VOLUME I:

ATTITUDES TOWARDS INTELLECTUAL DISABILITIES ACROSS CULTURES

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Overview

This thesis proposes that attitudes of British South Asians towards people with intellectual disabilities (ID) differ from those of White British people in the general population. Part I reviews the international literature on attitudes towards people with ID and highlights the shortage of cross-cultural research.

Part II reports on an empirical study, which investigated attitudes and beliefs about ID among adolescents from British South Asian and White British backgrounds. This study found support for the hypothesis that British South Asian adolescents are less in favour of the principles of social inclusion than their White British peers. This study also found that South Asian adolescents were more likely to believe that ID can be cured, that parents should bear the main responsibility for children with ID and that the marital prospects of siblings are adversely affected by having a sibling with ID. Findings are discussed in terms of clinical, educational and political implications.

Part III is a critical appraisal of the thesis. Conceptual and methodological issues are examined, including an exploration of the usefulness of the category of 'South Asians' and a discussion of the concept of 'culture'. This is followed by a personal reflection of the research process and a final summary.

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PART I:

REVIEW PAPER

ATTITUDES TOWARDS PEOPLE WITH INTELLECTUAL DISABILITIES: A REVIEW OF CROSS-CULTURAL RESEARCH

Abstract

Culture appears to be an important influence on attitudes towards people with intellectual disabilities (e.g., Fatimilehin & Nadirshaw, 1994). The author aimed to identify and review all relevant studies. This review highlights the complexity of conclusions drawn from cross-cultural attitudinal research and emphasises that social inclusion is a western concept that is not necessarily applicable to non-western cultures. Suggestions for future research are made, including the importance of investigating attitudes in multicultural societies. This is particularly relevant in the UK, which is culturally diverse, whilst employing a western conceptualisation of intellectual disabilities.

1.0. Introduction

The term 'intellectual disabilities' (ID) is not easily defined as people with ID form a very heterogeneous group. In the UK and North America, three core criteria must be met for someone to be considered to have an ID: significant impairment of intellectual functioning, significant impairment of adaptive or social functioning, and age of onset before adulthood (World Health Organisation, 1992). In the UK, it is estimated that people with ID comprise 2.94% of the population (Department of Health, 2001).

In the course of history, attitudes towards people with ID have occupied every part of the spectrum between adoration and eradication (c.f. Heal & Haney, 1988; Mateer, 1917, cited in Henry, Keys, Jopp & Balcazar, 1996). The emergence of attitudes in favour of societal inclusion for people with ID began in 1971 with the United Nations' declaration of human rights for people with mental retardation (UN, 1971). Over the past 37 years, institutionalisation and segregation have given way to greater engagement with the community in housing, education, employment and leisure (Emerson & Hatton, 1996), at least initially, through the principles of normalisation or social role valorisation as it was later renamed (Wolfensberger, 1983). The issue of social integration has been regarded as critical to successful service delivery (Department of Health, 2001). In the UK, almost all the long-stay hospitals are now closed and the rights of people with ID have been acknowledged in law (Disability Discrimination Act, 2005). A useful distinction is made by Cummins & Lau (2003) between physical and social integration: they question the assumed benefits of increased physical integration with the non-disabled general community. They argue that it is social integration and not simply physical integration that has a positive influence on the wellbeing of people with ID. Whilst this review acknowledges this distinction as important, the term 'social inclusion' will be used to refer to both the physical and social integration of people with ID into the valued aspects of mainstream society (such housing, education, employment and leisure). The principles of social inclusion suggest that these changes should lead to societal attitudes towards people with ID becoming more pro-inclusion and less stigmatising.

Research has highlighted a number of important variables that may affect people's attitudes towards people with ID, including gender, prior contact and severity of ID (e.g., Horner-Johnson, 2002; Krajewski & Flaherty, 2000; Krajewski, Hyde & O'Keeffe, 2002; Siperstein, et al. 2007). Culture has also been identified as an important influence on attitudes towards people with ID (e.g., Fatimilehin & Nadirshaw, 1994). However, social science research has largely focused on Caucasian and middle-class participants, to the exclusion of minority ethnic and low socio-economic groups (Mink, 1997). Moreover, studies investigating attitudes towards people with ID have almost entirely focused on developed countries in the west; less is known about attitudes in Asia, Africa and Latin America. It is argued (Hatton, 2002), that this gap leads to potential cross-cultural differences being overlooked. Cross-cultural research has the potential to clarify whether western concepts, such as social inclusion, are universally applicable.

'Culture' has been defined as "the set of attitudes, values, beliefs and behaviours shared by a group of people" (Matsumoto, 1996, p.16). However, defining cultural groups is increasingly difficult since, within each cultural group, there is much ethnic, racial and religious diversity. The category of 'American Indian', for example, comprises more than 500 tribes (US Bureau of the Census, 1992) and the UK category of 'Indian' contains substantial differences in language, religion and ethnic identification (Modood et al., 1997). This review will consider 'culture' in its broadest sense, referring to a person's nationality or ethnic origin, and will address the question of how attitudes towards people with ID differ across cultures. This review consists of eleven sections: (1) A conceptual overview; (2) Defining attitudes; (3) Multinational comparative attitudinal research; (4) Attitudes in a Caucasian context; (5) Attitudes in an Asian context; (6) Attitudes in other parts of the world; (7) Attitudes in multicultural societies; (8) The role of religion; (9) Issues in attitudinal research; (10) Integrating the literature; and (11) Recommendations for future research.

2.0. Specifying the search

The aim of this literature review was to identify and review all recent cross-cultural and international studies on attitudes towards people with ID. The following bibliographic databases were searched: PsychInfo, Medline, CINAHL and Social Sciences Plus.

The inclusion criteria are that:

(a) Research studies should be recent (i.e., post-1990) and published in English.

(b) Research studies should not be confined to a single professional group (with the exception of staff working with people with ID).

(c) Research studies should either compare attitudes between two or more countries/cultures or use a research design that facilitates comparison of data with data collected from other countries/cultures.

(d) Research studies should focus on attitudes towards ID, rather than disability in general (opinion based articles which focus on disability and religion are included where relevant and are not limited by date).

Searches were conducted for the keywords: *Intellectual Disability**, *Learning Disability**, *Mental Retardation** and *Mental Handicap**. Each of these searches was combined with the word OR to form an inclusive list. This list was then combined with a search for the keywords, *Attitudes, Beliefs*, OR *Perceptions,* using the AND function. Thus, this search was initially restricted to articles containing at least one of the terms denoting *Intellectual Disability* and one of the terms denoting *Attitudes.*

Searches were also carried out for the following keywords: *Culture, Multinational, International, America, Africa, Antarctica, Europe, Russia, Asia, Developing Countries, Religion, Islam, Hindu, Sikh* and *Christianity.* Each of these searches was combined with the word OR to form an inclusive list. This list was then combined with the keywords denoting *Intellectual Disability.*

Both text word searches and indexed terms were used with appropriate truncation and masking. These searches were supplemented by personal bibliographies of the author and his supervisor, citation tracking (using Web of Science citation index databases) and references from retrieved articles.

In addition, individual searches were completed for each journal pertinent to attitudes, ID and cultural research, including: *Applied Research in Intellectual Disabilities, Disability and Society*; *International Journal of Developmental and Physical Disabilities*; *International Journal of Social Psychology*; *International Review on Research in Mental Retardation*; *Journal of Applied Research in Intellectual Disability; Journal of Intellectual Disability Research;* and *Policy and Practice in Intellectual Disability.*

Using these methods produced over 100 articles, of which 34 were relevant. Of these, 20 were research based articles and 14 were opinion-based articles.

3.0. Literature Review

A conceptual overview

This review is concerned with providing an overview of how ID is conceptualised and viewed in different cultures. It explores the extent to which ethnicity and country of birth impact on the potential of people with ID to lead independent and satisfying lives. In some cultures, stigma towards people with ID may exist, which impedes the community inclusion and promotion of people with ID as valued members of society, as advocated by the principles of social inclusion (Department of Health, 2001). This review aims to identify and review all relevant studies regarding the relationship between culture and attitudes towards people with ID. On the basis of this review, recommendations for future research are made.

3.1. Defining attitudes

‘Attitudes’ have been described (Antonak & Livneh, 2000, p.552) as “…latent psychological constructs postulated as residing within the individual…, which lie dormant unless evoked by specific stimuli or referent objects (e.g., individuals, social groups, situations, events, social issues)”. Contextual conditions can affect the relevance of an attitude for a particular behaviour. For example, individuals often report their attitudes to others but perform their actual actions in private (Kraus, 1995). A recent meta-analysis (Glasman & Albarracin, 2006) found that attitudes strongly correlate with behaviour and concluded that 52% of behaviour can be predicted by attitudes. Attitudes correlated with a future behaviour most strongly when attitudes were easy to recall and stable over time, when participants were confident that their attitudes were correct and when only homogenous information about the attitude referent was considered.

Attitudes are commonly regarded as having three components: a cognitive element, an affective element and a behavioural element (Antonak & Livneh, 2000). The cognitive element refers to a person’s thoughts, ideas, perceptions and beliefs in relation to the attitude referent. The affective element refers to the emotional basis of the attitude, which drives the cognitive component. The behavioural element refers to both a person’s intent and the resultant behaviour. (Fishbein & Ajzen, 2005). All three components are regarded as closely related, which is conveyed in the following definition: “an attitude is an idea charged with emotion which predisposes a class of actions to a particular class of social situations” (Triandis, 1971, p.2).

3.2. Multinational comparative attitudinal research

The "Multinational Study of Public Attitudes towards Individuals with Intellectual Disabilities" (Special Olympics, 2003; Bardun & Corbin, 2005) investigated how the general population in 11 countries (USA, Brazil, China, Egypt, Germany, India, Ireland, Japan, Nigeria, Russia and South Africa) view people with ID. An attitudinal questionnaire was developed, consisting of five scales (contact, perceived capabilities, inclusion, impact of inclusion and obstacles to inclusion). To ensure that it captured appropriate cultural meanings, the questionnaire was translated, back-translated and pilot tested in each country. Altogether, questionnaire data were gathered from 9123 members of the general public (52% female, 48% male, ranging from 28 to 51 years old) via face-to-face or telephone interviews. Globally, it was found that the public: underestimates the competence of individuals with ID; believes that people with ID should live, work and learn apart from people without ID; and regards the family as the most appropriate living environment for people with ID. In addition, whilst the public recognise negative attitudes as obstacles to inclusion, they also believe that the inclusion of people with ID in workplaces and schools would create problems for others. Overall, these results indicate that the principles of social inclusion (Department of Health, 2001), adopted in the west, might not be universally applicable.

However, there are two key limitations to this study. Firstly, the analysis was limited to ranking countries according to mean percentages (without any statistical analysis), which limits confidence in conclusions that can be drawn. Secondly, the majority of the world's countries were not represented (most of Latin America and Africa). Nevertheless, this is an important and unique piece of research as it is the first study to investigate attitudes towards people with ID across more than three countries. Therefore, the findings of this study will be referred to at various points in this review.

3.3. Attitudes in a Caucasian Context

The media appear to exert a potentially powerful influence on attitudes towards people with ID (Hall & Minnes, 1999). In the USA, a recent study (Pardun, 2005) examined 3900 American film and TV scenes and newspaper articles from 1962 to 2003. It found that, over time, media portrayals of this group moved away from unrealistically heroic types (e.g., superhero portrayals) towards depictions as pitiable, vulnerable victims. The under-representation of people with ID in the UK media has also been noted (Viewpoint, 2005).

Hastings, Sjostrom and Stevenage (1998) investigated adolescents' attitudes in England (n=130) and Sweden (n=96) towards the presence of people with ID in the community. An attitudinal questionnaire, originally constructed in English, was translated into Swedish by two independent translators who were fluent in both languages. Following a pilot study, the revised 22-item questionnaire was administered to participants in four class groups in a Swedish school and in four class groups in an English school. Participants were first asked to read one of two short vignettes (which were randomly distributed) and then asked to complete the attitude scale. The two vignettes were identical, except for the labels used in the description. In one version, the target individual was described as having a speech impediment and in the other version, as having ID. It was predicted that English respondents would hold less positive views than Swedish participants. This hypothesis was based on differences in social policies of normalisation, which was first developed in Scandinavia by Bank-Mikkelsen and Nirjie (see Emerson, 1992). However, the results did not support this hypothesis as the two groups did not differ on the attitudinal scales.

In an effort to develop a measure which could examine the relationship between service policies and public attitudes, Henry, Keys, Balcazar & Jopp (1996) developed the Community Attitudes Living Scale – Mental Retardation Form (CLAS-MR). The CLAS-MR is a 40-item measure of attitudes towards the inclusion of people with ID (Appendix B). In an analysis of items, Henry et al. found four factors associated with attitudes towards the inclusion of people with ID in society: (a) *Empowerment*, the extent to which people with ID are granted the freedom to make their own life decisions; (b) *Exclusion*, the extent to which respondents would like to isolate people with ID from community life; (c) *Sheltering*, the extent to which respondents think that people with ID need help in keeping safe; and (d) *Similarity*, the extent to which respondents feel that people with ID share a universal humanity. CLAS-MR subscales have shown acceptable internal consistency, retest reliability, and construct validity in correlations with other similar attitude scales and no significant relationship with social desirability (Henry, Keys, Jopp & Balcazar, 1996). Studies using the CLAS-MR to investigate attitudes among Israeli (Henry et al, 2004; Schwarz & Armony-Sivan, 2002), Australian, Korean and Japanese populations (Horner-Johnson, 2002; Horner-Johnson, et al. 2002) have also shown cross-cultural validity.

The initial two studies using the CLAS-MR were conducted in the USA. The first study looked at students and people in the local community (Henry et al., 1996a), whereas the second study (Henry et al., 1996b) looked at staff members in community-living programmes for people with ID, mental illness and dual diagnosis (of ID and mental illness). Further studies have used the CLAS-MR to investigate attitudes amongst Japanese students (Horner-Johnson et al., 2002), Israeli students (Schwarz & Armony-Sivan, 2002), Israeli and American community agency staff (Henry, Duvdevany, Keys & Balcazar, 2004) and, most recently, Australian students and disability professionals (Yazbeck, McVilly & Parmenter, 2004). The results of these studies are summarised in Table 1. Compared to the Australian sample, the American respondents demonstrated more inclusive attitudes towards people with ID (higher mean scores on the *Similarity* and *Empowerment* subscales and lower mean scores on the *Exclusion* and *Sheltering* subscales). One possible explanation for this pattern of results is that social inclusion is a relatively new social policy in Australia (Yazbeck et al., 2004).

However, research has failed to find a clear link between positive attitudes and the duration of a country's history of deinstitutionalisation (e.g., Hastings et al., 1998). Moreover, this finding is not limited to the field of ID. A recent cross-cultural investigation of public attitudes towards people with mental illness in Russia, Slovakia and Germany found that all three groups showed similar degrees of discrimination, despite being at differing stages of psychiatric reform (Schomerus et al., 2006). This is surprising since, with increased contact, attitudes are thought to become significantly more positive (e.g., Hudson-Allex & Barrett, 1996). The relationship between positive attitudes and social inclusion policies is therefore unclear and requires further research.

Henry et al. (2004) compared the attitudes of American (n=147) and Israeli (n=74) community staff towards people with ID using the CLAS-MR. Controlling for age, education and agency, they found that Israeli staff had lower *Empowerment* scores and higher *Sheltering* and *Similarity* scores and marginally higher *Exclusion* scores than did staff from the USA. This suggests that, compared to US staff, Israeli staff are more likely: to be against people with ID making their own decisions; to regard people with ID as needing help in keeping safe; to regard people with ID as different to themselves; and to be slightly more against community inclusion. Henry et al. argued that this pattern of results can be explained by differences between the two countries; the self-advocacy movement has not yet had a major impact on policy and public opinion in Israel, unlike in the USA. They also maintained that staff training in Israel has not been reflective of the principles of inclusion to the same extent as it has in the USA. Moreover, whilst empowerment appears to be necessary in fostering inclusion in individualistic cultures, they argued that it may be less important in collectivistic cultures. They found significantly higher mean scores on the *Similarity* subscale in the Israeli sample. They speculated that whilst community inclusion in the west is based on individual rights, the principle underlying community inclusion in Israel is a common humanity (Henry et al. 2004).

In summary, the need for an internationally recognised and well validated psychometric tool appears to be met by the CLAS-MR (Henry et al., 1996). The next section focuses on attitudes in an Asian context.

Table 1: A summary of studies that have used the CLAS-MR

			CLAS subscales							
			Sheltering		***Similarity***		***Empowerment***		***Exclusion***	
		N	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
USA (Henry et al., 1996a)	Students & Community members	387	3.26	0.76	4.9	0.65	3.91	0.78	1.87	0.66
USA (Henry et al., 1996b)	Staff members	340	3.26	0.79	4.64	0.64	4.02	0.79	1.77	0.63
Japan (Horner-Johnson et al., 2002)	Students	275	3.17	0.49	4	0.53	3.41	0.47	1.96	0.62
Israel (Schwarz & Armony-Sivan, 2001)	Students	149	3.96	0.66	4.48	0.61	3.73	0.66	2.41	0.72
Israel vs. USA (Henry, Duvdevany, Keys & Balcazar, 2004)	Staff from USA	147	3.15	0.84	4.68	0.67	4.04***	0.77	1.66	0.59
	Staff from Israel	74	3.99***	0.87	5.08*	0.53	3.83	0.71	1.72*	0.52
Australian**** (Yazbeck, 2004)	Students	140	3.43**	0.57	4.46**	0.39	3.69**	0.46	4.62**	0.55
	Disability Services Staff	174	3.32	0.67	4.38	0.38	3.62	0.59	4.52	0.66
	Other	106	2.86	0.66	4.19	0.49	3.27	0.55	4.36	0.58

* p < .05, **p< .01, ***p<.001, **** Whilst the CLAS-MR (Henry et al., 1996) uses a 6-point scale, this study used a 5-point scale.

3.4. Attitudes in an Asian Context

3.4.1. China

Cheung and Ngan (2007) argue that, to understand the community integration of people with ID within a Chinese context, it is important to first look at the emphasis in traditional Chinese culture on self-restraint, selflessness and collectivism. They argue that the values embedded within the culture may act as an opposing force to the feasibility of empowerment in Chinese society.

Tang et al. (2000) investigated Chinese children's attitudes towards people with ID. Chinese children (n=489) aged between four and fifteen participated in the study. Attitudes towards ID were assessed by a 20-item questionnaire, originally developed by Gash (1993) for an Irish study. This questionnaire was translated into Chinese then shown to three Chinese clinical psychologists to check for literal equivalence and face validity. On the basis of their comments, minor changes were made. A pilot study (with 10 children) confirmed that the instructions and meanings of the questionnaire items were understandable to Chinese children. In the main study, participants were asked about a hypothetical child with ID who was new to their class.

Results showed cross-cultural differences, when compared to the Irish sample (Gash, 1993). The Chinese sample was more positive about school integration and more willing to have social interactions and to form social relationships with people with ID. Conversely, the Irish sample appeared to be less afraid, less intolerant and more concerned about people with ID, when compared to the Chinese sample. The authors proposed that the Chinese children's willingness to form social relations with children with ID may be the result of cultural training. Chinese children are often raised to be polite towards people who are seen as less fortunate than themselves. Thus, their responses may reflect a sense of social appropriateness, sympathy and pity, as opposed to an acceptance of people with ID. Alternatively, the rapid social changes brought about by modernisation in Chinese society in the past few decades may have been accompanied by western values, such as human rights, equal opportunities and social inclusion; these may have permeated into the attitudes of Chinese people (Tang et al., 2000).

However, inconsistencies were identified in the data. Whilst the Chinese sample appeared to favour inclusion (e.g., by favouring integration), the principles of social inclusion were not reflected in their other responses (e.g., high scores on the 'afraid of' item). Tang et al. (2000) argued that this apparent contradiction could be due to the questionnaire being originally designed for a western population. For example, one item asks about whether the respondent would invite the person with ID to their home to play. This is culturally applicable to an Irish sample, but does not apply to a Chinese context in which children are rarely allowed to invite other children to their homes to play. Thus, the low endorsement frequency on this item may be attributable to cultural practices rather than to negative attitudes towards people with ID.

In summary, researchers looking at cross-cultural differences need to ensure that the measures used are culturally relevant to the participants under study. Further research is needed to investigate the nature of attitudes in modern Chinese society.

3.4.2. Japan

A recent study (Tachibana & Watanabe, 2004) investigated attitudes of Japanese adults towards people with ID. A questionnaire was distributed to all families whose children attended one of 11 schools in Kasugai. This yielded a large sample (N=2381) and represented a high return rate (87.6%). Results were compared with studies conducted 20 and 40 years previously. This indicated that, over time, attitudes towards people with ID in Japan had become more positive. The authors also attempted to compare these results to several US studies of attitudes towards ID and, on this basis, concluded that Japanese attitudes appeared less inclusive than American attitudes. However, given that different measures were used in the Japanese and US studies, it was not possible to draw any definite conclusions as to the existence of cross-cultural differences from this data.

Another study (Horner-Johnson et al., 2002) investigated attitudes of Japanese students towards people with ID. Participants (n= 286) completed three measures of attitudes towards people with ID, including the CLAS-MR (Henry et al., 1996), a demographic questionnaire and a social desirability scale. Semantic equivalence was achieved through translation and back-translation of this measure. The pattern of results revealed a mixed picture of attitudes towards inclusion in Japan; the means of the *Similarity*, *Empowerment* and *Sheltering* subscales were lower than studies in Australia (Yazbeck, 2004) and the USA (Henry et al., 1996a, 1996b), whilst the *Exclusion* subscale was similar to the US sample but considerably lower than the Australian sample. This suggests that Japanese students are more likely: to oppose people with ID making their own life decisions; to regard people with ID as in need of protection; to see people with ID as different to themselves and to be in favour of community inclusion. One explanation for this mixed pattern of results is that "...inclusion attitudes comprise multiple dimensions that may exist in tension with each other" (Henry et al., 2004, p.34). An alternative explanation is that attitudes in Japan are in a transitional state; it is only relatively recent that community groups have been campaigning for inclusion and disability rights (e.g., Japan League for the Mentally Retarded, 1996, cited in Horner-Johnson et al., 2002).

In summary, attitudes in Japan are currently unclear; ongoing research is needed to gain a better understanding of changing attitudes towards people with ID in contemporary Japanese society.

3.4.3. India

Goel (2000) suggests that, although changes are occurring in Indian society, negative attitudes towards people with ID are still very prevalent. Census data indicate that 80.5% of the population of India are Hindus; Muslims and Christians make up less than 16% of the population (Census of India, 2001). Gabel (2004) carried out a 2-year ethnographic study involving first-wave North Indian Hindu immigrants (N=20) residing in the USA, of whom 17 were professionally employed and had at least an undergraduate degree. The study was conducted using traditional ethnographic methods with the intention of understanding attitudes from the perspective of the people being interviewed. Gabel and her team (which included an interpreter) conversed with the participants in their first language (Hindi). The first interview was unstructured and involved the use of picture prompts to elicit open-ended conversations about ID. Respondents were shown nine black and white pictures of people with and without visible features of ID or physical disability and were asked, in Hindi, to describe what they saw in the picture. Follow up questions were asked where appropriate. The second interview was also unstructured and participants were asked to talk about their experience and knowledge of ID. The third interview was structured and was based upon the results from the initial two interviews. Gabel reported three dominant beliefs about people with ID. The first was the belief in the consequence of bad deeds (*Karma and Punarjanamphala*). This reflects the Hindu belief in reincarnation and regards any disability as a result of bad deeds in a previous life. The second belief identified was the idea of 'suffering through', i.e., that a person must endure disability without complaint. However, Gabel argued that 'suffering' does not have the same negative connotation that it might have for someone born and raised in the West; in contrast, it is regarded as a welcome opportunity for learning that could free oneself from rebirth. Gabel's findings were in line with observations by Agrawal (1994), a professor of psychology and education in India, who wrote about the fatalism inherent in the philosophy of *karma;* he argued that the majority of Indians regard any kind of disability as irrevocable, as the cause is deemed to be supernatural. The third belief identified was that of a *mundh buddhi,* which is often used in Hindi to refer to people with ID, in the absence of any Hindi word for this concept. Whilst there was no consensus as to its meaning, several prominent meanings of this term surfaced in the data analysis, including the idea that a person with ID is able to the same things and at the same pace as people without ID, but chooses not to due to laziness.

As was noted earlier, social factors largely determine whether or not a person is identified as having an ID. In support of this idea, Prabhu (1983, cited in Miles, 1992) reported that in rural and agrarian communities, where there is little emphasis on education and individual striving, many individuals with ID fulfil their social functions and therefore do not become identified as having ID. This suggests that eastern concepts of ID, though very different to western concepts, also lend themselves to inclusive and integrated practices. Indeed, in the past, due to a lack of identification, children with mild ID in India joined mainstream schools and received integrated education (Miles, 1992).

Miles' (1992) paper refers to India as it was in the 1980s and early 1990s. However, it appears that its findings are still relevant to contemporary Indian society. As noted earlier, India was included in the multinational study (Special Olympics, 2003). Overall, the Indian public's responses regarding capabilities are lower than all other countries except Egypt. Consistent with this finding, 90% of the Indian public believes that children with ID should be either educated at home or in a special school, higher than all other countries except Egypt. Independent living is not seen as an option by many Indians (98%), which fits with the fact that specialised community services in India are almost non-existent. However, only 20% of Indians believe that people with ID should live in institutions; similar to Egypt (29%), Nigeria (16%) and China (15%), where institutions still operate. As regards employment, 11% of the Indian public believe that individuals with ID should not have a job, which is higher than all other countries (e.g., USA = 0.7%), with the exception of the African countries in the study. However, this is perhaps unsurprising given that the Indian respondents live in a country where unemployment is high and in which independent living for people with ID is not encouraged. In summary, Indian attitudes towards ID appear to sit uncomfortably within a western framework of ID. Nonetheless, other aspects of Indian society (simple rural communities) demonstrate that, whilst Indian practices are different to western ones, they can also support inclusive and integrated practices. Unfortunately, in contemporary Indian society, services for people with ID are almost non-existent and independent living, as advocated in the west, is not an option for most people with ID.

3.4.4. Pakistan

Having considered attitudes in India, where Hinduism is the main religion, it is now useful to consider Pakistan, where Muslims make up 96.3% of the population (Population Census Organisation, 1998). It is therefore pertinent to begin with a brief summary of Islam and people with ID. In a discussion article about Islam and people with ID (Morad, Nasri & Merrick, 2001), the authors emphasise Islamic compassion towards people with ID, quoting the Koran (51:19): “And in their wealth there is acknowledged right for the needy and the destitute” (Morad et al., 2001, p.65). They maintain that, according to Islam, the community should assess, assist and respect people with ID in order to provide them with equal life opportunities. They also highlight that, in the Koran, people with ID are regarded as legally incompetent.

As noted in the previous section, the western concept of ID is culturally specific with its own set of socially constructed criteria that do not easily fit into South Asian cultures. In support of this idea, Miles (1992) argues that the criterion ‘unable to learn to read’ would not indicate ID in Pakistan, where only 30% of the population can read. Conversely, if a Pakistani adolescent did not consistently engage in polite conversation and serve tea respectfully to guests, this might be seen as signs of a developmental delay. Miles (1992) argues that for the majority of people in Pakistan, girls and boys are expected to learn to obey and grow up to be like their same sex parent. If it becomes clear that a child is unlikely to become like their same gender parent, it appears "...as a severe disturbance of the natural order" and a plausible theory is that "...this child has been overtaken by 'djinn' (spirit), or that this child is a changeling" (p.215). This suggests that the Pakistani general public may hold stigmatising attitudes towards people with ID.

In summary, the available literature presents a contradictory picture of attitudes towards people with ID in Pakistan. On the one hand, Islam appears to advocate a morally neutral view of ID, seeing it neither as a blessing nor a curse (Morad et al., 2001). On the other hand, people with ID, in failing to live up to parental expectations, may be viewed very negatively (Miles, 1992).

As yet, there are no studies to the author's knowledge that have measured attitudes towards people with ID in Pakistan using standardised measures. Cross-cultural research is needed in order to better understand attitudes towards people with ID in Asian countries. It would also be useful to investigate whether attitudes among immigrants to western countries are more in line with their home or host country.

3.5. Attitudes in other parts of the world

3.5.1. The Middle East

There appear to have been no studies investigating attitudes towards people with ID in the Middle East, except for Israeli research with Caucasian samples (e.g., Henry et al., 2004). However, the published work available indicates that people with ID in the Middle East are devalued (Crabtree, 2003). A qualitative study of Arab Muslim parents (N=15) of children with ID in the United Arab Emirates (UAE) found that social stigma is rife, in terms of discrimination from health professionals and the general public (Crabtree, 2007). Crabtree concluded that the concept of community integration is not a concept that is easily applicable to the UAE, where there is little concept of an individual's rights in relation to the duty of the state. Young (1997) found that, in Jordan, the life prospects of relatives of people with ID are adversely affected by negative attitudes towards ID (e.g., mothers may be repudiated by their husbands and the marriage prospects of non-disabled siblings may be greatly reduced).

3.5.2. Africa

South Africa, Egypt and Nigeria were included in the Special Olympics study (2003). Although culturally and religiously very distinct, data from these three countries were summarised in the study's report and hence is presented here in this manner. In comparison to other nations, the African public's responses regarding capabilities were lower than those from the USA, Europe, Russia, Japan and China. A substantial percentage of the public in Nigeria, South Africa and Egypt believed that institutions are the best place for people with ID to live (16%, 17% and 29% respectively). Moreover, the majority of respondents in Egypt, Nigeria, and South Africa believed that individuals with ID should not have a skilled job (87%, 85% and 95% respectively). These findings could, in part, reflect the present economic situation in these countries where there is high unemployment.

3.5.3. Latin America

In the multinational study of attitudes towards people with ID (Special Olympics, 2003), 80% of Brazilian participants believed that people with ID should live at home. This is very much in line with a discussion article (Watson, Barreira & Watson, 2000) which suggests that Brazilian families keep members of the family with ID in the family home due to religious values, lack of knowledge about disability and a lack of awareness about community services and suggests that people with ID tend to be "kept out of sight" and are "rarely discussed" (p.66). This strongly suggests that the principles of social inclusion are not reflected by contemporary attitudes in Brazil.

In summary, there is a dearth of research on attitudes towards ID in Africa, Latin America and developing countries. This is of great concern as it is estimated that the majority of people with ID live in the poorest countries of the world (World Health Organisation 1999).

3.6. Attitudes in multicultural societies

There are many countries across the world whose members originate from cultural backgrounds, which differ from the majority or indigenous culture, often through migration. Countries such as the UK, US, Canada and Australia had, until recently, relatively homogenous populations (Hatton, 2002). Over the past 50 years, their populations have become substantially more diverse with regard to ethnicity, culture, language and religion. Estimates predict that this diversification will continue to increase (ONS, 2001).

Research shows that attitudes of people from ethnic minorities regarding disability and illness often appear to differ from the principles embedded in the health care systems of the host countries (Westbrook, Legge & Pennay, 1993). However, there has been little research exploring attitudes towards people with ID among different cultures in the UK. One hypothesis, as to why this topic has been avoided, is that it has the potential to raise some sensitive issues. Nevertheless, this is an important area in need of further study.

The importance of cross-cultural differences in attitudes towards ID in a multicultural society is now considered with regard to the British South Asian population. 'South Asian' is a term used to refer to people originating from India, Pakistan, Bangladesh and Sri Lanka (Modood et al., 1997). Based on 2001 Census data, South Asian communities constitute 3.5% of the UK population (ONS, 2001) and have a higher incidence of ID (Hatton, 2002). Prevalence rates for severe ID amongst school age children from South Asian communities are approximately 9 per 1000 compared to around 3 per 1000 in non-South Asian communities (Emerson et al., 1997). High levels of social and financial deprivation have been shown to exist amongst South Asians with ID and their families (Azmi et al., 1996). Risk factors also include inequalities in access to maternal health care, misclassification and higher rates of first cousin marriages as well as other genetic and environmental risk factors (Emerson, 1997). It has been suggested that these factors may combine with higher levels of deprivation to create higher prevalence rates (Emerson, 1997).

Whilst British South Asian families report a substantial need for formal service support, access of community services is low (Hatton et al., 1998). In particular, there is low parental awareness of specialist services for people with ID and low uptake of (family) support services such as respite care (Hatton et al., 2002) and support groups (Chamba et al., 1999). The Government White Paper *Valuing People* (Department of Health, 2001) flagged up this issue as an area that requires further attention. It has been acknowledged that services need to better recognise South Asians' language and information needs in order to make accessing services easier (e.g., Baxter et al., 1990; Mir et al., 2001). In addition, within services, stereotypical views that South Asian families 'look after their own' may lead to services neglecting the needs of this group (Mir et al., 2001). It is equally possible, though, that attitudes towards people with ID in South Asian communities may also play a part in the poor uptake of services.

One study, which supports this hypothesis, investigated attitudes towards ID in British Caucasian and British South Asian families with a family member with ID (Fatimilehin & Nadirshaw, 1994). This study concluded that differences in attitudes were attributable to religious and cultural differences. The British South Asian families revealed a lack of knowledge about possible causes of ID and a lack of awareness about the availability of services. They also showed evidence of non-western beliefs about ID, including the concept of curability and the belief that marriage lessens the level of impairment, consistent with previous research (Bhatti, Channabasavanna & Prabhu, 1985). However, a key limitation of Fatimilehin and Nadirshaw's (1994) study is the very small sample in each group (n=12), which restricts the analysis to descriptive and basic qualitative analysis. In addition, their research does not provide any information as to the nature of British South Asian attitudes towards people with ID at a broader societal level.

In summary, research into attitudes towards people with ID in multicultural societies, although in its infancy, suggests that cross-cultural differences exist.

3.7. The role of religion

Whilst religious beliefs and practices regarding disability are not the focus of this review, it is important to consider, in a little more depth, the role that religion may play in attitudes towards people with ID. For the majority of human history, the major world religions have provided an all-encompassing social context which informed peoples' beliefs and attitudes (Miles, 1995). In modern times, approximately 80% of the world's population classify themselves as a member of one of the world's religions (Bernstein et al., 1995) and at least 70% of global disability occurs in nations "...upon which western ethics and philosophy impinge only peripherally" (Miles, 1995, p.50). However, there is a paucity of research on the impact of religious practices and beliefs on people with a disability, fewer still which focus on ID. Selway & Ashman (1998) hypothesise that this is because "...there has been little interest in the spiritual lives of people with a disability or the influence of religion on their health or well-being" (p.429). Miles (1995) suggests that this could also be due to the difficulty of attempting to succinctly summarise how a major world religion addresses disability. Miles (1995) provides valuable insight by investigating the description of disability in Eastern religious texts (Hinduism, Buddhism and Islam). In Hindu texts, for example, disabilities are frequently understood as retributive consequences (e.g., if a person steals a lamp they will go blind). However, the idea of *karma* does not always appear in such retributive terms. For example, people who were "over-intellectual" or "domineering" in a previous life might need the 'rehabilitative' experience of having an ID in the next life "...to overcome the arrogant tendency and thus enable the soul to progress towards enlightenment" (Miles, 1995, p.61).

Rose (1997) describes four types of perceptions of people with disabilities in Judeo-Christian texts: disability as a punishment and as an indication of evil; disability as a challenge to God's perfection; disability as a focus of pity and care; and disability as an incompetent person. It is argued (Rose, 1997) that the negative emphasis has resulted in the distancing of many religious people from people with disabilities.

Religious approaches to persons with disabilities appear to be ambivalent. Religious beliefs can affect attitudes either positively or negatively: the belief that disability is God's punishment might lead to negative attitudes, whereas the belief that disability is an opportunity awarded by God to prove the strength of one's faith might lead to positive attitudes (Weisel & Zaidman, 2003). It is interesting to note that both of these beliefs exist (and sometimes co-exist) within different religions; disability as a punishment is found in Judeo-Christian theology (e.g., Rose, 1997) and Hinduism (e.g., Keith, 1924, cited in Miles, 1995); disability as a test of religious faith and of the believer's devotion can be found in Judeo-Christian theology (Abrams, 1998) and Islam (Quayyum, 2006).

In short, religious approaches to people with ID are inconsistent. Whilst, they appear to promote understanding and support, they also appear to promote the lower status of people with disabilities. Further research is needed to understand the extent to which religious texts, practices and beliefs promote positive or negative attitudes towards people with disabilities. This is particularly important in the field of ID, given the particular dearth of research in this area.

3.8. Issues in attitudinal research

Antonak and Livneh (2000) argue that researchers frequently select research methods on the basis of familiarity with a given method. This, they argue, is a key weakness in attitudinal research as methods should be chosen according to the research question. Methods to measure attitudes can be regarded as belonging to two categories: direct and indirect methods (Livneh & Antonak, 1994). Direct methods are those in which the participants are aware that their attitudes are being measured and include interviews, opinion surveys and adjective checklists (Antonak & Livneh, 2000). However, data from direct methods can be confounded by respondent sensitisation, reactivity and response styles. For example, a respondent may be influenced by a conscious or unconscious motivation to avoid criticism from others through social conformity. In order to address such concerns, researchers often include measures such as the Marlowe-Crowne Social Desirability Scale (Crowne & Marlowe, 1960).

Indirect measurement tools are also available to researchers and are broadly divided into four classes: those in which participants: (a) are unaware that they are being observed; (b) are aware that they are being observed, but are unaware of the purpose of the research; (c) are intentionally deceived as to the actual nature of the research;

and (d) are aware of being measured but are inactive participants in the process e.g., physiological methods (Livneh & Antonak, 1994). Whilst indirect methods are increasingly used in general attitude research, they have not yet been taken up in the area of disability, where direct methods dominate (Antonak & Livneh, 2000).

3.9. Integrating the Literature

This review has highlighted the importance of culture, worldview and religion on attitudes towards people with ID. Based on this review, the following issues seem pertinent in comparing attitudes across cultures:

Intellectual Disability is culturally determined

Our understanding of ID is socially constructed. Cultural and social factors largely determine whether or not a person is identified as having an ID and the meaning attached to the ID.

Non-Caucasian research is lacking

There appear to be few non-Caucasian studies, which investigate attitudes towards people with ID and fewer still which address the role of culture. There is a particular lack of research from developing countries.

Social inclusion is not universally applicable

Whilst the principles of social inclusion are generally well established in western countries, it does not follow that this concept fits in other parts of the world where non-western cultures prevail. In non-western countries, it is often the home, rather than the community, that is seen as the most appropriate place for people with ID (e.g., Crabtree, 2007). It has been argued that the idea of social inclusion makes little sense in less industrialised societies (Littlewood, 1988). However, eastern concepts of ID can also support inclusive and integrated practices (Prabhu, 1983, cited in Miles, 1992). Therefore, while concepts such as independence do not appear to be universally applicable, other aspects such as the importance of fulfilling a valued social role and the presence of inclusive education appear to be shared with non-western cultures (Miles, 1992).

Sampling procedures are variable

Sample sizes in quantitative attitudinal studies tend to be reasonably large and range from 221 (Henry et al. 2004) to 9123 (Siperstein et al., 2007). However, the use of convenience samples (e.g., Horner-Johnson et al., 2002) means that sampling bias is sometimes overlooked. Attitudinal measures employed in studies range from unstandardised survey questionnaires (e.g., Tachibana & Watanabe, 2004) to measures with good psychometric properties such as the CLAS-MR (e.g., Henry et al., 1996b).

4.0. Suggestions for further research

Culture plays an important part in determining how people see themselves and the world (Keith & Schalock, 2000). Parents in individualistic cultures bring up their children to be independent, able to reach their own decisions and make their own friends. In contrast, in communal societies parents teach their children the value of interdependence and reliance upon families and other societal groups (Keith & Schalock, 2000). This may lead to major differences in the way that the principles of social inclusion are viewed across cultures and raises the question of whether it is at all possible or desirable to attempt to make social inclusion a universal principle. Whilst the principles of social inclusion could lead to more choice and independence for people with ID around the world, social inclusion policies are based on a western mode of thinking, which may bear no relevance to cultures that have a different set of values. In order to assess whether it is appropriate to apply social policies associated with social inclusion in non-western countries, it is vital that cultural differences and similarities in attitudes towards people with ID are better understood. The relationship between culture and attitudes towards people with ID is an area with a lack of clarity. There are many unaddressed areas for further research to address, including: the role that religion plays in shaping attitudes towards ID; the potential interplay between culture and religion; the media's portrayal of people with ID across cultures and their influence on attitudes; and the extent to which the rapid modernisation of traditional countries such as China and India impacts on attitudes towards people with ID.

As well as investigating attitudes between countries, future research should also focus on multicultural societies. Attitudes towards people with ID in India and Pakistan (Agrawal, 1994; Miles, 1992) appear contrary to the western principles of social inclusion (e.g., Siperstein et al., 2007). However, little is known, for example, about South Asian attitudes towards people with ID in the UK general population. Research comparing British South Asian attitudes towards people with ID with those of White British people could begin to address the question of the respective influence of culture of origin versus host country. Such research could also be useful in furthering our understanding of possible reasons for low service uptake and in finding potential ways of tackling this.

5.0. References

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PART II:

EMPIRICAL PAPER

ATTITUDES TOWARDS PEOPLE WITH INTELLECTUAL DISABILITIES: A COMPARISON OF YOUNG PEOPLE FROM BRITISH SOUTH ASIAN AND WHITE BRITISH BACKGROUNDS

Abstract

Uptake of community services among South Asian families with a child with intellectual disabilities (ID) is poor (Mir et al., 2001). It is hypothesised that British South Asian culture does not favour the principles of *Valuing People* (Department of Health, 2001). This study surveyed 737 sixth form students using the Community Living Attitudes Scale (Henry. et al., 1996a). Results indicated that the British South Asian sample (n=355) were less in favour of the social inclusion of people with ID than the White British sample (n=382), were more likely to believe ID can be 'cured', and that parents should bear the main responsibility. Implications for policy, service provision, education and further research are discussed.

1.0. Introduction

People with ID do not form a homogenous group. In the UK and North America, a person is considered to have ID if they meet the following criteria: significant impairment of intellectual functioning, significant impairment of adaptive or social functioning and age of onset before adulthood (e.g., British Psychological Society, 2001; World Health Organisation, 1992). In the UK, it is estimated that people with ID comprise 2.94% of the population (Department of Health, 2001). ID is socially constructed as its meaning and measurement has varied over time and its definition has varied across countries, in relation to a large number of cultural, political and economic factors (Hatton et al., 1998).

Attitudes towards social inclusion

The emergence of attitudes in favour of societal inclusion for people with ID began in 1971 with the United Nations' declaration of human rights for people with ID (UN, 1971). Over the past 37 years, institutionalisation and segregation have given way to greater engagement with the community in housing, education, employment and leisure (Emerson & Hatton, 1996), at least initially, through the principles of normalisation or social role valorisation as it was later renamed (Wolfensberger, 1983). The issue of social integration has been regarded as critical to successful service delivery (Department of Health, 2001). In the UK, almost all the long-stay hospitals are now closed and the rights of people with ID have been acknowledged in law (Disability Discrimination Act, 2005). Cummins & Lau (2003) maintain that the normalisation is not always beneficial to people with ID. They make the distinction between 'physical' and 'social' integration with the wider community. They question the assumed benefits of increased physical integration with the non-disabled general community. They argue that physical integration without social integration does not have a positive influence on the wellbeing of people with ID. Whilst this paper acknowledges the distinction, it will use the term 'social inclusion' to refer to the physical and social integration of people with ID into the valued aspects of mainstream society, such housing, education, employment and leisure. The principles of social inclusion suggest that these changes should lead to societal attitudes towards people with ID becoming more pro-inclusion and less stigmatising.

'Attitudes' have been described (Antonak & Livneh, 2000, p.552) as "...latent psychological constructs postulated as residing within the individual..., which lie dormant unless evoked by specific stimuli or referent objects (e.g., individuals, social groups, situations, events, social issues)". Attitudes have been found to strongly predict human behaviour (Glasman & Albarracin, 2006). The principles of normalisation suggest that educational integration and deinstitutionalisation is likely to contribute to change in societal attitudes towards people with ID. In particular, the increased presence and participation of people with ID in ordinary community life is likely to result in less stigmatised attitudes and greater acceptance by society at large (Wolfensberger, 1983). Indeed, research has shown pro-inclusion attitudes towards people with ID are important in facilitating the process of social inclusion (e.g., Henry, Keys, Jopp, & Balcazar, 1996a). Current policies emphasise the need to empower people with ID, to maximise their choices and their social inclusion. However, the extent to which Wolfensberger's original vision has been fulfilled and just how far the general population subscribes to the values of current policies is unclear, especially with regard to black and minority ethnic groups (BME) in Britain (Mir et al., 2001).

The impact of culture on people with intellectual disabilities

Culture has been identified as an important variable on attitudes towards people with ID (e.g., Fatimilehin & Nadirshaw, 1994). However, social science research has largely focused on Caucasian and middle-class participants, to the exclusion of ethnic minority and low socio-economic groups (Mink, 1997). In addition, studies investigating attitudes towards people with ID have almost entirely focused on developed countries in the west; less is known about attitudes in Asia, Africa and Latin America. This may lead to potential cross-cultural differences being overlooked (Hatton, 2002). Research indicates that attitudes of people from ethnic minorities regarding disability and illness often appear to differ from the principles embedded in the health care systems of the host countries (Westbrook, Legge & Pennay, 1993). Moreover, cross-cultural studies between Asian and western countries have indicated fundamental differences in the perceptions, attitudes and responses to ID (e.g., Aminidav & Weller, 1995; Downs & Williams, 1994; Tse, 1991). These studies indicate that, on the whole, people from western countries tend to be more in favour of the social inclusion and social integration of people with ID. The study of attitudes towards people with ID from the perspectives of different cultural groups is particularly important in the UK. Whilst the UK is culturally diverse, it employs a classification of ID based on western models of thinking. However, there has been a scarcity of research exploring attitudes towards people with ID among different cultures in the UK. One reason why this topic may have received less attention is because it has the potential to raise some sensitive issues.

Attitudes towards people with intellectual disabilities among British South Asian families with a member with intellectual disabilities

One of the largest cultural groups in the UK is the British South Asian population. 'South Asian' is a term which refers to people originating from India, Pakistan, Bangladesh and Sri Lanka (Modood et al., 1997). South Asian communities constitute 4% of the population of the UK. By 2021 it is predicted that 7% of all British people with ID will be of South Asian origin (Emerson & Hatton, 1999; Hatton, et al., 2003). According to Mir et al., (2001), higher rates of ID in South Asians are associated with greater material and social deprivation. This may be compounded with "other factors such as poor access to maternal health care, misclassification and higher rates of environmental or genetic risk factors" (p.2). Research has shown that informal and formal supports received by South Asian families of people with ID are not adequate to meet their needs; they receive less support from extended family networks compared to White families in similar positions (Chamba et al., 1999; Hatton et al., 2003) and contrary to expectations, frequently do not receive much support from community or religious groups (Atkins & Rollings, 1996).

Despite South Asian families reporting a substantial need for formal services (e.g., Chamba et al., 1999; Mir et al., 2001), there is a low parental awareness of specialist services for people with ID and a low uptake of services such as respite care for families (e.g., Hatton et al., 1998, 2003) and family support groups (e.g., Chamba et al., 1999). Mir et al., (2001) point out that people with ID from BME groups are doubly disadvantaged and that "negative stereotypes and attitudes held by service professionals contribute to the disadvantage they face" (p.2). It is well documented that providers need to do more to make services more accessible, e.g., addressing South Asians' language and information needs (Chamba et al., 1999; Mir et al., 2001). For these reasons, the White Paper *Valuing People* (Department of Health, 2001) flagged up South Asian communities as one group which is underserved by services and needs more attention.

Attitudes held by South Asian families with a member with ID may also play their part in the poor uptake of services. Fatimilehin and Nadirshaw (1994) compared South Asian (n=12) White British families (n=12) with a member with ID. Among the South Asian families they found evidence of fatalism, the search for a cure, the stigma of bearing a child with a disability and fears about how this may impact on the marriage prospects of siblings. However, this study used very small samples (n=12), which restricted the analysis to descriptive and basic qualitative analysis. Moreover, it did not provide any information as to the nature of British South Asian attitudes towards people with ID at a broader societal level.

Attitudes towards people with intellectual disabilities among British South Asians in the general population

Ethnicity

It is not known how attitudes towards people with ID among British South Asians would compare to those of White British people in the general population. South Asian communities often regard close family relationships as an essential source of identity and support (Ahmad & Atkin, 1996). Based on this, it is tentatively hypothesised that British South Asians are less likely to favour the empowerment of people with ID. It is also tentatively hypothesised, based on the findings of other studies (Fatimilehin and Nadirshaw, 1994; Hatton et al., 2003; Katbamna et al., 2000), that British South Asians are more likely to believe that: people with ID can be cured; parents should bear the main responsibility for children with ID; the marriage prospects of siblings are adversely affected by having a sibling with ID; and families should conceal their members with ID rather than make the ID obvious through using services. These hypotheses will be explored in the current study.

Gender and prior contact

Research on Western adolesents has found an impact of gender and prior contact (Krajewski & Flaherty, 2000; Krajewski, Hyde & O'Keeffe, 2002; Siperstein et al., 2007). That is, females and people who have had prior contact with people with ID often show greater pro-inclusion attitudes toward people with ID (compared to males and people who have had prior contact with someone with ID). These two variables have also been found to interact with on another; one study compared the attitudes of adolescents' attitudes in 1987 with attitudes in 1998 (Krajewski, Hyde & O'Keefe, 2002), found that females demonstrated significantly higher attitudes than males in 1987; however, by 1998, this difference was no longer significant. The authors attributed this to an increase in positive attitudes among the male respondents and hypothesised that this was due to ongoing contact with fellow students with ID through an inclusion program. It is expected that gender and prior contact will influence pro-inclusion attitudes among adolescents in the current study.

Religion

It is not known whether attitudes towards people with ID differ according to membership of different religions. Islam appears to emphasise compassion and the rights of people with ID to equal life opportunities (Morad et al., 2001). However, it does not appear to be in favour of independence that promotes individuality as this is contrary to the notion that the family should stay together (Fatimilehin & Nadirshaw, 1994). Hinduism appears to regard ID as "...the result of the sins of a past life" (Gabel, 2004, p.18). However, rather than it being seen as a punishment, Hinduism appears to regard ID as "...a learning opportunity, something that one welcomes because it brings one a chance to learn lessons that could release one from rebirth" (Gabel, 2004, p.18). The link between disability and past sins is also found in Islam (Qayyum, 2006) which views illness as a "...way of being forgiven for sins..." (Hussain, 2001, p.6). No studies could be identified that investigate whether attitudes towards people with ID differ according to membership of different South

Asian religions. Therefore, it is not possible to form clear hypotheses about the relationship between particular religions and attitudes towards people with ID. However, this is an exploratory area covered by the current study.

Generations

Current third generation British South Asian adolescents are among the first cohorts whose parents (the offspring of migrants to Britain) were schooled when normalisation policies were first being introduced. Hence, it is conceivable that later generations may demonstrate more pro-inclusion attitudes than earlier generations since the former will have been more exposed to the principles of normalisation. However, no studies could be identified that investigate whether attitudes towards people with ID differ according to membership of different generations. This is, therefore, a further exploratory area covered by the current study.

The current study

Much of the research that has investigated attitudes towards people with ID has studied narrow populations such as university students (e.g., Hall & Minnes, 1999) and staff working with people with ID (e.g., Henry et al., 1996b). These populations, however, are not representative of wider society. Adolescents' attitudes are useful to consider as they represent the new generation of adults whose attitudes will impact on the community in which people with ID live (Krajewski & Flaherty, 2000). Their attitudes are also more likely than those of younger children to reflect broader societal views of people with ID. Furthermore, large numbers of potential participants are fairly easily accessible through educational establishments. Therefore, it was decided that adolescents would be the most appropriate population for this study, in which we examined attitudes towards people with ID among British South Asian and White British adolescents.

It is tentatively predicted that:

Hypothesis 1: British South Asian adolescents will differ from White British adolescents in terms of pro-inclusion attitudes and beliefs about curability, care responsibilities and stigma.

Hypothesis 2: Ethnicity will be as predictive as other variables which have been shown to influence pro-inclusion attitudes among adolescents, e.g., gender and knowing someone with ID (Krajewski & Flaherty, 2000; Krajewski, Hyde & O'Keeffe, 2002; Siperstein et al., 2007).

Hypothesis 3: Religion and importance of religious beliefs will influence pro-inclusion attitudes and beliefs about curability, care responsibilities and stigma..

Hypothesises 4: British South Asian adolescents of different generations will differ in terms of pro-inclusion attitudes and beliefs about curability, care responsibilities, and stigma.

2.0. Method

2.1. Design

This study used a non-experimental and cross-sectional two groups design.

2.2. Participants

The study was restricted to people fluent in English who had been resident in the UK for at least 3 years. The sample consisted of 737 adolescents, aged between 16 and 19 years of age, from White British (n=382) and British South Asian (n=355) backgrounds. The category of 'South Asians' comprised of people who originated from India, Bangladesh, Pakistan or Sri Lanka. Participants were recruited during two open days at University College London and five visits to sixth form colleges in London, Essex and Cambridge.

2.3. Measures

2.3.1. Demographic variables

The following variables were assessed by means of a demographic questionnaire (Appendix A): age, educational level, gender, ethnicity, religion, importance of religious beliefs, country of birth (of participant and their parents) and generation. Participants were also asked if they knew someone with an ID and whether this was a relative, friend or acquaintance.

2.3.2. The Community Living Attitudes Scale – Mental Retardation Form

The Community Attitudes Living Scale – Mental Retardation Form (CLAS-MR) is a 40-item measure of attitudes towards the inclusion of people with ID (Appendix B). CLAS-MR subscales have shown acceptable internal consistency (ranging from .75 to .86), retest reliability, and construct validity in correlations with other similar attitude scales and no significant relationship with social desirability (Henry, Keys, Jopp & Balcazar, 1996). Studies using the CLAS-MR to investigate attitudes among Israeli (Henry et al, 2004; Schwarz & Armony-Sivan, 2002), Australian, Korean and Japanese populations (Horner-Johnson, 2002; Horner-Johnson, et al. 2002) have also shown cross-cultural validity. The CLAS-MR consists of 40 items related to four underlying subscales: (a) *Empowerment*, the extent to which people with ID are granted the freedom to make their own life decisions; (b) *Exclusion*, the extent to which respondents would like to isolate people with ID from community life; (c) *Sheltering*, the extent to which respondents think that people with ID need help in keeping safe; and (d) *Similarity*, the extent to which respondents feel that people with ID share a universal humanity.

Responses are on a six-point scale ranging from "strongly disagree" to "strongly agree". Subscale scores are calculated by averaging the items for each subscale (Appendix C). Relevant procedures outlined in the CLAS-MR scoring manual (Henry, Keys, & Jopp, 1998) were followed. Initially, all of the 13 reverse-worded items were re-coded. Next, an average score was produced for each of the four subscales for each respondent.

2.3.3. Six additional Items

Items 41 - 46 were added by the researcher to address hypotheses relating to the current study (Appendix B). These items concerned beliefs around curability, care responsibilities, service use, helpseeking and stigma towards families with a member with ID. Previous studies (Channabasavanna, Bhatti & Prabhu, 1985; Fatimilehin & Nadirshaw, 1994) have highlighted the belief, which exists in some South Asian communities, that ID can be cured or overcome through medical interventions, marriage or religion. It therefore seemed appropriate in the current study to investigate the extent to which participants agreed or disagreed with the following statements regarding curability:

- *41. People who have learning disabilities can be cured through a medical intervention.*
- *42. People who have learning disabilities can overcome these through religion.*
- *43. People who have learning disabilities can overcome these through marriage.*

Contrary to stereotypes, South Asians do not receive much support from community or religious groups (Hatton et al., 2002). A major national survey of minority ethnic families with severely disabled children also found that South Asian parents received very little family support in terms of care (Chamba et al., 1999). It therefore seemed important in the current study to ask to what extent South Asian participants agreed or disagreed with the following statement:

- *44. Parents should bear the main responsibility for children with learning disabilities.*

Katbamna and Bhakta (1998) carried out a qualitative study on the experiences of informal or family carers within South Asian communities in the UK. Many of the parental carers felt that negative attitudes in their community towards disability resulted in adverse repercussions on the marriage prospects of their other children. It therefore seemed important in the current study to ask to what extent South Asian participants agreed or disagreed with the following two statements:

- *45. Families should hide their relatives with learning disabilities rather than make it obvious through using services.*
- *46. Having a person with a learning disability in a family may damage the marriage prospects of siblings.*

2.4. Procedure

No impact of social desirability has been found in previous studies using the CLAS-MR, including studies on Asian populations (Horner-Johnson et al., 2002; Kan, 2008). Therefore, in the interests of brevity, a social desirability scale was not included in this study. The first phase of recruitment took place at the end of March 2007. Sixth form students nationwide had been invited to attend one of two Open Days at University College London as part of its *Widening Participation Programme*. The organisers agreed to a project stall being set up in the main hall to recruit students as they passed by. Participants were asked whether they would like to participate in a 12 minute survey. They were informed that they would be eligible to be entered into a prize draw to win one of three cash prizes: £100, £20 and £10 to thank them for participating. Those who chose to take part were first asked to read an "information sheet" about the study (Appendix D). They were then asked to read and sign an "informed consent" form (Appendix E), which outlined the project's aims and their rights to confidentiality and to withdraw at any stage. Once participants had signed the consent form, they were asked to explain what they understood by the term "learning disability". Where this was inaccurate, they were given a brief description, which was read aloud (see Appendix F). They were also informed that they should ask for clarification if they were unclear about any items in the questionnaire. Upon completion of the questionnaire, participants were given the opportunity to fill out their contact details if they wished to be entered into the prize draw or were interested in taking part in a focus group, due to be run by a fellow UCL trainee clinical psychologist, Sarah Coles (Appendix G). This method of recruitment yielded 374 questionnaires over two days.

The second phase of recruitment took place between May and December 2007. Large sixth form colleges in London and the Home Counties with a substantial South Asian student body were contacted in May 2007 and invited to participate. Letters were sent to head teachers in the first instance (Appendix H) and followed up by telephone calls. Visits to colleges took place between October and December 2007. A project table was set up in a communal area and passers-by were recruited in the same way as in the first recruitment phase (see above). This method of recruitment yielded a further 425 questionnaires. Around 7.5% (n=62) of the 799 completed questionnaires were not included in the analysis as they did not meet the criteria for inclusion in either the White British or the South Asian samples. Hence, the total number of questionnaires that met the inclusion criteria and were included in the analysis was 737. The prize draw was carried out with the use of an electronic random number generator. The three winners were subsequently contacted by telephone.

2.5. Ethics

Approval was obtained from UCL's Research Ethics Committee (Appendix I).

3.0. Results

Overview

The results section comprises six parts. The first section addresses data screening issues. The second section displays descriptive and correlational statistics. The third section presents the results of a reliability analysis. The fourth section presents the results of the CLAS-MR. The fifth section presents the results of the additional items addressing beliefs about curability. The sixth section presents the results of the additional items addressing beliefs about care responsibilities and stigma.

3.1. Data screening

The data were screened for normality and outliers prior to any analysis being carried out. There was significant skewness on the *Exclusion* and *Similarity* CLAS-MR subscales. Statistical transformations were not conducted as the data are in meaningful units on a standardised scale which enables comparison with previous (and future) studies (Norman & Streiner, 2000). Therefore, equivalent non-parametric tests were carried out to confirm the findings of the parametric tests. The approach to data analysis, unless otherwise indicated, was analysis of variance followed by post-hoc multiple comparisons in SPSS. Due to the increased risk of Type 1 errors associated with multiple testing, alpha levels have been adjusted by applying the Bonferroni correction to multiple comparisons for each analysis. The domains (subsets of tests) are considered individually.

3.2. Descriptive and correlational statistics

Table 1 shows descriptive statistics for the White British and South Asian samples. Although there were considerably more females (n=465) than males (n=272), the average age of males (16.7 years old) and females (16.8 years old) did not differ [t (733) = -.16, p = .111]. Over three quarters of the South Asian sample described themselves as Muslim (50%) or Hindu (28.4%). The White British sample described themselves as predominantly Christian (38.1%) or Atheists (55.1%).

The majority (71.1%) of the South Asian sample described themselves as second generation, compared to just 6.3% of the White British sample, of whom one or both parents had migrated to the UK from other western European countries. A further 0.2% of the White British sample described themselves as third generation, where one or both grandparents had migrated to the UK from other western European countries. A further 2.9% of the White British sample described themselves as first generation; although these participants were born outside the UK (Western Europe or the USA), they had spent the majority of their life in the UK and were deemed appropriate for inclusion.

Table 1: Characteristics of the participants and the extent of their prior contact with people with intellectual disabilities

		South Asian		White British	
		Female % (n)	Male % (n)	Female % (n)	Male % (n)
Religion	Muslim	**51.8** (116)	**46.6** (61)	**0.0** (0)	**0.0** (0)
	Hindu	**29.0** (65)	**27.5** (36)	**0.0** (0)	**0.0** (0)
	Sikh	**4.9** (11)	**8.3** (11)	**0.0** (0)	**0.0** (0)
	Christian	**6.7** (15)	**6.1** (8)	**43.2** (104)	**29.1** (41)
	Other religion	**1.8** (4)	**2.3** (3)	**4.2** (10)	**2.8** (4)
	Atheist	**4.9** (11)	**6.1** (8)	**48.9** (118)	**66.0** (93)
	Agnostic	**0.0** (0)	**0.0** (0)	**1.2** (3)	**1.4** (2)
	Not specified	**0.9** (2)	**3.1** (4)	**2.5** (6)	**0.7** (1)
Importance of religious beliefs	Not at all	**9.0** (20)	**11.4** (15)	**61.3** (149)	**76.4** (107)
	Somewhat	**71.2** (158)	**68.2** (90)	**29.6** (72)	**20.0** (28)
	Very	**18.9** (42)	**17.4** (23)	**6.6** (16)	**2.9** (4)
	Not specified	**0.9** (2)	**3.0** (4)	**2.5** (6)	**0.7** (1)
Generation	First	**18.8** (42)	**14.5** (19)	**2.5** (6)	**3.6** (5)
	Second	**71.9**(161)	**72.5** (95)	**5.8** (14)	**6.4** (9)
	Third	**8.0** (18)	**11.5** (15)	**0.4** (1)	**0.0** (0)
	Not applicable	**0.0** (0)	**0.0** (0)	**91.3** (220)	**90.0** (127)
	Not specified	**1.3** (3)	**1.5** (2)	**0.0** (0)	**0.0** (0)
Country of origin	UK	**81.7** (183)	**86.2** (113)	**98.0** (233)	**96.5** (135)
	India	**2.7** (6)	**1.5** (2)	**0.0** (0)	**0.0** (0)
	Sri Lanka	**4.9** (11)	**3.0** (4)	**0.0** (0)	**0.0** (0)
	Bangladesh	**3.2** (7)	**2.4** (3)	**0.0** (0)	**0.0** (0)
	Pakistan	**2.2** (5)	**3.0** (4)	**0.0** (0)	**0.0** (0)
	Western Europe	**2.7** (6)	**0.8** (1)	**1.2** (3)	**1.4** (2)
	Africa	**2.2** (5)	**1.5** (2)	**0.4** (1)	**0.7** (1)
	Other South Asia	**0.4** (1)	**0.8** (1)	**0.0** (0)	**0.0** (0)
	Australasia/USA	**0.0** (0)	**0.8** (1)	**0.4** (1)	**1.4** (2)
Prior contact	Yes	**53.1** (119)	**48.9** (64)	**80.1**(193)	**71.6** (101)
	No	**46.0** (103)	**51.1** (67)	**19.5** (47)	**27.7** (39)
	Not specified	**0.9** (2)	**0.0** (0)	**0.4** (1)	**0.7** (1)
Type of contact	Relative	**36.4** (44)	**21.9** (14)	**25.8** (50)	**15.7** (16)
	Friend	**48.8** (59)	**65.6** (42)	**49.5** (96)	**60.8** (62)
	Acquaintance	**13.2** (16)	**12.5** (8)	**24.2**(47)	**21.6** (22)
	Not specified	**1.6** (2)	**0.0** (0)	**0.5 (1)**	**1.9** (2)

Table 2 contains the correlations between each of the subscales. The four subscales were correlated significantly and in the same directions as reported in previous studies (Henry et al., 1996b; Horner-Johnson et al., 2002; Henry et al., 2004).

Table 2: Correlations between each of the four CLAS-MR subscales

	Correlations			
	Empowerment	Exclusion	Sheltering	Similarity
Empowerment	1	-.51(*)	-.24(*)	.61(*)
Exclusion	-.51(*)	1	.24(*)	-.65(*)
Sheltering	-.24(*)	.24(*)	1	-.31(*)
Similarity	.61(*)	-.65(*)	-.31(*)	1

* Pearson's correlation is significant at the 1% significance level (1-tailed).

3.3. Inter-item reliability

Reliability analyses were conducted on each of the four subscales comprising the CLAS-MR. The four subscales yielded Cronbach's alpha scores ranging from .64 (acceptable fit) to .83 (close fit). Corrected item-total correlation coefficients indicate the strength of the relationship between each item and its respective subscale. Corrected item-total correlation coefficients were obtained, with values of ≥0.20 considered acceptable.

3.4. Ethnicity, gender and prior contact

A multivariate analysis of variance (MANOVA) was conducted to determine the relationship of the CLAS-MR subscales to ethnicity (i.e., British South Asian vs. White British) and to two other variables which have been shown to influence adolescents' attitudes toward people with ID, gender and prior contact (Krajewski & Flaherty, 2000; Krajewski, Hyde & O'Keeffe, 2002; Siperstein et al., 2007). MANOVA has been used in previous studies using the CLAS-MR (e.g., Henry et al., 1996; Horner-Johnson et al., 2002) to determine the relationship of one or more independent variables on the combined four subscales. Hence, it was thought that conducting MANOVA was would be appropriate in the current study (logistic regression would have also been possible). Significant skewness on the *Exclusion* and *Similarity* CLAS-MR subscales, however, meant that the normality assumption of parametric tests was not met. Nonetheless, parametric tests are reasonably robust to violations of the normality assumption. Therefore, it was decided that conducting MANOVA was appropriate.

Ethnicity had a significant effect on the combined CLAS-MR subscales [F (4, 723) = 2.65, p<.05]. There were significant differences on two subscales, the *Exclusion* and *Similarity* subscales. White British adolescents demonstrated higher pro-inclusion attitudes than South Asian adolescents, scoring lower on *Exclusion* and higher on *Similarity* (Table 3). Gender had a significant effect on the combined CLAS-MR subscales [F (4, 723) = 5.073, p<.001]. There were significant differences on three subscales, *Empowerment, Exclusion* and *Similarity.* Females demonstrated higher pro-inclusion attitudes than males, scoring higher on *Empowerment* and *Similarity* and lower on *Exclusion* (Table 3). Prior contact with someone with ID had a significant effect on the combined CLAS-MR subscales [F (4, 723) = 7.403, p<.01]. There were significant differences on all four of the CLAS-MR subscales. Respondents who knew someone with an ID demonstrated greater pro-inclusion attitudes than respondents who did not, scoring higher on *Empowerment* and *Similarity* and lower on *Exclusion* and *Sheltering* (Table 3). There was also a significant interaction of gender and prior contact, which is displayed in Figure 1 [F (4, 723) = 2.77, p<.05]. This suggests that the impact of prior contact on empowerment is greater for males than it is for females. A MANOVA was used to determine the relationship of "type of relationship" to the CLAS-MR subscales. This was found to be non-significant [F (8, 944) = 1.130, p = .340].

Figure 1: Interaction between gender and prior contact

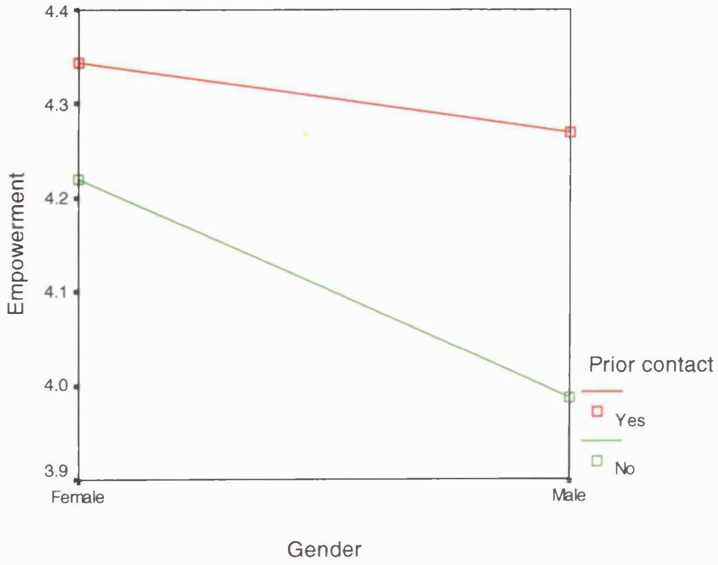

Table 3: CLAS-MR scores by ethnicity, gender and prior contact

	Empowerment *M (SD)*	d	Exclusion *M (SD)*	d	Sheltering *M (SD)*	d	Similarity *M (SD)*	d
South Asian (n=355)	4.20 (.55)	-	1.98 (.89)*	.32 (S)	3.27 (.72)	-	4.85 (.75)	-
White British (n=382)	4.31 (.62)	-	1.72 (.75)	-	3.10 (.70)	-	5.08 (.64)**	.33 (S)
Female (n=465)	4.32 (.54) **	.27 (S)	1.73 (.76)	-	3.18 (.72)	-	5.04 (.67)**	.27 (S)
Male (n=272)	4.16 (.66)	-	2.03 (.92)**	.35 (S-M)	3.18 (.72)	-	4.85 (.74)	-
Prior contact (n=477)	4.33 (.59) **	.36 (S-M)	1.72 (.75)	-	3.13 (.68)	-	5.06 (.67) **	.37 (S-M)
No prior contact (n=256)	4.12 (.58)	-	2.08 (.94) **	.42 (S-M)	3.27 (.77) **	.20 (S)	4.80 (.73)	-
Relative (n=124)	4.40 (.52)	-	1.69 (.75)	-	3.16 (.70)	-	5.07 (.66)	-
Friend (n=259)	4.33 (.60)	-	1.74 (.75)	-	3.09 (.70)	-	5.06 (.67)	-
Acquaintance (n=93)	4.23 (.63)	-	1.71 (.74)	-	3.19 (.62)	-	5.04 (.71)	-

* Significantly higher at p<.05 (Bonferroni corrected)
** Significantly higher at p<.01 (Bonferroni corrected)
S = Small effect
M = Medium effect

A MANOVA was used to determine the relationship of ethnicity, gender and prior contact with someone with ID to the three additional items (items 41-41) regarding beliefs about curability. Ethnicity had a significant effect on the combined curability items [F (3, 723) = 38.97, p <.001]. South Asian adolescents agreed significantly more with all three curability statements than White British adolescents (Table 4). Gender also had a significant effect on the combined curability items [F (3, 723) = 5.12, p <.01]. Males agreed with items 42 and 43 significantly more than females (Table 6). Prior contact had no significant effect on the combined curability items [F (3, 723) = .542, p = .654]. A MANOVA was used to determine the relationship of "type of relationship" to the curability items. This was non-significant [F (6, 944) = 1.67, p = .127]. There were no significant interaction effects between ethnicity, gender and prior contact.

A univariate ANOVA was conducted to determine the combined relationship of ethnicity, gender and prior contact with someone with ID to item 44 (Table 5). Ethnicity had a significant effect [F (1, 725) = 23.73, p <.001]. South Asian adolescents agreed significantly more with this statement than White British adolescents. Neither gender [F (1, 725) = 1.01, p =317] nor prior contact [F (1, 725) = .176, p = .625] had a significant effect. A univariate ANOVA was conducted to determine whether relatives, acquaintances and friends differed in terms of item 44. However, this was non-significant [F (2, 473) = .960, p = .384].

Table 4: Curability items by ethnicity, gender and prior contact

	Item 41†		Item 42††		Item 43†††	
	M (SD)	*d*	*M (SD)*	*d*	*M (SD)*	*d*
South Asian (n=355)	3.48 (1.47)**	.71 (M-L)	3.32 (1.55)**	0.84 (L)	2.98 (1.35)**	0.47 (S-M)
White British (n=382)	2.82 (1.15)	-	2.14 (1.25)	-	2.37 (1.23)	-
Female (n=465)	3.12 (1.38)	-	2.57 (1.49)	-	2.52 (1.32)	-
Male (n=272)	3.16 (1.30)	-	2.95 (1.54)**	.26 (S)	2.91 (1.30)**	0.30 (S)
Prior contact (n=477)	3.06 (1.32)	-	2.55 (1.46)	-	2.61 (1.30)	-
No prior contact (n=256)	3.27 (1.40)	-	3.02 (1.58)	-	2.78 (1.36)	-
Relative (n=124)	2.99 (1.27)	-	2.50 (1.40)	-	2.51 (1.28)	-
Friend (n=259)	3.19 (1.37)	-	2.59 (1.50)	-	2.71 (1.36)	-
Acquaintance (n=93)	2.78 (1.32)	-	2.49 (1.46)	-	2.45 (1.17)	-

† People who have learning disabilities can be cured through a medical intervention

†† People who have learning disabilities can overcome these through religion

††† People who have learning disabilities can overcome these through marriage

* Significantly higher at .05 significance level (Bonferroni corrected)

** Significantly higher at .01 significance level (Bonferroni corrected)

S = Small effect

M = Medium effect

L = Large effect

A univariate ANOVA was used to determine the relationship of ethnicity, gender and prior contact to item 45 (Table 5). Ethnicity had a significant effect [F (1, 725) = 22.80, p <.001]. South Asian adolescents agreed significantly more with this statement than White British adolescents. Gender also had a significant effect [F (1, 725) = 7.97, p <.01]. Males agreed significantly more with this statement than females. Prior contact did not have a significant effect [F (1, 725) = 1.68, p = .195]. A univariate ANOVA was used to determine the relationship of "type of relationship" to item 45. This was non-significant [F (2, 473) = 2.46, p = .086].

A univariate ANOVA was used to determine the relationship of ethnicity, gender and prior contact to item 46 (Table 5). Ethnicity was found to have a significant effect [F (1, 725) = 5.96, p <.05]. South Asian adolescents agreed significantly more with this statement than White British adolescents. Gender was also found to have a significant effect [F (1, 725) = 22.16, p <.001]. Males agreed with this statement significantly more than females. Prior contact did not have a significant effect [F (1, 725) = 2.17, p = .141]. A univariate ANOVA was used to determine the relationship of "type of relationship" to item 46. This was also non-significant [F (2, 473) = 1.13, p = 323].

Table 5: Items 44-46 by ethnicity, gender and prior contact

	Item 44†		Item 45††		Item 46†††	
	M (SD)	*d*	*M (SD)*	*d*	*M (SD)*	*d*
South Asian (n = 355)	3.91 (1.45)**	.40 (S-M)	1.83 (1.39)**	.42 (S-M)	2.11 (1.45)*	.38 (S-M)
White British (n = 382)	3.35 (1.37)	-	1.35 (.80)	-	1.77 (1.19)	-
Female (n = 465)	3.55 (1.42)	-	1.47 (1.07)	-	1.73 (1.21)	-
Male (n = 272)	3.73 (1.46)	-	1.78 (1.25)**	.27 (S)	2.28 (1.46)**	.41 (S-M)
Prior contact (n = 477)	3.57 (1.45)	-	1.48 (1.08)	-	1.84 (1.25)	-
No prior contact (n = 256)	3.71 (1.40)	-	1.76 (1.25)	-	2.11 (1.47)	-
Relative (n=124)	3.44 (1.42)	-	1.40 (1.06)	-	1.84 (1.31)	-
Friend (n=259)	3.65 (1.47)	-	1.58 (1.16)	-	1.90 (1.26)	-
Acquaintance (n=93)	3.52 (1.48)	-	1.33 (0.85)	-	1.68 (1.11)	-

† Parents should bear the main responsibility for children with learning disabilities
†† Families should hide their relatives with learning disabilities rather than make it obvious through using services
††† Having a person who has learning disabilities in a family may damage the marriage prospects of siblings
* Significantly higher at .05 significance level (Bonferroni corrected) than another religious denomination
S = Small effect
M = Medium effect
L = Large effect

3.5. Religion and importance of religious beliefs

A MANOVA was used to determine the relationship of religion to the subscales of the CLAS-MR. This was found to be significant [F (24, 2868) = 2.3, $p<.001$]. On all four subscales, Muslims demonstrated less pro-inclusion attitudes than one or more other religious denominations: on *Empowerment*, Christians and Atheists scored significantly higher than Muslims; on *Exclusion*, Christians, Atheists and Hindus scored significantly lower than Muslims; on *Sheltering*, Muslims scored significantly higher than Atheists; and on *Similarity*, Hindus, Christians and Atheists scored significantly higher than Muslims (Table 6). A MANOVA was used to determine the relationship of importance of religious beliefs to the subscales of the CLAS-MR. This was found to be non-significant [F (8, 950) = .857, $p = .553$].

Table 6: CLAS-MR by religion

	Empowerment			Exclusion			Sheltering			Similarity		
	M (*SD*)	†	*d*	*M* (*SD*)	†	*d*	*M* (*SD*)	†	*d*	*M* (*SD*)	†	*d*
Muslim (M) n=177	4.11 (.58)	-	-	2.10 (.97)	H C A	.37 (S-M) .48 (S-M) .39 (S-M)	3.30 (.80)	A	.33 (S)	4.71 (.79)	-	-
Hindu (H) n=101	4.30 (.50)	-	-	1.78 (.73)	-	-	3.29 (.58)	-	-	5.03 (.69)	M	.43 (S-M)
Sikh (S) n=22	4.18 (.60	-	-	2.12 (.85)	-	-	3.18 (.65)	-	-	4.92 (.60)	-	-
Christian (C) n=168	4.32 (.56)	M	.37 (S-M)	1.69 (.72)	-	-	3.15 (.71)	-	-	5.07 (.64)	M	.50 (M)
Other religion (O) n=21	4.34 (.57)	-	-	1.84 (.93)	-	-	3.26 (.58)	-	-	5.12 (.62)	-	-
Atheist (A) n=230	4.32 (.66)	M	.34 (S)	1.75 (.79)	-	-	3.05 (.71)	-	-	5.08 (.64)	M	.51 (M)
Agnostic (Ag) n=5	4.36 (.60)	-	-	1.93 (.45)	-	-	3.43 (.74)	-	-	4.78 (.82)	-	-

† Significantly higher than another religious denomination at 5% significance level (Bonferroni corrected)
S = Small effect
M = Medium effect

A MANOVA was used to determine the relationship of religion to the curability items. This was found to be significant [F (18, 2151) = 9.01, p <.001]. Significant effects were found on all three items. Post-hoc multiple comparisons (with Bonferroni adjustment) were carried out to determine the nature of these effects (Table 7).

Muslims and Hindus agreed with this item 41 significantly more than Christians and Atheists. Muslims and Hindus agreed with item 42 significantly more than Christians and Atheists. Sikhs also agreed with this statement significantly more than Atheists. Muslims and Hindus agreed with item 43 significantly more than Christians and Atheists (Table 7).

A MANOVA was used to determine the relationship of importance of religious beliefs to the curability items. Only respondents who had described themselves as belonging to a religious category were included in this analysis. A significant effect was found on item 42 [F (2, 2.5) = 15.84, p<.01]. Post-hoc t-tests showed that respondents who rate themselves as "somewhat" or "very" religious agree significantly more than those respondents who rate themselves as "not at all" religious (Table 8).

Table 7: Curability items by religion

	Item 41†			Item 42††			Item 43†††		
	M (SD)	*	*d*	*M (SD)*	*	*d*	*M (SD)*	*	*d*
Muslim (M) n=177	3.53 (1.51)	C A	0.55 (M) 0.46 (S-M)	3.50 (1.61)	C A	0.7 (M-L) 1.04 (L)	3.01 (1.29)	C A	0.45 (S-M) 0.50 (M)
Hindu (H) n=101	3.67 (1.46)	C A	.67 (M-L) .51 (M)	3.21 (1.36)	C A	.56 (M) .93 (L)	2.99 (1.40)	C A	.41 (S-M) .47 (S-M)
Sikh (S) n=22	2.86 (1.42)	-	-	3.41 (1.62)	A	.98 (L)	3.18 (1.56)	-	-
Christian (C) n=168	2.80 (1.11)	-	-	2.48 (1.26)	-	-	2.45 (1.22)	-	-
Other religion (O) n=21	2.76 (1.00)	-	-	2.75 (1.37)	-	-	2.43 (1.21)	-	-
Atheist (A) n=230	2.90 (1.24)	-	-	1.98 (1.29)	-	-	2.36 (1.29)	-	-
Agnostic (Ag) n=5	2.80 (1.10)	-	-	2.80 (1.30)	-	-	3.40 (1.34)	-	-

† People who have learning disabilities can be cured through a medical intervention
†† People who have learning disabilities can overcome these through religion
††† People who have learning disabilities can overcome these through marriage
* Significantly higher at .05 significance level (Bonferroni corrected) than another religious denomination
S = Small effect
M = Medium effect
L = Large effect

Table 8: Curability items by importance of religious beliefs

		Item 41†	*	*d*	Item 42††	*	*d*	Item 43†††	*	*d*
	n =	*M (SD)*	-	-	*M (SD)*	-	-	*M (SD)*	-	-
Not at all religious (N)	60	3.05 (1.33)	-	-	2.12 (1.22)	-	-	2.42 (1.33)	-	-
Somewhat religious (S)	337	3.29 (1.37)	-	-	3.11 (1.48)	N	0.73 (M-L)	2.84 (1.31)	-	-
Very religious (V)	83	3.22 (1.55)	-	-	3.47 (1.54)	N	0.97 (L)	2.80 (1.32)	-	-

† People who have learning disabilities can be cured through a medical intervention
†† People who have learning disabilities can overcome these through religion
††† People who have learning disabilities can overcome these through marriage
* Significantly higher at .05 significance level (Bonferroni corrected) than another religious denomination
S = Small effect
M = Medium effect
L = Large effect

A univariate ANOVA was conducted to determine the relationship of religion to item 44. Religion had a significant effect [F (6, 717) = 3.29, p <.01]. Post-hoc t-tests were carried out to determine the nature of these effects, with Bonferroni adjustment. Muslims and Hindus agreed significantly more with item 44 than Christians (Table 10). A univariate ANOVA was used to determine the relationship of importance of religious beliefs to item 44 (Table 11). Only respondents who had described themselves as belonging to a religious category were included in this analysis. However, this was non-significant [F (2, 477) = 1.14, p=.321].

A univariate ANOVA was used to determine the relationship of religion to item 45. Religion had a significant effect [F (6, 717) = 7.99, p <.001]. Muslims agreed significantly more with this statement than Christians or Atheists (Table 10). A univariate ANOVA was used to determine the relationship of importance of religious beliefs to item 45 (Table 11). Only respondents who had described themselves as belonging to a religious category were included in this analysis. However, this was non-significant [F (2, 477) = 2.4, p = .09].

A univariate ANOVA was used to determine the relationship of religion to item 46. Religion had a significant effect [F (6, 717) = 2.22, p <.05]. Muslims agreed significantly more with this statement than Christians (Table 10). A univariate ANOVA was used to determine the relationship between importance of religious beliefs to this statement (Table 11). Only respondents who had described themselves as belonging to a religious category were included in this analysis. However, whilst this was found to be significant [F (2, 477) = 3.39, p = .035], multiple comparisons were found to be non-significant after applying the Bonferroni adjustment.

Table 9: Items 44-46 by religion

	Item 44†			Item 45††			Item 46†††		
	M (SD)	*	*d*	*M (SD)*	*	*d*	*M (SD)*	*	*d*
Muslim (M) n = 177	3.84 (1.46)	C	.33 (S)	2.00 (1.51)	C A	.62 (M) .46 (S-M)	2.17 (1.38)	C	.38 (S-M)
Hindu (H) n=101	3.92 (1.46)	C	.39 (S-M)	1.59 (1.17)	-	-	1.96 (1.48)	-	-
Sikh (S) n=22	3.77 (1.51)	-	-	2.00 (1.48)	-	-	1.95 (1.43)	-	-
Christian (C) n=21	3.34 (1.53)	-	-	1.27 (.69)	-	-	1.70 (1.10)	-	-
Other religion (O) n=7	3.70 (1.49)	-	-	1.62 (1.16)	-	-	1.95 (1.50)	-	-
Atheist (A) n=19	3.42 (1.27)	-	-	1.42 (.91)	-	-	1.84 (1.30)	-	-
Agnostic (Ag) n=0	3.60 (1.14)	-	-	1.20 (.45)	-	-	2.60 (1.14)	-	-

† Parents should bear the main responsibility for children with learning disabilities

†† Families should hide their relatives with learning disabilities rather than make it obvious through using services

††† Having a person who has learning disabilities in a family may damage the marriage prospects of siblings

* Significantly higher at .05 significance level (Bonferroni corrected) than another religious denomination

S = Small effect

M = Medium effect

Table 10: Items 44-46 by importance of religious beliefs

	Item 44†	Item 45††	Item 46†††
	M (SD)	*M (SD)*	*M (SD)*
Not at all religious (n = 60)	3.05 (1.33)	2.12 (1.22)	2.42 (1.33)
Somewhat religious (n = 337)	3.29 (1.37)	3.11 (1.48)	2.84 (1.31)
Very religious (n = 83)	3.22 (1.55)	3.47 (1.54)	2.80 (1.32)

† Parents should bear the main responsibility for children with learning disabilities

†† Families should hide their relatives with learning disabilities rather than make it obvious through using services

††† Having a person who has learning disabilities in a family may damage the marriage prospects of siblings

3.6. Generations

A MANOVA was used on the data from South Asian respondents to determine the relationship of generation to the CLAS-MR subscales (Table 12). This was found to be significant [F (8, 690), = 2.21, p <.05]. However, a significant difference was found on only one of the subscales, *Empowerment* [F (2, 347) = 3.32, p <.05]. On *Empowerment*, third generation respondents scored significantly lower than second generation respondents. However, this should be interpreted with caution as the second and third generation groups have unequal group sizes; the number of participants who described themselves as second generation (n=256) was over seven times as many as those who described themselves as third generation (n=33).

A MANOVA was used on the data from South Asian respondents to determine the relationship of generation to the curability items (items 41-46). This was found to be non-significant [F (6, 692) = 1.12, p = .351]. A univariate ANOVA was used on the data from South Asian respondents to determine the relationship of generation to item 44. This was non-significant [F (2, 347) = 1.21, p = .300]. Univariate ANOVAs were conducted to determine the relationship of generation to item 45 [F (2, 347) = .494, p = .611] and to item 46 [F (2, 347) = 1.12, p = .327]. These were found to be non-significant.

Table 11: CLAS-MR means and standard deviations by generation (South Asian sample only)

	Empowerment		Exclusion		Sheltering		Similarity	
	M (SD)	*d*	*M (SD)*	*d*	*M (SD)*	*d*	*M (SD)*	*d*
First generation (n=61)	4.23 (.49)	-	2.09 (.90)	-	3.46 (.81)	-	4.85 (.69)	-
Second generation (n=256)	4.22 (.56)	-	1.92 (.87)	-	3.25 (.69)	-	4.87 (.76)	-
Third generation (n=33)	3.96 (.58) †	.46 (S-M)	2.22 (1.02)	-	3.11 (.70)	-	4.65 (.73)	-

† Significantly higher than second generation at the 5% significance level (Bonferroni corrected)
S = Small effect
M = Medium effect

4.0. Discussion

Overview

The discussion section comprises three parts. The first section addresses the research hypotheses with reference to the results. The second section discusses the strengths and limitations of the study. The final section discusses the implications of this study for education, policies and services, and for further research.

Summary of the findings

This study found that White British adolescents demonstrated higher pro-inclusion attitudes than South Asian adolescents. South Asian participants were more likely to hold the belief that parents should bear the main care responsibilities for children with ID and agreed more strongly with the notion of 'curability'. South Asian adolescents agreed more strongly with statements suggesting that families should hide their relatives with ID rather than draw attention through using services; and that the marital prospects of siblings are adversely affected through having a sibling with ID. Compared to gender and prior contact, ethnicity was less predictive of pro-inclusion attitudes and more predictive of beliefs about curability, care responsibilities and stigma. On the CLAS-MR, Muslim adolescents demonstrated less pro-inclusion attitudes than Atheists, Christians and Hindus. Participants describing themselves as first, second and third generation did not differ on the CLAS-MR or on the additional items.

4.1. Research hypotheses

Hypothesis 1: British South Asian adolescents will differ from White British adolescents in terms of pro-inclusion attitudes and beliefs about curability, care responsibilities and stigma.

The hypothesis, that the South Asian general population sample would demonstrate attitudes favouring inclusion less than the White British sample, was supported by the data. White British adolescents demonstrated higher pro-inclusion attitudes than South Asian adolescents, scoring lower on the *Exclusion* subscale and higher on the *Similarity* subscales of the CLAS-MR. South Asian participants were also more likely to hold the belief that parents should bear the main care responsibilities for children with ID. These findings are consistent with the idea that normalisation policies "run counter to the values of collectivism and close family relationships that exist in some communities" (Mir et al., 2001, p.3). Alternatively, given that the two subscales which showed differences between the two groups tap into beliefs beyond a straightforward 'individualism versus collectivism' dichotomy, there may be other explanations for the results. The finding that South Asian participants were more likely to advocate the exclusion of people with ID from activities and society and to view them as less similar to non-disabled people suggests perhaps higher levels of suspicion and stigma associated with people with ID.

South Asian respondents more strongly agreed with the notion of 'curability' compared to White British respondents. That is, they were more likely to believe that ID can be overcome through medical interventions, religion or marriage. These findings are in line with previous research (Fatimilehin & Nadirshaw, 1994; Mir et al., 2001). Interestingly, Coles (2008), in exploring notions of 'curability' in a qualitative study, found different understandings of the notion of curability among South Asian adolescents. Several participants in her study felt that their community's use of the term "cure" related to alleviation of the family's care responsibilities (as opposed to the meaning of "cure" in a western medical sense). One participant is reported to have said that the notion of 'cure' (with regard to marriage) could simply mean that life became easier for the family as the new marital partner was now responsibility for the person with ID. This suggests that ideas of 'curability' amongst South Asians may have been over-simplified in previous research (e.g., Fatimilehin & Nadirshaw, 1994).

In the current study, South Asian adolescents agreed more strongly with statements suggesting that families should hide their relatives with ID rather than draw attention through using services; and that the marital prospects of siblings are adversely affected through having a sibling with ID. These findings lend support to the suggestion of stigmatised attitudes towards people with ID and their families in the general South Asian population and are consistent with concerns expressed by families with a member with ID (Fatimilehin and Nadirshaw, 1994; Hatton et al., 2003; Katbamna et al., 2000).

The low uptake of services for people with ID by the British South Asian community has been partly attributed to beliefs about curability and fatalism amongst families with a family member with ID (see Mir et al. 2001). However, the current study suggests that the low uptake could be influenced by attitudes in the wider South Asian community; namely a realistic fear amongst families with a member with ID that they may be viewed negatively by their own community. The implications of these findings for services and policies will be addressed later.

Hypothesis 2: Ethnicity will be as predictive as other variables which have been shown to influence pro-inclusion attitudes among adolescents, e.g., gender and knowing someone with ID (Krajewski & Flaherty, 2000; Krajewski, Hyde & O'Keeffe, 2002; Siperstein et al., 2007).

In previous research, gender and prior contact have been shown to influence pro-inclusion attitudes among adolescents, with females and people who know someone with ID demonstrating the most positive attitudes (Krajewski & Flaherty, 2000; Krajewski, Hyde & O'Keeffe, 2002; Siperstein, et al. 2007). In the current study, ethnicity had a significant effect on two of the CLAS-MR subscales. However, ethnicity was not as predictive of CLAS-MR scores as gender on three of the CLAS-MR subscales, where females demonstrated more pro-inclusion attitudes towards people with ID than males. Neither was ethnicity as predictive of CLAS-MR scores as prior contact, where significant differences were found on all four subscales, with those who knew someone with an ID demonstrating more pro-inclusion attitudes than those who did not. There was also an interaction of gender with prior contact, suggesting that the impact of prior contact on pro-inclusion attitudes is greater for males than it is for females. This finding is consistent with a study, which compared the attitudes of adolescents' attitudes in 1987 with attitudes in 1998 (Krajewski, Hyde & O'Keefe, 2002) and found that females demonstrated significantly higher attitudes than males in 1987; however, by 1998, this difference was no longer significant. The authors attributed this to an increase in positive attitudes among the male respondents and hypothesised that this was due to ongoing contact with fellow students with ID through an inclusion program.

In the current study, males also more strongly agreed with the beliefs that ID can be overcome through religion or marriage, families should hide their relatives with ID rather than draw attention to the ID through using services, and having a family member with ID may damage siblings' marriage prospects, compared to female respondents.

Whilst ethnicity was not as predictive of CLAS-MR scores compared to gender or prior contact, it was more predictive than gender or prior contact in terms of responses to items 41 to 43 (the 'curability' items), with South Asian adolescents agreeing more with all three statements than their White British peers. In addition, ethnicity was more predictive of responses to items 44-46 (regarding care responsibilities and stigma) than either gender or prior contact, with South Asians agreeing more with each statement than White British adolescents.

In summary, these findings suggest that, compared to gender and prior contact, ethnicity is less predictive of pro-inclusion attitudes but more predictive of beliefs about curability, care responsibilities and stigma. The implications of these findings for education are discussed later.

Hypothesis 3: Religion and importance of religious beliefs will influence pro-inclusion attitudes and beliefs about curability, care responsibilities and stigma..

On the CLAS-MR, Muslim adolescents demonstrated less pro-inclusion attitudes than Atheists (on 4 subscales), Christians (on 3 subscales) and Hindus (on 2 subscales). There were no other differences between religious groups, nor was importance of religious beliefs found to influence CLAS-MR scores. Moreover, Muslims, Hindus and Sikhs did not differ from each other on the curability statements (items 41-43) or on the additional statements about care responsibilities and stigma (items 44-46).

This pattern of results is interesting as it reveals heterogeneity within the South Asian sample. It has been acknowledged in the literature (e.g., Hubert, 2007), that there is a tendency to group together different ethnic cultural groups from South Asia (e.g., Mir et al. 2001). This labelling suggests homogeneity when there are marked cultural and historical differences between the different sub-groups of South Asians. The above findings suggest the conclusions drawn from the current study should not be generalised to all South Asians and that future research should differentiate between different ethnic and religious groups subsumed under the label “South Asian”.

Hypothesises 4: British South Asian adolescents of different generations will differ in terms of pro-inclusion attitudes and beliefs about curability, care responsibilities, and stigma.

If generation played a role in determining attitudes towards ID, it would be expected that third generation migrants to the UK would differ from more recent first generation migrants. However, these two groups did not differ from each other on any of the four CLAS-MR subscales. Therefore, it would seem that this variable does not appear to influence pro-inclusion attitudes. It is equally possible that this lack of a difference is due to the study's focus on a narrow age range. Azmi et al. (1997) noted that the extent to which adolescents "...maintain traditional practices such as arranged marriages, gender roles, family obligations and religious observance varies widely, and young people may subscribe to some aspects of traditional ethnic identity... while not subscribing to others..." (p.251).

A concurrent study (Kenyon, 2008) investigated attitudes toward people with ID among adult Hindu participants, who were predominantly first generation immigrants (70% were first generation, 25% were second generation and 5% were third generation). By contrast, in the current study, South Asians were mainly second generation (16.8% were first generation, 76.2% were second generation and 6.9% were third generation). Interestingly, the adult Hindus demonstrated less positive attitudes than Hindu adolescents reflected in lower scores on the *Empowerment* and *Similarity* subscales and higher scores on the *Exclusion* and *Sheltering* subscales of the CLAS-MR (Kenyon, 2008). Therefore, amongst Hindus, age would appear predictive of attitudes. However, it is unclear whether such differences are simply due to age, or the impact of migration and acculturation. This is an area for further research.

4.2. Strengths and limitations of the current study

This study investigated attitudes towards people with ID in the British South Asian general population, a topic which had not previously been investigated. The questionnaire was administered face-to-face, which enabled respondents to clarify their understanding of key concepts used in the questionnaire (such as "learning disability"), suggesting good construct validity. Moreover, the study achieved a large sample of both British South Asian and White British participants. As well as facilitating the comparison of attitudes between South Asian and White British groups, the diverse sample also facilitated the comparison of attitudes of different ethnic and religious sub-groups of British South Asians (Muslims, Hindus, and Sikhs). Lastly, the use of a well validated measure, the CLAS-MR, allows the results to be used by future researchers wishing to compare British South Asian adolescents' attitudes to other groups.

However, it is acknowledged that there are limitations in this study. The high proportion of participants who said that they had a friend with ID (35.1%), suggests a possible degree of self-selection. Some of the participants may have been willing to do so because they knew someone with ID. However, this was countered to some extent by the recruitment procedure; most participants were recruited through colleges where whole classes of students were encouraged by staff to participate and were offered entry in a prize draw as an incentive. In addition, the generalisability of the findings may be limited by the sources from which the participants were recruited. Young people aiming at higher education and training may not be representative of the wider population. Had the current study investigated attitudes among British South Asians of a different demographic (age or generation) or recruited in a different context (e.g., through religious centres such as mosques), then different results may have been found. Such research would, however, have its own limitations in terms of generalisability.

Furthermore, conversations with participants who agreed to take part in the study revealed that at least some of them were unclear about the meaning of the term "learning disabilities". Several participants had been under the impression that the term was synonymous with 'specific learning difficulties' such as dyslexia. Indeed, there is widespread confusion over the term "learning disability" in the UK population (Mencap 2008). The design of the study attempted to reduce risk of confusion by providing each participant with a brief clarification of the term "learning disabilities" prior to questionnaire completion (Appendix F). At the time, an official leaflet was not available so it was deemed necessary to develop a brief explanation. There is now such a factsheet which would serve this purpose (British Psychological Society, 2008). In future, it would be much better to use or adapt this since the brief explanation provided unfortunately contained an error (it stated that Asperger's Syndrome is associated with ID). Therefore, it is a limitation of the current study that the responses of participants who received this explanation were influenced by a inaccurate definition.

People with ID are generally categorised into four levels according to the severity of the ID (e.g., British Psychological Society, 2001; World Health Organisation, 1992). A person with mild ID would therefore differ somewhat to people with moderate ID but would differ greatly to people with severe and profound ID, not least in terms of their capacities and support needs. It is therefore to be expected that people's attitudes towards people with ID (e.g., perception of similarity) will differ according to the severity of the ID. The CLAS-MR, however, makes no mention of the severity of the ID. Several respondents commented on this as being "frustrating". One of the participants commented that she would respond very differently to the statement, "I would trust a person with learning disabilities to baby sit" (item 16), depending on whether it referred to someone with mild ID or someone with severe ID. This suggests that the measure might well benefit from further refinement.

Moreover, whilst large effects were found for several statistically significant differences (on items 41-44), the statistically significant differences in the current study showed predominantly small to medium effect sizes (CLAS-MR and items 44 to 46). This suggests that these differences should be interpreted with caution.

Lastly, the current study does not allow for causal inference as to the impact of stigmatising attitudes among the South Asian general public on service uptake among South Asian families with a family member with ID. Nevertheless, the findings of this study validate concerns expressed by South Asian families with a family member with ID regarding attitudes towards ID within their communities (Fatimilehin & Nadirshaw, 1994; Hatton et al., 2003; Katbamna et al., 2000).

4.3. Implications of the Findings

Implications for policy and services

South Asian families report a considerable demand for formal service support (e.g., Chamba et al., 1999; Mir et al., 2001). However, this is at odds with the low uptake of specialist services for people with ID (e.g., Hatton et al., 1998, 2003) and low use of family support groups (e.g., Chamba et al., 1999) that is reported. The current study suggests high levels of stigmatised attitudes among the British South Asian general public towards families in which there is a family member with ID.

Importantly, more British South Asian respondents believed that "parents should bear the main responsibility for children with ID". While the cultural emphasis on family cohesion may have many positive effects, it may also increase reluctance by South Asian parents to seek help due to a sense of failure and shame. Efforts should be made to make services less stigmatising to access for members of British South Asian communities, to develop more culturally sensitive services and to tackle stigma towards people with ID in the wider South Asian community.

Implications for education

In the current study, British South Asian adolescents demonstrated less pro-inclusion attitudes and higher stigmatised beliefs about people with ID and their families compared to White British adolescents. Less pro-inclusion attitudes and more stigmatised beliefs were found among Muslims (compared to Hindus and Sikhs). These findings suggest a need for more education aimed at increasing awareness of ID and tackling negative beliefs. However, in order for this to be effective it would need to be culturally sensitive, focusing on Muslim adolescents in South Asian communities.

Implications for further research

The current study has identified several areas that could benefit from further research. Firstly, research is needed to explore the potential influence of different generations on attitudes towards people with ID. The finding that first, second and third generations did not differ from each other on any of the four CLAS-MR subscales was somewhat surprising, given potential differences in acculturation and migration histories. However, this could be due to the sample's narrow age range and overrepresentation of second generation respondents. In support of this idea, attitudes towards people with ID amongst predominantly second generation South Asians in the current study were far more pro-inclusive than predominantly first generation adult South Asians (Kenyon, 2008). Research is needed to explore whether such differences are simply due to age, or whether they can be attributed to the impact of migration and acculturation. Further research could also investigate intergenerational differences in attitudes towards people with ID amongst families in the South Asian general population.

Research is also needed in developing and measuring the impact of culturally sensitive interventions at increasing awareness of ID and tackling stigmatising beliefs. Within the South Asian sample, lower pro-inclusion attitudes and more stigmatised beliefs were present amongst Muslim adolescents (compared to Hindus and Sikhs), suggesting a need for culturally appropriate interventions for adolescents in the classroom. Further research could investigate the effectiveness of such interventions through systematic evaluation. In addition, research is needed to determine to what extent attitudes towards people with ID differ according to the severity of the ID. It would be useful to investigate whether specifying a specific level of ID (e.g., mild ID) influences peoples' responses on the CLAS-MR. Whilst this would require a refinement of the CLAS-MR, it would allow more specific conclusions to be drawn about attitudes towards people with ID.

More research into cultural differences in attitudes towards people with ID is needed, so that variations in service uptake among different ethnic and cultural groups can be better understood.

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PART III:

CRITICAL APPRAISAL

Overview

This critical review consists of five sections. The first section addresses the question of why the study of attitudes towards people with ID among the South Asian population in the UK was considered an important area of research. This is followed by a discussion of methodological issues. The third section discusses conceptual issues relevant to the current study. The fourth section is a personal reflection on the research process. The fifth section offers a summary and conclusions.

1.0. Background to this study

1.1. Cross-cultural attitudes towards intellectual disabilities

There is a dearth of research examining cultural differences in attitudes towards disability, particularly ID. It is suggested (Westbrook, Legge & Pennay, 1993) that this may be due to researchers' fears of being criticised as ethnocentric if they were to compare attitudes of an ethnic minority group with the dominant cultural group. Whilst such research has the potential to raise sensitive issues, attitudes are very relevant to the extent to which people with ID are accepted in society. If it is accepted that people with ID should have rights, choice, independence and social inclusion, as advocated by current policy (Department of Health, 2001), then this applies to people with ID from all cultural backgrounds. It is the job of researchers to identify whether attitudinal barriers exist to achieving these goals and whether such goals are realisable in all parts of society.

A recent meta-analysis (Glasman & Albarracin, 2006) found that 52% of behaviour can be predicted by attitudes alone. Other factors thought to influence behaviour include the meditating role of intentions on the attitude-behaviour link and the moderating influence of the type of topic or behaviour (Armitage & Conner, 2001). However, in relation to attitudes towards people with ID, research is unclear about the attitude-behaviour link and to what extent different conditions make attitudes more predictive of pro-inclusion behaviours. These are areas in need of further research.

2.0. Methodological issues

2.1. Generalisability of the findings

The attitudes of adolescents are arguably very relevant as they represent the next generation of adults whose understanding of ID will impact on the way that they interact with people with ID. However, attitudes of older British South Asians are likely to differ from those of younger British South Asians. The adolescent Hindus in the current study, for example, showed greater pro-inclusion attitudes than the adult Hindus in a concurrent study (Kenyon, 2008). The generalisability of the current study may also be limited by the sources of recruitment. That is, the responses of participants who are aiming at further training and higher education may not be representative of the wider population of their gender, age, ethnic background or religion. Had the current study investigated attitudes among British South Asians of a different demographic (e.g., generation) or recruited in a different context (e.g., through religious centres such as mosques), then different results may have been found (such research would, however, have its own limitations in terms of generalisability). A related area for further research would be the study of intergenerational differences in attitudes towards people with ID within British South Asian families in the general population.

2.2. Limitations of quantitative attitudinal research

As previously discussed, this study has a number of strengths, including, investigating a subject, which had not previously been investigated and achieving large samples of British South Asian and White British adolescents. In addition to facilitating the comparison of attitudes towards people with ID between South Asian and White British groups, the large samples also facilitated the comparison of attitudes between different ethnic and religious sub-groups of South Asians (Muslims, Hindus, and Sikhs). Moreover, the questionnaire was administered face-to-face, which enabled respondents to ask questions and to clarify their understanding of key concepts.

Questionnaires with good psychometric properties provide a useful way of eliciting attitudes. However, the small and inflexible number of items on the CLAS-MR meant that subtle and potentially useful information may have been overlooked. In particular, the CLAS-MR only focuses on ID so it does not reveal commonalities or differences in respondents' attitudes towards other disability groups. Also, the CLAS-MR does not differentiate between different levels of ID. It is therefore unclear whether respondents' attitudes relate to mild, moderate, or severe and profound ID. Moreover, a questionnaire based study does not allow the researcher to investigate unexpected findings in more detail. Qualitative methodologies (e.g., focus groups and interviews) could be used to explore these unexpected findings in more detail.

2.3. Brief definition of learning disabilities

Conversations with participants revealed that some of them were unclear about the meaning of the term "learning disabilities". Several participants had been under the impression that the term was synonymous with 'specific learning difficulties' such as dyslexia. Indeed, there is widespread confusion over the term "learning disability" in the UK population (Mencap 2008). The design of the study attempted to reduce risk of confusion by providing each participant with a brief clarification of the term "learning disabilities" prior to questionnaire completion (Appendix F). At the time, an official leaflet was not available so it was deemed necessary to develop a brief explanation. There is now a factsheet available which would serve this purpose (British Psychological Society, 2008). In future, it would be much better to use or adapt this factsheet since the brief explanation provided unfortunately contained an error (it stated that Asperger's Syndrome is associated with ID). It is a limitation of the current study that the responses of participants who received this explanation were influenced by a inaccurate definition.

2.4. Defining categories of generation

From early on in the recruitment, it became clear that many British South Asian participants were unclear about whether they were "first generation", "second generation" or "third generation". Where participants were unclear, a verbal explanation was given. However, it is acknowledged that it would have been clearer if Appendix A had included an explanation of what was meant by these terms.

3.0. Conceptual issues

3.1. The meaning of culture

'Culture' appears to be an important part of identity but the meaning of this concept depends on the individual to whom it applies. The meaning of 'culture' could equally relate to religion, nationality, country of birth, country of residence, or generation. Where 'culture' is closely related to religious affiliation, this may take priority over country of birth or residence. For example, Muslims originating from the Punjab region of India may perceive themselves to have more in common with Muslims from other continents than with Hindus and Sikhs from the same geographical region. Hence, 'culture' is a concept that is difficult to define in a way that is consistently meaningful for all members of a 'culture' all of the time. Defining cultural groups is also increasingly difficult as there is much ethnic, racial and religious diversity within each 'cultural' group; the category of 'American Indian', for example, comprises more than 500 tribes (US Bureau of the Census, 1992, cited in Hatton, 2002) and the UK category of 'Indian' contains substantial differences in language, religion and ethnicity (Modood et al., 1997). Therefore, whilst 'culture' has been defined as "the set of attitudes, values, beliefs and behaviours shared by a group of people" (Matsumoto, 1996), it is important to recognise that it is a socially constructed phenomenon, which varies over time and across individuals.

3.2. Cultural context and attitudes

Cultural context may also determine which aspects of identity are most influential on attitudes. For a British South Asian adolescent at school or college, their membership of youth culture in Britain might be a more salient part of their identity than their religion or country of origin. However, the religious and ethnic parts of their identity may become more salient aspects of their identity when they are in the presence of their family or during religious ceremonies.

The impact of cultural context on reported attitudes towards people with ID is an interesting area, which has received little attention. To this end, it would have been interesting in the current study to have included a short section at the end of the CLAS-MR, which asked participants to rate, in order of importance, which factors they felt most influenced their attitudes. In particular, it would have been useful to explore whether the observed influences on attitudes towards ID (ethnicity, gender, prior contact, religion, and importance of religious beliefs) were mirrored by their self-reported influences or whether other factors (e.g., youth culture) were seen by the participants as more important.

Further studies could explore the impact of context on attitudes further. This could take the form of a 2 x 2 within groups design: at the first time point, a certain aspect of the participants' identity is made salient (e.g., by completing a questionnaire about their membership of youth culture) before the CLAS-MR is administered; at the second time point, a different aspect of the participant's identity is made salient (e.g., by completing a questionnaire about their religious affiliation) before the CLAS-MR is administered. It is tentatively hypothesised that participants' responses would differ according to which aspects of their identity and culture are brought to the fore before completing the CLAS-MR.

3.3. The category of "South Asians"

As is acknowledged elsewhere (e.g., Hubert, 2006), the literature on ID and culture tends to group together different ethnic groups from South Asia (e.g., Mir et al. 2001). This labelling of people as 'South Asians' implies homogeneity. Certainly, in this study, there were areas of homogeneity. For example, Muslim, Hindu and Sikh respondents did not differ in relation to the curability statements (items 41-43) or the additional statements about care responsibilities and stigma (items 44-46). However, there were also areas of marked difference. For example, Muslim respondents demonstrated significantly less pro-inclusion attitudes on the CLAS-MR than did the Hindu or Sikh respondents.

Nevertheless, the grouping together of different ethnic groups under the label 'South Asians' masks the marked religious and historical differences between South Asian immigrants in the UK. Even within the Muslim subgroup there is clear heterogeneity in terms of countries of birth and migration histories. The vast majority of British South Asians are people who migrated to the UK in the 1950s, 60s, and 70s and their descendants (BBC, 2000). Most British South Asians fall into one of three broad population groups: those from the Punjab region of North-western India and Pakistan; those from Gujarat, north of Mumbai; and those from Sylhet, Bangladesh. The first wave of immigrants were mainly from farming areas and tended to immigrate because of poverty, violence and enforced relocation during the separation of British India. The next wave of immigrants of South Asian origin came from Africa, mostly from Kenya and then Uganda (many of whom migrated due to being no longer welcome in Africa under the new policy of Africanisation). The second wave of immigrants was generally better educated than the first wave; many were professionals or from skilled trades (National Archives, 2007).

Given this heterogeneity in terms of migration history, country of birth and education, it seems reasonable to expect that, if the Muslim sample were studied further, differences in cultural practices around ID may become apparent. Indeed, a wide range of perspectives on disability have been reported within religious groups (e.g., Begum, 1992).

4.0. Personal reflections on the research process

4.1. How I came to the research

Initially, I had planned to investigate the impact of stigma on the social identity of people with ID. However, I discovered that there had already been a lot of interesting research in this area (e.g., Beart, Hardy & Buchan, 2005; Craig et al., 2002; Jahoda & Markova, 2004). In contrast, recent general population research on attitudes towards ID in the UK appeared to be almost non-existent; I therefore chose to study attitudes, which are closely linked to stigma. Contemporary perspectives regard stigma as a threat to identity and "...emphasise the extent to which stigma's effects are mediated through targets' understanding of how others view them..." (Major & O'Brien, 2005, p.397). Attitudes are therefore indicative of how people with ID (and their families) experience stigma and how they define themselves (Crocker et al., 1998). On reflection, I believe that my study has contributed to this under- researched area and has resulted in a study which has clear implications for both education and policy.

4.2. Data collection

In formulating my hypotheses, I spoke to several trainee clinical psychologists and qualified clinical psychologists from South Asian backgrounds who were all very positive about the aims of the research. Interestingly, they were each able to form some tentative thoughts on how members of their respective communities might view people with ID, but felt that this was a subject which had received little attention.

I initially focused my efforts on educational establishments with a high proportion of South Asian students. The sixth form colleges that I contacted were generally positive about the study. The head teachers seemed keen to accommodate this study as it gave their students an opportunity to take part in real-world research and fitted with the educational inclusion of people with ID.

I was aware of the obvious cultural differences between myself as a White British man and the target participants. Contrary to my expectations, I found that, on the whole, South Asian adolescents were more willing to take part than their White British peers. The initial lack of White British data necessitated subsequent visits to sixth form colleges in areas where White British adolescents were over-represented (Cambridge and Essex). I feel that the good sample size and good recruitment uptake were partly due to skills developed as a trainee clinical psychologist in communicating to people who were different from myself in terms of culture, age and gender. I am nonetheless indebted to the South Asian adolescents and their willingness to engage in this research.

4.3. Stigma in the context of the South Asian Muslim community

Stigma occurs when an individual differs from prevailing social norms in a specific dimension and is negatively judged by others. As a result, the individual's whole identity becomes defined by that one dimension (Jahoda & Markova, 2004). Contemporary researchers tend to regard stigma as a social construction and emphasise variation across cultures and over time in terms of which groups are stigmatised (Crocker et al., 1998). Whilst the current study addressed the impact of stigma on people with ID, South Asians (particularly Muslims) are also affected by society's stigmatisation and stereotyping of their culture (e.g., Alibhai-Brown, 2008). I am aware that this social context means that my study has the potential to raise some difficult issues. I sincerely hope that this study does not feed into existing stereotyping about South Asians in the UK. Throughout this research, I have tried to adopt an attitude of respect for cultural differences, which I hope has been conveyed to both the participants and to the people who read this study.

5.0. Summary and conclusions

The government White paper *Valuing People* (Department of Health, 2001) argues that services for people with ID should be provided to maximise the principles of independence, inclusion, rights and choice. These were the principles advocated by normalisation or social role valorisation as it was later renamed (Wolfensberger, 1983). However, whilst *Valuing People* advocates the rights of people with ID, there is little acknowledgement of the views of ethnic minority communities in the UK, whose religious and cultural values do not necessarily conform to the principles of normalisation. The current study aimed to acknowledge cultural diversity, an area which has been much overlooked (Baum et al., 2000). It is hoped that future research will add to our understanding of ethnic and cultural differences in relation to the principles of social inclusion. It is also hoped that future research will add to our understanding of how service providers, governed by the principles of *Valuing People,* can be reconciled with differing ethnic and religious perspectives. This study found support for the expressed fears of South Asian families with a family member with ID in terms of the stigma they face from their own communities. Education also needs to do more towards combating stigma towards people with ID among adolescents. It is suggested that culturally appropriate interventions could focus on reducing stigma and increase understanding of ID among British South Asian adolescents.

Obstacles to service uptake by ethnic minorities include: the provision of services that are inappropriate to the culture of the intended recipients; the unwillingness of services to meet the needs of communities who speak foreign languages; a lack of consideration for the needs and views of unpaid family carers; the complexities and bureaucracy of service provision; and the service providers' assumptions and overestimations about the availability of extended family support (Ahmad & Atkin, 1996; Katbamna et al., 2001). The identification of lower pro-inclusion attitudes and stigma towards people with ID among the South Asian public challenges the implicit blame directed towards families for not accessing services. It puts the onus back on services to understand and work with the attitudes and beliefs of British South Asians towards people with ID. Providers need to develop ways of offering services in a way that is less stigmatising. Whilst the principles of *Valuing People* and ethnic and religious perspectives can raise tensions for learning disability services, research is emerging that suggests how good practice may be achieved (Summers & Jones, 2004).

6.0. References

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Appendices

Appendix A: Demographics

Appendix B: The Community Living Attitudes Scale – MR Form

Appendix C: The Community Living Attitudes Scale – Scoring Key

Appendix D: Information sheet

Appendix E: Informed consent form

Appendix F: Brief description of learning disabilities

Appendix G: Distinction between my study and a related study

Appendix H: Letter inviting participation to heads of sixth form colleges

Appendix I: Research Ethics Committee Form

Appendix A: Demographics

Date...................... **Age**.............. **Male / Female**

Country of birth:.....................................

Age of entry to UK: (if born elsewhere).........

Generation (please tick ***one***)

1st generation ☐ 2nd generation ☐ 3rd generation ☐

Parents' country of birth:............................

Ethnicity: (please tick ***one***)

White British	☐	Indian / British Indian	☐
Pakistani / British Pakistani	☐	Bangladeshi / British Bangladeshi	☐
Sri Lankan / British Sri Lankan	☐		

Other, please specify________________

Religion:______________

Importance of religious beliefs: (please tick ***one***)

Not at all religious ☐ Somewhat religious ☐ Very religious ☐

Qualifications attained

GCSEs	☐	NVQ	☐	GNVQ	☐	BTEC	☐
AS levels	☐	A levels	☐	University degree	☐		

Other, please specify________________

Do you know someone with a learning disability? (please circle **one**)

Yes / No

If yes, how do you know them? (please circle **one**)
Relative / Friend / Acquaintance

Appendix B: The Community Living Attitudes Scale: MR Version (Henry, Keys, Jopp & Balcazar, 1996)

Indicate the extent to which you agree with the following statements according to this scale:

1 = Disagree strongly
2 = Disagree moderately
3 = Disagree somewhat
4 = Agree somewhat
5 = Agree moderately
6 = Agree strongly

Please note: people with learning disabilities are sometimes known as 'mentally handicapped'.

1. People who have learning disabilities are happier when they live and work with others like them. 1 2 3 4 5 6

2. People who have learning disabilities trying to help each other is like "the blind leading the blind". 1 2 3 4 5 6

3. People who have learning disabilities should not be allowed to marry and have children. 1 2 3 4 5 6

4. A person would be foolish to marry a person who has learning disabilities. 1 2 3 4 5 6

5. People who have learning disabilities should be guaranteed the same rights in society as other persons. 1 2 3 4 5 6

6. People who have learning disabilities do not want to work. 1 2 3 4 5 6

7. People who have learning disabilities need someone to plan their activities for them. 1 2 3 4 5 6

8. People who have learning disabilities should not hold positions in the government. 1 2 3 4 5 6

9. People who have learning disabilities should not be given any responsibility. 1 2 3 4 5 6

10. People who have learning disabilities can organise and think for themselves. 1 2 3 4 5 6

11. People who have learning disabilities do not care about advancement in their jobs. 1 2 3 4 5 6

12. People who have learning disabilities do not need to make choices about the things they will do each day. 1 2 3 4 5 6

13. People who have learning disabilities should not be allowed to drive. 1 2 3 4 5 6

14. People who have learning disabilities can be productive members of society. 1 2 3 4 5 6

15. People who have learning disabilities have goals for their lives like other people. 1 2 3 4 5 6

16. I would trust a person who has learning disabilities to be a babysitter. 1 2 3 4 5 6

17. People who have learning disabilities cannot exercise control over their lives like other people. 1 2 3 4 5 6

18. People who have learning disabilities can have close personal relationships just like everyone else. 1 2 3 4 5 6

19. I would not want to live next door to people who have learning disabilities. 1 2 3 4 5 6

20. People who have learning disabilities are usually too limited to be sensitive to the needs and feelings of others. 1 2 3 4 5 6

21. People who have learning disabilities should live in sheltered facilities because of the dangers of life in the community. 1 2 3 4 5 6

22. People who have learning disabilities should be encouraged to lobby legislators on their own (i.e. to try and influence legislation) 1 2 3 4 5 6

23. People who have learning disabilities are the best people to give advice to others who wish to move into community living. 1 2 3 4 5 6

24. The opinion of a person who has learning disabilities should carry more weight than those of family members and professionals in decisions affecting that person. 1 2 3 4 5 6

25. People who have learning disabilities can plan meetings and conferences without assistance from others. 1 2 3 4 5 6

26. People who have learning disabilities can be trusted to handle money responsibly. 1 2 3 4 5 6

27. Residents have nothing to fear from people who have learning disabilities living and working in their neighbourhoods. 1 2 3 4 5 6

28. People who have learning disabilities usually should be in group homes or other facilities where they can have the help and support of staff 1 2 3 4 5 6

29. Sheltered workshops for people who have learning disabilities are essential. 1 2 3 4 5 6

30. The best care for people who have learning disabilities is to be part of normal life in the community. 1 2 3 4 5 6

31. Most people who have learning disabilities prefer to work in a sheltered setting that is more sensitive to their needs. 1 2 3 4 5 6

32. Without some control and supervision, people who have learning disabilities could get in real trouble out in the community. 1 2 3 4 5 6

33. The rights of people who have learning disabilities are more important than professional concerns about their problems. 1 2 3 4 5 6

34. Services for people who have learning disabilities should have them on their boards. 1 2 3 4 5 6

35. The best way to handle people who have learning disabilities is to keep them in institutions. 1 2 3 4 5 6

36. Homes and services for people who have learning disabilities should be kept out of residential neighbourhoods. 1 2 3 4 5 6

37. Increased spending on programs for people who have learning disabilities is a waste of money. 1 2 3 4 5 6

38. Homes and services for people who have learning disabilities downgrade the neighbourhoods they are in. 1 2 3 4 5 6

39. Professionals should not make decisions for people who have learning disabilities unless absolutely necessary. 1 2 3 4 5 6

40. People who have learning disabilities are a burden on society 1 2 3 4 5 6

41. People who have learning disabilities can be cured through a medical intervention* 1 2 3 4 5 6

42. People who have learning disabilities can overcome these through religion* 1 2 3 4 5 6

43. People who have learning disabilities can overcome these through marriage*. 1 2 3 4 5 6

44. Parents should bear the main responsibility for children with learning disabilities*. 1 2 3 4 5 6

45. Families should hide their relatives with learning disabilities rather than make it obvious through using services*. 1 2 3 4 5 6

46. Having a person with a learning disability in a family may damage the marriage prospects of siblings*. 1 2 3 4 5 6

**Q41- 46 have been designed for the current study and do not form part of the Community Living Attitudes Scale – MR Version (Henry, Keys, Jopp & Balcazar, 1996).*

Appendix C: CLAS-MR - The Community Living Attitudes Scale – Scoring Key

Subscale	Subscale Items
1. Empowerment	23, 22, 34, 24, 26, 13 (R), 33, 25, 16, 3 (R), 8 (R), 4 (R), 39
	Total / 13
2. Exclusion	30 (R), 35, 37, 40, 36, 27 (R), 19, 38
	Total /8
3. Sheltering	29, 7, 31, 28, 32, 21, 1
	Total / 7
4. Similarity	18, 15, 14, 6 (R), 10, 17 (R), 20 (R), 9 (R), 5, 11 (R), 2 (R), 12 (R)
	Total / 12

R = Reverse scored

Appendix D: Information sheet

Title of Project:	Attitudes towards people with learning disabilities: a cross-cultural study of White British and South Asian adolescents.
This study has been approved by the UCL Research Ethics Committee [Project ID Number]:	0960/001
Name, Address and Contact Details of Investigators:	Joel Sheridan / Dr Katrina Scior Sub-dept of Clinical Health Psychology, University College London, Gower Street, London W1 Email:

Introduction
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. Ask us if there is anything that is not clear or you would like more information.

Purpose of the research
We are interested in finding out more about attitudes towards people with learning disabilities in South Asian adolescents. We are also interested in finding out whether there are any cross-cultural differences in patterns of responding between South Asian and White British participants.

The expected duration of participation
Completing this questionnaire will take you roughly 15 minutes.

Participants' participation in the research
It is up to you to decide whether or not to take part.

If you choose not to participate it will involve no penalty or loss of benefits to which you are otherwise entitled.

If you decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

All data will be collected and stored in accordance with the Data Protection Act 1998.

Appendix E: Informed consent form

Title of Project:	Attitudes towards people with learning disabilities: a cross-cultural study of White British and South Asian adolescents.

This study has been approved by the UCL Research Ethics Committee [Project ID Number]: 0960/001

Participant's Statement

I ....

agree that I have

- read the information sheet and/or the project has been explained to me orally;
- had the opportunity to ask questions and discuss the study;
- received satisfactory answers to all my questions or have been advised of an individual to contact for answers to pertinent questions about the research and my rights as a participant and whom to contact in the event of a research-related injury.

I understand that I am free to withdraw from the study without penalty if I so wish. I understand that such information will be treated as strictly confidential and handled in accordance with the provisions of the Data Protection Act 1998.

Signed: Date:

Investigator's Statement

I ....

confirm that I have carefully explained the purpose of the study to the participant and outlined any reasonably foreseeable risks or benefits (where applicable).

Signed: Date:

Appendix F: Brief description of learning disabilities

What is a Learning Disability?

- It is NOT the same as a "learning difficulty" (e.g. dyslexia).
- It is a global disability and affects the way someone learns, communicates or does some everyday things all through their life.
- There are many different types of learning disability. They can be mild, moderate or severe. People with a mild learning disability do not need a lot of support in their lives. Other people with a severe learning disability may need a lot of support 24 hours a day with all sorts of things, like getting dressed, going shopping, or filling out forms.
- Conditions associated with a learning disability include: Autism, Asperger's syndrome, Cerebral Palsy and Epilepsy.

Appendix G: Distinction between my study and a related study

To explore attitudes towards ID in more depth focus groups were carried out by a fellow UCL trainee clinical psychologist (Sarah Coles). My project was related to her project insofar as (1) we had the same supervisor, Dr Katrina Scior, (2) both of our projects aimed to explore attitudes towards people with ID among South Asian and white British adolescents, and (3) the participants in my study who were interested in taking part in a focus group, were followed up by Sarah for her project. Otherwise, both projects were carried out entirely independently of each other, employing different methodologies, separate data collection procedures and analysis.

Appendix H: Letter inviting participation to head teachers of sixth form colleges

Dear............,

We are planning to carry out a survey into attitudes towards people with learning disabilities living in the community among 16 to 19 year olds. We are looking to compare attitudes of white British youngsters to those of their South Asian peers, an area very much neglected in previous research. Participants would simply need to complete a 10-minute questionnaire about their attitudes to people with learning disabilities. This study has been approved by the UCL ethics board for approval.

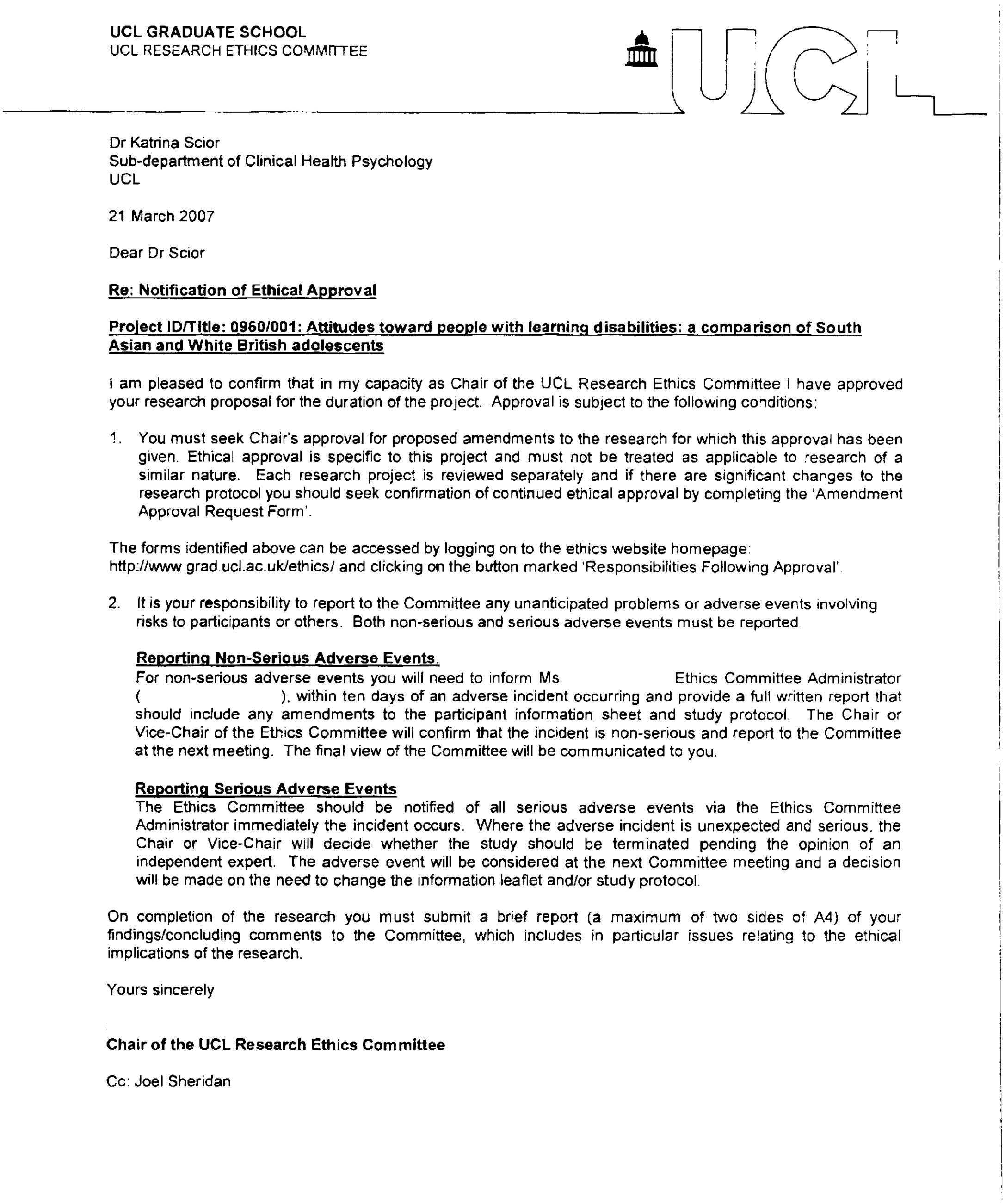
We are currently approaching heads of sixth form colleges in London and the Home Counties where there is a strong South Asian presence among the student body. We are very much hoping that you will grant us permission to come into your college at a suitable time to ask students to give up 10 minutes of their time to complete this questionnaire. In return for your college's participation in the project, we would like to offer a careers advice session for students who are interested in pursuing a career in psychology.

We look forward to hearing from you in the near future.

Best wishes

Mr Joel Sheridan	Dr Katrina Scior
Trainee Clinical Psychologist	Lecturer in Clinical Psychology

Appendix I: Research Ethics Committee Form



UCL GRADUATE SCHOOL
UCL RESEARCH ETHICS COMMITTEE

Dr Katrina Scior
Sub-department of Clinical Health Psychology
UCL

21 March 2007

Dear Dr Scior

Re: Notification of Ethical Approval

Project ID/Title: 0960/001: Attitudes toward people with learning disabilities: a comparison of South Asian and White British adolescents

I am pleased to confirm that in my capacity as Chair of the UCL Research Ethics Committee I have approved your research proposal for the duration of the project. Approval is subject to the following conditions:

1. You must seek Chair's approval for proposed amendments to the research for which this approval has been given. Ethical approval is specific to this project and must not be treated as applicable to research of a similar nature. Each research project is reviewed separately and if there are significant changes to the research protocol you should seek confirmation of continued ethical approval by completing the 'Amendment Approval Request Form'.

The forms identified above can be accessed by logging on to the ethics website homepage: http://www.grad.ucl.ac.uk/ethics/ and clicking on the button marked 'Responsibilities Following Approval'.

2. It is your responsibility to report to the Committee any unanticipated problems or adverse events involving risks to participants or others. Both non-serious and serious adverse events must be reported.

Reporting Non-Serious Adverse Events.
For non-serious adverse events you will need to inform Ms Ethics Committee Administrator ( ), within ten days of an adverse incident occurring and provide a full written report that should include any amendments to the participant information sheet and study protocol. The Chair or Vice-Chair of the Ethics Committee will confirm that the incident is non-serious and report to the Committee at the next meeting. The final view of the Committee will be communicated to you.

Reporting Serious Adverse Events
The Ethics Committee should be notified of all serious adverse events via the Ethics Committee Administrator immediately the incident occurs. Where the adverse incident is unexpected and serious, the Chair or Vice-Chair will decide whether the study should be terminated pending the opinion of an independent expert. The adverse event will be considered at the next Committee meeting and a decision will be made on the need to change the information leaflet and/or study protocol.

On completion of the research you must submit a brief report (a maximum of two sides of A4) of your findings/concluding comments to the Committee, which includes in particular issues relating to the ethical implications of the research.

Yours sincerely

Chair of the UCL Research Ethics Committee

Cc: Joel Sheridan