

To the Graduate Council:

I am submitting herewith a dissertation written by James David Sexton entitled "The Influence of Familial Econodemographic Status, Characteristics of the Retarded Child, and Placement Situation on Parental Attitudes Toward Mental Retardation." I recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Home Economics.

Priscilla White
Priscilla White
Major Professor

We have read this dissertation
and recommend its acceptance:

Charles H. Hargis
Ruth Hightberger
Alfred H. Jackson

Accepted for the Council:

Levan Beth
Vice Chancellor
Graduate Studies and Research

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THE INFLUENCE OF FAMILIAL ECONODEMOGRAPHIC STATUS,
CHARACTERISTICS OF THE RETARDED CHILD, AND
PLACEMENT SITUATION ON PARENTAL ATTITUDES
TOWARD MENTAL RETARDATION

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ABSTRACT

The purposes of the study were: (1) to determine if significant differences in attitudes toward mental retardation existed between parents of retarded children living at home and parents of retarded children living in an institution, (2) to find out if differences in attitudes toward mental retardation existed among parents of retarded children due to gender of the parent, (3) to ascertain if family attitude scores were related to selected family econodemographic variables, and (4) to determine if family attitude scores were related to certain child-related variables. Forty-seven pairs of parents with retarded children living at home and 47 pairs of parents with retarded children living at a large public institution served as subjects for the study. All parents lived in the State of South Carolina. Attitude score was determined by the Parental Attitudes Toward Mentally Retarded Children Scale. Data collection was by mailed questionnaire. A two-way ANOVA and multiple regression analyses were used to analyze the data.

The results of the two-way ANOVA indicated that there was a highly statistically significant (.0001) difference in attitudes between parents of retarded children living in the home and parents of retarded children living in an institution. Parents with retarded children at home

displayed more positive attitudes toward mental retardation. No significant interaction between placement of the child and gender of the parent was found. The following economic-demographic variables related to the family were correlated to family attitude score for both groups of parents: age of the father, educational level of the father, age of the mother, educational level of the mother, total family income, and number of other children living at home. It was found that only father's educational level was a relatively weak predictor of family attitude score for the home group. Child-related variables correlated with family attitude score included age, I.Q., and gender. No significant relationships were found for either group of parents.

The following suggestions were advanced for future research efforts. First, a longitudinal study of parents with retarded infants was proposed to determine the direction of the relationship between attitude and child placement. The second recommended area for research was the institutional career of the retarded child and family attitude development. Thirdly, it was suggested that other components of the conceptual model used in the study be investigated. A fourth suggestion was related to the influence of the environment, particularly the spatial needs of retarded children, on attitude development. The final suggestion for future research was in the area of instrumentation to assess family attitudes.

Implications of the study discussed included the need for further research in the processes leading to attitude development. It was suggested that parental attitudes are an important variable to be considered in institutional avoidance and deinstitutionalization programs. Finally, it was suggested that the relative success of deinstitutionalization, rather than its popularity, be considered. From this suggested framework, deinstitutionalization was viewed more as a process than a goal.

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CHAPTER I

INTRODUCTION

There appears to be general acceptance that one of the primary functions of the family in our society is procreation and the socialization of children. Only recently has the impact that children have on families received much attention. How successful an individual family unit is in the process of integrating the child into the family would appear to be a function of many variables. Parental desire for the child and resulting parental role expectations would influence this integration process.

The birth of a retarded child presents the family with even a greater challenge in terms of this integration process. The very bases and motivations for integrating the child may collapse or be subject to serious reexamination. No parent wants their child to be retarded. Given the choice, parents would prefer a "normal" healthy child. However, the parental role is one of the most difficult to change in our society. Once a parent, very few actions can remove one from the role. The parents of the retarded child must adapt to the irrevocability of their situation often without much enthusiasm or any clearly defined parental role model to follow.

Rationale

Little is known about how families attempt adjustment to the presence of a retarded child. There is a vast body of research devoted to developmental disabilities. However, most of this research falls within two categories, the medical and the educational (Katz, 1964). Relatively few attempts have been made to investigate and conceptualize what is probably the most long-term effect of a developmental disability, the effect of the disability on the functioning of the family unit (Martin, 1975). A review of the literature on families with retarded children indicated only a limited number of studies and that these can be characterized as inconclusive and often contradictory. Many researchers called for additional studies to broaden our understanding of the family with a handicapped child (Dorner, 1975; Katz, 1964; Martin, 1975).

One important variable related to how successful a family is at integrating the retarded child into the family is the attitudes held by parents. In fact, Willey and Waite (1964) stated, "the attitude of the parents toward their mentally retarded child determines the success or failure of family life and the life of the child" (p. 193). Cain (1964) stated that there is a great need to pursue the topic of parental attitudes toward the retarded child from many perspectives.

Parental attitudes toward the retarded child traditionally have been conceptualized as a dichotomy. Central to this theme has been the tendency to view family structure as dysfunctional to accommodate the retarded child (Dow, 1965; Farber & Rychman, 1965; Tallman, 1965). Those families choosing to maintain the child in the home have been stereotyped as crisis ridden, dysfunctional, and headed for disintegration (Dow, 1965; Farber & Rychman, 1965; Tallman, 1965). Such behaviors as "doctor shopping," the repeated questioning of professionals, and emotional reactions have been cited as proof of such unbalanced reactions (Cohen, 1962). Families who rapidly institutionalize the retarded child have been viewed as functional and balanced (Dow, 1965; Farber & Rychman, 1965; Tallman, 1965).

Few attempts have been made to view parental attitudes as a product of several antecedents which result in a continuum of possible responses. In order to understand behaviors exhibited by parents of retarded children, attitudes should be viewed within the unique context in which they develop. Fishbein (1966) argued that attitudes, behavior intentions, and behaviors must be defined separately and their relationships investigated.

The need for additional information about parental attitudes is being increased by the current trends of institutional avoidance and deinstitutionalization.

Institutionalization no longer is viewed by many professionals as the most desirable option for the retarded child (Blatt, Bogdan, Biklen, & Taylor, 1977). The recent emphasis on individual rights and due process mandates that institutionalization be viewed as a last resort when no other options are appropriate. Not only are new admissions being limited, but efforts are underway to reintegrate institutionalized retarded individuals back into the family unit and the community (Scheerenberger, 1976). The success of such efforts, to a large extent, will depend on the attitudes held by parents, other family members, and peers who offer advice or criticism.

Educators, social workers, family counselors and medical personnel will be faced increasingly with addressing parental attitudes in assisting families to arrive at a satisfactory adjustment. Unfortunately, few researchers have responded to this need.

Conceptual Framework

Vurdelja-Maglajlic and Jordan (1974) found that attitudes toward mental retardation were related to four categories of predictor variables: econodemographic factors, general value orientation, knowledge of mental retardation, and contact with the mentally retarded. For the purpose of this study, a combination of these factors provided the theoretical model. The first three of these categories were incorporated into the conceptual model as antecedents. The

last category, contact with the mentally retarded, was placed within the actual behavior dimension of the framework. Characteristics of the retarded child were identified as the last antecedent of parental attitudes.

Fishbein (1963) provided the remaining components of the conceptual framework used in the present study. From Fishbein's perspective, attitudes toward any object are a function of beliefs about the object. Beliefs about the object are related to the extent that the object is associated with other objects, concepts, values or goals. The evaluation aspect of these beliefs results in the attitude toward the related objects. Accordingly, an individual's attitude may be expressed algebraically,

$$\sum_{j=1}^N B_i a_i ,$$

where B_i = belief "i" about the object, a_i = the evaluative aspect of B_i and N = the number of beliefs.

Fishbein (1966) examined the relationship between attitudes and behavior. He postulated that an important bridge between attitudes and behavior was what he labeled behavior intentions. Although behavior intentions may be a valid indication of attitude, it is not assumed that any given behavioral intention will necessarily be related to that attitude or with actual behavior. For example, parents

may say that it is beneficial for the retarded child to remain in the home. However, the death of a spouse, loss of income, birth of another child, or some other event may result in the institutionalization of the child.

The conceptual framework used for the present study was designed to represent parental attitudes as occurring within a specific context. Antecedent variables are a source of beliefs. These beliefs are combined, undergo an evaluative process, and result in attitudes. Attitudes result in behavioral intentions which may be mediated by situational variables. The final component of the conceptual framework used is actual behavior. The model was designed to be interrelated with various components influencing each other. The conceptual framework can be seen in Figure 1.

Nominal Definition of Terms

Antecedent is any possible predictor variable related to beliefs and attitudes.

Attitude is a learned predisposition to respond in a consistent evaluative manner toward an object or class of objects.

Behavior intention is how individuals say that they would behave in a given situation.

Institutionalized retarded child is a child who resides for a majority of his or her time in a residential facility for the mentally retarded.

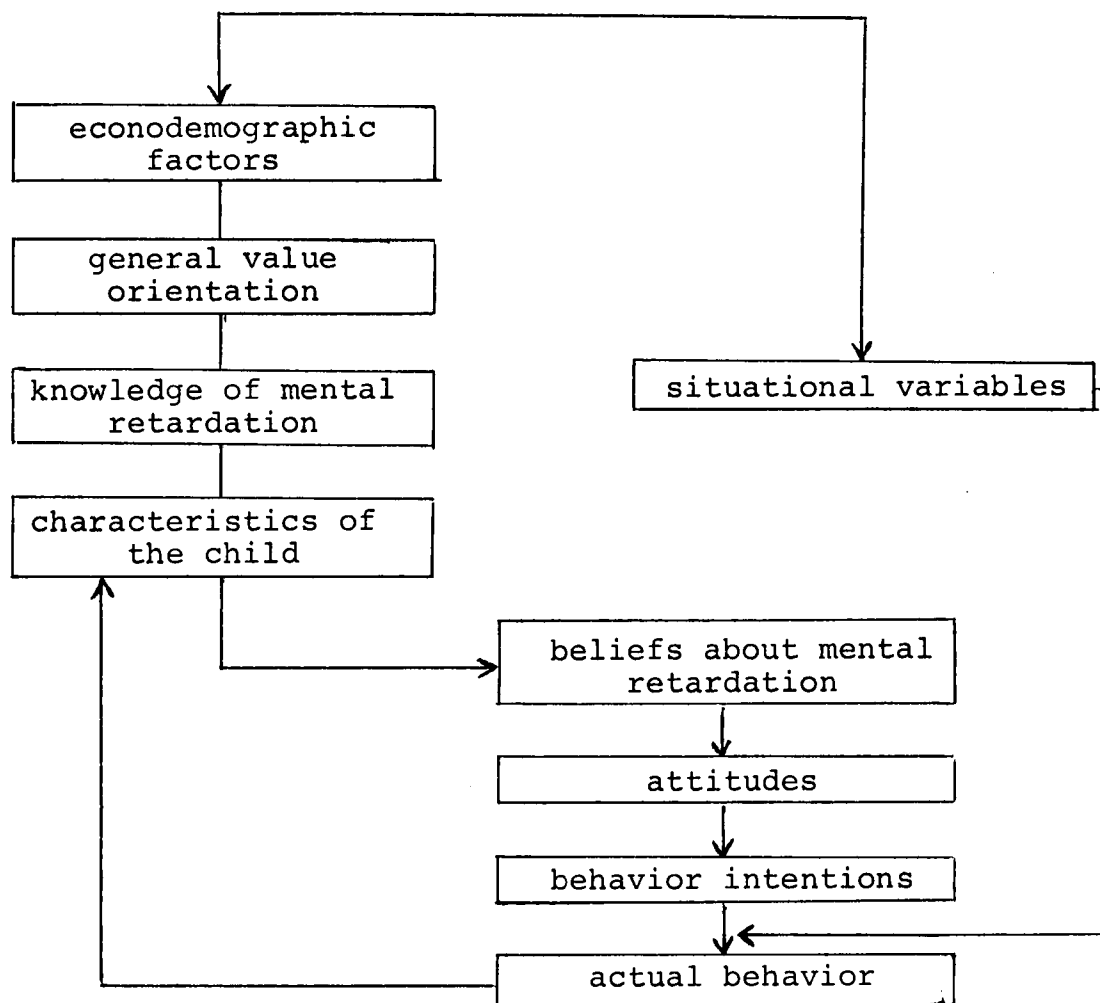


Figure 1. Model of Parental Attitudinal Development.

Noninstitutionalized retarded child is a retarded child who resides for a majority of his or her time in the family setting.

Retarded child is a child who has been certified mentally retarded by a licensed professional.

Situational variable is an event that mediates behavior intentions and actual behavior.

Assumptions

The following assumptions were used in the study:

1. Attitudes can be measured independent of behavior.
2. Attitudes can influence behavior.
3. Positive parental attitudes facilitate better adjustment patterns for families with retarded children.

Statement of Problem

If recent efforts at deinstitutionalization and institutional avoidance are to succeed, we must gain a better understanding of and appreciation for the role played by parental attitudes toward mental retardation. If relationships between attitudes and actual behavior exist, then programs must be developed to improve parental attitudes. Only then will the retarded child be accepted into the family unit with the provision of the familial support necessary to keep him or her there.

There is a great need to determine what attitudes are held by parents of retarded children. Do parents of institutionalized retarded children hold similar attitudes toward mental retardation as do parents of retarded children living in the home? Can attitudes be predicted based on familial characteristics? What relationships exist between characteristics of the retarded child and parental attitudes? At present there is no information to supply answers to these and other important questions such as the role of the physical environment in shaping attitudes and behaviors in families with retarded children. Without such answers we are left only with our best guesses as to what should be included in effective programs designed to address parental attitudes.

CHAPTER II

REVIEW OF THE LITERATURE

A review of the literature supported that there were two commonly-held points of view regarding the placement of a retarded individual (Larsen, 1977). One view held that institutionalization is the best alternative for both retarded individuals and their families. The opposing viewpoint held that the presence of a retarded individual is not necessarily disruptive to the family and that the retarded person should, if at all possible, remain in the home.

Many arguments were used to justify the continued institutionalization of retarded individuals. Larsen (1977) identified two of the most commonly used. First, there is the basic argument that handicapped individuals are happiest and best adjusted when they associate with their "own kind." Within such environments, each retarded individual can compete on equal footing with their retarded peers. Second, there is the argument that the presence of a retarded child is too demanding and disruptive for families.

Effect of Institutionalization on the Retarded Child

Although Kershner (1970) found that institutionalization actually improved the functioning ability of retarded

children in his study, other data indicated that institutionalization is detrimental to the development of retarded individuals. Comparative studies of the development of institutionalized and noninstitutionalized children with Down's Syndrome demonstrated that children placed in home or home-like environments had higher intellectual functioning and demonstrated more appropriate adaptive behavior. Centerwall and Centerwall (1960) concluded that the average baby with Down's Syndrome had a better chance of being a happy, easily cared for, and somewhat productive person, if a reasonable adjustment could be made to having him or her remain in the home especially during the first years of life. Stedman and Eichorn (1964) found that home-reared children scored significantly higher on mental tests and social quotients than did institutionalized children.

The long-term deleterious effects of institutionalization for the retarded individual were documented. Shipe and Shotwell (1965) reported that the intellectual and social deficits associated with immediate or very early institutionalization of children with Down's Syndrome were of a relatively permanent nature. Skeels (1970), in a longitudinal study, concluded that a group of retarded children, initially higher in intelligence, that remained in an institutional environment showed a marked decrease in academic and adaptive functioning when compared to a group

of retarded children placed in more home-like environments. He reported that the two groups maintained divergent patterns of competence into adulthood.

Wolfensberger (1971) characterized the average public residential facility in the following manner:

. . . a de-individualizing residence in which retarded persons are congregated in numbers distinctly larger than might be found in a large family; in which they are highly regimented; in which the physical and social environment aims at a low common denominator; and in which all or most of the transactions of daily life are carried out under one roof, on the campus, or in largely segregated fashion. (p. 15)

Goffman (1961) argued that the belief in and justification for institutions, based on the assumption that they exist for the benefit of those institutionalized, may be exaggerated. Institutions, most likely, exist for the benefit of society, to segregate deviant individuals. Although some institutions may be classified as more humane and client centered than others, the very nature of total institutions are, most likely, incompatible with the goal of maximizing the individual potentialities of retarded individuals (Dentler & Mackler, 1961).

Impact of Placement Decision on the Family

A second major area of concern related to the retarded child is the impact that he or she has on the family. As Fowle (1968) pointed out:

A common belief in the area of mental retardation is that the presence of a retarded child in a family has an adverse effect on his parents and siblings. This is one of the reasons most frequently given parents for recommending institutionalization of a mentally retarded child; however, there is little empirical evidence in the literature that substantiates or vitiates this supposition. (p. 468)

The family life cycle. It has been argued that the presence of a severely retarded child in the family is a factor resulting in the delay or arrest of the family life cycle. Farber (1968) suggested that this position is related to the deviant career of the retarded child. According to Farber, parents, in interactions with their children, assign a status to each child commensurate with the capabilities imputed to him or her. A primary consideration in this process is age grading with mental age approximating chronological age. Since age grading in a culture is viewed more as psychologically and socially based rather than chronologically based, the severely retarded individual is generally regarded as a "boy" or "girl" even though he or she may be middle-aged. As the retarded child proceeds in his or her career, the parents normally tend to revise their self-concepts and roles. In this manner, the severely retarded child eventually, regardless of birth order, becomes the youngest child socially.

Miller (1970) elaborated seven stages in the life cycle of a family with a mentally retarded child. He concluded

that the life cycle of a family with normal children moves toward reduced stress when the children leave home, while that of the family with a retarded child moves toward increasing stress at each stage.

The retarded child as a family crisis. Several researchers proposed a crisis orientation to the study of families with retarded children. Farber and Rychman (1965) argued that there is an absence of a general conceptual framework on which to base research or interpret results. They proposed five stages that families of retarded children appear to experience. The first stage consists of attempts to handle the deviance of the retarded child within existing family arrangements. The family regards the deviance as temporary or of minimal importance. The second stage involves distortions of family coalitions as a basis for defining the problem, the child is mentally retarded. The third stage involves the revision of age and sex roles within the family. The fourth stage relates to revisions of coalitions with extra family, individuals, and groups. The final stage results in the elimination of the deviant member or institutionalization.

Farber (1960) defined two types of family crisis related to the severely retarded child. The first crisis, tragic crisis, is the extreme initial impact on the family at the time the child is diagnosed as retarded. This type

of crisis was compared to bereavement. Anticipated life careers are frustrated and plans are demolished for those families experiencing tragic crisis. The second type of crisis was labeled role organization crisis. Families experiencing this type of crisis exhibit an inability to cope with the child over a long period of time. Farber postulated that tragic crisis tended to be found in families of high socioeconomic status. Role organization crisis was found to be generally a low status phenomenon.

Cohen (1962) defined four stages that families of handicapped children undergo in adjusting to the child. The first stage is a period of grief similar to a mourning period. The second stage involves acknowledging and learning to handle anger generated by the reality of having a handicapped child. In the third stage, family members learn to deal with the anxieties aroused by the impact of the child's handicap on usual adaptive patterns. Cohen's last stage focused on the family making certain adjustments in their way of life that affects not only the handicapped child but the total family unit.

Dow (1965), in a study of 58 families with physically disabled children, concluded that there were two general reactions to the crisis of having a handicapped child. The first reaction, extreme reaction, he characterized as an excessive duration of disbelief, hysteria, and hostility

after diagnosis. Such families reorganize family life around the patient. This was described as a period of transitory adjustment which was shattered by the necessity of institutionalization. Faced with this eventuality, families characterized by extreme reaction became hostile and dysfunctional. Disruption of practical routine, marked decline in marital relationship, and general depression began with the child's departure and continued for the length of his or her hospitalization. The second group of families experienced what Dow defined as a balanced reaction. The initial reaction to diagnosis was severe but positive bringing little practical or emotional disruption. During the period of home treatment, however, a general deterioration occurred at both the practical and interpersonal levels. Such problems were reduced by the child's institutionalization.

Dow predicted that family structure founded on a contracted network of interactions and obligations would be associated with an extreme or dysfunctional response, while one containing an extended network would prove functional in coping with the same crisis. He argued that his data supported that a contracted network has the natural consequence of encouraging, extended network discouraging, an excessive preoccupation with the illness.

Personal adjustments made by parents of retarded children. Some attention was given the relationship between

the presence of a retarded child and the personal adjustments made by parents. Kenney (1967) found a significant difference between the ego development of mothers with retarded children who were maladjusted in school and mothers of retarded children who were adjusted in school, with mothers of adjusted retarded children having higher levels of ego development. She concluded that low authoritarianism in a mother was related to a higher level of ego development.

Erickson (1970) found that mothers and fathers of young retarded children had significantly elevated Minnesota Multiphasic Personality Inventory (MMPI) scores when compared with the MMPI norm groups. Routh (1970), however, concluded that mothers and fathers of young mentally retarded children displayed no significant differences on any MMPI variable.

The concept of chronic sorrow experienced by parents of mentally retarded children was proposed by Olskansky (1970). Parents were viewed as suffering throughout their lives, regardless of placement decision. The intensity of chronic sorrow varies from parent to parent and is influenced by the parent's personality, ethnic group, religion, and social class.

Barsch (1968) studied the parents of 177 children having the following handicaps: cerebral palsy, organic brain damage, Down's Syndrome, blindness, and deafness. He concluded that the general tendency to characterize parents

of handicapped children as guilt-ridden and anxiety-laden individuals was unfortunate. His findings indicated that in fact such cases do exist, but the majority of parents are unduly stigmatized by this generalization.

Parental role strain and the retarded child. Some researchers undertook the study of parental role strain induced by the retarded child. Tallman (1955) concluded that gender of the retarded child had little influence on mother relations with the child. However, he stated that fathers were more threatened and therefore reacted more strongly to the presence of a retarded son in the family than a retarded daughter. He attributed this, in part, to fathers being deprived of the satisfaction of anticipating and observing instrumental achievement on the part of their sons. In addition, fathers were deprived of the opportunity to function as a socializing agent. Miller (1970) concluded that the father-child relationship does not develop if the child is retarded.

Peck and Stephens (1960) emphasized the importance of the father's rejection or acceptance of the mentally retarded child. Their data indicated that the father's feelings, not the mother's, sets the pattern of acceptance or rejection found in the home.

Data from another study, however, indicated that there was no relationship between gender of the retarded child and the decision to institutionalize (Paymer, 1965). These findings indicated that parents of retarded children do not have greater expectations for sons than daughters.

Marital integration and the retarded child. The marital integration of couples with retarded children has also been a focus for research. Mainord and Love (1973) stated that the divorce rate among parents with retarded children is three times that of parents who do not have retarded children. Miller (1970) argued that the mentally retarded child seriously threatens the husband-wife union. Farber and Rychman (1965) suggested that husbands view the retarded child as interfering with their previously companionate relationship with their wives. Fowle (1968) concluded that the marital role tension of wives is considerably greater than that of husbands regardless of whether the retarded child is institutionalized or remains in the home.

Other research indicated that the mere presence of a handicapped child does not necessarily adversely affect marital integration. Mercer (1966) studied families of retarded children in institutions and those remaining in the home. She found that the two groups of couples were roughly equivalent in the number of problems involving interpersonal conflict and tension. Fowle (1968) also

found no differences in marital integration between parents of severely retarded children in an institution and those kept at home.

Martin (1975) researched families of children with spina bifida cystica. She found that the overall divorce and separation rate for these parents was not statistically higher than the general population. Parents whose marriages did break up reported, in 75 percent of the cases, that the marriage was previously strained. Parents who did not divorce or separate reported that the affected child actually brought them closer together. Dorner (1975) also reported data on families of children handicapped by spina bifida. She concluded that a poor quality of life for these parents was not inevitable. A number of the parents in her study had made a good adjustment.

The status of the marital relationship prior to the presence of a retarded child may have some relationship to subsequent marital functioning. Data reported by Barsch (1968) did not suggest that marital difficulties could be attributed to the presence of a handicapped child in the family. He concluded that the day-by-day adjustments to integrating the child into the family should be viewed as a stress factor which could serve to aggravate basic conflicts within either or both parents.

Siblings of the retarded child. For the most part, the presence of a retarded child has been viewed as adversely affecting nonretarded siblings. Miller (1970) stated that in families of retarded children sibling relationships are skewed. Farber (1960), in a study of 240 Chicago families with a severely retarded child, concluded that the retarded child's siblings were affected adversely by the high degree of dependency of the retarded child. This dependency affected the siblings' relationship with their mothers in that increased responsibility was given to the siblings for the care of the retarded child. Farber found that the normal sister was helped by placing the retarded child in an institution although this move did not seem to help the nonretarded brother. Perhaps a sister is more likely to be assigned a surrogate parent role in relationship to a retarded sibling than is a brother.

Fowle (1968) found that the role tension of siblings in families where the retarded child was kept at home appeared to be significantly higher than in families where the retarded child had been institutionalized. Her data suggested that the oldest female siblings in families where the severely retarded children were present in the home appeared to manifest more role tension than did the oldest female siblings in families where the retarded children had been removed from the home.

Farber (1963) reported that interaction with retarded siblings affected the life goals of nonretarded siblings. He concluded that both girls and boys who interacted daily with their retarded siblings placed less emphasis on having many close friends, on focusing life around marriage and the family, and on being respected community leaders. Farber argued that all three of these goals were concerned with success in personal relations.

Tizard and Grad (1961) criticized the position that retarded children adversely affect nonretarded siblings. They concluded that the greatest handicap experienced by families who kept the retarded child at home was not the effect which a mentally retarded child has on other children. They argued such a popular view is greatly exaggerated.

Caldwell and Guze (1960) found that siblings of retarded children living at home were not any better adjusted than were siblings of retarded children removed from the home and placed in institutions. They concluded that the adjustment of brothers and sisters mirrored the family decision on placement. Adolescents and preadolescents who had the experience of a retarded child in the family were generally adaptable and had molded their value systems to conform to the family status quo.

Condell (1966) studied 152 families of retarded children in rural Minnesota. Sixty-five percent of the

parents in the sample tried to help the nonretarded siblings accept the retarded child. Most siblings tended to answer questions openly and frankly when asked about their siblings' retardation.

A study was conducted with 21 teenagers who had a severely retarded sibling living at home (Graliker, Fisher, & Koch, 1962). These teenagers felt comfortable in having friends visit their homes and displayed a general acceptance of and tolerance for the retarded sibling. In no case did the teenager feel burdened by the retarded sibling.

Barsch (1968) obtained data which suggested that the incidence of significant negative attitudes and behaviors from siblings in relation to the handicapped child were minimal. The general picture presented by parents was that nonhandicapped siblings tended to accept the handicapped child and to help the parents in many ways.

Family characteristics and the impact of a mentally retarded child. Several studies addressed the relationships between familial characteristics and the overall impact that a retarded child has on family relationships. Mainord and Love (1973) argued that middle and upper class parents usually are more frustrated and disappointed in having a mentally retarded child than are lower class parents. Farber (1968) concluded that the higher the socioeconomic status of the family, the greater the impact of labeling a child as

mentally retarded on family relationships. He argued that the intensity of child-care problems associated with mental retardation was related to socioeconomic status in affecting family relationships, regardless of the degree of retardation. If physical disabilities did not require a great deal of effort and attention, the consequences for family relationships were not severe at lower socioeconomic levels.

Some comparative data on families who keep their children at home and those institutionalizing their retarded children is available. Downey (1963) found that parents of low socioeconomic status indicated that intrafamily considerations were foremost in their willingness to institutionalize their retarded children. High socioeconomic status families gave extrafamily considerations such as neighborhood relations and the career and educational aspirations of other family members as deciding factors. Advice received from friends and physicians also influenced placement decision among high socioeconomic level families.

Stone (1967) concluded that parents who placed their children with Down's Syndrome in an institution had the least adequate socioeconomic situations and the poorest intrafamily relationships. Nonapplicants were characterized as having a generally adequate environment, good personal relations, and adequate family relations. Those parents who postponed the placement decision had the most favorable

social situations but weaknesses in family relations and maternal adjustment.

Downey (1965) found that if parents of retarded children were well educated, if the wife felt she could not provide care for all her children, and the husband's friends advised placement, then the child was likely to be placed in an institution at an early age with subsequent low parental interest. If the parents were less educated, if the wife felt that the child needed vocational training and feared neighborhood trouble, then it was likely that the older child would be institutionalized with subsequent parental interest being high. Time of placement appeared to be an important variable. Dittman (1962) argued that parents who hastily place a retarded child in the first days or weeks of his or her life probably are never able to develop true parental feelings about the child at all.

Characteristics of the child and those of the family may interact in determining familial involvement with the child after institutionalization. Anderson, Schlottman, and Weiner (1975) found that those children functioning at higher levels of intelligence and social maturity and those having no physical handicaps were visited more often by parents. Other factors correlated with visitation rate included the requirement for financial payments and the distance families lived from the institution.

Deinstitutionalization and the family. The effects of deinstitutionalization on family functioning have been explored. Paymer (1965) found that retarded adults from middle and upper class families living at home more adequately fulfilled parental expectations, had a higher I.Q., had no psychiatric problems, and had a shorter length of prior institutionalization than those who remained in an institution.

Mercer (1966) reported that families of resident retarded children differed from those who had been deinstitutionalized in reporting burden-of-care problems. Burden-of-care problems included physical or economic demands made upon the family social system, exhaustion of the mother, requirements for constant supervision, and the demands of frequent seizures.

Familial isolation and the retarded child. Considerable research has been devoted to the extent that the presence of a retarded child imposes isolation on the family. Farber (1965) stated, "One of the most consistent research findings is the limitation on participation of parents of severely retarded children in extrafamily relationships, such as organization memberships or recreation" (p. 7). This argument was supported by a number of studies (Peck & Stephens, 1960; Tizard & Grad, 1961; Weingold & Hormuth, 1963; Holt, 1968). Frampton and Gall (1956) argued that

parents often react to the presence of a retarded child by isolating themselves. They concluded that parents of retarded children withdraw from nearly all social contacts and lose their community interactions.

There was not unanimous agreement, however, that social isolation is inevitable for parents with retarded children. Barsch (1968) made this point in the following manner:

In none of the cases was there any evidence that parents had buried themselves in a social isolation as a result of having a handicapped child. Most of the parents held outside social interests which regularly engaged their time and attention such as clubs, recreational activities, etc. Where this was not true of a particular kind of parent, the evidence did not suggest that the limitation on social activity held a significant relationship to the fact that the family contained a handicapped child. Some people are "joiners" and some are "loners." (p. 343)

Support services available within the community. One important variable receiving attention is availability and knowledge of community-based support systems. Schonell and Rorke (1956) found that the majority of mothers of retarded children in their study reported that they had received no help of any kind with their children. Most of these mothers were characterized as almost desperate in their pleas for help. Paymer (1965) also reported that parents with retarded children desired more support services within the community. Justice, O'Connor, and Warren (1971) found that most parents involved in their study had not received any type of

assistance from public or private resources. In addition, a large number of parents reported that they did not know of any additional service that might help with their problems or reported that no services were needed. Such reports were particularly numerous among minority group parents. Dorner (1975) concluded that parents of children with spina bifida were totally lacking in regular supportive contact with an outside agency.

The benefits of community support services were documented by Schonell and Rorke (1960) in a follow-up study of mothers whose retarded children had been enrolled in a developmental center for at least six months. Mothers felt that as a result of having their children at the center they and their families were happier and healthier. Stone (1967) argued that parents who placed their children with Down's Syndrome in an institution could have been helped to make a satisfactory adjustment if their communities had provided more adequately for their personal, informational, and social needs.

Schonell and Rorke (1956) summarized the benefits of community support services as:

Experience shows that where facilities are available, parents may be helped with home problems, and where the child can attend an Occupational Center, his social development improves and he tends to be a more tractable being. He becomes more useful in the home; he is more stable and fits into family life more effectively. As a result, conditions within

the home improve, for family relationships are safeguarded, and, in particular, threats to the mental health of the mother are reduced. (p. 219)

Parental input appears to be a critical variable in the development of community support services. Condell (1966) found a discrepancy between what professionals generally agree should constitute program planning for the retarded and what parents themselves verbalize. Ehlers (1966) investigated the types of services found to be useful by mothers of retarded children. Casework services, the traditional approach to family services, were rated least valuable. These mothers reported that counseling, home training, support from other family members, and parent associations were very valuable.

Parental attitudes and the retarded child. Parental attitudes toward the mentally retarded child appeared to be a crucial variable in determining how successful a family is in achieving a satisfactory adjustment. In fact, Willey and Waite (1964) argued forcefully that the attitudes of the parents toward their mentally retarded child actually determines the success or failure of family life. Despite the importance attributed to parental attitudes, Haring, Stern, and Cruickshank (1958) concluded, "Research is grossly limited with regard to the attitudes of parents and other individuals toward physically and mentally handicapped persons" (p. 14).

Kanner (1953) distinguished three principle types of attitudes held by parents of retarded children. The first type was mature acknowledgment of the actuality and acceptance of the child. The second type of attitude was disguising reality, seeking either scapegoats upon which to blame the retardation or magic cures. The final type of attitude identified by Kanner was complete denial of the existence of any retardation.

Love (1967-1968) compared the attitudes of parents having mentally retarded children with parents not having retarded children. He found that parents of mentally retarded children scored significantly higher on an attitude scale while parents not having mentally retarded children displayed a greater knowledge of mental retardation. Overall, subjects who had the highest socioeconomic level scored higher on attitudes and knowledge but educational level was not a factor that determined a parent's attitude toward mental retardation although it did influence knowledge about mental retardation. The number of children in a family did not relate to attitude or knowledge. The gender of parents did not affect either variable.

A second study of parental attitudes conducted by Love (1971) contradicted many of his earlier findings. For example, women were found to have a more positive attitude toward the mentally retarded than did men. Also, educational

level was found to have the greatest influence on attitudes toward mental retardation.

Dingman, Eyman, and Windle (1970) investigated the child rearing attitudes of parents with retarded children. They found that mothers of mildly retarded children generally were more protective than mothers of severely retarded children. Cook (1963) concluded that mothers of children with Down's Syndrome had punitive attitudes, mothers of mildly handicapped children had rejecting attitudes, and mothers of severely handicapped children had overprotective attitudes. Barber (1963) argued that the attitudes of mothers toward their retarded children were not influenced by the gender of the child but were influenced by the mother's socioeconomic status. Lower status mothers were more rejecting of their retarded child. Peck and Stephens (1960) found that parents tended to rate their retarded children less favorably on personality than they did their normal or "ideal" child.

In a cross-cultural study of attitude-behaviors of mothers toward the mentally retarded, Vurdelja-Maglajlic and Jordan (1974) found that a continuum of attitudes-behaviors existed across nations and cultures. They concluded that those mothers who felt safe and in control of their environments also felt positive toward the retarded.

Barsch (1968) found only minimal indications that the rearing of a handicapped child significantly altered a

parent's child rearing attitudes. The parents in his study tended to employ similar child rearing practices with both their handicapped children and their nonhandicapped children.

Summary of Review of Literature

Although there is a general paucity of literature related to families of retarded children, much of the literature has placed a general emphasis on the classification of families according to placement decision. Families who decide to institutionalize their retarded children are viewed as balanced and healthy. Those families deciding to keep the retarded child in the home or postponing placement decision are labeled dysfunctional or unbalanced. There is a small but growing body of literature that challenged these basic assumptions. The amount of familial disruption is viewed on a continuum with the welfare of the retarded child being more of a central consideration in the placement decision process. With sufficient support systems, it is possible for families of handicapped children to live happy healthy lives.

The literature that favored early institutionalization of the retarded child appeared to reflect the following general themes: (1) having a retarded child should be viewed as a family crisis, (2) parents of retarded children are stereotyped as crisis-ridden, anxiety-laden, and isolated, (3) the retarded child threatens the marriage, and (4) the

presence of a retarded child has adverse effects on nonretarded children.

The opposing viewpoint of keeping the child in the home, if at all possible, tended to present the following considerations: (1) the impact that a retarded child has on family functioning varies from family to family, (2) there is no evidence to suggest that the mere presence of a retarded child results in maladaptive behaviors on the part of individual parents, (3) the quality of the marital relationship prior to the presence of the retarded child should be considered, (4) evidence and experience does not suggest that a retarded child necessarily adversely affects siblings, and (5) family and community attitudes may play a crucial role in subsequent familial adjustment.

CHAPTER III

METHOD

Subjects

The sample pool for this study was obtained from service lists maintained by the Whitten Regional Center, a division of the South Carolina Department of Mental Retardation, which serves a 16 county area of northwestern South Carolina. One list contained 2,589 names of guardians of retarded individuals institutionalized at the Whitten Regional Center. The second list used contained 2,437 names of guardians of retarded individuals who were residing in their homes.

The sample pool of parents with institutionalized children was reduced to 1,253 by eliminating parents of children under six years old and those of children over 40 years old. Also eliminated were retarded individuals whose guardian was a state or local service agency. The community service list was reduced down to 2,004 by using the same criteria.

A sample size of 600 names was selected, 300 from each list, by employing a table of random numbers. A total of 87 mothers and 67 fathers in the community group agreed to participate. In the institutional group, 118 mothers and 72 fathers agreed to participate. Fifty-one parents refused

to participate and another 19 parents indicated that they were not the natural parent of a retarded child.

The subjects used for this study were the 94 pairs of parents, or 94 fathers and 94 mothers, responding from the original sample. One group consisted of 47 pairs of parents whose children resided in a public institution for the mentally retarded. The other 47 pairs consisted of parents whose retarded children were living in the home.

Parents in the two groups appeared very similar when examined on the following variables: father's age, father's educational level, total family income, number of other children living at home, mother's age, and mother's educational level. (See Table I for data on subjects used in the study.)

The children of the subjects in the two groups also appeared similar when compared on the following variables: age, I.Q., and gender. Twenty-seven females and 20 males composed the institutionalized group of retarded children. Twenty-two of the home group were females and 25 were males. Fourteen of the children in the home group were black and 33 were white. Six of the individuals in the institutionalized group were black and 41 were white. A general description of the retarded individuals can be seen in Table II.

Procedures

After the sample was selected, a letter was sent explaining the purposes of the study and asking for informed

TABLE I
DATA ON SUBJECTS IN STUDY

Groups	Fathers Age	Fathers Years of Education	Total Family Income	No. of Children at Home	Mothers Age	Mothers Years of Education
Parents of Retarded Children Living at Home (N = 47)						
Range	32-67	2-18	5,000-50,000*	0-6	32-64	4-18
$\bar{X}$	50.8	10.7	18,903	1.3	47.4	11.4
Parents of Retarded Children Living at Institution (N = 47)						
Range	32-74	1-20	2,400-60,000**	0-4	30-76	1-18
$\bar{X}$	55.7	11.7	19,251	1.1	51.7	11.9

*N = 40 (Seven pairs of parents did not report total family income.)

**N = 43 (Four pairs of parents did not report total family income.)

TABLE II
DATA ON RETARDED CHILDREN OF PARENTS IN STUDY

Groups	Age	I.Q.
Retarded Children at Home (N = 47)		
Range	8-36	10-68
$\bar{X}$	20.3	39.8
Retarded Children in Institution (N = 47)		
Range	11-40	10-64
$\bar{X}$	22.9	30.6

consent to participate in the study. A stamped return envelope was included. Samples of these forms may be seen in Appendix A.

A packet of materials was mailed to those parents who agreed to participate in the study. This packet contained the following items: a cover letter, a questionnaire designed to gather econodemographic information on each family, and the Parental Attitudes Toward Mentally Retarded Children Scale. A stamped preaddressed return envelope was included. Samples of these materials can be seen in Appendix B. Characteristics of the child were recorded from official records maintained by the Whitten Regional Center staff.

Instrumentation

The instruments used in the study were the Parental Attitudes Toward Mentally Retarded Children Scale (Love, 1967-1968) and a questionnaire developed to gather descriptive information on parents involved in the study. The Parental Attitudes Toward Mentally Retarded Children Scale is a Likert-type scale consisting of 30 items to be rated on a 5-point scale ranging from strongly agree to strongly disagree. The higher the score, the more positive the attitudes held by parents are. For the present study, a family attitudinal score was obtained by summing the father's score with the mother's score and dividing by two.

Love (1968) presented information that indicated the Parental Attitudes Toward Mentally Retarded Children Scale is a valid and reliable instrument for the measurement of parental attitudes. Content validity was determined by a jury of seven Directors of Special Education Centers of the state colleges of Louisiana. Using the recommendations of the jury, items were revised and discarded as necessary. The revised instrument was then administered to a group of 62 parents in Greeley, Colorado. Approximately one half of the parents had mentally retarded children. The items were then analyzed for their discriminatory power with respect to the attitude in question.

The final instrument, which consisted of 30 items, was constructed by choosing the items from the total list which showed the greatest discrimination. The sequential order of the items included in the final instrument was determined through the employment of a table of random numbers. In 14 of the items an "agree" response represents a favorable attitude while in 16 of the items a "disagree" response represents a favorable attitude toward mentally retarded children.

The split-half method of determining a coefficient of reliability was used. The coefficient of reliability for the Parental Attitudes Toward Mentally Retarded Children Scale was $+ .91$ for the 62 parents in Greeley, Colorado.

Two hundred parents residing in Louisiana were given the scale. A coefficient of reliability of $+ .93$ was reported for this group.

Hypotheses

The following null hypotheses were developed for the present study:

1. There are no significant differences in attitudes between parents of institutionalized and noninstitutionalized retarded children.
2. There are no significant differences in attitudes of parents due to gender of the parent.
3. There are no relationships between selected econodemographic variables of the family and attitudes held by the family.
4. There are no correlations between characteristics of the retarded child and family attitudinal score.

Operational Definitions

Attitude is recorded by the Parental Attitudes Toward Mentally Retarded Children Scale.

Characteristics of the retarded child are I.Q., age, and gender.

Econodemographic factors of the family are the following variables: age of the father, highest educational level completed by the father, age of the mother, highest

educational level completed by the mother, total family income, and number of other children living at home.

Family attitude is recorded by summing the scores of the mother and the father on the Parental Attitudes Toward Mentally Retarded Children Scale and dividing by two.

Design

The design used for this study was a two-way ANOVA. The two main effects were placement of the child, home or institution, and gender of the parent, male or female. The dependent variable was the score on the Parental Attitudes Toward Mentally Retarded Children Scale. The experimental design used in the study can be seen in Figure 2.

Multiple correlation was employed using the following predictor variables: age of the father, highest educational level completed by the father, age of the mother, highest educational level completed by the mother, total family income, and the number of other children living at home. The criterion variable was family attitudinal score.

Multiple correlation was employed using the following predictor variables related to the retarded child: age of the child, I.Q. of the child, and gender of the child. The criterion variable was family attitudinal score.

Data Analysis

A two-way ANOVA was used to determine the differences between parents on all variables, placement of the child,

<u>Placement of Child</u>	<u>Gender of Parent</u>	
	<u>M</u>	<u>F</u>
<u>Institution</u>	47	47
<u>Home</u>	47	47

Figure 2. Experimental Design.

gender of the parent, and interaction between these two variables. Multiple correlation was used to predict family attitudinal score. A significance level of .05 was established for all analyses.

The statistical package used for the analysis was the Statistical Analysis System (SAS). A sample data card layout can be seen in Table III. The University of South Carolina Educational Research Department provided assistance in the analysis.

TABLE III
DATA CARD LAYOUT

Variable Name	Range	Columns
Location of Child	"H" or "I" for home or institution	1
Family Identifier	1-47	2-3
Fathers Age	0-99	4-5
Fathers Education (years of school completed)	0-20	6-7
Family Income	0-99,999	8-12
Number of Children at Home	0-6	13
Fathers Attitudinal Score	30-150	14-16
Mothers Age	0-99	17-18
Mothers Education (years of school completed)	0-20	19-20
Mothers Attitudinal Score	30-150	21-23
Childs Age	6-40	24-25
Childs I.Q.	10-99	26-27
Childs Gender	"M" or "F" for male or female	28

CHAPTER IV

RESULTS

The mean scores on the Parental Attitudes Toward Mentally Retarded Children Scale for fathers of retarded children living in the home was 122.8 with a mean score for mothers of 124.5. The mean score for fathers of retarded children in the institution was 113.4 with a mean score for mothers of 115.6. The family attitudinal mean score for families of retarded children in the home was 123.7. The family attitudinal mean score for the institutionalized group was 114.5. A summary of attitudinal scores for the two groups can be seen in Table IV.

Analysis of Differences Between Groups

A two-way ANOVA was used to analyze the data. F-values were generated for the two main effects, child placement and gender of the parent, and for the interaction between placement and gender.

A statistically significant difference between the two groups based on placement of the child was found. Parents who had the retarded child living at home had more positive attitudes as measured by the Parental Attitudes Toward Mentally Retarded Children Scale than did those parents who had placed the retarded child in an institution. Therefore,

TABLE IV
ATTITUDINAL SCORES OF PARENTS IN STUDY

Groups	Range	$\bar{X}$	SD
Fathers of Retarded Children at Home (N = 47)	95-150	122.8	10.9
Mothers of Retarded Children at Home (N = 47)	101-147	124.5	11.1
Fathers of Retarded Children in Institution (N = 47)	90-140	113.4	12.0
Mothers of Retarded Children in Institution (N = 47)	85-144	115.6	13.1
Family Attitude of Retarded Children at Home (N = 47)	99-135.5	123.7	9.4
Family Attitude of Retarded Children in Institution (N = 47)	90-135	114.5	11.1

the first hypothesis was rejected. No significant difference based on gender of the parent was found. Therefore, the second hypothesis failed to be rejected. There was no interaction effect found between placement of the child and gender of the parent. Results of the two-way ANOVA appear in Table V.

Econodemographic Variables of the Home Group

Econodemographic variables related to the families of retarded children living at home were analyzed by using multiple correlation analyses. The following variables were used as predictor variables: age of the father, educational level of the father, age of the mother, educational level of the mother, total family income, and number of other children living at home. The criterion variable was family attitudinal score. The only significant predictor variable found was fathers' educational level which was found to be a relatively weak predictor. Results of the multiple regression analysis of parent variables to family attitude for the home group can be seen in Table VI. The analysis of variance for the predictive model was not significant. Results of the ANOVA for the model can be seen in Table VII.

Econodemographic Variables for the Institutional Group

The following variables were used as predictor variables for families of retarded children who were institutionalized:

TABLE V
SUMMARY TABLE FOR TWO-WAY ANOVA

Source	df	SS	MS	F
Location of Child	1	3934.04	3934.04	60.30*
Gender of Parent	1	176.19	176.19	2.70
Interaction	1	2.57	2.57	0.04
Within (Error)	92	19570.83	212.73	
Total	95	23683.63		

*p < .0001

TABLE VI
MULTIPLE REGRESSION OF PARENT VARIABLES ON
FAMILY MEAN ATTITUDE FOR HOME GROUP

	df	SS	F
Fathers Age	1	52.8	0.74
Mothers Age	1	51.7	0.73
Fathers Education	1	336.7	4.47*
Mothers Education	1	3.5	0.05
Family Income	1	158.1	2.22
Number of Other Children Living at Home	1	1.3	0.02

*p < .05

TABLE VII
ANOVA FOR MODEL OF PARENT VARIABLES FOR HOME GROUP

	df	SS	MS	R ²	F
Model	6	661.0	110.2	0.22	1.55
Error	33	2345.1	77.1		
Corrected Total	39	3006.1			

p > .05

age of the father, educational level of the father, age of the mother, educational level of the mother, total family income, and number of other children living at home. Multiple regression analysis was used with family attitudinal score as the criterion variable. No significant relationship was found between any variable and family attitudinal score for the institutional group of families. Results of the multiple regression analysis of parent variables to family attitude for the institutional group can be found in Table VIII. The analysis of variance for the predictive model was not significant. Results of the ANOVA for the model can be found in Table IX. Based on the results of these regression analyses, the third hypothesis failed to be rejected.

Child Characteristics for the Home Group

The following variables related to the retarded children in the home group were analyzed by using multiple regression: age of the child, I.Q. of the child, and gender of the child. The criterion variable used was family attitudinal score. No statistically significant relationship was found for any of the child-related variables. Results of the multiple regression analysis of child-related variables to family attitude can be seen in Table X. Results of the ANOVA for the model can be seen in Table XI. The analysis of variance for the predictive model was not significant.

TABLE VIII
MULTIPLE REGRESSION OF PARENT VARIABLES ON FAMILY
MEAN ATTITUDE FOR INSTITUTIONAL GROUP

	df	SS	F
Fathers Age	1	232.0	1.97
Mothers Age	1	48.9	0.42
Fathers Education	1	4.7	0.04
Mothers Education	1	147.8	1.26
Family Income	1	1.3	0.92
Number of Other Children Living at Home	1	4.8	0.04

p > .05

TABLE IX
ANOVA FOR MODEL OF PARENT VARIABLES
FOR INSTITUTIONAL GROUP

	df	SS	MS	R ²	F
Model	6	1400.1	233.3	1.99	0.24
Error	36	4229.0	117.5		
Corrected Total	42	5629.1			

P > .05

TABLE X
MULTIPLE REGRESSION OF CHILD
VARIABLES FOR HOME GROUP

	df	SS	F
Age	1	139.0	1.57
I.Q.	1	132.8	1.50
Gender	1	20.4	0.23

$p > .05$

TABLE XI
ANOVA FOR MODEL OF CHILD VARIABLES FOR HOME GROUP

Source	df	SS	MS	R ²	F
Model	3	276.0	92.0	0.06	1.04
Error	43	3804.2	88.5		
Corrected Total	46	4080.2			

p > .05

Child Characteristics for the
Institutional Group

Multiple regression was used to analyze some child-related variables for the institutional group. No significant relationship was found between age of the child, I.Q. of the child, or gender of the child and family attitudinal score. Results of the multiple regression analysis of child-related variables to family mean attitude can be found in Table XII. Results of the ANOVA for the model for the institutional group can be found in Table XIII. Based on the regression analyses for child-related variables for both groups, the fourth hypothesis failed to be rejected.

TABLE XII
MULTIPLE REGRESSION OF CHILD VARIABLES
FOR INSTITUTIONAL GROUP

Source	df	SS	F
Age	1	329.9	2.85
I.Q.	1	31.2	0.27
Gender	1	220.0	1.90

$p > .05$

TABLE XIII
ANOVA FOR MODEL OF CHILD VARIABLES
FOR INSTITUTIONAL GROUP

Source	df	SS	MS	R ²	F
Model	3	728.5	242.8	0.13	2.10
Error	43	4976.7	115.7		
Corrected Total	46	5705.2			

p > .05

CHAPTER V

DISCUSSION, CONCLUSIONS, AND IMPLICATIONS

Discussion

The findings of this study indicate that there is a significant difference in attitudes toward mental retardation between parents with retarded children living at home and parents with retarded children who are institutionalized. Parents of retarded children in the home showed significantly ($p < .0001$) more positive attitudes about mental retardation than did parents of institutionalized retarded children.

The data showed no significant difference between the attitudes of fathers and mothers toward mental retardation. This finding supported the findings of Love (1967-1968). However, the findings of the present study did not support the conclusions of a second study of parental attitudes conducted by Love (1971) which found that mothers had more positive attitudes than fathers. Several other studies have suggested a relationship between gender of the parent and the amount of role strain induced by a retarded child, particularly for the father (Miller, 1970; Tallman, 1955). However, if this relationship existed for the sample of parents in the present study it was not evidenced in attitudes expressed toward mental retardation.

No significant interaction was found between placement situation of the retarded child and gender of the parent. This finding did not support the conclusions of Downey (1965) who indicated a relationship between gender of the parent and placement decision. If this relationship existed for parents in the present study, it was not expressed in attitudes toward mental retardation as measured by the Parental Attitudes Toward Mentally Retarded Children Scale.

One possible explanation for the presence of more favorable attitudes among the home group of parents could be the greater opportunity presented to integrate the retarded child into the family unit. Based on the theoretical model used in the study, knowledge of mental retardation should be an important variable in relationship to attitudinal development. Families of institutionalized retarded children are deprived of the day-to-day experiences of rearing a retarded child which could be a source for a knowledge base about mental retardation. Extended contact with the mentally retarded child would provide opportunities to reality test expectations and assumptions made by parents. The absence of the child may result in the family, over a period of time, feeling less and less like the retarded child is or ever could be a family member in terms of their integration into the family constellation.

There is also the possibility that Americans in general view institutional or mass residential living less favorably

than single family homes. Perhaps this view influenced these parents of retarded children in their attitudes toward mental retardation.

Another plausible explanation is that parents of retarded children who remain in the home may have initially held more positive attitudes. Such positive attitudes may have played an important role in the decision to keep the retarded child in the home initially. However, empirical analysis of this relationship has not been documented in the body of research.

No significant relationships were found between the econodemographic variables of the families and family attitudinal scores except for father's educational level in the home group. Love (1971) found that educational level had the greatest influence of any of the variables he examined on parental attitudes toward mental retardation. The present data indicated that fathers' educational level is a weak predictor of attitudes for families with retarded children in the home. The relationship is a positive one. There should be some positive relationship between father's income level and father's education. Since no significant relationship was found between family income and family attitude score, the significant relationship between father's educational level and family attitude score is probably not real important.

Love (1967-1968) found that economic standing had little influence on attitudes toward mental retardation. Data from

the present study indicated no significant relationship between family income and family attitudinal score for either group. There was a wide range of income levels in the sample used in the present study even though group means were fairly comparable. Love (1971) and Farber (1968) argued that middle and upper income families would be more frustrated and disappointed in having a retarded child than would lower income families. It would seem that these feelings might affect attitudes toward mental retardation. However, this assumption was not supported by the analysis of data in the present study.

Data from the present study supported the third hypothesis that there was no relationship between econodemo-graphic variables and attitudes. The relationship between these variables and attitudes are not direct as implied by the theoretical model. Another possibility may be that additional or different variables are involved in the processes of attitude formation. Vurdelja-Maglajlic and Jordan (1974) concluded that mothers who felt safe and in control of their environments had more positive attitudes toward mental retardation. Kenney (1967) found a relationship between mothers' level of ego development and the behavior of their retarded children. Findings such as these seem to indicate that intrapsychic variables such as locus of control may influence the process of attitude formation.

Such variables may influence attitudinal development in either one or both parents.

It may be that variables related to the behavior of the retarded child play a significant role in the process of attitude formation. Perhaps how the child behaves is of greater import than the age, gender, or I.Q. of the child. For example, a child that is aggressive or self-abusive may present a greater challenge to family resources than problems associated with low intellectual functioning. Such behaviors may be considered a direct result of mental retardation and thus influence parental attitudes toward the child and mental retardation.

No significant relationship between the age, sex, and I.Q. of the retarded child and family attitudes were found in the present study. The data did support the fourth hypothesis of the study. Perhaps this relationship in the overall theoretical model may have more subtle parameters than those used in the present study. Child characteristics such as social maturity, physical handicaps, and adaptive behavior may be related to attitudinal formation on the part of parents.

Limitations of Present Research

Many limitations of the present study are those associated with collecting data by mailed questionnaire. Although the return rate was fairly high (approximately

30 percent) for a mailed questionnaire, the vast majority of parents in the original sample did not respond. It is not known if and how these parents differ from parents included in the study. There are also limitations placed on the study by not knowing who actually completed the questionnaires. The reading level of the individual and the interpretation they made of certain items may have influenced responses. Since a self-report instrument was employed, there is the question of how accurately this reflects actual behavior.

Data were collected only from parents of retarded children residing in the State of South Carolina. Because of the unique cultural factors of the area, the generalizability of the findings should be limited or made with caution. For example, a strong commitment to organized religion may be a variable that influences attitudes and, most likely, varies from region to region.

The instruments did not allow parents to record attitudinal data that they themselves felt important in terms of individual situations. Such limitations were noted on the instruments by many parents. Also, the instruments used did not account for any differences that might have been due to variations of the physical environment itself. For example, variations in the physical environment may have some relationships to the attitudes and behaviors of both the retarded child and his or her parents.

Suggestions for Further Research

Perhaps the most obvious question raised by the present research is the direction of the relationship between attitude and child placement. Do initial positive attitudes toward mental retardation account for home placement or does placement of the child influence attitudes toward mental retardation? It would appear that a longitudinal study of parents with infants diagnosed as retarded and their subsequent decision related to placement might assist in our understanding of these processes.

Another possibility for future research would be an investigation of the relationship between the institutional career of the retarded individual and parental attitudes. What are the relationships between length of time spent in an institution and attitudinal development? What are the relationships between parental contact with the institutionalized retarded child and attitudinal development? These are just a few of the many questions needing investigation.

Other components, and their interrelationships, of the conceptual model used in the study need further study. For example, research comparing the general value orientation and knowledge about mental retardation of parents with retarded children kept in the home versus those placed in institutions should be conducted.

Another area needing research efforts is the relationships between variations in physical environments and

attitudes toward mental retardation. There may well be a significant relationship between attitudes and home versus institutional living in general. Parental perceptions of the retarded child's ability to cope with each of these environments may be an important variable.

The final suggested area for further research is in the area of instrumentation. Unfortunately, few instruments are available for use in the investigation of parental attitudes. Those that do exist appear to allow for few differences on an individual basis. Perhaps using parents themselves as a source of questions or items would be a productive approach. Fishbein (1962) suggested a method of constructing a semantic differential that appears appropriate for use with families of retarded children. Research utilizing interviews in conjunction with direct observations might well provide significant information.

Implications

The findings of this study indicate that a significant difference in attitudes exist between parents of retarded children kept in the home and parents of retarded children placed in institutions. The processes that lead to attitude development in parents of retarded children need further study and clarification.

On an applied level, the information gained from this study can be used by those service providers and social

planners concerned with families of retarded children. With the recent emphasis on deinstitutionalization and institutional avoidance programs, parental attitudes take on added importance. Successful programs will have to recognize and plan for the role that parental attitudes will play in such efforts. In fact, an investigation of and a program for ascertaining and improving parental attitudes would appear to be the logical first step in program development.

More attention has been focused on community attitudes toward the mentally retarded than on attitudes of the family. Certainly this emphasis reflects the political nature of deinstitutionalization proposals. If we were more concerned with the relative success, rather than the popularity, of deinstitutionalization greater attention should be given to the attitudes of the family group to which the retarded individual will return. Perhaps we should begin to view deinstitutionalization more as a process than as a goal. In this manner attention could be given to parental attitudes as well as community attitudes in the overall deinstitutionalization process.

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APPENDICES

APPENDIX A

INFORMED CONSENT FORM

Dear Parents:

This letter is to ask for your assistance in a study of parents with retarded children. I have been employed by the South Carolina Department of Mental Retardation, Whitten Center, since 1974. Last year I returned to The University of Tennessee, Knoxville, to complete my Ph.D. degree. Part of the requirements for this degree is to conduct a research study. Having worked with retarded citizens and their families for several years, I am particularly concerned that service providers learn more about parents of retarded children in order to develop programs that meet the needs that you have as parents of a special child.

Your name has been selected from a service list maintained by the South Carolina Department of Mental Retardation. It is hoped that you will volunteer to be involved in this study. Participation in the study involves the following:

1. filling in the answers to six (6) questions about yourself and your special child;
2. completing a 30-item questionnaire related to your attitudes toward mental retardation;
3. giving your permission to use the following information from your special child's file: age, sex, I.Q., and, if your child lives at Whitten Center, how long he or she has been there.

If you agree to participate in the study, I will mail you the necessary form to fill out with directions on how to complete them. I know that many parents may feel uncomfortable in providing personal information about themselves and their families. I want to assure you that I have taken steps to insure that any information gained during this study will be strictly confidential. No individual names or identifying characteristics or participants will be used in any published materials or made available to any other individuals or agencies. A benefit from your participation is that the study may help professionals better understand and assist retarded citizens and their families.

Please complete the attached form and return it in the enclosed self-addressed pre-stamped envelope. It is extremely important that you do this at your earliest possible convenience. If possible, it would be most helpful if both natural parents would participate in the study. Thank you for your cooperation and assistance.

Sincerely,

J. David Sexton, Ph.D. Student

Charles H. Chadwell, Ph.D.,
Superintendent

Please check the following:

1. Yes () or No (). I/we are the natural parent(s) of a retarded child.
2. Yes () or No (). I am willing to participate in the study and give my informed consent.

Father's signature and date signed

3. Yes () or No (). I am willing to participate in the study and give my informed consent.

Mother's signature and date signed

4. Yes () or No (). We/I would like a summary of the findings of the study.

APPENDIX B

INSTRUMENTS USED IN STUDY

Dear Parent(s):

Thank you for your willingness to participate in my research study. Please find enclosed the necessary forms to complete. There is a questionnaire asking for six items of information. Please fill this information in the blanks. There is also a 30-item attitudinal instrument. If both mother and father are participating, please complete the Parental Attitude Scale Toward Mentally Retarded Children Scale separately, without discussion, since I am interested in your individual opinions. Also, please be careful to consider the following in completing and returning the materials:

1. Read the directions carefully.
2. Be sure to answer all questions and provide only one answer for each question.
3. Keep in mind that all information provided will be kept strictly confidential.
4. Complete the materials and return them in the stamped preaddressed envelope at your earliest possible convenience. It is extremely important that you complete and return the materials promptly.

If you indicated that you wanted a summary of the research findings, I will mail them to you as soon as they are available. Again, thank you very much for your assistance.

Sincerely,

J. David Sexton, Ph.D. Student

Directions

Please check or fill in the appropriate blank for each of the following questions. Remember, the answers to these questions will be held confidential. Please be careful to respond to each item.

1. What is your sex? (a) male___ or (b) female___
2. How old are you?_____
3. What is the highest grade that you completed in school?_____
4. What was the amount of your family's total income last year?_____
5. How many nonretarded children do you presently have living at home?_____
6. How many retarded children do you have?_____

Directions

Please find attached the Parental Attitudes Toward Mentally Retarded Children Scale. This instrument consists of a list of thirty statements about mentally retarded children. To the right of each statement are five columns: Column 1—Strongly Agree; Column 2—Agree; Column 3—Undecided; Column 4—Disagree; and Column 5—Strongly Disagree. After reading each statement you should indicate with a check mark (✓) whether you strongly agree, agree, disagree, or strongly disagree with the statement. If you are not sure as to whether you agree or disagree with a particular statement, you should then place a check mark (✓) in the "Undecided" column.

Please consider the following example:

Item No.	STATEMENT	Strongly Agree	Agree	Undecided	Dis-agree	Strongly Disagree
1	All mentally retarded children have blue eyes.					✓

The individual felt that he or she strongly disagreed with the statement so a check mark (✓) was placed in Column 5—Strongly Disagree.

As far as the scoring of this instrument is concerned, be assured that there is no "right or wrong" answer to any of these statements. However, please keep in mind the great

importance of checking only those columns that truly reflect your feelings concerning a particular statement. Don't let your judgment be swayed by what you think others believe. Remember, the results of this instrument will be held completely confidential.

Please respond to each statement only once and be sure to respond to all of the statements. Please turn the page and begin.

PARENTAL ATTITUDES TOWARD MENTALLY RETARDED CHILDREN SCALE

Item No.	STATEMENT	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
1	Mentally retarded children are usually better off in mental institutions.					
2	I would not mind if my child sat by a mentally retarded child in the classroom.					
3	If I were an employer, I would hire a mentally retarded person.					
4	There is a high relationship between immorality and mental retardation.					
5	Mentally retarded adults tend to lower the standards of living of their neighbors.					
6	"Feeble-Minded" is a more descriptive and appropriate term than "mentally retarded."					
7	Mentally retarded children have the same basic needs as any other children.					
8	I generally feel rather uncomfortable around mentally retarded children.					
9	On many occasions, the average-ability youngster is distracted, and prevented from learning, by his mentally retarded classmates.					

Item No.	STATEMENT	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
10	Mentally retarded children are inclined to be behavior problems.					
11	I would not mind paying extra taxes to establish a special education class in our community.					
12	Mentally retarded children can be identified by a decidedly different look in their eyes.					
13	Mentally retarded children usually grow up to be good citizens.					
14	Mentally retarded children are deserving of much consideration from the rest of the world.					
15	It does not "hurt" normal children to mingle with mentally retarded children.					
16	Mentally retarded children are, oftentimes, quite considerate of other people.					
17	I would not mind going to a social affair with a mentally retarded person.					

Item No.	STATEMENT	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
18	It is an unhealthy situation for average-ability children and mentally retarded children to have daily contacts with each other.					
19	I would not mind if my child invited a mentally retarded child to his or her birthday party.					
20	I would prefer that my own child did not play with a neighborhood child who is mentally retarded.					
21	It is a fact that mentally retarded people do not contribute anything to a community.					
22	Mentally retarded children are usually quite stingy.					
23	It would be better to take the money spent on educating the mentally retarded and spend it on the gifted child.					
24	Mentally retarded children usually end up in jail or in a detention home.					
25	The army should turn down all mentally retarded people.					

Item No.	STATEMENT	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
26	I would rather see mentally retarded children enrolled in public school special education classes than see them enrolled in state institutions.					
27	There is very little, if any, relationship between mental retardation and low morals.					
28	If I had a mentally retarded child, I think I could love him or her as dearly as I would love my normal children.					
29	Mentally retarded people contribute as much to a community as does the average person.					
30	On the whole, mentally retarded children are as affectionate as normal children.					

VITA

James David Sexton was born in Lenoir City, Tennessee, on May 20, 1948. He attended elementary school in that city and was graduated from East Ridge High School in 1966. The following September he entered The University of Tennessee, Knoxville, and in June 1970 he received a Bachelor of Science degree in Social Science Education.

After a two-year tour of duty in the United States Army, he entered the Graduate School of The University of Tennessee, Knoxville. In August 1974 he received the Master of Science degree in Child and Family Studies.

He was employed by the South Carolina Department of Mental Retardation in August 1974. In 1978 he returned to the Graduate School of The University of Tennessee, Knoxville, where he received the Doctor of Philosophy degree with a major in Home Economics in March 1980.

The author is a member of the American Home Economics Association, the American Association on Mental Deficiency, Omicron Nu, and Phi Kappa Phi. In 1976 he was selected Piedmont Region Employee of the year by the South Carolina Association for Retarded Citizens. He was employed as an Assistant Professor of Special Education by Auburn University, Auburn, Alabama, in January 1980.