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ATTITUDINAL BARRIERS TO DISABILITY AND THE LONELINESS AND SOCIAL ISOLATION OF PHYSICALLY DISABLED PEOPLE IN READING, ENGLAND

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Research findings produced for an undergraduate dissertation in Human Geography at the Department of Geography and Environmental Science, University of Reading.

PARTICIPATION LAB RESEARCH REPORT

FEBRUARY 2020



ACKNOWLEDGEMENTS

I would like to thank all the organisations and individuals who gave up their time to participate in interview and focus group, because without their input completion of this research would not have been possible. Special thanks to Readibus, particularly Peter Absolon, Liz Johnson and Dr Sophie Bowlby, for the role they played in recruiting participants and for allowing me to use their offices to conduct interviews and focus groups. I also wish to thank Dr Ruth Evans and Dr Hilary Geoghegan for all their guidance and support for the duration of this research.

This research was undertaken to accompany a larger research project on tackling Loneliness and Social Isolation in Reading commissioned by the Health and Wellbeing Team, Reading Borough Council. The findings of the larger project are reported in: Bridger, O. and Evans, R. (2019) *Tackling Loneliness and Social Isolation in Reading, England*. Research Report, Participation Lab, University of Reading, Reading, UK.

To cite this report

Bridger, O. (2020) *Attitudinal Barriers to Disability and the Loneliness and Social Isolation of Physically Disabled People in Reading*. Research Report, Participation Lab, University of Reading, Reading, UK.

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Participation Lab Reports

Participation Lab Reports are intended to present our research results to as wide an audience as possible and may contain preliminary research findings or highlight results of relevance to policy and practice.

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SUMMARY

Guided by principles of enabling geography, this study aimed to investigate the relationship between attitudinal barriers to disability and the loneliness and social isolation (LSI) of physically disabled people, and to comment on the best practices for reducing attitudinal barriers. To understand this relationship, five semi-structured interviews were conducted with practitioners who work with physically disabled people, and three paired interviews and one large focus group were conducted with physically disabled people. This study found that disabled people experience extensive attitudinal barriers in their day-to-day lives, and such barriers contribute significantly to feelings of loneliness, and experiences of social isolation because they impede on both the quantity and quality of disabled people's social encounters; social encounters that essential for preventing loneliness and social isolation.

1. INTRODUCTION

1.1 Aims of the Study

This study aims to investigate the role attitudinal barriers toward disability might have in contributing to feelings of loneliness and social isolation (LSI) amongst physically disabled people in Reading.

Using qualitative data collected from semi-structured interviews with both practitioners who work with disabled people, and physically disabled adults, this report seeks to critically consider the following research questions:

1. What are the attitudinal barriers experienced by physically disabled people in Reading?
2. To what extent and in what ways, do attitudinal barriers toward disability contribute to feelings of loneliness, and experiences of social isolation amongst physically disabled people in Reading?
3. How could a reduction in attitudinal barriers be achieved, and what might be the best practices for reducing attitudinal barriers toward disability in Reading?

1.2 Research Context

Tackling loneliness and social isolation has recently become a policy priority for both non-governmental organisations (NGOs) and local and national government, due to the numerous studies that suggest prolonged experiences of LSI are detrimental to both physical and mental health. For instance, Holt-Lunstad et al's., 2010 study found loneliness to be as detrimental to health as smoking 15 cigarettes per day, and their 2015 study suggests loneliness increases mortality by up to 26%. Similarly, the onset of disability (Lund, et al., 2010), frailty (Gale, et al., 2018) and cognitive decline (James, et al., 2011) occurs quickest for the loneliest individuals. Furthermore, loneliness is linked to completed suicide (O'Connell, et al., 2004) and poor emotional development and wellbeing (Besevegis & Galanaki, 2010).

Although numerous studies (ONS, 2018; Qualter et al., 2015) suggest feelings of LSI are experienced across the life course, physically disabled people have been identified as a demographic who are disproportionately affected. Sense¹ (2017) found that over half of disabled people feel lonely, with a quarter of disabled people feeling lonely every day. Equally, an analysis of the characteristics and circumstances associated with 'feeling lonely' by the Office of National Statistics (2018) found ill health and disability to be correlated to higher self-reported feelings of loneliness. Additionally, a project commissioned by Reading Borough Council's (RBC) Health and Wellbeing team in the summer of 2018 (Bridger & Evans, 2019) that aimed to investigate the dynamics of, and factors for, loneliness and social isolation in Reading also found that disabled residents experience higher levels of loneliness and social isolation, and these feelings arise, in part, due to negative public attitudes toward disability- factors framed by the social model of disability as attitudinal barriers to disability². It is these findings that

¹ Sense is a UK disability charity.

² Please see chapter 1.21

informed the research questions outlined in chapter 1.1. Therefore, by reflecting on disabled people's own experiences and opinions, this study aims to highlight the role attitudinal barriers have in preventing disabled people from experiencing full social equality and participation, and may illustrate some of the ways to overcome this.

1.2.1 The Social Model of Disability

The social model of disability is the model which most disability geographers use to understand and conceptualise disability (Hall & Wilton, 2017). Although not without criticisms (Owen, 2014), this model informs this study's approach and understandings. Linked closely with disability rights movements, the origins of the social model can be attributed to the UPIAS's³ declaration that "it is society which disables physically impaired people. Disability is something imposed on top of our impairments by the way we are unnecessarily isolated and excluded from full participation in society" (1975, p4). However, disabled scholar Mike Oliver first termed the phrase 'the social model of disability' in 1983, with the view that this model would not be used as an all-encompassing theory of disability, but as a useful tool from which to consider and reframe the role society has in shaping disability (Oliver, 2013).

The social model suggests disability is socially constructed; the presence or absence of societal barriers restrict the functioning of ill and impaired people, and in turn create disability (Thomas, 2001). These understandings emerged due to concerns surrounding the individualistic, medicalised explanations of disability that had previously dominated thinking (Shakespeare, 2017). This medical or individual model suggests disability is a direct consequence of impairment or illness, because such deviations in bodily norms or abilities leave people physically incapable of doing certain 'things' and thus disabled (Edwards, 2005; Thomas, 2004). Using a very simple example, table 1.1 illustrates the differences in understandings. Ultimately, the social model suggests disability is an experience that can be challenged and overcome (Shakespeare, 2017).

Table 1.1: Differences in understandings between the social and medical models of disability

<i>Example: A wheelchair user cannot enter a shop because there are several steps at the entrance</i>	
Social model understandings	Medical model understandings
This person experiences disability because there isn't a ramp available allowing them to enter the shop in their wheelchair.	This person experiences disability because their impairment or illness means they cannot walk up the stairs.

³ UPIAS (Union of the Physically Impaired Against Segregation) was an early UK disability rights organisation

1.2.2 Attitudinal Barriers

Within social model understandings, attitudinal barriers are behaviours, assumptions and perceptions toward and about disabled people; not only are they disabling, but through active or passive discrimination act as barriers and prevent disabled people from participating fully and equally within society (Goreczny, et al., 2011). Such barriers are the cumulative outcome of individual and collective misunderstandings, confusions, or fears concerning impairment, illness or disability (Sahu & Sahu, 2015).

1.3 Research Structure

This report is structured in the following way. The next chapter (chapter two) will provide an overview of existing literature. Chapter three provides an in-depth account of this study's methodological approach, including details of data collection and analysis. Chapter four discusses the attitudinal barriers experienced by participations, and the implications these barriers have for feelings and experiences of LSI. Chapter five discusses the suggestions made by participants for reducing attitudinal barriers to disability. Finally, chapter six summarises and draws conclusions from key findings, and makes suggestions for future academic research, and policy intervention.

1.4 Positionality Statement

My interest in this topic stems from the work I completed for RBC in the summer of 2018. Although I believe this work gave me a sound insight into local experiences of LSI and an understanding of the current strategies being implemented to tackle this issue, it is important to be reflexive and recognise that my work with RBC may have influenced how I approached this research (Berger, 2013). For example, I have attended several meetings of the LSI steering group and have developed working relationships with those involved. Moreover, as a healthy, abled-bodied young woman I do not have lived experience of impairment, illness or disability, so in this way may never fully understand the complexities of these experiences, and could be perceived as an 'outsider' by participants (Dwyer & Buckle, 2009). My position as an 'outsider' became apparent in one interview. When I asked whether a participant had ever experienced negative attitudes, he hesitantly replied with *"if I came across you on the street... that's the person I mean who would be against me,"* therefore illustrating how he might expect someone with characteristics similar to my own to have negative attitudes toward disability.

2. LITERATURE REVIEW

2.1 Introduction

This chapter aims to situate this study within existing academic work. In the absence of any geographical conceptualisations of LSI, this chapter begins by briefly outlining how LSI is defined and considered within other social sciences. A discussion of how disability geographers have conceptualised and explained the exclusion of disabled people follows. This chapter concludes by reflecting on issues of disablism, and how negative attitudes toward disability are considered.

2.2 Loneliness and Social Isolation

The emergence of multiple medicalised studies⁴ have conceptualised LSI as a public health issue (Macdonald, et al., 2018), yet neither loneliness nor social isolation have a universally accepted definition (de Jong Gierveld, et al., 2006). However, loneliness is frequently understood to be a “chronic distress without redeeming features” (Weiss, 1973, p. 14), whereby the social relationships an individual has are not consistent with the social relationships they desire (Asher & Paquette, 2003). Social isolation, however, is an objective state whereby an individual has very limited social interactions (Heinrich & Gullone, 2006). The simplest way to distinguish between the two terms is that an individual who has no contact with another person for a substantial period of time must be considered socially isolated, yet may feel perfectly content and in no way lonely or distressed (Macdonald, et al., 2018). Yet, another individual (or indeed the same individual) may feel intensely lonely at a large gathering but, due to the presence of others, cannot be deemed socially isolated (Heinrich & Gullone, 2006). Therefore, loneliness should not only be viewed an affectual, emotional response to prolonged experiences of social isolation, but as a feeling that exists when an individual’s emotional and social needs of closeness, mutual understanding, and reciprocity are not met (Weiss, 1973). Ultimately, feelings of loneliness, and experiences of social isolation arise from inadequate and unfulfilling social encounters (Rokach, 2004). Subsequently, maintaining strong social networks that result in frequent, quality social encounters are essential for preventing loneliness and social isolation (Dahlberg & McKee, 2014; Tanskanen & Anttila, 2016).

Despite the abundance of work indicating that disabled people are more likely to feel lonely, and to experience isolation than able-bodied people,⁵ disabled people’s experiences of LSI are under-investigated both within disability geography and disability studies, even though both disciplines are well established (Hall & Wilton, 2017). Of the few studies that do consider the link between LSI and disability, most attention has been paid to the experiences of deafness and learning disabilities. Chappell (1994) found the stigmatisation of friendships between people with learning difficulties to be a key factor in experiences of isolation, in addition to a lack of finances and early bedtime routines by caregivers that prevented people with learning disabilities from going out in the evening. Valentine and Skelton (2003) found feelings of loneliness to be common amongst deaf youths as they transitioned to adulthood and became increasingly excluded from a hearing

⁴ Please see chapter 1.2

⁵ Please see chapter 1.2

society, particularly in term of access to employment and popular culture. Similarly, Taylor (1999) identified how societal prejudices toward both race, and deafness, are factor for the isolation of ethnic minority deaf people. Ultimately, these studies illustrate how LSI and disability must be considered the context of society's continued exclusion, marginalisation and oppression of disabled people.

2.3 Disability and Exclusion

"Disabled people are marginalised and excluded from 'mainstream' society" (Kitchin, 1998, p. 343); disability geographers consider this in relation to the socio-political processes that produce disabling and exclusionary spaces and places.

Materialist's suggest the exclusion of disabled people exist because of concerns surrounding their socio-economic 'worth' (Kitchin, 1998). Oliver (1990) suggests disabled people are socially excluded because they are viewed as unproductive, and a hindrance to the accumulation of capital.

Conversely, idealists suggest attitudes, aesthetics and representations are integral in shaping the human experience of impairment and illness and explaining the exclusion of disabled people (Asch & Fine, 1988). The use of idealism in disability studies suggests disability is an ideological construct- therefore representations of disability matter (Sharp, 2009). Moreover, Goffman's (1983- as cited in Colomy and Brown, 1996) interactionist perspective suggest a disabled individual's personality and experience is shaped through social interaction, or lack of, and such interactions are formed by the perceived attributes of others. Therefore, since disability is viewed as negative attribute, for reasons of normality, deviance and stigma, a disabled person's social experiences are moulded and underpinned by stigmatising encounters. Although idealist approaches are criticised for their lack of belief formation and failure to appreciate materialities of social practices (Abberley, 1993), such idealist approaches have significant implications (Gleeson, 1999). For instance, they demonstrate that disability is constructed not only by the structural and material barriers emphasised by materialists, but by prejudice and stigma (Priestly, 1998).

Similarly, psychoanalytic approaches to disability suggest the exclusion of disabled people is an outcome of the fear or repulsion of difference that is embedded in human nature (Sibley, 1995). Sibley (1995) argues there is a socialised need to categorise objects and people into good or bad, based upon difference related to ourselves. In the context of social exclusion, the creation of different 'others' lead to groupings of similar individuals (in this context able-bodied people) to preserve assumptions of normality or the threats that 'deviant others' can bring. Emerging from feminist exploration of issues of difference, othering has become a useful theory of approaching disability and exclusion (Priestly, 1998).

Indeed as Hahn (1995) argues, failing to meet prescribed standards of 'normality' mean disabled people are "not only assumed biologically inferior, but they are exposed to the stigma that depicts them as not quite human" (Hahn, 1995). Consequently, disabled people are frequently presented as 'scape-goats' or viewed as a threat to able-bodied dominance and normality- hence their exclusion. However, Morris (1991) considers such exclusion in the context of fear and articulates that "our disability frightens people... So we become separated from common humanity, treated as fundamentally different and alien" (Morris, 1991, p. 192).

2.4 Disablism and Attitudes to Disability

Regardless of how the exclusion of disabled people is conceptualised, the above understandings are united in the fact they view society as disablist. Disablism is defined as “discriminatory, oppressive or abusive behaviour arising from the belief that disabled people are inferior to others” (Miller et al., 2004, p9). The concept of disablism illustrates how beliefs and behaviours have a significant role in producing exclusionary spaces (Imrie, 2000). However, there are limited academic studies which consider the direct implications negative beliefs or behaviours have on disabled people’s lived experiences. It is worth noting that within social model understandings, such beliefs or behaviours are viewed as attitudinal barriers (NCWD, 2016). Bi, et al., (2007) investigated the attitudinal barriers encountered by physically disabled tourists in the Chinese travel industry and concluded that although significant, attitudinal barriers weren’t as disabling or exclusionary as structural barriers. However, as Butler and Bowlby (1997) argue, it is socio-political attitudes and values (attitudinal barriers) that construct exclusionary and disabling spaces (structural barriers) because in a disablist society disability is not valued or seen as existence worth accounting for. Thomas (2007) supports this point, by ascertaining that disablism has two key implications; a disablist society produces structural barriers that limit what a disabled person can do, yet also has psycho-emotional dimensions that undermine disabled people’s wellbeing and affects who they can be.

To date, there have been no widespread geographical studies that consider public perceptions toward disability geography. This gap is instead filled by government and NGO reports⁶.

2.5 Summary

The key points of this literature review are as follows:

- Positive social relationships are essential for wellbeing and to prevent LSI.
- Disabled people are more likely to experience LSI than abled-bodied people, therefore it is essential to consider issues of difference and exclusion.
- Attitudinal barriers represent a key part of exclusion and disablement.
- The exclusion of disabled people has a significant effect on disabled people’s ability, self-perceptions and social relationships.

⁶ For a comprehensive review of such government and NGO reports, please see Bridger & Evans (2019) report.

3. RESEARCH METHODS

3.1 Introduction

This chapter outlines this study's approach, and discusses the influence this had the project's aims, research questions, methodological framework, and methods of data collection and analysis. The process of data collection, and the ethical and confidentiality procedures employed are described, and as the limitations of this study.

3.2 Study Approach and Overview

This study is guided by principles of enabling geography. Termed by Gleeson (2000), enabling geography is a political ethical research approach that rests on two normative aims; the social model of disability⁷, and the assumption that disability research should positively contribute to the socio-political struggles of disabled people. This approach argues disability research should empower, but can (often inadvertently) contribute to the further marginalisation and 'othering' of, disabled people (Valentine, 2003). Therefore, to prevent this marginalisation and 'othering', authors including Chouinard (1997), Kitchin (1999), and Dyck (2000) argue researchers should not simply record and disseminate disabled people's experiences within their research. Instead, they argue researchers have a moral responsibility to ensure their work contributes to the every-day struggles of disabled people and focuses both on issues of emancipation and justice- consideration of one's own positionality is also highly important⁸ (Gleeson, 2000). Ultimately, enabling research attempts to ensure socio-spatial causes of disablement are acted upon, as well as identified (Gleeson, 1999).

With this approach in mind, the over-arching aim of this study and the research questions are as follows- see table 2.1. Such research aims and questions are essential within human geography research, to break down and focus the study (Peters, 2017).

A qualitative methodological framework is used to consider the research questions below; the methods used, and timeline of collection are outlined in table 2.2. By interviewing both practitioners and REDIbus users, and holding a focus group, multiple qualitative methods are integrated (Darbyshire, et al., 2005). This allows for a more extensive understanding of the topics, and gives more diverse range of experiences and opinions that would not have been accessed through a single method of data collection (Darbyshire, et al., 2005).

⁷ Please see chapter 1.21 for a discussion of the social model.

⁸ Please see chapter 1.4 for my positionality statement, and chapter 3.5 for a discussion of how I considered my positionality within this study.

Table 3.1: Aim and Research Questions*Aim:*

To investigate and understand the role attitudinal barriers to disability may have in contributing to experiences of loneliness as social isolation amongst physically disabled people in Reading, and to consider the best practices for overcoming such barriers.

Research Questions:

1. What are the attitudinal barriers experienced by physically disabled people in Reading?
2. To what extent and in what ways, do attitudinal barriers toward disability contribute to feelings of loneliness, and experiences of social isolation amongst physically disabled people in Reading?
3. How could a reduction in attitudinal barriers be achieved, and what might be the best practices for reducing attitudinal barriers toward disability in Reading?

Table 3.2: Research Methods and Timeline of Data Collection

July- September 2018: 5 semi-structured interviews with practitioners who work with people with physical impairments and long-term health conditions in Reading

December 2018: 1 large focus group with users of Reading's ReadiBus service

January 2019: 3 semi-structured paired interviews with users of Reading's ReadiBus service

Qualitative methods, such as interviews and focus groups, provide extensive and detailed understandings (Begay, et al., 2004). Therefore, they are increasingly favoured in disability research because they "can be the first step in untangling the compound effects of social, economic, and cultural barriers....[experienced by] people with disabilities" (O'Day & Killeen, 2002, p. 12). Moreover, qualitative methods are useful when conducting research with disabled participants, because they reveal how lived experiences of disability can differ from academic understandings and conceptualisations. Such 'revelations' that qualitative methods can offer are highly important in the context of enabling geography (and for allowing me to consider research question 3 of this study) as they can illustrate the policies needed to address the self-reported reality (O'Day & Killeen, 2002).

3.2 Data Collection

3.2.1 Semi-Structured Practitioner Interviews

As table 2.2 demonstrates, interviews with practitioners were conducted first. Interviews are "verbal exchanges where one person, the interviewer, attempts to elicit information from another person" (Longhurst, 2003, p. 145). Interviews are useful research methods for allowing participants to express themselves in their own words and language that is familiar to them (Dunn, 2016). These advantages were amplified through my choice to use semi-structured interviewing because, using the schedule in appendix B, I was able to ensure key topics were covered, while maintaining flexibility and allowing participants to guide the conversation (Dunn, 2016). I conducted all interviews at each practitioner's offices, and interviews lasted between 28 and 62 minutes. The group(s) each practitioner works with are shown in table 2.3.

Table 3.3 Practitioner Groups

<i>Practitioner 1:</i> People with mobility problems
<i>Practitioner 2:</i> Deafness and sensory impairments
<i>Practitioner 3:</i> Blind and visually impaired
<i>Practitioner 4:</i> Life-limiting illnesses
<i>Practitioner 5:</i> Befriending service for people with all physical disabilities

I initially organised these interviews for RBC's project, however I soon realised that examining the views of practitioners could enhance this study. Practitioners, or 'experts' have extensive and detailed understandings of this research area, and since they draw on the experiences of multiple people are able to summarise recurrent themes or issues (Meuser & Nagel, 2009). Equally, because practitioners are often more detached from the research area, they can reflect in a more objective way, are less likely to be overcome with emotion (Obelene, 2009). However, although practitioners can give detailed insights into some of the issue experienced by the people they support, it is important to emphasise that they cannot, and should not be seen as speaking for, or representing the views and opinions of disabled people (Kitchin, 2000). Therefore, practitioner interviews are used to accompany and complement the opinions and experiences of disabled participants.

3.2.2 Readibus Users

Readibus is an alternative bus service in Reading for people who cannot access mainstream transport usually because of physical disability or ill health, and acted as a gatekeeper organisation for this study. A gatekeeper is an individual or institution who can provide a researcher with access to potential participants (Peters, 2017). Given that I had no direct access to disabled people, and that disabled people have been identified as potentially vulnerable within the research process⁹, a gatekeeper was essential for this project (Campbell, et al., 2006; Chouinard, 2000).

I presented my aim, research questions and interview/focus group schedule to Readibus. Once Readibus were happy with what I wanted to achieve, on my behalf, a Readibus employee contacted users who she thought would be willing to participate. This is convenience sampling (Robinson, 2013). All interviews and the focus group took place at Readibus offices, all participants travelled to the offices using Readibus and were provided with a 'sandwich' lunch by way of compensating their time. Indeed, as Head (2009) argues, small material compensations (for example a lunch) demonstrates that a researcher values participants time and knowledge, yet doesn't coerce participants into participating into research if the financial incentive is too high to refuse.

3.2.2.1 Readibus Focus Group

Focus groups enable researchers to access the opinions and experiences multiple people at once, while considering any differences in opinions or experiences, and allowing any debate to flow (Conradson, 2005). As table 2.2

⁹ Please chapter 3.4

illustrates the focus group was conducted before the interviews, and was arranged just before Christmas. I used the interview schedule found in appendix C, and although important data was generated, given that a buffet lunch was provided and that many passengers knew each other, keeping conversation on topic was difficult and at times felt like a social gathering. This was in part due to the size of the gathering, there were ten people however it is recommended that a focus group ideally contains four and eight participants (Bloor, et al., 2001). Originally, it was my intention to split the room into two, and hold two separate focus groups back to back, however it soon became apparent that given the space available that this wasn't going to be possible. This demonstrates how although familiarity, and informality is essential for keeping participants at ease there are occasions when this can be detrimental to the research process and data collection (Barbour, 2008). Moreover, it seems likely that due to the large number of people, members of the group may have felt unable to express their honest views, or share personal experiences (Conradson, 2005).

This led me to revise my approach and request interviews. Also, following the focus group I asked Readibus whether it was possible to speak to younger users to ensure I captured experiences and opinions related to disability, opposed to experiences and opinions related to the natural ageing process.

3.2.2.2 Readibus semi-structured paired-depth interviews

Following the focus group, I used the same schedule (appendix C) to conduct three semi-structured paired-depth interviews. Interviews lasted 26, 49 and 57 minutes.

Paired interviews, also known as dyadic or joint interviews, recognises there is an interdependent relationship between individuals, and allows participants to reflect each other's opinions, experiences, and how they relate to each other (Morgan et al., 2013; Morgan et al., 2016). Morgan (1996) suggests this calls this 'sharing and comparing' approach gives the researcher a broader understanding of the topic.

All paired interview participants were frequent Readibus users, however they didn't know each other prior to interview. Table 2.4 illustrates the pseudonyms¹⁰ I use to refer to participants, and illustrates their gender and disability.

Paired-depth interview 1	Paired-depth interview 2	Paired-depth interview 3
<u>Archie:</u> Male, diagnosed with Multiple Sclerosis (MS)	<u>Charlotte:</u> Female, mechanical wheelchair user	<u>Edward:</u> Male, manual wheelchair user
<u>Bella:</u> Female, mechanical wheelchair user	<u>Debbie:</u> Female, partially sighted	<u>Fiona:</u> Female, mobility impairment

¹⁰ See chapter 3.4 for more detail regarding my use of pseudonyms

3.3 Data Analysis

I audio recorded all interviews and focus groups, this was to allow me to focus solely on engaging with participants (Valentine, 2005). Due to the overlaps between this project and the RBC project practitioner interviews were professionally transcribed. However, I transcribed the paired interviews and ReadiBus focus group. I transcribed as soon as possible after the interview/focus group to preserve the integrity of data by ensuring I could add any non-audio details that would've be lost in the audio-recording and I would be likely to forgot after time, for example, atmosphere, facial expressions, and hand gestures (Bryman, 2016). Moreover, immediate transcription enabled me to discuss themes that had arisen in early interviews in more depth with later participants (Bryman, 2016).

All data was coded and analysed in the same way to preserve validity and ensure rigour (Maher, et al., 2018). I used a thematic coding, which involved labelling parts of data in relation to each of my research questions (Rapley, 2011). Appendix D shows excerpts of an analysed transcript, and table 2.5 demonstrates the emerging themes that I identified. I used these emerging themes to structure my discussion.

Research Question for Analysis	Emerging Themes
What are the attitudinal barriers experienced by physically disabled people in Reading?	<ul style="list-style-type: none"> • Hate and prejudice • Fear • Pitying and patronising behaviour • Internalised oppression/internalised attitudinal barriers
To what extent and in what ways, do attitudinal barriers toward disability contribute to feelings of loneliness and social isolation amongst physically disabled people in Reading?	<ul style="list-style-type: none"> • Self-confidence • Mood • Superficial encounters • The importance of structural and systemic barriers
How could a reduction in attitudinal barriers be achieved, and what might be the best practices for reducing attitudinal barriers toward disability in Reading?	<ul style="list-style-type: none"> • Emphasis on importance of reducing barriers • Emphasis on difficulties of reducing barriers • Education/ awareness • Representation • The role of services

3.4 Ethics

It was important to consider ethical protocols throughout this study, particularly since disabled people have been identified as potentially vulnerable research participants (Fawcett & Hearn, 2004; Parr, 1998). I obtained ethic approval from the University of Reading's ethics committee, gave all participants a project information sheet (see appendix E) and asked participants to sign a consent form (see appendix F).

The project information sheet provided participants with details of my research questions and their role in this research, and was designed to ensure participants could give their informed consent. I emphasised in the

project information sheet, consent form, and verbally before interview that participation was entirely voluntary meaning participants could withdraw at anytime, and without consequence. I reiterated to participants that all data would be stored securely, and destroyed following the completion of this study.

I made it clear that no outside parties would be able to identify participant's views, hence I have allocated each participants with a pseudonym, which I use to refer to participants in my discussion¹¹. Pseudonyms are useful because they preserve participants right to anonymity but put a human face on the data and experiences (Lahman, et al., 2015). Due to the number of focus group participants it was not possible when transcribing to accurately distinguish between participants, therefore I have elected not used pseudonyms and will instead refer to participants as 'focus group participants' throughout the discussion.

3.5 Limitations

Although I carefully considered my research design, there is no single way to collect data (Peters, 2017). However, the use of convenience sampling, and failure to consider other intersectional identities, such as sexuality or ethnicity is a key limitation. Equally, women were over-represented in the sample; 4 out of 5 practitioners, 9 out of 10 of the focus group participants, and 6 out of the 8 paired interview participants were female. This overrepresentation of women may mean that the external validity of this study is low (Eitakan, et al., 2016). Similarly, although paired interviewing was used to put people at ease, and to overcome the potential power relations of having an abled-bodied researcher asking a disabled person about disabled issues (Fawcett & Hearn, 2004), the presence of another person may have prevented people from feeling as though they could be honest (Morgan, et al., 2015). Likewise, my involvement with RBC may have meant that practitioners were unwilling to be open, because many of the organisation's practitioners worked for receive their funding directly from RBC (Berger, 2013).

¹¹ Please see table 3.5

4. ATTITUDINAL BARRIERS, AND IMPLICATIONS FOR LONELINESS AND SOCIAL ISOLATION

This chapter discusses participant's experiences of attitudinal barriers, identifies the implications such barriers have in constructing feelings and experiences of LSI. Given the highly personal nature of both disability, and LSI, I do not aim to provide a determinist explanation of this relationship nor do I suggest that these experiences are shared by all disabled people; disabled people are not one homogenous group (Hughes, 2004). Instead, I aim to reflect upon participant's accounts, and comment on the key themes that emerged from this data; however, I do hope these findings may relate to a wider cohort so could be used to inform local decisions and influence change. From the data I have collected, I have identified commonly experienced attitudinal barriers, as discussed below.

4.1 Violence, Abuse and Harassment

Attitudinal barriers in the form of violent, abusive and harassing behaviours, were unfortunately common. As table 3.1 illustrates, two participants shared experiences of physical violence. Similarly, 6 out of the 8 paired interview participants recalled experiences of verbal abuse. As Bella explained, "*some [people] don't understand what I'm saying. They say 'spit it out'".* This prevalence is unacceptably high and illustrates that disablist hate crimes, incidences which are "perceived to be based upon prejudice towards or hatred of the victim because of their disability" (CPS, 2007, p.7), are likely to be underreported. In 2015/16-2017/18 only 52,000 disablist hate crimes were reported against the 13.9 million disabled people living in the UK (DWP, 2018; Home Office, 2018), however 75% of ReadiBus users who participated in interview said that they had experienced something that could have constituted a hate crime.

Table 4.1: Transcript excerpts- participants' experiences of violence

"When I was using walking sticks, people just wouldn't think anything of just kicking my stick out the way and watching me fall over, and they thought it was hilarious."— Charlotte

"I've even had experiences of where a person has physically tried to take the wheelchair away from underneath me, and getting me to [try] and stand up and walk, without any crutches or anything."— Edward

Hate crimes are the most overt forms of disablism since they arise "from the belief that disabled people are inferior to others" (Miller, et al., 2004, p. 9). Charlotte's experience (see table 3.1) demonstrates this, in this incidence the perpetrator viewed Charlotte's wellbeing less important than their own entrainment, since they found causing her to fall over "*hilarious*". As Roulstone, et al., (2011) argue disabled people experience hate crimes because they don't conform to societal norms or expectations.

4.2 Disregard, Ignorance and Exclusion

In addition to overt form of hate and discrimination, participants recalled experiences of being both passively and actively disregarded and ignored, table 3.2 illustrates these experiences.

Table 4.2: Transcript excerpts- participants' experiences of being disregarded or ignored

"I've been in somewhere and people don't want to talk to me because I'm at a lower level. Or if I've been into a pub or a bar or something I'm completely ignored because of me being in a wheelchair which is so poor, so wrong." –Charlotte

"People pass me in the shops yeah, I ask them to help, and they ignore me. They pass me" -Bella

"They don't want to look at you, they don't want to communicate with you, because they see you differently" -Focus group participant

Space "is the medium in which people act, intersect move and locate themselves" (Freund, 2001, p. 694), therefore, being ignored or excluded in public spaces such as *"the shops"* or *"in a pub or a bar"* not only reflects how negative attitudes toward disability are exclusionary, but how such attitudes have a significant effect on how disabled people navigate public spaces (Butler & Bowlby, 1997). Indeed, as Edward claimed, disabled people are frequently *"shoved in the corner"*.

Additionally, ignorance for the numerous ways disability and impairment are embodied is a significant misconception, and frequently occurs when friends, family and strangers question the 'legitimacy' of participants' disability. Fiona and Edward discussed this in relation to their use of blue badges. As Fiona explained, *"when I'm walking [people will say] "What do you need a blue badge for?" "I'm phoning the council"*. Likewise, Edward recalled a time when he *"was driving and I heard this woman shout out.... "Oh, what he's doing in a disabled person's park" and that's because I could get out my car [and into my wheelchair]."* Such experiences demonstrate how disabled people doing typically 'abled bodied things', such as driving and walking, are questioned. Inahara (2009) explains confusion to emerge when disabled people display any kind of ability, because it challenges engrained understandings that disabled people are helpless and without agency. Similarly, Charlotte explained how her friends and family have only recently accepted her as a disabled person, *"as my condition has progressed over the years people have gone from thinking oh okay "Oh she's just being lazy" to eventually "actually now she's disabled"*.

The effect negative attitudes toward disability have on impeding disabled people's ability to move freely within public space is a major attitudinal barrier and, as I will discuss later, has significant emotional affects and implications for reducing the quantity and quality of disabled people's social encounters. However, it is important to note that participants also commented on why they thought disabled people were excluded, ignored and disregarded. One focus groups participant suggested these attitudes arise simply because as a disabled person people *"see you differently"*.

However half of the paired interview participants suggested how disabled people and disability are represented is significant in constructing and reinforcing attitudinal barriers. For example, Charlotte suggested *"television programmes [can be] sort of teaching people the wrong things"* about disabled people and disability. However, Fiona and Edward argued how disabled people are treated and represented by politicians within national policy and is highly important. Indeed, Fiona said that disabled people are stigmatised within policy, meaning *"the first thing people think when they see someone disabled or with health conditions is that 'oh they're a benefits*

cheat". Briant et al., (2013) suggest media representations and public attitudes toward disability have become increasingly negative since the 2010 Coalition Government's radical restructured disability benefits. Briant et al., (2013) also go as far to suggest disabled people have become a 'folk devil', reinforcing ideas that disabled people are deviant Others (Imrie, 1996). Ultimately, Edward argued that political and media discourses have created an atmosphere whereby abled-bodied people support the exclusion and isolation of disabled people in society: *"In my personal experience in society someone like you, abled-bodied¹², and someone like me, disabled, are two separate items. And one normally, no offence, yours, doesn't want others, mine, to mix."*

In addition, such disregard for disabled people continues with the dismissal of disabled people's feelings, abilities and agency. For example, as Bella explained because she uses a mechanical wheelchair, she felt people assume or *"think I'm dumb"*. This is an example of 'the spread effect', whereby people assume that a disabled person's impairment or illness negatively affects all other abilities (NCWD, 2016). Similarly, as table 3.3 illustrates, participants expressed how abled-bodied people frequently *"talk for me"*, or talk *"over you, as though you're not there"*. This was particularly common when with an able-bodied person, be it a family member, friend or carer. Indeed, as one focus group participant acknowledged she copes fine when she's on her own, however when she goes out with her daughters *"instead of talking to me, they'll¹³ talk to them"*.

Table 4.3 Transcript excerpts- Participants experiences of being overlooked or talked about

"when I go out with my daughters instead of talking to me, they'll talk to them" – focus group participant

"the person would say something which sounds as though it was going to one person but they're saying it to another. It's like here if I were to say "oh that's a nice blue hat you've got [Bella]" I'd say it to you [Olivia], and it's like they're talking over you, as though you're not there" – Edward

"My mum, everybody. Everybody talks for me, but I say 'No' I want to talk to for myself!" – Bella

Moreover, all participants with mobility issues, expressed that that their abilities have been overlooked, and underestimated. Table 4.4 illustrates some of these experiences. Such *"amazement"* of disabled people's capabilities, and failure to understand *"how well I can cope"*, support social model theorists work that the experience of disability is often exacerbated by society focusing only on impaired people's disability, not their ability (Oliver, 2013).

Table 4.4 Transcript excerpts- participants' experiences of being underestimated

"My girls, as good as they are, they really don't have a clue how well I can cope" – Focus group participant

"I also get a lot of "oh you can't do that"... but it's my health, it's my mobility issues"

¹² See chapter 1.4 for my positionality statement

¹³ "they'll" refers to shop assistants, waiting staff and people in other customer service roles

and the best judge of what I can and can't do is me." – Fiona

"I've been told in the past that I can't do things, yet when I'm told them, the people have told me I can't do things, what I have done people fall back in amazement." – Edward

However, Edward also expressed that there are times his *disability* has been overlooked, and abilities overestimated, meaning he was asked to do things he was not comfortable with, *"he suggested that I did something one day and there was no way, I could already see it in my head, I wasn't going to be able to do it, there's no way I could do it. And yet he tried to get me to do it"*. This suggests the agency of disabled people is overlooked in numerous ways.

4.3 Fear, Discomfort and Pity

In contrast to behaviors underpinned by ignorance or prejudice, participants understood many of the negative attitudes that exist toward disability to be underpinned by fear, discomfort and pity. Indeed, as practitioner 3, who works with blind and visually impaired people, explained *"sighted people can find it very difficult to be amongst people with a visual impairment because they don't know what to say, they don't know how to deal with it"*. Likewise, practitioner 5, who finds volunteers to assist physically disabled people, articulated that non-disabled people not knowing what to say, or how to act around a disabled person, can result in very awkward, uncomfortable encounters or social interactions.

Similarly, Fiona accepts that, as a disabled person, being feared (in addition to being fearful¹⁴) is part of life:

"I think that there's this perception, and it doesn't matter what the health condition or disability is, I think people are scared they're going to catch it... I think it's a very real, probably unspoken fear...nobody actually admits that's how they feel but I think a lot of people do."

A fear or discomfort of disability often reflects non-disabled people's concerns for their own abled-bodied position within society (Shakespeare, 1994). However, as French and Swain (2004) argue such fears may be perfectly rational in a disablist society that discriminates against, and belittles disabled people.

Participants suggested being pitied and patronised were common. For example, Fiona explained *"I really hate it when I say something, and [someone says] "oh bless". Just don't say that, it's just a punch in the nose"*. Fiona's rejection of such patronising behaviour not only illustrates how disabled people have agency, but since disability is part of a disabled person's identity it should not be belittled or dismissed (French & Swain, 2004). However, as Fiona continued to explain, her disability means her family view her as the *"the problem one"* and frequently ask *"what can we do with Fiona?"* Deal (2007) argues these aversive forms of disablism are just as damaging as more overt forms of violence and prejudice, not because they ensure disabled people remain in an inferior position within society, but they result in an internalised oppression impacting upon a disabled person's wellbeing.

¹⁴ Please see chapter 4.1 about hate crime, and chapter 4.5 for the implications fear of crime has on isolation.

Ultimately, participants illustrated how attitudinal barriers are extensive. However, participants indicated that these attitudinal barriers play a significant role in constructing feelings of LSI because they affect both the quantity and quality of disabled participants' social encounters; encounters which are essential for preventing feelings and experiences of loneliness and social isolation.

4.4 Self-confidence and Mood

As table 3.5 illustrates, attitudinal barriers affect participants' confidence and mood. Both Charlotte and Fiona suggested that negative attitudes can *"make me feel as though I don't want to go out"* or just *"hideaway"*. For Charlotte, this was due to the impact it had on her self-confidence; experiencing negative attitudes and behaviors made her less confident to go out. The implications attitudinal barriers have for LSI are most evident in the context of hate crime and overt forms of disablism. Indeed, Pain (1991; 2000) suggests fear of crime influences an individual's activities therefore impedes on their freedom and reinforces social exclusions, and isolation.

However, Fiona explained that frequently encounter negative or patronising attitudes affected her mood, and left her with no desire to go out because *"what's the point" if "I'm just going to get looked at... [seen as] claiming benefits I'm not entitled to, being lazy because I don't work"*.

Table 4.5 Transcript excerpts- the implications attitudinal barriers have on self-confidence and mood

"It can make me feel as though I don't want to go out.....And that'll make me feel like that for a good while. Until, you know I keep being told "you are stronger than this, you can get over it". It's only words, it's only thoughts in somebody else head don't worry about it. And then I start again, and maybe the process will then happen again." –Charlotte

"I think the hostility for this and all, this actually is compounded matters further because it gets to the point where I don't want to go out. Yeah, if I'm just going to get looked at... [seen as] claiming benefits I'm not entitled to, being lazy because I don't work...so you think what's the point of going out, and the you are getting lonely because you don't want to go out, and you just want to hide away really." - Fiona

The behaviours, assumptions and perceptions of third parties have significant implications on participants mood and self-confidence which in turn consolidate exclusions, isolation and loneliness, however as Archie articulated although he had never experienced overtly negative attitudes, and he found people generally accommodating and accepting, his own attitudes towards his disability played a key part of his feelings of exclusion and isolation because *"I can't help but think how other people are thinking."* For instance, he explained, *"I go to church on a Saturday...the vast majority of them are used to seeing me on the crutches, [so when I'm] having to roll in on the wheelchair which I've only done two times... I don't like it... So in those situations I'm separating myself"*. These are psycho-emotional implications.

However, these psycho-emotional implications were not an issue for all participants. For example, as Debbie proclaimed since her disability is *"nothing to do with them"* it does not matter what others think, equally Bella professed she's *"not bothered"* how people view her. These differences can be considered in the context of each individual's impairment or illness, as such psycho-emotional dimensions were most prevalent in

participants who had previously lived-non disabled lives, or who had progressive illnesses. As Galvin (2005) argues an individual's own negative self-perceptions toward disability can have the greatest impact on identity transformation following the onset of impairment or illness. For example, as table 3.6 illustrates, Bella's longevity in the chair "*since was 14*" has given her the time to become "*used to it now*", however because MS is "*constantly changing or degrading*" Archie admitted he has found it difficult to accept, and come to terms with his disability.

Table 4.6: Transcript excerpt- Archie and Bella's conversation

Prior to this Archie had been talking about his concerns about what people may think of him, and how that makes him feel

Bella: I don't mind, I'm fine.

Archie: Maybe I'm not used to it.

Bella: I've been in the chair since I was 14, so I'm used to it now.

Archie: I'm not used to it

Bella: Time, it takes time.

Archie: that's the thing with MS those, because its constantly changing or degrading by the time you get used to something, perhaps something else has come.

Bella: It's different

Ultimately, my research suggests attitudinal barriers have significant implications for LSI because frequent encounters with negative or discriminatory attitudes erodes disabled people's self-confidence, mood, and self-perceptions to the point where they either feel unable to, or choose not to go out.

4.5 Superficial Encounters

Disablist behaviours also had significant effects on the quality of disabled peoples encounters. Indeed, as Bella explains "*When I'm talking to people they blank me most times, or they don't bother*". Moreover, quite often Phillip said he though abled-bodied people are "*not really interested in what the [disabled] person is saying*", with Fiona explaining this as people feeling as though "*I've got to talk to you because you're disabled to tick the box to [say] I'm an inclusive person I'll speak to everyone. But a lot of the time they're not.*" Therefore, interactions frequently become tokenistic and superficial, and not meaningful enough to prevent feelings of loneliness, Indeed as Charlotte explained "*that's when you feel that little bit different, that little bit separated from other people*". Moreover, I argue that attitudinal barriers, whereby people only talk to you because they feel they have, also contributes to feelings of loneliness because these encounters are not meaningful and heightened feelings of loneliness in turn prevent people from socialising in many ways it creates a vicious cycle situation whereby people choose not to integrate or interact for fear of explaining in experiencing it.

Charlotte also spoke about how there are times when she "*can feel really jealous, that somebody else has really got all of these things going on and*

then it takes you back to the time we used to work and used to running at full pelt.....you can miss it, miss it a lot."

4.6 Understandings of Structural and Systemic Barriers

In addition to the role of attitudinal barriers, participants also identified the role structural and systemic barriers have in hindering their ability to develop and maintain the close and meaningful relationships that are essential for preventing LSI. Structural and systemic barriers are barriers that are associated with the physical environment, or policies and procedures respectively. (Imrie, 2000)

Indeed, as Fiona observed when living in a disablist society *"you can't pop to get a coffee"*, whenever you feel like it because everything requires more planning and preparation in terms of finding accessible transport and accessible venues. Indeed, as Archie explains unless friends and family are *"very, very understanding and appreciative of your situation"* they either *"intentionally or unintentionally, have kinda backed away"* including those *"who were good friends, or so I thought"*. Archie's experiences are supported by practitioner 4's account, as she explained *"we've got a lady who's in her thirties, and her condition is really complicated.... at first everybody really rallies round, but [now]...she's seen a real depletion in her social network, and friends dropping off... [so] she's just left on her own."* This demonstrates how abled-bodied people's understandings and awareness of the nature of illness, impairment and disability are significant for enabling disabled people to have meaningful encounters that account for their disability.

However, participants identified that in addition to socially constructed barriers, whether they be attitudinal, structural or systemic, there are occasions when *"when the actual disability itself causes the problem itself....and then you're then forced to stay in, and you're back to square one again looking at four walls."* This explanation contrasts with social model understandings, and supports socio-relational conceptualisation of disability that acknowledges the *"the role played by impairment and illness in restricting activity and in determining the life experiences of disabled people"* (Thomas, 2004, p. 25).

4.7 Chapter Summary

This chapter has aimed to identify the attitudinal barriers experienced by the participants, and to reflect on the implications these barriers have for loneliness and social isolation. I summarise my findings as follows:

- Attitudinal barriers are plentiful, but most commonly exist as violent, abusive and harassing behaviours, or pitying or patronising behaviours
- Media representation and fear are significant in influencing attitudinal barriers
- The emotional, affectual responses to attitudinal barriers, have significant implication for disabled people's self-confidence and mood, and impacts how they perceive social encounter
- Structural and systemic barriers, and abled-bodied oversight of such barriers negatively effects the maintain of social relationships between disabled, and abled-bodied people.

5. ADDRESSING ATTITUDINAL BARRIERS

Overwhelmingly, participants said attitudinal barriers should, and must be reduced. As chapter four illustrates the attitudinal barriers experienced by disabled people are extensive, and have a key role in constructing feelings of loneliness, and experiences of social isolation. This chapter discusses the suggestion made by participants, to tackle and address these barriers. Improving education and more positive representations of disability, increasing social contact between disabled people and non-disabled people, and the approach of services were identified to be key¹⁵. However, I begin this chapter by outlining the emphasis participants placed on the importance of reducing attitudinal barriers, but also of the difficulties associated with achieving such reductions.

5.1 The Importance and Difficulties of Reducing Attitudinal Barriers

As Shakespeare et al. (1996) proclaims “daily experiences of rejection and humiliation are among the hardest aspects of being a disabled person” (Cited in Reeve, 2002, p493). This may explain the overwhelming affirmations, outlined in table 4.1, that attitudinal barriers need to be reduced, and attitudes toward disability improved.

Table 5.1: Transcript excerpts- responses to the question “do you think attitudes toward disability need to improve?”

“Yeah big-time change” – Bella

“Yes, yeah. Sooner rather than later” – Charlotte

“Yes, definitely, one thousand million percent they do need to be changed” – Edward

Recognition that “*big time change*” should occur “*sooner rather than later*” demonstrates how participants viewed attitudinal barriers as a significant aspect of their lives. However, as Bella recognised although attitudes can be changed “*it will be hard*”. Indeed, as table 4.2 illustrates, when reflecting upon her own experience of negative attitudes, Bella concluded that in this incidence “*nothing*” would change these people’s opinions.

Table 5.2 Transcript excerpts- Bella’s experience

Olivia: So you said you worry what other people might think of you, so have you received any comments from people, or people being unpleasant or rude?

Bella: No, not yet! [Actually] some people were rude to me on Monday, and then my mum had to educate her.

Olivia: Do you think that helped in anyway? Do you think it changed their opinions?

Bella: No, it didn’t change their opinions. Nothing [would].

The difficulties of changing engrained social norms, attitudes and beliefs are discussed extensive by psychoanalytical geographers (Valentine, 2010), indeed many of whom suggest negative attitudes toward disability can never be truly eradicate or eliminated, simply because disability is synonymous with difference and difference is synonymous with prejudice (Wilton, 2003).

¹⁵ | discuss such practices as policy recommendations in chapter 7.2

Indeed, as Fiona explained *“there’s got to be a combination of practicalism [sic] and idealism.”*

When I asked participants what they thought would be the best practices for changing attitudes, many hesitated before answering, and as Fiona articulated *“It’s a difficult question to answer because you’ve probably got to change a large percent of people’s attitudes, you’ve got to change society and that’s difficult”*. However, Daruwalla and Darcy (2005) argue that it is easier to societal attitudes than personal attitudes because although individuals verbalise positive attitudes toward disabled people, in reality they hold deeper, rejecting views.

This may explain Edward’s account. Edward explained how although he hears within the media and political discourse that attitudes to disability are improving, *“when it comes to it, what you actually experience...it’s totally different. Totally.”* Indeed, this suggests that alleged improvements in the position of disabled people in society (SCOPE, 2018) may be better attributed to progress within the systems and institutions that discrimination against disabled people, opposed to transformations in individual or collective attitudes (Deal, 2007).

Nonetheless, although reducing attitudinal barriers is not easy, as Deal (2007) argues directly challenging all forms of oppression and disablism is important part of emancipation, and without this disabled people will always occupy an inferior position within society.

5.2 Education, Representation and Opportunities for Social Contact

Participants identified positive, accurate representations of disabled people, in combination with education, to be integral for reducing attitudinal barriers. Mass media and communication has a significant role in shaping behaviours and attitudes (Bandura, 2002), therefore the inclusion and portrayal of disabled people in mainstream media and the arts has a significant influence in constructing attitudinal barriers. Indeed, as Charlotte explained *“there aren’t enough people with disabilities on TV, so therefore they’re not really worried about it because they don’t see it... I like it when I see a television actually showing a person with a disability in it... very much so”*. Absent or inaccurate representations of disabled people can reinforce otherness by presenting disabled people as deviant or absent actors within society (Darke, 2004). For instance, SCOPE (2018) found 60% of able-bodied people in the UK underestimate the number of disabled people in society. However, the role of media cannot be underestimated, because *“the media are the most important influence on many opinions, and the actions of the government in particular”* (Duffy & Rowden, 2010, p14).

Since attitudes are *“held by individuals but are also formed, reinforced and experienced at a community level”* (Fisher & Purcal, 2017, p. 2), Fisher and Purcal (2017) also identify long-term public education, and awareness raising campaigns have been observed as best for changing attitudes. Indeed, Charlotte mentioned how education in schools *“so that little ‘uns can learn more about people with disabilities...might make it easier for [disabled] people in the future”*. Bunch and Valeo (2004) conclude that within schools is essential for primary school age children who had more contact with disabled people had held more positive attitudes toward disability. However, as Archie expressed individual’s approaches towards such initiatives is highly important, because *“you can give people information but if they’re not willing*

to accept it, nothing's going to change. "Improved social contact between disabled and non-disabled people has also been recognized as key for changing attitudes toward disability and reducing attitudinal barriers (Scope, 2018), however this was not something identified by these research participants- perhaps reflecting the abundance of negative attitudes they had experienced? Participants suggest that it was important to be able to meet with, as Bella expressed, *"people like me"*. Practitioner 2, who works with deaf people and those with sensory impairments, reiterated the role of deaf club in creating a *"deaf culture"* allows people to let go of their *"frustration...of isolation at home...they can go and they can enjoy themselves and it's forgotten that we're signing."*

5.3 Service Approaches and Active Inclusion

The way that professional services and advocacy groups approach disability and include disabled people in their policy was also seen as highly important for reducing attitudinal barriers. Indeed, as practitioner 1, who works with people with mobility impairments commented, approaches that attempt to assist disabled people through *"somebody going to their house with a t-shirt on saying 'help the whatever'"* perpetuate stereotypes of presenting disabled people as in need of help, and reinforce these attitudinal barriers (Callon & Law, 2005). Therefore this practitioner argued service must provide in an *"in an unidentified way....anonymously, inconspicuously."* He also noted that it was important for supporting services to forget about themselves, and their 'brand', instead they must *"think of it from the person's perspective."* Similarly, practitioner 5 argued one of the reasons her organisations approach of befriending is so successful is because *"there is no pity involved. There is no view of, 'I'm helping you.' It is such a two-way thing."*

ReadiBus participants suggested that including disabled people in decision making is also highly important. Indeed, as Fiona expressed, *"everyone's a disability expert apart from us, we don't know anything and we're the ones with it"*. Therefore, she would prefer it if people *"ask us what to do with us"*, opposed to making assumptions and speaking *"behind our backs like we don't exist"*.

5.4 Chapter Summary

This chapter has aimed to illustrate the best practices for reducing attitudinal barriers to disability, as suggested by participants. These points form the basis of my policy recommendations in chapter 6.3. I summarise my findings as follows:

- Reducing attitudinal barriers are of the utmost importance, however this is not a simple task.
- Education about disability issues through increased social contact and positive representation is highly important.
- Organisations that aim to support people with physical disabilities must ensure their approaches do not reinforce attitudinal barriers.
- Disabled people should lead approaches to reduce attitudinal barriers.

6. CONCLUSIONS AND RECOMMENDATIONS

This research project aimed to investigate the relationship between attitudinal barriers to disability and the loneliness and social isolation of disabled people. Therefore, in this chapter I conclude my main findings in relation to each of my research questions. In light of these conclusions, I suggest directions for further academic research, and make recommendations for policy implementation.

6.1 Conclusions

Despite the prevalence of anti-discrimination legislation in the UK (Valentine, 2010), and suggestions that public attitudes toward disability have improved over time (Bromley & Curtice, 2003), my research suggests attitudinal barriers toward disability continue to exist, and are extensive and multifaceted. Attitudinal barriers to disability play both an active and passive role in consolidating the exclusion of disabled people and constructing experiences of isolation, and feelings of loneliness. Such barriers inhibit disabled people's ability to participate within society and maintain and develop the meaningful social relationships that are essential not only for wellbeing but for preventing loneliness. Firstly, such attitudinal barriers impact on people's self-confidence and mood to the point where they don't feel confident or don't want to go out. Secondly, such attitudinal barriers mean disabled-abled-bodied encounters people are frequently tokenistic and superficial.

6.2 Recommendations for Further Research

This study has attempted to investigate the relationship between attitudinal barriers to disability and the loneliness and social isolation of disabled people, however I feel as though I have only just scratched the surface of what is an incredibly complex relationship between two equally complex issues. Therefore, I argue that there is extensive scope for further research. Firstly, participatory action research should be used to empower disabled participants. Secondly, I suggest it would be advantageous to repeat this study using a larger sample and with deeper reflection on participants personal circumstances, characteristics and other intersectional identities, for example race, gender and socio-economic background. Research integrating both qualitative and quantitative methods would also be advantageous to ensure it had the greatest impact at policy level (Brannen, 2005). Finally, I make recommendations for research studies that assess how effective the best practices I have outlined really are in reducing attitudinal barriers.

6.3 Policy Recommendations

From the research I have gathered, I suggest the following should be implemented into Reading Borough Council's LSI steering group's action plan:

- Recognise that attitudinal barriers are just as significant as structural and systemic barriers, both in constructing disability, and feelings and experiences of LSI, and prioritise accordingly.
- Include the views and opinions of disabled people in the action plan (and indeed any group identified to be vulnerable to LSI) in policy.

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ATTITUDINAL BARRIERS TO DISABILITY AND THE LONELINESS AND SOCIAL ISOLATION OF PHYSICALLY DISABLED PEOPLE IN READING, ENGLAND

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