriers Compliance Board

Resource guide to literature on barrier-free environments, with selected annotations. Second edition. Washington, D.C., The Board, 1980. xiii, 279 p. paper. (Stock No. 017-090-00049-6)

An updated edition of the 1977 text, this bibliography contains nearly 1500 citations on accessibility published from 1960 through 1978. Research studies, surveys, books, dissertations, and fact sheets are among the material included. The format for citations consists of information for ordering copies, descriptors for indexing, and a brief annotation. The materials are grouped into 9 major categories: architecture; transportation; parks and recreation; standards, legislation, and legal matters; general, statistical, and human factors research; disabilities (by type); attitudes; aids and devices; and information resources and visual aids. Appended are travel guides for handicapped persons and pertinent periodicals and addresses of organizations.

Copies of this publication are available for \$7.50 from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402.

ACCESSIBILITY—LEGISLATION

414. American Bar Association Commission on the Mentally Disabled. Developmental Disabilities State Legislative Project

Eliminating environmental barriers. Washington, D.C., The Project, [1980]. xi, 94 p. paper. (Stock No. 065-000-00047-4)

The Developmental Disabilities State Legislative Project was initiated by the American Bar Assn. to safeguard the rights of developmentally disabled citizens and assure them equal access to quality services consistent with the philosophy and program of P.L. 94-103 and other federal mandates. The project will address this task by disseminating reports that review existing legislation in this area and propose model laws. This project report is focused on making the environment accessible to developmentally disabled persons. An introductory section on the importance of mobility discusses the adverse effects of physical, attitudinal, and legal restrictions. Federal and state statutes designed to eliminate environmental barriers are then reviewed and evaluated for their effectiveness. Nine charts outlining various aspects of the state statutes—policy and purpose, design and construction standards, administrative authority—are provided. Components that should be considered in alternative

legislation are recommended, and a model act for establishing an environmental design board is presented. This complete law contains commentaries and alternative versions of some sections for certain states.

Copies of this publication are available for \$4.25 from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402.

AGING

See 401.

APHASIA

See 398.

APHASIA—SPEECH CORRECTION

See 404, 410.

ARTHRITIS

415. Ross Laboratories

Arthritis in Childhood: Report of the Eightieth Ross Conference in Pediatric Research, edited by Tom D. Moore. Columbus, Ohio, Ross Laboratories, 1981. xiii, 134 p. figs., tabs. paper.

The conference reported in this volume was convened at Freeport, Bahamas, on Dec. 2-5, 1979. In addition to rheumatologists from Canada, England, West Germany, and the U.S., participants included geneticists, immunologists, radiologists, and orthopedic surgeons. Recent advances in the etiology, diagnosis, and treatment of childhood arthritis and new directions in research were addressed.

Partial contents are: Diagnostic Dilemmas: An Orthopedic Surgeon's Perspective, by Alvin H. Crawford, p. 13-17.—Arthritis is a Manifestation of Connective Tissue Diseases, by Jerry C. Jacobs, p. 18-22.—Radiologic Techniques, by Barbara N. W. Weissman, p. 29-33.—Infection and Chronic Rheumatic Disease in Children, by Paul E. Philips, p. 37-42.—Antigen-Induced Arthritis, by J. Roger Hollister, p. 48-52.—Familial Incidence of Juvenile Rheumatic Diseases, by Barbara M. Ansell, p. 64-66.—Predisposition to Juvenile Arthritis: Genetic Aspects, by Nicole Suci-Foca and others, p. 72-74.—Prostaglandins and Inflammation, by Ira M. Goldstein, p. 95-100.—Salicylates in Pediatric Rheumatology, by Daniel E. Furst, p. 104-112.—Gold Salts in the Rheumatic Diseases, by Joseph E. Levinson, p. 120-125.

Further information on this publication is available from Ross Laboratories, Division of Abbott Laboratories, 625 Cleveland Ave., Columbus, OH 43216.

ATTITUDES

See p. 344.

AUDIOMETRIC TESTS

416. McFarland, William H. (*Chairperson, Dept. of Audiol., Gallaudet College, Kendall Green, Washington, DC 20002*)

An automated hearing screening technique for newborns, by William H. McFarland, F. Blari Simmons, and Frederica R. Jones. *J. Speech & Hearing Disorders*. Nov., 1980. 45:4:495-503.

The Crib-o-gram is an automated screening technique that measures the movement of a newborn immediately before and after the presentation of a calibrated acoustic stimulus. The movements are recorded on a strip chart for post-test analysis. This article reports on the use of the Crib-o-gram in a hearing screening program at Stanford University Medical Center. The method of using this device in nurseries, scoring criteria, and follow-up of the infants with and without hearing loss are discussed. In tests of over 12,000 infants the Crib-o-gram has been found to be an effective technique for hearing screening, with a current detection rate of 93%. The false positive rate for a sample of over 1,500 infants in an intensive care nursery was 15%; the evidence of hearing impairment in this same sample was 1 in 56, indicating a need for mandatory screening among infants receiving this care. Planned improvements of the Crib-o-gram are described, and tabular data and an example of the device's readings are included.

AUTISM

417. Luce, Stephen C.

How to reduce autistic and severely maladaptive behaviors, by Stephen C. Luce and Walter P. Christian. Lawrence, Kan., H & H Enterprises, 1981. vi, 37 p. paper.

Maladaptive behaviors are disruptive or excessive actions of students that interfere with learning new skills. This booklet tells parents and teachers how they can change these behaviors in children with autism or other severe behavioral disorders without resorting to restrictive or harmful punishment. Examples of maladaptive behavior are provided, and respondent and operant behaviors are defined. Five general procedures for reducing behavior are then presented: defining, assessing, and changing the behavior, and evaluating and maintaining this change. Also explained are specific applications of these procedures, including differential reinforcement of other behavior, extinction, removal of part of the reinforcement, and contingent effort. Review questions and numerous examples of children's behaviors help readers understand the concepts and techniques. Sources of additional information complete this functional text.

Copies of this publication are available for \$3.25 from H & H Enterprises, Box 1070, Lawrence, KS 66044.

BEHAVIOR MODIFICATION

See 417, 468.

BIOGRAPHY

See p. 367.

BLIND—RECREATION—ADMINISTRATION

See 418.

BLIND—SOCIAL SERVICES—ADMINISTRATION

418. National Accreditation Council for Agencies Serving the Blind and Visually Handicapped

Social services: Self-study and evaluation guide. New York, The Council, 1981. x, 40 p. paper.

To help agencies working with blind and visually handicapped persons improve their services, the accreditation standards presented in this manual emphasize outreach to underserved populations, coordination with other community agencies and programs, advocacy of the rights of this population, and consumer participation in program development. The standards cover 2 distinct types of services: social work, and recreation and leisure. Each set of standards addresses planning and organization, personnel, program services, and program evaluation. In addition, the social work standards consider social casework, work with community organizations, and home interviews, and the recreation and leisure standards encompass family participation, camping, sales of arts and crafts products, and leisure education. The format allows administrators to rate performance against the standards. Evaluation questions help agencies focus their efforts to improve programming.

Copies of this publication are available for \$1.50 from National Accreditation Council for Agencies Serving the Blind and Visually Handicapped, 79 Madison Ave., New York, NY 10016.

BLOOD PRESSURE—PROGRAMS

419. Clyburn, Steven A. (*Rural Specialist, Natl. High Blood Pressure Educ. Program, Office of Prevention, Educ., and Control, Natl. Heart, Lung, and Blood Inst., Natl. Insts. of Health, NIH Bldg. 31, 9000 Rockville Pike, Bethesda, MD 20205*)

Hypertension in rural America, by Steven A. Clyburn, Graham W. Ward, and Jacquelyn B. Admire. *Urban Health*. Sept., 1980. 9:7:38-40, 48.

Inner-city programs to control high blood pressure (HBP) have been documented in numerous studies, but similar efforts in rural areas have received less coverage. This article discusses the resources that are available in rural areas for controlling hypertension. Educating patients about appropriate medical regimens is said to be the primary means of controlling HBP. Since there are a limited number of health care professionals in rural areas, patient education is often performed by community hospitals, cooperative extension services, community colleges, and community health clinics. Described are programs in Troup

ABSTRACTS

County, Ga., Bamberg County, S.C., and Plattsburgh, N.Y., that compensate for sparse health care resources by coordinating cooperative ventures and soliciting help from volunteers and organizations that do not ordinarily provide health care. These programs' screening, counseling, and monitoring activities are summarized, and the support they receive from federal and state sources, such as the Bureau of Community Health Services, is indicated. Tabular data on hypertension in urban and rural areas are included.

CEREBRAL PALSY—EMPLOYMENT

420. George Washington University. Job Development Laboratory

Working with cerebral palsy, by Elaine M. Shaver and Kalisankar Mallik. Washington, D.C., The Laboratory, 1981. 92 p. photos. paper.

Lack of knowledge about how persons with cerebral palsy (CP) can use equipment and individualized methods to perform jobs has led to an underestimation of such persons' potential for employment. This book describes ways that adults with CP have managed to obtain competitive employment despite their disabilities. The first section contains interviews with 12 persons with CP who have launched successful careers in such fields as law, computer programming, art, micrography, and personnel counseling. The interviews underscore the unique attributes and resourcefulness of each person, describe the extent of their handicaps and work accommodations, and encourage readers to use their ingenuity to devise similar adaptations. The Job Development Laboratory's system for determining an individual's job potential is explained in the second section. This system is contrasted with traditional vocational evaluation, and specific suggestions are made for developing job skills. The final section of the text consists of a comprehensive chart of alternative techniques and devices that can be used to accomplish certain tasks, such as writing messages, typing, filing, moving materials, and using the telephone. Manufacturers of assistive devices, ABLEDATA brokers, and references complete this valuable resource.

Copies of this publication are available for \$6.00 (prepaid) from Rehabilitation Research & Training Center, George Washington Univ., 2300 Eye St., N.W., Rm. 714, Washington, DC 20037.

CHILDREN—GROWTH AND DEVELOPMENT—PROGRAMS

421. Trohanis, Pascal (*Director, Technical Assistance Development Systems, Univ. of North Carolina at Chapel Hill, Chapel Hill, NC 27514*)

Services for young exceptional children, by Pascal Trohanis, Michael Woodward, and Shirley K. Behr. *The Exceptional Parent*. Feb., 1981. 11:1:S13-S15, S18-S20.

New services for preschool handicapped children (from birth to 3 yrs.) mandated by federal legislation differ in each state because of the nature of the mandates and various standards of teacher certification.

The purpose of this article is to present comprehensive information on state services for this population in an organized fashion. The status of each state's early childhood special education (ECSE) legislation is indicated in a table showing mandated or permissive age ranges. Also supplied are the administering agency, purpose, eligible population, means of providing funds, and source of additional information for 8 related federal programs (Indian Health Services, Head Start, Title XX). Two additional tables show the status of the states' ECSE teacher certification and ECSE program guidelines and standards. Background information on these areas is provided, and ways of using the tables are suggested.

CHILDREN—GROWTH AND DEVELOPMENT—SPECIAL EDUCATION

See 397.

CHRONIC DISEASE—PARENT EDUCATION

422. Bergman, Arlene M. (*Associate Director of Patient and Community Services, Natl. Office of Muscular Dystrophy Assn., 810 Seventh Ave., New York, NY 10019*)

Living with progressive childhood illness: Parental management of neuromuscular disease. *Social Work in Health Care*. Summer, 1980. 5:4:387-408.

Most of the studies on parents' reactions to children who are chronically ill or disabled have been conducted in clinical settings and have centered on preselected aspects that may not have been of primary importance to the participants. To document parents' behaviors that assist handicapped children, the researcher in this participant observation study lived with 6 families with children who had progressive neuromuscular diseases. The methodology of the study, which included the researcher's spending 4 days and nights with each family, and the backgrounds of each family are fully described. The functional strategies that parents performed to manage their children's diseases are presented in 5 categories: changing their focus from the future to the present, trying to create as normal a life as possible for their families, obtaining beneficial services, developing and utilizing personal strength, and organizing support networks. The 27 specific activities discussed can be used as a basis for parent education programs. (18 refs.)

CLEFT PALATE

See p. 351.

COLOSTOMY

See 405.

COMMUNICATIVE DISORDERS—BIBLIOGRAPHY

423. Update Publications

Speech language hearing UPDATE. Tempe, Ariz., Update Pubs., 1981. v, 69 p. paper.

Intended for parents, students, and librarians, as

well as specialized professionals, this bibliography describes new and forthcoming resources in speech, language, and hearing. Books, diagnostic and treatment materials, and portable equipment are cited. The format includes a summary of the resource, components, and price. Also provided are author, publisher, manufacturer, and subject indexes. Most of the text is devoted to publications, which are grouped according to publisher.

Further information on this publication is available from Update Publications, P.O. Box 26377, Tempe, AZ 85282.

COMMUNICATIVE DISORDERS— LEGISLATION

424. *Government Affairs Review*. Spring, 1980. 1:1:1-33.

Premier issue of journal.

During the past 2 decades sponsored by Federal and state governments research, training, and services have had significant effects on persons with speech, language, and hearing impairments. Presently government's commitment to assist these persons is challenged by cost and indications of anti-professionalism. Intended for government officials, speech-language pathologists, and audiologists, this new publication directly addresses these challenges. This premier issue provides current information on federal and state legislation, federal regulations, litigation, and speech and hearing disabilities among residents of nursing homes. Other sections present relevant news items and sources of additional information.

Governmental Affairs Review will be published four times a year by the American Speech-Language-Hearing Assn., 10801 Rockville Pike, Rockville, MD 20852.

CYSTIC FIBROSIS—PARENT EDUCATION

425. Oppenheimer, Jeanette R. (R.W.R., Director, Cystic Fibrosis Center, Children's Hosp. of Orange County, 1109 W. La Veta, Orange, CA 92668)

The effect of parental relationships on the management of cystic fibrosis and guidelines for social work intervention, by Jeanette R. Oppenheimer and Ralph W. Rucker. *Social Work in Health Care*. Summer, 1980. 5:4:409-419.

Effective management of cystic fibrosis (CF) requires complex regimens, which when not followed can result in recurrent lung infections. With special consideration for the recent changes in family structure in the U.S. (increased divorce rates, remarriages, changes in the status of women), this study investigated the effects of parental relationships on the home care of children with CF. Thirty-seven families completed the questionnaire, the clinical design and uses of which are fully described. Findings showed that children living at home with both natural parents received better care and were in better physical condition than those living with one natural parent, and that in families with problematic relationships caring for the child often worsened social and emotional conditions. Examples of families' strengths, weak-

nesses, and accommodations are illustrated in 3 case studies. Recommended strategies for social workers involved with these families are the assessment of nature and quality of family relationships, resolution of major marital problems, emotional and practical support for single parents, and formation of parent groups. (10 refs.)

DEAF

See 402, 453.

DEAF—MENTAL HYGIENE

426. Cohen, Beverley K.

Emotional disturbed hearing-impaired children: A review of the literature. *Am. Annals Deaf*. Dec., 1980. 125:9:1040-1048.

Although both hearing and hearing impaired children are affected by many of the same psychological, psychosocial, and physiological variables, there are other complex implications of hearing impairment that must be considered. This article reviews pertinent literature to determine the effects of hearing impairment on children and their families and the degree to which this impairment can cause emotional disturbances. Preliminary information is presented on the utility of residual hearing, familial acceptance of the hearing impaired child, communication, and physiological factors. Several surveys on the incidence and prevalence of emotional disturbances in hearing impaired children are reviewed, and the problems of interpreting data from these surveys are noted. It was found that sources of frustration are intensified for children with this disability and that their communication problems affect child rearing practices, early home experiences, and the attitudes of others. Characteristic behaviors of these children are also reviewed. Four factors involved in the identification of emotional disturbances in hearing impaired children are identified: 1) secondary disabilities caused by the etiology of hearing impairment, 2) the high prevalence in this population of educationally significant disabilities other than behavioral disturbances, 3) the problems of hearing parents who are not trained to communicate with deaf children, and 4) the lack of professionals working in this field. Recommended educational methods for these children include focusing on the underlying causes of behavior and resolution of conflicts, well-planned parent counseling programs that teach parents communication techniques, and a team approach to management. (37 refs.)

American Annals of the Deaf is published at 5034 Wisconsin Ave., N.W., Washington, DC 20016.

DEAF—PARENT EDUCATION

427. Miller, Alfred L.

Hearing loss, hearing aids and your child: A guide for parents. Springfield, Ill., Charles C Thomas, 1980. vii, 97 p. figs.

Using "difficulty responding to regular speech" as a basis for his definition of hearing loss, the author of this handbook for parents discusses the various forms

of this disability and their implications for children. A chart of responses to sound stimuli in infants and young children and forms for audiometric evaluation are provided. Procedures for evaluating hearing—pure-tone hearing assessment, visual reinforcement audiometry, tympanometry—are explained. Six types of hearing aids are described. Common problems with these aids are addressed and suggestions for learning to use them correctly are offered. A final section is devoted to therapy conducted by a speech and hearing therapist in a regular school. Statements by school children on their hearing losses and use of hearing aids complete the text.

Copies of this publication are available for \$7.50 from Charles C Thomas, Pub., 301-327 E. Lawrence Ave., Springfield, IL 62717.

DEAF—SPECIAL EDUCATION—EQUIPMENT

428. *Am. Annals. Deaf.* Sept., 1980. 125:6:613-888.

Symposium on research and utilization of educational media for teaching the deaf. Back to media: How to use better what you already have.

The thirteenth in a series of symposia on educational media for deaf students, the conference reported in this issue reviewed the progress that has been made in this area and explored ways of improving the use of technology already available in classrooms for this population. Designed for supervisors, teachers, and media specialists, the presentations primarily consisted of demonstrations of equipment currently used in schools. The forms of media discussed in this state-of-the-art include new applications of standard equipment (8 mm film, overhead projectors), videotapes, nonverbal films, auditory training materials, and special equipment for severely handicapped persons.

Partial contents are: Learning and Instructional Theory Revisited, by W. C. Meierhenry, p. 626-631.—English Remediation and the Older Deaf Student: The Computer as a Tool, by David Dolman, p. 655-661.—The Teletypewriter and the Videotape Recorder: Media Equipment that Tap Student Resources, by Joan Ruberry and Edythe Lyon, p. 674-678.—Creating Visual Materials for Multi-Handicapped Deaf Learners, by Carole Hack and Susan Brosmith, p. 702-709.—Switched-On Learning: Education Through Modern Media, by Virginia Stevenson, p. 714-720.—How About That!: TV Programs for Deaf Students, by Sarah Raymond, p. 721-725.—The Human Body: A Unique Media Experience, by Sandra D. Tracy, p. 743-746.—A Videotape Series for Teaching Job Interviewing Skills, by Deborah J. Veatch, p. 747-750.—The Evaluation Program and Nationwide Field Test Effort of the Media Development Project for the Hearing Impaired, by Ronald R. Kelly, p. 798-801.—Out of the Locker Room and into the Classroom: Innovative Approaches to the Use of Media and Strategies in Sex Education for the Deaf, by Michael I. Kessler, p. 822-825.—Computer-Aided Instruction at the Florida School for the Deaf and the Blind, by Dennis B. Hoffmeyer, p. 834-840.—The Language Arts Curriculum Goes Hollywood, by Christine O'Brien

Pollock, p. 849-854.—Using Imagery to Teach Independent Pronunciation Skills to Deaf College Students, by Lawrence Pschirrer, p. 855-860.

American Annals of the Deaf is published at 5034 Wisconsin Ave., Washington, DC 20016.

DEAF—VOCATIONAL REHABILITATION

429. Tomlinson, Patricia A. (*Coordinator of Services for the Deaf and Hard of Hearing, State Dept. of Labor and Industry, Div. of Voc. Rehab. Services, Labor and Industry Bldg., John Fitch Plaza, Trenton, NJ 08625*)

Expansion of vocational rehabilitation services for deaf and hard of hearing clients. *Am. Rehab.* Jan.-Feb., 1981. 6:3:25-28.

In order to reach a greater number of hearing impaired persons who were eligible for services, the New Jersey Division of Vocational Rehabilitation Services initiated a grant in 1975 to fund the salaries of staff specializing in deafness and alternative modes of communication. This article contains a report of the 3-yr. project's objectives, approaches, implications, and follow-up. New staff positions created by the project included a full-time State Coordinator for the Deaf, a Rehabilitation Counselor, Deaf Language Specialist (RCD), and a Rehabilitation Counselor Aide, Deaf Language Specialist (RCAD); RCD/RCAD teams were used in 5 regional offices. Also described are the staff's responsibilities—case load comprised totally of hearing impaired clients, consultations with general counselors serving this population, outreach activities, monthly meetings, and special training sessions. As a result of this project, there was a steady increase in the successful rehabilitation of deaf persons. The continuation of project activities is summarized, and 15 recommendations for starting similar projects focused on the area of staffing are provided.

DEAF-BLIND—PROGRAMS

430. Sternberg, Les

Prelanguage communication programming for the severely and profoundly handicapped, by Les Sternberg, Christy Battle, and Janet Hill. *J. Assn. Severely Handicapped.* Fall, 1980. 5:3:224-233.

Intended primarily for deaf-blind persons and used extensively in the Netherlands, the Van Dijk program teaches communicative intentions and procedures through movements, signals, gestures, objects, pictures, signs, and speech. This article describes the instructional interaction methods that are used in this program and considers its application to other severely handicapped populations. The instructional objectives of the major levels of the Van Dijk program are: 1) resonance—children learn that their movements can be used to affect another's behavior and an order of movements develops their anticipation and memory, 2) co-active movement—children follow a variety of symmetric and asymmetric sequences with the teacher and improve body image, 3) deferred limitation—students duplicate a movement pattern demonstrated by the teacher or initiate the activity by providing the expressive cue and 4) natural

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ABSTRACTS

gestures—in this transition from reference to representation, children learn that refined body movements can be used to communicate. To help practitioners determine appropriate communicative levels and activities, an assessment chart presents indexes of cognitive development, receptive communication, and expressive communication for each Van Dijk level.

Journal of the Association for the Severely Handicapped is published at 1600 W. Armory Way, Seattle, WA 98119.

DENTAL SERVICES

431. Melia, Richard P. (*Program Analyst, Div. of Policy Development, Rehab. Services Admin., 300 C St., S.W., Washington, DC 20201*)

Recent steps to improve dental care for handicapped people. *Am. Rehab.* Jan.-Feb., 1981. 6:3:11-13.

Disabled persons' access to dental care services before and since the Rehabilitation Act of 1973 is discussed. Prior to 1970, these services were primarily the concern of the Veterans Administration, federal programs in the areas of maternal and infant health, and such groups as the Academy of Dentistry for the Handicapped. Passage of the Rehabilitation Act led to systematic and widespread efforts for better dental care for this population, as well as less attention to major disabling dental conditions, as priorities were set for severely handicapped persons. Cited as a model of cooperation is a program to improve care of disabled persons at 11 dental schools involving the American Fund for Dental Health, the American Dental Assn., and funding from a private foundation. Also summarized are the purposes and activities of the National Foundation of Dentistry for the Handicapped and the scope of the U.S. Public Health Service's *Special Report on Dental Care for Handicapped People*. Implications for independent living and vocational rehabilitation programs are addressed, and descriptions of pertinent reports are provided.

DEVELOPMENTAL DISABILITIES—PROGRAMS

See 407.

DIABETES

See 399.

DISABILITIES

See p. 344.

DISABILITIES—CANADA

432. Canada—House of Commons. Special Committee on the Disabled and the Handicapped

Obstacles. Ottawa, Ontario, The Committee, 1981. 189 p. photos. paper.

The Committee that prepared this report for the Canadian government points out that compared with efforts being made in other countries, "Canada shows

poor progress in assisting disabled persons in the areas of employment opportunities, income security, community support services, and technical aids." Concluding that there is no reason why Canada cannot assume a leadership role in promoting greater independence for disabled persons, this report describes the major obstacles faced by disabled persons in Canada, and suggests legislative, fiscal, and organizational actions that can overcome them.

One hundred and thirty recommendations are grouped into 20 categories, including human and civil rights, housing, independent living, accessibility, education, institutional living, attitudes, prevention, aids and devices, and research and development. Interspersed with these recommendations are profiles of 12 disabled persons who discuss their daily experiences in a society that often frustrates their attempts to live independently. This comprehensive volume also contains background information on its preparation and a glossary.

Further information on this publication is available from the Special Committee on the Disabled and the Handicapped, House of Commons, Ottawa, Ontario K1A 0A6, Canada.

DISABILITIES—ATTITUDES

433. Regional Rehab. Research Institute on Attitudinal, Legal and Leisure Barriers

Barrier awareness: Attitudes toward people with disabilities, edited by Debra A. Cornelius. Washington, D.C., The Inst., 1981. 72 p. illus. paper.

In this informative booklet an attitudinal barrier is defined as "a way of thinking or feeling resulting in behavior that limits the potential of disabled people to be independent individuals." A preliminary section provides general information about disabled persons, such as distinctions in terminology and primary implications of handicaps. The main body of the text is devoted to specific information about persons who use wheelchairs and those with hearing impairments, visual impairments, mental retardation, and "hidden disabilities" (ostomies, cancer, diabetes). The innovative and concise format consists of clarifications of popular misconceptions about the disabilities, examples of attitudinal barriers and suggestions on how nondisabled persons should respond in certain situations (shopping, eating out, traveling), and outlines of ways of interacting with persons with these disabilities. Working to make facilities accessible, including disabled persons in community planning groups, and contacting responsible persons regarding their portrayal of disabled persons are some of the positive actions that are recommended. This useful booklet also provides sources of additional information.

Copies of this publication are available for \$4.50 from the Regional Rehab. Research Institute on Attitudinal, Legal, and Leisure Barriers, George Washington Univ., 1828 L St., N.W., Suite 704, Washington, DC 20036.

DISABILITIES—BIOGRAPHY

See p. 367.

DOWN'S SYNDROME—DIAGNOSIS

434. Smith, J. David (*Director of Graduate Studies in Educ., Dept. of Educ., Lynchburg College, Lynchburg, VA 24501*)

Down's syndrome, amniocentesis, and abortion: Prevention or elimination. *Mental Retardation*. Feb., 1981. 19:1:8-11.

In recent years the use of amniocentesis among women at high risk for bearing an infant with Down's syndrome (DS) has increased dramatically. This article explains the amniocentesis procedure and discusses using its results as a basis for aborting fetuses with DS. It is suggested that readily accepting the abortion of a fetus with DS as the best alternative may be due to a misunderstanding of the level of mental retardation or other disabilities associated with this condition, or "assigning" a subhuman status to persons with this disability. Evidence is cited showing that many children with DS are educable and that organizations of parents of mentally retarded children do not endorse abortion as a means of preventing this disability. It is recommended that the American Assn. on Mental Deficiency respond to these issues. (16 refs.)

DOWN'S SYNDROME—PHYSICAL THERAPY

See p. 339.

EDUCATION—PERSONNEL

435. American Association of Colleges for Teacher Education

Educators with disabilities: A resource guide. Washington, D.C., The Assn., 1981. ix, 153 p. photos. paper. (Stock No. 065-000-00104-7)

Personal experiences related by more than 900 educators who have disabilities were used to formulate an overview of opportunities in the teaching profession. Although the picture is improving, probably due to the implementation of Section 504 of the Rehabilitation Act, comments received indicate that discrimination is still apparent in career counseling, access to teacher education programs, and obtaining employment. Barriers, both attitudinal and environmental, also exist to a degree for people with disabilities who do find employment as educators. This guide points out, however, how obstacles can be or have been surmounted. Tactics that advocates can use to prevent or circumvent problems typically met in teacher education and employment are suggested by the authors, and strategies used on the job in coping with problems related to their disabilities are described by some of the teachers surveyed, including those with visual or hearing impairments, neurological or neuromuscular disorders, orthopedic handicaps, and amputations.

A directory of educators with disabilities comprises a large portion of this publication. It is provided as a resource for career counselors, prospective employers, persons with disabilities and personnel in educational or other agencies. In addition to providing name and address, academic degree, present position

held, and the nature of the disability, the listing includes areas in which each individual has agreed to act as a consultant or resource.

Copies of this publication may be ordered for \$5.50 from Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402.

EMPLOYMENT

See p. 362, p. 367.

EMPLOYMENT—PROGRAMS

436. Wehman, Paul (*Dept. of Special Educ., Div. of Educ. Services, Virginia Commonwealth Univ., 910 W. Franklin, Richmond, VA 23284*)

Competitive employment for moderately and severely handicapped individuals, by Paul Wehman and Janet W. Hill. *Exceptional Children*. Feb., 1981. 47:5:338-345.

Described are the design, implementation, and progress of Project Employability, a program funded by the Virginia Dept. of Rehabilitative Services for vocational training and job placement of moderately and severely handicapped persons in Richmond, Va. The program consists of the following conceptual sequence of activities: general job assessment in the community, client assessment, establishment of realistic performance objectives, formulation of a work adjustment program, contact with specific employers, matching jobs with clients, setting up a training period, field placement, and program evaluation. Also discussed is Project Employability's system of service delivery, including staffing, interagency coordination, and client pools and referrals. During the first 18 mos. of the program, 33 persons (most of whom never before worked competitively) cumulatively earned over \$90,000. These successful results are attributed to a comprehensive network of assistance for clients during initial stages of placement and gradual withdrawal of assistance as the client progressed. (23 refs.)

HEALTH SCIENCES

See 449.

HOME CARE

437. Sharma, Rabinder K. (*Graduate School of Public Health, Univ. of Pittsburgh, Pittsburgh, PA 15261*)

Forecasting need and demand for home health care: A selective review. *Public Health Reports*. Nov.-Dec., 1980. 95:6:572-579.

Since a concise theory regarding the determinants of home health care (HHC) has not been set forth, 3 models for forecasting this service used by the following agencies are reviewed: the Health Systems Agency of Southwestern Pennsylvania (HSA/SP), the Florida State Dept. of Health and Rehabilitation Services, and the Rhode Island Dept. of Community Affairs. In the HSA/SP and Florida models, the need for HHC is based on a certain proportion of hospital admissions and patients from other sources. The major

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advantage of these models is that they are easy to use and explain; disadvantages are an imprecise definition of need and an incomplete specification of design. The Rhode Island system defines need for HHC in terms of chronic limitations of activity among the population. In its favor, this approach makes explicit assumptions and emphasizes consumers' needs, but it requires considerable data on the local area. Also presented is utilization approach to forecasting demand for HHC, which is based on extrapolation from observation of the use of HHC among the target population.

Although this model is limited by current market imperfections, it has the advantage of exposing present deficiencies in HHC. It is suggested that each approach be tested empirically in order to refine it, and that need and demand be considered together in the planning process. (15 refs.)

438. United Cerebral Palsy Associations

For this respite much thanks: Concepts, guidelines and issues in the development of community respite care services for families of persons with developmental disabilities, by Rachel D. Warren and Irving R. Dickman. New York, The Assns. 1981. vi, 134 p. paper.

In this comprehensive guidebook, respite care is defined as "a system of temporary supports for families of developmentally disabled individuals which provides the family with relief"—"temporary" meaning periods from an hour to 3 months. Several models of community respite care services are presented, and the process of organizing these services is conceptualized. Among the programs described are those organized by City University of New York and United Cerebral Palsy Associations (UCPA), the Kalamazoo (Mich.) Respite Care Co-op Program, and UCPA of Sacramento-Yolo Counties (Calif.). Objectives, funding, parent training, and technical assistance are discussed. The main components of establishing respite care services are: initiating the program (assessing needs and resources, formulating policies and procedures, choosing a model of care), community development (including public information), family involvement (parents' role in planning, matching families and caregivers), and direct services (selecting staff, accepting new families, and evaluation). The implications of this form of care—greater responsibility for parents, possibilities of permanent placement, promotion of independent living—are also considered. Over half of the text consists of documents from the sample programs, including recommendations, guidelines for parents, and reports on workers; and appended material on a consumer survey, financing respite care, and additional resources.

Copies of this publication are available for \$3.00 from United Cerebral Palsy Associations, 66 E. 34th St., New York, NY 10016.

LEARNING DISABILITIES

439. Spadafore, Gerald J.

LDRP: Learning disability rating procedure manual, by Gerald J. Spadafore and Sharon J. Spadafore.

Novato, Calif., Academic Therapy Pubs., 1981. 47 p. paper.

Educators often have difficulty differentiating students with learning disabilities from those with mental retardation or emotional disabilities. The Learning Disability Rating Procedure (LDRP) provides a score that indicates the student's suitability for placement in a learning disabilities program. Designed for both elementary and secondary school students, the LDRP assesses 10 major areas: general intelligence, reading decoding, listening comprehension, variance in comprehension, socially inappropriate behavior, expressive verbal language development, learning motivation, expressive writing development, independent work level (distractibility), and severe learning discrepancy. This procedure identifies the diagnostic testing and observations that must be completed before the student's staffing, and provides a focus for discussion during the staffing. A section on development and technical data describes standardization methods ensuring that the LDRP fosters placement decisions consistent with P.L. 94-142, and presents information on reliability and validity. A considerable portion of the text is devoted to case studies illustrating the use of this procedure.

Copies of this manual (No. 265-1) are available for \$7.50 from Academic Therapy Publications, 20 Commercial Blvd., Novato, CA 94947. Also available is a package of 25 rating forms (No. 266-X) for \$6.00.

440. Weller, Carol

WSSAB: Weller-Strawser Scales of Adaptive Behavior for the Learning Disabled: Manual, by Carol Weller and Sherri Strawser. Novato, Calif., Academic Therapy Pubs., 1981. 112 p. tabs. paper.

Designed to meet the requirements of P.L. 94-142, the Weller-Strawser Scales of Adaptive Behavior (WSSAB) assess the severity of behavioral problems among elementary and secondary school students with learning disabilities. The scales yield a profile of either mild to moderate or moderate to severe behavioral problems in 4 areas: social coping—how the student responds to different environments, relationships—how the student relates to others, pragmatic language—how the student uses language in social situations, and production—how the student behaves while working. The WSSAB allows the examiner to determine the severity of the student's learning disability, identify specific areas requiring remediation, and plan compensatory teaching strategies to help students cope in various environments. The major section of this volume provides recommendations for programming and environment modifications for each possible profile that can be obtained on the scales. Another section documents the reliability and validity of the WSSAB. Specific suggestions for implementing the 4 subtests and 3 sample case studies are appended.

Copies of the manual (No. 258-9) are available for \$15.00 from Academic Therapy Publications, 20 Commercial Blvd., Novato, CA 94947. Also available are packages of 25 elementary forms (No. 259-7) and 25 secondary forms (No. 260-0) for \$6.00 per set.

LEARNING DISABILITIES—SPECIAL EDUCATION

See 408.

LIBRARY SERVICE

441. Stough, Helen (*Children's Librarian, Winnetka Public Library District, Winnetka, IL 60093*)

"Let me hear your hand"—Library service for handicapped children. *Illinois Libraries*. Dec., 1980. 62:10:878-883.

Children's librarians are told how they can extend their services to disabled children. It is suggested that preliminary research determine the number of handicapped children in the community, the disabilities which are most prevalent, which schools the children attend, and what organizations serve them. Librarians are also advised to become knowledgeable about one particular disability and to talk to professionals working with disabled persons, disabled children themselves, and their parents regarding their interests in library services. Guidelines are then presented for establishing special services, inviting handicapped persons for a tour of the library, compiling bibliographies of children's books about handicaps (an example of which is included), cooperating with nearby libraries to share resources, and offering signed story hours in the library and appropriate schools. Other libraries with functioning programs and national and local organizations for disabled persons (a list of which is provided) are cited as sources of further assistance. The importance of overcoming fears about serving handicapped persons is emphasized.

LIBRARY SERVICE—ACCESSIBILITY

442. National Library Service for the Blind and Physically Handicapped

Planning barrier free libraries: A guide for renovation and construction of libraries serving blind and physically handicapped readers. Washington, D.C., The Service, 1981. iv, 61 p. figs.

Addressing a neglected topic, this concise volume presents a practical planning guide to the design of barrier-free libraries. Emphasizing function, safety, and efficiency, the guide covers the progress of the new construction or renovation from feasibility study through construction. It opens with a discussion of the important planning phase, which involves the architect, library director, and other librarians in a team effort to provide services and equipment for handicapped persons. The functional program is then considered, including criteria for selecting an architect, funding sources, and such details as elevators, reading and study areas, and book shelves. Elements of the architectural program—schematic design, working with consultants, barrier-free design, bidding, and negotiation—are discussed. Throughout these sections architects' drawings illustrate specific functions and work flows. A final section focuses on renovation. Included in the appended material are minimal space and personnel requirements, an accessibility

checklist, and approximate time schedules for construction and renovation.

Additional information on this publication is available from the National Library Service for the Blind and Physically Handicapped, Library of Congress, Washington, DC 20542.

MENTAL RETARDATION

443. Golden, Gerald S. (*Univ. of Texas Medical Branch, Univ. of Texas, Galveston, TX 77550*)

Tourette syndrome in mentally retarded children, by Gerald S. Golden and Lawrence Greenhill. *Mental Retardation*. Feb., 1981. 19:1:17-19.

Tourette syndrome (TS) is a condition that begins in childhood and is characterized by chronic motor and vocal tics as well as bizarre stereotyped movements, compulsive behavior, and coprolalia. Most persons with TS have normal intelligence, but the recognition of this syndrome in persons with mental retardation (MR) and application of effective treatment can aid in the socialization of this stigmatized group. In this study, 6 persons with MR who had symptoms of TS were first thought to exhibit manneristic behavior frequently associated with the former disability. However, prompt response to treatment with haloperidol revealed the true nature of these symptoms to be associated with TS. Clinical data on these children are summarized. The children demonstrate how the diagnosis of TS, which is often made after long delays and visits to several physicians, may be confounded among persons with MR.

MENTAL RETARDATION—INSTITUTIONS

444. Ellis, Norman R. (*Dept. of Psychol., Univ. of Alabama, University, AL 35486*)

A follow-up of severely and profoundly mentally retarded children after short-term institutionalization, by Norman R. Ellis and others. *Mental Retardation*. Feb., 1981. 19:1:31-35.

The Columbia State School in Columbia, La., is a residential facility for severely and profoundly mentally retarded children that provides intensive training in self-help skills so that the children will be less demanding at home and long-term institutionalization will be minimized. This article reports a follow-up study of 100 children who participated in the program; average length of stay in the school was 10.5 mos. Data were obtained in 3 ways: analysis of school clinical records, training and progress reports, test data, and supplemental interviews with staff and a conversion of these data to scores on the Adaptive Behavior Scale (ABS); home visits and interviews with the parents of each child; and administration of the ABS during the home visits. Parents' early intentions regarding a care plan for their child and rate of return to institutions were also investigated. Institutional training improved the self-help skills of the majority of these children. At the time of follow-up, children at home had a higher level of skills than those who had been institutionalized again. It is suggested that significant improvement in self-help

skills may lead to home care because the child is more self-sufficient, which relieves part of the parents' responsibilities, but also because the parents' hope for improvement is strengthened. Tabular data included.

MENTAL RETARDATION—PROGRAMS

See 409.

MENTAL RETARDATION—SELF CARE SKILLS

See 396.

MUSCULAR DYSTROPHY

445. Bach, John (*Augusta Alba, Dept. of Rehab. Med., New York Univ. Medical Center, Goldwater Memorial Hosp., F. D. Roosevelt Island, New York, NY 10044*)

Long-term rehabilitation in advanced stage of childhood onset, rapidly progressive muscular dystrophy, by John Bach and others. *Arch. Phys. Med. & Rehab.* July, 1981. 62:7:328-331.

The most common cause of death in patients with rapidly progressive neuromuscular disease is respiratory failure. The medical community and the general public have not recognized that proper medical management and rehabilitation of these patients can markedly extend their life expectancy and increase their productivity. From a total population of 120 patients with early childhood onset, rapidly progressive muscular dystrophy, 29 were selected for this study. They were in the most advanced stage, requiring mechanical ventilation 24 hrs. a day, and had vital capacities of less than 10% predicted for their age and height. Of these patients with severely weakened bulbar innervated muscles, 10 have been receiving positive pressure ventilation via indwelling tracheostomy tubes for an average of 3 yrs. The average age of the 29 patients is 27 yrs., with a range of 15 to 54 yrs. Three are married and have a total of 5 children. Some patients are in professional careers, or active in political and community organizations. Also discussed are the management of these patients and their potential for improved quality of life and increased longevity. (11 refs.)

PARTIALLY SIGHTED

446. Weisse, Fran Alexander

Coping with sight loss: The vision resource book, by Fran Alexander Weisse and Mimi Winer. Newton, Mass., Vision Foundation, 1980. x, 219 p. paper.

The purpose of this guidebook is to provide persons who are losing their vision with comprehensive information so that they can gain confidence and learn to adjust to their new way of life. The text is written in large (18 pt.) type so that persons with visual handicaps can locate information by themselves.

The first part of the book answers common questions about sight loss—What is legal blindness? How do I locate an eye doctor? How can my eye doctor help me when he can no longer help my eyes?—and identifies resources in over 20 areas. Legal rights, employment, low-vision services, mobility, sports and

recreation, and relevant national organizations are among the topics covered. A directory of services for Massachusetts residents with this disability, which is intended as a model for states, comprises the second part of the volume. The final part contains an index and a comprehensive listing of associations, publications, and other useful resources for persons with limited vision.

This publication is available for \$10.00 from Vision Foundation, 770 Centre St., Newton, MA 02158. A cassette edition is also available for \$10.00 from the Foundation.

447. World Health Organization. Regional Office for Europe

The use of residual vision by visually disabled persons: Report on a WHO meeting, Brussels, 28-30 January 1981. Copenhagen, Denmark, The Organization, 1981. 28 p. figs. paper.

Participants in this meeting of the World Health Organization included representatives of national research organizations and laboratories, professors of visual science, ophthalmologists, and representatives of private societies for persons with visual disabilities. This interdisciplinary group discussed criteria for categorizing persons with residual vision and for assessing their numbers and their various problems. Special emphasis was placed on the availability and evaluation of current technology, and on the need for appropriate and simple aids to enable persons with visual handicaps to maintain their independence. Existing services and available rehabilitation manpower were addressed. Also considered was research in the area of visual impairment at the basic clinical, epidemiological, and health service levels, including the contributions of biomedical, behavioral, and environmental sciences. The recommendations of the meeting in each of these areas are outlined.

Further information on this publication is available from WHO Publications Centre USA, 49 Sheridan Ave., Albany, NY 12210.

PARTIALLY SIGHTED—ADMINISTRATION

448. National Accreditation Council for Agencies Serving the Blind and Visually Handicapped

Low vision service: Self-study and evaluation guide. New York, The Council, 1981. x, 36 p. paper.

Intended primarily for use in accreditation of institutions and organizations that provide services to persons with low vision, the standards presented in this volume respond to this population's need for specialized services. The accreditation standards were prepared by a technical committee of ophthalmologists, optometrists, consumers, and administrators. An introductory section supplies an historical perspective on low-vision services, statistics on persons with this disability, and criteria that must be met before applying for accreditation. The standards are grouped into 6 sections: planning and organization, personnel, low-vision evaluation, continuing services, facilities and equipment, and program evaluation. The roles of consumers in planning and evaluating the

ABSTRACTS

program are stressed. Also provided are questions designed to stimulate program improvements and selected references.

Copies of this publication are available for \$2.00 from the National Accreditation Council for Agencies Serving the Blind and Visually Handicapped, 79 Madison Ave., New York, NY 10016.

REHABILITATION

449. Purtilo, Ruth

Justice, liberty, compassion—"humane" health care and rehabilitation in the U.S.: Some lessons from Sweden. New York, World Rehab. Fund, 1981. xiii, 79 p. paper.

In this comparative study of rehabilitation systems in Sweden and the U.S., the author explores the moral and ethical issues involved in the development of humane medical policies and practices toward persons with long-term illnesses. Both of these countries value access to personal health services regardless of ability to pay. Some of the innovative programs that the author observed were government-subsidized vacations for persons who care for chronically ill relatives, the use of dolls and toys in therapy for emotionally disturbed patients, and coordinated home and hospital care for chronically ill and dying persons. Patients in both countries thought that humane health care implied exercising control over their own lives, sharing in decisions affecting their care, and maintaining a reciprocal relationship with medical professionals. The author concludes that an interpretation of justice that addresses all of a patient's needs leads to greater independence for chronically ill persons.

The second part of the volume consists of 6 authorities' responses to the Purtilo monograph. Among the topics covered are the influence of economic constraints, conflicts of ideals in U.S. society, and the implication of principles in medical practice.

Additional information on this publication is available from World Rehabilitation Fund, 400 E. 34th St., New York, NY 10016.

See also 395.

REHABILITATION—PROGRAMS

440. *J. Rehab. Admin.* Aug., 1980. 4:3:89-122.

Issue devoted to program evaluation.

The editor of this journal states that program evaluation is a valuable tool for management and justification of programs for external sources, and that with certain changes in approach and preparation this process can generate useful new knowledge. Addressing theory, research, and practice, the articles are introduced by editorials and followed by comments from rehabilitation professionals.

Contents are: Confronting Barriers to the Utilization of Program Evaluation, by David K. Hollingsworth and Kenneth W. Reagles, p. 93-98.—The Use of Evaluation Information for Policy Changes in State Rehabilitation Agencies, by Ralph M. Crystal and Lois F. Brinkman, p. 101-105.—Microtraining as a Strategy in Training Rehabilitation Administrators

for the Performance Evaluation, by Horace W. Sawyer and Harry A. Allen, Jr., p. 107-110.—A Model for Evaluating the Performance of Rehabilitation Counseling Trainees, by Hanoch Livneh, p. 114-119.

Journal of Rehabilitation Administration is published at Administration Studies Center, DePaul Univ., 25 E. Jackson Blvd., Chicago, IL 60604.

REHABILITATION CENTERS—PERSONNEL

451. Wisconsin University—Stout. Stout Vocational Rehabilitation Institute

Developing the rehabilitation facility personnel manual, by Alan D. Gilbertson. Menomonie, Wis., Materials Development Center, 1981. 65 p. paper.

Although most personnel manuals used by rehabilitation facilities provide important information to staff, they often do not give reasons for their policies and tend to be inconsistent and unclear. The purpose of this guidebook is to help facility personnel directors write concise staff manuals so that their office can operate more efficiently. Opening sections address gathering information for the manual defining the purpose of this publication, and choosing a format. The specific policies are then discussed, such as recruitment, hiring, and orientation; absenteeism; wage and salary administration; promotions, transfers, and layoffs; employee benefits; disciplinary and grievance problems; and termination of employment. Examples of the policies of various rehabilitation facilities are presented throughout the text, and references are included.

Further information on this publication is available from the Materials Development Center, Stout Vocational Rehab. Inst., Univ. of Wis.—Stout, Menomonie, WI 54751.

RESPIRATION

See 445.

RESPIRATION—PROGRAMS

452. Petty, Thomas L. (Head, Div. of Pulmonary Sciences, Univ. of Colorado Health Sciences Center, 4200 E. 9th Ave., Denver, CO 80262)

Quality of life for the chronic lung disease patient, by Thomas L. Petty and Louise M. Nett. *Am. Lung Assn. Bul.* Jan.-Feb., 1981. 67:1:5-8.

Accurate diagnosis, therapy, emotional support, and patient education are considered to be the main components of a pulmonary rehabilitation program. The goals of patient education are to encourage patients and their families to take responsibility for medical care and to establish a daily self-care program. Use of 4 classes of drugs in treating chronic lung disease—antibiotics, bronchodilators, corticosteroids, and diuretics—is summarized, and the benefits of breathing training and walking are identified. The prescription and costs of supplemental oxygen are also covered. Physicians are provided with guidelines for starting a pulmonary rehabilitation pro-

gram, such as coordination of responsibilities, use of visual aids, and performance of key laboratory tests.

RIGHTS (LEGAL)

See 406.

RUBELLA

453. *Am. Annals Deaf*. Nov., 1980. 125:8:957-1032.

Special issue. Deafness and rubella: Infants in the 60's, adults in the 80's, edited by E. Ross Stuckless.

The thousands of children who were born deaf as a result of the 1963-65 rubella epidemic are now approaching adulthood and soon will be eligible for post-secondary education, rehabilitation, and other social services. This special issue presents the proceedings of a recent conference devoted to the significance of the sequelae of maternal rubella. The goals of the conference were to attract national attention to the problems of these young adults; to consider the particular needs of multiply handicapped young adults in this group, including those who are deaf-blind; and to encourage state, regional, and national planning to assure that these persons will receive necessary services.

Partial contents are: The Demographics of Deafness Resulting from Maternal Rubella, by Raymond J. Trybus and others, p. 977-984.—Projections for Deaf Students with Maternal Rubella: College and Other Alternatives, by E. Ross Stuckless, p. 985-992.—Handicapping Conditions Associated with the Congenital Rubella Syndrome, by McCay Vernon, Bonnie-Jo Grieve, and Kathleen Shaver, p. 993-997.—Neurological Damage and Behavior Disorder in Rubella Children, by Stella Chess and Paulina Fernandez, p. 998-1001.—But Don't Quote Me: Reflections by Parents on Deafness and Rubella, by Bonnie Fairchild, p. 1007-1011.—Rubella-Caused Deafness: Maintaining Objectivity and a Positive Frame of Reference, by Albert T. Pimentel, p. 1012-1014.—Multihandicapped Deaf Students in Postsecondary Programs: Guidelines for Planning Services, by Barry L. Griffing, p. 1018-1021.

American Annals of the Deaf is published at 5034 Wisconsin Ave., Washington, DC 20016.

SELF-CARE SKILLS

See 395.

SELF-CARE SKILLS—EQUIPMENT

454. Davis, Wendy M.

Aids to make you able: Self-help devices and ideas for the disabled. New York, Beaufort Books, 1981. 155 p. illus., spiralbound.

The occupational therapist who compiled this guidebook compares assistive devices to recipes: "you learn a few basic ones, invent your own, and . . . try those of other people." Her informative and uplifting book presents self-care aids to help disabled persons resume activities of daily living and encourages others to invent new equipment. Illustrated with simple drawings, the aids are grouped into 9 categories:

communication, eating and drinking, dressing, toileting, household chores, transportation, recreation, sexuality, and smoking. Some of the clever devices described are an elastic band for holding a pencil, adapted cutlery, a potato peeler that can be used with one hand, a dressing stick, a split-back jacket, chair-raisers, and a sliding board for wheelchair transfers. Also presented are instructions for putting on trousers for persons with stiff hips, buttoning a shirt with one hand, and bathing. A concluding section contains sources of additional information on specific topics, a bibliography, and addresses of medical suppliers.

Copies of this publication are available for \$8.95 from Beaufort Books, 9 E. 40th St., New York, NY 10016.

SEVERELY HANDICAPPED— EMPLOYMENT—BIBLIOGRAPHY

455. Bilotto, Gerardo

Work independence and the severely disabled: A bibliography, by Gerardo Bilotto and Veronica Washman. Albertson, N.Y., Human Resources Center, 1980. xiii, 94 p. paper.

The result of an extensive review of the literature on promoting social and an economic independence among severely handicapped persons, this bibliography suggests that expanded services for this population will lead to more independent employment. The abstracts cover 6 aspects of independence at work: architectural barriers, mobility, transportation, job modifications, specialized equipment, and general and vocational rehabilitation. Each of the 6 sections contains an introduction providing a theoretical perspective and a brief summary of contents. Two basic types of information are described: conceptual material, including purpose and content; and research data, stating purpose, results, conclusions, and methods. The citations document the increasing use of rehabilitation engineering.

Copies of this publication are available for \$7.50 (plus \$.45 for postage) from Products Manager, Human Resources Center, I.U. Willets Rd., Albertson, NY 11507.

SOCIOLOGY

456. Jones, Thomas W. (Asst. Prof., College of Educ., Texas Tech Univ., Lubbock, TX 79409)

Changing children's perceptions of handicapped people, by Thomas W. Jones and others. *Exceptional Children*. Feb., 1981. 47:5:365-368.

To study the effects of a concentrated educational program on children's perceptions of persons with mental and physical disabilities, 74 children (ages 7 to 9 yrs.) were randomly assigned to 2 groups. One group was administered a pretest of their perception of handicapped persons. Both groups then participated in a 5-hr. program of activities designed to help the children to understand the needs of disabled persons and to synthesize their perceptions. Activities included simulations of disabilities, interactions with handicapped persons, and discussions. Post-test

ABSTRACTS

scores showed significant positive changes in children's perceptions of disabled persons as a result of these activities. Tabular data are included. (10 refs.)

SPECIAL EDUCATION

457. Anastasiow, Nicholas J. (*Associate Director for Research, Univ. of Colorado, Health Sciences Center, John F. Kennedy Child Development Center, Denver, CO 80262*)

Early childhood education for the handicapped in the 1980's: Recommendations. *Exceptional Children*. Jan., 1981. 47:4:276-282.

Thirteen specialists in early childhood special education were interviewed concerning their recommendations and predictions for this field during the next decade. These professionals emphasized the need for early identification and treatment, community advocacy groups for handicapped persons, and increased public awareness of the value of these persons. It is suggested that training programs for special education teachers focus on normal child development, optimal learning environments, and cognitive psychology, and that these teachers learn how to communicate effectively with parents and to work cooperatively with other professionals. Other aspects of special education that are discussed are screening children with several instruments, establishing family centers (offering such services as prenatal care and day care), psychological counseling for emotionally disturbed students, curricula on living with a disability, and junior high school programs on child rearing and human development. (38 refs.)

458. U.S. Office of Special Education. State Program Implementation Studies Branch

"To assure the free appropriate public education of all handicapped children." Second annual report to Congress on the implementation of Public Law 94-142: The Education for All Handicapped Children Act. Washington, D.C., The Office, 1980. ix, 219 p. figs., tabs. paper.

The third in a series of reports on progress in implementing P.L. 94-142, this volume addresses the concerns expressed by the Congress when the Act was being formulated, as well as the interests of disabled persons, parents of handicapped children, and educators. Service to intended beneficiaries, educational settings, types of services, implementation of the Act through local agencies, and administrative procedures are covered. Both progress made to date and remaining problems are indicated. Some of the major findings of the report are: 3.8 million children (ages 3 through 23 yrs.) are benefiting from special education and related services under P.L. 94-142; the majority of handicapped children have been placed in regular classrooms, with such placements having increased during the last 2 yrs. from 67.85% to 69.31%; and almost all of the individualized education program being written now include a statement of the specific educational services to be provided. Extensive tabular data are appended.

Additional information on this publication is available from the U.S. Dept. of Education, 400 Sixth St., S.W., Rm. 4030, Washington, DC 20202.

SPECIAL EDUCATION—SEGREGATION AND NONSEGREGATION

459. Johnson, David W. (*Dept. of Social, Psychological, & Philosophical Foundations of Education, Univ. of Minnesota, Minneapolis, MN 55455*)

Integrating handicapped students into the mainstream, by David W. Johnson and Roger T. Johnson. *Exceptional Children*. Oct., 1981. 47:2:90-98.

The most important aspect of mainstreaming is said to be the promoting of true friendships between handicapped and nonhandicapped students. Through a review of the literature, this article cites research demonstrating the importance of constructive interactions between handicapped and nonhandicapped students. The decisions involved in making social judgments about handicapped peers are delineated, and the effects of stigmatization and labeling are examined. The processes of acceptance and rejection of handicapped students are discussed in terms of teaching methods and arrangement of the classroom. Research on cooperative, competitive, and individualized instruction is compared, indicating that structured cooperative learning leads to greater social acceptance of disabled students by nondisabled peers. Practical strategies for integrating handicapped students in cooperative activities are presented, including selecting the group size most appropriate for the lesson, arranging the classroom so that group members are close together and focused on each other, helping the group work together to solve problems, and evaluating products of the group according to established criteria. (19 refs.)

SPEECH CORRECTION

460. Morgese, Zoe Larsen

Group remediation of language skills, by Zoe Larsen Morgese, Ann Bonifas Snipes, and Shelia Taylor Woodfin. Danville, Ill., Interstate Printers & Pubs., 1980. xxiii, 166 p. figs. paper.

Intended for groups of 2 or more children between the ages of 3 to 8 yrs. who have more than one language problem, this workbook systematically pairs 2 remedial goals in each lesson. The activities are presented in a developmental sequence and in terminology that is readily transferable to individualized education programs. The book consists of 3 units: concepts, such as size, weight, and senses; grammar, emphasizing use and covering comprehension; and auditory processing, encompassing discrimination and memory for directions. The procedures in each activity contain objectives for both of the paired remedial targets; all targets are cross-referenced in the index. Measurements of individual performance consists of obtaining baseline data, collecting data during the activity, and evaluating the student's performance. Suggestions for implementing group instruction, visual aids for activities, and a bibliography are appended.

Copies of the publication are available for \$7.25 from Interstate Printers & Publishers, 19-27 N. Jackson St., Danville, IL 61832.

461. Peterson, Carole Walton

Conversation starters for speech-language pathology. Danville, Ill., Interstate Printers & Pubs., 1981. v, 17 p. paper.

Obtaining examples of non-imitative speech is essential in certain stages of speech-language services and in diagnostic settings. But persons with communicative problems are often hesitant to talk beyond supplying basic information. This book presents numerous items intended to elicit measurable verbal responses within the limited time of speech therapy sessions. The questions and leading statements range from demonstrations of logic to personal interests and can be used in articulatory remediation, voice improvement, fluency training, and oral and written speech-language therapy. Designed to supplement established programs, this material can be personalized for individual clients. The items have been used with both children and adults.

Copies of this publication are available for \$2.75 from Interstate Printers & Pubs., 19-27 N. Jackson St., Danville, IL 61832.

SEVERELY HANDICAPPED

See 417.

SOCIAL SERVICE—AGENCIES

See 412.

SPECIAL EDUCATION—STUDY UNITS AND COURSES

See 397.

SPINA BIFIDA

462. Hunt, Gillian M. (*Research Clinician, Dept. of Urol., Addenbrooke's Hosp., Hills Rd., Cambridge CB2 2QQ, England*)

Spina bifida: Implications for 100 children. *Developmental Med. & Child Neurol.* Apr., 1981. 23:2:160-172.

To ascertain the implications of spina bifida for schooling, 100 children with this disability were examined at home and reviewed at the schools they attended. Twenty-seven of the 41 children who were over 10 yrs. of age were confined to wheelchairs, 39 of the 100 children had an IQ below 80, and incontinence was a problem for 68 children. Examinations also showed that 64 children had visual defects, 27 had epilepsy, and 87 had experienced fractures, burns, scalds, or pressure sores. Most of the children began their education in regular schools, where teachers found they had to give them a disproportionate amount of attention without having adequate information or support. Many of the children had learning disabilities. Incontinence became a more serious problem as the children grew older. Since dependency on wheelchairs precluded their admission to regular secondary schools with stairs, the majority of older children attended special schools. It is predicted that very few of the students will find regular employment and that many will require post-

secondary education and training. Suggestions are made for helping children with spina bifida achieve the maximum degree of self-care, such as supplying their teachers with information about this condition. Tabular data included. (28 refs.)

See also 400.

SPINA BIFIDA—MENTAL HYGIENE

463. Goldstein, Susan B.

The effect of mainstreaming on self-esteem in adolescents and young adults with spina bifida. *Spina Bifida Therapy.* Apr., 1980. 2:4:309-319.

Most of the research on mainstreaming has focused on its effects on teacher training, curriculum, and teaching methods, with less attention given to disabled students' psychological reactions to this practice. This study compares the self-esteem of disabled persons educated in special schools with that of disabled persons who have been mainstreamed. Participants were 54 young persons (ages 11 to 25 yrs.) with spina bifida selected from regional spina bifida associations' mailing lists. Data were obtained through a questionnaire consisting of the Coopersmith Self-Esteem Inventory, a scale for children to report parental behavior, and items about school experience, severity of disability, and a number of demographic factors. Theories on self-esteem and its relation to mainstreaming are discussed. Results indicated that type of schooling did not have a significant effect on the self-esteem of these handicapped persons. Instead, perceived rejection by parents and their arousal of anxiety were found to be the main influences on self-esteem. Implications of the findings are explored, and tabular data are included. (35 refs.)

Spina Bifida Therapy is published by the Eterna Press, P.O. Box 1344, Oak Brook, IL 60521.

SPINA BIFIDA—SPECIAL EDUCATION

See 463.

SPINAL CORD INJURIES—SEXUALITY

464. Miller, Sherrill (*Sexual Health Care Service, Acute Spinal Cord Injury Unit, Shaughnessy Hosp., 4500 Oak St., Vancouver, BC, Canada V6H 3N1*)

Sexual health care clinician in an acute spinal cord injury unit, by Sherrill Miller, George Szasz, and Leslie Anderson. *Arch. Phys. Med. & Rehab.* July, 1981. 62:7:315-320.

Described is the role of the sexual health care clinician, a specialist trained to diagnose and treat sexual dysfunctions of disabled persons. Working under medical supervision, the clinician is part of the treatment team in an acute spinal cord injury unit, a general rehabilitation center, and an extended care unit. The clinician's role encompasses direct patient care; education for professionals, students, and community agencies; liaison with other rehabilitation groups; and research. The process of sexual rehabilitation is explained, and experience with the specialty in an acute setting is summarized. Sexual assessment, diagnosis, and management are considered to be technical

ABSTRACTS

specialties requiring comprehensive training. The major benefits of this service are early recognition of sexual concerns; definition of physiologic, emotional, and social capabilities and needs; and precise instructions for experimentation with various sexual alternatives. (19 refs.)

See also p. 347; 403.

SPORTS

465. Royal Ministry of Church and Education. State Office of Youth and Sports

The first international medical congress on sports for the disabled, edited by Harold Natvig. Oslo, Norway, The Ministry, 1980. 231 p. figs., photos. paper.

One hundred thirty doctors and researchers converged in Ustaøset, Norway, for a medical congress held in 1980 under the auspices of The Norwegian Sport Organization for the Disabled and the Organizing Committee of the Second Winter Olympic Games for the Disabled in Geilo, Norway. The aim of the conference was to demonstrate how competitive sports can be part of a rehabilitation program to help persons with any of a wide range of physical and mental conditions overcome handicaps. This publication contains the lectures presented at the conference by experts from a number of countries.

Partial contents are: Aerobic Capacity, Muscle Strength and Fiber Composition in Young Paraplegics, by Gunnar Grimby, p. 13-17.—Doping Control for the Disabled Sportsmen? by Svein Oseid, p. 18-28.—Classification of Paralyzed and Amputee Sportsmen, by Fin Biering-Sørensen, p. 44-54.—Medical Aspects of Sports for the Blind and Partially Sighted, by Asbjørn Tønjum, p. 85-92.—Sports and Physical Activities for the Mentally Handicapped in Institutions, by Gunnar Mathiesen, p. 113-119.—Cross Country Skiing for Coronary Patients, by Svein Nilsson, p. 123-133.—Sports for the Diabetic, by Sverre Maehlum, p. 142-148.—Short-Term Physical Training in Bronchial Asthma, by Allan Bundgaard, p. 157-161.—Sports for the Mentally Retarded Outside the Institution, by T. Hognset, p. 178-183.—Sport Activities in Severe Motor Paralysis in Adolescents; Their Therapeutic and Preventive Value, by Spira Ralph, p. 200-205.—Sports for Severely Handicapped Children Living in a Boarding School, by Bodil Eskesen, p. 206-210.—Research and Training Centres for Physically Disabled Athletes, by Robert Steadward, p. 219-226.

Further information about the publication is available from the Royal Ministry of Church and Education, State Office for Youth and Sports, Box 8172-Dep., Oslo, Norway.

STROKE

See 410.

STUTTERING

466. National Institute of Neurological and Communicative Disorders and Stroke. Office of Scientific and Health Reports

Stuttering: Hope through research. Bethesda, Md., The Office, 1981. 16 p. figs., photos. paper. (Stock No. 017-049-00120-4)

Research describing differences in the way normal speech and stuttering are produced has led to new directions in therapy for this disability. This succinct, informative pamphlet discusses the early warning signs of stuttering and characteristics of the population with this handicap. Recent studies on speech are summarized, including those focused on laryngeal muscles and vocal cords, the period of time required to begin vocalization, and the activity of the brain in persons who stutter. Findings from these studies have led some scientists to conclude that stuttering may be more than one condition, each with a different cause. New modes of therapy for stuttering are using biofeedback to relax throat muscles, modifying sound production at the larynx, and slowing the rate of speech. The 2 traditional schools of treatment are compared, and the parents' role in therapy for children with this disorder is considered. Also presented are suggestions for talking with persons who stutter and sources of additional information.

Copies of this publication are available for \$2.25 from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402.

467. Riley, Glyndon D. (Prof. of Communicative Disorders, California State Univ., Fullerton, CA 92634)

Motoric and linguistic variables among children who stutter: A factor analysis, by Glyndon D. Riley and Jeanna Riley. *J. Speech & Hearing Disorders*. Nov., 1980. 45:4:504-513.

If stuttering is not a unitary disorder, as some researchers have suggested, then the components that affect a person's threshold for fluency should be identified. This study investigated a variety of factors that are thought to be related to stuttering development. Seventy-six children who stuttered (ages 5-12 yrs.) were administered tests of motor coordination, psycholinguistic abilities, and stuttering severity. Factor analysis of 19 selected variables yielded 4 statistically useful factors indicating the development of associated skills in the sample population. Based on this analysis, it is suggested that the oral motor problems and the relatively deficient linguistic and perceptual skills exhibited by the sample may be predisposing conditions that affect the children's threshold for fluency and make them vulnerable to the development of stuttering. Implications for diagnosis and treatment are discussed and tabular data are included. (43 refs.)

See also 411.

VOCATIONAL EDUCATION

468. Mithaug, Dennis E.

How to teach prevocational skills to severely handicapped persons. Lawrence, Kan., H&H Enterprises, 1981. v, 62 p. figs., tabs. paper.

Intended for teachers of students with severe behavioral and learning disabilities, this booklet specifies behaviors and skills that are prerequisites for successful vocational placements in schools and the

community, identifies students who exhibit a combination of learning and behavioral disorders, and describes procedures for developing new skills while managing or eliminating behaviors that interfere with work. Study questions directly involve the reader in formulating prevocational programs. Sequencing, sorting, following directions, assembling, and counting are among the skills covered; reduced disruptive behavior, continuous periods of independent work, and accurate production are some of the behaviors that are taught. Three case studies illustrate typical behavioral and learning problems and a teacher's reactions to them. The major portion of the manual consists of a 10-step training and management approach to teaching, including monitoring levels of inappropriate response, recording base line data, selecting positive reinforcements, introducing more complex tasks, and reviewing the effects of increased attention to tasks.

Copies of this publication are available for \$3.25 from H&H Enterprises, 946 Tennessee St., Lawrence, KS 66044.

VOCATIONAL GUIDANCE

469. Vandergoot, David (*Human Resources Center, Albertson, Long Island, NY 11507*)

The relationship of selected rehabilitation counseling variables with job-seeking behaviors, by David Vandergoot and James Engelkes. *Rehab. Counseling Bul.* Nov., 1981. 24:2:173-177.

In response to criticisms of evaluations of rehabilitation outcome that are limited to vocational placement, new criteria and instruments have been developed to reflect additional benefits of counseling. This study explored the relationship between selected variables used in these new instruments and clients' job-seeking behaviors. Data were obtained on 15 counselors and 56 of their clients. The following counseling variables were studied: the rehabilitation status of clients at time of counseling, counselor rating of case difficulty, counselor rating of client's vocational goals, client's satisfaction with counseling and with vocational goal developed through counseling, and the client's knowledge of vocational counseling concepts. Results of empirical cluster analysis showed that there was only a minimal relationship between counseling variables and rehabilitation outcome, and that the viewpoints of clients and counselors on key issues differed significantly. These findings indicate that measures of counseling outcome are multidimensional and that counselors should address specific concerns of clients.

VOCATIONAL REHABILITATION

470. Crewe, Nancy M. (*Counseling Psychol. Service, Dept. of Physical Med. and Rehab., 860 Mayo Memorial Bldg., Box 297, Univ. of Minnesota, Minneapolis, MN 55455*)

Functional assessment in vocational rehabilitation: A systematic approach to diagnosis and goal setting, by Nancy M. Crewe and Gary T. Athelstan. *Arch. Phys. Med. & Rehab.* July, 1981. 62:7:299-305.

The Functional Assessment Inventory (FAI) has been developed for diagnostic use in vocational rehabilitation. This study consisted of the field testing and initial validation of the FAI. Thirty vocational rehabilitation counselors administered the inventory to 351 clients. Factor analysis identified 8 scales: cognitive function, motor function, personality and behavior, vocational qualifications, medical condition, vision, hearing, and economic disincentives. Content and concurrent validity of the inventory were assessed by comparing the scores of clients grouped by medical diagnosis and by relating scores to counselors' judgements of severity of disability and employability. On both the factor scales and individual items, clients with various primary disabilities appeared to differ with one another in predictable ways. Total functional limitations scores were highly correlated with counselors' ratings. Plans to develop a more comprehensive functional assessment system are discussed, and tabular data are included.

VOCATIONAL REHABILITATION—PROGRAMS

471. U.S. Dept. of Education. Rehabilitation Services Administration

Program evaluation in vocational rehabilitation; Vols. 1-3. Washington, D.C., The Admin. 1981. 3 vols. various pagination. paper.

In 1978 the Rehabilitation Services Administration initiated model evaluation and management information support units within the departments of vocational rehabilitation in 6 states: Delaware, Oregon, Michigan, Virginia, Pennsylvania, and Mississippi. The major objectives of these model units are: organize comprehensive program and policy systems in terms of evaluation; field test and assess federal evaluation standards and a facilities information system; and develop new evaluation techniques that can be used in other states. The first 3 publications in a planned series of 12, these volumes discuss the achievements and problems of the model units, trends in program evaluation, the states' efforts to increase their capacity for evaluation. The articles were contributed by principal investigators of the model units, federal personnel, the staffs of firms and agencies under contract to RSA, and evaluation specialists.

Among the articles in these 3 booklets are Vol. 1: Tracing the Failures of Program Evaluation in Vocational Rehabilitation, by Richard A. Nida, p. 1-6.—The Durability of a Model Evaluation Unit, by William W. Jerkins, p. 12-16.—Managing Requests for Evaluation Information, by Laurilee B. Hatcher, p. 25-28. Vol. 2: The Case Review Schedule Process in Delaware, by Gabriel Markisohn and Martha Jackson, p. 1-17.—Methodology for Discrete Evaluation, by Janet Slipow and others, p. 39-50.—Benefit-Cost Analysis as a Tool in Program Evaluation, p. 60-65. Vol. 3: Developing Capacity for Data Analysis for Program Evaluation: Michigan's Experience, by James Nuttall, p. 4-20.—Evaluation Section Library, by Leah Kuhns, p. 31-35.—Planning an Independent Living Program in Virginia, p. 36-43.

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Further information on these publications is available from Rehabilitation Services Administration, Dept. of Education, 330 C St., S.W., Washington, DC 20201.

VOLUNTARY HEALTH AGENCIES

See 412.

VISION

See 446.

WHEELCHAIRS

472. George Washington University. Rehabilitation Research and Training Center

Coping with inaccessibility: Assisting the wheelchair user, by Anne-Marie O'Hanlon Barry and Lorraine B. Priestley. Washington, D.C., The Center, [1981]. 43 p. photos. paper.

Although many persons who use wheelchairs are

independent in their personal lives, they sometimes can use assistance in overcoming architectural and transportation barriers, particularly when traveling. This booklet explains how to help these persons maneuver in inaccessible environments. Opening sections offer points to consider in offering and requesting assistance and facts about various types of wheelchairs. The major sections of the text present step-by-step procedures for coping with architectural and transportation barriers. Clearly illustrated with numerous photographs, these recommendations pertain to such areas as curbs, narrow doorways, escalators, automobiles, buses, trains, and airplanes. It is suggested that nondisabled persons practice these procedures until they become easier and always ask disabled persons about their preferences when assisting them.

Copies of this publication are available for \$2.00 from Rehabilitation Research & Training Center, George Washington Univ. Medical Center, 2300 Eye St., N.W., Suite 714, Washington, DC 20037.

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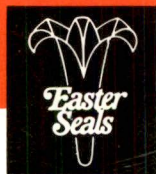
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Part II

Annual Index, Volume 42, 1981



THE NATIONAL EASTER SEAL SOCIETY

REHABILITATION LITERATURE

Annual Index, Volume 42, 1981

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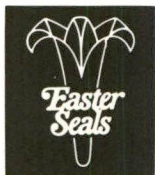
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