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Preschoolers' Acceptance of Peers with Disabilities:  
A Cross Cultural Analysis

by

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## Table of Contents

Acknowledgements.....	iii
List of Figures.....	vi
List of Tables.....	vii
Abstract.....	1
Introduction.....	2
Legislation Regarding Education of Children with Disabilities.....	3
Cultural Orientations.....	5
Parent Advocacy.....	11
Practices in Schools and Attitudes of Teachers.....	16
Relation between Children and Adults' Attitudes.....	22
Children's Attitudes Related to in-group/out-group formation.....	25
Cultural Contexts of Altruism and Social Obligation.....	27
Gender Differences in Children's Attitudes to Peers With Disabilities.....	29
Children's Attitudes to Peers with Disabilities.....	31
Method.....	35
Participants.....	35
Materials.....	37
Procedure.....	39
Results.....	40
Analysis of Children's Attitudes to Peers with Disabilities.....	40
Scales of Acceptance.....	40

Overall Acceptance of Peers with Disabilities Across Age, Gender and Nationality.....	41
Acceptance of Peers As a Function of Their Disability.....	43
Children’s Reasoning Regarding the Occurrence of Disabilities.....	45
Acceptance of Children with Disabilities Across Particular Activities	50
Comparison of Parents’ Attitudes Across Nationality.....	57
Acceptance of Children with Disabilities.....	57
Preferences in Children’s Peer Contacts.....	58
Correlation Between Parents’ Attitudes and Knowledge Regarding Inclusive Education and Acceptance of Children with Disabilities...	59
Comparison of Parents’ and Children’s Attitudes in India and the United States.....	64
Acceptance of Children with Disabilities.....	64
Importance of Skills and Activities.....	64
Relation Between Acceptance of Children With Disabilities and Importance of Skills and Activities in School.....	69
Discussion.....	71
References.....	94
Appendix A: Parent Permission Letter and Parent Questionnaire.....	102
Appendix B: Script of Child Interview.....	105

## List of Figures

<i>Figure 1.</i> Children's overall acceptance of peers with disabilities.....	44
<i>Figure 2.</i> Interaction effect of role and nationality on acceptance of children with disabilities.....	66

## List of Tables

<i>Table 1.</i> Scales of acceptance for peers with disabilities.....	42
<i>Table 2.</i> Two-way interaction effect of disability and age on acceptance.....	46
<i>Table 3.</i> Summary of means and standard deviations for three-way interaction of disability, nationality and gender.....	47
<i>Table 4.</i> Interaction effect of nationality, gender, age and disability.....	48
<i>Table 5.</i> Summary of main effect of disability for six repeated measures analysis of variance for children’s acceptance of peers in particular activities as a function of their disability.....	52
<i>Table 6.</i> Means, standard deviations, and n for children’s acceptance of peers in particular activities as a function of their disability.....	54
<i>Table 7.</i> Percentage of children who chose a particular peer for each activity	56
<i>Table 8.</i> Parents’ knowledge of and attitudes towards inclusive education	59
<i>Table 9.</i> Main effect of nationality for multivariate analysis of variance for parents’ preferences for children’s peer contacts.....	60
<i>Table 10.</i> Means and standard deviations for parents’ preferences for children’s peer contacts as a function of their nationality.....	61
<i>Table 11.</i> Intercorrelations, Means and standard deviations between parents’ acceptance of children with disabilities and their knowledge and attitudes toward inclusive education ( $N=108$ ).....	63
<i>Table 12.</i> Summary of main effect of nationality, multivariate analysis of variance of the value parents and children place on school activities and skills.....	67
<i>Table 13.</i> Means, standard deviations, and of the value parents and children place on school activities and skills as a function of their nationality.....	68
<i>Table 14.</i> Intercorrelations, Means and standard deviations of parents’ and children’s acceptance of peers with disabilities and the value they place on goals, skills and activities in school ( $N=215$ ) .....	71

## ABSTRACT

The purpose of this study was to examine Indian and American children's acceptance of peers with disabilities through 108 interviews with preschoolers and survey data from 113 parents. Analyses of the data showed that children's perceptions of peers with disabilities varied with age, gender, and nationality. Overall, Indian children were more accepting of peers with disabilities than American children, and girls were more accepting than boys of peers with disabilities. Finally, contrary to the expectation that parents and children would have similar levels of acceptance of children with disabilities, Indian children were more accepting than their parents, whereas American children were less accepting than their parents.

## INTRODUCTION

In 2001 the first Indian census to include disability as a category reported that there were 78 million people with disabilities in India (Murdick, 2004). The World Health Organization placed this number at a higher, but still conservative, estimate of 98 million or 10% of the population. Fifty percent of all people with disabilities in India are children. In contrast, of the 49 million people with disabilities in the United States only 10% are children. Yet, laws regarding inclusive education were implemented in the United States 20 years before they were implemented in India. Although similar legislation regarding inclusive education has been passed in India and the United States, the timeline of the implementation of the laws in the two countries has been very different.

Placing children with disabilities in the least restrictive environment is ethical practice and also provides educational benefits for children with disabilities (Nabors, 1995). One of the goals of inclusive education is to foster an acceptance of individual differences (Nowicki, 2007). Thus, legislation regarding inclusive education also benefits typically-abled children because they become aware of others' needs and may potentially develop prosocial personal characteristics and an acceptance of diversity (Nabors, 1995).

In June 1994 representatives of 92 governments and 25 international organizations met in Salamanca, Spain and agreed on a dynamic new statement on the education of all disabled children, which called for inclusion to be the norm. Since the Salamanca Statement was adopted by the World Conference on Special Needs Education in 1994, legislation regarding inclusive education has

found global support (Singal, 2005).

Many researchers have examined the laws and their effects in both India and the United States. Research has also been conducted to examine the attitudes of parents and teachers toward children with disabilities in India and in the United States. In countries such as the United States, where legislation regarding inclusive education has been passed and successfully implemented, some research has been conducted to examine typically developing children's views about peers with disabilities. In countries such as India, where similar legislation exists but has not been as successfully implemented, no studies have been conducted to examine typically-abled children's views about peers with disabilities.

Information on factors that promote typically-abled children's positive views of peers with disabilities is essential to implement successful interventions to improve attitudes and interactions with children with disabilities into early-childhood curricula (Nabors, 1995). In this literature review, I will compare existing information regarding legislation, attitudes, cultural beliefs and practices related to inclusive education. Against this backdrop, I will discuss what is known about children's attitudes to peers with disabilities from studies that have been conducted in United States.

### *Legislation Regarding Children with Disabilities*

#### *India*

The Indian Ministry of Education, which is a part of the Ministry of Human Resource Development, is responsible for the formulation and

implementation of all educational policies and programs (Alur, 2002). Prior to 1960, the Ministry of Education used to be responsible for the education of people with disabilities. However, since 1960, the education of people with disabilities has been seen as separate from regular education and has been treated as a social justice endeavor as opposed to human resource development (Alur, 2002). Thus, in 1960 the responsibility of educating children with special needs was shifted to the Ministry of Welfare. Since 1960, the objective of the Ministry of Welfare has been to “rehabilitate” rather than to “educate.” In India, there seems to be a sense that children with disabilities require care and welfare but not education (Alur, 2002).

In 1974 the Indian Government proposed a plan known as Integrated Education for Disabled Children (IEDC) to encourage regular schools to admit children with moderate disabilities (Legislation on Equal Opportunities and Full Participation in Development for Disabled Persons, UN, 1997). The IEDC was supposed to be implemented in 15,000 schools in 26 States and seven Union Territories serving 65,000 disabled children. IEDC goals incorporated pre-school training, counseling for parents, allowances for books and stationery, uniforms, transport, readers and escorts, and other forms of assistance. Recommendations of the IEDC included one special teacher for every eight disabled children and a resource room in a cluster of eight to ten schools (Singhal, 2006). The IEDC was never a law; it was at best a guideline which was never widely enforced by the Government. In fact, the Government turned the IEDC program over to NGOs and grass-root level organizations in India soon after its inception. However, since

the government did not enforce the IEDC, and since the NGOs had limited reach due to lack of funding and personnel, the IEDC was not successfully implemented.

Since then, the Indian Parliament has enacted only two pieces of legislation regarding the education of children with disabilities, namely the Persons with Disabilities Act of 1995, and the National Trust Act of 1999 in conformity with UN directives. The Indian Parliament passed the first legislation regarding education of children with disabilities called The Persons with Disabilities (Equal Opportunities and Protection of Rights and Full Participation) Act in 1995 (Legislation on Equal Opportunities and Full Participation in Development for Disabled Persons, UN, 1997). This legislation was meant to ensure that every child with a disability had access to free education in an appropriate environment until the child attained the age of 18 years. It endeavored to promote the integration of students with disabilities in normal schools but also promoted setting up of special schools in government and private sectors for those in need of special education. The Persons with Disabilities Act also provides for both preventive and remedial aspects of rehabilitation such as education, employment and vocational training, a job quota for persons with disabilities, research and manpower development, creation of barrier-free environments, unemployment allowance for the disabled, special insurance provision for disabled employees, and establishment of homes for persons with severe disabilities (Legislation on Equal Opportunities and Full Participation in Development for Disabled Persons, UN, 1997).

The National Trust Act of 1999 mandated safeguards for the care and protection of persons with disabilities in the event of the death of their parents by providing procedures for appointment of guardians and trustees for persons in need of such protection. This act also mandated support to registered organizations that provide need-based services to the families of people with disabilities (Rao, 2001). In 2001, an Amendment to the Constitution made access to education a fundamental right for children ages 6 to 14 and explicitly included those with disabilities.

In India, the term “integrated education” which has been used interchangeably with “inclusive education” has permeated the rhetoric of the nation in government documents, at the school level and in popular media (Singal, 2005). However, just who is to be “integrated” and how this is to be done remains unclear. It is the policy of the Ministry of Welfare to rely on non-government organizations to develop services through voluntary agencies (GOI Planning Commission 1961: 598). The ministry itself has made very little attempt to enforce or make provisions for the legislation. For instance, although there is a strong focus on “mainstreaming” students with disabilities, teacher preparation is still categorized as either general education or special education. Courses on special education are optional in teacher preparation for general education, and these courses focus mainly on theoretical knowledge and not on practical applications. This inadequacy of teacher preparation has resulted in even those teachers who are willing to work with children with disabilities being untrained to do so (Dev and Belfior, 1997).

As recently as 1990, the methods of assessment of eligibility for the accommodations prescribed by the Acts of Parliament were, in some cases, decided using outdated 1965 World Health Organization (WHO) definition and classification of mental retardation based on IQ levels. The categories contained terms such as “feeble minded,” “high grade defect” and “imbecile” (Rao, 2001). The use of these terms exemplifies the stigmatization of differently-abled persons prevalent in India. Reluctance on the part of the families to disclose information about members with disabilities due to social stigma and the lack of well-trained field investigators make an accurate census difficult (Singhal, 2005). The Office of the Registrar General (2006) has voiced serious concerns about the accuracy and reliability of the reported number of individuals with disabilities in India. Although it is estimated that 10-15% of children in India have disabilities they make up only 0.5% of children in typical schools (Dev and Belfior, 1997). Other estimates suggest that 98% of all people with disabilities have not had access to appropriate services (Alur, 2001).

### *United States*

Historically, agencies in the United States have responded to the needs of those with disabilities earlier and on a larger scale than those in India. In contrast to India, where until 1947 the need for special education was largely unrecognized, the first public schools for children with disabilities in the United States were established in the late 1800s and early 1900s. These were segregated programs, and often served children with specific disabilities. For instance, there

were many more programs for children who were hearing impaired or visually impaired than for children with severe cognitive or emotional disabilities. In the late 1940s and early 1950s, several national disability organizations composed of parents and professionals, who provided services to children and adults with disabilities, were established in the United States to advocate for people with these specific disabilities (Love, 1985).

The United States passed the first legislation for accommodation in public schools for children with disabilities in the mid 1970s. Considerably more progress, including the passing of more legislation, has been made in the United States than in India. The Education of All Handicapped Children Act, now known as Individuals with Disabilities Education Act (IDEA), which passed in 1975, stated that to have access to federal funds, states must develop and implement policies that assure a free appropriate public education (FAPE) to all children with disabilities (Love, 1985). This law went into effect in October of 1977 when the regulations were finalized. Services for preschoolers and early intervention services for infants were added in 1986. A 1990 amendment mandated transition services and assistive technology for disabled children who are beginning public school. It also added autism and traumatic brain injury to the eligibility list and made significant changes to the discipline sections by mandating that positive behavior intervention be used with students with behavioral disabilities instead of corporal punishment and other physical forms of intervention.

In the United States, federal legislation (e.g., PL 94-452 and the Individuals with disabilities Act) mandated that children with disabilities are

placed in the least restrictive educational settings, which may or may not include typically developing peers (Nabors, 1995). This meant that many more children with disabilities were integrated into mainstream schools and by 1995, 73% of children with disabilities were integrated into regular schools. In 2004 there was another reauthorization of the IDEA, and in 2007 80% of high school seniors with disabilities graduated from high school.

In contrast to India, it appears that agencies in the United States have had a more holistic approach to integrating children with disabilities in mainstream classrooms and have targeted many fronts including early intervention and appropriate preschool education for all. Disability services in the United States also included the provision of parent training and information centers under the 1983 amendments. Thus, in contrast to the reliance on non-governmental organizations to provide care and services for those with disabilities in India, in the United States legislation relies wholly on government mandates and their enforcement.

### *Cultural Orientations*

#### *India*

Murdick (2004) states that, in collectivist or interdependent cultures such as India and China, people see the goals of the individual as being secondary to the goals of the group. Indian culture does not consider the existence of the individual as separate from society (Sinha, 1984 as cited in Chadha et al., 2004). Researchers such as Kalyanpur and Harry (1999) have argued that the organization of a society has a significant impact on its response to people with

disabilities. Indian society and other collectivist societies are characteristically interdependent, a situation that influences the perception of the dependence of people with disabilities. Murdick et al. (2004) contend that because of this interdependence, attitudes towards people with disabilities have historically been less extreme in India than in the Western world. However, in India, due to lack of knowledge regarding disabilities, reactions to those with disabilities have ranged from reverence to embarrassment to a fatalistic acceptance of the disability (Murdick et al.). Children with disabilities were either viewed as divine gifts to parents who had been entrusted with their care or as divine retribution for some past wrong doing.

Research has shown that conformity, especially behavioral conformity, is highly valued in interdependent cultures (Sibia et al., 2004). If conformity is one of the main goals of an interdependent culture, and a child has a disability that may not be explicable or acceptable, then parents of children with disabilities might try to minimize the disability. This need to make a child appear to conform to social norms by minimizing disability may preclude parent advocacy as a catalyst for change in legislation regarding the education with disabilities. Factors such as the need to minimize disabilities, compounded with lack of awareness regarding disabilities, poor access to services, and extreme poverty of a large number of families of the people with disabilities could explain why legislation in India regarding education of children with disabilities is still in its infancy.

#### *United States*

Kalyanpur and Harry (1999) assert that the IDEA in the United States is a

cultural statement and that it embodies American cultural values such as individual rights and choice. If their contention is true then it becomes easier to understand why India has been 20 years behind the United States in passing laws regarding inclusive education (Murdick et al., 2004). Murdick et al. suggest that individualistic cultures such as the United States tend to consider the needs and goals of the individual as being paramount rely on the self to make meaning of life, and see autonomous functioning as positive. Murdick et al. go on to argue that, in individualistic cultures, individuals with disabilities are seen as dependent and in need of protection, even in adulthood. Thus, in the United States the goal for people with disabilities would be for them to have “true” societal membership would be to have them to stop being dependent and to have them function autonomously. The path to “true” societal membership and autonomous functioning can be seen as being rooted in education. To this aim, based on the philosophy of the United States that every person should have opportunity for an education regardless of his/her gender, race or disability, people invested in the lives of those with disabilities began to advocate for legislation that would support children with disabilities in mainstream classroom. Thus, in the United States consistent advocacy on the part of parents and educators and the importance of individual rights were among the reasons that legislation regarding the education of children with disabilities is mandated and implemented in the United States.

### *Parent Advocacy*

#### *India*

In contrast to the United States, where parental participation is one of the

foundational principles of the IDEA, none of the Acts passed by the Indian parliament ensures parental rights to services or information (Kalyanpur and Gowramma, 2007). In fact, in a study conducted with 12 parents of children with disabilities, only one parent was aware of any Acts passed by the parliament (Kalyanpur and Gowramma, 2007). Within the context of the Indian collectivist culture, parents have no rights, by either legal or socio-cultural sanction.

Social stigma, lack of access to diagnostic services and to information and consequent low visibility of people with even mild and moderate disabilities in school and work settings has resulted in lack of awareness of disabilities. Most people do not recognize technical words like “autism” and “cerebral palsy,” let alone understand them. Others avoid acknowledging disabilities, which is illustrated by the use of words such as “inconvenience.” This term implies that a child has a problem and needs some accommodation (Rao, 2001). Rao also found that parents of children with disabilities used the term “inconvenience” to describe various aspects of their own lives and their child’s disability.

Rao (2001) found that some mothers of children with disabilities in India believe that ambiguity in defining a child’s disability protects the child from people who would otherwise speak of the disability in pejorative terms. These mothers explain that the word “inconvenience” implies that the child’s disability is within the “normal” range of day-to-day difficulties that people encounter, and thus protects the child from prejudice he/she may encounter in Indian society due to his/her disability (Rao, 2001). The word “inconvenience” was also used to elicit required accommodation without argument or awkward questions and to

place their child within the normal range of difficulties that people encounter to avoid arousing pejorative comments or actions. The frequent usage of the term “inconvenience” sums up the attitude of Indian parents to disabilities as being something that has an impact on their lives but does not need to be discussed.

Many parents of children with disabilities live with the knowledge that their child is an embarrassment to their families, especially if the child demonstrates cognitive impairments or socially inappropriate behavior (Kalyanpur and Gowramma, 2007). Kalyanpur and Gowramma report that the grandmother of a child with a disability did not want to have the child diagnosed because to acknowledge his problems was to admit failure in her lineage. Kalyanpur and Gowramma add that the mother of a child with a disability who participated in their study said that her in-laws, who referred to her son as being “mad,” told her not to introduce the boy to visitors. Murdick et al. (2004) also discuss that there are numerous anecdotal accounts of Indian adults who report having childhood friends in their neighborhood, only to find out, years later, that their playmates had a sibling who had a disability who had been hidden away. Thus, children with disabilities are often hidden from public view because of the shame that they are supposed to bring to the family.

Some parents have a fatalistic attitude and provide explanations such as “My karma,” or “A result of past deeds,” as an explanation for having a child with a disability (Alur, 2001). Most research on families with children with disabilities in India conclude that the child places a huge burden on the family (Annapurna, 1997; Gandotra, 1991; Gupta and Singhal, 2005; Peshwaria, Menon, Ganguly,

Roy, Rajam Pillay and Gupta, 1998 as cited in Kalyanpur and Gowramma, 2007) due to lack of information, mothers' lack of education and negative attitudes among extended family members (Kalyanpur and Gowramma, 2007). Thus the term "inconvenience" seems to sum up not only the work and time involved to overcome the disability but also the social isolation that is involved.

In India, parents of children with disabilities have to contend with social stigma, negative attitudes among extended family members, and lack of information regarding the disability itself and the rights that their children are entitled to. There are very few places that they can turn to for legal, emotional or educational counsel (Alur, 2002). While Indian parents have advocated for their children on an individual basis there has been very little organized advocacy. Parents Mobilization Action Group India Program (PMAG), which was started in 2001, was one of the first national organizations geared towards more effective parent advocacy in the country. It is a joint venture program between Inclusion International (II), a global federation of family-based organizations advocating for the human rights of people with intellectual disabilities worldwide, and the National Federation of Parents' Associations for persons with Mental Retardation, Autism, Cerebral Palsy and Multiple disabilities (PARIVAAR) in India. The major objectives are empowerment of parents by disseminating information and creating awareness, increasing PARIVAAR membership, facilitating networking with the Government and NGOs and other grass-root level agencies, providing leadership training to Parent Associations and encouraging local fund raising (About PMAGs (Parent Mobilization Action Groups), 2005). While these efforts

are praiseworthy, these organizations have little power to improve the current understanding of disabilities in India because the population they reach out to is limited by socioeconomic class and region.

Indian parents, especially those of lower socioeconomic status, have repeatedly spoken of service agencies that refused admission to their children on various grounds, including children's ineducability due to the severity of the disability (Kalyanpur and Gowramma, 2007). In India, parents of children with disabilities, especially those who cannot afford private services, are expected to accept professional decisions with equanimity and are often kept out of their children's treatment sessions (Kalyanpur and Gowramma, 2007).

#### *United States*

In the wake of the 1964 Civil Rights legislation in the United States, the right to education for people with disabilities was viewed as a civil right, and parents of children with disabilities began to form alliances or coalitions with organizations of and for adults with disabilities. Thus, in the United States, parents of children with disabilities have joined, and in many cases led, professionals in efforts to develop and improve special education and rehabilitation services, and this movement has been a catalyst for improved facilities for children with disabilities (Searcy and Lee-Lawson, 1995).

Historically, parents in the United States were forced to play the passive role of recipients of professional decisions (Turnbull, et al., 2007). Legislation that mandates parent participations and a professional and social ethos that

accepts and expects parents to advocate on behalf of their child have given parents both the authority and opportunity to do so (Alur, 2001). In the United States, several lawsuits were also a catalyst for change. The Pennsylvania Association for Retarded Citizens (PARC) v. Pennsylvania and Mills v. District of Columbia Board of Education won decisions affirming that exclusion of children with disabilities from public education may be a violation of their due process and equal protection rights (Searcy and Lee-Lawson, 1995). These decisions, along with the 1954 Brown v. Topeka ruling that segregated schools violated the 14th amendment, gave parents the legal avenue they needed to demand the inclusion of children with disabilities in the public schools (Searcy and Lee-Lawson).

National parent organizations such the Learning Disabilities Agency of America sponsor a variety of efforts to increase public awareness, education, and congressional support for efforts to improve special and inclusive education in the United States. The organizations also publicize the need for research and assist in recruiting participants for research studies (Bristol, McIlvane, and Alexander, 1998). Thus, in the United States parents have played a significant role in expediting the growing understanding of disabilities and the needs of those with disabilities.

### *Practices in Schools and Attitudes of Teachers*

#### *India*

In India, mainstream private schools will rarely admit students with disabilities because of societal pressures for academic success, and the regular

educational curriculum is not adapted for students with disabilities (Dev and Belfior, 1996). The estimated number of children with disabilities in India suggests that Indian children often encounter peers with disabilities. However, the results of a survey of 89 schools conducted by the National Centre for Promotion of Employment for Disabled People show that a mere 0.5% of the total number of students in regular schools had disabilities whereas 10-15% of all children in India are thought to have disabilities (Dev and Belfior, 1996). Thus, in India the pervasive idea is that education for typically developing individuals and those with disabilities must be separate.

Mithu Alur (2001) points out that, although there is a view that education for typically developing children and those with disabilities should be separate, a de facto integration may have taken place because of lack of special schools. Children with disabilities do not have the choice of attending a special or an integrated school due to lack of availability or because their families cannot afford it, and thus they attend mainstream, government schools (Alur, 2001). However, students with disabilities at these schools face all the ills of the Indian public school system, with teachers who are poorly trained to teach them, lack of funding leading to unsatisfactory facilities, and negative attitudes from all concerned.

While mainstreaming children with disabilities is mandated by law, the Bachelor of Education degree, which is necessary for teacher licensure in India and the Master of Education degree do not require many courses on special education (Singhal, 2005). In fact, courses on special education are optional and

the content is extremely theoretical with no provision for practical experience (Singhal, 2005). Thus, teachers in mainstream schools do not necessarily have the skills to work with children with special needs.

While many studies in India have placed emphasis on the need for change in the role and repertoire of skills of teachers, very few studies have focused directly on the teachers' attitudes. Dev and Belfior (1996) conducted a study in New Delhi, India and found that 78% of surveyed teachers thought that mainstreaming children with disabilities was hypothetically a good idea. However, only 28% were willing to educate children with disabilities in their classrooms. While none of the teachers implied that children with disabilities were unable to learn, teachers who were surveyed were generally of the opinion that students with disabilities should be segregated to be given appropriate special attention (Dev and Belfior, 1996).

When teachers were asked how they could help the students in their class who were below average, teachers' responses suggested that they overlooked their responsibility and neglected problems pertaining to curriculum delivery, pedagogical skills and other issues related to teaching (Dev and Belfior, 1996). Some teachers who participated in the study were also of the opinion that the curriculum for students with disabilities should place more emphasis on vocational training and sports, rather than on academic learning. Teachers also suggested that the curriculum should be easier for children with disabilities so as to require less effort, less time, and less complexity for the students concerned (Dev and Belfior).

Kalapuram (2006) conducted a study which measured the acceptance levels of different groups of teachers using the Attitude Toward Disability Scale (ATDP) and Attitudes Toward Inclusive Education Scale (ATIES). Teachers between the ages of 20-30 had more positive attitudes toward students with disabilities than older teachers (Kalapuram, 2006). The groups of teachers with the fewest and greatest years of teaching experience had more positive attitudes toward educating children with special needs than teachers who had been teaching for between five and 25 years (Kalapuram, 2006). Also, groups of teachers who had a monthly income of more than 21, 000 rupees, or those that belonged to what Kalapuram (2006) defined as the upper middle class had positive attitudes. In contrast, teachers who had a monthly income of less than 10,000 rupees, and who were therefore defined by Kalapuram (2006) as being in the lower middle class had a less positive attitude. Miller and Bersoff (1990) found that higher socio-economic status may be associated with a change in orientation toward social responsibilities, which supports Kalapuram's research. Kalapuram (2006) also found that teachers who had received Masters Degrees in Education had a more positive attitude than those who did not. Thus globalization, years of education and upper middle class status seemed to be associated with a more positive attitude toward people with disabilities whereas the reverse was true for those who had been less advantaged. However, Kalapuram (2006) found that the most decisive variable for positive attitudes toward children with disabilities was found among those teachers who reported previous contact in any context with a person with a disability.

### *United States*

In the United States there is a higher degree of openness and availability of support for those with disabilities. The idea of inclusive education is supported by parents of children with and without disabilities, especially at the preschool level, and parents and teachers identify a number of benefits of inclusion for children with and without disabilities (Rafferty and Boettcher, 2000). Regardless of individual opinions and beliefs, most schools in the United States practice inclusive education due to legislation and guidelines that have been established by the government and are enforced. Although the degree of integration in schools in the United States may vary, unlike in India, in the United States teachers work with children with disabilities in regular classrooms and, most importantly, typically developing children and children with disabilities have contact with each other.

Also in contrast to the attitudes of teachers in India, in the United States a large number of teachers are willing to adjust their teaching methods to include children with difficulties (Heiman, 2004). However, teachers had different levels of acceptance across disabilities. They were most willing to include children with physical or medical difficulties, followed by those with specific learning disabilities and speech defects, and were least willing to include those with severe emotional and behavioral problems (Ward et al., 1994).

School climate creates an environment that plays a large role in teachers' attitudes and it is important to understand the informal attitudes that may hinder positive attitudes toward integration (Dupoux et. al, 2005). Dupoux et. al. (2005)

suggested that teachers who perceived other teacher's attitudes as favorable were themselves more positive. Thus, schools with a substantial number of teachers opposing integration may remain negative toward the inclusion of students with special needs (Dupoux et. al., 2005).

Variables that influenced teachers' attitudes to children with disabilities were teacher education, teacher's range of accommodation, class size, and previous experience with people with disabilities (Dupoux et. al., 2005; Monsen and Frederickson, 2004). Dupoux et. al. also suggested that that teachers who had advanced degrees in education were more likely to hold positive attitudes toward people with disabilities than those that did not hold advanced degrees. Teachers who had a greater range of strategies to accommodate the needs of children with different categories of disabilities had more positive attitudes toward children with disabilities than those who had a smaller range. Monsen and Frederickson found that teachers who taught smaller (15-21 students) classes had more positive attitudes toward including children with disabilities in their classrooms than teachers who taught larger classes (22-30+ students). However, as in India, the most salient variable which determined teachers' attitudes to children with disabilities proved to be teachers' prior experiences with individuals with disabilities (Monsen and Frederickson, 2004). Teachers who had had prior experience of individuals with disabilities had more positive attitudes towards educating children with disabilities than those who had not had prior experience with individuals with disabilities.

However, this picture is not entirely perfect. When describing levels of

required additional curriculum support required to teach students with average ability and the level of support required to teach the children with mild and severe intellectual disabilities, teachers only differentiated between typically-abled children and children with disabilities (McNally, Cole and Waugh, 2001). Teachers did not seem to perceive the need for a difference in the levels of requested additional curriculum support required to teach students with mild and severe learning disabilities (McNally, Cole and Waugh, 2001). Thus, they seemed to divide children into those who had disabilities and those who did not. Teachers also did not take into account the effect of student effort, preferring to determine curricular and personnel accommodations based on ability (McNally, Cole and Waugh, 2001).

Thus, while it appears that teachers in the United States are on the whole more willing to educate children with disabilities than teachers in India, there is still a lot of variability. Prejudice still exists, and is often related to the type or the degree of the child's disability.

#### *Relation between Children's and Adults' Attitudes*

Children imitate the behavior and attitudes of important adults in their lives (e.g. Diamond and Innes [1999], Diamond [2005] etc.) Miller and Bersoff (1993, 1992) found that American and Hindu Indian children's interpretations of interpersonal responsibilities more closely resemble those of adults from their own culture than those of children from the comparison culture. Diamond (2005) found that children can learn positive or negative stereotypes from other adults, even when they are unable to reliably describe who belongs in the stereotyped

group. Bar-Tai (1996) found that preschool-aged Israeli children held negative stereotypes about people who were identified as Arabs, even when a child could not reliably identify whether or not a particular person was an Arab (cited in Diamond, 2005).

Innes and Diamond (1999) found that mothers' and children's responses to children with Down's syndrome were positively correlated. Furthermore, Okagaki et. al (1998) found that the relationships between parents' ideas about social interaction, preschool children's acceptance of people with disability, and the frequency of children's contact with classmates revealed positive relationships among all three variables. Both these studies imply that children's attitudes towards peers with disabilities are closely related to the way they observe their parents' behaving toward and talking about differently-abled children.

Generally, more teachers in India than in the United States are of the opinion that a child with a disability is different and must necessarily be educated in a separate classroom from typically-abled peers. Monsen and Frederickson (2004) found that pupils' perceptions of the learning environment created by teachers who have strongly positive attitudes to inclusion differ from the perceptions of students of teachers who do not have strongly positive attitudes to inclusion. Taken together, these two studies suggest that typically-abled Indian children may perceive peers with disabilities as outsiders.

Parents and teachers in the United States are generally more accepting of children with disabilities in a classroom setting than Indian teachers and parents. However, parents and teachers in the United States are more likely to point out

similarities between typically-abled children and children with medical or physical disabilities, than between typically-abled children and children with severe emotional and behavioral problems (Diamond, 1995). Thus, in the United States parents' attitudes and teachers' attitudes may influence typically-abled children to view peers with severe emotional and behavioral problems as outsiders, whereas children with medical or physical difficulties might be considered as part of their in-group in some circumstances.

In the United States, parents are quite likely to discuss disabilities with their children, however even these discussions are not free from some bias. Stoneman, Rugg and Rivers (1996) found that when asked about whether they would respond to their children's questions about cerebral palsy, mental retardation, ADHD, and aggression, parents in the United States indicated that they would do so. However, Stoneman et al. (1996) also found that parents were more likely to point out similarities with their own children and include positive comments regarding the strengths of children with cerebral palsy and mental retardation than those with ADHD. Less blame was attached to children with cerebral palsy and mental retardation than the children with ADHD and aggression issues, and these attitudes were communicated to their children. Positive correlations were found between parents' and children's attitudes towards cerebral palsy, mental retardation, ADHD and other disabilities, further emphasizing the importance of the home environment (Diamond and Innes, 1999).

While not much research has been conducted in India about the parents of typically-abled children's reactions to children with disabilities, Rao's (2001)

study described how parents of children with disabilities use the word “inconvenience” to describe a disability. While Rao (2001) took pains to point out that parents always made the distinction that it was the disability and not the child that was the inconvenience, it is easy to see how this nuance may not be evident to young children. While the word “inconvenience” is not meant to be pejorative (Rao, 2001), it clearly marks the child with the disability as being different from everyone else. Thus, the child with the “inconvenience” would be marked as different and unlike them by typically-abled children.

Thus, the manner in which parents and teachers in the United States discuss children with disabilities with typically-abled children seems to be very different from the manner in which these things are dealt with in India. These differences, in conjunction with the frequency with which children may or may not have contact with peers with disabilities may affect their attitudes and understanding of disabilities in general.

#### *Children’s attitudes related to in-group/out-group formation*

In early childhood, children frequently select friends on the basis of proximity and similarity of surface features such as play preferences, age and gender (Schneider et al., 1994). Ramsey (1991) also suggests that children are more likely to play with similar peers because they know what to expect. The definition of who they are like (girls, boys, older children, younger children, children who live on the same street) could define their in-group, and also inherently determine their out-group or those who are different to them (Myers, 2005). Diamond et al (1994) found that disability, age and gender were equally

salient in children's categorizations of others. The finding that children use ability or disability as a salient category equal in importance to age and gender suggests that children may use ability as a measure by which to judge whether children are potential friends.

Research conducted in the United States by many people including Powlishta (1995), Doyle and Aboud(1995), and Langlois and Downs (1979) show that intergroup attitudes emerge during the preschool years (as cited in Diamond, 2005). Thus, it is possible that preschool children are beginning to develop positive attitudes towards children they see as being part of their group, and more negative attitudes toward children in the out-group. Following this argument, differential treatment, societal attitudes and societal reactions to children with disabilities may mark them as part of the out-group which may result in typically-abled children developing more negative attitudes to their peer with disabilities.

Many different studies have investigated how children interact with peers whom they perceive as members of their in-group versus those that they perceive as members of their out-group. Both on the playground and in the classroom, children prefer to interact with peers who are most similar to them, or are members of their in-group (Schneider et al., 1994). Moreover, children are more likely to be accepting of people in out-groups when participating in casual school activities such as eating at the same table in the cafeteria, rather than more intimate, personal, friendship activities such as sleeping over at each other's houses (Hazzard, 1983).

The formation of "in-groups" and "out-groups" may also be influenced or

reinforced by attitudes and behaviors expressed by teachers to and about children who are different. Bigler, Jones and Lobliner (1997) found that adult behaviors and program-related structures that have the effect of removing children with disabilities from the classroom group, either physically or psychologically foster children's identification of their classmates with disabilities as members of an out-group. They also found that when teachers make functional use of categories, they communicate to children that particular characteristics, like ability, are uniquely important for understanding individuals and their behavior.

#### *Cultural Contexts of Altruism and Social Obligation*

One of the valued personal characteristics within Indian society is altruistic behavior. Indian parents and teachers rank social concern and willingness to help as being amongst the most desired qualities in a child (Sibia, Misra and Srivastava, 2004). One could argue that this is a direct result of Indians perceiving themselves as occupants of social roles (Miller and Bersoff, 1994). When contrasted with the western notion of an individual centered world view it is not surprising that Indians display and value prosocial behavior more than Americans (Sibia et al., 2004).

The work of Miller and Bersoff has demonstrated that as compared with Americans, Indians tend to treat interpersonal responsibilities as socially enforceable moral duties rather than as matters for personal decision making (Miller and Bersoff). Indians also tend to treat individual inclinations as consonant with interpersonal social expectations, whereas Americans tend to treat them as opposite (Miller and Bersoff). This was exemplified in a study during

which children had to choose between a hedonistic choice that would give a child personal satisfaction, and a choice that would lead to collective happiness at the expense of the child's personal satisfaction (Miller & Bersoff, 1990). It was found that American children were more likely to choose the hedonistic choice than Indian children. It was also found that in contrast to Indian children, American children viewed the choice that would lead to collective happiness as being in opposition to their personal happiness.

Miller and Bersoff (1990) found that Indians more than Americans frequently viewed responsiveness to another's needs as an objective obligation in all cases that involved minor needs or the moderately serious needs of friends or strangers. For an Indian, the primary criterion for categorizing social responsibilities in moral terms was the existence of some unmet need; the magnitude of this need and the nature of the role relationships had virtually no effect on Indian subjects' judgments (Miller and Bersoff, 1990).

Attitudes towards peers with disabilities may be different among typically abled children in India and the United States because of different social obligations of altruism. Cultural differences have been found between the United States and India in the concepts of interpersonal harmony, concern for the welfare of others, mutual benevolence, and love (Keller, Edelman and Schmid, 1998). Compared with children from America, children in India were more oriented toward issues of care and gave priority to interpersonal responsibilities (Miller and Bersoff, 1995). Children in India also made no difference between the obligations of helping a friend and helping a stranger (Miller and Bersoff, 1995).

Thus, it is possible that, even though typically abled children in India perceive an “inconvenienced” peer as being different from themselves, they will still feel obligated to help the peer out in their difficulties, whereas since the United States doesn’t have as strong a social obligation of altruism, typically-abled children in the United States may not be as prone to be helpful to peers with disabilities.

However, Chadha and Misra (2004) suggest that reasons other than altruism could motivate Indian children’s pro-social behavior, such as shame orientation and immanent justice. Shame orientation is the compunction to do something because one is being watched, and one must be conscious of how one appears to others, for example, “If she would not share it would look bad.” Immanent justice is the expression of anxiety about divine justice being meted out, in the form of some suffering resulting from not having behaved prosocially, for example, “If he would not help, God would punish him.” These are important factors to keep in mind when ascribing the prosocial behavior of Indian children to the social obligation of altruism.

#### *Gender Differences in Children’s Attitudes to Peers with Disabilities*

If cross-cultural differences related to acceptance of children with disabilities can be related to care, then perhaps it would be useful to examine gender differences from this same perspective. Miller and Bersoff (1995) suggest that the morality-of-caring framework developed by Gilligan portrays the development of this morality as affected, in part, by the normative beliefs and practices of the culture related to gender. Gilligan’s ethics of care, a model based on female interactions suggests that women and men differ in their moral

judgment of situations because women pay greater attention to interpersonal relationships than men and so take interpersonal outcomes into consideration more than men do. In contrast, Kohlberg's principles of morality describe justice in rigid, rule-bound terms with no flexibility to include interpersonal relationships (Gilligan, 1982). However, Gilligan asserts that Kohlberg's model is wholly based on male subjects, and leaves women out of the equation entirely. Kohlberg would thus describe pre-school boys as being at the stage where their goal is shifting from obedience for its own sake to avoiding punishment and seeking reward. In contrast, Gilligan would describe girls as being at the stage where their goal is shifting from self-survival to responsibility to others. Using this framework, one would assume that older girls would be more accepting than younger girls of peers with disabilities. In contrast, while younger boys may accept children with disabilities readily, older boys' acceptance of peers with disabilities would depend on the consequences.

Another important factor to take into account is the difference in competitiveness between girls and boys. Madsen (1994) found that across many cultures, boys are more competitive than girls, and are also more likely to engage in active, competitive activities. Madsen also found that older boys were more competitive than younger boys. On the other hand, Madsen found that girls found competition detrimental and generally engaged in more cooperative activities. Using this finding in conjunction with Gilligan and Kohlberg's assertions of morality one could hypothesize that there would be an interaction of gender and age in children's acceptance of peers with disabilities. Older boys who may feel

the need to be competitive may see the outcome of interacting with a peer with a disability as hindering their ability to win. Thus, older boys may be less accepting than younger boys of children with disabilities. The increased importance of interpersonal responsibilities for girls seems to indicate that older girls would be more accepting than younger girls of children with disabilities.

In the past, researchers have not found consistent gender differences in children's acceptance of peers with disabilities. Some researchers have found that although typically-abled girls have a somewhat more positive attitude to children with disabilities than typically-abled boys, this difference was not significant. Nabors (1995) found that while typically-abled girls' acceptance of peers with disabilities increased with age through preschool, i.e. from 3 years to 5 years, the opposite effect was found with boys with acceptance decreasing with increases in age. Although Nowicki (2006) found that girls selected more positive patterns of descriptors than boys, she also found that the youngest girls had the most negative attitudes toward children with intellectual disabilities.

#### *Children's Attitudes to Peers with Disabilities*

Although we know that age and gender affect children's perceptions of peers with disabilities, across age groups and socioeconomic status, acceptance of peers with disabilities by typically-abled children also seems to be related to frequency of contact, understanding of disabilities, and the attitudes of important adults (Diamond, 1995). Studies of children's attitudes towards with peers with disabilities have revealed the following trends. Overall, children have been found to be less accepting of and interact less frequently with children with disabilities

than with typically-abled children (Nabors, 1995). Children's lack of acceptance of peers with disabilities as playmates may be the relative competencies and skills of all available playmates become important (Diamond et al, 1994). Children can not only discriminate among the skills of children with physical disabilities and sensory impairments, but are also able to rate a child's capability on specific tasks, such as running for a child with an orthopedic disability (Diamond, Hestenes and O'Connor, 1994). Thus it seems that in the United States children's attitudes toward people with disabilities are linked to their understanding of disabilities (Diamond, 1995). Understanding may be related to the frequency with which they have contact with peers with disabilities (Diamond, 1995).

Children have different attitudes to different types of disabilities. Available evidence suggests that in the United States typically developing preschoolers are likely to be most aware of functional disabilities for peers with disabilities (Nabors, 1995). Functional disabilities are those impairments which prevent a child from participating fully in particular activities. For example, an orthopedic disability would be a functional disability in the context of playing on the playground. This suggests that when the disability is visible and easily comprehensible children are most to understand that the person's disability limits them from performing a certain task, and thus they do not blame the person with the disability for their limitations.

There are differences in how children apportion blame for and assume control of learning or physical difficulties (Nowicki, 2007). Some children suggested that peers with learning difficulties were partly or completely

responsible for having academic difficulties, and believed that a child's effort could improve their academic ability. Children were much less likely to suggest that effort would help those with physical difficulties. Across age groups, children made clear distinctions between the malleability of biological and psychological traits, believing that negative biological traits to be less malleable than negative psychological traits and less subject to a person's control (Lockhart, Chang & Story, 2006). Nowicki (2006) also found that all children were more biased against children with intellectual and both intellectual and physical disabilities than they were to those that had no disability or those who only had physical disabilities. But, as suggested by Diamond (2005), this preference may stem from children's preference to play with peers who will be most likely to be good at certain activities.

Findings substantiated by many scholars including Harasymiw et al. (1976) suggest that, generally, all people hold positive attitudes exist about peers with disabilities who conform most closely to the norms set by society. Borideri and Drehmer (1987) also suggest that social acceptance of a person with a disability is influenced by presumed personal blame for the disability.

Children's ages affect their understanding of the causes and ramifications of disabilities. Nowicki (2007) found that children between 8 and 11 years of age knew more about the reasons for learning and physical difficulties than children between 4 and 6 years of age. In Nowicki's study, both older children and younger children believed that biological traits were less changeable and were less within a person's control than psychological traits, but younger children were

more optimistic about the improvement of both kinds of traits over time. Older children were also able to distinguish that the type of injury would dictate how long someone would remain in the wheelchair, whereas younger children assumed that they wouldn't need a wheelchair once they were "better" (Nowicki, 2007). The findings of Lockhart, Chang and Story (2006) describe younger children's perpetual optimism. Lockhart et al. found that younger children were more likely to believe that negative traits would change in the positive direction over time. This included biological traits such as missing a finger and having poor eyesight.

The current study examined Indian and American children's perceptions of peers with disabilities through their reactions to a number of vignettes and questions. The study also included questions to assess parents' attitudes toward children with disabilities and knowledge regarding inclusive education. The primary question underlying this study is whether there are cross-cultural differences in how children perceive/choose to interact with peers with different disabilities. A second question is whether differences such as age and gender play a role in how children react to peers with disabilities. Third, are there differences in children's acceptance of peers with disability based on the type of disability? Fourth, are there cross-cultural differences in parents' knowledge regarding inclusive education and their attitudes toward their child interacting with peers who are differently abled? Finally, it would be important to examine whether there is a correlation between parents' and children's attitudes towards children with disabilities.

## METHOD

### *Participants*

Fifty nine children and 68 parents from Bangalore, India participated in my study. The children attended three different schools in the city. I interviewed 17 students from Sophia High School, 23 students from Sacred Heart High school and 20 students from St. Joseph High School. All the children were between 3 and 6 years old. Sophia High School has a co-ed elementary school, Sacred Heart High School is an all-girls' school and St. Joseph High School is an all-boys' school. Sacred Heart High School and Sophia High School are run by nuns of the order of the Good Shepherd and Notre Dame respectively. St. Joseph High School is run by Jesuit priests. Students from all religious and cultural communities are educated at these schools.

The reason that these schools were chosen was partly based on convenience. I had approached the principals of a number of different schools and was not able to attain their consent to interview their students. As I or someone from my family had attended the three schools that were eventually chosen, the principals knew me and felt comfortable with me speaking to their students. Another reason for choosing these particular schools is that students who attend any of these schools would be from families who have similar economic status to the families of the children interviewed in the United States. Parent permission letters and parent questionnaires were sent home with the students. At each school only about one-fourth of the parents filled out the questionnaire and gave me

permission to speak to their children. The reasons for the parents' low response rate could have been lack of familiarity with research that involved interviewing children, or discomfort with a researcher asking their children questions about disabilities.

Forty nine children and 45 parents from South Hadley, MA participated in my study. The children were students from the Gorse Child Study Center, a part of the Psychology department of Mount Holyoke College. With the help of the Acting Director of Gorse, each child's parents/caregivers were given parent permission letters and parent questionnaires. Those who consented to having their child interviewed, filled out the questionnaire and returned it with the consent form.

Schools in the United States are generally equipped to serve the needs of children with mild and moderate disabilities, and practice inclusive education. For instance, 16% of children at Gorse have been diagnosed with mild disabilities. In contrast, only one of the children I interviewed in India had been diagnosed with a disability. Like most schools in India, none of the schools where I conducted my interviews were equipped with ramps for wheelchairs or elevators. However, most of the primary classes were conducted on the ground floor. Children who are currently enrolled in the three Indian schools may not have interacted with peers who have been officially diagnosed as differently-abled. However the incidence of disabilities in the general population of India is high enough that it is likely that children at all three schools may have interacted with children with disabilities inside and outside the classroom.

### *Materials*

The parent permission questionnaire was a paper and pencil questionnaire which was used to assess parents' preferences about their child interacting with peers who do not have comparable social, academic and emotional abilities (See Appendix A). It was also used to assess the parents' attitude towards inclusive education, especially with regard to their child attending school with and with peers who have significantly different abilities (See Appendix A). All the questions were coded on a 3-point Likert Scale. The questions were intentionally kept as un-intrusive as possible to ensure that parents were not made uncomfortable.

The child interview was scripted to test the children's acceptance and preference of peers with disabilities, and their understanding of the causation of disabilities. I adapted measures used by Nabors (1995), Miller (1984) and Diamond (1994) (See Appendix B). The interview involved reading each participant five short vignettes about children with disabilities. For each vignette I showed the participants a photograph of a child who was matched to the participant for gender and ethnic group. The vignettes described a disability (physical, cognitive etc.) without using specific terms such as "cerebral palsy" or "attention deficit disorder." An example of a vignette is, "This is Jack. He cannot walk. His legs cannot hold him up. He can talk like other kids. Schoolwork is easy for him. Jack knows how to play lots of games. He acts like most kids his age but cannot run or climb." Each vignette was followed by questions regarding whether or not the participant would interact with the disabled child socially (Would you

invite him to your birthday party?), interact with the child co-operatively (Would you work on a project with him?) and the participant's understanding of that disability (i.e. Why can't he walk?). Questions regarding participants' ideas about how the disability was caused followed the questions regarding participating in specific activities. The next task involved the participants picking one child from all the children discussed in the vignettes to participate in a specific activity (Point to one child you would like to play with).

After conducting a pilot study with 26 children at the Gorse Child Study Center in April 2007, I revised the original interview to include a few more elements. I added one question at the beginning of the interview that asked the child what makes someone good at school. I also added a task at the end of the interview to further examine the children's understanding of the physical limitations of some disabilities. The children were shown five models of people with different abilities (a girl in a wheelchair, a boy with crutches, a boy with a hearing aid, a man wearing a brace and a girl holding a white cane) designed by Lakeshore Toys. They were asked what sort of activities they would participate in with children who are like the toy people in order to get to know them better.

During the pilot study it seemed that some participants found it difficult to match photographs to disabilities. To help the participants keep track of what each child could or could not do, I used small, hand-drawn pictures to represent the child's disability. For instance, I matched the photograph of the child with the orthopedic disability to a picture of crutches. The pictures appeared to be a good memory aid because after I started using them during the pilot, children had no

trouble matching photographs to disabilities. I used both the toys and the hand-drawn pictures in the current study.

### *Procedure*

The parents of children at all four schools were sent letters asking them for permission to interview their children. Parent questionnaires were sent along with the letters. If they agreed to allow their child to participate, they were asked to fill out the questionnaire and return them along with the consent forms.

Upon receiving consent from parents, I interviewed all children either at a table in their classroom or in the hallway attached to the classroom. Their answers were recorded on paper as well as on tape. The tape recording may have been another cause for concern from the parents' point of view, but again, they were assured that the child's name would not be attached to the recording; the data would only be identified by an ID number.

All the questions in the child interview were coded on a 3-point Likert scale (yes, maybe, no) except the open-ended questions which asked the child to explain the causes for the different disabilities and asked the child about appropriate activities to engage in with children with disabilities. The open-ended questions were reviewed for categories of ideas and then coded accordingly.

After I collected data from each school, I conducted a brief interview with the director of the program to find out about the amount of contact that children in the study may have had with peers with disabilities. This information was included in my description of the participants' school environments.

## RESULTS

For the purpose of the results section “peers” refer to children mentioned in the vignettes and “children” refer to child participants. Also, children were divided into younger and older groups using a median split (median=4.2years). Henceforth “younger” refers to children who were 4.2 years old or younger, and “older” refers to children who were older than 4.2 years. “Role” refers to whether the participants were parents or children. Finally, I refer to the typically-abled peer as having “no disability” in the tables.

For the results, analyses are divided by role. I first discuss children’s attitudes to peers with disabilities overall and for each activity. Second, I discuss parents’ knowledge and attitude to inclusive education and their reactions to their children interacting with peers with disabilities. Third, I compare children’s and parents’ attitudes to peers with disabilities and about important skills and activities in school. Finally I examine the relationship between what all participants consider to be important in a school setting and their acceptance of children with disabilities.

### *Analysis of Children’s Attitudes to Peers with Disabilities*

#### *Scales of Acceptance*

This section will focus on the scales of acceptance that were created using children’s answers to questions that tested their acceptance of peers with disabilities in different activities. A principal components factor analysis using a varimax rotation on the 24 items that pertained to children’s reactions to peers with disabilities showed that 23 items had factors loading over .40. After

discarding the item with factors loading less than .40 (Would you play in the playground with him/her? in relation to the child with the emotional disability) the 23 items with factors loading over .40 mentioned above were used to create an overall scale of acceptance. The scale of acceptance of peers with disabilities was created by taking the mean of these 23 items. I refer to this as the overall acceptance of disabilities measure.

To compare children's acceptance of peers with various disabilities with their acceptance of typically-abled peers, I created a scale of acceptance for children with each disability and for the typically abled child. These scales were created by calculating the mean of the children's responses to the questions related to interacting with each peer in six activities. All scales of acceptance were on a 3 point Likert scale with 1 signifying low acceptance and 3 signifying high acceptance, and each had a Cronbach's alpha of over .850 (See Table 1)

*Overall Acceptance of Peers with Disabilities Across Age, Gender and Nationality*

Children's overall acceptance of peers with disabilities was measured using a univariate analysis of variance to examine how the overall acceptance of disabilities measure varied across nationality, age and gender. No significant effects were found. However, on comparing the means a trend emerged. It appeared that in India older ( $M=2.77$ ) and younger ( $M=2.73$ ) girls and older ( $M=2.67$ ) and younger ( $M=2.66$ ) boys had similar levels of acceptance, whereas in America, older ( $M=2.73$ ) and younger ( $M=2.71$ ) girls had similar levels of acceptance, but younger boys ( $M=2.87$ ) were more accepting than older boys

*Table 1: Scales of Acceptance for Peers with Disabilities*

	Cronbach's Alpha
No disability	.93
Would you play with him/her?	
Would you invite him/her to your house?	
Would you invite him/her to your birthday party?	
Would you play on the playground with him/her?	
Would you make a birthday card with him/her?	
Do you think he/she could be good at school?	
Orthopedic Disability	.86
Would you play with him/her?	
Would you invite him/her to your house?	
Would you invite him/her to your birthday party?	
Would you play on the playground with him/her?	
Would you make a birthday card with him/her?	
Do you think he/she could be good at school?	
Cognitive Disability	.86
Would you play with him/her?	
Would you invite him/her to your house?	
Would you invite him/her to your birthday party?	
Would you play on the playground with him/her?	
Would you make a birthday card with him/her?	
Do you think he/she could be good at school?	
Visual Disability	.89
Would you play with him/her?	
Would you invite him/her to your house?	
Would you invite him/her to your birthday party?	
Would you play on the playground with him/her?	
Would you make a birthday card with him/her?	
Do you think he/she could be good at school?	
Emotional Disability	.89
Would you play with him/her?	
Would you invite him/her to your house?	
Would you invite him/her to your birthday party?	
Would you play on the playground with him/her?	
Would you make a birthday card with him/her?	
Do you think he/she could be good at school?	

( $M=2.23$ ),  $F(1,99)=2.37$ ,  $p=.13$  (See Figure 1). Although this three way interaction effect is not statistically significant, it is mentioned here because it is consistent with children's reactions to peers with specific disabilities.

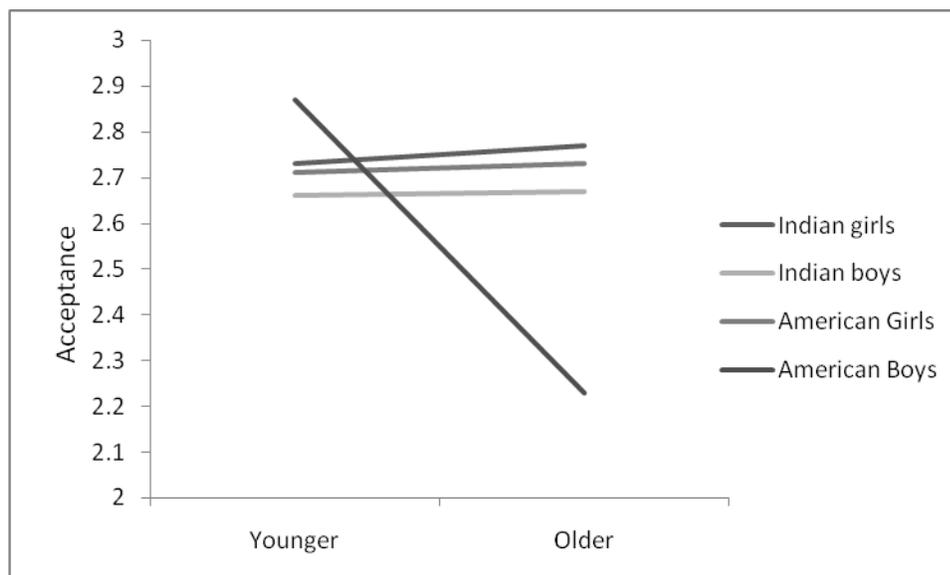
#### *Acceptance of Peers As a Function of Their Disability*

Next, to test whether children were in general more accepting of some disabilities than others, a repeated measures analysis of variance was used to examine within-subject variance in acceptance. The within-subjects variables were the measures of acceptance of typically-abled peers, and peers with orthopedic, cognitive, visual and emotional disabilities. The between-subjects variables were age, gender and nationality. There was a main effect for the type of disability. There were also interaction effects for (a) disability and age, (b) disability, nationality and gender and (c). disability, age, gender and nationality

The main effect for type of disability showed that children were most accepting of typically-abled peers ( $M=2.90$ ), followed by peers with orthopedic ( $M=2.73$ ), visual ( $M=2.713$ ), cognitive ( $M=2.70$ ) and emotional ( $M=2.57$ ) disabilities,  $F(4,106)=8.23$ ,  $p=.000$ . The interaction effect of disability and age indicates that younger children were less accepting than older children of typically-abled peers, whereas the reverse was true for peers with cognitive, visual and emotional disabilities,  $F(4,392)=2.96$ ,  $p<.05$  (See Table 2). No age difference was apparent for acceptance of the child with the orthopedic disability.

The interaction effect between disability, nationality, and gender shows that in India, girls were more accepting than boys of the typically-abled peer and peers with orthopedic, visual and emotional disabilities, while acceptance did not

Figure 1: Children's overall acceptance of peers with disabilities



vary by gender for peers with cognitive disabilities. However, in the United States girls were more accepting than boys of peers with orthopedic, cognitive and visual disabilities, whereas the opposite is true for typically-abled peers and peers with emotional disabilities,  $F(4,392)=2.48, p<.05$  (See Table 3).

Finally, the interaction between disability, age, gender and nationality shows similar patterns of acceptance of typically-abled peers and peers with orthopedic, cognitive and visual disabilities. The pattern shows that in India, girls had similar levels of acceptance across age, whereas younger boys were less accepting than older boys. In contrast, in America, younger girls were less accepting than older girls whereas the reverse was true for the boys. However, only Indian girls showed an increase in acceptance of peers with emotional disabilities with age. Across the other three groups (Indian boys, American girls and boys) acceptance of peers with emotional disabilities decreases with age,  $F(4,392)=3.44, p<.01$  (See Table 4).

#### *Children's Reasoning Regarding the Occurrence of Disabilities*

The answers to the open-ended question provide some clues as to why children were more accepting of peers with some disabilities than others. In this section categories used to code children's open-ended answers are described. Since very few children answered the questions, statistical analyses were not conducted. However, some evidence of cross-cultural differences did emerge in the frequency of use of certain categories.

*Orthopedic Disability.* Answers to the question, 'Why do you think she can't walk like other kids?' were coded into six categories. The categories were

*Table 2*  
Two-Way Interaction effect of disability and age on acceptance

<u>Disability</u>	<u>Younger</u>		<u>Older</u>	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
No Disability	2.87	.05	2.93	.07
Orthopedic	2.73	.07	2.73	.09
Cognitive	2.76	.07	2.64	.09
Visual	2.78	.07	2.64	.09
Emotional	2.70	.09	2.43	.12

*Table 3*

Summary of means and standard deviations for three-way interaction of disability, nationality and gender

<u>Disability</u>	<u>Indian Female</u>		<u>Indian Male</u>		<u>American Female</u>		<u>American Male</u>	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
No Disability	2.98	.08	2.86	.09	2.87	.10	2.90	.08
Orthopedic	2.80	.10	2.68	.12	2.81	.13	2.64	.11
Cognitive	2.75	.10	2.75	.12	2.78	.13	2.52	.10
Visual	2.75	.10	2.73	.13	2.80	.13	2.56	.11
Emotional	2.71	.14	2.50	.16	2.49	.17	2.58	.14

*Table 4:*  
Interaction effect of nationality, gender, age and disability

<u>Disability</u>		<u>Indian</u>				<u>American</u>			
		<u>Female</u>		<u>Male</u>		<u>Female</u>		<u>Male</u>	
		<u>Younger</u>	<u>Older</u>	<u>Younger</u>	<u>Older</u>	<u>Younger</u>	<u>Older</u>	<u>Younger</u>	<u>Older</u>
No	<i>M</i>	3.00	2.96	2.75	2.97	2.73	3.00	3.00	2.80
Disability	<i>SD</i>	0.13	0.07	0.09	0.16	0.10	0.17	0.10	0.12
Orthopedic	<i>M</i>	2.79	2.80	2.62	2.72	2.69	2.93	2.81	2.47
	<i>SD</i>	0.18	0.10	0.13	0.21	0.13	0.23	0.13	0.16
Cognitive	<i>M</i>	2.75	2.76	2.66	2.83	2.75	2.80	2.88	2.17
	<i>SD</i>	0.18	0.10	0.13	0.21	0.13	0.23	0.13	0.16
Visual	<i>M</i>	2.75	2.75	2.75	2.72	2.67	2.93	2.96	2.17
	<i>SD</i>	0.19	0.10	0.13	0.21	0.13	0.24	0.13	0.17
Emotional	<i>M</i>	2.63	2.79	2.61	2.39	2.74	2.23	2.83	2.32
	<i>SD</i>	0.24	0.13	0.17	0.28	0.17	0.30	0.17	0.22

temporary, permanent, use of the word “weak”, description of feelings of pain (e.g. his leg hurts), and overall health concerns (e.g. he does not drink enough milk). While 40% of children who answered the question said that they thought that the disability was temporary, only 17% thought that it might be permanent. Children were more likely to give answers that implied temporary injuries such as a fracture or a sprain to explain why a peer with an orthopedic disability could not walk. Of Indian children who answered this question, 28% used words such as “lame” or “weak” to describe the child, however only 6% of American children used such words.

*Cognitive Disability.* Answers to the open-ended question, “Why do you think she does not remember things like everyone else?” were coded into four categories. The categories were willful disobedience (i.e. the child chose not to pay attention), age (i.e. too young), desire to go home, and the understanding that there might be a permanent problem. When children were asked why the peer with a cognitive disability was not able to pay attention or remember things well, their answers differed across nationality. 39% of Indian children who answered this question implied that this disability was willfully caused. For instance, “talks too much”, “talking in class”, “not studying” were common answers. However, only 16% of American children who answered this question said that the child was willfully trying not to pay attention. Of the American children who answered this question 20% suggested that the child was too young to pay attention, such as “he’s too little” or “she was born that way” whereas only 3% of Indian children gave age as a reason.

*Visual Disability.* Children's answers to the question, "Why do you think she cannot see?" were coded into three categories. The categories were blind, needs glasses and other (such as he won't open his eyes, he's crying). There were no striking differences in children's answers to the question, however, children seemed aware of visual impairment. Of the Indian children who answered this question, 26% used the term "blind" whereas only 36% of American children did so. Five percent of Indian children and 13.6% of American children said that the child needed glasses. Most children answered that they did not know, or used the "other" category.

*Emotional Disability.* Answers to the open-ended question, "Why do you think this child cries and gets mad a lot?" were coded into six categories. The categories were sadness, anger, age (i.e. too young), was punished, is a "bad" child and "wants mother/wants to go home." Thirty-five percent of Indian children and 32% of American children who answered this question implied that peers were upset because they were sad. However, 26% of American children compared with 3% of Indian children said that the peers were angry or mad at someone. While 19.4% of Indian children utilized the explanation that the peer who was crying wanted his mother or wanted to go home, only 2% of American children used this category. There were no differences in answers based on nationality for the other categories such as the child is "bad" or "too young."

#### *Acceptance of Children with Disabilities Across Particular Activities*

One of the research questions of this study was whether children's level of acceptance of peers differed across the type of activity. To answer that question

children were asked to perform two tasks. First, they were asked whether or not they would interact with typically-abled peers and peers with orthopedic, cognitive, visual and emotional disabilities in six different activities. Henceforth, I will refer to this task as the “acceptance task.” Second, they were given a choice of all five peers (typically-abled peers and peers with orthopedic, cognitive, visual and emotional disabilities), and they were asked to pick one peer for each activity. From here on out, I will refer to this second task as the “choice task.” This section contains an analysis of children’s responses in the acceptance tasks using repeated measures ANOVA (See Tables 5, 6), as well as a description of children’s answers to the choice task (See Table 7).

*Play.* Children were asked whether or not they would play with each peer. Children’s responses to the acceptance task for this activity were analyzed using a repeated measures analysis of variance. The analysis yielded a significant main effect for type of disability. Children were most accepting of the typically-abled peer ( $M=2.90$ ), followed by peers with orthopedic ( $M=2.81$ ), visual ( $M=2.72$ ), cognitive ( $M=2.720$ ) and emotional ( $M=2.40$ ) disabilities,  $F(4,424)=13.09$ ,  $p=.002$ . In the choice task, when children were asked who they would like to play with, 46.3% chose the typically-abled peer, 21.3% chose the peer with the cognitive disability, 10.3% chose the peer with the orthopedic and emotional disability respectively and 9.3% chose the peer with the visual disability.

*Invite to house.* Analysis of children’s answers in the acceptance task for the question whether or not they would invite each peer to their homes using a repeated measures analysis of variance yielded a significant main effect for the

*Table 5*

Summary of main effect of disability for six repeated measures analysis of variance for children's acceptance of peers in particular activities as a function of their disability

Activity	<i>df</i>	<i>F</i>	<i>p</i>
<b>Play</b>			
Between groups	4	13.09	.000
Within groups	424		
Total	428		
<b>Invite to house</b>			
Between groups	4	4.25	.002
Within groups	424		
Total	428		
<b>Birthday</b>			
Between groups	4	3.42	.009
Within groups	424		
Total	428		
<b>Playground</b>			
Between groups	4	7.77	.000
Within groups	424		
Total	428		
<b>Drawing</b>			
Between groups	4	3.44	.009
Within groups	424		
Total	428		
<b>Good at school</b>			
Between groups	4	20.283	.000
Within groups	424		
Total	428		

type of disability. Once again, children were most accepting of the typically-abled peer ( $M=2.83$ ), followed by peers with orthopedic ( $M=2.75$ ), visual ( $M=2.74$ ), cognitive ( $M=2.74$ ) and emotional ( $M=2.55$ ) disabilities,  $F(4,424)=4.25$ ,  $p=.009$ . When children were given a choice of all 5 peers and asked to pick whom they would like to invite to their home, their choices were as follows: 32.4% chose the typically-abled peer, 22.2% chose the peer with the cognitive disability, 14.8% chose the peer with the orthopedic disability, and 13.9% chose peers with visual and emotional disabilities respectively.

*Birthday.* On using a repeated measures analysis of variance to analyze children's answers to the acceptance task when asked whether or not they would invite all peers to their birthday party, a significant main effect of disability was found. Children were most like to say that they would invite typically-abled peers to their birthday party ( $M=2.86$ ), followed by peers with visual ( $M=2.80$ ), orthopedic ( $M=2.76$ ), cognitive ( $M=2.70$ ) and emotional ( $M=2.64$ ) disabilities,  $F(4,424)=3.42$ ,  $p=.009$ . In the choice task, when children were asked to pick one peer that they would like to invite to their birthday party 25% chose the typically-abled peer, 20.4% picked the peer with the emotional disability, 17.6% picked the peer with the emotional disability and 16.7% picked the peer with the cognitive and visual disability respectively.

*Playground.* A repeated measures analysis of variance using children's answers to the acceptance task when asked whether or not they would play on the playground with each peer yielded a significant main effect for type of disability. Children were most likely to accept the typically-abled child ( $M=2.90$ ), followed

*Table 6*

Means, standard deviations, and n for children's acceptance of peers in particular activities as a function of their disability

Activity	Play	Invite to house	Birthday	Playground	Drawing	Good at school
N	107	107	107	106	107	107
<u>Disability</u>						
No Disability	2.90 (.43)	2.83 (.54)	2.86 (.50)	2.90 (.43)	2.92 (.39)	2.93 (.34)
Orthopedic	2.81 (.58)	2.75 (.66)	2.76 (.64)	2.50 (.85)	2.78 (.62)	2.78 (.61)
Cognitive	2.60 (.80)	2.70 (.70)	2.71 (.70)	2.78 (.62)	2.80 (.59)	2.66 (.74)
Visual	2.72 (.68)	2.74 (.66)	2.80 (.59)	2.69 (.70)	2.74 (.66)	2.65 (.75)
Emotional	2.40 (.90)	2.55 (.83)	2.64 (.76)	2.73 (.68)	2.71 (.69)	2.64 (.77)

by peers with cognitive ( $M=2.78$ ), emotional ( $M=2.73$ ), visual ( $M=2.69$ ) and orthopedic ( $M=2.51$ ) disabilities,  $F(4,424)=7.77$ ,  $p=.000$ . In the choice task, when asked to pick one peer that they would like to play on the playground with 26.9% chose the typically-abled peers, 23.1% chose peers with cognitive and visual disabilities respectively, 16.7% chose peers with emotional disabilities and 7.4% chose peers with orthopedic disabilities.

*Drawing.* Analysis of children's answers to the acceptance task when asked whether or not they would engage in a drawing project with each peer using a repeated measures analysis of variance yielded a significant main effect for the type of disability. Children were most accepting of the typically-abled peer ( $M=2.92$ ), followed by peers with cognitive ( $M=2.80$ ), orthopedic ( $M=2.78$ ), visual ( $M=2.74$ ) and emotional ( $M=2.71$ ) disabilities,  $F(4,424)=3.44$ ,  $p=.009$ . In the choice task, when asked to pick one child that they would like to work on a drawing project with, 26.9% chose the typically-abled child, 22.2% chose the child with the orthopedic disability, 19.4% chose the child with the cognitive disability, 18.5% chose the child with the visual disability and 10.2% chose the child with the emotional disability.

*Good at School.* For the acceptance task, a repeated measures analysis of variance yielded a significant main effect for the type of disability in children's answers to whether or not they thought whether each peer could be good at school. Children were most likely to think that the typically-abled peer could be good at school ( $M=2.93$ ), followed by peers with orthopedic ( $M=2.78$ ), cognitive ( $M=2.66$ ), visual ( $M=2.65$ ) and emotional ( $M=2.64$ ) disabilities,  $F(4,424)=20.283$ ,

*Table 7*

Percentage of children who chose a particular peer for each activity

	<u>No</u> <u>Disability</u>	<u>Orthopedic</u> <u>Disability</u>	<u>Cognitive</u> <u>Disability</u>	<u>Visual</u> <u>Disability</u>	<u>Emotional</u> <u>Disability</u>
Play	46.30	10.20	21.30	9.30	10.20
Invite to House	32.40	14.80	22.20	13.90	13.90
Birthday	25.00	17.60	16.70	16.70	20.40
Playground	26.90	7.40	23.10	23.10	16.70
Drawing	26.90	22.20	19.40	18.50	10.20
Good at School	51.90	13.00	13.90	12.00	6.50

$p=.000$ . In the choice task, when asked to pick one peer whom they thought would be good at school, 51.9% chose the typically-abled peer, 13.9% chose the child with the cognitive disability, 13% chose the child with the orthopedic disability, 12% chose the child with the visual disability and 6.5% chose the child with the emotional disability.

### *Comparison of Parents' Attitudes Across Nationality*

#### *Acceptance of Children with Disabilities*

To measure parents' acceptance of children with disabilities, I created a scale of acceptance by calculating the mean of three questions related to whether they would want their child to go to school with peers with comparable cognitive ability, emotional control and social skills (*Cronbach's alpha* = .754). Recall that a similar scale was used to compare children's overall acceptance of peers with disabilities. Using this scale, I conducted a one-way ANOVA to examine whether there was a significant effect of nationality. There was a significant main effect of nationality. Indian parents ( $M=2.22$ ) were less accepting of children with disabilities than American parents ( $M=2.68$ ),  $F(1,106)=24.83$ ,  $p=.000$ .

#### *Attitudes towards and knowledge regarding inclusive education*

To measure parents' attitudes toward and knowledge regarding inclusive education varied across nationality I conducted a multivariate analysis of variance using parents' answers to five questions. All answers were scored on a 3 point scale with 3 being the highest amount of knowledge or acceptance of inclusive education. The only significant result was that American parents ( $M=2.37$ ) were more aware of laws regarding inclusive education than Indian parents ( $M=1.56$ ),

$F(1,105)=45.741, p<.01$  (See Table 8). Across nationality parents' answers indicated that they had not spent a lot of time discussing disabilities with their children. Although these differences were not significant, American parents were neutral and Indian parents were moderately negative in their answers to questions regarding whether (a) they would make an effort to place their children in inclusive settings, and (b) they would not place their children in inclusive settings if a large portion of the teacher's attention was focused on children with special needs. Finally, across nationality parents seemed to perceive moderate benefit in placing their children in inclusive classrooms.

#### *Preferences in Children's Peer Contacts*

To examine whether the value parents placed on the abilities and skills of their children's peers varied by nationality I conducted a multivariate analysis of variance. The five dependent measures were parents' answers to whether they would be willing for their children to interact socially with peers who did not have comparable social skills, emotional control and academic abilities and whether they would prefer their children to interact with peers who were developmentally or academically advanced. There was a main effect for nationality for four out of the five dependent measures (See Tables 9 and 10).

Indian parents were less likely than American parents to say that it was important for their children to interact socially with peers who had comparable social skills, emotional control, and academic ability. However, Indian parents ( $M=2.54$ ) were more likely than American parents ( $M=2.21$ ) to say that they would encourage their children to befriend a developmentally advanced peer,

*Table 8*  
Parents' knowledge of and attitudes towards inclusive education

	<u>India</u>		<u>America</u>	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Discussed disabilities with child	1.76	.56	1.81	.55
Aware of laws	1.56	.59	2.37	.62
Effort to place child in inclusive environment	1.82	.74	2.05	.79
Consider inclusive education knowing child may have less of teacher's attention	1.89	.63	2.09	.72
Benefit of inclusive education	2.26	.51	2.42	.63

*Table 9*  
Main effect of nationality for multivariate analysis of variance for parents' preferences for children's peer contacts

Parents Willingness for Children to Interact with peers who	<i>df</i>	<i>F</i>	<i>p</i>
Have comparable social skills			
Between groups	1	13.78	.00
Within groups	102		
Total	103		
Have comparable academic skill			
Between groups	1	12.30	.00
Within groups	102		
Total	103		
Have comparable emotional control			
Between groups	1	19.77	.00
Within groups	102		
Total	103		
Are academically advanced			
Between groups	1	1.28	.26
Within groups	102		
Total	103		
Are developmentally advanced			
Between groups	1	6.12	.02
Within groups	102		
Total	103		

*Table 10:*  
Means and standard deviations for parents' preferences for children's peer contacts as a function of their nationality

Parents Willingness for Children to Interact with peers who	<u>India</u>		<u>America</u>	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Do not have comparable social skills	2.34	.63	2.77	.48
Do not have comparable academic skills	2.34	.63	2.77	.57
Do not have comparable emotional control	1.95	.62	2.49	.59
Are academically advanced	2.64	.48	2.51	.67
Are developmentally advanced	2.54	.56	2.21	.80

$F(1,102)=2.774, p<.05$ .

*Correlation Between Parents' Attitudes and Knowledge Regarding Inclusive Education and Acceptance of Children with Disabilities*

Recall that to create the scale of parents' acceptance of children with disabilities, the mean of three questions related to whether they would want their child to go to school with children with comparable cognitive ability, emotional control and social skills were calculated (*Cronbach's alpha* = .754). The scale showed that American parents were more accepting of children with disabilities than Indian parents.

Although there were differences across nationality in parents' awareness of laws, there were no differences in parents' reported attitudes toward (a) whether they had discussed disabilities with their children (discussion), (b) making an effort to place their child in inclusive settings (effort), (c) placing their child in an inclusive setting knowing that the teacher may pay less attention to their child than would otherwise be the case (teacher attention) and, (d) perceived benefit of placing their child in an inclusive setting (benefit).

To examine whether there were any correlations between these variables and parents' acceptance of children with disabilities, a bivariate correlation was completed. Acceptance of children with disabilities was significantly positively correlated with all variables except whether or not parents had discussed disabilities with their children. Because there are six variables, the recommended significance level is  $.05/6$  or  $.008$ . Thus correlations of  $p > .008$  are not reported as being significant (See Table 11).

*Table 11*

Intercorrelations, Means and standard deviations between parents' acceptance of children with disabilities and their knowledge and attitudes toward inclusive education ( $N=108$ )

Variable	1	2	3	4	5	6	<i>M</i>	<i>SD</i>
1. Discussion	--	.14	.18	.32**	.20	.25	1.76	.56
2. Awareness of law	--	--	.18	.22	.28**	.30**	1.86	.72
3. Effort	--	--	--	.51**	.56**	.30**	1.90	.75
4. Attention	--	--	--	--	.56**	.31**	1.95	.67
5. Benefit	--	--	--	--	--	.35**	2.32	.56
6. Acceptance	--	--	--	--	--	--	2.41	.52

\*\* $p < .008$

### *Comparison of Parents' and Children's Attitudes in India and the United States*

In this section I compare how participants' attitudes vary by role and nationality. First I examine differences in overall acceptance of disabilities across role and nationality. Next, I compare how the value that is placed on skills and activities in school varies by role and nationality. Finally, I use correlations to compare whether parents and children place similar values on activities and whether acceptance of disabilities is correlated to these values.

#### *Acceptance of Children with Disabilities*

To compare how overall attitudes toward children with disabilities varied according to role and nationality, I conducted a two-way ANOVA on the using the overall acceptance of peers with disabilities measure as the dependent variable. There were main effects for role and nationality as well as a two way interaction effect for role and nationality. Participants from India ( $M=2.46$ ) were less accepting than participants from the United States ( $M=2.67$ ),  $F(1,214)=9.34$ ,  $p<.01$ . Children ( $M=2.70$ ) were more accepting of children with disabilities than parents ( $M=2.41$ ),  $F(1,214)=13.57$ ,  $p=.000$ . Indian children ( $M=2.72$ ) were more accepting than Indian parents ( $M=2.22$ ), and American children ( $M=2.66$ ) and American parents ( $M=2.68$ ) showed similar levels of acceptance,  $F(1,214)=15.55$ ,  $p=.000$  (See Figure 2).

#### *Importance of Skills and Activities*

To examine how the importance of friendship, academics, social awareness and fun in a school setting varied according to role and nationality I conducted a multivariate analysis of variance. Parents' answers were originally

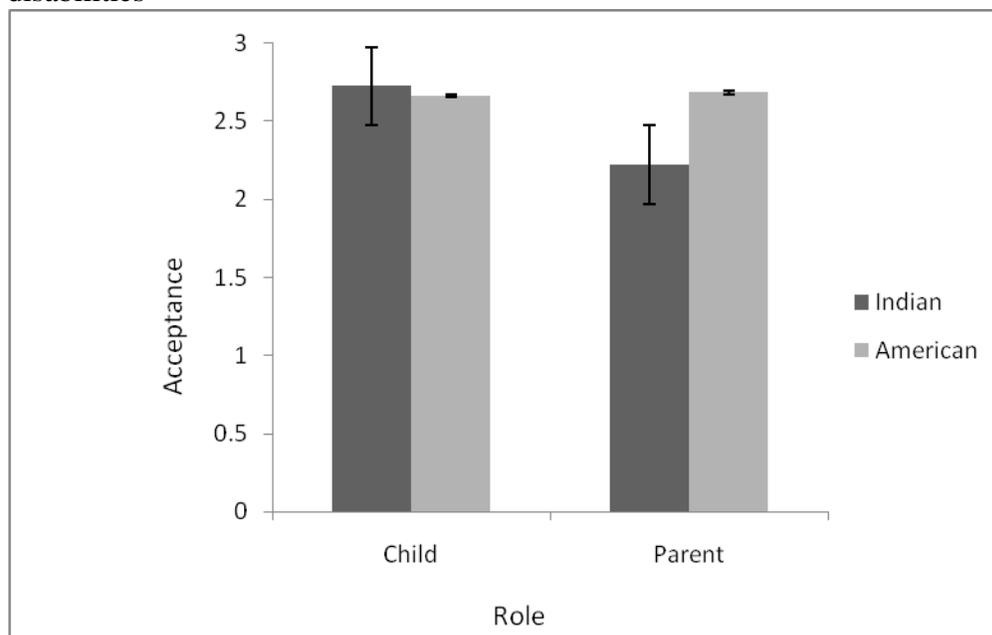
scored on a 5 point Likert scale, and children's answers which were originally scored on a 3-point scale were converted to a five point scale. There were significant main effects for nationality for friendship, academics, social awareness and fun. There was also a significant main effect for role for academics. Finally, there was a significant two way interaction of role and nationality for academics.

The main effect of nationality shows that in general, Americans consider friendship, social awareness, and fun as more important in school settings than Indians do. Conversely, Indians consider academics to be more important than Americans do (See Tables 12 and 13). The main effect of role shows that children ( $M=4.83$ ) consider academics to be more important in school settings than parents ( $M=4.28$ ) do,  $F(1,213)=22.80$ ,  $p=.000$ . However, the two way interaction effect shows that Indian children ( $M=4.66$ ) and parents ( $M=4.69$ ) consider academics to be of equal importance, whereas American children ( $M=5.00$ ) consider academics to be more important than American parents ( $M=3.88$ ) do,  $F(1,213)=25.04$ ,  $p=.000$ .

*Relation Between Acceptance of Children With Disabilities and Importance of Skills and Activities in School*

To examine whether there are any correlations between what participants thought were important in school settings and their acceptance of children with disabilities in a school setting, I utilized a bivariate correlation with 5 variables, namely the importance of friendship, academics, social awareness, fun, and overall acceptance of children with disabilities. The importance of social

*Figure 2*  
Interaction effect of role and nationality on acceptance of children with disabilities



*Table 12*

Summary of main effect of nationality, multivariate analysis of variance of the value parents and children place on school activities and skills

Skills/Activities	<i>df</i>	<i>F</i>	<i>p</i>
Make friends			
Between groups	1	9.11	.00
Within groups	213		
Total	214		
Social Awareness			
Between groups	1	25.54	.00
Within groups	213		
Total	214		
Fun			
Between groups	1	30.38	.00
Within groups	213		
Total	214		
Academics			
Between groups	1	4.32	.26
Within groups	213		
Total	214		

*Table 13*

Means, standard deviations, and of the value parents and children place on school activities and skills as a function of their nationality

Skill/Activity	<u>Indian</u>		<u>American</u>	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Make friends	4.69	.06	4.67	.08
Social Awareness	4.11	.10	4.85	.11
Fun	3.83	.11	4.75	.13
Academics	4.67	.08	4.43	.09

awareness was positively correlated with disabilities acceptance,  $r(214)=.30$ ,  $p<.01$ . The importance of fun was also positively correlated with disabilities acceptance,  $r(214)=.25$ ,  $p<.01$ . The  $r$  squared indicates that 9% of the variance in acceptance of disabilities can be predicted from how important social awareness is to a person, whereas 6.25% of variance can be predicted by how important fun is to a person.

A simultaneous multiple regression was conducted to investigate the best predictors of acceptance of children with disabilities. The means, standard deviations and intercorrelations can be found in the table below (See Table 14). When the combination of variables to predict acceptance of children with disabilities included the importance of fun and the importance of social awareness,  $F(2,210)=12.22$ ,  $p,.001$ . Placing high value on fun and social awareness predict acceptance of disabilities when both variables are included. The adjusted R squared value was .104. While it appears that this regression indicates that 10.4% of the variance in acceptance of disabilities can be explained by these factors, this regression should be interpreted with caution as there could have been different interpretations of “fun” and “social awareness” across nationality.

*Table 14*

Intercorrelations, Means and standard deviations of parents' and children's acceptance of peers with disabilities and the value they place on goals, skills and activities in school ( $N=215$ )

Variable	1	2	3	4	5	<i>M</i>	<i>SD</i>
1. Importance of friends	--	.28**	.30**	.34**	.07	4.81	.65
2. Importance of academics	--	--	.18**	.08	-.05	4.56	.92
3. Importance of social awareness	--	--	--	.45**	.30**	4.42	1.13
4. Importance of fun	--	--	--	--	.25**	4.22	1.23
5. Acceptance	--	--	--	--	--	2.55	.52

\*\* $p < .01$

## DISCUSSION

In this analysis of the results I primarily summarize the overall trends in children's responses, and discuss in more detail the patterns of children's responses to the interviews. I will use children's answers to open-ended questions to illustrate these patterns and discuss the roles of nationality, age and gender. Comparison between parent and child responses will mainly be drawn to support trends shown in the interviews conducted with children. Finally, I will discuss the limitations of the study, the implications of the results, and directions for future research.

The most important factor to remember is that overall acceptance of peers with disabilities was relatively high across all participants. However, the analysis of the interview responses of children in India and the United States revealed a few salient patterns in differences in levels of acceptance across participants. First, all children preferred to play with other typically-abled peers rather than with peers with disabilities. Second, although children were more accepting of the typically-abled peer as a playmate, their lack of acceptance of peers with disabilities was related to specific activities that the peer was limited from participating in due to their disability. Third, all children were least accepting of peers with emotional and cognitive disabilities. Fourth, overall Indian children were more accepting of peers with disabilities than American children. Fifth, all girls were generally more accepting of peers with disabilities than boys. Finally, an interaction effect of age, sex and nationality showed that, in India, older

children were generally more accepting than younger children of peers with disabilities, whereas the reverse was true in the United States. It is important to keep in mind that while it seems as though all older children in the United States were less accepting, it was the older boys who were really driving this interaction. Likewise, while it appears that all older children in India were more accepting, it was really the girls who were driving this effect. These patterns are described in detail below.

The information that children prefer to play with typically-abled peers rather than with peers with disabilities is not unexpected. Schneider et al.(1994) discussed that children frequently select playmates and friends on the basis of similarity of surface features such as age and gender. Diamond et al (1994) found that disability, age, and gender were equally salient in children's categorization of peers. These findings seem to predict that children would prefer to participate in activities with peers who are most like themselves, in this case, typically-abled peers, which proved to be the case.

Children's negative attitudes toward peers with disabilities seem to reflect stigmatization. However, Diamond (2005) offers an explanation based more on a more practical evaluation of ability. Diamond suggests that children prefer to play with other children who would most likely be good at certain activities. For instance, given a choice between two typically-abled children one of whom was better at drawing, a child would probably choose to work on an art project with the child who was a better artist than a child who was not. This choice would be made by virtue of ability, and not because of stigmatization per se. Thus, in

interacting with peers with disabilities, children would choose to play with children who would not be limited in participating in a particular activity due to their disability. This hypothesis could explain why children's lack of acceptance of peers in certain activities is connected to the limitations imposed on them by their disability. In the case of interacting with the peers with disabilities, children were the most accepting of the peer with the orthopedic disability. However, when given a choice of all peers in the study and asked whom they would play with on the playground the peer with the orthopedic disability was chosen least often. Similarly, children were also less likely to choose to play with a child with a visual disability when the playground was mentioned than when it was not. Also, children were least likely to choose peers with cognitive and emotional disabilities and visual impairments when asked whom they thought could be good at school. Thus children's lack of acceptance of peers with disabilities may in part stem from evaluations of abilities specific to a particular activity.

However, the results of this study also show that children had more negative attitudes to peers with emotional and cognitive disabilities when asked whether they would play with them, invite them to their home or invite them to their birthday party. At the same time, children had significantly more positive attitudes toward these peers when asked whether they would make a card with them or if they would play with them on the playground. Hazzard (1983) also found that children were most discerning in choosing play-mates with surface similarities in close, personal friendship activities such as inviting a peer to one's birthday and to one's house and less discerning in who they chose to interact with

when participating in less intimate, classroom activities. Thus, we can gather that children seem to somehow perceive peers with physical disabilities as being more similar to them than peers with emotional or cognitive disabilities.

One possible explanation could be that children think of peers with physical disabilities and peers with cognitive and emotional disabilities in fundamentally different ways. Children's answers to open-ended questions regarding the reason why a peer had a disability are useful in throwing light on these differences. Children more readily described plausible reasons for physical disabilities but did not quite seem to understand that the peers with emotional and cognitive disabilities actually had disabilities and seemed to blame them for their disability. Their responses implied that children with cognitive and emotional disabilities are willingly "bad" and not trying hard enough to conform. These findings are congruent with the research of Harasymiw et al. (1976) and Borideri and Drehmer (1987) who suggest that, generally, all people hold positive attitudes exist about peers with disabilities who conform most closely to the norms set by society, and that social acceptance of a person with a disability is influenced by presumed personal blame for the disability.

To elaborate further, when discussing the child with the orthopedic disability, children were asked the question, "Why do you think he/she cannot walk?" Their answers suggested that they thought that the child may have been injured and that this injury was temporary. When discussing the child with the visual disability children were asked "Why do you think he/she cannot see?" Their answers suggested that the disability was temporary, and many of them

used the word “blind” and suggested that visual aids would help. Thus, children’s explanations of why a child might not be able to see, or walk very well showed that they did not attach any blame to the child with the disability for the limitations imposed by the disability.

Children’s ideas regarding cognitive disabilities varied across nationality. For instance, when Indian children were asked why a child could not pay attention in class like other children, their answers reflected that they thought that this was a willful choice on the part of the peer (e.g. “he talks too much”) and that this made the peer “bad.” This finding is similar to that of Nowicki (2007) which suggested that children think that peers with learning disabilities were partly or completely responsible for having academic difficulties and were more likely to suggest that a peer’s effort could improve their academic ability. In contrast, when American children were asked the same question they used age (“she’s a little kid”, “he’s too young”), birth defects (“she was born that way”) and personal attributes and feelings (“he’s shy”, “he’s sad”) to explain the disability. Although there is no blame implied in these explanations, the words “young” and “little” seem to belittle the peer with the cognitive disability. However, even though Indian children seemed to blame the peer for the disability and American children did not, Indian children seemed to be more accepting of peers with cognitive disabilities. We know that children are most accepting of peers who are most like them, so one explanation for Indian children’s relatively high levels of acceptance could be that they saw the peer as having potential to try harder and conform, whereas American children may not have seen potential in the peer at all.

To further understand why children were less accepting of peers with cognitive disabilities, one must consider how children responded to the question of whether or not academics were important in a school setting. Both Indian and American children reported thinking that academics were important. However, American children thought that academics were more important than Indian children did. Thus, since academic proficiency seems to be important to children, it seems logical that they would not want to interact with peers who could not be proficient due to age or other factors or who willfully chose not to be proficient. This difference could also explain why American children were less accepting of peers with cognitive disabilities than Indian children.

Acceptance of peers with emotional disabilities can also be explained by taking children's answers into account. When children were asked why they thought the peer with the emotional disability was often angry and cried a lot. Many of the American children mentioned that the peer might be "not very nice," "a very bad girl," "mad a lot." Their answers seem to blame the peer for not having emotional control and that not controlling your emotions is a willful choice, and that lack of self-control is not good. Indian children's answers, on the other hand, assign less blame. Their answers imply that they thought that something had happened which led to the peer having been scolded, or that the peer might want to go home to be with parents etc. Thus, Indian children seemed to see emotional disabilities as a manifestation of sadness, whereas American children seem to see emotional disabilities as evidence of being "bad." Given this difference in perceived intention, it makes sense that Indian children were more

accepting of children with emotional disabilities than American children.

The fact that children are more accepting of peers with physical disabilities than they are of peers with cognitive and emotional disabilities is consistent with past research that relates children's attitudes to parent attitudes. Parent data from the current study and literature available on the subject did not suggest that there was any particular prejudice toward children with physical disabilities (Stoneman et al., 1996). However, Stoneman et al. (1996) found that when American parents discussed disabilities with their children, they were likely to draw positive comparisons between their children and children with cerebral palsy and mental retardation, but they were not likely to include positive comments regarding children with ADHD and aggression issues. Stoneman et al. also found that parents attached more blame to children with ADHD and aggression issues than they did to children with cerebral palsy and mental retardation. Similarly, in studying "emotional intelligence" across different cultures Sibia (2004) found that Indian parents and teachers most valued "emotional control" in their children. In the current study, parents' answers to the question "Would you want your child to go to school with peers who have comparative control over their emotions?" showed that while neither group of parents valued their children's peers' emotional control highly, American parents seem to value it more than Indian parents. This could possibly have been because the children were too young for the parents to have any real expectations of emotional control.

One might hypothesize that because of the emphasis on conformity in an

interdependent culture such as Indian culture, those children who manifest the most behavioral problems would be among the most stigmatized (Murdick, 2004). In fact, in an interdependent culture such as India where social tolerance is based on conforming to social norms, one would imagine that people would be less accepting of children across all disabilities than in the more independent American culture. Parent data from this study corroborates this hypothesis. Indian parents were in fact less accepting of all children with disabilities than American parents. Indian parents were also more likely to indicate a desire for their children to befriend peers who were academically advanced and they generally appeared more concerned than American parents about their children's academic development.

If it is indeed the case that children's attitudes are similar to those of their parents as Stoneman et. al. (1996) hypothesize, then attitudes of parents in both cultures would lead us to predict that Indian children would be less accepting of peers with disabilities than American children because their parents would be less likely to accept children with disabilities. However, this was not the case. Indian children were more accepting of peers with cognitive and emotional disabilities than their parents and than American parents and children. In fact, across most disabilities and activities, Indian children are more accepting of peers with disabilities than American children. This consistently high acceptance shown by Indian children seems to be at odds with the way disabilities are understood in their culture, but not if one considers their overarching cultural orientation.

Indian children may partially be influenced to choose one child over

another based on abilities or social approval, as exemplified by their greater acceptance of the typically-abled child than children with disabilities. However, the fact that Indian children are consistently more accepting of children with disabilities than American children cannot be explained by ingroup/outgroup theories, nor can they be explained by theorizing that children share the views of salient others. We know that children perceive children who are most similar to them as part of their in-group (Myers, 2005). Because of the importance of conformity in India, one would imagine that peers with disabilities would stand out more than they would in a culture where conformity was not as important. Thus, children with disabilities ought to be viewed as part of the “out-group” and so should be less accepted by typically-abled peers. However, this is not the case. Also, if it was really the case that children shared the views of salient adults such as parents, then in the current study Indian children should have been less accepting than American children because Indian parents were less accepting than American parents. Other factors that could influence the attitudes of Indian children could be the belief in the theory of karma and the “social obligation of altruism” as defined by Miller and Bersoff (1995).

The principle of karma is often invoked to explain major life events in India, including the occurrence of a disability. According to the theory of karma, all good and bad deeds accumulate over previous births, and present suffering is explained as a consequence of the misdeeds of previous births. Thus, while people may accept that a disability is something which has resulted from past karma or due to God’s will (Dalal et al, 1999), this theory also has implications for how a

person would behave towards someone with a disability. Performing “good deeds” in relation to someone who has a disability could mean that one is accumulating good karma which will mitigate past misdeeds. This theory of karma may also explain Chadha et. al’s (2004) claim that Indian children behave pro-socially for fear of divine justice. Chadha et al. go on to define this fear as anxiety that lack of prosocial behavior would result in divine justice being meted out in the form of some suffering. For instance, if a child does not behave prosocially, he might fear accumulating bad karma and thus being punished by God.

The theory of karma also validates Miller and Bersoff (1995) suggestion that, unlike Americans, Indians tend to treat interpersonal responsibilities as socially enforceable moral duties rather than matters for personal decision making. Miller and Bersoff (1995) go on to say an Indian will consider it a social obligation to meet the unmet need of a person, regardless of that person’s relationships to them or the magnitude of the need. Miller and Bersoff’s argument that altruism underlies the ideology of interdependent cultures, in conjunction with the theory of karma, may explain why Indian children may think of interpersonal responsibilities in terms of socially enforceable moral duties. In the instance of interacting with a child with a cognitive disability, an Indian child may see the interaction in the light of a social obligation. Although they know that the child is displaying behavior that is contrary to what is expected of children, they may feel obliged to include the child in activities because they think that they should be kind and inclusive to a peer who may otherwise be left out. The

contradiction between parents' and children's acceptance may be expressed in the following way. The parent data may reflect the stigmatization of those who do not conform and the cultural emphasis on academics, while children who may not yet understand the cultural norm of conformity may reflect the value of altruism.

It is possible that Indian children view social interactions in a different light than American children. Miller and Bersoff (1992) contend that American children see things in terms of right and wrong, and not in terms of interpersonal relationships. Thus, American children are motivated by justice obligations or doing what is "right" and not by interpersonal obligations. Miller and Bersoff (1992) suggest that, in contrast to American children, Indian children see interpersonal obligations as, equally if not more, important than justice obligations. Thus, for Indian children, although a peer may be considered "bad" for losing control over their emotions, or for "choosing" not to focus on work, the obligation to include that child seems to carry more weight than the justice component, (i.e. the child is bad and therefore must be shunned.) It could also be the case that, as members of a more interdependent culture, Indians tend to view the consequences of interpersonal violations as being greater than the consequences of justice violations (Miller and Bersoff, 1995). Parents and teachers support the development of pro-social characteristics by placing great emphasis on their children "helping" those in need and showing "concern for others" (Murdick, 2004). Finally, the fear of immanent justice and the resultant emphasis on good deeds being rewarded and bad deeds being punished may together create a very different method of reasoning for Indian children.

However, considering Indian children's reasoning regarding acceptance of children with disabilities in this pro-social, interpersonal light, may make the lack of implementation of legislation and adults' lack of acceptance of children with disabilities seem anomalous with their cultural orientation. An important point to remember at this juncture is that pro-social behavior and altruism in India has very little to do with individual rights and more to do with the greatest good of all concerned. Given the lack of knowledge and understanding of disabilities and the resultant stigma, the greatest good for the families of children with disabilities within the Indian context may be the minimization of the disability. Thus, altruism, the importance of interpersonal care and pro-social behavior make it likely that Indians would prefer to make accommodations for a person with a disability within the context of the home or school setting, without attempting to gain formal accommodations or legislations for them. This mentality could explain why there seems to be a lack of legislation for the rights of children with disabilities in India. Also, given the stigma attached to "disabilities" in India, Indian parents' "lack of acceptance" of a child who is described as having a disability is not surprising. If the questions in this study had been presented to the parents in terms of the child having a problem, as opposed to the child having a disability, Indian parents' levels of acceptance may have been higher because of the idea of socially enforceable moral obligations.

If we are going to look at cross-cultural differences in terms of socially enforceable moral obligations, then we need to examine the evident gender differences in the child sample for the same differences. It is interesting to note

that there were no consistently significant gender differences in Indian children's attitudes toward peers with disabilities. Boys were often less accepting than girls, but this difference was not significant in the Indian sample. This pattern seems to fit with previous research that has shown that expectations of pro-social behavior in Indian children are not defined by gender (Sibia et al, 2004). Thus it seems that at this early stage in their lives, Indian children have similar levels of prosocial behavior across genders.

However, this was not the case for the American sample. The gender difference between American girls and boys were quite stark. In fact, American girls and Indian children across both ages seemed to have similar attitudes regarding acceptance of children with disabilities. In contrast, younger American boys were more accepting than older American boys. We know that the basis for Miller and Bersoff's (1994) analysis of a social obligation of altruism is the interdependent culture in India and the resultant importance of interpersonal relationships. Given the similarity in attitudes of Indian children and American girls, it may be realistic to expect that American girls also place importance on interpersonal relationships. In her book "In a Different Voice," Carol Gilligan (1982) suggests that this is indeed a valid claim.

We can examine gender differences in the American child sample as the juxtaposition of Kohlberg's and Gilligan's theories of morality. Kohlberg's principles of morality based on justice were formulated by looking at a male sample. Gilligan argues that Kohlberg focuses more on justice as enforced by rigid rules, whereas women are more likely to consider interpersonal elements and

thus view a situation from a number of different perspectives rather than looking at a situation as being unidimensional and rule bound. She goes on to explain that, if one considers Kohlberg's stages of morality to be universal, then women are left out of the equation. The research of Madsen (1994) suggests that older boys are more competitive than younger boys, and that boys in general are more competitive than girls. This gender difference, in combination with the theories of Gilligan and Kohlberg potentially explain the gender differences in the American child sample.

Taking Kohlberg's principles of justice into account, the American boys that I interviewed would be considered to be at what Kohlberg defined as the pre-conventional level. The younger boys would be considered to be at the first stage where obedience would be considered important for its own sake. In this study, accepting a child with a disability may have been considered to be obedience. The older boys in this study would be at the second stage, where they seek reward and avoid punishment or seek success and avoid failure. Given that competition is an extremely important part of American masculine identity and interpersonal relations it seems that if a boy chose to play with a child with a disability, he would not be as successful because he would not fare well in the "competition." In contrast, if the boy chose not to play with a child with a disability, the reward would be that he would fare well in the competitive activity. Thus, this increased focus on competition with age could explain why older boys are less accepting than younger boys.

In contrast, Gilligan's ethic of care implies that girls at a similar stage of

development as pre-conventional boys could either be at the stage where they perceive concern for the self as selfish, or where they believe that goodness is concern for others and is therefore equated with self sacrifice (Gilligan, 1982). Thus, at this stage a girl who has to consider whether or not to play with a peer with a disability may, as in the Indian example, perceive this peer as being in need of help and be more likely to accept a peer with a disability as a playmate.

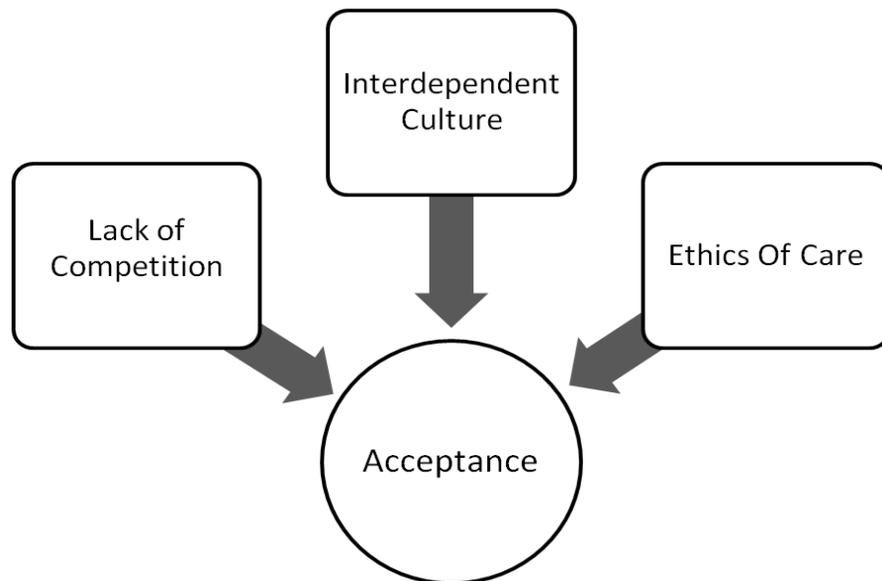
Children's acceptance of a child with a disability may be related to functional limitations imposed by the disability and the attitudes of salient adults. However, children's attitudes toward peers with disabilities may also be affected by other, more fundamental values that arise as a result of their socialization. For example, the ethic of care as defined by Gilligan and the social obligation of altruism as practiced by children in India may determine whether or not children will accept peers with disabilities. Children who are socialized to perceive and respond to others' needs may be more likely to want to help peers with disabilities and therefore be more likely to accept peers with disabilities as playmates. Children in the United States who are primarily socialized to be self-aware and to be individually successful may be less likely to accept peers with disabilities as playmates.

To consolidate the above ideas it seems possible to isolate three factors that may affect acceptance of children with disabilities. The first factor is cultural orientation; it appears that children from interdependent cultures such as India are more accepting of people with disabilities than children from independent cultures such as America. And in fact, the data in this study shows that Indian children are

more accepting of peers with disabilities than American children. The second factor the understanding of justice; children who see justice in unidimensional rule-bound terms seem less likely to accept peers with disabilities than children who view justice in terms of the ethics of care. And as the data shows, boys in both cultures are less accepting than girls. The last factor is competition; the more competitive one is, the less likely one is to accept disabilities. Madsen (1994) found that across different cultures, boys are more competitive and are more likely to thrive in competitive environments than girls and older boys are more competitive than younger boys. And, as explained earlier, if we consider competitiveness to be inversely proportional to acceptance of peers with disabilities, this would explain why boys are less accepting than girls of peers with disabilities.

The interaction of these factors seems to indicate children's acceptance of peers with disabilities. For instance, consider the overall acceptance levels of children in this study. Older Indian girls who are from an interdependent culture, think of justice in terms of the ethics of care and are not competitive were the most accepting of children with disabilities. However, older American boys who are from an independent culture, and think of justice in terms of unidimensional, rule-bound terms are generally the least accepting. American girls and Indian boys often had similar levels of acceptance; however, the interplay of culture, justice and competition were slightly different for both groups. While American girls are from an independent culture, according to Gilligan's ethics of care they ought to view justice in an interpersonal light and they are uncompetitive.

Similarly, although Indian boys are from an interdependent culture which tempers their views, they still view morality in a somewhat unidimensional light and they are competitive. Considering these three factors, the levels of acceptance for Indian girls and boys and American girls and boys ought to be as depicted in the figure below. This pattern is mirrored in much of the data from this study.



Neerja Chadha (2006) found that when Indian children were asked whether or not they would help a peer who was “in need,” some children responded that they would do so because otherwise it would not look good. This gives rise to several questions about the intention of the Indian children as they were answering questions during the interview in the current study. Chadha identifies several categories by which children reason, some of which include “shame orientation” and “honoring request made.” Shame orientation means that children do something because they are being watched or are concerned about how they appears to others, or the impression they are making. “Honoring request

made” is doing something because someone has requested one to do so, even if that person is not an authority figure. Culturally, sometimes requests are couched in terms of a question. In asking children whether they would interact with a hypothetical peer, it may have appeared that I was requesting them to interact with the child. Thus, in questioning the children about their levels of acceptance I may have unwittingly activated their “shame orientation” or made them feel that they had to “honor a request” and therefore caused children to report higher levels of acceptance than would otherwise have been the case.

One might argue that given that teachers often try to facilitate social interaction among children in American pre-schools, my question may have had a similar impact on the American children; asking children whether or not they would play with a peer may have elicited higher levels of acceptance of children with disabilities than would have otherwise been the case. However, I would argue that this would have been less prevalent in the American sample because the norm of unquestioningly complying with the requests of older persons is not as embedded within the culture as it is in India.

However, responding to questions in a socially appropriate manner was a theme in the American sample too. It was interesting to note that, although American children seemed to value academics highly, American parents stated that they did not. This seems incongruent because for all other school activities and skills, children and parents from both cultures had similar attitudes, and, for academics in particular, Indian parents and children had similar attitudes. The other activities and skills were social awareness, making friends and having fun.

Thus, American parents' answers may have reflected the socially-acceptable norms: that is it is not socially appropriate in American culture to place a great deal of emphasis on academics in preschool, and that social skills and awareness are primary goals of preschool. However, there may be a discrepancy between what parents in the United States say and what they do. The ideas expressed by the American children suggest that American parents value education more than their answers reflected. Parents' may subtly and unintentionally be giving their children the message that academics are important (e.g. educational games may often be used at home). Correlations suggest that the more important one considers academic achievement, the less accepting one is of children with disabilities. Correlations also suggest that the more emphasis one places on social awareness and fun, the more likely one is to accept children with disabilities. Finally, as indicated by children's answers, competition seems to decrease children's acceptance of peers with disabilities.

These findings are worrisome because the emphasis on academic achievement and competition appear to negatively impact populations who cannot compete at the level of their peers. Thus, policies which focus on making sure children reach a particular academic "standard" and rely on testing and other measures of achievement to measure academic success may create unsupportive environments for children with special needs, and may cause their peers to be less accepting of them. In contrast, environments where social interactions, fun, and learning are valued seem to create spaces where children with disabilities can be accepted.

In summation, the results of this study were quite heartening as most children in both countries who were interviewed showed relatively high levels of acceptance of peers with disabilities. However, one limitation of the study, as in any study that deals with subjects of a sensitive nature, is the uncertainty of whether both parents and children were giving “socially acceptable” answers or if they were actually being completely honest. Thus, future studies in this area that are conducted with children may want to explore interviews that do not ask a child outright whether or not they would interact with a peer.

For instance, it would be interesting to study how children play with toys that depict people with disabilities. This task was included as part of the current study, because during the pilot study I had observed that extremely rich data emerged when children were able to play with dolls with disabilities during free play. During the pilot study I had left toy people with disabilities made by Lakeshore toys, similar to the ones I used in the study, in the block area. As I was working in the classroom at the time, I could observe children how children played with these toys for a relatively long time during free play. The blocks, houses, and other toys available in the block area also served to enhance children’s play. They used the blocks as ramps, found “helpers” for people who were blind and scripted games that seemed to depict their understanding of the limitations of disabilities. Children were more engaged and vocal in the presence of, or with the help of peers. However, during the study itself, the children were not in the classroom and thus they were not interacting with peers, nor did they have access to other toys. Thus play was not as rich as it had been in the

classroom. Also, the interviews had to be limited to a short period of time. Thus, due to constraints of time and resources during the current study, the use of figures did not result in meaningful data. Finally, the use of this method would make it harder to examine children's attitudes toward peers with cognitive and emotional disabilities using the method mentioned above.

Another limitation of the study was the sample itself. The Indian sample, while matched to the Gorse sample for relative socioeconomic status, may not be representative of Indian children simply because of the relatively high socioeconomic status of their families. Moreover, because of the difficulty with getting access to research sites in India, the institutions that I had access to were schools that I or someone in my family had attended. Thus, the sample was necessarily drawn from two single sex institutions, and one institution that is co-educational only until third grade.

The low percentage of Indian parents who gave me permission to interview their children may have skewed the results. It is possible that those parents who were willing to answer a questionnaire regarding their knowledge and attitudes toward inclusive education, and give permission for a researcher to discuss disabilities with their child had more positive attitudes regarding people with disabilities than the general population. One of the reasons for the low rate of positive responses from the Indian parents could have been because the concept of interviewing a child for research purposes is unfamiliar in India. The novelty of the situation may have made parents apprehensive about allowing a researcher to speak to their children. Another reason could have been apprehension about the

subject matter itself, especially because in India, people seem prefer to ignore the fact that disabilities exist rather than verbally acknowledge that they do. In contrast, because Gorse is a research school, I had no trouble getting permission to conduct my study, and was able to interview almost every child who attended the school.

While the cross-cultural analysis was revealing, more inferences could have been made had the parent surveys and child questionnaires been more comparable. Because discussing disabilities is such a culturally sensitive issue, I refrained from asking the parents any direct questions about their attitudes towards disabilities. Also, since I met many of the parents at all the research sites while I was conducting interviews with their children, I wanted to ensure that the parent surveys were as anonymous and unintrusive as possible. Thus, I did not ask for any identifying information or information regarding history of experience with people with disabilities in the questionnaires. On the one hand, given the already low response rate at the Indian sites, this probably was a wise decision. On the other hand, valuable information regarding parent backgrounds was lost in the process. In future studies researchers may want to explore ways of getting this background without discouraging parents from participating in the study.

Despite all the limitations of the study, it does give us some valuable insights. First, even though all children appear to prefer to choose typically abled peers as playmates rather than peers with disabilities, they also accept children with disabilities as playmates. Second, planning inclusive curriculum and interventions to help typically-abled children accept peers with disabilities in the

classroom is no substitute for a social environment that stresses the importance of community, social concern, helpfulness and inclusiveness. Third, focus on competition may undermine efforts to teach children to be inclusive of people who are differently abled. Finally, it appears that the academic and social benefits of inclusive education for both children with disabilities and typically abled children that are apparent in the American model, would also be as, if not more, apparent in inclusive preschool classrooms in India.

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Appendix A  
Parent Permission Letter

Dear Parents,

I am a student at Mount Holyoke College currently working on an Honors Thesis. As you know, learning about diversity is one of the goals of the Gorse program. I am interested in children's perceptions of differently-abled children and how their perceptions and attitudes may be related to cultural frameworks. I will be interviewing children about fictional playmate preferences and asking parents to complete questionnaires that explore ideas of inclusive/integrated education. During the summer I completed half the study in Bangalore, India. I hope to complete the study in the United States this fall. This project is being conducted under the supervision of Professor Patricia Ramsey.

This semester I am hoping to complete my study at Gorse. I will be conducting short interviews with the children in the hallway near the classrooms at Gorse. The interview will involve the child listening to five fictional short stories (4-5 lines) about children with specific developmental differences and answering 7 questions related to the story. I will use pictures of children's faces to illustrate the stories. All interviews will be no longer than 15 minutes and will be tape recorded. To protect confidentiality, children's names will not be used in any of the data, reports or analyses. Participation is voluntary and your child may withdraw at any time.

I am also hoping that you will fill out the parent questionnaire. These are short, anonymous paper and pencil surveys that would be filled out by parents whose children are participating in the study. If you agree to allow your child to participate in this study, please have one parent complete the attached parent questionnaire.

If you have any questions, please feel free to contact me. I would be happy to speak with you about any aspect of the project and share the interview materials with you. I can be reached at 493-5330 or [arandhaw@mtholyoke.edu](mailto:arandhaw@mtholyoke.edu). Patricia Ramsey would also be available to speak with you about any other concerns or questions you may have. She can be reached at 538-2052 or [pramsey@mtholyoke.edu](mailto:pramsey@mtholyoke.edu).

I look forward to working with your child. I would like to extend my appreciation to you in advance for signing and returning the enclosed permission slip by October 5, 2007. Thank you for your time and support.

Sincerely,  
Amrita Randhawa

Parent Questionnaire

**Please circle the option that best expresses your opinion. Please free to add any additional comments.**

1. Have you talked about disabilities (For the purposes of this study, please consider disabilities to encompass cognitive, behavioral, physical and academic abilities that are different from what is considered “typical”) with your child?

**A lot   Some   Not at all**

**Please Comment:**

2. Are you aware of various laws regarding integrated education? (Integrated education seeks to include children with disabilities into regular classrooms, while still providing them with special attention/education as and when it is necessary)

**A lot   Some   Not at all.**

**Please Comment:**

3. Would you make a special effort to enroll your child in a school that practices integrated education over one that does not?

**Yes   Maybe   No**

**Please Comment:**

4. Would you enroll your child in a school that practices integrated education knowing that a lot of the teacher’s attention might be focused on the children with disabilities?

**Yes   Maybe   No**

**Please Comment:**

5. Do you think your child would benefit from integrated education?

**Yes   Maybe   No**

**Please Comment:**

6. Would you be willing for your child to interact with peers who might not have comparable social skills?

**Yes   Maybe   No**

**Please Comment:**

7. Would you be willing for your child to interact at school with peers who might not have comparable academic abilities?

**Yes Maybe No**

**Please Comment:**

8. Would you be willing for your child to interact socially with peers who might not have comparable control over their emotions?

**Yes Maybe No**

**Please Comment:**

9. Would you prefer for your child to go to school with children who have similar/more advanced academic abilities?

**Yes Maybe No**

**Please Comment**

10. Would you encourage your child to befriend peers who are developmentally advanced?

**Yes Maybe No**

**Please Comment:**

11. Please rank the reasons you send your child to this school:

**(1: very important, 2: somewhat important, 3: important, 4: not very important, 5: unimportant)**

i. To develop social skills	1	2	3	4	5
ii. To develop academic skills	1	2	3	4	5
iii. To have a good time	1	2	3	4	5
iv. To learn about other people	1	2	3	4	5
v. To develop motor skills	1	2	3	4	5



to play lots of games and likes to play them. He usually likes to play with his classmates. He acts like most kids her age.

**a. Would you ask him/her to play with you?**

1-----2-----3

Yes

Maybe

No

**b. If he/she invited you to his/her house for a play-date, would you go?**

1-----2-----3

Yes

Maybe

No

**c. Would you invite him/her to your birthday party?**

1-----2-----3

Yes

Maybe

No

**d. If he/she asked you to play tag, would you?**

1-----2-----3

Yes

Maybe

No

**e. Would you work with him/her to make a birthday card for another classmate?**

1-----2-----3

Yes

Maybe

No

**f. Do you think he/she could be good at school?**

1-----2-----3

Yes

Maybe

No

**2. Child with an Orthopedic handicap**

Female: This is Terry/Arun. She cannot walk. Her legs cannot hold her up. She can talk like other kids. She can build with blocks and legos. She can sing. She cannot dance. She knows how to play lots of games. She usually likes to play with her classmates. She acts like most kids her age. She cannot run on the playground.



likes to play with her classmates. Most of the time she acts like a younger kid.

Male: This is Tony/Preetham. He can walk. He cannot talk like other kids. He can build with blocks and legos. He does not pay attention at circle and often talks out of turn. He cannot sing all the songs that are sung at circle. He can dance. He knows how to play a few games. He usually likes to play with his classmates. Most of the time he acts like a younger kid.

**a. Would you ask him/her to play with you?**

1-----2-----3

Yes

Maybe

No

**b. If he/she invited you to his/her house for a play-date, would you go?**

1-----2-----3

Yes

Maybe

No

**c. Would you invite him/her to your birthday party?**

1-----2-----3

Yes

Maybe

No

**d. If he/she asked you to play tag, would you?**

1-----2-----3

Yes

Maybe

No

**e. Would you work with him/her to make a birthday card for another classmate?**

1-----2-----3

Yes

Maybe

No

**f. Do you think he/she could be good at school?**

1-----2-----3

Yes

Maybe

No

**g. Why do you think he/she does not act like other kids?**





**Playmate Preferences:**

- a. Point to one child you would like to play with.
- b. Point to one child you would like to invite to a play-date.
- c. Point to one child you would like to invite to your birthday party.
- d. Point to one child with whom you would like to play tag.
- e. Point to one child you would like to sit with at snack time.
- f. Point to one child with whom you would like to make a birthday card for another classmate.