Attitudes of Occupational Therapy Personnel Toward Persons With Disabilities

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Key Words: attitude of health personnel • Down’s syndrome • ethics, professional

The study described in the following article investigated the attitudes of occupational therapy personnel toward persons with disabilities. The examination involved attitudes in general as measured by the Scale of Attitudes Toward Disabled Persons (SADP) (Antonak, 1981), specific attitudes toward infants with Down’s syndrome, beliefs concerning the importance of favorable attitudes toward patients, and beliefs concerning the role of the American Occupational Therapy Association (AOTA) in the development of ethical guidelines for the delivery of health care services.

The results of a survey of 619 occupational therapy personnel indicate that they hold a very favorable attitude toward persons with disabilities, and that they believe that a negative attitude would adversely affect the therapeutic relationship. The majority agree that the expression of a favorable attitude should be a criterion in student selection. The majority also agree that AOTA should develop position papers on ethical issues and take a public position on issues pertinent to the rights of the disabled person.

Occupational therapy personnel proved to be very homogeneous on the general attitudinal scale. However, the Down’s syndrome scenario uncovered significant differences among the different categories of respondents in the variables for professional level, area of practice, years of practice, and geographic location. A majority of respondents agreed that it is unethical to withhold needed surgery from a child because of disability. However, they differed on the ethics of aborting a fetus with Down’s syndrome (most thought it was unethical).

For more than 30 years researchers have investigated attitudes toward persons with disabilities. The literature reveals largely negative attitudes, tracing them to historical cultural values, the socialization process, childhood fears, and incidences of negative behavior by disabled individuals (Bender, 1981).

Those negative attitudes often shape the development of persons with disabilities and the roles they are allowed to assume in society. Of great importance are the attitudes of professionals involved in their rehabilitation. McDaniel (1969) suggests that the attitudes of professionals in rehabilitation are more important in determining the disabled person’s response to treatment than any other force. Health care professionals are the gatekeepers of both information and services. If the professional’s attitudes toward persons with disabilities are negative, the options or alternatives generated by the professional for such a person will be narrowed (Altman, 1981). This is demonstrated by a study of physicians (Todres, Krane, Howell, & Shannon, 1977) in which 51% of the pediatricians surveyed felt that a newborn with Down’s syndrome should not receive high-risk surgery, and by another study (Shaw, Randolph, & Manard, 1977), which found that two-thirds of the pediatric surgeons and more than one-third of the pediatricians surveyed would not have their own child receive surgery for an intestinal obstruction if the child had Down’s syndrome.

Do occupational therapy personnel share these unfavorable attitudes toward persons who are disabled? Although the literature does not single out occupational therapy personnel, several studies suggest that there are more negative attitudes among health care professionals in general than might be expected. Parallels have been found between general societal attitudes and those held by social workers (Begab, 1970; Belinkoff, 1960), counselors (Dufree, 1971), and physicians (Wolraich, 1982). It might be assumed that the attitudes of occupational therapists would be similar to those of other health care professionals.

Commentators on the profession, however, have traditionally assumed that persons who choose occupational therapy as a profession have a positive and caring attitude toward persons with disabilities. Yerxa and Sharrott (1986) state:

Occupational therapy’s founders perceived their patients as people for whom illness or disability constituted a challenge to their inborn adaptive capacities. Patients were conceptualized not as different from other people, but as people who had human needs in common with others and also needed to overcome unique challenges. This perspective placed the patient in the mainstream of humanity and within the universal human condition rather than in a diagnostic category or class. (p. 154)

The emphasis on caring is demonstrated by the theme of the 1980 American Occupational Therapy...
Association’s Annual Conference: Caring Is the Key. To have chosen caring for a conference theme in the throes of a technological health care revolution emphasizes its viability as an issue of the eighties in occupational therapy.

Occupational therapy personnel often contend that they are unique among health care practitioners because they look beyond the pathology and see the whole individual, recognizing and focusing on what is healthy about him or her. This implies an attitude that is positive—one that is respectful of the person with a disability.

Closely related to attitudes are the ethical foundations of the profession that those attitudes reflect. Occupational therapy literature relating to ethical issues, however, is scarce. With the explosion of contemporary health care issues and the inherent ethical dimensions of such issues, one would expect occupational therapy personnel to lead the way in formulating ethical guidelines for patient care, and the American Occupational Therapy Association to offer guidance to enable the membership to think critically about the issues.

In 1980, Yerxa put forth the argument that occupational therapists have an ethical responsibility to influence society and the medical profession in their perceptions of disabilities. Yerxa and Sharrott (1986) have argued that occupational therapy is a profession in crisis. A primary factor contributing to this crisis is the profession’s inability to achieve consensus regarding its ethical stance and its contribution to society.

The study described below investigated attitudes of occupational therapy personnel toward persons with disabilities. It examined both their general attitudes and their specific attitudes as applied to a case example. It also explored their beliefs concerning the importance of a favorable attitude in the therapeutic relationship, the importance of students’ attitudes as a criterion for selecting occupational therapy students, and the role of the American Occupational Therapy Association in the development of ethical guidelines for the delivery of health care services.

Method

Instrument

The survey consisted of four parts: (a) the Scale of Attitudes Toward Disabled Persons (SADP) (Antonak, 1981); (b) a scale of statements related to respondents’ beliefs; (c) a Down’s syndrome scenario, and (d) demographic information.

The SADP is a Likert format scale that measures attitudes toward disabled persons as a group. Scores range from 0, indicative of a very negative attitude, to 144, indicative of a very favorable attitude. The SADP is a psychometrically sound instrument: Reliability is .81; the alpha index of internal consistency is .88. It has strong content validity. The SADP is composed of three subscales: Optimism/Human Rights, Behavioral Misconceptions, and Pessimism/Hopelessness. The reliability indices of the subscales are .71, .55, and .61, respectively, and the internal consistency indices are .81, .77, and .82, respectively. Analysis of the three subscales indicates favorable results, suggesting that the items within each subscale are similar, that the subscales are reliable and specific, and that they are reasonably independent (Antonak, 1981).

The second part of the survey consisted of five statements pertaining to attitudes toward persons with disabilities and two statements regarding the role of the American Occupational Therapy Association in the development of ethical guidelines. The third part of the survey contained a scenario that described an ethical dilemma regarding a child with Down’s syndrome. A Likert format was used on the second and third parts of the survey. The categories were collapsed and the “no responses” were deleted from the analysis. The statements in the second and third parts of the survey were composed by the author. They were reviewed by peers and revised until judged to be clear, unbiased, and relevant. The final part of the survey contained demographic information: professional certification, household income, highest degree achieved, sex, years of practice, age, primary area of practice, and geographic location.

Subjects

Subjects included registered occupational therapists, certified occupational therapy assistants, and students in occupational therapy professional and technical programs who attended the AOTA Annual Conference held in Minneapolis in 1986. Of the 1,850 surveys distributed, 619 were used in the study. Surveys with four or more items omitted on the SADP were excluded from the analysis; this resulted in a response rate of 33%. The majority were female (94%), were from the Midwest (66.3%), and were occupational therapists (71.2%). Fifty-one percent had 6 or more years of experience. The mean household income range was $25,000 to $39,999; the mean educational achievement was at the baccalaureate level; and the mean age range was 30–39 years. The primary areas of practice indicated were: 24.4% physical disabilities, 20.2% pediatrics, 13.1% mental health, 8.7% gerontology, 8.1% administration, and 6.1% education. This sample appears to be representative of the occupational therapy membership according to the AOTA 1986 Member Data Survey (AOTA, 1987), which found that 94.6% members are female and have a baccalaureate degree (76.3%), have a mean age of 32 years and a mean income of $26,528. The geographic

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areas are approximately equal in their representation except for the larger percentage from the Midwest, which reflects the conference location in Minneapolis.

**Results**

**Scale of Attitudes Toward Disabled Persons (SADP)**

The results indicate that respondents have a very positive attitude toward the disabled. The mean score for the 619 respondents was 122.86 (SD = 11.89) with a slightly negative skew to the distribution of scores (skew = 1.05). The Tukey's Studentized Range test indicated that the only significant difference among the variables was in mean scores for the variable years of practice between categories 6 to 10 years (M = 120) and 16 or more years (M = 126) at F(5, 613) = 2.88, p < .05. This means that occupational therapy personnel with 16 or more years of practice had significantly more positive scores than those with 6 to 10 years of practice.

These results appear to be reliable. The value of the corrected Spearman-Brown split-half reliability coefficient (Spearman-Brown prophecy formula) was .81 (SD = 11.8). The coefficient of the standardized item alpha internal-consistency homogeneity index was .77.

The mean subscale scores were 33.7 (SD = 7.10), 36.4 (SD = 4.33), and 32.7 (SD = 3.56) for Subscales I, II, and III, respectively, indicating a very positive attitude on each subscale. The Tukey's Studentized Range (HSD) test showed a significant difference for Subscale I (Optimism/Human Rights) between the years of practice categories 6 to 10 years (M = 51.6) and 16 or more years (M = 55.6) at F(5, 613) = 4.10, p < .001, indicating that those with 6 to 10 years of practice were less optimistic than those with 16 or more years of practice.

**Beliefs About Attitudes**

The results for each statement are shown in Table 1. A Pearson correlation coefficient test indicated that the relationship between the subject's SADP score and the first three statements was significant at p < .001. Therefore, the beliefs about the importance of a positive attitude are highly correlated with the actual attitudes held by respondents as measured by the SADP. A chi-square analysis indicated that there were no significant differences between the expected outcomes and the actual outcomes for the variables for years of practice and area of practice. A significant difference (X^2 [8, N = 615] = 16.110, p < .04) was found among the professional levels for the statement regarding the responsibility of AOTA to take a public position on health care issues pertinent to persons with disabilities. The chi-square analysis approached significance (X^2 [8, N = 615] = 14.692, p < .06) among the professional levels for the statement about AOTA's role in the development of position papers on ethical issues. A significant difference (X^2 [12, N = 615] = 26.80, p < .05) was found in the variable for geographic location for the statement that there should be increased curricular emphasis on the ethical dimensions of health care.

**Down's Syndrome Scenario**

The results for each of the seven statements are presented in Table 2. A chi-square analysis (see Table 3) indicated that there were significant differences (p < .05) between the outcomes and expected outcomes for nearly all of the statements in the variables for

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**Table 1**

Beliefs About Attitudes and the Role of the American Occupational Therapy Association

<table>
<thead>
<tr>
<th>Statement</th>
<th>n</th>
<th>Mean</th>
<th>SD</th>
<th>Percent Responding</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The behavior of occupational therapists should reflect favorable attitudes toward the disabled.</td>
<td>617</td>
<td>4.74</td>
<td>.65</td>
<td>Agree</td>
</tr>
<tr>
<td>2. A negative attitude toward the disabled would adversely affect the ability of occupational therapists to function in a therapeutic manner.</td>
<td>616</td>
<td>4.65</td>
<td>.68</td>
<td>Agree</td>
</tr>
<tr>
<td>3. Most occupational therapy personnel hold favorable attitudes toward the disabled.</td>
<td>615</td>
<td>4.19</td>
<td>.72</td>
<td>Agree</td>
</tr>
<tr>
<td>4. One criterion in the selection of prospective occupational therapist students should be the expression of favorable attitudes toward the disabled.</td>
<td>616</td>
<td>3.99</td>
<td>.88</td>
<td>Agree</td>
</tr>
<tr>
<td>5. There should be increased emphasis in occupational therapist curricula on the ethical dimensions of health care issues.</td>
<td>615</td>
<td>4.12</td>
<td>.76</td>
<td>Agree</td>
</tr>
<tr>
<td>6. AOTA should take a public position on health care issues pertinent to the rights of the disabled person.</td>
<td>615</td>
<td>4.37</td>
<td>.70</td>
<td>Agree</td>
</tr>
<tr>
<td>7. AOTA should develop position papers which examine the ethical issues pertinent to the delivery of health care services for the disabled.</td>
<td>613</td>
<td>4.18</td>
<td>.76</td>
<td>Agree</td>
</tr>
</tbody>
</table>

*Note: Likert scale was collapsed for percentage scores. Mean of 5 = strongly agree.*

*Number varies because not everyone responded to each question.*
Table 2
Mean and Percent Scores on Down's Syndrome Scenario

<table>
<thead>
<tr>
<th>Statement</th>
<th>n</th>
<th>Mean</th>
<th>SD</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. It is unethical to deny the needed surgery for this infant because he is disabled.</td>
<td>609</td>
<td>4.06</td>
<td>1.21</td>
<td>13.0</td>
<td>10.8</td>
<td>76.2</td>
</tr>
<tr>
<td>2. Allowing this child to die because he is disabled constitutes a threat to society's tolerance of disabled persons.</td>
<td>607</td>
<td>3.98</td>
<td>1.12</td>
<td>14.2</td>
<td>12.4</td>
<td>73.4</td>
</tr>
<tr>
<td>3. A society that allows an infant to die because he is disabled demonstrates an intolerance for persons with disabilities.</td>
<td>604</td>
<td>3.78</td>
<td>1.18</td>
<td>19.8</td>
<td>12.3</td>
<td>67.8</td>
</tr>
<tr>
<td>4. It is ethically proper to abort a fetus if Down's syndrome is diagnosed.</td>
<td>608</td>
<td>2.57</td>
<td>1.30</td>
<td>46.6</td>
<td>27.0</td>
<td>26.7</td>
</tr>
<tr>
<td>5. If the above scenario were slightly changed in that the infant had a congenital amputation of the upper extremity instead of Down's syndrome, the decision to allow the child to starve would have been unethical.</td>
<td>596</td>
<td>4.16</td>
<td>1.14</td>
<td>10.7</td>
<td>9.7</td>
<td>79.6</td>
</tr>
<tr>
<td>Assume that the occupational therapist who works in the high-risk nursery becomes aware of this situation prior to the infant's death. The occupational therapist should:</td>
<td>554</td>
<td>3.25</td>
<td>1.18</td>
<td>26.9</td>
<td>30.9</td>
<td>42.3</td>
</tr>
<tr>
<td>6. Notify the authorities in order to reverse the parents' decision.</td>
<td>554</td>
<td>3.25</td>
<td>1.18</td>
<td>26.9</td>
<td>30.9</td>
<td>42.3</td>
</tr>
<tr>
<td>7. Respect the decision not to perform the surgery as per the parents' wishes and do nothing.</td>
<td>537</td>
<td>2.70</td>
<td>1.20</td>
<td>45.5</td>
<td>27.4</td>
<td>27.3</td>
</tr>
</tbody>
</table>

Note. Likert scale was collapsed for percentage scores. Mean of 5 = strongly agree.
Number varies because not everyone responded to each question.

Table 3
Chi-Square for Variables on Down's Syndrome Scenario Statements

<table>
<thead>
<tr>
<th>Statements</th>
<th>Professional Certification</th>
<th>Years of Practice</th>
<th>Area of Practice</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. It is unethical to deny the needed surgery for this infant because he is disabled.</td>
<td>18.25 .019*</td>
<td>38.59 .007**</td>
<td>40.59 .058</td>
<td>27.85 .006*</td>
</tr>
<tr>
<td>2. Allowing this child to die because he is disabled constitutes a threat to society's tolerance of disabled persons.</td>
<td>22.03 .005**</td>
<td>34.06 .026*</td>
<td>26.04 .571</td>
<td>27.30 .007*</td>
</tr>
<tr>
<td>3. A society that allows an infant to die because he is disabled demonstrates an intolerance for persons with disabilities.</td>
<td>26.51 .001**</td>
<td>32.83 .035*</td>
<td>52.67 .005**</td>
<td>25.35 .013*</td>
</tr>
<tr>
<td>4. It is ethically proper to abort a fetus if Down's syndrome is diagnosed.</td>
<td>15.43 .051</td>
<td>49.78 .000**</td>
<td>39.87 .068</td>
<td>37.04 .0001*</td>
</tr>
<tr>
<td>5. If the above scenario were slightly changed in that the infant had a congenital amputation of the upper extremity instead of Down's syndrome, the decision to allow the child to starve would have been unethical.</td>
<td>11.15 .193</td>
<td>26.96 .136</td>
<td>41.68 .046*</td>
<td>3.231 .994</td>
</tr>
<tr>
<td>Assume that the occupational therapist who works in the high-risk nursery becomes aware of this situation prior to the infant's death. The occupational therapist should:</td>
<td>26.04 .001**</td>
<td>40.07 .005**</td>
<td>39.68 .070</td>
<td>23.21 .026*</td>
</tr>
<tr>
<td>6. Notify the authorities in order to reverse the parents' decision.</td>
<td>31.83 .000**</td>
<td>52.04 .000**</td>
<td>52.86 .003**</td>
<td>18.39 .104</td>
</tr>
<tr>
<td>7. Respect the decision not to perform the surgery as per the parents' wishes and do nothing.</td>
<td>31.83 .000**</td>
<td>52.04 .000**</td>
<td>52.86 .003**</td>
<td>18.39 .104</td>
</tr>
</tbody>
</table>

* df = 8. ** df = 20. *** df = 28. * p < .05. ** p < .01.
favorable attitudes toward persons with disabilities. There were no significant differences among the variables for professional level, area of practice, or geographic location. The only difference was found in the years-of-practice variable. Students and practicing personnel with up to 5 years of practice have favorable attitudes. Positiveness declines at 6 to 10 years and more favorable attitudes resume with 11 plus years of experience. This information raises new questions. Are those who have had 6 to 10 years of professional experience typically disillusioned and less optimistic about clients? Do the more positive attitudes beginning at 11 years reflect attrition, or a readjustment of attitudes?

Also, why do beginning practitioners of occupational therapy express the same favorable attitudes seen in students? Other professional fields have reported a decrease in positive attitudes as students begin clinical practice. Perhaps the answer is that occupational therapists avoid early disillusionment because as students they have gained experience in Levels I and II fieldwork placements and already are aware of the realities of practice.

Occupational therapy subjects clearly do not follow the trend seen in the studies cited above, which suggest that the attitudes of health care professionals and the general public are similarly negative. The difference could be attributable to the profession's emphasis on the intrinsic worth of each person with a disability. However, other effects could have influenced the high positive scores. The "halo effect" might have caused perceptions and attitudes to be overly favorable. The respondents may have responded in a manner they perceived as socially acceptable. Or perhaps the scale does not distinguish between a favorable attitude and one that is patronizing.

Other factors that may foster a positive attitude toward persons with disabilities are education beyond high school, female gender, and amount of contact with such persons (Yuker, Block, & Young, 1966). These factors certainly apply to occupational therapy personnel.

Another explanation for the favorable attitudes could be the setting in which the survey was conducted. Possibly the results were influenced by the conference environment. It may be easier to feel favorable when enjoying a respite from the day-to-day work environment. One could also argue that those who attend a conference are likely to be more enthusiastic about their work than those who do not.

Beliefs About Attitudes and the Role of AOTA

Consistent with the favorable attitudes toward persons with disabilities expressed in the SADP is the subjects' belief that occupational therapists should have only a positive attitude toward their patients. The study showed that those surveyed believe that therapists' behavior is influenced by their attitudes and that a negative attitude would adversely affect the therapists' ability to function. The majority also believe that prospective students should demonstrate a favorable attitude and, in fact, that the expression of a favorable attitude should be one criterion in the selection of students. Although not significantly different, the mean scores for attitude on the SADP were higher for students than for occupational therapists and certified occupational therapy assistants. Does this mean prospective students already have favorable attitudes or that favorable attitudes are developed during their course of study? Do requirements that students have volunteer experiences subtly screen out students who have negative attitudes toward persons with disabilities?

There is a strongly perceived need for direction from AOTA on ethical issues pertinent to the delivery of health care services. The majority agree that AOTA should take public positions and develop position papers on ethical issues, although opinions on these issues divide among professional levels. Certified occupational therapy assistant respondents were less likely than registered occupational therapist respondents to feel the need for directions from AOTA on ethical issues. These different attitudes may reflect the differences in decision-making responsibilities between therapists and assistants. Therapists may be more likely than assistants to be faced with decisions concerning ethical issues such as allocation of resources or client and program selection.

Overall, respondents were strongly in favor of an increased emphasis on health care ethics in occupational therapy curricula, in AOTA publications, and in AOTA's public advocacy for persons with disabilities.

Down's Syndrome Scenario

There is a significant correlation between a favorable attitude on the SADP and an agree response to the statements on Down's syndrome scenario (except for Statement 4). This correlation can be interpreted to mean that to believe it is unethical to deny needed surgery to a child with a disability indicates a favorable attitude. The majority of respondents also agreed that such an action suggests a negative disposition toward persons with disabilities.

The results of this survey further indicate that there is some uncertainty among occupational therapy personnel about the ethics of abortion when a prenatal diagnosis of Down's syndrome is made, even though a near majority agreed that such an abortion would be unethical.
Respondents also disagreed about the action to take if a child with Down’s syndrome was being starved to death rather than receiving surgery to correct an intestinal blockage, although a near majority agreed that some action should be taken to reverse the decision. These findings suggest that a positive attitude toward the disabled more closely approximates an ethical stance opposing the denial of a lifesaving treatment than an ethical stance opposing the abortion of a disabled child.

Although there was little difference among the different categories of respondents in the variables on the SADP, there are significant differences in the variables for professional certification, years of practice, area of practice, and geographic location in the Down’s syndrome scenario. An examination of the results suggests two trends in the data: Occupational therapist subjects seem to be different from certified occupational therapy assistant subjects and student subjects in that those who disagreed with the statements (except for Statement 4) were more likely to be occupational therapists. It also appears that the more years of experience the subjects had had, the more likely they were to disagree with the statements. If the assumption is valid that a favorable attitude is related to agree responses on the scenario, then it would seem that occupational therapist subjects and those with more years of experience have less favorable attitudes than others surveyed. Students were the most likely to agree with the statements. This raises questions about the influence of education and experience on attitudes toward persons with disabilities.

The results of this study suggest that as a group occupational therapy personnel are very much in agreement with regard to a favorable attitude when applied to a general, nonspecific population of persons with disabilities. This homogeneity, however, is not observed in a specific case example. This finding reinforces the perceived need for position papers and opportunities for the membership to think critically about specific ethical issues.

Conclusion

This study has shown not only that occupational therapy personnel hold very favorable attitudes toward persons with disabilities, but also that they believe it is important to do so. There was less unity among occupational therapy personnel regarding a specific case application of these beliefs. This finding suggests that although occupational therapy personnel are in general very favorably disposed toward persons with disabilities, there is a lack of clarity about ethical applications. To remedy this situation, AOTA should offer direction to the membership on ethical issues pertinent to health care.

The study has raised questions for further investigation. For example: Are the attitudes expressed truly favorable, or could other influences like social acceptability or the “halo effect” have caused those surveyed to respond positively to statements on the SADP? Should prospective students be screened for favorable attitudes, or should their education include the formation of favorable attitudes toward those with a disability? Does a negative attitude adversely affect behavior and, therefore, the therapeutic relationship? On what ethical issues would the membership like position papers from AOTA? What emphasis is now being placed on the ethical dimensions of issues in health care in occupational therapy curricula? What would be the response from occupational therapy personnel to other case examples? Why are there significant differences in variables such as professional level and years of practice for the statements in the Down’s syndrome scenario? All these questions should be addressed in further studies.

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