

**Including Persons with Disabilities in Faith Communities**

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## **DEDICATION**

I offer this work to God, and to all of His good and perfect gifts seen as imperfect through our eyes. To those who read this, may it provide an opportunity for insight and reflection.

“None too lost to be saved; none too broken or ashamed; all are welcome in this place.”

-Matt Redman

## **ABSTRACT**

This exploratory study used both a quantitative and qualitative research approach to acquire information regarding the application of principles and practices of inclusion common to our childcare and education settings in communities of faith throughout the Halifax Regional Municipality. Outcomes of this study were to a) gain knowledge of the availability and accessibility of local faith communities b) determine rates and areas of participation for individuals with disabilities and c) explore faith leaders' views of disability and inclusion.

Faith leaders (n =33) completed a faith participation survey developed by the researcher. Responses to the open-ended questions on the survey were evaluated and coded for emerging themes using qualitative methodologies, while close-ended survey responses were coded and analyzed using quantitative techniques. Results indicated that although individuals with disabilities were participating across several areas, a significant participation gap existed between individuals with disabilities and their non-disabled peers within local communities of faith. Respondents shared views of disability and inclusion that were in keeping with those expressed and favoured by the broader community. Their perceptions of barriers to inclusion were also consistent with those of previous research findings, but did not necessarily reflect the opinions expressed by individuals with disabilities. Highlighted was the general lack of programs and policies developed specifically for individuals with disabilities. Emphasized was the need for further awareness and knowledge related to this topic.

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# **CHAPTER I**

## **Introduction**

### **A. Statement of Problem**

Both the philosophy and practice of inclusion have expanded vastly over the past 40 years. Disability was made visible in our society primarily as an outcome of military engagement, while society managed to keep members of the general population with disabilities out of sight by building institutions and using statutes to prohibit these individuals from public places (Lifchez, 1987). Until the latter half of the twentieth century, people who were different were largely invisible. At that time, the social and physical isolation of people with physical and mental disabilities became a focal point of civil rights legislation.

In the 1970s the notion of mainstreaming or integrating individuals with special needs in regular settings became more prominent. Although the concept of inclusion began as a way to ensure that disabled children were educated at the same school they would have attended if not disabled, current practice surpasses the idea of physical integration and fully advocates basic values that promote and advance participation, friendship, and a celebration of diversity (Child Care Advocacy Association of Canada, 2004).

As inclusion of children with disabilities in typical childcare and educational settings continues to expand, researchers must continue to examine the best practices for meeting their developmental needs. However, parents and families also seek to have their children act as full

participants in community, recreational, and religious programs. Therefore, there also exists a need to explore ways in which these best practices can be applied in other settings.

A review of the inclusion literature reveals an abundance of research concerning early childhood education and school programs (see for example, Cross, Traub, Hutter-Pishgahi, & Shelton, 2004; King & Edmunds, 2001; Ryndak, Jackson, and Billingsley, 2000). Research regarding inclusion in community and recreation programs has also begun to emerge (see for example, Mulvihill, Cotton, & Gyaben, 2004). On the other hand, research on inclusion of individuals with special needs, and in particular children with developmental disabilities, in communities of faith is more limited. Previously, researchers have identified spirituality and religious participation as indicators of individual and family quality of life (Brown, Anand, Isaacs, Baum, & Fung, 2003; Poston & Turnbull, 2004). It follows that opportunities to engage in these practices in meaningful ways would also be of interest to individuals and families faced with special needs.

The present research project examined how the principles and practices of inclusion common to our childcare and education settings are applied in communities of faith throughout the Halifax Regional Municipality (HRM). This research focused on the issue of inclusion as it relates to full participation in all religious services and events offered by faith communities and leaders. The compelling question is, “How do faith leaders view current inclusion practices in faith communities?” Religious leaders were given opportunities to share their experiences, perspectives, and perceptions on this topic.



## **B. Personal Interest**

*The inspiration for this research topic came from my personal and professional experiences in the disabilities field, coupled with my Christian faith. Over the past ten years I have gained experience with children and families as a dedicated student, interventionist, researcher, and parent. More recently, I have become an active participant in my own faith community and have developed an interest in ministering to children with unique and extensive developmental needs.*

*As I continue to grow in my own relationship with God and expand my involvement in my faith community, I often reflect upon the spiritual needs of individuals with disabilities. I continually notice the absence of this significant portion of our population at religious services and events. In the Christian tradition, the Bible tells us that*

*Just as each of us has one body with many members, and these members do not all have the same function, so in Christ we who are many form one body, and each member belongs to all the others. We have different gifts, according to the grace given us. - Rom. 12:4-6a NIV (Barker, Stek, Wessel, & Youngblood, 2002).*

*God invites all people to worship, to have fellowship, to learn, and to serve. This invitation comes without modifiers or restrictions and is never diminished by a disability. In my personal experience, I have witnessed very few congregations that include individuals with special needs; fewer still seem to advocate for the full participation of these individuals. Informal conversations with parents have also led me to believe that the spiritual needs of entire families are often going unmet. In professional and personal settings, parents often mention that they have not attended*

*services or events either at all or as an entire family since the birth of their child who has special needs.*

*As a proponent of inclusion who continues to develop in my own faith, every day I attempt to treat all people as nothing less than human beings, created by God. This philosophy has led to an interest in exploring the extent to which faith communities include and support children with disabilities and their families. My personal beliefs tell me that the value of every single human being comes from what he or she is: a creature made in the image and likeness of God.*

*Then God said, "Let us make man in our image, in our likeness ... So God created man in his own image, in the image of God he created him; male and female he created them. - Gen. 1:26-27 NIV (Barker et al., 2002).*

*However, being created in the image of God means more than having certain abilities and attributes. It means that each human life exists as an expression of God and His character, regardless of what an individual can or cannot do. Thus, individuals with disabilities are neither exceptions to nor perversions of this image, and should be treated accordingly within our faith communities. God created us in His image to provide direction and guidance in how we treat one another. Attitudes and behaviours that act to exclude individuals with disabilities from communities of faith run contrary to this fundamental tenant.*

*I also firmly believe that inclusion of persons with developmental disabilities in communities of faith and the broader community can led to improved adaptive functioning (e.g., communication and socialization skills), better developed social networks, and positive changes in parent and community attitudes. At the same time, typically developing members will benefit*

*from opportunities to interact with disabled peers, and family members will benefit from opportunities for spiritual involvement. However, the benefits of creating opportunities for all to worship far exceed these tangible gains. Scriptures tell us that promoting full participation of individuals with disabilities will lead to far greater rewards.*

*Then Jesus said to His host, “When you give a luncheon or dinner, do not invite your friends, your brothers or relative, or your rich neighbours; if you do, they may invite you back and so you will be repaid. But when you give a banquet, invite the poor, the crippled, the lame, the blind, and you will be blessed. Although they cannot repay you, you will be repaid at the resurrection of the righteous.” – Luke 14:1 NIV (Barker et al., 2002).*

*As I attempt to delve further into this issue, I find myself asking even more questions.*

*How does having a child with special needs affect family participation in religious services and events? Do families seek support from faith communities and leaders when facing challenges with their children who have special needs? What are these communities and leaders doing to provide for these needs? Do religious communities and leaders respond proactively to meet the needs of all individuals who may wish to have access?*

### **C. Purpose and Rationale for Study**

Since 1986, the National Organization on Disability has commissioned Harris Interactive to conduct a series of polls of Americans with disabilities to assess differences in levels of participation in basic life activities between people with and without disabilities. Participation gaps have been identified in community, education, employment, health care, politics, technology, transportation, and religion (NOD, 2002). For example, 35% percent of Americans with disabilities reported being completely uninvolved in their communities, compared to 21% of those without disabilities. In 2004, 44% of adults with severe disabilities reported attending a place of worship at least once a month versus 57% of adults without disabilities (NOD/Harris Interactive, 2004). The aim of the present inquiry is to explore access to congregations and places of worship for people with disabilities in HRM.

The purpose of the present research project was to explore the views of religious leaders regarding inclusion of individuals with special needs in communities of faith. Faith leaders were asked to share both their experiences and perceptions related to this issue. One specific aim of this study was to determine the ways in which a person's disability has an impact on individual and family participation in religious services and events. To do this, levels of involvement in faith communities, were explored. This research also aimed to compare perceptions of accessibility held by religious leaders to previously reported needs of parents whose children have special needs. Programs and services offered by multiple faith communities were examined and compared to the reported needs of families who would access these services.

While there is a great deal of research on inclusion in educational and recreational programs, less attention has been given to the full participation of individuals with disabilities in faith communities. Surveys and polls completed by adults with disabilities have suggested that individuals with special needs place the same value on religious participation as their typically-developing peers, but feel they are given fewer opportunities to be involved. These findings suggest a participation gap in religious life between disabled and non-disabled populations.

The presence and impact of this participation gap on individuals with disabilities and their families in our region has received little to no attention. According to the 2006 Participation and Activity Limitation Survey (Statistics Canada, 2007), 20 percent of Nova Scotians report some degree of disability. It follows that, with an estimated population of 372,858, approximately 74,570 residents of HRM live with a disability. By employing qualitative research methodologies, the present research project endeavored to highlight the extent to which a participation gap exists within our community. Allowing congregations to share their personal stories provided an opportunity to develop recommendations for inclusive practices in local communities of faith.

#### **D. Research Questions**

Are religious services and programs available and accessible for individuals with disabilities?

In what ways do individuals with disabilities participate in local faith communities and how does the rate of participation compare to individuals without disabilities?

Are rates of participation related to availability of programs and services?

How do religious leaders view disability?

How do religious leaders define inclusion?

What do religious leaders perceive as barriers to full inclusion?

Are religious leaders willing to make the necessary changes for these individuals and families to feel like welcomed and valued members of their faith communities?

## **E. Definition of Terms**

*Child* – any dependent age birth-19 years.

*Disability/Special needs* - requiring additional resources beyond what are normally required for healthy development.

*Faith/Religious community* - a congregation or group linked to a specific religious tradition that provides ways for individuals to mature in faith and to learn to use their spiritual gifts (for example, churches, synagogues, mosques).

*Faith/Religious leader* - leader of a body of believers adhering to a particular set of values and practices.

*Parent* – biological, adoptive, foster, or legal guardian who is the primary caregiver of a child with special needs.

## CHAPTER II

### Literature Review

#### A. Definitions of Inclusion

While the term inclusion is widely used throughout the disabilities field, there is no universally accepted definition. For the most part, discussions on inclusion focus on child-care and educational settings, with the simplest definitions centred on placement issues. These definitions state that inclusion means that all children can attend and benefit from the same programs. Child and Family Canada defines inclusion as *removing barriers and providing supports in order to allow children with disabilities to participate in all aspects of life to the best of their abilities* (CFC, n.d.). According to the Child Care Advocacy Association of Canada, the principle of inclusion goes beyond physical integration and wholly endorses participation, friendship, and a celebration of diversity. Children of all ability levels are active participants; no one is left to just observe (CCAAC, 2004).

In a 2000 study, Ryndak, Jackson, and Billingsley examined how experts in inclusion defined the term for students with moderate to severe disabilities. When these definitions were analysed, 7 common elements of inclusive schooling were apparent: (a) students were placed in natural typical settings; (b) all students were together for instruction and learning; (c) supports and modifications were provided within general education to meet appropriate learner outcomes; (d) principles such as belongingness, equal membership, acceptance, and being valued were endorsed; (e) collaborative integrated services by education teams; (f) a systemic philosophy or belief system; and (g) general and special education were meshed into one unified system. The



authors concluded that the first five themes listed must be incorporated for services and programs to be defined as inclusive. These findings lend support to Child & Family Canada's principles of inclusion, which are: zero reject; naturally occurring proportions; range of options; full participation; and advocacy, proaction, and parent involvement (Irwin, 1997).

Though the terms are often used interchangeably, the concept of inclusion differs from its predecessors, mainstreaming and integration, in a number of important ways. Mainstreaming is an older term referring to a more gradual, partial, or part-time process. A student who is mainstreamed attends separate classes within a regular school, or participates in only a limited number of programs, such as regular gym and lunch programs. In mainstreamed programs students tend to be moved from special education classrooms to regular education classrooms only in situations where they are able to keep up with their typically developing peers without specially designed instruction or support. Integration also provides only partial inclusion. Integrated students are often placed with the peers, but participate in a different curriculum, preventing students from becoming full citizens in the classroom community. This differs significantly from inclusion where children are accommodated in natural settings with their peers and the principles of inclusion noted by Ryndak et al (2000) are practiced.

## **B. Successful Inclusion**

Just as there is no universally accepted definition of inclusion, there is also debate regarding what it means to successfully include a child with disabilities in a child-care, educational, or community program. Henteleff (2004) provides four systemic factors that he considers central to the success of inclusive approaches. Class sizes must be manageable for teachers and support staff, and curriculum must be adapted to meet diverse needs. As well, teachers should be provided with pre-service and in-service training, and specialists must be available to support classroom teachers. In addition, the author proposed six clusters of educational expertise required by every classroom teacher: full comprehension of exceptional conditions and appropriate accommodations to meet such conditions; ability to apply Individual Education Plans (IEP / IPP) and to function within the system that creates them; skills in managing students in complex activities and through transitions; skills in making systematic observations of students and in making appropriate referrals; expertise in creating social structures in classrooms appropriate to diverse needs; and understanding of family dynamics and capacity to interact with parents.

Other researchers have proposed that children have been successfully included if they have made progress on their individualized outcomes or goals, made gains in their personal development and acquired new knowledge and skills, and been welcomed and accepted as full members of the group by staff members and peers. In addition, parents must be pleased with their children's gains and see their children as comfortable and happy in the group setting (Cross, Traub, Hutter-Pishgahi, & Shelton, 2004). Considering these standards, the authors identified

four elements of successful inclusion common to each of the four research sites included in their investigation. The providers and parents who supported community inclusion all had optimistic, clearly positive attitudes toward inclusion. The relationships between parents and providers were also identified as crucial to the success of the inclusive experience. The coordination of therapeutic interventions, along with the individual flexibility of team members, was noted as an important strategy in supporting inclusive practices. Finally, making adaptations to support the child's basic functioning, play and learning, and socialization was also deemed necessary.

Mulvihill, Cotton, & Gyaben (2004) identified a number of best practices for effective inclusive out-of-school care. As in previous studies, the authors acknowledged the need for adapted settings, activities, and time parameters, as well as, proficient collaboration with families. In addition, they called for a written program philosophy and plan for inclusive programs, strong leadership, disability awareness, sufficient staff who are trained and supported, working collaboration and communication, and an evaluation plan.

### **C. Inclusion in Nova Scotia**

While other nations have legislated federal policy guaranteeing free and appropriate education for children with disabilities, inclusive child-care services in Canada are strictly voluntary at the preschool level. Most provinces have supported inclusion at some level, through funding, consultation, and/or resources, but none require it. In Nova Scotia, all licensed child-care centres are eligible to receive funding to cover additional costs associated with including children with special needs in child-care programs. In 2004, 521 supported spaces were funded for children with disabilities; 85 were attached to developmental centres having a designated

allotment of special needs spaces, and 436 were portable special needs spaces allocated on an as-needed case-by-case basis (Lero, Irwin, & Darisi, 2006). These spaces have certainly increased the choices available to parents when seeking care for their children with special needs.

However, neither the centres nor Early Childhood Development Services are able to organize suitable consultation. In addition, staff members are not always adequately trained, and there is very little monitoring of the effectiveness of the programs offered. Together these factors lead to inconsistencies in the quality of both the specific inclusion practices and overall programs.

According to the Nova Scotia Department of Education, inclusion is *an attitude and a value system that promotes the basic right of all students to receive appropriate and quality educational programming and services in the company of their peers*. Pursuant to the Education Act (NSDE, 1995), individual school boards are responsible for determining placements (6.1) and developing and implementing educational programs for students with special needs within the regular instructional settings with their peers. King & Edmunds (2001) explored the inclusion attitudes and knowledge of 61 teachers at a junior-senior high school in Nova Scotia. Their analysis revealed that teachers feel inadequately prepared for inclusion, need specific inclusion training, and feel that reducing workloads and class sizes would help. Significant positive correlations were found among teachers' knowledge of inclusion, inclusive practice, and self-confidence in facilitating inclusion.

#### **D. Barriers to Inclusion**

It is clear through the policies being put in place and the line of research being conducted that inclusion is a priority of many in the field. Professionals, researchers, and agencies throughout the province and across the country are moving toward the full and successful

inclusion of children with special needs. While there have been a number of positive changes for children with disabilities in our child-care centres and schools over the past few decades, there are still many barriers to overcome. Throughout published research, the identified barriers tend to fall into four categories: attitudinal, architectural/access, administrative/policy, and programming.

In a 1997 study, Walther-Thomas determined four barriers to inclusive education related to policy and program design: (a) scheduled planning time; (b) student scheduling; (c) caseload concerns; and (d) administrative support. The author found that planning time generally occurs during specialty classes, and while principals in elementary schools attempt to accommodate teachers with greater blocks of planning time, coordinating the planning schedule of all teachers involved so they coincide is complicated. The size of special educator's caseload was also found to have an impact on inclusion from both the teacher and student's perspective. Unfortunately, the necessary supports essential to help balance caseloads are often not available. Administrator support is also necessary in the provision of professional development opportunities for all relevant personnel.

In addition to these policy and program roadblocks, negative attitudes of personnel resulted in a lack of developmentally appropriate learning opportunities for special need students in inclusive classrooms. This finding was supported by Weiner's (2003) report that a number of teachers surveyed believed that not all students could learn. Teachers identified as not being inclusive assumed little responsibility for making sure that all students were learning. Lessons were not differentiated and specialists were responsible for working with challenging learners.

Attitudinal barriers may take the form of misconceptions, stereotypes, or labeling, and are often the most difficult obstacles to overcome. Researchers have found that it is the presence of these barriers that perpetuate exclusion (Bach, 1999). This type of barrier has been identified as leading to lack of acceptance, perpetuation of negative stereotypes, and adherence to certain norms, habits, and societal rules designed by and for the dominant group in society (Parmenter, McVilly, & Yazbeck, 2004). Many people believe that if people do not fit into these norms they should not be included (Allison & Hibbler, 2004; CCAAC, 2004). Education personnel, early childhood program personnel, parents, and other children can hold these negative attitudes toward inclusion.

Apart from identifying both intentional (e.g., isolation, bullying) and unintentional attitudinal barriers (e.g., lack of knowledge/awareness), Pivik, McComas, and Laflamme (2002), outlined a number of architectural barriers recognized by children with physical disabilities and their parents. Children with mobility limitations from 8 schools in the Ottawa area identified aspects of their physical environment that prevented them from being full included. These obstacles included doors, passageways, elevators, washrooms, stairs, ramps, lockers, fountains, and recreational areas. Along with the environmental barriers students faced daily, they also listed a number of physical barriers related to their own abilities and limitations. The need for both physical assistance and extra time to complete daily activities was seen as a major barrier to full participation.

## **E. Overcoming Barriers to Inclusive Child-care and Education in Nova Scotia**

Many of our child-care centres and schools in Nova Scotia are laden with obstacles like those outlined above. However, between 2002 and 2003, a number of stabilizing and enhancing childcare initiatives were introduced in the province of Nova Scotia (Childcare Resource and Research Unit, 2004). Increases in funding to nonprofit full- and part-day child care centres resulted in new full- and part-day spaces. In 2003/04, a one-time-only Materials and Resources Grant to Promote Physical Activity for part-day child-care centres was also provided. Facilitators have worked with child-care centres to evaluate their program and environment, and to make necessary improvements in order to support the inclusion of children with special needs. In June 2003 province-wide training was undertaken to facilitate the full inclusion of children with special needs.

The purpose of Building Blocks: Strategies for Inclusion Training Program was to promote inclusion in child care programs by encouraging early childhood educators to use their creative resources to support the needs of all the children in their child care program (Monaghan, Berryman, Carruth, & Versnel, n.d.). During the training program, early childhood educators examined issues surrounding inclusion within child care programs, such as program philosophies and policies, administrative challenges, community partnerships, and resources. Training exercises were designed to allow educators to come up with practical solutions to everyday problems.

Within the Halifax Regional School Board, funding is allocated to ensure that there is at least one elementary school, one junior high school and one high school in each family of

schools that is considered to be barrier-free. In 2001, Thiessen and Cottrell analyzed data regarding current practices in Nova Scotia schools collected through surveys and focus groups. Thirty-six percent of respondents felt that significant improvements had been made in inclusive schooling. In all focus groups there was agreement that a more consistent understanding of the concept of inclusive schooling is needed. Attitudes were thought to be based on misconceptions of what is meant by inclusion, and suggestions were made surrounding specific education and training for teachers, parents, and the general public. Teachers felt they needed more support from school administrators and more expertise at the board level, while teaching assistants believed that inclusion would be more successful when all partners collaborate fully.

In response to the recommendations made, the Minister of Education has set out to inform the government of the need to establish a capital fund to guarantee barrier-free access to public school buildings so that every special needs student would be able to attend their neighborhood school (HRSB, 2007). However, obstacles such as intentional and unintentional attitudinal barriers do not seem to have been addressed.

## **F. Inclusion in Faith Communities**

Carter (2007) asserts that people of faith are called to regard people with disabilities as integral parts of their community; that every member should be viewed as indispensable. When an entire segment of the population is excluded from the body of believers, the community not only remains less than it could be, it remains less than it was intended to be. Therefore, congregations should feel compelled to offer this same invitation and gladly receive the gifts and



contributions of people with disabilities. Despite the affirmations that every single person is of inestimable worth, the history of inclusion in communities of faith is similar to that of any other institution or organization, with individual programs that act as exemplars and others that are gravely lacking.

### **G. Faith, Spirituality, and Religious Participation**

A number of research projects that have specifically targeted religious inclusion of individuals with developmental disabilities have yielded results similar to the Harris/NOD polls. Hayden, Lakin, Hill, Bruininks, and Copher (1992) found that approximately 30% of children and adults with intellectual disabilities living in foster or group homes “practically never” attended religious services. The authors also found that only about one quarter of the individuals involved “sometimes” attended. Based on parental report, less than 50% of children and youth with autism, deaf-blindness, intellectual disabilities, or multiple disabilities participated in religious group activities at any point during the previous year (Wagner, Cadwallader, & Marder, 2003; Wagner et al., 2002). Orsmond, Krauss, and Seltzer (2004) surveyed more than 200 parents of adolescents and young adults with autism and found that less than one third reported that their child attended worship on a weekly basis.

Furthermore, children and adults who do attend religious services may find that many other aspects of full or meaningful participation remain inaccessible. Riordan and Vasa (1991) reported that 44% of clergy surveyed stated that religious education was not available to individuals with disabilities. Orsmond, Krauss, and Seltzer (2004) also reported that only 11% of

youth and adults with autism attended social events in religious settings more than once per month. This result supports the findings of an earlier study concluding that although almost half of young adults with intellectual disabilities attended church services, only 14% participated in other congregational activities, such as youth groups or choirs (Kregel, Wehman, Seyfarth, & Marshall, 1986).

Several research projects have also examined the ways in which faith communities are failing to meet the needs of individuals with disabilities and their families. A national survey of American Presbyterian pastors indicated that almost 30% were aware of members of their congregations who were unable to fully participate because the facilities were not easily accessible (Presbyterian Panel, 2004). An American Congregational Life Survey suggested that only 10% of faith communities offered some form of care to people with disabilities (Woolever & Bruce, 2002). Focus group discussions involving parents of children with disabilities revealed that many families felt unwelcome and lacked the supports necessary to fully participate in worship or related activities (Poston & Turnbull, 2004).

A number of studies have examined faith and spirituality in individuals with disabilities. Shogren and Rye (2005) explored the religious beliefs and practices of forty-one people with mild and moderate intellectual disabilities. Their findings suggested that the majority of participants attended worship services, prayed, and rated religion as an important part of their lives. These results are consistent with the 2004 Harris poll conclusion that religious faith is equally important to adults with and without disabilities. That is, 84% of adults with disabilities and 84% of adults without disabilities rated their religious faith to be “somewhat important” or

“very important” (NOD/Harris Interactive, 2004). Thus, neither the extent of one’s faith nor interest in religious activity adequately explains the religious participation gap.

## **H. Barriers to Inclusion in Faith Communities**

Many of the proposed or identified barriers to full participation in communities of faith parallel those found in the broader community. Examination of these obstacles can guide research and practice specific to the field of faith community inclusion. Cavet (1995) collected detailed information from services across Europe about leisure provision for children and adults with profound and multiple disabilities. The findings highlighted a number of problems commonly encountered, such as lack of availability of staff and poor staff morale, poor environmental design, and difficulties identifying individuals’ personal interests. Messent, Cooke, & Long (1999) found that barriers to ongoing participation in leisure and recreational activities included lack of staff for one-to-one assistance, lack of finances, and poor transportation. More recently, Reynolds (2002) also found that managers of service delivery programs perceived inadequate financial support, transport costs and access, and a lack of one-to-one staff as limiting leisure choices and opportunities.

Interestingly, when people with and without disabilities were asked why they did not participate more in their communities, transportation was reportedly no more of a barrier for people with disabilities than for people without (NOD/Harris Interactive, 2000). According to the 2000 NOD/Harris Survey on Community Participation, people with slight or moderate disabilities most commonly cite lack of time, lack of income, and lack of awareness of activities

as explanations for not participating more in their communities. For people with severe disabilities, lack of encouragement from community organizations was by far the most common barrier to participation. Lack of awareness and lack of income are also commonly cited by persons with severe disabilities.

Research studies that aim to investigate the barriers to inclusion specific to communities of faith are also emerging in the literature (see Stookey, 2003; Vogel, Polloway, & Smith, 2006; Christensen & Weil, 2007). Children and adults with developmental disabilities who wish to be included in a faith community encounter a variety of barriers to full participation. Obstacles related to architecture, attitude, communication, programming, and liturgy within congregations present a variety of challenges to individuals with disabilities.

As in the broader community, physical barriers preventing access can include stairs, narrow entrances and hallways, and washroom facilities that are difficult to navigate. These architectural barriers frequently receive the most attention when addressing issues of accessibility. Such an emphasis seems logical, as presence is necessary for participation. Inaccessibility of this sort also has an impact on other members of the congregation, such as the elderly or young children. In addition, solutions for architectural barriers often seem easier to address than those involving other types of barriers (Carter, 2007).

Advocates in the field have adopted the motto “a ramp is not enough”, suggesting that efforts beginning and ending with ramps, pew cuts, automated doors, and designated parking spaces do little to fully welcome individuals with disabilities. Roadblocks to full inclusion may also emerge in the areas of sight and sound, language, and listening (Carter, 2007). The avenues

through which worship is presented and information is shared may be inaccessible to certain populations, and the level at which information is presented may be challenging for some members. Haythorn (2003) challenged congregations to discover new ways of communicating the doctrines, beliefs, and traditions of their faith effectively to members from an increasingly wide range of backgrounds and abilities. Many congregations offer additional supports such as large print materials, Braille texts, and sign interpreters, but rarely consult individuals with disabilities to better meet their needs or examine the gifts they have to offer (Swinton, 2002). Even in institutions that called themselves inclusive, invitations, assurances of welcome, and adaptations are often not extended to encourage involvement beyond weekly worship services.

Christensen and Weil (2007) found that the most prevailing barrier was institutions' attitudes that negated even the possibility of inclusion. Leaders of religious institutions frequently assumed that inclusion would be expensive and therefore not possible. Others placed blame on the individuals with disabilities who had never been welcomed in the first place, claiming that few people had taken advantage of the inclusive services offered. A number of professionals accused parents of being uncooperative and felt they knew what was best for children with disabilities. Furthermore, many programs determined that certain families could not be served before meeting the parents and/or child.

Perkins (2001/2002) concluded that many faith communities and their leaders are uncertain and fearful about including people with disabilities in their congregational life. Webb-Mitchell (1993) also suggested that faith community leaders commonly ask families to find an alternative community due to their own lack of confidence in their ability to care for families

affected by disability. In other instances, leaders are comfortable ministering *to*, but not ministering *with* persons with disabilities (Carter, 2007). That is, children and adults with disabilities are seen as objects of pity and paternalism to be cared for in a segregated manner.

Negative stereotypes may also have an impact on participation for many individuals with disabilities and their families. Gaventa (2005) found that many Americans equated faith and cognitive ability, presuming that faith is not important to individuals with disabilities because of an inability to grasp complex doctrines and/or express personal beliefs. Many people with disabilities and their family members also feel that the messages communicated in their places of worship are inconsistent with their own experiences of disability (Eiseland & Saliers, 1998). Both members and leaders of faith groups sometimes come to faulty conclusions about the causes and implications of disabilities. For instance, researchers have highlighted presumed links between disability and parental sin, lack of faith, and divine rejection (Abrams, 1998; Covey, 2004).

Interpretations of various guidelines concerning eligibility for certain religious rites and rituals present further barriers to inclusion in faith communities (Vogel, Polloway, & Smith, 2006). In many circumstances, congregational leaders are unwilling to make adaptations or alterations to long-held traditions for individuals who are unable to participate in the usual way.

Vogel, Polloway, & Smith (2006) present a number of scenarios in which children with disabilities are denied access to religious rites and rituals. For example, children with autism and mental retardation are not permitted to be baptized or receive communion because of an inability to communicate understanding. Swinton (2001) argues that typically developing members of the

congregation frequently do not understand the true theological meaning of liturgical traditions and deems it inappropriate to question the understanding of people with disabilities, but not other members of the congregation. Some theologians suggest that it is impossible to determine eligibility and that in many cases true understanding is not necessary to participate. Furthermore, this requirement may actually be incompatible with the very premises of the faith community (Vogel, Polloway, & Smith, 2006).

### **I. Impact of Inclusion and Exclusion**

Based on an extensive research review, Gleeson (2002) outlined the benefits of religious faith and belonging to a religious community for the general population. Members of faith communities experienced greater longevity, better stress and crises management, and a greater sense of meaning and purpose in one's life. To date, there has been no extensive research investigating the advantages specific to the disabilities field, but it is reasonable to conclude that such benefits should also extend to these individuals (Vogel, Polloway, & Smith, 2006).

Researchers and professionals in the field have suggested that spirituality and religious participation may have a positive influence on the self-concept of individuals with disabilities (Boswell, Knight, Hamer, & McChesney, 2001; Nosek, 2001). That is, inclusion may provide a means for conceptualizing oneself in a broader, more holistic view beyond the traditional medical model of disability.

Participation in faith communities may also have a positive impact on social relationships, friendships, and one's sense of belonging (Gleeson, 2002). The social networks of

children and adults with developmental disabilities are often quite limited and tend to be dominated by family members and paid service providers. Orsmond, Krauss, and Seltzer (2004) found that 46% of youth and young adults with autism reportedly had no friendships with same age peers within or outside of prearranged settings. Only 8% of their sample was reported to have at least one same aged friend with whom varied, mutually responsive, and reciprocal activities were engaged in outside of organized settings. Faith communities can play an important role in restoring disconnected lives by intentionally fostering mutual relationships among all members of the congregation. In addition to activities focused on worship and spiritual growth, plenty of activities and events organized within communities of faith are centred on sports, leisure, arts, fitness, and personal enrichment (Dudley & Roozen, 2001). Such activities present a natural means for individuals with disabilities to be actively involved in the broader community and engage in recreation and leisure with their peers.

The effects of inclusion – and exclusion – are not limited to individuals with disabilities. Bennett, Deluca, and Allen (1995) identified prayer, church attendance, and specific religious beliefs as sources of support that helped some parents of disabled children feel a growing sense of hope and strength. However, Coulthard & Fitzgerald (1999) found that their sample of 60 parents of children with autism reported significantly more support from their personal beliefs than from their organized religion. Only 4 participants (7%) agreed that their faith leader had been helpful at the time of diagnosis, while only 5% of the participants reported seeking help from their church, frequently claiming that having a child with autism isolated them from their



faith community. The authors also found that only 5% reported being as active as ever in their congregation.

Tarakeshwar and Pargament (2001) also assessed the use of religious coping methods among parents of children with autism. While almost three quarters of their sample reported that they were moderately to very religious, less than half attended services more than 10 times per year. Thirty percent of the parents who were surveyed reported discontent with their clergy and church members. The authors also found that the insensitivity of faith communities and leaders toward the challenges of raising a child with autism caused a strain on being able to function as a family. Approximately 10% of parents reported that religion acted to separate the family because they could not attend worship services and religious events together. An additional 9-15% of parents found that church rituals served as a calming experience for their child and that sharing religious faith with their partner seemed to be a resource in coping with the various demands of parenting a special needs child. Lehrer and Chiswick (1993) concluded that shared faith decreases marital distress and enhances the support that spouses provide to each other. This finding is of particular consequence given that couples who have children with disabilities are at tremendous risk for separation and divorce.

The National Autism Association (2007) suggests that up to 80% of marriages end in divorce when a child with autism is present in the family. Researchers have suggested that families of children with disabilities experience more stressors and resultant distress than do similar families of typically developing children and youth (Boyce, Behl, Mortensen, & Akers, 1991). Numerous studies have also shown that approximately one third of parents of children

with autism experience clinically significant levels of psychological symptomatology (e.g., Coulthard & Fitzgerald, 1999; Cox et al., 1987).

Just as inclusion is assumed to be beneficial to physical and mental well-being of people with disabilities, research outlining the health benefits for family members of individuals with disabilities who participate in religious beliefs and practices is also emerging. Rogers-Dulan (1998) surveyed 52 African American families who were caregivers of a child with mental retardation and found that church attendance and scores on the Religious Connected Domain were negatively associated with depression, family stress, and the impact of the child's disability on the family. Tarakeshwar and Pargament (2001) suggested that greater use of positive religious coping methods (e.g., seeking religious direction, spiritual connectedness) was related to greater stress-related growth and religious outcomes. More frequent use of negative religious coping mechanisms (e.g., questioning the benevolence of God, spiritual discontent) was associated with increases in depressive affect, poorer religious outcomes, and greater anxiety.

Promoting the full participation of individuals with disabilities also proves beneficial to other members of the congregation and community at large. Verbal (2004) proposes that developing a special needs ministry will allow Christian congregation leaders and members to fulfill the "Great Commission" by following Jesus' example of including those who seem to get left out. Verbal also argues that inclusion allows congregations to reflect God's love in the broader community. They can act as a support for parents, siblings, and families as a whole, while providing a model of care for those outside the faith community. Furthermore, the author

proposes that inclusion will invite some astonishing people into the community of faith and allow for capitalization of their special gifts.

Ministering to and with individuals with disabilities in inclusive settings also provides many social benefits for children and youth without disabilities by promoting tolerance and acceptance of peers with special needs (Verbal, 2004; McPherson, 2004). Typical children can benefit from joint participation in activities with children with disabilities by becoming more sensitive, patient, positive, and tolerant. They develop a more accurate view of individual differences, and may have opportunities to learn many new skills, values, and attitudes related to human differences (Alper & Ryndak, 1992; Farrell, 2000; Karagiannis, Stainback, & Stainback, 1996).

Inclusive faith communities offer an important opportunity for persons with disabilities to experience valued social roles (Vogel, Polloway, and Smith, 2006), providing typical peers with a model of success despite challenges. The notion that all people have strengths and weaknesses, can both teach and learn, and have value may increase others' acceptance of their own abilities and difficulties, and increase their tolerance of diversity.

## **J. Summary**

An inclusive faith community is more than a place where people with disabilities are present, attend services, and receive offerings. Inclusion is an attitude of support and openness toward others that recognizes everyone's right of equal access. It is a commitment to remove barriers between individuals and among communities that deny such access. Truly inclusive

places of worship involve extending invitations for full participation and opportunities to serve both God and the congregation.

## **CHAPTER III**

### **Methods**

#### **A. Framework**

The present inquiry aimed to gain an understanding of issues related to inclusion of individuals with disabilities in faith communities, from the point of view of those who live it using a survey questionnaire. Survey research is a method of gathering data from respondents, using an instrument composed of closed structure and/or open-ended questions. A dominant form of data collection in the social sciences, survey research provided the researcher an opportunity for efficient data collection from a large number of religious leaders. Critics of survey research methodology hold it to be a method that artificially forces respondents to formulate opinions, masking the complexity of conflicting views and unconscious biases within each respondent (Garson, 2002). Therefore, qualitative data collected through open-ended questions stand alongside and complement the quantitative survey items to provide depth and richness to the investigation. Qualitative research methods were utilized to develop further understanding of the research topic and its contextual setting, and to provide explanation of reasons and associations.

Qualitative research is characterized by an emphasis on describing, understanding, and explaining complex phenomena. The focus is on studying, for example, the relationships, patterns and configurations among factors, or the context in which activities occur, with a concentration on understanding the full multi-dimensional, dynamic picture of the subject of

study (Sofaer, 2002). Qualitative researchers study things in their natural settings, attempting to make sense of phenomena in terms of the meaning people bring to them (Denzin & Lincoln, 2005). Given that the aim of this inquiry was to identify and investigate perceptions, perspectives, and experiences of inclusion in faith communities, qualitative research methods provided the framework allowing the researcher an opportunity to collect and interpret non-numerical data. Inherent in the rich descriptions of individuals' experiences is the understanding that qualitative research is a situated activity that locates the observer in the world, and the qualitative researcher uses this naturalistic approach to interpret and analyze data (Denzin & Lincoln, 2005).

## **B. Measures**

A survey composed of closed- and open-ended questions was developed to establish participants' experiences and perceptions of inclusion in faith communities. This measure was designed based on both a careful review of the literature and the researcher's experiences. The survey questions deal with participants' general perceptions of and experiences with inclusion and accessibility. The objective was to establish the perspectives of faith leaders within the context of their faith communities.

The survey consisted of four sections. In Section A, participants were asked to provide general demographic information such as age range, gender, education, and religious affiliation. In Section B, respondents were asked to indicate whether or not a number of services and programs, such as accessible parking and materials, are offered by checking YES or NO in a

table format. Respondents were also asked to provide additional information about provision of such programs and services (i.e., Do you intend to offer any in the future?). Section C consisted of 2 tables outlining participation of parishioners with and without disabilities. Section D was comprised of 6 short answer questions regarding faith leaders perceptions and experiences of disability and inclusion related to their religious backgrounds and communities.

### **C. Data Gathering & Participants**

One hundred faith communities in HRM were asked to complete the mail-in survey. Data for this research project came from these faith communities. Individual faith communities were randomly selected on the basis of contact information provided in local listings. The participants consisted of faith leaders who complete the survey questionnaire.

### **D. Procedure**

Following approval from the Mount Saint Vincent University Research Ethics Board, the researcher arranged to contact the participants. Faith leaders received a letter of invitation/informed consent, survey, and a postage-paid return envelope by mail. Faith leaders who had neither contacted the researcher nor identified themselves on returned surveys within 3 weeks of initial mailing were contacted by phone or e-mail to ensure the survey was received. At that time, participants were given the opportunity to complete the survey with the researcher by phone or electronically, or they could opt not to participate.

## **E. Data Analysis**

Data analysis included both qualitative and quantitative data.

**i. *Qualitative Data.*** Data analysis in qualitative research involves organizing data, breaking it into clusters, then further narrowing the data and categorizing it into themes. For this study, responses to the open-ended questions on the survey were evaluated and coded for emerging themes. Data were coded by two researchers and tested for inter-rater reliability (inter-rater reliability equaled approximately 95%).

**ii. *Quantitative Data.*** Close-ended survey responses were coded and analyzed. Percentages, means, and standard deviations were calculated. Chi squares were calculated to investigate whether distributions of categorical variables are statistically different from one another.

## **F. Ethical Considerations**

### ***i. Informed consent and confidentiality***

Informed consent was explained in a letter to participants before completing the questionnaire. Participants were assured that results reported from survey questionnaires will be presented as group data in the final summary of the research, and no identifying information would be included where direct quotes are used. Data used in the final summary of the research or provided in any additional communications does not contain identifying information.

Additionally, procedures for the storage and disposal of data were carried out according to University policy.



Measures to protect the confidentiality of all participants were strictly employed.

Packages including a letter outlining the nature of the investigation were mailed directly from the researcher to faith leaders. Those willing to participate in the study could anonymously complete and return the survey and/or contact the researcher for further information or assistance.

***ii. Voluntary participation***

Participation in this study was entirely voluntary. Faith leaders were contacted once by each mail and phone/e-mail, and only those who expressed interest in participation were contacted further. There were no costs incurred by the participants throughout this research project.

***iii. Possible benefits and potential harm***

Taking part in this study was of no direct help to individual faith communities. However, faith communities may benefit indirectly from an increased awareness of the research topic. The researcher hopes that the results of this study will improve the future inclusion of children, youth, and adults with special needs in communities of faith. Therefore, this investigation may benefit the larger community as a whole.

There were no known risks for children, parents, or faith leaders associated with participation in this study. Participants were asked to share information at their level of comfort, and were in control of the information-sharing process.

## **G. Limitations**

Although survey research allows a researcher to collect data about a number of variables from a large number of persons for relatively little cost, there are also a number of inherent limitations. One serious disadvantage concerns the validity and reliability of responses obtained to the questions. Surveys provide only a self-report, and responses cannot always be taken as accurate descriptions of what the respondents actually do or how they really feel about something. This is particularly true for behavior contrary to generally accepted norms of society. Many individuals are hesitant to indicate engagement in behavior not accepted by their group or society as a whole. Participants may have provided responses that they felt conformed to researcher expectation or chosen not to complete the survey. Due to the sensitive nature of the material in the present study, the researcher kept this limitation in mind both while preparing items and interpreting results.

The number of respondents choosing to complete the questionnaire is always a concern in survey research. The researcher took measures to ensure a good response rate by providing a concise, but brief, explanation justifying the survey. Individuals were notified in advance that the survey would be arriving by mail, and they were assured that the instrument was short. The survey began with non-threatening questions to increase comfort level and arouse interest. The researcher also assured confidentiality and anonymity for all participants and offered to provide final results when available.

When interpreting the results of qualitative data, it is possible for the interpreter to be subjective. Such subjectivity could possibly cause the investigator to ignore valid results or add

results that are not present. To prevent subjectivity, a second reviewer was utilized and inter-rater reliability was established.

## CHAPTER IV

### Results

#### A. Introduction

The data for this study on inclusion of persons with disabilities in faith communities was obtained through a survey comprised of open- and closed-ended questions. Both quantitative and qualitative data were obtained from these surveys.

Quantitative data from close-ended survey responses were coded and analyzed. Percentages, means, and standard deviations were calculated. Correlation co-efficients were calculated and tested to determine whether statistically significant relationships existed between variables. Finally, Chi squares were calculated to investigate whether distributions of categorical variables were statistically different from one another.

Qualitative data from open-ended survey responses were coded, and themes and patterns were identified by the research and a second independent reviewer. To identify meanings from the qualitative data, it was read initially as a whole, and then several more times in greater detail. During the readings, major themes began to emerge that reflected the participants' thoughts, perspectives, and attitudes toward inclusion in faith communities. Further detailed reading revealed consistently expressed views within these major categories, as well as ideas that were significant but expressed less frequently. This chapter will summarize the major emergent themes from the data, and provide illustrative examples from the surveys to highlight the meaning to the participants.

## **B. Summary of Demographic Information**

One hundred faith community leaders were invited to take part in this research project. Thirty-three responded to some or all of the survey questions by mail, e-mail, or telephone. Fourteen of the respondents were female, 12 were male, and 7 did not indicate gender. Four of the respondents fell within the 25- to 39-year-old range, 14 were between the ages 40 and 54 years, and 8 were 55 or older. The remaining 7 participants did not indicate their ages. Five of the respondents identified their location as rural, 11 as suburban, and 10 as urban. Again, the remaining 7 did not identify a location. Fifteen of the respondents identified themselves as the congregational leader (i.e., pastor, priest, minister), another 8 respondents held an administrative position, and 3 were volunteers. Seven respondents did not indicate their roles within the faith community (see Table 4.1).

## **C. Research Question 1:**

**Are religious services and programs available and accessible for individuals with disabilities?**

### *Services.*

Participants were asked to indicate whether or not a number of services were available within their faith communities. These included structural supports such as accessible parking, doorways, and bathrooms (see Table 4.2). The majority of respondents indicated that accessible parking (66.7%), entrances (84.9%), restrooms (72.7%), and seating (69.7%) were offered by their faith communities. Services less likely to be offered included accessible transportation (12.1%), adapted materials (30.3%), elevators (18.2%), and sign language interpretation (18.2%).

**Table 4.1**

**Summary of Background Information on Participants**

Gender		
	Female	14
	Male	12
	No response	7
Age		
	25-39	4
	40-54	14
	55+	8
	No response	7
Locale		
	Rural	5
	Suburban	11
	Urban	10
	No response	7
Role		
	Congregation Leader	15
	Administrator	8
	Volunteer	3
	No response	7

**Table 4.2**

**Percentage of Respondents Indicating Services Available for Individuals with Disabilities**

<b>Service</b>	<b>%</b>
Accessible parking (e.g., clearly marked, close to entrance)	66.7
Accessible entrance (e.g., ramp, automated doors)	84.9
Accessible transportation	12.1
Accessible restroom (e.g., large space, hand rails)	72.7
Accessible seating (e.g., wide aisles, pew cuts, reserved seating area)	69.7
Accessible materials (e.g., large print, adapted curriculum)	30.3
Elevator or chair lift (if building is one level, circle N/A)	18.2
Sign language interpreter	18.2

***Programs.***

Participants were also asked to indicate whether or not a number of programs were available within their faith communities. These included specialized programs such as counselling and respite care (see Table 4.3). These programs were not reported to be offered by the majority of faith communities. Of the communities surveyed, 33.3% offered additional support to participate in regular activities, 27.3% offered counselling, and disability resource materials and parent support groups were available in 18.2%. Only 12.1% of respondents reported that their faith communities offered programs designed specifically for persons with disabilities. Three percent offered respite care, while 6.1% had a stated policy of welcome concerning individuals with disabilities.

**Table 4.3**

**Percentage of Respondents Indicating Programs Available for Individuals with Disabilities**

<b>Programs</b>	<b>%</b>
Books on disabilities that provide awareness and information in library/resource centre	18.2
Additional support to participate in regular activities	33.3
Special programs designed specifically for persons with disabilities	12.1
Respite care	3.0
Parent support group	18.2
Counselling for individuals and families affected by disabilities sponsored by place of worship	27.3
Stated policy of welcome for persons with disabilities	6.1

**D. Research Question 2:**

*In what ways do individuals with disabilities participate in local faith communities and how does the rate of participation compare to individuals without disabilities?*

*Areas of participation.*

Section C of the survey consisted of 2 tables outlining participation of parishioners with and without disabilities. The combined data of all respondents indicated that at least one individual with a disability participated in each area, which included weekly worship, religious education, music, serving, community outreach, missions, prayer meetings, leadership or committees, volunteering, recreation, counselling, retreats, participation in the service, and taking sacraments.



### ***Rate of participation.***

Respondents indicated the number of individuals both with and without disabilities that participated in each of the above noted areas. In all cases, the individuals without disabilities outnumbered those with disabilities. The number of participants in each area having a disability ranged from less than 1% for counselling to almost 5% for recreational/social activities. Chi squares were calculated to investigate whether the percentages of participants with disabilities were statistically different from the expected 20% based on the 2006 Participation and Activity Limitation Survey. For each area of participation, the number of actual participants differed significantly ( $p < .0001$ ) from the number of expected participants (see Table 4.4).

### **E. Research Question 3:**

#### ***Are rates of participation related to availability of programs and services?***

The researcher expected that participation would increase in relation to the number of supports offered by the faith community. However, calculation of Pearson's correlation coefficient indicated that there was no relationship between the total number of supports and attendance,  $r(26) = 0.0078$ ,  $p > .01$ . There was not a statistically significant relationship between the number of structural supports and attendance of individuals with disabilities,  $r(26) = -0.22793$ ,  $p > .01$ . Nor was there a statistically significant relationship between the number of specialized programs and attendance of individuals with disabilities,  $r(26) = 0.12586$ ,  $p > .01$ .

**Table 4.4**

**Rates of Participation of Individuals With and Without Disabilities**

<b>ACTIVITY</b>	<b>Total number of participants (including those with a disability)</b>	<b>Number of participants with a disability</b>	<b>Percentage of participants having a disability</b>	<b><math>X^2</math> <math>df = 1</math> <math>p &lt; .0001</math></b>
Weekly services/worship	3222	98	3.04	579.13
Religious education	1174	38	3.56	206.19
Music programs	347	14	4.03	55.28
Serving	589	15	2.55	112.14
Community outreach activities	667	20	3.00	120.50
Global mission activities	194	3	1.55	41.29
Prayer meetings	671	11	1.64	141.38
Leadership or committee work	498	11	2.21	98.52
Volunteer work	724	20	2.76	143.45
Recreational/social activities	1417	70	4.94	200.86
Counselling	103	1	0.97	23.31
Retreats	375	9	2.40	72.60
Participation in service	639	20	3.13	113.66
Taking sacraments/rites	2015	82	4.07	319.60

#### **F. Research Question 4:**

##### ***How did religious leaders view disability?***

When the respondents were asked to define disability, a number of themes emerged. A large number of responses highlighted various types of disabilities, while others focused on limitations associated with being disabled. The faith leaders surveyed also described ways in which their perceptions of disability were influenced by their religious backgrounds and personal experiences.

The faith leaders surveyed frequently noted a variety of types of disabilities. The emphasis was on physical impairments, but responses also encompassed intellectual, mental, and emotional difficulties. These included but were not limited to blindness, deafness, and mental illness. Faith leaders also commented that these various types of disabilities reflected differences from the norm, and in some cases stipulated that disability is expected to be a life-long condition. The definitions provided were generally in keeping with the prevailing medical/rehabilitation models of disability, which regard disability as an illness or deficiency to be cured by medical professionals or otherwise corrected by helping professionals.

“There are various types of disabilities. Some mental handicaps to physical ones. Some brought on by stroke or heart attack or genetic defect. Loss of limbs due to accident or disease.”

“I think in terms of physical disability – e.g. people in wheelchairs, deaf, blind, etc – and also mental disability – e.g. intellectually challenged.”

“Differences from the norm in a range of ways (physically, intellectually, emotionally) that leads to limitations on one’s ability to participate fully in settings and circumstances as presented to him/her.”

Respondents also commonly defined disability in terms of limitations on the amount of participation possible and the accommodations required for participation. Many of these descriptions were vague in nature,

“Disability to me is any issue that causes a person to be unable to fully participate in the community ...”

“... inhibits full mobility or participation ...”

while others were more specific,

“... affects a person’s ability to participate fully in activities within their community including work and recreation.”

“Any physical or mental condition that limits one from normal activity without outside assistance. Room should always be made for those in extra need of help to participate in worship, work, play, etc.”

Half of the faith leaders surveyed reported that their perceptions of ability and disability had been shaped by their religious backgrounds. Many referenced Christian scripture, particularly creation in the image of God and examples set by Jesus.

“My views of all things (including ability) are shaped by the belief that we are all good and perfect gifts from God, created in his image.”

“Christian religion values loving others & doing unto them as we would like them to do unto us. I try to think of how I would like to be treated if I had a disability.”

“Jesus was always trying to include others especially so-called “outsiders” – people on the fringe.”

The remaining faith leaders felt that their views of ability and disability were not shaped by their religious backgrounds, but rather by personal experiences.

“I would say that definition doesn’t come from religious background, rather from society/school/media and people I know who live with various disabilities.”

“I’m not sure it has, but my life in general certainly has.”

#### **G. Research Question 5:**

##### ***How did religious leaders define inclusion?***

When asked to define inclusion, again a number of themes emerged. Many of the faith leaders surveyed described inclusion both with and without limits. Several of the respondents indicated that it was the community’s responsibility to promote inclusion, while others implied that individuals with disabilities must find ways to be involved.

The majority of respondents indicated that inclusion meant all persons having full access to all aspects of religious life, including opportunities for relationship with God and belonging to a community of believers.

“All are welcome.”

“We help each other – care for our physical needs & our spiritual needs – we also love to teach others about the truths contained in God’s Word the Holy Bible. We are not prejudiced – we talk to everyone & will help everyone. Acts 10: 34, 35 (Then Peter began to speak: "I now realize how true it is that God does not show favouritism but accepts men from every nation who fear him and do what is right.) God is not partial.”

“Inclusion means everyone (regardless of gender, ability, sexuality, economics, etc). Everyone welcome, participating, and if issues arise around not being able to participating, finding ways to make this possible.”

“Should be no exclusions in involvement in expressions of faith – participation in worship – due to disability.”

A number of respondents suggested that inclusion was limited based on ability and many placed the onus on the individual with disability to make participation possible.

“People are encouraged to participate in whatever activities they feel able or can be accommodated.”

“Inviting and offering support to integrate as fully as possible.”

“Important to include all members of the family of God in congregational life to the degree they can participate.”

“Those who want to be included ought to have the privilege of inclusion regardless of handicaps.”

As with views of disability, approximately half of the faith leaders surveyed reported that their definitions of inclusion had been shaped by their religious backgrounds. Many referenced Christian scripture, relationship with God, and belonging to a community of believers.

“Jesus empowered people, sometimes by healing, but also by accepting them and restoring dignity.”

“Christianity is about being a community who has decided to live and follow in a particular way. Faith following is following Jesus’ example – including all people despite their differences and aiding people to overcome the things that stop them from being able to participate in their community.”

“People want to “belong”. It’s part of relationship & sense of community to be included and accepted fully.”

A number of the respondents felt that their perceptions of inclusion were not shaped by their religious backgrounds, but rather personal experiences.

“I grew up with a grandmother who suffered from mental illness and a brother who is diabetic. It has really brought home to me personally the importance of inclusion, equality and a right to be free to be who we are.”

“I have firsthand experience with an adult family member who is mentally challenged ...”

## **H. Research Question 6.**

### ***What did religious leaders perceive as barriers to full inclusion?***

When asked to describe limitations to participation and barriers to full inclusion, the majority of faith leaders acknowledged that their communities were not completely barrier-free. Many of the respondents provided examples of circumstances in which families or individuals decided not to participate or to discontinue participation in their services and/or events due to actual or perceived barriers. Further analysis of their responses revealed a number of common barriers.

An overwhelming number of faith leaders cited the inaccessibility of their facilities and a lack of financial resources to make the necessary upgrades as barriers to full participation.

“We are aware of a few members who do not participate in activities in church hall as stairs are a barrier. This means they cannot attend after church coffee hour, receptions following funerals, church bazaar, and dinners, etc.”

“We cannot afford at this time \$25000+ to renovate our facilities.”

“Our buildings are old, and were not built with wheelchairs or hearing aids in mind. Unfortunately, we do not have funds to upgrade – although we do the best we can with what we’ve got.”

A number of the faith leaders surveyed also indicated that their lack of knowledge and qualified volunteers stood as barriers to full participation.

“Having capable volunteers to participate and support programs/services; not because of a lack of want but due to age or strength or their own limitations.”



“... people willing to run programs.”

“Participation is limited by ... lack of extra supports available, and attitudes of others.”

“One family stopped attending because grandchild’s behavioural needs could not be met by children’s programming.”

### **I. Research Question 7.**

*Were religious leaders willing to make the necessary changes for these individuals and families to feel welcomed and valued members of their faith communities?*

Respondents were asked to indicate whether or not their faith communities would increase services and programs to persons with disabilities provided unlimited resources. Approximately 3/4 of the faith leaders surveyed responded that they would make improvements if financial restraints were not an issue, suggesting a willingness to make changes for these individuals and families. Again, the emphasis was on physical accessibility, with some mention of gaining knowledge and expertise.

“It would provide services requested by these individuals, just as other programs are run/decided upon in the community. A driver and an access-a-bus for our use at times needed – no waiting required for users.”

“We would like to add programs geared to meet needs of those who experience handicaps or alienation because of handicaps.”

“We would help with transportation, make changes to space to improve accessibility, have/train volunteers for support in specialized programs.”

## CHAPTER V

### Discussion and Recommendations

#### A. Introduction

The present research study explored participation of individuals with disabilities in faith communities in the Halifax Regional Municipality. While a considerable amount of research has examined inclusion in other areas such as child-care and education settings, little research has addressed inclusion in local faith communities. Both qualitative and quantitative data were collected from survey responses. The survey, which was designed specifically for this research project, provided an avenue for faith leaders to share their experiences and perspectives concerning disability and inclusion. Participation gaps were identified and opportunities for inclusion were explored. The information generated can be used to extend our knowledge in the area of faith inclusion and to enhance current practices.

In the following discussion section the results summarized are examined and explored in relation to the topics presented. As well, limitations of the present research will be addressed. Finally, recommendations for future research, families and individuals with disabilities, and faith leaders will be outlined.

#### B. Discussion

##### *i. Opportunities for and gaps in participation.*

The responses provided by the faith leaders surveyed provided an overview of the availability and accessibility of religious programs for individuals with disabilities in our region. As the data unfolded it became apparent that structural supports such as automated doors and

designated parking were commonly available in local faith communities, particularly in newer buildings. Additional supports, such as services and programs designed specifically to meet the needs of the disabled population, occurred less frequently. The researcher expected that participation would increase in relation to the number of supports offered by the faith community. However, there was no relationship between the total number of supports and attendance.

The findings of this study are consistent with previously reported experiences of individuals with disabilities who have attempted to access religious programs and services (see for example, Hayden, Lakin, Hill, Bruininks, & Copher, 1992; Orsmond, Krauss, & Seltzer, 2004; Wagner, Cadwallader, & Marder, 2003; Wagner et al., 2002). As mentioned earlier, advocates in the field have adopted the motto “a ramp is not enough”. To be truly inclusive, institutions must offer invitations, assurances of welcome, and greater adaptations to encourage further involvement.

Faith leaders responding to the research survey also provided insight into the rates and areas of participation of individuals with disabilities within their faith communities. Previous surveys and polls completed by adults with disabilities have suggested that individuals with special needs place the same value on religious participation as their typically-developing peers, but feel they are given fewer opportunities to be involved (Kregel, Wehman, Seyfarth, & Marshall, 1986; Riordan & Vasa, 1991). The present findings recognize this participation gap in religious life between disabled and non-disabled populations in our region. While up to 20% of the general population report having some form of disability, faith leaders reported that approximately 3% of their weekly attendees were disabled.

The results of this study and supporting literature (such as, Carter, 2007; Haythorn, 2003; Swinton, 2002) underlie the critical need to do more to fully welcome individuals with disabilities. The avenues through which worship is presented should be explored to ensure that they are accessible to all populations and that information is shared in a meaningful and understandable way. Congregations must discover new ways of communicating the doctrines, beliefs, and traditions of their faith effectively to members from an increasingly wide range of backgrounds and abilities, and consult individuals with disabilities to better meet their needs or examine the gifts they have to offer.

***ii. Perceptions of disability and inclusion.***

Despite a willingness to provide supports, the majority of respondents fell into the cultural habit of regarding the condition of the person, not the built environment or the social organization of activities, as the source of the problem. Overall, the definitions of disability provided by the faith leaders surveyed were in keeping with the prevailing medical/rehabilitation models of disability. Disability was generally regarded as an illness or deficiency to be cured by medical professionals or otherwise corrected by helping professionals. The respondents highlighted a number of specific forms of disability, with an emphasis on physical impairments.

Interestingly, none of the responses provided by the faith leaders reflected the religious or moral model of disability, in which disability is explained as a punishment, curse, or sometimes a blessing inflicted upon an individual by an external force or Higher Being. Themes embracing notions of sin or sanctity did not form the dominant bases of the faith leaders conceptualizations of, and responses to, disability. Though none of the faith leaders expressed an interpretation of disabled people as recipients of blessings or punishments, they frequently highlighted the ways

in which their perceptions had been shaped by their religious backgrounds. Many referenced Christian scripture, particularly creation in the image of God and examples set by Jesus.

The definitions of inclusion offered by faith leaders were generally consistent with the overarching views within the disabilities field, which state that inclusion means that all individuals can attend and benefit from the same programs. The majority of faith leaders made some reference to inclusion meaning all or everyone.

However, within the disabilities field, inclusion is also considered to go beyond physical integration to endorse full participation, friendship, and celebration of diversity. Aside from highlighting full participation, the definitions of inclusion offered by the respondents mainly did not reflect Child and Family Canada's principles of inclusion (Irwin, 1997). Little to no attention was given to naturally occurring proportions, range of options, proaction, advocacy, and parental involvement.

### ***iii. Barriers to inclusion in faith communities.***

As in previous research (Carter 2007) and inclusion discussions in the broader community, architectural barriers received the most attention in the survey responses. When questioned about barriers to full participation, the majority of the faith leaders surveyed focused on the inaccessibility of their facilities and a lack of financial resources to make the necessary upgrades. Architectural barriers were likely the focus for two reasons. First, as presence is required for participation, it is common to place the emphasis on the physical accessibility of the space. It is difficult to encourage participation if individuals with disabilities are unable to get through the door. Second, solutions for structural barriers are often the easiest to address. Physical barriers preventing access including stairs, narrow entrances and hallways, and washroom facilities that are difficult to navigate can be corrected quite easily provided adequate

financial support is available. As was pointed out by a number of the faith leaders, there are very few sources of funding for such upgrades. The majority of the faith leaders surveyed suggested a willingness to make changes for these individuals and families if financial restraints were not an issue. Again, the emphasis was on physical accessibility, with some mention of gaining knowledge and expertise.

The faith leaders surveyed also cited transportation as a barrier to participation for many individuals with disabilities. A number of the faith leaders referenced specific individuals for whom they believed transportation was a concern, while others cited this issue more generally. Interestingly, in previous polls and surveys, when people with and without disabilities were asked why they did not participate more in their communities, transportation was reportedly no more of a barrier for people with disabilities than for people without (NOD/Harris Interactive, 2000). Therefore, it seems the lack of adequate transportation does not explain the significant participation gap of people with disabilities in our faith communities as evidenced by the findings of the present study.

One of the most interesting results is perhaps what did not show up in the responses provided, and that was any mention of attitudinal barriers. Personal experiences have proved that the negative attitude of even one member can negatively impact the participation of an entire family. As well, previous research findings have indicated that negative attitudes were the most prevailing barrier preventing participation in faith communities (Christensen & Weil, 2007). In another poll, people with slight or moderate disabilities most commonly cited lack of time, lack of income, and lack of awareness of activities as explanations for not participating more in their communities (NOD/Harris Interactive, 2000). For people with severe disabilities, lack of encouragement from community organizations was by far the most common barrier to

participation. Lack of awareness and lack of income were also commonly cited by persons with severe disabilities. However, none of these barriers was explicitly identified, and received little to no attention from the respondents in the present study. This finding suggested a lack of awareness of the issues and concerns of the disabled population, as the barriers reported were not consistent with those reported by individuals with disabilities in previous studies and personal experiences.

*iv. Summary.*

This research was designed to capture information regarding accessibility of religious programs and perceptions by faith leaders regarding the constructs of disability and inclusion. In order to explore the policies and practices of including persons with disabilities in faith communities, rates and areas of participation were explored, and perceptions of disability and inclusion were examined. Due to the relatively small sample size, it is difficult to establish conclusive outcomes, and the results herein must be interpreted with caution. That being said, several interesting findings did emerge.

Overall, the faith leaders who participated in this study demonstrated a good general knowledge of the constructs of disability and inclusion. In general, the respondents implied an attitude of support and openness toward others, and most recognized everyone's right of equal access, particularly in relation to weekly attendance in a worship service. However, few acknowledged that an inclusive faith community is more than a place where people with disabilities are present, attend services, and receive offerings. As well, they did not implicitly or explicitly address the attitudes of their congregations, and most lacked formal policies concerning disabilities and inclusion.



The respondents showed varying levels of commitment to removing barriers between individuals and among communities that deny such access. The findings also suggested a lack of awareness of the issues and concerns of the disabled population, as the barriers reported were not consistent with those reported by individuals with disabilities in previous studies. Few indicated that they had made attempts to be truly inclusive places of worship, such as extending invitations for full participation and opportunities to serve both God and the congregation.

The results of this study also served to identify a participation gap within the religious communities throughout the HRM. The number of individuals attending weekly services and participating in other aspects of faith communities was significantly less than the naturally occurring proportions in the general population. This participation gap could not be explained by the presence or lack of structural supports, as the number of supports available held no relationship with the number of disabled attendees. Factors influencing the lack of participation of individuals with disabilities in our local communities of faith were not evident in the results of the present study. As previous surveys and polls suggest that attitudinal barriers may play the largest role, but were not addressed by the respondents in the present study, further investigation in this area is merited.

### **C. Limitations of the Research**

One major limitation of the present research study was the use of survey data collection. While survey research allowed the researcher to collect data about a number of variables from a large number of persons for relatively little cost, there was concern about the validity and reliability of responses obtained to the questions. Though the researcher kept this limitation in mind both while preparing items and interpreting results, due to the sensitive nature of the

material in the present study, the self-reports provided are not guaranteed to be accurate descriptions of what the respondents actually do or how they really feel about the research topic.

Despite taking measures to ensure a good response rate, such as providing a concise, but brief explanation justifying the survey and employing follow-up contact measures, only 33% of the faith leaders contacted completed part or all of the questionnaire. Given that the findings of the present study are drawn solely from the experiences and perspectives of a small sample, it is possible they do not represent the issues, concerns, and opinions of all faith leaders in the Halifax Regional Municipality. Certain faith leaders who chose not to participate in the study may have had significantly different perspectives on disability and inclusion, affecting their enthusiasm to contribute to the research topic. The sensitive nature of the research topic may have created certain pressure for some of the respondents to conform to the generally accepted views and attitudes. As well, the opinions and information shared by the faith leaders may not accurately reflect the perspectives of their faith community as a whole.

When interpreting the results of qualitative data, there is an inherent risk for the interpreter to be subjective. To prevent subjectivity, a second reviewer was utilized and inter-rater reliability was established. However, it may still be possible that subjectivity caused the investigator to ignore valid results or add results that were not present.

Another major limitation of the present research lies in addressing the topic from only one perspective, that of the faith leader. Exploring the topic from the viewpoints of other members of the congregation, including individuals with disabilities, may have led to a more well rounded picture. Individuals with disabilities and their family members who do not belong to a faith community likely have much to contribute to this topic, as well.

## **D. Recommendations**

### ***i. For future research.***

1. Future research could examine in more detail factors that contribute to the low participation rate of persons with disabilities in faith communities identified in the present study. Factors such as age, gender, degree of disability, and attitudinal barriers also require greater attention.
2. Approaching the topic from the perspectives of individuals with disabilities and their families may lead to the identification of further barriers, such as negative attitudes, impacting participation in faith communities and provide personal insight into the challenges they encounter. Individual interviews or focus groups with people with disabilities and/or their families should be conducted to access their feelings and perceptions on these issues.
3. In addition, the perceptions of persons with various types and severity of disabilities and their families regarding their inclusion in faith communities should be explored to delineate the role, if any, that specific disabilities play in this process.
4. Future research may further study individuals with disabilities within the context of their families, to examine the impact of inclusion and exclusion in faith communities. The impact of their experiences on individual and familial factors such as personal and parental stress, and meeting of spiritual needs may be addressed. Parental views and concerns regarding their children and families' experiences would be a worthwhile dimension to this research.
5. Significant issues and challenges set forth in this research by the surveyed faith leaders, related to their attempts to improve accessibility and availability while promoting inclusion should be explored through individual interviews. Issues that warrant further examination include, but are not limited to, the lack of financial resources available for these purposes and the lack of training, expertise, attitudes, and awareness in the areas of disability and inclusion. The

need to develop specific faith-oriented programs for individuals with disabilities could also be assessed.

6. The perceptions of all members of faith communities should be sought regarding inclusion of persons with disabilities . Change only occurs when everyone's perceptions are sought and issues identified so they can be addressed.

7. Faith communities should be given an opportunity to share their successes through focus groups and videoconferences. Such sharing would provide positive examples of how person with disabilities can be included and challenge others.

***ii. For individuals and families.***

8. Individuals with disabilities and their families are encouraged to take advantage of the faith-based services and programs that are currently available and accessible within the HRM.

9. They are also urged to openly and assertively communicate their needs for inclusion and support with their families, peers, and faith leaders.

10. Families and persons with disabilities are encouraged to generate and participate in opportunities to inform and increase awareness among members and leaders of their faith communities. It is essential to discover ways they can be involved in closing the participation gap.

***iii. For faith leaders and communities.***

11. Faith leaders, along with other members of faith communities, are encouraged to extend their focus for inclusion beyond structural supports, inadequate financial support, and transportation issues.

12. The opportunities for worshippers to bestow grace, broaden relationships, and affect the lives of people with disabilities and their families are vast, but these potential supports remain basically unused.

13. Faith leaders and community members are urged to find ways to move beyond their own lack of confidence in their ability to care for families affected by disability.

14. Faith leaders are encouraged to consult individuals with disabilities to better meet their needs and examine the gifts they have to offer. As individuals gain awareness and adequate training, any reservations they may have had about inclusion or serving those with special needs should be eliminated.

15. Faith leaders are also challenged to meet the needs of individuals with disabilities and their families who feel unwelcome and lack the supports necessary to fully participate in worship or related activities by discovering new ways of communicating the doctrines, beliefs, and traditions of their faith.

16. Faith leaders are persuaded to minister not only to, but also with individuals with disabilities to promote tolerance and acceptance. From a cultural and ideological perspective, equal access for someone with a disability is a human rights issue of major concern that requires individual, community, and large-scale social change. Inclusion in faith communities allows congregations to reflect God's love in the broader community, while providing a model of care for those outside the faith community.

## **E. Summary**

The present research project endeavored to highlight the extent to which a participation gap exists within faith communities in our region. Allowing congregations to share their personal

stories provided an opportunity to develop recommendations for inclusive practices in local communities of faith. The findings highlight the need for inclusive faith communities that provide more than a place where people with disabilities can attend services and receive offerings. Inclusion must be viewed as an attitude of support and openness toward others that recognizes everyone's right of equal access. Our faith community leaders and members are urged to explore the barriers between individuals and among communities that deny such access, particularly in the area of attitudinal barriers. They are further encouraged to create truly inclusive places of worship that extend invitations for full participation and provide opportunities to serve both God and the congregation.

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## **APPENDICES**

Appendix A  
Faith Participation Survey

**RELIGIOUS PARTICPATION SURVEY**

**SECTION A – DEMOGRAPHIC INFORMATION**

**Your role within the faith community:**

\_\_\_\_\_ **Religious affiliation/denomination:**  
\_\_\_\_\_

**Your location:** Urban Suburban Rural

**Your gender:** Male Female

**Your Age:** under 25 25-39 40-54 50+

**SECTION B – SERVICES AND PROGRAMS**

Please indicate if the following programs/services are available at your place of worship:

<b>1. Accessible parking (e.g., clearly marked, close to entrance)</b>	<b>YES</b>	<b>NO</b>
<b>2. Accessible entrance (e.g., ramp, automated doors)</b>	<b>YES</b>	<b>NO</b>
<b>3. Accessible transportation</b>	<b>YES</b>	<b>NO</b>
<b>4. Accessible restroom (e.g., large space, hand rails)</b>	<b>YES</b>	<b>NO</b>
<b>5. Accessible seating (e.g., wide aisles, pew cuts, reserved seating area)</b>	<b>YES</b>	<b>NO</b>
<b>6. Accessible materials (e.g., large print, adapted curriculum)</b>	<b>YES</b>	<b>NO</b>
<b>7. Elevator or chair lift (if building is one level, circle N/A)</b>	<b>YES</b>	<b>NO</b>
<b>8. Sign language interpreter</b>	<b>YES</b>	<b>NO</b>
<b>9. Books on disabilities that provide awareness and information in library/resource centre</b>	<b>YES</b>	<b>NO</b>
<b>10. Additional support to participate in regular activities</b>	<b>YES</b>	<b>NO</b>
<b>11. Special programs designed specifically for persons with disabilities</b>	<b>YES</b>	<b>NO</b>
<b>12. Respite care</b>	<b>YES</b>	<b>NO</b>
<b>13. Parent support group</b>	<b>YES</b>	<b>NO</b>
<b>14. Counseling for individuals and families affected by disabilities sponsored by place of worship</b>	<b>YES</b>	<b>NO</b>
<b>15. Stated policy of welcome for persons with disabilities</b>	<b>YES</b>	<b>NO</b>

Of the above programs/services not presently offered, please indicate which, if any,

**have been requested or inquired about:**

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**you plan to offer in the future:**

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**you feel it is not possible to offer:**

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## SECTION C - PARTICIPATION

Please estimate how many parishioners in your faith community participate in:

	<b>Under 19 – No disabilities</b>	<b>Under 19 – With disabilities</b>	<b>Over 19 – No disabilities</b>	<b>Over 19 – With disabilities</b>
<b>Weekly religious services/worship</b>				
<b>Religious education (e.g., Sunday school, preparation for sacraments, studies of sacred writings)</b>				
<b>Music programs (e.g., choir, worship musicians)</b>				
<b>Serving (e.g., greeting, ushering)</b>				
<b>Community outreach activities</b>				
<b>Global mission activities</b>				
<b>Prayer meetings</b>				
<b>Leadership or committee work</b>				
<b>Volunteer work</b>				
<b>Recreational/social activities</b>				
<b>Counseling</b>				
<b>Retreats</b>				
<b>Participation in service (e.g., witnessing/sharing faith, readings)</b>				
<b>Taking sacraments/rites</b>				



**SECTION D – SHORT ANSWER (Feel free to use additional sheets if more space is required.)**

**1a. Please share your perception of disability.**

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**1b. How has your religious background influenced this perception?**

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**2a. Please share your perception of inclusion.**

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**2b. Please describe how your background and experiences have influenced this perception.**

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**3a. Do you feel that persons with disabilities can participate in your faith community?**  
YES / NO

**3b. If yes, please describe some ways in which persons with disabilities can participate. If no, please explain.**

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**3c. Do you feel there are limitations on the participation of persons with disabilities in your faith community? YES / NO**

**3d. If yes, please note some of these limitations.**

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**4. Please indicate any barriers that could prevent your faith community from offering programs and services for persons with disabilities?**

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**5. Describe any circumstances in which families or individuals decided not to participate or to discontinue participation in your services and/or events due to actual or perceived barriers.**

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Appendix B

Letter of Introduction/Informed Consent

Dear Faith Leader,

My name is Lindsay Fleming and I am currently enrolled in the Master of Arts (Child and Youth Study) program at Mount Saint Vincent University. As part of my degree requirements, I am conducting research on inclusion of individuals with disabilities in faith communities. The proposed study will gather information on current levels of participation of individuals with disabilities in faith communities (such as churches, synagogues, mosques, temples, etc). I am also interested in exploring your perceptions of disabilities and inclusion as they relate to your religious background. Rest assured, this is NOT a comparative analysis among religions, but rather an overview of the opportunities to worship available to individuals with disabilities. My goal is that this information will act as a resource to stakeholders who are invested in providing and maintaining religious services and programming throughout Halifax Regional Municipality.

If you are willing to participate in this research, please complete the enclosed religious participation survey. The completion of this survey should take approximately 30 minutes. Please understand that your participation in this study is completely voluntary. You do not have to complete any questions that cause you discomfort. All information will be kept completely confidential. Only group results will be reported and no single person or faith community will be identified. The surveys will be numerically coded and destroyed after data has been coded and inputted for analysis. If desired, a summary of the research findings will be shared with your faith community when the thesis is completed.

If you choose to participate, please enclose your completed survey in the postage-paid envelope provided and return by (*place date here*).

If you have any questions or comments, you can contact me, Lindsay Fleming at (phone) or (email) or my thesis supervisor Dr. Carmel French at 902-457-6187 or (phone) or (email). If you have any questions about how this study is being conducted, you may contact the University Research Ethics Board (UREB) c/o MSVU Research and International office, who is not directly involved in the study, at 902-457-6350 or [research@msvu.ca](mailto:research@msvu.ca).

I would like to thank you for your participation and support in this research project. It is my hope that that this research will lead to improved participation of persons with disabilities in faith communities.

Sincerely,

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Lindsay Fleming  
Graduate Student  
Mount Saint Vincent University

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Dr. Carmel French  
Department of Child and Youth Study  
Mount Saint Vincent University