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**THE SOCIAL SIGNIFICANCE OF SHORT STATURE: A STUDY OF THE  
PROBLEMS OF DWARFS AND MIDGETS**

*City University of New York*

**Ph.D. 1982**

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THE SOCIAL SIGNIFICANCE OF SHORT STATURE:  
A STUDY OF THE PROBLEMS OF DWARFS AND MIDGETS

by

JAMES MATHEW MONEYSMAKER

A dissertation submitted to the Graduate Faculty  
in Sociology in partial fulfillment of the require-  
ments for the degree of Doctor of Philosophy, The  
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1982

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1982

This manuscript has been read and accepted for the Graduate Faculty in Sociology in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy.

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Abstract

THE SOCIAL SIGNIFICANCE OF SHORT STATURE:  
A STUDY OF THE PROBLEMS OF DWARFS AND MIDGETS

by

James Mathew Moneymaker

Adviser: Professor Edward Sagarin

This study is an examination of the physical, social, and psychological problems of a highly stigmatized group, namely dwarfs and midgets. Emphasis was placed on the social-psychological problems that little people face in day-to-day social interaction concerning their identity, self-perception, and social adjustment. The investigation also examines the function and structure of an organization, Little People of America.

The research entailed a study of 67 short statured people, including members and non-members of LPA, some of whom were interviewed while others responded by answering a questionnaire. Interviews were conducted with normalized family members and professionals working in the field. An analysis of the sociological, psychological, and medical literature was made.

The findings of this study reveal patterns of difficulties and adjustments. Discrimination in employment

opportunities had been experienced by all respondents. Managing home chores and responsibilities was not a major strain. Personal appearance and hygiene were concerns of young adult females. Stigma is a source of constant anxiety, particularly because many average-sized persons equate age with size. Finding a date or a mate was difficult, with LPA serving as a reservoir of eligible marital partners. There were mixed feelings about short statured people and average-sized persons dating one another; however, females felt less threatened and more able to date either short statured or average-sized men. Parent-child relations centered about many short statured couples declining the risk of having a short statured child. Overprotectiveness was found to stifle and infantilize the child's own sense of self-worth. There continues to be a state of confusion and uncertainty over how to conduct an open and honest communication between short statured and average-sized persons.

Apart from the function of LPA as a focal point for courtship, membership was more a matter of personal interest or choice rather than an expectation. The organization provided support for many, but it was not a true self-help organization, because it did little to relieve the stigma or solve the problems of dwarfism. For some members,

the organization served as an umbrella of security against the onslaughts of society. For other persons, particularly non-members of LPA, the organization was seen as a crutch. Once the individual has achieved self-acceptance, independence, and self-assurance, he can proceed with the difficult task of living, having come to terms with the problem of physical differentness. Unlike many other disabilities, dwarfism is a handicap solely because of the social stigma.

## ACINCOLEBOLINIS

This work rests largely on the personal experiences and feelings that were provided me by many short statured persons whom I systematically interviewed, some in-depth while others more informally. The experiences and insights drawn from these short statured persons' life careers should not be understood as encompassing their lives exclusively nor should it be seen as encompassing a very small proportion of short statured people's feelings, emotions, opinions, and needs, but should be seen as a significant introspection for average-sized people to better understand and accept others who, at worst, may be significantly diminutive in stature but equally as capable and willing citizens to achieve to the best of their ability if only they be given the chance and not be turned away, chided, and indiscriminately stigmatized simply because of their size.

I would also like to express my thanks to those professionals on the staff of the Moore Clinic of Johns Hopkins Hospital. In addition, this work would never have been completed without the continued support and editing of Professor Edward Sagarin, my mentor, colleague, and dear friend. Lastly, special thanks go to my mother for standing by when I needed help the most. Finally, the work is dedicated to the memory of my father, whose professional advice and love will forever be cherished.

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## CHAPTER I

Nature of Problem: A General Orientation

Today, in our society, we are experiencing accelerative trends in both statural size and biological maturation than did our forefathers at the beginning of this century. According to a report by the Department of Health, Education and Welfare, the average adult male living in the first quarter of this century, was 5'7" tall - a difference of two to three inches shorter than today.<sup>1</sup> Many reasons have been offered to account for this phenomenon, including improved nutrition and diet, the reduction of many previous childhood diseases, and a cross-breeding of persons from many social and cultural backgrounds. In any case, the magnitude of this secular trend of people attaining heights greater than did previous generations, is considerable and tends to overshadow differences between socio-economic classes and between geographical regions. What has partly resulted from this taller trend in mankind, has been a direct adversity by our society toward those individuals who are considered shorter than average. Society has as a result, done itself a disservice by refining and tempering this adversity to short statured people because it has failed to tap a great resource of people who constitute a

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<sup>1</sup>Department of Health, Education and Welfare, Human Growth and Development. Government Printing Office: Washington, D.C., 1973, p. 21.

vast reservoir of skills, talents, and energies.

In brief, in modern and specifically Western society, height is an extremely vital ingredient to a concept of self and a vision of the world in which we live. One author writes, "Because your body is psychologically closer to you (being indistinguishable from your identity or existence) than any other object, it serves as a unique screen upon which you project your concerns and wishes."<sup>2</sup> Thus, one's physical stature or height seems to be acutely significant to the reactions one has to other people, and vice versa. More important, the way people react to a person's height will ultimately affect the sense of identity and feeling of self of the object of that reaction. For those persons in our society, whose height is considered approximately average - the male being 5'9", the female 5'3.6"<sup>3</sup> - their niche in their respective social repertoires of life are sufficiently acceptable, at least in terms of their stature. But individuals who are far smaller than average have always held a less than agreeable niche socially vis-a-vis persons of more normal dimensions. The moral of this dilemma has been eloquently

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<sup>2</sup>Seymour Fisher, Body Consciousness: You Are What You Feel. Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1973, p. 114.

<sup>3</sup>National Center for Health Statistics, Height and Weight of Adults 18-74 Years of Age in the United States. Government Printing Office: Washington, D.C., 1976, p. 2.

expressed by Saul Feldman who writes;

The rhetoric of the joys of being tall and the evils of being short are well demonstrated in our daily language. The ideal man is viewed as tall, dark and handsome. Impractical people are "shortsighted," dishonest cashiers "short-change" customers, losers get the "short end of the stick," electrical failures are known as "short circuits," and individuals with little money, no matter their height will state of their impecuniousness, "I'm short."<sup>4</sup>

Indeed, as when we wish to degrade people, we speak of "putting them down," "belittling" them, or "looking down" on them. Consequently, it is this social hostility the dwarf must face because of his diminutive stature that is the emphasis of this study. That dwarfs and midgets are not alone in their master status, the physically handicapped, the disabled, ill, different, all are and have been stigmatized, avoided, looked upon with disfavor although sometimes with pity, denied opportunities which they are quite capable of fulfilling, etc. etc.. This social disparity has attracted the attention of physicians and biologists, government agencies and public policy makers, psychologists, sociologists, and of course the victims of the stigmatization and discrimination themselves.

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<sup>4</sup>Saul D. Feldman, "The Presentation of Shortness in Everyday Life - Height and Heightism in American Society: Toward a Sociology of Stature," in Saul D. Feldman and Gerald Thielbar (eds.), Life Styles: Diversity in American Society. Boston: Little, Brown & Company, 1975, pp. 437-38.

The purpose of this investigation then is to study the process of stigmatization and of the management of stigma in the daily lives of a highly visible handicapped population, namely, persons of profoundly abnormal short stature, otherwise known as dwarfs or midgets.

For purposes of clarification, I should like to distinguish between dwarf and midget as the two terms are applied in the medical literature, in everyday parlance and in the body of this research. Medically speaking, the term dwarfism is used to refer to persons whose adult height is approximately 4' 10" and under, and to children who are showing signs that they will not attain higher heights than 4' 10" when they have matured. There are over 100 different types of dwarfism, each with varying degrees of physical characteristics, and in total the approximate number of dwarfs in the United States today is somewhere between 20,000 to 100,000.<sup>5</sup> Perhaps the most common form of dwarfism, and by far the most prevalent among members of Little People of America who largely made up the bulk of the sample of this research, is the achondroplastic.

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<sup>5</sup>Joan Weiss, "Social development of dwarfs," in W. T. Hall and C. L. Young (eds.), Proceedings of a Conference on Genetic Disorders: Social Service Interventions. Pittsburgh, PA.: University of Pittsburgh, Graduate School of Public Health, 1977, p. 56.

Those having this condition are visibly distinguished by unusually short arms and legs on an otherwise normally sized torso. The achondroplastic dwarf may also typically have a large head with short stubby fingers, and these physically anomalous characteristics make his disproportionate stature most visibly distinctive.

The term midget is commonly used to refer to hypopituitary dwarfs, namely those individuals who, as a result of a deficiency in human growth hormone secretion, show a marked decrease in growth at an early age. However, today research has been able to reproduce synthetically the hormone so that many hypopituitary children can be able to reach normal and/or near normal height if treated early enough. The hypopituitary dwarfs, along with other individuals whose growth is retarded because of delayed puberty or hormonal imbalance, are of proportionate body build. Although they may at first sight appear younger than their actual age, they do not differ greatly in appearance from normal-sized persons. In contrast, achondroplastic dwarfs, their condition being the result of a congenital bone disorder and at this point in the history of science, neither changeable nor reversible, produce an unusually dramatic and negative reaction to

their presence from normal-sized persons.

There are fewer midgets than dwarfs. Hence, in terms of popular usage, persons of unusually short stature are often referred to simply as dwarfs, regardless of the distinction. In terms of social interaction with normal-sized persons, it seems to matter less with either the normals or the dwarfs as to whether a condition is a result of bone dysplasia or a deficiency in human growth hormone.

I originally chose to use the term dwarf in my research to refer to all undersized people. However, as I began to read the literature, particularly pamphlets, books, and articles provided me by Little People of America and several of its members, I learned that undersized people do not react favorably to the use of either dwarf or midget when referring to themselves. Because the term dwarf conjures demonic or abhorrent ideas associated with victims of medical scrutiny, and midget relates to the stereotype of performers in the circus or side show, it has been felt that these two terms are derogatory and that they inaccurately label all undersized people into one of these categories. As a result, the terms little people (or persons) or short statured people

(persons) was suggested to me by the undersized men and women during the early part of my research, because they felt these terms helped to relieve the stigma so long associated with the terms dwarf and midget. Now it is true that, in social science as in all other science, terminology should be used for its accuracy. I believe that a highly stigmatized group can make known its sensitivity, and that the researcher should find ways of being accurate without being insensitive. Hence, for purposes of this research, the terms dwarf and midget will only be used in order to emphasize a special point or to make a distinction in the text of the work; otherwise, little person or short statured person will be used, interchangeably and synonymously, to cover all types of dwarfism.\*

Finally, the term average or average-size is used to refer to normals or to normal-sized persons when comparing them to short statured people. This is done solely on the basis of eliminating any further psychological or value-judgemental implications beyond their physical condition. I am not denying the abnormal and anomalous character of dwarfism, but the term normal and the concept conjure up

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\*It is also of interest to note that in Great Britain, the terms dwarf and midget have also been eliminated and in their place "restricted growth" was chosen in order to encompass the many different varieties and general appearances of short stature.

visions that are best avoided, and another terminology is suggested.

## CHAPTER II

Background of the Problem

Short stature has long been of medical as well as social and psychological interest. Cultural and social attitudes of societies toward people of short stature are recorded in ancient records and art forms around the world. Portraits of dwarfs can be found in early Egyptian, Greek, Roman, Mayan, and pre-Columbian cultures. Folklore has coined them with such names as "elves," "gnomes," "trolls," and "Kobolds," and alternately viewed them as capricious, friendly, or spiteful. But it is history that has well documented their plight. From the time of ancient Egypt through the late Middle Ages and far into the Renaissance of Europe, dwarfs and midgets were especially prized for what was felt they possessed, namely, an aura of magic and supernatural powers. Thus, some of the more renowned and respected (perhaps a more appropriate word might be "clever") dwarfs and midgets had themselves relegated to special roles as deities, while others were sought after by royalty for "pets," court jesters, acrobats, keepers of jewels or precious objects, or as companions for their children. Still others with various deformities and mental aberrations were discriminated against as being ill-omens or abominations. Finally, it was during the Victorian era that their status changed from symbolic,

demonic and angelic figures, to those of patients, subjects of medical study, and occasions for pity.<sup>1</sup>

Today, the problems faced by dwarfs and midgets are not altogether unlike some of those faced by many other groups in society that are visibly handicapped in a severe manner. What unites these groups under a single heading is not so much their handicap but that they share in common a master status that is stigmatized. As recipients of social hostility, they must find ways of coping with that hostility and surviving in a hostile world.

Perhaps the most unpropitious assumption in our society toward short stature is that we equate growing with maturity, both physically and mentally. John Money has attributed this phenomenon to our "tyranny of the eyes,"

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<sup>1</sup>See, for example, F. E. Johnston, "Some observations on the roles of achondroplastic dwarfs through history." Clinical Pediatrics, 2 (1963), 703; Gerald P. Hodge, "Perkeo, the Dwarf Jester of Heidelberg." Journal of the American Medical Association, 209 (1969), 403-4; Frederick Drimmer, Very Special People: The Struggles, Loves, and Triumphs of Human Oddities. New York: Amjon Publishers, 1973, pp. 205-64; Leslie A. Fiedler, Freaks: Myths and Images of the Secret Self. New York: Simon & Schuster, 1978, pp. 39-90; also, see Paul Horstmann, "Dwarfism: A clinical investigation." Acta Endocrinologica, Supplement 5, Copenhagen: Munksgaard, 1949; H. P. G. Seckel, Bird-Headed Dwarfs. Springfield, Illinois: C. C. Thomas, Publishers, 1960.

explaining, "All human beings have an automatic, unthinking capacity to orient themselves toward other people on the basis of stature and physique as indexes of age and mental maturity."<sup>2</sup> Consequently, the impact this has on a short statured child may largely determine how he or she will later respond to others. Its intrinsic meaning, however, is even more profound for the short statured adult. As Sagarin points out;

People are often evaluated according to their apparent age, and size is one criterion of that evaluation. Thus, one behaves toward a person as though he were of the age that his stature suggests; one also expects mental responses commensurate with that incorrectly estimated age level. This process results in a babying of the dwarf.<sup>3</sup>

Hence, although a short statured person may be able to accept his self, others continue to categorize him by his size rather than viewing and respecting a little person for his own merits earned.

In a society that tends to emphasize "bigger and better," shortness to many suggests deficiency. Whenever we inquire about an individual's stature, we would not ask how short he is, but how tall. When we "look up" to someone, it is an expression of automatic respect. Of course, there is always the very real possibility

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<sup>2</sup>John Money, "Dwarfism: Questions and Answers in Counseling." Rehabilitation Literature, 28 (1967), 137.

<sup>3</sup>Edward Sagarin, Odd Man In: Societies of Deviants in America. Chicago: Quadrangle Books, 1969, p. 199.

that the same person may later prove unworthy of respect, but until then just the physical act of looking up to someone's face produces a feeling of awe and esteem. Conversely, one has to prove himself if others look down on him, because to look down on someone makes us question that person's ability both mentally and physically.

Throughout childhood one is continually reminded that authority comes from people who are taller than we are. As full body stature is reached, the teenager increasingly demands consideration as an adult. Clearly then, height gives us varying points of view and altered perspectives in our relationship with space and time, and more importantly, with other people. Erik Erikson has perhaps expressed this relationship best by emphasizing:

Every adult, was once a child. He was once small. A sense of smallness forms a substratum in his mind, ineradicably. His triumphs will be measured against this smallness, his defeats will substantiate it. The questions as to who is bigger and who can do or not do this or that, and to whom - these questions fill the adult's inner life far beyond the necessities.<sup>4</sup>

Thus, the way a person feels about his height can affect the way he feels about himself as well as the responses he receives from others as he progresses through life.

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<sup>4</sup>Erik Erikson, Childhood and Society. New York: W. W. Norton, 1963, p. 404.

### Dwarfism As a Stigmatized Condition

Martin Weinberg has shown that the social problems for little people stem primarily from the erroneous interpretations made by persons of average size to the social stigma attributed to short statured persons' size. For the short statured person in our society, his reactions to the largely negative societal reaction to his presence, such as curiosity, aversion or surprise, may take the form of withdrawal or isolation - becoming wary of others; to deny that differences do exist; or perhaps to capitalize their physical uniqueness as assets rather than as liabilities. Although there are many practical problems little people must face daily - e.g., finding clothes that fit properly, climbing stairs, and getting on and off public conveyances, there are two other major problems little people face that are more socially based, namely employment and heterosexual relationships.<sup>5</sup>

### Employment

The barriers to normative lifestyle expectations in the job market seem to be based largely on attitudes of potential employers who often set the short statured person apart as distinct kinds of functioning persons and create expectations of lower or special levels of per-

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<sup>5</sup>Martin S. Weinberg, "The Problems of Midgets and Dwarfs and Organizational Remedies: A Study of the Little People of America." Journal of Health and Social Behavior, 9 (March, 1968), 65-71.

formance and general ability than are true for other people. In the business world and particularly perhaps, political life, success for the short statured person seems always to be equated with height. That is to say, it is generally assumed and considered admirable for an average size person to exhibit political and economic power when he has been given a raise in both salary and position, in either the business world or politics. But, when an individual of short stature assumes power, first impressions are that it is an anomaly, and second, he is usually seen as having a Napoleonic complex - to wit, Andrew Carnegie, Fiorello H. LaGuardia, Richard Daley, or Abe Beame, to name but just a few.<sup>6</sup>

In terms of the significance of how stature may ultimately affect income, a personnel director at the University of Pittsburgh did a survey of graduates between 1968-1971 in order to compare their heights with their starting salaries.<sup>7</sup> The findings revealed that among ninety-one graduates of one class, there was an average of \$1,000 a year salary penalty for those under six feet. Moreover, those men reaching a height of 6'2" received a starting salary 12.4% higher than graduates of the same school who were under six feet. Interestingly, those individuals whose height rose above the

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<sup>6</sup>Milton R. Konvitz, "Review of Andrew Carnegie by Joseph F. Wall." Saturday Review, (September 21, 1970), p. 34.

<sup>7</sup>Leland Deck, "Short Workers of the World Unite." Psychology Today, 5 (1971), 102.

preferred and best rewarded height of 6'2" had their salaries decreased.

In one further study done by a professor of marketing from Eastern Michigan University, it was found that when 140 sales managers from various corporations were asked to make a hypothetical recruiting choice between two equally qualified candidates - one 6'1" and the other 5'5" - for a sales position, 72% said they would prefer hiring the taller man, 27% expressed no preference, and only 1% chose the shorter of the two candidates.<sup>8</sup>

Perhaps an implication from this bias in hiring persons of tall stature over persons of smaller stature, at least in the business world, might be that tall men may very well obtain their successful positions with an advantage that is, in fact, meaningless. However, for this very reason, so as not to offend tall people or discourage short people, very little research has been done nor is it likely to be allowed, since there is already a vast amount of research on discrimination in hiring against minorities. Thus, discrimination based on height has been relatively untouched primarily because of its "subtleness." As one employment firm executive said of his difficulty in confronting height discrimination by employers, "It's like fighting a ghost."<sup>9</sup>

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<sup>8</sup>The Wall Street Journal (November 25, 1969).

<sup>9</sup>Ralph Hayes, The Height of Your Life. Boston: Little, Brown & Company, 1980, p. 132.

The fact that the short statured man has been discriminated against in the job market seems more than clear, but what about the short statured woman? Typically, she is shorter than the short statured man, thus her problems in finding a job might seem doubly compounded by her size, let alone her sex. As one woman comments, "I do know that a lot of people tend to treat us as if an undersized brain is the inevitable complement of your cute little body."<sup>10</sup> Credibility seems to be the major issue for short statured women in the business world. Even if they become successful at their job, recognition is on a very low keel.

Although a few successful politicians have been relatively short statured - e.g., Fiorella LaGuardia, George Wallace - height is clearly seen as a prominent issue pertaining to hopeful presidential candidates. As one writer suggests, symbolism rides very high in the campaign for the presidency.<sup>11</sup> The role is seen as symbolic of the country's perceptions of what the President is supposed to represent, the "kinglike role of the President," "paternal ones," or "the hope that he'll be a superman embodying everything you want the country to be."

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<sup>10</sup>Keyes, p. 193.

<sup>11</sup>Ibid., p. 225.

In show business, height is seen to be integral to typecasting. In other words, size becomes so symbolic for directors of a given look, that actors may tend to be less concerned with their height than with the "type" implied by their height. Thus, actors and actresses often feel they have been "typed-out" of certain roles by the appearance their height suggests. Dustin Hoffman was felt to be too short to play the shy, young Benjamin in the film The Graduate, but director Mike Nichols cast him nevertheless, and with notable success. Since then, such actors as Al Pacino, Richard Dreyfuss, Joel Grey and others have been specially "typed", but their height is a factor, either an advantage or disadvantage, depending upon the film and the character to be played. For some short male actors, short stature has proven to be advantageous when playing the buffoon (e.g., Mickey Rooney), the arch-villain (e.g., Peter Lorre) or the small tough guy with the big Napoleonic complex (e.g., Edward G. Robinson).<sup>12</sup>

One of the more creditable films of 1980 emphasizes evil's banality and centers on a little (person) drummer boy and his tin drum. Oskar is an evil-eyed three year-old with the ability to shatter glass with his shriek and the inclination to kill off adults who get in his way,

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<sup>12</sup>Keyes, pp. 241-45.

but The Tin Drum should not be mistaken for a Damien III sort of film. It is actually a remarkably respectable adaptation of the well-known German novel by Gunter Grass.

From its obscure beginning among the potato fields on the eastern borders of Germany, the film lets the little boy tell his own story; how only the promise of a tin drum could budge him from the womb and how he purposefully stunts his growth for seventeen years because he doesn't want any part of the ugly, base, and common world of the German lower middle-classes. These are evil years for both Oskar and Germany, 1924-1945, and the movie is as much about the destructive banality of Nazism as it is about the vicious solipsism of a peculiar child. The only brilliant Nazi in The Tin Drum is Bebra, the dwarf actor and magician, and he's in uniform only to protect himself as an artist. Oskar eventually meets and joins up with Bebra's troupe of dwarfs and midgets entertaining the German soldiers at the front (some of the few who ever managed to escape the concentration camps) and travels to Paris in the company of the beguiling midget, Roswitha Raguna, whom he loves. Unfortunately, he's instrumental in her death as he has been before with others, and by the end of the war, Oskar is much more frightening than the Nazis.<sup>13</sup>

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<sup>13</sup>The New Haven Advocate, Volume 5 (August, 1980).

As for groups of little persons being portrayed in films, the most recent attempt by a director to employ a great many short statured people, Under the Rainbow,<sup>14</sup> depicts neither a warm feeling nor a good laugh but instead only perpetuates a myriad of feisty, villainous, and mindless little people. This is a movie that depicts little people as witless and worthless. Indeed, the approximately 150 little people employed for this feature are made the butt of endless "short" jokes. A movie that has as its two running gags the violent deaths of small dogs and Japanese tourists isn't likely to endear itself to anyone. The inspiration for the film is an apocryphal bit of MGM history during the 1938 shooting of The Wizard of Oz. Legend has it that the little actors recruited to play the "Munchkins" turned their living quarters in the Culver Hotel into a bacchanalia.

The film, Under the Rainbow, is enveloped by numerous complications involving a spy caper, a visiting archduke and his would-be assassin, a secret service agent and a talent coordinator for the studio. The producers, thinking the original idea was not enough, added a "normal" (average-size) romantic couple for the public to relate to. Then, they added a comic suspense plot, with Billy Barty as a Nazi agent who's supposed to contact a Japanese spy and

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<sup>14</sup>Life Magazine, (June 1981); The Washington Star, (July 31, 1981).

hand over a map of America's defenses. Their rendezvous, however, is complicated by the arrival of the "Munchkins" and a Japanese tourist group, who are murdered one by one in "comical" fashion, as Barty and the Japanese spy try to get their map and an assassin tries to kill the archduke. The big joke is predicated on the demeaning notion that all the Orientals and the diminutive actors look alike, an odd ploy for comedy whose makers proudly boast the production as a boost for little people. Moreover, the people who made Under the Rainbow seem determined to court one's emotions as well as one's laughter. They not only want you to giggle at their moldy puns and cruel sight gags - a glimpse of nude women in a shower and some lewd comic moments designed to advance the notion that little people have a sex life, too, probably accounts for its PG rating, but there are many objectionably violent bits of slapstick. The producers ultimately want the viewer to come away from this senseless and heartless attempt at entertainment with a nice, warm and compassionate feeling.

Traditionally, Americans and other Westerners have cherished size and strength on the athletic field, in all sports activities from basketball to log splitting. Indeed, it is a self-fulfilling prophecy, if not a tautology, that tall players are better suited to the games than are shorter players because the games themselves are specifically designed for taller persons. This is supported even among women athletes participating in intercollegiate sports where most tend to average nearly 2½ inches above the national average of women (5'3") and approximately one inch taller than college women as a whole.<sup>15</sup> Interestingly enough, however, one of the most cherished sports, basketball, an American invention, was not intended to favor tall players at the outset, but rather by placing the baskets at a height of ten feet off the floor, a player would be rewarded for style, accuracy, and grace over strength to make a ringer. Soccer is considered one of the most size-neutral of sports throughout the world. The game was invented by the English Football Association in 1863 specifically to reward skill over size.<sup>16</sup> This seems to be well documented when one views such champion soccer players as Pele (Brazil) and others who are shorter than the average male, which may give them an advantage over taller players in terms of greater dexterity and speed where strategic footwork can be crucial.

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<sup>15</sup>Keyes, op. cit., p. 253.

<sup>16</sup>Ibid., p. 254.

In sum, how one's body size may affect one's prospects in various types of sports can be correlated in terms of height with demands on performance. Among a variety of physical activities that seem viable and perhaps especially advantageous for persons of short stature, the following is only a partial listing: swimming, diving, gymnastics, horseback riding, long-distance bicycling, long-distance running, skiing, surfing, weight lifting, lightweight boxing and wrestling, soccer, handball, squash, racquetball, and even car racing as evidenced by the internationally acclaimed Grand Prix race car drivers Mario Andretti and Jackie Stewart whose careers lend credence to the virtues of lighter, smaller drivers, who save the designer cockpit space. Consequently, the prospects in sports for people of all sizes and shapes, to enjoy either socially or to envision as a professional, seem to be getting better with more and more realization of just what a person requires in order to compete. However, the irony still persists in our society, and particularly in sports, that we are continually and indelibly ingrained in our early childhood to believe that height produces champions. For short statured people, the implication of this is that they have little chance of ever participating in sports; for short statured teenage boys, this can be a very painful experience of feeling rejected.

Ultimately, because our society seems to expect less capability from a short statured person, a performance that might be considered acceptable for average-sized people is considered extraordinary for a short person to handle. Without height and bulk to impress a client or customer or boss, the short statured person is placed at a disadvantage because he must display an extra amount of hard work, intelligence and personality to balance his (if you will) shortcomings. Hence, the social pressure against short stature seems to lie at the basis of why so many short statured persons are discriminated against in terms of jobs. Although some dwarfs have used their size to an advantage as entertainers, others who are rejected for positions are frequently told that it is their size that would prevent them from doing the job properly. However, for most short statured persons, this is seen as an employer's prejudicial ploy to dissuade them from applying for a job, because in truth the employer and other workers are uncomfortable around them. As a result, there exists a disproportionate share of unemployed or underemployed short statured people because of isolation and prejudice which has denied them an equal opportunity in the job market.

### Male-Female Relationships

As Weinberg has suggested, second only to problems of employment amongst little people, is that of heterosexual relationships.<sup>17</sup> He goes on to explain that the little person's range of eligibility is extremely limited due in part to the fact that where a little person works (his "social space") is not likely to have a great many other little people working there. Consequently, this rather narrows the number of primary relationships that might be potentially available to him (his "sociable space").

One important service the organization of little people (Little People of America, Inc.) offers to dwarfs is the opportunity for making friends, and meeting dates and potential spouses. The chance of meeting others with short stature is not great without such an organization. Just as all people generally seek individuals with similar likes and dislikes, education, religion, etc., so too do little people. Thus, for many adults attending an L.P.A. function, it may well be their first opportunity to date. Hence, quite often some little people will become romantically involved during one annual convention and shortly thereafter announce their marriage plans.

As for little people having relationships with average-sized people, the fact that it is such a highly

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<sup>17</sup>Weinberg, op. cit., p. 66.

visible union, and one that seems so contradictory to the social taboo of dating someone not of similar height, the stigmatization attributed to the couple would probably be more pronounced toward the average-sized person. In actuality, very little has been done in the way of research about how height affects American male-female relationships with perhaps one exception, which although may seem slightly outdated (1954), it in fact reveals conclusions not unlike those we might expect to find today in our society. Basically, the study was socio-psychological in nature, in that, it revealed the ongoing taboo of dating someone shorter than thou, but what was really at issue wasn't size or height so much as the need to dominate, primarily for the man, hence a question of relative power.<sup>18</sup> The study revealed that the more dominating a man wished to be, the more he wished to look down to his female partner. The women in the study wished for a less than average height difference between their mate and themselves. Those women who wished for a more than average height difference between their mate and themselves, also expressed a desire to be submissive. From this study, we can clearly see how many women are still frustrated by their traditional role of playing the submissive

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<sup>18</sup>Hugo Beigel, "Body Height in Mate Selection." Journal of Social Psychology, 39 (1954) 257-68.

partner even when they may be taller than their mate.

In sum, males will often tend to express their dominant role by seeking partners who are shorter than they, usually spurning females of equal height, let alone those taller. Thus, for the short statured male, his range of potential partners is considerably limited. Conversely, the range of potential partners for a tall woman is about equally as limited. Since a man must be taller than she is, any attempt at a relationship with a shorter man is typically met with formidable but informal social sanctioning. Moreover, the short statured female may feel that perhaps short statured males date them only because of their height. Such attitudes toward height may be changing as increasing numbers of men and women are attempting to narrow the power gap that separates them. But the American woman who wants to look down on her man is still as rare as the man who wants to look up to his woman.

### Social Significance of Stature

Parent-child metaphors tend to be at the heart of our feelings about tallness and smallness. Taller people are regularly chosen for positions of leadership because they necessitate us to look up at them as we once did to our parents - as if to say, this person will take care of us. Perhaps the discomfort we all feel when confronted with a situation where we are opposite a short person or a tall person has less to do with that individual than with our own feelings that his height has triggered. Moreover, looking up to someone may release our latent infant eye orientation that whatever it looks up to is powerful - as our parents once were. Thus, the level of eye contact can be crucial in terms of how we judge others to be; that is, subconsciously we estimate another person's size by how we feel toward him when our eyes meet. When we are confronted with an individual whose behavior clearly contradicts our stereotype for his size - e.g., a short statured professional lawyer or physician - then our mind finds it easier to misperceive that person's size rather than to alter our stereotype of what his behavior should be. The end result to this fascinating social phenomenon that takes place ritually in perhaps all cultures and societies, on a more or less unconscious level, is not so much a self-

fulfilling prophecy as a "social-fulfilling" prophecy, in which, our behavior conforms to that expected from someone with the type of body one inhabits.<sup>19</sup>

Learning to accept one's status as being either tall or short, and the behavior commensurate with it, can be a slow and often very tedious process, particularly if the individual has not been overwhelmingly content with his size. At the same time, he may have become used to it, and found that there were certain rewards. A new dimension in size (for example, as a result of injury or disease) calls for a whole new way of being-in-the-world. For the rest of us who are more or less resigned to the fact that we are the height we are, our only alternatives are to learn by practice a behavior suitable to someone else's height we'd prefer, or to make do with the one we have. Ironically, most of us rarely view the latter in terms of the virtues and rewards it has to offer; instead we seem far more conscious of the drawbacks our size denotes. Clearly, when viewing physical stature symbolically as a social issue, we can begin to confront our own derogatory assumptions about size and the social significance attached to it - all of which can be changed - rather than our physical dimensions, which with rare exceptions cannot.

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<sup>19</sup>Boyd McCandless, Adolescents. Hinsdale, Illinois: The Dryden Press, 1970, p. 92.

## CHAPTER III

Theoretical Approaches and Relevant Literature

Dwarfism has characteristically constituted an irremediable and stigmatized condition in Western society, where height and physical perfection are highly prized. The condition of profoundly abnormal short stature can in only a small fraction of cases ever be corrected. Moreover, the daily problems of coping with a social milieu replete with ridicule can scarcely be solved by professionals working with these people in order to attempt to ameliorate their disvalued status in society. The psychosocial impact of the birth of a dwarf child may have unusually traumatic effects on family and community life; so much so, that problems and coping patterns of individuals and family members vary, but most short statured persons have shared the same generalized painful kinds of stigmatized and stigmatizing experiences, whatever their socioeconomic backgrounds.

In examining some of the theoretical approaches and relevant literature on dwarfism, there exists a rather large gap in the sociological orientations. However, two major works stand out; the first deals almost entirely with the organization of little people (LPA) by Martin Weinberg,<sup>1</sup> while the other deals with the general problem

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<sup>1</sup>Martin S. Weinberg, "The Problems of Midgets and Dwarfs and Organizational Remedies: A Study of the Little People of America." Journal of Health and Social Behavior, 9 (March, 1968), 65-71.

of dwarfism by Marcello Truzzi.<sup>2</sup> Both of these works discuss dwarfism within the purview of sociology in general as well as pointing out some of the essential problems faced by short statured persons. The sociological approach to dwarfism encompasses various theoretical subdivisions of the discipline, including the sociology of deviance, the sociology of medicine, the sociology of everyday life, sociology of occupations and work, and the sociology of minorities and collectivities.

Two studies which offer a rich blueprint for the definition of vital dimensions and issues to be considered when addressing "stigma" as a social and cultural phenomenon are Erving Goffman's works on impression management<sup>3</sup> and stigma.<sup>4</sup> Taken together, these contributions to the field continue to represent perhaps the most important discussions we have on the nuances of being stigmatized in a hostile world of normals, and in attempting to cope with the social hostility attributed to one's stigma. Says Goffman:

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<sup>2</sup>Marcello Truzzi, "Lilliputians in Gulliver's Land: The Social Role of the Dwarf," in Edward Sagarin (ed.), The Other Minorities: Nonethnic Collectivities Conceptualized as Minority Groups. New York: John Wiley & Sons, 1971, pp. 183-204.

<sup>3</sup>Erving Goffman, The Presentation of Self in Everyday Life. Garden City, New York: Doubleday, Anchor Books, 1959.

<sup>4</sup>Erving Goffman, Stigma: Notes on the Management of Spoiled Identity. Englewood Cliffs, New Jersey: Prentice-Hall, 1963.

Society establishes the means of categorizing persons and the complement of attributes felt to be ordinary and natural for members of each of these categories. Social settings establish the categories of persons likely to be encountered there. The routines of social intercourse in established settings allow us to deal with anticipated others without special attention or thought. When a stranger comes into our presence, then, first appearances are likely to enable us to anticipate his category and attributes, his 'social identity' - to use a term that is better than 'social status' because personal attributes such as 'honesty' are involved, as well as structural ones, like 'occupation'.<sup>5</sup>

Goffman continues by suggesting that:

While the stranger is present before us, evidence can arise of his possessing an attribute that makes him different from others in the category of persons available for him to be, and of a less desirable kind - in the extreme, a person who is quite thoroughly bad, or dangerous, or weak. He is thus reduced in our minds from a whole and usual person to a tainted, discounted one. Such an attribute is a stigma, especially when its discrediting effect is very extensive; sometimes it is called a failing, a shortcoming, a handicap.<sup>6</sup>

Thus, Goffman centers his attention upon stigma as a discrediting attribute in which dwarfs and midgets, as well as the physically disabled or deformed (e.g., the blind, amputees, and epileptics), are seen as possessing some characteristic that is deeply discrediting to their personal

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<sup>5</sup>Goffman, Stigma, p. 2.

<sup>6</sup>Ibid., p. 3.

identities. This characteristic leads to a "spoiled identity" and renders the individual suspect in moral character. Thus, as Goffman and others have pointed out, part of the attribution of stigma to those with physical deformities is reflected in the irrational societal labelling of these people as being "immoral" or "morally inferior".<sup>7</sup> Hence, while most stigmatizing conditions make their presence known gradually or accidentally through conversation or increasing acquaintance, dwarfism is an immediately visible condition with a dramatically negative social stimulus value.

The more visible the stigma is to others, the more difficulty the handicapped or disabled person faces in managing the tension created by the other person's knowledge of his condition. If it is not particularly visible to others, the basic problem becomes one of information management: deciding whether or not to inform others, who should be informed, and how to conceal his condition from those he does not want informed. This becomes more clear when we read in Goffman how the reactions of the

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<sup>7</sup>See especially, Edward Sagarin, Deviant and Deviance: An Introduction to the Study of Disvalued People and Behavior. New York: Praeger Publishers, 1975; Robert A. Scott, The Making of Blind Men: A Study of Adult Socialization. New York: Russell Sage Foundation, 1969; Robert B. Edgerton, The Cloak of Competence: Stigma in the Lives of the Mentally Retarded. Berkeley, California: University of California Press, 1967.

"normals"\* toward the stigmatized are essentially negative:

By definition, of course, we believe the person with a stigma is not quite human. On this assumption we exercise varieties of discrimination, through which we effectively, if often unthinkingly, reduce his life chances. We construct a stigma-theory, an ideology to explain his inferiority and account for the danger he represents, sometimes rationalizing an animosity based on other differences, such as those of social class...Further, we may perceive his defensive response to his situation as a direct expression of his defect, and then see both defect and response as just retribution for something he or his parents or his tribe did, and hence a justification of the way we treat him.<sup>8</sup>

Although some types of physical conditions or handicaps need not in themselves be disabling, they nevertheless tend to carry a stigma, perhaps out of the fear of contagion (e.g., the classic case is Hansen's Disease, otherwise known as leprosy), visibility (facial scars, obesity, dwarfism), or in the case of the individual with a colostomy, there is the complicating factor of the unique relationship between excretory and sexual functions - both are invested with an air of secrecy, suggestive of concealing a criminal act. Mental illness, imprisonment, homosexuality, and even unemployment are characteristics

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\*The word "normals" and the adjective "normal" should be understood as being used in the sociological sense by Goffman, rather than in any psychological or value-judgmental manner. The words are used throughout the literature to simply refer to those persons who do not have the stigmatizing trait, characteristic or attribute.

<sup>8</sup>Goffman, Stigma, op. cit., pp. 5-6.

that, in addition to physical defects (Goffman calls the latter "abominations of the body"), result in the same generic outcome:

An individual who might have been received easily in ordinary social intercourse possesses a trait that can obtrude itself upon attention and turn those of us whom he meets away from him, breaking the claim that his other attributes have on us. He possesses a stigma, an undesired differentness from what we had anticipated.<sup>9</sup>

Indeed, to be physically impaired or deformed in our society is to be "different," but different in a pejorative way, where once valued attributes have all been stripped away. Hence, to varying degrees and depending on the nature and extent of the physical condition or handicap, there is the taunting social and psychological handicap it ubiquitously imposes - "chief among them" as one writer suggests, is "the anxiety-provoking question of whether or not one can make it - economically, socially and sexually - on one's own."<sup>10</sup>

In many instances, physical disabilities are clearly obtrusive by nature, so that the disabled individual rarely has an opportunity to cloak the disvalued characteristic.

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<sup>9</sup>Goffman, Stigma, p. 5.

<sup>10</sup>Leonard Kriegel, "Uncle Tom and Tiny Tim: Some reflections on the cripple as Negro," in Edward Sagarin (ed.), The Other Minorities: Nonethnic Collectivities Conceptualized as Minority Groups. New York: John Wiley & Sons, 1971, p. 167.

His adaptation to the stigmatized condition would entail what Goffman has termed "impression management" which will hopefully provide for the stigmatized individual "what is often, if vaguely, called 'acceptance'" by all others.<sup>11</sup> Hence, the success or failure of the deformed individual in his adaptation to a socially stigmatizing condition rests largely on his "management" of his "spoiled identity" as it is directly related to the visibility of the condition itself and the degree of social hostility against it or tolerance of it.<sup>12</sup> It has been suggested by one author that the major overriding problem of the short statured person, is one of extreme visibility; and that "one does not see an individual, one sees a member of a group, malformed, handicapped, hence inferior."<sup>13</sup> Moreover, the vulnerability implicit in their master status and their highly obtrusive visibility seem to have distorted many of their lives, by predetermining their behavior with respect to their "social identities" as well as their "ego identities" in the eyes of average-sized persons.<sup>14</sup> Thus, their control of stigma management seems almost perilous on both the personal

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<sup>11</sup>Goffman, Stigma, op. cit., p. 8.

<sup>12</sup>Fred Montanino and Edward Sagarin, "Deviant: Voluntarism and responsibility," in Edward Sagarin and Fred Montanino (eds.), Deviant: Voluntary Actors in a Hostile World. New Jersey: General Learning Press, 1977, p. 5.

<sup>13</sup>Truzzi, op. cit., p. 163.

<sup>14</sup>Goffman, Stigma, op. cit., p. 106.

level (social identity), as well as the subjective (ego identity). Goffman discusses the way in which the stigmatized play up to such expectations by society and calls this phenomenon "minstrelization," "whereby the stigmatized person ingratiatingly acts out before normals the full dance of bad qualities imputed to his kind, thereby consolidating a life situation into a clownish role."<sup>15</sup>

He then goes on to illustrate minstrelization:

I once knew a dwarf who was a very pathetic example of this, indeed. She was very small, about four feet tall, and she was extremely well educated. In front of people, however, she was very careful not to be anything other than "the dwarf," and she played the part of the fool with the same mocking laughter and the same quick, funny movements that have been the characteristics of fools ever since the royal courts of the Middle Ages. Only when she was among friends, she could throw away her cap and bells and dare to be the woman she really was: intelligent, sad, and very lonely.<sup>16</sup>

Thus, the appearance and visibility of the young woman's highly stigmatized condition, dwarfism, albeit an involuntary one, nonetheless largely dictates how she is expected to take special pains in organizing her behavior and her life-style in such a way as to save others from embarrassment. The burden of adjustment (through permissiveness and support) lies with the young woman

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<sup>15</sup>Goffman, Stigma, p. 110.

<sup>16</sup>Ibid., p. 110.

because the stigma attributed to her short stature spoils any attempt toward "normal" identity --- "acceptance" and tolerance seem at best to be her lot.

### Sociology of Medicine

Within the literature of the sociology of medicine, the significance of the impact of stigma on certain disabilities or illnesses is clearly seen in the work of Freidson, particularly with respect to the imputed responsibility of one's stigmatized condition and its apparent prognosis.<sup>17</sup> For Freidson, dwarfism is seen as a type of stigmatized deviance in which, although the individual who has such a disability is not responsible for it, any more than is the patient with the highly stigmatized Hansen's Disease, nevertheless it is incurable and unimprovable, whereas leprosy is to a considerable extent curable.<sup>18</sup>

In support of Goffman's earlier work on stigma, Freidson suggests that many forms of organic dysfunction or maldevelopment for which the sufferer cannot be held responsible - as in the case of dwarfism - clearly impose severe barriers to a normal social life because they serve as stigmata, or an undesired differentness from the norm.<sup>19</sup> Furthermore, the stigmatizing label of "defective," "incapacitated," "impaired," or "tainted," that all too often

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<sup>17</sup>Eliot Freidson, "Disability as Social Deviance," in Eliot Freidson and Judith Lorber (eds.), Medical Men and Their Work. Chicago: Aldine Atherton, 1972.

<sup>18</sup>Ibid., p. 337.

<sup>19</sup>Ibid., p. 336.

a group of persons may apply to those with a physical handicap or deformity, may well provoke many of the latter into accepting the label in terms that would be acceptable to the "normals," as well as to the disabled or impaired individual's own self-concept. The process, which ultimately leads the individual to accept his new career or status, results in what Lemert has termed "secondary deviation," or the adaptation of a "specialized organization of social roles and self-regarding attitudes" indicative of society's expectations, as a response to an original or primary deviation.<sup>20</sup> Whether by the individual's own capacities or through negative societal reaction, the adapted expectations of role behavior for the disabled or deformed individual become the new mode or means for the normalization of behavior, in which new standards are created so as to measure his conformity. For some individuals, the personal cost of acknowledging one's deviant status and adapting to a reification of one's self-identity may be too high. Hence, "deviance disavowal" may be intentionally employed so as to convey to others that although he may be impaired, a lust for life in the disabled or handicapped, expressed in enduring motivation and a desire for a fulfilling existence, is as strong as with anyone else.

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<sup>20</sup>Edwin Lemert, Human Deviance, Social Problems and Social Control. Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1967, pp. 40-41.

This was examined in Fred Davis' original work on "deviance disavowal" in which he discusses how the visibly handicapped (e.g., polio victims, paraplegics, the blind and facially disfigured) managed to promote successful social interaction with the non-handicapped.<sup>21</sup> Hence, the appearance and visibility of a stigmatized condition may be one of the most important factors in determining both the interpersonal social consequences of a disability, and its effects on one's self-image. However, as Thomas Scheff has so poignantly described in his analysis of the behavior of those called "mentally ill," the consequences of labelling an individual deviant may not be so easily disavowed.<sup>22</sup> Scheff's work is unique in interpreting the labelling perspective, as described earlier by Lemert, Becker,<sup>23</sup> and others, as Scheff deals with what is still a mystifying, misclassified, misnomer of health impairments - namely, mental illness. The significance of the labelling perspective for those persons labelled "mentally ill," is that the label is so pervasive that the individual is likely to "proceed on a career of chronic deviance,"<sup>24</sup> thus precluding any likelihood

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<sup>21</sup>Fred Davis, "Deviance disavowal: The management of strained interaction by the visibly handicapped." Social Problems, 9 (1961), 120-32.

<sup>22</sup>Thomas Scheff, Being Mentally Ill: A Sociological Theory. Chicago, Ill: Aldine Publishing Co. 1966.

<sup>23</sup>Howard S. Becker, Outsiders: Studies in the Sociology of Deviance. New York: Free Press, 1963.

<sup>24</sup>Scheff, op. cit., p. 88.

of recovery or rehabilitation as viable alternatives to initial labelling. Scheff does not mean to advocate the view that differences in personality and role performance do not arise as a result of possessing a disability or handicap. On the contrary, they do indeed, but they are not inevitable, and they arise more out of the social interaction than out of the disabling characteristics. Furthermore, certain kinds of affiliations and agencies, who by name are devoted to helping and rehabilitating the lives of many handicapped persons, have considerable influence over the life chances and important career choices made by their respective clients.<sup>25</sup>

In contrast to Scheff, others have shown how the labelling perspective has provided certain beneficial consequences for those individuals who are chronically impaired or disabled.<sup>26</sup> In effect, the work of various organizations

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<sup>25</sup>See, for example, Robert A. Scott, "Comments about interpersonal processes of rehabilitation," in Marvin B. Susman (ed.), Sociology and Rehabilitation. Washington, D.C.: American Sociological Association, 1966, pp. 132-38. Also, see Robert A. Scott, The Making of Blind Men, op. cit., pp. 117-21; and Robert A. Scott, "The construction of conceptions of stigma by professional experts," in Jack Douglas (ed.), Deviance and Responsibility: The Social Construction of Moral Meanings. New York: Basic Books, 1970, pp. 255-90. Also, see, Eliot Freidson, op. cit., p. 330.

<sup>26</sup>Cf. Lemert, op. cit., pp. 19-20; Saad Z. Nagi, Disability and Rehabilitation. Columbus, Ohio: Ohio State University Pr., 1969, pp. 66-90; Lawrence D. Haber and Richard T. Smith, "Disability and deviance: Normative adaptations of role behavior." American Sociological Review, 36 (1971), 87-97; Judith Lorber, "Deviance as performance: The case of illness," in Eliot Freidson and Judith Lorber (eds.), Medical Men and Their Work, op. cit., p. 423; and Richard T. Smith, "Societal reaction and physical disability: Contrasting perspectives," in Walter R. Gove (ed.), The Labelling of Deviance: Evaluating a Perspective. New York: Halsted Press, 1975, pp. 150-55.

(e.g., Disabled American Veterans) has resulted in positive societal reactions to the physically disabled or handicapped, and these have enhanced the disabled's claims for legitimate support and assistance. However, physical illnesses and handicaps are viewed by society as "undesirable" and often threatening. Depending on the tolerance levels of a family or community, visually stigmatizing physical illnesses or handicaps are approached from either a long-term rehabilitative career without stigmatization, or the ultimate in social rejection - where the handicapped or impaired are left isolated and alone, perhaps with "others of their own kind," the leper being the classic case of an outcast.<sup>27</sup> This almost total cultural uniformity in response to disability tends to permeate the relations between those with handicaps and others, thus proliferating further the ambiguity and uncertainty of appropriate role behavior. The pervasiveness of the cultural conceptions of disability seem so great that even persons who are congenitally born with a handicap share these typically negative values. Thus, it seems to be the burden of the disabled or handicapped to adapt or utilize, to the best of his ability, a strategy or coping tactic to deal with the stigma associated with his condition.

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<sup>27</sup>Zachary Gussow and George S. Tracy, "Status, ideology, and adaptation to stigmatized illness: A study of leprosy." Human Organization, 27 (1968), 316-25.

However, depending upon the condition and such other factors as family, the same person can at times be secretive, blatant, self-effacing or exploitative. Generally speaking, most disabled persons adapt to their stigma by one of two ways. The first is by projecting oneself as being physically different but not socially deviant.<sup>28</sup> Thus, as Davis describes "deviance disavowal," a person does not deny or attempt to conceal the handicap, but rather, seeks to normalize relationships in order to avoid the often awkward, embarrassing, or negative aspects of social interaction. Secondly, and in contrast to those who wish to convey a normal acceptance through a presentation of self, there are others who seek to make their handicap or disability their main focus in life, thus they could be seen as exhibiting "deviance avowal."<sup>29</sup> Still others try to conceal all information about their stigma and attempt to convey the impression of being physically normal, a strategy that is clearly applicable in only a few types of impairments.

The strains of social interaction between the handicapped or stigmatized and others is not solely monopolized by the former. Indeed, awkwardness, annoyance, frustration, ambiguity, anger, tension, and irritation describe the

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<sup>28</sup>Sagarin, Deviant and Deviance, op. cit., p. 204.

<sup>29</sup>Ralph H. Turner, "Deviance avowal as neutralization of commitment." Social Problems, 19 (1972), 308-21.

anxiety-laden interaction. Clearly, one can always follow a policy of avoidance with the pretense that the situation is normal, even though both parties know it is not. Goffman has suggested that to treat the stigmatized as though he were a normal is one mechanism for dealing with their deviance; he terms this "normalization," in contrast to "normification," which is "the effort on the part of a stigmatized individual to present himself as an ordinary person, although not necessarily making a secret of his failing."<sup>30</sup> Sagarin has pointed out some of the methods that people use for dealing with the deviance of others:

People banish, ridicule, and chastise; they create special enclaves where the stigmatized will not have to be seen and where the normals will not have to be reminded so frequently of the existence of these others. Sometimes the normals blurt out their hostility in the form of humor, demonstrating forcefully that the others are so fully accepted, so completely taken for granted, that their difficulties can be joked about, in the manner that ethnics make jokes about themselves that they would not permit from outsiders.<sup>31</sup>

Activities such as these may help to reinforce the feeling of normality for some handicapped, and perhaps at times it may be necessary for their ego or their survival. However, when people overcompensate with mockery and ridicule,

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<sup>30</sup>Goffman, Stigma, op. cit., pp. 30-31.

<sup>31</sup>Sagarin, Deviants and Deviance, op. cit., p. 356.

ostracize blatantly, and display considerable hostility, then they, the normals, by reason of their acts, become the fool victim.

Since there is a very real problem of violations of the norms of "social-identity" to contend with and adjust to for both the stigmatized and the disvaluators in social interaction, perhaps this can be better understood by examining a basic cultural uniformity - namely, that no matter what may be the degree of aversion toward a handicapped person, the societal sanctioning of verbalizing or indicating one's feelings of repulsion or discomfort stems from the cultural belief that the stigmatized person is "inferior" and it is therefore inhumane and cruel for others to reject or mistreat him.<sup>32</sup> Moreover, this normative belief can be seen as reinforcing the moral and social values of a society by proscribing the rejection or mistreatment of these individuals - for such behavior might well indeed result in their own punishment with a similar affliction or fate.

Whatever the origin of such a belief and how many conform to this line of reasoning, it only perpetuates further the strain of confusion and ambiguity between the

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<sup>32</sup>Sidney Jordan, "The disadvantaged group: A concept applicable to the handicapped." Journal of Psychology, 55 (1963), 316-17.

handicapped and others,<sup>33</sup> just as does the totally irrational idea that the acquisition of a handicap is something that some people intentionally bring on themselves. As Freidson points out, "Most illness, and most impairments, are not motivated - they are contingencies of inheritance, accidents of infection, and trauma."<sup>34</sup> With the exception of those having congenital or inherent disabilities, the physically handicapped or disfigured are the "purest of victims" of societal stigmatization.<sup>35</sup> They have committed no "immoral" act in being the way they are; in essence, they are "disvalued not for what they choose to do but for what they have no choice in being."<sup>36</sup> The categorization of the physically disabled as deviant, with potential behavioral inclinations toward aversive and "immoral" conduct, is without any inherent logic and only makes the burden of being "different" that much more difficult for the disabled to bear.<sup>37</sup>

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<sup>33</sup>For a lengthier discussion, see R. G. Barker et al., Adjustment to Physical Handicap and Illness: A Survey of the Social Psychology of Physique and Disability. New York: Social Science Research Council, 1953; Tamara Dembo et al., "Adjustment to misfortune - a problem of social psychological rehabilitation." Artificial Limbs, 3 (1956), 4-62; Beatrice A. Wright, Physical Disability: A Psychological Approach. New York: Harper & Row, 1960; and Goffman, Presentation of Self, passim.; as well as Goffman, Stigma, passim.

<sup>34</sup>Freidson, op. cit., p. 338.

<sup>35</sup>Sagarin, Deviants and Deviance, op. cit., p. 203.

<sup>36</sup>Montanino and Sagarin, op. cit., p. 4.

<sup>37</sup>Sagarin, Deviants and Deviance, op. cit., p. 203.

Clearly, the deep and perhaps unconscious fears and aversions amongst members of society toward most types of disabilities - visible and nonvisible, stigmatized and acceptable - are seemingly at the very heart of the prejudice against the handicapped who, along with other minorities, share similar types of discrimination, alienation, and isolation.<sup>38</sup> Many disabilities have a primary connotation, e.g., deafness - impaired communication; cerebral palsy - loss of control; muscular dystrophy - hopelessness and helplessness; paralysis - dependency; deformity - self-hate and estrangement from familial and social relations. Societies have commonly practiced the ritual of separating the pronounced physically deviant individual from his normal fellows, and this has resulted in varying degrees of isolation, persecution, and ridicule. The blind, the cripple, the leper, the dwarf, all have traditionally been the human outcasts thought to represent the consequences of evil and sin. Even the Bible contains specific passages:

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<sup>38</sup>Edward Sagarin (ed.), The Other Minorities: Nonethnic Collectivities Conceptualized as Minority Groups. New York: John Wiley & Sons, 1971; Constantina Safilios-Rothschild, The Sociology and Social Psychology of Disability and Rehabilitation. New York: Random House, 1970, pp. 110-30.

For whatsoever man he be that hath a blemish, he shall not approach: A blind man, or a lame, or he that hath a flat nose, or anything superfluous, or a man that is broken-footed, or broken handed, or crookback, or a dwarf, or that hath a blemish in his eye, or be scurvy or scabbed, or hath his stones broken; No man that hath a blemish of the seed of Aaron the priest shall come nigh to offer the offerings of the Lord made by fire; he hath a blemish; he shall not come nigh to offer the bread of his God. He shall eat the bread of his God, both of the most holy, and of the holy; Only he shall not go in unto the vail, nor come nigh unto the altar, because he hath a blemish; that he profane not my sanctuaries; for I the Lord do sanctify them.<sup>39</sup>

Still today, in our technologically advanced society where rationalism is at the forefront of scientific reasoning, superstition continues to engulf the disabled and particularly the deformed, who become the recipients of projections of unacceptable and hostile reactions, of pity and revulsion. "One who is physically deformed," as one insightful young man who has for all of his twenty-nine years been living in a wheelchair, totally dependent on others, said to me, "is ultimately faced with the reality that he could not be loved." Clearly, the intrapsychic impact of body deformity to this young man can be seen as so threatening at the most basic level of human needs, that one so afflicted may never honestly feel he is or ever can be loved.

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<sup>39</sup>Leviticus 21:16-23.

One of the major problems today facing leaders of various movements of persons who are largely stigmatized because of their visible attributes or conditions is, how to alleviate stigma without reducing a certain amount of preference for the "normal" or majority condition.

As Sagarin suggests:

That this task has largely been accomplished in the case of blindness and deafness (although many deny that stigmatization has disappeared entirely from either case, it is certainly less prevalent and less strongly felt than in centuries past) would indicate that it can also be accomplished for dwarfism.... their rising social expectations have provoked both the need to attain greater dignity and the belief in the possibility that such attainment is within their reach.<sup>40</sup>

This year, the President's Committee on the Employment of the Handicapped along with other organizations composed of, by, and for the handicapped, have emphasized a movement among handicapped persons away from passively accepting their fate, to one that, if an individual cannot change the condition that constitutes his handicap, then at least he should be allowed to pursue the goal of alleviating the stigma associated with the condition that makes him a victim without being a victimizer. The crucial fact for one who feels he isn't an outcast in

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<sup>40</sup>Edward Sagarin, Odd Man In: Societies of Deviants in America. Chicago, Illinois: Quadrangle Books, 1969, p. 241.

society is not so much the recognition that he is physically different, but that he is stereotyped in such a manner as to reinforce others' sense of righteousness and normality, thus entrenching further the chains of myths and distortions about his handicap.

For those physical conditions in which the medical profession is very limited in its potential for cure or treatment, various nonprofessional and peer-support (or mutual-aid) groups exist to aid in alleviating a variety of non-medical aspects of a disability by "destigmatizing" the person and enhancing his self-image. The two primary organizations with concern for those persons in our society with growth problems and short stature are the Human Growth Foundation (HGF) and Little People of America, Inc. (LPA). One other program, based on a pilot project and sponsored by the Moore Clinic of Johns Hopkins Hospital, is called PACT (Parenting and Counseling Training Program). The PACT program is based on the philosophy that new parents of dwarfed children can be helped by parents who have made a good adjustment to their own dwarfed child and who have been trained in communication and listening skills. Thus, PACT PARENTS, by virtue of their own personal experiences in raising a child of short stature, are available to talk to new parents of short statured children in person or by

telephone. PACT PARENTS believe that emotional support and factual information about medical services, educational programs, and supportive agencies enable parents to view, in a positive manner, a child's ability to develop to the fullest potential.

Human Growth Foundation (HGF) is a voluntary, non-profit organization dedicated to helping medical science better understand the process of growth, particularly dwarfism. It is composed of parents and friends of children with growth retardation problems, individuals with short stature, and interested physicians. The primary goal of HGF is to assist patients as well as parents of children with problems of either diminished or excessive growth. At local chapter meetings throughout the United States, parents participate in education programs, exchange experiences and problems, and share in searching for solutions. Another goal of HGF is to support both patient care and treatment by assisting the National Pituitary Agency in the collection of human pituitary glands for use in ongoing research concerning growth problems.

For those individuals who cannot be helped, and who will be dwarfed as adults, there is a special organization composed of persons under 4' 10" tall, the Little People of America, Inc. Whereas, the HGF mainly consists of

parents of children with growth problems, although anyone is welcome to join, the general membership of LPA is open solely to the severely short statured - the little people, as they prefer to call themselves in the United States.\* Organizations of short statured people adhere to the philosophy that every person of short stature is an individual with unique abilities, emotions and ambitions, that must be encouraged to unfold to the maximum benefit of that individual. The pleasures and problems that arise along the way will vary considerably, but the variations will be much like those that beset many other people.

Little People of America, Inc. was founded in 1957 by the Hollywood entertainer Billy Barty, along with twenty other little people who organized the group in Reno, Nevada. In 1960, over one hundred short statured persons attended a national convention, at which a constitution was adopted and the organization was formally incorporated into a nationwide, nonprofit, self-help group. Most of the 4,000 members of the organization today range in height between 2' 6" and 4' 6", with the majority disproportionate in stature - i.e., exhibiting an abnormally proportioned

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\*In Great Britain, the self-help organization for people of short stature does not feel the phrase "little people" satisfies all the medical conditions with which the organization is concerned. Because short stature is a feature of a number of different medical conditions (roughly 100 or more), it takes various forms, and individuals vary considerably in height and general appearance, thus the predominant term used in England when referring to a person of short stature is "restricted growth."

body with extremely short arms and legs (usually bowed), attached to a normally developed torso and large head. This condition, a congenital one that is sometimes hereditary, is commonly known as achondroplasia, one of the most common forms of chondrodystrophic dwarfism. Another category of short statured persons would include those more commonly referred to as "midgets" who, although normally proportioned, are extremely short.

The members of LPA come from all walks of life and represent many socioeconomic categories, educational backgrounds, and occupations. Through meetings at the local, district, and national levels, members share their problems and solutions and get medical advice and current research information from many physicians who serve as their advisors. As stated in the by-laws of LPA, "The purpose of LPA is to assist its members in adjusting to the social and physical problems of life caused by their small stature through mutual assistance and the personal examples by each of its members." In addition, the by-laws further note that LPA was especially concerned with "the need for people of small stature to become useful members of society through education, employment, and social adjustment, and to focus public attention to the fact that the magnitude of any physical limitation is a function of attitude of both the small and the average-

size person."<sup>41</sup>

In sum, LPA and HGF provide fellowship, moral support, a forum for information, and social interchange as related to the unique problems of the little person. Both groups offer opportunities for parents to meet others with similar problems, and each organization has close contact with the medical profession to help refer interested individuals to the experts nearest them. Contact with well-adjusted little persons should assist in allowing others not so well-adjusted to recognize that there is a whole range of occupational and social choices available to them. Thus, for short statured persons, LPA and HGF provides that opportunity in the form of mutual exchange as mutual-aid groups. Moreover, such groups, with particular emphasis on LPA, assist in the alleviation of the shame and/or guilt of some members resulting from their stigmatized status. The group's belief system and its various activities may help to foster a feeling of legitimacy of members' own particular identity and also to legitimize their condition to society at large.

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<sup>41</sup>Little People of America, Member's Handbook, p. S-1.

### Sociology of Everyday Life

In the literature emphasizing the sociology of everyday life, Goffman discusses at one point what he calls "information control" about one's personal identity particularly as it relates to a stigmatized person, "as he wends his way to and from his place of work, his place of residence, his place of shopping, and the places where he participates in recreation." In other words, he makes his "daily round," as Goffman would call it, or participates in his everyday social interaction: "...it is the daily round that links the individual to his several social situations. And (hence,) one studies the daily round with a special perspective in mind."<sup>42</sup> Specifically, Goffman gives attention to the distinction between the situation of the "discredited individual" with tension to manage and the situation of the "discreditable individual" with information to manage. As Goffman explains, "To the extent that the individual is a discredited person, one looks for the routine cycle of restrictions he faces regarding social acceptance; to the extent that he is discreditable, for the contingencies he faces in managing information about himself."<sup>43</sup>

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<sup>42</sup>Goffman, Stigma, op. cit., p. 91.

<sup>43</sup>Ibid., p. 91.

In the case of dwarfs, midgets, and other short statured persons, their stigmatizing condition is a highly visible one and therefore, in Goffman's terms, a discredited one. Because of the obtrusiveness of the stigma attributed to little persons' stature, they do not have the option of seeking to "pass" or to concealing their condition. Instead, they must attempt to reduce the tension between themselves and others in regard to their stigma in order to sustain spontaneous involvement in their social interaction with others. This is tactfully demonstrated through what Goffman calls "covering," or the process by which an individual organizes his social situations in order to cover his handicap or condition. The individual's main objective then is to minimize the obtrusiveness of the stigma so as to make it easier for himself and others to withdraw covert attention from the stigma in order to create a more normal ongoing reality.<sup>44</sup> Although some of the tactics and strategies used in covering may at first appear to be very much like those used in passing, the critical situation is whether or not the stigmatized individual's condition and society's recognition thereof will allow him to employ one or the other. In some cases, the means employed to conceal a stigma from unknowing persons

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<sup>44</sup>Goffman, Stigma, p. 102.

may be of little value aside from easing matters with those who are wise to his condition. A pertinent example would be the blind, "who sometimes have a facial disfigurement in the region of the eyes, distinguish among themselves according to whether this is the case or not. Dark glasses sometimes worn to give voluntary evidence of blindness may at the same time be worn to cover evidence of defacement - a case of revealing unsightedness while concealing unsightliness."<sup>45</sup> Thus, the cosmetic prescriptions of our society have created such negative social stimulus values for the physically impaired, or those who are simply different - too short, too tall, too fat - to the point that an eloquently managed, incisive interactional process is devised by a stigmatized person to use in his daily round of passing or covering. And, at any time, a conscious or an unconsciously motivated pretense in the seemingly commonplace of rituals of social interaction is played out.

On a more objective level of everyday analysis of behavior, as it relates to short statured people, Goffman has suggested yet another strategy of coping that is utilized by various discredited persons that sometimes occurs, along with the concealment of stigma symbols,

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<sup>45</sup>Goffman, Stigma, pp. 102-3.

namely "disidentifiers," or "...a sign that tends - in fact or hope - to break up an otherwise coherent picture but in this case a positive direction desired by the actor, not so much establishing a new claim as throwing severe doubt on the validity of the virtual one."<sup>46</sup>

Truzzi has suggested that many short statured persons overcompensate their size in public with the overuse of disidentifiers in an attempt to reconcile with the average-size world's recognition of them not to be confused with children, but instead, to show that they are adults and fellow human beings. Such disidentifiers include, "hats, canes, cigars, and facial hair by the men; high fashions and elaborate makeup and hairdo by the women; and more formal attire for both sexes than normal-sized persons might generally wear."<sup>47</sup> Although this may be true for some short statured persons, their usual adaptation to their size and choice of clothing is perhaps not so much a problem in choosing what to wear as where to find clothing that fits properly. Clothes for special occasions as well as for everyday wear pose various problems, according to the bodily dimensions and exact size of the person concerned. On the whole, clothing plays a very real part in the everyday socializing of people affecting their self-image and

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<sup>46</sup>Goffman, Stigma, p. 44.

<sup>47</sup>Truzzi, *op. cit.*, pp. 190-91.

the impression given to others. But virtually everything in our culture is seemingly designed to reinforce the old adage that "bigger is better" and that "smallness" is not a fast selling commercial commodity. One advertisement printed in a men's clothing magazine was attempting to influence the reader - presumably a male - that being taller meant not only looking more attractive but being more successful and desirable to the opposite sex, getting better jobs, earning more money, getting more respect, and in the long run being far happier than short people. The ad includes a photograph of two beautiful women tempting a man sexually and implying that if the reader were to order a copy of the Height Increase Method today, he too may be experiencing a comparably enjoyable life.<sup>48</sup> Such propaganda seems harmless at first, but when one considers other forms of media such as the television, radio, billboards, etc., height, strength, and of course sexual attractiveness, seem to permeate our cultural envision of the body-beautiful ethic while reinforcing the little person's sense of smallness. Thus, finding the appropriate clothing; seeking to make necessary mechanical adjustments on an automobile before it can be driven; difficulty in reaching public utilities such as telephones,

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<sup>48</sup>Gentlemen's Quarterly Magazine, (March, 1980), p. 245.

drinking faucets, or mailboxes; all seem to lead the short statured person not only to a frustrating everyday existence in terms of the over-sized nature of most of the socially produced items required in daily life, but also to spending a considerable amount of money to obtain them. Custom-made clothing and automobiles today require most anyone to pay exorbitantly and most of that in advance. Thus, there are many common everyday situations which, for the most part, average-sized persons have little difficulty in dealing with, but these same situations may call for a great deal of ingenuity on the part of the short statured person.

Sociology of Occupations and Work

Another major source of concern for short statured people is the area of employment and job opportunity. In terms of the literature on occupations, both Weinberg and Truzzi have pointed to the severe limitations placed on short statured people in terms of their finding various jobs because of their size, especially in relation to the geographic area in which a little person may live. In other words, there may be a variety of jobs available in one community, but practically none elsewhere. Moreover, transportation to and from place of work is also a crucial problem a little person may have to consider before accepting a job. Education, too, may be a limiting factor in a little person's acceptance for employment. If he has been overprotected in early childhood and not encouraged to seek training in a suitable skill or profession, then certainly the chances for competition in the labor market are even more seriously curtailed.

Weinberg has suggested that many little persons commonly believe they are rejected from potential occupations because of their short stature.<sup>49</sup> It would seem that many potential employers are reluctant to place alongside their employees someone who has a physical disability or handicap for fear that their presence might make the normals very

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<sup>49</sup>Weinberg, op. cit., p. 66.

uncomfortable and thus stifle work productivity. Perhaps it is the presence of the disabled in close proximity to the others that tends to instill a feeling of suspicion or aversion, particularly as it might bring to question the capacity of the normals being placed on par with a physically handicapped person performing the same job. Added to this and perhaps even more important are the value orientations of potential employers as they seem to look upon the stigmatized as having low levels of intelligence, a lack of trustworthiness, and perhaps even a lack of morals. Consequently, certain gatekeepers to career opportunities tend to respond to organizational pressures to block channels of opportunity for the stigmatized. Truzzi has suggested that perhaps some of our beliefs or prejudices toward little people have not been the result of socialization, but instead may lie in more basic human predispositions, such as a need to feel a sense of dominance over others.<sup>50</sup> Clearly, a feeling of superiority among average-sized persons over short statured people seems obvious in terms of size, and by extension the average-size person might feel a sense of intellectual superiority, although there is no objective reason to believe in the inferior mental capacity of the

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<sup>50</sup>Truzzi, *op. cit.*, pp. 199-200.

little person. Perhaps the negative predisposition among average-sized persons to persons of short stature lies in their repugnance or aversion toward the malformed, disproportionate or aesthetically aberrant. The dwarf, more so than the midget since the latter is proportionate in stature albeit exceptionally small, clearly represents this reality in living truth of an anti-cultural uniformity of the so-called "body beautiful" ethic.<sup>51</sup> This then is the legacy a short statured person must bear in his never ending plight for social acceptance. It would seem that through demonstration of many short statured people in numerous types of jobs - from unskilled to professional - the stigma attributed to size should be relatively easy to combat. Yet, in spite of all the able-bodied and intelligent short statured people who obviously are in no way handicapped aside from their size, the social scarring continues its merciless destruction of potential in the lives of many little people.

Prejudice will likely as not continue to survive among some employers toward anyone who is stigmatized by virtue of a physical deviation or condition which, in the eyes of many, indicates limited achievement or capacity, or worse. As a result, some short statured people remain

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<sup>51</sup>S. A. Richardson et al., "Cultural uniformity in reaction to physical disabilities." American Sociological Review, 26 (1961), 241-47; see also, Werner J. Cahnman, "The stigma of obesity." The Sociological Quarterly, 9 (1968), 283-99.

unemployed and are dependent on family or parents. However, many little people today have convinced prospective employers that, despite their small size, they are capable human beings.<sup>52</sup> Those little people who have been successful are usually the ones who accept themselves, understand their own limitations as well as capabilities, and exhibit a feeling of self-confidence in whatever they set out to accomplish. Some have achieved major success in the entertainment industry, both in the honored tradition of clowns and in serious acting. Billy Barty, the Founder of LPA, has made over 110 movies in addition to TV, stage and nightclub appearances. Michael Dunn, now deceased, is particularly remembered for many outstanding performances, but especially in Ship of Fools. Certainly there are some very successful entertainers among people of short stature, but the days have gone when many little people might align themselves with organizations as a "mascot," wherein they became the center of a business trademark, such as Johnny Clifton and his dog Tige of the Buster Brown Shoe Company, who must have tired from repeating at various department stores, theatres, and shoe stores: "I'm Buster Brown, I live in a shoe. That's my dog Tige, he lives there too." In 1932, a young New York City bellhop was

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<sup>52</sup>Sonny Kleinfield, "Dwarfs." Atlantic Monthly, 236 (September, 1975), 62-66.

overheard paging someone by an advertising agent for Phillip Morris cigarettes. Johnny Roventino, only twenty years old, was signed to a yearly contract of \$20,000 to sing in his highly distinctive voice for Phillip Morris. Captain Werner Ritter, perhaps one of the smallest persons used as a mascot for a major business concern, was shown at the Hiram Walker display at the 1933 Chicago Century of Progress Exposition. There have been numerous others, including Oscar Mayer & Co.'s "Little Oscars" and Squirt Bottling Co.'s "Little Squirt."<sup>53</sup> Obviously, these people have capitalized on their situation, both socially and economically; however, the important point here is that little people do not want to be used as little people - "show pieces," "clowns," etc. Actually, there is more scope in employment opportunities than might at first be realized for people of short stature with enthusiasm and a will to work hard, whatever their level of education. The range of jobs is considerable. Indeed, there is scarcely any career open to average-sized adults in which little people have not distinguished themselves, and there are a few which only they could handle.\* The only jobs that are likely to be unsuitable or unobtainable are those that depend purely or predominantly on physical prowess.

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<sup>53</sup>Hy Roth and Robert Cromie, The Little People. New York: Everest House Publishers, 1980, pp. 103-18.

\*In 1959, the Strategic Air Command base located in Westover, Massachusetts, employed its first little person to crawl into the air intakes of F-104 Starfighter jet planes to remove any debris collected in flight.

One problem area in employment opportunities for little people that occasionally comes up where there is heavy machinery or laboratory equipment is insurance. Some employers may not be prepared to have little people in such an environment if they feel they may be at risk. This was told to me by a four-foot three-inch plumber who, although employed by a major plumbing contractor, and disregarding the fact that he has a journeyman's license and has been a member of the union for over six years, his job primarily entails distributing nuts and bolts to major machine factories. In his own words:

They just don't give me any credit; after all, I've been trained to be a plumber but all they want me to do is assist others. In fact, there's nothing I can't do that any normal-sized plumber can with the aid of a stepladder, except maybe lift a bathtub, but then, neither do they, we use lifts and hoists. Anyway, they're all just afraid that a pipe might roll over me or something. I'm just frustrated, the only real plumbing I do is at my own home or for friends as a favor.

Clearly, for some short statured persons, the physical problems of small size may not be as difficult to overcome as most average-sized persons might think. Even so, employers may not want to take the risk, although it may be impossible to know whether this is a genuine problem

or simply an excuse from an employer who does not want to employ a little person or anyone else having a handicap. In my sample of respondents, several little people recounted experiences of being turned down for jobs just because of their size. Indeed, this sort of discrimination can sometimes be blatant, particularly when an application seems to be going well until the applicant's height is discovered, as one respondent conveyed:

A job was open for an individual with my skills and background. After speaking with the hiring authority at the company over the telephone, I was told that I was precisely what they were looking for. I was asked to come in and fill out the necessary forms, etc. When I arrived at the company, I was told there were no openings. This is not an isolated incident, there have been many.

Another young woman experienced the same sort of discrimination as soon as her height was known:

Potential employers frequently did so (prejudge my capacity) as evidenced by some of their interview remarks or other obvious ways - for example, "Our admission sign is bigger than you are."

Social acceptance seems to be the greatest problem for a little person today in applying for a job. Clearly, if the little person has a feeling of self-acceptance and self-confidence, then he or she can be more forthright to potential employers and others who might be prejudiced.

By realizing that the major social barrier between short statured people and average-sized people is based more on ignorance and curiosity than hostility, it may perhaps be easier to understand and overcome. As many little people have suggested to me, direct confrontation (non-antagonistic) with potential employers and other average-sized persons about a little person's height and hence his obvious limitations (although not at the expense of forgetting to mention his many skills) seems to be the way that many little people today are opening the doors to better interpersonal communication.

### Sociology of Minorities and Collectivities

It has been suggested that little people, along with others who share similar social hostility such as homosexuals, epileptics, and even lepers, or those members or groups of persons in society who are constantly stigmatized, stereotyped, and subjected to collective discrimination, be conceptualized as nonethnic collectivities falling under the categorization and study of minority groups.<sup>54</sup> However, as Sagarin has pointed out, there are two major objections against the inclusion of collectivities other than ethnic as minorities. The first and perhaps most forceful is the indignation on the part of self-righteous ethnic groups toward allowing people like homosexuals or lepers to be thought of as similarly experiencing the same humiliation and subjection to discrimination as do blacks, Jews or Italians. After all, these other people are "sick" or socially discredited or physically inferior; therefore, how can scientists think of associating "'us' (the good guys) with 'them' (the bad guys)?" The other objection to redefining minority groups to include collectivities other than ethnics comes from those groups who consider themselves disadvantaged in some ways but who are clearly more advantaged than most in other situations. These

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<sup>54</sup>Sagarin, The Other Minorities, op. cit., pp. 10-17.

groups seek the umbrella of the minority group as a form of sanctuary in order to receive societal respect, and hopefully to be seen as further victims of social injustice. This type of group, however, uses the sanctity of a social collectivity in order to perpetuate its own ideology, for no group of persons wish to be categorized as a minority group with all the stigmatization and subjugation it implies. But for some groups, for example, the police, although they may be relatively free from stigma (albeit, depending on who or what other group is doing the stigmatizing) and negative collective judgment, they elect to display themselves as a disadvantaged group in order to obtain whatever social advantages may come their way. Hence, the reasons for these groups not wishing to be associated with the other collectivities seems fairly clear, particularly the police. In any case, in order for the sociologist, as well as any other social scientist, to better understand and deal with the nature of prejudice and discrimination against ethnics as well as others (including homosexuals, epileptics, little people or even extremely tall people) from the dominant members of society, one way might be to examine conceptually the similarities and the dissimilarities, the

likenesses and the unlikenesses, between Jews and homosexuals, blacks and epileptics, Italian-Americans and lepers. For in so doing, the discovery of similarities and/or differences between them may ultimately reveal common bonds not previously considered or viewed as possible. This social bond (albeit, one must allow for individual group goals), may in turn provide a sense of social cohesion in their common struggle for acceptance and respectability.

Clearly, the problems of categorization are numerous and grouping various types of people together under one rubric raises conceptual and normative problems. However, for purposes of social scientific inquiry, and of the conceptual frameworks surrounding them, the inclusion of two things (e.g., people, groups, etc.) under one given rubric, for the purpose of categorization, does not mean to imply that they are identical - only that they may be alike in certain respects and unlike others in certain respects. It is under this condition that "social differentiation" takes place, and consequently, to discern under what conditions such social differentiations result in social inequality. Hence, for little persons in our society, apart from the nature of their short physical stature, they are

like others in many respects. Yet, they are highly stigmatized, ingrained with the self- as well as social-fulfilling prophecy that they are inferior, denied opportunities for both social and economic mobility, and are subjected to irrelevant and unwarranted collective discrimination; thus, their minority group status clearly emerges.

### Social-Psychological and Psychiatric Literature

Within the vast amount of literature discussing many of the social-psychological and psychiatric dimensions of short stature, most of the studies tend to summarize observations made or results of psychological tests, ordinarily made of children, in various clinics or hospitals which have a special unit for short statured people. Perhaps one of the most generally accepted and well established points of interest which has been highly documented by numerous authors is that a major source for the development of emotional difficulties among dwarfs seems to stem from the fact that their size attracts unusual attention and that there is a tendency for the dwarf to be treated as though he were younger than he really is, thus reinforcing immaturity and dependency.<sup>55</sup> Although diminutive, short statured

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<sup>55</sup>See, for example, James S. Brust et al., "Psychiatric aspects of dwarfism." American Journal of Psychiatry, 133 (1976), 160-64; S. Dorner and A. Elton, "Short, taught and vulnerable." Special Education, 62 (1973), 12-16; P. W. Drash, "Psychologic Counseling in Dwarfism," in L. I. Gardner (ed.), Endocrine and Genetic Diseases of Childhood. Philadelphia, PA: W. B. Saunders & Co., 1969, pp. 1014-22; P. W. Drash et al., "Intelligence and personality in four syndromes of dwarfism," in D. B. Cheek (ed.), Human Growth. Philadelphia, PA: Lea & Febiger, 1968, pp. 568-81; M. E. Krims, "Observations on children who suffer from dwarfism." Psychiatric Quarterly, 42 (1968), 430-43; Maria Kusalic et al., "Psychodynamic aspects of dwarfism." Canadian Psychiatric Association Journal, 17 (1972), 29-34; John Money, "Dwarfism: questions and answers," op. cit., pp. 134-38; Ernesto Pollitt and John Money, "Studies in the psychology of dwarfism. I." Journal of Pediatrics, 64 (1964), 415-21; John Money and Ernesto Pollitt, "Studies in the psychology of dwarfism. II." Journal of Pediatrics, 68 (1965),

children appear perfectly normal, except perhaps for their characteristically immature features, many authors seem to unanimously agree that dwarfs have a normal intellectual capacity.<sup>56</sup> However, many of these same authors have noted the frequent occurrence of various personality traits among dwarfs particularly in regard to certain ego-defense mechanisms including denial and withdrawal or social isolation.<sup>57</sup> Additional strategies used by adult dwarfs to achieve a certain mastery over their stigmatized social identity have been to adopt the role of "mascot." Among children with achondroplasia, there was "chronic cheerfulness" and "optimism."<sup>58</sup> Unfortunately, however, this last strategy, employed by many children with achondroplasia, was not shown to be carried over into adulthood by all those affected in one study.<sup>59</sup> It was instead suggested that the dwarf's

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381-90; Joan Weiss, "Social development of dwarfs," in W. T. Hall and C. L. Young (eds.), Proceedings of a Conference on Genetic Disorders: Social Service Interventions. Pittsburgh, PA.: University of Pittsburgh, Graduate School of Public Health, 1977, pp. 56-61; Roger Spencer and David Raft, "Adaptation and defenses in hypopituitary dwarfs." Psychosomatics, 15 (1974), 35-38.

<sup>56</sup>Drash et al., op. cit., passim; Money and Pollitt, op. cit., passim; Pollitt and Money, op. cit., passim; John Money et al., "Dwarfism and hypopituitarism. Statural retardation without mental retardation." American Journal of Mental Deficiency, 72 (1967), 122-26.

<sup>57</sup>See, Money and Pollitt, loc. cit.; Drash et al., loc. cit.; and Money, "Dwarfism: questions and answers," loc. cit.; Spencer and Raft, loc. cit.

<sup>58</sup>Money, "Dwarfism: questions and answers," *ibid.*, pp. 135-36.

<sup>59</sup>Brust et al., op. cit., p. 163.

cheerful demeanor is a part of learned coping mechanisms that one uses to place others at ease and thus facilitate interpersonal relationships. The authors also suggested that cultural factors played a critical role in determining why male dwarfs had experienced more emotional stress than did females in their overall adjustments to life. Since our culture often tends to identify masculinity with size and power, the male dwarf not only sees himself shorter than other men but also of most women, thus instilling a sense of incompetence and self-doubt. The female dwarf is better able to accept her short stature because it more closely approximates cultural attitudes and expectations of women, thus causing less anxiety or depression.<sup>60</sup>

Generally speaking, it would seem that the social significance of physical appearance, even the more relatively minor atypicalities, may either momentarily alter the quality and duration of a social encounter, or it may largely dictate both the quality and duration as well as the expectations and attitudes of the persons involved. In childhood, when one's sense of self-worth and personal identity seems to be mainly established in the myriad of interactions with parents, family and friends, it has been dramatically shown how major differences in physical appearances may ultimately lead to enduring

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<sup>60</sup>Brust et al., op. cit., pp. 162-63; also, see Sagarin, Odd Man In, op. cit., pp. 202-3.

and profound personality difficulties. The emotional scars of many children with severe rashes, facial anomalies, and orthopedic deformities are only a few examples of how painfully society can inflict an even greater harm on those persons who are disvalued not for what they choose to do but for what they have no choice in being. Their involuntary physical condition, with its disvalued traits, is counterposed to social norms and expectations.

The developmental problems of children with short stature seem to be in large part more clearly understood in relation to the type of parenting and social experiences they receive. Money and Pollitt did an early study on the psychological response of seventeen hypopituitary dwarfs to the treatment of HGH (human growth hormone or Somatotropin).<sup>61</sup> As the study indicated, the degree of social-behavioral and personality level of maturation achieved depended more on the degree to which the dwarf had been treated socially (primarily by parents and other adults) according to his age and not his size, rather than on the actual amount of growth. Clearly then, an average-sized child cannot ignore the reality of being smaller than his parents or older children, yet average-size children do not usually feel "small" or "inadequate" because their goals are real-

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<sup>61</sup>Money and Pollitt, loc. cit.

istically geared to their competence; consequently, they succeed far more often than they fail, becoming the object of affection rather than rejection. Consistent with some of the other findings by Money and Pollitt is that children with hypopituitary dwarfism, while they have a normal intelligence, often demonstrate a psychological lag or tendency toward general social and emotional immaturity which parallels their size and the quality of social interaction which their appearance elicits. In spite of knowledge and good intentions, many parents allow size and appearance to powerfully shape their expectations of their offspring. As a result, many parents tend to under-estimate their short child's emotional and developmental needs, because their standards of behavior were largely tailored to the child's size and appearance, not his emotional needs. Thus, the genetic guilt of many parents with a short statured child often finds expression through overprotectiveness and excessive control, which only further limits the child's own capacity for self-reliance.<sup>62</sup>

Clearly, since a child's sense of personal value seems to be directly related to his or her perception of self as competent and beloved, it follows that self-esteem also reflects the degree to which an individual reaches

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<sup>62</sup>Weiss, op. cit., pp. 56-59.

an ideal goal. In addition, the ability to express healthy aggression is fostered by an environment which encourages assertiveness and helps to assure individuals that their actions will not lead to personal disaster. In such an environment, children learn that they can control their own fate, at least in part. In normal development, children progressively become more able to evaluate their own performance in relation to these internalized standards and to reward themselves and be rewarded by significant others for achievement.<sup>63</sup> Psycho-social disturbances in self-esteem, derived from repeated instances of social rejection or failure in reaching these goals, often appear in the life of short statured children.<sup>64</sup>

Perhaps the two most difficult periods of adjustment for any child, preadolescence and early adolescence, are seen as having clearly an even more profound and enduring impact on the social development of a short statured child.<sup>65</sup> At no other time is the child exposed to such rapid growth acceleration of peers and the obvious appearance of major physical changes. But more importantly, the parents' capacity for forming a positive attachment

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<sup>63</sup>P. Katz and E. Zigler, "Self-image disparity." Journal of Personality and Social Psychology, 5 (1967), 186-95.

<sup>64</sup>See, Krims, op. cit., p. 430; Kusalic et al., op. cit., pp. 31-33; Money and Pollitt, op. cit., pp. 388-89; Spencer and Raft, op. cit., p. 35.

<sup>65</sup>See especially, Weiss, op. cit., pp. 57-59.

and encouraging the healthy aspects of development with their child, particularly by encouraging the child to compensate for his short stature by developing interests in areas in which he could succeed, and by allowing themselves (the parents) the reality of perceiving their child in some important ways as "different" and perhaps narcissistically frustrating to them, is critical for the short statured child who cannot find encouragement from a peer-group as readily as might an average-size child. It is suggested by the authors of one study,<sup>66</sup> that by fostering a sense of competence and a mastery of the emotional tasks of development in a short statured child by his parents, a sense of personal maturity, self-esteem, and a no-nonsense directness will ultimately prevail so that the child will neither expect nor will he accept infantilization. His behavior should significantly override the effect of his appearance in reshaping the present and all future social interactions.

It is clear that most of the studies mentioned, and numerous others that pertain to specific types of dwarfism, are largely concerned with the effects of dwarfism on child development. A few authors, however, have considered the psychological and psychiatric adjustment

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<sup>66</sup>D. Rotnem et al., "Personality development in children with growth hormone deficiency." Journal of the American Academy of Child Psychiatry, 16 (1977), 412-26.

of adult dwarfs. But here again, we are faced with several distinct types of dwarfism and no individual study proves to be conclusive of behavior of all adult dwarfs.

In two early studies,<sup>67</sup> it was found that dwarfs with hypopituitarism were more socially inhibited and compliant than achondroplastic dwarfs. Yet, in a more recent study of two groups of adult dwarfs, one consisting of achondroplastic dwarfs, the other those with hypopituitarism, it was found, through the use of psychiatric interviews and psychological testing, that there were no significant differences between the two groups. In general, the subjects had achieved a satisfactory life adjustment despite the stress of having bodies uniquely different from those of the general population. They had secure identities as "little people" and successfully used coping mechanisms, such as a sense of humor and a pleasant interpersonal style.<sup>68</sup>

Most recent is a study of eight-four adult chondrodystrophic dwarfs, conducted at the Johns Hopkins Medical Genetics Clinic, to assess the degree of physical and psychological impairment the dwarfs experienced, in addition to the degree of handicap based on social

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<sup>67</sup>Money and Pollitt, loc. cit.; Spencer and Raft, loc. cit.

<sup>68</sup>Brust et al., loc. cit.

stigma.<sup>69</sup> The authors found that although all the subjects in their sample were physically impaired, only those with severe physical impairments - for example, persons with achondroplasia had the least amount of physical impairment as opposed to those who suffer from osteogenesis imperfecta, a disease characterized by crippling bone deformities - were handicapped in obtaining educational and employment goals. However, it was pointed out that the association between increasing physical impairment and increasing "lie" scores on the Eysenck Personality Inventory suggests that by lying about or denying unpleasant symptoms or traits may frequently be used by severely impaired dwarfs to enable them to carry on with life despite serious obstacles.

Although there were various other findings in this study, only one other seems pertinent to mention here, namely, that the people in this sample suffered in terms of finding marital partners. Although fewer than half the subjects had ever married, and since most of the subjects were able to bear children, the authors surmised that the handicap was due to the stigma of dwarfism. Among those women who were married, half complained of emotional distress in their marriage, which points to the possibility that dwarfs who do marry find unsuitable

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<sup>69</sup>S. E. Folstein et al., "Impairment, Psychiatric Symptoms and Handicap in Chondrodystrophic Dwarfs," (unpublished manuscript).

mates, perhaps because of the limited number of available partners and the short time available for courtings which often takes place at the Little People of America conventions held annually once a year. According to the authors' clinical experience, those women who are unhappily married seem to believe that they must present a cheerful front in order to demonstrate to society that dwarfs are well adjusted. This interpretation lends support to an earlier finding, that fewer men than women claimed to be bothered by being noticed in public, meeting people, controlling their weight and using public facilities. In essence, and in contrast to the earlier study by Brust et al., the men in the sample, as measured by the Eysenck Personality Inventory, were seen as being more extraverted, complained less often of psychiatric symptoms, and felt less stigmatized than did the women subjects.

As mentioned in the beginning of this section, most of the groups of dwarfs in these studies were largely available through individual clinics or hospitals, where many were patients or in some way affiliated with the institution. Hence, the studies do not represent a total population of dwarfs or of dwarfism as a biological entity with all the physiological and psychological

variations thereof. It does, however, seem clear that just as in the population of average-sized persons, there is an equal representation of individuals who exhibit many of the same psychological and psychiatric symptoms as those discussed in the literature on dwarfism.

### Medical Literature

The medical and clinical complexities of short stature have been widely explored in the medical literature, with emphasis given to endocrine and orthopedic concerns. However, as mentioned in the previous section on psychological and psychiatric concerns, the reader must be cautioned that most of the studies done on dwarfism tend to summarize observations made on specific caseloads. As a result, it is difficult to generalize from these studies because they report on discrete types of dwarfism with each population exhibiting unique physiognomies and related psychological expectations. For example, hypopituitary dwarfs, commonly called "midgets" (a term which was made very clear to me that almost all little people consider derogatory and demeaning primarily because it is commonly related to the stereotype of "midget" circus performers, thus it inaccurately labels a large number of dwarfs) may benefit from growth hormone treatment, and possibly achieve normal or near normal height. However, most dwarfs cannot expect to ever increase their height through any known medical knowledge today. This is magnified socially and psychologically even more when one understands that the achondroplastic dwarf is readily identifiable in

society with his clearly non-conforming and disvalued physical characteristics which make his presence receive an onslaught of social scorn. Hypopituitary dwarfs, on the other hand, have a more proportionate body build, making their presence less non-conforming and hence their interaction in public more easily acceptable.

Only within the last fifteen years has physiological and psychological research on growth hormone and dwarfism resulted in recent medical advances which have produced a new interest in and new hope for the dwarfed child. However, few physicians will see more than one or perhaps two dwarfs during their entire career unless the doctor happens to be trained or employed at one of the few clinics in the country that specialize in treating dwarfism.\* As reported to this writer by various staff members of the Moore Clinic of Johns Hopkins Hospital, most physicians know very little about the physical, psychological or social complexities of dwarfism. Several parents of short statured children reported to me that perhaps the most resentful period they had in bringing up their dwarfed child was in the beginning

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\*Apart from the Moore Clinic of Johns Hopkins Hospital in Baltimore, Maryland, only two other clinics specialize in the treatment of short stature, one is located at Los Angeles' Harbor General Hospital and most recently one opened in Philadelphia, PA., at the Thomas Jefferson Hospital.

when no physician ever gave them a correct diagnosis until the child was forced to wear braces. In one case, a mother was told by her physician that after wearing the brace for a specified period of time, the child will then resume a normal growth pattern. Needless to say, he did not, and the results are visibly obvious. Thus, many ill-advised and often tactless statements to a family by an incompetent physician have significantly contributed to the psycho-social problems of their patients and families. With the advent of PACT (Parenting and Counseling Training) many families have been assisted in finding a hospital or clinic in their area that provides medical advice in cases of short stature. Its members also provide emotional support and give parents a realistic view of their child's potential in terms of his or her physical and social development. Also, the Parents Auxiliary of Little People of America provides a similar service. Parents whose new-born child is diagnosed with dwarfism are often referred to LPA and through the Parents Auxiliary members provide ways of helping the couple come to terms with themselves and their short statured child by helping to resolve their feelings of grief or sorrow and assisting them toward a successful

adjustment of acceptance. Other programs similar to these are COPE (Community Outreach Parent Education), ACCEPT (a project based in Baltimore, Maryland that deals primarily with children with Down's Syndrome but also with short statured children), and CONTACT (similar to ACCEPT but its members provide services to the Philadelphia, Delaware and New Jersey area).

### The Medical Dilemma

According to Leslie Fiedler, historically dwarfs were not necessarily seen as having a condition that required a medical cure because they were different from "Freaks" and also their condition was seen more as an act of God. As far back as 1662, they were categorized with Giants and Fat Men and Women as "mirabilia hominum," human marvels, rather than "mirabilia monstorum," monstrous marvels. But it was the 19th century and the invention of a new branch of biology and medicine called "teratology" that dwarfs and midgets, among other human oddities, became the scientific models for the treatment of abnormal growths or monstrosities: "creatures to be shuddered at and treated rather than, however ambivalently, adored."<sup>70</sup> It was not until the Victorian era that medicine began to truly study the numerous variations and conditions of dwarfism, yet major findings have proceeded extremely slow and inconclusively to the point that even today the numerous causes resulting to dwarfism have yet to be totally understood (see Appendix I). Indeed, that there are over 100 different types of dwarfism which differ widely, not only in their external appearance but also in the degree of disability which they may cause,

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<sup>70</sup>Leslie A. Fiedler, Freaks: Myths and Images of the Secret Self. New York: Simon & Schuster, 1978, p. 47.

only compounds the medical problems which may be associated with their inheritance.

The mature human body is the end result of a remarkable growth process that requires almost two decades for completion. Yet, contrary to popular belief, size increase is perhaps the least significant of the many components of human growth. Indeed, the human being at any age is very complex and represents a marvel of specialized tissues and complementary functions, all coordinated to allow continuing integrity of the body as a whole. Fundamental to the growth process is the fact that all body systems must continue to work in concert at every stage of growth. Changes must be timed with exquisite precision, not only to culminate in a unified adult, but also to insure the integration of body activities which is essential at each intermediate point in growth. For this highly complicated process to evolve normally, physiologic systems must come into being in nicely ordered sequence, and they must be synchronized with others already in existence or yet to come.

According to a study done through the National Institutes of Health on Clinical Research Advances in Human Growth and Development,\* much of the clinical

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\*Information was provided by National Institutes of Health, Division of Research Resources, General Clinical Research Centers Branch, Bethesda, Maryland, June, 1973.

research in the United States on the complex process of growth in humans has been conducted in General Clinical Research Centers supported in medical institutions across the nation by the Division of Research Resources of the National Institutes of Health. The General Clinical Research Centers program currently funds 80 research centers in 70 of the nation's research institutions and medical schools. In its ten year history, the General Clinical Research Centers program of the National Institutes of Health has contributed more than \$68 million in Federal funds to clinical research on human growth.

#### Characteristics of Normal Growth

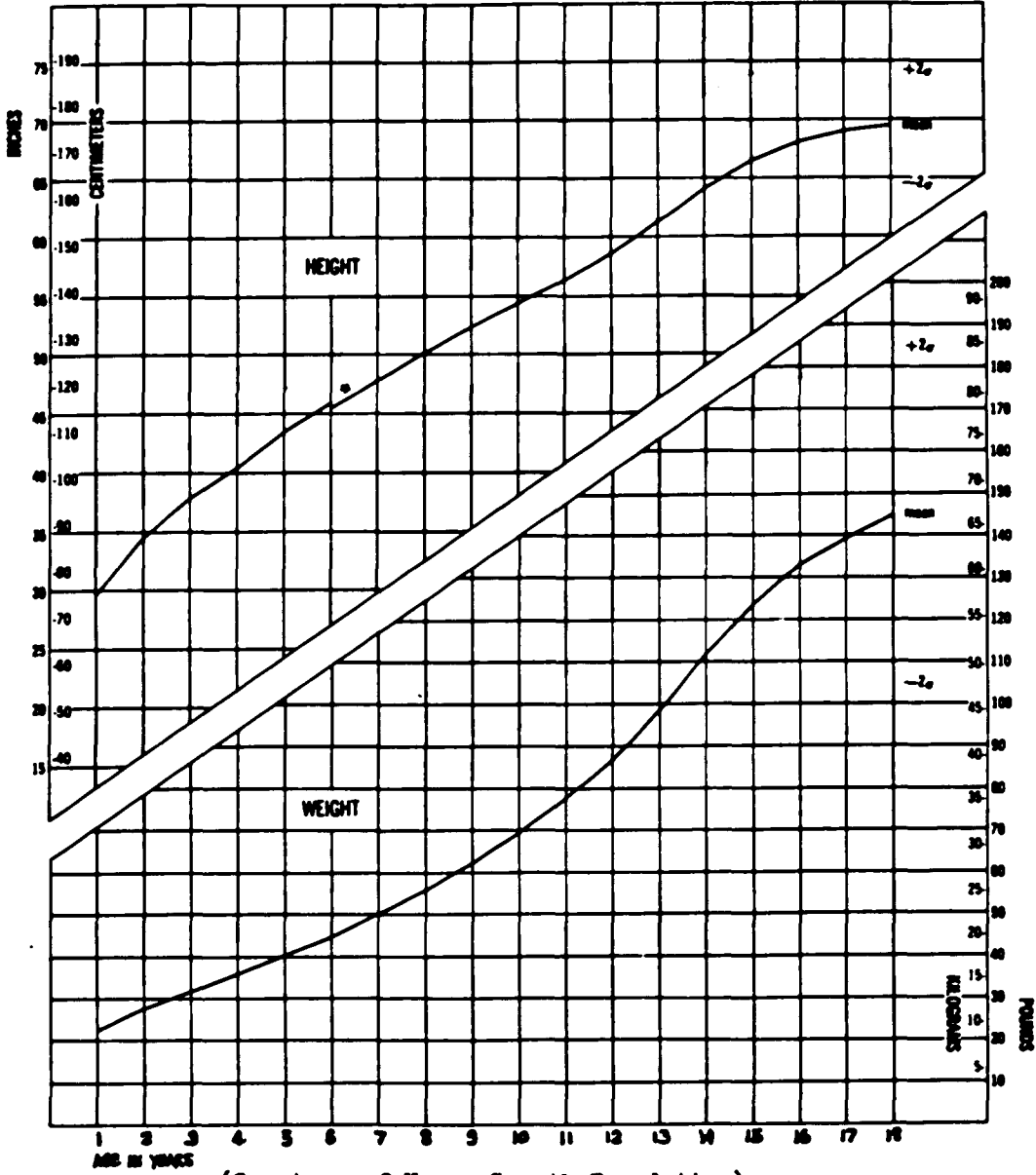
The height a person ultimately reaches is determined in part by the height of the parents, but also by the age of reaching adolescence. Probably one of the simplest gauges of a child's health status is whether inches and pounds are being added according to accepted timetables of normal growth (see Figures 1 and 2). On each standard growth chart (available through the Human Growth Foundation or from almost any physician or hospital) there is shown the average growth rate for boys and girls. By marking a child's height opposite the correct

BOYS / PHYSICAL DEVELOPMENT  
1 TO 18 YEARS

NAME \_\_\_\_\_

(Figure 1)

\*supine length to 6 years, standing height from 6 to 18 years



(Courtesy of Human Growth Foundation)

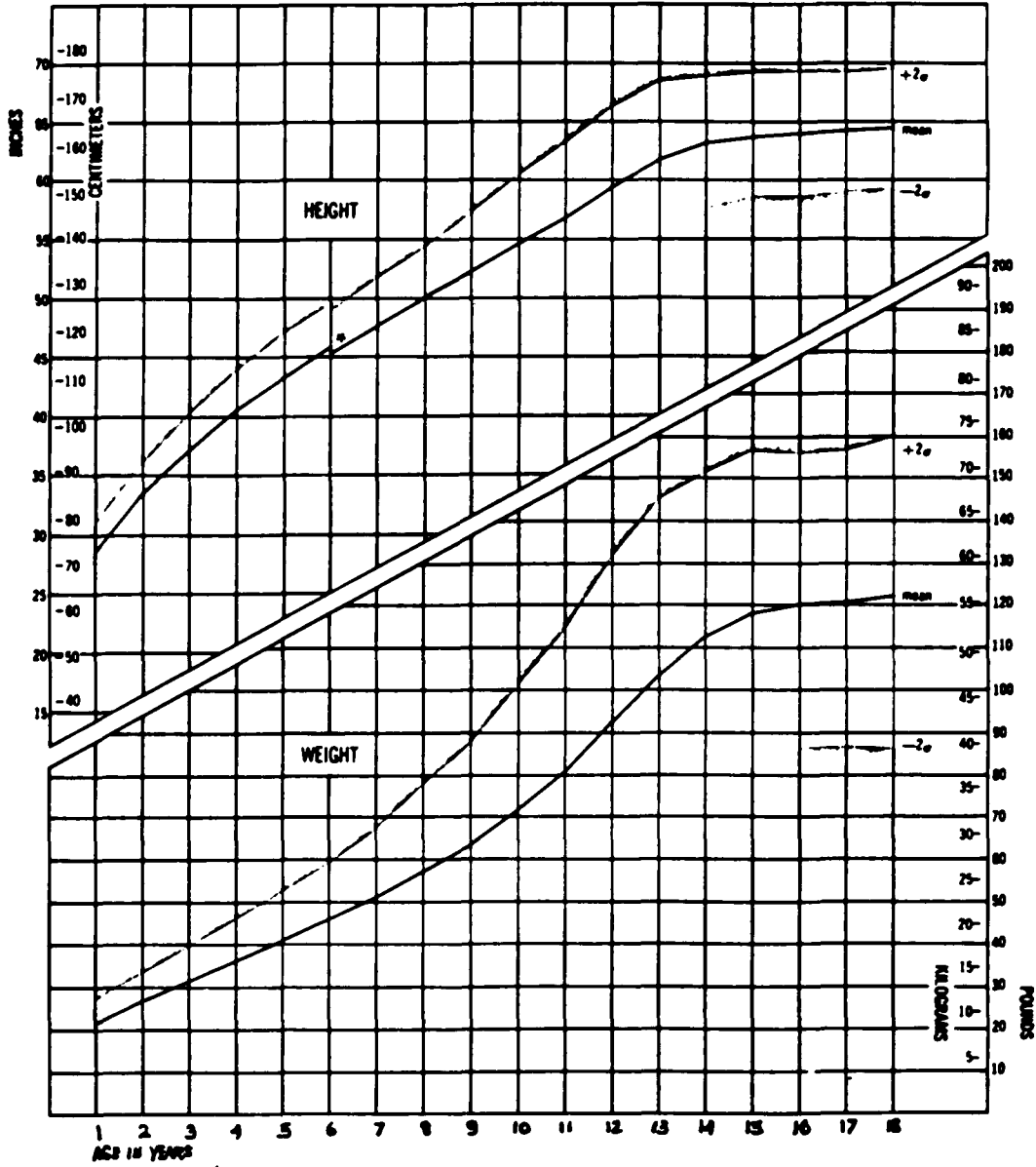
GIRLS / PHYSICAL DEVELOPMENT  
1 TO 18 YEARS

NAME \_\_\_\_\_

(Figure 2)

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\*supine length to 6 years, standing height from 6 to 18 years



(Courtesy of Human Growth Foundation)

age and number of inches or centimeters, a comparison with the average can be made. Hence, if we were to compare the growth rates of boys and girls at about the time of puberty or adolescence, we would find that generally speaking the average adolescent boy is only beginning his growth spurt at age 13. It would also appear to be more intense, and of longer duration than that of a girl. During the next  $2\frac{1}{2}$  years or so, his height is increasing most rapidly at about 3 to 4 inches a year. Between the ages of 12 and 16, he will almost double in weight.

Although there may be some variation between the beginning of the growth spurt in one child and another, the typical girl in the United States now begins puberty at approximately the age of  $10\frac{1}{2}$  years. For the next  $2\frac{1}{2}$  years, she grows at an average annual rate of 3 inches per year. Both boys and girls will show little or no further increase in height by the time they reach age 16 however, girls tend to reach their full growth nearly a year ahead of boys. Hence, this last growth spurt at puberty tends to vary between boys and girls, occurs at different ages, and involves a different number of inches gained. As both the boy's and girl's charts indicate, the older

the ages the more widespread the variation in the normal growth curve. Moreover, these wide differences in male and female average growth rates during adolescence are sometimes difficult to determine, but the age at which this maturation begins largely determines what the ultimate adult height will be.

Once the individual has reached full growth potential, all the cartilage (epiphyses) at the ends of the long bones of the arms and legs (the two most common examples demonstrative of linear growth) have become calcified through ossification, and no further growth of the bone subsequently occurs. This progression of normal growth is usually discussed in terms of two ages: chronological age, timed from the date of birth, and biological age, a measure of the degree of physical maturity of the individual, determined by equating his degree of maturity with the average age at which that degree of maturity normally becomes manifest. X-rays of the bones show what is called "bone age" allowing the physician to estimate whether or not the bones may grow any more. If the bones are growing in a normal, average manner, the biological age and chronological age should be the same.<sup>71</sup>

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<sup>71</sup>R. M. Blizzard and H. S. Sauls, Patterns of Growth. Baltimore, Maryland: Human Growth Foundation, 1976, pp. 3-5.

## Most Frequent Causes of Short Stature<sup>72</sup>

### I. Genetic or Familial Short Stature (see Figure 3)

Variations from the usual pattern of growth occur that are still considered to be within the normal range of growth development. For example, many children are short because they have inherited shortness from their parents, thus making genetic short stature the most prevalent of all types in the United States. Genetically short children normally grow at a constant rate each year, eventually equalling their parent's height. Although their bone age usually corresponds to their chronological age, their growth curve is usually below the average percentile lines.

### II. Constitutional Delayed Growth With Delayed Adolescence

A slightly unusual variation from the normal growth pattern occurs when a child is shorter than average for most of his or her life until adolescence when the growth spurt occurs, but this is usually later than other children. This is called constitutional delayed growth with delayed adolescence, affecting nearly ten times as many boys as girls. Although this pattern of delayed growth and puberty may not begin until age ten or even later, they continue to grow at a slow but normal rate until they reach adolescence sometimes as much as three to four years after

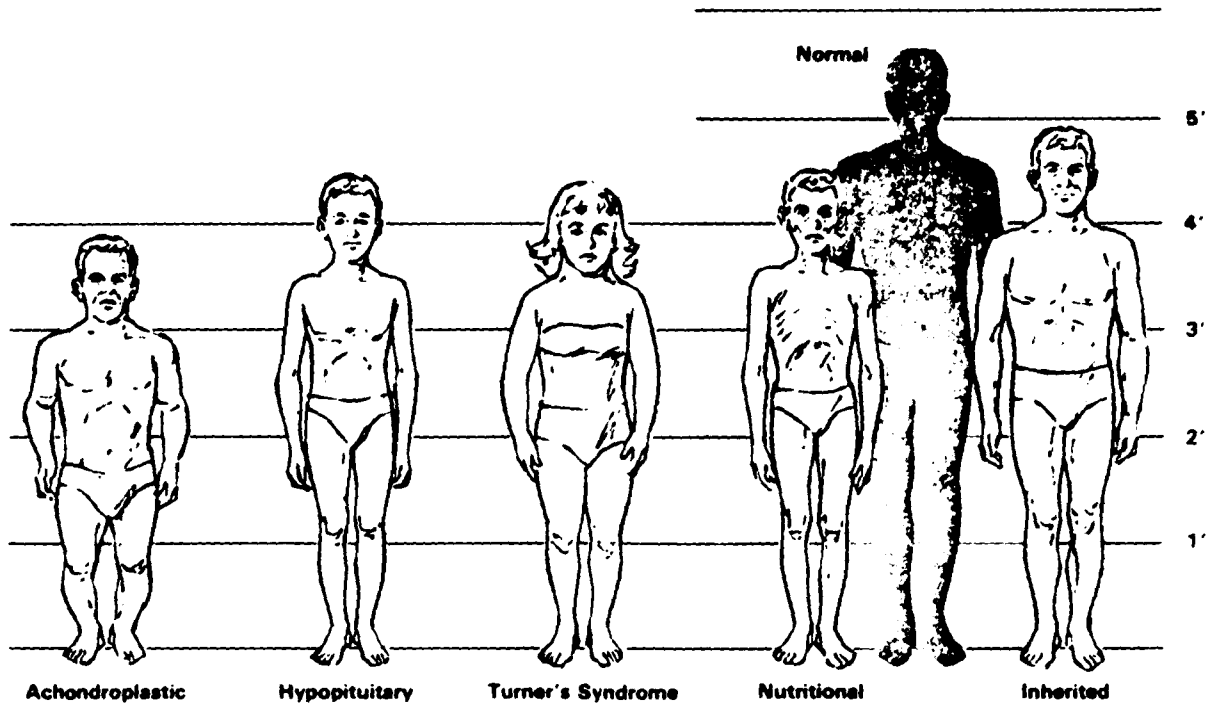
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<sup>72</sup>Blizzard and Sauls, pp. 5-18.

(Figure 3)

Patterns of Abnormal vs Normal Growth  
(Courtesy of Human Growth Foundation)

*A comparison of 18 year old dwarfs with a normal person of the same age.*



their age mates. Finally, they have a normal growth spurt and usually end up being as tall as their parents. This pattern of growth is strongly influenced by the height of the parents and by their growth pattern experiences (e.g., either the mother or the father may have experienced delayed puberty as well).<sup>73</sup> Needless to say, such information can be of great help in reassuring and allaying the fears of the short boy who is afraid he is not growing enough or the tall girl who thinks she will be a giant.<sup>74</sup> Some endocrine (gland) specialists prescribe female hormones for the girl whose prediction of adult height indicates she will be too tall. These hormones push the girl into adolescence at an early age. They act on the growing ends of the bones to speed up final growth, calcium deposition and formation of adult bone, so that the girl ends up shorter than she otherwise would have been.

Unlike the girls, adolescent boys are primarily concerned that they may not grow tall enough. Since most boys who are short in the early teenage years will eventually, if slowly, reach normal adult height, growth experts are less likely to intervene in their growth than in the case of girls who are growing too tall. However,

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<sup>73</sup>F. Dudley Hart (ed.), French's Index of Differential Diagnosis. 11th ed., Chicago, Illinois: Yearbook Medical Publishers, 1979, p. 218.

<sup>74</sup>John H. Gagnon, Human Sexualities. Glenview, Illinois: Scott, Foresman and Company, 1977, pp. 97-114.

if the boy is severely disturbed by his temporary short stature, some physicians will prescribe male hormones (androgens) to hasten his sexual maturation and, thereby, his growth spurt. The time at which androgens are utilized to promote growth is important, just as it is for the girl who is feared will be too tall, because at the same time that the hormones promote growth, they also begin to stimulate the closing of the epiphyses (normally referred to as epiphyseal closure) making taller growth impossible. If sexual maturation proceeds too rapidly, epiphyseal closure may occur prematurely, and the adolescent may be deprived of the ultimate height he would have reached had his intrinsic chronology of growth been realized without intervention.

Apart from the utilization of growth hormones prescribed by a physician to promote a faster growth spurt, heredity then clearly plays the major role biologically in determining whether an individual will mature sexually at an early age or at a later one. In essence, heredity can either delay biological age and therefore growth in the short teenager, or it can usher a tall teenager into puberty at an early age. The term "precocious puberty"<sup>75</sup> is used to describe this growth

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<sup>75</sup>R. Berkow (ed.), The Merck Manual of Diagnosis and Therapy. 13th ed., Rahway, New Jersey: Merck Sharp & Dohme Publishing, 1977, pp. 1288-89.

pattern, which includes the early maturation of sexual characteristics. In this condition, a girl may develop secondary sexual characteristics before the age of 8, or a boy before he is 10. Since sexual maturation tends to promote closure of the epiphyses, precocious puberty results in epiphyses closed before true potential height is realized and an early tendency for boys to exhibit aggressive behavior, while girls present an unusually active sex drive. This early onset of adolescence has been found to sometimes originate in a tumor of the ovary, adrenal, pituitary or hypothalamus region of the brain, which in turn, may prematurely cause the hormones of puberty to surge and produce this sexual precocity. Removal of the tumor or treatment of the hormonal condition will usually interrupt the rapid sexual maturation.<sup>76</sup>

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<sup>76</sup>For an early description, see C. P. Emerson, Physical Diagnosis. Philadelphia, PA: J. B. Lippincott, 1929, p. 19; also, see H. P. G. Seckel, "Precocious Sexual Development in Children." Medical Clinics of North America, (1946) 183-210; H. Jolly, Sexual Precocity. Springfield, Illinois: C. C. Thomas, Publishers, 1955; J. Thamdrup, Precocious Sexual Development. Munksgaard, Copenhagen, 1961; R. R. David, "The Endocrine Control of Growth." Medical Clinics of North America 47 (1963), 143-57.

### III. Secondary Growth Failure

There are several diseases and disorders that cause short stature, and which occur because of the presence or absence of a body substance vital in the control of growth. Any chronic debilitating illness which disrupts the careful synchrony of body activities and the efficient utilization of energy will likely disrupt or retard normal growth processes. Some disorders slow proportionately the entire growth process. Congenital deficiency of human growth hormone produces a form of dwarfism in which a normally proportioned small adult results (hypopituitarism). Other disorders affect only one component of growth, making it disharmonious to the overall growth process, for example, the prematurely fusing of the growing ends of bones (epiphyses) will permanently shorten one or more affected limbs.

Some conditions produce many adverse effects on growth by compromising the ability of the body to function at different levels of capacity, namely when the body fails to absorb or utilize nutrients due to endocrine dysfunction, inborn errors of metabolism, severe infection, or degenerative disease.<sup>77</sup> In other words, cases of chronic diarrhea, congenital physical obstruction of the esophagus,

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<sup>77</sup>Berkow, op. cit., p. 1147.

ineffective swallowing reflexes due to prematurity, or a host of other difficulties that prevent the proper intake and intestinal absorption of food, can frequently be the major cause of growth retardation.

Some diseases, such as severe asthma, kidney disease or arthritis, are treated with large doses of cortisone, and it is this drug that suppresses growth hormone action on bones and tissues. Treatment for other diseases, such as liver disease, diabetes insipidus and mellitus, also results in retarding the growth process. Thus, growth retardation may result as a secondary effect of the treatment of a serious disease.

#### IV. Nutritional Short Stature

Childhood deficiency of any of the many known vitamins and minerals can lead to serious distortions in growth.<sup>78</sup> For example, Vitamin-A deficiency thickens the long bones of a growing child and will lead to growth retardation. Without Vitamin-C, the body's cells cannot produce enough soft tissue for the making of cartilage; hence, calcification of the bones is impeded or retarded. Vitamin-D is required for the uptake of calcium from the intestine and is needed for the adequate mineralization of growing bone. Its absence in the diet gives rise to

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<sup>78</sup>Berkow, pp. 1149-57; also, see J. Zahorsky, Synopsis of Pediatrics. 3rd ed., St. Louis, MO: C.V. Mosby, 1939, pp. 105-23.

rickets - a disease characterized by soft bones, bowed legs, and cartilage that fails to mineralize adequately. Some children have a lowered response to Vitamin-D so that even though they may be receiving adequate amounts in their diets, their bodies react as though there were a deficiency. The most common form of this disorder is an inherited disease called Vitamin-D-resistant rickets. But perhaps the most common nutritional deficiency of all, and found throughout the world, is the chronic lack of protein in the diet, called kwashiorkor, causing severe growth retardation.

#### V. Intrauterine Slow Growth (Prenatal Growth Failure)

Until recently, all infants weighing less than 5½ lbs. at birth were automatically classified as "premature," and their postnatal conditions were evaluated and treated according to the same guidelines of care. However, physicians are recognizing increasingly that intrauterine growth retardation, not prematurity, may account for one-third to one-half of all low-weight newborns. The distinction is of paramount importance in providing the appropriate postnatal care.

Some of the conditions held to explain why this low birth weight occurs are: maternal cigarette smoking, exposure to high altitudes, the ingestion of certain drugs

by the mother producing a highly toxic blood chemistry, maternal high blood pressure and chronic vascular disease in the mother, or fetal infection from viruses such as German measles, and chronic maternal malnutrition. Special concern is given to mothers who consume large quantities of alcohol during pregnancy because they show an especially high risk of producing infants with severe intrauterine growth retardation and malformations (the fetal alcohol syndrome).<sup>79</sup>

It is not clear whether low birth weight babies can ultimately reach their inherited potential height, but among those babies who have no other congenital problems, most seem to develop into miniature adults, normal in every way except size.

#### VI. Thyroid Hormone Deficiency

The glands that manufacture hormones which control growth may occasionally be disordered and incapable of producing adequate amounts of hormone. This may lead to hormonal deficiencies which cause short stature. A deficiency of thyroid hormone, which may begin at any time after birth, is known as hypothyroidism.<sup>80</sup> In rare instances, the disorder can start during the prenatal

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<sup>79</sup>Berkow, op. cit., p. 1097.

<sup>80</sup>Ibid., pp. 1254-60; R. R. David, op. cit., pp. 144, 151-54; and Herbert A. Selenkow, "Thyroid problems during adolescence." Medical Clinics of North America 49 (1965), 325-38.

period if fetal thyroid tissue develops inadequately during pregnancy, severely retarding the newborn both intellectually and physically. Although such congenitally deficient children, known as "cretins," have a good chance of attaining normal stature if thyroid therapy is instituted at the time of birth, only a small number are ever able to attain normal mental capacity. Today, a pregnant woman who is expected to give birth to a cretinous child (which can now be determined by a laboratory test which measures the biochemical analysis of hormones, called radioimmunoassay) is given massive doses of one of the thyroid hormones. For normal growth to occur, the child must continue to receive the hormone throughout life.

For unknown reasons, a growing child with hypothyroidism has excessively large cells and, therefore, a reduced number of cells for his body size. He consequently grows at one-half the normal rate, and if the condition remains untreated, he can develop all the symptoms of cretinism. In an affected child, treatment with thyroxine (the hormone secreted by the thyroid gland) restores cell size to normal and increases growth to three times the pre-treatment rate until his size again approximates that normal for his age. However, thyroxine alone

is not always sufficient enough to promote normal growth. Some hypopituitary dwarfs lack sufficient quantities of both thyroxine and human growth hormone. They will grow only if thyroxine is administered concomitantly with HGH.

## VII. Chromosomal Disorders

Chromosomal disorders take the form of some abnormality or abnormalities of chromosomal replication, the result of which is a loss of or an addition to the number or parts of chromosomes, or an abnormal arrangement of the chromosomes. Chromosomes are the thin rod-like strands of material found in the nucleus of each cell. Within these thin rods are the genes - the basic units of heredity - which give each of us our individual characteristics. Each normal cell nucleus has 22 distinct pairs of chromosomes called autosomes (responsible for the individual characteristics in each person and which do not play a role in sex determination). In addition, there is a pair of sex chromosomes designated as XX for a female and XY for a male. This makes a total of 23 pairs, or 46 chromosomes in each cell. One chromosome of each of the pairs in one's body comes from the father and one from the mother.

The pair of sex chromosomes (XX) of the female contain numerous genes, some of which are specifically re-

sponsible for promoting a female's stature and for developing her ovaries, which in turn produce the sex chromosomes necessary for the development of adult female bodies. When there is only one complete X chromosome (written as 45,X0), many of the genes which are normally responsible for producing normal height and for producing functioning ovaries are missing, indicating that this female has Turner's Syndrome (also known as chromosomal ovarian dysgenesis or gonadal dysgenesis).<sup>81</sup> Sometimes the sex chromosome is missing from the sperm and sometimes from the ovum. There seems to be no way to predict when this will happen or why, and there is nothing either parent could have done at the time of conception that might have prevented this sex chromosome omission.

Girls with Turner's syndrome are shorter than their peers, have normal proportions, and reach an average adult height of about 4½ feet although some reach as much as 4 feet 11 inches.<sup>82</sup> During the teenage years, breasts fail to develop and menstrual bleeding does not occur unless treated with the proper hormones. Despite a missing or misshapen chromosome, underdeveloped ovaries, and poor bone growth, the other organs of the body function well, although some girls with Turner's syndrome are more

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<sup>81</sup>Thomas Aceto and Anke Ehrhardt, Turner's Syndrome. Baltimore, Maryland: Human Growth Foundation, 1974, pp. 2-3.

<sup>82</sup>Diane Plumridge, Good Things Come in Small Packages. Eugene, Oregon: University of Oregon Press, 1976, p. 9.

commonly prone to a few medical problems than are other females.<sup>83</sup> If these conditions are detected early they can usually be prevented from becoming serious. Medical problems may include; Renal disease (kidney problems are found in nearly 70-80% of all girls with Turner's syndrome), Heart disease (heart problems apparent at birth are found in about 20-50% of girls with Turner's syndrome, usually occurring before the XO problem is diagnosed). Naturally, there are some orthopedic difficulties associated with the short stature and hence, growth delay in some of the bones, but there is usually little or no deformity in the skeleton, as are the joints near normal in motion. Weight problems are associated with almost all girls with Turner's syndrome, primarily because of their height. Consequently, careful diet regimens are strongly advised and are normally always adhered to since excess weight contributes to a tendency towards Diabetes which is also associated with this syndrome. One symptom that usually does not occur with Turner's syndrome is mental retardation. Sometimes Turner's and Down's syndrome are confused, because both are caused by chromosomal abnormalities, but children with Down's syndrome (mongoloids) are

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<sup>83</sup>Plumridge, pp. 14-16.

severely retarded and the degree of mental retardation is usually more severe in autosomal aberrations and milder in sex-chromosome aberrations.<sup>84</sup> Girls with Turner's syndrome have an intellectual capacity that falls in the normal range; that is, from very bright to mentally retarded, just like the rest of the population. However, they often have slight difficulty in visualizing objects in relation to one another, thus their non-verbal IQ is often lower than their verbal IQ. Interestingly, this phenomenon of lower non-verbal IQ showing up as problems with mathematical ability, sense of direction, and manual dexterity, has been found to occur in the general population more often in women than in men.<sup>85</sup> Lastly, girls with Turner's syndrome can develop normal sexual characteristics with the administration of female sex hormones (estrogen and progesterone). Within several months, breasts will develop, hips will broaden and menstruation will begin, allowing the female to have normal sex relations but not allowing her to conceive children.

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<sup>84</sup>A. M. Freedman et al (eds.), Comprehensive Textbook of Psychiatry. Volume 1, 2nd Edition, Baltimore, Maryland: Williams and Wilkins Company, 1976, p. 1167.

<sup>85</sup>Plumridge, op. cit., p. 16.

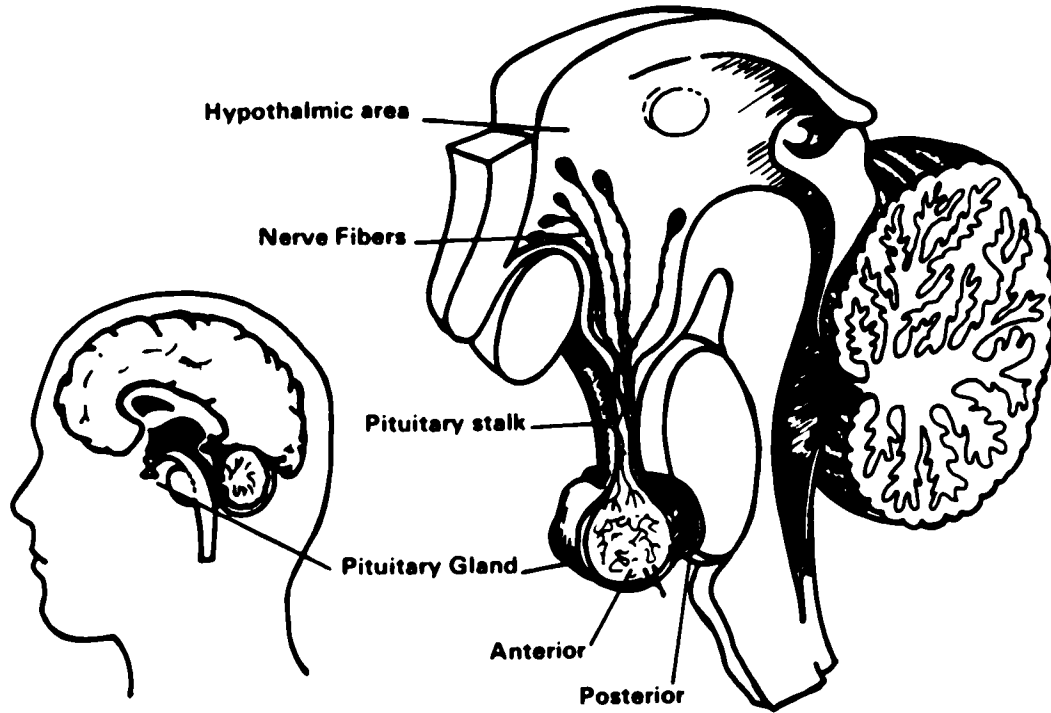
### VIII. Growth Hormone and the Pituitary Gland

Interaction of the hormones produced by the various endocrine glands in the body constitutes an important chemical control system for major body activities. Although synchronized activity of all hormones in the body is necessary for appropriate patterns of growth, the secretion of human growth hormone (HGH) from the pituitary gland is presently considered as fundamental to normal growth processes.<sup>86</sup> The pituitary gland is considered the "master gland," because it produces a variety of hormones that direct the functions of other glands in the body as well. It is located in the middle of the skull below a portion of the brain called the hypothalamus (see Figure 4). The anterior (front) portion of the pituitary gland produces hormones regulating growth. The posterior (rear) portion of the pituitary gland also secretes hormones but these do not directly affect the growth process.

Growth hormone is the primary pituitary hormone directly promoting growth, although other hormones affect the growth processes. The other anterior pituitary hormones work through other glands to cause their specific effects (see Figure 5). These include:

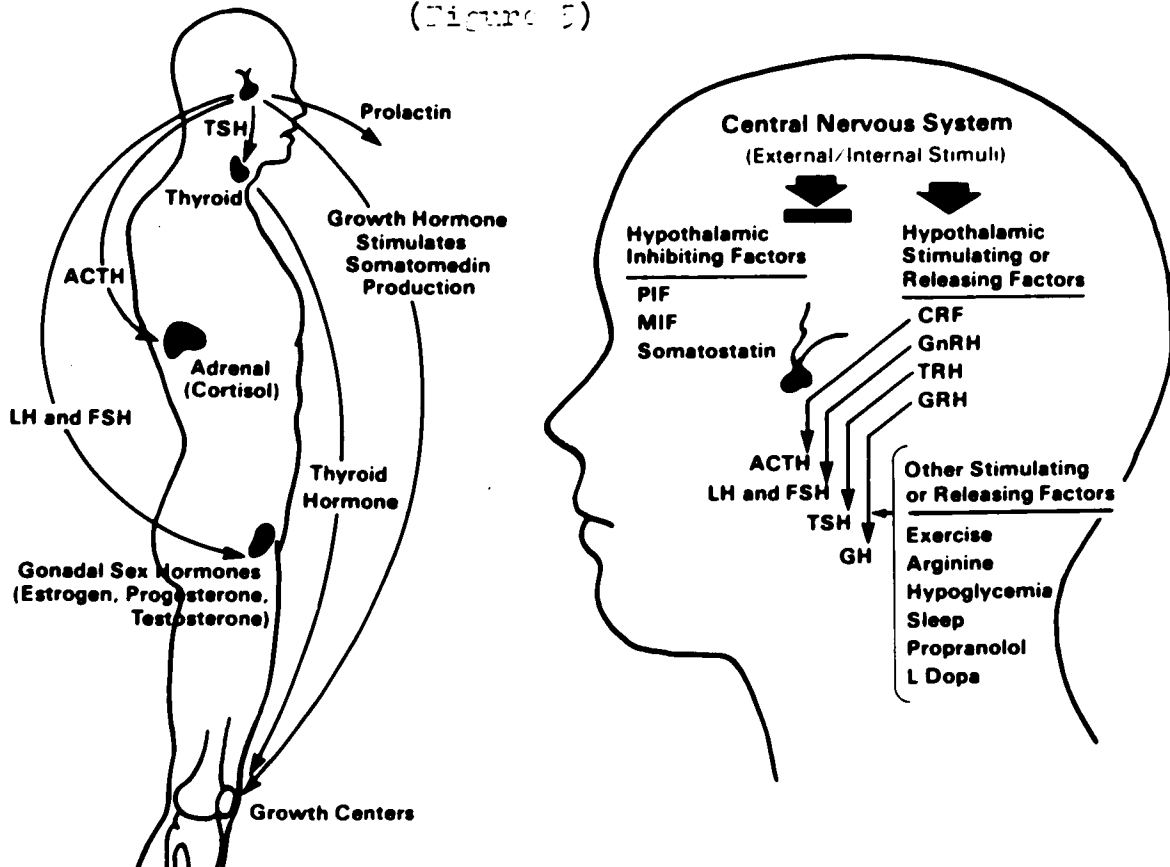
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<sup>86</sup>Berkow, op. cit., pp. 1246-50; R. P. Owens and A. W. Root, Growth Hormone Deficiency. Baltimore, Maryland: Human Growth Foundation, 1979, pp. 1-14.



(Both Charts courtesy of Human Growth Foundation)

(Figure 5)



Thyroid Stimulating Hormone (TSH) - causing thyroid hormone secretion by the thyroid gland.

Adrenocorticotrophic Hormone (ACTH) - causing hydrocortisone and other hormone production by the adrenal gland.

Luteinizing Hormone (LH) and Follicle Stimulating Hormone (FSH) causing production of sex hormones by the ovaries or the testes, which are necessary for normal adolescent sexual maturation. And lastly, Prolactin - which causes production of breast milk by the nursing mother.

Deficiency of any of the above hormones can retard a child's growth causing hypopituitarism. Many defects in human growth hormone secretion have long been recognized clinically by the disordered growth patterns they produce. The most important developmental characteristic of the hypopituitary dwarf is that while he usually is normal size at birth, and may grow normally for the first two or three years of life, he rarely grows more than  $1\frac{1}{2}$  inches a year after the age of three. His growth, however, is proportionate, and there are no deforming or unusual features. Intelligence is unaffected, and appetite is normal for size.

Radioimmunoassay tests\* have indicated that growth hormone deficiency in hypopituitary dwarfs may actually

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\*This test, developed in the early 1960's, has proven extremely valuable in measuring the amount of or absence of in body fluids, one thousandth the biochemical analysis of a hormone in the blood. Radioimmunoassay has demonstrated that HGH has been identified in fetal blood as early as 15 weeks after conception.

begin in the first few months of life. In some instances, the insufficiency stems from a tumor in, or an injury to, the pituitary gland. In most cases, however, the reason for the low HGH production by the pituitary is completely unknown. Also unknown is why hypopituitary dwarfism is twice as common among boys as among girls, and why it is frequently accompanied by delayed sexual maturation.

During the late 1950's, scientists discovered that injections of growth hormone extracted from monkey pituitary glands increased the rate of growth of hypopituitary dwarfs.<sup>87</sup> The amount obtainable from monkey pituitaries was so minute, however, that a new method of extracting the hormone from the pituitary glands of human cadavers was developed. Since 1958, human growth hormone has been used in the treatment of an estimated 2,000 hypopituitary dwarfs. However, because of its scarcity, priority for treatment is highest in the older child whose epiphyses are near closure; once epiphyses are closed, growth cannot be resumed by any known means. Also, in order that the limited supply of HGH may be allocated to the maximum number of affected children, therapy must usually be discontinued once a child is brought up to the height of 5 feet 6 inches.

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<sup>87</sup>C. H. Li and H. Papkoff, "Preparation and properties of growth hormone from human and monkey pituitary glands." Science 124 (1956), 1293-94.

For most hypopituitary children, the availability of HGH therapy has made a significant difference in physical growth and emotional adjustment. When successful, HGH replacement has meant the difference between marked physical atypicality and acceptable short stature.<sup>88</sup> Today, although there have been many setbacks, ongoing research to synthesize growth hormone and a search for other mechanisms to stimulate growth hormone production are currently being conducted. Most recently, scientists have produced strains of bacteria that genetically are engineered to produce large quantities of human growth hormone.<sup>89</sup> Another group of researchers see a role for a specific steroid called oxandrolone in the treatment of children with growth hormone deficits.<sup>90</sup> The authors suggest that by speeding growth rates per unit of HGH, they believe the combination of HGH and oxandrolone could correct the stunting effect more rapidly than with the administration of HGH alone.

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<sup>88</sup>See, Rotnem et al., loc. cit.; M. Kusalic and C. Fortin, "Growth hormone treatment in hypopituitary dwarfs." Canadian Psychiatric Association Journal 20 (1975), 325-31; J. Brasel and R. M. Blizzard, "The influence of the endocrine glands upon growth and development," in R. H. Williams (ed.), Textbook of Endocrinology. Philadelphia, PA: W. B. Saunders, 1974, pp. 1030-58; S. D. Frasier, "A review of growth hormone stimulation tests in children." Pediatrics 53 (1974), 568-81.

<sup>89</sup>See especially, Daily News, "Help for hopelessly short," (July 16, 1981); New York Times, "Human Growth Hormone made by bacteria: Tests in patients next step in several diseases," (January 6, 1981); and New York Times, "Human Growth Hormone is produced in Laboratory," (July 17, 1979).

<sup>90</sup>See, Medical World News, "Growth-hormone dose may be cut when reinforced by a steroid," (March 2, 1981), pp. 11-12.

### III. Bone Diseases

In recent years medical research has learned that there are over 70 different bone dysplasias (disorders), more commonly referred to as chondrodystrophies, that result in short stature, and that most are inheritable.<sup>91</sup> Achondroplasia is the best known and most common form, affecting about one child in every 40,000 births. It is one of the oldest birth defects known to man, and although much research has determined how it is inherited and how the disturbance of cartilage growth affects the ossification of virtually all of the bones in the body, there is no known cure for this disease.

An individual with achondroplasia has disproportionate short stature: the body size is essentially normal, the head is large and the arms and legs are short when compared to the body length. This shortness is particularly noticeable in the upper arms and thighs. Other signs are a prominent forehead, a flat or even depressed area at the base of the nose, a protruding jaw and poor dental structure - the teeth are crowded and the upper teeth are poorly aligned with the lower. In addition, the achondroplastic dwarf tends to have a straight upper spine with an exaggerated forward curve (lumbar lordosis)

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<sup>91</sup>David W. Smith, "Recognizable Patterns of Human Malformation: Genetic, Embryologic and Clinical Aspects," in A. J. Schaffer (Consulting editor), Major Problems in Clinical Pediatrics. Philadelphia, PA: W. B. Saunders Company, 1976, pp. 197-353.

or swayback appearance to the lower spine. His legs are almost always bowed and the elbows are usually enlarged, thus the arms cannot be straightened completely and sometimes the person has limited twisting ability in his elbows. The hands are short and the fingers stubby, while his feet are generally short, broad and flat. Loose jointedness may be present due to lax ligaments which ultimately contribute to their bowleggedness. Intelligence is normal. However, early motor progress may be slow due to delay in head control, short limbs and hypotonia (reduction in muscle tone) which usually abates around two years of age.<sup>92</sup>

The achondroplast seems predisposed to various physical complications including: a tendency toward middle ear infections in the first five or six years of life, probably due to the abnormal drainage angle of the tube from the middle ear to the throat; dental problems caused by overcrowding of teeth may occur requiring orthodontic bracing; and although the achondroplast's abnormally large head is often confused with hydrocephalus (excessive water on the brain), in achondroplasia, hydrocephalus may develop, but it rarely requires surgical treatment. If the child's bowleggedness is severe, braces and/or

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<sup>92</sup>Berkow, op. cit., p. 1031; Charles I. Scott, Achondroplasia. Baltimore, Maryland: Human Growth Foundation, 1975, pp. 3-13; Zahorsky, op. cit., pp. 125-35.

orthopedic surgery may be of benefit, but not all achondroplastic children require such extreme treatment.<sup>93</sup>

The mode of inheritance of achondroplasia is through a single dominant gene transmitted to the child, even though in nine out of ten cases, neither of the parents shows the dominant characteristic. When two average-size parents have a dwarfed child, the medical cause is a chemical change (mutation) in one gene from one of the parents. Its cause, and from which parent the mutated gene originated, cannot be determined. Thus, this chance occurrence of a very rare genetic event, a new mutation, is thought to be the cause of someone inheriting achondroplasia in over 80% of the cases, the majority having average-size, unaffected parents and siblings and no family history of dwarfism.<sup>94</sup> By the same token, the parent with achondroplasia runs a 50% risk that any given pregnancy will result in a dwarfed child. The risks are summarized as follows:

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<sup>93</sup>S. E. Kopits, "Orthopedic complications of dwarfism." Clinical Orthopedics 114 (1976), 153-79.

<sup>94</sup>Charles I. Scott, "Achondroplastic and hypochondroplastic dwarfism." Clinical Orthopedics 114 (1976), 18-30.

My spouse and I do not have short stature.

We have a child with achondroplasia.

risk

What is the probability that our next baby will have  
this condition? . . . . . 0%

What is the probability that our unaffected children will have  
offspring with this disorder? . . . . . 0%

I have achondroplasia but my spouse does not.

We have a child who is of average height.

What is the probability that this child will have children  
with achondroplasia? . . . . . 0%

What is the probability that our next child will have  
achondroplasia? . . . . . 50%

What is the probability that our next child will not  
have achondroplasia? . . . . . 50%

My spouse and I both have achondroplasia.

What is the probability that our children will inherit  
this condition? . . . . . 75%

What is the probability that we will have a child of  
average stature? . . . . . 25%

("Risk" chart courtesy of Human Growth Foundation,  
from "Achondroplasia" by Charles I. Scott, copy-  
right, 1975)

The genetic pattern of dominant inheritance also occurs in many other types of chondrodystrophies. One is hypochondroplasia, which resembles achondroplasia but the features are much milder. The head and face are not involved and the hands only slightly, but the limbs are slightly disproportionate. Adult height ranges from 52 to 58 inches. The severity of the condition is quite variable and many cases are overlooked or mislabeled as

being a result of normal genetic short stature. Another rare bone disorder but one that is inherited through a recessive gene pattern with a 25% risk of recurrence in siblings of affected individuals, is diastrophic dysplasia. Recognizable at birth, one of its major symptoms that sets it apart is severe club feet. Also, cleft palate is present in 25% of these cases, along with external and middle ear deformities which commonly lead to impaired hearing.

The above conditions and others related to them affect primarily the limbs more than the trunk; other disorders cause shortening of the trunk with relatively long limbs. Spondyloepiphyseal dysplasia (SED congenita) is a rare disorder that can be detected at birth; it is a form of short-trunk dwarfism. This condition may give very extreme growth restriction, often with spinal curvature. In the adult with SED congenita, osteoarthritis (a degenerative joint disease of unknown cause) may develop in the weight-bearing joints - e.g., the ankle, the knee or the hip - and back-pains may be a problem. Early signs of cervical cord compression and myopia occur in 50% of these conditions. SED (tarda) is described as a late onset type of spondyloepiphyseal dysplasia, not

appearing until late childhood and confined to males alone - i.e., "sex-linked" inheritance. SED tarda primarily involves growth restriction by a shortening of the spine.<sup>95</sup>

Almost without exception, dwarfed women must deliver a child through Caesarean section.<sup>96</sup> Many though not all women with conditions causing short stature are normally fertile and able to bear children. In general, pregnancy does not cause any deterioration in normal health, nor does it carry any special hazards; the problem seems to lie in the genetic risks which vary with the type of dwarfism.

For many short statured women who do not want to become pregnant, birth control measures prove to be extremely problematic and leave few options available. For example, the diaphragm cannot be properly inserted by some short statured women because their limbs and fingers are simply not long enough to reach up inside the vagina to place it properly. The intrauterine device is also a problem because of the malformation of the uterus. The "pill" cannot be used effectively without considerable

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<sup>95</sup>V. A. McKusick, Heritable Disorders of Connective Tissue. St. Louis, Missouri: C. V. Mosby Company, 1972, pp. 750-801.

<sup>96</sup>J. E. Tyson et al., "Obstetric and gynecologic considerations of dwarfism." American Journal of Obstetrics and Gynecology 108 (1970), 688-704.

side effects and contraindications since the dosage is normally regimented for an average-size woman. Consequently, any barrier method followed by foam is normally recommended for short statured women as a technique of birth control.

Almost all of the approximately 100,000 severely short statured people in this country are disproportionate in body build, as opposed to proportionate short stature which is caused by such conditions as hypopituitarism, hypothyroidism, intra-uterine growth retardation, malabsorption and other nutritional problems, constitutional delayed growth and Turner's syndrome. For most children who are diagnosed early enough with any of the latter conditions, there is now hope and treatment that will allow them to grow taller. However, for those thousands of little people with bone disorders, there is no present treatment that might allow them to grow much higher than 4 feet and a few inches. What does this imply about life expectancy? Some forms of dwarfism are lethal near birth, and some preclude a long life. Fortunately, as the most common form of over seventy different types of chondrodystrophy, achondroplasia is well tolerated and is not often a cause of death. The two bone diseases

that are characteristically associated with shortened life expectancy are Osteogenesis Imperfecta (OI) and Mucopolysaccharidoses (MPS).

The "brittle bone" disease (osteogenesis imperfecta) is a disease of the connective tissue characterized by extremely fragile bones.<sup>97</sup> It can be inherited from an affected parent or, through gene mutation, an OI child can be born to parents with no recognizable signs of the disease. Some infants are born with fractures; others experience their first fracture months or even years later. Many infants with "brittle bones" do not survive birth, while others die within the first year. Those who do survive often live with the daily threat of pain due to fractures, crippling bone deformities, corroding teeth, stunted growth, and deafness. Often, they spend their lives confined to a wheelchair or bed. The OI patient generally shows above average intelligence, despite educational difficulties derived from the pain and crippling caused by the disease. There is no early detection and no cure for the disease. Composed of families with affected members and other concerned individuals, Osteogenesis Imperfecta, National Capital Area, Inc. (OI-NCA), is dedicated to finding means for

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<sup>97</sup>Berkow, op. cit., p. 1031; McKusick, op. cit., pp. 390-454.

detecting, preventing, treating, and ultimately curing the "brittle bone" disease. Today, through the efforts of OI-NCA, a clinic has been established at Children's Hospital National Medical Center (Washington, D.C.) where OI patients and their families receive comprehensive medical care. In the Washington, D.C. area alone, OI-NCA estimates that there are nearly 200 families affected by OI. Ongoing research to identify the clinical signs of OI is being conducted by the National Institutes of Health to better understand this morbid disease that strikes any race, creed or color, and is estimated to affect between 30-40,000 Americans.\*

Mucopolysaccharidoses (MPS) is the name given to a group of extremely rare hereditary diseases caused by particular enzyme deficiencies and ranging in severity from strictly bone and joint involvement to massive complications in all organ systems.<sup>98</sup> Collectively, there is about one affected birth in 25,000. There are probably a few thousand cases in the entire country.

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\*The source for this information was made possible to the writer by the OI-NCA, Inc, National Capital Chapter, which operates under the auspices of the Public Service Committee, Public Relations Society of America.

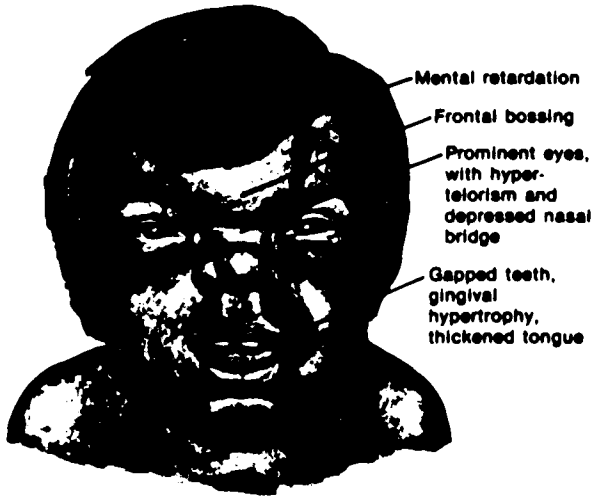
<sup>98</sup>Berkow, op. cit., pp. 1381-82; McKusick, op. cit., pp. 528-48; see also, V. A. McKusick et al., "The mucopolysaccharide storage diseases," in J. B. Stanbury et al., (eds.), Metabolic Basis of Inherited Disease. 4th ed., New York, New York: McGraw-Hill, 1978, pp. 1282-1307.

Perhaps the most common and therefore classic mucopolysaccharidosis is the Hurler Syndrome. Children with this disorder appear normal at birth and develop normally for several months, but then begin to deteriorate progressively. During the first year, an increasingly grotesque appearance develops. The striking alterations in the individual's morphogenesis (the developmental changes that occur in the shape and organization of the body and its parts), once led to their being referred to as "gargoyles" (see Figure 6). The features become coarse, and the head enlarges, with prominent eyes and a depressed nasal bridge. The lips and tongue are large and thickened while the low hairline and bushy eyebrows become hallmark features of Hurler's syndrome leading to complete mental regression. Individual's with Hurler's are generally very short with marked kyphosis (increased convexity of the spine backward). The joints become stiff, and mobility may be severely limited. Eventually, cardiac complications become a prominent feature causing valvular disease and congestive failure. There is no effective therapy for Hurler's syndrome, and the individual usually does not survive beyond the first ten years, dying of

(Figure 3)  
(Courtesy of Clinical Synopsis, 1954)

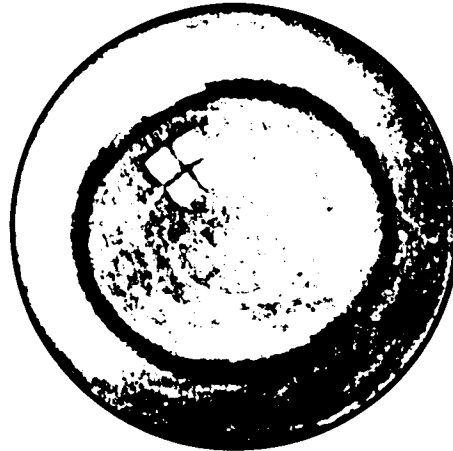
Plate 12

**Mucopolysaccharidoses—Signs and Symptoms**

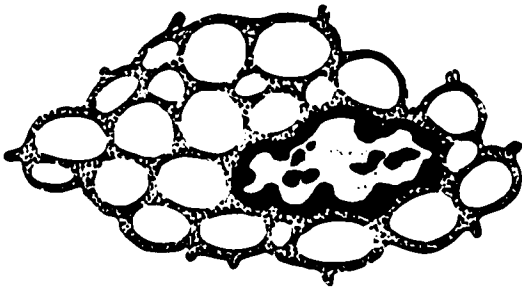


Mental retardation  
 Frontal bossing  
 Prominent eyes, with hyper-  
 telorism and  
 depressed nasal  
 bridge  
 Gapped teeth,  
 gingival  
 hypertrophy,  
 thickened tongue

Typical features of patient with Hurler syndrome



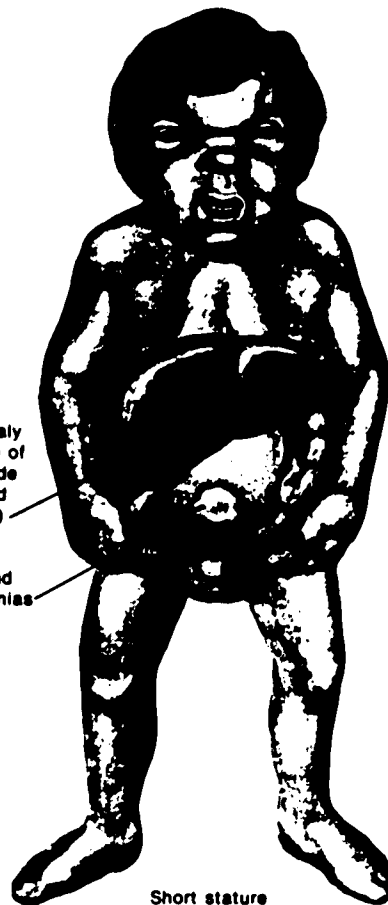
Corneal clouding, which may progress to severe visual loss (prominent feature of the Hurler, Scheie and Morquio syndromes)



Enzyme defect allows storage of specific mucopolysaccharides within cells of various tissues



Cardiac valves thickened by storage of mucopolysaccharide. Congestive failure and pneumonia often terminal events



Hepatosplenomegaly caused by storage of mucopolysaccharide (seen in Hurler and Hunter syndromes)

Umbilical and inguinal hernias

Short stature

JOHN A. CRAIG  
© CIBA

pneumonia or cardiac disease.<sup>99</sup>

Families with MPS children can become members of the MPS Society (located in Bethpage, New York) whose major goal is to educate the general public, discover and help new MPS families, facilitate diagnosis and treatment and ultimately work toward prevention and cure. A parent referral service has been set up to put new MPS families in touch with families who are MPS Society members.

Research has proceeded rapidly, and in most of the classic mucopolysaccharidoses, it is now possible to delineate the molecular defect in enzyme activity that is the primary product of the abnormal gene and fundamental cause of all the manifestations of these diseases (see Figure 7). The clinical technique used to identify the defective gene is amniocentesis, which enables the physician to examine some of the baby's cells that have sloughed off into the amniotic fluid. This fluid is withdrawn through a hollow needle inserted into the mother's abdomen, and then tested for the presence of MPS in the developing fetus. This is usually done between the 14th and 16th week of pregnancy. Down's syndrome can also be detected by this

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<sup>99</sup>William L. Nyhan, "Understanding Inherited Metabolic Disease." Clinical Symposia 32 (1980), 22-23.

## Clinical and Laboratory Features of the Mucopolysaccharidoses (MPS)

MPS	Syndrome	Inheritance	Mental Retardation	Eye	First Manifestation	Hepato-spleno-megaly	Bony Defect	Compound Stored, Excreted	Enzyme Defect
I <sub>H</sub>	Hurler	Autosomal recessive	+	Corneal clouding	Coarse facial features, motor weakness, mental retardation, hernia	+	+	Dermatan sulfate, heparan sulfate	$\alpha$ -L-Iduronidase
I <sub>S</sub>	Scheie	Autosomal recessive	-	Corneal clouding	Coarse features	-	+	Dermatan sulfate, heparan sulfate	$\alpha$ -L-Iduronidase
II	Hunter	X-linked recessive	+	Cornea clear	Weakness, coarse features, mental retardation, aggressive behavior	+	+	Dermatan sulfate, heparan sulfate	L-Iduronosulfate sulfatase
III <sub>A</sub>	Sanfilippo type A	Autosomal recessive	+	Cornea clear	Hyperkinetic behavior	+	+	Heparan sulfate	Heparan sulfate sulfamidase
III <sub>B</sub>	Sanfilippo type B	Autosomal recessive	+	Cornea clear	Hyperkinetic behavior, mental retardation	+	+	Heparan sulfate	$\alpha$ -N-acetylglucosaminidase
IV <sub>A</sub>	Morquio	Autosomal recessive	+	Corneal clouding	Bony deformities	-	+	Keratan sulfate	N-acetylgalactosamine-6-sulfatase
IV <sub>B</sub>	Morquio-like	Autosomal recessive	+	Corneal clouding	Bony deformities	+	+	Keratan sulfate, heparan sulfate	N-acetylglucosamine-6-sulfatase
VI	Maroteaux-Lamy	Autosomal recessive	-	Corneal opacities	Growth retardation	+	+	Dermatan sulfate	N-acetylgalactosamine-4-sulfatase (arylsulfatase B)
VII	$\beta$ -Glucuronidase deficiency	Autosomal recessive	+	$\pm$ Corneal clouding	Coarse features	+	+	Dermatan sulfate, heparan sulfate, chondroitin-4, 6-sulfate	$\beta$ -Glucuronidase

(Courtesy of Clinical Symposium, CIBA)

(Figure 7)

method. Although only one-half of 1 percent of parents stand a chance of bearing such a child, the rate applies whether or not the family has already had a "mongol" child. The disorder cannot be cured, but since fetal cells are constantly cast off into the amniotic fluid in which the growing child is suspended, amniocentesis by the 14th week of intrauterine life can now reveal if the fetus is carrying the defect. Turner's syndrome is another classic example of an inherited, potentially growth-retarding disease which can be diagnosed in intrauterine life by amniocentesis. More recently, a new technique is being developed that would seek the presence of a protein that women who have given birth to Down's children have in their blood.<sup>100</sup> The head researcher claims that in less than two years a simple, inexpensive and accurate blood test could be available to tell women before pregnancy if they are likely to give birth to a child with Down's syndrome. Women now have no way of knowing before becoming pregnant whether they might bear a child with Down's syndrome (although the risk is higher if the woman is over 35) or for that matter Hurler's syndrome and a host of other genetically deficient and/or abnormal diseases.

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<sup>100</sup>See, Washington Post, "Down's Syndrome Test Being Developed," (August 28, 1981).

## X. Psychosocial Short Stature

There is a syndrome of growth failure associated with child abuse. It has been identified variously as "deprivation dwarfism," "psychosocial dwarfism," "emotional dwarfism," "abuse dwarfism," "maternal deprivation," "failure to thrive," and "reversible hyposomatotropism."<sup>101</sup> The latter term is perhaps the most thorough description reflecting laboratory evidence that, concomitant with growth impairment, pituitary growth hormone (somatotropin) secretion is suppressed. Both deficits are reversed, however, on a change of domicile. John Money brilliantly describes this relationship between reversible growth failure (reversible hyposomatotropism with dwarfism) and child abuse, through the presentation of a case report of unusual duration and severity of abuse which inhibited the normal onset of puberty.<sup>102</sup> It is posited that the

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<sup>101</sup>R. G. Patton and I. L. Gardner, "Influence of family environment on growth: The syndrome of 'maternal deprivation.'" Pediatrics 30 (1962), 957-62; G. F. Powell et al., "Emotional deprivation and growth retardation simulating idiopathic hypopituitarism: I. Clinical evaluation of the syndrome." New England Journal of Medicine 276 (1967), 1271-78 and II. Endocrinologic evaluation of the syndrome, *ibid.*, pp. 1279-83; J. Money and G. Wolff, "Late puberty, retarded growth and reversible hyposomatotropism (psychosocial dwarfism)." Adolescence 9 (1974), 121-34; J. Money and June Werlwas, "Folie à Deux in the parents of psychosocial dwarfs: Two cases." Bulletin of the American Academy of Psychiatry and the Law IV (1976), 351-62.

<sup>102</sup>John Money, "The syndrome of abuse dwarfism (psychosocial dwarfism or reversible hyposomatotropism): Behavioral data and case report." American Journal of Diseases of Children 131 (1977), 508-13.

behavioral signs of the syndrome of abuse dwarfism (which is used synonymously with psychosocial dwarfism) include: a history of unusual eating and drinking behavior, reversible on change of domicile, such as eating from a garbage can and drinking from a toilet bowl; stealing food; polydipsia (excessive drinking of water) and polyphagia (excessive food intake) alternating with vomiting, and possibly alternating with self-starvation. Also, a history of such behavioral symptoms as enuresis (inability to control urine), encopresis (inability to control sphincter), social apathy or inertia, defiant aggressiveness, sudden tantrums, crying spasms, insomnia, eccentric sleeping and waking schedule, pain agnosia (loss of sense of pain), and self-injury, all occurring only in the growth retarding environment, are reported. Retardation of motor development and intellectual growth, both reversible on removal from the domicile of abuse, are also found. A history of pathological intra-familial dynamics, including unusual cruelty and neglect on the part of the mother, who is theorized to have undergone personality changes after learning of her incestuous family origins, is reported. In addition to the above

conditions related to the syndrome, one further condition is mentioned which is thought to have relevance to abuse dwarfism, namely Munchausen's syndrome. In its classic form, Munchausen's syndrome is a condition in which the etiology of symptoms appears completely hidden, but in fact, the symptoms are self-induced. There is a close parallel with the symptoms observed in abuse dwarfism except that the symptoms are parent-produced instead of self-induced. Whereas, in Munchausen's syndrome the individual gives a false medical history, in abuse dwarfism, the parents give the false history while the child remains silent. In essence, one has a case of Munchausen's syndrome by proxy. Consequently, proof of abuse in the child's home is often extremely difficult to establish because abused children will often euphemize and cover up their plight while the parents share a delusion (*folie à deux*) of righteous parenthood. The syndrome is perhaps the clearest known example of a correlation between factors in the social and behavioral environment, on the one hand, and impairment of endocrine regulation of physical growth as well as behavioral maturation, on the other.



## CHAPTER IV

Methodology

The data reported here has resulted from personal observations and systematic in-depth interviews, as well as questionnaires. The information and findings were amassed over a two-year period, and encompasses a wide variety of dimensions of the everyday social-psychological living experiences of short-statured persons, namely dwarfs and midgets. The analysis is also based on personal observations at local and regional meetings and various social events, which the researcher was allowed to attend.

Specifically, the ninety-two individuals in the sample were composed of both members and nonmembers of LRA. They were found largely through social contacts and by the use of the snowball method of data collection. I made known to a large group of people the nature of my interest through a variety of means: (1) First and foremost, I made my interest known to other sociologists, psychologists, social workers, geneticists, nurses and physicians, as well as by telephoning and writing government agencies to find the address and telephone numbers of organizations and/or persons affiliated with organizations made up of dwarfs

and midgets. (2) My major source of entry into the extensive information network among little people was derived from social contacts. I attended several local meetings of the LPA in New York, Philadelphia and Maryland, as well as two district meetings (one in New York and one in Philadelphia) and a chapter meeting in Philadelphia. Also, I attended a meeting of PACT (Parenting and Counseling Training Program) in Maryland, and a pre-Christmas social gathering held in New Hope, Pennsylvania in 1980. (3) Questionnaires were distributed at these various meetings on the local, district, and chapter levels, as well as at the national convention held in St. Paul, Minnesota in July of 1981. (4) Notice of research, and interest in having members as well as nonmembers of LPA fill out questionnaires and/or be interviewed, was placed in newsletters of both LPA and HGF. (5) The nature of the research was also made known at the Moore Clinic of Johns Hopkins Hospital which specializes in the treatment of short stature. This was done in the hope that professionals there might know of short statured persons who might be interested in talking to me and possibly being interviewed. (6) Again, through

word-of-mouth and social contacts, mention of my research was made to short statured people attending the Short Stature Symposium VIII in June of 1981.

Finally, an evaluation and discussion of the present structure and function of the host organization (LPA) was made with comments from various leaders within the organization as well as individual members and non-members.

### Target Population

My first major contact was with the Vice-President of LPA, Mr. George Baehm. It was very fortunate for me to be able to speak with a major officer of the organization, and also convenient, as he lived in the immediate vicinity of New York. Mr. Baehm was most helpful in providing information on the organization and its members. He then referred me to the District Director of District II which encompasses the states of New York, New Jersey, and Pennsylvania. With the assistance and approval from the district leader, I was told that I would be allowed to attend upcoming meetings and from

then on I was able to generate contacts with a variety of little people who varied by age, education, vocation, and the nature of the problems they encountered in their daily lives, especially with average-sized persons. During some of the meetings, I was able to spend time during coffee breaks and before or after a speaker had formally introduced me and spoke of my research to numerous short statured persons. In some cases, I was able to interview on-the-spot, while for others, arrangements were made to visit them in their homes where they felt more comfortable at being interviewed or filling out a questionnaire. I was also fortunate enough to speak with parents and other members of families with children of short stature, either at the PACT meeting or at the Moore Clinic. At the PACT meeting, for instance, I was able to interview a couple in which one member was of average-size, while in two other cases both parents were average-size and they had produced short statured children.

Among the little people themselves, I was able to talk with husbands and wives, singles and divorced, separated and widowed. Moreover, the extent of education

of my sample ranged from some high school to college graduates, including three with graduate degrees. The informal interview was the primary way in which I gathered data among LPA members and nonmembers as well. This was done in order to get a more rounded approach to the various lifestyles and problems encountered by little people, in addition to coping techniques utilized in their everyday activities, with special emphasis on the differences, if any, between members and nonmembers of LPA.

I made a content analysis of the extensive literature on the subject of dwarfism, including the medical, psychological, and other literature, and the material published by LPA and NCF. Literature on LPA was provided by appointed officers within the organization who, only after a lengthy process, decided my purpose for the inquiry was legitimate. Similarly, I wrote to the home office of NCF, identified myself and the purpose for my investigation. Their response was punctual and most informative. In any case, I was finally able to procure copies of newsletters, brochures, newspaper clippings, etc., through LPA which provided a rich source of material.

In this literature, there are notices of upcoming events such as district or chapter meetings, parties, banquets, convention news, profiles of individual members and their families, articles on medical research, marriages, etc. Also, other publications not otherwise available in book stores were made available to me privately through individuals who had themselves sponsored publications on various short statured persons' lives or their families. PACT, too, was most helpful in providing me with newsletters and items of their organizational meetings and activities. HGF was indeed the most helpful in providing me with the extensive and rich source of medical literature on short stature, particularly literature intended for the nonmedical person. Lastly, the bulk of the articles and books on short stature that I researched were unquestionably helpful in supplementing my interviews and observations.

During the course of my research, I was able to examine the function and structure of the organization of LPA. I asked my LPA respondents whether or not the organization had been helpful to them, in many ways discussed in this study. For example, was LPA helpful

in finding them employment or establishing contacts for them to find employment? Was it helpful in answering questions about their own marital or nonmarital relations? I wanted to know whether members of LPA felt that the organization had made a difference in their lives in the areas mentioned. Among nonmembers, I was interested in knowing why they had not joined and whether they feel that their lives might be any different if they had.

An examination of the structure and function of the organization of LPA will precede the analysis of the responses by both members and nonmembers to my questions. The Little People of America, Inc., is a nationwide, voluntary organization dedicated to helping people of short stature by providing fellowship, moral support, and helpful information to the individual and to the unique challenges of being a little person. Through informal gatherings, local and district meetings, and an annual national convention, little people come in contact with other little people. Formed in 1957 under the direction of TV and movie personality Billy Barty in Reno, Nevada, with only twenty members, it has

grown nationwide until it has over four thousand members today. LPA also has "Auxiliary" members, composed of average-size family members in the household of the little person. The organization also has an Adoption Committee, which places dwarfed children who have been given up for adoption by their natural parents to short statured parents.

The LPA is divided into twelve districts, each encompassing a part of the United States. The members in each district elect their own directors. National officers are elected bi-annually at the national convention, and together with the District Directors, form the organization's governing body, the Board of Directors.

Area chapters are formed when sufficient interest is shown on a more local level. These chapter members also elect their own chapter officers, who work with the District Director and the national Vice-President.

The Little People of America, Inc. Foundation was established in 1968 for the purpose of being able to gather and disburse funds in the areas of vocational training and educational scholarships. Also, to help support medical and scientific research for little people.

The LPA Foundation is governed by the Executive officers of LPA, Inc., and elected-at-large officers, thus forming a continuing link between LPA, Inc., and its Foundation.

LPA has also created a Medical Advisory Board so that members can be better informed about their physical problems, particularly those concerning short stature. Physicians and specialists familiar with the unique physical and developmental problems of little people are located at selected medical centers throughout the United States. These professionals offer valuable services in the areas of consultation and diagnosis, in addition to helping with medical referral services for the little person and for the parents of "little littles."

#### Problems Encountered During Research

For the social scientist doing research on a highly stigmatized group of people in society, there are numerous difficulties one encounters. I think it is imperative to mention that among the more obvious of these situations, access to these people's lives and a development of their trust are perhaps the two most crucial conditions which

first must be met. In this study, it was made very clear to me from the very outset that, based on personal experiences, many little people in my sample harbored suspicion and mistrust of the intentions of the researcher. In addition, the importance of confidentiality and privacy could not be stressed enough. For these reasons alone, many of the persons whom I spoke with at the beginning of the study refused to participate or answer any questionnaire. However, as my exposure at meetings continued, and my research was mentioned in the newsletters and became better known, the refusal rate lowered considerably.

I learned that because of a previous disrupting, discouraging, and/or personally shameful experience with a similar study or researcher, some of the respondents' feelings of security about their identity had been severely injured. Although I was confident that my intentions had from the very beginning of the research been based on total honesty and sincerity, there was no way I could emphasize this enough. Hence, developing and maintaining trust with the short statured people in my sample was particularly difficult, yet crucial, in order to get an insider's view of this specific group

of outsiders' lives. Because of the very nature of the historical and social relations between outsiders and the larger world (as well as between the researched and the researcher), one might expect outsiders not to trust intruders from the wider world, even if the intruders' research hands are unsullied and they come with impeccable credentials.<sup>1</sup> Thus, the problems that resulted in this research were not uncommon, in that an elaborate game of impression management occurred which contributed to inconsistencies and a sense of cognitive dissonance between many of the little people's self-perception with reference to their group identity and to the outside world.

During my initial field experience, people were unusually reluctant to talk to me, even though I had been formally introduced and they had been told in advance that I would be at a meeting and they knew the purpose of the research I was conducting. Thus, I played the participant-as-observer role and the observer-as-participant role, never intentionally keeping my identity

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<sup>1</sup>Edward Sagarin and James Honeywater, "The dilemma of researcher immunity," in Carl B. Klockars and Finbarr W. O'Connor (eds.), Deviance and Decency: The Ethics of Research with Human Subjects. Sage Annual Reviews of Studies in Deviance. Volume III. Beverly Hills, California: Sage Publications, 1979, pp. 175-93.

a secret nor attempting to mislead others about my purpose for being there.<sup>2</sup> This was all carefully planned in advance by myself and the person in charge of holding any one of the several meetings I attended, normally a Chapter President or Vice-President or District Leader. Nevertheless, after several of these meetings, it was reported to me that I was perceived by some as a threat to their feelings and was seen as a reminder (both in fact and fantasy perhaps) that the world is not necessarily the way it is perceived by the in-group (in this case, members of LPA). Conversely, interaction within the group enhanced feelings of normality, reinforcing their positive feelings about their own abilities and validating their own sense of self-worth. When several little people were in a group with other short statured people, they were talkative, confident, outgoing, and relaxed, but when they were interacting with average-sized persons (particularly as was experienced by this researcher who could not pass because my height 6' 0", body build etc., produced a distinct gulf between us) they became unusually quiet, wary, hesitant, and in some cases withdrawn. Hence, many of the little people's self-perceptions continued to shape

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<sup>2</sup>Raymond L. Gold, "Roles in sociological field observations." Social Forces 36 (1958), 217-23.

their behavior as it is so often reflected in such a distinct dichotomy. This sort of behavioral expectation was not, however, always true for nonmembers of LPA. Instead, they felt a mild sense of uncertainty perhaps at worst, but otherwise nonmembers tended to show a far greater sense of self-worth and dignity so that the presence of an average-size person rarely seemed to put them ill at ease.

The last main problem area that concerned this researcher was that of finding a large enough sample from the few sources that were available to me. As one of my main sources for finding enough little people for my sample was through medical channels, even here the number of persons were largely patients who had additional physical problems other than just being short statured. Of this original group, only ten were willing to talk to me and only half of these were willing to fill out a questionnaire. I was grateful to HGF, since this organization is made up of professionals, family members and friends of short statured persons as well as little people themselves. Fortunately for me, there were many contacts made and much was shared with

people in HGF, particularly in terms of family members and their experiences and feelings of carrying a courtesy stigma. LPA, on the other hand, which I had assumed was going to be fully cooperative and most willing to provide me with as large a sample as I might need, was, to the contrary, not nearly as cooperative or helpful as HGF or other various sources. In many ways, LPA is extremely protective of its members and is necessarily cautious and sensitive to situations where its members may be exploited by an organization or individual outside its own private universe. As such, and in contrast to some other organizations of highly stigmatized individuals (e.g., homosexuals or drug addicts), LPA, as an organization of visibly stigmatized individuals, does not offer its services gladly to the social scientist, and more important, as this researcher found, it does not like to be studied.<sup>3</sup> As I later discovered, however, such a position was not necessarily held by the members of LPA, but primarily by its officers. In fact, several respondents told me that some of the officers in LPA were so overzealous about their positions in the organization and

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<sup>3</sup> Edward Sagarin, Odd Man In: Societics of Deviants in America. Chicago, Illinois: Quadrangle Books, 1969, pp. 236-37.

what it stands for, and how outsiders see little people as deviant, that they frown on any social scientific research done on them. Unfortunately, with so little exposure and an increased amount of isolation brought on by various authorities within the organization, there is only further perpetuation of the deviant status of its members.

#### Nature of the Questionnaire and Investigation

General topics covered by the questionnaire and in the interviews included such background information as the respondent's occupational history and the problems he/she may or may not have encountered on the job, home-care chores and responsibilities, self-care in terms of personal hygiene and appearance, self-perception in terms of body-image, marital relationships, parent-child relationships, nonmarital relationships, and feelings about social interaction among short statured persons, as well as among average-sized persons.

The investigation was an exploration seeking to uncover how and what these short statured people felt socio-psychologically about their identity, their sense of self-

perception about their size, their problems and solutions for adjustments not only among themselves but also for average-sized persons as well, in terms of alleviating the tensions that occur in day-to-day social interaction.

## CHAPTER V

Findings of Research

All in all, 67 short statured persons (29 males and 38 females) filled out questionnaires and 15 of them (4 males and 11 females) volunteered themselves to be interviewed as well. In addition, interviews were conducted with 12 average-sized persons who are members of families with a dwarf or midget, and 15 professionals working in the field. Thus, there were 27 persons of average height in this sample, all of whom are closely concerned with the problem here under study. In Table I, I asked parents and others related to a dwarf or midget, and professionals (not short statured people) to express to me their overall ratings of importance of the categories that the short statured respondents commented on in the questionnaire. I asked them to rate these categories from 1 to 3 with 1 representing the most concern.

As can be seen from an examination of Table I, parents and other family members indicated that their outstanding concerns were problems that short statured people faced in parent-child relationships and social interaction with others. It was expressed to me that as a parent of a

TABLE I  
Ratings of Areas of Concern

	Parents and Others N = 12	Professionals N = 15
Employment	3	6
Homecare Responsibilities	3	6
Self-Care	4	2**
Insight Body-Image	6	5
Marital Relationships	4	6
Parent-Child Relationships	2**	3
Non-Marital Relationships	3	3
Social Interaction	2**	2**

Topics ranked 1 - 8: 1 represents highest area of concern.

\*\* denotes outstanding concern expressed

Note: Results of interviews conducted with short statured persons were not included in this table as that would have been duplicative to their filling out a questionnaire. Hence, Table I reflects only as specified - i.e., parents and others, and professionals.

"little little," there is often a tendency to be over-protective and overconcerned about the welfare of their child. This was particularly felt very strongly among all the parents both short and average-sized, when the short statured child was beginning to go to school and having to cope with other normal size children, some of whom deliberately taunted the short statured child with nicknames. Thus, teasing of dwarfed children by average-sized children was both a cause for alarm and for concern by the parents. Several of the other family members were quick to point out that they had felt protective of their "little" brother or sister too until the teasing and taunting finally subsided and others began to accept them. As one average-size sister remarked about her one year older dwarfed sister:

When I was about age five or six, I first began to notice my sister as being different - maybe it was that I was becoming conscious of others' reactions. I dealt with it at first (especially when the hostile reaction came from children) with a great amount of resentment, but as time went on I seemed to get more and more conscious of it. Throughout school my friends always took notice of my sister, but after I explained that she was just like their brother or sister only she was shorter, they accepted it.

It was also made very clear to this researcher while talking to average-sized parents of a dwarfed child, that the learning to accept their dwarfed child and the ability to cope with their own feelings of having produced a short statured human being was a very long and difficult phase of adjustment. Once acceptance of their child had more or less gained reality, the need to protect, however, seemed to be overwhelming for some. As one father stated, "It were as though I have a double responsibility, not only do I have child but a handicapped one. That's taken me a while to learn to live with, but now my main concern is his future."

Family members also showed a major concern and interest in the area of employment and homecare responsibilities. In terms of employment, their major complaint was based on their feelings about discrimination against little people in jobs, their feelings that people with other handicaps had been accepted, but because their child was a dwarf he was unacceptable. One mother writes:

My son was given this part-time job at a fast food place but he was only allowed to work evenings and when he did work, he was in the back making sandwiches or something so no one could see him. Actually he was happy to have the job but they called him when they needed him. Anyway, it only lasted for awhile, eventually they just stopped calling.

Responsibilities around the home, including such jobs as cleaning up one's room, changing linen, mopping floors, washing clothes, etc., were typical of the jobs left to the small child. Outdoor work, such as painting and mowing the lawn, were felt to be too dangerous for the little member of the family. All family members were concerned about the future potential of their short statured member's dating and eventually marrying someone. They all agreed, that there were real barriers for potential relationships aside from other short statured people, because of their size which clearly limited their prospects. The families felt that their main concern, while the short person was still a child, was to keep their "little littles" happy and to be aware of blatant discrimination or ridicule from average-sized persons.

Professionals were overwhelmingly consistent in their concern with the short statured people's self-care, particularly as it relates to managing and following strict regimens regarding physical exercise and dieting habits. One physician showed his fear about the problem of over-eating: "Excess weight can generate great anxiety and

depression in a teenager, and eventually may lead to ill health in adulthood." Obesity may seriously impede or limit a younger person's social and/or dating prospects. Indeed, as one short statured respondent told me, "The problem isn't so much being short as being fat (overweight), then nobody wants to talk to you or be with you, especially girls, not even other short fats." The combination of little exercise and a short statured frame can easily lead to weight gain that is far more readily discernible than would be a few extra pounds added to a six foot frame. Thus, obesity remains a problem common to all ages in dwarfed individuals.

Social interaction was also considered paramount for little people amongst professionals, but particularly with average-sized persons, with whom they might develop a more outgoing and relaxed sense of self-worth. Self-acceptance was a major key term used by physicians and social workers working with little people, in order to reassure them of their capabilities in the larger society in competing for jobs and in friendship and other non-marital relations. The attitude that the dwarfed person

develops toward himself will clearly be influenced by how he sees others reacting to him, based on what he projects from their expectations. Consequently, if the dwarf has a low self-esteem, then he's likely to transmit this to his offspring. Hence, an important point agreed upon by all the professionals was that an individual must first have a healthy view of himself both physically and mentally before he can hope to develop an equally capable and worthy offspring. In short, once an individual has accepted his self, regardless of size, then he should face fewer problems in accepting his offspring that may in this case, also be a dwarf.

Of the ninety-two short statured persons asked to fill out the questionnaire, 67 (73%) agreed and returned it, satisfactorily completed. Table II shows how the respondents were divided according to their sex and the origin or nature of their small size. According to the table, we see a preponderance both of males and females having some sort of bone disease. As discussed earlier in the medical literature, these were typically among the various chondrodystrophies, with achondroplasia

TABLE II  
Diagnosis and Sex

	N	Men	Women
Genetic Mutation	8	3	5
Late Onset of Growth	2	2	0
Inherited Short Stature	17	8	9
Bone Diseases	27	13	14
Hormone Diseases	8	2	6
Other	3	0	3
Unknown	2	1	1
Total Sample	67	29	38

TABLE III  
Age by Sex

	N	Men	Women
15 - 18 years	24	9	15
19 - 25 years	23	11	12
Over 25 years	20	9	11
Total Sample	67	29	38

being the most common. The second most prevalent form of short stature amongst both men and women was that of an inherited trait. Since height is largely an inherited characteristic, some people who are short, but proportionate, may simply represent the shortest members of the general population. Since short males will tend to marry short females, there will be a tendency in such families toward shortness, and for that reason the inherited characteristic tends to be one of the most prevalent sources of short stature. It would seem that women slightly outnumber the men in hormonal conditions resulting in shortness, including hypopituitarism, hypothyroidism, and other anomalies. Also, women who designated "other" as the cause or nature of their short stature might likely have Turner's syndrome. Thus, the sample is clearly demonstrative of the two most common origins of dwarfism namely, bone disease and inherited short stature, both of which are demonstrative of the cases seen at the Moore Clinic of Johns Hopkins Hospital.

The sample is composed of fewer persons over 25 than under, and fewer males than females (see Table III). There was an almost even division between singles on the one hand,

and married or formerly married on the other, with a slight difference between males and females. Nearly half the females were single (42%) while 41% of the males were single. The dominant religion is Protestant (see Tables IV and V).

For the most part, both males and females had completed high school and some college but males tended to outnumber females in terms of graduating from college and continuing on to graduate school (see Table VI), and this no doubt accounts for differences in their jobs (see Table VII). In other words, the women are typically holding down the traditional secretary/clerical positions. However, there are nearly as many women as men in business, but the males tend to outnumber women professionals as is reflected in their higher incomes (see Table VIII). Whether these findings tend to reflect today's population trends between the sexes, or is unique to dwarfs, is rather difficult to ascertain. However, with today's job market the way it is, the disparity between the professionals and non-professionals, particularly between the sexes, seems to be at a more or less steady rate regardless of the increasing number of women entering the professions.

TABLE IV

## Marital State by Sex

	N	Men	Women
Married	20	8	12
Single	28	12	16
Divorced/ Separated	14	7	7
Widow/ Widower	5	2	3
Total Sample	67	29	38

TABLE V

## Religious Affiliation by Sex

	N	Men	Women
Catholic	16	5	11
Protestant	31	16	15
Jewish	9	4	5
Other	4	1	3
Non-affiliated	7	3	4
Total Sample	67	29	38

TABLE VI  
Education by Sex

	N	Men	Women
Some High School	5	2	3
Completed High School	22	7	15
Some College	20	8	12
Completed College	12	7	5
Some Graduate School	5	3	2
Graduate Degree	3	2	1
Total Sample	67	29	38

TABLE VII  
Occupation by Sex

	N	Men	Women
Unemployed	9	4	5
Housewife	11	0	11
Secretary/Clerical	9	1	8
Business	6	3	3
White Collar Management	6	4	2
Professional	8	6	2
Self-employed	4	2	2
Student	10	6	4
Retired	4	3	1
Total Sample	67	29	38

TABLE VIII  
Income by Sex

	N	Men	Women
Under \$5,000	7	5	2
\$6,000 - \$9,000	10	3	7
\$10,000 - \$12,000	14	5	9
\$13,000 - \$15,000	17	10	7
\$16,000 - \$20,000	5	4	1
Over \$20,000	3	2	1
Total Sample	56*	29	27

\*Excluded from this table are housewives.

### Employment Problems and Perceived Discrimination

In terms of employment problems (see Table IX), nearly all the respondents answered that they had at one time or another experienced friction or difficulty in their interpersonal relationships with others on the job. Among both men and women, younger people seem to be faced with this dilemma more than older, perhaps because, as one respondent suggested, "They (younger people) are just starting out and that is the worst time for them to find a job or an employer who might not discriminate against them because of their size." Perceived bias may also determine the choice of career an individual may enter. Hence, the young more than old, with the difference being only slight both for males and females, perceived job discrimination as being a major difficulty in their lives. Many had expressed upon numerous occasions, experiences in which they felt a potential employer had rejected them because of their size.

TABLE IX

## Perception of Job Discrimination, by Age and Sex

	Men		Women	
	Under 25	Over 25	Under 25	Over 25
YES	15	10	15	18
NO	2	2	1	4
Total	(17)	(12)	(16)	(22)
	N = 29		N = 38	

Sample = 67

There appears to be little or no indication of strong differences between the sexes or by age concerning their perception of job discrimination.

Another difficulty that many of the short statured respondents reported was that of architectural barriers, there are telephone booths out of reach, water fountains too high, stairways or public conveyances too fast, and public toilets too difficult to use. Among the few who had complained to their supervisors about these barriers (the others stated pointedly that they feared their complaint would fall on deaf ears and worse, they might lose their jobs), many of the changes had been remedied largely due to Section 504 of the Rehabilitation Act of 1973.<sup>1</sup> Although this legislation was passed on behalf of the more severely handicapped, particularly wheelchair users, it nevertheless has helped to provide better physical accessibility to public facilities for short statured persons as well, because their height offers a difficulty comparable to that of persons in wheelchairs. Thus, each new change that helps to provide persons in wheelchairs with better accessibility clearly benefits little people too.

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<sup>1</sup>The President's Committee on Employment of the Handicapped, "Disabled U. S. A." Volume 4, No. 4-5, 1981.

### Homecare Responsibilities

Despite their obvious disadvantage of height, most respondents reported that managing household chores was not a major strain or difficulty. Although a few complained that their arms fell short of faucets, shelves and switches, most felt that they had adjusted to these physical obstacles. With increasing age and when the physical disability of the little person was marked, the more strenuous activities around a home were allotted to professional gardeners, painters, and other hired workers. In families where there were average-sized persons, many of these outdoor chores were the responsibilities of the taller people. There are several publications which are useful for short statured people, offering suggestions in helping to manage their tasks of daily living, especially around the home.<sup>2</sup> Little People of America publishes a pamphlet (available only to members) which helps to simplify work considerably around the house by following various "rules of the thumb," including basic aids and adaptations for short statured people.<sup>3</sup>

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<sup>2</sup>P. C. Cheever, Accent on Living. Privately printed, Bloomington, Illinois; also, Ohio Governmental Committee on Employment of Handicapped, Access for All. Columbus, Ohio.

<sup>3</sup>Little People of America Foundation, The Idea Machine. San Bruno, California.

### Self-Care Responsibilities

Almost all respondents were concerned with and had special interest in self-care, whether it be daily hygiene, personal appearance, or something pertaining to their overall physical self-image (see Table X). As would be expected, younger men and women showed a stronger interest in problems of self-care and personal hygiene. Females tend to be slightly more concerned than males in the over 25 age group and particularly in the under 25 age group.

### View of Body-Image

In response to the question "How satisfied are you with your bodily proportions?" - males tended to express a very favorable image (82%). Among younger females with less than a college education (N = 11), 9 or 82% were constantly viewing themselves in the mirror and comparing their height as well as other secondary physical characteristics to average-sized girls in their class. Females who were twenty-one and over, with at least some college (N = 12), 10 or 83% were presently

TABLE X  
Self-Care Concern by Age and Sex

	Men		Women	
	Under 25	Over 25	Under 25	Over 25
HIGH	12	4	20	12
LOW	2	4	0	2
Total	(14)	(8)	(20)	(14)
	N = 22		N = 34	

Sample = 56\*

\*The total is less than the entire sample because some of the respondents refused to answer this question because they felt it was too sensitive.

There is little difference between the sexes or by age concerning proper self-care. Indeed, the entire sample showed overwhelming concern with the issue with women (young and those over 25) being slightly more concerned than men.

working at a job they enjoyed and one in which personal appearance was clearly a "must" and reported that they were totally satisfied with their body proportions and were not particularly concerned any longer about any differences between their own and that of an average-size person.

This feeling of satisfaction with one's bodily proportions was not, however, shared by all the respondents, as one young woman remarked to the question:

Short or tall, fat or thin - no one, at least that I know of and that runs the gamut, is totally satisfied with the way they look. Actually, for me it's not so much my size as it's my eating habits, I always have to watch my weight.

Another respondent had this to say:

It's very annoying at times not to be able to bend my knees out straight. There are times, especially in public places, in which I'm embarrassed about my appearance, no matter how well I'm groomed and dressed.

Indeed, for many little people in the sample, the reaction by average-sized persons to them is so often one of

insult, abhorrence, or curiosity, so that they can't avoid feeling a sense of rejection and hostility to their presence. On the other hand, there is protectiveness to the point of some average-sized persons over-emphasizing the obvious. No little person wants to be treated as though he were either a child or disabled beyond the fact of his short stature. This phenomenon of being evaluated according to size (stature) rather than chronological age was felt by nearly all the respondents as a continual nuisance that they experience daily in their interaction with average-sized persons. This feeling of being "infantilized" (or the "Peter Pan syndrome"<sup>4</sup> as John Honey would call it) has clearly produced in many little people a negative evaluation about themselves, of their image of self and their social identity. As one little person remarked, "People equate small frames with small brains." Clearly, only by overcoming this sort of shallow reasoning could a short statured person feel comfortable with himself and ultimately accept his self. If a little person withdraws from this onslaught of negative evaluations, then he is likely to take on the traits others imbue to him. But, by accepting

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<sup>4</sup>John Honey, "Dwarfism: Questions and answers in counseling." Rehabilitation Literature 28 (1967), 134-36.

his size and getting on with the task of living, many little people had learned what may be perhaps one of the most heart rendering acceptances they may ultimately have to face in life, their shortness and its stigmatizing consequences. Although some attempt to pass as though they were no different than anyone else, but their visibility negates that possibility, prompting the question of how many are actually pretending to themselves as a means of coping with their stigma. Most, however, have conceded to their physical differentness, noting that it was when average-sized people so obviously felt uncomfortable or hostile to their presence that they felt uneasy. Hence, how these little people react to the larger world depends on how they see themselves, and how they feel about themselves depends largely on how others react to them. In other words, as Mead, Cooley, and Goffman<sup>5</sup> have so well expressed it, Mead using the distinction between the "significant and generalized others," Cooley the "looking-glass-self" and Goffman "impression management," an individual's perception of himself (i.e., his self-concept, self-image, or identity) primarily consists of the attitudes, feelings,

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<sup>5</sup>See George Herbert Mead, Mind, Self and Society. Chicago, Illinois: University of Chicago Press, 1934; Charles Horton Cooley, Human Nature and the Social Order. New York: Charles Scribner's & Sons, 1902; Erving Goffman, Presentation of Self in Everyday Life. Garden City, New York: Doubleday, Anchor Books, 1959.

and beliefs he has about the kind of person he is, his strengths and weaknesses, his potentials and limitations, and so on. In developing this sense of who we are and how we feel about ourselves, we take into account the views of others. Clearly, in the case of little people (as well as average-sized persons) the overall view of their self is partly composed of their body-image, and how they think they look has a strong bearing on how they feel about themselves. Hence, feeling badly about their bodily proportions might only reinforce the feeling that "bigger is better." Thus, the overall general feeling of satisfaction with their bodily proportions could be seen as a cover or a reaction formation by many little people to the slings and arrows of others to which one is actually extremely sensitive.

#### Marital Relationships

There were 20 married couples in the sample, consisting of short statured husbands and wives. There were eight couples in which one spouse was of average height; of the eight, the male was the short statured

in five cases, the female in three. Among the married short statured couples, 5 (25%) said they had met their spouse at a party, while 3 (15%) related how they met their spouse at a neighborhood or college town bar. One couple said that they had met through a prearranged date, in which neither the man nor the woman was aware of the other's short stature. Over half the married short statured couples (53%) related how they had met their future husband/wife at an LPA organizational activity or function. It had been a local, regional or district meeting in which they first met one another, or at one of the national conventions which are well known amongst short statured people to encourage an environment of social mingling with the goal in mind that for many little people this may be their only opportunity to examine a host of potential marital candidates. Hence, many romances blossom here and result in marriages.

Among the eight "mixed marriages," three of the male dwarfs married to average-sized females and two female dwarfs married to average-sized males related that they had met their spouse while working in their

present jobs. One male dwarf explained meeting his wife:

I was working in a local government agency for better housing and she was working as a clerk in another department. Well, I had to come to her to have certain data verified by the zoning commission. Well, it seems we agreed a lot about districting and a lot of other things. I guess we just agreed about a lot of things in general. That's when I realized we had a lot in common and soon we started dating and finally I sprang the big question.

The major source of stress and/or strain with the "mixed couples" tended to be related to social interaction, particularly with average-sized persons. The problem seemed to stem from what was called by one couple "a lack of awareness or acceptance by others," and was felt to be more significant for the average-size spouse to cope with because of the stigma society has placed on the little person. This in turn, then, has prompted what Goffman calls "courtesy stigma"<sup>6</sup> which the average-size spouse must endure because of his association with his stigmatized mate. Clearly, in a world that is physically and psychologically geared for tall people, anyone who is different from the typically American ideal body-image is frowned upon. But this social hostility

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<sup>6</sup>Irving Goffman, Stigma: Notes on the Management of Spoiled Identity. Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1963, pp. 30-31.

tends to be more pronounced when short and tall are seen together in public. This has apparently come about as an entrenched social expectation that the man must be taller than the woman for he must give the impression of being his woman's superior both mentally and physically, thus perpetuating the age old vision of male dominance. But certainly, this disparity between the sexes regarding height is changing, although not perhaps attaining the degree of tolerance of traditional "mixed marriages" between people of different religions, national heritages, or races.

#### Parent-Child Relationships

Among short statured parents with short statured children, six of the couples had their children naturally while three other couples adopted through LPA's adoption program. Lee Kitchens, past President of LPA, has remarked that "Little people sometimes adopt small children who are diagnosed as dwarfs or midgets."<sup>7</sup> Not infrequently this occurs among short statured couples who are childless by choice (presumably because of the genetic problems they faced), of which there were two

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<sup>7</sup>The Baltimore Sun (February 24, 1961).

couples in this category. However, these same two couples saw nothing inherently wrong with other short statured couples having children either naturally (biologically) or through adoption. Other couples were planning to have children naturally unless there proved to be some insurmountable medical reason that they might face. With few exceptions, dwarfed women must deliver by cesarean section,<sup>3</sup> but apart from this type of delivery there are few other complications.

In speaking with several genetics counselors regarding natural childbirth and/or adoption for little people, it was interesting to note how the little people felt on the subject. In essence, little people have become increasingly sophisticated with regard to family planning and genetic risks. As one genetics counselor remarked, "Most of the little people that we see here in the clinic (the Moore Clinic of Johns Hopkins Hospital), that are seeking answers to family planning, are actually concerned about the moral obligations to their offspring." This is interesting because what is really at issue here are the value judgments of little people and just how they feel about giving birth to a dwarfed

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<sup>3</sup>J. E. Tyson et al., "Obstetric and gynecologic considerations of dwarfism." American Journal of Obstetrics and Gynecology 103 (1970), 587-704.

child. They know that there is a 75% chance that two achondroplastic dwarfs will have an affected child, and only a 25% chance that their child may be average-size. Consequently, many dwarfed couples, when faced with this situation, decline to accept the risk of having a dwarfed child. Depending on the type of dwarfism, there is an even greater risk that the child may inherit defective genes from both parents, and this double-dominant inheritance will cause the child to be born dead. Thus, the decision to have a child subsequently demands a great deal of consideration on the part of the couple. However, among some of the short statured couples desiring to have children naturally in my sample (N = 15), all but one couple supported the view that the risk of having a "normal" child was also great, and that they did not want one but instead preferred a "little little" (a short statured child). Moreover, this feeling seemed to be shared by other short statured parents who had "little littles," for they agreed that their children had shown remarkable coping abilities in learning how to deal with their size, as they have learned how to deal with average-sized children's remarks to them.

It is important that children of short stature should know from the outset that their families value them for their individual qualities and that their height is not significant. That security will help them to cope when people stare at them in the street, at school, or when other children make cruel remarks. Unfortunately, this sort of response from outsiders, which can be as painful for brothers, sisters and other family members (bearing the burden of "courtesy stigma") as for the children themselves, seems inevitable and only careful training in the early years can prepare a child for handling it.

One further problem that came up with two average-sized couples with a dwarfed child was a sense of over-protectiveness and concern with their child's well-being. As one husband expressed it:

One of the first experiences my wife and I had after learning that she had just given birth to a dwarfed child was anger, shock, and even a sense of holding blame toward the other. After some readjustment and the realization that our child's size was not enough to ruin the love we have for it as well as between ourselves, we began to receive "sympathy cards" from neighbors. That was the last straw. Ever since, I guess you might say, we've been over-protective because of people like that.

Trying to maintain the belief that people are just naturally curious or concerned, and aren't being deliberately insulting or hostile, can sometimes be extremely self-deceptive. In any case, perhaps one of the most determining factors in a dwarfed child's social development is the attitude of the parents toward their child's growth problem.<sup>9</sup> Overall, it is suggested by professionals working with short statured people to emphasize to parents that by over-protecting the child, one tends to "infantilize" and ultimately stifle the child's own sense of his self-worth. By not being over-protective and by teaching skills on how to handle the big world, one not only gives the child the opportunity to be successful and thus build a positive self-image, but also offers him the opportunity to fail and thus be able to absorb the necessary and inevitable knocks that come later in life.

#### Non-Marital Relationships

Among a sample of 42 short statured, single, separated or divorced persons (widows and/or widowers were not included), 29 (69%) were presently involved in some sort

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<sup>9</sup>Joan Weiss, "Social development of dwarfs," in W. D. Hall and G. L. Young (eds.), Proceedings of a Conference on Genetic Disorders: Social Service Interventions. Pittsburgh, PA: University of Pittsburgh, 1977, pp. 56-61.

of regular non-marital relationship with one other person. Of these, 7 (24%) were having a relationship with an average-size person; among them were four females with an average-size man and three males with an average-size female. This was interesting from the standpoint of whether dwarfed females go more frequently with average-sized males or vice versa. Two of the dwarfed females expressed their preference for a relationship with an average-size man because, as one put it:

Short statured men have a complex. In thinking back over past experiences of dating short statured men, in almost every case he would act as though he had to impress me or something because of his size. Take for instance this one guy who kept telling me he was in a major league bowling tournament. Personally, I never did care much for bowling. Anyway, I guess he was just trying to impress me that he bowled with average-sized people. Anyhow, I guess I feel sorry for short statured men in a way because let's face it there really aren't many average-sized women who date men shorter than they are, but a lot of short women can get away with dating an average or average-short man. Consequently, a lot of short statured men put everything they've got into a date and end up trying too hard.

Whether any of these relationships with average-sized persons were leading in the direction of marriage was uncertain.

For some short statured males, the dating boundary was based on the premise that abnormal appearance is a rejectionable quality. As one young man explains:

I was constantly rejected by average-sized females, I was sure they rejected me because of my appearance. The worst part of this dilemma was that all the disabled gals I had met had very little in common with me. The normal gals I met in college enjoyed my friendship. A few of these gals had a lot in common with me intellectually, and we got along except when I asked for a date. This reinforced in me the reality that my abnormality was somehow rejectionable.

This young man and many of the other short statured males were seeking to reach beyond the dating boundary of height restriction. The following statement seems to suggest how many saw their plight in regard to such relationships:

I would like to say that I'm interested in compatibility and I'm much less reluctant to date a disabled person now than ten years ago. However, to date someone because she's disabled or able-bodied is an error. I'm not really interested in trading sob stories with a similarly affected woman. I'm interested in compatibility - a relationship based on respect, love, friendship and a certain amount of similar interests, someone who is intellectually stimulating as well as sensually. The problem is, where does one meet such a person?

### Social Interaction

By and large, all the respondents agreed that interaction between short statured and average-sized people, depending upon the circumstances and how tolerant both groups or individuals are of one another, causes situations that can easily bring on much stress and tension. "Familiarity with the unfamiliar," as one little person suggests, helps him to be frank and forthright with average-sized persons in public, and particularly those who show their bad taste (albeit, curiosity perhaps to others) by staring at him for long periods of time. Other suggestions or tactics that some short statured people have used to alleviate tension between an average-size person and a short statured person, interacting for the first time, include: "...being assertive but not aggressive," "...definitely a sense of humor helps me to have a clear road," "...warmth, friendliness, a good handshake and an interest in the other person works for me."

Generally speaking, it was found that among most dwarfs I spoke with, their views on socially interacting with average-sized persons did not differ sharply from

the views of the normals. In other words, because interaction between them is rare, neither the short nor the tall person has actually had enough opportunity to develop the necessary technique(s) or skill(s) to communicate interpersonally in such a way that the average-size person does not intimidate or offend, and the little person is able to put others at ease with his presence. Needless to say, as a result, nearly all my respondents felt more comfortable with other short statured persons, but considered average short people (average-size persons whose height varies from 5' 0" to at most 5' 5") as less a threat than a taller person.

Apart from the obvious disparity in their height, many dwarfs expressed that some average-sized people will often naturally presume that someone so small couldn't possibly be capable of very much. Hence, the discrimination that is prescribed to them is felt to be both physically and mentally discouraging. In the end, most respondents agreed, that only rarely do average-sized people truly view them as ordinary normal human beings apart from their shortness. For this reason, many understandably feel compelled to withdraw socially

from the "big world" except when the situation involves average-sized people whom they know as personal friends; as one short statured female states, "A difference doesn't matter so much when you're with friends."<sup>10</sup>

#### LPA: A Reservoir for Potential Dates and Mates

Within my sample of short statured members of LPA, there were eight males who fit the following description: between the ages of 19 and 25, single, having at least a high school education, and who were either attending a college or were working in some sort of business or white-collar management position. For these young men, LPA served one purpose: namely, they hoped to meet and ultimately marry another short statured woman with a similar socio-economic background. Apart from attending the national conventions, and then only when they could afford it, they pay their dues and patiently wait for the next "big bash" (convention). Interestingly, six women fitting nearly the exact same categories had very similar opinions, except that three of the young women had found that the conventions were not only a place for them to find a "steady" but they also enjoyed the various

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<sup>10</sup>A. J. Brightman, Ginny. New York: Scholastic Books, 1978, p. 15.

other activities that the conventions normally hold, including workshops, bake sales, hobbies, and games. As for their life being any different had they not joined LPA, only four males and four females answered in the affirmative, contending that they would be more concerned about socializing and meeting enough people, short and tall, in order to have a regular source of friends and dates.

For these people, LPA was seen as important but not absolutely necessary. Perhaps it was more necessary for their parents, and for little people who had not yet developed a sense of self-acceptance which was still hindering their ability to become socially acceptable. This was basically the feeling among non-members who voiced that, for them, either there was self-acceptance, and thus they saw LPA as a crutch more than a helping organization, or there was no self-acceptance, and hence people could not bring themselves to socializing or joining with others whom they had yet to acknowledge. One non-member seemed to focus in on the very issue, when he proclaims:

When I finally began to accept the fact that I was a dwarf and that I would be little for the rest of my life - well, I sort of likened my situation to that of a blind person. Once knowing and then accepting the fact that I might be blind doesn't mean I should hang around with other blind people just to feel good, on the contrary, it would only make me feel sorry about myself and being with them would make matters even more miserable.

Stated another:

It's not that I don't have other short statured friends or care to be around them, it's just that I have average-sized friends too, and besides, the organization as I see it is like a meat market, otherwise all that stuff in the newsletters is such trivia - like who's who in LPA or who got married, or who just had a little little, or when is the next bake sale or fashion show, it's like their own little world.

Such statements notwithstanding, for many of the respondents LPA has proven to be extremely helpful and supportive in many ways. Depending upon the individual, membership in the organization is largely a matter of personal choice and/or interest. All the persons in my sample seemed quite independent and had an otherwise quite normal life, with membership in LPA simply being one of many activities

or organizations in which a little person might have been a member. In short, whatever role LPA played in making a date and meeting a mate, these people were not revolving their lives around this voluntary association.

## CHAPTER VI

Conclusion: The Social Significance of Short Stature:  
Notes on the Management of Short Statured  
Identity.

While there has been a great deal of sociological literature on the highly stigmatized physically handicapped, very little has been directed toward a study of dwarfs and midgets in particular. The significance and contributions of this pilot study into the lives of these highly stigmatized people will hopefully have provided some measure of explanation in the literature of the field. This was done by particularly expanding on the works of Erving Goffman in the areas of the sociology of disability and deviance, as combined in his insightful studies of stigmatization.

As the literature has shown, from a socio-psychological perspective, short statured persons are handicapped from birth. Even before they can realize this themselves, it is understood by significant others - namely, family, friends and professionals - how this will seriously affect their socialization and the formation of a confident and secure identity of self. In the examination of the sociological, psychological and biological (medical) factors, the effect that stigma

has on personality formation, on life chances, on family interaction, and other important aspects of the lives of these people, is germane to a much clearer understanding of a highly stigmatized group of people.

### The Stigma of Dwarfism

In an effort to complement Goffman's classic works in the sociology of deviance, particularly his work on stigma, this research has focused on the stigma attributed to short statured people (otherwise more commonly referred to as dwarfs or midgets) and the problems they encounter as recipients of social hostility.

Stigma is an oppressive and infamously universal social phenomenon, in that every society delegates certain individuals as possessing a stigma, be it a physical "blemish" or a particular form of behavior that contradicts the norm.<sup>1</sup> As societies develop negative attitudes to some conditions more pejoratively than others, individuals with these conditions quickly learn to be aware of how others view them. Consequently, the stigmatized individual must struggle with these negative attitudes and with the discredited status that accompanies them and ultimately develop strategies for coping with the stigma.

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<sup>1</sup>Erving Goffman, Stigma: Notes on the Management of Spoiled Identity. Englewood Cliffs, New Jersey: Prentice-Hall, 1963.

Failure to learn such coping skills may result in institutionalization, social ostracism or mere existence on the fringes of society. Occasionally, sufficient numbers of stigmatized individuals may form a subgroup based on a "consciousness-of-unkind,"<sup>2</sup> which refers to the awareness of their differentness and to their efforts to build coping strategies among themselves. These handicapped, including short statured people, share with one another common values and outlooks on the conventional world, which in turn provides them with a sense of ingroup solidarity and similarity not extended to others.

Characteristically, dwarfism constitutes an irremediable and stigmatized condition in American society where abundance of size and quantity in most all aspects of life is highly prized. The condition of profoundly abnormal short stature can in only a small proportion of cases be corrected medically (only those children who are diagnosed with pituitary hormone deficiencies can be readily treated; however, this is not the case with the chondrodystrophies). In addition, the daily problems of life caused by a hostile social milieu can scarcely be

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<sup>2</sup>Edward Sagarin, Deviants and Deviance: An Introduction to the Study of Disvalued People and Behavior. New York: Praeger Publishers, 1975, p. 295.

prevented, considering their highly visible and stigmatizing condition. Employment opportunities are often given to others as soon as the short statured person arrives for a personal interview. Relationships with average-sized persons are hampered, be they business or social, largely due to uncertainty on how to conduct an otherwise normal conversation. Indeed, as the literature has shown, social prejudice against short people tends to encompass a great many aspects of their lives, including a lack of self-respect instilled by a feeling of social hostility, discrimination on the job, underestimation of intelligence and other abilities, and a weak self-image fostered by the above, particularly as it applies to the business and professional world, and ultimately how it affects their social life. Yet, Money and others have shown that the mental development and intelligence levels of dwarfs are not affected biologically by their physical afflictions.<sup>3</sup> The fact that most people equate age with size and therefore assume that a person the size of a young child must also think like a child,<sup>4</sup> is perhaps one of the most

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<sup>3</sup>John Money et al., "Dwarfism and hypopituitarism: Structural retardation without mental retardation." American Journal of Mental Deficiency 72 (1967), 122-26.

<sup>4</sup>John Money, "Dwarfism: Questions and answers in counseling." Rehabilitation Literature 28 (1967), 134-38.

difficult stigmas that all short statured people in my sample felt was a never-ending chronic source of anxiety, particularly in interaction with others, namely, average-sized persons.

Dwarfs are immediately the victims of social ostracism because their difference is so visible. Not being able to reach a light switch or the top of a dresser was considered to be trivial by many respondents in my sample, in comparison to finding a mate or job. In fact, it was reported to me by many respondents that physical problems could somehow be creatively dealt with by simply using stools or by designing ingenious little devices to hook onto the bottom of a light switch for example, so that one could pull it from four feet off the floor. It was when little people were in fast food restaurants, airports, supermarkets and drug stores, that occasionally they would find themselves in a difficult situation trying to reach high counters, shelves, and booths. Crowds are at best a nuisance for average-sized persons, but for everyone in my sample, agreement was unanimous that being short was a distinct physical disadvantage in crowded subways, elevators and even on

electric conveyors. As one respondent put it, "As soon as I leave the office, I'm up to belts, butts, and belly-buttons."

Shopping for clothes and shoes was considered a problem for some of the short statured people in my sample. Although fitting into children's sizes was considered to be advantageous by a few of the respondents because it was cheaper, the majority did not care for the quality or style of pre-teen or adolescent clothes. Some of the women did their own sewing and seam work for most of their families' clothes. In a recent article, it was suggested that several men's and women's clothing stores have opened their businesses almost exclusively to little people.<sup>5</sup> In 1977, there was only one major retail store that catered particularly to the "petite miss" in New York, called Matthew Love Fashions. Today, shops in San Francisco, two near Detroit, and in Milwaukee are already looking to expand. One Cleveland outlet has started a successful mail-order business. And several other stores catering to short statured people are expected to open soon in Chicago. The article points out that when the short customer comes into

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<sup>5</sup>Wall Street Journal, (February 23, 1981).

one of these stores, he is made to feel that the merchandise business has finally given the little person the care and consideration that other haberdasheries have always provided the average-size man. A dozen or more owners have formed the Small Man's Association of America in order to buy in large quantities merchandise especially tailored for the little person. Moreover, the mirrors in the stores are short, checkout counters are low, coat racks are close to the floor, and suits range from "short" to "extra short" to "extra, extra short" to "portly cadet."

As many of the short statured respondents agreed, it was the social significance of their highly visible and stigmatized physical stature that they felt prompted the psychological, emotional and social obstacles that made their everyday lives so isolated and their sense of self unworthy. For those who had accepted their size and had learned how to cope with others' negative evaluations of them in the "Big World," they had apparently sought and accomplished what for many other short statured people is extremely difficult to attain in their lives, namely, independence and self-acceptance,

coupled with self-assurance.

Clearly, in order to build character, one must know and like oneself by overcoming one's deficiencies and enhancing one's strengths. Short people have to work doubly hard at earning respect, because their size almost always seemed to be the brunt of others' interpretations of their capability. For many of the short statured people in my sample, it was just these types of painful experiences that anyone with an obvious physical deviation must first force himself to overcome in order to mold his sense of self-respect and integrity and then he might be better able to overcome other people's prejudice. Most of those who were successful in their occupation, as well as in finding a mate, admitted that it was not easy at first, there was always a feeling of isolation, embarrassment and the constant fear of latent hostility which imbued a sense of loneliness even in a room filled with other employees or potential partners. But, for these little people, their being successful was based on their coming to terms with their own differentness, being open in their communication with others, and ridding the air of curiosity by generally putting others at ease.

### Our Bodies, Our Selves

As adults, we are so used to how our bodies feel in relation to other people and things that we sometimes don't even think about, for example, our hairstyle or dress. Our physical stature becomes an extremely vital ingredient to our construction of identity and attitudes toward the self through interaction with others. Cooley has described the phenomenon this way:

As we see our face, figure and dress in the glass, and are interested in them because they are ours, and pleased or otherwise with them according as they do or do not answer to what we should like them to be; so in imagination we perceive in another's mind some thought of our appearance, manners, aims, deeds, character, friends, and so on, and are variously affected by it.<sup>6</sup>

Indeed, we imagine the attitudes of others towards us as the reflection of a mirror ("looking-glass-self") creating our definition of what we are. In this research, it was found that height or stature seems to play the crucial role in how little people imagine the attitudes toward them held by tall or average-sized persons, not as a mirrored image but rather as a negative cultural conception of their condition.

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<sup>6</sup>Charles H. Cooley, Human Nature and the Social Order. New York: Charles Scribner's & Sons, 1902, p. 104.

It was my experience, in standing next to a short statured person, that I had the feeling of my own body size being altered or distorted in its size. However, in standing near another who is of extreme height, I suddenly became conscious of my own smallness. Similarly, very thin people may give a person the feeling that he is unusually wide, and an overweight person may feel amazingly thin in the presence of another who is grossly obese. Indeed, one's stature may seem to shift because of the psychological impression that someone makes on an individual, particularly if that individual has unusual body dimensions or is someone of special significance. As discussed in the early part of this dissertation, the presence of one's boss or parent, or anyone of great authority, may make one literally feel smaller than usual. Moreover, being reprimanded by any of these figures tends to reduce a person's image of himself drastically.

For the dwarf, having a depreciated perception of self because of his size may ultimately imbue him with a sense of unworthiness and disgust. However, for some dwarfs one measure of coping with this type of attitude

by others is to attempt to "pass," as Goffman suggests, through the utilization of various "disidentifiers" - namely, carrying a cane, wearing a top hat, or having a special pair of shoes made with lifts. Similarly for women, I noticed one short statured woman at a holiday party who wore a long train on her dress, while others had long flowing hair and wore jewelry (particularly necklaces), all of which tended to enhance their size. This seems to support the fact that people of all sizes and shapes tend to labor to build up the size of specific body parts whose psychological importance requires a parallel size emphasis. The example of the padded bra and the padded shoulders of a man's suit coat are clearly efforts that people still use today. However, dwarfism is so highly visible that passing and the use of disidentifiers are rare; other means of coping with the stigma must be found. There are secret deviants and concealed characteristics that stigmatize, but dwarfs and dwarfism are not among them.

If a person's body-image fails to live up to his own perception of how it ought to be, this then can become a focus of chronic anxiety. Indeed, so important

is it, as conveyed by cultural norms, that a woman with small breasts may forever doubt her own femininity, or a man may have doubts about his masculinity or potency because of his penis size. Thus, it is a fact that we have rather strict definitions of what are proper body dimensions, and anyone who is the slightest degree dysplastic in size proportions is overwhelmingly viewed as peculiar, deviant and in some circles, morally deficient. As discussed in the literature on disability, almost all of us are disturbed when we see someone with a body noticeably deviant from the norm. The upsurge of tension that grips one during an encounter with an amputee or a badly scarred face, or with a Thalidomide baby, is sometimes tantamount to the realization of how we are supposed to look. The sight of an amputee is alarming because it proclaims an image of a human frame lacking an arm or leg and in so doing, implies that the same loss could potentially afflict our own body. However, the anxiety elicited in others by the distorted body image (amputee, cripple, etc.) is a measure of the centrality of body stability. The dwarf's body, on the

other hand, has not been distorted by war or accident.

The status accorded the amputee is of course that of the involuntary deviant, as is the deviant status of the dwarf. For the dwarf, his condition was typically inherited, and hence he cannot be held responsible for his state. As for his stability and body integrity, the dwarf has easily shown that he can equally perform almost any task that an average-size person can, if only he were given the equal opportunity.

#### Dwarfism as a Master Status

Dwarfism is a condition that is perhaps best understood as sharing with other physically disabled persons a "master status,"<sup>7</sup> based on society's hostility and aversion toward their condition. As Hughes first noted in his discussion of the concept, persons having a master status normally have a key trait to their identity which distinguishes them from others. He uses the example of the physician, whose medical degree certifies him as eligible to practice medicine, as his master trait. However, reference to a specific status as being synonymous

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<sup>7</sup>The original concept of master status was suggested by Everett C. Hughes, "Dilemmas and contradictions of status." American Journal of Sociology 50 (1945), 353-59. It was later applied to the study of deviance by Howard S. Becker, Outsiders: Studies in the Sociology of Deviance. New York: Free Press, 1963, pp. 33-34.

with the individual - i.e., being upper middle-class, male, WASP, etc. - tends to dominate how a physician is seen in other aspects of his life, and how he sees himself in relation to other activities. Being a female or a black physician tends to offset the other status of physician because sex or skin color is a more dominant status and thus overrides all other statuses as the master status.

Dwarfism can be seen as a master status, overriding all other auxiliary statuses such as physician, lawyer, or pianist, being from the upper middle-class or the ghetto, Protestant or Catholic, outgoing or introverted, intelligent or dull. Because the stigma of dwarfism carries more socially defined symbolic value than any of these other traits, in the eyes of the normals dwarfs are considered either weak, inferior, and incapable of doing any demanding task, or they are seen as possessing exceptional capacities or abilities. Rarely will the dwarf be evaluated objectively on the basis of his knowledge, abilities, skills, strengths and weaknesses, but rather on his size. Thus, the dwarf's short stature becomes his one major negative attribute that society

deems as his master trait. And because it is highly visible and extremely stigmatizing, and for most dwarfs beyond change, it becomes a handicap in his everyday life beyond that which is rationally necessary.

### Social Interaction

As a result of their negative status in society, there is a great deal of strain toward normalization among dwarfs and average-sized persons, particularly in the area of social interaction, in order to diminish the highly visible obtrusiveness of their deviance. Many short statured people have developed strategic mechanisms of coping with their master status in order to alleviate this strain, particularly since the basis of their problem and of their plea for acceptance is rooted in their unintentionally acquired condition. This in itself becomes a source of confusion and uncertainty, in that the condition of dwarfism, or any other kind of physical disability, could hardly be imagined as something the individual voluntarily or intentionally brought on himself. Yet, his involuntary physical condition, with its discredited (or highly visible) and disvalued traits.

is considered counterposed to social norms and expectations. The labeling perspective tends to examine this phenomenon most succinctly because it stresses the importance of societal reaction and the treatment that is afforded the deviant actor, as well as the defense strategies he in turn creates for himself. Goffman's insightful discussion of the problems that arise in face-to-face interaction between the disabled as one group of stigmatized individuals in society, and the so-called normals, is germane to the very same difficulties that dwarfs face as well. More important, however, is how the involuntary deviant manages his impression to others.

Whatever may be the type of disability or handicap (blindness, being crippled or a paraplegic, an amputee, facial disfigurement, dwarfism, etc.), ordinarily individuals with such conditions attempt to construct a modus operandi that can feasibly be used to convey impressions of managing an otherwise intolerable situation. The works of Scott, Edgerton, Freidson, Davis, Goffman, Sagarin, and others, include examples of these, the purest of society's victims, and how many manage to cope with their stigma.<sup>6</sup>

For the short statured person, his discredited visibility is perhaps by far the "real" handicap he faces physically, that is, rarely is his vision or use of his limbs impaired. Hence, other than an obvious disparity in height, dwarfs share the same capacities, needs, skills, intelligence, wit and charm, as any average-size person. Most respondents in my sample found that, with a simple amount of insight and ingenuity, they were able to deal with most physical tasks that might have appeared too difficult for them because of their diminutive size.

The major difficulties arose for short statured persons when they were out socially or were being introduced to someone of average height for the first time. Nearly always a state of confusion and uncertainty prevailed over how to conduct an open and honest mode of conversation. Moreover, this situation has been further complicated by the pervasiveness of society's conceptions of disabilities in general and of dwarfism in particular.

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<sup>8</sup>See especially, Robert A. Scott, The Making of Blind Men: A Study of Adult Socialization. New York: Russell Sage, 1969; Robert B. Edgerton, The Cloak of Competence: Stigma in the Lives of the Mentally Retarded. Berkeley, California: University of California Press, 1967; Eliot Freidson, "Disability as social deviance," in E. Freidson and J. Lorber (eds.), Medical Men and Their Work. Chicago, Illinois: Aldine Atherton, 1972, pp. 330-52; Fred Davis, "Deviance disavowal: The management of strained interaction by the visibly handicapped." Social Problems 9 (1961), 120-32; Erving Goffman, Stigma, loc. cit; Edward Sagarin, Deviant and Deviance, loc. cit; and Edward Sagarin, Odd Man In: Societies of Deviants in America. Chicago, Illinois: Quadrangle Books, 1969.

This is partly due to its rarity, but when present it is highly visible and extremely stigmatized. Indeed, the type of discrimination our culture exhibits toward dwarfism, as well as a few other highly discredited disabilities, is reflected in literature and the arts, in which, in effect, it is seen as a profound and perpetual fear and anxiety about losing one's own physical integrity, as the following suggests:

...the disabled are a threatening reminder of our own culpability - they stir up archaic castratory fears, they portray in the flesh the dreaded outcome of possible parental revenge for transgressions, real or imagined.<sup>9</sup>

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<sup>9</sup>Shari Thurer, "Disability and monstrosity: A look at literary distortions of handicapping conditions." Rehabilitation Literature 41 (1980), p. 14; also, see the works of Leslie A. Fiedler, Freaks: Myths and Images of the Secret Self. New York: Simon & Schuster, 1978; Susan Sontag, Illness as Metaphor. New York: Farrar, Strauss & Giroux, 1977; Carson McCullers, The Ballad of the Sad Cafe and Other Stories. New York: Bantam Books, 1969; Ashley Montagu, The Elephant Man: A Study in Human Dignity. New York: E. P. Dutton, 1971; and Henry Viscardi, Jr., A Man's Stature. New York: Paul S. Eriksson, Inc., 1972. For two early medical depictions of dwarfs, see Paul Horstmann, "Dwarfism: A clinical investigation." Acta Endocrinologica 5 (1949); and H. P. G. Seckel, Bird-Headed Dwarfs. Springfield, Illinois: C. C. Thomas Publishers, 1960. As for individual works depicting the dwarf or midget in a discredited way, see Charles Dickens, The Old Curiosity Shop. London: Oxford University Press, 1841 (Penguin reprint, 1977); Orrin Klapp, Heroes, Villains and Fools. Englewood Cliffs, New Jersey: Prentice-Hall, 1962; and Par Lagerkvist, The Dwarf. New York: Hill and Wang, 1945. Also, see, Walter Bodin and Burnett Hershey, It's a Small World. New York: Coward McCann, 1934; and Walter de la Mare, Memoirs of a Midget. New York: Alfred A. Knopf, Inc., 1922.

On the other hand, any type of deformity may reinforce the positive images of self-satisfaction of others who do not show visible defects, as in the following:

...the sinning character in fiction is a convenient receptacle...we unconsciously identify with. No individual could remain impervious to such an avalanche of prejudice, especially as it is conveyed in such a respected medium as our literature. What can the pockmarked woman feel when she is endlessly portrayed as noxious; or the dwarfed man, who is forever debased?<sup>10</sup>

In either case, the disabled do not represent an homogeneous minority group sharing characteristics that may typically bring about discrimination, in the same way that blacks or women bear the discrimination against them. Instead, there is a continuum of severity, visibility, and stigmatization among the disabled that largely determines the nature and intensity of discrimination accorded them by society. Moreover, the appearance and visibility of a condition may be the most important factor in determining both the interpersonal social consequences of a disability and its effect on one's self-image. For example, as Cooley's concept of the "looking-glass-self" suggests, the attitudes and reactions of

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<sup>10</sup>Thurer, op. cit., p. 14.

others to the self can largely predict how we feel about our self. Hence, because of its highly individualized features, the face has perhaps the greatest symbolic significance for a person's self-esteem. Those who must suffer with a facial disfigurement, as the result of an accident or illness, are reportedly the most extremely depressed of patients.<sup>11</sup> Clearly, much of the depression for these victims of social repugnance, but also for dwarfism as well, is amplified by the cultural uniformity to the "body beautiful" ethic.<sup>12</sup> Yet, there seems to prevail, if only minimally, a sense of guilt at showing our aversion, disgust, or even curiosity to others who exemplify deviations from the normal physique.

Consequently, since normals must watch their every gesture and word so closely in order not to make a negative slip or show their aversion, and since the norms regulating social interaction between normals and the physically disabled in general are quite ambiguous for both parties, it is no wonder that such interactions are usually uncomfortable, rigid and strained. Davis has

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<sup>11</sup>See Francis C. MacGregor, "Some psycho-social problems associated with facial deformities." American Sociological Review 16 (1951), 629-38; and Tomatsu Shibutani, Society and Personality. Englewood Cliffs, New Jersey: Prentice-Hall, 1961, pp. 237-38.

<sup>12</sup>S. A. Richardson et al., "Cultural uniformity in reaction to physical disabilities." American Sociological Review 26 (1961), 241-47; also, Werner J. Cahnman, "The Stigma of Obesity." The Sociological Quarterly 9 (1968), 283-99.

discussed this problem perhaps the clearest by suggesting that those who seek neither to deny nor conceal their handicap, but merely to normalize relations and counter the negative aspects of social interaction, are basically projecting themselves as physically different so as not to be considered as socially different. Davis calls this technique of neutralizing the strain in interaction on the part of the disabled, vis-a-vis normals, "deviance disavowal."<sup>13</sup> The difficulties, however, that too often result from this situation are mainly due to misinterpretation by the normals; that is, a normal may become overcompassionate and thus overcompensate his feelings by reacting to the disabled person as though his situation were worse than it really is. On the other hand, in order to avoid embarrassment, he may ignore the difficulties altogether.<sup>14</sup> Further complicating matters is the possibility in which the disabled individual may attempt to embrace his role by conveying an image of normalcy, with his impairment being the central focus of his life. This is considered to be essentially the reverse of deviance disavowal and

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<sup>13</sup>Davis, loc. cit.

<sup>14</sup>Sagarin, Deviance and Deviants, op. cit., p. 212.

is termed "deviance avowal."<sup>15</sup> However, this latter technique of neutralizing social interaction between the disabled and normals may ultimately reinforce the disabled person's deviant status not only to his own self identity but in the minds of normals as well, thus perpetuating and reinforcing their stigmatization.

In the case of dwarfs, their highly visible and stigmatized condition hardly allows them to conceal their differentness; thus, most attempt to disavow their deviance and hopefully promote some degree of normalization between themselves and average-sized persons when they interact. However, some attempt to use their stature as a formidable means to a hopefully worthy and/or beneficial end, that may prove helpful either to themselves or at least to short statured people as a discriminated collectivity. That is to say, some short statured people, and in particular (as this researcher found to be the case) certain leaders of the organization of little people (LPA), continue to embrace their deviant role in an effort to counter social hostility towards them through effective mediums of public relations, in order to get their interests advanced or at least heard.

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<sup>15</sup>Ralph H. Turner, "Deviance avowal as neutralization of commitment." Social Problems 19 (1972), 308-21.

Through various lobbying channels, as the President of LPA discussed with me, he was instrumental in forcing the Federal government to increase the accessibility of public institutions - including government office buildings, museums, universities, etc. - to the disabled. It is granted that much of this program was devoted to Section 504 of the Rehabilitation Act of 1973, which primarily assisted wheelchair victims, but many older short statured persons, because of orthopedic problems, must wear braces or, in fact, use wheelchairs themselves. In any case, the building of ramps and escalators met with much approval by short statured people, since their legs tire quickly. However, it was also pointed out to me by the President of LPA that "just because we tire more quickly doesn't mean that we aren't able to cover the same distance as average-sized persons. We simply have to move our legs at twice the speed in order to keep up."

Apart from obtaining some physical changes in the construction of better facilities for the handicapped in general, this effort has not helped short statured people to become more integrated into normal or conventional society.

On the other hand, any special privilege granted them may only contribute to their apartness by singling them out as unable to compete, thus reinforcing their stigmatized position in society as being one of helplessness, therefore diminishing their chances for societal integration.

One thing is for certain, as an involuntary deviant, the dwarf cannot be held responsible for his condition; hence, the burden of coping with negative societal responses to his stigma should not rest entirely with him. Part of the reason why interaction with average-sized persons is so strained is because the short statured person's perception of how to alleviate tension and/or in finding resources for dealing with it are basically as ambiguous to him as it is to average-sized persons.

Most short statured people rarely associate with or encounter average-sized people. The exception occurs when they work in the same office, or when one is occasionally introduced to the other at a social gathering such as a party, but they are not likely to be invited or to attend such gatherings. Consequently, rarely is there the opportunity to develop interpersonal skills

needed to manage the impression that they (little people) make on average-sized people. Needless to say, the same predicament seems to apply for average-sized persons as well. Perhaps if the latter were better able to learn to cope with the fears and anxieties that the short statured person may have aroused in them, this would be a first step in alleviating some of the strain during a first confrontation. In addition, more contact generally between average-sized and short statured persons would help to diminish the highly visible obtrusiveness of their deviance. These two points were emphasized repeatedly to me during my research by people of all heights. It was felt especially important for future generations in order to lessen the strain between the average and the short.

It has been suggested earlier and throughout this research that physical differentness tends to conjure up a discrepancy to social norms and expectations of the individual, his capabilities notwithstanding. Hence, one's physical appearance, and for the dwarf or midget his stature, largely determines what is expected of him vis-a-vis everyday interaction at all times in his life.

Thus, the image one conveys of himself to his self and to others is extremely important in how others will receive him.

As a child with a disability quickly learns, society evaluates his cultural prognosis and ultimately his future, no matter how protective his parents may be. More important, his impairment may become the central focus of his life, and his avowal of his role may foreclose any potential change or development that might otherwise have been pursued. The child born with achondroplasia, the most common form of short-limbed dwarfism and occurring in approximately 1 in 40,000 live births, is not only accorded a deviant master status based on bodily nonconformity, but as a direct result, he may begin to develop very negative feelings about his body-image and self-image, as he internalizes conventional society's values governing just what is proper physical integrity, competence, and beauty. Since his short stature does not meet such criteria, he has literally but one alternative, to accept his body as it is and learn to adjust to others' conceptions of him. His major task is to be open, honest and forthright to those

who show ignorance based on superstition, and otherwise to get on with the task of living as normal a life as he can.

For the rest of us, it is our task and responsibility to learn to eradicate superstition toward those whose physical stature may be diminutive, but since they have committed no immoral act, there is no logical reason to disvalue them and to exclude them from the world of normals.

Little People of America, Inc. as a Voluntary Self-Help Organization.

From the perspective of the sociology of deviant behavior, minorities and collectivities, voluntary and involuntary associations, and social movements, two problem areas were explored in relation to the examination of LPA as a self-help organization. However, I should like to first summarize what Sagarin, Goffman, and others have said on the distinction between voluntary and involuntary associations among societies of deviants, their motives for formation, and problems, if any, they may encounter. As Sagarin states:

The voluntary association is not only a group that a person can enter and exit at will but one that is formally organized. An involuntary association would be one to which the individual member belongs through no will of his own and which he cannot leave as he pleases; it might take on formal or informal organizational character. As a formal structure it could be a prison or mental institution into which the inmate is placed because of some alleged antisocial behavior or disvalued status.<sup>16</sup>

Perhaps the most important goal for members of voluntary associations of deviants is to strive to overcome their stigma. These associations can also provide protection for its members from the hostile and disapproving members of conventional society. By helping the individual to change his own traits and by developing alternative social causes that will allow their members to become more acceptable to the world of normals, the voluntary association may be limited in its capacities to change entrenched social attitudes, but it is a revolution of sorts that may be necessary in today's changing society. The real drawback is that through the act of joining such an organization, an individual must bear the risk of increasing his stigma by publicly avowing his deviance and his membership to a socially disapproved category.

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<sup>16</sup>Sagarin, Deviants and Deviance, op. cit., p. 313.

In the involuntary associations of deviants, and particularly those with a formal structure, the members' entire world is defined for them by structural demands based on a formal hierarchy and bureaucratically designed, thus the inhumaneness and almost totalitarian sense of order of the association. Goffman calls these "total institutions"<sup>17</sup> in some of which the individual's alleged antisocial behavior or disvalued status is examined under a microscope for purposes of ideally rehabilitating. Unfortunately, the procedures used in such institutions only denigrate and debilitate, intensifying whatever may have been the stigma associated with admission to the institution.

For purposes of this research, the voluntary association has been linked to what has also been called self-help groups or organizations whose motives for joining and goals of its members are similar. Generally speaking, self-help groups take on the following characteristics:

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<sup>17</sup>Erving Goffman, Asylums. New York: Doubleday, Anchor Books, 1961.

Self-help groups are voluntary, small group structures for mutual aid and the accomplishment of a special purpose. They are usually formed by peers who have come together for mutual assistance in satisfying a common need, overcoming a common handicap or life-disrupting problem, and bringing about desired social and/or personal change. The initiators and members of such groups perceive that their needs are not, or cannot be, met by or through existing social institutions. Self-help groups emphasize face-to-face social interactions and the assumption of personal responsibility by members. They often provide material assistance, as well as emotional support; they are frequently "cause" oriented, and promulgate an ideology or values through which members may attain an enhanced sense of personal identity.<sup>18</sup>

With the above definition in mind, I should now like to discuss the first major problem I examined in relation to LPA as a voluntary self-help organization. In essence, it shares with other voluntary associations similar difficulties, namely, a chronic problem of encouraging participation, reducing apathy, and increasing commitment to organizational goals and activities among their members. The major basis of differentiation of members is largely one of activity, rather than rank or status, as one ordinarily finds in a complex or formal organization.<sup>19</sup>

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<sup>18</sup>Alfred H. Katz and Eugene I. Bender, The Strength In Us: Self-Help Groups In The Modern World. New York: Franklin Watts, 1976, p. 9.

<sup>19</sup>See Amitai Etzioni, A Comparative Analysis of Complex Organizations. New York: Free Press, 1975; and Arthur L. Stinchcombe, "Social structure and organizations," in James G. March (ed.), Handbook of Organizations. Chicago: Rand McNally, 1965, pp. 142-93.

The level of participation is of special interest not only because of the general problems LPA shares with other voluntary associations, but also because of the nature of dwarfism and LPA. Participation in LPA was largely segmental; that is, depending upon the individual's enthusiasm, time or interest, he may or may not choose to attend meetings and even then only on special occasions, such as a district or chapter meeting rather than more periodic local meetings. Moreover, there seemed to be a discouragement of outside friendships among LPA members. Apart from other little people interested in joining the organization, there was stern criticism to those little people who saw LPA as only a social club. As for average-sized persons not having a relative or family member already in the organization, or if they were not a medical professional working in the field, their presence was scoffed at and many showed glances of rage and discomfort (particularly to this researcher, even though my presence and the purpose of my research had been formally announced).

Much of this aura of self-imposed isolation was often contradicted in hearing various speakers encourage little

people, at meetings I attended, to associate with average-sized persons. Thus, the organization seems to retain a division or conflict between those who have dropped all pretense of their deviant status and have attempted to change society's negative evaluation of them, and those who still deceive themselves by perpetually cloaking their stigmatized condition to appear normal and respectable (some dwarfs used various "dis-identifiers" such as hats, canes, etc. to bring this appearance about).

This latter point brings to mind the second problem area I examined involving LPA. What "therapy" is offered members, and does it work? In other words, to what extent do members of LPA see their deviant status reduced as a result of participation in the organization and conformity to society's norms; or do they learn to adjust to the stigmatization and lack of acceptance accorded them by society? First, it is interesting to note that Sagarin describes the tendency of stigmatized persons with physical abnormalities and emotional handicaps to form self-help groups or organizations of deviant and stigmatized people for two major purposes: (1) as a means of enabling

members to conform more easily to societal norms, or (2) to change the old norms and create new standards that will accommodate their deviant behavior.<sup>20</sup> The first of these may be seen as an example of self-change; while the second could be seen as encompassing the group's struggle for rights as against privileges, their rejection of the concept of stigma, and their mutual reinforcement of deviant values, all pointing to a greater acceptance of the worthwhile aspects of self.

As was earlier stated, LPA is a nationwide, voluntary organization whose membership is limited to persons 4' 10" or under, with the majority ranging anywhere between 2' 6" and 4' 6" tall. The organization was initiated and is controlled by dwarfs. In fact, professionals (consisting of physicians, geneticists, nurses and social workers) are welcomed and encouraged to provide valuable services in the areas of consultation and diagnostic services. But any efforts by professionals to control the organization or any part thereof, or direct its activities, is quickly discouraged. This was particularly true with regard to LPA's association with Johns Hopkins Hospital, in that there was considerable strain by some professional staff

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<sup>20</sup>Sagarin, Odd Man In, op. cit., p. 21.

members on how to handle certain cases that required extensive testing and occasionally post-operative consultation. Apparently, the consultations and follow-ups of some patients were considered unnecessary by various members of LPA. As a result, and for various unknown other reasons, LPA was occasionally reluctant to provide patients to the hospital. Instead, many of the short statured people I spoke with said that they had heard by word of mouth about interest and research in their problem at Johns Hopkins, rather than through LPA.

LPA does have auxiliary members, composed of fathers, mothers, and others in the household of the little person. On the local, district, and national levels, they are included in a few activities, for example a pre-Christmas party I attended. Otherwise, they are encouraged to conduct their own meetings and gatherings by themselves. In addition, parents in Human Growth Foundation and those in the Parenting and Counseling Training Program were especially concerned about their children and the activities that only they (the children) were privy to as members of LPA; as one average-size mother stated: "They (LPA) just don't want us around as though we might spoil their

activities or say something about the way they're running the organization."

The major goals of the organization, apart from providing fellowship and perhaps some helpful information to new members about physicians or clinics in their particular area who specialize in giving medical care and advice to short statured people, seemed to include very little about helping little people help themselves by increasing their knowledge about dwarfism (but perhaps this is because the majority of the members of LPA, as exemplified by my sample, were disproportionate, meaning that there is essentially no medical recourse to their condition), or by changing their attitudes toward their deviant status, their self-concept, and the stigma they experience in social interaction primarily with average-sized persons.

Occasionally, in fact once a year, there are lectures and workshops at the national convention, attended by those able to travel a great distance and is able to afford the time and cost of a week long event. At the 1981 convention, at one of the more informative workshops, a discussion was held on nutritional problems of little

people. One short statured person told how he had lost twenty pounds by following a strict diet. Another workshop included many parents who expressed their concern over the difficulties of their short statured children in school. Here, support was given and advice offered on possible solutions to these problems.

Otherwise, the convention centered on fashion shows, dances, talent shows, business meetings (including, when and where next year's convention was to be held), and other routine matters. However, in June 1981, Johns Hopkins Hospital sponsored the eighth in a series of Short Stature Symposia, where little people were exposed to a plethora of information, from "Creative Clothing Designs" to "Preparation for and Coping with College." Yet, LPA was and has remained only a consultant for these major seminars which bring professionals, family members, and the short statured people together for one day and provide much more enthusiasm, information and fellowship for everyone involved than seemingly any other event of the year. Paradoxically, it was told to me by one of the hospital staff that after this year's symposium, LPA apparently no longer cared to act even as a consultant,

much less a participant, in future symposiums.

Unlike Alcoholics Anonymous or Synanon, participation in LPA was, as mentioned earlier, limited and segmental. Even the active members rarely attended local or district meetings on a regular basis. Hence, most of the members of LPA in my sample did not come regularly to meetings but maintained their membership and an active involvement over a period of several years. The respondents who had been members of LPA for at least one year, and had attended several meetings during that time, reported that they had gained some knowledge and had a slightly less negative attitude toward their own self-acceptance as a result of their organizational participation. But attitudes toward dwarfism and its treatment, and the type of dwarfism, were not associated with the amount or type of benefits, if any, received by members. In fact, some reported negative benefits, including, as one respondent called it:

A distinct feeling of self-rejection because of what I saw these people doing. I mean it was the silly games and frivolous activities they enjoy that perpetuates an image that so many of the rest of us are trying to make others see is a myth. That we are real, that we are not children, that we are intelligent, normal human beings, just shorter than most. If only they could accept themselves and get on with it.

It became clear to this researcher that LPA primarily attracts and holds onto certain types of dwarfs. This is partly explained by a tension, as Sagarin points out:

LPA's members are caught in a contradiction: they want to meet one another, but, once they do, there is no purpose, goal, or structure to their meetings - nothing to bind them to the organization. If they avoid the problems encountered in being little, they lose any *raison d'etre*; on the other hand, if they center the meetings around such problems, members say that they came to get away from them.<sup>21</sup>

During the course of examining these people's marginal lives, I concluded that by encountering social disapproval, hostility or petty curiosity, many short statured people have felt pushed into seeking substitute group affiliations. Constant social ridicule and "belittlement" on the job, frequently reinforced by unsatisfactory personal relationships, can all become internalized by the little person, prompting a personal need to join an organization that seems to offer the promise of personal acceptance and satisfaction by hopefully lessening his marginal status.<sup>22</sup> However, as is typical of other such self-help groups, a precondition for a

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<sup>21</sup>Sagarin, Odd Man In, op. cit., p. 205.

<sup>22</sup>Everett C. Hughes, "Social change and status protest: An essay on the marginal man." Phylon X (1949), 58-65.

prospective member is that he must define himself as in need of the help of others. Just as a "problem" gambler must affirm his problem, a short statured person must risk the potential embarrassment or pain of seeing others like himself and therefore learn to cope with that reality. But more important, he must then choose between conforming by society's standards to the behavior appropriate to his deviant status, or to assist in changing the traditionally held beliefs and propagandize his existence as different but not deviant so that conventional society might learn to accommodate him.

The act of identification of the individual as a dwarf may appear synonymous with the evaluation of self as an alcoholic in Alcoholics Anonymous or the gambler in Gamblers Anonymous. However, membership in LPA differs somewhat, in that the alcoholic or gambler must first accept his identity as an alcoholic or gambler. His task, then, is to change his behavior.

In contrast, for the dwarf, his deviant status cannot be attributed to his behavior, but instead he is disvalued not for what he may have chosen to do but

for what he has no choice in being. Hence, his task then is to get on with living the same life, only more happily and with a clearer sense of identity and self-worth.

Unlike the alcoholic or gambler's acceptance of his identity which may bind him socially and emotionally to A. A. or G. A., the dwarf, after accepting his identity and learning how to "normalize" (in Goffman's sense of "normification"<sup>23</sup>) his position in society, may or may not choose to remain with the group (LPA) and, in fact, get on with the business of daily living.

In any case, it became clear that LPA professes to make one aware of a deviant status, by isolating its members and discouraging outside information (with the possible exception of medical breakthroughs, the most important presently being the experiments on synthetically produced human growth hormone). As a result, with little public exposure and awareness of their plight, accommodation seems hardly more tolerable today than twenty years ago. Surely, some dwarfs have catapulted themselves to praise and recognition (largely in the spotlights of Hollywood or some area of the entertainment industry).

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<sup>23</sup>Goffman, Stigma, op. cit., pp. 30-31.

But little people as a social category, as a discriminated against minority or collectivity, will remain stigmatized largely because of their height, but also because there seems to be hardly any emphasis in the direction of a social movement or revolution of sorts by LPA in the direction of enhancing individual social competence and relationships while simultaneously affecting society's hostile attitudes.

It would seem that the education of average-sized persons to the plight of little people's lives, similarly to how millions have been educated to learn to accept other minorities, for example blacks and aged, apparently is the only sure solution for society to learn to accept "short" brethren. Indeed, if dwarfs themselves, as a collectivity, cannot break away from their marginal status because of their physical "differentness," then it is society's negative evaluations of them that should be reexamined and the responsibility of this task lies with all of us.

What success LPA has had can be seen in the increased number of members and the emphasis on trying to emphasize to its members (albeit, perhaps, only by

acknowledging their own stigma) that their self-image and lifestyles should be reinforced as "normal." Even their humanity, because they are victims without being victimizers, requires reinforcement.

In sum, LPA can be seen as a socializing group where there is a pairing off of its members and exchange of ideas. Interaction is derived from the feeling of security about being with one's own kind, where inhibitions are relaxed that might otherwise be felt in the presence of average-sized persons. Consequently, the organization becomes a focal point for courtship, dating and marriage for many little people whose chance of meeting otherwise potential partners is extremely limited.

The LPA seeks to change public attitudes toward the deviant status. It seeks to substitute sympathy and compassion for pity, acceptance for scorn, and normalized relationships for the strained ones that comprise the majority of social interaction with the average-sized world. Unfortunately, rather than working toward breaking down the barriers between the larger society and the dwarfs, LPA has caused many to withdraw

from interaction with average-sized persons by acting as a protective cocoon from a world in which they cannot cope. This is ironic when one considers that the organization is attempting to counter secrecy by attempting (however poorly) to integrate and eventually mainstream its members into a world of respectability.

Nevertheless, LPA has proven to offer some therapeutic value to members and this may well be its chief *raison d'etre* - by sharing with other short statured people experiences and information about intimate aspects of their daily lives, this has given many a sense of pride in knowing that there are others such as themselves. Unfortunately, beyond the socializing aspect of this primary motive for many little people to become members of LPA, it falls shy of concentrating on the reduction of stigma. Still, for others, membership has given them insight and strength to overcome their physical stature as a socially stigmatizing and debilitating trait, and has consequently motivated them to integrate into the mainstream of society with people of all types and predilections.

## Conclusion

In the process of personal development and the enhancement of feelings of confidence among the extremely visibly handicapped, the literature has shown that short statured people, as well as polio victims,<sup>24</sup> the blind,<sup>25</sup> and others must evolve a range of coping mechanisms to deal with their stigma.<sup>26</sup> My own research has suggested that because of the variable attitudes society holds toward persons of abnormally short stature, a normalization process on the part of the dwarf is used in many different situations as a strategy in order to diminish the tension and uncertainty and to allow social interaction to proceed.

Indeed, it became more and more clear in my research with little people that the barriers to a normative lifestyle for them were in the main social, rather than medical. Attitudes of potential employers, school and workmates, and the general public have far more often than not set dwarfs apart as a distinct category of persons whose expectations, behavior and potential capacity is largely based on the negative perceptions that average-sized

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<sup>24</sup>Fred Davis, Passage Through Crisis: Polio Victims and Their Families. New York: Bobbs-Merrill Company, 1963.

<sup>25</sup>Scott, The Making of Blind Men, passim.

<sup>26</sup>Goffman, Stigma, passim.

persons have of them. Whether it be fact or fantasy, imagination or lore, exaggeration or realism, they perceive, fear, and anticipate discrimination toward them because of their size.

### Future Research

In terms of further studies based on the implications drawn from the present work, one ought to study whether the achondroplastic dwarf might make a better adjustment than the normally proportioned dwarf, commonly called "midget," because the former has been socialized to see himself as having a stigmatizing defect, and has been aware of it from the earliest years, and the latter may have been smaller than other children, but not sufficiently different until his growth spurt years, when he just failed to grow at the normal rate or at all.

Inasmuch as the present study did not attempt to investigate differences in terms of how the achondroplast might differ from the hypopituitary dwarf (midget), indeed, the sort of problems that each encounters in terms of socialization, development, membership or non-membership in a self-help group, employment, etc., may well be perceived differently between the two, which in turn will

ultimately affect their own lifestyles and self-image. The different subtleties between the normally proportioned dwarf (midget) contrasted with the congenitally deformed dwarf (achondroplast) may better help us to understand some of the behavioral components of each of these little persons' lives and how they perceive themselves in contrast to other achondroplastic dwarfs, other hypopituitary dwarfs, and average-sized persons.

Also, of further interest for potential research, one might investigate the very special problems that average-sized parents face, having produced a short statured child and confronted with the problems of their accepting and adapting to socializing and bringing up the child. Parents are often reluctant to accept responsibility for a genetic defect when they themselves, i.e., the parents, are ostensibly normal, and were unaware of an unwelcome gene in the family. Such parents may feel inadequate and may not be well prepared to give a handicapped child the necessary amount of care, love, and affection, together with the training and discipline that are needed. Research on such parents might focus on the assistance they receive from families, social service, and parents in similar situations; on the con-

trast between the parents of short statured and those of mentally retarded or other handicapped children; on the difference between the handicapped (particularly short statured) parent with such a child and the average statured parent. These are but a few avenues that can prove useful in further studies of deficient height and social adjustment.

## APPENDIX I

## Classification of Causes of Dwarfism:\*

1. Delayed Adolescence.
2. Genetic:
  - a. Constitutional.
  - b. Sporadic.
  - c. Chromosomal.
    - i. Gonadal dysgenesis: Turner's syndrome.  
(cf. Noonan's syndrome.)
    - ii. Autosomal anomalies:
      - Trisomy 21 (Down's syndrome or Mongolism).
      - Trisomy 17 or 18 (Edward's syndrome).
      - Trisomy 13, 14, or 15 (Patau's syndrome).
3. Skeletal:
 

Congenital:

  - a. Chondrodystrophy (Achondroplasia).
  - b. Chondro-osteo-dystrophy (Brailsford-Morquio disease).
  - c. Dysostosis multiplex (Gargoylism or Hurler's syndrome).
  - d. Chondrodystrophia calcificans congenita.
  - e. Epiphyseal dysplasia multiplex (Diastrophic, Metatropic, STD).
  - f. Chondro-ectodermal dysplasia (Ellis-van Creveld syndrome).
  - g. Osteogenesis imperfecta.

Acquired:

  - a. Rickets: infantile, late, vitamin-D-resistant.
  - b. Spinal caries (decay) and deformities due to other causes, e.g., poliomyelitis.
4. Nutritional and Metabolic:
  - a. Malnutrition.
  - b. Malabsorption syndromes.
  - c. Diabetes insipidus.
  - d. Protein deficiency.
  - e. Electrolyte imbalance.
  - f. Glycogen storage disease.
5. Infective:
 

Tuberculosis: malaria: congenital syphilis: hookworm infestation.
6. Systemic:
  - a. Renal.
  - b. Coeliac.
  - c. Fibrocystic disease of the pancreas.
  - d. Hepatic.
  - e. Circulatory.
  - f. Congenital heart disease with cyanosis.
  - g. Cerebral.

## 7. Endocrine:

- a. Hypothyroid: cretinism.
- b. Precocious puberty.
- c. Sexual precocity of gonadal origin:
  - i. Interstitial-cell tumour of the testis.
  - ii. Granulosa-cell tumour of the ovary.
- d. Sexual precocity of adrenocortical origin:
  - i. Congenital adrenal hyperplasia.
  - ii. Adrenocortical tumour.
  - iii. Cushing's syndrome.
- e. Hypopituitary:
  - i. Congenital hypopituitary dwarfism: pituitary infantilism.
  - ii. Isolated growth hormone deficiency.
  - iii. Acquired hypopituitary dwarfism, e.g., tumour, etc.
- f. Pseudohypoparathyroidism.
- g. Hand-Schuller-Christian syndrome (Xanthomatosis).

## 8. Hypothalamic:

- a. Frohlich's syndrome.
- b. Laurence-Moon-Biedl syndrome.

## 9. Other Syndromes of Unknown Cause:

- a. Progeria (Hutchinson-Gilford syndrome).
- b. Cockayne syndrome.
- c. Amsterdam dwarfism (de Lange syndrome).

\*F. Dudley Hart (ed.), French's Index of Differential Diagnosis. 11th ed., Chicago, Illinois: Yearbook Medical Publishers, 1979, pp. 217-29; and David W. Smith, "Recognizable Patterns of Human Malformation: Genetic, Embryologic and Clinical Aspects," in Alexander J. Schaffer (Consulting editor), Major Problems in Clinical Pediatrics. Volume VII in the Series. Philadelphia, Pa.: W.B. Saunders Company, 1976, pp. 197-353.

APPENDIX II  
QUESTIONNAIRE SCHEDULE\*

1. \_\_\_\_\_ Short Stature Attributed to:
- a) Genetic Mutation
  - b) Late Onset of Growth
  - c) Inherited Short Stature
  - d) Previous Medications in Treatment of a Disease  
(e.g., kidney disease)
  - e) Bone Diseases
  - f) Hormone Diseases
  - g) Other
  - h) Unknown
- 2a \_\_\_\_\_ Age (in years) / 2b \_\_\_\_\_ Sex
3. \_\_\_\_\_ Marital Status
- a) Married
  - b) Single
  - c) Divorced or Separated
  - d) Widow or Widower
4. \_\_\_\_\_ Religion
- a) Catholic
  - b) Protestant
  - c) Jewish
  - d) Other
  - e) Non-affiliated
5. \_\_\_\_\_ Highest Education Completed
- a) Elementary School
  - b) Junior High School
  - c) Some High School
  - d) Completed High School
  - e) Some College
  - f) Completed College
  - g) Some Graduate School
  - h) Graduate Degree

\*Portions of this questionnaire are based on the Remington Tryor Social Functioning Scale.

6. \_\_\_\_\_ Occupation
- a) Unemployed
  - b) Housewife
  - c) Secretary/Clerical
  - d) Laborer
  - e) Business
  - f) White Collar Management
  - g) Professional
  - h) Self-employed
  - i) Student
  - j) Retired
  - k) Other
7. \_\_\_\_\_ Income
- a) Under \$5,000
  - b) \$6,000 - \$9,000
  - c) \$10,000 - \$12,000
  - d) \$13,000 - \$15,000
  - e) \$16,000 - \$20,000
  - f) Over \$20,000
- 

The following questions represent a cross section of contemplated areas that are felt to be of significant importance relative to problems faced by persons of short stature. Some questions may not apply to everyone, but for those that do, please allow yourself plenty of time and space to complete your statements. In your answers, please include, for example, under employment: personal experiences, type of job, locale, etc.. This additional information could be especially helpful to others.

Finally, your assistance in filling out this questionnaire is especially appreciated as I know the time and effort that it requires could be used for some other endeavour. For this reason, I wish to thank you in advance and gratefully acknowledge your interest in this research.

Respectfully,

*James Moneymaker*

## EMPLOYMENT\*

- 1) In terms of employment, do you feel a sense of friction or difficulty in your interpersonal relationships - your boss, workmates, customers (as appropriate) - at work? Do you ever find yourself being resented or ostracized by others at work and consequently feel shut out?

SATISFACTORY RELATIONSHIPS

SEVERE DIFFICULTIES

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- 2) Did being of short stature in any way influence your choice of a career?

NOT AT ALL

GREATLY

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\*Please answer the questions in accordance to the scale designated for each - i.e., from greater to lesser severity - depending on your own experiences or opinions. For example, in question #1, if you feel you've experienced satisfactory or normal relationships at work, then you would check satisfactory and explain why. The same would apply for severe difficulties. If you have experienced both good and bad relationships, then write this out and explain why. In this way, answers will be examined and evaluated according to how many respondents have experienced extremes or moderate situations in all the categories and those who have extreme or moderate views on others.

- 3) Do you believe that employers prejudged you in any way because of your height? If so, elaborate.

NOT AT ALL

GREATLY

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- 4) Were you ever faced with other difficulties at work involving such matters as architectural barriers, transportation problems, employee facilities - i.e., telephones, water fountains, stairways, toilets, etc. etc., all being unaccommodating to a person of short stature? Was there ever anything done about these inconveniences so as to make life less exhausting for you?

Yes  No  SPECIFY:

- 5) Why might you think that a short statured child, from a family of short statured persons, would decide to become a physician, lawyer, engineer, etc. etc., and another short statured child from the same family decide to become involved with the entertainment industry - including films, circuses, etc.? In your answer, let us assume that the parent's wishes are not at issue, only those of the child.

## HOMECARE RESPONSIBILITIES

- 1) Have you found managing household chores - cooking, shopping, the washing, cleaning, gardening, decorating (exterior as well as interior), household repairs and so on - a major strain or difficulty as a result of your height? In your answer, please give specific examples of the types of difficulties you face.

**MANAGING WELL**

**SEVERE DIFFICULTY**

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## SELF-CARE

- 1) Sometimes, when people have a handicap, disability or some type of physical disorder, they can lose interest in themselves, in their health or appearance. Have you ever found yourself neglecting your eating habits, your personal appearance - hair, make-up, shaving, dressing, bathing, etc.? Have you neglected any of these things at all because of the way you feel about your self?

GREAT INTEREST

COMPLETE NEGLECT



## INSIGHT BODY-IMAGE

1) How satisfied are you with your bodily proportions?

**EXTREMELY**

**NOT AT ALL**

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2) Do you feel that many average sized persons tend to constantly evaluate short statured persons according to their size (stature) rather than their chronological age? If so, why? Can you recall any illustrative incidents?





- 3) As a parent of a "little little," do you often worry about your feelings for your child? In other words, are you sometimes concerned about your not being able to show enough interest or to become as involved with your child as you would like, or do you find yourself overly involved with your child i.e., overprotective, overconcerned, etc.?

NOT ENOUGH INTEREST

OVERLY PROTECTIVE

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- 4) As a short statured parent, do you feel that your own experiences of growing up will help you in preparing your short statured child to adjust to a world of average sized persons? What sort of techniques of coping do you stress most in your child's adjustment to the outside world?

NOT AT ALL

GREATLY

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- 5) As a short statured parent of an average-sized child, what concerns, if any, do you have about your relationship with that child? How is he/she coping with having a parent who is short statured?



## SOCIAL INTERACTION

- 1) Do you ever feel lonely or alienated because of your height?  
NO DISTRESS MARKED DISTRESS
- 

- 2) Is your social network composed of other short statured persons alone, or do you have friends and acquaintances who are average sized as well, and with whom you feel equally as comfortable?
- 3a) What do you find to be the most difficult problem a short statured person faces when he/she is introduced to an average sized person?
- b) How do you feel such a problem could be better managed for both the short statured person and the average sized person - i.e., what sort of tactics do you find most helpful in alleviating the tension that may occur?

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