MENTAL HEALTH COUNSELING FOR INDIVIDUALS WITH INTELLECTUAL/DEVELOPMENTAL DISABILITIES: ATTITUDES AND EXPERIENCES OF LICENSED COUNSELORS

By

Alysha Blagg

Liberty University

A Dissertation Presented in Partial Fulfillment of the Requirements for the Degree Doctor of Philosophy

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A Dissertation Presented in Partial Fulfillment of the Requirements for the Degree Doctor of Philosophy Liberty University, Lynchburg, VA

2020

APPROVED BY:

(Signature on File)_____

John Thomas, Ph.D., Committee Chair

(Signature on File)_____

Kevin Hull, Ph.D., Committee Member

(Signature on File)_____

Lisa Sosin, Ph.D., Committee Member

ABSTRACT

The following study examined the attitudes and beliefs of licensed mental health counselors toward individuals with intellectual/developmental disabilities (IDD) and those providing services to the population. This study examined if professional and/or personal contact with individuals with IDD impacts counselors' attitudes. A quantitative research design was utilized to examine the relationships among counselors' attitudes toward individuals with IDD, contact with the population, perception of treatment effectiveness, and confidence in working with individuals with IDD. The responses from 74 participants were used in data analysis for this study. Findings in this study suggested that counselors may hold neutral to low positive attitudes toward the IDD population. Overall findings of this study suggested that counselors' attitudes impact expectations of counseling effectiveness and counselors' confidence in providing services to individuals with IDD. Results also suggested that counselors' contact with individuals with IDD impact counselors' attitudes, counselors' confidence, counselors' expectations of counseling effectiveness, and the relationship between counselors' attitudes and counselors' confidence.

Keywords: intellectual/developmental disabilities, IDD, attitudes, contact theory, counselor

DEDICATION

This work is dedicated to all the individuals with intellectual and developmental disabilities who struggle to receive the mental health treatment they need. It is my desire that this research will be used to bring you the mental health services you need and deserve. You are valuable people!

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List of Abbreviations

American Association on Intellectual and Developmental Disabilities (AAIDD)

American Counseling Association (ACA)

American Psychological Association (APA)

American Rehabilitation Counseling Association (ARCA)

Attitudes toward Disabled Persons Scale (ATDP)

Community Living Attitudes Scale – Intellectual Disability (CLAS-ID)

Council for Accreditation of Counseling and Related Educational Programs (CACREP)

Institutional Review Board (IRB)

Intellectual/Developmental Disability (IDD)

Intellectual Disability (ID)

Interaction with Disabled Persons Scale (IDP)

Marlowe-Crowne Social Desirability Scale (MCSDS)

National Association of Dually Diagnosed (NADD)

Persons with Disabilities (PWD)

Therapist Expectancy Inventory – Factor II (TEI)

Therapy Confidence Scale – Intellectual Disabilities (TCS-ID)

World Health Organization (WHO)

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CHAPTER ONE: INTRODUCTION TO STUDY

Counselors provide mental health services to all individuals, which often call for multicultural competency and confidence in providing services to individuals of differing backgrounds and needs. Individuals with intellectual and developmental disabilities (IDD) face many challenges in mental health, including anxiety, depression, and difficulty in social relationships (American Association on Intellectual and Developmental Disabilities, 2011; Cooper, Smiley, Morrison, Williamson, & Allan, 2007). It is important for counselors to have an awareness and understanding of how their attitudes, biases, stigmatizations, and reactions affect their professional relationship and the services provided to individuals with IDD. This study looked at the impact of counselors' attitudes and biases on their confidence in and perception of treatment for individuals with IDD.

Background of Study

According to research at the University of Minnesota, over 7 million people in the United States have an intellectual or developmental disability (Larson et al., 2018); similarly, McDermott and colleagues (2018) estimate the total to be close to 8 million. Individuals with IDD present with higher rates of mental health disorders than the general population (Kishore, Udipi, & Seshadri, 2019). Researchers have reported co-occurring psychiatric disorders as high as 54 percent (Gustafsson & Sonnander, 2004; Hronis, Roberts, & Kneebones, 2018). In a Canadian study, Balogh, Hunter, & Ouellette-Kuntz (2005) found that approximately one-third (33.98%) of all hospitalizations of individuals with IDD were due to mental health concerns.

After the enactment of the American's with Disabilities Act, more attention has been given to this population, but mental health services continue to be an issue (Committee on Disability in America, 2007). Common problems include: "inadequate attention to care needs"

(Krahn, Hammond, & Turner, 2006, p. 70), diagnostic overshadowing (i.e., the tendency to overlook symptoms of mental illness and attribute the symptoms to IDD) (Bishop, Robinson, & VanLare, 2013; Mason & Scior, 2004), lack of access to quality health care services (Jahoda & Markova, 2004; Krahn et al., 2006), lack of knowledge about IDD (Bishop et al., 2013), and lack of provider training related to dual diagnosis (Lunsky & Bradley, 2001). Integration into community services has continued to take place, yet Antonak (1994) points out that "full acceptance" of individuals with IDD into community services will not occur without addressing attitudes of professionals (p. 347).

Counselors have reported feeling ill-trained, uncertain in how to adapt treatment approaches, and a lack of confidence (specifically related to giving and interpreting assessments) when faced with working with individuals with IDD (Dagnan, Masson, Cavagin, Thwaites, & Hatton, 2014; Hronis, Roberts, Kneebone, 2018; Marwood, Chinn, Gannon, & Scior, 2016). Consequently, when feeling ill-prepared to work with a specific group or culture, the therapeutic relationship and overall treatment are impacted (Dagnan et al., 2014; Hronis et al., 2018). Research has shown that there is a strong positive relationship between the therapeutic relationship and what the client gains from therapy (Orlinsky, Grawe, & Parks, 1994). Client outcomes, in non-disabled populations, have also been directly related to counselor confidence (Heinonen, Lindfors, Laaksonen, & Knept, 2012; Jones, 2013; Keijsers, Schaap, & Hoogduin, 2000; Lambert & Barley, 2001).

In a literature review conducted by Jones and Donati (2009), the authors found that not only is there a lack of research on the therapeutic relationship specific to individuals with disabilities but there is a tremendous need for research in this area. Jones (2013) and Crotty and Doody (2015) followed the research by Jones and Donati and also found the importance of the

therapeutic relationship when working with individuals with disabilities and echoed the lack of and all-around poor empirical and theoretical understanding of the therapeutic relationship when working with individuals with disabilities. Jones (2013) concluded that the therapeutic relationship is "highly significant in the delivery" of counseling services to individuals with disabilities (p. 196). Jones (2013) also argued that the importance of the therapeutic relationship found in research with the non-disabled population should have the same significance with individuals with disabilities.

Crotty and Doody (2015) provided a discussion regarding the therapeutic relationship and communication between medical professionals and clients with IDD. Crotty and Doody (2015) reported that an element of the therapeutic relationship is the communication between parties and the impact on communication caused by "internal and external noise" (p. 27). It can be presumed that a counselor's attitudes and beliefs would have an impact on the therapeutic process. Specifically, the counselor's internal psychological noise of "individual beliefs, behaviors, and values" (Crotty & Doody, 2015, p. 28) can affect the counselor's insight and acuteness. Research conducted by Benham (1988) and Edwards, Lennox, and White (2007) supports these statements and has shown that when counselors have negative attitudes and perceptions of a client, the therapeutic relationship and quality of care are impacted. Yet, the current attitudes of mental health counselors toward individuals with IDD remain unknown.

While there is a growing body of research and interest in new areas regarding the mental health concerns of individuals with IDD (Anslow, 2013; Antonak, 1994; Barol & Seubert, 2010; Dagnan, Masson, Thwaites, James, & Hatton, 2017), research remains limited in regard to counselors' attitudes toward the IDD population and the impact these attitudes may have on therapy outcomes. Specifically, in a review of literature using PsychInfo/APA PsycNET, ERIC,

and Google Scholar, only two published pieces were identified. The first of the two pieces was a dissertation completed internationally, which specifically focused on mental health counselors' attitudes toward individuals with IDD (Coughlin, 2007). The second was an anecdotal article that briefly discussed the impact of stereotyping attitudes of counselors when working with individuals with IDD (Berliner, 1986). By addressing this gap in research, not only will a better understanding of the counseling field and how to better serve individuals with IDD be developed, but resources and education will be better allocated to counselors.

Historically, similar to other minority groups, people with disabilities have experienced negative attitudes and stereotypes (Akrami, Ekehammar, Claesson, & Sonnander, 2006; Werner & Araten-Bergman, 2017). In recent years, researchers have focused on many groups' attitudes toward and beliefs about individuals with IDD (Araten-Bergman & Werner, 2017; Cage et al., 2018; Friedman, 2019). Results from these studies indicate that general education teachers have higher levels of indifference and rejection toward students with IDD (Cook, Cameron, & Tankersley, 2007) and that as many as 39% (Lennox & Chaplin, 1996) to 43% (Edwards, Lennox, & White, 2007) of psychiatrists are reluctant to provide services to the IDD population. In an initial study, special education majors reported having increased perceived knowledge about IDD and were found to have more positive attitudes toward the population, but no significant relationship was found in a follow-up study (Hampton & Xiao, 2007). Social work and nursing students were found to have poorer attitudes toward this population compared to medical students (Kritsotakis et al., 2017). Self-exploration and evaluation of biases, beliefs, and emotional reactions toward disabilities are important tasks in the development and maintenance of counselor identity, professionalism, and skill (American Psychological Association, 2012).

Attitudes of medical professionals toward individuals with IDD impact the quality of services provided to that population (Dorji & Solomon, 2009). Thus, due to negative attitudes, biases, and stereotypes, individuals with IDD struggle to fully integrate into their community and they experience differences in medical treatment and care (Lorenzo, Van Pletzen, & Booyens, 2015). Yet, the efforts to decrease negative attitudes toward this population have been seemingly unsuccessful (Akrami, Ekenhammar, Claesson, & Sonnander, 2006; Berry & Meyer, 1995; Capozza, Di Bernardo, Falvo, Vianello, & Calo, 2016; Gordon, Tantillo, Feldman, & Perrone, 2004).

Theoretical Framework

The use of contact as a study variable allows for a bridge in the gap between the concrete aspects of multicultural competent counseling with individuals with IDD and the more abstract constructs of stereotypes, biases, and exposure. The idea of contact as a means of reducing negative stereotypes and attitudes has been studied and deemed "The Contact Hypothesis" (Stephan, 1987) and offers the idea that positive attitudes can be cultivated through familiarity (Desforges et al., 1991; Lau & Cheung, 1999; Triblet & Sugarman, 1987). This study accepts this premise and seeks to explore the impact of personal and professional exposure to/contact with individuals with IDD on counselor's attitudes toward the population.

Conceptual Framework

This study sought to understand counselors' attitudes toward individuals with IDD, counselors' contact with individuals with IDD, counselors' perception of counseling effectiveness, and counselors' confidence in providing mental health services to individuals with IDD. Each of these variables made up the conceptual framework for this study. This has been visually represented in Figure 1.1.

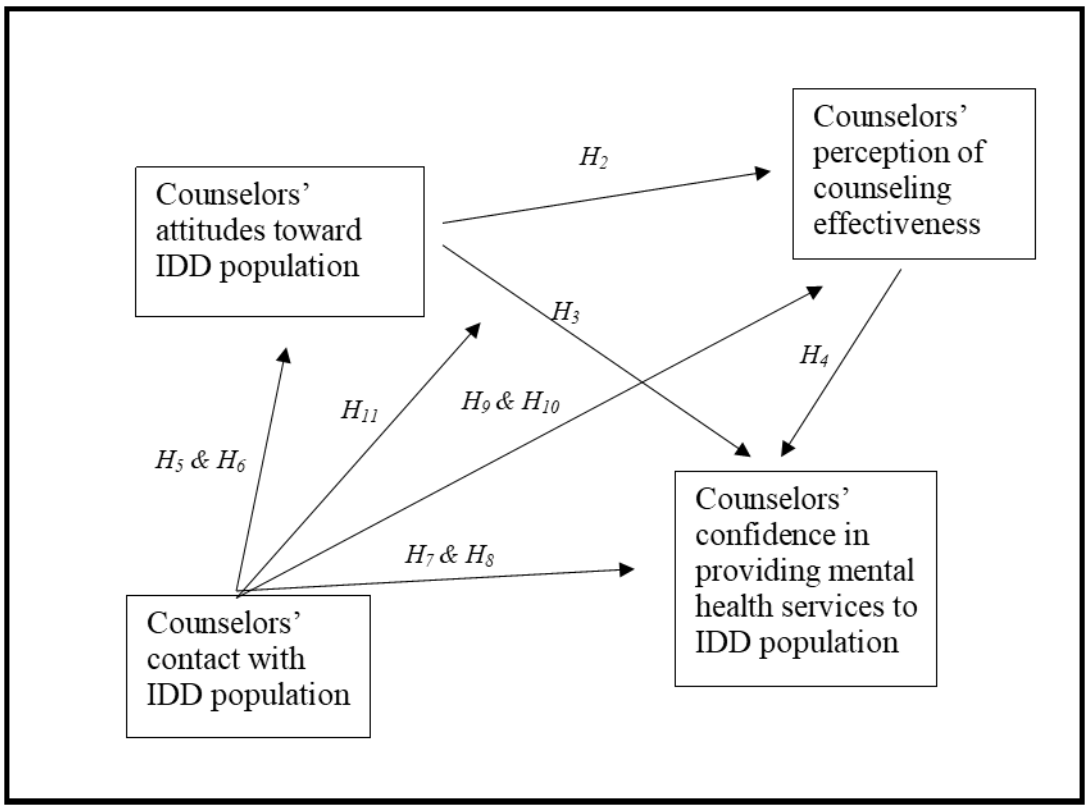

Figure 1.1. Conceptual Framework.

Statement of Problem

General public stigmatization and biases toward individuals with IDD have been well documented (Angermeyer & Dietrich, 2006; Werner, 2015). One such stigmatization toward individuals with IDD was reported by Siperstein, Norins, Corbin, and Shriver (2003) in which they stated that the general public typically has low expectations of those with IDD. Similarly, Sheridan and Scior (2013) found that college students held the belief that individuals with IDD should be sheltered and not empowered. Researchers have also examined stigmatization of many different professional groups (e.g., police, nurses, teachers, medical students, psychiatry residents) and have found similar results. Individuals with IDD have been characterized as lacking the potential for change (Jahoda & Markova, 2004) and as not "fully human" (Capozza et al., 2016, p. 505). Stigmatization and attitudes toward individuals with disabilities has been

recognized by the World Health Organization (WHO, 2001) as negatively impacting full integration and participation into one's community and accessing community resources, yet no research has investigated counselors' attitudes towards this population.

Counselors continue to report little confidence and feeling ill-prepared in providing counseling services toward individuals with IDD (Hronis et al., 2018; Dagnan et al., 2014; Marwood et al., 2016). Despite the research that has indicated mental health providers' concern with their preparation to provide mental health services to this population and their lack of confidence in doing so, little research has explored the attitudes of providers to meet the needs of this population (Ong et al., 2017). Attitudes impact interactions with individuals (Triblet & Sugarman, 1987) and can impact the therapeutic relationship held between counselors and clients (Benham, 1988; Edwards, Lennox, & White, 2007). Carl Rogers (1957) identified six conditions that must occur in a therapeutic relationship for change to occur, (1) psychological contact, (2) client is in a state of incongruence, (3) therapist is congruent/genuine, (4) unconditional positive regard for client from therapist, (5) therapist provides empathy, and (6) communication is empathic. By their very nature, genuineness, unconditional positive regard, and empathic understanding cannot be made-up or fabricated and they cannot be provided without identifying and understanding one's attitudes and beliefs. Thus, understanding the personal and professional attitudes, biases, and beliefs of counselors toward individuals with IDD is important to the mental health treatment received by the population. As discussed previously, individuals with IDD encounter health care that is inadequate to their needs (Krahn et al., 2006) and providers who are ill-prepared (Lunsky & Bradley, 2001). However, that battle will continue without counselors examining their attitudes and beliefs toward the population.

Purpose of Study

This study aimed to better understand how interpersonal factors impact the services provided by mental health counselors to individuals with IDD. This study investigated the attitudes that counselors hold regarding individuals with IDD and attitudes in regard to providing counseling services to individuals with IDD. Counselors' confidence and expectations when working with individuals with IDD were also measured. Finally, this project explored whether attitudes about IDD predict confidence and whether this relationship is moderated by the amount of exposure counselors have had with those with IDD.

Research Questions

Specifically, this study sought to answer the following questions:

1. What attitudes/beliefs do counselors hold regarding individuals with IDD?
2. What attitudes/beliefs do counselors hold regarding providing counseling services to individuals with IDD?
3. Do attitudes/beliefs predict counselors' confidence in working with individuals with IDD?
4. Do attitudes/beliefs predict counselors' perception of counseling effectiveness with individuals with IDD?
5. Does exposure to individuals with IDD moderate the relationship between counselors' attitudes and confidence?

Significance of Study

In the field of counseling, it is expected that counselors will self-examine attitudes and biases and increase professional skills necessary to become multiculturally competent. Multicultural competency is not only necessary to provide good treatment to the specific

population but is also ethically mandated (ACA, 2014). This study offers counselors, counselor educators, and the mental health field, in general, needed information about the effects of attitudes/biases and contact on counselors' confidence in serving individuals with IDD and ultimately the quality of services provided to individuals with IDD.

Delimitations of Study

While there are opportunities for social workers, psychologists, and other mental health workers to provide counseling services to individuals with IDD, this study was specifically delimited to licensed counselors in the United States of America. This study looked at all levels of counseling licensure (e.g., dependent licensure, independent licensure, and residency/trainee licensure).

Limitations of Study

A weakness of this study was the solo use of self-report, survey measures in order to collect data from study participants. It was acknowledged that participants could attempt to respond in socially acceptable ways and thus this study attempted to limit this by including a measure of social desirability. Scores of social desirability were taken into account during data analysis.

Many factors also played a role in whether participants receiving the invitation to participate actually completed and submitted the survey. It was not possible to request participation from all licensed counselors in the United States, so the researcher chose to invite participation through professional counseling organizations and this researcher's university of study. Out of the survey invitations sent out through COUNSGRAD listserv, American Counseling Association (ACA) Connect "Call for Participants" forum, the Ohio Counseling Association (OCA) listserv, CESNET listserv, and Liberty University students and faculty 106

responses were received. Out of submitted surveys, some were eliminated due to missing data or if the participant did not meet the requirements to participate. The data from 78 participants was used for analysis in this research.

Definition of Key Terminology

Intellectual and Developmental Disability

Intellectual and developmental disabilities are characterized by below average IQ and limitations in multiple areas, including cognitive functioning, adaptive behavior deficits, and limitations in social skills. The *Diagnostic and Statistical Manual of Mental Disorders* 5th edition (DSM-5) characterizes the diagnosis with three criteria: deficits in intellectual functions, deficits in adaptive functions, and the onset occurring during the developmental period (APA, 2013).

Mental Health Counselor

This study specifically looked at the field of counseling and licensed counselors within that field, thus mental health counselors will be defined as any individual who is a licensed counselor (e.g., Counselor Trainee, LPC, LPCC) within their state. For this study, all levels of experience within this demographic were considered, including dependently licensed, independently licensed, and independently licensed with supervision endorsement.

Attitudes/Beliefs

Attitudes and beliefs were used semi-interchangeably throughout this writing meaning the underlying personal assumptions held by a person to be true or believable. In this research, the following measures are used to assess this variable:

- Modern and Classical Attitudes Scale Toward People with Intellectual Disabilities (Akrami et al., 2006). Akrami and colleagues (2006) composed a set of questions to assess the underlying classical and modern attitudes toward people with IDD.

- Interactions with Disabled Persons Scale (IDP; Gething, 1994). The IDP seeks to measure the attitudes of people without a disability regarding their level of discomfort when interacting with people with a disability (Gething, 1994).
- Attitudes Toward Disabled Person Scale (ATDP) – Form B (Yuker, Block, & Younng, 1970).

Exposure/Contact

Exposure/contact to a population was measured in two separate categories, personal exposure and professional exposure. Personal exposure was defined as interactions with a population or someone in that population in one's personal life (e.g., family member, friend). Professional exposure was defined as interactions with a population or someone in that population in professional settings (e.g., employment, education, training).

Counselor Confidence

Counselor confidence explored the counselor's self-assurance in providing all aspects of therapy. Counselor confidence is a counselor's comfortability in diagnosing mental health disorders; administering, interpreting, and explaining assessments; and providing interventions and use of counseling techniques. This study used the following instruments to assess this variable:

- Attitudes to the Treatment of People with Intellectual Disabilities in Mainstream Services (Melville et al., 2005). Melville and colleagues (2005) asked specific questions regarding nurses who work with individuals with IDD and their attitudes toward working with that specific population.
- Therapy Confidence Scale – Intellectual Disabilities (TCS-ID) was utilized in order to assess a counselor's confidence in "working therapeutically with people

with intellectual disabilities" (Dagnan et al., 2014, p. 765). The TCS-ID assesses comfortability by asking questions on topics such as comfortability in communicating with a client who has a disability.

Organization of Study

This dissertation is divided into five chapters. Chapter One includes an introduction, theoretical framework, statement of problem, purpose of study, research questions, research hypotheses, significance of study, delimitations of study, limitations of study, and definition of terms. Chapter Two provides an in-depth overview of literature relevant to this study. Chapter Three describes the methodology for the study, including the participants, instrumentation, procedures, and data processing and analysis. Chapter Four presents the study results after it was collected and analyzed. Each hypothesis was tested for rejection or acceptance. Chapter Five provides a discussion of results, discussion of implications of the results to the field of counseling, and recommendations for further research.

Chapter Summary

This research sought to fill a gap in research in the field of counseling and the field of IDD. In order to provide individuals with IDD the best possible mental health services and provide mental health professionals the best possible training and education, this study examined the extent to which attitudes and beliefs impact services received by individuals with IDD and mental health concerns. Throughout the next several chapters of this dissertation, a thorough investigation of literature, an outline of methodology used, presentation and analysis of results, and future recommendations is presented.

CHAPTER TWO: LITERATURE REVIEW

This study examined the impact of counselors' attitudes and beliefs on providing counseling services to individuals with intellectual and developmental disabilities (IDD). This chapter presents literature related to this study's purpose and topic. Overall, little research has been published regarding counselors' attitudes toward individuals with IDD. Yet, there is a body of research on relevant and related topics, including attitudes toward individuals with IDD from the general population and specific professions, the impact of contact on attitudes, and the impact of counselors' confidence and attitudes on treatment. This body of related research provided a theoretical basis for the proposed study.

This literature review begins with an exploration of historical and current attitudes and biases toward individuals with IDD. This information provided the historical context of discrimination toward this population, the impact it has had on the population, and the continued fight against stigmas for basic rights (specifically health care in this study) for this population. By understanding the historical context of the discrimination experienced by those with IDD and the fight for equal access to health care, an understanding of the need for this research will begin to develop. Next, this literature review presents research that has explored the impact of contact with minority groups on attitudes of majority groups. This research provides insight into the contact theory, how contact with a population can impact attitudes, and what the research results suggest regarding contact with individuals with IDD. Last, this literature review examines the prevalence of mental illness of individuals with IDD, the availability and accessibility of mental health treatment for individuals with IDD, expectation of counselors, and counselors' confidence and treatment outcomes.

Attitudes and Beliefs

Attitudes have an important impact on culture and individuals on a daily basis. Conflict between people groups based on negative attitudes and biases has been referred to as intergroup conflict or intergroup bias; this conflict has been described as a division between groups that separates the groups into "us" and "them" categories which leads to "us" over "them" preference (Alves, Koch, & Unkelbach, 2018). Attitudes and beliefs impact how people are treated, what goods and services are available to them, and the quality of goods and services received (Goodyear, 1983; Miller, 1984; Rees et al., 1991). Research in social psychology has shown that people hold more negative attitudes toward minority groups compared to majority groups (Alves et al., 2018).

Historically, people with disabilities have experienced negative attitudes and stereotypes, similar to other minority groups, which led individuals with IDD to not fully integrate into their community and experience differences in medical treatment and care (Akrami et al., 2006; Lorenzo et al., 2015). Institutionalization of people with IDD and prejudice and negative attitudes/beliefs toward people with IDD are historically intertwined (Friedman, 2019). Research has shown that individuals with IDD are pitied, seen as a group that needs to be taken care of, cannot make their own decisions, dangerous, and less-than human (Araten-Bergman & Werner, 2017; Cage et al., 2018; Capozza et al., 2016; Friedman, 2019). In the past, parents have not only chosen to institutionalize their children with IDD but have also engaged in eugenics and involuntary sterilization of children with IDD in order to prevent individuals with IDD from having children (LaLiberte, Piescher, Mickelson, & Lee, 2016). These negative views, attitudes, and biases have such a long-standing ideology within the United States and world-wide.

In the early 1800s, individuals with IDD were believed to have nothing to contribute to society and were sent to live out their lives in institutions (Friedman, 2019). The deinstitutionalization of individuals with IDD began in June 1967 and state and federal run institutions began to close (Scott et al., 2008). It was not until the *Wyatt v. Stickney* (1971) that deinstitutionalization really started to pick up and then *Olmstead v. L.C.* (1999) began to reinforce the idea that people with IDD have the right to be in their community. Rees and colleagues (1991) were interested in finding out if societal attitudes toward individuals with IDD had changed over the years as the population more fully integrated into communities. In comparing their research to a study completed by Spreen in 1977, Rees and colleagues (1991) found that there had indeed been a mostly positive attitude shift in undergraduate students' concept of "mentally retarded" between 1975 and 1988. What they also found was that there were five concepts/descriptors associated with individuals with IDD that did not change: emotional, suggestible, slow, weak, and small (Rees et al., 1991). The researchers speculated that these adjectives may be more resistant to change because they are "considered to be characteristic descriptors" of individuals with IDD (Rees et al., 1991, p. 84). They wrote, "It is possible that no matter how much attitudes shift over time, there remains a negative image of persons with [IDD] as emotional, weak, and suggestible" (Rees et al., 1991, p. 84-85). In the United States and around the world, policies are being established regarding the community integration and inclusion of individuals with IDD. However, without an awareness and understanding of attitudes and biases present, integration and inclusion may be met with resistance (Scior, 2011).

Individuals with disabilities have experienced discrimination, devaluation, and cruelty even with the recent history of de-institutionalization and more attention and awareness being

given to the IDD population (Jones, 2013). Although, more research is showing that there is a push toward generating more positive attitudes (Scior, 2011). Research has shown that attitudes continue to be negative and present with stigmatizing beliefs within general society (Dhillon & Chaudhuri, 1990; Eggert & Berry, 1992; Nagata, 2007; Scior, 2011; Wilson & Scior, 2015). Britain's Department of Health (2001) recognizes that individuals with learning disabilities continue to be one of the most "socially excluded and vulnerable groups" (p. 789). Still, some have argued that there is a positive shift occurring and individuals with IDD are experiencing an improved quality of life (Hodges, 2003; Jones, 2013). Scior (2011) looked at 75 articles covering 68 studies conducted between January 1990 and May 2011 regarding attitudes, knowledge, beliefs, discrimination, and stigma of individuals with IDD. Within this comprehensive review, Scior (2011) reported finding "attitudes that are generally pro-inclusion" (p. 2176) within Western culture, but also showed reports of both positive and negative attitudes and beliefs toward individuals with IDD. Even with these mixed results, individuals with IDD continue to experience discrimination in employment, health care, mental health care, education, and recreational activities (APA, 2012; Capozza et al., 2016; Schriner, 2001; Smart, 2001). After the comprehensive review of studies, Scior (2011) concluded that there is "a surprising lack of evidence about possible changes in attitudes across time" (p. 2178).

Research is showing that negative attitudes remain a concern across professional groups. In a historical study of teachers' attitudes toward individuals with mild intellectual disability and individuals with severe intellectual disability, Siperstein and Gottlieb (1978) found that respondents held significantly more positive attitudes toward mild IDD than severe IDD and were not supportive of placing individuals with severe IDD into an integrated classroom. In a more recent study of teachers, students with disabilities received higher ratings of teacher

indifference and rejection and lower ratings of attachment when compared to students without disabilities (Cook et al., 2007). Capozza and colleagues (2016) studied educators' perceptions of individuals with IDD and found that individuals are denied "a fully human status" (p. 505) meaning the respondents perceive individuals with IDD as having more non-unique traits (traits that are not just unique to humans but could also be attributed to animals and other items [e.g., joy, fear]) than unique human traits (traits that are uniquely human and are only attributed to humans [e.g., hope, shame, regret]) Similarly, Cage, Di Monaco, and Newell (2018) found that individuals with autism are viewed in dehumanizing ways (as described by Bastian and Haslam (2010) through assessing "human nature" and "human uniqueness" traits), including viewing individuals with autism as child-like and having less self-restraint. In spite of integration efforts in classroom settings occurring over many decades, research continues to show that educators hold negative attitudes toward and perceptions of individuals with IDD.

Similarities can be seen between educators and those in health and helping professions. Araten-Bergman and Werner (2017) reported on social workers' perceptions of individuals with IDD and found that there were high levels of coercion (mean = 6.06 on a 1-9 scale with a standard deviation of 2.20) reported by social workers and the stereotype of "dangerousness" (mean = 2.62 on a 1-5 scale with a standard deviation of 1.50) associated with individuals with IDD. A study that offered a different perspective of attitudes toward individuals with IDD was conducted with participants involved in a mentoring program with individuals with IDD. In this study, Goreczny and colleagues (2011) found that participants had an overall positive attitude with respect to right and competency, but also found that attitudes and beliefs regarding social interactions with individuals with IDD were ambiguous and uncertain (i.e., when responding to

the statement “Most people enjoy socializing with people with disabilities” on a 6-point Likert scale, the mean score was 3.64 with a S.D. of 1.43).

In an analysis and comparison of research that reported on attitudes toward the IDD population, Werner and Stawski (2012) reported that attitudes remained negative among psychiatrists between 1996 and 2007. Approximately 40% of psychiatrists have also reported a preference to not work with patients with IDD (Edwards et al., 2007; Lennox & Chaplin, 1996). While not a direct study of personal attitudes, Weiss and colleagues (2009) reported on caregivers’ perceptions of attitudes toward people with IDD and found that caregivers believed a lack of respect and negative attitudes were present when working with individuals with IDD. Caregivers reported negative attitudes and comments, lack of time spent when completing assessments, and lack of attention given to patient with IDD when being cared for in the hospital (Weiss et al., 2009).

In order to address biases and discrepancies in services, researchers have looked at the attitudes of professional groups regarding those with IDD. While studies have assessed many different groups (e.g., nurses, teachers, medical students, and psychiatry residents) and their attitudes toward individuals with IDD, research has not been done on counselors’ attitudes towards this population (Araten-Bergman & Werner, 2017; Capozza et al., 2016; Chubon, 1982; Dorji & Solomon, 2009; Geckil et al., 2017). The American Psychological Association (2012) stated specifically that psychologist should, “become aware of how their own attitudes, reactions, conceptions of disability, and possible biases may affect their professional relationships with clients who have disabilities,” but the same should be said for all professionals working in the mental health field (p. 43). In order for individuals with IDD to experience complete integration into their communities and to also receive the services they need within their communities,

attitudes and biases must be assessed across all groups and professions, especially those who work in helping professions. Specifically, regarding counselors, Stuntzner and Hartley (2014) stated:

> Counselors that work with individuals with disabilities and/or their families should be aware of the impact of historical and societal perceptions toward disability…In addition, counselors have a professional responsibility to be cognizant of their own word-choice and use of terms…and its potential impact. More specifically, they need to be mindful of whether they view the person as an individual who has the same rights, needs, and desires as anyone else or if they perceive him as incapable, weak, less than, suffering, pitiful, handicapped, or physically/mentally challenged. (p. 3)

Similarly, Sue and colleagues (1992) implore counselors to understand their personal beliefs and attitudes toward culturally different clients in order to become culturally competent, by stating:

> Counselors who are unaware of the basis for differences that occur between them and their culturally different clients are likely to impute negative characteristics. What is needed is for counselors to become culturally aware, to act on the basis of a critical analysis and understanding on their own conditioning, the conditioning of their clients, and the socio-political system of which they are both a part. Without such awareness, the counselor who works with a culturally different client may be engaging in cultural oppression using unethical and harmful practices. (p. 480)

People groups experience intergroup conflict and negative cultural attitudes on a regular basis. Intergroup conflict is impacted by attitudes held by and acted on by the in-group/majority population toward the out-group/minority population. People with IDD are typically considered an out-group because the disability characteristic of group members is different from mainstream

culture. Individuals with IDD have experienced historical and current injustice in many areas of life but specifically related to mental health. Those working in health care and helping fields continue to hold negative views of individuals with IDD, which impact their desire to work with clients with IDD.

Contact

Rees and colleagues (1991) assert that as a means of changing attitudes, research has focused on two areas: contact and education. The researchers suggest that research has continued to show mixed results in the helpfulness of contact promoting positive attitudes; thus indicating that sometimes contact is helpful in promoting positive attitudes, sometimes it is not helpful, and other times it has no impact on attitudes (Rees et al., 1991). They also report the same mixed results regarding the helpfulness of education promoting positive attitudes (Rees et al., 1991). In the following section, research on contact theory will be examined.

Contact Theory

Contact theory was originally developed in relation to racial discrimination. Allport's (1954) theory of contact states that peoples' attitudes can change toward outgroup members when the group members have increased contact with one another. This increase in contact often results in more positive attitudes toward the outgroup (Allport, 1954). Allport found that social status, lack of knowledge of a people group, and competition between groups contributed to negative attitudes and prejudice (Allport, 1954). Within his research, Allport (1954) concluded that there are four conditions that are optimal for intergroup contact: (1) equal status within a situation, (2) common goal, (3) intergroup cooperation/lack of competition, and (4) authority support. Social researchers have argued that social exclusion of minority groups is due to a lack

of opportunity for contact, but that casual (e.g., happenstance) contact alone is not sufficient for changing attitudes (Allport, 1954; Al-Kandari, 2015).

Since Allport's initial theory, researchers have continued to find similar results and use the contact theory with positive outcomes of reducing prejudice toward groups (Cook & Selltiz, 1955; Desforges et al., 1991). Social psychologists, including those interested in intergroup relations, have suggested that people who engage in contact with another people group are likely to hold less negative attitudes and beliefs toward the minority or outgroup members compared to those who do not have contact with the people group (Allport, 1954; Al Ramiah & Hewstone, 2013; Brown & Hewstone, 2005; Hewstone & Brown, 1986; Pettigrew, 1998). Some researchers have asserted that attitudes and biases have become more subtle rather than blatant (Dovidio et al., 2008; Staub, 1996; Wilson & Scior, 2015). This suggestion of change in subtly has left researchers looking at the different types of prejudice and how contact may be impacted. Al Ramiah and Hewstone (2013) proposed that intergroup contact could be a way in which groups could reduce, resolve, and prevent further conflict between different people groups. They suggest that two conditions of contact must be considered, quantity of contact and quality of contact.

Wilson and Scior (2015) looked at implicit (automatic and occur without effort) and explicit (intentional and consciously controllable) attitudes toward individuals with IDD and found that implicit attitudes (slightly negative in reporting) did not change with level of contact or type of contact with individuals with IDD but explicit attitudes did. The results of Wilson and Scior's (2015) study begs the question of whether attitudes have really changed at all regarding contact or if people are just able to control what is shown to others. This is an important distinction that needs to be made, as future research will need to determine what implicit

attitudes are still in place toward a specific minority and the impact of those attitudes on the outgroup.

Still, others have argued that the type of contact is a determining factor in whether or not attitudes change and if conditions are favorable to reduce prejudice (Amir, 1969; Sherif & Sherif, 1953). Amir (1969) conducted a study on ethnic intergroup contact and presented several principles that came out of that research. He found a consistent presence of research affirming the view that contact between groups and group members will lead to attitude changes between these groups. That being said, Amir (1969) also concluded that if attitudes between people groups are to change, several conditions must be in place. Amir (1969) identified two types of conditions: favorable and unfavorable. A favorable condition is when there is frequent and direct contact but also having contact that must also be positive whereas an unfavorable condition is when the contact is negative and possible a forced contact (Amir, 1969). Based on the principles identified, Amir (1969) proposed that the change direction (either positive or negative) is dependent on the conditions in which the change takes place. In other words, if the change takes place in "favorable" conditions biased and negative attitudes will lessen, but if the change takes place when conditions are "unfavorable," attitudes and beliefs may actually become more negative and increase intergroup tension (Amir, 1969). Positive and favorable conditions that reduce negative attitudes include: equal status between the groups; if unequal status is in place, contact must be between members of the majority group and higher status members of the minority group; a social climate that is in favor of and promotes contact between the groups; and contact that is rewarding (Amir, 1969). Amir's (1969) research concluded that while attitudes may change, that change may be limited to a specific situation (e.g., personal life, professional life, etc.) and may not be generalizable to other situations or environments.

An example of the impact contact can have on attitudes is found in the research by Goreczny and colleagues (2011). They reported that individuals who have a family member with IDD reported more positive attitudes toward individuals with IDD than those without family members with IDD. It was also reported that there was no significant difference in attitudes toward the population between those with a close friend with IDD and those who do not have a close friend with IDD (Goreczny et al., 2011). In a quantitative study that explored implicit and explicit attitudes and contact with individuals with IDD, it was found that higher quantity of contact with the IDD population was not associated with the measure of prejudice, but quality of interactions was strongly related to positive attitudes (Keith et al., 2015). This suggests that personal relationships with individuals with IDD are important. Although, it is not merely the *amount* of contact but instead the *quality* of contact and relationship that is positively associated with positive attitudes toward individuals with IDD.

Contact with Individuals with IDD

In studies where contact with the IDD population has been explored, favorable results have been reported. Kennon and Sandoval (1978) found that teachers who had more experience and contact with students with IDD held more positive attitudes toward the students than teachers with less contact. Similarly, Stainback and Stainback (1982) suggest that teachers who have opportunities to observe and interact with students with IDD become less fearful of and intimidated by having them in their classrooms than teachers who only receive training. In a quantitative study seeking to show the mediation relationship of misconceptions about disabilities between contact and being an education major, Barr and Bracchitta (2008) reported that contact with the IDD population was negatively associated with misconceptions and positively associated with optimism. Alternatively, some studies have shown that more

experienced teachers (having more contact with students with IDD) hold more negative attitudes toward students with IDD thus suggesting that contact with individuals with IDD has no impact on attitudes held (Harvey & Green, 1984; Rizzo & Vispoel, 1991).

While the dehumanization of individuals with IDD was previously discussed, it must be understood within the context of contact and bias. Staub (1996) identified characteristics of a culture that encourage group prejudice and violence. One of those characteristics was devaluation or dehumanization. Staub (1996) noted that if the majority culture can change the view of the out-group to be one of "not likable, stupid, lazy, or generally inferior" the devaluation has taken place, as has been seen in the Jews in Germany and the Armenians in Turkey (p. 119).

The awareness and understanding of counselors' views of individuals with IDD must be achieved for this reason. As will be noted in more depth in the following section, counselors' have an ethical responsibility to competently serve all individuals. Regarding the IDD population, research has shown that such individuals are often seen as different and labeled with other stereotypes. Due to these negative stereotypes, the quality and quantity of the services received by individuals with IDD have been negatively impacted (Barr & Bracchitta, 2008; Furnham & Thompson, 1994; Rees et al., 1991; Yuker, 1994).

Mental Health and IDD

IDD and Mental Health Treatment

According to research at the University of Minnesota, over 7 million people in the United States have an intellectual or developmental disability (IDD) (Larson et al., 2018). Research has shown that rates of co-occurring mental health disorders in individuals with IDD range from 16 percent (Cooper et al., 2007) to 54 percent (Gustafsson & Sonnander, 2004; Hronis, Roberts, &

Kneebone, 2018). Some researchers have argued that co-occurring mental health disorders occur at higher rates to the extent of almost 50 percent of women with IDD having a mental illness (Cooper, Smiley, Morrison, Williamson, & Allan, 2007). Other research has shown nearly 40 percent of adults with IDD having at least one mental health disorder (Rimmer & Hsieh, 2011). And still others have reported co-occurring mental health disorders three to five times higher than the general population (Kishore et al., 2019). It has been proposed that mental health disorders are higher within the IDD population due to the decline in cerebral functioning that causes both IDD and mental health disorders (Kishore et al., 2019). It is suggested that social difficulties such as discrimination impact mental health and may lead to psychiatric conditions (Kishore et al., 2019).

Attention has been brought to the health services received by individuals with IDD through the United States Department of Health and the American's with Disabilities Act (Committee on Disability in America, 2007). Still, availability and accessibility of mental health services remains a problem for this population. Findings show that less than ten percent of individuals with co-occurring IDD and mental health disorders received treatment over a 14-year period (Einfeld et al., 2006). Durbin and colleagues (2017) completed a qualitative study with over 2000 adults receiving mental health case management services, in which 212 participants (8.3%) had a co-occurring diagnosis of IDD. In that study, individuals with IDD were shown to have more unmet needs and poorer quality care than individuals with strictly mental health diagnoses (Durbin et al., 2017). While many researchers argue that mental health disorders remain poorly treated within the IDD population (Anderson et al., 2013; Anderson et al., 2003; Durbin, Sirotich, Lunsky, & Durbin, 2017; Koch et al., 2014; Krahn et al., 2006; Lunsky et al., 2014), other studies have found that psychiatric modalities of treatment (i.e., psychotropic

medications) are widely used and seemingly overused (Edward et al., 2007; Krahn et al., 2006; Lewis et al., 2002). Regarding use of psychotropic medications, Krahn and colleagues (2006) stated, "Across the studies reviewed, approximately one-third to one-half of each sample was medicated for psychiatric concerns. Record reviews indicated that psychiatric diagnoses had not been made to support this level of medication use" (p. 74).

Accessibility and availability of mental health services remain a significant issue for individuals with IDD as counselors remain unwilling to provide counseling services to individuals with IDD (O'Brien & Rose, 2010). Some researchers have even stated that individuals with IDD do not have the cognitive ability to truly participate in psychotherapy and, thus, cannot benefit from such services (Raffensperger, 2009; Westerhof et al., 2016). Many studies have argued that this is indeed not the case, and in fact, the IDD population can benefit from psychotherapy (Kanellakis, 2010; O'Hara, 2008; Parkes et al., 2007). Ultimately, counselors must first understand professional expectations and ethical responsibilities in order to gain appropriate competency and knowledge to work with individuals with IDD.

Expectations of Counselors

Across all professional counseling organizations (e.g., American Psychological Association, American Counseling Association, Council for Accreditation of Counseling and Related Educational Programs), multicultural competency is set as an expectation of ethical practice. For example, ACA Code of Ethics (2014) has identified the following codes and standards related to providing mental health services to individuals with disabilities:

> A.2.c. Developmental and Cultural Sensitivity: Counselors communicate information in ways that are both developmentally and culturally appropriate (p.4).

> A.4.b. Personal Values: Counselors are aware of – and avoid imposing – their own values, attitudes, beliefs, and behaviors (p. 5).
>
> C.5. Nondiscrimination: Counselors do not condone or engage in discrimination against prospective or current clients…based on…disability… or any basis proscribed by law (p. 9).

The American Rehabilitation Counseling Association (ARCA; a division of ACA) Task Force on Competencies for Counseling Persons with Disabilities identified the following competency standards for rehabilitation counselors:

> A.5 Understand that various forms of ignorance about or prejudice against disability tend to influence authorities and others to make discriminatory decisions, either conscious or unconscious, that limit opportunities for [persons with disabilities (PWDs)] within the social, familial, vocational, housing, and healthcare environments (pp. 2-3).
>
> A.7 Understand how prejudice and fear of disability are a part of the history and ingrained culture of many institutions and social practices and, therefore, continue to contribute to higher rates of disenfranchisement, abuse, and neglect of PWDs (p. 3).
>
> A.9 Examine their beliefs and assumptions about disability to reveal unintended, indirect, or subtle ways in which biases may influence counselor behavior and interpretations (e.g., immediately assuming that the disability is the presenting problem or the cause of it) (p. 3).
>
> A.13 Use professional development opportunities as needed to develop or enhance their attitudes, knowledge, and competencies specific to issues, preferences, and concerns of those with disabilities whom they serve as well as the disability community at large (p. 3).

CACREP (2015) has identified several standards that they believe to be appropriate and necessary for university counseling programs to meet when providing education to future counselors. The following areas of foundational knowledge have been identified by CACREP as areas that all counselor education graduates must obtain during their counselor licensing program:

> 2.F.2.a. multicultural and pluralistic characteristics within and among diverse groups nationally and internationally
>
> 2.F.2.c. multicultural counseling competencies
>
> 2.F.2.d. the impact of heritage, attitudes, beliefs, understandings, and acculturative experiences on an individual's views of others
>
> 2.F.2.h. strategies for identifying and eliminating barriers, prejudices, and processes of intentional and unintentional oppression and discrimination
>
> 2.F.3.h. a general framework for understanding differing abilities and strategies for differentiated interventions (CACREP, 2015, pp. 10-11)
>
> 5.D.2.p. environmental, attitudinal, and individual barriers for people with disabilities (CACREP, 2015, p. 26).

The American Psychological Association (APA) formed a task force (the American Psychological Association's Task Force on Guidelines for Assessment and Treatment of Persons with Disabilities, 2012) in order to evaluate the mental health needs of individuals with disabilities and best practices of mental health practitioners (specifically psychologist) (APA, 2012). The following are five of the 22 guidelines identified by the APA task force related to the topic of this proposed research:

> Guideline 1. [Mental health providers] strive to learn about various disability paradigms and models and their implications for service provision.
>
> Guideline 2. [Mental health providers] strive to examine their beliefs and emotional reactions toward various disabilities and determine how these might influence their work.
>
> Guideline 3. [Mental health providers] strive to increase their knowledge and skills about working with individuals with disabilities through training, supervision, education, and expert consultation.
>
> Guideline 5. [Mental health providers] strive to provide a barrier-free physical and communication environment in which clients with disabilities may access psychological services.
>
> Guideline 9. [Mental health providers] strive to learn how attitudes and misconceptions, the social environment, and the nature of a person's disability influence development across the life span (APA, 2012, p. 1).

As demonstrated by these standards, guidelines, and codes, these professional organizations recognize the importance of mental health providers being educated on the needs of individuals with disabilities (including those with IDD), providing services that are barrier-free, understanding how attitudes and beliefs impact individuals with disabilities, and examining their own attitudes and beliefs toward the population. The organizations attest to the importance of multicultural competence for treating individuals with disabilities.

Despite the recognized importance, it is still reported that counselors are not always willing to provide mental health services to individuals with IDD or assert that they do not know government policy for mental health services to be provided to people of any ability level (O'Brien & Rose, 2010; Rose, O'Brien, & Rose, 2007). Rose and colleagues (2007) reported that

mental health professionals make comments such as "…it's your personal choice if you want to work in that area…" in regard to working with the IDD population (p. 56). Further, research has repeatedly reported that mental health professionals do not feel competent or comfortable providing treatment and services to individuals with IDD (Dagnan et al., 2014; Hronis et al., 2018; Marwood et al., 2016; O'Brien & Rose, 2010). Multicultural competency requires that counselors must be aware that their perceptions of a client will affect intervention strategies and has the potential to promote or hinder the effectiveness of treatment (Baruth & Manning, 2016). To provide mental health services to individuals of different backgrounds and abilities without competence is unethical, potentially harmful, and a violation of human rights (Baruth & Manning, 2016; Brown & Pomerantz, 2011; Korman, 1974; Ridley & Kleiner, 2003; Sue et al., 1992).

Counselor Confidence

Counselor confidence has been recognized as a predictor of outcomes in therapy for many years (Dagnan et al., 2014; Heinonen et al., 2012; Jones, 2013; Orlinsky et al., 1994). Increasing interest in the area of counselor confidence has been a positive step toward improving the mental health treatment available for individuals with IDD but the downside has been the research results that are being presented. According to researchers, while professionals in the mental health field receive extensive training on mental health disorders and multicultural differences, rarely any training is received on disabilities or disability issues (American Psychological Association [APA], 2012; Olkin & Pledger, 2003; Rubino, 2001; Strike, Skovholt, & Hummel, 2004). Counselors have reported feeling ill-trained, a lack in confidence when faced with working with individuals with IDD, and uncertainty in how to adapt treatment approaches (Hronis et al., 2018; Dagnan et al., 2014; Marwood, Chinn, Gannon, & Scior, 2016). Counselors

have reported feeling as though they do not possess the ability to work with and treat the unique needs of individuals with IDD (Dagnan et al., 2015; Rose, O'Brien, & Rose, 2007).

While there is a growing body of research and attention being given to the mental health concerns of individuals with IDD, research remains limited regarding counselors' attitudes toward this population. In order to bring the treatment deserved by all humans to this population, additional research is absolutely necessary. Dagnan and colleagues (2014) stated, "It is only through ensuring that mainstream therapists are confident in working with people with lower ability that this client group will begin to obtain equitable access to therapy services" (p. 397).

Counselor confidence has been attributed to training and education received, experience, and comfort level in adapting tools and techniques. More recently, researchers are finding that there is some correlation between counselors' confidence and their experience with and exposure to individuals with IDD. Dagnan and colleagues (2014) completed a quantitative study on counselors' confidence in working with individuals with IDD; the results showed that there were significant differences in confidence based on the study participants' experience in working with the population. In another quantitative study, Hronis and colleagues (2018) examined 152 clinicians who had professional experience working with individuals with IDD. Study findings revealed that the increased professional experience accounted for the significant increase in confidence in providing mental health services to individuals with IDD (Hronis et al., 2018). A qualitative study with eight counseling psychologists found that the participants were able to identify how they form a therapeutic relationship, adapt tools, and choose techniques when working with individuals with IDD but, interestingly, every participant reported having experience and familiarity with individuals with IDD prior to becoming a psychologist (Jones, 2013). Jones (2013) stated, "Whilst for some there was a sense that it was an unintentional

decision to work in the field, for others it was clear that their early experiences and familiarity led to their interest" (p. 200). Moreover, in their research, Berry and Meyer (1995) found that individuals with disabilities are often avoided and excluded due to negative attitudes toward them.

Methodology-Based Literature Review

Throughout this review of literature, differing methodologies were found across studies. Research on attitudes and beliefs, contact, and mental health services has been conducted using quantitative methods of data collection through questionnaires, rating scales, and other survey-type means. Quantitative research on these topics has been helpful in determining the attitudes toward individuals with IDD held by specific populations, the extent of contact with individuals with IDD, and mental health services needed (Akrami et al., 2006; Araten-Bergman & Werner, 2017; Barr & Bracchitta, 2008; Cage et al., 2018; Edwards et al., 2007; Keith et al., 2015; Melville et al., 2005; Werner & Stawski, 2012). Also, many of these studies have provided items that were used to construct valid and reliable instruments, such as: Modern and Classical Attitudes Scales toward people with Intellectual Disabilities (Akrami et al., 2006), Attitudes to the Treatment of People with Intellectual Disabilities in Mainstream Services (Melville et al., 2005); and Therapy Confidence Scale – ID (Dagnan et al., 2014).

Although quantitative research was helpful, other studies on these topics have been conducted using qualitative and mixed methods of data collection. Qualitative research has been used to provide a more intimate look at the topic being studied and the social experience of population being examined. For example, Potvin and colleagues (2019) used qualitative means to better understand the attitudes of mothers with IDD. It was in that study with Potvin and colleagues (2019) that one young woman was describing negative attitudes she had encountered

by stating, “I didn’t need people’s negative thoughts” (p. 158). Researchers who have used this form of research have also used it in instrument development. For example, Gething and colleagues (1994) originally identified items for the Interaction with Disabled Persons Scale after reviewing open-ended responses from 633 participants.

Literature Informed Study

As will be discussed further in Chapter Three , the research question that has developed out of this literature review and will ultimately guide this study is, “What attitudes and biases do mental health counselors hold toward individuals with IDD and what (if any) impact do those attitudes and biases have on the therapeutic experience?” Individuals with IDD make up a large percentage of clientele with mental illness who could benefit from the services of counselors. Yet, a review of past and present attitudes and beliefs regarding the IDD population has shown that many health and helping professional fields (e.g., teachers, psychiatrists, social workers) continue to hold negative attitudes toward the group, which has negatively impacted services delivered by those professionals. Social psychologists have considered the impact of contact and exposure to out-groups for years. As previously reviewed, research has shown that contact itself does not change attitudes for the better but quality contact and relationships between in-group and out-group members can positively change attitudes. Research on professional groups (e.g., teachers) has shown that those who have more contact with students with IDD have more positive attitudes toward the out-group (Kennon & Sandoval, 1978; Stainback & Stainback, 1982). Yet, after this exhaustive review of literature, no study has been found that relates to counselors’ attitudes and beliefs toward individuals with IDD and the impact of contact on those attitudes. Furthermore, when counselors report more experience (i.e., contact) with individuals with IDD they also report increased confidence in working with the population (Dagnan et al.,

2014; Hronis et al., 2018), which ultimately impacts services delivered by the counselor to the individual with IDD.

Chapter Summary

It must be understood that counseling often reflects the values of the larger society through the counselor's worldview and values (Katz, 1085; Sue & Sue, 1990; Sue et al., 1992). It was reasoned that with the push for community integration of individuals with IDD, society and individuals would develop more positive attitudes towards the IDD population. Yet, research has shown mixed results of continued negative and developing positive attitudes. Counselors are not exempt from these attitudes and biases; Sue and colleagues (1992) stated, "counseling professionals need to recognize that counseling does not occur in isolation from larger events in our society" (p. 479). By becoming aware of and addressing attitudes and biases held by counselors and mental health professionals, the counseling profession can move toward inclusiveness, altruism, community, care, and justice (Sue et al., 1992).

While the argument can be made that additional training is necessary for counselors to increase their knowledge and competence in adapting treatment and providing services to individuals with IDD, this research strived to make the argument that prior to making plans for how to provide better education on competent service delivery to the IDD population to counselors, the field must first recognize the underlying biases and attitudes toward the IDD population held by counselors.

The purpose of this study was to examine the effects of counselor's attitudes and beliefs toward the IDD population on their own confidence and ability to provide treatment to the IDD population. Once it is determined if there is a relationship between counselor's beliefs and

attitudes, a more specific route of preparing counselors for working with this population can be examined.

CHAPTER THREE: METHODS

This chapter outlines the methods that were used in this study to examine the impact of counselors' attitudes and beliefs on their confidence in providing mental health services to individuals with intellectual and developmental disabilities (IDD). This chapter explores the rationale for the research approach chosen, the research setting and data source, data collection method, data analysis method, limitations and delimitations, and issues of trustworthiness.

Research Design

The guiding question for this research was, "What attitudes and biases do mental health counselors hold toward individuals with IDD and what (if any) impact do those attitudes and biases have on the therapeutic experience?" This question has been used to guide the development of the research questions in this study. This study used a quantitative, non-experimental, survey research design to address the identified research questions. As the above guiding question states, this research was designed to explore relationships between variables in which one of the variables (i.e., attitudes and biases) cannot be manipulated or randomly assigned to conditions. As can be seen below, the research hypotheses addressed the relationship between variables and were analyzed through a correlational assessment.

This research design involved the collection of data from participants utilizing the instruments discussed later in this chapter. An online survey was used for participants to answer a variety of questions related to their attitudes and beliefs toward people with IDD, their contact with individuals with IDD, and the counseling services they have provided to individuals with IDD. This study strived to determine if there is a correlation between counselors' contact with individuals with IDD and their attitudes/beliefs toward the population as well as if there is a correlation between counselors' attitudes/beliefs toward the population and counselors'

confidence in providing mental health services to individuals with IDD. Also, this study attempted to identify the differences (if any) between counselors who reported more contact with individuals with IDD and counselors who reported less contact with individuals with IDD.

Research Questions and Hypotheses

Research Question #1

What attitudes/beliefs do counselors hold regarding individuals with IDD?

H_1. Counselors hold statistically significant negative attitude/biases toward the IDD population.

H_{01}. Counselors will not hold statistically significant negative attitudes/biases from the general population and other professionals toward the IDD population.

Research Question #2

Do the attitudes/beliefs that counselors hold about people with IDD have an effect on their perception of counseling treatment for individuals with IDD?

H_2. Counselors' attitudes/beliefs have an effect on counselors' perception of treatment outcomes and counseling effectiveness for individuals with IDD.

H_{02}. There is no statistically significant relationship between attitudes/beliefs toward the IDD population and perception of treatment outcomes and counseling effectiveness for individuals with IDD.

Research Question #3

Do attitudes/beliefs predict counselors' confidence in working with individuals with IDD?

H_3. Counselors' attitudes/beliefs influence counselors' confidence in providing counseling services to individuals with IDD.

H_{03}. There is no statistically significant relationship between counselors' attitudes/beliefs toward the IDD population and counselors' confidence in providing counseling services to individuals with IDD.

Research Question #4

Do counselors' perception of counseling effectiveness/treatment outcomes predict counselors' confidence in working with individuals with IDD?

H_4. Counselors' perception of counseling effectiveness/treatment outcomes have an effect on counselors' confidence in providing counseling services to individuals with IDD.

H_{04}. There is no statistically significant relationship between counselors' perception of counseling effectiveness/treatment outcomes and counselors' confidence in providing counseling services to individuals with IDD.

Research Question #5

Does exposure to individuals with IDD predict counselors' attitudes/beliefs?

H_5. Personal exposure to individuals with IDD has an effect on counselors' attitudes/beliefs toward individuals with IDD.

H_{05}. There is no statistically significant relationship between personal exposure and counselors' attitudes/beliefs toward individuals with IDD.

H_6. Professional exposure to individuals with IDD has an effect on counselors' attitudes/beliefs toward individuals with IDD.

H_{06}. There is no statistically significant relationship between professional exposure and counselors' attitudes/beliefs toward individuals with IDD.

Research Question #6

Does exposure to individuals with IDD predict counselors' confidence?

H_7. Personal exposure to individuals with IDD has an effect on counselors' confidence in providing counseling services to individuals with IDD.

H_{07}. There is no statistically significant relationship between personal exposure and counselors' confidence in providing counseling services to individuals with IDD.

H_8. Professional exposure to individuals with IDD has an effect on counselors' confidence in providing counseling services to individuals with IDD.

H_{08}. There is no statistically significant relationship between professional exposure and counselors' confidence in providing counseling services to individuals with IDD.

Research Question #7

Does exposure to individuals with IDD predict counselors' perception of counseling effectiveness/treatment outcomes?

H_9. Personal exposure to individuals with IDD has an effect on counselors' perception of counseling effectiveness/treatment outcomes for individuals with IDD.

H_{09}. There is no statistically significant relationship between personal exposure and counselors' perception of counseling effectiveness/treatment outcomes for individuals with IDD.

H_{10}. Professional exposure to individuals with IDD has an effect on counselors' perception of counseling effectiveness/treatment outcomes for individuals with IDD.

H_{010}. There is no statistically significant relationship between professional exposure and counselors' perception of counseling effectiveness/treatment outcomes for individuals with IDD.

Research Question #8

Does exposure to individuals with IDD moderate the relationship between counselors' attitudes and confidence.

H_{11}. Exposure to individuals with IDD has an effect on the relationship between counselors' attitudes/beliefs and counselors' confidence in providing services to individuals with IDD.

H_{011}. There is no statistically significant effect on the relationship between exposure and counselors' attitudes/beliefs and counselors' confidence in providing services to individuals with IDD.

Research Variables

Independent Variables

Out of the research questions listed above, several independent variables were identified: counselors' attitudes toward individuals with IDD, counselors' exposure to the IDD population, and counselors' perception of treatment outcomes and counseling effectiveness with individuals with IDD. Counselors' attitudes toward individuals with IDD was measured by the *Modern and Classical Attitudes Scale Toward People with Intellectual Disabilities* (Akrami et al., 2006), *Community Living Attitudes Scale – Intellectual Disability* (CLAS-ID; Henry, Keys, & Jopp, 1999), and *Attitudes towards Disabled Persons Scale – Form B* (ATDP; Yuker, Block, & Younng, 1970). Counselor's treatment outcome expectation was measured by *Attitudes to the Treatment of People with Intellectual Disabilities in Mainstream Services* (Melville et al., 2005) and *Therapist Expectancy Inventory – Factor II* (TEI; Bernstein, Lecomte, & Des Harnais, 1983).

Counselor's exposure to IDD population was divided into two domains, personal exposure and professional exposure. Personal exposure was examined through demographic questions regarding family and friend relationships the participant has had with individuals with IDD (see Appendix A). Professional exposure was also measured through general questions

regarding contact with individuals with IDD through the participant's education and/or employment experiences (see Appendix A). Counselor's perception of and attitudes toward his/her interactions with individuals with IDD was measured by *Interaction with Disabled Persons Scale* (IDP; Gething, 1994).

Dependent Variable

A single dependent variable was examined in this study. Counselors' confidence in providing therapy to individuals with IDD was measured by the *Therapy Confidence Scale – Intellectual Disabilities* (TCS-ID; Dagnan et al., 2014).

Procedures

An application for permission for this study to be completed was submitted to the Liberty University Institutional Review Board (IRB). A copy of the IRB approval letter is included in Appendix B.

Participants were presented with an informed consent page which provides additional information on the study and participants were given the opportunity to agree to participate or not. If participants agreed to participate, they were directed to begin the survey. Participants were able to complete the survey wherever and whenever they chose within the three-week timeframe the survey was available. Participants were also given the choice to drop out of the survey at any time by closing their browser window. Incomplete surveys and partial data sources were eliminated during analysis.

Participants

Licensed counselors were recruited to participate in completing the study survey. An invitation to participate in the survey were issued to counselors through the American Counseling Association (ACA) Connect "Call for Participants" forum, COUNSGRAD listserv,

the Ohio Counseling Association (OCA) listserv, CESNET listserv, and Liberty University students and faculty. The researcher was not present when surveys were completed, as survey invitations were distributed to participants via listserv and email and completed on the participants' own time.

Inclusion Criteria

Participants were asked to indicate on the survey if they hold a current counseling license (e.g., LPC, LPCC, Counselor Resident) in order for their data to be included in the final analysis. Additionally, participants had to be at least 18-years-old to participate.

Exclusion Criteria

Participants who completed the survey but did not hold a current state counselor license were excluded from analysis due to this study specifically utilizing licensed counselors. Participants who do not complete the survey were also excluded from analysis.

Recruitment

An invitation to participate in this study was sent to potential participants through the American Counseling Association (ACA) Connect "Call for Participants" forum, COUNSGRAD listserv, the Ohio Counseling Association (OCA) listserv, CESNET listserv, and Liberty University students and faculty. With the invitation, survey information, and a survey link were provided to potential participants. The invitation briefly described the study and the approximate length of the survey. Participation in this study was completely voluntary; members of these professional groups were given the option of completing the survey or not. It was estimated that it would take participants 15- to 20-minutes to complete the survey.

Instrumentation

The research study conducted in this writing used a quantitative research design and methods. This study used multiple questionnaires assembled into one document to explore each of the variables identified. In addition to the instruments assessing confidence, knowledge, and attitudes/biases, this study sought to gather information regarding the participants' experiences (personal and professional) with individuals with IDD and training specific to IDD. These questions were part of the demographic (see Appendix C) and experience questionnaires (see Appendix A). The demographic survey was included in the questionnaire in order to gather data on age, experience/training, licensure, gender, and race.

Demographic and Experience Questionnaire

Questions used in this section were based on survey questions from previous research (Barr & Bracchitta, 2008; Gething, 1994; Plant & Devine, 2003) but whole measures were not used from those studies in order to only use items applicable to this study. Questions were presented on a 2-point dichotomous scale (Yes/No and True/False), a 5-point Likert scale (e.g., 1- strongly disagree to 5-strongly agree), or a 7-point Likert scale (e.g., 1- completely disagree to 7-completely agree) depending on the nature of the item.

Therapy Confidence Scale – Intellectual Disabilities

The *Therapy Confidence Scale – Intellectual Disabilities* (TCS-ID; Dagnan et al., 2014) was created to assess the confidence of counselors working with individuals with IDD. The TCS-ID is composed of 14 items answered on a 5-point Likert scale ranging from *not confident* to *highly confident*. Dagnan and colleagues (2014) found the Cronbach's alpha for the scale to be 0.93 and the test-retest reliability to be 0.83. The measure was adapted for this study by replacing

the term “learning disability” that appears in the original measure with “intellectual/developmental disability” or “IDD.”

Attitudes to the Treatment of People with Intellectual Disabilities in Mainstream Services

The *Attitudes to the Treatment of People with Intellectual Disabilities in Mainstream Services* was created to measure the attitudes, knowledge, training, and self-efficacy of practice nurses’ working with individuals with IDD (Melville et al., 2005). The entire survey was not used for this research but instead only the portion investigating attitudes of practice nurses toward people with IDD; this portion of the survey was composed of seven questions answered on a 5-point Likert scale. These survey items were not originally reported as a single scale. In the original study by Melville and colleagues (2005), participants were nurses, so for this research the survey items were adapted to address counselors. For example, one original item stated, “[Intellectual Disability] nurses should have the main role in meeting the nursing needs of people with ID” (Melville et al., 2005, p. 195). For the purpose of this research, employment/vocation information was adapted to reflect that of counselors, thus that same item would say, “Counselors should have the main role in meeting the mental health needs of people with ID.” Dagnan and colleagues (2017) used five of the questions from Melville and colleagues (2005) in a study of therapist’s attitudes toward individuals with IDD and found a pre-training/pre-research sample of 66 people to have a Cronbach’s Alpha of 0.69.

Therapist Expectancy Inventory – Factor II

The *Therapist Expectancy Inventory – Factor II* (TEI) was created to measure the diagnostic, prognostic, and process expectancies of clinical psychologists, clinical social workers, and counselors (Bernstein, Lecomte, & Des Harnais, 1983). The entire measure was not used for this research but instead only the portion examining the “Expectancies of Outcome for

Client" also known as *Factor II* in the measure was used (Bernstein et al., 1983, p. 485). *TEI-Factor II* is composed of nine items addressing the therapists' perception of treatment expectancies for clients. The original study in developing this measure placed half of the items on a Likert scale ranging from 1 to 8 and the other half of the items on a scale ranging from 1 to 99 (where 1 represented "not at all expect," 50 represented "moderately expect," and 90 represented "greatly expect) (Bernstein et al., 1983, p. 480). In a later study, using this measure, Katz and Hoyt (2014), assessed counselors' anticipated client outcome by placing items from this measure on a 7-point Likert scale (1- strongly disagree to 7- strongly agree). While Bernstein and colleagues (1983) reported an internal consistency of $\alpha = .67$, Katz and Hoyt (2014) reported an α ranging from .94 to .95. For the purpose of this study and in trying to bring some consistency to Likert scales used between measures, this measure was responded to on a 7-point Likert scale ranging from *strongly disagree* to *strongly agree*. Also, for the purpose of this study, participants were asked to think specifically about working with clients with IDD and base their responses to the items on working with that specific population.

Interaction with Disabled Persons Scale

The *Interaction with Disabled Persons Scale* (IDP) was created to measure discomfort caused by social interaction with people with disabilities in Australia (Gething, 1994). This measure theorizes that personal attitudes are formed from lack of interaction with and lack of information about the subject. The IDP is composed of 18 items answered using a 5-point Likert scale (from *strongly agree* to *strongly disagree*). An internal consistency was assessed using Cronbach's alpha and reported to be between .74 and .86, indicating a satisfactory level of consistency (Gething, 1994). Gething (1994) reported that measures similar to the IDP reported

similar consistency ratings (ranging from .47 for the *Disability Factor Scale* to .87 for the *Scale of Attitudes Toward Disabled Persons*).

Community Living Attitudes Scale – Intellectual Disability

The *Community Living Attitudes Scale – Intellectual Disability* (CLAS-ID) is a measure consisting of four subscales (i.e., Empowerment, Exclusion, Sheltering, and Similarity) that explore attitudes about people with IDD (Henry et al., 1996). For the purpose of this research, only the Similarity subscale was used. The Similarity subscale is comprised of 12 items asking participants to "indicate the extent to which you agree or disagree with the following statements" on a 6-point scale ranging from *strongly disagree* to *strongly agree* (Henry et al., 1996, p. 151). The measure was originally developed using a sample of staff members from community agencies and later tested for internal consistency, test-retest reliability, and construct validity with college students and community members (Henry et al., 1996). The internal consistency (Cronbach's alpha) of the Similarity subscale was shown to be acceptable ($\alpha = .84$) and having a retest reliability of .75 (Henry et al., 1996). The measure was originally named the *Community Living Attitudes Scale – Mental Retardation* but has since been updated to current, positive language about the IDD community; the updated version will be used for this study (Henry et al., 1996). For consistency within the survey for this study, an additional point (the mid-point) was added to the response selection, making it a 7-point Likert scale (from *strongly disagree* to *strongly agree).*

Attitudes towards Disabled Persons Scale – Form B

The *Attitudes toward Disabled Persons Scale – Form B* (ATDP – Form B) is composed of items assessing attitudes toward individuals with disabilities as a group and specifically looks at emotions often attributed to the population (e.g., "have a chip on their shoulder," "less

aggressive," "do not worry") (Yuker et al., 1970). There are 30 items in this measure and participants are asked to indicate their response using a 7-point Likert scale; the original study completed by Yuker and colleagues (1970) a range from +3 (*I agree very much*) to -3 (*I disagree very much*) was used. Yuker and colleagues (1970) reported test-retest reliability to be .71 and .83 for this measure. For the purpose of consistency in this study, responses were presented using a 7-point Likert scale but without the numerical values. Also, the term "disabled persons" was replaced with "individuals with intellectual/developmental disabilities" or "individuals with IDD."

Modern and Classical Attitudes Scale toward People with Intellectual Disabilities

The *Modern and Classical Attitudes Scale toward People with Intellectual Disabilities* was developed to investigate the classical and modern prejudice toward individuals with disabilities (Akrami et al., 2006). Classical attitudes are identified to be more "overt and blatant" whereas modern attitudes and biases are more "subtle and covert" (Akrami et al., 2006). This scale is made up of 19 items (8 items examine classical attitudes and 11 items examine modern attitudes). In the study that developed this scale, Akrami and colleagues (2006) conducted two rounds of sampling where the measure was originally responded to using a 4-point scale with no mid-point and later in the second sample, it was presented using a 5-point Likert scale ranging from *strongly disagree* to *strongly agree*. In the first study, internal consistency reliability was satisfactory for the modern attitudes scale ($\alpha = .71$) and low for the classical attitudes scale ($\alpha = .63$). In the second study, while Cronbach alpha remained lower for the classical attitudes scale it did improve ($\alpha = .68$) as did the Cronbach alpha for the modern attitudes scale ($\alpha = .82$) (Akrami et al., 2006). For the purpose of consistency within this survey, items from this measure were responded to using a 5-point Likert scale (from *strongly disagree* to *strongly agree*) and the

measure's wording of "intellectual disabilities" was replaced with "intellectual/developmental disabilities" or "IDD."

Marlowe-Crowne Social Desirability Scale

For this study, a social desirability measure was included in the assembled survey. Due to this study being a self-report survey, it would not be uncommon for participants to respond to items in a way that is viewed as socially acceptable or favorable (Lambert, Arbuckle, & Holden, 2016). While many measures have been developed over the years and report strong validity and reliability (e.g., Balanced Inventory of Desirable Responding by Paulhus (1998)), the Marlowe-Crowne Social Desirability Scale (MCSDS; Crowne & Marlowe, 1960) continues to be widely used and highly effective in research (Lambert et al., 2016).

The MCSDS was developed to examine and identify research participants who have attempted to "fake good" or "fake bad" when responding to research items. The MCSDS is a 33-item, true-false measure that seeks to identify if participants are attempting to respond to items in a way that presents the participant as unrealistically favorable. In a study, that used undergraduate students as a sample, internal reliability of the MCSDS was high ($\alpha = .88$) (Crowne & Marlowe, 1960).

Statistical Analysis

Research Question 1

This research question is specifically examining the average scores of counselors' attitudes/beliefs toward individuals with IDD. For the statistical analysis of this set of hypotheses (H_1 and H_{01}), the mean and variability (i.e., standard deviation) were calculated.

Research Questions 2, 3, 4, 5, 6, and 7

The set of hypotheses in Research Question 2 (H_2 and H_{02}) is investigating the relationship between the independent variable (counselors' attitudes and beliefs) and the dependent variable (counselors' perception of treatment outcomes and counseling effectiveness), thus a Pearson product-moment correlation (*r*) was used to measure correlation. This correlation coefficient indicates the degree to which the two variables are related and provided information regarding the direction and magnitude of the relationships between counselors' attitudes/beliefs and counselors' perception of treatment/counseling effectiveness. Scores can range from -1.0 to +1.0 with the inverse/indirect (-) and direct (+) indicating the direction of the relationship. Scores closer to -1.0 and +1.0 indicate a stronger relationship while scores closer to zero (0) indicate weaker correlations.

Research Question 3's set of hypotheses (H_3 and H_{03}) were examined in the same manner with the independent variable being counselors' attitudes and beliefs and the dependent variable being counselors' confidence in providing counseling services to individuals with IDD. Research Question 4's set of hypotheses (H_4 and H_{04}) were examined in the same manner with the independent variable being counselors' perception of counseling effectiveness/treatment outcome and the dependent variable being counselors' confidence. Research Questions 5, 6, and 7 were examined in the same manner as described above.

Correlation values range from -1.0 to +1.0. A correlation value of +/- .70 is considered to be a strong correlation and a value of +/- .50 is considered to be statistically significant.

Research Question 8

In order to examine the effect exposure/contact has on the relationship between attitudes and confidence, a regression analysis was utilized. In this hypothesis, counselors' attitude is set

as the predictor variable, counselors' confidence is the outcome variable, and personal/professional exposure is the moderator variable. The regression analysis was conducted through a moderation model allowing the effect of the moderator variable on the relationship between attitudes and confidence to be measured. If the interaction between the independent variable and the moderator variable is not found to be statistically significant, then the moderator does not have a moderating effect and instead is an independent variable. If the interaction is statistically significant, then moderation is supported.

Ethical Considerations

In adhering to ethical research standards, permission to conduct this research was sought out through the Liberty University IRB. An informed consent statement (see Appendix D) was included at the beginning of the survey as an additional ethical protective measure; participants were required to give consent prior to continuing with the survey. No identifying information from participants was gathered in this study. Participants were given the option to withdraw from the survey at any time during the study by simply closing their browser. Once completed, surveys have been stored on the researcher's password-protected computer and only the researcher and her dissertation chair have access to the data. There were minor anticipated risks for participants of this study. The anticipated risks that participants may encounter were the same minor discomforts that would be encountered in daily life such as minor agitation or stress. No risks anticipated in this study were expected to present a risk to the participant's mental or physical safety or well-being.

Chapter Summary

This research study sought to examine the relationships among counselors' attitudes toward individuals with IDD, counselors' exposure to the population, counselors' perception of

treatment effectiveness, and counselors' confidence in working with individuals with IDD. Eight research questions and the corresponding eleven hypotheses were identified. In order to investigate these hypotheses, several measures were assembled into a single, online survey in order to be sent to potential participants and completed within the identified timeframe. The identified statistical analyses that were used include mean, variability, Pearson product-moment correlation, and regression analysis.

CHAPTER FOUR: RESULTS

Multicultural competency is imperative in the counseling field. As such, it is important that counselors are aware of their attitudes, biases, stigmatizations, and reactions to different cultures and people groups. In order to better understand counselors' attitudes and beliefs towards individuals with intellectual and developmental disabilities (IDD), this present study sought to gather information regarding counselors' attitudes toward individuals with IDD and their confidence related to providing services toward individuals with IDD. This chapter presents participant demographics, survey results, and statistical analyses conducted.

Research Questions and Hypotheses

This quantitative study sought to answer the following research questions and address the following hypotheses:

Research Question 1

What attitudes/beliefs do counselors hold regarding individuals with IDD?

H_1. Counselors hold statistically significant negative attitude/biases toward the IDD population.

H_{01}. Counselors will not hold statistically significant negative attitudes/biases from the general population and other professionals toward the IDD population.

Research Question 2

Do the attitudes/beliefs that counselors hold about people with IDD have an effect on their perception of counseling treatment for individuals with IDD?

H_2. Counselors' attitudes/beliefs have an effect on counselors' perception of treatment outcomes and counseling effectiveness for individuals with IDD.

H_{02}. There is no statistically significant relationship between attitudes/beliefs toward the IDD population and perception of treatment outcomes and counseling effectiveness for individuals with IDD.

Research Question 3

Do attitudes/beliefs predict counselors' confidence in working with individuals with IDD?

H_3. Counselors' attitudes/beliefs influence counselors' confidence in providing counseling services to individuals with IDD.

H_{03}. There is no statistically significant relationship between counselors' attitudes/beliefs toward the IDD population and counselors' confidence in providing counseling services to individuals with IDD.

Research Question 4

Do counselors' perception of counseling effectiveness/treatment outcomes predict counselors' confidence in working with individuals with IDD?

H_4. Counselors' perception of counseling effectiveness/treatment outcomes have an effect on counselors' confidence in providing counseling services to individuals with IDD.

H_{04}. There is no statistically significant relationship between counselors' perception of counseling effectiveness/treatment outcomes and counselors' confidence in providing counseling services to individuals with IDD.

Research Question 5

Does exposure to individuals with IDD predict counselors' attitudes/beliefs?

H_5. Personal exposure to individuals with IDD has an effect on counselors' attitudes/beliefs toward individuals with IDD.

H_{05}. There is no statistically significant relationship between personal exposure and counselors' attitudes/beliefs toward individuals with IDD.

H_{6}. Professional exposure to individuals with IDD has an effect on counselors' attitudes/beliefs toward individuals with IDD.

H_{06}. There is no statistically significant relationship between professional exposure and counselors' attitudes/beliefs toward individuals with IDD.

Research Question 6

Does exposure to individuals with IDD predict counselors' confidence?

H_{7}. Personal exposure to individuals with IDD has an effect on counselors' confidence in providing counseling services to individuals with IDD.

H_{07}. There is no statistically significant relationship between personal exposure and counselors' confidence in providing counseling services to individuals with IDD.

H_{8}. Professional exposure to individuals with IDD has an effect on counselors' confidence in providing counseling services to individuals with IDD.

H_{08}. There is no statistically significant relationship between professional exposure and counselors' confidence in providing counseling services to individuals with IDD.

Research Question 7

Does exposure to individuals with IDD predict counselors' perception of counseling effectiveness/treatment outcomes?

H_{9}. Personal exposure to individuals with IDD has an effect on counselors' perception of counseling effectiveness/treatment outcomes for individuals with IDD.

H_{09}. There is no statistically significant relationship between personal exposure and counselors' perception of counseling effectiveness/treatment outcomes for individuals with IDD.

H_{10}. Professional exposure to individuals with IDD has an effect on counselors' perception of counseling effectiveness/treatment outcomes for individuals with IDD.

H_{010}. There is no statistically significant relationship between professional exposure and counselors' perception of counseling effectiveness/treatment outcomes for individuals with IDD.

Research Question 8

Does exposure to individuals with IDD moderate the relationship between counselors' attitudes and confidence?

H_{11}. Exposure to individuals with IDD has an effect on the relationship between counselors' attitudes/beliefs and counselors' confidence in providing services to individuals with IDD.

H_{011}. There is no statistically significant effect on the relationship between counselors' attitudes/beliefs and counselors' confidence in providing services to individuals with IDD.

Summary of Participants

For this study, participants were recruited through an invitation to participate through the American Counseling Association (ACA) Connect "Call for Participants" forum, COUNSGRAD listserv, the Ohio Counseling Association (OCA) listserv, CESNET listserv, and Liberty University students and faculty. Through these outlets, 106 participants responded and agreed to participate in the study.

Inclusion Criteria

Participants had to hold a current counseling license. Nine participants were disqualified from participating due to not having a current license; this dropped the number of respondents from 106 to 97. The other inclusion criterion was that participants had to be at least 18-years-old and no participants were excluded from the survey based on this criterion. Four participants'

responses were excluded from data analysis due to reporting only being licensed in the field of social work. Lastly, 19 participants' responses were excluded from data analysis due to not completing the survey. The remaining 74 participant responses were used in the following data analysis. Four participants did not complete the Marlowe-Crowne Social Desirability Scale; their responses were excluded from data analysis to determine social desirability but were included for all other data analysis.

Participant Demographics

Participants were asked to indicate their age range, gender, and race/ethnicity as part of the demographic part of the survey (see Table 4.1). Majority of the participants reported being female (75.67%, *n* = 56), White or Caucasian (77.03%, *n* = 57), and falling in the age range of 45- to 54-years-old (39.19%, *n* = 29).

Participants were also asked professional demographic questions such as highest level of education, current licenses (i.e., type and state), length of practice, and setting in which he/she practices. Majority of participants reported having a master's degree (64.86%, *n* = 48) and the remaining participants reported having a doctorate degree (35.14%, *n* = 26). License type, states in which participants were licensed, and years practicing under current license were varied; Table 4.2 presents information on license type and years practicing with current license. Participants were also distributed across a variety of practice settings including private individual practice (28.38%, *n* = 21), private group practice (16.22%, *n* = 12), community mental health agency (18.92%, *n* = 14), and a variety of other settings.

Table 4.1
Age Range, Gender, and Race/Ethnicity of Participants

Demographic	Frequency	Percentage
Age Range		
18-24y/o	0	0.00
25-34y/o	15	20.27
35-44y/o	15	20.27
45-54y/o	29	39.19
55-64y/o	10	13.51
65-74y/o	3	4.05
75+y/o	2	2.70
Total	*N* = 74	100.00
Gender		
Male	18	24.32
Female	56	75.67
Total	*N* = 74	100.00
Race/Ethnicity		
White/Caucasian	57	77.03
Hispanic, Latino, or Spanish	2	2.70
Black or African American	9	12.16
Asian or Asian Indian	1	1.35
American Indian or Alaska Native	1	1.35
Middle Eastern or North African	0	0.00
Native Hawaiian or Other Pacific Islander	1	1.35
Other (Please specify)	3 (all specified as two or more races)	4.05
Total	*N* = 74	100.00

Table 4.2
License Type, State of License, and Years Practicing with Current License

Demographic	Frequency	Percentage
License Type		
Licensed Professional Counselor (LPC)/ Licensed Mental Health Counselor (LMHC)	56	75.67
Licensed Professional Clinical Counselor (LPCC)	5	6.75
Marriage and Family Therapist (MFT)	1	1.35
Licensed Marriage and Family Therapist (LMFT)	1	1.35
Other (responses ranged from counselor-in-training to multiple licensure to substance use counselor to school counselor)	11	14.86
Total	*N* = 74	100.00
Years Practicing with Current License		
0-4 years	30	40.54
5-9 years	25	33.78
10-14 years	9	12.16
15-20 years	4	5.41
21-30 years	5	6.75
31-40 years	1	1.35
41+ years	0	0.00
Total	*N* = 74	100.00

Experience with IDD

Information regarding personal experience with IDD was also gathered. Participants were asked to indicate whether they identified as having a disability (20.27%, *n* = 15) or identified as not having a disability (79.73%, *n* = 59). Participants were asked to indicate whether they identified as having an IDD (135.00%, *n* = 1) or identified as not having an IDD (98.65%, *n* = 73). Participants were also asked to indicate if they had a personal relationship with an individual with IDD and the nature of that relationship (Table 4.3). All participants were then asked to answer the following prompt using a 5-point Likert scale (1-very positive to 5-very negative), "I would classify my personal experience(s) with individuals with IDD as being?" Results ranged from neutral (16.22%, *n* = 12) to positive (47.30%, *n* = 35) to very positive (36.49%, *n* = 27).

Table 4.3
Personal Relationships with Individuals with IDD

Type of Relationship	Frequency	Percentage
Immediate or Extended Family Member	28	29.79
Friend	18	19.15
Neighbor	10	10.64
Not applicable	28	29.79
Other (responses mainly indicated current and previous clients and church relationships)	10	10.64
Total	*N* = 74 (94*)	100.01

* Participants were allowed to select more than one option in response to item.

Information regarding participant's professional experience with IDD was also gathered. Participants were asked to indicate if they had specific in-classroom training regarding working with clients with IDD during graduate training (22.97%, *n* = 17) or not (77.03%, *n* = 57). Participants were asked to indicate if they had specific on-site training on working with clients with IDD during their graduate practicum/internship experience (27.03%, *n* = 20) or not (72.97%, *n* = 54). Participants were asked to indicate if during their graduate practicum/internship they worked with clients with IDD (45.95%, *n* = 34) or not (54.05%, *n* = 40). Participants were asked to indicate if they have ever had a paid position in which they worked with a person with IDD (54.05%, *n* = 40) or if they have not had a paid position working with a person with IDD (45.95%, *n* = 34). Participants were asked to indicate if they have ever volunteered with a person with IDD (39.19%, *n* = 29) or if they have never volunteered with a person with IDD (60.81%, *n* = 45). Participants were then asked to answer the following prompt using a 5-point Likert scale (1-very positive to 5-very negative), "I would classify my professional experience(s) with individuals with IDD as being?" Results ranged from negative (1.35%, *n* = 1) to neutral (21.62%, *n* = 16) to positive (45.95%, *n* = 34) to very positive (31.08%, *n* = 23).

Survey Results and Data Analysis

Research Question 1

Research question 1 asks, "What attitudes/beliefs do counselors hold regarding individuals with IDD?" and hypothesis 1 states, "Counselors hold statistically significant negative attitude/biases toward the IDD population." Due to the vast variety of instruments available that measure attitudes toward individuals with IDD, this researcher chose to use three different instruments in order to diversify the types of questions being responded to by participants. The three instruments chosen to measure attitudes toward individuals with IDD were *Modern and Classical Attitudes Scale toward People with Intellectual Disabilities* (divided into two separate scales – modern and classical; Akrami et al., 2006), *Community Living Attitudes Scale – Intellectual Disability* (CLAS-ID; Henry et al., 1996), and *Attitudes towards Disabled Persons Scale – Form B* (ATDP; Yuker et al., 1970). The mean and standard deviation of three instruments were calculated (Table 4.4).

The total score for the modern scale in the *Modern and Classical Attitudes Scale toward People with Intellectual Disabilities* was calculated with score possibilities ranging from 11 to 55. The lower the total score, the more negative the attitude toward individuals with IDD. The total score for the classical scale in the *Modern and Classical Attitudes Scale toward People with Intellectual Disabilities* was calculated with score possibilities ranging from 8 to 40. The lower the total score, the more negative the attitude toward individuals with IDD. Total scores for CLAS-ID were calculated with score possibilities ranging from 12 to 84. In this instrument, the lower the score the more positive the attitude toward individuals with IDD presented. Total scores for ATDP were calculated with score possibilities ranging from 30 to 210. The lower the score the more negative the response. The results indicate that while participants seem to hold

relatively positive attitudes toward individuals with IDD, CLAS-ID and ATDP indicate that attitudes may be closer to neutral or low positive.

Table 4.4
Mean and Standard Deviation of Three Instruments Measuring Counselors' Attitudes toward Individuals with IDD

Instrument	N	Mean	Standard Deviation
Modern and Classical Attitudes Scale toward People with Intellectual Disabilities (Akrami et al., 2006), modern scale only	72	45.97	5.12
Modern and Classical Attitudes Scale toward People with Intellectual Disabilities (Akrami et al., 2006), classical scale only	74	32.82	4.22
Community Living Attitudes Scale – Intellectual Disability (CLAS-ID; Henry et al., 1996)	73	27.53	6.67
Attitudes towards Disabled Persons Scale (ATDP) – Form B (Yuker et al., 1970)	73	143.84	16.94

Research Question 2

Research question 2 asks, "Do the attitudes/beliefs that counselors hold about people with IDD have an effect on their perception of counseling treatment for individuals with IDD?" and hypothesis 2 states, "Counselors' attitudes/beliefs have an effect on counselors' perception of treatment outcomes and counseling effectiveness for individuals with IDD." In order to explore the relationship between the independent variable (counselors' attitudes and beliefs) in this hypothesis and the dependent variable (counselors' perception of treatment outcomes and counseling effectiveness), a Pearson product-moment correlation (*r*) was utilized (Table 4.5).

Table 4.5
Hypothesis 2 – Pearson Product Moment Correlations

	Attitudes to the Treatment of People with Intellectual Disabilities in Mainstream Services		TEI	
	r	*p*	*r*	*p*
Modern and Classical Attitudes Scale toward People with Intellectual Disabilities, modern scale only	-.35	.00	-.22	.06
Modern and Classical Attitudes Scale toward People with Intellectual Disabilities, classical scale only	-.41	.00	-.19	.09
CLAS-ID	.46	.00	.27	.01
ATDP	-.41	.00	-.16	.17

Three instruments (*Modern and Classical Attitudes Scale toward People with Intellectual Disabilities,* CLAS-ID, and ATDP) are used to measure the independent variable. To measure the dependent variable, two instruments (*Attitudes to the Treatment of People with Intellectual Disabilities in Mainstream Services* (Melville et al., 2005) and *Therapist Expectancy Inventory* (TEI; Bernstein et al., 1983)) were used. *Attitudes to the Treatment of People with Intellectual Disabilities in Mainstream Services* was not originally developed as a scale but instead individual items to measure respondent attitudes toward providing services. For this research, a total score of items was calculated and used to measure correlation. The total score was calculated by reverse coding items which were written in a negative way (i.e., items 1 and 2). Lower total scores indicate a more positive attitude toward providing services to individuals with IDD. Lower TEI total scores indicate a more positive view of effectiveness of counseling services for individuals with IDD.

A statistically significant negative correlation was found at the *p*=0.01 level between the *Modern and Classical Attitudes Scale toward People with Intellectual Disabilities* (classical scale) and *Attitudes to the Treatment of People with Intellectual Disabilities in Mainstream Services.* The data shows that as scores on the *Modern and Classical Attitudes Scale toward People with Intellectual Disabilities* (classical scale) decrease (indicating more negative attitudes toward individuals with IDD) the scores on *Attitudes to the Treatment of People with Intellectual Disabilities in Mainstream Services* increased (indicating more negative attitudes toward providing services to individuals with IDD) (*r*=-.41, *p*=.00).

A statistically significant negative correlation was found at the *p*=0.01 level between the *Modern and Classical Attitudes Scale toward People with Intellectual Disabilities* (modern scale) and *Attitudes to the Treatment of People with Intellectual Disabilities in Mainstream Services.* The data shows that as scores on the *Modern and Classical Attitudes Scale toward People with Intellectual Disabilities* (modern scale) decrease (indicating more negative attitudes toward individuals with IDD) the scores on *Attitudes to the Treatment of People with Intellectual Disabilities in Mainstream Services* increased (indicating more negative attitudes toward providing services to individuals with IDD) (*r*=-.35, *p*=.00).

A statistically significant positive correlation was found at the *p*=0.01 level between the CLAS-ID and *Attitudes to the Treatment of People with Intellectual Disabilities in Mainstream Services.* The data shows that as scores on the CLAS - ID increase (indicating more negative attitudes toward individuals with IDD) the scores on *Attitudes to the Treatment of People with Intellectual Disabilities in Mainstream Services* also increase (indicating more negative attitudes toward providing services to individuals with IDD) (*r*= .46, *p*=.00).

A statistically significant positive correlation was found at the p=0.05 level between the CLAS-ID and TEI. The data shows that as scores on the CLAS-ID increase (indicating more negative attitudes toward individuals with IDD) the scores on TEI also increase (indicating more negative outlook regarding treatment expectancies for individuals with IDD) (r= .27, p=.01).

Research Question 3

Research question 3 asks, "Do attitudes/beliefs predict counselors' confidence in working with individuals with IDD?" and hypothesis 3 states, "Counselors' attitudes/beliefs influence counselors' confidence in providing counseling services to individuals with IDD." Again, the same three instruments (*Modern and Classical Attitudes Scale toward People with Intellectual Disabilities,* CLAS-ID, and ATDP) were used to measure the independent variable (counselors' attitudes toward individuals with IDD). To measure the dependent variable (counselors' confidence in providing counseling services to individuals with IDD), the *Therapy Confidence Scale – Intellectual Disabilities* (TCS-ID; Dagnan et al., 2014) was used. In order to explore the relationship between the independent variable in this hypothesis and the dependent variable, a Pearson product-moment correlation (r) was utilized (Table 4.6). While there are mixed results between instruments in this analysis, two strong statistically significant correlations were found, and a statistically suggestive correlation was found.

A statistically significant positive correlation was found at the p=0.01 level between the TCS-ID and CLAS-ID. The data shows that as scores on the CLAS-ID decrease (indicating more positive attitudes toward individuals with IDD) the scores on TCS-ID also decrease (indicating more confidence in providing services to individuals with IDD) (r= .36, p=.00).

Table 4.6

Hypothesis 3 – Pearson Product Moment Correlations

	TCS-ID	
	r	*p*
Modern and Classical Attitudes Scale toward People with Intellectual Disabilities, modern scale only	-.22	.06
Modern and Classical Attitudes Scale toward People with Intellectual Disabilities, classical scale only	-.17	.15
CLAS-ID	.36	.00
ATDP	-.26	.02

A statistically significant negative correlation was found at the p=0.05 level between the TCS-ID and ATDP. The data shows that as scores on the ATDP increase (indicating more positive attitudes toward individuals with IDD) the scores on TCS-ID decrease (indicating more confidence in providing services to individuals with IDD) (r=-.26, p=.02).

Research Question 4

Research question 4 asks, "Do counselors' perception of counseling effectiveness/treatment outcomes predict counselors' confidence in working with individuals with IDD?" and hypothesis 4 states, "Counselors' perception of counseling effectiveness/treatment outcomes have an effect on counselors' confidence in providing counseling services to individuals with IDD." In order to explore the relationship between the independent variable (counselors' perception of counseling effectiveness) in this hypothesis and the dependent variable (counselors' confidence in providing counseling services), a Pearson product-moment correlation (r) was utilized (Table 4.7).

Table 4.7
Hypothesis 4 – Pearson Product Moment Correlations

	TCS-ID	
	r	*p*
Attitudes to the Treatment of People with Intellectual Disabilities in Mainstream Services	.39	.00
TEI	.23	.04

A statistically significant positive correlation was found at the p=0.01 level between the TCS-ID and *Attitudes to the Treatment of People with Intellectual Disabilities in Mainstream Services.* The data shows that as scores on the TCS-ID decrease (indicating more confidence in providing services to individuals with IDD) the scores on *Attitudes to the Treatment of People with Intellectual Disabilities in Mainstream Services* also decrease (indicating more positive attitudes toward providing services to individuals with IDD) (r= .39, p=.00).

A statistically significant positive correlation was found at the p=0.05 level between the TCS-ID and TEI. The data shows that as scores on the TCS-ID decrease (indicating more confidence in providing services to individuals with IDD) the scores on TEI also decrease (indicating more a positive outlook regarding treatment expectancies for individuals with IDD) (r= .23, p=.04).

Research Question 5

Research question 5 asks, "Does exposure to individuals with IDD predict counselors' attitudes/beliefs?" Two hypotheses were identified for this research question. Hypothesis 5 states, "Personal exposure to individuals with IDD has an effect on counselors' attitudes/beliefs toward individuals with IDD." Hypothesis 6 states, "Professional exposure to individuals with IDD has an effect on counselors' attitudes/beliefs toward individuals with IDD." In order to explore the relationship between the independent variables (personal contact and professional

contact) and the dependent variable (counselors' attitudes toward individuals with IDD), a Pearson product-moment correlation (*r*) was utilized (Table 4.8).

Table 4.8
Hypotheses 5 and 6 – Pearson Product Moment Correlations

	Personal Contact Demographic Question		Professional Contact Demographic Question		IDP	
	r	*p*	*r*	*p*	*r*	*p*
Modern and Classical Attitudes Scale toward People with Intellectual Disabilities, modern scale only	-.21	.07	-.27	.02	-.12	.29
Modern and Classical Attitudes Scale toward People with Intellectual Disabilities, classical scale only	-.29	.01	-.19	.08	.04	.71
CLAS-ID	.36	.00	.29	.01	-.03	.76
ATDP	-.26	.02	-.14	.21	.25	.03

In order to measure the independent variables, two measures were used. To measure personal contact, a single question from the demographic questions was used; the question is "I would classify my personal experience(s) with individuals with IDD as being?" Participants then rated their experiences on a 5-point Likert scale (1-very positive to 5-very negative). To measure professional contact, a similar single question from the demographic questions was used; the question is "I would classify my professional experience(s) with individuals with IDD as being?" Participants, again, used a 5-point Likert scale to indicate their response. A single

instrument was also used to provide further information for the variable of contact. The *Interaction with Disabled Persons Scale* (IDP) was utilized to measure general contact.

A statistically significant positive correlation was found at the p=0.05 level between the ATDP and IDP. The data shows that as scores on the ATDP increase (indicating more positive attitudes toward individuals with IDD) the scores on IDP also increase (indicating more positive attitudes toward interactions with individuals with IDD) (r= .25, p=.03).

A statistically significant negative correlation was found at the p=0.05 level between the *Modern and Classical Attitudes Scale toward People with Intellectual Disabilities* (classical scale) and the personal experience demographic question. The data shows that as scores on the *Modern and Classical Attitudes Scale toward People with Intellectual Disabilities* (classical scale) decrease (indicating a more negative attitude toward individuals with IDD) the scores on the personal experience demographic question increase (indicating more negative contact experience with individuals with IDD) (r= -.29, p=.01).

A statistically significant positive correlation was found at the p=0.01 level between the CLAS-ID and the personal experience demographic question. The data shows that as scores on the CLAS-ID decrease (indicating a more positive attitude toward individuals with IDD) the scores on the personal experience demographic question also decrease (indicating more positive contact experience with individuals with IDD) (r= .36, p=.00).

A statistically significant negative correlation was found at the p=0.05 level between the ATDP and the personal experience demographic question. The data shows that as scores on the ATDP increase (indicating a more positive attitude toward individuals with IDD) the scores on the personal experience demographic question decrease (indicating more positive contact experience with individuals with IDD) (r= -.26, p=.02).

A statistically significant negative correlation was found at the p=0.05 level between the *Modern and Classical Attitudes Scale toward People with Intellectual Disabilities* (modern scale) and the professional experience demographic question. The data shows that as scores on the *Modern and Classical Attitudes Scale toward People with Intellectual Disabilities* (modern scale) decrease (indicating a more negative attitude toward individuals with IDD) the scores on the personal experience demographic question increase (indicating more negative contact experience with individuals with IDD) (r= -.27, p=.02).

A statistically significant positive correlation was found at the p=0.05 level between the CLAS-ID and the professional experience demographic question. The data shows that as scores on the CLAS-ID decrease (indicating a more positive attitude toward individuals with IDD) the scores on the personal experience demographic question also decrease (indicating more positive contact experience with individuals with IDD) (r= .29, p=.01).

Research Question 6

Research question 6 asks, "Does exposure to individuals with IDD predict counselors' confidence?" Two hypotheses were identified for this research question. Hypothesis 7 states, "Personal exposure to individuals with IDD has an effect on counselors' confidence in providing counseling services to individuals with IDD." Hypothesis 8 states, "Professional exposure to individuals with IDD has an effect on counselors' confidence in providing counseling services to individuals with IDD." In order to explore the relationship between the independent variables (personal contact and professional contact) and the dependent variable (counselors' confidence in providing counseling services), a Pearson product-moment correlation (r) was utilized (Table 4.9).

Table 4.9
Hypotheses 7 and 8 – Pearson Product Moment Correlations

	Personal Contact Demographic Question		Professional Contact Demographic Question		IDP	
	r	*p*	*r*	*p*	*r*	*p*
TCS-ID	.37	.00	.49	.00	-.42	.00

A statistically significant positive correlation was found at the p=0.01 level between the TCS-ID and the personal experience demographic question. The data shows that as scores on the TCS-ID decrease (indicating a more confidence in providing services to individuals with IDD) the scores on the personal experience demographic question also decrease (indicating more positive contact experience with individuals with IDD) (r= .37, p=.00).

A statistically significant positive correlation was found at the p=0.01 level between the TCS-ID and the professional experience demographic question. The data shows that as scores on the TCS-ID decrease (indicating a more confidence in providing services to individuals with IDD) the scores on the professional experience demographic question also decrease (indicating more positive contact experience with individuals with IDD) (r= .49, p=.00).

A statistically significant negative correlation was found at the p=0.01 level between TCS-ID and IDP. The data shows that as scores on the TCS-ID decrease (indicating more confidence in providing services to individuals with IDD) the scores on IDP increase (indicating a more positive attitude toward interactions with individuals with IDD) (r= -.42, p=.000).

Research Question 7

Research question 7 asks, “Does exposure to individuals with IDD predict counselors’ perception of counseling effectiveness/treatment outcomes?” Two hypotheses were identified for this research question. Hypothesis 9 states, “Personal exposure to individuals with IDD has an effect on counselors’ perception of counseling effectiveness/treatment outcomes for

individuals with IDD." Hypothesis 10 states, "Professional exposure to individuals with IDD has an effect on counselors' perception of counseling effectiveness/treatment outcomes for individuals with IDD." In order to explore the relationship between the independent variables (personal contact and professional contact) and the dependent variable (counselors' perception of counseling effectiveness/treatment outcomes), a Pearson product-moment correlation (*r*) was utilized (Table 4.10).

Table 4.10

Hypotheses 9 and 10 – Pearson Product Moment Correlations

	Personal Contact Demographic Question		Professional Contact Demographic Question		IDP	
	r	*p*	*r*	*p*	*r*	*p*
Attitudes to the Treatment of People with Intellectual Disabilities in Mainstream Services	.27	.02	.26	.02	-.07	.53
TEI	.21	.06	.10	.38	.08	.45

A statistically significant positive correlation was found at the p=0.05 level between the *Attitudes to the Treatment of People with Intellectual Disabilities in Mainstream Services* scale and the personal experience demographic question. The data shows that as scores on the *Attitudes to the Treatment of People with Intellectual Disabilities in Mainstream Services* scale decrease (indicating a more positive attitude toward counseling effectiveness) the scores on the

personal experience demographic question also decrease (indicating a more positive personal contact experience with individuals with IDD) (r= .27, p=.02).

A statistically significant positive correlation was found at the p=0.05 level between the *Attitudes to the Treatment of People with Intellectual Disabilities in Mainstream Services* scale and the professional experience demographic question. The data shows that as scores on the *Attitudes to the Treatment of People with Intellectual Disabilities in Mainstream Services* scale decrease (indicating a more positive attitude toward counseling effectiveness) the scores on the professional experience demographic question also decrease (indicating a more positive professional contact experience with individuals with IDD) (r= .26, p=.02).

Research Question 8

Research question 8 asks, "Does exposure to individuals with IDD moderate the relationship between counselors' attitudes and confidence?" and hypothesis 11 states, "Exposure to individuals with IDD has an effect on the relationship between counselors' attitudes/beliefs and counselors' confidence in providing services to individuals with IDD." In order to explore whether or not there is a moderating effect on the relationship between the independent and dependent variables, a simple moderation analysis was used. Significant interactions were found in three out of four of the analyzed relationships (Table 4.11). No interaction was found between the *Modern and Classical Attitudes Scale toward Individuals with IDD* (classical scale) and IDP.

Table 4.11

Hypotheses 11 – Moderator effect on the relationship between counselors' attitudes toward people with IDD and counselors' confidence in providing counseling services

	Coeff	*se*	*t*	*p*	Lower Limit Confidence Interval	Upper Limit Confidence Interval
	TSD-ID: R= .53, R^2=.28, MSE=69.39, F=8.64, p<.01					
Interaction: Modern/Classical Attitudes Scale toward Individuals with IDD (Modern) and IDP	.08	.03	2.55	.01	.01	.15
	TSD-ID: R= .48, R^2=.23, MSE=85.75, F=6.64, p<.01					
Interaction: Modern/Classical Attitudes Scale toward Individuals with IDD (Classical) and IDP	.06	.04	1.54	.12	-.01	.14
	TSD-ID: R= .59, R^2=.35, MSE=62.79, F=12.02, p<.01					
Interaction: CLAS-ID and IDP	-.07	.02	-2.89	.00	-.12	-.02
	TSD-ID: R= .54, R^2=.30, MSE=79.08, F=9.35, p<.01					
Interaction: ATDP and IDP	.03	.01	2.84	.00	.00	.05

The analysis shows that a statistically significant interaction is found between the *Modern and Classical Attitudes Scale toward Individuals with IDD* (modern scale) and IDP that accounts for 28.84% of the variance. The conditional effects of the focal predictor indicate that at low levels of IDP, significance is found. Low levels/conditions (indicating more negative attitudes toward interacting with individuals with IDD) show a lower limit confidence interval of -1.59 and an upper limit confidence interval of -.42.

The analysis shows that a statistically significant interaction is found between the CLAS-

ID and IDP that accounts for 35.70% of the variance. The conditional effects of the focal predictor indicate that at low and medium levels of IDP, significance is found. Low levels/conditions (indicating more negative attitudes toward interacting with individuals with IDD) show a lower limit confidence interval of .51 and an upper limit confidence interval of 1.32. Medium levels/conditions (indicating neutral attitudes toward interacting with individuals with IDD) show a lower limit confidence interval of .08 and an upper limit confidence interval of .68.

The analysis shows that a statistically significant interaction is found between the ATDP and IDP that accounts for 30.15% of the variance. The conditional effects of the focal predictor indicate that at the lower level of IDP, significance is found. Low levels/conditions (indicating more negative attitudes toward interacting with individuals with IDD) show a lower limit confidence interval of -.51 and an upper limit confidence interval of -.12. These findings indicate that counselors' contact with individuals with IDD has an influence on the relationship between counselors' attitudes toward individuals with IDD and their confidence in providing counseling services to these individuals.

Social Desirability

Participants also competed a social desirability instrument, the *Marlowe-Crowne Social Desirability Scale*, as part of this study's survey in order to determine if participants had potential sought to present themselves in a more positive or more negative way. As mentioned earlier, five participants failed to complete this instrument and were eliminated from this analysis (n=69). Total participant scores for this instrument ranged from 2 to 28 out of a possible 33. Despite the *Marlowe-Crowne Social Desirability Scale* being used for more than 60 years, this author was unable to locate guidelines for what amounts to a "low" or "high" score. Even though

there seems to be no specific guideline on what a high score is, it should be noted that there were several scores in the upper-20s with the highest score being a 28 while the mean score was 17.11. This could be interpreted as participants scoring in the upper-20s may be attempting to provide answers that make themselves appear in a more positive manner.

Chapter Summary

The purpose of this study was to better understand what impact (if any) counselors' attitudes and beliefs toward people with IDD has on their perception of counseling effectiveness and treatment outcomes and their own confidence in providing counseling services to individuals with IDD, and what impact (if any) contact with individuals with IDD has on those variables. Participants completed a demographic survey which included professional information, personal contact with individuals with IDD information, and professional contact with individuals with IDD information. Participants also competed the following instruments: *Therapy Confidence Scale – Intellectual Disabilities* (TCS-ID), *Attitudes to the Treatment of People with Intellectual Disabilities in Mainstream Services*, *Therapist Expectancy Inventory – Factor II* (TEI), *Interaction with Disabled Persons Scale* (IDP), *Community Living Attitudes Scale – Intellectual Disability* (CLAS-ID), *Attitudes towards Disabled Persons Scale – Form B* (ATDP), *Modern and Classical Attitudes Scale toward People with Intellectual Disabilities*, and *Marlowe-Crowne Social Desirability Scale* (MCSDS).

Overall, positive results were found throughout the analyses conducted for this study. Some results indicate that there are statistically significant relationships between counselors' attitudes and their perception of counseling effectiveness, counselors' attitudes and their confidence in providing services to the IDD population, counselors' contact with individuals with IDD and their perception of counseling effectiveness, and the impact counselors' contact

has on the relationship between counselors' attitudes and confidence in providing services to the IDD population. Additional discussion on these findings will be presented in Chapter Five.

CHAPTER FIVE: SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

An exploration of counselors' attitudes/beliefs, counselors' confidence, counselors' perception of counseling effectiveness, and contact with individuals with IDD has been evaluated through a quantitative research design using a survey to gather data. As a review, the identified problem that guided this research, conceptual framework, research questions, and hypotheses will be explored. This chapter concludes this dissertation with a summary and interpretation of findings and recommendations for the counseling field and future research.

Research Framework

Over several decades, a general negative attitude and bias toward individuals with intellectual and developmental disabilities (IDD) has been identified (Angermeyer & Dietrich, 2006; Sheridan & Scior, 2013; Siperstein et al., 2003; Werner, 2015). Individuals with IDD are believed to be "sheltered" and "not empowered" (Sheridan & Scior, 2013). People have generally low expectations of individuals with IDD (Siperstein et al., 2003) and consider them to be naïve and "childlike" (Milligan & Neufeldt, 2001). Research has shown that attitudes of professionals (e.g., doctors, nurses, teachers, and social workers) are not much different and ultimately impact the quality of services provided to individuals with IDD (Cook et al., 2007; Dorji & Solomon, 2009; Edwards et al., 2007; Lennox & Chaplin, 1996). Yet, little to no research has been done on the counselors' attitudes toward individuals with IDD.

Not only has minimal research been conducted regarding counselors' attitudes and beliefs regarding individuals with IDD, but counselors continue to report minimal training related to the disability population, feeling ill-prepared to work with this population, and have low confidence in working with individuals with IDD (Dagnan et al., 2014; Hronis et al., 2018; Jones & Donait, 2009; Marwood et al., 2016; O'Brien & Rose, 2010; Olkin & Pledger, 2003; Rubino, 2001).

Researchers have focused on providing counselors with information regarding adapting theories to work with this population (Anslow, 2013; Barol & Seubert, 2010; Fidell, 1996), what theories work best with this population, and how to incorporate new/different strategies into the counseling office in order to meet the needs of individuals with IDD. While this is valuable information and necessary to provide the best and most competent treatment, without first identifying counselors' underlying attitudes and beliefs held toward individuals with IDD, little difference will be made with these changes in protocol. As Rogers (1957) identified, three conditions that must occur in a counseling relationship is genuineness, unconditional positive regard, and empathic understanding and these reflect peoples' underlying thoughts, attitudes, and beliefs not knowledge and technique.

This study sought to understand what attitudes counselors hold toward individuals with IDD, the impact the attitudes have on counseling effectiveness, the impact attitudes have on confidence in providing mental health services to individuals with IDD, and, lastly, if a counselor's history of contact with individuals with IDD impacts any of these variables or the relationship between counselors' attitudes and counselors' confidence. Figure 5.1 is a depiction of this conceptual framework.

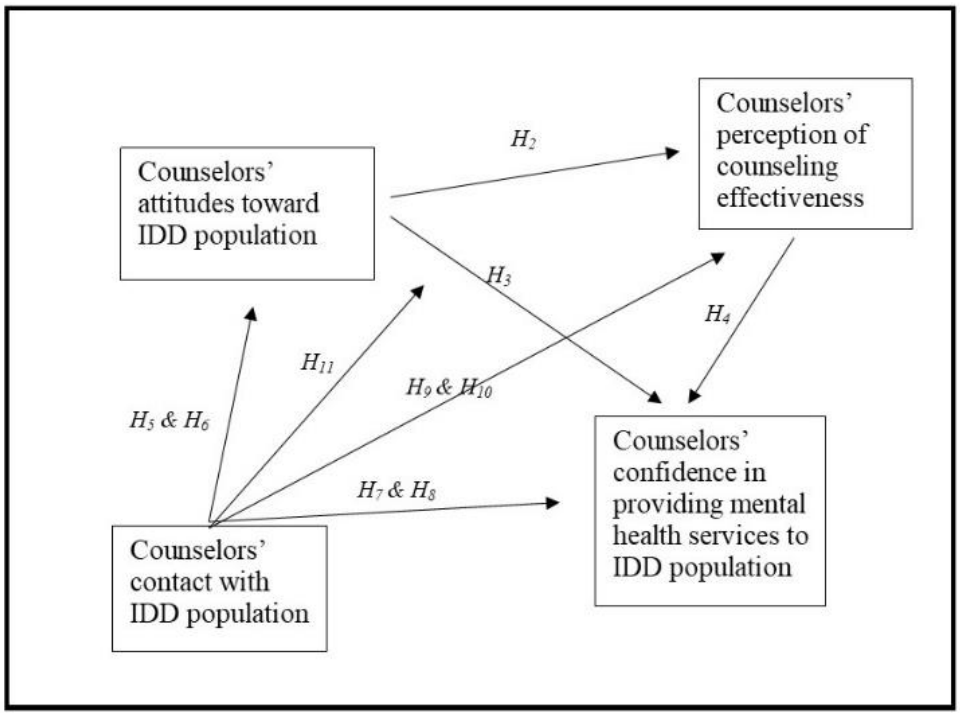

Figure 5.1. Conceptual Framework.

Summary of Participants

Participants were invited to participate in this study through the American Counseling Association (ACA) Connect "Call for Participants" forum, COUNSGRAD listserv, the Ohio Counseling Association (OCA) listserv, CESNET listserv, and Liberty University students and faculty. Responses were collected from these sources over the course of three weeks. The survey link was made available to participants through an invitation to participate. During that three-week period, 106 individuals responded and participated in the online survey. Out of the 106 respondents, a final count of 74 participant responses were used in data analysis.

At the beginning of the survey, participants were asked to report their age range, gender, and race/ethnicity. Participants were mainly female (75.68%, n = 56), White/Caucasian (77.03%, n = 57), and falling in the age range of 45 to 54 years old (39.19%, n = 29). Regarding age range, 15 participants were age 25 to 34 years old (20.27%), 15 respondents were 35 to 44 years old

(20.27%), 29 participants were 45 to 54 years old (39.19%), ten participants were 55 to 64 years old (13.51%), three participants reported being 65 to 74 years old (4.05%), and two participants reported being 75+ years old (2.70%). Out of 74 participants, 18 were male (24.32%).

Regarding professional demographics, majority of participants reported having a master's degree (64.86%, *n* = 48) and 26 participants reported having a doctorate degree (35.14%). Participants were also distributed across a variety of practice settings including private individual practice (28.38%, *n* = 21), private group practice (16.22%, *n* = 12), community mental health agency (18.92%, *n* = 14), and a variety of other settings. Participants were distributed across a variety of states of licensure as well.

Summary of Findings

Hypothesis 1

Research question 1 explored whether counselors hold negative attitudes/biases toward individuals with IDD. This was measured through three instruments, *Modern and Classical Attitudes Scale toward People with Intellectual Disabilities* (divided into two separate scales – modern and classical; Akrami et al., 2006), *Community Living Attitudes Scale – Intellectual Disability* (CLAS-ID; Henry et al., 1996), and *Attitudes towards Disabled Persons Scale – Form B* (ATDP; Yuker et al., 1970). Through mean and standard deviation computation, data analysis showed that in all of these measures, participants' report having neutral to positive attitudes toward individuals with IDD. Thus, the null hypothesis for research hypothesis 1 was accepted.

Hypothesis 2

Research question 2 explored whether counselors' attitudes/beliefs about people with IDD have an effect on their perception of counseling effectiveness for individuals with IDD. The independent variable was measured through the three instruments mentioned above (*Modern and*

Classical Attitudes Scale toward People with Intellectual Disabilities, CLAS-ID, and ATDP) and the dependent variable was measured using *Attitudes to the Treatment of People with Intellectual Disabilities in Mainstream Services* (Melville et al., 2005) and *Therapist Expectancy Inventory* (TEI; Bernstein et al., 1983). A Pearson product-moment correlation was used to analyze the data.

Data analysis indicated that as counselors' attitudes toward individuals with IDD become more negative the more negative their attitudes toward providing services to individuals with IDD. The data analysis between the CLAS-ID and TEI showed that as counselors' attitudes became more negative toward individuals with IDD the more negative counselors' outlook regarding treatment expectancies for individuals with IDD. The opposite can also be stated; as counselors' attitudes become more positive toward individuals with IDD their attitudes toward providing treatment to individuals with IDD and perception of counseling effectiveness also become more positive. This data supported the hypothesis that counselors' attitudes/beliefs influence counselors' perception of treatment outcomes and counseling effectiveness for individuals with IDD. The null hypothesis for hypothesis 2 was rejected.

Hypothesis 3

Research question 3 explored whether counselors' attitudes/beliefs predict counselors' confidence in providing counseling services to individuals with IDD. The independent variable continues to be measured by the three instruments mentioned above (*Modern and Classical Attitudes Scale toward People with Intellectual Disabilities,* CLAS-ID, and ATDP) and the dependent variable was measured using the *Therapy Confidence Scale – Intellectual Disabilities* (TCS-ID; Dagnan et al., 2014). A Pearson product-moment correlation was used to analyze the data.

Data analysis indicated that as counselors' attitudes toward individuals with IDD became more negative, the less confident they were in providing services to individuals with IDD. The opposite can also be stated; as counselors' attitudes became more positive toward individuals with IDD, their confidence in providing services to individuals with IDD increased. Data results supported the hypothesis that counselors' attitudes/beliefs impact counselors' confidence in providing counseling services to individuals with IDD. The null hypothesis for hypothesis 3 was rejected.

Hypothesis 4

Research question 4 explored whether counselors' perception of counseling effectiveness impacts counselors' confidence in working with individuals with IDD. A Pearson product-moment correlation was used to analyze the data. Data analysis indicated that as counselors' attitudes toward providing services to individuals with IDD became more positive, their confidence in providing services to individuals with IDD increased. Results also suggest that as counselors' attitudes toward providing services became more negative, the less confident they were in providing services to individuals with IDD. Analysis between the TCS-ID and TEI showed that as counselors report a more positive outlook regarding treatment expectancies for individuals with IDD they also reported increased confidence in providing services to individuals with IDD. Data results supported the hypothesis that counselors' perception of counseling effectiveness/treatment outcomes impact counselors' confidence in providing counseling services to individuals with IDD. The null hypothesis for hypothesis 4 was rejected.

Hypotheses 5 and 6

Research question 5 explored whether exposure to/contact with individuals with IDD impacts counselors' attitudes/beliefs about individuals with IDD. A Pearson product-moment

correlation was used to analyze the data. Data analysis indicated that as personal exposure to individuals with IDD increased, counselors reported more positive attitudes toward individuals with IDD (hypothesis 5). Also, as professional exposure to/contact with individuals with IDD increased, counselors reported more positive attitudes toward individuals with IDD (hypothesis 6). Participant's scores indicated that as attitudes became more positive toward individuals with IDD attitudes toward interactions with individuals with IDD became more positive. Also, based on past personal and professional experience, respondents reported that the more positive they viewed their previous contact with individuals with IDD, the more positive attitudes they held toward individuals with IDD. Data results supported the hypotheses that counselors' personal and professional contact with individuals with IDD impact counselors' attitudes toward/beliefs held regarding individuals with IDD. The null hypotheses for hypotheses 5 and 6 were rejected.

Hypotheses 7 and 8

Research question 6 explored whether exposure to/contact with individuals with IDD impacted counselors' confidence in providing counseling services to individuals with IDD. A Pearson product-moment correlation was used to analyze the data. Data analysis indicated that as counselors report more positive personal contact experiences with individuals with IDD the more confidence in providing services to individuals with IDD counselors report (hypothesis 7). Also, as professional exposure to/contact with individuals with IDD increased, counselors reported more confidence in providing services to individuals with IDD (hypothesis 8). Based on personal and professional experience, respondents reported that the more positive they viewed their contact with individuals with IDD the more confidence they had in working with and providing services to the population. Data results supported the hypotheses that counselors' confidence in

working with the IDD population is impacted by the professional and personal experiences with individuals with IDD. The null hypotheses for hypotheses 7 and 8 were rejected.

Hypotheses 9 and 10

Research question 7 explored whether exposure to individuals with IDD impact counselors' perception of counseling effectiveness/treatment outcomes for individuals with IDD. A Pearson product-moment correlation was used to analyze the data. Data analysis indicated that there was no statistically significant relationship between personal contact experiences with individuals with IDD and counselors' attitudes toward counseling effectiveness for individuals with IDD (hypothesis 9). Data analysis indicated that as professional exposure to/contact with individuals with IDD was reported to be more positive, the counselors reported a more positive attitude toward counseling effectiveness (hypothesis 10). Participant's scores indicated that as professional contact with individuals was perceived as more positive, counselors had a more positive perception of counseling effectiveness/treatment outcomes for individuals with IDD. The null hypothesis for hypothesis 9 was accepted. The null hypothesis for hypothesis 10 was rejected.

Hypothesis 11

Research question 8 explored whether counselors' exposure to individuals with IDD impact the relationship between counselors' attitudes toward individuals with IDD and their confidence in providing services to this population. Through a simple moderation analysis, data indicated that there was a statistically significant interaction that occurs when counselors hold more negative and neutral attitudes toward interacting with/contact with individuals with IDD. This means that counselors' exposure to individuals with IDD and the perception of that contact (i.e., whether the participant perceived the interaction to be positive or negative) impact the

relationship between counselors' attitudes toward individuals with IDD and their confidence in providing services to this population. The null hypothesis for hypothesis 11 was rejected.

Discussion and Interpretation of Findings

As this study addressed in the literature review, individuals with disabilities have experienced negative attitudes and stereotypes from the general population throughout history (Akrami et al., 2006; Werner & Araten-Bergman, 2017). Studies have shown that professionals (e.g., teachers, psychiatrists, and social workers) also hold negative attitudes toward and beliefs about individuals with IDD (Cook et al., 2007; Dorji & Solomon, 2009; Edwards et al., 2007; Lennox & Chaplin, 1996). While being aware of personal values and attitudes and multicultural competency are required of counselors, little information was available regarding counselors' attitudes and beliefs held toward individuals with IDD. As a first step in the direction of gathering more information on counselors' attitudes and beliefs regarding the IDD population, this quantitative research study was developed. By design, this study sought to examine counselors' attitudes toward the IDD population and offer generalizability to the counselor population.

This study's results do allude to the lack of training in the area of mental health and IDD; which is similar to findings already in literature (Dagnan et al., 2014; Hronis et al., 2018; Marwood et al., 2016). Only 17 out of 74 participants in this study reported receiving instruction during their graduate training that was specific to working with individuals with IDD (22.97%). Yet, when asked about the percentage of their clients who have/had IDD, only 19 reported that none of their clients have IDD (25.68%). The other respondents reported that they had the following percentage of clients, all of clients with IDD (n=4, 5.41%), almost all (n=6, 8.11%), some (n= 8, 10.81%), and almost none (n=37, 50.00%), which is reported as 100%, 75%, 50%,

and 25% respectively. Dagnan and colleagues (2014) found that close to 45% of their participants (though not all counselors but those who engage in counseling services as part of their job) reported having some type of training specific to IDD. While participants reported that they see clients with IDD in their professional practice, this is a stark contrast to those few who report receiving any training with regards to working with clients with IDD and mental health concerns.

The findings in this study suggest that counselors may hold more neutral to low positive attitudes and beliefs regarding individuals with IDD than suggested in the research on the general population or other professional groups. Research has shown that the general population holds negative attitudes and biases of individuals with IDD (Araten-Bergman & Werner, 2017; Cage et al., 2018; Capozza et al., 2016; Friedman, 2019) and that those in professional positions hold similar negative views of those with IDD (Cage et al., 2018; Capozza et al., 2016; Cook et al., 2007; Siperstein & Gottlieb, 1978). The participants in this study responded to the *Modern and Classical Attitudes Scale toward People with Intellectual Disabilities* with responses that indicate relatively positive attitudes toward individuals with IDD (modern scale: n=72, m=45.97, SD=5.12; classical scale: n=74, m= 32.82, SD=4.22).

It was the presumption of this researcher that the findings of this study would mirror contact theory and suggest that those who have more positive interactions with individuals with IDD, either personally or professionally, will have more positive attitudes toward the population and the services they provide to the population. It was also presumed that the findings of this study would mirror the findings of Hronis and colleagues (2018) which found that those who had more professional contact and experience with individuals with IDD had significantly higher confidence in providing mental health services to the population. Based on the affirmative results

received in the statistical analyses of this research, it is can be argued that interactions with the IDD population do impact attitudes toward the population, perception of counseling effectiveness, and confidence in providing counseling services to individuals with IDD. Results suggest that as counselors have more (perceived) positive interactions with/contact with individuals with IDD, counselors will have more positive attitudes toward this population. This suggests that if counselors are presented with more opportunities to interact with individuals with IDD and that those interactions are perceived as positive, the counselors will become more comfortable/confident in providing services to the population, have more positive attitudes toward individuals with IDD, and will have a more positive perception of counseling effectiveness for this population.

Results revealed counselors' hold mostly neutral to positive attitudes and beliefs toward individuals with IDD. Further analysis revealed that counselors' attitudes toward the IDD population impact counselors' perception of treatment outcomes/counseling effectiveness and counselors' confidence in providing mental health services to individuals with IDD. This suggests that if counselors hold more negative attitudes toward individuals with IDD, they are more likely to believe that counseling is not an effective means of treatment for individuals with IDD and also have lower confidence in providing counseling services to individuals with IDD. Results also revealed that the counselors' confidence in providing mental health services to individuals with IDD was impacted by the counselors' view of counseling effectiveness with the IDD population. Thus, suggesting that if counselors' do not believe that counseling is an effective means of treatment for individuals with IDD, they will have less confidence in providing that service to individuals with IDD.

Recommendations for the Counseling Field

The most important findings in this study were (1) while counselors' attitudes toward the IDD population may not be as low as other professions or people groups, they are also not entirely positive or high; (2) as counselors' attitudes toward the IDD population become more negative, so does their perception of counseling effectiveness; (3) as counselors' attitudes toward the IDD population become more negative, their confidence in providing mental health services to the IDD population becomes more negative; (4) as counselors' perceptions of counseling effectiveness becomes more negative, their confidence in providing mental health services to the IDD population decreases; and (5) personal and professional contact with the IDD population impacts counselors' attitudes toward the population, their perception of counseling effectiveness, counselor's confidence in providing mental health services to the population, and the relationship between their attitudes and confidence. The results of this study suggest that it is not just the lack of education and training that impacts counselors' work with individuals who have IDD. Instead, at least in part, it is the counselors' attitudes and biases toward the IDD population, and it is their contact experiences with the population that impact counseling services for the IDD population. These results have many implications for the counseling field and for individuals with a dual diagnosis of IDD and mental health concerns.

Ethical Considerations

Counselors are ethically mandated to have multicultural competency, address personal attitudes and beliefs held toward a specific population, and be able to provide mental health services to any individual regardless of disability (ACA, 2014; APA, 2012; CACREP, 2015; Chapin et al., 2018). This study suggests that counselors believe that counseling is not an effective means of mental health treatment for individuals with IDD. The assumption then may

be that if counseling is not an effective means of mental health treatment for individuals with IDD, then counselors do not need to know how to provide culturally relevant and adaptive treatment, counselors do not need to be confident in providing services, and ultimately, that counselors do not need to provide services to this population. This may then begin to provide some insight into why the IDD population is such an underserved population (Durbin et al., 2017; Einfeld et al., 2006) and why mental health disorders remain poorly treated within this population (Anderson et al., 2003; Anderson et al., 2013; Durbin et al., 2017; Koch et al., 2014; Krahn et al., 2006; Lunsky et al., 2014). Based on this study's results and this line of logic, it is suggested that counselors be provided with additional education regarding the efficacy of counseling techniques when used with individuals with IDD. This can be done through counselor education programs, continuing education opportunities, or similar means.

Counselor Education

Additionally, these results can be expanded and generalized to suggest that if counselors continue to hold negative views of counseling effectiveness and lack confidence in serving this population, nothing will change regarding mental health treatment of individuals with IDD. Instead, individuals with IDD will continue to receive sub-par mental health treatment (Durbin et al., 2017), receive increased psychiatric modalities of treatment (i.e., psychotropic medications) and the overuse of psychotropic medications to treat mental health disorders (Edward et al., 2007; Krahn et al., 2006; Lewis et al., 2002), and experience diagnostic overshadowing of mental health conditions (i.e., the tendency to overlook symptoms of mental illness and attribute those symptoms to the IDD) (Bishop et al., 2013; Mason & Scior, 2004). Research has shown that individuals with IDD can, not only, engage in psychotherapy/counseling but can benefit from those services (Kanellakis, 2010; O'Hara, 2008; Parkes et al., 2007) but in order for this to

happen, counselors must be willing to provide the services, be skilled in providing the services, and must believe in the value of providing these services to the IDD population.

Through counselor education programs and continuing education, counselors will be able to expand their knowledge of how to provide services to the IDD population, what services to provide to the IDD population, and the importance and efficacy of providing counseling services to this population. It is recommended that counselor education programs incorporate readings, contact, and experiential activities related to mental health services for individuals with IDD into program curriculums. As this study's results show, counselors' experiences and contact with individuals with IDD impact their confidence, belief in counseling efficacy, and overall attitudes toward the IDD population. Exposure could be provided through training in the classroom and incorporated into lessons, multicultural experiences, experiences during practicum/internships, or in a variety of other creative ways. By providing students with structured experiences and contact with individuals with IDD, it would be assumed that more positive beliefs and attitudes, confidence in providing mental health services to the population, and efficacy in mental health services would be gained.

Regarding counselor education, counselors must receive training in multicultural competency regarding working with individuals with IDD. Training must be received in assessment, diagnosis, treatment delivery, rapport building, collaborating with family members and care providers, and other aspects of providing counseling services to individuals with IDD. This means that counselor educators, themselves, must be educated in, have experience with, and feel comfortable providing counseling services to individuals with IDD.

Regarding counselor educators, it is important that they be prepared to not only provide education and instruction on how to work with the IDD population but they should also be

prepared to address counselors'-in-training insecurities in working with this population. It is important that counselor educators help to cultivate an identity in counselors-in-training that they are capable of supporting individuals with IDD and providing quality mental health services to the population. Counselor educators should also be prepared to address the efficacy of counseling services and provide counselors-in-training with information regarding best practices for working with the IDD population.

This researcher also wants to make it clear that it is recognized that the addition of IDD-related content and curriculum will be difficult for some programs due to the rigorous standards already in place in counselor education programs and accreditation; thus, it should also be a priority of professional organizations to provide continuing education opportunities focused on the IDD population. Through implementation of these recommendations for the mental health field, counseling field, and counselor education, it is believed that individuals with IDD will receive better counseling services; counselors-in-training will be better prepared to serve individuals with IDD; and counselors will have more confidence in providing services to individuals with IDD, will have more positive attitudes toward individuals with IDD, and will have more positive views of counseling effectiveness for individuals with IDD.

By including IDD-specific content to practicum/internship experiences, continuing education, and on-the-job training opportunities that focuses on specialized training regarding providing mental health services to individuals with IDD, counselors can be better prepared to work with this population. One recommendation for how this can be accomplished is through state licensing boards making continuing education in multicultural areas a priority, including continuing education regarding the IDD population. If counselors see that licensing boards find multicultural competency as a priority, it is the hope that they will also see it as a priority.

Additionally, more opportunities to receive specialized training in this area should be offered. The National Association of Dually Diagnosed (NADD) is currently offering an annual conference in Ohio and an annual conference that moves to different states around the United States from year-to-year; these conferences are offered for a mix of professions and not just aimed toward counselors. The American Counseling Association also has the division of American Rehabilitation Counseling Association (ARCA), which provides information and education regarding individuals with a wide range of disabilities that occur throughout their life span (i.e., not just information regarding the IDD population). The American Association on Intellectual and Developmental Disabilities (AAIDD) is another organization that strives to provide information and further research in the area of IDD. Again, the AAIDD is a mix of professions and not just aimed toward counselors and, actually, while this association has "interest networks" that professionals can join, there is no interest group for counselors. The AAIDD has interest groups for "psychology" and "social work" but not one specifically for counseling. While these organizations are a good start, there needs to be more focus on counseling services for the IDD population. The ACA provides the ARCA division but does not specifically recognize the IDD population as a group that needs to be addressed individually.

Advocacy

There are several specific suggestions that come out of this research for the counseling and the mental health fields related to advocacy. First, the mental health field, in general, should focus on breaking down systemic barriers that keep individuals with IDD from receiving the mental health care they need and deserve. One way to do this is by making mental health services more readily accessible to individuals with IDD. This can be done by ensuring that counselors take the insurance of individuals with IDD (which tends to be public insurance (e.g.,

Medicaid, Medicare)) or that individuals with IDD have access to more options for mental health treatment (e.g., individuals with IDD may not be able to receive counseling services from counselors in private practice due to not being able to afford self-pay costs or the counselor not being in network with their public health insurance). This is an area that needs to be heavily advocated for, by mental health/counselor professionals, individuals with IDD and their families, and professionals within the IDD field (e.g., support coordinators, boards/departments of IDD).

Counselors also need to advocate for their profession when working with professionals within the IDD field. One way this can be done is through a partnership between those within the mental health field and the IDD field. Counselors would benefit from opportunities to partner with and learn from professionals within the IDD field (e.g., IDD support professionals, state departments/boards of IDD, special education teachers). Professionals who have extensive experience with, training in providing services to, and contact with individuals with IDD will be able to provide invaluable information to the counseling field.

Aside from the information that can be shared between the two groups, counselors need to advocate for the services they can provide to the IDD population. As previously mentioned, individuals with IDD have been over-medicated with psychotropic medication (Edward et al., 2007; Krahn et al., 2006; Lewis et al., 2002) for far too long and diagnostic overshadowing has allowed professionals to wave off behavioral symptoms and mental health symptoms as a result of the IDD (Bishop et al., 2013; Mason & Scior, 2004) without acknowledging the mental health concerns of the IDD population. While it should not have to be stated this plainly, history has shown that it must be said, individuals with IDD will experience mental health concerns the same as other individuals; this includes: anxiety, depression, substance use disorders, grief/pain/loss, and so much more! Counselors must advocate for this population to have their

mental health needs met through counseling services. It is also important for families of individuals with IDD to advocate for individuals to get the mental health help that they need through counseling services.

Self-exploration

The last area of recommendation that comes from this study is regarding counselors' self-exploration. Counselors must engage in self-exploration. Through self-exploration, counselors must identify, address, and modify personal attitudes, beliefs, and perceptions toward individuals with IDD. As evidenced through this research, by addressing personal beliefs, counselors will be more prepared to provide culturally appropriate counseling services to individuals with IDD. Specifically, self-exploration can be taught and explored in counselor training programs and can be encouraged on job sites and in continuing education courses.

Out of this research, a rich amount of information has been gained regarding the interpersonal attitudes and beliefs of counselors toward the IDD population. Now, something must be done. This must be seen as a "call to action" for counselors to explore their own beliefs and attitudes toward the IDD population, expand their knowledge of counseling best practices with this population, and increase their contact with individuals with IDD.

Limitations

While this study has provided some insight into the various issues addressed in this dissertation, there are some limitations to this research. First, the lack of cultural diversity among the research participants (e.g., 75.7% of participants were female and 77.0% of participants were Caucasian) is a limitation of this study. This limitation can impact the thoroughness and applicability of generalizing the findings to a larger population. Another limitation to this study is the possibility that participant responses to the instruments may have been influenced by social

desirability. While a social desirability instrument was included in the research, it is unclear the amount of influence social desirability had on the other instruments completed in the survey. This researcher attempted to mitigate any participant desire to not respond honestly by asking for no identifiable information. These limitations can influence the objectivity and transferability of the study's findings.

Recommendations for Future Research

While this research provides some information that had previously not been investigated, continued research is absolutely necessary. This research begins to address the lack of research in this area and the counseling field should take notice. It is estimated that there is somewhere between 7 and 8 million people in the United States alone who have an IDD (Larson et al., 2018; McDermott et al., 2018). As high as 54 percent of those individuals (that's between 3.8 and 4.3 million individuals) have co-occurring mental health disorders (Gustafsson & Sonnander, 2004; Hronis et al., 2018). Yet, mental health services continue to be underutilized by this population and those who do seek out services encounter inadequate attention, diagnostic overshadowing, and poor quality of services (Bishop et al., 2013; Committee on Disability in America, 2007; Jahoda & Markova, 2004; Krahn et al., 2006; Mason & Scior, 2004). Research into the adaptability of techniques and theories alone is not enough.

First, it is recommended that similar research to this study be conducted in order to gather a broader sample size and increase cultural diversity among participants. This recommendation would allow for the results to be more generalizable to the larger population of counselors. Additionally, further research related to counselors' and clients' perception of treatment effectiveness and whether or not counseling is an effective tool for individuals with IDD is needed. By better understanding counselors' perception of treatment effectiveness for the IDD

population, the counseling field will be better prepared to equip counselors to address the mental health needs of individuals with IDD.

Another recommendation would be to pursue research on contact theory and how it relates to counselors' relationships with individuals with IDD. Allport's (1954) theory of contact stated that peoples' attitudes can change toward outgroup members when there is increased contact between the two groups. Qualitative research may be helpful in broadening the information the field has in this area and increasing the depth of understanding and advocacy for better counseling services for individuals with IDD. Beyond all of these recommendations, this research would be remiss if the recommendation to further explore the perception of individuals with IDD was not considered. Research providing individuals with IDD a voice and empowering them to inform the field as they share their lived experience related to counseling in general, the counselor-client relationship, the ability of counselors to meet the needs of individuals with IDD is absolutely imperative. This area of research is paramount as it provides individuals with IDD a voice and having a say in their mental health treatment.

Individuals with IDD and mental health issues is a large population that needs mental health services but is not being served adequately and additional research into why this is the case is not only necessary but imperative. This study begins to fill that gap in research and suggests that more information on counselors' attitudes toward this population, their perception of treatment outcomes/counseling effectiveness, and their confidence in providing services to individuals with IDD is necessary.

Chapter Summary

The ultimate goal of this research was to begin to shorten the gap in research available regarding counselors' perception of individuals with IDD and the impact these perceptions have

on mental health services provided to the population. The quantitative approach used in this study allowed this researcher to gather a large amount of data from a sample of counselors. This research provided information in response to eight research questions and 11 hypotheses and all but one hypothesis (hypothesis 1) was shown to be supported by the research results. Counselors and those working in the mental health field should not overlook the importance of self-reflection and understanding of one's own attitudes and beliefs about individuals with IDD.

Study Summary

Individuals with IDD have long held a history of institutionalization, discrimination, and stigmas and biases directed toward them. From institutions to segregated classrooms, the IDD population has been faced with different services from professionals. Along with the general population, professionals have reported holding negative views of individuals with IDD yet little to no research has been done on the attitudes and beliefs about the IDD population that counselors hold. This study was designed to look at whether or not professional and/or personal contact with individuals with IDD impacts counselors' attitudes and counselors' perception of counseling treatment effectiveness, and their confidence in providing counseling services to individuals with IDD. Overall, this study supported the research hypotheses and begins to close the gap in literature related to counselors' attitudes toward individuals with IDD and the impact those attitudes have on counseling treatment, outcomes, and counselors' confidence in providing services to this population.

REFERENCES

Akrami, N., Ekehammar, B., Claesson, M., & Sonnander, K. (2006). Classical and modern prejudice: Attitudes toward people with intellectual disabilities. *Research in Developmental Disabilities, 27*, 605-617. doi: 10.1016/j.ridd.2005.07.003

Al-Kandari, H. Y. (2015). High school students' contact with and attitudes toward persons with intellectual and developmental disabilities in Kuwait. *Australian Social Work, 68*(1), 65-83. doi: 10.1080/0312407X.2014.946429

Allport, G. W. (1954). *The nature of prejudice.* Cambridge, MA: Addison-Wesley.

Al Ramiah, A., & Hewstone, M. (2013). Intergroup contact as a tool for reducing, resolving, and preventing intergroup conflict: Evidence, limitations, and potential. *American Psychologist, 68*(7), 527-542. doi: 10.1037/a0032603

Alves, H., Koch, A., & Unkelbach, C. (2018). A cognitive-ecological explanation of intergroup biases. *Psychological Science, 29*(7), 1126-1133. doi: 10.1177/0956797618756862

American Association on Intellectual and Developmental Disabilities. (2011). *Intellectual disability: Definition, classification, and systems of supports* (11th ed.). Washington DC: American Association on Intellectual and Developmental Disabilities.

American Counseling Association. (2014). *Code of Ethics.*

American Psychological Association. (2012). Guidelines for assessment of and intervention with persons with disabilities. *American Psychologist, 67*(1), 43-62. doi: 10.1037/a0025892

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Association.

Amir, Y. (1969). Contact hypothesis in ethnic relations. *APA Psychological Bulletin, 71*(5), 319-342.

Anderson, L. L., Humphries, K., McDermott, S., Marks, B., Sisirak, J., & Larson, S. (2013). The state of the science of health and wellness for adults with intellectual and developmental disabilities. *Intellectual and Developmental Disabilities, 51*(5), 385-398. doi: 10.1352/1934-9556-51.5.385

Anderson, L. L., Larson, S. A., Lakin, K. C., & Kwak, N. (2003). Health insurance coverage and health care experiences of persons with disabilities in the NHIS-D. *DD Data Brief, 5*(1). Minneapolis: University of Minnesota, Research and Training Center on Community Living.

Angermeyer, M. C., & Dietrich, S. (2006). Public beliefs about and attitudes towards people with mental illness: A review of population studies. *Acta Psychiatrica Sandinavica, 113,* 163-179.

Anslow, K. (2013). Systemic family therapy using the reflecting team: The experiences of adults with learning disabilities. *British Journal of Learning Disabilities, 42,* 236-243. doi: 10.1111/bid.12048

Antonak, R. F. (1994). Development and psychometric analysis of an indirect measure of attitudes toward individuals with mental retardation using the error-choice method. *Mental Retardation, 32*(5), 347-355.

Araten-Bergman, T., & Werner, S. (2017). Social workers' attributions towards individuals with dual diagnosis of intellectual disability and mental illness. *Journal of Intellectual Disability Research, 61*(2), 155-167. doi: 10.1111/jir.12300

Balogh, R. S., Hunter, D., & Ouellette-Kuntz, H. (2005). Hospital utilization among persons with an intellectual disability, Ontario, Canada, 1995-2001. *Journal of Applied Research in Intellectual Disabilities, 18,* 181-190. doi: 10.1111/j.1468-3148.2005.00247.x

Barol, B. I., & Seubert, A. (2010). Stepping stones: EMDR treatment of individuals with intellectual and developmental disabilities and challenging behavior. *Journal of EMDR Practice and Research, 4*(4), 156-169. doi: 10.1891/1933-3196.4.4.156

Barr, J. J., & Bracchitta, K. (2008). Effects of contact with individuals with disabilities: Positive attitudes and majoring in education. *The Journal of Psychology, 142*(3), 225-243.

Baruth, L. G., & Manning, M. L. (2016). *Multicultural counseling and psychotherapy: A lifespan approach* (6th ed.). New York, NY: Routledge.

Benham, P. K. (1988). Attitudes of occupational therapy personnel towards persons with disabilities. *American Journal of Occupational Therapy, 42*,305-311. doi: 10.5014/ajot.42.5.305

Berliner, A. K. (1986). Overcoming obstacles to counselling with the mentally retarded. *British Journal of Mental Subnormality, 32*(62), 42-48. http://dx.doi.org.exproxy.liberty.edu/10.1179/bjms.1986.006.

Berry, J. O., & Meyer, J. A. (1995). Employing people with disabilities: Impact of attitude and situation. *Rehabilitation Psychology, 40,* 211-223.

Bernstein, B. L., Lecomte, C., & Des Harnais, G. (1983). Therapist expectancy inventory: Development and preliminary validation. *Psychological Reports, 52,* 479-487.

Bishop, K. M., Robinson, L. M., & VanLare, S. (2013). Healthy aging for older adults with intellectual and developmental disabilities. *Journal of Psychosocial Nursing & Mental Health Services, 51*(1), 15-18. doi: 10.3928/02793695-20121218-02

Brown, D. L., & Pomerantz, A. M. (2011). Multicultural incompetence and other unethical behaviors: Perceptions of therapist practices. *Ethics & Behavior, 21*(6), 498-508. doi: 10.1080/105084422.2011.622182

Brown, R., & Hewstone, M. (2005). An integrative theory of intergroup contact. *Advances in Experimental Social Psychology, 37,* 255-343. doi: 10.1016/S0065-2601(05)37005-5

Cage, E., Di Monaco, J., & Newell, V. (2018). Understanding, attitudes and dehumanisation towards autistic people. *Autism,* 1-11. doi: 10.1177/1362361318811290

Capozza, D., Di Bernardo, G. A., Falvo, R. Vianello, R. & Calo, L. (2016). Individuals with intellectual and developmental disabilities: Do educators assign them a fully human status? *Journal of Applied Social Psychology, 46,* 497-509. doi: 10.1111/jasp.12377

Chapin, M., McCarthy, H., Shaw, L., Bradham-Cousar, M., Chapman, R., Nosek, M., Peterson, S., Yilmaz, Z., & Ysasi, N. (2018). *Disability-related counseling competencies*. Alexandria, VA: American Rehabilitation Counseling Association, a division of ACA.

Chubon, R. A. (1982). An analysis of research dealing with the attitudes of professionals toward disability. *Journal of Rehabilitation, 48*(1), 25-30.

Committee on Disability in America (2007). *The future of disability in America.* (M. J. Field, & A. M. Jette, Eds.) Washington DC: The National Academies Press. Retrieved from http://www.nap.edu/catalog/11898.html

Cook, B. G., Cameron, D. L., & Tankersley, M. (2007). Inclusive teachers' attitudinal ratings of their students with disabilities. *The Journal of Special Education, 40*(4), 230-238.

Cook, S. W., & Selltiz, C. (1955). Some factors which influence the attitudinal outcomes of personal contacts. *International Sociological Bulletin, 7,* 51-58.

Cooper, S. A., Smiley, E., Finlayson, J., Jackson, A., Allan, L., Williamson, A., Mantry, D., & Morrison, J. (2007). The prevalence, incidence, and factors predictive of mental ill-health in adults with profound intellectual disabilities. *Journal of Applied Research in Intellectual Disabilities, 20,* 493-501. https://doi.org/10.1111/jar.2007.20.issue-6

Cooper, S. A., Smiley, E., Morrison, J., Williamson, A., & Allan, L. (2007). Mental ill-health in adults with intellectual disabilities: Prevalence and associated factors. *British Journal of Psychiatry, 190*(1), 27-35. https://doi.org/10.1192/bjp.bp.106.022483

Coughlin, E. (2007). *Working with clients with developmental disabilities: Attitudes and experiences of Canadian counsellors* (Doctoral dissertation). Retrieved from UMI Dissertation Publishing/ProQuest LLC. (1564104).

Council for Accreditation of Counseling and Related Educational Programs. (2015). *2016 CACREP Standards.*

Crotty, G., & Doody, O. (2015). Therapeutic relationships in intellectual disability nursing practice. *Learning Disability Practice, 18*(7), 25-29.

Crowne, D. P. & Marlowe, D. (1960). A new scale of social desirability independent of psychopathology. *Journal of Consulting Psychology, 24*(4), 349-354.

Dagnan, D., Masson, J., Cavagin, A., Thwaites, R., & Hatton, C. (2014). The development of a measure of confidence in delivering therapy to people with intellectual disabilities. *Clinical Psychology & Psychotherapy, 22,* 392-398.

Dagnan, D., Masson, J., Thwaites, R., James, A., & Hatton, C. (2017). Training therapists to work with people with intellectual disability in Improving Access to Psychological Therapies (IAPT) services. *Journal of Applied Research Intellect Disability, 31,* 760-767. doi: 10.1111/jar.12427

Department of Health. (2001). *Valuing people: A new strategy for learning disability for the 21st century*. London, UK: The Stationary Office.

Desforges, D. M., Lord, C. G., Ramsey, S. L., Mason, J. A., Van Leeuwen, M. D., & West, S. C. (1991). Effects of structured cooperative contact on changing negative attitudes toward stigmatized social groups. *Journal of Personality and Social Psychology, 60*(4), 531-544.

Dhillon, P. K., & Chaudhuri, S. (1990). A study of the "meaning" of the concept of mental retardation as held by the community. *Manas, 37,* 1-8.

Dorji, S., & Solomon, P. (2009). Attitudes of health professionals toward persons with disabilities in Bhutan. *Asia Pacific Disability Rehabilitation Journal, 20*(2), 32-42.

Dovidio, J. F., Glick, P., & Rudman, L. A. (Eds.). (2008). *On the nature of prejudice: Fifty years after Allport.* New York, NY: John Wiley & Sons.

Durbin, A., Sirotich, F., Lunsky, Y., & Durbin, J. (2017). Unmet needs of adults in community mental health care with and without intellectual and developmental disabilities: A cross-sectional study. *Community Mental Health Journal, 53*, 15-26. doi: 10.1007/s10597-015-9961-6

Edwards, N., Lennox, N., & White, P. (2007). Queensland psychiatrists' attitudes and perceptions of adults with intellectual disability. *Journal of Intellectual Disability Research, 50*(1), 75-81. doi: 10.1111/j.1365-2788.2006.00870.x

Eggert, D., & Berry, P. (1992). German, Irish and Australian high school students' perceptions of mental handicap. *International Journal of Rehabilitation Research, 15,* 349-354.

Einfeld, S. L., Piccinin, A. M., Mackinnon, A., Hofer, S. M., Taffe, J., Gray, K. M., Bontempo, D. E., Hoffman, L., R., Parmenter, T., & Tonge, B. J. (2006). Psychology in young people with intellectual disability. *JAMA, 296*(16). 1981-1989. doi: 10.1001/jama.296.16.1981

Friedman, C. (2019). The relationship between disability prejudice and institutionalization of people with intellectual and developmental disabilities. *Intellectual and Developmental Disabilities, 57*(4), 263-273. doi: 10.1352/1934-9556-57.4.263

Furnham, A., & Thompson, R. (1994). Actual and perceived attitudes of wheelchair users. *Counseling Psychology Quarterly, 7,* 35-52.

Geckil, E., Kaleci, E., Cingil, D., & Hisar, F. (2017). The effect of disability empathy activity on the attitude of nursing students towards disabled people: A pilot study. *Contemporary Nurse, 53*(1), 82-93. Retrieved from: http://dx.doi.org/10.1080/10376178.2017.1292143

Gething, L. (1994). The interaction with disabled persons scale. *Journal of Social Behavior and Personality, 9*(5), 23-42.

Goodyear, R. K. (1983). Patterns of counsellors' attitudes towards disability groups. *Rehabilitation Counselling Bulletin, 26*(3), 181-184.

Gordon, P. A., Tantillo, J. C., Feldman, D., & Perrone, K. (2004). Attitudes regarding interpersonal relationships with persons with mental illness and mental retardation. *Journal of Rehabilitation, 70*(1), 50-56.

Goreczny, A. J., Bender, E. E., Caruso, G., & Feinstein, C. S. (2011). Attitudes toward individuals with disabilities: Results of a recent survey and implications of those results. *Research in Developmental Disabilities, 32,* 1596-1609. doi: 10.1016/j.ridd.2011.02.005

Gustafsson, C., & Sonnander, K. (2004). Occurrence of mental health problems in Swedish samples of adults with intellectual disabilities. *Social Psychiatry and Psychiatry Epidemiology, 39*(6), 448-456. doi: 10.1007/s00127-044-0774-0

Hampton, N. Z. & Xiao, F. (2007). Attitudes toward people with developmental disabilities in Chinese and American students: The role of cultural values, contact, and knowledges. *Journal of Rehabilitation, 73*(3), 23-32.

Harvey, D., & Green, C. (1984). Attitudes of New Zealand teachers, teachers in training and non-teachers toward mainstreaming. *Journal of Educational Studies, 19,* 34-44.

Heinonen, E. I., Lindfors, O., Laaksonen, M. A., & Knept, P. (2012). Therapists' professional and personal characteristics as predictors of outcome in short- and long-term psychotherapy. *Journal of Affective Disorders, 138,* 301-312.

Henry, D., Keys, C., Jopp, D., & Balcazar, F. (1996). The community living attitudes scale, mental retardation form: Development and psychometric properties. *Mental Retardation, 34*(3), 149-158.

Hewstone, M., & Brown, R. (1986). Contact is not enough: An intergroup perspective on the 'contact hypothesis.' In M. Hewstone & R. Brown (Eds.), *Contact and conflict in intergroup encounters* (pp. 1-44). Oxford, England: Blackwell.

Hodges, S. (2003). *Counseling adults with learning disabilities.* Basingstoke, Hampshire: Palgrave Macmillan.

Hronis, A., Roberts, L., & Kneebone, I. (2018). Assessing the confidence of Australian mental health practitioners in delivering therapy to people with intellectual disability. *Intellectual and Developmental Disabilities, 56*(3), 202-211. doi: 10.1352/1934-9556-56.3.202

Jahoda, A., & Markova, I. (2004). Coping with social stigma: People with intellectual disabilities moving from institutions and family home. *Journal of Intellectual Disabilities Research, 48,* 719-729.

Jones, R. A. (2013). Therapeutic relationships with individuals with learning disabilities: A qualitative study of the counselling psychologists' experience. *British Journal of Learning Disabilities, 42,* 193-203.

Jones, R. A., & Donati, M. (2009). The therapeutic relationship in psychological therapy for individuals with learning disabilities: A review of existing literature. *Adv Mental Health Learn Disability, 3,* 47-51.

Kanellakis, P. (2010). Counselling psychology and disability. *Europe's Journal of Psychology,* 123-149.

Katz, A. D., & Hoyt, W. T. (2014). The influence of multicultural counseling competence and anti-black prejudice on therapists' outcome expectancies. *Journal of Counseling Psychology, 61*(2), 299-305. doi: 10.1037/a0036134

Katz, J. (1985). The sociopolitical nature of counseling. *The Counseling Psychologist, 13,* 615-624.

Keijsers, G. P., Schaap, C. P., & Hoogduin, C. A. (2000). The impact of interpersonal patient and therapist behavior on outcome in cognitive behaviours therapy: A review of empirical studies. *Behavior Modification, 24,* 264-297.

Keith, J. M., Bennetto, L., & Rogge, R. D. (2015). The relationship between contact and attitudes: Reducing prejudice toward individuals with intellectual and developmental disabilities. *Research in Developmental Disabilities, 47,* 14-26. Retrieved from: http://dx.doi.org/10.1016;j.ridd.2015.07.032

Kennon, A. F., & Sandoval, J. (1978). Teacher attitudes toward the educable mentally retarded. *Education and Training of the Mentally Retarded, 13*(2), 139-145. https://www.jstor.org/stable/23876887

Kishore, M. T., Udipi, G. A., & Seshadri, S. P. (2019). Clinical practice guidelines for assessment and management of intellectual disability. *Indian Journal of Psychiatry, 61*, 194-210.

Koch, A., Vogel, A., Holzmann, M., Pfennig, A., Salize, H. J., Puschner, B., & Schutzwohl, M. (2014). MEMENTA – 'Mental healthcare provision for adults with intellectual disability and a mental disorder'. A cross-sectional epidemiological multisite study assessing prevalence of psychiatric symptomatology, needs for care and quality of healthcare provision for adults with intellectual disability in Germany: A study protocol. *BJM Open, 4*(5), 1-7. doi: 10.1136/bmjopen-2014-004878

Korman, M. (1974). National conference on levels and patterns of professional training in psychology: Major themes. *American Psychologist, 29,* 301-313.

Krahn, G. L., Hammond, L., & Turner, A. (2006). A cascade of disparities: Health and health care access for people with intellectual disabilities. *Mental Retardation and Developmental Disabilities Research Reviews, 12,* 70-82. doi: 10.10002/mrdd

Kritsotakis, G., Galanis, P., Papastefanakis, E., Meidani, F., Philalithis, A. E., Kalokairinou, A., & Sourtzi, P. (2017). Attitudes towards people with physical or intellectual disabilities among nursing, social work, and medical students. *Journal of Clinical Nursing,* 4951-4963. doi: 10.1111/jocn.13988

LaLiberte, T., Piescher, K., Mickelson, N., & Lee, M. H. (2016). Child protection services and parents with intellectual and developmental disabilities. *Journal of Applied Research in Intellectual Disabilities, 30*(2), 521-532. doi: 10.1111/jar.12323

Lambert, C. E., Arbuckle, S. A., & Holden, R. R. (2016). The Marlowe-Crowne social desirability scale outperforms the BIDR impression management scale for identifying

fakers. *Journal of Research in Personality, 61*, 80-86. http://dx.doi.org/10.1016/j.jrp.2016.02.004

Lambert, M. J. & Barley, D. E. (2001). Research summary on the therapeutic relationship and psychotherapy outcome. *Psychotherapy, 38,* 357-361.

Larson, S. A., Eschenbacher, H. J., Anderson, L. L., Taylor, B., Pettingell, S., Hewitt, A., Sowers, M., & Bourne, M. L. (2018). *In-home and residential long-term supports and services for persons with intellectual or developmental disabilities: Status and trends through 2016.* Minneapolis, MN: University of Minnesota.

Lau, J. T. & Cheung, C. (1999). Discriminatory attitudes to people with intellectual disability or mental health difficulty. *International Social Work, 42*(4), 431-444.

Lennox, N., & Chaplin, R. (1996). The psychiatric care of people with intellectual disabilities: The perceptions of consultant psychiatrists in Victoria. *Australian and New Zealand Journal of Psychiatry, 30*, 774-780.

Lewis, M. A., Lewis, C. E., Leake, B., King, B. H., & Lindemann, R. (2002). The quality of health care for adults with developmental disabilities. *Public Health Reports, 117,* 174-184.

Lorenzo, T., Van Pletzen, E., & Booyens, M. (2015). Determining the competencies of community based workers for disability-inclusive development in rural areas of South Africa, Botswana and Malawi. *International Journal of Remote and Rural Health, 15,* 2919. Retrieved from http://www.rrh.org.au/publishedarticles/article_print_2919.pdf

Lunsky, Y., Balogh, R. S., Cobigo, V., Isaacs, B., Lin, E., & Ouellette-Kuntz, H. M. (2014). Primary care of adults with developmental disabilities in Ontario. *Healthcare Quarterly, 17*(3), 11-13.

Lunsky, Y., & Bradley, E. (2001). Developmental disability training in Canadian psychiatry residency programs. *Canadian Journal of Psychiatry, 46*(2), 138-143.

Marwood, H., Chinn, D., Gannon, K., & Scior, K. (2016). The experiences of high intensity therapists delivering cognitive behavioural therapy to people with intellectual disabilities. *Journal of Applied Research in Intellectual Disabilities, 31*, 76-86. doi: 10.1111/jar.12328

Mason, J., & Scior, K. (2004). Diagnostic overshadowing amongst clinicians working with people with intellectual disabilities in the UK. *Journal of Applied Research in Intellectual Disabilities, 17,* 85-90. doi: 10.1111/j.1360-2322.2004.00184.x

McDermott, S., Royer, J., Cope, T., Lindgren, S., Momany, E., Lee, J. C., McDuffie, M. J., Lauer, E., Kurtz, S., & Armour, B. S. (2018). Using Medicaid data to characterize persons with intellectual and developmental disabilities in five U.S. states. *American Journal on Intellectual and Developmental Disabilities, 123*(4), 371-381. doi: 10.1352/1944-7558-123.4.371

Melville, C. A., Finlayson, J., Cooper, S. A., Allan, L., Robinson, N., Burns, E., Martin, G., & Morrison, J. (2005). Enhancing primary health care services for adults with intellectual disabilities. *Journal of Intellectual Disability Research, 49*(3), 190-198. doi: 10.1111/j.1365-2788.2005.00640.x

Miller, M. (1984). Social acceptability characteristics of learning disabled students. *Journal of Learning Disabilities, 17,* 619-621.

Nagata, K. K. (2007). The measurement of the Hong Kong-based "baseline survey of students' attitudes toward people with a disability:" Cross-cultural validation in Lebanon. *International Journal of Rehabilitation Research, 30,* 239-241.

O'Brien, A., & Rose, J. (2010). Improving mental health services for people with intellectual disabilities: Service users' views. *Advances in Mental Health and Intellectual Disabilities, 4*(4), 40-47. doi: 10.5042/amhid.2010.0674

O'Hara, J. (2008). Attending to the health needs of people with intellectual disability: Quality standards. *Salud publica de Mexico, 50*(S2), 154-159.

Olkin, R., & Pledger, C. (2003). Can disability studies and psychology join hands? *American Psychologist, 58*(4), 296-304. doi: 10.1037/0003-066X.58.4.296

Olmstead v. L.C., No. 98-536, 527 581 (Supreme Court 1999).

Ong, N., McCleod, E., Nicholls, L. E., Fairbairn, N., Tomsic, G., Lord, B., & Eapen, V. (2017). Attitudes of healthcare staff in the treatment of children and adolescents with intellectual disability: A brief report. *Journal of Intellectual & Developmental Disability, 42*(3), 295-300. https://doi.org/10.3109/13668250.2016.1236368

Orlinsky, D., Grawe, K., & Parks, B. K. (1994). Process and outcome in psychotherapy: Noch einmal. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behaviour change* (pp. 270-376). Oxford, England: John Wiley & Sons.

Parkes, G., Mukherjee, R. A. S., Karagianni, E., Attavar, R., Sinason, V., & Hollins, S. (2007). Referrals to an intellectual disability psychotherapy service in an inner city catchment area – A retrospective case notes study. *Journal of Applied Research in Intellectual Disabilities, 20,* 373-378. doi: 10.1111/j.1468-3148.2006.00348.x

Pettigrew, T. F. (1998). Intergroup contact theory. *Annual Review of Psychology, 49,* 65-85. doi: 10.1146/annurev.psych.49.1.65

Plan, E. A. & Devine, P. G. (2003). The antecedents and implications of interracial anxiety. *Personality and Social Psychology Bulletin, 29,* 1-12. doi: 10.1177/0146167203252880

Potvin, L. A., Barnett, B. M., Brown, H. K., & Cobigo, V. (2019). “I didn’t need people’s negative thoughts”: Women with intellectual and developmental disabilities reporting attitudes toward their pregnancy. *Canadian Journal of Nursing Research, 51*(3), 154-167. doi: 10.1177/0844562118819924

Raffensperger, M. K. (2009). Factors that influence outcomes for clients with an intellectual disability. *British Journal of Guidance and Counselling, 37*(4), 495-509. doi: 10.1080/03069880903161369

Rees, L. M., Spreen, O., & Harnadek, M. (1991). Do attitudes towards persons with handicaps really shift over time? Comparison between 1975 and 1988. *Mental Retardation, 29*(2), 81-86.

Ridley, C., & Kleiner, A. (2003). Multicultural counseling competence: History, themes, and issues. In D. Pope-Davis, H. Coleman, & W. Liu (Eds.), *Handbook of multicultural competencies in counseling & psychology* (pp. 3-20). Thousand Oaks, CA: Sage. doi: 10.4135/9781452231693.n1

Rimmer, J. H., & Hsieh, K. (2011). Longitudinal health and intellectual disability study (LHIDS) on obesity and health risk behaviors. *Proceedings of the Lifespan Health and Function of Adults with Intellectual Disabilities: Translating Research into practice, State of the Science Conference,* Bethesda, MD.

Rizzo, T. L., & Vispoel, W. P. (1991). Physical educators’ attributes and attitudes toward teaching students with handicaps. *Adapted physical activity quarterly, 8*(1), 4-11.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21*(2), 95-103.

Rose, N., O'Brien, A., & Rose, J. (2007). Investigating staff knowledge and attitudes towards working with adults with learning disabilities and mental health difficulties. *Advances in Mental Health and Learning Disabilities, 1*(3), 52-59. doi: 10.1108/17530180200700031

Rubino, M. J., III. (2001). *Psychologists' clinical judgments about a female client with a visible disability, hidden disability or no disability.* Unpublished doctoral dissertation, California School of Professional Psychology, Berkley/Alameda.

Ruedrich, S., Schwartz, S., Dunn, J., & Nordgren, L. (2008). Educating psychiatric residents in intellectual disability: Does exposure during residency affect attitudes toward persons with intellectual disability? *Mental Health Aspects of Developmental Disabilities, 11*(4), 122-126.

Schriner, K. (2001). A disability studies perspective on employment issues and policies for disabled people: An international view. In G. L. Albrecht, K. Seelman, & M. Bury (Eds.), *Handbook of disability studies* (pp. 642-662). Thousand Oaks, CA: Sage.

Scior, K. (2011). Public awareness, attitudes and beliefs regarding intellectual disability: A systematic review. *Research in Developmental Disabilities, 32,* 2164-2182. doi: 10.1016/j.ridd.2011.07.005

Scott, N., Lakin, K. C., & Larson, S. A. (2008). The 40th anniversary of deinstitutionalization in the United States: Decreasing state institutional populations, 1967-2007. *Intellectual and developmental disabilities, 46*(5), 402-405. doi: 10.1352/2008.46:402-405

Sheridan, J., & Scior, K. (2013). Attitudes towards people with intellectual disabilities: A comparison of young people from British South Asian and White British backgrounds. *Research in Developmental Disabilities, 34*(4), 1240-1247. https://doi.org/10.1016/j.ridd.2012.12.017

Sherif, M., & Sherif, C. W. (1953). *Groups in harmony and tension: An integration of studies in intergroup relations.* New York, NY: Harper.

Siperstein, G. N., & Gottlieb, J. (1978). Parents' and teachers' attitudes toward mildly and severely retarded children. *Mental Retardation, 16*(4), 321-322.

Siperstein, G. N., Norins, J., Corbin, S., & Shriver, T. (2003). *Multinational study of attitudes toward individuals with intellectual disabilities.* Washington, DC: Special Olympics Inc.

Smart, J. (2001). *Disability, society, and the individual.* Austin, TX: Pro-Ed.

Stainback, S., & Stainback, W. (1982). Influencing the attitudes of regular class teachers about the education of severely retarded students. *Education and Training of the Mentally Retarded, 17*(2), 88-92. Retrieved from https://www.jstor.org/stable/23877166

Staub, E. (1996). Cultural-societal roots of violence: The examples of genocidal violence and of contemporary youth violence in the United States. *American Psychologist, 51*(2), 117-132.

Stephan, W. G. (1987). The contact hypothesis, in C. Hendrick (ed.) *Group Processes and Intergroup Relations (*pp. 13-40). Newbury Park, CA: Sage.

Strike, D. L., Skovholt, T. M., & Hummel, T. J. (2004). Mental health professionals' disability competence: Measuring self-awareness, perceived knowledge, and perceived skills. *Rehabilitation Psychology, 49*(4), 321-327. doi: 10.1037/0090-5550.49.4.321

Stuntzner, S., & Hartley, M. T. (2014). Disability and the counseling relationship: What counselors need to know. *VISTAS Online, 9,* 1-12.

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling and Development, 70*(4), 477-486. doi: 10.1002/j.1556-6676.1992.tb01642.x

Sue, D. W., & Sue, D. (1990). *Counseling the culturally different: Theory and practice.* Wiley.

Triblet, R. G. & Sugarman, D. B. (1987). Reactions to AIDS victims: Ambiguity breeds contempt. *Personality and Social Psychology Bulletin, 13*(2), 265-274.

Weiss, J. A., Lunsky, Y., Gracey, C., Canrinus, M., & Morris, S. (2009). Emergency psychiatric services for individuals with intellectual disabilities: Caregivers' perspectives. *Journal of Applied Research in Intellectual Disabilities, 22,* 354-362. doi: 10.1111/j.1468-3148.2008.00468.x

Werner, S. (2015). Stigma in the area of intellectual disabilities: Examining a conceptual model of public stigma. *American Journal on Intellectual and Developmental Disabilities, 120,* 460-475. doi: 10.1352/1944-7558-120.5.460

Werner, S. & Araten-Bergman, T. (2017). Social workers' stigmatic perceptions of individuals with disabilities: A focus on three disabilities. *Journal of Mental Health Research in Intellectual Disabilities, 10*(2), 93-107. https://doi.org/10.1080/19315864.2017.1284288

Werner, S., & Stawski, M. (2012). Knowledge, attitudes and training of professionals on dual diagnosis of intellectual disability and psychiatric disorder. *Journal of Intellectual Disability Research, 56*(3), 291-304. doi: 10.1111/j.1365-2788.211.01429.x

Westerhof, G. J., Beernink, J., & Sools, A. (2016). Who am I? A life story intervention for persons with intellectual disability and psychiatric problems. *Intellectual and Developmental Disabilities, 54*(3), 173-186. doi: 10.1352/1934-9556-54.3.173

Wilson, M. C., & Scior, K. (2015). Implicit attitudes towards people with intellectual disabilities: Their relationship with explicit attitudes, social distance, emotions and contact. *PLoS ONE, 10*(9), 1-19. doi: 10.1371/journal.pone.0137902

World Health Organization. (2001). *International classification of functioning, disability, and health.* Geneva: World Health Organization.

Wyatt v. Stickney, 325 F. Supp. 781 (M.D. Ala. 1971).

Yuker, H. (1994). Variables that influence attitudes toward people with disabilities: Conclusions from the data. *Journal of Social Behavior and Personality*, *9,* 3-22.

Yuker, H. E., Block, J.R., & Younng, J. H. (1970). *The measurement of attitudes toward disabled persons*. Albertson, NY: Human Resources Center.

APPENDIX A: Personal and Professional Experience Questionnaire

1. Do you consider yourself to have a disability?
    a. Yes
    b. No
2. Do you consider yourself to have an IDD?
    a. Yes
    b. No
3. In the past, I have interacted with individuals with IDD in many areas in my life (e.g., school, friends, clubs).
    a. Completely agree
    b. Agree
    c. I don't know
    d. Disagree
    e. Completely disagree
4. The neighborhood(s) I grew up in had individuals with IDD.
    a. Completely agree
    b. Agree
    c. I don't know
    d. Disagree
    e. Completely disagree
5. Do you have a personal relationship with someone with IDD? (Check all that apply.)
    a. Immediate or extended family member
    b. Friend

c. Neighbor

d. Other Relationship (please explain): _____

6. If you indicated that you have an immediate or extended family member with IDD, on average how much contact do you have with this individual?

    a. Less than once a year

    b. 1-6 times per year (less than every other month)

    c. 7-11 times per year

    d. Once per month

    e. Once per week

    f. 2-7 times per week

    g. Constant

7. If you indicated that you have a friend with IDD, on average how much contact do you have with this individual?

    a. Less than once a year

    b. 1-6 times per year (less than every other month)

    c. 7-11 times per year

    d. Once per month

    e. Once per week

    f. 2-7 times per week

    g. Constant

8. If you indicated that you have a neighbor with IDD, on average how much contact do you have with this individual?

    a. Less than once a year

b. 1-6 times per year (less than every other month)

c. 7-11 times per year

d. Once per month

e. Once per week

f. 2-7 times per week

g. Constant

9. If you indicated that you have some other relationship with an individual with IDD, on average how much contact do you have with this individual?

a. Less than once a year

b. 1-6 times per year (less than every other month)

c. 7-11 times per year

d. Once per month

e. Once per week

f. 2-7 times per week

g. Constant

10. Do you regularly see individuals with IDD in your day-to-day environment?

a. Yes

b. No

11. I have had many experiences with individuals with IDD.

a. Completely agree

b. Agree

c. Neutral

d. Disagree

e. Completely disagree

12. During your graduate training, did you receive specific in-classroom training on working with clients with IDD?
    a. Yes
    b. No
13. During your graduate practicum/internship experience, did you receive specific on-site training on working with clients with IDD?
    a. Yes
    b. No
14. During your graduate practicum/internship experience, did you work with clients with IDD?
    a. Yes
    b. No
15. Have you ever had a paid position in which you worked with a person with IDD?
    a. Yes
    b. No
16. If you have worked with clients with IDD, approximately how many of your clients had an IDD?
    a. All (100%)
    b. Almost All (75%)
    c. Some (50%)
    d. Almost None (25%)
    e. None (0%)

17. Have you ever volunteered with a person with IDD?

    a. Yes

    b. No

APPENDIX B: IRB Approval Letter

LIBERTY UNIVERSITY.
INSTITUTIONAL REVIEW BOARD

February 13, 2020

Alysha Blagg
IRB Exemption 4186.021320: Mental Health Counseling for Individuals with Intellectual/Developmental Disabilities: Attitudes and Experiences of Licensed Counselors

Dear Alysha Blagg,

The Liberty University Institutional Review Board has reviewed your application in accordance with the Office for Human Research Protections (OHRP) and Food and Drug Administration (FDA) regulations and finds your study to be exempt from further IRB review. This means you may begin your research with the data safeguarding methods mentioned in your approved application, and no further IRB oversight is required.

Your study falls under exemption category 46.101(b)(2), which identifies specific situations in which human participants research is exempt from the policy set forth in 45 CFR 46:101(b):

> (2) Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met:
>
> > (i) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained, directly or through identifiers linked to the subjects;

Please note that this exemption only applies to your current research application, and any changes to your protocol must be reported to the Liberty IRB for verification of continued exemption status. You may report these changes by submitting a change in protocol form or a new application to the IRB and referencing the above IRB Exemption number.

If you have any questions about this exemption or need assistance in determining whether possible changes to your protocol would change your exemption status, please email us at irb@liberty.edu.

Sincerely,

[redacted]

G. Michele Baker, MA, CIP
Administrative Chair of Institutional Research
Research Ethics Office

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APPENDIX C: Demographic Questionnaire

1. What is your gender?
    a. Male
    b. Female
2. What is your age in years?
    a. 18-24
    b. 25-34
    c. 35-44
    d. 45-54
    e. 55-64
    f. 65-74
    g. 75+
    h. Under 18-years-old
3. What is your race or ethnicity?
    a. White
    b. Hispanic, Latino, or Spanish
    c. Black or African American
    d. Asian or Asian Indian
    e. American Indian or Alaska Native
    f. Middle Eastern or North African
    g. Native Hawaiian or Other Pacific Islander
    h. Other (Please specify) _____
4. What is your highest level of education?

   a. Bachelors/4-year degree
   b. Masters
   c. Doctoral (Ph.D., Psy.D., etc.)

5. Do you hold a current counselor's license?
   a. Yes
   b. No

6. What is your current license?
   a. LPC
   b. LPCC
   c. MFT
   d. LMFT
   e. LSW
   f. LISW
   g. Other (please explain) _____

7. In what state do you currently use your license? _____

8. How long have you been practicing with your current license?
   a. 0-4 years
   b. 5-9 years
   c. 10-14 years
   d. 15-20 years
   e. 21-30 years
   f. 31-40 years
   g. 41+ years

9. In what mental health setting do you currently practice? (Check all that apply.)
    a. Private individual practice (i.e., you are the sole practitioner in this practice)
    b. Private group practice (i.e., you are an independent practitioner but there are other practitioners in this practice)
    c. Community mental health agency
    d. Alcohol/drug rehabilitation facility
    e. In-home treatment
    f. Residential treatment facility
    g. Hospital setting
    h. Other (Please specify)
10. With what age group do you typically work? (Check all that apply.)
    a. Children (up to 12-years-old)
    b. Adolescence (13- to 17-years-old)
    c. Young Adults (18- to 25-years-old)
    d. Older Adults (26- to 54-years-old)
    e. Senior Adults (55-years-old or older)

APPENDIX D: Informed Consent Statement

The Liberty University Institutional Review Board has approved this document for use from 2/13/2020 to -- Protocol # 4186.021320

Informed Consent
Mental Health Counseling for Individuals with Intellectual/Developmental Disabilities: Attitudes and Experiences of Licensed Counselors
Alysha Blagg
Liberty University
School of Behavioral Sciences

You are invited to be in a research study to better understand the beliefs counselors hold regarding individuals with intellectual and developmental disabilities (IDD). You were selected as a possible participant because of being a counselor with a current license. You are eligible to participate if you are at least 18-years-old and hold a current counseling license. Please read this form and ask any questions you may have before agreeing to be in this study.

Alysha Blagg, a doctoral candidate in the School of Behavioral Sciences at Liberty University is conducting this study.

Background information: The purpose of this study is to gain understanding of the beliefs counselors hold regarding individuals with IDD and how that impacts mental health services received by those individuals.

Procedures: If you agree to be in this study, I would ask you to do the following things:

1. Complete an anonymous survey. This survey should take approximately 15 to 20 minutes to complete. You are asked to complete all survey questions honestly and to the best of your understanding.

Risks: The risks involved in this study are minimal, which means they are equal to the risks you would encounter in everyday life.

Benefits: Participants should not expect to receive a direct benefit from taking part in this study. Benefits to society include, increased knowledge regarding counselors, mental health services, and how to better serve individuals with IDD and mental health concerns.

Compensation: Participants will not be compensated for participating in this study.

Confidentiality: The records of this study will be kept private. Research records will be stored securely, and only the researcher and her dissertation chair will have access to the records. Participant responses will be anonymous and no personally identifiable information will be collected. Data will be stored on a password locked computer and may be used in future presentations. Data will be destroyed after 3 years. A summary of findings resulting from this survey will be published as a completed dissertation document. Additionally, data collected from this survey may be used in additional publications, presented at a conference, or published in a scholarly journal.

Voluntary Nature of the Study: Participation in this study is voluntary. Your decision whether or not to participate will not affect your current or future relations with Liberty University. If

you decide to participate, you are free to not answer any question or withdraw at any time, prior to submitting the survey, without affecting those relationships.

How to Withdraw from the Study: If you choose to withdraw from the study, please exit the survey and close your internet browser. Your responses will not be recorded or included in the study.

Contacts and Questions: The research conducting this study is Alysha Blagg. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact Alysha at [redacted]. You may also contact the researcher's faculty chair, Dr. John Thomas, at [redacted].

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA, 24515 or email at irb@liberty.edu.

Please notify the researcher if you would like a copy of this information for your records.