Handicap-italizing on a New Volunteer Resource

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INTRODUCTION

In 1981, international recognition was given to the approximately 15% of our world's population who have physical handicaps. The International Year of Disabled Persons (IYDP), so designated by the United Nations, sought to bring to the attention of the world the human rights and human dignity of this long-neglected group, and to promote the full participation of disabled persons in the life of our society.

Persons with physical handicaps are generally of two types: those who were born with a disability and those who acquired it later in life, through a traumatic injury or through disease. The differences are usually not those of abilities but rather of opportunities and life experiences.

Mental retardation is characterized by limited intellectual functioning as well as by problems (or diminished capacity) in coping with some aspects of living. "Perhaps the most important point that has been learned over the past three decades about persons with mental retardation is that they are more like other people than had been thought. We know now that mentally retarded individuals grow and change, just as all human life grows and changes."[1]

The current definition of developmental disability as defined by law is a severe, chronic disability of a person which (a) is attributable to a mental or physical impairment or a combination of mental and physical impairments; (b) is manifested before the person attains age 22; (c) is likely to continue indefinitely. Developmental disability further results in substantial functional limitations in three or more of the following areas of major life activity: self-care; receptive and expressive language; learning; mobility; self-direction; capacity for independent living; and economic sufficiency.

Add to the above list persons with emotional disabilities and those with chemical dependencies and one wonders how such divergent groups could be classified under one common label of "handicapped" or "disabled."

Because these terms are used as umbrellas to cover a wide variety of physical, developmental and emotional disabilities the danger lies in the type of generalization that ignores the innate individuality of the persons so labeled. People with physical handicaps have long proven that they have the same physical, emotional and social needs as the so-called "able-bodied."

Another problem is the phenomenon of assigning a variety of attributes to persons who have experienced physical disability, the subject of research for many years. It has long been noted that physical deviation is often seen as the key factor in a person's behavior and personality.[2] In his excellent book, Stigma, Erving Goffman explains

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how society creates deviancy and then punishes the behavior that results from such labeling. The evaluation of a person is therefore based solely on a single characteristic.

In one research experiment, college students were asked to rate persons with handicaps on twenty-four character and personality traits, such as self-confidence, conscientiousness, kindness, restraint, persistence, unselfishness, tolerance, courage, sensitiveness and social adaptability. The subjects viewed this task as a sensible one, which in itself is startling, given that the only information available about the group to be rated was the fact that they were physically handicapped. Judgments were made on the wide variety of personality traits listed based on only one characteristic of the group, and a physical one at that.[3]

In another study, high school students were asked to rank order six photographs of college men according to a number of behavior and personality characteristics. One of the men was photographed in a wheelchair and this photo was presented to half of the subjects. The other half were shown a photo of the same man, but with the wheelchair blocked out. "When depicted as handicapped as compared to able-bodied, the stimulus was judged to be more conscientious, to feel more inferior, to be a better friend, to get better grades, to be more even-tempered, to be a better class president, to be more religious, to like parties less and to be more unhappy."[4]

This process of assembling different concrete realities only with respect to one feature forces us to overlook all other features. Gordon Allport refers to such symbols as "labels of primary potency" which "act like shrieking sirens, deafening us to all finer discriminations that we might otherwise perceive."[5]

Responses such as those described in these studies suggest that the subjects' impressions may not necessarily be arbitrary but reflect personal beliefs about disability. As Beatrice Wright notes:

> *He is able to generalize from the physical characteristic because this represents for him a crucial deviation that affects a person in ways he presumes to understand. That is to say, the subject's judgments are partly based on hypotheses as to crippling as a value loss. He sees, for example, that crippling leads to suffering, which is a necessary prerequisite for sensitivity to others' needs. If he regards crippling as a state to which one can adjust, his judgments could be expected to differ markedly from the case where he regards crippling as an overwhelming calamity.*[6]

Society's image in general has been to view handicappers[7] not as worthwhile, productive citizens, capable of giving, but rather as receivers, to be helped, protected and nurtured. Since they have been mainly ostracized as deviant and not considered as productive members of any work force, it is not surprising that they have generally been overlooked as a valuable resource for volunteer service.

This neglect has been due in great measure to a general lack of understanding of their abilities, since so much attention is given to their <u>dis</u>-abilities. Age-old stereotypes <u>are</u> deeply ingrained and difficult at best to overcome. Negative attitudes and lack of architectural accessibility have long imprisoned handicappers in institutions and in their own homes, barred from the mainstream of society. Over the past fifteen years, significant strides have been taken to overcome the negative aspects of disability. Federal and state legislation on behalf of handicappers, initiated and lobbied for primarily <u>by</u> handicappers, has paved the way by mandating elimination of architectural barriers. The pasage of the Rehabilitation Act of 1973, the first civil rights legislation affecting handicappers, offered great promise

to those who are categorized as physically, emotionally or developmentally disabled.

But laws are not self-executing and the great promise has yet to be fulfilled. As with other minorities, persons with handicaps face a long, hard road before they are recognized as equals.

It is generally accepted that giving volunteer service is a human right and a privilege of all citizens. It is the role of the volunteer administrator to provide the avenue or outlet for meeting the human need to be of service to others.

At the 1980 National Conference on Volunteerism, conference participants passed a resolution in support of IYDP, resolving to "convene workshops, seminars and other community education functions throughout their communities during 1981" and "to focus on eliminating attitudinal as well as architectural barriers which prevent disabled persons from volunteering."

PROBLEM

The state of the art of utilization of persons with physical handicaps as volunteers has generally been unknown. Two studies, one done in 1971, the other in 1972, appeared to provide the only documentation of handicapper volunteer participation.

The 1971 study of 695 rehabilitation facilities was approved by the U.S. Department of Health, Education and Welfare, and sponsored by Goodwill Industries of America.[8] It showed that although 69.2% of the facilities used volunteers, of the 69,193 volunteers active at the time, only 810 (1.2%) were persons with handicaps.

The 1972 study of 85 Chicago hospitals was conducted by Carol Bradford for the Chicago Council of Directors of Hospital Volunteers at the request of the American Society of Directors of Volunteer Services.

It seemed timely to conduct another survey to determine, if possible, if there had been any significant changes in numbers of volunteer handicappers in general and how they were being utilized. Rather than limit the survey to Chicago hospitals and in recognition of the increasing number of human service agencies using volunteers, it was decided to expand the scope of the 1972 survey.

METHODOLOGY

With permission from the Chicago Council and the American Society of Directors of Volunteer Services, the survey instrument developed by Ms. Bradford in 1972 was replicated intact. Three hundred volunteer administrators were selected at random using three resources:

1. Membership roster from the American Society of Directors of Volunteer Services
2. Membership roster from the Association for Volunteer Administration
3. Volunteer Opportunities Guide, Volunteer Action Center, Detroit

The response was unexpectedly high, with 138 respondents (46%), 70 from administrators of volunteer programs in hospitals and 68 from other types of agencies. An additional 25 responses were received after the cut-off time for the compilation of data and were not included in the results.

The majority of hospitals represented (71%) were general/acute/medical-surgical, with the balance psychiatric, physical rehabilitation, long term/chronic, V.A., community, cancer, university, women, residential and pediatric.

Among other agencies responding, national voluntary health organizations (Red Cross, UCP, Easter Seal, Heart Association, League/Goodwill) comprised 14%; social services, 12%; and nursing homes, 8%; followed by mental health, mental retardation, corrections, adult/family service, education, community service, human services, historic, religious, crisis intervention, employment, YWCA, family planning, Federal agency, Voluntary Action Center, Boys Club,

voter education, radio information (for the blind), zoo, residential/shelter for children, accounting/management service, RSVP and recreation.

RESULTS

Of the 138 respondents, 109 (79%)--60 hospitals and 49 agencies--reported that they now have persons with handicaps serving as volunteers, and 113 (82%) had used them in the past. In the 1972 study, 54% of the reporting hospitals had handicappers in the program and 55% had used them prior to that time.

There were 306 persons with handicaps serving in hospitals and 238 in agencies, compared to 97 in 53 hospitals in 1972, averaging 5.10 per hospital and 4.85 per agency in 1981, as compared to 3.34 per hospital in 1972.

Handicappers had applied as volunteers in 86% of the 1981 reporting facilities, 88% in 1972.

The types of disabilities represented were as follows:

		1981		
	1972	Hospitals	Agencies	Total
Visual impairment	24%	13%	18%	16%
Developmentally disabled	19%	11%	11%	11%
Physical (requiring use of crutches, cane)	17%	18%	12%	16%
Physical (involving arms or hands)	13%	10%	14%	12%
Hearing impairments	10%	13%	10%	12%
Speech impairments	8%	10%	10%	10%
Physical (requiring wheelchair)	8%	14%	13%	14%
Learning disabilities*	0%	10%	10%	10%

*added to the 1981 survey

In those instances where an applicant was not accepted as a volunteer, 40% of the respondents in 1981 gave as the reason "couldn't find a job he could do," as 36% of the 1972 responses had indicated. The responses were also the same for the second highest category, "difficulty of mobility within the building": 16% in 1981 and 31% in 1972. It would appear that in spite of legislation mandating architectural accessibility in agencies receiving Federal funding (and most hospitals and agencies would qualify), persons with wheelchairs still encounter difficulty.

"Difficulty of communicating with the applicant" constituted 13% of the responses in 1981 and 5% in 1972; "reluctance of staff to work with him," 6% in 1981, 5% in 1972. Only one respondent gave "reluctance of volunteer director to work with him" as the reason for not accepting the applicant; none in 1972.

Twenty-three percent of the respondents in each of the surveys listed other reasons and specified:

Some couldn't qualify for the job we needed done

Emotionally unstable

Transportation problems

Skills, interests, time availability and motivation weren't appropriate or compatible

Inappropriately referred due to misconception by referring agencies, social workers, doctors and other professionals

Reluctance of volunteer to accept those few jobs that could be worked out

Applicant inappropriate to hospital setting

Could not read well enough

Could not take care of self in emergency situation

Personality not "right" for hospital work

JOB CATEGORIES

In answer to the question,"in what capacities have persons with handicaps served as volunteers?" the responses were numerous and diverse, so categories of activity were developed for greater ease in tabulation. Responses to the 1972 survey were then assigned to the same categories and tabulated, with the results shown in the accompanying chart:

While the numbers of handicapped volunteers increased in some areas of the hospital setting, these were primarily limited to traditional assignments: clerical; technical/departmental (which included admitting, building services, central supply, dietary, emergency, housekeeping, laundry, mail room, medical records, nursing, pharmacy); and information/reception. The agencies seemed to have been able to use handicappers effectively in the categories of Public Relations/Education, Administrative/Fundraising/Board, Caseworker, Research, Counselors/Peer Counselors.

Seventy-nine percent of these assignments were categorized by the recent respondents as "Regular," five percent as "Special," and sixteen percent as a combination of both, which would indicate that most handicappers were able to fill assignments generally held by non-handicapped volunteers.

When respondents were asked to assess the extent of special assistance required by handicapped volunteers to satisfactorily perform their assignments, responses were:

	1972	1981
GREAT DEAL	7(13%)	11(10%)
SOME	11(22%)	49(40%)
VERY LITTLE	33(65%)	49(40%)
NONE		12(10%)

Almost one fourth of the 1981 respondents indicated that the special assistance required was additional orientation and training. Personal assistance was next, followed by an equal number of responses for adjusting the environment and transportation. Adaptive equipment was called for in some instances, and assigning the volunteer to a "buddy" proved successful for others.

Both surveys elicited a similar response when asking if respondents felt the extra effort was compensated for by the service given, with 96% affirmative in 1981, 79% in 1972.

Resistance of staff to working with and/or supervising/training volunteers with handicaps was reflected most often in the "Some" or "Very Little" range. Fifty-five percent of the 1981 respondents rate staff reluctance in that range, with forty-one percent reporting "None." In 1972, fifty-five percent reported "None" and forty-two percent encountered "Some" or "Very Little."

The majority of respondents to both surveys viewed extra time for training/supervision as the basis for staff resistance, along with:

Lack of understanding of abilities of handicappers

Extra time for physical assistance

Negative attitude/physical appearance

Concern for safety of volunteer

Fear

Lack of experience working with persons with handicaps

Limitations of volunteer

Lack of empathy

Concern for safety of patients/clients

Reluctance to use clients

Physical environment not conducive

In most instances where resistance was encountered, it was resolved by increased communication with staff, through in-service programs, discussion, etc. (26%). Allowing the volunteers to prove themselves was a very close second response (23%). Another effective measure was careful selection and matching of the staff with the volunteer and the volunteer to the task. In some instances it was necessary to transfer the volunteer or pair him/her with another volunteer. Other respondents felt that patience, time and tolerance were effective and some assumed responsibility for the majority of the supervision. Only one administrator found it necessary to terminate the volunteer.

Whatever problems may have been encountered in placing handicapped volunteers apparently did not carry over to the patients/clients. In response to the question, "what was the reaction of patients/clients to volunteers with handicaps?" the responses were:

	1972	1981
VERY FAVORABLE	32%	40%
GENERALLY FAVORABLE	45%	45%
MIXED	16%	11%
GENERALLY UNFAVORABLE	3%	1%
VERY UNFAVORABLE	3%	2%

How this reaction was measured, however, is unknown, and may only reflect staff perception.

Seventy-one percent of the 1981 respondents felt that volunteers with handicaps had special assets or contributions to make which were unique to them; sixty-four percent of the 1972 group also responded in the affirmative.

The majority of respondents to both surveys found personal acquaintance with a volunteer or employee as being the primary means by which volunteers with handicaps learned about their volunteer program. Being a former patient or client was second in both surveys, followed by a tie between volunteer bureau and radio/tv or newspaper publicity. Other resources included schools/colleges/universities, agency referral, a current patient/client, physician referral, senior groups/RSVP, self-referral, community presentations, Department of Rehabilitation, church groups, handicapped organizations and reputation of program.

As with the 1972 survey, a significant number of respondents (63%) said that they had no plan to recruit additional handicapped persons for volunteer service, though the majority did indicate that they would be given every consideration should they apply. One respondent had developed a concerted effort to train staff supervisors, improve physical access to patient areas, attend training sessions and focus attention throughout

the hospital on those areas where handicappers had been used successfully.

Ninety-six (82%) of the 1981 respondents (77% in 1972) stated that they had had no special administrative problems in regard to use of handicappers in volunteer positions. Four did require medical clearance from the handicapper's physician, two found transportation to be a problem and two limited places where the volunteer could be assigned. Initial expense for special facilities, fire safety for wheelchair users, time required for supervision and assistance, and authority to adapt phones were other problems. One respondent encountered difficulty distinguishing volunteers from patients.

Respondents were invited to make additional comments and the majority were very positive and offered excellent advice to any volunteer administrators working with handicappers:

> *"I make no special allowances for them; they have the same rules as able-bodied volunteers; they receive the same evaluations as others; if they screw up they're fired the same as anyone else."*

> *"Give the handicapped person the benefit of not doubting their capability; they want to and will freely discuss their problems."*

> *"Keep an open mind."*

> *"Consider first the person. Allow them to set limitations from their own knowledge."*

> *"We adhere to a policy of frankly discussing all volunteers' limitations and how they can be absorbed in our programs."*

> *"All humans have limitations in one area or another and we should place all volunteers in areas to minimize these limitations--our job is to place people where they can do, not cannot do."*

Not all comments were favorable, however:

> *"Our experience with students from a school for handicapped has led us to cancel the program. The children were too retarded/damaged to function in this environment."*

> *"I have found this to be a very frustrating experience in most cases. The most disappointing experiences we have had with handicapped volunteers has been with those who have suffered or were suffering mental illness and were referred by psychiatrists. We are not an O.T. program. We do not have the staff or the capacity to monitor these kinds of volunteers and cannot justify the amount of staff or office time and expertise needed to help them to become effective and 'safe' volunteers. A hospital does have a heavy responsibility to the patients for their protection and safety and in many cases handicapped persons are not appropriate for service."*

These comments were not the only reference to inappropriate referrals by professionals:

> *"Be sure referring source (usually professionals) is fully cognizant of needs and is not referring to get disabled 'off their back' or is the 'last resort,' that 'anyone can work with mentally handicapped.'"*

> *"Lack of mobility, getting out of home and transportation seem to me to be the biggest problems. I would hate to see involvement in volunteer programs seen as a solution to all handicapper problems. I am sure that handicapped persons have a right to volunteer, however we are seeing a number of developmentally disabled and learning disabled referred to volunteer service and then written off by the referring agency because they are busy doing something. Volunteering should be a part of whatever one wants in life--it's not all there is to life however."*

CONCLUSIONS

While the average number of volunteers with handicaps serving in 1981 increased over the 1972 report, it would have been helpful to know the percentage of handicappers to the total volunteer population.

There were no significant differences in the nature of the handicaps of the persons who served or applied, with the exception of the new category "learning disabled," a category that had not been identified as such and labeled ten years ago.

It would appear that finding jobs that can be done by handicappers remains a problem for most volunteer administrators. Whether this problem arises from the limited number of volunteer opportunities available or is due to the physical limitations of the volunteer applicant is unknown.

While hospitals generally increased the number of handicapper volunteers in their programs, the areas of opportunity did not seem to expand beyond the traditional ones.

The extent of special assistance required by handicapped volunteers increased from 35% in the "Great Deal" and "Some" level (1972) to 50% in 1981, which may be due only to the increase in number, since there were no significant differences in the types of disabilities which might require such special effort.

The very little staff resistance encountered was overcome primarily by communication and the volunteers themselves. This would substantiate existing theory regarding negative attitudes toward persons with handicaps wherein the most effective changes have been found to result from a combination of education and exposure.

How a patient/client will react to a volunteer handicapper is dependent upon a number of factors, including the timing of the first encounter (if the patient/client and the volunteer exhibit the same characteristics), the type of characteristic manifested by the handicapper and the patient/client's own attitudes toward disability itself. As stated earlier, without knowing the method of assessment, the reactions reported may only reflect the perceptions and observations of the staff.

The responses to the question regarding special assets of volunteers with handicaps were disturbingly revealing. While it is true that in certain situations handicappers have a distinct advantage by virtue of their own unique life experiences, such as in peer counseling and as role models for patients/clients with similar circumstances, handicappers in general bring to their volunteer service the same qualities as any other volunteers.

Volunteers who are viewed to be "more dependable, more understanding," who "try harder," who have "better listening skills," are "more accepting of others," have a "more compassionate nature," are "more tolerant," "sensitive," "spunky," "cheerful," honest," "forthright," "happy," "cooperative," "gentle," "loyal," "friendly," and "appreciative" quite frankly sound almost too good to be true. These attributes sound very much like those mentioned in the Mussen and Ray studies.

The most realistic responses to this question about special assets would have been "same as any other volunteer," and "some 'yes' and some 'no'," which would indicate that the respondents were able to objectively evaluate individual performance without falling prey to stereotyping. The tendency to imply that handicappers are better than can be as dangerous as viewing them as less than.

RECOMMENDATIONS

A potential problem that volunteer administrators should be aware of is the recent tendency to categorize under the label of "transitional volunteer." In 1973, the National Center for Voluntary Action published a manual on the topic, with the following explanation: "Volunteer

work undertaken by a volunteer specifically as a rehabilitative step in his life is frequently referred to as 'transitional volunteering.' Programs for this purpose have been developed for people recovering from mental illnesses, from the abuse of alcohol or drugs and for persons recently released from prison."[9]

More recently, transitional volunteers have been described as "individuals with emotional, developmental and physical handicaps who are offering their time and abilities to the concerns and needs of the community. This volunteer experience will assist in the transitional volunteers successfully making a move toward greater independence."[10]

Another definition is "persons recovering from mental illness, drug addiction, alcoholism or who might be mentally or physically handicapped or disabled, who desire to re-enter the community through volunteer work."[11] A 1980 workshop leader added "juvenile delinquents and first offenders."

While it may be true that a number of handicappers utilize volunteer service to gain the confidence and experience they need to re-enter society, why not include the homemaker, the widow, the divorcee in the same category?

Not all persons with handicaps are "transitional" since they are already in the mainstream of society and, like other citizens, wish to give volunteer service in addition to being employees, homemakers, students, etc. The problem of sorting out individuals who have specific abilities as well as specific limitations from these broad categorizations can be a complex one.

First impressions provide a reaction direction that exerts a continuous effect on later impressions of that person. Visible handicaps are especially potent in establishing impressions as the person is presented first in terms of physique, thus establishing the direction for later impressions.

When we first encounter a stranger, it is his or her first appearance that enables us to anticipate his or her "social identity," whether it is virtual or actual. If in this first encounter the individual appears to possess an attribute that makes him or her different from others and of a less desirable kind, s/he is reduced in our minds from a whole and usual person to a tainted and discounted one.[12]

The important element to remember in considering handicappers as potential volunteers is to avoid identification based on the visible appearance of the individual without considering his or her invisible personality. Misconceptions about physical disability can distort the meaning of crucial aspects of a person's life. Not only is the disability seen as a physical characteristic but it can be incorrectly interpreted as the critical element in the events of life.

The "villains" in history and literature are usually "explained" in terms of their physical deformities (the Kaiser's withered arm, Goebbels' club foot, Captain Hook's prosthesis, Richard III's birth-related deformities). Franklin Roosevelt, however, is said to have become great through his polio, and we are told that Robert Louis Stevenson, Charles Darwin, Lord Byron, Edgar Allan Poe, Nietzche, Kant, da Vinci, Goethe, Beethoven, Aristotle and Demosthenes achieved greatness and distinction because of their physical limitations. Disability is seen as being the critical element in the lives of all of these men. While their characteristics may have played an important role in their intellectual and emotional lives, it could hardly be construed as constituting the primary factor responsible for the directions they took in their lives.

Beatrice Wright explains:

The theory of compensation as indemnity gives to physique a central organizing role to which life motivations are dynamically linked. The view emphasizing

containment of disability, on the other hand, includes physique as but one among an array of factors that determine the direction and intensity of the person's efforts.

The unrestrained spread of physique is again seen in the attitude that persons who have a disability stand apart from, rather than are a part of, the community of others.[13]

It is important to remember that handicappers are a significant part of the community, regardless of the characteristic they manifest. It is also important to view handicappers as the individuals they are, first, with their group identification only as a secondary attribute. There are no limitations that are generally applicable to all disabilities. The disability resides in the individual--the handicap resides in the environment.

When interviewing volunteer applicants, administrators may benefit from the advice of Prudence Sutherland, a writer and a handicapper:

Much of society regards the handicapped person solely as someone to be pitied and to be "kept busy" for his own good. These two factors make it extremely hard for the handicapped person to feel that he can be genuinely useful to others. He may think that the recruiter wants him merely in order to make him "feel good" and not because the recruiter really needs his services. To undercut such doubt the recruiter should emphasize the reasons why he is seeking the handicapped person as a volunteer and should also emphasize the unique services he feels the person can give.

If a person's handicap is one of the reasons he is sought as a volunteer, the recruiter should tell him so quite frankly. The handicapped person who is secure in himself always appreciates an unfettered discussion of his disability, and even those who are less secure may gain much confidence once they see that their handicap can be a plus and not just a minus.[14]

It is reasonable to assume that we have arrived at a degree of social maturity which allows us to recognize the individuality of members of other minority groups and to recognize the differences among them without devaluing their abilities. It is therefore not unreasonable to assume that the same level of discrimination can be achieved in considering handicappers in the same light.

Volunteer administrators, by virtue of their work, should have achieved a level of consciousness which permits an objective evaluation of each candidate based on the individual's own merit, rather than on some preconceived notions based on stereotypes. By retaining that objectivity, the door is opened to a whole new experience in working with persons with handicaps and their involvement is limited only by the constraints of our own creativity.

Most persons with handicaps may possess an attribute some may consider "different." It is for us to take account wisely of the difference that difference makes.

FOOTNOTES

[1]*National Center for a Barrier Free Environment, Access Information Bulletin: "Architectural Barriers and People with Mental Retardation," 1981.*

[2]*Erving Goffman, Stigma: Notes on the Management of Spoiled Identity (New York: Jason Aronson, 1974).*

[3]*P.H. Mussen and R.G. Barker, "Attitudes Toward Cripples," Journal of Abnormal Psychology, 39, 1944, 351-355.*

[4]*M.H. Ray, "The effect of crippled appearance on personality judg-*

ment," Master's thesis, Stanford University, 1946.

[5] *Gordon Allport, The Nature of Prejudice (Garden City, N.Y.: Doubleday Anchor Books, Doubleday and Company, Inc.: 1958), p. 175.*

[6] *Beatrice Wright, Physical Disability: A Psychological Approach (New York: Harper & Row, 1960), p. 120.*

[7] *The term "handicapper" was developed and promoted by persons with physical handicaps in Michigan in preference to the terms "the disabled" and "the handicapped." Because it is a noun and not an adjective and refers to a person rather than a condition, it has acquired general acceptance and is even used in relevant State legislation. Since the "handicapper" is the one who determines the handicap, it reflects the movement toward self-determination.*

[8] *Goodwill Industries of America, Inc., "The State of the Art of Volunteering in Rehabilitation Facilities" (Stanley Levin, Project Director), 1971.*

[9] *Clearinghouse, National Center for Voluntary Action, Transitional Volunteering: Steps Toward Mental Health, 1973.*

[10] *Voluntary Action Center of Greater Kalamazoo: "Transitional Volunteer Program."*

[11] *Volunteer Bureau Division, United Way, San Diego, CA, 1981.*

[12] *Goffman, op. cit., p. 2.*

[13] *Wright, op. cit., p. 126.*

[14] *Prudence A. Sutherland, "The Handicapped: An Overlooked Volunteer Resource," Voluntary Action News, July, 1972.*