Changing Negative Attitudes towards People with Disabilities

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Overview

People with mobility impairments encounter many physical and attitudinal barriers living in the community after initial rehabilitation (Gray, Hollingsworth, Stark, and Morgan, 2006, Stark, Hollingsworth, Morgan and Gray, 2007). Leaving rehabilitation for people with disabilities, specifically those with mobility limitations, is just the beginning of a long process of reintegrating into the community. Community receptivity plays an important role in their reintegration. Bricout and Gray (2006) define community receptivity as, “the willingness, values, and knowledge of people in the community that facilitate the participation of people with disabilities in valued activities and events” (6). Environmental barriers and community receptivity need to be explored further in order to understand the process of reintegration and to intervene, where appropriate. Widespread acceptance of people with disabilities will not be reached until these barriers are eliminated. Outcome measures that assess these concepts will lead to a better understanding of the barriers that are faced by people with disabilities and may suggest ways to overcome these barriers.

The Americans with Disabilities Act (ADA) of 1990 was a milestone legislative success for people with disabilities. The Act officially defines disability as having a physical or mental impairment that substantially limits one or more major life activities, having a record of such impairment, or is regarded as having such an impairment (The Americans with Disabilities Act (ADA) and People with Physical Disabilities, 2006). A physical impairment is defined by the ADA as any physiological disorder or condition, cosmetic disfigurement, or anatomical loss of a body system. Mobility impairments affect the lower limbs and inhibit, in some way, an individual’s ability to walk. Many
mobility impairments are caused by a spinal cord injury (SCI); damage to the spinal cord affects the movement and sensitization of the lower limbs. With these clear definitions in hand, one can begin to measure the impact of attitudinal and physical barriers on the reintegration of people with disabilities into their communities and the improvements that are achieved as these barriers are reduced. We also need to know what personal interactions and behaviors of people in the community facilitate or are helpful with the reintegration process.

Background/Theory

The community receptivity towards people with disabilities has changed over time due to the actions and activities of people with disabilities. In order to understand where attitudes come from and the need for change, the history of the rights of people with disabilities must be understood. The Independent Living (IL) movement is a social movement concerned with equal rights and opportunities for people with disabilities. This social movement dates back to the 19th century as deaf and blind individuals began to stand up for themselves that initiated a slow change of attitudes towards these groups (Martinez, 2007). The IL movement was the foundation of new governmental policies that began to recognize the rights of people with disabilities as evidenced by new policies and the modification of existing policies. The 1973 Rehabilitation Act amended the Vocational Rehabilitation Act to provide IL services to those individuals for whom a vocational goal was not possible or feasible (DeJong, 1979). This Act allowed people with severe disabilities to receive many needed services. The IL movement advocates for accessible buildings and transportation as well as equal job opportunities and the overall inclusion of people with disabilities.
The Americans with Disabilities Act (ADA) of 1990 was a direct outcome of the IL movement and prohibits discrimination of people with disabilities with respect to housing, employment, and public places. One goal of the ADA is participation in major life activities by people with disabilities (Gray et al., 2006). The ADA has led to many organizational changes in businesses such as architectural modifications and policy changes that directly affect people with disabilities (Thomas et al., 2003). Even after these legislative changes and beginning stages of acceptance and inclusion, negative attitudes toward people with disabilities still exist. This illustrates that policies often do not influence the attitudes of people directly but are more a reflection of the needs of specific groups that advocate for civil rights and/or social benefits. The point is that as behaviors change, the attitudes of people regarding the issues change.

The International Classification of Functioning, Disability, and Health (ICF) is a classification system designed to organize factors that influence disabilities into a common and comprehensive language. The ICF recognizes disability as a universal human experience and takes into account social and environmental factors as well as biological factors (www.who.int). In the ICF, participation is the extent of a person’s involvement in an area of human life, comparing people with disabilities to people without disabilities (Gray et al., 2006).

The Disability Creation Process (DCP), a conceptual framework created by Patrick Fougéyrollas, considers disability a dynamic process. Disability is related to the interaction of personal factors (capability to carry out activities) and environmental factors (situation in which the individual lives) as they influence life habits (social and cultural roles) (Blanchet, 1999). The ICF and the DCP are both multidimensional
approaches, use a universal conception applying to human beings, and recognize the influence of the environment (Fougeyrollas, 2006). These definitions of terms and clearly defined categories facilitate the effort to measure the community receptivity.

Problem/Issue

Cox, Amsters, and Pershouse (2001) noted that acute and rehabilitation services for the more recently injured people with Spinal Cord Injury (SCI) exists; however, services for people with SCI living in the community after initial rehabilitation are lacking. Cox et al. (2001) studied the unmet needs of people with SCI living in the community and the barriers associated with meeting those needs. This study, conducted by telephone interviews, found that a high and often unmet need for a variety of follow-up services exists following rehabilitation after a SCI injury. A multidisciplinary approach is essential to meet the needs of people living in the community with SCI to educate them about existing resources in their community.

A strong need is present both to transition people with disabilities from the clinical setting to the real-life community and to meet the needs of people with disabilities already living in the community. Rehabilitation does not stop when the client leaves the clinic. Glass (1998) distinguishes three ‘tenses’ of function: hypothetical, experimental, and enacted. Hypothetical function, the more traditional measure of functional status, can be defined by a client’s capacity for self-report, which is mediated and influenced by cognition. Experimental function is the measure of a client’s capability in a laboratory setting, while enacted function is the measure of a client’s performance of an activity in a naturalistic setting. Studies show that these three aspects of function are related, but they do not measure the same constructs and should therefore
be assessed independently. Reuben et al. (1995) studied the relationships between self-reported, interviewer-administered, and performance-based testing of functional abilities and found many inconsistencies suggesting that these instruments do not measure the same construct. The enacted function should be investigated further because of the different answers yielded from outcome measures as well as the direct relationship to real life. This enacted function is most related to participation and will show outcomes based on actual performance in daily life as opposed to the completion of a task in a clinical setting. Outcome measures assessing community receptivity should be administered in the individual’s environment and should concern the factors of the environment that limit or facilitate participation.

Physical barriers in the environment hinder the participation of people with disabilities. In a study by Cox et al. (2001), participants rated the most important areas of needs assessment, the top four of which included physical changes, transportation, work issues, and ongoing education. In a study by Whiteneck (2004), the number one environmental barrier that was the most problematic for study participants with SCI was their physical environment. Physical barriers encountered in the environment include curbs, stairs, doors, and other means of inaccessibility. In addition, many people with disabilities encounter disadvantages due to their generally low social and economic status. As a result of these disadvantages, they encounter difficulty influencing the physical environment in which they live to accommodate their needs (Bricout & Gray, 2006). These barriers must be eliminated in order to ensure full accessibility of the community to people with disabilities and to improve their participation and quality of life. Reliable and valid outcome measures must be developed that assess the various
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factors contributing to an inaccessible environment followed by interventions to remove these barriers.

In addition to physical barriers encountered in the environment, people with disabilities are met with strong attitudinal barriers in the community as well. Positive attitudes of the general public can facilitate participation, while negative attitudes can hinder participation (Antonak & Livneh, 2000). Many instruments have been developed to measure attitudes but few have achieved general acceptance due to theoretical or psychometric limitations. Social desirability, the tendency to provide answers on measurement instruments that make the respondent look more appealing, is one problem frequently encountered in a self-report questionnaire indicating response bias. Attitudes can be stronger than physical barriers at times but can also be more difficult to objectively assess. The negative attitudes that people without disabilities have towards people with disabilities are a barrier to the participation of these people with disabilities and need to be addressed. Understanding these attitudes is necessary to understand the nature of the interaction between these two groups. If the negative attitudes and source of these attitudes are better understood and measured, they can be applied to interventions aimed at attitude change. In order to understand these attitudes, objective measures of attitudes must be developed that are psychometrically sound. The next step is to develop intervention programs aimed at changing these negative attitudes to increase community receptivity.

Evidence

To assess physical and attitudinal barriers, objective measures must be used. Current rehabilitation outcome measures focus on the performance of activities in the
Clinical setting. Gray, Hollingsworth, Stark, and Morgan (2006) address the fact that measures of participation in the community are lacking in research. In response, they describe the development and psychometric properties of a new measure of participation. This new measure, a participation survey for people with mobility impairments (PARTS/M), assesses what people with mobility impairments do in their current environments. The PARTS/M is a reliable and valid measure of participation in major life activities for people with functional mobility impairments and activity limitations in the environments in which they live.

Rehabilitation interventions generally concern the capability of a person with a disability to complete an activity in a clinical setting. Measuring a person’s capacity in the clinical environment does not necessarily predict one’s abilities in the community environment. By contrast the PARTS/M measures the participation of an individual in his/her current environment and integrates many components of participation that are already included in existing but independent instruments; this makes the PARTS/M very comprehensive, albeit lengthy. A limitation of the PARTS/M measurement is the survey cannot be generalized or applied to the total population of people with mobility impairments; however, the measurement does take into account the fact that disability is not only influenced by personal limitations but environmental factors as well. The use of qualitative interviews to identify the various components of the PARTS/M is very important because the actual experiences of individuals with mobility impairments are represented. The constructs of the survey are therefore very realistic and reliable.

The Community Health Environment Checklist (CHEC) is an objective measure of the features of the physical environment that are important to people with mobility
impairments (Stark et al., 2006). The CHEC is short, easy to use, and flexible with respect to scoring. The measure is intended to be administered by a community health professional or community member using the rulebook and glossary. The CHEC measures the physical environment with a focus on community receptivity and is based on the social model of disability that measures the influence of the environment on an individual’s ability to participate in community activities. Stark et al. (2006) presents the CHEC as an objective measure that can determine if a facility or building’s physical features are ecologically valid and can predict the community participation of individuals with mobility impairments. These objective measures of the environment are important when looking at the participation, acceptance, and inclusion of people with disabilities because a physically accessible site reflects the receptivity of the owner/designer to accommodate the needs of people with mobility limitations.

Antonak and Livneh (2000) reviewed literature on the current measurements used to assess attitudes and found that, “Without assurance of the psychometric soundness of the method and freedom of the obtained data from respondent biases, confidence in the conclusions of attitude research maybe unjustified.” Many scales are currently used to measure attitudes but few are found to be reliable, valid, and without limitations. With the aim to objectively measure attitudes, many instruments are effective but are subject to bias responding and therefore do not reflect the true attitude of the respondent.

Current outcome measures of attitudes can be divided into two methods: indirect and direct. Direct attitude measurements are methods in which the participant is aware that his/her attitude is being tested. Indirect attitude measurements are methods in which the participant is unaware that his/her attitude is being tested (Antonak, 2000). Direct
measurements are the most common and include primarily surveys and interviews. Rating scales such as the Likert scale are very common in direct methods of attitude measurement. The benefits of direct methods are the convenience of administration, that they appeal to a large population, and that they are widely used and understood.

Limitations of direct methods do exist. Respondent reactivity occurs when the respondent realizes that he/she is being measured in the context of attitudes, opinions, or values; the respondent may modify or change existing beliefs to appeal to the attitude instrument (Antonak, 2000). This bias responding renders the outcome measure subjective and invalid.

Indirect methods are less commonly used in attitude measurement. Examples of indirect methods include methods where the participant is either:

- Unaware that he/she is being observed or measured,
- Aware that he/she is being observed but unaware as to why,
- Deceived of the true purpose of the measurement situation, or
- An inactive participant in the measurement process (Antonak, 2000).

This last method, known as the physiological method, proposes that physiological changes occur when intense affective reactions are experienced. The participants’ reactions are measured using instruments that the participants have no conscious control such as pupil dilation or skin resistance. These methods are straightforward measures of attitudes but require a laboratory setting, expensive equipment, and technical expertise to interpret the data, therefore, physiological methods are not always the most practical.

Other limitations of indirect methods of measurement include the use and training of a confederate, obtaining permission to use a field setting, time, cost, difficulty generalizing
the findings due to local setting, clinical training for administration and interpretation of the results, and ethical questions (Antonak, 2000).

Using a multidimensional approach is important when measuring attitudes because attitudes consist of three distinct components: affect, cognition, and behavior. Findler, Vilchinsky, and Werner (2007) sought to construct and validate The Multidimensional Attitudes Scale (MAS), a scale that measures attitudes toward persons with disabilities. The three components are found to share a common core; however, each represents a distinct dimension; consequently, each component should be independently addressed. This study found that negative attitudes toward people with disabilities may be associated more with the affective states of discomfort and anxiousness than with archetypal emotions such as fear or happiness. Affects and cognitions revealed more negative attitudes than did behavior, which may be due to the fact that people do not tend to act on their feelings and thoughts of discomfort or that they will not admit to acting on their feelings or thoughts of discomfort. This may also reflect adherence to social norms and expectations that mandate polite and ‘politically correct’ behavior or social desirability and may have produced a response bias respectively (Findler et al., 2007). A multidimensional perspective is needed when studying attitudes because an instrument that assesses only one of the three components will produce biased results. Affect, cognition, and behavior should be independently considered in any assessment or intervention aimed at measuring or modifying attitudes respectively.

The Attitudes Towards Disabled Persons Scale (ATDP) is the best known and most widely used scale that measures attitudes towards people with disabilities (Thomas, Palmer, Coker-Juneau, & Williams, 2003). Although evidence of the scale’s reliability
and validity is documented, the ATDP is susceptible to the social desirability effect. With this shortcoming in mind, Gething developed the Interaction with Disabled Persons Scale (IDP). The IDP measures discomfort reported about social interaction with people with disabilities on a more personal level (Gething, 2006). The IDP instrument has displayed evidence of convergent validity in past research.

In a study by Thomas, Palmer, Coker-Juneau, and Williams (2003), the IDP was found to provide a reasonable measurement of multidimensional attitudes toward individuals with disabilities. The IDP is composed of 3 factors: the first captures a respondent’s social discomfort when interacting with a person with a disability; the second is a measure of one’s empathy toward the person with a disability; and the third encapsulates the fear of acquiring or having the disability (Thomas et al., 2003). The three factors appear to be conceptually distinct from each other and are clearly distinct from overall affect, as measured by the ATDP. The IDP was found to be susceptible to social desirability responding and all the data were collected through the use of self-report, paper-and-pencil method. The IDP does capture three interrelated dimensions underlying attitudes toward individuals with disabilities: social discomfort, empathy, and fear of acquiring a disability and is worth further exploration. Nevertheless, the ATDP was still found to provide a solid measure of a respondent’s overall global attitude toward individuals with disabilities in this same study. However, this general, global measure does not provide enough information to adequately describe attitudes toward people with disabilities. Clearly, a new scale or modifications to an existing scale is still needed that provides more detailed information about the specific dimensions of attitudes. The IDP Scale in conjunction with other established measures of attitudes towards people with
disabilities can obtain a more comprehensive picture incorporating attitudes on both the societal and personal levels (Gething, 2006). Further testing of these measurement methodologies is needed to understand and assess true attitudes that will, in turn, direct intervention.

Intervention measures need to be developed that target an individual’s cognitions, emotions, and behaviors towards people with disabilities. Krahe and Altwasser (2006) conducted an interesting intervention study aimed at changing negative attitudes towards people with disabilities. The two experimental conditions that were tested were a cognitive intervention and a combined cognitive and behavioral intervention; a control group was also used that received no intervention. The cognitive intervention consisted of talking about personal experiences with people with disabilities, developing a definition of physical disability, discussing the labeling of people with physical disabilities, presenting a historical overview of people with disabilities, discussing interacting with people with disabilities, and correcting stereotypes. The cognitive and behavioral intervention group had one session of the cognitive intervention and one session of the behavioral intervention that consisted of meeting and participating in modified sport activities in a gym with athletes with physical disabilities. Prior contact or experience with people with disabilities was also taken into account. Attitudes were measured at baseline, directly after the intervention, and at the three month follow up.

The results from this study show that a combined cognitive and behavioral intervention has the potential to decrease negative attitudes towards people with physical disabilities. Even though the effects were stronger immediately following the intervention, the effects were still present at the three month follow-up. The cognitive
only intervention and the control group were not found to significantly change the negative attitudes of the participants. An intervention involving personal contacts with people with disabilities and first hand experience that lasts no longer than two sessions of 90 minutes each can cause significant and sustained attitude change. This study did not have a behavioral only intervention group so we do not know if the attitude modification was due to a combination of cognitive and behavioral interventions or to just the behavioral intervention. People with prior experience with people with disabilities were found to have more positive attitudes towards this group of people than people without any pre-intervention experience. Interventions such as this one, with both a cognitive and behavioral component, have been found effective in changing negative attitudes of people with disabilities. This is additional evidence that a multidimensional approach for both measures and interventions are effective. The IDP Scale has been used successfully to assess attitude change as a result of intervention programs (Gething, 2006). Further exploration is needed to find the most effective strategy, one that would be facilitated by more reliable and valid outcome measures.

Specific Aims

I wish to further explore current measures that assess both the environment and attitudes of a community with a focus on community receptivity. I would like to modify an existing measure of attitude, or social receptivity, in attempt to propose a truly objective measure of attitude. Once a measure is chosen or modified, I will measure people’s attitudes towards people with disabilities to see how attitudes facilitate or hinder the participation of a person with a disability.
I will then assist in the development of an interactive, educational intervention program to tackle attitudinal barriers in an attempt to modify existing negative attitudes toward people with disabilities. In turn, this intervention will attempt to change existing attitudes towards people with disabilities to more positive attitudes with the hopes of removing some of the barriers experienced by people with disabilities.

In my study, the participants will consist of people without disabilities drawn from the general public. I will test four intervention groups: cognitive only, cognitive and behavioral, behavioral only, and a control. The cognitive only intervention will consist of a lecture or talk about disability much like the one described in the Krahe and Altwasser (2006) article. The behavioral intervention will include a session where the participants without disabilities meet and interact with people with disabilities and engage in some form of activity together. The cognitive and behavioral intervention will have some components of both and the control will have no intervention. I will measure the participants’ attitudes towards people with disabilities at baseline, after the intervention, and again at a three month and six month follow up. I would like to also conduct this intervention with students. If the intervention works in the school system then steps should be taken to implement the intervention to dispel negative attitudes toward people with disabilities early. The lowering of attitudinal barriers will facilitate the participation and inclusion of people with disabilities.

Role of Occupational Therapy

As a client-centered practice, occupational therapy emphasizes the importance of the environment pertaining to the client’s function, participation, and quality of life. Occupational therapists are aware of the significance of community receptivity and the
influence of community receptivity on participation of people with disabilities.

Occupational therapy incorporates the hypothetical, experimental, and enacted ‘tenses’ mentioned by Glass (1998) and an occupational therapist can make observations and discover through interviews what occupations are important to the client and can determine if and how the client is actually performing these activities in his or her daily life.

Additionally, an occupational therapist can serve as a facilitator with helping to educate and expand the client-centered approach to all aspects of rehabilitation and independent living. An occupational therapist works with a client to develop an intervention plan unique to that client taking into account personal, environmental, and occupational factors. Professionals can never lose sight of the individual’s goals; educating health care professionals about the benefits of a client centered approach allows professionals to better understand and relate to their clients. Occupational therapists can be a great resource for people with disabilities who are searching for opportunities to get involved in and services to increase their participation and overall quality of life. Peter Axelson says an occupational therapist can help restore the balance in life to people who have had an invasive medical problem.

The focus on function of occupational therapy assists clients with disabilities in becoming more independent by increasing self esteem, function, and quality of life. Occupational therapists can also relate to people with a wide variety of disabilities and can facilitate support and participation. An occupational therapist can make sure that rehabilitation does not stop when the client walks out of the clinic by maintaining a relationship and following up with a client’s progress. Measuring participation outside of
the clinical setting is very important to determine occupational performance and occupational therapists know this. Occupational therapists use the various measures described above and follow-up with clients to make sure that the clients are participating in their major activities of life. The importance of the environment should never be overlooked because the environment is the context in which real life takes place; also attitudes should be further studied because these attitudes are hindering participation within the environment. An intervention aimed at changing negative attitudes toward people with disabilities can improve community receptivity and quality of life for people with disabilities.
References


