“Let them shine”: Attitudes Towards People with Intellectual Disabilities in the British Bangladeshi Community

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Thesis declaration form

I confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

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Overview

Part 1 presents a systematic review with a narrative synthesis exploring public attitudes towards intellectual disabilities in Asian countries. A total of 25 studies conducted across seven countries were identified. The findings suggest that stigma towards individuals with intellectual disabilities persists across these contexts, although more recent research is needed to draw robust conclusions. It is recommended that future studies adopt longitudinal designs and focus on action-oriented approaches.

Part 2 presents a mixed-methods empirical study conducted in the UK about the attitudes held by the British Bangladeshi population about people with intellectual disabilities. A total of 102 participants took part in the study. Findings revealed that attitudes towards people with intellectual disabilities within the community are nuanced; whilst some participants expressed empathy and a desire for greater inclusion, others reflected stigma and discomfort. There was, however, a strong shared interest in tackling stigma from within the community. Moving forwards, studies promoting collective action may prove valuable.

Part 3 offers a critical reflection on the research process, addressing challenges encountered during participant recruitment, navigating complex geopolitical contexts, and conducting research with a marginalised group in the UK. It includes a reflexive account examining how my insider positionality and personal experiences of stigma influenced both my motivation for undertaking the study and the overall research process.

Impact statement

Stigma continues to significantly affect people with intellectual disabilities, however, most research on this matter has been concentrated in Western contexts, leaving the extent, expression, and impact of stigma in Asian and diaspora communities largely underexplored and unknown. This thesis contributes to the field of disability justice studies; a framework rooted in social justice that examines how societal structures and power relations create and sustain disability. Disability justice emphasises the interconnectedness of disability with other forms of oppression, such as racism, sexism, and classism, and centres the lived experiences of marginalised communities. Within this framework, examining public attitudes towards individuals with intellectual disabilities is critical, as the publics attitudes often reflect and reinforce broader systems of exclusion. Understanding these attitudes is therefore not only an academic concern but also essential for promoting inclusion and upholding fundamental human rights.

The findings of Part 1, the systematic review, strengthen the evidence base by highlighting critical gaps in research on public attitudes towards individuals with intellectual disabilities, particularly in South Asian countries. Addressing these gaps is essential in terms of identifying targets for attitude change efforts and addressing social determinants that affect the quality of life of persons with intellectual disabilities. This work underscores the urgent need for cross-cultural research and draws attention to the neglect of disability stigma in non-Western contexts, helping rebalance the global literature. This work paves the way for more inclusive policies and targeted interventions that promote social justice and accessibility worldwide.

The findings of Part 2, the empirical study, address a significant gap in the evidence base by exploring public attitudes towards people with intellectual disabilities within the British Bangladeshi community, a group largely absent from existing Western dominated studies. This study is among the first to explore British Bangladeshi lay attitudes towards people with intellectual disabilities, offering culturally grounded insights that can help improve their inclusion, rights, and lived experiences within the community. The findings suggest that there are some negative attitudes amongst the British Bangladeshi community; however, most participants had a keen interest in wanting to endorse the inclusion of people with intellectual disabilities and uphold their human rights.

This study demonstrated how factors such as religion and culture intersect to shape societal attitudes towards people with intellectual disabilities, with implications for their inclusion and future intervention studies. These findings can support service providers and policymakers in developing appropriate, community-based interventions aimed at reducing stigma, and supporting people with intellectual disabilities and their carers who are known to suffer in silence. This study contributes to academic and policy debates on disability justice, advocating for the rights and recognition of people with intellectual disabilities, especially within minoritised communities.

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Part 1: Literature Review

Attitudes of Community Members Towards People with Intellectual Disabilities in Asian Countries: A Systematic Review

Abstract

Background: Public attitudes towards people with intellectual disabilities can significantly impact the effectiveness of interventions and policies designed to promote inclusion and uphold their equal rights. This review systematically examines research on awareness and attitudes within the general population across Asian countries to provide a clearer understanding of the current landscape.

Method: A literature review was conducted using PsycINFO, Embase and Scopus. The search returned 1029 articles, of which 25 met the inclusion criteria. Their quality was appraised and their findings narratively synthesised.

Results: The 25 articles pertained to 22 studies examining public attitudes towards people with intellectual disabilities. There appears to be misconceptions and superstitious beliefs about intellectual disabilities across Asian countries. Prior contact and higher educational attainment were consistently associated with more positive attitudes. However, the effects of age and gender on attitudes were mixed. Evidence is limited as most studies relied on small, non-representative samples and used cross-sectional designs.

Conclusion: The evidence indicates that individuals in the general population who have had prior contact with people with intellectual disabilities, have higher levels of education, or come from more developed regions tend to hold more positive attitudes towards people with intellectual disabilities. This review also identifies key areas for future research, highlighting the importance of culturally sensitive approaches and interventions.

Introduction

People with intellectual disabilities have been described as "*probably the most marginal group of disabled people in both society and in research*" (Mietola, 2017). Historically, they have faced extreme persecution; for instance, the Nazi regime's 'euthanasia programme' systematically targeted and killed thousands of disabled people (Proctor 1988). Despite this dark history, individuals with intellectual disabilities continue to face social exclusion and stigma in modern day society. Intellectual disabilities are defined by intellectual impairments and notable difficulties in at least two areas of adaptive functioning, with onset occurring before adulthood (World Health Organization, 2022).

Firstly, if we understand the term stigma in its Greek etymology, which was to mark, tattoo, scar, burn or place a dot or sign on the skin of slaves or those who had committed a crime, stigma came to be understood as "an attribute that is deeply discrediting and reduces the bearer from a whole and usual person to a tainted, discounted one" (Goffman, 1963). Stigma is a complex social phenomenon reflecting negative societal attitudes, stereotypes, and discriminatory behaviours directed towards marginalised groups (Corrigan & Watson, 2002). It manifests through both attitudes and behaviours, as people's perceptions often shape how they act and respond to others (McCaughey & Strohmer, 2005). To understand this relationship between attitudes and behaviour, the Theory of Planned Behaviour (Ajzen, 1985) provides a useful framework. This theory proposes that behaviour is most immediately predicted by an individual's intention to act, which is influenced by three factors: attitudes towards the behaviour, perceived social norms, and perceived behavioural control. Moreover, perceived behavioural control can directly affect behaviour when it accurately reflects an individual's actual ability to perform the action (Hardeman et al., 2002). Taken together, the theory highlights the significance of attitudes in shaping behaviour, suggesting that fostering positive attitudes may promote more inclusive social outcomes. Supporting this, a seminal meta-analysis ($k = 128$ conditions; $N = 4{,}598$) by Glasman and Albarracín (2006) found that attitudes significantly predict behaviour, reinforcing the idea that negative attitudes can perpetuate discriminatory responses towards stigmatised groups.

In addition to the Theory of Planned Behaviour, several other psychological theories help explain why people with intellectual disabilities may be viewed and treated differently. Social Identity Theory (Tajfel and Turner, 1979) provides insight into marginalisation by suggesting that people tend to categorise others into in-groups and out-groups. Individuals with intellectual disabilities may be perceived as out-group members, which can lead to devaluation, social distancing, or exclusion.

How are people with intellectual disabilities treated and viewed in Asian countries?

A plethora of studies suggest that people with intellectual disabilities are stigmatised, discriminated and experience some of the most difficult living conditions in the world (Ditchman et al., 2016; Heitplatz et al., 2020; Pelleboer-Gunnink et al., 2017; Scior, 2011; WHO; 2007). There are many reasons as to why this may be the case, such as, widespread misconceptions about the causes of intellectual disabilities, political and attitudinal barriers (Hussey, MacLachlan, & Mij, 2016; Scior & Furnham, 2016). Some researchers argue that members of the general population may have developed negative beliefs partly due to the lasting and disabling impacts of eugenic movements and colonialism (McConnell & Phelan, 2022; Meekosha, 2011). Whilst this is not the fault of the community, negative attitudes unjustly dehumanise people with intellectual disabilities, breach their human rights and negate the fullness of their human experience.

As a result of negative attitudes in society, people with intellectual disabilities often experience abuse, neglect and ostracisation from society (Byrne, 2017, Reiter et al., 2007; Rohwerder, 2013; Tomsa et al., 2021; Siperstein et al., 2005). Moreover, people with intellectual disabilities often have poor physical and mental health (Emerson et al., 2016; Perera et al., 2019). Whilst efforts have been made at local, national, and international levels to improve attitudes (for example, WHO, 2007), negative beliefs in society continue to persist. The effectiveness of policies promoting the social inclusion of people with intellectual disabilities largely relies on the public's openness to accepting, welcoming, and engaging with them. Asia is the world's largest continent, home to nearly 60% of the global population. However, understanding of the life circumstances of people with intellectual disabilities and public attitudes towards them in Asian countries is limited, as most research has been conducted with Western populations (Fujiura et al. 2005; Jeevanandam 2009). Parmenter (2008) argues that the adoption of Western-style, consumer driven economic models by some Asian countries may contribute to the reproduction of exclusionary patterns, whereby certain marginalised groups, such as people with intellectual disabilities, are constructed as the "other" and their contributions to society are undervalued.

Why might negative attitudes continue to prevail across Asian countries?

Stigma is not a static phenomenon, it is shaped by changing social, cultural, and political contexts. Although modernisation, psychology, and Western medicine influence perceptions, historical experiences such as colonialism and eugenics continue to shape stigma towards people with intellectual disabilities today. Recognising that multiple factors cause stigma can helps us understand the biases and highlights points for change at both the individual and systemic levels. These intersecting influences will be explored in turn below to better understand how stigma operates and how it might be challenged.

Tyler and Slater (2018), argue stigma is a political mechanism which operates at various levels, such as media and policy to legitimise inequality. These processes are not isolated; they are shaped by historical legacies, including those of European colonialism and imperialism, which exported and embedded hierarchical worldviews and negative stereotypes into global structures. As Grech (2014) argues, the history of colonialism remains significant as its impacts have not simply vanished, rather, colonialism continues to underpin the ideological and cultural foundations of ongoing domination in the Global South. Gretch (2014) further suggested that disabled people in formerly colonised countries experience ongoing marginalisation shaped by colonial history. Thus, he positions people within neocolonial countries as “neocolonised bodies”, highlighting how their current experiences are shaped by complex histories of oppression (Grech, 2014). Moreover, the concept of the “coloniality of knowledge” describes how indigenous or traditional knowledges from non-Western societies have often been demonised or portrayed as inferior, while simultaneously being appropriated to serve imperial interests and reinforce white supremacy (Ramugondo, Lepere & Nebe, 2018).

The Department of Economic and Social Affairs of the United Nations have suggested that in Africa attitudes towards people with disabilities prior to colonisation may have been more respectful, but colonialism and the introduction of medical models of disability introduced more stigmatising ways of being (United Nations

Department of Economic and Social Affairs, 2016). Whilst this report focuses on the challenges faced in Africa, similar issues regarding stigma and inclusion may also be the case in Asian countries, were historical and social contexts shape attitudes towards disabilities. The violence imposed by colonisers on people from the Global South were extensive. Colonial violence harmed people but also reinforced social categories of difference. Colonisation was used to justify oppression, which has likely created lasting stigmas and social hierarchies in society (Grech, 2014).

This is not to say stigma towards disabilities did not exist prior to colonisation, but rather that, colonisation likely intensified stigma and processes of othering by imposing Western biomedical and moral frameworks. This shift became particularly evident with the rise of eugenics, a pseudo-scientific ideology aimed at “improving the genetic quality of the human population” by discouraging the reproduction of those deemed to have "undesirable" traits, and promoting people seen as genetically "fit". The term was coined by British scientist Francis Galton in 1883 (Galton, 1883). Eugenics became deeply embedded in colonial thinking, reinforcing racial and ableist hierarchies and legitimising social exclusion through the guise of scientific progress. One way in which this was manifested was the legislation of forced sterilisation of disabled people, which occurred across the world (Sobański & Kmieciak, 2020).

Traces of eugenic thinking persist in certain laws and policies in several post-colonial Asian countries that have contributed to the marginalisation of people with intellectual disabilities, often framed in terms of public health or population control. For example, Japan enacted the National Eugenics Law 1940, where people with disabilities were forcibly sterilised. This policy remained in place under the Eugenic Protection Law until it was replaced by the Motherhood Protection Act in 1996 (Park

& Park, 2022). In China, influenced by both Western and Soviet eugenics, enacted the Maternal and Infant Health Care Law (1995) to help “improve population quality” (Moran, 2016). In 1980s Singapore, “educated women” were encouraged to have more children, a policy that may be seen as a benign form of eugenics, aiming to improving the national gene pool (Chan, 1985). In India, the legacy of population control persists through ongoing efforts to reduce birth rates, often disproportionately targeting marginalised communities (Rowlands & Amy, 2017). Whilst direct evidence of the sterilisation of people with intellectual disabilities remains limited in the Global South, the absence of literature does not necessarily indicate an absence of unjust practices that may have occurred (Rowlands & Amy, 2017). These historical eugenic policies have likely had lasting impacts on societal attitudes and state policies, as they are inherently stigmatising and violate the physical integrity of people with intellectual disabilities (Rowlands & Amy, 2017). Understanding this legacy is crucial for examining how stigma and exclusion are perpetuated today. This understanding can inform culturally sensitive approaches that promote inclusion and uphold the human rights of people with intellectual disabilities.

Attitudes are learned and shaped by a range of factors, including social influences, cultural norms, and personal experiences (Shrigley et al., 1988; Kelman et al., 1970). When these attitudes are negative, this can lead to public stigma. Public stigma refers to stereotypical beliefs, prejudicial attitudes, and discriminatory behaviours endorsed by the general population towards individuals with a discredited attribute (Corrigan & Watson 2002). By identifying and understanding attitudes towards people with intellectual disabilities, we can better define factors that hinder or facilitate their social inclusion, as well promote the development and effectiveness of necessary interventions to help integrate people with intellectual disabilities into society, thus the general population can see this group hopefully through a different, non-stigmatising lens. Little is known about public perceptions in Asian countries. Understanding these attitudes is essential for promoting social inclusion, which forms the rationale for the current review. Therefore, this review aims to explore public perceptions, factors influencing attitudes, and prevalent causal beliefs across Asian populations, where cultural norms may further shape psychological processes. To date, only one review has examined public awareness, attitudes and beliefs about people with intellectual disabilities globally (Scior, 2011), which is currently outdated.

Aims and objectives of this systematic review

The aim of this systematic review was to explore existing knowledge on public attitudes toward people with intellectual disabilities across Asian countries, a region where research remains limited. The review was guided by the following research questions:

1. What perceptions and beliefs do the general population across Asian countries have about people with intellectual disabilities?
2. What factors influence attitudes towards people with intellectual disabilities?
3. What beliefs about the causes of intellectual disabilities are prevalent among the public?

By addressing these questions, the review aims to provide a culturally informed understanding of public attitudes and to inform interventions promoting social inclusion of people with intellectual disabilities across diverse Asian contexts.

Methods

Registration

The current review was conducted in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Moher et al., 2009). It was registered on the Prospective Register of Systematic Reviews (PROSPERO) (registration number: CRD42024573650).

Search strategy

The full search terms are detailed in Appendix A. Asian countries listed under the United Nations Statistics Division (2013) were considered for the review. Although parts of Russia and Middle Eastern countries are geographically located in Asia, these countries are culturally dissimilar from the rest of Asia and were therefore excluded. The searches were conducted on 31st August 2024, using PsycINFO, EMBASE and Scopus. Google Scholar and Elicit were searched to identify any additional published studies that the database search might have missed. The reference lists of all relevant articles were also searched for additional studies that met the inclusion criteria.

Eligibility Criteria

Inclusion criteria:

- Studies conducted in the following Asian countries: Afghanistan, Bangladesh, Bhutan, Brunei, Cambodia, China, India, Indonesia, Iran, Japan, Kazakhstan, Kyrgyzstan, Laos, Malaysia, Maldives, Mongolia, Myanmar, Nepal, North Korea, Pakistan, Philippines, Singapore, South Korea, Sri Lanka, Tajikistan, Thailand, Timor-Leste, Turkmenistan, Uzbekistan, Vietnam.

- Studies which examined attitudes/stigma/perceptions among the general population and/or at community level about people with intellectual disabilities.
- Studies published in peer-reviewed journals.
- Empirical methodologies employing either qualitative or quantitative methodologies. To ensure a broad scope, the review included studies of all designs, including cohort, epidemiological, cross-sectional, longitudinal, randomised, and case-control studies.
- All population groups of any age.
- Articles published from database inception to August 2024.

Exclusion criteria:

- Studies not reported in English.
- Grey literature (unpublished theses, discussion papers or abstracts).
- Studies focused on future service providers, such as medical students or trainee teachers.
- Secondary studies such as systematic reviews or meta-analyses.

Review process and screening

The search strategy yielded 1029 items (Fig. 1), which were exported to EndNote. Following automatic removal of 294 duplicates, 735 articles remained to be screed at title and abstract phase against the inclusion and exclusion criteria. One researcher screened all titles and abstracts of retrieved records. 20% of titles and abstracts were screened by a second independent reviewer (LS). At the subsequent full text stage, both the main researcher and a second reviewer (TW) screened 100% of the full text articles and reached consensus regarding whether they should be included or excluded. Interrater reliability between the two reviewers (KA and LS) was substantial during the title and abstract screening process (Cohen’s k = 0.76; McHugh, 2012; Gisev, Bell, & Chen, 2013). Interrater reliability between the two reviewers (KA and TW) was substantial during the full text review process (Cohen’s k = 0.76; McHugh, 2012; Gisev, Bell, & Chen, 2013). Conflicts were reconciled by the research supervisor. The final articles were then exported into Microsoft Excel for data extraction.

Figure 1

Flowchart of the study selection process

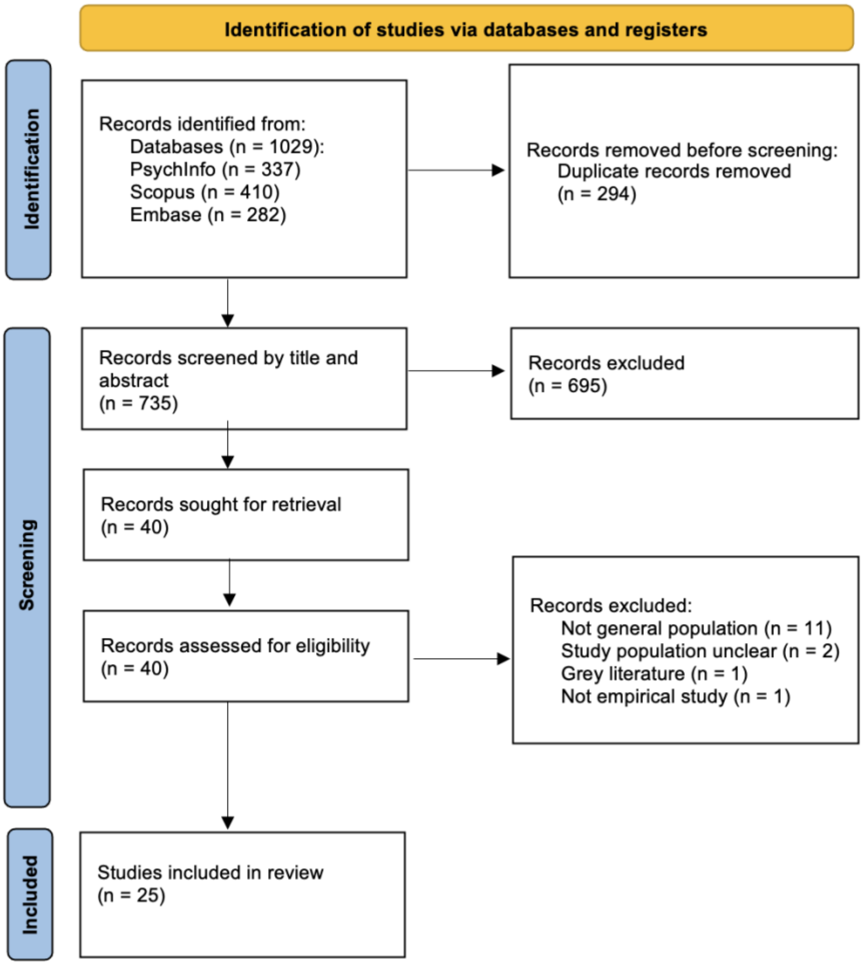

Figure 1. PRISMA 2020 flow diagram adapted from Haddaway et al. (2022).

Quality assessment of included studies

Methodological recommendations from PRISMA were followed to assess the quality of studies found eligible for this review (Moher et al., 2009). The QualSyst and QuantSyst tools (Kmet et al., 2004) were used to critically appraise the included papers, providing a systematic and reproducible method for evaluating research quality across various study designs. Prior to their development, quality appraisal methods varied widely for qualitative and quantitative studies, making comparisons across studies difficult. QualSyst was designed specifically for qualitative research, evaluating criteria such as clarity of research question, rigor of data collection and analysis, and credibility of findings. QuantSyst was developed for quantitative studies, assessing aspects including study design, sampling, measurement validity, and completeness of outcome reporting. By providing clear scoring criteria and a summary score, these tools allow reviewers to make transparent, reproducible judgments about study quality and facilitate the synthesis of evidence across studies in systematic reviews.

The QualSyst was applied to qualitative studies, assessing 14 criteria including clarity of research question, appropriateness of study design, rigor of data collection and analysis, and credibility, transferability, and confirmability of findings. The QuantSyst was applied to quantitative studies, assessing 14 criteria including clarity of objectives, appropriateness of study design and sampling, validity and reliability of measurement instruments, and completeness of outcome reporting, including estimates of variance and effect sizes.

Each study was scored on all relevant criteria: Yes = 2, Partial = 1, No = 0, N/A = not applicable, depending on the extent to which the criterion was met. Scores were summed and normalised to a summary score (0–1.0**)**, with higher scores indicating higher methodological quality. A summary score ≥0.8 was considered high quality, 0.6–0.79 moderate, and <0.6 low quality. All studies were independently assessed by two reviewers (the main researcher and an independent reviewer, TW), and inter-rater reliability was calculated using the intraclass correlation coefficient (ICC = .896, 95% CI [.770, .953]), indicating good agreement (Koo & Li, 2016).

Table 3 presents the full quality assessment results, showing individual criterion scores, summary scores, quality ratings, and brief notes on key strengths and limitations. For quantitative studies, criteria 1 (research question/objective) and 2 (study design) generally scored highly, whereas criterion 11 (reporting of variance for main outcomes) was often under-reported, limiting the robustness of some conclusions. Studies not reporting effect sizes are highlighted in the narrative synthesis below.

Data extraction

A data extraction sheet was created in Excel to summarise the findings from the 25 studies included in the review. The characteristics extracted were: author(s), year, country, research design, control group (if appropriate), measure of stigma, age, sample, aims, and key findings (including correlation coefficients, comparison of high and low scores, means, and standard deviation where appropriate).

Synthesis of results

As anticipated, the study designs, measures and reported outcomes varied widely between in the studies included in this review; therefore, this review describes eligible studies using a narrative synthesis. Popay et al. (2006) described narrative synthesis as an approach of synthesising findings from multiple studies, with an emphasis on the use of words and text to summarise and explain the results of data synthesis. Therefore, there are three stages of narrative synthesis which included the development of a preliminary synthesis, exploration of the relationships within and between studies, and exploration of the robustness of the synthesis. A meta-analysis was not undertaken due to the heterogeneity of the studies included, and due to the file drawer issue, which rests on the assumption that non-significant results are less likely to be published in primary-level studies, therefore less likely to be included in meta-analyses (Rosenthal, 1979). All studies were included irrespective of whether they reported a statistical association, enabling a more comprehensive synthesis of the evidence to inform policy and practice and guide future research.

Results

Overview of studies

This review included 25 papers, which reported on 22 unique studies (see Table 2 for an overview of each study included). Three papers were follow-up analyses or extensions of earlier studies. Studies included were conducted across seven different countries (see Figure 1). The largest number of studies were conducted in the East Asia region, including China (N=9), Japan (N=7), and South Korea (N=1). The second-largest number of studies came from South Asia, including India (N=5), Bangladesh (N=1), and Pakistan (N=1). Finally, only one study was included from the Southeast Asia region, specifically Indonesia (N=1).

The ages of the samples in the included studies ranged from 4 to 55+ years. Only two studies conducted research with a child population, with the ages of the participants ranging from 4 to 16 years old (Tang et al., 2000). In the other child study, the authors did not report the age of participating children (George et al., 2014). Studies recruited participants from various sections of the community; the majority sampled students. One study did not report the number of participants they had recruited (Ojha, 1993).

Two studies used stratified sampling (Siperstein et al., 2011;Zaman et al., 1987). All other studies utilised convenience sampling. Two studies aimed to increase participants' awareness and improve attitudes among lay people (Ojha et al., 1993; Li & Wang, 2013).

The included studies employed a diverse set of psychometric instruments to assess the publics attitudes towards people with intellectual disabilities. Whilst most tools were standardised and validated, this variation in outcome measures introduces some limitations in cross-study comparability. See Table 1 for further details.

Figure 2

Countries included in the systematic review

Table 1
Overview of included studies psychometric tools

Psychometric tool	Outcome domain	Number of studies (n)	Authors of study (year)
Mental Retardation Attitude Inventory – Revised (MRAI-R; Antonak & Harth, 1994)	affective, cognitive and behavioural intentions	5	Hampton & Xiao, (2009, 2013); Horner-Johnson et al. (2002); Li & Wang, (2013); Li & Wu, (2019)
Community Living Attitudes Scale - Mental Retardation (CLAS-MR; Henry, Keys, Balcazar, et al., 1996)	empowerment, exclusion, sheltering, similarity of people with intellectual disabilities	4	Horner-Johnson et al. (2002); Scior et al. (2010); Patka et al. (2013); Su et al. (2015)
Chinese Value Survey (CVS; Chinese Culture Connection, 1987)	culture values perseverance, thrift, respect for tradition, and social obligations over short-term gains.	2	Hampton & Xiao, (2009; 2013)
Scale of Attitudes toward Disabled Persons (SADP; Antonak, 1982)	affective, cognitive, and behavioural components of attitudes.	2	Chan et al. (1988); Choi & Lam, (2001)
Scale of Attitudes Toward Mental Retardation and Eugenics (AMRE; Antonak et al., 1993)	explores eugenic beliefs towards people with intellectual disabilities	1	Horner-Johnson et al. (2002)
Marlowe-Crowne Social Desirability Scale (MCSDS short form; Strahan & Gerbasi, 1972)	social desirability of people with intellectual disabilities	1	Horner-Johnson et al. (2002)
Attitude Toward Mental Retardation (ATMR; Gash et al., 1993)	evaluates children's attitudes towards intellectual disabilities	1	Tang Davis Wu & Oliver, (2000)
Multinational Youth Attitudes Toward Inclusion (MYAI; Siperstein et al., 2007)	perceived competence, social acceptance/willingness to interact and support for inclusive education for people with intellectual disabilities	1	Siperstein et al. (2011)
Attitudes to Sexuality Questionnaire–Individuals with an Intellectual Disability (ASQ-ID; Cuskelly & Gilmore, 2007)	assess attitudes toward sexuality in people with intellectual disabilities	1	Evlyn et al. (2021)

Table 2
Overview of studies included in the review

Authors (year)	Study design and focus	Location	Sample (N)	Data collection methods	Data analysis methods	Key findings relevant to the review
Murthy, Wig, and Dhir, (1980)	Qualitative; Community attitudes towards ID in India.	India	N = 108 Community health workers, village leaders, schoolteacher.	Interview using a vignette developed by the authors and questions about reaction to boy in vignette: illness, likely causes, treatment, social acceptance	Not reported	• Participants knowledge about ID incorrect. • Medical treatment was emphasised. • Majority of participants thought that people with ID should stay in the family, not work or get married.
Zaman et al. (1987)	Mixed-methods Attitudes and knowledge regarding ID in rural/urban areas.	Bangladesh	N = 240 - 80 specialists (80 urban) -80 general public (40 rural, 40 urban) - 80 parents of children with ID (48 urban, 32 rural)	2 semi-structured questionnaires developed by the authors: one for specialists and one for general public (17 items), parents (22 items). Administered via interviews for general public and parents, specialists completed questionnaire themselves.	Chi squared analysis	• Differences between all groups in attitudes and knowledge regarding definition, possible causes, rights and privileges, rituals, services and treatment, and legal rights of ID. • Parents held more scientific views than the public in knowledge and perceptions about ID. • Participants from urban areas held more positive attitudes and had more awareness than rural participants.
Chan et al. (1988)	Survey. Examined attitudes towards three major disabilities groups (physical disabilities, ID, mental health issues	China, Hong Kong	N = 338 Secondary school students	Scale of Attitudes toward Disabled Persons (SADP; Antonak, 1982) translated into Chinese to assess community attitudes.	Analysis of variance (ANOVA)	• HK students held more positive attitudes towards people with physical disabilities than people with ID or mental health issues • Attitudes did not differ towards people with ID and people with mental health issues • Personal contact associated with improved attitudes for both people with ID and people with mental health issues. • No sex differences

Table 2
Overview of studies included in the review

Authors (year)	Study design and focus	Location	Sample (N)	Data collection methods	Data analysis methods	Key findings relevant to the review
Dhillon and Chaudhuri, (1990)	Survey. Examine the 'meaning' of ID in the community.	India	N = 120 Community: parents, teachers and doctors.	Semantic differential scale developed by the authors, consisting of 21 bipolar adjective scales measuring 3 factors: evaluation, potency and activity.	Descriptives and a one-way ANOVA.	• Overall negative attitudes towards people with ID • Participants not closely associated with people with ID held a slightly more negative image of ID than those with a relative with ID • Parents of children with ID held more positive attitudes towards people with ID than other groups
Madhavan et al. (1990)	Survey Case vignette	India (rural Hyderabad)	N = 289 246 parents & 43 community health volunteers (+67 teachers and 37 midwife trainees)	Case vignette of boy with severe ID followed by 5 open ended questions	Descriptives	• Approximately half of parents and community health workers were able to recognise ID in the vignette
Ojha et al. (1993)	Quantitative Effects of an integrated education programme	India, New Delhi	N = not reported (assumed N = 43) Slum dwellers	Effects of an integrated education programme consisting of a film, slides and vignette of ID assessed by a questionnaire developed by NIMH in India.	T-tests	• Increased awareness of ID post-intervention • Pre-tests showed parents seen as at fault for ID (32.65%) and post-tests showed belief in pre-natal causes (32.6%) • Idea of marriage as cure evident in pre-tests but not in post-tests

Table 2
Overview of studies included in the review

Authors (year)	Study design and focus	Location	Sample (N)	Data collection methods	Data analysis methods	Key findings relevant to the review
Lau and Cheung, (1999)	Quantitative survey Investigated discriminatory attitudes towards people with ID and mental heath	China, Hong Kong	N = 822 General population	Telephone interviews using 9 items developed by the authors to understand control, rejection and keeping people with ID away.	Linear regression	• Discrimination higher towards people with mental health difficulties than ID • Contact in past 6 months associated with less discrimination • Social distance much lower for ID then mental health problems. 8.3% would mind people with ID as a neighbour, compared to 34.7% for mental health problems.
Tang, Davis, Wu and Oliver, (2000)	Qualitative study Attitudes of school children towards people with ID, compared to previous Irish data	Japan	N = 481 Kindergarten: 62, Primary school: 380, Secondary school: 39	Face-to-face interviews using the Attitude Toward Mental Retardation (Gash et al., 1993) which was translated into Chinese	Factor analysis 2-way ANOVA	• Age had an effect on attitudes. • Children in kindergarten and primary school held more positive attitudes than secondary school children. • No sex differences.
Choi and Lam, (2001)	Quantitative survey Investigating the effects of acculturation influencing attitudes towards disabilities.	South Korea and USA	N = 359 Student population	Scale of Attitudes towards Disabled Persons (SADAP; Antonak, 1982).	2-way ANOVA	• Contact associated with more positive attitudes • No differences between Korean American and Korean student on attitudes to physical disabilities, but Korean people held more negative views regarding ID

Table 2
Overview of studies included in the review

Horner-Johnson et al. (2002)	Quantitative survey Exploring attitudes of Japanese students towards people with ID, how they structure and organise their attitudes	Japan	N = 286 University students	1) CLAS-MR (Henry, Keys, Balcazar, et al. 1996), (2) MRAI-R (Antonak & Harth, 1994) (3) AMRE (Antonak et al., 1993) (4) MCSDS short form (Strahan & Gerbasi, 1972)	Confirmatory factor analysis	• Participants with a friend or relative with ID more likely to endorse rights of people with ID • Those with friend or relative with ID more likely to endorse rights of people with ID
Tachibana and Watanabe, (2003)	Quantitative survey Exploring attitudes of parents recruited through 2 primary schools to assess the influence of schemata on attitudes.	Japan	N = 375 Parents of children in two elementary schools	25-item scale developed by the authors: attitudes, knowledge and beliefs re. intellectual disabilities,	Multiple regression	• Prevalence of ID underestimated at 0.5% • ID due to heredity causes estimated at 10% and those who thought this had more negative attitudes towards people with ID • No clear associated between prevalence estimates and attitudes • Demographic variables associated with more positive attitudes: had a family member with ID, familiarity with ID through a friend, volunteer work.
Tachibana and Watanabe, (2004a)	Quantitative survey; Exploring differences in attitudes towards people with ID, e.g, between those who have a member with ID and those without	Japan	N = 2381 Parents recruited through 11 elementary schools	16-item scale developed by authors: attitudes to integration of people with ID	Not reported	• Age (younger) and having a friend who has family member with ID associated with more positive attitudes • If family member had ID, less positive attitudes than expected
Tachibana and Watanabe, (2004b)	Survey Attitudes of Japanese adults toward persons with ID – results compared to surveys	Japan	N = 2381 Parents recruited through 11 element schools (same sample as Tachibana 2005)	16-item scale developed by authors: attitudes to integration of people with ID	Not reported	• Over time attitudes in Japan have become more positive • Only 30% of the participants agreed with community living

Table 2
Overview of studies included in the review

	completed 20 & 40 years earlier					
Tachibana, (2005)	Survey Experiences that shape perceptions towards people with ID	Japan	N = 2381 Parents recruited through 11 elementary schools	As Tachibana (2004)	Categorization of responses Cluster analysis	• Negative contact experiences with individuals with ID, especially in childhood, strongly associated with negative attitudes • Most respondents judged self as holding more positive attitudes than average person
Tachibana, (2006)	Survey Perceptions and attitudes from parents about ID	Japan	N = 2381 Parents recruited through 11 elementary schools	As Tachibana (2004)	Cluster analysis	• Participants underestimated prevalence of ID at 0.5% • Participants estimated ID due to hereditary causes at 10% • Attitudes associated with estimated proportion of hereditary cause, and possibility of ID in a participant's future family.
Scior et al. (2010)	Survey. Investigated attitudes towards people with ID in general pop in UK and Hong Kong.	UK and Hong Kong	N = 284 149 Hong Kong residents and 135 White British residents	CLAS-MR (Henry, Keys, Balcazar, et al., 1996)	One-sample t tests	• Chinese adults were higher on Exclusion and Sheltering people with ID and lower on Similarity compared to White British adults • Gender had a small effect size • Age had modest effect on attitudes
Siperstein et al. (2011)	Survey. Focussing on middle school students' attitudes toward peers with ID compared to data previously collected from students in USA.	China	N = 4059 Middle school students	Multinational Youth Attitudes Questionnaire (Siperstein et al. 2007)	Structural equation modelling	• Students with ID perceived as moderately, rather than mildly, impaired. • Participants not willing to interact with a peer with ID in academic tasks. • Youths' perceptions of the competence of people with ID predicted willingness to interact with peers with ID. • Unexpectedly, youths who had direct contact with peers with ID expressed less willingness to interact with them.
Hampton and Xiao, (2009)	Survey. Focussing on university students views on	China	N = 534	The Chinese Value Survey (CVS) (Chinese Culture	Factor analysis, correlation tests and	• Values of cultivation of virtues (benevolence, humanity, and a sense of justice) was positively related to attitudes.

Table 2

Overview of studies included in the review

	people with intellectual disabilities.		University students majoring in regular and special education from two education universities in the People's Republic of China	Connection, 1987) The Mental Retardation Attitude Inventory—Revised (MRAI-R) (Antonak & Harth, 1994)	multiple regression analysis	• Values of social traditionalism and cultural inwardness were negatively correlated with attitudes toward people with intellectual disabilities. • Students majoring in special education or those who had more knowledge of disabilities had more favourable attitudes
Hampton and Xiao, (2013)	Survey. Exploring Chinese university students' attitudes towards people with ID.	China, Beijing	N = 240 Introduction to education class students	Mental Retardation Attitude Inventory – Revised (MRAI-R) (Antonak & Harth, 1994) Chinese Value Survey (CVS) (Chinese Culture Connection, 1987)	Correlation tests and multiple regressions	• Negative attitudes were predicted by Social Traditionalism (held traditional beliefs), and Cultural Inwardness (associated with cultural superiority and intolerance). • Age, gender, ethnicity, and the contact variables were not correlated with attitudes.
Li and Wang, (2013)	Quantitative Experimental study examining the effect of exposure on attitudes of volunteers towards inclusion of people with ID.	China	N = 100 College students	Mental Retardation Attitude Inventory – Revised (MRAI-R) pre and post test Repeated measures, 2 groups 1 week)/follow-up (4 weeks) measure	Factorial analysis with repeated measures	• 1-week exposure to Special Olympic Games enhanced volunteers' positive attitudes towards inclusion of people with ID and maintained up to month follow up. • Female held more favourable attitudes across the groups at all time points
Patka et al. (2013)	Quantitative survey. Attitudes of Pakistani Community Members and Staff	Pakistan, Karachi	N = 262 Community members and 190 disabilities service providers serving people with ID.	Community Living Attitudes Scale towards Mental Retardation (CLAS-MR; Henry et al., 1996) delivered door to door.	Multivariate analysis of variance	• Community members showed more negative attitudes than service providers.

Table 2
Overview of studies included in the review

George et al. (2014)	Qualitative study to understand perspectives towards children with ID (interviews and focus group)	India Selected villages in Bangalore (rural and urban).	N = 39 Children without disabilities sample	Focus group	Inductive thematic analysis	• All children used words like 'deaf', 'dumb', 'blind', 'handicapped' to describe children with disabilities. • Children were ready to accept people with ID and voluntarily promised their wholehearted cooperation to help in any way they could.
Su et al. (2015)	Survey. Examining attitudes towards ID in China	Mainland China	N = 325 Community members	Community Living Attitudes Scale towards Mental Retardation - short form (CLAS-MR; Henry et al., 1996),	Multivariate analysis of variance	• Chinese community members hold positive attitudes towards people with ID generally and disagreed with the exclusion of someone with ID in community life.
Li and Wu, (2019)	Quasi-experimental design. Understanding how Special Olympics programs impact volunteers' self-esteem/attitudes towards people with ID.	China	N = 243 Participants (n = 120) Undergraduate students (not studying special education or a related subject)	Participants attended a pre-service training program and provided a half-day service. The Social Distance subscale from the Mental Retardation Attitude Inventory - Revised (MRAI; Antonak & Harth, 1994) was used to measure participants' tendencies to be associated with individuals with ID.	Independent t-tests, Pearson's correlation and repeated measures analysis of variance.	• The training programme improved volunteers' self-esteem and attitudes regarding inclusion towards people with ID.
Evlyn et al. (2021)	Cross-sectional survey. Attitudes of Indonesian health science undergraduates towards sexuality of individuals with ID.	Indonesia	N = 617 Undergraduate students (medicine, psychology and public health)	Attitudes to Sexuality Questionnaire in Individuals with an Intellectual Disability (ASQ-ID; Cuskelly & Gilmore, 2007)	Descriptives. Mann-Whitney U test also used to compare groups.	• Indonesian undergraduate students majoring in the health science had varying attitudes toward sexuality in individuals with ID. • Medical/psychology students had more favourable attitudes whereas public health students have less favourable attitudes. • Religion influenced the attitudes

Critical appraisal of included studies

Quantitative studies appraisal

The summary scores of the 25 studies included show a broad range of quality appraisal ratings (Table 3). For all quantitative studies criterion 1 (question/objective described sufficiently) and criterion 2 (study design/method appropriate) received high scores, whilst scores for criterion 13 (results reported in sufficient detail) were more mixed. Scores were lowest for criterion 11 (some estimate of variance reported for main results/outcomes) which limits the ability for this review to draw robust conclusions as it is not possible to state if the results are statistically robust. Moreover, studies which did not report an effect size have been noted within the narrative synthesis below.

Amongst the 24 quantitative studies included, the majority were rated as high quality, with summary scores ranging from 0.80 to 1.00. Only one study (Madhavan et al., 1990) was rated as moderate quality (0.72), mainly due to incomplete reporting and limited control of confounding factors. High-quality studies generally employed robust designs, controlled for confounders, and reported clear outcome measures (see table 4 and 5 for quality ratings on each criterion).

Qualitative studies appraisal

One qualitative study was included which had a mixed critical appraisal. The authors did not include a ‘reflexivity of account’ (criterion 10), making it unclear how much the authors’ personal experiences may have influenced the interpretation of the data, thus making it a moderate quality study.

Table 3

Overview of checklist items of the QualSyst and QuantSyst (Kmet et al., 2004)

ITEM NUMBER	CRITERION
	Quantitative QualSyst checklist
1	Question/objective sufficiently described?
2	Study design evident and appropriate?
3	Method of subject selection described and appropriate?
4	Subject characteristics sufficiently described?
5	Random allocation to treatment group described (if possible)?
6	Blinding of investigators reported (if possible)?
7	Blinding of subjects reported (if possible)?
8	Outcome/exposure measures well defined and robust to bias? Means of assessment reported?
9	Sample size appropriate?
10	Analysis described and appropriate?
11	Some estimate of variance reported for main results/outcomes?
12	Controlled for confounding?
13	Results reported in sufficient detail
14	Results support conclusions?

ITEM NUMBER	CRITERION
	Qualitative QualSyst checklist
1	Question/objective sufficiently described?
2	Study design evident and appropriate?
3	Context for the study clear?
4	Connection to a theoretical framework/wider body of knowledge?
5	Sampling strategy described, relevant and justified?
6	Data collection methods clearly described and systematic?
7	Data analysis clearly described, complete and systematic?
8	Use of verification procedure(s) to establish credibility?
9	Conclusions supported by the results?
10	Reflexivity of the account?

Table 4
Quantitative Studies' QuantSyst scores

Study	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**Summary score**	**Quality rating**
Zaman et al. (1987)	2	2	2	2	-	-	-	1	1	1	1	-	2	2	0.80	High
Chan et al. (1988)	2	2	2	2	-	-	-	2	1	2	0	2	2	2	0.81	High
Murthy, Wig, and Dhir (1980)	1	2	2	2	-	-	-	1	2	-	-	-	2	2	0.88	High
Dhillon and Chaudhuri (1990)	2	2	2	2	-	-	-	2	1	2	0	-	2	2	0.85	High
Madhavan et al. (1990)	2	2	2	0	-	-	-	1	2	1	-	-	1	2	0.72	Moderate
Ojha et al. (1993)	2	2	1	2	-	-	-	1	-	1	-	-	2	2	0.81	High
Lau and Cheung (1999)	1	2	2	2	-	-	-	2	2	2	1	-	1	2	0.85	High
Choi and Lam (2001)	2	2	1	2	-	-	-	1	2	2	0	-	2	2	0.80	High
Tang et al. (2000)	2	2	2	2	-	-	-	2	1	2	1	-	2	2	0.9	High
Horner-Johnson et al. (2002)	2	2	2	2	-	-	-	2	1	2	1	-	2	2	0.9	High
Tachibana and Watanabe (2003)	2	2	2	2	1	-	-	2	2	2	1	1	2	2	0.88	High
Tachibana and Watanabe (2004a)	2	2	2	2	-	-	-	2	2	2	1	-	2	2	0.95	High
Tachibana and Watanabe (2004b)	2	2	2	2	-	-	-	2	2	1	2	-	2	2	0.95	High
Tachibana (2005)	2	2	2	2	-	-	-	2	2	2	0	-	2	2	0.9	High
Tachibana (2006)	2	2	2	2	-	-	-	2	1	2	2	-	2	2	0.95	High
Hampton and Xiao (2009)	2	2	2	2	-	-	-	2	1	2	1	-	2	2	0.9	High
Scior et al. (2010)	2	2	2	2	-	-	-	2	2	2	2	-	2	2	1.00	High
Siperstein et al. (2011)	2	2	2	2	-	-	-	2	2	2	2	-	2	2	1.00	High
Hampton and Xiao (2013)	2	2	2	2	-	-	-	2	2	2	1	-	2	2	0.95	High
Li and Wang (2013)	2	2	2	2	-	-	-	2	1	2	1	2	2	2	0.91	High
Patka et al. (2013)	2	2	2	2	-	-	-	2	2	2	1	-	2	2	0.95	High
Su et al. (2015)	2	2	2	2	-	-	-	2	2	2	1	-	2	2	0.95	High
Li and Wu (2019)	2	2	1	2	-	-	-	2	2	2	1	2	2	2	0.91	High
Evlyn et al. (2021)	2	2	2	2	-	-	-	2	1	2	2	-	2	2	0.9	High

Table 5
Qualitative Studies' QualSyst scores

Study	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Summary score**	
George et al., (2014)	2	2	2	1	2	2	2	2	2	0	0.85	Moderate

Note:

A summary score of ≥0.8 was considered high quality, 0.6–0.79 moderate, and <0.6 low quality

Public attitudes and beliefs about people with intellectual disabilities held across Asian countries

An earlier review found that age, education level, and prior contact with people with intellectual disabilities predict attitudes (Scior, 2011). The following section will begin by broadly discussing members of the general population’s attitudes and perceptions of people with intellectual disabilities and will then move onto discussing factors (such as socio-demographics) that may influence attitudes. Outcomes of interventions, cross-cultural comparisons and the impact of prior contact with someone with intellectual disabilities on attitudes will also be considered. The term ‘attitude’ in this review is used with synonymous terms such as ‘views’ or ‘perception’. How these terms were operationalised in each study differ, as well as how ‘attitudes’ were measured, which increases heterogeneity. For example, different studies measured different constructs of attitudes for example, knowledge, self-efficacy, peer acceptance, social distance, stigmatised attitudes, etc.

Lay knowledge and perceptions of people with intellectual disabilities

Attitude surveys were the most popular way to assess lay people’s knowledge, beliefs and perceptions, with 18 of the 25 articles reporting survey data. In South Asia, generally negative perceptions were found in the studies (Dhillon & Chaudhuri, 1990; Madhavan et al., 1990; Ojha et al., 1993; Patka et al., 2013; Zaman et al., 1987). In India participants considered intellectual disabilities to constitute a severe health problem caused by ‘fate’ (Murthy et al., 1980). In Bangladesh, greater endorsement of biomedical causes of intellectual disabilities (for example, malnutrition, consanguinity) was associated with more positive attitudes (Zaman et al., 1987). In Bangladesh, professionals working in city schools and hospitals were also more likely to hold such beliefs compared to the rural and urban general public (Zaman et al., 1987).

Views in East Asia differed from those in South Asia. Chinese community members (mostly young and educated) held mostly positive attitudes towards people with intellectual disabilities. Participants rejected the idea of excluding individuals with intellectual disabilities from community life and viewed them as fundamentally equal in humanity (Su et al., 2015). However, as noted by the authors, the sample was recruited via the internet, which means generalisability across China is low. In another Chinese study, the general population held more stigmatising attitudes towards people with mental health difficulties than towards people with intellectual disabilities; for example, they wanted greater social distance from people with schizophrenia and held overall more negative perceptions and attitudes towards mental health difficulties (Lau & Cheung, 1999). A similar finding was observed among students in China (Chan et al., 1988) and in Korea (Choi & Lam, 2001); participants favoured people with intellectual disabilities over people with mental health difficulties. However, as this is a student sample the results should be treated with caution. In another study in China, student participants were less willing to interact with peers with intellectual disabilities when they perceived them as lacking in competence (Siperstein et al., 2011). In Japan, the general population held incorrect knowledge about intellectual disabilities which was linked to negative attitudes (Tachibana, 2006).

Only one study specifically examined attitudes towards sexuality (Evlyn et al., 2021). This study in Indonesia, a predominately Muslim country, recruited health science undergraduate students and, utilising the ASQ-ID (Cuskelly & Gilmore, 2007), found that religion had a significant effect on attitudes towards nonreproductive sexual behaviour (*p* = .038). Religious participants had less favourable attitudes towards sexuality than those who were not religious.

Few studies measured longitudinal changes of community-based interventions or influences of policies on public attitudes. As stated in Scior (2011) review, Tachibana and Watanabe (2004b) concluded that attitudes in Japan have become more positive over time, however, their analyses were compared with data collected 25 and 40 years earlier, which used different measures and samples, therefore a robust conclusion cannot be drawn. In an experimental study in China (Li & Wang, 2013), exposure to the Special Olympic Games (SOG) improved volunteers' attitudes towards people with intellectual disabilities and this effect was maintained at one month follow-up.

Only one study (Horner-Johnson et al., 2002) included a social desirability measure and found no significant link between social desirability and attitudes towards people with intellectual disabilities.

Effects of socio-demographic characteristics on beliefs and attitudes

Age and attitudes towards people with intellectual disabilities

There have been six studies which have examined the effect of age on attitudes towards people with intellectual disabilities, with mixed results. In Pakistan, a small effect size (η^2 = 03) was found for age (Patka et al., 2013). Moreover, participants between the ages of 18-20 years old had significantly higher endorsement of sheltering of people with intellectual disabilities (i.e., the degree to which participants believe people with intellectual disabilities require protection from harm) than participants between the ages of 21-50 years old (η^2 = .07). The authors attributed this finding to the growing Islamic state in Pakistan, which has possibly influenced the younger generation into fostering overall more negative attitudes, including towards people with intellectual disabilities. In Japan, younger children in kindergarten reacted more positively towards people with intellectual disabilities than secondary school children (Tang et al., 2000). The authors attributed these findings to younger children holding fewer rigid stereotypes and being more socially motivated to make friends than older children (Tang et al., 2000). However, the authors did not report the p value or effect size, which limits the ability to draw a robust conclusion. In George et al.'s (2014) study, in focus groups children without disabilities used stigmatising language to describe children with disabilities, such as calling them 'deaf', 'dumb' and 'handicapped'. However, they were also willing to accept them and invite them into their friendship groups.

Finally, three studies found no significant relationship between age and discriminatory attitudes toward people with intellectual disabilities. Lau and Cheung (1999) reported no correlation between age and either the composite or individual discrimination variables. Similarly, Su et al. (2015) found that age was not significantly related to responses on the Exclusion subscale (p = 1.00), the Similarity subscale (p = .69) of the CLAS-MR (Henry et al., 1996), or the total score (p = .86).

The influence of gender on attitudes towards intellectual disabilities

Fourteen studies examined the association between gender and attitudes towards people with intellectual disabilities. Six found no gender differences (Chan et al., 1988; Choi & Lam, 2001; Evlyn et al., 2019; Hampton & Xiao, 2013; Lau & Cheung, 1999; Tang et al., 2000). In contrast, four studies found female participants expressed more positive attitudes than male participants (Li & Wang, 2013; Patka et al., 2013; Tachibana & Watanabe, 2003, 2004). In Scior et al.'s (2010) study, which compared Hong Kong Chinese students' attitudes with British students' attitudes, an initial apparent gender difference, however this disappeared once other sociodemographic were accounted for, such as age, suggesting that there is likely a more complex relationship with other factors which influence attitudes.

Educational attainment and attitudes towards people with intellectual disabilities

Six studies have explored the link between educational attainment and attitudes. Those with higher educational attainments consistently held more positive attitudes (Choi & Lam, 2001; Lau & Cheung, 1999; Patka et al., 2013; Scior et al., 2010; Zaman et al., 1987). This relationship may be explained by greater awareness and more scientific understanding of the causes of intellectual disabilities by those with higher educational attainment (Zaman et al., 1987). In contrast, one study found no relationship between educational attainment and attitudes towards people with intellectual disabilities (Su et al., 2015). The authors reported this may be due to little variation in the sample's educational attainments.

Contact and other factors

The below section defines the role of contact and other factors which may influence the general population's attitudes towards a person with intellectual disabilities. For example, other factors which may influence a person's attitudes which have been examined in Asian countries are university subject specialisms and prior contact.

University subject specialism and attitudes

Three studies examined the association between university subject specialisms and attitudes towards people with intellectual disabilities. Japanese students majoring in subjects such as social work and psychology were more likely to hold more positive attitudes when compared to those studying economics, physical sciences and engineering (Horner-Johnson et al., 2002). This being said, the authors noted that overall attitudes towards people with intellectual disabilities expressed by the students in their sample were more on the positive side of neutral. Whilst this is positive, this cannot be generalised to the wider Japanese population. In Indonesia, varying views were identified between students on health sciences undergraduate courses (Evlyn et al., 2021). On the Indonesian version of the ASQ-ID (Cuskelly & Gilmore, 2007) psychology students had the most favourable attitudes on the subscale of ‘self-control’ (which measures the belief of whether people with intellectual disabilities can regulate their sexual desires and behaviours), compared to public health and medicine students. The difference found between psychology and medical and public health students was p =.009 and p =.011, respectively. The authors stated that this difference may be because public health undergraduate students have less knowledge and teaching about the sexual rights of individuals with intellectual disabilities, which points to the importance of the role of education. Finally, when comparing 534 university students majoring in regular and special education in China (Hampton & Xiao, 2009), the former had less favourable attitudes towards people with intellectual disabilities. The authors stated that the difference in their training might contribute to these differences.

Prior contact and attitudes towards people with intellectual disabilities

Of all factors that may affect attitudes, prior contact has received the most attention. Contact is a complex concept encompassing both quantitative aspects, such as frequency and duration, and qualitative aspects, like the level of intimacy and the positivity of the interaction (Schwartz & Armony-Sivan, 2001). Research from 16 studies has explored this, and 12 reported a positive link between prior contact and attitudes towards people with intellectual disabilities. Participants who had prior contact with someone with intellectual disabilities, either through work, as a family member or as friends, would hold more positive attitudes (Chan et al., 1988; Choi & Lam, 2001; Dhillon & Chaudhuri, 1990; Horner-Johnson et al., 2002; Lau & Cheung, 1999; Li, Tsoi, & Wang, 2012; Li & Wu, 2019; Patka et al., 2013; Tachibana & Watanabe, 2004). In China, participants reporting more prior contact were more optimistic and concerned about the human rights of people with intellectual disabilities and held fewer misconceptions about intellectual disabilities (Chan et al., 1988). Moreover, contact was positively linked to behavioural intentions of interacting with people with intellectual disabilities (Lau & Cheung 1999).

Several studies revealed inconsistent links between prior contact and attitudes. For example, Chinese students reported limited direct interaction with people with intellectual disabilities (Siperstein et al., 2011). Surprisingly, those who had previous contact were actually less willing to engage with peers with intellectual disabilities in school, challenging common assumptions about the benefits of contact. The authors suggested this may be because, in the context of school, students with intellectual disabilities were provided with little support, and participants may have had negative experiences as they have likely witnessed the struggles of these students. Moreover, Su et al. (2015) found that in China, the frequency of contact with people with intellectual disabilities had no significant effect on attitudes. They suggested that the quality of contact may play a more crucial role. Supporting this, a study from Japan (Tachibana, 2005) found that adults who had negative contact experiences with people with intellectual disabilities during childhood were more likely to hold negative attitudes. Prior contact similarly did not predict positive attitudes amongst people from Hong Kong (Scior et al., 2010). It is important to note that most studies on prior contact use cross sectional designs, which limit conclusions about cause and effect. The following section reviews research that has directly assessed how contact influences public attitudes, including outcomes of interventions aimed at increasing understanding and social acceptance of people with intellectual disabilities.

Outcomes of interventions aimed at increasing the public's understanding and social acceptance of people with intellectual disabilities

Only three studies across Asia have attempted to evaluate the outcomes of contact-based interventions at a general population level. In New Delhi, Ojha et al. (1993) evaluated a public awareness campaign with 'slum dwellers'. The recognition of intellectual disabilities increased from 1/34 respondents at baseline to 19/30 by the end of the programme. This was not a controlled study, and the vignette used in their study was not included in their write-up, therefore it is difficult to draw conclusions about the efficacy of this study. In East Asia, Li and Wang (2013) found that during the International Special Olympics, volunteers' attitudes improved, and this effect was maintained at 1 month follow-up. The authors concluded that this supports the role of contact as an effective way of enhancing attitudes and social inclusion. The authors noted it was not possible to conclude how this effect occurred or whether any mediators were involved. This warrants further research into the nature of the interaction between contact and attitudes towards intellectual disabilities.

In a study in China by Li and Wu (2019), the intervention group attended a training programme before they volunteered at the Special Olympics. The authors concluded that the volunteers' self-esteem and attitudes improved after the intervention The study employed a post-test only design with non-randomised groups, where only the intervention group received the training, raising the risk of selection bias and limiting the internal validity of the findings.

Cross-cultural comparisons

Cross-cultural differences in attitudes towards people with intellectual disabilities have been investigated in three studies involving lay participants from Asian countries (Choi & Lam, 2001; Horner-Johnson et al., 2002; Scior et al., 2010). In Korea, students expressed less favourable attitudes towards people with intellectual disabilities when compared to Korean American students residing in the United States (Choi & Lam, 2001). The authors suggested that in this context, Western acculturation mediates and improves attitudes towards individuals with intellectual disabilities. This suggestion may also explain a similar finding in a comparison of attitudes between North American and Japanese students, in which the latter were less inclusion-friendly (Horner-Johnson et al., 2002). Moreover, in Hong Kong, participants expressed less favourable attitudes than White British participants (Scior et al. 2010); they were less likely to perceive people with intellectual disabilities as similar to themselves, more in favour of sheltering people with intellectual disabilities from mainstream society and less opposed to their exclusion.

Discussion

The aim of this systematic review was to synthesise existing research on public attitudes towards people with intellectual disabilities within Asian countries. The review sought to address three research questions: (1) what perceptions and beliefs about people with intellectual disabilities prevail across Asian countries; (2) what factors may influence these attitudes; and (3) what beliefs about the causes of intellectual disabilities are common within the public. This review identified 25 peer reviewed studies conducted between 1987 and 2021. Overall, there is a lack of recent studies in Asian countries, with only three published in the past ten years, which limits this review's ability to draw robust present-day conclusions.

Nonetheless, despite the heterogeneity between studies and their methodological flaws, it is tentatively concluded that majority of the participants across Asian countries perceive people with intellectual disabilities in a negative manner and tend to be unwilling to interact with people with intellectual disabilities. Misconceptions and superstitious beliefs regarding intellectual disabilities appear to be common. However, as in Scior's (2011) review of attitudes towards people with intellectual disabilities, factors such as prior contact with people with intellectual disabilities and higher educational attainment, appear to contribute to more positive attitudes. It is crucial for the public to perceive people with intellectual disabilities as valued members of society. Failure to do so perpetuates the abuse and social exclusion that people with intellectual disabilities frequently encounter, which can, in some cases, implicitly or explicitly reinforce, stigmatising views. It is important to foster inclusive and supportive environments, both through education and policy initiatives that affirm the dignity and rights of people with intellectual disabilities.

What perceptions and beliefs about people with intellectual disabilities prevail across Asian countries?

Across the studies reviewed, a pattern emerges: negative perceptions of individuals with intellectual disabilities are widespread. Previous studies across Asian countries have suggested that stigma exists towards people who have mental health difficulties for many years (Gaiha et al., 2020; Pal, Saxena, & Avinash, 2021; Paul, 2017; Zhang et al., 2020). This systematic review confirms that stigma also exists towards people with intellectual disabilities in various Asian countries. In reviewing the literature, much of the research is outdated, for example, only one study was identified in Bangladesh (Zaman et al., 1987), thus more updated research is needed on general populations attitudes.

We note that the outdated term ‘mental retardation’ was used in a number of the included studies. Whilst this was standard clinical terminology at the time, the term is now regarded as offensive (Nash et al., 2012). Yet, when looking at other recent research areas (such as Mamatkulova, 2022), it is a term that continues to be used in some parts of Asia. In Western countries, people with intellectual disabilities have expressed a preference for certain terminology (Higgins, 2014) which may warrant similar studies to be conducted across Asia. The context of language is important, as it carries stigma. This is a global issue, and efforts are being made worldwide to utilise more neutral terminology (such as in America; Friedman, 2016). Therefore, this review highlights the importance of examining the language used in research and practice as terminology plays a key role in either reinforcing or challenging stigma.

The cross-cultural comparison studies (Choi & Lam 2001; Horner-Johnson et al., 2002; Scior et al., 2010) found that participants living in the USA had more positive views when compared to Asian counterparts - of note these were not matched sample studies. These studies suggest that people in Asian countries may hold fewer positive attitudes compared to Western counterparts. Further cross-cultural research with representative samples is required to draw more definitive conclusions. This finding is interesting as even in Western countries, racialised members of society held more stigmatised views than White westerners (Scior et al., 2013). Whilst Mulatu (1999) suggests that racialised groups may favour somatic or endorse fate related explanations, it is unclear whether somatic understandings universally increases stigma. In some contexts, they may in fact reduce blame towards the family, highlighting the importance of culturally informed interpretations of explanatory models.

In this systematic review, it was interesting to see that in three studies in East Asia (Chang et al., 1988; Choi & Lam, 2001; Lau & Cheung, 1999) participants (students and general population) favoured people with intellectual disabilities over people with mental health difficulties. This points to the importance of public education, as there is potential that people with mental health difficulties are portrayed in a more negative way (Srivastava et al., 2018).

In terms of factors that may possibly moderate the relationship between stigma and negative attitudes, the limited evidence base makes it difficult to draw upon any obvious patterns. Prior contact seems to be the most well-researched, albeit it is important to note that this relationship between contact and attitude is not straightforward. As noted in the studies which have examined the relationship, there seems to be a need for an ‘optimal dose’ and the experiences with people with intellectual disabilities need to be of a certain kind, in line with the contact hypothesis (Allport, Clark, Pettigrew, 1954). For contact to lead to positive attitudes, it must meet certain conditions, including positive personal interactions, engaging equally, and working on common goals. A recent systematic review (Kármán, Szekeres & Papp, 2022) concluded that contact-based interventions helped increase acceptance and inclusion of people with intellectual disabilities. It is important to ensure that these interventions are adapted and culturally relevant. It has been well researched that education can often improve attitudes towards people with intellectual disabilities. Two studies included in this review support this finding (Tachibana & Watanabe, 2004b; Li & Wang, 2013).

Only one study included in this review (Su et al., 2015) did not find a positive relationship between educational attainment, age and gender, which as noted by the authors is inconsistent with most previous research. However, as already mentioned the authors stated this may be because the sample was too homogenous. One way to challenge systemic injustices and stigma towards people with intellectual disabilities is through education, particularly by applying the concept of conscientisation coined by Paulo Freire (1970). Conscientisation refers to the process by which individuals and communities develop critical awareness of the social injustices and inequalities that affect their lives. Through this awareness, they recognise their ability to become active agents of change in society (Lloyd, 1972). Educational interventions grounded in this approach may be especially effective in Asian countries, where community values and shared responsibility are emphasised. Furthermore, there is a strong case for conscientisation to take place on two levels: firstly, for individuals with intellectual disabilities themselves, to foster critical awareness and self-empowerment; and secondly, for the wider public, to challenge prejudiced attitudes and promote inclusive social change. Whilst it is important to acknowledge that some people with intellectual disabilities may have limited capacity for this type of work due to the severity of their disabilities, Freire would suggest that many are capable of reflexivity when supported by nondisabled facilitators (Cuddeback-Gedeon, 2018).

Religion and cultural values may further explain the persistence of negative attitudes. In some religious contexts, disability is viewed as a punishment, curse, or sign of moral failing (Rose, 1997). Such interpretations perpetuate stigma but can be effectively challenged through targeted interventions (Odukoya, Chege, & Scior, 2024). Moreover, in many Asian cultures, the emphasis on family honour and social harmony may amplify feelings of shame, positioning disability as a threat to family reputation or success (Scior et al., 2020). Hofstede and Bond's (1988) concept of the Confucius connection also suggests that social norms in many Asian societies discourage open discussion or challenges to inequality, which may serve to maintain stigma. Critically examining these cultural frameworks is therefore essential for promoting inclusive change.

In sum, negative attitudes towards people with intellectual disabilities persist globally, shaped by a complex interplay of cultural, social, historical, and structural factors. Stigma is not merely rooted in perceptions of impairment but is produced and reinforced through systemic inequalities and dominant ideological frameworks, including those influenced by colonial histories. Understanding these layered influences is vital for contextualising public attitudes and developing culturally responsive approaches to inclusion.

Strengths and limitations of this review

This is the first systematic attempt to synthesise the evidence base narratively regarding public attitudes towards people with intellectual disabilities across countries in Asia. We have identified some implications for practice as well as directions for future research. This systematic review has some limitations. First, grey literature and theses were excluded from this systematic review, which means that potential valuable data has not been included in this review.

Secondly, the studies which were included in this review have some methodological limitations, therefore the results of this review should be treated tentatively. Only one study utilised a social desirability scale, thus it is difficult to draw a robust conclusion on whether social desirability is correlated with attitudes reported. Furthermore, all the studies utilised different measures to assess attitudes, making the results heterogeneous. Moreover, the 'general population' samples were mostly convenience-based which lacks representation and generalisability, with many using university student sample. This means the results are unlikely to be representative of the wider population in the countries examined. It is also important to note that there is criticism surrounding the value of statistical significance. Some argue that statistical significance is an arbitrary measure, and that clinical significance is more important (Amrhein, Greenland & McShane, 2019).

Thirdly, the search strategy was limited to articles published in English which may introduce an anglophone bias. Due to resource constraints within this thesis the inclusion of non-English publications requiring translation was not feasible. Nonetheless, it is important to acknowledge that incorporating articles in other languages could have broadened the scope of the review, enabling a more comprehensive comparison of cultural differences and inclusion of studies from a wider range of Asian countries.

This review has compared studies across Asian countries, whilst on the one hand it is helpful to compare research to other similar contexts, it is imperative not to assume that Asia is a singular homogenous entity. It may be argued that it is reductionist to group all data from Asia and compare it. Where possible in this review we have stated the different regions of Asia from where data is drawn. However, this in itself is met by limits, and it is important to name that different parts of each Asian country will have different colonial and historical contexts, economic structures, culture and religious diversity which will impact the general populations' attitudes towards people with intellectual disabilities. Due to the limited number of studies from each country, it was not possible to conduct a review in specific areas or regions of Asia.

Finally, this review only included studies which explicitly mentioned intellectual disabilities. This means studies which have examined "disabilities" in a broader context, and which may have included studies with individuals with intellectual disabilities may have been missed.

Implications for practice

Policy makers across countries in Asia should consider the impact the general population's negative attitudes towards people with intellectual disabilities may have, including for their families. It is paramount to consider the context of why stigma and negative attitudes might exist particularly within Asian societies. If we view people with intellectual disabilities through a decolonial lens, there may be other ways to understand 'difference'. For example, when policymakers address matters concerning people with intellectual disabilities, reliance on the Western medical model may inadvertently contribute to further marginalisation. This study argues that alternative approaches (such as the social model of disabilities, Shakespeare, 2006), may offer better insights into understanding attitudes and developing interventions to destigmatise people with intellectual disabilities in the Global South.

Directions for future research

There has been no longitudinal study that has measured whether attitudes towards people with intellectual disabilities are changing in Asia. Without this, it is difficult to conclude whether views in society are shifting. The current evidence base only focuses on the cognitive aspects of attitudes, with little attention to the affective (feelings) or behavioural (intentions or overt behaviours) dimensions of attitudes. Only the scale developed by Siperstein et al. (2011) explicitly measured behavioural intentions on one of its subscales. Thus, future research may consider utilising multi-dimensional scales, such as the Attitudes towards Intellectual Disability scale, which measures both affective and behavioural responses (Morin et al., 2013).

Future research should also consider the use of qualitative methods which may be valuable in Asian countries where English literacy rates may be lower and there is not capacity to adapt attitudinal outcome measures. Qualitative research may be well placed to access beliefs and meanings attached to people with intellectual disabilities in different cultural and religious contexts that are dominant in Asia. It is also recommended to interview older adults on their attitudes as their views will likely impact younger generations due to the hierarchal family systems that exist within several Asia countries (Ankori, Yaacovi & Carmeli, 2022). Finally, a systematic review on service providers’ attitudes and beliefs in Asian countries is merited to help better understand attitudes of health care workers, which can lead to improved and targeted training programmes.

Conclusion

The aim of this systematic review was to comprehensively summarise and critically appraise the evidence base on public attitudes towards people with intellectual disabilities across Asian countries. This review addresses a gap in the existing literature by consolidating findings that indicate predominantly negative attitudes within the populations studied. If we as a society aspire to provide individuals with intellectual disabilities and their families with the highest quality of care and social acceptance, it is essential to understand prevailing public attitudes and to develop interventions that challenge negative perceptions and promote critical awareness. Effective interventions have the potential to reduce stigma, which can enhance opportunities for inclusion and the protection of human rights for people with intellectual disabilities.

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Part 2: Empirical Paper

"Let them shine": Attitudes Towards People with Intellectual Disabilities in the British Bangladeshi Community

Abstract

Aim: People with intellectual disabilities often face significant stigma, which can limit their inclusion, rights, and sense of belonging in society. Public attitudes are one of several important factors that shape how individuals with intellectual disabilities are treated and supported within their communities. This study explored how attitudes are expressed within the British Bangladeshi community, to better understand the cultural influences shaping perceptions of intellectual disabilities.

Method: A cross-sectional survey design was employed. A total of 102 British Bangladeshi participants were recruited online. The survey included the Attitudes Toward Intellectual Disability Short-Form (ATTID-SF; Morin et al., 2019a) and a single open-ended qualitative question to capture more nuanced perspectives.

Results: Quantitative findings from the ATTID-SF revealed a range of attitudes towards people with intellectual disabilities, with some responses reflecting discomfort towards people with intellectual disabilities, whilst also showing moderate levels of acceptance. Effect sizes were small due to the study being underpowered. Qualitative responses enriched the findings, revealing a desire amongst many participants to deepen their understanding of intellectual disabilities and to support the inclusion of this group in society.

Conclusion: This study found that attitudes within the British Bangladeshi community are complex and multifaceted. Whilst some stigma and uncertainty were evident, many participants expressed openness and a willingness to challenge prevailing norms. These findings underscore the importance of developing culturally sensitive interventions that engage with beliefs held within the community. Such efforts may meaningfully promote inclusive change and help uphold the human rights of people with intellectual disabilities.

Introduction

Across different societies and time periods, people with intellectual disabilities remain one of the most marginalised and socially excluded groups in the world (Scior et al., 2015). From historical attempts by eugenicists and the Nazi regime to eliminate people with intellectual disabilities, to everyday instances such as playground insults, and cultural beliefs that associate disabilities with evil forces, they continue to face exclusion and stigma worldwide (Scior et al., 2015).

Stigma is a universal social process in which certain groups are devalued and positioned as “other”. The term stigma originates from the Greek word meaning to mark, tattoo or brand, referring to symbols once used to identify slaves or criminals. Goffman (1963) conceptualised stigma as “an attribute that is deeply discrediting and reduces the bearer from a whole and usual person to a tainted, discounted one”. People with intellectual disabilities are frequently subjected to devaluation due to social, cultural and historical factors. Negative attitudes may arise from perceptions that they deviate from social norms of competence, independence and productivity, which are often viewed as valued traits across many different societies.

Research suggests that stigma is not universal but varies across cultures. For example, Abdullah and Brown (2011) highlight in their article that in many collectivistic Asian cultures, mental health difficulties are often seen as a source of family dishonour, potentially bringing shame and negative social consequences (U.S. Department of Health and Human Services, 2001; Lauber & Rössler, 2007). Other culturally influenced beliefs include viewing mental health issues as divine punishment (Fogel & Ford, 2005), or as the result of “bad genes” (Chen, 2005). They further note that remarkably few studies have examined how cultural context shapes stigma, highlighting a critical gap in the literature.

Theoretical perspectives on self and identity provide insight into how these perceptions may influence social rejection. As discussed by Crabtree, Mandy and Mustard (2016), Cooley's (1909) Looking Glass Self and Gergen's (1977) Social Constructionist Theory suggest that individuals develop their sense of self through interactions and reflected appraisals from others. These frameworks highlight how societal attitudes can shape both individual self-concept and collective perceptions of difference. Social Identity Theory (Tajfel and Turner, 1979) further proposes that people derive self-esteem from belonging to valued groups, which can contribute to the marginalisation of those considered members of an "out-group" (Crabtree, Mandy and Mustard, 2016). These frameworks illuminate how societal attitudes, shaped by cultural, social, and familial norms, can influence both individual self-concept and collective perceptions of difference. Understanding these processes is therefore essential for exploring public attitudes toward people with intellectual disabilities, particularly within specific communities such as British Bangladeshi communities.

In the UK, approximately 1.5 million people are diagnosed with intellectual disabilities (Boyd, 2025). Whilst experiences vary, many people with intellectual disabilities, alongside their family members, are at heightened risk of social exclusion and stigma due to enduring cultural, social, and institutional barriers. Intellectual disabilities are characterised by intellectual impairment and significant deficits in two or more areas of adaptive functioning that have an onset before adulthood (World Health Organization, 2022).

In 'the West', the 'medical model' is primarily used to understand human distress and disabilities (Bendevis, 2024). The medical model primarily understands intellectual disabilities as a neurodevelopmental disorder. The traditional medical model views disability primarily through a lens of deficits, framing it as a deviation from typical functioning (Scheffers, 2023). Whilst for some the diagnosis can offer clarity and access to NHS services and specialist schools, the label of intellectual disabilities has often been critiqued, as disability-related labels have been noted to increase the separation between “us” and “them”, which can cause discrimination (Link et al., 2004). The labelling of “intellectual disabilities” may reveal more about society’s need to classify and manage difference than any inherent ‘problem’ within the individual. For example, people with intellectual disabilities are often described using derogatory terms such as “slow” based on the idea that they have a “low IQ”. These ableist beliefs reveal more about societal prejudices than about the individuals diagnosed with intellectual disabilities themselves.

The social model of disability offers an alternative view to the medical model by suggesting that people are not disabled by their impairments alone, but by the physical, attitudinal, and institutional barriers they encounter (Oliver, 1990). This model encourages a shift in focus from individual deficits to the broader social and cultural factors that shape exclusion. Building on this, critical disability theory suggests that society should shift focus further away from bodily or mental impairments and towards the social norms and power structures that define certain attributes as impairments, and contribute to ongoing marginalisation (Hall, 2019). Together, these perspectives highlight that exclusion is not an inevitable outcome of impairment, but a product of cultural values, social comparisons, and group boundaries that shape how difference is perceived.

Despite the dark history of eugenic movements, people with intellectual disabilities continue to face widespread discrimination and social exclusion worldwide (Scior et al., 2020). The United Nations Convention on the Rights of

Persons with Disabilities advocates for their full inclusion and participation across all areas of life, emphasising that disability is fundamentally a human rights issue, not merely a medical one (United Nations, 2006). People with intellectual disabilities often encounter overlapping inequalities in healthcare, education, and employment, which negatively affect their wellbeing and inclusion. For example, premature mortality rates are significantly higher among this group, partly due to factors like diagnostic overshadowing (While & Clark, 2010). It has been argued that one way to enhance the quality of life for individuals with intellectual disabilities is through societal inclusion (Cummins & Lau, 2003). Identifying and understanding public attitudes towards people with intellectual disabilities is one way to support with their inclusion, as by identifying the factors that either facilitate or hinder their inclusion, changes can then be made in society.

Intersecting social determinants, such as race and socioeconomic status, compound the inequalities faced by people with intellectual disabilities, especially people from Black, Asian, and minority ethnic backgrounds (Robertson et al., 2019). Overlapping disadvantages highlight the need to understand how people with intellectual disabilities are perceived within specific communities. Attitudes shape everyday interactions, support within families, and access to services. As the UK Department of Health noted, "*the needs of people from minority ethnic communities are often overlooked*" (Department of Health and Social Care, 2001). Exploring community attitudes is therefore a crucial step in promoting inclusion and informing efforts to reduce systemic inequalities.

Community attitudes and cultural influences

Attitudes reflect how people are likely to respond to certain groups (McCaughey & Strohmer, 2005). Attitudes are one of the best predictors of behaviour (Ajzen & Fishbein, 1980; Kraus, 1995). Thus, positive attitudes towards individuals with intellectual disabilities support inclusion, whilst negative ones contribute to stigma and discrimination (Morin et al., 2013). A consequence of widespread negative attitudes is public stigma, which refers to the stereotypical beliefs, prejudicial attitudes and discriminatory behaviours endorsed by the general population towards individuals with a stigmatised characteristic (Corrigan & Watson, 2002).

This means that community attitudes play a key role in shaping how individuals with intellectual disabilities are treated and supported within society. Whilst research in the UK has explored public attitudes across various ethnic groups, South Asian communities are often treated as one homogenous category, ignoring important differences in culture, class, religion, and migration history (Bhachu, 1985; Gany et al., 2019). British Bangladeshis, one of the UK's largest South Asian communities making up 1.1% of the population of England and Wales in the 2021 census (Office of National Statistics, 2021), remain especially underrepresented in this area. Understanding their specific attitudes is essential to addressing stigma in a culturally meaningful way. Kaplan and Celik (2023) emphasise that racialised parents of children with disabilities face distinct cultural and linguistic challenges, further underscoring the need for tailored research and services.

Although research into public attitudes towards individuals with intellectual disabilities has expanded, McManus, Feyes and Saucier (2011) emphasised that much remains unknown about how adults in the general population perceive individuals with intellectual disabilities, particularly within underrepresented communities. They also argued that people with intellectual disabilities are often socially marginalised or misunderstood, highlighting the need to better understand what attitudes exist, thus, interventions can be created to target any negative attitudes. Moreover, without knowing what attitudes exist in each community, it is unclear whether attitudes are shifting and improving within different communities.

In the UK context, British Bangladeshis often navigate the intersection of traditional cultural expectations and broader British societal norms. Cultural beliefs around family roles, education, and disability-related stigma can significantly shape how people with intellectual disabilities are perceived and addressed. These beliefs, in turn, influence important processes such as help seeking, diagnosis, and access to care. Understanding specific community attitudes is therefore crucial, as one-size-fits-all approaches to disability awareness and service provision risk overlooking the complex and varied needs of this population. A more nuanced, culturally-informed approach can support more inclusive and equitable services for people with intellectual disabilities.

The Bangladeshi diaspora in the UK

Predominantly originating from the Sylhet region in Bangladesh (Gardner, 1993), British Bangladeshis often navigate the dual pressures of maintaining cultural and religious traditions whilst adapting to life in a Western society. According to the 2021 Census, approximately 652,535 British Bangladeshis live in the UK, with nearly half residing in Greater London (Office of National Statistics, 2021). The duality of being British and Bangladeshi could influence attitudes towards people with intellectual disabilities, where attitudes may be shaped by both inherited cultural beliefs and contemporary societal factors.

British Bangladeshi communities face multiple forms of social and economic disadvantage, often more pronounced than those experienced by other minority groups. These include disparities in housing, employment, education, and health (Office for Standards in Education, 2004). For example, British Bangladeshis are more likely to be victims of racially motivated incidents. Additionally, British Bangladeshi children have the highest eligibility rates for free school meals, a key indicator of socioeconomic deprivation (Office for Standards in Education, 2004).

Structural inequalities such as these likely influence the communities' attitudes towards intellectual disabilities in several ways. Limited access to education, healthcare, and social support due to poverty can reduce awareness and understanding of intellectual disabilities. Experiences of racial marginalisation may increase the community's sensitivity to social exclusion, leading to greater stigma and shame around disabilities. As a result, intellectual disabilities may be perceived as shameful or burdensome, affecting how individuals with such conditions are socially positioned within the community. To better understand these perceptions, it is important to consider the broader historical and structural factors that shape identity and social attitudes.

Postcolonial theory offers a valuable lens for understanding how colonial histories and power structures continue to shape identity and social perceptions within diasporic communities (Easterly, 2006, as cited in Bhati, 2023). As Cleall (2022) argues, the application of a postcolonial lens to disability serves to challenge Global North assumptions by revealing how colonial histories have shaped dominant understandings of the body. Alongside this, intersectionality theory highlights how race, religion, class, gender, and disability intersect to produce specific experiences of marginalisation (Crenshaw, 2013). Together, these frameworks guided this study by focusing attention on the complex ways that historical power relations and multiple social identities influence attitudes towards people with intellectual disabilities in the British Bangladeshi community. This study therefore aims to investigate attitudes towards individuals with intellectual disabilities within the British Bangladeshi community, exploring whether also cultural and religious factors may shape these perceptions.

Attitudes towards people with intellectual disabilities within South Asian communities

There is limited research focused specifically on British Bangladeshi communities, most research on this community is shaped by policy concerns (Alexander, Firoz & Rashid, 2010). As a result, mainstream services such as the NHS and government initiatives often adopt Western models of intellectual disabilities that may not fully reflect the cultural beliefs or needs of this community. This lack of cultural alignment can reduce the accessibility and effectiveness of care, potentially reinforcing stigma and social exclusion. Therefore, understanding community attitudes is essential to developing culturally appropriate interventions and improving support for people with intellectual disabilities within this population.

Understanding public attitudes towards people with intellectual disabilities is essential for promoting inclusion and reducing discrimination (Ajzen & Fishbein, 1980; Kraus, 1995; Morin et al., 2013). Attitudes influence behaviour and can contribute to either supportive practices or societal stigma (Corrigan & Watson, 2002). Research suggests that culturally sensitive investigations are particularly important in underrepresented communities, such as the British Bangladeshi population, where religious, cultural, and structural factors may shape perceptions of disability (Coles & Scior, 2011; Durling, Chinn & Scior, 2018; Fazil et al., 2002; Nesa, 2017). Such understanding can guide interventions and policies aimed at fostering inclusion, addressing misconceptions, and supporting equitable treatment of individuals with intellectual disabilities (Bhati, 2023; Crenshaw, 2013).

Although limited, existing research has begun to shed light on attitudes towards people with intellectual disabilities within the Bangladeshi community. For instance, Hepper (1999) described the case of a Bangladeshi woman in the UK with intellectual disabilities whose parents arranged her marriage, believing this would help her "get over her slowness." Though this is only a single case, it raises important questions about prevailing cultural attitudes and how they influence the lives of people with disabilities.

Further insight comes from a study in Bangladesh, where parents of children with disabilities described facing widespread stigma, including social exclusion, blame directed at mothers, and fears for their children's futures. Some parents even expressed the wish that their children would die before them, to avoid the anxiety of what would happen if they were to die first (Hussain & Raihan, 2021). These findings suggest that parents of children disabilities experience significant distress, potentially stemming from fears about community judgment and the broader societal stigma associated with intellectual disabilities, which may also influence attitudes within the UK Bangladeshi diaspora.

Due to limited evidence on British Bangladeshis, broader South Asian studies are relied upon. For example, Sankhla and Theodore (2015) found that South Asian participants expressed more negative views about the rights of individuals with intellectual disabilities compared to White British participants. Yet, the study treated South Asians as a homogeneous group, ignoring cultural, religious, and linguistic diversity. The authors themselves called for more nuanced, community-specific research. Therefore, exploring community attitudes towards people with intellectual disabilities is essential to identify these barriers and inform culturally appropriate interventions that improve support and inclusion within this population. Understanding these attitudes also provides a foundation for examining key factors, such as age and personal contact, that may predict how individuals perceive intellectual disabilities.

Factors shaping the public's attitudes towards people with intellectual disabilities

The general populations attitudes towards individuals with intellectual disabilities are shaped by a range of individual and contextual factors. Demographic variables such as age and experiential factors, such as previous contact with individuals with intellectual disabilities, have consistently emerged as key influences in the evidence base (Barr & Bracchitta, 2012; Breau et al., 2019; Murch et al., 2017; Scior, 2011). However, influencing factors will likely differ depending on the community in question.

Age has been widely studied in relation to attitudes towards people with intellectual disabilities, particularly outside of South Asian populations. For example, in Poland, the youngest and oldest age groups expressed the most positive attitudes, whilst individuals aged 35 to 60 were more likely to report negative views (Domagała-Zyśk, 2021). In another study in Norway, older people were more against excluding people with intellectual disabilities than younger people, albeit this association was weak (Orm, Blikstad-Blumenthal & Fjermestad, 2023). These findings suggest that attitudes towards people with intellectual disabilities differ by age, possibly reflecting broader social and cultural changes.

Previous contact with individuals with intellectual disabilities has consistently been associated with more positive attitudes (Scior et al., 2013). According to Contact Theory (Allport, Clark & Pettigrew, 1954), the nature and context of such interactions are crucial; positive outcomes are more likely when contact is frequent, voluntary, and occurs under conditions of equal status, cooperation, and institutional support. Not all contact is equally beneficial. Negative or superficial encounters may reinforce existing stereotypes and discomfort (Pettigrew & Tropp, 2006). However, research exploring how these dynamics unfold within racially minoritised communities remains limited. A recent systematic review further supports the importance of these factors, concluding that public attitudes towards people with intellectual disabilities are shaped by both the level of knowledge individuals hold and their prior contact experiences (Wang et al., 2021). Contact theory has primarily been explored in the West. Whilst there are studies from certain regions in Asia (Techakesari et al., 2015), their applicability to racially minoritised communities in the UK may be limited, as cultural factors could influence how knowledge and contact impact attitudes.

Within the British Bangladeshi diaspora, cultural norms and collective values may influence how contact with individuals with intellectual disabilities is experienced and interpreted. For example, stigma related to the disability may be intertwined with beliefs about fate or punishment, which may complicate the effect of contact on attitudes, as seen with mental health conditions in Bangladesh (Roy & Chowdhury, 2024). Therefore, contact may not always produce the positive attitude shifts predicted by contact theory and cannot be assumed to operate in a culturally neutral way.

Aims and rationale

Despite growing research on attitudes towards individuals with intellectual disabilities in the UK, there remains a significant lack of empirical data on South Asian communities, specifically the British Bangladeshi community. This study addresses this gap through a mixed-methods approach. Whilst stigma surrounding people with intellectual disabilities is reinforced by systemic issues such as policy gaps, institutional barriers, and service inequalities, societal attitudes play a central role in sustaining stigma. Public perceptions shape how individuals with intellectual disabilities are treated and how their families navigate daily life, particularly where cultural and religious values intersect with Western societies. Positive attitudes are central to social inclusion (Hepper, 1999), making it essential to explore these views in underrepresented communities, as the success of policies aimed at increasing the social inclusion of people with intellectual disabilities depends largely on the public's willingness to welcome, accept, and interact with them. A secondary aim of the study was to pilot a Bangla version of the survey and explore its feasibility for future validation if there was enough uptake.[1] In addition, this study examined whether attitudes differ between individuals with mild and severe intellectual disabilities.

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[1] The Bangla version was offered with an additional incentive, however, no participants completed it, therefore validation was not possible.

Research questions and hypothesis

The following questions were proposed with the corresponding hypothesis tested:

Research question 1: What attitudes do British Bangladeshi people hold towards people with intellectual disabilities, as measured by discomfort, knowledge of capacity and rights, interaction, sensitivity/tenderness, and knowledge of causes, and do these attitudes differ according to the severity of the disability (mild versus severe)?

Research question 2: Does age, frequency of contact, and perceived closeness predict attitudes held by the British Bangladeshi community towards people with intellectual disabilities across the aforementioned five ATTID-SF dimensions?

Hypothesis 1: Age, frequency of contact, and perceived closeness of contact will predict attitudes towards and knowledge about people with intellectual disabilities among the British Bangladeshi community, as measured by levels of discomfort, interaction, sensitivity/tenderness, knowledge of capacity and rights, and knowledge of causes.

Research question 3: What additional stereotypes or perceptions emerge from participants' responses to an open-ended question designed to explore their views on intellectual disabilities?

Methods

Research design

A mixed-method cross-sectional survey was conducted targeting the British Bangladeshi population. Given challenges in accessing this often-underrepresented community, recruitment combined posts on online social media forums, in-person outreach in parts of London with a large Bangladeshi population, and snowball sampling. Multiple regression analysis explored the influence of age and contact (measured by frequency and closeness) on attitudes towards people with intellectual disabilities.

Sample size: power analysis

A power analysis was conducted using GPower 3.1 for a multiple regression with three predictor variables. The analysis was informed by Pooh (2015), who examined the general population's attitudes towards intellectual disabilities in Singapore. She reported that previous contact with people with intellectual disabilities significantly predicted discomfort in explicit attitudes, accounting for 3.2% of the variance ($R^2 = 0.032$). Since the effect size was not reported, it was calculated using the formula: $f^2 = R^2$ divided by (1 minus R^2), that is, $f^2 = R^2 / (1 - R^2)$. Substituting the value gives $f^2 = 0.032 / (1 - 0.032) = 0.033$. A power analysis using G*Power with power set at 0.80 and alpha at 0.05 indicated that a sample size of 295 would be needed to detect a small to medium effect in a regression analysis. Given the smaller sample size in this project, interpretation of results will focus on effect sizes rather than p-values.

Participants and recruitment

A convenience sample of 102 British Bangladeshi adults were recruited (aged 18 years and above). Most were recruited online via social networking websites such as LinkedIn, Facebook, Instagram and advertising in different forums (for example, ‘Bangladeshi’s living in the UK’ and Reddit forums) using a research poster that was available in English and Bangla (see Appendix B). Popular Bangladeshi influencers were also contacted via Instagram to circulate the study. Inclusion criteria for the study required participants to be Bangladeshi adults living in the UK. All participants were asked to confirm this on the consent page. To support recruitment, participants were incentivised via an entry to a prize draw to win an online retail voucher. There were 10 chances to win a £20 voucher and those completing the Bangla version of the questionnaire had a chance to win one £100 voucher. No participants opted to complete the Bangla version of the survey.

Recruitment was attempted in person. The main researcher attended areas with a high Bangladeshi population in London (Tower Hamlets) to promote the research, distribute flyers, and engage with the community. The researcher's contact details and a QR code linking to the online survey were provided. Individuals approached in public were also invited to complete the survey in person, though all declined. Posters were placed in community centres, cafes, and mosques across East London. To build trust and encourage participation from older individuals, the researcher also communicated in Sylheti (Bangla dialect) where possible, to enhance approachability and cultural familiarity.

Measures

Attitudes towards Intellectual Disability questionnaire

The Attitudes towards Intellectual Disability short-form (ATTID-SF; Morin et al., 2019a) questionnaire draws on a multidimensional model that considers cognitive, affective and behavioural dimensions of attitudes. It is a validated self-report questionnaire designed to assess public attitudes. It consists of five subscales, each capturing a distinct dimension of attitudes. The first subscale, Discomfort, measures the degree of unease or anxiety participants feel when interacting with individuals with intellectual disabilities. The second subscale, Knowledge of Capacity and Rights, assesses participants' awareness of the abilities, rights, and social inclusion needs of people with intellectual disabilities. The third subscale, Interaction, captures willingness to engage or socialise with individuals with intellectual disabilities. The fourth subscale, Sensitivity and Tenderness, evaluates empathy, caring attitudes, and perceived moral responsibility towards people with intellectual disabilities. The fifth subscale, Knowledge of Causes, examines beliefs about the origins or causes of intellectual disabilities, including biological, environmental, or social factors. The ATTID-SF does not generate a single overall or mean score of attitudes; instead, it assesses multiple dimensions, allowing for a more nuanced analysis of participants' views.

In addition to the questionnaire, vignettes are used to present participants with brief, realistic scenarios describing individuals with intellectual disabilities in everyday situations (ATTID-SF items not reproduced in this thesis due to copyright, the full measure can be found here: https://chaireditc.uqam.ca/attid-en-accueil/). Each vignette represented different levels of ability, behaviour, and social context, allowing participants to respond in a way that reflected their attitudes and beliefs. Participants are asked to read each vignette and then respond to questions regarding their perceptions, comfort, and intended behaviours. The inclusion of vignettes enables the assessment of both cognitive and affective components of attitudes, capturing more context-dependent responses that may not emerge from the questionnaire alone. By including the vignettes, researchers can compare whether participants have more negative attitudes towards the vignette displaying severe or mild intellectual disabilities. Modifications were made to be culturally relevant which are explained in further detail below.

Participants responded on 36 Likert-scale items (1 = completely agree to 5 = completely disagree), with 14 items reverse scored. Higher scores indicate more negative attitudes. In the current study, the ATTID-SF subscales and vignettes were used together to assess multiple dimensions of attitudes among the British Bangladeshi community, enabling an examination of both affective and cognitive components of public attitudes in realistic social contexts. Each participant was asked to complete the ATTID-SF alongside a demographic questionnaire.

Modifications to the ATTID-SF

English version

At the start of the survey, a definition of 'learning disability' was provided, along with the transliterated Bangla term "*bohdikhom*", which is commonly used in the community. This term is derived from two Bangla words: *bohdi*, meaning "intellect" and *khom*, meaning "lacking". Together, *bohdikhom* roughly translates to "reduced intellectual ability". Whilst it is widely understood and used within the British Bangladeshi community, the term itself carries deficit-based connotations that reflect broader societal attitudes toward disability. Nevertheless, it was included to ensure that participants understood the survey was focused specifically on intellectual disabilities, and to avoid conflation with other presentations such as autism or psychosis.

Moreover, modifications were made to the names used in the vignette. As suggested by Scior and Furnham (2011) validity may increase if culturally matched names are given in vignettes. Thus, traditional Bangladeshi names were given. To improve cultural relevance and participant engagement, minor adaptations were made to the ATTID-SF case study. The original names "Dominic" and "Raphael" were replaced with "Rima" (mild intellectual disabilities) and "Farzana" (severe intellectual disabilities) to better reflect gender representation and align with culturally familiar Bangladeshi names. Additionally, culturally specific behaviours were adjusted for example, "eating with a spoon" was changed to "eating with her hands" to reflect common practices in Bangladeshi culture.

In a similar vein to a previous study (Odukoya, Chege & Scior, 2024), the causal beliefs listed in the ATTID-SF were supplemented with three items from the supernatural causes' subscale of the Intellectual Disabilities Literacy Scale (ILDS; Scior & Furnhan, 2011). Adaptions were made to the ATTID-SF to tap into supernatural causal attributions that are common in the Muslim faith and among people from Bangladesh (Mullick et al., 2013). These items addressed intellectual disabilities potentially being seen as due to a test from God/Allah, possession by spirits, and punishment for past wrongdoings. This subscale in the IDLS has previously been tested in various contexts, showing high internal (α = 0.76) and acceptable test-retest reliability (>0.7) (Scior & Furnhan, 2011).

In this study, internal consistency was assessed using Cronbach's alpha for each of the five ATTID-SF subscales. The alpha values indicated acceptable to excellent reliability: discomfort (α = .90), knowledge of capacity and rights (α = .89), interaction (α = .88), sensitivity/tenderness (α = .84), and knowledge of causes (α = .71).

Bangla version of the ATTID-SF

The adapted English version was translated into Bangla with permission from the original ATTID author to assess the validity and reliability of the translated scale. The Bangla version was translated by professional independent translators and then an independent expert conducted the back translation. The main researcher and supervisor compared the original and the back translated versions to ensure the meaning of the original ATTID-SF was not lost. Seven native readers (four academics and three members of the general population studying for a masters/PhD) evaluated content validity. The native readers reported that the translation was appropriate.

Demographic questions and contact

Participants were asked to provide demographic information, including their gender, age, and occupation (see Appendix C for detailed list of occupations). Participants were asked if they knew a person with intellectual disabilities and were then presented with different questions related to contact. Contact was operationalised using two continuous variables: frequency and closeness of the contact relationship, measured on a scale from 0 (not at all close) to 100 (extremely close). This approach was chosen as Blundell et al. (2015), found that incorporating multiple aspects of contact, such as frequency, closeness, and the nature of the relationship, better explained the variance in social distance than using only binary contact variables (for example, contact present versus contact absent).

Open-ended question

Based upon Pelleboer-Gunnick et al.’s (2021) study, an open-ended question was included. Participants were asked to type their answer to the following question: “Finally, can you give us, in a few sentences, a characterisation of people with intellectual disabilities? What comes first to your mind when you think about people with intellectual disabilities?”. As suggested by Pelleboer-Gunnick et al. (2021), this question was utilised to determine whether there were any stereotypes that were not yet described in the literature. Moreover, it was used to access other perceptions that may be held by the community. A modified version of consensual qualitative research was used to analyse the data (CQR-M; Spangler et al., 2012) in a similar vein to Oswald et al. (2025).

Researchers’ positionality

The researcher is a British Bangladeshi clinical psychology doctoral student with lived cultural understanding of the community; therefore, positionality may have shaped how participants' answers were analysed in the qualitative analysis. Positionality describes how the individual’s worldview and the stance they take regarding research within the social and political context (Holmes, 2020). The researcher remained mindful of potential bias during analysis through discussing this with other researchers.

Procedure

Participants took part in an anonymous online survey via Qualtrics XM aimed at exploring attitudes towards people with intellectual disabilities. Each participant was presented with an information sheet (see Appendix D) explaining that the survey targeted the views of British Bangladeshis. Before starting, participants were asked to provide informed consent via a consent form (see Appendix E). The survey emphasised the importance of honest responses and made clear that there were no right or wrong answers. Participants were informed about incentives and advised that the survey would take approximately 15–20 minutes to complete. The survey was open to the public from 29th January 2025 to 31st June 2025. Although available in both English and Bangla, all participants completed the survey in English.

Ethical approval

The project received ethical approval from the University College London Research Ethics Committee (see Appendix F). Participants were informed that their involvement was entirely voluntary and that they could withdraw at any point before submitting their survey responses. They were also able to skip any demographic questions if they wished. To encourage participation, a prize draw was offered, all participants could enter to win a £20 voucher if they desired, whilst those completing the Bangla version of the ATTID-SF survey were eligible for a separate £100 voucher draw. As noted, no participant took part in the Bangla version.

Data analysis

Following data collection, a “bot likelihood” risk score was generated using built-in Qualtrics features to identify potentially automated or invalid responses. The score was based on indicators such as speed of completion, nonsensical open-text responses, and repeated entries with identical data. Additionally, a validation question was included in the survey: “Which of the following is a vegetable?”, to which participants were expected to select “broccoli”. Failure to answer this correctly would be flagged as a potential indicator of bot activity. Upon review, no responses met the criteria for exclusion. All responses were retained and subsequently exported to IBM SPSS Version 30 for analysis. A syntax file was created for data management and processing.

As per the ATTID-SF manual (Morin et al., 2019b), missing data were coded as 9. For each ATTID-SF factor, the 10% threshold for missing items was applied. The manual advises that, if the proportion of missing items exceeds 10% for a given factor, the respective participant data should be excluded from analysis for that factor. Based on this criterion, no participant was excluded from the analysis.

Data were screened for univariate outliers. Univariate outliers were assessed using visual inspection of stem and leaf plots. One participant was found to have substantial missing data across several ATTID-SF items and also showed an extreme outlier on the Knowledge of Capacity and Rights factor, identified via a stem and leaf plot. Given the extent of missing responses and the extreme deviation from the rest of the sample, this participant was excluded from further analysis, resulting to the final sample of n = 101.

Following the above, the data were screened for normality, multicollinearity and homogeneity of variance via SPSS. A correlation matrix was conducted to assess whether the five factors of the ATTID-SF and whether age, frequency and closeness of contact were correlated. Descriptive statistics were computed, including means, standard deviations and ranges for each of the dependent variables and for demographics.

To address Research Question 1, descriptive statistics were used to summarise responses across the five ATTID-SF dimensions. In addition, comparisons were made between attitudes towards individuals with mild versus more severe intellectual disabilities. This allowed for a more nuanced understanding of whether perceived severity influenced participants' responses. This was done by conducting paired sample t-tests to examine within-subject differences between the mild and severe intellectual disability vignettes for matched items, allowing valid within-subject comparisons..

For Research Question 2, five multiple regression analyses were performed, each using a different ATTID-SF subscale as the dependent variable. I. Multiple regression was used to examine whether age, contact frequency, and closeness predicted attitudes towards people with intellectual disabilities. This method was chosen as it enabled the simultaneous examination of multiple predictors. Alternative approaches, such as correlations or group comparisons, were considered but deemed less appropriate as they would not capture the predictive relationships of interest. To control for Type I error due to multiple testing, a Bonferroni correction was applied across the 15 primary tests (three predictors across five models), setting the significance threshold at $p < .003$. Effect sizes (Cohen's d) were calculated and reported alongside p-values to help with interpretation. This approach aimed to balance the risk of false positives and false negatives, allowing for a more nuanced understanding of the results.

Qualitative analysis

For research question 3, responses to an open-ended question were analysed using CQR-M (Spangler et al., 2012). A combined deductive and inductive coding approach was employed, following Pelleboer-Gunnink et al. (2021), which allowed the researcher to stay close to participants' words whilst incorporating relevant theoretical frameworks. The analysis was guided by principles of critical community psychology and relational ethics, ensuring sensitivity to cultural context and aiming to avoid perpetuating harmful stereotypes. To focus on widely held attitudes and reduce overinterpretation, themes mentioned five or more times were included in the results.

Results

This study explored British Bangladeshis' attitudes towards people with intellectual disabilities. The results are presented in four sections:

1. Participant characteristics
2. Research question 1: What attitudes do British Bangladeshi people hold towards people with intellectual disabilities, as measured by discomfort, knowledge of capacity and rights, interaction, sensitivity/tenderness, and knowledge of causes, and do these attitudes differ according to the severity of the disability (mild versus severe)?
3. Research question 2: Does age, previous contact, and perceived closeness predict attitudes towards people with intellectual disabilities on the aforementioned dimensions?
4. Research question 3: What additional stereotypes or perceptions emerge from participants' open-ended responses?

Participant characteristics

Following data cleaning, 101 participants were included in the final analysis. Of these, 74 identified as female (73.3%), 25 as male (24.8%), and 2 participants (2%) did not report their gender. Age was reported in categories, with most participants falling into the 25–34 age group. 71 participants reported previous contact with a person with intellectual disabilities, either as a family member, social circle, through fostering or work. Participants came from diverse occupational sectors, including healthcare, education, government, policy, law, technology, and a range of other employment statuses (for example, self-employed, homemakers, or unemployed, further details are available in Appendix *C*). Table 1 provides a detailed distribution of the participants' demographics.

Table 1
Participants' demographics

Demographics	Category	N	%
Age	18-24	24	23.8%
	25-34	40	39.6%
	35-44	18	17.8%
	45-54	11	10.9%
	55-64	4	4%
	65-74	3	3%
	Prefer not to say	1	1%
Gender	Male	25	24.8%
	Female	74	73.3%
	Prefer not to say	2	2%
Religion	Not religious	2	2%
	Christian	4	4%
	Muslim	94	93.1%
	Prefer not to say	1	1%
Generation status	First generation	24	23.8%
	Second generation	73	72.3%
	Third generation	2	2%
	Prefer not to say	2	2%
Education	Primary school	1	1%
	Secondary school	1	1%
	College/sixth form	4	4%
	Vocational qualification	46	45.5%
	University degree	26	25.7%
	Postgraduate degree	21	20.8%
	Prefer not to say	2	2%
Religion guidance score	0-59	18	17.8%
	60-79	13	12.9%
	80-100	70	69.3%

Note.
Generations are defined by: First generation (born in Bangladesh), Second generation (born in UK, with at least one parent born in Bangladesh), Third generation (born in the UK, with grandparents born in Bangladesh).
Religion guidance score is measured on a scale from 0 to 100, where 0 indicates no importance of religion in guiding life, and 100 indicates high importance.

Research question 1

To address this question, descriptive statistics were used to examine participants' attitudes across the five ATTID-SF subscales, reflecting the multidimensional nature of attitudes toward individuals with intellectual disabilities. In addition, attitudes were compared between individuals with mild versus more severe intellectual disabilities to explore whether perceived severity influenced participants' responses. Each domain is reported separately below. Unless otherwise specified, higher scores reflect more negative attitudes. A summary of the results is presented in Table 2.

Table 2
Results of the ATTID Questionnaire

ATTID-SF Dimension	Mean	Standard deviation	% reporting positive attitudes (score of 1 or 2)	% reporting neutral attitude (3)	% reporting negative attitude (4 or 5)
Discomfort	4.02	0.83	14.72%	9.12%	76.16%
Knowledge of Capacity and Rights	2.18	0.73	71.7%	17.52%	11.32%
Interaction	2.07	0.71	72.24%	10.80%	11.97%
Sensitivity or Tenderness	3.14	0.88	40.23%	19.47%	40.30%
Knowledge of Causes	2.27	0.62	70.17%	20.15%	13.78%

Discomfort

Participants' comfort levels toward people with intellectual disabilities were assessed using two vignettes describing 'Rima' and 'Farzana'. These vignettes explored participants' reactions to interacting with a person with mild and severe intellectual disabilities respectively. The mean score was 4.02 (*SD* = 0.83), suggesting a relatively high level of discomfort. Only 14.72% of responses reflected a positive attitude, whilst 9.12% were neutral, and a substantial 76.16% indicated negative attitudes. This suggests that discomfort during direct interaction remains a significant concern.

Discomfort scores were compared between Rima and Farzana. For both the vignettes the overall mean score fell within 3 and 4, with the highest mean score being 4.53 (*SD* = .782) regarding the item about feeling afraid of meeting Rima on the street (mild intellectual disabilities). Overall, the sample experienced high levels of discomfort, as indicated by Table 3.

Table 3
Descriptive statistics of Discomfort items

	N	Minimum	Maximum	Mean	Std. Deviation
Farzana - feel afraid	101	1	5	4.14	1.068
Farzana - feel anxious	100	1	5	3.79	1.233
Farzana - feel insecure	101	1	5	4.18	1.062
Farzana - be wary	101	1	5	3.41	1.290
Rima - feel afraid	101	1	5	4.53	.782
Rima - experience anxiety	98	1	5	4.06	1.082
Rima - feel insecure	101	1	5	4.31	.903
Rima - be wary	99	1	5	3.78	1.174
Valid N (listwise)	96				

Further analysis was conducted to examine whether there was a statistically significant difference between discomfort scores toward Rima and Farzana. The means and standard deviations for discomfort toward both Rima and Farzana are presented in Table 4. Results indicated a statistically significant difference between the discomfort score for Rima (*M* = 4.17, *SD* = 0.76) and for Farzana (*M* = 3.87, *SD* = 0.09); *t*(100) = 4.80, *p* < .001. This suggests that participants reported significantly more discomfort when thinking about Rima than Farzana. The mean difference was 0.29, with a 95% confidence interval of [0.17, 0.41]. The effect size was medium to large, *d* = 0.61, indicating a meaningful difference in reported discomfort between the two vignettes (see table 5).

Table 4

Descriptive Statistics for Paired Samples T-Test on Discomfort Ratings

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	Discomfort Rima	4.1691	101	.76489	.07611
	Discomfort Farzana	3.8771	101	.98033	.09755

Table 5

Paired Samples T-Test Comparing Discomfort Ratings Between Rima and Farzana

		Paired Differences							**Significance**	
					95% Confidence Interval of the Difference					
		Mean	**Std. Deviation**	**Std. Error Mean**	Lower	Upper	**t**	**df**	**One-Sided p**	**Two-Sided p**
Pair 1	Discomfort Rima Discomfort Farzana	.29208	.61188	.06088	.17129	.41287	4.797	100	<.001	<.001

Knowledge of Capacity and Rights

This subscale measures participants' understanding of the abilities and rights of individuals with intellectual disabilities, such as the right to marry or have sex. The mean score was 2.19 (*SD* = 0.73), indicating generally positive attitudes (see Table 6). Overall, 71.7% of responses reflected a positive attitude, whilst 17.52% were neutral. Notably, this subscale recorded the lowest proportion of negative responses across all five domains, with only 11.32% of participants selecting "disagree". These findings indicate that within this sample, participants tended to express supportive views regarding the rights and abilities of individuals with intellectual disabilities.

The mean scores for each question on Knowledge of Capacity and Rights were examined. The mean scores of each item still fell between 2 or 3, with the highest mean score being on the item of being able to handle money (*M* = 2.72, *SD* = 0.95), indicating agreement and the lowest mean on the item of having the right to get married (*M* = 1.75, *SD* = .91) and right to have sex (*M* = 1.76, *SD* = .89), indicating agreement. As shown in Table 7, the sample generally agreed with each of the items, indicating higher knowledge of capacity and rights and positive attitudes.

Table 6
Descriptive statistics of Knowledge of Capacity and Rights

	N	Minimum	Maximum	Mean	Std. Deviation
Knowledge of capacity and rights	100	1.00	5.00	2.1941	.72082
Valid N (listwise)	100				

Table 7
Descriptive statistics of Knowledge of Capacity and Rights

In your opinion, the MAJORITY of people with ID are able	**N**	**Minimum**	**Maximum**	**Mean**	**Std. Deviation**
To hold down job	99	1	5	2.65	.940
To handle money	97	1	5	2.72	.955
To carry a conversation	99	1	5	2.22	.887
To make decisions	100	1	5	2.41	.922
In your opinion, the MAJORITY of people with ID					
Should have the rights to get married	100	1	5	1.75	.914
Should have the rights to have sex	99	1	5	1.76	.893
Should have the rights to vote	100	1	5	1.92	1.002
Should have the rights to have children	100	1	5	2.05	1.086
Valid N (listwise)	91				

Interaction

This subscale assesses participants' willingness to interact socially with people with intellectual disabilities by presenting two vignettes: Rima (mild intellectual disabilities) and Farzana (severe intellectual disabilities). For example, participants are asked how willing they would be to supervise Rima or Farzana at work. The mean score of 2.07 (*SD* = 0.71) indicating generally positive attitudes towards interaction. A total of 72.24% of responses reflected positive attitudes, 10.80% were neutral, and 11.97% indicated negative attitudes. These findings suggest that participants were largely open to interacting with people with intellectual disabilities.

Interaction scores were compared between Rima and Farzana (see Table 8). For both vignettes the overall mean score fell within 1 and 2, suggesting generally positive attitudes towards Interaction. The highest mean score was 2.48 (*SD* = 1.16) regarding the item about supervising Farzana at work, indicating a slightly lower willingness to supervise her at work. Overall, participants showed a relatively high level of openness to interacting with both individuals, though willingness varied slightly depending on the specific scenario.

Table 8
Descriptive statistics for Interaction items

	N	Minimum	Maximum	Mean	Std. Deviation
Would you accept being advised by Rima in a clothing store?	101	1	5	1.96	.882
Would you accept being advised by Rima in an electronics store?	100	1	5	2.28	1.111
Would you accept Rima being your child's friend?	97	1	5	1.56	.692
Would you accept supervising Rima at work?	96	1	5	2.15	.906
Would you accept Farzana as your child's friend?	95	1	5	1.84	.960
Would you accept supervising Farzana at work?	93	1	5	2.48	1.157
Would you feel comfortable talking to Farzana?	99	1	5	2.11	.957
Valid N (listwise)	82				

Sensitivity/tenderness

The Sensitivity/Tenderness subscale assessed participants' emotional responses to the vignettes describing "Farzana" and "Rima". The mean score was 3.14 (*SD* = 0.88), indicating a more mixed emotional response. A total of 40.23% of responses reflected positive attitudes, 19.47% were neutral, and 40.30% indicated negative attitudes. These results suggest that participants were divided in their emotional responses, with a substantial proportion neither strongly positive nor strongly negative.

Sensitivity/tenderness scores were compared between Rima and Farzana (see Table 9). The items for this factor were all reverse scored, so a score of 1 or 2 indicates disagreement with the statement and reflects lower levels of sensitivity/tenderness. For both vignettes, overall mean scores fell between 2 and 3, indicating moderate to low sensitivity/tenderness (see Table 10). The highest mean score (*M* = 3.58, *SD* = 1.22) was observed for the item assessing feeling sad about Rima's situation (mild intellectual disabilities), whilst the lowest mean score (*M* = 2.78, *SD* = 1.05) was for feeling touched or moved by Farzana (severe intellectual disabilities). These findings suggest that, although participants' emotional engagement was generally moderate to low, there was a slightly greater emotional response to individuals with mild intellectual disabilities compared to those with severe intellectual disabilities.

Further analysis was conducted to examine whether there was a statistically significant difference between sensitivity/tenderness scores towards Rima and Farzana. The means and standard deviations for sensitivity/tenderness towards both

Rima and Farzana are presented in Table 9. Results indicated a statistically significant difference between the sensitivity/tenderness score for Rima (*M* = 3.42, *SD* = 0.99) and for Farzana (*M* = 2.82, *SD* = 0.96); *t*(100) = 7.18, *p* < .001. Participants reported significantly greater sensitivity and tenderness toward Rima (mild intellectual disabilities) than toward Farzana (severe intellectual disabilities), as reflected by higher mean sensitivity/tenderness scores (see Table 11). This indicates that participants felt more empathetic and emotionally engaged when considering Rima's situation. The mean difference was 0.60**,** 95% CI [0.43, 0.76]. The effect size was medium to large, *d* = 0.84, indicating a large difference in between the two vignettes (see Table 12).

Table 9

Descriptive statistics for Sensitivity/Tenderness item

	N	Minimum	Maximum	Mean	Std. Deviation
Rima - feel pity	100	1	5	3.75	1.158
Rima - feel sad	101	1	5	3.58	1.219
Rima - feel touched	101	1	5	2.94	1.190
Farzana - feel pity	101	1	5	3.03	1.269
Farzana - feel sad	101	1	5	2.66	1.227
Farzana - feel touched or moved	98	1	5	2.78	1.051
Valid N (listwise)	97				

Table 10

Descriptive Statistics for Sensitivity Ratings Toward Rima and Farzana

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	Rima sensitivity	3.4224	101	.98533	.09804
	Farzana sensitivity	2.8218	101	.95982	.09551

Table 11

Paired Samples T-Test Comparing Sensitivity Ratings Toward Rima and Farzana

		Paired Differences							Significance	
					95% Interval of the Difference					
		Mean	Std. Deviation	Std. Error Mean	Lower	Upper	t	df	One-Sided p	Two-Sided p
Pair 1	Rima sensitivity – Farzana sensitivity	.60066	.84066	.08365	.43470	.76662	7.181	100	<.001	<.001

Table 12

Effect Size Estimates for Paired Samples T-Test on Sensitivity Ratings (Rima versus Farzana)

					95% Confidence Interval	
			Standardizer^a	Point Estimate	Lower	Upper
Pair 1	Rima sensitivity – Farzana sensitivity	Cohen's d	.84066	.715	.494	.932
		Hedges' correction	.84703	.709	.491	.925

Knowledge of causes

The Knowledge of Causes subscale assessed participants' understanding of the factors believed to cause intellectual disabilities. The mean score for this subscale was 2.27 (*SD* = 0.56), indicating generally positive attitudes. A total of 70.17% of responses reflected positive beliefs ("strongly agree" = 1, "agree" = 2), 20.15% were neutral, and 13.78% indicated negative attitudes. These findings suggest that most participants had an accurate understanding of the causes of intellectual disabilities, although a minority held different views. The highest mean score was for the item "intellectual disabilities are caused by punishment for parental sins" (*M* = 4.11, *SD* = 1.06), indicating widespread disagreement with this belief (see Table 13). In contrast, the lowest mean was for "caused by maternal consumption of drugs or alcohol during pregnancy" (*M* = 1.69, *SD* = 0.82), indicating strong agreement with this established cause. These results suggest that whilst most participants demonstrated accurate understanding, some misconceptions persist.

Table 13
Descriptive Statistics for Knowledge of Causes

	N	**Minimum**	**Maximum**	**Mean**	**Std. Deviation**
Caused by malnutrition in mother	90	1	5	2.86	1.045
Caused by serious head injury	99	1	5	2.03	.974
Caused by lack of stimulation in childhood	95	1	5	2.61	1.142
Caused by chemicals in the environment	98	1	5	2.42	.952
Caused by consumption drugs by mother	101	1	5	1.69	.821
Caused by problems during birth	97	1	5	2.08	.812
Caused by possession by Jinns (spirits/ghosts)	99	1	5	3.52	1.320
Caused by punishment for past sins of parents	99	1	5	4.11	1.058
As a test from Allah/God	96	1	5	2.79	1.329
Valid N (listwise)	76				

Summary of the ATTID-SF Subscale Results

Overall, participants demonstrated generally positive attitudes toward individuals with intellectual disabilities, particularly in the domains of knowledge of capacity and rights, interaction, and knowledge of causes with positive responses exceeding 70%. However, discomfort scores were notably higher, with the majority of participants indicating possible negative attitudes or unease. Sensitivity and tenderness responses were mixed, reflecting more complex emotional responses among participants. These findings underscore the multidimensional nature of attitudes towards people with intellectual disabilities in this sample. Furthermore, significant differences were found in discomfort and sensitivity/tenderness between mild and severe intellectual disabilities, suggesting that participants' attitudes varied based on the severity of the condition.

Research question 2

The following sections present the results for each regression model in turn. To help with interpretation, Cohen's *d* was calculated for categorical predictors by dividing the unstandardised regression coefficients by the standard deviation of the outcome variable. For the continuous predictor variable (closeness to people with intellectual disabilities), the standardised beta coefficient was used as effect size estimate, as Cohen's *d* is not applicable for continuous variables.

Regression Results for Discomfort

A multiple regression analysis was conducted to examine whether age, frequency of contact, and closeness to people with intellectual disabilities predicted discomfort attitudes, using combined discomfort scores from both vignettes. The overall model was not statistically significant, *F*(10, 59) = 0.93, *p* = .515, and explained 13.6% of the variance in discomfort attitudes (R^2 = .136; see Table 14). None of the individual predictors significantly predicted discomfort (all β values ranged from –0.10 to 0.24, all *p* > .003; see Table 15). Although no predictors reached statistical significance, some demonstrated small to moderate effect sizes, suggesting potential trends that may be meaningful with a larger sample. Overall, the hypothesis that these predictors would be associated with discomfort was not supported.

Table 14

Regression Model for Discomfort

R	R Square	Adjusted R Square	Std. Error of the Estimate
.368[a]	.136	-.011	.64229

Table 15

Regression coefficients for Discomfort by demographics

	B	SE B	β	t	p	d
(Constant)	3.637	.337		10.804	<.001	
Age (18-24)	.088	.218	.057	.406	.686	0.10
Age (35-44)	.343	.221	.236	1.550	.126	0.40
Age (45-54)	.029	.269	.014	.107	.915	0.03
Age (55-64)	-.154	.407	-.049	-.379	.706	-0.10
Age (65-74)	-.555	.675	-.104	-.822	.414	-0.10
Age (prefer not to say)	1.032	.687	.193	1.503	.138	-0.21
Contact: several times a month	.285	.243	.184	1.172	.246	0.31
Contact: occasionally during the year	.347	.257	.265	1.352	.182	0.35
Contact: less than once a year	.272	.326	.167	.837	.406	0.22
Closeness to person with intellectual disabilities	.003	.003	.174	.994	.324	-

Regression Results for Knowledge of Capacity and Rights

A multiple regression analysis was conducted to examine whether age, frequency of contact, and closeness predicted knowledge of capacity and rights. The overall model was not statistically significant, *F* (10, 59) = 0.91, *p* = .531, and explained 13.4% of the variance in knowledge (R^2 = .134; see Table 16). None of the individual predictors were significant, with standardized beta coefficients ranging from –0.18 to 0.20 (all *p* > .003; see Table 17). Effect sizes were small, indicating that these variables explained only a minimal amount of variance in knowledge of capacity and rights. Therefore, the hypothesis predicting associations between these demographic variables and knowledge was not supported in this sample, knowledge of capacity and rights was not influenced by age, frequency of contact, or closeness.

Table 16

Regression Model for Knowledge of Capacity and Rights

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.365[a]	.134	-.013	.70381

Table 17
Regression model for Knowledge of Capacity and Rights

	B	SE B	β	*t*	*p*	*d*
(Constant)	1.919	.218		8.795	<.001	
Age (18-24)	.098	.237	.058	.414	.681	0.108
Age (35-44)	.023	.242	.015	.096	.924	0.025
Age (45-54)	.336	.294	.154	1.144	.257	0.299
Age (55-64)	.610	.446	.178	1.366	.177	0.357
Age (65-74)	.701	.743	.120	.943	.349	0.247
Age (prefer not to say)	-1.055	.753	-.180	-1.402	.166	-1.402
Contact: on a weekly basis	.330	.282	.199	1.170	.247	0.31
Contact: several times a month	-.077	.262	-.046	-.295	.769	0.091
Contact: less than once a year	.091	.261	.049	.349	.728	0.091
Closeness to person with intellectual disabilities	.001	.004	.027	.156	-	0.041

Regression Results for Interaction

A multiple regression analysis was conducted to examine whether age, frequency of contact, and closeness to people with intellectual disabilities predicted attitudes related to interaction with them. The overall regression model was not significant, *F*(10, 57) = 0.82, *p* = .61, and explained only 12.6% of the variance in interaction attitudes ($R^2 = .126$; see Table 18). None of the individual predictors significantly predicted interaction attitudes (all *p* > .003; see Table 19). Effect sizes were mostly negligible to small, indicating these variables accounted for a minimal amount of variance and likely have limited practical impact. Therefore, the data did not support the hypothesis of a relationship between these predictors and attitudes toward interaction with people with intellectual disabilities.

Table 18
Regression Model for Interaction

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.355[a]	.126	-.028	.65632

Table 19
Regression Model for Interaction

	B	SE B	β	*t*	*p*	*d*
(Constant)	1.850	.215		8.597	<.001	
Age (18-24)	.072	.224	.047	.323	.748	0.09
Age (35-44)	-.025	.229	-.017	-.108	.915	0.03
Age (45-54)	.299	.288	.141	1.037	.304	0.27
Age (55-64)	.613	.417	.196	1.471	.147	0.39
Age (65-74)	.236	.694	.044	.340	.735	0.09
Age (prefer not to say)	-.994	.704	-.186	-1.411	.164	0.37
Contact: on a weekly basis	.447	.289	.288	1.549	.127	0.41
Contact: several times a month	.101	.248	.065	.405	.687	0.11
Contact: less than once a year	.075	.246	.045	.307	.760	0.08
Closeness to person with intellectual disabilities	-.003	.004	-.157	-.841	.404	-

Regression results for Sensitivity/Tenderness

A multiple regression analysis was conducted to examine whether age, frequency of contact, and closeness predicted attitudes of sensitivity/tenderness toward people with intellectual disabilities. The overall model was not statistically significant, *F*(10, 57) = 1.29, *p* = .256, and explained 18.5% of the variance in sensitivity/tenderness attitudes (R^2 = .185; see Table 20). None of the individual predictors significantly predicted interaction attitudes (all *p* > .003; see Table 21). These results suggest that, in this sample, sensitivity or tenderness was not strongly influenced by age, frequency of contact, or closeness. Therefore, the hypothesis predicting associations between these predictors and sensitivity/tenderness was not supported.

Table 20
Model Summary for Sensitivity/Tenderness

R	R Square	Adjusted R Square	Std. Error of the Estimate
.430^a	.185	.042	.82547

Table 21
Model Summary for Sensitivity/Tenderness

	B	SE B	β	*t*	*p*	*d*
(Constant)	3.436	.429		8.011	<.001	
Age: 18-24	.225	.281	.111	.800	.427	0.21
Age: 35-44	-.154	.287	-.080	-.536	.594	-0.14
Age: 45-54	.127	.361	.046	.351	.727	0.09
Age: 55-64	.303	.525	.074	.578	.565	0.15
Age: 65-74	.279	.867	.040	.322	.748	0.09
Age: prefer not to say	.190	.885	.027	.214	.831	0.06
Closeness: several times a month	.357	.316	.177	1.130	.263	0.30
Closeness: occasionally during the year	-.418	.336	-.240	-1.243	.219	-0.33
Closeness: less than once a year	-.707	.417	-.332	-1.697	.095	-0.45
Closeness to person with intellectual disabilities	-.001	.004	-.051	-.293	.770	-

Regression model for Knowledge of Cause

A multiple regression analysis was conducted to examine whether age, frequency of contact, and closeness to people with intellectual disabilities predicted knowledge of causes. The overall model was not statistically significant, $F(10, 60) = 1.48$, $p = .171$, explaining 19.8% of the variance in knowledge of causes attitudes ($R^2 = .198$; see Table 22). None of the predictors reached the adjusted significance threshold of $p < .003$. Age group 35–44 showed a trend toward significance ($\beta = .331$, $t = 2.27$, $p = .027$; see Table 23), indicating a possible positive association with knowledge of causes. Closeness to people with intellectual disabilities was positively related to knowledge ($\beta = .177$), though this was not statistically significant ($p = .295$). Effect sizes for all predictors were small to moderate, suggesting limited practical impact.

These findings indicate that demographic and contact variables did not strongly predict knowledge of causes, although some age groups may exhibit slightly greater understanding.

Table 22
Model Summary for Knowledge of Causes

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.444^a	.198	.064	.56148

Table 23
Regression model for Knowledge of Causes

	B	SE B	β	*t*	*p*	*d*
(Constant)	2.375	.173		13.715	<.001	
Age (18-24)	.199	.189	.141	1.056	.295	0.28
Age (35-44)	.438	.193	.331	2.274	.027	0.68
Age (45-54)	-.083	.233	-.045	-.353	.725	0.09
Age (55-64)	.443	.356	.155	1.245	.218	0.31
Age (65-74)	.861	.589	.176	1.460	.150	0.36
Age (prefer not to say)	-.298	.600	-.061	-.497	.621	0.12
Closeness: on a weekly basis	-.380	.225	-.276	-1.693	.096	0.57
Closeness: several times a month	.014	.209	.010	.068	.946	0.02
Closeness: less than once a year	-.032	.204	-.021	-.155	.877	0.04
Closeness to person with intellectual disabilities	.003	.003	.177	1.056	.295	-

Summary of the regression results

In total, five separate regression analyses were conducted to examine whether age, previous contact, and closeness of contact significantly predicted attitudes across the five subscales: discomfort, knowledge of capacity and rights, interaction, sensitivity/tenderness, and knowledge of causes. None of the models reached statistical significance. Cohen's *d* was estimated for each predictor to assess the magnitude of its effect, and these values are explored further in the discussion to provide context on potential practical significance despite the lack of statistical findings.

Qualitative analysis

Around 12% of participants (12 out of 101) did not respond to the qualitative question. One response was removed due to ambiguous response (“Allah knows best”). Despite the brevity of the prompt, participants generally engaged thoughtfully, with many offering nuanced reflections on their thoughts of people with intellectual disabilities. The responses varied from a few words (for example, “capable”, “Down syndrome”, “social anxiety”) to some participants writing several sentences (for example, “in social terms, people with intellectual disabilities might have some limitations but with appropriate support and positive environment they can have normal life like us all. All it needs an empathetic response towards others who might not develop like so many of us”).

Eight categories were created as shown in Table 24. An additional four categories were identified, but since each contained only two quotes, they were excluded from the final analysis. Approximately 48% of participants’ comments reflected the perception that individuals with intellectual disabilities have reduced independence and require additional support. Regarding the salience of stereotypes, approximately 6% of comments spoke about this explicitly. In contrast, a larger proportion, around 52%, expressed rejection of stigma held by the community.

Table 24 - *Codes Identified in CQR-M analysis*

Coding Category	*Definition*	*Examples*	*% of responses* (n)
Rejection of stigma and awareness of dehumanisation	Participants reject stigma related to intellectual disabilities and recognise how wider society can dehumanise individuals with intellectual disabilities.	"…. the first impressions that come to mind often include resilience, warmth, and the capacity to form meaningful relationships when supported appropriately. With the right environment and support, they can lead fulfilling lives and make valuable contributions to their communities" "They're people with struggles that don't have a short-term fix and aren't maskable - as other learning disabilities are, so people treat them inherently differently. but they're still people and it's hard watching their personhood being taken away in public settings"	52.3% (*n* = 46)
Reduced independence	Includes the view that individuals may be unable to engage in some/all daily activities, access opportunities, or maintain wellbeing	"They might also struggle with everyday life skills and adapting to complex situations" "Able to live a normal life day to day life, only struggle with specific type of intellectual tasks maybe"	28.4% (*n* = 25)
Different social skills	There is an assumption that there are different abilities on how people with intellectual disabilities communicate with others in social contexts	"In social terms, people with intellectual disabilities might have some limitations but with appropriate support and positive environment they can have normal life like us all. All it needs an empathetic response towards others who might not develop like so many of us."	27.3% (*n* = 24)
Support needs	This category captures that individuals may need assistance to participate fully in life, focusing on what helps someone succeed, not what they lack.	"They are nice people but may need a bit of extra support" "People who need an extra bit of help in life and see the world a little differently. It ranges from person to person, but they aren't "ill people" or "crazy"."	20.5% (*n* = 18)
Spectrum of disabilities	Participants recognise there is a spectrum of disabilities.	"The first thing that comes to mind are people who are non-verbal, but I remind myself that is the minority amongst people with intellectual disabilities"	10.2% (*n* = 9)
Overlapping understandings of neurodiversity and intellectual disabilities	Some participants referred to people with intellectual disabilities in broad terms, grouping them with other forms of neurodiversity	"First thing that comes to mind is modern labels like ADHD, autism and other learning disabilities etc. People that struggle to learn, communicate and are overactive or underactive. These are the types of people I have encountered. When I was growing up in the 80's, children like this were just seen as naughty, lazy or troublesome, there were no labels or reasons for it…"	5.7% (*n* = 5)
Impairments in thinking	Participants reflected on the cognitive differences	"People with intellectual disabilities are individuals who may experience limitations in intellectual functioning and adaptive behaviour, affecting areas such as communication, social skills, and daily living..."	5.7% (*n* = 5)
Beliefs shaped by spiritual, social, and familial influences	This category includes possible stigma (conscious or unconscious), stereotypes and ways of trying to understand why someone has intellectual disabilities	"Were their parents related?" "They think without speaking most times" "Sometimes i think Allah has given the persons parents a chance to go Jannah. i dont think their condition is necessarily a test i think they are a means of the test for others"	5.7% (*n* = 5)

Discussion

This study aimed to explore explicit attitudes towards individuals with intellectual disabilities within the British Bangladeshi lay population. A mixed-methods approach was used to examine whether age, frequency of contact, and perceived closeness predicted participants' attitudes. In addition, CQR-M (Spangler et al., 2012) was conducted to identify broader themes and community perceptions. As Murthy (2002) argues, understanding local manifestations of stigma is essential for effective stigma reduction. Furthermore, this study establishes an important baseline for assessing current attitudes within the community.

Contrary to our initial hypotheses, none of the five regression models showed significant predictors of attitudes towards people with intellectual disabilities in the British Bangladeshi community. A Bonferroni correction was applied to account for multiple testing across these models, setting a more stringent significance threshold of $\alpha = 0.003$ (three predictors across five regression models). Although the study was originally powered at 80% to detect a small effect size ($f^2 = 0.03$) at the conventional alpha of 0.05, the application of a stricter significance threshold likely reduced statistical power. Given the sample size was smaller in this study, it may have been underpowered to detect effects of this size. Therefore, it is possible that true associations exist but are weaker than the threshold detectable within the current study, and these findings should be interpreted with caution.

Previous research with larger, more representative samples across the globe has found age and contact influences attitudes towards people with intellectual disabilities (Keith, Bennetto, Rogge, 2015; McManus, Feyes & Saucier, 2010; Morin et al., 2013; Zamorano et al., 2024). However, other studies have found that age and contact are weak predictors, with cultural and personal factors, including religiosity, potentially having greater influence (Himmelberger et al., 2021; Maftei et al., 2023; Mirete et al., 2020)

In the context of the British Bangladeshi community, these mixed findings may reflect the complex cultural norms around family caregiving and community involvement, which do not necessarily vary in predictable ways with age. This complexity can be better understood using intersectionality theory (Crenshaw, 2013), which emphasises how different aspects of a person's identity, such as race, religion, gender, class and age, combine to shape people’s experiences and views. From this perspective, age alone may not account for people's attitudes towards intellectual disabilities, as it interacts with other factors such as gender roles or socioeconomic background. Future research with a larger sample could provide a clearer picture of how age and possibly other social factors work together to influence contact experiences.

Although this study was underpowered and future research with a larger sample is needed, the descriptive statistics showed participants generally expressed positive attitudes, particularly in the domains of Knowledge of Capacity and Rights, with high endorsement of relational and sexual rights. This is notable given that prior research suggests South Asian communities often hold more conservative attitudes towards sexual behaviour (Kennedy & Gorzalka, 2002). For instance, Sankhla and Theodore (2015) found that South Asian participants expressed significantly more negative attitudes towards the sexual rights of individuals with intellectual disabilities than White Western participants. Similarly, a study in Hungary reported lower public approval of rights for people with autism and intellectual disabilities (Bernat, Turnpenny & Gabor Petri, 2025). This study’s finding may reflect specific cultural dynamics or shifting perspectives among British Bangladeshis.

This study found that the baseline attitudes of the British Bangladeshi community was less stigmatising than Odukoya et al.’s (2023) Nigerian and Kenyan samples. However, in this sample, attitudes were less positive towards the ability of individuals with intellectual disabilities to handle money. This may reflect a cultural emphasis on financial responsibility, or different thresholds of trust depending on this domain. These contrasts suggest that different types of capacity (for example, sexual versus financial) may be valued differently depending on cultural and contextual factors.

A notable finding in this study was that a relatively high proportion of participants endorsed the belief that intellectual disabilities may result from punishment for parental sins. This reflects culturally specific explanatory models within the British Bangladeshi community and has potential implications for stigma. Such beliefs may contribute to families feeling the need to shelter their children with intellectual disabilities or may discourage parents from engaging with the wider community, due to a sense of personal responsibility or fear of negative judgment. These findings are consistent with previous research in South Asian contexts (Ojha et al., 1993; Zaman et al., 1987) and highlight how religious or spiritual interpretations can influence perceptions of disabilities.

Markedly, Discomfort was higher in response to the vignette describing mild intellectual disabilities than the one describing more severe intellectual disabilities. This may reflect greater uncertainty around interacting with those whose disabilities are less visible or clearly defined. Goffman (1963) distinguishes between “discredited” conditions, which are immediately visible and often elicit sympathetic responses, and “discreditable” conditions, which are concealed and can lead to discomfort or suspicion due to their ambiguity. This distinction may help explain participants’ unease in response to the mild vignette, where the signs of intellectual disabilities were subtle and not immediately apparent. Moving forward, public awareness efforts should also show people with milder or less visible intellectual disabilities.

Responses related to Sensitivity and Tenderness were mixed, indicating emotional nuance and ambivalence. This ambivalence may reflect broader discomfort with vulnerability or uncertainty about how to appropriately engage with individuals with intellectual disabilities. Cultural influences may also shape these responses, as emotional expression and interpretation can vary across contexts. South Asian communities, for instance, may exhibit more indirect or restrained emotional communication (Sharif et al., 2022). These findings are consistent with the concept of aversive disablism (Deal, 2006). This concept describes subtle and often unconscious discomfort among individuals who nonetheless express generally positive attitudes. As demonstrated, participants may endorse the dignity of individuals with intellectual disabilities in principle but still experience discomfort or uncertainty in real life interactions. For example, the participants may generally support for the rights and inclusion of people with intellectual disabilities but may feel uncomfortable if they were asked to interact closely with a neighbour with intellectual disabilities. Indeed, this may not stem from overt prejudice, but from unfamiliarity and a desire to avoid emotional discomfort, which is characteristic of aversive disablism (Deal, 2007). As seen in previous research on responses to wheelchair users (Vilchinsky, Werner, & Finder, 2010), care and discomfort can coexist, highlighting the need for interventions that address not only knowledge and beliefs, but also emotional and relational dynamics.

Participants showed slightly more Sensitivity/Tenderness towards Rima (vignette describing a person with mild intellectual disabilities). This could indicate an unconscious distancing from people with severe intellectual disabilities. Such patterns align with research showing lower social acceptance of individuals with severe intellectual or mental health difficulties compared to milder ones (Ouellette-Knutz et al., 2010; Norman et al., 2008; Silton et al., 2011; Norman et al., 2012). These findings suggest that the severity of the disability may influence emotional responses and perceived social distance, highlighting the importance of addressing public attitudes across the full spectrum of intellectual disabilities in awareness and inclusion efforts.

Interestingly, whilst quantitative findings indicated discomfort, the open-ended question provided valuable context and deeper insight into the participants attitudes, which reflected supportive and compassionate attitudes. Participants in the qualitative question emphasised respect, equality, and inclusion, suggesting that many of them actively resist dehumanising narratives, in a similar view to participants in China (Su et al., 2015). Compared to Pelleboer-Gunnick et al. (2021), who found a broad range of stereotypes in the Dutch population, only five participants in the current study expressed stereotypical views. Indeed, this could be due to the limited sample size in this study. In this study, one participant described people with intellectual disabilities as “unclean, cursed” which likely reflects the influence of cultural or societal stigma around disabilities, possibly shaped by traditional or religious beliefs. Another commented, “they are innocent, and their understanding is limited” which whilst well-meaning these views can unintentionally reinforce dependency by framing individuals with intellectual disabilities as lacking autonomy (Cuddy, Fiske & Glick, 2008). This highlights how broader societal narratives can influence attitudes in subtle ways.

The code “overlapping understanding of neurodiversity and intellectual disabilities” indicated that some participants conflated intellectual disabilities with other conditions, despite the explanation of ‘learning disabilities’ at the start of the study. Over 15 years ago, Mencap (2008) found that 73% of participants in Britain had an inaccurate understanding of the term ‘learning disability’. Although only five comments in this study suggested there was a conflation, this may reflect a broader challenge in how the term is understood within the British Bangladeshi community. Given the limited number of comments and participants in this study, this observation should be interpreted cautiously and warrants further exploration in future research.

This study demonstrated that positive attitudes toward individuals with intellectual disabilities do exist within the lay British Bangladeshi community, although these attitudes are nuanced and mixed, consistent with previous research (Coles & Scior, 2011; Scior, 2011). This complexity suggests that attitudes are likely shaped by intersecting historical, cultural, and social factors. Recent global events have increased public awareness of systemic inequalities (Grain & Lund, 2016), which may partly explain heightened sensitivity to social justice issues within the UK community. Additionally, research suggests that communities affected by trauma, such as war (Bauer et al., 2013; Canevello, Hall & Walsh, 2022), may develop greater empathy and attunement to marginalisation, particularly towards their own in-group.

In summary, none of the regression models reached statistical significance, however several predictors and descriptive tests revealed meaningful trends that merit further investigation. The qualitative data further suggested that an overwhelming majority of participants recognise the dehumanisation occurring within the community and expressed a strong desire to dismantle it. Overall, this study contributes to a more nuanced understanding of the factors influencing attitudes and knowledge, providing a foundation to inform culturally sensitive interventions aimed at promoting inclusion and support within the British Bangladeshi community. As Mencap, the UK's leading learning disability charity asserts, "*it is our belief that the general public's understanding and perception of the condition must improve if we are to eliminate discrimination against people with learning disabilities in the UK*" (Mencap, 2022). This underscores the need to move beyond understanding and towards action now that some knowledge has been gained. The following section outlines key community and policy implications emerging from this research.

Community and policy implications

This study shows the importance of understanding the communities' attitudes as such insights are essential for developing culturally appropriate interventions and improving support for people with intellectual disabilities within the British Bangladeshi population. Whilst understanding societal attitudes toward intellectual disabilities offers valuable insight, focusing solely on attitudes risks overlooking structural challenges such as under-resourced services and institutional discrimination. Therefore, meaningful change must occur across multiple levels. Thus, the findings from this study offer both community and policy level considerations.

To reduce aversive disablism within the British Bangladeshi community, service providers should implement culturally sensitive interventions that foster meaningful contact between community members and people with intellectual disabilities. Creating safe spaces for open dialogue and promoting inclusive language can further support attitudinal change.

As it’s possible that lay people are not exposed to people with mild intellectual disabilities, possibly due to the way in which media, such as Hollywood/Bollywood, represents people with intellectual disabilities, encouragement for more people with mild intellectual disabilities in mainstream media may be worthwhile, as it could be used to educate the population on their abilities (Patel & Rose, 2013). If people with severe intellectual disabilities are only presented in a negative way, this will inevitability shape the public’s negative perception (Deb, 2022; Renwick, Schormans & Shore, 2013).

There was evidence of culturally specific beliefs, such the relatively high agreement that intellectual disabilities may result from punishment of parental sins. The points to the importance of increasing awareness and understanding of intellectual disabilities within the British Bangladeshi community, addressing misconceptions and reducing stigma. Collaborating with community leaders and faith leaders could help ensure that educational messages are respectful, relevant, and effective in promoting more inclusive attitudes. Such educational messages must also recognise the broader social factors that shape stigma, including past experiences of exclusion, racism in public institutions, and mistrust of services. Rather than adopting a one-size-fits-all approach, programmes should be co-developed with communities to respect their cultural values whilst encouraging open conversations about harmful beliefs that portray disabilities as shameful or overly burdensome. Considering these findings, future action-based research might explore community-led initiatives such as a Mela (Bangladeshi festivals) could provide visible, empowering roles for people with intellectual disabilities.

At the policy level, investment in inclusive education, accessible services, and supported employment remains crucial. This is particularly important given that even where attitudes are positive, structural barriers continue to hinder inclusion. Government officials may consider launching a targeted program to raise awareness about intellectual disabilities within the British Bangladeshi community. Such an initiative could enhance understanding of intellectual disabilities, and in turn, create a safer environment for people with intellectual disabilities and their families.

Strengths and limitations

This study is among the first mixed-methods investigations into the attitudes of British Bangladeshi people toward individuals with intellectual disabilities. Given the limited research on this community's beliefs, particularly through an intersectional lens, this study contributes to an important gap in the literature. Its findings offer real world implications for designing culturally-informed awareness campaigns and policy initiatives that address stigma more effectively. Another strength is the diverse occupational background of participants, offering broader insights than studies limited to student samples. Moreover, given this was an online study, it reduced the possibility of socially desirable responses.

As with all research, this study is not without limitations. A limitation of this study is that the regression analyses were underpowered due to the modest sample size, which increases the risk of Type II error. Alternative analyses such as correlations or non-parametric tests were considered; however, they would not have addressed the study’s central aim of examining the predictive role of multiple factors simultaneously. Thus, it is imperative the regression findings are interpreted as exploratory.

Moreover, the ATTID-SF vignettes were presented in a fixed order across all participants; therefore, the potential influence of order effects cannot be ruled out. Participants’ responses may have been shaped by the sequence in which the scenarios were presented, rather than by the content alone. Future research should counterbalance vignette order to reduce such effects to enhance the internal validity of the findings.

It is unclear whether participants were able to fully conceptualise a person with intellectual disabilities from reading the description/vignettes included in the study. Incorporating videos/pictures may have helped. Additionally, piloting vignettes with members of the community may have ensured cultural relevance and clarity. However, due to time constraints, community collaboration was not possible for this research. Future studies should prioritise involving the community, people with intellectual disabilities, and their families in the design, data collection, and analysis to ensure their perspectives are accurately represented.

Another limitation of the study is that only female names were used in the adapted ATTID-SF case study. This was done intentionally to increase the visibility of women with intellectual disabilities, who are often underrepresented in research. However, this may have introduced gender bias by limiting participants’ responses to perceptions of women only, potentially affecting how generalisable the findings are to men with intellectual disabilities.

Finally, the use of ATTID-SF survey questions may have limited the accuracy of capturing genuine attitudes. For instance, asking participants whether they would agree to supervise Rima or Farzana at work may not fully reflect real-world complexities. Given that some participants were medical professionals or worked in fields such as technology or architecture, supervising a person with severe intellectual disabilities might not be feasible in these contexts, which may indicate why attitudes in this domain were more negative towards Farzana (vignette presenting severe intellectual disabilities). Qualitative methods could provide deeper insights into the complexities of attitudes toward people with intellectual disabilities across different settings. This would help to address the limitations of standardised surveys.

Future research

Future studies should move beyond questionnaires to explore how religion, community norms, and intergenerational dynamics influence attitudes towards people with intellectual disabilities. Employing longitudinal and qualitative methods would allow for a deeper understanding of how attitudes evolve over time and across different social contexts.

Conclusion

This study explored attitudes towards people with intellectual disabilities within the British Bangladeshi community and revealed a complex and nuanced picture. Whilst quantitative data indicated the presence of some negative perceptions, most qualitative responses reflected empathy, cultural understanding, and a strong commitment to the humanisation and inclusion of individuals with intellectual disabilities. Participants also recognised that existing social and structural systems often fail to protect people with intellectual disabilities. These findings highlight the importance of challenging deficit-based narratives, addressing systemic barriers within policies and services, and promoting community-led interventions. As researchers and members of society, we share a collective responsibility to critically examine existing systems and actively work towards fostering inclusion.

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Part 3: Critical Appraisal

Critical appraisal

This critical appraisal reflects on my experiences of completing this thesis. It covers my motivation for researching the British Bangladeshi community, the initial project I had to abandon due to the socio-political context in Bangladesh at the time, and the lessons I have learned along the way. I will then discuss my empirical study, focusing on my experience with participant recruitment and offering recommendations for future researchers. Personal reflections will be integrated throughout.

Researcher positionality: Why study the Bangladeshi community?

I approach the study of stigma with my own assumptions, which cannot be entirely separated from the research process. For transparency and reflexivity, I believe it is important to acknowledge this. As a second-generation British Bangladeshi, Muslim, cisgender woman raised in London, I have been aware of what it feels like to be "different". Growing up in a predominantly White area exposed me to both explicit and implicit racism. Additionally, I did not learn to speak English until I was in primary school, having only spoken in Sylheti at home. Having a family member with severe mental health difficulties, further led my family to ostracisation from the community. I therefore feel acquainted with the experience of being "othered" which has shaped my perspective of the world. My life experiences motivated me to study psychology at undergraduate level, because I wanted to understand why people who do not fit dominant social norms are treated unfairly with a strong interest in social change. I recognise that I have been extremely privileged in many respects throughout this process, such as having access to education and support, which also influences my perspective. Nevertheless, this background allows me to approach the topic with personal commitment and insight, enriching the depth of this thesis.

I have always been motivated to give back to my community, therefore, for my doctoral research, I wanted to do something meaningful, not by imposing psychological concepts onto my community, but by hoping to open space for dialogue between psychological knowledge and the lived experiences of people who are often excluded. I wanted to challenge dominant Western perspectives in psychology by exploring how psychology can be tailored to the Bangladeshi community.

It seemed a natural fit to combine my interest in stigma with a study based in Bangladesh. With the support of my UCL supervisor, I began developing an e-intervention aimed at reducing stigma toward people with intellectual disabilities. This involved plans to travel to Bangladesh to co-create a video featuring people with intellectual disabilities and presenting them in a humanising and empowering manner, to help reduce negative attitudes towards them as an intervention. This approach was informed by evidence showing the effectiveness of similar interventions in African countries (Odukoya, Chege, & Scior, 2024). Initial planning and strong local partnerships were established during the first and second year of my doctorate. However, due to political unrest and subsequent travel advice issued by the UK government, travel to Bangladesh became unfeasible (see: www.bbc.co.uk/news/articles/ck5g9xd9rrwo).

This situation taught me a great deal about the challenges of conducting research in complex sociopolitical contexts. Political instability can disrupt timelines, limit access to participants, and introduce ethical and safety concerns. It also underscored the importance of adaptability in research and highlighted the value of strong local partnerships in navigating such uncertainty. Ultimately, due to time constraints within the clinical psychology doctorate, I had to abandon this project. This experience not only revealed the realities of conducting research under tight deadlines but also reinforced how external sociopolitical forces can shape the direction and feasibility of academic research.

This experience also brought into focus the dynamics of power in research. Although I share a cultural background with the Bangladeshi community, as a UK based doctoral researcher, I held significant power in setting the research agenda, timelines, and methods, including the decision to end the project. The abrupt shift in plans due to political unrest further highlighted how fragile these assumptions of control can be, particularly when working in international and socio-politically unstable contexts.

In response to this challenge of not being able to travel to Bangladesh, my supervisor offered access to secondary data. However, I chose to continue my commitment to stigma-related research within the British Bangladeshi community which she kindly supported. At the time, I was on placement within a learning disabilities team in London, where I regularly observed the profound consequences of stigma faced by people with intellectual disabilities and the families I supported, including many British Bangladeshis. The consultant clinical psychologist of the service suggested that conducting a study investigating attitudes towards intellectual disabilities would be worthwhile, given the evident impact of societal perceptions on service users’ well-being and access to support. Therefore, I developed a new project, obtained ethical amendments, and shifted my focus to the study presented in Part 2 only in November 2024. Whilst this sudden pivot was challenging and conducted under significant pressure, it ultimately strengthened my skills in flexibility, critical thinking, and working within real-world research constraints.

This section provides a reflection on how my personal life experiences have informed and shaped this research. It is important to acknowledge that researchers' positionalities inevitably influence their approaches and interpretations, and that another researcher with a different background may have engaged with the write-up of this study in a different manner. As an individual with lived experience of marginalisation, I recognise that my positionality has shaped both the focus of this research and my sensitivity to the cultural and contextual nuances inherent in studying the Bangladeshi community. Throughout the research process, I have maintained a stance of critical reflexivity to consider how my background and assumptions may have influenced the analysis and interpretation presented.

Researcher reflexivity: Researching my community

Researching the British Bangladeshi community was both insightful and challenging. My thinking and approach to this research was strongly influenced by my final year placement, which is focused on leadership and community psychology. As described by Orford (1992, 2008), community psychology encourages us to understand the difficulties people face within broader social, cultural and political contexts. This means that the difficulties people face in society and life are influenced by many layers, including government policies, NHS funding, local authority decisions and the wider impact of austerity. These structural forces have a direct impact on the lives of people with disabilities (Smail, 2005).

Community psychology values prevention, social justice and liberation. It aims to strengthen community resources and move away from top-down approaches. As a Clinical Psychologist in training who is committed to these values, I felt it was important to challenge dominant narratives and frame my research in a way that highlights the structural factors affecting people with intellectual disabilities, rather than focusing solely on individual outcomes. This perspective shaped how I made sense of the recruitment challenges, how I interpreted participants' responses, and how I wrote up the findings. Although the process was not without difficulty, it deepened my understanding of what it means to carry out research with communities rather than 'on them'. It also reinforced the importance of staying grounded in reflexivity and an awareness of power when conducting research.

As a member of the British Bangladeshi community myself, I initially approached recruitment with a sense of familiarity and optimism. However, I realised that sharing an identity with the community did not automatically translate into easy access or engagement. Despite considerable effort within a limited time frame and resources, the study was underpowered, with 266 participants visiting the website but only 101 viable responses for analysis. I believe several factors contributed to these challenges.

To begin, I was aware of the harms racialised communities have faced through research, such as the Tuskegee Syphilis Study (Gamble, 1997). Awareness of such historical abuses helps explain the understandable cautious or sceptical attitudes some members of racialised communities hold toward researchers. It was important to hold the historical context in mind, thus this shaped my approach to community engagement and recruitment, highlighting the need for transparency and building trust to overcome these barriers. Hence my efforts were focused on building relationships and working collaboratively with key community organisations, rather than simply seeking participants for the sake of data collection.

Despite multiple attempts via email (see Appendix I) and phone calls, establishing contact with relevant people proved challenging. When I was able to connect, I was often assured that a response would follow; however, despite follow-ups, I did not receive any replies. Additionally, many of my emails were returned as undeliverable, which made me more frustrated given the limited time available to complete my thesis alongside other responsibilities. I emailed researchers in the UK who had successfully recruited 100+ British Bangladeshi participants for advice and if they could help me to collaborate with an organisation but unfortunately, I received no response. Although at times I felt discouraged, conversations with colleagues allowed me to adopt a more reflective stance, appreciating the broader systemic and resource limitations impacting communication. I recognised that grassroots organisations face significant constraints on their capacity to engage with research requests.

I also considered the concept of ‘helicopter research’, where researchers enter communities briefly to collect data without fostering genuine collaboration or presenting any lasting benefit (Nature, 2022). Whilst my original study was designed with collaborators in Bangladesh who felt the research was necessary, the UK study was not co-designed or co-produced with the community, primarily due to limited time (the first project was abandoned in November 2024 with the thesis deadline of June 2025). It was never my intention to appear as if I was conducting ‘helicopter research’, however, I recognise how community members may have viewed me. If I had more time, employing participatory methods such as a World Café (Löhr, Weinhardt & Sieber, 2020), which brings stakeholders, including people with intellectual disabilities and their families together for reflective, co-productive dialogue, may have fostered more meaningful community involvement.

I recognise that it would be incomplete not to consider intersectionality when it comes to recruitment challenges. Despite posting the study on active Reddit forums and Facebook groups with over 1,000 daily users and having well-known British Bangladeshi Instagram influencers share my study, participant numbers did not increase. This suggests that factors beyond visibility such as complex social identities, trust, and cultural dynamics, may have influenced engagement. Intersectionality offers a framework for understanding how systems of power, such as race, gender, age, and culture, intersect to shape individuals' experiences of marginalisation and inclusion (Crenshaw, 2013). It is therefore essential to consider how these intersecting social identities influence inclusion in research.

For instance, within the British Bangladeshi community, cultural expectations regarding gender roles may have restricted some women's participation, whilst age related factors could have affected the availability or willingness of younger or older individuals to engage. Moreover, experiences of racial marginalisation or language barriers may have fostered mistrust towards me, or the institution that I was representing (UCL). Although I attempted to address the language barrier issue by translating the ATTID-SF into Bangla, these overlapping identities create complex layers of potential mistrust. Understanding such intersections is critical to designing recruitment strategies that are respectful, inclusive, and tailored to overcome the specific barriers faced by diverse subgroups within the community.

During three days of face-to-face recruitment in Whitechapel and Aldgate East I handed out flyers of my research project. There was an overall evident lack of interest from the general public. Notably, the data showed that no participants were recruited through this method, despite distributing over 100 leaflets in areas densely populated by the Bangladeshi community across London. I wondered if cultural beliefs surrounding people with intellectual disabilities contributed to this reluctance to engage with the research. I also sought permission to speak about my project inside two Mosques in London but was denied. I wondered if being a woman in my early 30s, may have influenced how I was received by older community members particularly considering cultural expectations around age and gender. Mosques have been a good place to recruit in other research studies regarding physical health issues (Abu-Ras et al., 2024). Therefore, it was unlucky that I was not granted permission to speak about my research inside the mosque. I wondered whether the topic of intellectual disabilities holds less perceived urgency or legitimacy when compared to physical health issues. This may reflect broader societal hierarchies of value, where medical conditions are more readily discussed and prioritised than mental health difficulties or intellectual disabilities. This highlights how stigma could shape not only attitudes but also access to research spaces and recruitment.

I was struck that no participants took part in the Bangla ATTID-SF. This raises important questions around the British Bangladeshis language preference and accessibility. Whilst the Bangla version was developed to encourage inclusivity, its lack of uptake could indicate that participants felt more comfortable engaging in English. Perhaps this signifies a generational shift in language preference in UK Bangladeshis, with English seen as more appropriate for formal or research settings. Whilst speculative, this observation points to the need for further exploration into how language shapes participation in research within bilingual communities. As this finding could also signify that the population who prefer to read and write in Bangla were not reached in my study.

Through the course of this research, I gained many insights into attempting to engage the British Bangladeshi community. These experiences have shaped a set of reflections and recommendations for future researchers intending to work with this population. A significant lesson learned was the importance of beginning with co-production. Establishing trust and psychological safety within the community is essential, and this requires genuine collaboration from the earliest stages of the research process. Whilst this principle is well established in the literature, my experience confirmed its practical importance in building rapport and promoting meaningful engagement.

Recruitment strategies also required careful consideration. Face-to-face recruitment in London proved largely ineffective in my case. Many people were unresponsive, for example, one gentleman told me in Bangla "Please God save me and do not talk to me". This comment, along with similar experiences, for example, laughter when speaking to the public about my research may highlight broader discomfort or suspicion towards unsolicited engagement from researchers. This may reflect past negative experiences, a lack of familiarity with research processes, or deeper issues of understandable mistrust. Considering this, more sensitive access routes should be considered. For example, informal networks, such as family connections or relationships with respected community figures such as Imams, may be more effective and appropriate than public recruitment methods.

Whilst writing this thesis, I remained mindful of how I might be perceived, like other doctoral researchers who have expressed concerns about being seen as "too loud" (Ali, 2023). As both Ali (2023) and Williams (2023) highlight, such concerns are grounded in evidence that some professionals within clinical psychology continue to hold problematic biases. However, as Wood and Patel (2017) argue, unless Clinical Psychologists actively challenge systemic injustices, meaningful societal change is unlikely. This informed my decision to take a decolonial approach throughout this thesis, remaining attentive to the voices and experiences of marginalised communities who have historically been harmed by researchers, doctors, and psychologists.

Learnings from quantitative research

During the analysis phase, I realised that the variable age would have been better treated as a continuous variable, rather than categorical. This decision was initially influenced by the survey layout employed in Morin et al. (2013), however, in retrospect, this likely restricted the sensitivity of the analysis.

As this was my first experience conducting quantitative research, I have learned a lot. I became more aware of the importance of thoughtful variable selection, considering matters such as counterbalancing and the implications of statistical decisions for both validity and interpretability. This process has deepened my appreciation for the complexity of quantitative analysis.

Researching whilst caring

In reflecting on my positionality, I feel it is important to acknowledge a personal experience that closely intersected with the themes of stigma explored in this research. During the course of this doctorate, I was also a carer for a family member, who experienced several hospital admissions since the start of the empirical phase.

I often had to advocate for my family member’s needs as they are not fluent in English, where I was met with many obstacles. As a researcher, I could not help but consider how such experiences might be like for people who are unable to advocate for themselves and for those who lack advocates, such as people with severe intellectual disabilities. This reinforced my awareness of how easily marginalised groups can be overlooked or silenced within systems. At the same time, I recognise that many healthcare professionals work under intense pressure within systems that constrain their ability to deliver person-centred and culturally responsive care. This reflection is not about blaming individuals but about acknowledging the structural barriers, such as limited time, insufficient interpreter services, and unconscious biases, that shape people's experiences, be it at school, hospital or any other system.

This experience whilst conducting my research deepened my commitment to advocating for people whose voices are marginalised. As Clinical Psychologists, we are uniquely positioned to influence policy, support multidisciplinary teams, and uphold the rights and dignity of the people we serve.

Conclusion

Conducting this research has been both challenging and rewarding. Although at times stressful, I have learned many valuable lessons, and writing up this thesis has been a joy. From an early age, I have been motivated by a strong commitment to challenging stigma. This thesis represents a step in that ongoing journey. I have come to appreciate that even quantitative research, often regarded as 'objective', is shaped by the researcher's assumptions, the framing of questions, and participants' perceptions of the researcher and the research process. Changing attitudes and promoting social change is a complex task, yet I believe it is possible. Conversations with fellow trainees have reinforced my belief that social change can occur when enough voices demand it. As a (nearly) Clinical Psychologist, I recognise our unique role in promoting the humanisation and inclusion of marginalised people.

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Appendix A: Search terms for systematic review

Topic of interest	**Topic of interest**	**Asian countries**
intellectual disabil* OR mental* retard* OR mental* handicap* OR developmental disab* OR developmental delay	attitude* OR stigma OR belief* OR prejudice OR discriminat*	Central Asia OR Kazakhstan OR Kyrgzstan OR Tajikistan OR Turkmenistan OR Uzbekistan OR East* Asia OR China OR Japan OR Mongolia OR North Korea OR South Korea OR Korea OR South* Asia OR Afghanistan OR Bangladesh OR Bhutan OR India OR Iran OR Maldives OR Nepal or Pakistan OR Sri Lanka OR South* East Asia OR Brunei OR Cambodia OR Indonesia OR Laos OR Malaysia OR Myanmar OR Philippines OR Singapore OR Thailand OR Timor-Leste OR Vietnam OR Asia*

Appendix B: Research poster

English research poster

Clinical, Educational, & Health Psychology

UCL

If you have any questions or concerns, please contact the main researcher, Konenica Ali, at ucjuk09@ucl.ac.uk

This project is being supervised by Prof Katrina Scior - k.scior@ucl.ac.uk

RESEARCH PARTICIPANTS WANTED

Why take part?

We hope that this study will help us understand the Bangladeshi communites attitudes towards people with learning disabilities in the UK.

What should I expect and how long will it take?

You will complete one short questionnaire. It will take you only 10 to 20 minutes. You can complete the questionnaire in English or Bangla.

Who can take part?

Any Bangladeshi person living in the UK, who is over 18 years old and has access to the internet.

What's in it for me?

You can opt into a prize draw to win one of 10 x £20 gift vouchers!
If you complete the Bangla version of the questionnaire and opt-in to the follow up study you also have a chance to win a £100 gift voucher!

TO TAKE PART SCAN THE BELOW QR CODE

A STUDY INVESTIGATING UK BANGLADESHI PEOPLE'S VIEWS ON DISABILITIES

The UCL REC committee has granted ethical approval: ID number: 27343/001

Bangla research poster

Clinical, Educational, & Health Psychology

UCL

আপনার মনে কোনও প্রশ্ন বা উদ্বেগ থাকলে তবে দয়া করে প্রধান গবেষক কোনেনিকার সাথে ইমেইল যোগে ucjuk09@ucl.ac.uk যোগাযোগ করুন

এই প্রকল্পের তত্ত্বাবধানে রয়েছেন প্রোফেসর ক্যাটরিনা স্কিওর- k.scior@ucl.ac.uk

গবেষণার জন্য অংশগ্রহণার্থি আবশ্যক

কেন অংশ নেবেন?

আমরা আশা করি, এই গবেষণাটি যুক্তরাজ্য বসবাসরত শেখা প্রতিবন্ধী ব্যক্তিদের প্রতি আমাদের মনোভাব বুঝতে সহায়তা করবে

আমার কী করতে হবে এবং এতে কতক্ষণ সময় লাগবে?

আপনি নামবিহীনভাবে একটি সংক্ষিপ্ত প্রশ্নাবলী পূরণ করবেন. সময় লাগবে মাত্র ১০ থেকে ২০ মিনিট. আপনি ইংরেজি বা বাংলায় প্রশ্নপত্রটি পূরণ করতে পারবেন.

কারা অংশ গ্রহণ করতে পারবে?

যুক্তরাজ্যে বসবাসরত যেকোনো বাংলাদেশি ব্যক্তি, যার বয়স ১৮ বছরের বেশি এবং যার ইন্টারনেট ব্যবহারের সুযোগ রয়েছে

এতে আমার জন্য কী আছে?

আপনি 10 x £20 গিফট ভাউচার এর মধ্যে একটি জিততে প্রাইজ ড্রতে আসতে পারেন! মাত্র কয়েক মিনিট সময় দিয়ে ফলোআপ স্টাডিতে অংশ নিন। তবেই আপনি আপনার পছন্দের £100 ভাউচার জিততে পারবেন!

অংশ গ্রহণ করতে নিচের কিউআর কোডটি স্ক্যান করুন

শেখা অক্ষমতা সম্পর্কে যুক্তরাজ্য বসবাসরত বাংলাদেশীদের দৃষ্টিভঙ্গি বোঝার জন্য একটি তদন্ত

ইউসিএল আরইসি কমিটি কর্তৃক এথিক্যাল অনুমোদন: আইডি নম্বর 27343/001

Appendix C: Sample demographics

Table 1: Sample occupation

Occupational Category	*Included Roles*	*n*
Healthcare and Mental Health	CAMHS therapist, Clinical support worker, Doctor, Healthcare professional, Mental Health Advisor, Social Prescribing Link Worker, Therapist, Trainee Clinical Psychologist, Working in Hospital	14
Psychology, Research and Academic	Assistant Psychologist, Psychology Graduate, Research Assistant, Researcher, Senior Investigator, Student Support Officer, English Lecturer	9
Education sector	Teacher, Teaching Assistant, Cover Teacher, Learning Support Assistant	9
Students	Students	16
Government, Civil Service, and Policy	Civil Servant, Government Officer, Housing Officer, Leasehold Officer, Information Disclosure Officer, Economist	9
Business, Finance, and Management	Programme Manager, Project Manager, Project Manager / Artist, Business Development, Corporate Finance Manager, Finance, CRM Manager, Investment Management, Partnerships Manager, Validation Analyst	13
Human Resources, Administration, and Legal	HR Professional, Admin, Advocate, Paralegal	5
Technology, Data, and Engineering	Technology, Data Analyst, Engineer	3
Creative, Media and Marketing	Content Creator, Event & Marketing Director, Project Manager/Artist	2
Public Service and Social Care	Foster Carer, Parent Support Worker, Housing Officer	3
Homemakers and Unpaid Roles	Full-time Mum, Homemaker, Housewife, Mother	7
Unemployed or Prefer Not to Say	Unemployed, Prefer Not to Say	4
Self-Employed and Skilled Trades	Restaurant Owner, Taxi Driver	3
Architecture	Architect	1
Total		98

Note: missing 4 participants data

Appendix D: Information sheet

English version

University College London
Department of Clinical Psychology

Information Sheet

Thank you for your interest in our study. The aim of this study is to understand the general UK Bangladeshi's public perception of personal difficulties that people face. This study has been approved by the Ethics Chair for the Psychology and Language Sciences Research Department. Ethics ID number: 27343/001

This study is being run by Konenica Ali (ucjuk09@ucl.ac.uk) under the supervision of Prof Katrina Scior (k.scior@ucl.ac.uk) and Dr Tanvir Khan (Bangladesh BRAC University).

We would like to invite you to participate in this research project. You should only participate if you want to; choosing not to take part will not disadvantage you in any way. Before you decide whether you want to take part, it is important for you to read the following information carefully and discuss it with others if you wish. Please contact the researchers by email if anything is not clear, if you have questions, or if you would like more information about the study. You can also contact the researchers with any queries or concerns related to this study after completion.

Data Protection Privacy Notice:

The data controller for this project will be University College London (UCL). The UCL Data Protection Office provides oversight of UCL activities involving the processing of personal data and can be contacted at data-protection@ucl.ac.uk. UCL's research privacy notice can be read here. Your personal data will be processed for the purposes outlined in this notice. The legal basis that would be used to process your personal data will be performance of a task in the public interest. Whilst your data will be provided anonymously, at the point of data collection, your responses in the survey could, theoretically, be linked back to you via your email address. This is collected to enable your chance to win a voucher, if you wish to provide your email address. After we have used the data for this purpose, this information will be deleted from the datafile. **The data will subsequently be stored anonymously, such that your individual responses will not be traceable back to you.**

What is the project’s purpose?

The aim of this study is to understand the Bangladeshi general public’s perceptions relating towards people with some types of disabilities in the UK.

Who is this study for?

This study is open to all people aged 18 or above living in the UK, who are Bangladeshi with fluency in English or Bangla.

What does taking part involve?
You will be invited to take part in a survey which will take up to 20 minutes to complete. If you wish, you can opt-in to complete the Bangla survey again after one week. You will be asked to provide some data during the survey, e.g., your email address and creating a unique code so we can anonymously identify you.

Do I have to take part?
No. It is up to you to decide whether or not to take part. If you do decide to take part, you will be asked to sign a consent form. Even after agreeing to take part, you can still withdraw at any time and without giving a reason, simply by closing your browser.

Is everything confidential and anonymous?
Yes. No-one besides the research team will know of your participation or your responses in this study, unless you tell them. All data will be securely stored and accessed only by our research team. You will have the opportunity to enter a prize draw to thank you for taking part - for this purpose we will ask for your contact details at the end of the study. Your contact details will be stored separately from your responses to the questions to ensure your anonymity. We will not pass your details on to any third party. Whilst your data will be provided anonymously, at the point of data collection, your responses in the survey could, theoretically, be linked back to you via your email address. This is collected to enable your chance to win a voucher, if you wish to provide your email address. After we have used the data for this purpose, this information will be deleted from the datafile. The data will subsequently be stored anonymously, such that your individual responses will not be traceable back to you.

What if my internet cuts off, would I have to start again?
No. Any incomplete responses will be saved for two weeks. During this time, you can continue from where you left off, as long as you can access the study from the same device. After two weeks, any incomplete responses will be deleted.

What are the possible disadvantages of taking part?
The study has received ethical approval from the University College London Research Ethics Committee (Ethics ID Number: 27343/001). There are no known risks associated with this study.

What are the possible benefits of taking part?
To show our appreciation for taking part, all participants who complete the study will stand the chance to win one of ten vouchers worth £20 each. For those who take part in the Bangla follow-up study, they can opt-in to win a £100 voucher of their choice. Participants will be picked in a prize draw after data collection has ended, by 30th May 2025.

What if something goes wrong?
If you have any concerns about this study, please contact Prof Katrina Scior at k.scior@ucl.ac.uk.

If you feel your complaint has not been handled to your satisfaction, please contact the Chair of the UCL Research Ethics Committee at ethics@ucl.ac.uk.

What will be done with the results?
The results from this study will be written up for publication in academic journals and may also be shared at conferences and other events. The results will also be submitted as a thesis for the clinical psychology doctorate at University College London.

Who is organising and funding the research?
UCL is funding this study.

Who can I speak to about this study further?
We would be very happy to address any queries or comments you may have.

Name and Contact Details of the Researcher: Konenica Ali, ucjuk09@ucl.ac.uk
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Thank you so much for taking the time to read this information sheet. Your help makes this study on an important cause possible.

Bangla version

ইউনিভার্সিটি কলেজ লন্ডন
ক্লিনিকাল সাইকোলজি ডিপার্টমেন্ট

ইনফরমেশন শীট

আমাদের গবেষণায় আগ্রহ প্রকাশের জন্য আপনাকে ধন্যবাদ। যুক্তরাজ্যে বসবাসরত বাংলাদেশি সাধারণ মানুষ যে ধরণের ব্যক্তিগত সমস্যার সম্মুখীন হয় সে সম্পর্কে জনসাধারণের ধারণা বোঝাই হল এই গবেষণার উদ্দেশ্য। এই গবেষণাটি সাইকোলজি অ্যান্ড ল্যাঙ্গুয়েজ সায়েন্সেস রিসার্চ ডিপার্টমেন্টের এথিক্স চেয়ার কর্তৃক অনুমোদিত। এথিক্স আইডি নম্বর: 27343/001
গবেষণাটি প্রোফেসর ক্যাটরিনা স্কিওর (k.scior@ucl.ac.uk) ও ড. তানভীর খান (বাংলাদেশ ব্র্যাক বিশ্ববিদ্যালয়) এর তত্ত্বাবধানে কোনেনিকা আলী (ucjuk09@ucl.ac.uk) কর্তৃক পরিচালিত।

এই গবেষণা প্রকল্পে অংশগ্রহণ করার জন্য আমরা আপনাকে আমন্ত্রণ জানাতে চাই। আপনি যদি আগ্রহী থাকেন তবেই অংশগ্রহণ করবেন; অংশগ্রহণ না করতে চাইলে কোনওভাবেই আপনার অসুবিধা হবে না। অংশগ্রহণ করা বা না করার সিদ্ধান্ত নেওয়ার আগে, নিম্নোক্ত তথ্যগুলি মনোযোগ সহকারে পড়ুন এবং আগ্রহী হলে এবিষয়ে অন্যদের সাথে আলোচনা করুন। যদি কিছু বুঝতে সমস্যা হয় বা কোনও প্রশ্ন থাকে অথবা আপনি যদি গবেষণা সম্পর্কে আরও তথ্য চান, তবে অনুগ্রহ করে ইমেলের মাধ্যমে গবেষকদের সাথে যোগাযোগ করুন। পড়া শেষে আপনি এই গবেষণা সম্পর্কিত যে কোনও প্রশ্ন অথবা উদ্বেগ নিয়ে গবেষকদের সাথে যোগাযোগ করতে পারেন।

ডেটা সুরক্ষা গোপনীয়তা সংক্রান্ত বিজ্ঞপ্তি:

এই প্রকল্পের সকল তথ্যের নিয়ন্ত্রক হবে ইউনিভার্সিটি কলেজ লন্ডন (ইউসিএল)। ইউসিএল ডেটা প্রোটেকশন অফিস ব্যক্তিগত ডেটা প্রক্রিয়াকরণে জড়িত যাবতীয় ইউসিএল ক্রিয়াকলাপের তদারকি করবে এবং তাদের সাথে যোগাযোগের ইমেইল: data-protection@ucl.ac.uk ইউসিএল এর গবেষণা গোপনীয়তা বিজ্ঞপ্তি পড়তে এখানে ক্লিক করুন। আপনার ব্যক্তিগত তথ্য কেবলমাত্র এই বিজ্ঞপ্তিতে বর্ণিত উদ্দেশ্যেই প্রক্রিয়া করা হবে। আপনার ব্যক্তিগত ডেটা প্রক্রিয়া করার জন্য যে আইনি ভিত্তি ব্যবহার করা হবে তা জনস্বার্থে যেকোনও কার্য সম্পাদন করবে। আপনার ডেটা নামহীনভাবে সরবরাহ করা হবে, ডেটা সংগ্রহের সময়, জরিপে আপনার প্রতিক্রিয়াগুলি তাত্ত্বিকভাবে আপনার ইমেইল ঠিকানার মাধ্যমে আপনার সাথে সংযুক্ত করা যাবে। আপনি যদি আপনার ইমেইল ঠিকানা দিতে চান, তবে তা ভাউচার জেতার সুযোগ সক্ষম করার জন্য সংগ্রহ করা হবে। উপরোক্ত উদ্দেশ্যে ডেটা ব্যবহার করার পরে এই তথ্যটি ডেটাফাইল থেকে মুছে ফেলা হবে। ডেটা পরবর্তীকালে নামহীনভাবে সংরক্ষণ করা হবে, যাতে আপনার ব্যক্তিগত প্রতিক্রিয়ার পিছু করে আপনার পর্যন্ত যাওয়া না যায়।

প্রকল্পের উদ্দেশ্য কী?

এই গবেষণার উদ্দেশ্য হলো যুক্তরাজ্যে বসবাসরত কিছু ধরণের প্রতিবন্ধী মানুষ সম্পর্কে বাংলাদেশি সাধারণ মানুষের ধারণা বোঝা।

কাদের জন্য এই গবেষণা?

এই গবেষণাটি ইংরেজি বা বাংলাভাষী যুক্তরাজ্যে বসবাসরত ১৮ বছর বা তদূর্ধ্ব বয়সের সকল মানুষের জন্য উন্মুক্ত।

অংশগ্রহণ করলে কী করতে হবে?

আপনাকে একটি জরিপে অংশগ্রহণের জন্য আমন্ত্রণ জানানো হবে, যা সম্পন্ন করতে ১০ থেকে ২০ মিনিট সময় লাগবে। ইচ্ছা করলে আপনি এক সপ্তাহ পরে বাংলা জরিপটি পুনরায় সম্পন্ন করার জন্য সম্মতি দিতে পারেন। জরিপে আপনাকে কিছু ব্যক্তিগত তথ্য প্রদান করতে হবে, যেমন আপনার ইমেইল এবং একটি ইউনিক কোড তৈরি করতে হবে যার দ্বারা আমরা আপনাকে নাম-পরিচয় ছাড়াই সনাক্ত করতে পারি।

আমাকে কি অংশ গ্রহণ করতেই হবে?

না। অংশ গ্রহণ করবেন কি করবেন না তা আপনার ব্যাপার। আপনি যদি অংশ গ্রহণ করার সিদ্ধান্ত নেন তবে আপনার কাছে রাখার জন্য এই ইনফরমেশন শীটের একটি কপি দেয়া হবে। কোনও কারণ দর্শানো ছাড়াই যে কোন সময় আপনি উইথড্র করতে পারবেন। আপনি যদি অংশ গ্রহণ করার সময় গবেষণা থেকে বেরিয়ে যেতে চান তবে জাস্ট আপনার ওয়েব ব্রাউজারটি বন্ধ করে দিন

সবকিছু কি গোপনীয় এবং নামহীন রাখা হবে?

হ্যাঁ। গবেষণা দল ব্যতীত অন্য কেউ এই গবেষণায় আপনার অংশগ্রহণ অথবা আপনার প্রতিক্রিয়া সম্পর্কে জানতে পারবে না, যদি না আপনি তাদের জানান। সমস্ত তথ্য নিরাপদে সংরক্ষণ করা হবে এবং শুধুমাত্র আমাদের গবেষণা দলই কেবল অ্যাক্সেস করতে পারবে। অংশগ্রহণ করার জন্য আপনাকে ধন্যবাদ জানাতে আপনাকে প্রাইজ ড্রতে থাকার সুযোগ দেয়া হবে - এই উদ্দেশ্যে আমরা গবেষণা শেষে আপনার যোগাযোগের বিশদ জানতে চাইব। আপনার পরিচয় গোপন রাখার জন্য আপনার যোগাযোগের তথ্যাদি প্রশ্নের উত্তর থেকে আদালা করে সংরক্ষণ করা হবে। আমরা আপনার বিবরণ কোনও তৃতীয় পক্ষের কাছে প্রেরণ করব না। আপনার ডেটা নামহীনভাবে সরবরাহ করা হবে, ডেটা সংগ্রহের সময়, জরিপে আপনার প্রতিক্রিয়াগুলি তাত্ত্বিকভাবে আপনার ইমেইল ঠিকানার মাধ্যমে আপনার সাথে সংযুক্ত করা যাবে। আপনি যদি আপনার ইমেইল ঠিকানা দিতে চান, তবে তা ভাউচার জেতার সুযোগ সক্ষম করার জন্য সংগ্রহ করা হবে। উপরোক্ত উদ্দেশ্যে ডেটা ব্যবহার করার পরে এই তথ্যটি ডেটাফাইল থেকে মুছে ফেলা হবে। ডেটা পরবর্তীকালে নামহীনভাবে সংরক্ষণ করা হবে, যাতে আপনার ব্যক্তিগত প্রতিক্রিয়ার পিছু করে আপনার পর্যন্ত যাওয়া না যায়।

আমার ইন্টারনেট বন্ধ হয়ে গেলে কি আমাকে আবার শুরু করতে হবে?

না। যে কোনও অসম্পূর্ণ প্রতিক্রিয়া দুই সপ্তাহ পর্যন্ত সংরক্ষণ করা হবে। এই সময়ের মধ্যে আপনি যেখানে রেখে গিয়েছিলেন সেখান থেকে শুরু করতে পারবেন, যতক্ষণ আপনি একই ডিভাইস থেকে গবেষণা অ্যাক্সেস করছেন। দুই সপ্তাহ পরে যেকোনও অসম্পূর্ণ প্রতিক্রিয়া মুছে ফেলা হবে।

অংশ গ্রহণের সম্ভাব্য অসুবিধাগুলি কী কী?

গবেষণাটি ইউনিভার্সিটি কলেজ লন্ডন রিসার্চ এথিক্স কমিটি কর্তৃক এথিক্যাল অনুমোদন প্রাপ্ত (এথিক্স আইডি নম্বর: 27343/001) এই গবেষণায় কোনও ঝুঁকি নেই।

অংশ গ্রহণের সম্ভাব্য সুবিধাগুলি কী কী?

অংশগ্রহণের কৃতজ্ঞতা স্বরুপ গবেষণা সম্পন্ন করা সকল অংশগ্রহণকারী £20 মূল্যের দশটি ভাউচারের মধ্যে একটি জেতার সুযোগ পাবেন। তথ্য সংগ্রহ শেষ হওয়ার পর ৩১ মার্চ ২০২৫ তারিখের মধ্যে অংশগ্রহণকারীদের নিয়ে একটি প্রাইজ ড্র এর আয়োজন করা হবে।

যদি কিছু ভুল হয়ে যায়?

এই গবেষণা সম্পর্কে আপনার যদি কোনও উদ্বেগ থাকে তবে অনুগ্রহ করে k.scior@ucl.ac.uk এড্রেসে প্রোফেসর ক্যাটরিনা

স্কিওর এর সাথে যোগাযোগ করুন।

আপনি যদি মনে করেন যে আপনার অভিযোগ পরিচালনায় সন্তুষ্টি পাননি, দয়া করে ethics@ucl.ac.uk এড্রেসে ইউসিএল গবেষণা এথিক্স কমিটির চেয়ারম্যানের সাথে যোগাযোগ করুন।

ফলাফল দিয়ে কী করা হবে?

একাডেমিক জার্নালে প্রকাশের জন্য এই গবেষণা থেকে প্রাপ্ত ফলাফল লেখা হবে ও সম্মেলন ও অন্যান্য ইভেন্ট এ শেয়ার করা হবে। ইউনিভার্সিটি কলেজ লন্ডন এ ক্লিনিক্যাল সাইকোলজি ডক্টরেটের থিসিস হিসেবেও এই ফলাফল জমা দেওয়া হবে।

কারা এই গবেষণার আয়োজন ও অর্থায়ন করছে?

এই গবেষণায় অর্থায়ন করছে ইউসিএল।

এই অধ্যয়ন সম্পর্কে আমি কার সাথে অতিরিক্ত কথা বলতে পারি?

আমরা আপনার যে কোনও প্রশ্ন বা মন্তব্যের উত্তর দিতে পারলে খুব খুশি হব।

এই অধ্যয়ন সম্পর্কে আমি কার সাথে অতিরিক্ত কথা বলতে পারি?

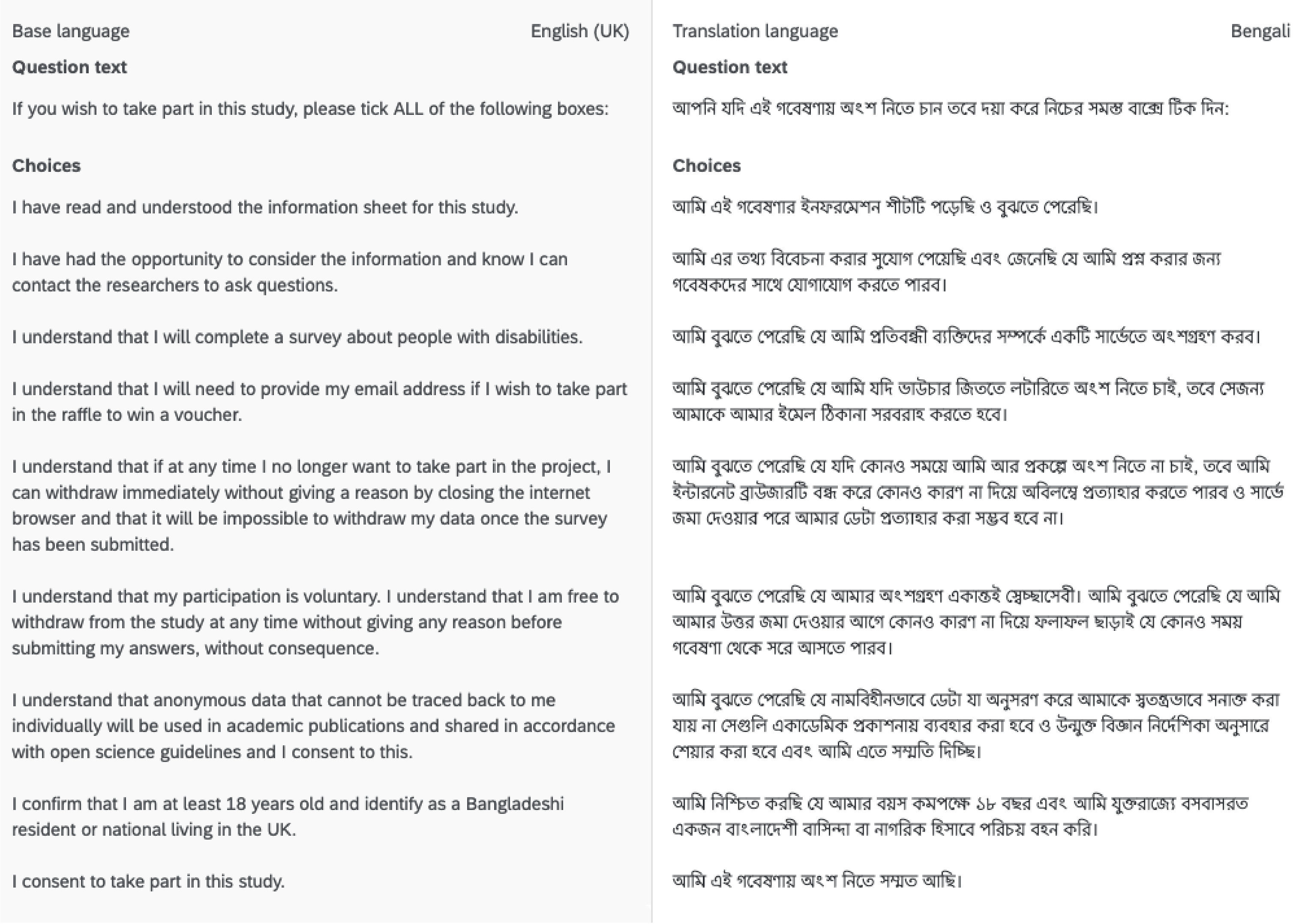
আমরা আপনার যে কোনও প্রশ্ন বা মন্তব্যের উত্তর দিতে পারলে খুব খুশি হব।

গবেষকের নাম ও যোগাযোগের বিবরণ: কোনেনিকা আলী, ucjuk09@ucl.ac.uk
প্রধান গবেষকের নাম ও যোগাযোগের বিবরণ: প্রোফেসর ক্যাটরিনা স্কিওর, k.scior@ucl.ac.uk
ডিপার্টমেন্ট: জেমস পি গ্রান্ট স্কুল অব পাবলিক হেলথ, ব্র্যাক বিশ্ববিদ্যালয়, ঢাকার সহযোগিতায় ইউসিএল ক্লিনিক্যাল সাইকোলজি
সেকেন্ডারি সুপারভাইজার: ড. তানভীর হাসান, ব্র্যাক বিশ্ববিদ্যালয়, ঢাকা

এই ইনফরমেশন শীটটি পড়ার পেছনে সময় দেওয়ার জন্য আপনাকে অনেক ধন্যবাদ. আপনার সহায়তা একটি গুরুত্বপূর্ণ বিষয়ে আয়োজিত এই গবেষণাকে সম্ভব করে তুলবে.

Appendix E: Consent form

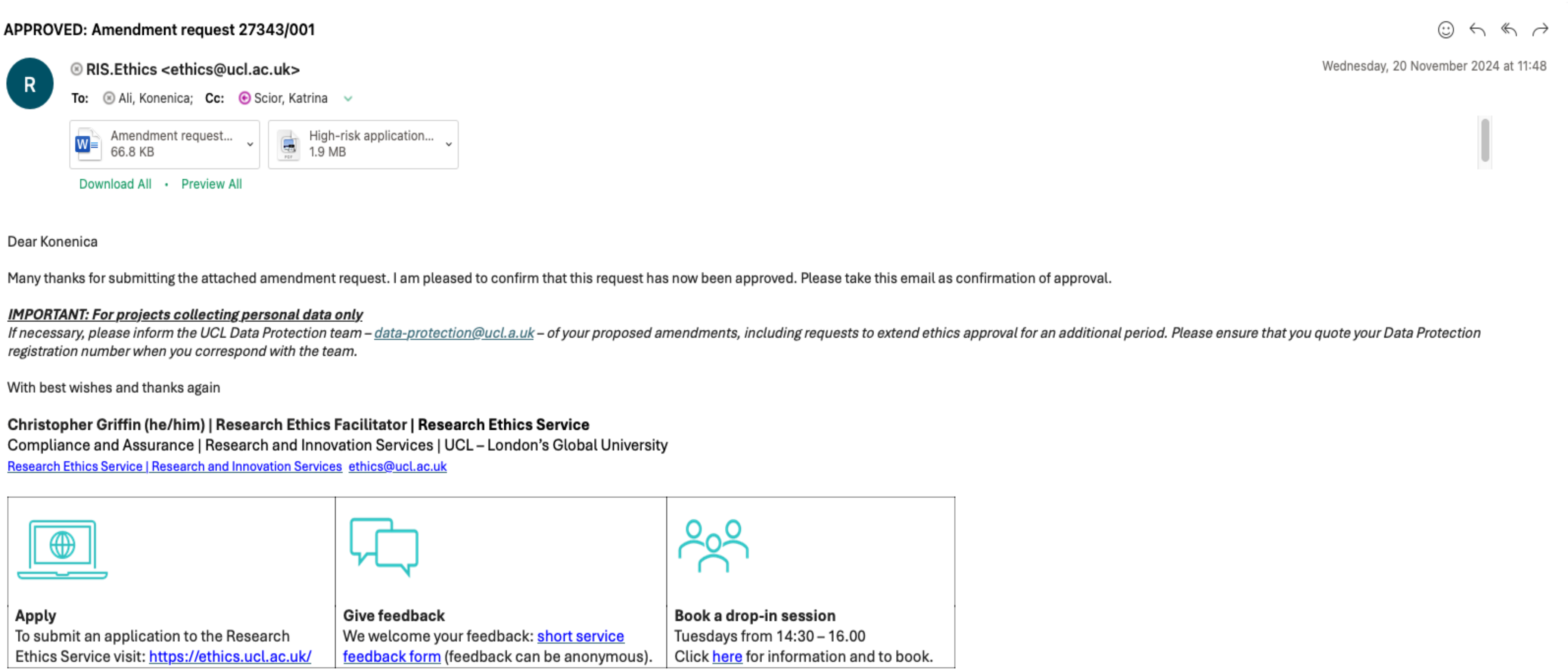
English and Bangla version of the consent form



Base language English (UK)	Translation language Bengali
Question text	**Question text**
If you wish to take part in this study, please tick ALL of the following boxes:	আপনি যদি এই গবেষণায় অংশ নিতে চান তবে দয়া করে নিচের সমস্ত বাক্সে টিক দিন:
Choices	**Choices**
I have read and understood the information sheet for this study.	আমি এই গবেষণার ইনফরমেশন শীটটি পড়েছি ও বুঝতে পেরেছি।
I have had the opportunity to consider the information and know I can contact the researchers to ask questions.	আমি এর তথ্য বিবেচনা করার সুযোগ পেয়েছি এবং জেনেছি যে আমি প্রশ্ন করার জন্য গবেষকদের সাথে যোগাযোগ করতে পারব।
I understand that I will complete a survey about people with disabilities.	আমি বুঝতে পেরেছি যে আমি প্রতিবন্ধী ব্যক্তিদের সম্পর্কে একটি সার্ভেতে অংশগ্রহণ করব।
I understand that I will need to provide my email address if I wish to take part in the raffle to win a voucher.	আমি বুঝতে পেরেছি যে আমি যদি ভাউচার জিততে লটারিতে অংশ নিতে চাই, তবে সেজন্য আমাকে আমার ইমেল ঠিকানা সরবরাহ করতে হবে।
I understand that if at any time I no longer want to take part in the project, I can withdraw immediately without giving a reason by closing the internet browser and that it will be impossible to withdraw my data once the survey has been submitted.	আমি বুঝতে পেরেছি যে যদি কোনও সময়ে আমি আর প্রকল্পে অংশ নিতে না চাই, তবে আমি ইন্টারনেট ব্রাউজারটি বন্ধ করে কোনও কারণ না দিয়ে অবিলম্বে প্রত্যাহার করতে পারব ও সার্ভে জমা দেওয়ার পরে আমার ডেটা প্রত্যাহার করা সম্ভব হবে না।
I understand that my participation is voluntary. I understand that I am free to withdraw from the study at any time without giving any reason before submitting my answers, without consequence.	আমি বুঝতে পেরেছি যে আমার অংশগ্রহণ একান্তই স্বেচ্ছাসেবী। আমি বুঝতে পেরেছি যে আমি আমার উত্তর জমা দেওয়ার আগে কোনও কারণ না দিয়ে ফলাফল ছাড়াই যে কোনও সময় গবেষণা থেকে সরে আসতে পারব।
I understand that anonymous data that cannot be traced back to me individually will be used in academic publications and shared in accordance with open science guidelines and I consent to this.	আমি বুঝতে পেরেছি যে নামবিহীনভাবে ডেটা যা অনুসরণ করে আমাকে স্বতন্ত্রভাবে সনাক্ত করা যায় না সেগুলি একাডেমিক প্রকাশনায় ব্যবহার করা হবে ও উন্মুক্ত বিজ্ঞান নির্দেশিকা অনুসারে শেয়ার করা হবে এবং আমি এতে সম্মতি দিচ্ছি।
I confirm that I am at least 18 years old and identify as a Bangladeshi resident or national living in the UK.	আমি নিশ্চিত করছি যে আমার বয়স কমপক্ষে ১৮ বছর এবং আমি যুক্তরাজ্যে বসবাসরত একজন বাংলাদেশী বাসিন্দা বা নাগরিক হিসাবে পরিচয় বহন করি।
I consent to take part in this study.	আমি এই গবেষণায় অংশ নিতে সম্মত আছি।

Appendix F: Ethics amendments confirmation

Ethics amendments confirmation



APPROVED: Amendment request 27343/001

RIS.Ethics <ethics@ucl.ac.uk>

Wednesday, 20 November 2024 at 11:48

To: Ali, Konenica; **Cc:** Scior, Katrina

Dear Konenica

Many thanks for submitting the attached amendment request. I am pleased to confirm that this request has now been approved. Please take this email as confirmation of approval.

IMPORTANT: For projects collecting personal data only
If necessary, please inform the UCL Data Protection team – data-protection@ucl.a.uk – of your proposed amendments, including requests to extend ethics approval for an additional period. Please ensure that you quote your Data Protection registration number when you correspond with the team.

With best wishes and thanks again

Christopher Griffin (he/him) | Research Ethics Facilitator | Research Ethics Service
Compliance and Assurance | Research and Innovation Services | UCL – London's Global University
Research Ethics Service | Research and Innovation Services ethics@ucl.ac.uk

Apply To submit an application to the Research Ethics Service visit: https://ethics.ucl.ac.uk/	**Give feedback** We welcome your feedback: short service feedback form (feedback can be anonymous).	**Book a drop-in session** Tuesdays from 14:30 – 16.00 Click here for information and to book.

Appendix G: Email sent to potential collaborators

From: Ali, Konenica <konenica.ali.22@ucl.ac.uk>
Date: Friday, 2 May 2025 at 17:12

Dear colleagues at X,

I am a UCL British Bangladeshi doctoral student, currently conducting research on attitudes to disability among the British Bangladeshi community in the UK. I am hoping that you might be able to share information about this study among your network and users.

The study involves a short survey (10–20 minutes) that can be completed in either English or Bangla. We're inviting anyone of Bangladeshi heritage who lives in the UK to take part. The study has been reviewed and approved by the UCL Research Ethics Committee.

How you could support the study:

- Display a poster (I'm happy to send printed copies or come by in person to help set it up)
- Allow me to visit during open sessions and/or group activities to share information about the study and, where desired, support participants in completing the survey
- Share the study with your network

I would really appreciate any support you can offer.

Link to the study: https://qualtrics.ucl.ac.uk/jfe/form/SV_daFUdJASgk7q7dkor or see QR code in the posters attached (English version and Bangla).

Please let me know if this sounds possible. I'd be very grateful for your time and help.

With warm wishes,

Konenica

Konenica Ali
Trainee Clinical Psychologist | UCL Doctorate in Clinical Psychology
University College London | Gower Street | London WC1E 6BT
Email: konenica.ali.22@ucl.ac.uk