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Attitudinal Barriers to Rehabilitation

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The focus of this article is how attitudinal barriers influence our understanding of disability and therefore shape how we "manage" individuals with disabilities. Attitudes are habits of thought that are consistent over time, are complex and multidimensional (Eiser 1994). Barriers are obstacles that prevent people with disabilities from fully participating in society. Barriers can be physical, communication, programmatic, and social (Bryen et al. 1995). Attitudinal barriers, the focus of this article, refer to the fears and assumptions that prevent people with and without disabilities from meaningfully interaction with one another.

Attitudes are Multidimensional

Attitudes are composed of three interrelated dimensions of personality: emotions, cognition and behavior. Each dimension is a complex interplay of several factors. Looking at the cognitive dimension, an attitude is a view or opinion that a person has towards a certain state of existence, of an object, an idea, of another person, or of other people (Eiser 1994). In this dimension, attitudes can be overt and explicit or they can be hidden and implicit. Furthermore, a person can hold an implicit attitude that he knows or assumes is not socially acceptable and, for this reason, he may express overtly a completely opposite attitude (Eiser 1994). The person can be aware of this incongruence or he can be largely unaware of it.

The emotional dimension of attitudes is equally complex. Attitudes are frequently loaded with an emotional response. They can be positive, for example, happiness, pleasure, wanting to experience an event, be near the person, or get hold of the object of reference. Attitudes can also be negative, when a person feels he has a dislike towards a situation, object, or another person. In this case the person will likely feel unhappy, fearful, disgusted, sad, etc. The two dimensions of cognition and emotion may not always be congruent.

The third dimension of attitudes is a behavioral one. Here, too, human reactions are complex. Similar to the relationship between cognitive and emotional components of attitudes, there is not always congruence between our attitudes and our behavior. For example, an individual can have a positive attitude towards persons with disabilities and be likely to hire (behavior) a qualified job applicant (cognitive) with a disability. In this case there is congruence among emotion, cognition, and behavior. However, there can also be incongruence between expressed attitudes and actual behavior. For example, an

employer can express a positive attitude towards the employment of qualified persons with a disability, yet at the same time the employer has a long history of not hiring any job applicants with a disability regardless of their qualifications. The reason for this apparent incongruence between behavior (hiring a qualified person with a disability) and the expression of positive attitudes is that this employer may actually have deep-seated negative attitudes which the employer is either unaware of or is aware of but not willing to admit. In this situation, the implicit negative attitude is the real barrier to employment rather than the objective characteristics of the potential applicant with a disability. As Eiser (1994) describes it: "…ordinary language is inherently rhetorical. …it can be recruited to the service of contrary causes. That is, almost anything can be described in ways that make it sound good rather than bad, or bad rather than good. Abortion can be described as women exercising their right of choice or as the murder of unborn babies".

Incongruence between cognition, emotion and behavior can be the outcome of cultural norms. For example, one can express positive attitudes about the civil rights of persons with disabilities but at the same time refuse to have them live in a supported living arrangement in one's neighborhood. The argument used to explain this incongruence may appear to be unrelated to the disability but rather based on economic factors such as "it will lower the value of our houses". However, when refusing to support having a person with a disability "living next door" despite overall general democratic attitudes, the home owner reverts to economic rather than emotional reasons. Given that it may be is politically incorrect to express negative views regarding the rights of persons with disability to live in the community, the home owner expresses overall positive attitudes in general about persons with disabilities. These general views do not reflect true feelings about persons with disabilities but they do fit in with the current democratic values of western societies.

Similarly, school teachers can express positive attitudes, in general, towards educational inclusion but follow the practice of tracking students with disabilities into segregated special education settings, justifying their behavior by bringing forth a medical perspective. The medical view of disability is contrary to an inclusive model where the underlying principle is that any person with a disability is first and foremost a human being, albeit with a disability, which is a state of existence to be supported and accommodated rather than an illness to be cured. In such cases the incongruence between cognition, emotion and behavior is not felt by the individual as problematic since their behavior fits within societal norms.

Culture and Attitudes

Indeed, attitudes are a product of culture. We 'learn' to think, feel and behave in this rather complex and often incongruent manner. Furthermore, we learn that the same event, object or person can evoke different attitudes in different contexts. As stated by one of the graduates of the ACES - Augmentative Communication and Empowerment Supports program for people with little or no functional speech (Bryen et al. 1995), "until I got my voice output communication device, people were 'nice' to me in the same way they were nice to their pets. They fed me, dressed me, and took care of me, but didn't expect very much from me. However, when I got my communication device, they treated entirely

differently. Even though I was the same person with the same disabilities, people's attitudes and behaviors towards me changed significantly."

Culture is the basis of our values, beliefs, world view, and ways of understanding life. Based on these, we form, at a very early age, our attitudes. Language, which is the main vehicle of culture, is unique to human beings. Animals may have ways of communicating; however it is only human beings that are able to construct complex systems out of a limited number of abstract symbols. Language is the 'glue' that unites one group of people with each other and distinguishes it from another group. A common language enables a group of people to share their experiences; it provides them with a sense of identity and belongingness (Kramsch 1998).

Cultures, however, are not limited to the abstract linguistic and mathematical symbols. They also encompass the structure of society, social norms, social values, social institutions, human relationships and styles of communication. Cultures are also expressed in its artifacts - the everyday utensils people use, their technical instruments, artistic works, architecture, etc. Creativity and inventiveness and the creation of new forms in all aspects of life are the capacities on which cultures are formed. Thus, unlike the animal kingdom, culture is not genetic but rather socially transmitted from one generation to the next. Culture is not static. Instead, it is dynamic, ever changing (Tomaselo 1999).

We can summarize the definition of culture as the holistic framework of human societies which give them both a frame of reference and a source of guidelines for life experiences. Culture is the integrated pattern of human knowledge, beliefs and values, and behavior. It is the *set of shared attitudes*, values, goals and practices that characterizes an institution, organization or group.

Looking at culture in a holistic way we can see why attitudes are closely linked to social norms and structures, to the artifacts, and to the technical aids of a society. For example, the attitude towards persons with disabilities is exhibited in pictures, in movies, on television, in literature and other media. People with disabilities are depicted as objects of pity, as "useless eaters" and societal burdens, or as ordinary human beings. The way people with disabilities are depicted, simultaneously reflects and shapes the attitudes held by a particular society at any particular time in history. See for example, how people with disabilities were portrayed by the Third Reich in the early 1930s to begin to understand how more than 70,000 were killed during the Holocaust under the T4 Program (Cook, 2008).

Attitudes influence how a society prioritizes the distribution of its finite resources. If we view people with disabilities as sick or diseased, the investment in assistive technology to for independent or architectural accessibility in the community is limited. Rather we are more likely to invest in building segregated educational, rehabilitation centers or asylums. If, on the other hand, we view people with disabilities as equal members of our society, not only will we remove physical, programmatic, communication, and social barriers, we will also build new technologies, structures, and programs that are

responsive to the diversity of valued members of a society, including those with disabilities.

According to the International Classification of Functioning (ICF 2001) "attitudes are the observable consequences of customs, practices, ideologies, values, norms, factual beliefs and religious beliefs. These attitudes influence individual behavior and social life at all levels, from interpersonal relationships and community associations to political, economic and legal structures; for example, individual or societal attitudes about a person's trustworthiness and value as a human being that may motivate positive, honorific practices or negative and discriminatory practices (e.g. stigmatizing, stereotyping and marginalizing or neglect of the person)."

Attitudinal Barriers

When looking at attitudes as barriers to inclusion of persons with disabilities, two questions arise: First of all what is a 'barrier', and, secondly, when does an attitude become a barrier? A *barrier* is anything that blocks equitable access to goods, services, or information of a person or group of people. Barriers can be physical or programmatic. Physical and programmatic barriers are not due to the characteristics of the person or group of people but rather to the attitudes held by others towards that individual or group. Negative attitudes often result in denying basic human and civil rights afforded to other members of their community.

Negative attitudes, like any cultural artifact, are social constructs. As such these negative (or positive) attitudes can culturally create a persistent image of an individual and group often resulting in stigma (Goffman 1963). Stigma in turn can become a doubled edged barrier. On one hand, a society can create barriers to education, employment, independent living, access to goods and services, and even rehabilitation. On the other hand, when stigma is internalized by the person or group in question, they are at risk of accepting a lower status in society. A vicious cycle emerges when members of society view the person negatively and the person behaves according to societal expectations which in turn strengthen the stigma. This vicious cycle becomes a subtle but powerful barrier.

When society views disability as deviance, people with disabilities are often seen as deviant and harmful to society. Emotions attached to these negative images can be ones of disgust, alienation, or fear. The behavior associated with this view of disability can lead to segregation and denial of basic civil and human rights creating a major barrier to rehabilitation and access to goods and services in the community.

Similarly, when society views disability as imperfection, emotions attached to this image can be pity, compassion and mercy. Behaviors generating from view and its resultant emotions may lead to the development of asylums and “homes” where compassionate care is provided. Like the view of disability as deviance, this view can also result in the denial of basic civil and human rights, once again creating a major barrier to rehabilitation and access to participation in the community. In contrast, when the view of disability is based on disease and illness, emotions attached to this model can be similar

to emotions attached to cancer. There may be a combination of fear, pity, and hope - hope for a cure. Here we have the origins of the medical model of disability. Professionals try to cure the person with a disability. When functionally limited, the practice of trying to 'fix' the person, normalize their behaviour, or remediate the disorder to become more normalized might strengthen their categorization into a different group, mostly an inferior one (Reiter 1997)

Negative attitudes towards people with disabilities can result in barriers to rehabilitation. They can also have devastating effects on the development of the person affected. The following demonstrates this devastating effect on Americans with disabilities. According to Kilbery, Benshoff, and Rubin (1992), Americans with disabilities are more than twice as likely as their nondisabled peers to be poor (DeJong and Lifchez 1983; Harris and Associates 1986). Much of this poverty among Americans with disabilities can be attributed to insufficient employment opportunities. For example, in 1986 only 33% of citizens with disabilities between the ages of 16 and 64 were working, while two-thirds of those unemployed indicated an interest in working (Harris and Associates 1986). These statistics become even more negative when compounded with the reality that individuals with disabilities who are employed tend to earn substantially less than their nondisabled counterparts (Jackman 1983).

Insufficient or underemployment opportunities and consequent inadequate income can create a "shut-in" status for many persons with disabilities. Therefore, not surprisingly, Americans with disabilities are found to have significantly fewer opportunities than their nondisabled counterparts to participate in social activities, such as attendance at movies and sporting events, or even eating out in restaurants (Harris and Associates 1986). This situation is not unlike other countries (Albert 2007, Reiter 2008).

Attitudes towards people with disabilities, like many other aspects of culturally-defined attitudes, can change. Evidence of this is witnessed in the landmark international United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) in 2006. According to the UNCRPD, there has been a recent shift in expressed attitudes towards persons with disabilities. This attitudinal shift is expressed in a move from the view where Persons with disabilities are not viewed as "objects" of charity, medical treatment and social protection; rather as "subjects" with rights, who are capable of claiming those rights and making decisions for their lives based on their free and informed consent as well as being active members of society (UNCRPD 2006). Furthermore, the Convention gives universal recognition to the dignity of persons with disabilities. As such, culturally based attitudes of patronization and professionals as the only “experts” are no longer acceptable.

According to the UNCRPD (2006), persons with disabilities are:

- No longer an object to be fixed through medical treatment but a subject of rights with choices as to how he or she wants to live and what treatments, if any, he or she wishes to use.

- No longer objects of charity of social welfare - a burden on society - but active members of society with something to contribute to society

- Are entitled to avenues to defend rights (complaints mechanisms, rights advocacy etc) and to change society so that society becomes more enabling (UNCRPD 2006).

What does the UNCRPD mean for changing attitudes and the future of rehabilitation?

Given the changing views of persons with disabilities from regarding them as objects to viewing them as subjects with both rights and responsibilities, rehabilitation will likely adopt a new vision: supporting the empowerment of people with disabilities while at the same time re-educating the public. In turn, many attitudinal barriers as well as physical and programmatic barriers will diminish.

This change is reflected in Article 26 of the UNCRPD. Article 26, focusing on habilitation and rehabilitation provide the following international obligations:

> "States Parties shall take effective and appropriate measures, including through peer support, to enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life. To that end, States Parties shall organize, strengthen and extend comprehensive habilitation and rehabilitation services and programmes, particularly in the areas of health, employment, education and social services, in such a way that these services and programmes:
>
> (a) Begin at the earliest possible stage, and are based on the multidisciplinary assessment of individual needs and strengths;
>
> (b) Support participation and inclusion in the community and all aspects of society…. (UNCRPD 2010)".

Through participation and inclusion, the needs and concerns of persons with disabilities become clearer to professionals and to the general public. Furthermore, persons with disabilities will have the opportunity to raise issues and hold decision-makers accountable. Finally, through participation and inclusion, persons with disabilities will become more visible, and persons without disabilities will have the opportunity to learn and change negative attitudes which continue to be the real barriers to full participation and membership in their communities.

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