Review of Disability Studies: An International Journal
Volume 7, Issue 1
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Forum
The Intersection of Gender and Disability: An International Perspective

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The Intersection of Gender and Disability: An International Perspective

Dear Readers:

We would like to welcome you to this special issue of the Review of Disability Studies. This issue focuses upon the intersection of gender and disability within a global perspective. Existing research tells us that disability often presents challenges and barriers to integration and quality of life. The social model of disability (Corker & French, 1999; Shakespeare 2006) assumes that disability is not inherent in the person, but is constructed by society in its failure to provide people with access and treat them with the same respect afforded persons without disabilities.

We have somewhat limited research on the intersection of gender and disability. How does the intersection of these demographics impact the experience of individuals? Does the intersection of gender and disability serve to further marginalize individuals? What we do know is that gender often creates challenges and barriers to accessing health care, education, and employment services and supports, potentially impacting community integration (Gerschick, 2000; Nosek, Grabois, & Howland, 1992). In terms of employment, women with disabilities are less likely than men to be employed and more likely to earn less money than men when they are employed (O'Harrah, 2004; Traustadottir, 1990). Women are underrepresented in rehabilitation programs and women with disabilities experience inequality in education and health care, more poverty, and less social inclusion compared to their male and able-bodied counterparts, as well as being subjected to policies and practices that were not originally designed to meet their needs (Fine & Asch, 1985, 1988; Kutza, 1985; Mudrick, 1988).

Not only does the relationship between gender and disability produce unique barriers to social resources and institutions, but also gender and disability combine to shape the interpersonal experiences of women and men with disabilities. Because of the widespread discrimination they face in many social domains, women with disabilities experience multiple psychosocial challenges, lack of social support, low income or poverty, and abuse that impacts their quality of life (Berkman & Syme, 1979; Hart, Rintala, & Fuhrer, 1996; McGrath, Keita, Strickland, & Russo, 1990; Warren & McEachren, 1983; Brownridge, 2006; Nosek, Foley, Hughes, & Howland, 2001; Nosek & Hughes, 2003).

Rehabilitation research in the last 20 years has begun to explore the impact of the combined social locations and identities of gender and disability on quality of life, as well as health and well-being. According to Nosek and Hughes (2003): "We have little empirically based evidence suggesting that clinical practice is different in the psychosocial rehabilitation and community reintegration of women and men with disabilities...it is time to think and respond differently to femaleness and maleness in rehabilitation and research" (225).

Within this issue, several studies will address the intersection of gender and disability through an international perspective. In the United States, Armstrong et al., explore the allegations of ADA Title 1 employment discrimination relevant to characteristics of charging parties including gender and disability. Koch et al. investigate allegations of employment discrimination relevant to characteristics of employers such as size, industry, and region.

Bagnato et al. investigate the health and disability status among people aged 14 and older living in high poverty urban areas of Uruguay's capital and surrounding areas, with a special focus on women. In Lo-Hui et al., rural Chinese migrant workers who experience work-related injuries are highlighted within a traditional cultural context including the perceived impact upon roles, relationships, social connectedness, and quality of life.

Each of these studies further contributes to the body of research relevant to gender and disability. Further research is warranted exploring this topic. However, we must also be more cognizant of our research impact these days. In our current phase of research development in the area of disability education and services, we have solid documentation that disability disparities due to gender as well as cultural orientation exist. Research to date has done a laudable job pinpointing that there is a problem and describing its nature. However, we need strategies that begin to achieve the research outcome of the elimination of the challenges related to gender and disability disparities. Research must embrace a stronger focus on interventions and solutions that tackle these challenges.

Given this, we urge each of you to accept the responsibility to help the field progress from mere documentation and description of the problem of disability disparities toward the research outcome of developing, identifying, and promoting strategies that will begin to effectively address, and eventually ameliorate these challenges. As change agents in our field, we charge each of you to use the take away lessons from the manuscripts in this special issue and advocate that they begin to influence everyday disability service practice in the spirit of knowledge translation. For we not only have a responsibility to produce the research and knowledge that is so derived from it, but equally important, we have a duty to ensure that what we learn in the name of research positively informs everyday practice.

We hope that this issue will provide a catalyst for you to consider either contributing to the existing body of research on this topic and/or to engage in addressing and creating solutions to enhance the inclusion and quality of life of women and men with disabilities.

Sincerely,

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Women with Disabilities Living in Poverty: The Case of Uruguay

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Abstract: The goal of this study was to determine health and disability status among people living in poor urban areas of Uruguay's capital and surrounding areas, with a focus on women. Despite living in the same locations, women reported worse health status than men and more limitations across all disability domains.

Keywords: disability, women, poverty, Uruguay

The World Health Organization (WHO) estimated that 650 million people in the world have a disability, representing 10% of the world population, and approximately 80% live in countries with weak economies (WHO, 2010a). Demographic trends and social indicators, such as health and poverty, indicate that the number of people with disabilities and the impact of disability on individuals, families, and communities are growing. Numerous factors determine this tendency: increased life expectancy, advances in applied science and technology, the aging process, consequences of violence, and vehicle accidents, to mention a few. More studies to characterize people with disabilities living in poverty areas are needed in order to determine their health, educational, work, and recreational needs. Population studies are vital to increase our understanding of disability issues and to influence disability public policy.

The interactions between disability and poverty have long been the object of research interest in public health, social medicine, and rehabilitation (Burkhauser, Houtenville, & Rovba, 2005; Lustig, & Strauser, 2007; Reyes-Ortiz, 1999; Wolff, 2004). Numerous international studies relate poverty to certain types of disability. For instance, among the elderly Brazilian population, higher income is strongly correlated with reduced disability prevalence (Parahyba, Stevens, Henley, Lang, & Melzer, 2009). Hernández-Jaramillo and Hernández-Umaña (2005) concluded after conducting a secondary analysis of three national databases that people with disability in Colombia typically belong to the lowest socioeconomic strata and had low levels of education. The inverse relationship between socioeconomic status and disability holds true also in affluent societies. For example, European and American comparative population studies found health problems and disability are more prevalent among the poorest groups (Avendano, Glymour, Banks, & Machenbach, 2009; Schoenborn, & Heyman, 2009). There is an international consensus that disability is both a cause and consequence of poverty (WHO, 2010a, 2004).

Women with disabilities are especially at a disadvantage, as they face not only disability-based but also gender-based discrimination (Lewis, Brubaker, & Armstrong, 2009; O'Hara, 2004). They are more likely to be poor than the rest of the population (Parish, Rose, & Andrews, 2009), and they have lower employment rates than females without disabilities and males with disabilities (Erickson, Lee, & von Schrader, 2008).

Disability in Uruguay

Uruguay has only recently devoted research resources to disability studies. The collection of disability data in the past was not done at regular intervals. The latest available data are the 2003-2004 First National Survey on People with Disabilities (Instituto Nacional de Estadistica [INE], 2004a) and the 2006 Health Supplement of the National Household Survey (Encuesta Nacional de Hogares Ampliada, Modulo Salud) (Trylesinski, 2007).

According to the First National Survey on People with Disabilities, 7.6% of Uruguayans had a disability, approximately 210,400 individuals (INE, 2004a). Overall, the prevalence of disability among females was found to be higher than for males (8.2% versus. 7%, respectively). However, among individuals who were younger than 30 years of age, males reported higher disability frequencies than females; and the opposite occurred for individuals older than 50. Between 30 and 49 years of age, males and females reported similar disability percentages (INE, 2004a). The 2006 survey estimated a population prevalence of disability of 9.2% (Trylesinski, 2007). In addition, the Ministry of Social Development published a comparative report on Disability and Extreme Poverty, and approximated 5.4% of people with disabilities were living in extreme poverty (Ministerio de Desarrollo Social, 2008). Although the percentage of reported disability increases with age, it remained similar for males and females. However, frequencies peaked markedly for females after age 50, probably due to the fact that females live longer than males (Ministerio de Desarrollo Social, 2008).

Regarding health status and morbidity, the household survey of 2006 (Trylesinski, 2007) found that 5.5% of the general population in Uruguay had reported feeling sick in the past 30 days, and 79% of these had seen a doctor. Five percent of the national sample conveyed permanent visual limitations (that cannot be corrected with glasses), with females having slightly higher rates (5.5% vs. 4% for males). Permanent hearing limitations were present in 1.7% of the sample, approximately equally distributed by gender. Permanent walking difficulties (mobility limitations) were reported by 1.8% of males and 2.6% of females. Relationship difficulties due to permanent mental limitations affected 1.1% of the surveyed population, and 2.1% reported learning difficulties secondary to the same origin. Learning and relationship difficulties were more frequent among children and the elderly (Trylesinski, 2007). However, data on Uruguayans with disabilities, especially among vulnerable groups, are still very limited.

The present study is part of a larger ongoing research effort to gain information on disability prevalence among Uruguay’s most vulnerable population, and collect data on their quality of life, and perception of the quality of health and social services received. This study presents preliminary data on health status and disability among residents of five poor urban areas of Uruguay’s capital (Montevideo) and its surrounding areas (Canelones). It is of particular importance to study the situation of women in relation to disability, as they make up the majority of our sample. Women with disabilities living in poverty are of special interest due to the relationships among gender, income gap, and disability, which may place Uruguayan women at more risk for disability and health problems.

The goal of this study was to determine health and disability status among people aged 14 and older living in high poverty urban areas in Montevideo and Canelones (Uruguay), with a focus on women. To accomplish this goal, (a) information on health status in the past 30 days was obtained using the Spanish version of the WHO Disability Assessment Schedule II (WHO DAS II), and (b) the relationship between gender and health status was examined using scores on WHO DAS II disability domains that were analyzed to determine if gender differences existed.

Methods

The current study was exploratory. It is the first attempt at conducting a systematic, ongoing descriptive investigation of people with disability living in poverty, their quality of life, and perceptions of services in Uruguay.

All residents of selected poor urban neighborhoods in the "Cerro Norte" area of Montevideo ("19 de Junio", "33 Orientales", and "Amanecer") and in the "Barros Blancos" area of Canelones ("Villa Carmen" and "Villa Manuela") aged 14 or more were targeted as participants in this study. According to information provided by the "Programa de Integración de Asentamientos Irregulares" (Integration of Irregular Housing Program) of the Uruguayan Department of Organization of Territory and Environment it was estimated that there were 740 households with a population of 1,700 people, including persons under 14 years of age living in the "Cerro Norte" neighborhoods mentioned above. Data on the population of Barros Blancos, Canelones were not available.

Various preparatory activities preceded the door-to-door interview process. Interviewers received training and information on ethical aspects of research, disability concepts, communication, and assessment tools (e.g., WHO DAS II interview). Because many of the residences built in the neighborhoods to be surveyed were illegally built and not registered in official documents, interviewers did a thorough mapping of the neighborhoods to identify the number and location of residences in each block before data collection. Finally, the interview was advertised with the help of the neighborhood organizations and local radio stations.

Neighborhood residents who were younger than 14, those who declined to participate, or were not at home on the day the interviewers visited them were excluded from this study. Interviewers obtained informed consent from each participant, or their representatives for cases with severe communication limitations. Door-to-door interviews were performed by 120 trained university students (Medicine, Psychology, and Social Work majors, among others), and volunteer neighbors, who worked in teams with a supervisor.

Participants' characteristics

The demographic characteristics of the sample of 731 individuals are summarized in Table 1. The participants in this sample were primarily females (64.2%) with low educational attainment (89.1 % had some secondary school or less); approximately half of them were married or cohabiting with a partner and 47.1% were gainfully employed.

Table 1: Demographic Characteristics of the Sample

Characteristic	Mean Females (SD)	Mean Males (SD)	Mean Overall (SD)
Age	40.26 (17.97)	37.96 (17.95)	39.32 (17.98)
Education Level			
Some primary school	17.7	13.1	16.0
Primary school completed	35.4	33.0	34.9
Some secondary school	34.9	44.5	38.2
Secondary school completed	6.9	6.3	6.6
College	2.9	1.0	2.3
Illiterate	1.9	1.6	1.7
Special education	0.3	0.5	0.3
Marital Status			
Never married	30.5	34.6	32.2
Married/ cohabiting	46.7	49.4	47.6
Divorced	12.9	9.8	11.7
Widowed	9.9	6.2	8.5
Employment Status			
Employed	38.4	62.4	47.1
Unemployed (for health reasons)	5.9	2.7	4.7
Unemployed (all other reasons)	6.9	5.9	6.5
Student	5.9	10.6	7.6
Retired	6.3	9.4	7.3
Homemaker	25.3	0.4	16.6
Other	11.3	8.6	10.2

Measures

This study utilizes the concept of disability consistent with the International Classification of Functioning, Disability and Health (ICF) (WHO, 2001), that defines disability as a global concept involving the health status of an individual in interaction with his context (personal and environmental factors). From this viewpoint, disability is a negative product of the person-environment interaction. It is not only a consequence of a physical or mental dysfunction, it also includes contextual factors to take into consideration the impact of the environment on the functioning of the individual (WHO, 2001).

The WHODAS II Spanish version (WHO, 2000) was used to assess disability and health status. WHO DAS II is an internationally validated disability assessment instrument based on the ICF, and is available in Spanish (WHO, 2010b). It is a generic measure of functioning and disability with well-established psychometric properties. Construct validity was determined through correlations between the global scores on the WHO DAS II 36 items Spanish version and two disability scales, the "London Handicap Scale" (LHS), and "Escala de Evaluación de Discapacidad según el Entrevistador" (-.61 and .71, respectively) (Vázquez-Barquero, Herrera Castanedo, Vázquez Bourgón, & Gaite Pintado, 2006, p. 78). In addition, convergent and discriminant validity for the WHO DAS II domains was studied using the SF-36, and WHOQOL-BREF, as well as specific domains of the LHS and "Escala de Evaluación de Discapacidad según el Entrevistador." Reliability measures such as test retest correlations ranged between .83 to -.96 for both global scores and domain scores (Vázquez-Barquero et al., 2006, p. 71).

WHO DAS II provides demographic and background information as well as health status. It reviews difficulties in six domains of individual functioning (WHO, 2000): (1) understanding and communicating with the world (cognition), (2) mobility, (3) self-care, (4) getting along with people (interpersonal interactions), (5) life activities, and (6) participation in society (WHO, 2010b). WHO DAS II provides a global disability score (scores range between 0-100; higher scores indicate more severe disability) and six domain scores which correspond to the functional domains mentioned above (Vazquez-Barquero et al., 2006). The present study only analyzed WHO DAS II domains of functioning.

Participants were asked whether they had physical or mental health problems, and rated separately their overall physical and mental health in the past 30 days on a five-point scale ranging from "very good" (score of 1) to "very bad" (score of 5). In addition, respondents reported their degree of difficulty (none, mild, moderate, severe, extreme/cannot do) in performing activities in each of the six domains. Answers to the items on the different disability domains were coded, and scores for each domain were calculated following the criteria indicated in the WHO DAS II manual (Vazquez-Barnero et al., 2006). In addition, this research team defined three cut-off criteria (based on statistical and clinical considerations) to determine four disability categories: (1) no limitations, (2) mild limitations (people at risk of developing more serious limitations), (3) moderate limitations, (4) and severe/ extreme limitations. Mild limitations were considered health problems in this study, given that respondents with mild limitations may be at risk of deteriorating health, or disability. The last two categories were considered to be indicative of presence of disability.

Statistical Analyses

All statistical analyses were performed using SPSS version 15.0. Descriptive statistics (e.g., percentages, means) were used to characterize participant demographics, as well as health and disability status. In order to determine whether there was a relationship between gender and health status, Chi-square tests were used. Differences between male and female mean WHO DAS II domain scores (disability domains) were examined with T-tests.

Results

The majority of participants (71.9%) did not report any physical problems and described their physical health as “very good” or “good.” 21.6% reported “moderate” health, 3.3% “bad” health, and 0.8% “very bad” health. In terms of mental health, 78.6% of participants stated they did not have any mental health problems. Of the 21.4% who had mental health problems, 78.3% stated they had “very good” and “good” mental health, 18.2 % “average”, and 3.5% reported “bad” or “very bad” mental health. Furthermore, females reported significantly more physical health problems (31.8% vs. 21.4%, respectively, X^2=8.87, p=0.003) and mental health problems (24.1% vs.15.6%, respectively, X^2=7.15, p=0.007) when compared to males.

Table 2 provides information (across all WHO DAS II domains) on the percentages of the overall sample that reported no limitations of functioning, those who reported mild limitations, moderate limitations, and severe/extreme limitations. Moderate and severe/extreme limitations were considered to be indicative of a disability.

Table 2: Disability-related categories by WHO DAS II domain as percentage of the sample

	Disability-related Categories				
WHO DAS II Domains	**No Limitations Reported**	**Mild Limitations**	**Moderate Limitations**	**Severe and Extreme Limitations**	**Totals**
Understanding and Communicating	76.2	15.0	5.4	3.3	100
Getting Around	78.9	10.8	3.4	6.9	100
Self Care	93.7	3.1	1.3	2.0	100
Getting Along with People	86.8	8.7	2.1	2.5	100
Life Activities: Household	91.1	___	3.7	5.2	100
Life Activities: Work	90.8	3.2	2.7	3.2	100
Participation in Society	75.4	12.7	5.1	6.8	100

Regarding differences between males and females across disability domains, females scored higher than males across all six WHO DAS II domains, indicating that there are more severe limitations among females than males. More specifically, females differed significantly from males in understanding and communicating (domain 1), getting around (domain 2), life activities (household and work, domain 5), and participation in society (domain 6). Please refer to Table 3.

Table 3: Mean Scores for Males and Females on WHO DAS II Domains

WHO DAS II Domains	Mean		T-statistic	P-value
	Males	Females		
Understanding and Communicating	6.14	8.54	2.701	0.007**
Getting Around	5.37	10.15	3.562	0.000**
Self Care	2.16	3.72	1.840	0.066
Getting Along with People	4.22	5.27	1.070	0.260
Life Activities: Household	3.33	8.74	4.060	0.000**
Life Activities: Work	2.47	5.26	2.100	0.036*
Participation in Society	6.60	10.08	2.722	0.007**

* p≤ .05; **p≤ .01

The items indicating the more severe limitations were “remembering to do important things” (p=0.0008), and “learning a new task, for example, learning how to get to a new place” (p=0.0006) within the “understanding and communicating” domain.

Significant gender differences were found across all items in domain 2 (mobility): “standing for long periods such as 30 minutes” (p=0.014), “standing up from sitting down” (p=0.001); “moving around inside the home” (p=0.000); “getting out of the house” (p=0.004); “walking a long distance such as a kilometer” (p=0.001).

Within the life activities domain, female mean scores on items related to household tasks were significantly higher than males: “taking care of your household responsibilities” (p=0.000), “doing most important household tasks well” (p=0.000), “getting all the household work done that you needed to do” (p=0.001), and “getting your household work done as quickly as needed” (p=0.001). Regarding work related life activities, the only significant gender difference was "getting all the work done that you need to do" (p=0.041).

In the participation in society domain, women obtained significantly higher scores than men on the items; "How much have you been emotionally affected by your health condition?" (p=0.001) and "How much has your health been a drain on the financial resources of you or your family?" (p=0.004).

Discussion

Among the demographic characteristics of the overall sample, we focused on educational attainment and employment because of their strong connection to socioeconomic status. With educational level, it is important to note the disconnection from the educational system: 16% did not complete the lowest level of education. Although 38% started secondary school, only 6.6% completed it. Because only individuals 14 years and older were surveyed, it is unlikely that the educational situation will improve. It should be noted that females seem to be at higher risk of abandoning formal education at an earlier age than males. While males reported accessing secondary school more frequently than females, they have a slightly lower percentage of completion.

The First National Survey of People with Disabilities of 2003-2004 reported large educational attainment gaps between adults with disabilities and adults without disabilities: 37.7% of the former received no instruction or did not complete their primary education, compared to 12.6% of the latter; and only 13.7% of adults with disabilities had a secondary school degree or higher, compared to 32.5% of people without disabilities (INE, 2004a). These data reveal low levels of educational attainment, which happens to be one of the factors that contributes to understanding negative health outcomes in the person-environment interaction, and may perpetuate the poverty-disability-poverty cycle. People with disabilities are more likely to remain poor because they have barriers to accessing the labor market, engaging and influencing decision-making political processes in their communities. Although we did not analyze educational attainment among people with disabilities in this population, an educational gap with respect to people without disabilities is likely.

In the employment arena, 47.1% of the population interviewed was working, and 4.7% were pursuing a course of study. Among males, 62.4% were working at the time of the interview, compared to only 38.4% of females. These figures are in accord with national general population occupational data (INE, 2004b, 2009). The occupational data have consistently shown lower labor force participation of females than males in Uruguay. In addition, a high percentage of women exclusively engage in domestic activities (25%), which include taking care of the home, children, people with disabilities, and aging relatives. However, another characteristic of Uruguayan females is that those who work also frequently take over domestic responsibilities (Monge, 2010). Employment data (INE, 2004a) on working-age Uruguayans with disabilities reveal an important employment gap when compared to people without disabilities (16.5% vs. 53.4%, respectively), and the gender differences are pronounced (22.4% for males, and 12.3% for females with disabilities reporting being employed in 2003) (INE, 2004a).

The majority of the 731 people interviewed reported their overall physical and mental health status as “good” or “very good” and reported no problems in these areas (74.3% and 78.6%, respectively). However, there were significant gender differences in this study’s sample, with females reporting significantly more physical and mental health problems. There is a small difference between data from the household survey of 2006 (Trylesinski, 2007), with 5.5% of the national sample reporting health problems in the past 30 days, compared to 4.1% of our sample reporting bad or very bad physical health in the past 30 days (3.5% for mental health). Mental problems among males in the general population tend to be diagnosed during school age years and increase frequency later in life, probably due to neurological disorders (Trylesinski, 2007). Our sample excluded individuals younger than 14 years old, so this may have lowered males’ reported health problems. National population figures (Trylesinski, 2007) revealed that females do seek psychological treatment more frequently than males (4.2% vs. 3.0%, respectively), which supports our findings.

The percentages of people who reported having moderate to extreme limitations in cognition, mobility, self care, interpersonal interactions, life activities (domestic and work), and participation in society (indicative of disability) ranged from a low of 3.3% (self-care) to 11.9% (participation in society).

Because of the differences in assessing functioning and disability, only a limited number of WHO DAS II domains of functioning are comparable to information from the First National Survey on People with Disabilities (INE, 2004a) and the Health Supplement of the National Household Survey of 2006 (Trylesinski, 2007). Nevertheless, the domain that can be compared shows an important difference between the population surveyed and the national data. The prevalence of disability in the mobility domain (“Getting Around”) for our sample was 10.3%. National estimates are approximately 7-8 percentage points lower than our figures, 1.8% of males and 2.6% of females in the general population reported permanent walking difficulties (mobility limitations) (Trylesinski, 2007). Further research is needed to understand the reason for higher mobility disability in the sample under study. Mobility difficulties and lack of available help in turn may affect community participation.

We consider that the relationship of the person with his/her environment is a determining factor in order to achieve full social inclusion; the health condition of an individual can deteriorate due to his/her environment. Mobility is closely linked to personal or technological supports that may or may not be available to the person, as well as environmental conditions, such as unpaved streets or long distances to get to the public transport system. Social participation is related to social opportunities, attitudes of others, and economic resources.

Another domain amenable to analysis is interpersonal relationships. In the present sample, 4.6% of the respondents reported disability in the “getting along with people” WHO DAS II domain. Relationship difficulties due to permanent mental limitations were present in only 1.1% of the 2006 national survey (Trylesinski, 2007). WHO DAS “understanding and communicating” domain is related to the ability to speak. Data on speaking limitations were included in both the First National Survey on People with Disabilities (INE, 2004a) and the National Household Survey of 2006 (Trylesinski, 2007). The former survey also collected information on mental limitations that limit relationships with others. It seems that comparisons might be not be meaningful because of the number and differences in concepts.

Females have significantly more limitations across most of the WHO-DAS II domains in this sample (all except "self-care", and "getting along with people"). Two items within the "understanding and communicating" domain, "remembering to do important things", and "learning a new task, for example, learning how to get to a new place" may be related to cognitive difficulties due to aging.

In our sample we found significant differences between males and females in all the items that assess mobility, with females reporting more mobility limitations. National data also reveal gender differences in mobility with more females reporting ambulation problems than males, which have been linked to a higher number of women in older age, when walking becomes more difficult (Trylesinski, 2007). Limited functioning in this particular domain is related to physical problems, which worsen without the necessary supports to reduce their impact. Mobility disabilities are among the most frequently reported among people with disabilities. According to the 2006 national survey, 31.3% of people with disabilities manifested difficulties walking; of these 40% required assistance to move about or out of their home (INE, 2004a). It is unclear if age is the determining factor for this type of disability or if it could be related to health-illness conditions and barriers to access rehabilitation services, technological aids, or transportation, that is, limitations imposed by the living conditions and the environment.

The significant differences found in the items in the "life activities" domain invite an analysis of the social role of women, because domestic activities are usually performed by females. In addition, women with disabilities may perceive household activities as an area affected the most because they may engage in this type of tasks more frequently than males.

Conclusions and Future Prospects

This study presents some limitations, such as the limited number of neighborhoods screened, thus preventing generalization of results. However, it provides valuable data for the residents of those neighborhoods, and it is consistent with information of studies from around the world, as we mentioned in the previous section. Another limitation is that the present study is one of the few scientific studies on disability in Uruguay, so we cannot draw parallels; comparisons with national survey data are limited. The variability of national survey data emphasizes the importance of using adequate assessment instruments to obtain information on people with disabilities, such as the WHO DAS II. Despite these limitations, we arrive at conclusions that are relevant both for the scientific study of disability, and as input for disability related public policy.

The ICF defines disability as a negative product of the individual-environment interaction; the WHO DAS II was designed to assess disability from the ICF framework and to provide a wealth of information. First of all, it establishes clearly defined health domains. Secondly, it allows identification of health limitations and the extent of these limitations (no limitations mild, moderate and extreme limitations). Therefore, it supplies relevant information on health status as well as limitations in activities and participation of individuals with or without a disability, allowing researchers to identify population needs. In this manner, it delivers valuable information to streamline resources required to offer prevention and health care services. WHO DAS II data is also useful from a primary health care perspective, as well as to determine population needs for mental and physical rehabilitation services. For example, by analyzing data on the various WHO DAS II domains we were able to identify those health domains reported as negatively affected by the majority of the population assessed.

In this study, health problems were considered mild limitations, whereas moderate and more severe limitations were considered disability. Respondents who reported mild limitations may be at risk of developing a disability, so a follow up of people at risk seems relevant to prevent a negative outcome. Given limited access to educational and health resources and scarce employment opportunities in high poverty areas, a minor health problem may over time lead to restrictions of activities and social participation. Study participants frequently reported working unskilled, heavy, low paying jobs, such as brick making and construction, which can cause and aggravate health problems such as back pain. This information is important to underscore the need for comprehensive rehabilitation services accessible to all Uruguayans, including vocational assessment and job placement regardless of the educational level of the person seeking services.

In the present study, the areas where most people, regardless of gender, reported moderate and severe or extreme limitations were participation in society (approximately 12%), mobility (10.3%), household activities (8.9%) and understanding and communicating (8.7%). These percentages are higher than the Uruguayan estimated disability prevalence (7.6%), but they are consistent with international estimates of prevalence of disability. Given that the WHO DAS II, as the WHO points out, is an assessment instrument that adequately distinguishes between health conditions and disability, it may provide better information on disability than census questions and other Uruguayan government survey disability data.

If we consider the high percentage of reported limitations in this sample, it is possible to posit a link between the living conditions in high poverty areas and disability. For example, difficulties in understanding and communicating may be due to learning problems in individuals who did not receive adequate educational supports which in turn can limit their educational and work opportunities. This information is relevant to plan for interventions, which may involve environmental modifications such as removal of physical, attitudinal, and communication barriers.

Finally, it should be stressed that finding a larger number of female residents than males in the poor neighborhoods included in this study is not surprising, as it is a common situation of Uruguayan families living in poverty. The majority of these women were heads of their households, with the added burden of responsibility for children and older adults, which may lead to neglect of their own health care needs. This study showed that females reported more health limitations and described the types and extent of these limitations. Thus, despite the present study's limitations the information it provides is valuable in order to raise awareness about the need to break the invisible circle that generates poverty and disability. Determinants of disability are produced in the environment and living conditions, so disability can be prevented once these aspects of reality are known.

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Acknowledgment

This research was supported in part by a research and development grant from Comisión Sectorial de Investigación Científica (Universidad de la República), Uruguay (2008-2011).

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Gender, Disability, and ADA Title I Employment Discrimination: A Comparison of Male and Female Charging Party Characteristics: The National EEOC ADA Research Project

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Abstract: Demographic characteristics of female charging parties in comparison to males who filed allegations of workplace discrimination under the Americans with Disabilities Act were examined using a secondary database maintained by the United States' Equal Employment Opportunity Commission (EEOC). Findings indicated that charging parties have distinct profiles related to demographic characteristics.

Keywords: gender, disability, employment, Americans with Disabilities Act

Even with the enactment of Title I (employment) of the Americans with Disabilities Act (ADA), men and women with disabilities continue to encounter discrimination in the workplace. Women with disabilities are often doubly disadvantaged, encountering discrimination on the bases of being female and disabled (Nosek & Hughes, 2003; O'Hare, 2004). In this article, the authors summarize the results of an investigation that compared and contrasted the employment discrimination allegations filed with the Equal Employment Opportunity Commission (EEOC) under Title I of the ADA by females to those filed by males. The focus of this examination is on the demographic characteristics (e.g., impairment type, discrimination issue, age, race) of female charging parties in comparison to male charging parties. This study addresses a particularly timely topic given the renewed interest in re-energizing the intent of the ADA with the recent passage of the ADA Amendments Act of 2008 by the United States Congress (2008). These research findings offer a gender-driven vantage point on how successful the ADA has been in engineering positive social attitudes toward disability as viewed through the characteristics of charging parties. From this vantage point, rehabilitation professionals can tailor career planning interventions and job placement supports to the specific factors that differentiate the employment discrimination experiences of female and male service recipients.

Background and Problem Statement

Until recently, limited research has explored the relationship of gender to employment discrimination as perceived by people with disabilities (Asch & Fine, 1988; Kutza, 1985; Mudrick, 1988). Nevertheless, in fiscal year 2008, the EEOC received 28,372 charges of sex-based discrimination. The EEOC resolved 24,018 sex discrimination charges and recovered $109.3 million in monetary benefits for charging parties and other aggrieved individuals (not including monetary benefits obtained through litigation. Although arguably the ADA has elevated the awareness of the problem of discrimination against individuals with disabilities, Title I has not been successful in decreasing discrimination based on gender and disability (Burkhauser, Houtenville, & Wittenburg, 2001).

Increasingly, gender is being viewed as an important demographic factor that influences the disability experience (Nosek & Hughes, 2003). Women with disabilities are one of the largest and most marginalized groups within our society (Nosek & Hughes, 2003; Jans & Stoddard, 1999) based on their status as females as well as being identified as persons with a disability (Menz, Hansen, Smith, Brown, Ford, & McCrowey, 1989; Traustadottir, 1990). According to the U.S. Census Bureau (2000) and Centers for Disease Control (2006), one in five females in the United States experiences a disability. They outnumber males with disabilities and constitute 21% of the population of females in the United States (Jans & Stoddard, 1999).

Females with disabilities are less likely to be employed than males with disabilities, and those who are employed earn less than their male counterparts (Burke, 1999; Featherstone, 2009; U.S. Census Bureau, 2001). Jans and Stoddard (1999) found that males with a mild disability earned 55% more than females with a mild disability, and males with a severe disability earned 26% more than females with a severe disability. In addition, 31.8% of males with severe disabilities and 89.9% of males with moderate disabilities compared to 27.7% of females with severe disabilities and 73.0% of females with moderate disabilities either worked, looked for a job, or were on layoff status during the last four months of 1994 (Hale, Hayghe, & McNeil, 1998). According to Smith (2007), disability is the strongest relative predictor of unemployment and being female is the second strongest predictor across time for the total population.

Overall, more employment discrimination complaints are filed under Title I of the ADA by males than females. This does not suggest, however, that more males are discriminated against than females, only that they are more likely to file. For example, McMahon, et al. (2008) examined the characteristics of charging parties alleging discrimination in hiring and found that they were disproportionately more male. In another study, Mitchell, McMahon, & McKee (2005) examined 1,637 allegations of employment discrimination by individuals with speech impairments compared to a group of individuals with orthopedic and visual impairments. Findings indicated a higher proportion of complaints were filed by males and younger individuals with speech impairments. Conyers, Boomer, and McMahon (2005) found that, in contrast to individuals with other physical, sensory, and neurological impairments, a higher proportion of discrimination charges were filed by males with HIV/AIDS who were ethnic minorities and between the ages of 25-44. Lowman, West, and McMahon (2005) compared and contrasted key dimensions of workplace discrimination involving persons with cerebral palsy and persons with other physical, sensory, and neurological impairments. Findings indicated that more allegations of discrimination were derived from persons with cerebral palsy if they were male, White, and largely between the ages of 30 and 39. Similarly, researchers examined several aspects of employment discrimination experienced by individuals with spinal cord injury (SCI) in comparison to those of a group of individuals with other physical, sensory or neurological impairments (McMahon, Shaw, West, & Waid-Ebbs, 2005). Relative to the comparison group, proportionately more allegations were filed by persons with SCI who were male, 22 to 39 years of age, or White. Proportionately fewer allegations were filed by charging parties with SCI who were female, 50 or more years of age, or African American.

In contrast to the above-mentioned patterns of more males filing, McKenna (2005) found that charging parties with cancer were more likely to be female with a median age of 49 (p. 87). Lewis, et al. (2005) also found a higher proportion of female complaints in their investigation of employment discrimination allegations filed by persons with asthma. These allegations were disproportionately filed by African American women who were between 22 and 29 years of age. Tartaglia and his colleagues (2005) compared and contrasted employment discrimination allegations of persons with disfigurement and persons with missing limbs. Results showed that persons with disfigurement were more likely to (a) be females between 30 and 39 years of age and (b) encounter more employment discrimination than males with missing limbs. In addition, Vierstra, Rumrill, Koch, and McMahon (2007) investigated the employment discrimination experiences of individuals with multiple chemical sensitivity (MCS) and found that charging parties with this disability were proportionally more likely to be female, white, and older in comparison to persons in a general disability group with allergies, asthma, HIV, gastrointestinal impairment, and tuberculosis.

Methods

Study researchers conducted a retrospective analysis of secondary data to compare allegations of employment discrimination filed under Title 1 of the ADA by males to those filed by females. The research questions that guided the inquiry are:

- Is there a significant difference in the proportion of male vs. female allegations in relation to charging party basis or disability?
- Is there a significant difference in the proportion of males vs. female allegations in relation to charging party discrimination issue?
- Is there a significant difference in the proportion of males vs. female allegations in relation to charging party age?
- Is there a significant difference in the proportion of male vs. female allegations in relation to charging party race?

The EEOC is the agency responsible for enforcing Title I of the ADA, which prohibits employment discrimination against people with disabilities. The EEOC maintains the Integrated Mission System (IMS), which is used to track the filing, investigation, and resolution of all allegations of workplace discrimination under federal statutes. The IMS contains over two million allegations of employment discrimination. Through an Interagency Personnel Agreement between the EEOC and Virginia Commonwealth University, study researchers have access to a de-identified version of the database (see http://www.eeoc.gov/eeoc/foia/ims-pia.cfm).

The researchers used the IMS to extract a dataset that contains only those allegations *closed* under ADA Title I from the ADA's effective date of July 26, 1992 through December 31, 2008, the last date before the American's with Disabilities Amendments Act of 2008 went into effect. To ensure confidentiality, all identifying information was purged. All discrimination allegations brought under federal statutes other than the ADA were excluded as were those filed under state laws. Also excluded were allegations filed under ADA Title I that were still being investigated or were currently open by the EEOC for litigation, as allegations such as these could not provide information regarding resolution status which ultimately determines whether or not an act of discrimination actually occurred. Additional allegations not included were recording or duplication errors or those allegations filed in an act of retaliation, since these allegations would not offer insight into the existence or consequence of disability.

The remaining master dataset consists of 402,291 allegations of employment discrimination filed under ADA Title I with the EEOC. Of note, the unit of interest in this investigation is an allegation, not an individual who filed an allegation since an individual may bring more than one allegation (i.e., two or more charges brought simultaneously if multiple discriminations have occurred at once or two or more charges brought consecutively if multiple discriminations have occurred over a period of time such as one in 1992 and one in 2001).

From the master dataset detailed above (with 402,291 allegations), researchers for the current study further divided these allegations into three subsets: (1) Males (206,014 or 51.210%); (2) Females (194,035 or 48.232%); and Null (2,242 or 0.557%). Because the Null subset would not contribute to knowledge sought by the study's research questions pertaining to the comparison of male and female allegations and because of its relatively small size, the Null subset was not included in the current study. This left researchers with a study-specific dataset with a total of 400,049 allegations for both the Male (206,014 or 51.497%) and Female (194,035 or 48.503%) allegation groups.

Variables

A person who brings an allegation of discrimination against an employer is the charging party (CP) and the employer against whom the allegation is brought is the Respondent. This study explores characteristics of charging parties only and the following are the variables associated with the CP: "basis" or CP's disability; the "issue" or type of discrimination filed in the allegation (e.g. wrongful firing, failure to make a reasonable accommodation, failure to hire); and the race (White, African American, Native American/Alaskan Native, Hispanic, Asian, Mixed Ethnicity, Other, or Unknown), age (grouped for the current study as 15-34, 35-54, 55-64, 65+, or Unknown), and gender (male or female) of the CP.

Data Analysis

Using Minitab 15, nonparametric tests of proportion were conducted to compare male and female allegations for each of the above variables on all of their respective categories. All confidence intervals were set at 99.999% with $p < .001$ and variable categories with p-values outside of this range were judged to have no significant difference between the male and female allegation groups. The resulting variables and their respective categories with significant differences were ranked by magnitude (Z-score) for comparison within variables.

Results

Basis (or disability) categories with significantly more male allegations included:

- HIV/AIDS ($z = 52.03$, $p < .001$)
- heart/cardiovascular ($z = 38.31$, $p < .001$)

- alcoholism (z = 31.86, p < .001)
- back (z = 28.09, p < .001)
- missing digits/limbs (z = 27.34, p < .001)
- learning disability (z = 18.86, p < .001)
- vision (z = 17.25, p < .001)
- drug addiction (z = 17.25, p < .001)
- paralysis (z = 14.37, p < .001)
- hearing (z = 13.52, p < .001)
- schizophrenia (z = 11.54, p < .001)
- mental retardation (z = 10.57, p < .001)
- speech (z = 10.27, p < .001)
- kidney (z = 9.80, p < .001)
- regarded as having a disability (z = 9.50, p < .001)
- traumatic brain injury (z = 9.21, p < .001)
- autism (z = 6.81, p < .001)
- cerebral palsy (z = 6.34, p < .001)
- record of disability (z = 5.84, p < .001)
- disfigurement (z = 5.16, p < .001)
- Alzheimer's (z = 4.00, p < .001)

Basis categories with significantly more female allegations included:

- impairment not otherwise specified (z = -30.57, p < .001)
- depression (z = -31.74, p < .001)
- asthma (z = -30.22, p < .001)
- multiple sclerosis (z = -27.94, p < .001)
- cumulative trauma disorder (z = -27.42, p < .001)
- cancer (z = -27.16, p < .001)
- diabetes (z = -22.82, p < .001)
- allergies (z = -22.03, p < .001)
- anxiety disorder (z = -15.11, p < .001)
- association with person with a disability (z = -14.10, p < .001)
- other neurological impairments (z = -13.72, p < .001)
- non-paralytic/orthopedic (z = -13.44, p < .001)
- chemical sensitivities (z = -10.88, p < .001)
- bipolar disorder (z = -8.98, p < .001)
- other psychological disorders (z = -8.78, p < .001)
- gastrointestinal disorders (z = -8.02, p < .001)
- other blood disorders (z = -5.53, p < .001)
- other respiratory or pulmonary impairments (z = -3.07, p < .001)

Basis categories with no significant difference included:

- tuberculosis (z = 0.94, p < .001)
- epilepsy (z = 0.61, p < .001)
- dwarfism (z = -1.50, p < .001)
- and cystic fibrosis (z = -2.62, p < .001).

Discrimination issue categories with significantly more male allegations included:

- hiring (z = 40.96, p < .001)
- layoff (z = 16.64, p < .001)
- discharge (z = 15.22, p < .001)
- reinstatement (z = 10.46, p < .001)
- recall (z = 10.45, p < .001)
- involuntary retirement (z = 9.74, p < .001)
- promotion (z = 9.54, p < .001)
- benefits—pension (z = 9.13, p < .001)
- union representation (z = 8.96, p < .001)
- suspension (z = 5.66, p < .001)
- referral (z = 5.66, p < .001)
- testing (z = 5.40, p < .001)
- prohibited medical inquiry (z = 4.42, p < .001)
- apprenticeship (z = 4.04, p < .001)
- severance pay (z = 3.82, p < .001)

Discrimination issue categories with significantly more female allegations included:

- constructive discharge (z = -22.06, p < .001)
- reasonable accommodation (z = -21.17, p < .001)
- harassment (z = -19.98, p < .001)
- terms/conditions of employment (z = -14.78, p < .001)
- maternity (z = -12.20, p < .001)
- discipline (z = -11.73, p < .001)
- intimidation (z = -10.46, p < .001)
- other (z = -3.57, p < .001)
- assignment (z = -2.13, p < .001)

Discrimination issue categories with no significant difference between male and female allegations included:

- references unfavorable (z = 2.61, p < .001)
- qualification standards (z = 2.33, p < .001)
- early retirement incentive (z = 2.12, p < .001)
- seniority (z = 1.79, p < .001)
- segregated union locals (z = 1.59, p < .001)
- benefits—insurance (z = 1.55, p < .001)
- job classification (z = 1.55, p < .001)
- training (z = 1.32, p < .001)
- demotion (z = 0.67, p < .001)
- segregated facilities (z = 0.54, p < .001)
- benefits—not insurance (z = 0.25, p < .001)
- exclusion/segregated union (z = 0.06, p < .001)
- waiver of ADEA rights (z = -0.38, p < .001)
- tenure (z = -0.92, p < .001)

- advertising ($z = -1.53, p < .001$)
- posting notices ($z = -1.68, p < .001$)
- wages ($z = -1.75, p < .001$)
- assignment ($z = -2.13, p < .001$)

Age categories with significantly more male allegations included:
- 55-64 ($z = 19.11, p < .001$)
- 65+ ($z = 17.40, p < .001$)

Age categories with significantly more female allegations included:
- 35-54 ($z = -13.01, p < .001$)
- 15-34 ($z = -4.93, p < .001$)

Age categories with no significant difference between male and female allegations included:
- null or unknown ($z = -1.04, p < .001$)

Race categories with significantly more male allegations included:
- White ($z = 15.48, p < .001$)
- Hispanic ($z = 14.76, p < .001$)
- Mixed Race ($z = 5.86, p < .001$)

Race categories with significantly more female allegations included:
- African American ($z = -23.24, p < .001$)
- null or unknown ($z = -8.25, p < .001$)

Race categories with no significant difference between male and female allegations included:
- other ($z = 5.86, p < .001$)
- Native American/Alaskan Native ($z = -0.33, p < .001$)
- Asian ($z = 0.69, p < .001$)

Discussion

Results of this study highlight the differences and similarities in the characteristics of male and female charging parties. Exploring gender differences and allegations of hiring discrimination, McMahon et al. (2005) found that males with disabilities were more likely than females with disabilities to file a report. Indeed, in terms of the current findings, males slightly edged out females in reports of alleged discrimination (51.5 vs. 48.5 percent). Whether or not an allegation is found to be meritorious, males may be more inclined to file a report due to socially based norms in which they are the majority class despite the occurrence of a disability. In general, males and females present significantly different profiles in terms of impairment type, discrimination issue, age, and race.

Gender and Impairment Type

In examining impairment type, proportionally more discrimination allegations were reported by males who had "traditional" disabilities (i.e., those that are more obvious, medically established, easy to diagnose, and less stigmatizing) in comparison to females who filed proportionally more discrimination allegations based on "emerging" impairment types (e.g., chemical sensitivities, impairment not specified, other neurological) that are less obvious, more difficult to diagnose, often medically contested, and more stigmatizing (Fox & Kim, 2004; McNeil & Kroll, 2004). The one exception to this finding is the proportionally greater number of discrimination complaints due to HIV, also a highly stigmatizing emerging disability, filed by males. Many of the emerging disabilities associated with female allegations are autoimmune diseases (ADs; e.g., lupus, multiple sclerosis, arthritis). ADs represent the fourth leading cause of disability among women in the United States (American Autoimmune Related Diseases Association, Inc. [AARDA], 2009). Given that the ratio of women to men with ADs in the general population ranges from 2:1 to 50:1, depending on the specific AD diagnosis, it is not surprising that more allegations of discrimination on this basis would be filed by women (Joffe & Friedlander, 2008).

Although the greater proportion of allegations by women with emerging disabilities can be explained by their greater proportion in the general population, research has documented that women with unusual symptoms who seek medical diagnosis and treatment are less likely than their male counterparts to be taken seriously by physicians, and their symptoms are more likely to be labeled as psychosomatic (AARDA, 2009; Lipson & Doiron, 2006). These women are, therefore, more likely to encounter reactions such as discrimination from employers who question the validity of their conditions.

A greater proportion of female allegations in comparison to male allegations was also filed on the basis of psychiatric impairments (e.g., depression, other psychiatric impairment, anxiety disorders, bipolar disorder). In the general population, overall rates of occurrence of psychiatric disabilities are almost identical for females and males (National Institute of Mental Health [NIMH], 2010). However, gender differences are found in the patterns of mental illness that affect males and females (World Health Organization, 2009). For example, both depression and anxiety occur twice as frequently in females as in males, and posttraumatic stress disorder is more common in women than men (NIMH, 2010). The data analyzed in the current study reflect gender differences in impairment types along similar lines. However, in the current study, there were proportionally more male allegations filed on the basis of schizophrenia, and proportionally more female allegations filed on the basis of bipolar disorder. In contrast, there are no marked gender differences in the rates of schizophrenia and bipolar disorder in the general population (NIMH, 2010).

Gender biases in the diagnosis and treatment of mental illness have been indicated as another plausible explanation for differences in patterns of mental illness between males and females in the general population. For example, research has documented that physicians are more likely to diagnose depression in women than in men, even when they present with identical symptoms or scores on standardized measures of depression (Munch, 2004). Physicians are also more likely to prescribe psychotropic medications to women. On the other hand, men are more likely than women to be diagnosed with alcoholism and substance use disorder providing a potential explanation for the higher proportion of male allegations filed due to both alcoholism and drug addiction.

Proportionally more allegations were also reported by women who had impairment types that can be environmentally induced (e.g., chemical sensitivities, allergies, asthma). It has been estimated that 12 to 18% of the U.S. population has chemical sensitivities, with 80% of those affected being women (Lipson & Doiron, 2006). Because women still typically assume primary responsibility for household duties, they are more frequently exposed to environmental toxins in the home (e.g., cleaning products, pesticides, air fresheners, disinfectants), and, thus, at greater risk of developing disabilities that are environmentally induced (e.g., allergies, some cancers, chemical sensitivities). In addition, female employees are disproportionally more represented in industries (e.g., textile industry, health care and clinical laboratories, manufacturers of electronic equipment, dry cleaners) where ongoing exposure to environmental hazards in the workplace is common (Stellman, 1996).

The clustering of women's work in "pink collar" occupations (e.g., secretaries, cashiers, waitresses, housekeepers, hairstylists, nursing aides) that require repetitive use of certain muscles and tissues to perform job tasks may account for the higher proportion of allegations filed by women in the current study who have cumulative trauma disorders (Stellman, 1996). Finally, the greater proportion of discrimination complaints filed by women on the basis of association with an individual with a disability could be explained by the fact that women typically assume primary care giving responsibilities, and discrimination based on workers' responsibilities to care for family members (e.g., children, partners, elderly parents, other family members with disabilities) is becoming a widespread concern in the twenty-first century workplace (Von Bergen, 2008). Of particular relevance in the interpretation of these findings, the EEOC in 2007 noted that:

> While care giving responsibilities disproportionately affect working women generally, their effects may be even more pronounced among some women of color, particularly African-American women, who have a long history of working outside the home. …Women of color also may devote more time to caring for extended family members, including both grandchildren and elderly relatives, than do their White counterparts (section IA, para. 4).

Gender and Discrimination Issue

In comparing male allegations to those of females in terms of issue or type of discrimination, proportionally more alleged discrimination was reported by males in 15 of the 41 issue categories and females in 8 of the 41 categories. Thus, allegations are more spread out across categories for males. While the highest ranked issue category for men was hiring, the highest ranked issue category for women was constructive discharge. These are followed by layoff and discharge for men and reasonable accommodation and harassment for women. Exploring gender differences and allegations of hiring discrimination, McMahon et al. (2008) found that males with disabilities were more likely than females with disabilities to file a report. A possible explanation for this finding is that more women have hidden disabilities and/or disabilities that do not require accommodations to complete the interviewing process. Thus, they may not have the need to disclose their disability status and request accommodations until after they have been hired. An alternative explanation is that women file less on the basis of hiring because they are more likely to encounter covert forms of discrimination in the hiring process, which are more difficult to document and prove than more overt forms of discrimination

(Cortina, 2008). Examples of covert discrimination in hiring include holding women applicants with disabilities to higher standards, evaluating their applications more critically, devoting less time to the interview than is given to other applicants, or failure to provide them with important information about the position or application process that is provided to other applicants.

The higher proportion of allegations by women of issues in the constructive discharge category could also be explained by covert discrimination. This finding could be further linked to the finding that proportionally more female allegations in comparison to male allegations are filed on the basis of impairment types that can be classified as autoimmune diseases. The symptoms associated with autoimmune diseases tend to be chronic, progressive, unpredictable in their course, and exacerbated by stress (Joffe & Friedlander, 2008). Symptoms may not be visible to others, leading to doubt regarding claims of disability and triggering covert acts of discrimination. Among women, the higher proportions of alleged discrimination by harassment, intimidation, and reasonable accommodation could also reflect negative attitudes toward individuals with emerging disabilities and autoimmune diseases. Research has demonstrated that more stigma is associated with hidden disabilities and especially disabilities that are questioned in terms of their legitimacy (Fox & Kim, 2004).

Gender and Age

In comparing gender by age, proportionally more instances of alleged discrimination were reported by females between 35 and 54 years of age and males between ages 16 to 34 years. These age ranges represent the prime years of labor force participation for both males and females. However, males in comparison to females reported more incidents of alleged discrimination as they are aging out of the workforce (55 to 65 plus years). In interpreting these findings, it should be noted that female participation in the workforce has substantially increased since 1950 as male participation has decreased. Overall, declining trends in labor force participation are indicative of an aging workforce as reflected by the baby boomer generation (Toossi, 2009). Across gender, more than one in eight individuals in the 65 plus years age group is working (Endicott, 2005). However, a larger proportion of older men are participating in the labor force compared to older women (Hill, 2002).

In terms of the potential interplay of gender and age, several considerations may be relevant. For example, older women may be less likely than younger women and men of all ages to report alleged discrimination because of generational work values, socialization, and economic factors. Older women may also be more committed to their employers in terms of loyalty and willingness to "go the extra mile" (The Sloan Center on Aging and Work), less comfortable with an empowered interactional style, and less likely to question workplace expectations (Dittmann, 2005). Furthermore, women under 50 have outpaced older women in educational attainment (Sloan Center on Aging and Work). Armed with more formal education, younger females may be more knowledgeable regarding legislative protection, personnel policies, services, and supports than older female workers. Thus, they may be more prepared to pursue resolution for alleged discriminatory actions. From an economic perspective, older women are also likely to be the primary wage earners in the household; such dependency on a single income may result in a reluctance to challenge the workplace culture. The Sloan Center on Aging and Work (2009) reported that older female workers are less likely to be married or living with a partner, earn less than their male counterparts, are less educated than their male counterparts, live in households with lower family incomes, and experience working poverty as a form of underemployment.

The fact that older male workers disproportionally reported higher rates of alleged employment discrimination may be indicative of the existence of age discrimination in the workplace (Gutman, 2000). That is, the older worker may perceive that discrimination is occurring based upon their age as they wind down their work years. In the 2008 fiscal year, age discrimination complaints were up 30% compared to 2007 (EEOC). This increase, in part, may be due to the growing numbers of older employees in the workplace. Interestingly, this pattern does not appear to hold for older female workers. Also, according to the Sloan Center on Aging and Work (2009), older male workers are more likely to be married than older female workers and more likely to live in households with a higher income. These factors may impact the decision of the older male worker to not file a discrimination allegation. Finally, Pitt-Catsouphes, Matz-Costa, and Besen (2009) found that older Baby Boomers (ages 53 to 61) perceived lower supervisor support compared to Generation X'ers (ages 27 to 42) and the Younger Baby Boomers (ages 43 to 52). This study did not account for gender. However, this finding sheds light on the possibility that the older worker may not feel supported in the workplace, thereby, influencing a decision to file a complaint.

Gender and Race

White males, followed by Hispanic males and males of mixed race filed proportionally more allegations of discrimination than Asian, Native American/Alaskan Native, African-American and Other males as well as females. Because White males represent the majority of labor force participation, they may be more fully informed of their rights in the workplace. They may also possess a stronger sense of self efficacy and have more positive outcome expectations than women and members of racial/ethnic minority groups because of their privileged status in the workplace. Thus, they are likely to be more confident about filing a complaint, and more secure in the belief that the outcome of that complaint would be constructive (McMahon et al., 2008). Conversely, African-American males and females may have developed more negative outcome expectations because of their marginalized status in American society as well as the workplace. Interestingly, the current findings contradict Coleman, Darity and Sharpe's (2008) research findings indicating that male and female Black workers are far more likely than White workers to report racial discrimination at work.

Also of note, Hispanic males filed proportionally more allegations than other ethnic minority group males. According to the United States Bureau of Labor Statistics (BLS, 2008b), Hispanics have the highest rate of labor force participation with more than two-thirds employed. However, they tend to be employed in occupations with low to medium weekly earnings such as farming, forestry, maintenance, building and grounds keeping, construction, and serving related occupations. In many of these occupations (e.g. farming, construction), employees have union representation which could account for the greater proportion of EEOC complaints filed by Hispanics. Unions often have capacity building programs that address advocacy, legal rights and protections, or employment support programs.

Latina, as well as Black, women typically work in service occupations, and are more likely to be members of the working poor, than White and Asian women (BLS, 2008a). Perhaps cultural norms combined with employment in occupations associated with less power and prestige influence the reporting of alleged discrimination by Latina women. That Hispanic males were more likely to file than other ethnic minority males is particularly intriguing as Balcazar, Keys, and Suarez (2001) found that 93% of Hispanics/Mexicans with disabilities in Chicago were unaware of their rights and responsibilities under the ADA.

Proportionally more African-American females filed allegations in comparison to males. This finding is not surprising considering the feasibility of intersectional discrimination based upon race, class, gender and disability. However, this result is somewhat counterintuitive in terms of other factors as formerly discussed related to gender and likelihood of filing a complaint. One could speculate that the nature of the alleged discrimination is so blatant that filing a charge is the obvious recourse.

Implications and Conclusions

The interplay of employee characteristics and allegations of employment discrimination are complex and therefore difficult to understand. Regardless, rehabilitation professionals must proactively consider the potential influences of the demographic characteristics of service recipients as they develop supports and provide services to enhance employment outcomes. Targeted education and awareness efforts must address age, gender, and cultural differences (e.g., race and ethnicity), as well as the potential influence of type of impairment on employment. Such activities will inform the experiences of rehabilitation clients, the practices of rehabilitation professionals, and the hiring and employment behaviors of employers. Additionally, alternative career development models need to be constructed and evaluated that better represent the experiences of contemporary workers in an increasingly diversified workforce. Traditional models are based on the assumption that career development follows a predictable, linear and uninterrupted progression from education through employment to retirement (Dainty & Lingard, 2006). These models do not reflect the career development experiences of modern workers including women, people with disabilities, minorities, and older workers. Nor do they reflect contemporary workforce trends.

In preparing consumers to be self-advocates regarding their rights and responsibilities under Title I of the ADA, it is imperative that interventions be tailored to individual characteristics of the consumer (e.g., age, gender, age, ethnicity/race, impairment type) rather than providing a one-size fits all approach that is predicated on outdated assumptions about career development and employment discrimination. Similarly, workplace policies and practices need to be modified to address the needs of a more diverse workforce. Organizational practices and policies are still structured around traditional models of career development that impede the career success of non-traditional workers (Dainty & Lingard, 2006).

Finally, rehabilitation professionals should be knowledgeable about legislation that makes it illegal to discriminate against members of other protected classes in employment (e.g., Title VII of the Civil Rights Act, Age Discrimination in Employment Act, Family and Medical Leave Act) because both women and men with disabilities are likely to encounter multiple forms of discrimination on the job and should be informed about all avenues for redress. Rehabilitation professionals also have a role in assisting to eradicate barriers to employment experienced by people with disabilities by educating employers about how reasonable accommodations (e.g., flexible work schedules, part time work, career break programs, job sharing, home-based work, etc.) and family friendly policies can be combined to attract and retain employees from a diversified workforce.

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Authors' note

This study was funded by the National Institute on Disability and Rehabilitation Research (# H133A060087). Appreciation is extended to Dr. Ronald Edwards from the Equal Employment Opportunity Commission for technical assistance provided.

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Psychosocial Adjustment of Women with Work-related Disabilities in Rural China

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Abstract: The impact of gender roles on the psychosocial adjustment of women in rural China with work related disabilities is explored. The influence of economic reform, traditional family orientation, and gender expectations on the ability of women to work in rural China are discussed via three case studies.

Keywords: *Gender, China, disability experience*

In the past few years, there were a number of reforms of the work injury insurance system in China. The purpose of these reforms is to establish a well-organized policy framework and rehabilitation services delivery in addressing the needs of people with work injury disability. Since 2003, the staff from the Hong Kong Workers' Health Centre and the Guangdong Provincial Work Injury Rehabilitation Center have worked together to explore the psychosocial and vocational rehabilitation needs of people with work injury disability and have begun to apply the case management model to develop the first occupational and social rehabilitation service protocol for people with work injury in China (Lo-Hui et al., 2005).

In the process of exploring the psychosocial and vocational rehabilitation needs of people with work injury disability, it was clear that a portion of these workers were coming from rural China and experienced a work injury while they worked in urban cities. In supporting the occupational and social rehabilitation of these injured migrant workers, the authors, as the rehabilitation practitioners, started to recognize a gender difference related to their psychosocial adjustment. The awareness of this gender difference stimulated this discussion of the psychosocial adjustment of women with work-related disabilities who originated from rural China.

The Economic Reform of China

After a 29 year experiment in establishing a communist economic system in China, a drastic economic reform began in 1978 commonly referred to as an "open door policy." For the past few decades since 1978, many Hong Kong, Taiwan, and overseas enterprises have moved their production base to the coastal areas of Mainland China. By setting up the production lines in these coastal areas, many of the multinational companies captured the competitive advantage via lowering labor costs associated with production. More and more products in the world have been tagged as "Made in China" as China positioned herself as a "world factory."

The rapid economic changes also parallel drastic social changes. This economic reform provided an opportunity for people from rural China to work in the factories in the cities of China as migrant workers. The *hukou* system (residential registration) in China officially limits people to change their residential registration other than their birth place. Therefore, many of these migrant workers are growing up in rural China while they are temporarily and unofficially working in the factories in coastal cities. They are counted as the "floating population" in China (Jacka & Gaetano, 2004); the estimated size of the floating population was around 211 million in 2009 (Takungpao, 2010). A proportion of the floating population consists of young females coming from rural China; they are named *dagonmei* (working sisters). Most of these migrant women are single and either in their teenage years or early twenties.

Traditional Culture and Gender Roles in Rural China

One of the core traditional cultural aspects in rural China is the value system of familism (Yuen, Law, & Ho, 2004). One of the common understandings of familism refers to core values of a family type which emphasizes commitment to the family as a unit (Sociologyindex, 2010). The key relationship in Chinese familism is the bonding of father-son as the center of other relationships within the family. Women, on the other hand, are subservient within the family. Therefore, a male dominated "patriarchal culture" is one of the characteristics of Chinese familism (Yuen, Law & Ho, 2004). This implies that men are treated as superior while women are treated as inferior and expected to follow the commands of the men. One of the famous Confucian teachings on the traditional role of women is: a woman has to obey her father in her maidenhood, her husband in married life, and her son in her old age. This clearly illustrates the expectation of women in the traditional Chinese culture to stick to the family role by following the decisions of the males in the family.

In fact, the traditional patriarchal Chinese culture still predominates in rural China even after decades of economic reform. The daughters are expected to leave their natal families upon marriage. These daughters would then be considered members of another family and temporary members of their natal homes (Beynon, 2004). Therefore, the educational opportunities are less for young women; many quit their study after primary school and a significant proportion are illiterate (Fan, 2004).

For a rural woman, marriage is not just about finding a partner but also finding a secure home that provides stability in her life. The pressure for rural women to get married escalates once they have reached their early twenties. Traditionally, rural women are expected to do the housework and support the family farming before and after marriage (Fan, 2004). The contributions of rural women, especially unmarried daughters in general, are undervalued.

Working Before Marriage

After finishing school, while most of the young women are still too young to get married, they become a surplus labor force in rural China. As previously stated, marriage is then expected in the mid-twenties (Fan, 2004). Thus, the production lines of manufacturing products as "Made in China" in coastal areas creates an opportunity for these women and girls to work as *dagonmei* (working sisters) and become more economically independent while living in the cities.

In exploring the subjective experience of migrant women, motives for the out-migration from rural to urban cities was due to several reasons: (1) the escape from enduring gender oppression or violence; (2) the expectation of having autonomy from the patriarchal authority of parents; and (3) a broadening of horizons by working in urban areas (Jacka & Gaetano, 2004). As the majority of these migrant women are young and single, this may also provide an opportunity to evade early marriage and early motherhood by seeking a sense of independence (Beynon, 2004).

While most of these women had earned an independent living and were exposed to a more modern city when they worked in the factories of cities, they were mostly nurtured in traditional Chinese culture with a clear division of work and expectations of the female role in the family. They were still expected to return to their village to get married and find a permanent home for themselves. The beginning of married life is a critical turning point for these migrant women. They become settled and their "career" as migrant women ends. (Some may still move out to work again in the city as migrant women after marriage, and economic expectations are the major motivation for this migration in order to support child and family expenditures.) Under this social and cultural context, work accidents occurred in the factories, resulting in an impairment of these single migrant women.

Problem of Work Injury

The statistics provided by the Ministry of Human Resources and Social Security of the People's Republic of China showed that the country has approximately 148 million workers joining the work injury insurance scheme. This program is provided by the government's social security department. . In 2009, 950,000 workers experienced a work injury; 390,000 resulted in a disability. Considering those workers were injured in prior years, approximately 1.3 million workers experience a work injury and were covered under the work injury compensation system in China during 2009. The number of work injuries is increasing (China Economic Net, 2010). Work accidents occurring in the workplace result in a range of severity levels from cutting fingers to burn injuries to spinal cord injuries.

Methods

The study aim is to explore how the gender role of traditional Chinese culture in rural China impacts the psychosocial adjustment of single migrant women after experiencing a physical disability due to work injury. A qualitative case study approach was utilized. Case study is one of the research methodologies for researchers to study complex phenomena within their contexts (Baxter & Jack, 2008). This approach allows a close collaboration between the research and the research participant enabling the participant to tell her story. This in turn provides insight into our comprehension of specific social phenomenon. Three cases were selected from the list of female patients of Guangdong Provincial Work Injury Rehabilitation Center. These are single migrant women who grew up in rural China. Afterwards, each moved from rural China in order to work in Guangdong Province (one of the coastal provinces in South China). Each experienced a work injury resulting in different functional impairments.

Case Background

Case 1: Ms A, is a single, currently 19 year old woman with a junior high school education. She moved from a rural village in Henan Province of China and began working at a coastal city in early 2009. After only two months of working in the coastal city, she experienced a neck injury due to a work accident which resulted in paralysis. Her parents live in a rural village and she has a younger brother studying at primary school in a home village. At the time of the interview, she was still receiving rehabilitation treatment in the Guangdong Provincial Work Injury Rehabilitation Center.

Case 2: Ms B, is a single, 24 year old woman with a high school education. She moved from a rural village in Guangxi Province of China to work in a coastal city. She experienced a crush injury at work in 2007 which resulted in a right-hand impairment. Her parents live in a rural village. At the time of interview, she was still searching for a job in the city.

Case 3: Ms C, is a single, 25 year old woman with a junior high school education. She moved from a rural village in Henan Province of China and worked in a factory of a coastal city. She experienced a burn injury at work in 2006. This resulted in an 85% burn scar and facial disfigurement. Her parents are farmers in a rural village and she has an elder brother who also worked in the city at the time of her work injury. At the time of interview, she was working as an instructor of handicrafts for a vocational support program in a hospital in the city.

In order to provide a framework of the interview, a semi-structured interview guideline was written for reference. The questions and answers of these interviews were documented for review and analysis. Common concerns were identified in reviewing participant experiences in psychosocial adjustment to a disability.

Results

After reviewing the participant interview records, the major reasons for moving out from rural China to work in coastal areas were to earn more money and expand their horizons. This is similar to the other female migrant workers in other studies (Jacka & Gaetano, 2004). The following issues were identified as important concerns related to adjustment to disability.

Became a Burden to the Family

In all the cases, the migrant women shared that one of their strong worries over the course of having a work injury was their "*becoming a burden for the family*." Instead of presenting shock, denial, or anger feelings immediately after the work injury, they claimed that they had strong guilt feelings toward their parents due to having a disability. This became a strong motivation to commit to training in self-care by improving their functions in performing activities of daily living.

> Ms A: "*My first reaction immediately after the injury was to practice rehabilitation and hope to recover as soon as possible, so that I don't add a burden into my family. I did worry about my parents as they are old now and physically not healthy. It is such a trauma for them to witness the suffering of disability of me."*

> Ms B: "*I was worrying that I need to be cared by my parents in the future. I hope to less the burden of my parents by learning the rehabilitation*".

> Ms C: "*My parents did cries out strongly in visiting me at hospital and I was worrying about bringing more burdens to the family after suffering from work injury. So, I told myself that I need to be tough and if I could learn to perform the self-care, then maybe I will be able to live independently without bordering [bothering] my parents."*

Marriage Concern

Ms C said that she was planning to return to the village just before the work injury for marriage as she was approaching her mid-twenties, which is the expected latest marriage age for females in rural China. Ms B also mentioned her plan to get married in her mid-twenties and then settle down in a rural village after giving birth to a child. While for Ms A, she said that she was too young to consider marriage. For both the cases of Ms B and Ms C, they indirectly shared their hopelessness in having a partner for marriage in the future after suffering from a disability. They worry about being "*looked down upon*" by the man or his family members due to the disability.

> Ms B: *"I don't want to talk about marriage with others after suffering from disability. Even when I can get marriage (sic), I may still worry as being look down by the partner and in-law family due to the disability."*

> Ms C: "*I still hope to try to find a husband but it is important for finding a man who will not discriminate [against] me due to the disability."*

Community Inclusion and Discrimination

The worry of discrimination, no matter if it is from the strangers on the street or from close relatives, creates a strong pressure on these migrant women after experiencing a disability. They did not just worry about the discrimination on themselves but also that of their family members by revealing a feeling of shame after suffering from a disability.

> Ms A: "*I am worrying to return back to my home village to meet all the close friends and relatives as I was once an able person before but now became disabled."*

> Ms B: "*Since people in my village know me well before suffering from disability, I don't know how to response with their pity on my existing situation in returning back home. I also worry about my parents as how they cope with the reactions of other relatives on my disability."*

> Ms C: "*Originally, I planned to stay in Guangzhou (the city in coastal area) instead of returning back to village as I was worrying over the reactions of friends and relatives to me and also to my family. However, I also found the curious expression of the strangers when they looked at me and I felt being discriminated."*

Personal Life Planning

When asked about the most major impact of the disability upon their personal life planning, all of them voiced that the disruption of their plan to get married was the most problematic issue they faced. The disability also limited their choice in job searching. For the future life planning, they all shared ambivalence in returning back to their home village versus staying in the city for independent living.

> Ms A: "*I will probably return back home as all my family members and friends or relatives were staying here. . .but it is not clear for how I could continue to live in the village.*"
>
> Ms B: "*I hope to stay in Guangzhou (the city in coastal area) if there is still a possibility for me to work in a shelter workshop as it might be less discriminative in these workshops. However, my parents would like me to return to home village. I am still thinking about this.*"
>
> Ms C: "*I was fluctuating in considering whether or not to return to home village. Originally, I planned to live independently in the city and tried to find a job. However, the living standard was very high in the city and I once decided to go home even though I worried about the reaction of my friends and relatives on my disability. My grand-parents were hurt when they visualized my facial disfigurement. Then, I moved back to the city again and hope to settle myself down here.*"

Discussion

In reviewing the case studies, we found that the four key concerns were rooted in the gender roles nurtured in the traditional Chinese culture in rural China. The concern of becoming a burden on the family was related to the fact that women are inferior in the traditional Chinese culture in rural China. The experience of disability will further de-value the role of these women in her natural family. This creates a stress in psychosocial adjustment of disability for these migrant women with work injury. The self value and self concept of these migrant women after suffering from disability will be, to a large extent, based on the reactions of the significant others in the natural family.

Marriage is a critical concern voiced by these migrant women with disability. Migrant women working in cities are viewed by them and their parents as a temporary arrangement, and they are all expected to get married in their mid-twenties by finding a "home" to settle in. Therefore, the experience of disability will decrease their chance of getting married. Without the long term support from the members of their natural family, these women also have to worry about the discrimination from the potential husband and the in-law family.

The concern of community inclusion and discrimination, especially from the friends or relatives of the village, was very distinctive in the migrant women with disabilities. These women are not just worrying about the discrimination on themselves, but also against their parents and members of the natural family. As culturally expected, unmarried young woman are only supposed to temporarily stay in the natural family until marriage. This will create a problem of her survival in the natural family when her disability brings more social and economic pressure to the parents or other members in the family.

This will also help explain the reason why these migrant women will have ambivalence in choosing between the options of returning back to their home villages versus staying in the city after experiencing a disability. Unless there was a very strong social and family support in the home village, these single migrant women with disability will found it very harsh to stay permanently in the home village as they were all treated as "another family member" in the patriarchal marriage system in rural China.

The above considerations were very different from the male migrant workers as served by the authors in the rehabilitation center. In general, the male migrant workers with disability secured more social and family support from their parents and relatives of the home village due to the fact that they are the "sons" in the family and are treated as permanent members in the existing family. Many of the parents and the relatives of these male migrant workers actively arranged the marriage for their sons with disability by identifying suitable girls in rural China to "take care" of their sons in the long run. The concern on whether to stay in the city or return back to the home village of these male migrant workers was mainly due to the consideration of more work opportunities or transportation accommodations for people with disability in the city.

In conclusion, we found that as young women are treated as the temporary members of their natural family and are expected to find a new home by getting married due to the traditional Chinese culture in rural China, this creates further psychosocial stress for these single migrant women in adjusting to their disability due to work accidents. It also limits the potential family and social support from the home village for these migrant women compared to the male migrant workers with disability in rural China.

This has an implication for rehabilitation practitioners in that they need to enhance sensitivity in understanding how the gender roles of the traditional Chinese culture in rural China of these single migrant women will cause an impact on their disability experience. The results indicate that these Chinese women with disability, especially single migrant women who are coming from rural China, may face more psychosocial stress in the process of disability adjustment. Therefore, it may be ideal for rehabilitation counseling personnel to increase the intensity of service provision for this population. The discussion of the rehabilitation plan should help empower these women in resolving their ambivalence related to a return back to their home village versus staying in the city and address their concern regarding marriage. It is also important for rehabilitation counselors to facilitate the communication of these women with members of their natural family in order to strengthen their social support for community re-integration. In the long run, an occupational and social rehabilitation program may need to be tailored for these single migrant women to facilitate psychosocial adjustment to disability due to work accidents.

Limitations

This is a small scale case study exploring how the gender roles of Chinese culture in rural China creates an impact on the psychosocial adjustment of the migrant women with disability due to work accidents. Further methodologically rigorous studies are needed to examine and confirm the impact of gender roles on the disability experience of single migrant women originating from rural China.

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Native Americans with Disabilities: A Comparison of Male and Female Eastern Tribal Members

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Abstract: This study identified prevalence of disabilities, employment, and rehabilitation needs of four eastern tribal members. Chi-square tests were conducted to compare females to their male counterparts. Females were more likely to experience arthritis and orthopedic challenges; males to experience substance abuse. No gender difference in employment rate was found.

Keywords: Native Americans, disabilities, employment.

According to the 2000 U.S. Census, about 2.5 million Americans (0.9 percent) of the U.S. population identified themselves as Native Americans, and approximately 4.1 million (1.5 percent) identified as Native Americans in combination with another race. Native Americans have disproportionally higher disability rates compared to other races or ethnic groups. Nearly two decades ago, 22 percent of Native Americans, with 27 percent of Native Americans between the ages of 16 and 64, were estimated to have a disability in 1991-1992 (Bradsher, 1995). The disability rate of Native Americans remained the same several years later according to the 1997 Survey of Income and Program Participation (SIPP) data: a higher percentage (22 percent) of Native Americans was estimated to have a disability in comparison to the general U.S. population (20 percent) (McNeil, 2001). An estimated 12 percent of Native Americans had a developmental or other disability of sufficient severity to require the use of a wheelchair, cane, or crutches, or for which they required assistance in performing activities of daily living or instrumental activities of daily living and to prevent them from working (McNeil, 2001).

Recently the 2008 American Community Survey (ACS) adopted a dynamic definition of disability, in order to better identify people with disabilities and to improve the estimate of the population of persons with disabilities. The definition considers a person's risk of participation limitation when he or she has a functional limitation or impairment (U.S. Census Bureau, 2008). From the 2008 ACS, Native Americans had the highest prevalence of disability (18.8 percent) for working-age people (ages 21 to 64) among all races compared to 14.3 percent among African Americans and 10.2 percent among Whites (Erickson, Lee, & von Schrader, 2009).

Several studies report possible reasons for racial and ethnic minorities collectively experiencing a greater disability burden than do their white counterparts. The high incidence of disabilities among minority groups is not likely due to illnesses being inherently more severe or prevalent in the community, but rather "is fundamentally a measure of exposure to health risks" (LaVeist, 1996, p. 24), including perhaps limited access to culturally sensitive treatments (U.S. Department of Health and Human Services, 2001). In addition, multiple factors need to be considered, including poverty, socio-demographic and cultural factors, inadequate resources, discrimination, and historical contexts (e.g., devastating population losses through war and disease, appropriation of aboriginal lands by governments, and loss of traditional economies) (Beals, Manson, Whitesell, Spicer, Novins, & Mitchell, 2005).

A socioeconomic disparity also exists among Native Americans with disability. In the 2008 ACS, the employment rate of working-age whites (ages 21 to 64) with disability in the U.S. was 41.1 percent, while employment of Native Americans with disability was only 36.5 percent (Rehabilitation Research and Training Center on Disability Demographics and Statistics, 2010). This indicates a special challenge for Native Americans with disability to find employment. The unemployment rate for all Native Americans at 15 percent, ages 16 and over, was higher compared to a rate for the general population of 6 percent. This is almost three times as high as the unemployment rate for the white population in 2003 (U.S. Bureau of Labor Statistics, 2003). Specifically, the unemployment rate was 22% for all non-gaming tribes and 15% for gaming tribes (Taylor & Kalt, 2005). According to U.S. Census Bureau (2004), the income level for Native Americans was 73 percent of the U.S. average, and the poverty rate (26 percent) was 2.6 times higher than that for whites and more than twice the average for all Americans (approximately 12 percent).

This disparity still exists even though estimates of unemployment rates for Native Americans are not shown separately by the U.S. Bureau of Labor Statistics after 2003 due to small number of survey respondents (Bowler, Ilg, Miller, Robison, & Polivka, 2003). The gap between Native American and White unemployment increased over the recession, and the jobs crisis for Native American may be even worse than the unemployment numbers reflected due to becoming discouraged and ceasing to look for jobs (Austin, 2009).

The gender differences in health conditions have been well discussed among general populations (Bird & Rieker, 2008; Idler, 2003, Yang & Lee, 2009). In 2008, 12.4 percent of females of all ages and 11.7 percent of males of all ages in the U.S. reported a disability (Erickson, Lee, & von Schrader, 2009). Women in general have, on average, more nonfatal chronic conditions (Bird & Rieker, 2008), physical disabilities (Yang & Lee, 2009), functional limitations (Rohlfsen, 2008), and depression and anxiety disorders (Bird & Rieker, 2008; Rohlfsen, 2008; Yang & Lee, 2009), while men have higher odds of problem drinking, substance abuse (Bird & Rieker, 2008; Rohlfsen, 2008), and life-threatening chronic disease (Bird & Rieker, 2008).

Contrary to common belief, Bradsher (1995) reported that there were no significant differences observed between disability rates for Native American men and women and those between the ages of 15 and 64. After more than a decade, there are only a handful of studies reporting the prevalence of disabilities and health conditions among Native American women. Research on Native Americans has been limited due to the small size of this population, its heterogeneity, surveys of organizations serving Native Americans (e.g., tribal representatives, independent living centers), or analyses on administrative data instead of tribal members (National Council on Disability [NCD], 2003). Existing studies suggest that Native Americans, both men and women, experience a disproportionate burden of various disabilities (Huang et al., 2006; NCD, 2003). There have been several studies on the rehabilitation needs of Native Americans with western tribes and Native Americans as a whole (Schacht, Gahungu, White, LaPlante, & Menz, 2000). Marshall, Johnson, Martin, Saravanabhavan, & Bedford (1992) used a community-based approach and the Participatory Action Research model to identify incidence of disabilities and rehabilitation needs of Native Americans in Denver, Colorado. However, there has been scarce research on the health and disability needs of Native Americans with disabilities in eastern tribes.

To address the issue of this lack of awareness regarding eastern tribes' health and rehabilitation needs, the authors have conducted a series of studies and reported results elsewhere (Ni, Wilkins-Turner, Ellien, Harrington, & Liebert, 2008; Ni, Wilkins-Turner, Liebert, & Ellien, 2008; Ni, Wilkins-Turner, Liebert, Ellien, & Harrington, 2009). Continuing previous efforts, this study further explored the disabilities and employment status among Native American men and women in four eastern tribes. The purpose of this study was to identify the prevalence of disabilities of females from four eastern tribes as compared to their male counterparts. This study also examined functional limitations in daily activities, employment status, and receipt of public services.

The following research questions were addressed:

1. What was the prevalence of major disability among Native American men and women (age 16 and above) from four eastern tribes?
2. What was the prevalence of major disability among working-age (21-64) Native American men and women from four eastern tribes?
3. Was there significant difference between disability rates of Native American men and that of women from eastern tribes?
4. Was there significant difference between Native American men and women from eastern tribes in the proportions of major disabilities?
5. What were the functional limitations due to disabilities and rehabilitation needs?
6. Was there significant difference between Native American men and women from eastern tribes in the proportions of employment?
7. Was there significant difference between Native American men and women from eastern tribes in the proportions of concerns related to finding and keeping jobs?

Method

Participants

A convenience sampling approach was used for this study and participation was voluntary. In the early stages of data collection (2004-2006), random sampling from tribal rolls was possible. Later, during 2007-2008, barriers to the access of tribal rolls arose and research technicians actively recruited tribal members to participate, resulting in a predominantly convenience sampling throughout the study.

30% of all tribal members from four eastern tribes, with and without disabilities, were recruited from tribal rolls. A total of 858 tribal members were invited to participate in a 30-minute face-to-face screening interview with structured questions about health, mental health, disability and employment. Participation in the screening interview was voluntary. All participants received an incentive under $10 in appreciation for their time. From screening interview, tribal members with disabilities were identified using four primary criteria based on self-report: (a) ages 16 and above, (b) a Native American with at least one disability that limited their daily functions; (c) alcoholism was not the primary disability, and (d) a member of the tribal roll of four eastern tribes.

Instrumentation

An Advisory Council from eastern tribes, with representation from each of the tribes, was formed to promote a culturally sensitive research design and provide expert opinions regarding the content of survey questions in the initial stage. The survey was adapted from a survey used by Marshall and her colleagues (1992), which had an inter-rater reliability of 97.9%. The inter-rater reliability for the instrument used in this study was 98.6%. All of the disability related items consisted of statements that were answered either “Yes” or “No”. For example, one of the questions is, “Do you have a disability or one of the following health conditions? Yes or No.”

Procedure

This study is part of a five-year research project that focuses on the health and service needs of Native Americans with disabilities from four eastern tribes. This study applied the Participatory Action Research model to facilitate collaboration among four eastern tribes in the planning and implementation of community-based research. This collaboration between the research team and the Advisory Council continued throughout the five-year study period. In addition, this culturally appropriate network comprised tribal leaders who advised the research team and referred competent Native American research technicians.

Beginning in 2004, tribal council members selected research technicians from each of the participating tribes, with a goal of interviewing 30% of tribal members over 16 years of age. To ensure consistency of interviewing procedures among the Native American research technicians, a mandatory three-day training was offered prior to collecting survey data. The training consisted of a reading of the needs assessment survey, question by question, answering concerns and modeling in response to the questions. Role-playing and observation during interviews were used as an evaluation tool to ensure that research technicians were adequately trained. Research technicians conducted individual interviews in various locations, including tribal members’ homes, tribal offices, and tribal events.

Between 2004 and 2008, 35 trained tribal research technicians conducted a screening interview to identify tribal members with disabilities. Tribal members having one disability limiting daily function or two disabilities and more were included for the study. The results of that survey were reported elsewhere (Ni, Wilkins-Turner, Ellien, et al., 2008). From that survey, 160 tribal members with disabilities were identified and invited to participate in this presented study and complete a survey on employment and rehabilitation needs. The interview was approximately 50 minutes in length. Research technicians were paid $50 for each interview completed, plus providing compensation for travel costs.

Data Analysis

Both descriptive and inferential procedures were used to analyze the data collected. The level of significance, α, for all statistical tests was set at .05, and all statistical analyses were conducted with SPSS. Chi-square tests were conducted to compare the differences between 98 females and their 62 male counterparts in terms of disability rates, employment status, and rehabilitation needs. The following assumptions of chi-square were checked before conducting the tests: independence of observation, normality, and inclusion of non-occurrences.

Results

Participants

Tribal members from four eastern tribes participated in the study. Research technicians using the disability screening survey interviewed 858 tribal members and identified 174 tribal members (20.5 percent) above 16 years of age as having disabilities (see Table 1). Among those, 154 (88.5 percent) participated in the current study with 59 (38.3 percent) being males and 95 (61.7 percent) females. The average age was 49 years; with males averaging 47 and females 50, the age range was 17 to 86. Almost all of the participants lived in small towns, suburbs, or cities in the northeast states.

Table 1. Prevalence of Disability by Gender from Screening Survey

	Total in screening survey		*Tribal members with disabilities*		*Disability rate*
	number	percent	number	percent	percent
All (age 16 and above)	858	100	176	100	20.5
Male	396	46	62	39	15.7
Female	462	54	99	61	21.4
Working-age*	785	100	128	100	16.3
Male	372	47	51	40	13.7
Female	413	53	77	60	18.6

* age 21-64

Prevalence of Disability

The prevalence of disability for all participants above 16 years of age was 20.5 percent, and for working-age participants (ages 21 to 64) 16.3 percent. Disability rates between all females (21.4%) and males (15.7%) were significantly different [X^2 (1, N=858) = 4.66, p=.03], and between working-age females and males were not significantly different [X^2(1, N=785) = 3.49, p=.06]. As shown in Table 2, the most prevalent physical disabilities for males and females include hypertension, eye conditions, arthritis, obesity, diabetes, orthopedic disorders, and heart problems.

Over a third (36%) had one or more mental health conditions, with anxiety (25.5%) and chronic depression (18.8%) the most prevalent. Of the 54 with mental health conditions, 16% had one condition, 10% had two, and 10% had three to six mental health conditions. Substance abuse, including alcohol, non-prescription drugs and sniffing glue, was reported as a problem for 21 (13.9%); 13 (62%) of these had co-occurring mental conditions (four had one co-occurring mental condition, four had two to three co-occurring disorders, and five had at least four co-occurring mental conditions).

Females had significantly more arthritis [X^2(1, N=153) = 6.36, p=.01] and orthopedic disorder [X^2(1, N=150) = 6.37, p=.01], whereas males had significantly higher substance abuse [X^2(1, N=150) = 4.1, p=.04].

Table 2. Prevalence and Comparison of Major Physical and Mental Health Conditions by Gender

	All (n=154)		*Male (n=59)*		*Female (n=95)*		*Comparisons*	
	number	percent	number	percent	number	percent	Pearson Chi-Square	*P* value
Physical conditions								
Hypertension	74	48.1	28	47.5	46	46.4	0.002	0.96
Eye conditions	64	42.4	21	37.5	43	45.3	0.74	0.39
Arthritis	58	37.7	15	25.4	43	45.3	6.36	0.01*
Obesity	53	35.1	16	28.6	37	38.9	1.47	0.27
Diabetes	43	28	14	23.7	29	31	0.99	0.32
Orthopedic disorders	39	25.8	8	14.3	31	32.6	6.37	0.01*
Heart problems	37	24	19	32.2	18	18.9	3.37	0.07
Asthma	34	22.1	9	15.3	25	26.3	2.7	0.1
Mental health conditions								
Anxiety	39	25.5	13	22.4	26	27.4	0.52	0.47
Depression, chronic	29	18.8	11	18.6	18	18.9	0.006	0.94
Substance abuse	21	13.9	12	21.4	9	9.5	4.1	0.04*
Bipolar disorder	11	7.1	4	6.8	7	7.4	0.02	0.88
Personality disorder	7	4.6	2	3.6	5	5.3	0.24	0.62
Eating disorder	7	4.5	1	1.7	6	6.3	1.83	0.18
Schizophrenia	5	3.3	1	1.8	4	4.2	0.66	0.42

Note. * p<.05

Self-Reported Functional Limitations and Needs

Disabilities limited all participants in doing the following: working on a job (48%), walking (41%), seeing (39%), and lifting (38%), with no statistical difference between males and females. Participants reported the following needs related to their disability:

- 44% (69) used medications with 12% (19) needing new or improved medications;
- 41% (63) used glasses and 24% (38) needed new or improved glasses;
- 10% (16) used a cane or a crutch and two (2) needed new cane/crutches;
- 5% (7) used a wheelchair and 1% (2) needed a new wheelchair.

Employment

Of all participants, only 89 (56 percent) were working for pay; among those, 59 (68 percent) were employed full-time. There was no statistical difference of employment rate between males and females [X^2(1, N=149) = 0.12, p=.73]. The number one reason for having difficulty finding or keeping a job was disability (25 percent), and home responsibilities were a more significant reason for having difficulty finding or keeping a job for females than males [X^2(1, N=134) = 6.72, p=.01]. Of those not working, 31 (43 percent) said they wanted a job, and of these, 20 (65 percent) had been looking for work (i.e. Internet, newspaper, temporary job service). However, only 3 percent received services from the state vocational rehabilitation agency to find a job, and over 70 percent did not know (at the time the survey was conducted) whether state VR would respond to their needs.

Discussion

This study identified the prevalence of disability of Native Americans in four eastern tribes; 176 (20.5%) out of 858 tribal members were identified as having disabilities. Disability rates between females (21.4%) and males (15.7%) were significantly different. Females had significantly more arthritis and orthopedic disorder; whereas males had significantly higher substance abuse. Of all participants, only 56% were working for wages. There was no difference of employment rate between males and females.

Prevalence of Disability

The prevalence of disability for all participants above 16 years of age was 20.5 percent and for working-age participants was 16.3 percent. These rates were lower than that of Native Americans between the age of 16 and 64 (27 percent) from the 2000 U.S. Census data (Waldrop & Stern, 2003) and were also lower than that of working-age Native Americans (18.8 percent) from the 2008 ACS (Erickson, Lee, & von Schrader, 2009).

One possible explanation for these lower disability rates is perhaps economic status which allowed access to good health care, including preventive health care, perhaps reducing the number of certain types of disabilities and health conditions. One of the four tribes had a high level of economic development and successful tribal businesses (e.g., hotels, casinos), which contributed to a higher household median income (approximately $62,500) among participants than overall Native American households in 2003 ($44,347).

One challenge of comparing disability rates is that the definition of disability is quite complex and variable; often resulting in inconsistent definitions of disability among different federal and state laws, public programs, insurance plans, and organizations (NCD, 2008). Statistics vary depending on the source of data, the definition of disability, and the type and severity of the disabilities included. In this study, the most prevalent physical disabilities for males and females include hypertension, eye conditions, arthritis, obesity, diabetes, orthopedic disorders, and heart problems. These results are somewhat different from an earlier study, in that the highest prevalent disabilities among continental Native Americans were diabetes (29 percent), emotional disabilities (22 percent), and learning disabilities (11 percent), while emotional disabilities (31.3 percent), learning disabilities (17 percent), and deafness or hardness of hearing (17 percent) were the most frequently reported disabilities among tribes in Alaska (Fowler, Seekings, Locust, Dwyer, & Duffy, 1995). Clay (1992) reported that the most frequently observed disabilities among Native Americans using independent living centers on reservations were spinal cord injury, diabetes, blindness, mobility disability, traumatic brain injury, deafness or/and hardness of hearing, orthopedic conditions, and arthritic conditions. Rates of each of these disabilities were not provided.

Another study suggested that of tribal members who received VR services from Native American VR programs in 2001, over 28 percent had a substance abuse problem, 22 percent had an orthopedic disability, 17 percent had a mental or emotional disability, and 15 percent had a learning disability (Hopstock, Baker, Kelley, & Stephenson, 2002). In the 2008 American Community Survey, the highest prevalence rate for all working age people (ages 21 to 64) was for ambulatory disability (5.4 percent), followed by cognitive disability (4.1 percent), and independent living (3.6 percent) (Erickson, Lee, & von Schrader, 2009).

Compared to these studies documenting prevalence of disability among Native Americans in various periods of time, it is likely that there was a different epidemiological trend in the four eastern tribes. For example, hypertension was not reported in those studies, but it is not uncommon in today’s high stress environment for many individuals. However, the prevalence of hypertension in eastern tribes (48 percent) appeared to be higher than that of all Americans (31 percent) between age 45 and 54 (Centers for Disease Control and Prevention, 2005). In addition, individuals with mental illness are more likely to be diagnosed today than fifteen years ago. According to another study (Huang et al., 2006), Native Americans as a whole had significantly greater prevalence rates of alcohol use disorders, drug use disorders, mood disorders (i.e., depression, manic-depression disorder), anxiety disorders, and personality disorders compared to the general population.

Substance abuse might have been under-reported as it was lower (13 percent) in this population compared to the western tribes (24 percent) (Marshall et al., 1992) and others (Huang et al., 2006; Hopstock et al., 2002). Using the 1997 Rehabilitation Services Administration (RSA) 911 data, alcohol abuse or dependence was the most common disability among Native Americans who sought vocational rehabilitation services, followed by learning disabilities (9 percent) (Schacht, Gahungu, White, LaPlante, & Menz, 2000). Approximately 11 percent of Native Americans receiving VR services had a major diagnosis of alcohol abuse compared with only 4 percent of White, nearly 6 percent of Black, and less than 2 percent of Asian clients (Schacht et al., 2000).

Gender Differences in Health

In this study, females above 16 years of age had significantly higher disability rates (21.4 percent) than males (15.7 percent) [$X^2(1, N=858) = 4.66, p=.03$]. Females had significantly more arthritis[$X^2(1, N=153) = 6.36, p=.01$] and orthopedic disorder [$X^2(1, N=150) = 6.37, p=.01$], whereas males had significantly higher substance abuse [$X^2(1, N=150) = 4.1, p=.04$]. This gender difference in physical and mental health can be influenced by a combination of social and biological factors, both directly and indirectly (Bird & Rieker, 2008).

The difference in health perception between men and women may have also contributed to the gender difference in health discrepancies, as the participants self-reported their disabilities. In a study of over 22,000 men and women in Britain, women were significantly less likely to rate their health as excellent regardless of social class (McFadden, Luben, Bingham, Wareham, Kinmonth, & Khaw, 2009). However, self-rated health is not as uniform as once thought. While some researchers reported that women on average assess their health to be worse than men (McFadden et al., 2009; Yang & Lee, 2009), others reported that females have the same or better self-rated health compared to males regardless of more physical limitations, acute and non-fatal chronic health conditions, and depressive symptoms (Rohlfsen, 2008). Even the same disease, depression, can be defined differently and carry varying levels of stigma in males and females (Johansson, Bengs, Danielsson, Lehti, & Hammarstro, 2009).

Difference in health-seeking behavior between men and women may also shape health discrepancies. One study reported that women are more likely to seek treatment earlier than men for similar symptoms (Gochfeld, 2009); while others argued that the ability to choose health among competing priorities is shaped by contextual factors (e.g., work and family obligations, communities, policy in a broad network of influence), rather than gender directly (Bird & Rieker, 2008). Because contextual factors differ across individuals, and often differ more generally across men and women, not everyone is similarly able to choose health (Bird & Rieker, 2008).

Employment and Rehabilitation Needs

Despite only 56 percent of tribal members with disabilities working for wages, this sample had high household income. Financial support from family members was a common resource among them. There was no statistical difference of employment rate between males and females. However, male and female tribal members had different reasons for experiencing difficulty finding or keeping a job; disability was a common reason among men and home responsibilities was common among women.

Of those not working, 43 percent wanted a job but only 3 percent had utilized vocational rehabilitation (VR) agencies to find a job. VR agencies can provide services to tribal members with disabilities to achieve gainful employment. However, a majority did not know whether state VR would respond to their needs, which indicated a lack of knowledge and use of public health or social agencies. Participants minimally involved with social service agencies could relate to the stigma felt by tribal members with disabilities or a lack of trust of state agencies, and it is also likely due to either ineffective, or a lack of, cultural competence of service providers. Depending on tribal beliefs and values surrounding disability related terms, tribal members asked to self-report their disabilities may be reluctant to participate in programs that promote independent living objectives, vocational rehabilitation, or special education (NCD, 2003).

The fear of stigma often deters individuals from seeking help, and also remaining in service or treatment (U.S. Department of Health and Human Services, 2001). Moreover, tribal values are likely to affect the adequacy and comprehensiveness of many programs dealing with access to and services for Native Americans with disabilities as well as tribal members' willingness to participate in initiatives to reduce barriers (NCD, 2003). Consequently, effective strategies including education or health promotion programs are needed to reach out to Native Americans with disabilities and expand their contact with health providers and other services.

Capacity Building

Native American programs that fail to incorporate cultural beliefs will have difficulty in obtaining community support (NCD, 2003). With this in mind, this study incorporated the capacity building component to enhance the involvement of tribal members throughout the research process. This participatory action research method, which includes Native Americans in the design, data collection, and implementation process, has been recommended elsewhere as a means to ensure that research is culturally sensitive and findings are both accurate and relevant (Davis & Reid, 1999; NCD, 2003). One outcome of this study related to the capacity building component was an awareness of tribal members with disabilities that did not exist prior to this research project. Ni, Wilkins-Turner, Ellien, Harrington, & Liebert (2009), found that the research technicians hired for this study were the most valuable resources to inform participants about available services including a tribal Vocational Rehabilitation Program. The support network among research technicians, service providers, and tribal members was expanded via use of participatory action research, which may lead to improved VR outcomes. VR knowledge translation was evident (Ni, Wilkins-Turner, Ellien, et al., 2009).

The results of this study suggest several implications. First, to address the accessibility of social services with culturally relevant outreach to tribal communities, researchers should consider using Participatory Action Model as it is a highly effective approach with Native Americans. Second, health education programs within a community may be developed to promote health care, especially regarding highly prevalent disabilities. These education and information programs for the tribal community may emphasize health and wellness. They may also provide specific information about how to cope with mental illness and other disabilities in order to alleviate functional limitations related to work and independent living. To increase culturally relevant services, there is a need for making efforts to train, hire, and retain Native Americans in health related fields. Third, to make social services more accessible with culturally relevant outreach to tribal communities, service providers may utilize community-based resources or direct contact by tribal members, councils and elders to establish a culturally appropriate network. This community-based study is an example of providing a unique opportunity for tribal members to learn firsthand about careers in health and disability research and to become resource persons for their respective tribes.

Limitations of this study include the use of convenience sampling, over-representation of women, and self-report. In addition, Native Americans' cultures, languages, traditions, and beliefs concerning health and disability are distinct across tribes (NCD, 2003). These differences among four tribes were not discussed due to the scope of this study. Cause and effect was not examined in this study. Due to heterogeneity among Native American tribes, one should not make generalizations to Native Americans as a whole or to those in other geographic locations. Thus, one should be cautious in interpreting the data. Future research which continues to explore the disability, employment and health experience of Native Americans of the eastern tribes is warranted due to the continued marginalization of this culture within American society.

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Authors' Note

This report is part of a five-year grant (2003-2008) from the National Institute on Disability and Rehabilitation Research (H133A031706) and the collaboration of four eastern tribes. The statements made are solely the responsibility of the authors.

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A Comparison of Male and Female Title I ADA Discrimination Allegations in Relation to Employer Characteristics

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Abstract: This investigation determined if there is a difference in the proportion of Title I workplace discrimination allegations filed by females in comparison to males under the Americans with Disabilities Act (ADA) in relation to the employer characteristics. Findings are reported and implications for future research and vocational rehabilitation practice.

Keywords: employment, gender, Americans with Disabilities Act

Although recent statistics indicate that 56% of adults with disabilities in the United States are female (Kessler Foundation & National Organization on Disability, 2010), research related to disability and employment discrimination has historically attempted to take a gender blind approach and has neglected to explore the influence of gender on the employment discrimination experiences of individuals with disabilities (Asch and Fine, 1988; Kutza, 1985; Mudrick, 1988). Most of this research has assumed the irrelevance of gender (Asch and Fine, 1988) despite the fact that research in related fields has unequivocally established that workplace discrimination based on gender is still prevalent in the U.S. employment arena. Also concerning is the relative absence of research examining employer characteristics that are related to gender-by-disability discrimination. One exception is a study completed by Rumrill, Roessler, McMahon, Hennessy, and Neath (2007) who found that women with multiple sclerosis (MS) were more likely to file ADA Title I discrimination allegations against employers in the service industries and men with MS were more likely to file allegations against employers in the construction, manufacturing, and wholesale industries.

Given that the combined role of gender and employer characteristics in predicting the employment discrimination experiences of people with disabilities has not received adequate research attention, the purpose of our investigation was to compare the gender of individuals across disability categories who filed employment discrimination claims under Title I of the Americans with Disabilities Act (ADA) with respect to attributes of the employers against whom claims were filed. By examining the organizational context in which these claims derive, we can obtain a gender driven vantage point on how successful the ADA has been in engineering positive social attitudes towards disability.

Disability, Gender, and Employment Discrimination

Females with disabilities are one of the largest and most marginalized groups within our society (Nosek & Hughes, 2003; Jans & Stoddard, 1999) based on their status as females as well as being identified as persons with a disability (Menz, Hansen, Smith, Brown, Ford, & McCrowey, 1989; O'Hara, 2004; Traustadottir, 1990). They outnumber males with disabilities and constitute from 8% to 21% of the population of females in the United States, depending on the data source used (Jans & Stoddard, 1999; Erickson, Lee, & von Schrader, 2010). Although males between the ages of 5 and 15 tend to have higher rates of disability than females; the rate of disability reverses later in age, as females have higher rates of disability between the ages of 16 and 65 (U.S. Census Bureau, 2000).

Females with disabilities are less likely to be employed than males with disabilities and females without disabilities, and those who are employed earn less than both these comparison groups (Hill, 1985; Kregel & Wehman, 1989; Emmett & Alant, 2006; U.S. Department of Labor, 1991; Bowe, 1992; Baldwin, Johnson, & Watson, 1993; U.S. Census Bureau, 1994, 2001; Baldwin and Johnson, 1995; Burke, 1999; Kaye, 2001; Randolph & Andresen, 2004). Among labor market participants, 31.8% of males with severe disabilities and 89.9% of males with moderate disabilities compared to 27.7% of females with severe disabilities and 73.0% of females with moderate disabilities either worked, looked for a job, or were on layoff status during the last four months of 1994 (Hale, Howard, & McNeil, 1998). In 1999, Jans and Stoddard reported that males with a mild disability earned 55% more than females with a mild disability. In the case of a severe disability, males earned 26% more than females. In comparison to females without disabilities, according to Smith (2007), disability is the strongest relative predictor of unemployment with the gender factor of being female the next significantly strong predictor of unemployment across time for the total population.

In addition, gender differences in occupational distributions suggest that the effect of disabilities on levels of labor force participation (i.e., part-time vs. full-time) will also differ between men and women. Acemoglu and Angrist (1998) found that females with disabilities between the ages of 21 and 39 worked fewer weeks from 1992 through 1995 than they did before the ADA was enacted. Males in the age range of 40 to 58 also exhibited a decrease in the number of weeks worked from 1992 to 1993. There was no effect on the employment rates of females with disabilities aged 40 to 58. However, females under 40 experienced a decrease in their levels of employment after the ADA became effective. This decrease has been confirmed by other researchers as well (e.g., DeLeir, 2000. In addition, in a telephone survey (Randolph & Anderson, 2004) of 66,592 respondents from disability surveillance programs and the Behavioral Risk Factor Surveillance System (BRFSS), the association between gender and employment was analyzed using logistic regression analysis. The researchers found that 13.9% of the respondents aged 18-64 had a disability. Those with a disability were older (mean age of 46.1), more likely to be females, and females were much more likely to be unemployed (55.1%) compared to males (45.3%).

Randolph and Anderson also collected information from 560 intellectually disabled adults to ascertain whether gender played an important role in their type of employment (Olson, Andrea, Yovanoff, & Mank, 2000). The findings suggested that women worked in jobs traditionally stereotyped by gender, had fewer hours than did the men, and therefore earned less money. Overrepresentation in low-status, socially isolating, monotonous occupations that are associated with high stress and high turnover is problematic for all individuals with disabilities, but especially for women with disabilities (Baldwin, 1991; Bergmann, 1974; Merz, Bricout, & Koch, 2001; Tomaskovic-Devey et al., 2006). While it is not always known whether this phenomenon is related to gender differences in occupational choice, employer biases, or both, there is evidence that the career options perceived as open to people with disabilities are restricted. Smart (2008) described this phenomenon as occupational role entrapment and identified the "five Fs" (i.e., food, filth, flowers, filing, and folding) as the jobs in which people with disabilities are overrepresented. Bergmann (1974) attributed this phenomenon to occupational segregation (i.e., the unequal distribution of people across occupations resulting from the discriminatory actions of employers). Research based on occupational segregation on the basis of both gender and disability is limited; however, in an investigation of differences in the occupational segregation of women with disabilities in comparison to women without disabilities, Baldwin (1991) found no significant differences between the two groups and concluded that women with disabilities and women without disabilities both experience occupational segregation based on their gender. Related research on occupational segregation based on race and gender is more prevalent and has established that it is a common employer practice in the United States and limits both the type and range of employment opportunities available to women and minorities.

In sum, disability status coupled with being female consistently shows significance in predicting lower employment status and income in comparison to men or non-minorities with disabilities, and occupational segregation on the basis of gender further complicates the employment experience for women with disabilities. These issues are particularly concerning given that females’ participation and earnings in the labor force indicate that more females than males will receive disability benefits in the future (U.S. Department of Health and Human Services, 1993) because, on average, females live about five years longer than males and therefore may have more aging-related disability issues (Altman & Bernstein, 2008).

Employer Characteristics

As previously stated, research is sparse on employer characteristics in relation to discrimination based on both disability and gender. However, researchers have documented that organizational factors contribute to variations in the incidence of charges of race and sex discrimination against employers. Among these factors are size of the employer, extent of formalization of personnel and evaluation procedures, workplace norms regarding equity and civil rights, extent of supervisory control, degree of occupational segregation within the establishment, prevalence of female and minority managers, and the number of women and minorities in the workplace and across hierarchical occupational positions (Hirsh & Kornrich, 2008).

Employer industry is another factor that has been found to influence perceptions and allegations of discrimination based on gender and race, with different norms regarding equality and discrimination present in the labor and non-labor sectors (Hirsh & Kornrich, 2008)). In addition, the size of the employer has been discussed as a factor, with larger employers who are more likely to have formalized anti-discrimination policies and procedures presumed to have fewer discrimination charges based on race and gender. Conversely, norms of informality and personal contact often associated with employers in smaller businesses may dissuade employees from filing claims against them (Hirsch & Kornrich, 2008). Finally, researchers have noted that the culture and working practices of the industry often combine to impede achievement of individuals who do not belong to the dominant worker group within the industry, whereas organizational cultures of employers that are embedded in a civil rights consciousness do the opposite (Dainty & Lingard, 2006).

Methods

Data Source and Study Variables

Using the Equal Employment Opportunity Commission's Integrated Mission Database,[1] we extracted a study-specific dataset which follows the exclusion criteria described in the Armstrong et al. article published elsewhere in this issue (2011). The dataset uses an allegation of discrimination as a unit of measurement, not the individual who filed the allegation. The dataset was divided into male and female groups, with Males comprising 51.497% and a frequency of 206, 014 and females 48.503%, and 194, 035. Employer variables analyzed consist of: Employer Industry, Employer Size, and Employer Region.

Employer Industry is based on the North American Industry Classification System (2002) and includes the following categories: Manufacturing; Health Care and Social Assistance; Public Administration; Educational Services; Retail Trades; Transportation and Warehousing; Professional, Scientific, and Technical Services; Administrative, Support, Waste Management, and Remediation Services; Other Services (except Public Administration); Finance and Insurance; Information, Construction; Accommodation and Food Services; Wholesale Trades; Utilities; Mining; Agriculture, Forestry, Fishing, and Hunting; Arts, Entertainment, and Recreation; Real Estate, Rental, and Leasing; and Management of Companies and Enterprises. Employer Size begins at 15 employees since this variable is based on the definition of employer size as covered under the ADA. It includes the following categories: 15-100 employees; 101-200 employees; 201-500 employees; and 501+ employees. Employer Region is based on the U.S. Census Regions and includes the following categories: Northeast; South; Midwest; West; Foreign and Territories; and Null.

Research Questions

The following research questions guided this study:

- Is there a significant difference in the proportion of male vs. female allegations in relation to Employer Industry?
- Is there a significant difference in the proportion of males vs. female allegations in relation to Employer Size?
- Is there a significant difference in the proportion of males vs. female allegations in relation to Employer Region?

Data Analysis

Non-parametric tests of proportions were conducted for each variable category to compare male and female allegations using Minitab 15. All alpha levels were set at < .001 and variable categories which fell outside of this range were judged to be without significance. Each variable's categories were ranked by z-score for comparison between male and female allegations.

Results

Employer Industry categories with significantly more male than female allegations included: Manufacturing; Construction; Transportation and Utilities; Mining; Wholesale Trades; Public Administration; Administrative, Support, Waste Management, and Remediation Services; Agriculture, Forestry, Fishing, and Hunting; and Other Services Except Public Administration. Employer Industry categories with significantly more female than male allegations included: Health Care and Social Assistance; Finance and Insurance; Educational Services; Information; Retail Trades; and Accommodation and Food Services. Employer Industry categories with no significant difference between the proportion of male and female allegations included: Arts, Entertainment, and Recreation; Real Estate and Rental and Leasing; Professional, Scientific, and Technical Services; and Management of Companies and Enterprises. Employer Industry Results including z-scores are displayed in Table 1.

Table 1. Males vs. Females Ranked by Z-Score

Industry	**Males n**	**Males %**	**Females %**	**Females n**	**Favors Whom?**	**z-Score**	**p Value**
Manufacturing	40,519	19.668	12.975	25,177	MALES	57.62	0.000
Construction	5,873	2.851	0.739	1,434	MALES	50.88	0.000
Transportation and Warehousing	13,032	6.326	3.138	6,089	MALES	47.82	0.000
Utilities	3,955	1.920	0.808	1,568	MALES	30.52	0.000
Mining	2,105	1.022	0.377	732	MALES	24.63	0.000
Wholesale Trades	4,452	2.161	1.372	2,662	MALES	19.01	0.000
Public Administration	19,610	9.519	8.284	16,073	MALES	13.73	0.000
Administrative, Support, Waste Management, and Remediation Services	8,760	4.252	3.591	6,968	MALES	10.78	0.000
Null	37,027	17.973	16.690	32,385	MALES	10.72	0.000
Agriculture, Forestry, Fishing and Hunting	1,186	0.576	0.450	874	MALES	5.55	0.000
Other Services (Except Public Administration)	7,540	3.660	3.433	6,662	MALES	3.87	0.000
Arts, Entertainment, and Recreation	1,419	0.689	0.633	1,228	NO SIG DIFF	2.12	0.029

Real Estate, Rental, & Leasing	1,528	0.742	0.715	1,388	NO SIG DIFF	0.98	0.327
Professional, Scientific and Technical Services	7,300	3.543	3.514	6,818	NO SIG DIFF	0.51	0.611
Mgmt. of Companies and Enterprises	34	0.017	0.017	33	NO SIG DIFF	-0.12	0.902
Accommodation and Food Services	4,143	2.011	2.262	4,389	FEMALES	-5.48	0.000
Retail Trades	15,334	7.443	7.954	15,434	FEMALES	-6.06	0.000
Information	7,199	3.494	4.304	8,351	FEMALES	-13.20	0.000
Educational Services	8,268	4.013	6.365	12,351	FEMALES	-33.46	0.000
Finance and Insurance	5,706	2.770	5.549	10,767	FEMALES	-43.90	0.000
Health Care and Social Assistance	11,024	5.351	16.828	32,652	FEMALES	-116.70	0.000
TOTALS	**206,014**	**100.001%**	**99.998%**	**194,035**			

The Employer Size category of 15-100 Employees was the only variable category which had significantly more male than female allegations. Similarly, the Employer Size category of 501+ Employees was the only variable category which had significantly more female than male allegations. All other variable categories for the variable of Employer Size showed no significant differences in the proportion of male and female allegations: Null; 101-200 Employees; and 201-500 Employees. Employer Size Results are shown in Table 2, including z scores.

Table 2: Distribution of Allegations by Employer Size: Males vs. Females Ranked by Z-Score

Employer Size	**MALES n**	**MALES %**	**FEMALES %**	**FEMALES n**	**Favors Whom?**	**z-Score**	**p Value**
15-100 Employees	65,222	31.659	30.543	59,264	MALES	7.62	0.000
Null	11,392	5.530	5.295	10,275	NO SIG DIFF	3.27	0.001
101-200 Employees	23,311	11.315	11.226	21,782	NO SIG DIFF	0.89	0.371
201-500 Employees	21,777	10.571	10.652	20,668	NO SIG DIFF	-0.83	0.406
501+ Employees	84,312	40.926	42.284	82,046	FEMALES	-8.71	0.000
TOTALS	**206,014**	**100.001%**	**100.000%**	**194,035**			

*p < .001

Two categories for the variable of Employer Region had significantly more male than female allegations: Northeast and Midwest. The only variable category for the variable of Employer Region that had significantly more female than male allegations was Null. Employer Region categories that showed no significant difference between the proportion of male and female allegations included: West; Foreign and Territories; and South. Results for Employer Region, including z-scores, are depicted in Table 3.

Table 3: Distribution of Allegations by Employer U.S. Census Region: Males vs. Females Ranked by Z-Score

Region	**Males n**	**Males %**	**Females %**	**Females n**	**Favors Whom?**	**z-Score**	**p Value**
Northeast	19,988	9.702	8.678	16,838	MALES	11.22	0.000
Midwest	50,080	24.309	23.548	45,691	MALES	5.64	0.000
West	30,589	14.848	14.616	28,360	NO SIG DIFF	2.07	0.038
Foreign and Territories	641	0.311	0.330	640	NO SIG DIFF	-1.05	0.296
South	69,509	33.740	34.000	65,972	NO SIG DIFF	-1.74	0.082
Null	35,207	17.090	18.829	36,534	FEMALES	-14.32	0.000
TOTALS	**206,014**	**100.000%**	**100.001%**	**194,035**			

*p < .001

Discussion

Employer Industry

The distinction between male allegations and female allegations is most notable as it relates to employer industry. Males file discrimination claims in more industries than females (9 vs. 6), and these claims are filed in traditionally male-dominated occupations. This finding is not surprising when interpreted in the context of occupational segregation. Research has established that the range of occupations in which women are employed is much smaller than the range of occupations in which men are employed. Although the U.S. Census recently identified more than 500 occupations, more than 30% of female employees in the United States work in just 10 of these occupations (Silva, 2003). Nor is it surprising that significantly more allegations were filed by females in the industries of accommodation and food services, retail trades, information, educational services, finance and insurance, and health care and social assistance given that women in general are employed at greater rates in these very industries. These findings provide evidence that occupational segregation in "pink-collar" fields is still a common occurrence in the American labor force, and from a career development perspective, could further restrict the range of occupational choices that both females and males with disabilities perceive as open to them.

Employer Size

The finding that proportionally more allegations were filed by males against employers with 15 to 100 employees while proportionally more allegations were filed by females against employers with 500+ employees could be interpreted in several ways. For example, small businesses with fewer than 500 employees represent over 99 percent of all employers (Bruyere, Erikson, & VanLooy, 2006), and perhaps the industries in which the males in our study were more likely to be employed (e.g., manufacturing, construction, transportation and warehousing utilities, etc.) are clustered in small businesses. Conversely, employers with 500+ employees could be more likely to have a diversified workforce with more female employees, and the industries in which proportionally more female allegations are filed (e.g., health care and social assistance, finance and insurance, educational services, information, retail trades, accommodation and food services) are more likely to be clustered in businesses or organizations with a large number of employees. It is also likely that the acceptability of making a claim for women increases with larger organizations that tend to have more well developed ADA policies and procedures, arguably more widespread understanding of such issues across the board within the organization, and perhaps organizational cultures that support such claims.

Employer Region

Proportionately more allegations are filed by males against employers located in the Northeast and Midwest regions of the U.S., with there being no regional pattern for females. On one hand, this finding is not surprising, given that labor unionization has traditionally been more heavily concentrated in these regions (Schmitt & Warner, 2010), and employees may feel more empowered to seek recourse if they have a union to represent them (Budd, 2006). On the other hand, women (with and without disabilities) accounted for 45.2 percent of unionized laborers in 2008, representing a 35.4 percent increase since 1980 (Schmitt & Warner, 2010). If this trend continues, it is projected that by 2020, women will represent the majority of unionized workers. Coupled with this trend, the number of unionized workers in the manufacturing industry is declining while it is increasing in the service industry and the public sector (Schmitt & Warner, 2010). Thus, because these are the very industries in which proportionally more female allegations in comparison to male allegations were filed, we can anticipate that the number of claims filed by women with disabilities will steadily increase in the coming years.

Implications for Rehabilitation Professionals

In examining industry-related differences in the employment discrimination experiences of women and men with disabilities, it becomes apparent that gender-specific considerations in rehabilitation planning process are warranted. As Baldwin and Johnson (1995, p. 575) noted, "Efforts to reduce discrimination against women [and men] with disabilities will not be effective if they are based on the idea that gender is irrelevant." Thus, it is imperative that rehabilitation counselors understand the dual disadvantage of sexism and ableism that exists for women with disabilities (Reed, 1999). In this regard, rehabilitation counselors must be cautious not to steer consumers toward gender-stereotyped occupations. Female consumers, in particular, should be encouraged to pursue careers in fields that have traditionally excluded them on the basis of either or both disability and gender. Non-traditional occupations span all major occupational groups and growth in the economy is projected to occur in many of these occupations (Women's Bureau, 2008). These offer higher entry-level wages and career ladders that provide numerous opportunities for growth and advancement. At present, jobs in information technology are among the fastest growing occupations in the labor market, but women are less likely than men to pursue educational training to prepare them for these occupations (Silva, 2003). Career development interventions that emphasize consideration and pursuit of non-traditional occupational goals should be implemented based on feminist principles such as choice, advocacy, equality and inclusion, and education and mentoring (Reed, 1999).

Along with encouraging consumers to consider non-stereotypical occupations as career goals, self-advocacy training that encompasses consideration of the dual disadvantage of sexism and ableism should be designed to (a) inform individuals with disabilities of differences in male and female reporting patterns in relation to employer characteristics. This may increase awareness and influence understanding and application of the ADA more evenly across the board. Self-advocacy training should also (b) increase consumer understanding of their rights as mandated by other civil rights protections in addition to the ADA, and (c) proactively prepare consumers to anticipate and respond to discriminatory behavior of employers, as employment discrimination against individuals who have traditionally been excluded from gender-stereotyped occupations is well documented.

These findings also have implications for providing technical assistance to employers. Regional disability technical assistance and business centers (DBTACs) should target general training to all employers about the reporting patterns of males and females in relation to industry characteristics. Brief training interventions can be developed that have a twofold purpose: (1) to illuminate current reporting patterns of males and females as they relate to employer characteristics, and (2) to generate ideas on why these patterns prevail by way of brief focus groups. Ideas generated from the second purpose can then be packaged in a palatable manner as part of standard educational efforts about the ADA and other anti-discrimination legislation as per the efforts of DBTACs and other entities that interface routinely with employers around ADA topics. These entities can also develop short issue briefs to disseminate to employers and private rehabilitation professionals that outline these reporting patterns and strategies that employers can implement to decrease the likelihood that their employees will file discrimination charges with the EEOC.

Future Research

In considering future research directions, the limitations of the current study should be noted. First, we only examined allegations of discrimination in relation to employer characteristics and not the EEOC's legal outcome or resolution of those allegations. Therefore, additional research is needed to examine the role of gender and employer characteristics in predicting outcomes. A limitation of the data set used is that specific occupations within industry are not designated. Thus, there is no way to determine if differences between men and women with disabilities occur in relation to the status of jobs they occupy. An investigation of specific jobs held by charging parties in relation to gender is thus warranted. Future research is also needed to examine the interaction effects of employer characteristics with charging party characteristics on discrimination allegations. Regardless of whether the industry differences found in this study reflect cross-industry worker characteristics or actual gender by disability employer biases, there is a need to examine in greater detail how industry type influences both the rate and type of allegations filed with the EEOC and employer responses to the on-the-job needs of male and female workers with disabilities. Finally, there is a need to design, implement, and evaluate rehabilitation interventions that prepare women with disabilities for employment in non-traditional, high growth occupations where they will earn higher wages. An examination of strategies that have been implemented to increase labor force participation of females in science and engineering fields could help to inform the design of these interventions.

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Endnote

[1] The EEOC is the agency responsible for enforcing Title I of the ADA, which prohibits employment discrimination against people with disabilities. The EEOC maintains the Integrated Mission System (IMS), which is used to track the filing, investigation, and resolution of all allegations of workplace discrimination under federal statutes. Through an Interagency Personnel Agreement between the EEOC and Virginia Commonwealth University, study researchers have access to a de-identified version of the database. More information can be found on the EEOC-ISM website, http://www.eeoc.gov/eeoc/foia/ims-pia.cfm

Book and Media Reviews

Book Review

Title: *Blind Man's Bluff*
Author: Geri Taeckens
Publisher: Accessibilities, Sault Ste Marie, MI
ISBN: 978-0-9774546-1-7
Soft Cover: $19.95, 445 pages
Reviewer: Beth Omansky

Organized across specific points in time from 1957-1993 -- from early childhood through adolescence, college years, and young adulthood, *Blind Man's Bluff* chronicles Geri Taeckens' journey into blindness. Her first memory of an encounter with a blind person defined her life in many ways as it taught her how society thinks about blind people as incapable objects of pity, charity, helplessness, and hopelessness.

After buying two pencils from a blind vendor outside their local five-and-dime store, Taeckens' father explained:

> I know we don't really need his pencils, Geri, but—it's just that—I mean, blind people, they can't work, you know? They aren't able to really take care of themselves, so it's up to people like you and me to help them out when we can. Understand? …"[w]hat I mean is, the man would feel so bad about not working for his money that he maybe wouldn't want to live at all (pp. 9-10).

Taeckens uses this seminal recollection to frame her fall into substance abuse, high risk-taking behavior, and attempted suicide as the strain of trying to "pass" as "normal" became too much for her. She chose the book title from her ironic experience of being superior at the game of "Blind Man's Bluff" despite (or maybe because) her failing vision caused her to lag behind or drop out altogether of tag, kickball, jump rope, and hopscotch. She "appreciated the level playing field" (p. 50) of Blind Man's Bluff in which one child puts on a blindfold, the other players hide, and the blindfolded child seeks and "tags" them.

Eventually, she was transferred from "normal" school to a school for the blind where students were subjected to visits from charity representatives and were put on display in "feel-good" stories at Christmastime. Taeckens recalls the atmosphere among the children "moved from enthusiastic griping to oppressive defeat" (p. 68).

Taeckens successfully incorporates cultural elements indicative of each decade and how some influenced her behavior, such as falling into a "hippie freak" drug-taking scene, and her narrative voice changes nimbly and appropriately through each life stage.

I would have enjoyed this self-published book more if it were edited down by 150 pages. Dialogues between characters seemed awkwardly invented, and multi-page length descriptions of minute detail ran from tedious to florid. As one among numerous examples, she describes a kiss, “like a parched desert traveler, thirsty from days of drought, I began to drink from his moist lush lips” (p. 365). Also, many passages of dialogue and description were too lengthy, and failed to move the story forward. Perhaps if the book were marketed as a “fictionalized memoir” rather than an “autobiographical account,” my expectation would have been different.

My favorite message in this book is Taeckens’ observation that advocacy work in the disability community failed to provide a safe place for her to express her feelings about the prospect of encroaching blindness. This insight points up the need for members of the organized disability community to drop the “disability is cool” stance that is required of them to do successful advocacy in the nondisabled world, and support each other’s expression of their phenomenological and emotional experiences.

This memoir is a story of a woman with a wealth of inner strength and resolve who sometimes took the easy road, who discovered ‘”easy” was ineffective and self-defeating, who struggled to find self-acceptance, self-love, and a successful social work career. Despite the book’s failings, I appreciate the author’s candor, self-knowledge, and inspirational intent. This memoir could be used in disability studies to analyze and critique stories rooted in the medical model of disability, as a book that fails to challenge the concept of “normal.” However, I would not consider it a disability studies book per se as evidenced not only by its content but by the author’s marketing on the back cover, “traveling under the cloud of impending tragedy…threat of impending loss…battling an unknown darkness.”

Beth Omansky, Ph.D., is an activist and disability studies scholar in Portland, Oregon. Her book, *Borderlands of Blindness,* will be published by Lynne Rienner Publishers in April, 2011.

Book Review

Book Title: *The Professional Helper: The Fundamentals of Being a Helping Professional*
Author: Bryan, Willie V.
Publisher: Charles C. Thomas Ltd., Springfield, IL, 2009
Cost: Hardback, $51.95; Paper, $31.95; 220 pages
ISBN: 978-0-398-07889-8 (hardback); 978-0-398-07890-4 (paperback)
Cost: Hardback, $51.95; Paper, $31.95; 220 pages
Reviewer: Mari Ono

Willie V. Bryan reflects in the preface of his book, “…every human being needs help, and every human has the capacity to be a helper” (p. vii). With this premise in mind, the author casts a wide net in his effort to capture and define a range of helping roles as well as the qualities, characteristics, and skills requisite to be an effective helper. The book is divided into 10 short chapters, nine of these concluding with review questions, “mental exercises,” references, and suggested readings.

The chapters include introducing the author’s list of characteristics of an effective helper, an overview of processes within helping relationships, and touching upon issues relevant to human behavior, cultural differences, disabilities, resources, and advocacy. The last chapters focus on brief descriptions of classic counseling models for individual and family practice. Generally, it appears the author's material is gleaned from standard social work and counseling models. For example, the processes of the helping relationship reflect the Generalist Intervention Model commonly used in social work. This model consists of engagement, assessment, planning/goal setting, intervention, evaluation, termination and follow-up (Kirst-Ashman & Hull, 2006). Within each of these areas, the writer provides his thoughts on how the helping professional can collaborate and assist the helpee.

Interestingly, this book is written in the first person with scant citations or references. This leads to an impression that the material is not intended as a reference tool but more as the author's personal collection of helpful tips and reflections. The chapter on "Understanding Disabilities" reads somewhat like a lecture session. The author broadly sweeps through definitions, prevalence, historical and current perspectives, policies regarding those with disabilities, advocacy needs, and counseling tips. While these topic areas could be considered fundamental in building a base of knowledge for those considering a helping profession, the chapter's content appears fairly sketchy and at times, dogmatic.

The brief subsection that offers strategies to assist persons with disabilities is embedded in a list of "things not to do." While these tips can be useful in checking one's assumptions and communications, it would have been beneficial to organize a basic framework for positive and effective ways to dialogue and formulate a plan of assistance with the client. Instead, under the subheading of "Additional Tips for Effectively Assisting Persons with Disabilities" (pp. 119-120), the author essentially provides three quoted paragraphs from different authors to address assessment of individuals with disabilities; needs of families of children with disabilities; and identifying goals of helping professionals. These paragraphs could have better served as supportive excerpts within a fuller discussion and outline for interviewing and developing an effective assessment plan. Unfortunately, they are left as detached bits and pieces of information.

The following chapter on "Understanding Resources" was equally broad and unevenly written. While the author begins promisingly with introducing a strengths-based perspective in determining appropriate resources for a client, the following material soon fragments into a random list of resources interjected with personal warnings to the helper. The author further offers his perspective on possible resources for the elderly, persons with disabilities and their families, women, and ethnic/racial minorities in this piecemeal fashion.

In this chapter, the author's spare, unreferenced segment on women begins with global gender inequality and then veers quickly into physical and mental abuse of women in the U.S., and ends with women with disabilities who are victims of abuse. The simplistic advice the author offers is for the helping professional to be familiar on where and how to access resources that can "protect women from abuse" (p. 141). Moreover, the author describes why many women may choose not to seek help or accept services but does not offer guidance on what the helping professional should consider in these circumstances. The end result is an awkward discourse with rough descriptions of needs and issues within each population and within a discussion of resources. The overall content provides little in the way of articulating an effective paradigm for identifying and prioritizing resources with and on behalf of the client.

Unfortunately, I found his suggestions far more confusing than clarifying from an instructor perspective. As a guideline for students in social work, there is an emphasis placed upon differentiating personal opinion from validated evidence and practice. Perhaps for these reasons, the utility of this book may be insufficient for a classroom setting. While it presents snippets of useful information and history, the parts appear disjointed and too often, unsubstantiated.

Mari Ono, MSW, LSW, Faculty, Coordinator of Student Services, Myron B. Thompson School of Social Work, University of Hawaiʻi at Mānoa. Her professional interests includes cross cultural practice in mental health and substance abuse recovery.

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Disability Studies Dissertation Abstracts

Editor's Note: The information for this section of RDS is provided by Jonathon Erlen of the University of Pittsburgh. A full list of disability-related dissertation abstracts may be found at http://www.hsls.pitt.edu/guides/histmed/dissertations/

National bodies/embodied nations: Reading disability in Chicana/o, Mexican and Spanish cultural production
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