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A Comparison of Attitudes Toward Persons with Mental Retardation in Three Age Groups

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A Comparison of Attitudes Toward Persons with Mental Retardation in Three Age Groups

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Abstract

This study is an attempt to compare attitudes toward persons with mental retardation in different age groups. It attempts to determine if public attitudes toward adults and elderly persons with mental retardation are more negative than attitudes toward children with mental retardation, and if attitudes toward elderly persons with mental retardation are more negative than attitudes toward adults with mental retardation.

The instrument used in this study was a set of three semantic differential scales. The scales measured attitudes toward three concepts: mentally retarded child, mentally retarded young adult, and mentally retarded elderly person.

A stratified sampling procedure was used to select the subjects for this study. The instrument was distributed to 142 individuals. These subjects completed all three scales -- one for each age group. The group responses to each concept were then compared using three *t* -tests, and significant differences were found between each of the three paired groups.

Chapter I

THE PROBLEM

Introduction

There has been, in recent years, a growing number of programs designed to prepare mentally retarded individuals to assume productive roles in society. In the 1960s, deinstitutionalization programs brought thousands of handicapped individuals back to the community. This was followed in the 1970s with legal advancements and many programs designed to provide extensive educational and vocational training to these individuals.

Until recently, the focus of program development for disabled persons has been on children. The last few years have shown an increase in studies involving young adults. To date, however, little has been done with regard to the needs of aging or aged people with mental retardation. It was only in 1975 that the NARC changed its name from the National Association for Retarded Children to the National Association for Retarded Citizens, indicating a late awareness that retarded children do indeed grow up into adulthood. Researchers are only now beginning to acknowledge the fact that retarded individuals not only grow up, but that they also grow old.

As community placement for individuals with mental retardation has become commonplace, it is essential to evaluate those factors which may have an effect upon such placement. One factor which affects successful integration of mentally retarded individuals into society is acceptance by the general public. The extent to which community-based programs are successful is determined, in large part, by the acceptance of the community

residents. It is doubtful that a community-based program can succeed without community acceptance.

Background of the Problem

Historically, services for disabled persons have focused primarily on the needs of children, with attention being extended to the adult and elderly only recently. According to Robert Segal (1978b), negative professional and community attitudes have been responsible for blocking the development of new services for elderly mentally retarded persons and for hindering the utilization of existing services. In addition to the lack of services, the elderly disabled population also encounters social problems related to the interaction with others. Mentally retarded people of all ages have always been victims of negative attitudes. These attitudes have taken various forms through the ages, but have had the same dehumanizing effect (Wolfensberger, 1985). Since attitudes play a major role in defining the life experiences of most handicapped people, any negative attitudes toward the disabled population present a real barrier to their filling appropriate roles in society.

The role of attitudes has been studied in young children with disabilities, but little has been done among adult, and particularly elderly, populations. The limited attention adult and elderly retarded persons have received is due in part to the fact that, in the past, retarded persons had a shorter life span than nonretarded persons (Seltzer, Seltzer, & Sherwood, 1982). It could also be that negative attitudes toward adult and elderly mentally retarded people have kept professionals in the area of mental retardation from studying this group. The question of whether attitudes of the

nonretarded toward the retarded become more negative as the retarded population ages is not reported in the literature. This question needs to be answered before appropriate programs can be designed to ensure full participation of elderly people with mental retardation in the community.

Statement of the Problem

The lifespan of mentally retarded persons is increasing, and these individuals are no longer hidden behind the walls of an institution. Because of this, researchers, service providers, and those responsible for planning and administering services are beginning to adopt a life span perspective, and to devote more attention to mentally retarded persons across all age ranges.

This study attempts to address the entire life cycle of mentally retarded individuals. The primary question it addresses is: Are public attitudes different toward mentally retarded people of different age groups?

Purpose of the Study

The purpose of this study is to measure attitudes toward mentally retarded people of different ages. If the attitudes of the public toward mentally retarded people become more negative as these people age, then constructive action to deal with these negative attitudes may become part of program planning for adult and elderly mentally retarded individuals. In order to do appropriate, effective planning for these individuals, it is important to know the attitudes of the surrounding community.

Outline of Remainder of Proposal

The remainder of this proposal consists of a review of literature relating to attitudes toward mentally retarded people and toward the normal aging population. Also included in the review are some recent articles which attempt to outline program needs of the aging retarded population.

The third chapter of this project contains the methodology used in this study. Included in that chapter is a discussion of the semantic differential and its use in measuring attitudes. The method which was used to develop the instrument used in this particular study is also discussed.

That chapter also includes a description of the procedure used to select the subjects for this study. The procedure used to administer the instrument and collect the data is also described.

Definition of Terms

Mental retardation. Definitions of mental retardation have varied over the years, yet there is basic agreement among the various disciplines about what is meant by this term today. Currently, the American Association of Mental Deficiency definition is one that has been adopted by the American Psychiatric Association and is the definition used in the federal legislation. The most recent AAMD definition states, "Mental retardation refers to significantly subaverage general intellectual functioning, associated with impairments in adaptive behavior and manifested during the developmental period [prior to age 22]" (Grossman, 1983). It is important to note that mental retardation involves both intellectual functioning and deficits in adaptive behavior, and that these conditions manifest themselves in the first 22 years of life.

Aging. Aging generally refers to changes which occur with the passage of time. While there is no clear-cut definition of aging, most decisions affecting the aging population have been made on the arbitrarily established chronological age of 65. However, the mentally retarded aging population may not fit into this designation since, historically, they have had shorter life spans than the non-mentally retarded population (Rowitz, 1979). Most studies involving the aging mentally retarded population have used ages 55 (Dickerson, Hamilton, Huber, & Segal, 1974), 50 (Keiter, 1979), or as low as 40 (Kriger, 1975) as the lower age limit in defining aging. While there is no evidence that the physiological aging process is necessarily more rapid in the retarded population (Chinn, Drew, & Logan, 1979; Menolascino, 1985), the mentally retarded person is subject to premature aging because of his or her greater degree of dependency and premature role loss (Fancolly, 1975). Because of these social factors, it is appropriate to use the lower age limit of 50 or 55 when defining aging in the mentally retarded population.

Attitudes. In this study attitudes are defined as emotional states of an individual created by the beliefs or perceptions of that individual. Attitudes are predispositions which are composed of cognitive, affective, and behavioral components and can be influenced by direct and indirect experience (Gottlieb, Corman, & Curci, 1985). Benedict and Ganikos (1984) defined "negative attitudes" as negative prejudgments about individuals who are identified as belonging to a group. They further contend that negative attitudes are an internalization of prevailing myths and stereotypes about a group, that they lead to stigmatization, and determine a person's expectations of, and behavior toward, members of that group.

Osgood, Suci, and Tannenbaum (1957) distinguish "attitudes" from other predispositions to respond in that they predispose toward an evaluative response. This idea is related to the view that attitudes can be ascribed to some basic bipolar continuum with a neutral or zero reference point, implying that they have both direction and intensity.

Chapter II

REVIEW OF RELATED LITERATURE

Introduction

According to Wolf Wolfensberger (1972), all human services are based on belief systems that shape the quality and type of services to citizens who are disabled. Traditional belief systems and attitudes have resulted in human service systems based upon segregated settings and large institutions. The institutions are now closing down, and mentally retarded people are now living in community settings. However, since the underlying belief system has not been addressed, there have been fewer changes than expected by the pioneers in the deinstitutionalization movement. Deinstitutionalization has not kept its promises, and that may be largely because community attitudes have not been addressed (Baker, Seltzer, & Seltzer, 1977).

Attitudes Toward the Mentally Retarded Population

Most attitude studies involving persons with mental retardation have focused on children in educational settings. The majority of these studies have indicated a general lack of acceptance of handicapped children, both by their peers (Goodman, Gottlieb, & Harrison, 1972; Gottlieb & Budoff, 1973; Bruininks, Rynders, & Gross, 1974) and by their teachers (Shotel, Iano, & McGettigan, 1972; Stephans & Braun, 1980). A study of teacher attitudes in a recreational setting indicated that contact in a non-educational setting did not significantly improve teacher attitudes (Hourcade, 1981).

There is some evidence that attitudes toward retarded children have become slightly more positive within the last couple of decades. In a study

that attempted to identify the factors comprising public attitudes toward mentally retarded children (Gottlieb & Corman, 1975), a large majority of respondents expressed accepting attitudes toward retarded children. This acceptance, however, was not accompanied by an equally strong acceptance of integrated educational placement for these children. Attitudes of three groups of nonretarded fourth graders toward people who are mentally retarded were examined in an attempt to facilitate mainstreaming of retarded children into regular classrooms. One group heard a story about a boy who was mentally retarded. They were later given the opportunity to answer questions and talk about the story. The second group heard the same story, but did not discuss it afterward. The third group was the control group and heard a story about outer space. Students in the first two groups expressed positive attitudes and a willingness to live near or be associated with children who are retarded. With very little intervention (a 778-word story), children were willing to accept mentally retarded students into their classroom.

The entrance of many mentally retarded individuals into the employment market has forced professionals in the mental retardation field to address concerns about the mentally retarded young adult. Since mentally retarded students often stay in the public school system until the age of 21, many attitude studies focusing on mentally retarded young adults are carried out in the schools.

In a study of school principals' attitudes toward mentally retarded students in secondary work-study programs (Smith, Flexner, & Siegelman, 1980), mentally retarded students were consistently rated lower than non-handicapped students or students with learning disabilities. Both non-

handicapped students and students with learning disabilities were perceived as stronger, healthier, saner, neater, and more useful than the students with mental retardation. In another study which attempted to identify problems interfering with mainstreaming on the secondary level, the researchers discovered that teachers were ignorant of exceptionality and that they lacked understanding of individual differences which resulted in fear, prejudice, hostility, and even ridicule (Post & Roy, 1985).

Millberg (1985) surveyed employers about their willingness to hire individuals who are mentally retarded. The employers surveyed were reluctant to hire mentally retarded workers. Employers would provide money or contract work, but were unwilling to provide on-site employment, due to their negative attitudes about mentally retarded workers. In a survey of college students' attitudes toward adults with mental retardation, even those having had direct experience with adults with mental retardation expressed negative attitudes (Hill, 1985).

Elderly retarded persons have received relatively little attention from investigators and policy makers in the field of mental retardation (Seltzer, Seltzer, & Sherwood, 1982). However, as the number of elderly retarded persons is now growing (Di Giovanni, 1978), this group is beginning to receive some attention. Many communities are now developing programs for this population, and more professionals are beginning to discuss the needs of elderly persons with mental retardation (Seltzer and Kraus, 1989). However, in the resources and literature that were reviewed for this study, no studies measuring attitudes toward this group were found.

There is some evidence that mental retardation is perceived more negatively than other handicaps. An investigation of different attitudes toward specific disability groups among high school and college students (Tringo, 1970) established the existence of a hierarchy of preferences toward the disability groups studied. A Disability Social Distance Scale that listed 21 disabilities was administered to a total of 455 subjects. The order of preference was stable across all groups regardless of mean scores. Demographic variables affected the extent of social distance expressed toward specific disability groups but did not affect the relative position of disability groups in the hierarchy. Mental retardation was ranked 19 (out of 21) in the disability hierarchy.

Investigations of teacher attitudes substantiate Tringo's hierarchy of preferences. In a study of teacher attitudes regarding the integration of handicapped children into regular programs, the responses toward mental retardation were consistently more negative than the responses toward other disabilities (Shotel, Iano, & McGettigan, 1972). In a similar study on the secondary level, mentally retarded students were again perceived more negatively than those with learning disabilities (Smith, Flexner, & Siegelman, 1980).

Attitudes Toward Old People

Our society is overwhelmingly youth oriented. Negative attitudes toward old people are evident throughout the media, in advertising, and in individual misconceptions and fears about the aging process. According to Atchley (1980), old age is in itself a stigma, and older people often find that

the stigma of old age limits their opportunities for full participation in society. Elderly people are often thought of as senile, rigid, unproductive, dependent, and untreatable.

Butler (1975) uses the term ageism to describe societal attitudes toward old people. Ageism is defined as the "process of systematically stereotyping and discriminating against people because they are old" (Butler, 1975, p. 894). These negative societal attitudes have been documented extensively over the years (Tuckman & Lorge, 1953; Tuckman & Lorge, 1958; Kogan, 1961; Tuckman, 1965).

In a study of college students' perception of aging (O'Connell & Rotter, 1979), the researchers discovered that negative attributes are associated with increasing age. In another study involving college students (Auerbach & Levenson, 1977), the researchers reported that the attitudes of college students became even more negative after a semester of contact.

According to Benedict & Ganikos (1981), older people are largely neglected by rehabilitation professionals. People in the rehabilitation field tend to avoid certain conditions and will help the individuals who they feel can most "benefit from assistance" (Siller, 1985, p. 195). Rash, Crystal, & Thomas (1977) compared the attitudes of rehabilitation trainees toward older, physically disabled and nondisabled people. The older persons were seen as less able to cope than either physically disabled or nondisabled persons.

Numerous researchers have reported negative attitudes toward elderly people among health professionals (Campbell, 1971; Gunter, 1971; Futrell & Jones, 1977). Greenhill (1983) showed that even though expressed attitudes

might become more positive with classes and clinical experiences, this does not affect nursing students' interest in working with older people.

Butler (1980) stated that up to 30% of all treatable mental disorders in older people are misdiagnosed as untreatable because the physician assumes that mental impairment is to be expected with advancing age. Heller, Bausell, & Ninos (1984) reported negative attitudes toward the aged, and found a significant relationship between attitudes and perceptions of care.

Palmore (1982) published a summary of 100 previously published studies on attitudes toward aging. He reported abundant evidence of widespread ageism in our culture. This included negative ratings of old age and negative attitudes toward aging persons. There was also a general acceptance of negative stereotypes throughout the populations studied.

Austin (1985) conducted a study which suggested that a positive shift in attitudes toward older persons may have taken place in recent years. In a study of medical students' attitudes toward the elderly (Green, Keith, & Pawlson, 1983), the subjects expressed a generally positive view of elderly patients. Schonfield (1982) charged that gerontologists are stereotyping society and have deliberately misinterpreted the evidence. This idea has been expressed by others (Seltzer & Atchley, 1971; Kalish, 1979) who charge that gerontologists may perpetuate ageism by creating self-fulfilling prophecies.

Parallels Between Aging Persons and Mentally Retarded Persons

Benedict & Ganikos (1981) pointed out that parallels exist between negative attitudes toward older persons and negative attitudes toward mentally retarded persons. The public tends to perceive both groups as being apart

from the mainstream, as helpless, useless, and dependent. Panitch (1983) also wrote of the similarity between handicapism and ageism. Both sets of attitudes and practices may promote unjust treatment of people because of apparent or assumed physical or mental disabilities. Some problems experienced by people who are old and by those who have a mental handicap are: (a) rejection, (b) low expectations, (c) residential and social segregation, and (d) stereotyping through labeling.

Characteristics associated with aging in "normal" individuals are evident in mentally retarded persons throughout their lifetimes. These characteristics include (a) occasional physical impairment, (b) occasional mental deterioration, (c) low income potential, (d) sense of personal loss and family rejection, (e) excess leisure time with no activities to fill it, and (f) physical and social dependence (Cotten, et al., 1981).

It has been suggested that one reason why the aging process has received less attention among the mentally retarded population is that the changes in functioning ability in terms of losses experienced are not as noticeable (Willer & Igtagliata, 1984). Many mentally retarded persons have had significant health problems from their youngest years, and all have had a limited mental capacity. Most never had the opportunity to hold meaningful jobs or other valued roles, so these assets are not lost through aging. Also, most mentally retarded persons have been heavily dependent on other people all their lives. It seems that only in old age do mentally retarded people receive the same treatment as their non-mentally retarded peers.

Needs of the Aging Mentally Retarded Population

There is evidence that the size of the aging mentally retarded population is growing (Cotten, Sison, & Starr, 1981; Segal, 1978b; Kriger, 1975; Di Giovanni, 1978), but it is difficult to describe this change numerically because of the problems of identifying and locating this group (Segal, 1978a). With advances in medical science and wider availability of health services for mentally retarded people, this population is surviving longer. Also, with the advent of the deinstitutionalization program of the 1960s and 1970s, this population has become more visible in community life.

Jones (1972) indicates that older mentally retarded persons are one of the most vulnerable groups in society. Not only do they face the problems of the aged, but they also face the problems of the mentally impaired. This has led to a sort of "double jeopardy" of being both old and mentally disabled in a society that fears both.

Aging mentally retarded people face the same needs as mentally retarded people of any age, as well as other needs faced by aging people. Wolfensberger (1985) points out that the situation of elderly retarded people is particularly difficult because of the decreasing societal respect for elderly people in general. To suggest that an elderly retarded person in our culture receive the same services as an elderly non-retarded person runs contrary to human dignity. Wolfensberger (1985) describes most services for the elderly as "segregatory, demeaning, image- and competency-diminishing, and quite possibly even socially and physically destructive" (p. 73). Thus he claims that professionals cannot look to the "normal" population for a model.

Despite a lack of models, some programs and services have been planned for the elderly mentally retarded population. Residential settings for the aged mentally retarded population fall along a continuum, moving from most restrictive to least restrictive. Wood (1979) identifies nine settings on the residential continuum: nursing home (most restrictive), public institutions, clustered cottages or "villages," special purpose facilities located in the community, large group homes (7-15 beds), small group homes (4-6 beds), 2-3 person alternative living arrangement, surrogate family, supported natural home, and independent living (least restrictive).

If the cycle of dependence and regression in aged mentally retarded persons is ever to be broken, their educational needs must be met (Janicki, Knox, & Jacobson, 1985). As community living becomes the focus for this population, it becomes apparent that skills which facilitate community adjustment are needed. These skills include daily living skills, leisure and recreational skills, and personal interaction skills, including personal hygiene. All of these needs require the cooperation and support of the community in which the mentally retarded person lives in order to be met (Putnam & Bruininks, 1980).

The medical needs of aged mentally retarded people are not much different from the medical needs of the normal aged. Some of the services required to provide adequate health care are (Kutz & Frost, 1978): (a) home health care/homemaker service, (b) home nutrition counseling, (c) nutrition services, (d) dental care, and (e) clinical facilities.

According to Wolfensberger (1982), advocacy should be added to this list of medical needs of the aged mentally retarded population. The medical

profession is often reluctant to treat mentally retarded persons of any age, and when they become aged they experience a double jeopardy. They need advocates who will step in and see that they receive the medical care that they need.

Consequences of Negative Attitudes

A major problem in the rehabilitation of the disabled is the attitude of the public toward them (Tringo, 1970). A person with a mental disability may be well prepared to perform a job and to cope with normal life situations, yet be unable to find employment because of prospective employers' attitudes toward the disability. Even the most capable of the mentally retarded population can be victims of prejudice and negative attitudes.

According to Cooper (1979), worker attitudes play a major role in the quality of care a client receives. In a study comparing members of the helping professions to the general population (Harasymic, Horne, & Lewis, 1976), the researchers discovered that professionals in the rehabilitation field shared the same negative attitudes as the population at large, and that the hierarchy of preferences was the same for both groups.

In a major study of community residences for retarded adults (Baker, Seltzer, & Seltzer, 1977), the researchers found that public attitudes largely determine the success of community integration of retarded persons. In communities where positive attitudes were expressed by the public, the level of community activity was much higher for the retarded persons living there. In a survey of state-level mental retardation coordinators (Luckey & Newman,

1975), attitudes of professionals and of the general public were frequently cited as a major barrier to community services.

An investigation of community attitudes toward persons with mental retardation documented a disparity between attitude and actual practice (Kastner, Repucci, & Pezzali, 1979). In this study, the authors learned that people who believed that mentally retarded persons were being moved into their neighborhoods responded more negatively than people who were asked about mental retardation in more general, less personal terms. One conclusion of this study was that if community services are to be used successfully, some effort will have to be directed toward increasing the level of community awareness and acceptance of mentally retarded persons.

Since the deinstitutionalization movement and its resulting placement of mentally retarded people into community settings, professionals in the human services field can expect more of the retarded population to grow to old age in community settings rather than in institutions (Menolascino, 1985). Given this fact, agencies need to plan for these aged mentally retarded individuals. A primary impediment to community programming for these people is a lack of community understanding. This often leads to their isolation and alienation from the community in which they live (Kriger, 1975).

Even though mentally retarded adults and many elderly retarded people now live in the community, many of them live in relative isolation (Panitch, 1983). Hostile attitudes of neighbors often prevent these people from taking advantage of what the community can offer. The normal aging population often experiences rejection and isolation, and older people with impairments risk multiple rejection (Kriger, 1975).

In recent years there has been a dramatic increase in legislation and services for persons with mental retardation. The courts and Congress have assumed that full integration into the community would alter traditional views of handicapped persons, but such changes appear to be possible only through a better understanding of the attitudes that determine the status and treatment of people with handicaps in our social institutions (Jones & Guskin, 1985).

An important area in which negative attitudes impact on the lives of mentally retarded individuals is mental health. Mental health professionals have expressed concern about the impact of the community's negative attitudes on the mental health of the mentally and physically disabled (Anthony, 1972), and attempts to change these attitudes have largely failed unless they combined information about the disability with actual contact with disabled persons. Anthony (1972) stated that any effort to improve the mental health of the disabled will need to include changing the attitudes of the public toward them.

Altman (1981) stated that attitudes toward disabled people are important to handicapped individuals on three levels: (a) in their relationship with peers who can contribute to the handicapped person's adjustment by providing acceptance and support; (b) in their interaction with professionals who control services, opportunities, and jobs which control the handicapped person's dependence on others; (c) in their interactions with the general public whose reactions to them often determine the handicapped person's self-esteem and self-confidence, as well as his or her chances for a full life in the community. These three levels illustrate how important public attitudes are in determining the quality of life for mentally handicapped people in our community.

Summary

This review of literature has described some of the research concerning attitudes toward persons with mental retardation and attitudes toward the aged and aging population. It has also shown some parallels between attitudes toward these two groups. This was done because both groups are victims of myths and prejudices, and a person who is both mentally retarded and aged experiences a "double jeopardy" as a member of both these groups.

There has been little written about the aging mentally retarded population until recently. As a life-span perspective pervades the research and service delivery, this population will begin to receive more attention. Given the importance of public attitudes in the planning and delivery of services, and the lack of attitude studies on this population, it seems important to investigate the attitudes of the public toward aging mentally retarded people.

Chapter III

METHODOLOGY

Overview

This study is an attempt to address the question of attitudes toward mentally retarded individuals of different ages. The subjects completed a 20-item semantic differential for each of three concepts: Mentally Retarded Child, Mentally Retarded Young Adult, and Mentally Retarded Elderly Person. Group responses to these concepts were then totaled and compared.

Hypotheses

There are three hypotheses proposed for this study: (1) Attitudes toward children with mental retardation will be significantly more positive than attitudes toward young adults with mental retardation; (2) attitudes toward children with mental retardation will be significantly more positive than attitudes toward elderly people with mental retardation; and (3) attitudes toward young adults with mental retardation will be significantly more positive than attitudes toward elderly people with mental retardation.

Description of Instrument

The attitude scale used in this study is a semantic differential instrument modeled after similar instruments used by Osgood et al. (1957). The semantic differential was adapted by Stagner and Osgood (1946) for

measuring social stereotypes. They developed the notion of a continuum between polar terms, using such terms to define the ends of seven-step scales.

Using a semantic differential scale provides a way to objectify expressions of subjective states. It is not a "test," having some definite set of items and a specific score. Rather, it is a general way of getting at a certain type of information. It is a highly generalizable technique of measurement which must be adapted to the requirements of each research problem to which it is applied (Osgood, et al., 1957).

The reliability of an instrument is defined as the degree to which the same scores can be reproduced when the same objects are measured repeatedly (Best, 1981). The average errors of measurement of the semantic differential scales are less than a single scale unit (Osgood, et al., 1957). This means that we can expect subjects, on the average, to be accurate within a single unit of the scale.

Evaluative scales produce even smaller average errors of measurement. Test-retest reliability data obtained by Tannenbaum (1953) produced reliability coefficients ranging from .87 to .93. Additional reliability data (Osgood, 1957) confirm these scores.

An instrument is said to be valid when it measures what it is supposed to measure (Best, 1981). Attitude studies using the semantic differential have been compared to two independently devised measuring instruments, the Thurstone scales and the Guttman scale (Osgood, 1957). Correlation between the semantic differential scores and the corresponding Thurstone scores was significantly greater than chance (rho = .90). The correlation between the

Guttman scale and the evaluative scales of the semantic differential was also highly significant (rho = .78).

Two considerations in the selection of scales for the semantic differential used in this study are: factorial composition and relevance to the concepts being judged. To index attitude, sets of scales that have high loadings on the evaluative factor should be used (Osgood, 1957). In developing the scale, 30 items were pulled from Osgood's (1957) list of analyzed adjective pairs. These items were chosen for their high evaluative rating and for their relevance to the area of mental retardation. To further increase the relevance to the field of mental retardation, these 30 items were reviewed by a panel of 10 professionals who work with persons with mental retardation. These 10 professionals were asked to rank the adjective pairs for their relevance to mental retardation. The 20 top-rated items were then chosen for the instrument used.

The specific instrument used in this study consists of three sets of 20 items each. The first set measured attitudes toward the concept "Mentally Retarded Child." The second set measured attitudes toward the concept "Mentally Retarded Young Adult." The final set measured attitudes toward the concept "Mentally Retarded Elderly Person." All three sets consisted of the same 20 items, in a different order and in different directions. Each subject was asked to complete all three attitude scales.

The instrument also contained a "Personal Information Sheet" which identified the subject's sex, age, educational level, type of previous contact with persons with mental retardation, and previous training in the area of special education. The directions were adapted from Osgood et al. (1957) and

Kogan and Wallach (1961), and were clearly written on a separate page preceding the scales.

Population and Sample

This study is an attempt to measure public attitudes toward people with mental retardation in the city of Omaha. In order to ensure that all parts of the city were represented in the sample, a stratified sampling process was used. Omaha was divided into five strata or sections: West Omaha, South Omaha, North Omaha, Central Omaha, and Downtown. The instrument was distributed in three ways within each section: 10 sets were given to a person living in that area to distribute, 10 sets were taken to a church located in that area, and 10 sets were taken to a fast-food restaurant in that area. The one exception is the downtown area where only 22 scales were distributed, 10 in the food court area of a shopping mall and 12 at a large downtown business.

Since the sample consisted of individuals from all parts of the city, and the instrument was distributed in public places which drew from the entire population of that area, it can be claimed that the sample is acceptably representative for purposes of this study.

According to the demographic information, the sample consisted of 66 males (46.5%) and 76 females (53.5%). Only six (4.2%) had not finished high school. Twenty-six (18.3%) had completed high school, 45 (31.7%) had completed some college, and 65 (45.8%) were college graduates.

Distribution among the age groups was: 21 (14.8%) in the 18-25 years age group, 39 (27.5%) in the 26-35 years age group, 44 (31.0%) in the 36-45

years age group, 18 (12.7%) in the 46-55 years age group, and 20 (14.1%) in the over 55 age group.

Twenty-one of the subjects reported no contact with persons with mental retardation. Out of the 121 subjects who reported having had contact, 53 reported casual contact (no personal relationship), 30 reported having a family member with mental retardation, 17 reported having a friend with mental retardation, and 46 reported having worked with persons with mental retardation (either in paid employment or a volunteer setting). Forty subjects (28.2%) reported having had training in the area of special education.

Data Collection Procedure

Once the stratification process was completed and the five areas of the city identified, a systematic plan of distribution was developed. One contact person living in each area was identified and this person was asked to distribute 10 sets of attitude scales in his or her area. A church in each area was also selected, and 10 sets of scales were distributed and completed there. Finally, a fast-food restaurant in each area was selected and 10 sets of scales were distributed in each of these places. A slightly different procedure was followed in the downtown area. Ten sets of scales were distributed and completed in the food-court area of a shopping mall located downtown, and 12 sets were completed at a large downtown business.

The subjects were approached and asked to complete the set of attitude scales. They were asked to complete the scales at the time they were presented. The process took approximately ten minutes. The completed forms were then collected and scored.

Treatment of Data

After all the forms were completed and returned, the scales were scored using the procedure described by Osgood, et al. (1957). The raw data obtained were a collection of check-marks on seven-point bipolar scales. A score of seven was given to the positive end of the scale and a score of one was given the negative end. A person's score on an item was the digit corresponding to the scale position he or she checked.

The scores on the 20 individual items were then added together to form the score on the scale. Thus, each subject had three scores: one for the concept "Mentally Retarded Child," one for the concept "Mentally Retarded Young Adult," and one for the concept "Mentally Retarded Elderly Person."

All the individual scores of each of these concepts were then totaled, and the group responses to each of the three concepts were compared using *t* tests, using the five percent (.05) alpha level of significance.

Assumptions

The primary assumption made in this study is the assumption that the subjects responded honestly when presented with this attutude scale. It is assumed that their responses reflected their actual feelings and were indicative of their internal states. Another assumption involves the definition of "attitudes" used in this study. It is assumed that attitudes have both direction and intensity, and that they can be measured quantitatively.

It is also assumed that the subjects had an image of persons with mental retardation (not necessarily an accurate one) and that they had feelings about mentally retarded individuals.

Finally, it is assumed that the subjects understood the directions, and that they knew how to complete the scale so that their responses reflected their actual attitudes.

Limitations

There are some weaknesses in the procedure used to select subjects for this study. While the use of stratified sampling helped ensure that subjects were chosen from all parts of Omaha, the selection of subjects within each stratum was not random. There were attempts to be systematic in this selection process, but convenience and accessibility of subjects played a major role in the sampling procedure.

Another limitation is the fact that some of the subjects completed these scales in the presence of the investigator. This might have inhibited an honest expression of attitudes in cases where the investigator was known to the subjects.

Moreover, a study such as this is naturally limited by the items used on the instrument. Using a panel of experts in the field of mental retardation to assist in item selection was helpful. However, whether or not the particular items chosen actually measured attitudes is always open to discussion.

Chapter IV

DATA ANALYSIS

The 142 individual scores of each of the three concepts ("Mentally Retarded Child," "Mentally Retarded Young Adult," and "Mentally Retarded Elderly Person") were figured (see Appendices A-C for frequencies and ranges). These scores were then totaled and the group responses to each concept were compared using three *t* tests. Tables 1-3 list the results of the tests.

Table 1

t Test Comparison of Child and Adult Means

		Mean	Standard Deviation	N
child		100.25	17.97	142
adult		95.60	19.36	142
t statistic =	-4.7677			
Degrees of freedom =	141			
$p < .0001$				

The range of scores for "Mentally Retarded Child" was 49-140. The mean score for this group was 100.25 and the mode was 99. The scores for "Mentally Retarded Young Adult" ranged from 41-140, with a mean score of 95.60. This group was tri-modal, with modes of 75, 98, and 100. For the "Mentally Retarded Elderly Person" scale, the low score dropped to 20 (range = 20-140) and the mean dropped to 82.93. The mode for this group was 98.

Table 2

t Test Comparison of Child and Elder Means

		Mean	Standard Deviation	N
child		100.25	17.97	142
elder		82.93	23.55	142
t statistic =	-10.0580			
Degrees of freedom =	141			
$p < .0001$				

Table 3

t Test Comparison of Adult and Elder Means

		Mean	Standard Deviation	N
adult		95.59	19.36	142
elder		82.93	23.55	142
t statistic =	-10.8845			
Degrees of freedom =	141			
$p < .0001$				

In comparing the scores for the "Mentally Retarded Child" scale and the "Mentally Retarded Young Adult" scale, a *t* value of -4.7677 was computed. When the concept of "Mentally Retarded Child" was compared to "Mentally Retarded Elderly Person," a *t* value of -10.0580 was calculated. Thus, there was a larger difference between the attitudes toward mentally retarded children

and mentally retarded elderly persons than there was between attitudes toward mentally retarded children and mentally retarded young adults. This indicates that attitudes toward persons with mental retardation become increasingly more negative as the mentally retarded population ages.

Given the computed *t* values, there is clearly a significant difference between each of these groups, which supports the three hypotheses. Attitudes toward adult and elderly mentally retarded persons are significantly more negative than attitudes toward mentally retarded children, and attitudes toward elderly mentally retarded persons are significantly more negative than attitudes toward mentally retarded young adults.

Chapter V
SUMMARY AND CONCLUSIONS

Summary of Problem

The lifespan of persons with mental retardation is increasing, and mentally retarded persons of all ages are becoming increasingly visible in our communities. Because of this, a lifespan perspective is slowly pervading program planning and service delivery.

In order to do appropriate and effective planning for persons with mental retardation, it is important to know the attitudes of the surrounding community. This study was an attempt to address the question of attitudes toward mentally retarded individuals of different ages. Specifically, it attempted to answer the question: Are public attitudes different toward mentally retarded individuals of different age groups?

Summary of Procedures

The instrument used to measure attitudes in this study was a semantic differential instrument modeled after similar instruments used by Osgood and other researchers. Three attitude scales were developed. One measured attitudes toward the concept "Mentally Retarded Child," one measured attitudes toward the concept "Mentally Retarded Young Adult," and one measured attitudes toward the concept "Mentally Retarded Elderly Person."

The instrument was distributed to 142 subjects in a stratified sampling procedure. Each subject was asked to complete all three scales. Subjects were also asked to complete a "Personal Information Sheet." After the scales

were completed and returned, each one was scored. Each subject had three scores: one for the concept "Mentally Retarded Child," one for the concept "Mentally Retarded Young Adult," and one for the concept "Mentally Retarded Elderly Person." Finally, the individual scores for each concept were totaled, and the group responses compared using three *t* tests.

Findings

The mean score on the concept "Mentally Retarded Child" was 100.25. The mean for "Mentally Retarded Young Adult" was 95.60, and the mean for "Mentally Retarded Elderly Person" was 82.93. When *t* tests were performed on each of the three paired variables, significant differences were found.

The paired *t* test for for "Mentally Retarded Child" and "Mentally Retarded Young Adult" yielded a *t* value of -4.7677 and a probability of 0.0001. The paired *t* test for for "Mentally Retarded Child" and "Mentally Retarded Elderly Person" produced a *t* value of -10.0580 and a probability of 0.0001. The third *t* test compared "Mentally Retarded Young Adult" to "Mentally Retarded Elderly Person" and yielded a *t* value of -10.8845 and a probability of 0.0001. Given these scores, it is clear that there was a significant difference between each of the three paired groups. The three hypotheses were supported.

Conclusions

From these results, it was concluded that attitudes are different for mentally retarded persons in different age groups. Attitudes toward adult and

elderly mentally retarded persons are significantly more negative than attitudes toward mentally retarded children, and attitudes toward elderly mentally retarded persons are significantly more negative than attitudes toward mentally retarded young adults. Therefore, as a person with mental retardation ages, he or she can expect to encounter increasingly negative attitudes from the general public.

Discussion

One possible explanation for the more positive attitudes toward children with mental retardation than toward other age groups is that children are more visible in the community. Services for children with mental retardation are mandated by federal and state laws, and all children receive an educational program. This ensures a certain amount of visibility. Adults with mental retardation do not always receive services, and so are not necessarily visible to the public. Those who do receive services are usually found in a workshop or another segregated setting. Perhaps as adults with mental retardation become more visible, attitudes toward them will improve.

Mentally retarded children are often "cute" and usually non-threatening. Many of the common myths and stereotypes (for example, "Angel Unaware," "Eternal Child," "God's Very Special Child") are seen as positive when applied to children. However, when these children grow up, they are no longer "cute" and their behavior which was acceptable as children is no longer acceptable. This may partially explain the more negative attitudes toward adults with mental retardation.

Children with mental retardation are most often found in a school setting, which is the "normal" setting for children. They blend in with their non-handicapped peers. Adults with mental retardation, on the other hand, are most often found in a segregated setting. As more memntally retardedadults are placed in competitive employment and in more "normal" adult settings, perhaps the public will begin viewing them more positively.

Since public attitudes toward non-retarded aged and aging people are largely are largely negative, it is no surprise that attitudes toward the mentally retarded elderly population would also be negative. As the image of old people improves, it is to be hoped that attitudes toward mentally retarded old people will also improve.

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Appendix A

Appendix A

Frequency and Range of Scores for "Mentally Retarded Child"

49	1	91	3	112	3
52	1	92	1	113	4
56	1	93	1	115	2
57	1	94	5	116	3
62	1	95	5	118	1
63	1	96	2	120	5
67	1	97	2	121	1
71	1	98	4	122	1
73	2	99	8	123	4
75	1	100	5	124	2
77	1	102	4	125	2
78	1	103	2	126	1
80	4	104	1	127	1
83	1	105	3	128	2
84	5	106	1	131	1
85	2	107	3	133	1
86	2	108	2	136	1
87	3	109	4	137	1
88	5	110	2	138	1
89	4	111	4	140	1
90	3				

Appendix B

Appendix B

Frequency and Range of Scores for "Mentally Retarded Young Adult"

41	1	86	4	110	1
43	1	87	4	111	1
54	1	88	2	112	2
55	1	89	2	113	2
56	1	90	3	114	4
58	1	91	3	115	1
60	1	92	2	116	2
63	1	93	3	117	2
64	1	94	1	118	2
65	1	95	1	119	2
73	1	96	4	120	2
74	1	97	3	121	1
75	6	98	6	124	2
76	3	99	4	125	1
77	2	100	6	126	1
78	2	101	5	127	2
79	2	102	3	130	2
80	4	103	1	131	1
81	5	105	2	132	1
82	1	106	1	133	1
83	3	107	2	137	1
85	2	108	3	140	1

Appendix C

Appendix C

Frequency and Range of Scores for "Mentally Retarded Elderly Person"

20	1	69	3	98	8
32	1	71	3	100	1
38	1	72	2	101	2
41	1	73	1	102	2
46	2	74	1	103	1
47	3	75	1	104	2
50	2	76	3	105	2
51	2	77	5	106	4
52	2	78	1	109	2
53	1	79	4	110	1
55	3	80	5	111	1
56	1	81	2	112	2
57	1	86	3	115	1
58	1	87	3	116	2
59	2	88	2	118	1
60	4	89	2	120	2
62	2	90	3	123	1
63	2	91	4	124	1
64	3	92	2	128	2
65	5	94	1	131	2
66	1	96	5	136	1
68	1	97	2	140	1

Appendix D

Directions:

The purpose of this study is to measure attitudes toward persons with **mental retardation** at different ages. There are three sets of scales: one measures attitudes toward **children** with mental retardation, the second measures attitudes toward **adults** with mental retardation, and the third measures attitudes toward **elderly people** with mental retardation.

Look at the concept at the top of the page. Then look at the adjective pairs. Put an "**X**" in one of the seven spaces between the paired adjectives, depending on how well either adjective describes your feelings about the concept. For example, your feelings toward "Mentally Retarded Child" could fall on "good" or "bad" or on any of the spaces in between. Please be honest and express your real feelings.

Do not go back over the items. Do not try to remember how you checked similar items earlier in the test. Make each item a separate and independent judgment. Go through this test fairly quickly. Do not stop to puzzle over individual items. What I want are your first impressions, your immediate "feelings" about the items. Be sure you mark every scale for each concept -- do not omit any. Never put more than one mark on a single scale.

PERSONAL DATA SHEET

1. Have you ever had contact with a person with mental retardation?

_____ yes _____ no

2. If "yes," please check any of the following which describe the contact:

_____I have had contact, but do not know anyone with mental retardation personally.

_____I have an immediate family member who is mentally retarded.

_____I have a relative (but not a member of my immediate family) who is mentally retarded.

_____I have a friend who is mentally retarded.

_____I have worked with mentally retarded persons (volunteer or paid)

3. Please indicate your age range:

____18-25 ____26-35 ____36-45 ____46-55 ____over 55

4 Sex: _____male _____female

5 Educational level: _____below high school level

_____high school graduate

_____some college

_____college graduate or above

6. Have you ever taken any college courses in special education or had any training in this area?

_____yes _____ no

MENTALLY RETARDED CHILD

1.	good	___	___	___	___	___	___	___	bad
2.	beautiful	___	___	___	___	___	___	___	ugly
3.	clean	___	___	___	___	___	___	___	dirty
4.	active	___	___	___	___	___	___	___	passive
5.	strong	___	___	___	___	___	___	___	weak
6.	useless	___	___	___	___	___	___	___	useful
7.	quarrelsome	___	___	___	___	___	___	___	congenial
8.	valuable	___	___	___	___	___	___	___	worthless
9.	cruel	___	___	___	___	___	___	___	kind
10.	unpleasant	___	___	___	___	___	___	___	pleasant
11.	unsociable	___	___	___	___	___	___	___	sociable
12.	awkward	___	___	___	___	___	___	___	graceful
13.	successful	___	___	___	___	___	___	___	unsuccessful
14.	important	___	___	___	___	___	___	___	unimportant
15.	dishonest	___	___	___	___	___	___	___	honest
16.	agitated	___	___	___	___	___	___	___	calm
17.	healthy	___	___	___	___	___	___	___	sick
18.	happy	___	___	___	___	___	___	___	sad
19.	insane	___	___	___	___	___	___	___	sane
20.	insensitive	___	___	___	___	___	___	___	sensitive

MENTALLY RETARDED YOUNG ADULT

1.	useless	___	___	___	___	___	___	___	useful
2.	quarrelsome	___	___	___	___	___	___	___	congenial
3.	clean	___	___	___	___	___	___	___	dirty
4.	active	___	___	___	___	___	___	___	passive
5.	strong	___	___	___	___	___	___	___	weak
6.	good	___	___	___	___	___	___	___	bad
7.	valuable	___	___	___	___	___	___	___	worthless
8.	beautiful	___	___	___	___	___	___	___	ugly
9.	cruel	___	___	___	___	___	___	___	kind
10.	important	___	___	___	___	___	___	___	unimportant
11.	unsociable	___	___	___	___	___	___	___	sociable
12.	awkward	___	___	___	___	___	___	___	graceful
13.	successful	___	___	___	___	___	___	___	unsuccessful
14.	unpleasant	___	___	___	___	___	___	___	pleasant
15.	dishonest	___	___	___	___	___	___	___	honest
16.	insane	___	___	___	___	___	___	___	sane
17.	healthy	___	___	___	___	___	___	___	sick
18.	happy	___	___	___	___	___	___	___	sad
19.	agitated	___	___	___	___	___	___	___	calm
20.	insensitive	___	___	___	___	___	___	___	sensitive

MENTALLY RETARDED ELDERLY PERSON

1.	valuable	___	___	___	___	___	___	___	worthless
2.	dishonest	___	___	___	___	___	___	___	honest
3.	clean	___	___	___	___	___	___	___	dirty
4.	active	___	___	___	___	___	___	___	passive
5.	strong	___	___	___	___	___	___	___	weak
6.	good	___	___	___	___	___	___	___	bad
7.	useless	___	___	___	___	___	___	___	useful
8.	beautiful	___	___	___	___	___	___	___	ugly
9.	cruel	___	___	___	___	___	___	___	kind
10.	healthy	___	___	___	___	___	___	___	sick
11.	unsociable	___	___	___	___	___	___	___	sociable
12.	awkward	___	___	___	___	___	___	___	graceful
13.	successful	___	___	___	___	___	___	___	unsuccessful
14.	unpleasant	___	___	___	___	___	___	___	pleasant
15.	quarrelsome	___	___	___	___	___	___	___	congenial
16.	insane	___	___	___	___	___	___	___	sane
17.	important	___	___	___	___	___	___	___	unimportant
18.	happy	___	___	___	___	___	___	___	sad
19.	agitated	___	___	___	___	___	___	___	calm
20.	insensitive	___	___	___	___	___	___	___	sensitive