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# COGNITION & INCLUSION

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**C&I – IO2**

**BELIEF SYSTEM TOOLS FOR PROFESSIONALS.  
A QUANTITATIVE APPROACH.**



European Network  
of Social Authorities





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***Authors:***

José Manuel Gil Guzmán. Instituto Valenciano de Atención Social y Sanitaria.

Johan Warnez. Groep Ubuntu x 8K.

María Ana Sorzano Castellón. Instituto Valenciano de Atención Social y Sanitaria.

***Editor:*** Johan Warnez

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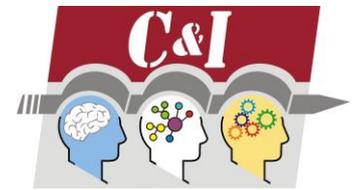
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## ABSTRACT

*Background* - Professionals working in the field of disability vary in their beliefs about the presumed competence, modifiability and learning potential of people with an intellectual disability. (e.g.. Biklen, 2006; Dweck, 2015; Feuerstein, 1988).

*Design/methodology/approach* - Quantitative approach based on a web-based self-administered questionnaire answered by disability professionals from four European countries (n=259).

*Results* - In order to implement successfully educational strategies for adults with intellectual disabilities, professionals need to develop an appropriate supporting belief system. Five constructs have been found to be critical to understand and to measure this belief system: 1) professionals' beliefs on change, modifiability and plasticity of adults with an intellectual disability, 2) professionals' beliefs on transversal skills within adults with intellectual disability, 3) professionals' beliefs on critical environmental conditions to promote change and learning of adults with intellectual disability, 4) professionals' beliefs on Quality of Life and intellectual disability and 5) professionals' beliefs on employment and intellectual disability.

Based on these five key constructs, the project has developed a set of tools to assess beliefs. Part of the tools are new tools, part of the included tools are existing assessment tools : a) Cognition & Social Inclusion beliefs scale (J. Gil Guzmàn, M. Sorzano Castellon, J. Warnez – IVASS & Groep Ubuntu x 8K, with contributions from the C&I partnership), b) Mindset questionnaire (C. Dweck, s.d.), c) General Self-Efficacy Scale (Schwarzer & Jerusalem, 1995), and d) Social pressure-scale (J. M. Gil Guzmàn & M. Sorzano Castellon, IVASS). The objective is to help professionals to measure, self-reflect or discuss with others how their own belief system has an impact on the outcome of their efforts to improve the learning potential, the quality of life and social inclusion/employment of adults with an intellectual disability.



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## O. Introduction

(Johan Warnez)

The Cognition & Inclusion project aims to develop tools to assess conditions for optimal implementation of transversal skills training methodologies, in order to promote successful adaptation, inclusion and employment of adults with an intellectual disability. The tool in this second intellectual outcome is on *the belief system of the professional*, who is expected to support and train adults. The main focus of the tool is on beliefs of the professional on *intelligence, modifiability, learning potential*, effort, intrinsic motivation, etc... As it is most relevant for this project, the tool also assesses beliefs on *inclusion and Quality of Life* and on *employment* : training transversal skills makes only sense when people with intellectual disability are supported to be more independent, to become part of society and to contribute to it.

As described in the next section, the cognitive modifiability theory developed by Feuerstein<sup>1</sup> since the sixties and seventies of previous century is one of the most elaborated models that provides information on the conditions of the *social* environment. Part of these conditions refer to the belief system with as content: perceptions, convictions, beliefs, implicit theories on the *learner*, i.e. the adult with intellectual disability, the *impairment*, i.e. the intellectual disability, and the nature of the *interventions*. The content of the inclusion and Quality of Life related items, is based on the framework of the Universal Declaration of Human Rights and on the worldwide accepted model on Quality of Life developed by Bob Schalock<sup>2</sup>. Besides these models, the Mind Set – framework (Carol Dweck<sup>3</sup>) and the concept of Presumed Competence (D. Biklen<sup>4</sup>) inspired the development of the tool.

*If competency is not expected, no competence will arise. (DB)*

This main idea, as part of the unconditional and supporting belief system that the partnership agrees upon, is a necessary prerequisite for successful implementation of educational strategies that aim to promote change, learning, autonomy within adults with intellectual disability.

The assessment tool can be used in a quantitative and qualitative way. It can be used to define a baseline or an actual situation (e.g. for Human Resources applications) or for evaluation of Vocational, educational training-efforts. Moreover, this kind of assessment tool, that fundamentally is based on self-reflection, has the potential to initiate - if indicated - the process of change of the belief system of the professional and will be used for that reason.

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<sup>1</sup> E.g. Feuerstein, R., Falik, L., & Feuerstein Ra.S. (2010). *Beyond Smarter : Mediated Learning and the Brain's Capacity for Change*. New York: Teachers College Press.

<sup>2</sup> E.g. Schalock RL, Keith KD, Verdugo MA, Gomez LE. *Quality of life model development and use in the field of intellectual disability*. In: Kober R, editor. *Quality of Life: Theory and Implementation*. New York, NY, USA: Sage; 2010. pp. 17–32.

<sup>3</sup> E.g. Dweck, C. (2006). *Mindset: The new psychology of success. How we can learn to fulfill our potential*. New York: Ballantine.

<sup>4</sup> E.g. Biklen, D. & Burke, J., 2006, *PresumingCompetence, Equity and Excellence in Education*, 39: 166-175.



## 1. Development of the *Cognition & Social Inclusion beliefs scale for professionals; statistical analysis*<sup>5</sup>.

(Jose Manuel Gil Guzmán)

*1.1* During the first phase of the C&I-project (September 2017 – November 2018), the partnership shared good practices that intend to promote transversal skills within adults with an intellectual disability. As summarized in the C&I IO-1 (*Overview of successful methodologies to train transversal skills in adults with an intellectual disability*)<sup>6</sup>, different approaches with different scopes show different ways to realize the goal. While analyzing and reviewing these approaches, opportunities were created to learn about *cognitive models* and about – based on concrete practices – *conditions* for successful implementation. These models (as described in detail below) all refer to specific beliefs that significantly determine the (quantity and quality of professional) efforts to realize the desired outcome: becoming competent in using adaptive, transversal skills for successful inclusion and employment.

Based on these models and on the lessons learnt (IO1), the partners generated a set of several hundred statements – organized in 5 domains and reflecting the content of the beliefs supported by the theoretical models: 1. Beliefs on change, *modifiability*, plasticity of adults with intellectual disability, 2. Beliefs on *transversal skills* within adults with intellectual disability, 3. Beliefs on *environmental conditions* to promote change and learning within adults with intellectual disability, 4. Beliefs on *Quality of Life* and intellectual disability, and 5. Beliefs on *employment* and intellectual disability.

The many statements were reduced, by canceling items reflecting similar idea's, or items with a content very close to each other. A Delphi study (November 2018) with all members of the partnership helped us to find the most relevant, most important and preferential items. The items – based on the mean scores - were arranged from high to low. Based on the outcome, taking into account as much as possible different relevant themes (e.g. lifelong learning, problem solving, environmental conditions,...) and in coordination with members of their local expert groups (with researchers, university and high school staff) to be sure that the items are congruent to the selected models, IVASS and “Groep Ubuntu x 8K” proposed 24 items. These items were presented to and accepted by the complete partnership (March 2019). The items were rephrased according to common rules of test construction. We opted for a 5-point Likert scale (1 - not agreeing at all; 5 - strongly agreeing). A small try out was organized especially to find out if items were understood in the same way; minimal adaptations in phrasing had to be done. In June 2019, this version of the scale was implemented in 5 partner organizations - Vale and IVASS (Spain), NARHU (Bulgaria), Irecoop (Italy), Groep Ubuntu x 8K (Belgium) – to collect 259 responses and data for statistical analysis (July – August 2019).

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<sup>5</sup> Full report with the statistical analysis of Cognition & Social Inclusion Beliefs scale: see annex 1

<sup>6</sup> Overview of successful methodologies to train transversal skills in adults with an intellectual disability.  
[http://www.ensa-network.eu/cognitionandinclusion/Documents/CognitionInclusion\\_IO1\\_report.pdf](http://www.ensa-network.eu/cognitionandinclusion/Documents/CognitionInclusion_IO1_report.pdf)



The sample consisted of 259 professionals (74,7% females and 25,3% males) working with people with intellectual and/or learning disabilities. A distribution of the sample by country and partner organization can be seen in Table 1.

Table 1. Country and partner sample distribution.

COUNTRY	CONTACT ORGANIZATION	SAMPLE
Belgium	Groep Ubuntux8K	61
Spain	VALE	25
Spain	IVASS	86
Italy	IRECOOP	45
Bulgaria	NARHU	42
TOTAL		259

Source: own elaboration.

77,3% of participants are disability front-line professionals (care-givers, educators, employment mediators, occupational therapists, psychologists...). The other 22,7% are professionals working in tasks related to supervision, programs design or evaluation.

Most of the participants are professionals with a high professional experience. The 88,1% of the respondents have stated to have more than 3 years of experience in the sector. In addition, 77,29% of the professionals have stated to work with people with disabilities not having a great level of dependence. (more information in table 2.)

Exploratory *factor analysis* was conducted to identify the correlation between the 24 Likert-scale items and the underlying factor structure. Although the test reveals 6 underlying factors, only the first one of them has been retained and use to develop the scale. This factor explains the 25,58% of the total variance. According to the research team, this factor represents the beliefs of professionals towards cognition and social inclusion. 17 items with a loading higher than .40 have been finally included in this factor and in the final scale. The final items, orientation and related constructs can be seen in the table 3.

*Cronbach's Alpha* test was run to check the internal reliability of the 17 Likert-scale items that formed the final scale (*reliability*). The test showed a score of .868 which is considered "good". A board of internal project experts and the participants of the Flanders and Spanish local expert groups determined that the scale apparently reflects contents of cognition and social inclusion that are appropriate for the research questions (*face validity*). The research team selected 11 professionals with a very good professional background an "excellent" presumed beliefs towards cognition and social inclusion to complete the questionnaire. The *Mann-Whitney U test* found significant differences and higher mean rank of this "control" group compared with the rest of the participants (248).



Table 2. Summary of Sample figures.

	UBUNTU x 8K		IVASS		VALE		NARHU		IRECOOP		TOTAL	
	Frequency	%	Frequency	%	Frequency	%	Frequency	%	Frequency	%	Frequency	%
<b>SAMPLE</b>	61	23.5	86	33.2	25	9.6	42	16.2	45	17.3	259	100
<b>GENDER</b>												
Male	12	19.7%	18	21.4%	9	36%	9	21.4%	17	37.8%	65	25.3%
Female	49	80.3%	66	78.6%	16	64%	33	78.6%	28	62.2%	192	74.7%
<b>AGE</b>	ge											
18-30	6	9.8%	7	8.3%	5	20%	6	14.3%	4	8.9%	28	10.8%
31-40	21	34.4%	15	17.9%	10	40%	12	28.6%	14	31.1%	72	28%
41-50	16	26.2%	28	33.3%	8	32%	12	28.6%	15	33.3%	79	30.7%
Over 50	18	29.5%	34	40.5%	2	8%	12	28.6%	12	26.7%	78	30.3%
<b>YEARS OF EXPERIENCE</b>												
Less than a year	0	0%	1	1.2%	2	8%	4	9.8%	0	0%	7	2.8%
1-3 years	4	6.6%	4	4.8%	5	20%	8	19.5%	2	4.7%	23	9.1%
3-10 years	13	21.3%	20	23.8%	5	20%	7	17.1%	8	18.6%	53	20.9%
3-10 years	22	36.1%	24	28.6%	8	32%	12	29.3%	20	46.5%	86	33.8%
More than 20 years	22	36.1%	35	41.7%	5	20%	10	24.4%	13	30.2%	85	33.5%
<b>SIZE OF ORGANIZATION</b>												
1-5 workers	1	1.6%	1	1.2%	0	0%	2	4.9%	1	2.2%	5	1.9%
6-10 workers	0	0%	6	7.1%	1	4%	6	14.6%	0	0%	13	5%
11-50 workers	1	1.6%	34	40.5%	3	12%	27	65.9%	8	17.8%	73	28.5%
51-250 workers	5	8.2%	21	25%	21	84%	4	9.8%	34	75.6%	85	33.2%
More than 250 workers	54	88.5%	22	26.2%	0	0%	2	4.9%	2	4.4%	80	31.2%
<b>PROFESSIONAL CATEGORY</b>												
Front-line professionals	35	57.4%	75	88.2%	21	87.5%	33	78.6%	34	77.3%	198	77.3%
Others	26	42.6%	10	11.8%	3	12.5%	9	21.4%	10	22.7%	58	22.7%

Source: own elaboration



Table 3. Final tool Likert-scale items composition, orientation and related constructs

ITEM	Orientation	Constructs
1. Adults with an intellectual disability can learn to self-regulate	Positive	Transversal skills and change, modifiability and plasticity
2. Adults with an intellectual disability lack emotional self-control skills	Negative	Transversal skills
3. The best way to promote independence is to create opportunities for adults with an intellectual disability to live in society	Positive	Environmental conditions
4. Adults with an intellectual disability need continuous support at work	Negative	Employment and change, modifiability and plasticity
5. Adults with an intellectual disability can develop a professional identity	Positive	Employment
6. Adults with an intellectual disability can learn to adapt to changing situations	Positive	Change, modifiability and plasticity and Transversal skills.
7. Adults with an intellectual disability need to do only simple and repetitive work tasks	Negative	Change, modifiability and plasticity
8. Adults with an intellectual disability can fully participate in society	Positive	Social inclusion/QOL
9. Adults with an intellectual disability can learn to adapt to unexpected situations	Positive	Change, modifiability and plasticity and transversal skills.
10. Adults with an intellectual disability always need help to solve problems	Negative	Transversal skills
11. A protective environment promotes the learning of adults with an intellectual disability	Negative	Environmental conditions
12. Adults with an intellectual disability learn from mistakes	Positive	Transversal skills
13. It is useless to work on the communication skills with of adults with an intellectual disability	Negative	Change, modifiability and plasticity
14. The quality of life of adults with an intellectual disability is different from people without an intellectual disability	Negative	Social inclusion (QOL)
15. Adults with an intellectual disability have the right to decide where to live	Positive	Social inclusion (QOL)
16. Adults with an intellectual disability can learn skills for independent living	Positive	Change, modifiability and plasticity
17. Adults with an intellectual disability are capable of lifelong learning	Positive	Change, modifiability and plasticity



1.2 Supported by the theoretical models and the experiences of the organizations involved, 3 control tools are added to the Likert scale above, anyhow being the core part of the *Cognition & Social Inclusion beliefs scale*. These control tools with a limited number of items, provide necessary information for a proper understanding of the responses of the professional.

1.2.1. *Mindset* scale. As one can assume a high correlation between a professionals' belief system on plasticity, modifiability, learning potential of other people, like e.g. adults with an intellectual disability on one side, and their *own mind set* – being a growth mind set or rather a fixed mind set – on the other side, a first additional tool is to assess the professionals mind set. For this, we can use the Mindset Questionnaire developed by C. Dweck and colleagues<sup>7</sup>.

1.2.2. *Self efficacy* scale. Also, you can assume that the belief system and the scores on the Likert scale can be influenced by someone's *self efficacy* (for description see below): the General Self-Efficacy scale based on A. Bandura's work and developed by Schwarzer and Jerusalem<sup>8</sup> - available in many languages - is added. GSE is a 10 item scale designed to assess optimistic self-beliefs to cope with a variety of difficult demands in life, especially beliefs that someone's actions are responsible for successful outcomes.

1.2.3. *Social pressure* scale. Finally, as psychological pressure from the social environment can be at stake, a set of items developed by IVASS is part of this Intellectual Output. Literature review<sup>9</sup>, interviews and group discussions<sup>10</sup> with experts and professionals generated 48 items; 12 items were selected as being most relevant regarding the focus of this project.

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<sup>7</sup> <http://blog.mindsetnetworks.com/what-is-my-mindset>

<sup>8</sup> General Self-efficacy Scale (GSE Scale) [cited: 01-04-2012] Available from: <http://userpage.fu-berlin.de/~health/selfscal.htm>

<sup>9</sup> Several academic papers and belief scales using the social pressure items were analyzed (Heuckmann et Al., 2018; Conatser et Al., 2002; and Ermitage and Conner, 2001) in order to understand the nature of the social pressure items.

<sup>10</sup> IVASS carried out 5 face-to-face interviews with experts and professionals, and 2 internal discussion groups with the objective: a) to determine and define the theoretical links of the concept of "social pressure" with the five "cognition and social inclusion" constructs; b) to create 48 initial items; c) to filter those items with higher relevance for the project



## 2. Description of the theoretical models of the *Cognition & Social Inclusion beliefs scale for professionals*

### 2.1 Feuerstein's beliefs (*Structural Cognitive Modifiability - SCM*) : *Active Modificational versus Passive Acceptant approach*<sup>11</sup>

*"Intelligence is not a static structure, but an open, dynamic system that can continue to develop throughout life". (RF)*

The title of Feuerstein's book *Don't Accept Me as I Am* symbolizes "an unvoiced cry of despair, the despair of thousands of people with retarded performance whose passive-acceptant (unchallenging/unmodifying) circumstances doom them to a relatively low quality of life. Out of love, parents may offer their child every type of comfort and pleasure in order to maintain his happiness. Anything that might disturb their child's placid environment is withheld. The child's comfort, complete peace of mind, feeling of being totally accepted, and even his ignorance of his being different, become all-important. Very little thought is given to the possibility of enhancing development in a substantial way. The active-modificational (AM) approach, in contrast to the passive-acceptant (PA) one, reveals itself as an unwillingness on the part of the parent, caregiver, teacher, employer to accept the person's impairment - be it physical, mental, educational, or behavioral - as it is. The SCM theory is anchored deeply in the AM approach, advocating the continual mobilization of environmental resources in order to enhance not only the individual's potential but his capacity to become modified. Educators, social workers, parents, and others will vary greatly in their belief in the potential for human modifiability. This variance can be thought of as a position held on a bipolar continuum running between the passive-acceptant (PA) approach on the right and the active-modificational (AM) approach on the left end. In reality, though, these approaches can be described in terms of a spectrum of positions, each one closer to, or more remote from, one of these poles. These two views do not refer to the quantitative aspects of educational intervention. Instead, they address its qualitative aspects, that is, its nature, goals, and direction toward which interventional energies and resources are directed. In order to determine someone's position on the PA-AM continuum, two interrelated questions should be asked: "To what extent is the individual's level of functioning, or impairment, considered immutable and consequently accepted as a given?" "To what extent are the social resources, interventional processes, and educational practices geared toward meaningfully modifying the individual himself as well as shaping his environment to be more modifying?" In responding to these questions, whenever educational activities are geared toward significantly increasing the individual's modifiability and enhancing his adaptive capacities, we may consider them an active-modificational (AM) approach. Whenever an individual's modifiability is not the major objective of intervention, a passive-

<sup>11</sup> Based on chapter 2 of Feuerstein, R., Rand, Y., & Rynders, J. E. (1988). *Don't accept me as I am: Helping retarded people to excel*. New York, NY, US: Plenum Press.



acceptant (P A) approach is reflected. Activities of a PA nature may be highly resourceful and varied and yet considered passive because they aim at adapting the environment to the individual's present level of functioning, rather than at enriching the individual's coping behavior for a better quality of life. There are situations, however, in which a passive-acceptant approach is not only commendable but necessary, as for instance in building special ramps for people in wheelchairs. Even in this circumstance, though, it is important that the person himself commute from one place to another without requiring the direct assistance of someone else, if at all possible. Acceptance does not refer to the emotional attitude that we may have, or develop, toward a person with a disability. It refers to the attitude we have toward that disability. Passive acceptance means to tolerate the impairment, considering it as unmodifiable. To "live with" the impairment means that an investment is made not in the individual's modification but in his surroundings. Conditions are created for him that will not require modifications in his level of functioning. Thus, low-level or inappropriate functioning becomes reinforced and perpetuated.

## 2.2 Dweck : *Mindset Theory*<sup>12</sup>

People vary in the degree to which they attribute the causes of intelligence and other traits. Are they innate and fixed factors ("fixed" mindset) or are they variable factors that can be influenced through learning, effort, training, and practice ("growth" mindset)? A *growth mindset* is generally seen as more advantageous. Dweck proposed *mindset theory* as a way to understand the effects of the beliefs that individuals hold for the nature of intelligence. This in turn has implications for learning and education.

*"Test scores and measures of achievement tell you where a student is, but don't tell you where a student could end up."*

*"Becoming is better than being." (CD)*

Dweck proposed that the implicit theories that people hold for the nature and causes of intelligence have a number of implications, particularly for motivation to practice and learn. In her earlier research, she identified "entity" and "incremental" theorists, based on whether individuals attributed success in tasks that required intelligent behavior to having sufficient native aptitude (entity) versus having practiced a skill and improving performance over time (incremental). Later, she proposed a *theory of mindset* to integrate a number of related ideas that she had developed over the years.

*Mindset* refers to implicit theories that individuals hold regarding the nature of intelligent behavior: to the degree that individuals attribute intelligence to fixed traits, they hold a *fixed*

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<sup>12</sup> Based on : David L, "Mindset Theory – Fixed vs. Growth Mindset (Dweck)," in *Learning Theories*, December 14, 2015, <https://www.learning-theories.com/mindset-theory-fixed-vs-growth-mindset-dweck.html>; Dweck, C.S. (2012). *Mindset: The New Psychology of Success*. Constable & Robinson Limited.



theory of intelligence (i.e. a fixed mindset), and to the degree that they attribute intelligence to learning, effort, training, and practice, they hold a *growth* theory of intelligence (i.e. a growth mindset).

Individuals with a *fixed mindset* believe that their qualities (such as intelligence or other personality traits) are “set in stone”— how God made you is basically who you are. Someone’s traits are fixed — not something that can be practiced or developed. Individuals with a *growth mindset*, on the other hand, believe that effort or training can change someone’s qualities and traits.

Individuals with a *fixed* mindset tend to be interested only in feedback on their success in activities to the degree that it serves to evaluate their underlying ability. They are not using the feedback to learn, since they do not believe that their success depends on their effort to learn. Rather, they believe that success depends on the level of innate ability that they have. Therefore, they dread failure, because it suggests constraints or limits that they will not be able to overcome.

A *growth* mindset, on the other hand, attributes success to learning. Therefore, the individual is not terrified of failure, because it only signals the need to pay attention, invest effort, apply time to practice, and master the new learning opportunity. They are confident that after such effort they will be able to learn the skill or knowledge, and then to improve their performance.

Messages by parents, teachers, social workers,... to children, youngster or adults can influence the development of their mindset. If parents, teachers,... constantly seem to attribute success to inborn or innate abilities, children will come to develop a fixed mindset. Praise of someone’s performance can be particularly likely to produce a fixed mindset when it attributes the success to intelligence (implying aptitude or fixed traits). However, if success is attributed to effort and practice, children (or youngsters, adults,...) will be more likely to developed a growth mindset. Praise of efforts to practice, or attributions of success to the prior practice in which the person engaged, can contribute to the development of a growth mindset.

Differences in mindset may affect broader issues as well, including how *employers* focus on hiring staff and in how *politicians* fund public education. Employers that hold a fixed mindset may focus more on investment in high ability employees and correspondingly invest less in professional development and ongoing training. Politicians who believe that the learning of which children are capable is limited by fixed traits may resist calls to improve funding for public education, perhaps considering such additional funding an unnecessary investment to try to improve fixed abilities. However, those same politicians might be willing to support spending on programs for the gifted when entrance to such programs is filtered by intelligence tests.



Also it is possible that there may exist international *differences* in mindset; e.g. Americans and Western Europeans, given the history of the prevalence of the use of intelligence tests for the past century, may be more likely to attribute success to innate ability (fixed mindset) than to effort and practice; the reverse may be the case in many Asian nations, and particularly China, where the culture of education emphasizes learning and rigorous practice.

### **2.3 Biklen: *presuming competence***<sup>13</sup>

*Presuming competence* is a framework of educational engagement that invites everyone involved in education or support (professionals and non-professionals), to approach people as wanting to be fully included, wanting acceptance and appreciation, wanting to learn, wanting to be heard and wanting to contribute. To not presume competence is to assume that some individuals do not have the potential and cannot learn, develop, or participate in the world.

“*Presuming competence* is nothing less than a Hippocratic oath for educators” : it means being open to a persons’ (intellectual) competence, assuming that a person (with a disability) has the capacity to think, to learn and to understand, even if evidences that such is the case are not visible. It’s assuming that a person is not inherently incapable, but that he/she needs the right supports and systems to help him/her succeed. *Presuming competence* is not idealism. It is not about ignoring or overlooking the challenges a person faces. *Presuming competence* is about giving someone a chance, and helping them take that chance, in any way. Being open to individuals’ competence especially is crucial to promote (transversal) skills, and so to successful contribution in society and employment.

*“Aim low, and you can only expect low results. But aim high, and your client will be more likely to rise to meet those expectations”.* (DB)

Not assuming potential, often is assumed in persons with developmental, intellectual disabilities, and... is reinforced by outcomes of tests, definitions, diagnoses, categorizations, etc.<sup>14</sup> Assuming incompetence happens through the process of classification: someone *becomes* mentally retarded on the basis of his performance on intelligence tests and adaptive behavior scales. *Labeling* often occurs, and people learn to behave according to the label and the (negative) expectations of the social environment.

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<sup>13</sup> Douglas Biklen & Jamie Burke (2006) Presuming Competence, *Equity & Excellence in Education*, 39:2, 166-175

<sup>14</sup> To illustrate, the way the American Psychiatric Association (APA, 2000) defines severe retardation, declares a person retarded because of difficulties in performance: “The group with Severe Mental Retardation constitutes 3%–4% of individuals with Mental Retardation. During the early childhood years, they acquire little or no communicative speech. During the school-age period, they may learn to talk and can be trained in elementary self-care skills. They profit to only a limited extent from instruction in pre-academic subjects, such as familiarity with the alphabet and simple counting, but can master skills such as learning sight reading of some “survival” words. In their adult years, they may be able to perform simple tasks in closely supervised settings. (...)”



## 2.4 Schalock & Verdugo: *Quality of Life (QOL)*<sup>15 16</sup>

Just as is the case for all people, and based on the United Nations Convention on the Rights of Persons with Disability (UNCRPD; United Nations, 2006), Quality of Life is widely accepted as the main goal of education and support of people with intellectual disability. Schalock & Verdugo's model has significantly impacted the field of intellectual and developmental disabilities.

Quality of Life – being aligned to principles as human and legal rights, inclusion, active participation, valued roles, equity, empowerment and self-determination - incorporates a holistic, positive approach to individuals based on positive psychology and strengths-based models of growth and development. It provides a framework for person-centered planning. The QOL-model has a broad and holistic focus on the person as a whole, distinguishing it from Health Related QOL (HRQoL), which has a more delimited focus on the impact of illness, disease or disability on the level of individual functioning.

Schalock & Verdugo suggest not to define the QOL-concept as such, but rather to agree upon its core domains (set of factors composing personal well-being) and indicators (domain specific perceptions, behaviors, or conditions that reflect a person's well-being). The QOL-model is composed of eight universal core domains (between brackets some indicators)

2.4.1. Emotional well-being (feeling safe and secure, predictable home and school environments, expressing satisfaction, contentment and happiness)

2.4.2. Interpersonal relations (having close friends, interacting socially, being part of family interactions)

2.4.3. Material well-being (having enough money to buy personal possessions, having own physical space)

2.4.4. Personal development (demonstrating self-help skills, having opportunities to learn and grow)

2.4.5. Physical well-being (participating in physical activities, eating healthy food, using supportive technology if needed (e.g., glasses, braces, wheelchair))

2.4.6. Self-determination (making decisions, setting personal goals, expressing personal feelings)

2.4.7. Social inclusion (participating family and community activities, receiving assistance and help from others)

2.4.8. Rights (being treated the same way as peers, having a pet if he or she wants one,...)

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<sup>15</sup> Van Hecke, N. et al. (2018). Conceptualization and measurement of Quality of Life based on Schalock & Verdugo's model: A cross-disciplinary review of the literature. UGent.

<sup>16</sup> Schalock, R.L. & Verdugo, M.A. (2002). Handbook on Quality of Life for human service practitioners. Washington DC: American Association on Mental Retardation.



## 2.5 Bandura : Self-efficacy<sup>17 18</sup>

Self-efficacy, often named 'confidence, is the *optimistic self-belief in our competence* or chances of successfully accomplishing a task and producing favorable outcomes.

“Nothing is impossible, the word itself says  
I’m possible.”(AH)

“When you believe, you will achieve!”(RF)

According to Bandura, self-efficacy beliefs lie at the core of human functioning. It is not enough for a person to possess the requisite knowledge and skills to perform a task; one also must have the *conviction* that s/he can successfully perform the required behavior under difficult circumstances. Effective functioning, then, requires skills and efficacy beliefs to execute them appropriately—two components that develop jointly as individuals grow and learn. Moreover, these two components of successful human functioning act upon one another in reciprocal fashion, what Bandura (1997) calls “reciprocal causation” where the functioning of one component depends, in part, upon the functioning of the other.

Self-efficacy plays a major part in determining our chances for success; in fact some psychologists rate self-efficacy above talent in the recipe for success. Bandura, names 4 sources of efficacy beliefs, Maddux<sup>19</sup> adds a 5th:

2.5.1. The first and foremost source of self-efficacy is through *mastery* experiences. However nothing is more powerful than having a direct experience of mastery to increase self-efficacy. Having a success, for example in mastering a task or controlling an environment, will build self-belief in that area whereas a failure will undermine that efficacy belief. To have a resilient sense of self-efficacy requires experience in overcoming obstacles through *effort* and *perseverance*.

2.5.2. The second source of self-efficacy comes from our observation of people around us, especially people we consider as role models. Seeing people similar to ourselves succeed by their sustained effort raises our beliefs that we too possess the capabilities to master the activities needed for success in that area.

2.5.3. Influential people in our lives such as parents, teachers, managers or coaches can strengthen our beliefs that we have what it takes to succeed. Being (verbally) persuaded by

<sup>17</sup> Bandura, A. (1994). Self-efficacy. In V. S. Ramachandran (Ed.), Encyclopedia of human behavior (Vol. 4, pp. 71-81). New York: Academic Press. (Reprinted in H. Friedman [Ed.], Encyclopedia of mental health. San Diego: Academic Press, 1998).

<sup>18</sup> Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. Psychological Review, 84, 191-215.

<sup>19</sup> Maddux, J. E. (1999a). Expectancies and the social-cognitive perspective: Basic principles, processes, and variables. In I. Kirsch (Ed.), How expectancies shape behavior (pp. 17-40). Washington, DC: American Psychological Association.



them that we possess the capabilities to master certain activities means that we are more likely to put in the effort and sustain it when problems arise.

2.5.4. The emotional or physiological state you're in will influence how you judge your self-efficacy. Depression, for example, can dampen confidence in our capabilities. Stress reactions or tension are interpreted as signs of vulnerability to poor performance whereas positive emotions can boost our confidence in our skills.

2.5.5. Maddux has suggested a fifth route to self-efficacy, namely through imaginal experiences, the art of visualizing yourself behaving effectively or successfully in a given situation

### ***2.6 Ajzen – Theory of Planned Behaviour and Social pressure***

The theory of Planned Behaviour (Ajzen<sup>20</sup>) provides a conceptual framework for dealing with the complexities of human behaviour in a specific context. It proposes that a person intentions to behave might be predicted by: a) attitudes towards behaviours (person's positive/negative assessment of the behaviour in question); b) subjective norms (social pressure to perform (or not) the behaviour); and c) perceived behavioural control (person's perception of the difficulty (or ease) of performing the behaviour). These intentions, along with person's perception of behaviour control (Normative beliefs, control beliefs and behavioural beliefs) can be good predictors of the behaviour performance.

The theory postulates that behavior is a function of salient information, or beliefs, relevant to the behavior. Three kinds of salient beliefs are distinguished: behavioral beliefs which are assumed to influence attitudes toward the behavior, normative beliefs which constitute the underlying determinants of subjective norms, and control beliefs which provide the basis for perceptions of behavioral control.

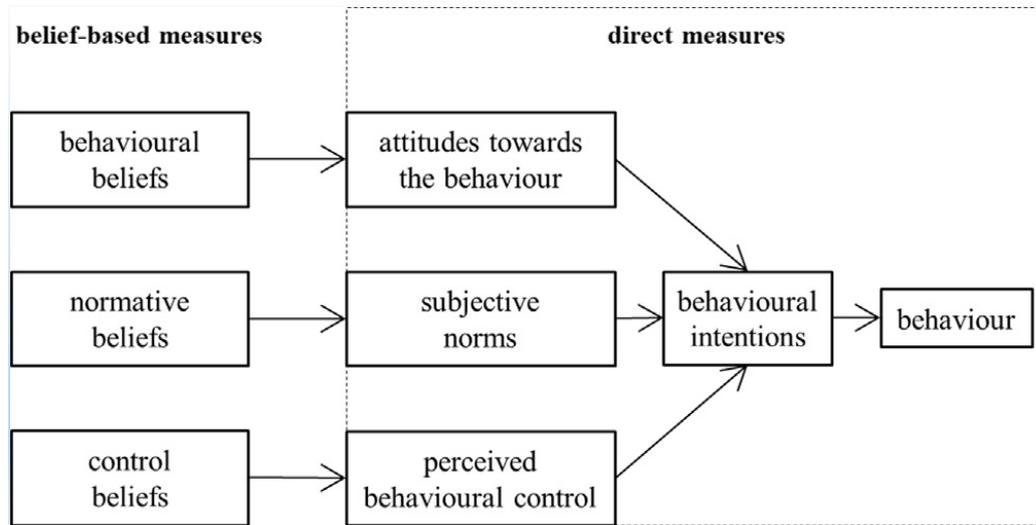
Social pressure would be associated with subjective norms and normative beliefs (probability that key individuals or groups approve (or not) a certain behaviour). In the context of the Cognition & Inclusion-project, it refers to the social pressure that families, colleagues, tutors, society and even the own final users can exerting over the professional to choose for and perform a given behaviour.

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<sup>20</sup> Ajzen, I. 1991. The Theory of Planned Behaviour. *Organizational behavior and human decision processes*, 50, p. 179-211



Figure 1. The Theory of Planned Behaviour. (Fishbein & Ajzen, 2010).





### 3. Content of the items

(Johan Warnez, María Ana Sorzano Castellón & Jose Manuel Gil Guzmán)

#### 3.1 Professionals' beliefs on Cognition and Intelligence, Inclusion and QOL, and Employment

As described earlier (see 1.1) 24 items – covering the content of 5 domains - were selected to be the item pool of this core part of the *Cognition & Social Inclusion beliefs scale*. Some items refer to more than one domain, especially when the item refers to the ability to learn (1) and/or to a specific transversal skill (2).

3.1.1. Beliefs on *Change, modifiability, plasticity* of adults with an intellectual disability: items 1, 4, 6, 7, 9, 13, 16, 17

16 “Adults with an intellectual disability can learn skills for independent living.”

Items in this domain refer to general beliefs of the professional on the learning potential of adults with an intellectual disability. The presuming competence framework and the active modifiability approach are good starting points for reflection on ‘dynamic’ questions: Is intelligence something that is static? Are an IQ-score and the level of functioning at a certain time good predictors for future performance? Are adults with an intellectual disability able to adapt, to learn from mistakes, to self-regulate etc. and so, able to become independent citizens. Does the professional presume a growth mind set and confidence to change in people with an intellectual disability? Is plasticity a relevant concept also in adults with an intellectual disability, and can they learn lifelong?

Only when competence, learning potential and change are unconditionally presumed in professionals, cognitive programs and transversal skills training will be effective and thus, promote successful inclusion and employment.

According to the partners of the C&I-project, the items included in the tool are seen as significant. Many more items can be found in tools developed by b.o. Dweck, Feuerstein and Haywood: although these tools are developed for professionals working with children or young people, the content is transferable and not exclusively related to age or domain of life.

3.1.2. Beliefs on *Transversal skills* of adults with an intellectual disability: items 1, 2, 6, 9, 10, 12

12 “Adults with an intellectual disability learn from mistakes”

Transversal skills are part of people’s development, and play an important role for effective, efficient autonomous functioning and for continuous adaptation to changes. Within the axis



from Transversal competencies<sup>21</sup>, Cognition & Inclusion focuses on the intrapersonal skills, namely, in Cognition. People with special needs want to be included in society and need transversal skills order to succeed in life and in the labor market. C&I focuses on Cognition because it involves mental processes present in daily life, for instance learning and thinking: they are often underdeveloped or ignored. Cognition guides our thoughts and actions, and also influences how information is processed and how people interact with the world. Therefore, we need to effectively work on these skills. Based on Sternberg, the C&I team selected and defined 5 transversal skills.

*Problem solving* is a higher level cognitive process that can be conceived as a cycle of emotional, cognitive and behavioural activity, starting with the awareness that a problem exists, then the definition of the problem, the allocation of mental and physical resources to solve the problem, the finding of a strategy (or strategies) that could be implemented to solve the problem, the implementation of that solution, the monitoring of the ongoing problem solving process, and the evaluation of the solution found as well as of the completed process. *Self-regulation* refers to the subject's competence to change himself and have control over its internal processes and external resources. Self-regulation consists of using specific techniques to direct attention, to use self-instructions, to manage time, to structure the environment, to search for help and to maintain motivation.

*Cognitive flexibility* as a high cognitive function, influences the way knowledge is received, represented, (re)structured and applied during response elaboration. This way, cognitive flexibility incorporates three dimensions: attention flexibility; representation flexibility and response flexibility.

*Self-directedness* is a dimension of character that refers to self-determination or willpower, and is considered the ability to control, regulate or adapt behaviour in regard to chosen goals or values.

*Creativity* is the ability to innovate (being divergent and original) and to respond to requests, challenges, or imposed or self-imposed goals. The creative process is a systemic phenomenon, because it is developed in accordance with potentiality from the setting (extrinsic features) and the characteristics of people (intrinsic features) to produce innovative, divergent and/or original solutions for old/new problems.

The items in the questionnaire referring to these transversal skills especially invite professionals to reflect on questions as: are adults with an intellectual disability able to perform these transversal skills (rather than: are they able to acquire these skills – this is to be seen as part of the previous domain – 3.1.1.) Again, and more specifically regarding these skills, the professional is invited to show evidence of 'presuming' competences in this field of cognitive skills.

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<sup>21</sup>E.g. <https://bangkok.unesco.org/content/assessment-transversal-competencies-current-tools-asian-region> (2019)



3.1.3. Beliefs on *environmental conditions* for learning, problem solving, autonomy of adults with an intellectual disability:  
items 3, 11

3 *“The best way to promote independence is to create opportunities for adults with an intellectual disability to live in society.”*

Many of the lessons learnt from the reviews of the methodologies (C&I IO1-report<sup>22</sup>) refer to the impact on the outcome of social, environmental or methodological conditions: conditions in the (social) environment may hinder or can promote the acquisition and/or the performance of (transversal) skills, especially within people with a disability. A safe and at the same time challenging environment has a significant impact on how someone develops and learns. The quality and quantity of support etc. are critical conditions for development and learning, and for autonomy and successful inclusion: just think about the impact of a social environment that ‘takes over’ the problems of a person, not giving the opportunity to solve a problem by himself, to try things out and to ‘trial and error’, to learn how to benefit from mistakes, to learn to take initiative,... . Indicators for a hindering condition may be: choosing for ‘simple’ tasks, continuous support and assistance, adapting the environment to the client, not expecting the client to adapt to the environment, or to be ‘the professional who knows what is good for someone’. Only a few items appear in the final tool, but the qualitative use of the tool opens the door for many elaborations on these conditions.

3.1.4. Beliefs on *Inclusion and QOL* of adults with an intellectual disability:  
items 8, 14, 15

14 *“The quality of life of adults with an intellectual disability is different from people without an intellectual disability.”*

The concept of Quality of Life (QOL) refers to a desired welfare of a person in relation to many aspects of their life and is closely linked to the Universal Rights declaration. It might help professionals to create a framework for their work, quality improvement and evaluation. The main idea behind the items is to find out the beliefs of the professionals on QOL of the adult with an intellectual disability. Often, due to the intellectual disability, the QOL of people with a disability is perceived as QOL of all citizens. However, QOL addresses "the issue of lives of persons, ensuring that citizens with intellectual disability experience the same human rights and a life of quality as any other member of society"<sup>23</sup>

<sup>22</sup> Overview of successful methodologies to train transversal skills in adults with an intellectual disability.  
[http://www.ensa-network.eu/cognitionandinclusion/Documents/CognitionInclusion\\_IO1\\_report.pdf](http://www.ensa-network.eu/cognitionandinclusion/Documents/CognitionInclusion_IO1_report.pdf)

<sup>23</sup> The concept of quality of life and its role in enhancing human rights in the field of intellectual disability.  
Verdugo MA1, Navas P, Gómez LE, Schalock RL. (2012) in : *Journal of Intellectual Disability Research*. 56(11):1036-45.



The items in this section invite professionals to think about these rights and the nature of the QOL of adults with an intellectual disability: what differences are seen in these rights and QOL-matters between adults with and without a disability. Also here, why would you do efforts, if you are convinced that inclusion, employment has no impact on the QOL of these adults. Three items are included, but many tools to evaluate QOL have been developed and can be used as a source to elaborate this domain while doing the assessment.

3.1.5. Beliefs on *employment* of adults with an intellectual disability:  
items 4, 5

5 “*Adults with an intellectual disability can develop a professional identity.*”

In accordance with the Convention on the Rights of Persons with Disabilities, people with a disability have the right to the opportunity to gain a living by work freely chosen and/or access to vocational guidance programs (Article 27). This section - compared to 3.1.4. – refers more specifically to employment, earning money, material wellbeing, professional identity, ownership, contributing to society, etc. Often, because of convictions different from the beliefs underlying the rights paradigm, people with an intellectual disability don’t have the opportunities to work or contribute in a mainstream setting; they work as a volunteer – doing valuable work - without earning money, or have to stay in sheltered organizations, far away – physically and psychologically - from society.

### 3.2 Control tools

As described in the introductory chapters, the professionals own mindset, their general self-efficacy and the perceived social pressure may influence the professionals response pattern on the previous part. To help the assessor to fully understand the responses given by the testee/professional, three short control scales are added to find out if the responses are ‘biased’ by significant ‘personal’ factors.

3.2.1. The *Mindset* Assessment questionnaire (Carol S. Dweck)

7 “*When something is hard, it just makes me want to work more on it, not less.*”

Someone’s own mindset – especially, but not necessarily when a fixed mind set is at stake - may explain ones negative or pessimistic beliefs on the potential of adults with intellectual disability (see also 2.2.). The Mindset Assessment questionnaire is a quick diagnostic tool drawn from research-validated measures for people age 12 and over to use to assess their mindsets. The testee is asked to answer 16 questions by agreeing or disagreeing with the statements, that refer to the professionals own mindset. As an outcome, you may find a more growth mind orientation or a more fixed mind orientation.



### 3.2.2. The *General Self-Efficacy* scale (Schwarzer, R., & Jerusalem, M.)<sup>24</sup>

9 *“When I am in trouble, I can usually think of a solution.”*

It may be that a negative score on the C&SIB-P, giving indication of not presuming competence or not creating equal opportunities to adults with an intellectual disability, may be (partially) explained by not knowing how to support or previously not being successful in supporting these adults towards transversal skills competency or towards successful inclusion or employment.

The GSE is a reliable and valid 10 item self-report measure of general self-efficacy. A total score is calculated by finding the sum of all items. For the GSE, the total score ranges between 10 and 40, with a higher score indicating more self-efficacy.

### 3.2.3. The *Social Pressure Scale* (IVASS)

10 *“My colleagues believe that getting a job for adults with an intellectual disability is irrelevant.”*

The items developed by IVASS and presented in this section belong to the construct of "social pressure". According to the planned behaviour "social pressure" is related to the normative beliefs & subjective norms which refer to the perceived social pressure to perform or not to perform the behaviour. The selection of the items is based on the estimated relevance according to the research team of IVASS after review of literature and interviews. (see higher 1.2.3.)

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<sup>24</sup> Schwarzer, R., & Jerusalem, M. (1995). Generalized Self-Efficacy scale. In J. Weinman, S. Wright, & M. Johnston, Measures in health psychology: A user's portfolio. Causal and control beliefs (pp. 35-37). Windsor, UK: NFER-NELSON)



## **4. Cognition & Social Inclusion beliefs scale for professionals: instructions and how to use?**

(Johan Warnez & María Ana Sorzano Castellón)

### **4.1 General instructions**

The instructions for each part of the complete set of tools (C&I IO2) can be found on the forms, available in the annexes of this report. Although the assessor may decide to use only a single part of the device, it is recommended - for reasons outlined earlier - to present the complete set of tools to the professional: the ‘core’ *Cognition & Social Inclusion beliefs scale for professionals* and the 3 control tools, to find out what may have influenced the responses, and so the belief system of the professional.

For the *Cognition & Social Inclusion beliefs*-part, it is important to invite the professional to score the items according to their very personal beliefs and subjective perceptions or convictions, and not to score according to what may actually be observed at the organization or working place of the professional. You may believe that ‘participating actively in society’ is what really matters – and so you can give a positive score on this as you believe that this is important. At the same time, you may observe that your clients – for whatever reason – are all staying, living and/or working in an institution; no efforts are done to help them make the transition. The testee is invited not to score (negatively) according to this observation, but to score to their own personal beliefs..

The control *Mindset questionnaire* is a self-assessment tool, looking for the orientation of the mindset of the professional him/her selves; the questions and the responses are – in contrast to the previous part of the device - not related to the clients, the adults with an intellectual disability, but to someone’s *own* mindset.

The *General Self-Efficacy scale* – as is in the name – is on the general perception of his/her own competences and skills and on the degree the testee trusts on his potential. It is not in the general instruction, but for this tool, the assessor may introduce the items within the context of the working situation of the testee.

The *Social Pressure Scale* gives the assessor an indication to what degree the responses on the *Cognition & Social Inclusion beliefs scale* are influenced by social environmental pressure. It may be introduced by saying that what and how we do, is not always according to our own beliefs, but sometimes is given direction and

### **4.2 How to use the beliefs scales: quantitative or qualitative?**

4.2.1. All subtools can be used in a *quantitative* way by summing up the scores or calculating a mean score.

The score on the *Cognition & Social Inclusion beliefs scale* can be calculated by adding the scores given by the testee. The assessor takes into account the orientation of the items (see table 3): part of the items have a positive orientation - agreeing is ‘positive’; another part has



a negative orientation, and so agreeing is ‘negative’. The assessor may find the positive and the negative items on the form. The higher the score, the more the professionals beliefs correlate with the concept of “beliefs on cognition and social inclusion” and the more this condition for a successful outcome is fulfilled. A high score reveals an active modifiable orientation, presuming competence, recognition of the rights of people with a disability, and the value of employment; a low score indicates a rather passive acceptant approach, not presuming competence or learning potential,... There are no norm or criteria for good or bad profiles. The scores can be seen as a baseline and starting point for support, training, etc...

To calculate a score on the *Mindset Questionnaire*, the assessor can calculate a G-score and a F-score, by calculating a mean score for the G- and the F-items (see form). The highest score, G or F, gives an indication of someone’s mindset orientation, being rather a Fixed mindset or a Growth mindset. As outlined earlier, the score on this sub-tool may help the interpretation of the outcome of the previous sub-tool.

The *General Self-Efficacy* score is easily calculated by adding the points given by the testee: a high score is an indication of the perception of the testee on his being competent.

Calculating a score on the *Social Pressure* sub-scale is not meaningful, as the items are all inviting the testee to reflect on signs of pressure or influence from the (social) environment that makes someone act professionally in a different way compared to someone’s own beliefs.

4.2.2. The first sub-tool on the beliefs of the professional on potential, cognition, social inclusion and employment of adults with an intellectual disability, can be used in a *qualitative* way. All items invite the testee to make a choice, but evoke reflections and considerations and doubts...and so, the items are a starting point for sharing ideas and beliefs, reflections, discussions with the assessor or with colleagues at the working floor.

In this approach, it is important to realize, that the items are indicators and so, they are only a selection of content and themes that are part of the domain they belong to. Each item can be elaborated with complementary or deepening questions. The main goal of the assessment – being quantitative or qualitative – is to find out if there are ‘hindering’ beliefs that can be changed by coaching and/or training the professional, in order to realize a better outcome for the adult with an intellectual disability.

Each item of the scale, and the response on the item of the professional, is a starting point for reflection and exchange of ideas.

Illustrative suggestions:

Items that refer to the general idea ‘Everyone, also adults with an intellectual disability can learn’, are starting points for reflection, initiated by the assessor. When the professional doesn’t give the ‘highest’ score, the assessor can ‘challenge’ the professional by asking questions as: ‘I see that you believe that almost all people with an intellectual disability can



learn, but as you indicate ‘agree’ and not ‘strongly agree’, I understand, that according to you, it is for some people not possible. What do you mean...’. This can be an introduction to reveal the ‘restrictions’ and discuss the ‘reasons’ for that, by inviting the testee to give examples of experiences. Starting from real experiences, you can make things more concrete, and find out what was at stake. This may help to formulate new, tailored goals in the supports plan of the client, and to find out what the professional needs (e.g. training, knowledge,...) to deal with the challenges experienced. Etc....

It may be interesting to challenge the testee by behaving as a ‘devil’s advocate’ or to be creative in formulating new statements. Being a devil’s advocate, the assessor makes a statement that is different from his own belief, to find out if someone is really convinced of what he states and is willing to go against the assessors thesis. Interesting and complementary ideas to discuss and to share points of view can be found in the description of the content of the items (see chapter 3.1.). Some useful interesting additional statements are:

- The actual level of functioning of the adult with an intellectual disability is a good predictor for functioning in the future/for future success/future employment...
- Learning is pure memorizing.
- Everyone can adapt to the environment.
- For people with an intellectual disability, the environment needs to adapt to the person.
- Employers have to set high standards and high quality work.
- Mistakes need to be avoided at any time.
- Adults with an intellectual disability profit from a ‘diverse’, mixed environment with people different in age, sex, background,...
- It’s important to know the diagnosis and the etiology of the disability.
- You have to invite adults with an intellectual disability to find help for any problem they have.



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ANNEX 1

**Cognition & Social Inclusion beliefs scale for professionals: Statistical analysis**  
Jose Manuel Gil Guzmán, IVASS, 2019



***COGNITION & SOCIAL INCLUSION BELIEFS SCALE***  
*for professionals*

**STATISTICAL ANALYSIS**  
**José Manuel Gil Guzmán (IVASS)**

## **1. Introduction**

Although the existing literature shows there are several methods to measure beliefs such as "observed behaviour" (Armitage and Conner, 2001), vignettes (Stuart, 2018), individual interviews using a semi-structured guide (Friedman and Sheppard, 2007), scenarios (Siminoff, Burant and Younger, 2004), protocols to identify beliefs..., it might be stated that quantitative self-reported questionnaires or scales are the most common methods to evaluate beliefs.

Some examples following this line of thought are: a) Allison et Al. (2015) stated the current relevance of scales and questionnaires to measure beliefs and attitudes; b) Armitage and Conner (2010) state that the belief predictions are superior for self-reported (scales) than observed behaviour; and c) Mogoşe et al. (2013) developing a theory and a scale as a method to measure irrational and rational beliefs.

In case the reader looks for further information on the use of a Likert-scale in this context, appendix 1 of this statistical analysis report includes a summary of several references about measuring beliefs (or attitudes) related to the objectives and topics of this project (disability, transversal skills/cognition, learning, educators...). These articles has been used as references on content and on methodology for this project and might inspire those who are interested in developing Likert-type scales to measure or modify beliefs (or attitudes).

## **2. The constructs underlying the *Cognition & Social Inclusion* beliefs**

### ***2.1 First phase: "Overview of successful methodologies to train transversal skills in adults with an intellectual disability"***

The information from different successful training methodologies and the analysis of the critical factors for success, as summarized in the report<sup>25</sup> of the first intellectual output of the "Cognition & Inclusion" Erasmus+ project, have been a key source of information to define what practical cognitive methodologies, theories and models should guide the production of this scale.

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<sup>25</sup> Overview of successful methodologies to train transversal skills in adults with an intellectual disability.  
[http://www.ensa-network.eu/cognitionandinclusion/Documents/CognitionInclusion\\_IO1\\_report.pdf](http://www.ensa-network.eu/cognitionandinclusion/Documents/CognitionInclusion_IO1_report.pdf)



## ***2.2 Second phase: Literature review***

In order to improve the partnerships' knowledge and understanding of the beliefs on cognition and social inclusion, a literature review on the following approaches was carried out:

- Structural Cognitive Modifiability: Active modification vs. Passive acceptance (Feuerstein)
- Mindset Theory – Fixed vs. Growth Mindset (Dweck)
- Social cognitive Theory: Self Efficacy (Bandura)
- Presumed Competence (Biklen).
- Theory of Planned Behaviour (Ajzen)
- Health Belief Model (Hochbaum et al.)

These approaches form the theoretical background to define the constructs (and the questionnaire items).

## ***2.3 Third phase: Interviews and group discussions***

In addition, the partnership carried out 10 face-to-face interviews with experts and professionals, and 8 discussion groups (1 internal during the transnational meetings and 7 external with national local expert groups) to determine and define the key constructs linked to the beliefs of professionals working in the field of disability towards cognition and social inclusion.

As a result of this mixed-method methodology, 5 constructs<sup>26</sup> were selected:

- Change, modifiability and plasticity
- Transversal skills
- Environmental conditions
- Dimension of social inclusion from the concept of quality of life
- Employment.

## **3. Developing the Likert Scale questionnaire**

The partnership agreed that the best tool to reach the sample and to collect enough quantitative information to develop a cross-cultural tool to measure beliefs, is the development of a web-based self-administered questionnaire. Therefore, once the constructs were identified, the research team (with professionals of the participating organizations and with external experts from the national local expert groups) could start to develop the itempool on which the final tools can be based. A set of 160 pre-items were selected and classified according to the 5 selected constructs:

- Construct 1: 35 items
- Construct 2: 34 items

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<sup>26</sup> Definition of the constructs can be found in the main general report, Chapter 2 and 3



- Construct 3: 35 items
- Construct 4: 29 items
- Construct 5: 27 items

The research team individually ranked each item. A focus group session with 9 professionals was organized in order to analyze statistically the items, and to select, re-write and edit the most relevant of them. An initial tool was created with 27 items.

A pilot test was completed with a sample of 9 professionals (face-to-face interviews) and 1 online focus group with 4 professionals. The objective was to evaluate whether the features of the items (wording, clarity, aesthetics, sequence, response time...) were appropriate and whether the instructions were clear. As a result of this, the instructions were adapted, some concepts (self-regulation, design for all) were explained, 5 sentences were rephrased and 3 items were removed.

Finally, 11 professionals, considered to have an ‘excellent’ belief on cognition and social inclusion, completed the questionnaire (control group).

The final questionnaire consisted of :

- 8 demographic questions (gender, age, years of working experience, type of organization, size of organization, level of dependence of the clients/people with disabilities, and professional category). The objective of these questions was to gather background information about the sample; these questions have also been used as independent variables to conduct the one-way ANOVA test.
- The core of the questionnaire is formed by 24 Likert-scale items to measure the beliefs of professionals on cognition and social inclusion.
- In addition, the respondents had the opportunity to write down their email address if they wanted to receive information about the project.

Finally, the original English version of the questionnaire (see Appendix 2 of this statistical analysis report) was translated into Bulgarian, Italian, Dutch and Spanish.

#### 4. Data source (N=259)

The sample consisted of 259 professionals (74,7% females and 25,3% males) working with people with an intellectual and/or learning disabilities. See table 1 for the distribution of the sample by country and partner organization.

Table 1. Country and partner sample distribution.

Country	Contact organization	Sample
Belgium	Groep Ubuntu x 8K	61
Spain	VALE	25

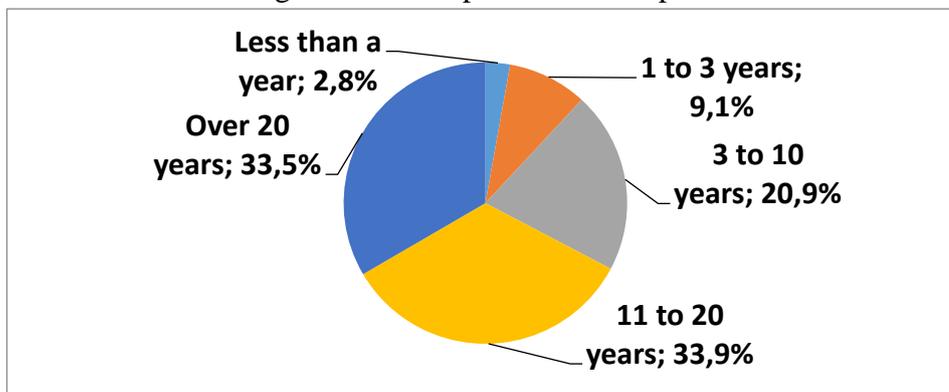


Spain	IVASS	86
Italy	IRECOOP	45
Bulgaria	NARHU	42
<b>TOTAL</b>		<b>259</b>

Source: own elaboration

77,3% of participants are disability front-line professionals (care-givers, educators, employment mediators, occupational therapists, psychologists...). The other 22,7% are professionals working in tasks related to supervision, programs design or evaluation. Most of the participants are professionals with a high professional experience. The 88,1% of the respondents have stated to have more than 3 years of experience in the sector (figure 1).

Figure 1. Sector professional experience



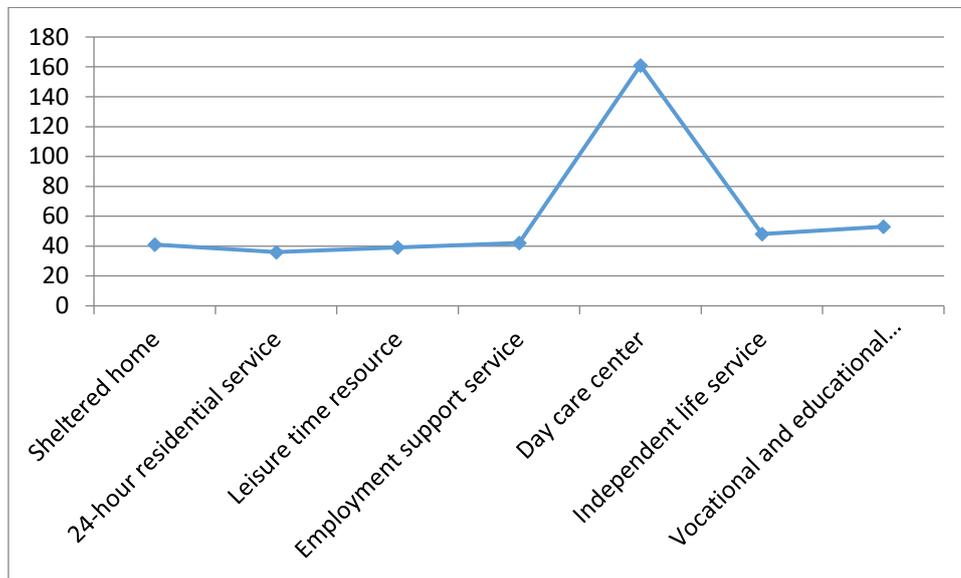
Source: own elaboration

In addition, 77,29% of the professionals have stated to work with people with disabilities not having a great level of dependence. 48,56% of respondents are working with people suffering from severe dependence (needed help to carry out several daily life activities two or three times per day, but not needed permanent presence of a care-giver); 28,73 % of participants are working with people needed help to carry out one or several daily life activities (moderate dependence); and only the 22,7% are professionals dealing with people with a great level of dependence.

Related to the type of organizations, 93% of the professionals belong to private, public and mixed services providers bigger than 10 workers. Moreover, and as it can be seen in figure 2, most of these professionals are working in a daycare center (non-residential facilities offering nutritional, health and social support) or/and in vocational and educational centers (tailor-made workshops and vocational and educational training courses).



Figure 2. Type of service provider (frequency of answers)



Source: own elaboration



Table 2. Summary of sample figures

	Groep Ubuntu8K		IVASS		VALE		NARHU		IRECOOP		TOTAL	
	Frequency	%	Frequency	%	Frequency	%	Frequency	%	Frequency	%	Frequency	%
<b>SAMPLE</b>	61	23.5	86	33.2	25	9.6	42	16.2	45	17.3	<b>259</b>	<b>100</b>
<b>GENDER</b>												
Male	12	19.7%	18	21.4%	9	36%	9	21.4%	17	37.8%	<b>65</b>	<b>25.3%</b>
Female	49	80.3%	66	78.6%	16	64%	33	78.6%	28	62.2%	<b>192</b>	<b>74.7%</b>
<b>AGE</b>												
18-30	6	9.8%	7	8.3%	5	20%	6	14.3%	4	8.9%	<b>28</b>	<b>10.8%</b>
31-40	21	34.4%	15	17.9%	10	40%	12	28.6%	14	31.1%	<b>72</b>	<b>28%</b>
41-50	16	26.2%	28	33.3%	8	32%	12	28.6%	15	33.3%	<b>79</b>	<b>30.7%</b>
Over 50	18	29.5%	34	40.5%	2	8%	12	28.6%	12	26.7%	<b>78</b>	<b>30.3%</b>
<b>YEARS OF EXPERIENCE</b>												
Less than a year	0	0%	1	1.2%	2	8%	4	9.8%	0	0%	<b>7</b>	<b>2.8%</b>
1-3 years	4	6.6%	4	4.8%	5	20%	8	19.5%	2	4.7%	<b>23</b>	<b>9.1%</b>
3-10 years	13	21.3%	20	23.8%	5	20%	7	17.1%	8	18.6%	<b>53</b>	<b>20.9%</b>
3-10 years	22	36.1%	24	28.6%	8	32%	12	29.3%	20	46.5%	<b>86</b>	<b>33.8%</b>
More than 20 years	22	36.1%	35	41.7%	5	20%	10	24.4%	13	30.2%	<b>85</b>	<b>33.5%</b>
<b>TYPE ORGANIZATION</b>												
Private	28	45.9%	22	26.2%	8	32%	8	20%	36	81.8%	<b>102</b>	<b>40.1%</b>
Public	26	42.6%	31	36.9%	2	8%	26	65%	2	4.5%	<b>87</b>	<b>34.2%</b>
Mixed public-private	6	9.8%	31	36.9%	15	60%	5	12.5%	5	11.4%	<b>62</b>	<b>24.4%</b>
Self-employed professional	1	1.6%	0	0%	0	0%	1	2.5%	1	2.3%	<b>3</b>	<b>1.1%</b>



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<b>SIZE ORGANIZATION</b>												
1-5 workers	1	1.6%	1	1.2%	0	0%	2	4.9%	1	2.2%	<b>5</b>	<b>1.9%</b>
6-10 workers	0	0%	6	7.1%	1	4%	6	14.6%	0	0%	<b>13</b>	<b>5%</b>
11-50 workers	1	1.6%	34	40.5%	3	12%	27	65.9%	8	17.8%	<b>73</b>	<b>28.5%</b>
51-250 workers	5	8.2%	21	25%	21	84%	4	9.8%	34	75.6%	<b>85</b>	<b>33.2%</b>
More than 250 workers	54	88.5%	22	26.2%	0	0%	2	4.9%	2	4.4%	<b>80</b>	<b>31.2%</b>
<b>PROFESSIONAL CATEGORY</b>												
Front-line professionals	35	57.4%	75	88.2%	21	87.5%	33	78.6%	34	77.3%	<b>198</b>	<b>77.3%</b>
Others	26	42.6%	10	11.8%	3	12.5%	9	21.4%	10	22.7%	<b>58</b>	<b>22.7%</b>

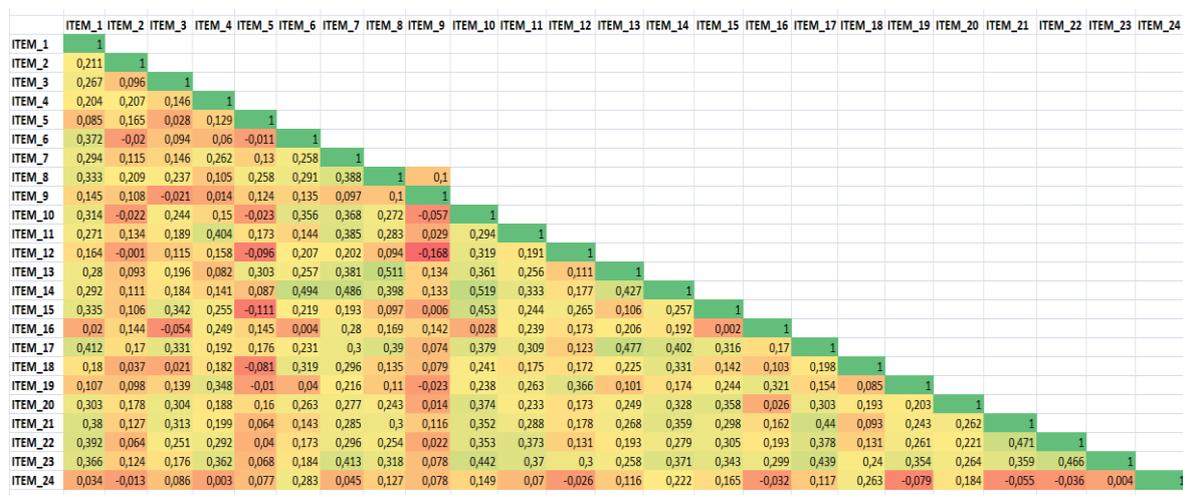
Source: own elaboration



## 5. Analysis

Exploratory factor analysis was conducted to identify the correlation between the 24 Likert-scale items and the underlying factor structure. KMO and Bartlett's test (Table 3) indicates the suitability of the sample and the test. 231 observations were considered valid. A minimum Eigenvalue of 1 was used to define the factors. Component analysis was conducted as the variable-reduction technique. Factor loading  $>.40$  was used to include an item in the 6 factors obtained. 17 items were included in the final questionnaire.

Figure 3. Correlation matrix among the 24 Likert-Scale Items



Source: own elaboration

Table 3. SPSS' test of KMO and Bartlett

Medida Kaiser-Meyer-Olkin de adecuación de muestreo		,866
Prueba de esfericidad de Bartlett	Aprox. Chi-cuadrado	1541,315
	gl	276
	Sig.	,000

Source: own elaboration

In addition to 8 demographic questions (independent variables) and the 24 likert-scale items (dependent variables), three new variables were created. A new independent variable was added to be able to compare the scores of the 11 experts (control group) with the rest of the participants (248). The other two variables were created by obtaining the mean "Mean\_17\_items" and the median "Median\_17\_items" of the selected 17 final Likert-scale items.

One-way ANOVA test was conducted to determine whether: a) the mean and median of the 17 Likert-scale items (dependent variables) differ by the categories included in the 8 demographic



questions (independent variables), and b) the means of the control group are higher than the rest of respondents.

A p-value <0.05 was considered in all the tests performed as an indication of statistical significance.

## 6. Reliability and validity

### 6.1 Reliability

Cronbach’s Alpha test was run to check the internal reliability of the 17 Likert-scale items that formed the final scale. The test showed a score of .868 which is considered "good". The results obtained when the test was run independently for each of the 4 participant countries are the following: Spain: .816; Belgium: .89; Bulgaria: .707; and Italy: .890.

Table 4. Cronbach’s Alpha using the 17 final Likert-scale variables

**Estadísticas de fiabilidad**

Alfa de Cronbach	N de elementos
.868	17

Source: own elaboration from the sample data

### 6.2 Face validity

A board of internal project experts and the participants of the Flanders and Spanish local expert groups determined that the scale apparently reflects contents of cognition and social inclusion that are appropriate for the research questions. In addition, the research team selected 11 professionals with a very good professional background an "excellent" presumed beliefs towards cognition and social inclusion to complete the questionnaire. The objective of this "control group" was to compare their scores with the rest of the respondents to evaluate if the 11 "excellent-belief" professionals scored higher than the rest of the sample. As it can be in the table 5, the Mann-Whitney U test has found significant differences in the mean rank between these 11 professionals and the rest of participants (248).



Table 5. The Mann-Whitney U test

Rangos				
ID_CONTROL		N	Rango promedio	Suma de rangos
Mean_24_items	Control	11	213,77	2351,50
	rest_of_respondents	248	126,28	31318,50
	Total	259		
Median_24_items	Control	11	206,55	2272,00
	rest_of_respondents	248	126,60	31398,00
	Total	259		

Estadísticos de prueba<sup>a</sup>

	Mean_24_items	Median_24_items
U de Mann-Whitney	442,500	522,000
W de Wilcoxon	31318,500	31398,000
Z	-3,792	-4,194
Sig. asintótica (bilateral)	,000	,000

a. Variable de agrupación: ID\_CONTROL

Source: own elaboration from the sample data

## 7. Findings

### 7.1 ANOVA test

Related to the means of different categories of 6 independent variables (demographic questions) and the variables "Mean\_17\_items" and "Median\_17\_items", ANOVA test has found significant differences for the following variables : country, type of organization, size of organization and professionals categories. ANOVA test hasn't found differences between the means of the different categories of the dependent variables: gender, age, years of experience in the sector.

Table 6. ANOVA test. Statistical differences between means

Dependent variable (factor)	Independent variable	Independent variable
Demographic questions	"Mean of "Mean_17_items"	"Mean of "median_17_items"
<b>Gender</b>	No differences between means	No differences between means
<b>Country</b>	Means differ	Means differ
<b>Age</b>	No differences between means	No differences between means
<b>Sector tenure</b>	No differences between means	No differences between means
<b>Type of organization</b>	Means differ	No differences between means
<b>Size of the organization</b>	Means differ	Means differ
<b>Professionals categories</b>	Means differ	Means differ

Source: own elaboration from the sample data



## 7.2 Factor analysis

A principal component factor analysis was run on the 24 Likert-scale items. Although the test reveals 6 underlying factors, only the first one of them has been retained and use to develop the scale. This factor explains the 25,58% of the total variance (Table 7). According to the research team, this factor represents the beliefs of professionals towards cognition and social inclusion. 17 items with a loading higher than .40 have been finally included in this factor and in the final scale (Table 8). No rotation was needed to determine the factor and the items included in it.

Therefore, the final tool will contain 17 items, all of them with a loading higher than .40 and with a internal reliability of  $\text{Alpha}=.868$ . The figure 4 shows the 17 Likert-scale items, their direction and the construct they belong to.

Table 7. SPSS's principal components extraction

**Varianza total explicada**

Componente	Autovalores iniciales			Sumas de extracción de cargas al cuadrado		
	Total	% de varianza	% acumulado	Total	% de varianza	% acumulado
1	6,139	25,578	25,578	6,139	25,578	25,578
2	1,885	7,856	33,434	1,885	7,856	33,434
3	1,777	7,404	40,837	1,777	7,404	40,837
4	1,464	6,101	46,939	1,464	6,101	46,939
5	1,178	4,906	51,845	1,178	4,906	51,845
6	1,108	4,616	56,461	1,108	4,616	56,461
7	,932	3,882	60,343			
8	,873	3,637	63,980			
9	,790	3,290	67,270			
10	,733	3,056	70,326			
11	,710	2,958	73,284			
12	,685	2,853	76,138			
13	,642	2,676	78,813			
14	,595	2,479	81,293			
15	,577	2,406	83,699			
16	,547	2,280	85,979			
17	,522	2,173	88,152			
18	,488	2,032	90,184			
19	,466	1,943	92,127			
20	,459	1,911	94,038			
21	,406	1,692	95,731			
22	,393	1,638	97,369			
23	,321	1,336	98,705			
24	,311	1,295	100,000			

Método de extracción: análisis de componentes principales.



Table 8. Factor loadings higher than .40

**Matriz de componente<sup>a</sup>**

	Componente					
	1	2	3	4	5	6
ITEM_1	,599					
ITEM_2					,472	
ITEM_3	,420			-,529		
ITEM_4	,437	-,423			,433	
ITEM_5			,605			
ITEM_6	,473	,437				
ITEM_7	,629					
ITEM_8	,573					
ITEM_9						-,615
ITEM_10	,660					
ITEM_11	,578					
ITEM_12						
ITEM_13	,571					
ITEM_14	,682					
ITEM_15	,526		-,433			
ITEM_16			,468	,433		
ITEM_17	,668					
ITEM_18				,471		
ITEM_19	,416	-,551				
ITEM_20	,540					
ITEM_21	,600					
ITEM_22	,594					
ITEM_23	,681					
ITEM_24		,502			,448	

Método de extracción: análisis de componentes principales.

a. 6 componentes extraídos.

Source: own elaboration from the sample data



Table 9. Final tool Likert-scale items composition, orientation and related constructs

ITEM (Position in the web questionnaire)	Orientation	Constructs
1. Adults with an intellectual disability can learn to self-regulate	Positive	Transversal skills and change, modifiability and plasticity
3. Adults with an intellectual disability lack emotional self-control skills	Negative	Transversal skills
4. The best way to promote independence is to create opportunities for adults with an intellectual disability to live in society	Positive	Environmental conditions
6. Adults with an intellectual disability need continuous support at work	Negative	Employment and change, modifiability and plasticity
7. Adults with an intellectual disability can develop a professional identity	Positive	Employment
8. Adults with an intellectual disability can learn to adapt to changing situations	Positive	Change, modifiability and plasticity and Transersal skills.
10. Adults with an intellectual disability need to do only simple and repetitive work tasks	Negative	Change, modifiability and plasticity
11. Adults with an intellectual disability can fully participate in society	Positive	Social inclusion
13. Adults with an intellectual disability can learn to adapt to unexpected situations	Positive	Change, modifiability and plasticity and transersal skills.
14. Adults with an intellectual disability always need help to solve problems	Negative	Transversal skills
15. A protective environment promotes the learning of adults with an intellectual disability	Negative	Environmental conditions
17. Adults with an intellectual disability learn from mistakes	Positive	Transversal skills
19. It is useless to work on the communication skills with of adults with an intellectual disability	Negative	Change, modifiability and plasticity
20. The quality of life of adults with an intellectual disability is different from people without an intellectual disability	Negative	Social inclusion (QoL)
21. Adults with an intellectual disability have the right to decide where to live	Positive	Social inclusion (QoL)
22. Adults with an intellectual disability can learn skills for independent living	Positive	Change, modifiability and plasticity
23. Adults with an intellectual disability are capable of lifelong learning	Positive	Change, modifiability and plasticity



**FINAL TOOL**

SA: Strongly agree A: Agree N/N: Neither agree/disagree D: Disagree SD: Strongly disagree

		SA	A	N/N	D	SD
1	Adults with an intellectual disability can learn to self-regulate	<input type="radio"/>				
2	Adults with an intellectual disability lack emotional self-control skills	<input type="radio"/>				
3	The best way to promote independence is to create opportunities for adults with an intellectual disability to live in society	<input type="radio"/>				
4	Adults with an intellectual disability need continuous support at work	<input type="radio"/>				
5	Adults with an intellectual disability can develop a professional identity	<input type="radio"/>				
6	Adults with an intellectual disability can learn to adapt to changing situations	<input type="radio"/>				
7	Adults with an intellectual disability need to do only simple and repetitive work tasks	<input type="radio"/>				
8	Adults with an intellectual disability can fully participate in society	<input type="radio"/>				
9	Adults with an intellectual disability can learn to adapt to unexpected situations	<input type="radio"/>				
10	Adults with an intellectual disability always need help to solve problems	<input type="radio"/>				
11	A protective environment promotes the learning of adults with an intellectual disability	<input type="radio"/>				
12	Adults with an intellectual disability learn from mistakes	<input type="radio"/>				
13	It is useless to work on the communication skills with of adults with an intellectual disability	<input type="radio"/>				
14	The quality of life of adults with ID is different from people without an intellectual disability	<input type="radio"/>				
15	Adults with an intellectual disability have the right to decide where to live	<input type="radio"/>				
16	Adults with an intellectual disability can learn skills for independent living	<input type="radio"/>				
17	Adults with an intellectual disability are capable of lifelong learning	<input type="radio"/>				



## 8. Limitations

It has been decided to use the Likert-scale items as quasi-interval variables in spite of the existing controversy on this issue. This has allowed us to calculate the means and medians, prioritize the items and run several tests.

Kolmogorov-Smirnov test showed that the Likert-scale variables do not behave as normal data. But as ANOVA may tolerate some violations of the normality, the sample size is greater than 30 in many categories and there is no reasons to believe that the observations are not independent, it was decided to conduct this test. Therefore, the obtained results must be carefully interpreted.

This research has used a non-probability sampling method. This means that the organizations and professionals closer to the partners organizations and research team have been more likely to be selected. This is considered as a sampling bias. Future research should consider improving the sampling method and types of organizations to the sampling.

The use of web-based self-administered questionnaires have some limitations such as the impossibility to contact the respondents before sending the questionnaire; the difficulty for some professionals to access the questionnaire; the fact that the respondent can only view a part of the questionnaire on their PC or Smartphone; or the impossibility to know the non-response rate.

It should be also taken into account the social desirability and acquiescence response bias of the Likert-scale questionnaires.



## Appendix 1 : Examples of Likert-scales measuring beliefs and attitudes

- *Eakin, 2017: Development and validation of CF-Medication Beliefs Questionnaire: A mixed-method approach.*

Within the framework of the "Social Cognitive Theory", the author develops a questionnaire formed by six sub-scales and five domains: motivation, self-efficacy, perceived importance, and decisional balance to take or miss medications. Method: The domains were created by studying previous literature and conducting 15 interviews. The sample used to validate the scales was 128 patients.

- *Manya C. Whitaker, Kristina Marie Valtierra, (2018) "The dispositions for culturally responsive pedagogy scale".*

Scale development for teachers beliefs about diversity and/or inclusive education. The scale development consists of a six-step process including item development, expert review, exploratory factor analysis, factor interpretation, confirmatory factor analysis and convergent and discriminant validity analyses. The sample used to validate the scale was 253 teachers. The final scale contains 19 Likert items across three dispositional domains: Disposition for Praxis, Disposition for Community and Disposition for Social Justice. The article provides with the pre-items used to create the scale which some of them have been inspiring examples for C&I scales.

- *Hassanein, 2014. Changing Teachers' Negative Attitudes Toward Persons With Intellectual Disabilities.*

The research used a 60-item likert-type scale, Attitudes Towards People with Disabilities (Alkoreity, 1992), which includes 24 positive statements and 26 negative statements about people with intellectual disabilities.

- *Rose, 2011. Health professionals' attitudes and emotions towards working with adults with intellectual disability (ID) and mental ill health.*

Attitudes of staff towards people with ID in mental health services may be negative and negative staff attitudes may have a detrimental impact on service provision. A questionnaire was designed to investigate the attitudes and emotions of staff towards delivering mental health care to adults with ID. It was completed by 84 staff from mainstream and specialist ID services. The attitude scale consists of 25 'attitude' statements relating to the provision of mental health care to adults with ID. The wording of each statement implies either a positive (13) or negative (12) bias.

- *L. Strike, 2004. Mental Health Professionals' Disability Competence: Measuring Self-Awareness, Perceived Knowledge, and Perceived Skills.*

The paper describes the mental health professionals' self-reported competence when working with clients with disabilities. The Counseling Clients With Disabilities Survey (Strike, 2001) was developed because no measure of mental health professionals' disability competence was found. Diane Strike developed the CDDS scales of Self-Awareness, Perceived Knowledge, and perceived skills using a process of literature review and expert review. Each of the three scales contains 20 items about which respondents express their agreement or disagreement on a 6-point scale (1 \_ strongly agree to 6 \_ strongly disagree). Six sample items illustrate a positive and a reverse keyed item for each of the three scales. The Self-Awareness items, "I consider people with disabilities to be a minority group," and "It is difficult for me to understand how disability could be a source of pride for people with disabilities," address adherence to a minority model of disability and awareness of disability culture. The Perceived Knowledge items, "I believe that unemployment/ underemployment is common among people with disabilities in the U.S.," and "I think English is the native language of Americans who are deaf



from birth,” address knowledge of employment issues and language barriers. The Perceived Skills items, “I could take a client’s disability into account when interpreting the results of assessment instruments,” and “I am not aware how disability may interact with human sexuality (e.g., family planning),” address assessment skills and case conceptualization skills.

- *Stuart, 2018. A Cross-National Comparison of Attributional Patterns Toward Students With and Without Learning Disabilities. Journal of Learning Disabilities.*

This article aims to raise awareness of the importance of attributional beliefs in relation to the educational outcomes of students with LD. The article uses as a framework the attribution theory. The instrument that was used for this study was adapted from Woodcock and Vialle’s (2010, 2011) study that used a modified version from Clark’s (1997) original study investigating elementary teachers’ perception of the achievement of U.S. students with and without LD. (N = 240) trainee teachers at the end of their training were surveyed with vignettes and Likert-scale questions to ascertain their responses to students with and without LD. Eight vignettes were created that described hypothetical boys who had just failed a class test. After the trainee teachers read the vignettes, they were asked four likert-type questions.

- *Neumark-Sztainer, 1999. Beliefs and attitudes about obesity among teachers and school health care providers working with adolescents.*

The aim of this study was to assess and describe obesity-related beliefs and attitudes among school staff. Beliefs were assessed with an eight-item scale (6-point likert scale) developed by Allison et Al. Attitudes towards obese persons were assessed with a modified version of Allison et Al. scale with 16 items (6-point likert). The 24 items are shown in the article. The final study sample included 115 respondents (teachers, nurses and social workers)

- *Chin, 2002. Development of the Attitudes Toward Vegetarians.*

Although this study has not much to do with learning barriers or disability, the well-explained methodology to develop the scale and the kind of items used and the sample (N= 244 students) might be very useful to develop C&I scales and validate them. The focus of this study was to develop a scale designed to measure attitudes toward vegetarians (ATVS). This scale measures a one-factor construct with adequate internal consistency. The ATVS correlated significantly with the construct of authoritarianism, and, as expected, the ATVS did not correlate significantly with social desirability. The scales (ATVS) was formed by 21 items (7-point likert style).

- *Brown & Haywood, 1989. Development of an empirical scale of philosophies of education.*

This study very specifically starts from the idea that educators operate according to a set of assumptions about what they think ‘education’ is, why they do it, and what can be accomplished through it. These educational philosophies define a variety of teaching activities, including methods, contents, techniques of behavior management, (relative) optimism about the long term effects of their efforts on knowledge and behavior. The idea that ‘educators’ beliefs influence their teaching/supporting behavior to a great extent, is especially relevant when linked to learning challenges within ‘disadvantaged’ people. The development of the scale was done within the context of preschool and cognitive education/transversal skills, but is easily generalizable to other contexts where ‘learning’ is a challenge. The scale has been developed, starting from statements in 10 educational domains, written down by a small group of teachers. The domains are e.g. content of education, nature of the learning environment, modifiability of intelligence, student role, nature of learning,... 228 statements have been formulated, later on sorted according to domain, and reduced (according to a few criteria) to 54 items. The order of these items was randomized and formatted in a 5 point Likert scale (strongly disagree, strongly agree). 271 preschool teachers, administrators and university students were asked to indicate their level of agreement with each scale. A principal components factor analysis was performed



on the ratings of the participants. 18 factors (eigenvalue > 1.00) were extracted from the data on the initial analysis. 4 of these factors were defined adequately and were associated with a large enough percentage of the total variance to merit retaining them (teacher authority – referring to specific view of education, student independence – active learners versus passive recipients of information, parent participation and student interest).

The first two factors are highly aligned with the active modification approach as explained by Feuerstein.

- *Enea-Drapeaua.o. 2017. Implicit theories concerning intelligence of individuals with Down syndrome.*

Starting point is evidence (studies over past three decades) that learning difficulties are not only determined by neurological disorders, but also by motivational and socio-cognitive factors. Among these, implicit theories of intelligence are key elements. The belief that intelligence is fixed (entity theory/fixed mind set, passive acceptance) versus malleable (active modification, growth mind set, incremental theory) is associated with negative teaching practices and poor 'student' outcomes. This study assessed the beliefs about intelligence of Down syndrome and 'typical' people of 55 professionals and 81 non professionals. The implicit theories of intelligence were assessed using the Dweck's 8-item Theories of Intelligence Scale, measuring what people believe about intelligence in general (with 4 items on fixed, and 4 on growth mind set), and 2. an adaptation of this scale, all items referring to DS. A Likert scale was used together with an association test (Greenwald e.a.1998).

Both groups see DS people as less 'malleable' (stereotypical judgement, and intelligence of DS is seen 'different'). The study shows that professionals are more positive, considering DS people more intelligent, educable and 'less stupid' than non professionals do.

The study is giving inspiration on the content of implicit theories of intelligence and judgments about intelligence toward people with DS. Especially the finding that a growth mindset in teachers and students, school/training outcomes and teaching strategies can improve. (see relevance for an IO2 tool). The study suggests to include in further studies to investigate the beliefs of people with intellectual disabilities about their own abilities and intelligence.

This study refers to several similar studies and reflections, b.o. Gutschall (2003) – teachers mindset for students with and without disabilities

Very interesting article as it refers to our problem definition : the perception, beliefs,... about the abilities and learning potential of the 'students' has implication on the kind of interventions (quantity, quality, content,...). Author refers to growth and fixed mindset, self fulfilling prophecy,... teachers were asked to complete a Likert scale (6) based on the Dweck-scale to assess their own mind set; next – with some 'stories' as basis, the same was asked about students (Michael will not improve his ability, e.g.) There was found a strong correlation between the mindset of the teacher and the perception of the ability to change within students.

- *Developing the Educational Belief Scale – Yilmaz a.o.*

This study aims to develop a valid and reliable scale to be used in determining educational beliefs of teachers. 455 (prospective) teachers were involved. After factor analysis, 5 factors were defined. 40 items were selected, a five Likert scale was used. This article is interesting for it provides useful definitions of the concept of beliefs, being cognitions one gets in his relationship with the environment, and consist of the individuals past and present knowledge of an object. Beliefs are stronger than the effects of experiences in building human behavior (Bandura), affecting peoples manners. Studying teachers beliefs is important to understand teacher behavior.

Educational beliefs are based on educational philosophies, that orients education, shapes goals, leads education applications (why teaching what? Functions of education? Choice for program or methods,...)



- *De Castella & Burn, My Intelligence May Be More Malleable than Yours: The Revised Implicit Theories of Intelligence (Self-Theory) Scale is a Better Predictor of Achievement, Motivation and Student Disengagement.*

The belief that intelligence is malleable has important consequences for achievement and motivation (Blackwell et al., 2007; Dweck, 1999; Robins & Pals, 2002). However, believing that it is possible to improve intelligence does not necessarily mean students are always confident they can improve their own. The current study presents a revised ‘self-theory’ measure of the implicit theories of intelligence scale, which assess students’ beliefs about their ability to mould their own intelligence in contrast to their beliefs about the malleability of intelligence in general. In testing with 643 Australian high school students (62% female) ranging from 15 – 19 years of age ( $M = 16.6$ ,  $SD = 1.01$ ), the belief that intelligence is ‘fixed’ was predictive of lower endorsement of achievement goals, greater helplessness attributions and poorer self-reported academic grades. Fixed ‘entity’ beliefs were also predictive of academic self-handicapping, truancy and disengagement. On all of these measures, the new self-theory scale, uniquely explained greater outcome variance. These results indicate that students’ implicit beliefs – particularly about their own intelligence – may have important implications for their motivation, engagement and performance in school.

- *Inclusive schools in action – chapter 4 – examining beliefs - McLeskey & Waldron 2000*

This chapter is very inspirational as it describes a way of examining and changing beliefs regarding to schooling and inclusion for both teachers and administrators. This paper is on the role of teachers, their prejudices, goals of education, long term goals (societal and academic, relationship, problem solving, personal goals and independence!), willingness to teach in an inclusive setting,....

- *Elliot, B & Chan K. (1998) – paper on ‘epistemological beliefs in learning to teach’*

This paper describes the development of a scale, with 4 subscales (belief in authority/expert knowledge, belief in certainty of knowledge, belief that learning requires significant effort), belief that ability to learn is innate)



## Appendix 2. QUESTIONNAIRE (English version)



### Tool to assess professionals' mindset on Quality of Life, Social Inclusion, Cognition and Employment of adults with Intellectual disabilities (ID)

#### INSTRUCTIONS

This tool has been developed within the project "Cognition & Inclusion" which belongs to Erasmus+ programme.

The objective of this tool is to identify the beliefs of professionals working with adults with intellectual disabilities (ID)

The data obtained from this tool will be only used for research purposes. The final tool, and a report with instruction and conclusions will be published on the project website: <http://www.ensa-network.eu/cognitionandinclusion/index-c-i.html>

Your answers are anonymous. You can leave blank the questions that you do not have a clear opinion.

If you are interested in receiving a copy of the tool or the material developed by the project, write your email in the last question.

Thank you for your participation!

#### 1. Gender

- Male
- Female

#### 2. Age

- 18-30
- 31-40
- 41-50
- Over 50

#### 3. Number of years of experience working as a professional with adults with intellectual disabilities

- Less than 1 year
- Between 1 year and 3 years
- Between 3 and 10 years
- Between 10 and 20 years
- More than 20 years



4. I am currently working in an organization

- Private
- Public
- Mixed public-private
- Self-employed professional

5. Size of the organization or company you are working for:

- From 1 to 5 workers
- From 6 to 10 workers
- From 11 to 50 workers
- From 51 to 250 workers
- More than 250 workers

6. Level of dependency of the target group you work with (You may Choose one or several options)

- GREAT DEPENDENCE: The person needs help to carry out several daily life activities several times per day and, due to the total loss of mental and physical autonomy, the person needs the indispensable and permanent presence of a person
- SEVERE DEPENDENCE: The person needs help to carry out several daily life activities two or three times per day, but the person does not need permanent presence of a care-giver
- MODERATE DEPENDENCE: The person needs help to carry out one or several daily life activities, at least once per day.

7. Choose the option that suits your professional tasks best

- Frontline professionals: direct contact intervention with the final beneficiaries (clients). (For example: occupational therapists, educators, employment mediators, nurses, psychologists...)
- Others (ex. Office staff, supervisors, program designers, evaluators..)

8. Type of service provider. (You may Choose one or several options)

- Sheltered home (easier-to-manage home with a warden to live more independently with your couple or other persons with disability and receiving some support)
- 24-hour residential service: living less than 20 people with intellectual disabilities (ID)
- 24-hour residential service: living between 20 and 40 people with intellectual disabilities (ID)
- 24-hour residential service: living between 41 and 60 people with ID
- 24-hour residential service: living more than 60 people with ID
- Leisure time resource
- Employment support service
- Day care center (non-residential facility offering nutritional, health or social support)
- Independent life service
- Vocational and educational center (tailor-made workshops and vocational and educational training courses)
- Other



LIKERT SCALE QUESTIONS



Tool to assess professionals' mindset on Quality of Life, Social Inclusion, Cognition and Employment of adults with Intellectual disabilities (ID)

Please tick one circle to show how much you agree or disagree with the following statements

KEY CONCEPTS

Self-regulation (question 1): refers to the person's competence to change himself and have control over its internal processes.

Design for all (question 2): the design of products and environments to be usable by all people.

1. Adults with Intellectual disabilities (ID) can learn to self-regulate

- I strongly agree
- I agree
- Neither agree nor disagree
- I disagree
- I strongly disagree

2. Design for all helps adults with ID to improve their Quality of Life

- I strongly agree
- I agree
- Neither agree nor disagree
- I disagree
- I strongly disagree

3. Adults with Intellectual Disabilities (ID) lack emotional self-control skills

- I strongly agree
- I agree
- Neither agree nor disagree
- I disagree
- I strongly disagree



4. The best way to promote independence is to create opportunities for adults with ID to live in society

- I strongly agree
- I agree
- Neither agree nor disagree
- I disagree
- I strongly disagree

5. Adults with ID have the freedom of choice in all aspects of life

- I strongly agree
- I agree
- Neither agree nor disagree
- I disagree
- I strongly disagree

6. Adults with Intellectual Disabilities (ID) need continuous support at work

- I strongly agree
- I agree
- Neither agree nor disagree
- I disagree
- I strongly disagree

7. Adults with ID can develop a professional identity

- I strongly agree
- I agree
- Neither agree nor disagree
- I disagree
- I strongly disagree

8. Adults with ID can learn to adapt to changing situations

- I strongly agree
- I agree
- Neither agree nor disagree
- I disagree
- I strongly disagree



9. Professionals are a barrier for the autonomous functioning of adults with ID

- I strongly agree
- I agree
- Neither agree nor disagree
- I disagree
- I strongly disagree

10. Adults with ID need to do only simple and repetitive work tasks

- I strongly agree
- I agree
- Neither agree nor disagree
- I disagree
- I strongly disagree

11. Adults with ID can fully participate in society

- I strongly agree
- I agree
- Neither agree nor disagree
- I disagree
- I strongly disagree

12. Individualized supports are irrelevant for the quality of life of adults with ID

- I strongly agree
- I agree
- Neither agree nor disagree
- I disagree
- I strongly disagree

13. Adults with ID can learn to adapt to unexpected situations

- I strongly agree
- I agree
- Neither agree nor disagree
- I disagree
- I strongly disagree



13. Adults with ID can learn to adapt to unexpected situations

- I strongly agree
- I agree
- Neither agree nor disagree
- I disagree
- I strongly disagree

14. Adults with ID always need help to solve problems

- I strongly agree
- I agree
- Neither agree nor disagree
- I disagree
- I strongly disagree

15. A protective environment promotes the learning of adults with ID

- I strongly agree
- I agree
- Neither agree nor disagree
- I disagree
- I strongly disagree

16. Employment is important for adults with ID

- I strongly agree
- I agree
- Neither agree nor disagree
- I disagree
- I strongly disagree

17. Adults with Intellectual Disabilities learn from mistakes

- I strongly agree
- I agree
- Neither agree nor disagree
- I disagree
- I strongly disagree



18. The actual level of functioning of an adult with ID is a good predictor for the future level of functioning

- I strongly agree
- I agree
- Neither agree nor disagree
- I disagree
- I strongly disagree

19. It is useless to work on the communication skills with of adults with ID

- I strongly agree
- I agree
- Neither agree nor disagree
- I disagree
- I strongly disagree

20. The quality of life of adults with ID is different from people without ID

- I strongly agree
- I agree
- Neither agree nor disagree
- I disagree
- I strongly disagree

21. Adults with ID have the right to decide where to live

- I strongly agree
- I agree
- Neither agree nor disagree
- I disagree
- I strongly disagree

22. Adults with Intellectual disabilities can learn skills for independent living

- I strongly agree
- I agree
- Neither agree nor disagree
- I disagree
- I strongly disagree



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23. Adults with Intellectual disabilities (ID) are capable of lifelong learning

- I strongly agree
- I agree
- Neither agree nor disagree
- I disagree
- I strongly disagree

24. The environment needs to be adapted in order to make adults with ID's personal development possible

- I strongly agree
- I agree
- Neither agree nor disagree
- I disagree
- I strongly disagree

If you wish to receive a report with the conclusions of the assessment, please write your email address

Your answer \_\_\_\_\_

**To finish, click on the "submit" button. Thank you for your participation!**

BACK

SUBMIT

Never submit passwords through Google Forms.



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## ANNEX 2

### **Final English versions of the assessment tools**

Cognition & Social Inclusion Beliefs scale for Professionals  
Mindset Questionnaire  
General Self-Efficacy scale  
Social Pressure scale



## *COGNITION & SOCIAL INCLUSION BELIEFS SCALE*

### **My professional beliefs on Cognition and Intelligence, Inclusion, Quality of Life and Employment of adults with an intellectual disability**

#### **Instruction**

The statements below refer to opinions you – as a professional - may have on intelligence, learning potential, quality of life, employment and the goals of support of adults with an intellectual disability. You are invited to indicate to what degree you agree with the 17 statements. Mark one of the boxes on the right that is representing in the best way your personal belief on what is stated in the item. In case you strongly agree, mark the right-most box; in case you strongly disagree, mark the left-most box. You also can express your opinion between these two extremes.

#### **Scoring instructions**

Items 1, 3, 5, 6, 8, 9, 12, 15, 16, 17 have a positive orientation and score

Strongly agree: 5 points

Agree: 4 points

Neither agree nor disagree: 3 points

Disagree: 2 points

Strongly disagree: 1 point

Items 2, 4, 7, 10, 11, 13 and 14 have a negative orientation and score in the opposite direction

Strongly agree: 1 point

Agree: 2 points

Neither agree nor disagree: 3 points

Disagree: 4 points

Strongly disagree: 5 point

The higher the sum of the scores, the more the professional beliefs are congruent with the concept of "beliefs on cognition and social inclusion of adults with an intellectual disability" as defined by this C&I-project.

#### **Conclusions**



My Cognition & Social Inclusion Beliefs	strongly disagree	disagree	neither agree nor disagree	agree	strongly agree
1 Adults with an intellectual disability can learn to self-regulate. Self-regulation refers to the person's competence to manage his own behavior and thinking processes and have control over his internal processes.					
2 Adults with an intellectual disability lack emotional self-control skills. Having Emotional Self-Control means staying clear-headed and calm, balancing one's impulses and feelings for the good of the group or mission.					
3 The best way to promote independence is to create opportunities for adults with an intellectual disability to live in society.					
4 Adults with an intellectual disability need continuous support at work.					
5 Adults with an intellectual disability can develop a professional identity.					
6 Adults with an intellectual disability can learn to adapt to changing situations.					
7 Adults with an intellectual disability need to do only simple and repetitive work tasks.					
8 Adults with an intellectual disability can fully participate in society.					
9 Adults with an intellectual disability can learn to adapt to unexpected situations.					
10 Adults with an intellectual disability always need help to solve problems.					
11 A protective environment promotes the learning of adults with an intellectual disability.					
12 Adults with an intellectual disability learn from mistakes.					
13 It is useless to work on the communication skills of adults with an intellectual disability.					
14 The quality of life of adults with an intellectual disability is different from people without an intellectual disability.					
15 Adults with an intellectual disability have the right to decide where to live.					
16 Adults with an intellectual disability can learn skills for independent living.					
17 Adults with an intellectual disability are capable of lifelong learning.					



## *MINDSET QUESTIONNAIRE – C. Dweck*

### My personal mindset

#### **Instruction**

All people have personal beliefs on their own way of thinking and learning, their potential to learn, the way they learn, etc... This tool helps you to reflect on these beliefs. Read each sentence below and mark the corresponding box that shows how much you agree with each sentence. There are no right or wrong answers.

While marking the box that represents your opinion in the best way, think about your intelligence and learning and not how people with an intellectual disability are thinking and learning.

#### **Scoring instructions**

Mean score of Items 1 3 5 7 : G-score =

Mean score of Items 2 4 6 8 : F-score =

Strongly agree: 5 points

Agree: 4 points

Neither agree nor disagree: 3 points

Disagree: 2 points

Strongly disagree: 1 point

The highest sum or mean score (G-score or F-score) gives an indication for the orientation of your own mindset. Is it rather a Growth mindset or rather a Fixed mindset as defined by C. Dweck and as adopted in this C&I-project.

#### **Conclusions**



My Personal Mindset	strongly disagree	disagree	neutral	agree	strongly agree
1. No matter how much intelligence you have, you can always change it a good deal.					
2. You can learn new things, but you cannot really change your basic level of intelligence.					
3. I like my work best when it makes me think hard.					
4. I like my work best when I can do it really well without too much trouble.					
5. I like work that I'll learn from even if I make a lot of mistakes.					
6. I like my work best when I can do it perfectly without any mistakes.					
7. When something is hard, it just makes me want to work more on it, not less.					
8. To tell the truth, when I work hard, it makes me feel as though I'm not very smart.					



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## *GENERAL SELF EFFICACY SCALE – Jerusalem & Schwarzer*

### My perceived general self-efficacy

#### **Instruction**

In this questionnaire, you will find 10 questions on how someone generally acts and thinks. This questionnaire gives you an idea on how you perceives yourself regarding coping and adaptation abilities in both daily activities and isolated stressful events. For each statement, give an indication of the degree you are agreeing by putting a cross in the box that is at this moment, most applicable to you.

#### **Scoring instructions**

Add up all scores.

Not at all true: 1 point

Hardly true: 2 points

Moderately true: 3 points

Exactly true: 4 points

The higher the score, the higher your perceived Self-Efficacy.

#### **Conclusions**



<b>My General Self-Efficacy</b>	Not at all true 1	Hardly true 2	Moderately true 3	Exactly true 4
1. I can always manage to solve difficult problems if I try hard enough				
2. If someone opposes me, I can find the means and ways to get what I want.				
3. It is easy for me to stick to my aims and accomplish my goals.				
4. I am confident that I could deal efficiently with unexpected events.				
5. Thanks to my resourcefulness, I know how to handle unforeseen situations.				
6. I can solve most problems if I invest the necessary effort.				
7. I can remain calm when facing difficulties because I can rely on my coping abilities.				
8. When I am confronted with a problem, I can usually find several solutions.				
9. If I am in trouble, I can usually think of a solution				
10. I can usually handle whatever comes my way.				



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## *SOCIAL PRESSURE SCALE – IVASS*

**The impact of the social and professional environment on my beliefs and job**

### **Instruction**

In this questionnaire, you will find 12 questions on what families, your colleagues and/or your organization believe what is important and/or what they expect from you. It happens that professionals are not aware of the influence that the social and professional environment may have on what you do and how you do your job. For each statement, give an indication of the degree you are agreeing by putting a cross in the box that is at this moment, most applicable to you.

### **Scoring instructions**

No scores need to be calculated. This questionnaire helps you to reflect on the impact of beliefs, expectations,... of your environment on how you do your job.

### **Conclusions**



My Perceived Social Pressure	strongly disagree	disagree	Neither agree nor disagree	agree	strongly agree
1. Families of adults with intellectual disability support actions to make them visible in society.					
2. Professionals promote the participation of adults with intellectual disability in the society.					
3. Families expect me to improve the self-determination skills of my clients.					
4. My colleagues believe that adults with intellectual disability are unable to learn during their life.					
5. My organization expect me to work the problem solving skills of my clients.					
6. Society prefers having adults with intellectual disability invisible.					
7. Families believe that professionals are a barrier for an autonomous functioning of the person.					
8. Family of adults with intellectual disability support them to live where they wish.					
9. My organization believes that adults with intellectual disability do not value having a job					
10. My colleagues believe that getting a job for adults with intellectual disability is irrelevant					
11. My organization believes that a protective environment prevents adults with intellectual disability from learning					
12. My organization believes that change depends on the person´s decision to change					