

**Attitudes towards People with Intellectual
Disabilities: A Cross Cultural Study**

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An Overview

Part 1, the literature review, considers the historical context of conceptualisations of ID and service provision for people with intellectual disabilities in the UK. Current policies are outlined and research on public attitudes towards people with intellectual disabilities is considered, to help us understand the broader climate within which policies are implemented. Furthermore, this review critiques the quantitative approaches currently dominant within attitudinal research. It concludes that the impact of demographics particularly culture and religion, on attitudes to ID remain under researched areas.

Part 2, the empirical paper, reports on a study which explores attitudes towards people with intellectual disability among young people (ages 16-19) from white British and South Asian backgrounds (Total $N=61$), and how they arrive at their beliefs. Five themes regarding attitudes were identified: confusion versus more sophisticated understandings of ID; invisibility of people with ID versus representations in the media; universal humanity; positioning self as accepting and empowering; and views on care giving, with marked differences occurring between cultural groups. The main influences on attitudes towards people with ID acknowledged by participants were culture, religion, parents, education and previous contact with people with ID. Of note, there were more similarities than differences between groups in terms of what they viewed as influencing their attitudes. Both individual interviews and focus groups were useful in generating data.

Part 3, the critical appraisal, discusses the strengths, weaknesses and limitations of the present study, with references to changes in understandings of phenomena, sampling, being a white researcher and critically evaluating qualitative

research. Finally, this part concludes with a discussion of areas for future research and possible clinical implications derived from the study.

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Part 1: Review Paper

**Attitudes to People with Intellectual Disabilities within the
General Population: a Review of the Literature**

Abstract

Policy relating to intellectual disabilities in Western society has changed considerably over recent years. Wolfensberger's (1983) *Normalisation* approach increases the presence and participation of people with ID in community life in an attempt to engender less stigmatised attitudes and greater acceptance. This approach has been widely implemented in policy arena, however only limited research has considered the validity of its underlying premise.

Research in ID appears to concentrate on the attitudes of relatives of people with ID, rather than the general population. There are exceptions to this, with a small body of work considering attitudes towards people with ID beyond the family environment. Such research, however, centres on questionnaire based studies and this approach fails to explore the belief systems underlying expressed attitudes. Such attitudes flow from the social, cultural and historical positioning of the individual. Therefore, this review paper begins to analyse how issues relating to social and cultural standpoint may influence attitudes towards people with ID. By so doing it uncovers the preponderance in academic and clinical studies to focus on white western populations.

The paper also offers a review of the literature surrounding ID and critiques the quantitative approaches currently dominant as it examines beliefs and attitudes towards people with ID among the general population. This paper outlines areas for further research.

Introduction

This review paper explores cross-cultural constructions of ID¹ and attitudes towards people with ID. Four key themes are discussed: 1) the strategy utilised in gathering relevant literature; 2) the historical context of policy and attitudes with regards to interventions with people with ID; 3) current knowledge relating to attitudes to people with ID including methodological issues within this field; 4) the literature considering the impact of culture and religion on attitudes to ID within white western and Asian populations. The rationale for this focus is that the study presented in the empirical paper focuses on white western and South Asian populations. Finally, the paper concludes with a summary and recommendations for future research.

1 Research Strategy

The research strategy employed for this review was multi-faceted. Searches of the following databases were utilised: *Medline*, *Psycinfo*. Over time, numerous terms have been used to describe people with ID (Emerson, 2001). Thus, the following terms were considered in each of the search engines: *Learning Disability*, *Learning Dis**; *Intellectual Dis**; *Mental Retard** *Learning Difficult**.

Furthermore, bibliographies of published journals were reviewed and accompanied by citation searches. Best practice suggests that electronic searches are supplemented by hand searching particular key journals (Petticrew & Gilbody, 2004). Thus, hand searching of *Clinical Psychology*; *Clinical Psychology and People with Learning Disabilities*; *The Journal of Intellectual Disabilities*; *Mental Retardation and Developmental Disabilities*; *Journal of Applied Research in*

¹ *The term Intellectual Disabilities is utilised throughout this review rather than the British term 'Learning Disability.'* This reflects current practice within the international scientific community to privilege this terminology (Emerson, 2001). The term 'Intellectual Disability' refers to a person with cognitive functioning difficulties (IQ <70); associated difficulties with adaptive functioning and an onset during childhood.

Intellectual Disabilities; Intellectual and Developmental Disabilities; Mental Retardation; Journal of Intellectual Disability Research; Research in Developmental Disabilities; Journal of Policy and Practice in Intellectual Disabilities and *Journal of Intellectual and Developmental Disability* was undertaken. Additionally, the reading list for the UCL Clinical Psychology Course was also included.

This literature review cannot be considered exhaustive, but within the given time constraints and resources this review reflects a thorough attempt at data gathering and full examination of the most relevant and prominent publications.

2 Historical Context

2.1 Introduction

Consideration of historical context is imperative when contemplating people with ID. The concept of ID is socially constructed; how it is measured, who is viewed as having an ID and interventions are changeable over time and across cultures. The next section aims to consider how individuals with ID have historically been treated within the UK.

2.2 Middle ages to the 19th century

In contrast to the linear narrative that constructs the change from institutional to community care systems as ‘progress,’ systems were in place during the middle ages that offer similarities to contemporary attitudes towards community orientated care (Caine, Hatton & Emerson, 1998). During this period, the legislative and judicial systems identified two categories: ‘lunatics’ who in contemporary terms may be described as those with episodic mental illness; and ‘idiots’ who are probably best thought of as people with intellectual disabilities.

In such a system, ‘lunatics’ are identified as experiencing momentary madness interspersed with lucid and coherent periods, whereas ‘idiots’ suffer permanent congenital and irreversible difficulties (Andrew, 1996; Rushton, 1996). In practice, the judicial system only appeared to play a role if the ‘idiot’ needed financial support, perhaps due to a family crisis, or behaved in a disruptive manner (Caine et al., 1998). This support was provided by poor law administrators and the types of interventions differed greatly. However, admittance to a workhouse or asylum was rare as often ‘idiocy’ was an exclusion criterion. The main interventions offered tended towards meeting basic needs for a limited period, this could be offered to the family to enable them to support the person at home, to carers/nurses who provided accommodation and care; or to the person directly to enable independent living (Andrews, 1996; Rushton, 1996; Caine et al., 1998). The similarities between the care offered during this period and the contemporary notions of care management, crisis intervention, respite care and independent living are striking. Indeed, in his historical study of ‘idiocy’ and the impact on family and community in Northern England, Rushton (1996) reported “*little sign of the wholesale cruel neglect from which nineteenth-Century reformers suggested the mentally disabled needed rescuing*”(p. 60). Furthermore, he drew parallels between this period and the 1990’s in that care is only transferred entirely to the state if the family “*collapse under their burden of care.*” Furthermore, Berkson (2006) reports care at this time as more humane than in later centuries.

2.3 The Victorian Era – 19th Century

During the Victorian era, a number of social and cultural processes became increasingly prominent and were reflected in changes in attitudes to individuals with

ID. The three core processes were industrialisation, a drive for social reform within UK society that led to a rise in institutions, and a reconceptualisation of the term 'idiot' (Caine et al., 1998).

Industrialisation led to both the urbanisation of the UK and drive for a better educated workforce through the introduction of Elementary Education in the 1890s. Caine et al. (1998) argue that these developments increased the visibility of individuals with ID and also created a change in attitude where people with ID were considered a social problem, as the impact of an individual not working became a financial stressor for the family. This was compounded by the gradual decline of the extended family, which resulted in people with ID being perceived as an increased burden on their families and society.

Goodey (1996) reports a shift in thinking regarding definitions of mental illness and ID during this period. (John) Locke's attitudes became increasingly prominent as 'lunacy' was conceptualised as the 'right reasoning from the wrong principles'; whereas 'idiots' were regarded as lacking the ability to reason. The argument followed that *reasoning* was a defining characteristic of humanity and, consequentially, a dismissing of 'idiots' as not fully human. Caine et al. (1996) state that this significant shift in conceptualisation of ID continues to be reflected in attitudes towards people with ID that are prevalent in contemporary society; namely the perception of difference, being less than human, and lacking in intelligence.

Social Reforms during the Victorian era had far reaching impacts on the way that people with ID were perceived and treated. Gladstone (1996) reports the establishment of institutions during the 1800s, run by voluntary organisations, with the aim of teaching skills to people formally perceived as 'incurable'. However, only small numbers of people were considered likely to benefit from this approach. They

were handpicked as children and taken for five years training ‘to be productive members of society’ (Caine et al., 1998). It seems that there were few success stories and people tended to remain longer than 5 years (Caine et al., 1998). Estimations for this period suggest half of all people with ID lived within institutions; the other half remaining in the community (Gellband, 1979; cited in Gladstone, 1996).

Towards the latter stages of the Victorian era, government agencies began to fund institutions. These appeared to be qualitatively different from the voluntary institutions in three ways: firstly, they were larger in size reflecting drives towards ‘economies of scale’ and increased demand; secondly, criteria for entrance became dependent upon a state imposed classification system; thirdly, the aims of the institutions were education, training or treatment rather than attempting to create ‘productive members of society’. Gladstone (1996) suggests that costs were kept down by the retention of adults with ID to work within the institutions. Gladstone (1996) and Jackson (1996) argue that this retention, based on the understanding that people with ID were in some way vulnerable and needed protection from society in ‘safe places’, led to a culture in which people with ID were regarded as needing containment.

2.4 The early twentieth century

In the early parts of the twentieth century, an increase of individuals with ID was reported. In part, it has been argued that improved health care and social conditions during this period may have contributed to increased survival rates for infants with disabilities. This, combined with increased life expectancy, may have increased the overall prevalence rate within the population. Furthermore, changes to the conceptualisation of ID may have increased demand for places within institutions.

A darker side to this changing construction of ID was a growing Eugenics movement and attitudes which represented people with ID as 'a threat to society' (Caine et al., 1998). The arguments surrounding this purported threat came from a number of developments which converged during this period; namely the rise of the medical profession, particularly psychiatry, who began to consider the people with ID as having an organic disease which could not be cured or improved. This reinforced the idea of people with ID being qualitatively different from other humans. The terminology changed during this time as the term 'mental deficiency' began to be used. This incorporated 'idiots', 'imbeciles', the 'feeble minded', and 'moral imbeciles' into a single term (Caine et al., 1998). This extended definition was used to include people engaging in behaviour thought to be socially unacceptable, such as drunkenness or sexual 'immorality' (Cox, 1996; Jackson, 1996).

This represents a significant moment in the history of the institution as the ethos of permanent segregation began to emerge (Jackson, 1996). Such segregation stood in stark contrast to the training and reintegration dominant during the early Victorian era. Jackson highlights numerous arguments that were mobilised to defend these changes. Such arguments centred on the financial implications to society and the economic efficiency of institution based intervention; a need to protect the public from people with ID; as well as a narrative that suggested people with ID needed sheltering from wider society. This concept of protection and sheltering as a prominent discourse appears to first develop in the literature at this time.

These changing attitudes towards individuals with ID were translated into legislative and judicial reforms. The Royal Commission of the Care and Control of the Feeble-minded (1904-1908) recommended segregated institutions for all people

with ID. This advice was enacted by the 1913 Mental Deficiency Act, however the act failed to provide funding and thus recommendations were not fully implemented (Caine et al., 1998; Digby, 1996; Thomson, 1996). In contrast, the 1913 Act also permitted local authorities to place people with ID with their families or under guardianship with other service providers. Cox (1996) and Thomson (1996) both report that such mechanisms for care were widely used as a compliment to institutional care. ‘Occupation Centres’ also emerged during this period to provided day time activities for people with ID in an attempt to support families.

2.5 The Post war years

The social and cultural forces that followed World War II crystallised into a welfare system in the UK that was radically different from what had been present in earlier society. The 1944 Education Act led to the establishment of ‘special schools’ for children which segregated children with ID. This was compounded by the founding of the National Health Service (NHS) in 1948, which bought all institutions under the various government agencies under the general remit of the health service. This had far reaching consequences for institutions as they were remodelled as ‘hospitals’ and the people in their care redefined as patients with health problems (Caine et al., 1998).

The institutions that had emerged during the Victorian era continued to gain credence during the early twentieth century and rose to a peak in the 1950 and 60s. During this time approximately 60,000 to 64,000 individuals with ID were institutionalised (Caine et al., 1998). This increased institutionalisation and segregation of individuals with ID reiterated the protection and sheltering ethos prevalent during the inter-war years (Caine et al., 1998).

In view of the connection between the eugenic movement and the atrocities experienced under the Nazi regime, arguments relating to the inheritability of desirable human characteristics became increasingly untenable. The associated arguments regarding people with ID and their segregation were increasingly undermined. This was coupled with arguments that questioned the appropriateness of institution dominated care (Goffman, 1963). These developments reflected more general changes in social and cultural attitudes regarding institutionalisation. Increasingly people with ID were seen as less of a threat to the wellbeing of society. Such changes were further influenced by rising beliefs that the hierarchy which disregarded people with ID as less than human should be undermined and the citizenship of people with ID should be recognised (Emerson, 1992).

2.6 Post 1960's and Normalisation

The institutionalisation of individuals with ID was further undermined by various empirical studies during the 1960s. Such work highlighted the negative impact of institutional care on child development and children with ID specifically (Caine et al., 1998). Research also demonstrated how people with ID who were previously viewed as incurable and unsuitable for education, could develop many skills with appropriate support and the correct environment. Criticisms of traditional care were reinforced by a series of scandals regarding the abuse of patients. It is likely that increasing doubts about traditional care meant that closer attention was paid to activities within larger hospital thus resulting in a number of investigations. The first of these was the damning report of the committee of enquiry into Ely Hospital in Cambridgeshire in 1969 and South Ockendenon Hospital in Essex in the early 1970s (Mittler & Sinason, 1996).

As a consequence of the increasing dissatisfaction with the institutional arrangement, alternatives were sought throughout the 1960s. In 1970, statutory regulations introduced a 'social services' department to local authorities. Such services were instigated in an effort to provide a more complete, and integrated approach that provided support for both individuals and their families to enable individuals with ID to live apart from the institution. A government white paper in 1971 entitled 'Better Services for the Mentally Handicapped' outlined a new approach that resulted in an increase in community based care, alongside a decline in institutionalised care, though the recommendations at the time did not go as far as suggesting total closure of all hospitals.

Community based care increasingly became the preferred option throughout the 1970s and 1980s as Governmental committees became focused on the individual. Furthermore, the Jay report, introduced the concept of normalisation (Wolfensberger, 1972) to UK policy relating to individuals with ID (Emerson, 1992). Normalisation was originally a Scandinavian concept based on a number of statements regarding basic human and civil rights for all. The theory had egalitarian aims regarding the rights of service users and saw deviance as the outcome of societal rejection rather than individual pathology (Emerson, 1992). It pivoted on the theory that the more devalued the person, the greater the impact of any further devaluing characteristics, and thus services should work to decrease the impact of devaluing characteristics and instead provide opportunities for increased acquisition of socially valued characteristics. Wolfensberger (1972) proposed that through increased exposure to people with ID in the community, widely held stereotypes would be challenged and this attitude within the general population would become positive. A further aim was

to challenge socially held stereotypes by direct experiences with the individual. This theory later became known as Social Role Valorisation (Wolfensberger, 1983).

The number of people with ID living in institutions fell dramatically during the 1980s. Further emphasis was placed upon day centres, first in the form of industrial training and later education. Services offering family support and respite were also extended during this period (Gray, 1996).

These developments led to a shift from the construction of ID as a primarily medical issue towards a social model of disability. The meaning of ID was re-conceptualised in terms of social barriers to engaging in a meaningful life. This emphasis resulted in the idea that services and society need to adapt, rather than the individual. This idea is reflected in the emergence of self-advocacy and service user groups.

2.7 Current Situation

Currently, both national and international policies promote the acceptance, integration and inclusion of people with disabilities into mainstream society (IASSID, 2001; United Nations, 1975, 1993; Department of Health, 2001). In 1995 the Disability Discrimination Act enshrined in law the rights of people with ID. Nearly all large long-stay hospitals have closed and people with ID have moved into the community. In 2001, the Department of Health published a White Paper titled “Valuing People” with the aim to improve services so that individuals with ID would be empowered; their choices maximised and their independence and social inclusion increased. In 2008, “Valuing People Now” was published. This has similar aims but with attached funding to enable realisation of objectives.

Caine et al. (1998) comment that Normalisation principles regarding raising the status of people with ID as a group have been replaced by principles concerning individuals' rights and empowerment. They argue that this is reflected within the growth of self-advocacy and person centred planning which places people with ID at the centre of any planning about their life. Further policies have continued to expand on this notion, for example, Self Directed Support, Individual Budgets and the extension of Direct Payments to people with ID, so that they directly employ staff to support them.

Even though community living is now considered the norm for individuals with ID, it is unclear to what extent Wolfensberger's (1972, 1983) original theory, particularly the argument that increased community presence would result in less stigmatised attitudes and increased acceptance by wider society, has been realised. Particularly as Cummins and Lau (2003) challenge Wolfensberger's assertion that community presence reduces stigma. There is also an increasing body of (case-study) work that indicates that discrimination against people with ID is alive and well (for example, Mencap's report *Death by Indifference*, 2007; the *Healthcare for All* report, 2008; and the report of the serious case review following the murder of Steven Hoskin, 2008). Therefore, it is unclear to what extent the general UK population subscribes to the values of "Valuing People Now", particularly when considering black and minority ethnic groups (BME) in Britain.

2.8 Summary

In summary, there have been significant changes in constructions of people with ID over time in the UK (Caine et al., 1998; Wright & Digby, 1996). In line with Wolfensberger's theory (1972, 1983), one would hope that changes in policy and

services will influence attitudes in the general population and interactions with individuals with ID. However the extent to which current key values in national policy are mirrored in public attitudes is unclear. Accordingly the next section of this review considers empirical literature on attitudes towards people with ID and methodological concerns within the field.

3 Attitudes towards ID

3.1 Introduction

This section considers current research within the field of attitudes towards individuals with ID. It examines the impact of culture and religion on attitudes towards people with ID. Specific issues for the South Asian community are also considered. Finally, methodological concerns within attitudes research are considered and theories from the wider social psychology research are reviewed.

3.2 The importance of attitudes

Determining attitudes toward people with ID is important because attitudes are considered one of the best predictors of behaviour (Aizen & Fishbein, 1980; Kraus, 1995). Positive attitudes towards people with ID have been shown to be important in facilitating the process of normalisation (Antonak & Livneh, 1991; Geskie & Salasek, 1988; Henry, Keys, Jopp & Balcazar, 1996). Thus, for social policy to be fully implemented, attitudes towards individuals with ID need to be sympathetic to the values enshrined within policy.

Furthermore, attitudes towards individuals with ID impact on both the person with ID and their families. This is a consequence of societal attitudes affecting others' behaviours towards both the family and the individual (Chamba, Ahmad,

Hirst, Lawton & Beresford, 1999). For example, Woolfson's (2004) socio-psychological model suggests that societal views of disability strongly affect a parent's view of interactions with their child. On a broader level, the way a culture understands ID is likely to affect the amount or type of support that is offered to those with ID and their families. Indeed, Tak-fai Lau and Cheng (1999) argue that increased well-being for individuals with ID is facilitated by acceptance in local communities. This was confirmed by White's and Hastings' (2004) study which found that increased social support increased parental well-being of children with ID and affected resources available to both the individual with ID and the family. Furthermore, Rees et al. (1991) found that attitudes can influence the opportunities that are made available to an individual with ID and have been shown to affect the quality and availability of services. Meanwhile, Myers et al. (1998) highlight the impact of negative attitudes and stigma towards people with ID and their families. They determined that negative attitudes were often associated with a lack of knowledge about people with ID and a suspicion and even antagonism regarding the idea of community integration. The extent to which the general population subscribes to the principles of normalisation is explored below.

3.3 The impact of culture on attitudes

There is a small body of literature regarding the impact of culture on attitudes towards individuals with ID. Such studies seem very relevant to the UK population, due to its culturally diverse populations. Furthermore, most policy is "*based on western notions of 'independent living' and 'self advocacy' which is of questionable relevance*" (Miles, 1992, p.235) to those from Asian backgrounds whose values may centre on more collectivist value systems. Cross-cultural studies between eastern and

western countries (see for example Aminidiv & Weller, 1995; Downs & Williams, 1994) have highlighted fundamental differences in constructions of ID and attitudes towards people with ID.

The majority of research in this area has utilised scales measuring attitudes towards ID and concern regarding whether these attitudes are ‘positive’ or ‘negative.’ Henry, Keys, Jopp and Balcazar (1996) note that this simplistic approach defies the complexity of the subject area and does not inform the extent to which specific attitudes such as integration or empowerment are considered in the general population. Thus, Henry et al. (1996) created the Community Attitudes Living Scale – Mental Retardation Form (CLAS-MR) in an attempt to measure inclusion related attitudes in line with current social policy. In an analysis of items, they found four factors associated with attitudes towards the inclusion of individuals with ID in society. These factors suggest four discrete, though related dimensions of inclusion attitudes: a) Empowerment, the extent to which individuals with ID are granted freedom to make their own life choices; b) Exclusion, the extent to which respondents would like to isolate individuals with ID from community life; c) Sheltering, the extent to which respondents think that individual with ID need help keeping safe; and d) Similarity, the extent to which people feel that individuals with ID share a universal humanity. Within the literature, empowerment and similarity are considered positive attitudes and exclusion and sheltering as negatives attitudes. However, Horner-Johnson et al. (2002) argue that is somewhat simplistic as individuals who score high on the subscale Sheltering may think that individuals with ID need help, which could very well be the case, and it shows that *“people (with ID) are valued enough to be worthy of care and concern”* (Horner-Johnson et

al., 2002, p. 375). The CLAS-MR is currently considered the pre-eminent measure in the field due to its alignment with values subscribed to under current ID policy.

Downs and Williams (1994) used a questionnaire based survey targeting a large sample of 371 undergraduate students in universities in England, Denmark, Belgium and Portugal. They found significant cultural differences, with students from Belgium having more negative attitudes than those from England, Denmark and Portugal. Furthermore, Eggert and Berry (1992) in a comparison study between German, Irish and Australian students noted that German students demonstrated less positive attitudes towards the integration of people with ID. These studies have numerous shortcomings, most notably the emphasis on a student population limiting generalisations to wider populations. In addition, discrepancies in attitudes towards individuals with disabilities and learning disabilities and between cultures could be measured but not readily explained.

Schwartz and Armony-Sivan (2001) researched 149 Israeli students' attitudes towards integration of people with ID and mental illness in the community. They administered the CLAS-MR to a random sample of students. Overall, it was found that the attitude most endorsed by the Israeli students was Empowerment, and they favoured Similarity over Exclusion. Prior contact with a person with ID was not related to positive attitudes towards individuals with ID. Furthermore students were more likely to endorse exclusion for mental illness than ID. Schwartz and Armony-Sivan compared the results from their study to Henry et al.'s (1996a; b) studies of students and staff who worked with individuals with ID in the US. The Israeli sample scored lower on Empowerment and Similarity and higher on Exclusion and Sheltering than the US sample. The authors hypothesized that these differences were due to the establishment of normalisation for a longer period in the US than in Israel.

Furthermore, Hasting, Sjoström, and Stevenage (1998) compared 122 adolescents from England and Sweden regarding their attitudes towards community presence of people with ID. The researchers designed a 24-item scale that reflected a number of situations that the authors thought would be characteristic of normative lives for those with ID. 12 of these questions were worded positively and 12 negatively. They found that English adolescents held less positive attitudes towards integration in leisure situations than Swedish adolescents, and tentatively suggested that the longer implementation of normalisation in Sweden has resulted in more positive attitudes. Limitations of the study include not matching on social economic status and not using a standard measure, making comparison to other research difficult. Furthermore, the authors note that a major question remains about the direction of the influence between integration and attitudes towards ID. Is it that more positive attitudes towards people with ID have resulted in more progressive approaches to care in Sweden, or should findings be considered in line with Wolfensberger's (1972, 1983) theory that deviant roles for individuals with ID result in negative attitudes?

Horner-Johnson et al. (2002) utilised the CLAS-MR in conjunction with other attitude scales to investigate attitudes toward people with ID among 286 Japanese students. A key finding of this study was that the factor structure of the CLAS-MR held for the Japanese sample, with those who scored highly on Empowerment and low on Exclusion more likely to endorse principles of normalisation policy. Not surprisingly, students who were considering a career in ID were more likely to have positive attitudes towards individuals with ID than those who did not wish to have a career in this field. Additionally the Sheltering subscale was less correlated with the other subscales, and the authors suggested that this may be due to this sub-scale

being harder to define as positive or negative as sheltering can be viewed as negative in that it does not promote independence or alternatively as positive as individuals consider that people with ID need support.

So-Kum Tang et al. (2000) explored 489 Chinese children's attitudes towards ID and individuals with ID utilising a 20-item questionnaire previously used by Gash (1993). This study found that Chinese children had favourable attitudes towards individuals with ID and were positive regarding school integration. The authors compared the results to Gash (1993) who collected data from 326 children in Dublin, Ireland. It was found that children from a Chinese background were more positive towards school integration and more willing to have social interactions and form social relationships with individuals with ID than the Irish children. However, the children from an Irish background appeared to be more tolerant and less afraid of children with ID and showed increased concern for them. The authors' hypothesised the process of normalisation having begun in Ireland before it began in China may account for increased tolerance and decreased fear. Furthermore So-Kum Tang et al. state that within Chinese culture it is socially appropriate to be polite and nice to people, especially those less fortunate than oneself thus the apparently more positive attitudes amongst the Chinese children may be due to social norms.

Additionally, So-Kum Tang et al. report that traditionally in Chinese culture ID is perceived as a form of punishment for parents of violation of Confucian teaching such as dishonesty or misconduct. It is the cultural understanding that families rather than society should be responsible for individuals with ID. Those who subscribe to such beliefs, often engage in avoidance coping strategies, wishful thinking, denial and social withdrawal (Cheung & Tang, 1995; Chen & Tang, 1997). Such studies have also revealed practices that appeal to supernatural powers and

reject social integration to minimise the stigma attached to having someone with an ID as a family member. One could further hypothesise that these beliefs regarding causation may result in fear in children's attitudes towards individuals with ID.

3.4 The impact of other demographics on attitudes

Research has examined the influence of a range of demographic variables on attitudes. Being younger has been found to be associated with more positive attitudes (So-Kum Tang et al., 2000; Yazbeck, McVilly & Parmenter, 2004). Higher levels of educational attainment appear to be associated with more positive attitudes towards ID (Yazbeck, McVilly & Parmenter, 2004) and with more accurate knowledge of ID (Aminidiv & Weller, 1995). There is somewhat inconsistent evidence to date regarding the impact of gender and previous contact with people with ID on attitudes. Some researchers have found that females hold more positive attitudes towards people with ID than males (Downs & William, 1994; Oullette-Kuntz et al., 2003). Others have found no association between gender and attitudes towards people with ID (Aminidiv & Weller, 1995; So-Kum Tang et al., 2000). Prior contact has been associated with both more positive attitudes towards people with ID (Yazbeck, McVilly & Parmenter, 2004) and less positive attitudes (Downs & Williams, 1994; Schwartz & Armony-Sivan, 2001).

In summary, there is a small body of empirical work examining attitudes towards ID in the general population. However, limitations in this research include emphasis on student populations and the use of different measures of attitudes which make cross-comparison difficult. The evidence suggests an association between educational attainment, age and attitudes, but is inconsistent regarding the impact of gender and prior contact on attitudes towards people with ID. At present it is unclear

if this is due to sampling issues or perhaps due to an unknown mediating variable, for example the quality of the experience of knowing someone with ID. The use of attitude questionnaires in all the studies cited has produced some interesting results, but also has its limitations, not least giving little indication why certain beliefs may be dominant, how people arrive at their attitudes and whether attitudes as measured by these scales reflect actual behavioural practice towards individuals with ID.

3.5 Specific issues in the South Asian Community

Overall, very little research has investigated the way ID is viewed by the various ethnic, cultural and religious communities represented in the culturally diverse UK. Madood et al. (1997) define 'South Asian' as a term used to refer to people originating from India, Pakistan, and Bangladesh and Indians who have lived in east Africa for a period of time. With 4% of British nationals being of South Asian descent, cross-cultural understandings of ID become important, especially as it is expected that by 2021 7% of individuals with ID in Britain will be from South Asian communities (Emerson & Hatton, 1999; Hatton, Akram, Shah, Robertson & Emerson, 2003). According to Mir et al. (2001), higher levels of material and social deprivation compounded with other risk factors such as poor access to maternal health care, misclassification and higher rates of environmental and genetic risk factors contribute to the increased incidence of ID in South Asians in the UK.

Within the literature depicting cross-cultural differences in attitudes towards people with ID, there is limited research comparing attitudes of people from South Asian backgrounds in the UK with those of white British origin. One of the few studies in this area (Fatimilehin & Nadirshaw, 1994) used a structured interview schedule to compare 12 South Asian and 12 white British families. This study suggests that religious and cultural differences between the two groups underpin the

differences in attitudes and use of services relating to ID rather than characteristics of the parents or the child with ID. However, it is limited by the use of a small sample, thereby restricting analysis to descriptive and basic qualitative analysis. Furthermore, participants were all parents of children with ID, whose ideas are highly unlikely to be representative of wider societal views.

The preference of South Asian parent carers to have their child looked after by relatives when they are unable to look after them (Fatimilehin & Nadirshaw, 1994) may be indicative of the greater role of the family within the South Asian community; it may also explain low uptake rates of certain ID services by South Asians. Hatton et al. (1997a) found that only a third of South Asian carers make use of short-term break care, as the service is often only available for a set time period of either one or two weeks which does not allow either longer trips to visit family abroad or shorter breaks for religious festivals or weddings. Additionally, Bywaters et al. (2003) conducted a series of semi-structured interviews with 19 Pakistani and Bangladeshi families with a disabled child investigating families' understanding of the cause of disability and whether shame and stigma influenced service uptake. Families who experienced increased shame and stigma were less likely to use services than others. However, the study only recruited individuals who utilised an advocacy service, thus resulting in a biased sample who were utilising at least one service.

On a broader level the way a cultural group understands ID is likely to affect the amount of support offered to people with ID and their families. Hussian, Atkin and Ahmad (2002) conducted qualitative interviews with 29 young South Asians with ID and their parents. Many participants reported a lack of understanding from their own communities. Furthermore, participants described conflict with

overprotective parents as problematic. Within this, there were gender differences, with females' reputations being seen as more easily damaged and thus increased restrictions were placed upon females in terms of activities that could be enjoyed in the community. Furthermore, gaining independence, leaving home, living separately or having personal control of resources did not have the same significance as for their white counterparts. A limitation of the study is that it was carried out only with individuals with ID, thus the extent to which some of the reported findings might apply to other young people in South Asian communities without ID and thus be a normative part of adolescence is unclear. Despite these limitations, this study highlights the need for policy and practice to reflect diversity and not assume that western ideas regarding independence and disability have the same meaning and appropriateness for individuals from South Asian backgrounds (Bignall & Butt, 2000).

Similarly, Baxter et al. (1990) found that Asian parental attitudes are equally influenced by lack of access to information as by cultural and spiritual beliefs. Asian parents hold differing beliefs about ID, including the concept of curability and the belief that marriage can lessen the level of ID (Bhatti, Channabasavanna & Prabhu, 1985). However, this study is constrained by small sample size, 25 parents of a child with ID and its age. The study also took place in India, so its relevance to South Asians living in the UK is unclear. Miles (1995) adds that over history there have been changes in eastern religious attitudes towards people with ID, including the belief that the person is being punished by God for something they have done in a past life or a view of the person as special and protected from the evil eye. Furthermore the concept of ID is undefined in some areas of Pakistan and India, particularly when the overall literacy rate is low (Miles, 1992, 1995). However,

Hatton et al. (2003) note that often parents are given insufficient information with their child's diagnosis. For example, the information is given in English when this is not the preferred language, which may add to the complexity of understanding for parents. However, many parents in the study reported satisfaction with the process and praised clinicians' explanations. Some parents reported that clear, medical explanations helped with family and community acceptance of ID and helped families to overcome beliefs they felt had been stigmatising.

A major limitation of this body of work is the lack of clarity regarding these views and whether they have changed over time. Channabasavanna et al. (1985) provided psychoeducation to parents of children with ID and parents of children without ID. Following the education it appeared that the parents of children with ID had significantly higher levels of knowledge and more positive attitudes towards ID than the other group indicating an interaction between prior contact with ID, education and impact on attitudes.

While South Asian families report a substantial need for formal service support (Baxter et al., 1990; Hatton et al., 1998, 2002; Chamba et al., 1999; Mir et al., 2001), there is both a low awareness of specialist services available for individuals with ID and a low uptake of family support services such as respite care (Hatton et al., 1998, 2002; Chamba et al., 1999. Mir et al., 2001) and family support groups (Chamba et al., 1999; Mir et al., 2001). Research has shown that informal and formal support networks within South Asian families of individuals with ID such as support from extended family are inadequate compared to white British families in similar positions (Hatton, Azmi, Caine & Emerson, 1998, 2002; Chamba, Ahmad, Hirst, Lawton & Beresford, 1999) and, contrary to expectation (Atkins & Rollings, 1996), do not receive much support from community or religious groups (Hatton et

al., 2002). Mir et al. (2001) observe a double disadvantage for people with ID from BME backgrounds as *“negative stereotypes and attitudes held by service professionals contribute to the disadvantage they face”* (p.2). “Valuing People” (2001) identified South Asian communities as currently underserved and requiring better support and understanding.

Jervis, (1987) in a brief anecdotal editorial stated that attitudes held by the South Asian community toward individuals with ID may also explain poor uptake of services. Fatalistic attitudes and the search for a cure are frequently given by staff as explanation for low uptake of services by people with ID and their families. The stigma of bearing a child with ID and the consequential impact this may have on the marriage prospects of siblings (Hughes, 1984) may offer other explanations for the relatively low uptake of services. Such attitudes may lead the family to conceal the (person with) ID, as opposed to drawing attention to the situation through accessing services. However, a constraint of this study is its age and its use of anecdotal rather than empirical research. In 2003, O’Hara conducted an empirical study considering parenthood on individuals with ID in East London. She noted a major cultural difference between those from white British and those from Bengali backgrounds, in that those from a Bengali background wished to see their children with ID married as they felt this would strengthen the individuals’ social identity and enable the person to “adopt adulthood”. Furthermore, securing a marriage served to reassure and provide comfort to the parents that their child will be cared for after their deaths. Hepper (1999) also observed this phenomenon in a single case study design considering the impact of marriage on a young woman from a Bengali ethnicity on her mental health and ID. It was notable that the family felt under considerable pressure for their eldest daughter to marry otherwise the family would be stigmatised

and it would also jeopardise the marriages of their other daughters. However a limitation in the design of this study makes it difficult to generalise. McGrother et al. (2002) also reports that some parents avoid using health services due to stigma associated with being “mentally ill.” However, Hubert (2006) conducted 20 qualitative interviews with families of individuals with ID in London and found that a number of families described more positive treatment in the UK compared with their countries of origin, with some telling of the common cultural belief that having a child with ID was a punishment for past sins

Whilst these studies hypothesise about the nature of attitudes in the South Asian community within their countries of origin, little research has actually looked at attitudes of South Asians towards people with ID in the general population in the UK. Miles (1995) highlights the lack of research in the context of eastern religions, namely Hinduism, Buddhism and Islam, when considering cross-cultural understandings of ID and stresses the importance of considering popular notions associated with disabilities in these religions and the significance of the dominance of Western perspectives in analysing attitudes to ID.

3.6 Impact of religion on attitudes towards people with ID

A number of studies have shown a link between religious belief systems and attitudes to individuals with ID (Selway & Ashman, 1998; Miles, 1995; Skinner et al, 2001). This seems particularly pertinent when considering people of South Asian origin who historically are a religiously diverse group. Furthermore, Fatimilehin and Nadirshaw (1994) found that consideration of religious belief was often neglected in research concerning people from South Asian backgrounds.

Miles (1992) explored concepts of ID in Pakistan by utilising official documents and attitude surveys. He found attitudes to individuals with ID amongst Pakistani communities differed considerably from established orthodoxies in western societies. Such differences may be contrary to western notions of 'independent living' and 'self advocacy' so prevalent since normalisation became favourable. In 1995, Miles explored original scriptures and historical data to consider attitudes towards ID across Hinduism, Buddhism and Islam in South Asia. He suggested similarities between these three major religions in their subscription to the view of disability as something "*fearful, usually a punishment for misdeeds*" (p.60). This supports similar global discussions by Aminidav and Weller (1995) regarding Middle Eastern cultures understandings of disability as punishment from heaven or the evil eye as well as Cheng and Tang's (1995) observation that Chinese people believe in fate and seek supernatural powers and praying to ancestors as a way of coping with ID.

However, it is important not to oversimplify these findings as religion has positives to offer, with both Fatimilehin and Nadirshaw (1994) and Bywaters et al. (2003) finding evidence of religion and faith enabling coping amongst South Asian samples in the UK, with different faiths offering different interpretations of ID. For example, Gabel (2004) studied Hindu immigrants in the US and found that Karma was a key belief in relation to ID, believing that ID provided an opportunity to fulfil one's duties, as ID was seen as a result of actions in a past life. Meanwhile, Miles (1995) explains that Muslims believe if they endure and take care of a family member who has ID wholeheartedly; they will be rewarded by Allah (God). Furthermore, Miles went on to describe an example of a family with a child with ID wanting an intervention to enable 'recovery' from

Polio for their child with ID, but not for the ID itself, which the family felt was God's wish.

Furthermore, Bywaters et al. (2003) conducted a series of semi-structured interviews with 19 Pakistani and Bangladeshi families with a disabled child and found that whilst religious beliefs did inform the ways in which families conceptualised their experiences, most families held religious explanations alongside medical explanations for disability and that *"although they might believe that their child's life was in God's hand, this did not usually mean that they did not want and seek assistance or strive to provide the best care they could themselves"* (p.508). Religious beliefs also helped parents to cope with their own feelings and experiences of stigma thus reducing emotional stress.

Thus, it is notable that Miles issued caution in considering any religion as having one viewpoint on ID, as this reductionist approach belies the complexity inherent in understanding belief systems. Indeed, Selway and Ashman (1998) in a review paper considering the potential of religion to effect the lives of individuals with ID observe how religious beliefs are fundamental to how many people approach the world, including individuals with ID. However, of particular note for this review is the exploration of Christian understandings of ID which indicated that New Testament in the bible, discusses how *"disability was something to be healed, not accepted"* (p.433) as well as the alternative message that all individuals are accepted as they are. Furthermore, Skinner, Correa, Skinner and Bailey (1998) interviewed 250 parents of children with ID in the USA and concluded both the social networks relating to religious practice (such as church communities) and 'faith' provided supportive roles in acceptance of having a child with an ID. Their findings also indicated that religion provided

the majority of parents with a framework for understanding what disability meant for them as individuals, their families and their relationships with God.

Additionally, there are certainly parallels regarding attitudes towards people with ID and hypotheses of possible causations of ID, across religions. For example, Treloar (2001) interviewed 30 people, 13 parents of children with ID or physical disabilities and 9 adults with physical disabilities, who were white American Christians. She found that many participants were challenged by the ID and physical disabilities and spent time questioning the relationship of disability to sin, the judgement of God, adequacy of faith and miraculous healing. Treloar noted that these individuals considered disability to be a spiritual challenge, which led to an increased reliance on God and increased faith. However, many participants felt that the church was not always able to accept ID easily and felt those with disabilities were often underrepresented in church.

Meanwhile, Pridmore and Pasha (2004) note that the communal ideals of Muslim teachings may stand in stark contrast to the individualised ethos prevalent in contemporary Western society. Whether such differences flow from a historical dominance of the Protestant work ethic or rather reflect the favouring of the individual in late or post modern capitalist society is open to debate.

In summary, it can be hypothesised that individuals' understanding of the meanings of their own particular faith influences attitudes towards ID and beliefs about causation, possible intervention and the way in which those with ID should be treated. However, the direction of these influences is unclear. Of the little research conducted in this field, most has concentrated on exploring historical understandings of religion, or impact on attitudes of countries of origin for South Asians. Little is known about the impact of moving to the west on these attitudes within the general

population. Furthermore, there is no research considering the impact of religion on attitudes towards ID within the general population as a whole.

3.7 Understanding attitudes and behaviours

Understanding theories of attitudes and their relationships to beliefs and behaviour is integral to understanding the process of normalisation. Of particular importance is consideration of how attitudes can be measured, the mechanisms through which attitudes can be changed, and the ways in which attitudes guide thinking and behaviour.

There are a number of theories which are pertinent to this study. Firstly, determining attitudes towards people with ID is important because attitudes are the best predictors of behaviours (Ajzen & Fishbein, 1972; 1980; Kraus, 1995). Current literature considers this theory to be essential to the hypothesis that positive attitudes towards people with ID are important in facilitating the process of normalization (Antonak & Livneh, 1991; Geskie & Salasek, 1988; Henry, Keys, Jopp & Balcazar, 1996).

Furthermore, research into attitudes to ID relies on unidimensional scales of attitude measurement. This reflects a common trend in attitude research, but belies the complexity of human attitudes. Research into the cognitive structure of attitudes indicates that they are multi-dimensional (Festinger, 1957; Heider, 1958) and this has been replicated in research investigating attitudes towards people with mental illness (Taylor & Dear, 1981) and ID (Antonak & Harth, 1994). Indeed, Armitage and Conner (2000) argue that individuals can simultaneously hold both positive and negative attitudes in mind. The term attitudinal ambivalence is used to describe a state where a person has strong negative and positive attitudes towards something.

Armitage and Conner (2000) found that attitudinal ambivalence has a moderating effect on the relationship between attitudes, intentions and behaviour. Their findings indicated that less ambivalent attitudes were more predictive of subsequent behavioural intentions and behaviour but were unrelated to attitudinal stability. Furthermore, ambivalent attitudes were found to be more pliable in the face of persuasive communication.

Tentatively it may be suggested that attitudes towards people with ID are not one attitude. How people think about ID will be made up of a number of attitudes or ideas that may be in conflict with one another, i.e. some positive and negative attitudes, which would result in increased ambivalent attitudes and thus would impact on intentions and behaviours. Attitudinal ambivalence implies that the individual experiences both attitudes as strong and valid (Wilson et al., 2000), which suggests that questionnaires that allow the reporting of multidimensional attitudes would overcome previous limitations of unidimensional scales. However, in many situations a person may experience an attitude that they consider to be illegitimate and not in keeping with their values. In such instances the individual is unlikely to report the attitude they do not consider to be valid. Most models of attitudes suggest that once an attitude has been rejected it is no longer present in memory. However, Wilson, Lindsey and Schooler (2000) proposed a Model of Dual Attitudes in which the rejected attitude remains in memory and can continue to influence behaviour. Wilson et al. drew a distinction between implicit attitudes, defined as evaluations that have unknown origin, are activated automatically, and influence uncontrolled processes (Greenwald & Banaji, 1995), and explicit attitudes, which are deliberative and involve conscious processing. The distinction between implicit and explicit attitudes was not identified by Wilson et al., but they provide a clear framework for

understanding how these attitudes relate to each other and influence behaviour. In simple terms, when an individual has the time and motivation to process information and deliberate over a response, they will report the explicit attitude; while implicit attitudes, which are activated automatically, are not reported when the individual has the cognitive capacity to override them. As such, both attitudes might influence behaviour, depending on whether an individual is willing or able to control their response. Perugini (2005) also demonstrated that implicit attitudes measures were more predictive than explicit attitude measures particularly for automatic and behaviour responses that do not allow for deliberation.

The Model of Dual Attitudes (Wilson et al., 2000) seems particularly relevant when considering attitudinal surveys that are self-report. When people complete questionnaires they have time to think about their responses and are more likely to respond with their explicit attitude. More qualitative research would allow individuals to explore their thought processes and explain their reasoning and justifications for their attitudes. As such, they might reveal more about the attitudes they hold but reject as invalid. For example, group discussions or in-depth interviews allow more probing to take place, and this could elicit both implicit and explicit attitudes and description of the cognitive processes that moderate the relationship between the two.

In summary, research within the attitude, intention, behaviour field indicates that attitudes are complex, and to state that attitudes predict behaviour belies the complexity of the field. To uncover the complexity of attitudes to ID it is necessary to explore attitudes more fully and allow individuals to explain and expand on their responses.

3.8 Summary

Culture remains a salient factor in affecting perception of attitudes towards those with ID, highlighting the differences between positive attitudes and need for help in enabling positive behaviour towards those with ID. In terms of quantitative research in the general population it would appear that relationships between attitudes and variables such as gender, education, prior contact with people with ID, age and country of origin are not consistently associated in either a positive or negative direction (Schwartz & Armony-Sivan, 2001). However, culture appears to consistently result in differences in attitudes toward individuals with ID (Downs & Williams, 1994; Aminidiv & Weller, 1995). These discrepancies may occur due to methodological limitations such as sample size, the relationship between the attitude stated and specific behaviour, and the meaning of certain experiences and their impact on relationships. Furthermore it would appear that beliefs about the causes and curability of ID appear anecdotally to be very different in South Asian communities compared with the UK, and these beliefs appear to impact on the attitudes towards people with ID and their carers. There is also a dearth of information regarding attitudes to ID within the general population as a whole. Furthermore, although it appears that religion and faith increase coping skills in people with ID and their families it remains unclear the extent to which religion impacts on attitudes and understandings of ID in the general population across religions. To add further complexity there are a number of theories relating to attitudes as predictors of behaviour which highlight a major limitation of utilising questionnaire based studies to examine behaviour. This paper will now highlight areas for future research.

4 Areas for further research

Deinstitutionalisation has been the hallmark of public policy with individuals with ID for the last 40 years. Britain is set to complete this policy towards the end of 2008, but the extent to which this initiative has been successful is uncertain, beyond the closing of the hospitals. In order to examine and analyse these outcomes, Hamlin & Oakes (2008) recommended that research needs to be carried out thinking about relationships between people with ID, their supports and services as well as the community as a whole. Furthermore, Holland (2008) identified the need for research that considers the impact that ID has on the lives of individuals, their families and the barriers that exist to integration and participation in society.

Hasting, Sjöström and Stevenage (1998) recognise the need for further research to consider the impact of normalisation on individuals' attitudes to ID. They considered that one particular area of research is the speed of changes in societal attitudes towards individuals with ID. This would lend itself to a longitudinal methodology. Furthermore they identified that expression of positive attitudes on standardised measures does not equate to changes in interactions with people ID, thus stating that both quality and quantity of integration needs to be explored, perhaps by comparing internationally to enable levels of integration and policy to be considered. Another way of considering interactions with individuals with ID may be to borrow methodology from the social psychology field and to consider waiting room experiments and to film participants' interventions with 'actors.'

While the CLAS-MR appears to be a very useful measure of attitudes in line with current thinking, it tells us little about the process by which individuals come to hold particular attitudes. Yazbeck, McVilly and Parmenter (2004) suggest the use of qualitative techniques within the general population in an attempt to explore the

formation of attitudes in more depth. They further recommended the utilisation of longitudinal studies considering changes in attitudes over time. Moreover, Raghavan and Small (2004) state that there is a need for more qualitative research to reveal the richness of diverse cultural beliefs, value systems and their significance for the development of inclusive services in the UK. Hepper (1999) also identified the need for cross-cultural research considering attitudes towards sexuality and marital relationships of individuals with ID in the general population.

Thus it would appear from both this review and from gaps identified by other researchers that a qualitative methodology considering general populations formations and understanding of beliefs would help to enhance our understanding of this area. There is also a dearth of empirical literature regarding cross cultural general population in the UK views on both causation of, and attitudes towards individuals with ID.

5 Conclusions

There have been significant changes in constructions of individuals with ID over time in the UK (Caine et al., 1998; Wright & Digby, 1996) as viewed via explicit attitudes towards people with ID, through the actions of society and documented policy. However, a limitation of historical review is the inability to gain access to implicit views that may have been held by the general population throughout history. This is compounded by the fact that often ‘the ordinary’ person and most certainly the local ‘idiot’s’ view of life is lost in history and remains undocumented.

Current knowledge regarding attitudes to individuals with ID in the general population was explored. This highlighted that at present there are a number of

possible variables that may be influencing attitudes towards people with ID and ideas about causation of ID, including gender, educational level, prior contact with people with ID, professional designation, and age. However, there seems to be a lack of consensus regarding the exact nature of these variables. It is unclear whether this is due to methodological concerns highlighted in the review, including lack of clarity and the extent the studies are representative of the general population as a whole, particularly when considering their emphasis on student populations. Furthermore the use of different measures of attitudes makes cross-comparison difficult. It is also possible that unknown mediating variables impact on attitudes towards individuals with ID, for example individuals may be considering individuals with different levels of ability. Discrepancies were also found regarding the impact of prior contact with people with ID and attitudes, with this sometimes resulting in more positive attitudes and sometime less positive. Thus, some studies suggest that it is quality of experience of contact that impacts on attitudes towards people with ID rather than quantity of meetings. Current research within the general population fails to consider the quality of relationships. Channabasavanna et al. (1985) found an interaction between experience of a person with ID and an understanding of the concept and causes of ID was associated with more positive attitudes towards individuals with ID. A further issue highlighted was the overall lack of depth to understandings produced utilising this type of methodology in that it is unclear why certain beliefs exist, the direction of the belief, and whether attitudes as measured by these scales reflect actual behavioural practice towards individuals with ID.

It seems that there are some tensions within the methodologies implemented within this field of this research. Rizzo and Vispoel (1992) and Downs and Williams (1996) concur that due to the variety of research designs employed and the

populations and samples used it is difficult to draw definitive conclusions from attitudinal studies. Similarly, it has been noted that the lack of consensus regarding attitudes may be a reflection of the lack of consensus in terminology and the labelling of those with ID. This review noted that there was an absence of qualitative research regarding attitudes to ID within the general population

Furthermore, the review considered the impact of culture and religion on attitudes towards ID and highlighted both similarities and differences across cultural contexts and religions. It was notable that little research accounts for cultural or religious diversity which is fundamental when considering the impact these have on both understandings of ID and interactions with people with ID (Fatimilehin & Nardiashaw, 2001). It can perhaps be hypothesised that individuals' understanding of the meanings of their own particular faith influences attitudes towards ID and beliefs about causation, possible intervention and the way in which those with ID should be treated. However, the direction of these influences is unclear. Of the little research conducted in this field, most has concentrated on exploring historical understandings of religion, or impact on attitudes on countries of origin for South Asians. Little is known about the impact of moving to the West on these attitudes within the general population. Furthermore, there is no research considering the impact of religion on attitudes towards ID within the general population as a whole.

It appears evident from this review that both the field of attitudes towards individuals with ID, cross cultural studies of attitudes on ID, and the impact of religion on ID remains an under researched area. Thus, to enable clearer understandings, more research is needed, particularly to evaluate Wolfensberger's (1972, 1983) argument that if individuals with ID are integrated in society, society will change and become more accepting.

References

- Aizen, I., & Fishbein, M. (1980). *Understanding Attitudes and Predicting Social Behaviour*. Prentice Hall, Englewood-Cliffs, NJ.
- Aizen, I., & Fishbein, M. (1972). Attitudes and normative beliefs as factors influencing behavioural intentions. *Journal of Personality and Social Psychology*, 21, 1-9.
- Aminidav, C., & Weller, L. (1995). Effects of country of origin, sex, religion and social class on breadth of knowledge of mental retardation. *British Journal of Developmental Disability*, 80 (1):48-56.
- Andrews, J. (1996). Identifying and providing for the mentally disabled in early modern London. In D. Wright & A. Digby (Eds.) *From idiocy to mental deficiency: historical perspectives on people with learning disabilities*. 65-92. Routledge: London.
- Antonak, R.F., & Harth, R. (1994). Psychometric analysis and revision of the Mental Retardation Attitude Inventory. *British Journal of Developmental Disability*, 80 (1): 48-56.
- Antonak, R.F., & Livneh, H. (1991). Survey research on attitudes. In J.L. Matson and J.A. Mulick (Eds.), *Handbook of mental retardation* (2nd edn.), 552-568. New York: Pergamon Press.
- Armitage, C., & Conner, M. (2000). Attitudinal ambivalence: a test of three key hypotheses. *Personality and Social Psychology Bulletin*, 26, 1421-1432.
- Atkins, K., & Rollings, J. (1996). 'Looking after their own?' Family care-giving among Asian and Afro-Caribbean communities. In: *'Race' and Community Care* (Eds. W.I.U. Ahmad & K. Atkin), pp.73-86. Open University Press, Buckingham.

- Baxter, C., Poonia, K., Ward, L., & Nadirshaw, Z. (1990). *Double Discrimination. Issues and Services for People with Learning Difficulties from Black and Ethnic Minority Communities*. King's Fund Centre.
- Bhatti, R.S., Channabasavanna, S.M., & Prabhu, L.R. (1985). A tool to study the attitudes of parents towards the management of mentally retarded children. *Child Psychiatric Quarterly*, 18 (2), 44-7.
- Bignall, T., & Butt, J. (2000). *Between Ambition and Achievement: Young black disabled people's views and experiences of independence and independent living*, Bristol: Policy Press/Joseph Rowntree Foundation.
- Butcher, H.K., Holkcup, P.A., Park, M., & Maas, M. (2001). Thematic analysis of the experience of making a decision to place a family member with Alzheimer's disease in a special care unit. *Nursing & Health*, 24, 470-480.
- Bywaters, P., Ali, Z., Fazil, Q., Wallace, L., & Singh, G. (2003). Attitudes towards disability amongst Pakistani and Bangladeshi parents of disabled children in the UK: considerations for service providers and the disability movement. *Health Soc Care Community*, 11, 502-509.
- Caine, A., Hatton, C., & Emerson, E. (1998). Service Provision. In E. Emerson, C. Hatton, J. Bromley, & A. Caine (Eds). *Clinical psychology and people with intellectual disabilities*. (pp.54-75). Chichester: John Wiley and sons.
- Chamba, R., Ahmad, W., Hirst, M., Lawton, D., & Beresford, B. (1999). *On the edge: Minority ethnic families caring for a severely disabled child*. Joseph Rowntree Foundation: The Policy Press. ISBN 1 86134 134 2.
- Cinnirell, M. & Loewenthal, K. (1999). Religious and ethnic group influences on beliefs about mental illness: A qualitative interview study. *British Journal of Medical Psychology*, 75, 505-524.

- Cummins, R.A., & Lau, A.L.D. (2003). Community integration or community exposure? A review and discussion in relation to people with intellectual disability. *Journal of Applied Research in Intellectual Disabilities*, 26 (2), 145-157.
- Department of Health. (2001). *Valuing People*. London: HMSO
- Department of Health. (2008). *Valuing People Now*. London: HMSO
- Department of Health and Social Security. (1971). *Better Services for the Mentally Handicapped*. London: HMSO
- Digby, A. (1996). Contexts and perspectives. In D. Wright & A. Digby (Eds.) *From idiocy to mental deficiency: historical perspectives on people with learning disabilities*. 1-21 Routledge: London.
- Disability Discrimination Act (2005). The Stationary Office. ISBN 0 10 5411105 1
- Downs, P., & Williams, T. (1994). Student attitudes towards integration of people with disabilities in activity settings: A European comparison. *Adaptive Physical Activity Quarterly*, 11: 32-43.
- Eggert, D., & Berry, P. (1992). German, Irish and Australian high school students' perceptions of mental handicap. *International Journal of Rehabilitation Research*, 15, 349-354.
- Emerson, E. (1992). What is normalisation? In H. Brown, & H. Smith (Eds.). *Normalisation: a reader for the nineties*. (pp.1-18). London: Routledge.
- Emerson, E. (2001). *Challenging Behaviour: Analysis and intervention in people with severe intellectual disabilities*. (2nd edn). Cambridge: Cambridge University Press.
- Emerson, E., & Hatton, C. (1999). Future trends in the ethnic composition of British society and among British citizens with learning disabilities. *Tizard Learning Disability Review*, 4, 28-32.

- Fatimilehin, I., & Nadirshaw, Z. (1994). A Cross-Cultural Study of Parental Attitudes and Beliefs About Learning Disability (Mental Handicap). *Mental Handicap Research*, Vol. 7 (3).
- Felce, D. (1996). Changing residential services: from institutions to ordinary living. In P. Mittler & V. Sinason (Eds.) *Changing policy and practice for people with learning disabilities*. (pp.127-145). London: Cassell education.
- Festinger, L. (1957). *A theory of cognitive dissonance*. Stanford: Stanford University Press.
- Flynn, M. (2007). *The murder of Steve Hoskin: A serious case review executive summary*. Cornwall Adult Protection Committee: Cornwall.
- Gash, H. (1993). A constructivist attempt to change attitudes towards children with special needs. *European Journal of Special Education*, 8, 107-125.
- Geskie, M.A., & Salasek, K.L. (1988). Attitudes of health care personnel towards people with disabilities. In H.E. Yunker (Ed.), *Attitudes towards persons with disabilities*, pp.187-200). New York: Springer-Verlag.
- Gilbert, P., Gilbert, J & Sanghera, J. (2003). A focus group exploration of the impact of izzat, shame, subordination and entrapment on mental health and service use in South Asian women living in Derby. *Mental health, religion & culture*. Vol 6 (3), 1-22.
- Gladstone, D. (1996). The changing dynamic of institutional care: the western counties idiot asylum, 1864-1914. In D. Wright & A. Digby (Eds.) *From idiocy to mental deficiency: historical perspectives on people with learning disabilities*. (pp. 134-160) Routledge: London.
- Goodey, C. F. (1996). The psycho-politics of learning and disability in seventeenth century thought. In D. Wright & A. Digby (Eds.) *From idiocy to mental deficiency: historical perspectives on people with learning disabilities*. (pp.93-117) Routledge: London.

- Goffman, E. (1963). New Edition (1990) *Notes on the Management of Spoiled Identity*. Penguin Books: London
- Gray, G. (1996). Changing day services. In P. Mittler & V. Sinason (Eds.) *Changing policy and practice for people with learning disabilities*. (pp.146-164). London: Cassell education.
- Greenwald, A.G., & Banaji, M.R. (1995). Implicit social cognition: attitudes, self-esteem, and stereotypes. *Psychological Review*, 102, 4–27.
- Hamlin, A., & Oakes, P. (2008). Reflections on deinstitutionalisation in the United Kingdom. *Journal of Policy and Practice in Intellectual Disabilities*, 5, 47-55.
- Hastings, R., Sjöström, K., & Stevenage, S. (1998). Swedish and English adolescents' attitudes toward the community presence of people with LD. *Journal of Intellectual Disability Research*, 42, 314.
- Hatton, C., Akram, Y., Shah, R., Robertson, J., & Emerson, E. (2003). *Supporting South Asian Families with a Child with Severe Disabilities: A Report to the Department of Health*. Institute for Health Research. Lancaster University, Lancaster.
- Hatton, C., Azmi, S., Caine, A., & Emerson, E. (1998). Informal carers of adolescents and adults with learning difficulties from the South Asian communities: family circumstances, service support and carer stress. *British Journal of Social Work*, 28, 821-837.
- Hatton, C., Akram, Y., Robertson, J., Shah, R., & Emerson, E. (2003). The Disclosure Process and its Impact on South Asian Families with a Child with Severe Intellectual Disabilities. *Journal of Applied Research in Intellectual Disabilities*, 16, 177-188.
- Heider, F. (1958). *The psychology of interpersonal relations*. New York: Wiley.

- Henry, D.B., Keys, C.B., Jopp, D. & Balcazar, F. (1996). The Community Living Attitudes Scale: Development and psychometric properties. *Mental Retardation*, 34, 149-158.
- Hepper, F. (1999). 'A woman's heaven is at her husband's feet'? The dilemmas for a community learning disability team posed by the arranged marriage of a Bangladeshi client with intellectual disability. *Journal of Intellectual Disability research*, 43, 558-561.
- Holland, T. (2008). Determining priorities in intellectual disability research. *Journal of Intellectual Disability Research*, 52, 1-2.
- Horner-Johnson, W., Keys, C., Henry, D., Yamaki, K., Oi, F., Watanabe, K., Shimada, H. & Fugjimura, I. (2002). Japanese students attitudes toward people with intellectual disabilities. *Journal of Intellectual Disability Research*, 44, 326.
- Hughes, J.M. (1984). Some selected attitudes to mental retardation in developed and developing countries. *Mental Handicap Bulletin*, 53.
- Hussian, A. (2001). Islamic beliefs and mental health. *Mental Health Nursing*, 21(2), 6-9.
- Hussian, Y., Atkin, K., & Ahmad W. (2002). *South Asian Disabled Young People and their Families*. Joseph Rowntree Foundation: The Policy Press. ISBN 1 86134 326 4.
- IASSID (International Association for the Scientific Study of Intellectual Disabilities). (2001). *The Edinburgh Principles*. Clifton Park, NY: Author .
- Jackson, M. (1996). Institutional provision for the feeble-minded in Edwardian England: Sandlebridge and the scientific morality of permanent care. In D. Wright & A. Digby (Eds.) *From idiocy to mental deficiency: historical perspectives on people with learning disabilities*. (pp. 161-183) Routledge: London.
- Jervis, M. (1987). Across the cultural divide. *Mental Handicap Bulletin*, 65: 10. Kennedy, C., Kools, S., & Krueger, R. (2001) Methodological consideration in children's focus groups. *Nursing Research*. Vol 50 (3), 184-187.

- Kraus, S.J. (1995). Attitudes and the prediction of behaviour: a meta-analysis of the empirical literature. *Journal of Personality and Social Psychology*, 21, 58-75.
- McConkey, R., McCormack, B., & Naughton, B. (1983). National survey of young people's perceptions of mental handicapped. *Journal of Mental Deficiency Research*, 27, 171-183.
- Mencap. (2007). *Death by indifference: following up the treat me right report*. Campaigns: London.
- Michael, J. (2008). *Mencap Report of the independent inquiry into access to healthcare for people with learning disabilities*. Mencap: London.
- Miles, M. (1992). Concepts of Mental Retardation in Pakistan: toward cross cultural and historical perspectives. *Disability, Handicap & Society*, Vol.7 (3).
- Miles, M. (1995). Disability in an Eastern religious Context: historical perspectives. *Disability & Society*, 10 (1), 49-69.
- Mir, G., Nocon, A., Ahmad, W., & Jones, L. (2001). *Learning Difficulties and Ethnicity*. Department of Health, London.
- Mittler, P., & Sinason, V. (Eds.) (1996). *Changing policy and practice for people with learning disabilities*. London: Cassell education.
- Modood, T., Berthoud, R., Lakey, J., Nazroo, J., Smith, P., Virdee, S. & Beishon, S., (1997). *Ethnic Minorities in Britain: Diversity and Disadvantage*. Policy Studies Institute, London.
- Oullette-Kuntz, H., Burge, P., Henry, D., Bradley, E., & Leichner, P. (2003). Attitudes of senior psychiatry residents towards persons with intellectual disabilities. *Canadian Journal of Psychiatry*, 48, 538-545.
- O'Hara, J. (2003). Learning disabilities and ethnicity: achieving cultural competence. *Advances in Psychiatric Treatment*, 9, 166-176.

- Park, M., Butcher, H.K., & Maas, M.L. (2004). A thematic analysis of Korean family caregivers' experiences in making the decisions to place a family member with dementia in a long term care facility. *Nursing & Health, 27*, 345-356.
- Petticrew, M., & Gilbody, S. (2004) Planning and Conducting Systematic Reviews. In S. Michie & C. Abraham. (Eds). *Health Psychology in Practice*. (pp.150-179). London. BPS Blackwells.
- Perugini, M. (2005). Predictive models of implicit and explicit attitudes. *British Journal of Social Psychology, 44(1)*, 29-45.
- Pridmore, S., & Pasha, M.I. (2004). Religion and Spirituality: Psychiatry and Islam. *Australasian Psychiatry, 12 (4)*, 380-385.
- Priestley, M. (1998). Constructions and Creations: idealism, materialism and disability theory. *Disability and Society, 13 (1)*, 75-94.
- Raghavan, R., & Small, N. (2004). Cultural diversity and intellectual disability. *Current Opinion in Psychiatry, 17*, 371-375.
- Rushton, P. (1996). Idiocy, the family and the community in early modern north east England, In D. Wright & A. Digby (Eds.) *From idiocy to mental deficiency: historical perspectives on people with learning disabilities*. (pp. 44-64) Routledge: London.
- Schwartz, C., & Armony-Sivan, R. (2001). Students attitudes to the inclusion of people with disabilities in the community. *Disability & Society, 16*, 403—413.
- Selway, D., & Ashman, A. (1998). Disability, religion and health: a literature review in search of the spiritual dimensions of disability. *Disability and Society, 13 (3)*, 429-439.

- Skinner, D., Correa, V., Sinner, M., & Bailey, D.B. (2001). Role of religion in the lives of Latino families of young children with developmental delays. *American Journal on Mental Retardation, 106* (4), 297-313.
- So-Kum Tang, C., Davis, C., Wu, A., & Oliver, C. (2000). *Journal of Developmental and Physical Disabilities, Vol 12* (1), 73-87.
- Tak-fai Lau, J., & Cheung, C. (2001). Discriminatory attitudes to people with intellectual disability or mental health difficulty. *International Social Work, 42*, 431-444.
- Taylor, S.M., & Dear, M.J. (1981). Scaling community attitudes toward the mentally ill. *Schizophrenia Bulletin, 7*, 225-240.
- Thomson, M. (1996). Family, community, and state: the micro-politics of mental deficiency. In D. Wright & A. Digby (Eds.) *From idiocy to mental deficiency: historical perspectives on people with learning disabilities*. (pp. 207-230) Routledge: London.
- Treloar, L. (2002). Disability, spiritual beliefs and the church: the experience of adults with disabilities and family members. *Journal of Advanced Nursing, 40*(5), 594-603.
- United Nations. (1975). *Declaration on the rights of people with disability*. New York: Author.
- United Nations. (1993). *The standard rules on the equalisation of opportunities for persons with disabilities*. New York: Author.
- White, N., & Hastings., R. (2004). Social and professional support for parents of adolescents with severe intellectual disabilities. *Journal of Applied Research in Intellectual Disabilities, 17*, 181-190.
- Wilson, T.D., Lindsey, S., & Schooler, T.Y. (2000). A model of dual attitudes. *Psychological Review, 107*(1), 101-126.

- Wolfensberger, W. (1983). Social Role Valorization: A proposed new term for the principle of normalisation. *Mental Retardation*, 21, 234-239.
- Woolfson, L. (2004). Family well-being and disabled children: A psychosocial model of disability-related child behaviour problems. *British Journal of Health Psychology*, 9, 1-13.
- Wright, D. & Digby, A. (Eds.) (1996). *From idiocy to mental deficiency: historical perspectives on people with learning disabilities*. Routledge: London.
- Yazbeck, M., McVilly, K., & Parmenter, T.R. (2004). *Journal of Disability Policy Studies*. Vol.15 (2), 97-111.

Part 2: Empirical Paper

Attitudes towards People with Intellectual Disabilities: a Cross Cultural Study

ABSTRACT

Background: National and international policies promote the acceptance, integration and inclusion of people with intellectual disabilities into mainstream society. However, there is little systematic research into general population attitudes towards people with intellectual disabilities, and even less research which considers the impact of culture on attitudes.

Aims: The aim of this study was to explore how young people from white British and South Asian backgrounds differ in their attitudes towards people with intellectual disabilities, and above all how they arrive at their beliefs.

Design and participants: A qualitative design utilising focus groups and individual interviews with white British and South Asian adolescents aged 16-19 years ($N=61$) was employed. Questionnaire data was collected to compare this sample to findings from a larger study.

Analysis: Interview and focus group data were analysed using thematic analysis. Questionnaire data was analysed and the representativeness of the current sample assessed by comparison to a larger data set. Furthermore, the richness of data gathered in focus groups and individual interviews were compared.

Finding and implications: Thematic analysis yielded 5 themes which enabled cross cultural understanding of attitudes towards people with intellectual disabilities. Six factors were found that helped explain influences on participants' attitudes towards people with intellectual disabilities. Frequency counts allowed comparisons between cultural groups and this highlighted the importance of culturally sensitive support tailored to meet the needs of service users.

INTRODUCTION

This study explored cross-cultural constructions of intellectual disabilities (ID)² and attitudes towards people with ID. Many changes in social/political policy have taken place over recent years, following from *normalisation* (Wolfensberger, 1972, 1983) and its key arguments that increased presence and participation of people with ID in community life would lead to less stigmatised attitudes and greater acceptance by society (Department of Health, 2001). National and International policies promote the acceptance, integration and inclusion of people with disabilities into mainstream society (IASSID, 2001; United Nations, 1975, 1993; Department of Health, 2003). The British Government published white papers (Department of Health, 2001; 2008) that aim to empower individuals with ID, maximise their choices, improve services, improve their social inclusion, presence and participation in community life, and ultimately to improve individuals' quality of life. However, the extent to which Wolfensberger's original theory has been realised and how far the general population subscribes to the values of these policies is unclear. Attitudes of the general population can be less positive than those found in public policy and it may take time for attitudinal changes to take place following changes in policies (Yazbeck, McVilly & Parmenter, 2004). Hastings, Sjöström and Stevenage (1998) found differences in attitudes between Swedish and English adolescents, with Swedish participants holding more positive attitudes, perhaps due to normalisation having been part of national policy for longer than in the UK.

² *The term Intellectual Disabilities is utilised throughout this paper rather than the British term 'Learning Disability.' This reflects current practice within the international scientific community to privilege this terminology (Emerson, 2001). The term 'Intellectual Disability' refers to a person with cognitive functioning difficulties (IQ < 70); associated difficulties with adaptive functioning and an onset during childhood.*

The importance of attitudes

Understanding theories of attitudes and their relationships to beliefs and behaviour is integral to understanding the process of *normalisation*. Current literature in the field is underpinned by the theory that attitudes are the best predictors of behaviour (Ajzen & Fishbein, 1972; 1980; Kraus, 1995). A number of studies have emphasised that positive attitudes towards people with ID are important in facilitating the process of normalization (Antonak & Livneh, 1991; Geskie & Salasek, 1988; Henry, Keys, Jopp & Balcazar, 1996).

However, a limitation of this research is a reliance on unidimensional scales of attitude measurement. Research into the cognitive structure of attitudes indicates that they are multi-dimensional (Festinger, 1957; Heider, 1958) and this has been replicated in research investigating attitudes towards people with mental illness (Taylor & Dear, 1981) and ID (Antonak & Harth, 1994). Furthermore, Armitage's and Conner's (2000) concept of *attitudinal ambivalence* and Wilson et al.'s (2000) Model of Dual Attitudes would suggest that attitudes towards people with ID are made up of a number of attitudes or ideas that may be in conflict with one another, i.e. some positive and negative attitudes, which participants may or may not report dependent upon feelings regarding the attitude. Thus, to uncover the complexity of attitudes held in the general population towards individuals with ID it is necessary to explore attitudes more fully and allow individuals to explain and expand on their responses.

Henry, Keys, Jopp and Balcazar (1996) created the Community Attitudes Living Scale – Mental Retardation Form (CLAS-MR) in an attempt to measure inclusion related attitudes in line with current social policy. In an analysis of items, they found four factors associated with attitudes towards the inclusion of people with

ID in society. These factors suggest four discrete, though related dimensions of inclusion attitudes; a) *Empowerment*, namely the extent to which people with ID are granted freedom to make their own life choices; b) *Exclusion*, that is the extent to which respondents would like to isolate people with ID from community life; c) *Sheltering*, that is the extent to which respondents think that people with ID need help keeping safe; and d) *Similarity*, the extent to which people feel that people with ID share a universal humanity. While the CLAS-MR appears to be a useful measure of attitudes in line with current thinking, it does not provide information about the process by which individuals come to hold particular attitudes.

Other demographics and their impact on attitudes

Research has examined the influence of a number of demographic variables on attitudes towards people with ID. Being younger has been found to be associated with more positive attitudes (So-Kum Tang et al., 2000; Yazbeck, McVilly & Parmenter, 2004). Higher levels of educational attainment appear to be associated with more positive attitudes towards ID (Yazbeck, McVilly & Parmenter, 2004) and with more accurate knowledge of ID (Aminidiv & Weller, 1995). There is inconsistency regarding the impact of gender, and previous contact with ID, on attitudes towards people with ID. A more positive attitude in females than males was found in some studies (Downs & William, 1994; Oullette-Kuntz et al., 2003) but not others (Aminidiv & Weller, 1995; So-Kum Tang et al., 2000). Prior contact has been associated with both more positive attitudes towards people with ID (Yazbeck, McVilly & Parmenter, 2004) and less positive attitudes (Downs & Williams, 1994; Schwartz & Armony-Sivan, 2001). The reason for inconsistencies regarding prior contact is unclear and may stem from the quality of interactions participants had with

people with ID. Alternatively, these inconsistencies may stem from ambivalent/dual attitudes, which qualitative research would allow to be further explored.

The impact of culture and religion on attitudes

The way a cultural group understands ID is likely to affect the amount of support offered to members of the group whose children have an ID. Cross-cultural studies comparing Asian and Western countries (Aminidiv & Weller, 1995; Downs & Williams, 1994) suggest that people from western countries show more positive attitudes and tend to be more in favour of the social integration of people with ID. However, there is limited research comparing attitudes of people from South Asian backgrounds in the UK with those of white British origin³. Such research is important because four percent of British nationals are of South Asian descent and it is expected that by 2021 7% of people with ID in Britain will be from South Asian communities (Emerson & Hatton, 1999; Hatton, Akram, Shah, Robertson & Emerson, 2003). According to Mir et al. (2001), higher levels of material and social deprivation, compounded with other risk factors such as poor access to maternal health care, misclassification and higher rates of environmental or genetic risk factors, cause increased incidence of ID within South Asian populations.

Two studies that have compared these two groups suggested that South Asian families held different constructions of ID and its possible causes, as well as knowledge regarding the availability of services (Fatimilehin & Nadirshaw, 1994) and that young South Asians with ID found a lack of understanding from their own communities (Hussain, Atkin & Ahmad, 2002). While these studies inform us about

³ 'South Asian' is a term used to refer to people originating from India, Pakistan, Bangladesh or to Indian families who have lived in east Africa for a considerable time.

individuals with ID and their families from South Asian backgrounds, they tell us little about wider community attitudes

Research has shown that informal and formal support networks within South Asian families of people with ID, such as support from extended family, are inadequate compared to white British families in similar positions (Hatton, Azmi, Caine & Emerson, 1998, 2003; Chamba, Ahmad, Hirst, Lawton & Beresford, 1999). Contrary to expectation (Atkins & Rollings, 1996) these families do not receive much support from community or religious groups (Hatton et al., 2003). While South Asian families report a substantial need for formal service support (Baxter, et al., 1990; Hatton, et al., 1998, 2003; Chamba et al., 1999; Mir et al., 2001), there is both a low awareness of specialist services available for people with ID and a low uptake of family support services such as respite care (Hatton, et al., 1998, 2002; Chamba et al., 1999. Mir et al., 2001) and family support groups (Chamba et al., 1999; Mir et al., 2001). Attitudes held by the South Asian community towards people with ID may also explain poor uptake of services. Fatalistic attitudes and the search for a cure are frequently given by staff as explanations for low uptake of services (Jervis, 1987). The stigma of bearing a child with ID and the impact this may have on the marriage prospects of siblings (Hughes, 1984) may offer other explanations. Such attitudes may lead the family to conceal the (person with) ID as opposed to drawing attention to the situation through accessing services.

Fatimilehin and Nadirshaw (1994) suggest that religious and cultural differences underpin the differences in attitudes and use of services relating to ID. Baxter et al. (1990) found that Asian parental attitudes are equally influenced by lack of access to information as by cultural and spiritual beliefs. Asian parents hold differing beliefs about ID, including the concept of curability and the belief that

marriage lessens the level of ID (Bhatti, Channabasavanna & Prabhu, 1985). Miles (1995) highlights the lack of research in the context of eastern religions, namely Hinduism, Buddhism and Islam, when considering cross-cultural understandings of ID and stresses the importance of considering popular notions associated with disabilities in these religions. The current study uses qualitative research methods, which can reveal the richness of diverse cultural beliefs, value systems and their significance for the development of inclusive services in the UK (Raghavan and Small, 2004). Previous, qualitative research such as Fatimilehin's and Nadirshaw's (1994) study is limited by its small sample, restricting analysis to descriptive and basic qualitative analysis.

Conceptual Framework

There are a range of conceptual frameworks that can be utilised in qualitative research, some which position themselves as similar to IPA and rely on processes of interpretation of participants' statements whereas other qualitative research relies less heavily on interpretation and stays closer to participants' statements (Sullivan, 2003). The purpose of thematic analysis is to directly represent an individual's own point of view through descriptions of experience, belief and perception (Park, Butcher & Maas, 2004) and has been used extensively in clinical and health psychology studies (Butcher, Holkcup, Park & Maas, 2001; Loweenthal, Lee, Macleod, Cook & Goldblatt, 2003).

Furthermore, Braun and Clarke (2006) argue that thematic analysis can be seen as a foundational method for all types of qualitative analysis, as it enables broad understandings and is driven by the narrative and not a particular epistemological approach. It is essentially independent of theory and this seemed important given the

dearth of knowledge within the area (Braun & Clarke, 2006). When considering the conceptual framework of qualitative research it is important to consider whether themes are drawn from existing theoretical ideas that the researcher brings to the data, known as deductive coding or from the raw information itself known as inductive coding (Joffe & Yardley, 2004). It is recommended that themes flow from the principles that underpin the research and the specific questions one seeks to answer. In this study the themes are informed by the ID and cross-cultural literature.

Summary

There are a number of variables that might influence attitudes about people with ID and ideas about causation of ID, and research indicates that there are differences between cultural groups regarding these issues. However, little qualitative research has been conducted within the general population leading to the design of this study which aimed to explore in-depth how individuals drawn from South Asian and white British samples may arrive at their attitudes and beliefs about ID and what may have influenced their constructions of ID.

Research Questions

- 1) What attitudes do young people from white British and South Asian backgrounds in the UK hold towards people with ID?
- 2) What are the similarities and differences in attitudes towards people with ID in white British and South Asian young people?
- 3) What may help us to understand these differences? Particularly what is the potential influence of factors such as; culture, religion, media, parents, friends, age and knowing someone in understanding these differences?

METHOD

A 2-part study was devised: Part 1 was completed by Joel Sheridan (2008), a fellow UCL trainee, and utilised a quantitative methodology to investigate cross-culturally what attitudes young people in the general population hold towards people with ID and what they believe are the common causes of ID. The study compared white British and South Asian samples of 6th form students (16 to 19 year olds). Part 2 (the current study) explored in-depth how individuals drawn from comparable samples may arrive at their attitudes and beliefs about ID and what may have influenced their constructions of ID.

Participants

Participants ($N=61$) were recruited from individual sixth form colleges across London ($n=47$), and from participants who consented to being contacted about follow up research in Sheridan's (2008) study ($n=4$). Additional participants ($n=10$) were recruited via an email sent to University College London Staff to ask if they had children in the correct age range. It was felt that sixth forms would offer a better representation of the population in terms of socio-economic factors than a university sample. By recruiting a white British and a South Asian British Group from the same college, it was hoped that the groups would be similar in terms of demographics such as gender, age, education and social economic status (SES). This was important as the literature currently indicates that these variables influence attitudes towards people with ID (Downs & William, 1994; So-Kum Tang et al., 2000; Schwartz & Armony-Sivan, 2003; Oullette-Kuntz et al., 2003; Yazbeck, McVilly & Parmenter, 2004). As an incentive for taking part in the research all participants were paid £6.

Thirty one participants described their ethnicity as South Asian⁴ and 30 described their ethnicity as white British. Eight individual interviews were conducted; 4 with participants from a South Asian background and 4 with participants from a white British background. Additionally, 9 focus groups were conducted. 26 white British participants were divided into 5 groups with between 3 and 9 participants. 27 South Asian participants were divided into 4 groups with between 6 and 7 participants in each group. It is recommended that focus groups have less than 10 participants per group, as conversations tend to fragment in larger groups (Kreuger & Casey, 2000).

Participant demographics are shown in Table 1. The study focussed on young people between the ages of 16-19 as they are the first generation to grow-up in an inclusive educational environment, it also meant the level of education was held constant. Three white British participants were born outside of the UK but had spent a substantial part of their life in Britain, so were deemed appropriate for inclusion in the study.

There were a number of marked differences between the South Asian and white British participants in terms of religion and prior contact with people with ID. 43.3% of white British participants described themselves as atheist or non-religious, compared to only 3.2% of South Asian participants. 70% of white British participants reported knowing someone with an ID, compared to 48.4% of South Asian participants. In particular, white British participants were more likely to report knowing someone with ID as a “friend” whereas South Asian participants were somewhat more likely to have a relative with ID.

⁴ *South Asian was operationalised in this study inline with Madood's et al. (1997) definition thus including people originating from India, Pakistan, Bangladesh and Indians who have lived in east Africa for a period of time.*

Table 1

Demographics of South Asian and British Samples

		Ethnicity			
		South Asian (N=31)		White British (N=30)	
		N	% of sample	N	% of sample
Gender	Female	17	54.8	17	56.7
	Male	13	41.9	13	43.3
	Missing	1	3.2		
South Asian	Indian	20	64.5		
	Pakistani	3	9.7		
	Bangladeshi	6	19.4		
	Other	1	3.2		
	Missing	1	3.2		
	N/A			30	100.0
Generation	First	26	83.9		
	Second	2	6.5		
	Third	2	6.5		
	N/A	0	0.0	30	100.0
	Missing	1	3.2		
Religion	Muslim	12	38.7	1	3.3
	Hindu	15	48.4	1	3.3
	Christian	1	3.2	13	43.3
	Sikh	1	3.2	0	0.0
	Other religion	0	0.0	2	6.7
	Atheist/non-R	1	3.2	13	43.3
	Missing	1	3.2		
How religious?	Not at all	5	16.1	18	60.0
	Somewhat	20	64.5	10	33.3
	Very	4	12.9	2	6.7
	Missing	2	6.4		
Prior Contact	Yes	15	48.4	21	70.0
	No	15	48.4	9	30.0
	Missing	1	3.2		
Relationship	Relative	5	16.1	3	10.0
	Friend	8	25.8	13	43.3
	Acquaintance	2	6.5	5	16.7
	N/A	15	48.4	9	30.0
	Missing	1	3.2		

Ethical consideration

Ethical approval was obtained from the University College, London ethics committee (Appendix A1).

Measures

All participants in the study completed a demographic information sheet (age, gender, ethnicity, importance of religious beliefs, level of education and prior contact with someone with ID) (Appendix B1). Participants also completed the CLAS-MR (Henry et al., 1996; Appendix B2) so that they could be compared to participants within a larger sample (Sheridan, 2008) to check for self selecting bias of positive attitudes within this group.

Focus Groups

In focus groups the emphasis is on the interaction within the group, based on discussion topics that are supplied by the researcher. The researcher acts as a facilitator of this discussion. A balance needs to be struck between the researcher's agenda of covering specific topics and allowing participants to discuss their experiences and interest in more depth (Barker, Pistrang & Elliott, 2002). The purpose of a focus group is to provide insight into, and 'understandings' of, participants' perspectives. It enables questions such as 'how' and 'why' to be addressed (Hague, 1993). Focus groups are particularly appropriate for use in areas about which relatively little is known, as they allow participants to introduce ideas the researcher might not have considered and thus have the potential to give fresh insight (Powell & Single, 1996).

Individual Interviews

One concern of conducting group research is that certain views may dominate the group discussion while others are unheard. It was therefore appropriate to conduct individual interviews to ensure richness of data collected.

Photos and Vignettes

The severity of learning disability can vary greatly and this may influence attitudes. Photos and simple vignettes were provided to facilitate discussion and to ensure understanding from participants (Appendices C1 & C2). To hold constant other possible variables such as gender and ethnicity, both photographs were of young white men. One person was chosen to represent a mild ID and the other to represent a person with a moderate ID.

Focus Group and Individual Interview Schedule

The questions used during the focus groups and individual interviews included general questions exploring views and causation and more specific questions based on the CLAS-MR. The key items extracted from the CLAS-MR (1996) are 6, 11, 14, 18, 24, 26, 30, 32, 35, and 39. These items were chosen as they had the highest factor loadings around the four key themes: empowerment, exclusion, sheltering and similarity. These items were developed and reworked to facilitate discussion. The interview schedule consisted of 5 question areas designed to engage the participants and allow a variety of viewpoints to be expressed (Appendix C3 and C4). The term 'Learning Disability' was utilised in all written materials in line with UK policy.

Procedure

On arrival participants were asked to read an information sheet (Appendix D1) and sign a consent form (Appendix D2). The researcher gave a brief overview of the study and the purpose of conducting the focus group or individual interview and consent was obtained for audio-recording the discussion. Participants were paid on completion. It was not expected that participation would cause harm or distress to participants, however, participants were told to share only what they felt comfortable to share during the study. They were told that they had the right to decline to take part, and if they did participate, were free to change their mind and could leave at any time without giving a reason. All focus groups members were reminded of the confidential nature of what was shared by others within the group. A short debriefing session followed participation in the study.

Design and Data Analysis

This study considered the differences and similarities in attitudes towards people with ID in white British and South Asian samples. Part 1 (Sheridan, 2008) and Part 2 are independent studies, running concurrently in different locations within London but with similar samples. Part 2 of the study aims to explore views, beliefs and ideas of the general population in more detail. Therefore the design of this study is a qualitative approach utilising focus groups and individual interviews.

Quantitative data was explored using Chi Square and *t*-tests to identify variables may have influenced the qualitative data. The quantitative data set was then compared to a larger sample of participants (Sheridan 2008) to check how representative the data is of a larger sample.

The qualitative data were analysed in line with Braun and Clarke’s (2006) outline of the process of thematic analysis (Table 2). Detailed reading and rereading of transcripts led to the generation of initial codes. Evidence for each code was collated, discussed and revised with my supervisor. The revised table of initial codes can be found in appendix (E1). Subsequently, phase 3 involved collating codes into potential overarching themes (E2). In phases 4 and 5 these were reviewed and revised in discussion with my supervisor until the final defined themes were arrived at.

Table 2

Phases of thematic analysis

No	Phase	Description of the Process
1	Familiarising self with the data	Transcribing the data, listening to transcriptions and checking these back with paper copies. Then reading and re-reading and noting down initial ideas.
2	Generating initial codes	Coding interesting features of the data across the entire data set and collating data relevant to each code.
3	Searching for themes	Collating the potential codes into potential themes, gathering all data to each potential theme.
4	Reviewing themes	Checking if the themes work in relation to the coded extracts and the entire data set.
5	Defining and naming themes	Ongoing analysis to ensure the specifics of each theme, and the overall story the analysis tells. Generating clear definite and names for each theme.
6	Producing the report	Selection of extract examples, final analysis of the selected extracts, and the relating back of the analysis to the research questions and literature and writing the report of the analysis.

Credibility checks

In order to ensure the qualitative data analysis represented the data, credibility checks were utilised (Elliot, Fischer & Rennie, 1999; Braun & Clarke, 2006). My supervisor

read the transcripts, and emerging themes were critically examined and agreed upon before a table of themes was constructed.

Researcher's Perspective

Good practise guidelines in qualitative research recommend that the researcher explicitly acknowledges his or her theoretical orientation and expectations relevant to the area that is under investigation (Elliot, Fischer & Rennie, 1999; Braun & Clarke, 2006). I have extensive experience of relating to and working with people with ID across numerous settings; support worker, teaching assistant, behavioural therapist, executive committee member of an advocacy charity, researcher and assistant, and trainee psychologist. I am currently completing my DCLinPsy at UCL which is enabling me to consolidate my learning regarding issues relating to ID. As a professional I feel that it is important to work to maximise the quality of the life for an individual by enabling the person to achieve the most they can for themselves, but also recognise that a certain level of support provided with dignity is often necessary.

Furthermore, I recognise that I am a white researcher and that this could impact on how I am perceived by participants from different cultural backgrounds. It may mean that people are unwilling to explore certain issues with myself (e.g. spirituality or Izzat: Gilbert, Gilbert & Sanghera, 2003). I aimed to address these concerns by acknowledging my cultural background when collecting data and by providing evidence that I was culturally sensitive (e.g. "some people tell me that they have seen a spiritual healer").

RESULTS

Quantitative Data

Chi square was used to test whether variables other than ethnicity might influence differences between white British and South Asian participants. Age and educational level were held constant through the design of the study. Previous research has demonstrated that gender and prior contact with someone with ID influence attitudes towards people with ID. There was no significant difference in gender distribution between the white British and South Asian samples: $\chi^2(1)=.984, p=0.611$. There was also no difference in prior contact with people with ID: $\chi^2(1)=2.500, p=0.114$.

Table 3

Descriptive Statistics for the four CLAS-MR subscales comparing South Asian (N=31) and White British (N=30) participants

Subscale	Ethnicity	M	SD
Empowerment	South Asian	3.96	0.55
	White British	4.45	0.59
Exclusion	South Asian	1.94	0.71
	White British	1.67	0.57
Sheltering	South Asian	3.26	0.69
	White British	3.25	0.65
Similarity	South Asian	4.42	0.81
	White British	5.09	0.72

To investigate differences between the two groups on the CLAS-MR subscales, independent-samples *t*-tests were conducted (Bonferroni corrected: $p=0.0125$). White British participants scored higher on *empowerment* $t(69) = -3.357, p=0.001$ than the South Asian samples. White British respondents also scored higher on the *similarity* sub-scale than South Asian participants, $t(69) = -3.021, p=0.004$.

Generalisability of Results

In an attempt to determine how representative the participants who volunteered for this study are of the wider population of 16-19 year olds, a number of variables were compared against Sheridan's (2008) larger data set ($N=738$) using Chi-Square. There was no significant difference in ethnicity distributions (South Asian vs white British) between the two studies: $\chi^2(1)=0.167, p = 0.683$. There was a higher proportion of females in Sheridan's (2008) study than in this study where the gender split is more equal $\chi^2(1)=13.095, p = 0.001$. There was no notable difference in the experience participants had of meeting people with ID between the two studies: $\chi^2(1)=0.638 p = 0.425$.

Finally, four independent *t*-tests were used to investigate whether mean scores on the four subscales of the CLAS-MR; *empowerment*, *exclusion*, *sheltering* and *similarity* differed significantly across the two samples (See Table 3). There was no significant difference between the two samples on the four subscales: *Empowerment*, $t(797) = -0.748, p=0.460$. *Exclusion*, $t(797) = -0.326, p=0.745$. *Sheltering* $t(797) = -0.827 p=0.408$. On *similarity* equal variance could be not assumed, $t(65.828) = -2.828, p=0.74$.

Table 4

Descriptive Statistics for the four CLAS subscales comparing study 1 (N=737) and 2 (N=61)

Subscale	Data source	<i>M</i>	<i>SD</i>
Empowerment	Study 1*	4.26	0.59
	Study 2**	4.12	0.62
Exclusion	Study 1	1.84	0.83
	Study 2	1.81	0.66
Sheltering	Study 1	3.18	0.72
	Study 2	3.26	0.67
Similarity	Study 1	4.97	0.74
	Study 2	4.75	0.93

* *Sheridan (2008)*

** *This study*

Due to study 1's sample size being much larger than study 2 it was necessary to look at the differences between the samples by considering effect sizes. Effect size was compared across the studies considering ethnicity and scores on the four CLAS-MR subscales: *empowerment*, *exclusion*, *sheltering* and *similarity*.

Comparing effect size on *empowerment* indicated that that study 2 ($d=0.86$) had a much larger effect size than study 1 ($d=0.20$). The difference seemed to be attributable to both white British participants scoring higher and South Asian participants scoring lower on *empowerment* in study 2 than their counterparts in study 1. Comparing effect size on *exclusion* indicated that both studies had a medium effect size ($d=-0.32$) versus ($d=-0.43$). Comparing effect size on the *sheltering* subscale indicated that both studies had a small effect size ($d=-0.23$) versus ($d=-0.02$). Finally on the *similarity* subscale study 2 had a large effect size ($d=0.79$), whereas study 1 only had a medium effect size ($d=-0.33$). The difference seemed to be attributable to a decreased score on the subscale for South Asian participants in study 2 compared to study 1.

Summary

Findings suggest that this sample is fairly representative of the larger population. However, the current study was more representative of males than study 2. There were also larger between group differences of ethnicity for the empowerment and similarity subscales of the CLAS-MR. These differences between the studies mean that any generalisations can only be tentative.

Thematic Analysis

Themes are presented in relation to the research questions and illustrated with quotes from the interviews and focus groups. Each quote is coded for easy identification by ethnicity; white British participants (WB), South Asian participants (SA) and by data collection method; individual interviews (I) and focus groups (FG). Participants within each focus group are numbered sequentially from number 1. They are also numbered 1 to 4 in the SA and WB individual interview categories. Thus WBFG1-1 would denote participant 1 in the first focus group with white British participants. ? denotes a participant whose number could not be determined due to the quality of the recording. (...) denotes material omitted from the quote; square brackets [] denote clarifications or interjections between interviewer and participants.

Research Question 1 - *What attitudes do young people from white British and South Asian backgrounds in the UK hold towards people with ID?*

Overarching themes in addressing research questions 1 and 2 are presented in Figure 1.

Figure 1: Overarching themes for questions 1 and 2

Theme

Confusion versus More sophisticated understandings

Invisibility versus Representations in the media

Universal humanity

Positioning self as accepting and empowering

Views on care giving

A major theme in trying to understand attitudes to ID appeared to be a differentiation in participants' understandings and awareness of ID, with individual participants displaying both confusion and more sophisticated understandings. This appeared linked to individuals' acknowledgment of representations in the media in some instances, but on the whole an invisibility of people with ID in the media. The frequencies of references to each theme are presented in Table 5, where the differences between the two groups are examined.

Confusion versus More Sophisticated Understandings

Approximately half of the participants appeared to experience confusion about the definition and meaning of ID. This was evident across the transcripts and continued even after photos and detailed vignettes of fictitious individuals with ID were presented. Many participants included within the definition of ID specific learning difficulties such as dyslexia, but also physical disabilities and illness, sensory impairments and the effects of migration and coping with being a foreigner. Furthermore, participants indicated rape, abuse in childhood or parents being in prison as possible causes of ID.

SAFG1-3: Yes, there are people with dyslexia and dyspraxia and stuff but like even though they had a learning disability at secondary school they all got all A's and stuff like that in their GCSE's, it's just that they learn differently to us and they got extra help.*

WBFG1-3: Like accidents and things that happen, like loss of limbs and things.

WBFG1-2: I think having Leukaemia when you are young can cause a learning disability. It happened to a friend's brother.

South Asian participants reflected a broad range of understandings of the idea of 'curability'; some participants indicated they felt that 'cure' was impossible because of ID having a biological basis. Others stated that maybe people considered marriage as a 'cure' of sorts for ID due to the burden of care being transferred to another person. At other times it seemed that although individual South Asian participants subscribed to the idea of 'curability' when questioned further they actually appeared to mean improving an individual's quality of life through education or changes in the environment, rather than the ID being 'cured' as such. Others stated that they had not heard of the idea of 'curability' at all.

I: I did some reading about this cultural idea that if maybe you get married then you could cure the person of the disability I don't know if you have heard of that?

Group: No (laughs), it's biological so you can't get rid of it.

SAFG2-4: The only think I can think of in relation to a cure is the fact that you would have to take care of the person and stuff like that.

SAFG2-2: And that would be a cure?

I: At least the parents wouldn't have to look after them.

SAFG2-4: Yeah you wouldn't be a burden to society, your parents or the government, it would just be one person.

SAFG3-2: ... But for Simon I think he's better off he would stay with his mum and dad and then they can like cure him bit by bit.

I: Ok and how would they cure him?

SAFG3-2: Like I said, they can send him to a special school, they can sit down with him everyday, and they can take him out like normal.

In contrast with this confusion, some participants displayed a more sophisticated understanding of ID. They showed an understanding of the possible biological basis of ID and that levels of support an individual with ID might need would depend on their level of ID and individual abilities.

WBF5-6: Downs Syndrome and stuff like that is genetically passed on whereas there are mild ones that are like malfunctions during birth and stuff like that [yeah]. Like if the baby doesn't get oxygen or is deprived of oxygen or something it can like cause brain damage, which would cause learning difficulties and that kind of thing.

WB11: I don't think there is a certain answer you can use for every case. I think it's very case specific depending how they react, like certain people with Autism have trouble with new people, so then maybe it's better if they only have a few people who they get on with and they can get to know better to have a better relationship with

them. But if they want to get to know you then I think people should be in the community. It probably does depend on what learning disabilities they have.

Invisibility Vs Representations in the media

Confusion regarding ID and terminology appeared to be compounded by an absence of representations of people with ID in the media and by participants' acknowledgment of the invisibility of people with ID within society. When asked if they had read or heard anything about people with ID in the media, approximately one third of participants initially responded with a firm "no". Furthermore, when questioned regarding the likely views of their friends and family, some felt they were unable to comment as it was not something they had ever considered or discussed with others.

In contrast to this common sense of an invisibility of people with ID in the media and general discussion, later in the interview participants recalled representations of people with ID in the media in the form of documentaries, articles, magazines, and works of fiction. Some of these recollections appeared to be isolated and lacking in depth whereas others had obviously stuck in participant's minds. Of particular note is the Eastenders story (2007) regarding the birth of a baby with Downs Syndrome which spanned several episodes of the popular soap opera, and Mark Haddon's "*The curious incident of the dog in the night-time*" of which numerous participants provided vivid accounts. Participants indicated that these sources provided them with increased understandings of people with ID.

SAFG4-1: It's really funny but (laughs) I don't know if you watch Eastenders but you know Honey her daughter [mmm] has Downs Syndrome that scene, storyline

kind of helped me to understand what it was. Well I knew what it was but more in depth about what it is and how the mother has to suffer, not suffer but what she has to change in order to give them a good life so yeah.

WBF2-3: Even through like films though as well, you see how different people deal with disabled people in films and you see whether you believe what happens in the film to be right or wrong. And it helps you to make your own mind up about what you think should be done. Like the way they are treated and if it should be done like that.

SAI4: Erm (pause) maybe a little bit cause you know when you see on the telly like a disabled person you always see another person with them holding bags for them, paying for things, that's what you always see in the media. Like at college today some disabled boy brought his own lunch for himself and he knew exactly what he was doing, he knew exactly how much change he needed back, so I think the media is quite negative on that [ok] they don't show that they are normal and they can do normal things.

This sense of invisibility and later vivid recall of representations of people with ID in the media is highlighted by WBI3 in the following quotes.

I: Ok do you think you have read anything about people with disabilities or learning disabilities that has influenced your views?

WBI3: Probably not really, cause I can't actually think of reading anything about anyone with a learning disability.

WBI3: ...and the book 'The Curious Incident of the Dog in the Nighttime.' I like that book [ok] (laughs). I think that was well good but I think that might have changed my views slightly too. And there was the thing on the TV the other week, it might have been a while ago now, I'm not sure. About a boy whose brother had learning disabilities [mmm] and he took him away to Wales or something and he didn't really love him anymore but then he realised that he did because his brother was a real person and that might have slightly affected my views.

Universal Humanity

Many participants subscribed to ideas of universal humanity, including free choice for individuals with ID and subscription to the notion that “we are all people.” They stressed that “everyone is an individual” and related to this how they themselves would want to be treated. Many participants subscribed to the view that choices should be made by individuals with ID. They described human rights and the idea of free choice as underlying this belief. Many voiced views relating to empowerment, such as individual choice, it “being their life” and having the right to try things for themselves. While stressing these ideas, participants were often aware of different levels of ability.

S11: 'Cause it's their lives and no one should try to tell them how to live, how they should live.

WBF2-3: You must let them have some independence

WBF2-4: It has to be their life.

SAI4: Just personally I believe everyone has got their equal rights. It doesn't matter if you are big, small you should be able to say whatever you think is right, whereas people with learning disabilities it's a little bit trickier decision because they might say one thing but it might not be the best thing. [mmm] But what they feel should be considered at the same time so it shouldn't be displaced or ignored or anything like that.

In stating “we are all people,” some participants explicitly attributed the same feelings to people with ID as other people and made statements relating to ‘normal lives’ for people with ID in terms of love, sense of humour, need for family support, marriage, work and being integrated within the community. They talked about people with ID in terms of equality, as being “the same” as them and “on the same level” as them. A small number of these participants discussed ID as “a flaw” and stressed that all people have flaws.

WBI3: I see it as if they want to work then they can work and they should, it's not really a fact of whether they can work or not. It's if they want they should be allowed to. It's up to them what they do in life, so that's just it.

WBFG5-1: We are all humans we all have feeling with the lowest or highest IQ's and just because of these learning disabilities doesn't mean they are completely alien or live on planet Mars they live on Earth and we are all different and we all experience these different kinds of feelings [mmm].

Alongside emphasising ‘universal humanity,’ some participants also subscribed to the belief that people with ID would ‘live better lives’ in the community. Using

themselves as points of reference, they noted that they would not wish to be excluded from the community if they were in that position. Furthermore, participants stated that people with ID would learn more from 'normal' people in the community than from other people with ID. Many also mentioned that if people were excluded from society to live with people with ID, they would pick up bad habits and not learn as much. Participants described integration as a two way process whereby the general population can learn greater acceptance by being around people with ID.

WBFG5-7: Sometimes with some people it can get worse it depends on the type of treatment but I think that everyone needs some interaction with people without learning disabilities around them because some people with learning disabilities have different behavior...and they just can't learn, they might learn the abnormal behavior.

SAFG1-5: Also I think being part of the community helps us to accept them for who they are and yeah they have learning disabilities, but none of us in this room can say what is normal...people can have other problems like having a short temper that is a problem as well, so like learning to interact with people helps you to develop as person. So I think if I was in that situation, I'd rather be with everyone in the community.

WBFG4-4: Yeah I think it's a two way thing because if we... non learning difficulties people are around different kinds of people it teaches us more because everyone is different. You are going to meet people who don't have learning disabilities who are

different to us anyway in other ways and the more variation there is in the community the more you can learn about getting on with things.

Within this theme, fit some ideas regarding relationships. Many participants endorsed the idea of romantic relationships between people with ID. They conveyed a belief that it was up to the partner to choose if they wanted to conduct a relationship with a person with ID, some commented that they had viewed relationships between people with ID in the community, or seen it portrayed in the media. Many stated that due to the increased responsibility within a marriage, careful consideration was needed. Some participants wondered how difficult relationships might be for people with ID when they themselves were having difficulties with communication within their own relationships. Others expressed concern that those with more severe ID would be unable to understand the nuances of a relationship.

WBF5-4: There's no reason why a person with leaning difficulties should have different rights to everyone else and there is no reason you can decide someone is not allowed to marry based on you know a genetic disability or whatever.

SAFG2-2: It is a complex issue marriage is the union of two people if one person is like severely disabled then it's like one person taking care of the other person for the rest of their lives rather than a union so you would have to take into consideration all the various different factors and issues that spring up from the marriage of a disabled person.

Interestingly, whilst it was mainly accepted that individuals with ID were entitled to romantic relationships, consideration of having children was met with a greater range of responses. Some participants stated that this was “their choice” to decide, others that it should not be an option for those with ID due to their not being able to cope or it not being “fair” on the child. It was notable that a marked shift occurred from ‘universal humanity’ and the idea “they’re just like us” to “their lives are not worth living.”

WBFG3-1: I guess like having children then it does depend on the disability but I think if it's getting married then it's down to the person.

The following quotes show the shift in thinking within a focus group with participants emphasising the rights of people with ID before subscribing to a view more in line with what Wolfensberger (1983) termed ‘death making’, namely the idea that life with a severe disability is a life not worth living.

WBFG2-3: I think it [decision regarding where a person with ID should live] should be based on the person with disability having quite a lot of say.

WBFG2-2: I think it is nice for them to be left to make as many decisions for themselves.

WBFG2-2: If it's genetic but then you can like have a designer baby.

WBFG2-3: Yeah, like if you can have the disability removed. Personally my view is that you shouldn't bring another person into the world if they are going to suffer and

be teased from it. But I'm not against it happening, but I just don't personally think it's fair on the child.

WBF2-2: Fair on the child...

WBF2-3: But I think that like, my parents had to be tested for Downs Syndrome and personally I would rather not be in the world if...

Participants also demonstrated a number of ambivalent attitudes within this theme, for example moving from the position of stating that it is the person with ID's choice and similar to themselves before moving onto express concern regarding people with ID working and taking jobs from 'normal' people. The quotes below demonstrate this shift for SAF2-7.

SAF2-7: They are people at the end of the day and they are people like us.

SAF2-7: Basically people that are not able shouldn't take up jobs of people who are able.

Positioning self as accepting and empowering

By emphasising 'universal humanity,' participants seemed eager to position themselves as empowering and accepting. Many participants described awareness of the prejudice that individuals with ID face in life, such as exclusion from community life, or difficulties with relationships or possible parenthood. Some also mentioned a feeling of discomfort that may be raised in others when meeting people with ID. A few discussed the influence of extreme politics or the possible influence of genetics on attitudes towards people with ID. These ideas were generally stated as being held by others rather than the person expressing them.

Furthermore, the process of the interview appeared to have an influence, with participants at the start presenting as accepting and empowering, later on though when prompted to think about a range of more complex scenarios, less empowering and at times negative views emerged. This shift is evident in the following quotes, one taken from early in the interview, the other at a later point.

SAll: You don't look down on them because they have learning difficulties... there's nothing wrong with them. You can't discriminate against them or anything.

I: Mmm, can you think of any activities that, that you think they should be separated from the normal community?

SAll1: Erm, I don't think so... maybe sports I think, some sports like swimming.

I: And why do you think that?

SAll: Because, I don't know, pause, they could... I'm just trying to imagine a pool with people with disabilities and how they would be. Maybe the other people... mm if it was all mixed the normal and disabled people, then the normal people won't, I don't know why, but they won't feel comfortable around them.

Views on care giving

There was a general acknowledgement that a person with ID needed to be supported and different ideas were posited regarding who should provide this role. The majority of participants indicated that choices needed to be made taking into account the view of the individual with ID, family and service providers if necessary. A few participants purported to an underlying negative view of service providers.

Many participants stated that the family know the individual the best and therefore would be best placed to provide support. This appeared to be reflected equally across both cultural groups which seems surprising in view of the literature and will be discussed in more depth later.

WBI3: I think the family has got a big input because obviously you have grown up with your family the whole time and they stay with them for good. So the family has got to know what is best for Simon in the long run.

SAFG1: I think it should be family members because they understand the person with the difficulty the most and if the person can't speak up for themselves, the family member will consider their feelings and what they actually want and will speak up for them.

However, a notable number of participants viewed service providers as more knowledgeable due to their increased education and experiences of working with ID. Others noted that the involvement of service providers could be useful if the case was complex.

SAFG1-2: I think that person with the LD can't choose for themselves..., the family will be biased and the professionals will know what to do because they have been in that situation before so they can think what is best and will make the right choice

In contrast, some participants indicated that service providers might be cold and might not understand the individual with ID as a 'whole' person. These participants

thought it might be daunting for people with ID and their families to receive help from service providers. Furthermore, some participants felt that service providers may be abusive and try to take advantage of people with ID.

WBI2: Probably the family, people who are closest to them, because you wouldn't want anyone else interfering. [Ok] They might not trust other people. Family you can trust more, well you would hope that you could trust the family.

WBF3-2: Like the kids I was talking about, he goes to this place called a day centre and stuff and then in the evening this carer comes in the evening for like two hours and the government pays, and there have several, several ones, and once she found one was hitting him when he didn't eat his food and they like seem to be nice but when the parent isn't there then they can be ridiculous.

Many participants noted that support would be best coming from numerous sources and indicated that service providers would be able to offer advice that could be utilised in conjunction with the individuals' choices and with the family's knowledge. Of note, they privileged the person's choice in determining what support should be provided.

WBF1-1: I think the most important is the person with the disability so they would be the most important and probably the family second, you should listen to the professionals' opinion but they are not going to have as much understanding of the person's character so they should have the least say.

SAFG1-3: I think it depends on the capability of the person and how they can look after themselves, like the family might be too protective and say no, I want them to stay here so I can look after them. So maybe the person with disabilities should talk to the professional about how they feel personally and they can sort of analyse and then see how much independence they should be given.

Summary

In summary, the data indicates variations and complexities in participants' understanding of, and attitudes towards, individuals with ID. At times a number of ambivalent attitudes were expressed. For example, some participants' expressed a strong belief that "it's their choice," whilst expressing reluctance about a person with ID being offered a job if there was a 'normal' person who could do it.

Research Question 2 - What are the similarities and differences in attitudes towards people with ID in white British and South Asian young people?

In order to ascertain whether there were differences between the two groups, frequency counts were made for sub-themes across participants (see Table 5). Each statement made by participants that fitted within a sub-theme was counted, thus the total frequency count for the theme could be greater than the total number of participants in the study.

Table 5

Comparison of frequencies across themes

Theme	South Asian (n=31)	White British (n=30)
Confusion vs. Sophisticated understandings		
<i>"Confusion"</i>	20	15
<i>"More Sophisticated understandings"</i>	28	26
Representations in the Media vs. Invisibility		
<i>"Representations in the Media"</i>	14	22
<i>"Invisibility"</i>	9	11
Universal humanity		
<i>"It's their choice"</i>	9	20
<i>"Everyone is an individual"</i>	4	11
<i>"Similarity"</i>	25	22
Positioning self as accepting and empowering	13	23
Views on care giving:		
<i>They need to be look after</i>	9	14
<i>Family</i>	19	15
<i>Service providers</i>	6	11
<i>Negative views of service providers</i>	4	8

There seemed to be some differences between the two cultural groups. South Asian participants showed a higher level of confusion and were much less likely to recall representations of people with ID in the media than their white British counterparts. The theme 'universal humanity' reflects several ideas with marked differences between the two groups, namely on the idea that "it's their choice" and "everyone is an individual," with white British participants much more likely to endorse these ideas. The latter were also more likely to make statements that would suggest their attitudes were more accepting and empowering than South Asian participants. There were also differences regarding thoughts about who should offer support to people with ID, with white British participants more likely to endorse professional support yet also more likely to hold negative views of service providers. As noted previously,

there was little difference between the two cultural groups in their acknowledgment of the importance of the role of the family in offering support to people with ID.

Research Question 3 - *What may help us to understand these differences? Particularly, what is the potential influence of factors such as culture, religion, media, parents, friends, age and prior contact with someone with ID understanding these differences?*

Overview

Participants acknowledged that their attitudes towards people with ID were influenced by culture, religion, parents, education and prior contact with people with ID. The frequencies of reference for each factor for each participant are presented in Table 6. There were a number of differences between cultural groups. Furthermore, it is notable that few participants considered their peers an influence on their attitudes.

Table 6

Perceived influences on attitudes towards ID and comparison between cultural groups.

Influences	South Asian (n=31)	White British (n=30)
Culture		
<i>References to culture</i>	18	10
<i>Generational differences*</i>	15	12
<i>Old culture replaces new culture*</i>	4	1
Religion	19	18
Parents	7	13
Education		
<i>Impact of education*</i>	15	11
<i>Superstition/lack of education*</i>	6	2
<i>You learn more as you get older*</i>	14	14
Knowing someone with ID	23	26
Influences of peers		
<i>Peers</i>	1	3
<i>Political correctness*</i>	0	6

* *Italics indicate categories within the factors*

Participants from both South Asian and white British backgrounds reported that cultural values and norms influenced their attitudes towards people with ID. Both groups referred to generational changes within society, with white British participants linking these changes to 'political correctness' and changes in ID policy, whereas South Asian participants were more likely to link these changes with cultural diffusion as a result of migration. A small number of South Asian participants commented that it would not be the cultural norm for them to leave home and that if someone had an ID this would be even less likely. It was also notable that arranged marriages were the norm for some participants in the study, thus rendering ideas regarding choice for individuals with ID and romantic relationships less relevant.

SAFG1-5: If you go by traditional Asian culture, ... if you take me for example, for me to move out of home it's not possible until I'm like married, because my parents don't really see it as an option. So if I had a learning disability, then that's even more of a big no. But if I was guy that might be different, like my for my brother, like if he had a learning disability, they might like delay it, or say no, but they would be more inclined...I think the thing with Asian culture is that it is protective as it is, but if you had a learning disability they would be even more protective.

Participants also noted that culture and religion gave rise to superstitious thinking and ideas about possession by spirits. Such ideas tended to be linked to more traditional views and were only subscribed to by a small number of participants. South Asian participants noted the influence of country of birth on attitudes and the mixing of cultures.

WBFG4-2: I think different cultures deal with disabilities in different ways some people see it as just weakness [mmm] you see like historically people have just got rid of the people with learning disabilities. Some cultures just treat people with disabilities as just completely wrong but I think we live in quite a moderate society.

Participants also commented on generational differences which were influenced by migration and the integration of different types of cultures on participants' views and on general changes in British society. A number of participants commented on the influence of greater integration and how this results in different norms for people of different ages in terms of their attitudes towards ID. They indicated they believed that people from older generations would be more likely to hold negative attitudes as

they were used to people with ID being excluded from society. Both South Asian and white British participants positioned themselves as more understanding of people with ID than older generations. South Asian participants noted that some religious beliefs such as parents being punished by God for their wrongdoings or ideas regarding spiritual possession tended to be held by older generations who were less influenced by biological understandings. A minority of white British participants subscribed to the notion that previous generations would have had similar superstitious understandings of the causes of ID. South Asian participants also spoke about changes in family constitution within their generation, with people more likely to live in nuclear rather than extended families, but stated that it would still be important for the family to look after a person with ID.

WBF5-6: Yeah I think people were probably more religious when they were older like older generations because they knew less about it and I think maybe because we have grown up with all this research we think more about the science behind it.

I: Do you think your age affects what you think?

WBI2: Yeah because they used to lock them up didn't they? Yes so because older people would believe that's the better way because of the way they grew up, but when I grew up it was a different situation.

SAFG2-7: I was talking to my mum about it and she said her parents were like "we don't talk about that [ID] sort of thing, why would you want to." No one kind of knew anything about it and it wasn't well known... No one was actually out there

saying stuff like they are today. I think it's just like our generation that have an open mind about disabilities in general.

I: And what do other people think about that?

SAFG2-2: Yeah I reckon if you go back a few generations they might, but not now first and second generation.

SAFG2-7: Yeah it's like openly discussed and everyone knows about it so it's not such a hush hush.

SAFG1-?: Yeah, I think like my nan may think like they've been possessed or something, she would feel really sorry for them and think that need to have some religious intervention or she might think that they need to be looked after, like sheltered at home and thinking that they are not capable of doing anything for themselves, thinking that there is something wrong with them type of thing.

Participants who said they were non-religious had a tendency to view religion as influencing negative attitudes towards people with ID. Karma was acknowledged by a few participants as instrumental in understandings of attitudes towards people with ID, in terms of thinking about punishment for past wrong doings or thinking about how everyone should be treated equally and with respect. Those participants who considered themselves religious were likely to view religion as having a **positive** influence on their attitudes towards people with ID, in contrast to beliefs expressed by their non-religious peers. However, participants seemed to have little clear sense what their religion say about people with ID and how to respond to them.

WBI3: I think it's (Christianity) just generally just treat them as you would like to be treated yourself because that's generally the main message I get from the bible.

SAll: I don't think so. (Pause). No I think it (Islam) just says that, erm I don't know, it just says like if you are pregnant and you know that your child has a disability you're still not allowed to have an abortion. They should still be brought into the world and you should still love them because they are from God and everyone is different.

Furthermore those who said they were religious would apply underlying religious philosophy such as treating others with respect, which seemed to be similar across religions.

I: And how would that (religion) influence your thoughts?

SAFG3-2: Well things I've learnt from my mum and dad. Like how to not take the Mick, just to treat everyone fairly. Like, all of us here, we believe in God, so believe that whatever is here is because of God. So if people are like this... it's just the way they have been made.

Some Islamic participants mentioned that religion would influence them because it highlights the importance of marriage and children and this was instrumental in them thinking these would also be important for individuals with ID.

SAll: I think everyone should be able to do what they want to do, kind of, yeah. Like ... in the traditional Pakistani culture and it is kind of influenced by Islam as well,

the man should work and provide food, money and shelter for the family, for the wife and children. So maybe a male person with disabilities should be able to work more than a woman, but then again culture comes into it and my culture is kind of mixed so I think a woman should be able to work as well.

More white British than South Asian participants noted their parents or family as an influence on their attitudes towards people with ID. It is possible that this was due to more white British individuals reporting that their parents worked within the ID field. Alternatively, this may be due to cultural differences between groups in that white British participants are more likely to think of family as influence whereas South Asians are more likely to consider culture as an influence on their attitudes.

WBI3: I'm not sure really I think it's probably because of mum's views ... I take her views on board as well so I think in that sense family would come into that. And with like books and TV as well, if there was going to be a programme on about people with learning disabilities I think my mum would probably want to watch it because she is a learning support assistant so she likes to find out as much about it as she can. So I would probably end up watching that and that might change my views slightly.

Education influenced people's attitudes towards ID in a number of ways. Firstly, education provided a framework for understanding people's disabilities and was thought to lead to more positive attitudes towards ID. Secondly, a lack of education was attributed to superstitious thinking. Furthermore, participants linked age with education and the notion that they have learnt more with age and therefore become

more understanding and have more positive attitudes towards people with ID and less stigmatised attitudes than when they are younger. This is in contrast to ideas about generational attitudes towards people with ID.

SAFG3-6: Some people might actually study up on learning disabilities and that's how they know stuff whereas others might not know as much, so they would have different opinions. And some people might want a carer helping people with disabilities so they might study it.

WBFG5-6: Yeah they teach you like that in GCSE and A Levels.

WBFG5-1: Yeah I remember biology lessons they teach you about Downs Syndrome extra chromosome write it down [mmm] so it's sort of stuck in my head.

A small number of participants, mainly of South Asian origin, attributed beliefs regarding 'curability' and superstitious beliefs to people with less education, who do not have a scientific framework for understanding ID. They also noted that a lack of education may mean diagnosis of disability does not occur.

SAI2: You see the superstitious beliefs are mostly started by people who live in the villages who are not much aware about the scientific condition that lies behind the problem.

SAFG1-6: Then again in the villages they like don't have a chance to know if they have a learning disability or something because they don't have no schools, so you might not be able to tell.

SAFG1-3: And it's also that they like look for reasons and they can't see none and you can't see god and spirits so they think that it is that.

SAFG1-6: Maybe they don't think about it enough to think of it properly, logically, so they blame it on religion.

An equal number of South Asian and white British participants subscribed to the notion that people learn more about ID and become more accepting as they get older. A number of people noted that when they were younger they may have made fun of people with ID but had learnt that this was not acceptable. Conversely others felt that younger children would be less aware of ID and therefore more accepting.

SAll: Cause when you are younger, like I'm 18 now, but when you are younger, you just.... a lot of people just take the Mickey out of people like that [Mmm]. But as you get older, you learn that there are, that there are... that everyone is different that not everyone is perfect and some people do have... some people are a bit disabled and everyone has their weaknesses and stuff like that.

SAFG1: Yes, I think when people are younger you're more naïve, you don't notice when people have a learning disability because you don't take in that much anyway but then when you get older you start to do more hands on things that you notice and you think something's a bit wrong here.

Equal numbers of South Asian and white British participants stated that prior contact with people with ID influenced their attitudes. Some participants posited that individuals with ID should be independent because it was how they would like the

person they know to be treated whereas others subscribed to views more in-line with Sheltering. It would appear that this may be due to the nature of the disability in question. A number of participants noted that previous contact with ID resulted in an increased sensitivity of the complexity of the decisions that they were being asked to make in the vignettes. Furthermore, participants stated that knowing a person with ID resulted in closer relationships, increased understandings and ideas of Similarity.

I: And do you think knowing someone with a disability might have affected your thoughts?

SAll: Yeah, my little cousins again.

I: Yeah. And in what way might that have influenced you?

SAll: I don't know, like as they got older I wouldn't want to see them as being restricted and being alone. I would want to like, I want to see them as being normal and living normal lives like not in a box or anything.

WBF3-3: I think it's just that when you form an attachment to someone with a learning disability and then you care about them so much that you see them get hurt, then you get hurt too. And then when you see other people with disabilities then you have some sort of little soft spot for them as well because you've been brought up around them.

Participants discussed the impact of integration on attitudes towards people with ID in a number of ways. They discussed how changes in policy increased visibility of people with ID in the community and resulted in more positive attitudes towards people with ID in younger people. Some directly referred to people with ID they had

seen in the community when considering whether the fictitious individuals in the vignettes should be able to have relationships or to work. Conversely, others acknowledged the invisibility of romantic relationships involving people with ID within society. Participants described exclusion and integration as influencing their attitudes and the impact on increasing acceptance.

SAI3: I think they could get married... yeah definitely.

I: Ok and why is that your answer?

SAI3: Erm because I have seen it.

I: Yeah where have you seen that?

SAI3: Where I live there are couples.

SAFG1-2: I think seeing disabled people working in minor jobs like at checkouts and stuff so it shows it shouldn't be discouraged.

Few participants mentioned influence of peers on their attitudes. One participant said they had joined in teasing a person with ID to prevent themselves being teased. Others mentioned that friends would influence whether people with ID felt that they were able to be honest regarding their disability, others described avoiding those who would behave in negative ways towards people with ID and others suggested that they would hide their ID from their friends.

WBF1-2: My views have not really been influenced that much by people at school because I avoid groups who say bad things about people with learning disabilities because I don't think its right to make those comments especially if the people are not there to defend themselves.

SAFG3-5: I think it depends on your friends a lot, because if you can tell your friend and they are nice to you would tell them but if they take the piss out of you, you would say, no I'm not kind of thing.

A number of participants mentioned 'political correctness' as a possible influence on attitudes towards people with ID. Some felt political correctness has impacted on society by encouraging a greater belief in equality, whereas a minority felt that people did not express certain views due to wishing to present themselves in a certain light. It is possible that this may have occurred to some extent within the focus groups, as well as other research in attitudes to ID. The implications of this are discussed later.

WBF4-2: I think that probably because we live in a society where we try not to discriminate against people. [Mmm] It's probably that kind of attitude that most of us have and is why I have come to most of my decisions really because I don't really want to discriminate against disabled people or anyone really. It's just in my psyche.

Summary

The main influences acknowledged by participants were culture, religion, parents, education and prior contact with people with ID. Peer influences were not widely acknowledged but appeared to have relevance. Frequency counts indicated that South Asian and white British participants equally acknowledged the influences of religion, education, previous contact with people with ID and peers. However, a higher

number of South Asian participants endorsed culture as an influence and more white British than South Asian participants endorsed parental influence.

DISCUSSION

This study aimed to enhance our understanding of the impact of ID policies which emphasise choice, inclusion and rights on general population attitudes towards people with ID in the UK. In the following discussion the findings will be briefly summarised and discussed in the light of previous research and in terms of what they add to the evidence base. Strengths and limitations of the research are considered. Finally implications for research and clinical work are considered.

A major finding of this study was widespread confusion and lack of knowledge regarding ID and its causation. Participants conveyed a sense of the invisibility of people with ID from community life and the media, but cited some memorable stories about people with ID in the media and noted that these had greatly affected their understanding and attitudes. One might argue that as only 2-3% of the population have ID (Hatton, 1998) their visibility is low, perhaps even more so to an adolescent population who have very different concerns. Alternatively one might suggest that despite normalisation and policies aimed at greater inclusion, people with ID largely continue to be absent from community life and marginalised. Of note, white British participants were more likely to cite representations of people with ID in the media than their South Asian peers, but in the absence of any research evidence one can only surmise that this reflects an even greater invisibility of people with ID in Asian media in the UK. Further research might usefully explore this area by analysing media portrayals in different cultural contexts, similar to Pardun's (2005) analysis of US media. Pardun found that over the period 1962 to 2003 media

portrayals of this group moved away from unrealistically super-heroic types towards depictions as pitiable, vulnerable victims. Identifying how this group is portrayed in the British and South Asian media may hold important clues for the likely success of increased social inclusion and above all equality of people with ID, as the way in which people with ID are portrayed in the media may impact on attitudes towards people with ID and integration into the community.

Confusion regarding terminology and constructions of ID are in line with a recent UK survey of 1600 people which found that 73% of respondents had an inaccurate understanding of 'learning disability' (Mencap, 2008). Furthermore, only 22% of 103 MPs were able to give a correct definition, indicating a lower level of understanding than in the general population. Sheridan (2008) found an association between cultural background and knowledge about causes of ID, with South Asians demonstrating a less accurate understanding.

In interviews and focus groups participants frequently stressed what I have termed the 'universal humanity' of people with ID, namely as invested with the same feelings and rights as non-disabled people. At face level this would appear as very encouraging as it fits with current UK policy. Analysis of the process of the interviews and group discussions illustrated that participants frequently stated views which reflected attitudes that were accepting and empowering, which is not surprising in an adolescent sample where a wish for acceptance by peers may be a key factor (Jackson & Rodriguex-Tome, 1993). Importantly though, the views expressed at times became less empowering once more complex scenarios were discussed, such as the right of people with ID to work, marry or have children.

Regarding differences between white British and South Asian participants, in this study the former were more likely to emphasise 'choice' and 'individuality', the

latter to describe people with ID as similar to themselves. This appears to be a different to previous research, for example Kenyon (2008), who found Hindu attitudes to be less in line with the principles of *Valuing People*, endorsing *Similarity* and *Empowerment* significantly less than the British sample, and being less opposed to *Exclusion*. Bibi (2008) found that Bangladeshi adults held more pro-inclusive attitudes than their white British counterparts. Thus it may be that by utilising a large cultural grouping such as South Asian some of the nuances of the data are lost. A further possibility is that this research divided participants on basis of culture where they may in fact be other mediating factors that are interacting with attitudes for example, Sheridan (2008) found those white British adolescents' demonstrated higher pro-inclusion attitudes than South Asian adolescents scoring lower on the *Exclusion* scale and higher on the *Similarity* scale of the CLAS-MR. Although overall, he found that pro-inclusion values such as 'independence' and 'rights' were more closely associated prior contact and gender were more predictive of pro-inclusion attitudes towards people with ID than cultural background.

The current study provides evidence that people from South Asian backgrounds may have beliefs that run counter to the emphasis on individualism and choice in current ID policy in the UK. Miles (1992) also argued that policy based on western notions of independent living may have little value if the beliefs systems of service users centre on collectivist value systems more typical of Asian cultural traditions. However, the fact that Sheridan (2008), as previously noted, found gender and previous contact to be more significant determinants of attitudes sounds a note of caution and suggests the need for greater research in this area.

This study found no difference between cultural groups on privileging the family in terms of care-giving. This contrasts with previous research which found

that South Asian participants were more likely to endorse family care than white British participants (Fatimilehin & Nadirshaw, 1994; Hatton, Azmi, Caine & Emerson, 1998, 2003, 2003). Sheridan (2008) also found cultural background to be predictive of beliefs about who should provide care, with white British participants more likely to consider formal services in conjunction with the family, rather than seeing the family as holding the main care responsibility. Previous research also suggests marked differences in who provides care, with access to services lower for South Asians compared to white British groups (Hatton et al., 1998, 2002; Chamba et al., 1999; Mir et al., 2002). This disparity may relate to the difference in gender split between studies. Alternatively it may relate to the different methodologies employed, for example in utilising a quantitative approach to data collection, white British participants may choose professionals as the most important but underlying this is a belief that the family is also important. A qualitative approach to data collection as utilised in this study is able to demonstrate the complexities of beliefs.

The utilisation of a qualitative approach to the research was integral to considering attitudes towards people with ID. The results indicate complexities and nuances in participants' understanding and thinking, with participants' attitudes often becoming more differentiated and less positive over the course of an interview or group discussion. As noted previously, at times the discussion process showed a shift in attitudes. While many participants began by emphasising that people with ID should have equal rights and be treated fairly, once the discussion turned to more complex issues participants increasingly demonstrated more negative attitudes. On this note one participant expressed very pro-inclusion attitudes early on, yet later noted that if her parents had discovered during testing that they were to have a child with an ID she would have rather not been born. Such instances hint at more deep-

seated beliefs in line with Sinason's (1992) observation that a life with ID is often considered as not worth living, or what Wolfensberger (1987) described as "death-making", namely viewing the person with ID as not human. These findings underline the value of a qualitative methodology which allows the discovery of more complex and at times contradictory attitudes, something a questionnaire measure would likely miss.

The observed shift in attitudes expressed by participants in the current study fits with research by Armitage and Conner (2000) considering attitudinal ambivalence. They observed that participants can simultaneously hold both positive and negative attitudes in mind, which moderate the relationship between attitudes, intentions and behaviour. Ambivalent attitudes were found to be more pliable in the face of persuasive communication (Armitage & Conner, 2000); this has implications regarding the validity of focus group research, as participants may change their views to fit with persuasive others in the group. This may be a particular issue in the current study, given the age of participants. Armitage and Conner (2000) also found that less ambivalent attitudes were more predictive of subsequent behavioural intention and behaviour, whereas more ambivalent attitudes are less predictive of behaviour. As this study appears to demonstrate ambivalent attitudes towards people with ID the extent to which their attitudes will predict behaviour is questionable.

This study found more similarities than differences in terms of factors that participants thought influenced their attitudes towards people with ID. These included age, religion, the benefits of education, and knowing someone with ID. These factors are in line with previous research findings; for example, being younger has been found to be associated with more positive attitudes (So-Kum Tang et al., 2000; Yazbeck, McVilly & Parmenter, 2004; Kenyon, 2008). Participants in this

study argued that younger people would have more positive attitudes due to increased interaction and experience of people with ID. Meanwhile, higher levels of educational attainment appear to be associated with more positive attitudes towards ID (Yazbeck, McVilly & Parmenter, 2004) and with more accurate knowledge of ID (Aminidiv & Weller, 1995). This supports ideas participants in this study expressed regarding education increasing understanding and reducing the likelihood of prejudice and belief in supernatural causes of ID.

Prior contact has been associated with both more positive attitudes towards people with ID (Yazbeck, McVilly & Parmenter, 2004; Sheridan 2008) and less positive attitudes (Downs & Williams, 1994; Schwartz & Armony-Sivan, 2001). Participants in this study showed that the relationship between attitudes towards ID are mediated by relationships with people with ID in a multi-dimensional way and may be more dependent on ability. For example, knowing someone with mild ID may result in more pro-inclusion attitudes, whereas knowing someone with a more severe ID may result in increased values relating to Sheltering.

Participants did not mention gender as an influence on their attitudes towards ID, which is interesting as some researchers have found that females hold more positive attitudes towards people with ID than males (Downs & William, 1994; Oullette-Kuntz et al., 2003; Sheridan, 2008), while others found no such association (Aminidiv & Weller, 1995; So-Kum Tang et al., 2000).

A few participants mentioned the influence of peers and wider influences such as political correctness on their attitudes towards people with ID and wider. There appears to be no research at present in this area.

South Asian participants were more likely to note culture as an influence on their attitudes than white British participants. This may have been a direct result of

the methodology employed in the study, as discussed below in limitations. In addition, it is likely that being from a minority culture increases awareness of differences in culture generally. Most South Asian participants related superstitious beliefs regarding the causation of ID to generational changes, education and an increasingly scientific understanding amongst younger people and those in Western countries. Of interest, South Asian participants noted that ideas about the 'curability' of ID referred to in the literature (Fatimilehin & Nadirshaw, 1994; Miles, 1992; 1995), can be misunderstood, because South Asian people may think of improvements in behaviour or learning of new skills in terms of 'cure' without, meaning an eradication of the underlying problem. Miles (1992) and Selway and Ashman (1998) stressed the importance of not applying a reductionist approach that belies the complexity of belief systems within different cultural groups.

Another possible mediating factor on cross-cultural differences may be visibility. For example, if there is increased sheltering of people with ID within certain cultures, this would lead to their increased invisibility and thus reduced opportunities for prior contact with ID, which may in turn prevent a shift towards more positive attitudes towards people with ID. Furthermore, Wolfensberger's original argument that contact with people with ID would eventually lead to more positive attitudes within wider society appears to hold. However, it is perhaps not as straightforward as he argued as there appear to be mediating variables present such as the nature of the contact with people with ID (Yazbeck, McVilly & Parmenter, 2004; Downs & Williams, 1994; Schwartz & Armony-Sivan, 2001) and the possible differential impact of contact on males and females (Downs & William, 1994; Oullette-Kuntz et al., 2003; Aminidiv & Weller, 1995).

Strengths

The major strength of this study is that it goes beyond previous qualitative research by engaging a larger sample size and considering attitudes within a general population sample rather than people with ID or their families. The utilisation of the CLAS-MR allowed an assessment of the generalisability of the findings, given that a much larger sample quantitative study was conducted with the same population by fellow trainee Joel Sheridan. Often, in qualitative research the generalisability of findings can be hypothesised about but not examined in any systematic fashion.

The design of the qualitative part of the study was closely informed by the CLAS-MR, as questions were designed to understand attitudes towards people with ID in more depth. The CLAS-MR was originally designed by a US based team of researchers (Henry et al., 1996). Although the measure has since been used in a number of countries and there are some suggestions of its cross-cultural validity (Horner-Johnson et al., year), the accounts of South Asian participants in the current study suggest that some further changes could be made to the CLAS-MR to make it more culturally relevant to South Asians. At present, those who scored high on Sheltering may be considered to have less favourable attitudes to people with ID. In contrast, this study demonstrated that amongst individuals from non-Western backgrounds, beliefs in line with Sheltering could be underpinned by beliefs regarding Similarity to self and a strong value placed on interdependence on family and community responsibility, with less value attributed to promoting independence. Thus, the mixed methodology allowed me to examine the validity of a fairly widely used quantitative measure and develop some thoughts on its limitations.

Finally the use of vignettes and photos enabled increased validity in terms of constructions of ID and went some way to ensuring that participants understood the

level of ability and definition of ID, which increases the reliability and validity of the study.

Limitations

It is possible that the ethnicity of the researcher as white British may have influenced the research in that South Asian participants may have felt less able to share certain information or may have wished to present their culture in a certain light. Also the researcher may not have been sensitive to cultural nuances in dialogues (Fern, 2001).

Furthermore, the setting of the research, which was mainly undertaken in sixth form colleges, may have resulted in teacher-pupil interactions, whereby further questioning resulted in participants changing their answers, as in education repeated questions often imply an incorrect answer has been supplied.

The qualitative part of the study utilised a mixed methodology, involving both individual interviews and focus groups. The focus groups appeared to have both advantages and disadvantages over the individual interviews. Advantages included lively discussions and numerous views being displayed simultaneously, however disadvantages concern the process of group discussion and evidence that in some groups more dominant participants influenced the direction and outcome of discussions.

The mixed methodology posed challenges so as not to over-represent data gathered during individual interviews compared to focus groups, therefore frequency counts were utilised so that each individual participant's view was counted, however no inter-reliability data was collected. In future work frequency counts for each theme should be calculated independently by two raters and inter-rater reliability checked. The utilisation of the CLAS-MR prior to completion of the qualitative

interviews was useful in priming participants about the focus of the ensuing interview or group discussion. However, it may have also resulted in participants positioning themselves as more empowering at the beginning of interviews and changing their position throughout the study.

A further limitation of the study relates to sampling issues. While recruitment to this study involved a number of parallel strands (Sheridan's 2008 study, an email sent to University College London Staff and sixth forms), the eventual sample was self selected and is likely to be biased towards individuals who have a pre-existing interest in this area and possibly more positive views as a result. Due to the design of the study it was possible to compare the CLAS-MR results from participants in this study to those in Sheridan's (2008) larger sample. Statistical analysis indicates that the current sample was representative of the larger population of 16 to 19 year olds who took part in Sheridan's study. However, this does not guarantee representation in terms of the general population. Furthermore, although statistically, there was no difference in terms of prior contact with people with ID between cultural groups, there was evidently a difference. It is possible that this might have been significant in a larger sample. However, Sheridan (2008) found no difference in terms of prior contact between groups. Bibi (2008) found no difference in terms of prior knowledge between Bangladeshi adults and white British adults. Kenyon (2008) noted a difference in prior contact between cultural groups, with white British adults being more likely to know someone with ID than adult Hindus but did not test for statistical significance. As previous research has indicated that contact with people with ID influences attitudes in both positive and negative ways, possibly being mediated by the quality of the experience (Yazbeck, McVilly & Parmenter, 2004), this is an area for further research.

Due to concerns regarding the validity of statistical analysis, effect sizes were compared. These indicated that South Asian participants were more traditional in their views than South Asians in Sheridan's (2008) study and that white British participants' views were more in line with pro-inclusion policy as measured by the CLAS-MR. There are numerous possibilities for these differences as explored in the Critical Appraisal. However, the main implication in terms of this study is that participants might be quantitatively different from the wider population. This may be due to differences within the sample or as a result of the focus group methodology and the age of participants, whereby participants wish to present themselves as more similar to their peers when discussing their views with their peer group (Jackson & Rodriguez-Tome, 1993).

The use of a qualitative methodology allowed exploration of a little-researched field, but also means that the study is limited to a small number of participants. Finally, as all participants were 16-19 years old in full-time education living in London, generalisations to other age groups and populations cannot be made.

Research Implications

The findings highlight a number of areas for further research, namely issues regarding the construct validity of ID, sensitivity of the CLAS-MR, and the impact of relevance of ID on participants' lives in a general population focussed study.

This study and the recent large scale Mencap survey (2008) underline widespread confusion regarding the terminology of ID. This confusion calls into question the construct validity of ID in other studies, which assume some form of shared understanding of the concept of 'intellectual' or 'learning disabilities'. In the

current study and in the Mencap survey participants frequently had a very confused understanding which would have obvious repercussions for the validity of results from any questionnaire based research. Furthermore, measures such as the CLAS-MR assesses respondents' attitudes to a general, undefined group of people with ID. In the present study participants' attributions of decision-making skills to people with ID were frequently (and rightly) dependent on level of ability which is not taken in to account in general attitudinal measures. The issue of definitions of ID and the resulting construct validly could be addressed in future research by spending more time priming participants with case-studies of people with ID, vignettes, and perhaps utilising video methodology. It needs to be borne in mind though that providing information can in itself influence attitudes.

Furthermore, there are implications in terms of the cultural specificity of attitude measures such as the CLAS-MR. For example, the present findings indicate that South Asian participants were more likely to consider looking after others as important, which may be linked to higher scores on Sheltering. Such attitudes may be deemed negative in terms of the CLAS-MR interpretation and current policies guiding ID services which emphasise concepts such as independence and choice.

Finally, it would seem that many of the questionnaire and interview/ focus group questions asked in this study in trying to tap into young people's attitudes towards ID were hypothetical and perhaps lacking in relevance to the young people at their developmental stage. Future research should consider asking questions which have higher salience to respondents' lives; in the context of adolescent college students these might include "How would you feel if X asked you out for a date?" or "What would think if someone with ID was sitting on your school board and

deciding how part of the school budget would be spent?” or “How would you feel if you were asked to take X with you to go out on a Friday night?”

Clinical Implications

As indications are that the UK public hold numerous misconceptions about ID there is clearly a case for some form of public education. This study indicates that general information holds little value, but that specific and detailed stories that can produce some real and likely lasting shifts in people’s attitudes (for example, the Eastenders story line and Mark Haddon’s book), which several participants recalled vividly.

This study found more similarities than differences between South Asian and white British young people’s attitudes towards people with ID. The key differences that were found appeared to relate to choices, independence and individual rights which white British participants were more likely to endorse. This seems particularly relevant within the UK, which is culturally diverse and employs social policy “*based on western notions of ‘independent living’ and ‘self advocacy’ which is of questionable relevance*” (Miles, 1992, p.235) to those from Asian backgrounds whose values may centre on more collective values. Previous research has attributed low use of services by South Asian to different understandings of curability and increased family responsibilities compared to white British families. However, this research indicates a difference in broader values that may create conflict and misunderstandings between professionals and service users and their families from the onset. Furthermore, previous research has indicated that Asian services users are more likely to have superstitious understandings of curability. However this research indicated that some white British participants held these views. Thus, a major clinical implication seems to be increased communication between professionals and services

users from the outset exploring values and beliefs regarding causation of ID, and the meaning of a good quality of life and outcome for all clients.

The differences highlighted between cultures demonstrate the importance of culturally sensitive support tailored to meet the needs of service users and their families. Current policy and practise needs to reflect diversity more carefully and not assume western notions regarding independence and choice hold the same relevance for people from diverse cultural backgrounds (see also Bignall & Butt, 2000). One might argue that at the least the values guiding services should be made more explicit by service providers and their fit discussed with service users to indicate greater openness and flexibility.

Summary

In summary, this study has added to the evidence base by increasing understandings of the similarities and differences between white British and South Asian young people's understandings towards people with ID. Key strengths and limitations of the study were identified. In addition, implications for research and clinical work are considered. Strengths, limitations, implications for future research and clinical work are further examined in the Critical Appraisal.

References

- Aizen, I., & Fishbein, M. (1980). *Understanding Attitudes and Predicting Social Behaviour*. Prentice Hall, Englewood-Cliffs, NJ.
- Aizen, I., & Fishbein, M. (1972). Attitudes and normative beliefs as factors influencing behavioural intentions. *Journal of Personality and Social Psychology*, 21, 1-9.
- Aminidav, C., & Weller, L. (1995). Effects of country of origin, sex, religion and social class on breadth of knowledge of mental retardation. *British Journal of Developmental Disability*, 80 (1):48-56.
- Antonak, R.F., & Harth, R. (1994). Psychometric analysis and revision of the Mental Retardation Attitude Inventory. *British Journal of Developmental Disability*, 80 (1): 48-56.
- Antonak, R.F., & Livneh, H. (1991). Survey research on attitudes. In J.L Matson and J.A Mulick (Eds.), *Handbook of mental retardation* (2nd edn.), 552-568. New York: Pergamon Press.
- Armitage, C., & Conner, M. (2000). Attitudinal ambivalence: a test of three key hypotheses. *Personality and Social Psychology Bulletin*, 26, 1421-1432.
- Atkins, K., & Rollings, J. (1996). 'Looking after their own?' Family care-giving among Asian and Afro-Caribbean communities. In: *'Race' and Community Care* (eds W.I.U. Ahmad & K. Atkin), pp.73-86. Open University Press, Buckingham.
- Barker, C., Pistrang, N., & Elliot, R. (2002). *Research Methods in Clinical Psychology: An introduction for students and practitioners* (2nd edn.). Chichester: John Wiley & Sons.
- Baxter, C., Poonia, K., Ward, L., & Nadirshaw, Z. (1990). *Double Discrimination*. Issues and Services for People with Learning Difficulties from Black and Ethnic Minority Communities. King's Fund Centre.

- Bibi, R. (2008). Attitudes to People with Learning Disabilities amongst Bangladeshi in the UK. UCL Undergraduate Thesis submitted.
- Bhatti, R.S., Channabasavanna, S.M., & Prabhu, L.R. (1985). A tool to study the attitudes of parents towards the management of mentally retarded children. *Child Psychiatric Quarterly*, 18 (2), 44-7.
- Braun, V., & Clarke; V. (2006). Using thematic analysis in Psychology. *Qualitative Research in Psychology*, 3, 77-101.
- Butcher, H.K., Holkcup, P.A., Park, M., & Maas, M. (2001). Thematic analysis of the experience of making a decision to place a family member with Alzheimer's disease in a special care unit. *Nursing & Health*, 24, 470-480.
- Chamba, R., Ahmad, W., Hirst, M., Lawton, D., & Beresford, B. (1999). *On the edge: Minority ethnic families caring for a severely disabled child*. Joseph Rowntree Foundation: The Policy Press. ISBN 1 86134 134 2.
- Coyne, J., & Calarco., M. (1995). Effects of the experiences of depression: application of focus group and survey methodologies. *Psychiatry*, 58, 149-163.
- Department of Health. (2001). *Valuing People*. London: HMSO.
- Department of Health. (2008). *Valuing People Now*. London: HMSO.
- Disability Discrimination Act (2005). The Stationary Office. ISBN 0 10 5411105 1.
- Downs, P., & Williams, T. (1994). Student attitudes towards integration of people with disabilities in activity settings: A European comparison. *Adaptive Physical Activity Quarterly*, 11: 32-43.
- Eggert, D., & Berry, P. (1992). German, Irish and Australian high school students' perceptions of mental handicap. *International Journal of Rehabilitation Research*, 15, 349-354.
- Emerson, E., & Hatton, C. (1999). Future trends in the ethnic composition of British society

- and among British citizens with learning disabilities. *Tizard Learning Disability Review*, 4, 28-32.
- Fatimilehin, I., & Nadirshaw, Z. (1994). A cross-cultural study of parental attitudes and beliefs about Learning Disability (Mental Handicap). *Mental Handicap Research*, Vol. 7 (3).
- Fern, E. (2001). *Advanced Focus Group Research*. London: Sage Publications.
- Festinger, L. (1957). *A theory of cognitive dissonance*. Stanford: Stanford University Press.
- Geskie, M.A., & Salasek, K.L. (1988). Attitudes of health care personnel towards people with disabilities. In H.E Yuker (Ed.), *Attitudes towards persons with disabilities*, pp.187-200). New York: Springer-Verlag.
- Gilbert, P., Gilbert, J & Sanghera, J. (2003). A focus group exploration of the impact of izzat, shame, subordination and entrapment on mental health and service use in South Asian women living in Derby. *Mental health, religion & culture*. Vol 6 (3), 1-22.
- Hague, P. (1993). *Interviewing*. London: Kogan Page
- Harrison, K., & Barlow, J. (1995). Focused group discussion: a 'quality' method for health research? *Health Psychology Update*, 20, 11-13.
- Hastings, R., Sjöström, K., & Stevenage, S. (1998). Swedish and English adolescents' attitudes toward the community presence of people with LD. *Journal of Intellectual Disability Research*, 42, 314.
- Hatton, C. (1998). Intellectual disabilities-epidemiology and causes. In Emerson, E., Hatton, C., Bromley, J & Caine A. (Eds.), *Clinical Psychology and People with Intellectual Disabilities* (pp. 20-38). Chichester: John Wiley & Sons.
- Hatton, C., Akram, Y., Shah, R., Robertson, J., & Emerson, E. (2003). Supporting South Asian Families with a Child with Severe Disabilities: A Report to the Department of

Health. Institute for Health Research. Lancaster University, Lancaster.

Hatton, C., Azmi, S., Caine, A., & Emerson, E. (1998). Informal carers of adolescents and adults with learning difficulties from the South Asian communities: family circumstances, service support and carer stress. *British Journal of Social Work*, **28**, 821-837.

Heider, F. (1958). *The psychology of interpersonal relations*. New York: Wiley.

Henry, D.B., Keys, C.B., Jopp, D., & Balcazar, F. (1996). The Community Living Attitudes Scale: Development and psychometric properties. *Mental Retardation*, *34*, 149-158.

Hughes, J.M. (1984). Some selected attitudes to mental retardation in developed and developing countries. *Mental Handicap Bulletin*, *53*.

Hussain, Y., Atkin, K., & Ahmad W. (2002). *South Asian Disabled Young People and their Families*. Joseph Rowntree Foundation: The Policy Press. ISBN 1 86134 326 4.

IASSID (International Association for the Scientific Study of Intellectual Disabilities). (2001). *The Edinburgh Principles*. Clifton Park, NY: Author.

Jackson, S. & Rodriguez-Tome. (Eds.). (1993). *Adolescence and it's Social Worlds*. Lawrence Erlbaum Associates Ltd: Hove, UK

Jervis, M. (1987). Across the cultural divide. *Mental Handicap Bulletin*, *65*: 10.

Joffe, H., & Yardley, L. (2004). Content and thematic analysis. In D.F. Marks & L. Yardley (eds.). *Research Methods for Clinical & Health Psychology*. London: Sage.

Kennedy, C., Kools., S., & Krueger, R. (2001). Methodological Considerations in Childrens Focus Groups. *Nursing Research*. *50*(3):184-187.

Kenyon, M. (2008). Attitudes towards People with Learning Disabilities within the UK South Asian Hindu community. UCL Undergraduate Thesis submitted.

Kitzinger, J. (1995). Introducing focus groups. *British Medical Journal*, *311*, 299-302.

- Kraus, S.J. (1995). Attitudes and the prediction of behaviour: a meta-analysis of the empirical literature. *Journal of Personality and Social Psychology*, 21, 58-75.
- Krueger, R.A., & Casey M.A. (2000). *Focus Groups: A Practical Guide for Applied Research*. Sage Publications: Thousand Oaks, CA.
- Lowenthal, K.M., Lee, M., Macleod, A.K., Cook, S., & Goldblatt, V. (2003). Drowning your sorrows? Attitudes towards alcohol in UK Jews and Protestants: a thematic analysis. *International Journal of Social Psychiatry*, 49(3) 204-215.
- Luborsky, M. (1994). The identification and analysis of themes and patterns. In J.F. Gubrium & A Sunker (eds.). *Qualitative Methods in Aging Research*. 189-210. Thousands Oaks, California: Sage
- MENCAP. Lack of Knowledge of learning disability revealed. Article downloaded from the World Wide Web on 18/4/08: www.mencap.org.uk/news.asp
- McConkey, R., McCormack, B., & Naughton, B. et al (1983). National survey of young people's perceptions of mental handicapped. *Journal of Mental Deficiency Research*, 27, 171-183.
- McLoughlin, A. (2008). The impact of age and gender on attitudes towards learning disabilities in a White British sample. UCL Undergraduate Thesis submitted.
- Miles, M. (1992). Concepts of Mental Retardation in Pakistan: toward cross cultural and historical perspectives. *Disability, Handicap & Society*, Vol.7 (3).
- Miles, M. (1995). Disability in an Eastern religious Context: historical perspectives. *Disability & Society*, 10 (1), 49-69.
- Mir, G., Nocon, A., Ahmad, W., & Jones, L. (2001). *Learning Difficulties and Ethnicity*. Department of Health, London.
- Modood, T., Berthoud, R., Lakey, J., Nazroo, J., Smith, P., Virdee, S., & Beishon, S. (1997).

- Ethnic Minorities in Britain: Diversity and Disadvantage. Policy Studies Institute, London.
- Morgan, D.L. (1988) *Focus groups as qualitative research*. London: Sage.
- O'Hara, J. (2003). Learning disabilities and ethnicity: achieving cultural competence. *Advances in Psychiatric Treatment*, 9, 166-176.
- Pardun, C.J. (2005). *Media's portrayal of people with intellectual disabilities*. Special Olympics, Washington, DC.
- Park, M., Butcher, H.K., & Maas, M.L. (2004). A thematic analysis of Korean family caregivers' experiences in making the decisions to place a family member with dementia in a long term care facility. *Nursing & Health*, 27, 345-356.
- Powell, R.A., & Single, H.M. (1996). Focus groups. *International Journal of Quality in Health Care*, 8(5), 499-504.
- Priestley, M. (1998). Constructions and Creations: idealism, materialism and disability theory. *Disability and Society*, 13 (1), 75-94.
- Raghavan, R., & Small, N. (2004). Cultural diversity and intellectual disability. *Current Opinion in Psychiatry*, 17, 371-375.
- Sheridan, J. (2008). Attitudes to People with Intellectual Disabilities: a cross cultural study. UCL Thesis submitted.
- Sinason, V. (1992). *Mental Handicap and the Human Condition: New Approaches from the Tavistock*. London: Free Association Book.
- So-Kum Tang, C., Davis, C., Wu, A., & Oliver, C. (2000). Chinese children's attitudes towards mental retardation. *Journal of Developmental and Physical Disabilities*, Vol 12 (1), 73-87.
- Sullivan, C.F. (2003). Gendered cybersupport: a thematic analysis of two online cancer support groups. *Journal of Health Psychology*, 8(1), 83-103.

- Taylor, S.M., & Dear, M.J. (1981). Scaling community attitudes toward the mentally ill. *Schizophrenia Bulletin*, 7, 225-240.
- United Nations. (1975). *Declaration on the rights of people with disability*. New York: Author.
- United Nations. (1993). *The standard rules on the equalisation of opportunities for persons with disabilities*. New York: Author.
- Wilson, T.D., Lindsey, S. & Schooler, T.Y. (2000). A model of dual attitudes. *Psychological Review*, 107(1), 101-126.
- Wolfensberger, W. (1983). Social Role Valorisation: A proposed new term for the principle of normalisation. *Mental Retardation*, 21, 234-239.
- Wolfensberger, W. (1987). *The New Genocide of Handicapped and Afflicted People*. New York: Syracuse University.
- Yazbeck, M., McVilly, K., & Parmenter, T.R. (2004). *Journal of Disability Policy Studies*. Vol.15 (2), 97-111.

Part 3 Critical Appraisal

Researching Attitudes to People with Intellectual Disabilities: A Critical Appraisal

Introduction

In this critical appraisal I reflect on the research process and conceptual and methodological issues, including pragmatic choices made to complete the research on time. I also consider how my own understandings of attitudes towards people with ID have changed. Furthermore, I evaluate the strengths and weaknesses of the research and highlight implications for clinical practice and possible directions for future research.

Context

In the present study I intended to add to the evidence base regarding attitudes towards people with ID. Empowerment of individuals with ID is an area that is central to providing services to those with ID and a major part of this is integration into community settings. An understanding of the general population's attitudes towards people with ID is integral to ensuring effective integration of those with ID in the community, as public attitudes have potentially far reaching implications for the quality of life and social inclusion of people with ID.

An initial literature search indicated that little research has been conducted to date investigating the impact of the process of *normalisation* on public attitudes in the UK. Furthermore, the research that had been conducted indicated some inconsistent findings. While some studies found gender, level of education and previous contact with people with ID to be associated with more positive attitudes towards people with ID, other studies found this not to be the case (Downs & William, 1994; Oullette-Kuntz et al., 2003; Aminidiv & Weller; 1995; So-Kum Tang et al., 2000). Therefore, Yazbeck, McVilly and Parmenter (2004) called for qualitative research to consider why these differences may be occurring.

Changes in understandings of the phenomena

Constructions of ID

I was surprised with the level of confusion that was displayed by participants when questioned regarding their understandings of ID and initially was uncertain as to why this was occurring. I felt in a difficult position as it was imperative to the validity of the results to ensure that participants had a reasonable understanding of the nature of ID when questioning them regarding their attitudes towards people with ID. Yet, it was interesting to explore participants' constructs of ID. I think that this was addressed in the study by the utilisation of photographs and vignettes at a later point. However, it was notable that, even after receiving definitions, participants continued to refer back to dyslexia. This appears to be in line with Kenyon's (2008) study investigating attitudes towards ID within the UK Hindu Population utilising the CLAS-MR. Kenyon provided participants with a fairly detailed, yet at face level straightforward definition of ID, but anecdotally found that participants frequently were still unclear about the exact meaning of the term.

I also found it interesting when discussing my thesis with others how often people have little understanding of constructions of ID, and the confusion that arises amongst even well educated individuals outside ID services. This was further compounded by a press release by Mencap in 2008 based on their survey of 1600 participants who were asked to give 2 definitions of 'learning disabilities'. The survey found that 73% of respondents gave examples that were wrong. This led them to estimate that 3 in 4 people cannot give an accurate definition of ID. Furthermore they interviewed 103 MPs and only 22% were able to give a correct definition, indicating a lower level of understanding than in the general population survey.

This has particular implications as much research within the field of attitudes and ID presumes a shared understanding of the construct of ID. It is therefore unclear whether previous research has measured attitudes to ID as understood by professionals and researchers, or in fact attitudes to a confused understanding of ID, which includes sensory impairments and specific learning difficulties. It is clear that future research needs to consider issues of definitions more carefully. It also indicates a need for increased education within the general population to facilitate understandings of ID to enable better integration in the community.

Attitudinal research

I feel that increasing my understanding of attitudinal research in other areas of psychology has benefited my understanding of attitudes towards ID. One key learning point for me from the wider literature has been the hypothesis that attitudes towards people with ID are not one attitude, but rather may be made up of a number of attitudes or ideas that can be in conflict with each other. Research by Armitage and Conner (2000) considering attitudinal ambivalence concluded that individuals can simultaneously hold both positive and negative attitudes in mind which act as a moderating effect on the relationship between attitudes, intentions and behaviour. Their findings indicated that less ambivalent attitudes were more predictive of subsequent behavioural intentions and behaviour but were unrelated to attitudinal stability. Furthermore, ambivalent attitudes were found to be more pliable in the face of persuasive communication which has implications in terms of the validity of focus group research which may be dominated by certain individuals.

A major strength of the methodology of this study was its ability to uncover the complexity of attitudes to ID, allowing more thorough exploration of attitudes,

space for participants to explore their thought processes and explain their reasoning and justifications for their attitudes. As such, they revealed more about the attitudes they hold but reject as invalid which was demonstrated by the seeming contradictions in the data.

Political correctness and social desirability

I was surprised that participants in my study felt that peers did not influence their attitudes towards people with ID. There are a number of possible explanations for this. Firstly, the lack of representations of people with ID in the media, the general invisibility of people with ID within society, and the low salience of this issue for adolescents may mean that participants were genuinely not influenced by peers. However, I feel that the issue may be more complex than this and may indicate wider influences of social desirability and political correctness.

I hypothesised that individuals may be influenced by social desirability which created a certain amount of congruency within groups. However, previous studies considering attitudes towards ID which explicitly examined the impact of social desirability biases on CLAS-MR scores indicated that this was not the case (Kenyon, 2008; Bibi, 2008). It is possible that this was due to the self report measure that was utilised in these studies. The Marlow-Crowne Social Desirability Scale-short form (1960) has been shown to have both internal reliability and validity (Ray, 1984), but more recently Barger (2002) found a lack of validity and reliability in the measure. These changes may reflect societal changes over the last 40 years. Furthermore, the questions asked as part of the scale may not reflect the type of social desirability that is important in this context.

I also think that the way in which participants demonstrated contradictions in their attitudes towards people with ID (for example, positioning themselves as empowering and pro-choice, yet later on stating that those with ID should not be allowed to have children), can be partly explained by attitudinal ambivalence in which individuals experience both attitudes as strong and valid. However, in many situations a person may experience an attitude that they consider to be illegitimate and not in keeping with their values. Wilson, Lindsey and Schooler (2000) proposed a 'Model of Dual Attitudes' in which the rejected attitude remains in memory and can continue to influence behaviour. They drew a distinction between implicit attitudes, defined as evaluations that have unknown origin, are activated automatically and influence uncontrolled processes (Greenwald & Banaji, 1995), and explicit attitudes, which are deliberative and involve conscious processing. The distinction between implicit and explicit attitudes was not identified by Wilson et al. (2000), but they provide a clear framework for understanding how conflicting attitudes relate to each other and influence behaviour. In simple terms, when an individual has the time and motivation to process information and deliberate over a response, they will report the explicit attitude. In contrast, implicit attitudes, which are activated automatically, are not reported when the individual has the cognitive capacity to override them. As such, both attitudes might influence behaviour, depending on whether an individual is willing or able to control their response. A strength of the methodology utilised in the present study was that it allowed more probing to take place, which enabled both implicit and explicit attitudes to be elicited and at least some observation of the cognitive processes that moderate the relationship between the two.

These ideas have interesting implications for the social inclusion of people with ID, as it has also been demonstrated that implicit attitude measures can predict behaviour both independently of and synergistically with, explicit attitude measures, with implicit attitude measures more predictive of automatic and behaviour responses that do not allow deliberation (Perugini, 2005). Thus the implicit attitudes that people hold and may not openly express initially, may give rise to prejudices and discrimination.

Sampling

Several points are worth noting related to the representativeness of my sample. By recruiting a white British and a South Asian British Group from the same college, it was hoped that the groups would be similar in terms of demographics such as gender, age, education and social economic status (SES). This was important as the literature indicates that these are variables that influence attitudes towards people with ID. However, this was further supplemented by recruitment via participants who consented to being contacted about follow up research in Sheridan's (2008) study and at a later stage e-mails to University College London staff .

Recruitment via sixth form colleges meant that there were numerous barriers to sampling, with teachers acting as a mediator between participants and myself. It is difficult to know who they asked to participate in the studies and if these individuals were representative of the wider population of the college, or were more likely to be articulate, or have an interest in ID. A number of teachers noted they had chosen participants they felt would be "able to talk about the topic." This suggests a bias as participants may have had a vested interest in ID. Money was offered as an incentive to participants; interestingly some indicated that they had only agreed to take part due to this incentive whereas others stated they felt the money could have been

utilised more effectively for people with ID (although everyone accepted the payment).

A major strength of this qualitative study was the opportunity to consider representativeness by comparing participants to Sheridan's (2008) much larger sample ($N=799$). The data from both studies was compared statistically which indicated few differences, apart from on the gender distribution, with this study having a more equal gender distribution.

Furthermore effects sizes were compared. This provided interesting data as it appeared that white British participants in my sample were more likely to demonstrate pro-inclusion attitudes than South Asian participants. One could hypothesise that this was a result of the methodology employed within this study which may have resulted in group dynamics whereby convergence was created within the groups. Alternatively this may be due to South Asian participants holding values that are less in line with current policies within the UK. Conversely, due to differences in recruitment methods between my study and Sheridan's (2008) study it may be that my sample were more traditional in their views than participants in Sheridan's study, given that he recruited mainly from young people attending UCL open days, suggesting higher educational aspirations than in an average sixth form college student body.

Within this study, although statistically, there was no difference in terms of prior contact with people with ID between cultural groups, there was evidently a difference. It is possible that this was due to the study being underpowered due to sample size and may have been different in a larger sample although Sheridan (2008) did not find this to be the case. To date, there is some discrepancy within the literature regarding cultural groups and contact with ID, for example, Bibi (2008)

found no difference in terms of prior contact between Bangladeshi adults and white British adults. Previous research has indicated that contact with people with ID influences attitudes in both positive and negative ways, possibly being mediated by the quality of the experience (Yazbeck, McVilly & Parmenter, 2004). Prior contact with people with ID is more predictive of pro-inclusion attitudes than gender or ethnicity (Sheridan, 2008). Thus prior contact with people with ID appears to have implications in terms of attitudes towards people with ID. It can also be hypothesised that differences occurring in previous contact could reflect how Sheltering occurs within different cultures and thus the different levels of visibility of people with ID within cultures. This appears to be an area for further research.

A further limitation of this study is that due to the small numbers of participants recruited from a South Asian background, participants were considered on the main denomination of belonging to an admittedly heterogeneous group of 'South Asians', rather than breaking this down further by ethnicity or religion. This has implications as other studies considering attitudes towards ID have found differences in attitudes between participants from different cultural backgrounds on their scores on the CLAS-MR, with Bibi (2008) finding that Bangladeshi adults expressed more positive attitudes compared to their white British counterparts.

Being a white researcher

Some methodological difficulties in researching attitudes within a South Asian cultural context may result from my essentially holding a white British viewpoint. Being from a different cultural backgrounds to interviewees may have put some barriers in place, such as interviewees expecting me not to understand certain cultural ideas, or being less willing to share certain ideas, for example regarding 'possession

by spirits' as a possible cause for ID (Fatimilehin & Nadirshaw, 1994). Conversely, cultural difference may in some ways be an advantage in trying to explore ideas which may seem obvious to participants. I think that clinical training and systemic ideas of positioning oneself as curious were helpful in managing these issues. Furthermore, I was able to convey an awareness of possible differences in understandings based on the literature, as participants feel more comfortable when the researcher has some experience of the issues being discussed (Speck et al., 2005). I think that I managed to balance these roles effectively as participants seemed able to talk and to both agree and disagree with myself and each other. Furthermore careful attention to overcoming difference from the outset helped me to take a similar position as curious with those from a white British background.

I feel that focus groups were helpful in enabling understanding the diversity of views that exist in both white British and South Asian 16-19 year olds and their understandings and attitudes to ID. The groups appeared effective as individuals discussed a number of ideas that could be considered culturally sensitive, such as ideas about curability. The focus groups also highlighted variance in the experiences of young South Asians in the UK, for example, when asking participants questions regarding people with ID leaving home and who should make such decisions. Some participants viewed this as being a normative experience, whereas others stated that it would not be the norm for young people to leave home unless they were getting married. It was striking to me as a white British woman how different experiences were across the participants and also to my own experiences regarding expectations of at what age one leaves home. This variance in the experiences and conceptualisation of curability in different cultures remains an area that has not received much research interest.

I was particularly struck by the use of language within groups and the different meanings that words were given by different individuals. I think a strength of the methodology utilised within the study was the ability to take a curious stance and to be able to explore this with participants to elicit deeper understandings. The curious stance that was taken in the research allowed exploration of the operationalised definitions of ID and consideration of the meaning of language between myself and participants. For example, this enabled greater knowledge regarding the term curability which some participants meant as a 'cure' whereas others meant improvement in quality of life.

A possible weakness of this study is that by splitting participants based on ethnicity I may have influenced the discussions that were held within the focus groups. For example, South Asian participants may have been more likely to discuss cultural differences due to the fact that the very method of data collection drew attention to shared cultural values and experiences. In contrast, white British participants in meeting with other members of the dominant cultural group may have been less likely to consider culture as an influence on their attitudes.

Photos and vignettes

To hold constant other possible variables influencing attitudes, both photographs within the study represented two young white men. However, this has a number of possible limitations. For example, some South Asian participants discussed differences in what South Asian men and women are able to achieve independently (for example leaving home prior to marriage or working) compared to their white British counterparts. This would be an interesting area for further exploration.

The photographs and vignettes were chosen to represent a person with a mild ID and a person with a moderate ID and the visual characteristics of Downs Syndrome. It may be that the utilisation of this methodology created profiles of people with ID which lacked depth and humanity and therefore in the future the use of a video methodology with people with ID talking about their lives may elicit more genuine attitudes.

Qualitative research

Personal experiences

This was the first time I had conducted qualitative research. I found conducting the interviews and focus groups interesting, as participants varied greatly in their responses to the questions and interactions with myself as the researcher. Generally individuals were lively and enthusiastic in engaging with the subject matter, yet some participants were more articulate than others. Some participants required a lot of prompting to enable engagement with the topic and in some cases in larger groups some individuals did not speak. It was unclear if this was due to shyness, not having anything to say, views already having been expressed by others in the groups or their views being so different to others in the group that they did not wish to speak up.

Transcribing conversations was complex. Often participants talked over each, were difficult to hear, or were seemingly coherent when speaking, but what they said appeared incoherent once transcribed. The written word appeared to not always accurately reflect the depth of the conversations that were being held and I wondered to what extent some of the data was lost. I think that this limitation was overcome to some extent by careful preparation of the transcripts, re-listening to tapes and my

involvement in conducting the interviews and the analysis so that I had a familiarity with the conversations and a feeling for how conversations had been in reality.

I also wonder how my theoretical commitments and resulting interview schedule impacted on the generation of the data. It may have been that the phenomena could have been investigated differently by having fewer prompts for participants. However, a limitation of this may have been that participants would have had little to say regarding the topic area. Many participants were unfamiliar with meta-cognitions and needed help initially to consider what types of influences had impacted on their attitudes. By providing prompts regarding possible influences on attitudes the data is influenced by my thoughts and the literature. However, participants seemed able to disagree with me and to provide their own hypothesis for their thinking.

Having had more time to reflect on the items in my interviews and having seen the data generated through the use of the schedules I can now see how changing the wording may have increased relevance to participants within the study. It was notable that many participants initially stated views that could be considered empowering yet later on showed signs of discrimination when discussing employment for individuals with ID or relationships

A further reflection is that the use of the tape recorder appeared to have an impact on some participants in terms of what they were willing to discuss. For example, in one South Asian focus group, after the interview was over, the tape recorder was turned off and some of the group had left, participants began discussing how more traditional Asians may think differently to themselves. Thus a possible limitation of the design of the study is that participants would self monitor when being recorded. This would be a difficult limitation to overcome due to the nature of

qualitative methodology. However, providing an individual space for these participants may have resulted in richer data where participants were able to express themselves more freely without concerns of repercussions from others within the group.

Conceptual Framework

A strength of utilising thematic analysis in the current study was the clear and coherent guide that was followed to carry out the analysis which was grounded in participants' statements. A further strength conceptually of thematic analysis is that it is a phenomenological analysis which incorporates a range of approaches for example, it can be considered as both similar to IPA and its process of interpretation or nearer to content analysis work (Saunders & Byrne, 2002; Sullivan, 2003;)

This allowed the research flexibility in that it includes frequency counts and interpretations of the data. Alternatively it appears that there are a number of similarities to the approach utilised in this study and that of Kreguer's (1994) framework analysis approach which also provides clear guidelines to first time researchers in managing the large amounts of complex data that is the nature of qualitative analysis (Rabiee, 2004)

Evaluating qualitative research

Evaluating the validity of the findings is integral to the process of thematic analysis. Braun's and Clarke's (2006) method of analysis was closely followed in the initial stages of this study and therefore their approach to assessing quality of analysis will be considered here. Please see table 1.

Table 7

*A 15-point checklist for good thematic analysis*⁵

Process	No.	Criteria
Transcription	1	The data has been transcribed to an appropriate level of detail, and the transcripts have been checked against the audio-recordings for 'accuracy'.
Coding	2	Each data item has been given equal attention in the coding process.
	3	Themes have not been generated from a few vivid examples but instead the coding process has been thorough, inclusive and comprehensive.
	4	All relevant extracts for each theme have been collated
	5	Themes have been checked against each other and back to the original data set.
	6	Themes are internally coherent, consistent and distinctive.
Analysis	7	Data have been analysed – interpreted, made sense of –rather than just paraphrased or described.
	8	Analysis and data match each other- the extract illustrates the claims.
	9	Analysis tells a convincing and well organised story about the data and topic.
	10	A good balance between analytic narrative and illustrative extracts is provided.
Overall	11	Enough time has been allocated to complete phases of the analysis adequately, without rushing a phase.
Written Report	12	The assumptions about, and specific approach to, thematic analysis are clearly explicated.
	13	There is a good fit between what you claim you do, and what you show you have done.
	14	The language and concepts used in the report are consistent with the epistemological position of the analysis.
	15	The researcher is positioned as active in the research; themes do not 'emerge.'

Braun's and Clarke's (2006) good practice guidelines indicate 5 overall areas to consider in the evaluation of thematic analyses. I will now consider how I have addressed each of these areas whilst conducting my research. Numbers 1-3 were carried out as stated in the table above. As part of number 4, I spent some time compiling all coded evidence into a word document from which evidence for themes was compiled. Examples of these can be seen in appendix E2. I spent time with my supervisor critically examining the themes to ensure they made sense together and in

⁵ Based on Braun and Clarke (2006).

terms of the data set as a whole. This also ensured the internal consistency of the themes (Number 5, 6). These discussions formed an integral part of the analysis, as this provided space to develop ideas regarding the data. I hope that the checklist for analysis and the written report are as easily examined by others as by myself. Numbers 7-10 were addressed by ensuring through critical examination in supervision that the data had been analysed, that quotes matched the interpretation and told a convincing and well organised story of the data and the topic. Furthermore, the thesis hopefully provides evidence that a good balance was struck between the analytic narrative and the extracts provided. As a newcomer to qualitative research, ensuring criterion 11 was met was particularly challenging as I underestimated the time that was needed to complete a thorough analysis, particularly in terms of familiarising oneself with the data and consideration of writing up the final report in a coherent manner. During the writing of my thesis I have attempted to be specific about my analysis and how I conducted it, as well as providing evidence (Numbers 12 & 13, also see appendix E1 and E2). The language and concepts used in the report are consistent with the epistemological position of the analysis which is both exploratory but informed by current literature. Furthermore, the research and I were guided by the language which dominates UK policy in the area of ID, namely privileging choice and inclusion over dependence (Number 14). I feel that I have made my position in the research in terms of my underlying assumptions and beliefs clear from the outset to enable others to understand my possible bias. Furthermore, supervision provided space for critically examining the data to ensure that bias did not occur (Number 15).

Future research

There are a number of ways that this study could be built on to enhance our understanding of this area further. Firstly, future research should consider asking questions that are more relevant to participants. While the use of photographs and vignettes partly addresses the confusion regarding definitions of ID it would be interested to consider employing a video methodology instead of photographs and vignettes to attempt to bring case studies to life a bit more.

Lack of representations in the media were particularly pertinent in the South Asian sample. Further research should investigate whether this is reflected in reality, or if it is more to do with a lack of awareness amongst South Asian participants in the study.

Clinical implications

I think it is particularly interesting that previous research has related lack of uptake of services by South Asians to different understandings of ID and views of curability. I think that my research has generated an alternative understanding as to why uptake may be lower in South Asian cultures, namely as due to cultural values and a mismatch with values dominating ID services, such as choice and independence.

It would appear that there was a difference between South Asian and white British participants in terms of their understandings of what constitutes a good quality of life. It was striking within the study that white British participants were more likely to cite independence and choices being “up to the individual” than those from a South Asian background. In contrast, South Asian participants were more likely to subscribe to the view that individuals should be treated equally to themselves and were less likely to subscribe to values of independence and

empowerment. As the CLAS-MR is designed to be in line with current service and policy values, namely values of choice, individual rights, and empowerment which are not in line with South Asian values neither by definition will the CLAS-MR.

As current national policy subscribes to views regarding empowerment, independence and personal choice it can be hypothesized that those who come from cultures where independence is not a key value may be alienated by the values that are subscribed to by services. This has implications for service delivery and perhaps more honesty and awareness of these issues from the outset would create more collaborative relationships between services users and professionals. It is also an area for further research within the NHS in terms of evaluation of services provided to individuals from different cultures and how this impacted on their views of service delivery.

Summary

In conclusion, the present study goes some way to exploring differences in attitudes towards people with ID amongst 16-19 year olds from white British and South Asian backgrounds. These differences in understanding and influences on their attitudes towards ID have interesting implications for service delivery within the NHS and for future research within the field of attitudes towards ID.

References

- Aminidav, C., & Weller, L. (1995). Effects of country of origin, sex, religion and social class on breadth of knowledge of mental retardation. *British Journal of Developmental Disability, 80* (1):48-56.
- Armitage, C., & Conner, M. (2000). Attitudinal ambivalence: a test of three key hypotheses. *Personality and Social Psychology Bulletin, 26*, 1421-1432.
- Barger, S.D. (2002). The Marlowe-Crowne affair: short forms, psychometric structure, and social desirability. *Journal of Personality Assessment, 79* (2): 286-305.
- Bibi, R. (2008). Attitudes to People with Learning Disabilities amongst Bangladeshi in the UK. UCL Undergraduate Thesis submitted.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in Psychology. *Qualitative Research in Psychology, 3*, 77-101.
- Crowne, D.P., & Marlowe, D. (1960). A new scale of social desirability independent of psychopathology. *Journal of Consulting Psychology, 24*, 349-354.
- Downs, P., & Williams, T. (1994). Student attitudes towards integration of people with disabilities in activity settings: A European comparison. *Adaptive Physical Activity Quarterly, 11*: 32-43.
- Fatimilehin, I., & Nadirshaw, Z. (1994). A Cross-Cultural Study of Parental Attitudes and Beliefs About Learning Disability (Mental Handicap). *Mental Handicap Research, Vol. 7* (3).
- Greenwald, A.G., & Banaji, M.R. (1995). Implicit social cognition: attitudes, self-esteem, and stereotypes. *Psychological Review, 102*, 4-27.
- Kenyon, M. (2008). Attitudes towards People with Learning Disabilities within the UK South Asian Hindu community. UCL Undergraduate Thesis submitted.

- McLoughlin, A. (2008). The impact of age and gender on attitudes towards learning disabilities in a White British sample. UCL Undergraduate Thesis submitted.
- MENCAP. Lack of Knowledge of learning disability revealed. Article downloaded from the World Wide Web on 18/4/08: www.mencap.org.uk/news.asp
- Oullette-Kuntz, H., Burge, P., Henry, D., Bradley, E., & Leichner, P. (2003). Attitudes of senior psychiatry residents towards persons with intellectual disabilities. *Canadian Journal of Psychiatry*, 48, 538-545.
- Perugini, M. (2005). Predictive models of implicit and explicit attitudes. *British Journal of Social Psychology*, 44(1), 29-45.
- Ray, J. (1984). The reliability of short social desirability scales. *The Journal of Social Psychology*, 123, 133-134.
- Rabiee, F. (2004). Focus-group interview and data analysis. *Proceedings of the Nutrition Society*, 63, 655-660.
- Saunders, J.C., & Byrne, M.M. (2002). A thematic analysis of families living with schizophrenia, *Archives of Psychiatric Nursing*, 16, (5), 217-233
- Sheridan, J. (2008). Attitudes to People with Intellectual Disabilities: a cross cultural study. UCL Thesis submitted.
- So-Kum Tang, C., Davis, C., Wu, A., & Oliver, C. (2000). *Journal of Developmental and Physical Disabilities*, Vol 12 (1), 73-87.
- Speck, P., Bennett, K.M., Coleman, P.G., Mills, M., McKiernan, F., Smith, P.T., & Hughes, G.M. (2005). Elderly bereaved spouses: Issues of belief, well-being and support. In A. Walker (Ed.) *Understanding Quality of Life in Old Age*. Berkshire: Open University Press.

Sullivan, C.F. (2003). Gendered cybersupport: a thematic analysis of two online cancer support groups. *Journal of Health Psychology, 8(1)*, 83-103.

Wilson, T.D., Lindsey, S., & Schooler, T.Y. (2000). A model of dual attitudes. *Psychological Review, 107(1)*, 101-126.

Yazbeck, M., McVilly, K., & Parmenter, T.R. (2004). *Journal of Disability Policy Studies. Vol.15 (2)*, 97-111.

Appendices

Appendix A

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Appendix B

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E1 Initial table of codes

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Appendix A

Ethics

A1 Ethical Approval Form



Dr Katrina Scior
Sub-Department of Clinical Health Psychology
1-19 Torrington Place
London WC1E 7HB

17 May 2007

Dear Dr Scior

Notification of Ethical Approval

Project ID/Title: 1099/001: Attitudes towards people with learning disabilities: a cross cultural study

I am pleased to confirm that in my capacity as Chair of the UCL Research Ethics Committee I have approved your research proposal for the duration of the project. Approval is subject to the following conditions:

1. You must seek Chair's approval for proposed amendments to the research for which this approval has been given. Ethical approval is specific to this project and must not be treated as applicable to research of a similar nature. Each research project is reviewed separately and if there are significant changes to the research protocol you should seek confirmation of continued ethical approval by completing the 'Amendment Approval Request Form'.

The forms identified above can be accessed by logging on to the ethics website homepage:
<http://www.grad.ucl.ac.uk/ethics/> and clicking on the button marked 'Responsibilities Following Approval'.

2. It is your responsibility to report to the Committee any unanticipated problems or adverse events involving risks to participants or others. Both non-serious and serious adverse events must be reported.

Reporting Non-Serious Adverse Events.

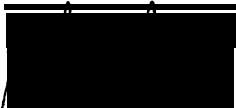
For non-serious adverse events you will need to inform Ms Helen Dougal, Ethics Committee Administrator (h.dougal@ucl.ac.uk), within ten days of an adverse incident occurring and provide a full written report that should include any amendments to the participant information sheet and study protocol. The Chair or Vice-Chair of the Ethics Committee will confirm that the incident is non-serious and report to the Committee at the next meeting. The final view of the Committee will be communicated to you.

Reporting Serious Adverse Events

The Ethics Committee should be notified of all serious adverse events via the Ethics Committee Administrator immediately the incident occurs. Where the adverse incident is unexpected and serious, the Chair or Vice-Chair will decide whether the study should be terminated pending the opinion of an independent expert. The adverse event will be considered at the next Committee meeting and a decision will be made on the need to change the information leaflet and/or study protocol.

On completion of the research you must submit a brief report (a maximum of two sides of A4) of your findings/concluding comments to the Committee.

Yours sincerely



Sir John Birch
Chair of the UCL Research Ethics Committee

Appendix B

Example Forms

Information Sheet for Participants in Research Studies

You will be given a copy of this information sheet.

Title of Project: Attitudes towards people with learning disabilities: A cross-cultural study

This study has been approved by the UCL Research Ethics Committee [Project ID Number]: 1099/001

Name, Address and Contact Details of Investigators: **Sarah Coles and Katrina Scior**
Sub-dept of Clinical Health Psychology, University College London, Gower Street, London, W1
Tel: [REDACTED]
Email: sarahjane_coles@hotmail.com
k.scior@ucl.ac.uk

We would like to invite you to participate in this research project. You should only participate if you want to; choosing not to take part will not disadvantage you in any way. Before you decide whether you want to take part, it is important for you to read the following information carefully and discuss it with others if you wish and feel free to contact us if there is anything that is not clear or you would like more information.

The aim of this research is to explore how young people from White British and South Asian backgrounds differ in their attitudes and beliefs about people with learning disabilities and the causation of learning disabilities. The focus is on considering how people reach their individual beliefs and what may have influenced these attitudes. There are no 'right' or 'wrong' beliefs or views, but we are very much interested in how people arrive at the views they hold.

The research will take place in the form of focus groups. These are groups with approximately six people. A range of questions and case studies will be presented to the group and discussion on the topics will ensue. The groups will last for approximately one hour. Following the focus groups you may be invited to take part in an individual interview to further explore your ideas. Obviously, this further involvement is at your discretion and you are free to choose not to take part if you so wish. If you are interested in taking part, you will be asked to provide your contact details at the end of the focus group. The interviews will also last approximately one hour.

There are no foreseeable risks or discomforts in taking part in this research, however, you are asked only to offer that which you are happy to share with others about your views. The benefits of taking part in the research are that you will hopefully enjoy a lively discussion with your peers and you will also be providing valuable insights into understanding of learning disabilities. You will be paid £6 for taking part in the focus group to thank you for giving up your time.

It is up to you to decide whether or not to take part. If you choose not to participate it will involve no penalty or loss of benefits to which you are otherwise entitled. If you decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

All data will be collected and stored in accordance with the Data Protection Act 1998.

Informed Consent Form for Participants in Research Studies

(This form is to be completed independently by the participant after reading the Information Sheet and/or having listened to an explanation about the research.)

Title of Project: Attitudes towards people with learning disabilities: A cross-cultural study.

This study has been approved by the UCL Research Ethics Committee [Project ID Number]: 1099/001

Participant's Statement

I
agree that I have

- read the information sheet and/or the project has been explained to me orally;
- had the opportunity to ask questions and discuss the study;
- received satisfactory answers to all my questions or have been advised of an individual to contact for answers to pertinent questions about the research and my rights as a participant and whom to contact in the event of a research-related injury.

I understand that my participation will be taped and I am aware of and consent to, any use you intend to make of the recordings after the end of the project.

I understand that I am being paid for my assistance in this research and that some of my personal details will be passed to UCL Finance for administration purposes.

I understand that I am free to withdraw from the study without penalty if I so wish and I consent to the processing of my personal information for the purposes of this study only and that it will not be used for any other purpose. I understand that such information will be treated as strictly confidential and handled in accordance with the provisions of the Data Protection Act 1998.

Signed:

Date:

Investigator's Statement

I Sarah Coles confirm that I have carefully explained the purpose of the study to the participant and outlined any reasonably foreseeable risks or benefits (where applicable).

Signed:

Date:

Appendix C

Stimuli

C1 Image & Vignette of 'Simon' (Mild ID)



This is Simon; he has a mild learning disability. This means he has difficulty learning new things, struggles to know what is expected of him and often doesn't live up to other people's expectations. Throughout his schooling he has needed some help to keep up. He still needs help from his parents to manage his money and do more difficult things, like filling in job applications.

C2 Image & Vignette of 'Tom' (Moderate ID)



This is Tom; he has a moderate learning disability. Tom has attended a special school throughout his childhood. Tom has many friends but in order to travel beyond his local neighbourhood to meet them or go for evening out, he needs help from others to find his way around public transport. Tom has always found it difficult to learn more difficult things. He currently studies 'life skills' at his local college, but doesn't have any GCSEs, and has few plans for his future.

Appendix D

Questionnaires

D1 Demographic Information

DEMOGRAPHICS

Date..... Age..... Male / Female

Country of birth:.....

Age of entry to UK: (if born elsewhere).....

Generation (please tick *one*)

1st generation 2nd generation 3rd generation

Parents' country of birth:.....

Ethnicity: (please tick *one*)

White British Indian / British Indian

Pakistani / British Pakistani Bangladeshi / British Bangladeshi

Other Asian, please specify _____

Religion: _____

Importance of religious beliefs: (please tick *one*)

Not at all religious Somewhat religious Very religious

Qualifications attained

GCSEs NVQ GNVQ BTEC

AS levels A levels University degree

Other, please specify _____

Do you know someone with a learning disability? (please circle one)

Yes / No

If yes, how do you know them?* (please circle one)

Relative / Friend / Acquaintance

Attitudinal Survey

Community Living Attitudes Scale

Indicate the extent to which you agree with the following statements according to this scale:

- | | |
|-------------------------|----------------------|
| 1 = Disagree strongly | 4 = Agree somewhat |
| 2 = Disagree moderately | 5 = Agree moderately |
| 3 = Disagree somewhat | 6 = Agree strongly |

Please note: people with learning disabilities are sometimes known as 'mentally handicapped'.

- | | | | | | | |
|--|---|---|---|---|---|---|
| 1. People who have learning disabilities are happier when they live and work with others like them. | 1 | 2 | 3 | 4 | 5 | 6 |
| 2. People who have learning disabilities trying to help each other is like "the blind leading the blind". | 1 | 2 | 3 | 4 | 5 | 6 |
| 3. People who have learning disabilities should not be allowed to marry and have children. | 1 | 2 | 3 | 4 | 5 | 6 |
| 4. A person would be foolish to marry a person who has learning disabilities. | 1 | 2 | 3 | 4 | 5 | 6 |
| 5. People who have learning disabilities should be guaranteed the same rights in society as other persons. | 1 | 2 | 3 | 4 | 5 | 6 |
| 6. People who have learning disabilities do not want to work. | 1 | 2 | 3 | 4 | 5 | 6 |
| 7. People who have learning disabilities need someone to plan their activities for them. | 1 | 2 | 3 | 4 | 5 | 6 |
| 8. People who have learning disabilities should not hold positions in the government. | 1 | 2 | 3 | 4 | 5 | 6 |
| 9. People who have learning disabilities should not be given any responsibility. | 1 | 2 | 3 | 4 | 5 | 6 |
| 10. People who have learning disabilities can organize and think for themselves. | 1 | 2 | 3 | 4 | 5 | 6 |

1 = Disagree strongly	4 = Agree somewhat
2 = Disagree moderately	5 = Agree moderately
3 = Disagree somewhat	6 = Agree strongly

- | | | | | | | |
|---|---|---|---|---|---|---|
| 11. People who have learning disabilities do not care about advancement in their jobs. | 1 | 2 | 3 | 4 | 5 | 6 |
| 12. People who have learning disabilities do not need to make choices about the things they will do each day. | 1 | 2 | 3 | 4 | 5 | 6 |
| 13. People who have learning disabilities should not be allowed to drive. | 1 | 2 | 3 | 4 | 5 | 6 |
| 14. People who have learning disabilities can be productive members of society. | 1 | 2 | 3 | 4 | 5 | 6 |
| 15. People who have learning disabilities have goals for their lives like other people. | 1 | 2 | 3 | 4 | 5 | 6 |
| 16. I would trust a person who has learning disabilities to be a babysitter. | 1 | 2 | 3 | 4 | 5 | 6 |
| 17. People who have learning disabilities cannot exercise control over their lives like other people. | 1 | 2 | 3 | 4 | 5 | 6 |
| 18. People who have learning disabilities can have close personal relationships just like everyone else. | 1 | 2 | 3 | 4 | 5 | 6 |
| 19. I would not want to live next door to people who have learning disabilities. | 1 | 2 | 3 | 4 | 5 | 6 |
| 20. People who have learning disabilities are usually too limited to be sensitive to the needs and feelings of others. | 1 | 2 | 3 | 4 | 5 | 6 |
| 21. People who have learning disabilities should live in sheltered facilities because of the dangers of life in the community. | 1 | 2 | 3 | 4 | 5 | 6 |
| 22. People who have learning disabilities should be encouraged to lobby legislators on their own (i.e. to try and influence legislation) | 1 | 2 | 3 | 4 | 5 | 6 |
| 23. People who have learning disabilities are the best people to give advice to others who wish to move into community living. | 1 | 2 | 3 | 4 | 5 | 6 |
| 24. The opinion of a person who has learning disabilities should carry more weight than those of family members and professionals in decisions affecting that person. | 1 | 2 | 3 | 4 | 5 | 6 |
| 25. People who have learning disabilities can plan meetings and conferences without assistance from others. | 1 | 2 | 3 | 4 | 5 | 6 |
| 26. People who have learning disabilities can be trusted to handle money responsibly. | 1 | 2 | 3 | 4 | 5 | 6 |
| 27. Residents have nothing to fear from people who have learning disabilities living and working in their neighborhoods. | 1 | 2 | 3 | 4 | 5 | 6 |
| | 1 | 2 | 3 | 4 | 5 | 6 |

1 = Disagree strongly	4 = Agree somewhat
2 = Disagree moderately	5 = Agree moderately
3 = Disagree somewhat	6 = Agree strongly

- | | | | | | | |
|---|---|---|---|---|---|---|
| 28. People who have learning disabilities usually should be in group homes or other facilities where they can have the help and support of staff. | 1 | 2 | 3 | 4 | 5 | 6 |
| 29. Sheltered workshops for people who have learning disabilities are essential. | 1 | 2 | 3 | 4 | 5 | 6 |
| 30. The best care for people who have learning disabilities is to be part of normal life in the community. | 1 | 2 | 3 | 4 | 5 | 6 |
| 31. Most people who have learning disabilities prefer to work in a sheltered setting that is more sensitive to their needs. | 1 | 2 | 3 | 4 | 5 | 6 |
| 32. Without some control and supervision, people who have learning disabilities could get in real trouble out in the community. | 1 | 2 | 3 | 4 | 5 | 6 |
| 33. The rights of people who have learning disabilities are more important than professional concerns about their problems. | 1 | 2 | 3 | 4 | 5 | 6 |
| 34. Services for people who have learning disabilities should have them on their boards. | 1 | 2 | 3 | 4 | 5 | 6 |
| 35. The best way to handle people who have learning disabilities is to keep them in institutions. | 1 | 2 | 3 | 4 | 5 | 6 |
| 36. Homes and services for people who have learning disabilities should be kept out of residential neighborhoods. | 1 | 2 | 3 | 4 | 5 | 6 |
| 37. Increased spending on programs for people who have learning disabilities is a waste of money. | 1 | 2 | 3 | 4 | 5 | 6 |
| 38. Homes and services for people who have learning disabilities downgrade the neighbourhoods they are in. | 1 | 2 | 3 | 4 | 5 | 6 |
| 39. Professionals should not make decisions for people who have learning disabilities unless absolutely necessary. | 1 | 2 | 3 | 4 | 5 | 6 |
| 40. People who have learning disabilities are a burden on society | 1 | 2 | 3 | 4 | 5 | 6 |

D3 Focus Group Interview Schedule

Guide for facilitation of Focus Groups

Outline and Purpose of Study

Signing of consent Forms

1) Context and icebreaker:

What is meant by the term learning disability?
What else do people call people with learning disabilities?
In your college are there young people with LD?
Were there any at your previous school?
Do you know anyone with an LD?

2) Causes:

What do you think causes a learning disability?
Where do your ideas come from?

Do your parents have similar ideas to you?
Do your friends have similar ideas to you?
Do you know anyone who thinks differently to you?
Do you think your age affects what you think?
Do you think your religion influences your thoughts?
Do you think your culture influences your thoughts?
Can you tell me anything more about this?

3) Clinical Vignettes:

Now I'd like to tell you about some people I have met that have learning disabilities. (Pictures will be provided of the person and they will be a similar age to the participants in the study).

Present picture of person with mild LD. This is Simon; he has a mild learning disability. This means he has difficulty learning new things, struggles to know what is expected of him and often doesn't live up to other people's expectations. Throughout his schooling he has needed some help to keep up. He still needs help from his parents to manage his money and do more difficult things, like filling in job applications.

Present picture of person with Down's syndrome (similar age to previous picture). This is Tom; he has a moderate learning disability. Tom has attended a special school throughout his childhood. Tom has many friends but in order to travel beyond his local neighbourhood to meet them or go for evening out, he needs help from others to find his way around public transport. Tom has always found it difficult to learn more difficult things. He currently studies 'life skills' at his local college, but doesn't have any GCSEs, and has few plans for his future.

4) Empowerment:

Simon and Tom have been keen to leave home for a while. A meeting was held and a number of different options were discussed (for example the person staying at home, living with others with LD or living on their own). Whose opinion at the meeting should carry more weight; the professionals, the family members or the person with the LD?

What is your view on this?

Why is that your answer?

Who should help them?

Why do you think that?

How have you arrived at these ideas?

Hold up photos – thinking back to Simon and Tom, would you say the same for both of them?

Does anyone you know think the same?

Are you aware of anyone who thinks differently?

It sounds like people hold different ideas, why do you think this?

Have you read or heard anything about people with disabilities/LD. that has influenced your views?

Do you think your age affects what you think?

Do you think knowing someone with an LD may affect your thoughts?

Do you think your religion influences your thoughts?

Do you think your culture influences your thoughts?

Can you tell me anything more about this?

Say Simon/Tom moved out of home, should they get help handling their money?

What is your view on this?

Why is that your answer?

Who should help them?

Why do you think that?

How have you arrived at these ideas?

Hold up photos – thinking back to Simon and Tom, would you say the same for both of them?

Does anyone you know think the same?

Are you aware of anyone who thinks differently?

It sounds like people hold different ideas, why do you think this?

Have you read or heard anything about people with disabilities/LD. that has influenced your views?

Do you think your age affects what you think?

Do you think knowing someone with an LD may affect your thoughts?

Do you think your religion influences your thoughts?

Do you think your culture influences your thoughts?

Can you tell me anything more about this?

5) Exclusion:

Some people might suggest that people with learning disabilities are better off if they are included in the community as part of 'normal' life whereas other people think those with LD are better off in separate homes for PWLD and doing activities separate from community life.

What is your view on this?

Why is that your answer?

Who should help them?

Why do you think that?

How have you arrived at these ideas?

Hold up photos – thinking back to Simon and Tom, would you say the same for both of them?

Does anyone you know think the same?

Are you aware of anyone who thinks differently?

It sounds like people hold different ideas, why do you think this?

Have you read or heard anything about people with disabilities/LD. that has influenced your views?

Do you think your age affects what you think?

Do you think knowing someone with an LD may affect your thoughts?

Do you think your religion influences your thoughts?

Do you think your culture influences your thoughts?

Can you tell me anything more about this?

6) Sheltering:

Some people might say that PWLD need control and supervision otherwise they might get into trouble in the community whereas other people think they should have their own control in life

What is your view on this?

Why is that your answer?

What is control and supervision?

Who should help them?

Why do you think that?

How have you arrived at these ideas?

Hold up photos – thinking back to Simon and Tom, would you say the same for both of them?

Does anyone you know think the same?

Are you aware of anyone who thinks differently?

It sounds like people hold different ideas, why do you think this?

Have you read or heard anything about people with disabilities/LD. that has influenced your views?

Do you think your age affects what you think?

Do you think knowing someone with an LD may affect your thoughts?

Do you think your religion influences your thoughts?

Do you think your culture influences your thoughts?

Can you tell me anything more about this?

7) Similarity:

Some people think that PWLD can have girlfriends/boyfriends and get married whereas others think that this not appropriate

What is your view on this?

Why is that your answer?

Who should help them?

Why do you think that?

How have you arrived at these ideas?

Hold up photos – thinking back to Simon and Tom, would you say the same for both of them?

Does anyone you know think the same?

Are you aware of anyone who thinks differently?

It sounds like people hold different ideas, why do you think this?

Have you read or heard anything about people with disabilities/LD. that has influenced your views?

Do you think your age affects what you think?

Do you think knowing someone with an LD may affect your thoughts?

Do you think your religion influences your thoughts?

Do you think your culture influences your thoughts?

Can you tell me anything more about this?

Some people think that PWLD can be productive members of society and hold down jobs whereas others think that those with LD don't want to work or that it's not right for them to get jobs, or that they might not care about working and doing well.

What is your view on this?

Why is that your answer?

Who should help them?

Why do you think that?

How have you arrived at these ideas?

Hold up photos – thinking back to Simon and Tom, would you say the same for both of them?

Does anyone you know think the same?

Are you aware of anyone who thinks differently?

It sounds like people hold different ideas, why do you think this?

Have you read or heard anything about people with disabilities/LD. that has influenced your views?

Do you think your age affects what you think?

Do you think knowing someone with an LD may affect your thoughts?

Do you think your religion influences your thoughts?

Do you think your culture influences your thoughts?

Can you tell me anything more about this?

8) Debrief:

Any questions

Thanks to the group for participating.

D4 Individual Interview Schedule

Guide for Individual interviews

Outline and Purpose of Study Signing of consent Forms

1) Context and icebreaker:

Reminder of survey at UCL open day

Consent Form

Audio-recording?

People use many different terms to refer to this group of people, e.g. learning disability, mental handicap or learning difficulty.

What terminology do you and others around you mostly use?

In your college are there are young people with LD?

Were there any at your previous school?

Do you know anyone with a LD?

(If yes:) Do you think knowing someone directly has influenced your views?

How?

2) Causes:

What do you think causes a learning disability?

Where do your ideas come from?

Media: Have you read or heard anything about people with disabilities/ LD. that has influenced your views?

Do your parents have similar ideas to you?

Do your friends have similar ideas to you?

Do you know anyone who thinks differently to you?

Do you think your age affects what you think?

Culture:

To help with the next question, could you tell me a little about your cultural background, i.e. where your parents are from? If appropriate, when did they come to the UK?

Does your culture say anything about what causes disability?

Same for LD.?

How does your culture view or treat people with disabilities?

What about people with LD.?

Do you agree with these ideas from your culture?

Religion: What about religion: are you/your family religious?

(prompts: strengths of religious beliefs and practices)

Does your religion say anything about what causes disability?

Same for L.D.?

How does your religion (insert name) view or treat people with disabilities?

What about people with L.D.?

Do you agree with these ideas from your religion?

3) Clinical Vignettes:

Now I'd like to tell you about some people I have met that have learning disabilities.

Present picture of person with mild LD. This is Simon; he has a mild learning disability. This means he has difficulty learning new things, struggles to know what is expected of him and often doesn't live up to other people's expectations. Throughout his schooling he has needed some help to keep up. He still needs help from his parents to manage his money and do more difficult things, like filling in job applications.

Present picture of person with Down's syndrome (similar age to previous picture). This is Tom; he has a more severe learning disability. Tom has attended a special school throughout his childhood. Tom has many friends but in order to travel beyond his local neighbourhood to meet them or go for evening out, he needs help from others to find his way around public transport. Tom has always found it difficult to learn more difficult things. He currently studies 'life skills' at his local college, but doesn't have any GCSEs, and has few plans for his future.

4) Empowerment:

Simon and Tom have been keen to leave home for a while. A meeting was held and a number of different options were discussed (for example them staying at home, living with others with LD or living on their own). Whose opinion at the meeting should carry more weight; the professionals, the family members or Simon's or Tom's?

What is your view on this?

Do you have any ideas what influenced your thinking?

How have you arrived at these ideas?

Hold up photos – thinking back to Simon and Tom, would you say the same for both of them?

Do other people around you think the same?

Are you aware of anyone who thinks differently?

Have you read or heard anything about people with disabilities/LD that has influenced your views?

Do you think your age affects what you think?

Do you think knowing someone with a disability might affect your thoughts?

Do you think your religion influences your thoughts?

Do you think your culture influences your thoughts?

Can you tell me any more about this?

Say Simon or Tom moved out of home, should they get help handling their money?

What is your view on this?

Do you have any ideas what influenced your thinking?

How have you arrived at these ideas?

Hold up photos – thinking back to Simon and Tom, would you say the same for both of them?

Do other people around you think the same?

Are you aware of anyone who thinks differently?

Have you read or heard anything about people with disabilities/LD that has influenced your views?

Do you think your age affects what you think?

Do you think knowing someone with a disability might affect your thoughts?

Do you think your religion influences your thoughts?

Do you think your culture influences your thoughts?

Can you tell me any more about this?

5) Exclusion:

Some people might suggest that people with learning disabilities are better off if they are included in the community as part of 'normal' life whereas other people think those with LD are better off in separate homes for PWLD and doing activities separate from community life.

What is your view on this?

Do you have any ideas what influenced your thinking?

How have you arrived at these ideas?

Hold up photos – thinking back to Simon and Tom, would you say the same for both of them?

Do other people around you think the same?

Are you aware of anyone who thinks differently?

Have you read or heard anything about people with disabilities/LD that has influenced your views?

Do you think your age affects what you think?

Do you think knowing someone with a disability might affect your thoughts?

Do you think your religion influences your thoughts?

Do you think your culture influences your thoughts?

Can you tell me any more about this?

6) Sheltering:

Some people might say that PWLD need control and supervision otherwise they might get into trouble in the community whereas other people think they should have their own control in life.

What is your view on this?

Do you have any ideas what influenced your thinking?

How have you arrived at these ideas?

Hold up photos – thinking back to Simon and Tom, would you say the same for both of them?

Do other people around you think the same?

Are you aware of anyone who thinks differently?

Have you read or heard anything about people with disabilities/LD that has influenced your views?

Do you think your age affects what you think?

Do you think knowing someone with a disability might affect your thoughts?

Do you think your religion influences your thoughts?

Do you think your culture influences your thoughts?

Can you tell me any more about this?

7) Similarity:

Some people think that PWLD can have girlfriends/boyfriends and get married whereas others think that this not appropriate.

What do you think about this?

Do you have any ideas what influences your views?

Hold up photos – thinking back to Simon and Tom, would you say the same for both of them?

Do other people around you think the same?

Are you aware of anyone who thinks differently?

Have you read or heard anything about people with disabilities/ L.D. that has influenced your views?

Do you think your age affects what you think?

***Do you think knowing someone with a disability may affect your thoughts?

Do you think your religion influences your thoughts?

Do you think your culture influences your thoughts?

Can you tell me anything more about this?

Some people think that PWLD can be productive members of society and hold down jobs whereas others think that those with LD don't want to work or that it's not right for them to get jobs, or that they might not care about working and doing well.

What is your view on this?

Do you have any ideas what influenced your thinking?

How have you arrived at these ideas?

Hold up photos – thinking back to Simon and Tom, would you say the same for both of them?

Do other people around you think the same?

Are you aware of anyone who thinks differently?

Have you read or heard anything about people with disabilities/LD that has influenced your views?

Do you think your age affects what you think?

Do you think knowing someone with a disability might affect your thoughts?

Do you think your religion influences your thoughts?

Do you think your culture influences your thoughts?

Can you tell me any more about this?

8) Debrief:

Any questions

Thank you for participating.

Appendix E
Examples of Thematic Analysis

E1 Initial table of codes

	Code	References
1	Confusion of the concept of LD	<p>WB11: 1: 11-14; 2: 1-4; 2: 21-28; 3: 2-3 WB12: 1: 23-24; 2: 6-16; 3: 2-7; 5: 7-9; 6: 11-12; 6: 14-19 WB13: 1: 13-17; 4: 5-11 WB14: 1: 6-15; 1: 29-33 SAI1: 2: 16-22; 4: 26-29 SAI2: 2: 5-14; 4: 11-29; 5: 4-6 SAFG1: 1: 4-24; 2: 4-7; 2: 15-20; 2: 24; 3: 1-3; 3: 12-17; 5: 18-20; 14: 12-20; 16: 18-20 SAFG2: 1: 3-6; 1: 14-24;; 2: 36; 4: 1-6; SAFG3: 1: 3; 1: 12-18; 1: 26-28; 2: 7-11; 3: 4-5; 3: 32-33; 14: 24-26; 15: 5-14 SAFG4: 1: 13-27; 10: 19-27; 11: 18-30; 15: 7-13 WBFG1: 1: 3-9; 10: 14-17; 10: 31-33; 2: 24-26 WBFG2: 3: 5-6; 9: 1-3; 16: 17-18 WBFG3: 1: 16-18; 1: 22; 2: 11-22; 3: 5-14; 3-4: 30-14; 4: 18-29 WBFG4: 1: 2-9; 2: 15; 7-8: 33-15; 8: 23-25; 10: 17 WBFG5: 1: 25-28</p>
2	<p>"It's their choice"</p> <p>"It's their life"</p> <p>Human rights</p>	<p>WB11: 2: 1-4; 2: 12-13; 7: 11-15; 7: 17-18; 8: 3-8; 10: 27; 11: 20-25; 13: 1-4; 15: 13-19 WB12: 8: 9-12; 9: 15-18; 11: 9-11; 12: 21-23; 13: 12-18; 14: 6-10 WB13: 5: 30-34; 5: 36; 7: 13-22; 8: 21-24; 9: 16-21; 10: 29-35; 11: 2-6; 11: 12-17; 12: 19-22; 13: 4-6; 13: 30-34; 14: 8-11; 15: 5 WB14: 5: 3; 5: 5-10; 9: 14-20; 10: 15-21; 11: 21-23 SAI1: 7: 2-3; 7: 5-11; 7: 23; 7: 25; 9: 2-5; 17: 1-4; 3: 25-35 SAI4: 3: 22-28; 3: 30-35 SAFG1: 7: 4-15; 7: 36-40; 8: 10-21; 11: 1-7 SAFG2: 16: 17-21 SAFG3: 6: 9-10; 11: 1-8 SAFG4: 6: 27-29 WBFG1: 6: 7-16; 6: 17-22; 6: 24-26; 6: 29-31; 6: 32-34; 6-7: 37-6; 9: 20-22; 9: 34-36; 10: 1-3; 11: 19-22; 13: 10-11; 14: 16-34; 14-15: 37-3; 16: 27-31 WBFG2: 6: 25-26; 6: 32-35; 6-7: 36-2; 7: 3-4; 7: 17; 8: 29-34; 8: 29-34; 9: 22; 10: 31-34; 12: 1-2; 15: 9-12; 15: 20-25; 18: 9-16; 19: 3-6 WBFG3: 11: 4-10; 13: 15-17; 13: 26-2; 15: 16-17; 16: 2; 18: 7-15 WBFG4: 4: 21-23; 4: 32-34; 5: 1-3; 5: 14-15 WBFG5: 5: 26-31; 5: 33-35; 8: 34; 12: 24-31; 13: 1-5; 13: 9-12; 15: 3</p>
3	"Can't trust service providers"	<p>WB12: 9: 20-24; 9: 27-32 WB13: 7: 29-34 SA4: 4-5: 33-2 SAFG1: 12: 17-28 SAFG3: 9: 21 SAFG4: 6-7: 38-2 WBFG1: 6: 2-6; 12: 1-2; WBFG3: 13: 10-14; 14: 8; 16: 21-25 WBFG4: 4: 26 WBFG5: 6: 1-2</p>
4	Professionals know best	<p>WB11: 7: 4-9; 7: 11-15; 7: 27-34 WB12: 8: 9-12 WB13: 5: 30-34; 6: 6-10 WB14: 5: 19-22 SAI2: 7: 15-20; 7: 22-24; 8: 3-10; 8: 25-31; 14: 2-4 SAI3: 3: 25-35; 7: 8-16 SAI4: 3: 22-28; 3-4: 38-2</p>

		SAFG1: 6: 36-41; 7: 16-21; 8: 22-27; 11: 18-20 WFBG 1: 6: 17-22 WFBG2: 6: 27; 6-7: 36-2 WFBG3: 12: 3-4 WFBG4: 4: 24-25; 4: 27-28 WFBG5: 5: 37-40; 6: 1-5; 6: 23-28; 6: 31-32
5	The family know best	WBI3: 5: 30-34; 5: 38-39 WBI4: 5: 3; 5: 5-10 SAI2: 7: 30-32; 8: 16-24; 13: 10-15 SAFG1: 7: 26-29; 8: 3-7; 12: 3-8; 12: 17-28; SAFG3: 6: 14-20; 13: 1-17; 13: 14-17; 13: 24-29 WFBG1: 6: 2-6; 6: 17-22 WFBG2: 6: 25-26; 6-7: 36-2 WFBG4: 4: 29-31 WFBG5: 5: 32-36; 8: 4-5
6	"Everyone is different/everyone is an individual"	WBI1: 10: 12-24; WBI2: 11: 9-11 WBI3: 5: 30-34; 7: 29-34; 11: 28-31 SAI2: 11: 6-8 SAI4: 4: 25-31; 11: 1-4 SAFG1: 14: 4-11; 15: 1-6 WFBG1: 8: 23-36; 11: 12-17 WFBG2: 7: 6-7; 10: 27-30 WFBG3: 14: 13-14 WFBG4: 5: 1-3; 8: 26-30 WFBG5: 9: 13-16
7	Invisible in the media	WBI1: 9: 29-30; 11: 5-6 WBI2: 11: 31-32; 14: 30-31 WBI3: 2: 27-30 WBI4: 8: 24 SAI1: 2: 9-18; 7: 38-40; 11: 8-13; 17: 20-21 SAI2: 12: 1-3 SAI3: 5: 11-13; 6: 10-12; 7: 17-18 SAI4: 6: 12-21; 8: 26-27 SAFG2: 15: 19-24 WFBG1: 8: 19-20; 13: 33-35; 13: 33-35; 15: 6-7 WFBG2: 17: 1-9; 17: 20-22 WFBG3: 13: 10-14; 14: 26-27 WFBG5: 7: 15-17
8	Visible in the media	WBI1: 3: 17-24; 8: 3-8; 12: 4-5; 13: 19-22 WBI2: 9: 27-32 WBI3: 6: 15-24; 7: 9-12; 9: 25-32; 13: 12-15; 14: 12-14; 14: 27-31 WBI4: 5-6: 29-5; 7: 13-19; 10: 26-28; 12: 4-9; SAI1: 14: 30-45 SAI2: 2: 16-21; 3: 1-6; 8:3; 10: 5-9; 15: 30-33 SAI4: 5: 7-13; 7: 24-30; 11: 14-21 SAFG1: 5: 25-37; 9: 5-21; 17: 18-25; 17-18: 35-7 SAFG2: 2: 26; 8: 2-11 SAFG3: 4: 8-12 SAFG4: 7: 10-14; 7: 20-24; 12-13: 31-8 WFBG1: 4: 4-7; 8: 1-8; 8: 13-18; 9: 24-29; 10: 11-13; 12: 11-13; 12: 6-24; 17: 1-10 WFBG2: 10: 1-2; 10: 6-10; 10: 12-15; ?25-38; 17: 10-17 WFBG3: 7: 33; 8: 1-7; 14-15: 28-4 WFBG4: 5: 29-31; 11: 6-13; 13:3; 13: 15-21 WFBG5: 6: 6-10; 7-8: 18-5; 10: 27-33; 13-14: 25-3
9	Support in place to help/ the role of services	WBI1: 9: 3-5; 9: 13-18 WBI3: 11: 12-17; 12:23-26 WBI4: 6: 30 SAI1: 12: 25-26 SAI3: 5: 2-4; 7: 8-16 SAFG2: 10: 8-11; 13: 7-8 SAFG3: 6: 23-25; 11: 3-4 WFBG2: 9: 19 WFBG3: 16: 6-17

		WBFG4: 7: 1-2 WBFG5: 11: 37
10	The family should support the person	WBI3: 7: 29-34; 11: 33 SAI2: 9: 12-14; 10:14-26; 11: 16-19; 12: 18-19; 13: 10-15 SAI3: 5: 2-4; 7: 8-16 SAFG1: 7: 36-40; 8: 3-7; 12: 3-8; 12: 17-28 SAFG2: 6: 22-23; 6: 26-29; 10: 4-7; 10: 14-23; 13: 14-20 SAFG3: 9: 7-13; 9: 16-18; 10: 1-13; 11: 3-4; 13: 24-29 SAFG4: 6: 30-37 WBFG1: 9: 12-17; 14: 32-34 WBFG2: 9: 19; 9: 24-27; 18-19: 32-3 WBFG3: 11: 22-28; 14: 5-7 WBFG4: 7: 1-2; 10: 19-21; 3: 22-28; 4-5: 33-2
11	Professionals as a last resort	WBI1: 8: 23-18; 9: 20-25 WBI3: 11: 33
12	Political correctness	WBI1: 1: 20 WBI4: 3: 30-33 WBFG1: 3: 28-34 WBFG2: 3: 28-30; 4: 11-13 WBFG4: 13: 15-21
13	Biological model of understanding	WBI1: 2-3: 26-16 WBI2: 4: 2-3; 4: 8-12 WBI3: 2: 2-6 WBI4: 2: 3-8 SAI1: 2: 1-8; 3: 36; 4: 35-37 SAI2: 2: 7-14 SAI3: 1: 4; 1: 19-24 SAI4: 1: 22-24; 9: 29-34 SAFG1: 2: 28-32; 3: 4-5; 3: 19-20 SAFG2: 2: 12-25; 14: 30-33 SAFG3: 1: 19-20; 1: 29-32; 8: 18-20 SAFG4: 1: 9-12; 3: 10-22 WBFG1: 2: 30-32; 2-3: 33-2; 3: 5; 5: 15-16 WBFG2: 2: 23 WBFG3 3: 11-17; 4-5: 38-27; 6:7-22 WBFG4: 2-3: 23-2 WBFG5: 3: 10-14; 4: 8-14
14	"We haven't talked about it"	WBI1: 3-4: 25-1 WBI3: 2: 2-6; 10: 4-8 SAI1: 3: 12-15 SAI2: 3: 12-15 SAI3: 2: 6-13 SA4: 7: 19-22; 11: 5-8 SAFG3: 4: 16-17 SAFG4: 9: 13-15 WBFG1: 7: 10-12
15	Awareness of prejudice	WBI1: 4: 3-7; 10-11: 34-1; 13: 14-17 WBI2: 3: 28; 11: 24-26; 12: 22-24 WBI3: 3: 34-35; 7: 13; 8-9: 31-8; 10: 13-18; 10: 20-27; 13: 30-34 WBI4: 9: 24-27; 10: 1-3; 10: 27-30; 11: 27-30 SAI1: 10: 29-44 SAI2: 3: 1-6; 11: 28-31; 14: 6-8; 14: 13-14 SAI3: 8: 9-12 SAI4: 1: 9-12; 5: 34-36; 6: 1-10; 7: 24-30 SAFG1: 11: 13-16 SAFG2: 11: 16-21; 11: 24-25; 16: 8-13 SAFG3: 13: 1-17; 14: 5-10; 14: 24-30 SAFG4: 10: 3-6; 10: 10-14; 12: 6-7 WBFG1: 2-3: 33-2; 3: 15-18; 15: 25-33 WBFG2: 2: 8-11; 4: 18-21; 4: 24-33; 5: 1-3; 5: 6-9; 8: 3-9; 12: 14-16; 12: 28-36; 13: 4-9; 16: 5-16; 18: 19-22; 20: 23-24; 20: 32-34; 21: 1-3; 21: 17-20 WBFG3: 1: 25-29; 8-9: 31-21; 13: 26-2; 14: 24-25;

		<p>WBFG4: 7: 4-7; 10: 19-21; 10-11: 28-2; 11: 20-25; 12: 25-26</p> <p>WBFG5: 2: 2-3; 3: 23-30; 7: 6-9; 10: 12-23; 13: 20-24; 15: 11-16</p>
16	<p>Person's ability/ depends on the level of ability</p>	<p>WBII: 8: 13-15; 10: 12-24; 14: 8-11</p> <p>WBII2: 8: 9-12; 8: 14-17; 9: 15-18; 11: 9-11; 11: 21-22; 12: 27-31; 13: 12-18; 14: 14-20</p> <p>WBII3: 15: 8-10</p> <p>WBII4: 5: 11-18; 7: 4-10; 8: 17-18; 9: 10-13</p> <p>SAII: 8: 37-43; 12: 37-38; 18: 5-18</p> <p>SAII2: 7: 22-24; 9: 7-8; 9: 16-21; 15: 25-28; 16: 9-14</p> <p>SAII3: 4: 22-29</p> <p>SAII4: 11: 1-4</p> <p>SAFGI: 7: 4-15; 7: 16-21; 8: 10-21; 11: 1-7; 11-12: 34-2; 14: 4-11; 15: 1-6; 15: 19; 15-16: 28-2; 16: 21-27; 18: 18-24; 19: 6-9</p> <p>SAFG2: 6: 31-35; 7: 1-5; 7: 8-12; 9: 13-15; 13: 1-3; 16: 1-5; 16: 22-31; 17: 1-11</p> <p>SAFG3: 6: 11-13; 7: 1-3; 13-14: 34-3; 14: 5-10; 14: 21-23; 14: 24-30</p> <p>SAFG4: 7: 7; 8: 1-14; 9: 5</p> <p>WBFGI: 6: 7-16; 9: 12-17; 11: 12-17; 12-13: 37-4</p> <p>WBFG2: 6: 22-24; 6: 32-35; 7: 18-20; 7: 23-24; 8: 29-34; 15: 6-12; 18: 17-19; 19: 34-36; 20: 1-3; 20: 20-22; 6: 22-24; 6: 32-35; 7: 18-20; 7: 23-24; 8: 29-34; 12: 8-13; 15: 6-12; 18: 17-19; 19: 34-36; 20: 1-3; 20: 20-22</p> <p>WBFG3: 13: 23-25; 13: 26-2; 16:1; 17: 15-36; 18: 22-23; 19: 33</p> <p>WBFG4: 4: 32-34; 5: 9-11; 8: 23-25; 8: 26-30; 9: 18-20; 10-11: 28-2; 12: 6-8; 12: 21</p> <p>WBFG5: 6: 23-28; 6: 31-32; 6-7: 35-2; 8: 24-32; 9: 1-7; 9: 13-16; 11: 30-32; 14: 11: 14: 31-34; 15: 4-7</p>
17	<p>Personal experience</p> <p>Knowing someone with ID</p> <p>Not just knowing someone but the impact on decision making</p>	<p>WBII: 14: 32-34</p> <p>WBII2: 10: 24; 10-11: 30-2; 13: 6-11; 14: 23-25; 14: 5-7</p> <p>WBII3: 2: 2-6</p> <p>WBII4: 2: 9-12; 6: 10-13; 7: 26-31</p> <p>SAII: 1: 37-43; 2: 34-42; 8: 1-4; 9: 37-43; 11: 14-24; 13: 19-27; 15: 15-20; 17: 24-28</p> <p>SAII2: 16-17: 27-2;</p> <p>SAII3: 6: 19-25; 9: 1-5</p> <p>SAII4: 1: 13-20; 2: 17-29; 7: 6-13; 8: 31-32; 10: 23-28; 10: 34-39</p> <p>SAFGI: 5: 25-37; 9-10: 34-2; 12: 12-13; 14: 31-38</p> <p>SAFG2: 4: 17-23; 10: 1-2; 18: 18-20</p> <p>SAFG3: 3-4: 32-3; 5: 13-19; 8: 14-17; 14: 21-23</p> <p>SAFG4: 7-8: 28-1; 14: 33-34</p> <p>WBFGI: 1-2: 22-28; 4: 4-7; 8: 13-18; 9: 1-8; 13: 14-28; 15: 19-23; 17: 27-31</p> <p>WBFG2: 2: 13-19; 3: 24-26; 10: 3-5; 11: 1-24; 16: 28-33; 19: 10-18; 19: 10-18; 19: 16-20; 21: 22-27</p> <p>WBFG3: 2: 3-6; 3: 16-23; 3-4: 30-14; 4: 31-34; 8: 16-23; 9: 9-10; 12: 15-34; 15: 19-22; 15: 27-30; 16: 26-34; 17: 4-8; 18: 30-39; 19: 7-20; 20: 5; 20: 18-23</p> <p>WBFG4: 2: 7-12; 6: 7-10; 7-8: 33-2; 9: 32-33</p> <p>WBFG5: 5: 1-4; 6: 23-28; 7: 15-17; 8: 15-18; 9: 13-16; 11: 1-11; 11: 13-16; 11: 18-23; 12: 4-9; 13: 7; 14: 20-30</p>
18	<p>Parents influence views</p> <p>Family influence views</p>	<p>WBII: 4: 5</p> <p>WBII3: 2: 33-35; 3: 29-31; 7: 24 9: 25-32; 12: 6; 13: 7-8; 14: 12-14; 14: 17</p> <p>WBII4: 2: 9-12</p> <p>SAII2: 3: 9-10</p> <p>SAFGI: 6: 8-11</p> <p>SAFG2: 15: 13-14</p> <p>SAFG3: 4-5: 30-3</p>

		SAFG4: 5: 3-6; 5: 7-22 WBF1: 3: 9-13; 3: 15-18; 6: 24-26; 7: 29-32 WBF2: 5: 28 WBF3: 13: 19; 20: 5-6; 20: 10-12 WBF4: 7: 4-7 WBF5: 6: 14-21; 11: 1-11
19	Generational differences	WBI2: 5: 16-20; 9: 2-6; 10-11: 30-2; 12: 2-3; 14-15: 33-2; 11: 2-6 SAI1: 4: 1-7 SAI4: 2: 5-11 SAFG1: 3-4: 26-5; 5: 7-10; 16: 5-11; 18: 30-36 SAFG2: 5: 6-15; 5: 19-27 SAFG3: 4-5: 27-8; 8: 33-35; 9: 7-13; 10: 20-23 SAFG4: 3-4: 25-4; 13-14: 22-2 WBF1: 4-5: 22-26; 8: 23-26; 8: 27-32 WBF2: 4: 6-8; 4: 11-13; 4: 15-16 WBF4: 5: 19-24 WBF5: 4: 18-20
20	Relationships	WBI1: 13: 1-4 WBI2: 13: 12-18 WBI4: 9: 10-13; 10: 15-21 SAI1: 16: 1-34 SAI2: 13: 22-29 SAI3: 7-8: 24-4 SAI4: 9: 19-22 SAFG1: 16: 28-37; 17: 18-25; 17: 26-34; 18: 8-9 SAFG2: 14: 7-14; 14: 19-20 SAFG3: 11: 32-35; 13: 1-17; 13: 14-17 WBF2: 17: 32-34; 17-18: 35-8; 18: 22-32; 19-26-29 WBF3: 17: 31-37; 18: 2-15; 19: 7-20 WBF4: 10: 7-21; 10-11: 28-2 WBF5: 12: 24-31; 13: 1-5; 13-14: 25-3
21	Impact of integration/ personal knowledge or acceptance	WBI2: 15: 9-11 WBI3: 10: 13-18; 11: 2-6; SAI1: 7: 30-35; 10: 14-28 SAI3: 5: 20-28; 6: 19-25; 7-8: 24-2; 9: 1-5 SAI4: 2: 17-20; 5: 22-30; 7: 6-13; 8: 31-32; 10: 34-39; 11: 14-21; 11: 27-28 SAFG1: 5: 25-37; 6: 12-14; 13: 13-19; 13: 21-42; 14: 1-3; 14: 12-20; 14: 26-30; 18: 15-17; 19: 4-5 SAFG2: 8: 12-19; 11: 26-28; 11: 31-34; 18: 18-20 SAFG3: 5: 13-19; 10: 9-13; 14: 17-20 SAFG4: 14: 6-11; 14: 19-29 WBF1: 5: 4-12; 11: 8-11; 11: 23-26; 12: 26-28; 13: 29-32; 15: 19-23; WBF2: 12: 18-18; 19: 8-13; 21: 22-33 WBF3: 15: 19-22; 20: 7 WBF4: 7: 24-31; 12: 12-16; WBF5: 9: 27-32; 11: 18-23; 14: 20-30
22	"It's how I would want to be treated myself"	WBI3: 4: 32 WBI4: 8: 14-16 SAI1: 8: 27 SAI4: 10: 1-3 SAFG1: 7: 33-35; 12: 12-13; 15: 7-9 SAFG2: 7: 29-31 SAFG3: 11: 13-14 SAFG4: 9: 21-24 WBF4: 9: 23-26; 13: 4
23	"We are all people" "They have feelings too"	WBI3: 3-4: 34-2; 5: 4; 13: 16-23 SAI1: 6: 9-16; 9: 9-19; 9: 28-34; 10: 1; 11: 35-39; 12: 31-34; 13: 29-33; 14: 26-29; 15: 9; 17: 12 SAI2: 6: 18-21 SAI4: 3: 22-28; 8: 2-4; 8: 10-14 SAFG2: 10-11; 29-2; 11: 7-13; 11: 30; 16: 28-33 SAFG3: 1: 5-8; 8: 21-28 SAFG4: 11: 7 WBF1: 9: 9; 16: 7-10;

		<p>WBFG3: 8-9: 31-6; 11: 11-17; 1: 20-21; ?: 9-10; 12: 15-34; 20: 13-17</p> <p>WBFG4: 7: 10-12; 8: 16-17; 9: 10-13</p> <p>WBFG5: 10: 7-8; 13: 13-16; 14: 18-19</p>
24	Culture isn't an effect	<p>WBI3: 3: 28-31</p> <p>SAI1: 11: 4-5</p> <p>SAI3: 4: 18-19; 5: 11-13;</p> <p>SAI4: 4: 19-20; 5: 16-17; 6: 24-25; 8: 5-6; 9: 1-2; 11: 28-29</p> <p>SAFG1: 10: 22-26; 13: 1-7</p> <p>SAFG2: 10: 1-2</p> <p>SAFG3: 11: 24-25; 15: 1-3</p> <p>SAFG4: 8-9: 25-2; 10: 30-31</p> <p>WBFG2: 17: 25-29</p> <p>WBFG3: 13: 7-9</p>
25	Culture is an Effect	<p>WBI3: 8-9: 31-8; 12: 19-22</p> <p>SAI1: 3: 1-21; 4: 18-25; 14: 1-15; 15: 33-44; 17: 38-45</p> <p>SAI2: 4: 11-29; 5: 11-12; 10: 14-26; 16-17: 27-2;</p> <p>SAFG1: 4: 6-17; 4-5: 22-4; 5: 7-10; 9: 28-33; 10: 5-21; 12: 31-40; 16: 5-11; 19: 10-23</p> <p>SAFG2: 16: 5-11; 19: 10-23</p> <p>SAFG2: 5: 19-23; 8: 26-30; 15: 16-18</p> <p>SAFG3: 7: 16-17; 13: 1-17; 14: 14-17; 13: 24-29</p> <p>SAFG4: 5: 7-10; 8-9: 25-2; 12: 21; 13: 9-23</p> <p>WBFG1: 14: 1-8; 15: 25-27</p> <p>WBFG2: 5: 21-27; 8: 10-12; 8: 15-18; 16: 24-26</p> <p>WBFG4: 4: 11-17; 10: 3-6; 11: 17-19; 13: 3; 13: 7-10</p> <p>WBFG5: 4: 4-7</p>
26	Impact of education	<p>WBI3: 3: 12-16; 15: 11-15</p> <p>SAI1: 2: 1-8</p> <p>SAI3: 4: 4-15</p> <p>SAFG1: 5: 13-17</p> <p>SAFG2: 2: 27; 3: 1; 4: 30-35; 5: 19-27; 15: 13-14; 18: 21-26</p> <p>SAFG3: 7: 16-17; 7: 20-29;</p> <p>SAFG4: 2: 19-21; 8: 19-31; 14: 3-5</p> <p>WBFG1: 3: 7-8; 4: 4-7</p> <p>WBFG2: 3: 2-21; 8: 15-18; 10: 11; 10: 17-21; 13: 24-27; 14: 21-24</p> <p>WBFG3: 7: 33; 20: 10-12; 7: 33; 20: 10-12</p> <p>WBFG4: 3: 18</p> <p>WBFG5: 4: 12-14</p>
27	Religion as an influence	<p>WBI2: 7: 8-16; 7: 18-19</p> <p>WBI3: 4: 17-36; 7: 2-5; 8: 26-29; 11: 11-15</p> <p>SAI1: 5: 25-30; 5-6: 33-11; 10: 1; 15: 33-34; 17: 34-35; 17: 38-45</p> <p>SAI2: 6: 9-16</p> <p>SAFG1: 8-9: 26-2</p> <p>SAFG2: 9: 3-7</p> <p>SAFG3: 4: 19-26; 9: 7-13; 10: 20-23; 12: 10-25; 13: 1-17</p> <p>SAFG4: 4: 9-28; 5: 7-22; 13: 9-23</p> <p>WBFG1: 15: 28-33</p> <p>WBFG2: 5: 14-18; 17: 25-29; 29: 21-24</p> <p>WBFG3: 7: 33; 15: 7-8; 20: 10-12</p> <p>WBFG4: 3: 19-21; 4: 16-27</p> <p>6: 11-17</p> <p>WBFG5: 3: 23-30; 7: 6-9; 10: 12-23</p>
28	Religion is not a factor	<p>WBI3: 12: 17; 13: 28;</p> <p>SAI1: 5-6: 33-11; 11: 4-5; 15: 33-44; 17: 36-37</p> <p>SAI2: 8: 13-14; 10: 12-13; 16: 22-25</p> <p>SAI3: 2: 23-24; 4: 18-19; 5: 11-13</p> <p>SAI4: 2: 30-31; 8: 5-6; 9: 1-2; 11: 28-29</p> <p>SAFG2: 8: 21-32; 10: 1-2</p> <p>SAFG3: 11: 24-25;</p> <p>SAFG4: 12: 21-30</p>

		WBFG1: 12: 29-32 WBFG3: 13: 7-9 WBFG4: 6: 11-17; 11: 14-15
29	Superstition/lack of education	SAI2: 14-15: 19-19 SAI3: 8: 16-21 SAFG1: 5: 1-4; 5: 18-24; 8-9: 26-2; 16-17: 38-14 WBFG2: 4: 1-5; 8: 13
30	"It's common sense and logic"	SAI2: 12: 21 SAI3: 5: 9-10 SAFG1: 3: 7-11 SAFG1: 5: 18-24 SAFG2: 7: 8-12 SAFG2: 12: 1-4 SAFG4: 11: 8-9 WBFG4: 4: 35-36 WBFG5: 11: 36
31	Positive discrimination	SAFG2: 17: 12-30; 18: 2-5; 18: 9-10 WBFG1: 16: 11-22; 17: 19-25 WBFG4: 12: 27-31; 13: 17-12
32	"You learn more as you get older"	WBI2: 4: 12-15 WBI3: 6: 26-30; 6: 14-18; 10: 13-18; 13: 16-23 WBI4: 3: 8-12; 3: 15-19 SAI1: 3: 37-43; 2: 21-22 SAI3: 4: 17 SAI4: 7: 32-37 SAFG1: 5: 25-37; 6: 3-6; 9: 25-27 SAFG2: 4: 30-35; 5: 2 SAFG3: 5: 11; 7-8: 32-11; 10: 20-23; 11: 18-23 SAFG4: 5: 27-29; 10: 17-18; 12: 17-19 WBFG1: 3: 26-27; 3: 28-34; 10: 21-26; 15: 13-15 WBFG2: 11: 26-29; 13-14; 24-19; 14: 33-38 WBFG3: 8: 8-12; 3: 24 WBFG5: 4: 21-24; 8: 15-18
33	Similarity to self due to age	WBI1: 12-16 WBI4: 7: 21-23 WBI4: 10: 7-9; 10: 29-31 SAI1: 9: 28-34; 13: 14-18 WBFG1: 8: 23-26; 8: 33-35; 13: 19-28; 17: 12-17 WBFG4: 6-13
34	New culture replaces old culture/mixed culture	WBI1: 5-6: 30-1 SAI1: 4: 44-45; 5: 1-6 SAI4: 10: 5-11 SAFG1: 10: 28-31 SAFG4: 12: 21-30
35	"They live better lives in the community"	WBI2: 10: 13-19 WBI3: 9: 16-21 WBI4: 8: 6-12; 9: 1-4 SAI2: 11: 10-12; SAI3: 5: 20-28; 5-6: 27-7 SAI4: 5: 22-30 SAFG1: 13: 21-32 SAFG2: 14: 26-30 SAFG3: 2: 14-20; 3: 9-13; 10: 33-34 SAFG4: 10: 1-6; 10: 10-14 WBFG2: 12: 8-13 WBFG4: 7: 24-31 WBFG5: 9: 27-37; 9: 33-37
36	Level of knowing the person/quality of the relationship	SAI4: 1: 18-20 SAFG2: 2: 6-8
37	Ideas about 'curability'	SA4: 9: 3-26; 10: 12-21 SAFG2: 14-15: 30-9 SAFG3: 6: 30-35; 12: 26-28 SAFG4: 4-5; 28-3; 12: 10-15
38	Parent's behaviour	SA4: 9-10: 27-3 SAFG3: 1: 15-18; 1: 24-29; 3: 6-28

		WBFG3: 6-7: 35-8 WBFG4: 3: 4-15
39	“They need to be looked after” “They need help”	SAI1: 11: 35-39 SAI2: 11: 6-12 SAI3: 6: 29 WBI2: 11: 15-19 WBI3: 7: 13-18; 11: 12-17; 12: 24-26 WBI4: 5: 11-18; 6: 21-28 SAFG1: 10: 5-12 SAFG2: 13: 1-3; 13: 7-8 SAFG3: 6: 11-13; 6: 23-27 SAFG4: 7: 28-32; 8: 3-9; 8: 12-13; 8: 19-23 WBFG1: 6: 7-16; 11: 12-17; 14: 32-34 WBFG2: 15: 9-23 WBFG3: 12-13: 36-2 WBFG4: 8: 26-30; 9: 10-13; 9: 18-20 WBFG5: 11: 30-32; 11: 37
40	Ideas are influenced by peers	WBFG2: 13: 28-33 SAFG3: 8: 4-11

E2 Examples of Analysis

(Phase 4: reviewing the themes and checking if the themes work in relation to the coded extracts).

Example 1: Theme: Confusion

Code 1: Confusion about the concept of ID

Mental handicapped probably means that you know there's something wrong with more the way they learn, whereas, learning disability, I don't know, it's the way they learn as well but it's not as, I don't know, just like it doesn't mean it's so bad or something.

WBI1: 1: 11-14

Yes they do, they erm get offered extra help, whether they take it or not is up to them I think, but most of them do and there's like erm things like when it comes to exams they can like ask for extra time if they can't work as fast or something like that and then they go on to better stuff.

WBI1: 2: 1-4

P1: Not all the time but that's what I might think if someone said they had a learning disability like they find it hard to concentrate or something which might not be directly related to something medical but erm [pause].

I: Ok when you say medical do you mean kind of biological, genetic or you haven't really thought about it?

P1: Could be genetic, I don't know, I haven't heard of something that is inherited although there is a couple of things but I don't know they are quite severe erm I'm not sure I don't really know why they cause certain erm.

WBI1: 2: 21-28

As is like other things I'm not sure if you would call those learning disabilities though so I don't really want to name anything,

WBI1: 3: 2-3.

I don't know. Do you mean something as extreme as someone with Downs Syndrome or something like dyslexia?

WBI2: 1: 23-34

I: So dyslexia would be one kind of learning difficulty and then at the other end there might be Downs Syndrome? [Yeah] It's all kind of the same?

P2: Yeah. (Pause) It's the same spectrum but then again those people. Those posh kids are they thinking oh yeah I'm on the same level as someone with Downs Syndrome? No, they would never say anything like that, especially one girl she's proper snobby and she would never say (laughs). You know what I mean? She would claim that she is dyslexic but she would never claim that she is on the same level as them. You know what I mean?

I: Ok so are you saying that they are on the same level?

P2: Yeah I'm saying that they are but they wouldn't consider themselves the same [ok] if that makes any sense, yep [yeah ok] ok.

WBI2: 2: 6-16

Oh yeah, in a way they would kind of brag. "Yeah I'm dyslexic." You know what I mean? (Laughs) Because they are getting more time in their tests. "Oh, I'm dyslexic, that's why I'm bad at this, actually I'm great at everything really but I'm dyslexic that's the thing that's keeping me down. It's not because I'm actually bad at it" [Ok]. Again, I feel kind of bad for saying that. It's extremely cynical you know but (laughs) [but its something that you've noticed] Yeah, definitely yeah.

WBI2: 3: 2-7

That the middle class kids are kind of putting it on a bit [ok right] when the working class kids maybe like putting on a bit of a front (pause) it does exist but it's not at prevalent as some of the people in our new school would act like it is.

WBI2: 5: 7-9

What do you mean physical like? [Kind of like being in a wheelchair or not being able to...] Oh, ok yeah, there would be a difference, because ones mental the others [yeah ok] you can't do anything [ok].

WBI2: 6: 11-12

I don't know, yeah, I would say they are more accepting to physical disabilities because they probably do think the other is a bit... Actually they probably think it's not genetic with the other one they probably think "Yeah, fair enough someone in a wheelchair they probably cannot do much about it." It's a bit more obvious you know [yeah]. Bit more like I can see that, that's the problem but that, what you're talking about I can't see it. I can't make anything of it.

WBI2: 6: 14-19

I think we have got a couple of people who are dyslexic in our year [Mmm] but apart from that that's about it.

I: So dyslexia is a learning disability?

P3: Yeah, I would say it is. [What, sorry?] I'm not sure if it's definitely classed as a learning disability [ok] I think I have always been told that it is [ok that's fine].

WBI3: 1: 13-17

I think probably a bit because I think if it's a learning disability its probably easier to give up on a person because they don't understand what they are doing, they can't learn things, whereas if it's a physical disability you can always like kind of help them out. Like you can get like fake legs and things and like prosthetic arms and legs [oh yeah, right] I don't mean fake ones (laughs) but erm I think with a learning disability it's a little harder because you can't just give someone a new brain or anything can you to help them out [ok].

WBI3: 4: 5-11

I: Ok and in your college or sixth form school were there any young people with learning disabilities?

P4: Erm, there was one that I saw she was like in a wheelchair and I think she did have some mental health issues. I'm not exactly sure because she was like in year 8 or she joined in year 7 and when I left she was in year 8. Yeah and I saw her in the library a lot but I don't know exactly what she had [ok].

I: So what do you mean by mental health issues?

P4: Erm, I think she couldn't really walk very well. She couldn't speak very well and they had to have a like special teacher to like talk to her and she it would take her quite a long time to learn it and she couldn't speak [ok] at all.

WBI4: 1: 6-15

P4: Erm I knew about what like dyslexia was but I didn't understand. I knew like people had said it but I didn't understand that you could get over it and you could have special lessons and it was ok, it took you a bit longer than everyone else to get something [sure].

I: And can people get better from other learning disabilities?

P4: Depends how serious and what it is [ok].

WBI4: 1: 29-33

P1: I don't really remember...but I know there's stuff to do with Braille that has come into my head and I don't know why.

I: Ok. Well. Just?

P1: So when you go out and about like in the shopping aisles you've got stuff to do with Braille, like the Braille writing so blind people can read it and stuff.

I: I've never noticed that, that's really interesting.

P1: It's even on the shampoos bottles.

SAI1: 2: 16-22

I: Does your culture differentiate between learning difficulties and physical disabilities?

P1: Erm, kind of but I think I think they see learning difficulties and erm physical disabilities as one sometimes.

SAI1: 4: 26-29

I2: What do you think causes a learning disability?

P2: (Pause) erm an accident [an accident ok].

I: And do you think anything else might cause a learning disability?

P2: Maybe a genetic problem.

I: Can you say anything else about that?

P2: Mmm, I think it's mainly because of any damage to the brain [mmm] or something like that [ok].

I: And you said that an accident might cause a learning disability [yeah] can you tell me a bit more about that?

P2: Any accident to the brain like head injury [ok and that would] yeah [ok].

SAI2: 2: 5-14

P2: Erm my culture? [Actually thinking about in India?] In India people don't give much importance to learning disability you just go to a school and you learn and you write exams.

I: Ok so everybody would go?

P2: Everybody would be treated the same whether they have learning disability or not.

I: So there must be a big variation of the people in [yeah a big variation in the marks we get as well [mmm].

I: So were you in school with anyone in India who couldn't read or write?

P2: You never know who has learning disabilities they might face problems but they never tell it out. [They don't tell you?] Yeah.

I: So you wouldn't be able to tell by looking at someone if they had a learning disability?

P2: No I don't think so (laughs) [Ok].

I: (Pause) Ok so how would your Indian culture view or treat people with a learning disability?

P2: If they find out that they have learning disabilities then I think they may give them more opportunities [ok] but I don't think they would take any major steps to improve their studies.

SAI2: 4: 11-29

P2: Like if they are good at talking and delivering speeches rather than writing then maybe they will send them to become (pause) erm something (laughs) a politician maybe (laughs) [ok for that you wouldn't have to write?].

SAI2: 5: 4-6

P1: People that have trouble learning basically that's it. [OK].

P2: People that struggle with certain tasks like writing or reading.

P3: Maybe they find it harder to grasp new concepts and stuff like it might take a longer time to learn new stuff. Like for a dyslexic they might look at it but they might not be able to focus on what is said because they get confused.

I: Ok, like a learning difficulty?

P3: Yes.

P4: It is like someone who learns different to how we like learn in college. Like something that is not very common, not like just reading or writing, it might be their actions. [So it might be?] So a different way of carrying out tasks, like not just problems with reading and writing concepts, a different way of grasping concepts.

I: Ok.

P1: Some people like dyslexics, they can't write properly.

I: So you're saying there might be two different things, so one might be a sort of learning difficulty where people find it hard to learn like us [yes] or you're kind of saying that there might be more to it than that, and that people learn in a different way. Is that sort of right? [Yes].

P1: And they can't recognise words and stuff so it takes them much longer to actually learn simple stuff.

I: OK, and do you know of any other terms that people use to name people with learning disabilities?

P3: Well, it depends like if they are autistic or something then offensively people might say retard or something.

SAFG1: 1: 4-24

P3: Yes, there are people with dyslexia and dyspraxia and stuff but like even though they had a learning disability at secondary school they all got all A*'s and stuff like that in their GCSE's, it's just that they learn differently to us and they got extra help.

SAFG1: 2: 4-7

P1: I think like ADD or something? [I: ADHD] There was a boy who was hyperactive and stuff and he couldn't learn in class. He wouldn't like do any work or nothing.

I: Ok, so did you all go to schools which had people with learning disabilities?

P's: Yes.

P5: What do you call it when like light affects you and you get headaches or something [I: I'm not sure] I can't remember what it's called?

P1: Epilepsy?

P5: Yes that's right.

SAFG1: 2: 15-20

P?: I don't know what it's called. He just can't learn stuff, maybe dyslexia, yeahh.

SAFG1: 2: 24

P3: Maybe if they moved to a country when they were younger and they couldn't speak the language and they'd have to work hard to catch up learning a foreign language that they didn't know and that might affect them.

SAFG1: 3: 1-3

P5: I think through the experience of what you know. So like with people that you know who have an accident that did affect them and they had brain damage that would affect them physically.

P2: Like it's the most common reasons for persons with learning difficulties is accidents and stuff.

I: So you think that would be the most common-reason?

P2: Yes.

SAFG1: 3: 12-17

P6: Then again in the villages they like don't have a chance to know if they have a learning disability or something because they don't have no schools, so you might not be able to tell.

SAFG1: 5: 18-20

P3: Yeah, like with mild cases of learning disabilities like dyslexia and dyspraxia they don't need to be integrated because they have some disabilities with learning and stuff but not disabilities with communicating to people, like they don't have a different mentality. Whereas with autism and stuff like that maybe they might need extra help but at the same time if you segregate them it will affect how others treat them because they won't see people like that and they will become ignorant to it or if they do see them they won't know how to act whereas if they together always they are used to it and just treat them how they treat everybody.

SAFG1: 14: 12-20

P6: I think a mental disability is different to a physical disability and I think that you can have a family, like a normal person can, like they can have children and a family too.

SAFG1: 16: 18-20

P1: Someone who has a problem learning like at school.

P2: Problems understanding questions.

P3: Someone whose brain works slower than everyone else's but still gets to the same place [ok so it would just be slower] yeah.

SAFG2: 1: 3-6

P6: What about dyslexic is that the same?

P7 – Yeah, dyslexia yeah, that's true.

I: Ok so you might name something like dyslexia is a learning disability?

Group: Yeah.

I: But other disabilities you would probably just refer to as handicapped?

P?: Yeah, there is like Dyspraxia as well

P?: Me personally, I would class everything as a learning disability because anything that stops you from learning at the same pace as everyone else does [ok] whether it be dyslexia, dyspraxia its all the same thing [mmm].

I: And would other people agree with that do you think?

Group: Yeah [ok].

SAFG2: 1: 14-24

P?: I still think of dyslexia (inaudible) when I was doing that form.

SAFG2: 2: 36

P7: That might affect their performance like academically, how clever they are but it doesn't affect their, it doesn't stop them. Their performance could still be at a higher level, its just not really affecting you; it's not really slowing your brain down.

P6: You are still mentally able you can do everything else that everyone can.

P2: Yeah, you could still reach your potential mentally.

P7: It wouldn't be classed as a learning disability.

SAFG2: 4: 1-6

P2: People who are deaf or have problems with phonetics.

SAFG3: 1: 3

P4: There are basically different types of learning disabilities you have like dyslexia or something like that which means it takes you time to process and learn stuff.

P1: It might not even be a health problem it might be to do with the family or something, like it said on the sheet, like the parents for their wrongdoings. It might affect them mentally [ok]. Therefore their concentration would like be less in whatever they do.

SAFG3: 1: 12-18

P1: I wouldn't say they were disabled, not like proper, proper disabled. I think it's just the way they learn, it's not like physical disabilities. It won't really affect them. They are going to learn in one way. It's just slower than everyone else.

SAFG3: 1: 26-28

P1: Yeah, like in my high school I saw one girl she had dyslexia and I literally saw how her friends were treating her. They were treating her completely different. She didn't understand like erm sometimes they used to run away from her and stuff and I used to see that kind of thing and I just thought it was showing how they were differentiating her because she had dyslexia [mmm ok].

SAFG3: 2: 7-11

P4: Could be deaf or blind, so you have to find different ways of learning and that could make you slower.

SAFG3: 3: 4-5

P4: The opinions I've got are because I've got two people with dyslexia in my family and so I get my information from that.

SAFG3: 3: 32-33

P6: But then do disabled people tend to marry each other or not really? [I don't know] then again it depends what it is (laughs) slight dyslexics don't have to marry dyslexics do they (laughs).

SAFG3: 14: 24-26

P4: I just want to add something. You know when you asked about if we knew someone who is disabled or something like that? [mm] and if you can notice them? I don't agree with that, like when you look at him, you can't tell he is dyslexic but then when you talk to him and you can kind of tell because of how he reads and things. But then my aunty, she is in her last year of uni. They know she has dyslexia. When she was doing her A-levels no-one knew she was dyslexic, only now she is her last year of uni that she has actually found out she has dyslexic. So I don't think that it is true that you can tell. But my brother, the teachers helped him so they already knew but with my aunty they never found out until now which is quite surprising.

SAFG3: 15: 5-14

P2: Like some learning disabilities are mild and not as severe as others.

P5: It could be like mild dyslexia or something.

P2: Yeah.

I: So dyslexia would be a learning disability?

Group Yes, yeah, yeah.

I: And you are saying there is a spectrum - that is quite a mild one what do you think might be at the other end?

P6: Can't talk or...

P1: Physically disabled or...

P3: Can't write answers for themselves or can't understand what they are doing.

P2: They need computers and that to help do their schoolwork and communicate.

I: Ok and do all people with physical disabilities do they all have learning disabilities?

Group: No, no, no.

SAFG4: 1: 13-27

P1: I saw something in a documentary. [Yeah, can you remember what happened?]. Yeah, I think it was about a lady who had a disability or something. I can't remember.... Yeah, I think half of her body was missing, sort of a physical disability. This was in America and how she lived a normal life still, even though she was missing half her body. She still lived a normal life but just had to do things differently.

P4: Oh I know what you are talking about the half woman, half body whatever [ok].

I: And that's kind of influenced you maybe?

P1: It proves to people they can live their life.

SAFG4: 10: 19-27

P4: I think it's a shame. Like everyone has the right to be happy, so I don't see why they can't. That programme, "little people big world" just shows you how normal they can be. [Yeahh] They have different things, like a smaller house, car. He has a car he drives around, just so normal.

I: What programme is that sorry?

P4: Little people big world.

I: What is that about?

P4: It's about short people [oh yeah] (laughs) [ok] dwarfs or something.

Group all talking at once (laughs).

P4: They are an American family, and mum, dad is small and the two sons are taller, regular size and it just shows how normal they can be. [Ok] I think everyone's normal just different everyone has different qualities.

P3: Yeah, they are really happy people [yeah] happy with their lives.

SAFG4: 11: 18-30

P4: Yeah, I think they are quite intelligent. They just have difficulties in showing it [mmm]. I think they know more than we do about society and life because they have experience of growing up being different, going to work being different. If we had to do that I don't think we would be able to do it, so in a way it makes them more tougher and more better than us. They have accepted who they are. They have learnt to deal with it. Like many people who are normal could end up like that. I think they would have a mental breakdown or commit suicide or something [ok].

SAFG4: 15: 7-13

P1: It's like people that are not perhaps able to learn, as to take in information around them or to try to apply what they have learned or sort of how they live [ok] sort of.

P2: Well it's probably people not just with mental disabilities but also physical disabilities. Like say they are blind it might stop them learning is some way and in some way impedes them learning but doesn't stop them from being a part of society all the time. It may just affect their behavior. It may not be noticeable some of the time [ok].

P3: I just thought that maybe people that generally struggle with learning that maybe you could teach it over and over again but they still don't quite grasp the same concept [ok that sounds good].

WBF1: 1: 3-9

P1: Money is a big issue for people with learning disabilities because they could potentially get into gambling perhaps they haven't understood how to sort of moderate. [Sure] Maybe that is an example; people perhaps have got a compulsive personality then that might be a problem [ok].

WBF1: 10: 14-17

P2: Not really because you know them. You know they can look after themselves. The person there has only got very minor learning disabilities [Mmm] so you know they can look after their money and stuff.

WBFG1: 10: 31-33

P3: Like accidents and things that happen, like loss of limbs and things.

P2: I think having Leukaemia when you are young can cause a learning disability. It happened to a friend's brother

WBFG1: 2: 24-26

P3: There was that bus accident ages ago and someone was paralysed, so things like that and car crashes.

WBFG2: 3: 5-6

P2: A lot of people with learning disabilities are like really clever, like a lot of people with autism, [P4: yeah]. And they are really intelligent so they wouldn't need help with that type of thing.

WBFG2: 9: 1-3

P3: Yeah, like Tourettes as well.

P1: Yeah, like stuff like Tourettes.

WBFG2: 16: 17-18

P2: Like I know someone who has learning difficulties and when like he had his GCSE's he had someone sitting with him and going over the questions. So like I think it is learning slowly compared to the other people?

WBFG3: 1: 16-18

P2: Inaudible [sorry?] dyslexic.

WBFG3: 1: 22

P2: I'm not sure if it's a learning disability but there is a girl in my class who is deaf and every lesson she has a person to come in to do sign language and stuff. [Ok] Every single lesson.

I: So do you think being deaf is a learning disability?

P2: I don't think so, no. It might have been before but now there are more people to help. In the past it wasn't so advanced with money, education and learning. There weren't so many people to help so it might have been but not now. It might be a bit slower as it might take longer to understand than listening but the person is used to it so I don't think it's a problem [ok].

P4: I don't think it would be a learning disability but I don't think she would be able to respond as quickly as people who aren't deaf. [P's: yeah]. Like I don't think it's a proper disability, like it's not a problem with the learning itself.

WBFG3: 2: 11-22

P3: My boyfriend is really badly dyslexic, he will add letters, take away letters, and write back to front.

P1: They write it how it sounds don't they?

P3: Yeah he spells it how they sound. So it could be a five letter word but he uses two letters. So I sometimes go through his work and like write it all out again for him because he's doing a course and when they get it in front of them and they're like "oh god what the hell does this mean?" so most of the time he says can you come and check it, or I'm on the phone to him and I'm spelling out all the words and he says it doesn't sound right and I'll get out the dictionary [laughter] and I say I'm not the dyslexic.

WBFG2: 3: 5-14

P3: My god daughter is autistic and her brother has high functioning autism. Where he is a bit like loopy at times and well he has ADHD too, so, and he finds it difficult to comprehend what is going on a lot of the time. And then X has really bad autism where she can understand you but she can't speak, well she can swear [laughs] but she can't speak normal, and finds it hard to walk and stuff like that but she understands everything, and she's really smart that's the thing, she acts like she doesn't understand you but she does. She understands 100% what you're saying [P4: Oh like my cousin] but she will like use her disability to her advantage sometimes, like, when you say to her, like X don't throw the cup of drink all over the floor, she will look at you and smile so you know she's understood and then she'll go

and do it. And then you can't do anything about it because obviously she's disabled and you feel like if you hit a disabled child or like shout at them so you just let her get on with it, but like sometimes because she can't communicate she gets really angry and upset and she goes into these big raging fit things when she just goes around hitting people. I've been attacked before and had DVD boxes thrown at me. The other day she came at me with a fork because erm I think she wanted someone to play with her with the ball but because she can't say it, she's just bouncing it front of them and she basically just threw it at them and their head and going a bit angry, but she understands everything that you say to her. She can't speak to you, but she understands, but then she's smart because she uses it to her advantage and she pretends she don't understand you when she does, so like she is a bit sneaky.

WBFG3: 3-4: 30-14

P2: Like one of my friends has OCD or OCR and he has to like wash his hands all the time and clean the floors and hoovers and when he's at school he often goes out washes his hands and comes back in and then if something is like this he has to do this, and if it's like this he has to do this (demonstrating with objects on table). And I think it's affecting him, like cause lessons are for one and half hours in college and he goes out like ten times to wash his hands and sometimes, for example, if they show like a Power Point or a video he would like get scared and he would not speak for about a week and it's a problem but he's like really smart and he's getting really good results.

I: Ok, so are you saying that's a learning disability as well?

P2: I'm not really sure.

WBFG3: 4: 18-29

P1: Er like a handicap, an impairment to learn it's not as easy to learn as a normal person.

I: Does everyone kind of agree with that?

Group: Yeah.

I: Does anyone have anything they would add to that or does that seem...?

P1: No, it could be like physical or mental so that would stop them learning the same as everyone else

P2: I don't agree with that.

WBFG4: 1: 2-9

P4: I guess autism is kind of a learning disability.

WBFG4: 2:15

P1: Erm maybe like the experience of like you know David Blunkett [Mmm]. He's like disabled but he's like in a health authority. He was in a health authority position, so maybe it really depends for the person himself if he will be better off in like the real world or like a segregated community, so you can only analyse each situation.

P2: But he's blind.

P1: Yeah.

P2: Can that be seen as a learning difficulty?

P1: Yeah.

I: Do you think it would be?

P2: I think it could impair your ability to learn but I'm not necessary sure it would be a learning difficulty [Mmm].

P4: No, I don't think it would.

I: From a professional point of view you wouldn't count it as a learning disability?

P2: Yeah.

I: Because it's not [P1: I understand it's not dyslexia or something].

P2: Because you can learn on vibrate or something [Mmm].

WBFG4: 7-8: 33-15

P2: If there is more disability then yeah, because I think if you have got dyslexia then I don't think you need help in monitoring your life, but if you have got like, I don't know, Downs Syndrome possibly then maybe you might [Mmm].

WBFG4: 8: 23-25

P1: Like two people have dwarfism or something...

WBFG4: 10: 17

P1: It is a disability but we shouldn't call them permanently disabled because of this, they do have some talents. Some dyslexic people could be great actors or great mathematicians. There are some people like Albert Einstein, a good example, it means they have a disability in some stages but they are not permanently disabled [ok].

WBF5: 1: 25-28

Example 2: Theme: Positioning self as accepting

I think there would be a few people who would think differently erm but in what way differently I'm not completely sure. I think they probably wouldn't know as much about it. I'm not saying I know much about it at all. Therefore they would be slightly more prejudiced to say things like maybe people are not trying hard enough or something like that.

WBI1: 4: 3-7

P1: I'm sure there are people around who would say if they had Downs Syndrome they shouldn't be in the community. Personally, I don't know anyone. I think they may say it for benefit to them it would be for the best.

I: The best benefit to who sorry?

P1: The person saying. Who is looking in on the situation.

WBI1: 10-11: 34-1

Erm I'm sure if - ok this is really extreme views. I'm sure if you had particularly extreme views you'd say that possibly Tom shouldn't because genetically they might influence their children but I wouldn't think. I think you would have to take their views into consideration.

WBI1: 13: 14-17

I would never be a judgmental person in the first place.

WBI2: 3: 28

I would imagine but I wouldn't really know. I would think some people would say give them as much help as they need and the more extreme would think they need lots of help. They might say lock them up. So a mix.

WBI2: 11: 24-26

Don't know. I can imagine people being a bit like confused by it because they wouldn't really understand how they are not able to function in a lot of things and then how would they be able to do that so [I: to have a relationship?] Yeah, basically I think people would say (inaudible).

WBI2: 12: 22-24

I think some people might treat them like they are complete idiots and things and just act as if they are not really there at all as if they are not really a person.

WBI3: 3: 34-35

I think if they need it then it's probably better to have someone help them otherwise you are going to get people coming to prey on them and try and take their money away from them.

WBI3: 7: 13

I: Erm (pause) and do you think being English influences your thoughts?

P3: It might do I suppose because it depends, different cultures you get brought up in. Because in some places it could be frowned upon to have a child like that because it might make you an outcast or something like that. [Mmm] Cause that's just what some cultures are like cause it might not relate directly. I saw it on TV the other day, I think it was in India, having girl children, nobody wanted them because they all wanted boys. [Mmm] Cause you have got to pay money for them to get married and you have got to pay money for everyone to get there. So everyone wouldn't really want a girl. If you did get a girl its quite common for them to try and lose dead baby girls in places. [Right] So I think that in some cultures it might be the same sort of way for people with learning disabilities, that if you knew that your child had one then you wouldn't want to have it [Mmm] And I know that some places would think it would be alright to abort a baby if they had Downs Syndrome or something but I don't see that as right myself and I think religion would probably say the same sort of thing that I do on that sort of thing so [Mmm].

WBI3: 8-9: 31-8

I'm not sure really on this one because I think if you're younger then you are going to think they are part of the community as it is so if they are there you are going to grow up with the acknowledgement that they are there and you wouldn't mind it. As you get older your views might change slightly (pause)

because when you have children you might not want your children to have to cope with that sort of thing being around or nearby them but I wouldn't be too bothered myself really.

WBI3: 10: 13-18

I'm not sure really. It might be the whole idea that they are freaks in a way to some people and they don't want their children to go near that sort of person because I think they were thinking about changing the council in my school into a half-way house sort of and I think some of the parents had a bit uproar about that because they were worried about people with learning disabilities in the school grounds during school days or whatever but I wouldn't really be too bothered with that 'cause it's up to them where they go. So I would go and chat with them if I saw one [ok] cause I just don't see anything wrong with them they are just another person.

WBI3: 10: 20-27

I'm not so sure on culture really because I think there are some aspects of the culture that wouldn't want them to get married and things [mmm] because with the reason that I said earlier they don't really want more people with learning disabilities but I would like to think that most people would accept it because they are people and it's up to them what they do [ok].

WBI3: 13: 30-34

I think that some people, like some people I know might think it should be more controlled like just because they might say if they have learning difficulties then they don't know perhaps not what's right or wrong but they can't make the right decisions as such they should have more control [mmm] over their lives [ok].

WBI4: 9: 24-27

They might think that because they have a carer so they might think it must mean something so that the carer should have total control so rather than listen to someone who doesn't know what to say or do [sure].

WBI4: 10: 1-3

They might be more harsh with that and kind of say no, automatically no, rather than look at the individuals and say well maybe yes for them but no for everyone else [ok].

WBI4: 10: 27-30

I think yes but some might say that though they might agree with their opinions that they might be productive but they might rather than thinking about trying them out say they wouldn't be good at this so don't bother [ok so they might not bother to try].

WBI4: 11: 27-30

I: Mmm, can you think of any activities that, that erm you think they should be separated from the normal community?

P1: Erm, I don't think so... maybe sports I think, some sports like swimming.

I: And why do you think that?

P1: Because, I don't know, they could... I'm just trying to imagine a pool with people with disabilities and how they would be.

I: Mm.

P1: Maybe the other people... mm if it was all mixed the normal and disabled people then the normal people won't, I don't know why but they won't feel comfortable around them.

I: Ok and why do you think that might be?

P1: I really don't know where that idea comes from but... (Pause).

I: It sounds like an interesting idea, so you think that some people might not feel comfortable?

P1: Yeah, but I don't know why, because... I don't know... maybe just because they behave differently and the way they look as well.

SA11: 10: 29-44

P2: Like you get to know what kind of problems they face [ok] because others are race prejudiced against them.

I: Ok so that would be a problem that they face [yeah] can you say anything more about that?

P2: Because I read in an article that they may not be good at learning like reading and writing but they are good at talking delivering speeches but still they won't get proper opportunity because people won't give them the opportunity because they are (pause). They have views against them.

I: Right so some people might be prejudiced?

P2: Yeah.

SAI2: 3:1-6

They won't feel inferior to normal people [ok] They might feel inferior to normal people because we are able to do stuff more [ok] but with their own people with learning disability, they might be more comfortable in telling the problems [I: to people with learning disabilities?] yeah.

SAI2: 11: 28-31

No, I don't think so some people might be against the fact that they should get married especially for Tom it's a genetic disorder he might pass it on to his children [right] so that's creating more problems for his children [sure].

SAI2: 14: 6-8

Especially for people with genetic disorders they think if it is passed on then they should not be able to marry because they will be spreading the disease.

SAI2: 14: 13-14

I: Do you think anyone would think differently?

P3: (Pause) I do think that but I'm not sure what the reason is behind that.

I: Some people might think they shouldn't get married but you don't know why?

P3: Yeah.

SAI3: 8: 9-12

P4: There are quite a few words I have heard but they are a bit horrible words like if I was to say disabled, mentally retarded I have heard, retarded and then just other words are quite horrible really they are not words I would like to use to call someone who has a disability [ok].

SAI4: 1: 9-12

P1: Erm I know some people that might say they will be better off. They will be safer but I understand there are different levels. If someone can't handle people then yeah they are going to be better off [Mmm] but it depends on the situation.

SAI4: 5: 34-36

I: And why do you think people hold different views of what would be best?

P1: Discrimination, prejudice all those kind of things. [Mmm] It's like if you are not like me then you are not good enough that's what I personally think this world is like. If you are not like me then you are not good enough [Mmm].

I: And why do you think people might be like that?

P1: Because we have simply things like racism still going on. If you can't handle someone's race how are you going to handle someone being completely different. They are still the same race as you they are just going to see someone as oh you're less to me you are inferior and everyone's like that, and I just think that's not fair and that's why people are unhappy.

SAI4: 6: 1-10

Erm first of all media like Eastenders, for example, the old woman who has a disabled child. First she didn't want that and that's giving a negative view to that, she didn't want a child that was her own flesh and blood she didn't want that. Then she warmed up to the idea and now she just treats her normally so I think its good and bad at the same time but there are other things in the world. Being prejudice and discriminating we all have our own views and people always like to stick to their own views and I don't think people are too accepting of this.

SAI4: 7: 24-30

P7: I think that the person would need help, because there are people out there that might want to fool the person and to take their money.

P2: Yeah like some don't understand the value of things and how much things should cost so if they don't have help they might get ripped off and that.

SAFG1: 11: 13-16

P2: Yeah (inaudible) I think everyone should be able to be included in the community regardless of what they have and the majority of this country are not going to treat a disabled person in a mean way are they? Unless they are ignorant, stupid or drunk they are not going to treat someone in a mean way (laughs) cause they are not, think about it, you think if you go down the street and you see a disabled person are you going to kick them on the floor?

SAFG2: 11: 16-21

P6: Some people act like not that comfortable around them they are like; oh I don't know what to say to them so I just ignored them.

SAFG2: 11: 24-25

P7: I think they might find it harder to get jobs because employers might not want to take them on as employees [why do you think that?] I think it's just discrimination basically (laughs).

P1: They won't be as productive, they won't get that much money out of the employees [so economics would be?] yeah they haven't got a problem probably with people having disabilities but from a business view they are not an asset.

SAFG2: 16: 8-13

I: You were worried maybe about people taking advantage?

P6: Yeah, taking advantage.

P1: The passport?

P6: Yeah, because he didn't really want to marry her, he just wanted the passport.

P2: Then did he want to divorce her? That is just really bad.

P4: I think like the religion that I come from, if you can't find anyone here to marry then you go back home to get married. So he must have taken advantage of her, by just leaving her afterwards.

P1: But then if you know the person is going to be taken advantage of then it is better that the person doesn't get married.

P6: yeah, but I think the marriage was actually arranged so maybe the parents should have got to know the guy more, and so in that way, yeah, you were saying about the family but the parents just wanted to get her married so they wouldn't have the responsibilities.

SAFG3: 13: 1-17

P1: It might be harder for them to find a job. There might be jobs that they can do and people that are willing to take them on. Whereas like I said they might find it hard to get jobs as sales assistants because they would need skills, numerical and communication skills, which they might not have, in order to make sales and obviously businesses wouldn't want that so they not recruit people like this.

SAFG3: 14: 5-10

P2: So, it's like a person might be able to read and write but they can't talk. They might be able to understand what they need to do but in order to complete the task they might need something that forces them or limits their choices because they can't do it for one particular reason. They might be able to understand, write, read but they can't talk, and like you said for jobs, people might not recruit them because you have to be able to talk to customers and clients or whatever in order to be able to complete the task.

SAFG3: 14: 24-30

P4: People talk about equal rights, what's the point if people are put in a corner? They don't know what they are doing and they just need a bit of help but I don't see why people are scared and don't want them around them at the end of the day. They are humans as well [Mmm].

SAFG4: 10: 3-6

P1: Some people think that because they have got a learning disability erm they are not like normal people so they need to be kept separate. The only reason I would say they needed to be separate would be to protect them because people might laugh at them and that's the only reason otherwise I think they should be part of the community.

SAFG4: 10: 10-14

I: Do you think some people might think differently?

P3: Because they might think their disability could get passed on to the children.

SAFG4: 12: 6-7

P1: The reason obviously in my opinion is scientific rather than not like say something like I don't believe in say like punishing the parent [have you heard that as an idea?] Yeah I think so because I think someone like Glen Hoddle was sacked from being the England manager because he said like mentally handicapped people are being made to pay for the sins of their parents or something.

WBFG1: 2-3: 33-2

P2: My parents yeah and my views have not really been influenced that much by people at school because I avoid groups who say bad things about people with learning disabilities because I don't think it's right to make those comments, especially if the people are not there to defend themselves.

WBFG1: 3: 15-18

P2: Probably because culture, you have someone telling you they shouldn't marry them especially from a young age then you are likely to have the same beliefs but not always [mmm] but I think to a certain extent it may but...

P1: Maybe like in other religions where there is like more emphasis on arranged marriages they might not been so keen say on someone from their family marrying someone with learning disabilities that might affect their judgment really.

P3: Yeah, I think maybe religion in some religions because erm some religions have a strong importance on children and they might have pre-prepared the future of their child and maybe they have views and want to stick to that [ok].

WBFG1: 15: 25-33

P5: I think our school is more subjective.

P4: It is highly selective and hard to get into.

P1: I don't think they would discriminate against people with learning disabilities but it is selective on ability so that discriminates in itself.

WBFG2: 2: 8-11

P3: Yes, loads of people at my school who are from X. Yes, the people that live in the dodgy area. Where I live, there is the nice part and then you have got the not so nice part. In the not nice part people will take the Mickey out of them and stuff like that, and just generally....

WBFG2: 4: 18-21

P2: There is the type of people that just wouldn't be friends with them because they have got a learning disability type of thing.

P3: People at my school as well wouldn't want to know people with learning disability or they would just take the Mickey

P4: I think there are quite a lot of people that would take the Mick.

P1: I can't think of anyone in our school who would actively take the Mickey but there are people at our school who think less

P's: Like out in the community,

P1: I think in our school no-one would openly take the Mick, but I think there are people that have different views, and there are people that would think less of them.

WBFG2: 4: 24-33

P3: There are a lot of people who would have opinions of them but they manage to keep it to themselves, but there are the people that would show and there are others who would tease them for it.

WBFG2: 5: 1-3

I: Do you think religion or culture affects what you think?

P5: I think in a way it does. I know this going very, very extreme, but like what Hitler did, he did because he had this thinking that they were different and that they in a way were the bad people in society. And there have to still be people like that even if we don't know of many people but there must still be people who think like him.

WBFG2: 5: 6-9

P3: I think to be fair that most of the people I know think as I do but about a third of people would think just get rid of them.

P?: I think most people I know would agree.

I: When you say get rid of them?

P3: You know like put them in homes all together. [I: Segregate?] Yeah, you know like they should be out of sight and stuff. Personally I think that is wrong, they should be able to live their life like everyone else.

WBFG2: 8: 3-9

P4: I think it depends how accepting the other people are though. Because if they are in a place where they are really discriminated against then they would be happier maybe with other people with disabilities.

WBFG2: 12: 14-16

P1: I think that they would both benefit from being in a normal society as long the society wasn't one to discriminate against them and make them feel uncomfortable but I think they would both benefit from being integrated.

P3: Yeah, be integrated but at the same time have the other group....

P2: Yeah, they should have the other group where there are people they can relate to.

P3: Yeah, even if it was just once a week or once a month, where they can talk through.

P1: Yeah, where they have that security to...

P2: And so they know they might not be only one who is suffering with discrimination.

P3: Yeah, so they don't feel alone and so they always know that there are others around.

WBFG2: 12: 28-36

P1: I think that some people would think like, that they don't deserve maybe, but that they shouldn't be in the community, and that they should have their own groups and that they would benefit more from just having their own groups, with people like them maybe.

P5: I know at my old school it wasn't an English school, it was an international school in south east Asia, there were, because it was an international school, they took anyone who was international you know? [I: ok]. There were, they only had this in the primary school but they had a scheme for kids that needed extra help, and there were kids with all sorts of ranges of disabilities because there were no specialist schools and erm, there were parents who thought it was a waste of school fees to have people with disabilities in the school. Like if your child has disabilities don't come to this school, go their own way and have their own support, because they had the same school fees as everyone else, because the school thought that just because they had disabilities doesn't mean that they should have to pay extra fees they just sort of funded it through the school but yeah there were parents who thought that they shouldn't have done it or that they should have been charged extra to have extra help.

WBFG2: 13: 4-19

P1: I think there are some people with views that are less accepting of people with disabilities, would think that they need to be supervised like for the benefit of others, like I don't think this but, but for the benefit of the public and stuff they need to be like controlled and like supervised properly.

P3: Yeah and a lot of people get put into homes.

P2: Lots of people think that they need to be with other people like them and just sort of be hidden away from the rest of us. I don't think that personally but there are quite a few people that...

P1: Yeah, like in public, yeah, because like I don't really know how to put this but sometimes they have outbreaks and they make different noises and stuff that people aren't accepting of in society in public areas, and some people would say like they need to be controlled.

WBFG2: 16: 5-16

P2: Yeah, and some parents of like young children might be quite cautious, I'm not sure if that is the right word?

P1: Yeah, like controlling of?

P2: Because they don't want their children's innocence being tainted.

WBFG2: 18: 19-22

P2: And as long as everyone at the work place can accept them and isn't unhappy there.

WBFG2: 20: 23-24

P3: Yeah, I think there would be some people who might believe either that they couldn't work because they wouldn't look at how severe the disability is, they would just say they have a disability and they are not worthy in a way of doing that.

WBFG2: 20: 32-34

P1: Yeah, a lot of people, lots of employers wouldn't be comfortable, and a lot of employers wouldn't be comfortable working in a workplace with people with disabilities because they are not as accepting.

WBFG2: 21: 1-3

P2: Because some people are brought up, like parents for example, like the way you are brought up, like people say they shouldn't be able to work, it's like peer pressure thing again, like if they get teased in the workplace or something then you feel pressurised to tease them as well or you're the one who doesn't.

WBFG2: 21: 17-20

P2: They say rude words, they're not nice but you know.....

I: you're too polite to say them?

P's: Yeah

P4: They should look in mirror themselves first.

P1: They are stupid.

WBFG3: 1: 25-29

P2: It's just there are a lot of idiots nowadays. It's just not how society is. People are just really bad towards them. Like in my area, it's awful, if you were to go down the road and you have any sort of problem, no matter what it is they'll take the piss out of you.

I: And why do you think that this?

P2: I don't know, they're idiots.

P3: It's because they are ignorant and they've had no proper guidance. Most things boil down to parental guidance and at the end of the day if you're going to sit there and your mum lets you do what you want to do then you are going to think that the only person who is going to stop me is my mother and if she can't stop me then no-one else can. At the end of the day, if people are put in situations, where you know where you like have bliss ignorance and you're not around disabled people or you're not related to, or friends with anyone who is disabled then as far as you are concerned then it's not going to happen to you. So you don't fully understand the situation or what it's like. Where like people who have been brought up with like parents who have been guiding them with morals, or know people who are disabled then they understand at the end of the day everyone has disabilities but at the end of the day we are the same, we've all got a heart, a face, a brain, we're the same, no-one is special, we've all got our flaws, but it's the way the we deal with and better our self from the flaws that makes the difference.

P2: Like when I told you about neighbour, the disabled one, he's got a little brother, he's 6 years old, but he would never go down the road with him, or shopping with him, because he's really embarrassed because once when he went to primary school the kids were always asking why is your brother like this and that so now he's really embarrassed [P4: why should he be?] I know he wouldn't go anywhere with him, nowhere with him.

P4: Like when I was in Portugal I used to go with my cousin because she can't be 24 hours in the home she has to go out and sometimes I used to go out with her and people would look at her and I don't like that, I just don't like it, they look at her like she's different, like she's not from the world.

P3: She's not a flipping pig in a sty, she's not an exhibition, and you don't stare at people.

P1: Inaudible.

P4: They used to make noises and laugh and I didn't like it. I think they should look in the mirror first.

WBFG3: 8-9: 31-21

P3: Yes because if they are seriously disabled then people might take the piss out of them and like take their money and [P1: absolutely] they'll just take their money and just make a laugh and a joke from it because some people are just nasty but erm if they do not have a high level disability but they have something like dyslexia or something like that then or you know why not let them go and do it give them some kind of erm [P4: credit] where they can do it for themselves. You don't know how much it means to them for them to be able to go to the shops to buy their own loaf of bread. It's like oh my god they have let me out to the shops on my own to buy my own loaf of bread and you know it means a lot to them people.

WBFG3: 13: 26-2

P3: Characteristics of people, like if they are arrogant and unfortunately there are a lot of very arrogant and ignorant people they're not going to, you know.

WBFG3: 14: 24-25

P4: (Pause) for me its definitely from my dad. He's told me like times when people he knows have been stolen from [ok] or they have been made to give their money to someone because they don't understand so I think that's really horrible [so that's personal knowledge?] yeah.

WBFG4: 7: 4-7

P4: Yeah and also like I think that it's fine and everything but I think that people should be watching out for their family members because people might want to take advantage again [ok] like people do and stuff [ok].

WBFG4: 10: 19-21

P2: I would probably say it might not be appropriate for Tom to have a relationship with someone who hasn't got disabilities because they might take advantage of him possibly but Simon I don't think he would have any problems [Mmm].

P3: I think it's alright for Tom to have a relationship with someone who doesn't have a learning disability [Mmm but you're more worried about him having a child maybe?] I don't know like I said it's a big issue [Mmm] but I think that most people you know are not going to take advantage of them.
P2: Yeah.

WBFG4: 10-11: 28-2

P4: I know some people who would probably say erm someone like Tom with Down's syndrome shouldn't have children [Mmm] or like I mean I don't think a lot of people would go as far as to say he shouldn't have a relationship but a lot of people would probably say its not fair for a child to have a father who maybe isn't even able. I don't know Simon, but or anybody with learning difficulties some people would say it's not fair [ok].

WBFG4: 11: 20-25

P1: Maybe like the boss would prefer someone who is all round who wouldn't have a problem doing something [Mmm] Yeah.

WBFG4: 12: 25-26

P8: Yeah there is loads of derogatory terms that people use but they are mean people.

WBFG5: 2: 2-3

P6: Yeah, I know some people who might...

P1: People who might have extreme religious tendencies...

P6: Carry on.

P1: Thinking about that they could like say stuff relating to spirits converting to a religion and no you haven't done this, saying stuff like Satan and you get the effects so we blame it on that it could not be possible.

P9: Punishment for parents [ok].

P7: Yeah, if they are deeply religious [yeah].

WBFG5: 3: 23-30

P6: Erm I think like we were saying before religion does have an effect if erm I don't know if they have strong religious beliefs like if parents have strong religious beliefs they might think that erm like if they thought it was a punishment then they would be more likely to keep it concealed from everyone else.

WBFG5: 7: 6-9

P9: I think maybe some people. I think again it's to do with religion say if they are. Religions believe it as a punishment and see it as something to be ashamed of, which isn't right but that's how they see it. So if they were kept separate then some people would see it like that's the right thing.

I: And when you are mentioning about religious ideas what types of religion are you thinking about?

P9: Erm I'm not very good at knowing the exact religions but I think some people would see it as a punishment and I think that was strong Christians mostly.

P5: Most of the religions probably.

Group: Yeah, yeah, yeah most religions.

P7: Unless you were severely devout like the extremist would probably believe that kind of thing.

WBFG5: 10: 12-23

Group: No, maybe just extremists (laughs). Yeah they might think they shouldn't be able to breed or something like that. Political extremists as well, yeah, yeah (laughs).

P4: Going back to the Nazi Party and stuff (all talking at once) (laughs).

P6: There is the British National Party which is quite Nazi views keeping pure bloodlines or whatever.

WBFG5: 13: 20-24

P3: The same as the other ones extremist people who hate people with learning disabilities and don't think they are capable of learning anything and think they won't be able to hold down a job. I don't know anyone like that so.

P1: Probably people like from history like the Nazis who didn't respect them because they were not pure enough to conform be the perfect normal human being [ok].

WBFG5: 15: 11-16