DEMOGRAPHIC DIFFERENCES IN MENTAL HEALTH CLINICIANS' ATTITUDES TOWARD PEOPLE WITH DISABILITIES

by

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(Under the Direction of Alan E. Stewart)

ABSTRACT

Individuals with disabilities constitute the largest minority population in the United States Nario-Redmond, 2020). Given the high prevalence and the unique stressors that coincide with the lived experience of disability, it is highly likely that mental health professionals will interface clinically with this population. However, most psychologists do not feel culturally competent to work with clients with disabilities (Conner et al., 2023). The current quantitative study analyzed the attitudes of mental health clinicians as measured by the Multidimensional Attitudes Toward Disabilities Scale (Findler et al., 2007) to understand if differences existed across areas of specialization, work setting, or ability status. In an independent samples t-test, participants who identified as disabled scored higher on the MAS (M=87.05, SD=16.55, SE=2.55) than able-bodied individuals (M=81.43, SD= 16.62, SE=1.39). Those who identified as disabled had significantly more positive attitudes, particularly about their thoughts and cognitions related to disability, when compared to their non-disabled counterparts.

INDEX WORDS: People with disabilities; attitudes; mental health; clinicians; demographic differences

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CHAPTER 1

INTRODUCTION

Approximately 1 in 4 noninstitutionalized adults within the United States report having a disability (Okoro et al., 2018), which can include impairment to vision, hearing, cognition, mobility, self-care, or independent functioning (The United States Department of Health & Human Services, 2015). As the single largest minority group in the United States (Nario-Redmond, 2020), disabled persons reported their health to be four times poorer than those without a disability (Krahn, 2019). The COVID-19 pandemic shed a unique light on the increasing prevalence of both temporary and long-term disabling health conditions (Centers for Disease Control and Prevention [CDC]; 2022). It has been well documented (Krahn et al., 2015; lezzoni, 2011; Altman & Bernstein, 2008) that people with disabilities have significantly poorer health outcomes and face greater health disparities compared to those who do not have disabilities (Emerson et al., 2011). The adult disabled population is especially impacted by difficulties in obtaining employment, lacking access to transportation and housing, and a higher overall likelihood of poverty (Frier et al., 2018). People with disabilities make up 20% of the global poverty population (Groce & Trani, 2009) and are 2.5 times more likely to delay or skip health interventions due to financial barriers (Reichard et al., 2017).

The health disparities people with disabilities face expand well beyond the domain of physical health (Serpas et al., 2024; Friedman, 2024; Friedman, 2022). Recent research (Cree et al., 2020) indicates people with disabilities experience significant mental health disparities compared to their nondisabled counterparts. 17.4 million adults with disabilities reported

frequent mental distress, which was 4.6 times the rate of those without disabilities (Cree et al., 2020). Cree and colleagues (2020) found mental distress to be reported 70% more often in those that are living below the federal poverty line, which includes many individuals with disabilities. Mental distress is associated with mental health diagnoses such as anxiety and depression, which also is more often reported in adults with disabilities (Cree et al., 2020). Given the nature of increased mental distress and a higher likelihood of mental illness, people with disabilities are more likely to receive mental health treatment (National Center for Health Statistics, 2021).

Problem Statement

The *World Report on Disability* (World Health Organization [WHO] & World Bank, 2011) highlighted the growth, high prevalence, and diverse nature of disability. Results from this report (WHO & World Bank, 2011) emphasized the general problem being the vulnerability and widespread barriers individuals with disabilities face, including notable healthcare disparities (Havercamp & Scott, 2015; National Council on Disability, 2009). As a significant portion of the national population, people with disabilities experience significant mental health disparities compared to their nondisabled counterparts (Cree et al., 2020), including four times the risk for suicide attempts (Metzler et al., 2012), and increased risk for the occurrence of psychiatric and substance use disorders (Turner et al., 2006).

The specific problem is that given the significant mental health disparities disabled people face (Cree et al., 2020), it is highly likely every practicing mental health provider has worked with a disabled client (Brodt & Lewis, 2024), and there is an ethical responsibility for clinicians to provide culturally competent care (Cornish et al., 2008). Despite these realities, the American Psychological Association (APA; 2022) publicly acknowledged mental health clinicians have little to no training in working with the disabled population. Recent research

(Conner et al., 2023) examined the therapeutic experiences of physically disabled clients and demonstrated over 50% of participants expressed their mental health provider had little experience in working with disability. People with disabilities have a great need for mental health services but often report negative mental health outcomes (Conover & Israel, 2019; Mazur, 2008; Green 2003) due to negative biases or attitudes of disability (APA, 2022).

Background of the Problem

Historical and political events over time influenced the understanding and conceptualization of disability. During the early 1800's, people with disabilities were viewed as inhumane "freaks" who provided forms of entertainment (Vogtan, 1988). Further degrading the individual, disability was initially viewed through a religious perspective as a result of sin (Covey, 1998). The psychological testing era, intended to assess for wartime readiness, significantly influenced the view of disability and furthered the oppression of poor and disabled individuals (Auguste et al., 2023). Henry Herbert Goddard was a prominent psychologist at the time who coined the term "feeble-minded" (Goddard, 1911), which soon became a blanket term for those from ethnic minority groups (Dolmage, 2017). Consequently, people with disabilities experienced forced institutionalization (Crowe & Drew, 2021), as a problem to be rectified much like the medical model of disability. Pseudo-scientific advances, such as the Eugenics Movement during World War II, further exacerbated the idea of disability being a curable deficit (Gallagher, 1995). This movement was a form of genocide for minoritized groups, including people with mental and physical disabilities (Gallagher, 1995). These historical events have largely informed the moral and medical models of disability that still exist today (Andrews, 2016).

Veterans returning home from World War II ignited a focus of disability through the context of rehabilitation and vocation. Notable activist, Ed Roberts, headed the first Center for

Independent Living (CIL; History of Independent Living Movement, 2020) in the 1960s, which allowed individuals with disabilities to de-segregate and function within the community. This Independent Living Movement (ILM) sparked a national movement for disability civil rights. The passage of Section 504 of the Rehabilitation Act of 1973 prohibited discrimination in public educational spaces based on disability; similarly, the Education for All Handicapped Children Act passed in 1975, the Americans with Disabilities Act (ADA) act passed in 1990, and the Individuals with Disabilities Education Improvement Act (IDEA) passed in 2004. Despite these advances, DeJong and Batavia (1990) argued the Disability Rights Movement did not provide individuals with disabilities the same amount of equitable opportunity in comparison to the able-bodied majority.

Context Within Counseling Psychology

Diversity, equity, and inclusion (DEI) is often prioritized in the field of psychology (Council of Chairs of Training Councils, 2020). Particularly, counseling psychology has distinguished itself from other divisions of professional psychology due to its foundational principles and commitment to multiculturalism, social-justice, and strengths-based perspectives (Chung, 2011; Delgado-Romero et al., 2012). As such, counseling psychologists are equipped with the knowledge, skills, and awareness to work effectively across cultural differences (Sue et al., 1992). This multicultural competence encompasses but is not limited to cultural facets such as age, generation, gender, ethnicity, race, religion, spirituality, language, sexual orientation, gender identity, social class, ability/disability status, national origin, immigration status, as well as prior and current experiences of marginalization (APA, 2017a).

Given the fact that people with disabilities comprise the largest minority group both globally (United Nations, n.d.) and nationally (Artman & Daniels, 2010), the likelihood that

counseling psychologists will encounter this population is almost guaranteed. In consideration of the high prevalence of disability, Pope (2005) argues that a profession's values reflect the extent to which its practices are accessible to this population. Some efforts have been made to address barriers of access (Pope 2005), such as the implementation of the American Psychological Association's (APA) Office of Disability Issues (2009) or the creation of the *"Guidelines for the Treatment and Assessment of Persons With Disabilities"* (APA, 2022). Additionally, disability was also included as a competency in the *Multicultural Guidelines* (APA, 2017a).

Despite these attempts towards the inclusion of disability, Elliot and Rath (2012) suggest that it is not an area of emphasis in counseling psychology literature. The lack of disability-related literature in counseling psychology journals has been reiterated (Olkin, 2002; Peterson & Elliott, 2008), with only 18 empirical articles published over a 20-year period (Foley-Nicon, & Lee, 2012). It has not been until only recently that several psychologists with disabilities have been working to include disability in both research and practice (Andrews, 2019; Andrews et al., 2019, Forber-Pratt et al., 2019). Even so, most psychologists are not culturally competent to work with clients with disabilities (Conner et al., 2023; Hampton et al., 2011; Olkin & Pledger 2003).

These ideas are particularly troublesome, as disability knowledge, skills, and awareness are considered a part of multicultural competence (Foley-Nicon, & Lee, 2012). Cornish et al. (2008) re-emphasized the ethical responsibility that all practicing psychologists have to provide culturally competent care. Given the increasing prevalence of disability and commitment to multiculturalism, counseling psychologists have a unique responsibility to be well-informed of the complexity of disability as it influences cultural competence and the human experience.

Purpose of This Study

The purpose of this exploratory study is to understand mental health clinicians' attitudes toward people with disabilities. This study identified the differences in attitudes amongst clinical specializations, professional work setting, and ability status. These constructs were analyzed through scores on various measures such as the *Balanced Inventory of Desirable Responding (BIDR),* a *Demographic Questionnaire*, the *Multidimensional Attitudes Towards Disabled Persons Scale* (MAS).

This study included data from self-identified graduate students or licensed mental health professionals in counseling or psychology-related fields and programs. These individuals were 18 years and older and data were collected using an online Qualtrics Survey constructed by the Imagining Disability Equity, Access, and Liberation (IDEAL) Research Collective.

The Imagining Disability Equity, Access, and Liberation (IDEAL) Research Collective is a group of mental health care researchers and practitioners within the University of Georgia's Counseling Psychology program. This team seeks to identify gaps between theory, training, and practice as it relates to living with a disability. The experiences and narratives of people with disabilities are centered with the understanding that advancements for the community must be led by voices within the community. In alignment with the primary research and outcome goals of the collective, the aim of this study was to produce meaningful research that removes barriers and increases access to mental health care for people with disabilities. By gaining insight into the differences that exist amongst attitudes of mental health clinicians across specializations, settings, and ability status, this study provided direction on future research, training, and practice.

Though this study is meant to be exploratory in nature given the dearth of research geared towards disability and mental health, the researcher offered hypotheses based on previous

research trends and lived experiences as a clinician in training. Hypothesis 1 predicted attitudinal differences from those who identify with a Rehabilitation Specialization, particularly because of the historical impact of vocation and rehabilitation on the Disability Rights Movement. Within the field, Rehabilitation Psychology, has historically provided psychological care to individuals with disabilities (Scherer et al., 2010). Perrin (2019) explored Rehabilitation Psychology as the study of disability, emphasizing the role of rehabilitation psychologists in understanding the social model of disability. Hypothesis 2 predicted attitudinal differences from those working in VA or Hospital/Medical Settings. These settings have a traditional healthcare focus and psychologists are often embedded into care. With that consideration, clients often do not attend medical settings for the sole purpose of mental health services and may see a clinician as part of holistic care. Under this hypothesis, the assumption is that practitioners are practicing from a more traditional medical model. Hypothesis 3 is rooted in the Social Identity Theory (Tajfel & Turner, 1979), where individuals tend to favor their ingroup or the group they belong to.

Research Questions

1. What is the difference between attitudinal dimensions toward people with disabilities, as measured by MAS, among those who classify themselves with Rehabilitation Specialization as opposed to other areas of interest?

   Hypothesis 1: There are significant differences between attitudinal dimensions, as measured by the MAS, among those who classify themselves with a Rehabilitation Specialization as opposed to other areas of interest.

   $H1_0$: There are no significant differences between attitudinal dimensions toward people with disabilities, as measured by the MAS, among those who classify themselves with a Rehabilitation Specialization as opposed

to other areas of interest.

$H1_A$: There are significant differences between attitudinal dimensions toward people with disabilities, as measured by the MAS, among those who classify themselves with a Rehabilitation Specialization as opposed to other areas of interest.

2. What is the difference between attitudinal dimensions toward people with disabilities, among those who work in VA or Hospital/Medical Settings as opposed to other work settings?

   Hypothesis 2: There are significant differences between attitudinal dimensions, as measured by the MAS, among those who work in VA or Hospital Medical Settings as opposed to other work settings.

   $H2_0$: There are no significant differences between attitudinal dimensions toward people with disabilities, as measured by the MAS, among those who work in VA or Hospital/Medical Settings as opposed to other work settings.

   $H2_A$: There are significant differences between attitudinal dimensions toward people with disabilities, as measured by the MAS, among those who work in VA or Hospital/Medical Settings as opposed to other work settings.

3. What is the difference between attitudinal dimensions toward people with disabilities, as measured by MAS, among those who identify as disabled as opposed to those who identify as able-bodied?

   Hypothesis 3: There are significant differences between attitudinal dimensions toward people with disabilities, as measured by MAS, among those who identify as disabled as opposed to those who identify as able-bodied.

$H3_0$: There are no significant differences between attitudinal

dimensions toward people with disabilities, as measured by the MAS,
among those who identify as disabled as opposed to those who identify as able-bodied.

$H3_A$: There are significant differences between attitudinal dimensions
toward people with disabilities, as measured by the MAS, among those who identify as disabled as opposed to those who identify as able-bodied?

Definition of Terms

- **Ableism:** "a network of beliefs, processes and practices that produces a particular kind of self and body (the corporeal standard) that is projected as perfect, species-typical and therefore essential and fully human" (Campbell, 2001, p.44)
- **Attitudes:** Based on a multidimensional approach, attitudes are comprised of three dimensions: affect, cognition, and behavior (Findler et al., 2007). Aligns with an early idea which "an attitude is an idea charged with emotion which predisposes a class of actions to a particular class of social situations" (Triandis, 1971, p. 2).
    - **Explicit Attitudes:** conscious or intentional evaluations about a certain individual or group (Ajzen, 2001)
    - **Implicit Attitudes:** automatic or unconscious evaluations of a certain individual or group (Greenwald & Banaji, 1995).
- **De- Facto Approach:** Informal way of making decisions driven by seeking consensus (Drum & Blom, 2001)
- **Denial of Identity:** A microaggression that either defines disability as one's only and most important characteristic or denies the lived experience of having a disability (Keller & Galgay, 2010).

- **Desexualization:** A microaggression that perceives persons with disabilities as unattractive or unable to engage in sexual activities (Keller & Galgay, 2010).
- **Disability:** "The outcome or result of a complex relationship between an individual's health condition and personal factors, and of the external factors that represent the circumstances in which the individual lives" (WHO, 2001, p. 17).
- **Frequent Mental Distress: "**14 or more self-reported mentally unhealthy days in the past 30 days" (CDC, 2000)
- **Microaggression:** "subtle, stunning, often automatic, and non-verbal exchanges, which are 'put downs'" (Pierce, Carew, Pierce-Gonzalez, & Wills, 1978, p.66). Further studied by Sue and colleagues in the context of race (2007, p.271) to include "brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults." Microaggressions have since been applied to contexts of other minoritized identities.
- **Multiculturalism:** "The coexistence of diverse cultures that reflect varying reference group identities. Multicultural can embody the coexistence of cultures within an individual, family, group or organization." (APA, 2017, Appendix A: Definitions). Culture can include, but is not limited to, age, gender, race, ethnicity, national origin, sexual orientation, ability status, language, religion, and social class.
- **Otherization:** A microaggression that labels persons with disabilities as abnormal or deficient (Conover et al., 2017).
- **Patronization:** A microaggression that can manifest in two different ways including infantilization and false admiration (Yilmaz et al., 2024)

- **Persons with Disabilities/Disabled Persons:** Those who identify as having a disability as well as those who are perceived as disabled by the general public. It is up to the individual whether or not they prefer person-first language. Being labeled is not always seen as "inherently negative" (Dunn & Andrews, 2015), so "disabled" is also used interchangeably.
- **Stigma:** an attribute or characteristic that is devalued in a particular social context (Crocker et al., 1998).
- **Superordinate Categorization:** a classification system that is automatically activated, highly salient, and perceived independently of group membership and current context (Brewer & Lui, 1989; Carpenter & Trentham, 2001; Crisp & Hewstone, 2001; Ito & Urland, 2003; Stangor et al.,1992; Zarate & Sanders, 1999).

CHAPTER 2

REVIEW OF RELEVANT LITERATURE

The Emergence of Specialties in Psychology

The emergence of specialties within any line of work occurs naturally and is driven by an expanding knowledge base (Drum & Blom, 2001), as individuals cannot hold advanced knowledge and skill in all areas of their profession (Napoli, 1981). In fact, specialization is an ‘‘inevitable and necessary product of developmental processes in a discipline and a profession’’ (Roberts, 2006, p.863). The recognition of specialty areas within counseling-related fields has been further solidified by the accreditation and credentialing processes (Bobby & Kandor, 1992; Bradley, 1991; Gerstein & Brooks, 1990). Following World War II, the discipline of psychology expanded into a range of applications, creating a need to delineate areas of practice to the public (Drum & Blom, 2001; Kaslow et al., 2011). The American Board of Examiners of Professional Psychology (now ABPP) responded to the urgency of this need using a de-facto approach to recognize the first four general practice specialties: clinical, industrial-organizational, counseling, and school psychology (Drum & Blom, 2001).

Although the ABPP initialized some delineation within professional psychology, a standardized process to acknowledge specialization was still lacking. Thus, new areas of expertise did not have a framework by which they could emerge (Drum & Blom, 2001). The responsibility of specialization transferred to the American Psychological Association (APA) in 1995, who developed the Council for Recognition of Specialties and Proficiencies in Professional Psychology ([CRSPPP]; Drum & Blom, 2001) and defined a specialty as,

> a defined area of psychological practice that requires advanced knowledge and skills acquired through an organized sequence of formal education, training, and experience. The advanced knowledge and skills specific to a specialty are obtained subsequent to the acquisition of core scientific and professional foundations in psychology. (p.518)

Despite professional standards influencing the acknowledgement and credibility of specializations, there are varied opinions on whether divisions of counseling constitute single or multiple professions (Bobby, 2013; Neal 2020, Zotlow et al., 2011). The "broad and general" approach (Berenbaum & Shoham 2011) to training would suggest that specializations within counseling are not separate disciplines (Bower, 1993), but rather specializations involve a set of skills and knowledge that are added to the core body of knowledge required of all counselors (Manuele- Adkind, 1992). Rather, professional and ethical responsibilities of counselors require that they practice within the confines of their competence. (Berven & Scofield, 1987). The "skilled and technical" approach suggests that training should be geared towards preparation for specialty work roles (Tackett et al. 2022) and thus requiring earlier exposure to specialty skills (Gold et al., 1982).

Regardless of the approach to training, there is a consensus about core academic components of professional psychology programs (Matarazzo, 1987). Rather, specialties are largely differentiated by parameters of practice (Rodolfa et al., 2005) or areas of application (Hosie, 1995). Specialties allow the public to identify areas and activities that land within the confines of psychology (Kaslow et al., 2011). Thus, an individual's role as a mental health professional will be largely influenced by the type of setting within which they function. Counseling is a profession with various work settings (Pate 1995) such as healthcare settings, academic counseling centers, and community mental health agencies. Furthermore, there seems

to be an overlap in the information taught across specializations (Matarazzo, 1987). For example, as a specialty area that has historically provided psychological care to individuals with disabilities to maximize independent living (Scherer et al., 2010), rehabilitation psychology also encompasses aspects of clinical, counseling, social, and health psychology (Frank & Elliot, 2000; Cox et al., 2010).

Disability as a Part of Multicultural Competence

Competence suggests performance at an appropriate level and requires the integration of specific skill areas, also known as competencies (Kaslow et al., 2004). Given that there are key proponents across professional psychology, regardless of specialty area, competencies provide a basis for designating and measuring learning outcomes throughout the course of psychologists' training and careers thereafter (Foud et al., 2009). The National Council of Schools and Programs of Professional Psychology (NCSPP) began identifying and implementing standards of competence for training programs in 1986 (Peterson et al., 1992; Peterson et al., 1997). The original six core competencies necessary for training were expanded upon during the 2002 Competencies Conference: Future Directions in Education and Credentialing (Kaslow et al., 2004) and lead to the establishment of the Cube Model (Rodolfa et al., 2005). Of note, the individual and cultural diversity competency was included as an addition.

This model (Rodolfa et al., 2005) provided a framework that is now widely accepted by training programs and classifies core competencies as either foundational or functional. While functional competencies describe areas of practice, foundational competencies speak to the knowledge, skills, and attitudes (Kaslow et al., 2004, Sue, 1992) that act as rudimentary principles. Both types of these competencies are interconnected, along with another component: stage of professional development. It is important to note that individual and cultural diversity is

characterized as a foundational competency, suggesting all psychologists are expected to possess a certain aptitude for this domain regardless of specialty area. Following the Competencies Conference and over time, various groups have continued to further specify competencies related to individual and cultural diversity.

The seminal *Multicultural Counseling Competencies* (Sue et al., 1992), that were later revised into the *Multicultural and Social Justice Counseling Competencies* (Ratts et al., 2016), were designed to consider diverse populations that had not been previously acknowledged by mental health professions (Wilson et al., 2019). Within psychology specifically, The *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* (APA, 2002) were developed in response to work done by Sue and colleagues (1982) to account for diversification in the United States as well as the ever-changing socio-political landscape. Early definitions of the term *multiculturalism* were narrowly defined in terms of race and ethnicity (APA, 2002; Arredondo, 1996) but have since developed to consider other components of identity such as national origin, religion, sexual orientation, language, or socioeconomic status. The expansion in terminology can be reflected in the *Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality* (APA, 2017a) which incorporates a more holistic, intersectional definition, including disability as a primary facet of multiculturalism.

Within the context of psychology, standards, unlike guidelines, are both mandatory and enforceable (APA, 2001). Standard B of the *Ethical Principles of Psychologists and Code of Conduct* (APA, 2017b) details competence and recognizes knowledge of various identities, including disability, as a requirement for competent, effective practice. The inclusion of disability and other identities in the term *multiculturalism* speaks to the ongoing ethical

responsibility that psychologists must maintain their levels of competence not only while in training, but throughout the various stages of their professional development.

To reiterate, professional psychology programs classify individual and cultural diversity as a foundational competency of training. Over time, multiculturalism has shifted to embody a more comprehensive idea of what is included as part of the term. In defining it more extensively, multiculturalism has encompassed disability. Psychologists are bound by ethical code to work competently with all the identities that are captured in the term multiculturalism

Models of Disability

Over 41 million noninstitutionalized Americans are living with a disability (American Community Survey, U.S. Census Bureau, 2019). Due to the increasing prevalence of people with disabilities, proficiency in disability related issues is required to meet the minimum standard of counseling practice (Smart & Smart, 2012; Hayes, 2001; Hulnick & Hulnick, 1989), regardless of specialty area. As one of the most prominent obstacles for persons with disabilities, societal attitudes can create barriers that prevent inclusion and equitable participation in activities of daily living (Antonak & Livneh, 2000; Weisel et al., 1988). To alleviate these barriers, it is important to understand how attitudes are defined and operationalized. Thus, disability models have provided insight into the cognitions related to the cause, nature, and treatment of disability (Bogart et al., 2022; Bogart et al., 2019). The moral model attributes disability as a punishment for a particular sin or transgression (Retief & Letšosa, 2018). In some instances, this model is based on the assumption that disability is a divine gift or test of faith presenting the opportunity to overcome adversity (Groce, 2005; Mackelprang & Salsgiver, 2016; Olkin, 2012).

The medical model, which is most predominant in Western culture, pathologizes disability and assumes that the inherent cause is abnormality, disease, or injury. (Olkin, 2002).

Dokumaci (2019) suggested that the medical model is a linear progression, moving swiftly from pathology to disease to disability. The focus of this model is individualized with emphasis on restoration of the norm through mitigation of symptoms and a cure. The medical model of disability ignores the environmental barriers, such as the explicit and implicit biases, that can largely inform client experiences within the healthcare system (Patten, 2024).

Where the medical model can invoke personal, internal attributions about the cause and treatment of one's disability (Dirth & Branscombe, 2017), the social model suggests that disabilities are a social construct that favors able-bodied individuals (Wendell, 1996). Thus, the environment has political, economic, and social barriers that prevent equal participation for individuals with disabilities (Dirth & Branscombe, 2019). The minority or diversity model frames disability as a diverse cultural and sociopolitical experience (Altman, 2001), like other cultural identities (e.g. race). Additionally, the minority model presents disability as a neutral difference and emphasizes the degree to which individuals identify with their own disabilities (Hahn and Belt 2004).

The models of disability have put language to how disability is talked about (Martin, 2018). The language used to describe individuals with disabilities has influenced the way others interact with them (Haegele & Hodge, 2016). Furthermore, the language used around disability can provide insight into the underlying attitudes one has about ability status. Dunn and Andrews (2015) discussed how person-first and identity-first language are connected to particular models of disability. For example, person-first language rejects the idea of disability as an impairment (the medical model) to put the individual before the disability (Dunn & Andrews, 2015). In alignment with the minority model, identity-first language stresses the role of disability culture and connection to the disability community (Dunn & Andrews, 2015).

Disability models have contributed to disability etymology and have therefore influenced the conceptualization and interaction of disability (Haegele, & Hodge, 2016). While these frameworks have emerged over time to conceptualize disability beyond the idea of an impairment (Murugami, 2009), the models of disability have also influenced attitudes related to ability status (Darling, 2013). There has been much debate in the literature, as more than 30 definitions of attitudes exist (Rao, 2004). Despite the various nuances spread across numerous definitions, there is consensus that attitudes consist of cognitive, affective, and behavioral components (Olson & Zanna, 1993). To illustrate the association between disability language and attitudes, LoBianco & Jones (2007) tested the degree to which medical and social factors have influenced perceptions of disability. By highlighting how language can shape societal attitudes toward disability, the authors (LoBianco & Jones, 2007) found attitudes to be significantly influenced by factors like degree of impairment or employment status.

Given the interconnectedness, careful consideration is given to how disability models inform the language and attitudes of individuals at large, but also mental health providers. Psychologists' awareness of their beliefs about disabilities and in turn how those beliefs may affect their clients will help improve clinical processes and outcomes (Altman, 2001; Olkin & Pledger, 2002; Schultz, et al., 2007; Smart & Smart, 2007). However, prior research (Ordway et al., 2021, Rogers et al., 2015, and Ali et al., 2013) has suggested that a lack of disability awareness and stigmatizing attitudes serve as a barrier to mental health care for persons with disabilities. This lack of awareness and stigmatization often translates into ableism.

Ableism's Influence on Attitudes

The Minority Stress Model (Meyer, 2003) suggested those in marginalized populations experience additive stressors as a result of belonging to a minority group. These stressors can be

further classified as proximal and distal and are theorized to be chronic and a result of prejudice, harassment, and discrimination (Meyer, 2003). The idea that stressors are a result of social interactions directly challenges the ideology of the medical model of disability (Smart, 2006). For the disabled population, oppression is rooted in ableism, or "a network of beliefs, processes and practices that produces a particular kind of self and body (the corporeal standard) that is projected as perfect, species-typical and therefore essential and fully human". (Campbell 2001, p.44).

Although the Minority Stress Model (Meyer, 2003) is empirically supported for sexual minority populations (Frost & Meyer, 2023; Michaels et al., 2016; Plöderl et al., 2014), little research has been done to apply the framework to individuals with disabilities. Lund (2021) examined the Minority Stress Model (Meyer, 2003) in relation to understanding suicidality of people with disabilities. Compared with the general population, people with disabilities experienced distal stressors such as, an increased risk for interpersonal violence (Lund et al., 2019; Hughes et al., 2011), peer victimization (Blake et al., 2016; Blake at al., 2012), and social discrimination (Lund et al., 2020). Botha and Frost (2020) found that discrimination and harassment as distal stressors were associated with poorer psychological well-being in adults with autism.

Lund (2021) discusses internalized stigma and self-concealment as proximal stressors. Early ideas of "disability" as both inherently bad and undesirable, which are consistent with the moral and medical models (Bogart et al., 2022), have further perpetuated the stigmatization of disabled persons. Evidenced by nondisabled persons avoidance of the "disability" (Andrews et al., 2019), disability stigma can be internalized and cause rejection of an individual's disability identity (Bogart et al., 2018).

The study by Botha and Frost (2020) produced results that indicated lower levels of "outness" were associated with poorer psychological well-being. This finding was not consistent with the Minority Stress Model (Meyer, 2003) as greater outness would lead to less self-stigma and less psychological distress. Botha and Frost (2020) suggest that more visibility or "outness" would be associated with greater harassment and discrimination. This idea was explored further by Raymaker et al. (2020) who found that masking behaviors among autistic adults have been linked to higher levels of suicidality and psychological distress.

Self-concealment could increase the proximal stressor of internalized stigma and lead to psychological distress over time (Raymaker et al., 2020; Lund, 2021). Serpas et al. (2024) found the relationship between the frequency of disability-based microaggressions, and symptoms of psychological distress were greater as disability visibility decreased. This finding (Serpas et al., 2024) aligns with the notion that anxiety and depression are internalizing disorders which are particularly common among those who are concealing minoritized identities. Thus, those with invisible disabilities might be reporting fewer disability-based microaggressions, the psychological distress was greater. Kattari (2020) emphasizes the idea that ableist microaggressions are present for all disabled people, regardless of disability type.

Ableism and Mental Health Treatment

Attitudes about marginalized groups have been documented as barriers to healthcare access, particularly for the way provider beliefs can inform patient encounters and subsequent treatment (Patten, 2024; Carillo et al., 2011). VanPuymbrouck et al. (2020) examined secondary data from 25,006 healthcare providers to understand their explicit (conscious) and implicit (unconscious) attitudes about disability. Results indicated that while the majority of providers indicated little explicit prejudice, their implicit attitudes suggested a preference for non-disabled

patients (VanPuymbrouck et al., 2020). This combination of low explicit bias coupled with high implicit bias characterizes an aversive ableist profile (Son Hing et al., 2008). Friedman (2018, 2019) suggested that an aversive ableist, though well-meaning, is biased in action and thought especially when their prejudice is less apparent. This type of ableist profile highlights the cognitive, affective, and behavioral (Olson & Zanna, 1993) components of an attitude.

Given the idea that attitudes largely inform clinical interaction, Katarri (2020) explored implicit attitudes in the form of identity-related microaggressions. The research (Katarri, 2020) suggested that the ongoing experience of identity related microaggressions can negatively impact mental health outcomes. Not only are ableist microaggressions negatively correlated with positive mental health outcomes, but the chronic experience of ableism through microaggressions has been associated with increased negative affect and somatization (Katarri, 2020). Friedman (2022) emphasized the presence of mental health challenges in the disabled population during the COVID-19 pandemic, including high reports of generalized anxiety and major depressive symptomatology. 15% of the sample endorsed needing mental health services, but the inability to receive them (Friedman, 2022). Despite more frequent use of mental health services, persons with disabilities reported higher unmet mental health service needs than nondisabled people (Houston et al., 2016, Xie et al., 2022). Manning and colleagues (2023) discovered anticipatory disability provider bias as a barrier to using mental health services for 70% of disabled persons.

Nario-Redmond (2019) discusses the mental and emotional toll of ableism, which can be further compounded by the presence of co-morbid mental health conditions (Friedman, 2022).

In addition to ableism that manifests through direct patient-provider interaction, it is important to consider how environmental barriers can perpetuate ableism. Lindsay et al. (2023)

conducted a systematic review of literature pertaining to disabled persons within healthcare and educational settings. Findings emphasized the prevalence of workplace ableism from an institutional and individual standpoint. Instances of workplace ableism included inaccessible environments, physical barriers, unsupportive workplaces, and fear of disability disclosure due to stigma (Lindsay et al., 2023). Consistent with the social model of disability, 75% of PWD reported environmental barriers as a barrier to mental health usage (Manning et al., 2023, Whittle et al., 2018).

Friedman (2022) examined the mental health outcomes of Medicare beneficiaries with disabilities during the COVID-19 Pandemic. 43.3% of Medicare beneficiaries had symptoms of generalized anxiety disorder and 36.8% had symptoms of major depressive disorder. 15% percent of these Medicare beneficiaries with disabilities reported needing mental health services, but did not receive them. Friedman (2022) emphasized the presence of mental health challenges in the disabled population, the difficulty of obtaining services, and the distress of managing symptomatology as well as discrimination in the form of ableism. Of note, these individuals with disabilities were experiencing mental health symptoms while also managing discrimination from ableism. Notably, higher rates of negative mental health experiences have been related to ableism (Conover & Israel, 2019).

Katarri (2020) found the ongoing experience of identity related microaggressions can negatively impact mental health outcomes, increase somatic symptoms, increase negative affect. Findings suggest ableist microaggressions are negatively correlated with positive mental health outcomes.

Though there is an increased need for mental health services reported by persons with disabilities, Manning et al. (2023) found 70% of persons with disabilities reported receiving

anticipatory disability provider bias as a barrier to using mental health services. Further, 75% of persons with disabilities reported environmental barriers as a barrier to mental health usage (Manning et al., 2023). Conner et al. (2023) conducted a qualitative study of the psychotherapy experiences of adults with physical disabilities. Conner and colleagues (2023) found themes centered around avoidance, psycho-pathologizing, or invalidation of disability, along with barriers to attending therapy.

Demographic Variables Related to Disability Perceptions

Past literature has presented ableism as a general attitude, implying that persons with disabilities do not fit into the norm of being 'able-bodied' (Bogart & Dunn, 2019). Seminal work (Jones et al., 1984) would suggest that stigma has 6 different dimensions: aesthetics, concealability, cause, course, disruptiveness, and peril. Given the variation of disability type, it has been shown that disability can be applied to these different dimensions (Pachankis et al., 2018; Bogart & Dunn, 2019). Nario-Redmond et al. (2019) used open-ended responses from adults with disabilities to categorize different types of ableism. Findings suggested individuals with visible, physical disabilities reported more frequent experiences of unwanted help or infantilization (Nario-Redmond et al., 2019). For adults with more concealable disabilities, reports included accusations of fraud or validity (Nario-Redmond et al., 2019). Bogart and colleagues (2019) found that congenital disabilities are more stigmatized than acquired disabilities.

Other research (Canton et al., 2022) has applied different theories, such as the Stereotype Content Model (Cutty et al., 2008), to better understand how specific disabilities elicit different perceptions of competence and warmth. The study (Canton et al., 2022) examined 12 different types of disabilities with various presentations to find that most were rated high in warmth and

low in competence. These findings would suggest some uniformity in stereotypes of disability. The exceptions in this research were individuals with schizophrenia and depression who were ranked equally low in competence and warmth (Canton et al., 2022) which supports the notion that some variation in stereotyping could be related to disability type. Timmons et al. (2023) further investigated ableism in the context of different disabilities and found harsher ableist judgements for disabilities such as autism compared to a spine disorder. Overall, the consistencies in the literature support the idea that particular disabilities hold more negative stereotypes (Canton et al., 2022; Timmons et al., 2023)

Berdhal & Moore (2006) presented the double-jeopardy hypothesis to describe the discrimination that increases with each additional stigmatized identity one holds. Within the literature describing disability and gender, findings have shown mixed results. Rohmer and Louvet (2009) further investigated perceptions of disability related to gender and ethnicity, as superordinate dimensions of social categorization. The research (Rohmer & Louvet, 2009) revealed that when it is visibly presented, disability is highly salient and described independently of gender and ethnicity. When a visible impairment was not part of the target, participants were primarily categorized by gender and ethnicity. Similar findings were replicated in Vilchinsky et al. (2010) where visibility of disability outweighed the impact of gender on attitudes. Timmons et al. (2023) found female wheelchair users received less acceptance than their male counterparts for entering a romantic relationship. No gender differences were observed for individuals with intellectual disabilities (Timmons et al., 2023), which is more supportive of research that views disability as less gendered (Nario-Redmond, 2010). Friedman and Awsumb (2019) found women to have more favorable views of disabled persons than men.

There is further support for the double-jeopardy hypothesis (Berdahl & Moore, 2006) hypothesis when considering who is seeking mental health services and stressors that coincide with holding marginalized identities (Meyer, 2003). Manning et al. (2023) found cisgender women with disabilities 5 times more likely to be currently using mental health services. Transgender and gender diverse (TGD; Manning et al., 2023) individuals with disabilities were 6 times more likely to report need for mental health services and 40 times more likely to report using mental health services.

Perceptions of Counselors with a Disability

Knowing the prevalence of persons with disabilities and the rate at which this population is requesting a need for mental health services, how do psychology and counseling-related fields perceive practitioners with disabilities? The American Psychological Association (2022) has publicly stated mental health clinicians receive little to no training in working with the disability population. From a training standpoint, Andrews and Lund (2015) found only 3% of students in APA-accredited doctoral programs identified as having a disability, which is far below the 26% documented prevalence of disability in the national population (Lund, 2021). The aforementioned individual and systemic discrimination faced by persons with disabilities has been well documented (Lund et al., 2020; Lund et al., 2016, 2014) as barriers to training for disabled trainees. Much like themes explored by Lindsay and colleagues (2023), psychology trainees with disabilities could be afraid to report their ability status due to fear of stigmatization. The lived experience of disability has a direct impact on attitudes, as providers who have disabilities themselves typically have less explicit and implicit attitudes (VanPuymbrouck et al., 2020).

Disability has traditionally been a largely understudied group in mental health research (Rios et al., 2016). Though it is scarce, much of the research has focused on client perceptions of working with a disabled counselor. Brabham and Thoreson (1973) sought to understand whether a visible physical disability had an impact on counselor selection and preference. Results indicated that both able-bodied and non-able-bodied students preferred counselors with an obvious disability (Brabham & Thoreson, 1973). A similar study followed suit (Mitchell & Frederickson, 1975) and found counselors with obvious physical disabilities were preferred based on their enhanced ability to understand and empathize. Additionally, this study's (Mitchell & Frederickson, 1975) findings yielded preferences for disabled counselors in personal, threatening situations. When counselors were asked to explicitly disclose their disability, results did not reveal a significant impact on the client's perceptions of their counselor (Mallinckrodt & Helms, 1986). However, similarly to the aforementioned studies, the results did indicate that counselors with obvious disabilities were perceived as more expert than their able-bodied counterparts (Mallinckrodt & Helms, 1986).

Mitchell and Allen (1975) found that when compared to a counselor who was perceived as able-bodied, the disabled counselor was rated significantly higher on all therapeutic variables. In contrast, Strohmer and Biggs (1983) rated the nondisabled counselor as more attractive and expert than the disabled counselor when both counselors displayed the same attending nonverbal behaviors.

Attitudes of Counselors and Counselors in Training

Huitt and Elston (1991) used a one-way ANOVA to compare attitudes between rehabilitation, school, and mental health counselors. Results indicated no significant differences between specializations, but participants expressed overall more positive attitudes toward people

with disabilities than the normative group. Carney and Cobia (1994) found that counselors-in-training held more positive attitudes towards persons with disabilities than the normative sample. Significant differences existed between counselors-in-training based on their area of emphasis. Overall, rehabilitation counseling majors reported the most positive attitudes followed by school counseling majors, and, lastly, community counseling majors (Carney & Cobia, 1994). These findings are consistent with the idea that individuals with disabilities have historically been considered a part of Rehabilitation Psychology (Artman & Daniels, 2010; Olkin & Pledger, 2003).

More recently, a qualitative study (Camilleri-Zahra, 2021) conducted interviews to understand the social construction of disability among counselors in Malta. Findings of thematic analyses revealed the influence of personal attitudes and beliefs on participants' conceptualization of disability. Participants described their understanding of the social model of disability but discussed difficulty implementing it into practice due to lack of training. Some participants distinguished persons with disabilities as "deserving" and "underserving", noting someone in a wheelchair as more "deserving" of counseling services than someone with an intellectual disability (Camilleri-Zahra, 2021). Not only was the distinction of "deservedness" based on impairment, but also clients' level of acceptance towards their disability. While the findings of this study were done in Malta, the themes that emerged are comparable to previous studies where clinicians felt incompetent (Conner et al., 2023). To connect microaggressions to clinical practice, Yilmaz et al. (2024) interviewed school psychologists who worked with students with disabilities from primary and secondary schools. Findings revealed significant themes of patronization, otherization, denial of identity, and desexualization amongst others (Yilmaz et al., 2024).

In summary, it is important to recognize that all psychologists, regardless their of specialization or training program, are required to maintain individual and cultural diversity as a foundational competency (Kaslow et al., 2004). As such, ability status is included as a facet of cultural competence, per the *Multicultural Guidelines* (APA, 2017a). Of equal importance, psychologists also have an ethical duty to uphold their competence as it relates to disability. To understand how psychologists conceptualize disability, the models of disability have provided language to describe ability status. The terminology provided by the models of disability has influenced the way individuals interact with disabled persons (Haegele & Hodge, 2016). Interactions with individuals with disabilities are often guided by underlying ableist attitudes, which serve as a barrier to equitable participation in everyday life (Antonak & Livneh, 2000). The presence of ableist attitudes has readily expanded into the healthcare setting, and particularly to the mental health domain. The lived experience of disability coincides with unique stressors (Meyer, 2003) that which support a greater need for mental health services (Friedman, 2022). Yet, past literature related to disability and mental health has been largely understudied (Rios et al., 2016). It has largely focused on specific types of disabilities (Canton et al., 2022), and perceptions of made by those in the general, able-bodied population (Carney & Cobia, 1994; (Camilleri-Zahra, 2021).

CHAPTER 3

METHODS

Description of the Sample

Participants meeting inclusion criteria for this study consisted of self-identified graduate students or licensed mental health professionals in counseling or psychology-related fields and programs. All eligible participants were 18 years or older. Data for this study were collected using an online Qualtrics Survey constructed by the Imagining Disability Equity, Access, and Liberation (IDEAL) Research Collective Team. The samples for this study were used to compare areas of interest/specialization, work setting, and ability status and were derived from a larger study and data set. Total demographic samples information for each sample was provided. Demographic information included area of specialization, work setting, and ability status. Demographic characteristics of the sample (N=190) are presented in Table 4 (Chapter 4).

Design

The intent of this study was to understand the similarities and differences between different demographic variables of mental health clinicians as it relates to their attitudes toward people with disabilities. This study employed an exploratory research design to examine potential differences in attitudes among different demographic variables across professional settings, specializations, and ability status. (Shadish et al., 2002). By looking at differences across specialization area, work setting, and ability status, this study can inform gaps in training and professional practice. This exploratory study can not only contribute to existing literature

centering on disability and counseling but will also suggest possible future directions to protect and uphold the treatment and care of this population.

Instruments

The instruments used in this study include the *Balanced Inventory of Desirable Responding (BIDR),* a *Demographic Questionnaire*, the *Multidimensional Attitudes Towards Disabled Persons Scale* (MAS).

Balanced Inventory of Desirable Responding Impression Management Subscale (BIDR-IM)

The Balanced Inventory of Desirable Responding (BIDR; Paulhus, 1988) is a 40-item instrument designed to measure the constructs of self-deceptive positivity and impression management. For the purposes of this study participants were asked to complete only the Impression Management subscale, which focuses on deliberate self-presentation to a particular audience. Participants are asked to rate their level of agreement with items on a 7-point scale. Scores on the Impression Management (IM) subscale range from 0-20, with higher scores indicating exaggeratedly desirable responses. Given that the scoring procedures for the BIDR-IM included reverse coding and extreme responses (e.g. 6 or 7) are weighted, the researcher presented a total summation of BIDR-IM scores in addition to a score consistent with scoring procedures. The typical values of Cronbach's coefficient alphas (Cronbach, 1951) for Impression Management Subscale (Paulhus, 1988) range from .77 and .85. For the present sample, the alpha was 0.86. The entirety of the BIDR-IM is displayed in Appendix A.

Demographic Questionnaire

A Demographic Questionnaire was constructed to better understand the experiences of the mental health clinicians who are participating in this study. Participants were asked to notate their area interest or specialization. These options include General, Clinical Child,

Rehabilitation, Neuropsychology, Health Psychology, Counseling, Clinical, School, Geropsychology, and Other. Individuals were able to select multiple professional identifications. Additionally, participants disclosed their Work Setting and Ability Status. The categories for work setting include VA's, Hospital/Medical, University and Educational. Community Mental Health, Forensic/Judicial, Independent Practice, and Other. The entirety of the Demographic Questionnaire is displayed in Appendix B.

The Multidimensional Attitudes Towards Disabled Persons Scale (MAS)

The Multidimensional Attitudes Towards Disabled Persons Scale (MAS; Findler et al., 2007) was initially developed in response to the difficulty and complexity of measuring attitudes toward persons with disabilities. The instrument is designed to capture attitudes from multiple facets, including affect (emotions), cognitions, and behaviors.

Participants are asked to read a vignette about an interaction between "Alex" and a person in a wheelchair. Please note the name "Alex" was adapted from the original vignette to represent a gender-neutral name. After reading this vignette, respondents indicated the degree to which they believe the item accurately reflected the way "Alex" would feel, think, and act in that situation. Their responses were marked on a 5-point Likert-type scale ranging from 1 (not at all) to 5 (very much). The higher the score, the more negative the attitude.

The scale was validated by researchers who compared it to the Attitudes Toward Disabled Persons Scale (ATDP: Yuker et al., 1966), which is one of the most popularly used and highly validated scales regarding attitudes about disability. Findler et al. (2007) conducted a factor analysis to identify items for inclusion. Each had factor loadings greater than 0.4 and fit easily into one of the three categories (Findler et al, 2007). The Cronbach's alpha from Findler et al's., (2007) sample was 0.86 for the 34 items. The original authors of the measure obtained

alpha levels of 0.88 for Cognition, 0.90 for Affect, and 0.83 and Behavior. For the present sample, Cronbach's coefficient alphas (Chronbach, 1951) were 0.88 for Cognition, 0.90 for Affect, and 0.82 for Behavior. The entirety of the MAS is displayed in Appendix C.

Data Collection

The data for this study were collected from a Qualtrics Survey constructed by the IDEAL Research Collective. The study was approved by UGA/Sterling Institutional Review Board and assigned as PROJECT 00005028. Participants were recruited via email, where the recruitment statement, PI contact information, and the survey link were also shared. Email addresses were obtained through public records and internet searches for the survey to be shared with student and community organizations. Authorized research personnel recruited in-person and electronically via personal contacts. Any persons who received the forwarded survey link were invited to forward the recruitment message and survey link to other potential participants. Using a randomizer function in Qualtrics, measures presented to participants in a randomized order with the demographic questionnaire always presented at the end of the survey.

The researcher analyzed the data provided from the survey to obtain samples of participants from various areas of professional specialization. These areas include General, Clinical Child, Rehabilitation, Neuropsychology, Health Psychology, Counseling, Clinical, School. Geropsychology, and Other. The researcher provided samples of participants from various work settings. These settings will include Veterans Administration (VA), Hospital/ Medical, University/Educational, Community Mental Health, Forensic/Judicial, Independent Practice, or Other. The researcher obtained a sample of both able-bodied and non-able-bodied participants. Data were analyzed via SPSS Statistics, a statistical analysis software.

Statistical Treatment

This study intended to better understand the attitudes that mental health practitioners, both in the field and in training, hold about persons with disabilities. Furthermore, this study explored the relationships that exist between three particular variables including area of interest/ specialization, work setting, and ability status. Statistical and correlational analysis were used to examine similarities and differences among the different levels of specialization area, work setting, and ability status.

An analysis of variance (ANOVA) is a statistical test that compares means across three or more groups (Kroes & Finley, 2023). The researcher assessed the underlying assumptions of the ANOVA, including normality, homogeneity of variance, and independence. No violations were found. Thus, an ANOVA was conducted to compare statistical values among areas of specialization and different work settings. A one-way ANOVA allowed the researcher to compare the different samples of counseling professionals to better understand the differences in attitudes toward people with disabilities. An independent samples t-test is a statistical method that compares means from the same sample under different conditions (Field, 2013). Given that the researcher is anticipating those with their own disability to be more accepting of others with disabilities, a one-tailed t-test is most appropriate to reflect the directionality of the hypothesis (Field, 2013). Correlation analyses were also used to explore the relationship (Field, 2013) between how participants answered the MAS (Findler et al., 2007) and the BIDR-IM (Paulhus, 1988).

Data Preparation

Data collected electronically through Qualtrics were entered into SPSS 29 data entry for analysis. The preliminary sample consisted of 294 self-identified graduate students or licensed

mental health professionals in counseling or psychology-related fields and programs who were 18 or older. Using procedures consistent with Tababachnick and Fidell (2007), the data were cleaned and assessed for missing data and potential outliers. Participants with survey responses under 10 minutes and exceeding 640 minutes were removed from the data set. Given the research questions, participants whose responses did not include all or most of the MAS were also excluded from further analyses. After completing these steps, only a small amount of MAS data was missing. To address the three cases of missing MAS data, the Expectation Maximization algorithm (McLachlan et al., 2004) was used to estimate the missing values. The resulting sample size after data preparation was 190.

Regarding areas of specialization, participants were able to select multiple areas of interest. The data did not significantly capture enough responses to warrant groupings based on distinct specializations. The breakdown of responses is displayed in Table 1. Therefore, data analysis consisted of a hierarchical cluster analysis to identify natural groupings within the dataset. These groupings were based on MAS totals. A hierarchical cluster analysis was conducted according to procedures outlined by Blei and Lafferty (2009) to combine responses into six clusters. Cluster 1 included participants in clinical and neuropsychology. Cluster 2 included participants in counseling psychology. Cluster 3 included participants in pediatric, rehabilitation, counseling, and clinical psychology. Cluster 4 included participants from general, rehabilitation, counseling, and clinical specializations. Cluster 5 consisted of individuals specializing in counseling psychology and neuropsychology. Cluster 6 consisted of providers from clinical, health, and counseling psychology. The mean and standard deviation for each of the professional clusters is displayed in Table 2.

Table 1 Frequencies of Specialization Areas

Specialization Areas	N	%
General	31	16.3
Pediatric	14	7.4
Rehabilitation	13	6.8
Neuropsychology	11	5.8
Health Psychology	15	7.9
Counseling	129	67.9
Clinical	50	26.3
School	17	8.9
Geropsychology	1	0.5
Other	20	10.5

Table 2 Comparison of Means by Professional Cluster Across MAS Totals

Variable	n	M	SD
Cluster 1	18	85.28	15.97
Cluster 2	63	82.25	17.32
Cluster 3	36	81.28	14.74
Cluster 4	26	80.65	16.97
Cluster 5	17	81.00	17.34
Cluster 6	16	86.25	16.53

Regarding professional work setting, hypothesis 2 is particularly interested in VA and Hospital settings. Therefore, responses for ‘VA’ and ‘Hospital/Medical’ settings were re-coded together as a single grouping. Originally, there were 4 VA responses and 18 Hospital/Medical responses. The ‘Forensic/Judicial’ setting only yielded 3 total responses. Due to a small sample size decreasing the statistical power of a one-way ANOVA, ‘Forensic/Judicial’ responses were re-coded to be included in the ‘Other’ category to reduce the likelihood of Type II error (Shadish et al., 2002). The number of responses in each category after accounting for Type II error are displayed below in Table 3.

Table 3 Frequencies of Professional Work Setting

Professional Work Setting	N	%
Hospital/Medical & VA	22	11.6
University/Educational	36	18.9
Community Mental Health	45	23.7
Independent Practice	54	28.4
Other	26	13.7
Did Not Identify	7	3.7

Assumptions

It is assumed that all of the participants answered each of the survey questions truthfully and honestly. It is also assumed that all of the measurements and assessments that were administered are valid. Results of the measures will be analyzed for validity.

CHAPTER 4

RESULTS

Descriptive Statistics

Participants for the study consisted of self-identified graduate students or licensed mental health professionals in counseling or psychology-related fields and programs who were 18 or older. Demographic information detailing sample characteristics is displayed in Table 4. The mean age for the sample was 37 years old.

Table 4 Demographic Characteristics of Sample

Demographic Characteristic	N	%
Sex		
Male	31	16.3
Female	153	80.5
Did Not Identify	6	3.1
Race		
Asian	9	4.7
Black	25	13.2
Latino(a)/Hispanic (Non-White)	2	1.1
Latino(a)/Hispanic (White)	12	6.3
Pacific Islander (Hawaiian)	1	0.5
White	121	63.7
Multiracial	9	4.7
Other	6	3.2
Did Not Identify	5	2.6
Ability Status		
Disabled	42	22.1
Non-Disabled	143	75.3
Did Not Identify	5	2.6
Professional Stage		
Graduate Student	57	30.0
Early Career	52	27.4
Mid-Career	42	22.1
Late Career	29	15.3
Other	5	2.6
Did Not Identify	5	2.6

Statistical Analyses

A correlation analysis was conducted to examine the relationships between the BIDR-IM and the three MAS subscales. The correlation analyses included both the total BIDR-IM and the scored BIDR-IM. After scoring, the analysis revealed a significant negative correlation between

the BIDR-IM Scored ratings and the MAS Cognition subscale ($r = -0.26$, $p < 0.001$), indicating that higher scores on BIDR-IM are associated with lower scores on MAS Cognition. Those who were trying to respond in a favorable fashion demonstrated more negative thoughts about those with disabilities Results indicated no significant correlation between BIDR_IM scores and the MAS Affect ($r = -0.03$, $p = 0.72$) or MAS Behavior ($r = -0.14$, $p = 0.05$) subscales. The MAS Affect subscale showed a significant positive correlation with MAS Behavior Subscale ($r = 0.58$, $p < 0.001$), suggesting that higher MAS Affect scores are associated with higher MAS Behavior scores. The MAS Cognition also demonstrated a significant positive correlation with the MAS Behavior subscale ($r = 0.30$ $p < 0.001$). However, the correlation between MAS Affect and MAS Cognition subscales were not statistically significant ($r = 0.14$, $p = 0.06$). The results are summarized in Table 5.

Table 5 Correlation of Scored BIDR-IM and MAS Subscales

Variable	n	M	SD	BIDR Total	MAS Affect	MAS Cognition	MAS Behavior
BIDR Scored	187	10.01	3.64	-			
MAS Affect	190	39.39	10.75	-.03	-		
MAS Cognition	190	25.98	6.07	-.26**	.14	-	
MAS Behavior	190	17.43	5.11	-.14	.58**	.30**	-

A similar trend was observed between totaled BIDR-IM Scores and MAS subscales. The BIDR-IM scores were totaled together in summation to further confirm and explore its relationship with MAS subscales. The analysis revealed a significant negative correlation between the BIDR-IM Totals and the MAS Cognition subscale ($r = -0.27$ $p < 0.001$), indicating

that higher scores on total scores on the BIDR-IM are associated with lower scores on MAS Cognition. Those who were deliberately trying to answer questions in a favorable way, held more negative thoughts about those with disabilities. Results indicated no significant correlation between BIDR-IM total scores and the MAS Affect ($r = 0.07$, $p = 0.37$) or MAS Behavior ($r = -0.06$, $p = 0.45$). subscales. Impression management did not seem to significantly impact behavioral or affective attitude scores. The MAS Affect subscale showed a significant positive correlation with MAS Behavior Subscale ($r = 0.58$, $p < 0.001$), suggesting that higher MAS Affect scores are associated with higher MAS Behavior scores. The MAS Cognition also demonstrated a significant positive correlation with the MAS Behavior subscale ($r = 0.30$, $p < 0.001$). The correlation between MAS Affect and MAS Cognition subscales was not statistically significant ($r = 0.14$, $p = 0.06$). The results are summarized in Table 6.

Table 6 Correlation of Totaled BIDR-IM Scores and MAS Subscales

Variable	n	M	SD	BIDR Total	MAS Affect	MAS Cognition	MAS Behavior
BIDR Total	187	99.04	12.46	-			
MAS Affect	190	39.39	10.75	.07	-		
MAS Cognition	190	25.98	6.07	-.27**	.14	-	
MAS Behavior	190	17.43	5.11	-.06	.58**	.30**	-

Hypothesis 1

Hypothesis 1 predicted significant differences would exist between attitudinal dimensions toward people with disabilities, as measured by the MAS, among those who classify themselves with a Rehabilitation Specialization as opposed to other areas of interest. The results indicated no statistically significant differences between the 6 clusters, $F(5,170) = 0.39$, $p = 0.85$. These

findings suggest that the group means for total MAS scores are similar and that area of professional specialization does not significantly impact attitudes as measured by the MAS.

Hypothesis 2

Hypothesis 2 predicted significant differences between attitudinal dimensions, as measured by the MAS, among those who work in VA or Hospital Medical Settings as opposed to other work settings. Given that veterans played a significant role in shaping the Disability Rights Movement, it was predicted that VA and Hospital Settings would ascribe more heavily to a rehabilitation model of care. Since rehabilitation has traditionally adhered to the medical model of disability (Andrews, 2016), it was anticipated that MAS scores would reflect this framework. A one-way ANOVA revealed significant differences in Total MAS scores among the groups, $F(4,178) = 2.52$, $p = 0.043$, $\eta^2 = 0.54$. The results from a Tukey HSD Post Hoc test indicated the Independent Practice significantly differed from University/Educational (M = 81.56), Other (M = 84.42), Hospital/Medical (M = 85.45), and Community Mental Health (M = 86.51) settings. Specifically, Independent Practice had a significantly lower mean score (M = 77.09) compared to Community Mental Health (M = 86.51), with a mean difference of -9.42, $p = 0.034$, and a 95% confidence interval of [-18.39, -0.45]. Other comparisons did not reach statistical significance. The overall significance level for the comparisons was $p = 0.130$. Although results did indicate meaningful differences between attitudinal dimensions on the MAS, differences appeared across the Independent Practice Specialization instead of across VA and Hospital Settings. Given that higher overall MAS scores indicate more negative attitudes toward individuals with disabilities, these findings suggest that those in Independent Practice have significantly more positive attitudes.

Hypothesis 3

Hypothesis 3 predicted significant differences between attitudinal dimensions, as among those who identify as disabled as opposed to those who identify as able-bodied. In an independent samples t-test, participants who identified as disabled scored higher on the MAS (M=87.05, SD=16.55, SE=2.55) than able-bodied individuals (M=81.43, SD= 16.62, SE=1.39). Levene's test for equality of variances was not significant, F(1, 183) = 0.59, p = 0.44, indicating that the assumption of equal variances was met. The 95% confidence interval for the mean difference was [-0.13, 11.37]. This difference between the two groups was significant *t*(183) = 1.93, p= 0.03 (one-tailed), with a mean difference of 5.62. The effect size was calculated using Cohen's d (d = 0.34) and Hedges' g (g = 0.34), both of which indicated a small effect size. Those participants who identified as disabled endorsed significantly more positive attitudes about others with disabilities when compared to non-disabled participants.

Upon further explanation and analysis into the MAS subscales, independent samples t-tests revealed disabled participants scored higher on the Affect (M= 40.81, SD= 11.59, SE= 1.79), Cognition (M= 28.24, SD= 7.51, SE= 1.16) , and Behavior subscales (M=18.00, SD=5.18, SE=0.80) than able-bodied individuals (Affect: M=38.85, SD= 10.56, SE=0.88; Cognition M=25.39, SD= 5.50, SE=0.46; Behavior M=17.19, SD= 5.09, SE=0.43). Levene's test for equality of variances was not significant for the Affect, F(1, 183) = 0.28, p = 0.60, Cognition F(1, 183) = 2.93, p = 0.09, or Behavior F(1, 183) = 0.62, p = 0.43 subscales, indicating that the assumption of equal variances was met. The 95% confidence interval for the mean difference was [-1.78, 5.70] for Affect, [0.77, 4.93] for Cognition, and [-0.96, 2.58] for Behavior. This difference between the two groups was significant for only the Cognition subscale *t*(183) = 2.70, p= 0.04 (one-tailed), with a mean difference of 2.85. The difference between the disabled and

nondisabled participants was not significant for the Affect $t(183) = 1.04$, $p = 0.15$ (one-tailed) or Behavior $t(183) = 0.90$, $p = 0.18$ (one-tailed) subscales. Cognitive attitudinal differences existed between disabled and non-disabled participants from this study. Those who identified as disabled had significantly more positive attitudes, particularly about their thoughts and cognitions related to disability, when compared to their non-disabled counterparts. Significant differences did not exist between the two groups when comparing behavioral or affective attitude scores.

CHAPTER 5

DISCUSSION

This quantitative study aimed to explore attitudinal differences among mental health clinicians about persons with disabilities. Using cognitive, affective, and behavioral components, this study compared attitudes across three different demographic areas to see if there were significant differences. Previous studies have examined the impact of ableist attitudes (Serpas et al., 2024; Katarri, 2020) on disabled persons as well as perceptions related to different types of disabilities (Timmons et al., 2023; Bogart & Dunn, 2019). Literature related to attitudes towards persons with disabilities has been limited and more focused on healthcare as a whole (VanPuymbrouck et al., 2020). To my knowledge, this study is the first of its kind to examine disability-related attitudes in solely mental health providers while accounting for the following three demographic variables: professional work setting, area of specialization, and ability status. Given the prevalence and great need for mental health services (Manning et al., 2023; Conover & Israel, 2019) among the largest minority population (Nario-Redmond, 2020), this study fills a gap in the literature by promoting disability-related cultural competence within counseling-related fields.

Study Findings

Broadly, this study hypothesized significant differences existed in the attitudinal dimensions measured the MAS across three different demographic variables. Higher scores on the MAS reflected more positive or favorable attitudes towards persons with disabilities. To account for desirable responding, participants were asked to fill out the Impression Management

Subscale on the Balanced Inventory of Desirable Responding (Paulhus, 1988). Given that past research has shown a discrepancy between implicit and explicit attitudes related to disability (VanPuymbrouck et al., 2020; Friedman, 2019), the BIDR-IM was intended to assess the degree to which individuals presented themselves in a favorable manner. To explore the relationship between how participants answered MAS questions, a correlation analysis was conducted between the MAS subscales and BIDR-IM. With the consideration that higher scores indicate a more favorable presentation, the BIDR-IM was both totaled in summation and scored accordingly. Results indicated significant negative correlations between the BIDR-IM Scored and Total ratings and the MAS Cognition subscale. These findings suggested that individuals trying to present themselves more favorably tended to score lower on Cognition items from the MAS. Those who were deliberately trying to answer questions in a favorable way, held more negative thoughts about those with disabilities. Many of these items focused on belief around interacting with someone with a disability. This finding reinforces the idea that individuals generally want to think of themselves as accepting when it comes to how they conceptualize disability, but in reality, they might hold negative thoughts about someone with a disability. The strong positive correlation between MAS Affect and MAS Behavior subscales highlights a unique interrelatedness of these two constructs.

Hypothesis 1

Hypothesis 1 found no significant differences across total MAS scores when considering area of specialization. This finding could emphasize the perspective that there is overlap in the information taught across specializations (Matarazzo, 1987). The area of specialization does not lead to any meaningful differences in biases. No cluster revealed significantly more positive attitudes towards people with disabilities. If there is consensus that mental health clinicians are

not competent to work with disabilities (Conner et al., 2023; Hampton et al., 2011; Olkin & Pledger 2003), the findings of this study would suggest a great need for more comprehensive training across all emphasis areas of mental health. The lack of significant differences offered by the results would support a lack of disability-related competence across all cluster areas. As the field of psychology, there is a need for further attention dedicated to disability. Given that most participants identified as counseling psychologists prior to the cluster analysis, the data did not warrant enough responses to yield distinct specializations. Therefore, the study was not able to capture sufficient distinctions across specialty areas to generalize its findings to the overall field.

Hypothesis 2

Hypothesis 2 found those working in an Independent Practice Setting to differ significantly from those working in other settings. Specifically, analyses revealed that Independent Practice had a significantly lower mean score compared to participants working in Community Mental Health. Given that higher overall MAS scores indicate more negative attitudes, findings suggest that those in Independent Practice have significantly more positive attitudes. These results could be related to the high levels of emotional exhaustion experienced by those in community mental health roles (Onyett, 2011). In looking through the open-text responses of those who notated Independent Practice, many participants emphasized their work with disabled clients. Some open-text responses iterated that the majority of their clinical work included people with disabilities. According to one participant, “95% of my current clients identify as having a disability” (participant 178, 2022). It could be that these findings suggest those in Independent Practice have significant exposure to disability-related clinical work. In other words, the participants in Independent Practice emphasize clinical work with clientele who identify as disabled. Much like a neuropsychologist specializes in the functioning of cognition,

these findings could suggest an area of emphasis in disability. Another alternative explanation for these results could speak to selection bias. Independent Practice settings may be distinct from others in that they serve a more advantaged individual and are better equipped with resources. Thus, the clientele from an Independent Practice Setting may not be highlight the same health disparities that generally exist for the disabled population.

Hypothesis 3

The findings for hypothesis 3 revealed significant differences between attitudinal dimensions, as among those who identify as disabled as opposed to those who identify as able-bodied. When considering disability in the framework of the minority stress model (Meyer, 2003), those who live with the experience of a disability have first-hand knowledge of proximal and distal stressors. As such, "lived experience provides a unique perspective that is essential for understanding" (Jones, 2019, p. 45). Consistent with Social Identity Theory (Tajfel & Turner, 1979), individuals tend to favor their ingroup or the group they belong to. Thus, it would be reasonable to conclude that those with their own lived experiences of disability would hold more positive and accepting attitudes towards others with disabilities. The significance revealed by the Cognition subscale could be explained by the unconscious nature of implicit attitudes. Automatic thoughts can also be unconscious. In alignment with findings from Friedman (2018, 2019), individuals can be well-intentioned but biased in thought when their prejudice is less apparent. Those living with disabilities could possess more accepting thoughts of disability, rather than the majority (able-bodied) holding socialized ideas of impairment or deficit.

Limitations

Limitations of this study include all self-report measures, and no objective measures of attitudes were used. The Multidimensional Attitudes Towards Persons with Disabilities Scale

(MAS; Findler et al., 2007) presented a vignette of an individual in a wheelchair. Consistent with other literature (Bogart et al., 2019; Deal, 2003; Antonak & Livneh, 1991), different types of disabilities can elicit various perceptions and reactions. Given the presentation of an individual with a visible, physical disability, this study does not account for other disabilities that manifest differently. The majority of the participants in the sample were nondisabled, white, females. The findings do not capture the experiences of racially and ethnically diverse populations, which is consistent with disability research omitting those from marginalized backgrounds (Foley-Nicpon & Lee, 2012). This study also consists of a single sample, so it does not offer a comparison group. The researcher was unable to confirm the status of clinicians' licenses, or the number of years participants have been in practice. Therefore, all data were self-reported. Despite efforts of thoughtful survey design and data collection procedures, self-report data lends itself to variability in responses. In consideration of Research Question 1, the data did not significantly capture enough responses to warrant groupings based on distinct specializations. Given that participants were able to select more than one area of specialization, this study recognizes that it did not accurately capture the intended distinction across specializations.

Implications and Future Directions

The American Psychological Association has publicly acknowledged the negative biases that mental health practitioners hold about persons with disabilities, further suggesting the inadequate amount of training and competence hindering effective clinical work with the disabled population (APA, 2022). The field of psychology has made strides to include disability as a component of diversity. The APA has included disability as part of the *Multicultural Guidelines* (2017a) and recently updated the *Guidelines for Assessment and Intervention with Persons with Disabilities* (2022). The public acknowledgement of a lack of competence is a

crucial first step towards increasing awareness. Additionally, the increased scholarship has further contributed to the disability conversation and dialogue. Yet, it is important to consider next steps to increase the knowledge and skills involved with clinically working with individuals with disabilities. There is an almost guaranteed likelihood of working with a disabled client. Olkin (1999, p.96) emphasized, "saying that one doesn't treat clients with disabilities is rather like saying one doesn't treat depression- you never know where in therapy the issue will arise". The need for disability-related competence is impending and dire, as psychologists are bound by an ethical code (Cornish et al., 2008).

Despite its limitations, this study is a contribution to counseling psychology and counseling-related research. With commitments to bring psychological services to the underserved (Cooper et al., 2019), the results of this study provide a basis for current attitudes of mental health professionals toward disability. Intentionally replicating this study would further validate and generalize its results and provide further support for the topic. Significant differences did not exist between MAS totals across the cluster areas. This finding supports the idea that all psychologists, regardless of specialization or practice area, have a responsibility to work towards increasing disability competence. Knowing significant differences pinged on the Cognition Subscale, efforts toward increasing knowledge should be geared towards the thoughts and frameworks surrounding disability. Course curricula should readily incorporate and discuss the models of disability and facilitate conversations surrounding the implicit biases that individuals may unconsciously hold.

With evidence to support that harmful ableist microaggressions can significantly rupture the therapeutic working alliance (APA, 2017, p.32; Conner et al., 2023), it is important to consider the dynamics that are significantly contributing to incompetent care. On an individual

level, ableist attitudes and microaggressions can prevent the implementation of effective psychological services. Clinical skills courses should incorporate scenarios involving disabled clientele where trainees have an opportunity to apply their knowledge related to disability. *Disability-Affirmative Therapy* (Olkin, 2009) provides a basis for conceptualizing disability in the context of psychotherapy or clinical supervision. Systemically, inaccessibility of counseling spaces (Lindsay et al., 2023; Conner et al., 2023) act a barrier to mental health treatment. In efforts to continue increasing awareness, dialogue surrounding types of accommodation will increase critical consciousness of environmental barriers.

Seeing as counseling psychology has pledged to prioritize training, it is important for counseling and psychology programs to incorporate disability competence into their curriculums. Given the scarce number of psychology trainees who are reporting their ability status (Lund, 2015), it is evident training programs are not promoting accessible environments to accommodate the needs of their own. If psychologists are required to recognize disability as an element diversity, there is also a professional expectation for them advocate for inclusion. This process must begin within the field itself. Inclusivity of disability through clinical supervision, teaching, mentorship would demonstrate a strong dedication to supporting trainees with disabilities. Additionally, practica, internships, and conferences should provide appropriate access, accommodations, and support (Lund et al., 2021). These accommodations would illustrate a deep commitment to fostering an inclusive environment for those with disabilities.

Future scholarship examining the attitudes of clinical supervisors towards disabled trainees would provide insight into the biases occurring within training programs. Qualitative research supporting the experiences of trainees with disabilities in supervision would center the voices of psychology trainees.

While the *Guidelines for the Treatment and Assessment of Persons with Disabilities* (APA, 2022) has been recently revised, it is important to note that these guidelines are aspirational for psychologists. Much like the American Rehabilitation Counseling Association (ARCA) has established *Disability-Related Counseling Competencies* (Chapin et al., 2018), it would be beneficial for the APA to formulate action-oriented competencies. This would further demonstrate and reinforce the commitment to developing disability-related competence within the field. These documents, along with recent research regarding disability, should be readily incorporated into course syllabi as a basis for the development of the competence required of psychologists and counselors-in-training.

Despite the increased scholarship on disability in recent years (Lindsay et al., 2023; Conner et al., 2023), research moving forward should continue to center the voices of those living with disabilities. Future scholarship should give special consideration to ability status in the context of other minoritized identities. Disability is more prevalent in minoritized groups than with European descended groups (Erickson, Lee, & von Shrader, 2014). Given the minority stress model (Meyer, 2003), future studies could examine the influence of other identities (e.g. race, ethnicity, or sexual orientation) on attitudes towards the disabled population. Are those with other minoritized identities more inclined to hold more positive attitudes toward ability status?

Understanding how different cultures view disability could provide insight into cultural stereotypes that inform implicit biases. Additionally, it may be worthwhile to investigate differences in attitudes across professional career stages. Future research would also benefit from further examination of how impression management relates to the cognitive process of implicit bias towards people with disabilities. Although exposure to clinical work with individuals with

disabilities will happen, it would be worthwhile to understand the timeline by which gaps in competence occur. Results would guide further instruction and training.

As a part of competence, psychologists and counselors-in-training, should develop attitudes, knowledge, and skills related to disability which would equip them to work effectively with the disabled population. Commitment to change is shown when words are followed by purposeful action. The field of psychology will fully embrace disability competency as intention and action become aligned to create lasting change.

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Appendices

Appendix A

BIDR

Balanced Inventory of Desirable Responding
Impression Management Scale

Instructions: Using the scale below as a guide, indicate the number that most describes how much you agree with the statement.

1	2	3	4	5	6	7
Not True			**Somewhat True**			**Very True**

1.) I sometimes tell lies if I have to.
2.) I never cover up my mistakes.
3.) There have been occasion when I have taken advantage of someone.
4.) I never swear.
5.) I sometimes try to get even rather than forgive and forget.
6.) I always obey laws, even if I'm unlikely to get caught.
7.) I have said something bad about a friend behind his or her back.
8.) When I hear people talking, I avoid listening.
9.) I have received too much change from a salesperson without telling him or her.
10.) I always declare everything at customs.
11.) When I was young I sometimes stole things.
12.) I have never dropped litter on the street.
13.) I sometimes drive faster than the speed limit.
14.) I never read sexy books or magazines.
15.) I have done things that I don't tell other people about.
16.) I never take things that don't belong to me.
17.) I have taken sick leave from work or school even though I wasn't really sick.
18.) I have never damaged a library book or store merchandise without reporting it.
19.) I have some pretty awful habits.
20.) I don't gossip about other people's business.

Appendix B

Demographic Questionnaire

What is your age?
Open Text:

Although the categories listed below may not represent your full identity or use the language you prefer, for the purpose of this survey, please indicate which group below most accurately describes your racial identification (Both Open Text and Categories)
Alaskan Native/ Native American/ Indigenous
Asian
Black
Latino(a)/ Hispanic (Non-White)
Latino (a)/ Hispanic (White)
Pacific Islander/ Native Hawaiian
White
Multiracial (please specify)
Other (please specify below)

Ethnicity or ethnic culture refers to patterns of ideas and practices associated with a group of people sharing a common history, geographic background, and/or language, rather than their racial background. It might include things like values, patterns of interacting, food, dress, holidays, or ways of seeing the world, yourself, or other people. There are hundreds of different ethnic culture backgrounds within the people in the United States (such as Cuban, Haitian, Cambodian, African American, Ukrainian, etc.). In your own words, what is your ethnic identification(s)?
Open text:

Although the categories listed below may not represent your full identity or use the language you prefer, for the purpose of this survey, please indicate which group below most accurately describes your ethnic culture identification. Keep in mind we are interested in the ethnicity that *affects your daily experience*. You may check "American" if that is your primary cultural identity, or check a panethnic identification (e.g. Asian American,Latinx American). *Check as many as apply, but please check only those that affect your current daily experience in a major way*—do not include those that are your more distant heritage or ancestry. Categories are listed in relation to the regions of the world from which they originate and not all ethnicities are listed—please write in your ethnicity if you do not see it listed. **Check only those that apply to you.**
a) United States/American (pan-ethnic American)

- o American (United States)
- o African American (pan-ethnic)
- o Asian American (pan-ethnic)
- o European American (pan-ethnic)
- o Latinx American (pan-ethnic)
- o Native or Indigenous American (pan-ethnic)
- o Middle Eastern American (pan-ethnic)

b) North American (not United States)
- o Canadian
- o Mexican

c) Asian
- o Cambodian
- o Chinese
- o Filipino
- o Hmong
- o Indian
- o Japanese
- o Korean
- o Laotian
- o Thai
- o Vietnamese
- o Other Asian (please specify)

d) African
- o Cape Verdean
- o Egyptian
- o Ethiopian
- o Nigerian
- o Sudanese
- o Other African (please specify)

e) Caribbean
- o Cuban
- o Dominican Republic
- o Haitian
- o Jamaican
- o Puerto Rican
- o Other Caribbean (please specify)

f) Australia and Pacific Islanders (including Hawaii)

Senior Career Professionals (21+ years since doctorate)

Please indicate your professional credentials

- Open Text:
- Master's Student
- Doctoral Student
- LAPC's Associate's Clinical Mental Health Counselor
- LPC's /CMHC
- MSW's
- LCSW's
- Licensed Marriage and Family Therapist
- PhD (specify area of practice)
- PsyD
- Certified Rehabilitation Counselor (CRC)
- Other

Areas of interest/specializations?

General
Clinical Child
Rehabilitation
Neuropsychology
Health Psychology
Counseling
Clinical
School
Geropsychology
Other

What type of setting do you practice in?

VA
Hospital/Medical
University/Educational
Community Mental Health
Forensic/Judicial
Independent Practice
Other

Have you previously or are you currently working with clients with disabilities?

Open Text:
Yes

- Automatically populate a follow-up question
- In what capacity? (e.g. assessment, case management, counseling via open text maybe?)

No

Appendix C

MULTIDIMENSIONAL ATTITUDES SCALE TOWARD PERSONS WITH DISABILITIES (MAS)

Vignette:

"Imagine the following situation. Alex went out for lunch with some friends to a coffee shop. A person using a wheelchair, with whom Alex is not acquainted, enters the coffee shop and joins the group. Alex is introduced to this person, and shortly thereafter, everyone else leaves, with only Alex and the person using the wheelchair remaining alone together at the table. Alex has 15 minutes to wait for their ride. Try to imagine the situation."

People experience a variety of *emotions* when they are involved in such a situation. In the next column is a list of possible emotions, which may arise before, during, and/or after such a situation. Please rate on each line the likelihood that this *emotion* might arise in Alex.

	Degree of Likelihood				
Affect	**Not At All**				**Very Much**
Tension	1	2	3	4	5
Stress	1	2	3	4	5
Helplessness	1	2	3	4	5
Nervousness	1	2	3	4	5
Shame	1	2	3	4	5
Relaxation	1	2	3	4	5
Serenity	1	2	3	4	5
Calmness	1	2	3	4	5
Depression	1	2	3	4	5
Fear	1	2	3	4	5
Upset	1	2	3	4	5
Guilt	1	2	3	4	5
Shyness	1	2	3	4	5
Pity	1	2	3	4	5

Disgust	1	2	3	4	5
Alertness	1	2	3	4	5

People experience a variety of *cognitions* when they are involved in such a situation. Following is a list of possible thoughts that may arise before, during, and/or after such a situation. Please rate on each line the likelihood that this *cognition* might arise in Alex:

	Degree of Likelihood				
Cognitions	**Not At All**				**Very Much**
They seem to be an interesting person.	1	2	3	4	5
They look like an OK person.	1	2	3	4	5
We may get along really well.	1	2	3	4	5
They look friendly.	1	2	3	4	5
I enjoy meeting new people.	1	2	3	4	5
They will enjoy getting to know me.	1	2	3	4	5
I can always talk with them about things that interest both of us.	1	2	3	4	5
I can make them feel more comfortable.	1	2	3	4	5
Why not get to know them better?	1	2	3	4	5
They will appreciate it if I start a conversation.	1	2	3	4	5

People experience a variety of *behaviors* when they are involved in such a situation. Following is a list of possible behaviors that may arise before, during, and/or after such a situation. Please rate on each line the likelihood that Alex would *behave* in the following manner:

		Degree of Likelihood			
Behavior	**Not At All**				**Very Much**
Move Away	1	2	3	4	5
Get up and leave	1	2	3	4	5
Read the newspaper or talk on a cell phone.	1	2	3	4	5
Continue what they're doing.	1	2	3	4	5
Find an excuse to leave.	1	2	3	4	5
Move to another table.	1	2	3	4	5
Initiate a conversation if they don't make the first move.	1	2	3	4	5
Start a conversation.	1	2	3	4	5