Original Research

Attitudes of Senior Psychiatry Residents Toward Persons with Intellectual Disabilities

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Objectives: This study examined the attitudes of senior residents in psychiatry toward persons with intellectual disabilities. Examining residents' attitudes will highlight areas of training that could be enhanced to better prepare psychiatrists to work with individuals with intellectual disabilities.

Method: A questionnaire was distributed to senior psychiatry residents at a Canada-wide preparatory session for the Royal College of Physicians and Surgeons of Canada. Included in the questionnaire was the Community Living Attitudes Scale Mental Retardation - Short Form (CLAS) as well as demographic items (for example, age, sex, and marital status) and questions about training in intellectual disabilities. Scores on the 4 CLAS subscales (Empowerment, Similarity, Exclusion, and Sheltering) are reported, and analyses of variance were performed to identify factors associated with each subscale score. The residents' scores are compared with those obtained in surveys of other groups.

Results: Fifty-eight senior residents from across Canada completed the questionnaire. The residents' scores favoured Empowerment and Similarity over Exclusion and Sheltering. Men and women responded differently. Training in intellectual disabilities during residency only appeared to influence the Similarity subscale scores.

Conclusion: Senior psychiatry residents hold attitudes toward persons with intellectual disabilities that are not entirely consistent with the community living philosophic paradigm. More research is needed to uncover how attitudes of psychiatrists develop, as well as how training can influence attitudes.

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Clinical Implications

- The study provides a basis for examining current and future training of psychiatry residents in the field of intellectual disabilities.
- Results suggest that residents' future clinical practice may benefit from exposure to individuals with intellectual disabilities who reside in the community and have no current mental health or behavioural challenges.

Limitations

- Results may not be generalizable to all residents, given the moderate response rate.
- Residents were given limited opportunities to respond to open-ended questions, making it difficult to determine the extent to which attitudes may impact on practice.
- The measure of exposure to intellectual disabilities during training was limited; it did not extend to the context and quality of the interaction nor to the severity of disability and nature of mental health problems seen in the individuals with whom the residents had contact.

Key Words: *medical education, intellectual disabilities, mental retardation, developmental disabilities, psychiatry residents, attitudes, community inclusion, Community Living Attitudes Scale Mental Retardation (CLAS)*

Individuals with intellectual disabilities have long been marginalized (Note 1). Until the mid-1980s, they were commonly institutionalized, particularly if they suffered from a psychiatric disorder. Viewed as the "Cinderella of psychiatry" (1), the field of intellectual disabilities has been largely overlooked by the discipline over the past several decades, particularly in North America. With the exception of a few specialists who have devoted their careers to enhancing the mental health and quality of life of individuals with an intellectual disability and a concurrent psychiatric disorder, psychiatrists in Canada express little interest in working with this group of patients. Further, Canadian-trained psychiatrists receive minimal training in this area (2–4). This is in contrast to the UK, where there has been a long tradition of training specialist psychiatrists in intellectual disabilities as well as more comprehensive articulation of mental health needs of persons with intellectual disabilities (5).

Up to 60% of individuals with intellectual disabilities will experience mental health problems (6,7) covering the full range of psychiatric disorders (8–10). Since deinstitutionalization and community integration have resulted in increasing reliance on generic mental health services (10,11), it is imperative that psychiatrists and other physicians be prepared to assess, treat, and support this client group. Many more psychiatrists will need to have a proficiency and comfort level in treating this growing community-based patient group. To work effectively with persons with dual diagnosis (Note 2), whether in private practice or on multidisciplinary teams, psychiatrists and other physicians will need to hold beliefs and values consistent with the expectations of community inclusion held by their patients and their patients' caregivers.

Societal attitudes toward intellectual disabilities have shifted dramatically over the past 2 centuries. Throughout history, society's perceptions of individuals with intellectual disabilities have evolved from a view that they were subhuman organisms, a menace to society, objects of pity, burdens of charity, holy innocents, or eternal children to an understanding that they are developing persons (12). These attitudes have been reflected in the approaches to treatment of this population throughout history as exemplified by the setting in which individuals with intellectual disabilities were cared for: from asylums to hospitals to specialized institutions to the community (13,14). Over the past 30 years, philosophies of normalization (15) and valorization of the innate worth of individuals (16) have contributed to more positive societal attitudes toward persons with intellectual disabilities.

Today, a philosophy of community inclusion guides policies and services for individuals with intellectual disabilities. This perspective advocates the empowerment of persons with intellectual disabilities to make life decisions, denounces their exclusion from community life, and opposes unduly sheltering them from harm.

The extent to which the psychiatrists of the future are embracing this philosophy is unknown. Since negative attitudes toward certain patient groups have been found to influence choice of specialization (10) and adversely affect the therapeutic relationship (17), understanding how well we are preparing psychiatrists to work with individuals with intellectual disabilities requires consideration of trainees' attitudes.

Internationally, undergraduate and postgraduate medical education in intellectual disabilities has been generally lacking in teaching important information and values to future physicians (18,19). Studies by Ash (20), McCreary (21,22) Leichner (23,24), Lunsky and Bradley (4), and recent work by Burge and colleagues (25) suggest that, in Canada, medical professionals are not receiving adequate training in intellectual disabilities. Specifically, Burge and others report that 68% of the senior psychiatry residents surveyed indicate that their own response and attitudes toward intellectual disabilities were not explored or were inadequately addressed during their residency training (25). Leichner noted a significant lack of interest in intellectual disabilities as a subspecialty among psychiatry residents (23,24).

In a study of university or college students, Macdonald and MacIntyre found that education about disabilities could lead to an improved attitude towards persons with intellectual disabilities (26). Haslam and Milner reported that medical practitioners with training in intellectual disabilities were more active in the treatment of these patients than those practitioners who did not have such training (13). Conversely, they found that older physicians and those reporting more years in practice were less supportive in treatment of persons with intellectual disabilities; for example, they were more likely to recommend withholding lifesaving surgery for a child with Down syndrome.

Over the past decade, research on attitudes toward intellectual disabilities has focused on assessing the views of various groups related to issues that are of importance to individuals with intellectual disabilities themselves. Attitudinal scales have been developed to tap into aspects of the community living philosophy, including integration–segregation, social distance, private rights, subtle derogatory beliefs (27,28), empowerment, exclusion, sheltering, and similarity (29,30).

This study examined the attitudes of senior residents in psychiatry across Canada toward persons with intellectual disabilities in the context of community inclusion. Insight into residents' attitudes will serve to highlight areas of training and awareness that could be enhanced to better prepare psychiatrists and other medical professionals to support and interact with individuals with intellectual disabilities.

Methods

Procedure

A questionnaire was distributed and self-administered at the annual Canada-wide preparatory session for the certification examination of the Royal College of Physicians and Surgeons of Canada. This elective preparatory session is in the form of a written examination and is sponsored by the Association of Directors of Postgraduate Education in Psychiatry and Elected Residents, Canada (COPE). Residents from the 16 psychiatric training programs across Canada participate. This occasion has been traditionally used as a venue to conduct national surveys requiring resident involvement. Residents participate in such surveys on a voluntary and anonymous basis.

Residents were given the option of completing either a French- or English-language version of a questionnaire that took approximately 25 minutes to complete. The questionnaire included the Community Living Attitudes Scale Mental Retardation - Short Form (CLAS) (31). The CLAS consists of 17 statements that comprise 4 discrete subscales. Each statement is scored by the respondent using a 6-point Likert-like scale. Subscale scores each indicate the respondent's views on items representative of the community inclusion philosophic paradigm. The subscales measure Empowerment (attitudes toward self-advocacy and empowerment), Exclusion (the desire of the respondent to exclude persons with intellectual disabilities from community life), Sheltering (the extent to which the respondent believes that persons with intellectual disabilities need to be sheltered or protected), and Similarity (the perceived similarity of persons with intellectual disabilities to oneself) (29).

Demographic items (for example, age, sex, and marital status), as well as questions related to exposure to intellectual disabilities and medical training in the field of intellectual disabilities, were also included in the questionnaire. Pearson correlation was used to determine the association between the residents' age and their scores on the 4 CLAS subscales. Analysis of variance (ANOVA) was used to study the relationship between categorical variables (other demographic items and measures of exposure to persons with intellectual disabilities) and the residents' scores on the 4 CLAS subscales.

The attitudes of residents as measured by the 4 CLAS subscale scores were compared with the attitudes of 2 groups in the US previously studied by the third author. One of the comparative samples consisted of students and community members. The other sample comprised individuals working in the field of intellectual disabilities. Differences in the residents' mean subscale scores and those of each of the 2 samples were analyzed using *t*-tests. Differences significant at the $P < 0.05$ level are discussed.

Results

Survey Respondents

Eighty-nine senior residents (Note 3) from 14 Canadian psychiatric training programs (out of the total national complement of 208 senior residents, or 42.8%) participated in the COPE session and were invited to participate in our survey. Of these, 58 agreed to complete our survey and returned usable questionnaires (65.2%). This represents 28% of the national complement of senior residents. The respondents ranged in age from 27 to 50 years (mean 33.92 years, SD 5.79) and just over one-half were men. Most were married, and approximately one-third had children. Over 80% received their undergraduate medical training in Canada. The respondents were distributed across the following 4 regions in Canada in proportions representative of the distribution of training positions available across the regions: Atlantic, 10%; Quebec, 22%; Ontario, 45%; and Western, 23%.

Thirteen respondents (22.4%) indicated that they had an immediate or extended family member with an intellectual disability. A slightly higher number (31.0%) reported having had a person with an intellectual disability as their neighbour. Some respondents had volunteered for a person with an intellectual disability or had held paid positions working with persons with intellectual disabilities before their residency training (13.8%). Fourteen respondents (24.1%) indicated that they had never met a person with an intellectual disability outside of their medical training.

Respondents were asked several questions about their exposure to the field of intellectual disabilities during their undergraduate medical training and their psychiatric residency training. Close to one-half (48.3%) reported that they had seen persons with intellectual disabilities as patients in their undergraduate medical school training. Slightly fewer (46.5%) indicated that they had received specific teaching in intellectual disabilities during that training. Notably, more respondents (86.2%) indicated that they had had specific training in intellectual disabilities during their psychiatric residency program. A detailed report of residents' views of their training is provided elsewhere (25).

Residents' Attitudes

As measured by the CLAS, the respondents' views toward persons with intellectual disabilities can be characterized as favouring Empowerment (attitudes toward self-advocacy and empowerment) and Similarity (the perceived similarity of persons with intellectual disabilities to oneself) over Exclusion (the desire of the respondent to exclude persons with intellectual disabilities from community life) and Sheltering

Table 1 Community Living Attitudes Scale Mental Retardation - Short Form (CLAS): items and subscale means and SDs (*n* = 58 senior psychiatry residents)

Subscales and items	Mean (SD)
Empowerment	4.32 (0.65)
1. People with mental retardation should not be allowed to marry and have children (R).	3.91 (1.22)
2. A person would be foolish to marry a person with mental retardation (R).	3.86 (1.21)
3. People with mental retardation can plan meetings and conferences without assistance from others.	3.48 (1.26)
4. People with mental retardation can be trusted to handle money responsibly.	4.05 (0.85)
5. The opinion of a person with mental retardation should carry more weight than those of family members and professionals in decisions affecting that person.	4.26 (0.98)
Exclusion	1.75 (0.71)
7. Increased spending on programs for people with mental retardation is a waste of tax dollars.	1.64 (0.83)
8. Homes and services for people with mental retardation downgrade the neighborhoods they are in.	1.74 (1.12)
9. People with mental retardation are a burden to society.	2.04 (1.19)
10. Homes and services for people with mental retardation should be kept out of residential neighborhoods.	1.59 (0.75)
Sheltering	3.63 (0.75)
6. Sheltered workshops for people with mental retardation are essential.	5.05 (0.98)
11. People with mental retardation need someone to plan their activities for them.	3.52 (0.96)
16. People with mental retardation should live in sheltered facilities because of the danger of life in the community.	2.43 (1.24)
17. People with mental retardation usually should be in group homes or other facilities where they can have the help and support of staff.	3.52 (1.16)
Similarity	5.30 (0.61)
12. People with mental retardation do not need to make choices about the things they will do each day (R).	4.17 (0.98)
13. People with mental retardation can be productive members of society.	5.17 (0.80)
14. People with mental retardation have goals for their lives like other people.	5.29 (0.94)
15. People with mental retardation can have close personal relationships just like everyone else.	5.57 (0.73)

R = Items reverse-scored to reflect their scale loadings. Items are scored from 1 (strongly disagree) to 6 (strongly agree). Subscales are scored by taking the mean of the responses to the items, thus also resulting in a range of scores from 1 to 6.

(the extent to which the respondent believes that persons with intellectual disabilities need to be sheltered or protected). Table 1 provides the mean and standard deviations for the CLAS item and subscale scores.

Table 2 highlights the significant ANOVA outcomes for each of the CLAS subscales when tested against demographic and exposure variables. The residents' age did not correlate with any of the four CLAS subscale scores. Differences in responses between the sexes were noted, however. Women had higher scores on the Similarity and Sheltering subscales, while men had higher scores on the Exclusion subscale. None of the variables measuring exposure to individuals with intellectual disabilities outside of professional training (that is, family member, volunteer or paid position, and any contact) were associated with the differences in scores on the CLAS subscales. Formal training in intellectual disabilities or contact with individuals with intellectual disabilities during the undergraduate medical program had no impact on any of the 4 CLAS subscale scores. However, those who reported having had specific training in intellectual disabilities during their psychiatric residency program had significantly higher scores on the CLAS Similarity subscale.

Attitudes of Residents Compared With Those of Other Groups

The first comparative sample consisted of 200 students and community members surveyed by Henry and others (29) during development of the CLAS. Ages of participants ranged from 16 to 69 years, with a median of 26 years. The demographic characteristics of this sample were as follows: 51.1% were women; 37.3% reported their occupation as "student"; 31.7%, as "business or government"; 11.9%, as "education or human services"; 7.1%, as "laborers or trades people"; and 20.4% reported having a relative or friend with an intellectual disability.

The second comparison sample contained data from 78 managers and professionals who had worked in the field of intellectual disabilities for an average of 7.8 years (30). Over two-thirds of this sample were female (77.8%). The median

Table 2 Demographic and exposure variables significantly associated with CLAS subscale scores among senior psychiatry residents (*n* = 58): mean (SD) and ANOVA outcomes

	CLAS subscale scores			
	Similarity	Sheltering	Exclusion	Empowerment
Sex[a]				
Men (*n* = 27), mean (SD)	5.13 (0.69)	3.41 (0.73)	1.97 (0.79)	4.60 (0.74)
Women (*n* = 25), mean (SD)	5.49 (0.46)	3.87 (0.74)	1.52 (0.59)	4.35 (0.63)
F value (*P*), df = 51	4.79 (0.03)	5.14 (0.03)	5.36 (0.03)	1.70 (0.20)
Received specific training in ID during psychiatry residency training				
Yes (*n* = 50), mean (SD)	5.38 (0.58)	3.67 (0.76)	1.79 (0.72)	4.58 (0.70)
No (*n* = 8), mean (SD)	4.84 (0.61)	3.41 (0.93)	1.53 (0.66)	4.31 (0.61)
F value (P), df = 57	5.73 (0.02)	0.81 (0.37)	0.88 (0.35)	1.00 (0.32)

[a]Sex not specified by 6 respondents
ANOVA = analysis of variance; ID = intellectual disability.

Table 3 CLAS subscale scores: a comparison of Canadian psychiatry residents with 2 other sample groups

	CLAS subscale scores, mean (SD)			
Sample group	Similarity[a]	Sheltering[a,b]	Exclusion[b]	Empowerment[a,b]
Psychiatry residents (*n* = 58)	5.30 (0.61)	3.63 (0.75)	1.75 (0.71)	4.32 (0.65)
Community members (*n* = 200)	4.90 (0.65)	3.26 (0.76)	1.87 (0.66)	3.91 (0.78)
Intellectual disabilities managers and professionals (*n* = 78)	5.29 (0.80)	2.92 (0.84)	1.35 (0.60)	4.71 (0.89)

[a]Significant difference ($P < 0.05$) between psychiatry residents and community members
[b]Significant difference ($P < 0.05$) between psychiatry residents and intellectual disabilities managers and professionals

age of the sample was 37 years. Over 60% of the sample had college, graduate, or professional degrees. This sample consisted predominantly of individuals of non-Hispanic white ethnicity (85.2%); 8.0% were African-American, and 3.4% identified themselves as Hispanic.

Table 3 reports CLAS subscale means for the 2-sample comparisons as well as for the psychiatry residents. The residents' mean scores differed from those of the community sample on the Empowerment, Sheltering, and Similarity subscales. Residents had higher mean scores than the community sample on the Empowerment (mean 4.32 vs 3.91, $t = 3.64$, df 256, $P < 0.01$) and Similarity (mean 5.30 vs 4.90, $t = 4.17$, df 256, $P < 0.01$) subscales. The residents differed from the intellectual disabilities (ID) managers and professionals on the Empowerment, Exclusion, and Sheltering subscales. The residents had lower Empowerment subscale scores than did the ID managers and professionals (mean 4.32 vs 4.71, $t = 2.80$, df 134, $P < 0.01$) and higher Sheltering subscale scores than did the ID managers and professionals (mean 3.63 vs 2.92, $t = 5.77$, df 134, $P < 0.01$). Residents had a significantly higher mean score on the Exclusion subscale, compared with ID managers and professionals (mean 1.75 vs 1.35, $t = 2.32$, df 134, $P < 0.05$). The Similarity subscale mean for the residents was comparable with that of the sample of ID managers and professionals (mean 5.29).

Discussion

To our knowledge, this is the first investigation of attitudes toward persons with intellectual disabilities among senior psychiatry residents. This study found patterns of demographic difference, differences by discipline, and training differences in the 4 dimensions tapped by the CLAS.

Female residents had higher scores on the Similarity (the perceived similarity of persons with intellectual disabilities to oneself) and Sheltering (the extent to which the respondent believes that persons with intellectual disabilities need to be sheltered or protected) subscales, whereas male residents had higher scores on the Exclusion (the desire of the respondent to

exclude persons with intellectual disabilities from community life) subscale. These sex differences parallel those of previous studies of sex and disability attitudes (32,33). This pattern of findings may be consistent with literature that suggests women are more oriented toward relationships, interdependence, and empathy than are men (34,35). Such a difference in empathy could easily explain the sex difference in Similarity attitudes found in this sample. It is possible that stronger Sheltering attitudes and weaker Exclusion attitudes among women reflect this same sex difference in interpersonal orientation.

Comparisons of the psychiatry residents with community (students and community members) and staff (managers and professionals working in intellectual disabilities) samples showed that the residents had higher mean scores than the community sample on the Empowerment and Similarity subscales. This difference is consistent with reports of differences between staff in community agencies and the general public (30). Compared with ID managers and professionals, the residents had lower Empowerment subscale scores and higher Sheltering subscale scores. Residents also had a higher Exclusion subscale scores than did ID managers and professionals.

The residents' high scores on the Sheltering subscale, relative to both community members and ID managers and professionals, may reflect a bias inherent in their training. Their recent exposure to patients with intellectual disabilities is most likely to have involved individuals with severe behaviour or psychiatric disorders. While residents are expected to have such exposure and training to assist these individuals, it should not come at the expense or exclusion of knowledge concerning the many strengths, adaptive abilities, and successes in independent living enjoyed by many individuals with intellectual disabilities. The above finding may point to the need to provide trainees with an opportunity to have contact with individuals with intellectual disabilities who do not have comorbid mental illnesses and with the opportunity to see persons with intellectual disabilities in their usual living and work environments. However, in this study, it is impossible to differentiate the effects of exposure to intellectual disabilities during training from those of differences in discipline (that is, community members, students, managers, and psychiatry residents), because only 8/58 residents did not receive training in intellectual disabilities.

Specific training in intellectual disabilities during residency was associated with differences on the Similarity subscale only. Residents who had received the training expressed greater endorsement of the common humanity of persons with intellectual disabilities than did those who had not received such training. This finding is encouraging regarding the potential effectiveness of training for psychiatrists in intellectual disabilities. Recent evidence from a longitudinal study of disability attitudes (36) shows that Similarity attitudes predict change in Empowerment, Exclusion, and Sheltering attitudes at a later time. If training in intellectual disabilities can change the Similarity attitudes of psychiatry residents in a positive direction, then change in other attitudes may be likely to follow.

This study did not find a significant association between exposure to intellectual disabilities outside of professional training (for example, in one's extended family or neighbourhood) and the residents' scores on the CLAS subscales. Nevertheless, differences between the residents' scores on the Exclusion and Sheltering subscales and those of the ID managers and professionals may indicate that direct contact and specific training related to the philosophy of inclusion can influence attitudes related to these values.

Limitations

Several considerations recommend some caution in interpreting these findings. First, the CLAS has not previously been used with a Canadian sample. Hence, the comparison groups available were limited to American samples. Differences observed between the residents' attitudes and those of the comparative samples may reflect differences in the experience of working and growing up in different cultures, where philosophies of care for persons with intellectual disabilities are played out in different ways, as is the case for the US and Canada.

Second, the residents are substantially older than the sample of community members. The experience of the younger community sample has likely been different from this group in terms of exposure to integration policies. Younger cohorts are more likely to have grown up with individuals with intellectual disabilities as classmates and neighbours.

Third, the ID managers and professionals sample included proportionately more women than did the sample of residents. Since sex was significantly associated with the residents' scores on 3 of the subscales, one must question whether sex accounts for some of the differences. In particular, since male residents had significantly higher Exclusion scores, it is possible that the apparent difference between residents and ID managers and professionals on this subscale results from the differences in the representation by sex in each sample.

Finally, this study is limited in not being able to compare the attitudes of residents who received training in intellectual disabilities with those of residents who did not because of the small number in the "no training in intellectual disabilities group" (8/58 residents). In the absence of this statistical power, real differences on subscales other than Similarity may have been obscured. In any case, the data collected on training were likely not sensitive enough to identify key qualities of the exposure to intellectual disabilities (for example,

mentorship and quality of contact) during training, qualities that are likely to be significant predictors of career choice and positive attitudes in this area of practice (37).

Conclusion

Psychiatry residents nearing the end of their training appear to hold attitudes about intellectual disabilities that differ in some respects from the values and attitudes inherent to the community inclusion philosophy. This philosophy guides current policies and services in the field of intellectual disabilities and in particular advocates for the empowerment of persons with intellectual disabilities to make life decisions, denounces their exclusion from community life, and opposes unduly sheltering them from harm. Psychiatrists can be expected to encounter this philosophy as the dominant perspective embraced by advocates and professionals in the field of intellectual disabilities.

The key concern from this study relates to the residents' relatively high endorsement of Sheltering. Attitudes that favour sheltering persons with intellectual disabilities may bias psychiatrists toward provision of mental health services to individuals with intellectual disabilities in institutional settings rather than in the community. However, as noted previously, the extent to which this attitude may reflect a bias in training is unknown. Residents who received training in intellectual disabilities were likely exposed to persons with severe behavioural or psychiatric disorders who often require complex and intensive supports. The residents may not have experienced the range of community options and supports available to persons without mental disorders or with lesser severity of psychiatric and behavioural disorder.

Psychiatrists have a duty to protect individuals whose capacities for self-direction may be impaired by a mental health disorder. On the other hand, they are increasingly required and encouraged to facilitate, and not to interfere with, self-direction by persons with intellectual disabilities. Tensions may arise when the philosophy of inclusion is perceived as resulting in a neglect of the physical or mental health needs of persons with intellectual disabilities who have variable capacities to make autonomous decisions about their care (38). This conflict is not unlike the tension between self-direction and safety that is debated in residential psychiatric care for children (39). Endorsement of both the Empowerment and Sheltering subscales of the CLAS may reflect such a predicament, sometimes referred to as the "dilemma of difference" (40). Further study of attitudes toward persons with intellectual disabilities may assist in understanding this tension.

The current data provide a baseline for an assessment of changes in attitudes among Canadian psychiatry residents over time and a baseline against which to compare other groups that may be studied in the future. More research is also needed to identify how attitudes of psychiatrists and other health care providers develop and specifically how training can influence such attitudes.

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Notes

1. Intellectual dsiabilities are also referred to as developmental disabilities (Canada), learning disabilities (UK), and mental retardation (DSM-IV).
2. Dual diagnosis generally refers to intellectual disability with comorbid psychiatric disorder.
3. Senior residents are in the final 2 years of a 5-year postgraduate training program in psychiatry.

References

1. Potter HW. Mental retardation: the Cinderella of psychiatry. Psychiatr Q 1965;38:537–49.
2. McCreary BD. Developmental disabilities: still the Cinderella of Canadian psychiatry. Plenary address given at the State of the HART: Habilitative Achievements in Research and Treatment for Mental Health in Developmental Disabilities. Vancouver: University of British Columbia; 2002.
3. Leverette J, Leichner P, Wright L, Neilsen J. Community intervention: contributions to training and practice from child psychiatry. Proceedings of the Ontario Psychiatric Association 76th Annual Meeting; January 14, 1996.
4. Lunsky Y, Bradley EA. Developmental disability training in Canadian psychiatry residency programs. Can J Psychiatry 2001;46:63–7.
5. Day K. Professional training in the psychiatry of mental retardation in the UK. In: Bouras N, editor. Psychiatric and behavioural disorders in developmental disabilities and mental retardation. Cambridge (UK): Cambridge University Press; 1999. p 439–57.
6. Borthwick-Duffy SA. Epidemiology and prevalence of psychopathology in people with mental retardation. J Consult Clin Psychol 1994;62:17–27.
7. Yu D, Atkinson L. Developmental disability with and without psychiatric involvement: prevalence estimates for Ontario. Journal on Developmental Disabilities 1993;2:92–9.
8. Addington D, Addington JM, Ens I. Mentally retarded patients on general hospital psychiatric units. Can J Psychiatry 1993;38:134–6.
9. Burge P, Ouellette-Kuntz H, Saeed H, McCreary B, Paquette D, Sim F. Acute psychiatric inpatient care for people with a dual diagnosis: patient profiles and lengths of stay. Can J Psychiatry 2002:47:243–9.
10. Saeed H, Ouellette-Kuntz H, Stuart H, Burge P. Length of stay for psychiatric inpatient services: a comparison of admissions of people with and without developmental disabilities. Journal of Behavioural Health Services and Research. Forthcoming.
11. Kon Y, Bouras N. Psychiatric follow-up and health services utilization of persons with learning disabilities. British Journal of Developmental Disabilities 1997;43:20–6.
12. National Institute on Mental Retardation. Orientation manual on mental retardation. Available from the Roeher Institute. Downsview (ON): York University; 1981.
13. Halsam R, Milner R. The physician and Down syndrome: are attitudes changing. J Child Neurol 1992;7:304–10.
14. Rees L, Spreen O, Harnadeck M. Do attitudes towards persons with handicaps really shift over time: comparison between 1975 and 1988. Ment Retard 1991;29(2):81–6.

15. Wolfensberger W. The Principal of normalisation in human services. Toronto: National Institute on Mental Retardation; 1972.
16. Vanier J. Eruption to hope. Toronto: Griffin House; 1971.
17. Benham PK. Attitudes of occupational therapy personnel toward persons with disabilities. American Journal of Occupational Therapy 1988;42:305–11.
18. Hollins S. How mental handicap is taught in U.K. medical schools. Medical Teacher 1988;10:289–96.
19. Willer B, Ross M, Intagliata J. Medical school education in mental retardation. J Med Educ 1980;55:589–94.
20. Ash L. Training in mental retardation for psychiatric residents. Can Psychiatr Assoc J 1974;19:55–7.
21. McCreary BD. A study of full time medical practitioners in Canadian mental retardation facilities. Can Psychiatr Assoc J 1974;19:51–3.
22. McCreary BD. Educating physicians for contemporary responsibilities in the field of developmental disabilities. Can J Psychiatry 1991;36:601–5.
23. Leichner P. Present psychiatric postgraduate education and future professional trends in Canada: a survey of the opinions of fourth-year residents. Can Psychiatr Assoc J 1977;22:131–6.
24. Leichner P. Post-graduate education in psychiatry 10 years later. Annals of the Royal College of Physicians and Surgeons of Canada 1987;20:511–7.
25. Burge P, Ouellette-Kuntz H, McCreary BD, Bradley EA, Leichner P. Senior residents in psychiatry: views on training in developmental disabilities. Can J Psychiatry 2002;47:568–71.
26. Macdonald J, MacIntyre P. A rose is a rose: effects of label change, education, and sex on attitudes toward mental disabilities. Journal on Developmental Disabilities 1999;6(2):15–31.
27. Antonak RF. Development and psychometric analysis of an indirect measure of attitudes toward individuals with mental retardation using the error-choice method. Ment Retard 1994;32:347–55.
28. Antonak RF, Harth R. Psychometric analysis and revision of the Mental Retardation Attitude Inventory. Ment Retard 1994;32:272–80.
29. Henry D, Keys C, Jobb D, Balcazar F. The Community Living Attitudes Scale, Mental Retardation Form: development and psychometric properties. Ment Retard 1996;34:149–58.
30. Henry D, Keys C, Balcazar F, Jobb D. Attitudes of community living staff members towards persons with mental retardation, mental illness, and dual diagnosis. Ment Retard 1996;36:367–79.
31. Henry D, Keys C, Jopp D. The community living attitudes scale - mental retardation version reference manual. Available from D. Henry. Chicago: University of Illinois at Chicago; 1998.
32. Hampton NZ, Crystal R. Gender differences in acceptance of disabilities among vocational rehabilitation consumers. Journal of Applied Rehabilitation Counselling 1999;30:16–21.
33. Nabuzoka D, Ronning JA. Social acceptance of children with intellectual disabilities in an integrated school setting in Zambia: a pilot study. International Journal of Disability, Development, and Education 1997;44:105–15.
34. Cross SE, Madson L. Models of the self: self construals and gender. Psychol Bull 1997;122:5–37.
35. Fehr B, Broughton R. Gender and personality differences in conceptions of love: an interpersonal theory analysis. Personal Relationships 2001;8:115–36.
36. Keys C, Henry D, Horner-Johnson W. Facets of inclusion attitudes: longitudinal relationships. New Millenium Research to Practice Congress Abstracts, 11th World Congress of the International Association for the Scientific Study of Intellectual Disabilities. Abstract no. 605. J Intellect Disabil Res 2000;44(Parts 3 and 4):346.
37. Lunsky Y, Bradley E, Korrosy M. Developmental disability psychiatry: an analysis of residents' feedback. Plenary address given at State of the HART: Habilitative Achievements in Research and Treatment for Mental Health in Developmental Disabilities. Vancouver: University of British Columbia; 2002.
38. Henry DB, Duvdevany I, Keys CB, Balcazar F. Attitudes of American and Israeli staff toward persons with intellectual disabilities. Ment Retard. Forthcoming.
39. Parker JG. Chemical restraints and children: autonomy or veracity? Perspect Psychiatr Care 1995;31:25–9.
40. Bickenbach J. Physical disability and social policy. Toronto: University of Toronto Press; 1993.

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Résumé : Attitudes des résidents seniors en psychiatrie à l'endroit des personnes déficientes intellectuelles

Objectifs : Cette étude examinait les attitudes des résidents seniors en psychiatrie à l'endroit des personnes déficientes intellectuelles. L'examen des attitudes des résidents mettra en lumière les domaines de la formation qui peuvent être améliorés afin de mieux préparer les psychiatres à travailler avec les personnes déficientes intellectuelles.

Méthode : Un questionnaire a été distribué aux résidents seniors en psychiatrie lors d'une séance pancanadienne préparatoire au Collège royal des médecins et chirurgiens du Canada. Le questionnaire comprenait la forme abrégée de l'échelle d'intégration communautaire des attitudes à l'égard de la déficience mentale (CLAS) ainsi que des données démographiques (par exemple, l'âge, le sexe et l'état civil) et des questions sur la formation en matière de déficience intellectuelle. Les scores aux 4 sous-échelles de CLAS (habilitation, similarité, exclusion et hébergement)sont mentionnés, et des analyses de variance ont été effectuées pour déterminer les facteurs associés à chaque score de sous-échelle. Les scores des résidents ont été comparés avec ceux obtenus dans des sondages d'autres groupes.

Résultats : Cinquante-huit résidents seniors de tout le pays ont rempli le questionnaire. Les scores des résidents favorisaient l'habilitation et la similarité plus que l'exclusion et l'hébergement. Les hommes ont répondu différemment des femmes. La formation en déficience intellectuelle durant la résidence ne semblait influencer que les scores de la sous-échelle de la similarité.

Conclusion : Les résidents seniors en psychiatrie ont des attitudes à l'endroit des personnes déficientes intellectuelles qui ne correspondent pas tout à fait au paradigme philosophique de l'intégration communautaire. Il faut davantage de recherche pour découvrir comment se développent les attitudes des résidents et comment la formation peut influencer ces attitudes.