Increasing Adequate Social Interactions Among People With and Without Disabilities

Meghan Link

Western Oregon University, meghanlink@hotmail.com

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Increasing Adequate Social Interactions Among People With and Without Disabilities

By

Meghan E. Link

An Honors Thesis Submitted in Partial Fulfillment of the Requirements for Graduation from the Western Oregon University Honors Program

Dr. Amber Feist, Thesis Advisor

Dr. Gavin Keulks, Honors Program Director

Western Oregon University

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Abstract

Individuals with disabilities share the same desires as people without disabilities to develop personal independence and experience a rewarding social life. However, people with disabilities often go without the opportunity to satisfy social needs as a result of isolation. The purpose of this conceptual thesis is to address this issue by exploring what research has been done in order to design a study to identify current attitudes towards people with disabilities and satisfaction of life. Results indicate there is a need for integration programs in order for social skills to allow individuals to comfortably interact with people without disabilities. It is necessary to incorporate people with and without disabilities in order to provide the opportunity for interaction to potentially decrease feelings of isolation through increased social interaction.

*Keywords:* disability, social needs, isolation, attitudes, satisfaction
Classification of Disability: Neurodevelopmental Disorders

The Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5; American Psychiatric Association, 2013) is the most widely accepted nomenclature used by clinicians and researchers for the classification of mental disorders. This thesis will focus on neurodevelopmental disorders. The DSM-5 classification of neurodevelopmental disorders includes the onset in the developmental period and characterized by developmental deficits that produce impairments of personal, social, academic, or occupational functioning (American Psychiatric Association, 2013). Neurodevelopmental disorders often co-occur in individuals (American Psychiatric Association, 2013).

Intellectual disability, or intellectual development disorder, is characterized by deficits in general mental abilities including reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience (American Psychiatric Association, 2013). According to the Individuals with Disabilities Education Act (IDEA) of 1990, intellectual disabilities manifest during the developmental period and often result in significantly subaverage intellectual functioning coexisting with deficits in adaptive behavior that adversely affects an individual’s educational performance (Pub. L. No. 101-476). These deficits often result in impairments such as an individual failing to meet the standards of personal independence and social responsibilities, which include: communication, social participation, academic or occupational function and person dependence in the home or community (American Psychiatric Association, 2013).

Communication disorders include language disorder, speech sound disorder, social (pragmatic) communication disorder, and childhood-onset fluency disorder
As described in IDEA, speech and language impairments such as stuttering, impaired articulation, or voice impairments negatively impact an individual’s educational performance. Communication disorders begin early in life and may produce lifelong functional impairments (American Psychiatric Association, 2013).

Autism spectrum disorder is characterized by persistent deficits in social communication and social interaction across multiple contexts (American Psychiatric Association, 2013). IDEA also defines other characteristics often associated with autism which include: engagement in repetitive activities and stereotyped movements, resistance to environmental change or change in daily routines, and unusual responses to sensory experiences or stimuli. Autism spectrum disorder also includes deficits in social reciprocity, nonverbal communicative behaviors used for social interaction, and skills in developing, maintaining, and understanding relationships (American Psychiatric Association, 2013).

The *DSM-5* defines attention deficit hyperactivity disorder, or ADHD, by impairing levels of inattention, disorganization, and/or hyperactivity-impulsivity (American Psychiatric Association, 2013). ADHD is classified under “Other health impairment” in IDEA, which means the individual has limited strength, vitality, or alertness as a result of chronic or acute health problems. Hyperactivity-impulsivity entails over activity, fidgeting, inability to stay seated or still, intruding other people’s activities, and inability to wait (American Psychiatric Association, 2013). ADHD often results with impairments of social, academic, and occupational functioning (American Psychiatric Association, 2013).
Neurodevelopmental motor disorders include developmental coordination disorder, stereotypic movement disorder, and tic disorders. The DSM-5 characterizes developmental coordination disorder by deficits in the acquisition and execution of coordinated motor skills and is manifested by clumsiness and slowness or inaccuracy of performance of motor skills that cause interference with activities of daily living (American Psychiatric Association, 2013). Stereotypic movement disorder is diagnosed when an individual has repetitive, seemingly driven, and apparently purposeless motor behaviors, which interfere with social, academic, or other activities (American Psychiatric Association, 2013).

The DSM-5 characterizes tic disorder by the presence of motor or vocal tics, which are sudden, rapid, recurrent, nonrhythmic, stereotyped motor movements or vocalizations (American Psychiatric Association, 2013). Tourette’s disorder is diagnosed when an individual has multiple motor or vocal tics that have been present for at least one year and have a waxing-waning symptom course (American Psychiatric Association, 2013).

The DSM-5 diagnoses specific learning disorders when there are specific deficits in an individual’s ability to perceive or process information efficiently and accurately (American Psychiatric Association, 2013). Specific learning disorders manifest during the early years of formal schooling (American Psychiatric Association, 2013). According to IDEA, the term “Specific learning disability” includes such conditions as perceptual disabilities, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia. IDEA states that the term “Specific learning disability” does not apply to individuals who have learning problems that are primarily the result of visual, hearing or
motor disabilities, intellectual disability, emotional disturbance, or environmental, cultural, or economic disadvantage. The *DSM-5* characterizes specific learning disorders by persistent and impairing difficulties with learning foundational academic skills in reading, writing, and/or mathematics (American Psychiatric Association, 2013).
Literature Review

Current cultural perspectives on disability involve the idea that people with disabilities are objects of pity who exist to be taken care of. However, this perspective needs to move toward the perception to see people with disabilities merely as people who, in superficial ways, are different from people without disabilities. It is important to recognize that people with disabilities are, like everyone else, striving to get by, to live, to have jobs, to have homes, to have fun, and to lead fulfilling lives. People without disabilities often experience unconscious and automatic feelings such as pity, fear, and revulsion. Although rooted in superstition or lack of knowledge, the bias against people with disabilities is generally not meant to be malicious or to segregate the population into a caste system (Abbott & McConkey, 2006). Regardless of the intentions, many people without disabilities exhibit feelings of frustration or uncertainty when encountering a person with a disability. These attitudes serve to separate the “nondisabled” from the “disabled”, which further isolates people with disabilities.

History of Treatments and Attitudes

The mistreatment of people with disabilities in the United States traces back to the concept behind early immigration legislation, which had the ultimate goal of preventing the immigration of people considered undesirable in order to protect the people and welfare of the United States (Marini & Stebnicki, 2012). The term “undesirable” referred to people from any race, ethnicity, religion, and or with a disability. Anti-disability legislation began in 1882 and continued through 1924, and some of the original laws were in effect until the 1980’s (Braddock & Parish, 2001). People with disabilities were devalued, dehumanized, and discriminated.
Prior to the 19th century, people who were mentally ill were labeled as witches and often subject to exorcism, beating, flogging, ridicule, or burning at the stake (Braddock & Parish, 2001). It became the responsibility of relatives to care for a person with a disability; otherwise, authorities would confine the individual to an asylum, hospital, prison, or workhouse. Asylums in the early 19th century were largely therapeutic institutions providing moral treatment, and the early asylum physicians believed they could cure the majority of all cases involving disability (Marini & Stebnicki, 2012). Only a few institutions, however, had physicians who emphasized a positive change in environment, avoidance of immoral behavior and temptations, living a healthy lifestyle through exercise and proper nutrition, and abiding by a consistent daily schedule (Marini & Stebnicki, 2012).

Moral treatments began to decline in the second half of the 19th century in favor of somatic therapies and behavioral control techniques. Patients, who displayed behaviors that were loud, offensive, or obnoxious, were frequently managed by being strapped to beds, confined in cells, or wrapped tightly in wet sheets (Marini & Stebnicki, 2012). Another popular method was to sedate patients and control the symptoms of mental illness through the use of a highly addictive sedative: chloral hydrate (Marini & Stebnicki, 2012).

The American psychiatrist Dr. Benjamin Rush is most widely known for introducing two mechanical contrivances for behavior treatment in institutions. The first, called a gyrator, was used in cases of “torpid madness” to spin the body and raise the heart rate to 120 beats per minute (Braddock & Parish, 2001). The second device, the tranquilizing chair, was intended to reduce sensory-motor activity and reduce the pulse...
INCREASING INTERACTIONS AMONG PEOPLE WITH AND WITHOUT DISABILITIES

(Braddock & Parish, 2001). Dr. Rush, along with other physicians, was also known for prescribing various forms of hydrotherapy treatment techniques.

The hydrotherapy behavior treatment techniques in institutions were based on the idea that water had healing powers. Hydrotherapy mainly consisted of wet-sheet packs or hours of hot continuous baths and remained in use until 1940 (Marini & Stebnicki, 2012). Patients were tightly wrapped in either cold or hot-water-drenched sheets where they had to remain until the treatment was considered complete (Marini & Stebnicki, 2012).

In 1883, Sir Francis Galton introduced the concept of eugenics. He believed that natural selection could rid mankind of problems such as disease, criminality, alcoholism, and poverty (Marini & Stebnicki, 2012). Following along with the idea of eugenics, the first sterilization law passed in 1907; however, unauthorized sterilization had been occurring in institutions as early as the 1890’s (Braddock & Parish, 2001). Forced sterilization to control reproduction began and continued throughout the years. Patients, who were considered incurable, were subject to forced sterilization because this meant their offspring was at risk of inheriting the undesirable trait. Despite the injustice associated with forced sterilization of people considered to be developmentally disabled, mentally ill, or criminals, sterilization laws lasted well into the 1980s.

In the 20th century, disability stereotypes continued to pervade societies throughout; however, in the second half of the century, attempts to redefine disability gained steam, and the disability rights movement began. The Individuals with Disabilities Education Act (IDEA) of 1975 allowed equal access to free appropriate public education for all children with disabilities in the least restrictive environment, which emphasized special education and related services designed to meet the student’s unique needs (Pub.
Education in the least restrictive environment means students with disabilities are educated with students without disabilities (Winnick, 2011). However, what is relevant and appropriate depends on individual situations ranging from a student with a disability being integrated into a regular classroom to being in a very restrictive out-of-school segregated placement (Winnick, 2011). The 1990 revision of IDEA extended services to provide early intervention for children from birth through pre-kindergarten, help with equipment purchases, and offer legal assistance for families with children with disabilities (Marini & Stebnicki, 2012).

The Americans with Disabilities Act (ADA) of 1990 extended the civil rights protection for individuals with disabilities in all areas of American life (Pub. L. No. 101-336). The purpose was to end discrimination, reduce barriers to employment, and ensure access to education for people with disabilities. The ADA also led to the reshaping of the physical environment and improved the access of communications (Pfeiffer, 2005). The ADA increased funding for public vocational rehabilitation programs and increased affirmative action in hiring of federal employees; however, there was no enforcement to check whether policies were being followed or not (Marini & Stebnicki, 2012). The disability civil rights movement had to not only overcome prejudice, but also physical barriers that limit access to employment and inclusion in other aspects of daily life (Pfeiffer, 2005). Activists successfully lobbied for laws that required curb cuts, ramps, and buses with wheelchair lifts (Pfeiffer, 2005). The various accommodations provided through IDEA and ADA increased the possibility of economic and social mobility.

In the past, people with disabilities were segregated from society, and parents of children born with disabilities were expected to institutionalize their children. Routines
and living conditions in institutions were a far cry from what ordinary people would consider minimally acceptable. Over-crowding, lack of privacy, inhumane treatment, and abuse were everyday realities in institutions. Institutional settings represented segregation and confinement. Customary justifications for keeping children with disabilities out of society have centered on their impairments. Social isolation was inevitable with institutionalized practices; however, society, people’s attitudes, and the resulting discrimination need to be observed.

Through ancient and contemporary times, disability and people with disabilities have primarily been perceived as negative, abnormal, and to be avoided. During deinstitutionalization, people with disabilities became present in the community but not part of it. People with disabilities were still seen as different, needing special places and services, and not seen as contributing community members (Amado, 2013). Although people with disabilities make use of the ordinary places that define community life such as going to restaurants, shopping, and movies, the current disability services system design still results in people with a disability being socially isolated from the community members without a disability.

It is important to differentiate between community presence and community participation. Community presence refers to the sharing of ordinary places that define community life and involvement in everyday settings, activities, and schedules (Clement & Bigby, 2007). Community participation refers to the experience of being part of a growing network of person relationships including close friends (Clement & Bigby, 2007). Community participation moves beyond impersonal and temporary community
interactions. While people with disabilities may experience physical integration, they often do not experience social integration (Amado, 2013).

Through the years, the United States disability policies have developed from basic care at institutions to education for children with disabilities and rehabilitation for people who become disabled later in life. Through education and rehabilitation, people with disabilities become a more active force and a catalyst for further development of the disability policy. However, a wider social perspective needs to be considered, including an examination of what kind of facilities outside of schools are truly available to people with disabilities. Clubs and programs targeting people with disabilities play a part in social development, but often times, these are sheltered environments, which do not adequately reflect the real world (Thomas, Bax, & Smyth, 1991).

For many people with disabilities who receive services, paid service providers make up a large proportion of their relationships (Amado, 2013). A typical pattern for individuals with disabilities is having relations with people in only three categories: paid staff, other people with disabilities they live with or work with, and, occasionally, their family (Amado, 2013). Most social interactions are with people who are paid to be in their lives for support. But is this adequate enough?

Isolation experienced by people with disabilities was highlighted by the finding that, on average, a person with a disability makes only two trips from home a week, compared to the average twenty trips per week for a person without a disability (Thomas et al., 1991). There is a clear association between an impoverished social life and the severity of the disability, but those with less severe disabilities are still socially disadvantaged in comparison to able-bodied peers (Thomas et al., 1991). Many
circumstances influence the social conditions for people with disabilities, including attitudes.

**Social Attitudes**

Societal attitudes are one of the greatest barriers faced by people with disabilities. An attitude is any belief or opinion that includes a positive or negative evaluation of some target (object, person, event) and that predisposes us to act in a certain way toward the target (Marini & Stebnicki, 2012). Attitudes towards disability are ambivalent due to conflicting cognitions of wanting to help and wanting to avoid an encounter (Marini & Stebnicki, 2012). Selfish impulse versus social conscience states that it is natural to be selfish because of evolution in regards to natural selection and survival of the fittest (Baumesiter & Bushman, 2014). However, culture demands that what is best for society needs to take precedence over an individual’s own wants and needs. The ultimate conflict in the selfish impulse versus social conscience theory is this: the automatic reaction is to avoid someone with an undesirable trait; however, many people consciously recognize that these people do not deserve to be avoided, so the social conscience may motivate someone to overcome their initial tendency to avoid the stigmatized person (Baumesiter & Bushman, 2014). Often, the social obligation to help someone perceived as not being able to help him or herself overrides interaction anxiety or the desire to avoid the situation. However, sometimes people are so conditioned to offer some sort of assistance toward those with disabilities that when an opportunity to simply interact with a person with a disability occurs, many people without disabilities do not know what to say or do (Marini & Stebnicki, 2012).
Society will not see what an individual has to offer if the individual is only seen for their disability. The current disability system is established on identifying what is “wrong” with people, or what they need to improve or change. Individuals are only in the service system because their disability has been measured or identified (Amado, 2013). Despite this fact, each individual with a disability is still a whole person, and it takes a special skill to recognize an individual for the gifts they have to offer and contribute.

Empowerment and Inclusion

It is necessary to explore various ways societies and cultures perceive people with disabilities. This is important in determining intervention approaches and activities to facilitate or support the development of enfranchised, empowered, and independent human beings (Mackelprang & Salsgiver, 1998). How people choose to approach people with disabilities depends on how people view disability and being disabled. Charles Dickens’s 1843 *A Christmas Carol* presents Tiny Tim as a cute but powerless and inadequate child whose primary reason for existence is to remind people without disabilities how well off and fortunate they are to be able bodied. If people choose to see individuals with disabilities as perpetual children, they often expect them to be helpless.

Rather than being expected to go through the developmental process, perpetual children have few expectations placed on them, thus few opportunities for growth and development are provided. These low expectations result in the expenditure of fewer resources that would help people with disabilities reach their developmental potential (Chenoweth & Stehlik, 2004). If society perceives people with disabilities as competent and having potential for success, they will recognize the strengths individuals with disabilities possess and can use to empower themselves. If society sees people with
disabilities as a minority group that has been stereotyped and subjected to discrimination, they will advocate social justice and seek the changes in society, economics, and politics that will empower the disabled population (Chenoweth & Stehlik, 2004).

Human service professionals, who may have a vested interest in the dependence of the people who they support, have a direct effect on the general public’s view of disability. People without disabilities often view people with disabilities as incompetent and helpless. In restaurants, rather than taking people with disabilities’ orders, servers will ask and talk to their staff or companion regarding what they would like to eat (Davis, 2010). Many servers assume people with disabilities are incapable of ordering, and they need the help of someone else.

Professionals should provide leadership in their area of expertise without dominance. They could provide services, be active advocates, share their unique skills, and provide appropriate training. Professionals seeking to promote independent living and foster the empowerment of people with disabilities can assure there are the same opportunities to positively develop that are available to the able-bodied population (Bigby & Clement, 2009).

People with disabilities often form their social and personal identities based on the negative stereotypes placed upon them by history and the society in which they live. Like other minorities, people with disabilities find themselves devalued, objectified, and subject to comparison. Isolation and unfamiliarity from and within the community have led to stereotypical attitudes toward people with disabilities and ableism. The term ableism describes the belief that people with disabilities are inferior to people without disabilities because of their differences (Linton, 1998). Ableism is similar to other –isms
like racism and sexism. The dominant segment of society often defines the minority, or non-dominant segments, in stereotypical or negative ways. Ableism devalues people with disabilities and results in segregation, social isolation, and social policies that limit opportunities for full social participation (Linton, 1998). Because of this, people underestimate capabilities, limit self-determination, and behave oppressively toward people subjected to the –ism.

The paradigm shift from individual incapacity to environmental discrimination is in itself empowering. Society can only understand the behavior, the self-concept, the educational achievement, and the economic success of people with disabilities by looking at people with disabilities as part of a group that is a minority and subjected to discrimination found in the social environment (Symes & Humphrey, 2010). This perspective encourages people with disabilities to begin to assert their capabilities, personally and politically, rather than remain objects of pity. People with disabilities can then see themselves as part of the diversity that makes up society.

The empowerment of people with disabilities also requires that they remain in control of this change. Empowerment begins with raising consciousness. People with disabilities need to be aware of their rights and aware that they are deserving citizens rather than marginal people dependent on the assistance of an otherwise indifferent society (Griffith, Totsika, Nash, & Hastings, 2011). As consciousness rises, people with disabilities come to realize that they are not what the stereotypes depict them to be, but instead recognize their worth.

Through person-centered approaches and individualized service delivery, people with disabilities identify what is important to each individual in order to live a good life.
with tailored support and access to greater opportunities (Clement & Bigby, 2007). Individual person-centered work leads to inclusion work (Wilson, 2012). Community building and inclusion happens in direct response to the expressed interests, needs, and aspirations of people with disabilities. There also needs to be opportunities being sought out and created in the community. Community development and community inclusion aims to change relationships, practices, structures, and discourses to develop an inclusive and welcoming community (Wilson, 2012). Community building and inclusion requires workers to be proactive in identifying, creating, and offering opportunities to people with disabilities. There also needs to be a broad level of community, organizational, and structural change. Community building and inclusion focuses on broader structural and attitudinal work (Clement & Bigby, 2007). There needs to be a change from a disability organization to a community organization.

Social inclusion has been largely defined in the field of disability as greater participation in community-based activities and a broader social network (Abbott & McConkey, 2006). In wider societal definitions, social inclusion embraces other dimensions of community participation such as acting as consumers of goods and services or participation in economic and socially valued activities, such as employment and child rearing (Abbott & McConkey, 2006). And for some people, social inclusion might simply mean meeting other people in ordinary settings and being treated similarly (Thomas et al., 1991). Physical presence within a community does not guarantee greater social inclusion; however, taking part in activities and using local facilities may lead to meaningful social contact with others, particularly community members without disabilities.
Considerations

It is necessary to move beyond the definition of “inclusion” and “participation” and examine the activities that people with disabilities are doing, where they are doing them, who they are doing them with, and how they are doing them. How do activities or programs foster an individuals’ capacity and simultaneously foster the communities’ capacity to connect with each other in a positive and meaningful way? Activities need to be refocused to begin to transition toward empowerment objectives: to maximize and expand the range of life choices, to facilitate their decision making with regard to life choices, and to bolster the achievement of these life choices (Bigby & Clement, 2009). Programs must employ a conceptual framework that maximizes people with disabilities involvement in establishing the full range of their available options (Abbott & McConkey, 2006). Through this, programs will prepare individuals with disabilities to deal effectively with professions or agencies and empower groups of people with disabilities to consider policy and program alternatives that can help improve their situation. Programs and activities must also move toward a position where there is greater emphasis on integrated social and leisure pursuits so people with and without disabilities have the opportunity to develop the confidence to interact with each other (Thomas et al., 1991).

Relationships between people with and without disabilities in the community usually take a significantly different type of effort, energy, and activities to support these connections. There are many segregated groups and programs in which people with disabilities can participate; however, the system is designed to keep people with disabilities together (Amado, 2013). In order to build relationships among community
members with and without disabilities, it takes doing things differently and using different types of effort.

Lack of knowledge, neglect, superstition, and fear are social factors that intensify the isolation of people with disabilities. Through integrated programs, factors in overcoming social isolation can be addressed. Regardless of where people with disabilities live or work, their opportunities to enjoy a good lifestyle with supported accommodations are, in most cases, not fully exploited. Many people living in group homes spend much of their day waiting for activities to happen, there are few chances to make choices in day-to-day matters, little community presence, and few relationships with people without disabilities or paid staff.

When considering social programs or activities, it is important to explore what factors and conditions are necessary to potentially enhance people’s attitudes. These conditions include increased contact and familiarity with people with disabilities and providing accurate education and information to minimize misconceptions about disability (Marini & Stebnicki, 2012). Many complex factors contribute to the formation of negative attitudes towards people with disabilities. Any attempt for a change to positive attitudes, in order to be successful, must be aware of the fact that attitudes are learned and conditioned over years; therefore, any program of short duration hoping to change attitudes towards people with disabilities will be ineffective at best (Marini & Stebnicki, 2012). There are no quick or easy solutions; however, positive attitudes follow from increased social contact, thus there needs to be a priority to provide continuous opportunities for interactions to occur in social, religious, educational, and work settings on a regular basis (Abbott & McConkey, 2006).
Future Implications

The purpose of this thesis is to explore the available research in order to design a study to seek feedback from people with and without disabilities in regards to identify current attitudes towards people with disabilities and current satisfaction with quality of life. An application will be submitted to the Institutional Review Board for approval.

Participation will be voluntary and self-selected, as invitations will be issued. The selection will be determined by the following: participants must be age 18 or older. There will be no discrimination regarding gender, age, ethnic background, etc. because this study will be seeking feedback on quality of life and attitudes towards people with disabilities.

An Informed Consent Release will be provided; however, the participants will not be asked to sign or print their name anywhere, therefore ensuring confidentiality (see Appendix A). By completing the questionnaire, consent will be implied. Involvement in the study will be voluntary, so participants may choose to contribute or not.

To address current attitudes towards people with disabilities, the Attitudes Toward Disabled Persons (ATDP) scale will be utilized (see Appendix B). Once participants have been selected, instructions for taking the survey will be given, and the surveys will be administered.

Attitude is an abstract concept difficult to accurately measure. Unless the respondents’ answers to attitude surveys are anonymous, many people respond how they think to be socially desirable (Marini & Stebnicki, 2012). The scale most often utilized in the field of disability work to assess attitudes is the Attitudes Toward Disabled Persons scale (ATDP). In a review of the scales available to assess attitudes, the ATDP was
termed the best known and widely used of all the scales intending to measure attitudes towards people with disabilities (Antonak & Livneh, 2000). The scale was designed by Yuker, Block, and Younng (1970) as a unidimensional measure of overall attitudes toward individuals with disabilities (Thomas, Palmer, Coker-Juneau, & Williams, 2003). Three forms of the ATDP exist: Form-A, Form-B, and Form-O. The diverse nature and number of results concluded from conducting the ATDP show consistent evidence for convergent and divergent validity for the total scale scores (Thomas et al., 2003).

When creating attitude scales, researchers often make the disability the most prominent aspect of a survey without accounting for other factors that also form attitudes towards others. Some of these factors, which are not considered, include: age, education, physical appearance, and socioeconomic status (Marini & Stebnicki, 2012). Possessing good social skills and having relatable status in regards to age, education, competence, and occupation are all similar to the factors necessary for anyone to determine their attitudes for another individual, regardless of disability status (Marini & Stebnicki, 2012). Although the ATDP may help assess the overall attitude a given person may have for an individual with a disability, it will not be completely descriptive in understanding how that given person feels about a particular individual with a certain disability in a specific situation (Thomas et al., 2003). It would be inaccurate to conclude a participant has negative attitudes towards people with disabilities solely based on administering a survey where the disability is the most significant feature and where the person with the disability is a stranger (Marini & Stebnicki, 2012). The ATDP is the mainstay in the field of disability work; however, concerns regarding the potential for socially desirable responding or faking, the potential for multidimensional attitudes towards individuals
with disabilities, and the need for attitudes measured at more of a personal level indicate that other measures may be required to understand the full range of a person’s attitude toward a specific individual with a disability (Thomas et al., 2003).

To assess current satisfaction with quality of life, the Comprehensive Quality of Life Scale Fifth Edition (ComQol-I5) will be utilized for participants with disabilities, and the Comprehensive Quality of Life Scale Fifth Edition (ComQol-A5) will be utilized for participants without disabilities (See Appendices C and D). The results will then be coded and entered into SPSS for descriptive statistics analysis.

Quality of life is a multidimensional concept that takes into account both subjective and objective dimensions. In the past, quality of life for people with disabilities has been judged either by objective criteria relating to the person’s environment or by the opinions of caregivers, both highly questionable sources of data in relation to quality of life (Cummins, 1997). The Comprehensive Quality of Life Scale (ComQol) was developed with three forms targeting different sectors of the population. The first form, ComQol-A, is designed for use with the general adult population (Cummins, 1997). The second form, ComQol-I, is designed for use with people who have an intellectual disability or other forms of cognitive impairments (Cummins, 1997). The third form, ComQol-S, is designed for use with adolescents age 11-18 who are attending school (Cummins, 1997).

The ComQol includes two parts: objective and subjective. Each objective and subjective axis is composed of seven domains: material well-being, health, productivity, intimacy, safety, place in community, and emotional well-being (Cummins, 1997). The
ComQol is reliable, stable, and valid, multidimensional, multi-axial, and different forms of the scale can be used with any section of the population (Cummins, 1997).

This study will involve minimal to no risk. Participants will be voluntary and may discontinue at any time. Knowledge from this study will benefit and contribute to the body of knowledge in the field of disability. Results may indicate there is a need for integration programs in order for social skills to develop allowing individuals to comfortably interact. Results from the surveys could also lead to the development of social intervention programs aiming to increase attitudes towards people with disabilities and potentially enhance the quality of life and interactions among people with and without disabilities. Possible implications could include the necessity of incorporating people with and without disabilities in order to provide the opportunity for interaction to potentially decrease feelings of isolation through increased social interaction.
References


doi:10.1080/096382800296782


The Individuals With Disabilities Education Act Amendments of 1990 (PL 101-476).


doi:10.1177/0143034310382496


Appendix A

INFORMED CONSENT RELEASE

I am inviting you to participate in a research study. Involvement in the study is voluntary, so you may choose to participate or not and may discontinue at any time without penalty. Please feel free to ask any questions that you may have about this study.

I am interested in seeking feedback for the following: attitudes towards people with disabilities and satisfaction with quality of life. Both areas will be assessed from the perspective of people with and without disabilities. You will be asked to complete the Attitudes Toward Disabled Persons Scale (ATDP) and the Comprehensive Quality of Life Scale (ComQol).

The ATDP includes three forms. All answers are based on a Likert scale ranging from “I agree very much” to “I disagree very much”. Completing the ATDP will take approximately 30 minutes of your time.

The ComQol includes two parts: objective and subjective. Each objective and subjective axis is composed of seven domains: material well-being, health, productivity, intimacy, safety, place in community, and emotional well-being. The questions involve a Likert scale with ranging scale descriptors depending on the question and category. There is no time limit for completing the ComQol; however, pre-testing and full scale administration takes about 45 minutes.

All information will be kept anonymous and confidential. This means you are not asked to sign or print your name anywhere. By completing the questionnaires, consent is implied. In any articles I write or any presentations that I make, I will not reveal details about you.

The implications from the results could lead to the development of social intervention programs aiming to increase attitudes towards people with disabilities and potentially enhance the quality of life and interactions among people with and without disabilities. The risks to you for participating in this study are minimal to none. If you do not wish to continue, you have the right to withdraw from the study, without penalty, at any time.

If you have any questions or concerns, contact:

<table>
<thead>
<tr>
<th>Researcher</th>
<th>Institutional Review Board</th>
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<td>Name</td>
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Participant – “By taking these surveys, I certify that all of my questions and concerns about this study have been addressed. I choose, voluntarily, to participate in this research project, and I certify that I am at least 18 years of age.”
Appendix B

ATDP SCALE

READ EACH STATEMENT AND PUT AN "X" IN THE APPROPRIATE COLUMN ON THE ANSWER SHEET. DO NOT MAKE ANY MARKS ON THE QUESTION SHEETS.

PLEASE ANSWER EVERY QUESTION

1. Disabled people are often unfriendly.
2. Disabled people should not have to compete for jobs with physically normal persons.
3. Disabled people are more emotional than other people.
4. Most disabled persons are more self-conscious than other people.
5. We should expect just as much from disabled as from non-disabled persons.
6. Disabled workers cannot be as successful as other workers.
7. Disabled people usually do not make much of a contribution to society.
8. Most non-disabled people would not want to marry anyone who is physically disabled.
9. Disabled people show as much enthusiasm as other people.
10. Disabled persons are usually more sensitive than other people.
11. Severely disabled persons are usually untidy.
12. Most disabled people feel that they are as good as other people.
13. The driving test given to a disabled person should be more severe than the one given to the non-disabled.
14. Disabled people are usually sociable.
15. Disabled persons usually are not as conscientious as physically normal persons.
16. Severely disabled persons probably worry more about their health than those who have minor disabilities.
17. Most disabled persons are not dissatisfied with themselves.
18. There are more misfits among disabled persons than among non-disabled persons.
ATDP SCALE

19. Most disabled persons do not get discouraged easily.
20. Most disabled persons resent physically normal people.
22. Most disabled persons can take care of themselves.
23. It would be best if disabled persons would live and work with non-disabled persons.
24. Most severely disabled people are just as ambitious as physically normal persons.
25. Disabled people are just as self-confident as other people.
26. Most disabled persons want more affection and praise than other people.
27. Physically disabled persons are often less intelligent than non-disabled ones.
28. Most disabled persons are different from non-disabled people.
29. Disabled persons don't want any more sympathy than other people.
30. The way disabled people act is irritating.
INCREASING INTERACTIONS AMONG PEOPLE WITH AND WITHOUT DISABILITIES

CODE #__________  ATDP SCALE  ANSWER SHEET

FORM A

Use this answer sheet to indicate how much you agree or disagree with each of the statements about disabled people on the attached list. Put an "X" through the appropriate number from +3 to -3 depending on how you feel in each case.

+3: I AGREE VERY MUCH  -3: I DISAGREE A LITTLE
+2: I AGREE PRETTY MUCH  -2: I DISAGREE PRETTY MUCH
+1: I AGREE A LITTLE  -1: I DISAGREE A LITTLE

PLEASE ANSWER EVERY ITEM

(1)  -3  -2  -1  +1  +2  +3  (16)  -3  -2  -1  +1  +2  +3
(2)  -3  -2  -1  +1  +2  +3  (17)  -3  -2  -1  +1  +2  +3
(3)  -3  -2  -1  +1  +2  +3  (18)  -3  -2  -1  +1  +2  +3
(4)  -3  -2  -1  +1  +2  +3  (19)  -3  -2  -1  +1  +2  +3
(5)  -3  -2  -1  +1  +2  +3  (20)  -3  -2  -1  +1  +2  +3
(6)  -3  -2  -1  +1  +2  +3  (21)  -3  -2  -1  +1  +2  +3
(7)  -3  -2  -1  +1  +2  +3  (22)  -3  -2  -1  +1  +2  +3
(8)  -3  -2  -1  +1  +2  +3  (23)  -3  -2  -1  +1  +2  +3
(9)  -3  -2  -1  +1  +2  +3  (24)  -3  -2  -1  +1  +2  +3
(10) -3  -2  -1  +1  +2  +3  (25)  -3  -2  -1  +1  +2  +3
(11) -3  -2  -1  +1  +2  +3  (26)  -3  -2  -1  +1  +2  +3
(12) -3  -2  -1  +1  +2  +3  (27)  -3  -2  -1  +1  +2  +3
(13) -3  -2  -1  +1  +2  +3  (28)  -3  -2  -1  +1  +2  +3
(14) -3  -2  -1  +1  +2  +3  (29)  -3  -2  -1  +1  +2  +3
(15) -3  -2  -1  +1  +2  +3  (30)  -3  -2  -1  +1  +2  +3
ATDP SCALE
READ EACH STATEMENT AND PUT AN "X" IN THE APPROPRIATE COLUMN ON
THE ANSWER SHEET. DO NOT MAKE ANY MARKS ON THE QUESTION SHEETS.
PLEASE ANSWER EVERY QUESTION

1. Disabled persons are usually friendly.
2. People who are disabled should not have to pay income taxes.
3. Disabled people are no more emotional than other people.
4. Disabled persons can have a normal social life.
5. Most physically disabled persons have a chip on their shoulder.
6. Disabled workers can be as successful as other workers.
7. Very few disabled persons are ashamed of their disabilities.
8. Most people feel uncomfortable when they associate with disabled people.
9. Disabled people show less enthusiasm than non-disabled people.
10. Disabled people do not become upset any more easily than non-disabled people.
11. Disabled people are often less aggressive than normal people.
12. Most disabled persons get married and have children.
13. Most disabled persons do not worry any more than anyone else.
14. Employers should not be allowed to fire disabled employees.
15. Disabled people are not as happy as non-disabled ones.
16. Severely disabled people are harder to get along with than are those with minor disabilities.
17. Most disabled people expect special treatment.
18. Disabled persons should not expect to lead normal lives.
19. Most disabled people tend to get discouraged easily.
20. The worst thing that could happen to a person would be for him to be very severely injured.
21. Disabled children should not have to compete with non-disabled children.

22. Most disabled people do not feel sorry for themselves.

23. Most disabled people prefer to work with other disabled people.

24. Most severely disabled persons are not as ambitious as other people.

25. Disabled persons are not as self-confident as physically normal persons.

26. Most disabled persons don’t want more affection and praise than other people.

27. It would be best if a disabled person would marry another disabled person.

28. Most disabled people do not need special attention.

29. Disabled persons want sympathy more than other people.

30. Most physically disabled persons have different personalities than normal persons.
Use this answer sheet to indicate how much you agree or disagree with each of the statements about disabled people on the attached list. Put an "X" through the appropriate number from +3 to -3 depending on how you feel in each case.

+3: I AGREE VERY MUCH
+2: I AGREE PRETTY MUCH
+1: I AGREE A LITTLE
-1: I DISAGREE A LITTLE
-2: I DISAGREE PRETTY MUCH
-3: I DISAGREE VERY MUCH

PLEASE ANSWER EVERY ITEM

(1) -3 -2 -1 1 +2 +3 (16) -3 -2 -1 1 +2 +3
(2) -3 -2 -1 1 +2 +3 (17) -3 -2 -1 1 +2 +3
(3) -3 -2 -1 1 +2 +3 (18) -3 -2 -1 1 +2 +3
(4) -3 -2 -1 1 +2 +3 (19) -3 -2 -1 1 +2 +3
(5) -3 -2 -1 1 +2 +3 (20) -3 -2 -1 1 +2 +3
(6) -3 -2 -1 1 +2 +3 (21) -3 -2 -1 1 +2 +3
(7) -3 -2 -1 1 +2 +3 (22) -3 -2 -1 1 +2 +3
(8) -3 -2 -1 1 +2 +3 (23) -3 -2 -1 1 +2 +3
(9) -3 -2 -1 1 +2 +3 (24) -3 -2 -1 1 +2 +3
(10) -3 -2 -1 1 +2 +3 (25) -3 -2 -1 1 +2 +3
(11) -3 -2 -1 1 +2 +3 (26) -3 -2 -1 1 +2 +3
(12) -3 -2 -1 1 +2 +3 (27) -3 -2 -1 1 +2 +3
(13) -3 -2 -1 1 +2 +3 (28) -3 -2 -1 1 +2 +3
(14) -3 -2 -1 1 +2 +3 (29) -3 -2 -1 1 +2 +3
(15) -3 -2 -1 1 +2 +3 (30) -3 -2 -1 1 +2 +3
ATDP - FORM 0

No.__________

3-9/10/57

ATDP SCALE

Mark each statement in the left margin according to how much you agree or disagree with it. Please mark every one. Write +1, +2, +3 or -1, -2, -3; depending on how you feel in each case.

+3: I AGREE VERY MUCH
+2: I AGREE PRETTY MUCH
+1: I AGREE A LITTLE

-1: I DISAGREE A LITTLE
-2: I DISAGREE PRETTY MUCH
-3: I DISAGREE VERY MUCH

1. Parents of disabled children should be less strict than other parents.
2. Physically disabled persons are just as intelligent as non-disabled ones.
3. Disabled people are usually easier to get along with than other people.
4. Most disabled people feel sorry for themselves.
5. Disabled people are the same as anyone else.
6. There shouldn’t be special schools for disabled children.
7. It would be best for disabled persons to live and work in special communities.
8. It is up to the government to take care of disabled persons.
9. Most disabled people worry a great deal.
10. Disabled people should not be expected to meet the same standards as non-disabled people.
11. Disabled people are as happy as non-disabled ones.
12. Severely disabled people are no harder to get along with than those with minor disabilities.
13. It is almost impossible for a disabled person to lead a normal life.
14. You should not expect too much from disabled people.
15. Disabled people tend to keep to themselves much of the time.
16. Disabled people are more easily upset than non-disabled people.
17. Disabled persons cannot have a normal social life.
18. Most disabled people feel that they are not as good as other people.
19. You have to be careful of what you say when you are with disabled people.
20. Disabled people are often grumpy.
Appendix C

3 ComQol - I5

[Questions are asked by the interviewer]

“I am going to ask some questions about your life. [Carer] can help you at the start. Later I will ask you to answer some questions by yourself. Is that OK?”

“If you do not understand a question, just let me know.”

When were you born? _____/_____/_____
day month year

Client sex? (circle one) Male Female
### Objective Scale

#### 1(a) Where do you live?
- A house [ ]
- A flat or apartment [ ]
- A room (e.g. in a hostel) [ ]

Do you own the place where you live or do you rent?
- Own [ ]
- Rent [ ]

(Prompt: Think about the things you own, like your clothes, furniture, etc.)

#### 1(b) How many personal possessions do you have compared with other people?
- More than almost anyone [ ]
- More than most people [ ]
- About average [ ]
- Less than most people [ ]
- Less than almost anyone [ ]

#### 1(c) What is your personal or household (whichever is most relevant to you) gross annual income before tax?
- Less than $10,999 [ ]
- $41,000 – $55,999 [ ]
- $11,000 – $25,999 [ ]
- More than $56,000 [ ]
- $26,000 – $40,999 [ ]

#### 2(a) How many times have you seen a doctor over the past 3 months?
- None [ ]
- 1 - 2 (about once a month) [ ]
- 3-4 (about every two weeks) [ ]
- 5-7 (about once a week or more) [ ]
- 8 or more [ ]
(b) Do you have other disabilities or medical conditions? (other than an intellectual or cognitive disability) (e.g. visual, hearing, physical, health, etc.).

Yes □ No □

If yes please specify:

Name of disability or medical condition

- e.g. Visual
- Diabetes
- Epilepsy

Extent of disability or medical condition

- Require glasses for reading
- Require daily injections
- Requires daily medication

(c) What regular medication do you take each day?

If none tick box □

or

Name(s) of medication

3(a) How many hours do you spend on the following each week?
(Average over past 3 months)

<table>
<thead>
<tr>
<th>Hours paid work</th>
<th>0</th>
<th>1-10</th>
<th>11-20</th>
<th>21-30</th>
<th>31-40+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hours formal education</td>
<td>0</td>
<td>1-10</td>
<td>11-20</td>
<td>21-30</td>
<td>31-40+</td>
</tr>
<tr>
<td>Hours unpaid child care</td>
<td>0</td>
<td>1-10</td>
<td>11-20</td>
<td>21-30</td>
<td>31-40+</td>
</tr>
</tbody>
</table>
(b) In your spare time, how often do you have nothing much to do?

<table>
<thead>
<tr>
<th></th>
<th>Almost always</th>
<th>Usually</th>
<th>Sometimes</th>
<th>Not Usually</th>
<th>Almost never</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

(c) Do you watch TV? How much TV do you watch? (average over a typical week).

Hours per day

<table>
<thead>
<tr>
<th></th>
<th>None</th>
<th>1 – 2</th>
<th>3 – 5</th>
<th>6 – 9</th>
<th>10 or more</th>
</tr>
</thead>
<tbody>
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<td></td>
</tr>
</tbody>
</table>

4(a) Do you have a close friend? How often do you talk with your friend?

<table>
<thead>
<tr>
<th></th>
<th>Daily</th>
<th>Several times a week</th>
<th>Once a week</th>
<th>Once a month</th>
<th>Less than once a month</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(b) If you are feeling sad or depressed does someone show they care for you? How often?

<table>
<thead>
<tr>
<th></th>
<th>Almost always</th>
<th>Usually</th>
<th>Sometimes</th>
<th>Not Usually</th>
<th>Almost never</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(c) If you want to do something special, how often does someone else want to do it with you? How often?

<table>
<thead>
<tr>
<th></th>
<th>Almost always</th>
<th>Usually</th>
<th>Sometimes</th>
<th>Not Usually</th>
<th>Almost never</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
5(a) Do you sleep well?
   How often?
   Almost always  Usually  Sometimes  Not Usually  Almost never

(b) Are you safe at home?
    How often?
   Almost always  Usually  Sometimes  Not Usually  Almost never

(c) Are you ever worried or anxious during the day?
    How often?
   Almost always  Usually  Sometimes  Not Usually  Almost never
6(a) Below is a list of leisure activities. Indicate how often in an average month you take part in or attend each one for your leisure (not for employment).

<table>
<thead>
<tr>
<th>Activity</th>
<th>Number of times per month</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Go to a club/group/society</td>
<td></td>
</tr>
<tr>
<td>(2) Go to a hotel/bar/pub</td>
<td></td>
</tr>
<tr>
<td>(3) Watch live sporting events</td>
<td></td>
</tr>
<tr>
<td>(Not on TV)</td>
<td></td>
</tr>
<tr>
<td>(4) Go to a place of worship</td>
<td></td>
</tr>
<tr>
<td>(e.g. church)</td>
<td></td>
</tr>
<tr>
<td>(5) Chat with neighbours or shopkeepers</td>
<td></td>
</tr>
<tr>
<td>(6) Eat out</td>
<td></td>
</tr>
<tr>
<td>(7) Go to a movie</td>
<td></td>
</tr>
<tr>
<td>(8) Visit family or friend</td>
<td></td>
</tr>
<tr>
<td>(9) Play sport or go to a gym</td>
<td></td>
</tr>
<tr>
<td>(10) Other (please describe)</td>
<td></td>
</tr>
</tbody>
</table>

(b) Do you belong to any club, group, or society?

Yes [ ] No [ ] If no, go to question (c)

Do you hold an unpaid position of responsibility?

If ‘yes’, please indicate the highest level of responsibility held:

- [ ] Committee Member
- [ ] Committee Chairperson/Convenor
- [ ] Secretary/Treasurer
- [ ] Group President, Chairperson or Convenor
(c) Do people outside your home ask for your help or advice? How often?

<table>
<thead>
<tr>
<th>Almost every day</th>
<th>Quite often</th>
<th>Sometimes</th>
<th>Not often</th>
<th>Almost never</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7(a) Can you do things you really want to do? How often?

<table>
<thead>
<tr>
<th>Almost always</th>
<th>Usually</th>
<th>Sometimes</th>
<th>Not Usually</th>
<th>Almost never</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(b) When you wake up in the morning, do you ever wish you could stay in bed all day? How often?

<table>
<thead>
<tr>
<th>Almost always</th>
<th>Usually</th>
<th>Sometimes</th>
<th>Not Usually</th>
<th>Almost never</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(c) Do you have wishes that cannot come true? How often?

<table>
<thead>
<tr>
<th>Almost always</th>
<th>Usually</th>
<th>Sometimes</th>
<th>Not Usually</th>
<th>Almost never</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix D

ComQol–A5

This scale has three sections. The first will ask for some factual information. The next two will ask how you feel about various aspects of your life.

To answer each question put a (✓) in the appropriate box. Please ask for assistance if there is anything you do not understand.

Please answer all the questions and do not spend too much time on any one item.

What is your date of birth?        _____/_____/_____

        day  month  year

What is your sex? (circle one)    Male  Female
Section 1

This section asks for information about various aspects of your life. Please tick the box that most accurately describes your situation.

1(a) Where do you live?

<table>
<thead>
<tr>
<th>Option</th>
<th>Do you own the place where you live or do you rent?</th>
</tr>
</thead>
<tbody>
<tr>
<td>A house</td>
<td></td>
</tr>
<tr>
<td>A flat or apartment</td>
<td>Own</td>
</tr>
<tr>
<td>A room (e.g. in a hostel)</td>
<td>Rent</td>
</tr>
</tbody>
</table>

(b) How many personal possessions do you have compared with other people?

<table>
<thead>
<tr>
<th>Option</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>More than almost anyone</td>
<td></td>
</tr>
<tr>
<td>More than most people</td>
<td></td>
</tr>
<tr>
<td>About average</td>
<td></td>
</tr>
<tr>
<td>Less than most people</td>
<td></td>
</tr>
<tr>
<td>Less than almost anyone</td>
<td></td>
</tr>
</tbody>
</table>

(c) What is your personal or household (whichever is most relevant to you) gross annual income before tax?

<table>
<thead>
<tr>
<th>Income Range</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $10,999</td>
<td></td>
</tr>
<tr>
<td>$11,000 - $25,999</td>
<td>More than $56,000</td>
</tr>
<tr>
<td>$26,000 - $40,999</td>
<td></td>
</tr>
</tbody>
</table>

2(a) How many times have you seen a doctor over the past 3 months?

<table>
<thead>
<tr>
<th>Frequency</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td></td>
</tr>
<tr>
<td>1 - 2 (about once a month)</td>
<td></td>
</tr>
<tr>
<td>3-4 (about every two weeks)</td>
<td></td>
</tr>
<tr>
<td>5-7 (about once a week or more)</td>
<td></td>
</tr>
</tbody>
</table>
(b) Do you have any disabilities or medical conditions? (e.g. visual, hearing, physical, health, etc.).

Yes [ ] No [ ]

If yes please specify:

<table>
<thead>
<tr>
<th>Name of disability or medical condition</th>
<th>Extent of disability or medical condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>e.g. Visual</td>
<td>Require glasses for reading</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Require daily injections</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>Requires daily medication</td>
</tr>
</tbody>
</table>

_______________________ _________________________________
_______________________ _________________________________
_______________________ _________________________________
_______________________ _________________________________

(c) What regular medication do you take each day?

If none tick box [ ]

or

Name(s) of medication

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

3(a) How many hours do you spend on the following each week? (Average over past 3 months)
### Table: Hours Spent on Various Activities

<table>
<thead>
<tr>
<th>Activity</th>
<th>0</th>
<th>1-10</th>
<th>11-20</th>
<th>21-30</th>
<th>31-40+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hours paid work</td>
<td></td>
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<tr>
<td>Hours formal education</td>
<td></td>
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<tr>
<td>Hours unpaid childcare</td>
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</tbody>
</table>

(b) **In your spare time, how often do you have nothing much to do?**

- Almost always
- Usually
- Sometimes
- Not Usually
- Almost never

(c) **On average, how many hours TV do you watch each day?**

<table>
<thead>
<tr>
<th>Hours per day</th>
<th>None</th>
<th>1–2</th>
<th>3–5</th>
<th>6–9</th>
<th>10 or more</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

4(a) **How often do you talk with a close friend?**

- Daily
- Several times a week
- Once a week
- Once a month
- Less than once a month

(b) **If you are feeling sad or depressed, how often does someone show they care for you?**

- Almost always
- Usually
- Sometimes
- Not Usually
- Almost never
(c) If you want to do something special, how often does someone else want to do it with you?

<table>
<thead>
<tr>
<th></th>
<th>Almost always</th>
<th>Usually</th>
<th>Sometimes</th>
<th>Not Usually</th>
<th>Almost never</th>
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</tbody>
</table>

5(a) How often do you sleep well?

<table>
<thead>
<tr>
<th></th>
<th>Almost always</th>
<th>Usually</th>
<th>Sometimes</th>
<th>Not Usually</th>
<th>Almost never</th>
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</table>

Are you safe at home?

<table>
<thead>
<tr>
<th></th>
<th>Almost always</th>
<th>Usually</th>
<th>Sometimes</th>
<th>Not Usually</th>
<th>Almost never</th>
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</tbody>
</table>

(b) How often are you worried or anxious during the day?

<table>
<thead>
<tr>
<th></th>
<th>Almost always</th>
<th>Usually</th>
<th>Sometimes</th>
<th>Not Usually</th>
<th>Almost never</th>
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</thead>
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</tbody>
</table>
6(a) Below is a list of leisure activities. Indicate how often in an *average month* you attend or do each one for your enjoyment (not employment).

<table>
<thead>
<tr>
<th>Activity</th>
<th>Number of times per month</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Go to a club/group/society</td>
<td>__________________________</td>
</tr>
<tr>
<td>(2) Go to a hotel/bar/pub</td>
<td>__________________________</td>
</tr>
<tr>
<td>(3) Watch live sporting events (Not on TV)</td>
<td>__________________________</td>
</tr>
<tr>
<td>(4) Go to a place of worship</td>
<td>__________________________</td>
</tr>
<tr>
<td>(5) Chat with neighbours</td>
<td>__________________________</td>
</tr>
<tr>
<td>(6) Eat out</td>
<td>__________________________</td>
</tr>
<tr>
<td>(7) Go to a movie</td>
<td>__________________________</td>
</tr>
<tr>
<td>(8) Visit family or friend</td>
<td>__________________________</td>
</tr>
<tr>
<td>(9) Play sport or go to a gym</td>
<td>__________________________</td>
</tr>
<tr>
<td>(10) Other (please describe)</td>
<td>__________________________</td>
</tr>
</tbody>
</table>

(b) Do you hold an *unpaid* position of responsibility in relation to any club, group, or society?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>If no, go to question (c)</th>
</tr>
</thead>
</table>

If ‘yes’, please indicate the highest level of responsibility held:

- [ ] Committee Member
- [ ] Committee Chairperson/Convenor
- [ ] Secretary/Treasurer
- [ ] Group President, Chairperson or Convenor
(c) How often do people *outside your home* ask for your help or advice?

<table>
<thead>
<tr>
<th>Frequency</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Almost every day</td>
<td></td>
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<td></td>
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<tr>
<td>Quite often</td>
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<tr>
<td>Sometimes</td>
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<tr>
<td>Not often</td>
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<tr>
<td>Almost never</td>
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</tbody>
</table>

7(a) How often can you do the things you *really* want to do?

<table>
<thead>
<tr>
<th>Frequency</th>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Almost always</td>
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<tr>
<td>Usually</td>
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<tr>
<td>Not Usually</td>
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<tr>
<td>Almost never</td>
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</tr>
</tbody>
</table>

(b) When you wake up in the morning, how often do you wish you could stay in bed *all day*?

<table>
<thead>
<tr>
<th>Frequency</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Almost always</td>
<td></td>
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<tr>
<td>Usually</td>
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<tr>
<td>Almost never</td>
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</table>

(c) How often do you have wishes that *cannot* come true?

<table>
<thead>
<tr>
<th>Frequency</th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Almost always</td>
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<tr>
<td>Almost never</td>
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</tbody>
</table>
Section 2

How *important* are each of the following life areas to you?

Please answer by placing a (✓) in the appropriate box for each question.

There are no right or wrong answers. Please choose the box that best describes how **important each area is to you.** Do not spend too much time on any one question.

1. **How important to you ARE THE THINGS YOU OWN?**

<table>
<thead>
<tr>
<th>Could not be more important</th>
<th>Very important</th>
<th>Somewhat important</th>
<th>Slightly important</th>
<th>Not important at all</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

2. **How important to you is YOUR HEALTH?**

<table>
<thead>
<tr>
<th>Could not be more important</th>
<th>Very important</th>
<th>Somewhat important</th>
<th>Slightly important</th>
<th>Not important at all</th>
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</tbody>
</table>

3. **How important to you is WHAT YOU ACHIEVE IN LIFE?**

<table>
<thead>
<tr>
<th>Could not be more important</th>
<th>Very important</th>
<th>Somewhat important</th>
<th>Slightly important</th>
<th>Not important at all</th>
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</tbody>
</table>
4. **How important to you are CLOSE RELATIONSHIPS WITH YOUR FAMILY OR FRIENDS?**

<table>
<thead>
<tr>
<th>Could not be more important</th>
<th>Very important</th>
<th>Somewhat important</th>
<th>Slightly important</th>
<th>Not important at all</th>
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5. **How important to you is HOW SAFE YOU FEEL?**

<table>
<thead>
<tr>
<th>Could not be more important</th>
<th>Very important</th>
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</table>

6. **How important to you is DOING THINGS WITH PEOPLE OUTSIDE YOUR HOME?**

<table>
<thead>
<tr>
<th>Could not be more important</th>
<th>Very important</th>
<th>Somewhat important</th>
<th>Slightly important</th>
<th>Not important at all</th>
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</table>

7. **How important to you is YOUR OWN HAPPINESS?**

<table>
<thead>
<tr>
<th>Could not be more important</th>
<th>Very important</th>
<th>Somewhat important</th>
<th>Slightly important</th>
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</table>
Section 3

How *satisfied* are you with each of the following life areas?

There are no right or wrong answers. Please (✓) the box that best describes how *satisfied* you are with each area.

1. **How *satisfied* are you with the THINGS YOU OWN?**

<table>
<thead>
<tr>
<th>Delighted</th>
<th>Pleased</th>
<th>Mostly satisfied</th>
<th>Mixed</th>
<th>Mostly dissatisfied</th>
<th>Unhappy</th>
<th>Terrible</th>
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</tr>
</tbody>
</table>

2. **How *satisfied* are you with your HEALTH?**

<table>
<thead>
<tr>
<th>Delighted</th>
<th>Pleased</th>
<th>Mostly satisfied</th>
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3. **How *satisfied* are you with what you ACHIEVE IN LIFE?**

<table>
<thead>
<tr>
<th>Delighted</th>
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<th>Mostly satisfied</th>
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</tbody>
</table>

4. **How *satisfied* are you with your CLOSE RELATIONSHIPS WITH FAMILY OR FRIENDS?**

<table>
<thead>
<tr>
<th>Delighted</th>
<th>Pleased</th>
<th>Mostly satisfied</th>
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</tr>
</tbody>
</table>
5. **How satisfied are you with HOW SAFE YOU FEEL?**

<table>
<thead>
<tr>
<th>Delighted</th>
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6. **How satisfied are you with DOING THINGS WITH PEOPLE OUTSIDE YOUR HOME?**

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7. **How satisfied are you with YOUR OWN HAPPINESS?**

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