



RTC/IL MONOGRAPHS IN INDEPENDENT LIVING

**A Social
Psychological
Perspective**

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Abstract: Frederick Gibbons examines the social experiment of independent living from an experimental social psychological perspective. First, Gibbons writes, there is the relevant theoretical work that emphasizes the basic human need for independence. At the same time, important individual differences in this general need and problems will likely be produced by the movement. Finally, research, some that has already been done and some that still needs to be done will be guide to the movement's problems and solutions. Control, the ability to determine what happens to us, is at the heart of the independence movement. To live independently means having as much control over one's life as one is capable of having. In this respect, independence can be thought of as the freedom to make fundamental behavioral decisions that have immediate and long-term effects on the direction of one's own life. One such freedom, and it is an important one, is the right to determine how much independence one wants.

Perhaps the best way to illustrate the importance of this concept is to talk about what happens when we believe we do not have control over our lives. There is a strong relationship between the recognition of personal control and mental health. In particular, it appears that perceived loss of control is very disturbing and can lead to severe psychological and physical problems.

Mildly depressed people, for example, often feel that they are losing control over their environment. In other words, they feel that what they are doing is having very little influence over what happens to them. Typically, this process occurs gradually, sometimes over a period of years, with seemingly minor events (such as a poor grade or failure to get a promotion at work) having cumulative effects. If the process continues unchecked, the person can enter what Seligman has called a state of learned helplessness, which is characterized primarily by severe depression together with a surrendering of all hope of regaining control.

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PREFACE by Lex Frieden

The question is often asked, "What are the long term goals of severely disabled people?" The answer is, more likely than not, that the goals of persons with severe disabilities are generally the same as those for anyone else. Most people want to have a family, a home, a car, a job, and recreational opportunities.

Some rehabilitation professionals, friends, and family members once discouraged persons with disabilities from adopting or seeking these goals. Severely disabled people were led to believe that these goals were unrealistic and impossible to reach and that they should be satisfied and happy to be alive. Little hope was given for disabled people to achieve near-normal lives. In fact, the general public's expectations of life for people with disabilities could have been weighed on a different scale of normality from their own. What was considered a normal lifestyle for the general population was not considered normal for those with severe disabilities. As a result, many disabled persons adopted restricted goals and lowered expectations. Sometimes, even hope for a better life was buried so deep that it could not be resurrected.

During the late 1960s and early 1970s, a new concept related to rehabilitation and improvements in quality of life began to emerge and to be expressed by persons with disabilities. This concept, called Independent Living, was at first a reaction to repression. Some disabled people felt their lives were unnecessarily restricted by their disabilities. They acknowledged that barriers everyone faces to reach independence were further complicated by disability, but they believed those barriers could be overcome. They felt that supportive programs could be established and that environmental accommodations could be made to allow them to have opportunities and seek goals open to the general public. They rejected the notion, often expressed by professionals, that they should be confined to institutional care. They rejected the assumption that they had fewer rights than non-disabled people, and they rejected the idea that the government's obligation to them was limited by their disability.

Persons with disabilities began to assert themselves in public forums. They organized and formed lobbying groups. They claimed equal rights as citizens to public services like transportation, housing, education and employment, and they demanded the right to vote. Although most of these rights were not denied intentionally or directly, they were indirectly denied by virtue of the fact that public transportation was inaccessible, as were housing, schools, businesses, public offices, and polls.

From the concept of independence, a movement² emerged to overcome the barriers to a higher quality of life for disabled people. This movement was joined by disabled people, family members, friends, neighbors, politicians, opinion leaders, rehabilitation professionals, policymakers, and others throughout society. The movement led to new laws asserting equality and protecting the rights of disabled people. It led to new or adapted accommodations that made housing, trans-

portation, public places, schools, and job sites accessible to persons with disabilities. It led to new, more positive attitudes by the general public toward persons with disabilities and to new attitudes of disabled people toward themselves. Perhaps most important of all, it led to new opportunities for severely disabled people to seek independence, to enjoy the benefits of their labors, and to enjoy the high standards and quality of life that society offers (Frieden, 1978).

As a result of the independent living (IL) movement and the changes that have occurred during the past few years, individuals with disabilities can now realistically seek goals that once were limited to those without disabilities. In fact, the limits imposed by severe disability may be less important in determining the achievements of one's goals than certain other demographic and socioeconomic variables that are not related to a disability.

The principal barriers to achieving goals of independence may be categorized into three groups. They are environmental, personal, and economic. Environmental barriers are those that are independent of and beyond immediate control of the individual. Examples are curbs, steps, and narrow doorways. Personal barriers to independence relate directly to the individual and, more likely than not, can be changed. Personal barriers include negative attitudes, low self-esteem, feelings of dependence, unreasonable insecurity, unwillingness to take risks, preoccupations with cure, lack of ability to organize and plan, poor self-image, and unnecessarily limited expectations and goals. Economic barriers are those that relate to an inability to purchase needed equipment, supplies, and services. Economic barriers may confound one's ability to overcome both environmental and personal barriers by restricting the range of possible solutions.

Solutions to overcoming barriers to independence exist now more than ever before. For overcoming environmental barriers, one may purchase or make adaptive equipment and devices. For example, high-level quadriplegics may purchase electrically powered wheelchairs controlled by slight movements of the chin or by sipping and puffing into a straw. Also available are sophisticated remote control devices and primitive robots. In addition to solutions that are customized and suitable for individuals, there are also more general and systematic solutions. These include mandated use of mass transportation vehicles made accessible by widening doorways, expanding seating areas, and installing ramps or lifts. They also include community-wide efforts to install ramps on curbs and to provide access to both public and private buildings. Solutions like these to overcoming environmental barriers are now widespread, and continued advocacy efforts are leading to more solutions each day.

With respect to personal barriers, there are several possible solutions. Rehabilitation counselors, psychologists, social workers, and other professional human service providers can help a person to analyze and overcome personal barriers. Peer counselors can share information, serve as role models, and provide necessary support. Family members and friends can give encouragement and help. Finally,

on the personal level, self-determination, self-encouragement, self-control, and simply the passage of time can be instrumental in resolving personal barriers. On a broader scale, positive attitudes and expectations on the part of the general public, as well as realistic portrayals of disabled people by the mass media, would serve the same purpose.

Economic barriers may be the most difficult to overcome and the most important, since they can affect solutions to the other two types of barriers. Most people must depend on private and public insurance, private and public aid, and/or their own ability to work and earn money in order to overcome economic barriers. Independence costs more for disabled people than it does for non-disabled people, because, in addition to the normal expenses of housing, transportation, food, clothing and routine medical care, people with disabilities have expenses for adaptive equipment, medical supplies, and attendant care. The economic barriers to independence for disabled people are frequently complicated by the fact that in order to be independent, most people need a job. In order to have a job, however, they need to be reasonably independent.

Individual solutions to overcoming economic barriers are typified by the case of a person who receives housing subsidies to help pay for housing, vocational rehabilitation agency grants or subsidies to help pay for educational or work-related expenses, welfare or human service agency subsidies to help pay for attendant expenses, and work income or Supplemental Security Income payments to cover the balance of other expenses. More general solutions to overcoming economic barriers may be legislated in the form of a nationalized health insurance program, a nationwide attendant care or home health care program, or the establishment of a nationwide system for purchase and distribution of equipment and devices for disabled people.

During the past decade, a unique type of human service program has emerged to assist people with disabilities to reach their goals of independence. Independent living programs, which have been established since the independent living (IL) movement began and subscribe to the tenets of the IL philosophy, are located in at least one community in every state. Altogether, there are currently about 200 IL programs and service providers in the United States (Frieden & Veerkamp, 1984). These community-based programs are unique, because they are generally run by or managed in large part by consumers-- disabled people themselves. They provide a variety of services, including housing referral, attendant care referral, information about goods and services provided by other agencies, peer counseling, transportation, equipment repair, independent living skills training, and advocacy. Their goal is to assist severely disabled people by increasing self-determination and minimizing unnecessary dependence on others.

In the early 1970s, IL programs were viewed as experiments in community living by severely disabled individuals. By 1978, these programs had demonstrated an unmatched ability to help disabled people live comparatively independent lives in their communities. As a result

of their effectiveness, Public Law 95-602, the Rehabilitation Act Amendments of 1978, included a section (Title VII) authorizing federal support for IL programs. With this support, the independent living movement blossomed, and many new programs were established (Frieden, Widmer, & Richards, 1983). Although political and economic contingencies make the future of IL programs difficult to predict, there is no doubt that these programs have contributed to a "coming out" of severely disabled people all over the United States.

Independent living has developed as both a concept and a programmatic thrust affecting the lives of thousands of severely disabled people and many more family members, co-workers, and friends. Conceptually, independent living asserts that all who can should be encouraged to make important decisions that affect their own lives. The theory of independent living, however articulated, affirms every person's right to choose from among available options where to live, work, and worship, what to eat and wear, and with whom to associate. The theory also suggests that society has the responsibility to facilitate the independence of its disabled members by providing physical access to the environment and needed supportive services (Frieden, 1981).

The IL movement has made great progress helping society to recognize and meet its responsibility to facilitate independence by its disabled members. Many people who only a few years ago were living in their parents' homes or in institutions because of their disabilities are now living in the community. They are assuming responsibility for directing their own lives and making significant contributions to improving the quality of life for us all. Nevertheless, there are many thousands of disabled people who have yet to realize dreams of independence and self-determination. In order to help them reach their goals, it is necessary to continue developing new programs, explore new ways of facilitating independence, and address issues of policy, programming, and individual adjustment to disability.

Many important issues related to the concept of independent living and to the barriers that inhibit progress toward independence are discussed in the *RTC/IL Monographs in Independent Living* series. The multidisciplinary approach is vital to reach the kinds of synergistic and catalytic solutions needed to facilitate independence by those people who desire it. This second monograph, *A Social Psychological Perspective*, uses innovative psychological research on independence and mental and physical health to extend and clarify independent living philosophy.

To those of us who are researchers or academicians, application of the concept of independence to people with disabilities is intellectually stimulating and challenging. To those of us who are practitioners in the field of rehabilitation or in other areas of human service, the idea of independent living by people with disabilities is imaginative and promising. Finally, to those of us who are disabled, independence is a goal that we believe is justifiable and worth making great sacrifices to achieve.

Footnotes

1. **Independent Living (IL):** Control over one's life based on the choice of acceptable options that minimize reliance on others in making decisions and in performing everyday activities. This includes managing one's affairs, participating in day-to-day life in the community, fulfilling a range of social roles, making decisions that lead to self-determination, and minimizing physical or psychological dependence on others (Frieden, Richards, Cole, & Bailey, 1979).

2. **Independent Living Movement (IL):** The process of translating into reality the theory that, given appropriate supportive services, accessible environments, and pertinent information and skills, severely disabled individuals can actively participate in all aspects of society (Frieden et al., 1979).

3. **Independent Living (IL) Program:** A community-based program that has substantial consumer involvement. It provides direct or indirect services necessary to assist severely disabled individuals to increase self-determination and minimize unnecessary dependence on others (Frieden et al., 1979).

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A Social Psychological Perspective

by Frederick X. Gibbons

In a chapter on social attitudes among white and minority children, David Rosenfield and Walter Stephan (1981) suggested that forced integration is "America's most important social experiment." They say this because of the way racial desegregation and integration were implemented in this country, especially busing. For the most part, the procedure has been to initiate a new policy and **then** find out whether it is effective and what effects it has on the children who are participating in the change. In many respects, the independence as well as the normalization movements among persons with disabilities has developed in a similar manner. Like integration, they are also social programs that have been instituted quickly in an attempt to improve an unacceptable social situation. Like busing, they are also social experiments that can and will have a tremendous impact on those involved in them.

The learn-from-experience approach to social programs causes difficulties for service consumers and confusion for service providers. Nevertheless, as was the case with many black leaders and student activists in the 1960s and early 1970s, the message presented by many disabled persons is clear. They want independence--as much and as soon as possible--and they are not willing to adopt a wait-and-see attitude while social scientists or policy planners experiment with conservative implementation methods. The programs are here, they will continue to increase in number, and they are going to affect thousands of persons and cost millions of dollars. In the meantime, it is essential that we direct some of our attention to program evaluation. What we have in the independent living movement is a social experiment of tremendous importance but little or no data to either understand how it works or evaluate its effectiveness. I want to argue here that if we take an empirical look at social interaction within the independent living (IL) movement, we may be able to see how these programs function and, therefore, how they might be validated and improved.

In this second monograph in the RTC/IL Monographs in Independent Living series, I examine the social experiment of independent living from an experimental social psychological perspective. I touch on a number of divergent but related topics. First, there is the relevant theoretical work that emphasizes the basic human need for independence. This is the fundamental postulate of my argument. At the same time, there are important individual differences in this general need and problems that are likely to be produced by the movement. Finally, there is the research, some that has already been done and some that still needs to be done, to provide information on how some of the inevitable problems might be met. Throughout the monograph, evidence from the literature is discussed to suggest what kind of an effect independence and the freedom that comes with it are likely to have on those who are directly and vicariously involved in the

independent living movement. Although very little of this research is concerned specifically with independence per se, it is all-applicable to this topic and the issues that are a part of it. The first such issue is the most basic: the need for independence.

Perceptions of Independence and Health

The concept of behavioral independence is something psychologists have been examining for quite some time. There has been a definite resurgence of interest in the last 6 or 7 years, due, in large part, to the pioneering work of Martin Seligman (1975) and others in the areas of learning and clinical psychology. At the same time, there has been renewed interest among social psychologists in a related topic--the concept of control.

As defined by psychologists, control refers to the ability to determine, at a very basic level, what happens to us--in other words, the ability to affect our environment, including the persons in it, while it, in turn, affects us. This concept of control is really at the heart of the independence movement. To live independently means having as much control over one's life as one is capable of having. In this respect, independence can be thought of as the freedom to make fundamental behavioral decisions that have immediate and long-term effects on the direction of one's own life. One such freedom, and it is an important one, is the right to determine how much independence one wants.

Perhaps the best way to illustrate the importance of this concept is to talk about what happens when we believe we **do not** have control over our lives. There is a strong relationship between the recognition of personal control and mental health. In particular, it appears that perceived **loss** of control is very disturbing and can lead to severe psychological and physical problems. Mildly depressed people, for example, often feel that they are losing control over their environment. In other words, they feel that what they are doing is having very little influence over what happens to them. Typically, this process occurs gradually--sometimes over a period of years--with seemingly minor events (such as a poor grade or failure to get a promotion at work) having cumulative effects. If the process continues unchecked, the person can enter what Seligman has called a state of learned helplessness, which is characterized primarily by severe depression together with a surrendering of all hope of regaining control.

Helplessness occurs as a result of frustration. What usually happens is that the person tries repeatedly to reach some goal or change some behavior, but to no avail. Trial after unsuccessful trial eventually leads the individual to the conclusion, "There is nothing I can do to help myself, so why bother?" Worse yet, repeated failure at one (important) task can lead to a generalized state of resignation in which the person stops trying altogether. The helpless individual may stop caring for him or herself and become physically ill. This is a very severe psychological state, which, fortunately, does not appear to be common. However, laboratory research has indicated that milder

forms of the same psychological state are quite common and are also associated with a general decline in motivation and effort and various types of psychogenic illnesses (e.g., Pennebaker, 1982).

Control and Effort

Some examples from the research literature might help clarify this point and further define the concept of control. Carol Dweck (1978) has demonstrated in her work with non-disabled children that they will manifest mild symptoms of helplessness in response to certain types of attributional feedback (i.e., explanations for behavior) from their teachers. For example, when their failures at cognitive or artistic tasks are consistently attributed to low ability, children are likely to start believing that their efforts are not going to make much of a difference and, therefore, that their outcomes are uncontrollable. When this happens, they lose what psychologists call a sense of effectance, or the feeling that they are doing something and getting something accomplished. As a consequence, their subsequent performance declines, sometimes drastically. In contrast, when children are told that their failure is due to insufficient effort (rather than the fact that they have no ability), the message to them is that improvement and success are possible, given their level of ability, if they will continue to try. Under these circumstances, they are very likely to increase their efforts and improve. In general, the more children or adults are led to believe that they can control their environment and what happens to them, the more they will actually try to exert control. However, if they perceive that they do not have the ability to affect the contingency between behavior and outcome, their motivation will decline, and some will eventually give up.

It is important to point out here that it is the person's **perception** or subjective impression of how much control he or she has that determines how much effort to exert. It is quite possible that a teacher or staff member may believe that a particular child or client is almost totally helpless, whereas the individual feels otherwise. For some people, control over simple day-to-day activities may be sufficient to keep their motivation level up, while for others even this basic level of control may not be considered necessary or important. Thus, a feeling of control at some level is essential for mental health, but that level can vary, sometimes, considerably, from one person to the next. In fact, individual differences in needs for independence and reactions to it constitute an important topic with many implications for service delivery.

Control and Disabled Persons

Work (similar to that of Carol Dweck's) by John Weisz with a disabled population has produced comparable results. He found that mentally retarded children, like non-retarded children, would drastically reduce their efforts if they were told that they have not done well on some task because they do not have much ability. They will also increase their efforts, if they are

led to believe that they do have control (ability) but have not exerted it enough. Unfortunately, Weisz also found evidence that this was not always the case among older retarded children. Adolescents behaved in a manner that reflected feelings of learned helplessness, but only after they had failed. Reactions to failure are particularly important. As Weisz (1979; 1981) suggests, years of experience with feedback indicating that failure is due to uncontrollable factors, primarily low ability, can seriously damage the child's motivation and cause the child to feel that further effort is pointless. After all (from the child's perspective), why try if others, especially teachers, are telling you that it doesn't make any difference anyway? Once this point has been reached, the child--like the adult, for that matter--will become much more dependent on others, and learning will become difficult if not impossible. Moreover, the damage takes a long time to repair, and considerable effort may be required to convince the person once again that more effort can result in success. What all of this suggests, then, is that teachers and others working with children who are disabled need to pay attention to the feedback they provide. Every attempt should be made to avoid the long-term debilitating effect that low ability attributions can have on motivation. Attention should be focused instead on what is possible through increased effort. Moreover, environments should be structured so that long-term low ability attributions can be replaced with others more likely to promote effort.

Perhaps the most dramatic demonstration of the influence of behavioral control on mental and physical health can be found in a series of studies with older persons by Langer and Rodin (1976) and by Schulz and Hanusa (1978). They examined the effects of a very simple intervention to increase feelings of perceived control among several groups of nursing home residents by assigning more responsibility to them. Experimental subjects in the research by Langer and Rodin (1976) heard a talk by staff members that placed considerable emphasis on the amount of independence the residents had and on the fact that they were the ones who were primarily responsible for their own well-being. The talk heard by the control group suggested that staff members were the ones who were responsible for residents' care.

There was one other manipulation--again, a simple one: Experimental subjects were given a houseplant that they were supposed to care for, whereas control subjects' plants were tended by the staff. As basic as this intervention may seem, it had impressive results. The self-responsible group reported that they were happier than the other-responsible residents, and they were rated by the staff as more sociable and more vigorous. However, the most impressive finding was that a follow-up analysis revealed that the latter group actually lived significantly longer than did the low-control group!

Many ILCs practice a similar type of control intervention in which consumers are given some say about the services they receive. This may range from some simple participation in the decision as to

when and where attendant care is provided up to allocating funds to individuals so they can arrange for payment of their own care or services. Arrangements of this type do foster a sense of control or effectance among clients of ILCs as well as nursing homes and institutions and are likely to promote adjustment and mental health. Moreover, these interventions tend to be easy to implement and relatively cost-effective, because the consumer takes responsibility for the supervision and coordination of his or her own services and also because the consumer can tailor the services to his or her own needs. This reduces duplication and waste. In general, with some constraints (see below), the more control consumers have, the more independent they are likely to feel and the more adaptable they will be.

A word of caution has been given by Schulz and Hanusa (1978). They conducted a similar intervention with nursing home residents in which residents were given control over visiting schedules of student volunteers. There was evidence of significant improvement in psychological outlook within the experimental group. But several months after the intervention had been terminated, the high-control group had shown more psychological decline than had the no-control group. In other words, gaining some control over this seemingly trivial aspect of their lives and then losing it seemed to have a devastating effect on them.

Schulz and Hanusa suggest that long-term effects of the intervention were not favorable, because participants may not have believed they actually had been given control over this aspect of their lives.

Instead, they believed that control really remained with the administration, because administrators were responsible for initiation and termination of the intervention itself. In a sense, this may have caused the process to backfire.

Loss of Control

One point made clear by the Schulz and Hanusa research with nursing home residents is that it is more damaging psychologically to believe that one has some degree of control or behavioral freedom and then to lose it than it is to think that one has never had control in the first place. In fact, this is the central thesis of a chapter by Camille Wortman and Jack Brehm (1975) on the general topic of behavioral control. They argue that there is often a two-step response to a severe loss of an important behavioral freedom. As might be expected, the first reaction is characterized by increased attempts to restore the freedom; the second step, however, is the opposite. The individual begins to realize that he or she has lost freedom and that there is little or nothing to do about it. It is this second step that leads to feelings of resignation and learned helplessness.

This monograph is based on Brehm's earlier theory of psychological reactance (1966). The theory suggests that when a person perceives that he or she is losing the freedom to perform a particular behavior (e.g., deciding where one wants to work or live), that

individual will react by trying to regain the freedom. At the same time, the attractiveness of the behavior increases sharply for the person. Bream (Bream, 1966; Brehm & Brehm, 1981) states that there are two prerequisites for reactance to occur: a) The behavior and the freedom to perform that behavior must be important to the individual; b) The individual must believe that he or she actually had the freedom to perform the behavior at one time. Psychological reactance is not likely to occur if the individual believes either that he or she was not free or able to perform the behavior in the first place, or if the individual was not aware that the freedom existed.

Unfortunately, Brehm's theory has never been applied to situations in which an individual perceives that others possess freedoms that they themselves have been unable to develop.

In particular, the question of the extent to which disabled people desire to assert behavioral freedoms that others have but that they do not have remains, for the most part, unanswered. The theory does suggest, however, that once the individual believes that a particular type of freedom is *potentially* available, any limits or restrictions placed on that potential lead to increased efforts to assert the freedom. In an independent living situation, it would be expected that once a disabled person becomes aware of the types of freedom that are associated with independent living, this awareness should increase the person's desire to achieve those freedoms. In short, the movement may act as its own impetus, necessarily attracting more and more consumers as its public visibility increases. Also, once the freedom of independence is recognized and experienced by persons with disabilities, they are likely to react very strongly against attempts to place restrictions on that freedom, including proposed cuts in funding and/or legislation that is thought to be restrictive.

Summary

Brehm's theory and the work of Wortman and Brehm are particularly appropriate to a discussion of independent living. Their research, together with that of Seligman and his colleagues, indicates that people have a need for behavioral freedom as well as control, and they will react against any attempts to restrict that freedom. Such a reaction is initially constructive and of benefit to the individual's psychological health. In contrast, the individual who perceives that there is **nothing** that can be done to reassert behavioral freedom may begin to feel a lack of control and enter a state of helplessness and hopelessness. This severe reaction is likely for people who believe that they once had, but have now lost, all control of behavioral freedoms.

One last point on this issue should be mentioned. Seligman has suggested that one way to counteract this depressed state is to strongly encourage individuals to attempt new behaviors that are guaranteed to be effective. This demonstrates to them that there is something they can do to help themselves.

Once they realize this, they should be able to resume the learning process. Of course, there are some limits to this approach.

It would be pointless to demand that an individual attempt new behaviors--one person cannot force motivation on another. Nonetheless, demonstrating that people are capable of performing many of the functions that are a part of independence --and that could require a considerable amount of encouragement--might be sufficient to convince them to try. For many people, the primary obstacle to complete independence may be the psychological barrier that comes with lack of familiarity or simply lack of awareness of what can be done. For various reasons, the freedoms of persons with disabilities may be restricted simply by the fact that they are unaware of how much independence is actually available to them. Once they become aware of what independence means, ideally from demonstrations by others with disabilities who are living independently, this barrier might be overcome. This careful demonstration is also likely to inhibit the attribution process that promotes helplessness (cf. Weisz, 1981).

Differences in the Desire for Independence

One aspect of independence seems to be universal. The need for control in one form or another appears to be basic to human nature. When it is lost, the individual often suffers definite, sometimes severe negative consequences psychologically. Because there are consistencies in responses to loss of control does not mean that the need itself is consistent from one person to the next. On the contrary, research suggests that there are large individual differences in both the need for freedom and control and in reactions to independence. These differences are a function of a number of characteristics of the individual, the most important of which are his or her previous experiences with independence and freedom. Persons with disabilities vary enormously. Some have experienced almost total freedom in the past, some hardly any. Some disabilities might severely limit some people's expression of independence, while other people have no obvious restrictions. In short, there is an incredible range in the independent living movement, and no one program or policy will effectively serve the needs of everyone involved. To better understand this diversity of needs, it is necessary to examine the background of the consumer.

In a provocative work entitled *Asylums*, Goffman (1963) talks about the kind of environment that existed in institutions and many hospitals throughout the early 1960s. He uses the term total institution to refer to places where the individual surrenders virtually all sense of responsibility to the hospital and its staff members. As a result, residents become almost totally dependent on the institution for day-to-day functioning, sometimes to the point where they may refuse attempts to increase the control they have over their lives and even grow reluctant to leave the institution when it comes time to do so. Institutions have changed noticeably in the last 20 years, but this type of dependency problem is likely to remain prevalent as long as the emphasis on de-institutionalization is maintained. Although it is difficult to understand why a person would actually reject independence when offered, some insight into this question is found (once again) in theoretical work by Brehm.

Brehm and his students have been actively engaged in research into his theory of motivational suppression (Brehm, 1982). The theory is similar to reactance and, in fact, has its roots in the cognitive consistency theory tradition (Brehm & Cohen, 1962).

They suggest that the amount of motivation or what Brehm calls energization an individual invests in attaining a particular goal, and also the actual **attractiveness** of that goal, are both functions of the person's perceptions of his or her ability to attain it. If someone believes that a goal is within his or her reach but realizes that achieving it will require considerable effort, chances are high that effort will be expended, and the goal will take on new and added value. However, an object or behavior that is thought to be easily reached is not seen as particularly attractive, and relatively little energy is put into achieving it. Similarly, a goal thought to be impossible to achieve is devalued, and the energy that might have been invested in reaching it is suppressed.

This concept is relevant to a discussion of restrictive environments and independence. For example, it suggests that an institutionalized person or a disabled person living at home who has spent many years in a highly dependent living situation might firmly believe that independence is beyond his or her reach. Indeed, as Goffman has suggested, independent behavior is often discouraged in these settings. Consequently, the person living in an institution or in any other dependent living situation may very well decide dependence is a way of life--the only life available. People who feel this way are likely to suppress any desire to achieve independence, thus substantially reducing the appeal of freedom. When it comes time to leave the institution or family, they are psychologically unprepared for the community and have convinced themselves that they do not want independence and are not prepared to invest any energy to achieve it.

An analogous situation is described in a paper by Averill (1973). He suggests that sometimes believing that one has control over one's environment might be stressful. The reason is that being able to control various factors that influence one's life places pressures on the individual to perform or perhaps overcome adversity. Fromm (1941) refers to this as the burden of freedom. That pressure can be very difficult to handle. First of all, there is the risk of failure and the damage that both worrying about the failure and the failure itself can cause. With freedom comes responsibility. The more control people have, the more responsibility they must accept for the consequences of their behavior. And even if the person is successful, it could appear that the reward does not outweigh the cost of the effort or the concern that possible failure has promoted. In general, the stress appears to be a function of how important the person thinks the control is and how extensive the consequences of failure are anticipated to be. Once again, the difficulty produced by this stress is likely to vary from one person to the next.

Without data, it is difficult to predict how individuals react to the stress that accompanies independence. An important factor is the

person's previous history with independent or non-independent living environments. Individuals who perceive that they once had control and have given it up will experience a strong need to reassert that freedom, presumably in a nonrestrictive environment.

On the other hand, persons who have lived most of their lives in a dependent living environment or an institution may have experienced independence only vicariously. They may not be fully aware of what independence really means and may not want freedom and the problems that come along with it—at least not right away. Even if such people are capable of living independently, they may feel that the stress associated with freedom outweighs the benefits. Regardless of their capabilities, if they have suppressed the desire to have control, they will not exert the effort required to have an independent existence. Under these circumstances, immediate independence could be more harmful than helpful.

In this situation, the first step toward resolution might be to convince clients that they are capable of accepting more responsibility by encouraging attempts at new behaviors in a transitional environment. Thus, a program of service delivery that effectively eases clients into supportive independent-type environments may be preferable, especially for persons who have been institutionalized for a long time, individuals who are mentally retarded, or those who have had no previous experience with behavioral and decisional freedom.

The Client in the Community

As the independent living movement gains momentum, the visibility of persons with physical and mental disabilities in community settings will increase as will the amount of contact they have with members of the community. How will community members respond to a growing group of disabled people who are living in the community? This continues to be very important question from the perspective of policy planners, advocates, consumers, and social scientists. It is also a question that has received some (though not much) empirical attention in the last 7 or 8 years. Specifically, the question is this: What attitudes and behaviors can disabled people expect from others whom they meet in the community?

A significant proportion of research in this area has stemmed from theoretical work by Katz and Glass (Katz, 1981; Katz & Glass, 1979). The basic contention of Katz and Glass's theory is that attitudes toward persons with disabilities are characterized by ambivalence. On the one hand, non-disabled people have feelings of sympathy and admiration for the courage and determination demonstrated by persons with disabilities. However, at the same time, they are also likely to have feelings of distaste and, perhaps, aversion. As might be expected, these ambivalent attitudes often translate into a confusing behavioral pattern. Sometimes non-disabled persons may respond more to the positive component of their feelings and sometimes more to the negative. Predicting which is likely to manifest itself is very difficult.

The object of one of our studies in this area (Gibbons, Stephan, Stephenson, & Petty, 1980) was to determine under what circumstances the sympathetic and aversive components of ambivalent attitudes are likely to predominate when a disabled person interacts with a non-disabled person. We had college students work on a task with teammates who were physically disabled and teammates who were non-disabled. The finding was that how the disabled person's behavior affected the non-disabled observer was a determining factor in the interaction. When team members failed on a task they and their non-disabled partners were working on together, they received much more blame (and were liked less) if they were disabled than if they were non-disabled. In other words, what we found was a classic example of scapegoating. Disabled persons took more than their share of the blame for problems non-disabled persons shared with them.

These results can be generalized to situations outside the laboratory. The study suggests that a person with a disability who displays incompetent behavior may receive more blame than a non-disabled person who has made the same mistake. Consider, for example, the reaction that is likely to be elicited by a mentally retarded woman who is holding up the checkout line at a grocery store because she does not have the correct change, or (worse yet) has no money at all, or by a man in a wheelchair who drops his tray in the cafeteria line. These people are quite likely to be targets of more ridicule than are persons without disabilities who are having the same problems.

The negative component of the ambivalent attitude is not likely to be manifested unless there is some ostensible reason to justify it. In fact, one of the more interesting suggestions to come out of our study and others (e.g., Snyder et al., 1979) is that discrimination against disabled persons in a real-world situation is likely to be very subtle. It is generally considered poor form, for example, to make some comment about an individual's prosthetic device or to complain when the person's wheelchair runs over one's toe. It would be much more likely, however, for prejudice to be demonstrated in a situation that was more ambiguous, where it was not completely clear that discriminatory attitudes or actions were being displayed. Thus, one might simply choose to avoid a restaurant consistently patronized by persons in wheelchairs (claiming, when asked, that one considers the food there not very good), or one might choose to vote against curb cuts and ramps because they are too expensive or because other (unspecified) social programs should have higher priority.

Positive Prejudice

There is another side to this problem. There are situations in which the disabled person is expected to receive the benefit of the doubt. In particular, the disabled person who is living in the community and obviously doing well (i.e., well-adjusted, competent, professionally successful, etc.) might receive more praise for accomplishments than an equally successful person who is not disabled. In attributional terms, this is referred to as an

augmentation effect. This means that a person who can perform a task despite an obvious inhibiting factor has greater ability or (as is more likely with disabled persons) more motivation than someone who has done the same thing without a disability to overcome. In either case, the person is generally seen in a more favorable light and is liked more because of it.

Even though a reaction of positive prejudice can sometimes be beneficial to the disabled individual, the disadvantages associated with ambivalence in non-disabled persons outweigh the advantages. Not knowing how others are likely to respond to one's behavior can be very stressful. Moreover, problems are exacerbated by the independent living movement simply because there are more opportunities for others to display their ambivalent feelings. Independence puts extra pressure on disabled people and affects both what is expected of them and what rewards they expect to receive. An independent person who **appears** to be coping adequately in the community is likely to receive the benefit of the doubt, the extra favor at the right time, or additional cooperation when it is needed. But the converse is true as well. A disabled person who is struggling in the community is likely to have it much tougher there than in a sheltered environment and certainly much tougher than a non-disabled person would under the same circumstances.

Preparing disabled persons for the environment they are likely to face in the community, in terms of the attitudes and behavior of people they meet and interact with, should be a high priority for ILCs. It is first necessary to find out what disabled people expect from community members, based on their previous experiences. These experiences can then be shared with other disabled individuals. In fact, the best preparation persons with disabilities receive will come from others like themselves, people who have had similar experiences. This is the basis for peer counseling programs used in ILCs.

Independence and Mentally Retarded People

Although mentally retarded people living in community settings have traditionally not been participants in the independent living movement, this situation will change as they become more aware of the services available to them and more vocal in their demands for those services. For a number of reasons (some of which are described below), independence has a different impact on this segment of the developmentally disabled population than it has had on persons with physical disabilities. People who are mentally retarded view independence differently. They have different needs for freedom and control. When they are in the community, they are likely to evoke different reactions from individuals who come in contact with them. They are unique people with unique problems. For this reason, I have chosen to deal with this group separately. In doing so, I shall present some of the work pertinent to a discussion of independence, beginning with our own. Most of this research focuses on the social climate that is likely to develop in community settings that include people with mental disabilities.

Our earliest work (Gibbons, Sawin, & Gibbons, 1979) in this area

concerned the perceptions of non-retarded people about the abilities of retarded individuals to function socially on a day-to-day basis in a community-like setting. In particular, we looked at the predictions college students made for the behavioral outcomes of mentally retarded people (e.g., success at work, popularity with friends, social skills, etc.). We presented the college students with descriptions of individuals who were retarded and non-retarded and were either socially active and successful (had plenty of friends, remained active, seemed happy, etc.) or inactive and less successful (few friends, difficulty at work, etc.). We then asked the college students to make predictions for future social behavior and to give explanations of causal attributions for previous social behaviors.

The college students had very low behavioral expectations for those who were mentally retarded. They expected them to fail at a number on non-cognitive behaviors that should not be greatly influenced by level of intelligence. These included the ability to find employment, likelihood of getting married, ability to raise a family, etc. In general, the college students tended to make external attributions for outcomes of those who were retarded and indicated that these individuals had little or no control over their lives. Instead, they saw retarded persons as being at the mercy of exogenous factors (such as luck) and especially susceptible to other people's influence. In other words, they saw them as being highly dependent. Consistent with this lack of control perception, college students also revealed evidence of patronization. They did not give retarded people as much credit for success as they did non-retarded people, nor did they blame them as much (or at all, in some cases) after identical failures. People who were retarded were not seen as being responsible for their own lives. The students apparently saw little point in blaming them if they could not bake a cake or make friends or hold down a job. By the same token, mentally retarded individuals who could do these things and do them well were thought to be flukes whose success was a chance or lucky event not likely to recur. Another study (Gibbons, Gibbons, & Kassin, 1981) indicated that the patronization pattern may carryover into the courtroom. In this study, hypothetical criminal offenders received less blame and lighter sentences, regardless of the crime committed, when they were said to be mentally retarded. Again, the reasoning appeared to be that retarded people are not completely responsible for or in control of their own behavior.

This research suggests that, at the very least, non-retarded people are skeptical about the abilities of retarded people to function in a non-supervised environment. Although this does not necessarily mean that people in the community favor institutional placements for those who are disabled, it does suggest that support for more independent living arrangements in community settings may sometimes be less than wholehearted. Many people need to be convinced that independence is a viable concept before they will offer their support. They must be convinced that disabled people can function independently. If non-disabled individuals expect independent living centers to fail, there are many circumstances they can condone to make those expectations come true. Even skepticism from certain individuals in the community at certain times can cause problems for a disabled

person looking for employment or access to a particular political committee or advisory board.

Research in community attitudes toward mentally retarded people living in the community has not been favorable or encouraging (e.g., Gottlieb & Corman, 1975). Most of the research was conducted before the independent living, or, for that matter, even de-institutionalization movements had reached their peaks. Consequently, the full impact of these programs, in terms of their effect on societal attitudes, has not been accurately reflected. The process is definitely a two-way street. Just as the attitudes of community members have a significant effect on what happens to ILCs, ILCs have an effect on the attitudes of people in the community. More research is needed to determine what effect ILCs are having on the many individuals who are directly and indirectly involved in the independent living movement.

The Center and Its Consumers

The attitudes that ILC consumers are likely to face in the community have a profound influence on the centers themselves, including how quickly they become established and how smoothly they function. Whether centers survive or fail, however, is determined ultimately by what happens **inside** the centers--in other words, how consumers relate to each other. Although a reasonable amount of research has examined how non-disabled persons view those who are disabled, the question of how disabled people view each other has been virtually ignored.

By its very nature, independent living promotes interactions among disabled persons and encourages them to rely heavily on each other (as well as on themselves), not only for assistance in day-to-day functioning, but also (and perhaps more important) for the encouragement and support that is essential to independence. Evidence of this is the extent to which ILCs are staffed by people with disabilities. The issue of living and working together raises a number of questions. For example, the general question of how disabled people view and relate to each other and to themselves is basic. Questions of equal importance, such as the following, also need to be asked: Do disabled people prefer the company of others similar to themselves, or does the company of other disabled individuals serve as a reminder of their own disability? Do they prefer to date other individuals with disabilities? Do they see disabled people as less physically attractive than non-disabled people? What kinds of behavioral expectations do they have for others like themselves? The attitudes revealed by these questions can make the difference between a successful program and one that in the long run could foster less, rather than more, independence among its consumers.

Social Relations Among Mentally Retarded People

The most truly independent living arrangements are those that promote interdependence in relationships among inhabitants. One factor that influences how persons with disabilities relate to each other is

their perception of the stigma associated with disabilities. We have looked at this question (cf. Gibbons, 1981) and examined how awareness of the stigma affects social relationships among disabled people, primarily people with mental retardation. This first step was to look at awareness of what the label mentally retarded denoted and connoted. We had evidence of patronization in our previous work with non-retarded individuals and decided to examine this phenomenon among our sample of mentally retarded people.

Earlier studies (Gibbons & Gibbons, 1980; Gibbons & Kassin, 1982) suggested that people with mental retardation living in state institutions were very much aware of the negative connotations of the labels institutionalized and mentally retarded. Moreover, this awareness seemed to carry with it some prejudice. Institutionalized people typically reported that they would prefer not to have other **institutionalized** retarded people as friends, roommates, and workmates, if they had a choice. They also reported that mentally retarded people were less intelligent than non-retarded persons, less likely to perform adequately on cognitive tasks (such as jigsaw puzzles), **and**, most important, less likely to have what would be considered a normal social life, including getting married and raising a family. The prejudice these people were demonstrating was directed as much to the institution itself as to those in it. Apparently, they had learned--from a variety of sources--what the term institutionalized, mentally retarded meant to the community outside the institution--and that the institution was a place for individuals who were incompetent or (more accurately) socially inept.

We also asked retarded people for their self expectations in terms of specific abilities to perform a cognitive task, as well as their general expectations for future social behavior. Their responses to these questions indicated that they had higher expectations for themselves on the cognitive tasks than they did for their **retarded** peers. Their self-expectations fell between their predictions for retarded and non-retarded persons. Thus, they perceived themselves as being more competent cognitively than the average mentally retarded person. In contrast, their expectations for their own social behavior were very low--as low as those that they maintained for the retarded people (and lower than those for non-retarded people). One reason may be the relatively poor opinions they hold of other retarded people's social skills (see below). If they see other retarded people--who are likely to be the targets of most of their social interactions--as socially unskilled, then it stands to reason that they would have relatively pessimistic predictions of their own chances for social success. In this sense, the stigma perception can act as a self-fulfilling prophecy. As long as mentally retarded people hold negative impressions of each other, their social interactions and self-perceptions are likely to be hampered. Moreover, their social lives (and lives in general) are likely to be restricted.

One particular finding that stood out in that early research was that the low opinions of retarded peers were particularly evident in the cross-sex evaluations, with mentally retarded females being harshest on mentally retarded males (more so than on non-retarded

males). Our current research is looking at cross-sex perceptions and relationships among mentally retarded persons to see how they are related to social behavior. This time, we will be comparing the responses of institutionalized people with those of people living in more independent community environments to see if there are differences in the social behavior patterns within the two types of residences and to see if differences are related to satisfaction with social lives. In particular, we are obtaining a rough measure of the amount of social freedom available in community facilities to determine whether this factor is related to levels of adjustment to living environments.

Only recently has much attention been given to social skills and satisfaction with social lives as part of successful community adjustment. Unfortunately, some studies report that many mentally retarded people have trouble adjusting in these settings. Birenbaum and Re (1979), for example, conducted a 4-year follow-up study of clients of a community facility and found that the clients' lives became more routinized, and they appeared to be **less** independent after 4 years. Nonetheless, most clients preferred a more independent environment. The leading choice of living arrangement was a separate apartment.

In addition, this research revealed two social factors that, surprisingly, seemed to be strongly related to social adjustment. Landesmann-Dwyer, Berkshon, and Romer (1979) found that mentally retarded people who maintained active contact with their parents while living in a group home appeared to be more socially isolated from their peers than others who were more independent of their parents. By the same token, some independence from peers also seemed to be beneficial. Reiter and Levi (1981) found that having non-retarded friends was very important to the well-being of community-based subjects who were mentally retarded. Those whose peer group consisted exclusively of other mentally retarded people were not doing as well as those with a mixture of mentally retarded and non-retarded friends.

Our own research suggests that the negative opinions that some institutionalized retarded individuals have of mentally retarded people of the opposite sex might be at the core of this apparent social or group concept problem. This (social) aspect of behavior should be a primary concern of those in the institution who are preparing mentally retarded people for life in the community. Specifically, this would include allowing and (where necessary) actively promoting social interactions between male and female residents, tolerating personal relationships and, perhaps most important, providing sexual and social education for mentally retarded adolescents and young adults. The issue of social freedom within the institution is clearly a difficult one. If it is assumed that one of the institution's primary goals is to prepare residents for less restrictive environments, every effort should be made to normalize the social environments that exist in institutions. In other words, the more social experiences people have inside the institutions, under settings that are more or less supervised, the more capable they become of handling social pressures in the community.

Before leaving this topic, I should point out that all research in this area is not pessimistic. A series of studies by Romer and Berkshon (1980; Berkshon & Romer, 1980) shows a more positive social interaction among mentally retarded people. They have demonstrated, for example, that mentally retarded people in independent environments, such as sheltered workshops, spend considerably more time socializing with each other than with staff members. In addition, like non-retarded persons, they tend to seek out other mentally retarded people who are similar to themselves (e.g., in terms of physical attractiveness) as friends. Many of the principles that apply to social relationships among non-retarded people could be applicable to mentally retarded populations in non-institutional settings. Right now, the data on cross-sex relationships are sketchy. The more data we collect, however, the more important this variable appears to be.

There are two additional questions raised by this research on stigma perceptions among those who are disabled, the answers to which may help those involved in organizing ILCs determine where priorities should be placed. The first question is how do individuals with physical disabilities perceive other disabled individuals? In particular, do they maintain ambivalent attitudes toward each other? Are they over solicitous of successful peers, thereby undermining intrinsic motivation? Are they over harsh on less competent colleagues, thereby inhibiting the latter from asserting themselves? Just as the notion of group concept might be a problem for mentally retarded individuals living independently, ambivalence might be a problem for disabled people trying to establish an effective interdependent living arrangement.

The second question is how people with different types of disabilities perceive and relate to each other. Changes in federal laws over the past decade have resulted in the term handicapped being expanded to include more and more people with different disabilities, all of whom are interested in obtaining funding for essential services. The Reagan administration's move toward state autonomy and state control of social funding has caused groups of disabled individuals to compete for very limited resources. The result of this unhealthy competition can exacerbate cross-stigma prejudice. This, in turn, can interfere with the independence and advocacy movements. Moreover, differences in the abilities of various consumer groups to advocate for their own causes inevitably results in some groups receiving a smaller share of the funding pie. Because mentally retarded people are the least capable at self advocacy, they are most likely to be hurt by this competition. In the long run, all consumer groups will be hurt if they are unable or unwilling to support each other in their efforts toward common goals. If this problem does exist--and that is yet to be determined--than the extent to which the problem is interfering with the movement and affecting the behavior of those who are part of it should be assessed.

Future Research

Research in this area suggests a very important empirical question. That is, what effect does the patronization response pattern have on mentally retarded people--specifically, on their motivation to succeed at what they are doing and to function successfully on their own? The clear message in the responses of college students to the mentally retarded people in our research was, "Why try when there is little you can do to help yourself?" To the extent that mentally retarded people accept this message, we can expect their motivation to be low. Likewise, should they carry this attitude into the community, their chances of attaining and maintaining independence are reduced. Our future work, then, will look at the extent to which mentally retarded people patronize themselves and each other, how this attitude affects specific behaviors such as achievement motivation, task persistence, and self-help abilities, and how it affects the social climate that develops in the community.

Finally, there is one point, although anecdotal, that is more optimistic and perhaps as revealing as the data presented. Our first pilot study was conducted with formerly institutionalized mentally retarded people (protégées) from a citizen advocacy program in Texas. At the end of our interviews, we asked them whether they would like to go back into the institution. As one might expect, with no exceptions the answer was "no." More important, when we asked them **why** they would like to continue living outside the institution, the clear consensus was that they liked the freedom to come and go and do as they pleased. In spite of all the difficulties, they did not want to give that up.

Is Independence Worth the Risk?

Two major points in the IL movement can be concluded from the research presented here. The first is that there is every reason to believe that individuals with disabilities, including those who are mentally retarded, like the freedom associated with independence. The second is that independence brings serious problems that place a considerable amount of added pressure on persons with disabilities. One such problem is that independent living (and the philosophy associated with it) requires much more intense interactions among disabled people. This may serve to exacerbate the psychological problems associated with their various stigmas. This may be one reason why some research has indicated that the level of social adjustment of people who are mentally retarded in the community does not always improve with time.

Another problem is that having control over one's life (including behavioral freedom) can in itself be stressful, especially for people who have not had freedom in the past. Independence requires more initiative and effort and could lead to more failures and the potentially debilitating causal attributions associated with failure. In this regard, recent work in the area of attribution theory has indicated that individuals avoid information that might show that their failures are due to low ability and that they prefer to avoid situations that might provide this information. Thus, it could very

well be that a disabled person **might** not be willing to find out if he or she can live independently, because he or she may not consider the rewards sufficient to outweigh the risk of failure.

These are definitely real and serious issues. There is no doubt that with independence come difficult problems, many of which would not exist for persons living in more dependent environments. In fact, given the amount of time I have spent describing and discussing these problems, the reader may have the impression that the research--or at least my interpretation of it--suggests that independence is just not worth the risk.

In a provocative and informative paper, Robert Perske (1972) talks about the risks involved in living in nondependent environments. With the help of a Dybwad award, Perske observed the service delivery systems for mentally retarded people in Scandinavia. He noted that in those countries, much more so than here, mentally retarded people are encouraged to go out into the community, try new behaviors, and attempt to live normal lives. Independence is almost forced upon them. Of course, they run a great risk of failing, and they do fail quite often. But Perske (like many service providers in Scandinavia) does not see this as a bad thing. In fact, he has quite the opposite opinion. He believes that something can be learned from trying and failing and to deny disabled persons the **opportunity** to try normal behaviors, even though they are bound to fail, is to deny them basic human dignity. There is, he says, a dignity of risk that all humans, whether disabled or not, should have the opportunity to experience.

Determining ahead of time how much risk is appropriate and how much failure can be tolerated would be very difficult for any person. That can only be learned from experience. It is also likely to vary considerably from one person to the next. Total independence is certainly not for everyone. The point is that we have little choice--many disabled people believe there simply is no acceptable alternative. We do know what the consequences of dependency and the loss of freedom associated with it are, and those consequences are not tolerable. The laws and the mandates are very clear--whatever needs to be done to promote normalization among disabled persons and to provide them with an environment that is least restrictive will be done. By any definition, that environment includes independence. In sum, independence is vital, it is necessary, and it is essential to mental health. But it does not come easily.

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Commentary by John H. Berg

I was immediately interested when I was asked to write a commentary on Gibbons' monograph, "A Social Psychological Perspective," because I am both a social psychologist and a disabled person living independently. In reading the monograph, I was repeatedly reminded of the often-used (and perhaps overused) remark of Kurt Lewin concerning how practical good theories are. The study of independent living epitomizes the Lewinian concept of action research. In this approach, data from the experimental laboratory are integrated with data from the field, and the result is applied to the solution of social problems. While almost every social psychologist pays lip service to this ideal, it is all too seldom practiced. Gibbons makes it clear that there is much social psychology can contribute to the independent living movement. There is also much it can gain. I believe both the movement and social psychology will be the poorer, if social psychologists fail to address the really important issues where there are common gains to be made.

One process social psychologists have begun to explore (which has broad implications for independent living) is the process of social interaction. Social interaction, however, involves numerous sub-processes, each of which impacts on the disabled person attempting to live independently. One sub-process social psychologists have given considerable research attention to is social perception. While examples of social perception can be found throughout the monograph, they are perhaps most apparent in the section called, "The Client in the Community." Two sets of perceptions are involved here: those of the disabled person and those of the non-disabled person.

About the former, we currently know very little. One recent study (Kleck & Strenta, 1980) suggests that people who believe themselves to be physically stigmatized tend to interpret the responses of others as reactions to that stigma, regardless of what those responses might actually be. If this is correct, or if a disabled person is aware of the potential operation of positive prejudice, he or she could very well discount expressions of support or praise. The disabled individual might, in effect, say, "Oh, she doesn't really believe I have much ability. She feels sorry for me and is just trying to be nice and make me feel good." I do not know when a process such as this would be most likely, but should it exist, it would have a profound impact on the adjustment and self-concept of the disabled person.

A second set of questions involving the perceptions of disabled people concerns the manner in which they perceive themselves and

their alternatives. The latter aspect of this question is addressed in the sections dealing with control. As Gibbons notes, the degree to which people believe they have control over significant life events or outcomes is of tremendous importance for their motivation to become more independent. Gibbons also notes that a lack of awareness of what can be accomplished may be the greatest obstacle for many individuals. In this regard, it can be of great help if there is contact between people who are living more independently and their less independent colleagues. Encouragement to become independent could be more effective with exposure to others with similar handicaps who are independent. I wish to note here the contribution made by many returning Viet Nam veterans. These men wanted, expected, and demanded more control over their lives and thus served as models for other disabled people. The task of increasing awareness is, however, far from complete. The comment of a disabled man in a support group in which I was participating comes to mind here. He said, in effect, that he expected very little and had learned to "be grateful for crumbs." Regardless of whether this was true, the fact that such a statement would be made is indicative of the helplessness or hopelessness that can occur when people view themselves as having no alternatives.

While the existence of models may increase the awareness disabled people have of the amount of control they can exert, Gibbons also adds a caution. The work of Schultz & Hanusa that he reviews makes it appear crucial that perceptions of control be vertical. If early attempts at control meet with failure, it is unlikely that motivation will continue. This is not to say a disabled person can or should be protected from all failures. To do so is impossible and, perhaps more important, denies the individual dignity. Goals, however, should be realistic, and attempts should be made to prepare the person for the difficulties she or he may encounter and to learn from failures to achieve these goals. Here again, contact with other disabled individuals who are living independently is useful. The question of how disabled persons perceive themselves is not addressed to any large extent by Gibbons, but it is also an area in which social psychology can make a significant contribution. The work of Duval and Wicklund (1972) suggests that when individuals focus on themselves, they become aware of discrepancies between the way they are and the way they would like to be. If there are no means by which they can reduce these discrepancies, they will attempt to avoid the situation that led them to focus on themselves. Duval and Wicklund note that a potent stimulus leading to such self-attention is the perception that others are watching you and what you are doing. The disabled person who feels that she or he stands out and is the object of a crowd's attention may thus become anxious and avoid social situations. The temptation to view oneself as the object of everyone else's attention may be exacerbated when extraordinary measures must be taken to permit a disabled person's access. As accessibility for disabled people becomes more routine, the avoidance process should decline. Feeling oneself to be the focus of others' attention might also decline with experience and with routine accessibility. The tendency of non-disabled persons to stare at a novel event should decline as well.

An additional factor likely to affect the way in which disabled persons view themselves and their alternatives is the amount of time they have lived with their disability. Someone who becomes disabled later in life may be particularly likely to feel a loss of control. Research attention also needs to be paid to the manner in which individuals with different disabilities differ. In this regard, the monograph is perhaps too inclusive. Speaking of an undifferentiated independent living movement obscures important differences among individuals with different disabilities. We do not know to what extent people with particular disabilities perceive themselves and the problems they encounter as being similar or dissimilar to problems faced by people with other disabilities.

The second set of perceptions I want to discuss briefly are those of the non-disabled individual. As Gibbons notes, most of what is known about reactions to disabled people comes from the work of Katz and Glass. In the section on "The Client in the Community," Gibbons discusses the ambiguous attitude many people have toward disabled people. While some may feel sympathy and admiration for a disabled person, there can also be a similar amount of distaste and aversion. For many individuals, contact with a person who is disabled might threaten a belief in a just world where we get what we deserve and deserve what we get. It is the threat to this belief that could underlie feelings of distaste and aversion.

Furthermore, the feelings of sympathy and admiration that contribute to the operation of positive prejudice can also have negative implications for disabled persons attempting to live independently. As noted above, awareness of positive prejudice might lead a disabled person to discount the praise of others. Even if such praise is not discounted, it could place an added responsibility on the disabled person living independently. Lavish praise, especially when given for what one views as a routine task, could create an added burden of living up to such praise. I have met several disabled people who have been quite successful at living independently but who react very strongly when others tell them how much they are admired.

One final question is social perception, about which we know little, but to which social psychologists may provide answers concerning the manner in which both disabled and non-disabled people organize information about individuals with disabilities. A study by Brewer, Dull, and Lui (1981) indicates that information about the elderly is hierarchically organized into types and prototypes. This study could serve as an example for similar investigations into the ways disabled people are perceived. The questions one might explore would include the following: How do disabled and non-disabled people differ in the way in which they perceive and organize information about individuals with disabilities? Is this information processed or organized differently for different disabilities? What behaviors are seen as most associated with different disabilities?

A final comment concerns the question Gibbons raises in the concluding section of his paper about whether independent living is worth the added risks, responsibilities, and problems it entails. I do

not presume to answer for all people with disabilities and would respect whatever decisions others might make. However, as a disabled person living independently, my answer to this question is a most emphatic "Yes!"

References

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