

OBSTACLES IN THE SOCIAL INTEGRATION OF ORTHOPEDICALLY HANDICAPPED CHILDREN * †

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The Social Experience of the Handicapped

SINCE 1959 the New York Service for Orthopedically Handicapped has been helping to integrate orthopedically handicapped children into the regular programs of neighborhood centers. It was hoped that these efforts would influence hospitals and schools to make direct referrals of orthopedically handicapped children to neighborhood centers. Another objective was to encourage community centers, hospitals and schools to work together cooperatively in a more comprehensive program to aid in the rehabilitation of handicapped children. Finally, it was thought that neighborhood centers might reach out into their communities and find orthopedically handicapped children whom they could integrate into their program.

The above objectives have been achieved only partially or not at all. Handicapped children generally remain isolated and alienated from the main stream of society. This paper will discuss the following questions:

1. What are the obstacles toward integrating

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handicapped children into community centers?

2. What are the factors that prevent inter-agency coordination in the integration of orthopedically handicapped?
3. What is necessary to insure that the orthopedically handicapped child will receive the same socio-recreational opportunities as the normal child?

The Orthopedically Handicapped Child and Society

Families of the orthopedically handicapped are somewhat isolated from the community. Perhaps the experience of having an orthopedically handicapped child makes parents feel guilty and thus they protect themselves through withdrawal. Our experience, however, has pointed to their being exposed to a variety of negative societal attitudes. Parents of orthopedically handicapped children, when given the opportunity in counseling, have complained, "Do you know what it's like to take your child out into the street and have everybody gawking at him?" Not only do people stare but some stare with disgust, some stare with a morbid kind of curiosity, some stare and turn away. One mother said, "Sure I keep my child home quite a bit; I want to protect him from the way people look at him."

Left to themselves, the vast majority of families would not apply to the community centers. This is true even when

a non-handicapped sibling may be going to the same program. In one situation a community center was located in the same housing project in which a family lived; the family did not, however bring the handicapped child to the center for possible inclusion. On the other hand, the philosophy of most centers seems to be: "We have a service to offer which is available to the community. It is the responsibility of interested families to apply for our services." Obviously a parent who feels that his child is an object of curiosity or even aversion is not going to bring the child into the community center. For the most part, it won't even occur to the parent that his child might be able to function in a community center program together with non-handicapped children. When parents do consider the possibility, they frequently discard the idea by assuming that their children would not be accepted.

At present, there is no one who takes responsibility for serving as a "broker" or "advocate" for physically handicapped children. For the non-handicapped child, the parents naturally serve in this capacity. As we have seen, however, the parents of the orthopedically handicapped are psychologically unable to fill this role. Who is able and willing to represent the needs of the handicapped child?

The life of the handicapped child is fractured and fragmented in living and in receiving services. No one at this point who is directly involved with the child sees his total needs. No one is ready to help him receive the services that will provide him with equality of opportunity! It is against this background that one must view the project of integrating orthopedically handicapped children into community centers with non-handicapped children.

The orthopedically handicapped child, for the most part, goes to a special health

class. When he comes home, he spends a good deal of time passively watching T.V. He has little active contact with non-handicapped children. Most of his time is spent within the circle of the classroom, his home, the clinic and outings to see members of his family. But the child is not a part of his neighborhood and the family views him, for the most part, as being better off isolated from the non-handicapped population. To help the handicapped child and his family break out of this withdrawal and isolation was one of the main reasons for the project to integrate orthopedically handicapped children in community centers.

Not every child who is physically handicapped can be integrated into an after-school program. When one thinks of the setting of the community center, one realizes that the orthopedically handicapped child who would benefit from the center program is a child with some physical and social skills. Who is this child? In all aspects, except for his physical handicap, he is probably just like his peers in the group. He can walk, though he may walk with crutches and braces. He is fully capable of taking care of all his personal needs. He uses language for communication. Though he may have some difficulty in articulation, he can be understood. He goes to school, but is in a special class. What differentiates this child from his peers? Only his physical disability which may be or may not be a major handicap. But as long as this child has learned to take responsibility for his own physical management, he can and should go to a community center. He can participate with non-handicapped peers in almost all of the group activities. He can join in sports, dancing, arts, crafts, drama and games. His participation may be more or less limited in any specific activity, depending on the

nature of his handicap and the type of program. But he does participate.

Where do you find this child who until recently was comparatively unknown in the non-handicapped community of children? He is to be found in the schools, in special classes, and in the out-patient clinic of hospitals. But he can, unfortunately, be found only by looking for him.

The Orthopedically Handicapped Child and the Hospital

In the recent NYSOH project, only 11 out of 34 hospitals made direct referrals to this agency. All 34 had received the same publicity about the program. Even though all medical social workers when interviewed expressed positive feelings about the program only a small percentage made referrals for integrated socio-recreational experiences in community centers. Why is this so?

In the hospital, the mildly orthopedically handicapped child does not have the first priority. Social workers are more concerned with the severely limited child. The child who is able to walk and is relatively independent in the activities of daily living is almost a non-handicapped child when compared with the child in the wheelchair. The child who today can walk and can take care of his needs however was once a helpless child. Through modern rehabilitation he has been helped to achieve a degree of independence. Much as the social worker is interested in all handicapped children, her first concern is not for the "mildly" handicapped child.

This does not mean that the hospital is not an excellent source of referral, but it does in part explain why it is so difficult for hospitals to make referrals independently to community centers. We have found that hospitals do not make sufficient referrals for the following reasons:

1. Social workers in hospitals are most con-

cerned with finding facilities for the more severely handicapped child.

2. The hospital has not assigned one person to be directly responsible for referrals.
3. The Social Service staff has many responsibilities and often the hospital is understaffed.
4. There is a great turn-over of staff so that each year new people come onto the staff who have no knowledge of this program. A study in 1967 by students from Fordham University School of Social Service¹ found a high positive correlation between referrals to community centers and longer tenure on the job. Medical social workers on the job for 3 years or more significantly made more referrals than those on staff for 3 years or less. The same study found that there were significantly higher numbers of children referred to community centers when the workers were knowledgeable about the program. The fewest referrals or none at all came from social workers who had only a superficial knowledge of the program.
5. Most social workers work in a "crisis" atmosphere. The families they serve have many emergencies such as: a child needing a new wheelchair; a child needing additional surgery; a family needing counseling; a family on welfare not receiving their check; etc: These and many other difficulties need a great deal of attention and are so immediate that social workers conceive their role as almost that of a "crisis worker."
6. The worker may not have up-to-date knowledge of a particular child. Sometimes a child is not seen for a long period of time, since he may no longer be active in the physical therapy program.

Many of the hospitals service children from all over the city and no social worker is responsible for finding out which center might be closest to the child, or whether or not the child is so close that he can get to the center by walking over. For all the above reasons,

¹ Barbara Major, Theresa Monaco, *et al.*, *An Evaluation of the Process Used in the Integrated Social Recreational Project by the New York Service for Orthopedically Handicapped, 1960-65*, Unpublished Masters Thesis, Fordham University School of Social Service, New York, 1967.

it is difficult for social workers in hospitals who are serving the families of orthopedically handicapped children to include in their work referrals to community centers for social-recreational activities.

In addition, the direct referral involves setting up a mechanism including getting in touch with the center, after finding out which center is available to the child and arranging for getting the child there. All this takes time out of an already heavy schedule.

Many hospital social workers are so involved with the immediate needs of the child that they cannot quite envision servicing the total needs of child development. Many social workers see the need for the involvement of a child in a community center, but cannot assume the additional responsibility.

The School

Teachers do not make direct referrals to community centers because they do not see it as part of their responsibility for the education of the child. And yet the basic philosophy of education is that the teacher must see the "total child." But just as the social worker in the hospital is focused on the medical needs of the child, the teacher focuses on "scholastic achievements."

Teachers are aware of the social needs of the child. They see the child five times a week. They often have more current knowledge of the functioning of the child than the social worker who may see the child only at clinics where the social interaction is quite limited by the clinical setting. Then again the social worker sees the child at intervals; sometimes there is a lapse of many months. The teacher sees the child throughout the year, in social settings, with his peers, and with adults. So the teacher recognizes the needs that the child has for socialization and will cooperate with a social worker who comes

to the school but, they do not get involved on their own in making referrals or seeking out resources for socialization. There are a number of practical reasons for this: most of the special classes serve children from various parts of the city and it takes time to contact parents and persuade them to seek this service, it takes time to seek out a center which is close to the child's home, to contact it and to make arrangements for a child to be invited to it. But beyond these practical reasons is the underlying approach to education—the teachers (just as the social workers) have not yet moved out beyond the confines of their institutional walls. They still function largely within the school environment and education, or responsibility for education, of the "total" child is still a dream—as of now, education ends at the school room threshold.

The Role of the Community Centers in Integrating Orthopedically Handicapped Children

In some centers the programs were too unstructured to be of any benefit to the handicapped child. The supervision was so minimal that the physically handicapped child could not function in this setting.

In some instances, the philosophy of the center militates against the full integration of the handicapped child. For example, some centers believe in leaving the initiative to the child and his family for making use of the center's services. If a child was absent, the center did not make an attempt to discover the reasons. As a result, many a child's absence, which could have been temporary, became prolonged into a drop-out.

In Jewish community centers where the handicapped children were accepted, community center personnel often felt inadequate to meet the challenge of some children who were from a different ethnic minority, as well as being physi-

cally handicapped. These centers are primarily set up to serve the needs of the Jewish community. The background of most of their personnel reflects this goal. There was some understandable anxiety on the part of staff in working with children who were so obviously different.

Many of the centers used are settlement houses and are located in low income areas. Here the centers were unable to meet the needs of the handicapped child because the centers are under great social pressure to meet the more visible needs of the community, those of the delinquent youth, the unemployed, the aged, the poor. Under these kinds of pressure the handicapped child who because of isolation has been described as an "invisible problem," will remain unnoticed in the community. The center workers are involved in trying to meet the pressing needs of an urban society and like many of the hospital personnel, they live on a "crisis" basis. Into this environment the integration program attempted to facilitate the re-entry of the handicapped child and his family. As with space missiles re-entry has been a difficult but not insoluble problem. Let us examine how re-entry has been accomplished for some children.

Breaking the Barriers

As a result of eight years of work, a process has begun which hopefully will continue and broaden. A number of community centers who did go out into the community to recruit the children have learned that in order to serve the orthopedically handicapped child, one must meet these families more than halfway, and so there are community centers that do go out into the schools and hospitals and are beginning to look for the children who can benefit from their program. The centers have learned that the orthopedically handicapped child

can be found, is able to participate and can make a unique contribution to the life of the center.

When the directors and supervisors were first approached, they had many reservations about the feasibility of this kind of "integration." Wouldn't there be a safety hazard? How would the children get to the centers? How would the non-handicapped child react in an active game? Wouldn't the regular members object? Wouldn't the groups require assistant leaders? Don't we need leaders with special training?

If the center program was not on one floor, then they were concerned about the physical plant. Didn't they need an elevator? Was it necessary to have a ramp so that the child could come in and out of the center? How much would they have to modify the program?

All of these questions have been answered by life. The orthopedically handicapped child in community centers had less accidents than the non-handicapped child. Some children did have to make use of elevators but they were in the minority. Only when the program involved very active games did it have to be modified. Where a child could not participate in active games he spent his time in special activities. Sociometric analysis has revealed that orthopedically handicapped children are chosen as "desired" playmates and workmates almost as frequently as their normal peers. The regular members of all ages not only did not object but there is evidence to indicate that the normal children became more accepting of individuals with disabilities. A more complete picture of how the orthopedically handicapped child did at the center is seen in the opinions of the program supervisors, a copy of which is attached.

After several years of the program, few of the staff members in the centers can remember the fears they once had. And the anxieties were understandable.

There is a kind of mystique about the "handicapped." They are "special" people and are given the status of being special by a society that will contribute some money (never quite enough) and verbal goodwill but understands the handicapped child so little that the special status becomes a form of exclusion. The staff in the centers did not know the physically handicapped child. How could they? The entire emphasis for so long was on the "normal" child. When handicapped children were admitted to the centers, they were generally organized into special groups. But here was an agency, the New York Service for Orthopedically Handicapped, that proposed including these handicapped children right into the center of activities together with the rest of the children. This was a challenging and sometimes anxiety-producing concept.

The centers did accept the children. In the course of eight years, 50 centers accepted over 300 children. The handicapped child became known, not only to the children in his group, but to the children in the center. Just like all other children, he became a part of the life in the center and a part of the life of the community of children. He was a member of a group, his own club group or special activities group, and he also participated in the big events of the center such as holiday plays, special events and trips. He learned to know the older children and the younger children. And they accepted him or rejected him as a child not as a "handicapped" child.

The Tasks Ahead

Although some important strides have been made in integrating the orthopedically handicapped child into community centers there are still some major barriers that impede progress.

As we have seen there are many obstacles that deter the orthopedically handicapped child from full participation in our society. Part of the problem is that the schools, hospitals and community centers have been insulated, fragmented and cut off from each other and the community as a whole. There are however, major trends at work that are breaking up the traditional patterns of insularity and moving these organizations into closer contact with the community. One hears now of "Community Health Programs," "Community Rehabilitation," "Consumer Involvement in Health," and "Community Mental Health." The NYSOH Integration Project itself may be both part cause and part effect of this trend. There are however barriers that still remain which screen out many orthopedically handicapped children from becoming fully integrated into community center programs.

Many hospitals and medical social workers are strongly influenced by a traditional medical diagnostic viewpoint. Dr. Stephen Richardson makes an interesting point in this regard; he says, "One of the serious obstacles in the socialization of the physically handicapped child is the pervasiveness of a traditional medical diagnostic viewpoint. . . . By this, I mean a physiological orientation, a pathological orientation—the notion that you are dealing with a form of sickness. . . . However where restoration of a specific function cannot be achieved within a relatively short time, and where the treatment can only partially improve function, or is inadequate, I think the traditional approach can be very damaging to a young person. . . . The focus on pathology . . . detracts from attention on the development of other functions of the child which may be intact."² Dr. Richardson

² Stephen A. Richardson, "The Handicapped Child-Social Obstacles to Growing Up" in *The*

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goes on to point out how the traditional medical—diagnostic—pathological approach may foster dependency and prevent the child from fully developing communication skills and social relationships.

Another barrier is that the people in the community centers who have the power and decision-making responsibility are the most insulated from the problem. We have found that staff members (club leaders and junior program supervisors) who have the greatest contact with the orthopedically handicapped child became most convinced of the value and efficacy of integration. On the other hand, the further we move up the administrative ladder there tends to be less commitment. We have found that the most effective programs occur when the board of directors and/or the executive have become involved with some aspect of the program.

When community centers define their major goals in terms of serving the so-called "normal population" this too serves as an indirect obstacle. In practice what this frequently means is that the orthopedically handicapped is not served. As we have seen finding and placing the orthopedically handicapped child is a time consuming process. Should community centers invest the extra time and money necessary to include handicapped children in their programs?

Before attempting to answer this question, it is necessary to redefine the problem. As we have seen, the project has demonstrated that many orthopedically handicapped children can successfully participate in community center programs. They are accepted as part of the regular groups that meet at the center—they play games, they make

things, they go on trips, they move out into the community.

And now it is time for the community to accept these children as their own. Until now these children have been the special concern of specialized agencies dedicated to servicing their needs. Some children still need this support. But many children have shown that they can be part of the mainstream if given a chance. And it is time now for the community to give them this chance without the intervention of a special agency. The role of the special agency like the NYSOH is only to point the way. The direction is toward integration into society. The organizations of society must take the responsibility for integrating the child who will someday have to function as an adult in a nonhandicapped world. How can this be accomplished?

For the handicapped child to become part of the mainstream of life the basic institutions of hospital, school and community center must also become part of the mainstream. Hospitals, schools and community centers must establish a continuing, cooperative program of socio-recreational services for the handicapped. But who is to bring these institutions together? Who will do the important job of serving as catalyst and coordinator?

The answer seems obvious. It must be that institution which by its nature, its history, and by its name is in a unique position to cut across organizational barriers to serve the entire community—the community center.

ANSWERS BY SUPERVISORS OF THE PROGRAMS IN WHICH ORTHOPEDICALLY HANDICAPPED CHILDREN PARTICIPATED

May 1967

Number of Respondents—Settlements	—	16
Jewish Community Centers	—	9
	Total	25
	Yes	No N.R.
1. Would you like to see this program continued?	24	0 1

Social and Emotional Needs of the Handicapped Child—Philips Research Project, The Florence Heller Research Center. Brandeis University, Waltham, Mass. 1965, pp. 15–16.

2. Did you have any serious problems with the program?	0	22	3
3. Did you have any problems in maintaining the orthopedically handicapped child in the program?	5	20	0
4. Did any of your regular membership object to the handicapped child?	4	21	0
5. Did you have any special physical facilities as			
Elevators?	4	20	1
Ramps?	2	18	5
6. Do you feel it is necessary in order to integrate an orthopedically handicapped child to have			
Elevators?	3	19	3
Ramps?	2	18	5
7. Was it necessary for you to give the group leaders support and guidance in working with handicapped children?	16	9	0
Types of Guidance Given —			
Regular Supervision —	6		
Special Supervision —	9		
(only 15 examples were given)			
8. Did you find that the handicapped child had more, the same, or less injuries or accidents than the non-handicapped child?			
Same —	16		
Less —	7		
More —	2		
9. Attitudes of group leaders when they learned that they would have an orthopedically handicapped child in the group:			
Positive and Accepting —	16		
Curious —	1		
Anxious —	6		
Negative —	11		
No Reaction —	3		
	—		
	28 *		
10. Kinds of difficulties experienced by junior supervisors regarding transportation of the children:			
Lateness —	8		
Children Not Picked Up —	4		
Details —	1		
Drivers Attitude —	1		
11. Have you taken an active part in arranging for the transportation of the children?			
Yes —	17		
No —	8		
12. Was there any change in the attitude of the			

* Some centers reported on more than one leader.

group leader in the course of working with the orthopedically handicapped child?
(See below for explanation of "yes" answers.)

Yes — 13
No — 12
N.R. — 0

Answers given by the supervisors to the above question—

1. greater understanding of need for experiences—after seeing gains, could control anxiety—another leader learned group dynamics and was able to get children to relate to each other under difficult circumstances—
 2. learned to work with child—
 3. gained confidence in ability to handle an orthopedically handicapped child—
 4. found orthopedically handicapped child very mobile and could not handle few activities—
 5. found orthopedically handicapped child presented no problem—
 6. found orthopedically handicapped child can participate—
 7. found handicap did not restrict as they had imagined—
 8. leader adjusted to limitations of child—
 9. became more accepting and better able to allow children to work out their problems—
 10. group accepted orthopedically handicapped children and program was not restricted—
 11. found he had to give additional support—
 12. goals of working with orthopedically handicapped child was accomplished—
 13. trips had to be shortened to get back in time for cab service.
13. Attitudes toward handicapped child—
Did membership object?
4 centers out of 25 reported objection by members—Reasons given are listed below:
A. *How was this manifested?*
1. one child was frightened when she saw child without arm—director spoke to her—arts and crafts leader let her work near boy wearing braces and who used crutches—
 2. resentment towards child's lack of participation in boys group—
 3. one of the kindergarten children was frightened by a dwarf child—
 4. group felt that orthopedically handicapped child was holding the group back (child had cast and crutches)—supervisor did not feel group was held back by child.

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B. What was done about it?

1. let child talk about her fears—helped her to work with orthopedically handicapped child wearing braces—
2. some explanation of child's limitation given to group—
3. spoke to mother who understood what we were trying to do—
4. group continued with work and assistant worked with orthopedically handicapped child—case worker went to home of handicapped child and helped family and child to accept new disability and child was given a great deal of support to help her retain her place in the group as an active member.

14. What do you think was the greatest gain to center?

- (a) children had chance to become friendly with handicapped children and leaders learned from experience—
- (b) children integrated with so-called normal children and participated whenever possible as part of group—
- (c) served more of the community, improved group programs, taught children that everyone is not the same—
- (d) gratifying to the agency to be of service to handicapped child and family—
- (e) having children from another neighborhood and other but similar backgrounds—
- (f) realization that orthopedically handicapped children were able to fit properly in a program not necessarily designed for them—
- (g) new work for center integrating orthopedically handicapped children with normal children—
- (h) that center personnel can handle orthopedically handicapped children in group—
- (i) ability to expand our services—
- (j) understanding and realization that orthopedically handicapped children need moral support of their peers—
- (k) group leader gained most in working with handicapped children—
- (l) built relationship with family and experience for the normal children—
- (m) day to day planning proved orthopedically handicapped children can function as well as, or sometimes

better, than the non-handicapped child in group situation—

- (n) the awareness that a handicapped child can adjust normally to a normal routine program—
- (o) allowing the other children to be exposed to a handicapped child in a group situation—
- (p) exposure for non-handicapped child to the handicapped child—learning some people are different—for the leaders: opportunity to work with all kinds of children—
- (q) encourage acceptance by regular membership of the handicapped child—
- (r) gain was not to the center but to the children—
- (s) acceptance of orthopedically handicapped children—
- (t) being with and becoming friendly with children who are different—
- (u) greatest gain was to orthopedically handicapped children—
- (v) reach out into community and go beyond ordinary group work program and provide beneficial experience for orthopedically handicapped children.

15. Evaluation of program—

Did you have any problems in maintaining the orthopedically handicapped child in program?

5 supervisors out of 25 answered "yes" to this question—Reasons given are listed below:

- (A) behavior was not of the best—was generally unkind and rude to the group, especially to his brother—
- (B) poor attendance by some kids (cab problems, etc.) made true group participation difficult—
- (C) poor attendance—child tired when he got home from school at 4 o'clock—
- (D) drop out—some returned after home visit, others did not—
- (E) too much paperwork from New York Service.

16. Was there any modification in program to enable you to integrate the handicapped child?

	Yes	No	N.R.
(A) Dance Programs	2	18	5
(B) Active Games	13	10	2
(C) Dramatics	0	21	4
(D) Trips Away From Center	8	16	1