



# PERSONAL AND SOCIETAL ATTITUDES TO DISABILITY

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**Abstract:** The research addresses theoretical and conceptual frameworks dealing with the formation and change of attitudes, cognitive dissonance, positive and negative prejudice, the concept of “spread”, overt and covert attitudes and their formation, and the nexus between attitudes and behavior toward disability. Two attitude scales—the interaction with disabled persons and the scale of attitudes toward disabled persons—are reviewed and results of two studies are presented. Major findings are that it is easier to change societal attitudes than personal attitudes. Additionally, the use of contact with a person with a disability was more efficacious in changing attitudes than only information provision. Implications for the practice of hospitality and tourism management service provision are discussed. **Keywords:** disability, service provision, attitudes. © 2005 Elsevier Ltd. All rights reserved.

**Résumé:** Les attitudes personnelles et sociétales envers les handicaps. La recherche aborde les cadres théoriques et conceptuels concernant la formation et le changement des attitudes, la dissonance cognitive, les préjugés positifs et négatifs, le concept de la “propagation”, les attitudes déclarées et cachées et leur formation, et le lien entre les attitudes et les comportements envers les handicaps. Deux échelles d’attitude, l’interaction avec des personnes en situation de handicap et l’échelle des attitudes envers les personnes atteintes de handicaps, sont examinées. On présente les résultats de deux études. Les conclusions principales sont qu’il est plus facile de changer les attitudes sociétales que de changer les attitudes personnelles. En plus, l’utilisation du contact avec une personne en situation de handicap était plus efficace pour changer des attitudes que seulement la provision d’information. On discute des implications pour la pratique de la gestion de la prestation de services dans l’hospitalité et le tourisme. **Mots-clés:** handicap, prestation de services, tourisme. © 2005 Elsevier Ltd. All rights reserved.

## INTRODUCTION

In research on attitudes of the general public towards people with disabilities, [it was] concluded that the public verbalizes favorable attitudes towards people with disabilities but actually possesses deeper un verbalized feelings which are frequently rejecting (Daruwalla 1999:61).

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The purpose of this paper is to explore the role, nature, and impact of disability awareness training in the industry. Central to this examination are the differences in personal and societal attitudes and, in examining them, it is important to understand their genesis and formation as well as important related constructs regarding people with disabilities. It is evident that the service providers in the tourism industry are given very little education and training concerning legislation, access provision, and service related to people with disabilities (Darcy 2000; McKercher, Packer, Yau and Lam, 2003; Miller and Kirk 2002; O'Neill and Knight, 2000). Additionally, literature dealing with attitudes towards people with disabilities is scarce. A survey of the subject index in the *Annals of Tourism Research* revealed only one study (Smith 1987) addressing this issue.

The hospitality, tourism, leisure, and recreation literature represents disability in very distinctive ways. Leisure and recreation focus on constraints to inclusive provision (Bedini and Henderson 1994; Bedini and McCann 1992; Luken 1993; Muloin and Clarke 1993), while the hospitality and tourism literature reviews the issue from an employment perspective (Alexander 1994; Kohl and Greenlaw 1992; Romeo 1990, 1992; Woods and Kavanaugh 1992). Economic issues of hiring and easing staff shortages are examined by Dietl (1988), Lattuca and Scarpati (1989), Schapire and Berger (1984), and Smith (1992) and Stokes (1990).

In Australia, Darcy (2000, 1998), Darcy and Daruwalla (1999), Daruwalla (1999), and O'Neill and Knight (2000) address the issue of attitudes, education and awareness as part of the experience. Murray and Sproats (1990), Darcy (1998, 2002, 2002a), and Darcy and Daruwalla (1999) examine the demand-side perceptions, while supply-side are limited to Darcy (2000) who completed a scoping study of the accommodation sector and O'Neill and Knight's (2000) study of operators to ascertain their understanding of the needs of tourists with disabilities. Attempts to measure attitudes and attitude change in the industry have been limited. This paper reports on research to redress this gap in the literature.

## ATTITUDE FORMATION AND CHANGE

Attitudes are generally thought to be part of the socialization process. Authors such as Chubon (1992:303) broadly classify attitude formation into four major categories, behavioral, consistency, information integration, and function theory. Each of these is briefly discussed to contextualize the discussion on the data gathered from the Interaction with Disabled Persons Scale (IDP) and Scale of Attitudes towards Disabled Persons (SADP) used in the study.

Horne (1985) explains behavioral theories as being construed as a response to environmental stimuli. Incentive is a further factor to consider in the forming and changing of attitudes towards a referent object. Triandis (1971) and Gergen and Gergen (1986) suggest that communication practices play an important role in behavioral change

theories. These communication practices then have a vital function in the development of change programs.

Consistency theories refer to the need for persons to maintain balance or consistency in interpersonal relations and cognitions thorough their beliefs, feelings and actions. The concept of "cognitive dissonance" relates to the incongruities and the psychological discomfort experienced by nondisabled persons, who attempt to avoid this "inconsistency" by either reducing their interactions or avoiding situations with people with disabilities (Gething 1986; Nicoll 1988). Siller (1964) referred to this phenomenon as that of "strain in social interaction". Age old practices and consequent worldviews of institutionalization, segregation from mainstream society, and the societal exposure of charity recipients has further reinforced cognitive dissonance aspects in nondisabled persons. The Lewinian model of change proposed that such dissonance could be modified through the reduction of the discomfort or by introducing a "driving force" (Hickson 1995:49-50), including the presentation of information aimed at modifying or changing presently held positions. These may cover equal status contact with a person with a disability as part of an attitude change/modification intervention.

Information integration theory deals with the concept that a person's attitudes are a reflection of their knowledge and belief about an object and that it is possible to change these through the introduction of new information. Thus, information integration is the cornerstone of attitude change programs providing salient and contemporary information. For example, the introduction of information aimed at changing people's perceptions from a medical model to a social model (Oliver 1990, 1996) contributes significantly to the contemporary understanding of disability.

Function or functionalist theory is subdivided into four categories based on the purpose served. The knowledge function allows a person a frame of reference for evaluating attitudes toward referent objects. These frames of reference serve to help individuals understand the world and events (Antonak and Livneh 1988:12). The social adjustment function allows a person to identify with, or gain the approval of, important reference groups. It is intrinsically related to the earning of rewards and the minimization of penalties by conforming with and completing sanctioned tasks and behaviors (Katz 1960). The value expressive function allows an individual to give expression to their central values and self-concept or to facilitate value expressions. They achieve self-satisfaction through the combined function of asserting their own self and assimilating the values and attitudes of their group (Antonak and Livneh 1988). The ego defensive function allows individuals to reflect or externalize unresolved inner personal problems (Voyatzakis 1994). Antonak and Livneh (1988) suggest a fifth function: that of "reinforcers". These trigger certain behaviors, whether positive or negative, dependent on the perspective held.

Yuker (1977) and Gellman (1960) have indicated that attitudes are learned. Both positive and negative prejudices are learned and often these attributions have little bearing on the disability itself. Thus, in

the case of positive prejudice, people are lionized as being selfless, brave, and so on. In the case of negative prejudice, they may be perceived as helpless, dependent, ungrateful, selfish, freakish, evil, de-ranked, tragic, depressed, or special (Hume 1995). Wright (1980, 1983) termed this a form of prejudice "spread". These stereotypical views of disability also include the assumption that one disability includes the characteristics of other impairment groups. An example of this would be a service provider who, assuming that a wheelchair user is unable to communicate, does not address this person directly but talks to the companion instead. Lack of information, knowledge, and fear generally experienced by wider society contribute towards negative attitudes.

Wrightsmann and Brigham's (1973) observation that attitude change may help a person to function more effectively is important in introducing disability awareness to industry service providers. This in turn may be extrapolated to persons who take on particular attitudes in order to be "consistent" with their peers, to fit into certain environments, or simply to avoid attracting sanctions by going against prevailing ideas and trends. This idea also leads to the importance of the changing personal attitudes of service personnel as a means of reflecting prevailing societal beliefs.

At their most basic level, personal attitudes may be described as beliefs and opinions held by an individual about a referent object, for instance, voting, disability, or multiculturalism. Societal attitudes, on the other hand, refer to prevailing beliefs espoused by and influenced by governments, cultural orientation, historical background, or other prevailing conditions. Societal attitudes tend to be more remote and do not necessarily have congruence with personal ones. This very remoteness allows for differences between the two. Such distinctions may also be understood in terms of distancing, with greater accountability demanded in personal rather than societal attitudes. Overt political correctness has also influenced societal perspectives, so rhetorical and abstract notions, particularly as measured by scales, are influenced by media exposure or other educative campaigns. However, these campaigns often fail to change the deeply held and internalized belief systems of individuals. Media portrayals tend to lionize or demonize, positive prejudice being applied to Paralympic athletes and other exceptional "superhero" examples, at the same time as people who are mentally ill are being demonized. The media also play a significant role in attitude formation by stereotyping disability and issues related to it (Adams 2000; Chynoweth 2000; Gilbert, MacCauley and Smale, 1997).

Sources of negative bias towards people with disabilities include sociological perspectives. The most common of these is the "labeling or deviance theory". Goffman (1961) and Rosenhahn (1973) describe the "nonhumanization" and stigmatization particularly of those with a mental illness. The construction of what is "normal" or "abnormal" contributes to this stigmatization and stereotyping and is a function of socialization processes. The move away from constructing disability through this medical model worldview to a social model perspective is an important refinement of perspective.

Conceptualizations of “normalcy” are the basis of the medical model (Oliver 1990). Disability, impairment and handicap are underlying assumptions of an “objective scientific” construct of the normal. As such, these concepts are supposed to be objectively measurable. However, Barnes, Mercer and Shakespeare (1999), Chadwick (1994) and Linton (1998) challenge these notions of scientific normalcy. In contrast, the social model views disability as the product of social structures and places it firmly on the social, economic, and political agendas. The oppression, exclusion, and segregation of people with impairments from participation in mainstream activities are not a result of the person’s impairment but a function of the *disabling* social environments and prevailing “hostile social attitudes” (Barnes 1996:43). These hostile social views represent it as a personal tragedy of the individual and the impaired body (Oliver 1996; Shakespeare 1994). This medical model worldview in Western society also implies a normative value structure that is challenged by the social model. The social model views it not as “other” but as part of human diversity. As Charlton (1998) argues, disability is part of the continuum of humanity, as evidenced by the 500 million people with disabilities living today. Statistical data collection of Western governments shows that between 10 to 19% of their populations identify as having a disability.

As suggested by Alexander (1994), the industry holds the same negative attitudes and stereotypes as the rest of society. However, as Alexander discovered, managers of destination marketing organizations became very astute at providing politically correct responses about employing people with disabilities while their behavior and practices remained unchanged. This reaction echoes the behavior and practices to be found in wider social policy formation and evaluation which reflect the policymakers’ view that it is a personal tragedy of the individual. This has led to an orientation of charity over civil rights, professional hegemony over user power, individual rehabilitation over collective needs, and segregation over inclusion (Priestly 1998). The social model has been applied to understand and construct debate and experiences of tourists with disabilities discussed at some length by Darcy (2002a:62–63). His research includes the call to identify socially constructed constraints and formulate strategies to mitigate the resulting negative tourism experiences.

### *The Attitude-Behavior Nexus*

“Behavior is a mirror in which everyone shows his (sic) image” (Goe-the quoted in Ajzen 1988:1). In examining the attitude behavior consistency approach, Oskamp defines behavior as “overt responses” (1977:226–227). The two key concepts of “situational thresholds and pseudo-inconsistency” were used to define and explain the connection (or lack thereof) between attitudes and behavior.

Ajzen (1988) refers to the differences in probability levels of occurrence between a person’s verbal attitude statements and overt behaviors as “situational thresholds”. This discrepancy may involve such factors as the instability of attitudes and intentions over time;

competing attitudes, motives, and values; and the inadequacy of the attitude holder who may lack the intellectual, verbal, or social skills to recognize that their attitudes and behavior do not match (Fishbein and Ajzen 1975). Other factors that cause this discrepancy relate to lack of "volitional control", where the individual is unable to exercise the behavior voluntarily because of external or other limitations and the possibility that they may have no suitable alternatives available. A further discrepancy may be engendered by the need for "proper" behavior. This is particularly salient for the study reported in this paper where verbal/written attitudes measured by a paper pencil instrument (scale) may not necessarily translate into appropriate behaviors when confronted by the referent "object". Additionally, the fear of sanctions or repercussions may cause inconsistencies in the attitudes espoused and the behaviors exhibited.

The second concept of "pseudo-inconsistency" between behaviors and attitudes is magnified when race and disability are raised. Due to the notions of "proper" behavior, persons might be constrained in face-to-face interactions. However, their underlying attitudes might be quite different when measured in a questionnaire. The converse may be equally true, when attitudes measured by a paper and pencil instrument are shown to be quite positive but overt behaviors may be less than positive. Bogardus (1933) and Thurstone and Chave (1929) address the issues of overt-covert expressions or opinions. Bogardus believed that opinions represented logical, rational, and conscious aspects of beliefs while attitudes did not. Thurstone, on the other hand, postulated that written and oral opinions are overt expressions and attitudes were more likely to be inferred and covert in nature. For example, a nondisabled person who might reply in the affirmative when asked face-to-face (overt) whether people with disabilities should have children but mark "strongly disagree" on a written scale when anonymity was guaranteed.

### *Scales and Issues of Measurement of Attitudes*

A number of scales exist to measure attitudes towards disability. These gauge those which are impairment specific (attitude to blindness scale, a scale of knowledge and attitudes toward epilepsy and people with epilepsy) and general (interaction with disabled persons scale, attitude towards disabled persons scale, and disability factors scale). In the studies described, two scales were used to measure personal and societal attitudes. Both instruments have been widely tested and the literature attests to their psychometric soundness (Antonak and Livneh 1988; Gething 1994a; Gething, Wheeler, Cote, Furnham, Hudek-Knezevic, Kumpf, McKee, Rola and Sellick 1997). Factors considered in selecting the scales included dimensionality (uni- or multi- where more than one dimension of attitude is measured), focus (societal or personal), social desirability bias and potential for faking, disability type (general or specific-named), reliability and validity criteria, concept clustering, forced response, length of scale, and additional information

regarding the presence of test banks and the origins of the instrument. Psychometric soundness, applicability of the scales to industry contexts, and the use of two reliable scales were infinitely preferable to a one-shot model (self-developed scale) and more likely to yield data that could be generalized and compared with other vocational groups such as nurses, rehabilitation professionals, and retail employees.

The first scale was the interaction with disabled persons scale (Gething 1994a). It is an instrument comprising 20 items that are rated on a six point scale (ranging from “strongly agree” to “strongly disagree”). There is no midpoint or neutral option. “The scale was devised for Australian conditions to measure discomfort in social interaction which is posited to reflect reactions associated with non-accepting or negative attitudes towards people with disabilities” (Gething 1991:12). It measures attitudes at a personal level and is based on the assumption that negative attitudes are reflections of the subjects’ lack of association with the object and that this lack of information or strangeness engenders feelings of uncertainty and anxiety (Gething 1993). It is these feelings of cognitive dissonance, referred to earlier, that are measured by the scale. A *pro forma* accompanies the scale to gather sociodemographic information on gender, age, education level, occupational status, and prior level of contact and knowledge of people with disabilities. While it was developed and primarily tested in Australia, the scale has been translated into four languages and tested in nine different countries. It has also been tested as part of a battery of research scales designed to assess attitudes towards people with disabilities.

The second scale used was the scale of attitudes towards disabled persons (Antonak 1981). It consists of a summated rating scale with 24 items. Respondents rate each item on a six point scale, ranging from “I disagree very much” (-3) to “I agree very much” (+3). No midpoint or neutral response is provided and the scale is designed to measure attitudes to disability as a group and at a societal level. The score ranges from 0 to 144, with a higher score indicating a more positive attitude. Three factors were delineated in assessing the reliability of the instrument and these broadly related to human rights, behavioral misconceptions, and societal perceptions of pessimism/hopelessness as aspects related to disability. The measures of validity of the scale gauge attitude domains have been broadly classified as civil and legal rights; equity and equality; and destructive stereotypes of personality and social characteristics (Antonak and Livneh 1988:161).

### *Research Design*

Two samples of convenience (Jennings 2001) and captive groups (Veal 1997) were used. The initial sample had 175 respondents drawn from a university (120) and a technical college (55), with data collected in September 1996. The second sample was a government tourism organization where disability awareness training was being

implemented as part of Australian legislative procedures to comply with this ruling under the Australian “*Disability Discrimination Act 1992*”. This second study consisted of 176 respondents who were drawn from a state-based tourism organization (137) and from government employees (39) involved in industry provision. Data was collected between June and November 2002. In both studies, attitudes were measured prior to and post training. For the initial sample a follow-up measurement was done after one month.

The initial study of 175 respondents comprised a mixture of hospitality and tourism students enrolled in a diploma program at vocational institutes and first- and second-year university degree in urban New South Wales, Australia. The primary differences between the two institutions are that the former provides technical training as opposed to a more management focused, less hands-on experience offered by the latter.

For the initial sample, 33% were male and the rest female. The predominant age group (49%) of respondents was 20–29, followed by 16–19 (45%). Respondents (52%) identified themselves as having contact with a person with a disability less than once in three months. Surprisingly, 20% of the sample identified themselves as having weekly contacts. In terms of educational qualifications, 79% of the sample identified as having received high school diplomas, which was unsurprising given that most such students continue with training and education plans. A majority of the respondents (54%) were involved in food and beverage provision, 3% in front office, 14% in a customer service role, and 28% full-time students.

The study aimed to measure the most efficacious means of changing attitudes towards people with disabilities. It used an experimental design, with a control group and two groups where the intervention variables were manipulated. One group received only lecture and video intervention while the other lecture, video, role-play and contact with disabled people as an intervention. The respondents were surveyed three times: prior to any intervention taking place, immediately post the intervention, and a follow up one month after the interventions. The results were then collated to measure differences *between* (intervention method, control, lecture and video or lecture, video, role play and contact) and *within* (pre, post or follow up measurement) groups on both scales. Analysis of variance (ANOVA) was used to measure the relationship of the demographic variables.

The results showed that differences were detected in terms of levels of significance and in trends of mean scores (not statistically significant). A number of hypotheses were tested. These included whether attitudes could be altered through a disability attitude intervention program. The efficacy of using contact and two-way communication (lecture, video, role play, and contact) as compared to one-way (lecture and video only) and comparisons between attitudes of different cohorts of students were studied. Coding was done to ensure matched pairs/triples of the surveys could be identified. Thus, it was possible to measure an individual’s scores through pre-, post- and follow-up testing.

The second study of 176 employees consisted of 118 respondents drawn from a large state-based tourism organization and 19 trainees from the same organization. Of the respondents 39 were government tourism employees in a regional area. Demographic variables were completed by only 101 of the sample and data revealed that 29% were female. Results revealed that 30% had less than a once-in-three-months contact with a disabled person and 23% had weekly contact. Age demographics revealed 32% were 30–39 years old, followed by 31% 20–29, 24% 40–49 and 13% 50–59 years. Educational demographics indicated 43% were graduates and 22% postgraduates while 24% graduated from high school.

The second study of tourism organizations was designed to implement the best practice identified by the results of the first study. All groups received the interaction with disabled persons scale in a pre- and post-measurement. The intervention consisted of a disability awareness training program that included lecture, video, role-play, and contact with disabled people. The confidentiality and anonymity provisions of the research did not allow for matched pairs and individual scores to be tracked. Further, while the organization was supportive of the research, it stipulated a two-hour time limit to the training and would only approve the use of the Australian IDP scale.

Results indicated that this second group had significant change in attitude after the training, with women being more affected than men. Analysis of the data also revealed that the trainee group experienced the least significant changes in attitudes after the training. This might have been due to the small sample size or alternatively to a general resistance to personal attitude changes. Compared to other vocational groups such as judicial system employees, nurses, rehabilitation professionals and so on, industry employees had more negative attitudes prior to training. Their post-training scores, however, were more positive and comparable to other vocational groups.

### *Study Results*

Results from both studies indicated that it was possible to change attitudes of industry staff and students through an intervention program. An analysis of the data revealed that this change tended to be more efficacious and longer lasting when subjects were exposed to a controlled form of contact with a person with a disability, giving them the opportunity to increase their knowledge about such individuals. Additional findings from the initial study concluded that it was subjects who were both better educated (second year students) and had greater exposure to working in the industry (TAFE and second year university students) who tended to have longer lasting attitude change. First year students, while more impressionable and reactive to the initial awareness, tended to have short-lived attitude change as measured by the one-month follow up. This would suggest that repeated exposure and practical knowledge would enhance knowledge and behaviors of service personnel. In terms of demographic significance, an analysis

of the data revealed no differences between male and female attitudes of students.

In the initial study of 175 students from the industry, it was hypothesized that significant differences would emerge between personal and societal attitudes. The results indicated that significant differences occurred at the  $p < .05$ ,  $p < .01$  and  $p < .001$  between, within, and in the ANOVA on scales. Tables 1 and 2 show the differences in pre-, post- and follow-up surveys for the initial sample. The tables show an administration (Admin) column that identifies the intervention to each sample group (Cont = Control; LV = Lecture and Video; LVRC = Lecture, Video, Role play and Contact), the pre-, post- and follow-up survey scores, and the significant difference scores within the groups (Sig.Diff. within). The other columns represent each sample group (TAFE 1, 2, and 3; Univ 1, 2, and 3) and the significant difference scores between the TAFE and university sample groups (Sig.Diff. between TAFE; Sig.Diff. between Univ). The significant difference scores are presented or nonsignificance (n.s.) noted. The tables also illustrate the changes between and within groups. Lower scores on the IDP scale represent positive attitudes. The SADP scale is the reverse, with lower scores representing negative attitudes.

An examination of the frequency of significance levels (that is,  $p < .001$ ,  $p < .01$ , and  $p < .05$ ) revealed that the societal had many more highly significant scores as compared to the personal data scale. Table 3 represents these results by comparing the numbers of items on the scales. Results indicated that the IDP scale showed changes in personal attitudes in terms of within (3 at  $p < .05$ , 3 at  $p < .01$ , and zero at

**Table 1. Means and Standard Deviations using the IDP Scale**

Admin	TAFE 1	TAFE 2	TAFE 3	Sig. Diff. between TAFE	Univ 1	Univ 2	Univ 3	Sig. Diff. between Univ
Intervention	Control	LV	LVRC		Control	LV	LVRC	
Pre	71.94 (8.64)	69.24 (9.97)	70.17 (8.09)	n.s.	71.38 (8.26)	73.00 (8.69)	68.96 (8.14)	LV&LVRC $t = 2.23$ $p > .05$ (.029)
Post	0	66.10 (9.12)	63.33 (11.73)	n.s.	0	72.65 (9.75)	69.07 (9.69)	n.s.
Follow up	72.19 (8.27)	64.48 (8.07)	63.67 (10.85)	LV&Cont $t = -2.85$ $p < .01$ (.007) LVRC&Cont $t = -2.55$ $p < .02$ (.016)	71.94 (8.75)	72.22 (10.63)	66.46 (9.97)	LV&LVRC $t = 2.59$ $p = .01$ LVRC&Cont $t = 2.56$ $p = .01$
Sig. Diff. Within	n.s.	Pre&Post $t = 2.42$ $p < .05$ (.025)	Pre&Post $t = 3.14$ $p < .01$ (.006)		n.s.	n.s.	Post&Fol $t = 2.35$ $p < .05$ (.023)	
		Pre&Fol $t = 2.57$ $p < .02$ (.018)	Pre&Fol $t = 3.10$ $p < .01$ (.007)				n.s. Pre&Post	
		n.s. Post&Fol	n.s. Post&Fol				Pre&Fol	

**Table 2. Means and Standard Deviations using the SADP Scale**

Admin	TAFE 1	TAFE 2	TAFE 3	Univ 1	Univ 2	Univ 3	Sig. Diff.
Intervention	Control	LV	LVRC	Control	LV	LVRC	
Pre	98.3 (14.6)	99.4 (17.0)	106.9 (11.6)	100.7 (13.4)	100.5 (14.0)	103.0 (14.0)	$F = .946$ $df\ 5,164$ $p > .05$
Post	0	113.2 (14.3)	120.0 (11.7)	0	115.1 (14.8)	115.9 (12.7)	$F = .872$ $df\ 3,117$ $p > .05$
Follow	108.6 (13.5)	111.1 (17.0)	120.8 (12.2)	108.1 (12.5)	113.8 (12.5)	111.7 (14.5)	$F = 2.29$ $df\ 5,161$ $p = .05$
Sig. Diff. within groups	Pre&Fol $t = 2.47$	Pre&Post $t = 5.752$	Pre&Post $t = 5.962$	Pre&Post $t = 3.163$	Pre&Post $t = 8.849$	Pre&Post $t = 9.093$	
Paired T Tests	df 15 $p < .05$	df 17 $p < .001$ Pre&Fol $t = 5.041$ df 19 $p < .001$	df 17 $p < .001$ Pre&Fol $t = 5.229$ df 17 $p < .001$	df 30 $p < .001$	df 37 $p < .001$ Pre&Fol $t = 6.921$ df 35 $p < .001$	df 41 $p < .001$ Pre&Fol $t = 2.780$ df 42 $p < .01$ Post&Fol $t = 3.487$ df 40 $P = .001$	

$p < .001$ ) administrations (that is, pre-, post- and follow-up). Equally significantly, differences were also observed between groups (3 at  $p < .05$ , 4 at  $p < .01$ , and 1 at  $p < .001$ ) in terms of the intervention. Further, as to the ANOVA of demographic variables, the results indicated that prior contacts, the method of the intervention, and whether the respondent was a first-year or second-year student were all significant.

**Table 3. Frequency of Significance on the IDP and SADP Scales**

Level of significance	Within	Between	ANOVA
.05 IDP	3 e.g. LV TAFE, Pre and Post, $t = 2.42\ p < .05\ (.025)$	3	2 Prior contact with a person with a disability
.05 SADP	2	0	0
.01 IDP	3	4 e.g. LV and Control TAFE Follow up, $t = -2.85\ p < .01\ (.007)$	2 Use of intervention Prior contact with a person with a disability
.01 SADP	3	0	1 Whether first or second year university student
.001 IDP	0	1	5 e.g. Intervention, TAFE and University, Post, $f = 24.91$ $p < .001$
.001 SADP	15	0	0

On the other hand, the results from the SADP measurement demonstrated that changes in attitude were at highly significant ( $p < .001$ ) levels within administrations of the instrument (pre-, post- and follow-up). However, differences between groups (Control, LV and LVRC) and ANOVA of demographic variables, while not being statistically significant, demonstrated major trend differences in mean scores. Statistically significant differences occurred in terms of whether the respondents were first-year or second-year students. TAFE and second-year university students had less positive attitudes than did first-year students immediately after the interventions.

The IDP scale has been administered to thousands of Australians and the establishment of a data bank allows for comparisons between different administrations of the instrument. Results comparing attitudes of tourism-related personnel from the second study with other occupational groups in Australia, such as health and rehabilitation personnel, indicated that tourism employees tended to have less positive attitudes. The attitudes of the second study group tended to be comparable to university students. Table 4 illustrates differences in mean scores between tourism and other occupational groups (adapted from Cameron, Darcy and Daruwalla 2002). It also presents the mean scores on the IDP scale between pre- and post-testing of the sample, showing the shift to more positive attitudes after the intervening training.

**Table 4. Comparisons with other Australian Groups**

Sample	Sample Size	Mean	SD
<b>Tourism Employees</b>			
Pre	118	74.3	11.1
Post	109	69.8	11.0
<b>Tourism Trainees</b>			
Pre	19	75.0	14.4
Post	25	71.2	9.2
<b>H&amp;T Govt Employees</b>			
Pre	39	73.6	10.9
Post	39	67.0	10.3
<b>Comparative Data</b>			
General population	4180	64.1	12.2
Members of judicial system	59	67.5	12.2
Government employees	541	63.0	12.5
High School students	181	69.3	11.3
University education students	118	72.8	10.8
University nursing students (Year 1)	272	67.3	10.1
University nursing students (Year 2)	104	65.5	9.8
University nursing students (Year 3)	136	63.3	10.4
Registered nurses	372	62.3	10.3
Enrolled nurses	376	60.0	11.0
Physical therapists	123	58.6	9.7
Medical therapists	171	61.1	10.2
Rehabilitation professionals	351	58.8	12.3
Members of a disability agency	63	60.8	12.8
H&T Students	175	69.2	11.0

Significant differences between the two scales should not have been surprising, given their different foci (personal versus societal) and Gething's (1994a) commentary regarding the nonsignificant relationship between them. Researchers such as Eberly, Eberly and Wright (1981), Rickman (1993), Semmel and Dickson (1966), Snyder, Kleck, Strenta and Mentzer (1979), and Stovall and Sedlacek (1983) give credence to the notion that it is much easier to make an impact on societal attitudes when contrasted to personal where individuals are likely to feel more threatened by contact with disabled people. According to Rickman, "data from studies investigating interaction behavior showed that, whenever possible college students have avoided contact . . . . . attitudes were generally more favorable for relatively distant or transient situations than for more permanent situations" (1993:58).

While results from the analysis of both instruments indicated changes in attitudes, some significant disparities arose, indicating that personal attitudes tended to be more affected by the type of intervention and immediately after the intervention. Thus, respondents who met a person with a disability tended to have more significant changes in personal attitude than those who had none. Societal attitudes as measured by the SADP, while affected at much more significant levels ( $p < .001$ ), tended to be independent of the type of intervention received. Thus, in the initial study, respondents showed significant change in societal attitudes, regardless of the intervention employed, whether lecture and video or lecture, video, role play and contact. This would imply that societal attitudes improve regardless of the type of intervention used, whereas for personal to improve, it is important to incorporate individual contact. Thus, in the second study of industry employees, two out of three facilitators in the component using direct contact were persons with a disability. Data resulting from this intervention and measured by the IDP scale indicates that, while there was some change, it was not as significant as the change in SADP scores in the initial study.

In the one-month follow up conducted after the initial study, the data revealed that personal attitudes were affected immediately after the intervention, but reverted to more negative levels in the intervening one-month period (Table 1). Societal attitude change, however, tended to persist at more positive levels in the one-month intervening period (Table 2). The implications of this for education are that constant reinforcement and refreshers are needed if attitude change is to become internalized and persistent. On the job interaction with disabled people would further affect attitude, and managers could reinforce training outcomes by incorporating customer service in routine practices.

There are three possible reasons for the incongruity in results in the initial study. The first involves the simultaneous positioning of the instrument as both were handed out to respondents together. However, they were encouraged to complete the IDP before the SADP. This positioning might in itself have had an "edumetric" (Gething 1994b:246) effect wherein the former scale tended to make respondents more sensitive to the issue of attitudes towards people with disabilities. It might equally be suggested that completing the IDP had

a “contamination effect” (Gething 1994:13) and this highlights the need to change the order of the administration of the instruments in future studies, to test whether there is any impact of the positioning of the instruments. Thus, more positive attitudes in the societal scale pretest scores even by those in the control group might be explained by this edumetric effect, caused by first completing the personal scale.

The second issue is the wording of items on the instruments. Gething (1991a) suggests that this may tend to polarize views and affect responses. The wording on the SADP may be interpreted as being both provocative and challenging, whereas the IDP tends to state items more mildly. Reactions by respondents to societal items were quite forceful in certain instances. For example, item 22 states, “Disabled people indulge in bizarre and deviant sexual behavior”. This item elicited written responses such as “Not my business”, “How should I know about this”, and “I can’t comment”.

The third issue is the origin of each instrument: respondents queried terminology, wording and meaning of statements on the SADP. This querying, however, did not occur for items on the Australian developed IDP and linguistic interpretation difficulties were not presented to a primarily Australian audience. The SADP is American in origin and used both terminology and contextual references that were unfamiliar to a primarily Australian audience. This finding is important as it shows that even in Western nations, where there are many cultural similarities, there are still cultural differences involving language use and approaches to disability.

### *Implications for Management*

The implications for tourism management drawn from these results include the likelihood that societal attitudes will change and remain more positive, regardless of the type of intervention (education, training, disability awareness program). However, for personal attitudes to change and become more positive, an intervention program that uses role-play and contact with disabled people will be more effective. It may be argued that in an industry context, the attitude change needs to be more personal. This assertion is based on some specific characteristics of the tourism industry, namely the intangibility of personal service provision, the heterogeneity of services, and the inseparability of the production and consumption of many services (Shames and Glover 1989; Zeithaml, Parasuraman and Berry 1990). Thus, the “one on one” nature of services and the unpredictability (situational, locational, or people specific) of the service encounter, point to the need for operators to have positive personal attitudes to maximize the satisfaction of the service encounter, which is not “a relatively distant or transient situation” (Rickman 1993:58) allowing for good societal but poor personal attitudes. This then raises the issue of how to improve attitudes, using contact as a major influencer.

The use of contact as an intervention method in changing attitudes has its genesis in Allport’s (1954) seminal work on contact theory.

More specifically the use of equal or higher status contact to change attitudes is emphasized by writers such as Cook (1962), Gething (1994), Hannah (1988), Leach (1990), Westwood, Vargo and Vargo (1981), and Wright (1988). Equal or higher status contact refers to the contact where the audience and the person with a disability are from a similar background. Examples would be tourism academics and students in an attitude change workshop facilitated by one of their own with a disability. The focus of this contact also needs to be based on the person's abilities and the disabling environments encountered rather than the medical diagnoses of impairment. There is a need to place the contact in the context of a social model approach, rather than reinforce the curiosity of the nondisabled about one's "personal tragedy/individual heroism" as is so often espoused by the media. Positive experiences involving the nature and perspective of disability are more likely to achieve positive attitude change and overcome "cognitive dissonance" in the nondisabled. A peer with a disability facilitated the student respondents of the initial study. Some with a range of disabilities (mobility, sensory, and intellectual) were incorporated into the survey design. For the respondents drawn from tourism organizations, the research design included facilitators (with disabilities) who were industry and academic specialists in tourism.

The use of videos such as "The Year of the Patronizing Bastard" (Denton 1990), the trigger tape with some industry related contexts from the disability awareness package (Gething 1994) and industry specific awareness ones (WADSC 2000) also provide support for discussions. The roles of stereotyping and stigmatization need attention when attitude change programs are considered. Participants need to be reminded that persons with disabilities are a microcosm of the general population and individuals in their own right. Thus, the application of broad generalities is both dehumanizing and inappropriate. It is critical that, in developing programs using contact, this contact is meaningful and relevant to the situation. Positive contact serves to reinforce where the negative may result in stereotyping and avoidance.

In industry contexts, it is essential that both business enterprises and educational institutes offering tourism and hospitality programs put disability awareness firmly on the agenda. Organizations may do this through a variety of ways, including mandatory modules on disability awareness in both orientation and performance appraisal programs. Educational institutes need to address these issues as subjects, or by lectures within generic subjects, including topics of market segmentation and human rights obligations under national and international frameworks.

The delivery of disability awareness programs needs to be carefully considered, including the delivery of relevant and industry-specific information. The human rights and legislative implications of the discriminatory nature of poor attitudes in a business context need to be highlighted. These same frameworks identify the need for education to form the basis of social change and promote the use of people from the community to provide the contact and act as facilitators. Well structured programs focusing on ability and employing appropriate

material could also be used to form part of a worldwide accreditation system that to some extent would standardize the service a person can expect from enterprises within the tourism industry.

Among other recommendations for industry and educational institutions interested in implementing disability awareness education would be modifying the demographic instrument to collect information about ethnicity. This information would greatly enhance the provision of diversity training to people of different cultural backgrounds. As Miles (2000) argues, there are different conceptualizations of disability from Western and Eastern and from developed and developing world perspectives. A cross-cultural/cross-countries study would add to the information on how different cultures perceive and respond to disability and people affected by it in the industry. A further recommendation would be the testing of the instruments in an industry setting among service providers.

Apart from the human rights and social justice issues that surround negative attitudes and behavior, management of industry enterprises needs to be cognizant that discriminatory practice can result in legal proceedings. These include lawsuits in the United States (Andorka 1999; Peniston 1996; Salomon 1996; Seal 1994; Worcester 2000), United Kingdom (Goodall 2002), and Australia (Darcy 2002). The lawsuits highlighted in these studies document a multitude of practices that ignore basic customer service provision and deny people their citizenship rights. From an industry perspective, the effects go beyond the scope of monetary restitution required of the providers, resulting in poor publicity, loss of good will, and loss of business.

The economic implications of legal proceedings and the underservicing of the group impact on the industry. People with disabilities have friends, family, and business associates similar to nondisabled customers. The multiplier effect of inadequate access to premises and services extends beyond the person with a disability to those who accompany them when partaking these services (Darcy 2003; Harris Interactive Market Research 2002). Management that claims, "we don't have people with disabilities using our premises/services" is excluding a significant proportion of the population and a great number of other patrons, such as families with small children and the seniors market, who require similar services. The practice of universal design (Aslaksen, Bergh, Bringa, and Heggem 1998) and disability awareness training for staff offer the potential of securing a loyal and growing market.

## CONCLUSION

This paper has examined the role, nature, and impact of disability awareness training in the industry. It has shown that such training can be a valuable resource in forming and changing the personal attitudes of nondisabled persons towards those with disabilities. While previous studies have identified the need for disability awareness training, tourism has not been forthcoming in developing access and service

provisions to meet the needs of this group. Human rights legislation in many Western countries has had the salutary effect of preventing service providers from overtly discriminating. However, the industry as a whole has been reluctant to embrace the concepts of universal design (for access) and disability awareness training, while at the same time it claims to be informed (Darcy 2002; Goodall 2002; O'Neill and Knight, 2000).

Operators and service providers need to be moved from the mindset of just wanting to meet their legislated human rights obligations to exemplary service provision. As they do when focusing on any market segment, service providers need to internalize a more holistic embrace of attitudinal modification to accommodate the tourism experience. The service and the experience would then be lifted from the banal to the truly memorable. This internalization of positive attitude by industry service personnel would influence both personal and societal attitudes towards people with disabilities and help in the creation of a more civil society. **A**

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