Attitudes, Bias, Ableism, and Stereotyping

This document is an excerpt from Module 2 of *Intellectual and Developmental Disability: A Toolkit to Enhance Education of Health Care Professionals to Provide Quality Health Care to Persons with IDD*. Access the full toolkit.

This module addresses a key and pervasive barrier to quality health care encountered by many people with a disability: negative attitudes toward people with disabilities by health care professionals. Such negative attitudes are consequential in the health of people with disabilities and their satisfaction with the health care they receive as well as the quality of that care. Attitudes, bias, ableism, and stereotyping are discussed in this module along with the concepts of diversity, equity, and inclusion (DEI) and accessibility (A). Legal mandates to address the civil rights of people with disabilities in general and IDD specifically are identified, along with strategies to address those factors that result in their receiving poor health care.

Overview

Most people believe that our judgments of others are fair, objective, and unbiased. However, even members of health care professions have unconscious biases that affect how we interact and respond to other people. Such biases affect the health care we provide to people with disabilities and their resulting health status.

People with disabilities, including those with intellectual and developmental disabilities (IDD), experience health disparities, defined as differences in health status compared to that of people without disability. These disparities are due in part to health inequities, defined as unfairness and injustice, affecting the health care they receive (Kneipp et al., 2018). Although the history of how people with IDD have been viewed and treated around the world and in the U.S. over time is troubling (Conrad, 2020), improvements have been made in health care for this population. Further efforts are still needed to ensure that those with IDD live their lives to the fullest and reach their potential. The health professions are an important part of reaching those goals. Health care professionals' lack of information about IDD and negative attitudes serve as barriers to quality health care and result in compromised health for those with IDD. The effects of the barriers and the strategies used to address those barriers are discussed in this module.

Diversity, Equity, Inclusion, and Accessibility

In the aftermath of social unrest and calls for social justice, many schools, businesses, organizations, and government agencies developed or strengthened existing programs to ensure that they adequately address diversity, equity, and inclusion (DEI). Once considered an issue of concern limited to organizations' human resources departments, DEI efforts began to be addressed in strategic plans and made a priority by many organizations. Although efforts to address DEI go back to the 1960s, the need for them grew in importance in response to the blatant racism and social unrest that erupted in 2020. Of concern is that these DEI programs often fail to include disability as one of several areas where greater efforts are needed to ensure that disenfranchised groups are treated equitably. Although 62 percent of businesses report having DEI policies and practices, only 4 percent of them include disability in their DEI efforts (Relias, 2021, 2022).

Attention to disability in health care through DEI programs remains sparse. The unique needs and experiences of people with disabilities, including those with IDD, continue to be ignored and unaddressed in educational programs or clinical practice for the health care professions. Thus, despite the large and growing population of people with disabilities (> 70 million), the U.S. health care system and health care professions education have failed the quarter of the U.S. population with disability (National Council on Disability [NCD], 2022). Many health care professionals have little knowledge about disability in general and even less about IDD. They fail to communicate effectively with people with disabilities and have biased attitudes about them, their quality of life, and their general health needs. As a result, people with disability often use the health care system for emergencies only and are reluctant to access it for health promotion and disease prevention; thus, the system is a source of potential harm for this population (NCD, 2022).

President J. Biden issued an executive order on DEI, adding "A" for accessibility (DEIA) to address disability in the federal workforce. However, in 2025 attacks on DEI efforts across the U.S. and across organizations and agencies resulted in many DEI programs and efforts being dismantled. Despite these changes, health care systems and health professions would benefit from maintaining their efforts to address diversity, equity, inclusion, and accessibility that are so vital to the health care of individuals with disability, including those with IDD.

Attitudes, Bias, Ableism, and Stereotyping

Negative attitudes, bias, ableism, and stereotyping on the part of health care professionals have consistently been identified as major barriers to quality health care for people with disabilities. These factors have the potential to lead to significant discrimination and prejudice. Attitudes, bias, ableism, and stereotyping are terms key to this discussion and are defined in the following table along with examples related to disability.

Term	Definition	Examples
Attitude	A set of emotions, beliefs, and feelings about someone or something; attitudes can be negative or positive and can affect our behaviors toward someone or something.	• *Positive attitude*: believing that all patients with disabilities should be approached with a warm and inviting manner. • *Negative attitude*: seeing nothing wrong with ignoring the views and questions of patients with IDD because they are viewed as incapable of understanding accurate information.
Bias	Tendency to favor or disfavor one group over another; may be conscious (explicit) or unconscious (implicit); although bias may favor or disfavor one group over another group, the term is often used to indicate unfair response to groups not seen favorably. *Conscious/explicit bias*: Intentional favoring or disfavoring of one group over another; aware of effect of actions. *Unconscious/implicit bias:* Unintentional favoring or disfavoring of one group over another without realizing it; unaware of effect of actions.	• Intentionally withholding accommodations for people with disabilities for health care visits because of the costs or efforts required. • Not providing information about health-related procedures and tests to patients with IDD because of belief that they will not understand the information.

Ableism	Stigma, prejudice, and discrimination specific to disability; refers to favoring able-bodied people and disapproval and negative views of people with disability; social prejudice against those with disabilities based on the belief that typical or "normal" abilities are superior and those with disability are "less than" and in need of "fixing." Objectivizing people with disability for the benefit of those without disability (referred to as "inspiration porn").	• Talking to people with disability as if they are children; talking *about* them rather than to them; speaking *for* them. • Assuming that we know what is best for those with disability without asking them. • Scheduling a health care visit or meeting without providing needed accommodation. • Assuming people with disability have a poor quality of life and depend on others to care for them. • Framing disability as either tragic or inspirational in news stories, movies, and other media. Praising people with disability (as heroes, extraordinary, or inspirational) for everyday activities.
Stereotyping	Oversimplified, fixed, and widely held beliefs about an individual based on one's views about an entire group of people. Stereotypes are often inaccurate, especially when they lead to judgments applied to people within that group. Can lead to diagnostic overshadowing (attributing all health issues to a person's disability and failing to diagnose and treat the actual disorder).	• Believing that people with IDD are unpredictable and prone to violence. • Assuming that people with disability are asexual. • Having low expectations about what people with IDD can achieve. • Attributing all health issues to a person's disability rather than to other possible causes and, as a result, not providing timely and appropriate treatment.

Attitudes refer to feelings or ways of thinking that affect how we engage with others. Attitudes are formed during childhood and are influenced by the world and people around us. If these attitudes are negative, they can be result in bias, ableism, stereotyping, prejudice, and discrimination.

Multiple studies conducted around the world indicate that society as a whole and many health care professionals across disciplines have negative attitudes toward people with a disability (Desroches et al., 2022; Iezzoni et al., 2021; Morin et al., 2018; NCD, 2009; Pelleboer-Gunnink et al., 2017). Further, people with intellectual disability and psychiatric/mental health disability are viewed more negatively than those with other types of disability. While most people would be reluctant to openly admit that they have negative attitudes toward people seen as different from themselves, such as people with a disability, unconscious or implicit negative attitudes can have devastating effects that result in discrimination, inferior health care, and health disparities.

Bias can be either explicit or implicit. Explicit biases are those at the conscious level, are deliberately formed, and easy to report, observe, or measure. In contrast, implicit attitudes are those at the unconscious level. Such attitudes are involuntarily formed and unknown to us. They are also much more difficult to report, observe, or measure. Because individuals are unaware of their implicit biases, these are more difficult to modify than the explicit biases an individual usually recognizes and acknowledges.

Ableism refers to valuing independence over interdependence, and viewing being able-bodied (the absence of disability) as the norm. The concept of ableism is consistent with the medical model of disability, which views disability as a defect or deficit to be overcome, resting with the individual and not related to environmental and social factors (Borowsky et al., 2021). Ableism results in persons with disability being devalued or diminished because of their disability.

Ableism includes negative perceptions of the quality of life of persons with disability, which has consistently and as recently as 2021 been perceived as poor by health care professionals (Iezzoni et al., 2021). Activities and equipment that are part of the daily life of persons with disability (e.g., wheelchairs, feeding tubes, respirators) are often viewed by health care professionals as indicators of poor quality of life (Janz, 2019), resulting in inadequate health care for people with disability. A major consequence of these negative perceptions and ableism became apparent during the COVID-19 pandemic, when people with disabilities were denied high-level health care and instead were identified as candidates for palliative and end-of-life care, based only on their having a disability (Fuentes et al., 2021; NCD, 2022). A bulletin issued by the Office of Civil Rights (2020) during the pandemic emphasized the need for fairness, equality, and compassion in treating people with disabilities, stating they have the same dignity and worth as everyone else. The Office of Civil Rights further stated that people with disabilities should not be denied health care on the basis of stereotypes, assessments of quality of life, or judgments about the person's relative "worth" based on age or the presence or absence of disability.

Stereotyping refers to having oversimplified and fixed beliefs about an individual based on one's views about an entire group of people. Stereotypes are often inaccurate, especially when they lead to judgments applied to people within that group. Stereotyping can lead to overshadowing (attributing all health issues to a person's disability and failing to diagnose and treat the actual disorder). Diagnostic overshadowing with failure to treat health conditions and delays in treatment have been identified as possible explanations for a 26-year shorter lifespan of people with IDD compared to those without disability. Other health disparities, such as poverty, unhealthy living environments, and challenges with communication and self-advocacy in this this population, also contribute to their shortened lifespan (Lauer & McCallion, 2015; Landes et al., 2020).

Despite the negative effects of such attitudes, bias, ableism, and stereotyping on the health and health care of persons with IDD, these factors can be changed through education, experience, and exposure of health care professionals to people with IDD (Crane et al., 2021; Smeltz et al., 2023). However, effort is needed to ensure appropriate education for members of society in general and for members of the health care professions specifically. Such efforts have been identified as essential by private, governmental, and national as well as international organizations, including the Centers for Disease Control and Prevention (2020), World Health Organization (2021), United Nations Department of Economic and Social Affairs (2006), the Institute of Medicine (2007), the U.S. Surgeon General's Office (2005), and the National Council on Disability (2022).

In addition, there are legal mandates to address these issues, including those of the Americans with Disabilities Act (1990), the Americans with Disabilities Amendments Act (2008), and the Developmental Disabilities Assistance and Bill of Rights Act of 2000.

Strategies to Address Attitudes, Bias, Ableism, and Stereotyping

A number of strategies have been identified to address the attitudes, bias, ableism, and stereotyping that result in poor health and health care for persons with IDD. Several strategies are the following:

1. Consider and reflect on your own bias about disability by asking yourself these questions:
   - When you first meet a person with IDD or another disability, do you see the disability before you see the person?
   - When you first think of a person with IDD, do you focus on what the person *can* do or what the person *cannot* do?
   - When you see or meet someone with IDD, do you direct your attention and conversation to that person or to an accompanying person?
   - When you think of a person with IDD, do you have pity for that person?
   - When you interact with a person with IDD in a health care encounter, do you provide the same quality of care that you give to other patients?
   - When you communicate with a person with IDD, do you talk to that person as an adult or as a child?
   - When you are providing care to a person with IDD, do you ask the same types of questions about health practices you ask of other patients?
   - When you see someone with IDD, do you consider that person's quality of life as poorer than that of persons without IDD?
2. Interact with people with IDD and establish a one-to-one relationship to get to know them as people with individual characteristics, interests, and preferences, discarding stereotypes.
3. Consider the perspectives of people with IDD to better understand their responses and the adaptive techniques they use to function in their environment.
4. Focus on what people with IDD *can* do rather than what they *cannot* do.
5. Learn about IDD and its diversity and the effects of negative attitudes, bias, ableism, and stereotyping on the health and health care of people with IDD.
6. Consider completing the Disability Attitudes Implicit Association Test (DA-IAT) to assess your own explicit and implicit attitudes toward people with disabilities. Available without cost at https://implicit.harvard.edu/implicit/selectatouchtestv2.html

Summary

This module has summarized information about the attitudes, bias, ableism, and stereotyping that are major barriers to quality health care for people with IDD. In addition, strategies to address these issues have been presented. These strategies are essential for health care professionals across disciplines if the large and growing numbers of people with IDD are to receive the equitable and quality health care essential for them to live healthy lives and thrive.

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