Adolescent Attitudes Toward Disabilities: What Every School Counselor Needs to Know

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ABSTRACT

This study examined high school attitudes toward persons with physical and mental disabilities using a social distance scale. Results indicated that physical disabilities (e.g., ulcer, stomach disorder, heart disease, visual impairment, hearing impairment, spinal cord injure) were rated as most accepted (excluding HIV/AIDS) and mental disabilities (e.g., chemical dependency, schizophrenia, depression, alcoholism, behavior disorder, mental retardation) were the least accepted. That is, more social distance was placed between the participant and the disability group. These findings were similar to other studies. As diversity awareness continues to drive the counseling arena, it seems vital that attitudes toward disabilities be addressed. Implications of these results as well as techniques to modify student attitudes toward disability are reviewed.

Negative attitudes toward individuals with disabilities have been prevalent throughout history. The Americans with Disabilities Act (ADA) was implemented to decrease discriminatory practices; however, negative attitudes toward persons with disabilities (PWD) continue to exist (Hunt & Hunt, 2004; Lerner & Belts, 2005; Noe, 1997). Certain types of disabilities such as mental illness are frequently viewed in a negative manner based on unfounded stereotypical attitudes (e.g., that all persons with mental illness are dangerous) (Noble & Collington, 1987). In fact, individuals with physical disabilities (e.g., ulcer, stomach disorder, kidney disorder, cancer, spinal cord injury, etc.) receive less stigma and discrimination as compared to those (e.g., schizophrenia, bipolar disorder, substance abuse) with mental disabilities (Chandras, DeLambo & Chandras, 2007; Noe, Mayville, Wachelka, & Gipson, 1997). Fortunately, an array of techniques are available to modify these attitudes toward PWD (Barrett & Pullo, 1993; McReynolds & Garske, 2003; Beck, Deitrich, Matschinger, & Angermeyer, 2003). The current study explored high school senior's attitudes toward PWD as well as techniques to modify their attitudes. Since diversity training is an utmost concern in both the business as well as academic world, it is imperative to address students' attitudes toward disabilities as early as possible in their career development.

Attitudes are difficult to measure because they are not directly observable but are descriptive concepts inferred from observations or behavior. Attitudes are believed to influence behavior (Antonak & Livneh, 1988) and there are a number of appropriate instruments to measure this construct (Antonak, & Livneh, 2000). A frequently used method for measuring attitudes is a social distance scale. Social distance has been defined as "the degree of sympathetic understanding between persons or between a person and a group" (Bogardus, 1933, p. 268). Social distance is directly related with attitudes toward disabilities; persons tend to distance themselves (i.e., degree of social contact) from negatively perceived disabilities (e.g., alcoholism, HIV/AIDS, Schizophrenia).

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Tringo (1970) devised a 21-item Disability Social Distance Scale (DSDS) from Bogardus's (1925) Social Distance Scale. The DSDS used handicapping language (e.g., schizophrenic, hunchback, dwarf, etc.). Disabilities were rated on a 9-point Likert scale measuring the degree of closeness one would be willing to have with a person with a particular disability. The Likert categories in regard to a PWD were: (1) Would marry; (2) Would accept as close kin by marriage; (3) Would have as a next door neighbor; (4) Would accept as a casual friend; (5) Would accept as a casual employee; (6) Would keep away from; (7) Would keep in institution; (8) Would send out of my country, and, lastly, (9) Would put to death (The current authors removed this category from the scale based on its negative view toward persons with disabilities). When using the DSDS, Noe, et al. (1997) found that both high school and college students rated physical disabilities as more acceptable than mental illness, developmental disabilities, and substance abuse. Likewise, Corrigan, River, Lundin, Wasowski, Campion, Mathisen et al. (2000) found that students rated the individuals with cocaine addiction, psychosis, and other psychiatric disabilities in a much less favorable light than individuals with physical disabilities. Arokiasamy, Rubin, and Roessler (2001) as well as Chandras, DeLambo & Chandras (2007), found a similar preference hierarchy.

The purpose of this study was to explore high-school student's attitudes toward disabilities and then explore techniques that can be used in the high school environment to modify these attitudes. The 1970 Tringo DSDS was adopted in order to address this study's purpose.

Methods

Participants

One hundred and twenty-five 18 year-old high school seniors (67 females and 58 males) volunteered to participate. The participants were selected from 6 classrooms at three high schools from a Midwestern rural area.

Construction of the Person-First Disability Scale (PFDS)

Antonak and Livneh (1988) suggested that the DSDS be modified to include standardized terminology, deletion of uncommon disabilities and the inclusion of common disabilities. The current authors adopted the DSDS and made the following modifications: (a) the addition of new disabilities (i.e., acquired immune deficiency syndrome and human immunodeficiency virus) nonexistent three decades ago; (b) the addition of current disabilities (e.g., multiple sclerosis, HIV/AIDS); (c) the deletion of uncommon disabilities (e.g., poliomyelitis); (d) the removal Likert scale category 9 "Would Put to Death," and, (e) the utilization "person-first" disability language (e.g., refer to client as "a person with schizophrenia" instead of "a schizophrenic client"). Fifty-eight disability types were submitted for content validation (Falvo, 1999).

Content Validation of PFDS

Nine rehabilitation professionals examined the modified instrument and reported if each item should be either included, excluded, or modified. Suggestions were made for inclusion of disorders not listed. As suggested by Allen and Yen (1979) 80% agreement was used for retention of an item. Items not reaching 80% agreement were deleted or modified. An 8-point Likert scale was used. The final questionnaire consisted of 40 items (see appendix for PFDS questionnaire).

Procedure

The instrument was dispersed to each of the six classrooms. The directions were provided to each group of students. Names were not used and confidentiality was assured, reducing validity threats associated with reactivity. Students were instructed to place their completed survey in a large manila envelope.

Results

There was a hierarchy of preference toward disability type (see Table 1). Lower scores indicate less social distance and higher scores demonstrate more social distance. In general, physical disabilities were viewed more favorably than mental disabilities (e.g., schizophrenia). The entire sample of physical disabilities (excluding HIV/AIDS) ranked lower than mental illness, alcoholism, chemical dependency, tuberculosis; these mental disabilities were all rated in a less than favorable manner (see Table 1).

Discussion

The finding that attitudes of high school students did not differ significantly from other college students in terms of social distance ratings was not unexpected (Chandras et al., 2007). These participants may not have had contact with persons with disabilities; consequently, as contact with individuals with disabilities increases, positive attitudes often times become evident (Alexander, & Link, 2003). Another reason for the students' social distance may be feelings of existential and aesthetic anxiety among the participants in this study (Rubin & Roessler, 2001). Both types of anxiety occur when the person without a disability becomes

anxious when coming in close proximity to a person with a disability. From an existential anxiety standpoint, one may realize how fragile the human body is and avoid contact with a person with a disability (e.g., individual who has a mental illness). Since mental illness affects 25% of American families (National Institute of Mental Health [NIMH], 1988), students may not want to acknowledge the fact that they could develop a mental disability. Moreover, current societal trends emphasizing youth and beauty may contribute to aesthetic anxiety (Gatens-Robinson & Rubin, 1995). Aesthetic anxiety occurs when persons without disabilities avoid those with disabilities due to an uneasy feeling associated with being in contact with a person with a disability. For example, students may not view a person with Cerebral Palsy (CP) as having physical beauty and therefore display anxiety when in contact with such an individual.

Tringo (1970) claimed that societal attitudes vary depending on the disability. It could be that alcoholism, chemical dependency, AIDS/HIV are viewed differently because of a belief in the perceived cause of the disability. Rubin and Roessler (2001) purported that negative societal attitudes may be influenced by factors such as the perceived cause of the disability. For example, persons with mental illness, and persons with alcohol or chemical dependency may be seen as responsible for creating their disability which may lead to them being viewed in a more negative manner.

Most importantly, Tringo (1970) claimed that discrimination against persons with disabilities may impede employment opportunities. Many of the high school students in this study may become employers, may become employed as direct service providers, or may become co-workers of persons with disabilities. Therefore, negative attitudes toward persons with disabilities, or specific disability groups, may hinder employment opportunities or vocational success.

HIV/AIDS ranked low in regard to acceptance among these students. As the number of persons who have HIV and AIDS continues to rise, attitudes toward these individuals should be assessed. Falvo (1999) reported that discrimination, fear, and prejudice are serious impediments to employment for persons with HIV and AIDS. The fact that HIV and AIDS ranked high (more social distance) within the hierarchy suggests that much training is needed in the area of social acceptance. Students can be trained with knowledge that discredits certain myths surrounding these disabilities.

Attitudinal Changes

Education and Attitudes

Attitudes are difficult to change; however, Barrett and Pullo (1993) were able to change students' attitudes towards persons with disabilities within a structured activity called "The Handicapping Experience". The teachers emphasized areas such as psychosocial aspects of disability, stigma associated with disability, accessibility, ethics, myths associated with disability, stress, defense and coping, adjusting to the disability, and disability rights. In addition, students had various assignments such as completing an assessment of a building for physical accessibility, a computerized simulation of using a wheelchair, and an interview with a person with a disability. Using the Attitudes Toward Disabled Persons Scale, Barrett and Pullo assessed students' attitudes before and after the activity. Significant differences were found from pretest to posttest in that both male and female students had positive attitude changes toward persons with disabilities after completion of the activity.

Education has been shown to promote positive attitudes toward PWD. For example disability education is key in positively impacting respondents' attitude related to benevolence and social restrictiveness of persons with mental illness (Holmes, Corrigan, Williams, Canar, & Kubiak, 1999; Corrigan, 2006). Likewise, McReynolds and Garske (2003) reported on training programs that could incorporate topics of psychiatric disability within different courses. For example, a high-school class might discuss the issue of psychiatric disability within a general psychology or a social studies course. In addition, assignments pertaining to disability would certainly fit within this model. For example, a project addressing the psychological and social implications of HIV/AIDS is likely to increase awareness for students at different levels, such as a high school English term-paper pertaining to vital topics (e.g., as mental illness and violence).

Guest Presentations by Community Members

Two of the authors continue to have guest speakers from the community address their courses as well as implement course-specific assignments (site visit to hospital) related to this topic. For example, previous speakers include persons with disabilities, members from National Alliance for the Mentally Ill (NAMI), psychiatrists, and family members of persons with disabilities. Students are very responsive toward these techniques. A person with a disability addressing these courses typically produces rich discussions between the speaker and the audience. A discussion on the impact of

blindness, for example, on daily life activities typically gets the audience's attention. A school counseling program curriculum could integrate this type of activity within the classroom. Local branches of NAMI can be contacted for speakers and other relevant training ideas or materials in order to assist with changing attitudes toward disabilities. NAMI is the largest organization in our nation dedicated to improving the lives of individuals impacted by serious mental illness. This group is a self-help, education, support, and advocacy organization. (NAMI, 2006).

Advocacy for Persons with Disabilities

Mental health advocates and family members of persons with mental illness have a grave concern that the media perpetuate negative stigma toward mental illness (Gerbner, 1980; Wahl, 1980; 1992). Fortunately, groups such as NAMI through its "Mental Illness-Stigma Busters" program have helped battle bias and discrimination toward the portrayal of persons with mental illness in the media, as have Hollywood actors with mental illnesses, who have publicized their disabilities through "coming out" presentations (Simmons, 2001a). Corrigan (2006) reported that NAMI's advocacy through its Stigma Busters campaign, played a key role in ABC's decision to cancel "Wonderland"; a primetime show that depicted persons with mental illness as dangerous and unpredictable. Furthermore, key governmental figures such as the previous U.S. Surgeon General, David Satcher continue to address mental illness discrimination and stigma (Simmons, 2001b). These examples illustrate how students, through guidance lessons, can be trained to selectively determine media biases and either debunk these myths or merely realize the inaccuracies of these programs. School counselors can play a vital role in this process.

Media and Attitudes Toward Disabilities

Newspaper articles and other media presentations can negatively impact attitudes toward disability. School counseling program curriculum can benefit from this knowledge. For example, Thornton and Wahl (1996) found that attitudes toward persons with mental illness were negative following exposure to articles where a murder committed by a person with mental illness is portrayed and elements believed to perpetuate stigma are included. The following elements were presented: a) a horrific murder of an innocent human being by a "psychiatric deviant" type; b) a graphic description using emotionally charged terminology; c) attention grabbing headline such as "Boy, Dismembered at Park: Escaped Mental Patient At-large"; lastly, d) a description of the person with mental illness as bizarre, and no social ties/identity. Respondents were strongly attracted to sensational headlines (e.g., Mental Patient Murders Child with Ax) and were likely to read the article if found in a newspaper. Thornton and Wahl also provided a group of readers with articles that addressed misconceptions about mental illness and provided facts (e.g., violence and mental illness are rare) and made the point that the media inaccurately portrays persons with mental illnesses. Those that read the prophylactic-type articles tended to have a more favorable attitude toward mental illness. In fact, by reading this material first, the original biased article, was viewed as flawed by the respondents. These results suggest that school counselors and teachers, through education, can assist with debunking myths and bias that students either hold or arm them to address media bias.

Attribution and Disability

In regard to coworkers' acceptance of PWD, Bordieri and Drehmer (1987) found that when applicants were perceived to have caused their disability (e.g., spinal cord injury from driving while intoxicated), respondents deemed these individuals to have difficulties getting along with and being accepted by coworkers. Since attribution influences attitudes toward disabilities, school counselors and teachers can address attributional processes within a training program. For example, a guidance lesson can discuss the issue of morality as compared to the disease model. Students then may view the accident as resulting from a disease verses a moral failure. For example, a spinal cord injury due to substance abuse (e.g., driving while intoxicated) could be viewed as symptom of the disease (i.e., substance abuse), not a flaw in character (Rubin & Roesslor, 2001; Roesslor & Rubin, 2006).

Despite the fact that the ADA is responsible for lifting barriers for persons with disabilities, there is still much work to be done in changing attitudes towards persons with disabilities. This study suggested that attitudes have not changed since Tringo completed his study in 1970. For example, attitudes toward mental illness and substance abuse disorders continued to be viewed in a negative manner. In fact, Thomas (2000) found in a follow-up study that a similar preference toward disability continues to exist when utilizing the original scale developed by Tringo. Thus, it is imperative that students receive some type of training in regard to acceptance of persons with disabilities. In regard to alcoholism, Beck et al. (2003) reported that health campaigns that increase awareness by explaining it is not a personal failure, but a disease with severe health and social implications, could positively impact acceptance and in turn, decrease structural discrimination (e.g.,

governmental or insurance monies toward substance abuse). In fact, when persons were believed to be responsible for their disability, the public was less apt to donate money to reputable fundraising efforts (Corrigan, Watson, Warpinski, & Garcia, 2004). Information such as this can be used as a major underpinning of a high school attitude modification program.

School counseling program curriculum can play an instrumental role in the modification of attitudes toward disabilities. If proper training and education occurs, students will have the necessary skills and knowledge to identify biases within the media. Also, they may avoid harboring misperceptions of persons with disabilities. Armed with knowledge concerning disabilities, these young students, who will be our future co-workers and employers, will be less likely to harbor stigmatized attitudes. Consequently, they will avoid discriminating against PWD, either in the workplace or society in general. By providing education to change negative attitudes and stereotypes, both high schools and universities can play an active role in creating a society that is more accepting of persons with disabilities.

Limitations

The authors did not utilize equal numbers from each classroom nor did they do random sampling (i.e., in-tact classes were utilized). Furthermore, previous respondent contact with disabilities was not assessed (e.g., family members, friends, or coworkers, or consumers). In addition, the original Tringo scale was modified from its format for this study. However, results were similar to other studies that indicated similar preferences toward disability.

Future Research

Researchers could categorize the different disability types. For example, the Person-First Disability Scale could be expanded to include specific categories within chemical dependency such as heroin, LSD, methamphetamine, cocaine, crack, marijuana, alcohol, and solvents, and assess for a hierarchy of preference within these categories. Also, future research could gather data about the respondents' prior contact with substance abuse as well as social/familial contact or educational experiences. Cocaine users may have a different view on cocaine users than other respondents. If this is the case, training modules can be used to address this. Likewise, areas such as ex-offenders can be categorized (e.g., white collar crime, rape, incest, specific murder types, etc.) and addressed. Hence, with a thorough understanding of the respondents' background, relationships can be assessed between these and preference toward disabilities. With more specific types of information, training modules can be developed accordingly.

Table 1

Disability Hierarchy Means of Total Sample (N=125) Utilizing 8-point Likert scale

Rank	Disability	Mean
1.	Person who has an ulcer	2.00
2.	Person who uses crutches	2.15
3.	Person who has a stomach disorder	2.20
4.	Person who has heart disease	2.23
5.	Person who has a visual impairment or is blind	2.25
6.	Person who is short statured	2.26
7.	Person who has a kidney disorder	2.31
8.	Person who is deaf or hard of hearing	2.32
9.	Person who has had a stroke	2.33
10.	Person who has an amputation	2.35
11.	Person who has cancer	2.35
12.	Person who uses a wheelchair	2.35
13.	Person who has a respiratory condition	2.35
14.	Person who has spinal curvature	2.41
15.	Person who has a learning disorder	2.46
16.	Person who has spinal cord injury	2.56
17.	Person who has a skin disorder	2.58
18.	Person who is over 65 years of age	2.59
19.	Person who has chronic pain	2.60
20.	Person who has a musculoskeletal disorder	2.62
21.	Person who has epilepsy	2.65
22.	Person who has Parkinson's disease	2.66
23.	Person who has a seizure disorder	2.70
24.	Person who has multiple sclerosis	2.73
25.	Person who has depression	2.76
26.	Person who has cerebral palsy	2.80
27.	Person who has muscular dystrophy	2.84
28.	Person who has Trisomy 21 (Down Syndrome)	2.91
29.	Person who has autism	2.92
30.	Person who has mental retardation	3.00
31.	Person who has traumatic brain injury (TBI)	3.01
32.	Person who has depression and mania	3.21
33.	Person who has a behavior disorder	3.28
34.	Person who is identified as having alcoholism	3.44
35.	Person who has human immunodeficiency virus (HIV)	3.47
36.	Person who has tuberculosis	3.49
37.	Person who has acquired immunodeficiency syndrome (AIDS)	3.54
38.	Person who is identified as having other chemical dependency	3.88
39.	Person who has schizophrenia	3.95
40.	Person who is an ex-offender	4.55

Note: A higher mean indicates greater social distance

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Appendix

Person-First Disability Language Scale (PFDS)

Participation in this survey is voluntary. You may elect not to participate or drop out at any time with no penalties. The results of your survey will remain anonymous. Thank you for your participation.

Age _____ Gender M____ F____

INSTRUCTIONS: There are many degrees of understanding that may exist between persons. Some of these relationships are listed below in order of closeness, with *number 1 describing the closest relationship and number 8 the most distant relationship.*

Which item on the scale below best describes the closest relationship you feel toward each disability group listed below? Next to each disability, circle the number of the item on the scale that describes the closest relationship you would be willing to have with persons with a disability.

1	**2**	**3**	**4**	**5**	**6**	**7**	**8**
Would Marry	Would accept as a close kin by marriage	Would have as a next door neighbor	Would accept as a casual friend	Would accept as a fellow employee	Would keep away from	Would keep in an institution	Would send out of my country

Circle one:

1.	Person who is identified as having alcoholism	1	2	3	4	5	6	7	8
2.	Person who is identified as having other chemical dependency	1	2	3	4	5	6	7	8
3.	Person who is over 65 years of age	1	2	3	4	5	6	7	8
4.	Person who is an ex-offender	1	2	3	4	5	6	7	8
5.	Person who has tuberculosis	1	2	3	4	5	6	7	8
6.	Person who is hard of hearing or deaf	1	2	3	4	5	6	7	8
7.	Person who has spinal cord injury	1	2	3	4	5	6	7	8
8.	Person who has cancer	1	2	3	4	5	6	7	8
9.	Person who has spinal curvature	1	2	3	4	5	6	7	8

	1 Would Marry	2 Would accept as a close kin by marriage	3 Would have as a next door neighbor	4 Would accept as a casual friend	5 Would accept as a fellow employee	6 Would keep away from	7 Would keep in an institution	8 Would send out of my country
Circle one:								
10. Person who has an amputation	1	2	3	4	5	6	7	8
11. Person who is short statured	1	2	3	4	5	6	7	8
12. Person who has a visual impairment or is blind	1	2	3	4	5	6	7	8
13. Person who has heart disease	1	2	3	4	5	6	7	8
14. Person who has an ulcer	1	2	3	4	5	6	7	8
15. Person who has acquired immune deficiency syndrome (AIDS)	1	2	3	4	5	6	7	8
16. Person who has human immunodeficiency virus (HIV)	1	2	3	4	5	6	7	8
17. Person who has a seizure disorder	1	2	3	4	5	6	7	8
18. Person who has schizophrenia	1	2	3	4	5	6	7	8
19. Person who has muscular dystrophy	1	2	3	4	5	6	7	8
20. Person who has multiple sclerosis	1	2	3	4	5	6	7	8
21. Person who has depression	1	2	3	4	5	6	7	8
22. Person who has depression and mania (bipolar disorder)	1	2	3	4	5	6	7	8
23. Person who has chronic pain	1	2	3	4	5	6	7	8
24. Person who uses a wheelchair	1	2	3	4	5	6	7	8
25. Person who uses crutches	1	2	3	4	5	6	7	8
26. Person who has a behavior disorder	1	2	3	4	5	6	7	8
27. Person who has a learning disorder	1	2	3	4	5	6	7	8
28. Person who has a respiratory condition	1	2	3	4	5	6	7	8
29. Person who has a kidney disorder	1	2	3	4	5	6	7	8

	1 Would Marry	**2** Would accept as a close kin by marriage	**3** Would have as a next door neighbor	**4** Would accept as a casual friend	**5** Would accept as a fellow employee	**6** Would keep away from	**7** Would keep in an institution	**8** Would send out of my country

Circle one:

30. Person who has a stomach disorder	1	2	3	4	5	6	7	8
31. Person who has a skin disorder	1	2	3	4	5	6	7	8
32. Person who has a musculoskeletal disorder	1	2	3	4	5	6	7	8
33. Person who has Parkinson's disease	1	2	3	4	5	6	7	8
34. Person who has had a stroke	1	2	3	4	5	6	7	8
35. Person who has autism	1	2	3	4	5	6	7	8
36. Person who has mental retardation	1	2	3	4	5	6	7	8
37. Person who has epilepsy	1	2	3	4	5	6	7	8
38. Person who has Trisomy 21 (Down Syndrome)	1	2	3	4	5	6	7	8
39. Person who has cerebral palsy	1	2	3	4	5	6	7	8
40. Person who has traumatic brain injury (TBI)	1	2	3	4	5	6	7	8