Citation: Deal, Mark (2006). Attitudes of disabled people toward other disabled people and impairment groups. (Unpublished Doctoral thesis, City University, London)

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ATTITUDES OF DISABLED PEOPLE TOWARD OTHER DISABLED PEOPLE AND IMPAIRMENT GROUPS

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A thesis submitted in fulfilment of the requirements
for the degree of Doctor of Philosophy

At

City University, London

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Midwifery

April 2006

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Acknowledgements

Firstly, I would like to thank my supervisor, Professor Mike Floyd (City University, London), for his support over many years, giving advice and guidance throughout this research, but most of all, his faith in this work. Also, thanks goes to Dr. Patrick Callaghan and Dr. Teresa Allan of City University who offered support and guidance through the annual review process. I am equally grateful to Doria Pilling, Paul Barrett, Megan Rhys and Dilys Deal for their guidance in the writing-up of this thesis. Sponsorship and general support for this research was generously provided by Enham, who gave me time away from work over six years, and the Ian Karten Trust who paid my fees for the first two years. I would also like to thank, (along with many others), Bill Brewer, Shane O'Leary, Judith Jameson, James MacCallum and my family, who generously assisted in distributing the research tools to respondents. Special thanks goes to Mary, Melanie, Tara, Richard and Malcolm, whose insightful and frank comments helped steer the early development of the research tools. Equally, the later thoughts of Brenda Smith and Sue McMullan who assisted in improving the final version of the research tools are greatly valued. Finally, I would like to thank the many people who gave their time to complete the research tools.

Declaration

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Abstract

This research set-out to: a) investigate attitudes of disabled people (adults) toward other disabled people; and, b) attitudes of disabled people toward different impairment groups. Comparative data from a non-disabled sample was also collected. Two new attitude rating scales were developed for this research: the General Attitude Scale Toward Disabled People (GASTDP) and the Attitude Toward Impairment Scale (ATIS). Both scales achieved acceptable levels of internal and external reliability.

Positive attitudes toward disabled people were found from both the disabled ($\underline{M} = 41.08$; n = 193) and non-disabled samples ($\underline{M} = 39.29$; n = 120). However, a hierarchy of impairment also appears to exist, with the disabled sample producing a rank ordering of most accepted to least of Deaf, Arthritis, Epilepsy, Cerebral Palsy, HIV/AIDS, Down's Syndrome and Schizophrenia. The non-disabled sample rank ordering was the same for five of the seven impairment groups, with only Cerebral Palsy and HIV/AIDS being placed in reverse order.

The GASTDP contains two sub-scales (Subtle and Blatant Prejudice sub-scales). Statistically significant results between the two sub-scales were found for both the disabled and non-disabled samples, suggesting people tend to hold subtle forms of prejudice toward disabled people. The discussion therefore utilises the term *aversive disablism*, based on aversive racism. This theory argues that whilst people may be reluctant to express negative attitudes toward disabled people, they may also support policies that are disablist, i.e. segregated housing.

The contact hypothesis, whereby contact with members of a minority group influence attitudes, was not supported by the data.

This thesis recommends further research into subtle forms of prejudice toward disabled people from an in-group perspective and attitudes toward different impairment groups.

Chapter 1

Introduction

1.1 Introduction

This research was initially stimulated from the personal experience of living and working with other disabled people, who, through my casual observations, would sometimes try and disassociate themselves from other disabled people in general or people with other impairment groups (for instance, cerebral palsy, schizophrenia, epilepsy, etc.). This could be either through the use of language, such as referring to other disabled people as *they* rather than *we*, or physically, by avoiding direct contact. This observation also led me, as a person with a degenerative physical impairment and a wheelchair user, to question whether there were some impairment groups I was more comfortable being associated with than others. I therefore also questioned why this might be the case and whether this was true for other disabled people. Such issues are important if disabled people are going to work together in order to reduce the social oppression faced.

Disability is increasingly being seen by academics as a form of identity, (in the manner of race and sexuality) (Krauss, Mehnert, Nadler and Greenberg, 1993; Barnes and Shardlow, 1996; Gill, 1997; Darling, 2003). However, little is known about the attitudes disabled people hold toward other members of this group. It is the intention of this research to identify whether disabled people hold attitudes toward other disabled people similar to those held by non-disabled people, and whether the strength of attitude is affected by the type of impairment. Whilst proponents of the social model of disability view disability as a form of social oppression with impairment simply a description of the body (see Oliver, 1996), other scholars have been challenging this paradigm arguing, *"..., it seems politically naïve to suggest that the term 'impairment' is value-neutral, that is 'merely descriptive', as if there could ever be a description which was not also a prescription for the formulation of that to which it is claimed innocently to refer"* (Tremain, 2002). This thesis will argue impairment is indeed, value-laden, and that a hierarchy of impairment exists based on the oppression faced by disabled people as a consequence of belonging to different impairment groups.

Attitudes held towards groups, (such as disabled people), are important as they have been found to be predictors of behaviour. The theory of planned behaviour (TPB) (Ajzen, 1991) hypothesises *"that an individual's overtly stated intention to act is the most proximal predictor of behaviour"* (Hagger and Chatzisarantis, 2005). It is also the intention of this thesis to identify whether subtle forms of prejudice toward disabled people are invasive, building on earlier work within Critical Race Theory. For instance, Meertens and Pettigrew (1997), argue how advances for a minority group are only supported by the majority group when it also advances the majority group self-interest. This thesis will test whether subtle forms of prejudice can be identified from both within the disabled out-group and the non-disabled in-group.

Many disabled people, as consequence of the services they access, for instance Day Care services, residential care, etc., have high levels of contact with other disabled people. Earlier work in social psychology that utilized the contact hypothesis (see for example, Higgs, 1975; Weisel, 1988; Callaghan, Shan, Yu, Ching and Kwan, 1997; Pettigrew and Tropp, 2000), (whereby it is suggested previous contact with a particular group may influence attitudes), has produced ambiguous results. Little is know, however, about the influence of contact on attitudes of disabled people toward other members of the group. This research will use quantitative research methodology to test the contact hypothesis for this group in society. The location of the contact, in addition to the number of other disabled people contact regularly takes place with, will be tested. In other words, the contact hypothesis will be tested with specific reference to disabled people having contact with other members of the group, even when those people do not choose to be members of that said group.

1.2 Thesis Presentation Summary

In order to explore the attitudes of disabled people toward other disabled people, it is necessary to also identify attitudes of non-disabled people toward this group, thus giving a greater context to the findings.

Goodley (2001) identifies writers in disability studies are locating impairment at the forefront of such research, and are critically examining the assumptions that underpin the social model of disability.

This research will therefore:

Firstly: review the literature in relation to attitudes toward disabled people in general and wherever possible draw on the experiences of disabled people, including the work of disabled academics.

Secondly: through the direct involvement of other disabled people, develop two attitudes rating scales, one measuring attitudes toward disabled people in general and another toward specific impairment groups. These attitude scales will reflect positive attitudes toward disabled people from the disabled person's perspective. A detailed explanation of each item of the attitude scales will be offered, in order to enable future researchers to challenge the research findings (see Chapter 6).

Thirdly: this research will measure attitudes toward disabled people and specific impairment groups using both disabled and non-disabled samples, in order to identify whether these two groups hold different beliefs toward disabled people, and whether the strength of attitude varies according to the impairment. Thus, this research will attempt to identify whether a hierarchy of impairment exists for both disabled and non-disabled people.

Fourthly: the data will reveal whether differing levels of contact and the situation whereby the contact takes place has an influence on attitudes toward disabled people.

This thesis is divided into three main sections: Literature Review, Methods and Results, and Discussion. The literature review explores the principal and emerging models of disability (Chapter 2); what is meant by the term attitude and its function, how attitudes toward disabled people can be both positive and negative and how this affects the lives of disabled people in terms of employment, raising a family, and so on, and that cultural factors may influence these said attitudes, followed by whether the strength of attitudes varies according to the impairment, know as the hierarchy of impairment, with particular reference to the views of disabled people, leading to a discussion on how disabled people have been afforded a status of Other, and whether a disability 'movement' or culture exists (Chapter 3). The literature review then explores the psychosocial adjustment process with 'acceptance' of the impairment as an important factor in whether the individual will hold a positive self-esteem. Chapter 4 also explores how disabled scholars are increasingly arguing that positive self-esteem can come about at least in part, by viewing disability as a form of social oppression rather than functional limitation. The literature review then moves on to discuss how disabled people view other disabled people. Chapter 5 discusses methods used to modify attitudes toward disabled people, with particular emphasis on contact with disabled people. Methods by which to measure attitudes are also discussed in this chapter, with particular emphasis on measuring attitudes toward disabled people, and making reference to two attitude rating scales that have been widely utilised for this purpose.

The thesis then presents in Chapter 6 the design of the research, the research hypotheses and the samples (demographic details of both the disabled and non-disabled samples). This chapter then presents the measures developed for this research (General Attitude Scale Toward Disabled People and Attitude Toward Impairment Scale). These are two attitude rating scales, specifically developed for this research to test the hypotheses presented in Chapter 6. A rationale for each of the statements utilised in these research tools is presented, along with the internal and external reliability of the scales, as well as the data generated through factor analysis. Finally, Chapter 6 raises the ethical issues pertinent to this research. Chapter 7 presents the results from the data collected from both disabled and non-disabled samples, after the key characteristics of the statistical tests employed for the analysis of the data are presented.

The third section of this thesis is Chapter 8 and is presented in six main sections. After the limitations of this research are presented, this chapter discusses the results under the headings of: The contact hypothesis and disabled people; The hierarchy of impairment; Locating impairment in society; Aversive Disablism – Building on Aversive Racism; and finally, Recommendations. Hence, the role of contact with disabled people as an independent variable in influencing the attitudes expressed will be explored; next, the extent to which disabled people hold a hierarchy of impairment as compared to non-disabled people will be discussed. Through the discussion of the hierarchy of impairment, the discussion moves on to attempt to *"bridge the gap between the individual and the social"* (Howard, 2003: p. 5). The term *aversive disablism* will then be introduced, developed from the theory of aversive racism, highlighting how subtle forms of prejudice may exist toward disabled people from both disabled and non-disabled people.

1.3 Conclusion

By focussing on the perspectives of disabled people with respect to attitudes of this group toward other disabled people, the body of knowledge will be furthered. This perspective is not to deny the importance of the non-disabled perspective, but rather to be clear from the outset of the possibility that disabled people may have beliefs (attitudes) in relation to disability unique to this group. In addition, in the manner that Grillo and Wildman (2000) comment that for people of colour who are victims of racism, race is the filter through which they view the world (p. 649), people with impairments who face social oppression and disablism, disability is likely to be the filter through which they view the world. The extent to which a person's impairment affects the attitude toward them as a member of that group is important to be identified, thus enabling a more targeted approach to attitude change strategies in relation to disabled people and impairment. The following literature review will develop an argument that will justify the subsequent research.

Chapter 2

Definitions and Models of Impairment and Disability

2.1 Introduction

To understand attitudes toward disabled people, it is important to be clear as to what is meant by the word "disabled" and its distinction from the term "impairment", for any discussion in relation to disability will be sensitive to the definition used (Howard, 2003: p. 4). A great deal of debate has taken place since the 1970's over the meaning of these terms, for, as Olney and Kim (2001) recognise, *"...disability itself is a slippery category"*, with Bajekal, Harries, Breman and Woodfield (2004) arguing *"There is no single, accepted definition of what 'disability' means"* (p. 4). This has led in part to the wide range of estimates in relation to the number of disabled adults in the United Kingdom from 8.6 million to 11 million (Bajekal *et al,* 2004: p. 2). This chapter will therefore discuss the two predominant models of disability (the medical/individual and social model) before reviewing the emerging post-modern approach to disability and impairment.

2.2 Medical / Individual and Social Models of Disability

The first section of this chapter will discuss the key issues relating to the two principal models of disability; the 'medical' or 'individual' model and the 'social' model of disability. Llewellyn and Hogan (2000), with reference to models of disability, say that:

"... a model represents a particular type of theory, namely structural, which seeks to explain phenomena by reference to an abstract system and mechanism. Models of disability are not synonymous with theory as their usage does not involve data collection, but they may have some usage as generators of hypotheses. It is important to remember that models may help to generate an explanation in some way, but they do not themselves constitute an explanation." (Llewellyn and Hogan, 2000)

The individual or medical model of disability tends to regard disability as a personal tragedy that has befallen the individual and therefore a 'cure' is sought (Oliver, 1990; Oliver, 1996b). This places the individual with an impairment into a 'sick role' whereby others may make decisions about the quality of that person's life (Pfeiffer, 1998).

Within the United Kingdom the legal definition of disability under the Disability Discrimination Act (1995) is:

"*...a person has a disability for the purposes of the Act if he has a physical or mental impairment which has a substantial and long-term adverse effect on his ability to carry out normal day-to day activities*" (Doyle, 1996).

The meaning of terms such as 'normal', 'adverse', 'substantial' and so on are discussed elsewhere (see Doyle, 1996). However, what is important in relation to this research is this definition takes an individual or medical standpoint, viewing the functional limitations of the individual as the determining factor as to whether the person is disabled or not.

Perhaps one of the most widely accepted definitional schemas that takes an individual approach is the World Health Organisation Classification of Impairment, Disability and Handicap (ICIDH), developed by Wood (1980). This states:

"Impairment: *In the context of health experience, an impairment is any loss or abnormality of psychological, physiological, or anatomical structure or function.*

Disability: *In the context of health experience, a disability is any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being.*

Handicap: *In the context of health experience, a handicap is a disadvantage for a given individual, resulting from an impairment or a disability, that limits or prevents the fulfilment of a role that is normal (depending on the age, sex, social and cultural factors) for that individual."* (Wood, 1980)

Oliver (1990) criticises the WHO classification of Impairment, Disability and Handicap, in that for the individual to fulfil their role as a 'normal' member of society, the person with a disability is expected to change, rather than the environment. Thus, Oliver suggests, the medical approach to disability is perpetuated through these definitions of impairment, disability and handicap, in that the individual is expected to be 'cured' through some form of intervention.

In light of criticisms toward the ICIDH the World Health Organisation instigated the development of the ICIDH-2, which later became know as the *International Classification of Functioning* (ICF) (World Health Organisation, 2001). The ICIDH-2 (International Classification of Functioning, Disability and Health) has been based on an attempt to integrate both the social and medical models of disability (Barnes, 2000; Barnes and Mercer, 2004; World Health Organisation, 2000: p. 23). ICIDH-2 provides a:

"... multi-perspective approach to the classification of functioning and disability as an interactive and evolutionary process." (World Health Organisation, 2000: p. 21)

In summary, Ustun, Chatterji, Bickenbach, Trotter II and Saxena (2001) describe the ICIDH-2 as follows:

"All levels of disability occur with a health condition and within the context defined by environmental factors and personal characteristics (age, sex, level of education, life history and so on). The three dimensions of disability are not conceived as links in a causal chain, but as alternative, but conceptually distinct, perspectives on the disablement process. One perspective is at the level of body or body part, and abnormalities of function or structure are called impairments. *If in association with a health condition, a person does not perform a range of activities that others perform, this person level difficulty is called an* activity limitation. *Finally, from the perspective of complete context of a person's life, characterized for the most part by the physical and social environment in which the person lives, disability may be manifested as restrictions in major areas of human life – for example, parenting, employment, education, social interaction and citizenship. In the ICIDH-2, these are termed* participation restrictions.*"* (Ustun, Chatterji, Bickenbach, Trotter II, and Saxena, 2001: pp. 7-8)

It is important to note, however, as Barnes and Mercer (2004: p. 6) stress, "*Its* [ICF] *concept of 'participation' is underdeveloped and linked to individual circumstances rather than grounded in social and political inclusion*". Likewise, Waddell and Burton (2004) comment that the International Classification of Functioning, Disability and Health (ICF) (formally the ICIDH-2) "*...still often seems to assume that functioning and disability are primarily a matter of disease and impairment*", with the ICF framework fitting best with a biological stereotype of severe medical conditions. This has led to critics such as Pfeiffer (1998) calling for the abolition of the ICIDH-2 as it "*does not conform to the minority group paradigm*".

In response to the 'oppressive' nature of the medical model of disability, the social model was developed during the mid-1970's. A revised definition of impairment and disability that was adopted by the international disability association, Disabled Peoples' International, which states:

"Impairment *is the lack of part of or all of a limb, or having a defective limb, organ or mechanism of the body.*

Disability *is the loss or limitation of opportunities that prevents people who have impairments from taking part in the normal life of the community on an equal level with others due to physical and social barriers.*" (Cited in Finkelstein and French, 1993)

The social model of disability, Oliver (1996a) argues, does not deny the problems or barriers faced by disabled people, but places the responsibility for those problems within society, rather than with the individual. Hence, the social model of disability is a break away from the victim-blaming individual/medical model, suggesting that disability is a form of social oppression (see Tregaskis, 2002; Barnes and Mercer, 2004, for a review of the social model of disability) in the manner of homophobia, racism, ageism, sexism and so on (Reeve, 2004: p. 83).

However, the social model of disability is not free from criticism. Marks (1999) summarises the limitations of the social model of disability by identifying that firstly it tends to ignore the different experiences of disability as a result of gender, sexuality, race, culture or other distinctions, (added to this list could also be impairment). The social model of disability and the disability movement in general has also faced accusations of being sexist, due to the predominant image portrayed being based on the image of white male wheelchair users, often ignoring the role played by disabled women, gay men, lesbian women and black people. As a consequence the social model of disability and the disability movement have tended to focus on structural barriers, primarily in relation to work, often ignoring other social factors such as family (O'Toole, 2004). Oliver (1996c) refutes such criticism, claiming that the UK disability movement has done 'more than most' to address many of these issues, stating that the movement has been 'dominated by women'.

By focussing on disabling environments, Marks (1999) contends the emphasis of the social model is principally on physical barriers at the expense of other forms of barrier. She notes earlier works which suggested this was due to the social model having been created by wheelchair users, who in turn feared being labelled by the non-disabled population as 'thick' or 'stupid' if there was any association with people with learning difficulties or mental health problems. Secondly, Marks identifies that the social model has been closely linked with many of the values of a capitalist society, citing work and independence. She goes on to note the conflict faced by many disabled people who as a result of their impairment feel they have a legitimate right to withdraw from the labour market, whilst at the same time the social modellists are demanding the right to work. Thirdly, in the social model's attempt to avoid any form of medicalisation or link with impairment, the disabled people's movement requires an individual to positively identify themselves as a disabled person. Marks notes, however, that many people with impairments do not regard themselves as disabled, to which the social model responds by accusing them of having a 'false consciousness'.

Again, Oliver (1996c) offers a defence to the social model when he argues:

> *"It is worth remembering too that impairment related experiences are unique to the individual; often people with very similar conditions experience them in very different ways. What is 'painful' or depressing for one person may be less so for another. People can only talk of their own experiences of impairment. This makes any notion of a 'social' model of impairment extremely difficult, if not impossible to conceive."* (Oliver, 1996c)

The themes raised by Oliver (1996c) as a defence of the social model of disability are challenged by other writers who have taken a different perspective and are discussed below.

2.3 Postmodernism and Disability

Whilst the two principal models of disability have dominated the debate during the 1990's, other writers are now arguing for impairment to be placed at the heart of this discourse. This can be identified as a feminist/postmodernist approach to disability, (Wendell, 1996; Corker and French, 1999; Thomas, 1999a; Corker and Shakespeare, 2002; Davis, 2002; Shakespeare and Watson, 2002). Feminists have noted that the individual experience of impairment must have a part to play in the ongoing debate concerning disability (Mulvany, 2000; Thomas, 1999a).

French (1993), whilst acknowledging the importance of the social model and the need to present a unified front in order to bring about social change, also suggests that some problems faced by disabled people cannot be solved by social manipulation. Hence, Fawcett (2000) contends that the adoption of an either/or approach to the debate over the individual model or the social model of disability has created an oversimplification of the complex relationship between the individual disabled person and society. She asserts that the 'binary distinctions' with their resultant viewpoints, such as residential care (which creates dependency) versus community care (which exploits female carers), social model versus medical model, and so on, has led to ridged thinking and therefore the possibility of alternative conclusions not explored. Such views are supported by Corker and Shakespeare (2002) who argue the case for postmodernism as one such alternative theoretical tool. They state:

"We believe that existing theories of disability – both radical and mainstream – are no longer adequate. Both the medical model and the social model seek to explain disability universally, and end up creating totalizing, meta-historical narratives that exclude important dimensions of disabled people's lives and their knowledge. The global experience of disabled people is too complex to be rendered within one unitary model or set of ideas. Considering the range of impairments under the disability umbrella; considering the different ways in which they impact on individuals and groups over their lifetime; considering the intersection of disability with other axes of inequality; and considering the

challenge which impairment issues to notions of embodiment, we believe it could be argued that disability is the ultimate postmodern concept." (Corker and Shakespeare, 2002: p. 15)

Clare (1999) in her personalised discourse on disability also supports the notion that impairment and disability cannot be conveniently separated when she states:

"To neatly divide disability and impairment doesn't feel right. My experience of living with CP has been so shaped by ableism – or to use Oliver's language, my experience of impairment has been so shaped by disability – that I have trouble separating the two." (Clare, 1999: pp. 6-7)

Such a view would appear to find support from Hedlund (2000) who suggests that rather than seeing the medical model as 'antiquated' and the social model as a 'modern conceptualisation', it is useful to view disability as a phenomenon with each model having different domains to describe that phenomenon. Thomas (1999a) adds to this debate by arguing there should be no difficulty in seeing disability as a form of social oppression, whilst simultaneously acknowledging that impairment categories are culturally constructed and thus exist in certain times and places, (hence, changing and fluid).

However, other writers, (Oliver, 1996a), argue that there is no causal relationship between impairment and disability and that any linkage between the two is likely to weaken the argument for social change. As an illustration of the split between writers on the way in which disability studies should be researched, Corker and French (1999) cite Barnes, who leaves no doubt in the readers mind as to his opinion of the feminist approach:

*"I have little doubt that [*Wendell, *The Rejected Body] will be welcomed by the true confessions brigade; those intent on writing about themselves rather than engaging in serious political analysis of a society that is inherently disabling."* (Cited in Corker and French, 1999: p. 5)

Wendell (1996), taking a feminist approach to her research argues that:

"...the distinction between the biological reality of a disability and the social construction of a disability cannot be made sharply, because the biological and the social are interactive in creating disability. They are interactive not only in that complex interactions of social factors and our bodies affect health and functioning, but also in that social arrangements can make a biological condition more or less relevant to almost any situation." (Wendell, 1996: p. 35)

Williams (1998) adds a word of caution to the debate of when researchers use their own experiences of disability (such as Wendell, 1996; Clare, 1999; Willey, 1999) to explain the interaction of the individual self in society and illness and disability. Williams (1998) suggests that what can start out as, "*...a sociological analysis becomes a quasi-religious or spiritual quest for the truth which illness is supposed to reveal*" (p. 241). What is required, he argues, is recognition of both the individual's unique experiences and the unifying similarities.

This challenge is to some extent addressed by Priestley (1998) who states that the debate between the individual and social models of disability is too simplistic. Priestley therefore puts forward a 'four-fold typology of disability theory', which recognises not only the individual and social models, but also what he refers to as the 'materialist-idealist dimension'. This approach argues that both the individual and social models can be either materialist or idealist in emphasis, drawing on works of Marx and Weber. The four approaches to disability are summarised by Priestley as:

Individual-Materialist: Disability is the physical product of biology acting upon the functioning of material individuals (bodies);
Individual-Idealist: Disability is the product of voluntaristic individuals (disabled and non-disabled) engaged in the creation of identities and negotiation of roles;

Social-Materialist: Disability is the material product of socio-economic relations developing within a specific historical context;
Social-Idealist: Disability is the idealist product of societal development within a specific cultural context. (Priestley, 1998).

The key distinction between the individual and social models, Priestly suggests, is that, *"...disability has some real collective existence in the social world beyond the existence or experience of individual disabled people,"* based on the, *"...collective experience of discrimination and oppression."* However, how Priestley reconciles the diverse experiences of discrimination faced by different impairment groups is unclear. For instance, the discrimination faced by a wheelchair user trying to access public transport will be very different from a person with schizophrenia seeking employment, which again may be very different in terms of a person who is both black and living with schizophrenia as opposed to a white, single mother with multiple sclerosis.

Thomas (1999a) suggests that whilst a synthesis between the models of disability would not be possible as the philosophical, epistemological and ontological approaches make them incompatible, there is a value in seeking a greater interaction or even collaboration between what she refers to as Disability Studies and medical sociology. This view is challenged by Sim, Milner, Love and Lishman (1998) who present a deconstruction of the medical and social models of disability, and a model they term as the 'Ideological

Constructions of Disability'. However, this model appears to be based on a white, male vignette of 'normality', which may have little relevance to other groups. Williams (1999) believes this process has begun through the perspectives of *critical realism*, arguing therefore that:

"Disability, ..., is neither the sole product of the impaired body, or a socially oppressive society. Rather, it is, ..., an emergent property, one involving the interplay of physiological impairment, structural enablements/constraints and socio-cultural elaboration over time." (Williams, 1999)

Williams contends that disability theorists, in 'by-passing' the body, have implicitly assumed a 'homogeneity of interest' within the disability movement and its supporters, which, he asserts, *"...is far from the case"*. He notes how the needs, wishes, desires and interests of a middle-aged women with chronic rheumatoid arthritis are very different from a young wheelchair user following a motor vehicle accident, arguing therefore that diversity and difference are *"...rooted in real impaired bodies"*.

Mulvany (2000) however, suggests that the 'lived experience of disability' has been incorporated into the study of mental illness through the work of 'interpretive sociologists', but has tended to label and stigmatise the individual as deviant and a victim, whilst ignoring, *"...the diversity of experience existing between people suffering from mental disorders,"* as a consequence of age, gender, ethnicity or psychiatric diagnoses. Mulvany concludes that the major challenge facing the sociology of mental health is how to link the social construction of disability with the concept of mental impairment. Such conclusions would appear to hold true for other impairment groups too, as illustrated by the examples offered by World Health Organisation (2000) in their draft of the ICIDH-2.

2.4 Normalisation

Within the field of services for people with learning difficulties/disabilities, normalisation principles have played an important role (Stalker, Baron, Riddell and Wilkinson, 1999), despite being dogged by misconceptions (Perrin and Nirje, 1989). Normalisation therefore deserves some attention within the context of this chapter.

One of the founders of the normalisation principles, Wolfensberger, says:

"Normalisation implies, as much as possible, the use of culturally valued means in order to enable, establish and/or maintain valued social roles for people." (Wolfensberger and Tullman, 1989)

Deeley (2002) adds:

"Normalisation promotes the independence of people with learning disabilities as far as is possible or feasible. It is believed that this can be most successfully achieved through making personal and individual choices about their own lives. By promoting individual autonomy through choice, the prevailing orthodoxy requires the professionals to provide people with learning disabilities with information about the options available to them." (Deeley, 2002)

Hence, according to Deeley, normalisation principles are grounded in ensuring disabled people have access to the same opportunities as other people. However, Deeley appears to neglect to state that attached to rights and choices are responsibilities. Despite this, some of the participants interviewed in her research (referred to as 'paternalists') did highlight how when a person with a learning disability looks unkempt or behaves in an inappropriate manner in a social environment, it is often the care service provider who is called into question, rather than the individual themselves, hence, challenging the notion that the person with a learning disability is completely passive.

The extent to which normalisation is about removing barriers as opposed to modifying the individuals behaviour is commented upon briefly by Tregaskis (2002) in her review of the social model. However, taking Deeley's (2000) observation above further, the modification of behaviour in order to facilitate social interaction may be seen as part of the individual model of disability paradigm, and therefore challenged as inappropriate by social modellists. Post-modernists may argue that greater tolerance from society towards diversity is a more acceptable way forward. Schalock (2004) attempts to create a degree of synergy between disability models arguing there is an emerging disability paradigm that has four characteristics focussing on; functional limitations, personal well-being, individualised supports and personal competence and adaptation. Although Schalock acknowledges the importance of *"social programs that emphasize the role that equity and opportunities play in leading a fuller, more meaningful, and more productive life,"* (p. 205) the emphasis of his argument is based on the need for the disabled person to adapt or be given appropriate support in order to function within society, rather than the need for society to change. Thus, it could be argued, Schalock's 'emerging disability paradigm' is an extension or even reiteration of the principles of normalisation and social role valorisation as purported by Wolfensberger (2000).

Social role valorisation (SRV) developed from normalisation principles and has three levels of 'goals' (Race, 2004). Race (2004) describes the goals thus: the primary goal is the 'good things in life' (i.e. family, friends, home, belonging, work, being valued and so on); the 'secondary goal' is encapsulated in the statement often used to define SRV, *"that it attempts to achieve the 'enablement, establishment, maintenance and/or defence of valued social roles for people'"*; (which is almost identical to the definition for normalisation cited above (Wolfensberger and Tullman, 1989)) and the 'tertiary gaol' is the attempt to achieve the first two goals through action, from the individual through to the societal level. Although not without its critics (Race, 2004), these 'goals' are reflected in the UK Government's white paper 'Valuing People' (DoH, 2001), and hence, it could be argued, highly influential in relation to social policy relating to people with learning disabilities.

2.5 Conclusion

The argument that disability has nothing to do with impairment (Oliver, 1996a), seems to be at best a political stand-point to help create the illusion of complete unity within the disability movement, thus giving greater strength to the critical disability rights campaign. Finkelstein (1993) argues that despite disabled people not wishing to be labelled as such, this is an outcome of the administration of services to disabled people which tends to be medicalised in approach, and therefore inadvertently creating an homogenous group. Both authors argue, however, that disability and impairment are separate entities and any linkage is likely to weaken the disability movement.

Fawcett (2000) however, views Finkelstein's and Oliver's 'unity' arguments with a degree of scepticism, drawing on feminist discourse around gender, which suggests that biological issues are at best marginal with respect to social processes. The argument that by incorporating impairment into the social model of disability and thus weakening the disability movement, should be viewed as 'misplaced' (Fawcett, 2000: p. 45). This view finds support from the World Health Organisation (2001), whose revised classification (ICF), makes clear the linkage between the person with an impairment and their interaction with the social environment. It is therefore suggested that whilst accepting the guiding principle of the social model of disability that disability is a form of social oppression rather than a functional limitation, there is a need for greater recognition of the role impairment plays in the creation of the social oppression faced by disabled people.

The remaining chapters of this thesis will recognise the distinction between impairment and disability from a social model perspective, acknowledging these two key terms are not interchangeable, but also seeking to identify how impairment, and attitudes towards impairment, are directly linked to social oppression.

Chapter 3

Attitudes Toward Disabled People

3.1 Introduction

In order to explore attitudes of disabled people toward other disabled people, it is important to be clear as to what is meant by the term attitude. Attitudes have been defined in a variety of ways over the past century, and have various meanings as a result of having bridged both psychology and sociology (Allport, 1954). Whilst it is not within the scope of this research to explore in detail the debates around the definition of attitudes, it is important to examine the key issues relating to the field of Disability Studies. This chapter will then explore the implications of attitudes toward disabled people, using employment and the debate surrounding the right to life as illustrations. In addition, the consequences of negative attitudes toward disabled people in terms of social exclusion will be explored, including the attitudes of professionals working in the field of disability. Likewise, the emerging 'positive' attitudes toward disabled people, including from disabled person's perspectives, will be discussed, thus offering an alternative to more traditional beliefs toward disability. There is also presented a discussion in relation to the hierarchy of impairment that identifies how the strength of attitude varies according to impairment type, thus challenging the notion that disabled people are an homogenous group, but rather, should be viewed in terms of impairment type.

3.2 Definition of Attitudes

Allport (1935: p. 810) views attitudes as a neuro-physiological disposition, defining an attitude as *"a mental and neural state of readiness, organised through experience, exerting a directive or dynamic influence upon the individual's response to all objects and situations with which it is related"*. Ostrom (1989) challenges Allport's 'state of readiness' concept as being, *"...too complex (and amorphous) a construct"* (p. 19), which could not be measured on an interval scale.

Whereas Oppenheim (1992) sees an attitude as:

"...a state of readiness, a tendency to respond in a certain manner when confronted with certain stimuli." (Oppenheim, 1992)

The 'certain stimuli', often referred to as the 'attitude object', in relation to this research, will be disabled people or a person with an impairment.

Alternatively, Breckler and Wiggins (1989) offer as a definition of an attitude in line with Allport's earlier definition as:

"*... mental or neural representations, organised through experience, exerting a directive or dynamic influence on behavior.*" (Breckler and Wiggins, 1989: p. 409)

Social psychologists, whilst subscribing to differing definitions of an attitude, tend to agree that a 'characteristic attribute' of an attitude is its evaluative nature (for instance, good/bad, pro/con) (Ajzen, 1988).

Ajzen (1988) argues that attitudes, be they positive or negative towards an attitude object, can be inferred from verbal or non-verbal responses towards the said object. These responses can be categorised as cognition (expressions of belief about the attitude object or perceptual reactions to the attitude object), affect (expressions of feelings toward the attitude object or physiological reactions to the attitude object) and conation (expressions of behavioural intentions or overt behaviours with respect to the attitude object) (Ajzen, 1989). Greenwald (1989a) notes the 'widespread adoption' of the three component definition, but cautions that this approach has created confusion. Chief amongst these is in relation to the attitude-behavioural relationship. Greenwald (1989a) purports that by affording a "*multiplicity of interpretations, the three-component definition appears to permit too broad an array of interpretations for a given set of data*" (Greenwald, 1989a: p. 6), thus weakening the attitude construct.

Armitage and Conner (1999) support the notion that beliefs can be inferred from attitudes or behaviour, although attitudes themselves may not necessarily be determined by behavioural beliefs. Drawing on the literature in relation to stigmatisation, Dovidio, Major and Crocker (2000) propose:

"...that the affective-cognitive-behavioral distinction does not represent necessarily separate processes. Instead, stigmatization reflects a blend of these processes and their interactions, with the primacy of the factors being a function of the nature of the stigma, the context in which it is encountered, and individual differences among the interactants." (Dovidio, Major and Crocker, 2000: p. 13)

Duckitt (1994) proposes a four-level model of possible causes of prejudice (1. genetic and evolutionary predispositions; 2. societal, organisational, and inter-group patterns of contact and norms for inter-group relations; 3. mechanisms of social influences that operate in group and interpersonal interactions; and, 4. personal differences in susceptibility to prejudiced attitudes and behaviour, and in acceptance of specific, inter-group attitudes). Duckitt argues *"Changes at the macro level in social structure or nature of the intergroup relations will generally have far more fundamental and extensive impacts than will interventions that target individuals, no matter how many are actually involved in the latter case"* (p. 251).

Trafimow (2000) regards attitudes and subjective norms as central components of the causal link between behaviour, attitude and subjective norm. According to Trafimow:

"An attitude *is the target person's opinion about whether the behavior is positive or negative, and a* subjective norm *is the target person's opinion about what most others who are important to him or her think he or she should do. Attitudes and subjective norms are determined by beliefs about the consequences of the behavior and beliefs about the opinions of specific important others, respectively."* (Trafimow, 2000: p. 47)

Oskamp (1977) suggests there are four functions of attitudes, which he refers to as; 1. The knowledge function, that helps us to make sense of the world around us, aiding the interpretation of new information and the assimilation of this information into a person's belief system; 2. The need satisfaction or utilitarian function that builds on the premise that many attitudes are formed as a result of our past rewards and punishments for saying and doing particular things. Once these attitudes have been formed, they will continue to be used to satisfy our needs or reach our goals; 3. The ego defence function of attitude helps to enhance our self-esteem and protect us from insecurities and our own inferiorities. Oskamp (1977) suggests that prejudiced attitudes are often used as a crutch and are often referred to as the 'scapegoat view of prejudice'; and 4. The value expression function which helps to establish a person's self-identity.

Greenwald (1989b) expands on this by proposing that attitudes have a *"powerful role in determining social behavior"* (p. 438), setting out three propositions. Firstly, he contends that for many people the self is the most important attitude object and that behaviour interpreted in these terms is linked to the self-esteem. He notes the phenomena of attraction to similar others and the repulsion from dissimilar others. This proposition would find support from Aronson (1999) who sees a clear linkage between the self-concept and behaviour within dissonance theory. In addition, Greenwald (1989b) views attitudes as a *"powerful determinant of evaluative responses to the source and content of influence attempts"* (p. 438). Thus, the individual, he asserts, will respond positively or negatively to statements that place the attitude object in a favourable or unfavourable light. Finally, Greenwald notes how direct experience can be used as a predictor of behaviour, although he acknowledges the limited research relating to subjects being confronted with novel objects, stating that this may be the most understudied aspect of attitudes.

This research will view disabled people both as an homogeneous group (i.e. disabled people in general) and different impairment groups (such as people with schizophrenia, osteoarthritis, etc.) as the attitude object. The following literature review will also highlight the three components of attitude structure (cognition, affect and conation), due to the importance of attitude modification and the view that different components may require different strategies for change. The next section of this chapter will now explore the literature with reference to attitudes toward disabled people.

3.3 Attitudes Toward Disabled People

"In the long-term, we can look forward to a time when disabled people's needs are mainstreamed and attitudes have changed so that disabled people are afforded full equality in society" (Cabinet Office: Prime Minister's Strategy Unit, 2004: p. 47). This statement sets out a utopian vision of the future for disabled people from the UK Government's Strategy Unit. However, through its very statement, it gives recognition to how far we have to go before disabled people will have full and equitable citizenship.

The barriers faced by disabled people has been extensively recorded elsewhere (see for instance, Swain, J., Finkelstein, V., French, S. and Oliver, M. (Eds.), 1993) and it is not the intention of this chapter to repeat this discourse here. This chapter, instead, intends to consider attitudes toward disabled people as a group and the consequences of the cognitive and affective components of attitudes upon behaviours toward this group in society.

3.4 Culture and Disability

Within the United Kingdom it is reported there are between 8.6 million to 11 million disabled people (Bajekal *et al,* 2004: p. 2). Attitudes toward disabled people are predominantly negative (DuBrow, 1965; English and Oberle, 1971; Florian and Kehat, 1987; Gething, 1991; Lee and Rodda, 1994; Fries, 1997; Stiker, 1997; Christie, Batten and Knight, 2000). Disability is often viewed as a form of deviance and dependency (Corker, 1998) leading to patronisation (Liesener and Mills, 1999), prejudice (Morris, 1991) and exclusion from the rest of society (Stiker, 1997).

Many attitudes toward disabled people are influenced by the culture from which the observer comes, with culture often playing a major role in shaping society's beliefs and behaviour towards disabled people (Ingstad and Whyte,1995; Nicolaisen, 1995; Bakheit and Shanmugalingam, 1997; Stone, 2001; Rao, Sharmila and Rishita, 2003), the study of which has often taken an anthropological approach (Vash, 1995; Kasnitz and Shuttleworth, 2001). In addition, cultures within cultures can influence behaviour, as illustrated by the UK Asian community (Katbamna, Bhakta and Parker, 2000). As Ustun, Chatterji, Bickenbach, Trotter II, and Saxena (2001) stress in their international validation of the World Health Organisation classification ICIDH-2:

"...not only are personal experiences of disability individual and unique, but perception of and attitudes towards disability are highly relative, since they are subject to cultural interpretations that depend on values, contexts, socio-historical time and place, as well as the perspective and social status of the observer. Disability and its social construction vary from society to society and from time to time." (Ustun, Chatterji, Bickenbach, Trotter II, and Saxena, 2001: p. 9)

Smith (1996) suggests that attitudes towards disability on a societal level have changed very little if at all, with Mairs (1996), in her personalised account of living with multiple sclerosis concluding that the physical and social environments sends the message to disabled people that their presence in society is, *"...not unequivocally either welcome or vital"* (p. 88). This view is supported by Blumberg (1998) who argues that whilst disabled people regard society's prejudices as more restrictive than the practical difficulties faced as a direct consequence of a person's impairment, non-disabled people tend to question the validity of such claims.

However, despite the predominantly negative attitudes toward disability, as the next section of this chapter will identify, a growing body of literature is beginning to view disability in positive terms.

3.5 Positive Attitudes Toward Disabled People

This section of the chapter will identify the literature that indicates what some have regarded as positive attitudes toward this group. However, it should be noted, positive representation of disability tends to be distorted and stereotypical, such as the 'triumph over tragedy' stories contained in the mass media (Asch, 1984; Barnes, 1992), and is therefore questionable as to whether it is truly 'positive'.

Salsgiver (1996) contends that positive attitudes towards having a disabled child have been expressed in a variety of ways in the literature. He notes the hopes and aspirations of parents with disabled children for their children's future are viewed positively when they are similar to the aspirations for non-disabled children. For instance, participating in recreational and social activities, a career, and financial security. In other words, living a 'normal' life. Parents have also expressed feeling 'empowered' by raising a disabled child, as well as viewing the child's disability as little concern. Some families also felt the family unit became closer, developing greater levels of tolerance and compassion towards others as a result of having a disabled child. However, it is also noted some parents felt that having a disabled child could be disruptive to the family unit. Brinchmann (1999), through the use of a descriptive field study design using 30 hours of field observations and seven in-depth interviews over a five month period with parents of severely disabled children, found ambivalent results with respect to their attitudes towards their relationships with their disabled child. Brinchmann concludes, these parents experience sorrow, stress and sadness on the one hand, and love and happiness on the other.

The longitudinal work of Bogdan and Taylor (1989) attempted to identify perspectives held by 'non-stigmatising non-disabled people' towards 'severely impaired people' with learning disabilities. Bogdan and Taylor conclude these individuals support the disabled person's 'humanness'. In doing so, they describe four key features of the relationship. 1. Accepting that the disabled person is capable of independent thought; 2. Viewing the disabled person as an individual with a distinct personality, likes and dislikes, feelings and emotions; 3. Regarding the relationship as reciprocal, in other words, all individuals offering something important to the relationship; and 4. Being defined as full members of the social unit, hence, part of the social group. Bogdan and Taylor (1989) recognise these factors are not unique to relationships between disabled and non-disabled people, but are sentiments underlying any relationship that allows the perceiver to view another as 'someone' rather than 'something'.

In an attempt to ascertain the extent and character of discrimination in Scotland, Bromley and Curtice (2003) undertook a national survey into attitudes towards women, minority ethnic groups, gay men, lesbians and disabled people. Whilst this research may have a biased sample with over 40% of respondents reporting a disability or long-term health problem, and therefore not truly reflective of a wider population, it still offers helpful data. These authors reported that *"few people expressed prejudicial or overtly prejudicial views"* (p. 41) with disabled respondents expressing very similar attitudes to those who did not report a health problem or disability. This survey found that the majority of respondents agreed wheelchair users were suitable for the job of primary school teacher (69%), the main problem faced by disabled people at work is other people's prejudice, not their own lack of ability (76%), and shops and banks should be forced to make themselves more accessible, even if this means higher prices (79%). In addition, only 4% of respondents said they would prefer a non-disabled member of the Scottish Parliament, and just 3% felt attempts to give equal opportunities to disabled people in Scotland had gone too far. However, men (from the entire sample) were found to hold more discriminatory views than women, although statistical significance is not reported. Other limitations of this survey must also be the use of wheelchair users as a representation of disabled people. Thus, these authors would have tapped into stereotyped representations of disabled people. In addition, the nature of the questions asked enabled respondents to be less than truthful, as expressions of belief may not be the same as behaviour. Therefore, the results found by Bromley and Curtice (2003) should be viewed with a degree of caution.

Positive attitudes toward disabled people can also be expressed in terms of supporting disabled people in self-determination. Powers, Ward, Ferris, Nelis, Ward, Wieck and Heller (2002) suggest there are a number of positive outcomes derived from 'person-directed services', including an enhanced control over one's own life. Alongside the right of self-determination, Powers *et al* (2002: p. 129) note the important principle of *responsibility*. These authors draw on the work of the North American based disability organisation's (National Centre for Self-Determination and 21st Century Leadership and the Alliance for Self-Determination) work relating to principles, recommendations and actions in order to increase leadership by disabled people. The 'living document' produced by these organisations states:

> *"People with disabilities have the responsibility to fulfil the ordinary obligations of citizenship (e.g., voting, obeying laws, directing their own lives, participating in community life) by using supports in ways that are wise, fiscally responsible, and life affirming."* (Powers *et al*, 2002: p. 129)

One such responsibility could be that of work. Work and employment in relation to disabled people will therefore be discussed in the next section of this chapter.

3.6 Employment and Disability

The employment and employability of disabled people remains an important factor in the lives of many individuals with impairments and it could be argued that the barriers faced in accessing employment are a reflection of society's attitude towards disabled people as equal citizens (Barnes, 2000). The section will therefore review employment and employability in relation to disabled people.

Work, in is broadest sense, as well as paid employment is generally regarded as having positive health benefits for the individual (Brenner and Bartell, 1983; Smith, 1985; DWP, 2002: p. 13). However, despite this, the unemployment rate for disabled people is almost twice that of the non-disabled population, using statistics that only include those who are regarded as economically active (DfEE/Skills and Enterprise Network, 1999; DWP, 2002). Waddell and Burton (2004: p. 13) however, caution about the use of such statistical data. These authors highlight that through closer analysis of the data, whilst according to the Labour Force Survey Summer 2002, 34% of people on disability and incapacity benefit said they would like to work, only 6% said they were currently available for work. Likewise, Grewal *et al* (2002) found 76% of economically inactive disabled people said their health condition/disability was the main reason for not seeking work, with only 6% having taken active steps to seek work in the previous four weeks.

Where disabled people are in employment they are likely to receive lower pay (Blackaby, Clark, Drinkwater, Leslie, Murphy and O'Leary, 1999; DfEE/Skills and Enterprise Network, 1999) and poorer career prospects and support (Colella and Varma, 1999). Of the disabled people who obtain employment, one-third loose that job by the following year, as compared to one-fifth of the non-disabled population who enter the labour market (Burchardt, 2000). Grewal, Joy, Lewis, Swales and Woodfield (2002) found that 17 per cent of disabled respondents (to a survey of 2064 people in Britain, of which 47 per cent were disabled) said they had experienced actual discrimination in the workplace, with a further 37 per cent, when prompted, saying they had experienced some form of prejudice or unfair treatment.

Barriers to employment are often as a result of the social environment that tends to stereotype disabled people as *"damaged goods"* (Boyle, 1997). Through a series of in-depth interviews with seven successfully employed disabled people in the United States of America, Boyle found that negative stereotypes resulted in four categories of barriers: 1. *A negative social image*, which resulted in the disabled person avoiding contact with non-disabled people; 2. *A rehabilitation system that exerted considerable control over the career options available to its clients*, taking little account of individual idiosyncratic needs and aspirations; 3. *Established job completion methodologies*, that were designed with physical requirements that only physically able people could meet; and 4. *A powerful image campaign by many organisations*, that created the illusion that the company was more responsive to employing disabled people than was in fact the reality. Earlier research (McCleary and Chesteen, 1990) found similar results with disabled people citing misconceptions and fears of employers, attitudes of the wider non-disabled population, difficulties obtaining education and job-skill training as major barriers to employment.

Barnes (2000) argues that Labour Government initiatives in the late 1990's onwards, to enable disabled people to access employment, will only have a minimal effect as they do not address the *"...very real environmental and social barriers that disabled people encounter within the world of work"* (Barnes 2000). Drake (2000) sees the 'Welfare to Work' programme, which includes 'New Deal for Disabled People', as focussing on the individual limitations (such as motivation to work, lack of confidence, poor personal skills and a need for in-work support), rather then the social barriers such as poor public transportation and discriminatory employment practices. This view is shared by Stanley and Regan (2003), who add that the 'Pathways to Work' Green Paper (DWP, 2002) fails to tackle employer responsibilities. Stanley and Regan do note, however, that it is unlikely one Green Paper from a single Government department (Department for Work and Pensions) can address the complex and wide ranging barriers faced by disabled people seeking employment, thus concluding a *"more ambitious strategy is needed"* (p. 81). Much of the proposed strategy suggested by these authors is based around the 'ethical business case' for recruiting and retaining disabled employees.

Barnes (2000) states that whereas during the 19th and 20th Centuries being 'able bodied' was a 'prerequisite for inclusion in the workforce', in the 21st Century it is likely to be those who are 'able minded' who will be most employable. Therefore, people with cognitive disabilities or mental health problems are likely to find themselves increasingly excluded from employment, whereas physically impaired people less so. If this hold true, then, for instance, the finding that people who develop rheumatoid arthritis tend to leave employment within ten years of diagnosis (Ryan, 2002), should diminish. The 'able minded' view finds support from a Eurobarometer survey (Marsh and Sahin-Dikmen, 2002), whereby respondents believed applicants with learning difficulties or those with a mental illness were thought to be the most disadvantaged group in the labour market (87%), with 77% believing people with a physical disability as the next most disadvantaged. Other groups included in his survey were people from another ethnic origin, people with minority beliefs, people under 25, people over 50, and homosexual people.

Likewise, O'Flynn (2001), when discussing the importance of employment for people with mental health problems states that, *"Most employers and employees are not yet ready to work alongside people with mental health problems..."* suggesting that within the employment environment, attitudes towards disabled people may be impairment based. Blackaby, Clark, Drinkwater, Leslie, Murphy and O'Leary (1999) through a longitudinal survey to explore the effects of disability on employment opportunities and earnings, found that men with mental health problems had the lowest probability of employment and women with chest or breathing problems. This survey would tend to support the notion that discrimination against disabled people is not only impairment based but also situational, i.e. in this instance employment. This view is supported by English and Oberle (1971) using Yuker's Attitude Toward Disabled Person's Scale – Form B, found that workers who placed a low emphasis on physique (typists) had more positive attitudes than workers who place a high emphasis on physique (airline stewardesses). Although this research was carried-out in the early 1970's, and there is therefore a possibility that alternative results may be found due to long-term attitudinal change on a societal level, it still illustrates how attitudes are multi-dimensional and situational.

The employment setting for disabled people who are able to work has generated interest, with respect to whether employment should be in integrated work settings, or whether supported workshops still have a role to play (Hyde, 1998; Storey, 2000) and if integrated work settings are preferable, methods to ensure their effectiveness (Nisbet, 1992; Jones, 1996; Callahan and Garner, 1997). Whilst Storey (2000) supports the use of integrated work settings, arguing that parents and teachers must embrace the philosophical judgement that all people have a right to work, so they can educate disabled children in employment skills, there may still be a role for supported workshops. However, this role is given the caveat that disabled people should only be employed in non-integrated settings if it is made through 'informed choice' by the disabled person. In other words, not as a consequence of being the only option available. Regardless of the work environment, what is clearer is that the positive self-esteem expressed by disabled people who are able to enter or re-enter the labour market. This strength of feeling cannot be underestimated, with one disabled person quoted in Heenan's (2002) discussion on the New Deal for Disabled People saying:

"When you say that you are disabled people automatically think, oh here we go another scrounger. I need to work for my own self-esteem and self-belief. There were days when I wasn't working and I thought well what's the point, what have I got to give. You just have to shake yourself out of it and this scheme has been like a lifeline to me. I can now prove what I always knew, that I am valuable". (Heenan, 2002: p. 392)

That said, it would appear that the positive health and social benefits derived from paid employment (where appropriate) outweigh the potential pitfalls of employment. The New Labour slogan of 'work for those who can, security for those who can't' (DWP, 2002: p. 5), reflected in the welfare to work programme, appears to be gradually supported by disabled people, with a growing recognition of social and economic benefits derived from employment, so long as support is delivered when employment is no longer viable.

3.7 Attitude of Health Care Professionals Toward Disability

One group of people who offer an important perspective on disability and disabled people, are those people who work within the health care and related professions. Although it is not the purpose of this thesis to specifically investigate this group's perspective over other groups, it is possible they may offer additional insights. Therefore, the next section of this chapter will briefly review the literature pertaining to this topic.

The attitude of health care professionals towards disability and disabled people should not automatically be assumed to be positive (Gething and Westbrook, 1983; Yedidia, Berry and Barr, 1996; Stalker, 1999) although they can be modified (Packer, Iwasiw, Theben, Sheveleva and Metrofanova, 2000; Crichton-Smith, Wright and Stackhouse, 2003). Health care professionals' attitudes towards disabled people, like other people, should also be looked at in terms of attitudes toward impairments (Janicki, 1970).

Eberhardt and Mayberry (1995), whilst reporting that the American Occupational Therapists (n = 172) who took part in their study generally held positive attitudes towards disabled people, it is interesting to note that those with the least contact with disabled person's held the more positive attitudes. This point will be discussed at greater length in Chapter 8, but what is important to note here is how the patient-professional relationship impacts upon the attitudes expressed. Cobb and de Chabert (2002) add to this discussion, that North American HIV/AIDS social service providers (n = 46) tended to blame victims of HIV/AIDS and were less willing to provide help, the greater the level of direct contact. Cobb and de Chabert conclude that a process of desensitisation takes place due to the provision of direct services, and therefore managers who have less direct contact than field workers working with people living with HIV/AIDS, tend to hold more positive attitudes. Similar finding were reported by McCann (1999) in a study of Australian doctors (n = 77) and nurses (n = 188) towards treating patients living with HIV/AIDS. A number of respondents saw children and people who acquired HIV through medical treatment as 'innocent' victims, whereas those who became HIV-positive through injecting drugs or sexual practices as blameworthy. McCann (1999: p. 358) warns that such attitudes could lead to poorer quality of care for one group over another.

White, Holland, Marsland and Oakes (2003) add to this debate with reference to people with intellectual disabilities. They highlight that care workers who view their client group as 'other' begin to dehumanise them, which in turn leads to forms of behaviour that would not be regarded as acceptable for other groups in society (such as forced sterilisation - see Aunos and Feldman, 2002). Yazbek, McVilly and Parmenter (2004) report, however, that disability service providers and students held more positive attitudes towards people with intellectual disabilities than the general population in Australia, rejecting eugenic policies, such as the sterilisation of women with intellectual disabilities on the pretext of menstrual management, rejecting "sheltering" and social distancing of this group of people. However, these authors recognise the sample of disability service providers may not have been representative, coming from community-based services and not institutional services.

The extreme consequence of negative attitudes toward people with learning disabilities from health care professionals is highlighted by Mencap (2004). Through interviews with approximately 1000 people with learning disabilities (although this report fails to offer exact research methodology or even the questions utilised), Mencap identified that whilst the majority of people were satisfied with health care received, others reported negative and even disturbing experiences. The report also concludes that some people with learning disabilities may have died as a consequence of poor health care due to a lack of understanding of their needs. One conclusion from the report is therefore the need for disability awareness training for health care professionals.

Recognition of the need for health care professional to listen to the views of disabled people is found in the collaborative research between the University of Bristol, University of the West of England and the Peninsula Medical School's 'Partners in Practice' project (Partners in Practice, 2004). This research utilised the Delphi Process, whereby participants (n = 150, of which approximately 45% self-identified as disabled) were asked to rate a series of learning outcomes for healthcare professionals undertaking training from 0-9, depending on the importance of each outcome in disability equality training underpinned by the social model of disability. Participants were then asked to reconsider their initial responses in light of the average rating by other respondents. This project identified the outcomes that received a score of 8 or 9 were "Understand that people with long-term conditions are experts on their medical problems and lifestyle issues" (89% respondents rated either 8 or 9), "Recognise that different disabled people have different needs, identities and preferences" (86%) and "Recognise that not all problems have a medical solution" (86%). A number of the fifteen outcomes listed on the project's website not only relate to the interaction between the disabled person and the healthcare professional with respect to the treatment, but a number also relate to issues of equality and diversity. Hence, this research appears to identify healthcare professionals would benefit from training in issues of dignity and respect toward disabled people. With 45% of respondents being disabled people, it is likely this issue is one that is of importance to disabled people, however, no breakdown of disabled and non-disabled respondent's results is given. It would therefore be helpful to identify whether these two groups held significantly different responses to any group of learning outcomes produced through the 'Partners in Practice' project.

Having identified that health care professional do not automatically hold positive attitudes toward disabled people, the next part of this literature review will focus on the controversial topic of the right to life, as an extreme illustration of behaviour and belief toward disabled people, and as stated in Article 12 of the Human Rights Act (1998) that *"Men and women of marriageable age have a right to marry and to found a family, according to the national laws governing the exercise of this right"* (Wadham and Mountfield, 2000).

3.8 The Right to Life

"Who has the right to live?" is by no means a new question, but it has received increased attention within the study of disability, not least because of the developments with respect to genetics. The debate stems in part from the growth of eugenic policies in the early to mid 20th Century (Hubbard, 1997; Hampel and Renn, 2000; Reinders, 2000; Mitchell and Snyder, 2003). Early advocates of eugenics argued that whilst everyone had a right to live, not everyone had a right to reproduce (Pernick, 1997). Hubbard (1997) notes the techniques currently being developed in relation to genetic screening, genetic counselling and pre-natal testing, have their roots in early eugenics.

The British Council of Disabled People (undated) (BCODP) recognised the complexity of the developments of human genetics, putting forward its position on the issue as: a) expressing 'alarm' over recent developments; b) genetic research as a serious threat to disabled people, that is *"fostering a more* *negative image of disability and is likely to lead to increased discrimination...* "; c) that there is a dangerous link between genetics and eugenics; d) that BCODP are not opposed to ethically approved medical research where the goal is treatment of illness; e) they support women's right to choose with respect to pregnancies, but express concern over the context in which these choices are made; f) that prenatal testing and "therapeutic abortion" are informed by prejudice toward disabled people; g) they reject the 'cost-benefit ethics'; h) BCODP are concerned that the law may collude in discriminatory practice citing the Human Fertilisation and Embryology Act 1990; and i) that *"new genetics not only poses a danger to disabled people, but for everyone."* Notably through insurance companies loading policies and multi-nationals patenting human genes.

Point e) of the BCODP position is challenged by Sharp and Earle (2002) who argue that the rejection of the right to take action (abort the foetus) on the grounds of the influence of the social context (prevailing negative attitudes towards disability) is flawed. Taking this argument to its logical conclusion they suggest, *"...a case could be made for denying virtually any individual the right to exercise virtually any preference."* Sharp and Earle conclude that it is not possible to reconcile the feminist position of a women's right to choose with that of the disability rights movements opposition to abortion on the grounds of impairment. Likewise, Rodgers and Howarth (2001) 'conveniently' found that they could *"move forward by acknowledging the validity of both* *views* [feminist 'right to chose' and disability 'right to life'] *and respecting the position of anyone who chose to follow one or the other"* (p. 18).

Disabled activist and academic Tom Shakespeare (1999) notes a similar dichotomy between medical clinicians and disabled activists, arguing there must be greater discourse between these two groups to enable a more balanced debate to take place. Shakespeare also suggests that both groups may be overstating the potential impact of genetics on the lives of disabled people.

On a societal level Reinders (2000) also considers the implications of the developments in human genetics in relation to policy making and service delivery. He argues:

"Assuming that disabled people will always be among us, that the proliferation of genetic testing will strengthen the perception that the prevention of disability is a matter of responsible reproductive behavior, and that society is therefore entitled to hold people personally responsible for having a disabled child, it is not unlikely that political support for the provision of their special needs will erode. If this development takes place, their access to social services, welfare, education, and the labor market will be in danger..." (Reinders, 2000: pp. 14-15)

Thus, it would appear that the literature reveals grave concerns from disabled activists as highlighted by the BCODP and academics, as to the implications of human genetic research, genetic screening and reproductive technologies, creating a call for a more creative and balanced debate (Blumberg, 1998; Shakespeare, 1999; Disability Now, May 2000). Such a debate seems, however, to be emerging from philosophers such as Belshaw (2000) who discusses the work of two identity theorists, (Kripke and Parfit), in relation to identity, disability and the effect of gene therapy.

An eloquent comment on genetic testing came from a person with a learning disability when she argues that we need to look for a different solution to the discrimination faced by disabled people:

"People with learning difficulties are different from to other people. We get picked on – others make fun of us. People shout at us in the street sometimes. Black people with learning difficulties get picked on even more. People with learning difficulties should be treated fairly and not discriminated against. Scientists should find the gene that makes people pick on those who are different. Then our lives would be better." (Cited in Howarth, Rodgers, Collins, Cook, Hamblett, Harris, Long, May and Webster, 2001: p. 39)

In a small but important piece of research, Chen and Schiffman (2000) interviewed 15 people with physical impairments, having recognised that much of the social science based literature and articles in the popular press on this topic, were primarily based on the views of disability rights activists. They found that this very small, and therefore unrepresentative, sample, contrary to other research, viewed genetic counselling and prenatal diagnosis favourably. Only a small percentage of this sample viewed such interventions as eugenic. Despite the limitations of Chen and Schiffman's research, it raises important questions as to how disabled people from a non-activist standpoint regard fundamental, and yet emotive topics such as prenatal testing. Further research, which includes a wider, and perhaps, more representative cohort of disabled people, appears to be required before firm conclusions can be drawn.

3.9 Parenthood and Disability

Linked to the debate around reproduction and disability, is the issue of disabled people being sexually active and becoming a parent. Monat-Haller (1992) comments that people with learning disabilities are often regarded as asexual, which is enforced through rules and regulations imposed upon this group of people, especially when living within residential care. Monat-Haller (1992) and Aunos and Feldman (2002) see this as part of the infantilisation of people with learning disabilities, whereby parents and care workers do not regard these individuals as having mature bodies with sexual needs. Such attitudes towards the sexual needs of disabled people are not confined to people with learning disabilities. Shuttleworth (2001), taking an anthropological approach to his research, identified that people with cerebral palsy specifically find difficulty in being regarded as sexual beings. Shakespeare, Gillespie-Sells and Davies (1996) note that disabled people in general are often discouraged from an early age from discussing matters of a sexual nature, with the misplaced assumption that disabled people are asexual. Shakespeare *et al* view the issue of disabled people's sexuality as part of the move toward viewing disabled people as equal citizens. They conclude that disabled people are often denied sexual relationships not because of biology, but social, political and economic barriers.

When sex is discussed with younger disabled people, however, Wates (1997) found it is more often associated with avoiding becoming pregnant, rather than child rearing. Despite this, more disabled people are becoming parents, in part because of improved medical science, but also as a consequence of changing attitudes of disabled people in seeing themselves as potential parents (Wates, 1997; Aunos and Feldman, 2002; McGaha, 2002; Olsen and Clarke, 2003).

It is also common for women who acquire an impairment, to no longer be viewed as capable of rearing a child (Gill, 1996; Wates, 1997; McConnell and Llewellyn, 2000) which in turn can lead to a devalued social status and even separation from their partner. Grue and Laerum (2002) in a Norwegian study of 30 women note the additional stress physically disabled women endure in order to present themselves as coping as a mother, rather than a 'disabled mother' or even as a mother at all. Some women in this study also expressed the fear that their child may be taken away if they did not perform their parental role in a manner over and above that which would be expected of other mothers (a finding supported by Aunos and Feldman (2002) in their review of the literature on sexuality and people with intellectual disabilities).

Wates (2002) found that disabled parents within the UK who required some form of support, had their children viewed as 'vulnerable' or 'at risk' by Social Services as a result of their policies and procedures. This approach by Social Services, Wates (2002) argues, has led some disabled parents not to seek services, through a fear of stigma as a 'bad' parent, or even the concern that the child be removed from the family home. Wates, comments, however, that such fears do not appear to be borne out in practice, according to Social Service Inspectors. Hence, disabled parents may perceive they are more at risk of having their child taken into care or viewed as 'at risk' than the reality.

Stalker (1999) drawing on research carried-out in Scotland argues that attitudes towards the sexuality of people with learning disabilities and their potential role as parents, is improving, although she concedes that such conclusions contrast with more negative conclusions from earlier research. Booth and Booth (1994) and McGaha (2002) challenge the view that people with intellectual impairments are unfit to be parents as a consequence of their impairment, arguing that a lack of parenting skills may in fact be as a result of both individual characteristics and the environment the individual develops, concluding that appropriate interventions, such as parenting skills training, can assist the individual to become an effective parent. Booth and Booth's (1994) research is particularly insightful, as it draws on accounts from parents who have learning disabilities, rather than non-disabled professional viewpoints. Aunos and Feldman (2002) note, in their review of the literature, that parenting difficulties are not solely as a consequence of cognitive limitations, but may also be as a result of 'attitudinal social factors' (p. 291). Aunos and Feldman therefore suggest that due to previous discrimination and stigmatisation faced by people with learning disabilities, this group may avoid accessing necessary support services for fear of being viewed as incompetent and therefore unfit parents.

Many of the themes discussed above in this chapter thus far, are reflected in the Government white paper *'Valuing People'* (DoH, 2001). This white paper was produced in order to help tackle the discrimination faced by people with learning disabilities, recognising *"People with learning disabilities have a right to be full member of the society in which they live, to choose where they live and what they do, and to be as independent as they wish to be"* (p. 14). *Valuing People* states there are four key principles at the heart of this white paper: legal and civil rights, independence, choice and inclusion. It states that people with learning disabilities have a right to a decent education, to vote, marry, have a family and express an opinion. In addition, this policy document makes the distinction between independence and dependence, with an understanding that independence *"does not mean doing everything unaided"* (p. 23). In addition, that support should be offered to ensure people with profound disabilities are able to express preferences in their day to day lives and to make use of mainstream services, such as going to the swimming pool or cinema.

Attitudes generally appear to be expressed in terms of negative behaviours towards this group in society on both an individual (for instance, repulsion and fear) and societal (for instance, eugenics and segregation) level. However, positive beliefs and behaviours toward disabled people may be emerging. Whether attitudes toward disabled people as a homogenous group are the same as those expressed toward different impairment groups also needs to be examined.

3.10 Hierarchy of Impairment

Contained within the research into attitudes toward disabled people, is the debate as to whether people hold attitudes toward disabled people in general, in other words, as a homogenous group, or, toward individual impairments (Gething, 1991; Harper, 1999).

The differentiation between impairment groups may be linked to the desire to preserve a positive self-concept, thereby portraying one's own group (the in-group) as superior to another group (the out-group), (Meeres and Grant, 1999). Hence, by doing so, the individual distances themselves from the 'out-group' others, effectively placing each 'out-group' into a hierarchy of acceptance in relation to the 'in-group'. Quist and Resendez (2002) add:

"Individuals in dominant groups have greater social dominance orientations and are motivated to maintain their dominance over subordinate groups and the corresponding privileges resulting from their higher status. This is accomplished through the generation and maintenance of hierarchy legitimizing myths, *which are beliefs (stereotypes) and attitudes (prejudices) suggesting that subordinate groups deserve their status. These are legitimizing myths in that they justify the hierarchy. These beliefs support the position that subordinate group members are inferior and deserve their subordinate status."* (Quist and Resendez, 2002: p. 287)

This chapter will now explore this concept, and identify the literature in relation to the concept of a hierarchy of impairments. This review will also identify whether evidence exists for a hierarchy of impairment from the perspective of disabled people.

3.11 Research into a Hierarchy of Impairment

An important series of questions in relation to the field of disability studies must therefore be, do disabled people regard themselves as part of an in-group of disabled people, an in-group of those with the same impairment, or as part of an out-group? Drawing on the wider literature, Linville (1998) comments that people tend to perceive a greater number of 'subtypes' within their in-group than within an out-group. It may be possible, therefore, that whilst disabled people view other disabled people as part of their in-group, due to the heterogeneity of impairment, the disabled person may view each impairment group as a subtype and thus different from themselves.

Haslam, Oakes, Turner and McGarty (1995) add to this discussion by giving an example of meta-contrast. Meta-contrast being defined as *"...a given set of stimuli is more likely to be categorized as a single entity to the extent that the intra-class differences between those items are smaller than the inter-class differences between those items and others that are salient in a given comparative context."* Thus, Haslam *et al* suggest, various pieces of fruit will be perceived as fruit rather than apples or pears, when in a collection of other food products. But, when only fruit is present, the perceiver is more likely to identify greater differentiation and categorise more fully. Thus, in the first instance, stereotype traits are likely to be used to self-categorise between one group or another (in-group or out-group). Building on this model, disabled people when in a group of non-disabled people are therefore more likely to view themselves as a disabled group than when they are only with disabled people. When only with disabled people, according to meta-contrast, disabled people should self-categorise on other traits, which may include impairment (for instance, learning difficulties, people with cerebral palsy, et cetera), as well as gender, race, occupation, and so on.

The use of ranking has been widely used in the study of attitudes, whereby the subjects are asked to place a series of items or statements into an ordered sequence according to some specified criterion, (Antonak and Livneh, 1995a). Mastro, Burton, Rosendahl and Sherrill (1996) note that the Social Distancing Scale as developed by Bogardus has been widely used, where social distance is defined as, *"The degree of sympathetic understanding that exists between persons."* This method has frequently been utilised to identify whether a hierarchy of disability exists, on the assumption that some impairments are more accepted than others.

Due to the nature of impairment, some sections of our society find themselves more marginalised than others, and not simply because of either functional limitations due to impairment, or socially constructed barriers (physical, attitudinal, etc.). Leary and Schreindorfer (1998) when discussing the stigmatisation faced by people living with HIV/AIDS refer to this as 'interpersonal disassociation' (p. 11). Hence, the marginalisation is created by the denial of basic rights that enable people to be seen as part of a society and function within it, but stigmatised through disassociation.

In order to explore the hierarchy of impairment, it may be helpful to utilise Leary and Schreindorfer's (1998) suggested four criteria that determine the degree to which people are socially accepted. They contend:

"...people are socially excluded to the extent that they
1. pose a threat to others' health or safety (by being dangerous, reckless, or contagious, for example);
2. deviate excessively from group standards (by violating morals, rules, or norms);
3. fail to contribute adequately to the welfare of other individuals or the social groups to which they belong (because they are perceived to be incompetent, irresponsible, infirm, or selfish); or
4. create negative emotional reactions in others (by being socially aversive, aesthetically displeasing, or emotionally threatening)". (Leary and Schreindorfer, 1998: p. 12)

Leary and Schreindorfer (1998) argue that people living with HIV/AIDS are one of the rare groups of stigmatised people who meet all four criteria for interpersonal disassociation. However, it is possible other impairment groups might equally meet these criteria to a lesser or greater extent.

Factors such as comfort in interaction (Gething, 1991), feelings towards termination of a foetus with an impairment (Fletcher, 1999), culture (Harper, 1999), cause of the disability, the body of medical knowledge, and the perceived threat of the impairment group to the community (Noe, 1997), in addition to the subconscious need of individuals to protect their relative positions in society (Harasymiw *et al,* 1976), all appear to contribute to the creation of a hierarchy of impairments. It could also be added, that if each impairment group regards other impairment groups as out-group members, then Fiske and Ruscher's (1993) assertion that out-group members hinder in-group goals, also needs to be considered.

Fiske and Ruscher (1993) hypothesise that out-group members will be assumed by in-group members to either passively or actively hinder long-term goals or short-term daily functioning (p. 245). Putting this into a disability context, persons with a physical impairment, such as multiple sclerosis or spinal cord injured persons, may thus view people with, for instance, learning difficulties or mental health problems, as blocking their goals by competing for the same resources or having different agendas in relation to service delivery within the context of social care. Thus, the literature would suggest, it is a complex range of factors, rather than any single factor that assists with the formation of a hierarchy of preference toward impairment groups. Strohmer, Grand and Purcell (1984) note the complexity and multidimentionality of the issue of the hierarchy of impairments, adding support to Yuker's (1983) contention that the rank ordering of preferences towards impairment groups, in some instances, may be situationally determined.

If a hierarchy towards specific groups exists, it could be suggested that those ranked as 'least preferred' will have the most difficulty in being accepted by society (Tringo, 1970). By using a nine point social distancing scale, ranging from "would marry" to "would put to death", with twenty-one impairments listed in alphabetical order, Tringo found that mental illness was least preferred by the subjects (n = 455). Abroms and Kodera (1979) in their analysis of Tringo's research, challenge Tringo's conclusion that a dichotomy exists between "hidden" and "overt" impairments, with overt ranking lower, due to a low ranking of cancer, (which according to Tringo is a hidden disability). Tringo's hierarchy has been found to be relatively stable thirty years later, with only people with cancer showing a change in position (Thomas, 2000). Although it should be noted, only a relatively small number of subjects (n = 171) were used in this follow-up research. Likewise, Crisp (2001) contends that people with mental illness have not only been historically stigmatised, but, he argues, unlike other stigmatised groups, such as *"the physically disabled, with their ramps, rumble strips, Olympic Games and back-up legislation"*, people with mental illnesses *"rarely fight their corner"*, which could offer one possible explanation for the placement of mental illness lower in the hierarchy of impairment than physical impairments.

Shears and Jensema (1969) utilised both a social distancing scale and a ranking task to ascertain whether there was a distinction in rank order when the impairment is associated with a friend as opposed to 'self'. Shears and Jensema found the rank order of impairment in relation to 'self' (from most to least accepted) as blind, deaf-mute (sic), mentally ill, cerebral palsied, homosexual, retarded (sic), wheelchair user, being an amputee, stutterer or having a hare lip. Shears and Jensema's study, found only 7% would accept a wheelchair user as a friend and yet 93% would accept a wheelchair user as a colleague. The era in which this research was performed (1969) must be noted however, with few disabled people living or working in integrated settings and so contact with disabled people for the subjects is likely to have been extremely limited.

Janicki (1970) asked 54 health professionals, including doctors, nurses, psychologists, social workers and other health related professionals, to rank twelve impairments in order of those they found most disturbing. Blindness was found to be ranked as the most disturbing with stomach ulcers the least. Paraplegia, amputated arm and amputated leg, were ranked second, third and fourth, respectively. Facial disfigurement was found to be ranked as low as eighth.

Harasymiw, Horne and Lewis (1976) in an eight year longitudinal study with 4459 subjects found, using one of three social distancing scales, that a stable hierarchy of preference existed. They suggest that those impairments that conform most closely to the norms set by society, such as acceptance of the work ethic and are not "value rejective" will be ranked as the more acceptable. Thus, the position within the hierarchy is a reflection of the relative position that impairment has on a continuum toward 'normalacy'. Whilst this is a longitudinal study, and although cultural norms are on the whole slow to change, a more detailed analysis of which aspects of society's norms affect attitudes towards different impairments would be of value. This insight would give an opportunity to identify specific stereotypes that need to be challenged if attitudes are going to improve toward different impairment groups.

Richardson and Ronald (1977) using a picture ranking task, whereby children were shown six drawings of girls who were all identical other than five of them had a physical impairment, (girl with crutches and a brace on her left leg, girl sitting in a wheelchair, girl with left forearm amputation, girl with facial disfigurement, and an obese girl), and were asked to say which girl they liked best. The girl with no disability was ranked as most popular, with the obese child the least and the wheelchair user fifth. Woodard (1995), however, in a study using kindergarten, first, second and third grade elementary school children (18 females and 15 males), found that a picture of a child who used a wheelchair was ranked more highly than a child with an amputation and a non-disabled child. Whilst the results indicated that the boys held slightly more positive attitudes toward disability, Woodard notes that the males in the study may not be a representative sample. She states that anecdotal observations revealed that 10 of the 15 boys tended to be *"non-physical"*, preferring to read, play chess, 'invent' things, and so on. These boys, Woodard suggests, may have felt threatened in physical activities with a non-disabled child, whilst feeling more confident in interactions with a child using a wheelchair or a child with an arm amputated.

Whilst Richardson and Ronald (1977) state that by using the picture ranking method, the order of preference has proven to be *"extraordinarily stable"*, the lack of consistency between researchers as to which impairments are included in the ranking task, means that such claims are difficult to generalise. Yuker (1983) goes as far as refuting Richardson and Ronald's findings, stating that the order of preference for the impairments used in their research are neither stable nor culturally uniform, and the findings difficult to generalise. Yuker notes that the hierarchy obtained by Richardson and Ronald was dependent upon a number of variables, including the task used, (picture ranking), specific questions asked, the general experimental procedures and the type of data analysis used. He therefore suggests that any cultural uniformity must be limited only to those results obtained using the same set of pictures administered in exactly the same way.

Richardson (1983) responds to Yuker's (1983) assertions by stating that he and his colleagues did *"not expect any value to be universal"* (with a value being defined as *"a general tendency for a culture, or group to hold a specific order of preference"*). Richardson also contends that they did not expect every child's order of preference to be identical. Although noting the limitations of his research, such as the inconsistent use of language and the lack of detail on the nature and severity of the impairments used, Richardson concludes that such analysis of research is part of an evolving tradition of research, which assists in answering questions relating to people's behaviour towards disabled people.

Esses and Beaufoy (1994) contribute to this discourse, when measuring attitudes towards people with amputations, people who have AIDS and people who are chronically depressed. They found that there are three key cognitive determinants of attitudes towards disabled people, (stereotypes attributed to group members; symbolic beliefs that group members may promote or threaten one's values; and control over the occurrence of the impairment, and one affective determinant (emotions elicited by group members)). Esses and Beaufoy found that all four factors can act as predictors of attitudes towards the three impairment groups used in this study to varying degrees, with emotions and stereotypes significantly correlated with attitudes towards all three groups.

In addition, symbolic beliefs were significantly correlated with attitudes towards people with AIDS and to a lesser extent people with amputations. Significant correlations were also found between the control over the occurrence of the disability and the two impairment groups of people with AIDS and people with chronic depression. Overall it was found that relatively favourable attitudes were held towards people with amputations, whereas people with AIDS and depression were regarded less favourably, in part because of the perceived control they had over acquiring their impairment. Thus, this study begins to highlight the complex nature of attitudes towards disability and the need to identify both affective and cognitive components. However, the limited number of subjects, (n = 108), and their background, (undergraduate psychology students within a Canadian university), alongside the limited range of impairment groups, would suggest further research is required before firm conclusions can be drawn.

3.12 Cultural Factors and the Hierarchy of Impairment

Harper (1999), using the methodology developed by Richardson, in a series of non-Western cultures, suggests that attitudes toward different impairments are culturally related. For example, Harper found that whereas in the USA the obese child was ranked as the least desirable person to have as a friend, this was not the case for many other countries, for instance, Nepal, Yucatan, Antigua and New Zealand, whereby this child was more highly ranked. The explanation offered for this finding was that larger people in some cultures can be associated with affluence and status, rather than in other cultures as laziness and greed. Such findings in relation to obesity support Segal-Isaacson's (1996) comments based on the literature that reactions to body fat are to some extent culturally based. Segal-Isaacson also notes that attitudes to obesity are also more negative in western societies where the obese person was overweight due to overeating rather than as a result of medical reasons. Such findings suggest that the hierarchy of impairments may to some extent be influenced by the perceived culpability of the disabled person in relation to their impairment.

Harper (1999) also found that the child with a facial disfigurement was consistently low on the ranking of preference. This finding is consistent with other literature that has found negative reactions to people with facial disfigurement (Lansdown, Rumsey, Bradbury, Carr and Partridge, 1997; Dijker, Tacken and van den Borne, 2000; Miles, 2000). The consequences of such reactions have been found to be so negative that this group have even been afforded specific protection under the Disability Discrimination Act (Doyle 1996).

In addition, some parents of children with Down's syndrome have sought cosmetic surgery for their child in order to alter their appearance to one that is less associated with this impairment (Aylott, 1999) despite no functional improvement gained, and no evidence of reducing the stigma attached to Down's syndrome (Jones, 2000). Stevenage and McKay (1999) when investigating the reaction to facial disfigurement and physical disabilities in an employment interview situation, found that the person with both a facial disfigurement (port-wine stain) and a wheelchair user, was least likely to offered employment, with a person using a wheelchair but no port-wine stain receiving a more positive recruitment decision than the person with a port-wine stain only. This limited hierarchy helps to illustrate the importance of attractiveness in social interactions.

Charlton (2000) through his observations as a disabled activist, who has travelled extensively throughout the world, contends that:

"There is a hierarchy of disability. This hierarchy extends across continents and zones of economic development. It breaks down like this: people with mental disabilities and those perceived as having mental disabilities have the most difficult lives, followed by people with hearing difficulties. People with physical and visual disabilities have greater political, social, and economic opportunities and support systems." (Charlton, 2000, p. 97)

Charlton (2000) offers a number of explanations for this hierarchy, citing as its causes, blind people having long established social services, whereas people with hearing impairments and mental health problems only fairly recently developed services. Mental health impairments, being 'invisible' or 'hidden', contributes to isolation and therefore inadequate support systems, alongside the notion that people with mental health problems are not in a position to, "*... organise their lives and fight for their rights.*" In addition, he lists as the causes of this hierarchy; people with mental health problems commonly being abused as other members of society view them as "crazy" and potentially dangerous. Finally, he suggests that people with hearing impairments and mental health problems require the most complex, professionalised and technical support systems, as compared to other impairment groups. Thus, Charlton (2000) appears to argue that a hierarchy of impairment not only exists and is not culturally bound, but that it is linked to both negative perceptions of different impairment groups and the services afforded to those groups by society. However, Charlton can only offer subjective evidence to support his assertion that a hierarchy exists.

The importance of culture on attitudes towards different impairment groups was recognised in the development of ICIDH-2 in its attempt to identify whether this revised schema was culturally relative. Room, Rehm, Trotter, Paglia, and Ustun (2001) report that when participating centres from fourteen countries were asked to rank 17 'health conditions' from "most disabling condition" (described as that which would make daily activities very difficult) to "least disabling", the differences were significant for 13 out of seventeen health conditions. However, the authors also comment that a convergence of judgements was also evident.

Quadriplegia was ranked as most disabling across all cultures, dementia ranked second, active psychosis third, and paraplegia fourth. Least disabling were viewed as vitiligo on the face, being infertile when desiring a child and having severe migraines. Least agreement between cultures for ranking of the 17 health conditions was found for being HIV positive, total deafness, mild mental retardation and amputation below the knee. However, different results were found when the participants were asked to rank on a ten-point Likert-type scale, the degree of social disapproval or stigma faced by people with the eighteen listed health conditions. Those with least social disapproval were wheelchair users, blind people and those who could not read. Most social disapproval were alcoholism, a criminal record, HIV infection and drug addiction. Thus, wheelchair users, whilst being regarded as facing the most disablement, are also the most socially accepted. In line with Harper (1999) obesity received ambiguous results, with Canada, Turkey and UK attaching greater levels of stigma and social disapproval than China, Greece, India and Japan. However, caution must be expressed with respect to the findings of this research due to the small numbers of subjects in each of the participating nations. For example, UK N=12, Canada N=15, Egypt N=16, and so on. But, due to the level of convergence in these ranking task results, it could be suggested that further investigation into the inter-cultural hierarchy of impairments may be of value.

Tringo (1970) notes the need to include disabled people in this area of research, to give insights into how disabled people view themselves and other disabled people. This view is supported by Yuker (1983) who also suggests that such information will assist in identifying methods of attitude change. The limited literature within this context will therefore be discussed below.

3.13 Disabled People and a Hierarchy of Impairment

In one of the early rare pieces of research that uses disabled people as subjects, Bertin (1959) asked seventy-two blind children based at a residential school for blind children to say which person they felt was worse off from a list of, can't feel, can't hear, can't see, can't smell and can't taste. The children were then asked if they had to do without one of the senses listed, (hearing, seeing, smelling, tasting or touching), which one would they choose. Only 18 per cent of the blind children chose the blind person as being worse off, as compared to 71 per cent of non-disabled children used in the study. In addition, 49 per cent of the blind children preferred remaining blind rather than losing any other sense, whilst only 3 per cent of the non-blind children made this choice. Yuker (1983) using a chi-square test for each of the research questions on the two sets of data, (blind children and non-blind children), found that there was an "extreme divergence", indicating that the values of disabled and non-disabled children are significantly different.

Mastro, Burton, Rosendahl and Sherrill (1996) in another of the rare pieces of research that focuses on the attitudes of people with impairments toward people with other impairments, investigated whether a hierarchy of preference existed from elite athletes with impairments (United States Disabled Sports Team participating at the 1992 Paralympics in Barcelona, Spain) toward other elite athletes with impairments. Using a modified version of Tringo's (1970) Disability Social Distance Scale, Mastro *et al* (1996) administered five parallel forms, each with 12 statements, referring to different impairments, (amputations, cerebral palsy, dwarfism or 'les autres' – including limb deficiencies, muscular dystrophy, osteogenesis imperfecta, postpolio conditions and multiple sclerosis – paraplegia or quadriplegia and visual impairment) to 320 disabled athletes. 138 completed surveys were returned that could be analysed, (106 men and 32 women with a mean age of 29.9 years). Mastro *et al* found that the athletes with impairments held a hierarchy of preference toward one another, the ordering of which, they suggest, is based upon the severity of 'disability'. Amputation was regarded as most accepted as it is regarded as having the, "lowest degree of disability", as it is often associated with the loss of a single limb. 'Les autres' was consistently placed next in the hierarchy, which the authors suggest is due to this category containing a variety of impairment groups, some of which have little effect of sports performance, and also includes people with dwarfism, who usually have no impairment other than size. Ranked third in the hierarchy was the impairment group paraplegia/quadriplegia, which, it is suggested, is due to this group facing more physical restrictions than the first two groups. There appears to be little consistency between the 4th and 5th ranked impairments, (cerebral palsy and visual impairment), although it is interesting to note that those with visual impairments ranked cerebral palsy 3rd and paraplegia/quadriplegia 4th, although no explanation is given for this.

Mastro *et al* (1996) state that the hierarchy of preference, as found from their subjects with impairments, is similar to the hierarchies expressed by non-disabled people toward impairment groups. However, due to the nature of the sample, i.e. young, mainly male, sports orientated disabled people, caution must be shown when trying to generalise these findings. A wider sample of disabled people covering a greater number of impairments groups and from a more generalised background is required to test whether each of the impairment categories used in Mastro *et al's* research do in fact hold different hierarchies to each other. It may also be useful to identify where each of those impairments groups place themselves in the hierarchy, for, if one of the main factors is the individuals self-esteem, then those impairment groups that consistently demonstrate low self-esteem may place themselves in a position ranked lower than 1st.

As a graphic illustration of the behavioural consequences of disabled people holding a hierarchy toward other impairment groups, Shakespeare, Gillespie-Sells and Davies (1996), when discussing disability, sex and gender, cite one research participant who explained about the so called 'pecking order' within the 'special' school for boys having sex with other boys:

"At the age of eleven, a special school for boys where there was plenty of opportunity for sex and I had lots of sex there with lots of different boys. Looking back it was the best thing about boarding school. The most desirable boys were the haemophiliacs because they were closest to being non-disabled, almost god-like. The least desirable were those with muscular dystrophy, and I felt I was somewhere in the middle." (Shakespeare *et al* 1996: p. 22)

Shakespeare *et al* (1996) also cite the earlier work of Wendy Chapkis on women and body image who says:

"There is a real hierarchy of what is acceptable appearance within the disabled community: what is beautiful, what is ugly. At the top is someone who sits in a wheelchair but looks perfect. I have a friend who has cerebral palsy; she always says cerebral palsy is the dregs. They drool and have a speech impairment, movement problems, that kind of thing. On the high end of the scale is the person with a polio disability because physically they look okay. It's something we have to work on." (Shakespeare *et al,* 1996: p. 71)

These two quotes give a clear indication that further research into this potentially controversial area is required. Although no detail is offered, Corker, Davis and Priestly (1999) comment that 'informal impairment hierarchies' appear to operate in special schools. Wates (1997) too notes the impairment hierarchy which is *"...often implicit but rarely stated"* (p. 54) when one of the interviewees from her research into disabled parents, who is described as a 'veteran of a school and college for disabled people', refers to a *"pecking order"*. This impairment hierarchy is described by Wates (herself a person with a physical impairment) in terms of people with physical impairments being offended by the assumption that they may also have a learning difficulty, and thus rejecting association with this other impairment group.

Deal (2003), as a disabled person, has witnessed other disabled people distancing themselves from those who have impairments different from their own. Deal recalls when residing in a residential care home for young men with Duchenne muscular dystrophy in the early 1980s, how these men living with a degenerative muscle impairment would refer to other wheelchair users who had greater upper body strength as 'Supercrips'. These young men tended to regard themselves as *genuine* disabled people, whilst other wheelchair users were seen as a sub-group of elitist disabled people. Thus, a hierarchy was even created amongst a small group of people with physical impairments, by taking an 'exclusive' attitude toward disability identity. Deal (2003) suggests this could in part be as a result of ego-defence (the maintenance of a positive self-concept). In addition, Deal highlights the internet discussion between disabled people on the University of Leeds, Centre for Disability Studies web-site (www.leeds.ac.uk/disability-studies) on the January 2003 Disability-Related Discussion list, under the heading 'An open debate to neuro diversity! - no labels.' This debate centres around the topic of who are 'real' disabled people, with one person who identifies as a person with cerebral palsy viewing people with 'newer' impairments such as Asperger's syndrome or dyslexia, as interlopers who do not face social oppression. The two main motivators for this belief appear to be: pride in identifying as a member of a minority group; and, a desire to restrict the number of competing groups for limited financial resources.

Drawing any firm conclusions about whether a stable hierarchy of impairments exits or not, based on the literature, is problematic. This is principally due to researchers using a variety of research techniques, tools, and perhaps most importantly, different impairment groups. Yuker (1983), for example, notes that no other research could be found that used the same five impairments as Richardson and colleagues. However, what does appear to be consistent is the low ranking of people with mental health problems, (Gething, 1991, Harasymiw *et al,* 1976 and Noe, 1997).

It is also important to note not all research supports the contention that an order of preference or, hierarchy of impairment exists. Gething (1991) through the development of the Interaction with Disabled Persons Scale (IDP Scale), found that by using twelve versions of the IDP Scale, one using the term disabled person and the others each stating a different impairment, (AIDS, alcohol dependence, Alzheimer's disease, blindness, cerebral palsy, diabetes, Down's syndrome, drug dependence, epilepsy, paraplegia and schizophrenia), non-significant effects were found between each of the scales. It could therefore be argued that Gething does not support the notion of a hierarchy of impairment existing. Gething does acknowledge, however, that "least discomfort" was measured against the diabetes, drug dependence and AIDS versions of the scale, whilst schizophrenia, Down's syndrome and paraplegia were associated with the "most discomfort".

Based on the assertion that a hierarchy of impairment exists, such ranking can have important implications for the allocation of resources. As the Canadian study illustrated, people with 'physical disabilities or mental handicaps' (sic) (87.9%) were seen as more deserving of government assistance than either people with 'chronic or debilitating illness' (86.1%) or people with 'mental health or psychiatric disability' (78.4%) from a survey of n = 715 (Freeze, Kueneman, Frankel, Mahon and Nielsen, 1999). Hence, the rank ordering of impairment groups is not simply an academic exercise, but could be instrumental in determining resource allocation, service provision and even social policy. In addition, the hierarchy of impairment may place some people into the position of Other within our society.

3.14 Placing Disabled People in the Position of Other

Disabled people have found themselves placed in the position of Other throughout history (Stiker, 1997) and therefore deserves specific attention.

This section will explore the implications of the status of Other on the lived experience of disabled people within society. Through this discussion the existence of a disability 'movement' and 'culture' will be explored.

3.15 Disability Culture

For disabled people to regard themselves as a distinguishable social entity, rather than a collection to individuals with impairments, *"there must be amongst some, many, most, or all of its members an awareness that they possess in common some socially relevant characteristics, and that these characteristics distinguish them from other social entities in the midst of which they live"* (Tajfel, 1978: p. 4).

Once a group status has been created (either by the minority group themselves or by the majority group), stereotyping of the group is likely to occur (Tajfel, 1978). Stereotypes have variously been defined as, *"...beliefs about the characteristics or behaviors of most members of a social group"* (Wilder, 1993), *"...mental structures, images, or beliefs which facilitate action toward liked or disliked social groups"* (Henwood, Giles, Coupland and Coupland, 1993: p. 270) and *"...the content of an assumed set of characteristics associated with a particular social group or type of person"* (Biernat and Dovidio, 2000: p. 89). These characteristics can be *"viewed as unjustified because they reflect faulty thought processes or overgeneralization, factual* *incorrectness, inordinate rigidity, an inappropriate pattern of attribution, or rationalization for a prejudiced attitude...* " (Biernat and Dovidio, 2000: p. 88), with extreme perceptions being drawn upon rather than 'typical' members of the group (Linville, 1998). Prejudice is often assumed to develop from negative stereotypes held towards a particular group (Olson and Zanna, 1993) with prejudice being defined as *"negative affect associated with out-groups"* (Stephan and Stephan, 2000: p. 27). Stereotyping of disabled people is therefore important to the understanding of why disabled people in general and people belonging to different impairment groups are often viewed as Other and subsequently stigmatised.

When reviewing the literature based on stereotype accuracy, Jussim, McCauley and Lee (1995) argue that *"...out-group and minority group members often see themselves as more homogeneous than they see in-group or majority group members"*, (p. 12). As a result, the perception of the out-group/minority group towards themselves could potentially ignore real difference. However, Ryan and Judd (1992) give a cautionary note to such conclusions, arguing that unless a subject's own choice in assessments of in-group and out-group differences are not controlled in psychological testing, then out-group homogeneity will be overestimated.

Whether a 'Disability Culture' exists or not remains a bone of contention (Peters, 2000). The existence of a 'Disability Culture' is, it should be noted, not as clear or inevitable as some writers suggest (Campbell and Oliver, 1996; Charlton, 2000). Peters (2000) cites Lois Bragg at the Society of Disability Studies Annual Conference in Washington DC, (May 1999), who argues that whilst a Deaf culture exists a disability culture does not. However, Peters (2000) refutes Bragg's contention by arguing that disabled people as a group meet the criteria of a culture. According to Bragg the requirements of a culture are:

> "(1) a common language;
>
> (2) a historical lineage that can be traced textually (through archives, memorials and distinctive media/press publications);
>
> (3) evidence of a cohesive social community;
>
> (4) political solidarity;
>
> (5) acculturation within the family at an early age (and/or in segregated residential schools and clubs);
>
> (6) generational or genetic links;
>
> (7) pride and identity in segregation from Others." *(Peters 2000)*

Although Peters presents a seductive argument as to how disabled people meet the above criteria, the examples presented seem to be more based on the exception rather than the rule. Whilst there may be a growing activist movement within the United Kingdom in relation to disability (Campbell and Oliver, 1996), whether this constitutes a genuine culture remains open to debate. For, many disabled people often do not regard themselves as having a disability or impairment either at some stage of their lives or even on a permanent basis (Livneh and Antonak, 1997). Corker, Davis and Priestly (1999) note how disabled children, (based on over three hundred observations and interviews with disabled children), held differing views as to what the term meant and even whether it applied to them. These authors comment, "*...even children with the same impairment do not agree on whether or not they are disabled.*" Hence, it is difficult to argue there is a common culture among this heterogeneous population, with 'pride and identity in segregation from Others', (point 7 above).

Likewise, Tollifson (1997) describes how she spent her youth avoiding being associated with other disabled people, saying:

"*I wanted to dis-identify myself with the image or label of being a cripple. I wanted to be normal. As I grew older, I sought out attractive lovers as a way of establishing my own normalcy. I avoided other disabled people. I refused to see myself as part of that group.*" (Tollifson, 1997: p. 106).

Shakespeare (1996) also notes that people with certain impairments (for example, congenital impairments, those associated with accident or early onset) are more likely to identify collectively and socially, and therefore by implication become more involved in the disability movement than other impairment groups. Shakespeare remarks that the majority of disabled people are over the age of sixty, and hence implies that those within the disability movement are in fact unrepresentative of the disabled population.

Paul K. Longmore (cited in Fries, 1997) would disagree, arguing instead that a disability culture exists and has been instrumental in developing the way disabled people and non-disabled people view disability. For instance, Longmore states:

"Beyond proclamations of pride, deaf and disabled people have been uncovering or formulating sets of alternative values derived from within the deaf and disabled experience...They declare that they prize not self-sufficiency but self-determination, not independence but interdependence, not functional separateness but personal connection, not physical autonomy but human community." (Paul K. Longmore cited in Fries, 1997: p. 9)

Watson (2004) builds on this theme, drawing on the work of German philosopher Axel Honneth by arguing that:

"What is therefore needed then is a political activism that is founded on ethical rights and expectations. The disabled people's movement, at the same time as focussing on, for example, employment legislation and environmental access, should be placing emphasis on interpersonal relations as it is through such

relations that people experience recognition as active, capable social agents or find such recognition denied." (Watson, 2004: p. 111)

Hence, Watson sees the need to turn private experiences of oppression as a consequence of society's attitude towards the individual with an impairment into political actions.

However, it should also not be assumed that by virtue of a person belonging to a minority group that a natural affinity towards another minority group will be apparent. Begum (1994) recalls how as a child attending a 'special needs' school she received racial taunts from the white disabled children. Whereas, Appleby (1994) found how disabled lesbians were often regarded by non-disabled lesbians as asexual at the same time as encountering homophobic attitudes from within the disabled community. In addition, Wolbring (2001) cites gay activist Stein, who whilst defending the right of homosexual babies to be born, views the use of genetic technology to prevent the birth of babies with "serious disorders" as acceptable, on the grounds that it will reduce suffering. Thus, the literature seems to suggest a complex psychological interaction takes place between the individual and the group, with multiple factors, including stereotyping and prejudice, having an influence upon the individual's relationship to the in-group or out-group.

3.16 Social Exclusion

A consequence of being placed in the position of Other, disabled people have been excluded from many aspects of society, be that due to physical barriers, segregated education, residential care, etc. Christie, Batten and Knight (2000) define social exclusion as:

"...a lack of access to opportunities and experiences that are central to realising one's potential, in work, social life and citizenship. Social exclusion is a process that blocks the paths to the possibility of a more included life and to the chance to make a valuable contribution to society." (Christie, Batten and Knight, 2000: p. 6)

These authors stress that social exclusion is not the same as poverty, as a person can be socially excluded and yet affluent, although there clearly is a strong correlation. Hence, UK Government policy since 1997 has been aimed at assisting disabled people to enter the employment market, with initiatives such as New Deal for Disabled People (Morris, 2001) and Pathways to Work (DWP, 2002), in order to tackle such exclusion. However these initiatives have not been without their critics (Drake, 2000; Roulstone, 2000).

The Commission of the European Communities (2000) see environmental barriers as key to addressing social exclusion when they state:

> *"The approach to disability endorsed by the European Union acknowledges that environmental barriers are a greater impediment to participation in society than functional limitations. Barrier removal through legislation, provision of accommodation, universal design and other means, has been identified as the key to equal opportunities for people with disabilities."*
> (Commission of the European Communities, 2000: p. 3)

Thus, the European Commission is locating the causes of social exclusion and the subsequent solutions within society, taking a social model of disability standpoint. They highlight as key areas, greater mobility through improved transportation systems; accessibility, including public buildings and the workplace; ensuring emerging communication technology benefits all citizens, including the internet; and the adoption of a 'design for all' approach to goods and services. Access to information and services were also highlighted through a user led conference attended by 180 disabled delegates (Turner, 1998). In addition, this conference highlighted the call from disabled people to have genuine involvement and control over services provided to meet their needs, rather than trying to meet the service provider's agenda.

However, Morris (2001) warns that there are significant differences between the mainstream perception of social exclusion contained within government policy agenda, and its meaning to young disabled people with high support needs. Through discussions with four groups of young disabled people in their teens and early twenties (n = 29) and individual interviews (n = 14), Morris (2001) found issues other than employment featured in this groups list of causes of social exclusion:

- "not being listened to;
- having no friends;
- finding it difficult to do the kinds of things that non-disabled young people their age do, such as shopping, going to the cinema, clubbing, etc;
- being made to feel they have no contribution to make, that they are a burden;
- feeling unsafe, being harassed and bullied; and
- not having control over spending money, not having enough money". (Morris, 2001)

Morris stresses that this group of people appear to have little relevance to policy makers, as their continued social exclusion *"poses little threat to social cohesion"*, unlike some other socially excluded groups in society. Morris argues that by taking more of a human rights agenda, social exclusion would not be measured in terms of employment or educational achievement, but rather the extent to which policies deliver human rights, such as participation in the community, freedom from prejudice, having a say in one's own life, and the right to dignity, respect and choice. Farrell (2001) warns, however, in his discussion on the development of special education during the 1980's and 1990's, that, *"...arguments in favour of inclusion based solely on human rights, powerful though they may sound, are logically and conceptually naïve."* Farrell stresses that the basic right is for all children to receive a good education, which, in some instances, may be best met in a special, rather than in a mainstream school.

This argument put forward by Farrell, appears to be principally based, however, on whether resources are or can be made available to ensure the disabled child benefits from a mainstream educational environment and whether the presence of the disabled child would diminish the rights of other children in the school, as a consequence of inappropriate behaviour. Thus, the inclusion of disabled children into mainstream education appears to be both impairment specific (i.e. whether the child has challenging behaviour that may disrupt the education of other children) and financial, in terms of meeting support needs.

The debate over the appropriateness of mainstreaming services is also discussed as part of the Department for Work and Pension's report into attitudes toward disability in Britain (Grewal, Joy, Lewis, Swales and Woodfield, 2002). Through 35 individual depth-interviews, 7 discussion groups with disabled people, 10 discussion groups with non-disabled people and a face-to-face survey (n = 2064) of which 47% were disabled, 86% of the disabled respondents went to a mainstream school, and of those 63% reported positive experiences in mainstream education. However, it was also found that 26% reported negative experiences in mainstream education, in part because of poor facilities and negative attitudes of other people. It was also reported that that 54% of disabled people left education with no qualifications compared with 28% of non-disabled people.

Similar findings are found in the Disability Rights Commission (2002d) research, where through a survey of disabled people aged between 16 and 24 (n = 305), 45% of respondents said they had experienced problems at school as a consequence of their impairment, 86% thought it was harder for disabled people to get jobs than non-disabled people, 13% said they had been turned down for paid employment for reasons related to their impairment and an additional 18% were not told they were rejected for a job because of their impairment, but they felt this was the case. This survey also found that 32% of respondents felt disabled people faced restrictions relating to leisure activities such as pubs, clubs, concerts, et cetera. The young disabled respondents, on a more positive note, held aspirations that many people would aspire to, such as having a well-paid job, having a family, owning their own home, et cetera.

In order to explore this theme further the focus of this chapter will now turn to the link between social exclusion and where a disabled person lives.

3.17 The Location of the Home and Social Inclusion/Exclusion

The place where a person lives is likely to have an effect upon whether that person experiences a degree of social exclusion and therefore is viewed as Other by the wider community. Although residential care was initially created to house and care for people who were often victims of destitution and abuse and thus based on philanthropic ideals (Finkelstein, 1991; Stalker and Hunter, 1999), Oliver (1990) argues that the growth of the capitalist society meant that institutions were used as a form of social control, thus incarcerating disabled people. Such a view is supported by postmodernist thinkers, who argue that the modernists sought to create order with *"no mess, no matter out of place"* (Hughes, 2002). Hughes goes on to state:

> *"No one can escape contamination by tragedy yet modernity deludes itself by embracing a project of purification and transcendence that is continuously hoist by its own utopian petard and, thus, it banishes and excludes what it should welcome and embrace."* (Hughes, 2002: p. 581)

Bauman (1993), whilst making no explicit reference to disabled people, cautions on the morality of choice, when in his exploration of postmodernist ethics argues:

"Few choices (and only those which are relatively trivial and of minor importance) are unambiguously good. The majority of moral choices are made between contradictory impulses. Most importantly, however, virtually every moral impulse, if acted upon in full, leads to immoral consequences (most characteristically, the impulse to care for the Other, when taken to its extreme, leads to the annihilation of the autonomy of the Other, to domination and oppression)". (Bauman, 1993: p. 11)

This theme is articulated by disabled academic Finkelstein (1991) in terms of the administrative model of disability. He notes, *"to be disabled means to be unable to function socially as an independent citizen having the same rights and expectations as 'normal' people and that the management of disability demands life-long care and professional expertise"* (p. 20) leading to what Finkelstein refers to as social death for disabled people living in residential care until actual death takes place. Thus, the moral act by humanitarians of assisting disabled people to live in residential care would be seen by postmodernists as a method by which to exile those who are different. It will be important to take a similar view of the UK Government's strategy for ensuring social inclusion for people with learning disabilities 'Valuing People' (DoH, 2001), which argues the case for people with learning disabilities to have the opportunity to live in the community (with appropriate levels and forms of support). This policy could, if the support is not appropriate, lead to isolation rather than inclusion in the community, leaving the individual still in the position of Other.

Sinson (1993), when discussing community based living for people with learning disabilities who had moved from large residential care facilities into small community-based group homes, comments on how increasing numbers of this group of people, rather then having increased interaction with the community, find themselves isolated (p. 142). Such views are echoed by Henley (2001), who takes a highly critical view of idealist policies in relation to integration in both living and Day Service provision for people with learning disabilities. Henley goes as far as to conclude:

> *"...the history of the development of day services is littered with the debris of policy changes inspired by 'visionary and innovative' concepts that, in the fullness of time, have failed through a loss of touch with reality, and the misuse or lack of specialist input. Despite being based on good intentions, the reality is that countless vulnerable and handicapped (sic) people have paid a high price, and suffered great deprivation as a consequence of misplaced idealism, a lack of foresight and strategic ineptitude."* (Henley, 2001)

Throughout the latter part of the 20th Century there has been a move toward independent living (Morris, 1993; Houston, 2004) rather than residential care for disabled people. However, this social policy has not been uniformly adopted across the UK (Sinson, 1993; Stalker and Hunter, 1999). In addition, Nichol and Mumford (2001) cite the United Kingdom Government Office of

National Statistics 1998, for numbers of disabled people living in residential care in the UK. These figures reveal that for the 'Mentally Ill', there has been an increase of 2,000 people living in residential care (1976-7) to 4,000 people (1986-7) to 12,000 (1995-6) and for people with 'Learning Disability' 8,000 (1976-7) to 17,000 (1986-7) to 35,000 (1995-6). Whereas, 'Young Physically Disabled People' (under 65 years) decreased from 12,000 (1976-7) to 13,000 (1986-7) to 10,000 (1995-6). Thus, only those with a physical disability saw a reduction in their numbers living in residential care. These figures may therefore suggest that the opportunity to live fully within the community may depend not only on geographical location, but also on the nature of the individual's impairment.

However, the use of residential care should not be automatically assumed to be negative, for Morris (1993) identified through interviews with twenty-one disabled people who had experience of residential care conflicting opinions as to its appropriateness. Whilst some interviewees found that residential care was restrictive and even abusive, creating a form of dependency and fear, others found it to be liberating because of the 24 hour care provision. Likewise, in relation to Further Education for disabled students, Pitt and Curtin (2004) through group interviews with ten disabled students who, after receiving education in mainstream schools opted for specialist college provision to continue their education, found enhanced opportunities for independence and increased self esteem. However, the choice of specialist educational provision appeared to be based more on the failings of mainstream education than an affirmation of specialist colleges. That said, as these students had experienced mainstream education they reported it had 'toughened them up' to cope with the 'real world'.

The predominant attitude from disabled people reflected in the literature, however, towards residential care appears to be negative, with independent living being seen as the preferred option (Finkelstein, 1991; Morris, 1993; Houston, 2004). Hunt (1998), writing in 1966, fleetingly although pointedly, mentions the subtle forms of abuse he had witnessed whilst living in residential care. Stalker and Hunter (1999) add to this how, as a consequence of Scottish social policy not to close the hospitals for people with learning difficulties, some people with learning difficulties remain fearful of being returned to these institutions, even to the extent of 'choking back the tears' when talking about living in them.

More recently the Disability Rights Commission (2002c) highlighted the situation in 2002 of how the London Borough of Tower Hamlets were considering 'forcing' disabled people who currently lived in the community to move into residential care if their community based care costs exceeded those living within residential care settings, regardless of the disabled person's wishes. Hence, a violation of those people's rights, according to the Disability Rights Commission. The Disability Rights Commission (2002e) made clear its standpoint on community based care provision, when in its policy statement on social care and independent living it argued, *"There should be a basic enforceable right to independent living for all disabled people. Policy objectives for social care services need to include guaranteed minimum outcomes, backed by a right to independence*" (point 4.1). The issue of consumer choice within the provision of long-term care has grown significantly within the United Kingdom and North America since the 1990's. The independent living model, whereby disabled people, hire, train and manage their own personal assistants, has identified an increasing desire from disabled people to be in greater control of this provision (Batavia, 2002).

Brown (2001) reports on the violation of human rights faced by people with learning disabilities living within group homes. Although the 'abuse' may not be malicious, but arising more from stereotyped assumptions, such as denying someone a key to the home they live in, or placing restrictions on a couple having a consensual relationship, these actions still amount to a restriction of an individuals rights as a consequence of their impairment. Institutional policies and practices of this nature can only cause the person living under such conditions to be viewed as Other by the wider community. As Young and Quibell (2000) conclude, whilst 'rights' have helped secure basic needs for people with learning disabilities, they do not *"address the misunderstandings from which the inequalities originally stemmed"* (Young and Quibell, 2000).

Disabled people have demanded the right to live within mainstream settings for many years (Hunt, 1998) and have been supported in more recently years by social policy that recognises this right (DoH, 2001; Cabinet Office: Prime Minister's Strategy Unit, 2004) and by initiatives such as Direct Payments (supported by legislation) to achieve this goal. Likewise, disability charities, such as Scope (a voluntary sector organisation that provides services principally to people with cerebral palsy), have shifted to a policy of providing integrated housing rather than residential care, now viewing specialist services as 'disempowering' (Carvel, 2005). But, as has been highlighted in the review above, without the appropriate support mechanisms, disabled people can become as isolated living in community settings as living in residential care.

3.18 Conclusion

This chapter, whilst questioning whether a genuine disability culture or movement exists, acknowledges that some groups of disabled people, such as the Deaf community, can be seen as holding a minority group identity, but whether this extends to disabled people in general remains questionable. However, disabled people, as an homogenous group do exhibit some qualities of a minority group status, and therefore face the consequences of negative stereotyping.

The literature review also highlighted the dearth of research using disabled people as respondents in relation to whether this group hold a hierarchy of impairment. It would appear there is therefore a need to further explore the contention of a hierarchy of impairment from the perspective of disabled people. In other words, to explore in-group variability from the disabled person's perspective. The literature in relation to disabled person's attitudes toward their own impairment and toward other disabled people will therefore be explored in the next chapter.

Chapter 4

Attitudes of Disabled People Toward the Self and Others

4.1 Introduction

This chapter will review the literature in relation to firstly, attitudes of disabled people toward their own impairment, and secondly, attitudes of disabled people toward other disabled people. The way in which the individual views themselves will have an impact upon whether they identify as a disabled person or not, and whether they view this status in a value neutral or positive manner.

Disabled people have historically come to regard themselves as less than normal and less capable than others, internalising this into self-pity, self-hate and shame, creating a false consciousness (Charlton, 2000; Grealy, 1997). Such negative perceptions towards the self can result in behaviour that is socially constructed (Gordon and Rosenblum, 2001). Disabled people who have physical impairments may find themselves rejected by other members of society because of their atypical bodies or facial features (Aylott, 1999; Dijker, Tacken and van den Borne, 2000), due to fear of difference, or the label of belonging to 'poor reproductive stock' (Pernick, 1997; Crisp, 2001), which can in turn lead to being viewed as *"poor economic bets"* (Crisp, 2001).

4.2 Psychosocial Adaptation to Impairment

An individualised or medicalised approach to impairment can therefore be seen through research into psychosocial adaptation to disability. Livneh and Antonak (1997) in their review of the literature in relation to this field, view psychosocial adaptation to chronic illness and disability as:

"*...an evolving, dynamic, general process through which the individual gradually approaches an optimal state of person-environment congruence manifested by (1) active participation in social, vocational, and avocational pursuits; (2) successful negotiation of the physical environment ; and (3) awareness of remaining strengths and assets as well as existing functional limitations*". (Livneh and Antonak, 1997: p. 8)

Thus, the focus is on the individual with an impairment, with the expectation that the individual will go through a process of change. The phases of coping have been listed as shock, anxiety, denial, depression, internalised anger, externalised hostility, acknowledgement and adjustment (Livneh and Antonak, 1997). This 'process' is qualified with the acknowledgement that a) not all people will pass through each of the phases of coping, b) there are distinct differences between psychosocial adaptation to congenital and adventitious impairments, and c) differences exist in the psychosocial adaptation to a disability caused by a traumatic event (for instance, a spinal cord injury), as opposed to a chronic illness (such as multiple sclerosis). Smith (1996) suggests that children with a degenerative impairment, such as Duchenne muscular dystrophy, are likely to move from a state of shock to one of acceptance, with feelings of isolation, loneliness, panic, guilt, hostility, and reconciliation, in between.

Murphy (1990), a North American anthropologist who gradually became paralysed due to a tumour in his spinal cord, when recalling the time when he needed to use a wheelchair on a permanent basis put it thus:

"From the time my tumor was first diagnosed through to my entry into wheelchair life, I had an increasing apprehension that I had lost much more than the full use of my legs. I had also lost a part of my self. It was not just that people acted differently toward me, which they did, but rather that I felt differently toward myself. I had changed in my own mind, in my self-image, and in the basic condition of my existence. It left me feeling alone and isolated, despite strong support from family and friend; moreover, it was a change for the worse, a diminution of everything I used to be." (Murphy, 1990: p. 85)

According to Li and Moore (1998), the degree to which a disabled person *accepts* their disability is a central feature as to whether society will accept that impairment group due to the stigma and prejudice placed by society on those individuals as a consequence of their impairment. Acceptance of disability, they note, is not about preferring your own state over another's, but regarding one's disability as non-devaluing. The attitude of disabled people toward their own impairment and resulting disability is therefore a key factor in the process of societal acceptance.

However, in the review of counselling for disabled people Livneh and Antonak (1997) consistently tend to regard the 'solution' as resting with the individual, rather than with changes in society. For, as Olney and Kim (2001) state, "..., *the literature appears to consistently frame the concept of adjustment to ones limitations rather than adjustment to* attitudes toward *disability.*" (Emphasis in original). An interesting illustration is offered by Shaver (2003: pp. 43-46), who, through a personal account as a non-disabled coach of a wheelchair basketball team in the USA during the 1970s-1990s, recalls how a student with cerebral palsy was asked to make a presentation to other students about himself and the effects of his impairment. The students, although not understanding a word he said, they pretended to understand. Once this was identified, the student with cerebral palsy was then asked to write his thoughts down, whereby he explained not only feelings of frustration at being patronised, but also how by taking time to get to know him people could learn to understand his speech. Hence, from this individual's perspective, by changing the attitude toward him as a person with a communication restriction, the barrier can be reduced.

The literature has revealed adjustment to the individual's long term situation as a disabled person is linked to interpersonal relationships and degree of independence (Livneh and Antonak, 1994). Chase and King (1990) similarly stress the importance of the psychological adjustment to spinal cord injury, with the feeling of being in control over one's life as one of the main factors in adjusting to the new life as a disabled person. Hence, adjustment to impairment for disabled people can be directly linked to the principles of the social model of disability, with its emphasis on environmental barriers and societal attitudes rather than individual limitations. This belief by some disabled people is reported by Johnson (2003), (herself a disability rights activist and academic), when making the ironic case that disabled activists in the USA are "bad cripples", whereas those disabled people who view the restriction on life activities as a consequence of the body's disease or injury are "good cripples". Johnson illustrates her point by citing a woman with muscular dystrophy as saying:

"Deny as we may want to, at the point when a person can not be totally independent physically from others, one is no longer equal in body...I do not want to be treated equally...I have to depend on others to drive for me and get me in and out of bed...I can still think, but for the life of me I can't think of a way to get rid of the wheelchair. Therefore, I am not on the same ground I used to be on. To me that makes me not equal. How can we bury our heads so deep

and say we are equal to the able bodies around us? We are not." (Un-credited reference in Johnson, 2003: p. 125)

Johnson therefore sees this person as belonging to the "good cripple" category of disabled people, as the women with muscular dystrophy is not viewing the way in which society is constructed as her primary barrier, but her own physical limitations. Hence, by blaming herself she is placing herself in the tragedy model of disability paradigm, as a passive recipient of support, exhibiting internalised anger.

In an insightful critique of the client-centred approach to service delivery for people with mental illness in Canada, (Corring and Cook, 1999), one participant in the focus group used to solicit views on the social and mental health system stated:

"...you have to look at stigma, I think you have to look at different kinds of stigma. The stigma of the general public towards the mentally ill. Stigma of the professional towards the mentally ill. Stigma of the mentally ill towards each other and worst of all the stigma each and every one of us have towards ourselves and our own illness. So we're looking at four kinds of stigma. You have to work on all of these things." (Corring and Cook, 1999)

This statement identifies the complex nature of stigma towards disabled people, and in particular, those with impairments least accepted by society. Cognitive dissonance theory (see Harmon-Jones and Mills, 1999 for explanation of cognitive dissonance), Warner (1994: pp. 182-184) argues, can assist in explaining how stigma and the degradation of mental illness can affect symptoms of schizophrenia and the course of the illness. Those with a poor self-image are more likely to accept a diagnosis of mental illness and, according to cognitive dissonance theory will try to resolve their dissonance *"by conforming to their new outcast status and to the stereotype of worthlessness; they will become more socially withdrawn and adopt a disabled role"* (Warner, 1994: p. 183). During the process of rehabilitation, a recurrence of symptoms is likely to occur as a *"defence against mounting dissonance"* created by pressure to return to normal functioning. Thus, it could be argued, the attitude of people with schizophrenia and other mental illness towards themselves is in part as a direct consequence of the prevailing negative attitudes towards this group by society in general.

Roe, Chopra, Wagner, Katz and Rudnick (2004) when discussing the recovery process for people with mental illnesses, see part of the recovery process as *"recovering from the stigma people with mental illnesses have often incorporated into their very beings, from the effects of treatment settings, from the lack of opportunities for self-determination, and from the negative side* *effects of unemployment and hopes for the future that have been destroyed"*. Thus, recovery is not just biological, but also social.

This view is significantly different from that reported by Wilson (2004) in relation to those who contracted polio in the 1940s and 1950s, whereby in particular, young men were encouraged to view their recovery and on-going life as a battle or athletic contest against the effects of the disease that threatened their masculinity. Hence, highly personalized and biological. Wilson also reports that in an era of post-polio syndrome, many people who have lived with the effects of this disease for over half a century are now beginning to re-evaluate their lives, including having to stop *"faking it"* in terms *"of denying or dismissing their disability"* (Wilson, 2004: p. 128).

Thus, the attitude of the individual towards the self is a complex interaction between the individual's psychological state and the level of functional limitation as a direct consequence of the environment (both physical and social). The next section of this chapter will explore the developing theory of viewing disability as a valid social identity.

4.3 Affirmation as a Disabled Person

Within the United Kingdom a more positive view of the disabled self has been emerging (Peters, 1996), and a growing collective movement empowering disabled people to take control of their lives and to view themselves as equal members of society, (Campbell and Oliver, 1996). As part of this notion of equality, the issue of 'quality of life' must be raised. Gulick (1997) sees 'quality of life' as a multi-dimensional concept, linked to a number of 'life domains' such as marriage and family; work; standard of living; education; health; recreational and social activities; et cetera. To be an equal member of society, it is therefore important to have a level of control over these domains, comparable to other members of society. To have such control, some disabled academics are arguing a positive affirmation as a disabled person is necessary. For instance, Swain and Cameron (1999) argue:

> *"Coming out, then, for disabled people, is a process of redefinition of one's personal identity through rejecting the tyranny of the* normate, *positive recognition of impairment and embracing disability as a valid social identity. Having come out, the disabled person no longer regards disability as a reason for self-disgust, or as something to be denied or hidden, but rather as an imposed oppressive social category to be challenged and broken down."*
> (Swain and Cameron, 1999)

Swain and Cameron (1999) are therefore effectively suggesting that in order to have a positive attitude towards disability and therefore as a disabled person, towards the self, the disabled person must embrace the social model of disability. They also state that 'coming out' as a disabled person requires the individual to identify with the theory of social oppression rather than through individual characteristics, but also to recognise that one has an impairment and it is nothing of which to be ashamed (a view Shakespeare and Watson (2002) do not share by referring to it as patronising). Swain and French (2000) further develop this argument through the advancement of what they term an *affirmative model of disability* (this 'model' may in fact be more akin to a *theory* such as the self-affirmation theory – see Aronson, Cohen and Nail (1999) for discussion on the self-affirmation theory).

The affirmative model of disability, Swain and French (2000) contend, builds on the evolving disability culture that asserts a positive identity as both a disabled person and as a person with an impairment, i.e. *proud, angry and strong*. This 'model' rejects the presumptions of tragedy, dependency and abnormality often associated with the medical model of disability, building upon the social model that locates 'the problem' in society. The authors conclude:

"Just as the social model signified, for disabled people, ownership of the meaning of disability, so the affirmative model signifies ownership of impairment or, more broadly, the body. The control of intervention is paramount. This is an affirmation by disabled people of the right to control what is done to their bodies." (Swain and French, 2000)

Morris (1989) notes that when a person first becomes disabled as a result of a spinal cord injury, that person becomes a member of *"one of the most discriminated against groups in society"*. The pre-injury attitudes towards disability held by that individual are therefore likely to have a significant affect upon their post-injury attitude toward themselves. Morris also comments that part of the experience of post-injury is the realisation that the person with a spinal cord injury suddenly belongs to part of a marginalised group, to whom previously they were likely to hold negative attitudes. These emotions will not have changed overnight as a result of a traumatic injury and are therefore an important aspect of the individual's attitude towards their impairment, disability and resulting self-esteem.

Such conclusions also find support from the wider social psychology literature. For instance, Johnson, Schaller and Mullen (2000) when investigating how people respond to discovering they are members of a group to which they hold negative stereotype attitudes, conclude that, *"... a newly acquired identity in the minority group was not enough to attenuate the previously formed negative stereotypes."* Thus, for a time at least, it would be reasonable to suggest that a period of adjustment from majority to minority group status is required, which for some people may not be possible even in the long-term with respect to a status as a disabled person.

The newly acquired social status as a disabled person may also create a level of cognitive dissonance in the individual. Therefore, when Cooper and Stone (2000) assert that dissonance can occur on a group as well as individual level, it may be that constructs such as the 'affirmative model of disability' can be used as tools to reduce dissonance on a group level as well as individual. Hence, enabling disabled people to reduce the inner conflict of belonging to a stigmatised group at the same time as seeing themselves in their pre-disability state. Tierney (2001), with reference to young women labelled as anorexic and Wendell (1996) more generally, caution however, that as many disabled people have little or no contact with other disabled people, or, in the case of people with anorexia, often do not perceive themselves as having a disability (Tierney, 2001). Additionally, Davies and Jenkins (1997) found that of the 53 people with learning difficulties they interviewed in relation to the subject's understanding of the term "learning disabilities", twenty-two (41.5%) did not know what the terms meant and sixteen (30.2%) did not believe the terms related to themselves. They are unlikely, therefore, to have positive experiences with other disabled people and hence make positive identification as disabled, difficult.

This argument is further supported by Watson (2002), who through interviews with twenty-eight disabled people concludes that many disabled people, whilst acknowledging their impairment, do not identify as a disabled person. Watson further argues that the idea of a common identity for disabled people, based on the shared characteristic of having an impairment *"is not sustainable"*. Despite the small size of Watson's sample, and the lack of data with reference to the range of impairments held by this group, Watson highlights the important issue of how many disabled people do not see themselves as 'other' from the non-disabled population, but rather members of it. Watson (2002) is at pains, however, to emphasise that he does not believe the research participants reject the social model of disability in favour of the medical model, but *"they are merely downplaying the significance of their impairments as they seek to access a mainstream identity"*; in other words, to be part of the 'normal' (Watson's term) population. Such a standpoint could therefore be viewed as a distancing of the 'impaired self' from the disabled population, in favour of the non-disabled norm.

Although the label of impairment does not automatically have to be seen as negative, the longer-term notion of being labelled as a disabled person, and the negative resultant consequences that it can bring, should not be underestimated. The initial relief of receiving a name or label on which to 'hang' the impairment (Wendell, 1996; Thomas, 1999b; Willey, 1999: p. 88) may soon turn to a fear of exposure as a disabled person, which will now be explored.

4.4 'Passing' and Disability

Goffman (1963) when discussing the implications of a person having an impairment, and therefore, according to Goffman, a subsequent stigma, considers the issue of 'passing'. Goffman suggests that for some stigmatised persons, the opportunity to 'pass' as belonging to a non-stigmatised group in society is a form of coping, albeit with a potentially high price due to the anxiety of being 'exposed' at any time (Allen and Carlson, 2003). However, Morris (1991) argues that for a disabled person to 'pass' as non-disabled is a denial of who they really are. But, Thomas (1999b), whilst acknowledging Morris' claim, also notes that such "coming out" or not 'passing' is linked to the nature of one's impairment, for instance, whether the impairment is visible (wheelchair user) or hidden (epilepsy).

Linton (1998) also considers the stress, anxiety and self doubt caused to people *concealing* an impairment. She therefore identifies that for some people the process of identifying oneself as a disabled person is comparable to members of the lesbian or gay community "coming out". Such a view is challenged by Crow (1996) who argues that there is a fundamental difference between identifying oneself as gay, lesbian, black, et cetera as opposed to disabled. Crow states that whilst there is nothing 'inherently negative' about sexuality, sex or skin colour, as these are neutral facts, impairment and disability *"can be unpleasant or difficult"* (p. 58). Samuels (2003: p. 237) too challenges the comparability of sexual orientation and disability "coming out". Samuels reflects on Swain and Cameron's (1999) analogy of coming out as gay or lesbian and coming out as disabled. Samuels (2003) concedes that Swain and Cameron's argument has validity when viewed in terms of seeing disability as a 'positive acceptance of difference', but challenge the idea that coming out is a 'static and singular event' as Swain and Cameron imply. Therefore, identity as a disabled person, and the idea that by doing so creates and opportunity for positive affirmation as disabled, may be too simplistic.

In reality, some disabled people make decisions about 'coming out' on a daily basis, in, as Samuels (2003) suggests, personal, professional and political contexts. The context or social environment of employment, and the subsequent consequences of disclosing an impairment is addressed by Allen and Carlson (2003). These authors found, through interviews with thirteen people with chronic illness, (including rheumatoid arthritis, osteoarthritis, cancer, HIV/AIDS and depression), that concealment of the impairment was a recurring theme that spontaneously occurred, thus suggesting this is an important factor for many disabled people, regardless of their impairment.

Additionally, Olney and Kim (2001) suggest that some people with 'hidden' impairments *"...exist in a neverworld, belonging solidly to neither the 'disabled' nor the 'non-disabled' class of people"*. This 'neverworld' is now being extended to people with physical and obvious impairments through the use of the Internet and 'chat-rooms'. This technological innovation has given disabled people the opportunity to interact via their computer terminals with non-disabled people without disclosing what may otherwise (in a face-to-face interaction) be obvious information (depending on the visibility of the impairment); hence, opportunities for passing that were hitherto rare are becoming available.

In a small New Zealand based piece of research, Bowker and Tuffin (2002) investigated the management of disclosing one's impairment/disability online. They conclude that three salient factors emerged from the fifteen interviews: relevance (appropriateness to disclose in relation to the conversation); anonymity (offering an equity in identity disclosure); and normality (whereby *"non-disclosure is conceptualised as a participatory right"*). Bowker and Tuffin interestingly argue that by *"constructing non-disclosure as a right detracts from the assumption that disabled people are denying the existence of impairment."* However, whether Swain and Cameron (1999) would support this viewpoint remains questionable, with their standpoint that impairment is not shameful and should not be hidden. However, Wahl (1999) in a study of self-selecting respondents with mental health problems (n = 1301), found that 74% of the subjects sometimes, often or very often, avoided disclosing the nature of their impairment to anyone other than their immediate family. However, the persistent fear of discovery was also found to cause anxiety.

Ingram, Jones, Fass, Neidig and Song (1999), using data from a sample of people living with HIV (n = 271) found that unsupportive social interactions accounted for a significant variance in depression beyond that accounted for by physical functioning and positive social support. In other words, negative social interactions, or rejection in a social interaction, could be a cause of depression in the individual, thus suggesting that social oppression may be a cause or at least have a correlation with, depression. The extent to which a person with an impairment that is associated with a stigma can manage the information about themselves therefore becomes an important factor. Whilst the use of Internet chat-rooms can be seen as an ideal method by which to 'pass' as someone who does not carry a stigma, Smart and Wegner (2000: p. 257) suggest that this medium of communication may offer people the opportunity to reveal stigmas and 'meet' with similar others. Thus, it could be argued, this group could gain the positive psychological effects of disclosing one's stigma, whilst avoiding the possible negative consequences of being rejected in further interactions of a face-to-face nature. Smart and Wegner (2000) suggest this process is also likely to lead to further disclosure to family and friends.

4.5 D/deaf Community and Disability

A group that has received particular attention in the literature, in part because of its uniqueness within the field of disability research, is the D/deaf community.

Those at the heart of the Deaf community offer an insight into the value of holding a positive self-identification on a collective level.

D'aoust (1999) makes clear the distinction between the Deaf community and people who are deaf. The lower case 'd' 'deaf' refers to those with a hearing loss of any degree, including those who cannot hear at all. Whereas, capital 'D' Deaf, refers to those who voluntarily belong to the Deaf community. D'aoust states that to be part of the Deaf culture a person must, firstly use sign language fluently, secondly, have a sense of belonging and 'collectivity', and thirdly, not identify as being disabled. This third point is not, she stresses, because Deaf people hate disability or view disabled people as 'less worthy', but because they do not 'feel' disabled. This may be in part as a consequence of viewing themselves as a linguistic minority rather than as people with a hearing loss. McCullough in McCullough and Duchesneau (1999) highlights the strength of feeling felt within the Deaf community about preserving their culture by stating how *"thrilled"* she and her lesbian partner were at having it confirmed that their baby was deaf, having deliberately chosen a sperm donor with hereditary deafness. The Disability Rights Commission (2002a) acknowledge the concern raised by such actions but state:

"The birth of any wanted baby is a cause for joy, not mourning. Deaf children's lives can be as happy and fulfilling as hearing children's - the challenge is to make society more accessible for all.

We also recognise that many deaf couples are keen to share their cultural identity and language with their children. Like all parents they value above all else the bond between parent and child and understand that strong communication in the same language is important for this." (Disability Rights Commission, 2002a)

Whilst the motives for such an action may be confusing to many people, including other disabled people and even some deaf people, Gannon (1998) when discussing the Deaf community and sexual education notes the extreme isolation faced by a sole deaf person in a family. Gannon identifies how where a child does not have signing parents, s/he will often eventually find a 'family of choice' where there is a positive acceptance of deafness and fluid communication through sign. It could be argued therefore, that Deaf people who have faced such isolation in their own childhood, will be keen to avoid such trauma occurring in the life of their own child. Wates (1997) too, when commenting on disabled people with physical impairments becoming parents of a disabled child, suggests that the disabled adult's insight into disability may well assist them in being better placed to raise a disabled child than non-disabled parents. Non-disabled parents may well be having to cope with internalised prejudice towards disabled people, and therefore their own child.

Middleton, Hewison and Mueller (1998) through the use of a self-completion questionnaire circulated to delegates at an international conference on the "Deaf Nation" (and therefore a non-representative sample), found that 55% of the 87 respondents thought genetic testing would "do more harm than good". 46% also felt that the potential use of such testing devalued deaf people. It is also interesting to note that those who self-identified as culturally Deaf participants were seven times more likely to use negative words describing how they felt towards new discoveries in genetic research than non-culturally deaf people did. Of the 14 respondents who said they would be interested in prenatal diagnosis for deafness, 8 were culturally Deaf and 6 non-culturally deaf. Four of the 14 respondents also said they would prefer to have deaf children (3 culturally Deaf and 1 non-culturally deaf). Despite these interesting findings, the limitations of the research necessitate caution when drawing any conclusions from the data, as the sample is unlikely to be representative of the wider population of deaf and hard of hearing people throughout the United Kingdom. However, Henn (2000), when commenting on Middleton *et al's* findings in relation to wanting a disabled child, highlights the counterintuitive nature of potentially terminating a pregnancy because the baby will be healthy, in other words, not deaf.

In addition to this debate, Michalko (2002: pp. 45-50) makes the moral point, (as someone with a genetically based impairment, resulting in 10% of 'normal' vision), that when told he had a 50:50 chance of passing this gene to his child, his doctor recommended he not have children. Michalko comments that he does not believe his doctor was advocating euthanasia on his part, but that there was an intuitive understanding that 'his type' of person (blind), was not wanted, and therefore he should avoid passing this gene on to future generations. Michalko, as a result of this encounter with the doctor then asked the question, 'Why not? have others of 'his type'. In answer to his own question, Michalko concludes that blindness leads to the loss of ability and sometimes pleasure and should therefore be avoided. This conclusion appears to be at odds with much of the rest of Michalko's discourse, whereby he supports the notion that disabled people do not *suffer* their impairment, but rather *suffer* society.

The desire to be amongst others with a similar impairment would, however, seem natural when considering how non-disabled people view deaf people. Cambra (1996) found Spanish students perceived deaf people as less communicative, less kind and pleasant, possessing fewer friends, and more bored and passive than people with no sensory impairment. This desire to be amongst one's own impairment group was also found by Dixon (1977) who identified that amputees, spinal cord injured and stroke sub-samples each showed a statistically significant preference for members of their own group compared to members of the other impairment groups either on a social distancing scale or a semantic differential scale. Neither the arthritis nor the 'emotionally disturbed' groups expressed a willingness to be associated with other members of their impairment group. Whether these findings would be replicated today would need fresh research. However, what this does suggest is that disabled people do not necessarily view other disabled people as belonging to the same group, based on impairment. This notion will be explored in further depth when reviewing the literature in relation to the hierarchy of impairment.

This chapter, so far, has identified two key themes in relation to disabled people and their attitude toward their own impairment. Firstly, that the literature tends to be focussed on the psychosocial adjustment process with 'acceptance' of the impairment as an important factor in whether the individual will hold a positive self-esteem. Secondly, that disabled scholars are increasingly arguing that positive self-esteem can come about at least in part, by viewing disability as a form of social oppression and therefore effectively distancing oneself from being the cause of the 'problem'. It is therefore important to identify next how disabled people view other disabled people, which will give an indication as to the homogeneity of disabled people as a social group.

The attitude of disabled people toward other disabled people has tended to be a neglected area of research, producing a paucity of evidence identifying how disabled people view others with different impairments. This chapter will therefore explore now the attitudes of disabled people, not toward the self, but toward other members of the disabled in-group.

4.6 Disabled People's Involvement in Research

Whilst it is not the intention of this research to discuss the role of disabled people in researching disability issues, as this has been discussed elsewhere (see, for example, Moore, Beazley, and Maelzer, 1998), without disabled people being at the heart of the research process it would not be possible to discover what the attitudes of disabled people are. Tringo (1970), Asch (1984) and Makas (1988) have all noted the importance of including disabled people in research. However, as Wendell (1996) stresses, disability *"cannot be deconstructed by consulting a few token disabled representative"* (p. 46). She adds, that whilst the disabled individual may have a greater insight into the issues relating to disability as a result of their personal circumstance, this does not mean s/he will see all the issues. Despite this cautionary note, valuable information can be gathered with relatively few subjects. The conclusions drawn from this chapter must therefore be viewed in light of this perspective.

4.7 Associating with Other Disabled People and Social Distancing

Based on the premise that disability is generally associated with negative traits and characteristics, it is not unreasonable to assume that members of this stigmatised group may choose to distance themselves from others perceived in this way (Nochi, 1998). Morris (1989), for example, by using postal questionnaire responses from spinal cord injured disabled women (n = 205), provides a valuable and honest insight into this group of disabled peoples' attitude towards other impairment groups and other disabled people in general. A number of the respondents, for instance, did not wish to be associated with other disabled people due to the negative connotations that disability brings with it. In a brief but insightful passage, Morris (1989) touches on the issue of one impairment group, (spinal cord injured), not wishing to be associated with other impairment groups, by reporting:

"... the arrogance of groups of spinally injured to other disabilities... Linda does not find it easy to relate to people with severe mental handicaps, and Ellen confesses to being ill at ease with people with cerebral palsy because as she puts it 'I don't want to be considered deficient' in the way that they are. Having admitted to these ambivalent and uncomfortable feelings, however, many of us, including Linda and Ellen, are trying hard to overcome our own negative attitudes as we suffer so much from these attitude ourselves." (Morris, 1989: pp. 72-73)

Such views are also expressed by Hooper (1994), writing in the United States of America based disability magazine 'The Ragged Edge' in a 1984 edition when he comments:

"I am often bemused by the statistics that say there are 30 to 40 million people with disabilities in this country.

Someone better tell 25 or 35 million of those folks that they're part of this big group – because they haven't a clue. If you use a wheelchair, try going up to someone with a hearing aid and explain to them that you're both in the same community. Good luck!" (Hooper, 1994: p. 5)

Hence, Hooper, whilst supporting the concept and ideal of a disability movement within the USA, notes also the diversity of its potential members, and the all too often lack of enthusiasm for belonging. More recently, de Wolfe (2002) challenges the UK disability movement to include those who may not necessarily regard themselves as 'disabled' but 'ill'. She suggests that if the UK disability movement is to avoid viewing itself as 'right' and therefore those who may have other perspectives, including regarding oneself as 'sick' or 'ill' rather than disabled (as identified by Tierney (2001), with reference to young women labelled as anorexic), as 'wrong', a *"redefinition of its scope is needed"* (de Wolfe, 2002). Such an approach may help the disability movement to embrace a greater understanding of pain, weakness, et cetera, and sick or ill people to focus less on their individual condition and broaden their thinking towards rights based issues. However, for this to happen, members of the disability movement need to view each impairment group (physical, learning disabilities, mental health, et cetera) as equal, recognising all people have strengths and skills to bring to the movement, and views other than the social model of disability have a validity.

Such a position is highlighted through the debate surrounding the actor, Christopher Reeve, who since breaking his back in 1995 antagonised the disability lobby within the United States of America in his quest for a 'cure' rather than social justice for all disabled people. Peace (2002) (himself a person with a spinal cord injury) typifies this argument in an article posted on the Ragged Edge web-site, when he states:

"I am convinced Reeve simply does not care about others with similar spinal cord injuries; and that he uses his privileged position to distance himself from other disabled people. I have never read nor heard Reeve bemoan the fact the unemployment rate among disabled people in the United States is about 66 percent. Or that the vast majority of spinal cord injured people lack access to basic health care and are routinely hospitalized for problems such as skin breakdowns that could easily be avoided." (Peace, 2002).

The distancing of oneself from others whom may be regarded as stigmatised is discussed extensively in the seminal work of Goffman (1963). Clare (1999) (who describes herself as a lesbian with cerebral palsy) when recalling her early life as a disabled schoolchild in the United States of America recalls how she would take great effort in distancing herself from the children in the special education unit.

"I was determined not to be one of them [the children in the special education unit]. *I wanted to be "normal", to pass as nondisabled, even though my shaky hands and slurred speech were impossible to ignore"* (Clare, 1999: p. 92).

Although now involved in disability civil rights, Clare comments that she did not have a disabled friend until her mid-twenties and still acknowledges that her *"chosen family"* are non-disabled. Likewise, Gill (1997) recognises that through the devaluation of disability, disabled people (of whom Gill includes herself) *"reject people with disabilities as valuable companions"*.

Such responses are supported by the wider literature of *social identity theory*, whereby people have a desire to maintain a positive self-concept and therefore portray their own group (the in-group) as superior to a relevant other group (the out-group), (Meeres and Grant, 1999). However, due to the complexity of identity in terms of disability, it is often unclear as to whether a disabled person views their identity in terms of disability, impairment (thus seeing disabled people with other impairments as members of the out-group), or whether other facets of their identity, such as race, gender, sexual orientation and so on, are their principal identity markers. Or, that a combination of the above, such as disabled women, or black disabled person, are the way individuals describes themselves. This can be illustrated through a comment made to the disabled sociologist Irving Zola, by a resident of the Dutch community (Het Dorp), built specifically for people with physical disabilities, during his week long stay in 1972. The disabled interviewee stated:

> *" 'They only know about their handicap. Why for me, it's only something recent. I used to walk, run, dance, play sports', she said with obvious pride. 'So many were born that way. I was not!'... 'And with some,' she added with exasperation, 'Well it's just so hard to talk to the spastics.' He* [the interviewee's partner] *nodded vigorously in agreement.*
>
> *I was immediately struck by some of the uncomfortable perceptions that the Falks shared, not only with other residents, but with the outside world. Naively I had expected that people at Het Dorp would be different. Whenever I have learned that a particular minority group was itself prejudiced, I have always been shocked."* (Zola, 1982: p. 79)

Hence, Zola found that not only did some disabled people with very high levels of contact with other disabled people hold prejudiced attitudes toward other impairment groups, but also that there was a desire to socially distance themselves from others viewed as different. Whilst the theme of identifying (or not) as a disabled person, is a recurrent one throughout Zola's (1982) work, it is important to also note the sense of belonging that is engendered. That said, although Zola makes reference to those within this community of disabled people who remain socially isolated, little attempt seems to have been made by this sociologist to make contact with them, preferring instead to cultivate informal encounters with the more articulate physically disabled members of the Het Dorp community.

Similarly, Klotz (2004) makes reference to the groundbreaking work of Bogdan and Taylor (1982) who recognised the importance of social and cultural concepts, and how labels, such as 'mental retardation', are socially constructed. Through recognising the importance of the lived experience of disability, Bogdan and Taylor interviewed two people labelled as 'mentally retarded' to discover, from their perspective, the social implications of being labelled in this manner. Klotz (2004) argues that Bogdan and Taylor were keen to emphasise the similarities between the two respondents and 'normal' people, but failed to *"fully acknowledge or interpret the assertions of difference made by Ed and Pattie* [the respondents who had previously left institutional care] *when comparing themselves with those in the institution who were more severely disabled than themselves. Despite Ed's compassion towards a young boy he cared for, both he and Pattie had a deep fear and distaste of those 'low grades' who were profoundly disabled, and were offended by any association with them, both categorically and in daily institutional life"*. Hence, these respondents not only tried to socially distance themselves from others similarly labelled, but also exhibited prejudicial attitudes through their offence at being associated with other disabled people. This raises the need for disabled people to recognise the implications of such attitudes.

A form of social distancing may be an unwillingness to discuss disability between disabled people. Ambiguous findings are presented by Royse and Edwards (1989) in a study of physically disabled people (n = 171) in the United States of America. One aspect of this research focussed on whether disabled people asked other disabled people about impairment/disability. Royse and Edwards found that 58% said they seldom ask, 30% sometimes ask, 11% usually ask and 1% did not respond. The authors noted that the longer the subject had lived with their disability, the less likely they were to ask about the other person's impairment/disability, suggesting that with the passage of time there is less interest in discussing these issues and a form of 'burn-out' takes place. Royse and Edwards, do note however, that whilst the overall findings of this research suggest that disabled people are on the whole comfortable discussing their impairment/disability, even with relative strangers, including non-disabled people, the study is limited by the subjects tending to be well educated, who may have more open attitudes towards disclosing details of their impairment/disability than people with lower educational attainment. However, no supporting evidence for this is provided.

4.8 Contact Between Disabled People

The topic of contact with disabled people will be discussed more extensively in Chapter 5. However, there is value in discussing the implications of contact between disabled people in the context of this chapter.

Bracegirdle's (1995) UK based study into children's stereotypes found that whereas the non-disabled subjects attributed seven stereotypical traits to two pairs of dolls (two sets of twins, boy/girl, one non-disabled and one with a visible physical impairment, i.e. the girl wore callipers and used crutches and the boy had a lower limb amputation and crutches) the disabled children assigned only one trait. The traits assigned by the non-disabled subjects to the disabled dolls were poor health, good interpersonal skills, preference for non-physical recreation, lack of verbal aggression, lack of physical aggression, lack of similarity to the subject and lack of 'naughtiness'. The disabled subjects however only assigned the trait of poor health to the disabled dolls. Bracegirdle suggests this finding may be as a result of a number of the disabled children having learning disabilities and therefore not fully understanding the stories that attributed the traits to the dolls. Alternatively, as the children came from a special school they may have been 'protected' from knowledge of the stereotypes by well meaning adults. However, in addition she also notes the possibility that as the disabled children had daily contact with other disabled children, then their attitudes may be less idealistic than the non-disabled children's. In other words, whilst their contact may not have fostered more positive attitudes towards their disabled peers, their insights and knowledge may be more realistic. Bracegirdle does however acknowledge the limitations of the research including the use of dolls instead of real children with impairments and that the boy and girl doll had different impairments, suggesting caution in generalising from this research.

In a similar vain, Richardson (1983) suggests that disabled children who do not have close contact with non-disabled peer culture, are less likely to learn the values of that peer culture, which includes negative and stereotyped attitudes toward disabled people. Thus, disabled children who are educated in segregated schools may have atypical attitudes towards other disabled people. But Richardson does not develop this point other than saying that further research into this area would be of value.

However, Hyde (1998) when investigating Sheltered and Supported Employment within the United Kingdom, found that some disabled people regarded working in a Sheltered Workshop, which would inevitably have high levels of contact between disabled people, as stigmatising. Although these individuals are likely to have also had high levels of contact with non-disabled people in wider society, and therefore have been exposed to the negative stereotypes commented on by Richardson (1983), it serves as an illustration that contact does not automatically create positive attitudes, even amongst those whom society would believe as belonging to the same group.

This point is further supported by Deal's (1994) findings, where, attitudes measured using Gething's 'Interaction with Disabled Persons Scale', disabled people with differing levels of contact with other disabled people were found to have similar attitudes toward disability. It was also found there was no statistically significant difference between the two disabled samples and the non-disabled sample (disabled people living and working in integrated environments (n = 20); disabled people living and working in residential care and/or supported workshops (n = 23); and, non-disabled people (n = 15)). Hence, contact between and with disabled people did not appear to be correlated with attitudes toward members of this minority group.

Wates (1997) refers, however, to disabled parents who whilst initially rejecting contact with other disabled people, (parents with disabilities), fearing negative stereotyping through association, found once contact was made, the informal support network liberating and rewarding. User Groups for people with mental health problems have similarly been seen as potentially stigmatising by people with this range of impairments, but equally supportive and emancipatory by offering opportunities for sharing experiences from a user perspective and collective action (Barnes and Shardlow, 1996).

Comer and Piliavin (1975) utilised three small samples, two of which were samples of disabled people (non-disabled; disabled people who had acquired an impairment within one year; and, disabled people who had acquired an impairment relating to their legs within two to three years). The subjects were presented with two photographs, one of a non-disabled person dressed in the manner of a mechanic and another of a man with a leg amputated sitting in a wheelchair. Subjects were then asked to rate each person in the picture against a list of adjectives. Comer and Piliavin found the non-disabled sample viewed 'handicapped' (sic) people more favourably than 'normals' (sic), the recently impaired sample also held more favourable attitudes toward disabled people than toward non-disabled people, whereas the two-three year group rated the 'normals' more favourably than the 'handicapped'. However, there was no difference between the two disabled samples attitudes toward the 'handicapped'. Comer and Piliavin suggest that the non-disabled subjects held more positive attitudes toward disabled people than non-disabled people due to both 'myth' and 'realism', whereas the disabled samples and a result of experience could see through the 'myth' of disabled people.

Comer and Piliavin's research appears, however, to be flawed in a number of ways. Firstly, many of the trait adjectives appear to reflect stereotypes of disabled people, and yet are regarded by these authors as positive. Whilst it could be argued that people who are 'kind' possess a personality trait that is more accepted than someone who is 'unkind', to attribute this to one group in society over another appears somewhat spurious. For example, people with Down's syndrome are often described as especially friendly and *"being endowed with qualities of the heart"*, which Robinson (1989: p. 251) contends, is *"romantic twaddle"*. Secondly, as Comer and Piliavin recognise, the photographs led the subjects to drawing the conclusion that the person was a mechanic, which, as a job, is highly unlikely to be performed by someone using a wheelchair. Thirdly, the sample sizes were small. Despite these limitations, Comer and Piliavin do raise a number of important issues, not least being whether disabled and non-disabled people hold similar or different attitudes toward disability and whether the length of time a person has been regarded as a disabled person is a significant variable in attitude formation.

4.9 Positive Attitudes Towards Disability from Disabled People's Perspectives

A recurring theme throughout the literature are the occasional glimpses of what could be regarded as positive attitudes towards disability, especially from disabled people themselves. This, perhaps contentious topic, will be discussed below.

In an innovative piece of research, Makas (1988) addressed the issue that disabled and non-disabled people have differing perceptions as to what constitutes a positive attitude and subsequent behaviour toward disabled people.

Using the Issues in Disability Scale (IDS), a 100 item, 7-point Likert-type scale, the questionnaire was administered to three distinct samples: disabled respondents; "good attitude" non-disabled respondents; and non-disabled student respondents. The first two groups completed the questionnaire but the "good attitude" sample were not informed of the purpose of the experiment or why they were chosen. The student sample was firstly asked to complete the IDS honestly and then secondly in a way they felt reflected "the most positive attitudes toward persons with disabilities". When the students were 'faking' their responses, 11 items on the scale were found to have been changed in the wrong direction. Makas suggests the results indicate that disabled and non-disabled people differ significantly in their perceptions as to what constitutes a positive attitude toward disability. Makas identifies the support of civil rights for disabled people, the rejection of the notion of special treatment on the basis of disability and that disabled people do not desire to be perceived as different, as three key attitudes supported by disabled people. However, care must be shown when generalising from Makas' research, primarily due to the background of the disabled sample. These people tended to come from disability related professions or were employed in professions such as business or politics in the United States of America. Therefore, whilst these people may have been regarded as having a positive attitude toward disability, what they felt this actually constituted may not be reflected in a wider, more diverse population of disabled people.

In Frank's (2000) study of Diana DeVries, an American women born with neither arms nor legs, she notes how from the late 1970's people with mobility based impairments began to view themselves *"... not as objects of charity but as a political minority with rights to equal access and opportunities."* (p. 69). Hence, a positive attitude toward disability and therefore other disabled people can be seen through the liberation of the civil rights movement (see Campbell and Oliver, 1996).

Such views find support from Fleischer and Zames (2001: pp. 200-215) who argue the case for disability pride through a group identity. Fleischer and Zames tend however, to focus on people with physical impairments, thus ignoring large sections of the disabled population, who may hold differing views to physically disabled activists. In addition, Brown (1992) highlights the importance of knowing what is meant by 'disability pride', arguing that those who have 'passed' as non-disabled, such as Franklin Delano Roosevelt, should not be viewed as heroes, stating forcefully that:

"As long as we buy into the mainstream notion of success through overcoming we are submitting to an ideal to which we cannot possibly remain true. No matter what we do, we remain disabled." Brown later states:

"I wish to see us not only recognize our disabilities, but to celebrate them. To sing clearly and out loud our praises, our struggles, our failures, and our successes: our lives." (Brown, 1992)

Hence, Brown is suggesting that a positive attitude toward one's own disability should be found in the positive recognition of oneself as a disabled person and the rejection of the more traditional view often referred to as 'triumph over tragedy'. Brown also rejects the strategy of 'passing', which effectively rejects the public recognition of an individual's impairment. However, whilst Brown recognises the daily 'struggles' faced by many disabled people, he fails to discuss why many disabled people feel the need to pass in the first place.

In a UK based piece of research, Sim, Milner, Love and Lishman (1998) researched whether there was a conformity of views between disabled and non-disabled people towards disabled people's needs. Using seven focus groups (six groups composed of up to six disabled people and one non-disabled control group), they were given a gradually evolving story of a fictitious person, (Mr Arthur Angus), through a series of five vignettes. It was not until the third vignette that the character's disability was revealed. The story involved Arthur's van breaking down in the second vignette whilst on holiday with his family (before the impairment is revealed) leading to discussion around Arthur's level of responsibility for the situation he and his family found themselves in, to his electric wheelchair breaking down in a later vignette. The groups of disabled people initially found Arthur to be highly culpable for his van breakdown and its subsequent repair, but once his impairment is revealed to being almost blame-free. However, eventually Arthur is seen as culpable for the van and the wheelchair breakdowns but only to a more moderate extent. Sim et al note that the disabled groups questioned Arthur's attitude rather than his impairment for his situation. In other words, viewing the solutions to his situation as laying with Arthur's level of personal responsibility and control over the situation, rather than his functional ability. This was in contrast to the non-disabled group's conclusion, which adopted more of a medical model approach, viewing Arthur's functional limitations as the source of his problems. Sim et al conclude that the disabled people in this study have *"...redefined the individualised approach to disability, and set it in an active and participative social context, rather than one which fosters only passivity and dependence."*

However, it is important when investigating attitudes of one group of people towards another, not to over generalise the out-group homogeneity. In other words, as has been alluded to above, attitudes toward disabled people, may in fact be attitudes toward other impairment groups. Dixon (1977) by administering a semantic differential scale and a social distance scale to various sub-samples of disabled people and sample of non-disabled people found that in general the disabled subjects expressed more favourable attitudes toward other disabled people than the non-disabled subjects. However, Dixon also found that the amputee, spinal cord injured and stroke sub-samples each showed a statistically significant preference for members of their own group compared to members of the other impairment groups, either on the social distance scale or the semantic differential scale. Neither the arthritis nor the 'emotionally disturbed' (Dixon's terminology) groups expressed a willingness to be associated with other members of their impairment group. One explanation Dixon gives is one the basis of visibility of the impairment. Those with 'invisible' impairments may conceal their disability or 'pass' as a "normal" (Goffman, 1963), and so avoid the marginalisation associated with disability, by avoiding contact with other disabled people. However, those with visible impairments, it is suggested, may find comfort in associating with like impaired people, thus avoiding the negative attitudes of society. Whilst Dixon (1977) qualifies this conclusion with the admission that this is not the ideal solution, it remains worrying that the cause and the solution lies with the removal from wider society, even on a voluntary basis, rather than challenging the attitudes of society.

4.10 Conclusion

In conclusion, the literature has revealed that disabled people do not hold consistent views towards other disabled people, ranging from a desire to avoid others labelled as disabled for fear of further stigmatisation through association, to proclamations of pride and strength through association. Also highlighted is that disabled people do not automatically wish to be associated with other impairment groups. The attention of this thesis will now therefore turn to attitude change strategies and how attitudes can be measured, thus giving data that can assist the process of modifying attitudes toward disabled people for the better.

Chapter 5

Methods of Attitude Change and Measurement of Attitudes Toward Disabled People

5.1 Introduction

This chapter aims to explore the literature in relation to methods of attitude change with specific reference to improving attitudes toward disabled people. Factors that can influence attitudes, in relation to belief or behaviour toward disabled people is a fundamental issue, as the improvement of attitudes toward this group in society must remain high on the agenda of social policy if disabled people are to be full members of society. Through the mainstreaming of education, younger people are increasingly having greater exposure to disabled people, and therefore the role of interactions between disabled and non-disabled children has received attention from researchers (see for instance, Weinberg, 1978; Weisel, 1988; Lockhart, French and Gench, 1998; Corker, Davis and Priestly, 1999).

However, the focus of this chapter will be on contact as a method of attitude change (in relation to the adult population) and staring at disabled people, the stress caused by the interaction between disabled and non-disabled people, the role of language in attitude change, disability awareness and equality training, and finally the role disabled people play in affecting attitude change toward disability. Although the focus of this thesis is attitudes of disabled people toward other disabled people, methods of attitude change remain an important aspect. For, unless attitudes of disabled people are not consistently improved, internalised oppression will remain. The literature will therefore be explored with the aim of offering insights that can be tested in relation to disabled people compared with non-disabled people.

This chapter also seeks to identify the key methods of measuring attitudes specifically in relation to disabled people. The measurement of attitudes is integral to the development of attitude theory (Ostrom, 1989) and therefore remains important in relation to disability studies. A review of the literature in relation to disability and attitude measurement will therefore be presented as well as a critique of two widely used attitude rating scale in relation to disabled people, to serve as an illustration.

5.2 The Role of Contact with the Minority Group in Changing Attitudes

Allport (1979, first published 1954) in his classic discourse on the nature of prejudice, although primarily discussing race, identified that contact with the stigmatised group is one of the key methods by which to affect attitudes, be it in a positive or negative direction. Allport (1979) also identified the complexity of the problem of predicting the effect of contact upon attitudes in that the nature of the contact will have differing effects, with a complex array of variables that will influence the impact of the contact (Allport, 1979: pp. 262-263).

Donaldson (1980) notes in her review of the literature on modifying attitudes toward disabled people the paucity of research into this area. She highlights the inconsistencies in the research findings with some research demonstrating positive shifts in attitude, others no significant changes, and others identifying negative shifts. Donaldson also notes how generalisations from much of the research are not possible because of a lack of experimental design and/or control groups. That said, she identifies as the principal techniques used in the attempts to modify attitudes as: a) direct or indirect contact with or exposure to disabled persons, b) information about disabilities, c) persuasive messages, d) analysis of the dynamics of prejudice, e) disability simulations, and f) group discussion. The use of contact with disabled people as a tool for attitude change has long been researched (see for example Gaier, Linkowski and Jaques, 1968) and is seen to be one of the principal methods cited and will therefore be discussed in detail.

McCauley (1995) when discussing stereotyping notes how it is those people who 'fit' the stereotype characteristics for that group who are recalled rather than those who do not. Thus, if McCauley is correct, then contact with an intelligent, dynamic disabled person who holds down a prestigious job, is less likely to be recalled than the contact with a disabled person needing assistance to get into a building with steps. Therefore, the recall of an interaction with a stigmatised person (in this instance a disabled person) is reported to cause a degree of anxiety, tension, discomfort and embarrassment for both or all the participants (Hebl, Tickle and Heatherton, 2000). Such emotions are likely to therefore result in the stigmatised and non-stigmatised person avoiding the interaction or ensuring it remains as brief as possible, based on their memories of past encounters.

Although contact between disabled and non-disabled people is one of the most commonly cited methods to elicit attitude change (Pernice and Lys, 1996), Donaldson (1980) stresses that for positive shifts in attitude to take place, structured experiences rather than unstructured social situations are more likely to be effective and with participants to be of an equal status. White, Kouzekanani, Olson and Amos (2000) found, however, that nursing students' attitudes, as measured by Yuker's Attitudes Towards Disabled Person's scale - Form B, improved after a six day camping experience with clients with multiple sclerosis. Whilst the experience could be viewed as structured, whether the status of the two samples of participants (nursing students and people with multiple sclerosis) is equal, must be questionable.

The relationship and therefore the nature of the contact between health care professionals and disabled people, however, are likely to influence the resultant attitudes toward this group. Eberhardt and Mayberry (1995), whilst finding that of the 172 respondents to a battery of questionnaires and attitude scales sent to 402 entry level Occupational Therapist's in the United States of America, held positive attitudes, those with the least contact held more positive attitudes. The explanation for this is given as those with higher levels of contact in the health care setting are seeing the disabled person in a dependent situation and with unequal status. Thus, the disabled person is unable, in this instance, to demonstrate their true abilities, therefore perpetuating the Occupational Therapists helper-caregiver role.

It should also be borne in mind that contact between a minority group member and a majority group member may not automatically be positive. For, as Marsh and Sahin-Dikmen (2002) in their Eurobarometer survey of discrimination in the European Union note, 12% of respondents had witnessed discrimination against people with learning difficulties or mental illness and 11% toward people with physical impairments. Only race, with 22% was placed higher. However, these authors caution that a single event of discrimination might have been witnessed by many people and therefore reported figures of discrimination may be greater than the actual number of discriminatory incidents. What is important therefore to consider, is the nature and context of the contact.

Higgs (1975) makes a correlation between contact, information and attitude, suggesting that groups with high contact tend to have more information about disability and more positive attitudes toward people with physical disabilities. However, Cobb and de Chabert (2002) when investigating social service provider's attitudes towards people living with HIV/AIDS in North America found that HIV/AIDS care providers tended to hold similar views as the general population. The more 'responsible' the person was perceived as being for their HIV/AIDS status the greater the anger and blame from the service provider, and the less willingness to provide assistance. This research also revealed that those with the greater levels of direct contact (and therefore are likely to hold greater levels of knowledge and information relating to this group) held less positive attitudes. Cobb and de Chabert suggest this may be due to those directly providing services become desensitised, whilst managers who tend to have less direct contact keep their views in tact. These authors, however, fail to report how contact is measured (if it was measured at all) thus suggesting the contact variable was assumed.

5.3 Staring at Disabled People

As a consequence of disabled people interacting with non-disabled people, a degree of staring may take place, due in part to the lack of familiarity between the two parties. Ingstad and Whyte (1995) however, note the paradox in middle-class American culture whereby *'disability is treated as unspeakable* *and invisible'* (p. 9), and children are taught not to mention a person's impairment or stare at them. Fleischer and Zames (2001) cite an interesting instance whereby the stress experienced in the interaction between the disabled person and non-disabled person can be turned to the disabled person's advantage. In their historical review of the disability movement in the USA, Fleischer and Zames (2001) refer to Ed Roberts, (one of the disabled activists who created the Independent Living Movement in Berkley, California, during the 1960's) who stated:

"If someone comes up to me and doesn't look me in the eye, if all they see is my ventilator and my chair, I can tell right away. If they don't see me as a human being, if they only see my equipment, I know I can get whatever I want out of them. As long as this is not used pathologically, but to create beneficial change for others, it is a strength. Disability can be very powerful. We used the power of disability in political struggles many times." (Ed Roberts, cited in Fleischer and Zames, 2001: p. 38)

The consequence of anxiety, according to Wilder (1993), when an in-group member (perceiver) encounters out-group members, is that the perceiver is prone to stereotype all members of the out-group, even when one member of the out-group is not behaving in a stereotypic manner. Hence, a non-disabled in-group member is likely not only to feel anxiety from the encounter, but also to make negative and unfavourable judgements about the disabled people involved. The result therefore is that the encounter remains awkward and stressful for both parties. Clare (1999) (herself a person living with cerebral palsy) supports this notion when she comments on how non-disabled parents smack their children for staring at a disabled person, teaching them *'how to pretend not to stare'* (p. 88). She adds how the medical profession condone this behaviour by having disabled children strip to their underwear in front of doctors, medical students, physiotherapists and so on, having them parade in front of this group of people, sometimes even videotaping the child, arguing it is for training purposes.

Lenney and Sercombe (2002) through secretly videotaping peoples behaviour towards a person with cerebral palsy who has no speech whilst in cafes and bars in Australia, noted how people would use sophisticated methods by which to stare unobtrusively, such as visually following another person walking past the disabled person, but allowing themselves extra time to linger on the disabled person. Interestingly, this limited piece of research highlights the paradox faced by people who rely on eye contact in order to initiate communication. For, whereas this particular individual required direct eye contact to be made in order to indicate to a stranger that he wished to communicate with them, social convention has taught us that it is 'rude to stare'. Hence, for someone in this situation it is extremely difficult to breakdown social barriers, potentially leading the individual to remain isolated and yet surrounded by people at one and the same time.

5.4 Stress in Interaction between and Non-Disabled People

When contact between a minority and majority group member takes place, the possibility that the two individuals or groups may experience a level of anxiety needs to be considered. Through the international validation of the Interaction with Disabled Persons Scale, (a scale designed to measure discomfort in interacting with disabled people), Gething, Wheeler, Cote, Furnham, Hudek-Knezevic, Kumpf, McKee, Rola and Sellick (1997), found that similar levels of discomfort were measured in each of the nine countries included in the research. Contact, although only measured in terms of frequency, was consistently found to be the best predictor of a positive attitude toward disabled people.

Boyle (1997) too notes the importance of the stress caused through the interaction between disabled and non-disabled people, within employment situations, saying that despite the Americans with Disabilities Act (1990) disabled people have withdrawn from employment because of the unpleasantness of social interactions. Thus, Boyle highlights that the discomfort in interactions is not located solely with the non-disabled person. The reduction of this anxiety, therefore, is clearly an important factor with respect to attitude change. Cahill and Eggleston (1994) in their analysis of people who use wheelchairs in public, argue that wheelchair users often find the emotional management of social interactions as challenging as the physical environment, often requiring the individual to 'manage' the emotions of others: for instance, the parent who is embarrassed by their child staring.

Although direct contact between disabled and non-disabled people is increasing (European Commission, 2001) for many people, it is still a rare occurrence in anything other than on a very casual basis, despite the increased activity of disabled people within the community. It is therefore important to look at alternative methods of attitude change.

5.5 The Importance of Language in Disability Discourse

The long-term representation of disabled people and disability can influence attitudes and therefore may bring about some level of attitude change. Gordon and Rosenblum (2001) drawing upon a sociological framework, identify that through naming categories it is possible to identify who holds the power and therefore deny rights and privileges to others. Drawing on Foucault's social constructionist theory, Gillman, Heyman and Swain (2000) identify that the labelling of people with learning disabilities can have a significant impact upon their quality of life and that whilst this was viewed as an important issue by people with learning difficulties, their families and care workers, this was not the case for professionals (social workers, GPs, psychiatrists, nurses and dentists).

Kuykendall and Keating (1990) found through an experiment where a country's name was paired with either positive or negative words, that those that were paired with positive words were thought to have more favourable economic conditions and vice versa. Similarly, Eayrs, Ellis, and Jones (1993) found that more positive attributes were afforded a person labelled as having learning difficulties, rather than 'mentally subnormal' or 'mentally handicapped'. Thus, labelling disabled people with terms that reflect negatively is likely to have a detrimental affect upon attitudes, changing them in a negative direction. Positively viewed labels, such as 'normal', have also been identified as holding potentially negative consequences for people who have experienced some form of brain injury.

As the mass media is an important influence on issue based awareness raising (Zimbardo and Leippe, 1991: p. 4), if not attitude change, Auslander and Gold (1999) suggest there is scope for much improvement on an international scale. Hermeston (2003: p. 33) cited in the disability magazine Disability Now, the Scope research 'Stop Press', whereby over an eight week period starting on the 7th June 1999, the term 'cripple' was used to describe disabled people twenty times in national and five times in local papers throughout the United Kingdom. In addition, 'sufferer' (a subjective and medicalised term) was used forty-five times in national and eighty-five times in local papers.

Saad (1999) argues that the representation of people with 'chronic illnesses', (defined by Saad as a protracted physical disorder which is progressive or changeable such as multiple sclerosis), in children's fiction, has tended to be sexist in nature with significantly more female lead characters than male being portrayed as chronically ill. Saad suggests that such biases can lead children to believe that it is only girls who have chronic illnesses and that sickness is a feminine quality. A more balanced and positive representation within children's fiction could therefore assist in attitude change of children towards chronic illness. The cultural reflection of the beliefs, or attitude, toward disabled people as a group in society can be reflected in the mass media, with the 'triumph over tragedy' stories (Barnes, 1992), or in fictional stories (Hamilton, 1997; Keith, 2001) and therefore need to be challenged by disabled people when negative portrayals of disability are represented (Brookes, 2004).

Whilst this change is often through the use of educational programmes (for example, Yedidia, Berry and Barr (1996) with respect to improving physicians attitudes toward AIDS), the use of public information advertisements on television has also been utilised. Kashima and Lewis (2000) in their exploration of the relationship between attitudes and behaviour, cite the AIDS awareness campaign in Australia that depicted AIDS as the Grim Reaper, playing ten pin bowling with people of various ages, sex, ethnic backgrounds and so on. Whilst this advertisement was effective in showing that AIDS kills indiscriminately, thus producing a negative shift in attitudes towards AIDS, it did not inform the viewers how to change their behaviour. Kashima and Lewis (2000) fail to comment, however, that the resultant negative attitudes towards the disease would also have had an impact on attitudes towards people with AIDS, and their consequential behaviours towards this group of people. Gilbert (2003: pp. 6-7) comments on the importance of such prevention messages being culturally specific, offering this as one possible reason why such messages have failed to reach African Americans. The majority of HIV/AIDS awareness campaigns, initially at least, being targeted at white gay men.

Hence, language used toward disabled people as an object group is not only a reflection of cultural beliefs toward this group, but can also be used as a method of attitude change. Likewise, educational programmes can also be effective, but may inadvertently reinforce stereotyped attitudes and need to be targeted appropriately. The reinforcement of stereotypes and negative perceptions of disability as a result of awareness training through simulation exercises will be explored further below.

5.6 Disability Awareness, Equality Training and Simulation Exercises

The use of disability simulation (which could more accurately be referred to as impairment simulation) as a method of attitude change deserves specific attention in this chapter. Disability simulation has been extensively used in disability awareness training in order to raise the awareness of non-disabled persons toward the effects of a particular impairment upon a person living with that impairment. Disability simulation is where the participant 'experiences' the functional loss as a consequence of an impairment, such as, using a wheelchair, dark glasses with glue smeared on them (to simulate sight impairment) or ear plugs.

However, French (1992), in her critique of the literature in relation to the use of simulation exercises, argues that such exercises give the participants *"a totally false impression of what it is like to be disabled"* (p. 260). In part this is due to the participant not holding the coping strategies developed by the person living with that impairment, thus creating the false impression stressed by French. For, as French highlights, as a person living with a sight impairment, poring water for her is a simple task, whereas a person doing it for the first time during a simulation exercise may find it overwhelmingly difficult. Equally important is the recognition that such exercises do not represent the long-term social oppression faced by disabled people, as the participant can, in the case of simulating a person who is unable to walk, quite literally walk away from the effects of the impairment, at the end of the task. Thus, the participant will not face the psychological effects of the impairment. French (1992) therefore advocates the uses of Disability Equality Training, presented by disabled people, giving non-disabled people an opportunity to hear how impairment and disability affect the lived experience of disabled people from their perspective.

Despite the reservation expressed for this method of attitude change, disability simulation exercises are still utilised (see Jackson, 2003). Peterson and Quarstein (2001) utilise the simulation of impairments in disability sensitivity training for professionals working within a school for deaf and blind students, whereby participants were required to perform cooking and life skills chores as a team, whilst simulating an impairment. These authors claim positive results, although these did not include an increased awareness not to disempower people with multiple impairments, including sensory and communication impairments. In addition, subjects reported disliking being 'confined' to a wheelchair, feeling isolated and frustrated. Considering Peterson and Quarstein were attempting to improve attitudes toward disabled people through sensitivity training, these authors not only use inappropriate language (for instance, wheelchair bound, p. 45) but also claim 'positive results' despite having no real basis for this conclusion, having used only self-evaluation and group discussion after the exercise.

Likewise, Grayson and Marini (1996) found participants in a simulated exercise using a wheelchair for just 30 to 60 minutes, travelling 400 yards across a North American university campus, in order to purchase a snack, expressed emotions such as 'I would kill myself if I really had to stay in a wheelchair'. However, both the participants in the task and the control group who only received a lecture on the subject, reported increased awareness into the 'frustrations' faced by disabled people, hence questioning the value of simulated disability exercises. In addition, the measurement tool utilised to measure whether the participants had improved their awareness had no reported internal or external reliability, with its development being based on Marini's thirteen year experience as a wheelchair user. Hence, it could be argued, the tool utilised was subjective in nature and possibly unreliable.

5.7 Disabled People's Involvement in Attitude Change

Disabled people have been at the heart of challenging and changing attitudes toward disabled people (Makas, 1988; Oliver, 1990; Morris, 1991; Shakespeare, 1993; Clare, 1999; Charlton, 2000; Fleischer and Zames, 2001; Johnson 2003). McBryde Johnson (1999) in the US civil rights based magazine 'Disability Rag', voicing her opinion as a lawyer and disability rights activist states:

"I think I've been most effective in changing attitudes when I've simply behaved like a "real person" instead of a "crip totem" – when I've won a client's legal case, given directions to a lost tourist, accepted a candidate's filing for public office, or tipped well for good service in a restaurant."
(McBryde Johnson, 1999)

She goes on to say that when accosted by a child in the street asking her about her disability, the child is given a polite but firm response that it is inappropriate to ask questions of that nature. McBryde Johnson argues that it is more appropriate for a child to learn that disabled people are busy individuals with as much right to privacy as anyone else, rather than learning about a specific disability. How effective such a strategy is however, bearing in mind the unstructured nature of an encounter of this kind, must be questionable.

Although there are limitations to the generalisation of the results from Wahl's (1999) survey of mental health consumers (n = 1301) due to the self selection of the subjects and the relatively high functioning levels, this research is valuable in that few strategies for attitude change are put forward by disabled people themselves. These were reported as; increasing the knowledge of non-disabled people about mental health issues, (including mental health caregivers), and the direct confrontation of stigmatising attitudes from non-disabled people.

The role of the stigmatised individual or group in reducing prejudice is a theme taken-up by Major, Quinton, McCoy and Schmader (2000) (although primarily discussing race). These authors contend that researchers have generally shied away from researching this important area of attitude change for a number of reasons. Firstly, on a practical level, members of a stigmatised group are often less accessible to researchers than the dominant group. Secondly, and in light of this research into attitudes of disabled people toward other impairment groups, more significantly:

> *"...we suspect that many psychologists find this perspective politically incorrect, if not downright distasteful. To ask what a target can do to reduce prejudice raises the specter of "blaming the victim" – after all, prejudice is not the victim's fault, so he or she should not be expected to take any responsibility for reducing it."* (Major, Quinton, McCoy and Schmader, 2000: p. 212)

Major *at al* challenge this perspective, arguing that by drawing on theory and research relating to coping with stressful life events, they suggest a series of possible strategies that could be employed by members of the stigmatised group. For example, boosting a prejudiced perceiver's self-esteem; avoiding categorisation altogether; assimilation to the perceiver's group; and, gaining power and status *"so as to induce a revision of attributions and stereotypes about oneself or one's group"* (p. 232). Major *et al*, do recognise, however, that these strategies 'carry a high risk to the integrity and self-esteem of the targets' (p. 232). Thus, whilst many disabled people who do not regard themselves as part of a disabled in-group may have a leaning towards the first three strategies listed above, those who affiliate themselves to the disability movement, are more likely to give support to the concept of gaining power and status, and simultaneously finding the idea of assimilation offensive.

This chapter has so far identified one of the key methods utilised in attitude change toward disabled people is that of direct contact, although this comes with a number of health warnings. Not least of these is that the interaction between the disabled and non-disabled person be of a positive nature, which in itself may be open to interpretation, for one person's concept of positive may be very different from another. In addition, as has been discussed in the earlier chapter on attitudes of disabled people toward other disabled people, it cannot be assumed contact between members of the minority group will automatically be positive. As part of the process to improve attitudes toward disabled people it is important to be able to measure such attitudes as accurately as possible. As Aiken (1996) remarks:

"Most human behavior is a complex function of nature and nurture and cannot be understood or predicted by a simple deterministic equation. For this reason, we often resort to complex statistical or probabilistic models and methods in order to predict and understand why people act in certain ways.

"...Quantifiable constructs should be measured as precisely as possible. The measurements must also be repeatable under similar conditions and clear in what they indicate". (Aiken, 1996: pp. 1-2)

The next section of this chapter will review the literature in relation to measuring attitudes, with particular reference to disability. In order to assist in this review, a critique of Gething's Interaction with Disabled Persons Scale (IDP) scale and Yuker's Attitude Toward Disabled People (ATDP) will also be presented, thus highlighting some of the key issues in relation to utilising attitude scales as a tool in research.

5.8 Attitude Measurement

Having defined earlier what is meant by an attitude (see Chapter 3), it is also important to consider what is understood to be an attitude measurement. Antonak and Livneh (2000) offer:

"Attitude measurement converts observations of a respondent's behaviour towards a referent into an index that represents the presence, strength and direction of the attitude presumed to underlie the observed behaviour. The researcher selects a measurement method reflecting assumptions about the respondent's internal state, the referent towards which the respondent directs his or her behaviour, and the relationship between the respondent's internal and external behaviour, as well as the parameters of the research situation, such as cost, time, availability of respondents, availability of scales, and the researcher's competence and motivation." (Antonak and Livneh, 2000)

Although methods by which to measure attitudes toward disabled people have become more sophisticated over the past half a century, there has been no substantial change in the methods of measurement toward this group (Antonak and Livneh, 1995b). This also appears to be the case in relation to attitude measurement in general (Vargas, von Hippel and Petty, 2004). Antonak and Livneh (2000) in a review of the literature on measuring attitudes toward disabled people list a variety of direct and indirect methods. Whilst it is not the purpose of this chapter to discuss the nature of each method, it may be helpful to briefly list the more widely used approaches. Included under the direct methods are opinion surveys, interviews, ranking methods, Q methodology, sociometrics (sociometric techniques are designed to uncover how a person either intends to behave or actually behaves towards a referent, when given a choice of behaviours), the Adjective Checklist, paired comparisons, the semantic differential method, rating scales and social distancing scales. Indirect methods are placed under four classes: 1. respondents are unaware they are being observed or measured; 2. respondents are aware they are being observed or measured but are unclear as to the purpose of the measurement situation; 3. respondents are purposefully deceived as to the true purpose of the measurement situation; and 4. respondents are aware of being measured but are inactive participants in the measurement. Antonak and Livneh (2000) go on to give examples of research using each of these four classes of indirect methods, illustrating the range of techniques available to researchers. However, it is interesting to note that of the 116 references cited throughout the article only 20 were published from 1990 or later, thus suggesting that either limited noteworthy research has been performed since 1990 on attitudes towards disabled people, or there is a need for a more thorough review of the literature pertaining to this topic.

Antonak and Livneh (2000) list seven threats to the validity of the data obtained through direct methods of attitude measurement. First, respondents may try to please the researcher by giving responses that they think will 'please' the researcher (experimenter demand effect); second, respondents may wish to give a good impression of themselves; third, grant the attitude referent the benefit of the doubt when asked to make evaluative judgements (the generosity effect); fourth, the respondent may 'deny socially undesirable traits'; fifth, the respondent may try to sabotage the research by 'disclosing inaccurate attitudes' (the sabotage effect, faking bad); sixth, respondents may have little interest in the attitude being measured and therefore fail to give discerning responses; and seventh, some respondents may refuse to provide responses as they fear revealing controversial views.

The use of attitude scales have been widely used in social psychology, with various techniques being available for constructing such scales, including Borgardus's cumulative scaling (a rank-ordering instrument, measuring attitudes on an ordinal level, but tends to be cumbersome and time-consuming and therefore not widely used), Thurstone's pair comparisons and equal-appearing intervals (a small number of items form the final scale, with each item representing a particular scale value with respect to the attitude object, ranging from highly favourable, through neutral to highly unfavourable), Likert's summated ratings (an attitude scale whereby the respondent states the extent to which they agree or disagree with a number of statements relating to an attitude object), and Guttman's scalogram analysis (a unidimensional scale whereby if a respondent accepts a particular item, they will also accept all previous items) (Aiken, 1996; Robson, 2002). An attitude scale is a pen and paper instrument consisting of a series of statements to which the respondent either endorses or rejects in relation to the attitude object (Aiken, 1996). The use of multi-item measures of attitude are recommended by Ajzen (1988) due to single item measures having poor reliability. Reliability being viewed as, *"...the extent to which repeated assessments of the same trait or attitude produce equivalent results"* (Ajzen, 1988: p. 10). The greater the number of items, Ajzen concludes, the more reliable the score will be, as different errors on different items are likely to cancel each other out, leaving the overall score unaffected. In addition, the need for multi-dimensional scales when measuring attitudes toward disabled people is supported by a number of scholars and researchers (Weisel, 1988; Antonak and Livneh, 2000), whereby, for instance, dimensions such as contact should not be viewed in simplistic terms, but in a variety of social contexts, intensity (for instance, the relationship with the disabled person, such as neighbour, colleague or lover) and status (equal or subservient). Roberts, Laughlin and Wedell (1999) suggest researchers should consider alternative methods of measurement to Likert, such as the Thurstone technique when deriving attitude scores from disagree-agree responses. This, they argue, is due to the Likert approach 'faltering' for individuals who hold extreme positions. In addition, respondents may produce identical scores, despite responding differently for each item, hence, as Ajzen (1988) warns, no single item on such scales represents the respondents attitude, but the overall score.

An alternative attitude scale used to measure attitudes towards groups of people in society is that of the Social Distancing Scale. Such scales have been used elsewhere in social psychology, such as attitudes toward race, and have also been utilised in measuring attitudes toward disabled people. An example of research that used this method is Tringo (1970), whereby respondents were asked to state the level of social proximity they would have with people with differing impairment. Research that utilises Social Distancing Scales in relation to disability has a number of weaknesses attached to this method. Bakheit and Shanmugalingam (1997) argue that one such weakness associated with Social Distancing Scales is that they do not measure attitudes toward disability directly. In addition they suggest that scales of this nature may be inappropriate in today's world, as a result of increased integration of disabled people into mainstream activities and society. In addition, the ease with which to fake responses leaves results gathered using this tool as questionable, for instance, for a respondent may say they would be happy to have a friend who is disabled, when in reality they would be fearful of such contact. The distinction between what a person believes and how they say they say they would behave will be explored further below.

5.9 Measuring Attitudes when Disability is the Attitude Object

As the importance of the social model of disability has increased, so the need to develop empirical research tools has also grown (Zarb, 1997). However, the quality of research into attitudes toward disabled people, Yuker (1994) suggests, has been poor. He lists amongst his criticisms that many studies have inadequate sampling, a lack of adequate control groups, a failure to randomly assign subjects to groups and a lack of pre-tests or retrospective pre-tests. Yuker (1994) argues that researchers should attempt to improve existing attitude measurement tools rather than develop new ones, even stating that, *"Dissertation students should be forbidden to develop new attitude measures"*. Whilst it is possible to understand Yuker's concerns, such a heavy handed approach is likely to stifle the progress of research into this field rather than improve it, although his warning about using a sound methodology when attempting to measure attitudes toward disabled people should be heeded.

Antonak and Livneh (2000) comment that the usefulness of research into attitudes and disability is dependent upon the *"psychometric soundness"* of the method used to obtain the data, and the data being free from respondent bias. This fundamental problem is consistently highlighted in the psychology based literature. Elsewhere, Antonak and Livneh (1995a) have argued that due to biasing influences of direct methods utilised to measure attitudes, these authors suggest indirect methods, making specific reference to the error-choice method.

The error-choice method requires the respondent to answer a series of questionnaires that require them to answer factual information and respond to true or false statements. Due to *"respondents' selectivity in retaining information"*, there will be a degree of guessing. The direction of this guessing will indicate the respondents' attitude toward the attitude stimuli. This method of attitude measurement is performed without the knowledge of the respondent and therefore is questionable in terms of ethics.

In his critique of the interdependence of attitude theory and the measurement of attitudes, Ostrom (1989) highlights the concern of subjects offering 'non-representative (or inaccurate) endorsements' to opinion items on a measurement tool (p. 15). It is suggested this may be as a result of the subject being embarrassed to agree with socially undesirable opinion. In addition, Ostrom suggests that as many beliefs lay in the subconscious, people may be unaware of subjective attitudes and the corresponding responses.

Sinson (1993) cites a clear example of how participants in research can respond to a question in one way, and yet believe the opposite. She states how after interviewing mothers on how they would rate themselves with respect to their feelings towards people with Down's syndrome, it was not infrequent for the women to rate themselves as having an accepting attitude, but at the conclusion of the interview say, *"Of course if I actually had one – I'd smother it at birth"*.

Santee and Maslach (1982) in a study on the social pressure to conform in an experimental condition, whereby some of the participants could hear three other people (confederates) agreeing on solutions, found that the comparison of self with others along with the social meanings inferred from that comparison, *"...are critical determinants of dissenting and conforming responses."* Thus, care in the method chosen to gather data with respect to a group of people who are likely to be influenced by their peer group is vital in order to avoid introducing contaminating factors.

Similarly, Meertens and Pettigrew (1997) in their research into racism throughout Europe, raise the important distinction between 'blatant' and 'subtle' prejudice. They state that:

"..., the critical distinction between blatant and subtle forms of prejudice involves the difference between overt expressions of norm-breaking views against minorities and the covert expressions of socially acceptable anti-minority views." (Meertens and Pettigrew, 1997)

Through the use of 'The Blatant and Subtle Prejudice Scales and Their Five Subscales' (containing two blatant scales and three subtle scales), Meertens and Pettigrew were able to identify positive correlations between respondents who held blatant prejudice views with regards to race and conservatism, as opposed to those who were classified as 'subtles'. The 'subtles' were those who scored high on the "Subtle Prejudice Scale" but low on the "Blatant Prejudice Scale". This group rejected the crude expressions of prejudice, but nevertheless still viewed minority groups as "a people apart" for whom they held no sympathy or admiration. Such a distinction in the measurement of attitudes towards out-groups may have important implications in the measurement of attitudes towards different impairment groups by disabled people, who may be reluctant to express blatant views towards other disabled people but may still hold negative attitudes.

MacDonald and Nail (2005) argue such differences are due to the distinction between private and public expressions of attitudes:

> *"[W]e conceptualize private attitudes as attitudes that are consciously recognizable, controllable, and that the attitude holder believes are not directly accessible to anyone other than him or herself. By consciously recognizable, we mean that the attitude can be deliberately brought into consciousness (unlike implicit attitudes). By controllable, we mean that the individual has the ability to maintain that attitude or change it, at least temporarily. We conceptualize public attitudes as verbal or non-verbal expressions related to an attitude domain that are made with the belief that one or more other people are able to learn of that expression and attribute it to the attitude holder. Importantly, this definition includes researchers as a potential audience."*
> (MacDonald and Nail, 2005: p. 17)

These authors contend the measurement of private attitudes must be done under conditions of complete anonymity to ensure they are reported accurately by the research participants.

The public-private distinction would be supported by Devine (1989) who, when researching racism, comments, "*...that both high and low prejudiced subject have cognitive structures that can support prejudiced responses*", (p. 193). Devine also stresses that an assumption should not be made however, that all people are prejudiced. She comments that whilst high prejudiced persons are likely to hold beliefs similar to the cultural stereotypes, low prejudiced persons experience a conflict between their egalitarian views and the content of automatically activated cultural stereotypes. Such a conflict may exist for disabled people who hold positive attitudes toward other disabled people but still face the predominantly negative cultural stereotypes towards disability and impairment. A measure of attitudes within this group should therefore give consideration to this issue.

Soder (1990) may offer an insight into this phenomenon in relation to disability. Soder argues for a need to question the assumption that attitudes toward disabled people are negative, but rather they are ambivalent. In conclusion to a critique of attitude scales utilised to measure attitudes toward 'disability', he states:

> *"What these data suggest is that there are at least two different valuations involved: the devaluation of disability as such on the one hand and a benevolent sympathy toward persons with disabilities on the other hand. This points to a situation that is not well understood in terms of prejudice. If most of us consider disabilities to be negative and at the same time feel sympathy for persons with disabilities, these valuations as such can not be taken as indicators of prejudice."* (Soder, 1990: p. 236)

What is unclear from Soder (1990) is his true intention of the word 'sympathy'. For many disabled people are not seeking *sympathy* but rather equality and social justice. Thus, whilst some people may attribute being sympathetic toward disabled people as a positive quality, others may view it as patronising. Hence, great care is required in ensuring measures of attitudes toward disabled people are not value laden, or are at least open to scrutiny.

Strohmer, Grand and Purcell (1984) and Tregaskis (2000) stress the importance of research into attitudes toward disabled people taking into account both the impairment group and the social context. Schwartz and Armony-Sivan (2001) in an Israeli based study also recognise the importance of social context in relation to attitudes, and as a consequence used the Community Living Attitude Scale for their research into college students' attitudes towards the integration of people with 'mental retardation' (their terminology) and mental illness into the community. The CLAS comprises of four sub-scales, including Empowerment; Excluding People from Community Life; Sheltering Disabled People from the Dangers of Community Life; and Similarity Between Disabled People and Test-Respondents with Respect to Life Goals and Basic Human Rights. The CLAS is a forty item scale, with each item measured by a six point Likert scale, ranging from strongly agree to strongly disagree. Llewellyn and Chung (1997) note that research into the self-concept of young people with physical impairments has provided inconclusive results, identifying that attitudes to the self may be specific to the type of impairment. They stress that research has tended to measure self-concept at a fixed point in time and thus ignores that this is likely to change over time, especially in children. Llewellyn and Chung also criticise how inappropriate social contexts have been used in the measurement of self-concept and physically disabled young people. For example, by using sporting prowess as a social context, they argue, a child will inevitably formulate negative attitudes towards their capabilities if the dominant language used in the research tool reinforces their limitations rather than their strengths.

Tregaskis (2000) identifies in her formative paper of proposed research into non-disabled people's attitudes toward disability within a social context, that previous research has been traditionally based on a 'within-person context' taking little or no account of the social environment that helped to form the attitudes. In other words, the measurement of attitudes has been based on individualistic measures, rather than the context in which the attitude was formed.

5.10 Attitude Towards Disabled People Scale' (ATDP) and Interaction with Disabled Persons Scale (IDP)

Two scales that appear in the literature and have received attention as to their validity and reliability are Yuker's 'Attitude Towards Disabled People Scale' (ATDP) and Gething's 'Interaction with Disabled Persons Scale' (IDP). These two scales will serve as an illustration of attitude rating scales utilised to measure attitudes toward disabled people.

The ATDP was originally created in the late 1950's and further developed in the 1960's as an attempt to design a measure of attitudes towards disabled people in general, rather than being impairment specific (Yuker and Block 1986). This scale has three versions, of which Form O is perhaps the most widely used (Gething, undated), with twenty items on the scale, for which the respondent states on a six point Likert-type scale ranging from "I agree very much" to "I disagree very much", where their belief lies. This scale holds two subc-scales, described by Gething as (i) treatment and (ii) characteristics. The treatment sub-scale views disability in terms of how a disabled person should be treated with respect to, for instance, education and employment. The characteristics sub-scale tries to tap into whether disabled and non-disabled people differ in non-disability related characteristics, for instance, social adjustment, self-pity and intelligence. Thus, Yuker has attempted in the development of the ATDP scale, to encompass a psychosocial approach to measuring disability with elements of the social model. For example, the statement, *"It would be best for disabled persons to live and work in special communities"*, taps into the notion of integration and therefore the social model, whereas as psychosocial statement may be, *"Most disabled people feel sorry for themselves"*.

However, whilst Yuker and Block (1986) defend the reliability and validity of the ATDP scale, other researchers do not appear to hold the same level of confidence. Antonak (1980) argues that due to the social changes between the ATDP's development and 1980, the scale may no longer hold validity and reliability for samples in 1979. This argument may hold even more weight when considering samples in the 21st Century. Antonak (1980) goes on to identify, through statistical analysis that the psychometric properties of the scale are no longer evident, and therefore suggests that conclusions drawn from data derived from the ATDP-O scale should be treated cautiously, whereas Gething and Wheeler (1992) conclude that this scale is no longer appropriate to use in Australia. In addition, Hagler, Vargo and Semple (1987), using ATDP Form A, found that students on an introductory speech pathology and audiology course were able to fake higher scores on the scale, although Hagler *et al* note this conclusion should be viewed cautiously, due to the nature of the subjects.

However, if these findings are accurate for these subjects who have an interest in disability issues, then caution would have to be shown when using the ATDP scale on disabled people.

Whilst Yuker and Block (1986) state that the ATDP was designed to measure attitudes towards disabled people with either disabled or non-disabled subjects, few studies have actually taken place using a disabled sample; although those that have, Yuker and Block report, tend to obtain significantly higher scores than non-disabled samples, although no analysis of this statement is offered.

Another widely utilised scale in the measurement of attitudes toward disabled people is Gething's Interaction with Disabled Person's Scale (IDP).

Gething's IDP Scale Manual states:

"The IDP Scale measures general attitudes in terms of the level of discomfort reported by a person during interaction with people with disabilities. This discomfort is posited to reflect emotions and motivations such as fear of the unknown, threat to security, fear of being disabled (vulnerability), guilt and aversion which are linked with level of prior close contact with people with disabilities. Thus, people with low levels of prior contact are predicted to report more discomfort on the Scale. The IDP Scale is designed to measure attitudes on a personal level and is predicted to provide a more sensitive

measure of attitude change and of actual behaviours in everyday situations than measures based on the societal level of measurement." (Gething, (undated) Interaction with Disabled Persons Scale Manual: p. 7)

The IDP Scale was developed during the 1980's in Australia and published in 1991, with the intention of designing an instrument that would measure generalised attitudes towards disabled people (Gething, 1991). Gething, Wheeler, Cote, Furnham, Hudek-Knezevic, Kumpf, McKee, Rola and Sellick (1997) contend that the measurement of discomfort in social interactions between the disabled person and another individual had been overlooked by other instruments, and therefore the IDP Scale was designed to rectify this gap.

Gething (undated) states that the IDP Scale has a reliability coefficient of between +0.51 and +0.82 as measured through a test-retest correlation. Reliability is stated as being, *"...concerned with stability or consistency of measurement,"* (Gething, undated). Gething raises the issue of the time period between the first and second administration of the scale, noting that if the administration is too close together then a high correlation may occur due to subjects remembering their responses the first time, whereas if they are administered too far apart, then genuine attitude change may have taken place.

The internal consistence (an index of the homogeneity of items within an instrument) of the IDP Scale as calculated using Cronbach's Coefficient Alpha was shown to have a repeatedly high internal consistency, with alpha ranging from 0.74 to 0.86 (Gething, undated). The IDP Scale has also received international validation from nine countries, with results indicating that there was item homogeneity regardless of the country and whether the IDP Scale had been interpreted into another language (Gething *et al,* 1997). Earlier research into the reliability of the scale did show however, that the IDP scale could be enhanced, particularly in relation to measuring attitudes towards people with learning disabilities and levels of contact (Beckwith and Matthews, 1994).

Despite the reported psychometric properties of the ATDP and IDP, the use of attitude rating scales of this nature have been criticised (Soder, 1990). Soder contends that such attitude scales are based on the assumption that a group of people can be distinguished according to a single characteristic (in this instance disability), questioning whether this is possible. This author also questions the use of an accept or reject distinction for each statement, leaving no neutral value and therefore no recognition that respondents may imply hold no opinion. However, Soder seems to ignore Ajzen's (1988) advice that it is the total score of a multi-item measure that gives the respondent's measure of attitude toward the given attitude object and not a single item.

A key factor in the measurement of attitudes toward disabled people is to do with the definition of disability, and specifically in relation to research that involves disabled people themselves, the identification as a disabled person.

Bajekal, Harries, Breman and Woodfield (2004) in research carried out on behalf of the UK Government state *"There is no single 'gold standard' measure of disability"* (p. 2). These authors continue:

"Theoretical and lay perceptions of disability differ, and previous research has demonstrated that public understanding of the concept is fraught with comprehension issues and that interpretations of question meaning vary widely. Research into attitudes towards and experiences of disability has shown that disabled people vary in their response when asked to say whether or not they see themselves as 'disabled'". (Bajekal, Harries, Breman and Woodfield, 2004: pp. 4-5)

Hence, any research must be viewed in relation to the subjective nature of the meaning of disability. In addition, what constitutes a positive attitude toward disability needs to be defined in terms of the perspective from which it comes. The involvement of disabled people in the construction of what constitutes a positive attitude toward disability is therefore a key feature. As Makas (1988) says:

"Disabled people themselves need to be involved in identifying attitudes and standards, and in defining social interactions for study. Research in the past has looked at interactions between disabled and non-disabled people primarily, if not exclusively, from the point of view of the non-disabled interactant. Such a

methodology reinforces the view that disabled people are passive recipients of social interaction, rather than active social negotiators in interactions with non-disabled people. It is crucial that "real" disabled people, not role playing experimental confederates, participate in...the design of research..." (Makas, 1988)

Yuker (1983) concurs with Makas (1988) when he concludes:

"...there is a need for more extensive study of the attitudes of disabled persons toward disabled persons. While some disabled persons have attitudes that are similar to those of the non-disabled majority, others have attitudes that reflect those of a specific subgroup, or may even be idiosyncratic... We need to discover the experiences that account for the attitudes of disabled persons toward other disabled persons, in part because such attitudes may provide information about the attitudes of disabled persons toward themselves, and in part because such information is crucial for understanding as well as changing people's attitudes." (Yuker, 1983)

In a more recent article, Wahl (1999) notes how people with mental illnesses views are rarely sought for the purpose of research into mental illness and stigma. Wahl lists as the possible causes of this omission as, firstly the belief that it can be inferred from attitudes of the public what it must be like to live with a mental illness. Secondly, the desire for a controlled, experimental methodology, through which to gather the date. Thirdly, a desire not to intrude upon the lives of those already deemed to be "significantly burdened". And finally, a belief from researchers that due to the disorder causing impaired perceptions and cognition, the individual may not be able to accurately describe their experiences. Such views towards other disabled people with a variety of impairments may also explain the paucity of research that involves disabled subjects in any role other than as passive participants. Tregaskis (2000) warns however:

> *"...unless disabled people attempt to engage with the 'attitude issue' at a theoretical level (as we are forced to engage with it at an everyday practical level), then it will be more difficult to achieve systematic overall change."*
> (Tregaskis, 2000)

It could be therefore suggested that disabled people need to develop the discourse based around the way in which society 'disables' people, into one that incorporates the individual with an impairment who may face prejudice, social oppression and discrimination to varying degrees, depending upon the dimension of the attitude. Thus, the multi-dimensional nature of the attitudes towards disabled people, linked to a number of factors, such as genetics, employment, integration and social interaction, rights, and so on, needs to reflect how these factors will have a greater or lesser bearing depending upon the overall attitude towards an impairment group. For example, whilst the literature has revealed that disabled people in general view pre-natal testing with concern, and therefore to argue that a person should have such tests to avoid having a child with a disability is viewed negatively, the strength of the attitude is likely to vary, according to the impairment under discussion.

5.11 Conclusion

It appears a range of both direct and indirect methods exist by which attitudes toward disabled people can be gathered. It is important, however, to ensure not only is methodological soundness present within the research design, but also that ethical considerations are at the forefront. If disabled people are to be respondents in research into attitudes toward other disabled people, it is vital that the respondents are fully aware of the nature of the research, despite the limitations of the direct approach, such as attitude rating scales. In addition, the attitudes measured in such scales must reflect the beliefs of disabled people themselves, rather than the beliefs of non-disabled people. Hence, disabled people must be at the heart of any attitude scale construction, and such scales need to reflect the culture within which they will be utilised. It is also important that where attitude rating scales are utilised, they hold both internal and external reliability.

Whilst attitude scales such as the ATDP and the IDP have both been utilised to measure attitudes toward disabled people and have monographs (Yuker and

Block, 1986) and supporting materials such as manuals (Gething, undated), scale designers do not appear to offer the researcher detailed explanations of why the statements utilised reflect either a positive or negative attitude toward the attitude object (in this instance, disabled people). It is therefore the intention of this research, as part of the attitude scale design, to produce a detailed rationale for each statement used on the resulting scales. This will afford an opportunity for any future researchers as well as the reader to either accept or reject the premise upon which each statement, and therefore the scales as a whole, are based.

Chapter 6

Investigating Attitudes Toward Disabled People and Impairment: New Tools to Measure Cognition Toward Disability

6.1 Introduction

This chapter will present the method used for this research. The principal sections presented below are design, sample, measures, procedure, data collection and ethical issues. An explanation and justification for the design chosen for the research will initially be presented, followed by details of the sample. The measures (two attitude rating scales) developed and utilised for this research will be presented, with a rationale for each of the statements used in the two attitude rating scales as well as how the scales were developed. This section will also report the internal and external reliability of the scales and data produced through factor analysis performed on the scales. Next, the procedure by which the data was collected will be reported. Finally, the ethical issues relating to this research will be discussed.

6.2 Design

Having identified the hypotheses to be tested (see below) the data was collected using a non-experimental between-groups design. The approach taken was a ‘single observation’, whereby respondents were asked to complete the two attitudes rating scales (see Appendix G), the Social Acceptance List (see Appendix H) and the Demographic Data Questionnaire (see Appendix C) on one occasion. Whilst an experimental design is more powerful in terms of identifying causal relationships, it was decided a survey design method would yield data that would allow the hypotheses presented in this thesis to be tested. Anonymity of the participant was assured through a letter sent with the research tools (see Appendix F) and information about the researchers impairment was not given so to reduce the possibility of influencing the responses (see MacDonald and Nail, 2005). Advances in statistical methods have assisted scholars to control for plausible rival interpretations of a potential causal relationship (see Cook and Campbell, 1979) and therefore a series of inferential tests were employed to analyse the data (see Chapter 7, section 7.1).

The dependent variables for this research were attitudes toward disabled people and attitudes toward different impairment groups. The independent variables were: 1. whether the respondent was disabled or non-disabled; 2. levels of contact with disabled people; and, 3. the location the contact takes place (home, work/college, social).

Other methods considered for conducting this research, but ultimately rejected, that have been often utilised in measuring attitudes were Semantic Differential Scales, Q-sorts, social distancing scales and Sociometric scales. The Semantic

Differential Scale, instead of measuring the extent to how much a respondent believes in a particular concept, instead is concerned with assessing the subjective meaning of a concept to the respondent (Robson, 2002: p. 299). Such scales are designed to explore the ratings the respondent gives to a concept against a series of bipolar ratings, i.e. good/bad, happy/sad, boring/exciting. However, this form of measure is easy to fake and therefore rejected for this research. As social distancing scales, such as that used by Tringo (1970) (see Chapter 5) is also easy to fake, this was likewise rejected. For, it is easy to state you would have a relationship with a disabled person, or a person with a specific impairment, but the actual behaviour may be very different. Q-sorts methodology is used to measure the relative position or ranking of an individual on a range of concepts. However, this method is most often used with individuals and small groups as the analysis is extremely complex with large numbers of subjects (Robson, 2002). It was therefore felt this method was inappropriate for this research. Sociometric scales (sociometric techniques are designed to uncover how a person either intends to behave or actually behaves towards a referent, when given a choice of behaviours), but again, as disabled respondents would be asked their attitude toward other disabled people, there may have been a tendency for respondents to give responses that they believed would be appropriate, rather than a reflection of their true beliefs. For instance, members of a group are asked to make choices amongst other members of the group (e.g. whom they like). Whilst this method was attractive due to its simplicity, and the data in relation to the hierarchy of impairment appropriate, it would not necessarily yield as much data as an attitude rating scale. It was therefore decided that attitude rating scales would be developed, (see section 6.5 below), as this tool is easy to administer, gives a large amount of data, and is widely used in social psychology (O'Neal and Chissom, 1994).

6.3 Research Hypotheses

In light of the issues identified through the literature review, the hypotheses presented below will be tested. In order to perform this research, two attitude rating scales will be developed (the General Attitude Scale Toward Disabled People and the Attitude Toward Impairment Scale), alongside the research tools (the Demographic Data Questionnaire and the Social Acceptance List).

H1: Disabled people hold significantly more positive attitudes toward disability than non-disabled people

H2: A hierarchy of impairments exists between different impairment groups

H3: A hierarchy of impairments exists for non-disabled people

H4: Disabled people with high levels of contact with other disabled people will express more positive attitudes toward disabled people than disabled people with lower levels of contact

H5: There will be a statistically significant relationship between the nature of contact with disabled people (work, home, social setting) and attitudes toward disabled people

H6: People who identify themselves as having a disability will hold significantly more positive attitudes toward disabled people than disabled people who do not identify themselves as having a disability

H7: Attitudes of disabled people toward other disabled people will score significantly more highly on the Subtle Prejudice sub-scale than the Blatant Prejudice sub-scale

6.4 Sample

Three hundred and thirty one respondents completed the attitude rating scales, (217 disabled and 114 non-disabled). The disabled sample came from a variety of sources (see Table 6.32 below). These sources were chosen primarily in order to attempt to reflect a more generalised population of disabled people, rather than those people who identify as disability activists. Listed below are a series of tables detailing the disability status, impairment status, contact, location and quality of contact with disabled people, age, sex, employment status, ethnic origin and educational level, for both disabled and non-disabled groups.

The size of both the disabled and non-disabled samples were above the minimum required for statistical testing for each of the statistical tests utilised in this research (see Appendix J for description of statistical tests). For instance, two-sample t-test requires a total sample minimum of 49 subjects, with a good sample being between 126- 784 subjects (Dunbar, 1998).

Through detailed scrutiny of the data, disabled and non-disabled data sets were created. The disabled sample includes any respondent who answered anything other than "no" to all three questions (8, 9 & 10) on the Demographic Data Questionnaire (see Appendix C for a version of the questionnaire and Appendix D for a rationale for items included in the questionnaire). In addition, people who were known to belong to the disabled sample, (for instance, people who had been referred by a Disability Employment Advisor onto a Residential Training programme and therefore had been categorised as disabled by a professional) but did not self-identify as disabled, were also placed in the disabled data set.

This data allowed the sample to be divided into a series of comparison groups upon which the dependent variable (attitudes toward disability and impairment groups) was statistically tested. Hence, comparisons between disabled and non-disabled people, males and females, people with differing levels of contact with disabled people, people with different impairments, and so on.

Below are a series of tables containing a breakdown of the sample according to these different categories.

Table 6.1: Disability Status of Sample from Questions 8 9 & 10 on Demographic Data Questionnaire

Disability Status		Number	Percentage
Do you have a disability?	Yes	204	61.6
	No	123	37.2
	Don't Know	4	1.2
Do people who know you well think you have a disability?	Yes	161	48.6
	No	152	45.9
	Don't Know	18	5.4
Do people who do not know you well think you have a disability?	Yes	84	25.4
	No	211	63.7
	Don't Know	18	10.9

Table 6.2: Size of Disabled and Non-Disabled Samples

	Number	Percentage
Disabled	217	65.56
Non-Disabled	114	34.44
Total	331	100

Table 6.3: Sex Distribution of Disabled & Non-Disabled Samples

Sex	Number		Percentage	
	Non-Disabled	Disabled	Non-Disabled	Disabled
Male	38	109	33.30	50.20
Female	76	108	66.70	48.80
Total	114	217		

Table 6.4: Age Distribution of Disabled & Non-Disabled Samples

Sex	N		Mean Age		Standard Deviation	
	Non-Disabled	Disabled	Non-Disabled	Disabled	Non-Disabled	Disabled
Male	38	109	45.66	45.68	12.434	13.019
Female	76	107 (1missing)	39.64	47.21	13.522	15.118

Table 6.5: Number of Disabled & Non-Disabled Samples with a Disabled Person as a Family Member

Family Member with a Disability	Number		Percentage	
	Non-Disabled	Disabled	Non-Disabled	Disabled
Yes	27	71	23.7	32.7
No	87	146	76.3	67.3
Total	114	217		

Although respondents were asked to provide the nature of the relationship with the family member, i.e. brother, sister, mother, father, etc., the vast majority of respondents failed to supply this data. No meaningful analysis was therefore possible under this independent variable.

Table 6.6: Ethnic Origin of Disabled & Non-Disabled Samples

Ethnic Origin	Number		Percentage	
	Non-Disabled	Disabled	Non-Disabled	Disabled
White British	97	204	85.1	94.0
Black British	0	2	0.0	0.9
White European Non-UK	11	5	9.6	2.3
White Non-European	5	0	4.4	0.0
Other	0	5	0.0	2.3
Prefer not to say	1	1	0.9	0.5
Total	114	217	100	100

Table 6.7: Educational Achievement of Disabled & Non-Disabled Sample

Level of Qualification Achieved	Number		Percentage	
	Non-Disabled	Disabled	Non-Disabled	Disabled
None	4	40	3.5	18.4
GCSE / O Level / (G) NVQ Level 2	20	60	17.5	27.6
A Level / (G) NVQ Level 3	15	31	13.2	14.3
Diploma / NVQ Level 4 / HND	9	33	7.9	15.2
Degree	35	19	30.7	8.8
Post-Graduate Qualification	28	16	24.6	7.4
Other	3	18	2.6	8.3
Total	114	217	100	100

Table 6.8: Special Needs Schooling of Disabled Sample

	Number of Sample	Mean Number of Years	Standard Deviation
Yes	39	6.84	4.097
No	178	N/A	N/A

Table 6.9: Employment Status of Disabled and Non-Disabled Sample

Employment Status	Number		Percentage	
	Non-Disabled	Disabled	Non-Disabled	Disabled
Full-time Paid	62	37	54.4	17.1
Part-time Paid	24	26	21.1	12.0
Full-time Voluntary	0	6	0	2.8
Part-time Voluntary	2	21	1.8	9.7
Unemployed Due to Age (Retired)	11	17	9.6	7.8
Never Worked Due to Disability	0	10	0	4.6
No Longer Work Due to Disability	0	74	0	34.1
Training	12	24	10.5	11.1
Other	3	2	2.6	0.9
Total	114	217	100	100

Table 6.10: Duration as a Disabled Person Distribution (Disabled sample only)

Duration	Number	Percentage
Never	21	9.7
1 – 2 years	28	12.9
3 – 5 years	36	16.6
6 – 10 years	28	12.9
11 –15 years	18	8.3
16 – 20 years	19	8.8
21 years or over	29	13.4
Always	38	17.5
Total	217	100

Table 6.11: Frequency of Contact with Disabled People (Non-Disabled Sample)

Frequency of Contact	Work / College (n)	Home (n)	Social Activities (n)
	(% in brackets next to number)		
Daily	25 (21.9)	5 (4.4)	8 (7.0)
Weekly	17 (14.9)	11 (9.6)	25 (21.9)
At Least Once a Month	11 (9.6)	5 (4.7)	28 (24.6)
Once Every Three Months	10 (8.8)	10 (8.8)	15 (13.2)
Less Often than Once Every Three Months	51 (44.7)	83 (72.8)	38 (33.3)

Table 6.12: Frequency of Contact with Disabled People (Disabled Sample)

Frequency of Contact	Work / College (n)	Home (n)	Social Activities (n)
	(% in brackets next to number)		
Daily	73 (33.6)	63 (29.0)	41 (18.9)
Weekly	44 (20.3)	26 (12.0)	75 (34.6)
At Least Once a Month	21 (9.7)	22 (10.1)	45 (20.7)
Once Every Three Months	13 (6.0)	5 (2.3)	6 (2.8)
Less Often than Once Every Three Months	66 (30.4)	101 (46.5)	50 (23.0)

Table 6.13: Size of Contact with Disabled People (Non-Disabled Sample)

Frequency of Contact	Work / College (n)	Home (n)	Social Activities (n)
	(% in brackets next to number)		
Nil	50 (43.9)	76 (66.7)	34 (29.8)
1 disabled person	26 (22.8)	25 (21.9)	38 (33.3)
2 – 5 disabled people	23 (19.3)	13 (11.4)	39 (34.2)
6 – 10 disabled people	6 (5.3)	0	2 (1.8)
11 – 20 disabled people	3 (2.6)	0	1 (0.9)
21+ disabled people	7 (6.1)	0	0

[NB: Not all respondents would have been in employment or within an educational environment, thus increasing the number of responses for the zero category]

Table 6.14: Size of Contact with Disabled People (Disabled Sample)

Frequency of Contact	Work / College (n)	Home (n)	Social Activities (n)
	(% in brackets next to number)		
Nil	103 (47.5)	106 (48.8)	59 (27.2)
1 disabled person	19 (8.8)	56 (25.8)	40 (18.4)
2 – 5 disabled people	27 (12.4)	40 (18.4)	65 (30.0)
6 – 10 disabled people	23 (10.6)	5 (2.4)	26 (12.0)
11 – 20 disabled people	12 (5.5)	1 (0.5)	14 (6.5)
21+ disabled people	33 (15.2)	9 (4.1)	13 (6.0)

[NB: Not all respondents would have been in employment or within an educational environment, thus increasing the number of responses for the zero category]

Table 6.15: Self-Rating of Relationship with Disabled People (Non-Disabled Sample)

Relationship with Disabled People Rating	Work / College (n)	Home (n)	Social Activities (n)
	(% in brackets next to number)		
Very Good	39 (34.2)	31 (27.2)	29 (25.4)
Good	34 (29.8)	28 (24.6)	50 (43.9)
Okay	8 (7.0)	9 (7.9)	15 (13.2)
Poor	1 (0.9)	2 (1.8)	4 (3.5)
Very Poor	0 (0.0)	2 (1.8)	0 (0.0)
Missing Value	32 (28.1)	42 (36.8)	16 (14.0)

Table 6.16: Self-Rating of Relationship with Disabled People (Disabled Sample)

Relationship with Disabled People Rating	Work / College (n)	Home (n)	Social Activities (n)
	(% in brackets next to number)		
Very Good	69 (31.8)	72 (33.2)	86 (39.6)
Good	46 (21.2)	47 (21.7)	80 (36.9)
Okay	23 (10.6)	19 (8.8)	20 (9.2)
Poor	3 (1.4)	5 (2.3)	4 (1.8)
Very Poor	2 (0.9)	4 (1.8)	4 (1.8)
Missing Value	74 (34.1)	70 (32.3)	23 (10.6)

Table 6.17: Impairment Category of Disabled Sample from Question 16 of Demographic Data Questionnaire

Impairment Category	Number	Percentage
Hearing Impairment	7	3.2
Learning Difficulties	10	4.6
Mental Health	30	13.8
Physical (Non-Wheelchair User)	72	33.2
Sight Impairment	10	4.6
Wheelchair User	49	22.6
Multiple Impairments	28	12.9
Other	4	1.8
Not Applicable	7	3.2
Total	217	100

Table 6.18: Type of Impairment of Disabled Sample from Question 11 of Demographic Data Questionnaire

Impairment Category	Number	Percentage
Arthritis	41	18.9
Depression	17	7.8
Spina Bifida	12	5.5
Cerebral Palsy	9	4.1
Multiple Sclerosis	10	4.6
Epilepsy	4	1.8
Myalgic Encephalomyelitis (ME)	6	2.8
Spinal Injury	12	5.5
Sight Impairment	11	5.2
Hearing Impairment	7	3.2
Mental Health (non-depression)	15	6.9
Other Impairments	63	29.0
Not Disclosed	10	4.6
Total	217	100

6.5 Measures

Robson (2002) recognises how it is *"...distressingly common to see scales cobbled together by assembling an arbitrary group of statements which sound as if they would be relevant, with similarly 'of the top of the head' ratings assigned to different answers, and a simple addition of these ratings to obtain some mystical 'attitude score'"* (p. 293). It is therefore recommended to utilise a 'systematic procedure' based on methods developed and tested by researchers such as Likert earlier in the 20th Century (see Robson, 2002: pp. 292-308 for analysis of commonly used tests and scales).

In light of O'Neal and Chissom's (1994) finding that rating scales, rankings and paired comparison tasks, when measuring attitudes, all demonstrated general agreement, the use of an attitude scale was chosen for this research. For, as O'Neal and Chissom also conclude, rating scales tend to yield more information than the other two methods and is also easier to administer. When considering the potential diversity of the respondents for this research, this factor may have important implications. However, the development of an attitude scale requires careful thought and repeated conceptualisation (Oppenheim, 1992) to ensure the final tool measures what the researcher actually wants to measure. This research recognises the potential threats to validity when using direct methods of measuring attitudes (Antonak and Livneh, 2000: p. 215) and therefore has attempted to minimise these threats.

A key aspect of the research tools developed was the development of the attitude statements to be included on the final scales (see below for rationale on each statement). An attitude statement can be defined as "... *a single sentence that expresses a point of view, a belief, a preference, a judgement, an emotional feeling, a position* for *or* against *something*" (Oppenheim, 1992: p. 174). The initial list of seventy-eight statements (see Appendix E) was drawn-up from a combination of sources. These sources were:

1. Literature review
2. Semi-structured interview with four disabled people attending day care services (see Appendix A)
3. Four responses to questionnaire from respondents working and/or living in Supported Workshops or Supported Housing for disabled people (see Appendix A for responses and Appendix B for questionnaire)
4. Questionnaire circulated to 10 disabled people living in the community (see Appendices A and B)

The statements were written in line with Oppenheim's (1992: pp. 174-186) recommendations for drawing-up statements for attitude scales and Edwards' guidelines for selecting statements for a Likert-type scale (cited in Aiken, 1996:

pp. 231-232). Edwards suggests scale developers should follow the following guidelines:

- Avoid statements that refer to the past rather than to the present
- Avoid statements that are factual or capable of being interpreted as factual
- Avoid statements that may be interpreted in more than one way
- Avoid statements that are irrelevant to the psychological object under consideration
- Avoid statements that are likely to be endorsed by almost everyone or by almost no one
- Select statements that are believed to cover the entire range of the affective scale of interest
- Keep the language of the statements simple, clear, and direct
- Statements should be short, rarely exceeding 20 words
- Each statement should contain only one complete thought
- Statements containing universals such as all, always, none, and never often introduce ambiguity and should be avoided
- Words such as only, just, merely, and others of a similar nature, should be used with care and moderation in writing statements
- Wherever possible, statements should be written in simple sentences rather than compound or complex sentences

- Avoid the use of words that may not be understood by those who are to be given the completed scale
- Avoid the use of double negatives

Each of the four sources of information above were used to formulate a series of attitude statements that reflected disabled people's views on disability, including the participation of socially valued roles, such as parenting and work, as well as interacting in society, such as living in the community and utilising services such as restaurants and cinemas.

The attitude statements were then compiled into a form which was circulated to a 'panel' of five disability experts, all of whom were disabled people, and coming from a variety of perspectives. The use of disabled people in the development of the attitude scales and questionnaire has been an important component of this research throughout. This is not in order to use disabled people as simply respondents or experimental subjects, but to ensure that the tools designed as a result of this research, genuinely reflect the opinions of as wide a cohort of disabled persons as possible. It is also important to stress at this stage, this research does not refute that non-disabled perspectives on disability are valuable (as commented on by the postmodernist's Price and Shildrick, 2002) – on the contrary. The design of these scales, however, coming from a disabled person standpoint, may give an insight into the tension experienced in interactions between disabled and non-disabled people due to misunderstanding, as identified by Makas (1988), as well as between people with different impairments.

The attitude statements form was sent with an accompanying letter requesting their assistance in this research, and the Demographic Data Questionnaire (see Appendix C) to the five disability experts. These people were chosen primarily because of their knowledge of disability related issues and were either known to the author or recommended as a disabled person with a positive attitude toward disability.

The experts on disability were asked to state against each statement:

a) They felt whether the statement was positive or negative towards disabled people by placing either a + or a – symbol.

b) They felt whether the statement was either blatant or subtle by placing a 'B' for blatant of an 'S' for subtle.

c) They felt whether the statement reflected the individual or the social model of disability by placing an 'IM' for the individual model or an 'SM' for the social model.

d) Which group they felt the statement belonged, (rights, employment/training, financial, integration/socialisation, other)

In order to ensure that the statements included on the pilot attitude scales had a consensus as to whether they reflected a positive or negative attitude, the disability experts were asked to state whether they believed the statement was positive or negative. Whilst for some statements this was relatively easy, for others, such as those relating to genetic testing, responses were not so clear cut. In conjunction with both the literature and the disability expert's views, each of the eighteen statements included in the pilot General Attitude Scale Toward Disabled People (see Appendix G) were assigned a status of being either a positive or negative statement, which in turn, determined the scoring received (see below for comments on scale scoring).

A definition of disability was included for both the medical/individual model (Wood, 1980) and social model of disability (Finkelstein and French, 1993). This was to ensure that each of the 'disability experts' used the same criterion to judge whether the statement belonged to the medical/individual or social model of disability.

Although one of the purposes of the scale was to ascertain whether a hierarchy of impairments exists, principally using the social model of disability as the basis of measurement, the term 'people with disabilities' was used at this stage. 'People with disabilities' was chosen over 'disabled people' as it was closer to the final terminology that would be used, for instance 'people with cerebral palsy' or 'people with schizophrenia', on the Attitudes Toward Impairment Scale. This was felt to be acceptable as research has shown that the use of either of these terms when measuring attitudes toward disabled people has no significant affect, (Lynch, Thuli and Groombridge, 1994; Millington and Leierer, 1996). However, it should be acknowledged that the term 'disabled people', with its affirmation of identifying disability as a positive status, is widely regarded in the United Kingdom as the most appropriate, especially by disabled activists who subscribe to the social model of disability (Gordon and Rosenblum, 2001).

The four groups listed under d) above (rights, employment/training, financial and integration/socialisation) were chosen as they appeared to represent the main themes arising from the statements produced for the attitude rating scales. Each of these themes also fell within the social model of disability paradigm. The final eighteen items selected for the General Attitude Scale Toward Disabled People reflected at least one of these four groups.

On completing the initial development of the two attitude scales, they were then piloted on disabled people to test the internal validity of the tools.

Presented below is a rationale for the inclusion of each of the eighteen statements utilised in the General Attitude Scale Toward Disabled People (GASTDP) and the five repeated statements on the Attitude Toward

Impairment Scale (ATIS) (see Appendix G for complete attitude scales and scoring). This is in order to give the reader a fuller understanding of the perspective from which this research is based and therefore the interpretation of the results. Whilst these attitude rating scales have been developed specifically for this research, it hoped by having the rationale for each statement future researchers will be able to utilise these tools.

Each rationale should also be viewed in light of the literature review presented above and the information gathered through the development of the scale statements (see Appendix A). As Cronbach (1990: p. 186) astutely comments, *"Many sentences are required to defend an inference from a score"*. Each individual statement should not be regarded as a reflection of a respondent's attitude. It is the sum of the responses to the eighteen statements on the GASTDP that gives the measure of the respondent's attitude toward disabled people in general. Likewise, the ATIS contains seven sub-scales, each one producing a score reflecting the respondent's attitude toward the specific impairment group.

This section attempts to give future researchers the opportunity to challenge to rationale behind each statement, recognising that attitudes are not only culturally bound, but also tied to a specific period of time. It should also be noted that responses to these statements by disabled people are a reflection of disabled people's attitudes toward other disabled people.

Covering Statement on Scales

The statement below was placed on both the General Attitude Scale Toward Disabled People and the Attitude Toward Impairment Scale (with the exception of the word 'different' that was used only on the Attitude Toward Impairment Scale in order to emphasise the scale was tapping into attitudes toward different impairment groups) in order to give the respondent brief instructions on how to complete the scale.

*"Listed below are a number of statements that are said to describe what people think about different disabled people. Usually, what we think about individuals depends on how well we know them. However, we would like to know what you think **in general**. Please read each statement carefully and then tick the box that best describes how you usually feel."*

This statement is based on Gething's statement at the head of the Interaction with Disabled Persons Scale (Gething, undated). The use of the words "in general" is important when considering the diverse nature of disability and impairment. For instance, the functional ability of two people with cerebral palsy may range from one person being able to walk without the need of prosthesis, to someone without speech and using a powered wheelchair, to someone with a very limited physical and cognitive ability range. Thus, both scales draw on the respondents stereotyped beliefs (which may be either accurate or inaccurate) about disabled people in general and specific impairment groups.

Rationale for General Attitude Scale Toward Disabled People Statements

Each of the eighteen statements on the General Attitude Scale Toward Disabled People were drawn from the original list of 78 statements circulated to the Disabled Experts (see Appendix E) after their responses had been analysed, and re-written where necessary, in order to increase the likelihood of construct validity.

No. 1 *"Residential care is usually the best option for disabled people"*

There appears to be a general consensus amongst disabled people that residential care should be regarded as the last option, with community-based self-directed options as the more appropriate living/care alternative (Batavia, 2002). Just the idea of returning to a large residential institution can cause some groups of disabled people to express their fear in highly emotional ways (Stalker and Hunter, 1999). This is not to argue that residential care is bad, *per se*, as many disabled people find they have greater independence and social interaction in aresidential care setting than in an integrated living environment (Morris, 1993). Statement 1 aims to challenge the <u>assumption</u> that residential care is the most appropriate option for disabled people as a homogenous group, rather than seeing it as simply one living option that may or may not suit the needs of the individual. The word 'usually' has therefore been utilised in this attitude statement, to draw upon the assumption that residential care is the most appropriate living option for disabled people, rather than within a more independent living environment.

McKenna (1997) in reviewing research relating to rehabilitation methods for people with acute schizophrenia identified that those 'patients' living in community based hostels with programmes to assist the individual to maintain and/or improve self care as well as acquiring domestic skills, were more likely to improve than those in more 'traditional' hospital settings (pp. 233-237). In relation to people with Down's syndrome (or other forms of learning disabilities) the UK Government strategy for people with learning disabilities *Valuing People* (DoH, 2001) supports the policy of integration. The paternalistic attitude toward people with Down's syndrome is being challenged, with increasing numbers now living successfully in the community, supported by innovative approaches (O'Hara, 2004b).

No. 2 *"Disabled people have a responsibility to seek employment if they are able to do so"*

Linked to the concept of *rights* is *responsibility*. As equal citizens within UK society, disabled people not only have rights that should be protected, but also have responsibilities (a view supported by North American based disability organisations advocating the right of self-determination (Powers *et al,* 2002)). Statement 2 draws on the rationale that linked with the right to be treated as equal citizens, often expressed in terms of wanting to be treated 'normally' (Wates, 1997), then part of that equality must be a willingness to take on the responsibilities of a citizen. Within Western culture, this may include work. It should also be noted that work or employment does not mean the ridged 9 to 5 culture. Statement number 2 does not argue that all people should seek employment, but those who '*are able to do so*'. This does not remove the right of the person who chooses not to work because of other demands on his or her life, such as childcare. But rather, suggests that if a person has the ability to function in the sphere of employment, then they should do so, with parity to other citizens (which includes choosing not to work if the person can afford not to). The need for flexible work practices, as advocated by Miller, Parker and Gillinson (2004: p. 47), may assist disabled people to take up the responsibility to contribute to society through work activities.

This statement is regarded as a positive statement due to the expression of a desire to be treated 'normally' by society, including a number of disabled people who contributed in the production of this scale (see Appendix A). Such views are supported by the United Nations, in that, in the *Standard Rules on the Equalization of Opportunities for Persons with Disabilities* (United Nations, 1993) they state, not only should disabled people have equal rights but also obligations alongside all other citizens. This standpoint is echoed in the UK Government's policy of 'work for those who can, security for those who can't' (DWP, 2002: p. 5).

It is also helpful to view statement 2 in light of the literature review presented in Chapter 3.

No. 3 *"Disabled people have a right to do government sponsored vocational training schemes even if they are unlikely to get a job"*

Statement 3 suggests that all disabled people, who choose the employment option, have a right to the same opportunities as their peers, despite the greater barriers they may face. The statement, whilst raising the issue that the individual may be *"unlikely to get a job"*, which can be supported by the high unemployment rates for disabled people (DfEE/Skills and Enterprise Network, 1999), it makes no mention of the nature of the barriers that may be faced. The reason the disabled individual is unable to gain employment, may be as a result of poor skills and knowledge directly relating to that person's impairment. But equally may be as a consequence of negative attitudes of employers, inaccessible public transport, poor quality educational opportunities, and so on, (see McCleary and Chesteen, 1990). To illustrate the power of this statement, if 'disabled people' was to be replaced with 'black people', a rejection of such a statement could be viewed as discriminatory, despite unemployment rates for the Black and Minority Ethnic (BME) community being greater than that of the white community (Strategy Unit, 2003).

In addition, with an emphasis on 'outcome' funding provided to training providers by the UK Government, some disabled people may find themselves excluded from training programmes, due to the training providers need to meet financial targets. As O'Flynn and Craig (2001) argue, (with reference to people with mental health problems), good practice must be the inclusion of the *"more disabled"* and not just the achievement of good outcomes through careful selection onto training programmes. This statement therefore suggests that a positive attitude is reflected in viewing the *right* to vocational training as part of an equalisation process that may assist disabled people to compete with others in the labour market, regardless of possible outcomes.

The therapeutic value of work should not be ignored, for instance, people with schizophrenia are more likely to make a speedier recovery if in a stimulating environment (Birchwood and Jackson, 2001: p. 107). One such environment is training for a job, with the actual finding of a job being an important aspect of recovery (Secker, Membrey, Grove and Seebohm, 2002: p. 411). Russinova *et al* (2002) have also found that people with schizophrenia can make a 'vocational recovery', whereby people in their study (n = 109) consistently sustained paid employment despite the individual living with long-term mental illness. This standpoint is supported by O'Flynn and Craig (2001) who argue that those with 'persistent negative symptoms' can sustain employment given appropriate reasonable adjustments within the work place, although people with mental health problems have disproportionately high levels of unemployment and limited opportunities to obtain appropriate vocational support (p.1).

No. 4 *"Disabled people should be required by law to have genetic testing to see whether they would pass their impairment onto their child"*, and,

No. 5 *"It is important for people with certain impairments to have genetic testing so they know whether their child will inherit the same impairment"*

Whilst statements 4 and 5 appear similar in nature, they are approaching the controversial and emotive subject of genetic testing from two different angles. No. 4 is a negative statement as it imposes upon disabled people the legal obligation to be medically tested. Such a legal obligation could be seen as an infringement of civil liberties, and at the very least, placing an obligation upon disabled people that is not placed upon the non-disabled population. From this perspective, statement 4 is regarded as negative, due to the infringement of human rights.

Statement No. 5 however, can be viewed as a positive statement as it offers the individual information from which they can make a more informed decision. Rather, than as is often the case, whereby genetic counsellors and physicians suggest selective abortion is a 'good thing' (Sharp and Earle, 2002). It should be noted from the literature, that this information might in fact enable the disabled person to choose to have a disabled child (Harris, 2000; McCullough in McCullough and Duchesneau, 1999; and Reindal, 2000) and thus be proactive and positive about passing-on their impairment. This is noticeable within the Deaf community (Middleton, Hewison and Mueller, 1998). Therefore, it should not be assumed that knowledge of this nature will automatically to be used to assist in decision making with respect to the termination of a pregnancy or not to attempt to have children at all. Chen and Schiffman (2000) offer an important glimpse of disabled people's views towards genetic testing from a small (but important) sample (n = 15) which appears to challenge the disabled activist standpoint of linking genetic testing to eugenics. Hence, the statements used in this scale relate to basic rights of freedom and the right to information without prejudiced opinions.

No. 6 *"Having a disabled person as a colleague would mean the non-disabled person would be given extra work and responsibility"*

This statement taps into the respondents' assumptions about the limitations of people with an impairment and the direct consequence it may have upon other people, i.e. additional work and responsibility for other people. Daone and Scott (2003: p. 44) found from a questionnaire survey of employers (n = 250), employees (n = 440) and disabled respondents (n = 279), that 18.7% of employers said they might not employ a disabled person because they may need more support from management and 26.4% of employees felt this also to be the case. 77.7% of disabled respondents felt employers wouldn't employ a disabled person because they would think the disabled person would require more support from colleagues or managers. Such assumptions about a disabled employee are likely to be unfounded, and where additional assistance is required, this is often as a direct consequence of the environment.

If beliefs of this nature are acted upon to the extent of refusing a disabled person a job or promotion, (assuming that the disabled person is the best person for the job), under the Disability Discrimination Act (1995) they could be illegal. Thus, according to Daone and Scott (2003), not only are significant numbers of employers and employees prepared to discriminate against disabled job applicants, but disabled people hold highly sceptical views as to non-disabled attitudes towards employing them. This statement is categorised as being subtle as it does not state the disabled person should not be employed (which could be viewed as a blatant statement) but rather a consequence of employing them may have an impact upon the non-disabled colleague.

No 7 *"Disabled people would be happiest living alongside other disabled people"* and,

No. 13 *"Disabled people are happiest when working alongside other disabled people"*

Independent living and access to integrated, mainstream services have long been a goal of many disabled people (Boyle, 1997; Christie and Mensah-Coker, 1999; Christie, Batten and Knight, 2000; Commission of the European Communities, 2000; Cook, Swain and French, 2000). Therefore, the assumption that disabled people wish to work and live alongside each other, especially when this is the only option available, is questionable. As Hyde (1998) notes, a number of disabled people working within Supported Workshops (and therefore working alongside significant numbers of disabled people) found this working environment stigmatising. However, as literature relating to the disability movement has also identified (for example, Campbell and Oliver, 1996; Fleischer and Zames, 2001), great strength can also be drawn by individuals by forming support groups (Barnes and Shardlow, 1996). These groups, however, often come together with a common goal, (i.e. to challenge an oppressive society, or find psychological support), and most importantly are associating with each other by choice. Many disabled people living in residential care, or working in a Supported Workshop, did not actively seek out this option, but found it was the only option open to them.

It is also helpful to view statement 2 in light of the literature review presented in Chapter 3, section 3.7, with particular reference to the discussion on the location where a person lives.

No. 8 *"Disabled people should be protected from situations that are likely to cause stress or anxiety to themselves"*

Whilst it is not the intention of this research to discuss the concept of stress, it is helpful at this point to give it a brief consideration in light of statement 8. Hans Selye identified stress as a biological concept through the creation of the general adaptation syndrome (GAS) or stress syndrome (Selye, 1956). The GAS is divided into three phases: the first phase being the alert or alarm reaction phase as an initial response to an aggressive agent; phase two is the resistance phase whereby the body attempts to adapt to the presence of the 'aggressor'; and third the exhaustion phase when the body fails to eliminate the aggressive agent (Franco, de Barros, Nogueira-Martins and Michel, 2003). Stress is variously defined as *"referring to aversive events associated with reports of negative mood states"* (Boyle, 2002: p. 255) and *"negative life* *events and emotional distress"* (Rutledge and Sher, 2001). Selye (1976) later argued that stress was always present in our lives and did not necessarily cause harm. It is the coping strategies, or management of stress, that becomes important, many of which come from exposure to situations from which people learn.

Part of being a citizen who takes responsibility for their own actions often requires an individual to face exacting situations. Going to a job interview, starting a new college course, meeting someone for the first time, taking an academic examination, starting or ending an intimate relationship, et cetera, can create levels of stress or anxiety. It is this common sense concept of stress and anxiety that subjects will be responding to.

A number of disabled respondents in the early development of the GASTDP stated the desire to be treated as a 'normal' person. Part of this normality can be expressed in terms of facing levels of stress and anxiety when interacting with others or meeting new challenges that are deemed normal. However, Gething (1992) refers to the ongoing overprotection by parents of their disabled child and thus the denial of the opportunities to develop skills and independence, as the 'dignity of risk' is denied (p. 187). Or, to put it another way, to learn from the consequences of our actions. Deeley (2002) states, when discussing the conflicts faced by professionals working with people with learning disabilities with respect to the principles of normalisation, *"Generally,* *the 'paternalists' and parents express the wish to protect people with learning disabilities from unpleasant experiences, but it is these very experiences that help towards human growth".* This does not argue that people should deliberately be put in situations that are going to cause ill health or prolonged stress. But rather, that disabled people are entitled to the right to participate fully in society, and as such, should be entitled to face appropriate levels of stress or anxiety, considered normal for a person living in our society. Nochi (1998) for instance, identified how people who had experience a traumatic brain injury wanted to take back control over their lives, and not be protected by loved ones or the medical and para-medical professions. In short, disabled people should not be mollycoddled, but given the tools to cope. As a consequence, statement 8 is seen as a subtle, negative statement. In other words, to protect disabled people from situations that may cause stress or anxiety is viewed as over protective, paternalistic, and ultimately damaging to the individual.

People with learning disabilities are often treated in a childlike manner; for instance, if a relative or a loved-one dies or becomes seriously ill, this is likely to be viewed as a stressful life event. Prolonged grief reactions can however be caused by the disabled person (in this instance, people with learning disabilities) not being involved in the funeral rituals (Raji, Hollins and Drinnan, 2003). Thus, 'protecting' the disabled person from this information, by not informing them, can in itself create distress at a later date. Hays *et al* (1994) would support this assertion as they found through interviews with 25 gay men with AIDS, that of the eleven 'unhelpful' behaviours identified towards people living with AIDS, one was treating people living with HIV/AIDS in a patronising or overprotective manner. What is important is how information or stressful life events are managed. Thus, whilst people with HIV/AIDS, arthritis and schizophrenia can become ill as a consequence of undue stress, the avoidance or shielding from such situations is not necessarily a positive solution.

Birchwood and Jackson (2001) in relation to people living with schizophrenia discuss a range of 'coping' strategies ranging from cognitive therapy (pp. 121-123) to social skills training (pp. 108-110), taking the view that people with schizophrenia and other schizo-affective disorders can live full and active lives within the community, whilst recognising the realities of this impairment. These authors importantly draw a distinction between the intrinsic impairment of schizophrenia (e.g. hallucinations) and the secondary impairments (e.g. unemployment, poverty, et cetera). Thus, the individual is not 'protected' from the stressor, but deals with it in a proactive manner. Schiller and Bennett (1994) give a personalised and often harrowing account of Lori Schiller's experiences of living through psychotic periods of her life as a result of schizophrenia. However, Schiller and Bennett ultimately identify, that in conjunction with improved medication, individualised coping strategies enabled Schiller to manage life's stresses and anxieties, without relapsing into another psychotic episode. This enabled her, after many years of hospitalisation, to live in a house on her own in the community, hold down a job and plan for a positive future, including marriage and family life.

Clearly, one person's story does not make a theory. But it does serve as an illustration to a movement towards positive life-styles for people with mental health problems, rather than institutionalised care. Warner (2000: p. 109) too lists cognitive-behavioural therapy, as well as drugs such as benzodiazepines to reduce stress-induced symptoms, to assist people living with schizophrenia, in order to manage stressful life events, but does not suggest the avoidance or protection from them.

Stress has been associated with the onset of rheumatoid arthritis for people with a genetic disposition (Arthur, 1998). However, this, by definition, means good coping strategies toward stressors will assist in reducing the incidence of this form of arthritis. Stress has also been linked to living with arthritis, although this is in part due to the limiting of social roles and the ability to function independently (Burke *et al*, 2002: p. 276). Whilst the relinquishing of social role obligations has been found to be positive in women with rheumatoid arthritis (n = 20), this small sample tended to be of people in later life and therefore may be due as much to the aging process as the rheumatoid arthritis (Plach, Stevens and Moss, 2004). The solution to the 'problem' tends to be viewed in terms of cure, thus taking a medical model approach (such as pain management), whereas if support mechanisms that make maintaining socially valued roles possible (for instance, comfortable and accessible public transport or making the built environment more accessible) the self-esteem is more likely to be maintained and therefore lowering stress.

Therefore, a positive attitude towards disabled people in relation to the issue if dealing with stress or anxiety lies in how such events are managed; in other words, good stress management. Simply trying to protect a disabled person from any form of stress or anxiety life may bring, is likely to inhibit the opportunity for developing long-term coping strategies, thus leaving the individual vulnerable when unavoidable stressful events have to be faced.

No. 9 *"A restaurant owner should be allowed to refuse service to a disabled person if they upset other customers because of their impairment"*, and,

No. 11 *"A cinema should be able to refuse entry to a disabled person if their presence spoils the show for other customers"*

Statements 9 and 11 both reflect the right of disabled people to access the same services as other people (Knight and Brent, 1998; Knight and Brent 1999), as enshrined in the law under the Disability Discrimination Act (1995) (see Disability Rights Commission, 2000). These statements reflect disabled person's experiences of being denied the opportunity to enjoy the same services as other people, because of their impairment. Both statements draw on the notion that the presence of a disabled person in a social situation with people they do not know, i.e. in a restaurant or cinema, may cause other customers some discomfort or embarrassment. The idea that the proprietor should have the right to exclude an individual, on the basis that his/her impairment is the source of the discomfort to other customers, is seen as a negative behaviour of a blatant kind.

These statements do not argue that disabled people have the right to behave anti-socially (any more than any other person), but that disabled people should not be excluded from enjoying the same services and entertainment as other people solely because of their impairment. For instance, Linton (1998: p. 34) cites the two anonymous women who suggest how disabled people should be positioned behind plants in restaurants, so as not to offend other customers. This is due to the assumption that a disabled customer using a wheelchair will be offensive to look at and have '*food running down her chin*'. Thus, by statements 9 and 11 using the term 'disabled person' rather than referring to any specific impairment group, the respondent will be tapping into their own stereotyped views of disabled person's behaviour in general.

No. 10 "*Disabled people should be charged for care services on the basis of their ability to pay*", and, No. 14 *"Disabled people should be charged for care services if they are employed"*

Statements 10 and 14 are both regarded as negative. These statements are based on the premise that unlike other minority groups, there are often additional financial costs associated with disability through the provision of care. This care, as with basic health care, should be viewed as a fundamental human right, free of means testing and budgetary constraints (Houston, 2004). It can therefore be argued that this cost should be borne by society as a whole rather than the individual, in the same way that all tax payers pay for the education of children, regardless of whether they have children themselves or not. If the individual is in employment they will be paying income tax and National Insurance, and therefore making a contribution towards the financial cost of the care provision. Although some local authority policy makers have argued that disabled people should pay for care services received, on a means tested basis, disabled people appear to have rejected this.

An illustration of the strength of feeling from disabled people towards the notion of charging for care services can be seen in the newsletter 'Direct', produced by disabled people, for disabled people, who use Direct Payments as a method providing care services. Issue No. 96 of 'Direct' (September 2001) calls for disabled people in Hampshire to resist the pressure from Local Government to start charging those who use Direct Payments, on a means tested basis. Disabled people have consistently regarded care services, based on the premise of independent living, as a right, and not something that should be based on an ability to pay. Hence, statements 10 and 14 both reject the notion of charging for care services, although 14 is seen as subtle prejudice. This is due to statement 14 suggesting that the individual earns an income and therefore may be in a better position to pay than someone whose income is solely derived from benefits. Batavia (2002: pp. 71-72) notes how within Europe the Netherlands, Austria and Germany provide non-means tested community-based care services, with the implication that these nations regard care services to disabled people as a right that should not be influenced by an ability to pay. This view was also adopted by a royal commission on long-term care, and although rejected by the Labour Government within England, was accepted by the devolved Scottish administration (Brindle, 2004).

No. 12 *"Internet shopping is good news for disabled people as it means they can avoid poor facilities for people with disabilities"*

Statement 12 is categorised as both negative in direction and subtle. This statement is principally about avoiding social barriers rather than taking a more proactive role by tackling them. Hence, whilst statements 9 and 11 reflected blatant negative behaviours towards disabled people, statement 12 attempts to measure the idea that disabled people should be satisfied with accessing goods and services through alternative mediums that do not require direct face to face interactions. This statement is not a measure of the use of the Internet, for the term 'Internet shopping' could be replaced with, for example, mail order catalogues. Neither is it a criticism of this communication and information medium. In fact, access to this medium is clearly of great importance to disabled people (Knight, Heaven and Christies, 2002: p. 17), as it is for many others. But, the use of the Internet does not negate the need to ensure that other forms of accessing goods and services are not equally accessible especially if those other methods encourage direct contact of a positive nature, between people of equal status, which has been identified as central to positive attitude change (see Donaldson, 1980; Fiske and Ruscher, 1993; Chapter 3).

The issue, in relation to this statement, centres therefore, around whether it is acceptable to accept equal access through one medium (the Internet) as a substitute to other mediums. The avoidance of poor facilities being due to barriers such as patronising attitudes of some shop-keepers (for instance, talking to the person with the disabled person rather than to the disabled customer), poor physical access, poor public transport, et cetera. Both Oliver (1990) and Johnson and Moxon (1998) recognise the importance of new technologies, but warn they may result in being "*... a disincentive to the development of more accessible public buildings and transport systems*" (Johnson and Moxon, 1998) and reduce public contact.

No. 15 *"It is wrong for a disabled couple to have children as they would be unable to raise the child safely"*

A prevailing attitude, even amongst professional's working within the field of disability, is that disabled people are unable to raise a child (as identified in Booth and Booth, 1994). However, a growing body of evidence has shown that disabled people can and do raise children successfully (see Wates, 1997; Grue and Laerum, 2002; Murphy and Feldman, 2002). It is also important to note, Article 12 of the Human Rights Act (1998) states, *"Men and women of marriageable age have a right to marry and to found a family, according to the national laws governing the exercise of this right"* (Wadham and Mountfield, 2000).

Statement No. 15 also draws on the fear many people have towards putting the safety of the child first, on the assumption that a disabled person would be unsafe as a parent. An illustration of such attitudes was reported in the press (Carter, 2001), where a couple with learning disabilities fled the United Kingdom to the Irish Republic in order to have their child, for fear that, like their other two children, it would be taken from them by social services. However, as with their other children, the baby was removed by social workers at birth. This concern is not just restricted to non-disabled people towards disabled people, but as Johnson, Traustadottir, Harrison, Hillier and Sigurjonsdottir (2001) report, people with learning disabilities express the same worries. However, Johnson *et al* conclude that the 'traditional discourse' relating to women with learning disabilities becoming parents remains dominant and their natural concerns over child rearing are an internalised reflection of this discourse, rather than a reality. Booth and Booth (1994) illustrate through the use of 'depth interviews' with 20 families with one of more parent with a learning difficulty, that this group in society, given the appropriate practical support, can fulfil the parenting role.

Statement 15 also taps into the notion that a child would be better off not to be born to disabled parents, rather than risk any form of danger. No mention of support is raised, or the fact that most parents have informal and formal support networks and many people are in fact *interdependent* rather than *independent*, especially when raising a child. Parents with disabilities are no different. Grue and Laerum (2002) in a Norwegian study illustrate how mothers with physical impairments find ways (if unconventional) to ensure their children remain safe, and how members of the general public may misconstrue their coping strategy, concluding the disabled mother is putting the child's safety at risk (p. 680).

Statement 15 may also be seen as controversial in respect of people with schizophrenia. However, this statement (through its rejection) acknowledges the right of all groups in society to have and raise children, so long as the child's safety is not threatened. In defence of this measure of attitudes for this impairment group, people with schizophrenia are more likely to 'self-harm' rather than harm another (see McKenna, 1997: Ch. 1-2 for review of schizophrenic symptoms). Some may argue that respondents to this statement may view this statement in terms of procreation and passing the parent's impairment on to the child. It should also be noted that research into genetic causes of schizophrenia has often been methodologically flawed, with inconsistent findings, thus leaving Boyle (2002: pp153-205) to conclude that the linkage between genetics and schizophrenia is highly questionable

Women who are living with HIV/AIDS have decreased risks than previously of passing the infection on to their child (Etiebet, Fransman, Forsyth, Coetzee and Hussey, 2004). Whilst Sowell, Murdaugh, Addy, Moneyham and Tavokoli (2002) recognise the concern expressed by women living with HIV/AIDS about long-term care issues with respect to raising a child, they also report that women of reproductive age are one of the fastest growing groups diagnosed as infected with the HIV virus in the United States of America. By taking appropriate precautions, a couple living with HIV/AIDS can raise a child safely, as can many other parents living with transmittable diseases.

No. 16 *"Disabled people should take as much responsibility for their own actions as any other adult citizen"*

Statement 16 links closely with a number of other statements that draw on the notion of responsibility (for instance, statement 2) and risk (for instance, statement 8). By this statement arguing that disabled people are as responsible for their actions as any other citizen it is moving away from the paternalistic, patronising and sometimes infantilising attitudes towards disabled people. Armstrong and Goodley (2000) conclude, in the context of self-advocacy groups for people with learning disabilities, that one of the essential aims of such groups should be to enable this group of people to demonstrate an ability to function as a group without the *"interventions of 'more capable' others."* Part of this self-governance must therefore also be an acceptance of responsibility. Thus, a positive attitude towards disabled people is to treat them as adult citizens, with the same rights and responsibilities as other people (United Nations, 1993). This statement could also be said to link to statement 15, whereby, whilst the disabled couple have a right to become parents, they also have a responsibility to raise the child in a safe and loving manner. Rao, Sharmila and Rishita (2003) would support this statement as they list as one of the methods of disability awareness raising in the community is for disabled people to be aware of and discharge their responsibilities as a citizen. In other words, to be seen as part of the community and act accordingly.

No. 17 *"All disabled people over the age of 18 should have the right to vote in political elections"*

Whilst statement 17 does not add caveats, such as legal reasons for non-eligibility to vote, it offers the respondent an opportunity to express an attitude relating to viewing disabled people as equal citizens in terms of their right to express their views through the electoral system. It should be noted, however, people disenfranchised under the Representation of the People Act (1983) includes any person with a mental illness who has been convicted of a criminal offence. But having a mental illness in itself does not exclude that person, and people living in mental institutions, be it as a voluntary or detained patient, does not stop a person being able to register to vote.

Whilst the issue of physical access to polling stations has been challenged through the 'Polls Apart' campaign by the charity SCOPE (Enticott, Minns and Philpott, 1997), this statement revolves more around the democratic right of all eligible citizens to have an equal say in the governance of their country through the ballot box. Kjellberg (2002), in a Swedish based piece of research, identified that whilst people with learning disabilities have a legal right to vote in elections, the majority tended not to exercise this right. Kjellberg offers a number of explanations for this, including the complexity of the voting process, but also the influence of significant others, including care workers and family members advising them not to vote. Such a view is supported by Bell, Mckay and Phillips (2001: p. 126) who conclude that barriers to voting for people with learning disabilities *"are more social and environmental than legal in nature"*. Hence, a positive attitude toward disabled people can be expressed through the belief that all people have a democratic right to vote and people should not be excluded from this right because of an impairment. According to the Disability

Rights Commission (2001) survey, 97% of the 2025 people interviewed during February 2001 (10% of whom identified themselves as disabled) believed that disabled people should have them same rights to vote as non-disabled people.

No. 18 *"Disabled people feel proud to identify with other disabled people"*

Statement 18 is different from statements 1, 7 and 13, as the earlier statements reflect environments where disabled people have had only limited choice in their interaction with other disabled people, through residential care or supported workshops. Statement 18, however, reflects the slowly emerging shift in attitudes from disabled people themselves, who choose to identify as disabled and find strength from associating with other disabled people. Statement 18 also reflects the strength gained through collective action (see Martin (2001) for discussion on New Social Movements), and self-affirmation as a disabled person (Swain and French, 2000). This is exemplified in the quote from Brown (1992) when he states:

"Whether every single person with a disability feels comfortable in being part of this group is not at issue. What instead must be recognized is that there are enough of us who do claim an identification with our brothers and sisters with disabilities that we relate to each other in a manner that is in some times like a society, at other times like a community, and in some instances like a family. In

all of these scenarios we fit into some kind of grouping based on disability."
(Brown, 1992)

Likewise, Crow (1996) states:

"Our pride comes not from 'being disabled' or 'having an impairment' but out of our response to that. We are proud of the way we have developed an understanding of the oppression we experience, of our work against discrimination and prejudice, of the way we live with our impairments."
(Crow, 1996: p. 72)

This positive response to the label of disability, coming from disabled people themselves, challenges the action reported in Tregaskis' (2002), whereby parents of children with learning disabilities believed they were protecting their children from the stigma attached to this label by not telling them they had a learning difficulty. Tregaskis (2002) reports how research challenges the attitudes behind this parental behaviour, by arguing that such denial means the child will not have opportunities to view their experiences in terms of oppression and therefore develop strategies to contest it. Thus, a positive attitude towards disability is reflected in the statement of pride in identification through association with others who belong to the minority group.

Attitude Toward Impairment Scale Statements

The Attitude Toward Impairment Scale (ATIS) is designed on the premise that attitudes toward different impairment groups will vary in intensity as measured against the same criteria. In other words, despite the same five statements (taken from the GASTDP) being repeated for each impairment group, the strength of attitude will differ in intensity. Despite each statement being for different impairment groups, the direction of the scoring remains the same.

The seven impairment groups chosen for the Attitude Toward Impairment Scale (ATIS) were:

- Down's syndrome
- Arthritis
- Cerebral Palsy
- HIV/AIDS
- Schizophrenia
- Deaf
- Epilepsy

These seven impairment groups were chosen as they are firstly, impairments that the majority of the general population are familiar with, at least to the extent they are able to form a stereotyped view, and secondly, are representative of a range of impairment groups. Hence:

- Down's syndrome represents learning disabilities;
- Arthritis represents physical impairment, usually non-wheelchair user and often associated with ageing;
- Cerebral palsy represents physical impairment usually associated with using a wheelchair and unconventional limb movement;
- HIV/AIDS represents a high stigma group, which tends to be associated with personal blame and responsibility for the acquisition of the virus;
- Schizophrenia represents mental health often associated with stigma, danger and fear;
- Deaf represents a sensory impairment group;
- Epilepsy represents a neurological impairment, often 'invisible'

Further details on each of the seven impairment groups are contained in Appendix I, although it should be noted, the respondents were not given this information and so based their responses on prior knowledge and stereotypes.

Clearly, the effects of each impairment will vary enormously in reality. For instance, one person with cerebral palsy may be able to walk, communicate using conventional speech and have attained post-graduate academic qualifications, whereas another person, labelled with the same impairment category, may be unable to speak, walk, hold no academic qualifications and have limited cognitive ability. However, the respondent is required to hold a view of each impairment group, and thus be able to give a measure of affect, using the six-point Likert-type scale, against each of the five statements used throughout this scale.

The five statements selected from the General Attitude Scale Toward Disabled People were:

1. Residential care is usually the best option for disabled people
3. Disabled people have a right to do government sponsored vocational training schemes even if they are unlikely to get a job
8. Disabled people should be protected from situations that are likely to cause stress or anxiety to themselves
9. A restaurant owner should be allowed to refuse service to a disabled person if they upset other customers because of their impairment
15. It is wrong for a disabled couple to have children as they would be unable to raise the child safely

Each of the five statements are repeated on the Attitude Toward Impairment Scale for each of the seven impairment groups, with 'disabled people' being substituted for 'people with Down's syndrome', 'people with Arthritis', et cetera. The Attitude Toward Impairment Scale, therefore becomes a 35 item scale with seven sub-scales (see Appendix G for ATIS statements and scoring).

The five statements reflect aspects of individuals rights, from the right to live in the community (statement 1), to participate in vocational training and thus improve employability (statement 3), to interact with others in a social setting and being treated fairly (statement 9), to being treated as an adult citizen with rights and responsibilities (statement 8), to the fundamental right of parenting and therefore reproduction (statement 15). The rationale for each of these statements remains the same as when used in the 'General Attitude Scale Toward Disabled People' with the assumption that all people have these rights, regardless of their impairment, and regardless of whether they wish to exercise these rights.

Scoring of the General Attitude Scale Toward Disabled People and Attitude Toward Impairment Scale

The scoring for each scale was based on a six-point Likert-type scale, whereby the respondent would identify the degree to which they agreed (or not) with the statement by placing a mark against the strength of feeling for each statement. The strength of feeling (or affect) was indicated by the following six-point scale, as used in Gething's 'Interaction with Disabled Persons' scale (Gething, undated), giving a score of 1 to 6 for each statement:

I disagree very much;

I disagree somewhat;

I disagree a little;

I agree a little;

I agree somewhat;

and, I agree very much

(see Appendix G for scoring sheet for General Attitude Scale Toward Disabled People and Attitude Toward Impairment Scale).

Pilot Internal Reliability of Scales

Having presented the statements utilised on the GASTDP and ATIS it is also important to identify whether these research tools contained appropriate psychometric properties. In other words, that the scales could give a score in relation to the respondent's attitude toward disabled people and impairment groups, and that these scores would be consistent over time. These research tools were therefore piloted and the information produced during this procedure is presented next.

The *internal consistency* of a scale is the extent to which each item of the attitude scale 'hang together' (Pallant, 2001: p. 85). Further explanations of statistical terms can be found in Appendix J, including validity and Cronbach's alpha.

The resulting pilot scale, containing the eighteen remaining statements included in the pilot General Attitude Scale Toward Disabled People (GASTDP) and thirty-five statements on the pilot Attitude Toward Impairment Scale (ATIS), together with the Demographic Questionnaire and Social Acceptance List task, was administered to 43 disabled people between September 2001 and January 2002: male (n = 22) ; female (n = 21) with a mean age 41.44 (S.D. = 13.5) between September 2001 and January 2002, of whom, 39 produced usable data. Data for the pilot was collected from a variety of sources:

- Arthritis Care South West England Regional Conference "Sharing Our Regional Diversity" on 6th October 2001;
- disabled people attending Residential Training based at The Enham Trust, Andover, Hampshire, on 16 October 2001 and January 2002;
- people receiving care services within the Andover, Hampshire area.

Both scales achieved acceptable levels of internal reliability as measured by Cronbach's alpha (see Table 6.19). Cronbach's alpha is extensively used as an index of reliability within psychometric testing and whilst there is no universal agreement on acceptable levels of alpha (Cortina, 1993; Shelvin, Miles, Davies and Walker, 2000), a result of 0.7 or higher is generally regarded as acceptable (Cortina, 1993; Nunnally and Bernstein, 1994).

Table 6.19: Cronbach's Alpha Coefficient Achieved for General Attitude Scale Toward Disabled People and Attitude Toward Impairment Scale – Pilot Sample

Scale Title	**Number of Respondents**	**Alpha Achieved**
General Attitude Scale Toward Disabled People	N = 39	.7393
Attitude Toward Impairment Scale	N = 39	.8844

As both scales achieved acceptable levels of reliability overall for this pilot sample of disabled people, it was decided not to remove any items from either scale.

It should also be noted that on the Attitude Toward Impairment Scale, the statement *"People with [IMPAIRMENT] have a right to do government sponsored vocational training schemes even if they are unlikely to get a job"*, received Corrected Item Total Correlation scores of below 0.3 for six of the seven impairment groups (arthritis achieving 0.3378). Corrected Item Total Correlation is an indication of the degree to which each scale item correlates with the total scale score. However, this statement on the General Attitude Scale Toward Disabled People achieved a score of 0.3634 and therefore, on the basis of an overall alpha of 0.8844 it was decided to keep this scale item in.

Pilot Subtle and Blatant Prejudice Sub-Scales of the General Attitude Scale Toward Disabled People

In line with Meertens and Pettigrew (1997) argument in relation to race and subtle/blatant prejudice, the 'disability experts' were asked to state whether each of the original 78 statements expressed either subtle or blatant forms of prejudice. This distinction enabled the final eighteen statements included in the General Attitude Scale Toward Disabled People scale to contain two sub-scales, (Blatant and Subtle: see Table 12.2). This would allow a score to be produced that tapped into individual's attitudes towards disabled people on a subtle level. For, a number of people, (with respect to race), have 'learnt' what is regarded as a positive attitude, and therefore may not express their true beliefs (Devine, 1989). This could also be true of disability as a result of greater levels of information, for example through the media, more opportunities for direct social interaction, et cetera, which may help to modify behaviours, but may not necessarily have improved beliefs or affect (emotions) toward disabled people.

Each sub-scale contained seven items, giving a possible score of between 7 and 42. As the Subtle Prejudice sub-scale obtained an alpha of only 0.6401, and thus, below the recommended 0.7, a paired-samples t-test was also conducted. However, for scale with fewer items (in this case seven), alpha of below 0.7 is acceptable (Pallant, 2001).

A paired-sample t-test was conducted on the pilot sample data to evaluate whether there was a significant difference between the subject's scores on the Subtle and Blatant Prejudice sub-scales of the General Attitude Scale Toward Disabled People (one-tailed). Subtle Prejudice (M = 19.26, S.D. = 5.395) and Blatant Prejudice (M = 15.08, S.D. = 5.238), $t(38) = 4.230$, $p<.0005$. As the observed value of t is greater than 2.457, we can conclude there is a significant difference between the Subtle Prejudice and Blatant Prejudice sub-scales. Given the eta squared value of 0.32 was achieved, we can conclude there was a large effect, with a substantial difference between the two sub-scales.

In light of these results, obtained from the pilot sample of disabled people, it was felt these two sub-scales should be utilised in the research.

Table 6.20: Subtle and Blatant Prejudice Sub-Scales of the General Attitude Scale Toward Disabled People

Sub-scale	Scale No.	Statement	Cronbach's Alpha
Subtle	3	Disabled people have a right to do government sponsored vocational training schemes even if they are unlikely to get a job	0.6401 (n = 42)
	6	Having a disabled person as a colleague would mean the non-disabled person would be given extra work and responsibility	
	7	Disabled people would be happiest living alongside other disabled people	
	8	Disabled people should be protected from situations that are likely to cause stress or anxiety to themselves	
	12	Internet shopping is good news for disabled people as it means they can avoid poor facilities for people with disabilities	
	13	Disabled people are happiest when working alongside other disabled people	
	14	Disabled people should be charged for care services if they are employed	
Blatant	1	Residential care is usually the best option for disabled people	0.7051 (n = 39)
	9	A restaurant owner should be allowed to refuse service to a disabled person if they upset other customers because of their impairment	

	11	A cinema should be able to refuse entry to a disabled person if their presence spoils the show for other customers	
	15	It is wrong for a disabled couple to have children as they would be unable to raise the child safely	
	16	Disabled people should take as much responsibility for their own actions as any other adult citizen	
	17	All disabled people over the age of 18 should have a right to vote in political elections	
	18	Disabled people feel proud to identify with other disabled people	

The blatant sub-scale items tended to be harsher and more direct in their approach than the subtle sub-scale, with clearer consequences for the disabled person. For example, non-admittance to either a cinema or a restaurant, solely on the grounds of the individual being a disabled person. It should be noted that items 16, 17 and 18 are all reverse scoring, and so agreement is seen as a positive attitude towards these items (as is item 3 on the subtle scale).

Pilot Social Acceptance List

In order to offer additional validation to the Attitude Toward Impairment Scale, in other words, to test the scales construct validity, a simple ranking task was produced, called the Social Acceptance List (see Appendix H). This task asks the respondent to place ten impairments into a rank order on the basis of the respondent's perception of the social acceptance of each impairment group. Included in the ten impairments are the seven impairment groups chosen for the

Attitude Toward Impairment Scale. The respondents were asked to place a number from 1 to 10 (1 = most accepted and 10 = least accepted) against each of the groups listed below (using a number only once). In other words, list the impairments/disabilities in order of how well they felt each group is accepted into society.

The ten impairment groups on the Social Acceptance List (arthritis, blindness, cerebral palsy, deafness, Down's syndrome, epilepsy, HIV/AIDS, paraplegia, quadriplegia and schizophrenia) were placed in alphabetical order, so that no bias was unwittingly placed on the rank order by the researcher.

The results shown in Table 6.21 indicate that the results obtained from the Attitude Toward Impairment Scale were congruent with the ranking task on social acceptance, thus suggesting that the Attitude Toward Impairment Scale had construct validity.

Although due to a number of respondents only giving responses to the pilot Attitude Toward Impairment Scale (n = 39) and not the Social Acceptance List (n = 30) it was felt the data has produced interesting comparative findings, with similar results for both the pilot ATIS and the Social Acceptance List. It was also felt that there was value in utilising both the ATIS and the Social Acceptance List in the subsequent research.

Table 6.21: Comparison of Attitude Toward Impairment Scale and Social Acceptance List Ranking Task Means – Pilot Sample of Disabled People

Impairment/Disability	Mean ATIS (n = 39)	Rank ATIS	Mean Social Acceptance List (n = 30)	Rank Social Acceptance List
Arthritis	11.00	1 =	2.7	1 (1)
Blindness (no eye sight)	N/A	N/A	3.0	3
Cerebral Palsy	12.92	3	6.1	6 (4)
Deafness (no hearing)	11.00	1 =	2.9	2 (2)
Down's Syndrome	14.44	6	6.9	7 (5)
Epilepsy	13.51	4	5.2	4 (3)
HIV/AIDS	14.26	5	7.7	9 (6)
Paraplegia (no use of legs)	N/A	N/A	5.5	5
Quadriplegia (no use of arms or legs)	N/A	N/A	7.0	8
Schizophrenia	15.87	7	8.0	10 (7)

[Bracketed numbers are the rank order of the impairments on the Social Acceptance List with those impairments not on the ATIS removed].

External Reliability of Attitude Scales

The external reliability of a scale *"refers to the degree of consistency of a measure over time"* (Bryman and Cramer, 1997: p. 63). In other words, if a scale is administered on two occasions, reasonably close together in order to reduce the possible influence of confounding variables, then the results should be similar if the scale holds external reliability. Hence, a strong correlation between the two sets of scores should be achieved. This method of assessing external reliability is known as *test – retest reliability*.

The General Attitude Scale Toward Disabled People (GASTDP) and the Attitude Toward Impairment Scale (ATIS) were circulated to both disabled (n = 25) and non-disabled (n = 15) groups (the term 'group' has been used in order to distinguish this data from the main results of this research) on two occasions (3rd April 2004 and 10th May 2004). Group sizes of 13 were calculated as necessary for test - retest reliability (Cohen, 1988). The disabled group was obtained from people receiving a training/employment provision funded through the Department for Work and Pensions' New Deal for Disabled People and Residential Training programme. Jobcentre Plus Disability Employment Advisors from within Hampshire would have categorised the disabled group as a person with a 'disability' under the Disability Discrimination Act (1995) definition of a disabled person (Doyle, 1996). The non-disabled group were employees of a voluntary organisation that provides employment opportunities for disabled people and care services.

External Reliability for the General Attitude Scale Toward Disabled People

The relationship between the scores achieved for the disabled group, as measured by the GASTDP, was investigated using Pearson product-moment correlation coefficient (one-tailed). Seven people did not respond on the second occasion and were therefore removed from the analysis. Preliminary analyses were performed to ensure no violations of the assumptions of normality, linearity and homoscedasticity. There was a strong, positive correlation between the two scores [$r = 0.832$, $n = 18$, $p < 0.0001$]. Correlation is significant at the 0.01 level (one-tailed). See Table 6.22 below.

Table 6.22: External Reliability of GASTDP for Disabled Group – Pearson Product-Moment Correlation Coefficient (One-Tailed)

GASTDP Mean Time 1	GASTDP Mean Time 2	GASTDP S.D. Time 1	GASTDP S.D. Time 2	Number	R	Sig. (one-tailed
43.89	44.11	9.474	9.311	18	0.832	0.0001

The relationship between the scores achieved for the non-disabled group, as measured by the GASTDP, was investigated using Pearson product-moment correlation coefficient (one-tailed). One person did not respond on the second occasion and was therefore removed from the analysis. Preliminary analyses were performed to ensure no violations of the assumptions of normality, linearity and homoscedasticity. There was a strong, positive correlation between the two scores [$r = 0.679$, $n = 14$, $p < 0.004$]. Correlation is significant at the 0.01 level (one-tailed). See Table 6.23 below.

Table 6.23: External Reliability of GASTDP for Non-Disabled Group – Pearson Product-Moment Correlation Coefficient (One-Tailed)

GASTDP Mean Time 1	GASTDP Mean Time 2	GASTDP S.D. Time 1	GASTDP S.D. Time 2	Number	R	Sig. (one-tailed
39.64	41.88	7.50	5.503	14	0.679	0.004

External Reliability for Attitude Toward Impairment Scale

The relationship between the scores achieved for the disabled group, as measured by the Attitude Toward Impairment Scale, was investigated using Pearson product-moment correlation coefficient (one-tailed). Seven people did not respond on the second occasion and were therefore removed from the analysis. Preliminary analyses were performed to ensure no violations of the assumptions of normality, linearity and homoscedasticity. There was a strong, positive correlation between the two scores for each of the seven impairments utilised for the ATIS (See Table 6.24 below).

Table 6.24: External Reliability of ATIS for Disabled Group – Pearson Product-Moment Correlation Coefficient (One-Tailed)

	Mean Time 1	Mean Time 2	S.D. Time 1	S.D. Time 2	Number	R	Sig. (one-tailed
Down's Syndrome	12.44	12.39	4.287	3.328	18	0.705	0.001
Arthritis	9.28	9.61	3.691	3.943	18	0.764	0.0001
Cerebral Palsy	13.83	11.78	5.305	4.413	18	0.679	0.001
HIV/AIDS	12.50	12.89	4.301	4.536	18	0.718	0.0001
Schizophrenia	13.78	12.39	6.005	4.513	18	0.635	0.002
Deaf	9.56	8.94	4.369	3.438	18	0.852	0.0001
Epilepsy	11.17	10.50	4.396	4.287	18	0.882	0.0001

All correlations are significant at the 0.01 level (one-tailed).

The relationship between the scores achieved for the non-disabled group, as measured by the Attitude Toward Impairment Scale, was investigated using Pearson product-moment correlation coefficient (one-tailed). One person did not respond on the second occasion and was therefore removed from the analysis. Preliminary analyses were performed to ensure no violations of the assumptions of normality, linearity and homoscedasticity. There was a strong, positive correlation between the two scores for each of the seven impairments utilised for the ATIS (See Table 6.25 below), although not as strong as for the disabled group.

Table 6.25: External Reliability of ATIS for Non-Disabled Group – Pearson Product-Moment Correlation Coefficient (One-Tailed)

	Mean Time 1	Mean Time 2	S.D. Time 1	S.D. Time 2	Number	R	Sig. (one-tailed
Down's Syndrome	10.71	10.43	3.148	3.180	14	0.735	0.001
Arthritis	8.29	8.36	2.730	2.818	14	0.826	0.0001
Cerebral Palsy	11.14	10.29	4.912	4.140	14	0.902	0.0001
HIV/AIDS	8.79	9.50	2.806	3.345	14	0.807	0.0001
Schizophrenia	12.50	11.00	4.090	3.721	14	0.768	0.001
Deaf	7.36	7.71	2.170	2.785	14	0.820	0.0001
Epilepsy	9.57	9.43	4.108	3.031	14	0.516	0.029

All correlations are significant at the 0.01 level (one-tailed) with the exception of Epilepsy whereby the correlation is significant at the 0.05 level (one-tailed).

Internal Reliability of General Attitude Scale Toward Disabled People

Using SPSS V.10, the internal reliability of the General Attitude Scale Toward Disabled People (GASTDP) was tested using Cronbach's alpha, for both the disabled and non-disabled samples. Cronbach's alpha is a widely used test based on the premise that *"if the scale is expected to measure a single underlying continuum, then the items should have strong relationships both with that continuum and with each other"* (Oppenheim 1992: p. 160). Thus, a scale will have *internal consistency* if items correlate highly with each other. The coefficient alpha gives an estimate of the proportion of the total variance that is not due to error. This represents the reliability of the scale. It is widely accepted that an alpha of 0.7 or above is regarded as acceptable (Cortina, 1993; Nunnally and Bernstein, 1994) although, as Cortina (1993) reminds us, that alpha is *"not a panacea"* and must be viewed with caution (p. 103). As the GASTDP did not reach the required alpha (0.7) as measured by Cronbach's alpha for the non-disabled sample, item 5 on the scale was removed, thus ensuring an acceptable measure of internal reliability (see Table 6.26 & 6.27 below). By removing item 5 from the GASTDP both samples then reached above the accepted 0.7 (disabled (0.7598); non-disabled (0.7338)).

Table 6.26: Cronbach's Alpha Coefficient Achieved for General Attitude Scale Toward Disabled People with Non-Disabled Sample

Scale Title	Number of Respondents	Mean	Standard Deviation	Alpha
General Attitude Scale Toward Disabled People – Complete Scale	N = 111	42.3243	8.6531	0.6700
General Attitude Scale Toward Disabled People – Item 5 removed	N = 111	39.2793	8.9951	0.7338

Table 6.27: Cronbach's Alpha Coefficient Achieved for General Attitude Scale Toward Disabled People with Disabled Sample

Scale Title	Number of Respondents	Mean	Standard Deviation	Alpha
General Attitude Scale Toward Disabled People – Complete Scale	N = 209	44.5072	11.1369	0.7159
General Attitude Scale Toward Disabled People – Item 5 removed	N = 209	41.2632	11.4675	0.7598

Eight disabled and three non-disabled respondents did not provided usable data.

All subsequent analysis of the General Attitude Scale Toward Disabled People is therefore as a 17 item scale, having removed item 5 from the original version.

Factor Analysis of General Attitude Scale Toward Disabled People With Disabled Sample

In order to explore the psychometric properties of the GASTDP further, it was felt exploratory factor analysis may offer information that would aid interpretation of the results. The objective of factor analysis is to *"represent a set of variables in terms of a smaller number of hypothetical variables"* through the use of a range of statistical techniques (Kim and Mueller, 1978: p. 9). Therefore, by performing factor analysis on this research tool, it was hoped to reveal whether certain facets of the rights agenda, in relation to disabled people, required further testing and analysis. See Appendix J for glossary of statistical terms.

The 17 items of the GASTDP was subjected to principal components analysis (PCA) using SPSS V.10.1 for all data (disabled and non-disabled samples were collapsed). Prior to performing PCA the suitability of the data for factor analysis was assessed. Inspection of the correlation matrix revealed the presence of many coefficients of 0.3 and above. The Kaiser-Maeyer-Oklin value was 0.766, exceeding the recommended value of 0.6 (Kaiser, 1974) and the Bartlett's Test of Sphericity (Bartlett, 1954) reached statistical significance, supporting the factorability of the correlation matrix.

Principal components analysis revealed the presence of five components with eigenvalues exceeding 1, explaining 24.825 per cent, 11.357 per cent, 10.474 per cent, 6.917 per cent and 6.346 per cent of the variance respectively. An inspection of the scree plot revealed a break after the third component. Using Cattell's (1966) scree test, it was decided to retain three components for further investigation. To aid in the interpretation of these three components, Varimax rotation was performed. The rotated solution (see Table 6.28) revealed the presence of a number of strong loadings on each component. The three factor solution explained a total of 46.675 per cent of the variance, with Component 1 contributing 19.973 per cent, Component 2 contributing 15.699 per cent and Component 3 contributing 10.984 per cent (see Table 6.29). The scale items for each Component are listed in Table 6.30 with means and standard deviations for each item in relation to the two samples (disabled and non-disabled).

Table 6.28: Rotated Component Matrix

GASTDP Item Number	Component 1	Component 2	Component 3
7	0.734		
13	0.733		
4	0.676		
8	0.648		
6	0.583		
1	0.543		
12	0.385		
10		0.755	
9		0.741	
11		0.718	
14		0.678	
15	0.429	0.518	
17			0.636
18	-0.401		0.579
3			0.560
16	0.415		0.558
2			0.400

Extraction Method: Principal Component Analysis

Rotation Method: Varimax with Kaiser Normalization

NB: Rotation converged in six iterations

Table 6.29: Total Variance Explained

Component	Rotation Sums of Squared Loadings		
	Total	% of Variance	Cumulative %
1	3.395	19.973	19.973
2	2.669	15.699	35.672
3	1.867	10.984	46.675

Table 6.30: GASTDP Items for Three Components for Items with 0.5 and greater loadings

Component	GASTDP Item		Mean		S.D.	
			Disabled (n=209)	Non-Disabled (n=111)	Disabled	Non-Disabled
1	1	Residential care is usually the best option for disabled people	2.1244	2.2613	1.3530	1.2983
	4	Disabled people should be required by law to have to have genetic testing to see whether they would pass the impairment onto their child	2.2201	1.9279	1.6494	1.3732
	6	Having a disabled person as a colleague would mean the non-disabled person would be given extra work and responsibility	2.2057	2.0721	1.4744	1.2039
	7	Disabled people would be happiest living alongside other disabled people	1.9474	1.7748	1.2412	1.0676

	8	Disabled people should be protected from situations that are likely to cause stress or anxiety to themselves	3.2297	2.8378	1.7054	1.5168
	13	Disabled people are happiest when working alongside other disabled people	2.2775	2.1892	1.3515	1.2248
2	9	A restaurant owner should be allowed to refuse service to a disabled person if they upset other customers because of their impairment	1.8995	1.6847	1.3062	1.1036
	10	Disabled people should be charged for care services on the basis of their ability to pay	2.8708	3.3874	1.7286	1.5907
	11	A cinema should be able to refuse entry to a disabled person if their presence spoils the show for other customers	2.1962	2.0541	1.5917	1.3806
	14	Disabled people should be charged for care services if they are employed	2.8421	3.0631	1.4997	1.3503

	15	It is wrong for a disabled couple to have children as they would be unable to raise the child safely	2.0478	1.7928	1.2625	1.0368
3	3	Disabled people have a right to do government sponsored vocational training schemes even if they are unlikely to get a job	2.1579	1.8108	1.4640	0.9392
	16	Disabled people should take as much responsibility for their own actions as any other adult citizen	2.0287	1.7568	1.3620	0.8761
	17	All disabled people over the age of 18 should have a right to vote in political elections	1.5981	1.3784	1.3160	0.7869
	18	Disabled people feel proud to identify with other disabled people	3.0526	3.0180	1.6762	1.1907

Kline's (1994) warning of 'bloated specific' when using factor analysis as part of the process of constructing a test or scale needs to be considered in relation to the three Component items. For instance, items 10 and 14 may be viewed as asking the same thing, and are therefore likely to have a high level of correlation. Similarly for items 7 and 13.

Component 1 may in fact be two factors, which could be called Social Distancing (items 1, 6, 7 and 13) and Over Protection (items 4 and 8).

Component 2 may be called Access to Goods and Services (items 9, 10, 11 and 14). Item 15 (with the weakest loading) was rejected for this component as it did not seem to relate to other items.

Component 3 may be called Rights & Responsibilities or Citizenship (items 3, 16, 17 and 18). Although item 2 (Disabled people have a responsibility to seek employment if they are able to do so) only loaded with 0.4, it is interesting to note that its emphasis on responsibility ties in with the other items for component 3.

Internal Reliability of Attitude Toward Impairment Scale

As with the GASTDP it was important to test the Attitude Toward Impairment Scale (ATIS) for internal reliability. Cronbach's alpha was again utilised for this purpose. Both the disabled (n = 193) and non-disabled (n = 119) samples achieved alpha scores above the recommended 0.7 (see table 12.13 below). Therefore, the ATIS can be said to hold good internal reliability.

Table 6.31: Cronbach's Alpha Coefficient Achieved for Attitude Toward Impairment Scale with Disabled & Non-Disabled Sample

Scale Title	Respondents	Mean	Standard Deviation	Alpha
Attitude Toward Impairment Scale	Disabled & Non-Disabled (n = 312)	80.0481	25.84	0.9282
	Disabled (n = 193)	83.2642	27.4309	0.9280
	Non-Disabled (n = 119)	74.8319	22.1609	0.9228

Having found acceptable levels of internal and external reliability for both the GASTDP and ATIS it was felt appropriate to utilise these tools. This data also gives a degree of confidence in the results presented in this thesis (see Chapter 7).

6.6 Procedure and Data Collection

All potential disabled respondents received a paper copy of the:

- General Attitude Scale Toward Disabled People

- Attitude Toward Impairment Scale
- Demographic Data Questionnaire
- Social Acceptance List and
- Covering letter (which included an email address whereby an electronic version could be obtained) (see Appendix F).

A FREEPOST envelope was also attached in order to encourage a greater response rate.

All the groups of disabled people contacted for this research had been identified through other sources of information as belonging to the disabled population. These groups of people were either in receipt of a government funded programme that required the individual to be regarded as 'disabled' within the definition of a disabled person under the Disability Discrimination Act, in receipt of a care service, or belong to an organisation that was exclusively for disabled people. Other disabled respondents were primarily acquired through the non-disabled group, for, with over 8.6 million of the UK population having an impairment (Bajekal, Harries, Breman and Woodfield, 2004) there is a likelihood that some disabled respondents will be achieved through this method.

As with the disabled sample, the non-disabled sample came from a variety of sources (see Table 6.32). As with the disabled sample, the distribution of the research tools was to people who were not *known* to directly have an awareness or interest in disability rights issues. This is not to say these respondents did not have an *actual* interest in disability issues, but they were not people known to the author to be involved in the delivery of services for disabled people or active in the field of disability rights. The two principal sources of respondents for the non-disabled sample were acquired through a direct mailing of the research tools, with a FREEPOST envelope, to people linked with an employment agency based in Andover, Hampshire, and people participating in 'pitch-and-putt' golf near Bath, Somerset, who were given the research tool when they collected their golf clubs. These people were simply asked if they would be willing to complete the research tools and return them using the FREEPOST envelope. It is interesting to note that a number of respondents chose to respond via email (an email address was given on the covering letter). This method assisted in increasing the circulation of the research tools, although it also reduced the level of control over who received these items and makes the calculation of response rates unreliable. This was identified through email replies who said they had passed the research tool onto friends and colleagues via email.

Below are two tables presenting the distribution of the research tools for both the disabled and non-disabled samples. Response rates for each distribution to each sub-group is also reported.

Table 6.32: Distribution of Attitude Scales and Demographic Data Questionnaire to Disabled Sample

Code	No. Responses	No. Distributed	% Response Rate
Job Broker Clients	35	95	36.84
Residential Trainees	19	25	76.00
Domiciliary Care Service User	25	40	62.5
Self Employment Database	59	260	22.69
Hampshire Coalition of Disabled People	24	80	30.00
Leonard Cheshire User Forum	8	15	53.33
Non-Disabled Random Sample (self identified as disabled)	14	N/A	N/A
Enham Visitor	2	N/A	N/A
Employer Database (self identified as disabled)	3	N/A	N/A
Essex Coalition of Disabled People	7	15	46.67
Bournemouth College Group	8	20	40.00
Other	12	N/A	
Total	217		

Table 6.33: Distribution of Attitude Scales and Demographic Data Questionnaire to Non-Disabled Sample

Code	No. Responses	No. Distributed	% Response Rate
MSc. Counselling Students – based at a London University	13	25	52.00
Golf-club and Email respondents*	61	135	45.19
Employment Agency Database	36	130	27.69
Other	4	N/A	N/A
Total	114		

* The number distributed are for those known to have been distributed, which does not include email distribution by respondents

6.7 Ethical Issues

This research was mindful of ethical issues in relation to the sensitive nature of the topic under investigation for some of the participants. Like Major, Quinton, McCoy and Schmader (2000) this research attempted to investigate prejudice from the perspective of the stigmatised; in this instance, the perspective of disabled people. As a consequence, this research ran the risk of 'blaming the victim' in terms of questioning whether disabled people held prejudiced or discriminatory attitudes toward other disabled people in general and toward other impairment groups. As a consequence, the 'questionable practices' listed by Robson (2002: p. 69) were scrutinised. These practices are listed as: involving people without their knowledge or consent; coercing people to participate; withholding information as to the true nature of the research; inducing participants to commit acts diminishing their self-esteem; violating rights of self-determination; exposing people to physical or mental stress; invading privacy; not treating participants fairly, with consideration or respect. Each of these 'questionable practices' assisted in the choice of research design, for attitude rating scales avoided violating each of them.

Every effort was made to ensure the attitude scales developed for this research were non-sexist, non-racist and mindful of differences in race, religion, culture and gender. All statements used on either the GASTDP and ATIS were written in a manner that would not cause offence to the respondent, and would only be a measurement of the respondents attitude toward disabled people and impairment groups, and not a measurement of some other group, for instance, gender or sexual orientation.

Deception is always a key issue in research within the field of social psychology, including research into person's attitudes. Dunbar (1998: p. 166) states researchers must not conceal things or tell participants untruths. This clearly has implications for some forms of research design, such as behavioural observations that may be affected by the subject being aware of the researcher's intentions. However, in the case of this research, it was felt the research design and the tools utilised allowed for a transparent approach. All respondents therefore received a covering letter (see Appendix F) that stated the purpose of the research. Whilst this approach to the ethical issue of deception risked that participants could try to 'fake-well' their responses on the attitude scales, it was felt the use of the Subtle and Blatant Prejudice Scales would identify such responses.

The ethical issue that anything learnt about individual participants through the course of the research must remain confidential. In line with this issue, respondents were assured their data would be treated in the strictest confidence, with anonymity assured. It was also hoped this approach would encourage honest responses to the attitude scales.

Chapter 7

A Measurement of Attitudes Toward Disabled People as a Homogenous Group and Impairment Sub-Groups

7.1 Introduction

In order to analyse the data a series of inferential statistics were utilised. The key features of the tests employed are presented below in Table 7.1; in addition, a glossary of statistical terms are presented in Appendix J. These are therefore presented in Table 7.1 below.

Table 7.1: Characteristics of Inferential Statistics

Tests	Statistic	Information necessary to find critical value	Relationship of obtained to critical statistic for significance
Independent t-test	T	Degrees of freedom (df)	Equal to or greater than critical value
Friedman test	F	Degrees of freedom (df)	Equal to or less than critical value
Kruskal-Wallis H	H	Alpha α	Mean rank for each group compared
Analysis of Variance	F	Degrees of freedom (df1 and df2)	Equal to or greater than the critical value
Mann-Whitney U test	U	Number of scores in the two groups (n1 and n1)	Equal to or less than the critical value

All data analysis has been produced using SPSS V10.1.

The results of this research have been placed under each of the hypotheses being tested. In addition, in order to maximise the information from data produced through this research, further analysis took place, and is presented at the end of this chapter under the heading Additional Results.

7.2 Results

H1: Disabled people hold significantly more positive attitudes toward disability than non-disabled people

H1 intends to investigate whether people who belong to a minority group (disabled people), hold more positive attitudes toward that group than those who are not part of that group. In other words, H1 suggests that the minority out-group will hold more positive attitudes to other members of its group than the majority in-group (non-disabled people).

An independent-samples t-test (one-tailed) was conducted to compare the General Attitude Scale Toward Disabled People scores for disabled and non-disabled samples. Classification into disabled and non-disabled samples was made through the respondent's response to question 8 of the Demographic Data

Questionnaire "Do you have a disability?" Therefore, the sample sizes are yes (n = 193) and no (n = 120), which is a slight variation on the disabled (n = 217) and non-disabled (n = 114) total sample sizes, due to some respondents either not completing this question or saying they 'don't know'. There was no significant difference in scores for disabled (M = 41.08, S.D. = 11.261) and non-disabled samples (M = 39.29, S.D. = 9.159); t (289.378) = 1.534, p = 0.126 (see Table 7.2 below). As the data violates the assumption of equal variance (Levene's test for equal variances p = 0.006), equal variance is not assumed. We cannot therefore reject the null hypothesis for H1.

Table 7.2: Independent Samples T-Test for Disabled and Non-Disabled Samples

Do you have a disability (Q8: Demographic Data Questionnaire)	GASTDP (Mean)	Standard Deviation
Yes = 193	41.08	11.261
No = 120	39.29	9.159

Table 7.2 cont.

	T	Df	Sig. (2-tailed)	Mean Difference
Equal Variances Assumed	1.462	311	0.145	1.79
Equal Variances Not Assumed	1.534	289.378	0.126	1.79

H2: A hierarchy of impairments exists between different impairment groups

The Attitude Toward Impairment Scale (ATIS) was specifically designed to test this hypothesis (see Chapter 6 for discussion on the ATIS). H2 suggests that disabled people, with different impairments, will hold different hierarchies of impairment. In other words, people with cerebral palsy, according to this hypothesis, will place people with other impairments in a different rank order, than people with depression. In order to validate the ATIS findings, the Social Acceptance List (where respondents were asked to place ten impairments in order or most to least accepted impairments by society) was also tested. Initially, however, it was thought beneficial to test whether disabled people, as an homogenous group, held a statistically significant hierarchy of impairment as measured by the ATIS and Social Acceptance List. Due to the nature of the data, non-parametric tests were regarded as most appropriate to test this hypothesis.

A non-parametric Friedman Test was conducted on the scores for each impairment group as measured by the ATIS for the disabled sample (n = 204; Chi-Squared 411.154; df 6). Thirteen respondents did not provide usable data. Table 7.2 below gives the mean rank (scores are converted to ranks and the mean rank for each group is compared) for the seven impairment groups and the subsequent rank ordering. The results of the test suggest there are significant differences between the impairment groups, indicated by a significance level of $p < 0.0005$.

Table 7.2: Friedman Test Mean Ranks as Measured by the ATIS for the Disabled Sample

Impairment	Mean Rank	Rank Order
Deaf	2.33	1
Arthritis	2.81	2
Epilepsy	3.70	3
Cerebral Palsy	4.27	4
HIV/AIDS	4.32	5
Down's Syndrome	5.00	6
Schizophrenia	5.57	7

A Friedman Test was then conducted on the results for the ten impairment groups on the Social Acceptance List (see Appendix H) for the disabled sample (n = 139; Chi-Squared 590.429; df 9). Seventy-eight respondents did not provide usable data or did not complete the Social Acceptance List. Table 7.4 below gives the mean rank for the ten impairment groups and the subsequent rank ordering. The results of the test suggest there are significant differences between the impairment groups, indicated by a significance level of $p < 0.0005$.

Table 7.4: Friedman Test Mean Ranks as Measured by the Social Acceptance Task for the Disabled Sample

Impairment	Mean Rank	Rank Order *
Arthritis	2.18	1 (2)
Blindness	3.19	3
Cerebral Palsy	6.54	6 (4)
Deafness	3.05	2 (1)
Down's Syndrome	6.74	7 (6)
Epilepsy	4.66	4 (3)
HIV/AIDS	7.62	9 (5)
Paraplegia	5.87	5
Quadriplegia	7.37	8
Schizophrenia	7.78	10 (7)

* Brackets denote place of rank ordering through the ATIS

Caution should be shown when interpreting result from the Social Acceptance List due to the large number of non-responses (n = 139 out of a possible 217).

Having identified that a similar hierarchy of impairments may exist using either the ATIS or the Social Acceptance List, the non-parametric test Kruskal-Wallis H was employed to identify whether each of the disabled sub-samples (based on self allocation to the groups listed in question 16 of the Demographic Data Questionnaire – see Appendix C) would hold statistically significant hierarchies in relation to the seven impairment groups on the ATIS (see Table 7.5).

Table 7.5: Kruskal-Wallis H Test on Ranking of Seven Impairments from the Attitude Toward Impairment Scale Score for Broad Impairment Categories (as identified through Q.16 Demographic Data Questionnaire)

	Impairment Score						
	Down's Syndrome	Arthritis	Cerebral Palsy	HIV/AIDS	Schizophrenia	Deaf	Epilepsy
Chi-Square	12.777	25.648	25.399	26.156	11.786	24.773	21.140
Df	7	7	7	7	7	7	7
Asymp Sig	0.078	0.001	0.001	0.001	0.108	0.001	0.004

Statistical significance was therefore achieved for Arthritis, Cerebral Palsy, HIV/AIDS, Deaf and Epilepsy, with significance levels less than the alpha level of 0.05. The results therefore suggest that there is a difference in the attitudes towards the five impairments across the impairment groups the disabled respondents placed themselves into. Listed below in Table 7.6 are the mean ranks (scores are converted to ranks and the mean rank for each group is compared) for each category.

Table 7.6: Mean Ranks: Kruskal-Wallis H in Relation to Table 7.5 above

	Impairment Category Q.16 Demographic Data Questionnaire	N	Mean Rank
Down's Syndrome	Hearing Impairment	6	132.75
	Learning Difficulties	10	103.10
	Mental Health	29	113.02
	Physical (non-wheelchair user)	68	104.69
	Sight Impairment	10	92.75
	Wheelchair User	44	75.16
	Multiple Disabilities	27	99.74
	Other	3	117.17

7.6 cont.	Impairment Category Q.16 Demographic Data Questionnaire	N	Mean Rank
Arthritis	Hearing Impairment	6	143.17
	Learning Difficulties	10	124.45
	Mental Health	29	120.79
	Physical (non-wheelchair user)	68	99.90
	Sight Impairment	10	83.40
	Wheelchair User	44	69.63
	Multiple Disabilities	27	101.33
	Other	3	156.67
Cerebral Palsy	Hearing Impairment	6	136.92
	Learning Difficulties	10	117.90
	Mental Health	29	118.88
	Physical (non-wheelchair user)	68	105.09
	Sight Impairment	10	95.30
	Wheelchair User	44	65.57
	Multiple Disabilities	27	97.54
	Other	3	145.83

7.6 cont.	Impairment Category Q.16 Demographic Data Questionnaire	N	Mean Rank
HIV/AIDS	Hearing Impairment	6	146.92
	Learning Difficulties	10	122.05
	Mental Health	29	114.76
	Physical (non-wheelchair user)	68	103.46
	Sight Impairment	10	99.15
	Wheelchair User	44	65.09
	Multiple Disabilities	27	101.85
	Other	3	144.00
Schizophrenia	Hearing Impairment	6	130.25
	Learning Difficulties	10	102.05
	Mental Health	29	94.84
	Physical (non-wheelchair user)	68	105.56
	Sight Impairment	10	112.50
	Wheelchair User	44	76.09
	Multiple Disabilities	27	110.93
	Other	3	101.50

7.6 cont	Impairment Category Q.16 Demographic Data Questionnaire	N	Mean Rank
Deaf	Hearing Impairment	6	118.75
	Learning Difficulties	10	148.60
	Mental Health	29	119.62
	Physical (non-wheelchair user)	68	94.89
	Sight Impairment	10	87.70
	Wheelchair User	44	74.56
	Multiple Disabilities	27	101.87
	Other	3	158.33
Epilepsy	Hearing Impairment	6	133.92
	Learning Difficulties	10	133.95
	Mental Health	29	118.17
	Physical (non-wheelchair user)	68	97.65
	Sight Impairment	10	92.00
	Wheelchair User	44	71.72
	Multiple Disabilities	27	104.11
	Other	3	135.33

In order to test H2 further, the disabled sample was divided into sub-sets according to their response to question 11 on the Demographic Data Questionnaire, requesting the type of impairment (i.e. arthritis, cerebral palsy, multiple sclerosis, et cetera). Question 11 was included in the questionnaire in order to gather more specific data than the broad categories of question 16.

The Kruskal-Wallis H test was therefore conducted to explore whether each sub-sample of disabled respondents (based on responses to question 11 on the Demographic Data Questionnaire) held different strengths of attitude toward impairment, as measured by the Attitude Toward Impairment Scale. Respondents were divided into thirteen groups (arthritis; depression; spina bifida; cerebral palsy; multiple sclerosis; epilepsy; myalgic encephalomyelitis; spinal cord injured; sight impairment; hearing impairment; mental health – non-depression; other; and not disclosed). Statistically significant difference was only found for one group - arthritis - on the continuous variable (see Table 7. 7below).

Table 7.7: Kruskal-Wallis H Test on Ranking of Seven Impairments from the Attitude Toward Impairment Scale Score for Impairment Categories (as identified through Q.11 Demographic Data Questionnaire)

	Impairment Score						
	Down's Syndrome	Arthritis	Cerebral Palsy	HIV/AIDS	Schizophrenia	Deaf	Epilepsy
Chi-Square	6.769	21.215	7.019	11.187	7.920	18.461	14.529
Df	12	12	12	12	12	12	12
Asymp Sig	0.872	0.047	0.856	0.513	0.791	0.102	0.268

Only the mean rank for arthritis is therefore reported below in Table 7.8

Table 7.8: Mean Ranks: Kruskal-Wallis H in Relation to Table 7.7 above

	Impairment Category Q.11 Demographic Data Questionnaire	N	Mean Rank
Arthritis	Arthritis	40	95.40
	Depression	16	130.25
	Spina Bifida	12	92.21
	Cerebral Palsy	9	124.39
	Multiple Sclerosis	7	57.43
	Epilepsy	4	79.13
	Myalgic Encephalomyelitis	5	98.40
	Spinal Cord Injured	11	63.59
	Sight Impairment	11	88.73
	Hearing Impairment	6	91.17
	Mental Health (non-depression)	15	131.63
	Other Impairment	58	110.77
	Not Disclosed	10	95.20

People with multiple sclerosis were therefore found to view people with arthritis most positively, people with a spinal cord injury second, with people who listed arthritis as their primary impairment eighth from the thirteen groups. People with mental health (non-depression) and depression, viewed arthritis least positively out of all thirteen sub-samples.

In order to ensure the data met the necessary requirements of the Kruskal-Wallis H test, in terms of size of groups, and to see whether different results emerged, it was decided to merge some of the impairment types. Spina bifida & cerebral palsy; depression & mental health; and multiple sclerosis & myalgic encephalomyelitis, were therefore placed into three merged categories for testing. Therefore, impairment groups for the merged sample are shown in Table 7.9 below.

Table 7.9: Breakdown of Merged Impairment Sample

Impairment Type	Number
Arthritis	40
Epilepsy	4
Spinal Cord Injured	11
Sight	11
Hearing	6
Other	58
Not Disclosed	10
Spina Bifida & Cerebral Palsy	21
Depression & Mental Health	31
Multiple Sclerosis & Myalgic Encephalomyelitis	12
TOTAL	204

The merged sample size (n = 204) is less than the overall disabled sample size (n = 217) due to incomplete data from thirteen subjects on the ATIS.

Findings for the merged impairment sample are presented in Table 7.10 below.

Table 7.10: Kruskal-Wallis H Test on Ranking of Seven Impairments from the Attitude Toward Impairment Scale Score for Merged Impairment Categories (as identified through Q.11 Demographic Data Questionnaire)

	Impairment Score						
	Down's Syndrome	Arthritis	Cerebral Palsy	HIV/AIDS	Schizophrenia	Deaf	Epilepsy
Chi-Square	6.705	18.246	6.860	9.832	6.242	14.064	14.353
Df	9	9	9	9	9	9	9
Asymp Sig	0.668	0.032	0.652	0.364	0.715	0.120	0.110

As before, only the arthritis category obtained a statistically significant result of $p < 0.05$, therefore only the results for arthritis will be reported.

Table 7.11: Mean Ranks: Kruskal-Wallis H in Relation to Table 7.10 above

	Impairment Category Q.11 Demographic Data Questionnaire	N	Mean Rank
Arthritis	Arthritis	40	95.40
	Epilepsy	4	79.13
	Spinal Cord Injured	11	63.59
	Sight Impairment	11	88.73
	Hearing Impairment	6	91.17
	Other Impairment	58	110.77
	Not Disclosed	10	95.20
	Spina Bifida & Cerebral Palsy	21	106.00
	Depression & Mental Health	31	130.92
	Multiple Sclerosis & Myalgic Encephalomyelitis	12	74.50

People with a spinal cord injury viewed arthritis most positively, with the merged sub-sample multiple sclerosis & myalgic encephalomyelitis second. As with the un-merged data set, those with depression & mental health viewed arthritis least positively of all the sub-samples of disabled people.

Although results in relation to the other six impairment categories on the ATIS did not achieve statistical significance, it is interesting to note the depression & mental health merged sub-sample held the least positive mean ranks of all twelve sub-samples towards epilepsy, deaf, HIV/AIDS, cerebral palsy and arthritis categories. With respect to the schizophrenia category however, the epilepsy sub-sample held the least positive mean rank, spina bifida & cerebral palsy next, sight impairment third, arthritis fourth, and depression & mental health sub-sample fifth. Hence, whilst viewing any conclusions cautiously, due to the data not achieving statistical significance, it could tentatively be suggested that people living with mental health problems tend to hold more positive attitudes toward people living with schizophrenia, than they do toward other impairment groups.

Overall, whilst the null hypothesis for H2 cannot be rejected, it would appear that disabled people as a group in society do hold a hierarchy of impairment. However, the type of impairment the respondent has does not appear to influence the hierarchy. In other words, people with cerebral palsy appear to hold the same hierarchy of impairment as people with mental illness, and so on. However, whilst only the Arthritis category obtained statistical significance, this data suggests that people with mental health or depressive impairments tend to hold the least positive attitudes toward other disabled people.

H3: A hierarchy of impairments exists for non-disabled people

In addition to H2, it was felt to be important to identify, using the ATIS and Social Acceptance List, whether non-disabled people also held a hierarchy of impairment. This would enable comparisons to be made with the findings from H2. As with H2, the non-parametric Friedman test was used to test for statistical significance in the rank ordering of impairments as measured by the two tools.

A non-parametric Friedman Test was conducted on the scores for each impairment group as measured by the ATIS for the non-disabled sample (n = 111; Chi-Squared 265.624; df 6). Three people did not provide usable data. Table 7.12 below gives the mean rank for the seven impairment groups and the subsequent rank ordering. The results of the test suggest there are significant differences between the impairment groups, indicated by a significance level of $p < 0.0005$. We can therefore reject the null hypothesis in favour of H3.

Table 7.12: Friedman Test Mean Ranks as Measured by the ATIS for the Non-Disabled Sample

Impairment	Mean Rank	Rank Order
Deaf	2.20	1
Arthritis	2.91	2
Epilepsy	3.30	3
HIV/AIDS	4.28	4
Cerebral Palsy	4.51	5
Down's Syndrome	5.21	6
Schizophrenia	5.59	7

A Friedman Test was also conducted on the results for the ten impairment groups on the Social Acceptance List (see Appendix H) for the non-disabled sample ($n = 91$; Chi-Squared 519.936; df 9). Twenty-three respondents did not provide usable data or did not complete the Social Acceptance List. Table 7.13 below gives the mean rank for the ten impairment groups and the subsequent rank ordering. The results of the test suggest there are significant differences between the impairment groups, indicated by a significance level of $p < 0.0005$. We can therefore reject the null hypothesis in favour of H3.

Table 7.13: Friedman Test Mean Ranks as Measured by the Social Acceptance Task for the Non-Disabled Sample

Impairment	Mean Rank	Rank Order *
Arthritis	1.52	1 (2)
Blindness	3.09	3
Cerebral Palsy	6.81	7 (5)
Deafness	2.66	2 (1)
Down's Syndrome	6.48	6 (6)
Epilepsy	4.35	4 (3)
HIV/AIDS	7.65	8 (4)
Paraplegia	6.27	5
Quadriplegia	7.99	9
Schizophrenia	8.19	10 (7)

* Brackets denote place of rank ordering through the ATIS

Caution should be shown when interpreting result from the Social Acceptance List due to the number of non-responses (n = 91 out of a possible 114). However, as Table 7.13 above indicates, similar results are achieved using either tool for the non-disabled respondents.

In order to support the findings for both H2 and H3, a parametric test was employed. A one-way between-groups multivariate analysis of variance was performed to investigate disability status in attitudes toward different impairment groups. The disabled and non-disabled samples were analysed using Multivariate Analysis of Variance (MANOVA) with disability (have disability / do not have disability) as the independent variable and attitude toward each of the seven impairment groups on the Attitude Toward Impairment Scale (Down's syndrome, arthritis, cerebral palsy, HIV/AIDS, schizophrenia, deaf and epilepsy) as the dependent variable.

To test for multivariate normality, Mahalanobis distances (the distance of a particular case from the centroid of the remaining cases) was calculated. This identified six outliers. These cases were therefore removed from the subsequent calculations.

Seven dependent variables were used based on the ATIS scores. The independent variable was disability status. Preliminary analysis identified six outliers, but more importantly Box's test of Equality of Covariance found that the data violated the assumption of equality of variance with $p < 0.001$. There was no statistically significant difference between those who identified as disabled and respondents who did not (as identified through question 8 of the Demographic Data Questionnaire) on the combined dependent variables: $\underline{F}$ (7, 302) = 1.842, $p = 0.079$; Wilks' Lambda = 0.959; partial eta squared = 0.41.

Therefore, this result suggests that both disabled and non-disabled people hold similar attitudes, as measured by the ATIS, toward each of the seven impairment groups utilised on the scale. In other words, both the disabled and non-disabled samples held statistically similar attitudes toward people with Down's syndrome, arthritis, cerebral palsy, HIV/AIDS, schizophrenia, deafness and epilepsy, as distinct groups.

These results, when considered in conjunction with the result found in relation to both the disabled and non-disabled samples holding almost identical hierarchies of impairment as tested by the Friedman test, appear to be consistent. Thus, whereas the Friedman test identified that a hierarchy of impairment may exist, the MANOVA suggests it may be the same for both samples as non-significant results were found. However, due to the violation of the assumption of equality of variance, this finding must be viewed cautiously.

H4: Disabled people with high levels of contact with other disabled people will express more positive attitudes toward disabled people than disabled people with lower levels of contact

The literature suggests that contact with stigmatised individuals and groups, either directly or indirectly, can lead to positive attitude change. H4 is intended to test whether disabled people who have high levels of contact with other disabled people (regardless of the type of impairment) hold more positive attitudes than disabled people with low levels of contact. The General Attitude Scale Toward Disabled People (see Chapter 6 for discussion on the GASTDP) was used to measure attitudes.

Parametric t-tests were utilised to test for statistical significance as Miller (1984: p. 65) suggests that such tests can be more powerful, even when the data is non-parametric. Therefore, using an Independent Samples t-test (one-tailed), H4 was initially tested on the two sub-samples of disabled people who either attended at some time in their childhood special needs education or did not. People who did attend such schooling would inevitably have had high levels or contact with other disabled children at some point in their lives.

An independent-samples t-test was conducted to compare the General Attitude Scale Toward Disabled People scores for disabled people who attended / did not attend Special Needs Education as identified through the respondent's response to question 6 of the Demographic Data Questionnaire. There was no significant difference in scores for disabled people who attended Special Needs Education ($\underline{M}$ = 41.08, s.d. = 13.633) and disabled people who did not attend Special Needs Education ($\underline{M}$ = 41.28, s.d. = 11.015); t (204) = -0.097, p = 0.923 (see Table 7.14). As $p > 0.05$, we cannot reject the null hypothesis for H4.

Table 7.14: Independent-Samples T-Test for Disabled Sample Attended / Not Attended Special Needs Education for GASTDP

Attended Special Needs Education	GASTDP (Mean)	Standard Deviation
Yes = 39	41.08	13.633
No = 167	41.28	11.015

	T	Df	Sig. (2-tailed)	Mean Difference
Equal Variances Assumed	-0.097	204	0.923	-0.20
Equal Variances Not Assumed	-0.085	50.201	0.933	-0.20

In order to test H4 further, one-way between-groups analysis of variance (ANOVA) was conducted on each of the three environments (Work/College; Home; and Social) to explore the impact of the level of contact with other disabled people in three different environments on attitudes towards disability, as measured by the General Attitude Scale Toward Disabled People. Respondents were divided into six groups based on self-reported level of contact (see Table 7.15 below). No statistical difference was found for any of the three environments between the six groups and therefore we cannot reject the null hypothesis.

Although not statistically significant, within the home environment, those disabled people with the highest level of contact (21+ disabled people), in other words, respondents who would have been living within large residential care facilities (n = 8), scored the least positive attitudes towards disabled people as measured by the GASTDP (M = 49.50). Those who indicated no contact with disabled people at home (n = 100) were found to have the next least positive attitudes (M = 42.80). The most positive group were found to be those with a contact rate of 6 – 10 disabled people within the home environment (see Table 7.15 below).

Table 7.15: One-Way Between Groups Analysis of Variance on Attitudes as Measured by GASTDP for Disabled Respondents Divided by Level of Contact

Number of Disabled People in Contact with	Number (Work/ College)	Mean (Work/ College)	Std. Dev. (Work/ College)	Number (Home)	Mean (Home)	Std. Dev. (Home)	Number (Social)	Mean (Social)	Std. Dev. (Social)
0	97	43.87	11.367	100	42.80	10.725	56	42.89	11.061
1	19	39.26	7.957	52	38.90	11.074	38	42.34	11.143
2-5	27	39.89	10.970	40	39.80	12.476	63	39.51	12.420
6-10	22	37.55	11.329	5	33.00	7.842	25	40.68	11.470
11-20	10	34.20	9.295	1	39.00	-	13	39.77	12.084
21+	31	40.41	13.469	8	49.50	15.784	11	41.91	9.884
Total	206			206			206		

Thus, it can be suggested, the intensity of contact between disabled people regardless of the size (in terms of numbers of other disabled people met) appears to have no affect upon attitudes towards other disabled people. The null hypothesis for H4 cannot therefore be rejected.

In order to provide comparative data, the level of contact for the non-disabled sample was analysed. No significant results were achieved for the non-disabled sample in any of the three environments reaching the required $p < 0.05$ (Work/College $p = 0.073$; Home $p = 0.179$; Social $p = 0.345$) utilising one-way between groups analysis of variance exploring the impact of the number of disabled people non-disabled people have in relation to each of the three environments. Non-disabled people reported zero contact with disabled people in all three environments, with the home environment achieving a majority (see Table 7.16 below).

Table 7.16: One-Way Between Groups Analysis of Variance on Attitudes as Measured by GASTDP for Non-Disabled Respondents Divided by Level of Contact

Number of Disabled People in Contact with	Number (Work/ College)	Mean (Work/ College)	Std. Dev. (Work/ College)	Number (Home)	Mean (Home)	Std. Dev. (Home)	Number (Social)	Mean (Social)	Std. Dev. (Social)
0	47	41.17	8.031	74	40.36	8.093	34	40.65	8.735
1	26	38.27	9.349	24	36.04	7.509	36	37.33	8.947
2-5	22	37.23	7.178	13	38.08	9.561	38	39.95	7.170
6-10	6	36.17	10.439	0	_	_	2	32.50	0.707
11-20	3	39.00	7.211	0	_	_	1	38.00	_
21+	7	37.71	6.921	0	_	_	0	_	_
Total	111			111			111		

H5: There will be a statistically significant relationship between the nature of contact with disabled people (work, home, social setting) and attitudes toward disabled people

The environment in which disabled and non-disabled people have social interactions with disabled people is further tested in H5. H5 assumes that each of the three environments (work, home and social) will have an affect upon attitudes towards disabled people. In other words, simple contact with other disabled people may not be enough to induce more positive attitudes, but the place or social situation that interaction takes place may also have an impact. For, those who have contact with other disabled people within a social setting are likely to be doing so through choice, whereas those having contact in a work or living setting are likely to be as a consequence of either chance or the segregated/specialised nature of some service provision for disabled people (for instance, supported businesses or residential care homes).

One-way between-groups analysis of variance was conducted on each of the three environments (Work/College; Home; and Social) to explore the impact of the frequency of contact with other disabled people for the disabled sample, in each of the three different environments on attitudes towards disability, as measured by the General Attitude Scale Toward Disabled People. Respondents were divided into five groups based on self-reported frequency of contact (see Table 7.17 below). No statistical difference was found for any of the three environments between the five groups and therefore the null hypothesis for H5 cannot be rejected with respect to the disabled sample. Eleven respondents did not provide usable data or did not complete the GASTDP.

Table 7.17: One-Way Between Groups Analysis of Variance on Attitudes as Measured by GASTDP for Disabled Respondents Divided by Frequency of Contact

Frequency of Contact	Number (Work/ College)	Mean (Work/ College)	Std. Dev. (Work/ College)	Number (Home)	Mean (Home)	Std. Dev. (Home)	Number (Social)	Mean (Social)	Std. Dev. (Social)
Daily	70	40.71	12.220	61	42.62	12.698	38	38.84	10.929
Weekly	41	39.39	11.762	23	37.65	11.773	71	41.52	11.345
At least once a month	19	44.21	11.098	22	36.09	11.944	44	41.98	12.701
Once every 3 months	13	42.00	12.035	5	48.00	12.570	6	34.17	8.727
Less often than once every 3 months	63	41.97	10.657	95	42.05	10.087	47	42.96	11.200
Total	206			206			206		

In order to explore this hypothesis further, it was felt beneficial to analyse the data in terms of where the research tools (the GASTDP and ATIS) were circulated. In other words, whether useful information could be derived from analysis based on sub-samples of the respondents, such as whether trainees on a government funded vocational training programme who completed the research tools held significantly different attitudes to people attending a university MSc Counselling course. Although this requires a degree of speculation and assumptions about the disabled respondents, it would be reasonable to assume that people who belonged to coalitions of disabled people would have high levels of contact with other disabled people within a social setting.

One-way between-groups analysis of variance was conducted to explore whether each sub-sample of disabled respondents held different strengths of attitude toward disability, as measured by the General Attitude Scale Toward Disabled People. Respondents were divided into twelve groups based on the research tool circulation (see Table 7.18). No statistical difference was found for any of the twelve groups. However, the three most positive sub-groups of the disabled sample were Leonard Cheshire User Forum (n = 8; M = 31.13), Essex Coalition of Disabled People (n = 7; M = 31.57) and Hampshire Coalition of Disabled People (n = 22; M = 37.00). These three groups are made up of disabled people who voluntarily meet and are involved in the forwarding of a disability rights agenda.

Table 7.18: One-Way Between-Groups ANOVA on Attitudes as Measured by GASTDP for Respondents Divided by Data Collection Groups

Code	Number	Mean	Std. Deviation
Job Broker Clients	33	40.39	10.037
Residential Trainees	19	42.47	9.371
Domiciliary Care Service User	23	42.96	13.012
Self Employment Database	57	43.65	10.020
Hampshire Coalition of Disabled People	22	37.00	10.506
Leonard Cheshire User Forum	8	31.13	15.824
Non-Disabled Random Sample (self identified as disabled)	13	46.69	15.348
Enham Visitor	2	48.50	14.849
Employer Database (self identified as disabled)	3	38.33	2.887
Essex Coalition of Disabled People	7	31.57	7.764
Bournemouth College Group	8	38.00	10.784
Other	11	42.91	13.375
Total	206		

In order to explore this hypothesis from a non-disabled perspective, in other words, to test whether the context (environment) and frequency of contact between non-disabled and disabled people had an impact, each of the three environments were tested.

One-way between-groups analysis of variance was conducted on each of the three environments (Work/College; Home; and Social) to explore the impact of the frequency of contact with disabled people in three different environments on attitudes towards disability, as measured by the General Attitude Scale Toward Disabled People, for the non-disabled sample. Respondents were divided into five groups based on self-reported frequency of contact (see Table 7.19 below). No statistical difference was found for the Work/College ($p = 0.798$) or Social ($p = 0.275$) environments between the five groups (daily, weekly, at least once a month, once every 3 months and less often than once every 3 months), with both groups greater than the required 0.05 probability. However, a significance of $p = 0.019$ was achieved for the home environment. Caution must be expressed with regards to this finding due to the unequal group sizes and that the Daily group only contains four respondents for the Home environment. Thus, a Type 1 error (rejecting the null hypothesis when it is, in fact, true) cannot be discounted.

Table 7.19: One-Way Between Groups Analysis of Variance on Attitudes as Measured by GASTDP for Non-Disabled Respondents Divided by Frequency of Contact

Frequency of Contact	Number (Work/ College)	Mean (Work/ College)	Std. Dev. (Work/ College)	Number (Home)	Mean (Home)	Std. Dev. (Home)	Number (Social)	Mean (Social)	Std. Dev. (Social)
Daily	25	38.48	7.366	4	30.50	5.447	8	39.75	9.285
Weekly	17	37.18	7.308	11	38.00	7.836	24	40.75	6.476
At least once a month	11	39.91	9.700	5	30.60	5.030	27	38.63	9.111
Once every 3 months	10	39.90	9.303	10	38.90	8.556	15	35.07	7.216
Less often than once every 3 months	48	39.90	8.677	81	40.31	8.123	37	40.05	8.698
Total	111			111			111		

H6: People who identify themselves as having a disability will hold significantly more positive attitudes toward disabled people than disabled people who do not identify themselves as having a disability

Many disabled people do not identify themselves as a disabled person, despite acknowledging they have some form of impairment. In addition, other people, including professionals working in the field of disability, may categorise the individual as 'disabled' and therefore entitled to benefits and services not available to non-disabled people. H6 (one-tailed) is designed to test the assumption that people who identify as disabled will have more positive attitudes toward other disabled people than those who do not self-identify as disabled, such as Swain and French (2000) contend with the affirmative model of disability.

Initially, a one-way between-groups analysis of variance was conducted to explore the impact of the self reported duration of regarding oneself as a disabled person on attitudes towards disability, as measured by the General Attitude Scale Toward Disabled People (Eleven respondents did not provide usable data or complete the GASTDP). Respondents were divided into eight groups (see Table 7.20 below). There was a statistically significant difference at the $p < 0.05$ level in the GASTDP results for the groups Never and 1-2 years [$\underline{F}(7, 198) = 0.428$, $\underline{p} = 0.024$]. The effect size, calculated using eta squared, was 0.077, which suggests a medium effect size. Post-hoc comparisons using the Tukey HSD test indicated that the mean score for group 'Never' (M = 37.65, SD = 12.115) was significantly different from group '1-2 years' (M = 48.86, SD = 9.868) (see Table 7.21 below). All other groups did not significantly differ and have therefore not been reported.

Table 7.20: One-Way Between-Groups ANOVA on Attitudes as Measured by GASTDP for Respondents Divided by Duration Disabled Respondents Have Viewed Themselves as Having a Disability

Duration	Number	Mean	Std. Deviation
Never	20	37.65	12.115
1 – 2 years	28	48.86	9.868
3 – 5 years	34	41.00	9.008
6 – 10 years	28	39.68	11.763
11 –15 years	15	39.40	9.912
16 – 20 years	17	40.00	10.302
21 years or over	26	39.62	13.900
Always	38	41.26	12.046
Total	206		

Table 7.21: Dependent Variable: GASTDP Tukey HSD

Duration as Disable Person	Duration as Disabled Person	Mean Difference	Std. Error	Sig.
Never	1-2 years	-11.21*	3.297	0.018
	3-5 years	-3.35	3.173	0.935
	6-10 years	-2.03	3.297	0.999
	11-15 years	-1.75	3.846	1.000
	16-20 years	-2.35	3.715	0.998
	21 years or over	-1.97	3.349	0.999
	always	-3.61	3.111	0.942
1-2 years	Never	11.21*	3.297	0.018
	3-5 years	7.86	2.874	0.119
	6-10 years	9.18	3.009	0.052
	11-15 years	9.46	3.603	0.153
	16-20 years	8.86	3.462	0.178
	21 years or over	9.24	3.067	0.058
	Always	7.59	2.804	0.126

7.21 cont. Duration as Disable Person	Duration as Disabled Person	Mean Difference	Std. Error	Sig.
Always	Never	3.61	3.111	0.942
	1-2 years	-7.59	2.804	0.126
	3-5 years	0.26	2.658	1.000
	6-10 years	1.58	2.804	0.999
	11-15 years	1.86	3.434	0.999
	16-20 years	1.26	3.286	1.000
	21 years or over	1.65	2.866	0.999

* Mean difference is significant at the 0.05 level

Responses to questions 8, 9 and 10 of the Demographic Data questionnaire were then used to identify sub-sets of the disabled sample in terms of self identification as a disabled person. Respondents were asked to state either 'yes', 'no' or 'don't know' to three questions, "Do you have a disability?", "Do people who know you well think you have a disability?" and "Do people who do not know you well think you have a disability?". A one-way between-groups ANOVA was performed for each of the three questions with the groups defined by the response of 'yes', 'no' or 'don't know'. The mean scores for the groups as measured by the GASTDP were used to identify whether each group held statistically significant differences in attitude. Although no statistical significance was achieved for any of the three sets of groups, with respect to the question, "Do you have a disability?" the 'don't know' sub-sample achieved the highest (least positive) score (n = 4; M = 49.25; S.D. = 7.544) with the 'yes' sub-sample achieving the lowest (most positive) score (n = 193; M = 41.08; S.D. = 11.261). However, caution must be shown in any interpretation of these results due to the very small number of people within the 'don't know' sub-sample (n = 4). Table 7.22 below lists the means and standard deviations for each sub-sample from the three questions, as measured by the GASTDP.

Table 7.22: One-Way Between-Groups ANOVA on Attitudes as Measured by GASTDP for Respondents Divided by Self Identification as a Disabled Person

Question		N	Mean	Standard Deviation
Do you have a disability	Yes	193	41.08	11.261
	No	9	41.11	17.403
	Don't know	4	49.25	7.544
Do people who know you well think you have a disability?	Yes	152	40.44	11.437
	No	37	43.73	11.716
	Don't know	17	42.94	11.551
Do people who do not know you well think you have a disability?	Yes	78	39.09	11.369
	No	92	41.89	11.090
	Don't know	36	44.22	12.352

Thus, whilst the null hypothesis for H6 (one-tailed) cannot be rejected, it would appear identification as a disabled person may be an indication as to attitudes towards disability.

H7: Attitudes of disabled people toward other disabled people will score significantly more highly on the subtle prejudice sub-scale than the blatant prejudice sub-scale

In order to test whether people hold disablist attitudes, but do so in subtle ways, rather than overt behaviours, H7 (one-tailed) was tested. The GASTDP was developed with subtle and blatant prejudice sub-scales (see Chapter 6), in order to test the hypothesis that people still hold negative attitudes toward disability, whilst saying they reject blatant discriminatory behaviour.

In order to test this theory, a paired-sample t-test was conducted on the disabled sample data to evaluate whether there was a significant difference between the respondent's scores on the subtle and blatant prejudice sub-scales of the General Attitude Scale Toward Disabled People (one-tailed). Eight respondents did not provide usable data. Results for the Subtle Prejudice sub-scale are $\underline{M} = 18.95$, $\underline{S.D.} = 5.850$ and the Blatant Prejudice sub-scale $\underline{M} = 14.95$, $\underline{S.D.} = 5.377$, with $t(208) = 9.787$, $p<.0005$. As the observed value of t is greater than 2.326, (Miller 1984: p. 174) we can conclude there is a significant difference between the Subtle Prejudice and Blatant Prejudice Sub-scales and can reject the null hypothesis for H7 (see Table 7.23). Given the eta squared value of 0.315 was achieved, we can conclude there was a large effect, with a substantial difference between the two sub-scales.

Table 7.23: Paired Samples T-Test for Disabled Sample between Subtle and Blatant Sub-Scales

	Mean	N	Std. Deviation	Std. Error Mean
Subtle Prejudice Sub-Scale	18.95	209	5.850	0.405
Blatant Prejudice Sub-Scale	14.95	209	5.377	0.372

Having rejected the null hypothesis for H7 with respect to the disabled sample, it was felt further information could be gained by analysing the non-disabled sample also. Three respondents did not provide usable data. A paired-sample t-test was therefore conducted on the non-disabled sample data to evaluate whether there was a significant difference between the subject's scores on the subtle and blatant sub-scales of the General Attitude Scale Toward Disabled People (one-tailed). Results for the Subtle Prejudice sub-scale were M = 18.0541, S.D. = 4.82388 and Blatant Prejudice sub-scale M = 13.9459, S.D. = 3.93547, with t(110) = 9.825, p<.0005. As the observed value of t is greater than 2.326, (Miller 1984: p. 174) we can conclude there is a significant difference between the Subtle Prejudice and Blatant Prejudice Sub-scales for the non-disabled sample (see Table 7.24). Given the eta squared value of 0.4673895 was achieved, we can conclude there was a large effect, with a substantial difference between the two sub-scales.

Table 7.24: Paired Samples T-Test for Non-Disabled Sample between Subtle and Blatant Sub-Scales

	Mean	N	Std. Deviation	Std. Error Mean
Subtle Prejudice Sub-Scale	18.0541	111	4.82388	0.45786
Blatant Prejudice Sub-Scale	13.9459	111	3.93547	0.37354

7.3 Additional Results

Having explored the data in relation to the hypotheses produced, it was felt additional information could be gathered through further exploration of the data.

Gender

Both disabled and non-disabled samples were therefore analysed with respect to gender in order to see whether men or women held different attitudes toward disabled people as measured by the GASTDP. Both sets of data were analysed using an independent-samples t-test and a Mann-Whitney U Test (see Tables 7.25 and 7.26 below).

An independent-samples t-test was conducted to compare the attitudes of disabled males and disabled females toward disability as measured by the GASTDP. A statistically significant difference in scores was found for males (M = 43.14, S.D. = 10.265) and females (M = 39.29, S.D. = 12.423), t(204) = 2.427, p = 0.016. However, the magnitude of the differences in the means was very small (eta squared = 0.028). Therefore, although there was a statistically significant difference between disabled males and disabled females in their attitudes towards disabled people (females presenting more positive attitudes), the effect was small and so any conclusions drawn must be cautious. As the data is non-parametric in nature and due to the small effect, it was felt appropriate to further test the data using the non-parametric Mann Whitney U Test.

The Z value was –2.485 with a significance level of $p = 0.013$. As $p < 0.05$ we can conclude the result is significant. Hence, disabled females hold more positive attitudes toward disabled people than disabled males (see table 7.25 below).

Table 7.25: Independent-Samples T-Test for Disabled Sample Male / Female for GASTDP

Gender	GASTDP (Mean)	Standard Deviation
Male = 104	43.14	10.265
Female = 102	39.29	12.423

	T	Df	Sig. (2-tailed)	Mean Difference
Equal Variances Assumed	2.427	204	0.016	3.85
Equal Variances Not Assumed	2.422	195.564	0.016	3.85

Table 7.26: Mann-Whitney U Test for Disabled Sample Male / Female for GASTDP

Gender	GASTDP (Mean Rank)	Sum of Ranks
Male = 104	113.72	11826.50
Female = 102	93.08	9494.50

With respect to the non-disabled sample, the independent-samples t-test and Mann-Whitney U test were also conducted. For the Mann-Whitney U test, the

Z value was -1.864 with a significance level of $p = 0.062$. As $p > 0.05$ we can conclude the result is not significant. Non-significant results were also achieved using the independent-samples t-test (see Tables 7.27 and 7.28 below), thus suggesting that non-disabled men and non-disabled women hold similar attitudes toward disabled people as measured by the GASTDP.

Table 7.27: Independent-Samples T-Test for Non-Disabled Sample Male / Female for GASTDP

Gender	GASTDP (Mean)	Standard Deviation
Male = 36	41.17	8.765
Female = 75	38.20	7.908

	T	Df	Sig. (2-tailed)	Mean Difference
Equal Variances Assumed	1.786	109	0.077	2.97
Equal Variances Not Assumed	1.722	63.136	0.090	2.97

Table 7.28: Mann-Whitney U Test for Non-Disabled Sample Male / Female for GASTDP

Gender	GASTDP (Mean Rank)	Sum of Ranks
Male = 36	64.21	2311.50
Female = 75	52.06	3904.50

What is noteworthy, however, is that for both samples (disabled and non-disabled), women consistently achieved slightly more positive (lower) scores than males.

Age

It has been highlighted elsewhere that younger people generally express more positive attitudes towards disability than older people. Therefore, it could be expected that a positive correlation would occur between age and scores on the GASTDP (higher scores equating to less positive attitudes). However, the relationship between age and attitudes toward disabled people measured by the GASTDP was investigated using Spearman's rho. No significant results were achieved for either the disabled ($r = -0.002$; $n = 205$) or non-disabled ($r = 0.099$; $n = 111$) samples using Spearman's rank order correlation.

Education

In order to explore whether people who achieve higher levels of education tend to express more positive attitudes towards minority groups, such as disabled people, one-way between groups ANOVA was performed on both the disabled and non-disabled samples with each sample divided by self-reported educational achievement level and attitude measured by the GASTDP. It was expected that the GASTDP scores would fall (more positive attitudes) as the level of educational achievement rose.

Although statistically significant results were not achieved for either disabled or non-disabled samples, there appears to be a 'trend' for more positive scores to be achieved by those with higher levels of education, with the Other and None categories reflecting the least positive attitudes in both sample (see Tables 7.29 and 7.30 below).

Table 7.29: One-Way Between-Groups ANOVA on Attitudes as Measured by GASTDP for Respondents Divided by Educational Achievement (Disabled People)

Level of Qualification Achieved	N	Mean	Std. Dev.
None	39	45.10	11.443
GCSE / O Level / (G) NVQ Level 2	57	41.65	11.128
A Level / (G) NVQ Level 3	31	40.32	11.297
Diploma / NVQ Level 4 / HND	29	37.28	9.614
Degree	18	38.00	11.872
Post-Graduate Qualification	16	37.75	12.239
Other	16	46.44	12.500
Total	206		

Table 7.30: One-Way Between-Groups ANOVA on Attitudes as Measured by GASTDP for Respondents Divided by Educational Achievement (Non-Disabled People)

Level of Qualification Achieved	N	Mean	Std. Dev.
None	4	49.25	6.185
GCSE / O Level / (G) NVQ Level 2	20	38.70	9.234
A Level / (G) NVQ Level 3	14	41.64	8.196
Diploma / NVQ Level 4 / HND	9	39.78	9.602
Degree	33	37.97	7.539
Post-Graduate Qualification	28	37.64	7.814
Other	3	42.67	5.859
Total	111		

Employment Status

Employment status was tested using one-way between groups ANOVA on attitudes as measured by the GASTDP and employment status as reported by question 7 of the Demographic Data Questionnaire for both the disabled and non-disabled samples. Respondents were divided into nine groups (full-time paid; part-time paid; full-time voluntary; part-time voluntary; unemployed due to age – retired; never worked due to disability; no longer work due to disability; training and other). Missing data for the GASTDP caused the number of respondents for each group to be lower than those reported in Table 6.9. Both samples achieved a significance value of $p > 0.05$ for Levene's test, and therefore have not violated the homogeneity of variance assumption.

Table 7.31: One-Way Between-Groups ANOVA on Attitudes as Measured by GASTDP for Respondents Divided by Employment Status (Disabled and Non-Disabled Samples)

Employment Status	N		Mean		Std. Dev.	
	Disabled	Non-Disabled	Disabled	Non-Disabled	Disabled	Non-Disabled
Full-Time Paid	36	61	42.83	39.98	12.698	7.841
Part-Time Paid	28	23	33.92	38.35	9.976	7.499
Full-Time Voluntary	5	0	52.80	0	17.254	0
Part-Time Voluntary	20	2	37.45	37.00	10.324	2.828
Unemployed Due to Age – Retired	14	10	50.93	43.40	9.034	11.306
Never Worked Due to Disability	10	0	38.50	0	6.852	0
No Longer Work Due to Disability	70	0	41.06	0	10.798	0
Training	23	12	43.91	32.92	10.233	6.529
Other	2	3	38.00	41.00	2.828	11.269
Total	206	111				

For the disabled sample there were statistically significant results at the $p < 0.05$ level in the GASTDP scores for the nine employment status groups [$F(8, 197) = 4.265$, $p = 0.0005$] were achieved. The effect size, calculated using eta squared, was 0.1476, which according to Cohen (1988), is a large effect. Post-hoc comparisons using Tukey HSD test indicated that the mean score for Full-Time Paid was statistically different from Part-Time-Paid; Part-Time Paid was statistically different from Full-Time Paid, Full-Time Voluntary and Training, Full-Time Voluntary was statistically different from Part-Time Paid, Part-Time Voluntary was statistically different from Unemployed Due to Age - Retired, Unemployed Due to Age – Retired was statistically different from Part-Time Paid and Part-Time Voluntary, and Training was statistically different from Part-Time Paid. See Table 7.31 above for mean scores and standard deviations for each group. See Table 7.32 below for post-hoc comparisons using Tukey HSD test – significant results only have been reported.

Table 7.32: Dependent Variable: GASTDP Tukey HSD (Disabled Sample)

Employment Status	Employment Status	Mean Difference	Std. Error	Sig.
Full-time Paid	Part-Time Paid	8.91	2.792	0.043
Part-Time Paid	Full-Time Paid	-8.91	2.792	0.043
	Full-Time Voluntary	-18.88	5.298	0.013
	Unemployed Due to Age – Retired	-17.01	3.596	0.001
	Training	-9.99	3.106	0.040
Full-Time Voluntary	Part-Time Paid	18.88	5.298	0.013
Part-Time Voluntary	Unemployed Due to Age – Retired	-13.38	3.781	0.013
Unemployed Due to Age – Retired	Part-Time Paid	17.01	3.596	0.001
	Part-Time Voluntary	13.48	3.781	0.013
Training	Part-Time Paid	9.99	3.106	0.040

The mean difference is significant at the $p < 0.05$ level.

For the non-disabled sample there were statistically significant results at the $p < 0.05$ level in the GASTDP scores for the nine employment status groups (three groups contained no respondents) [$F(5, 105) = 2.232$, $p = 0.056$]. The effect size, calculated using eta squared, was 0.096, which according to Cohen (1988), is a medium effect. Post-hoc comparisons using Tukey HSD test indicated that the mean score for Unemployed Due to Age – Retired was statistically different from Training. See Table 16.30 above for mean scores and standard deviations for each group. See Table 7.33 below for post-hoc comparisons using Tukey HSD test – significant results only have been reported.

Table 7.33: Dependent Variable: GASTDP Tukey HSD (Non-Disabled Sample)

Employment Status	Employment Status	Mean Difference	Std. Error	Sig.
Unemployed Due to Age – Retired	Training	10.48	3.448	0.034
Training	Unemployed Due to Age – Retired	-10.48	3.448	0.034

The mean difference is significant at the $p < 0.05$ level.

Self-Reported Quality of Relationship with Disabled People

A one-way between-groups analysis of variance was conducted to explore the association between self-reported quality of relationships with disabled people on attitudes and attitudes toward disability as measured by the GASTDP for the disabled sample (see Table 7.34 below). Respondents were divided into five groups (very good; good; okay; poor; very poor) according to responses to question 15 on the Demographic Data Questionnaire for each of the three environments, Work/College, Home and Social. In addition, non-responses (Missing) were placed into a separate category. There was a statistically significant difference at the $p < 0.05$ level for the GASTDP scores for each of the three environments.

Taking each of the three environments in turn, with respect to the Work/College environment [F (5, 200) = 5.333, p = 0.001], post-hoc comparisons using Tukey HSD test indicated that a mean score for the Very Good group (M = 35.80, SD = 12.109) was statistically different from the Good group (M = 45.46, SD = 10.156) and the missing value group (M = 42.72, SD = 11.100).

For the Home environment [F (5, 200) = 4.962, p = 0.001], post-hoc comparisons using Tukey HSD test indicated that a mean score for the Very Good group (M = 36.57, SD = 11.882) was statistically different from the Good group (M = 44.56, SD = 11.087).

For the Social environment [F (5, 200) = 4.585, p = 0.001], post-hoc comparisons using Tukey HSD test indicated that a mean score for the Very Good group (M = 36.83, SD = 11.735) was statistically different from the Good group (M = 43.64, SD = 10.382) and Okay group (M = 45.95, SD = 10.385).

Table 7.34: One-Way Between Groups Analysis of Variance on Attitudes as Measured by GASTDP for Disabled Respondents Divided by Self-Reported Quality of Relationship

Relationship	Number (Work/ College)	Mean (Work/ College)	Std. Dev. (Work/ College)	Number (Home)	Mean (Home)	Std. Dev. (Home)	Number (Social)	Mean (Social)	Std. Dev. (Social)
Very Good	65	35.80	12.109	69	36.57	11.882	81	36.83	11.735
Good	46	45.46	10.156	43	44.56	11.087	76	43.64	10.382
Okay	21	42.33	8.278	19	46.89	11.318	20	45.95	10.385
Poor	3	45.33	8.083	5	46.80	10.474	4	43.25	7.719
Very Poor	2	52.00	9.899	4	49.25	8.421	4	49.00	8.794
Missing	69	42.72	11.100	66	41.42	9.985	21	43.19	11.927
Total	206			206			206		

A one-way between-groups analysis of variance was conducted to explore the association between self-reported quality of relationships with disabled people on attitudes and attitudes toward disability as measured by the GASTDP for the non-disabled sample (see Table 7.35 below). Respondents were divided into five groups (very good; good; okay; poor; very poor) according to responses to question 15 on the Demographic Data Questionnaire for each of the three environments, Work/College, Home and Social. In addition, non-responses (Missing) were placed into a separate category. There was no statistically significant difference at the $p < 0.05$ level for the GASTDP scores for each of the three environments.

Table 7.35: One-Way Between Groups Analysis of Variance on Attitudes as Measured by GASTDP for Non-Disabled Respondents Divided by Self-Reported Quality of Relationship

Relationship	Number (Work/ College)	Mean (Work/ College)	Std. Dev. (Work/ College)	Number (Home)	Mean (Home)	Std. Dev. (Home)	Number (Social)	Mean (Social)	Std. Dev. (Social)
Very Good	39	37.41	8.525	31	36.68	9.631	29	36.48	8.326
Good	34	38.50	6.947	28	40.71	5.740	47	39.23	7.308
Okay	8	41.50	9.304	8	42.50	9.024	15	41.87	8.305
Poor	1	46.00	_	2	44.00	15.556	4	39.50	16.462
Very Poor	0	_	_	2	35.00	8.485	0	_	_
Missing	29	41.41	8.862	40	39.30	8.077	16	41.19	8.043
Total	111			111			111		

Hierarchy of Impairment- Breakdown of ATIS Statement Responses

Having identified that a hierarchy of impairments exists for both disabled and non-disabled samples, it was felt that a more detailed analysis of the responses to the ATIS statements may give further information on the causes of the hierarchy. Both samples were therefore further analysed by looking at the mean scores for each of the five statements in relation to the seven impairment groups. Numbers for each sample varies very slightly from the analysis above due to placing those who stated ‘don’t know’ to the question of whether they regard themselves as a disabled person or not and those who said ‘no’ to this question despite others regarding them as such, into the non-disabled data set. A score of between one and six (one reflecting most positive attitude and six least) could be achieved for each statement. It is important to note, however, that as Ajzen (1988) comments, single items do not tend to offer accurate reflections of attitudes, for it is the combined score that gives the more accurate reflection of the respondent’s attitude.

Data were initially analysed for the disabled sample (see Table 7.36 for mean scores and Table 7.37 for the Friedman test).

Table 7.36: Mean Scores and Standard Deviation for ATIS Statements for each Impairment (Disabled Sample)

	ATIS Statement	Down's Syndrome (n = 196)		Arthritis (n = 196)		Cerebral Palsy (n = 196)		HIV/AIDS (n = 196)		Schizophrenia (n = 196)		Deaf (n = 196)		Epilepsy (n = 196)	
		Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.
1	People with (impairment name) have a right to do government sponsored vocational training schemes even if they are unlikely to get a job	2.16	1.322	2.09	1.335	2.14	1.391	2.16	1.434	2.29	1.432	2.04	1.534	2.06	1.438
2	Residential care is usually the best option for people with (impairment name)	2.35	1.422	1.66	1.076	2.19	1.336	1.91	1.303	2.74	1.494	1.57	1.146	1.82	1.290
3	People with (impairment name) should be protected from situations that are likely to cause stress or anxiety to themselves	3.88	1.574	2.86	1.718	3.39	1.668	3.08	1.796	3.95	1.558	2.86	1.795	3.46	1.761

7.36 Cont.	ATIS Statement	Down's Syndrome (n = 196)		Arthritis (n = 196)		Cerebral Palsy (n = 196)		HIV/AIDS (n = 196)		Schizophrenia (n = 196)		Deaf (n = 196)		Epilepsy (n = 196)	
		Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.
4	A restaurant owner should be allowed to refuse service to a person with (impairment name) if they upset other customers because of their impairment	2.04	1.364	1.69	1.163	1.99	1.394	1.89	1.401	2.47	1.606	1.46	1.015	1.84	1.355
5	It is wrong for a couple with (impairment name) to have children as they would be unable to raise the child safely	2.81	1.562	1.80	1.206	2.60	1.584	3.37	1.842	3.03	1.679	1.55	1.054	2.13	1.408

Statement 3 appears to have caused the most negative response of all the statements, suggesting that, with the exception of deaf people and people with arthritis, there is a general concern about placing disabled people in position of stress or anxiety. Statement 5, relating to parenting skills, solicited a wide variation in responses from arthritis (M = 1.80; S.D. = 1.206) to HIV/AIDS (M = 3.37; 1.842) by the disabled sample.

The responses were further analysed using the Friedman Test to identify whether the differences in response to each statement for the seven impairment types by the disabled sample were statistically significant. Each of the repeated statements, (i.e. statement 1 was repeated seven times), was analysed using the non-parametric Friedman Test to see whether each of the statements held consistent ranking for each of the seven impairment groups used on the ATIS.

Table 7.37a: Friedman Test for ATIS Statements for each Impairment (Disabled Sample)

	ATIS Statement	Down's Syndrome		Arthritis		Cerebral Palsy		HIV/AIDS		Schizophrenia		Deaf		Epilepsy	
		Mean Rank	Rank	Mean Rank	Rank	Mean Rank	Rank	Mean Rank	Rank	Mean Rank	Rank	Mean Rank	Rank	Mean Rank	Rank
1	People with (impairment name) have a right to do government sponsored vocational training schemes even if they are unlikely to get a job	4.10	6	4.02	3	4.05	5	4.04	4	4.28	7	3.69	1	3.82	2
2	Residential care is usually the best option for people with (impairment name)	4.61	6	3.36	3	4.33	5	3.75	4	5.27	7	3.09	1	3.60	2
3	People with (impairment name) should be protected from situations that are likely to cause stress or anxiety to themselves	4.83	6	3.27	2	4.03	4	3.56	3	4.88	7	3.25	1	4.19	5

7.37a Cont.	ATIS Statement	Down's Syndrome		Arthritis		Cerebral Palsy		HIV/AIDS		Schizophrenia		Deaf		Epilepsy	
		Mean Rank	Rank	Mean Rank	Rank	Mean Rank	Rank	Mean Rank	Rank	Mean Rank	Rank	Mean Rank	Rank	Mean Rank	Rank
4	A restaurant owner should be allowed to refuse service to a person with (impairment name) if they upset other customers because of their impairment	4.21	6	3.68	2	4.13	5	3.98	4	4.85	7	3.32	1	3.82	3
5	It is wrong for a couple with (impairment name) to have children as they would be unable to raise the child safely	4.55	5	3.10	2	4.17	4	5.07	7	4.80	6	2.72	1	3.58	3

Table 7.37b: Significance Levels for ATIS Statements (Disabled Sample)

Statement No.	N	Chi-Squared	Df	Sig.
1	196	25.606	6	< 0.0005
2	194	267.045	6	< 0.0005
3	196	208.521	6	< 0.0005
4	195	153.126	6	< 0.0005
5	196	322.019	6	< 0.0005

Significance levels of less than 0.0005 were achieved for all five statement groupings, suggesting that the type of impairment has an effect upon the rank. Whilst most impairments remained fairly consistent in their ranking for each statement by the disabled sample, HIV/AIDS ranged from 3rd (statement 3) to 7th (statement 5) and epilepsy ranged from 2nd (statements 1 and 2) to 5th (statement 5).

The non-disabled sample data were then analysed using the same techniques as the disabled sample.

Table 7.38: Mean Scores and Standard Deviation for ATIS Statements for each Impairment (Non-Disabled Sample)

	ATIS Statement	Down's Syndrome (n = 121)		Arthritis (n = 121)		Cerebral Palsy (n = 121)		HIV/AIDS (n = 121)		Schizophrenia (n = 120)		Deaf (n = 121)		Epilepsy (n = 121)	
		Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.
1	People with (impairment name) have a right to do government sponsored vocational training schemes even if they are unlikely to get a job	1.91	1.025	1.90	1.083	1.98	1.110	1.97	1.271	1.92	1.026	1.77	1.031	1.86	1.059
2	Residential care is usually the best option for people with (impairment name)	2.30	1.430	1.74	1.086	2.27	1.271	1.79	1.176	2.63	1.322	1.48	0.923	1.60	0.935
3	People with (impairment name) should be protected from situations that are likely to cause stress or anxiety to themselves	3.59	1.289	2.64	1.449	3.12	1.343	2.55	1.384	3.55	1.353	2.58	1.459	2.83	1.518

7.38 Cont.	ATIS Statement	Down's Syndrome (n = 121)		Arthritis (n = 121)		Cerebral Palsy (n = 121)		HIV/AIDS (n = 121)		Schizophrenia (n = 120)		Deaf (n = 121)		Epilepsy (n = 121)	
		Mean Rank	Rank	Mean Rank	Rank	Mean Rank	Rank	Mean Rank	Rank	Mean Rank	Rank	Mean Rank	Rank	Mean Rank	Rank
4	A restaurant owner should be allowed to refuse service to a person with (impairment name) if they upset other customers because of their impairment	1.78	1.228	1.45	0.913	1.62	1.035	1.67	1.091	2.21	1.425	1.40	0.841	1.60	1.040
5	It is wrong for a couple with (impairment name) to have children as they would be unable to raise the child safely	2.64	1.348	1.62	0.915	2.35	1.334	2.98	1.703	2.75	1.398	1.31	0.643	1.76	1.021

As with the disabled sample previously, statement 3 appears to have caused the most negative response of all the statements for the non-disabled sample, suggesting there is a general concern about placing disabled people in position of stress or anxiety. Unlike the disabled sample, the mean scores for statement 5, relating to parenting skills, produced means of below three points (indicating a rejection of the statement) for all seven impairments, by the non-disabled sample.

The responses were further analysed using the Friedman Test to identify whether the differences in response to each statement for the seven impairment types by the non-disabled sample were statistically significant. Each of the repeated statements, (i.e. statement 1 was repeated seven times), was analysed using the non-parametric Friedman Test to see whether each of the statements held consistent ranking for each of the seven impairment groups used on the ATIS.

Table 7.39a: Friedman Test for ATIS Statements for each Impairment (Non-Disabled Sample)

	ATIS Statement	Down's Syndrome		Arthritis		Cerebral Palsy		HIV/AIDS		Schizophrenia		Deaf		Epilepsy	
		Mean Rank	Rank	Mean Rank	Rank	Mean Rank	Rank	Mean Rank	Rank	Mean Rank	Rank	Mean Rank	Rank	Mean Rank	Rank
1	People with (impairment name) have a right to do government sponsored vocational training schemes even if they are unlikely to get a job	4.03	3	4.04	5	4.10	6	4.03	3	4.12	7	3.75	1	3.93	2
2	Residential care is usually the best option for people with (impairment name)	4.58	5	3.57	3	4.60	6	3.67	4	5.17	7	3.08	1	3.33	2
3	People with (impairment name) should be protected from situations that are likely to cause stress or anxiety to themselves	5.07	7	3.35	3	4.25	5	3.30	1	4.90	6	3.31	2	3.83	4

7.39a Cont.	ATIS Statement	Down's Syndrome		Arthritis		Cerebral Palsy		HIV/AIDS		Schizophrenia		Deaf		Epilepsy	
		Mean Rank	Rank	Mean Rank	Rank	Mean Rank	Rank	Mean Rank	Rank	Mean Rank	Rank	Mean Rank	Rank	Mean Rank	Rank
4	A restaurant owner should be allowed to refuse service to a person with (impairment name) if they upset other customers because of their impairment	4.21	6	3.55	2	3.91	3	4.02	5	4.94	7	3.45	1	3.91	3
5	It is wrong for a couple with (impairment name) to have children as they would be unable to raise the child safely	4.82	5	3.05	2	4.26	4	5.00	7	4.97	6	2.54	1	3.35	3

Table 7.39b: Significance Levels for ATIS Statements (Non-Disabled Sample)

Statement No.	N	Chi-Squared	Df	Sig.
1	120	8.924	6	0.178
2	120	186.459	6	< 0.0005
3	120	158.715	6	< 0.0005
4	119	117.102	6	< 0.0005
5	119	248.719	6	< 0.0005

Significance levels of less than 0.0005 were achieved for four statement groupings, with the exception of statement 1 (n = 120; Chi-Squared 8.924; df 6; sig. 0.178), suggesting that the type of impairment has an effect upon the rank, except for the right to participate in vocational training. The right to vocational training may therefore be regarded as universal amongst disabled people. There appears to be less consistency in the rank ordering for the non-disabled sample than achieved for the disabled sample for each of the statements. Whilst deaf and schizophrenia remained fairly consistent in their ranking at either end of the scale, HIV/AIDS ranged from 1st (statement 3) to 7th (statement 5) and Down's syndrome ranged from 3rd (statements 1) to 7th (statement 3), thus suggesting a range of strength of attitude in relation to each of the statements on the ATIS based on these impairments, rather than a consistently positive or negative attitude.

7.4 Conclusion

In summary, the null hypotheses for H1, H2, H4, H5 and H6 cannot be rejected. Whereas the null hypotheses for H3 and H7 can be rejected in favour of the hypotheses (see Chapter 6, section 6.2 for hypotheses). Analysis for the data in relation to H2 did identify however, that disabled people as a group do hold a hierarchy of impairment. A large amount of data that has been presented in this chapter, which will now be interpreted and discussed.

Chapter 8

Exploring Disability and Impairment: Disabled Person's Perspectives

8.1 Introduction

This chapter will offer possible explanations for the results presented in Chapter 7 and interpret the data. The results will be discussed under the section headings: The contact hypothesis and disabled people; The hierarchy of impairment; Locating impairment in society; and, Aversive Disablism – Building on Aversive Racism.

The main findings of this research are:

- Disabled and non-disabled people achieved similar results, as measured by the GASTDP and were within the positive threshold for the scale, thus reflecting a positive attitude toward disability

- Both disabled and non-disabled samples produced higher scores when measured by the Subtle Prejudice sub-scale of the GASTDP than the Blatant Prejudice sub-scale, suggesting people may hold subtle forms of prejudice toward disability

- Both samples had a similar hierarchy of impairment, as measured by the ATIS, with the Deaf sub-group ranked first, followed by Arthritis, Epilepsy, Cerebral Palsy, HIV/AIDS, Down's Syndrome and Schizophrenia. Only HIV/AIDS and cerebral palsy were placed in reverse order by the non-disabled sample

- The contact hypothesis was not supported by the data produced through this research, for when attitudes toward disabled people were measured using the GASTDP against the three independent variables of 1. contact with disabled people in terms of frequency (how often), 2. levels (how many disabled people), and 3. location (work, home or social settings) did not produce statistically significant differences, for either disabled or non-disabled sample. However, those disabled people who voluntarily chose to associate with other disabled people scored lower on the GASTDP (more positive result) than those who had high levels of contact but not through personal choice

This chapter will aim to explore the contact hypothesis with particular reference to contact between disabled people, in other words, the influence of contact between members of a stigmatised group upon attitudes toward other members of that group (section 8.3). The possible causes of the results produced in relation to the hierarchy of impairment will then be discussed (section 8 .4) in order to identify specific influences upon the prejudice and discrimination faced by members of each of the impairment sub-groups. The theme of impairment will be continued in section 8.5 challenging the social model assertion that 'impairment is nothing to do with disability', arguing instead that impairment is to some extent, socially constructed. Section 8.6 will offer an argument that subtle forms of prejudice exist toward disabled people, even amongst those who purport holding positive attitudes toward disabled people. This section will draw upon earlier work in relation to Critical Race Theory, presenting an argument for aversive disablism. Finally, section 8.7 will suggest a number of recommendations for further research into attitudes toward disabled people in order to continue the development of Disability Studies with specific reference to attitudes of disabled people toward disability and impairment as a social construction. Firstly, however, as is standard when reporting research within social psychology, it is important to present the limitations of the research prior to the interpretation and discussion of the results.

8.2 Limitations of the Research

Self-Selection of Respondents

Due to the self-selecting nature of the research methodology there is a risk that respondents were only those who were motivated to do so. In other words, those with an interest in disability issues. This may have led to more positive results being produced than may be found if an alternative method of data collection is utilised.

Low Response from Black and Minority Ethnic Community

A very low response rate from the Black and Minority Ethnic (BME) community was achieved and therefore any inferences from this research cannot claim to represent the views of this particular minority group.

Research Tools Tended to Exclude People with Learning Disabilities

Due to the level of literacy required to complete the GASTDP, ATIS and the Demographic Data Questionnaire, it was found some people with learning disabilities were unable to provide the information requested unaided. In order to ensure the confounding variable of the person assisting the respondent did not influence the responses, where this was known to have occurred, these responses were removed from the data analysis.

Impairment Group Sample Sizes

Sample sizes in relation to each impairment group are small and therefore any conclusions drawn from the data in relation to one impairment group's attitudes as compared to another must be viewed with caution. In addition, caution on the interpretation of hearing impairment results needs to be shown as they tend to come from an elderly population rather than the Deaf community. As the literature has revealed, the Deaf community may hold distinct attitudes that are different from the majority of other disabled people, viewing themselves more as a linguistic minority than as disabled people (Middleton, Hewison and Mueller, 1998) and therefore may give different results from those found through this research.

This chapter will now discuss and interpret the data, paying particular attention to the data produced from the disabled sample. It is my intention to offer a 'disabled perspective' on attitudes toward disability and people living with impairments, thus building on the existing literature and research that has predominantly focussed on non-disabled attitudes toward disabled people. This will be done by paying particular attention to the data produced by the disabled sample.

8.3 The Contact Hypothesis and Disabled People

This research set out to test the contact hypothesis, which asserts attitudes towards a particular group will be influenced through contact with that said group (Higgs, 1975; Weisel, 1988). Unlike previous research into the contact hypothesis in relation to disabled people, which has primarily come from the perspective of non-disabled persons' contact with disabled people, the focus of this research was whether contact *between* disabled people influenced attitudes toward other disabled people as a group. This section will therefore explore the nature of the contact between disabled people, such as whether the association is voluntary or created through the structure of the services available to this group, for instance residential care, and how this variable may influence attitudes toward other disabled people.

Contrary to other research that found positive relationships between attitudes toward disabled people and levels of contact (Gething, 1991; Furnham and Thompson, 1994; Yazbek, McVilly and Parmenter, 2004), the results from the data presented in this thesis did not find a strong relationship for either the disabled or the non-disabled samples as measured by the GASTDP (see Tables 7.14 to 7.19). This is in line with Hagen, Powell and Adams' (1983) research, who also did not find a relationship between contact and attitudes.

The level of contact with disabled people was found to be comparable with the European Commission's (2001) finding that approximately sixty percent of Europeans said they know someone with a disability, long-term illness or infirmity. The majority of respondents from both the disabled and non-disabled samples reported some level of direct contact with disabled people on a relatively regular basis (see Tables 6.11and 6.12). This data suggests a discrepancy between the number of respondents who reported zero for the number of disabled people they had contact with and the frequency of contact within each of the three environments (work/college, home and social). This can be explained by respondents possibly regarding casual contact (for instance, seeing a disabled person in a pub but not being with them), as zero for the number of people they know in the social setting and yet seeing them on a reasonably regular basis (for instance, once a month).

The Influence of Choice of Contact in Influencing Attitudes Toward Disabled People

Social psychology literature suggests simple contact with a stigmatised group is unlikely to achieve attitude change (Pettigrew and Tropp, 2000) as a number of other factors also need to be present (Donaldson, 1980). In line with this proposition, those disabled people who voluntarily chose to associate with other disabled people in coalitions of disabled people, achieved lower scores as measured by the GASTDP than other sub-groups within the disabled sample (see Table 7.18). This association, however, is unlikely to be the cause of the positive attitudes, but rather, those disabled people who already hold positive attitudes are likely to seek out others with similar attitudes. Further research into this group of disabled people may help to identify other variables that may assist in identifying methods of positive attitude change.

Asch (2004: pp. 22-24) may offer an explanation for this finding. By drawing on Critical Race Theory (CRT) (which will be discussed further below under the theme of aversive disablism) the distinction between segregation and separation is articulated, with the key distinction between the two being choice and control. When an individual has control over key aspects of their life and are able to make genuine choices, this is likely to lead to empowerment and raised self-esteem. The raised self-esteem may give disabled people the empowerment to feel comfortable in seeking the company of other disabled people without fear of being stigmatised. The use of non-mainstreamed services, with tailored support, may then become a positive lifestyle choice, rather than an imposed service. Hence, it could be argued, by having choice and control over service provision, this may lead to improved self-esteem, which in turn may lead to a more positive attitude toward associating with other disabled people.

The voluntary association with other disabled people may have implications in relation to the role of group norms in attitude-behaviour consistency. White, Hogg and Terry (2002) found people tend to behave in accordance with their attitudes if those attitudes are 'accessible or held with certainty'. In addition, people, they conclude, may also bring their behaviour in line with their attitude when there is normative support from a salient in-group. Those people from both the disabled and non-disabled sample who achieved higher score as measured by the GASTDP may therefore lack a salient in-group in relation to disability. The importance of contact between disabled people with a positive affirmation of a disability identity and non-disabled people therefore increases.

Based on White *et al's* (2002) finding *"exposure to an ingroup norm, particularly if the group membership is salient, does influence the strength of the attitude-behavior relation"* by more people in the population having exposure to disabled people with a positive identity as a disabled person (hence, a salient in-group member), should improve behaviour toward disabled people.

Social identity theory argues that in general, people have a need for a positive self-esteem and that a symbolic threat, (such as when a person dislikes a certain group even when they do not pose a tangible threat), will reduce the in-group's collective self-esteem (Tajfel and Turner, 1986). This threat, Quist and Resendez (2002) argue, will lead to *"the bolstering of the ingroup identity through ingroup favoritism"* (p. 292) with *"people who derive satisfaction and value from their identification with a group are more likely to be biased in favor of that group"* (p. 288). Thus, it may be possible that the results obtained from the coalitions of disabled people in this research are a reflection of this 'bolstering' of identity, therefore enhancing self-esteem. This argument finds support from the DWP (2003: p. 32) report into disability, ethnicity, gender, age and sexuality, whereby those who were involved in disability campaigns were more likely to positively associate with being a disabled person as part of their identity and to view disability as a form of social oppression, than those who viewed disability as a form of 'loss'.

In addition, Weeber (2005) contends a time of 'bonding' with the disability community was found to be essential for the development of a disability identity and a sense of wholeness as a disabled person. Part of the process, Weeber argues, in developing a positive 'disability identity', is to relate to the wider rights agenda, such as women, sexual orientation, race, etc., as well as exposure to disabled people with a variety of impairments. Beart (2005) argues it should not be assumed people with learning disabilities who join advocacy groups subscribe to the label of learning disability. For many people, on an emotional level, this ascribed social identity remains a difficult one to acknowledge, and discuss. Secondly, people may only come to see collective action as important after joining the group, as their knowledge of the label they have been given grows. It should not therefore be assumed that all people who join a self-advocacy group align themselves with the cause of others labelled in the same way. The data presented in this thesis suggests those who had recently acquired an impairment may find the 'disability identity' difficult to ascribe to. Despite possibly not wishing to be labelled as such, this sub-group of disabled people may benefit from exposure to other disabled people who are members of advocacy groups, centres for independent living, etc. Hence, in line with the contact hypothesis purported by Donaldson (1980), the contact with disabled people will be positive and of equal status, and therefore more likely to elicit positive attitude change, not only toward other disabled people but also toward the self.

Haslam *et al* (2005) argue that the social identification/self-categorisation model of stress suggests that social identity protects individuals from adverse effects of potential stressors through the support of other in-group members. A positive identification by disabled people with the social category of disability may therefore be important in reducing stress for this group. The result that those disabled people who were members of an organisation of disabled people scored lower and therefore possibly reflecting more positive attitudes toward disabled people, could also have benefits to the individual in terms of reducing stress. A social support network is thought to reduce the effects of stress through four explicit functions (House, 1981). Specifically, it can provide an individual with (a) a sense of acceptance and self worth (emotional support), (b) affiliation and contact with others (social companionship), (c) concrete aid, material resources, and financial assistance (instrumental support), or (d) information useful in understanding and coping with potentially stressful events (informational support). If Haslam *et al's* (2005) findings can be generalised toward disabled people, this group could benefit from improved mental health by positively identifying with other disabled people. For, *"self categorisation principles suggest that social identification has the potential to create an 'upward spiral' whereby identification increases social support and psychological well being, which in turn increase social identification"* (Haslam *et al*, 2005: p. 367).

The voluntary nature of the contact is in contrast to the finding that those disabled people with high levels of 'involuntary' contact achieved higher score as measured by the GASTDP. For instance, those with high levels of contact in a home setting (more than twenty-one other disabled people and therefore living in a residential care home) achieved higher scores (suggesting less positive attitudes) on the GASTDP. This finding may in part be explained as a consequence of ego-defence. On the basis that people do not tend to aspire to be a disabled person, the close association with other disabled people may be viewed by some as a threat to the ego (Oskamp, 1977). Dovidio, Major and Crocker (2000) note in relation to the concept of stigma, the process of stigmatising others can produce an enhancement of the stigmatiser's own self-esteem through a 'downward-comparison' process. Thus, a member of a stigmatised group (such as a person with a particular impairment) may find that by comparing themselves to others perceived to be less "fortunate" than themselves (for instance, a person with a different impairment), their self-esteem is enhanced. Duckitt (1994), although referring to the literature relating to race, comments that according to the downward-comparison model, people with low self-esteem tend to be associated with greater prejudiced attitudes, and hold more negative attitudes toward both the out-group and their own in-group (Duckitt, 1994: p. 170). Thus, according to this model, it is vital that disabled people maintain a positive self-esteem (through positive and valued social roles, such as employment) in order to hold more positive attitudes toward other disabled people (the in-group).

The finding that for the disabled sample, those who self-reported having 'very good' relationships with other disabled people, produced the lowest scores, suggests more positive attitudes toward disability than other groups. However, it should be noted, statistical significance was not achieved between any of the other categories (good; okay, poor; and very poor). This finding may suggest that disabled people, who feel very positively about their relationship with other disabled people, tend to hold more positive attitudes toward disability in general. Hence, positive relationships, perhaps not surprisingly, may be reflected in positive attitudes more generally toward disability. But, whether these relationships actually produce the positive attitude is not possible to deduce from this data. By holding a positive attitude toward disability, this may help build a more positive relationship with other disabled people. It should be noted however, that the non-disabled sample did not produce significant results. However, there was a large amount of missing data and so incomplete findings were produced.

Linked to the argument of contact, disabled people have often faced forms of segregation including residential care and supported businesses. However, new forms of segregation may be emerging in the form of new technologies, including the Internet. Whilst it is beyond the scope of this thesis to discuss such technology, there is value in briefly exploring the consequences of how the use of the Internet may collude in further isolation, considering just over

75% of disabled respondents agreed with the notion that the Internet could be used to avoid poor facilities.

Passive Avoidance

Of particular concern was the finding that the majority of respondents agreed that an alternative method of accessing goods and services (the Internet) was appropriate in order to avoid poor facilities for disabled people. This behaviour could be viewed as a form of *passive avoidance*, in that disabled people may view avoiding taking more active forms of behaviour towards discrimination (for instance, taking collective direct action by demonstrating against a shop that has poor access) as a more suitable option (see Lalonde and Cameron (1994) for discussion on behavioural responses to discriminatory practice).

With the enactment in 2004 of part 3 of the Disability Discrimination Act, such attitudes from disabled people may collude with subtle forms of discrimination, by giving service providers an opportunity to deliver goods and services in a 'convenient' and yet discriminatory form. By not tackling the core issue of removing poor facilities by replacing these with service delivery methods that do not require direct contact, such methods are likely to further isolate many disabled people. Reeves (2004: p. 89) illustrates this by explaining how on some occasions she may decide not to go shopping in her local town because of the physical barriers she has to face, whereas on other occasions it may be due to not wanting to deal with the stares received from other people. The consequence of such behaviour is to limit contact with non-disabled people in a social setting.

Disabled people must therefore consider carefully the negative (real or potential) consequences of new technology such as Internet shopping, which, under the right circumstances is a valuable asset, but could equally become a mechanism by which to exclude some groups of disabled people. The results obtained in this research must be viewed in the light of Knight, Heaven and Christies' (2002: p. 17) finding that 54% viewed access to the Internet as 'necessary to modern life' compared with just 6% of a comparative sample of non-disabled people. It is imperative, therefore, that disabled people utilise this developing technology in a manner that complements a life-style and does not deny social interaction.

Linked to this argument the results for component 1 of the factor analysis of the GASTDP (see Chapter 6, Table 6.30) suggest that both samples were opposed to services and policies that could potentially marginalise disabled people within society, such as residential care rather than community care, or sheltered workshops rather than integrated work settings. Such views find support from disability rights activists. For instance, John Evans, when addressing the Disabled People's European Parliament, (reported in the newsletter aimed at disabled people receiving Direct Payments, "Direct") argues:

"The European Union should be redirecting resources away from institutions into Independent Living and so restoring disabled people's dignity, self-worth and self-respect. Independent Living enables us to contribute to society, to gain a decent education, job and the life of our own choosing, all of which is in the long term more beneficial to the state". (Evans, 2003: p. 2).

The results from component 1 would imply both disabled and non-disabled people view other forms of care services as more appropriate, rather than residential care. What is not known from this result is whether these same respondents would be equally enthusiastic if people with different impairments were, for instance, to live next door to them. The breakdown of the ATIS results for statement 2 (see Appendix L) suggests that people living with schizophrenia, cerebral palsy and Down's syndrome would be the least accepted of the seven impairments included on the ATIS. The desire for social distancing and therefore direct contact with some impairment groups appears therefore to remain an issue. This theme will therefore be explored further below.

Support for Specialist Provision

Whilst segregated services are generally rejected by both disabled and non-disabled samples, a sizeable minority of both disabled and non-disabled people appear to support the continued use of residential care and the notion that disabled people are 'happiest' living and working together (see Appendix K). This could be interpreted as support for the continuation to some extent, of specialist provisions. What cannot be deduced from this research is whether these respondents would rather see specialist or segregated services rather than mainstream or community-based, or, whether they believe both forms of service provision are appropriate. The argument for the continuation of specialist provision is still important, especially when this argument comes from disabled people themselves. For instance, a very small Australian survey (n = 14) of young people with Down's syndrome stated their aspirations towards employment, with nine respondents seeking open employment (with or without support) as opposed to three who desired sheltered employment in a workshop (Grantley, Brown and Thornley, 2001).

The case that has been put forward for the continuation of special needs education in the UK may also offer an insight into why a minority may see special or segregated provision as a positive option (Bunch and Valeo, 2004). Such arguments may be based on the experience of inappropriate provision within the mainstream environment, (often due to a lack of funding and/or expertise from staff), suggesting that more appropriate support and services can be offered within a specialist facility. This view is articulated by disabled student Kate Caryer in the magazine Disability Now when commenting on the restrictions of independent living:

"I believe every disabled person should have the right to make their own life choices. But I sometimes wonder if we have lost some of our freedom by shutting residential homes." (Caryer, 2005: p. 19)

An alternative explanation for some disabled people supporting the practice of special or segregated practices may be as a result of the respondents wishing to distance themselves from other disabled people, viewing segregated services appropriate for other disabled people, but not for them. Returning to Leary and Schreindorfer's (1998: p. 15) four criteria for social disassociation, the social distancing aspect of component 1 of the GASTDP may offer support for this model. These authors argue that stigmatisation occurs:

"...when a shared characteristic of a category of people becomes consensually regarded as a basis for disassociating from (that is, avoiding, excluding, ostracizing, or otherwise minimizing interaction with) individuals who are perceived to be members of that category". (Leary and Schreindorfer, 1998: p. 15)

Thus, using Leary and Schreindorfer's (1998) conceptualisation of stigma, it would appear that a minority of disabled people were prepared to stigmatise other disabled people in general through a process of 'interpersonal disassociation'.

Linked to this argument are what Young (1990) terms, the 'competing paradigms of liberation'. Young (1990: p. 157) contends *"In recent years the ideal of liberation as the elimination of group difference has been challenged by movements of the oppressed. The very success of political movements against differential privilege and for political equality has generated movements of group specificity and cultural pride"*.

Young adds:

"The assimilationist ideal assumes that equal social status for all persons requires treating everyone according to the same principles, rules, and standards. A politics of difference argues, on the other hand, that equality as the participation and inclusion of all groups sometimes requires different treatment for oppressed or disadvantaged groups" (p. 158).

But at what price does this 'different treatment' come? The respondents who agreed that Internet shopping was beneficial to disabled people as a means by which they can avoid poor facilities, could have been supporting Young's assertion that it is sometimes appropriate to treat people differently in order to create a more just and equitable society. However, there is a fine line between 'different treatment' to ensure equity, and segregated services. For instance, at what stage is it appropriate, taking Lennard Davis' illustration cited in Ryan (2006) of the lady with a noisy ventilator attending the opera, to provide 'special' performances for people using such equipment. This is not to argue that 'different treatment' is not appropriate in many instances, for, to treat everyone the same will inevitable lead to discrimination. It is sometimes necessary to offer different forms of service, support, treatment, etc., in order to treat people fairly, on the basis that different groups and individuals will have diverse needs, be that due to race, gender, religion, or, impairment. But, a 'special' performance for disabled people, or even people with specific impairments, cannot only be seen as segregated, but also limiting opportunities for equal status contact between disabled and non-disabled people to take place.

As no statistical difference was found for the independent variables tested in relation to contact, and yet both disabled and non-disabled samples achieved results that fell into the positive threshold as measured by the GASTDP, alternative explanations for these results need to be sought. One tentative explanation could be the influence of the prevailing cultural attitude toward disability.

The Disability Rights Commission (2005) report, ten years after the Disability Discrimination Act was passed, stated that 'significant progress' has been made in relation to the rights of disabled people in terms of employment, education and access. The Disability Rights Commission highlights employment rates have improved in the past five years from 46.6% to 51% of economically active disabled people; and, the number of disabled students in higher education has increased from 86,250 in 2000/1 to 121,080 in 2003/4. Likewise, access to goods and services have improved, with physical access to shops, cinemas, restaurants and other public amenities, being far more common than in 1995. This it can be argued is a reflection of a changing cultural attitude toward disabled people.

If the dominant cultural attitude toward disability, if not positive, is slowly moving toward a position of ambivalence, this may offer a possible explanation for the findings in relation to hypothesis H1 (see Chapter 6, section 6.3). Adams (2003) argues:

> *"What we call culture and society is implicated in the formation of self identity. It lies at its heart. Notions of reflexivity, and in fact any form of self consciousness are all a product of culture in this sense. The individual cannot stand aside from her social and cultural origins and use them, transparently, as a variety of options with which to resource an individualized reflexive self-identity."* (Adams, 2003: p. 234)

If Adams's (2003) assertion is correct, then the 'self consciousness' of disabled people toward the self as a disabled person could possibly be reflected in the response toward the GASTDP. Hence, as the societal attitudes toward disability improve, so the attitude toward the identity as a disabled person may improve. This argument can also be supported by the theory of planned behaviour, that hypothesises an overt intention to act is a significant predictor of behaviour (Ajzen, 1991). For, if people state they are going to act in a non-discriminatory manner towards disabled people, then, if the theory of planned behaviour is correct, then behaviours toward this group of disabled people will be non-discriminatory. Whilst the data presented in this thesis cannot draw any conclusions with respect to this argument, it is recognised overt behaviours toward disabled people have improved in recent years (see Disability Rights Commission, 2005), and the data presented infers attitudes toward disabled people were within the positive threshold as measured by the GASTDP. Hence, it is possible there is a correlation or relationship between behaviours and beliefs toward disabled people. However, as will be discussed below in section 8.6 the overt non-discriminatory behaviours may be masking more subtle forms of discriminatory behaviour.

If positive attitudes toward disabled people truly exist from within the disabled population, it could be argued, disabled people themselves should feel a sense of pride in being identified as a disabled person. With respect to the disabled samples response to statement 18 of the GASTDP this does not appear to be the case. However, this 'pride' is an important aspect of developing a disability culture or disability movement. This finding supports Watson's (2002) questioning of whether disabled people have a common group identity and therefore refutes Peters (2000) assertion that a disability culture exists with the minority group taking pride in 'segregation from Others'.

Watson (2002) directly challenges the idea of a New Social Movement for disability by highlighting Touraine's view that 'actors' must self identify as a collective member. However, Watson's research with 28 disabled people, led him to conclude that whilst disabled people share the common characteristic of having an impairment, this is not enough to sustain the notion of a common identity. Watson (2002) states:

"The image of a disabled person as one who is weak and dis-empowered seems to be as potent an image to disabled people themselves as it is to others who purvey this image, given that many of the informants chose to distance themselves from such an identity.

Self-identity is not formed on the back of a call for difference. Being disabled, for many of these informants, is not about celebrating difference or diversity, pride in their identity is not informed through the individuals labelling *themselves as different, as disabled, but it is about defining disability in their own terms, under their own terms of reference."* (Watson, 2002)

The theme of disability culture and social identity is taken up by Corker and Shakespeare (2002), who, in their analysis of postmodernism in the context of disability, comment, *"The entire concept of identity takes place through this repression of impairment, in such a way that people with impairments cannot affirmatively identify with others like themselves."* (p. 9).

Whilst the data presented in this thesis can neither support nor refute the existence of a disability culture or movement, the finding that 36.6% of disabled respondents disagreed with statement 18 of the GASTDP (see Appendix K), therefore rejecting the idea of feeling proud to identify with other disabled people, deserves comment. As argued above, despite over a third of disabled respondents disagreeing with statement 18, at the same time, disabled respondents appear to support the rights of disabled people. Hence, it can be argued, despite not wishing to belong to this group in society, both disabled and non-disabled respondents appear to support the rights of disabled people to be active members of society.

Those respondents who disagreed with statement 18 would find support from Shakespeare and Watson (2002) who highlight how many disabled people do not seek a 'disabled' identity, but may be seeking instead *"access to a* *mainstream identity"*. In addition, these disabled academics argue that many disabled people do not see themselves as part of the disability movement, viewing the refusal to define oneself as disabled or impaired, not as internalised oppression, but as a reflection of an individual's right to see themselves as a citizen or simply a human being. Hence, it is possible, if Shakespeare and Watson's contention is correct, that although disabled people may not find 'pride' in identifying with other disabled people they may still hold positive attitudes toward disabled people, by viewing the right of all people to access mainstream services.

With respect to statements 9 and 11 of the GASTDP (accessing a restaurant and a cinema) it is important to see them in light of a social inclusion context. In the Leonard Cheshire survey (Knight, Heaven and Christie, 2002) of disabled people's experience of social exclusion, marked differences were found compared to non-disabled responses identified through the Joseph Rowntree survey on poverty and social exclusion in the UK (Gordon *et al,* 2000). It is interesting to note that whilst responses to statements 9 and 11 on the GASTDP were overwhelmingly positive from both disabled and non-disabled samples, disabled respondents in the Leonard Cheshire survey reported 'feeling unwelcome' when participating in everyday social interactions (p. 18). This may be explained through meta-stereotyping taking place with respect to the Leonard Cheshire respondents. In other words, disabled people's beliefs about how non-disabled people feel in relation to disabled people may be inaccurate.

For, if we take the non-disabled responses to statements 9 and 11 at face value, it would appear the vast majority of non-disabled people believe disabled people have a right to take part in mainstream social activities. Although statistically significant results were achieved on the ATIS between the different impairment groups in relation to eating in a restaurant, all seven impairment groups fell within the positive range (see Tables 7.38 and 7.39). Hence, both disabled and non-disabled people appear to believe disabled people should be entitled to access the same services. Whilst the data does not give evidence to support this contention, it is possible disabled people inaccurately believe non-disabled people believe this is <u>not</u> the case.

This section has argued that whilst the data suggests disabled people held positive attitudes toward disability as measured by the GASTDP, contact between disabled people did not appear to be a significant influence. I have therefore argued that other causes for these results are possible, such as these results being a reflection of a wider cultural attitudinal shift toward disability. However, I will now put forward the case that attitudes toward disability should be viewed not in terms of a homogenous group, but rather in relation to each impairment group, for, as Gordon and Rosenblum (2001) contend, *"Each sub-category of impairment within the broader category "disability" is subject to social construction with all that implies"*.

8.4 The Hierarchy of Impairment

An important element of this research was to explore whether disabled and non-disabled people hold differing strengths of prejudice toward different impairment groups. Of particular interest was the attitude of disabled people toward other impairment groups, for as Young (1990) argues:

> *"Members of culturally imperialised groups, that is, themselves often exhibit symptoms of fear, aversion, or devaluation toward members of their own groups and other oppressed groups. Blacks, for example, not infrequently have racist reactions to other Blacks, as the differentiation between the "light-skinned" and "dark-skinned" Blacks exhibits. Gay men and lesbians themselves exhibit homophobia, old people denigrate the aged, and women are sometimes sexist".* (Young, 1990: pp. 147-148)

Young also recognises how members of the minority group 'live a subjectivity different from the dominant subject position' (p. 148) insofar that whilst being aware of the dominant cultural attitudes toward the minority group, such as fear, loathing, repulsion, etc., this group also has an identification with others in the group with social networks, giving what Young terms a 'double consciousness'. Hence, the minority group view of other members of the minority group will be subjectively different from the majority group, who, it can therefore be suggested, come from a single consciousness with reference to the minority group. This research attempts to present data to support the hypothesis that disabled people, who hold a 'double consciousness' toward other disabled people, will exhibit a differentiation between impairment groups, based on the measurement of attitudes toward different impairments through use of the ATIS. The analysis of the data presented in Chapter 7 found statistically significant results between the rank order of each of the impairment groups.

The following section of this discussion will therefore explore the results found through this research, offering possible explanations. Descriptions of the seven impairment groups utilised in the Attitude Toward Impairment Scale (ATIS) are presented in Appendix I.

Comparison of Data with Existing Research

The production of the ATIS was based on the assumption that disabled people could be placed into sub-groups based on impairment and that 'strength' of attitude would vary according to the impairment sub-group. The distinction between a sub-group and a sub-type is important at this stage of the discussion. Eckes *et al* (2005) note, *"Subtyping occurs when members of a target group clearly disconfirm the group stereotype; these poorly fitting members will be mentally clustered together and set aside as exceptions to the rule"*, whereas, *"...subgroups arise when participants sort members of a target group into* *coherent or meaningful clusters each of which is distinct from the others but still a psychological part of a larger group"*

Eckes *et al* cite (2005) Maurer *et al* (1995) who argued *"that each of these processes has distinct consequences for stereotype maintenance and change"*. The key point made by Maurer *et al* being the claim that sub-typing functions to leave the group stereotype largely unchanged, whereas sub-grouping entails weakening the stereotype through greater perceived variability among out-group members. The results presented in this thesis suggest both disabled and non-disabled people view impairment as a sub-group, but more importantly, by doing so, are able to 'weaken the stereotype'. The weakening of the stereotype of disabled people as an homogenous group may offer an opportunity to identify and therefore focus on those sub-groups facing the greatest oppression through the denial of their rights. Possible explanations for the 'variability' between the impairment sub-groups will be discussed below. However, in order to place this research in context with previous research into the hierarchy of impairment the first part of this section will briefly compare the findings generated through this research and earlier research into this subject.

As highlighted in the literature review, there has been a lack of consistency between researchers on the choice of impairments utilised in research into hierarchies of impairment. This inevitably means direct comparisons between the various pieces of research are difficult. However, some generalisations are possible and will be explored here.

The results produced through the ATIS support Tringo's (1970) and Thomas' (2000) finding of mental illness being 'least preferred'. Importantly, the data presented in this thesis suggests disabled people may hold similar attitudes to this group, with people living with schizophrenia ranked seventh. This finding will be discussed further below. Tringo (1970) also concluded that a dichotomy exists between "hidden" and "overt" impairments, with overt ranking lower. This research tentatively supports Tringo's conclusion, for both disabled and non-disabled samples, with the first three highest ranked impairments being regarded as 'hidden' impairments. That said, a person may be living with HIV/AIDS with no overt signs, and likewise, a person diagnosed as schizophrenic may be stable and able to 'pass' as non-disabled. However, the non-disabled sample did rank cerebral palsy fifth and Down's syndrome sixth, out of the seven impairments on the ATIS.

Harasymiw, Horne and Lewis' (1976) argument that a hierarchy of impairment is in part based on conformity to the norms set by society, such as acceptance of the work ethic, and are not "value rejective", appears to be supported by this research, with deafness and arthritis being ranked most positively, whereas HIV/AIDS was placed lower in the rank order. Specifically with respect to the disabled sample the placement of cerebral palsy fourth out of the seven impairments on the ATIS is consistent with Mastro *et al's* (1996) finding of cerebral palsy being ranked below those with only limited functional loss (such as amputation); although it must be stressed, Mastro *et al's* sample were not representative of a wider disabled population, having researched disabled athletes.

The finding that disabled people hold a hierarchy of impairment is supported by the limited earlier research by Bertin (1959) and Mastro *et al* (1996). More recently, as an illustration of the implications of a hierarchy between disabled people, O'Day and Goldstein (2005) comment how within the US Disability Movement some groups have been "stigmatized and excluded from participation". This, they argue, is due in part to a lack of understanding of the implications of different impairments, a lack of resources, and a questioning of the legitimacy of some groups of people with certain impairments (i.e. multiple chemical sensitivities). Although there is no evidence to support this argument, each of the factors listed by O'Day and Goldstein may also be, in part, factors that influenced the hierarchy of impairment produced by the disabled sample within the research presented in this thesis.

In order to explore the hierarchy of impairment presented in this thesis, the following sub-sections of this chapter will discuss the possible reasons for the placement of each impairment group. The order of the impairments presented is in the rank order as produced by the disabled sample. Where there is a more generalised cause (i.e. reciprocity to society) these will be discussed separately.

Placement of Deaf, Arthritis and Epilepsy in the Hierarchy

In light of the finding that Deaf, Arthritis and Epilepsy categories were placed highest in the hierarchy of impairment for both disabled and non-disabled samples, these results require specific attention. Rather than simply arguing the opposite to the reasons given below for the placement of the lower ranked impairments (i.e. people with schizophrenia being perceived as threatening and people with arthritis as non-threatening) analysis of the data will focus on distinctive features.

The commonly held stereotypes of both arthritis and deafness are likely to be overriding factors in relation to the placement of these two categories. For instance, arthritis is likely to be perceived as an impairment that affects people as they reach late middle age, and is therefore associated with the aging process. Stereotypically, arthritis (regardless of whether it is as osteoarthritis, rheumatoid or some other form of arthritis) is seen as causing discomfort or even pain, but unlikely to be regarded as something that significantly restricts a person's social roles, such as being a parent, worker, or being able to socialise.

Likewise, it is possible the Deaf category was seen in terms of a hearing impairment rather than profound deafness; often associated with a 'normal' aging process encountered by many non-disabled people. Whilst there is no evidence produced by the data for this assumption, it is likely most respondents had or have had, direct contact with an elderly member of the family, friend or colleague who lives with either arthritis or has a hearing impairment. These people could have been perceived as non-disabled, perhaps in terms of other facets of their life, such as parent, colleague, friend or neighbour. Hence, those ranked more highly in the hierarchy, may be as a result of familiarity with the impairment through personal knowledge, which may be lacking for those impairments ranked lower. This view is supported by Lee and Rodda (1994) who conclude from a review of the literature on attitude change toward disabled people that accurate information through direct contact can improve attitudes. In addition, Yuker (1994) contends that knowledge in relation to disability tends to focus on the negative aspects. Hence, by having contact with disabled people who are viewed in terms of other facets of their identity (for instance, race or gender), then more positive attitudes toward the particular impairment may be generated.

Epilepsy was ranked third in the hierarchy by both the disabled and non-disabled samples. Whilst epilepsy can sometimes cause a degree of discomfort or concern for a person witnessing a seizure (Gething, 1992), it is often controlled and therefore 'hidden'. It is therefore possible that many of the respondents whilst being aware of epilepsy (perhaps through health and safety training or television programmes), had not witnessed a person having a seizure. As a consequence, epilepsy may have been viewed as non-threatening in terms of the respondent's own safety, unlike those impairments ranked lower in the hierarchy.

The first three ranked impairments for each group (deaf, arthritis and epilepsy) can all be regarded as impairments that, in their less extreme form, are unlikely to restrict the individual from functioning is socially valued roles, such as within the employment market. The so called 'Protestant work ethic' still holds much sway within most cultures, whereby individual value (in social as well as monetary terms) is often measured in terms of employment. Likewise, these three impairment groups were ranked as most highly in terms of being 'safe' parents. Thus, these three impairments may have been regarded as having more social and economic value than the other four impairments. This argument may be viewed in terms of social reciprocation and will be discussed further below.

Placement of Cerebral Palsy in the Hierarchy

Cerebral palsy was placed fourth in the hierarchy by the disabled sample and fifth by the non-disabled sample. Possible reasons for these placements in the hierarchy as measured by the ATIS will now be discussed.

The very nature of cerebral palsy as an impairment means that how the impairment affects the individual will vary considerably (Liptak and Accardo, 2004). This may help to explain why this impairment was ranked both fourth and fifth by the respective samples. Tables 7.36 and 7.37a reveal that for each of the five statements on the ATIS the disabled sample consistently placed cerebral palsy fourth and fifth. However, the non-disabled sample responses ranged from third (statement 4) to sixth (statements 1 and 2) (see Table 7.39a).

This range of responses from the non-disabled sample suggests that non-disabled people hold differing strengths of attitude toward cerebral palsy depending upon the context. For instance, by placing cerebral palsy third in relation to statement 4, this finding suggests non-disabled people are comfortable being in a social situation such as a restaurant with people with cerebral palsy. It should be noted however, all mean scores for this statement, for each of the seven impairment groups, fell within the positive range (below three). Caution in interpreting this finding in an unreserved positive manner needs to be expressed in light of Lenney and Sercombe's (2002) research. These authors found that whilst non-disabled people expressed positive attitudes toward a confederate in the research who had no speech and used a wheelchair due to cerebral palsy, the confederate tended to misinterpret non-disabled people's responses to him. For instance, a female staring at him in a bar was interpreted as 'fancying' him as opposed to curiosity. Hence, the response to cerebral palsy on the ATIS may be based on respondents being comfortable to be in the same room as a person with this impairment, but may not feel so at ease in more intimate relationships. This view is supported in the literature whereby stress in interactions with disabled people (Cahill and Eggleston, 1994; Gething, Wheeler, Cote, Furnham, Hudek-Knezevic, Kumpf, McKee, Rola and Sellick, 1997) are recorded. One reason cited for such stress being the discomfort caused by difficulties in verbal communication.

Due to the variability of features relating to cerebral palsy it is possible respondents were holding significantly different stereotypes of this impairment group. For instance, as approximately 50% of people with cerebral palsy have an associated learning disability (Liptak and Accardo, 2004), if the respondent believed all people with cerebral palsy have a learning disability, then this stereotype would be inaccurate for the other 50%. Likewise, many people with cerebral palsy are wheelchair users, but this is not the case for all people with this impairment. However, the prevailing stereotype for people with this impairment group is that of a person with a speech impairment, unconventional body movements, a wheelchair user and some form of learning disability. These factors may have caused some respondents to view people with cerebral palsy in a paternalistic manner and therefore place cerebral palsy lower in the hierarchy than other impairments. For instance, the statement in relation to residential care was ranked fifth by the disabled sample and sixth by the non-disabled sample.

Due to the variability of features associated with cerebral palsy it is difficult to say with any degree of certainty which feature is seen as having a greater impact than another. However, one factor may be the extent this group of people are perceived as able to give back to society. This point will be explored in more detail below.

Placement of HIV/AIDS in the Hierarchy

HIV/AIDS was ranked fifth by the disabled sample and fourth by the non-disabled sample, as measured by the ATIS.

The placement of HIV/AIDS in the hierarchy of impairment may in part be influenced by attitudes towards other stigmatised groups from a UK and Western perspective (i.e. gay men, drug users, et cetera) as toward the impairment. Whilst it is not the purpose of this research to explore prejudice and discrimination towards other minority groups within the UK, it is important to recognise that HIV/AIDS has been closely associated with these groups in society. Therefore, any interpretation of the results must consider the possibility of responses to this group being influenced by homophobia, racism and stereotyped views of drug users.

Treichler (1999) discusses the link between AIDS and homophobia, identifying how a powerful cultural narrative (p. 37) surrounds AIDS, that is as much to do with homophobic attitudes as it is biomedical. Treichler emphasises the complex narrative surrounding AIDS when she states:

"AIDS is a nexus where multiple meanings, stories, and discourses intersect and overlap, reinforce and subvert each other. Yet clearly this mysterious male homosexual text has figured centrally in generating what I call here an epidemic of signification." (Treichler, 1999, p. 19 – emphasis in the original)

Gilbert (2003) picks up this theme in relation to African Americans, where she argues:

"...entire ethnic/racial groups, such as African Americans or Hispanics, are said to be in "high risk" groups, which emphasizes race/ethnicity and obscures the pervasive forms of disempowerment of the groups." (Gilbert, 2003: p. 5)

Associations of this nature, Gilbert states, ignore the sociopolitical construction of HIV/AIDS. Both Treichler (1999) and Gilbert (2003) identify that social policy in relation to the treatment and prevention of HIV/AIDS has been closely linked with stereotyped views of the so called "high risk" groups, such as the promiscuous gay man or the 'exotic' African woman. Hence, if scientists and policy makers are willing to view HIV/AIDS in a manner that may be construed as homophobic or racist, then respondents to the ATIS may also be guilty of doing likewise. Thus, whether some respondents were (albeit subconsciously) responding more to their beliefs or even prejudices towards homosexuality or race when completing the ATIS in relation to HIV/AIDS is not known.

The data generated from the ATIS found for the statement in relation to being able to raise a child safely that people living with HIV/AIDS (ranked seventh) and schizophrenia (ranked sixth) were viewed by both disabled and non-disabled as unsafe parents. It is particularly interesting that the disabled sample scored more highly (less positive) than the non-disabled sample (see Tables 7.37a and 7.39a) for these two impairment groups in relation to this statement, thus suggesting disabled people regard people with schizophrenia or HIV/AIDS as being poor parents. One possible explanation for this result in relation to people living with HIV/AIDS could be the concern of passing the infection onto the child. However, by taking sensible precautions and with improved medicines this is becoming less of a risk (Etiebet, Fransman, Forsyth, Coetzee and Hussey, 2004) although should not be dismissed.

If such results are translated into self-belief, then people with HIV/AIDS may view themselves as unable to raise a child safely. Jussim, Palumbo, Chatman, Madon and Smith (2000) note that research has indicated self-fulfilling prophecies are stronger among low status groups (p. 401). A self-fulfilling prophecy *"occurs when an initially erroneous social belief leads to its own fulfilment"* (Jassim *et al,* 2000: pp. 376-377). This erroneous belief may prevent potentially good parents raising a child and creating a family (which is viewed as a right under Article 12 of the Human Rights Act (1998) that states *"Men and women of marriageable age have a right to marry and to found a family, according to the national laws governing the exercise of this right"* (Wadham and Mountfield, 2000)).

The disabled sample produced a mean score of 3.08 and non-disabled sample 2.55 for the HIV/AIDS sub-group in relation to the statement *"People with [impairment name] should be protected from situations that are likely to cause stress or anxiety to themselves"*. Despite the non-disabled sample only marginally achieving a mean within the positive range, the HIV/AIDS category still received the most positive results of the seven impairment groups for this statement (see Table7.39a). As highly significant results were achieved between the impairments for this statement (Table 7.39b) it would appear the type of impairment is a significant factor in whether respondents believed this group of disabled people should be 'protected' or not from stress. With improved life-expectancy for people living with HIV/AIDS (Catalan, Meadows and Douzenis, 2000), the belief that this group should be exposed to normal day-to-day stresses should be seen as a positive result.

With improved life expectancy of people diagnosed with HIV long-term research into the placement of this impairment group may prove valuable. This should not be seen as a purely academic exercise, but as an opportunity to identify the influence of a range of independent variables upon attitudes toward a previously highly stigmatised group. Therefore, not only is there a need for standardised tools to be used to measure attitudes towards this impairment group, but also standardised tools to identify the effect of a range of independent variables. Tools such as the ATIS may be helpful in this process.

Placement of Down's Syndrome in the Hierarchy

Turning now to the finding that Down's syndrome was ranked sixth out of the seven impairment groups utilised on the ATIS, this finding suggests the vision set-out in the government White Paper *Valuing People* (DoH, 2001) still requires significant work in order to be reached. The placement of Down's syndrome in the hierarchy will now be discussed.

In relation to the ranking of people with Down's syndrome, this may have less to do with fear and more to do with disassociation as a consequence of embarrassment. It is often commented by people who use wheelchairs, how frustrated and even insulted they are when someone speaks to them as though they were a child. With a stereotyped view of people with Down's syndrome as being 'child-like', disabled respondents may have been distancing themselves from this particular stereotype. The 'downward comparison model' (Dovidio, Major and Crocker, 2000), which can be described as a process of stigmatising others that can produce an enhancement of the stigmatiser's own self-esteem through a 'downward-comparison' process, may give a helpful insight at this point.

People with impairments not associated with cognitive functioning may be downwardly comparing people with Down's syndrome, in order to enhance their own self-esteem. Hence, such people may be viewing themselves as belonging to a socially accepted group in society whose behaviour would not cause offence, unlike, they may argue, their stereotyped view of people with Down's syndrome. The stereotyped view of people with learning disabilities behaving in inappropriate ways in public are even found amongst care staff (Bell, Eells and Dodder, 2002), and so it is not surprising both disabled and non-disabled people who may have limited contact or knowledge of this group of people, may hold such views.

People with learning disabilities such as Down's syndrome have also been traditionally viewed as unable to raise children safely (Johnson, Traustadottir, Harrison, Hillier and Sigurjonsdottir, 2001; McGaha, 2002). This view still appears to hold true from both the disabled and non-disabled samples, who both ranked people with Down's syndrome fifth of the seven impairment groups against the statement '*It is wrong for a couple with (impairment name) to have children as they would be unable to raise the child safely*', (see Tables 7.37a and 7.39a). However, given appropriate support and guidance, this group of people have proven themselves to be effective parents (Jackson, 2004). If this explanation is true, this is particularly worrying for people whose appearance or behaviour does not fit neatly into what is deemed to be 'normal' within UK society.

As stated earlier, many of the beliefs expressed in the construction of both the ATIS and GASTDP are reflected in the Government White Paper *Valuing People* (DoH, 2001). When considering that *Valuing People* sets out the Labour Government policy on ensuring people with learning disabilities participate in society, it is of concern that people with Down's syndrome were ranked sixth out of the seven impairment groups by both samples overall. Considering this white paper states, for instance, *"People with learning disabilities can be good parents and provide their children with a good start in life, but may require considerable help to do so"* and *"People with learning disabilities are often socially isolated. Helping people sustain friendships is consistently shown as being one of the greatest challenges faced by learning disability services"* (DoH, 2001: p. 81), these findings suggest that greater awareness relating to the rights of people with Down's syndrome needs to occur.

One of those rights could be viewed as the right to take risks, which also means greater exposure to failure. Stephen Ladyman (Minister with responsibility for disability policy in the Department of Health until May 2005) when being interviewed on the topic of social inclusion for people with learning disabilities is quoted as wishing *"there was a way of making them* [paternalistic relatives] *understand a little more risk and a little more letting go might see the larva turn into a butterfly"* (Holman, 2004). Hence, Ladyman supports the standpoint that people with learning disabilities be exposed to risk and therefore face some forms of stressful situations, which will inevitably create a degree of anxiety. The denial (voluntarily or involuntarily) of social opportunity is likely to perpetuate the child-like status often attributed to disabled people.

Placement of Schizophrenia in the Hierarchy

Schizophrenia achieved least positive results overall, and therefore it could be argued, least social acceptance of any of the impairment groups as measured by either tool (ATIS or Social Acceptance List) for either sample (disabled and non-disabled). It would appear, given these findings that the stigma attached to schizophrenia has not waned over the years. Schizophrenia was ranked seventh out of seven impairment groups on the ATIS by both disabled and non-disabled samples. This finding will now be discussed below.

The findings presented in this thesis in relation to schizophrenia are consistent with government reports into mental health conditions whereby they argue, *"Adults with long-term mental health problems are one of the most excluded groups in society"* and that the social isolation faced by this group, which includes people living with schizophrenia (which affects one in two hundred adults per year) can cause increased health risks to this group, including increased mortality rates (Office of the Deputy Prime Minister, 2004). This may not be overly surprising when considering the level of misconception associated with schizophrenia. The World Psychiatric Association Programme Against Stigma and Discrimination Because of Schizophrenia (cited in Warner, 2000: p. 88) lists these misconceptions as:

- Nobody recovers from schizophrenia
- Schizophrenia is an untreatable disease
- People with schizophrenia are usually violent or dangerous
- People with schizophrenia are likely to infect others with their madness
- People with schizophrenia are lazy and unreliable
- Schizophrenia is the result of a deliberate weakness of will
- Everything people with schizophrenia say is nonsense
- People with schizophrenia are completely unable to make rational decisions about their own lives
- People with schizophrenia are unpredictable
- People with schizophrenia cannot work
- Schizophrenia is the parent's fault

Warner (2000: pp. 96-105) offers a range of stigma reducing strategies in relation to people with schizophrenia, including, neighbourhood campaigns, social marketing, lobbying news and entertainment media, and a global anti-stigma campaign. Taking on board the various caveats in relation to using contact between the stigmatised minority group and the majority group (Donaldson, 1980; Yuker, 1994; Lockhart, French and Gench, 1998) as discussed in the literature review (see Chapter 8), appropriate methods of increasing positive contact between the groups need to be further explored. Care in the Community within the UK may have increased the likelihood of people with mental illnesses living in the same neighbourhood as other people, but it does not seem to have had a significant impact upon improving attitudes. Wolff (1997: pp. 144-163) found, however, that with proactive campaigns greater levels of awareness and subsequent social acceptance can be generated.

The threat posed by an out-group member, whether real or perceived, may account for the results generated for the ATIS statements *'Residential care is usually the best option for people with [impairment]'* and *'A restaurant owner should be allowed to refuse service to a person with[(impairment] if they upset other customers because of their impairment'* (see Tables 7.37a and 7.39a for breakdown of results). Each statement gives the respondent an opportunity to socially distance themselves from the person with an impairment. Leary and Schreindorfer (1998) argue that one cause of social exclusion is the fear of the threat caused by a stigmatised person. Hence, by viewing residential care as the 'best' option and supporting the idea that someone with schizophrenia should be excluded from a restaurant if other people are 'upset', the respondent may be reducing the perceived 'threat' by socially distancing themselves and thus reducing their own fear.

Whilst it is outside of the scope of this thesis to discuss schizophrenia as a form of illness (see Boyle, 2002), the perception that it is an illness from which there is no recovery (either partial or full) is commonly held, although incorrect (Roe, Chopra, Wagner, Katz and Rudnick, 2004). This 'no hope' diagnosis, linked to the misconceptions listed above, may help to explain the placement of schizophrenia as seventh in the hierarchy. For, if respondents viewed people with schizophrenia as in need of permanent support so as not to be a risk to either themselves or others; being unemployable; being responsible for their impairment; and so on, the statements on the ATIS would all enable the respondent to report schizophrenia in negative terms.

When the disabled sample was broken down into sub-samples of impairment groups, it was found (although not statistically significant) that the depression and mental health sub-sample held the least positive mean ranks of all twelve sub-samples toward the impairments on the ATIS (see Table 7.8). Hence, this group held the most negative attitudes toward other impairment groups of all the sub-samples of disabled people. However, this sub-sample also tended to view schizophrenia more positively than they viewed other impairment groups.

In other words, schizophrenia was ranked more positively by people with mental health problems than the other impairment groups on the ATIS. This finding may be due to people who have experienced this impairment recognising the discrimination faced by this group and how their rights are being infringed. If these people also lived with schizophrenia, their insight may be more realistic about the rights and abilities of people with schizophrenia than other peoples. However, as stated above, any conclusions must be tentative due to non-significant results being achieved.

The Role of Reciprocity in the Creation of the Hierarchy

The hierarchy of impairment may be viewed, in part, as an indication of how much 'worth' each group of people have in respect to each other, according to social reciprocity. Neuberg, Smith and Asher (2000) suggest that disabled people, like others in society, are measured according to how much they can give back (reciprocate) to society. This links directly to point 3 of Leary and Schreindorfer's (1998: p. 12) criteria for social stigma. These authors contend *"...people are socially excluded to the extent that they...fail to contribute adequately to the welfare of other individuals or the social groups to which they belong (because they are perceived to be incompetent, irresponsible, infirm, or selfish)".*

One indication of the economic value afforded to disabled people was the response to the statement *'People with (impairment) have a right to do government sponsored vocational training schemes even if they are unlikely to get a job'* on the ATIS. This statement is suggesting that all people have a right to training with the goal of achieving employment. In other words, society (through paying taxes) are investing in an individual in the hope that they will then become employed and also pay taxes, thus, contributing to society themselves. Whereas the non-disabled sample did not produce statistically significant differences in the results for the seven impairments tested, this was not the case for the disabled sample.

Therefore, it could be argued, non-disabled people may view all people as not only having a right to vocational training and development, but also a responsibility to seek employment, even if it is a goal that may not be achieved. Thus, non-disabled people may view the social responsibility to contribute to society through work as one that is universal. At the same time, the non-disabled people (who were predominantly in employment, or had been before retirement due to age) could possibly understand the personal economic, social and psychological benefits of being in paid employment. However, as mentioned above, the seven impairment sub-groups were viewed differently (statistically significant differences) in relation to this statement by the disabled respondents', and so the possible causes for this will now be explored.

Disabled people did not see the right to vocational training as a universal right, but access to such services being based, in part at least, on the type of impairment. This may be as a consequence of the on-going concern expressed by disabled people with respect to losing benefits if they attempt to return to work, but fail to achieve an income that meets their financial needs. Or, if unsuccessful in gaining employment, having attempted to do so, are viewed as employable and therefore no longer entitled to higher rates of benefit. That said, the UK Government Green Paper (DWP, 2003) *Pathways to Work* reports an increasing desire from disabled people to enter into paid employment. Such views are also reported by Ferrier and Lavis (2003) in relation to people living with HIV/AIDS in Canada, who highlight that with improved health of this group of people, employment appears to be a more viable option as well as a desire. Paradoxically, these authors also note that with improved health, due to improved drugs, the disability status linked to the right to financial benefits becomes threatened.

The disabled sample's rank order may also be due to a perception that each impairment group is competing for limited resources and therefore if one group is viewed as less likely to benefit from a service, then it is better to use this resource on those more likely to succeed. Hence, the disabled sample may have been supporting the allocation of funding on the basis of those most likely to achieve the goal of employment, rather than on those with most need.

Those ranked lowest through the ATIS may be viewed as a 'poor economic bet' in terms of being able to provide for oneself. If this is true, then according to the ATIS results, it could be that people who are deaf, have epilepsy or arthritis, are viewed as better economic 'bets' than people living with HIV/AIDS, cerebral palsy, Down's syndrome or schizophrenia. Hence, those ranked highest in the hierarchy may have been viewed as being more able to give back to society than those ranked lower down.

Social Policy and the Hierarchy of Impairment

The finding that disabled people hold similar attitudes towards different impairments as their non-disabled peers may have important implications with respect to consultation on social policy relating disability issues. Policy makers, the results presented in this thesis suggest, should not assume that disabled people will not view different impairment groups with similar levels of prejudice as non-disabled people. As a consequence, where one impairment group is seen as 'less deserving' of a provision, (perhaps because of the cause of impairment), by another group of disabled people, then equitable emphasis on resource allocation may not be evident. Quist and Resendez (2002) comment upon the realist conflict theory, whereby inter-group conflict is produced by conflicting goals and competing for scarce resources. For instance, if a local authority seeks service user involvement in the development of its service delivery, then if the user involvement is skewed towards one impairment group as opposed to another, there is a risk that service delivery or even social policy will be more beneficial to one group over another. And yet, on the surface, there is an appearance of consultation. A possible illustration of this may be physically impaired service users demanding services that enable them to live fully integrated lives in the community, whilst simultaneously viewing such services as inappropriate for people with mental illness.

This issue will become highly significant with the creation of a single equality commission (Commission for Equality and Human Rights) within the United Kingdom, covering race, sex, sexual orientation, religion and disability (DTI, 2004). This single commission will merge the three existing equality Commissions (Disability Rights Commission, Commission for Racial Equality and Equal Opportunities Commission). This may create a real risk that marginalised groups who may fall within the disability remit of the commission may become even more marginalised due to even greater numbers of conflicting agendas. This is not to say that those most stigmatised according to the hierarchy, such as those with schizophrenia or Down's syndrome will necessarily become marginalised within the commission, as these groups have many mainstream advocates working on their behalf (for instance, Rethink and MENCAP). However, those impairment groups who do not have well recognised or high profile impairments may find issues that are important and yet unique to them squeezed off the commission's agenda.

It will also be interesting to see whether alliances are created and built upon between groups who have vested interests in ensuring other groups prosper, such as people living with HIV/AIDS, the gay community and increasingly the black community. However, alliances between other minority groups and disabled people are not easily created. Appleby (1994), for instance, found lesbian women held stereotypical attitudes toward disabled lesbians, and Johnson (2003: pp. 137-139) describes how traditional liberal groups, such as women's rights and gay rights groups, have little more understanding of disability issues than the general population.

Witcher (2003) recognises that impairment is only one facet of a person's identity, arguing that:

"The arrival of a Single Equality Body on the scene makes it imperative ... to identify common ground and strengthen the call for action, while not losing sight of important differences in the experiences and barriers affecting different groups". (Witcher, 2003)

Thus, Witcher (2003) sees the importance of recognising and valuing both difference and sameness between and within different groups. This approach may assist meaningful alliances to be created, avoiding the creation of devaluing hierarchies within the single equality commission. However, the distinction between values and attitudes may be important. Wilson (2005) offers the distinction between values and attitudes as a value being a context-independent proscriptive or prescriptive belief, whereas attitudes are evaluative beliefs that focus on a specific object. Wilson recognises a multitude of attitudes to a range of attitude objects 'can be tied to a finite set of values'. The link between attitudes toward disabled people (and specific impairment groups) and wider values, such as the belief in equality and diversity, and hence, that all citizens have a right to be treated as equal members of society, may create opportunities for working together toward common goals, despite the single equality commission being made up of a diverse set of minority groups. One such example could be the values associated with integration.

A further illustration of the importance of the hierarchy of impairment in relation to social policy is in relation to integration. Through interviews with 15 disabled participants who were deemed to be successfully integrated into society and people from the social network of the disabled participants, van de Ven *et al* (2005) contends integration consists of five elements: functioning in an ordinary way without receiving special attention; mixing with others without being ignored; taking part in and contributing to society; utilising opportunities; and, being the director of one's own life. However, as Dijkers (2006) notes, which aspects of these five elements are derived from disabled participants and which from non-disabled participants are not stated. Dijkers also questions whether the same 'elements' would have been produced had respondents been disabled people who had not become integrated into society. That said, these five elements have a resonance with the data produced in the initial stages of the development of the GASTDP (see Appendix A).

Ryan (2006) responds to van de Ven *et al 's* (2005) conclusions noting these authors drew their conclusions from people primarily with motor impairments, questioning the generalisability of their findings to other impairment groups, making specific reference to people with learning disabilities. However, whilst the data presented in this thesis suggests a hierarchy of impairment may exist, each of the five elements of integration are applicable to each of the seven impairment groups utilised on the ATIS. For instance, people living with schizophrenia require these same elements, as do people with arthritis. However, what the hierarchy of impairment could possibly highlight, is the 'distance' each of these different groups need to 'travel' in terms of social inclusion, before full integration is achieved.

Ryan goes on to state, "*...a related area which is not being engaged with is the impact of particular impairments upon other people (disabled and non-disabled) and, moreover, the extent to which the impact is not acceptable*". The data presented in this research offers a limited response to this issue through the analysis of the responses to the statements in relation to whether a restaurant owner should be allowed to refuse service to a person because of their impairment (statement 9) and whether a cinema should be allowed to refuse entry to a person, again because of their impairment (statement 11). This data suggests, albeit tentatively, that the vast majority of both disabled and non-disabled reject such discrimination (see Appendix K). However, perhaps most importantly, is the question whether such beliefs would translate into behaviour. Again, citing Ryan's (2006) reference to Lennard Davis' description of being seated in the opera near a women using a noisy ventilating machine, questioning whether people would be so tolerant if more people using such machines were also in the audience.

Finally, in relation to the hierarchy of impairment, it is of value to briefly explore some of the implications that have been deduced from the above discussion.

Implications of the Hierarchy of Impairment

A number of implications arise from the results of this research including methods by which to reduce those most stigmatised, the consequences of holding paternalistic attitudes toward certain impairment groups, and how the hierarchy of impairment held by disabled people may contribute to the continued oppression of some groups of disabled people. Each of these points will be discussed below.

Impairment specific attitude change strategies need to be developed further, in order to reduce the fear associated with impairments ranked lowest (least positive) in the hierarchy. Through the reduction of the fear caused by the stereotyped images of impairments often created by the mass media, such as schizophrenia (Laurance, 2003), this group of disabled people may become less marginalised in society. Negative and sensationalised representations of people with schizophrenia need to be replaced with non-threatening portrayals of people living with this impairment successfully in the community, creating a more representative image of this group of people. Where a tragedy does occur, it needs to be put into a wider context, such as people living with schizophrenia are far more likely to self harm than deliberately harm another person (Egdell, Horrocks, Lee and Warburton, 1988). Hence, the likelihood of ever being attacked by someone living with schizophrenia is very low.

More specifically, the understandable concern for a child's safety must not be based on prejudiced and stereotyped views of each impairment group. With appropriate support mechanisms (both formal and informal), which may include parenting skills training for people with Down's syndrome, safe and loving family units may be created. Likewise, if people living with HIV/AIDS are concerned about having their own children and the related risk of passing the infection onto the child, they may choose to adopt a child. By taking appropriate precautions the child can be raised with only minimal risk of infection. People living with HIV/AIDS may also offer a foster child who is already infected with HIV, support in a manner not possible by other parents.

Further research may be required to identify whether people are more or less accepting of a gay man who is living with HIV/AIDS, drug user, et cetera. Such research could therefore identify the role that perceptions of 'blame' associated with acquiring the disease play, such as Jones *et al* (1984) suggest through their work relating to stigma. Jones *et al* contend one contributing factor of stigmatising conditions is the origin of the stigma. Therefore, attitude change strategies, including educational programmes, can then be targeted to counter such prejudice.

It is important for disabled people to view life events as part of living, and not seek some form of paternalistic protection from society in general, if it is not warranted. This view is supported by Nosek, Hughes, Swedlund, Taylor and Swank (2003) in a study of both physically disabled (n = 475) and non-disabled (n = 406) North American women. These authors found that among disabled women overprotection during childhood correlated with lower self-esteem and greater social isolation. This is not to argue that disabled people, like any other citizen, are not entitled to the same form of support as others, such as protection from danger or poverty. It is also not to argue that at certain points in a person's life, that additional forms of protection may be required. Such protection may be in part as a direct consequence of that person's impairment, such as hospitalisation for a person experiencing a psychotic episode due to schizophrenia. However, it *is* to argue that if disabled people are to function fully in society, then risks need to be taken. It is the management of those risks, often through experience drawn from past events that we learn to cope with future situations of a stressful nature. However, it is necessary to again question the extent to which this argument is true for people with mental health problems as opposed to people with physical impairments, whereby the protection from stressful life experiences may be a positive coping strategy, be that long or short term. Hence, the results produced from the ATIS in relation to schizophrenia, must be viewed in light of this comment.

HIV positive gay men may give a valuable insight into positive coping strategies when living with a highly stigmatised impairment. Collins (1998) through interviews with symptomatic HIV positive gay men in Canada (n = 92), found that stressful life experiences enhanced the "life education", which aided in the development of coping strategies (p. 38). Any coping strategy in relation to managing stressful life events must also take account of cultural factors. For instance, in light of the increase in the number of African American women who are infected with HIV, these women require programmes and services that specifically meet their needs (McNair and Prather 2004) and are culturally sensitive. In addition, such services need to assist people to manage stress in a manner that is appropriate to socio-economic factors pertaining to their lives and not simply focus on psychosocial adjustment to impairment. Such approaches, and even wider awareness of the value of such approaches, may assist in improving the mean score achieved in relation to the stress and anxiety statement included on the ATIS.

This research therefore builds on previous research on the hierarchy of impairment by not only supporting previous findings that non-disabled people hold a hierarchy of impairments, but disabled people also rank order other impairments. The reasons for the placement of each impairment within the hierarchy may well be for different reasons, such as fear of one group more than another, or viewing one group as giving more back to society than another, and so on, but the data suggests these beliefs translate into a stable attitude toward each impairment, regardless of the context. When viewing this in light of the goals of independent living the findings from this research becomes particularly worrying. Independent living is founded on three fundamental beliefs:

"Disabled people should have access to the same human and civil rights as non-disabled people;
Society's reaction to impairment, and the failure to meet needs relating to impairment, have undermined disabled people's human and civil rights;
This is not inevitable; impairment does not have to determine life chances. Our biology is not our destiny." (Morris, 2004: p. 428)

The findings from this research suggest some disabled people may inadvertently be supporting forms of oppression toward people with certain impairments (including self-oppression). Therefore, it is possible the human and civil rights of some impairment groups are being undermined. The extent to which this is overtly disablist or a form of what could be termed 'aversive disablism' will be explored in more depth in section 8.6 below.

8.5 Locating Impairment in Society

As discussed above, this research contends that both disabled and non-disabled people hold a hierarchy of impairment. Each of the statements utilised on the ATIS offer the respondent the opportunity to accept or reject statements relating to the rights of people with different impairments. As such, this research suggests the effect of impairment on the lives of individuals is inextricably linked with societal reaction to the impairment group. As Crow (1996) contends, *"We need to find a way to integrate impairment into our whole experience and sense of ourselves for the sake of our own physical and emotional well-being, and subsequently, for our individual and collective capacity to work against disability"*. Hence, disability, viewed in terms of social oppression, is linked to impairment, thus challenging the view that 'impairment is nothing to do with disability' (Oliver, 1996c). This next section will therefore argue the need to incorporate impairment more centrally into the discourse relating to the social oppression faced by some sub-groups of disabled people.

O'Day and Killeen (2002: p. 11) comment on the complex interaction between the individual and society, noting Watson, Tucker, Baldwin and O'Day's (1994) contribution to this debate, who argue that disability is always *"...in flux, changing with the situation and within the cultural framework"*. Watson *et al*, note how the debate has moved on from suggesting that all people with impairments can function on parity with non-disabled people to one where the reality of the disability experience is acknowledged. O'Day and Killeen (2002) surmise:

> *"...the nature of disability is not merely the interaction between the person and society, nor is it the impairment itself, but rather a combination of both, varying in context and circumstance."* (O'Day and Killeen 2002)

In other words, the binary distinction debate between the social-medical model of disability has moved on to recognise the interconnection of functional ability, societal construction and attitudinal affect. Hence, the social oppression faced by one impairment group as opposed to another, or even one individual within a certain impairment group, may vary greatly, despite being within the same social setting. This view can be supported by the finding that both disabled and non-disabled samples found it more acceptable for a restaurant to refuse service to people with either schizophrenia (ranked seventh) and Down's syndrome (ranked sixth) because of their impairment, than the other impairment groups. It should be noted however, that the mean scores for both samples fell within the positive attitude threshold for statement 4 on the ATIS (less than three). However, being socially rejected in this manner, even if it is in subtle ways, such as being given a table away from other customers, is likely to damage the self-esteem of the individual and could ultimately cause the disabled person to avoid public settings that have the potential for further rejection.

Shakespeare and Watson (2002) put forward the notion of a 'social model of impairment', despite reservations from academics such as Oliver (1996d). The data produced through this research suggest a hierarchy of impairment exists, based on basic rights in terms of social interactions with other people, the right to hold culturally accepted roles (such as parenting) and social oppression. It would therefore appear there is a relationship between the impact of a person's impairment and that impact being to some extent socially constructed. This view is supported by Howard (2003) who argues for an 'interactionist' perspective that can *"bridge the gap between the individual and the social"* (p. 5). Howard states:

"As the interaction between the individual and their environment is a social process, this implies that disability is 'dynamic', occurring over time and within a particular social context. The problem is not located either in the individual or the social alone, so dynamics could be altered through elements of both

individual and social change, and targeted where they occur". (Howard, 2003: p. 5)

Hughes and Paterson (1997: p.335) contend, *"Disability is, therefore, experienced from the perspective of impairment. Ones body is ones window on the world".* If the hierarchy of impairment exists, each impairment group will view the world through a different 'window'. Whilst postmodernists may argue each individual's perspective is unique, and therefore we all view the world through our own 'window', it can be suggested there is a degree of commonality in experience, in part as a consequence of impairment.

Michel Foucault and Disability Studies

Through a process of 'self objectification and categorisation' human beings are given both a social and personal identity (Rabinow, 1984: p.8). The first mode of 'objectification', according to Michel Foucault, is 'dividing practices'. Such practices, according to Foucault, lead to exclusion, in a social sense (Rabinow, 1984). It is to the work of Michel Foucault this discussion will now briefly turn, as scholars are recognising the importance of Foucault's work in relation to social theory within a context of disability (Hughes and Paterson, 1997; Tremain, 2002; Tremain, 2005). Hughes and Paterson (1997) argue *"the sociology of the body could help the social model of disability to escape its reluctance to give impairment a sociological agenda."* These authors contend that Foucault takes issue with conventional sociology, and therefore, they suggest, with the social model of disability. This is due to the body being absent from analysis as a consequence of impairment being viewed as having no causal relationship with disability (see Oliver, 1996a).

Hughes and Paterson (1997) argue:

"Disabled people experience impairment, as well as disability, not in separate Cartesian compartments, but as part of a complex interpenetration of oppression and affliction. The body is the stuff of human affliction and affectivity as well as the subject/object of oppression. The value of a phenomenological sociology of the body to the development of a sociology of impairment is that it embodies the addition of sentience and sensibility to notions of oppression and exclusion. Disability is experienced in, on and through the body, just as impairment is experienced in terms of the personal and cultural narratives that help to constitute its meaning. Impairment and disability meet in the body not as the dualistic clash of inner and outer phenomena, but insofar as impairment structures perceptions about disability and disablement is part of the 'felt world' ". (Hughes and Paterson, 1997)

Galvin (2005) uses Foucault's concept of power and resistance coexisting and mutually reinforcing, arguing that the most marginalised and disenfranchised 'wield more power to disturb the status quo' than those more closely approximate to the norm, *"because, by having been forced to live at the edges of society, the oppressed occupy a location which lends itself to the disturbing of these boundaries."* If, therefore, the hierarchy of impairment represents a ranking of those most marginalised, theoretically, those ranked lower in the hierarchy (for instance, people with schizophrenia and Down's syndrome) may disturb the boundaries more than other impairment groups. Whilst people living with Down's syndrome may not traditionally be seen as a group who can disturb the status quo, their increased presence in social settings, such as restaurants, cinemas and the workplace, may indeed do this. The data presented in this thesis did not support the contact hypothesis in relation to disabled people as an homogenous group, in other words, contact with disabled people was not found to affect attitudes. Therefore, by more people with Down's syndrome and schizophrenia being in public, if Galvin's (2005) assertion is correct, then these people may remain continue to be perceived with negative affect, despite contact. But, with increased protection under UK law to receive equitable access to goods and services (see Doyle, 1996) and with policies to encourage integration (DoH, 2001; DoH, 2005), these groups of people are likely, through their very presence in society, to disturb the boundaries between the norm and those on the margins of society. Foucault challenged traditional views of power, arguing against the concept that power was held exclusively by dominant groups (see Rabinow, 1984) for instance, for Marxists, power could only be exercised by the rich ruling class who owned the means of production. Foucault, however, recognised power can be exercised by particular people in specific situations (Tremain, 2005), which will in turn produce other reactions and resistance.

Morris (1991) highlights the criticism levelled towards the social model that it ignores the bodily experience of people living with impairment, and that pain is often part of the lives many disabled people. Hughes and Paterson (1997) comment on this criticism by noting social modellists (a term used by Thomas, 1999a) argue pain is an issue for medicine, not politics. Hughes and Paterson challenge this position by stating *"...pain – like impairment – is clearly far more than a carnal sensation. The body is both sensational and meaningful."* Thomas (1999a) recognises the psycho-emotional effect of impairment in not only biological terms but also social. She argues that:

> *"...as well as the social barriers which are experienced as externally imposed 'restrictions of activity' as currently recognized by social modellists – for example, not being able to obtain employment, appropriate housing, the resources for independent living, and so on - there are also social barriers which erect 'restrictions' within ourselves, and thus place limits on our psycho-emotional well-being: for example, feeling 'hurt' by the reactions and behaviours of those around us, being made to feel worthless, of lesser value, unattractive, hopeless, stressed or insecure."* (Thomas, 1999: p. 47)

The rank ordering of the impairments could therefore be indicative of those who suffer more pain than others, not necessarily in terms of the physical, but in terms of psychological suffering as a consequence of social exclusion and oppression. Hence, those ranked lower in the hierarchy of impairment may be seen as those who face the greatest 'social suffering'.

Kleinman, Das and Lock (1997) argue:

"[The] incommunicability of pain arises from the asymmetry of access to experiential knowledge that it gives us. According to this view, to be in pain is to be certain about this knowledge. To be asked to react to another person's pain is to be in doubt about its existence. From the perspective of theories of social suffering, such a preoccupation with individual certainty and doubt simply seems a less interesting, less important question to ask than that of how such suffering is produced in societies and how acknowledgement of pain, as a cultural process, is given or withheld. After all, to be ignorant or incapable of imagining another person's pain does not signal blindness in moral sensibility in the same way in which the incapacity to acknowledge that pain does. Yet this latter failure is at the bottom of the cultural process of political abuse." (Kleinman, Das and Lock, 1997: p. xiii)

The psychological pain caused by 'social suffering' as a consequence of the denial of rights, such as participating as a citizen in an equitable manner, should not be understated. By viewing impairment and any associated pain as an issue for medicine, effectively places this approach within the sphere of 'political abuse', as quoted above. Whilst the social model does not deny the existence of pain, per se, it does argue the experience of pain is individual (Oliver, 1996c). However, by not acknowledging pain in terms of 'social suffering' due to oppression faced by people with different impairments, those people living with impairments ranked lower in the hierarchy of impairment, such as people living with schizophrenia, will be facing greater levels of political abuse.

However, taking a Foucauldian approach, Tremain (2005: p. 11) suggests, *"there is indeed a causal relationship between impairment and disability"* for disability (as a form of social oppression) cannot exist unless people have an impairment and therefore it is fantasy to argue they are not linked. It is perhaps the lack of causal relationship that has led to criticism of the World Health Organisation's attempt to seek a synthesis between impairment, activity limitation and participation restriction (Imrie, 2004), known as the International Classification of Functioning, Disability and Health (ICF) (WHO, 2001), with Imrie (2004) warning that with the biopsychosocial model of disability being at the heart of the ICF, "the biomedical origins of BPS may well lead back to the entrapment of reductive conceptions of disability and impairment, that is that the biological is prior to the social". Hence, an overemphasis on the medical aspect of the model, with the social consequences of impairment (activity limitation) being little more than a appendage.

Hughes (2000) offers a compelling argument for a 'sociology of impairment', seeing an approach that develops a cultural critique of medicine as enhancing the social model of disability. Hughes states that by making the distinction between impairment and disability the *"theoretical bedrock of the social model"*, it therefore *"focussed its attention upon socially produced disablement and its elimination to the neglect of a sociological account of impairment"* (p. 556). He goes on to argue that aesthetics and 'geneticisation' of contemporary life have added to the exclusion of people with impairments. Although a social perspective has been taken in relation to the interpretation of attitude statement 8 on the GASTDP *"Disabled people should be protected from situations that are likely to cause stress or anxiety to themselves"*, the results appear to support Hughes' argument for a need for a sociological account of impairment. The finding that the majority of disabled people agree with 'protecting' some other people with impairments from stress or anxiety, may result in a form of self-oppression, whereby disabled people themselves restrict opportunities to participate in socially valued social roles, such as employment, parenting, etc., and therefore add to the social exclusion already faced by many disabled people.

Social Construction of Impairment

The argument that impairment is to some extent socially constructed is not new, with people fighting for the rights of people living with HIV/AIDS arguing that many of the effects of HIV/AIDS are more to do with prejudice then the disease itself. Crimp (1987) puts this argument thus:

> *"AIDS does not exist apart from the practices that conceptualize it, represent it, and respond to it. We know AIDS only in and through those practices. This assertion does not contest the existence of viruses, antibodies, infections, or transmission routes. Least of all does it contest the reality of illness, suffering, and death. What it* does *contest is the notion that there is an underlying reality of AIDS, upon which are constructed the representations, or the culture, or the politics of AIDS. If we recognize that AIDS exists only in and through these constructions, then hopefully we can also recognize the imperative to know them, analyze them, and wrest control of them."* (Crimp, 1987: p. 3)

More recently, postmodernist writers have argued that other impairments are socially constructed. For instance, Wilson and Beresford (2002), like Crimp, do not deny the distress experienced by people facing mental illness or psychiatric conditions, but note the need to recognise 'diverse subjective realities' (p. 143). Corker and Shakespeare (2002) contend, *"Post-structuralism provides a different view of the subject, arguing that subjects are* *not the autonomous creators of themselves or their social worlds"* (p. 3). Hence, by taking a postmodernist approach, the diverse realities of the experience of impairment can be viewed in part in the context of the interaction with the environment or 'social world'. A call for a 'new norm' by deconstructing impairment as a social construct would:

> *"...encompass the acceptance and valuing of difference, individual diversity and attributes of the physical body and mind, and would allow physically disabled people to achieve the goals of the original 'normality' model, i.e. personal autonomy and self-determination but where individualism, i.e. the 'ability to stand on one's own two feet' without having to depend on others for help or personal assistance, etc., is no longer applicable."* (Houston, 2004: p. 319)

Houston (2004) recognises the limitations of impairment as a social construct, questioning *"how far society is prepared to go in terms of accepting, accommodating and valuing those people with the highest level impairment need"*. This concern in relation to a social model of impairment is supported by the findings of this research in relation to a hierarchy of impairment. A helpful way of developing a social theory of impairment may be found in the conceptualisation of mainstreaming gender equality. Rees and Parken (2003) in their guidance to the Equal Opportunities Commission on the principles of gender mainstreaming recognise that:

"Whilst gender mainstreaming argues respect for the individual, it does not reduce difference entirely to the individual level as 'managing diversity' can do. Group characteristics that have been used to produce social and economic disadvantage (sex, race', ethnicity, disability, sexuality) are to be challenged whilst the needs of the individuals who form part of these groups are to be given voice through the mainstreaming approach." (Rees and Parken, 2003: p. 8)

From a disability perspective, the 'group characteristic' based on impairment, (which may have produced the social and economic disadvantage), is recognised, with each individual and his or her experience forming part of the group who are given a 'voice' through mainstreaming. Booth and Bennett (2002) argue, in terms of gender equality, that equalities policies can be conceptualised as a "three-legged stool", which recognises the interconnection between three perspectives – the treatment perspective, the women's perspective and the gender perspective. Having argued that a linkage exists between impairment and disability; in other words, that, unlike proponents of the social model, it is proposed there are not only direct social consequences of impairment, but the level of affect varies according to the impairment. Hence, a social theory of impairment could be developed in terms of a 'three-legged stool' whereby the interconnectedness of impairment (functional limitation), disability (the social oppression faced) and the environment (the place of interaction between the individual and the place whereby the oppression occurs causing social limitation) is created. Hence, a social model or theory of impairment may require all three components to interact at once. This suggestion is along similar lines to the biopsychosocial model of disability proposed under the ICF (World Health Organisation, 2001) that attempts to achieve a synthesis *"thereby providing a coherent view of different perspectives of health from a biological, individual and social perspective",* (World Health Organisation, 2000: p. 23), but would respond to critics of the ICF such as Barnes and Mercer (2004) (see Chapter 2). Such an approach, whereby impairment is a fundamental part of the model, as opposed to a separate and distinct concept, may, as Shakespeare and Watson (2002) suggest, assist more disabled people to identify with the 'disability movement', for as these authors state, *"We are not just disabled people, we are also people with impairments, and to pretend otherwise is to ignore a major part of our biographies"*. In addition, with the social setting and social limitation linked to impairment and oppression, all facets of the disability experience must be recognised on an equal level.

In conclusion to this section, this approach would also respond to critics of normalisation principles (see Chapter 2) whereby the person with an impairment challenges the social oppression faced through a constant process of self-regulation to avoid drawing attention to oneself (Tregaskis, 2004: p. 14). As Thomas (1999a) forcefully argues:

> *"...it is quite possible simultaneously to make a conceptual distinction between impairment and disability, reconceptualize the latter as a form of social oppression, understand that bodily variations classified as impairments are materially shaped by the interaction of social and biological factors and processes, and appreciate that impairment is a culturally constructed category which exists in particular times and places."* (Thomas, 1999a: p. 141)

The finding presented in the data that a hierarchy of impairment may exist, as measured by the ATIS, which is based on social attitudes toward different impairment groups, therefore supports Thomas' contention that impairment is 'a culturally constructed category'. By placing impairment at the forefront, rather than the individual being assimilated into society by 'passing' as non-disabled, difference due to impairment, will be seen simply as one facet of identity, such as race and gender, and thus challenge negative cultural representations of disability and in particular, different impairment groups. However, for inclusion to be a reality for all impairment groups, having argued above that a hierarchy of impairment exists, subtle forms of oppression must be challenged as well as more blatant forms and it is this point that will be discussed next.

8.6 Aversive Disablism – Building on Aversive Racism

One intention of this research was to test the hypothesis that 'Attitudes of disabled people toward other disabled people will score significantly more highly on the Subtle Prejudice sub-scale than the Blatant Prejudice sub-scale' (H7). In other words, that disabled people, despite having an intimate knowledge of their own impairment from a physiological and psychosocial perspective (for instance, day-to-day functioning), they will still hold a level of prejudice toward disabled people in general. This section will explore the finding that both disabled and non-disabled respondents scored more highly (higher scores reflecting less positive attitudes) on the Subtle Prejudice sub-scale of the GASTDP than on the Blatant Prejudice sub-scale (see Tables 7.23 and 7.24). In order to assist in the explanation of these findings, the term aversive disablism will be utilised, based on 'modern' or 'aversive racism'.

Personal Experience of Impairment and Disability, and Response to Subtle and Blatant Prejudice

Due to the level of personal insight, disabled people, it was initially assumed, would be more aware than others of what is appropriate or inappropriate in terms of cognition and/or affect toward disability. Thus, when faced with blatantly negative attitudes towards disability (even if privately they agree), such views will be publicly rejected, hence giving what some may term as a 'politically correct' response. With respect to this research, this could be seen through responding on the GASTDP in a manner that is generally assumed to reflect a positive attitude. However, if negative attitudes toward disabled people are expressed in more subtle ways, then the response will not be as easy to 'second-guess'. (For details of the two sub-scales see Chapter 6, section 6.5, Table 6.20).

Introducing Aversive Disablism

A useful way forward in interpreting the results found from the Subtle/Blatant Prejudice sub-scales of the GASTDP may be found in the work relating to *aversive racism*. Aversive racism theory *"focuses on the conflict between an individual's negative feelings and his or her personal self-image of being fair and nonprejudiced"* (Gaertner and Dovidio, 2000: p. 4). Aversive racists recognise racism is bad, but do not recognise they themselves are prejudiced. An aversive racist may therefore vote for a political party at a General Election that holds values that reflect equality and diversity, and yet would choose a school for their child that is attended predominantly by white children and not reflecting the ethnic mix in their local community. Meertens and Pettigrew (1997) in their research into racism throughout Europe, raise the important distinction between 'blatant' and 'subtle' prejudice. They state that:

"..., *the critical distinction between blatant and subtle forms of prejudice involves the difference between overt expressions of norm-breaking views against minorities and the covert expressions of socially acceptable anti-minority views.*" (Meertens and Pettigrew, 1997)

Contentions of this nature are derived from earlier work within Critical Race Theory. Critical Race Theory (CRT) emerged in the mid-1970s when Bell and Freeman expressed concern over the slow pace of racial reform since the 1960s and how progress had begun to stall (see Delgardo and Stefancic, 2000: p. xvi). Underpinning CRT is the premise that elite whites will only tolerate or encourage racial advances when such advances also promote white self-interest (p. xvii). This premise may have a degree of resonance in relation to the progress made in relation to disability rights in the UK. For instance, disabled people have been arguing for the opportunity to obtain paid employment for many years (Daunt, 1991; Gouvier, Jackson, Schlater and Rain, 1991; Drake, 2000), with many people moving onto Incapacity Benefit having an expectation of going back into employment (DWP, 2002). The Labour Government's 'Pathways to Work' programme (DWP, 2002) supports this expectation and demand, but may be motivated as much from a desire to support the rights of disabled people to be in paid employment as it is to reduce the number of people claiming benefits, and hence, reduce the tax burden.

Likewise, the expansion of Direct Payments, whereby a disabled person is given finance directly from the Local Authority to pay for their agreed care needs (DoH, 2005), may have less to do with the laudable claim that it is delivering the promise of greater choice and control, and more to do with reducing the tax burden. Brindle (2005), for instance, reports how the pilot extension of Direct Payments into Individualised Budgets (see DoH (2005) Independence, Well-Being and Choice - Green Paper) can, in some instances, reduce the cost for services. Thus, such 'advances' in the rights of disabled people, could be supported by non-disabled people, in part because they also promote the non-disabled self-interest.

What is even more important, perhaps, is when the advances do not appear to promote the non-disabled self-interest. Hence, there is the potential for conflict between the rights of disabled people and the self-interest of the non-disabled population. For instance, builders and building control officers have been reported as seeing Part M Building Regulations as 'a half hearted and tokenistic regulation' in relation to housing design (Imrie, 2006: p. 8). The objective of Part M is to ensure all new privately constructed dwellings are 'visitable', permitting ease of access for disabled people. However, to be 'visitable' is a far cry from being habitable by a person who uses a wheelchair. The paucity of truly accessible housing throughout the UK (Office of Population Censuses Surveys, 2001) not only restricts the location some disabled people live in, but also restricts the ability to take up employment opportunities that may necessitate moving home. Hence, the self-interest of the majority non-disabled house buying population who wish to keep house prices down, are in conflict with mobility impaired individuals who seek greater property purchasing/renting opportunities and therefore flexibility in seeking employment.

This is not to argue that the building industry is inherently disablist, but, as Young (1990: pp. 41-42) notes, (whilst drawing on the work of Michel Foucault), *"The conscious actions of many individuals daily contribute to maintaining and reproducing oppression, but those people are usually simply doing their jobs or living their lives, and do not understand themselves as agents of oppression".*

Young offers an explication of 'five faces of oppression' (pp. 48-63), recognising a plural explanation of oppression is required. Young lists these 'five faces' as exploitation, marginalisation, powerlessness, cultural imperialism, and violence. An oppressed group may be exposed to any of the 'five faces' to a lesser or greater extent. Based on the data presented in this thesis in relation to the hierarchy of impairment, it is possible this data indirectly reflects the intensity of oppression faced by each impairment group. Whilst disabled people as an homogenous group may face oppression, for as Young (1990: p. 64) comments, physically and mentally disabled people face marginalisation and cultural imperialism, it is likely sub-groups, (based on impairment), will face different forms and intensity of oppression.

Young's 'five faces of oppression' has a high level of resonance for disabled people as a group, particularly in relation to marginalisation, as identified through segregated housing (Houston, 2004) and powerlessness, typified in the high unemployment levels for disabled people which is cited as a key factor in the cause of social exclusion (DWP, 2002). However, Young also contends all oppressed groups face cultural imperialism. *"To experience cultural imperialism means to experience how the dominant meanings of a society render the particular perspective of one's own group invisible at the same time as they stereotype one's group and mark it out as the Other"* (pp. 58-59). Young continues, *"Cultural imperialism involves the universalization of a dominant group's experience and culture, and its establishment as the norm"* (p. 59).

Ironically, many disabled people, often through non-identification as a disabled person or rejection of the label 'disabled' (Willey, 1999; Tierney, 2001; Watson, 2002) seek to belong to the dominant group and culture. Likewise, over a third of disabled respondents in this research disagreed with the notion of disabled people feeling a sense of pride in associating with other disabled people (see Appendix K, statement 18).

Subtle racists reject the crude expressions of prejudice, but nevertheless still view minority groups as "a people apart" (Meertens and Pettigrew, 1997). Young (1990: p. 134) contends, *"Many people are quite consciously committed to equality and respect for women, people of color, gays and lesbians, and disabled people, and nevertheless in their bodies and feeling have reactions of aversion or avoidance toward members of those groups"*.

Such a notion would be supported by Devine (1989) who, when researching racism, comments, *"...that both high and low prejudiced subjects have cognitive structures that can support prejudiced responses"* (p. 193). Devine also stresses that an assumption should not be made that all people are prejudiced. She comments that whilst high prejudiced persons are likely to hold beliefs similar to the cultural stereotypes, low prejudiced persons experience a conflict between their egalitarian views and the content of automatically activated cultural stereotypes. Such a conflict may exist for disabled people who hold positive attitudes toward other disabled people but still face the predominantly negative cultural stereotypes towards disability and impairment.

Hence, if this theory hold true for other minority groups, (in this instance disabled people), then what could be termed as *aversive disablism* could help to explain the result that the scores on the Subtle Prejudice sub-scale were significantly higher (therefore less positive attitudes) than on the Blatant Prejudice sub-scale for both disabled and non-disabled respondents.

Disablism has been defined as *"discriminatory, oppressive or abusive behaviour arising from the belief that disabled people are inferior to others"* (Miller, Parker and Gillinson, 2004: p. 9). Gaertner and Dovidio (2000) argue that aversive racists hold ambivalent attitudes towards Black people which are *"rooted in the tension between feelings and values"* (p. 13). These authors continue, *"These negative feelings do not reflect open hostility or hate; instead, the feelings involve discomfort, uneasiness, disgust, and sometimes fear"* (p. 14), which means *"aversive racism theory focuses on the conflict between an individual's negative feelings and his or her personal self-image of being fair and nonprejudiced"* (p. 4).

Thus, relating this to disabled people, the feelings listed by Gaertner and Dovidio are likely to cause the attitude holder to avoid contact with the attitude recipient. Support for well meaning social policies that reduce the possibility of meaningful interactions between disabled people and others are therefore likely to be supported by aversive disablists. For instance, supporting segregated schooling due to the belief that it can offer a higher quality education to disabled children, rather than mainstream education with appropriate backing within the school; the continuation of Day Care Services, rather than providing the same services and support within an integrated environment; the use of residential care homes rather than community based housing schemes; or Supported/Sheltered Businesses rather than job coaching schemes (see Nisbet (1992) for discussion on job coaching) assisting disabled people to work in integrated work environments.

Whilst Day Care Services, Supported Businesses, etc. are not inherently 'bad', they do distance the disabled person from other people, placing the individual in an environment that can be argued to be 'safe'. At the same time such services deny the disabled person the right to experience life in the manner of other people. Although only a minority of either the disabled or non-disabled sample agreed with statements such as "Having a disabled person as a colleague would mean the non-disabled person would be given extra work and responsibility" (statement 6 on GASTDP) and "Disabled people would be happiest living alongside other disabled people" (statement 7 on GASTDP) (see Appendix K for breakdown of GASTDP results), these results suggest a minority of people could hold aversive disablist beliefs. By supporting the above two statements aversive disablists could be denying the opportunity of working in open employment or living in the community.

The Labour Government Cabinet Office report on 'Ethnic Minorities and the Labour Market' (Strategy Unit, 2003: p. 101) also recognises "..., *overt forms of discrimination have become less frequently observed, while covert, indirect forms of discrimination have been more widely recognised*". In other words, subtle forms of racism are being identified, whereas blatant forms of discrimination are now less prevalent. Aversive racists, Gaertner and Dovidio (2000: p. 29) argue, are not anti-Black, but pro-White. Likewise, aversive disablists may be pro-non-disabled. This theory may hold true for both disabled and non-disabled people, bearing in mind, people do not on the whole choose to be disabled. But, not choosing to be disabled does not mean the person will automatically be anti-disabled. Again referring to Gaertner and Dovidio (2000), these authors note that the consequences of aversive racist pro-White behaviour can be as damaging to Black people as more overt forms of racism. They offer as an illustration how White employees in an organisation may be given opportunities for development that are not available to Black employees, thus damaging the Black employee's career opportunities.

Such in-group favouritism has important implications for disabled people if they do not identify as a disabled person. Non-identifiers, whilst believing they hold liberal attitudes toward disabled people, may support behaviours and social policy that excludes other disabled people. The implications of aversive disablism in relation to the finding that a hierarchy of impairment appears to exist will now be explored.

Aversive Disablism and the Hierarchy of Impairment

As discussed above, the disabled sample produced statistically significant findings in relation to a hierarchy of impairments and yet positive attitudes toward disabled people in general as measured by the GASTDP. Hence, aversive disablists may be viewing prejudice toward disabled people in general as bad, but have not recognised their own prejudice toward people with other impairments with whom they may not wish to be associated. Thus, using Miller, Parker and Gillinson's (2004: p. 9) definition of disablism, disabled people who may be aversive disablists, could be viewing people with different impairments as inferior. Specifically, people with schizophrenia, Down's syndrome or HIV/AIDS (i.e. those ranked lowest through the ATIS) may have been viewed as 'inferior'.

This links with the downward-comparison model discussed by Duckitt (1994: pp. 169-170) whereby the individual bolsters their self-esteem by viewing themselves as superior to others, in this case, including members of the same in-group (disabled people). By this it could be argued, disabled respondents, whilst believing that these groups of disabled people should not be discriminated against, simultaneously believe these people are not as 'capable' as they are. The consequence of this may be that certain rights, such as parenting, are not universally supported by all disabled people for all other disabled people or services are developed that, although with well intentioned philanthropic ideals (such as residential care originally was), lead ultimately to discriminatory practice with respect to certain impairment groups.

Subtle forms of prejudice may therefore be more difficult to combat than blatant forms, especially when they come from people who it would be expected were allies. Stephen Ladyman (Minister with responsibility for disability policy in the Department of Health until 2005) recognises one of the greatest barriers to social inclusion for people with learning disabilities are other people's attitudes (Holman, 2004). In addition, Ladyman has identified that people who would have been expected to have liberal, with a small "L", attitudes, actually hold *"almost Victorian attitudes about what can and cannot be achieved"* (Holman, 2004). In other words, advocates of liberal policies such as the implementation of Direct Payments, (whereby disabled people receive money direct from the Local Authority in order to employ their own care staff), may be reluctant to encourage the use of this service for people with learning disabilities. Aversive disablists may believe Direct Payments may be overly difficult to administer, with residential care or care services being provided through an agency or social services, being a 'safer' option. Hence, it could be argued, by holding stereotyped beliefs towards people with learning disabilities, these people may be exhibiting aversive disablist attitudes.

Psycho-Emotional Effect of Impairment

Subtle forms of prejudice toward disabled people should not be seen exclusively as attitudes of non-disabled people toward disabled people. People who have recently acquired an impairment are likely to hold pre-impairment attitudes toward disability and thus the disabled self (Morris, 1989), which are predominantly negative. Such attitudes are likely to influence the individual's psychological well-being, for as Johnson, Schaller and Mullen (2000) found when investigating how people respond to discovering they are members of a group to which they hold negative stereotype attitudes, "... *a newly acquired identity in the minority group was not enough to attenuate the previously formed negative stereotypes.*" Such beliefs can create subtle forms of self-oppression, which, as Thomas (1999a) recognises in terms of the psycho-emotional effect of impairment, can be viewed not only in biological terms but also social. She argues that:

"*...as well as the social barriers which are experienced as externally imposed 'restrictions of activity' as currently recognized by social modellists – for example, not being able to obtain employment, appropriate housing, the resources for independent living, and so on - there are also social barriers which erect 'restrictions' within ourselves, and thus place limits on our psycho-emotional well-being: for example, feeling 'hurt' by the reactions and behaviours of those around us, being made to feel worthless, of lesser value, unattractive, hopeless, stressed or insecure.*" (Thomas, 1999a: p. 47)

Aversive disablism, in terms of the 'restrictions within ourselves', by being pro-non-disabled, may add to the negative psycho-emotional effect experienced by disabled people. By seeking a non-disabled identity or attempting to 'pass' (see Goffman, 1963) as non-disabled can add to the oppression faced by disabled people. Wahl (1999) found, for example, the persistent fear of discovery that a person had a mental illness in itself created anxiety; likewise, subtle forms of prejudice can make disabled people feel as devalued or insecure as more blatant forms, for instance, being consistently overlooked for promotion in employment situations. The theme of employment in terms of subtle prejudice will now therefore be explored.

Aversive disablism has inevitably focused on attitudes toward *disability*, viewing the person's impairment as their main identity marker. However, it is important to recognise we all carry multiple identities, and whether one's gender, sexual orientation, race, social class, etc., is regarded as the principal identity marker depends on the perspective of the individual themselves or the observer toward the individual. Gordon and Rosenblum (2001) contend, however, *"Whites do not worry about becoming black; men don't worry about becoming women. Disability, however, is always a potential status and in that it is perhaps closest to sexual orientation, whether the latter is considered a choice or biologically determined"*. Tregaskis (2004) recognises the difficulty to disentangling multiple identities, for prejudice toward an individual or even group may be for a number of reasons. For instance, she considers the hostility she originally faced when initiating research in a leisure centre may have been because she is female, white, dressed formally, a disabled person, or of course, any combination thereof. In addition, it may even have been because she was accompanied by a black male.

Therefore, aversive disablism may need to be viewed simultaneously with aversive racism, aversive sexism, etc, in some instances. Whether it is truly possible to disentangle the motivation for prejudice towards people facing multiple-oppression is questionable. Such an argument can also be extended to people living with multiple impairments, which may have a greater affect depending on the impairment.

The final section of this thesis will present a number of recommendations for further research before offering final concluding comments.

8.7 Recommendations: Taking Disability Studies Forward

This section will draw on the themes presented in this thesis, offering a series of recommendations for further consideration by future researchers. This includes suggestions for the modification of the tools developed for this research as well as researching the attitudes of minority groups from within the Black and Minority Ethnic community and people with impairments who do not identify as a disabled person. The development of a new theory of disability that locates impairment at its heart is also recommended, that also recognises how prejudicial attitudes toward disabled people may be subtle in nature. In addition, the need to research further how disability can be viewed as a positive identity in order to assist in the psychosocial adaptation progress for those who have recently acquired an impairment and the development of a disability movement will be presented.

Black and Minority Ethnic Community

As this research failed to attract significant numbers of responses from the Black and Minority Ethnic (BME) community, it is recommended that specific research be performed to target this community that is culturally appropriate in relation to this group's attitudes toward disability. It will be important to recognise that the BME community, like disabled people, reflect a vast range of backgrounds and groups, each one possibly holding distinct differences in their beliefs toward disabled people. It would be particularly interesting to discover the views of disabled people who belong to the BME community to identify whether they hold similar attitudes as their disabled counterparts from the White community or whether there are cultural differences.

Likewise, Makas (1988) identified the disparity between the beliefs of what constitutes a positive attitude toward disability from disabled and non-disabled perspectives. This approach could be taken not only between the White and BME communities, but also within the BME community itself. In order to do this the question as to what constitutes a positive attitude toward disability from a BME perspective needs to be investigated. In addition, it will be helpful to identify whether disabled BME community members hold distinctly different beliefs toward a positive attitude toward disability than their non-disabled counterparts and whether similarities or divergence from the White community attitudes exist. Research of this nature would enable social policy makers to meet the needs of a greater number of disabled people within the UK, encouraging services that reflect cultural diversity. White disabled people and BME disabled people may also be able to learn from each other, developing a truly embracing standpoint.

Measuring Attitudes of People with Learning Disabilities Toward Other Disabled People

Due to the level of literacy and complexity of the tools developed for this research, low levels of response were received from people with learning disabilities. It is therefore recommended that new tools are developed in order to engage this group of people in further research on attitudes toward disabled people, taking into account issues in relation to performing research with this group (Rogers, 1999; Tregaskis, 2000; O'Day and Killeen, 2002). It may be possible to modify the GASTDP and ATIS to become more inclusive in their design, although appropriate testing would be required to ensure the existing and modified versions measured the same thing. In other words, both tools measured the same attitudes toward disabled people and different impairment groups, and did not, inadvertently through the modification, tap into attitudes toward some other attitude object.

It is interesting to note however, that one group of people with learning disabilities based within a college of Further Education utilised the attitude scales presented in this thesis as a basis for group discussion. Having determined that the potential respondents with learning disabilities were unable to complete the two attitude scales (GASTDP and ATIS), the college tutor decided to abandon collecting the data. However, those who were able to read parts of the two attitude scales spontaneously started to discuss the statements. Hence, with tutor support, the scales were used in this instance as a teaching aid.

Modification of the GASTDP

Whilst this research did not specifically set-out with the intention of developing new research tools in relation to attitudes towards disabled people, due to a lack of suitable existing tools, the need for this development arose. Now the GASTDP and the ATIS have been tested, future researchers may wish to utilise these tools as they stand or in a modified form. Although researchers need to be cautious when modifying existing attitude scales, (this is not only in order to ensure the scale retains appropriate levels of reliability, but also that any subsequent interpretation of the data gathered when comparing results with earlier data gathered using an unmodified scale needs to be clearly stated), modifications are possible. For instance, Beckwith and Matthews (1994), using a modified version of Gething's 'Interaction with Disabled Persons Scale' (IDP), identified how the IDP could be enhanced. In relation to the GASTDP an enhancement in the Subtle and Blatant Prejudice sub-scales to ensure greater internal reliability is recommended. The ATIS could be modified by using different impairment categories in order to test further the hypothesis that a hierarchy of impairments exists in relation to disabled peoples' rights.

The use of statement 8 on the GASTDP *"Disabled people should be protected from situations that are likely to cause stress or anxiety to themselves"*, and more importantly the subsequent use of this item on the ATIS needs to be considered in terms of its appropriateness for all forms of impairment. Whilst the intention of this statement was to support the contention that disabled people reported they wished to be treated 'normally' and have the same opportunities as other people, the wording of this item may need revising in the light of people with mental health impairments, such as schizophrenia. It may be too simplistic to assume that even with support services, some people with mental health impairments, such as bi-polar disorder, may not benefit from avoiding stressful situations. In other words, some people with certain impairments, rather than benefiting from being exposed to the stresses of daily life, may in fact be harmed by them. Hence, it is recommended that statement 8 on the GASTDP be reworded to *"Disabled people should* ***always*** *be protected from situations that are likely to cause stress or anxiety to themselves"*. This would therefore be a negative expression requiring reverse scoring on the GASTDP; thus, agreement is viewed as a reflection of a negative attitude toward disabled people. This statement reflects a generalisation that disabled people should be mollycoddled often reflected in 'paternalistic' attitudes that can lead to disabled people being kept in a 'child like' state and hence, has a negative affect upon disabled peoples lives.

This recommendation is despite the finding (although not statistically significant) that people with depression and mental health problems held more positive attitudes to the category Schizophrenia on the ATIS than some other sub-samples of disabled people (see results for H2). In other words, people with mental health problems were more likely to disagree with the original statement 8 in relation to people living with schizophrenia than some other groups of disabled people. That said, the reduction of any ambiguity in the meaning of any item on either of the attitude scales, will help to produce increasingly accurate results. Hence, by placing the word 'always' into statement 8 of the GASTDP, if the respondent agrees with this statement they will be placing the disabled person into a situation of need. By using this categorical word, when the statement is used in the ATIS, respondents who agree, for instance, with the notion that people with schizophrenia may benefit from a degree of protection from stress and anxiety, should still disagree with the statement. Hopefully respondents will recognise that to place **all** people with schizophrenia into a situation of **always** being 'protected', will inevitably limit opportunities for some people who do not require this form of protection.

The removal of statement 5 on the GASTDP is also recommended, thus giving the GASTDP greater internal reliability (as was the case for the analysis of the data presented in Chapter 7). In addition, only one of either statement 10 *"Disabled people should be charged for care services on the basis of their ability to pay"* or statement 14 *"Disabled people should be charged for care services if they are employed"* appears to be needed to be included on the GASTDP. The removal of one of these items will avoid the possibility of a 'bloated specific' (Kline, 1994), whereby two or more items on an attitude scale are simply repeating the same statement and hence 'bloating' the value of this aspect of the scale. It is suggested a modified and simplified version of these two statements be utilised, which could state, for instance, *"Disabled people should be charged for care services"*. However, it would be interesting to identify whether people feel elderly people should be charged for care services, and whether there are similarities or disparity of attitude toward these two groups in relation to this area of social policy.

Statement 18 of the GASTDP *"Disabled people feel proud to identify with other disabled people"* may also require modifying, or, an additional statement added to the scale. This would be in order to ensure a distinction is made between the belief that disabled people **actually** feel proud to identify with other disabled people, as opposed to **should** feel proud. This distinction would then highlight the gap between the two beliefs and therefore how far attitudes need to 'shift' with respect to 'disability pride'.

Researching Attitudes Toward Disability of Disabled People who Choose Not to Identify as Such

This research tested the hypothesis '*People who identify themselves as having a disability will hold significantly more positive attitudes toward disabled people than disabled people who do not identify themselves as having a disability*' (H6). However, any conclusions based on the findings presented in this thesis must be viewed cautiously due to the limited number of respondents who fell into the category of being a disabled person who did not identify as such.

Whilst it has been asserted in the literature that people who 'come out' or view disability as a socially valued identity hold more positive attitudes toward their own status as a disabled person than other disabled people, this research did not produce sufficient evidence to reject the null hypothesis. This may in part have been due to the uncertainty over the category 'Never' on question 12 of the

Demographic Data Questionnaire (see Appendix C). For, it is possible that a respondent, who 'denies' the reality of their impairment, may view themselves as falling into the 'Never' category, and yet the person who sees society as disabling and therefore does not view themselves as a disabled person but a person with an impairment who faces oppression, may likewise respond by stating 'Never'. Hence, it is recommended further research into the attitudes of these two distinct groups of disabled people be performed. Such research could help to identify how to assist those disabled people who view a status as a disabled person negatively to move to a belief that disability and impairment are different although related concepts, and that disability can be seen as a value neutral aspect or identity, if not a positive one.

Further research is required in order to ascertain whether people with one particular impairment and who have high levels of contact with other people with the same impairment, hold more positive attitudes toward the group than those with low levels of contact. For instance, it may be helpful to ascertain whether some impairment groups that are highly stigmatised, such as people living with schizophrenia or bi-polar disorder, view others more positively if they have high levels of contact with similar others, and whether there are other factors that affect attitude change for these highly stigmatised groups of people. Whilst it has been argued elsewhere that support groups are a helpful mechanism to assist disabled people to develop coping strategies (see for example, Birchwood and Jackson, 2001; Hatzidimitriadou, 2002; Yip, 2002;

Leung and Arthur, 2004), this does not automatically mean these same people will develop positive attitudes toward other members of the impairment group. However, as the research presented in this thesis found those who voluntarily chose to associate with other disabled people tended to hold more positive attitudes, this aspect of the research requires further attention from future researchers.

Researching and Measuring Attitudes Toward Impairment

This research tested the hypothesis that disabled people, like non-disabled people, hold differing strengths of attitude toward different impairments. In other words, to identify whether a hierarchy of impairment exists, from either sample. The results from this research appear to support this hypothesis, however, what is now required is further testing of this hypothesis, again from the disabled persons' perspective, using a variety of both quantitative and qualitative research methods. Due to the sensitivity of such research, innovative research methods will need to be adopted, at the same time ensuring such research does not add to the discrimination and prejudice faced by disabled people. Research of this nature could be likened to investigating racism within the Black and Minority Ethnic (BME) community, homophobia within the gay community or sexism within the feminist movement. Therefore, sensitivity is essential, whilst also ensuring honesty from the research participants.

Emancipatory research (Oliver, 1997) may be helpful if any findings from such research are going to hold credibility with disabled people in general, but in particular with disabled people who support the notion that a disability movement exists and who support a positive identification with a disability identity. This group of disabled people are particularly important, for, although not necessarily representative of the attitudes of a wider population of disabled persons, they are likely to be highly influential in driving forward the disability rights agenda and social policy.

Further research is also required into the behavioural component of attitudes, and attitude measures appropriate to this task therefore require development, specifically in relation to disability. Although attitudes have been measured since Thurstone's work in the 1920s, the methods have remained largely unchanged (Vargas, von Hipple and Petty, 2004). New and innovative methods that tap into the respondent's behaviour, or even predicted behaviour, toward disabled people or different impairment groups requires continued development. Such tools must be sensitive to the issue of honesty in responses (Bajekal, Harries, Breman and Woodfield, 2004: p. 33), especially in light of the data presented in this thesis finding that both disabled and non-disabled samples produced more negative attitudes with respect to the Subtle Prejudice sub-scale of the GASTDP compared to the Blatant Prejudice sub-scale (see section 8.6 above for discussion on *aversive disablism*).

Improving Disabled Peoples Attitudes toward Disability

Lessons from those groups who expressed the most positive attitudes toward disability can be utilised to assist people who acquire an impairment to adapt to their new status as a disabled person. It may be tempting to argue that if disability is seen as a positive or value neutral identity then there is no need for a person to require assistance and support with the psychosocial adaptation process (see Livneh and Antonak (1997) for discussion on psychosocial adaptation). However, this does not appear to be borne out by the finding that people who had recently acquired an impairment expressed some of the least positive attitudes toward disability, as measured by the GASTDP. It is therefore recommended that lessons be learnt from those who expressed some of the most positive attitudes from both the disabled and non-disabled samples; for instance, disabled people who belonged to organisation of disabled people and non-disabled counselling students on an MSc course.

Disability Equality Training and other rights based approaches could be developed and made freely available to assist a person who has recently acquired an impairment to see themselves as a valued citizen, thus raising the individual's self-esteem and consequently their overall health and well-being. By carrying out further research using qualitative research methods, specifically with those groups who expressed the most positive attitudes, additional information could be gleaned and incorporated into support services for disabled people (especially for those with newly acquired or degenerative impairments). In light of the finding that those disabled people who had recently acquired an impairment held higher scores on the GASTDP, these people may benefit from some form of disability equality training as part of the rehabilitation process. Such training may assist disabled people to enhance or at least maintain their self-esteem whilst going through a process of psychosocial adjustment. Likewise, counselling services for disabled people may need to focus as much on how disability is a social construction (Reeve, 2000; Swain, Griffiths and Heyman, 2003) and a rights-based issue, as on the psychosocial adjustment to impairment. Such counselling may assist people who have recently acquired an impairment to view disability as a part of their identity in the manner of race, gender or sexuality.

Awareness campaigns on behalf of disability rights must ensure they are relevant to and have a resonance for disabled people as well as non-disabled people. In other words, such campaigns must recognise the heterogeneity of the disabled population with respect to impairment and diversity in relation to other aspects of disabled people's identity, i.e. in terms of race, gender, etc. Failure to do so is likely to exclude some groups of disabled people, thus further marginalising some of the most vulnerable people in our society at a time in their lives when positive affirmation as part of the disabled in-group is required.

The Role of Impairment in Social Oppression

Further work on the development of the growing importance of the relationship between impairment and social oppression is required. This work could build on the existing biopsychosocial model of disability (see World Health Organisation, 2001), the emerging definition of disablism (Miller, Parker and Gillinson, 2004) and aversive racism (Gaertner and Dovidio, 2000). This research should not only incorporate the call for impairment to be viewed in terms of the personal experience (Shakespeare and Watson, 2002) but also the finding from this research that respondents expressed less positive attitudes when measured on the Subtle Prejudice sub-scale of the GASTDP than the Blatant Prejudice sub-scale, thus exhibiting what could be termed as *aversive disablism*.

Further testing of *aversive disablism* is required in the manner reported by Gaertner and Dovidio (2000: pp. 17-29) to identify the extent to which subtle prejudice toward disabled people is not so much anti-disabled but pro-non-disabled. Gaertner and Dovidio (2000) contend that aversive racists are predominantly pro-White rather than anti-Black. This may have important implications with respect to disabled peoples attitudes toward other disabled people in that, if disabled people are also aversive disablists then they may be more pro-non-disabled than anti-disabled. However, this may have important implications in relation to the development of a disability movement.

Contact Between Disabled People

This research did not find a relationship between attitudes toward disabled people and the number of disabled people the respondent had contact with. Neither was a relationship found between the frequency of the contact or the location (see Results for hypotheses H4 and H5). However, despite statistically non-significant results, it appears those who voluntarily chose to associate with other disabled people scored lower (most positive attitudes).

Whilst previous research has suggested that positive contact with a stigmatised group can elicit positive attitude change (Donaldson, 1980), it appears new research is required that reflects the societal changes that have taken place since the mid-1990s in relation to disability. Such research also needs to reflect the complex nature of the relationship between disabled people, including those who choose to associate with other disabled people and those who do not. This may therefore require recognition of those disabled people who are willing to identify as such and those who see themselves in terms of other aspects of their identity. In addition, it will be important to move on from the binary distinction of non-disabled-disabled as well as recognise how disability may be only one facet of a person's identity, for instance, black, female, etc.

Attitude change strategies for disabled people need to recognise that neither direct contact nor the number or frequency of the contact with other disabled people appear to be significant variables. The reason why some disabled people choose to associate with other disabled people, whilst others do not, requires further investigation. This may offer an insight into how to continue to improve attitudes of disabled people toward other disabled people, and therefore toward the self. Thus, assisting the psychosocial adaptation process for those people who have recently acquired an impairment.

8.8 Concluding Comments

It is my contention that both disabled and non-disabled people hold similar attitudes toward other disabled people in general, and with respect to different impairment groups, despite disabled people having what Young (1990) terms, a 'double consciousness', in relation to disability. In addition, building on the work of scholars such as Devine (1989), Young (1990), Gaertner and Dovidio (2000) and the earlier work in relation to Critical Race Theory, I argue that the data presented in this thesis suggests both disabled and non-disabled people hold aversive disablist attitudes. I also argue that the contact hypothesis could not be supported by the data, with levels of contact with disabled people not having a statistically significant affect upon results produced through use of the GASTDP, but I do suggest (albeit tentatively) that whether the contact between disabled people is voluntarily or involuntarily may be a significant variable. This research is important in that is highlights the role of impairment within a social context, adding to the discourse in relation to the social model of disability. I have therefore argued the intensity of the social oppression faced by disabled people is in part influenced by the impairment the individual holds. This research also gives new insight into attitudes toward disabled people by using not only disabled people as the main respondents in this research, but also using the beliefs of disabled people in the development of the research tools presented in this thesis.

Based on these findings, it is possible that benefit may be found in greater collaboration between non-disabled professionals and disability activists, working to promote disability rights and the removal of disablism from UK society. The role of disabled people who are active in the field of disability rights is especially important when considering that this research found the most positive attitudes towards disability were held by those disabled people who voluntarily met with other disabled people collectively. These groups of disabled people may have much to offer other disabled people in the general population, organisations who work on behalf of disabled people such as the major charities, policy makers and government. Collaboration between organisations *of* disabled people and organisations *for* disabled people has been rare, often viewing each other with suspicion and even animosity. However, as

Miller, Parker and Gillinson (2004) argue, much can be gained by working together, without compromising one's own principles.

If minority groups can work in unison, such coalitions based on the demand for social change could be far more powerful than working in silos. Each minority group, whilst respecting the uniqueness of their agenda, can gain greater influence by finding those areas of commonality. Black and minority ethnic groups could benefit from forging coalitions with organisations supporting the rights of people with mental health problems; likewise, organisations such as Arthritis Care may benefit from forging coalitions with those lobbying on behalf of pensioners such as Age Concern. However, as noted by Humphrey (1999) some minority groups may be reluctant to link impairment with disability, citing as an illustration how some organisations for people with HIV/AIDS may be reluctant to relinquish the 'ownership' of the issue.

It is vital that more sophisticated ways of interpreting attitudes toward disabled people are developed otherwise subtle forms of discriminatory practise may become entrenched and unchallenged. The ideas behind *aversive disablism* therefore require further development in order to capture subtle forms of prejudice, even from amongst those who purport to hold affirmative attitudes toward disabled people. Disabled people must be at the heart of this process, influencing policy makers and service providers. Therefore, it is my opinion that disabled people must acquire greater awareness of the rights of people belonging to other impairment groups in order to recognise discriminatory practice toward other members of the disabled in-group. This includes those disabled people who may have contact with large numbers of other disabled people, who, under other circumstances, they would not normally associate with. As Young (1990: p. 153) argues in relation to cultural attitudes toward minority groups, *"For people to become comfortable around others whom they perceive as different, it may be necessary for them to become more comfortable with the heterogeneity within themselves"*.

Subtle forms of prejudice still appear to exist and must therefore be challenged, particularly in relation to those facing the highest levels of prejudice. Failure to do so will mean the vision presented by the UK Government of a society whereby *"By 2025, disabled people in Britain should have full opportunities and choices to improve their quality of life, and will be respected and included as equal members of society"* (Cabinet Office: Prime Minister's Strategy Unit, 2005: p. 44) will not be achieved. This statement does not relate to *some* disabled people but *all* disabled people, irrespective of their impairment, gender, race, ethnicity, sexual orientation, class or religious beliefs.

It is hoped the results presented in this thesis offer a new perspective on how disabled people view disability and other members of the disabled in-group. It is also hoped other disabled people will continue to research attitudes toward other disabled people in order to reduce the discrimination faced by this group of people and to remove the possibility of oppression between disabled people. Finally, this research has continued to build on the work of 'second wave' writers in disability studies, who are locating impairment at the forefront of such research (Goodley, 2001). This body of knowledge needs to continue to be developed by disabled people, challenging traditional views of disability, thus smashing what Young (2004) (ex-president of Canada's People First) describes as the *"cocoon of impossibility"*, so the vision of full equality and inclusion for all disabled people can be achieved, ultimately removing disabled people from the status of Other.

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Appendix A

Attitude Scale Development

A1 Introduction

This Appendix will give more detailed information on the data gathered during the initial stages of the development of the General Attitude Scale Toward Disabled People (GASTDP) and the Attitude Toward Impairment Scale (ATIS). Presented below are firstly, the data gather through the use of a questionnaire designed for this research in order to gather information from disabled people about their beliefs in relation to disability (see Appendix B for questionnaire). Secondly, a summary of the responses made during a focus group held with four disabled people on 17th May 2000.

A2 Questionnaire Method

The two questionnaires 'Demographic Data Questionnaire' and 'Questionnaire to Identify Main Factors in Relation to Attitudes Toward Disabled People from a Disabled Persons Perspective' (see Appendix B) were circulated to four disabled people known to the author on 11th July 2000. All four respondents live and work within and for an organisation set-up to provide employment, training, housing and care support services to disabled people. Confidentiality was assured to the respondents, although a request for further contact was made in order to clarify or expand upon points raised in the questionnaire responses.

A3 Background Details of Scale Development Respondents

Respondent EN001: Did not complete either questionnaire

Respondent EN002:

Age = 50-59

Sex = Male

Ethnic Origin = White, British

Highest level of education = Technical College

Highest qualification achieved = ONC in Business Studies

Employment = Retired on health grounds

Regards self as disabled = Yes

Others regard as disabled = Yes

Nature of disability = Cerebellar Ataxia

Regarded self as disabled = 16+ years

Face to face contact with disabled people: Work = Never - Nil people

Home = Daily 2-5 people

Social = Daily 11-20 people

Quality of contact: Work = Not Applicable

Home = Very Good

Social = Good

Respondent EN006:

Age = 60-69

Sex = Female

Ethnic Origin = White, British

Highest level of education = Secondary School

Highest qualification achieved = None

Employment = Full-time – paid

Regards self as disabled = Yes

Others regard as disabled = Yes

Nature of disability = Epilepsy

Regarded self as disabled = 16+ years

Face to face contact with disabled people: Work = Daily 21+ people

Home = Daily 1 person

Social = Daily 1 person

Quality of contact: Work = Very Good

Home = Very Good

Social = Very Good

Respondent EN005:

Age = 50-59

Sex = Female

Ethnic Origin = White, British

Highest level of education = Sixth Form College

Highest qualification achieved = 'O' Levels in 8 subjects

Employment = Full-time – paid

Regards self as disabled = No

Others regard as disabled = "Some do, some don't"

Nature of disability = "Head injury causing nerve damage to side of face, inability to know core body temperature. Limited flex. in fingers of right hand, contracture in left hand, contractures in feet. Damage to nerves and tendons in groin. Arthritis of spine, shoulders, hips and knees. Tonic clonic epilepsy, absence seizures. Sight problems necessitating lenses."

Regarded self as disabled = Never

Face to face contact with disabled people:	Work = Daily 21+ people
	Home = Daily 21+ people
	Social = Daily 11-20 people
Quality of contact:	Work = Good
	Home = Good
	Social = Good

This group of people were contacted, as they were regarded as holding positive attitudes toward other disabled people. Three of the respondent's work within a Supported Business and the other had done so prior to taking early retirement on grounds of ill health. Three of the four respondents also lived within a supported housing complex alongside a significant number of other disabled people. The fourth participant lives in housing set in a village of whom approximately half of the residents have some form of impairment. Hence, this group of respondents was also known to have high levels of contact with other disabled people in a variety of settings.

In addition, a disabled person who lived in the local town, but had no connection with the organisation above, completed the two questionnaires (see Appendix B and C). Although not all details were supplied from AND01 the following data was supplied:

Subject AND01:
Age = 20-29
Sex = Female
Marital Status = Single
Ethnic Origin = White, British
Highest level of education = Sixth Form College
Highest qualification achieved = Diploma / NVQ Level 4 / HND

Employment = Part-time – voluntary; unemployed due to disability

Regards self as disabled = Yes, Always

Others regard as disabled = Yes

Nature of disability = Cerebral Palsy

Face to face contact with disabled people:
Work = At least once a month
Home = Not supplied
Social = Weekly

Quality of contact:
Work = Not supplied
Home = Not supplied
Social = Not supplied

A4 Findings

Although EN001 did not complete the questionnaires, he was willing to write a letter expressing his concerns around the research. In his response he emphasised that whether or not a person is 'disabled' depends upon their personal perspective. He states, "*Whether or not a person is disabled depends* *on their approach to it. Am I disabled or do I just use sticks to help me balance? Are you disabled or do you use a wheelchair to help you get around? Only I can answer the first question and only you the second."*

By taking an impairment based approach EN001 appears to be rationalising the concept of impairment and disability in terms of an individual model of disability. For, the use of sticks or a wheelchair as a prosthesis enables the individual to 'compensate' for the functional limitation but also to interact on equal terms with others.

Whilst respondent EN002 regarded the term 'disability' in individual terms, viewing as someone who, *"...is unable to undertake a task or action with the speed, skill or accuracy at which the task or action would be done by a 'Non-Disabled' person"*, many of his answers to the remaining questions took more of a social model stance. As a wheelchair user, EN002 viewed the barriers faced primarily in terms of physical access, for example, inaccessible public transport, high shop counters, self-service petrol stations, et cetera.

In addition, however, EN002 noted attitudinal barriers based on ignorance, or a lack of knowledge or awareness by non-disabled people, stating how the general public assume that if someone has a physical limitation then, *"the bit between the ears doesn't work either"*. This statement was however qualified that he felt it is less prevalent today then it used to be. When asked about the situation in which people had the most positive attitude towards disability, subject EN002 highlighted how in a social setting such as a motor racing meet, or a rugby match, other spectators treated the disabled spectator as an equal. His rationale for this was that the crowd may assume the disabled person is an ex-player or ex-driver who has been injured participating in the sport. Whether such a proposition only applies to people with clearly defined physical impairments would need to be tested, and whether people with head injuries are treated with the same positive attitude encountered by EN002 would require further research. However, the way in which the impairment was acquired appears to be important to respondent EN002.

EN002, when responding to question 6 (see Appendix B), 'Please describe what you would regard as a positive attitude towards disability', stated:

"A disabled person who I regard as having a positive attitude to their disability is one who does not consider that he/she should have any troubles becoming integrated with or accepted by the general public. They will consider that if any problems of acceptance do arise, those problems will be those of the public, not the disabled person."

Hence, clearly aligning his attitude within the construct of the social model of disability. When describing what makes a disabled person with a positive attitude different from other disabled people, this respondent believed the person will have, *"...an 'accept me as I am' attitude of self esteem."* In addition, AND01 when asked what she would regard as a positive attitude towards disability stated, *"A willingness to get to know the person BEHIND the disability"*, thus offering a recognition of the effects of the impairment and the individuals personality.

The theme of being treated as a 'normal' person occurred from both EN005 and EN006, with EN006 stating throughout her response the word normal, although no explanation or comment as to what she meant by this was offered. Bearing in mind that EN006 worked in a Supported Business alongside a number of other disabled people, thus receiving indirect government aided support that would not be available to other workers, it is questionable as to how she perceived the concept of normality.

AND01, when considering the three biggest barriers faced as a result of her disability listed employment, socialising with able-bodied peer groups and forming relationships with people of the opposite sex. Employment was also noted as an important factor by EN005 who when asked what is meant by the word 'disabled' stated, *"Incapacity to be employed in the work for which a person was trained before they became disabled...Also for people who are 'disabled' before working are the inability to do work which they would otherwise have been able to undertake. But one is only 'disabled' if one thinks one is – a subjective judgement."*

This data was used to develop themes throughout the production of the General Attitude Scale Toward Disabled People and the subsequent Attitude Toward Impairment Scale in conjunction with the literature.

A5 Focus Group

In order to gain additional information a small focus group of four disabled people also took place. This focus group aimed to explore in more depth the themes that were emerging from the literature review and the questionnaires that had been circulated. On the 17th May 2000 four disabled people who participated in a social services funded day care provision in Hampshire, referred to as an Occupational Development Programme, met with the researcher. The Occupational Development Programme aims to maximise personal potential progress toward a more independent lifestyle through educational and work based activities. The researcher had a limited knowledge of all four participants of the focus group through previous contact.

A6 Focus Group Participant Details

In order to gather background information from the focus group participants, each person completed the draft Demographic Data Questionnaire.

Participant A:

Age = 30-39

Sex = Female

Ethnic Origin = White, British

Highest level of education = Sixth Form College

Highest qualification achieved = RSA Level 1

Employment = Full-time - Voluntary

Regards self as disabled = Yes

Others regard as disabled = Yes

Nature of disability = "Can't read or write" (dyslexia)

Regarded self as disabled = 16+ years

Face to face contact with disabled people: Work = Daily 21 + people

Home = Daily 21+ people

Social = Daily 21+ people

Quality of contact: Work = Good

Home = Good

Social = Good

Participant B:

Age = 40-49

Sex = Male

Ethnic Origin = White, British

Highest level of education = Sixth Form College

Highest qualification achieved = City & Guilds Catering Cert. (level not known by participant)

Employment = Full-time - Voluntary

Regards self as disabled = Yes

Others regard as disabled = Yes

Nature of disability = "Nervous disposition"

Regarded self as disabled = 16+ years

Face to face contact with disabled people:	Work = Daily 11-20 people
	Home = Daily 21+ people
	Social = Daily 11-20 people
Quality of contact:	Work = Very good
	Home = Very good
	Social = Very good

Participant C:

Age = 40-49

Sex = Male

Ethnic Origin = White, British

Highest level of education = Secondary School

Highest qualification achieved = None

Employment = Part-time - Voluntary

Regards self as disabled = Yes

Others regard as disabled = Yes

Nature of disability = Muscular dystrophy and dyslexia

Regarded self as disabled = 16+ years

Face to face contact with disabled people: Work = Daily 11-20 people

Home = Daily 21+ people

Social = Daily 11-20 people

Quality of contact: Work = Very good

Home = Very good

Social = Very good

Participant D:

Age = 20-29

Sex = Female

Ethnic Origin = White, British

Highest level of education = Sixth Form College

Highest qualification achieved = GCSE

Employment = Part-time - Voluntary

Regards self as disabled = Yes

Others regard as disabled = Yes

Nature of disability = Spina Bifida and Hydrocephalus

Regarded self as disabled = 16+

Face to face contact with disabled people: Work = Daily 11-20 people

Home = 21+ people

Social = 11-20 people

Quality of contact: Work = Very good

Home = Very good

Social = Good

A7 Information Gathered Through Focus Group

With respect to the word 'disabled' all participants viewed it in terms of functional limitation and with negative connotations. All four participants held strong feelings toward the use of language that referred to disabled people, citing as examples their dislike for disparaging words such as 'cripple' and labels such as 'handicapped'. In line with the literature within the UK relating to disability studies, the respondents preferred the term 'disabled people' over 'people with disabilities' although no clear reason was able to be given for this preference.

In order to open up the discussion in relation to the respondents' attitudes toward other disabled people the focus group was asked to recall how they 'felt' the first time they met another disabled person. Two of the group stated that they enjoyed the opportunity to help other people, which, as people who had consistently been on the receiving end of care-giving, was a new experience giving them pride and a feeling of usefulness. Likewise, emotions such as fear, confusion and shock were described, which is consistent with non-disabled attitudes described in the literature. Although all four participants stated that they regarded themselves as a disabled people on the initial questionnaire, one participant (participant B) stated in discussion he wasn't sure because his impairment was not physical. Interestingly, this participant also stated later in the discussion how he did not like to be associated with other people with mental health problems, despite belonging to this group himself. Likewise, two other members of the group, when asked which groups of disabled people they would not like to be associated with responded by saying schizophrenics and "mad ones". These two respondents were both wheelchair users.

In relation to the discussion on barriers faced by disabled people, directly linking it to their own experiences, this topic solicited a number of strong responses. For instance, when discussing the general public's attitude toward disabled people as a barrier, one respondent commented how people would say things like "Look at those two spastics trying to read", to which another respondent supported with, "Yeah, I hate the word spastic". This discussion reminded a third participant of an incident in a hotel when she was verbally insulted by people she referred to as 'mothers'. Hence, labels, as well as non-disabled people assuming it is acceptable to verbalise their attitudes towards individuals, clearly caused a significant level of upset for members of the group. But, as one participant stated, "Getting angry or upset doesn't achieve anything, it is better just to walk away. The best thing I did was kept my mouth shut". This response suggests a level of resignation to the situation faced rather than feeling in a position to challenge negative beliefs and behaviours. Despite the identification of these negative attitudes, respondent B believed shop keepers were more helpful than they used to be, to which all other respondents agreed. In addition, despite the earlier comments, respondent D felt people in general were more 'accepting'. Such apparent contradictions are understandable, as whilst disabled people are becoming increasingly integrated, and therefore accepted within mainstream society, which is often reflected in day-to-day interactions with people such as shop keepers, many disabled people have encountered discriminatory practices at various points in their lives, often leaving emotional scars.

When asked whether the participants knew any disabled people who they felt had a positive attitude toward disability, the respondents paused for a considerable period of time. The respondents were therefore asked in more general terms what they believed was a positive attitude toward disability might be. To this respondent D replied, "Being able to be as independent as possible", and "Remaining cheerful, despite everything". This response suggests respondent D located the 'problem' internally, rather than seeing solutions to barriers as being located in society. In addition, according to respondent D, a disabled person with a positive attitude toward disability would be someone who was independent and cheerful.

One final area of discussion for the focus group was that of receiving 'special treatment'. This point had not been solicited through the questioning, but arose spontaneously from the respondents. Despite all four respondents being in receipt of what could be termed as 'special treatment' in terms of the day care services they received, there was disagreement over whether disabled people should receive this as a right. On one level, the respondents wanted to be treated the same as other people, with respondent C stating that he hated being molly coddled, to which others agreed. At the same time, however, it was felt that 'special treatment' such as not having to queue along with other people at a theme park was acceptable. In general terms, this highlighted the issue of rights and responsibilities, whereby whilst the group rightly felt they should be treated fairly, but at the same time felt being treated differently (but in a positive way) was acceptable. However, respondents did not make a link between being given 'special treatment' such as queue jumping and being molly coddled. Likewise, they did not view the desire to be treated 'normally' and such treatment as a contradiction.

As with the responses to the questionnaires above, the information gathered through the focus group was used to influence the development of the General

Attitude Scale Toward Disabled People and the Attitude Toward Impairment Scale.

Appendix B

Questionnaire Questions Circulated to Disabled People for the Development of the General Attitude Scale Toward Disabled People and Attitude Toward Impairment Scale

1. What do you think is meant by the word 'disabled'?

2. When and where was the first time you met a disabled person?

3. Describe how you felt on this occasion

4. Do you regard yourself as a person with a disability? Yes / No / Not sure

5. Do others regard you as having a disability? Yes / No / Not sure

6. If you were asked to list the three biggest barriers or problem you face in life as a result of your disability, what would they be?

7. In which situation do people have the most positive attitude towards your disability?

Work	Yes / No
Social	Yes / No
Home	Yes / No

Please state the reason for your answer

8. Do you know any disabled people who have a positive attitude towards disability?

Yes / No

9. If yes, describe what makes them different from other disabled people

10. Do you believe that the general public's attitude towards disabled people have changed over the past 10 years? Yes / No

Please give reasons for your answer

11. Please state which type of disability you believe to be the most severe and why

12. Please state which type of disability you believe to be the least severe and why

13. Do you think some disabilities are more accepted than others are by the general public? If so, which ones and why

14. Are there any groups of disabled people that you find you have more in common with than others? Please give reasons for your answer

15. Are there any groups of disabled people you would not like to be associated with? Please give reasons for your answer

16. Have there been any times when you felt uncomfortable or embarrassed to be seen with disabled people? Please describe the occasion(s)

17. If you could change three things in the world to make life better for disabled people, what would they be and why?

Appendix C

Demographic Data Questionnaire

[Note: In the form circulated to participants the layout of the questionnaire had greater space between questions]

PLEASE NOTE ALL RESPONSES ARE COMPLETELY ANONYMOUS SO PLEASE BE AS HONEST AS POSSIBLE IN GIVING YOUR ANSWERS.

IT IS IMPORTANT THAT YOU ANSWER ALL QUESTIONS

1. Please state your age:

....

2. Your sex:

Male [ ] Female [ ]

3. a) Could any other member of your immediate family be described as having a disability? (please tick)

Yes [ ] No [ ]

b) If yes to question 3a, please state the nature of the relationship (e.g. brother, sister, mother, uncle, etc.)

....

c) If yes to question 3a, please state the type of disability your relative has (e.g. MS, Cerebral Palsy, Learning Difficulties, etc.)

....

4. a) To which Ethnic Origin group do you most closely belong: (please tick)

Black (Caribbean) [ ]
Black (British) [ ]
Chinese [ ]
Pakistani [ ]
White (European – non UK) [ ]
Prefer not to say [ ]

Bangladeshi [ ]
Black (African) [ ]
Indian [ ]
White (British) [ ]
White (European) [[

Other (please state) [ ] ....

b) Nationality ....

5. Highest qualification achieved: (please tick)

None [ ]
GCSE / 'O' Level / (G)NVQ Level 2 [ ]
'A' Level / (G)NVQ Level 3 [ ]
Diploma / NVQ Level 4 / HND [ ]
Degree [ ]
Post-Graduate Qualification [ ]

Other (please state) ....

6. a) Did you attend a 'special needs' school at any time during your education? (please tick)

Yes [ ] No [ ]

b) If yes to question 6a), approximately how many years did you attend a 'special needs' school?

.... years

7. Employment:

Please tick which category reflects most closely your employment status:

a) Full-time – paid [ ]
b) Part-time – paid [ ]
c) Full-time – voluntary [ ]
d) Part-time – voluntary [ ]
e) Unemployed due to age (retired) [ ]
f) Never worked do to disability [ ]
g) No longer work due to disability [ ]
h) Training programme [ ]

If you work (or have worked), please state the type of work you do (or did) (be as precise as possible, e.g. teacher in primary school, clerk in accounts office)

....

8. Do you have a disability? (please tick)

Yes [ ]

No [ ]

Don't know [ ]

9. Do people who know you well think you have a disability? (please tick)

Yes [ ]

No [ ]

Don't know [ ]

10. Do people who <u>do not</u> know you well think you have a disability? (please tick)

Yes [ ]

No [ ]

Don't know [ ]

11. If yes to questions 8, 9 or 10 please state type of impairment/disability, e.g. cerebral palsy, arthritis, etc. (please be as specific as possible – if you have more than one impairment/disability, write the one <u>you</u> regard as affecting you the most first and so on):

1. ....

2. ....

3. ....

12. How long have you regarded yourself as a disabled person? (please circle)

Never 1-2 years 3-4 years 6-10 years 11-15 years

16-20 years 21 years or over Always

13. How often do you come into direct, face-to-face contact, with disabled people? (please tick your answer for each situation)

a)	At work / college	Daily	[ ]
		Weekly	[ ]
		At least once a month	[ ]
		Once every 3 months	[ ]
		Less often than once every 3 months	[ ]

b) At home (i.e. where you normally sleep)

Daily [ ]
Weekly [ ]
At least once a month [ ]
Once every 3 months [ ]
Less often than once every 3 months [ ]

c) Social activities (i.e. pub, club, cinema, shopping, Day Centre, etc.)

Daily [ ]
Weekly [ ]
At least once a month [ ]
Once every 3 months [ ]
Less often than once every 3 months [ ]

14. On average, how many disabled people do you meet in each of the following situations? (please circle for each situation)

a)	Work / college	0	1	2-5	6-10	11-20	21+
b)	Home	0	1	2-5	6-10	11-20	21+
c)	Social	0	1	2-5	6-10	11-20	21+

15. Please complete the statements below using one of the following:

Very good Good Okay Poor Very poor

a) In general, I feel my relationship with disabled people at work/college is...........

b) In general, I feel my relationship with disabled people at home is...........

c) In general, I feel my relationship with disabled people in my social activities are............

16. If you or others regard you as a person with an impairment/disability, please tick the category you fell reflects most closely your impairment/disability:

Hearing impairment	[ ]	Learning difficulties	[ ]
Mental health	[ ]	Physical (non-wheelchair user)	[ ]
Sight impairment	[ ]	Wheelchair user	[ ]

Multiple impairments/disabilities...

Other (please state)..

Appendix D

Demographic Data Questionnaire Development

In order to start to address the multi-dimensional nature of attitudes toward disabled people, the Demographic Data Questionnaire was developed. This data would enable disabled person's attitudes to be measured on a sub-group level. In other words, whereas the attitude scale would give a score for the respondent's attitude toward disability and with respect to different impairment groups, the Demographic Data Questionnaire would give categorical data in relation to:

- Age
- Sex
- Marital status
- Ethnic origin
- Level of education
- Employment status
- Nature of impairment
- Whether the subject regard themselves as a person with a disability
- Whether others (who know the respondent well or not well) regard the respondent as having a disability

Length of time living with a disability was also deemed to be important due to the nature of adjustment to one's own impairment. For, it was felt that people who had recently acquired an impairment, may hold different attitudes towards disability in general or specific impairment groups (including their own), than people with congenital impairments or those who had lived with an impairment for a significant period of time.

The interaction between a stigmatised group (out-group) and the dominant in-group has often been cited as a key method of attitude change; but, as Stroessner and Mackie (1993) stress, it is too simplistic to argue that simple contact between groups will increase perceptions of variability and thus reduce stereotyping. It is the variable of contact either on an inter-group basis (between disabled and non-disabled persons) or intra-group level (between groups of disabled people), however, that required further investigation in relation to this research. Hence, due to the importance of contact as a method of attitude change, as revealed through the literature, a measure of contact in differing settings, (work/college, social and home), the quality of that contact, and the level of contact in terms of size, was developed. Whilst Schwartz and Armony-Sivan (2001) took a simple dichotomous measure of prior personal contact ('some contact' versus 'no contact'), other researchers have taken a more thorough measure detailing the frequency of the contact (Gething undated), and the intimacy of the contact (Tringo, 1970). The Demographic Data Questionnaire developed for this research attempts to identify not only the frequency of the contact, but also the number of individuals known in each of the social settings and the quality or pleasantness of that said contact. Thus, recognising the importance of the variables listed by Allport (1979) which included *frequency, duration and number of people involved in the contact.* Hence, a simple 'some contact' / 'no contact' measure was seen as insufficient for this research.

The three settings were chosen, as they would encompass the majority of people's lives, and yet have distinct properties. For instance, within the work or educational setting, the subject may have little or no say over whether they have contact with a disabled person, or the number of disabled people. This may also be true within the home setting, where they may be living with a disabled relative or spouse. However, contact within the social setting has a higher level of choice attached to it. The self-reporting of the quality of the contact was seen to be an important additional variable that also needed to be investigated. For, it is possible that a person may have various levels of contact with disabled people, and yet regard that contact as ether good or poor. Although this would only offer a crude measurement, it was hoped this data would offer an insight into whether further research was required into this area.

Question 13 (frequency of contact) was produced in order to identify whether the frequency of contact (daily; weekly; at least once a month; once every three months; and less often than once every three months. Missing data for each of the three situations (work/college, home and social) was treated as the 'less often than once every months' category. As contact is generally regarded as a positive method of improving attitudes towards a stigmatised group, the greater the level of contact, the more positive the attitude is expected to be. In addition, a question asking whether the respondent had attended a Special Needs school was utilised. This was to identify disabled people who had received high levels of contact in the earlier years of their life.

Question 15 was produced in order to measure the self reported perceived feelings a respondent had in relation to their contact with disabled people, giving an opportunity to analyse the relationship between stated feelings and the scores produced by the attitude scales. This question was included in recognition of Yuker and Hurley's (1987) observation that researchers had given no concern over the quality of contact between disabled and non-disabled people. The research presented in this thesis attempts, however, to ensure not only inter-group contact is measured, but also intra-group. Respondents were asked to state whether they felt their contact with disabled people is very good; good; okay; poor; and very poor. Missing data was recorded separately order to differentiate no contact from very poor contact. Question 15 was also repeated for each of the three situations where contact was most likely to take place. The wording of question 15, *"In general, I feel my relationship with disabled people (at work/college or at home or in social activities) is ... "*, was chosen as the word contact instead of relationship was not felt to reflect the 'feeling/emotion' behind the question.

In order to assess whether the respondents regarded themselves as part of the 'in-group' or 'out-group' questions 8, 9 and 10 were devised. Question 8, "Do you have a disability?" gave the respondent an opportunity to give a categorical response that stated whether they believed they belonged to the 'in-group' of disabled people or not. Questions 9 and 10 were created to identify those who either believed they belonged to the in-group or not but others did or did not. For example, someone with a hidden or invisible impairment such as epilepsy, may identify themselves as a disabled person, but those who do not know them well may assume they are non-disabled. Therefore, question 9 asked, *"Do people who know you well think you have a disability?"* whereas question 10 asked, *"Do people who <u>do not</u> know you well think you have a disability?"* This gave an opportunity for the data to be analysed from the perspective of visibility or invisibility of the individual's impairment. Clearly, the response to these questions will be subjective in nature, not being based on some form of independent measurement, such as a detailed questionnaire measuring functional limitations in different domains of daily activity, such as mobility, communication, et cetera, based on the ICIDH (Wood, 1980). Questions 9 and 10 therefore leave open the opportunity for the respondent to respond in the affirmative regardless of whether they view disability in terms of functional limitation or social oppression.

The use of both the terms 'disability' and 'impairment' was to respond to the need for common usage, thus ensuring that respondents did not become confused or even potentially offended. Although in places the term disability was used where impairment would have been more accurate, this was done in order to use common parlance and thus ensure greater understanding (e.g. question 3).

In order to assist with categorising respondents in terms of their impairment group, question 16 was placed at the end of the questionnaire. The categories hearing impairment, learning difficulties, mental health, physical (non-wheelchair user), sight impairment, and wheelchair user were chosen in order to reflect as wide a range of impairment groups as possible. The list was placed in alphabetical order, in an attempt to avoid any inadvertent bias with respect to impairment groups, which could in turn influence the responses to the attitude rating scale, (however minimal such an influence may be).

Categories for Ethnic origin were adapted from the Employment Service's "New Deal for Disabled People Job Broker Guide: Draft Version 21/6/01". Ethnic origin was included in the questionnaire as an attempt to identify whether ethnic origin as an Independent Variable was an important factor with respect to the Dependent Variable (attitudes toward disabled people and different impairment groups) as measured by the two scales.

Level of education and employment status were utilised in order to identify whether these independent variables influenced attitudes toward disabled people. These variables have often been used in sociology as a measure of social status and background and therefore it was felt to be appropriate in this research.

Appendix E

Original Attitude Scale Statements

No.	Statement
1	People with disabilities would have been better off not having been born
2	It is kinder not to have a child if you know it will have a disability
3	People with disabilities are blameable for their disability
4	People are generally frightened of people with disabilities
5	People with disabilities cause other people to become frightened
6	People with disabilities in general tend to have a better understanding of what it is like to live with a disability than non-disabled people
7	People with certain impairments deserve more services than other disabled people
8	People with certain impairments deserve more financial support than other disabled people
9	Society deserves protection from people with certain impairments
10	People with disabilities are as important as anyone else in society
11	Many people believe that people with disabilities should not be given automatic rights to enter public places
12	Residential care is the best option for people with disabilities
13	People with disabilities would find it difficult to live independently
14	People with disabilities have a right to paid employment
15	People with disabilities should be made to find work if they are able to
16	People with disabilities should pay lower taxes
17	People with disabilities who work should pay lower taxes because of their additional financial cost as a disabled person
18	People with disabilities should be made to do government sponsored vocational training schemes
19	People with disabilities have a right to do government sponsored vocational training schemes
20	People with disabilities have a right to do government sponsored vocational training schemes even if they are unlikely to get a job
21	People with disabilities have a right to do government sponsored vocational training schemes even if it costs the taxpayer more money than non-disabled people
22	People with disabilities have a right to government sponsored vocational training even if it means there is less money available for other unemployed people to receive training

23	People with certain impairments have a right to do government sponsored vocational training schemes even if it costs the taxpayer more money than other disabled people
24	People with certain impairments should not be allowed to get married
25	People with certain impairments should only be allowed to marry so long as they don't have children
26	It is wrong for two people with disabilities to have children together
27	It is wrong for people with disabilities to have children as they would be unable to bring up the child properly
28	It is wrong for people with certain impairments to have children knowing their child will be disabled
29	People with certain impairments should be encouraged to have genetic testing to see whether they would pass their impairment onto their children
30	People with disabilities should be required by law to have genetic testing to see whether they would pass their impairment onto their children
31	It is important for people with certain impairments to have genetic testing to ensure that they don't pass their impairment onto their children
32	It is important for people with certain impairments to have genetic testing to ensure the parents are fully informed about the likelihood of their child inheriting their impairment from them
33	It would be irresponsible for people with certain impairments not to be genetically tested to see whether they would pass on their impairment to a child
34	People with disabilities are well integrated into society
35	I would be happy if a person with a disability was my next door neighbour
36	I would be happy if a person with a disability was my colleague at work
37	I would be happy if a person with a disability was my brother / sister in law
38	Having a person with a disability as a colleague would mean the non-disabled person would be given extra work to do
39	People with disabilities should be classified as sick or ill and therefore require medical help
40	People with disabilities would be happier living with other people with disabilities
41	People with disabilities would be happiest living in the community
42	People with disabilities find it difficult to become integrated into society
43	People with disabilities are happiest when working alongside other people with disabilities
44	People with disabilities would be happier working with other disabled people
45	In general, people would be happy if taxes were increased to help pay for better services for people with disabilities

46	People with disabilities deserve better services to assist them to live in the community
47	More public money should be given to assist people with disabilities to access employment
48	I feel happy to be associated with people with disabilities
49	People with disabilities have a right to special assistance appropriate to their needs
50	People with disabilities have a right to financial benefits to pay for the extra costs caused by their impairment
51	People with disabilities should not be put into stressful situations
52	People with disabilities should be protected from situations that are likely to cause stress or anxiety to themselves
53	People with disabilities should not be entitled to cause stress or anxiety to other people
54	A restaurant owner should be allowed to stop people with disabilities eating in the restaurant only if they are upsetting the other customers
55	A restaurant owner should provide private seating areas for people with disabilities to eat, so the disabled person does not feel embarrassed in front of the other customers
56	A cinema or theatre should be able to bar a person with a disability if their behaviour spoils the show for other customers
57	A cinema or theatre should be able to bar a person with a disability if their presence spoils the show for other people
58	A cinema or theatre should be able to bar a person with a disability if their behaviour, as a result of their impairment, spoils the show for other customers
59	Special seating areas should be provided in theatres and cinemas for people with disabilities
60	Special seating areas should be provided in theatres and cinemas for people with disabilities so that their behaviour does not upset other customers
61	People with disabilities have a democratic right to vote in UK political elections
62	People with disabilities should only be allowed to vote in UK political election if they have the ability to make a reasoned choice
63	It is undemocratic to exclude people with disabilities from voting in UK political elections
64	It is undemocratic to exclude people with disabilities from voting in UK political elections even if they do not understand what they are voting for
65	Postal votes should be available for people with disabilities who cannot get into polling stations because of access problems
66	People with disabilities should not have an automatic right to vote in UK political elections
67	Internet shopping is good news for people with disabilities as it will mean they do not have to go shopping in the normal way

68	Internet shopping good news for people with disabilities as they will no longer have to put up with negative attitudes from shop employees
69	Internet shopping is good news for people with disabilities as it will mean the cost of care will be reduced as they will not need so much assistance
70	Internet shopping is good news for people with disabilities as it removes the inconvenience of inaccessible shops
71	Having a person with a disability as a colleague would mean other workers would be given extra work to do
72	People with disabilities have a responsibility to undertake government sponsored vocational training schemes to help them find employment
73	People with disabilities have a responsibility to seek employment
74	People with disabilities have a responsibility to seek employment if they are able to do so
75	People with disabilities should have more direct control over the care services they receive to assist them to live independently
76	People with disabilities should be allowed to purchase for themselves the care services they need from money sent to them from the government
77	People with disabilities should not be charged for care services they receive
78	People with disabilities should be charged for care services if they are employed and earn enough money

Appendix F

Covering Letter Sent to Respondents

Dear Sir or Madam

First of all may I thank you in advance for taking the time to complete the attached questionnaire and attitude scales on disability. This is important research into attitudes towards disabled people that may, in the longer term, assist disabled people to participate more fully within society. It should take you approximately 15-20 minutes to complete all four forms.

a) Demographic Data Questionnaire
b) General Attitude Scale Toward Disabled People
c) Attitude Toward Impairment Scale
d) Social Acceptance List

It is important that you complete the questionnaire and scales as honestly as possible, as the information that you give will be used to assist in improving attitudes towards disabled people. This research forms part of a Doctoral thesis based at City University, London.

Please note that your responses are completely anonymous and there is no way that you can be identified from the information you give.

Once you have completed the questionnaire and scales, please place them in the enclosed envelope, so they may be returned to me. However, if you would prefer to respond electronically, please log on to [web-site name given], complete the questionnaire and scales and e-mail them to [e-mail address given].

Thank you again for your kind assistance.

Yours gratefully

Mark Deal

Appendix G

Scoring for General Attitude Scale Toward Disabled People & Attitude Toward Impairment Scale

General Attitude Scale Toward Disabled People

	Score
I disagree very much	1
I disagree somewhat	2
I disagree a little	3
I agree a little	4
I agree somewhat	5
I agree very much	6

Reverse scoring for items 2, 3, 5, 16, 17 and 18

Subtle Prejudice Sub-Scale – Items 3, 6, 7, 8, 12, 13 and 14

Blatant Prejudice Sub-Scale – Items 1, 9, 11, 15, 16, 17 and 18

Attitude Toward Impairment Scale

	Score
I disagree very much	1
I disagree somewhat	2
I disagree a little	3
I agree a little	4
I agree somewhat	5
I agree very much	6

Reverse scoring for items 1, 6, 11, 16, 21, 26 and 31

Higher scores equate to less positive attitudes

General Attitude Scale Toward Disabled People

Listed below are a number of statements that are said to describe what people think about disabled people. Usually, what we think about individuals depends on how well we know them. However, we would like to know what you think **in general**. Please read each statement carefully and then tick the box that best describes how you usually feel.

Please check that you have given a response to every statement.

I disagree very much	I disagree somewhat	I disagree a little				I agree a little	I agree somewhat	I agree very much
1	2	3	1	Residential care is usually the best option for disabled people	1	4	5	6
6	5	4	2	Disabled people have a responsibility to seek employment if they are able to do so	2	3	2	1
6	5	4	3	Disabled people have a right to do government sponsored vocational training schemes even if they are unlikely to get a job	3	3	2	1
1	2	3	4	Disabled people should be required by law to have genetic testing to see whether they would pass their impairment onto their child	4	4	5	6
6	5	4	5	It is important for people with certain impairments to have genetic testing so they know whether their child will inherit the same impairment	5	3	2	1
1	2	3	6	Having a disabled person as a colleague would mean the non-disabled person would be given extra work and responsibility	6	4	5	6
1	2	3	7	Disabled people would be happiest living alongside other disabled people	7	4	5	6
1	2	3	8	Disabled people should be protected from situations that are likely to cause stress or anxiety to themselves	8	4	5	6
1	2	3	9	A restaurant owner should be allowed to refuse service to a disabled person if they upset other customers because of their impairment	9	4	5	6
1	2	3	10	Disabled people should be charged for care services on the basis of their ability to pay	10	4	5	6
1	2	3	11	A cinema should be able to refuse entry to a disabled person if their presence spoils the show for other customers	11	4	5	6
1	2	3	12	Internet shopping is good news for disabled people as it means they can avoid poor facilities for people with disabilities	12	4	5	6
1	2	3	13	Disabled people are happiest when working alongside other disabled people	13	4	5	6
1	2	3	14	Disabled people should be charged for care services if they are employed	14	4	5	6
1	2	3	15	It is wrong for a disabled couple to have children as they would be unable to raise the child safely	15	4	5	6
6	5	4	16	Disabled people should take as much responsibility for their own actions as any other adult citizen	16	3	2	1
6	5	4	17	All disabled people over the age of 18 should have a right to vote in political elections	17	3	2	1
6	5	4	18	Disabled people feel proud to identify with other disabled people	18	3	2	1

Attitude Toward Impairment Scale

Listed below are a number of statements that are said to describe what people think about different disabled people. Usually, what we think about individuals depends on how well we know them. However, we would like to know what you think **in general**. Please read each statement carefully and then tick the box that best describes how you usually feel.

Please check that you have given a response to every statement.

I disagree very much	I disagree somewhat	I disagree a little				I agree a little	I agree somewhat	I agree very much
6	5	4	1	People with Down's syndrome have a right to do government sponsored vocational training schemes even if they are unlikely to get a job	1	3	2	1
1	2	3	2	Residential care is usually the best option for people with Down's syndrome	2	4	5	6
1	2	3	3	People with Down's syndrome should be protected from situations that are likely to cause stress or anxiety to themselves	3	4	5	6
1	2	3	4	A restaurant owner should be allowed to refuse service to a person with Down's syndrome if they upset other customers because of their impairment	4	4	5	6
1	2	3	5	It is wrong for a couple with Down's syndrome to have children as they would be unable to raise the child safely	5	4	5	6
6	5	4	6	People with Arthritis have a right to do government sponsored vocational training schemes even if they are unlikely to get a job	6	3	2	1
1	2	3	7	Residential care is usually the best option for people with Arthritis	7	4	5	6
1	2	3	8	People with Arthritis should be protected from situations that are likely to cause stress or anxiety to themselves	8	4	5	6
1	2	3	9	A restaurant owner should be allowed to refuse service to a person with Arthritis if they upset other customers because of their impairment	9	4	5	6
1	2	3	10	It is wrong for a couple with Arthritis to have children as they would be unable to raise the child safely	10	4	5	6
6	5	4	11	People with Cerebral Palsy have a right to do government sponsored vocational training schemes even if they are unlikely to get a job	11	3	2	1
1	2	3	12	Residential care is usually the best option for people with Cerebral Palsy	12	4	5	6
1	2	3	13	People with Cerebral Palsy should be protected from situations that are likely to cause stress or anxiety to themselves	13	4	5	6
1	2	3	14	A restaurant owner should be allowed to refuse service to a person with Cerebral Palsy if they upset other customers because of their impairment	14	4	5	6
1	2	3	15	It is wrong for a couple with Cerebral Palsy to have children as they would be unable to raise the child safely	15	4	5	6
6	5	4	16	People with HIV/AIDS have a right to do government sponsored vocational training schemes even if they are unlikely to get a job	16	3	2	1
1	2	3	17	Residential care is usually the best option for people with HIV/AIDS	17	4	5	6
1	2	3	18	People with HIV/AIDS should be protected from situations that are likely to cause stress or anxiety to themselves	18	4	5	6
1	2	3	19	A restaurant owner should be allowed to refuse service to a person with HIV/AIDS if they upset other customers because of their impairment	19	4	5	6
1	2	3	20	It is wrong for a couple with HIV/AIDS to have children as they would be unable to raise	20	4	5	6

				the child safely				
6	5	4	21	People with Schizophrenia have a right to do government sponsored vocational training schemes even if they are unlikely to get a job	21	3	2	1
1	2	3	22	Residential care is usually the best option for people with Schizophrenia	22	4	5	6
1	2	3	23	People with Schizophrenia should be protected from situations that are likely to cause stress or anxiety to themselves	23	4	5	6
1	2	3	24	A restaurant owner should be allowed to refuse service to a person with Schizophrenia if they upset other customers because of their impairment	24	4	5	6
1	2	3	25	It is wrong for a couple with Schizophrenia to have children as they would be unable to raise the child safely	25	4	5	6
6	5	4	26	Deaf people have a right to do government sponsored vocational training schemes even if they are unlikely to get a job	26	3	2	1
1	2	3	27	Residential care is usually the best option for deaf people	27	4	5	6
1	2	3	28	Deaf people should be protected from situations that are likely to cause stress or anxiety to themselves	28	4	5	6
1	2	3	29	A restaurant owner should be allowed to refuse service to a deaf person if they upset other customers because of their impairment	29	4	5	6
1	2	3	30	It is wrong for a deaf couple to have children as they would be unable to raise the child safely	30	4	5	6
6	5	4	31	People with Epilepsy have a right to do government sponsored vocational training schemes even if they are unlikely to get a job	31	3	2	1
1	2	3	32	Residential care is usually the best option for people with Epilepsy	32	4	5	6
1	2	3	33	People with Epilepsy should be protected from situations that are likely to cause stress or anxiety to themselves	33	4	5	6
1	2	3	34	A restaurant owner should be allowed to refuse service to a person with Epilepsy if they upset other customers because of their impairment	34	4	5	6
1	2	3	35	It is wrong for a couple with Epilepsy to have children as they would be unable to raise the child safely	35	4	5	6

Appendix H

Social Acceptance List

It has been found that people with different impairments/disabilities are accepted, in general, by society to different extents. In order to find-out which groups of people are accepted the most or the least, please place a number from 1 to 10 (1 = most accepted and 10 = lease accepted) against each of the groups listed below. In other words, list the impairments/disabilities in order of how well you feel they are accepted into society.

Place a number of 1 to 10 against each of the impairments listed, with 1 = most accepted in society and 10 = least accepted I society.

You may use a number only ONCE on this form

(1, 2, 3, 4, 5, 6, 7, 8, 9 or 10 once only)

Impairment/Disability	Number
Arthritis	
Blindness (no eye sight)	
Cerebral Palsy	
Deafness (no hearing)	
Down's Syndrome	
Epilepsy	
HIV/AIDS	
Paraplegia (no use of legs)	
Quadriplegia (no use of arms or legs)	
Schizophrenia	

Appendix I

Description of Impairments Used in the Attitude Toward Impairment Scale

I.1 Arthritis

Rheumatoid arthritis (RA) is an autoimmune symmetrically inflammatory arthritis of unknown cause (Ryan, 2002) affecting approximately one million people in the UK (Hill and Ryan, 2000). Ryan (2002) states RA is *"characterised by inflammation of the synovium (a substance that lines the joints and tendon sheaths of the body) and increased synovial exudate, which result in thickening of the synovium and joint swelling"*. As a consequence, people with RA will acquire multiple joint tenderness, swelling and pain. Onset of symptoms prior to the age of 16 is diagnosed as juvenile rheumatoid arthritis (Burke, Zautra, Schultz, Reich and Davis, 2002). Other forms of arthritis are Osteoarthritis and Fibromyalgia. Osteoarthritis is characterised primarily by cartilage destruction and bone erosion. Fibromyalgia is less well documented and diagnosis relies on subjective symptoms reported by the individual. This form of arthritis creates pain in specific 'tender spots', fatigue, stiffness, and non-refreshing sleep (Burke, Zautra, Schultz, Reich and Davis, 2002).

I.2 Cerebral Palsy

One of the key features of cerebral palsy is its variability (Liptak and Accardo, 2004). Cerebral palsy is a non-progressive disorder of movement and posture which results from damage to the nervous system (Gething, 1992). Liptak and Accardo (2004) note that approximately 50% of children with cerebral palsy have 'mental retardation' (sic). Which of course also means approximately 50% do not have a learning disability. The primary characteristic of cerebral palsy is loss of control over voluntary muscles. Approximately 40% of people with cerebral palsy are also affected in terms of one or more of: speech, vision, epilepsy, gait, balance, co-ordination, hearing and sensation (Gething, 1992: p. 10). Secondary conditions are affected by environmental factors, public attitudes, health policies and personal behaviour, often leading to social isolation (Liptak and Accardo, 2004). Definitions of cerebral palsy have developed over time reflecting increased knowledge and understanding, whereby, Shapiro (2004) argues for the need to broaden the classifications of function and therapy to reflect the expectations of disabled people.

I.3 Deaf

D'aoust (1999) makes clear the distinction between the Deaf community and people who are deaf. The lower case 'd' 'deaf' refers to those with a hearing loss of any degree, including those who cannot hear at all. Whereas, capital 'D'

Deaf, refers to those who voluntarily belong to the Deaf community. A hearing impairment may be congenital, or as a result of hereditary factors, infection, trauma, the environment or degeneration (Gething, 1992: p. 203). Although British Sign Language (BSL) is the second most commonly used language in the UK, its usage is still only used by a relatively small number of deaf people, with most people with this impairment viewing themselves more in terms of *hearing impaired*, in part due to an ageing population, and able to communicate verbally.

I.4 Down's Syndrome

People with Down's syndrome have three copies of chromosome 21 instead of the usual two. The result of the additional chromosome not only creates a number of more obvious physical characteristics, such as facial features, but also biological consequences (heart problems; greater risk of eye problems; increased incidence of infection). Despite this, people with Down's syndrome are now expected to live significantly longer than their predecessors, with 44% surviving to the age of 60 years and 13.8% to 68 years (Benjamin, 2004). People with Down's syndrome are increasingly accessing mainstream education, living in the community, maintaining paid employment and holding other socially valued roles.

With respect to attitudes towards people with learning difficulties, Stalker (1999) in her review of the literature relating to public attitudes toward this group of people, concludes that the said attitudes are both *'complex and ambivalent'*. Negative attitudes are attributed to *'a legacy of historical policies and practices as well as a response to current developments'*. Stalker also notes how public attitudes in Scotland are more positive than before, but also recognises that negative behaviours such as bullying and harassment of people with learning difficulties still exists, and remains a *'serious problem'*.

I.5 Epilepsy

An operational definition of epilepsy is *"the occurrence of more than one non-febrile seizure at any time"* (Brown and Hopkins, 1988: p. 210). An epileptic seizure is the result of a sudden discharge of impulses or messages from nerve cells in the brain (Gething, 1992). Anyone can develop epilepsy, although some people have more of a predisposition for it than others. Although little scientific evidence exists to suggest that stress is directly linked to seizures (Brown and Hopkins, 1988: p. 215) the possibility that stress may have an adverse effect seems likely and should therefore be managed accordingly. Gething (1992) identifies the two main classifications of epilepsy are *generalised* and *partial*. A generalised epileptic seizure is where the entire brain is involved, whereas partial epileptic seizure means there is a focal feature which ay take the form of an aura or warning, whereby the individual senses a seizure is about to occur.

The most common forms of generalised seizure are tonic-clonic (characterised by sudden onset with the person losing consciousness, becoming rigid and falling over, followed by rapid, short jerky movements and possibly frothing from the mouth, and a loosening of the bowel and bladder; this can last for a number of minutes) and simple absence seizure (characterised by a momentary unconsciousness for only a few seconds, swaying and sometime a rolling of the eyes or twitching, with the person often being unaware anything has happened).

Simple partial seizures may involve jerking of the foot, face, arm or any other part of the body, and may involve a 'peculiar tingling, burning, or abnormal sensation in any part of the body', depending on where in the brain the electrical activity began (Gething, 1992: p. 113).

Although some health and safety restrictions exist in relation to certain job types for people with epilepsy, one of the major barriers to employment remains employer attitudes rather than the control of seizures (Brown and Hopkins, 1988).

I.6 Human Immunodeficiency Virus (HIV) / Acquired Immunodeficiency Syndrome (AIDS)

HIV is a retrovirus of the human T-cell leukaemia/lymphoma line and is believed to be the primary cause of AIDS. Since the introduction of highly active antiretroviral therapy (HAART) in 1996, survival time has significantly increased among people living with HIV/AIDS, altering the form of HIV infection to that of chronic disease (Antoni, 2002). *"The decline in CD4 cells and related immunologic surveillance functions leaves the infected person susceptible to a number of opportunistic infections and cancers characteristic of AIDS"* (Antoni, 2002: p. 191). As no cure for AIDS currently exists, prevention is the principal tool used to reduce its spread, such as behaviour change (e.g. the use of condoms; using only clean needles for injection drugs). Worryingly, Smart and Wegner (2000), having identified the negative health effects on concealing a stigma such as HIV infection (p. 236), then suggest various strategies for concealing a stigma, including suppression, situation management and redefinition of the stigma (p. 238).

It is interesting to note that whilst there is still a high level of stigma attached to people with HIV/AIDS (Nilsson Schonnesson, 2002: p. 400), there does appear to be improvement, (from a Western perspective), with public perception shifting from a 'plague' mentality to viewing HIV/AIDS status as a chronic condition (Catalan, Meadows and Douzenis, 2000) since the introduction of highly active antiretroviral therapy (HAART) (Vidrine, Amick III, Gritz and Arduino, 2004). Catalan *et al* (2000) view this as a consequence of improved morbidity rates, with HIV being increasingly seen as a treatable condition rather than a *"death sentence"*. This change in status, they conclude from their analysis of mental health problems referred to the Psychological Medicine Unit of a London hospital, is leading those with an HIV/AIDS status to re-evaluate life goals (shifting from short-term due to the likelihood of early death, to longer-term such as work, relationships et cetera). Interestingly, Catalan *et al* (2000) suggest that as antiretrovirals improve life expectations of HIV positive people, it also means this group is having to adjust to *"being seen less as special and deserving of particular sympathy and more as people suffering from a disease as any other or, indeed, not ill at all, and thus less deserving of state benefits and support"*. Hence, for many people who have lived with this infection, building social networks and a sense of self around it, this new status may be seen as both liberating and a loss. Nilsson Schonnesson (2002) warns too, that due to the stigma attached to HIV, despite the gradual shift in medical prognosis to a chronic condition, people living with HIV live on a 'nebulous boundary' between chronic and terminal illness. This will inevitably have consequences as to how the individual views him or herself as a person with an impairment. Goggin, Sewell, Ferrando, Evans, Fishman and Rabkin (2000) also link more positive attitudes of people living with HIV to themselves as a consequence of improved health care since the arrival of protease inhibitors in 1996. Goggin *et al* found reduced numbers of HIV positive gay men (17% of n

= 167) who had made plans to take their own lives compared to pre-1996 research (ranging from 25% to 55%) (p. 133). Hence, with improved health and longer-term wellbeing, this negative method of maintaining a degree of control in the face of uncertainty appears to be reduced.

Paxton (2002) as an academic who is HIV positive, adds to this discussion by reporting that people living with HIV/AIDS found improved health, greater self-esteem and reduced levels of stress after publicly disclosing their health status. Through interviews with HIV positive participants (n = 75) from twenty countries in eastern and southern Africa and the Asia-Pacific region, Paxton (2002) concludes:

"The paradox of public HIV disclosure is that the very thing that seems the most dangerous thing to do, openly confronting stigma and facing possible discrimination, ultimately can be the most liberating." (Paxton, 2002: p. 565)

Thus, the stress of passing as a non-disabled people, through fear of victimisation if disclosure occurs, may be more harmful than 'coming out' as disabled, but, only if managed in an appropriate way with support networks available (Paxton, 2002). Hence, Paxton would argue that a positive attitude towards oneself as a person living with HIV/AIDS could be assisted through the public disclosure and identification as a person with this impairment. However, the importance of the subsequent interactions between the person living with HIV/AIDS and others, with respect to whether the interactions are viewed as supportive or unsupportive, appears to be a significant factor in association with depression for this group.

With respect to women who become HIV-infected, in a piece of research (n = 322) of predominantly African-American women based in southern USA, Sowell, Murdaugh, Addy, Moneyham and Tavokoli (2002) found that forty-eight per cent (n = 128) of the sample had become pregnant since becoming HIV-infected. Whilst concern was expressed by these women over being able to care for their child if they became ill, social and cultural factors appear to be greater motivators in whether to become pregnant or not. With decreased risks of passing the HIV-infection to the newborn child (Etiebet, Fransman, Forsyth, Coetzee and Hussey, 2004), non-HIV related motivators are likely to grow in importance with respect to this topic, in order for HIV-infected women to maintain their gender roles and therefore, social status.

I.7 Schizophrenia

Warner (1994: p. 4) defines schizophrenia as *"a disorder of thinking where a person's ability to recognise reality, his or her emotional responses, thinking processes, judgement and ability to communicate deteriorates so much that his or her functioning is seriously impaired. Symptoms such as hallucinations and delusions are common"*. The main symptoms of schizophrenia are: auditory hallucinations; experiences of control (for instance, person feels under the control of an alien force or power); delusions (false personal beliefs about the world, for instance, persecutory or grandiose); disorders of thinking (such as the feeling that thoughts have been inserted or withdrawn from the mind); and, emotional and violational changes (emotions and feelings often being described as 'flat') (Birchwood and Jackson, 2001: p. 8). Schizophrenia can be divided into the chronic and acute, and may occur at any age, but is commonest in the young adult (Egdell, Horrocks, Lee and Warburton, 1988). An acute episode may be short-lived but frightening, possibly leading to self-harm. This can progress into the chronic, which is characterised by social withdrawal, under or over activity, lack of conversation, few leisure activities, depression and 'odd' behaviour (Egdell *et al,* 1988: p. 391), but, as these authors state, this does not mean living with schizophrenia is incompatible with work, and many people who have experienced schizophrenia manage their impairment long-term, with 50% reporting little or no 'disability' (p. 389).

Appendix J

Glossary of Statistical Terms

J.1 Bartlett's Test of Sphericity

A statistical test to assess the 'factorability' of the data (Pallant, 2001: p. 153)

J.2 Cronbach's Alpha

Cronbach's alpha is a widely used test based on the premise that *"if the scale is expected to measure a single underlying continuum, then the items should have strong relationships both with that continuum and with each other"* (Oppenheim, 1992: p. 160). Thus, a scale will have *internal consistency* if items correlate highly with each other. The coefficient alpha gives an estimate of the proportion of the total variance that is not due to error. This represents the reliability of the scale. It is widely accepted that an alpha of 0.7 or above is regarded as acceptable (Cortina, 1993; Nunnally and Bernstein, 1994) all though, as Cortina (1993) reminds us that alpha is *"not a panacea"* and must be viewed with caution (p. 103)

J.3 Eigenvalues

"[A] mathematical property of a matrix; used in relation to the decomposition of a covariance matrix, both as a criterion of determining the number of factors to extract and a measure of variance accounted for by a given dimension" (Kim and Mueller, 1978)

J.4 Eta Squared

"Eta squared represents the proportion of variance of the dependent variable that is explained by the independent variable" (Pallant, 2001: p. 175). This is a calculation of the importance of the findings known as the 'effect size' or 'strength of association'.

J.5 Extraction Method - Principal Component Analysis (PCA)

PCA is similar to Factor Analysis in that they both try to reduce the number of linear combinations of the original variables. In PCA the original variables are *"transformed into a smaller set of linear combinations, with all of the variance in the variables being used. In factor analysis however, factors are estimated using a mathematical model, where only shared variance is analysed"* (Pallant, 2001: p. 151)

J.6 Factor Analysis

"Factor Analysis consists of a number of statistical techniques the aim of which is to simplify complex sets of data. In the social sciences factor analysis is usually applied to correlations between variables" (Kline, 1994)

J.7 Friedman Test

Non-parametric alternative to the one-way repeated measures analysis of variance. It is used when taking the same sample of subjects and measure them at three or more points in time or under different conditions (Pallant, 2001)

J.8 Independent-samples t-test

A parametric test of the difference between the means of two independent samples. The *t* formula measures the size of the difference between the means of two samples and converts this into a standard measure of deviation. A large *t* value signifies a marked difference between the samples means, and therefore a low probability that the difference was by chance (Miller, 1984: pp. 82-83)

J.9 Kaiser-Maeyer-Oklin

A statistical test to ascertain the smallest number of factors that can be used to best represent the inter-relationship among the set of variables (Pallant, 2001)

J.10 Kruskal-Wallis H-Test

Non-parametric alternative to a one-way between group analysis of variance. This test allows comparison of scores on some continuous variable for three or more groups. Scores are converted to ranks and the mean rank for each group is compared (Pallant, 2001) For an accurate estimation of probability, there should be at least five observations per group (McCall, 1975: p. 313)

J.11 Mann-Whitney U-Test

Non-parametric alternative to the t-test for independent samples. Used for data measured on an ordinal scale and makes no assumptions about the shape of population distributions (Miller, 1984: p. 86). The Mann-Whitney U-test, instead of comparing means, actually compares medians. It converts scores on the continuous variable to rank across the two groups and then evaluates whether the ranks for each group differ significantly

J.12 One-Way Between Groups Analysis of Variance (ANOVA)

ANOVA involves one independent variable, which has three or more different levels. ANOVA compares the variance *between* the different groups with the variability *within* the groups. An F ratio is calculated which represents the variance between the groups divided by the variance within the groups (Pallant, 2001: p. 186).

J.13 Orthogonal Rotation

"[T]he operation through which a simple structure is sought under the restriction that factors be orthogonal (or uncorrelated); factors obtained through this rotation are by definition uncorrelated" (Kim and Mueller, 1978)

J.14 Paired-Sample T-Test

As with the independent samples t-test, the *t* formula measures the size of the difference between the means and converts this into a standard measure of deviation. For the paired-sample one set of subjects (or matched pairs) provide both sets of scores, i.e. one continuous or dependent variable (e.g. attitude) measured on two different occasions (time 1 and time 2) (Miller, 1984; Pallant, 2001)

J.15 Scree Test

"[A] rule-of-thumb criterion for determining the number of significant factors to retain; it is based on the graph (scree plot) of the roots (eigenvalues) claimed to be appropriate in handling disturbances due to minor (unarticulated) factors" (Kim and Mueller, 1978)

J.16 Scree Plot

A graphical representation of a scree test

J.17 Spearman's Rank Order Correlation (r_s)

Non-parametric coefficient of correlation which is specifically designed to measure the degree of monotonic (whether one variable tends to increase or decrease as the other increases) relationship between two variables (Miller, 1984: p. 139)

J.18 Tukey's Honestly Significant Different Test (HSD)

This is a post-hoc test designed to protect against a Type 1 error (rejecting the null hypothesis when in fact there is no difference between the groups) due to a large number of comparisons being made between groups when using ANOVA (Pallant, 2001)

J.19 Validity

a) content validity, which seeks to establish that the items of a scale are a *"well balanced sample of the content domain to be measured"* (Oppenheim, 1992: p. 162); b) "construct validity, which shows how well the test links up with a set of theoretical assumptions about an abstract construct such as intelligence, conservatism or neuroticism" (Oppenheim, 1992: p. 162). See also above explanation of Cronbach's alpha.

J.20 Varimax Rotation

"[A] method of orthogonal rotation which simplifies the factor structure by maximising the variance of a column of the pattern matrix" (Kim and Mueller, 1978)

Appendix K

Breakdown of Responses to General Attitude Scale Toward Disabled People

Disabled Sample

	I disagree very much		I disagree somewhat		I disagree a little		I agree a little		I agree somewhat		I agree very much	
Statement	N	%	N	%	N	%	N	%	N	%	N	%
1	97	45.3	53	24.8	21	9.8	26	12.1	12	5.6	5	2.3
2 *	10	4.7	14	6.5	10	4.7	35	16.4	64	29.9	81	37.9
3 *	13	6.1	9	4.2	10	4.7	28	13.1	56	26.3	97	45.5
4	114	53.3	30	14.0	18	8.2	23	10.7	10	4.7	19	8.9
5 * #	36	16.8	17	7.9	17	7.9	61	28.5	50	23.4	33	15.4
6	105	49.1	35	16.4	28	13.1	25	11.7	15	7.0	6	2.8
7	106	49.5	52	24.3	30	14.0	13	6.1	7	3.3	6	2.8
8	52	24.3	27	12.6	31	14.5	50	23.4	27	12.6	27	12.6
9	127	59.3	28	13.1	25	11.7	22	10.3	9	4.2	3	1.4
10	77	36.0	24	11.2	24	11.2	41	19.2	30	14.0	18	8.4
11	119	55.9	18	8.5	23	10.8	27	12.7	16	7.5	10	4.7
12	25	11.7	16	7.5	12	5.6	39	18.2	55	25.7	67	31.3
13	82	38.5	46	21.6	48	22.5	20	9.4	7	3.3	10	4.7
14	65	30.4	23	10.7	34	15.9	62	29.0	24	11.2	6	2.8
15	104	48.8	40	18.8	37	17.4	20	9.4	10	4.7	2	0.9
16 *	8	3.7	7	3.3	14	6.5	33	15.4	42	19.6	110	51.4
17 *	11	5.1	4	1.9	4	1.9	9	4.2	24	11.2	162	75.7
18 *	25	11.7	22	10.3	31	14.6	43	20.2	38	17.8	54	25.4

Non-Disabled Sample

	I disagree very much		I disagree somewhat		I disagree a little		I agree a little		I agree somewhat		I agree very much	
Statement	N	%	N	%	N	%	N	%	N	%	N	%
1	39	34.5	39	34.5	13	11.5	14	12.4	6	5.3	2	1.8
2 *	2	1.8	1	0.9	2	1.8	24	21.2	40	35.4	44	38.9
3 *	0	0.0	1	0.9	6	5.3	17	15.0	36	31.9	53	46.9
4	66	58.4	20	17.7	10	8.8	8	7.1	6	5.3	3	2.7
5 * #	12	10.6	15	13.3	7	6.2	33	29.2	26	23.0	20	17.7
6	49	43.4	30	26.5	17	15.0	13	11.5	3	2.7	1	0.9
7	61	54.0	32	28.3	10	8.8	7	6.2	2	1.8	1	0.9
8	32	28.3	20	17.7	21	18.6	23	20.4	12	10.6	5	4.4
9	72	63.7	19	16.8	10	8.8	10	8.8	1	0.9	1	0.9
10	22	19.5	11	9.7	19	16.8	31	27.4	19	16.8	11	9.7
11	60	53.1	18	15.9	14	12.4	13	11.5	6	5.3	2	1.8
12	4	3.6	9	8.0	11	9.8	36	32.1	27	24.1	25	22.3
13	45	39.8	27	23.9	25	22.1	10	8.8	5	4.4	1	0.9
14	20	17.7	18	15.9	25	22.1	33	29.2	14	12.4	3	2.7
15	61	54.0	28	24.8	14	12.4	8	7.1	2	1.8	0	0.0
16 *	0	0.0	0	0.0	5	4.4	17	15.0	36	31.9	55	48.7
17 *	1	0.9	0	0.0	2	1.8	5	4.4	21	18.6	84	74.3
18 *	1	0.9	13	11.6	21	18.8	41	36.6	22	19.6	14	12.5

* agreement with statements 2, 3, 5 ,16, 17 and 18 reflects a positive attitude
\# statement 5 was removed from analysis due to low internal validity as measured by Cronbach's alpha

Subtle Sub-Scale Items are:	3, 6, 7, 8, 12, 13 and 14
Blatant Sub-Scale Items are:	1, 9, 11, 15, 16, 17 and 18

Appendix L

Breakdown of Responses to Attitude Toward Impairment Scale

Disabled Sample

	I disagree very much		I disagree somewhat		I disagree a little		I agree a little		I agree somewhat		I agree very much	
Statement	N	%	N	%	N	%	N	%	N	%	N	%
1 DS *	11	5.6	2	1.0	9	4.6	40	20.4	58	29.6	76	38.8
2 DS	74	37.9	47	24.1	31	15.9	25	12.8	11	5.6	7	3.6
3 DS	26	13.3	16	8.2	17	8.7	68	34.7	35	17.9	34	17.3
4 DS	108	55.1	24	12.2	28	14.3	25	12.8	7	3.6	4	2.0
5 DS	56	28.6	33	16.8	44	22.4	32	16.3	17	8.7	14	7.1
6 Arth*	9	4.6	4	2.0	11	5.6	36	18.4	47	24.0	89	45.4
7 Arth	122	62.2	40	20.4	21	10.7	8	4.1	1	0.5	4	2.0
8 Arth	67	34.2	29	14.8	21	10.7	38	19.4	25	12.8	16	8.2
9 Arth	129	65.8	28	14.3	18	9.2	15	7.7	3	1.5	3	1.5
10 Arth	117	59.7	35	17.9	24	12.2	10	5.1	7	3.6	3	1.5
11 CP *	9	4.6	8	4.1	10	5.1	36	18.4	44	22.4	89	45.4
12 CP	85	43.4	43	21.9	31	15.8	23	11.7	11	5.6	3	1.5
13 CP	41	20.9	24	12.2	26	13.3	52	26.5	29	14.8	24	12.2
14 CP	111	56.6	29	14.8	21	10.7	22	11.2	7	3.6	6	3.1
15 CP	73	37.2	29	14.8	38	19.4	28	14.3	16	8.2	12	6.1
16 HIV *	10	5.1	9	4.6	10	5.1	35	17.9	42	21.4	90	45.9
17 HIV	105	53.8	46	23.6	19	9.7	12	6.2	7	3.6	6	3.1
18 HIV	59	30.1	29	14.8	21	10.7	36	18.4	26	13.3	25	12.8
19 HIV	119	60.7	30	15.3	20	10.2	12	6.1	6	3.1	9	4.6
20 HIV	50	25.5	19	9.7	34	17.3	36	18.4	16	8.2	41	20.9
21 Sch *	13	6.6	6	3.1	6	3.1	52	26.5	41	20.9	78	39.8
22 Sch	52	26.5	46	23.5	36	18.4	33	16.8	20	10.2	9	4.6
23 Sch	25	12.8	15	7.7	13	6.6	69	35.2	40	20.4	34	17.3
24 Sch	85	43.6	30	15.4	20	10.3	33	16.9	18	9.2	9	4.6
25 Sch	55	28.1	28	14.3	30	15.3	40	20.4	25	12.8	18	9.2
26 Deaf *	17	8.7	3	1.5	6	3.1	27	13.8	34	17.3	109	55.6
27 Deaf	143	73.0	22	11.2	16	8.2	6	3.1	5	2.6	4	2.0
28 Deaf	71	36.2	28	14.3	21	10.7	33	16.8	20	10.2	23	11.7
29 Deaf	151	77.0	19	9.7	13	6.6	9	4.6	1	0.5	3	1.5
30 Deaf	140	71.4	26	13.3	16	8.2	8	4.1	4	2.0	2	1.0
31 Ep *	15	7.7	1	0.5	6	3.1	34	17.3	43	21.9	97	49.5
32 Ep	119	60.7	32	16.3	24	12.2	10	5.1	4	2.0	7	3.6
33 Ep	45	23.0	21	10.7	20	10.2	50	25.5	29	14.8	31	15.8
34 Ep	127	64.8	21	10.7	17	8.7	19	9.7	7	3.6	5	2.6
35 Ep	93	47.4	41	20.9	29	14.8	17	8.7	8	4.1	8	4.1

* agreement with statements 1, 6, 11, 16, 21, 26 & 31 reflects a positive attitude

DS – Down's Syndrome
Arth – Arthritis
CP – Cerebral Palsy
HIV – HIV/AIDS
Sch - Schizophrenia
Deaf – Deaf
Ep –Epilepsy

Non-Disabled Sample

	I disagree very much		I disagree somewhat		I disagree a little		I agree a little		I agree somewhat		I agree very much	
Statement	N	%	N	%	N	%	N	%	N	%	N	%
1 DS *	1	0.8	1	0.8	6	5.0	24	19.8	35	28.9	54	44.6
2 DS	48	39.7	29	24.0	21	17.4	11	9.1	7	5.8	5	4.1
3 DS	9	7.4	16	13.2	25	20.7	45	37.2	18	14.9	8	6.6
4 DS	75	62.0	19	15.7	14	11.6	8	6.6	2	1.7	3	2.5
5 DS	31	25.6	32	26.4	19	15.7	31	25.6	5	4.1	3	2.5
6 Arth *	0	0.0	3	2.5	10	8.3	17	14.0	33	27.3	58	47.9
7 Arth	72	59.5	22	18.2	19	15.7	4	3.3	3	2.5	1	0.8
8 Arth	40	33.1	18	14.9	25	20.7	24	19.8	12	9.9	2	1.7
9 Arth	92	76.0	11	9.1	11	9.1	6	5.0	1	0.8	0	0.0
10 Arth	75	62.0	24	19.8	15	12.4	7	5.8	0	0.0	0	0.0
11 CP *	2	1.7	1	0.8	7	5.8	26	21.5	32	26.4	53	43.8
12 CP	48	39.7	22	18.2	27	22.3	19	15.7	4	3.3	1	0.8
13 CP	20	16.5	20	16.5	27	22.3	36	29.8	16	13.2	2	1.7
14 CP	83	68.6	13	10.7	14	11.6	10	8.3	1	0.8	0	0.0
15 CP	45	37.2	24	19.8	27	22.3	18	14.9	4	3.3	3	2.5
16 HIV *	4	3.3	3	2.5	4	3.3	25	20.7	23	19.0	62	51.2
17 HIV	70	57.9	24	19.8	17	14.0	4	3.3	4	3.3	2	1.7
18 HIV	40	33.1	21	17.4	25	20.7	24	19.8	10	8.3	1	0.8
19 HIV	78	64.5	19	15.7	15	12.4	5	4.1	3	2.5	1	0.8
20 HIV	34	28.1	19	15.7	22	18.2	22	18.2	9	7.4	15	12.4
21 Sch *	0	0.0	2	1.7	5	4.2	31	25.8	25	20.8	57	47.5
22 Sch	32	26.7	23	19.2	37	30.8	16	13.3	10	8.3	2	1.7
23 Sch	14	11.7	14	11.7	17	14.2	47	39.2	23	19.2	5	4.2
24 Sch	59	49.2	17	14.2	15	12.5	19	15.8	9	7.5	1	0.8
25 Sch	33	27.5	18	15.0	30	25.0	27	22.5	9	7.5	3	2.5
26 Deaf *	1	0.8	1	0.8	3	2.5	28	23.1	19	15.7	69	57.0
27 Deaf	88	72.7	16	13.2	12	9.9	2	1.7	3	2.5	0	0.0
28 Deaf	42	34.7	19	15.7	23	19.0	26	21.5	7	5.8	4	3.3
29 Deaf	95	78.5	9	7.4	13	10.7	3	2.5	1	0.8	0	0.0
30 Deaf	95	78.5	16	13.2	9	7.4	1	0.8	0	0.0	0	0.0

31 Ep *	1	0.8	1	0.8	4	3.3	32	26.4	19	15.7	64	52.9
32 Ep	76	62.8	25	20.7	14	11.6	4	3.3	2	1.7	0	0.0
33 Ep	36	29.8	19	15.7	15	12.4	34	28.1	14	11.6	3	2.5
34 Ep	84	70.0	12	10.0	14	11.7	8	6.7	2	1.7	0	0.0
35 Ep	69	57.5	20	16.7	24	20.0	5	4.2	2	1.7	0	0.0

* agreement with statements 1, 6, 11, 16, 21, 26 & 31 reflects a positive attitude