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ASSESSMENT OF SOCIAL WORKERS' ATTITUDES TOWARDS PEOPLE WITH PHYSICAL DISABILITIES

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ABSTRACT

The purpose of this study was to explore the attitudes of social workers in Tennessee towards people with physical disabilities. A non-probability, convenience sample of social workers who were members of the National Association of Social Workers Tennessee Chapter (NASW TN), and accept email communication, were sent the on-line survey. Two hundred sixty five social workers responded to the survey and one hundred sixty eight respondents (N=168) completed the survey in its entirety and were included in analysis. The respondents' attitudes were assessed as either empowering or oppressive based on concepts and constructs of empowerment and oppression identified by disability scholars and social work researchers in the field of disability. The findings of the individual questions were analyzed. The survey questions worded toward an empowering attitude found that 80% of the subjects answered towards a possible empowering attitude regarding the self-determination of people with physical disabilities. The highest rate of *no opinion* responses was noticed with the questions related to sexual satisfaction, intimacy and depression. Due to the lack of validity and reliability of the survey tool it would be inappropriate to generalize the results to a broader social work population. The information gathered, however, may serve as a glimpse of the attitudes of social workers in Tennessee towards people with physical disabilities

TABLE OF CONTENTS

LITERATURE REVIEW……...…….1

METHODOLOGY……..……..16

RESULTS…….…….26

DISCUSSION…..……..30

IMPLICATIONS……...34

LIST OF REFERENCES.....……37

APPENDIX...…….43

VITA…….....…….44

LIST OF TABLES

Table 1: Demographic Characteristics of Study Subjects……..…….....25

Table 2: Survey Question Frequencies ……...……..27

LITERATURE REVIEW

Since the 1970's, the disabled community has embraced an empowering model of disability called the minority model (also called the "social model" (Pope and Tarlov, 1991). It posits that disability lies not within the person, but in the environment that fails to accommodate people with disabilities and in the oppressive societal view of people with disabilities (Charlton, 1998; Olkin, 1999). Yet, today's health care system continues to operate under the medical model. If social workers adopt the medical model view that people with disabilities have experienced a great loss and that they need to mourn and then learn coping skills to assimilate into society, they may be contributing to the oppression of people with disabilities (Beaulaurier & Taylor, 2001; Boehm & Saples, 2002; Charlton, 1998; Kim & Canda, 2006). Social workers may not fully understand the concept of empowerment and embrace a holistic view of health for people with disabilities (Kim & Canda, 2006).

"The 400 million people with disabilities are the poorest and the most powerless people on earth" (Charlton, 1998, p. 24). They are oppressed. Powerlessness and poverty are the keystones that many people with disabilities experience. People with disabilities are commonly viewed as not having the power to determine their needs or express their opinions (Beaulaurier & Taylor, 2001; Braddock & Parish, 2001; Charlton, 1998; Fawcett, White, Balcazar, Suarez-Balcazar, Mathews, Paine-Andrews, Seekins & Smith, 1999; Hahn, 1985; Northway, 1997). By the 20th century, the paternalistic idea that people with disabilities could be rehabilitated and normalized into society was established (Beaulaurier & Taylor, 2001; Braddock and Parish, 2001; Charlton, 1998; Hayes & Hannold, 2007; Mackelprang & Salsgiver, 1996; Pope and Tarlov, 1991; Shapiro, 1993). This perspective evolved into the medical model, which views disability as a medical problem that resides in the individual. Disability is seen as a defect or

failure of a body and therefore as inherently abnormal and pathological (Olkin, 1999). The medical model, which prevails today, focuses on an individual's limitations and offers a top-down treatment process. Medical care is seen as delivered by experts and the individual is viewed as a passive recipient of services. This model lends itself to oppression of people with disabilities as it does not offer collaboration nor does it empower people to take an active role in their medical decisions (Aguilar, 1997; Block, Balcazar & Keys, 2001; Charlton, 1998; Fawcett, White, Balcazar, Suarez-Balcazar, Mathews, Paine-Andrews, Seekins & Smith, 1999; Hahn, 1997; Hayes & Hannold, 2007; Mackelprang & Salsgiver, 1996; Nagi, 1991). The process of empowerment is important for understanding and improving the lives of people with disabilities, it allows them to gain control over events and outcomes that affect their lives (Aguilar, 1997; Block, Balcazar, Keys, 2001; Fawcett, et al., 1994; Hahn, 1997; Hayes & Hannold, 2007; Kim & Canda, 2006).

History of People with Disabilities

According to the U.S. Department of Health and Human Services, there are approximately 62 million people with disabilities in the United States. The report posits that disability theory and concepts have evolved, recognizing the complexity of disability. The definition of disability currently includes not just a person's physical impairment, but restrictions in social participation, the social and physical limitations of the environment and a person's social and financial resources (U.S. Department of Health and Human Services, 2008).

Historically, people with disabilities have experienced discrimination and oppression from as early as the Neolithic tribes when people with disabilities were considered possessed (Braddock and Parish, 2001). The Judeo-Christian tradition throughout and after the Middle Ages taught that people with disabilities were expressions of God's displeasure (Livneh, 1982) and in the 17th

century with the rise of capitalism and an industrialized society, England's Poor Laws attempted to categorize people into deserving and non-deserving recipients of charity. By the mid-1770's the idea that people could be treated and made more perfect evolved and institutions were built to separate people with disabilities from the rest of the population. By the end of the 19th century social Darwinism and eugenics became popular in the United States and people with disabilities were forbidden to reproduce. Eugenics fostered the notion that no intervention could bring about change as the laws of nature deemed people with disabilities unfit (Braddock and Parish, 2001). Throughout the 20th century theoretical models of biological and cultural pathology, such as eugenics, presented people with disabilities and other marginalized communities in terms of deficiency and dependence (Block, 2001). This philosophy may have further strengthened the idea of institutionalization and separation. According to Hayes and Hannold (2007) separating people according to a need-based system was the basis that disability became a clinical concept and the health care system assumed an administrative role in managing people with disabilities. The early 20th century did not offer progressive ideas of disability, yet the federal government offered legislation providing funds for treatment of veterans disabled by the wars.

The current medical model in the United States has not progressed much since the post World War era which offers a deductive approach to treatment wherein health care workers direct the medical care and the patients are seen as passive recipients (Mackelprang & Salsgiver, 1996). In the turbulent 1960's for the first time in the United States, people with disabilities demanded access to the mainstream of society (Makelprang, 1996). In the process, many people with disabilities began to distrust social workers and health care providers who they saw as doing things *to* them rather than *with* them (Beaulaurier and Taylor, 2001). Disability scholars and the independent living movement embrace a minority model, (Pope and Tarlov, 1991) which views

people with disabilities as active and responsible consumers, not as patients or clients. This significant shift occurred in the 1970s and 1980s, as people with disabilities organized for political action with the principal purpose of "gaining increased opportunity for independent and self-determined lifestyles in the wider community" (Beaulaurier & Taylor, 2001, p. 69).

While the disabled community embraces an empowering minority group model, the current health care system in the United States continues to operate under the medical model. For instance, the goal of rehabilitation is often to maximize a person's physical functioning to assimilate her back into the existing environment. According to Beaulaurier and Taylor, (2001) this can have unintended psychological consequences for the person, as it may lead to feelings of shame about her disability. The person with a disability may feel that her limitations are unacceptable. Conversely, the disability rights movement takes a different approach by accepting the impairments in people and emphasizing environmental, social and political barriers that limit full participation in society. These barriers are seen as discriminatory and oppressive (Kailes, 1988; Hayes & Hannod, 2007).

If social workers adopt the view that disability is a deviation from the norm that must be cured or repaired through medical expertise, (Hayes & Hannold, 2007) rather than an empowerment view, such as the minority group model, they may, unwittingly and contrary to their intentions, collude with social oppression of people with disabilities (Keilhofner, 2005). According to Boehm and Staples, (2002) the empowerment concept has developed through social theorists, but may not be embraced by practitioners or consumers of services. Additionally, the process of theory development, like the medical model, has been deductive and top-down rather than inductive and bottom-up. Charlton (1998) points out that the disability community needs to learn from the civil rights movement and that "when others speak for you,

you lose" (p.3). People with disabilities are oppressed when medical, political or cultural decisions are made about them without their full participation. Charlton defines oppression as "when individuals are systematically subjected to political, economic, cultural or social degradation because they belong to a social group." (p. 8).

Definition of Disability

During the last 50 years a significant change in the concept of health has occurred due in part to the advancement in technology, life saving endeavors and a trend toward health promotion and policy changes that define health and health measures (Dijkers, Whiteneck & El-Jaroudi, 2000). Prior to the 1940's, terms associated with people with a disability-including "handicapped, impaired and disabled"; all suggested an aberrant or deviant condition of a person, conceptualizing disability as a deviation from the norm, (Nagi, 1991), or an object of pity (Shapiro, 1993). However, changes surfaced in the 1940's with the World Health Organization's (WHO) definition of health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (Dijkers, Whiteneck & El-Jaroudi, 2000, p. 63). Increasing concern regarding the chronic nature of disability and its impact on sociopolitical and socioeconomic factors highlighted the need for a shift from the biomedical model to a more comprehensive model that accounts for the societal impact of health care for people with physical disabilities (Fougeyrollas & Beauregard, 2001). Consequently, the WHO revised the framework for measurement of health to reflect the heightened understanding that an absence of health or disease, which extends the definition beyond the individual and encompasses the entire

global society (WHO, 2001). Health is not the goal of life; it is a means or a resource to enable one to have control over life (Tengland, 2008). Social workers who embrace or practice in the bio-medical model may find it difficult to view individuals with physical disabilities as healthy, self-determined beings (Kim, 2006). While social workers may assist a client to enhance their "control over health" it is not an all-inclusive definition.

The modernized definition of disability more accurately reflects the National Association of Social Workers' *Code of Ethics* (1999), which includes the principle of service; stating social workers' primary goal is to help people in need and to address social problems and social justice. The *Code of Ethics* also indicates social workers are to pursue social change, particularly with and on behalf of vulnerable and oppressed individuals and groups of people. The more current definition of disability also encompasses social workers' ethical responsibility of self-determination of clients. Self-determination indicates the autonomy and respect one experiences and suggests one's behavior resulting from one's own wishes, choices and decisions (National Association of Social Workers, 1999).

The WHO released the new definition, encompassing society in the document entitled the International Classification of Functioning, Disability and Health (ICF) (WHO, 2001). According to the ICF (WHO, 2001), the context in which a person lives is considered to be of great relevance in defining one's adaptation to disability. Context is comprised of personal and environmental factors. Environment includes socio-cultural factors, physical-architectural space, the services available to persons with disabilities and access to health care. Disability, in this taxonomy, is not a characteristic of a person or the environment, but rather a result of the failure of the person to successfully interact with her environment. It can be suggested that the unsuccessful interaction may not primarily be the inadequacy of the individual with a disability,

but rather with the incongruence between the environment and the support systems in place for people with disabilities. Despite the social work model of person-in-environment, the profession has only recently embraced the perspective of the medical model. For example, social workers may tend to view the person with a disability as having undergone significant loss and consequently experienced loss, most likely resulting in depression and distress (Gilson, Depoy & Macduffie, 2002).

Accentuating the dynamic interaction of person-environment represents a shift from the medical model to a more comprehensive bio-psychosocial model of disability (Simeonsson, et al., 2003). Kim and Canda (2006) suggest that the alternative disability model, the social model of disability, that is grounded in disability studies and reflects many principles of the independent living movement, is becoming more accepted among advocates for people with disabilities and in the disability studies field. The social model, that shifts attention away from the functional limitation of a person and focuses on the social environments that impose restrictions upon people with disabilities (Fine & Asch, 1988; Hahn, 1987, 1996; Oliver, 1983, 1996; Oliver & Sapey, 1999; Rioux, 1997; Zola, 1988) mirrors the social work ethical principles of social justice and service. Social workers are expected to address social problems and injustices and to pursue social change on behalf of vulnerable and oppressed people (NASW, 1999). Moreover, Kim and Canda (2006) go on to say that under the social model it is important to analyze how society marginalizes, labels and categorizes people with disabilities.

Hahn (1985) argues that there is also a socio-political definition of disability. That is, a disability is a consequence of a disabling environment rather than the organic limitations of the disease process. Further he posits that this lack of empowerment is political, in that people with disabilities do not have a large national organization of disabled individuals comparable to other

interest groups (Hahn, 1997). People with disabilities may be invisible to the politically powerful; whose decisions positively and negatively influence their opportunities for power. While there may not be conspicuous opposition to the struggles of people with disabilities there is resistance to appropriate and adequate funding for the care of those with disabilities (Hahn, 1997). The oppression of people with disabilities too results from paternalistic and charitable sentiments that reflect sympathy and pity (Shapiro, 1993). Such depictions further serve to impede the emergence of politically powerful groups of citizens capable of confronting the policy-making processes that would ensure equal representation (Hahn, 1997).

Oppression

To further articulate the concept of physical disabilities it is beneficial to have an understanding of oppression. One form of oppression is marginalization, which refers to being excluded from participation (Northway, 1997). According to the ICF (WHO, 2001), participation is manifested as the physical, social or intellectual involvement in an activity. Individuals with physical disabilities state that health care professionals are part of the problem regarding their opportunities for participation (Kielhofner, 2004; Northway, 1997). By focusing on the client's impairment rather than addressing the environmental barriers, health practitioners reinforce the misconception that disability is an individual matter or deviation from the norm rather than a societal matter. Disability scholars assert that people are disabled not by their impairment but rather by social oppression (Charlton, 1998). In other words, as social worker's, we have a collective responsibility to develop an astute awareness of peoples' viewpoints and unique expressions of self-determination. To advocate for self-determination we must promote empowerment of all people rather than contribute to their oppression. Oppression may not be a result of an individuals' intentional effort to disadvantage people, but rather may occur because

preconceived norms, laws, policies and attitudes have gone uncontested by health care providers as well as those with disabilities.

Another aspect of oppression is the societal view that people with disabilities are powerless and to be pitied (Charlton, 1998; Northway, 1997, Shapiro, 1993). People with disabilities are seen as being incapable of determining their needs, desires or achieve the same status as those without disabilities (Northway, 1997). Clearly, this perspective is in contrast with social worker's code of ethics. While the social work code of ethics promotes self-determination and social justice it falls short of challenging and changing the collective view of disabilities at a social level. When people with disabilities lack power, they experience adverse conditions disproportionate to the able-bodied members of society (Fawcett, Suarez-Balcazar, Mathews, Paine-Andrews, Seekins & Smith, 1994). Miley and Dubois (2007) offer a more in-depth view of the *Code of Ethics* of the National Association of Social Workers (1999) by discussing the concept of "anti-oppressive practice." They go on to say that, "challenging oppression requires social workers to support individuals in naming their experience of oppression, examining the effects of oppression, and challenging oppression both personally and politically" (Dietz, 2000, p. 371). To advocate politically on behalf of oppressed people is a central activity of social work. If social workers are to embrace the concept of empowerment, "advocacy as an ethical practice assumes social workers speak along with, not for, others" (Miley, O'Melia & Dubois, 2004).

An aspect of oppression where there is a dearth of research concerns sexuality and disability (McCabe & Taleporos, 2003). There are many physical and social barriers that may impede the sexual expression of people with physical disabilities. According to McCabe & Taleporos (2003), people with more severe physical limitations had lower levels of sexual esteem and sexual satisfaction and higher levels of sexual depression than people who

experienced mild impairments or the able-bodied population. Moreover, studies of attitudes towards people with disabilities show as people develop a stronger emotional bond with a person with a disability their attitudes become more negative (Olkin & Howson, 1994). The researchers go on to say that most people indicated they would not marry a person with a disability. According to Olkin (1999), the most pervasive myth regarding sexuality and people with physical disabilities is that people with physical disabilities lack the basic biological sex drive. Social barriers, such as decreased access to information and dependence on caregivers and health care workers may lead to a lack of sexual expression for people with disabilities. It may be important for social workers to be knowledgeable of the barriers and the myths regarding disability and sexual expression to increase cultural competence and foster self-determination for people with physical disabilities.

Empowerment

Empowerment is the process by which people gain control or mastery over valued events, outcomes and resources (Fawcett, et al., 1994). According to Rappaport (1987), "empowerment is a construct that links individual strengths and competencies, natural helping systems, and proactive behaviors to social policy and social change" (p.569). In other words, empowerment defeats oppression. Tengland (2008) endeavors to articulate a plausible and useful definition of the concepts and constructs of empowerment. Such an enterprise reveals several tenets worthy of discussion for the purposes of determining strategies for empowerment of people with physical disabilities. Overall, empowerment is a process or approach as well as a goal. As such, three general goals emerge. Empowerment should "lead to an increase in the control of the individual's own health, … an increase in the individual's ability to control her life, and third, that it should consist in, or lead to, an increase in the ability to change the world" (Tengland,

2008, p. 81). Controlling one's life encompasses controlling one's health but is not synonymous with WHO's definition of health promotion. Rather, Tengland suggests the incorporation of other authors' more encompassing goals such as self-esteem, self-confidence or self-efficacy, ability, autonomy, and freedom should be considered. Therefore, Tengland offers a definition of empowerment as a goal; "a change (internal or external to the person) is an increase in empowerment if (if and only if) it is an increase in the person's ability (or opportunity) to control her own life" (p.82). The two central themes in this definition may contribute to the conceptualization of empowerment. Tengland elaborates on the constructs of what aspects of "life" one may want to control. These include: "a) one's health, b) one's home, c) one's work, d) one's close relationships, e) one's leisure time, f) one's values" (p. 82). These important aspects assume that the fulfillment of them may contribute to one's quality of life and that mastery over them is a goal or a manner of empowerment. In terms of the concept of "the ability to control," this may include deciding, acting, or having the opportunity to influence, change, end or initiate through physical manipulation, communication, or political influence (Tengland, 2008). Therefore, with more opportunity for the aforementioned construct's of "life" one may experience an increase or decrease in empowerment. As social workers we can assert that one aspect of our professional responsibility is to create opportunities for empowerment as a goal. Therefore, enabling those who seek our services to gain control over their lives is far from trite. It should be our aim.

Empowering one to gain mastery over their life requires a concomitant sense of autonomy and freedom. Autonomy, or self-determination, according to Tengland (2008) refers to one's "ability to reflect critically on and to choose what preferences, desires, and wishes to hold

and to pursue" (p. 82). Additionally, empowerment suggests knowledge acquisition, skill development and consciousness.

Inherent in methods and models of empowerment are concepts related to one's identity. Tengland (2008) distinguishes between several similar concepts in an effort to operationalize the concept. Self-esteem refers to an "attitude toward one's own holistic self, or how one values oneself as an individual" (p. 87). Whereas, self-confidence is "the belief about one's general capacity to handle situations and task in life, and self-efficacy has to do with an individual's beliefs about her own capacity to handle specific situations or tasks in life" (p. 87). Additionally, freedom intimately relates to empowerment in that it reflects one's ability to "control the external environment that influences one's actions and choices in life." (p. 88). Tengland (2008) notes that for freedom to represent a real opportunity for action and control, one must perceive it as such.

Social workers are uniquely positioned to assist people with disabilities to become empowered in their health and lifestyle decisions. The empowerment process can be greatly facilitated by replacing the biomedical model of disability with a socio-political model that emphasizes wellness and prevention versus treatments aimed at curing disability.

According Miley and Dubois (2007) empowerment-oriented social work practice focuses simultaneously on personal and socio-political arenas. Empowerment social work embraces the social justice contract between individuals and society. Although both personal and socio-political change, are considered foundational to empowerment, Miley and Dubois (2007) state that these ethical preferences are underrepresented in the National Association of Social Workers (1999) *Code of Ethics.*

According to Beaulaurier and Taylor, (2001) the disability rights movement has historically been a self-help movement and has sometimes taken an adversarial role toward professionals whom they have seen as not overly supportive. It is therefore, imperative that social workers understand how their practices may be influenced greatly by the biomedical model and that they might, unintentionally, contribute to the oppression of people with disabilities. Today's managed care settings may call for social workers to be more cognizant of both personal and political empowerment as increasing caseloads and decreasing social service budgets threaten the self-determination of people with disabilities (Beaulaurier & Taylor, 2001). Empowerment-oriented social work practice promotes self-determination (Miley & Dubois, 2007). It is incumbent on social workers to emphasize empowerment objectives rather than mere compliance with medically prescribed treatment plans or psychosocial clinical interventions (Beaulaurier & Taylor, 2001). This concept parallels the independent living movement's perspective on empowerment in that as people with disabilities move away from dependence on health care professionals to more self-direction or "client/patient mentality to "consumer mentality" (Kailes, 1988, p.5) they take the role of an informed and empowered consumer, not the passive role of a patient.

Guiterez (1990) identified psychological changes that are important for the client to become empowered. Changes that can be facilitated by the social worker within an advocacy practice include(p. 150);

> (1) self efficacy-the belief that one's actions can produce desired changes, (2) group consciousness-identification as a member of a class and recognition of how political, social and physical structures effect the class, (3) reduction of self-blame for negative consequences of being a member of the class, (4) assuming personal responsibility for change-preparing to take action to improve one's own situation.

Beaulaurier and Taylor (2001) emphasize that social workers need to help clients become effective advocates and negotiators for their own interests. As social workers embrace the shift from client to consumer, social work ethics of empowerment and self-determination will be more congruent with the empowerment views of the disability rights movement.

Boehm and Staples (2002) discuss how consumers and social workers conceptualize empowerment. Their findings indicate that consumers overwhelmingly emphasized tangible outcomes that resulted in concrete results while social workers frequently viewed empowerment as an important process in and of itself, without any connection to the outcome. Social workers tended to describe empowerment primarily as a function of professional interventions, not necessarily focusing on the actions and attitude of the client. The consumers often described the role of the professional as limited when discussing their empowerment while professionals were much more apt to see themselves as responsible for initiating consumer empowerment (Boehm & Staples, 2002). In other words, the authors point out that social workers continue to see themselves as experts, working within the biomedical model and possibly contributing to the oppression of the people with whom they work.

Thus, the purpose of this study is to examine social workers' attitudes towards people with physical disabilities. Additionally, the project assesses whether or not social workers use empowering language regarding people with physical disabilities versus oppressive language. Although the literature suggests health care workers may contribute to the oppression of people with physical disabilities, it is important to begin examining how social workers view people with physical disabilities. To truly foster empowerment, it may be essential that social workers consider a holistic view of health for people with disabilities (Kim & Canda, 2006).

Furthermore Aguilar (1997) argues that a holistic view of health is "critical for the enhancement of social work in health settings" (p. 83). All social work activities should include the consumers' self-defined aspirations and style of collaboration, (Kim & Canda, 2006). At present the author is not aware of any research incorporating disabilities studies and focusing on empowerment strategies for people with physical disabilities.

Research Hypotheses

Based on the literature review investigating the oppression or empowerment of people with physical disabilities, regarding health care professionals, the researcher hypothesized that social workers who have a Master of Science in Social Work (MSW) are likely to express an oppressive attitude towards people with physical disabilities.

METHODOLOGY

Sample

A non-probability, convenience sample of social workers who were members of the National Association of Social Workers Tennessee Chapter (NASW TN) was invited to complete an on-line survey. Inclusion criteria required participants to speak English, as no translation services were available to the researcher. Two hundred sixty five people responded to the survey (20% response rate). The data were cleaned by eliminating uncompleted surveys and any respondents who indicated a degree of BSW or PhD. One hundred sixty eight respondents (N=168) completed the survey in its entirety and were included in analysis.

Ethical considerations/procedures

As with all studies involving human subjects, Institutional Review Board approval was secured. All participants were afforded confidentially during the completion of the survey, as SurveyMonkey did not capture their internet addresses. Additionally, participants were asked to read and agree to informed consent on SurveyMonkey before gaining access to the survey. Researchers are not able to link identifying information to survey responses. Participants were able to exit the survey at any time without coercion and no questions were asked that could result in harm to the respondents.

Procedures

Social workers that were members of the National Association of Social Workers Tennessee Chapter (NASW TN) and accept email communication were sent a link to the on-line

survey. The self-administered, on-line questionnaire was developed using SurveyMonkey, a web-based survey tool (SurveyMonkey, 2010).

The respondents were allotted one month to complete the survey. The author collaborated with The National Association of Social Workers Tennessee Chapter (NASW TN) to distribute an email that contained an invitation to participate and the internet link to the survey to 1351 of their members. NASW TN sent a follow-up email, with the survey link, two weeks following the initial invitation.

Respondents were asked to respond to survey questions based on a Likert scale with five possible choices: strongly disagree, disagree, no opinion, agree and strongly agree. The questions were created to represent the concepts and constructs of empowerment and oppression identified by disability scholars and social work researchers in the field of disability. Each question was identified as suggesting an oppressive or empowering attitude corresponding to the "agree" of the Likert scale. The Likert scale was coded as -2 (strongly agree) to +2 (strongly disagree) for questions representing an oppressive attitude and, conversely -2 (strongly disagree) to +2 (strongly agree) for questions representing an empowering attitude. To examine attitudes, respondents were asked to rate their level of agreement with 16 survey questions (see Appendix). Coding allowed the author to examine the propensity of the respondents as possibly suggesting an oppressive or empowering attitude, the negative numbers representing a possible oppressive attitude and positive numbers representing an empowering attitude.

Survey Development

The task of measurement in scientific research is essential. In particular, measurement in clinical research is both essential and complex as there is increased awareness regarding the

impact of health and well being on the 'quality of life'. This is particularly true for disciplines such as social work. According to Steiner and Norman (2003) methods to measure what was previous thought to be immeasurable, such as quality of life or attitudes toward people with disabilities, development of appropriate scales is a multifarious endeavor. The first step in assessing subjective experiences of participants is to determine if a valid and reliable scale exists. A careful review of the literature was conducted to determine if an "empowerment scale" for health professionals existed. Because no measurement scale was found; a review of the literature related to empowerment theory, oppression, and social workers attitudes toward people with physical disabilities ensued.

When developing a scale, determining psychometric properties is important to determine the validity and reliability of the scale. It is critical to establish face validity and content validity. Face validity indicates whether the scale appears to be assessing the desired qualities. In the development of a survey to explore social workers attitudes toward people with disabilities, the constructs identified in the literature were used to create the specific questions. For example, Reeve, (2000) identified constructs such as "grief and mourning". Therefore, these terms were used to develop specific questions related to social workers' attitudes. The following sections discuss this in greater detail for each of the questions contained in the scale.

Reliability, another benchmark for appropriate scale development, refers to the measurement scale being capable of withstanding multiple or repeated assessment. Streiner and Norman (2003) warn that determining reliability should commence only after identifying that the scale measures something. That is to say the scale should be determined to have face validity before establishing reliability. When developing a measurement scale certain criteria are used to

determine how the questions and responses should be stated. The first criterion to be explored is the interpretability of the item. Interpretability includes reading level, ambiguity, double-barreled questions, jargon, value-laden words, positive and negative wording, and the length of the question (Streiner and Norman, 2003). A brief discussion of the relevant criterion follows. As the participants were social workers with college education, the reading level was assumed to be above the standard criterion of a measurement scale of a 12-year-old. Thus, there was no attempt to establish reading level. Ambiguity was be minimized by avoiding vague terms such as 'often', 'lately' or 'somewhat'. The measurement scale for this study attempted to quantify qualitative reflection; it was therefore necessary to provide terms such as "somewhat agree". Additionally, the phrasing of some of the questions relied on the respondents' understanding and experience of the subject matter. For example questions regarding poverty or a person's ability to influence their environment presupposed a masters level social worker understands these terms related to people with physical disabilities. Furthermore, it is difficult to create a valid scale without pilot testing the questions. However, no pilot testing of this scale was conducted.

Another criterion to consider is the use of double-barreled questions, which ask more than one question at the same time (Streiner and Norman, 2003). Every attempt was made to avoid this. This scale was developed without regard for the use of jargon as the author believed that educated social workers would be familiar and cognizant of terms such as oppression, empowerment, mourn and grief.

Additionally, criterion such as 'value-laden words' contribute to the interpretability of the scale questions. Because the measurement of empowerment and oppression are value-laden, or subjective in nature; it was difficult to phrase questions devoid of value. For instance the

question; “people with disabilities are an inspiration to me”, suggest that inspiration may be a positive attribute and therefore suggest social workers should be inspired. This is similar to the criterion of positive and negative wording. The development of the study’s scale attempted to avoid the use of negative terms such as “people with disabilities *never* know what is best for them”, instead the question was stated; “people with disabilities know what is best for them.” Rather, every attempt was made to use positive statements. Moreover, to avoid the ‘halo effect’ some items were skewed to discourage a respondent from simply identifying the most desirable response. The scale developed for this study attempted to maintain the aforementioned criteria to establish face validity. A reflection on the success of this is found in subsequent sections.

Another aspect of scale development is the recognition of biases in responding. While the researcher made an assumption the respondent will answer the question honestly there is considerable research suggesting a number of factors that may influence a participant’s response. The cognitive requirements for answering questions are dependent upon several features. One, the respondent must understand the question. That is, the scale designer’s ability to anticipate the respondent’s interpretation must be considered in the scale development and every effort made to use specific phrasing in the question. Additionally, a response is based on the respondent’s ability to recall a recent attitude or behavior (Streiner & Norman, 2003). In this study the respondent’s level of experience with people with disabilities may effect the respondents’ interpretation and responses to the survey.

Another concept regarding bias in response is *optimizing* and *satisficing* (Streiner & Norman, 2003). Optimizing refers to the investment the respondent has in accurately completing the survey. If the survey is of little interest to them, they may simply and quickly complete the

form with little regard for the accuracy of their responses. In this study, the researcher assumed the respondents are socially responsible and concerned about accurate data collection; therefore would answer honestly. Satisficing refers to the respondent answering a question in a satisfactory way without necessarily being the respondent's most accurate response. In other words, the respondent will answer "strongly agree" for every phrase as that seems to be the correct and desirable answer. When, in fact, some questions were phrased where a response of agreement was not necessarily a positive statement of an empowering attitude. Similar to 'satisficing', '*social desirability'* refers to a respondents tendency to answer a question in a way that most demonstrates their positive and altruistic tendencies. For social workers in this study, social desirability is a trait that may affect the overall validity of the scale as one would anticipate that social workers would have more positive attitudes toward people with disabilities. Thus, a respondent may answer the question as they think they *should* answer it. The validity of scale developed for this study is somewhat determined by this criterion, and is there suspect. This is further addressed in the limitations section.

The opposite of socially desirability are *deviation* or *faking bad* (Streiner & Norman, 2003). The concept of faking bad is self-explanatory. That is faking bad refers to the respondents propensity to answer questions in manner that makes them look deviant and would not be an expected response from social workers.

Similar to social desirability are the concepts of *yea-saying* and *acquiescence bias* (Streiner & Norman, 2003). To enhance the validity of the scale for this study attempts were made to phrase questions to encourage the respondent to think about their response. For example, the survey question, "I feel like it is my responsibility to help people with disabilities", may reflect an

empowering attitude if the respondent chose "disagree." That is to suggest it is an empowering attitude to presume it is the consumer's responsibility to seek help by exerting self-advocacy and choice.

Germane to the survey items developed for this study is the concept of *framing* (Streiner & Norman, 2003). As the name suggest, framing refers to the phrasing of choices offered to the respondent. Refraining from offering "outcomes" associated to the statement minimized this bias. For instance, instead of stating, "many people with disabilities feel alienated and should be encouraged to seek social interaction," the question simply stated; "many people with disabilities feel alienated".

Survey Question Development

The survey questions related to mourning or loss, "People with physical disabilities go through long periods of depression" and "People with physical disabilities need to mourn their loss" were fashioned from the literature suggesting social workers may be influenced by the current top-down medical model and view the person with a disability as having undergone significant loss and consequently experienced loss, most likely resulting in depression and distress (Gilson, Depoy & Macduffie, 2002). These questions were phrased to represent an oppressive attitude if the respondent agreed as disability scholars argue it is oppressive to view a person with a disability as less than whole (Charlton, 1998; Northway, 1997).

Survey questions regarding sexuality and intimacy were developed to represent an oppressive attitude if the respondent agreed to the following statements: "People with physical disabilities experience less sexual satisfaction" and "People with physical disabilities often do not experience physical intimacy with another person. According to Olkin (1999), the most

pervasive myth regarding sexuality and people with physical disabilities is that people with physical disabilities lack a basic biological sex drive. Additionally, social barriers, such as decreased access to information and dependence on caregivers and health care workers may lead to a lack of sexual expression for people with disabilities. These statements are considered oppressive as they may suggest the individual with a physical disability is not sexual versus the environment or attitudes of others prevent sexual expression (Olkin, 1999; Olkin & Howson, 1994)

The following questions were created to possibly represent an empowering attitude if the social worker agreed; "People with physical disabilities know what is best for them", "People with physical disabilities can influence their environment", and "People with physical disabilities have the ability to control their lives." These statements speak to the concept of self-determination that, according to the Social Work Code of Ethics (2008) is a foundational concept of the social work profession. Additionally, according to Tengland (2008), self-determination refers to one's "ability to reflect critically on and to choose what preferences, desires, and wishes to hold and to pursue" (p. 82). Other researchers posit that people with disabilities are commonly viewed as not having the power to determine their needs or express their opinions (Beaulaurier & Taylor, 2001; Braddock & Parish, 2001; Charlton, 1998; Fawcett, White, Balcazar, Suarez-Balcazar, Mathews, Paine-Andrews, Seekins & Smith, 1999; Hahn, 1985; Northway, 1997). Therefore, social workers agreeing with the above statements may reflect an empowering attitude regarding self-determination and people with physical disabilities.

The survey questions asking the respondents whether they agree with the concepts that people with physical disabilities are an inspiration, people with physical disabilities experience

poverty, people with physical disabilities often do not work because they are unable to and the idea that people with physical disabilities feel alienated were developed to represent a possible oppressive attitude if the respondent agreed with the statements. The idea that a person with a disability has something to overcome and therefore is an inspiration assumes the disability is subnormal. Disability scholars, who embrace the social model rather than the medical model, argue that disability lies not within the person, but in the environment that fails to accommodate people with disabilities and in the oppressive societal view of people with disabilities (Charlton, 1998; Olkin, 1999). An empowered person with a disability may not view himself or herself as courageous or an inspiration. Moreover, to assume people with disabilities experience poverty or cannot work may represent an oppressive attitude by possibly focusing on the individual rather than social environments that impose restrictions upon people with disabilities (Fine & Asch, 1988; Hahn, 1987, 1996; Oliver, 1983, 1996; Oliver & Sapey, 1999; Rioux, 1997; Zola, 1988)

The survey question, "I feel bad for people with physical disabilities may represent an oppressive attitude. Historically, people with disabilities have been viewed as aberrant or deviant condition of a person, conceptualizing disability as a deviation from the norm, (Nagi, 1991), or an object of pity (Shapiro, 1993). To feel bad for an individual may not be an empowering attitude, as it does not speak to the individual's strengths and self-determination (Tengland, 2008).

The survey questions, "It is my job to know how best to communicate with a person who has a physical disability," "I feel like it is my responsibility to help people with physical disabilities, and "One should always try to open a door for someone with a physical disability"

may represent an oppressive attitude. Health care workers who view an individual as needing "help" rather than an empowered consumer who can influence his or her environment and state his or her needs may be influenced by the top-down medical model (Beaulaurier and Taylor, 2001). Social workers who agreed with these statements may inadvertently express an oppressive attitude towards people with physical disabilities (Boehm & Staples, 2002).

RESULTS

All of the respondents data (N=168) used for analysis reported having a Master of Science in Social Work (MSSW). Fifty eight percent (n=98) of the social workers surveyed reported holding the title of Licensed Clinical Social Worker (LCSW), 34% (n=57) reported being certified as a Licensed Master Social Worker (LMSW) and 7% (n=12) indicated being certified as a Certified School Social Work Specialist (C-SSWS). Only a small number of social workers surveyed were members of a minority group (1%, n=2), while the vast majority (99%, n=166) reported being white. Ages of the subjects ranged from 22 to 79 years with a mean age of 46 (SD=12.8). Fourteen percent (n=23) stated their age range as 20-30, 24% (n=41) reported being between 31 and 40 years old, 17% (n=28) stated an age range from 41-50, 28% (n=47) indicated the age range of 51-60 years and 16% (n=27) reported being between the ages of 61 and 79.

In terms of social work experience, 25% (n=42) of respondents reported having zero to five years of experience, 17% (n=23) reported six to ten years of experience, 29% (n=49) with 11-20 years, 23% (n=39) reported 21-30 years, and 8% (n=14) indicated that they had more than 31 years of experience. Almost half of the sample (40%, n=132) reported that 0% -20% of their clients had physical disabilities. Eighteen percent (n=31) indicated 21%-50% of their clientele were people with physical disabilities, and 16% (n= 27) stated 51%-100% of their clients had physical disabilities. Of the professionals surveyed, 14% (n=23) indicated they had a physical disability and 85% (n=143) stated they did not have a physical disability. Finally, 24% (n=40) social workers reported working in an inpatient setting while 67% (n=113) indicated working in an outpatient environment (see Table 1)

Table 1: Demographic Characteristics of Study Subjects

Variable	Number	Percentage
Age		
20-30	23	14
31-40	41	24
41-50	28	17
51-60	47	28
61+	27	16
Years Practicing as a Social Worker		
0-5	42	25
6-10	23	17
11-20	49	29
21-30	39	23
31+	14	8
Respondent Disabled		
Yes	23	14
No	143	85
Race		
White	166	99
Non-white	2	1
Percentage of population with physical disabilities		
0%-20%	132	40
21%-50%	31	18
51%-100%	27	16

Data analyses were performed using SPSS version 16 for windows. Descriptive statistics were generated on the 16 Likert scale survey questions (see Table 2). A notable finding was the four questions worded towards an empowering attitude regarding self-determination and environmental accessibility (questions 6, 11, 12 and 15). They illustrated the most positive mean score, (> 1.00) and the questions "It is best to sit when talking with a client who is unable to stand" and "People with physical disabilities can influence their environment" (questions 11 and 12) point to the lowest *no opinion* responses (4%, < n=6). Additionally, the questions referring to self determination (questions six and 15) recorded no *strongly disagree* (-2) responses. Another noteworthy result is the results of the questions related to sex and intimacy (questions 5 and 16) and depression and mourning (questions 8 and 10) that represented the highest *no opinion* responses (>20%), yet yielded and overall oppressive response. The most negatively answered questions, suggesting a possible oppressive attitude, were questions regarding the concepts of "poverty", "people with disabilities are inspiration", "social alienation", and the social worker's knowledge of how to communicate with a person with a disability (questions 1, 2, 13 and 14) resulting in a mean range from -.60 to -1.02. Question numbers three four and nine all illustrated a slightly negative or positive mean with a low *no opinion* response suggesting a varied response from the subjects.

Table 2: Survey Question Frequencies

Survey Question	Mean	Range	Minimum	Maximum	No opinion
1. Many people with physical disabilities experience poverty.	-.61	4	-2	2	12 (7%)
2. People with physical disabilities are an inspiration to me.	-.96	4	-2	2	22 (13%)
3. People with physical disabilities often do not work because they are unable to.	-.17	4	-2	2	3 (2%)
4. One should always try to open a door for someone with a physical disability.	-.02	4	-2	2	16 (9%)
5. People with physical disabilities experience less sexual satisfaction.	.75	4	-2	2	52 (31%)
6. People with physical disabilities know what is best for them.	1.04	3	-1	2	22 (13%)
7. I feel like it is my responsibility to help people with physical disabilities.	-.27	4	-2	2	26 (15%)
8. People with physical disabilities go through long periods of depression.	.34	4	-2	2	45 (27%)
9. I feel bad for people with physical disabilities.	.02	4	-2	2	17 (10%)
10. People with physical disabilities need to mourn their loss.	. -.42	4	-2	2	34 (20%)
11. It is best to sit when talking with a client who is unable to stand.	1.08	4	-2	2	5 (3%)
12. People with physical disabilities can influence their environment.	1.47	4	-2	2	4 (2%)
13. Many people with physical disabilities feel alienated.	-.60	4	-2	2	27 (16%)
14. It is my job to know how best to communicate with a person who has a physical disability.	-1.02	4	-2	2	11 (6%)
15. People with physical disabilities have the ability to control their lives.	1.00	3	-1	2	15 (9%)
16. People with physical disabilities often do not experience physical intimacy with another person.	.70	4	-2	2	34 (20%)

DISCUSSION

Interpreting Results

The results of the survey questions regarding the self-determination of people with physical disabilities and worded toward an empowering attitude found that 80% of the subjects answered towards a possible empowering attitude . This may suggest social workers that responded to the survey hold the view that all people have should be able to influence their environment and control their lives. This finding may correspond to the idea that empowerment or self-determination is the process by which people gain control or mastery over valued events, outcomes and resources (Fawcett, et al., 1994). Moreover, according to Tengland (2008), self-determination refers to one's "ability to reflect critically on and to choose what preferences, desires, and wishes to hold and to pursue" (p. 82). Additionally the *Code of Ethics* of the National Association of Social Workers (1999) embraces the concept of self-determination and the individual's right to choose.

Survey questions addressing issues related to sexuality and intimacy regarding people with disabilities resulted in the highest *no opinion* answers. This is consistent with Olkin's (1999) view that people with disabilities are often viewed as not having a sex drive. Moreover, McCabe & Taleporos (2007), point out that the physical barriers to sexual expression may lead to decreased sexual esteem. Social workers who responded to the survey may not be educated in the complexity of physical and social barriers to sexual expression and disability and feel uncomfortability answering questions related to the topic. According to the literature, social

barriers, such as decreased access to information and dependence on caregivers and health care workers, may lead to a lack of sexual expression for people with disabilities (McCabe & Taleporos, 2003). It may be important for social workers to be knowledgeable of the barriers and the myths regarding disability and sexual expression to increase cultural competence and foster sexual expression for people with physical disabilities.

The survey questions asking the respondents whether they agree with the concepts that people with physical disabilities are an inspiration, people with physical disabilities experience poverty and the idea that people with physical disabilities feel alienated resulted in responses suggesting an oppressive attitude. These results seem to suggest that respondents tend to emphasize the individual's impairment rather than viewing the individual as whole and the environment as deficient (Charlton, 1998; Kielhofner, 2004; Northway, 1997). Furthermore, by focusing on the individual's impairment rather than addressing the environmental barriers, health practitioners may reinforce the misconception that disability is an individual matter or deviation from the norm rather than a societal matter (Charlton, 1998). As noted by Block (2001), the history of people with disabilities has been a struggle of a marginalized community to overcome theoretical models such as eugenics that defined the disabled community in terms of deficiency and dependence. Additionally, according to the literature, the current top-down medical model is viewed as oppressive as it continues to view the individual as a passive recipient of services from experts rather than embracing a collaborative approach, (Block, Balcazar & Keys, 2001). Social workers may be unintentionally influenced by the medical model's oppressive nature and may not embrace the minority model which asserts that disability lies not within the person, but in the environment that fails to accommodate people with disabilities (Beaulaurier & Taylor, 2001, Charlton, 1998, Olkin, 1999). In other words, it may be possible that social workers view people

with disabilities as being less than whole. These findings suggest that respondents may inadvertently hold an oppressive attitude when they pity or feel like the individual needs to mourn a disability (Boehm & Saples, 2002).

Limitations

The results of the current study must be interpreted with consideration of several limitations. A limitation of the survey instrument is that it did not have established validity or reliability. This is perhaps the greatest limitation of the study as the survey instrument was designed for this study based on a review of the literature. No similar tool was found in the literature review, thus the author utilized concepts and constructs inherent in empowerment and oppression creating questions related to social work values and ethics. Though the author used current research to establish content validity, a content validity index (CVI) was not established for the survey and a factor analysis was not performed. As such the validity of this survey instrument must be submitted to more stringent testing before used in additional research (Streiner & Norman, 2005).

For future research using this tool, other methods of establishing validity could include test of homogeneity using split half reliability. Additionally, statistical analysis such as Kuder-Richardson 20 and Cronbach's Alpha could be conducted on the survey instrument.

While this questionnaire sought to identify themes related to empowerment and oppression, the validity and reliability of the instrument remains uncertain. Hence, the results cannot be generalized. It would, however, serve as an exploratory study to develop additional questionnaires that could be validated. Further research could be directed to this aim.

Another limitation of the study is the small size of the sample. Statistically significant differences are very hard to determine with a small sample size and it is not recommended to generalize the results to a larger population. The small sample size was attributed to the limited number of social workers who are members of NASW TN and receive email communication. Additionally, utilizing a non-probability sample of convenience results in weak external validity (Trochim & Donnelly, 2007). As the subjects were invited through NASW TN, the sample may be biased towards social workers that have the extra income for membership dues.

Moreover, the response rate is less than desirable. The response rate for this study was 12% while it is recommended that survey research should have a response rate of 30%-60% (Streiner & Norman, 2005). Given a lower response rate it is not advised to generalize the results to the general population. Additionally, when using email for survey research it is unknown how many respondents opened the email and actually received the survey. Therefore, one cannot compute response rate when respondents are recruited through convenience sampling (Schonlau, Fricker & Elliott, 2002).

Previous research investigating empowering versus oppressive attitudes of people with physical disabilities was not known by the author. Having a larger empirically-based research pool of literature from which to draw would have strengthened the present study significantly.

IMPLICATIONS

As outlined in previous sections of this paper, the study as conducted is limited in terms of its non-probability sample of convenience, lack of validity and reliability, its small sample size and its low response rate. Nevertheless, it is the dearth of research about social workers and their attitudes towards people with disabilities that makes this study significant. This is an exploratory study to begin investigating the attitudes of social workers towards people with physical disabilities.

The study's most significant impact on policy and practice is simply to point out that social workers' may inadvertently have oppressive attitudes towards people with disabilities. For example, by noting that 80% of the subjects demonstrated a possible empowering attitude regarding questions related to the self-determination of people with physical disabilities may suggest social workers understand the concept of empowerment when it is worded positively. This may speak to social work curriculum emphasizing the self-determination of all people.

Additionally, the survey questions addressing issues related to sexuality and intimacy resulted in the highest *no opinion* answers. These responses may suggest a lack of education and awareness of the disabled community as a marginalized community with unique needs and risk factors. Social service providers and possibly social work educators have the opportunity to develop strategies and curriculum to bring more awareness to the disabled community. With this awareness, social workers and social work students may have the occasion to develop cultural awareness regarding the community of people with disabilities (Beaulaurier & Taylor, 2001; Boehm & Saples, 2002; Charlton, 1998; Kim & Canda, 2006).

For social service agencies to embrace cultural awareness of the disabled community it is important to recognize the distressing history of people with disabilities. The community has been fragmented from its earliest history as societies have separated people with physical differences and even tried to eliminate them entirely (Braddock and Parish, 2001). Like other cultures studied by social workers it is important to know its history and the point in time a marginalized community began to unite. It is from this knowledge social workers can possibly empower individuals with a physical disabilities to view themselves as whole and not as forever broken (Kim & Canda, 2006). It may be important for clinicians to understand that the disabled community is vibrant and offers support and empathy and may give an individual the opportunity to identify with similar people who are living well.

Although this research study in and of itself will have little impact on the lives of people with physical disabilities, it brings forth the discussion of how social workers view people with disabilities and possibly the lack of education regarding the disabled community and physical disabilities in general.

To conclude, future research should utilize a survey tool that is reliable and valid. Given a valid survey instrument, it may be possible to develop an empowerment scale for people with physical disabilities allowing social workers to advance their cultural competence regarding people with physical disabilities.

Furthermore, research should include people with physical disabilities. Through this inclusion, researchers will be less likely to unintentionally oppress people with physical disabilities. People with disabilities should be included in the development of and distribution of the survey tool. This will begin the process of changing the environment or the research design

to accommodate people with physical disabilities rather than excluding them due to social or physical barriers.

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APPENDIX

APPENDIX: Study Questionnaire

How much time do you spend working with people who have difficulty with the following activities:

Activities	Hours per week that you work with people with this difficulty					
walking	□ < 1 hour	□ 1-5 hours	□ 6-10 hours	11-20 hours	□ 21+ hours	□ not at all
toileting	□ < 1 hour	□ 1-5 hours	□ 6-10 hours	11-20 hours	□ 21+ hours	□ not at all
eating/swallowing	□ < 1 hour	□ 1-5 hours	□ 6-10 hours	11-20 hours	□ 21+ hours	□ not at all
dressing	□ < 1 hour	□ 1-5 hours	□ 6-10 hours	11-20 hours	□ 21+ hours	□ not at all
talking	□ < 1 hour	□ 1-5 hours	□ 6-10 hours	11-20 hours	□ 21+ hours	□ not at all
hearing	□ < 1 hour	□ 1-5 hours	□ 6-10 hours	11-20 hours	□ 21+ hours	□ not at all
seeing	□ < 1 hour	□ 1-5 hours	□ 6-10 hours	11-20 hours	□ 21+ hours	□ not at all

What do you call the people with whom you work who have difficulty in the above activities?

□ handicapped person
□ disabled person
□ person with a disability
□ patient
□ client
□ consumer
□ other: (specify) _____

Questionnaire instructions: Please indicate your level of agreement with the following questions:

1. Many people with physical disabilities experience poverty.

2 = strongly disagree, 1 = disagree, 0 = don't know/no opinion, -1 = Agree, -2 = strongly agree

2. People with physical disabilities are an inspiration to me.

2 = strongly disagree, 1 = disagree, 0 = don't know/no opinion, -1 = Agree, -2 = strongly agree

3. People with physical disabilities often do not work because they are unable to.

2 = strongly disagree, 1 = disagree, 0 = don't know/no opinion, -1 = Agree, -2 = strongly agree

4. One should always try to open a door for someone with a physical disability.

2 = strongly disagree, 1 = disagree, 0 = don't know/no opinion, -1 = Agree, -2 = strongly agree

5. People with physical disabilities experience less sexual satisfaction.

2 = strongly disagree, 1 = disagree, 0 = don't know/no opinion, -1 = Agree, -2 = strongly agree

6. People with physical disabilities know what is best for them.

-2 = strongly disagree, -1 = disagree, 0 = don't know/no opinion, 1= Agree, 2 = strongly agree

7. I feel like it is my responsibility to help people with physical disabilities.

2 = strongly disagree, 1 = disagree, 0 = don't know/no opinion, -1 = Agree, -2 = strongly agree

8. People with physical disabilities go through long periods of depression.

2 = strongly disagree, 1 = disagree, 0 = don't know/no opinion, -1 = Agree, -2 = strongly agree

9. I feel bad for people with physical disabilities.

2 = strongly disagree, 1 = disagree, 0 = don't know/no opinion, -1 = Agree, -2 = strongly agree

10. People with physical disabilities need to mourn their loss.

    2 = strongly disagree, 1 = disagree, 0 = don't know/no opinion, -1 = Agree, -2 = strongly agree

11. It is best to sit when talking with a client who is unable to stand.

    -2 = strongly disagree, -1 = disagree, 0 = don't know/no opinion, 1= Agree, 2 = strongly agree

12. People with physical disabilities can influence their environment.

    -2 = strongly disagree, -1 = disagree, 0 = don't know/no opinion, 1= Agree, 2 = strongly agree

13. Many people with physical disabilities feel alienated.

    2 = strongly disagree, 1 = disagree, 0 = don't know/no opinion, -1 = Agree, -2 = strongly agree

14. It is my job to know how best to communicate with a person who has a physical disability.

    2 = strongly disagree, 1 = disagree, 0 = don't know/no opinion, -1 = Agree, -2 = strongly agree

15. People with physical disabilities have the ability to control their lives.

    -2 = strongly disagree, -1 = disagree, 0 = don't know/no opinion, 1= Agree, 2 = strongly agree

16. People with physical disabilities often do not experience physical intimacy with another person.

    2 = strongly disagree, 1 = disagree, 0 = don't know/no opinion, -1 = Agree, -2 = strongly agree

Demographics

Are you a social worker?: □yes □no

How old are you?: _____

What is your race/ethnicity?

□ American Indian or Alaska Native
□ Asian
□ White
□ Black/African American
□ Native Hawaiian or other Pacific Islander
□ Hispanic or Latino
□ Other
□ I prefer not to answer

Do you have a physical disability? □ yes □ no □ I prefer not to answer

How many years have you practiced as a social worker? _____

Highest level of professional degree:
__ BSW __MS __Ph.D.

Certifications:
□ LCSW
□ LMSW
□ Certified School Social Worker
□ None of the above

□ I do not know

In what type of facility/agency do you work? (check all that apply) □ in-patient □ out-patient □ other (Specify): _____

What percentage of the population with whom you work have physical disabilities? _____

VITA

Ann Eubank was born in New York and grew up in New England. She graduated with departmental honors from California State University San Jose in 1992 with a Bachelor of Science in Occupational Therapy. Ann has spent most of her professional career advocating for people with physical disabilities as a public speaker and professional educator. She graduated from the University of Tennessee, Knoxville in 2010, receiving a Masters of Science in Social Work with a concentration in clinical practice.