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EMPATHIC DEVELOPMENT IN NORMAL BROTHERS OF MENTALLY RETARDED BOYS

DISSERTATION

Presented in Partial Fulfillment of the Requirements for the Degree Doctor of Philosophy in the Graduate School of The Ohio State University

by

Solomon Abraham Levin, B.A., M.A.

* * * * *

The Ohio State University 1979

Reading Committee:

Henry Leland, Ph.D.
George Thompson, Ph.D.
Charles Wenar, Ph.D.

Approved By

Adviser

Department of Psychology
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VITA

January 21, 1951 ........................................... Born - Bronx, New York
1971 ...................................................... Visiting Student, Department of Medicine, University of Newcastle-Upon-Tyne, England
1972 ...................................................... B.A., State University of New York at Stony Brook
1972-1975 .............................................. Research Associate, Children's Hospital, Columbus, Ohio
1975 ...................................................... M.A., The Ohio State University, Columbus, Ohio
1976-1977 .............................................. Psychologist, Franklin County Program for the Mentally Retarded, Columbus, Ohio
1978- ............................................... Staff Psychologist, South Shore Counselling Assoc., Hanover, Mass.

PUBLICATIONS

"Adaptive Behavior: Family and Sibling Interaction."

FIELDS OF STUDY

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INTRODUCTION

During my tenure as a psychologist with the Franklin County Program for the Mentally Retarded, Columbus, Ohio, I worked with a number of direct care personnel who exhibited a special sensitivity to the needs of the retarded clients. This appreciation of the retarded seemed on an intuitive level to reflect insight generated from past experience. Indeed, upon inquiry, I discovered that some of these people were siblings of retarded brothers and sisters.

Farber (1968) and Grossman (1972) corroborate the above impressions by citing research which indicates that there is a consistent trend for siblings of the retarded to go into the "helping" professions. This trend appears to be influenced by factors such as the degree of the handicap, whether or not the retarded sibling was institutionalized, the sociopsychological composition of the family, and the birth order of the siblings. Permeating all of the factors is the impressionability of the normal sibling, his reaction to the retarded brother or sister, and his adjustment to the demands placed upon the home with a special needs child.
In an effort to explore some of the issues mentioned above, Frances K. Grossman (1972) performed a series of projects that involved adolescent siblings of retarded persons. Her first efforts attempted to gain information from adolescents in the form of a forum designed to discuss issues confronting them as siblings of retarded people. Dr. Grossman soon discovered that for a number of clinical reasons, including guilt and embarrassment, these adolescents could not be forthright with their comments. A later study solicited siblings of the retarded from college settings, and derived data from retrospective interviews. Dr. Grossman admittedly did not control for factors such as degree of handicap in the retarded, nor extent of institutionalization.

The exploratory study that was developed derived a large amount of information concerning effects of growing up with a retarded sibling. Dr. Grossman's research indicated that 45% of the interviewed students were judged to have benefitted rather than have been harmed by the experience of growing up with a retarded brother or sister. To quote from her findings:

In our clinical judgements those who had benefitted had a greater understanding of people, more tolerance of people in general and handicap in particular, more compassion, more sensitivity to prejudice and its consequences, more appreciation of their own good health and intelligence than many of their peers who had not had this experience, as well as a sense that the experience had drawn the family closer together (p. 93-94).
The above impressions were clinically derived from adolescents, as there was minimal application of standard psychological tests. Dr. Grossman has not pursued her research in this area further, though she has granted permission to use her work in any subsequent study (personal communication, 1977).

It becomes apparent that, at least for those interviewed, nearly half of the siblings of the retarded developed certain personality characteristics that were quite sensitive to both their own and others' feelings. The extent to which these normal siblings were affected by their brother or sister varied in a number of ways. A child with a retarded sibling of the same sex was affected more than if they were of different sexes, the process being one of identification. The impact on the family as a whole was stronger when the retarded child was male, and also varied if that child was preceded or followed by a normal male sibling. And finally, it appeared that the extent to which the parents accepted the retarded child and his or her handicap related strongly to the normal siblings' own ability to deal adaptively with the meaning of the handicap, to themselves and their own lives. Those families who freely and comfortably talked about the retarded child, and promoted appropriate personal and social adaptation in the retarded child, also enhanced the social adjustment of the normal sibling (Grossman, 1972).
Those characteristics of the normal sibling of the retarded children referred to as sensitivity, compassion, and appreciation of the feelings of others may be termed empathy. There is little in the way of research that investigates those influences in a child's life that encourages empathic development (Shantz, 1975). Recent writings have dealt with definition, attempting to distinguish empathy from role taking, person perception, social cognition, and egocentrism. It seems that empathy is regarded as the ability to understand another's feelings, with the further dichotomy of either cognitive empathy (i.e., understanding what another person is feeling), affective empathy (i.e., having the same emotion as the other person), or both (Deutsch and Madle, 1975). The area remains controversial.

Nevertheless, there are indications that empathy undergoes developmental changes, increasing with age (Deutsch and Madle, 1975). In addition, there appears to be a strong positive relationship between empathy and intelligence (Grossman, 1972). Yet, there are very few studies that explore how empathy develops and those factors that may enhance empathic development (Shantz, 1975).

The present study will address the above issues in an attempt to contribute to our understanding of the effects of a mentally retarded boy on the empathic development of his normal brother. Included in the research was an effort to explore parental attitudes toward mental retardation, the
impact of a special needs child upon the home, and criticisms parents have of existing social service and educational agencies within this Midwest region. A concerted effort was made to integrate empirical and clinical data collection, permitting aspects of traditional as well as liberal information gathering. It is hoped that the reader finds the following material to be both interesting and enlightening.
CHAPTER I

REVIEW OF THE LITERATURE

Normalization

Societies have, for centuries, approached abnormal members of their culture in various ways. Each so-called abnormal group, from those with physiologically based diseases such as hemophilia and Down's Syndrome, to those with primarily mental aberrations, such as schizophrenia, have been treated at some time with scorn, ostracism, and even extermination. In the past, lack of knowledge of these characteristics led to fear of contamination; thus, people inflicted with deviant qualities were avoided (Potter, 1972). As time went on, and science as well as humanitarianism progressed, matters changed. Virtually all groups who had at one time or another been snubbed have a history attached to changes in their status. Present day causes include minorities, women, and homosexuals. Of concern for this paper are those with mental retardation.

Intellectual limitations, with concomitant handicaps in functional living, have been discussed for decades. As we have become more sophisticated as conscious citizens,
study has been geared toward discovering the etiology and later amelioration of those with cognitive deficiencies. One need only to look at the organizations formed to enlighten people of learning disabilities, Down's Syndrome, autism, and dyslexia to understand current society's interest in intellectual and functional deficiency. At the forefront of many of these organizations are the parents of handicapped children.

As advocates for their inflicted children, parents have led professionals in the field of mental retardation to take a closer look at attitudes, definition, and intervention. Spearheaded by work in Europe, the year 1959 found Denmark to be the first nation to pass legislation that established a unified agency concerned with the health, education, and welfare of people with special needs, specifically based on helping them experience life as normally as possible (Bronston, 1971). A decade later, Sweden passed similar legislation. From then on, Wolf Wolferbeger, Frank Menolascino, and their co-workers mobilized a campaign in Nebraska to extend this normalization principle in the United States.

The history of America's treatment of those with mental retardation is discussed at length elsewhere, including Baumeister (1967), Baumeister and Butterfield (1970), Robinson and Robinson (1976), and Wolfensberger (1972). Rather than review already well documented material,
attention will be focused on approaches to mental retardation since the mid-1960's, when the field took a radical turn away from pessimism and isolation. Suffice to compare later discussion with a definition of mental deficiency written in 1937 (Tredgold):

...a state of incomplete mental development of such a kind and degree that the individual is incapable of adapting himself to the normal environment of his fellows in such a way as to maintain existence independently of supervision, control, or external support (p. 4).

With a heightened awareness of the limitations inherent in the traditional definition of mental retardation with respect to a concept of normalization, the American Association on Mental Deficiency (AAMD) in 1973 published a revised manual on terminology and classification which provided the following definition: "Mental retardation refers to significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior, and manifested during the developmental period (p. 11)." Each key term is further explained, to provide a useful barometer of mental retardation. Furthermore, a system was developed that classified mental retardation according to severity of the symptoms, etiology, and clinical variety or symptom constellation. Sensitivity was stressed in utilizing the modern conceptualization of mental retardation, as labeling may have not only positive but also negative implications.
As the principle of normalization has been accepted by educators, medical personnel, and mental health workers, its essentials are sometimes overlooked. Bronston (1971) writes that "the essence of that principle requires the use of culturally normative means and methods... to offer a person life conditions at least as good as the average citizen... and to as much as possible enhance or support his/her behavior, experience, status and reputation (p. 495)."

The greatest undertaking within the realm of normalization is to modify the general population's attitude toward deviancy, and to alter past accepted practices of institutionalization (Wolfensberger, 1972). To this end, organizations such as the Association for Retarded Children (ARC), AAMD, and others have been active advocates for the study and implementation of normalization principles. Beyond this is the philosophical orientation and belief system to not only experiment with normalization, but to anticipate that it will work.

To put theory into practice meant going beyond ideology. Prejudice needed to be overcome. The populace needed to be alerted to the plight of those with mental retardation through the use of the media. Even professional nearsightedness and stubbornness had to be addressed. Concepts such as "dignity," "courage," and "compassion" were utilized to accompany the identity of mental retardation. But all of the slogans might have been fruitless had it not
been for the parents and relatives of those with mental retardation, who campaigned for programs of fairness and rehabilitation. The Special Olympics is one recognizable achievement on a long road toward normalization.

Normalization is described in detail by Wolf Wolfensberger (1972), who continues to be a leader in the field. Yet, a closer glance at the literature of normalization reveals some neglect of the positive role of families as they relate to their mentally retarded child or adult. Clearly, to change society's former handling of the mentally retarded by institutionalization, one must provide alternatives that include the family and its role as supporter, provider, teacher, and advocate. A discussion of the family of mentally retarded persons will now be presented.

Effects of a Mentally Retarded Child on the Family

The introduction of any newborn represents some degree of intrusion in the family setting. With the arrival of a retarded child, it is intensified. The retarded child will require more attention, care, and frequently greater expense to the family. The normal attention and time given to the husband or wife and to the other children may be diverted to the handicapped child who appears to be in greater need (Chinn, Drew, and Logan, 1975).
Morris (1955) noted that the emotional reactions to the parent of the mentally retarded child are essentially a reaction of his own personality characteristics. He states that "to some, the mentally retarded child comes as an additional family member, to be loved and cherished, subject to the same privileges and restrictions as his siblings, geared to his sameness and differences. To others, he comes as a pawn or added burden in interpersonal conflict."

One must recognize that a diagnosis of mental retardation may not come immediately upon the birth of the child. Because mental retardation describes a cluster of behaviors and etiologies, a family may learn that their child is somehow "different" in either a radical manner, as in the hospital upon delivery, in a more prolonged fashion, such as recognition that developmental milestones are lagging, or by hints offered by friends, family, teachers, or physicians (Koch and Dobson, 1976; Wolfensberger, 1967). Another variant influencing family reactions to a child with mental retardation is the severity of the handicap (Farber, 1960). It is generally recognized that the more retarded individual will precipitate greater stress upon the family than will a less retarded individual (Farber, 1964). Nevertheless, when the label mental retardation is applied to a child, the family is greatly affected.
Olshansky (1962, 1966) indicated that mental deficiency is a family tragedy, and that most parents respond to the incident with "chronic sorrow," lasting as long as the child lives. Solnit and Stark (1961) have the view that the birth of a mentally defective child is a severe narcissistic blow similar to loss suffered through the death of a loved one, leaving the parents in a state of acute grief. Solnit and Stark suggested that the mother expects to have a normal child, and builds up a fantasy image of it. The birth of a defective child means the loss of the normal child. The defective child is somehow equated with a dead child. When the damaged child is born, there is no time for working through the loss of the expected normal child because the "unexpected" abnormal baby requires immediate attention.

Jordan (1962), Kew (1975), and Levinson (1975) described the birth of a handicapped child as a precipitant to parental as well as family crisis. Farber (1960), however, suggested that the introduction of the retarded child need not create a family crisis, although this is a potentiality. How the event is defined by the family will determine whether or not a real crisis exists. Chinn (1974) stated that whether or not an event becomes a crisis depends on three basic conditions: 1. The nature of the event, 2. The resources of the family, 3. How the family defines the event. There are few families, however, in which the
stigma of mental retardation imposed by society will not cause the event to be interpreted as a crisis. Particularly for families in which the parents are educated and goal-oriented, the birth of a retarded child causes frustration and destruction of decisions and plans for the future (Chinn et al., 1975).

The myriad of psychological repercussions affecting a family with a mentally retarded child transcends use of the term "typical reaction." Nevertheless, parents and extended families have been studied, and research supplies us with a cluster of reactions, some of which may be experienced by all families with a retarded child. Kravaceus and Hayes (1969) and Ryckman and Henderson (1965) wrote that a child represents the extension of the parents' self, and the birth of a defective child can represent a serious threat to the parental ego. In addition, parents may also tend to view their child as a means of vicarious satisfaction. They often hope to see their children achieve physically, educationally, professionally, and financially as they themselves would like to have done, to fulfill their own denied dreams of success. Thus the mentally retarded child may cause his parents extreme disappointment in his failure to meet such expectations. Parents also have tendencies to feel that they can "transcend" death through their children, thus, even further frustration may develop when they realize that the retarded child deprives them of this
desire.

Because parents' egos are seriously jeopardized by the birth of a retarded child, defense mechanisms are activated to defend against the debilitating effect of this child on self concept. Kanner (1953) suggested that denial is a common reaction, especially during the initial stage of adjustment, providing a form of self protection against the painful realities. Parents simply deny that the handicap exists, explaining away the child's limitations by implying laziness, indifference, or lack of motivation. Farber and Rykman (1965) pointed out that denial of retardation by the parents should not be viewed as pathological. They suggested that it is merely a reaction, saying that the parents who deny the existence of retardation consider themselves and their family as normal, while those who accept the diagnosis readily merely have their suspicions of self-inadequacy confirmed.

When mental retardation continues to be evident for long periods or is severe, denial may be augmented by projection of blame. Frequently, the targets for attack are individuals who may be responsible for causing the parents considerable frustration and sometimes agony. Usually, the blame is placed on an incompetent obstetrician or pediatrician, who often is the first one to tell the parent of the diagnosis. How tactfully these professionals, as well as psychologists, nurses, teachers, or social
workers, tell the parent the "bad news," often will determine how much blame the parents project onto others. Another consideration that impacts upon the parents' relationship is whether or not the child was planned or spontaneous. If originally the child was not planned, parents may attack and blame each other for their misfortune. This puts further strain on a relationship already traumatized by the initial diagnosis of mental retardation.

Parents occasionally react to the birth of their retarded child with mourning or death wishes (Begab, 1966; Hart, 1970). Begab (1966) stated that it is not uncommon for parents to harbor death wishes toward their retarded child, particularly when he becomes burdensome and they wish to be rid of him. Many of these parents would deny their death wishes if confronted, as they are unable to acknowledge these hidden wishes on a conscious level. Wolfensberger (1967) noted that a parent may feel guilty because he notices that his anger and hostility is directed toward the child and that he feels impulses to reject and perhaps destroy the child. Cohen (1962) reasoned that parental anger was the same as that occasionally experienced by most people toward those they love, but because of the handicapped condition of the child the normally experienced guilt may be intensified. Wolfensberger pointed out that ambivalence, rather than purely guilt, may be a more readily
understood reaction of parents. On one hand, a handicap in a child is almost certain to make for disappointment, grief, frustration, and anger in a parent who will occasionally have these feelings even about a normal child. On the other hand, the impulse to love and protect the young is deeply rooted in human values, and probably instincts. Logically, ambivalence should be stronger in parents of handicapped than non-handicapped children, but the topic is hardly mentioned in the literature and remains open to further investigation.

Wolfensberger (1967) described three different types of parental reaction to the discovery that their child is retarded. The outright demolition of expectations is received with "novelty shock crisis." A second crisis may be described as "value crisis," which can lead to various degrees of emotional rejection of the retardate. This crisis may actually last a lifetime. And finally, the "reality crisis" forces the parents to face the demands of raising this child of many special needs. Wolfensberger adds that much of the data on long-range adjustment of parents are impressionistic, may be poorly controlled, and recommends that further research match families with a retarded child to other families without a mentally retarded child.

One of the most common but delicate parental reactions to deal with is that of rejection. If rejection
is equated with negative feelings that parents may
directs toward their children, then clearly all parents
experience these feelings toward all children at some time.
However, it is rejection in its extreme which we are con­
sidering. Gallagher (1956) defined parental rejection as
"the persistent and unrelieved holding of unrealistic neg­
ative values of the child to the extent that the whole
behavior of the parent toward the child is colored un­
realistically by this negative tone." Gallagher stated
four general ways in which rejection is expressed:
1. Strong underexpectations of achievement, thus minimizing
or ignoring any of the child's positive attributes and
generating in the child a "self fulfilling prophecy."
2. Setting of unrealistic goals, and when the child cannot
reach them, the parents feel justified in their negative
attitudes toward him, 3. Escape, or actual desertion, of a
parent from the family. More subtle forms of escape may be
to stay at the office longer or unnecessary placement of
the child in an institution, 4. Reaction formation, as the
public presentation of the parents as kind, loving, and
warm. It is often the case that primary rejection and
secondary rejection take different forms, and it is the
obligation of mental health professionals to distinguish
between the two when intervention is considered.
Differential effects are noted in relation to the mother and father with the retarded child. Cain and Levine (1963) and Tallman (1961) reported that fathers tended to be more highly motivated in coping with problems of retarded boys than of retarded girls. Similarly, fathers were better able to cope with non-Down's Syndrome children. Tallman also found that whereas the mother's ability to cope with the child was associated with factors intrinsic to the parent-child relationship (i.e., child's I.Q. and social competence), the father's ability to cope with the child was related to the child's sex and diagnostic classification. Peck and Stephens (1960) found a high correlation between the father's acceptance or rejection of his mentally retarded child and the amount of acceptance or rejection recorded in the home situation. Reeder (1973) also stated that the role of the father is critically important in a family's management of the problem of mental retardation. Dimperio (1975) added that psychosocial maladjustment may occur in specific relation to the presence of the retarded child in the family, but may not generalize to influence father's overall personality functioning to a significant degree.

That a mentally retarded child affects the family unit is generally unequivocal. The negative impact has been discussed at length, while the positive influence has been seriously neglected. Marital integration, the sex of
the retarded child, supportive versus nonsupportive community participation, and reaction of normal siblings all tend to influence how a family reacts to their retarded member (Farber, 1968). Patterns of coping by parents, which include counseling and religious involvement, are discussed by Hutt and Gibby (1976) and Wolfensberger (1967), and exceeds the scope and intent of this discussion. The influence of a mentally retarded child on his siblings is vital to this study, and is addressed in the forthcoming section.

Effects of a Mentally Retarded Child on his Siblings

Brian Sutton-Smith and B.G. Rosenberg (1970) wrote that "life among siblings is like living in the nude, psychologically speaking (p. 6)." Siblings are capable of stripping down their relationships to bare all, and in that manner influence one another immensely. To understand siblings one must concentrate on them in terms of interaction, rather than their differential treatment by parents. A discussion of the influence of a mentally retarded child upon his siblings must be preceded by an introduction to the literature of normal sibling relations.

Glass, Horowitz, Firestone, and Grinker (1963) claimed that birth order is not a psychological variable, but much of the literature on siblings concentrates on
primarily that factor. Most studies use middle class families from which to draw conclusions. Bossard and Boll (1956) wrote that "many older children...are exploited by being called upon to aid in the rearing of younger children to an extent that interferes with their own life plans. As a result, the older child tends to develop marked behavior trends in the direction of maturing and of habits of responsibility and service to others (p. ?)." Thus, the older sibling, as closest to parents, carry out surrogate responsibilities. The later born is more autonomous, and is modeled from more and varied sources.

The sex factor enters into discussion, as Sutton-Smith and Rosenberg commented that the sexual makeup of the siblings influence their interests, preferences, abilities, and behavior. First-borns are perceived by later borns as more bossy. To get siblings to comply with them, males use more physical techniques, females more symbolic techniques. These authors noted that the mother, expecting higher levels of achievement, paying much attention to her first-born as an infant, being inconsistently rewarding and demanding over time, shapes up a child who reaches out for her and for others who provides social guidance and partial reinforcement. Collective research implies that first-borns are more anxious, affiliative, and achieving toward adults, more like adults in being conservative, of high conscience, and preferring verbal means of role inference, but also
powerful and domineering in their relationships to subordinates (Sutton-Smith and Rosenberg, 1970).

Harris (1964) added that the first-born relies on a principle of coping which involves empathy based on verbal feedback from a model (parent), and leads to an understanding of the thoughts and judgements behind the external forms. The second-born uses withdrawal in the face of power from the older sibling and parents. Most evidence indicates that the later born are more affected by the older sibling than vice versa. Indeed, Adler (1959) wrote that the later born becomes a power seeker as a result of long years of subjection. MacFarlane, Allen, and Honzik (1954) commented that the second-born is more externalizing, the first-born more internalizing. Sears, Maccoby, and Levin (1957) noted that relatively greater amounts of frustration and discomforting control in a family comes from the persons who are immediately above the child in the power hierarchy than from other family members, and regardless of the parents' permissiveness and punitiveness, the younger child tends to be more aggressive towards those persons. Stotland and Dunn (1962, 1963) recognized that the later borns empathize more with those whom they perceive as similar to themselves and with whom they can interact, which is a replication of their developmental experience with older siblings. Eisenman (1965) also stated that aesthetics are higher in the later born, while Sutton-Smith and Rosenberg (1970) said
that the evidence for later born flexibility and empathy is tenuous.

It seems clear from the wealth of studies cited that siblings are inherently influenced by each other and their parents, to the extent that aspects of personality may be determined by ordinal position and sex of the siblings. Seeing that the factors of sibling interaction are complex, even in the relatively simple composition of a two-child family where both children are "normal," what added difficulties exist in the study of special needs children with their siblings? Fortunately, literature does exist in this area, primarily via research of the interview variety.

In a book written from the perspective of a social worker, Stephen Kew (1975) emphasized the prevention of difficulties in the normal sibling of a handicapped child. Historically, siblings of the handicapped lie on the periphery of concern, with evidence that these children show a greater degree of emotional disturbance (McMichael, 1971). Kew discussed primarily the negative effects of a handicapped child upon his siblings, to include disruptive behavior, clinging, tantrums, psychosomatic pains, promiscuity, and stealing. Farber (1965) pointed out that the more mildly handicapped the child, the less his effect will be on the able-bodied sibling. Kew (1975) added that with the overprotectiveness given to a mentally retarded child
by his parents, the normal siblings take on more responsibility but also generate jealousy and hostility toward this handicapped child.

Strauss (1963) offered a poignant summation of one positive effect of being raised with a handicapped child. He wrote that the sustained interaction with the retarded sibling comes to be regarded as a duty by the normal siblings, and in the performance of this duty the normal sibling internalizes welfare norms and turns his life career towards the improvement of mankind, or at least towards goals requiring dedication and sacrifice. Kew (1975) noted that the reaction of the normal sibling to the retarded sibling in influenced by the parents' reaction to the retarded child. He brings forth a number of variables that affect the normal sibling, which include the nature and degree of the handicap, its meaning to the parents, the age of the sibling, sex of the sibling, size of the family, birth order, religion, substitute parent figures, and the person's intrinsic personality. A complex and lengthy list indeed.

Wolfensberger (1967) wrote that studies of the siblings of the retarded have also been poorly controlled, and the findings on adjustment and maladjustment of siblings of the retarded can only be viewed as suggestive until equivalent families with nonretarded children are studied with the same methods and instruments. In a study that
approached teen-age siblings of retarded children, Graliker, Fishler, and Koch (1962) concluded that the presence of a young retarded child in the home did not seem to have an adverse effect upon the teen-agers. This seemed to be particularly the case where early parent guidance had helped the family to maintain its equilibrium. Until 1967, at Wolfensberger's writing, he concluded that no strong evidence existed to support or deny either the positive or negative adjustment of siblings of the retarded.

Farber (1968) agreed with the earlier comments of Strauss (1963) by suggesting that normal siblings who interact regularly with the retarded child and at times act as parent surrogates internalize welfare norms and tend to opt for the more altruistic vocational choices emphasizing "devotion to mankind" and "devotion to worthwhile causes." Farber further stated that the effect of the retarded child on normal siblings who maintain close relationships to their retarded brother or sister may not consider anyone as a marriage partner who demonstrates little tolerance for the handicapped child.

Grossman (1972), however, found that an equal number of subjects sampled in her study were judged to be affected negatively by the experience of having a handicapped sibling. Some of the negative effects noted included shame, a sense of being tainted or defective, and a sense of guilt for being the child who was not retarded or for their
negative feelings toward their retarded sibling. Some indicated resentment toward the disrupting influence on the family unity, such as stress on parental relationships and neglect of normal children in the family.

We are able to see clearly that the advent of a retarded child into the family has an impact on normal siblings as well as the parents. Younger children who do not have accurate information may develop fears and fantasies. Adolescents have many concerns and questions needing answers. The presence of a mentally retarded child may benefit a normal sibling, but may have an adverse effect on others (Chinn et al., 1975). Attention will now turn to a potential positive influence, and the foundation for the present study.

On the Concept of Empathy

Empathy is an imprecise quantity and quality; there are no material or "public" referents for it (Aspy, 1975). Yet, this intangible conception is referred to often in common expressions such as "I know what you mean," "I'm with ya," "Get inside his skin." To nonspecialists, empathy may simply be that human experience which is reflected in various ways by these commonplace expressions.

It is not enough, however, to be informal in our use of this vastly complex conception, even though everyday
usage may find the above acceptable. The nature of empathy has a history in philosophy as well as in psychology, dating back to 1909, when Lipps coined the term 'Einfühlung' which was translated into empathy or "feeling together with (Boring, 1929; Bushheimer, 1963)." But researchers (Lipps, 1909; Ribot, 1897; Titchner, 1910) assessed self in relation to physical objects rather than self-other person differentiation. They also were not interested in studying empathy as shared feelings, or an understanding of another's affect alone or in a context. In addition, the processes that might explain empathy were not investigated (Deutsch and Madle, 1975).

Originally written in 1917, Edith Stein's On the Problem of Empathy approached the definition of empathy from a philosophical and psychological vantage point. She wrote that empathy "is a kind of act of perceiving...it is the experience of foreign consciousness in general, irrespective of the kind of the experiencing subject or of the subjects whose consciousness is experienced." She delineated degrees, or grades, of empathy as 1. the emergence of the experience 2. the fulfilling explication 3. the comprehensive objectification of the explained experience. Her writings differentiated empathy as "in-feeling," and sympathy as "with-feeling." In the ideal case, for example, empathic joy expressly claims to be the same in every respect as grasped joy, to have the same content
and only a different mode of being given. Stein's enlightening, and grossly overlooked, book further differentiated between perception as having its object before it in embodied givenness, while empathy does not. Stein argued against mere semantics in the differentiation of empathy from projection, imitation, or reflection. She does posit the idea that empathy may be enhanced through a contagion of feelings. Stein even antecedes Piaget by saying that the "I" (id) at birth only later develops into "other perception." Stein added that expression may reflect different internal feeling states; it is empathy that differentiates one from the other. In a further effort to strengthen her views, Stein wrote that "the perceived world and the world given empathically is the same world differentially seen." Finally, she said that "if we take the self as the standard, we lock ourselves into the prism of our individuality. Others become riddles for us, or still worse, we remodel them into our image and so falsify historical truth."

The profound quality of Stein's book is realized even more when modern writings and research are reviewed. One begins to see Stein's themes repeating and repeating. Lipps (1926, 1935) altered his initial position for the inferences that the empathic response is: 1. a response to a person rather than an object, 2. both a sharing and understanding of postures and expressions, and 3. explained
by the mechanisms of projection and imitation. He argued that as a result of individuals partially imitating others with slight movements in either expressions or postures, inner cues are created which lead to an understanding and sharing of feelings. Therefore, his position appears to be an isomorphic one: as imitation of affect increases, empathy increases (Deutsch and Madle, 1975).

Kohler (1927, 1947) specified an empathic response as an observer's understanding of an individual's affect alone. He posed that the degree to which physical cues were used to infer another's emotion is empathy, rather than assessing an individual's replication of physical states. Insisting that the imitative explanation of empathy began in infancy, Freud (1961), Fromm-Reichman (1950), and Sullivan (1940, 1953) viewed empathy as a peculiar emotional linkage between mother and neonate. Stotland, Sherman, and Shaver (1971) maintained that the observer who actually shares the feelings of another is reflecting empathy. They wrote that "an observer's reacting emotionally because he perceives that another is experiencing or is about to experience an emotion" defines empathy.

The modern issues of the affective and cognitive components of empathy, reference to the environment, and need for self-other differentiation, was expressed by Mead (1934). According to Mead, the development of self
consciousness - that which makes us fully human - depends on the ability to regard oneself from the perspective of the others with whom one is involved. One must strive continually to envision the attitudes that others hold toward oneself - this is fundamental to the operation of society as well as to the development of personality (Hogan, 1975). Similarly, Kelly (1955) analyzed social interaction in terms of roles and role constructs. Neither Mead nor Kelly used the term empathy; nonetheless, the concepts of role taking (Mead) and role construction (Kelly) clearly depend on the existence of an underlying empathic capacity. As used by the role theorists, then, empathy refers to the process of representing to oneself the expectations that others hold with regard to one's behavior.

The issue of projection versus empathy was addressed again by Freud (Brown, 1967), who stated that whenever the internal becomes confused with the external or the subjective is confused with the objective, then the individual projects. Cronbach (1955) demonstrated that empathic ability may reflect the similarity between the response repertoires of two people or that by possessing knowledge of a type of person, one may project and thus seem empathic. Dymond (1950) distinguished empathy from projection and implied that the empathizer is neutral and detached.
Rogers (1958) introduced the clinician's view of empathy as the ability to sense the client's private world as if it were your own, but without ever losing the "as if" quality. His later sense of empathy included the idea that "for the time being you lay aside the views and values you hold for yourself in order to enter another's world without prejudice (p. 4)." A number of research findings in the area of psychotherapy and empathy, besides Rogers (1975) reference, lead to several enlightening conclusions. It appears that the ideal therapist is empathic (Raskin, 1974), empathy early in the relationship predicts later success (Tausch, 1973), the client comes to perceive more empathy in successful cases (Cartwright and Lerner, 1966; Van Der Veen, 1970), the more experienced the therapist, the more likely he is to be empathic (Fiedler, 1949; Mullen and Abeles, 1972), the better integrated the therapist is within himself, the higher the degree of empathy he exhibits (Bergin and Solomon, 1970), clients are better judges of the degree of empathy than are therapists (Rogers, Gendlin, Kiesler, and Truax, 1967), and, interestingly, brilliance and diagnostic perceptiveness are unrelated to empathy (Bergin and Jasper, 1969; Bergin and Solomon, 1970; Fiedler, 1953). Much of the process of empathy in counseling, and an assessment of empathy within psychotherapy, has been performed by Truax and Carkhuff (1967).
Deutsch and Madle (1975) remarked that much of the above discussion leads to a recent agreement that an empathic response requires self-other differentiation and that it is a response to another's affective state either alone or in a situation. It is related to person perception (Dubin and Dubin, 1965; Heider, 1958; Livesley and Bromley, 1973), but differs significantly in conceptualization and operation. Empathy shares some similarity to the process of moral development and judgement (Berndt and Berndt, 1975; Piaget, 1932), but again retains marked differences. Indeed, empathy has emerged as a field of study in its own right, subject to scrutiny and debate.

One controversial area concerns the actual measurement of empathy. While lacking an operational definition, researchers still have attempted to measure empathy as predictive or situational (Kagan et al., 1967). Predictive measures have been concerned with a person's accuracy in predicting the self ratings or preferences of another individual (Dymond, Hughes, and Raabe, 1952) or group (Kerr and Speroff, 1954). More diverse than predictive measures, situational ones require that the empathic response, whether affective and/or cognitive, be a response to a person's affect, situation, or both. The contexts portrayed have been real (Stotland and Walsh, 1963), photographs or line drawings of facial expressions, situations, or stories (Borke, 1971; Deutsch, 1975; Gates, 1923; Feshbach and
Roe, 1968), audio-recordings (Rothenberg, 1970), or video-taped interaction sequences (Danish and Kagan, 1971; Deutsch, 1974). In all cases, standardized, affectively laden situations are used to assess an individual's perception of affective or situational stimuli. Deutsch and Madle (1975) encouraged more thorough validation studies of existing empathy measuring devices, stressing a need for more internal consistency, convergent and discriminant validity, and intervention effects.

The need for better assessment devices to measure empathy has not prohibited studies in which some statement about empathy is made. As mentioned earlier, empathy began as a concept focused primarily upon adults. For the purpose of this discussion, empathy as applied to children will be reviewed.

Smither (1977), in a reconsideration of the developmental study of empathy, attempted to show that empathy constitutes, not a unidimensional ability, but a family of related skills. She added that the nature of the processes and skills involved in any one case of empathy depends on particular dimensions of the situational context, the nature of the empathetee's feeling-state, including certain appraisals about that context, and the manner in which those feelings are expressed. Most studies with children focus only on part of these dimensions. Gates (1923) presented six facial expressions to 438 children, ranging in age from
three to 14 years. Findings from this study showed empathy scores increasing with chronological age. Similarly, Walton (1936) found empathy to increase with age as well as to differentiate artistic from non-artistic children. Again measuring situational empathy, Burns and Cavey (1957) showed eight line drawings to children aged three to six and one-half years, found empathy and age as increasing together, and accept as an empathic response one in which the subject correctly inferred the feelings of a portrayed figure in a particular situation.

Feshbach and Roe (1968) developed an Affective Situations Test to investigate empathy with several of its parameters. The device presents eight three-slide sequences of four affective situations: happy, sad, angry, and afraid. Their first efforts with middle class first grade boys and girls showed that, while empathy presupposes some degree of social understanding, understanding the feelings of another person does not necessarily lead to an empathic response. They concluded that while the cognitive dimension of empathy is important, it is the affective component that gives the empathy construct its unique property. The 1968 study found interrater reliability to have a minimum value of $r = .96$. A later validation study (Fairbanks, 1973) found no significant difference between six and eight year olds, nor was there difference found between males and females. Another study using a variation of the Affective Situations
found similarity between stimulus person and subject to be significant: black girls empathized more with black stimulus persons and white girls with white stimulus persons (Klein, 1970).

In regard to other group comparisons, several studies bear on age and sex differences in empathy (Feshbach, 1975). The overall data indicate that children between the ages of five and eight become more empathic with increasing age (Fay, 1970; Feshbach and Feshbach, 1969; Kuchenbecker, Feshbach, and Pletcher, 1974). The data relating to sex differences are less consistent although there are some findings which suggest that girls are more empathic than boys, this effect being more evident between four and seven years of age (Fay, 1970; Feshbach and Feshbach, 1969; Kuchenbecker, Feshbach, and Pletsher, 1973; Feshbach and Roe, 1968; Hoffman and Levine, 1976).

Borke (1971) presented a series of short stories to children between the ages of three and eight years. Her study supported Piaget's observation that social sensitivity increases with age but challenges his position that young children are egocentric and unable to understand another person's viewpoint. Children as young as three years of age showed an awareness of other people's feelings and could identify the specific situations that evoke different kinds of affective responses. Both Borke and Chandler and Greenspan (1972) appear to accept a cognitive response as
a sufficient criterion for empathy, but they too arrive at conclusions similar to those from the Feshbach research. The affective versus cognitive response to the evaluation of situational empathy has generated much debate (Deutsch, 1974), the introduction of even more devices (Iannotti and Meacham, 1974; Iannotti, 1975, 1978), but the relationship of empathy to age, sex, and race appear to remain consistent among these instruments and approaches.

What appears to be lacking are studies that explore accepted aspects of empathic development within a population that may have opportunities to enhance empathy. These life situations differ from attempts to train people for increased empathy (Iannotti, 1978) in that their experiences are more realistic and long lasting. Otherwise normal children who are raised with a mentally retarded sibling may be influenced by factors that encourage empathic consideration, and intuitively this may make sense, but ultimately we do not have research to answer this question. The present study will look at this issue from the perspective of empathy as a situational factor that accepts the Feshbach three-component model of empathy (Feshbach, 1973). Two of these components are cognitive in nature: the ability to discriminate and label affective states in others and the ability to assume the perspective and role of another person, the latter reflecting a more advanced level of cognitive competence. Emotional capacity and
responsiveness constitute the third component. These three elements were considered in the development and present utilization of the Affective Situations Test.
Statement of Hypotheses

Having reviewed the concept of normalization, the effects of a mentally retarded child on the whole family, normal sibling relationships, and the effects of a mentally retarded child on his siblings, an extensive review of the literature on empathy was presented in conjunction with the above material to generate the following hypotheses:

I. Brothers of retarded boys will, as a group, have a higher level of empathy when compared to a matched control group of boys not influenced by a retarded brother.

II. Older brothers of retarded boys will have higher levels of empathy than younger brothers of retarded boys.

III. Older boys, as a group, will have a higher level of empathy than younger boys.

IV. Those homes which encourage adaptive behavior will, in general, enhance empathic development in normal boys.
CHAPTER II

METHOD

Subjects

An effort such as the present study necessitated the utilization of an organization that would have the resources to identify and locate families with a mentally retarded child. Permission was granted by Mr. Stephen G. Pleasnick, the Superintendent of the Franklin County Program for the Mentally Retarded, Columbus, Ohio, to gain access to the files of approximately 1,700 clients of the Program. From this population, families were selected who met the primary criterion of having a moderately retarded boy at home who had either an older or younger brother in the age range of five to twelve years without mental retardation.

In order to preserve the homogeneity of the sample so that confounding variables would be minimized, all families selected were Caucasian and from a predominantly middle class background (Hollingshead, 1957). The residences of these families were spread throughout Franklin County. No constraints were made for selection on the basis of
family size, religious preference, or kind and degree of mental retardation in the afflicted child, although these variables would be considered in an analysis of the findings.

Even with these relatively few conditions, of the 1,700 clients in the files of the Franklin County Program, only 24 families were identified that could meet the criteria. Because the study was performed in the summer, two families were on vacation and unable to participate. Upon initial recruitment, two families preferred not to take part in the research.

The design of the study called for samples of normal boys who were younger and older brothers of mentally retarded boys. Among the 20 remaining research families, four had both a younger and older normal boy. These four families agreed to participate. Of the remaining 16, four were eliminated due to unequal sample size considerations, logistics in travel time, and difficulty in coordinating the home visit. Therefore, the experimental group included that family who had a moderately retarded boy as well as a normal boy in the home, between the ages of five and twelve. Sixteen such families participated in the study, comprising 20 normal boys, ten of whom were younger, and ten of whom were older brothers of a mentally retarded boy. In each case, both parents lived at home.
The present study called for a control group consisting of families matched in characteristics to the experimental group, but not containing a mentally retarded child. These families were found in one of two ways. Either they were located through personal friends of the author (three families), or they were suggested by the experimental families themselves (seven families). When in the home, the author asked the parents if they knew a family in the neighborhood who had at least two boys, one of whom was in the age range of five to sixteen years. In this manner, seven families were identified and agreed to participate. Among the ten control families were 20 boys who fit the above criteria. In addition, within these same families, if two or even three boys were within the ages of five to twelve years, they were included as younger or older brother to their sibling. Of these ten families, one was a single parent family (mother at home), and one lived outside of the Franklin County region (Hingham, Mass.). Otherwise, these families were well matched in demographic characteristics to the experimental families.

Once a suitable family was identified, its cooperation was solicited by an initial telephone call. The author was familiar to many families active with the Franklin County Program, since he was a staff psychologist. A typical call would introduce the author by name, mention his affiliation with the Program and the Ohio State
University, and introduce the research. The project was described as "performing a study that will attempt to gather information about normal brothers of mentally retarded boys. In particular, I am interested in learning about how the normal boys' empathic development may be affected by growing up with a retarded child in the home."

Further discussion clarified the concept of empathy, mentioned the empathy test to be used, administration of a quick measurement of verbal intelligence, and asked for the parents' time to participate in filling out the Adaptive Behavior Scale as well as submitting themselves to a clinical interview. As mentioned earlier, two families preferred not to participate, while sixteen experimental and ten control families agreed to take part in the study. All families were promised strict anonymity and confidentiality of their identities.

To summarize, a total of 26 families participated in this research; 16 had a mentally retarded boy and thus were considered experimental families, while ten were devoid of retardation and considered control families. Among these 26 families were 40 boys who constituted the target subjects; 10 younger and 10 older brothers of mentally retarded boys, and 10 younger and 10 older brothers of boys similar in age to the retarded child but not mentally retarded themselves.
The mean age of boys in the experimental-younger brother group was 95.5 months, in the experimental-older brother group 108.8 months, in the control-younger brother group 91.4 months, and in the control-older brother group 115.0 months. The mean age for all subjects combined was 102.7 months, with a minimum age of 66 months and a maximum age of 144 months. Table 1 shows the demographic breakdown of the 40 individual subjects.

Materials

The Feshbach and Roe Affective Situations Test for Empathy (FRASTE) (1968) was identified as the only suitable empathy measurement for the population under study (Johnson, 1976). In this device (Appendix A), children are individually administered a series of slide sequences with narration depicting a boy in different affective situations. The slides were shown to all subjects on an Acme Lite Hand and Tabletop Viewer, No. 77, which has a 2 x 3 inch viewing screen. These slide sequences convey happiness, sadness, fear, and anger. Immediately following each sequence, the child was asked to state how he feels. In order for empathy to be scored, the feeling reflected in the response has to be a specific match with the affective situation observed. The subjects received a score of one for each specific match. Since there are two sequences of three slides for
Table 1

Demographic description of the 40 individual subjects.

All subjects were Caucasian, middle class; numbers 1-20 in experimental group; numbers 21-40 in control group.

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Table 1 (continued)
each of four affects, the empathy score for a specific affect can range from zero to two, while the total empathy score can range from zero to eight. Published reliability and validity information has been discussed in an earlier section.

Because of the paucity of published material using the Feshbach and Roe Affective Situations Test for Empathy on the age range of six to twelve years, reliability of the test was investigated. The Kuder-Richardson Reliability (No. 8) was performed on the total of 40 children tested, finding internal reliability as $r = .691$. Closer inspection revealed item number five to compare least favorably with overall reliability ($r = .146$).

The Peabody Picture Vocabulary Test (Dunn, 1965) is a widely used estimate of verbal intelligence through the measurement of hearing vocabulary. It is suitable for children between the ages of two years six months and eighteen years, who are able to hear words, see the drawings, and have the facility to indicate "yes" or "no" in a manner which communicates. The Peabody Picture Vocabulary Test was standardized on 4,012 cases in 1958, with extensive research and practical application since. Research findings with regard to validity and reliability of the PPVT are contained in the test manual. Intelligence quotients are found by using tables that convert raw scores and chronological age to I.Q.
The American Association for Mental Deficiency

Adaptive Behavior Scale (Nihira, Foster, Shellhaas, and Leland, 1974) has emerged as a widely accepted and often used device for rating behavior of mentally retarded, emotionally maladjusted, and developmentally disabled individuals (Appendix B). It is designed to provide objective descriptions and evaluations of a person's adaptive behavior, and functions as a practical adjunct to the more limited information gained from an I.Q. score. The Adaptive Behavior Scale manual describes part one of the two-part scale as "organized along developmental lines, and is designed to evaluate an individual's skills and habits in ten behavior domains...considered important to the development of personal independence in daily living." Part two is designed to provide measures of maladaptive behavior related to personality and behavior disorders. Methods vary in the administration of the Scale; for the purposes of the present study, the third party assessment was used, with the examiner asking a parent each question, one by one. Extensive description of the Scale is included in the manual, as is validity and reliability information.

Kennett (1977) introduced the Family Behavior Profile (FBP) as an extension of the AAMD Adaptive Behavior Scale (Appendix C). He wrote that the Profile "provides behavioral patterns of related individuals and a family constellation as an aid in identifying deficiencies in
the home environment, in developing appropriate training programs to increase awareness of the importance of the home environment to provide behavioral information relevant to cultural and familial aspects of etiology, to aid in developing realistic goals and to aid in devising modelling techniques in a real situation." Because of the recent introduction of the Profile, the present study used the scale on an experimental basis, providing reliability data as well as a means for evaluating adaptive atmosphere within the home.

The Family Behavior Profile consists of two graphs of pie-shape with each sector representing a sub-domain of the Adaptive Behavior Scale. The center of the circle represents non-coping behavior, while the outer perimeter of the circle reflects exceptional conformity to social norms and may indicate tendencies to be so exacting that normal flexibility is eliminated for the sake of conformity to social norms. For the purposes of this research, the area between zero and the outer perimeter was divided into ten sections: 0-3 as generally non-conforming, 4-7 as generally acceptable in society, and 8-10 as exceptional conformity. The Profile is used after the administration of the Adaptive Behavior Scale and applied
to the family as a whole. The person completing the FBP (in this case, one or both experimenters) should be familiar with the general composition and specific sub-domains of the Adaptive Behavior Scale.

The limited prior application of the Family Behavior Profile to families such as those in the present study pointed to a need for a measure of interrater reliability. Immediately after the 13 home visits in which both experimenters participated, the Family Behavior Profile was completed and scored. From these forms were 416 bits of data, representing the sub-domains of the instrument across 13 families in which both experimenters were involved. The correlation coefficient ($r = .608, p < .001$) substantiates the high degree of interrater reliability that was attainable using the Family Behavior Profile.

**Procedure and Experimental Design**

An integral part of the overall design of the study consisted of the need to include interrater reliability measures of the assessment devices. To that end, the author recruited a third year undergraduate student at the Ohio State University who indicated a desire to participate in
on-going psychological research. Having sensitized her to the demands of performing research in the home, and reviewing her knowledge of research, mental retardation, and interviewing techniques, the author gave her the aforementioned material to study and review. An extended follow-up period that included role playing satisfied this author that his assistant was competent to administer and score the Adaptive Behavior Scale and the Family Behavior Profile.

The procedure for identifying subjects for the study was described earlier. Once a parent indicated willingness to participate in the project, an appointment was arranged that would insure the availability of the parents, the normal brother, and in experimental families, the retarded boy as well. For 14 of the 26 home visits, the author's assistant participated in the data collection. Upon arriving in the home, the author offered an introduction to the research, reaffirmed confidentially, and asked for written permission to incorporate the findings into a final report. Once the experimenters were in the home, no parent withdrew permission to continue the study.

The initial testing was geared toward the normal brother, who was administered the Affective Situations Test for Empathy by the author in a quiet place after a brief warm-up period that included questions about the boy's age, school, hobbies, favorite activities, and a description of the study. Forty boys participated in this
phase of testing. The Empathy Test was introduced according to the standards provided with the test. Instructions were approximately as follows: "I am going to show you a series of slides and tell you a story of a boy in different situations. After I finish each story, I will ask you to tell me how you feel." The script of the stories is included in Appendix A. All boys responded to all affective situations; fatigue and attention span difficulties were never encountered. The responses were recorded on lined paper place discretely so as not to interfere with the testing. The sequence of affective situations were: Happy-I, Angry-I, Sad-I, Frightened-I, Angry-II, Sad-II, Frightened-II, and Happy-II. Acceptable synonym to Angry was Mad, to Sad was Unhappy, and to Frightened was Scared. A measure of social competence was elicited by asking each subject "how do you think the boy in the picture feels?" All responses matched the Empathy response.

At the completion of this test, which took on the average 15 minutes, the examiner asked the child how he felt, if he had any questions to that point, and if he felt like he could continue. The atmosphere was casual and non-threatening, and all boys agreed to continue. The Peabody Picture Vocabulary Test was introduced by saying that "I am going to show you some pictures. On this page are four pictures, with each of them numbered. I will say a word, then I want you to tell me the number of (or point
to) the picture which best tells me the meaning of the
word." Standard test procedures followed for the admin-
istration of Form A for all subjects. At the completion of
this phase of testing, which in total averaged 30 minutes,
the child was again asked if he had any questions. Some
boys wondered why I was doing all this, to which they were
told that it was part of a study I was doing for my grad-
uate degree, to see how sensitive they were to other
people's feelings. Care was taken to avoid the issue of
mental retardation per se, since it could not be assumed
that all boys were well informed by their parents as to
the etiology or degree of handicap exhibited by their brothers.
Indeed, some families did not overtly acknowledge to one
or more children that their sibling had a handicap, while
others discussed the matter openly. For control subjects,
it was not an issue. Experimental subjects were asked how
much time they spent with their brother, if they knew what
school he went to, and if they thought about him. These
questions were again geared toward eliciting information
without subjecting the boy to stress. The child was
thanked for his participation and excused.

For those homes with a mentally retarded child in
which there were two evaluators, the author's assistant
administered the Adaptive Behavior Scale to the parents
while the child was being tested. In those situations where
the author was alone, the Adaptive Behavior Scale was
administered after the child was tested. In all cases, the parents were asked the questions one by one, with leeway for clarification when confusing issues were raised. This phase of testing took between 25-40 minutes.

At the completion of the testing, which for all families included the Empathy Test and Peabody Picture Vocabulary Test, and the Adaptive Behavior Scale for experimentals, the parents were asked if they had any comments. Quite a few parents mentioned their interest in the community's response to mental retardation, inquired into available services, and opened the conversation to a general discussion of handicap. The parents were guided in discussion by the author, using prepared questions that were developed as a clinical interview. The extent of the conversation varied in length from family to family, depending on ease of discussion and time constraints. The following questions were used as a pool from which to elicit dialogue:

1. What is the family configuration, including age, sex, religion, occupation, of all family members?

2. Has the retarded child always lived at home?

3. How did mother and father find out their child's diagnosis? When?

4. How freely do parents discuss any difficulties with their retarded child?

5. How do the parents think their normal children understand their retarded sibling? How much time does their normal boy spend with their retarded boy?
6. Can they see any similarities between their normal and retarded sons?

7. How has the retarded child made a difference in your lives? How much has he disrupted life? What positive experiences has he brought?

8. How did the parents deal with the issue of having more children? Did they seek guidance or therapy after their retarded son's diagnosis?

9. How do the parents feel their retarded son sees himself? How are you like him? How are you different?

10. What do you foresee as your future with your mentally retarded child?

Finally, the parents were asked how helpful local services were to help them care for their special needs child. All topics were discussed sensitively, recognizing the emotional impact of these issues. Obviously, for control families, these talks were brief and hypothetical, although quite a few of these parents were interested in the study.

At the completion of the home visit, the parents were thanked for their participation and promised a follow-up letter once results were analyzed. Discussion between the author and assistant was minimal until that time at which the Family Behavior Profile could be individually completed. This usually took place one hour after the home visit. The Family Behavior Profile was done on both control and experimental families. After the Family Behavior Profile was finished, the author and his assistant discussed the families, making notes of impressions, relevant comments, and issues worthy of feedback for the Superintendent of the
Franklin County Program for the Mentally Retarded. At the completion of the study, the author met with Mr. Pleasnick, to relate to him the parents' comments about the services.
CHAPTER III

RESULTS

The primary emphasis of this study was the exploration of the influence of a mentally retarded boy upon his normal brother. Analysis of variance revealed no significant differences between experimental and control groups with regard to I.Q. ($F = 1.56$, $p > .10$), nor between boys in the younger brother versus older brother groups and I.Q. ($F = 2.02$, $p > .10$).

Having established the relative lack of significant difference among the normal brothers with regard to intelligence, a least-squares analysis of variance procedure was applied to the dependent variable Total Empathy with independent variables group, ordinal position, age, number of children in the family, place of the normal boy among his siblings, and I.Q. The results showed that age ($F 1, 37) = 10.75$, $p < .01$, and ordinal position ($F 1, 37) = 5.29$, $p < .05$, were significant factors in determining empathy, while the influence of a mentally retarded boy upon his normal brother had no significant bearing upon empathic development ($F 1, 35) = 1.33$, $p > .10$. The relationship among empathy
scores, group, and ordinal position are shown in Figure 1. Further analysis using a correlations matrix reinforced the link between empathy and age \( (r = .47, p < .01) \), and empathy and ordinal position \( (r = .52, p < .001) \). The correlation between age and ordinal position was strong as well \( (r = .49, p < .01) \).

Having established the reliability of the independent measures of adaptive atmosphere in the homes in an earlier section, a large correlation coefficient matrix was generated to see if any positive relationships could be found on specific sub-domains of the Adaptive Behavior Scale, and the Family Behavior Profile completed by each examiner, with all variables under investigation. Of special interest was the relationship among Total Empathy with the Adaptive Behavior Scale and Family Behavior Profile sub-domains. There were no outstanding patterns that emerged to unequivocally pair empathic development in normal brothers of mentally retarded boys to adaptive behavior in either the mentally retarded boy or the overall family (Table 2). However, the sub-domains of Untrustworthy Behavior, Stereotyped Behavior and Odd Mannerisms, and Inappropriate Interpersonal Manners did correlate substantially with Total Empathy \( (p < .15) \). On the Family Behavior Profile completed by the author on 25 families, Independent Functioning emerged as the only variable with a favorable correlation with empathy.
(r = .324, p < .12). When the Adaptive Behavior Scale sub-domains were compared with comparable Family Behavior Profile sub-domains, there emerged some correlation among seven sub-domains (p < .10), with a trend toward significance on several others (Table 3).
Figure 1. Comparison of mean total empathy scores between experimental and control groups with younger and older normal brothers.
Table 2

Comparison of Total Empathy with sub-domains of the Adaptive Behavior Scale and the Family Behavior Profile completed by both experiments 1, and 2.

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<td>.6986</td>
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Table 3

Correlations between Adaptive Behavior Scale sub-domains with similar sub-domains of the Family Behavior Profile completed by the author (n = 16).

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CHAPTER IV

DISCUSSION

Grossman (1972) found that nearly half of the students that she interviewed who had a mentally retarded brother or sister benefitted from this experience in a striking fashion. These people tended to have a greater tolerance and understanding of people, more compassion, more sensitivity to prejudice and its consequences, and a greater appreciation of their own good health and intelligence. A clustering of these characteristics seemed to describe the concept of empathy. In this author's experience with teachers of mentally retarded children, there appeared to be an unusually high representation of teachers who had retarded siblings. Further informal questioning revealed characteristics within these teachers that sounded like those described by Grossman. Once again, this trait seemed to be empathy.

A review of relevant literature in the field of mental retardation, sibling relationships, and empathy found much more emphasis on the negative impact of a mentally retarded child on society, his family, and his
siblings. With the development of the normalization principle, attitudes about retardation are changing, but research appears to have lagged behind. In particular, there is a paucity of research to explore the more positive influences of mental retardation on the family now that more mentally retarded children are remaining at home and schooled within each community.

The present research attempted to focus on this relevant issue of the effects of a mentally retarded child upon the family, and in particular, on his brother. In addition, the findings of Grossman (1972) were considered in the development of empathy as a focus for the study. Indeed, Wolfensberger (1967) emphasized the need to use control families (those without mental retardation within the family) in any study of the effects of mental retardation on the family, and stressed the need for tighter, empirical research. All of these factors contributed to this research undertaking to determine the extent to which a mentally retarded boy will affect the empathic development of his normal brother.

In relation to the main hypothesis, it appears that a mentally retarded boy in the home will not enhance his brother's empathic development, when compared with other boys his age who do not have a mentally retarded brother. This finding was unexpected and poses more questions than it answers. To find that empathy is not necessarily en-
hanced in brothers of mentally retarded boys during the formative years implies that other factors are operating to later influence these people's trend toward going into the helping professions. We must look elsewhere to find these causes, some of which became apparent during the interviews with both parents and normal brothers of the retarded children, and will be discussed shortly.

One must not overlook possible limitations in the Feshbach and Roe Affective Situations Test for Empathy for the population under study. The test was designed for a smaller age-range, while this research broadened that range in the upper ages. This factor, plus the questionable reliability of item number five of the test, may have weakened the strength of the instrument. Nevertheless, these factors were constant for both experimental and control groups, so that this aspect of the test can be only a small factor in the unexpected results pertaining to the first hypothesis.

Yet another factor influencing the utility of the FRASTE, and thus by implication affecting the results of this study, is that the range of empathy scores is quite narrow, thereby reducing the expected degree of inter-correlations. With the potential range of the empathy scores to be from zero to eight, and the actual range in this study of 40 subjects as between one and eight, one can see that this small range will affect the strength of
the correlation coefficients in subsequent analysis. Therefore, according to Sontag, Baker, and Nelson (1958), low correlations may be indicative of little variability between raters when scores are in a small range, and that this factor must be considered in future research when the FRASTE is used. With regard to the present research, low correlations have more validity than they otherwise might, but this does not minimize the difficulty in using the aforementioned scale. These points of contention imply that further study in this interesting and perplexing area is warranted.

Hypotheses two and three deal directly with the normal development of empathy, and with its link to age. It seems that the current results support earlier research to conclude that empathy increases with age. This finding concurs with the earliest work of Gates (1923) and Walton (1936), right up to the studies by Borke (1971) and Hoffman and Levine (1976). It again reminds us that Piaget's work in the field of social sensitivity relates well to empathy, but leaves us somehow baffled on the issue of how to enhance this empathic development. It may be that this process must unfold according to a chronological timetable and, at least for children, is not amenable to training. Or, it may be that the atmosphere in a home with a mentally retarded child actually does not focus directly on empathy, but on other personality factors.
Again, questions worthy for pursuit.

Finally, empirical results using the Adaptive Behavior Scale and the Family Behavior Profile indicate that the Family Behavior Profile has a very respectable degree of interrater reliability, and that the two scales seem to measure some similar characteristics with different foci. Yet, these measures of adaptive behavior in the mentally retarded child and in the family did not support the fourth hypothesis. Indeed, "mental retardation" and "empathy" seem to be concepts with very little overlap with respect to the normal family members. While this result was unexpected, its implications (as in the first hypothesis) call for further study.

Further supplemental analysis revealed that the number of children in the family had no significant bearing on the development of empathy in the normal boy. Thus, a smaller family did not differ from a larger family in regard to empathic atmosphere in the home and its impact on the normal boy under study. Similarly, the "visibility" and degree of mental retardation in the inflicted child was assessed by way of the Adaptive Behavior Scale, and as already discussed, extent of adaptive behavior does not seem to influence empathic development in the normal male sibling.

One consideration of this study with regard to family characteristics that must be reviewed is that in
some instances more than one child from a given family was used as a subject. Ideally, subjects for this research should all come from different families, so that for 40 subjects, there would be 40 families represented. That was not the case in this research; indeed, 26 families participated, incorporating 40 children. Inevitably, this influenced the variability of responses by having more than one subject from the same family. In the analysis of family characteristics, duplicate material was eliminated; that is, the data for two boys from the same family was analyzed as one unit. This helped to offset possible skewing of the data by repeating the same information for 40 children when 26 separate families were used. This overall problem of using more than one child from each family could not be avoided in the present research, due primarily to the constraints of subjects' demographic characteristics, the need for matching between experimental and control groups, and other logistical constraints. In future study, more worthwhile information may well be made available if one could avoid using more than one child per family.

The empirical research carried out as part of this study was supplemented by more liberal data collection via a clinical-type interview. From these interviews came some interesting implications, that must be reserved as hints for future investigation and not as outright conclusions.
First of all, a myth should be shattered immediately. Families to whom are born a mentally retarded child, and who choose to raise this handicapped child, are not themselves necessarily handicapped families. Indeed, those families who, on the Family Behavior Profile as well as in the interview, encouraged trustworthy behavior and discouraged stereotyped and odd behavior, promoted empathy in their normal boy. They also tended, as a whole, to provide comfortable surroundings for the whole family. Many parents talked about closeness within the family, with the normal siblings developing an increased sense of responsibility derived from sharing the household chores and duties of watching their mentally retarded brother. A few of these boys expressed anger at their sibling, who sometimes impinged upon their free time. Yet, these same boys also said that they defend their brother against criticism from neighborhood children. This latter finding seems to generate the idea that, for whatever psychological reason, the family mobilizes enough to develop an identity that includes the mentally retarded child.

The issues of responsibility and loyalty prevailed within these homes, and were expressed by both the normal brothers and parents. Concepts such as responsibility and loyalty within a family may be vague, and are certainly idiosyncratic. Nevertheless, the fact that a mentally
retarded child did not function as a precipitant for enhanced empathy in the normal boy does not necessarily eliminate the possibility that there are strong influences that draw siblings of the retarded toward benevolent professions. There is literature available to begin to explore the idea that the so-called crisis impact of a mentally retarded child on the home may mobilize feelings among people experienced during other crises in life, events that tend to draw people closer together. While the outcome of this bonding within a family appears to promote responsibility and loyalty among family members, it is too early to offer these suggestions as unqualified conclusions. Areas for further research are made manifest by the above material, and may provide added insight into the positive effects of raising a mentally retarded child.

For families with even the more severely retarded child, there was a sense of overcoming limitations and promoting adaptive behavior as much as possible. This enlightened approach naturally served their mentally retarded boy well, and also their other children. Restrictions
to freedom had to be tackled if the family could maintain normalcy. A clear ally to virtually all of these families in their effort to live with their child was the support given them by the Franklin County Program for the Mentally Retarded and other community agencies. Respite care was most important. So was the sharing of information about mental retardation from the time of diagnosis. Education for both parents and the child was invaluable, and at age three, when the child could enter preschool, it gave mother time off from the strain of parenting a mentally retarded child.

Not all of the research families presented an unmarred household. In one family, the husband became alcoholic. In others, one or both parents turned to counseling, religion, or friends for support. Often it was parents who helped extended family members to accept their mentally retarded child. Many families gave poor grades to the medical profession, who, they said, often avoided giving them a clear diagnosis, and when they did, lacked a tactful approach. This author also heard comments that supported prior research showing the progression of the family in their acceptance of the mentally retarded child. Many became "present" rather than "future" oriented. Others were particularly sensitive to the use of labels to camouflage mental retardation. And often parents had to come to grips with
how to discipline their special needs child.

I found that each family had their own approach toward coping with their mentally retarded boy. To all it was a burden, but for most it was a positive experience. Seeing beyond the handicap and deriving satisfaction were goals expressed sensitively, longingly, and firmly. With further advocacy of adaptive behavior in the child and the home, and appropriate community support, I feel that the 1970's and 1980's will continue to see a stronger investment in the mentally retarded child's future. We can help by looking closely at how the successful families survive and passing it on to others who are still trying.
The introduction of any newborn represents some degree of intrusion in a family, an effect which is intensified when the child is mentally retarded. While a great deal of research exists describing the negative effects of a mentally retarded child upon the family, considerably less attention has been paid to the beneficial impact of a mentally retarded child upon his family. Normal siblings of mentally retarded persons are seen as more compassionate, sensitive, and tolerant of others. In addition, a disproportionate number of these siblings tend to go into the "helping professions," a trend influenced by the degree of the handicap in the retarded family member, sociopsychological composition of the family, and birth order of the siblings. Are there factors operating in childhood that have yet to be identified that promote early sensitivity and later altruism in siblings of retarded persons?

The purpose of this dissertation was to explore empathic development in normal brothers of mentally retarded boys who were being reared in the home. A total of 26 families participated in this research; 16 had
a mentally retarded boy and thus were considered experimental families, while 10 were devoid of retardation and considered control families. Among these 26 families were 40 boys who constituted the target subjects: 10 younger and 10 older brothers of mentally retarded boys, and 10 younger and 10 older brothers of boys similar in age to the retarded child but not mentally retarded themselves. The normal boys ranged in age from 5 to 12 years.

During a home visit, the normal brother was given the Feshbach and Roe Affective Situation Test for Empathy and the Peabody Picture Vocabulary Test, while the parents were administered the AAMD Adaptive Behavior Scale, the Family Behavior Profile, and a brief clinical interview. The major hypothesis was not supported by the results of this investigation, in that it appears that a mentally retarded boy in the home will not enhance his brother's empathic development, when compared to a control population. There is a clear tendency for empathy to increase with age, supporting earlier studies. The Adaptive Behavior Scale and Family Behavior Profile appear to measure some similar characteristics with different foci, but they cannot be considered parallel instruments. Finally, homes which enhance specific domains of adaptive behavior may enhance empathic development in normal boys.
Several suggestions for additional research were discussed. Limitations existed in the Affective Situation Test for the age group under study, and must be considered in interpreting the results. Rather than empathy being enhanced in the home of a mentally retarded boy, indications are that responsibility and loyalty are major issues in these homes, and are worthy subjects for further investigation.
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APPENDIX A

NARRATION

THE FESHBACH AND ROE AFFECTIVE SITUATION TEST FOR EMPATHY

Norma D. Feshbach
Department of Education
University of California, Los Angeles
INSTRUCTIONS FOR ADMINISTRATION OF FRASTE TEST

Before administering the slide sequences, inform the children that they are going to observe pictures and hear stories about children their own age. Immediately following each sequence, ask the child to state how he or she feels. The specific instructions used in field testing the situation test were "How do you feel?" and "Tell me how you feel." Each child's direct verbal report should be recorded verbatim and will constitute the primary index of empathy.

If a measure of social comprehension is desired, the child can be asked "How does the child on the screen feel?" In the early studies, this question either was asked after the empathy procedure was completed or was asked of a separate group of children.

In order to heighten the impact of the affective content, the two sequences depicting a particular affective situation should be presented consecutively. To reduce the residual carry-over from one affect to another, a brief sorting task can be given between each of the three changes in affective categories.

In order for empathy to be scored, the feeling reflected in the response has to be a specific match with the affective situation observed. The subjects receive a score of one for each specific match. Since there are two
sequences for each affect, the empathy score for a specific affect can range from zero to two while the total empathy score can range from zero to eight.
INSTRUCTIONS

Each slide is labelled using the following abbreviations:

\begin{align*}
\text{B} & \quad \text{- Boy} \\
\text{G} & \quad \text{- Girl} \\
\text{A} & \quad \text{Aggression (Sequence I & II)} \\
\text{H} & \quad \text{Happiness (Sequence I & II)} \\
\text{F} & \quad \text{Fear (Sequence I & II)} \\
\text{S} & \quad \text{Sadness (Sequence I & II)}
\end{align*}

For example, a slide labelled B S I2 indicates that this is the second slide in the first sequence--depicting Sadness--for boys.

This script is labelled in the same fashion. The slides correspond to the script, and you should have no trouble in matching the two.
1. This boy decided to enter a contest that he learns about on T.V. The prize is two tickets for everything at Disneyland, even including food.

2. Here he is mailing his entry hoping that he will win.

3. He has won. Here he is receiving the good news in the mail and the tickets as well. Wait until his friends and family hear about this.
1. Two boys are playing ball. One boy is asking the other boy not to play so close to the window because it might break.

2. The boy didn't listen. The ball did hit the window and the glass shattered all over.

3. And when the owner rushed out to see what happened, the boy who really broke the window blamed it on the other boy.
1. Here is a boy and his dog. This boy goes everywhere with his dog but sometimes the dog tries to run away.

2. Here he is running away again.

3. This time the dog cannot be found and the boy realizes that the dog may be gone and lost forever.
1. This boy is picnicing with his family in a wooded forest. His parents asked him to bring some water from the well near the road.

2. He seems to have taken the wrong turn because there is no road, only trees and more forest.

3. He is getting deeper and deeper in the forest. It is getting darker. Night is coming and he cannot even see where to go. He doesn't know how to find his way back.
1. The boy in the grey sweatshirt is getting ready to test his new rocket. The boy standing up is watching him.

2. The boy who was watching is trying to grab this other boy's rocket away.

3. The boy has managed to grab and take away this boy's new rocket.
1. This boy has just moved into the neighborhood. He sees some boys playing a fun game. He would love to be able to join them.

2. He asks to join in. They say "no". They have enough children and besides they really don't know him.

3. The other children continue to play. He has no one to play with.
1. This boy sees a big dog. He does not know whether the dog is friendly or mean.

2. The dog begins to run after the boy. The boy tries to get away.

3. The boy is not able to get away and the mean dog is going to attack him.
1. This boy has just awakened and he remembers that today is his birthday.

2. Here he is greeting his friends who are coming to his party.

3. Now he is ready to blow out the candles on his delicious cake before he opens his many presents.
ADAPTIVE BEHAVIOR SCALE
For Children and Adults
1974 Revision

Name _____________________________ Identification _____________________________
(last) (first) Special

Date (mo) (day) (year) Sex: M Date of Birth (mo) (day) (year)
Name of person filling out Scale _____________________________

Source of information and relationship to person being evaluated (such as "John Doe - Parent," or "Self -
Physician") _____________________________

Additional Information: __________________________________________________________

This Scale consists of a number of statements which describe some of the ways people act in different situations.
There are several ways of administering the Scale; these, and detailed scoring instructions, appear in the
accompanying Manual.
Instructions for the second part of the Scale immediately precede the second half of this booklet.

INSTRUCTIONS FOR PART ONE

There are two kinds of items in the first part of the Scale. The first requires that you select only ONE of the
several possible responses. For example:

[2] Eating in Public (Circle only ONE)

Orders complete meals in restaurants 3
Orders simple meals like hamburgers or hot dogs
Orders soft drinks at soda fountain or canteen 1
Does not order at public eating places 0

(2) 

Notice that the statements are arranged in order of difficulty: 3,2,1,0. Circle the one statement which best
describes the most difficult task the person can usually manage. In this example, the individual being observed can
order simple meals like hamburgers or hot dogs (2), but cannot order a complete dinner (3). Therefore, (2) is circled
in the example above. In scoring, 2 is entered in the circle to the right.

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FAMILY BEHAVIOR PROFILE
(Score is a clock-wise direction)

I: Cleanliness
(7-11)

II: Appearance
(12-13)

III: Care of clothing dressing
(14-17)

IV: Physical eyes, ear
(22-23)

V: Independent functioning
(21)

VI: Telephonic
(5)

VII: Vocational
(0-52)

VI: Domestic activities
(41-49)

V: Toilet training
(5-6)

IV: Language, expression
(32-36, 39)

III: Economical, money, budgeting, shopping
(20-31)

II: Motor development
(24-27)

COMMENTS:

NAME: 

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