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The Measurement of Beliefs, Attitudes, and Roles Related to Disability in a Sample of Rehabilitation Professionals and Clients

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THE MEASUREMENT OF BELIEFS, ATTITUDES, AND ROLES RELATED TO DISABILITY IN A SAMPLE OF REHABILITATION PROFESSIONALS AND CLIENTS

A Dissertation
Submitted to the School of Graduate Studies and Research
in Partial Fulfillment of the
Requirements for the Degree
Doctor of Philosophy

Melissa Murray
Indiana University of Pennsylvania
December 2010

Indiana University of Pennsylvania
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Title: The Measurement of Beliefs, Attitudes, and Roles Related to Disability in a Sample of Rehabilitation Professionals and Clients

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Clients with disabilities participating in vocational rehabilitation services and vocational rehabilitation professionals providing services have each developed unique disability beliefs, attitudes, and roles as a result of their personal experiences, established values, and societal interactions. Identifying the beliefs, attitudes, and roles related to disability among clients and professionals may help improve client-professional relationships.

My dissertation research measured the beliefs, attitudes, and roles of 53 clients with disabilities receiving services at the Hiram G. Andrews Center, located in Johnstown, PA and 328 professionals employed at six of the eight rehabilitation centers in the United States. Professionals' beliefs, attitudes, and roles related to disability were measured using a modified version of Darling and Heckert's Questionnaire on Disability Identity and Opportunity. Clients' pre and post beliefs, attitudes, and roles related to disability were measured using Darling and Heckert's Questionnaire on Disability Identity and Opportunity.

The results support the use of Darling and Heckert's Questionnaire on Disability Identity and Opportunity as an instrument in determining clients' and professionals' agreement with the particular variables of pride, exclusion, social model, and medical model. The results also support that agreement with the variables can be indicators of clients' and professionals' beliefs, attitudes, and roles related to disability.

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CHAPTER ONE

INTRODUCTION

Beliefs, Attitudes, and Roles

Clients with disabilities participating in vocational rehabilitation services and vocational rehabilitation professionals providing services have each developed unique disability beliefs, attitudes, and roles as a result of their personal experiences, established values, and societal interactions. This research will examine how Darling and Heckert's (in press) disability orientation components of identity, model, and role and related variables contribute to effective client-professional relationships. Specifically, this research will examine clients' and professionals' "beliefs" towards identity (pride versus stigma/shame) and their agreement towards disability pride or shame and stigma. Secondly, this research will examine clients' and professionals' "attitude" towards model (medical versus social) and their agreement towards medical or social model treatment approaches. Thirdly, this research will examine clients' and professionals' "role" and associated behaviors and assumptions that clients or professionals will assume a passive or active role in the vocational rehabilitation process.

A client or professional's position with regard to their beliefs, attitudes, and roles as related to the components of identity (pride versus stigma/shame), model (medical versus social), or role (activism versus passivity) may influence the client-professional relationship. For example, clients' and professionals' differences in any one, two, or all three of the components identified by Darling and Heckert (in press) can lead to misunderstanding from the beginning of the client-professional relationship that can be sustained throughout the rehabilitation process. For example, professionals may recommend services that are not what the client wants or needs. Likewise, clients may accept a rehabilitation service under the assumption the professional knows what is best. Upon program entry the rehabilitation client and the rehabilitation professional may be closely aligned or vastly apart in disability beliefs, attitudes, and roles related to disability due to pre-existing ideas based on experiences interacting in society.

Darling and Heckert Research

Disability Orientation Components

Research conducted by Darling and Heckert (in press) has shown that disability orientation includes the components of identity, model, and role. According to Darling and Heckert, the first component, identity includes the notion that disability can be viewed with pride versus stigma/shame. The second component includes the medical and social models. The medical model views disability as inherent in the individual, versus the social model, which views disability as a social construction. The third component, role includes associated behaviors. For example, individuals with disabilities will either assume a passive or active role in disability rights movements.

Questionnaire on Disability Identity and Opportunity (QDIO)

Darling and Heckert's (in press) research on disability orientation has operationalized the concepts of disability orientation and disability identity. Specifically, their Questionnaire on Disability Identity and Opportunity (QDIO) quantifies disability orientations. Putnam (2005) states that furthering the body of disability identity knowledge will be accomplished through empirical investigation. Darling and Heckert's development of a measurement instrument for research contributes to quantitatively measuring individuals' disability orientation and related variables of pride, exclusion, social model, and medical model.

Darling and Heckert Pilot Study

Darling and Heckert (in press) conducted a pilot study using the Questionnaire on Disability Orientation and Opportunity (QDIO), an instrument they developed to measure the components of identity (pride versus stigma/shame), model (social versus medical), and role (active versus passive). Darling and Heckert administered the QDIO to an American sample of individuals with disabilities (n=388) associated with either four Centers for Independent Living, a social club, two assistance programs, a posting on a disability website, and an Internet listserv. In addition, Darling and Heckert's sample consisted of individuals with disabilities receiving services at the Hiram G. Andrews Center; however, I do not know the exact number of individuals that participated from the rehabilitation center. My study also included a sample of individuals from the Hiram G. Andrews Center, along with a sample of professionals and staffs from six rehabilitation center. Although the Darling and Heckert original study included a sample from the Hiram G. Andrews Center, their study also included individuals with disabilities from various organizations and resources. My study is different in that although the Hiram G. Andrews Center has been in operation for over 50 years, to the best of my knowledge a study that focuses on measuring both clients’ and professionals' beliefs, attitudes, and roles related to disability has never been conducted. My study also differs from Darling and Heckert's original study in that my sample was open only to clients who were receiving services for the first time at the Hiram G. Andrews Center, while Darling and Heckert's sample was open to all clients. Moreover, my study includes pre and post test measures of a sample of clients receiving services for the first time while the Darling and Heckert study did not.

Four subscales. Darling and Heckert (in press) reported the following four subscales: Disability pride; Exclusion + dissatisfaction; Social model; and Personal/medical model. After computing the mean subscale scores for the four factors, Darling and Heckert reported that high scores reflected agreement with each of the factors. Darling and Heckert (in press) concluded that their pilot research supports the use of the QDIO in understanding disability orientations that appear to include all three of the components of identity, model, and role.

Dissertation Research

This research expands on Darling and Heckert's findings and their recommendations for future research in attempting to validate the QDIO. I use a small sample of first time clients and a large sample of professionals to determine their agreement with the particular variables of pride, exclusion, social model, and medical model. It is my contention that more or less agreement with the variables can be an indicator of clients' and professionals' beliefs, attitudes, and roles related to disability.

In order to conduct research on the disability beliefs, attitudes, and roles as related to disability of clients who are receiving services from professionals employed at comprehensive rehabilitation centers, it is important to first determine the beliefs, attitudes, and roles related to disability of rehabilitation professionals. Therefore, the research was conducted in two parts, Phase 1, Professionals and Phase 2, Clients.

Research Objective I, Professionals

This research examined professionals and staff employed at six of the eight rehabilitation centers in the United States. Darling and Heckert’s (in press) QDIO was modified slightly for use with professionals (See Appendix B, QDIO-P) to determine if the QDIO-P (modified) will factor analyze the same or similar as they did for clients (Darling and Heckert, in press).

A convenience sample of professionals employed at six of the eight State operated comprehensive rehabilitation centers located in the United States were selected to participate in the study. All eight centers were invited to participate; administrators for two chose not to. Participants included rehabilitation professionals and staff who volunteered to participate in the study. I administered the QDIO-P questionnaire to professionals who provide direct services to clients or who supervise employees that provide direct services to clients receiving services at the six State operated comprehensive rehabilitation centers.

Research with the professional sample examined if the QDIO-P would factor analyze the same as in the Darling and Heckert study. Specifically, my research examined if the same four scales (Disability pride; Exclusion + dissatisfaction; Social model; and Personal/medical model) would emerge with the professional sample as occurred in the Darling and Heckert pilot study with individuals with disabilities.

Research Environment

Comprehensive rehabilitation centers. State operated rehabilitation centers provide clients with disabilities with comprehensive services that assist with obtaining employment and independent living. For example, most rehabilitation centers provide vocational, educational, medical, psychological evaluation, counseling, training, and job placement services (Rubin and Roessler, 1995) and offer residential living. The main purpose of a rehabilitation center is to centralize rehabilitation services that allow clients direct access to a multitude of rehabilitation professionals (Rubin and Roessler). Within the center, a client can receive concurrent services from various professionals ranging from evaluation, vocational, counseling and guidance, medical and psychological services, educational training, independent living skills, and job placement.

Study sites. The study sites included six centers in the Consortium of State Operated Comprehensive Rehabilitation Centers:

- Hiram G. Andrews Center, Pennsylvania
- Carl D. Perkins Comprehensive Rehabilitation Center, Kentucky
- Workforce and Technology Center, Maryland
- Roosevelt Warm Springs Institute for Rehabilitation, Georgia
- Tennessee Rehabilitation Center
- Woodrow Wilson Rehabilitation Center, Virginia

The Consortium of State Operated Rehabilitation Centers cites their mission in part is to "promote the value of State operated, comprehensive rehabilitation centers in America" (www.ncsocrc.org/vvmiss.htm, retrieved April 10, 2007). Annually, the Consortium reports that over 20,000 individuals with disabilities participate in rehabilitation services at any one of the nine centers, with 2,600 professional and supportive employees providing the services. When the information on employees was retrieved, there were nine comprehensive rehabilitation centers in operation; however, one Center (West Virginia) closed by the time of my study. Two other centers chose not to participate.

Research Objective II, Clients

This research examined clients with disabilities who are receiving services at the Hiram G. Andrews Center, located in Johnstown, PA. Pre and post test QDIO (See Appendix A, QDIO) was administered to clients to determine if clients' scores on Darling and Heckert's (in press) four subscales disability pride, exclusion, social model, and medical model would be significantly higher or lower relative to the variable at post test than at pre test. It was hypothesized that higher or lower scores on the four subscales would indicate if clients' post test scores changed as a result of exposure to rehabilitation professionals and rehabilitation services.

A convenience sample of clients receiving services for the first time from the Hiram G. Andrews Center was selected to participate in this study. In Phase 2, I administered pre and post test QDIO questionnaire to clients receiving services at the Hiram G. Andrews Center. The client data were analyzed to determine whether clients' beliefs, attitudes, and roles related to disability change over the course of a semester as a result of exposure to rehabilitation professionals and services. For example, this research examined if over the course of one semester, clients would be socialized more towards rehabilitation professionals' beliefs, attitudes, and roles related to disability.

Study Site

Hiram G. Andrews Center. The Hiram G. Andrews Center, located in Johnstown, Pennsylvania is a State operated comprehensive rehabilitation center. Hiram G. Andrews Center provides vocational, rehabilitation, and education services to individuals with disabilities. Hiram G. Andrews Center is part of Pennsylvania's Department of Labor and Industry. Functioning under the Office of Vocational Rehabilitation, the Hiram G. Andrews Center is an entity under the Bureau of Rehabilitation Center Operations. Individuals with disabilities are referred to the Center by Vocational Rehabilitation Counselors who are headquartered at one of Pennsylvania's Offices of Vocational Rehabilitation. Clients must apply for vocational rehabilitation services and, after eligibility determination, receive services based on the federal order of priority, with the "most significantly disabled" receiving services first.

Mission, goals, and objectives. The Center's mission is to provide comprehensive rehabilitation services that lead to increased employment opportunities and independent living skills (Hiram G. Andrews Center Catalog, 2007). Available comprehensive services include vocational evaluation, counseling, therapeutic recreation, allied health and educational training programs. Individuals with disabilities participate in one or more services with the goal of developing or enhancing independent living and employment skills that increase the likelihood of obtaining entry-level employment.

Purpose of the Research

The purpose of measuring beliefs, attitudes, and roles as related to disability is to help clients' and professionals' increase self-awareness of their own strengths and limitations. For example, if a professional maintains the belief that clients are passive participants in the rehabilitation process, they may apply the same rehabilitation modalities to all clients. Similarly, if a client maintains the attitude that the social model is more effective they may be less likely to accept helpful medical interventions. Additionally, this research is unique in that it is one of few studies attempting to quantify both vocational rehabilitation clients’ and professionals’ beliefs, attitudes, and roles for the purpose of emphasizing how they might affect client-professionals' relationships.

Practical Application

The findings of this research have practical applications for both clients and professionals. For example, if professionals had access to clients' QDIO scores, they would gain awareness of the clients' beliefs, attitudes, and roles related to disability. This is important in that it can take weeks or months to establish rapport in a client-professional relationship; beliefs, attitudes, and roles related to disability may or may not be disclosed during this time period. Awareness of clients' beliefs, attitudes, and roles related to disability may help with establishing rapport sooner, which is exceedingly important in the current time of reduced funding for vocational rehabilitation, expansive counselor case loads, and limitations in time for clients and professionals.

If professionals were aware of their own beliefs, attitudes, and roles related to disability, they may be able to recognize personal limitations when providing services. Moreover, if professionals, such as vocational rehabilitation supervisors had access to the QDIO-P scores of the professionals they supervise, they could implement strengths and limitations into performance reviews. Specifically, supervisors could discuss limitations and make recommendations for specific professional development.

Administering the QDIO to clients and the QDIO-P to professionals could be assumed within vocational evaluation departments at the six comprehensive rehabilitation centers. The role of the vocational evaluation department at a comprehensive rehabilitation center is to provide evaluative services to clients. Therefore, the QDIO could easily be introduced as an additional measurement instrument that is used in connection with standardized intellectual and academic achievement testing. Likewise, vocational rehabilitation professionals could be provided with the QDIO-P through the vocational evaluation departments where they are employed.

Employment for Individuals with Disabilities

This research is important given the significant amount of state and federal funding allotted for providing vocational rehabilitation services with the specific purpose of preparing individuals with disabilities to enter into employment. While it is not my intent to assess employment outcomes for individuals receiving services at a comprehensive rehabilitation center, it is important to include an overview of employment statistics for individuals with disabilities.

Rehabilitation Legislation

For the past 80 years, rehabilitation legislation in the United States has provided individuals with disabilities with vocational and educational services to assist with obtaining employment and acquiring self-sufficiency skills (Jenkins et al., as cited in Szymanski and Parker, 1996). As stated above, part of the Hiram G. Andrews Center's mission is to provide comprehensive rehabilitation services that lead to increased employment opportunities (Hiram G. Andrews Center Catalog, 2007) for individual with disabilities.

Employment gap. Employment is an integral part of social inclusion for individuals with and without disabilities and provides for the opportunity to become self-sufficient (Disability Status Report, 2007). The employment gap between individuals with and without disabilities is significant. In the United States in 2006, only 37.7% of working-age individuals (ages 21 to 64) with disabilities were employed versus 79.7% of individuals without disabilities (Disability Status Report, 2007). The 42% employment gap between individuals with and without disabilities is reflected in decreases in household income and annual labor earnings, and increases in poverty rates for individuals with disabilities (Disability Status Report, 2007). This unequal distribution of earnings impinges on individual identity, socioeconomic status, and ability to participate equally in society.

Development of Beliefs, Attitudes and Roles

In chapter two I will provide a review of the literature regarding the development of clients' and professionals' beliefs, attitudes, and roles related to disability. For example, clients' and professionals' each have been exposed to different personal experiences and societal interactions. Based on those individual exposures and experiences, they have developed unique disability beliefs, attitudes, and roles as related to disability.

Professionals' Experiences

Professionals are exposed to formalized training programs that may emphasize the medical model versus the social model. Helping professionals are also exposed to multiple treatment approaches as a result of formalized educational training programs. For example, some formalized training programs emphasize psychodynamic theories, while others focus on cognitive-behavioral approaches. Professionals’ develop unique beliefs, attitudes, and roles related to disability as a result of socialization into bureaucracies such as those governing state operated comprehensive rehabilitation centers. The organizational cultures at each of the six study sites may also help define the professionals' role in the vocational rehabilitation process. In other words, some centers may be more oriented toward the medical model. Other centers may view clients' as more active participants in their vocational rehabilitation and expectations for achievement may be higher. Finally, professionals tend to have greater occupational prestige and be of higher socioeconomic status than other members in society. Because of their occupation and economic independence, they are more likely to identify with the dominant culture that views clients with disabilities negatively and as non-contributors to society. Each of these experiences contributes to the development of professionals' beliefs, attitudes, and roles related to disability.

Clients' Experiences

Similar to professionals, clients enter into vocational rehabilitation programs with deeply ingrained predispositions based on their personal experiences and societal interactions. For example, the age at which a client acquired his or her disability may impact the clients' beliefs, attitudes, and roles related to disability. A child with a disability typically forms professional relationships when he/she is very young. On the other hand, adult client-professional relationships can be challenging for clients with a newly acquired disability. The attitudes of clients with a recently acquired disability can be the determining factor for their successful rehabilitation (Larner, 2005). Similar to professionals, clients involved with rehabilitation services have also been socialized into organizational cultures of bureaucracies and government agencies.

To summarize, rehabilitation professionals' and clients' both have developed unique beliefs, attitudes, and roles as a result of their personal experiences, established values, and societal interaction. To examine professionals' and clients' beliefs, attitudes, and roles, the next section will address the questions to be answered by this research.

Research Questions

This research will examine the following research questions:

Research objective I, professionals. Will the 30 disability items on the QDIO-P (modified) factor analyze the same or similar as they did for clients in the Darling and Heckert study?

For example, given professionals training in the medical model and their view of clients as passive participants in the rehabilitation, I predict higher scores for the variables exclusion and the medical model, and lower scores for the variables pride and social model.

Research objective II, clients. 1) Will the 30 disability items on the QDIO factor analyze the same with the current population of clients receiving services at the Hiram G. Andrews Center as it did in Darling and Heckert's original study?

2) Will clients' scores on disability pride, exclusion, social model, and medical model be significantly higher or lower at post test than at pre test? For example, based on clients' beliefs, attitudes, and roles related to disability prior to entering (pre) the Hiram G. Andrews Center, I predict clients' score will be higher or lower (direction to be discussed in Chapter Three) depending on the variable as a result of exposure (post) to rehabilitation professionals, services, and peers with disabilities.

Researcher's Positionality

For the past 18 years I have been associated with individuals with disabilities either through volunteer services, formalized education, or employment. Likewise, as a professional, I have been a provider of vocational rehabilitation services as a former vocational rehabilitation counselor for the Office of Vocational Rehabilitation and later as part of administration as a vocational rehabilitation specialist at the Hiram G. Andrews Center. Both experiences afforded significant opportunities to interact with individuals with disabilities and form client-professional relationships. This research will be reported in an academic voice; however, due to my passion and experiences with individuals with disabilities I will at times provide insight spoken from experience as a vocational rehabilitation professional. I include these examples in this research because they helped me recognize the need for an instrument that would help clients and professionals increase self-awareness of their own beliefs, attitudes, and roles related to disability.

The next chapter will discuss the concept of disability orientation in relationship to beliefs, attitudes, and roles related to disability, which includes the components of identity, model, and role, and the related concept of inclusion/exclusion.

CHAPTER TWO

LITERATURE REVIEW

The Concept of Disability Orientation

In Relation to Beliefs, Attitudes, and Roles

This section of my dissertation will review the literature on professionals' and clients' disability orientations in relationship to beliefs, attitudes, and roles related to disability. I will discuss Darling and Heckert's (in press) research and their concept of disability orientation, and will include a discussion on the use of Darling and Heckert's Questionnaire on Disability Identity and Opportunity (QDIO) in assessing disability orientations. Finally, I will discuss how my dissertation research will expand on Darling and Heckert's findings and their recommendations for future research in attempting to test the QDIO with two samples, clients and professionals, in determining their beliefs, attitudes, and roles as related to disability.

Darling and Heckert’s (in press) research is guided by orientation toward disability. They state that disability identity, the subject of previous research, is similar to disability orientation but is a narrower concept (see, e.g. Gill, 1997; Putnam, 2005, as cited in Darling and Heckert). For example, Gill (1997) has shown types of integration, and intrapsychic, interpersonal and social dynamics that occur during disability identity development. Putnam (2005) has shown the relationship between individuals' disability identity and amount of political disability activism. Hahn's (1994) minority group model of disability provides a foundation of disability identity theory and has shown the relationship between the individual with a disability and society, rather than the disability and the individual (as cited in Putnam).

Darling and Heckert (in press) suggest research using a typology of disability orientations would also be beneficial. For example, if research indicated that,

> Certain categories of individuals with disabilities were more likely to have high self-esteem or participate in desired social activities, practitioners and policy makers might engage in activities to assist individuals in the acquisition of resources that enabled them to become part of those categories (Darling and Heckert, p.2).

Similarly, when rehabilitation professionals provide services to individuals with disabilities, it would be valuable in understanding whether vocational rehabilitation was effective in moving clients closer to rehabilitation theory. In other words, are professionals who are trained in rehabilitation theories contributing to rehabilitating clients based on the overall goals, theories, and principles of rehabilitation? Or, are professionals' preconceived beliefs, attitudes, and roles related to disabilities regarding clients driving rehabilitation? Additionally, are clients with high self-esteem and participants in social activities such as disability activism, also more likely to accept rehabilitation theories and be active participants in vocational rehabilitation services?

Darling and Heckert's (in press) research on disability orientation addresses operationalizing the concepts of disability orientation and disability identity. Putnam (2005) states that furthering the body of disability identity knowledge will be accomplished through empirical investigation. Through Darling and Heckert's development of a measuring instrument, their research contributes to quantitatively measuring individuals' disability orientation. Darling and Heckert state the instrument they developed helps further quantify research that establishes the current prevalence and correlates of disability orientations. They add that the instrument could be beneficial when selecting participants for qualitative research that is focused on examining the prior circumstances and effect of orientations. Another benefit of the instrument, according to Darling and Heckert, is its usefulness to professionals in identifying intervention methods for clients using their services. This instrument, and its usefulness for professionals in determining appropriate and effective vocational rehabilitation intervention strategies for clients, could contribute to better client outcomes.

Components of Disability Orientation

Darling and Heckert (in press) have identified the following three components of disability orientation. I will discuss each component in detail in the next section.

- Identity (pride vs. stigma/shame)
- Model (medical vs. social)
- Role (activism vs. passivity)

Identity (pride vs. stigma/shame)

Identification with how one feels about being a person with a disability can range from feeling and expressing disability pride to disability stigma. Darling and Heckert (in press) state that:

> The concept of identity or self suggests a person's definition of him or herself and usually includes both cognitive (I am a person with a disability) and evaluative (I am proud to be a person with a disability) components (p. 3).

In other words, an individual's concept of self includes a cognitive awareness that he or she is a person with a disability. The identity is further defined by a self-evaluation that gauges how the individual feels regarding being a person with a disability.

It is evident that the resulting behaviors and activities of identifying with either disability pride or disability stigma would be vastly different. For example, Darling and Heckert (in press) cite that research on disability identity includes associated behavior variables along with the self-concept of individuals with disabilities. One behavioral outcome identified by Darling and Heckert that results from a specific identity is activism. Other researchers have identified other associated behavioral variables. For example, research conducted by Hahn and Belt (2004) has shown there is a relationship between individuals’ personal affirmation of their disability and their choice to act or participate in treatment or seek a cure for their disability. Their findings are drawn from research focused on social and political identity and two concepts of group identity important to the investigation of disability. The first concept, Hahn and Belt labeled communal attachments and includes how an individual with a disability experiences a relationship with the disability minority (Hahn, as cited in Hahn and Belt, 2004). The second concept is labeled personal identity and includes the cognitive and emotional view an individual with a disability has of him or herself.

To summarize Hahn and Belt's two-part concept, disability identity is formed in relation to how an individual with a disability views him or herself in relation to other individuals with disabilities (communal attachment), and also through an individualized cognitive and emotional assessment of how it feels to be an individual with a disability (personal identity).

Hahn and Belt's (2004) findings indicate that accepting or rejecting a cure for disability is related to personal identity. Individuals rejecting a cure for their disability were found to have "stronger positive affirmation of personal identity as being disabled" and "are more likely to reject a cure because curing their disability takes away their sources of self affirmation" (p. 460). It could be argued that these individuals feel a strong sense of disability pride and may not be as likely to accept rehabilitation. They may reject professionals who offer services that are viewed as wanting to change or fix them. On the other hand, individuals who do not have this sense of personal affirmation "are more likely to seek a cure for their disabilities due to the fact that they do not derive the same affirmation from their disabilities" (p. 460). This group of individuals may be more likely to accept assistance from rehabilitation professionals and subscribe to rehabilitation theories that promote the need for personal change. As related to Darling and Heckert's (in press) research, it is possible that individuals who do not view their disability as providing them with a strong sense of positive affirmation may feel less disability pride and more disability stigma. Using Darling and Heckert’s disability orientation instrument to measure clients' or professionals' disability beliefs about identity and the degree of disability pride or disability shame/stigma would allow the opportunity to empirically examine this possibility.

Disability pride. Identity that includes a strong sense of disability pride could be used to describe Laura Hershey, an individual with a neuromuscular disability who does not want to be cured, changed, or fixed (www.cripcommentary.com/frompost.html, retrieved February 10, 2008). She describes disability pride as part of her identity and states that “disability is part of my whole identity, one I’m not eager to change.

Especially not at the cost of my dignity and personhood, as the telethon implicitly demands," referring to the annual Jerry Lewis Muscular Dystrophy Telethon (www.cripcommentary.com/frompost.html, retrieved February 10, 2008). She disagrees with the message of the Muscular Dystrophy Telethon that she feels implies "people with disabilities sit around hoping and praying for a cure" (p. 3). Hershey states that "on the lists of things I want, a cure for my disability is pretty low" and places more of a priority on "achievement of my personal goals, professional, and social goals" that are not related to finding a cure for her disability. Applying Darling and Heckert's (in press) concept of disability identity to describe Hershey's self-concept may support that Hershey's identity is an individual with a disability (i.e., cognitive awareness) and an individual who is quite proud of having a disability (i.e., self-evaluative). Laura Hershey is highly active in the disability political arena, which tends to support activism as a behavioral outcome of an individual with a disability pride.

Putnam (2005) proposes "pride, as key element of disability identity, is theoretically composed of the following four components:"

- Claiming disability by acknowledging oneself as a person with a physical or mental impairment who experiences disability.
- Believing that impairment and disability are not unusual but rather, are a common human condition.
- Believing that impairment is not inherently negative but can become so in certain cultural, social, and physical environments.
- Recognizing this characteristic as engendering membership in a cultural minority group (p. 191).

Other researchers agree, "Central to the development of pride is claiming the socially devalued characteristics, in this case, physical or mental disability (Anspach; Hahn; Shultz, as cited in Putnam, 2005, p. 191)."

Darling and Heckert (in press) suggest that "identity may be an independent variable that produces varying levels of activism, and identity itself may depend on the model to which a person subscribes" (p. 4). The next section will discuss Darling and Heckert's second disability orientation component model and includes a literature review of the medical and social models.

Model (Medical versus Social)

Models represent perspectives or "organized systems of interrelated ideas and concepts to explain phenomena" (Feldman, 1996, p. 16). Feldman states that although no one model can provide the definitive explanation of behavior collectively, models do provide more than one perspective for understanding behavior. Identification with a model can represent an individual's group of ideals, patterns, or beliefs that contribute to how they will interpret, behave, or react in society. A rehabilitation professional's identification with a particular model contributes to his or her orientation towards the work they carry out with clients. Likewise, a client's identification with a model may affect their active or passive participation in vocational rehabilitation and the belief they have in their own abilities to participate in employment, independent living, and community activities.

Darling and Heckert (in press) identified model, specifically, the medical and social models, as the second variable that is part of disability orientation. Their review of the literature on disability orientation and model have shown that previously, "most orientations were based on a medial model and people with disabilities were commonly categorized on the basis of whether or not they had accepted or adapted to their limitations” (p. 4). The social model, according to Darling and Heckert, is indicated as more popular in recent literature and “shifts the focus from the individual to the larger society” (p. 4). However, Darling and Heckert caution that “not all people with disabilities share a common perspective, and whether most individuals with disabilities today have rejected the medical model in favor of a social one is an empirical question" (p. 4). Empirically determining the amount of disparity among clients’ perspectives will help professionals in their delivery of rehabilitation services and in recognizing that one model with one way of delivering services will not collectively benefit all individuals with disabilities.

The ability to empirically determine professionals’ and clients’ association with the medical or social models will help in the delivery and receipt of vocational rehabilitation services. For example, empirical research of client and professionals, and their model association is important in that, although professionals and clients may clearly be oriented toward the medical or social model, they may not be aware the association has on the following:

- Their own disability orientation
- Their own beliefs, attitudes, and roles related to disability.
- The client-professional relationship
- Professionals’ delivery of limited versus diverse services
- Clients’ active versus passive participation in services
- Vocational rehabilitation outcomes including:

- Employment
- Independent living
- Community participation

Medical Model

The medical model is “concerned with the real world” typified in terms of “concrete steps of diagnosis and treatment” (Matthews, 2006, p. 32). Clients are patients who are expected to take a submissive role and rely on the all-knowing medical professional for guidance (Matthews). It is believed, according to Matthews, that once doctors diagnose the patient, they know exactly what the individual needs. For example, medical professionals “could relatively easily quantify what constituted a health gain or measure the effectiveness of a strategy to limit the effects of an intractable health problem” (p. 32). Therefore, disability is viewed as a health problem that is easily defined, holistically corrected, and controlled and measured for effectiveness.

Over the last 50 years, two main models, the medical and social models have been dominant in understanding and describing disability (LoBianco & Sheppard-Jones, 2007). The medical model of disability, according to LoBianco and Sheppard-Jones,

> Defines a person with a disability as someone who has certain physically limiting indications: who requires the use of a mobility aid, who is unable to communicate in a standard fashion, who has a learning disability, who has a visual or hearing impairment, or who is unable to perform activities of daily living (p. 1).

Burch and Sutherland (2006) state that the medical model regards disability as pathological, and views disability as a “defect or sickness that requires medical intervention in order to cure the problem" (p. 128). Disability and related issues, according to Burch and Sutherland, can be found within the person. They state that by curing the disability, all of the individual's problems would be eliminated. Individuals with disabilities are dependent "on the authority of the medical profession-not just to get better but also to be better." (Burch & Sutherland, 2006, p. 128). In other words, reliance on the knowledge and guidance of the medical professional is crucial and will lead to individual improvement. If the professional takes away the individual's disability, they also take away the individual's problems.

Similarly, Albrecht (as cited in Ailshire, 2006) states the medical model "asserts that disability comes from the individual, taking the form of a deviation from an idealized, healthy body" (p. 2). For example, the medical model, "roots disability entirely in the individual, presuming disability to be a biological defect which is rooted in the body and thus unaffected by external forces" (Carey, as cited in Ailshire, p. 2). Applying these perspectives, an individual with a disability has a biological defect, is unhealthy or sick, and requires the assistance of a medical professional.

Sick role. In 1951, Parsons (as cited in Rubin and Roessler, 1995) introduced the sick role to describe the medical client. The sick role is an unwelcome state that necessitates the client seeking help from a professional in order to get better (Rubin and Roessler). Additionally, the sick role temporarily allows the patient "exemption from usual activities and responsibilities" (p. 138). In other words, sick clients are exempt from school, social and recreational activities, and employment until professionals determine that the client is no longer sick. While the client assumes the sick role, the professional provides the cure (Freidson, 1970).

Macionis (1992) states that Parsons' sick role derives from the structural-functional paradigm, in that it is the function of society to assist the sick so they can continue to perform their social roles. Additionally, Parsons believes that sick clients desire to get better, therefore, they will fully oblige professionals in order to return to being contributing members of society (Macionis). In direct conflict with identifying with the sick role are individuals with disabilities who do not perceive their disability as a sickness. For example, Darling and Heckert (2005) state that some individuals with disabilities identify with the social model, which is a rejection of the dominant society's guiding principles that view disability as weakness and individuals with disabilities as inferior. An adversarial client-professional relationship is the likely result for clients who identify with the social model and professionals who identify with the medical model, dominant culture, and the client in the sick role.

Friedson (1970) disagrees with Parsons's conception of the sick role stating that it fails to recognize the variability in the role. To compensate, Freidson suggests the concept of multiple sick roles to better describe the type of behaviors that individuals should exhibit relative to their sickness. Moreover, sick roles exist on a continuum including "minor, major, or fatal," illnesses that are "short or long" term and can be either curable or non-curable (p. 14). Friedson's (1970) suggestion of multiple sick roles aligns more closely with the range of disabilities and the resulting individual abilities and limitations. In other words, multiple sick roles at least recognize possible stages and time frames that can be applied to some disabilities. For example, an individual may have an occurrence of a major depressive episode that is long term or an individual can experience a minor incomplete paralysis that is short term.

To explain permanent conditions, the impaired role was coined for individuals with disabilities (Rubin and Roessler, 1996). In comparison to the sick role, the impaired role is permanent and extends the exemption from activities over the course of the client's lifetime (Rubin and Roessler). Exemption from lifetime activities could include social events, education, job training, and employment, and may lead to professionals assuming the role of warden. Similarly, the client may accept the professionals' warden role, particularly if he or she has not been exposed to other alternatives or opportunities for achievement.

A client may assimilate the perception that he or she cannot make his or her own decisions and needs to be taken care of, not only by a professional, but also by society and the government. Given that perception, a potential difficulty that exists for the client participating in the vocational rehabilitation program is the erroneous belief by both the client and professional that the client cannot make his or her own vocational choices. As a result, the client is denied the equal opportunity to participate in educational or job training programs that would lead to employment and economic independence. The consequences are that some clients are locked into a low socioeconomic status and are forced to reside in government housing projects, receive food stamps, monthly subsistence, and inferior medical assistance while they are merely checked up on by professionals. Due to discrimination and bureaucratic barriers, many individuals with disabilities find themselves in such situations against their will.

Vocational rehabilitation and the medical model. The medical model is the basis for the "state-federal Vocational Rehabilitation system" (Szymanski and Parker, 1996, p. 409). Szymanski and Parker state the medical model consists of the following:

- Diagnosing the problem
- Developing a treatment plan
- Administering the treatment
- Evaluating the effectiveness of treatment
- Modifying the treatment, as necessary
- When the patient has obtained the maximum benefit, terminating the treatment

The “medical specialist (physician, nurse, psychologist, and psychiatrist) begins with an ill or abnormal person, makes a diagnosis, then formulates a prescription for therapy (treatment) to result in a cure” (Szymanski and Parker, p. 409). The professional team is under the authority of the physician who decides on the client’s diagnosis, develops a treatment program, and determines if it was effective even though the physician typically spends the least amount of time in direct contact with the client.

The medical model is the “oldest theoretical model informing understanding of disability” (Brown, Hamner, Foley, and Woodring, 2006, p. 3). Brown and colleagues state that “disability is thought of as a medical condition that may be remedied through treatment and rehabilitation” (p. 3). For example, based on a focus group of 58 individuals with disabilities who were either employed or searching for employment, Brown and colleagues have shown that for the individuals who were not employed they “relied more heavily on medical understandings of disability than people who were currently employed” (p. 7). For one participant in the study, she “seemed comforted by having her learning impairment classified as a medical problem…being diagnosed as learning disabled seemed to provide her with partial explanation for her difficulties in obtaining employment” (p. 7).

Tragedy model. An extreme version of the medical model is sometimes referred to as the tragedy model, which views any type of impairment as a personal tragedy. Swain and French (2000) state that the "tragedy model is so dominant, so prevalent, and so infused throughout media representations, language, cultural beliefs, research, policy, and professional practice" (p. 572). Their research has shown examples in films that are typically viewed during the Christmas season. For example, they cite that *A Christmas Carol* portrays the "pitiable and pathetic Tiny Tim whose tragedy of using a crutch is miraculously overcome at the end of the picture" (p. 572). They also state that the film *It's a Wonderful Life* portrays,

> Just one disabled character, Mr. Potter, who is rich, evil, twisted, frustrated, and in a wheelchair. No other explanation for his inhumanity, which includes theft, is offered other than his response to a life as wheelchair user (despite the fact that he is the richest man in town). It is the tragedy that has twisted him. (p. 572).

Finally, Swain and French cite that even research "clearly demonstrates the tragedy model" (p. 572). For example, they discuss a questionnaire that participants with diabetes were required to complete. They found that the 32 questions were laced "with the implication that the tragedy of diabetes may negate any hope for the future" (p. 572). Two questions asked to participants included "Do you even for a moment wish that you were dead?" and "Do you wish that you had never been born?" (p. 572). These questions, according to Swain and French, reflect the "ultimate version of the tragedy model is that physical death is better than the social death of disability" (p. 572).

Clients are made to feel guilty and ashamed to have a disability according to the tragedy model perspective (Swain and French, 2003). Understanding how professionals who strongly align with the tragedy model contribute to promoting or maintaining the clients’ disability identity of stigma and shame is necessary in vocational rehabilitation research. In other words, instead of professionals blaming the vocational rehabilitation client for not achieving their vocational goals, a new understanding of how the components of disability orientation and clients' and professionals' beliefs, attitudes, and roles related to disability contribute to the overall vocational rehabilitation process can be identified. Professionals ascribing to the tragedy model would continue to view disability as a tragedy even if all social and physical barriers were removed for individuals with disabilities (Swain and French, 2003).

To summarize the medical model, clients with disabilities are reliant on the medical professional to diagnose and cure their disability. While they wait for a cure, they may be considered exempt from educational training, independent living, and employment. In other words, their goals and related activities are on hold until a cure is discovered. While they wait for a cure, they may need to rely on government assistance in the form of housing and medical care. Furthermore, it may be difficult for a professional to convince a client that subscribes to the medical model of the benefits of participating in vocational rehabilitation services. Similarly, the professional that subscribes to the medical model may overlook a client's strengths and ability to be an active participant in rehabilitation services.

Social Model

The next model to be discussed is the social model. In contrast to the medical model and individual blame for disability, the social model emphasizes that society is responsible for creating and maintaining physical and social barriers for individuals with disabilities. Darling and Heckert (in press) state that the social model moves the focal point from the individual to society at large, viewing disability as a problem of society rather than a personal problem. This view, according to Darling and Heckert, is more attuned to activities that contribute to generating social change. In the social model, the emphasis is placed on "the way in which physical, cultural, and social environments exclude or disadvantage people who are labeled as disabled" instead of on individual disability (Barnes, as cited in Bolt, 2005).

The medical model focuses on how individuals with disabilities should feel guilt and shame for affecting, interfering, and placing burden on society. The medical model tenets promote social change inertia and help support firmly placed physical, cultural, and social barriers. Conversely, the social model suggests that society should feel collective guilt and shame for affecting, interfering, and placing unfair burden on individuals with disabilities. The social model tenets promote social change through challenging long-standing societal norms, beliefs, and values that are strongly skewed against individuals without disabilities.

According to Mitra (2006) there are some nine or more versions of the social model. Pfeiffer (as cited in Mitra) identifies the nine versions as follows:

- Social model of the United Kingdom
- Oppressed minority model

- Social constructionist version of the United States
- Impairment version
- Independent living version
- Postmodern version
- Continuum version
- Human variation version
- Discrimination version

Mitra's (2006) discussion of the social model of the United Kingdom supports the idea that "Disability is not the attribute of the individual; instead, it is created by the social environment and requires social change" (p. 237). According to Mitra, this version developed in the United Kingdom by "disability activists in the Union of the Physically Impaired Against Segregation (UPIAS)" (p. 237). Burchardt (2004) states that in 1976, UPIAS and academics first articulated the social model as being rooted in the struggles of individuals with disabilities in relation to their civil rights. The UPIAS defined the British social model, according to Mitra in the document, *Fundamental Principles of Disability*. An edited version reprinted by Oliver (as cited in Mitra) includes the following: "In our view, it is society which disables physically impaired people. Disability is something imposed on top of our impairments by the way we are unnecessarily isolated and excluded from full participation in society" (p. 22).

In reference to the numerous versions of the social model, Oliver (as cited in Burchardt, 2004) states there are a "number of different versions and there have been disagreements within the disability movement about its precise interpretation" (p. 736). However, Burchardt states, "there are a number of central tenets which are common to all versions" (p. 736). For example, Burchardt states that each version makes an important distinction between impairment and disability. He defines impairment and disability as follows:

> Impairment is a condition of the body or mind, such as lacking a limb, being partially sighted, or experiencing depression. It is an attribute of an individual. Disability is the loss or limitation of opportunities to take part in the life of the community on an equal level with others. It arises from the social, economic, and physical environment in which people with impairments find themselves (p. 736).

In other words, impairment is a characteristic of an individual and disability is the impingement that society places on the individual with an impairment.

Oppressed minority view. In the United States, Mitra (2006) states that the oppressed minority view of the social model is supported. According to Mitra, because individuals with disabilities are faced with "discrimination and segregation through sensory, attitudinal, cognitive, physical, and economic barriers" they become an "oppressed minority" (p. 237). Similarly, Darling and Heckert (in press) discuss oppressed minority groups and the process of assumptions and stigmatization of individuals representing a particular race. For example, they discuss research on race that has shown most African Americans do not have low self-esteem, even though the norms of majority society favor whiteness. Likewise, Darling and Heckert surmise that this process is similar for other stigmatized groups, including individuals with disabilities.

Hahn (as cited in Mitra, 2006) states, "social inequalities encountered by persons with disabilities are considered as similar to those encountered by other minorities such as extraordinarily high rates of unemployment, poverty, and welfare dependency; school segregation; inadequate housing and transportation; and exclusion from many public facilities" (p.237). Research has shown (Barnartt and Scotch; Hahn, as cited in Putnam, 2005) that individuals with disabilities are extensively and habitually discriminated against by other members of society. For example, through Brown's et al. (2006) research with focus groups, the hiring process, and employment, "employers' views of individuals are obscured by visible markers of disability. Wheelchairs, canes, and other visible indicators of disability symbolically distinguished one group of people as different from another" (p. 9). The focus group participants consistently cited a "division between us and them" (p. 9) clearly indicating "us" (i.e., individuals with disabilities) as the oppressed minority and "them" as the majority or the employers who control their access to employment.

Social and physical barriers. The social model draws "attention to economic, social, and physical barriers" and the "demand for greater accessibility of buildings, transport, and information, and for measures to counter discrimination in employment and other spheres of activity" (Burchardt, 2004, p. 736). This is in direct conflict to the medical model in which the individual with a disability is somehow responsible for not being able to access all buildings and modes of transportation, and for experiencing discrimination in employment. For example, an individual with spinal cord injury and resulting paralysis said that in order for him to travel on a commercial aircraft carrier, he has to be separated from his wheelchair, then placed in a very small transfer chair to be put into his seat. He is stuck in his seat for the duration of the flight due to not having access to his wheelchair. However, he states that the "real issue is after they leave you in the seat after being separated from your wheelchair…. then realizing that if anything happens, you’re on your own…not a great feeling” (D. Rullman, personal communication, March 7, 2008). When the flight has ended, he must wait until all passengers have exited the aircraft, then he is again placed in the small transfer chair and taken off the aircraft.

Similarly, the following was posted on the Disabilities, Opportunities, Internetworking, and Technology (DO-IT), University of Washington discussion forum:

> The seating system for people in wheelchairs that can't transfer well or at all needs to be changed. I think there should be a way to allow the passenger to remain in his or her wheelchair. One possible way to do this is to have a section of removal seats at the front of the plane. These seats could be removed and then a wheelchair occupant could park in that place. It should be fairly simple to have straps to tie a wheelchair down like in buses. The only possible problem would be the width of the airplane door. That is one thing that definitely needs to be fixed. (http://www.washington.edu/doit/Newsletters/Apr07/14.html, retrieved March 1, 2008).

The discussion forum includes other examples provided by individuals who use wheelchairs such as not being able to access or use the restroom for the duration of the flight, wheelchairs being returned damaged and inoperable, and the experience of “being drug down sections of the plane because I am not part of the first or business classes” rather than being seated in the “closest seat possible” (http://www.washington.edu/doit/Newsletters/Apr07/14.html, retrieved March 1, 2008).

The previous example presents multiple problems for individual with disabilities that are clearly a result of imposed societal barriers. In the social model, according to Darling and Heckert (in press), deeming that disability is a social problem versus a personal problem could lead to actions that promote social change. In other words, the social model and the recognition for social change would look to society for change; specifically, overhaul the commercial aircraft system to fairly accommodate the needs of all individuals. Conversely, the medical model would look to the individual to change or accept their need to fit into society's standards.

Social construction of disability. Smeltzer et al. (2005) states that in the social model disability is socially constructed due to "social and physical barriers in the environment" (p. 214). The social model also purports that disability can be overcome by removing the physical and social barriers in the environment. Hurst argues that the social model "proposes that those who are disabled are hindered as a result of society's inability to remove those environmental barriers encountered by an individual with a disability" (as cited in LoBianco and Sheppard-Jones, 2007, p. 1). According to Burch and Sutherland (2006), "disability scholars argue that disability is a social construction, and some have summarized it this way: Disability is often less about physical or mental impairments than it is about how society responds to impairments" (p. 129). LoBianco and Sheppard-Jones state, "proponents of the social theory of disability argue that, with adequate response by society, disability would not exist" (p. 1). Therefore, the concept of disability is not only socially constructed but also maintained by society's inability to change or modify physical and social barriers in the environment.

Ecological systems theory. The ecological systems theory shares similarities with the social model. For example, Hepworth and Larsen (1993) discuss the ecological systems theory and the requirement of "goodness of fit between the needs of people with physical or mental limitations and environmental resources" (p. 16). In other words, more emphasis is placed on how society affects and fits the individual with a disability, rather than on how the individual does not fit in with the environment (Oliver as cited in Darling and Heckert, 2005). Relative to the examples of air travel and individuals who use wheelchairs, the goodness of fit between their needs and environmental resources are clear: Develop aircraft carriers that are accessible for all individuals that allow for the preservation of dignity and independence.

Dominant culture. The social construction of realty is such that it is improbable that all physical and social barriers will ever be totally removed to allow complete and equal access for individuals with disabilities or any group that is not a member of the dominant culture. However, while members in society can strive for this ideal, social inequalities will exist due to the dominant culture's guiding principles and the need to maintain the status quo. For example, early legislation was based on the medical model and provided services for individuals assumed to be unable to work. More recent legislation is based on the social model and making society more accommodating for individual with disabilities. Even with social policies and federal laws that span many decades including the Smith-Hughes Act of 1917, The Rehabilitation Act of 1973, and The Americans with Disabilities Act (ADA) in the 1990's (Rubin and Roessler, 1995), societal awareness and change is still necessary due to the control of the dominant culture. Social and environmental change agents need to be ever vigilant in their pursuit to promote equality and social acceptance for individuals with disabilities.

Prevalence of disability in the United States. Statistics on the number of individual with disabilities in the United States may prompt societal acceptance of the social model and the need for global change. For example, viewing "disability as common factor in life" is supported by the U.S. census of 1997 that indicates "one out of every five Americans qualify as disabled" or 33 million out of 55 million people qualifying as severely disabled (Burch and Sutherland, 2006, p. 129). More recent statistics support this figure. For example, according to the Rehabilitation Research and Training Center on Disability Demographics and Statistics (2007) in 2006, the prevalence of disability in the United States was indicated as follows:

- 15.0% for persons ages 5 +
- 6.3% for persons ages 5 to 15
- 6.9% for persons ages 16 to 20
- 12.9% for persons ages 21 to 64
- 30.2% for persons ages 65 to 74
- 52.6% for persons ages 75 +

For working age individuals in the 21 to 64 age group, 12.9% represents 22,382,000 out of 172,910,000 individuals reporting one or more disabilities.

Acquiring a disability. Due to the fact that Americans are living longer, the probability of acquiring a disability is significant (Burch and Sutherland, 2006). For example, a contributing factor to increases in the overall number of individuals acquiring a disability is due to the United States military involvement in the conflict in Iraq, Iran, and other mid-eastern countries. The final report of the President's Commission for Americans Returning Wounded Warriors was created on March 6, 2007 and indicated the following number of service members relative to serious injuries:

• Wounded in action	28,000
• Traumatic Brain Injuries	2,726
• Amputations	644
• Serious burns	598
• Polytrauma	391
• Spinal cord injuries	94
• Blind	48

It should be noted that these statistics include duplication in that some service members have one or more injuries.

Two signature injuries are noted for service members serving in the current Iraq and Afghanistan conflict and include Post Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI). The Commissioner's report indicates that 52,375 service members returning from Iraq and Afghanistan have received services from the Veterans Administration for PTSD symptoms. Mental health symptomology was indicated by 56% of active duty, 60% reserves, and by 76% of retired/separated service members. For over 35,000 service members who assumed they were healthy, mild TBI was reported by 10 to 20 percent.

Compared to the Vietnam era when "five out of eight seriously injured service members survived; today, seven out of eight survive, many with injuries that in previous wars would have been fatal" (p.2). In other words, while more individuals will survive injuries incurred during war, a significant number of service members will return to civilian life with a temporary or permanent disability. Many of these individuals will expect a smooth transition and return to their previous life which includes access to housing, employment, and the community; however, due to societal barriers they will encounter difficulties.

Societal change and barrier removal. Service providers who adopt tenets of the social model, rather than the medical model will help to increase the likelihood of societal change and barrier removal. For example, an organization in Pennsylvania that annually awards approximately 65 million dollars of grant funding to service providers is the Pennsylvania Developmental Disabilities Council. The Pennsylvania Developmental Disabilities Council's mission in part involves changing the system and includes the vision of "a Commonwealth comprised of inclusive communities where all people with disabilities are valued and thrive" (PDDC, 2008). Based on the Pennsylvania Developmental Disabilities Council's mission and vision, grant proposals that are based on the social model of disability are strongly encouraged. For example, according to the Pennsylvania Developmental Disabilities Council's Request for Proposals (2008):

> We believe that disability is a natural part of the human condition. We are not sympathetic to medical models of understanding disability. While we do not deny the importance of medical treatment and medical needs, we are more sympathetic to understandings of disability as a social construct imposed on people with disabilities labels rather than as a quality inherent in the person with a disability. We are therefore unlikely to be interested in proposals, which focus on the deficits of people with disabilities rather

> than on the social constructs, which dis-empower them. We are not impressed by the model of trying to "help" people with disabilities by making them more like people without disabilities (p. 7).

The Pennsylvania Developmental Disabilities Council's mission reflects the tenets of the social model in that individuals with disabilities should not be forced to fit into a society that is more conducive and available to other groups of individuals. Rather, society should construct systems that include all groups of individuals' needs, wants, and desires. Organizations such as the Pennsylvania Developmental Disabilities Council promote this goal by making grant funding available only to individuals and service providers that include tenets of the social model in project proposals, thereby forcing systems change.

To summarize, the social model is a radical departure from the medical model (Swain et al., 2003). Specifically, the medical model emphasizes and blames the individual, whereas the social model blames "the social origins of disability in a society organized and constructed by and for non-disabled people" (Swain et al., p. 138). In other words, disability exists due to an environment that separates and keeps individuals with disabilities in a holding cell; kept back from equal participation in life due to physical barriers and social prejudices. The social model supports equal participation in life. For example, Mathews (2006) states that:

> The social model is unpinned by the overriding principle of human freedom and personal empowerment: the individual always decides what will happen to him or her. A basic tenet is that nothing is done 'to' a person but rather 'with' a person (p. 32).

Having something done to a person with a disability rather than with them may depend on the role the individual perceives he or she plays. In other words, the individual's amount of active versus passive participation in society, vocational rehabilitation, and in the community may determine how effective they are in negotiating a system and society that is less than fair to individuals with disabilities. The next disability orientation component to be discussed is role (activism vs. passivity).

Role (Activism vs. Passivity)

The third disability orientation component identified by Darling and Heckert (in press) is role (activism vs. passivity). Darling and Heckert state that more recent disability identity research focuses on "some associated behavioral (role-playing) variables in addition to descriptions of the content of the self-concept of people with disabilities" (p. 3). Darling and Heckert cite activism as one of the behavioral outcomes that "may result from a particular identity" (p.3). Individuals with role orientations towards activism are involved in disability rights issues. Equally, Darling and Heckert include passivity as the converse of activism. For example, Darling and Heckert state, "a large number of individuals with disabilities who are not a part of recent social movements may continue to accept older views and regard themselves as victims of personal misfortune" (p. 6). Individuals with role orientations towards passivity are less likely to be aware of the benefits of disability activism.

The ability of professionals to identify clients' specific role orientations toward activism or passivity could change the dynamics of the work professionals carry out with clients. For example, Darling and Heckert (in press) discuss potential outcomes of identifying individuals with disability role orientations towards activism:

> Certain categories of individuals with disabilities were more likely to have high self-esteem or to participate in desired social activities, practitioners and policy makers might engage in activities to assist individuals in the acquisition of resources that enabled them to become part of those categories (p. 2).

According to Darling and Heckert, “if disability activism were the goal, and certain types were shown to be associated with activism, movement leaders might benefit from this information, because it would assist them in locating potential recruits for the Disability Rights Movement” (p. 2). Putnam (as cited in Darling and Heckert, in press) suggests that understanding why some individuals with disabilities become involved in disability rights issues and others do not is invaluable for understanding disability politics.

It is mainly through the hard work of the Disability Rights Movement (see, e.g., Charlton; Shapiro; Stroman, as cited in Darling and Heckert, in press) that “the identity of at least some individuals with disabilities has changed, and a stigma-based identity has been replaced by disability pride…. [This] newer identity has been rooted in the social model and has often been accompanied by activism” (p. 5-6). Therefore, “identity may be an independent variable that produces varying levels of activism, and identity itself may depend on the model to which a person subscribes” (Darling and Heckert, p. 4). In other words, individuals with disability identity orientations toward pride, and the social model or idea that disability is a social problem may assume more activist behaviors such as participation in group-organized political activities (Darling and Heckert). On the reverse side, individuals with disability identity orientation towards stigma/shame, and the medical model or idea that disability is an individual problem may assume role passivity with little to no participation in group-organized political activities (Darling and Heckert). To summarize this example, the following outlines Darling and Heckert's (in press) three disability orientation components and potential relationships:

Identity	Model	Role
Pride	Social	Activism
Stigma/Shame	Medical	Passivity

Isolating factors that contribute to disability roles that are oriented more or less toward activism versus passivity is of research interest. For example, Schur's (as cited in Putnam, 2005) research on "disability rights activism bridges the issues of individual and group identity, examining the personal traits and characteristics to political activism" (p. 189). According to Schur, political activism is linked to the following four views:

- Problems associated with disability exist and make a real difference in daily life.
- Many disability-related problems (in the social and political environment) can be eradicated.
- People must recognize that their problems are widely shared and identify with others who have disabilities before they can overcome isolation and organize politically.
- People must perceive that many disability-related problems can and should be addressed through political rather than purely individual means (p. 189).

In other words, there must first be recognition that problems encountered in society generate a real disadvantage relative to groups of individuals with disabilities. Secondly, daily encountered problems can be eliminated through systems change. Examples include making buildings and transportation accessible for all groups of individuals, and implementing and enforcing stronger laws against discrimination. Thirdly, collective organization, such as during the 1960s and the Civil Rights movement, can be extremely effective in conveying awareness of group issues. Lastly, regional, communal, and global changes start with organized goals, objectives, and outcomes. While one individual can affect another individual, groups of individuals fighting for the same goals and objectives can affect societal outcomes.

Disability activism characteristics. Groups of individuals that are involved in disability activism have been found to share certain characteristics. For example, Schur (as cited in Putnam, 2005) interviewed 64 individuals with spinal cord injury and found commonalities among those active in politics. She determined the following characteristics contribute to higher levels of activism:

- Young and middle aged adults.
- Higher levels of education.
- Spinal cord injury that occurred 11 years or more ago.
- Sustained a greater severity of injury (p. 189).

In this study, Schur (as cited in Putnam, 2005) also found that the sample group cited more experiences of discrimination and stated "that attitudes of nondisabled people were [more of] a problem for them than those who did not identify as political activists" (pp. 189-90). High levels of "personal satisfaction, control, and efficacy" were reported, "which was the reverse for those individuals who did not see discrimination and stigma as problems" (p. 190).

Individuals who are less likely to view discrimination and stigma as a problem represent a significant number of individuals with disabilities. For example, Putnam

(2005) states, “The proportion of politically active disability constituents is only a fraction of the population in the United States who are experiencing disability” (p. 188). The result of passivity relative to disability political activism is that it “will leave many disability rights goals unfulfilled” (Hahn, as cited in Putnam, p. 188). The global implications of an unfulfilled disability rights political agenda is society’s unresponsiveness to equalizing the economic, social, and physical environment.

The involvement of individuals with disabilities in political activism was the research topic of a more recent study conducted by Schur, Shields, and Schriner (2003). Four measures of efficacy that help to predict political activity were examined and included:

- External efficacy
- Internal efficacy
- Group efficacy
- Civic skills

Their sample included 1,240 individuals, of which 700 were individuals with disabilities. Schur and colleagues have shown that “people with disabilities report significantly lower average levels of external and internal political efficacy” (p. 128). In addition, people with disabilities report “lower average levels of civic skills, and are significantly less likely to perceive that people with disabilities receive equal treatment from public officials or have equal influence in politics” (p. 128). Differences in “efficacy and participation may reflect differences in demographic characteristics, resources, and social and recruitment networks” (p. 128). Schur colleagues state that these “differences may help to explain their lower levels of political activity” (p. 128).

The study by Schur and colleagues also indicates, “That employment plays an important role in the political efficacy of people with disabilities” (p. 134). They determined that:

> Employment appears to play an important role in increasing feelings of efficacy among people with disabilities; apart from its indirect effect of increasing household income, employment in a professional occupation has a significant positive impact of feelings of internal political efficacy, and full-time work has a positive impact on civic skills. This latter result is noteworthy because it suggests that employment-especially full-time employment-can substantially improve the ability of people with disabilities to relate to others in groups and to develop other important skills such as writing letters (p. 134).

Their results indicate, “That the lack of employment among people with disabilities creates negative feelings about their treatment and influence that may significantly color their views of the political system and incentives for participation” (p. 135). To summarize, employment for individuals with disabilities can lead to increases in civic skills as fundamental as letter writing, while not being employed can support the assumption of unequal influence in political issues.

Client-professional relationship. Being able to identify certain categories that were shown to be associated with activism would allow professionals to educate clients regarding the benefits of disability activism. Likewise, identifying clients with disability roles oriented toward passivity would allow professionals to pair groups of clients with other groups of clients with roles oriented towards activism who could serve as role models, mentors, and as the impetus for the creation of social networks. For example, clients with cognitive or learning disabilities attending post secondary schools are often not aware of their rights relative to receiving learning support accommodations. Recruiting groups of clients who have been successful in negotiating the higher education system and having them mentor passive clients could elevate the passive clients toward disability activism and positive social change. In this example, participation in higher education disability activism could mean the difference of realizing success in pursuing and achieving a higher education degree, employment, and financial independence. Moreover, it is through organized political activism that administration and educators at post secondary institutions of higher education become more aware of individuals with disabilities' legal and civil rights.

To review, this section discussed Darling and Heckert's (in press) three components of disability orientation including Identity, Model, and Role. The next section will introduce Darling and Heckert's typology of disability orientation including: Normalization I and Normalization II, Affirmation, Crusadership, and Resignation. My dissertation research focuses on disability orientation and related variables in relationship to clients' and professionals' beliefs, attitudes, and roles related to disability.

Typology of Disability Orientations

This dissertation does not focus on examining the existence of a typology of disability orientations for rehabilitation clients and professionals. However, discussion of this information provides for a more inclusive review of Darling and Heckert's research in relation to other potential QDIO measurement and research opportunities.

Based on the disability orientation components of Identity (pride vs. stigma/shame), Model (medical vs. social), and Role (activism vs. passivity), Darling (2003) have developed a typology of disability orientations that includes Normalization I and Normalization II, Affirmation, Crusadership, and Resignation. In developing this typology of disability orientations, Darling (2003) conducted an extensive review of the literature concerning people with disabilities including autobiographical and media accounts, disability activists' writings, and published studies conducted by academic researchers and social scientists. The results of Darling's literature review "suggested that orientations to disability do indeed reflect differential access to opportunities to achieve either (or both) normalization or (and) the alternative, affirmative definitions promoted through disability culture and disability rights movements" (p. 7).

Darling conducted research over 25 years ago that included interviewing parents of children with disabilities (Darling, 1988). Based in part on her interviews, Darling developed a typology of orientations among parents of children with disabilities. Specifically, Darling's "interviews with families had suggested that these orientations centered on attempts to achieve normalization, or a lifestyle that was similar to that of people who did not have disabilities, confirming the tenets of opportunity structure theory" (p. 5). According to Darling, opportunity structure theory "posits that individual outcomes are related to opportunities for integration into the larger society and its norms, or, alternatively, into smaller subcultures"' (p. 5). Anomie theory is the predecessor of opportunity structure theory, which assumes that members of society seek to achieve the same goals (Darling, 2003). In other words, individuals with access to normal social and employment roles are less inclined to be part of a disability subculture. Conversely, those individuals who are unable to integrate into normative social and employment roles may choose alternative roles and identities (Darling, 2003), but only if they have access to those roles and identities. The empirical research by Darling and Heckert (in press) found support for the theoretical model proposed by Darling (2003). Their cluster analysis identified most of the types of disability orientation predicted by Darling, including two types of normalization. These types of disability orientation will now be discussed.

Normalization

Normalization I. Clients with a disability orientation of normalization want to be viewed as normal based on the dominant culture's definition (Darling and Heckert, 2005). They do not want to be defined by their "abnormal" disability. They typically prefer interpersonal relationships with individuals without disabilities (Darling and Heckert, in press), thereby fitting in with the majority rather than standing out as one in the minority group of individuals with disabilities. These individuals want to experience lifestyles that are available to individuals without disabilities. In that respect, normalization aligns with the medical model of disability in that disability can be overcome.

Darling and Heckert (in press) state that,

> Individuals who adopt this orientation are those who accept the norms of the larger society with regard to appearance and/or ability and who manage to achieve lifestyles that are similar to those of individuals of their social status who do not have disabilities. Those with disabilities that are not highly visible may even choose to pass as normal. (p.8).

Darling and Heckert provide the example of Henry Kisor, “a deaf journalist working for a major newspaper who functions well orally, is married to hearing person, and whose social life is almost exclusively within the hearing world” (p. 8). In other words, normalization is achieved through exclusive associations that are outside of the minority deaf culture.

Achieving normalization can sometimes lead to rejecting necessary accommodations and supports. For example, Darling (2003) states that individuals may forego necessary accommodations due to their wish to be normal. They may reject the use of a white cane or orthopedic device due to the perceived negative connotation these supports convey (Darling and Heckert, in press). As an example, John Hockenberry (as cited in Darling) insisted on working in inaccessible places even though he relied on a wheelchair for mobility (p. 886).

Based on my professional relationships (note: for more information see the discussion under Researcher Positionality in the Introductory chapter) with clients with cognitive or learning disabilities who shared traits of this normalization orientation, many clients had difficulty accepting the diagnosis, results, and recommendations of their neuropsychological evaluation. For example, if learning support accommodations were strongly recommended to maximize academic success, often, these clients refused to seek out these services leading to a high percentage of clients failing or not completing an educational training program. Even if these clients participated in learning support services in secondary school, they often stated that at the post secondary level, they did not need any type of different assistance from their peers. Intervention from professionals who recognize this type of resistance as a characteristic of normalization may lead to improved outcomes for both professional and client.

The underlying theory of normalization explains this behavior from the clients' perspective. Seeking out learning support services is different and makes these clients stand out from their normal peers who do not use learning support services or accommodations in the classroom. These clients want to appear normal, and seeking out additional services or receiving special treatment calls attention to their disability. At the same time, by not acknowledging learning difficulties, the client-professional relationship may be made difficult.

Normalization II. Individuals with orientations towards normalization II differed from individuals with orientations toward normalization I. Darling and Heckert (2006) stated that these individuals had their disability since birth, regularly participated in social activities, but did not participate in disability activism. Darling and Heckert (2006) found that individuals with orientations towards normalization II may agree their disability enriched their lives and that they were not supportive of a cure for their disability. However, these individuals differed from individuals with orientations towards normalization I in that they did not have disability pride or accept the stigmatizing label of the normalization perspective (Darling and Heckert). In other words, while they view themselves as normal they do not view themselves with disability pride or with disability shame and stigma (Darling and Heckert).

Affirmation

Unlike individuals with a normalization I orientation, individuals with an affirmation orientation do not have the goal of normalization (Darling and Heckert, in press). In order to achieve their goals, individuals with an affirmation orientation may align with the disability subculture or minority group (Darling and Heckert). However, while they desire to be active participants in society, they feel their disability is part of their identity, which is perceived as a positive attribute (Darling and Heckert). This group of individuals may be more likely to accept accommodations, support, and use wheelchairs for mobility. They would not view these types of supports as stigma symbols but as part of their identity, which includes disability pride.

Darling and Heckert (in press) state that self-esteem and separation are two characteristics of disability pride. Russell (as cited in Darling and Heckert) sees similarities between disability pride and black pride. For example, Russell states, "like Malcolm [X], disabled people must learn to celebrate our own bodies and respect who we are" (as cited in Darling and Heckert, p. 9). According to Darling and Heckert, the second aspect, separation, includes rejecting integration into the majority. In other words, affirmation refers to the ability to accept and respect oneself as an individual with any type of disability (self-esteem) and being proud to be recognized as part of the disability subculture (rejection of assimilation) where it is acceptable not to amalgamate with the majority.

Clients with an affirmation orientation are in direct conflict with the tragedy model (Swain & French, 2000) and medical model in that they do not want to be fixed or treated. Disability is a positive part of their identity (Darling and Heckert, 2005), unlike clients with a normalization I orientation, who reject disability as their identity. Although these individuals desire to remove environmental barriers, a common theme in the social model of disability, they collectively and with pride work together to promote social change for individuals with disabilities (Swain & French, 2000). In that respect, they are far removed from the medical and tragedy models of helplessness and dependency (Swain & French).

Swain and French (2000) have shown that the growth of organizations of individuals with disabilities reflects a united resistance against oppression, discrimination, and group identity. Group identity, according to Swain and French, is a result of the work of the Disabled People's Movement, which has "underpinned the development of an affirmative model in a number of ways" (p. 577). They define the affirmative model as "essentially a non-tragic view of disability and impairment which encompasses positive social identities, both individual and collective, for disabled people grounded in the benefits of life style and life experience of being impaired and disabled" (p. 569). Darling and Heckert (2004) describe Swain and French's affirmative model as viewing disability "as part of a positive social identity" that "rejects older models that view disabilities as personal tragedies" (p. 6). In other words, positive social identity includes both individual and collective positive acceptance of being an individual with a disability. According to the affirmative model, viewing disability as something negative that happens to an individual who is waiting for a cure would be considered a step backwards to former, less than positive, views regarding disability.

In summary, although clients with affirmation orientations accept themselves and identify with the disability subculture, they are interested in promoting positive societal change. They will collectively resolve issues through campaigns that focus on promoting a positive image of disability (Swain and French, 2000). Issues are expressed and resolved through "collective identity" (Swain and French, p. 577). Their identification as affirmers is unchanging and consistent over time, unlike individuals with orientations towards crusadership (Darling and Heckert, in press), the next area of discussion.

Crusadership

Darling and Heckert (2004) describe individuals with crusadership orientations as “those who accept the norms of the cultural majority, but who do not have access to a normalized lifestyle” (p. 5). They are typically unemployed, less socially active, and acquired their disabilities later in life (Darling and Heckert, in press). They involve themselves in “larger social movements in order to create normalization-promoting social change” (Darling and Heckert, 2004, p. 5). Their activism may be due to lack of access to opportunities for social participation (Darling and Heckert, in press). Like affirmers, they associate with the disability subculture; however, “when their crusades were successful, these individuals would adopt a normalization orientation” (Darling and Heckert, 2004, p. 5). In other words, their activism is related to promoting positive social change for individuals with disabilities; however, once the goals of the crusade have been achieved, they prefer to achieve normalization.

Darling and Heckert (2004) provide an example of an individual with a crusadership orientation, Christopher Reeve, the late actor and activist for spinal cord injuries. Upon acquiring paralysis after an equestrian accident, he is described by Darling and Heckert as being a media campaigner for research into curing spinal cord injuries. Darling and Heckert state that:

> Although his celebrity afforded him access to a wealth of resources, the visibility and extent of his disability prevented him from achieving the normalization he desired. Consequently, he espoused a medical model,

> rather than simply affirming his new identity as a person with a disability (p. 6).

Espousing the medical model is evident in the following example of Madonna Long, a female with a spinal cord injury and resulting paralysis acquired at age 18. Long wrote (in the third person) and provided the following describing her political activism for individuals with spinal cord injuries:

> She has always advocated for science to help those who suffer from paralysis. She was the first person west of the Mississippi to walk with Electrical Stimulation in 1985…Today she still walks for exercise with her RGO braces the very same ones that helped her stand and walk with the Functional Electrical Stimulation over 25 years ago. When new therapies are available like the Functional Electrical Stimulation was, then people can live healthier lives and a cure is that much closer (April 16, 2008).

Long writes that she was part of a group of a group of individuals with spinal cord injuries that attended the Kellogg Conference in Washington D.C. April 2008. According to Long, this group learned "about the advances in science and help with the passing of the Christopher and Dana Reeves Paralysis Act (HR 1727, SB 1183)" (p. 1). She believes that this legislation will "promote collaborative research, advancing rehabilitation research and improving the quality of life for people who suffer from paralysis." Long believes this "bill will help improve people living with paralysis…and other types of disability diseases" (p. 2). Of Christopher Reeve, Long states "we all know who superman was, and we've seen him endure life from paralysis, and then he was gone. Dana his wife carried on the torch, not for her husband now but for the ones he wanted to help, those people who suffer from paralysis" (April 16, 2008).

Long (in press) believes that “researchers are close to a cure or therapies for people who are disabled or have paralysis.” For example, at the conference, Long states that she was “discussing the science of curing paralysis” with Dr. Wise Young and that “one small boy from Pennsylvania whose twin brother has been paralyzed from their birth gave Dr. Young his phone number and wrote down on a small piece of paper…when you find a cure for my brother, will you call me” (April 16, 2008).

It can be speculated that after Long’s crusades are successful she may adopt normalization I orientation (Darling and Heckert, in press). For example, as reported in the Johnstown Tribune Democrat:

> Grabbing the doorframe, 44-year old Madonna Long lifts herself and her wheelchair over the step into her living room. An advocate for the disabled, Long has few visible handicap-accessible alterations in her…home. “I just adapt,”…adding that she’s more interested in raising awareness for larger issues facing the disabled (Griffith, 2008, April, 25)

To summarize, clients with crusadership orientations identify with crusadership temporarily; once they achieve their objectives they typically fall into normalization (Darling, 2003; Darling and Heckert, 2005). For example, similar to clients who identify with affirmation, they join with groups of other individuals with disabilities to fight for collective rights; however, unlike affirmers, once the goal is achieved they return to normalization (Darling and Heckert, 2005). Moreover, the goal of organized campaigning is to achieve normalization, unlike affirmers who are proud to be permanently defined by their disability (Darling and Heckert).

Resignation

Clients that are cut off from information either by cognitive limitations or by lack of access may have a resignation disability orientation (Darling and Heckert, 2005). They may be unaware that individuals with disabilities have rights and collectively organize to ensure those rights are lawfully carried out or they may have significant disabilities that prevent them from readily engaging in activism (Darling and Heckert). They have resigned themselves to quiet acceptance of their life assuming or unaware that alternatives may exist. Individuals with resignation orientation have only experienced and assimilated the dominant culture ideals and values (Darling and Heckert, in press). They are "more likely to be exposed to the norms of the majority culture than to those of the disability subculture, because of the dominance of the majority view in the media and in society in general" (Darling and Heckert, pp. 10-11).

Darling and Heckert (in press) state, "some individuals who desire, but are unable to achieve, normalization do not have access to the disability subculture either" (p. 10). For example, these individuals may be illiterate, living in poverty, and residing in remote rural areas, often not even having access to a computer. Consequently, they would not only lack the means to attain normalization but would also be limited in learning about affirmation. In a sense, they do not belong to the majority or minority culture. They may have been exposed to how the majority culture without disabilities lives and works in society while unaware that individuals with disabilities can and do participate equally in society.

According to Darling and Heckert (in press), studies on individuals with resignation orientations are limited. They cite the example of a study conducted with African Americans with disabilities. In this study, Delieger and Albrecht (as cited in Darling and Heckert) interviewed individuals who resided in the inner-city. They found that these individuals were “more focused on issues of poverty and racism than they were on their disabilities” (p. 11). Darling and Heckert state that the participants in this study,

> In some ways, had more of a normalization than a resignation orientation, because they did not define themselves primarily in terms of their disabilities. However, they did seem to accept society’s negative definition of disabilities, based on a medical model (p. 11).

To conclude, studies on resignation orientation are limited. What is known is that individuals with resignation orientations typically identify with the dominant culture. They may lack access to information on disability rights and activism due to cognitive limitations or lack of access.

To summarize the typology of disability orientation, Darling and Heckert (in press) state that, “the typology…was intended as a framework for guiding future research in the disability field” (p. 13). They suggest the need for large-scale studies to determine the existence of and what proportion of the population of individuals with disabilities support a typology of disability orientations. Future research needs to examine the typology of disability. Specifically, Darling and Heckert propose that examining the “correlates of each type also is an important research topic” (p. 13).

As discussed, examining the existence of a typology of disability orientations for rehabilitation clients and professionals was beyond the scope of Phase I, Professionals and Phase II, Clients of this research. However, future research with professional and client samples could examine the existence of a typology of disability orientations and will be discussed in Chapter Six, Discussion.

Development of Disability Beliefs, Attitudes, and Roles

The next section in this chapter will review the literature for contributions to the development and maintenance of professionals' and clients' disability beliefs, attitudes, and role, including disability orientations and the components of identity (pride versus shame), model (social versus medical), and role (active versus passive).

Professionals

Prescribed roles. Prescribed roles can be deeply ingrained beliefs and attitudes that affect how clients and professionals view both their own and other's respective actions. Moreover, these beliefs and attitudes influence client-professional performance and behaviors as each one assumes he or she knows and can predict how the other should think, feel, behave, and respond. These beliefs and attitudes may interfere with the client-professional relationship, because the inability to hear each other due to preconceived perceptions decreases the exchange and flow of knowledge.

Development of ingrained beliefs and attitudes that influence client-professional relationships, performance, and outcomes occurs through exposure to multiple sources. For example, exposure to formalized training programs, the field of vocational rehabilitation, organizational culture, and views of society contribute to professionals' orientations. The next section will address the contribution of the following on professionals' beliefs, attitudes, and roles:

- Formalized training programs including exposure to the medical model and theoretical concepts including psychodynamic and cognitive behavioral.
- The field of vocational rehabilitation including the role of a state operated rehabilitation center.
- Socialization into organizational culture of the Hiram G. Andrews Center.
- Stigmatizing views in society including professional dominance.

Formalized training programs and medical model. How professionals assume their role in the vocational rehabilitation process may be related to their educational and organizational training. As previously mentioned, the medical model formerly dominated how professionals and clients perceived their roles. For example, based on professional training that is grounded in the medical model, one prescribed role of the professional based on the medical model is to help the sick client get better. If the client is deemed impaired and cannot get better, then custodial care is the primary professional role. The custodial role of the helping professional began to change in the 1960's and 1970's. During that time period, McPheeters (as cited in Harris and Maloney, 1999) suggested that professional training programs for mental health providers that were available in the 1960 and 1970's should include a generalist approach. The generalist approach recognized that clients required assistance in developing independent living skills as part of the movement toward deinstitutionalization (Harris and Mahoney). Prior to the generalist approach, professionals were trained that their role was to simply control clients in the institution and did not prepare clients for life on the outside of the institution's walls.

Harris and Mahoney (1991) state that the mental health worker's new role was based on the client's need to function independently in the community, in stark contrast to a controlled institutional environment. Due to the recognition of client's overall needs, the role of the human service worker was born in the 1970's, and mental health programs were now called human services (Harris and Mahoney). In theory, the role of the human service professional then and now is to expose clients to all opportunities so that he or she can equally choose to participate in education, vocational training, rehabilitation, supportive services, and employment, to name just a few.

Although training programs realized change in the 1970's, the role of the professional human service worker is still clouded and misunderstood at the training level. For example, although living independently in the community should also include the opportunity to equally participate in employment, McPheeters (as cited in Harris and Maloney, 1991) states that many human service-training programs' curriculums fail to recognize the entirety of human services. Similarly, Lee, Chronister, Tsang, Ingraham, and Oulvey (2005) state that although it has been demonstrated by Bolton and Akridge that vocational rehabilitation coupled with social skills for individuals with psychiatric disabilities results in better employment outcomes, it is not included in training for many rehabilitation counselor programs.

Professionals often perceive their own prescribed role as self-governing and above reproach (Giordano, 2001). Additionally, Freidson (as cited in Giordano) states that the medical profession intentionally creates client-professional walls with word usage. A group of professionals such as human service workers who are self-governing when providing services to clients can be likened to an oligarchy; a dominant group of professionals who control the entire field of human services. Using language that is germane only to professionals creates communication boundaries that cannot be broken by clients who are unfamiliar with professional jargon. These professional behaviors are in direct conflict with the overall role and vision of the human service professional that is assigned the role of assistant to the client in the delivery of human services.

Disability training in nursing programs. Explanation as to why professionals are oriented toward a particular disability model such as the medical model may be due in part to their educational training. For example, to determine the amount of disability training student nurses receive, Smeltzer, Dolen, Robinson-Smith, and Zimmerman (2005) administered a Disability Questionnaire to accredited schools of nursing. They received 234 responses from individuals identified as most knowledgeable in their school's undergraduate nursing program. In this study, Smeltzer et al. identified four models including medical, social, rehabilitation, and interface. Participants were asked to identify which of the four disability models were most utilized in their nursing training programs. Of the models identified by Smeltzer and colleagues, schools of nursing identified they used the medical model 89% of the time and the rehabilitation model 77% of the time. Smeltzer and colleagues define the rehabilitation model as growing out of the medical model, requiring the client to seek services from a professional, and viewing the client as failing if they are unable to overcome their disability. The social model was used 48% of the time, while the interface model was used 15.9%. Smeltzer et al. define the interface model as viewing disability "at the intersection (i.e. interface) of the medical diagnosis of a disability and environmental barriers" (p. 214). These percentage distributions clearly suggest that nursing students' predominant disability training exposure is toward medical and rehabilitation models, and less towards the social model.

Vocational Rehabilitation and the Medical Model

Many helping professions are rooted in the medical model. Freidson (1970) describes that in the United States, all of the healing professions are based on the medical profession. As previously discussed, current state and federal vocational rehabilitation programs originated from the medical model (Szymanski and Parker, 1996). The vocational rehabilitation professional team helps to cure the client based on the direction of the medical expert. For example, the vocational rehabilitation counselor essentially becomes part of the medical model team in that he or she administers the clients' rehabilitation plan based in large part upon the physician, psychiatrist, or psychologist's diagnosis and treatment recommendations. Consequently, the clients' vocational rehabilitation plan can be based more on the medical model and less on rehabilitation.

Vocational Rehabilitation professionals who adopt tenets of the medical model provide services to clients that will help to "cure" their disability. Theoretically, the medical model espouses that curing disability through medical methods and research will improve individuals with disabilities' lives. Similarly, tenets of normalization include the belief that individuals with disabilities want to experience lifestyles that are available to individuals without disabilities. Therefore, finding the cure for disability and improving clients with disabilities' lives enable them to return to or approach "normal," thereby fitting in with the dominant culture. Professionals trained in the medical model would agree that finding a cure for disability and returning a client to normal would allow clients with disabilities to be included in mainstream society.

Social Work and the Medical Model

The medical model approach was also used by social workers from 1920 to 1960 and consisted of diagnosing and treating the patient (Zastrow, 1996) with psychological disabilities. During that time period, clients with psychological disabilities were labeled as needing treatment (Zastrow) prescribed by physicians with expertise in psychiatry. Residential treatment was the medical model approach, and large numbers of individuals with psychological disabilities were involuntarily placed into hospital-like settings (Freidson, 1970). Institutionalization was the prescribed, long-term treatment for clients with psychological disabilities.

Potential impact on services to clients. The professional with orientation towards the medical model "equates disabled persons with their disabilities" (Smeltzer et al., 2005, p. 214). They are unable to extrapolate the human from the label. In other words, they fail to see beyond the textbook disability-related residual effects such as physical, emotional, or learning limitations. For example, they may fixate on a client with a spinal cord injury and resulting paralysis, focusing on the client's use of a wheelchair. They may equate all wheelchairs with sickness, assume a position of authority, and encourage client dependency and compliance (Smeltzer et al.).

Professionals with an orientation towards the medical model have a tendency to view clients with disabilities as pitiable. The client-professional relationship may be affected from the start, having little hope of becoming a positive experience for both client and professional. For example, professionals employed in comprehensive rehabilitation centers that provide medically orientated services such as physical or occupational therapy treat clients as if they are ill (Rubin and Roessler, 1997) when they may simply require help with services such as speech therapy or orientation to use of a manual or power wheel chair.

It can be speculated that because the predominant disability models used by nursing professionals are the medical and rehabilitation models (Smeltzer et al., 2005) nurses employed in vocational rehabilitation centers will focus on treating and fixing clients with disabilities. When professionals working in vocational rehabilitation centers treat clients with disabilities as if they are ill, clients reward the professional by assuming the sick role (Rubin and Roessler). Professionals who practice the medical model are providing services that are in direct opposition to preparing the client for independent living, reintegration into society, (Rubin and Roessler, 1995) and employment. These professionals perpetuate the client's dependency cycle and the belief that they require care by society and the government

Exposure to Theoretical Concepts

Helping professionals are exposed to multiple approaches as a result of formalized educational training programs. For example, professionals such as generalist human service workers, vocational rehabilitation counselors, and social workers are typically trained in psychological orientations, completing courses that emphasize contrasting theories such as psychodynamic/psychoanalysis and cognitive behavior.

Psychodynamic/Psychoanalytical Orientations

Psychodynamic theory espouses how individuals are driven by innate instincts (Ewen, 1993) as well as unconscious forces (Gerow, 1992) that battle to maintain psychological stability. Professionals with orientations toward psychodynamic theory espouse the importance of childhood memories and the effectiveness of long-term psychoanalytical therapy necessary to expose, identify, and resolve the unconscious conflict (Gerow).   Psychiatrists are extensively trained in psychodynamic theory and can provide long-term psychoanalysis.

Psychodynamic orientations have little to no relationship to organizational climates, in that human service professionals employed in government organizations have a fixed amount of time and resources. Professionals with psychodynamic orientations may waste precious time and resources attempting psychoanalytic techniques. Moreover, vocational rehabilitation professionals' client caseloads are enormous and constantly increasing (Szymanski and Parker, 1996), leaving no time to explore each client's childhood memories. Clients with disabilities seeking vocational rehabilitation services can become frustrated with practitioners who fail to recognize that vocational counseling, guidance, and employment assistance are priorities.

Cognitive-Behavior Orientations

Cognitive behavior theories focus on maladaptive cognitions and contingencies in the environment (Kanfer and Goldstein, 1991). In comparison to psychodynamic theories, which are grounded in innate, biological forces, cognitive-behavior theories focus on thinking as related to outward behaviors. Maladaptive thoughts that clients attribute to themselves, result in behavioral dysfunction (Hepworth and Larsen, 1993).

Professionals with cognitive-behavior orientations toward their clients may not have support from the medical professional to implement a cognitive-behavioral plan. In other words, the medical team may not have training, experience, exposure, or interest in the positive benefits of cognitive-behavior techniques, identifying more with the medical model. Consequently, vocational rehabilitation professionals are typically unable to provide and authorize funding for a cognitive-behavior program if not recommended by a physician. Similarly, supervisors functioning in organizations that adhere to prescribed structure may discourage cognitive-behavior techniques that are viewed as outside of the employee's scope of work.

State-Federal Vocational Rehabilitation Program

Professionals are required to work within the parameters of vocational rehabilitation. For example, the field of vocational rehabilitation operates under specific state and federal legislation. Due to state and federal requirements, state vocational rehabilitation programs must achieve mandated goals, objectives, and outcomes. These mandates are passed onto professionals as required performance standards and are assimilated into the client-professional relationship.

The following sections discuss selective placement primarily used is state-federal vocational organizations versus client-centered placement primarily used in non-profit community agencies, as well as the role of bureaucracy in state operated rehabilitation centers.

Selective Placement

Vocational rehabilitation professionals are required to successfully place at least 26 clients with disabilities into employment per fiscal year (Szymanski and Parker, 1996). Szymanski and Parker identify two diverse models or orientations of job placement for vocational rehabilitation professionals: selective placement, as based on the medical model and client-centered placement. The divergent models are utilized depending upon the particular type of organization in which a professional is employed. Selective placement is used in state-federal vocational rehabilitation organizations, and client-centered placement is used by non-profit community agencies (Szymanski and Parker).

The state-federal vocational rehabilitation counselors' orientation is the selective placement model (Szymanski and Parker, 1996). Szymanski and Parker explain that the United States Employment Service developed the selective placement model in 1933. Selective placement requires clients to complete medical and vocational evaluations. Based on the clients' evaluation scores, the counselor uses "trait-factor matching" to "employer requirements" to place the client into employment (Szymanski and Parker, p. 365).

The selective placement model implicitly gives power to the professional who decides the client's vocational future based on testing. Salomone (as cited in Szymanski and Parker, 1996) argues that selective placement increases clients' dependency on the counselor and does little in teaching clients how to get and keep a job. On the other hand, outcome statistics cited by the Pennsylvania Office of Vocational Rehabilitation appear to conflict with Salomone's argument about getting a job. For the year 2005, 97% of eligible individuals with disabilities were placed into employment (Pennsylvania Office of Vocational Rehabilitation Annual Report, 2005).

Client-Centered

Unlike government-operated organizations, non-profit community agencies allow the professional more treatment options. For example, professionals employed in non-profit rehabilitation and community agencies prefer orientations that are client-centered. Szymanski and Parker (1996) describe this approach as focusing on the counselor's optimistic outlook for the client. For example, the counselor and client dedicate considerable amounts of the vocational rehabilitation process in developing the clients' job seeking proficiencies. Psychoeducational counseling is used to promote client independence and increase opportunities for self-directed choices over their lifetime (Szymanski and Parker). Client centered orientations promote client empowerment and prepare clients for a future of financial independence and decision-making.

It is unclear whether data exist for successful client-centered employment outcomes. However, in Pennsylvania, only 35.6% of individuals with disabilities overall are employed, as compared to 78.4% of individuals without disabilities (United States Census Bureau, 2000). statistics for the year 2006 are similarly negative, citing that 37.7% of individuals with disabilities are employed relative to 79.7% of individuals without disabilities (Cornell University, Disability Status Report, 2007). Future studies should compare successful job placement statistics relative to practitioners' use of either selective placement or client-centered orientations.

Role of the State Operated Comprehensive Rehabilitation Center

Another contribution to professionals' orientations is the role the comprehensive rehabilitation center has on the client and professional. For example, comprehensive rehabilitation facilities such as the Hiram G. Andrews Center are large, state operated, and governmentally controlled entities. Legislation, established procedures, and funding streams govern what services professionals can provide. Likewise, the client's perception of the role a governmentally controlled rehabilitation center and the contribution bureaucracy plays in their vocational rehabilitation and the delivery of human services must be considered.

Bureaucratic Systems

Knopf (as cited in Zastrow, 1992) defines the trademarks of bureaucratic systems to include "power, hierarchy, and specialization; that is, rules and roles" (p. 601). Human service agencies and programs often exist under state, federal, and county control. Professionals who are employed by large, government human services organizations such as state operated vocational rehabilitation centers or county mental health agencies must function within a system that strongly adheres to policies established by the federal government, implement directives as developed by state government, and adapt to fluctuating funding for county mental health programs.

These types of organizations have a hierarchical organizational structure. The Executive Director is at the top of the hierarchy and may work in another part of the state, far removed from clients and professionals. Professionals may perceive the Executive Director as their invisible leader because he or she will never have the opportunity for a personal or professional interaction. The leadership style may be likened to laissez-faire in that "there is no exchange with followers or any attempt to help them grow" (Northouse, 2001). Likewise, it can be speculated that laissez-faire leadership could be assimilated into a government organizational climate and projected onto client-professional relationships. In other words, professionals may assume a hierarchical structure, positioning themselves as the leader in the client-professional relationship instead of as equal partners.

Mechanistic approach. The mechanistic approach is a derivative of Taylorism, a method by which employees perform like well operating, predictable, and efficient machines (Morgan, 1997). The mechanistic approach can be applied to bureaucratic systems in that the machine is identified as the organization (Morgan). In other words, the "mechanical imagery underplays the human aspects of organization" and ignores the reality that humans, not machines are necessary (Morgan, p. 27) in providing human services to humans. Mechanistic approaches can thrive in organizations where thinking and planning is done by a centralized staff (Morgan, 1997), such as in government organizations with central offices and top executives are located far removed from the delivery of human services.

Morgan identifies the following necessary elements for a mechanistic organization:

- *Perform a straightforward task*.
- *Stable environment that produces appropriate products*. While an organization can be stable and "appropriate products" can be likened to clients with successful outcomes, the organization can still be a thriving failure (J. Anderson, personal communication, 2005). For example, another unrelated variable might contribute to successful client outcomes that resulted in the client resolving his or her issues regardless of the association with the professional or organization.
- *Repeatedly produce the same product*. Due to policies and directives, government organizations can force professionals to fit all clients into the same plan.
- *Preciseness is highly valued.*
- *Human machines need to operate like machine parts, through compliance and behavior control*. Professionals may expect their clients to assume a mechanistic response with unquestioning agreement and compliance.

Mechanistic organizations require removing the human interference that might disrupt the structure that maintains the domination of top executives. Unquestioning authority, power, compliance, and control are highly valued, and professionals learn to accept those values if they want to survive. For those professionals who declare war with a bureaucracy, “the system will always find a way to dismiss you if you remain at war” (Zastrow, 1996, p. 603). While the dominant culture is maintained, organizations, professionals and clients remain stagnant.

Socialization into organizational cultures. Prescribed organizational climate/culture and performance roles are a result of how professionals experience, view, perceive, and interpret the workplace environment. Consequently, the professionals’ ideals of the workplace may be deeply ingrained and resistant to change. Similarly, clients may have preconceived ideas relative to government bureaucracies and professionals’ abilities in providing human services. Clients may assume all rehabilitation professionals are governmentalized and fail to recognize the existence of individual differences.

Personal values conflict. The relationship between an organizational climate/culture and professionals’ orientation toward their work and toward their clients can often be estranged. Zastrow (1996) outlines how human service professionals’ values can conflict with organizations that function under a bureaucracy. He states that helping professionals value a democratic system, equal distribution of power, organizational growth, innovative thinking, and focus on the feelings of clients and colleagues. Conversely, bureaucracies value an autocratic system, unequal distribution of power held by a few top executives, maintaining structure and the status quo, a focus on the organization, and highly stable procedures (Zastrow).

To compensate for their values conflict, helping professionals give the organization a personality (Zastrow). Knopf (as cited in Zastrow) explains this type of coping strategy as ineffective, because helping professionals cannot personally interact with an organization. Knopf states that the end results are professionals who expend a considerable amount of energy while in conflict with an organization in which “very little is accomplished” (p. 602). It can be assumed that the very little accomplished is at the expense of the client.

Effect on employee performance. Kopelman and colleagues (as cited in Patterson, Warr, and West, 2004) propose that organizational climate has a direct effect on employee performance and productivity, specifically, cognitive and affective states. They define a cognitive state as an employee’s motivation toward work and an affective state as the feeling that reflects how satisfied he or she is with his/her job. Kopelman and colleagues identify three kinds of behaviors that are influenced by the organization’s climate that can directly affect the employees’ output:

- *Attachment behaviors*. Employees who are committed to staying in the organization.
- *Role-prescribed behaviors*. Completing job tasks as identified by the organization.
- *Citizenship behaviors*. Employees who perform job tasks that are not mandatory.

Patterson, Warr, and West (2004) describe behaviors that may help explain government organizational climates and professionals. For example, if any one of the three above behaviors malfunctions it may harm the client-professional relationship while the organizational climate is unharmed. Professionals who have been employed for long periods of time in government organizations may be committed to the attachment behavior of staying in the organization. However, staying in the organization can malfunction when their commitment to stay is mostly motivated by large pension funds, cash payment for unused sick days, and paid medical benefits upon retirement. In other words, professionals who put time in only to ensure they will be rewarded with a comfortable pension lose sight of the purpose of their employment, namely, providing effective human services.

Professionals' orientation toward their clients can be affected by a malfunction of role-prescribed behaviors. Many human service professionals employed in a government system obtain their employment through the Civil Service Commission. Since the Civil Service Commission has a role in the professionals' job classification and minimum experience and training requirements for positions, the scope of work may not include all of the job tasks that need to be performed in order to have effective client-professional relationships. In other words, job classifications and minimum experience and training requirements lapses can occur when supervisors fail to update job descriptions, or bureaucrats who are located far away from professionals and the work performance approve job descriptions and minimum experience and training requirements.

The overall mission for professionals employed by vocational rehabilitation organizations and centers is to provide services to clients with disabilities that will lead to employment. However, due to a significant number of employees that represent multiple job classifications, the overall mission may get muddled. For example, vocational rehabilitation instructors employed in comprehensive vocational rehabilitation centers may erroneously assume that job placement is not part of their job responsibility since it is not specifically stated in their job description. In other words, professionals may feel as if the mission and vision of the organization does not apply to their specific prescribed role as indicated by their job description.

Effect on clients. Most government human service agencies usually "maintain a monopoly over the services they deliver" (Giordano, 2001, p. 35). The client seeking services may be unaware that professionals are operating within a mechanical, fixed, structured organizational climate. Complications can develop in client-professional relationships when professionals do not inform clients of the limitations relative to the organization. For example, clients with disabilities participating in vocational rehabilitation may have to wait up to 60+ days before being informed by the professional that they are or are not eligible for services. Without sufficient explanation from the professional of the allowable 60-day determination period, clients can conjure up many mistaken explanations as to why their services have not been initiated. If after 60 days the client is determined eligible for services, he or she may have already emotionally and physically dropped out of the program before services even get started.

Socialization into Hiram G. Andrews Center culture. Professionals at the Hiram G. Andrews Center are socialized into the Center's culture through formal staff orientation. According to information provided on February 11, 2008 by the Human Resources Director at the Hiram G. Andrews Center, "there are three forms of orientation for our staff." First, all Commonwealth Employees must complete "Formal New Staff Orientation." This is completed using the state's Employee Self Service system located on the Labor and Industry Online Network, a secure intranet site. The Human Resource Director states that once this is completed, "a checklist is signed off by both employee and supervisor, forwarded to [Hiram G. Andrews Center], and submitted to Harrisburg for insertion in the official personnel file."

The second type of formalized training is "Hiram G. Andrews Center New Staff orientation." New employees meet with the Director, Deputy Director and each of the five Division Managers representing the Business, Student Services, Maintenance, Education, and Allied Health Divisions. These meetings are "to provide an overview of the entire Hiram G. Andrews Center operation." During those meetings, the Human Resource Director states, "There are certain Hiram G. Andrews Center specific forms that are reviewed and signed." The Human Resource office "keeps a list of mandatory trainings that need to be completed" and can include topics such as Ethics, Drug and Alcohol, and Sexual Harassment (Hiram G. Andrews Center Human Resources, February 11, 2008).

The third type includes "Division/Job Specific Orientation" provided by Division Managers and Supervisors who "are responsible for providing all new staff the tools they need in their work environment." This also includes "reviewing and signing of position descriptions, job expectations, job standards, a tour of the facility, and staff introductions" (Hiram G. Andrews Center Human Resources, February 11, 2008).

There is only one peer-to-peer mentoring program at the Center. The Vocational Instructors in the Education Division developed a Mentoring Program and Manual, which is offered to new instructors.

Professionals' Views Toward Their Work

Morgan (1997) states that employees or professionals bring to the organization their own "private attitudes, values, preferences, beliefs, and set of commitments from outside of work" (p. 161). Professionals must fit their own system of existing in the world into a pre-established organizational culture. The fit may conflict with their ways of thinking, feeling, responding, and most importantly, interacting with clients creating an internal tension. In other words, the professional may have the tools and techniques to be effective but may be rendered ineffective due to organizational parameters.

Professional aspirations. While negotiating within an organization, professionals' attitudes toward their work and toward their clients are also affected by their career, promotion, and financial aspirations. A separate drama can unfold when professionals follow their own agendas (Morgan, 1997), and their orientation to their work can be altered. Personal agendas can lead to behaviors of "careerism, gamesmanship, task commitment, rigidity, turf protection, zealousness, detachment, and freewheeling" (Morgan, p. 163). For example, for professionals with promotion aspirations, resentment to work may develop and foster when they are passed over for a promotion. The professional may display the behavior of detachment from the organization and clients, becoming an employee who puts in time. As professionals strive to reach their own personal agendas, they can move farther away from the overall mission of the human service organization.

Professional burnout. Attitudes towards work can be affected by burnout. Many professionals may enter the human service profession thinking they can change the world but soon burn out due to the organizational climate, the need to strictly adhere to prescribed roles, and follow procedures that interfere with successful client-professional relationships. Cherniss (as cited in Harris and Maloney, 1999) identifies signs of professional burnout as "increasingly going by the book, stereotyping clients, discouragement and clock watching" (p. 210). Keiv and Kohn (as cited in Organ and Bateman, 1991) surveyed 2500 managers who indicated that organizational political climate is the third most frequent area of stress. Organ and Bateman caution that individuals who are not equipped to work within and around organizational politics will endure chronic stress.

Professional bias and stereotyping. Professionals working with individuals with disabilities might secretly (or openly) agree with disparaging stereotypes of disabilities. For example, more than any other disability, employers discriminate against individuals with psychiatric and substance abuse disabilities (Szymanski and Parker, 1996). Employers also assume individuals with disabilities will not be as productive, miss more work, and not have the abilities to perform the job (Rubin and Roessler, 1995). Vocational rehabilitation professionals may have assimilated these stereotypes resulting in a negative beliefs and attitudes toward their work. They may agree that individuals with disabilities will not be able to be employed or have a bias against a particular disability group. These professionals will assume their role is to provide very little assistance toward successful vocational placement. Moreover, professionals with biased beliefs and attitudes toward their work are in direct conflict with the organization's mission.

Professionals are typically part of the dominant culture and may subscribe to the guiding principles that maintain inequality. For example, Charles Murray (as cited in

Zastrow, 1996) is staunchly against government programs that provide public assistance. In the same way, professionals may be against the philosophy of public services and harbor resentment toward clients participating in the very government funded organization in which they are employed.

Professionals' beliefs about clients' rehabilitation needs. Professionals concentrate on their clients' problems (Seligman and Darling, 1997) as related to their diagnosis (Spengler et al., as cited in Seligman and Darling). Specifically, professionals may place more focus on making the diagnosis a personal problem and less focus on understanding how the client fits into his or her community. For example, a client participating in the vocational rehabilitation program may encounter a professional who is more fixated on his or her recently diagnosed physical disability. The client may have been previously employed in the construction trades but due to his or her physical disability may not be able to return to that profession in his or her previous capacity. Due to the professional's fixation on the client's diagnosis, the professional may insist the client needs to participate in multiple vocational rehabilitation services. The professional may develop an extensive vocational rehabilitation plan that includes adjustment to disability counseling, completion of multiple vocational and neuropsychological evaluations, functional capacity assessments, and enrollment in an educational training program. However, it may be that all the client really wants and needs is assistance in resume writing and job seeking skills to quickly locate and secure employment to maintain economic stability. Professionals need to account for individual needs relative to needing to fit into the perfect textbook vocational rehabilitation plan for a specific diagnosis.

In a study by Darling, Hager, Stockdale, and Heckert (2002), 188 human service professionals and 217 clients completed a survey that required the participants to indicate their perception of the level of the clients' needs. The professionals viewed their clients as needing significantly more support than what the clients perceive themselves as needing (Darling et al., 2002). Convincing the other that their perception of need and assistance is skewed can create incongruence in client-professional relationships. For example, if the client rejects the professional's recommendation for counseling, the professional may incorrectly assume the client has not accepted his or her disability. Consequently, the client may be labeled difficult and uncooperative.

Negative beliefs. Two highly damaging beliefs held by some professionals regarding clients with disabilities include: 1) the assumption that having a disability is negative and 2) that if given a choice, the client would choose not to have a disability. Rousso (as cited by Selgiman and Darling, 1997) states that professionals who would choose not to have a disability have difficulty relating to their clients. Their perception of their clients' life is one of tragedy and despair; they fail to see that clients' with disabilities can lead rich, full lives and are identified by more than just their disability.

Negative attitudes. The literature supports that in general professionals' attitudes towards individuals with disabilities are much more negative than clients. These negative attitudes may be acquired as a result of formalized training programs and exposure to negative attitudes held by professionals. For example, in a study conducted by Brillhart et al. (as cited in Johnston and Dixon, 2006) it was determined that nursing students attitudes towards individuals with disabilities deteriorated over the course of their training. The poorest attitudes were held by nursing faculty and upon graduation, nursing students’ attitudes were not significantly different from those of the nursing faculty. Brillhart et al. (as cited in Johnston and Dixon, 2006) state that the negative attitudes against individuals with disabilities held by nursing faculty had an impact on the development of negative attitudes in their nursing students.

Other negative attitudes held by professionals towards clients with disabilities may develop as result of contact with clients. Darling (1988) cites an example of a pediatrician's negative attitude toward providing health care service to a child with disability. The pediatrician states that he does not enjoy working with a "handicapped child" that is drooling and is unable to walk (p. 149). The experience reminds him of his own inabilities and view that medicine is geared to perfect the human body. Darling states that many physicians do not like treating clients they view as being incurable.

A study conducted by Gerhert and colleagues (as cited in Pfeiffer, et al., 2003) supports that professionals providing services to clients hold negative attitudes towards individuals with disabilities regarding their quality of life. For example, 86% of individuals with high level spinal cord injury rated their quality of life as average or better in comparison to the general population. In comparison, only 17% of the rehabilitation physicians, nurses, and technicians providing services to those individuals rated held the same opinion. This study indicates that almost 70% of professionals did not view clients with high level spinal cord injury as being capable of having a quality of life that is average or better in comparison to the general population. However, due to newer training programs for physicians, negative and stigmatizing attitudes towards patients with disabilities may be less prevalent than in than in the past (Seligman and Darling, 2007).

Incongruence between client-professional beliefs and attitudes can affect the relationship. The professional may view disability negatively and if given a choice, would not want to have a disability. The client, on the hand, may view disability positively and with acceptance. For example, I asked a highly successful vocational rehabilitation professional colleague if she would choose not to have her physical disability and visual impairment. She emphatically said, "No" stating her disabilities have made her what she is today, "a better person." However, she added, that just once she would like to see clearly enough to be able to drive a car and not have to wear a prosthesis when swimming. Professionals need to be able to distinguish the difference between being content with one's life as an individual with a disability and conversations that center around and allow the opportunity to momentarily wonder about performing feats that are not available given certain disabilities.

Professional Dominance/Occupational Prestige

Professionals tend to have greater occupational prestige and be of higher socioeconomic status than other members in society. Because of their occupation and economic independence, they are more likely to identify with the dominant culture that views clients with disabilities negatively and as non-contributors to society. Additionally, professional training programs in the past emphasized negative positions towards individuals with disabilities (Seligman and Darling, 1997).

The role of professional dominance in explaining potential difficulties in client-professional relationships can be examined through the symbolic importance society places on occupational prestige. Occupational prestige includes the assumption that one-group of individuals possesses a specific knowledge and expertise that places them above another group of individuals (Treiman, 1976 as cited in Grusky, 2001). Often, groups of individuals possessing this level of skill are financially rewarded. Marx contends that although political, religious, and cultural factors contribute to an individual's place in society, the ultimate determining factor is economics (Hurst, 2004). In many societies, economic superiority symbolizes power (Treiman, 1976 as cited in Grusky, 2001), which affords the type of authority that is less likely to be questioned or challenged.

Members of society in most developed countries place high prestige on certain occupations such as physicians (Freidson, 1970). The role of physician is associated with having the ability to affect life or death (Goldthorpe and Hope, as cited in Grusky, 2001). It is assumed that physicians have the knowledge, authority, and power to make decisions that can improve and increase an individual's quality and quantity of life. Consequently, physicians are symbolic healers and represent the highest authority (Freidson) over all other professions.

Perpetuation of societal acceptance of professional dominance may be understood through the structural-functional paradigm. This paradigm places more emphasis on "dominant cultural patterns" and less emphasis on the significance of change (Macionis, 1992, p. 46). As the dominant groups' guiding principles are accepted into a culture, clients assume the subordinate behaviors of "submissiveness, dependency, and helplessness" (Miller, as cited in Rothenberg, p. 76). Moreover, individuals with power have the ability to socially construct reality and "transform people into problems" (Tice and Perkins, 2002, p.200).

On the other hand, some professionals' have chosen to work with individuals with disabilities (Seligman and Darling, 2007). For example, some pediatric physical therapists choose to work with individuals with disabilities. Other reasons cited by Seligman and Darling that professionals' choose to work in the field of disability include interest, altruism, monetary gains or other rewards, and convenience.

Due to the economic benefits of occupational prestige, physicians have more opportunities to be decision and policy makers as members of non-profit, hospital, or local and county government boards. Clients, on the other hand, learn to assume subordinate behaviors and are less likely to have as many opportunities for occupational roles that lead to power, authority, and the ability to participate in policy development.

Professional Dominance in Residential Programs

Freidson (1970) describes residential treatment based on Erving Goffman's analysis of institutions. Goffman states that clients follow a standard schedule and are told by professionals when to dress, rest, and eat (Freidson). Clients' behaviors are viewed as symptoms of a disease and not as "deserving an answer on its own terms" (p. 29). In other words, the disease explains the clients' behaviors; therefore the disease needs to be managed (Freidson). Due to the identified skills and assumed expertise of professionals, would be healers such as therapists, nurses, social workers, and counselors have the authority and power to manage and control the clients' behaviors.

Clients in institutional settings are powerless and can only experience life from the inside while aware that professionals have the power to leave, make their own choices, and experience life from outside of the institution (Freidson, 1970). Behaviors that are acceptable outside of a residential setting such as sleeping late or choosing not to eat at specified time, may be deemed as symptoms of a clients' disease that need to be managed. Clients learn to placate professionals by adhering to the rules (Freidson, 1970);

clients eat, sleep, dress, and participate in recreational activities when told. In the intervening time, professionals wait for a medical cure, and clients are not rehabilitated (Rubin and Roessler, 1995).

An institutional community can develop and "drive a wedge between" the client and "those supposed to be helping him" (Freidson, 1970, p. 29). The community not only consists of professionals who work within "networks of organizations concerned with healing" but also clients' families and members of society (Freidson, p. 30). For example, parents often blindly follow physicians and other helping professionals' directives without hesitation or further contemplation (Seligman and Darling, 1997). Members of society support the perception that occupational prestige equals unquestioning power and authority. As a result, the client-professional relationship as based on the medical model and professional dominance is sustained directly by the client's intimate network of support and indirectly by members of society's dominant group.

Leader versus follower. As discussed, society places a significant amount of occupational prestige on the role of physician. Many human service programs and workers follow the medical model, and supportive professionals such as vocational rehabilitation workers become part of a team that is led by a physician. Consequently, it can be argued client-professional relationships that are based on the medical model and the dominant culture's guiding principles that equate occupational prestige with power and authority set up the roles of leader and follower. As the leader, the professional enters the relationship with a decided advantage.

A temporary inequality is created in client-professional relationships in which the professional/dominant has more power over the client/subordinate (Miller, as cited in Rothenberg, 1998). The "tension set up by equal individuals and unequal roles" (Meyer as cited in Grusky, 2001, p. 889) is related to professionals who have advanced degrees and credentials and clients who do not. By virtue of an educational degree, credentials, or job title, the professional has the prescribed role of judging the client. For example, throughout the history of providing human services to individuals with disabilities the role of the professional or groups of professional is to determine if the client is eligible for the service. Even clients with disabilities who identify with the disability pride model may be less likely to challenge a professional during the eligibility phase of the relationship due to the implications of power perceived in this unequal relationship. In other words, they need to play the subordinate role in order to be eligible for a necessary human service.

Clients who seek services from public agencies such as the Office of Vocational Rehabilitation may learn to present a quiescent-like role. For example, Gaventa's (1980) outline of the dimensions of power and powerless can be applied to unequal client-professional relationships. Gaventa states that power and powerlessness occurs when "A" or a professional has control and power over "B" or a client. When clients allow professionals to control the delivery of their human services without exhibiting any challenging behavior, doing nothing becomes an engrained expected pattern of behavior. Consequently, when a professional encounters a client who challenges his or her decision, the client may be labeled uncooperative and difficult.

The role of the medical service professional is symbolic of providing help that leads to healing and a reduction in problems for clients. However, what a professional perceives as a problem can differ dramatically from how a client perceives his or her reason for seeking out a human service. For example, in a study conducted by Darling and colleagues (2002), they determined that professionals tend to focus on clients' "personal and family problems" (p. 42) while clients wanted public services such as libraries. Diagnostic overshadowing, as defined by Spengler et al. (as cited in Darling, et al., 2002) is typical of professionals who fixate on a client's diagnosis as a contributing factor to the problem and solution. Clients have a tendency, in other words, to define their problems differently, which requires resolution through several modes such as family, employment, and community (Darling et al.).

Questioning professional dominance. Professionals, such as Goffman, who began to question the dominant groups' views relative to client-professional relationships (Freidson, 1970; Rubin and Roessler, 1995), helped to drive changes in residential treatment and institutional care. Additionally, disability consumer groups modeled after social activism of the 1960's also challenged professional dominance realizing "they did not have to be passive recipients of rehabilitation services" (Rubin and Roessler, p. 43). As a result, client-vocational rehabilitation professional relationships can be antagonistic and challenging. Outside agencies, for example, may need to referee the rehabilitation process. The Pennsylvania Client Assistance Program is a vocational rehabilitation watchdog organization that is knowledgeable in disability rights and advocacy. Their attorneys are extremely skilled in mediating disputes between vocational rehabilitation clients and professionals.

Professionals, disability, and consumer groups contributed to initiating change for individuals with psychological and other disabilities. Professional dominance continues to be questioned as only 43% of the population in 1975 supported confidence in physicians as compared to 72% in 1966 (Seligman and Darling, 1997). Due to the structure of managed care organizations, physicians have "less rigorous conditions of work" necessitating more involvement of "subordinate" staff in-patient care (Freidson as cited in Mick, 2004, p. 909). Moreover, the medical model faces challenge by the social model, which looks at social problems on a macro or societal level rather than on the micro or individual level (Darling and Heckert, 2005).

To summarize professionals' orientations, vocational rehabilitation professionals who have received training in the medical model are socialized into a bureaucratic culture and often accept stigmatizing views in society regarding individuals with disabilities. They may primarily focus on providing services that help clients return to normalization in order to ensure inclusion in society. To empirically determine the views of professionals at the Hiram G. Andrews Center, a slightly modified version of the Questionnaire on Disability Identity and Orientation (QDIO-P) will be administered. The next section will discuss clients' orientations in relation to their beliefs, attitudes, and roles related to disability.

Clients' Views Toward Professionals

Early Exposure

Similar to professionals, clients enter into vocational rehabilitation programs with deeply ingrained predispositions. Deeply ingrained beliefs and attitudes toward professionals and programs may be based on clients' early exposures. For example, depending on the situation, the client’s beliefs and attitudes of professionals may vary. Parents of children with learning, physical, or psychiatric disabilities may need to form multiple client-professional relationships beginning from the birth or adoption of their child. Similarly, the child with a disability typically forms relationships when he/she is very young. Due to this type of exposure occurring in various situations over a long period of time, the parents and the child with a disability probably have experienced both positive and negative client-professional relationships. Each of these exposures to different situations contributes to their beliefs and attitudes of how they view professionals.

Positive beliefs and attitudes. An example of a positive beliefs and attitude of professionals is when parents of children with disabilities develop a client-professional relationship that is a partnership. Summer, Hoffman, Turnbill, Poston, and Nelson (2005) define a partnership as collaboration between multidisciplinary teams, clients, and their families. Federal law and the Individuals with Disabilities Education Act require that parents of children with disabilities be informed and involved in their child's education (IDEA; A. P. Turnbull and H. R. Turnbull, 2001 as cited in Summer et al., 2005). When a child begins his/her education it is necessary for parents of children with disabilities to develop a client-professional partnership so that their child has equal access and opportunities to thrive educationally.

Parents who have worked in positive client-professional partnership relationships expect "mutually supportive interactions between families and professional" (Summer et al., 2005, p. 66). To help identify factors for a positive family-professional partnership, Summer et al. developed a Family-Professional Partnership Scale. The scale accesses the parents' perception of importance, satisfaction, and their experience with a family-professional relationship. They determined that families placed high satisfaction scores on the following:

- The professionals' ability to use words they could understand.
- To show respect for their family.
- To be friendly.
- To treat their child with dignity.
- Protected their family's privacy.
- To keep their child safe when in the care of the professional.

The above factors identifying positive family-professional partnerships are applicable to adult client-professionals relationships. These factors represent clients' early experiences and expectations of working with professionals. As an adult client working with professionals, difficulties may result when these expectations are not met.

Clients view professionals more positively if they are willing to step out of the professional role and challenge the human service system. For example, Hickman (as cited in Seligman and Darling, 1997) discusses a parent of a child with a disability who described a positive experience with a professional, a teacher who would battle the system. Similarly, a study conducted by Ribner and Knei-Paz (2002) indicated that women liked when their social worker showed a "sincere desire to help rather than just fulfilling a prescribed responsibility" (p. 384). Likewise, clients can view professionals as ineffective when they encounter those who strictly adhere to agency rules and ardently follow bureaucratic procedures. However, in a study by Giordano (2001) examining client-professional relationships, even when the client has a "positive attitude" toward professionals, clients still felt the professionals were "relatively ineffective at accomplishing major tasks" (p. 36).

Negative beliefs and attitudes. Parents or clients who have experienced a negative client-professional relationship may believe professionals are thoughtless, ineffective, and uncaring. For example, Seligman and Darling (1997) cite examples of negative professionals' behaviors including blaming a child's unrelated medical concerns on her diagnosis of Down syndrome or not taking the medical concerns of a child with a disability seriously. These experiences contribute to parents challenging professionals' authority (Seligman and Darling), or assuming all professionals' suggestions and guidance warrant challenging, which can interfere with positive client-professional relationship building. Moreover, disability experiences such as negative client-professional relationships can transfer into adult client-professional relationships.

Newly Acquired Disability

Adult client-professional relationships can be challenging for clients with a newly acquired disability. For example, the attitudes of clients with a recently acquired disability can be the determining factor for their successful rehabilitation (Larner, 2005). Prior to their newly acquired disability, clients were part of the majority culture and may have had positive interactions with professionals. However, as previously discussed, professionals can hold negative attitudes towards their clients with disabilities. Chubon (1982) states that rehabilitation professionals may agree with the general public and the erroneous assumption that client' attitudes are to blame for difficulties in vocational placement. Moreover, clients are the reason for resistance in assimilating individuals with disabilities into mainstream societies (Chubon). A client with a newly acquired disability, who until their disability lived a significant part of their life as part of the majority culture, could find this so called double standard confusing.

Clients can be in conflict with negative professional attitudes and procedures. For example, Larner (2005) identifies two challenges clients with a newly acquired disability may face that are directly related to organizations and professionals: 1) dealing with hospital procedures and 2) developing appropriate relationships with staff. This can be especially challenging to a client with a newly acquired disability when they are in need of services provided by professionals who may hold negative beliefs and attitudes towards individuals with disabilities. For example, Larner states all members of the multidisciplinary team have an important part in a client's rehabilitation. Nurses in particular are "in a position to influence the psychological outcome of the rehabilitation because of their intimate involvement in the health crisis" (p. 34). Likewise, McDaniel (as cited in Chubon, 1982) states that the attitudes of the professionals who provide rehabilitation to the client is the most important determinant in how the client will respond to rehabilitation. Professionals with negative attitudes towards clients with newly acquired disabilities may set the client up for unnecessary obstacles in their rehabilitation.

Similarly, clients’ pre-existing conceptions of health and professionals can influence their approach to rehabilitation. Maes and colleagues (as cited in Larner, 2005) state clients react to a newly acquired disability by "redefining the situation that threatens their usual conception of health” (p. 34). For example, clients may compare themselves to others they feel are less fortunate, focus on their own attributes that give the appearance they are more brave or well-adjusted than they are, or develop hypothetical scenarios where they imagine the situation could have been worse (Larner). Wills (as cited in Chubon, 1982) identified client-professional similarity as capable of influencing professionals' attitudes in separating the pathology from the person. Clients with a newly acquired disability are very dissimilar from a professional without a disability. Therefore, based on dissimilarity, the client-professional relation may be fraught with erroneous beliefs and attitudes that impinge the clients' rehabilitation.

Medical Model/Stigma

As previously introduced, many clients' predispositions can be traced back to the medical model. For example, the sick role as introduced by Parsons in 1951, is an unwelcome state that necessitates the client seeks help from a professional in order to return to normal (as cited Rubin and Roessler, 1995). Based on clients with disabilities' experiences with the medical model and sick role, they may become conditioned to responding as if they are individuals with a disease that can be cured or controlled by professionals. They may come to rely more on the system for support and less on family and community.

Root (2005) discusses her own experience as an individual with a psychiatric disability. The following describes her socialization into the medical model:

> I knew that I was in no danger of killing myself, but realized I had been playing brinkmanship with the counselor by repeatedly hinting at suicide as a cry for help. At the same time, I had a good job and was performing it well. I also had a home and a son to whom I had bid good-bye that morning with no inkling that never again would I return to that home nor to any semblance of the life I once lived and loved…Through a number of

> short-term hospitalizations during this period, I was indeed walking a borderline tightrope between being self-sufficient and giving in to a system upon which I was becoming more and more dependent (p. 144).

When she returned home after her hospitalization and treatment that included medication and electroshock therapy treatment, she discusses that she was "Alienated from home and community and stigmatized by mental illness, friends shunned me and my family members' lives went on as though I had died" (p. 145). Based on her statement, she attributes alienation to her experience with professionals, treatment, and the stigma of being an individual with a psychiatric disability.

Bureaucratic Systems and the Medical Model

Clients' orientation to vocational rehabilitation contains components of the medical model. For example, the Office of Vocational Rehabilitation refers clients to the Hiram G. Andrews Center. Prior to admittance to the Hiram G. Andrews Center, Vocational Rehabilitation field counselors representing one of the district offices meet with each of these clients and provide extensive vocational counseling and guidance. The Office of Vocational Rehabilitation field counselors gather and review the clients' medical and/or psychological history. If the medical or psychological histories are incomplete, the field counselor provides funding and coordinates evaluative services with the appropriate medical professional. Based on the clients' medical and psychological records and professionals’ recommendations, the field counselor determines if the client is or is not eligible to receive vocational rehabilitation services. The client and counselor develop an Individualized Plan for Employment including researching options, developing a vocational goal, and referral for services at the Hiram G. Andrews Center.

Clients' Exposure to the Hiram G. Andrews Center

Orientation

Medical model. Clients' orientation to the Hiram G. Andrews Center contains components of the medical model in that professionals take the lead in orienting clients to the Center. For example, residential clients typically arrive the Saturday or Sunday before the first day of the beginning of fall, spring or summer term. On the first day of the term, clients participate in "Term Registration Protocol." All clients convene in the Center's seminar theater and complete registration. Clients are seated and various Hiram G. Andrews Center staff stands in front and addresses the clients. For example, the counseling supervisor, financial aid representative, and education director address the clients explaining the rules of the Center and the roles and expectations of the clients.

The nursing staff also addresses the clients. The nurses discuss the hours of operation for the Center's health clinic and available services such as pharmacy. Clients are informed of the Center's general practitioner and psychiatrist's office hours. The nursing staff presents a video to the clients on sexually transmitted diseases. Nursing staff meets with clients in a separate room and complete a "Nursing Admission Assessment." This form includes assessment of the following: "present illness and chief complaint, past medical history, mental status/psych admission, and drug/alcohol history, assistive devices, and impaired skin integrity, medications, past surgical history, mobility, and activities of daily living function, bladder/bowels, menstrual history, and allergies."

After the morning program completion, clients are then directed to meet with their vocational rehabilitation counselor and academic advisor. In the afternoon, clients return to the seminar theater, are seated, and additional staff, including recreational, learning support, and transitional living staff, address the clients. During their first week of the term, clients are also required to complete a hearing evaluation conducted by a speech therapist.

Clients' expectations. Understanding what the clients' expectations are of their participation in vocational programs at the Hiram G. Andrews Center may help clarify their exposure to beliefs, attitudes, and roles related to disability. Research into clients' expectations for their participation in vocational rehabilitation is included in the literature. In a study conducted by Koch (2001), clients' preferences versus anticipations for participating in vocational rehabilitation were examined. Koch states, "The client and counselor must first develop an understanding of each other's expectations, even if these differ" (p. 76). This research is interesting in that Koch examined clients’ anticipations or preconceptions regarding vocational rehabilitation. To determine the clients' expectation of their counselor, rehabilitation process and services, Koch used "grounded-theory, qualitative methods" (p. 76). She designed "the survey of Vocational Rehabilitation Preferences and Anticipations, an open-ended, paper and pencil questionnaire" (p. 78).

Overall, Koch's (2001) questionnaire sought to determine what qualities the client "would like" in their counselor versus what qualities "do you think your counselor will have." In the response category of "client role", the results indicate, "the most frequently reported preference for the client role was to participate in planning" (27.7%). Conversely, results that examined anticipations regarding clients' role indicated 44.6% "don't know/no response” (p. 83). In other words, "preferences were much clearer than anticipations" (p. 84). These results suggest that clients "anticipate accomplishing less of what they most prefer to accomplish" (Galassi, as cited in Koch). Koch et al. (as cited in Koch, 2001) state, "Providing VR services based on client expectations increases the likelihood that people will truly feel involved in all phases of the rehabilitation process and therefore successful outcomes will result" (p. 85). Koch's study indicates that 44.6% of clients clearly had low expectations of working with vocational rehabilitation professionals even though the data indicate they desired to be a part of their own planning. Similarly, the vocational rehabilitation process of determining eligibility and orientation to the Hiram G. Andrews Center sets up a leader/professional-follower/client dynamic in that they are significantly led by professionals and the system.

Disability pride vs. shame/stigma. Various disability groups have been stigmatized more than others. Clients with learning and/or cognitive disabilities represent 40-50% of the Center’s population. Most of these clients have participated in some form of secondary learning support program that excluded or made them appear different from their peers. For example, their educational training took place in a separate classroom, which may have been located in another part of the building. They were required to have an Individualized Education Plan in which a team of professionals worked together to provide them with learning and/or emotional support services. This plan may have required the client to leave the classroom in order to meet with a counselor or a member of the team. Many clients had a therapeutic support staff person who accompanied the client throughout the school day, including going to class and lunch. All of these examples represent activities that are not typical for the majority of the student body attending secondary school. Therefore, by utilizing the services designed to assist individuals with disabilities, clients were identified as the minority. Based on these experiences, these clients would have had less opportunity for the development of disability pride due to being identified as part of a minority group that is stigmatized and being required to participate in activities that are separate and away from their peers.

Positive experiences. Clients with physical disabilities have been excluded from participating in normal recreational activities. For example, many clients at the Center with physical disabilities have never ridden a bicycle or gone water or snow skiing. The Center's recreation staff provides training in the use of adaptive recreation devices and has bicycles available that are peddled by hand. Clients' who use wheelchairs for mobility are able to ride the adaptive bicycles. Clients' introduction to other recreational activities includes adaptive water and snow skiing. Prior to this exposure, many Center clients were excluded from participating in recreational activities. Moreover, they have never been exposed to the disability subculture that actively participates in adaptive recreational activities, Para Olympics, or wheelchair basketball and football.

Vocational rehabilitation counselors and psychological associates at the Center devote a considerable amount of time counseling clients on interpersonal relationships and social skills. Due to clients' disability experience in a stigmatizing society, it is common for clients at the Center to feel accepted, form friendships, and enter into relationships for the first time. They were often excluded from normal youth oriented activities such as high school dances or hanging out at the mall. The Center holds an annual prom that includes providing prom gowns, hair, nail, and make-up services. While these services may be the norm for individuals without disabilities, often, this is the clients' first exposure to these types of costly personalized services.

A majority of the Center’s clients reside in rural areas or small towns that do not offer mass transit. Other clients, who acquired their disability later in life and use wheelchairs for mobility, come from families who are unable to purchase a modified van. For example, I worked with a client who resided in a remote area who used a motorized wheelchair. His family was not able to purchase a modified van with a lift so he was resigned to rarely leaving his home unless transported by ambulance. He had no awareness that individuals with paralysis owned and drove their own vehicles. He was referred to the Center, where they provide clients with modified van and adaptive driving equipment. Additionally, the Office of Vocational Rehabilitation has a modified van program that provides funding for the purchase of a modified van.

A limited number of clients who participate in vocational rehabilitation services at the Center own their vehicle. In collaboration with the Cambria County Transit Authority, the Center provides training in the use of mass transit. Clients are introduced to the mass transit system, bus schedule, and the availability of reduced fares for individuals with disabilities. The training ends with a group bus ride to the local mall, which according to the clients is strong incentive to participate. While attending the Center, clients use the bus system to do their own shopping, banking, and to participate in job practicum and internships. Upon exiting the Center, they are better equipped to utilize mass transit for social, employment, and community activities.

To summarize, clients enter into vocational rehabilitation programs, such as those offered at the Hiram G. Andrews Center with deeply ingrained predispositions regarding disability beliefs, attitudes, and role. Given a client’s socialization into the medical model and stigma, negative disability experiences and exclusion, and shame may be prevalent. Clients at the Center have limited exposure to individuals with disabilities who participate in activities that they considered were only available to individuals without disabilities. With clients' participation in activities that increase their independence, clients' disability predispositions regarding disability beliefs, attitudes, and role may change, resulting in an increase in pride and more opportunities for social inclusion.

Summary

In this dissertation I pursue the following research objectives.

Research Objective I, Professionals

Will the 30 disability items on the QDIO-P (modified) factor analyze the same or similar as they did for clients in the Darling and Heckert study?

For example, given professionals' training in the medical model and their view of clients as passive participants in the rehabilitation, I predict higher scores for the variables exclusion and the medical model, and lower scores for the variables pride and social model.

Research Objective II, Clients

1) Will the 30 disability items on the QDIO factor analyze the same with the current population of clients receiving services at the Hiram G. Andrews Center as it did in Darling and Heckert's original study?

2) Will clients' scores on disability pride, exclusion, social model, and medical model be significantly higher or lower relative to the variable at post test than at pre test?

For example, based on clients' beliefs, attitudes, and roles related to disability prior to entering (pre) the Hiram G. Andrews Center, I predict clients' score will be higher or lower (direction to be discussed in Chapter Three) depending on the variable as a result of exposure (post) to rehabilitation professionals, services, and peers with disabilities.

CHAPTER THREE

METHODOLOGY

Purpose of the Study

The purpose of this research is to examine how Darling and Heckert’s (in press) disability orientation components of identity, model, and role and related variables contribute to effective client-professional relationships. Specifically, this research will examine clients' and professionals' "beliefs" towards identity (pride versus stigma/shame) and their agreement towards disability pride or shame and stigma. Secondly, this research will examine clients' and professionals' "attitude" towards model (medical versus social) and their agreement towards medical or social model treatment approaches. Thirdly, this research will examine clients' and professionals' "role" and associated behaviors and assumptions that clients or professionals will assume a passive or active role in the vocational rehabilitation process.

In order to conduct research on the disability beliefs, attitudes, and roles as related to disability of clients who are receiving services from professionals employed at comprehensive rehabilitation centers, it is important to first determine the beliefs, attitudes, and roles related to disability of rehabilitation professionals. Therefore, the research was conducted in two parts, Phase 1, Professionals and Phase 2, Clients.

Professionals. This research will assess the disability beliefs, attitudes, and roles related to disability of professionals who work with persons with disabilities in rehabilitation settings. This research examined professionals employed at six of the eight rehabilitation centers in the United States. Darling and Heckert’s (in press) QDIO was modified slightly for use with professionals (See Appendix B, QDIO-P) to determine if the QDIO-P (modified) will factor analyze the same or similar as they did for clients (Darling and Heckert, in press).

Clients. This research will also examine how clients' beliefs, attitudes, and roles related to disability change over the course of receiving vocational rehabilitation services at a comprehensive rehabilitation center.

Therefore, results will be reported in two separate chapters. I will report results for Professionals in Chapter Four and Clients in Chapter Five. I will report my summary and discussion in Chapter Six.

Questionnaire on Disability Identity and Orientation

Darling and Heckert's (in press) research on disability orientation has operationalized the concepts of disability orientation and disability identity. Specifically, their Questionnaire on Disability Identity and Opportunity (QDIO) quantifies disability orientations. Putnam (2005) states that furthering the body of disability identity knowledge will be accomplished through empirical investigation. Darling and Heckert's development of a measurement instrument for research contributes to quantitatively measuring individuals' disability orientation and related variables of pride, exclusion, social model, and medical model. Darling and Heckert state the instrument could help establish the current prevalence and correlates of disability orientations. They add the instrument could be beneficial when selecting participants for qualitative research that is focused on examining the prior circumstances and effect of orientations. Another benefit of the instrument, according to Darling and Heckert, is its usefulness to professionals in identifying intervention methods for clients using their services. This instrument, and its utility for professionals in determining appropriate and effective vocational rehabilitation intervention strategies for clients, could contribute to better client outcomes.

Subscales

Darling and Heckert (in press) reported the following four subscales: Disability pride (four items); Exclusion + dissatisfaction (four items); Social model (seven items); and Personal/medical model (eight items). Darling and Heckert computed the mean subscale scores for the four factors. Darling and Heckert reported that high scores reflected agreement with each of the factors.

Reliability and validity. Darling and Heckert (in press) reported the QDIO is a useful tool that could be used to measure disability orientation in many different environments. Darling and Heckert reported that the QDIO "appears to validly and reliability measure the various components of disability orientation in various age groups" (p. 18). This research expanded on Darling and Heckert's findings and their recommendations for future research in attempting to validate the QDIO with two samples, clients and professionals, in determining their agreement with the particular variables of pride, exclusion, social model, and medical model. It is my contention that more or less agreement with the variables can be an indicator of clients' and professionals' beliefs, attitudes, and roles related to disability.

If the QDIO does factor analyze the same as in the original study, it will provide evidence that the QDIO has external validity and may be used as an effective instrument with other samples of individuals with disabilities. Specifically, disability orientation and agreement with the related variables of pride, exclusion, social model, and medical model could be potentially be measured for the more than 20,000 clients who receive services annually at any one of the eight comprehensive rehabilitation centers in the United States. It is my contention that more or less agreement with the variables can be an indicator of clients' and professionals' beliefs, attitudes, and roles related to disability

My dissertation research examined clients with disabilities who are receiving services at the Hiram G. Andrews Center, located in Johnstown, PA and professionals who provide the vocational rehabilitation services. Professionals employed at any one of the eight rehabilitation centers in the United States were asked to participate. Darling and Heckert’s (in press) Questionnaire on Disability Identity and Opportunity (QDIO) was used with clients. (See Appendix A, QDIO). The QDIO was modified slightly for use with professionals. (See Appendix B, QDIO-P). Modifications to the QDIO included changing first person questions into third person questions. For example, the QDIO was used with clients with disabilities and questions read "my disability." On the other hand, the QDIO-P was used with professionals who may or may not have had a disability and questions read "people with disabilities."

Research Objective I, Professionals

In order to conduct research on the disability beliefs, attitudes, and role of clients who are receiving services from professionals employed at comprehensive rehabilitation centers, it is important to first determine the beliefs, attitudes, and roles related to disability of rehabilitation professionals. Therefore, the research was conducted in two parts. A convenience sample of professionals employed at any one of six State operated comprehensive rehabilitation centers located in the United States were selected to participate in the study. In phase 1, I administered the modified QDIO-P to professionals employed at six rehabilitation centers in the United States that agreed to participate.

Institutional Review Board

I submitted approval to conduct Phase I, Professionals portion of my research to Indiana University of Pennsylvania's Institutional Review Board (IRB) for the Protection of Human Subjects. Phase I, Professionals was submitted as an expedited review based on the following:

- There are no known risks associated with this study
- Minor modifications or additions of existing approved studies
- The investigator does not manipulate subjects’ behavior
- The research will not involve stress to subjects

I received approval in August 2008 from Indiana University of Pennsylvania's IRB to conduct Phase I, Professionals. I also received approval from the Director of the Hiram G. Andrews Center to conduct my research at my place of employment, which at the time of data collection was the Hiram G. Andrews Center. The director of the Hiram G. Andrews Center is a member of the Consortium of State Operated Rehabilitation Centers and gave me permission to solicit the assistance of the eight rehabilitation centers in my dissertation research. The Director of Hiram G. Andrews Center contacted the members of the Consortium of State Operated Rehabilitation Centers informing the Directors I would be getting in contact with each of them regarding my dissertation research.

I sent an e-mail to the Directors of the eight comprehensive rehabilitation centers detailing the intent of my research, discussing my approval from the Indiana University of Pennsylvania's IRB, and outlining how professionals from their respective Centers could volunteer to be a part of this research. In my e-mail to the Directors, I asked permission to contact each Director at their convenience and included my contact information. I received replies from six of the eight Directors inviting me to contact them, and I followed up with phone conversations with six of the eight Directors.

The Director of the Woodrow Wilson Rehabilitation Center, Virginia approved the research project contingent on submitting a request to conduct research to the Commonwealth of Virginia, Department of Rehabilitative Services, Richmond Virginia. On January 15, 2009 my application was approved by the Department of Human Services, Human Research Review Committee as an exempted request pursuant to 46.101 as minimal risk research.

I continued to phone and send e-mails to the Directors of Hot Springs Rehabilitation Center, Arkansas and Michigan Career and Technical Center. After multiple attempts and no forthcoming responses, I assumed the Directors of the rehabilitation centers in Arkansas and Michigan were not interested in participating in my research and those Centers were not included in the study.

Study site. The study sites included six centers in the Consortium of State Operated Comprehensive Rehabilitation Centers. Participants included rehabilitation professionals who volunteered to participate in the study. The Consortium of State Operated Rehabilitation Centers cites their mission in part is to "promote the value of State operated, comprehensive rehabilitation centers in America" (www.ncsocrc.org/vvmiss.htm, retrieved April 10, 2007). Annually, the Consortium reports that over 20,000 individuals with disabilities participate in rehabilitation services at any one of the nine centers, with 2,600 professional and supportive employees providing the services. The total annual budget for the nine State operated centers exceeds $130 million dollars (retrieved April 10, 2007). When the information on employees and annual budgets was retrieved, there were nine comprehensive rehabilitation centers in operation; however, one Center (West Virginia) closed by the time of my study.

My research was conducted at the following study sites:

- Hiram G. Andrews Center, Pennsylvania
- Carl D. Perkins Comprehensive Rehabilitation Center, Kentucky
- Workforce and Technology Center, Maryland
- Roosevelt Warm Springs Institute for Rehabilitation, Georgia
- Tennessee Rehabilitation Center
- Woodrow Wilson Rehabilitation Center, Virginia

Professionals were included if they provided or supervised employees who provided direct services to clients.

Professionals who volunteered to participate in the study were administered the QDIO-P one time during the months of August, September, or October 2008. Professionals at Woodrow Wilson Rehabilitation Center, Virginia completed the survey in January, February, or March 2009 owing to the need to submit an application for approval to Human Research Review Committee, Department of Rehabilitative Services, Richmond, Virginia.

A coordinator was identified at each of the six comprehensive rehabilitation centers. The coordinator introduced (in person or via e-mail) participants to the study and asked for volunteers. The Directors representing each of the six Centers determined the time, place, and location for the coordinator to administer the QDIO-P.

The coordinator read the cover letter, provided the informed consent, answered questions, and instructed participants to place their completed QDIO-P in a box placed in the room where the survey was administered. The coordinator explained that anonymity was assured and that completing the QDIO-P was voluntary. The coordinator collected completed forms and sent them to me in a pre-paid postage envelope.

QDIO-P. Demographic questions 1 through 9 are the same for both QDIO and QDIO-P (Modified). After question 9, the QDIO-P (modified) states: "If you are person with a disability, please continue and answer questions 10 through 15." Questions 10 through 15 address specific disability data and inquire about the nature of their disability, how long have they had their disability, how much if any assistance is required with activities of daily living, amount of social activities participation, amount of disability activism, and type of disability activism.

The survey data obtained from rehabilitation professionals was exploratory and used a cross-sectional design. The data were analyzed using factor analysis and reliability analysis to determine professionals’ disability orientations.

Research Objective II, Clients

A convenience sample of clients receiving services from the Hiram G. Andrews Center was selected to participate in this study. In Phase 2, I administered pre and post test QDIO questionnaire to clients receiving services at the Hiram G. Andrews Center. The client data were analyzed to determine whether clients' beliefs, attitudes, and roles related to disability change over the course of a semester as a result of exposure to rehabilitation professionals and services. Computed scales were analyzed using paired t-test to determine if there are statistically significant differences between the pre and post test scores.

Institutional Review Board

I submitted approval to conduct Phase II, Clients portion of my research to Indiana University of Pennsylvania's Institutional Review Board (IRB) for the Protection of Human Subjects. I requested permission to conduct research with Protected Populations and Sensitive Subjects including:

- Educationally or economically disadvantaged persons
- Mentally disabled

I received approval in August 2008 from Indiana University of Pennsylvania's IRB to conduct Part II, Clients at the study site, Hiram G. Andrews Center with clients receiving services at the Center.

Study site. The study site for Phase II, Clients was the Hiram G. Andrews Center, located in Johnstown, PA. The Commission for the Accreditation of Rehabilitation Facilities (CARF) accredits the Center. Hiram G. Andrews Center is part of Pennsylvania's Department of Labor and Industry. Functioning under the Office of Vocational Rehabilitation, the Hiram G. Andrews Center is an entity under the Bureau of Rehabilitation Center Operations. Individuals with disabilities are referred to the Center by Vocational Rehabilitation Counselors who are headquartered at one of Pennsylvania's Offices of Vocational Rehabilitation. Clients must apply for vocational rehabilitation services. After eligibility determination, clients receive services based on the federal order of priority, with the "Most Significantly Disabled" receiving services first.

The Hiram G. Andrews Center provides the rehabilitation environment and also provides a population that consists exclusively (100%) of clients with disabilities.

Pre and post test. Clients receiving services for the first time during the fall of 2008 were eligible to volunteer to participate in the study. A total of 53 out of a possible 87 or 61% first time clients volunteered to participate.

A coordinator was identified at the Hiram G. Andrews Center. The coordinator introduced (in person) participants to the pre and post test study and asked for volunteers. The coordinator explained that the first QDIO (pre) would be administered at the beginning of the term (September) and the second QDIO (post) would be administered at the end of the term (December). The coordinator assigned a random four digit number to each of the 53 participants and explained this number would be used by the researcher for scoring purposes only.

The coordinator read the QDIO cover letter, provided the informed consent, answered questions, and instructed participants to place their completed QDIO in a box placed in the room where the survey was administered. The coordinator explained that anonymity was assured and that completing the QDIO was voluntary. Due to the high number of clients with cognitive disabilities (56%), the coordinator explained the QDIO was available in alternate format and that reading assistance (i.e. Kurzweil or professional tutor) was available in the Learning Support Services Department. In addition, the coordinator informed participants that interpreters were available for participants who were deaf/hard of hearing and also offered the QDIO in Braille for clients who are blind. The coordinator reported that no participants required alternate format for either the pre or post test. The coordinator collected completed pre and post test QDIO and provided them to me.

Measurement

Based on Darling and Heckert's (in press) research that support a Typology of Disability Orientations, Darling and Heckert's Questionnaire on Disability Orientation and Identity (QDIO) was used to empirically test hypotheses based on Research Objectives I and II. Darling and Heckert's (in press) QDIO was used to determine if the same factors, pride, exclusion, social model, and medical model emerge for the client and professional sample as in Darling and Heckert's original study.

Quantitative Component

The QDIO survey (reference Appendix 1) consists of two separate parts. To measure the dimensions of disability orientations, Part One of the QDIO includes a 30-item Likert-like scale (Darling and Heckert, in press). According to Darling and Heckert, the direction of the items is intentionally varied to eliminate response patterning. For example, one person with a certain attitude may agree with one item and disagree with another item that is measuring the same attitude (Darling and Heckert). Part Two of Darling and Heckert's QDIO includes 15 questions that gather participants' demographic and behavioral characteristics.

Darling and Heckert administered the QDIO to an American sample of individuals with disabilities (n=388) associated with either four Centers for Independent Living, a social club, two assistance programs, a posting on a disability website, and an Internet listserv. In addition, Darling and Heckert's sample consisted of individuals with disabilities receiving services at the Hiram G. Andrews Center; however, I do not know the exact number of individuals that participated from the rehabilitation center. Although the Darling and Heckert original study included a sample from the Hiram G. Andrews

Center, their study also included individuals with disabilities from various organizations and resources. My study is different in that although the Hiram G. Andrews Center has been in operation for over 50 years, to the best of my knowledge a study that focuses on measuring both clients' and professionals' beliefs, attitudes, and roles related to disability has never been conducted. My study also differs from Darling and Heckert's original study in that my sample was open only to clients who were receiving services for the first time at the Hiram G. Andrews Center, while Darling and Heckert's sample was open to all clients. Moreover, my study includes pre and post test measures of a sample of clients receiving services for the first time while the Darling and Heckert study did not.

Darling and Heckert received 388 usable QDIO's that included participants from at least six states. I do not have access to the total number of the 388 participants that were from the Hiram G. Andrews Center. Darling and Heckert analyzed the returned QDIO's using exploratory factor analysis on the 30-item scale only. Cross tabulations were also conducted between all of the items and age.

Their analysis revealed differing orientations toward disability. To determine if the items could be meaningfully grouped into subscales, Darling and Heckert (in press) conducted exploratory factor analysis. Darling and Heckert's examination of the scree plot for their exploratory factor analysis of the 30-items indicated that a four factor solution was appropriate. They ran exploratory factor analysis using oblique rotation and varimax rotation and the results were almost identical to which items loaded on the four factors.

Darling and Heckert (in press) reported the following four subscales: Disability pride (four items); Exclusion + dissatisfaction (four items); Social model (seven items);

and Personal/medical model (eight items). Darling and Heckert computed the mean subscale scores for the four factors. Darling and Heckert reported that high scores reflected agreement with each of the factors. Darling and Heckert dropped seven of the thirty items due to low factor loadings (if less than .30 on all four factors) or did not lower the Cronbach's Alpha coefficients. Table 1 shows the results for Darling and Heckert's reliability analysis for Cronbach's alphas.

Table 1

Summary of Darling and Heckert's Exploratory Factor Analysis Results for QDIO Using Varimax Rotation (N = 388)

	Alpha	Factor 1	Factor 2	Factor 3	Factor 4
Disability pride	.78				
I am a better person because of my disability		**.531**	.160	-.129	.016
My disability is an important part of who I am		**.613**	.131	-.091	-.072
I am proud of my disability		**.635**	.033	-.194	-.103
My disability enriches my life		**.706**	.059	-.209	-.069
Exclusion/Dissatisfaction	.73				
My disability limits my social life		-.014	.194	**.677**	.010
My disability keeps me from working		-.043	.170	**.594**	.133
In general, I am satisfied with the quality of my life (reversed)		-.486	.064	**.496**	-.178
I often am excluded from activities because of my disability		-.073	.408	**.556**	-.066
Social model	.72				
Lack of accessibility and discrimination by employers are the main reasons why disabled people are unemployed		.069	**.590**	-.017	.019
It isn’t easy for people with disabilities to be treated as “normal”		-.031	**.430**	.163	.118
People with disabilities need to fight for their rights more than nondisabled people do		.038	**.555**	.097	.092
The biggest problem faced by people with disabilities is the attitudes of other people		.082	**.596**	.127	.036
All buildings should be accessible to people with disabilities		.095	**.537**	-.064	.093
I am familiar with the Americans with Disabilities Act (ADA) and think it is a good law		.198	**.398**	-.043	-.039
I am familiar with the Disability Rights Movement and support its goals		.228	**.427**	-.025	-.021
Personal/Medical Model	.63				
If I had a choice, I would prefer not to have a disability		-.269	.213	.120	**.346**
I feel sorry for people with disabilities		-.093	-.060	.179	**.421**
I wish that someone would find a cure for my disability		-.219	.311	.319	**.416**
Doctors and other medical professionals know what is best for people with disabilities		.175	.002	.058	**.474**
People with disabilities need to learn to adjust to living in a world in which most people are not disabled		.024	.124	.067	**.353**
I try to hide my disability whenever I can		-.042	-.072	.351	**.406**
People should try to overcome their disabilities		-.100	.067	-.109	**.398**
The most important thing for people with disabilities is to learn to accept what they cannot change		.135	.044	-.120	**.410**
Eigenvalues		4.11	3.91	2.12	1.74
% of Variance		13.7	13.0	7.07	5.78

Although Darling and Heckert's (in press) alpha coefficients were not high, the researchers determined the alpha levels to be acceptable considering the following: 1) the small number of items in the subscales and 2) the use a self-report administration of the QDIO may have posed difficulty for some participants from the rehabilitation center who may have had lower levels of literacy.

Darling and Heckert concluded that their pilot research supports the use of the QDIO in understanding disability orientations that appear to include all three of the components of identity, model, and role. Darling and Heckert also suggest that future research should include validating the QDIO with a larger and more representative sample of individuals with disabilities. Darling and Heckert suggest that the validated QDIO could then provide opportunities for research with a national or international sample in determining the proportion of individuals who are typified by a particular disability orientation. My research expanded on Darling and Heckert's findings and their recommendations for future research in attempting to validate the QDIO with two samples, clients and professionals, in determining their agreement with the particular variables of pride, exclusion, social model, and medical model. It is my contention that more or less agreement with the variables can be an indicator of clients' and professionals' beliefs, attitudes, and roles related to disability.

Summary. My research examined two research objectives, Research Objective I, Professionals and Research Objective II, Clients. For Research Objective I, Professionals the QDIO was modified (QDIO-P) and administered to professionals employed at six rehabilitation centers in the United States. For Research Objective II, a QDIO pre test and post test was administered to clients receiving services at the Hiram G. Andrews Center in the fall semester.

Research Hypotheses

This research examined the following hypotheses:

Research Objective I, Professionals

Hypothesis 1. The 30 disability items on the QDIO-P (modified) will factor analyze the same or similar as they did for clients (Darling and Heckert, in press). Given professionals training in the medical model and their view of clients as passive participants in the rehabilitation, I predict higher scores for the variables exclusion and the medical model, and lower scores for the variables pride and social model.

Research Objective II, Clients

Hypothesis 2. The 30 disability items on the QDIO will factor analyze the same with the current population of clients receiving services at the Hiram G. Andrews Center as it did in Darling and Heckert's original study.

As previously discussed, Darling and Heckert's original study used a sample of individuals with disabilities from four Centers for Independent Living, a social club and two assistance programs, a posting on a disability website, and an Internet listserv. In addition, Darling and Heckert's sample consisted of individuals with disabilities receiving services at the Hiram G. Andrews Center, although I do not have access to the total number that was from the Hiram G. Andrew Center.

Hypothesis 3. Client scores on disability pride, exclusion, social model, and medical model will be significantly higher or lower relative to the variable at post test than at pre test. I administered pre and post test QDIO questionnaire to clients receiving services at the Hiram G. Andrews Center. I predict clients' score will be higher or lower (direction to be discussed below) depending on the variable as a result of exposure to rehabilitation professionals, services, and peers with disabilities.

- **Hypothesis 3a.** For clients, the mean score on disability pride on the posttest will be significantly lower than the mean pre test score (greater pride at post test).
    - I presume that clients' enter the Hiram G. Andrews Center with little disability pride due to their experiences that often included segregation in high school due to their disability and required participation in learning support or limited participation in recreational activities for individuals with physical disabilities. Based on these experiences, these clients would have had less opportunity for the development of disability pride due to being identified as part of a minority group that is stigmatized and being required to participate in activities that are separate and away from their peers.
- **Hypothesis 3b.** For clients, the mean score on exclusion on the posttest will be significantly higher than the mean pre test score (less exclusion at post test).
    - I presume that due to exposure to peers with disabilities and more opportunities for socialization, clients will have higher exclusion scores at post test. Higher exclusion scores reflect perceptions of lesser exclusion.

- **Hypothesis 3c.** For clients, the mean score on the social model on the posttest will be significantly higher than the mean pre test score (less adherence to social model at post test).
    - I presume that due to professionals training in the medical model and their view of clients as passive participants in the rehabilitation, I predict higher scores for the variable social model.
    - I presume that clients will have little to no exposure to the social model due to the dominance of the medical model in vocational rehabilitation.
- **Hypothesis 3d.** For clients, the mean score on the medical model on the posttest will be significantly lower than the mean pre test score (greater adherence to medical model at post test).
    - I presume that due to exposure to professionals training in the medical model and their view of clients as passive participants in the rehabilitation, clients will have lower scores for the variable medical model at post-test.
    - I presume that due to exposure to vocational rehabilitation theories that are grounded in the medical model, clients will have lower scores for the variable medical model at post-test.

Chapter Four will discuss methodology and results for Research Objective I, Professionals and Chapter Five will discuss methodology and results for Research Objective II, Clients. Chapter Six will include a discussion on the results of Research Objective I and II.

CHAPTER FOUR

RESULTS FOR PROFESSIONALS

Research Objective I, Professionals

For my first research objective I assessed whether the 30 disability identity items on the QDIO-P (Modified) factor analyzed the same as they did in the Darling and Heckert (2010) study. This is important to my study to determine if the QDIO can be used with populations other than clients.

Demographics

A total of 326 professionals from six different rehabilitation centers participated in the study. The total number of professionals completing the QDIO-P from each rehabilitation center is indicated in Table 2. I was unable to compute response rates because I do not have the data on the number of employees at each center.

Table 2

Total Number of Professionals Returning the QDIO, by Rehabilitation Center and State (N =326)

Rehabilitation Center	State	N	Percent
Hiram G. Andrews Center	PA	84	26%
Carl D. Perkins Comprehensive Rehabilitation Center	KY	90	28%
Workforce & Technology Center	MD	26	07%
Roosevelt Warm Springs Institute For Rehabilitation	GA	42	13%
Tennessee Rehabilitation Center	TN	48	15%
Woodrow Wilson Rehabilitation Center	VA	36	11%
Total		326	100%

QDIO-P, part two, demographics. The QDIO-P Part Two includes 15 questions that gather demographic and behavioral characteristics.

Univariate statistics for the sociodemographic variables are shown in Table 3.

Table 3

SocioDemographic Variables for Professionals, (N =326)

Variables	Percent
Sex	
Male	35.1%
Female	64.9%
Age	
20-29	06.8%
30-39	19.8%
40-49	25.0%
50-59	36.6%
60-69	10.1%
70 or older	00.4%
Other	01.2%
Race/Ethnicity	
White	84.4%
African American	10.0%
Latino/Hispanic	00.6%
Native American	02.2%
Asian American	00.6%
Other	02.2%
Marital Status	
Never Married	16.1%
Married	63.7%
Separated	01.6%
Widowed	01.2%
Divorced	17.4%
Residence	
Large City	05.5%
Medium/Small City	20.5%
Suburb	10.2%
Small Town	34.5%
Rural	29.8%
Education	
Some High School	00.3%
High School	12.8%
Some College	16.8%
College	29.6%
Some Graduate School	08.4%
Graduate School	32.1%
Employment	
Full-time	96.6%
Part-Time	02.8%
Other	00.6%
Income	
Under $25,000	8.9%
$25,000-$49,999	40.6%
$50,000-$100,000	41.9%
Over $100,000	8.0%

Approximately two-thirds of the sample was female (64.9%), with males constituting 35.1%. The 50-59 age group represented the modal age group (36.6%), although the average age was 46. Fully 63.7% of the respondents were married, and almost all were employed full-time (96.6%). The most common places of residence for the sample population were small towns (34.5%) and rural (29.8%) areas. The data indicate that the majority of the professionals attended at least some college or more (54.8%), and the modal category was "completed graduate school" (32.1%), so the sample was highly educated. The income for most of the respondents was either \$25,000 to \$49,999 (40.6%) or \$50,000 to \$100,000 (41.9%). In addition, the vast majority of the professionals were white (84.4%), and around 10% were African-American.

Table 4 reveals the distribution of job categories for the respondents.

Table 4

Professionals Job Category Variables (N =326)

Variable	N	Percent
Job Category		
Manager	23	07.0%
Supervisor	31	10.0%
Counseling	18	12.0%
Evaluation	17	00.5%
Instructor	67	21.0%
Recreation	22	00.7%
Medical	30	10.0%
Other	88	28.0%

The most frequent job categories were other (28%) and Instructor (21%). Around 12% indicated their position as Counseling and 10% as Supervisor or Medical. If a respondent answered other, the QDIO-P included a space for respondents to write in their job category. Some examples reported were Behavior Specialist, Case Worker, Dorm Counselor, Psychological Associate, and Social Worker. These job titles align more with job responsibilities included in this research's definition of a Counseling Job Category. It can be speculated that different rehabilitation centers may categorize these job functions into different job categories or the participants were not sure how to categorize their job function. On the other hand, additional examples for “other” appear to align more closely with my intent for the use of other. For example, other responses included Food Service Worker, Skilled Labor, Housekeeping, Janitor, Secretary, and Security. Future research may need to incorporate this finding and improve the operational definition for job categories.

To summarize job categories, some participants may have misunderstood how to categorize their specific job classification. For the purpose of my dissertation research, the data collected for job category are valid in that all participants were employees of a comprehensive rehabilitation center.

Table 5 shows the percentage of professionals who indicated their disability status, as well as other information pertaining to their participation in disability-related activities.

Table 5

Disability Status and Related Activities, Professionals (N=75)

Variables	Percent	N	M	SD
Type of Disability[a]				
Mobility	5.5%	18	.06	.229
Vision	.0%	11	.03	.181
Hearing	10.0%	11	.03	.181
Speech	12.0%	1	.00	.055
Cognitive	28.0%	6	.02	.135
Cosmetic	4.0%	4	.01	.110
Other	66.0%	24	.07	.262
Length of Disability				
Since Birth	24.6%			
Less than 5 Years	29.5%			
5-10 Years	11.5%			
More than 10 Years	34.4%			
Amount of Assistance				
With all Activities	1.5%			
With Some Activities	11.9%			
No Assistance Needed	85.1%			
Other	1.5%			
Amount of Social Activities				
More than Once a Week	44.3%			
Once/Several Times a Month	30.0%			
Less than Once a Month	18.6%			
Rarely or Never	7.1%			
Disability Activism				
Many Times	19.7%			
Few Times	26.3%			
Once	10.5%			
Never	43.4%			
Type of Activism				
Telephone	21.5%			
Computer/E-Mail	21.2%			
Disability Websites	9.8%			
Other Websites	20.2%			
Disability Meetings	8.6%			
Other Meetings	12.6%			
Religious Services	13.2%			
Reading Disability Magazines	9.8%			

[a] Respondents could have multiple disabilities.

The most common types of disability were other (7.4%) and mobility (5.5%), followed by vision and hearing (both 3.4%). If a respondent answered other, a space was provided to write in their type of disability. Examples of responses to other included diabetes, cardiac, and respiratory disorders. The total number of professionals indicating their type of disability ranged from a low of 1 (.003%) for the speech category, to a high of 24 (.07%), for the other category. Almost one-fourth of the sample (24.6%) had their disability since birth and 29.5% less than five years. I was unable to determine from the data the total number of professionals with a disability or if respondents had more than one disability.

The majority of the sample (85.1%) needed no assistance with activities and 44.3% participated in social activities more than once a week. The data indicate that 42.7% of the respondents have never participated in disability activism, while 26.3% indicated participating a few times. Using the telephone or computer/e-mail was the most common type of disability activism (42.7%), while attendance at disability meetings (8.6%) was the least common.

QDIO-P

Phase I, thirty-item likert scale. Darling and Heckert validated the QDIO on a large sample comprised of individuals with disabilities. As mentioned in Chapter Three, I modified the QDIO-P in order that individuals with and without disabilities could respond. Darling and Heckert's (in press) QDIO includes a 30-item Likert Scale with questions 1 through 30 written in the first person. For example, Question 1 reads "I don't think of myself as disabled person." For the QDIO-P, I modified first person questions like question 1 into third person. Question 1 (QDIO-P) modified reads "I don't think of a person with a disability as a disabled person."

Data analysis. Analysis of the data was conducted to confirm the validity of the QDIO-P for use with Professionals. The data were analyzed using exploratory factor analysis (EFA) with varimax rotation to determine common factor loadings. Results of the exploratory factor analysis for the professional data will be compared to results from the factor analysis for clients conducted by Darling and Heckert (2010).

Table 6

Cronbach's Alphas for Original Scales and Items from Darling and Heckert (N =388)

	α
Disability Pride	.55
I would be a better person if I had a disability.	
A person's disability is an important part of who they are.	
I would be proud to have a disability.	
For people with disabilities, having a disability enriches their life.	
Exclusion	
A disability limits a person's social life.	.44
Having a disability keeps people with disabilities from working.	
In general, people with disabilities are satisfied with their life.	
People with disabilities are often excluded from activities because of their disability.	
Social Model	.55
Lack of accessibility and discrimination by employers are the main reasons why disabled people are unemployed.	
It isn't easy for people with disabilities to be treated "normal."	
People with disabilities need to fight for their rights more than nondisabled people do.	
The biggest problem faced by people with disabilities is the attitudes of other people.	
All buildings should be accessible to people with disabilities.	
I am familiar with the Americans with Disabilities Act (ADA) and think it is a good law.	
I am familiar with the Disability Rights Movement and support its goals.	
Medical Model	.43
Given a choice, I would prefer not to have a disability.	
I feel sorry for people with disabilities.	
I wish a cure could be found for all disabilities.	
Doctors and other medical professionals know what is best for people with disabilities.	
People with disabilities need to learn to adjust to living in a world in which most people are not disabled.	
If I had a disability I would try to hide my disability whenever I could.	
People should try to overcome their disabilities.	
The most important thing for people with disabilities is to learn to accept what they cannot change.	

Cronbach's Alphas For Original Scales

All Professionals

First I computed Cronbach's alpha coefficients for the four subscales identified for clients by Darling and Heckert. In other words, the alphas were computed for professionals using the same items Darling and Heckert (2010) used to compute alphas for clients in their research. As shown in Table 6, all four were low, with alphas ranging from .55 for the disability pride and social model subscales to .43 for the medical model subscale.

First Exploratory Factor Analysis

All Professionals

The low alphas make it clear that is important to run an exploratory factor analysis for the professional sample to ascertain whether there is a different factor structure for professionals. Table 7 shows the data for the exploratory factor analysis using varimax rotation.

Table 7

Factor Loadings for Items Included in Each Factor: EFA using all Professionals (n=326)

	Alpha	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5
Disability Pride:	.64					
Rather associate with disabled.		.48				
Better person if had a disability.		.62				
Would be proud to have a disability.		.46				
Most of my friends have a disability.		.36				
Having a disability enriches life.		.63				
People with disabilities are satisfied		.39				
Social – Exclusion:	.60					
Lack of accessibility, unemployment.				.53		
Not easy to be treated as “normal”.				.46		
Disabled need to fight for rights more.				.38		
Biggest problem – others’ attitudes.				.45		
Disabled often excluded				.51		
Medical - Exclusion:	.62					
Don’t think of disabled as disabled.			.35			
Feel sorry for people with disabilities			.45			
Disabled can’t do available jobs.			.41			
Disability limits social life.			.46			
Disability prevents working.			. 37			
Would hide disability when could.			.50			
Can’t fit into “normal” society.			.35			
Social – Activist Orientation:	.46					
A lot in common.					.43	
Familiar with ADA – good law.					.49	
Familiar with/support Rights Movement.					.41	
Should include people with disabilities.					.41	
Medical Model:	.44					
Need to learn to adjust to world.						.45
Should try to overcome their disabilities.						.66
Should learn to accept what can’t change.						.34

Examination of the scree plot for the exploratory factor analysis including all professionals indicated a five factor or seven factor solution would be most appropriate. Based on inductive interpretation, I decided that the 5-factor model was most appropriate and interpretable. Rotated factor loadings and Cronbach's alpha levels are shown for the five factors in Table 7.

Importantly, the factor analysis for professionals' yielded similar scales as with clients in Darling and Heckert's (in press) study. The first factor, disability pride, had three items in common with the pride scale in Darling and Heckert's analysis, and the other three items in my pride scale also reflected dimensions of pride. The Cronbach's alpha for disability pride in my data was .64, which is only marginally acceptable. I labeled the second factor medical-exclusion because it included some items that clearly reflected the medical model and were included in Darling and Heckert's medical model scale, but it also included several items that tapped exclusion. The reliability coefficient for medical-exclusion was also marginal at .62.

The third factor I labeled social-exclusion because it included four items that reflected the social model and were in Darling and Heckert's social scale, but also included one exclusion item. In addition, the "social" items did reflect elements of exclusion (e.g., lack of accessibility causes unemployment; it is not easy to be treated as "normal and the like). The Cronbach's alpha for social-exclusion was only marginally acceptable as well at .60.

The fourth factor I labeled social-activist orientation. It contained four items, two of which were in Darling and Heckert's social scale. These two items pertain to being familiar with and supportive of the ADA and the disability rights movement. The

Cronbach’s alpha for this scale was .46, which is lower than desirable, even for a four item scale.

The fifth factor was labeled medical model, as it included only three items, all of which were in Darling and Heckert’s original medical scale for clients. Again, the Cronbach’s alpha was low at .44, even for a 3-item scale.

Second Exploratory Factor Analysis

Subset, Direct Service Providers

Because the reliability (alpha) coefficients for the five scales were not as high as desirable, I then conducted an exploratory factor analysis with a subset of direct service providers which included seven job categories. This group consisted only of individuals who provide direct services or supervise those who provide direct services to individuals with disabilities. I deleted 88 cases from the job category of other. Table 8 shows result for the second exploratory factor analysis for the subset of professionals. The anticipation was that the Cronbach’s alphas might be improved if the sample only included the higher level of professionals.

Comparison of Table 8 to Table 7 reveals that the same five factors emerged, disability pride, social-exclusion, medical-exclusion, social-activist, and medical model. All the items that had factor loadings above .34 loaded on the same scales as the first exploratory factor analysis, with the exception of two items. Item 13 (having a disability limits social life) and item 14 (having a disability prevents working) loaded on the medical-exclusion scale in the first exploratory factor analysis that used the entire sample of professionals and staff, whereas they loaded on the social-exclusion scale in the second exploratory factor analysis using the subset of professionals. The Cronbach’s alphas improved somewhat for the disability pride scale (from .64 to .70) and the social-exclusion scale (from .60 to .66). They declined, however, for the other 3 scales (from .62 to .53 for medical-exclusion, .46 to .44 for social-activist orientation, and .44 to .42 for the medical model).

Table 8

Factor Loadings for Items Included in Each Factor: EFA-Subset of Professionals (n=222)

	Alpha	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5
Disability Pride:	.70					
Rather associate with disabled.		.54				
Better person if had a disability.		.65				
Would be proud to have a disability.		.47				
Most of my friends have a disability.		.37				
Having a disability enriches life.		.68				
People with disabilities are satisfied		.53				
Social– Exclusion:	.66					
Lack of accessibility, unemployment.			.53			
Not easy to be treated as “normal”.			.48			
Disabled need to fight for rights more.			.41			
Disability limits social life.			.46			
Disability prevents working.			.39			
Biggest problem – others’ attitudes.			.41			
Disabled often excluded			.52			
Medical - Exclusion:	.53					
Don’t think of disabled as disabled.				.50		
Feel sorry for people with disabilities				.43		
Disabled can’t do available jobs.				.36		
Would hide disability when could.				.47		
Can’t fit into “normal” society.				.36		
Social – Activist Orientation:	.44					
A lot in common.					.44	
Familiar with ADA – good law.					.58	
Familiar with/support Rights Movement.					.43	
Should include people with disabilities.					.40	
Medical Model:	.42					
Need to learn to adjust to world.						.56
Should try to overcome their disabilities.						.54
Should learn to accept what can’t change.						.34

Summary

In summary, when I ran Cronbach's alpha coefficients from the subscales identified by Darling and Heckert (in press), they were very low. I then ran an exploratory factor analysis with all cases of professionals. Examination of the scree plot indicated a five factor solution, although some of the alphas were still unacceptably low.

I deleted 88 cases of professionals who do not provide direct services to individuals with disabilities (such as Skilled Labor, Janitor). I ran a second exploratory factor analysis with cases of professionals who either supervise or provide direct services to individuals with disabilities. The Alpha coefficients were acceptable for disability pride (.70) and marginal for social-exclusion (.66), while social-activist orientation (.44), medical-exclusion (.53), and medical model (.42) were not acceptable.

The results indicate Darling and Heckert's (in press) QDIO is an instrument that can probably measure disability orientation with populations other than clients. Since similar dimensions (scales) were extracted, my study supports the use of the QDIO-P with vocational rehabilitation professionals who either supervise or provide direct services to individuals with disabilities. Nonetheless, further refinement of the QDIO for use with professionals is clearly recommended. While the QDIO-P shows promise, further refinement is needed. Uses and limitations of this study and the QDIO-P will be expanded upon in Chapter Six.

CHAPTER FIVE

RESULTS FOR CLIENTS

Research Objective II, Clients

In this chapter for the second research objective I examined whether the scale items on the QDIO will factor analyze the same for my sample as they did for Darling and Heckert's original study. As previously discussed, Darling and Heckert administered the QDIO to an American sample of individuals (n=388) with disabilities associated with either four Centers for Independent Living, a social club, two assistance programs, a posting on a disability website, and an Internet listserv. Darling and Heckert's sample consisted of individuals with disabilities receiving services at the Hiram G. Andrews Center; however, I do not know the exact number of individuals that participated from the rehabilitation center. Additionally, Darling and Heckert's sample consisted of new and returning clients while my study was limited to clients receiving services for first the time at the Hiram G. Andrews Center.

If the QDIO does factor analyze the same as in the original study, it will provide evidence that the QDIO has external validity and may be used as an effective instrument with other samples of individuals with disabilities. Specifically, disability orientation and agreement with the related variables of pride, exclusion, social model, and medical model could be potentially be measured for the more than 20,000 clients who receive services annually at any one of the eight comprehensive rehabilitation centers in the United States. It is my contention that more or less agreement with the variables can be an indicator of clients' and professionals' beliefs, attitudes, and roles related to disability. Quantifying the client's beliefs, attitudes, and roles related to disability may help guide the client and professional relationship, as well as appropriate vocational counseling and individualized rehabilitation services.

In this chapter, I also report results for four hypotheses pertaining to changes in client scores on the four scales, disability pride, exclusion, social model, and medical model. Specifically I hypothesize that clients' scores for the subscales of disability pride, exclusion, social model, and medical model will be significantly higher or lower (depending on the factor) at post test than at pre test as follows:

1. H1. The subscale score for disability pride will be higher at post-test, which will represent greater pride at post-test.
2. H2. The subscale score for exclusion will be lower at post-test, which represents perceptions of less exclusion at post-test.
3. H3. The subscale score for social model will be lower at post-test, which represents less adherence to the social model.
4. H4. The subscale score for medical model will be higher at post-test, which represents greater adherence to the medical model at post-test.

Pre Test Results

Demographics

A total of 53 clients participated in the study. The QDIO Part Two includes 15 questions that gather demographic and behavioral characteristics. Table 9 indicates the demographics for the pre test population.

Table 9

SocioDemographic Variables for Clients, Pre Test (N =53)

Variables	Percent
Sex	
Male	66.7%
Female	33.3%
Age	
18	34.0%
19	28.0%
20-29	28.0%
30-39	4.0%
40-49	6.0%
Race/Ethnicity	
White	78.0%
African American	8.0%
Latino/Hispanic	6.0%
Native American	6.0%
Other	2.0%
Marital Status	
Never Married	90.2%
Married	5.9%
Separated	2.0%
Widowed	.0%
Divorced	2.0%
Residence	
Large City	2.0%
Medium/Small City	15.7%
Suburb	7.8%
Small Town	45.1%
Rural	29.4%
Education	
High School	80.8%
Some College	7.7%
College	1.9%
Graduate School	9.6%
Employment	
Full-time	7.7%
Part-Time	17.3%
Unemployed	1.9%
Student	73.1%
Income	
Under $25,000	52.1%
$25,000-$49,999	22.9%
$50,000-$100,000	16.7%
Over $100,000	8.3%

Approximately two-thirds of the sample is male (66.7%), with females constituting 33.3%. The under 20 age group represented the modal group (62%), although the average age was 22. Fully 90.2% of the respondents were never married, and two-thirds were students (73.1%). The most common places of residence for the sample population were small town (45.1%) and rural (29.4%) areas. The majority of respondents attended high school (80.8%). The income for most of the sample was less than $25,000 (52.1%). In addition, the vast majority of the clients were white (78.0%).

Table 10 indicates the pretest responses to Questions 10 through 15, which address the following areas:

- The nature of the client's disability.
- How long they had their disability.
- How much assistance is needed with activities of daily living.
- How often do they engage social activities outside of their home.
- Participation in disability activism (i.e. written a letter to congressional representative).
- Type of activities they participate in at least once a month (use a computer, attend religious events).

Table 10

Disability Status and Related Activities, Clients, Pre Test (N =53)

Variables	Percent	M	SD
Type of Disability			
Mobility	10.0%	.22	.887
Vision	.0%	.00	.000
Hearing	10.0%	.10	.303
Speech	12.0%	.12	.328
Cognitive	28.0%	.28	.454
Cosmetic	4.0%	.04	.198
Other	66.0%	.66	.479
Length of Disability			
Since Birth	43.1%		
Less than 5 Years	11.8%		
5-10 Years	15.7%		
More than 10 Years	29.4%		
Amount of Assistance			
With all Activities	2.0%		
With Some Activities	25.5%		
No Assistance Needed	72.5%		
Amount of Social Activities			
More than Once a Week	51.9%		
Once/Several Times a Month	26.9%		
Less than Once a Month	9.6%		
Rarely or Never	11.5%		
Disability Activism			
Many Times	5.8%		
Few Times	19.2%		
Never	75.0%		
Type of Activism			
Telephone	76.5%		
Computer/E-Mail	56.9%		
Disability Websites	11.8%		
Other Websites	49.0%		
Disability Meetings	11.8%		
Other Meetings	15.7%		
Religious Services	17.6%		
Reading Disability Magazines	3.9%		

Type of disability was greatest for other (66%) followed by cognitive (28%), speech (12%), mobility and hearing, both 10%. Examples of answers to “other” included 12 responses of either ADHD, learning, or comprehension which could be included in the cognitive disability category. Participants may or may not have had a thorough understanding of the subsets of cognitive disabilities and chose “other.” Other responses are very specific and appear to fit my operational definition of other. These responses will not be disclosed, however, due to confidentiality and potential for identification.

The number of clients indicating having their disability since birth was 43.1% while an additional 29.4% had their disability for more than ten years. Most clients indicated they did not need assistance with activities of daily living (72.5%). Half of the population (51.9%) participate in social activities, while only 5.8% have participated in disability activism. Client activities were greatest for using the telephone (76.5%), followed by using the computer/e-mail (56.9%) and accessing websites other than disability websites (49%).

Cronbach's Alphas

The sample size was too small to conduct a meaningful factor analysis. Therefore, I computed Cronbach's alphas for the items as they were derived in the four factors from the Darling and Heckert study. I then deleted 1 item from the social model subscale and 3 items from the medical model to produce acceptable alpha scores in the most parsimonious fashion. Table 11 reveals the Cronbach's Alphas, and the remaining items in each scale.

Table 11

Cronbach's Alphas, Clients, Pre Test (N = 53)

	Alpha
Disability pride	.82
I am a better person because of my disability	
My disability is an important part of who I am	
I am proud of my disability	
My disability enriches my life	
Exclusion/Dissatisfaction	.73
My disability limits my social life	
My disability keeps me from working	
In general, I am satisfied with the quality of my life	
I often am excluded from activities because of my disability	
Social model	.82
Lack of accessibility and discrimination by employers are the main reasons why disabled people are unemployed	
People with disabilities need to fight for their rights more than nondisabled people do	
The biggest problem faced by people with disabilities is the attitudes of other people	
All buildings should be accessible to people with disabilities	
I am familiar with the Americans with Disabilities Act (ADA) and think it is a good law	
I am familiar with the Disability Rights Movement and support its goals	
Medical Model	.67
I feel sorry for people with disabilities	
I wish that someone would find a cure for my disability	
Doctors and other medical professionals know what is best for people with disabilities	
I try to hide my disability whenever I can	
People should try to overcome their disabilities	

The alpha coefficients for pride (.82), exclusion (.73), and social model (.82) were acceptable while the alpha for medical (.67) was marginally acceptable.

The next section will report the results of the post test in determining whether the alpha values for these scales increased or decreased. In other words, will client responses to the QDIO change over the course of one semester?

Post Test Results

The 53 clients that completed the QDIO pretest in September could volunteer to complete the post test. Out of the 53 clients taking the QDIO pre test in September, 38 returned in December (72%) and completed the QDIO post test. Table 12 indicates the demographics for the post test population.

Table 12

SocioDemographic Variables for Clients, Post Test: (N =38)

Variables	Percent
Sex	
Male	75.0%
Female	25.0%
Age	
18	22.2%
19	22.2%
20-29	44.5%
30-39	5.6%
40-49	5.6%
Race/Ethnicity	
White	83.8%
African American	8.1%
Latino/Hispanic	0.0%
Native American	5.4%
Asian American	0.0%
Other	2.7%
Marital Status	
Never Married	86.8%
Married	2.6%
Separated	0.0%
Widowed	0.0%
Divorced	10.5%
Residence	
Large City	2.6%
Medium/Small City	21.1%
Suburb	10.5%
Small Town	47.4%
Rural	18.4%
Education	
High School	80.6%
Some College	8.3%
College	2.8%
Some Graduate School	2.8%
Graduate School	5.6%
Employment	
Full Time	10.5%
Part Time	15.8%
Unemployed	7.9%
Student	65.8%
Income	
Under $25,000	73.5%
$25,000-$49,999	14.7%
$50,000-$100,000	8.8%
Over $100,000	2.9%

Demographics

Approximately two-thirds of the post-test sample is male (75%), with females constituting 25%. The under 20-29 age group represented the modal group (44.50%), and the average age was 22. Fully 86.80% of the respondents were never married, and two-thirds were students (65.80%). The most common places of residence for the sample population were small town (47.40%) and medium/small city (21.10%). The majority of respondents attended high school (80.6%). The income for most of the sample was less than $25,000 (73.50%). In addition, the vast majority of the clients were white (83.80%).

Table 13 show the post test responses to Questions 10 through 15 (explained in pre test results), which address disability type, assistance, and activity.

Table 13

Disability Status and Related Activities, Clients, Post Test (N =38)

Variables	Percent	M	SD
Type of Disability			
Mobility	2.7%	.03	.164
Vision	2.7%	.03	.164
Hearing	13.5%	.14	.347
Speech	8.1%	.08	.277
Cognitive	35.1%	.35	.484
Cosmetic	2.7%	.03	.164
Other	60.5%	.61	.495
Length of Disability			
Since Birth	51.4%		
Less than 5 Years	13.5%		
5-10 Years	21.6%		
More than 10 Years	13.5%		
Amount of Assistance			
With All Activities	2.6%		
With Some Activities	10.5%		
No Assistance Needed	86.8%		
Other	0.0%		
Amount of Social Activities			
More than Once a Week	68.4%		
Once/Several Times a Month	18.4%		
Less than Once a Month	10.5%		
Rarely or Never	2.6%		
Disability Activism			
Many Times	7.9%		
Few Times	5.3%		
Once	2.6%		
Never	84.2%		
Type of Activism			
Telephone	81.6%		
Computer/E-mail	68.4%		
Disability Websites	13.2%		
Other Websites	57.9%		
Disability Meetings	2.6%		
Other Meetings	23.7%		
Religious Services	18.4%		
Reading Disability Magazines	10.5%		

Type of disability was greatest for other (60.5%) followed by cognitive (35.1%), hearing (13.5%), and speech (8.1%). Examples of answers to “other” included 8 responses of either ADHD, learning, or comprehension which could be included in the cognitive disability type. Participants may or may not have had a thorough understanding of the subsets of cognitive disabilities and chose “other.” Other responses are very specific and appear to fit my operational definition of other. These responses will not be disclosed due to confidentiality and the potential for identification.

The largest number of clients had their disability since birth (51.4%) followed by having their disability 5 to 10 years (21.6%). Most clients indicated they did not need assistance with activities of daily living (86.8%). Well over half of the population (68.4%) participate in social activities while only 7.9% have participated in disability activism. Client activities were greatest for using the telephone (81.6%) followed by using the computer/e-mail (68.4%) and accessing websites other than disability websites (57.9%).

In this section I report the results of the paired t-tests to assess whether clients' disability orientation scores changed over the course of one term for the following four variables: pride, exclusion, social model, and medical model. The results of the paired t-test are shown in Table 14. Because the sample size was so small, I chose .10 as the appropriate alpha level by which to decide whether to reject or fail to reject the null hypothesis. For an exploratory study with such a small sample and low power, choosing a higher alpha level is important to reduce the likelihood of failing to reject a null hypothesis when the null should be rejected.

Table 14

Paired Samples t-test, Clients pre/post (N=38)

Variables	Pre M	Post M	Diff in Means	p-value	Correlation	Direction of Interpretation
Pride	12.3	11.4	.9	.075 1 tailed	.60	Greater pride
Exclusion	14.7	15.1	-.4	.24 1 tailed	.50	Less exclusion
Social Model	14.7	15.6	-.9	.13 1 tailed	.40	Less adherence
Medical Model	14.3	13.9	.4	.25 1 tailed	.56	Greater adherence

Paired Samples t-test

With regard to disability pride, the post test mean (11.4) was statistically significantly higher than the pretest mean (12.3) at the .10 level. The mean difference of .9 demonstrates support for the conclusion that the participants displayed greater pride at post test. Thus, the null hypothesis of no change in pride scores was rejected in favor of the research hypothesis that participants would have greater pride after the intervention.

The post test mean score on exclusion (15.1) was slightly higher than the pre test mean (14.7), indicating support for less exclusion at post test, although the difference was not statistically significant. The post test average for the social model (15.6) was slightly higher than the pre test average (14.7), indicating support for less adherence to the social model at post test. However, the difference was not quite statistically significant ($p = .13$). Finally, the post test mean score (13.9) for the medical model was lower than the pre test mean (14.3), indicating slight support for greater adherence to the medical model at post test. The difference, however, was not statistically significant.

Summary

In summary, only one of the four hypotheses was supported, and it pertained to a statistically significant improvement in disability pride. The next section will discuss the results for professionals and clients with reference to the three main hypotheses given earlier. Specifically I will discuss the results for research objective I, professionals, hypothesis 1, and research objective II, clients, hypotheses 2 and hypothesis 3 including sub hypotheses 3a, 3b, 3c, and 3d.

Research Objective I, Professionals

Hypothesis 1: The 30 disability items on the QDIO-P (modified) will factor analyze for professionals the same as they did for clients in Darling and Heckert's (2010) original study.

Hypothesis 1 received partial support. Instead of four factors, as Darling and Heckert (in press) found with a large sample of clients, I found five factors for professionals. The four factors found by Darling and Heckert were disability pride, exclusion, social model, and medical model. I found the following factors, disability pride, social-exclusion, medical-exclusion, social model-activist orientation, and medical model. So, the factors I identified are very similar to and resonate with Darling and Heckert’s findings with clients. However, the Cronbach’s alphas for professionals were not as high as for clients, and three of the five were unacceptably low. For professionals, the disability pride scale and the social-exclusion scales were acceptably strong. Therefore, the first hypothesis is partially supported, but continued refinement of the QDIO-P is clearly warranted.

Research Objective II, Clients

Hypothesis 2: The 30 disability items on the QDIO will factor analyze the same with the current population of clients receiving services at the Hiram G. Andrews Center as it did in Darling and Heckert's original study.

I was unable to test this hypothesis because the sample size was too small to conduct a meaningful factor analysis. Since I had 30 items and a sample size of only 53, I did not achieve the minimally desirable ratio of cases to items, which is 5 to 1. Nonetheless, I computed Cronbach's alphas for the items as they were derived in the four factors from Darling and Heckert's original study. I then deleted one item from the social model subscale and three items from the medical model to produce acceptable alpha scores in the most parsimonious fashion. The alpha coefficients for pride (.82), exclusion (.73), and social model (.82) were acceptable while the alpha for medical (.67) was marginally acceptable. Overall, hypothesis 2 could not be formally tested, but the solid reliability coefficients support the use of the four scales with my sample.

Hypothesis 3. Client scores on pride, exclusion, social model, and medical model will be significantly higher or lower at post test than at pre test.

The conclusion for the results of Hypothesis 3 is that there was a significant change in client scores for only one scale, disability pride. However, the small sample size limited the power of the hypothesis tests and made it difficult to reject the null hypotheses. The next section will review the results for each of the four sub hypotheses.

- **Hypothesis 3a**. For clients, the mean score on disability pride on the post test will be significantly lower than the mean pre test score (greater pride at post test).

Sub hypothesis 3a was supported at the .10 level (p = .075). There was a slight decrease in post test means versus pre test mean for the variable pride. Clients' orientations towards disability pride increased over the course of receiving services; however, the difference was modest. Nevertheless, considering that the exposure to the programs was for only three months, even the modest effect on disability pride is impressive. Greater pride at post test may indicate support for the intervention of rehabilitation services and increases in disability orientation awareness.

- **Hypothesis 3b.** For clients, the mean score on exclusion on the post test will be significantly higher than the mean pre test score (less exclusion at post test).

Sub hypothesis 3b was not supported. There was a slight increase in the post test means versus pre test for the variable exclusion. Although the clients may have felt less excluded as individuals with disabilities after intervention, the difference at post-test was very small.

- **Hypothesis 3c.** For clients, the mean score on social model on the post test will be significantly higher than the mean pre test score (less adherence to social model at post test).

Sub hypothesis 3c was not supported. There was an increase in the post test means versus pre test means for the variable social model. At post test, clients had less adherence to the social model. This interpretation may support that the social model is less prevalent in rehabilitation centers in the United States.

- **Hypothesis 3d.** For clients, the mean score on medical model on the post test will be significantly lower than the mean pre test score (more adherence to medical model at post test).

Sub hypothesis 3d was not supported. There was a slight increase in the post test means versus pre test means for the variable medical model. Although clients manifested slightly greater adherence to the medical model at post test, the difference was small and not statistically significant. As discussed in Chapter Two, rehabilitation professionals are typically trained in the medical model. Additionally, many clients have experienced professional dominance, diagnostic labeling, and the assigning of the sick role. It is possible that longer exposure to rehabilitation centers would result in greater changes in adherence to the medical model.

In summary, overall, there were only small differences in mean scores for sub hypothesis 3a, 3b, 3c, and 3d. The direction of the change for pride, exclusion, social model, and medical model were as expected, and the change for disability pride was statistically significant.

The next chapter will provide a discussion of the results of this research. Additionally, the chapter will briefly review my hypotheses; discuss the relationship of this study to past research, strengths and limitations of my study, and implications for future research.

CHAPTER SIX

DISCUSSION

Disability orientation consists of the clients' or professionals' conception of an individual with a disability, expectations of their behavior, and understanding of their fit into society (Darling and Heckert, in press). Darling and Heckert developed a measuring instrument, the Questionnaire on Disability Identity and Opportunity (QDIO) to assess the disability orientation of individuals with disabilities. Darling and Heckert state the instrument helps further quantify research that establishes the current prevalence and correlates of disability orientations. This research expanded on Darling and Heckert's original study and recommendations for future research to administer QDIO to other samples of individuals with disabilities.

For my study, I examined the effectiveness of the QDIO in assessing the beliefs, attitudes, and roles related to disability for a sample of professionals who provide rehabilitation services. I also assessed the beliefs, attitudes, and roles related to disability for a sample of clients receiving services at the Hiram G. Andrews Center. Finally, I compared the clients the pre and post test mean scores over one term of receiving services at the Hiram G. Andrews Center.

To assess professionals' beliefs, attitudes, and roles related to disability, I used a convenience sample of professionals employed at six of the eight comprehensive rehabilitation centers in United States. To assess clients' beliefs, attitudes, and roles related to disability, I used a convenience sample of clients receiving services at the Hiram G. Andrews Center. Therefore, my study examined two research objectives. Research Objective I, Professionals, assessed the beliefs, attitudes, and roles related to disability of 326 professionals providing services to clients with disabilities receiving rehabilitation. Research Objective 2, Clients, assessed the beliefs, attitudes, and roles related to disability of 53 clients receiving services at the Hiram G. Andrews Center. Finally, the study also assessed if 38 clients' beliefs, attitudes, and roles related to disability changed over one term of receiving services.

Darling and Heckert's exploratory factor analysis produced a four factor solution: pride, exclusion, social model, and medical model. For my study, similar factors of pride, social-exclusion, medical-exclusion, social model-activist orientation, and medical model emerged for the professional sample, although the items were not always the same and the reliability coefficients were not all desirable. For professionals, similar dimensions as for clients are relevant, but additional work needs to be done on the items and scales. For clients, the sample size was too small to conduct exploratory factor analysis. Cronbach's alphas were computed for the items as they were derived in the four factors in the Darling and Heckert study. After dropping four items, the alpha coefficients were acceptable for the variables pride, exclusion, and social model, while the alpha coefficient for medical model was marginally acceptable. Finally, I computed paired t-tests for pre and post test client mean scores and overall there were modest effects of program intervention, although disability pride was significantly greater at post test.

In the next section, I will briefly review my three hypotheses, relationship to previous research, strengths and limitations of my study, and implications for future research.

Review of Hypotheses

Research Objective I, Professionals

Hypothesis 1. The 30 disability items on the QDIO-P (modified) will factor analyze the same or similar as they did for clients (Darling and Heckert, in press).

The five factors for professionals were similar to the four factors for clients found by Darling and Heckert (in press). The 5 factors are disability pride (same as for clients), social-exclusion (sub-type of exclusion for clients), medical-exclusion (sub-type of exclusion for clients), social-activist orientation (similar to social model for clients), and medical model (same as for clients). There was also variation in which specific items loaded with the various scales. In addition, the reliability coefficients for the professionals were not as high as for clients.

Hypothesis 1, therefore, was partially supported. Instead of the four factors that were identified by Darling and Heckert (in press), I found five factors for professionals. The alpha coefficients were acceptable for disability pride and social-exclusion, but not for medical-exclusion, social-activist orientation, and medical model.

Because the exploratory factor analysis results were slightly different when I excluded certain job categories, future research needs to improve the operational definition of professionals' job categories in the QDIO-P. Likewise, before administering the QDIO-P to other professionals employed in rehabilitation centers or in agencies that provide services to individuals with disabilities, the researcher could request a summary of all job categories and job descriptions. Then, the researcher could solicit participation for the study using only professionals from selected job categories that fit the researcher’s operational definition of job categories.

Results for hypothesis 1 support the use of Darling and Heckert's QDIO-P with vocational rehabilitation professionals who either supervise or provide direct services to clients with disabilities. Hypothesis 1 also supports the use of Darling and Heckert's QDIO as an instrument to measure beliefs, attitudes and roles related to disability with populations other than clients. Further refinement and improvement, however, of the QDIO-P is strongly recommended. Therefore, when using all 30 items in the QDIO-P with a new sample or population, it will be important to conduct an exploratory factor analysis to determine whether there is a different factor structure for the new sample.

Research Objective II, Clients

Hypothesis 2: The 30 disability items on the QDIO will factor analyze the same with the current population of clients receiving services at the Hiram G. Andrews Center as it did in Darling and Heckert's (in press) original study.

Hypothesis 2 could not be formally tested because the sample size was too small to conduct a meaningful factor analysis. Therefore, I computed alpha coefficients. The alpha coefficients for pride (.82), exclusion (.73), and social model (.82) were acceptable while the alpha coefficient for the medical model (.67) was marginally acceptable. Based on the alpha coefficients, the QDIO can be used with other samples of clients with disabilities. However, when using all 30 items with samples of clients, it is important to conduct an exploratory factor analysis with a large sample to be able to determine whether there is a different factor structure for various types of clients with disabilities.

Hypothesis 3. Client scores on pride, exclusion, social model, and medical model will be significantly higher or lower relative to the variable at post test than at pre test.

- **Hypothesis 3a.** For clients, the mean score on disability pride on the post test will be significantly lower than the mean pre test score (greater pride at post test). This hypothesis was supported.
- **Hypothesis 3b.** For clients, the mean score on exclusion on the post test will be significantly higher than the mean pre test score (less exclusion at post test). This hypothesis was not supported.
- **Hypothesis 3c.** For clients, the mean score on social model on the post test will be significantly higher than the mean pre test score (less adherence to social model at post test). This hypothesis was not supported.
- **Hypothesis 3d.** For clients, the mean score on medical model on the post test will be significantly lower than the mean pre test score (greater adherence to medical model at post test). This hypothesis was not supported.

The conclusion for the results of Hypothesis 3 is that there was a significant change in client scores for disability pride, but not for the other three scales. There were only slight differences in mean scores for all four hypotheses, although the direction of the change scores was as predicted. As discussed in Chapter Two, the medical model may continue to be the more prevalent model in rehabilitation centers. These findings support the following points made in Chapter Two: 1) vocational rehabilitation developed out of the medical model which continues to be the dominant model, 2) rehabilitation professionals' training is strongly influenced by the medical model, and 3) professionals’ continue to adhere to the medical model. In other words, through clients' exposure to rehabilitation professionals trained in the medical model, and participation in vocational rehabilitation programs that developed out of the medical model, clients' adherence to the medical model may be greater at program exit. The extent of change, however, may depend on length of exposure. This finding may indicate that more work needs to be done by professionals in rehabilitation centers to expose clients to the benefits of the social model in order that clients can assume a more active role in their own rehabilitation. Although beyond the scope of my dissertation, future research could better address these findings by comparing the views of clients and professionals directly to determine whether clients are influenced by professionals' views. A very important finding is that even with limited exposure to intervention, disability pride improved. This is a positive effect of interaction with rehabilitation professionals.

In summary, when administering pre and post test QDIO, it may be useful to allow more time between pre and post test. In other words, the effects of rehabilitation intervention may be more strongly supported when clients participate in rehabilitation services longer than one term as in my study. The next section will discuss my research in relationship to past research.

Relationship to Previous Research

In this section I will review the relationship my study has to the previous research of Darling and Heckert's (in press), including the QDIO and the variables pride, exclusion, social model, and medical model, and Putman's (2005) research on disability pride. Additionally, I will discuss my study's relationship to previous research on the social model and medical model.

Developing a valid instrument that measures disability orientation variables is important to disability and rehabilitation research. Putnam (2005) states that furthering

the body of disability identity knowledge will be accomplished through empirical investigation. Darling and Heckert's (in press) research on disability orientation addresses operationalizing the concepts of disability orientation and disability identity. Through Darling and Heckert's development of a measuring instrument, the QDIO, their research contributes to quantitatively measuring individuals' disability orientation.
My study expanded on Darling and Heckert's recommendation of using the QDIO to assess other samples of individuals with disabilities. Darling and Heckert's four factor solution of pride, exclusion, social model, and medical model was supported among clients and somewhat supported among professionals, although my alpha levels were lower than desirable in the professional sample. Overall, my study provided support for the value of quantitatively measuring disability orientation and the variables of disability pride, exclusion (social and medical), social model, and medical model. The results also support that greater or less agreement with the variables can be indicators of clients' and professionals' beliefs, attitudes, and roles related to disability.

The importance of this research and measuring disability orientations can contribute to changes in the client-professional relationship. Measuring the scores on the various dimensions will help clients and professionals better understand each other. For example, if professionals had access to clients' scores, they would gain awareness of the clients’ beliefs, attitudes, and roles related to disability. This is important in that it can take weeks or months to establish rapport in a client-professional relationship; beliefs, attitudes, and roles related to disability may or may not be disclosed during this time period. Awareness of clients' beliefs, attitudes, and roles related to disability may help with establishing rapport sooner, which is exceedingly important in the current time of reduced funding for vocational rehabilitation, expansive counselor case loads, and limitations in time for clients and professionals. Similarly, if professionals were aware of their own beliefs, attitudes, and roles related to disability, they may be able to recognize personal limitations when providing services.

Administering the QDIO to clients and the QDIO-P to professionals could be assumed within vocational evaluation departments at any one of the eight comprehensive rehabilitation centers. The role of the vocational evaluation department at a comprehensive rehabilitation center is to provide evaluative services to clients. Therefore, the QDIO could easily be introduced as an additional measurement instrument that is used in connection with standardized intellectual and academic achievement testing.

Likewise, the QDIO-P could be made available to professionals. For example, two times per year, all newly hired vocational rehabilitation counselors from across Pennsylvania, and counselors employed for over 10 years are required to participate in a two-day Hiram G. Andrews Center training. This training is specific to the center and has the purpose of introducing vocational rehabilitation counselors to the center's professionals, programs, and services. Moreover, this training includes an introduction to the vocational evaluation department. During the two-day training, vocational rehabilitation counselors could complete the QDIO-P under the direction of vocational evaluators. This unique opportunity would allow professionals to gain an awareness of their own beliefs, attitudes, and roles as related to disability. This information could be directly applied by counselors in the client-professional relationship. This is of particular importance for newly hired counselors who may be less experienced in providing vocational rehabilitation counseling.

The implications for the use of the QDIO with clients and the QDIO-P with professionals could reach beyond the Hiram G. Andrews Center. For example, while I am not aware of required training programs for professionals employed at the other seven comprehensive rehabilitation centers in the United States, use of the QDIO and QDIO-P could be piloted at the other seven centers. As discussed, all eight centers are members of the Consortium of State Operated Comprehensive Rehabilitation Centers. Six of the eight centers granted me permission to conduct my research at their centers and 326 professionals voluntarily participated in my study. For an initial research project, this amount of participation tends to support that professionals at these centers may be interested in pursuing use of the QDIO and QDIO-P for improving client-professional relationships and vocational rehabilitation outcomes.

A second relationship my study has to previous research is to Putman's study regarding disability pride. Putnam (2005) proposes that pride is comprised of four elements that includes 1) acknowledgement of a disability, 2) believing the disability is a common human condition, 3) understanding that having an impairment is not negative, but can viewed negatively in certain environments, and 4) recognition having a disability brings about membership into a minority group.

Putman's research may help to explain why in my study clients' post test versus pre test mean scores changed toward the variables pride and exclusion. For example, as mentioned, the center's entire population consists of individuals with disabilities (100%). Moreover, the greatest age group (62%) represented in my study for the client sample were in the 18 or 19 year old age group. Clients age 18 or 19 transition to the rehabilitation center immediately upon graduation from high school. Prior to rehabilitation, clients may have had limited exposure to individuals with disabilities who participate in activities that they considered were only available to individuals without disabilities. At the center, and perhaps for the first time, they are free to sit at any table in the cafeteria and join with their peer group, attend a prom and dance with their peers even if they use a wheelchair, and are strongly encouraged and invited to participate in recreational activities. With clients' participation in activities that increase their independence, they may begin to feel pride in their accomplishments and no longer feel excluded in the environment of the center. However, Rubin and Roessler (1995) caution, a limitation of a comprehensive rehabilitation center is that its sets up a protected environment. Professionals need to incorporate strategies that help sustain client increases in pride and decreases in exclusion in order that clients are better prepared to transition into independent living upon leaving the protected environment of the comprehensive rehabilitation center.

The third relationship my study has to past research is to the social model and medical model. In my study, I measured clients' pre and post test identification with the social model or medical model. My sub hypothesis 3c and 3d, that assumed clients post test scores would support less adherence to the social model and greater adherence to the medical model at post test was supported. This result may be due to the following contributions: 1) professionals' formalized training is grounded in the medical model, 2) vocational rehabilitation had its origin in the medical model, and 3) clients' orientation and experiences at the Hiram G. Andrews Center are medically focused. I will discuss the relationship of these three contributions in the next section.

As discussed in Chapter Two, clients at the Hiram G. Andrews Center participate in client orientation on their first or second day upon arrival to the center. At the orientation, medical staff provides information regarding the Center's Allied Health programs. Additionally, all clients are required to complete a “Nursing Admission Assessment.” The client's vocational rehabilitation counselor then coordinates necessary services based on the questionnaire, the vocational plan, and medical information contained in the client's record.

As a result of completing the "Nursing Admission Assessment" and recommendations by medical professionals, clients participate in medical services that may not have been available prior to rehabilitation. For example, clients with physical or mobility disabilities may participate in physical therapy or complete evaluations for wheelchair, prosthetic, or mobility devices. Through these evaluations and recommendations of the medical professional, clients are provided with appropriate therapies and devices. They may increase muscle strength and mobility, and become more independent. Likewise, clients with psychiatric disabilities or diabetes are required to be compliant with their medication or risk discharge. As a result of medication compliance, their attention, focus, and health may be improved. As a result of exposure to tenets of the medical model, clients may realize and connect the positive values of medical compliance.

Professionals whose training is in the medical model may agree their two prescribed roles are to help the sick client get better and to provide custodial care, as discussed in Chapter Two. Custodial care encourages client reliance on government programs such as housing, food stamps, and medical care. Consequently, the clients' vocational rehabilitation can be based more on the medical model and less on rehabilitation. In that respect, professionals' adherence to the medical model may overlook a clients' ability to be an active participant not only in the rehabilitation services, but also in society. Similarly, the vocational rehabilitation curriculum needs to provide equal distributions of social and medical model training

Darling and Heckert (2005) state that some individuals with disabilities identify with the social model. However, Darling and Heckert caution that “not all people with disabilities share a common perspective, and whether most individuals with disabilities today have rejected the medical model in favor of a social one is an empirical question" (p. 4). The QDIO would be a useful tool in identifying both clients and professionals with strong social model orientations so they can educate and empower clients with disabilities.

Finally, the mission of vocational rehabilitation and the Hiram G. Andrews Center is to promote independent living and increase clients' skills in order to obtain and maintain employment. This mission appears to be more in line with the social model and could be better promoted. On the other hand, too much focus on the tenets of the medical model such as reliance on the professional to guide and take care of the client appears to be in direct conflict with the mission of the Hiram G. Andrews Center. Likewise, not adhering to recommendations prescribed by medical professionals, such as prescribed medications or physical therapy, may not permit clients' to maximize their potential. It appears the ideal may be for clients and professionals to strike a balance between the social model and medical model, utilizing the benefits of both models to increase vocational rehabilitation outcomes.

In summary, my study's relationship to past research consistently centers on the use of the QDIO to measure clients' and professionals' disability orientations and related variables of pride, exclusion, social model, and medical model. The results also support that greater or less agreement with the variables can be indicators of clients' and professionals' beliefs, attitudes, and roles related to disability. This type of measurement will allow researchers to conduct future studies that examine disability orientations and other related disability perspectives in order to improve client-professional relationships, rehabilitation services, and client outcomes.

The next section will discuss the strengths and limitations of my study.

Strengths and Limitations of the Study

Strengths

The first strength of my study is its uniqueness. It was the first study to attempt to measure both professionals' and clients' disability orientations and related variables. Specifically, using both a sample of professionals employed at a comprehensive rehabilitation center and clients participating in services. Although the Center has been in operation since 1956 and is part of consortium of eight state operated rehabilitation centers, research has not focused on the contribution of examining disability orientations of both clients and professionals. This measurement facilitates awareness of clients' and professionals' beliefs, attitudes, and roles related to disability.

A second strength of my study is the large professional sample size. The large sample size permitted me to conduct an exploratory factor analysis. The results supported using the QDIO on other samples of professionals. Due to slight variation with regard to the specific items that loaded with each subscale, it is recommended to always conduct an exploratory factor analysis to determine whether there is a different factor structure.

A third strength of my study is measuring clients' disability beliefs, attitudes, and role change over the course of participating in services at a comprehensive rehabilitation center. Although no significant increases in pre and post test means were supported, this study introduced the possibility of quantitatively measuring individual change in beliefs, attitudes, and roles related to disability owing to the intervention of rehabilitation services provided by rehabilitation professionals.

Limitations

There were various limitations to this study. The first limitation and threat to internal and external validity was that my client sample size of 53 was very small. Moreover, over the one term period between the pre and post test, significant attrition occurred with 15 of the 53 participants (28%) not returning to take the post test and dropping out of the study. Attrition was especially problematic because my client sample was very small at the beginning of the study. Future studies should include a client sample composed of clients from as many of the eight comprehensive rehabilitation centers in the United States as possible. In addition, replication of the study over time at the Hiram G. Andrews Center would also be valuable.

A second limitation to my study was not having disability type variability in the client sample. For example, the pre (94%) and post test (89%) samples had a significant number of clients with cognitive or learning disabilities. Additionally, a high percentage of clients with cognitive and learning disabilities may not have fully comprehended some of the questions on the QDIO. Due to limitations in the variability of disability types, other disability types may not have been equally represented. Future studies should include a more diverse representation of disability types.

A third limitation of my study was not clearly operationally defining job categories for the professional sample. A high percentage of professionals indicated their job category as other. Many responses to other included my operational definition for the job categories of counseling, instructor, or evaluator. To eliminate confusion in responding to job category, the QDIO-P could include a brief description of the job specific category, including a list of the corresponding job classifications.

A fourth limitation was that one term between the pre and post test may not be enough time to reshape beliefs, attitudes, and roles related to disability. In attempt to control for extraneous variables, it was very important to my study to include only new clients that had never received any type of vocational rehabilitation services at the Hiram G. Andrews Center. However, due to this requirement, I may have limited my client sample. Moreover, I could not predict the total number of admissions for the time period when I conducted my study. Opening the study to all clients, both returning and new would have allowed for greater client participation and a larger client sample.

A fifth limitation in the study was in the wording of the 30-items and collection of demographic variable information. For example, several participants wrote comments in the margin of the QDIO and QDIO-P that the use of the terms "normal" or "impairment" was offensive or outdated. Mertens (1998) cautions that researchers should be aware those terms such as impairment are not without controversy. Mertens also states that measures used to identify an individual with disability on surveys, such as learning disability, are not without limitations. For example, in my study, participants with cognitive and learning disabilities appeared to have difficulty categorizing their disability. As previously discussed, the category of "other" was used at a high rate for individuals with disabilities such as cognitive or learning, even though the category of cognitive was an option.

Implications for Future Research

Putnam (2005) states that furthering the body of disability identity knowledge will be accomplished through empirical investigation. Darling and Heckert (in press) developed the QDIO to measure the following dimensions: 1) Access, both to mainstream and the disability subculture and 2) Orientation including the variables of Identity, pride versus stigma; Model, social versus medical; and Role, activism versus passivity.

Darling and Heckert validated the QDIO with an American sample of 388 individuals with disabilities. Their research produced a four factor solution of pride, exclusion, social model, and medical model. My study expanded on Darling and Heckert's (in press) original study and found support for similar factors among a large sample of professionals and staff. My results support that greater or less agreement with the variables can be indicators of clients' and professionals' beliefs, attitudes, and roles related to disability.

Conclusion

The QDIO did function similarly as it did in Darling and Heckert's original study, which provides evidence that the QDIO has external validity and may be used as an effective instrument with other samples of individuals with disabilities. Specifically, beliefs, attitudes, and roles related to disability could potentially be measured for the more than 20,000 clients who receive services annually at any one of the eight comprehensive rehabilitation centers in the United States. Quantifying client's disability beliefs, attitudes, and roles related to disability may help guide the client and professional relationship, as well as appropriate vocational counseling and individualized rehabilitation services, and employment outcomes. Moreover, the potential exists to use the QDIO to measure the growth and effectiveness of client-professional relationships and rehabilitation services. With a total annual budget for the eight comprehensive rehabilitation centers exceeding $130 million dollars, measuring effectiveness of services is extremely prudent especially in this current competitive economic market.

In conclusion, empirically determining the amount of disparity among clients' and professionals' beliefs, attitudes, and roles related to disability will help in the delivery of rehabilitation services. For example, congruence between rehabilitation clients' and rehabilitation professionals' beliefs, attitudes, and roles related to disability may have an effect on vocational rehabilitation outcomes. These outcomes include improved client-professional relationships, ranging from establishing rapport, to rehabilitation planning, to placement into employment and transition into independent living. Upon program entry the rehabilitation client and the rehabilitation professional may be closely aligned or vastly apart in beliefs, attitudes, and roles related to disability due to pre-existing ideas based on experiences interacting in society which can vastly effect the client-professional relationship.

Vocational Rehabilitation outcomes are also related to state and federal legislation and accreditation standards. For example, the Pennsylvania Office of Vocational

Rehabilitation is required annually to successfully rehabilitate or place a percentage of clients into competitive employment. The Hiram G. Andrew Center must meet accreditation standards in order to maintain compliance. Not meeting vocational rehabilitation outcome goals and accreditation standards can effect ongoing and future funding, the number of clients referred to the center, partnerships and collaborations, or credibility with business and industry.

Previous research has not focused on examining beliefs, attitudes, and roles related to disability of clients and professionals at a facility such as the Hiram G. Andrews Center. Continuation of this type of research would make a valuable contribution to the literature because identifying an instrument that measures beliefs, attitudes, and roles related to disability could change the delivery and receipt of vocational rehabilitation services. The implications for change could be realized not only at the Hiram G. Andrews Center, but also at the other seven state operated rehabilitation centers. Having awareness of professionals' and clients' beliefs, attitudes, and roles related to disability could improve vocational rehabilitation services from program initiation.

Research into beliefs, attitudes, and roles related to disability will continue to emphasize that one model with one way of delivering services will not collectively benefit all individuals with disabilities. Increased client and professional knowledge regarding each other’s beliefs, attitudes, and roles related to disability through use of the QDIO will assist in improving client-professional relationships.

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Appendix A

Questionnaire on Disability Identity and Opportunity (QDIO)

Clients

DO NOT PUT YOUR NAME ON THIS FORM

Questionnaire on Disability Identity and Opportunity

Please read each of the following statements and check (√) the box that best represents your level of agreement:

		Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
1.	I don’t think of myself as a disabled person.	☐	☐	☐	☐	☐
2.	I would rather associate with disabled people than with people without disabilities.	☐	☐	☐	☐	☐
3.	I am a better person because of my disability.	☐	☐	☐	☐	☐
4.	If I had a choice, I would prefer not to have a disability.	☐	☐	☐	☐	☐
5.	I am proud of my disability.	☐	☐	☐	☐	☐
6.	My disability is an important part of who I am.	☐	☐	☐	☐	☐
7.	I feel sorry for people with disabilities.	☐	☐	☐	☐	☐
8.	Most of my friends have disabilities.	☐	☐	☐	☐	☐
9.	Lack of accessibility and discrimination by employers are the main reasons why disabled people are unemployed.	☐	☐	☐	☐	☐
10.	It isn’t easy for people with disabilities to be treated as “normal.”	☐	☐	☐	☐	☐
11.	People with disabilities need to fight for their rights more than nondisabled people do.	☐	☐	☐	☐	☐

Please read each of the following statements and check (√) the box that best represents your level of agreement:

		Strongly Agree	**Agree**	**Not Sure**	**Disagree**	**Strongly Disagree**
12.	The reason most people with disabilities are unemployed is that they are not able to do the jobs that are available.	☐	☐	☐	☐	☐
13.	My disability limits my social life.	☐	☐	☐	☐	☐
14.	My disability keeps me from working.	☐	☐	☐	☐	☐
15.	The biggest problem faced by people with disabilities is the attitudes of other people.	☐	☐	☐	☐	☐

Continue →

		Strongly Agree	**Agree**	**Not Sure**	**Disagree**	**Strongly Disagree**
16.	All buildings should be accessible to people with disabilities.	☐	☐	☐	☐	☐
17.	I have a lot in common with other people with disabilities.	☐	☐	☐	☐	☐
18.	I wish that someone would find a cure for my disability.	☐	☐	☐	☐	☐
19.	Doctors and other medical professionals know what is best for people with disabilities.	☐	☐	☐	☐	☐
20.	People with disabilities need to learn to adjust to living in a world in which most people are not disabled.	☐	☐	☐	☐	☐
21.	I try to hide my disability whenever I can.	☐	☐	☐	☐	☐
22.	I am familiar with the Americans with Disabilities Act (ADA) and think it is a good law.	☐	☐	☐	☐	☐
23.	I am familiar with the Disability Rights	☐	☐	☐	☐	☐

		Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
	Movement and support its goals.					
24.	People should try to overcome their disabilities.	☐	☐	☐	☐	☐
25.	My disability enriches my life.	☐	☐	☐	☐	☐
26.	People with disabilities can never fit into “normal” society.	☐	☐	☐	☐	☐
27.	In general, I am satisfied with the quality of my life.	☐	☐	☐	☐	☐
28.	I often am excluded from activities because of my disability.	☐	☐	☐	☐	☐
29.	The people I care about always include me in activities I am able to enjoy.	☐	☐	☐	☐	☐
30.	The most important thing for people with disabilities is to learn to accept what they cannot change.	☐	☐	☐	☐	☐

Please answer the following questions by placing a check (√) nex the description that applies to you:

Continued ⟶

1. What is your gender?

   ☐ Male ☐ Female

2. What is your age?

   ☐ 18 – 35 ☐ 36 – 64 ☐ Over 65

3. What is your marital status?

   ☐

☐ Never married Married ☐ Separated ☐ Widowed
or divorced

4. What is your employment status?

☐ Work full-time ☐ Work part-time ☐ Retired

☐ Unemployed or homemaker ☐ Student

5. Where do you live?

☐ Small town ☐ Rural area ☐ Large City

☐ Medium-sized or small city

☐ Suburb of a large or medium-sized city

6. What is the highest level of school you completed?

☐ Less than high school ☐ High school

☐ Some college ☐ College

☐ Some graduate school ☐ Graduate school

Continued →

7. What is the nature of your disability, handicap, or impairment? (If you have more than one, please check as many as apply.)

☐ Mobility (Difficulty in movement)

☐ Vision

☐ Hearing

☐ Speech

☐ Cognitive (Difficulty in thinking)

☐ Cosmetic (Difference in appearance or size)

☐ Other: Please specify:

____

8. How long have you had your disability, handicap, or impairment (If you have more than one, please check the time that describes the condition you have had the *longest*.)

☐ Since birth	☐ More than 10 years
☐ 5 – 10 years	☐ Less than 5 years

9. How much assistance do you need with activities of daily living (like bathing, dressing, shopping, and cooking)?

☐ I need assistance with all activities.

☐ I need assistance with some activities.

☐ I don’t need any assistance.

Continued →

10. About how often do you engage in social activities outside of your home, like visiting friends or eating out in restaurants?

☐ More than once a week

☐ Once or several times a month

☐ Occasionally, less than once a month

☐ Rarely or never

11. Have you ever participated in a demonstration, written a letter to your congressional representative, or engaged in another activity to try to increase the opportunities available to people with disabilities?

☐ Yes, many times ☐ Yes, a few times ☐ Yes, once

☐ No, never

12. Please check the activities in which you participate at least once a month:

☐ Talking on the telephone with family, friends, or acquaintances

☐ Using a computer to communicate by e-mail

☐ Using a computer to access disability-related websites on the Internet

☐ Using a computer to access other websites

☐ Going to meetings or other activities sponsored by disability-related organizations

☐

Going to meetings or activities of other organizations

☐ Attending religious services

☐ Reading magazines or newsletters from disability-related organizations

Continued →

13. Please check the category that best describes your total, annual household income:

☐ Under $25,000 ☐ $25,000 - $50,000

☐ $50,000 - $100,000 ☐ Over $100,000

14. Please check the category or categories that best describe your racial/ethnic background:

☐ European American (white)

☐ African American

☐ Latino or Hispanic

☐ Native American or Indian

☐ Asian American

☐ Other: ________________________________

THANK YOU!

Appendix B

Questionnaire on Disability Identity and Opportunity (QDIO-P)

Professionals

DO NOT PUT YOUR NAME ON THS FORM

Questionnaire on Disability Identity and Opportunity (P)

Please read each of the following statements and check (√) the box that best represents your level of agreement:

		Strongly Agree	**Agree**	**Not Sure**	**Disagree**	**Strongly Disagr**
1.	I don’t think of a person with a disability as a disabled person.	☐	☐	☐	☐	☐
2.	I would rather associate with disabled people than with people without disabilities.	☐	☐	☐	☐	☐
3.	I would be a better person if I had a disability.	☐	☐	☐	☐	☐
4.	Given a choice, I would prefer not to have a disability.	☐	☐	☐	☐	☐
5.	I would be proud to have a disability.	☐	☐	☐	☐	☐
6.	A person’s disability is an important part of who they are.	☐	☐	☐	☐	☐
7.	I feel sorry for people with disabilities.	☐	☐	☐	☐	☐
8.	Most of my friends have disabilities.	☐	☐	☐	☐	☐
9.	Lack of accessibility and discrimination by employers are the main reasons why disabled people are unemployed.	☐	☐	☐	☐	☐
10.	It isn’t easy for people with disabilities to be treated as “normal.”	☐	☐	☐	☐	☐
11.	People with disabilities need to fight for their rights more than nondisabled people	☐	☐	☐	☐	☐

Please read each of the following statements and check (√) the box that best represents your level of agreement:

		Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagr
	do.					
12.	The reason most people with disabilities are unemployed is that they are not able to do the jobs that are available.	☐	☐	☐	☐	☐
13.	A disability limits a person's social life.	☐	☐	☐	☐	☐
14.	Having a disability keeps people with disabilities from working.	☐	☐	☐	☐	☐
15.	The biggest problem faced by people with disabilities is the attitudes of other people.	☐	☐	☐	☐	☐
16.	All buildings should be accessible to people with disabilities.	☐	☐	☐	☐	☐
17.	People with disabilities have a lot in common with other people with disabilities.	☐	☐	☐	☐	☐
18.	I wish a cure could be found for all disabilities.	☐	☐	☐	☐	☐
19.	Doctors and other medical professionals know what is best for people with disabilities.	☐	☐	☐	☐	☐
20.	People with disabilities need to learn to adjust to living in a world in which most people are not disabled.	☐	☐	☐	☐	☐
21.	If I had a disability I would hide my disability whenever I could.	☐	☐	☐	☐	☐
22.	I am familiar with the Americans with Disabilities Act (ADA) and think it is a good law.	☐	☐	☐	☐	☐
23.	I am familiar with the Disability Rights Movement and support its goals.	☐	☐	☐	☐	☐
24.	People should try to overcome their disabilities.	☐	☐	☐	☐	☐

Please read each of the following statements and check (√) the box that best represents your level of agreement:

		Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagr
25.	For people with disabilities, having a disability enriches their life.	☐	☐	☐	☐	☐
26.	People with disabilities can never fit into “normal” society.	☐	☐	☐	☐	☐
27.	In general, people with disabilities are satisfied with the quality of their lives.	☐	☐	☐	☐	☐
28.	People with disabilities are often excluded from activities because of their disability.	☐	☐	☐	☐	☐
29.	People that care about people with disabilities should always include them in activities they are able to enjoy.	☐	☐	☐	☐	☐
30.	The most important thing for people with disabilities is to learn to accept what they cannot change.	☐	☐	☐	☐	☐

Please answer the following questions by placing a check (√) next to the description that applies to you:

1. What is your gender?

   ☐ Male ☐ Female

2. Please provide your Month, Day, and Year of Birth
   (For example: 02/13/1964)

   ☐☐ ☐☐ ☐☐☐☐

3. What is your marital status?

   ☐ Never married ☐ Married ☐ Separated

☐ Widowed ☐ Divorced

4. What is your employment status?

☐ Work full-time ☐ Work part-time

5. Where do you live?

☐ Small town ☐ Rural area ☐ Large City

☐ Medium-sized or small city

☐ Suburb of a large or medium-sized city

6. What is the highest level of school you completed?

☐ Less than high school ☐ High school

☐ Some college ☐ College

☐ Some graduate school ☐ Graduate school

7. Please check the category that best describes your total, annual household income:

☐ Under $25,000 ☐ $25,000 - $49,999

☐ $50,000 - $100,000 ☐ Over $100,000

8. Please check the category or categories that best describe your racial/ethnic background:

☐ European American (white)

☐ African American

☐ Latino or Hispanic

☐ Native American or Indian

☐ Asian American

☐ Other: ________________________________

9. Please check the category that best describe your job function:

☐ Manager

☐ Supervisor

☐ Counseling

☐ Evaluation

☐ Instructor

☐ Recreation

☐ Medical

☐ Other: ____
(For example: Food Service Worker, Maintenance)

*If you are a person with disability, please continue and answer questions 10 through 15.

10. If you are a person with a disability, what is the nature of your disability, handicap, or impairment? (If you have more than one, please check as many as apply.)

☐ Mobility (Difficulty in movement)

☐ Vision

☐ Hearing

☐ Speech

☐ Cognitive (Difficulty in thinking)

☐ Cosmetic (Difference in appearance or size)

☐ Other: Please specify: ______________________

11. How long have you had your disability, handicap, or impairment (If you have more than one, please check the time that describes the condition you have had the *longest*.)

☐ Since birth

☐ 5 – 10 years

☐ Less than 5 years

☐ More than 10 years

12. How much assistance do you need with activities of daily living (like bathing, dressing, shopping, and cooking)?

☐ I need assistance with all activities.

☐ I need assistance with some activities.

☐ I don't need any assistance.

13. About how often do you engage in social activities outside of your home, like visiting friends or eating out in restaurants?

☐ More than once a week

☐ Once or several times a month

☐ Occasionally, less than once a month

☐ Rarely or never

→

14. Have you ever participated in a demonstration, written a letter to your congressional representative, or engaged in another activity to try to increase the opportunities available to people with disabilities?

☐ Yes, many times ☐ Yes, a few times ☐ Yes, once

☐ No, never

15. Please check the activities in which you participate at least once a month:

☐ Talking on the telephone with family, friends, or acquaintances

☐ Using a computer to communicate by e-mail

☐ Using a computer to access disability-related websites on the Internet

☐ Using a computer to access other websites

☐ Going to meetings or other activities sponsored by disability-related organizations

☐ Going to meetings or activities of other organizations

☐ Attending religious services

☐ Reading magazines or newsletters from disability-related organizations

THANK YOU FOR YOUR PARTICIPATION

*Upon request, this survey is available in a**lternate** format`

Appendix C

Informed Consent Form (Clients)

Informed Consent Form

You are invited to participate in this research study. The following information is provided in order to help you make an informed decision whether or not to participate. If you have any questions please do not hesitate to ask. You are eligible to participate because you are an employee of the Hiram G. Andrews Center.

The purpose of this study is to get your view of individuals with disabilities and their place in society, and to determine if there is any connection to those views and the services clients with disabilities receive or to how professionals provide those services.

Your participation in this study is voluntary and you are free to decide not to participate in the study. If you choose to participate, all information will be held in strict confidence and will have no bearing on your employment at the Hiram, G. Andrews Center. The information you provide will be considered only in combination with that of other participants. The information in this study may be published in scientific journals or presented at scientific meetings; however, your identity will be kept confidential.

If you are willing to participate in this study, please sign the statement below and return it to the person administering the survey. If you have additional questions for the researcher, you will be provided with her name and contact number.

Participant Name_____________________

Participant Signature__________________

Date_______________________________

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This project has been approved by the Indiana University of Pennsylvania Institutional Review Board for the Protection of Human Subjects (Phone: 724-357-7730).