

Sociological Aspects of Cleft Palate Adults:

IV Social Integration

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Introduction

The ability of the cleft adult to function in society is the major goal of the habilitative process. This paper seeks to measure the degree of limitation which the cleft adult may experience in his integration with social groups. The areas of investigation include family interdependence, geographic mobility, friendship patterns, and participation in secondary social groups.

A self-administered questionnaire was used in data collection.¹ The social functioning of 195 cleft subjects, 190 of their siblings and 209 nationally drawn random control subjects, between the ages of 24 and 54,² was compared to determine patterns of social integration.

The literature on the social integration of the cleft palate adult is severely limited in empirically based conclusions. Van Demark and Van Demark (14), in their study of speech and sociovocational aspects, interviewed thirty-nine subjects with cleft of the lip and/or palate, ages 18 and 19, using questions devised to provide comprehensive case histories. Results indicated that the cleft group did not appear to be grossly different from normals in family relationships; however, there was less teasing than might be expected in other families, closely paralleling the findings of Spriestersbach and Powers (12). Subjects tended to be observers rather than participants in social activities; where participation was required, they were less certain of their abilities to function in social situations. They tended not to belong to social organizations preferring individual rather than group associations.

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¹ The authors would be pleased to supply a copy of the survey questionnaire upon request.

² For a detailed description of research population, sample selection, controls, and methodology refer to Sociological Aspects of Cleft Palate Adults: I Marriage. John P. Peter & Rosalie R. Chinsky, *Cleft Palate Journal*, 11: 295-309, July, 1974.

Findings by Van Demark and Van Demark regarding the social adequacy of young adult cleft subjects are compatible with those reported in this paper where they share common areas of investigation.

Results

FAMILY INTERDEPENDENCE. Subjects were compared to determine the degree of interdependence with the extended family. This was done, in part, to assess the strength of the family kin network in each group. One factor in determining interdependence was subject's residence with relatives. Cleft subjects, regardless of marital status, more frequently than siblings or random controls were living with relatives. In the comparisons of cleft palate only (CPO) males with random control males and cleft lip and palate (CLP) males with random control males and cleft lip and palate (CLP) females with random control females chi square was significant at greater than the .05 level. In addition, a moderate positive association was found between having a cleft and living at home in the single, over thirty, cleft group.

Cleft subjects, who were not living with relatives, reported the frequency of their visits with members of the extended family. They visited relatives significantly more frequently than did siblings or random controls. The highest level of significance was achieved in the comparison of CPO males with sibling and random control males ($X^2 = >.02$). Of the cleft subgroups, CPO females were most like control females with regard to frequency of visits.

GEOGRAPHIC MOBILITY. The distance from the location at which subjects completed the last grade of primary or secondary school to their present address was calculated in miles to measure the factor of geographic mobility.³ Cleft subjects were the least mobile of the groups with the highest proportion falling in category one, 0-24 miles (see Figure 1). While more siblings fell in the higher categories of the scale, differences between the two groups failed to meet tests of significance. Random control subjects were significantly more mobile than cleft subjects ($D = .3159$, $X^2 = 33.77$, $>.001$). Comparisons by cleft type and sex with random control subjects were significant for all subgroups (see Table 1). Cleft subjects were in the closest geographical proximity to the location where parents and other extended family members had resided during the subject's school years. Sociological literature (13, 1) on the family reports an association of extended family kin networks both with rural residence and with the urban isolation of the nuclear family. We found no differences in urban-rural characteristics among any of the three subject groups.

HOME ACTIVITIES. Subjects reported the kinds of activities which were characteristic of their home life. These activities were classified by type—active (hobbies, reading, playing an instrument, etc.) or passive (watching television, listening to the radio or records, etc.). Cleft subjects more fre-

³ Unequal *N*'s occurred in the assessment of geographic mobility due to lack of specificity as to the location of the schools subjects attended.

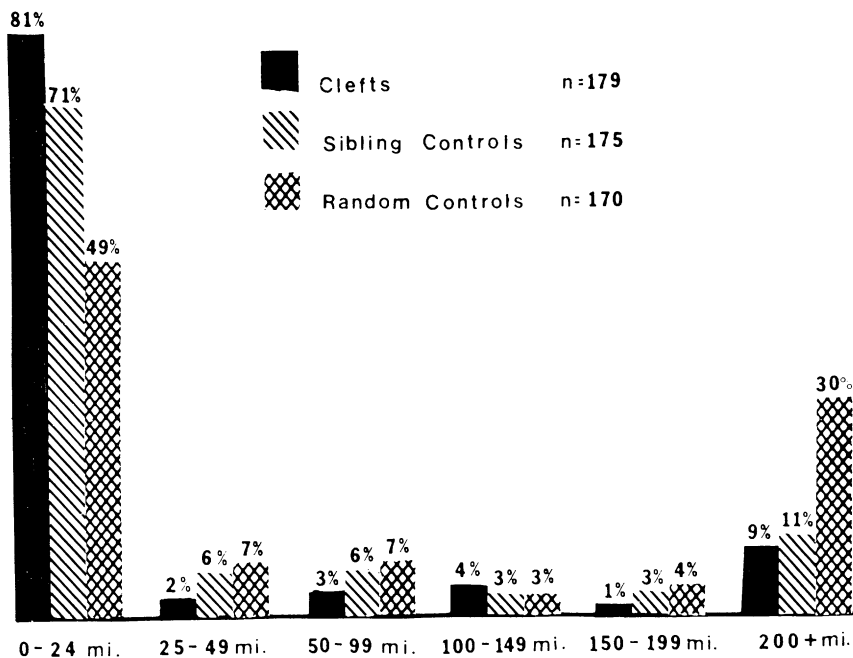


FIGURE 1. Geographic Mobility: Distance in miles from location of last primary or secondary school attended to present address.

quently than random controls were characterized by passive activities ($X^2 = 8.06, >.01$). High levels of passivity characterized all of the cleft subgroups with the exception of CPO males.

INITIAL SOCIAL CONTACTS. Feelings of ease or difficulty in meeting new people are one indication of subjects openness to personal association. Cleft subjects more frequently than siblings or random controls reported difficulty in meeting new people. The highest level of significance was found in the comparison of CLP females both with sibling and random control females ($X^2 = >.05$).

FRIENDSHIP PATTERNS. Subjects were compared to determine the nature of friendship patterns. Cleft subjects reported fewer close friendships than did siblings or random controls, however, differences did not reach levels of significance. In assessing the frequency of getting together with friends or visiting in each others homes, cleft subjects engaged in these activities significantly more frequently than did siblings ($X^2 = 4.04, >.05$). However, comparison of cleft subjects with random controls yielded significance only in the CLP male subgroup. This group visited friends significantly more frequently than did random control males ($X^2 = 5.54, >.02$). Subject groups did not significantly vary from one another with regard to the frequency of telephone conversations with friends. The only exception occurred in the comparison of CPO females with sibling females where the

TABLE 1. Geographic Mobility. Comparison of subject groups' geographic mobility using the Kolmogorov-Smirnov Test

	<i>no. of subj.</i>	<i>D-value</i>	X^2
1. Clefts to Controls			
Clefts.....	179		
Sibling controls.....	175	0.1015	3.64
Random controls.....	170	0.3159	34.77**
2. Clefts to controls by sex			
a. Cleft males.....	96		
Sibling control males.....	69	0.1440	3.32
Random control males.....	69	0.3533	20.04**
b. Cleft females.....	83		
Sibling control females.....	106	0.0515	0.48
Random control females.....	101	0.2739	13.67**
3. Clefts to controls by sex and type			
a. CLP.....	119		
CPO.....	60	0.0658	0.69
b. CLP males.....	74		
Sibling control males.....	69	0.1277	2.33
Random control males.....	69	0.3432	16.81**
c. CPO males.....	22		
Sibling control males.....	69	0.1989	2.63
Random control males.....	69	0.4018	10.77*
d. CLP females.....	45		
Sibling control females.....	106	0.0925	1.07
Random control females.....	101	0.3149	12.34**
e. CPO females.....	38		
Sibling control females.....	106	0.0764	0.65
Random control females.....	101	0.2254	5.61*

* significant at the .02 level

** significant at the .001 level

former talked with friends on the telephone significantly more frequently ($X^2 = 6.28, >.02$).

Friendship groups were substantially more cohesive among random controls. These subjects reported that most of their friends knew each other, whereas, friends of cleft subjects did not ($X^2 = 15.34, >.001$). This finding holds for all cleft subgroups with high levels of significance in the comparison of female subjects with random controls.

NEIGHBOR INTEGRATION. Subjects' interaction with close neighbors was evaluated to determine degrees of neighborhood integration. Cleft subjects reported knowing their neighbors only slightly less frequently than did sibling and random control groups. Of the cleft subgroups, CPO females were least acquainted with their neighbors. Cleft subjects also visited neighbors less frequently than did siblings or random controls. CPO males visited neighbors significantly less frequently than did sibling males ($X^2 = 4.69, >.05$).

VOLUNTARY ASSOCIATIONS. Membership in voluntary associations is one

indication of community status, social integration and relative social acceptability. Subjects reported the organizations in which they participated. Cleft subjects, more frequently than control subjects did not participate in social clubs, fraternal orders, service clubs, etc. Cleft females were most frequently not members of such groups. Of the subjects who were members, the cleft group participated in the fewest number, however, significance at the .05 level was achieved only in the comparison of CLP females with random control females.

Voluntary associations were classified by level of participation required for membership. Cleft subjects, on the whole, were more frequently members of groups and organizations which required medium or low participation. An exception to this finding occurred in the CLP male group when compared with random control males. CLP males belonged to high participation organizations significantly more frequently ($X^2 = 4.35, > .05$). Cleft subjects, who were members of voluntary associations, tended to hold office less frequently than did members of the control groups reaching the .05 level of significance in the comparison of CPO females with random control females. Within the cleft group, CLP subjects held office significantly more often than did CPO subjects ($X^2 = 4.18, > .05$).

Discussion

Investigators must approach the subject areas encompassed in this report with caution since it is difficult to assess the validity of responses in these somewhat self-revealing subject areas through the use of a self-administered questionnaire. In addition, there are methodological limitations which are inherent in the use of Likert type scales where one's perception of his behavior may not correspond to the behavior itself. The authors are of the opinion that improved techniques in measurement would tend to heighten the differences in patterns of primary and secondary group relationships we have investigated. In a related matter, it would seem that the sibling group is not a suitable control since they operate as part of the extended family network and thus freedom from influence can not be assumed. In general, however, their responses tended to be closer to those of the random control group than to the cleft group.

Extended family relationships may be characterized as systems of social activity and mutual aid often resulting in the providing of goods, money, services, etc. This system of extended family networks provides the cleft adult with greater social and economic security. It is apparent that the control group tends, on the whole, to conform more closely with the American nuclear family style than with the extended family style. It should also be remembered that the norm for American families is one of independence. We can say further, however, that mutual aid occurs at all social class levels with most assistance being given in the upper social classes (13). The interdependence of cleft subjects with the extended family borders on dependence when we note the frequency with which they live with relatives in both the single and the married groups. As we previously reported, the

lower income of the cleft adult may also lead to greater interdependence on relatives (9).

When cleft subjects were compared to determine the strength of the kin family network, we reported significantly more frequent visits with the extended family along with low geographic mobility from childhood residence.

We found that cleft subjects tended to have fewer friends but visited them more often, their friendships were less cohesive, and they participated in fewer voluntary associations. These findings are not incompatible with prevailing sociological theory. Where a group participates less in voluntary organizations and other secondary social groups, theory suggests that social activities will rely on informal visiting patterns with relatives and friends. Cleft subjects rely heavily on informal visiting patterns for their social activities.

This discussion of social relationships should not be read in isolation from the results of the study on marriage (7) which indicated difficulty in the mate selection process pointing to possible problems in relating to peers.

While all cleft subjects evidenced lower levels of social integration, the CPO male group tends to be the least socially integrated of the cleft subgroups. In our previous reports (8, 9) we also noted lower economic levels and fewer college graduations in this subgroup.

The researchers could not attribute these findings to aspects of physical condition or degree of physical restoration. In a supplemental questionnaire, fewer than 5% of the CPO group reported associated anomalies. This rate was only fractionally higher than for the CLP group. While recognizing the inadequacy of self reporting in this area, it would be more precarious to attribute differences to the presence of associated anomalies for which there was low awareness. In addition, the literature does not seem to support the view that CPO males, on the whole, achieve poorer speech results (5).

Researchers might arrive at a basis for determining causation by testing the following hypotheses:

- (a) that society is more supportive of persons whose physical problems are visible in that social norms require differential behavior toward this group. It might be true that the CPO group, due to the non-visible nature of their problem, are not extended this positive support.
- (b) on the other hand, researchers might find that CLP subjects encounter greater rejection from society and adopt more aggressive behavior to compensate for these threats of rejection; whereas, the CPO group experience less rejection but, conversely, are less able to cope with it when it occurs or they simply reflect societal indifferences.

The findings presented here have implications for the study of the cleft patient and his family during childhood and adolescence. We have noted the high interdependence of the extended family, the restricted nature of friendship patterns, and a lower level of group participation along with some neighborhood isolation. It would be hazardous to assume that these patterns of low social integration developed at adulthood. What is more likely is that these characteristics are even stronger in childhood and adolescence.

Summary

The patterns of social integration of adults with primary and secondary groups were evaluated for 196 adult cleft subjects, their 190 siblings and 209 random controls. Results indicated that cleft adults tended to rely on the extended family for mutual aid and social activities. They also participated less frequently in voluntary associations and relied on a few one-to-one friendships. Social activities tended to be that of informal visiting patterns. While it would be inaccurate to characterize the cleft adult family as grossly different from other American families, they are a definable population experiencing some degree of limitation associated with having a cleft.

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