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Effects of Disability Status and Introduction of an Attitudinal Prompt on Therapists' Projections of Client Self-Esteem

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LOYOLA UNIVERSITY CHICAGO

EFFECTS OF DISABILITY STATUS AND INTRODUCTION
OF AN ATTITUDINAL PROMPT ON THERAPISTS'
PROJECTIONS OF CLIENT SELF-ESTEEM

A DISSERTATION SUBMITTED TO
THE FACULTY OF THE GRADUATE SCHOOL
IN CANDIDACY FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY
DEPARTMENT OF COUNSELING PSYCHOLOGY

BY

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CHICAGO, ILLINOIS

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CHAPTER I

INTRODUCTION

According to the U. S. Bureau of the Census, (1993) 48.9 million persons or 19.4% of the general population was disabled in 1990. Those with a "severe" disability; i.e. defined as an inability to perform one or more functional activities or socially determined roles or tasks, numbered 24.1 million or 9.6% of the general population.

The census data further suggested non-significant variations in the incidence of disabilities among racial and ethnic groups. This lack of variability was attributed to the underrepresentation of African-American males and to significant variations in age composition across the various populations. Disability rates among Caucasians were reported as 19.7%, African-Americans 20.0%, and American Indians, Eskimos, and Aleuts 21.9%. Conversely, the disability rate of 15.3% reported among persons of Hispanic origin was lower than that of the aforementioned groups while higher than that of 9.9% observed among Asians and Pacific Islanders. Given the preceding figures, it would appear likely that many therapists have or will at some point become engaged in clinical work with a disabled client.

However, in their efforts to establish and maintain a

meaningful therapeutic relationship with visibly disabled clients, clinicians may encounter significant and unanticipated barriers to therapeutic effectiveness. This premise was introduced and addressed in a 1975 policy statement issued by Division 22 of the American Psychological Association (APA) which recognized the potentially unique clinical demands presented to therapists by disabled clients. Greengross (1980), Freeman, (1993), and Esten (1993) asserted that the therapist's value systems and subconscious attitudes are frequently tested by the considerations and challenges encountered in clinical work with disabled clients.

Assuming for the moment that disabled persons do in fact uniquely challenge the therapist's clinical effectiveness; What is the nature of these unique demands? From where might these demands emanate? and How might they best be addressed or circumvented? Presented here is perhaps partial support for the notion that clients with disabilities present to their therapists rare and subtle demands within the therapeutic process.

The first potential therapeutic impediment may arise from the possibility that disabled clients, due directly and largely to their physical status, may bring to the therapeutic relationship, secondary yet integral issues which may confound both assessment and therapy. For example, aside from the psychological implications

associated with the possession of a disability, persons with disabilities often confront numerous secondary difficulties including substantial under or unemployment. According to the 1990 census, persons with a vocation related disability numbered 19.5 million or 11.6% of the general working age population. Likewise, 14.9 million persons between the ages of 16 and 64 were classified as "work disabled" and of this figure, 8.4 million were "severely" work impaired. As a result, in 1990, employment rates for those with mild and severe disabilities were 76.0% and 23.2% respectively. Conversely, the employment rate for able-bodied persons was 80.5%.

The census data not only indicated that an inverse relationship existed between disability status and level of earnings but that persons with low incomes are significantly more likely to be disabled than are their more affluent counterparts. The data also revealed a strong inverse relationship between the number of years of formal education completed and the likelihood of having a disability. For instance, in the 25-64 age group, the incidence of a severe disability was 22.8% among persons who had not completed high school; 8.7% among high school graduates; 6.3% among persons who had attended some college; and 3.2% among college graduates. A similar pattern was noted for those persons 65 years of age and older. Among adults with disabilities, 12.6% held college degrees as compared to

20.3% among their able-bodied cohorts.

The likelihood of having a disability rises dramatically with increasing age. The survey data indicated a disability prevalence rate which rises from 5.8% among those under 18 through 44.6% among persons between 65 and 74 to a level of 84.2% among persons 85 years of age and older. Among persons with disabilities, the likelihood that a disability will be severe increases directly with age.

In short, the therapist who engages in a clinical relationship with a disabled client may well encounter numerous issues ancillary yet integral to the medical phenomena of disability. Issues of under and unemployment, education, aging, living standards, housing, and transportation will likely intermingle with and complicate the more tangible and visible physical condition.

A second potential hinderance to therapeutic efficacy springs from the pervasiveness and intensity of ambivalent societal and individual attitudes towards disabilities. Such attitudes not only influence the client and clinician as individuals but may surface in the dynamics of the therapeutic relationship as well. As noted by Greenberg (1974), Katz, Shurka, and Florian (1978), Rogers, Thurer, and Pelletier (1986), and Thurer and Rogers (1984), prevailing negative societal attitudes toward persons with disabilities are often internalized and mirrored in the self-perceptions of disabled persons themselves.

Similarly, Sinick (1981) maintained that prejudice is frequently encountered by disabled clients through the therapist's categorization of disabled people into stereotypic "families", by the inadvertent encouraging of client's helplessness and powerlessness, and by the inappropriate attribution of psychopathology to clients with disabilities. Tolor and Geller (1987) argued that psychotherapists often possessed disability specific attitudes toward children with physical impairments which may adversely influence their effectiveness with this population. Dickert (1988) determined that even those therapists most familiar with deaf psychiatric inpatients were inordinately influenced by their hearing impaired status. Finally, Elliott, Frank, and Brownlee-Duffeck (1988) suggested that people with disabilities are "expected" to mourn their condition; yet it is unclear if and how such expectations might influence therapists' inferences regarding the disabled person's emotional adjustment.

In sum, it appears possible that both client and therapist may enter therapy with preconceptions concerning the presence, nature, and magnitude of clinically relevant disability related issues. Such disparities in expectation and perspective may complicate and delay clinical progress if not preclude meaningful therapy.

A third potential barrier to therapeutic effectiveness

with disabled clients may arise from the therapist's potential reluctance to engage in a full and genuine exploration of his or her prejudices toward persons with disabilities. The therapist's cognitive and affective receptivity to disability related information and a willingness to examine and share, when appropriate, associated emotions may well be critical to the establishment of a meaningful rapport and the maintenance of an effective therapeutic relationship.

Although outcome studies addressing such issues are quite limited, Krauft, Rubin, Cook, and Bozarth (1976) found that counselor attitude toward disability was directly correlated with rehabilitation success. Likewise, Krausz (1980) noted that the therapist's attitude toward disability profoundly influenced the client's ascription of meaning to an impairment. Spear and Schoepke (1981) in a review of APA (American Psychological Association) Clinical and Counseling programs determined that psychotherapists' marginal awareness of legal and professional mandates, lack of familiarity with course work relating to disabilities, and limited knowledge of psychological aspects of disability may hamper their clinical effectiveness with disabled persons.

Given the apparent depth and prevalence of society's stereotypes and attributes regarding persons with disabilities, it appears reasonable to question the extent to which individuals trained and employed as therapists are

immune from such attitudes. A number of researchers have addressed this question and their findings provide both cause for optimism and concern. While it appears that professionals in the "helping professions" generally possess more favorable attitudes toward persons with disabilities than do members of alternative occupations, the research literature suggests that helping professionals nevertheless engage in attributional and stereotypic thinking similar to that of society-at-large. However, helping professionals, due in part to their educational training and occupational status, may be best equipped to either support the perceived validity of their personal biases or alternatively to recognize the wisdom of monitoring and concealing such attitudes.

At the foundation of the present study is the belief that clinicians involved in psychotherapy with disabled persons must be aware of the nature and depth of their personal biases, perceptions, and attitudes towards people with disabilities in order to realize maximum therapeutic movement. Awareness of and sensitivity to the realistic impact of a disability upon the psychological well-being of disabled clients may be central to effective therapy with this population.

However, given the relative transparency of many disability related attitudinal measures in combination with the "test wiseness" of psychotherapists, empirical evidence

relating to clinician's biases towards people with disabilities is suspect. Therefore, it is hoped that through this study; with its utilization of an alternative and indirect strategy for assessing psychotherapists' disability related attitudes, that the presence, extent, and nature of potential prejudices will be more adequately illuminated. If, in fact, therapists possess negative or ambivalent attitudes towards persons with disabilities and are unaware or actively deny the existence of such, the clinical implications for disabled clients whom they purport to serve are potentially immense.

The following research questions will be addressed in the present study:

1. To what extent if any will psychotherapists differentially project the self-esteem of a hypothetically disabled client based solely upon the possession of a disability?
2. Will therapists who are directed to complete an attitude towards disability scale prior to completing a self-esteem measure for a hypothetically disabled client project significantly higher self-esteem scores than therapists not completing the attitudinal measure?
3. Will clinicians who project the self-esteem of hypothetically disabled clients report significantly higher scores than those who estimate self-esteem for able-bodied clients?

4. Is the amount and/or type of disability related training to which therapists are exposed significantly associated with more favorable self-esteem estimates and/or higher attitude towards disability scores?

Responses to the above questions will not only suggest the depth and directionality of therapists' attributions toward persons with disabilities but will as well reveal the impact of a relatively transparent attitude measure upon therapist's projected self-esteem scores. Psychotherapists' performance on disability related attitude measures as compared with normative samples and those in alternative helping professions may provide additional insight into the degree to which societal biases have been internalized by the profession. Of equal if not greater importance is the degree of congruence between the attributions of clinicians and the self-perceptions of disabled persons regarding issues of self-esteem. Finally, the influence of both disability related academic and applied training upon clinician attitudes as reflected in their attributions and attitudes towards persons with disabilities can be further examined.

CHAPTER II
LITERATURE REVIEW

Limitations of Attitudinal Research Regarding
Persons with Disabilities

The assessment and interpretation of societal and individual attitudes toward persons with disabilities has historically proven problematic. McConkey (1988) identified four difficulties inherent in such research: (1) representativeness of samples, (2) type of instrumentation adopted, (3) verification of instrument reliability, and (4) the equating of expressed attitude with subsequent behavior. As a result, attitudes of and about persons with disabilities must often be inferred as much as measured.

In an effort to minimize psychometric and methodological deficiencies, researchers have developed a variety of innovative and diverse methods for assessing attitudes toward persons with disabilities. DeVenney and Stratford (1983) maintained that such investigations can be classified into three broad categories: picture ranking, sociometric studies, and questionnaires. However, regardless of the methodology adopted, investigators have frequently encountered significant and persisting difficulties in their efforts to obtain both meaningful and defensible results.

One limitation inherent in attitude toward disability measures is social desirability or differential and predictable responding to items with socially desirable or undesirable scale values. This response set has received considerable attention from developers and consumers of psychometric instruments yet its prevalence and impact remains contested.

The debate concerning social desirability in generic self-report measures has also been noted in attitude toward disability scales. The ATDP (Attitude Toward Disabled Persons Scale) (Yuker, Block & Young, 1960) has been scrutinized for the presence of social desirability in several studies.

Vargo and Semple (1984) directed students to answer the ATDP in a socially desirable fashion and found that "fake scores" were significantly higher than "honest" scores. Cannon and Szuhay (1986) found that rehabilitation counseling students, instructed to "fake good", subsequently achieved significantly elevated scores. Yuker (1986) examined the ATDP for evidence of social desirability and found that there is evidence that the scale is and is not fakable. This author suggested that the instrument may nevertheless be useful in illuminating an individual's awareness of components of "positive" attitudes toward disabled persons. Finally, Hagler, Vargo, and Semple (1987), utilizing the ATDP under directions to answer twice,

once honestly and second in a socially desirable manner, reported that "Fake" scores were significantly higher than "honest" scores.

Efforts to assess attitudes of the non-disabled towards persons with disabilities using self-report measures and to derive defensible results have proven problematic. Accordingly, in this study, primary reliance upon such instrumentation has been rejected in favor of a more indirect approach to the assessment of therapists' attitudes.

Societal and Individual Attitudes Toward Persons with Disabilities

Despite the research limitations noted above, numerous investigators have proffered their observations regarding the attitudinal environment encountered by people with disabilities. Although the etiology of societal attitudes remains contested, central to many theories is the role of society in creating and defining disabilities. Society's capacity to handicap those with disabilities was suggested in an investigation by Antonak (1985) wherein 66% of human service providers endorsed the notion that society further disables those who are physically impaired.

Hahn (1984) argued that discriminatory attitudes encountered by persons with disabilities originate from their status as members of a minority group. Wertlieb (1985) asserted that people with disabilities comprise a

organizations which restrict access by persons with disabilities. Schlaff (1993) asserted that attitudes toward the disabled are reflected in governmental policies based on medical, economic, and sociopolitical models. Finally, Law and Dunn (1993a; 1993b) and Cintas (1993) regarded a disability as the byproduct of a maladaptive relationship between the disabled individual and the environment.

Several authors persist in their belief that despite legislative mandates, disabled people remain essentially subjugated and segregated. Thoreson and Kerr (1978) and Hastings (1981) maintained that attitudes toward and treatment of people with disabilities remains essentially negative. Likewise, DeJong and Lifchez (1983) observed that despite the implementation of legislation, numerous and significant attitudinal barriers continue to exist.

Attitudinal Ambivalence Toward Persons with Disabilities

Wright (1974) maintained that attitudinal ambivalence contributes directly to the variability of attributions ascribed to persons with disabilities. Thus, despite the accumulation of a considerable body of evidence documenting the existence of negative attitudes toward persons with disabilities, the research literature simultaneously contains numerous studies which suggest that public attitudes are favorable. Thus, people with disabilities have been revered and regarded as possessing great courage and unique insights while simultaneously devalued as

inferior and to be avoided.

One explanation for attitudinal ambivalence lies in the multidimensionality or "contextual" framework associated with the evaluation. Shurka and Katz (1982) argued that the mere presence of a disability was insufficient to explain evaluative responses of the nondisabled. Rather, variables associated with both disabled and able-bodied parties interact with the impairment, shaping the direction and intensity of the evaluation.

Zych and Bolton (1972) maintained that distinctions between affective and cognitive components previously observed in attitudes toward racial minorities are operative in biases towards persons with disabilities. Similarly, Fichten, Tagalakis, and Amsel (1989) investigated affective and cognitive modeling may be ineffective in altering aspects of affectively based interactions.

Another potential source of attitudinal ambivalence arises from a lack of consensus regarding the construct under investigation. Coet and Tindall (1974) and Coet and Thornton (1975) found that definitions of the term "handicap" varied significantly according to age and sex of the evaluator. Makas (1988) asserted that disabled and able-bodied persons may hold distinctly different perceptions concerning constituents of positive and negative attitudes.

People with disabilities have situationally been

avored over their nondisabled counterparts and attributed with positive characteristics which appear to emanate directly from the possession of a disability. Comer and Piliavin (1975) examined evaluative responses of physically normal as well as recently and chronically disabled persons to individuals with disabilities and reported that the attitudes of the nondisabled were consistently more favorable to the disabled than the able-bodied. Baker, Dimarco, and Scott (1975) observed that blind workers were rewarded significantly more for work identical to that of their sighted co-workers. Mallinckrodt and Helms (1986) found that counselors with disabilities were situationally rated as significantly more expert and attractive than their non-disabled cohorts. Similarly, Carver, Glass, and Katz (1978) reported that subjects in an impression formation exercise rated interviewees more favorably if they were designated as "African-American" or "physically disabled" than if not labeled.

McKay, Dowd, and Rollin (1982) determined that "high influence" counselors who were disabled were rated much more positively than their non-disabled peers. Czajka and Denisi (1988) found that subjects absent clear performance standards rated disabled workers significantly higher than those believed to be nondisabled. Pfeiffer and Kassaye (1991) reported that students evaluated a hypothetically disabled instructor more positively than one presented as

nondisabled. Nosek, Fuhrer, and Hughes (1991) concluded that counselors with disabilities were preferred over those without disabilities.

Conversely, persons with disabilities have experienced isolation, rejection, and stereotypic treatment largely as a result of their impairments. Hastorf, Northcraft, and Picciotto (1979) determined that performance feedback provided to disabled subjects by nondisabled cohorts was artificially favorable. Juni and Roth (1981) concluded that women and disabled persons were condescendingly viewed as needy and requiring supplemental assistance. Stainback and Stainback (1982) assessed knowledge and attitudes of able-bodied elementary age children toward special needs peers and found that although nondisabled students reported understanding their disabled cohorts, they attributed to them more negative characteristics.

Thompson (1982) concluded that persons with disabilities received less eye contact and heightened stares from the able-bodied public and were avoided where possible. Fish and Smith (1983) determined that disabled counselors were regarded as significantly less effective than their able-bodied peers. Similarly, Russell et al. (1985) found that disabled students were evaluated more negatively than the nondisabled for identical levels of performance.

Fichten, Robillard, Judd, and Amsel (1989) found that nondisabled undergraduates felt less comfortable with

disabled than able-bodied students. Fichten, Goodrick, Amsel, and McKenzie (1991) determined that undergraduates were less likely to date visually impaired than sighted students, to feel less comfortable doing so, and disapproved of such dating behaviors in their friends. Finally, Rienzi, Levinson, and Scrams (1992) determined that one's status as hearing impaired negatively influenced perceived suitability as adoptive parents.

Preference Studies

Societal attitudes towards disabilities in general and the rank ordering of particular impairments have been evident in preference studies wherein the relative acceptability of specific disabilities are examined. Numerous investigators have documented public preferences for particular disabilities and have argued for their uniformity and stability. Related studies have investigated societal preferences for "categories" of disabilities. A brief review of these studies illustrates the breadth of occupations and disabilities scrutinized.

Richardson and Ronald (1977) reported the existence of a stable disability preference among children. Horne (1978) examined cultural influences upon attitudes towards disabilities and reported the presence of a moderately stable disability acceptance hierarchy. Conant and Budoff (1983) questioned nondisabled children and adults concerning their perceptions of a variety of disabling conditions and

discovered that psychological disturbance was regarded as the most difficult disability followed by mental retardation, orthopedic disabilities, and sensory limitations. Richardson (1983) reported that children exhibit a stable order of preference for nondisabled peers and that particular disabilities are favored over others regardless of disability specific information or contact.

Horne and Ricciardo (1988) determined that disability hierarchies remained intact over time (13 years) and geographical location. Campbell, Cull, and Hardy (1986) found that disabled persons regarded themselves as less disabled and more fortunate than individuals with alternative disabilities. Thus, it appears that both children and adults possess and express a preference for particular disabilities and that this preference may well persist over time.

Several investigators have examined the public's preference for general "categories" of disabilities. Harasymiw, Horne, and Lewis (1976) reported a highly stable and descending order of preference for physical, sensory, psychogenic, and social disabilities. These researchers concluded that the least limiting disabilities were the most accepted while the "self-imposed" disabilities (chemical dependency) were least preferred. Gottlieb and Gottlieb (1977) found that among junior high students, physical disabilities were preferred over mental deficiencies.

Abroms and Kodera (1978; 1979) factor analyzed subject's preferences and concluded that organic impairments responsive to medical treatment were regarded as most acceptable while psychoeducational or functional impairments were least accepted.

Miller, Armstrong, and Hagan (1981) found that third and fifth grade students exhibited a disability preference hierarchy with mental retardation least accepted. Furnham and Pendred (1983) concluded that physically disabled persons were consistently regarded as more acceptable than persons with mental disabilities regardless of rater's gender or familiarity with the disability. Goodyear (1983) reported that more positive attributes are ascribed to persons with physical disabilities than to those with social or emotional impairments. Thus it would appear from a synopsis of the literature that preferences for particular disability categories and specific impairments exist wherein physical disabilities are preferred over emotional and/or mental handicaps

Inferences About People With Disabilities

Attitudes toward persons with disabilities have been inferred by examining some of the stereotypes commonly held by persons who are able-bodied. Frequently in such studies, the possession of an impairment is systematically manipulated in order to determine its impact upon attributions.

Weinberg (1976) examined the characteristics attributed to disabled persons and concluded that the disabled are stereotypically regarded as different and lacking in qualities of a "liked" person. Blood, Blood, and Danhauer (1978) examined the relationship between speech of hearing impaired children and ratings on competency measures by college students and found that the more profound the hearing loss and conspicuous the hearing aid, the greater the number of negative attributes assigned. Robillard and Fichten (1983) reported that physically disabled students were perceived as more socially anxious, less gender role stereotyped, and less likely to be dating than able-bodied peers.

Fichten, Compton, and Amsel (1985) found considerable variability in the responses of able-bodied students asked to predict activity preferences of persons with disabilities. Gething (1992) introduced disability as a personal characteristic within a biographical profile and found that a wheelchair variable negatively influenced judgements of social and psychological adjustment as well as impressions of competence and capability.

Even parents of children with disabilities do not appear immune from application of dual expectations of their disabled children. Harvey and Greenway (1982) compared responses of mothers and their disabled children on a personal attribute inventory and determined that

discrepancies were related to the child's diagnostic label. Coleman (1983) asked mothers of mildly handicapped and non-handicapped children to complete self-concept measures as they would anticipate their children would and reported that mothers of disabled children consistently underestimated while those of the nondisabled overestimated their children's results. Conversely, Beckman (1984) found that professionals and mothers were consistent in their assessment of the functioning of disabled children except in those areas where parents had significantly greater access to observation.

Gething (1985) concluded that persons with Cerebral Palsy regarded difficulties which they encountered as less severe than did their relatives and able-bodied peers. Clark (1987) compared mothers and fathers ratings of their disabled child's cognitive and personality characteristics and determined that although parents generally concurred in their judgements, that mothers consistently exaggerated the severity of difficulties experienced by their children. McLoughlin, Clark, Mauck, and Petrosko (1987) examined perceptions of disabled adolescents and their parents concerning severity of their disability and its implications and concluded that parents amplified the disability, its implications, and expressed lowered expectations for their children.

Yuker (1988) found that maternal perceptions of their

disabled child were generally inaccurate and not shared by teachers, rehabilitation professionals, or their disabled children. Lewis and Lawrence (1989) compared locus of control perceptions of teachers, parents, and disabled children and found that teachers attributed to the disabled student a significantly greater number of internally generated success experiences than did either parents or disabled children.

Chiu (1990) assessed self-esteem among children classified as either gifted, "normal", or mildly mentally handicapped. Teachers as well completed self-esteem estimates for each population. Results indicated that the mildly mentally handicapped presented significantly lower self-esteem profiles than did nondisabled groups and that teacher ratings paralleled those of the children.

Sexton, Thompson, Perez, and Rheams (1990) compared judgements of mothers regarding the developmental status of their disabled child with independent assessments. These investigators found maternal judgements to be consistently inflated across developmental domains. Finally, Montgomery (1994) asked learning disabled children, parents and teachers to rate self-concepts of disabled students across a variety of dimensions. Teachers underestimated self-concepts of the learning disabled and the able-bodied but overestimated that of high achievers. Conversely, parents' self-concept ratings for the high achievers and learning

disabled paralleled those reported by their children. Thus, such studies suggest that the nondisabled attribute to those with disabilities levels of self-concept which are often inaccurate regardless of the degree of familiarity.

Reactions of the Nondisabled to Persons With Disabilities

Societal and individual attitudes toward people with disabilities are further illuminated in studies investigating reactions of the non-disabled to persons with disabilities. Vander-Kolk (1976) analyzed subjects' vocal patterns when verbalizing lists of disabling conditions for signs of discomfort and found that negative reactions to the disabled involve a physiological component which may emanate from a perceived threat to one's self-image.

Sigelman, Adams, Meeks, and Purcell (1986) argued that the public's elevated attentiveness to persons with visible physical disabilities springs more from an interest in than an aversion to those with impairments. Stephens and Clark (1987) monitored proximity patterns among students in college classrooms and discovered that greater distance existed between students with a visible disability and the nondisabled than among students with no visible disability.

Haley and Hood (1986) studied adolescent reactions to peers wearing hearing aids and found support for a "hearing aid" effect which appeared to result in differential perceptions of the hearing impaired by raters. Based upon the results of such studies, it appears that persons with

disabilities encounter negative reactions which are not experienced by their able-bodied peers.

Attitudes of the Helping Professions Toward
Persons with Disabilities

Given the apparent depth and prevalence of society's stereotypes regarding persons with disabilities, it appears reasonable to question the extent to which helping professionals share or are immune from such attitudes. A number of researchers have addressed this question and their findings provide cause for optimism and concern.

It appears that helping professionals generally possess more favorable attitudes toward the disabled than do members of alternative occupations yet educators, health care workers, and mental health professionals apparently engage in stereotypic thinking similar to that of society at large. Unfortunately, helping professionals may be best equipped to support and perpetuate the perceived validity of their biases or alternatively to recognize the wisdom of monitoring and containing such views. The potential impact of stereotypic attitudes upon the disabled may be enhanced by the education and status of many helping professionals. The citations which follow suggest the intransigence, variety, and pervasiveness of biases documented within the helping professions.

Mason and Muhlenkamp (1976) found that care-givers were frequently unable to accurately predict the affective state

of their patients, often exaggerating levels of anxiety, depression, and hostility. Parish and Copeland (1978) found that teachers felt that disabled students would evaluate themselves more negatively than their nondisabled peers. Green, Kappes, and Parish (1979) reported that educators generally perceive students with disabilities less favorably than able-bodied children.

Danhauer, Blood, Blood, and Gomez (1980) reported that professional and lay observers rated children significantly lower on achievement when a hearing aid was present although professional ratings appeared less sensitive to the device. Greengross (1980), Freeman (1993), and Esten (1993) asserted that therapists' value systems and subconscious attitudes are frequently challenged by the unique considerations encountered in clinical work with disabled clients. Eberly, Eberly, and Wright (1981) reported that although rehabilitation counseling students chose significantly more positive adjectives to describe disabled persons, they nevertheless preferred to work with the nondisabled. Sinick (1981) maintained that clinical prejudice is frequently encountered by disabled clients through the therapists' categorization of disabled people into stereotypic families, by inadvertently encouraging helplessness, and by the attribution of psychopathology through therapist projection.

Leyser and Abrams (1982) reported a preference hierarchy among teachers for "normal" and gifted students

followed by those with sensory and physical disabilities. Blood and Blood (1982) concluded that classroom teachers evaluated students with hearing aids more negatively than their able-bodied peers. Martin, Scalia, Gay, and Wolfe (1982) reported that disability related attitudes of beginning rehabilitation counselors were positive and that counselors holding degrees in Rehabilitation possessed significantly more favorable attitudes than those with alternative degrees. However these researchers also noted that with increasing age and experience, positive attitudes diminished.

Gargiulo and Yonker (1983) assessed attitudes of educators toward teaching the special needs pupil and discovered that self-report measures of acceptance were periodically contradicted by physiological indicators. Meadow and Dyssegaard (1983) asked American and Danish teachers to predict adjustment of disabled pupils and determined that teachers were nearly identical in their assessments regarding disabled students as lacking in motivation, independence, and initiative while viewing them as kind and non-aggressive. Elson and Snow (1986) found that level of education, amount of work experience, and presence of a disability were not significantly related to attitudes.

Yuker (1986) determined that attitudes of mental health professionals towards disabled persons were more positive

than those reported by psychiatrists and less educated persons. Flynn, Reeves, Speake, and Whelan (1986) reported that less than half of mental health staff's estimates of the moral awareness of their mentally retarded charges were correct and that familiarity with the patient did not significantly enhance the accuracy of predictions. Tolor and Geller (1987) suggested that psychologists possessed disability specific attitudes toward children with impairments which may influence their effectiveness with this population. Dickert (1988) determined that therapists who worked regularly with hearing impaired patients had more favorable attitudes toward the deaf than did those with limited exposure, yet they nevertheless assessed these patients differently than their hearing charges.

Cardell and Parmar (1988) determined that teachers of the learning disabled consistently evidenced more negative perceptions of their students than did teachers of the able-bodied. Elliott, Frank, and Brownlee-Duffeck (1988) asserted that people with disabilities are expected to mourn their loss and experience depression yet it is unclear if and how such expectations influence therapists' inferences concerning emotional adjustment and functioning. Tripp (1988) reported that Physical Education and Adaptive Physical Education instructors exhibited a preference for physically disabled students in contrast to the mentally or emotionally impaired. Clark, Reed, and Sturmey (1991) found

that staff perceptions of sadness among their mentally handicapped hospital residents were often inaccurate. Huitt and Elston (1991) found that school, mental health, and rehabilitation counselors held similar positive attitudes toward persons with disabilities.

Elliott, Hanzlik, and Gliner (1992) reported that attitudes of registered Occupational Therapists and Certified Occupational Therapy assistants were generally positive toward hypothetically disabled co-workers. Field, Hoffman, St. Peter, and Sawilowsky (1992) determined that teacher perceptions of self-determination were significantly lower for disabled students than for those without impairments even when observed behaviors were nearly identical.

Thus, the research literature appears to suggest that helping professionals to some extent share attitudes and assign attributes in ways similar to those of the general public. As a result, mechanisms to effect attitude change have been explored and proposed within the literature.

Disability Related Training and Attitudinal Outcomes

Professional organizations and researchers alike have argued for training regarded as necessary for the provision of meaningful psychological services to persons with disabilities. However, the research literature provides conflicting evidence as to the efficacy of training and targeted curricula in promoting more favorable attitudes.

Felton (1975) asserted that individuals preparing for professional health care worker positions realized significant increases in objective measures of attitudes toward disabled persons after one year of training. Crunk and Allen (1977) detected significant differences in attitudes toward the disabled among five educational levels in training for vocational rehabilitation. Parish, Eads, Reece, and Piscitello (1977) examined the attitudes of future teachers toward three diagnostic labels before and after one year of coursework and found no significant alteration in attitudes.

Gosse and Sheppard (1979) determined that as years of education increased, attitudes toward those with disabilities became more positive. Clark (1979) reported no significant difference in disability related attitudes between rehabilitation graduate students with and without field experience. McDaniel (1982) detected positive alterations in attitudes toward the disabled following training and advocated for enhanced instruction of vocational teachers. Wolraich and Siperstein (1983) maintained that variability in attitudes toward the disabled among graduates of various disciplines could, in part, be attributed to differential training.

Leyser and Abrams (1983) concluded that "mainstreaming" training was effective in enhancing attitudes towards those with disabilities among elementary education majors. Asmus

and Galloway (1985) found no significant correlation between attitudes towards people with disabilities and educational degree, type of contact, or academic class. Kirchman (1987) reported that attitudes of undergraduate students toward the disabled improved over a one year period due in part to disability related instruction and independent study.

Patrick (1987) noted a significant increase in positive attitudes toward the disabled by students who participated in an adaptive physical education class. Rowe and Stutts (1987) maintained that the students' disability related attitudes were influenced by previous experience but not by practicum site. Stewart (1990) determined that the quality of a practica experience differentially influenced students' attitudes towards the disabled.

Estes, Deyer, Hansen, and Russell (1991) reported that an Occupational Therapy curriculum appeared to favorably influence students' attitudes toward persons with disabilities. Lyons (1991) found that disability related attitudes of Business and Occupational Therapy majors did not vary significantly regardless of years of undergraduate education. Finally, Lyons and Hayes (1993) advocated for enrichment of curricula as a mechanism to combat preference hierarchies expressed by students.

Sources of Attitudes Toward Persons With Disabilities

While many researchers have chosen to dedicate their research efforts to establishing the nature and prevalence of disability related attitudes, others have opted to examine their etiology. A review of the literature regarding the origin of attitudes toward the disabled reveals little consensus regarding a single or predominant source for such attitudes.

Many of the sources from which attitudes toward the disabled are believed to emanate appear to share a universal human component. Numerous cross-cultural studies have investigated attitudes toward disabled persons within their respective communities and while some variation is to be expected and is noted, attitudes toward the disabled appear to parallel those of the majority culture in the United States (Abang, 1988; Decaro, Dowaliby, & Maruggi 1983; Dshen, 1987; Goerdt, 1986; Hardy, Cull, & Campbell, 1987; Kashyap, 1986; Lane, Mikhail, Reizian, Courtright, et al., 1993; Mardiros, 1989; Margalit, Leyser, & Avraham, 1989; Stratford & Au, 1986; Walker 1983; Westbrook & Legge, 1993; Westbrook, Legge, & Pennay, 1993; Winkelman & Shapiro, 1994).

Despite the apparent universality of many disability related attitudes, numerous researchers have identified and elaborated upon the source and determinants of these attitudes. Livneh (1982) provided a comprehensive overview

of theories pertaining to the genesis of disability related attitudes. Other investigators have proposed more unidimensional explanations for the development and tenor of attitudes toward people with disabilities.

Deegan (1975) maintained that the nondisabled regard possession of a disability as a transitional stage into death. Livneh (1980) argued that two fundamental notions are responsible for attitudes of the nondisabled toward those with atypical physique: an over concern with death and the attribution of infra-human life. Cloerkes and Neubert (1984) theorized that there exists within humankind a fundamental attitude toward exceptional people which is moderated only in part by cultural factors. Montagu (1985) maintained that individuals with visible disabilities evoke threatening and repressed images of a crippled self.

Fransella (1985) asserted that prejudice towards people with disabilities emanates from one's predisposition to generalize about the disabled based upon a single identifiable characteristic. Hahn (1988) emphasized the role of personal appearance and individual autonomy as contributors to the anxiety evoked by persons with disabilities while Bruce and Christiansen (1988) stressed the significance of language as a source of attitudes. Finally, Vargo (1989) identified the culture, bible, and media as primary sources of attitude formation in western societies.

Some researchers have looked to the formative years as a critical period within which attitudes are significantly influenced. Investigators have focused attention upon pre-school children to determine the age at which disability related attitudes may develop (Cohen, Nabors, & Pierce, 1994; Diamond, 1993; Diamond, Le-Furgy & Blass, 1993; Gerber, 1977; Nabors & Morgan, 1993; Popp & Fu, 1981; Thurman & Lewis, 1979; Weinberg, 1978). These researchers maintained that children ages three and four are capable of recognizing their disabled classmates and regard them as different from themselves.

Other developmental studies have focused upon the attitudes and behaviors of elementary school children. Findings by Dengerink and Porter (1984); Parish, Ohlsen, and Parish (1978); Petrusic and Celotta (1985); Wisely and Morgan (1981) indicated that these students are better able to refine their judgements about classmates with disabilities; incorporating contextual variables into the evaluation. Several investigators have considered the impact of maturation upon the valence of disability related attitudes. Degrella and Green (1984); Doherty and Obani (1986); Hazzard (1983); Kratzer and Gall (1990); Obani and Doherty (1986); Royal and Roberts (1987); Sigelman and Begley (1987); and Sigelman, Miller, & Whitworth (1986) have concluded that attitudes toward disabled persons and specific impairments appear to vary with maturation.

Other investigators have examined the role of the electronic and print media as sources of attitudes toward people with disabilities. Byrd, Byrd, and Allen (1977) and Elliott and Byrd (1982) monitored public and commercial prime-time television broadcasts and discovered that representations of the disabled on public television were primarily comedic or dramatic while the disability most frequently presented on commercial networks was that of mental illness.

Taylor (1981) reviewed the literature regarding the media's portrayal of the disabled and concluded that people with disabilities were generally presented in an unfavorable and stereotypic light. Donaldson (1981) analyzed prime-time television programming and determined that persons with disabilities are not particularly visible and concluded that the media likely serves to perpetuate their devalued status.

Hopkins (1982) examined basal texts and discovered that references to people with disabilities are infrequently incorporated within materials. Byrd and Elliott (1985) reviewed current feature films to assess the portrayal of disabled persons and determined that a significant number of films presented people with disabilities unfavorably. Finally, Byrd (1989) in a 20 year retrospective study, analyzed American produced and distributed films and concluded that little progress in the portrayal of disabled characters has been realized.

The Structure of Attitudes Toward Persons with Disabilities

The structure of attitudes toward persons with disabilities has been regarded by some as an integral research issue necessary for the full understanding of disability related attitudes. Despite this assertion, only a limited number of investigators have addressed this topic in a systematic fashion. Several researchers have argued that when measuring and interpreting attitudes toward disabled people, it is crucial to recognize that such attitudes are frequently multi-dimensional

Fichten, Tagalakis, and Amsel (1989) and Zych and Bolton (1972) argued that both cognitive and affective components contribute to the nature of disability related attitudes. Jones (1974) reported the presence of a general factor which transcended disability categories and interpersonal situations and could be differentiated into attitudes toward the physically disabled, psychologically disabled, and mildly retarded. Shurka and Katz (1976) asserted that attitudes towards the disabled are contingent upon both the context of the evaluation and the perceived degree of personal responsibility for the impairment.

Schmelkin (1982, 1984, 1985) maintained that attitudes underlying social distance preferences are multidimensional: comprised of the disability's visibility, the organic vs. functional character of the impairment, and an element of ostracism. Stovall and Sedlacek (1983) reported that

attitudes toward the disabled varied according to disability type and social situation. Cloerkes and Neubert (1984) hypothesized that much of the cross-cultural variability reported in biases toward persons with disabilities could be explained by cultural dimensions of an underlying universal attitude.

Livneh (1985a, 1985b) factor analyzed two attitudinal instruments and reported that each measure was composed of multiple factors which contributed to the valence of a disability. Harper, Wacker, and Cobb (1986) concluded that disability preferences were subject to type of disability, situational context, nature of sample tested, and type of question utilized. Katz, Kravetz, and Karlinsky (1986) reported that source of disability and degree of responsibility for the impairment were significant determinants in disability acceptance. Bordieri and Drehmer (1986, 1987a, 1987b, 1988) determined that attitude toward disability was significantly influenced by disability type and personal culpability.

Dooley and Gliner (1989) reported that generality and specificity of diagnostic labels significantly contributed to acceptance of a disability. Gordon, Minnes, and Holden (1990) and Berry and Jones (1991) supported the multidimensionality of attitudes toward persons with disabilities and the impact of interaction of disability type and situational context. Finally, Sigelman (1991)

maintained that responsibility for the disability and control of its manifestation contributed to its acceptance.

What Do Psychological Studies Suggest About
Persons with Disabilities?

Significant investigative effort has been dedicated to determining some of the psychological implications associated with the possession of a disability. As in other arenas of attitudinal research, findings and subsequent conclusions are at best mixed. Several researchers have concluded that a disability does not significantly elevate the risk of maladjustment while others appear equally convinced of its detrimental impact.

Cook (1976) determined that depression is not an integral component of adjustment to spinal cord injury. Andrews, Platt, Quinn, and Neilson (1977) reported that mental health profiles of men with cerebral palsy were similar to those of the non-disabled. Conversely, Crandell and Streeter (1977) found that blind persons reported a greater degree of hostility and significantly altered relationship histories when compared to sighted persons.

Spergel, Ehrlich, and Glass (1978) rejected the concept of a Rheumatoid Arthritic syndrome yet conceded that there may exist a chronic disease personality. Cook (1979) reported that average anxiety and depression scores of the spinal cord injured fell within normal ranges. Kessler and Milligan (1979) reported significantly higher degrees of

anxiety and lower levels of self-esteem among early onset individuals but noted that the relationship between age of onset and adjustment to disability was non-linear.

Miller and Morgan (1980) examined marriages between individuals with Cerebral Palsy and concluded that their marital lives were comparable to those of the nondisabled. Courington et al. (1983) asserted that many blind persons appeared to internalize stereotypes concerning their disability and perpetuated public misconceptions. Blum (1983) concluded that adolescents with spina bifida were more socially isolated and evidenced diminished self-esteem when compared with their able-bodied peers.

Shindi (1983) investigated the psychological adjustment of congenitally and adventitiously disabled persons and determined that individuals with acquired disabilities evidenced lower self-esteem, diminished happiness and autonomy, and heightened anxiety when compared with the congenitally disabled. Kashani et al. (1983) concluded that approximately half of females and a third of male amputees were clinically depressed. Thurer and Rogers (1984) reported that 75% of the disabled persons whom they interviewed perceived a significant need for mental health services among persons with disabilities.

Rouso (1984, 1993) asserted that congenitally disabled children have great difficulty reconciling societal perceptions of disability with their self-perceptions as

"intact". Weinberg (1984) reported that contrary to expectation, a substantial percentage of disabled persons interviewed indicated that they would not pursue medical procedures even if a guaranteed cure were assured. Similarly, Stensman (1985) found no significant differences between severely mobility impaired individuals and matched controls on self-reported quality of life.

Frank et al. (1985) determined that persons receiving spinal cord injuries face a significant long term risk of depression. Breslau (1985) concluded that children with disabilities presented an increased risk for psychiatric disturbance when compared with their nondisabled peers. Shulman and Rubinroit (1987) speculated that adolescents disabled from birth may be required to stay closer to the family, curtailing their development and individuation.

Frank, Elliott, Corcoran, and Wonderlich (1987) concluded that post injury depression is not a universal phenomena in psychological adjustment. Vesterager, Salomon, and Jagd (1988) found that the self-perception of hearing impaired persons was apparently not influenced by degree of hearing handicap. Druss and Douglas (1988) suggested that "healthy denial" may be an adaptive mechanism enabling the chronically disabled to remain optimistic.

Hickey and Greene (1989) determined that people with chronic disabilities experienced significantly heightened levels of depression and hopelessness when compared with

physically ill and psychiatric inpatient populations. Rogers (1991) concluded that children with disabilities are at greater risk of experiencing emotional distress than their able-bodied peers. Finally, Oberlander (1994) reported that some disabled patients suffer from excessive levels of secondary social anxiety relating to their disfigured or disabling physical conditions.

Disabilities and the Family

The impact of a disability often extends beyond the individual with an impairment to encompass both friend's and family. Often there are implications for family dynamics, interpersonal relationships, and for the content and flavor of messages communicated to the disabled family member. Particularly in the formative years, positive relationships with both family and peers are primary in providing for the foundation of one's self-concept and in strengthening the capacity to deal with negative evaluations.

Winnicott (1972) theorized that the existence of a satisfactory interrelationship between mind and body is prefaced upon positive parental attitudes toward the child's body. Heisler (1974) suggested that the child's adjustment to a disability is often facilitated or limited by parental reaction. Davis (1975) and Ormerod and Huebner (1988) observed that adaptive and maladaptive psychological reactions in parents and siblings invariably accompany disability; defining for the child the significance of the

impairment.

Kitchen (1978) maintained that the child's evaluation of the disabling condition appeared to be closely aligned with that of his or her parent; particularly with that of the mother. Harvey and Greenway (1982) concluded that parents consistent in their primary mood reaction to a disabled child had children whose self-esteem was generally elevated. Bicknell (1983), Power (1985) and Hallum (1993) maintained that the diagnosis of a disability in a child stimulates grief and bereavement and often engenders maladaptive responses within the family.

Seligman (1983) and Atkins (1989) theorized that familial discord is evident in sibling's anxiety concerning transmission of a disability and in repressed familial communication. Harvey and Greenway (1984) determined that global self-esteem scores for disabled children and their siblings were significantly lower than those of the able-bodied and their siblings. Rees, Strom, Wurster, and Goldman (1984) observed that parents of disabled children expressed greater uncertainty about encouraging creativity, reported a greater desire to control behavior, and were more likely to devalue the importance of play.

Maj, Del-Vecchio, and Tata (1987) found that persons with epilepsy regarded their parents as having been over-indulgent, encouraging of passivity, and accepting of lowered standards of behavior. Davis (1987) determined that

mothers of disabled children are expected to mourn their disabled child as a tragedy comparable to death. Wilson, Blacher, and Baker (1989) found that children with younger disabled siblings reported a consistently high level of involvement, strong feelings of responsibility, and an emphasis on positive aspects of family life.

Bischoff and Tingstrom (1991) found no significant differences in behavioral difficulties, social competence, or self-esteem between families with and without a disabled child. Hadadian and Rose (1991) concluded that a significant correlation existed between positive parental attitudes toward deafness and communication skills of their hearing impaired children. Bernbaum, Albert, Duckro, and Merkel (1993) determined that family functioning was significantly compromised by diabetes and blindness. Vision impairment in particular was determined to present a major stressor with totally blind individuals at greatest risk for marital separation. Finally, Saddler, Hillman, and Benjamins (1993) concluded that families with disabled members were comparable in their functioning to nondisabled controls.

The Self-Concept and Self-Esteem of
Persons with Disabilities

One of the primary research interests of investigators concerned with the psychological impact of a disability has been in the arena of self-esteem or the self-concept. The underlying premise in many such studies has been an assumption that due to their unique and persisting life experience, persons with disabilities may develop diminished self-esteem or distinct self-concepts. However, as in other areas of disability related attitudinal research, consensus in researcher's conclusions have remained elusive. A number of correlates including the nature, severity, and chronicity of a disability have been isolated and examined as potential factors influencing the character of self-concept. Inner-personal characteristics such as ethnicity, gender, and chronological maturity have been scrutinized as potential contributors.

Harless and McConnell (1982) reported that individuals who had accepted the use of a hearing aid scored higher in overall self-esteem than did those who had yet to initiate hearing aid use. Patrick (1984) compared veteran and novice wheelchair athletes on self-concept measures and discovered significant differences between groups on acceptance of disability, perceived social adequacy, and consistency of self-perception: with novice athletes receiving the lowest scores.

Several investigators have considered the impact of a disability upon the self-perceptions of children within the classroom context. Sarfaty and Katz (1978) compared the impact of disparate educational environments upon the self-esteem of hearing impaired pupils and determined that students instructed in integrated settings had higher self-esteem than did subjects in special schools. Conversely, Coleman (1983) compared the self-esteem of mildly mentally handicapped children with that of regular class subjects having significant academic difficulty. These investigators found slightly higher self-esteem scores for MMH students and concluded that one's self-esteem depends largely upon social comparison with others in the primary references group.

Kelly and Colangelo (1984) and Colangelo, Kelly, and Schrepfer (1987) examined the academic and social self-concepts of gifted, general, and special learning needs adolescents and determined that gifted subjects tended to score highest and special needs students lowest on all variables. Similarly, Bryan (1986) reported that learning disabled students possess negative self-concepts when questioned about academic performance but do not differ significantly from achieving students in general feelings of self-worth. Finally, Widaman et al. (1992) determined that regular class students held significantly higher self-concept levels on most scales than did students who were

learning handicapped.

Many investigators concerned with the self-esteem of disabled persons have focused attention upon those persons with physical disabilities due to the public nature of their condition. Nelson and Gruver (1978) compared paraplegics, hospitalized tuberculosis patients, and non hospitalized normal subjects on three psychological measures to ascertain the relationship between body image and self-concept. These researchers detected no significant differences between paraplegics and non hospitalized "normal" subjects on any of the dimensions measured.

Anderson (1982) analyzed the relationship between self-esteem and disability in individuals with scoliosis and concluded that subjects with scoliosis did not differ significantly from their able-bodied peers. Ostring and Nieminen (1982) reported that children with Cerebral Palsy had similar body images when compared to their nondisabled peers. Moreover, Beck, Nethercut, Crittenden, and Hewins (1986) explored the potential relationship between the visibility of a disability and both self-image and social maturity in survivors of end stage renal disease. These investigators determined that the visibility of a disability was significantly and inversely correlated with both social maturity and self-esteem.

Brown (1988) concluded that while no significant difference in the global self-esteem of congenitally

disabled adults was evident when compared with normative samples, significantly lower self-identity and self-acceptance scores were present. Magill-Evans and Restall (1991) discovered that significant differences previously observed between Cerebral Palsied and able-bodied adolescents had virtually abated by adulthood. Lawrence (1991) investigated the relationship between development of self-esteem and perceived body image. This researcher concluded that the presence of a physical handicap impacts learning effectiveness and retards self-concept formation.

In an investigation examining global self-perceptions of the disabled and able-bodied, Weinberg-Asher (1976) determined that people with disabilities perceive themselves in much the same way as do persons without disabilities. Conversely, Garrison, Tesch, and Decaro (1978) found that deaf students had lower self-esteem levels than did a normative hearing sample. However, these authors noted that deaf subjects who scored higher on a test of reading comprehension obtained more positive scores on the self-esteem measure than did students who were lower in reading ability.

Mayer and Eisenberg (1982) reported comparable self-esteem profiles for veterans with spinal cord injuries and the nondisabled except for depressed physical self-esteem scores. Smith, Gad, and O'Grady (1983) reported that scores of adolescents with Cystic Fibrosis placed them at the 30th

percentile of a normative adolescent population. Carroll, Friedrich, and Hund (1984) reported that nondisabled subjects possessed greater levels of positive self-esteem than did learning disabled or mentally retarded persons and that teacher evaluations supported these findings. Cowen et al. (1984) discovered a generally normal self-concept among individuals with Cystic Fibrosis except for depressed subscale scores in positive physical self and psychosis among subjects older than 20.

Simmons et al. (1985) found that adolescents with Cystic Fibrosis were able to maintain a positive self-concept despite having heightened episodes of behavioral difficulties. Obiakor and Stile (1990) reported that visually impaired persons scored higher than sighted individuals on five of 12 self-concept subscales. Similarly, Beaty (1991) found significant differences in both global and subscale self-concept scores between visually impaired and sighted children.

Cates (1991) determined that self-esteem scores for hearing impaired and able-bodied individuals were not markedly different. Super (1992) predicted and found negligible differences in self-concepts of athletically active and inactive disabled and able-bodied males. King, Shultz, Steel, and Gilpin et al. (1993) reported significant interaction effects between several self-concept dimensions and gender in self-concepts of able-bodied and physically

disabled persons.

The Therapist and the Client with a Disability

Discriminatory treatment of the disabled by the non-disabled has long concerned psychotherapists and social service providers committed to maximizing psychological adjustment of those with disabilities. Perhaps underlying this concern is the belief that prevailing societal attitudes toward persons with disabilities are mirrored in the self-perceptions of the disabled themselves. The belief that those with disabilities often internalize prevailing societal attitudes has been documented in several studies.

Sussman (1976) maintained that attitudes of hearing people toward deafness are a key ingredient in the feelings that deaf people have about their disability. Katz, Shurka, and Florian (1978) determined that prevailing attitudes toward the disabled effected both their self-esteem and the impact of the disability as a perceived stressor. Furnham and Lane (1984) discovered that the deaf have more negative attitudes toward deafness than did hearing persons.

Rogers, Thurer, and Pelletier (1986) found that state vocational rehabilitation counselors and administrators perceived a significant need for mental health services among individuals with severe physical disabilities. Likewise, Thurer and Rogers (1984) discovered that 75% of the disabled persons whom they interviewed perceived a significant need for mental health services among persons

with physical disabilities.

Awareness of and sensitivity to the impact of a disability upon the psychological well being of clients may well be central to effective therapy with this population. According to Krauft, Rubin, Cook, and Bozarth (1976) counselor attitude toward disability was directly correlated with rehabilitation outcome as therapists who held more positive attitudes toward the disabled experienced greater success than less positive counselors. Krausz (1980) argued that a therapist's attitude toward a disability will profoundly influence the client's ascription of meaning to that impairment. With this in mind, the sensitivity and soundness with which the therapist approaches and disposes of disability related matters may well determine the success of the therapeutic endeavor.

CHAPTER III

METHODOLOGY

Participants

Participants were graduate students in Clinical and Counseling psychology, unlicensed Ph.D. and Psy.D. Clinical and Counseling psychologists, and licensed psychologists identified through APA accredited training programs and facilities in eight states.

Sample Demographics

The sample from which the following descriptive data was derived represents 168 participants or 61% of the 275 packets distributed to APA accredited training sites. The mean age of participants was 37.2 years with a standard deviation of 10.7. The mean years of graduate study was 4.5 with a standard deviation of 3.4. Forty-six percent of respondents holding a Ph.D., 23% a M.A., and 26% a B.A. degree.

Nearly 60% of participants identified their primary field of study as Counseling (35.7%) or Clinical (25.4%) Psychology. Primary employment settings were reported as Veteran's hospitals (25.3%), University counseling centers (29.9%), and Rehabilitation hospitals (8.4%).

Participants self-identified on the Race/Ethnicity

dimension as 86.4% Caucasian, 5.2% African-American, 3.9% Asian, 3.2% Hispanic and 1.3% "other". Representation of women in the study nearly doubled that of men at 65% and 35% respectively. Of the 168 participants, nine persons or 5.4% identified themselves as physically disabled.

Procedure

A total of 275 packets were distributed to pre-determined designees at each site for distribution. In addition to survey packets, each site designee received a standard description of their role and parameters in assisting with distribution and collection of materials. Designees randomly distributed and collected packets from participants at his or her respective site. Completed packets were returned to the site designee in an unmarked and sealed envelope provided for this purpose and identified only by group membership (1, 2, or 3).

At one week intervals following packet distribution, this investigator contacted each site designee to assess the status of the project and assist in circumventing unforeseen difficulties. Roughly three weeks following distribution of materials, each designee was directed to forward all completed packets to this investigator. All packets remained sealed until received by this investigator and opened for data entry and analysis. At no time were participants identified by name or number on survey materials, return packets, or by site designee.

Within each data packet, participants received: (1) a brief cover letter detailing the participant's role within the study, (2) one of two client scenarios, minimally describing a fictitious client as among other things congenitally blind or able-bodied, (3) a Coopersmith Self-Esteem Inventory (CSEI) Form B, and (4) a demographic data sheet. In addition, one third of participants received the ATDP (Attitudes Toward Disabled Persons Scale, Yuker Block & Young, 1960) (see Appendix C for packet of information).

The sample of 275 participants was randomly and equally divided into three groups. Group 1 received generic demographic and study information along with (1) a case scenario presenting a prospective client as "congenitally blind", (2) the ATDP, and (3) the CSEI. Group 2 received identical demographic and study information along with (1) a case scenario presenting a prospective client as "congenitally blind", and (2) a CSEI. Group 3 received identical demographic and study information along with (1) a case scenario presenting a prospective client identical to that presented to groups 1 and 2 minus any reference to congenital blindness, and (2) a CSEI.

Participants were directed to review generic study information and to subsequently read the accompanying case scenario. Amended to each scenario was a brief directive; please identify in descending order of importance, what you

regard as the three most clinically salient issues presented in this case. Participants who received the ATDP were directed to complete this instrument prior to proceeding with supplementary materials.

Participants, regardless of group membership, were next directed to respond to items on the CSEI as they anticipated their fictitious client would. Finally, participants were asked to complete the demographic data sheet prior to returning survey information.

Each of the participant's three issues identified as clinically salient along with accompanying information such as group membership, case number, and ATDP and CSEI composite scores were recorded. Participant selections were identified as either first, second, or third in clinical salience and with the assistance of three raters content analyzed and placed within 10 naturally occurring categories as determined through group consensus.

Finally, the CSEI was utilized as a dependent measure of self-esteem in two fashions. First, as a single or global entity, defined as the mean of the three groups and second, as polychotomous categories defined by placement in low, average, or high self-esteem quartiles. The utilization of "quartile breaks" as a measure of high, average, and low self-esteem is consistent with the scoring and interpretation protocol recommended by Coopersmith.

Instrumentation

ATDP (Attitudes Toward Disabled Persons Scale)

According to Antonak (1988), the Attitudes Toward Disabled Persons Scale or ATDP (Yuker, Block, & Campbell, 1960; 1962) is the best known and most widely utilized scale purporting to measure attitudes toward disabled persons. The scale assesses attitudes of the nondisabled toward persons with physical disabilities on an acceptance-rejection or similarity/dissimilarity continuum. The ATDP was first published as a 20 item summated rating scale in 1960 (Form O) with 230 item equivalent forms (A and B) subsequently developed in 1962.

ATDP scale items are statements suggesting differences or similarities between disabled and able-bodied persons. Respondents express their agreement or disagreement with each item on a six point scale. Potential scores range from 0 to 120 (Form O), or from 0 to 180 (Forms A and B) with higher scores suggesting more favorable attitudes. Administration time for the ATDP Form O is approximately 10 minutes.

ATDP Reliability. According to Antonak (1988), estimates of test-retest reliability for Form O range from .66 to .89. Antonak (1988) further reported a single stability estimate of .79 for Form A and two estimates of .71 and .83 for Form B. Time intervals associated with these studies ranged from two weeks to 18 months.

Estimates of alternate forms reliability included .57 (Form O to Form B) and .83 (Form A to Form B) (Antonak 1988). Split half reliability estimates of .75 to .85 (Form O); .73 to .89 (Form A); and .72 to .78 (Form B) were likewise reported by Antonak (1988). Stability estimates ranged from .41 to .83 with time intervals varying from two weeks to five months (Antonak, 1988).

ATDP Validity. The ATDP was developed through an extensive review of the literature in which descriptive statements regarding persons with disabilities were initially identified and subsequently extracted (Yuker et al., 1960; 1970). Several psychologists reviewed the appropriateness of the extracted statements for incorporation into the ATDP. An item analysis was conducted to determine item discrimination between high and low scoring groups on each of the alternate forms.

Criterion related and construct validation of the various ATDP scales was performed through correlations with numerous demographic and personality measures. Women were found to register more positive attitudes than men towards persons with disabilities while heightened levels of education were associated with more favorable attitudes. Age and intelligence of respondents were not significantly related to either negative or positive attitudes.

Personality variables such as low aggressiveness, anxiety, and hostility, as well as positive self-concept,

degree of introspection, and ego strength were positively related with higher ATDP scale scores. Inverse correlations between ATDP scale scores and measures of authoritarianism, ethnocentrism, dogmatism, and machiavellianism were reported by Antonak (1988). Finally, ATDP scale scores were correlated with attitudes toward chemical dependency, mental illness, older persons, and members of various "minority groups.

Investigations relating to the susceptibility of the various ATDP scales to faking, social desirability, and acquiescence response tendencies have resulted in conflicting findings. Yuker et al. (1970; 1986) presented data supporting their contention that the ATDP is not "fakable". These researchers noted that the ATDP Form O is not significantly correlated with either the Edwards (1957b) or the Marlowe Crowne (1960) social desirability scales suggesting that the ATDP measures more than one's tendency to respond in a socially desirable manner. Other researchers (Cannon & Szuhay, 1986; Hagler, Vargo, & Semple, 1987; Hornstein, 1978; Scott & Rohrbach, 1977; Vargo & Semple 1984) adopted the contrary position asserting that scores on the ATDP are influenced by social desirability.

Although the ATDP authors maintain that the three forms are unidimensional, reflecting a generalized attitude towards persons with disabilities, considerable research evidence suggests that the ATDP is in fact multidimensional.

According to Antonak (1988), there is little empirical evidence supporting the existence of a unitary favorable-unfavorable continuum as proposed by the test's developers.

Several researchers have examined the factorial structure of the ATDP and have concluded that the scale is composed of multiple dimensions. Antonak (1980c) (Form C) and Livneh (1982a; 1983) (Form A) determined that the ATDP may contain between two and four independent factors.

The Coopersmith Self-Esteem Inventories

The Coopersmith Self-Esteem Inventories are a collection of three related self-report questionnaires varying in length and targeted population. Instruments are designed to assess "self-esteem", defined by Coopersmith (1967) as an expression of approval or disapproval, indicating the extent to which a person believes him or herself competent, successful, significant, and worthy. Questionnaires consist of generally favorable or unfavorable self-statements to which test takers are directed to respond as like or unlike themselves.

Adair (1984, as cited in Test Critiques, 1984) maintained that the Coopersmith Inventories provide a well accepted, thoroughly researched, and validated measure of the concept. Johnson, Redfield, Miller, and Simpson (1983) asserted that the Coopersmith Inventories are among the best known and widely utilized self-report instruments developed to measure self-esteem. The forms are brief, easily scored,

reliable, stable, and are supported by considerable evidence of construct validity. Testing time rarely exceeds 10 minutes and hand scoring and tabulation of the School Form and Short Form are characteristically completed in less than two and one minutes respectively.

Coopersmith's original instrument was published in 1967 as Form A or the long form and consisted of 50 items including an eight item Lie or "defensiveness" scale. This Long or School Form is appropriate for ages 5-15 and is scored on five self-esteem scales: General self, social self-peers, home-parents, school-academic, total self, and the supplemental Lie scale.

The School Form A was first administered to two classes of fifth and sixth grade children ($n = 86$), resulting in scores ranging from 40 to 100 with a mean of 82.3 and a standard deviation of 11.6. The mean score for 44 males was 81.3 with a standard deviation of 12.2 while the mean for the 43 females was 83.3 with a standard deviation of 16.7. Differences between the two sexes were found to non-significant.

The inventory was subsequently administered to 1,748 public school children resulting in a mean for females of 72.2 with a standard deviation of 12.8. The mean score for males was 70.1 with a standard deviation of 13.8.

The School Short Form (Form B), consisting of 25 items, is likewise targeted for use with children 5-15 and was

developed through an item analysis of Form A. The 25 items are duplicates of Form A's self-statements and correlate at .86 with the lengthier instrument.

Although the Coopersmith inventories have much to recommend them as measures of self-esteem they nevertheless have their limitations. As Crandall (1973) and Wylie (1974) (as cited in Peterson & Austin, 1985) noted, several limitations observed in the Coopersmith may be inherent to all self-esteem measures. Such limitations arise in part from researchers' inability to arrive at a consensus regarding the definition of self-esteem. As a result, reliance upon convergent and discriminant validity as support for the construct of self-esteem is tenuous. While the Coopersmith correlates well with many alternative self-esteem measures (Johnson et al. 1983), its discriminant validity is less impressive (Cowan, Altmann, & Pysh, 1978).

Additionally, measures of self-esteem are often impacted by social desirability, further confounding the accuracy of assessment (Wells & Marwell, 1976, as cited in Peterson & Austin, 1985). Crandall (1973, as cited in Peterson & Austin, 1985) reported correlations of .44 and .75 with the Coopersmith and Marlowe-Crowne and Edwards social desirability scales.

Although the Coopersmith defines self-esteem as a global or unitary construct, the school forms present multiple self-esteem subscales. However, the Coopersmith

manual presents no evidence in support of differential validity for these subscales (Adair, 1984, as cited in Test Critiques, 1984; Shavelson, Hubner, & Stanton, 1976, as cited in Peterson & Austin, 1985). While the validation research has considered Coopersmith scores as continuous, recommended applications often utilize derived scores as cut-off values. As a result, interpretations beyond levels of high, average, or low self-esteem may be unacceptably speculative since no additional criteria are provided.

Additional criticisms levied against the Coopersmith include dissatisfaction with the precision of the norm samples provided in the manual and the absence of a clear explanation for the basis and interpretation of the Lie scale (Adair, 1984). Sewell (1985, as cited in Mental Measurements Yearbook, 1985) reported a troublesome lack of a standardization sample. Finally, while "self" or "personal" evaluations are presumed by the Coopersmith, specific items appear to reflect "other's" assessments.

Reliability of the Coopersmith. Numerous researchers have investigated the reliability of the various Coopersmith inventories. Chiu (1985) investigated both the test retest reliability and concurrent validity of the Coopersmith Form B. This researcher determined that test-retest reliability for a two month period ranged from .72 to .85 with all indices being significant. Prewitt (1984) converted the Coopersmith to Puerto Rican Spanish and administered this

translation to both mainland and island Puerto Rican students. This investigator found that the standard error of measurement for the Coopersmith subscales was not significantly different for the two samples tested. Furthermore, the standard error of measurement for the Coopersmith total score was likewise not significantly different.

Watkins and Astilla (1980) found a nine month test-retest reliability coefficient of .61 for a sample of Filipino subjects. Ryden (1978) reported a test-retest reliability coefficient of .80 for periods ranging from six to 58 weeks for a modified adult version of the Coopersmith.

Drummond, McIntire, and Ryan (1977) investigated the stability of the Coopersmith over a six month period for children, grades two through 12. These investigators found significant correlations for all grades on general self and total self scales. Bedeian, Teague, and Zmud (1977) examined the internal consistency of the Coopersmith and reported a KR of .74 for males and .71 for females. Spatz and Johnston (1973) determined that reliability coefficients (KR 20) ranged from .80 for twelfth grade students to .86 for ninth grade children.

Sewell (1985, as cited in *Mental Measurements Yearbook*, 1985) maintained that reliability data are impressive and reported that internal consistency ranged from .87 to .96 for grades four to eight. Finally, in their critique of the

instruments, Peterson and Austin (1985, as cited in *Mental Measurements Yearbook*, 1985) reported the Coopersmith inventories to possess sufficient reliability and validity to merit their utilization in research.

Validity of the Coopersmith. Considerable effort has been dedicated to the validity of the Coopersmith. One foci of research has concentrated upon construct validity as explored through factor analytic studies. In an investigation by Roberson and Miller (1986), the factorial validity of the Coopersmith was examined in an attempt to reproduce the hypothesized structure of the instrument. These researchers determined that the school curriculum, home-parent, social-peer, and lie scales appeared to measure distinguishable features of self-concept. Roberson and Miller concluded that considerable support exists for both the hypothesized subscales and empirically derived factors.

Kokenes (1978) extracted five distinguishable negative and four positive factors which contributed to global self-esteem. This author concluded that findings supported the construct validity of the Coopersmith subscales as proposed. Myhill and Lorr (1978), utilizing a modified version of the Coopersmith Adult Form, differentiated psychiatric from non-psychiatric patients on four of five derived factors. Despite general support for the multi-dimensional nature of the Coopersmith, the various factor analytic studies have yielded competing factorial

structures.

A second major area of focus for validation studies has concentrated upon issues of construct and discriminant validity. Kozeluk and Kawash (1990) supported the Coopersmith's convergent validity by reporting high agreement between the Coopersmith and the Culture-Free Self-Esteem Inventories for Children and Adults. Omizo and Amerikaner (1985) examined the predictive and differential validity of the Coopersmith Form B, relative to criterion measures of the Adolescent Communication Inventory and determined that the Coopersmith possessed both predictive and differential validity with regard to the ACI.

Ahmed, Valliant, and Swindle (1985) examined the homogeneity of the Coopersmith and reported a Cronbach's Alpha of .75. Using a modified construct validation model and regression analysis, Johnson, Redfield, Miller, and Simpson (1983) determined that the Coopersmith demonstrates both convergent and discriminant validity, is sensitive to differences in achievement level, and is internally consistent. Calhoun, Whitley, and Ansolabehere (1978) reported a significant relationship between scores obtained on the Good Enough Harris Drawing test and those on the Coopersmith.

On the other hand, Crandall (1973, as cited in Peterson & Austin, 1985) noted the substantial contribution of social desirability to self-esteem scores reporting correlations of

.44 and .75 between the Coopersmith and the Marlowe-Crowne and Edwards scales. However, use of the Coopersmith Lie scale to identify persons whose self-reports were substantially influenced by social desirability reduced the correlation to .32. Finally, Gibbs and Norwich (1985) administered the Coopersmith Short Form to persistent school non-attenders and found no evidence that the short form assessed general self-esteem. Despite the limitations and caveats noted above, Adair (1984, as cited in Test Critiques, 1984) asserted that with thoughtful and appropriate use of the Coopersmith, one can obtain a measure of self-esteem which is as accurate as possible given the nature and limitations of self-report instruments.

Hypotheses

1. Those therapists receiving and completing the ATDP will report significantly more favorable attitudes towards persons with disabilities than scores reported by the general population.

2. Therapists who are directed to respond to the ATDP prior to completing the Coopersmith (CSEI) will project significantly higher self-esteem scores for persons with hypothetical disabilities than those therapists who complete only the CSEI.

3. Therapists' projected self-esteem scores for persons with hypothetical disabilities as reflected on the CSEI will significantly exceed those attributed to the able-bodied

4. Clinicians' projected CSEI scores for the hypothetically disabled client will be significantly higher than those reported in the literature by disabled persons themselves.

5. Therapists who report having received or participated in disability related training, whether academic or applied, will not demonstrate significant differences from clinicians absent such training on the CSEI.

CHAPTER IV

RESULTS

Results derived from the present study are presented in two distinct yet related sections. First, each of the five research hypotheses will be presented individually, accompanied by relevant research results. Second, more "generic" or ancillary results related to and of potential import to multiple research hypotheses will be detailed.

The first hypothesis, "Those therapists receiving and completing the ATDP will report significantly more favorable attitudes towards persons with hypothetical disabilities than scores reported by the general population" was rejected. In the present study, the mean ATDP score for therapists was 79.1 with a standard deviation of 17.2, (Median = 78.0; Mode = 62.0). This figure falls well within the range of means reported by other researchers utilizing this instrument with both comparable and more general populations.

The ATDP results from this investigation along with those from studies with more "generic" populations as reported by Yuker (1988) are presented in Appendix A. Appendix B presents ATDP results for individuals employed in selected "helping professions" from Forms O, and equivalent

Forms A and B. Specific populations and gender differences where available are reported.

The second hypothesis, "Therapists directed to complete the ATDP prior to completing the CSEI will project significantly higher self-esteem scores for persons with disabilities than those therapists who complete only the CSEI" was rejected [$F(2,164) = .984; p = .38$]. Of the three groups in the present study, the mean score of Group 1 (Blind-ATDP) in which participants completed the ATDP prior to responding to the CSEI was not significantly different from mean scores reported by either Group 2 (Blind-no ATDP) or Group 3 (Sighted-no ATDP). Employing a one-way ANOVA, no significant mean differences emerged from the data [$F(2,164) = .98; (p > .05)$]. However, Group 1 (Blind-ATDP) displayed the greatest degree of variability in attributed CSEI scores while Group 3 (Sighted-no ATDP) presented the least. CSEI means and standard deviations are reported for each of the three groups in Table 1.

Table 1

CSEI Mean Scores and Standard Deviations by Group

	n	Mean	SD
Group 1: Blind-ATDP	55	40.6	23.8
Group 2: Blind-no ATDP	55	44.4	22.2
Group 3: Sighted-no ATDP	58	38.7	19.4
Sample Mean = 41.3; Standard Deviation = 21.8			

When continuous scores were transformed and placed within corresponding high, average, and low self-esteem quartiles as recommended by Coopersmith (1967), significant differences between self-esteem categories were detected. Mean scores for participants projecting low self-esteem were significantly different than means for both average and High self-esteem quartiles [$F(2,163) = 3.06; (p < .05)$]. Quartile means and standard deviations are presented in Table 2.

Table 2

CSEI Means and Standard Deviations by Quartiles

	Percentile	n	Raw Score	Mean	SD	%
Low Self-Esteem	25	58	< 28.1	20.1	7.8	34.5
Average Self-Esteem	26-74	58	28.1- 51.9	39.6	6.3	34.5
High Self-Esteem	75	49	> 51.9	68.2	14.9	29.7
Missing cases = 3 or 1.9%						

The impact of hypothetical blindness upon subsequent CSEI mean scores is suggested by examining the representation of hypothetically blind clients in high, average, and low self-esteem quartiles. As can be seen in Table 3, hypothetically blind clients represented the majority of those assigned to the Low self-esteem quartile, 37 of 58 clients or 63.8%. Of the 37 hypothetically blind clients, 24 clients or 64.9% were contributed by participants from Group 1 (Blind-ATDP). Group 3 (Sighted-no ATDP) contributed 21 clients or 36% of the Low self-esteem quartile.

The average self-esteem quartile comprised 35.2% of the data set and contained 58 persons. Of these 58 clients, 37 or 60.4% were hypothetically blind clients contributed by Groups 1 or 2. Group 1 (Blind-ATDP) contributed 11 persons

or 31.4% of the 37 hypothetically blind clients in this quartile.

The high self-esteem quartile consisted of 49 individuals, 37 of whom or 75.5% were hypothetically blind clients generated by groups 1 (Blind-ATDP) and 2 (Blind-no ATDP). Of the 37 hypothetically blind clients in the quartile, 19 or 51.4% were contributed by participants from Group 1 (Blind-ATDP). Group 3 (Sighted-no ATDP) contributed 12 clients or 24.5% of the high self-esteem quartile.

Table 3

Self-Esteem Quartiles and Blind Client Representation

High Self-Esteem (n = 49)

Blind clients in quartile = 37 or 75.5%
 Blind clients contributed by Blind-ATDP group = 19
 Blind-ATDP % of quartile = 38.8
 Blind-ATDP % of blind clients = 51.4

Average Self-Esteem (n = 58)

Blind clients in quartile = 35 or 60.3%
 Blind clients contributed by ATDP group = 11
 Blind-ATDP % of quartile = 19.0
 Blind-ATDP % of blind clients = 31.4

Low self-esteem (n = 58)

Blind clients in quartile = 37 or 63.8%
 Blind clients contributed by ATDP group = 24
 Blind-ATDP % of quartile = 41.37
 Blind-ATDP % of blind clients = 64.9

Missing cases = 3 or 1.9%

Chi square = 10.53; df = 4; P < .03

The third hypothesis, "Therapists' projected self-esteem scores for persons with hypothetical disabilities as reflected on the CSEI will significantly

exceed those attributed to the able-bodied" was rejected [$F(2,164) = .984, p = .38$]. Although CSEI mean scores for both groups with a hypothetically blind client exceeded that of the Sighted-no ATDP group, differences between groups failed to reach required levels of significance. This observation remained constant whether employing Dunn's procedure or a one-way ANOVA. However, as noted previously, Group 1 (Blind-ATDP) evidenced the greatest degree of variability while Group 3 (Sighted-no ATDP), the least variability in projected mean scores. Summary data for mean score by group are presented in Table 4.

Table 4

CSEI Mean Scores by Sighted vs. Hypothetically Blind Scenarios

	n	Mean	SD
Group 1: Blind-ATDP	55	40.6	23.8
Group 2: Blind-no ATDP	55	44.4	22.2
Group 3: Sighted-no ATDP	58	38.7	19.4
Sample Mean = 41.3; standard deviation = 21.8			

When continuous scores were transformed and placed within corresponding high, average, and low self-esteem quartiles, significant differences between groups were obtained. Group 1 (Blind-ATDP) ascribed significantly lower self-esteem scores to clients than both Groups 2 (Blind-no

ATDP) and 3 (Sighted-no ATDP) [Chi square (4) = 10.54, $p = .03$]. Blind and sighted group membership by self-esteem quartiles are presented in Table 5.

Table 5

CSEI Quartiles and Hypothetically Blind vs. Sighted Membership

	Mean	n	%	Blind Members	Sighted Members
High Self-Esteem	68.2	49	28.6	37	12
Average Self-Esteem	39.6	58	35.1	35	23
Low Self-Esteem	20.1	58	34.4	37	21
Missing cases = 3 or 1.9%					

The fourth hypothesis, "Clinicians' projected CSEI scores for clients with hypothetical disabilities will be significantly higher than those reported in the literature by disabled persons themselves" was rejected. In the present study, it would appear that persons with disabilities did not receive the elevated self-esteem scores anticipated by this hypothesis. This position is supported by the finding of no significant difference between projected self-esteem scores ascribed by therapists to hypothetically disabled and able-bodied clients.

A direct and truly meaningful comparison between projected CSEI scores attributed to the disabled in the

present study with those reported within the literature was essentially non-productive. The Coopersmith Manual provides no normative data relating to persons with disabilities. Furthermore, a search of the research literature concerning utilization of the Coopersmith with persons having disabilities produced relatively few studies. In addition, a significant proportion of these investigations targeted invisible disabilities i.e., learning disabilities and were thus not cited.

Those investigations which dealt directly with physical disabilities (Blindness: Beaty, 1991; Leukemia: Mullis, Mullis, & Kerchoff, 1994; Renal transplant: Melzer, Leadbeater & Reisman, 1989; and Cerebral Palsy: Ostring & Nieminen, 1982), suggested that in general, little differences exist between self-esteem levels reported by disabled and able-bodied persons. The non-significant differences obtained in the present investigation would appear to support the findings of these previous studies.

The fifth hypothesis, "Therapists who received or participated in disability related training, whether academic or applied, will not demonstrate significant differences from clinicians absent such training as reflected by scores on the CSEI" was rejected. The training and exposure of therapists to clinical issues associated with the possession of a disability was assessed through participant responses to eight items inserted on the

demographic data sheet. Of these eight items, only one reported the necessary significance level required to demonstrate a relationship with mean scores on the CSEI. The utilization of both quartile assignment and mean scores further clarified and confirmed this relationship as significant.

Highest degree held was determined to be significantly related to attitudes reflected on the CSEI at a P of .001. An examination of the highest and lowest quartiles by degree held revealed that while participants holding a Ph.D. were as likely as those with a M.A. or B.A. to ascribe low self-esteem to the blind client, they were far more likely to ascribe high self-esteem when compared to those with less education. Table 6 illustrates the interrelationship between degree held and attributed self-esteem.

Table 6

Ascription of Low and High Self-Esteem by Degree Held

	B.A.	M.A.	Ph.D.	Total
Low Self-Esteem Quartile	16	20	22	53
High Self-Esteem Quartile	10	10	29	44

The remaining seven training and exposure to disability items displayed little or no relationship with CSEI mean scores. However, a brief review of these non-significant items accompanied by descriptive data are informative.

Table 7 presents those items determined to be non-significant in determining CSEI mean scores. Two items (years of graduate study completed to date and approximate number of semesters in which you received clinical contact hours with physically disabled persons) defied meaningful analysis due to a substantial number of missing cases.

Table 7

Non-Significant Training Indices in Attitudes toward Disability

	% Reporting None	Mean	SD	Median	Mode
1. Years of graduate study completed to date	0.0	4.5	3.3	5.0	6.0
2. Approximate number of semesters in which you received clinical contact hours with physically disabled persons	14.3	7.5	10.0	6.0	0
3. In approximately how many "under-graduate" courses did you receive what you regard as "substantial" exposure to psychosocial aspects of physical disability? [F (3,161) = 1.57, p = .20]	78.0	.41	1.0	0	0

Table 7 (continued)

	% Reporting None	Mean	SD	Median	Mode
4. In approximately how many "graduate" courses did you receive what you regard as "substantial" exposure to psychosocial aspects of physical disability? [F (4,162) = .30, p = .88]	54.2	1.1	2.6	0	0
5. To approximately how many physically disabled clients did you serve as primary therapist during your various practica? [F (5,147) = 1.18, p = .32]	44.6	5.7	18.0	1.0	0
6. To approximately how many physically disabled clients did you serve as primary therapist during your internship? [F (5,129) = 2.09, p = .07]	54	6.8	16.9	1.0	0
7. Excluding those attended during your graduate training, approximately how many hours have you spent in workshops or seminars which you regard as "substantially" related to clinical work with physically disabled clients? [F (3,155) = .72, p = .54]	56	9.9	23	0	0

Ancillary Results

Responses to five additional items contained on the demographic data sheet generated results of interest if not significance to specific hypotheses.

First, in order to assess non-professional exposure to persons with disabilities, participants were requested to estimate the number of physically disabled persons with whom they have shared a meaningful non-professional relationship [$F(6,163) = 1.42, p = .21$]. Responses to this item paralleled findings addressing academic training and experience. Participant responses indicated that 27.3% of respondents had no meaningful contacts, and that although the item mean was 2.5 with a standard deviation of 4.9, the median was 1.0 and the mode was 0.

Participants were also asked to estimate the percentage of their current annual client caseload represented by persons with physical disabilities [$F(4,144) = 1.11, p = .35$]. Responses to this item indicated that 35.7% of participants had no physically disabled persons represented in their annual client caseload. The mean reported by participants was 16.4 with a standard deviation of 30.9; the median was 1.0% and the mode 0.

Two items questioned participants as to their self-perceived comfort and effectiveness in clinical work with physically disabled persons on a 10 point Likert type scale. Participants expressed nearly uniform levels of comfort

regarding clinical work with those having physical disabilities [$F(7,163) = 1.25, p = .28$]. On a 1-10 scale with one denoting total discomfort and 10 total comfort, participants reported a mean score of 7.4 with a standard deviation of 1.8, a median of 8.0, and a mode of 8. Likewise, participants reported nearly uniform perceptions of effectiveness in their clinical work with clients having physical disabilities [$F(7,159) = .57, p = .78$]. Participants reported a mean score of 7.0 with a standard deviation of 1.8, a median of 7, and a mode of 8.

Finally, a content analysis of participant responses was conducted for the purpose of determining the number and nature of naturally occurring categories regarded by participants as clinically salient within the client scenario. Ten categories were generated from a review of the 504 distinct responses identified by participants as either primary, secondary, or tertiary in clinical salience. These categories accompanied by a brief definition are detailed below.

1. Blindness; responses referencing lack of sight, disability, or difficulties emanating directly there from.
2. Social Withdrawal; responses noting phobia, avoidance, or discomfort in social interactions.
3. Family constellation; issues of birth order, parental over-protectiveness, issues regarding mother and father specifically or other issues concerning family

dynamics.

4. Social Isolation; presented as non-voluntary isolation i.e., solitude created by potential peer rejection and disregard or dissimilarity in interests and abilities.

5. Introversion; defined as a genuine preference for solitary and asocial activities which is not the result of social avoidance or peer disregard.

6. Age; presented as difficulties attributed to adolescence and encountered by persons during maturation.

7. Self-Esteem; defined by participants as a diminished view of one's importance or self-worth, particularly in comparison with that of significant others.

8. Lack of interests; presented as difficulties arising from an inability or reluctance to find and benefit from rewarding and/or enjoyable avocational experiences appropriate for the age group.

9. Other; most commonly consisting of references to positive traits such as intelligence, academic performance, or desired behavior which implied an inconsistency between self-perception and reality.

10. No Clinical Issues; comprised of responses which regarded the scenario as presenting no significant clinical issues.

In examining and considering the salient categories most frequently identified, Group 3 (Sighted-No ATDP) was not presented with a hypothetically disabled client and thus

could not select blindness as a category. In addition, since no two groups received identical materials, differences in issues regarded as most salient were anticipated and observed.

In Table 8, the three categories most frequently identified as salient by group are presented, confirming that groups responded differentially to presented materials.

Table 8

Clinical Categories Most Frequently Identified as Salient by Group

Group 1, Blind-ATDP: Blindness; Social Withdrawal; Family Constellation

Group 2, Blind-no ATDP: Social Withdrawal; Blindness; Family Constellation

Group 3, Sighted-no ATDP: Social Withdrawal; Family Constellation; Lack of Interests

CHAPTER V
DISCUSSION

As noted in the preceding chapter, none of the five research hypotheses were totally supported at necessary levels of significance. Nevertheless, meaningful results were obtained in several areas which are of direct relevance to the premises which served to guide this study. The discussion which follows will highlight by hypothesis those findings regarded as significant to the underlying issues raised by this investigation and will discuss implications of these results.

Hypothesis 1. Those therapists receiving and completing the ATDP will report significantly more favorable attitudes towards persons with hypothetical disabilities than scores reported by the general population. This hypothesis was not supported. The ATDP Form O is a brief, relatively transparent, and reputedly unidimensional self-report instrument which purports to measure attitudes toward persons with disabilities. The scale is designed to assess attitudes of the non-disabled toward persons with physical disabilities on an acceptance-rejection or similarity/dissimilarity continuum.

Several investigators have maintained that the

instrument is susceptible to social desirability, acquiescence response sets, and is "fakable" (Cannon & Szuhay, 1986; Hagler, Vargo, & Semple, 1987; Horenstein, 1978; Scott & Rohrbach, 1977; Vargo & Semple, 1984). Several of these investigators succeeded in elevating scores on the measure by directing participants to answer items in a favorable or socially desirable direction. The primary author of the measure has conceded that the instrument is to some degree fakable yet maintains that it remains useful as a tool to evaluate one's awareness of elements which may constitute positive and negative attitudes.

In the present study, the ATDP was utilized in a dual capacity: first, as a direct measure of disability related attitudes held by therapists and secondly, as a prompt or independent variable adopted for the purpose of favorably influencing ascribed scores for hypothetically disabled persons on a subsequently administered self-esteem measure. With regard to the former, the ATDP given its relative transparency, was regarded as an appropriate vehicle to assess therapists' willingness to distort responses in order to present themselves in a socially desirable or favorable light. However, as detailed in Chapter IV, those therapists who completed the ATDP in this investigation did not register significantly higher mean scores than those reported by the general population or other helping professionals in previous studies. Several factors may have

contributed to this result. One explanation for the equivalence of therapists' scores with those of other populations may arise from properties of the ATDP itself. Although the ATDP authors maintained that the three forms are unidimensional reflecting a generalized attitude towards persons with disabilities, considerable research evidence suggests that the ATDP is in fact multidimensional. According to Antonak (1988), there is little empirical evidence supporting the existence of a unitary favorable-unfavorable continuum as proposed by the test's developers. Rather, several researchers have examined the factorial structure of the ATDP and have concluded that the scale is multidimensional, composed of multiple factors ranging in number from two through nine (Antonak, 1980c; Livneh, 1982a; 1983).

As a result, the ATDP as a unidimensional measure may provide what appears to be equivalent attitudinal scores, yet fail to detect subtle and important distinctions among populations completing the instrument. The research literature provides numerous examples of contextual variables that influence if not determine attitudes toward persons with disabilities which the ATDP, given its unidimensionality, may not address. Among such variables are the nature, chronicity, visibility, and severity of the disability, personal culpability for the impairment, the disability's responsiveness to treatment, as well as the

personal characteristics of the evaluator (Berry & Jones, 1991; Bordieri & Drehmer, 1986; 1987a; 1987b; 1988; Dooley & Gliner, 1989; Gordon, Minnes, & Holden, 1990; Harper, Wacker, & Cobb, 1986; Katz, Kravetz, & Karlinsky, 1986; Sigelman, 1991).

In addition, due to its unidimensionality, the ATDP may not be capable of recognizing and quantifying another major component of attitudinal ambivalence. Such ambivalence has been documented throughout the research literature and yet the absence of subscales or distinct factors against which subject's profiles might be contrasted limits one's ability to detect and assess the contribution of contradictory attitudes. In short, reliance upon a unidimensional instrument such as the ATDP appears to provide little more than a global estimate of one's general attitudes toward the disabled. Consequently, confidence in the meaning and equivalence of scores must be tempered by the knowledge that the relative contribution of multiple attitudinal determinants remains unknown.

Another limitation of the ATDP is the implicit assumption that one's behavior will parallel stated attitudes. However, several investigators have observed that behavior towards persons with disabilities, whether unconscious or intentional, is not necessarily consistent with declared attitudes (Eberly, Eberly, & Wright, 1981; Vander-Kolk, 1976). Of particular salience to this

investigation is the concern that generally positive attitudes expressed by therapists toward disabled persons may not be reflected in clinically beneficial behaviors. Unfortunately, this question was neither posed nor addressed in the present study and must remain as an issue for future investigation.

Another common concern encountered in the utilization of disability related attitudinal measures such as the ATDP relates to the considerable variation among participants regarding the perceived definition of a disability. Without a mutual understanding of the primary construct's meaning, it is unclear if comparable scores, even on the same measure, are in fact equivalent.

However, perhaps a more critical issue associated with such instruments is the definition and/or components of what are regarded as positive and negative attitudes towards persons with disabilities. The ATDP, for example, defines positive attitudes towards disabled persons primarily in terms of perceived similarity with oneself or as the minimization of differences. While such a perspective may appear valid to the able-bodied, disabled persons may not be so willing to have tangible differences in their life experiences dismissed or reduced to inappropriate biases of those without disabilities.

In sum, the results obtained for hypothesis 1 appear to suggest that therapists do, to some degree, share attitudes

held by other helping professionals and the public-at-large toward persons with disabilities. This outcome would appear to imply that therapists in the present investigation did not succumb to social desirability demands by artificially elevating ATDP scores.

However, a competing and equally plausible reaction to demands of social desirability may be to regard positive or favorable attitudes as uninformed and prejudicial reflecting unequal and diminished expectations of those with disabilities. Under this scenario, the presence of favorable attitudes as reflected by elevated ATDP scores does not necessarily preclude the presence and operation of social desirability or bias. Rather, it is possible that to view and report people with disabilities as "different" even if preferred, represents a challenge to prevailing norms of political correctness. Therefore, it is possible that therapists, given their test wiseness may attempt to portray persons with disabilities as "no different" from those without disabilities. Such a position may be more defensible and less suggestive of prejudice. This interpretation is supported by results from related hypotheses in the present study suggesting possible prejudicial attitudes of therapists towards persons with disabilities.

Hypothesis 2. Therapists directed to respond to the ATDP prior to completing the CSEI will project significantly

higher self-esteem scores for persons with hypothetical disabilities than those therapists completing only the CSEI. This hypothesis was not supported. One of the purposes for introducing and directing participants to complete the ATDP was to prompt or sensitize participants to the existence of a disability variable within the case scenario. This strategy was apparently successful as evidenced by the fact that blindness was most frequently identified as of greatest clinical salience by those participants who completed the ATDP.

In addition, the ATDP was introduced with the expectation that those participants who completed the measure would subsequently project significantly higher self-esteem scores for a hypothetically disabled client than would participants not receiving the ATDP. This premise was based upon the assumption that participants completing the ATDP would not only be more alert to the existence of a disability but would as well be more likely to recognize and respond to perceived demands of social desirability.

However, as with hypothesis 1, no significant differences between and among groups were detected when mean scores were examined. If, in fact, socially desirability was operative in the present case, its directionality and magnitude failed to reach anticipated levels of significance. As reported in Chapter IV, of the two groups presented with hypothetically blind clients, those

participants who received the ATDP prior to completing the self-esteem measure (CSEI) projected lower mean scores than did the non-ATDP group; yet this difference was not significant.

The rejection of hypothesis 2 may have resulted in part from the properties and limitations of the self-esteem instrument employed in the present investigation. Although the 25 item CSEI correlates at .86 with its lengthier predecessor, it may lack sensitivity due to the omission of both a Lie scale and five subscales (General self, Social self-peers, Home-parents, School-academic, and Total self). As such, the instrument may be less capable of detecting subtle yet important distinctions between populations by relying upon unitary scores. A number of researchers have documented the existence of significant differences among participants on various CSEI subscales while simultaneously reporting no difference in unitary self-esteem scores (Melzer, Leadbeater, Reisman, & Jaffe et al., 1989; Mullis, Mullis, & Kerchoff, 1992; Rosenberg & Gaier 1977).

In order to capture potentially undetected data when employing the CSEI, Coopersmith recommends the transformation of continuous scores into high, average, and low self-esteem quartiles. This classification permitted more meaningful inner group comparison and eliminates the use of arbitrary self-esteem cut-off points. As a result, several significant results were detected.

First, significant differences were noted between the self-esteem quartiles to which hypothetically blind clients were assigned by Group 1 (Blind-ATDP) and Group 2 (Blind-No ATDP) members. Second, the variability of CSEI scores was greatest among those participants who received the ATDP, suggesting a potential tendency to ascribe more extreme scores to their hypothetically blind client.

For example, 65% of the hypothetically blind clients assigned to the low self-esteem quartile were generated by Group 1 (Blind-ATDP) members. Moreover, nearly 80% of the hypothetically blind clients assigned to self-esteem quartiles by Group 1 (Blind-ATDP) members appeared in either the high or low quartiles. Conversely, Group 2 (Blind-No ATDP) members assigned 69% of their hypothetically blind clients to the average self-esteem quartile and over 78% to a combination of average and high quartiles. Hypothetically sighted clients were much more uniformly distributed among self-esteem quartiles.

Clearly the introduction of a blindness variable significantly influenced the level of self-esteem attributed to clients by group members. It would appear that introduction of the ATDP resulted in polarization of hypothetically blind clients into extreme quartiles. In essence, the group for which the presence of a disability was made most salient was apparently the group most likely to ascribe extreme self-esteem scores to their

hypothetically disabled client.

This apparent tendency to polarize hypothetically blind clients raises a multitude of issues concerning the generally positive attitudes towards disabled persons as reported by study participants. First, these findings appear to lend support to those who maintained that attitudes towards persons with disabilities are frequently ambivalent. Second, this polarization may provide some indication of therapists' assessment of the clinical salience and magnitude of a visually impaired status. Third, these findings may suggest the existence of a therapist prejudice in which one's disabled status supersedes or exacerbates co-existing clinical issues in a quite dichotomous fashion.

Hypothesis 3. Therapists' projected self-esteem scores for clients with hypothetical disabilities as reflected on the CSEI will significantly exceed those attributed to the able-bodied. This hypothesis was not supported. While members of both Group 1 (Blind-ATDP) and Group 2 (Blind-No ATDP) ascribed higher self-esteem scores to a hypothetically blind client than did Group 3 (Sighted-No ATDP) to a sighted client, differences fell short of required levels of significance. Group 1 (Blind-ATDP) members displayed the greatest degree of variability in attributed self-esteem scores. Group 2 members (Blind-No ATDP) in turn evidenced less variability than Group 1 but more than Group 3 members

(Sighted-No ATDP). Thus, those participants who projected the self-esteem of sighted clients (Group 3) not only attributed the lowest mean scores of the three groups but were most consistent in their range of responses. In essence, while both groups projecting self-esteem scores for clients who were hypothetically blind generated scores which marginally exceeded those attributed by the third group to the able-bodied, such differences may have resulted from varying degrees of homogeneity.

Although the research literature frequently testifies to a contextual preference for disabled persons over their able-bodied peers (Baker, Dimarco, & Scott, 1975; Carver, Glass, & Katz, 1978; Comer & Piliavin, 1975; Czajka & Denisi, 1988; Mallinckrodt & Helms, 1986; McKay, Dowd, & Rollin, 1982; Nosek, Fuhrer, & Hughes, 1991; Pfeiffer & Kassaye, 1991), an equal if not greater number of studies suggest that people with disabilities are often isolated, pitied, devalued, and viewed as different (Fichten, Goodrick, Amsel, & McKenzie, 1991; Fichten, Robillard, Judd, & Amsel, 1989; Fish & Smith, 1983; Hastorf, Northcraft, & Picciotto, 1979; Juni & Roth, 1981; Rienzi, Levinson, & Scrams, 1981; Russell et al., 1985; Stainback & Stainback, 1982; Thompson, 1982). Recurrent themes of internalized negative parental, professional, and societal projections resulting in psychological distress, poor self-concept, and the adoption and application of dual standards are reported

in the research literature (Courington et al., 1983; Furnham & Lane, 1984; Greenberg, 1974; Katz, Shurka, & Florian, 1978; Rogers, Thurer, & Pelletier, 1986; Thurer & Rogers, 1984; Sussman, 1976). Thus, when as in the present case, persons with disabilities are attributed with levels of self-esteem which are higher than that of the nondisabled, such results merit further scrutiny.

Three potential explanations for the elevated self-esteem scores assigned to the hypothetically blind client would appear most plausible. First, in the case scenario as presented, the hypothetically blind client's situation sufficiently parallels those contexts within which favoritism towards persons with disabilities has been extended so as to elevate self-esteem scores. While this is possible, the case scenario utilized in this study was neither modeled after nor to the knowledge of this investigator parallels any of the contexts noted in the literature as favoring persons with disabilities.

Second, that the utilization of a unidimensional self-esteem measure yielding a unitary score may not have been capable of detecting subtle yet meaningful distinctions between participants projecting self-esteem scores for hypothetically blind and able-bodied clients. Several studies have contrasted the global self-esteem of disabled and able-bodied persons and have failed to detect substantial differences. Yet in several of these studies,

when subscales are available and examined, significant differences between populations become apparent (Melzer, Leadbeater, Reisman, & Jaffe et al., 1989; Mullis, Mullis, & Kerchoff, 1992; Rosenberg & Gaier, 1977). Potential support for this position is suggested by significant alterations in data profiles which appear on the CSEI after continuous scores are transformed into quartile categories.

Several alternative self-esteem instruments such as the Coopersmith Form A and the Tennessee Self-Concept Scale incorporate between five and 12 subscales regarded as particularly salient to persons with disabilities. These subscales address dimensions such as physical self, body image, social self, family self, and peer relations and are often successful in eliciting disability relevant information. In short, utilization of a multidimensional measure, incorporating multiple scales sensitive to constructs of particular import to persons with disabilities, may have revealed significant differences between participants and groups undetected in this investigation.

Third, is the potential presence, magnitude, and influence of prejudicial attitudes held by therapists towards visually impaired persons. While the nature and extent of such biases are difficult to predict and quantify, its existence is suggested when findings are critically scrutinized. In the present case, three groups of

therapists were provided with an identical case scenario within which a single variable was manipulated; that of blindness. One of the two groups presented with a hypothetically blind client was directed to complete the ATDP prior to responding to the CSEI. Differences among the three groups were observed in two areas; variations in projected mean self-esteem scores and differential variability in the range of group responses. Both groups receiving a case scenario containing a hypothetically blind client projected higher mean self-esteem scores than did the group presented with an able-bodied client. Although this pattern was predicted, differences between groups receiving hypothetically blind and able-bodied clients failed to reach required levels of significance.

The projection of higher mean self-esteem scores in combination with heightened variability in responses by therapists for a hypothetically blind client may suggest the presence and operation of prejudicial attitudes. Members of Group 3 who projected self-esteem scores for the able-bodied client assigned lower yet more homogeneous self-esteem scores. This diminished variability may suggest greater consensus and comfort in the assessment of the nondisabled client.

The bias proposed as operative in the present study has been variously described as that of "lowered or differential expectations" or as a desire to comply with a "norm of

kindness". Therapists operating with such a bias would attribute to a blind client heightened self-esteem due primarily to his or her functioning as a disabled person encountering and overcoming disability associated life experiences. The reasoning at the foundation of such a bias may be that blind persons who confront unique difficulties and stressors due to their disability, must possess and exercise superior effort and skill in order to overcome or circumvent these challenges. Conversely, persons absent a disability yet in psychological distress may be viewed less favorably by the therapist due to the clinicians personal familiarity with, fuller understanding of, and presumably heightened objectivity towards many of the client's presenting problems.

The therapist who views persons with disabilities as "stronger or more resilient and courageous" than those free of impairments, may assume and convey to the disabled client his or her belief that being disabled is inherently undesirable and that he or she neither understands nor appreciates the true magnitude of the impairment. Therapists in the present investigation, knowing little of the client's feelings regarding her visual impairment, may have pre-judged its meaning and significance by permitting their own attitudes toward such to indirectly become those of their client. The presence and persistence of such attitudes may inhibit if not preclude effective therapy with

clients who are disabled.

Hypothesis 4. Clinicians' projected CSEI scores for a hypothetically disabled client will be significantly higher than those reported in the literature by disabled persons themselves. This hypothesis was not supported. The analysis of results for hypothesis 4 requires an examination of not only self-concept scores reported by persons with disabilities and those attributed to them by therapists, but consideration of the difficulties and limitations inherent in such a comparison. The limitations of the CSEI, as a measure of self-esteem, have been noted and discussed in the analysis of previous hypotheses. Unfortunately, the number of studies exploring the self-reported self-esteem of persons with physical disabilities utilizing the CSEI is quite limited.

In general however, these studies suggested that persons with visible disabilities possess similar levels of self-esteem when compared with nondisabled persons. Despite this observation, hypothesis 4 predicted that therapists would attribute to disabled clients higher self-esteem scores than those reported by disabled persons themselves. Underlying this hypothesis was the assumption that therapists, either consciously or unconsciously, would distort self-esteem estimates for persons with disabilities due to the presence of bias and/or social desirability.

Unfortunately, hypothesis 4 relied upon a questionable

methodological assumption which would generate dubious results regardless of the magnitude or directionality of results. This assumption was operationalized by utilizing the CSEI, an objective self-report measure as a projective device completed by a second party directed to respond "as if" he or she were the client. Employing the CSEI in such a manner is not sanctioned by the author and its use as such severely limits any confidence in the validity of derived results. Thus, it is entirely possible that the non-significant differences noted here emanated directly and predominately from the unorthodox application of the CSEI. This methodological deviation would appear to be the most likely source of non-significant results.

However, alternative explanations for non-significant findings can be advanced albeit with less certainty. For example, therapists likely share in many of the publically held attitudes, both positive and negative, towards persons with disabilities. It is reasonable to assume that at least a portion of their opinions and attitudes are based upon misinformation and/or prejudice.

A number of researchers have maintained that persons with disabilities, seeking psychological services have encountered prejudice in the views of their therapists. According to Dickert (1988), Elliott, Frank, and Brownlee-Duffeck (1988), Sinick (1981), Tolor and Geller (1987), some therapists harbor beliefs regarding persons with

disabilities which may unnecessarily complicate and retard therapeutic progress. Among these is a societal expectation that persons with disabilities mourn their condition and inevitably experience varying degrees of depression.

Additionally, as noted by Wills (1978), mental health workers by profession tend to identify and assign more pathology to the thoughts, feelings, and behaviors of individuals than do lay persons. Wills maintained that therapists often over pathologize clients, focusing their clinical efforts upon what they regard as negative aspects of the psyche rather than promoting the positive and adaptive. Such a tendency may lead therapists to over-report issues as clinical concerns creating heightened discrepancies between their assessments and those of non-professionals.

However, at least some of the attitudes and beliefs reportedly possessed by therapists regarding persons with disabilities appear to find support within the research literature. Multiple studies have suggested that persons with disabilities encounter a quite different and often hostile environment creating in them a heightened potential for psychological distress (Breslau, 1985; Frank et al., 1985; Hickey & Greene, 1989; Kashani et al., 1983; Rogers, 1991; Rogers, Thurer, & Pelletier, 1986; Thurer & Rogers, 1984; Zola, 1993). This premise has been endorsed not only by mental health professionals but by persons with

disabilities and their advocates as well.

Several investigators have noted that persons with disabilities regard themselves as both more fortunate and less disabled than others with alternative disabilities (Campbell, Cull, & Hardy, 1986; Weinberg, 1984). In essence, persons with disabilities may possess disability preferences similar to those observed in the able-bodied. Given such studies, positive attitudes reported by persons with disabilities may disproportionately reflect comfort with those sharing the same impairment rather than disabled persons in general.

In sum, it appears possible that therapists share to some degree the prejudicial and attributional attitudes operative within society at large. As a result, their perceptions of those with disabilities and the implication of that disability are potentially distorted. At the same time however, given the potential influence of social desirability and cognitive dissonance, it is reasonable to question the accuracy of self-esteem scores reported by persons with disabilities. As a result, uncertainty regarding the accuracy and subsequent magnitude of differences in reported vs. regarded self-esteem appears to be a valid and persisting concern.

Hypothesis 5. Therapists who report having received or participated in disability related training, whether academic or applied, will not demonstrate significant

differences from clinicians absent such training on CSEI scores. This hypothesis was not supported. Recognition of the potentially unique therapeutic demands placed upon clinicians by persons with disabilities was observed 20 years ago by the APA (Division 22). In 1981, Spear and Schoepke surveyed all APA accredited Clinical and Counseling programs to determine the extent to which students were aware of various aspects of both legal and professional issues concerning persons with disabilities. These researchers concluded that student's lack of awareness regarding legal, clinical, and professional issues relating to disabled persons may negatively impact their effectiveness with this population. Since that time, several investigators have echoed the concerns of Division 22, reiterating the unique demands encountered by therapists in clinical work with disabled persons.

Yet, despite the assertions of many that disability related training is warranted if not essential for truly effective clinical work with this population, the research literature is less than unanimous concerning the effectiveness of targeted training in enhancing attitudes. In general, the research literature appears to suggest that those who receive heightened levels of disability related training realize corresponding increases in favorable attitudes as reflected by objective measures of attitudes towards people with disabilities (Crunk & Allen, 1977;

Estes, Deyer, Hansen, & Russell, 1991; Felton, 1975; Gosse & Sheppard, 1979; Kirchman, 1987; Leyser & Abrams, 1983; McDaniel, 1982; Patrick, 1987; Stewart, 1990; Wolraich & Siperstein, 1983). Similarly, it appears that more favorable attitudes are generally associated with years of education and type of training (academic or applied). However, it should be noted that the effectiveness of disability related training in enhancing attitudes toward persons with disabilities is characteristically gauged through utilization of objective measures such as the ATDP with its aforementioned limitations.

In the present investigation, the impact of disability related training upon projected self-esteem scores for persons with disabilities was assessed through the insertion and analysis of multiple items on the demographic data sheet. In total, eight items dealt with disability related training while another five questioned participants about feelings and experiences regarded as potentially significant in analyzing disability related attitudes. Of the eight items concerned with disability related training, seven failed to demonstrate any significant relationship with projected CSEI scores. However, despite their "insignificance", these items provided both interesting and useful information.

Two items questioned participants as to the number of courses within which they had received "substantial exposure

to psychosocial aspects of disability." Of those participants who had completed only their undergraduate education, 78% indicated that they had receive no substantial exposure in any of their classes. Of those participants who had completed their graduate education, 54% stated that they had received no substantial exposure within their coursework. Another two items concerned clinical exposure to persons with disabilities during the practica and/or internship experience. Of those respondents who had served only in practica, 45% stated that they received no clinical exposure to persons with disabilities during their training. Likewise, comparable figures were reported by individuals who had completed their internship training.

A fifth item questioned participants as to the number of post graduate hours spent in workshops or seminars "substantially related to psychosocial aspects of disability." Responses indicated that 56% of participants had received no such training since completion of graduate school.

The sole significant finding related to training and attitudes reflected in CSEI scores was detected in differences between participants holding a Ph.D. and persons with a M.A. or B.A.. This distinction became apparent after CSEI scores were transformed and categorized into high, average, and low self-esteem quartiles. Specifically, significant differences were observed in the high quartile

where those holding a Ph.D. were approximately three times more likely to ascribe a high level of self-esteem to blind clients than were either the M.A. or B.A. participant.

However, it is unclear if significant differences noted between participants were based upon degree held or other co-existing factors related to advanced education. The lack of significant results in complimentary training indices in combination with the absence of empirical support for substantial degree-based elevation in disability related attitudes, raises questions concerning the unitary influence of one's degree upon attitudes towards persons with disabilities.

A competing explanation for the degree based differences noted in the present study is the possibility that during advancement towards a doctorate, students become increasingly familiar with test construction as well as sensitive to the nature and demands of political correctness. This sensitivity in conjunction with the possession of skills required to detect and manipulate reasonably transparent instruments, may equip persons holding doctorates with the capacity to mold outcomes in desired directions.

Four additional items contained on the demographic data sheet were regarded as of considerable import to a full analysis of the data. The first two addressed participants exposure to disabled persons external to the academic arena.

Results from these two items paralleled exposure patterns observed in academic training. Sizable percentages of participants reported literally no interaction with disabled persons.

Responses to the final two items provide cause for considerable concern given the reported levels of contact between therapists and persons with disabilities. Both items questioned study participants as to their self-perceived comfort and effectiveness in clinical work with physically disabled clients. Participants in a normally distributed sample reported means of 7.4 for comfort and 7.0 for effectiveness on a 1-10 scale with 10 representing maximum comfort and/or effectiveness. Such elevated perceptions of comfort and effectiveness are somewhat surprising and disturbing given the relative absence of both training and exposure reported by many participants.

It, of course, can be argued that comparative levels for the able-bodied are not available and thus therapists' purported comfort and effectiveness with disabled clients is relative. Yet the fact remains that therapists report feeling quite comfortable and effective in clinical work with a population to which they have had relatively little training or exposure. It appears that the reported levels of self-perceived comfort and effectiveness enjoyed by therapists in the present study may bolster the position of those who assert that clinicians may too often be unaware of

concerns of people with disabilities. In practical terms, given the levels of comfort and effectiveness reported by these therapists, it is possible that the disabled client and his or her clinician may frequently enter therapy at divergent points on the disability continuum. As a result, some therapists will initially at least fail to provide effective and equivalent services to those clients with a physical disability.

Conclusions

Findings derived from this investigation are perhaps as notable in their non-significance as in the confirmation of any specific research hypothesis. First, attitudes towards persons with disabilities as reported by therapists on the ATDP were not significantly different from others employed in the helping professions or from the public-at-large. Second, although therapists attributed to disabled clients marginally heightened self-esteem when compared to their able-bodied counterparts, mean differences detected were not significant. Third, due to reliance upon questionable methodological assumptions which necessitated an unorthodox application of the CSEI, confidence in the non-significant differences observed between reported and attributed self-esteem scores for blind clients was severely compromised. Finally, seven of eight training and exposure to disability indices reported by therapists failed to demonstrate a significant relationship with projected

self-esteem scores for clients with disabilities.

However, further inspection and analysis of supplementary findings casts these "non-significant" results in a somewhat different light. When quartile membership was utilized as a measure of projected self-esteem, significant differences between Group 1 (Blind-ATDP) and Groups 2 (Blind-No ATDP) and 3 (Sighted-No ATDP) were detected. Those participants who completed the ATDP prior to the CSEI (Group 1) projected significantly lower self-esteem scores for their blind client than did either of the alternative groups.

Group 1 (Blind-ATDP) projected a significantly lower self-esteem than both Groups 2 (Blind-no ATDP) and 3 (Sighted-no ATDP). Moreover, Group 1 (Blind-ATDP) consistently evidenced the greatest degree of variability in CSEI scores while Group 3 (Sighted-no ATDP) displayed the least. Group 3 (Sighted-no ATDP) projected the lowest and most homogeneous mean self-esteem score of any group.

Thus, it would appear that the introduction of a blindness variable within the case scenario had a direct and significant impact upon self-esteem projections by members of Groups 1 (Blind-ATDP) and 2 (Blind-no ATDP). Both groups presented with a hypothetically blind client subsequently identified blindness as either the first or second most salient of 10 participant generated clinical issues. In addition, hypothetically blind clients appeared to be

disproportionately dichotomized into self-esteem categories. Those participants who received and completed the ATDP (Group 1) assigned nearly 80% of their hypothetically blind clients to the low and high self-esteem quartiles while members of Group 2 (Blind-No ATDP) placed over 78% of hypothetically blind clients to the average and high self-esteem quartiles.

Participant responses to training and exposure to disability indices illustrated a surprising lack of contact with disabled persons and accompanying clinical issues. A substantial percentage of therapists reported little if any academic, experiential, or personal exposure to people with disabilities. Post-graduation and extra-curricular experiences appeared to parallel patterns of exposure noted while in academia. Yet, therapists reported substantial levels of self-perceived comfort and effectiveness in clinical work with disabled clients.

The single significant training variable related to "degree held" with participants holding a Ph.D. evidencing significant differences from those with lesser degrees in the frequency of attributed high self-esteem for persons with disabilities. However, the absence of significant results in complimentary training indices provides little guidance for interpretation of the source and significance of degree held as it relates to attitudes toward the disabled.

Limitations

Limitations of the present study are numerous and potentially significant. The ATDP as a self-report, unidimensional, and transparent instrument completed by testwise and sophisticated subjects was troublesome. Likewise, utilization of the CSEI, an objective self-esteem measure as essentially a projective device, raises methodological concerns with potential implications for derived results. In addition, constructs such as "self-esteem" and "disabled" are far from precisely defined and universally understood. As a result, an unfortunate degree of uncertainty was introduced through definitional ambiguity. Finally, as is notorious with self-report and attitudinal measures, valid questions concerning consistency between expressed feelings and subsequent behavior are inevitable and justified.

Implications

The most current U. S. census indicated that 48.9 million people or 19.4% of the nation's population was disabled in 1990. Moreover, severely disabled persons numbered 24.1 million or 9.6% of the U. S. population. Given these figures along with a sharp increase in aging Americans with accompanying disabilities, it would appear likely that therapists will increasingly encounter those with disabilities in their clinical practice. Aside from concerns exclusive to their disability, clients will likely

bring to therapy ancillary issues of under or unemployment, inadequate transportation, economic difficulties, and declining health.

Findings derived from this investigation suggest that persons with disabilities may encounter clinician bias in at least the initial stages of therapy. It appears that therapists prejudge attributes of disabled persons artificially placing them within arbitrary categories solely as a result of their physical status. Moreover, results from this investigation suggest that the more evident the disability to the therapist, the more likely is the clinician to ascribe extreme attributes. In short, results from this investigation appear to support those who have asserted that persons with disabilities may encounter clinician prejudice or bias when seeking psychological services.

Second, results from this investigation suggest that nearly four of five therapists or those in training for such work feel quite comfortable and effective in clinical work with disabled clients. At the same time however, a significant proportion of survey participants reported little if any academic, clinical, or personal exposure to persons with disabilities. In addition, many therapists or those in training reported having had little or no disability related training.

The effectiveness of disability related training has

generally been acknowledged in the literature with some distinctions drawn between cognitively and affectively based programs (Fichten, Tagalakis, & Amsel 1989; Zych & Bolton, 1972). However, some doubts persist regarding the effectiveness of such training due in large part to the utilization of objective attitudinal measures with their attendant weaknesses. Yet the goal of enhancing clinicians' attitudes towards those with disabilities remains an identified need by many in the profession.

This goal may arise in part from recognition that therapists' attitudes toward disabilities are directly correlated with rehabilitation success (Krauft, Rubin, Cook, & Bozarth, 1976). Similarly, as Krausz (1980) noted, the therapist's attitude towards disabilities profoundly influences the client's ascription of meaning to that impairment. It appears likely that in many instances, both client and clinician may enter therapy with preconceptions concerning the presence, nature, and magnitude of disability related issues. Some discrepancy in clinician and client perspective is to be expected and is accepted if not beneficial. However, the depth and persistence of significantly divergent views can prove detrimental not only to the therapeutic relationship but to the client as well. Only by recognizing and exploring disability related biases will therapists move towards the essential tenets of psychology; "unconditional positive regard" and empathy.

Prejudice by its very nature negates both and may well preclude meaningful therapy.

Future research efforts may wish to focus upon the identification of enhanced mechanisms for the assessment of therapist's attitudes towards persons with disabilities. Secondly, and of equal if not greater importance is the development of a methodology or instrument which will illuminate the relationship if any between expressed attitudes towards those with disabilities and subsequent clinical effectiveness. Finally, the nature and impact of disability related training whether academic or experiential may need to be revisited to determine the desirability and effectiveness of such exposure.

This investigation has perhaps raised more issues than it has satisfactorily resolved. It is hoped that this study will serve as a point of departure for future research which will more adequately expose and address questions raised by this investigation.

APPENDIX A
ATDP RESULTS FROM YUKER (1988)

GENERIC ATDP FORM O MEAN SCORES BY YEAR AND POPULATION FORM
O: RANGE 0-120

Bowling (1995), psychotherapists; 79.13
Urie (1991), undergraduate students, females 79.6, males
73.7
Yuker (1986), adults, 83.3
Fichten (1986), Montreal adults, females 82.7, males 76.4
Wilson (1983), undergraduate students, 82.0
Furnham (1983), british sample, 72.1
Avery (1982), undergraduate students, 81.5
Alessandrini (1982), undergraduate students, females 80.3,
males 72.5
Smith (1978), English undergraduate and Graduate students,
females 71.3, males 70.5
Lenhart (1976), adults, 78.9
Ashburn (1973), non-disabled adults, 81.9
Smits (1971), undergraduate students, females 72.6, males
70.9
Bishop (1969), undergraduate students, females 74.0, males
71.6
Conine (1968), subjects no contact with disabled persons,
76.4
Conine (1968), friend's of disabled persons, 81.3
conine (1968), family members of disabled persons, 77.1
Conine (1968), teachers, females 80, males 75.1
Yuker (1966), general sample, females 75.4, males 72.8
LeCompte (1966), undergraduate students, 66.3
LeCompte (1966), Turkish undergraduate students, 90.4

APPENDIX B
ATDP RESULTS FOR INDIVIDUALS

ATDP FORM O, A, and B MEAN SCORES FOR HELPING PROFESSIONALS
BY YEAR AND POPULATION FORM O: RANGE 0-120

Bowling (1995), psychotherapists, 79.13
 Marsh (1983), teachers, 82.1
 Cortez (1983), Faculty members, 97.0
 Kelly (1982), college disability coordinators, females 98.0,
 males 93.9
 Wolraich (1980), Pediatricians, 73.6
 Wolraich (1980), Pediatric Students, 75.3
 McDaniel (1980), vocational teachers, 79.4
 Rosswurm (1980), nursing students, 81.8
 Rosswurm (1980), nursing students, 79.6
 Fonosch (1979), Faculty without contact, 79.8
 Fonosch (1979), higher education faculty, 83.0
 Fonosch (1979), faculty with contact, 85.3
 Fonosch (1979), higher ed faculty, females 89.2, males 81.7
 Clark (1978), high school principles, 77.6
 Clark (1978), high school physical ed teachers, 79.7
 Foley (1978), school teachers, females 78.9, males 76.1
 Dillon (1977), Teachers, females 98.9, males 95.4
 Lenhart (1976), Rehabilitation professionals, 79.8
 Felton (1975), child care trainees, females 93.0
 Ashburn (1973), rehabilitation administrators, females 76.5,
 males 83.8
 Conine (1968), elementary special ed teachers, 83.1
 Conine (1968), Elementary teachers, 78.6
 Conine (1968), teachers, females 80, males 75.1
 Stiff (1964), dental students, 75.6

(Although neither ATDP forms A nor B were utilized in the present investigation, as equivalent forms, an examination of mean scores for comparable samples may prove informative. note however that both Forms A and B permit maximum scores of 180, and as such, direct comparison of mean scores with those of Form O is inappropriate. A mean score of 118.69 on Forms A or B would approximate that of 79.13 as obtained on Form O in the present study.)

Form A: Range 0-180

Yuker (1986), graduate student psychology, 127.0
 Yuker (1986), rehabilitation personnel, 129.2
 Livneh (1982), graduate student counselors, females 126.6,
 males 131.0
 Martin (1982), graduate student rehabilitation counselors,
 females 128.0, males 136.0
 Martin (1982), disabled graduate rehabilitation Counselors,
 females 125.0, males 131.0

Darnell (1981), Rehabilitation personnel, females 128.1,
males 119.0
Elston (1977), rehabilitation personnel, 123.2
Downes (1968), Rehabilitation Counselors, 120.5
Downes, (1968), graduate student rehabilitation Counselors,
117.2

Form B: Range 0-180

Yuker (1986), Rehabilitation Personnel, 123.1
Yuker (1986), Rehabilitation personnel, 120.8
Yuker (1986), rehabilitation personnel, females 121.4, males
128.3
Yuker (1986), rehabilitation Personnel, 127.9
Fish (1983), graduate student rehabilitation Counselors,
132.0
Jenkins (1982), special education Teachers, 127.4
Hendlin (1981), special education teachers, 121.4
Hendlin (1981), teachers, 93.1
Peterson (1977), graduate student special education, 116.6
Levy (1975), Rehabilitation workers, females 122.6, males
118.4
Carter (1974), Vocational Rehabilitation Counselors, 119.3
Carter (1974), Vocational Rehabilitation Counselors, females
122.1, males 118.6
Drude (1971), graduate student counselors, females 126.6,
males 126.8
Durfee (1971), Graduate student social workers, Females
104.0, males 110.0
Durfee (1971), Graduate students psychology, females 121.0,
males 121.0

APPENDIX C
PACKET OF INFORMATION



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Thank you for agreeing to serve as a participant in my dissertation; a commitment which I believe should demand no more than 30 minutes of your time. This data packet includes several components which are to be read and completed strictly in their order of presentation. Once completed, please seal and return your responses in the enclosed envelope to my designee from whom your packet was initially received.

Please note that nowhere on these materials are you requested to identify yourself, and that your "sealed" packet will be opened only upon return to this researcher for data entry and analysis. Thus, as your involvement in the present study is both confidential and voluntary, the completion and return of this survey packet will be regarded as an expression of your informed consent for participation in this research.

I have requested that site designees collect survey packets within two (2) weeks of their distribution. In the meantime, questions or concerns regarding this process may be directed to me (Dennis Bowling, 708-738-3588) or my dissertation supervisor (Dr. Suzette Speight, 708-853-3348). Once data has been gathered and analyzed, I would be happy to further elaborate upon the purpose and findings of my dissertation. Once again, thank you for your participation in this research; your time and effort is invaluable in the completion of this dissertation and award of my doctorate.



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Mark each statement in the left margin according to how much you agree or disagree with it. Please mark every one. Write +1, +2, +3: or -1, -2, -3: depending on how you feel in each case.

+3	I AGREE VERY MUCH	-1:	I DISAGREE A LITTLE
+2	I AGREE PRETTY MUCH	-2:	I DISAGREE PRETTY MUCH
+1	I AGREE A LITTLE	-3:	I DISAGREE VERY MUCH

-
- ___ 1. Parents of disabled children should be less strict than other parents.
 - ___ 2. Physically disabled persons are just as intelligent as non-disabled ones.
 - ___ 3. Disabled people are usually easier to get along with than other people.
 - ___ 4. Most disabled people feel sorry for themselves.
 - ___ 5. Disabled people are the same as anyone else.
 - ___ 6. There should not be special schools for disabled children.
 - ___ 7. It would be best for disabled persons to live and work in special communities.
 - ___ 8. It is up to the government to take care of disabled persons.
 - ___ 9. Most disabled people worry a great deal.
 - ___ 10. Disabled people should not be expected to meet the same standards as non-disabled people.
 - ___ 11. Disabled people are as happy as non-disabled ones.
 - ___ 12. Severely disabled people are no harder to get along with than those with minor disabilities.
 - ___ 13. It is almost impossible for a disabled person to lead a normal life.
 - ___ 14. You should not expect too much from disabled people.
 - ___ 15. Disabled people tend to keep to themselves much of the time.
 - ___ 16. Disabled people are more easily upset than non-disabled people.
 - ___ 17. Disabled persons cannot have a normal social life.
 - ___ 18. Most disabled people feel that they are not as good as other people.
 - ___ 19. You have to be careful of what you say when you are with disabled people.
 - ___ 20. Disabled people are often grouchy.



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CASE SCENARIO

You are about to meet your next client for the first time and a cursory review of intake notes indicates the following:

Your client's name is Tina and she is 14 years of age. She is the youngest of 4 children, the only daughter, and is the only child still residing at home. She has been blind from birth but is generally fit and free of any chronic medical condition. Her father is a police officer; her mother has not been employed outside the home since the birth of her oldest brother.

Tina is in 8th grade and is reported to be an above average student who is quite and behaved in her classes. According to her parents, Tina has a few friends with whom she interacts primarily at school but demonstrates little interest in extracurricular activities. She has no consuming interests or hobbies other than reading and listening to the radio and/or television.

Despite her parents efforts to promote greater social involvement, Tina has elected to engage in generally solitary activities, stating she is sometimes "uncomfortable" in social gatherings. Tina's parents are concerned and have referred her to you for an evaluation.

Prior to completing the accompanying material, please indicate below (in descending order of importance) what you regard as Tina's 3 most clinically salient characteristics.

1:

2:

3:

Finally, drawing upon your clinical training, professional experience and utilizing what you regard as most "salient" from the intake notes, please complete the accompanying material as you anticipate Tina would. Please note that in completing the "Coopersmith" answer only the first 25 items presented.



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DEMOGRAPHIC DATA SHEET

Your responses will be anonymous, confidential and utilized solely for purposes of sample description.

1. Age: _____
2. Gender: M F (Please Circle)
3. Race/Ethnicity: (Please Specify) _____
4. Highest degree currently held: _____
5. Degree working towards, if appropriate: _____
6. Name of school, if appropriate: _____
7. Major field of study: _____
8. Years of graduate study completed to date: _____
9. Approximate number of semesters in which you received clinical contact hours: _____
10. Beyond those in graduate school, designate the sum of your years of professional practice (if appropriate): _____



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11. If employed, check your primary employment setting:
- | | |
|------------------------------------|--------------------------|
| Private psychiatric hospital | <input type="checkbox"/> |
| State psychiatric hospital | <input type="checkbox"/> |
| University counseling center | <input type="checkbox"/> |
| Community counseling center | <input type="checkbox"/> |
| Private general hospital | <input type="checkbox"/> |
| County general hospital | <input type="checkbox"/> |
| State general hospital | <input type="checkbox"/> |
| VA hospital | <input type="checkbox"/> |
| Private practice | <input type="checkbox"/> |
| Health Maintenance or managed care | <input type="checkbox"/> |
| Correctional facility | <input type="checkbox"/> |
| Other, please specify _____ | |
12. Do you regard yourself as having a physical disability? (Please specify):

13. Estimate the number of physically disabled persons with whom you have shared a meaningful non-professional relationship: _____
14. In approximately how many "undergraduate" courses did you receive what you regard as "substantial" exposure to psychosocial aspects of physical disability? _____
15. In approximately how many "graduate" courses did you receive what you regard as "substantial" exposure to psychosocial aspects of physical disability? _____



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16. To approximately how many physically disabled clients did you serve as primary therapist during your various practica? _____
17. To approximately physically disabled clients did you serve as primary therapist during your internship (if appropriate)?

18. Excluding those attended during your graduate training, approximately how many hours have you spent in workshops or seminars which you regard as "substantially" related to clinical work with physically disabled clients? _____
19. Approximately what percentage of your current annual client caseload is represented by persons with physical disabilities? _____
20. On a scale from 1 to 10, with 1 denoting extreme discomfort and 10 indicating total comfort, please designate your degree of "comfort" in clinical work with physically disabled persons. (Please Circle)
- 1 2 3 4 5 6 7 8 9 10
21. On a scale of 1 to 10, with 1 denoting extreme ineffectiveness and 10 indicating total effectiveness, please estimate your self-perceived clinical effectiveness in therapy with physically disabled clients. (Please Circle)

1 2 3 4 5 6 7 8 9 10

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The final copies have been examined by the director of the dissertation and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the thesis is now given final approval by the committee with reference to content and form.

The dissertation is, therefore, accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

Nov 20, 1995

Date



Director's Signature