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WORKING WITH PEOPLE WITH DISABILITIES -
INVESTIGATING THE ETHICS, VALUES AND MOTIVATION OF
THE EMPLOYEES WORKING AT THE GOLD COAST
RECREATION & SPORTS INC.


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Since the early 1990's, inclusion of people with disabilities has become an increasingly relevant topic. The purpose of this thesis was to study the values effecting on the motivation of employees and service providers working at the Gold Coast Recreation & Sports Inc. in Queensland, Australia. With the collaboration of the organization, the aim was to identify possible patterns and/or similarities in the values of the employees and service providers working with people with disabilities. Little research has been done on this topic, making it a current subject to be studied. The values we work to act according to in everyday life are connected to motivation and lead in our decision making. Accordingly, it has been proposed by theorists that motivation can be examined through values.

This thesis was conducted through a survey. Following data collection, survey screening and cleaning of data, the respondents resulted in 35 people, of which 89% consisted of staff members and 11% of service providers. The results of the survey suggest, that the majority of the employees and service providers working with people with disabilities are most motivated through self-transcendence values, which emphasize enhancement and preservation of the welfare of all people and nature. In comparison, they are least motivated by self-enhancement values, which emphasize personal success, pleasure or sensuous gratification for oneself, social status and prestige.

The results show, that the main reason for getting involved in working with people with disabilities was employment opportunity with 29% of the responses. Results also conclude, that work experience with disability groups changed attitudes in 83% of the sample group. This in turn can be linked to the ICF model, and its aim of seeing the entirety of a human being, and not just the disability/diagnosis of him/her. Therefore, the work with disability groups has changed views, understanding and perhaps action of employees to be more ethically sensitive and respectful towards people with disabilities. This suggests, that the implementation of work experience with disability groups would be extremely important in education from an early stage, especially in vocational schools and universities with degree programs in health care. Further studies are required on this topic, with special emphasis on the effect of attitudes and values in working with disability groups. For example, a study could be proposed to investigate the attitudes and values of volunteers and employees from different organizations, since it is a topic yet unstudied.

CONTENTS

# 1 INTRODUCTION

*Adapted physical activity* is a term used to define the physical activity of people, who encounter difficulty participating in generally offered activities. Instead of focusing on disability, the term emphasizes the importance of providing physical activity for all, regardless of possible restrictions participants may have. Without discrimination, service providers need to take into consideration possible special needs regarding physical ability. (Ala-Vähälä & Rikala 2013, 10.) In principle, almost all sports can be adapted for people with disabilities. In Finland, about 1/5 of the population participates in adapted physical activities which are offered by different organizations, counties and some private service providers. (Huovinen, Niemelä & Rintala 2012, 489.) Adapted physical educators/coordinators work together with physical educators, nurses, physicians, coaches and other related service personnel, e.g. physical and occupational therapists, to provide quality programs in adapted physical education and sport. (Winnick 2005, 33-36). The roles and responsibilities of health professionals in the field of APA require mastering of skills such as adapting activities, working as a part of multidisciplinary teams, inclusion and knowledge about specific disability populations (Lieberman & Houston-Wilson 2009, 8). The general aims for physical activity are the same for everyone, including people with disabilities.

The *ICF* (The International Classification of Functioning, Disability and Health), explains functional ability as a term which refers to all body functions, personal ability and participation in one's current life situation (Kaski, Manninen, Mölsä & Pihko 2001, 19). It doesn't classify people, but instead describes the health of people in accordance to their functional capacity within their environment. Health is described as the ability of an individual to perform the full dimension of activities required in engaging in all aspects of life. (Sykes 2006, 1.) Every professional of each field of work should act according to the right and approved societal goals of health and welfare, safety, justice, freedom and equality. Especially in the fields of social care, health care and education, experts are professionally responsible for all matters concerning the health of their clients. Caretaking of others requires for ethical sensitivity, which stands for the skills of acknowledging ethical tensions or problems in unclear and complicated situations in everyday life. It involves the skills of identifying people's characteristics,

needs, rights and responsibilities in the situation, and being able to put yourself in another person's position. (Juujärvi, Myyry & Pesso 2007, 79- 217.)

Ethical thinking happens all the time, and is related to our encounters with others; what to do, think, and how to react. A combination of different ethical theories need to be taken into consideration in the practice of professionals in the field of APA. (Goodwin & Rossow-Kimball 2012.) The ethical principles of occupations are usually molded from values that act as desirable goals in that field of work, and which are fundamental in vocational practice. Values connect emotions to our experiences, which lead our actions, choices and decision making, and can even define the field of work we choose. They are thought to be beliefs that a certain action or goal is personally or socially more desirable than the opposing action or goal. People strive to act according to their values, and therefore motivation to act in the desired way comes as a result. (Juujärvi, Myyry & Pesso 2007, 28-35.) Our motivation can be divided into intrinsic and extrinsic motivation, which are defined by the goals we work towards to (Deci, L. & Ryan, M 2000, 54-64).

According to the *Schwartz Theory of Values*, ten basic values can be ruled out universally and be put into order of importance to describe societies, cultural groups and individuals. Each of these values has an underlying broad motivational goal, which is worked towards when pursuing to act according to one's values. (Schwartz, S. 2012, 3-8.) Therefore, motivation for action can be examined through the ten universal values. This thesis aims to investigate the values of staff, volunteers and service providers working with people with disabilities at the Gold Coast Recreation & Sports Inc. in Australia. The study topic is important for the organization itself and the development of quality of work. Furthermore, little research has been done specifically about the motivation and values of people that work with people with disabilities, which makes the matter at hand current.

# 2 DISABILITY

## 2.1 ICF classification of disability

*The International Classification of Functioning, Disability and Health* (ICF), is a classification system created by the World Health Organization in 2001, handling functional ability, disability and health. According to the ICF, functional ability is an umbrella term referring to all body functions, personal ability (what a person with an illness or functional impairment does or is able to do) and participation in one's life situation. (Kaski, Manninen, Mölsä & Pihko 2001, 19.) With that said, the three components of the classification model include body functions and structures, activities in participation (individual and societal) and both personal and environmental factors (Sykes 2006, 1).

The term disability includes impairments (either in body function or structure), and limitations in function and participation. Environmental factors include one's immediate living environment and the services and their providers. In addition, environmental factors include the physical and social world and attitudes, which effect on functional ability either in a progressive or restraining way. Personal factors consist of an individual's background and current life situation. They are composed of individual attributes that are not linked to their health status, e.g. sex, race, age, fitness, other health factors, lifestyle, habits, upbringing, survival skills, social background, education, past and present experiences, character, behavior and mental resources. (Kaski, Manninen, Mölsä & Pihko 2001, 19.) When assessing activity and participation, two different qualifiers are used: performance and capacity. Performance expresses the activity of the individual in his/her current environment, and capacity indicates the ability of the person to execute a task or activity. Capacity measures the highest level of function the person can reach in that environment at that moment. (WHO 2001, 123.)

The ICF model (Figure 1) doesn't classify people, but instead describes the health of people in accordance to their functional capacity within their environment. Health is described as the ability of an individual to perform the full dimension of activities required in engaging in all aspects of life. In comparison to the ICD, which codes

health conditions, the ICF classifies and codes functioning and disability related to health conditions. The ICF is beneficial in treatment of patients through incorporation of functional information in administrative recording, which enhances consistency of records across health care sectors. This aids in evaluating outcomes, comparing treatments and managing and predicting costs. The model components are interactive with one another and go in both directions. For example, a disability may modify the health condition and therefore effect on other components. (Sykes 2006, 2.)
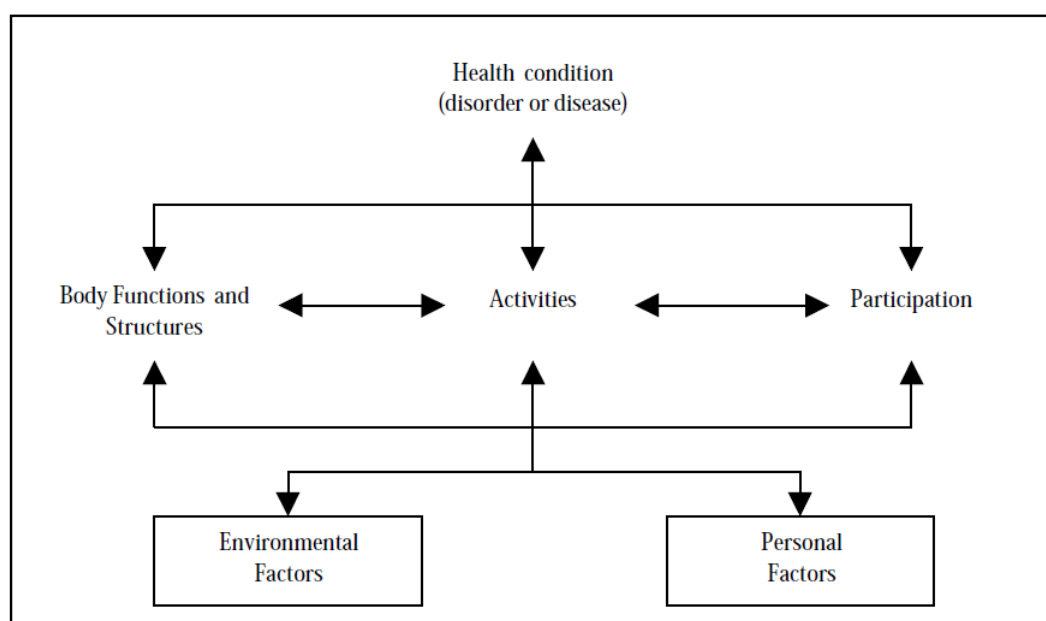


Figure 1 - Interactions between the components of ICF (World Health Organization 2001, 18).

The contract on the Convention on the Rights of Persons with Disabilities (CRPD) established in 2006 by the United Nations strives to specify how existing human rights can be further implemented into the lives of people with disabilities. The contract also examines which threats in particular effect on the execution of the implementation. When using the ICF model in the examination of functional ability of a disabled person, it must be done in light of the CRPD. This requires respecting the clients self-determination and privacy, as well as appropriate ethical conduct. Ethical instructions in the use of ICF entail respect and confidentiality, the use of the ICF tool generally and the use of ICF for societal purposes. (Website of THL 2016.)

2.2 People with disability

The World Health Organization (WHO) describes disability as "complex, dynamic, multidimensional, and contested". It is a term that covers a broad category of functions, such as impairments, restrictions in participation and activity limitations. Activity limitations and restrictions in participation are experienced by the individual in different life situations, whereas body impairments are physical problems in structure or function. It refers to the negative outlook on the disabled individual's intercommunication with personal and environmental factors. (Website of the World Health Organization 2011.)

The first signs concerning disability in children are usually noticed during the first years of life. Some hereditary illnesses, chromosome abnormalities and developmental disorders of the nervous system can be screened during pregnancy. Severe developmental disability is generally diagnosed during the first year of age, and minor abnormalities often in the beginning of school age. Evident structural abnormality can be noted at the time of birth. Some of these defects can predict for continuous need of special care throughout life. One of these examples being 21-trisomy (Down-syndrome), or some other chromosome anomalies effecting on appearance. Additionally, certain risk factors such as premature birth, lack of oxygen during labor and neurological symptoms can be identified in newborns. The development of the central nervous system can also be damaged due to trauma, infection and brain tumors in the developing child. (Kaski, Manninen, Mölsä & Pihko 2001, 32-33.) Developmental disability is seen before 18 years of age (Sillman, K 1995, 15). Each child that portrays abnormal development, or loss of skills need to be examined whatever the age. If developmental screening or monitoring gives reason for the suspicion of delayed mental development, the child is sent for examinations to investigate the reasons and extent of the disability. A preliminary evaluation can be made in outpatient care, with the collaboration of doctors and psychologists. (Kaski, Manninen, Mölsä & Pihko 2001, 34.)

People with disabilities often require rehabilitation from an early age, emphasizing physical, psychological, social and educational aspects. Certain characteristics associated with age, such as individuality and developmental age need to be taken into con-

sideration in treatment planning and implementation. (Martin 2016, 72) The rehabilitation and treatment of people with disabilities involves the person being treated, their relatives, and the collaborating professionals from different fields. (Kaski, Manninen, Mölsä & Pihko 2001, 259-262.) Without the acknowledgement of family and the commitment of the clients' parents, rehabilitation cannot successfully be supported (Martin 2016, 73). The goal of treatment is the wellbeing of the client and to help the person live an independent and full life. Overall wellbeing includes all physical, mental and social aspects of life, including work, education and living environments which should all be taken into consideration in treatment and rehabilitation. Rehabilitation stands for action, through which the client/patient can achieve better physical capacity, social acacceptance and personal satisfaction. It is the entirety of procedures that result in enhancing autonomy in everyday life and preventing further long-term decline of functional capacity. (Kaski, Manninen, Mölsä & Pihko 2001, 259-262.)

The clients at the Gold Coast Recreation & Sports Inc. consist mainly of people with disabilities of the central nervous system, intellectual disability and chromosomal defects including Cerebral Palsy, Down syndrome and disabilities included in the Autism Spectrum. These will be further discussed in the following chapters.

2.2.1 Intellectual disability

The definition of disability is described by the AAMR (American Association on Mental Retardation) as a significant restriction in an individual's present functional capacity. A distinctive feature to it is a significantly lower intellectual function (IQ, intelligence quotient, is under 70-75) combined with limitations of at least two of the following adaptive subgroups: communication, social skills, taking care of oneself, living at home, working in a community, self-rule, health and safety, ability to learn, leisure time and work. (Sillman, K 1995, 15.) According to the World Health Organization, with the Stanford-Binet intelligence scale test results (IQ test), classification of disability can be done. However nowadays, disability is no longer measured solely on the intelligence quotient, but more so in a person's ability to adapt to the surrounding society. Therefore, the classification of disability has been simplified into 'mild' and 'severe' cases. (Figure 1) (Mälkiä & Rintala 2002, 34.)

In mild cases of disability, children face learning difficulties in school, but may be able to take part in general education with regular need for aids and some special education. These children will most likely be independent in personal matters, and may be able to live independently as adults. Many adults with mild disability are able to work and sustain social interaction and relationships. However, in most of these cases, constant guidance and supervision is required, which often leads to the inability to work due to growing demands in task difficulty. Even though a person with a mild disability is independent in most aspects of life, they often require help and support in managing affairs and services. In severe cases of disability, support and guidance is needed consistently. Considerable assistive measures need to be taken into consideration in education and living situations. There may be serious deficiencies in activity, communication and managing personal affairs. A lot of work is required for rehabilitation to be successful. (Kaski, Manninen. Mölsä & Pihko 2001, 25-26)

**WHO CLASSIFICATION OF DISABILITY**

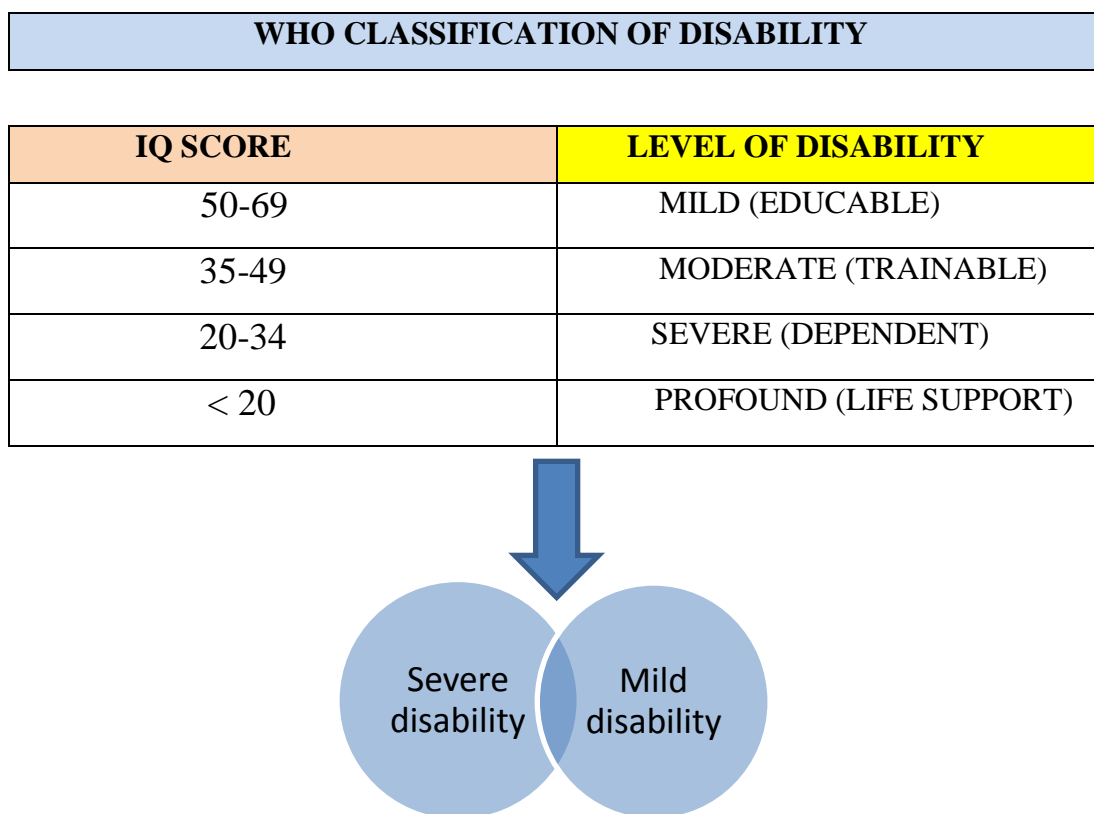| IQ SCORE | LEVEL OF DISABILITY |
|----------|---------------------|
| 50-69 | MILD (EDUCABLE) |
| 35-49 | MODERATE (TRAINABLE) |
| 20-34 | SEVERE (DEPENDENT) |
| < 20 | PROFOUND (LIFE SUPPORT) |

Figure 2 - Intellectual disability, *mental retardation,* according to the World Health Organization (Modified Kaski, Manninen, Mölsä & Pihko 2001, 23).

Disability does not only limit to the impairment and damage of the nervous system, but includes the damage to other organs as well. However, the most significant group consists of the nervous system's diseases, injury and other abnormalities; which are called the developmental disorders of the nervous system. Of these developmental disorders, the most important are those of the brain. They are often related to the insufficiency of intellectual function. According to the World Health Organization's ICD-10 (International Statistical Classification of Diseases and Related Health Problems) intellectual disability is a state, where the development of mental functions is incomplete or prevented. These deficits usually consist of cognitive, linguistic, motor and social skills that develop in adolescence and effect on general mental capacity.

A vast variety of different forms of disability that restrict physical and mental capacity belong to developmental disorders. The most central ones of these are intellectual developmental disabilities. The presence of other disabilities or illnesses alongside developmental disabilities often require for special care and needs. The severity and presence of these disabilities are individual and dependent on the level of disability. The manifestation of disability and illness may differ significantly from common manner in these cases, thus making the interpretation of behavior very challenging for professionals working with these clients/patients. (Kaski, Manninen, Mölsä & Pihko 2001, 20-121.)

2.2.2 Down syndrome

Down syndrome, also known as trisomy 21, is a condition that is connected to recognizable characteristics or traits and intellectual developmental disability. It is the most common chromosomal abnormality and the main chromosomal cause of intellectual disability, which varies significantly in children with Down syndrome. The uneven division of chromosome 21, referred to as nondisjunction, is the main reason for the cases of trisomic Down syndrome, at a 90% prevalence. Maternal factors such as age, earlier menopause, lower number of oocytes (immature egg cells) and gene variations in folate metabolism have an effect on the occurrence of trisomy. Genetic findings suggest, that the presumable cause for Down syndrome is multifactorial and may include genetic predisposition to nondisjunction, autoimmunity, hormonal alterations in women, environmental and chemical factors e.g. drug use and smoking, gestational diabetes and viral infections. Diagnosis of Down syndrome is most often made shortly after birth due to its distinctive observable characteristics. Treatment of this condition include genetic counselling and therapy, surgical correction in case of congenital anomalies, prevention of secondary conditions and inclusion in education from preschool to high school. However, there is no treatment for the elimination of the chromosomal defect. (Jackson Allen & Vessey 2004, 445-449.)

2.2.3 Cerebral Palsy

Another developmental disability linked to intellectual and learning deficits is Cerebral palsy (CP). CP is a non-progressive disorder of the central nervous system (CNS), resulting from damage to the brain and can occur before, during or after birth, affecting the motor system of a child. Poor coordination, balance and abnormal movement patterns, or the combination of these three are affected. CP may be linked to other medical issues such as epilepsy, intellectual disability, learning disabilities and/or attention deficit hyperactivity disorder (ADHD). (Miller & Bachrach 2006, 3.) Impaired motor functions originating from the CNS are acquired in all people with CP. Different assessment tools and classification systems such as the *Gross Motor Function Classification Test* can be used to determine the severity of dysfunction.

The primary motor disorder of CP is described through the level of motor function and nature of the movement disorder. These may include spasticity (high muscle tone), dyskinesia (involuntary muscle movement), ataxia (abnormal pattern of movement), hypotonia (low muscle tone) and aphasia (a loss of ability to produce and/or comprehend speech) or a combination of these. (Dodd, Imms & Dodd 2010, 8-10.) Three considerable factors leading to diagnosis of CP consist of a delay in motor function development with non-progressive signs and symptoms, inability in reaching normal motor milestones and abnormality of the central nervous system. Diagnosis is based on assessment of the functional, developmental and the physical capability of a child.

Treatment of CP involves the collaboration of physical and occupational therapists, doctors and family members of the patient. In therapy, maintenance of mobility and range of motion alongside with communication skills, muscle control, balance and performance of daily functions are goals of treatment that need to be determined by the child's health, developmental and functional needs. Orthotic devices, assistive aids and pharmacotherapy are most likely involved in the care process. Learning disabilities and intellectual developmental delay is frequently seen in children with CP, and is most profound in cases with spastic quadriplegia and least profound in cases with hemiplegia, in which 60% of children have a normal IQ. Despite having a normal IQ, perceptual impairments and learning disabilities are generally present in people with CP. (Jackson Allen & Vessey 2004, 327-333.)

2.2.4 Autism Spectrum Disorders

Autism Spectrum Disorders (ASD) also referred to as Pervasive Developmental Disorders (PDD) are umbrella terms used to define a group of conditions. They cover Autistic Disorder, Rett's Disorder, Asperger's Disorder, Childhood Disintegrative Disorder and the Pervasive Developmental Disorder – Not Otherwise Specified (PDD-NOS) which also covers Atypical Autism. (Yapko 2003, 24.) Autistic features can be connected to other separate learning disorders, and there are evidently many reasons for the development of autism. Hereditary components combined with possible risk factors generate vulnerability in certain parts of the central nervous system, causing

inability of the brain to process and assemble sensory information from the environ-ment. These developmental disorders are notable in behavior. Typical behavioral dis-orders to autism usually become evident in the first two and a half years of life. (Kaski, Manninen, Mölsä & Pihko 2001, 122.)

Autism Spectrum Disorders influence three fundamental areas of development includ-ing communication, interests and activities, social interaction and repetitive patterns of behavior. (Yapko 2003, 24)  To aid with diagnosis, several different assessment and interview forms have been developed to examine and determine the strengths, weak-nesses and level of autism in preparation for future rehabilitation and education pur-poses. Distinctive indications for ASD's are severe social interaction and communica-tion impairments, abnormal and restricted behavior and sensory hypersensitivity. Se-vere problems in communication are present in understanding verbal, gesture and sym-bol language, and may be portray as inability to express oneself verbally and non-verbally. (Kaski, Manninen, Mölsä & Pihko 2001, 123-124.)

As with other disorders, the treatment plan for a person with autism needs to be inclu-sive of educational, behavioral and often pharmacological treatments that need to be developed and carried out by multidisciplinary teams of parents, care providers, school personnel, psychiatrists, and physical, speech and occupational therapists. (Jackson Allen & Vessey 2004, 221.) Before the treatment of people with ASD begins, thorough medical, psychological and pedagogical examination is required. Diagnosis in early age is beneficial in terms of having a beneficiary effect on rehabilitation and functional capacity. (Kaski, Manninen, Mölsä & Pihko 2001, 123.)

# 3 ADAPTED PHYSICAL ACTIVITY

## 3.1 The definition of Adapted Physical Activity

*Adapted physical activity*, (APA) is a term introduced in 1973, which elicits many meanings, depending on different variables that affect discussion. These variables include for example history, culture, language, country, education and social communication with others that support a different meaning for the term. (Hutzler & Sherrill 2004, 1.) IFAPA, 2004 defines APA as *"a service delivery profession and an academic field of study that supports an attitude of acceptance of individual differences, advocates access to active lifestyles and sport, and promotes innovation and cooperative service delivery programs and empowerment systems. Adapted physical activity includes, but is not limited to, physical education, sport, recreation, dance and creative arts, nutrition, medicine, and rehabilitation."*

In the following years of World War 2, opportunities increased concerning traveling, communication and leisure activities. Attitudes began to change about the abilities of disabled people when veterans returned home from war. This lead to change in physical activity philosophy, and sparked a movement called "Sports for all", which emphasized on promoting competitive and recreational sports, for people with disabilities. In 1952, the USA announced adapted physical exercise (APE) to replace disciplinary physical education (PE) in school programs. As a result, a diverse program was set up for people with disabilities that may not have safely or successfully engaged in regular PE classes. (Hutzler & Sherrill 2004, 2.)

Adapted physical activity was later introduced in the 1970's as a wider term, which refers to all adapted activity, whereas adapted physical education refers mainly to physical activity in schools. Adaptations in physical activity can be technical (use of assistive devices or structural adaptations), structural (e.g. changes in the rules of a game/sport) or educational (adapting teaching-, training- and coaching methods). Before adaptations in activity can be made, health restrictions such as impairments and illnesses must be recognized for guaranteed safety of the participants and the best possible benefit of the exercise. (Mälkiä & Rintala 2002, 5.)

People with disability benefit from regular exercise, most likely each in their own way. Exercise contributes an important role in children's physical, mental and social development as well as to an adult's general health condition, fitness and physical capacity, leisure time activities, work wellbeing and quality of life. Physical activity is directly linked to the prevention and treatment of some diseases including cardio-pulmonary diseases, musculoskeletal disorders and even some cancers. In addition, physical activity can be utilized in the different stages of rehabilitation with people suffering from chronic illnesses or disability. Not every patient/client is aware of the benefits of exercise as a method in rehabilitation. Therefore, a great deal of responsibility is left on the professionals in the field of rehabilitation and physical education to estimate, guide and motivate a person with disability or chronic illness. These measures include determining the patient's opportunities and need of exercise, and becoming aware of one's restrictions in activity. (Mälkiä & Rintala 2002, 6.)

3.2 Inclusion

The coordination of special- and basic education in the Nordic countries has been called integration since the 1970's. Generally, it aspires to accomplish special education in the midst of basic educational services and to merge the two into one whole. An idealistic goal would be one common educational system that serves every student well. The motivation behind this ideology has been to create a school for all, through which to create a wider base for the development of equality and justice in society.

Dissatisfaction with the integration system in the 1980's created new movements, which demanded a comprehensive re-evaluation and a more complete merge in special-, and regular education. The movements aspire to enhance the ideological goals behind integrational thinking. These are the REI (Regular Education Initiative), and the Inclusive Education movement, born in the 1980's. The regular education initiative demands the merge of basic and special education in a way, that basic education would take responsibility of those that have special education needs. (Hautamäki et al. 2015, 84.)

In the western world, people with disability are often seen to be substantially different from others. Attitudes and practice in society portray, that the disability of a person has caused the individual's humanity and social acceptance to be questioned. (Vehmas 2005, 5.) From the initiative of the United Nations in 1990, Education for All (EFA) has become a worldwide pursuit. UNESCO describes the education for all movement to be "a global commitment to provide quality basic education for all children, youth and adults." (Website of UNESCO 2016.)  The translation for the term *inclusive education* is, that every student with disabilities should be placed in age-appropriate general education classrooms in local schools which they would attend if not disabled, with access to required support, accommodations and services (Peterson & Tamor 2001, 1).

Inclusion is described as the education process of children with and without disabilities, together at all times (Lieberman & Houston-Wilson 2009, 1). Inclusive teaching starts with equal attendance in local schools, where everyone receives teaching according to their personal requirements. The foundations of inclusion are social justice, equality and democracy. For inclusion to function, requirements necessary in teaching and assistance services need to be available. In addition, profound structural changes have to be made in the existing education system.

In contrast to the terms integration and mainstreaming, inclusion better expresses what is needed. Firstly, each student needs to be included in all activities in schools, and not just be set in the mainstream. Secondly, integration refers to someone being an outsider, and being brought into activities, whereas with inclusion everyone is together in the same school from the start. Thirdly, a school that includes all students will need to develop a system where all of their students' needs are taken into consideration. Lastly, the term emphasizes the co-operation and involvement of staff in the education of all students. (Hautamäki et al. 2015, 84-85.)

In addition to the benefits mentioned above, inclusion also boosts personal development in people with and without disabilities through contributing opportunities in leadership. Further, research suggests that students without disabilities that have ongoing contact with students with disabilities, will be more able to handle the onset of disability in the future in their own lives. While the results of inclusion are positive in

quality, a fail in administrating an inclusion program won't produce the same outcome. Having said this, well implemented inclusion practices produce positive effects, as poorly implemented practices produce negative ones. (Lieberman & Houston-Wilson 2009, 9-10.)

# 4 WORKING WITH PEOPLE WITH DISABILITIES

## 4.1 Ethics

The roles and responsibilities of physical education teachers, physical therapists and other health professionals in the field of APA require mastering of skills such as adapting activities, working as a part of multidisciplinary teams, inclusion and knowledge about specific disability populations. (Lieberman & Houston-Wilson 2009, 8.) Ethical thinking happens all the time, and is related to our encounters with others; what to do, think, and how to react. A combination of different ethical theories need to be taken into consideration in the practice of professionals in the field of APA. (Goodwin & Rossow-Kimball 2012.) The word ethics refers to morals, beliefs and values of an individual, family/group or society. The term ethical, is also used to represent something that is "morally correct". (Naagarazan, R.S. 2006, 5.) Morals and ethics have similar definitions, but however, nowadays slightly varying meanings. Morals are used to explain individuals' own perceptions of what is right and wrong. Ethics, on the other hand, is its own philosophical field of study which investigates right and wrong. (Juujärvi, Myyry & Pesso 2007, 13.) The study of ethics helps in getting accustomed with these beliefs, values and morals and learning the good and bad of them. The study of ethics guides us in living, and responding to issues through our rights, responsibilities, duties and obligations. (Naagarazan, R.S. 2006, 5.)

### 4.1.1 Ethics in work

Professional identity is directly linked to social identity, which is attached to the occupational field one works in. It reflects the way a person identifies themselves as an expert and advocate for that occupation. In addition, it can also reflect the position of ethics and moral values in working practice. The foundation for professional conduct are professional skills, which are distinctive qualifications gained through experience and education to work in a profession. Nowadays, ethical proficiency is seen as an essential part of professional expertise. Work ethics consists of a shared systematic view about what type of professional behavior/action is right and good and what is seen as wrong and bad in a specific professional field. When a person encounters an

issue, and is unaware of how to act in a situation, they have a moral problem. These problems encountered in occupational work are called ethical issues. The basis of work ethics is the assumption that moral problem-solving in work is based on a reflected conception of right and wrong. Ethical issues are also those matters that generally puzzle the mind and generate discussion about right and wrong. (Juujärvi, Myyry & Pesso 2007, 9-44.)

Typically, all occupational conduct is related directly, or indirectly to other people. Therefore, health and safety are important values to all professionals. Justness and the aim for discrimination free work environments play a central role in the values and ethical guidelines in many fields of work, in which fairness and equal treatment of customers/patients is mentioned and highlighted. (Juujärvi, Myyry & Pesso 2007, 9-153.) Ethical questions concerning special education and disability fall into the category of "adaptive ethics". The term describes the adapting of ethical theories to, for example, a practical moral dilemma in a work situation. These practical questions are defined, simplified and organized to be understandable by traditional philosophical methods, in an effort to find justified answers to the questions. For adaptive ethics to be genuinely adaptive, it needs to be relevant in practice. Thus, adaptive ethics deals with practical questions in life. (Vehmas 2005, 156-157.)

Ethics that focus on close relationships is called ethics of care. Ethics of care emphasizes emotional commitment as the foundation of ethical action, and can be connected to personal or occupational relationships of care. Especially in the fields of social care, health care and education, experts are professionally responsible for all matters concerning the health of their clients. The desire to enhance other people's wellbeing and respond to their needs motivates caretaking. That being said, the aim of caretaking is not to strengthen one's dependency, but to support them into becoming autonomic and independent decision making individuals that live their own lives. Furthermore, caretaking requires for ethical sensitivity, which stands for the skills of acknowledging ethical tensions or problems in unclear and complicated situations in everyday life. It involves the skills of identifying people's characteristics, needs, rights and responsibilities in the situation, and being able to put yourself in another person's position. This for one, requires role-taking and empathy skills. (Juujärvi, Myyry & Pesso 2007, 79- 217.)

4.1.2 Ethics and moral conduct

The role of ethical motivation is essential in moral conduct. The motivation to act morally and ethically, means that a person is committed to a moral aim, and feels personal responsibility about the moral consequences of the situation. (Rest, Narvaez, Bebeau & Thoma 1999, 101.) From time to time, people may act in ways that seem morally arguable or unethical. In these situations, the case isn't necessarily the lack of knowledge about what is right or wrong. In fact, another goal of the individual, other than ethics, may cause the person to act in an opposing way to what they know to be right. The contradiction between the theory of ethical motivation and actions in choosing opposite to them has been a question yet unanswered. Some proposed suggestions to this question have been moral feelings, such as empathy, guilt and shame.

The feeling of empathetic care can be strong enough to make a person act in a certain way, despite knowing that the choice will cause themselves inconvenience (Juujärvi, Myyry & Pesso 2007, 33-34.) According to some outlooks, empathy is the strongest trigger of moral action. Guilt and shame are both feelings of self-awareness and role, because they require the ability to examine our own behavior from an outsider's perspective. These feelings are linked to situations where someone has been hurt due to the actions of the individual. (Juujärvi, Myyry & Pesso 2007, 33.)

*The four component model*, developed in 1983 by James Rest, aims to explain the psychological processes that are associated with moral behavior. The model is made up of four components, which include moral sensitivity, moral judgment, moral motivation and moral character. Moral sensitivity includes the initial step, which is the examination of who are concerned in the matter, which actions are potential in the situation, and how the consequences of actions will effect on the people concerned in the matter. Secondly, moral judgement needs to be made as to what type of action is morally right or fair and choosing one option of choice. The third component, moral motivation is explained through the aims of individuals to be able to choose and obtain the values and ideals which serve an ethical outcome. Lastly, moral character is connected to the implementation skills and courage in executing action even under pressure. Rest emphasizes that the order of the four components is not chronological, but

more so logical. The value priorities that underlie motivation vary from person to person and can effect on interpretation of situations and what a person considers important. (Myyry 2003, 6.)

4.2 Values

The term *value* is multidimensional, and it can be defined in many different ways. Usually values are thought to be beliefs that a certain action or goal is personally or socially more desirable than the contrary action or goal. Values can be personal, reflecting an individual's own rank of values, or social, which are made up of those values that the individual perceives to be appreciated by others. (Juujärvi, Myyry & Pesso 2007, 35.) Values are connected to plans and goals made in concrete aspects in our lives, such as work, family, education and leisure time (Ruohotie 1998, 53). They are adopted in childhood, but continue to change throughout life.

Values can be used as tools of self-expression, and are a part of a person's perception of self. For example, a professional may feel that it is important to present themselves as trustworthy and responsible in their occupation, to gain the trust of clients and coworkers. Consequently, values are a part of identity. Values play a fundamental role in vocational practice. Every professional of each field should act according to the right and approved societal goals of health and welfare, safety, justice, freedom and equality. These values act as desirable goals in professional practice, and the ethical principles of professions are usually molded from these values. Contradiction in values are common in vocational practice, and can happen between one's own values and those of others. According to Schwartz (1992), the contradiction of values creates uncomfortable and stressful conflicts to a person. This type of contradiction between two values becomes a typical moral dilemma. (Juujärvi, Myyry & Pesso 2007, 36-57.)

Values assist in decision making and assessing different situations. They are made up of intellectual and emotional components. The intellectual component refers to a person being consciously aware of those goals and outcomes, which certain values represent.  On the other hand, emotions are those that trigger us to reach those goals. Without emotions, values are indifferent. (Juujärvi, Myyry & Pesso 2007, 59.) Attitudes

and norms are related concepts to values, and the three are often spoken of together. Gordon Allport (1954), defines attitudes as "*A learned predisposition to think, feel and behave towards a person or object in a particular way.*" (Erwin, P. 2001, 5.) Attitudes are based on experience and always have a target, in contrary to values. Also, changes in attitudes can happen quite fast, whereas changes in values are relatively slow. For example, a documentary about climate change can make a change in a person's attitude towards public transportation into a more positive one. In the example mentioned, environmental activism serves as a value, which therefore guides our attitudes towards a certain subject, in this case public transportation. (Juujärvi, Myyry & Pesso 2007, 36.)

Norms can be described as rules that have been decided within a group. Failure to abide by the rules, is followed by punishment; e.g. getting scolded by the boss at work. Norms can be ethical professional rules that have been written on paper, or they can be unwritten norms, ones that exist in the mind. An example of an unwritten norm could be, that everyone is expected to contribute equally to work assignments. If someone breaks the norm, they are disapproved of and thought as lazy. Values and norms are related concepts, yet differ in meaning at least in three ways; Firstly, values are general life directing principles, while norms are bound to certain actions or situations. Secondly, values refer to goals or the way of acting, whereas norms always refer to the way of acting. Thirdly, norms are linked to social interaction with the environment, whereas values are personal and self-adopted (Juujärvi, Myyry & Pesso 2007, 37.)

4.2.1 Values and motivation

Our values play a role in motivation, and there are many different definitions for the term. Personal values can be defined as "Emotional beliefs in principles regarded as particularly favorable or important for the individual." (Naagarazan, R.S. 2006, 3.) Values connect emotions to our experiences, which lead our actions, choices and decision making. Values can even define the field of work we choose. (Juujärvi, Myyry & Pesso 2007, 28.) There is ongoing interaction between values and motivation. Our goals reflect on values; when goals change due to feedback from an action, it effects our values and motivation. (Ruohotie 1998, 53.) Values can be thought of as scales, which we use for weighing choices for our actions, e.g. whether we decide to approach

or avoid something. One's beliefs, identity and values are most commonly attained unconsciously, based on personal experience of observation of others, and their outcomes for their actions. (Naagarazan, R.S. 2006, 4.) Motivations that represent values come from our biological, social and environmental/societal needs. People strive to act according to their values, and therefore motivation to act in the desired way comes as a result. (Juujärvi, Myyry & Pesso 2007, 28-35.)


4.2.2 Schwartz' theory of values

A theory introduced by Shalom Schwartz (1992) suggests that values are general principles, directing and guiding life, which can be put into personal order of importance (Juujärvi et al, 2007, 35). They are used to describe societies, cultural groups and individuals. Furthermore, they are used to investigate change over periods of time, and to describe attitudes and behavior and their motivational bases. Values represent things that are important to us in life, (e.g. achievement, self-direction). They are personal and differ in degrees of importance from person to another. (Schwartz 2012, 3.) The Schwartz value theory exhibits a conception of values that indicates six main features (Table 1).

**THE SIX MAIN FEATURES OF THE SCHWARTZ VALUE THEORY**

| | |
|---|---|
| **1.** | <u>Values are beliefs</u> – The triggering of values results in them infusing with feelings. For example, if independence is an important value for a person, they become provoked if it's jeopardized. |
| **2.** | <u>Values refer to desirable goals</u> – People are motivated to reach certain goals, when the values they stand for are important to them. |
| **3.** | <u>Values transcend specific actions and situations</u> – Values are general life directing principles, and are not bound to a certain situation or action. This feature separates values from norms and attitudes. |
| **4.** | <u>Values serve as standards or criteria</u> – People decide what is right and wrong, justified or not, based on potential consequences for their loved values. Values enter awareness when they conflict. |
| **5.** | <u>Values are ordered by importance</u> – People's values form an order of priority that define them as individuals. |
| **6.** | <u>The relative importance of multiple values guides action</u> – Behavior and attitudes commonly have indication for more than one value, which guides them. Values influence action when they are relevant and important. |

Table 1 - The nature of values (Schwartz 2012, 3-4).

The six points illustrated in figure 3 are features of **all** values. The motivation or type of goal the value indicates is what differentiates one from the other. The values theory describes ten expansive values, according to the motivation that guides each one of them. The ten values are expected to be universal, since they are all found in at least one of three universal requirements of our human existence. Schwartz describes these requirements as "*needs of individuals as biological organisms, requisites of coordinated social interaction, and survival and welfare needs of groups.*" People do not handle well with these requirements on their own, but preferably have become to express appropriate goals to cope with them. The theory expresses the structure of dynamic relationships between the ten values (Figure 3). One explanation for the value

structure is that actions result in consequences when reaching for a value goal, which results in conflict between some values, and compatibility with others. For example, the pursuit of achievement values generally clash with the pursuit of benevolence values, because success seeking for oneself tends to interfere with actions aimed at enhancing the wellbeing of others (universalism and benevolence).
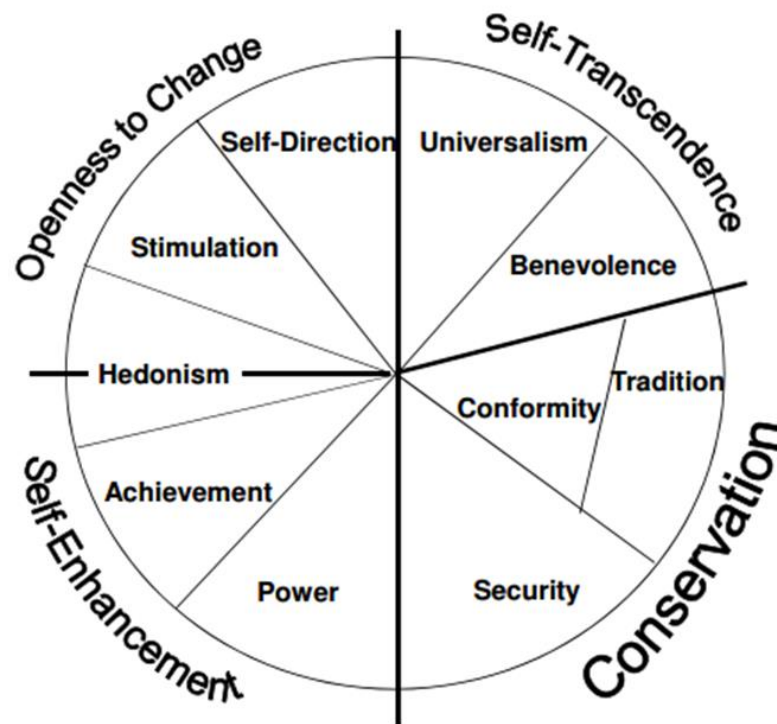


Figure 3 - Theoretical model of relations among ten motivational types of value (Schwartz 2012, 9).

The circular design above illustrates the complete pattern of relations of both conflicts and compatibility of values. Conformity and tradition are situated in a single block since they share the same vast motivational goal. Additionally, as seen in the design, conservation and openness to change represent opposing values. This captures the clash between values that emphasize readiness for change and independence of thought, action and feelings (self-direction, stimulation) and those that emphasize self-restriction, order, preservation of the past and resistance to change (security, conformity, tradition). The second dimension portrays conflict between self-enhancement and self-transcendence values which represent emphasis of seeking one's own interest and success and dominance over others (power and achievement), and values that emphasize concern for the interest and welfare of others (universalism and benevolence).

Hedonism shares components of both openness to change and self-enhancement values. Even though the theory distinguishes ten basic values, it presupposes that at a more basic level, these values create a continuance of related motivations, hence creating the circular structure. Having said that, the closer any two values are in the circle in either direction, the more compatible their underlying motivations are, and the more distant they are, the more opposing their motivations. (Schwartz 2012, 4-8.) Below (Figure 4) are listed the ten values of the Schwartz value theory, the broad underlying motivational goals they express and connecting features of the values.

| VALUE | Underlying motivational goals |
|---|---|
| Power | - Avoiding and overcoming threats by controlling relationships and resources<br>- Social superiority and esteem (Self-Enhancement) |
| Achievement | - Social superiority and esteem<br>- Self-centered satisfaction (Self-Enhancement) |
| Hedonism | - Self-centered satisfaction<br>- Desire for effectively pleasant arousal (Openness to change & Self-Enhancement) |
| Stimulation | - Desire for effectively pleasant arousal<br>- Intrinsic interest in novelty and mastery (Openness to change) |
| Self-direction | - Intrinsic interest in novelty and mastery<br>- Reliance in own judgement and comfort with diversity of existance (Openness to change) |
| Universalism | - Reliance in own judgement and comfort with diversity of existance<br>- Enhancement of others and transcendence of selfish interests(Self-Transcendence) |
| Benevolence | - Enhancement of others and transcendence of selfish interests & normative behaviour supporting close relations<br>- Devotion to one's "in-group" & normative behaviour that promotes close relationships (Self-Transcendence) |
| Tradition | - Devotion to one's "in-group"<br>- Subordination of self in favor of socially imposed expectations & Preserving social arrangements that give certainty to life (Conservation) |
| Conformity | - Normative behaviour that promotes close relationships<br>- Subordination of self in favor of socially imposed expectations & protection of order and harmony in relations (Conservation) |
| Security | - Order and harmony in relations & social certainty in life<br>- Avoiding and overcoming threats by controlling relationships and resources (Conservation) |

Figure 4 – The ten values in terms of the goals they express (Schwartz 2012, 5).

The first measurement tool developed for the measuring of values is The Schwartz Value Survey (SVS) in 1992, in which responders rate each value in order of importance to them on a 9-point scale. The results are scored through average ratings of those items marked as preferences of those values. An alternative measurement tool to the SVS is The Portrait Values Questionnaire (PVQ) which measures the same ten basic values of children from the ages of 11-14 and those people not educated in Western schools. The questionnaire is set up with short verbal descriptions of cases of the values, and the responder is asked whether that person in the description is alike them or not. The responses are scaled from a range of 'very much like me' or 'not like me at all'. These verbal descriptions depict what is important to them, thus capturing their values without explicitly identifying values as the main topic of investigation.

Cross-cultural evidence for the theory of ten basic values has been studied through data from hundreds of cases in 82 countries around the world, using either the SVS or PVQ measurement tools which include diverse, cultural, geographical, linguistic, age, gender, religious and occupational groups. In 90% of these samples each of the ten values are recognized, which displays that in most cultures people respond to these ten values distinctively almost universally. These findings firmly support the idea that the human values form a motivational continuance hypothesized by the theory. (Schwartz 2012, 10-12.)

4.3 Motivation

Our motivation to act derives from needs. There is a vast range of literature on motivation, and depending on what you're studying, e.g. Bioscience, Education, Business or Psychology; motivation is expressed in thoroughly diverse ways. (Nukpe 2012.) The word motivation originates from the Latin word *movere,* which stands for movement. The term has since been further extended to signify the structure of factors that lead and excite behaviors. Motivation is dynamic, and is effected according to different situations. It refers to an individual's mental state, which determines their focus of interest and the level of activeness. (Ruohotie 1998, 36-42.) A person that feels no

incentive or inspiration to act, is defined as unmotivated, whereas someone that is activated and energetic on reaching an end result, is perceived as motivated. (Deci & Ryan 2000, 54.)

Freud's psychoanalytic theory presents the most common and leading perception to the definition of motivation. The basic principles of this theory consider *homeostasis* and *hedonism*, which act on an individual's strive to satisfy personal needs in an environment of restricted resources. To satisfy these needs, behavior must be adapted for the individual to fulfill these desired goals. *Homeostasis* refers to the maintenance of one's internal equilibrium, where a relatively stable environment is desired internally. A disturbance to this causes disequilibrium. An example of this could be the feeling of hunger accompanied by stomach ache or cramps. When the need is satisfied, it brings the body back to equilibrium and an unmotivated state. *Hedonism,* a term associated with philosopher Jeremy Bentham (1779), refers to the main goals in life being feelings of gratification and pleasure. If homeostasis of the body is the ruling foundation of behavior, then the byproduct of the result of equilibrium is the feeling of pleasure: when all of one's needs are satisfied. (Weiner 2013, 9-11.)

Motivation is described as a state produced by motives, thus making motive the base term for motivation. When talking about motives, they are usually referred to as needs, desires, drives and internal incentives. They are also connected to rewards and punishment, thus maintaining and guiding an individual's general way of behavior. They are goal-oriented, and either conscious or subconscious. (Ruohotie 1998, 36-42.) Comparably to values, people's needs may change throughout life as we grow and gain new experiences. Change in for example, thoughts, culture, environment, beliefs and social relationships effect on our needs, and can change our motives. (Website of Khanacademy 2015.) In adult life, one's work arguably serves as the most notable and enduring task among developed and still evolving countries. Work contributes to people's identity and security, and can also have dramatic effects on one's physical and psychological wellbeing. (Chen. & Gilad 2008, 2). An employee that loves what they do and get a feeling of gratitude from feedback and their input at work, are likely to be satisfied and more motivated. Rewards and incentive have a big impact on how enthusiastically goals are pursued, and can be divided into internally or externally rewarding outcomes. (Ruohotie 1998, 37.)

4.3.1 Extrinsic and Intrinsic motivation

Motivation can be divided into intrinsic and extrinsic motivation, of which both play equally important roles in people's lives. Motivation that comes from the things that interest you and that can make you feel e.g. success and self-fulfillment is called intrinsic motivation. (Ruohotie 1998, 38.)When we are intrinsically motivated, we are moved to act according to joy and satisfaction which comes as a reward from a certain activity. From birth, healthy children are playful, curious, inquiring and on the move. They exhibit a never-ending keenness to learn and explore without needing the presence of external encouragement. This is a natural, and vital part of social, cognitive and physical development, to encourage the individual's inherent interests, through which skills and knowledge will grow. After early childhood, the freedom for being intrinsically motivated becomes more and more diminished due to social roles and demands that depend upon taking responsibility from the environment for non-intrinsically interesting tasks. In schools, intrinsic motivation turns weaker with each grade you move up. (Deci & Ryan 2000, 54-64.)

In comparison to intrinsic motivation, extrinsic motivation is dependent on the environment. The rewards for one's actions are defined by someone else than the individual them self, and the motivation behind these actions is linked to doing things because they produce separable outcomes. Extrinsically motivated behaviors aren't intrinsically interesting and require external motivators. However, they are done nevertheless, because the values they represent are meaningful or significant to others, with whom the individual feels a personal connection with, e.g. family, society or peer group. (Deci & Ryan 2000, 54-64.)

In any case, intrinsic and extrinsic motivation cannot be held as solely independent, even though they differ in content. Instead, they complete each other by being present at the same time. Extrinsic rewards are usually only momentary, and need for these may exhibit very often. In contrast, intrinsic rewards are long-term, and can form to become a source of "permanent" motivation. For this reason, intrinsic rewards are often more effective than extrinsic ones. The difference of these two rewards isn't always easily defined. For example, a student may get a paid scholarship for excellent academic success, which not only rewards extrinsically, but also intrinsically.

The *Cognitive Evaluation Theory* model created by Deci in 1975, strives to explain the conflicting connection between extrinsic rewards and intrinsic motivation. According to the theory, extrinsic rewards can effect on intrinsic motivation. The CET has two outlooks: the *controlling aspect*, which suggests that behavior is controllable by rewards and incentive, and the *informative aspect*, which produces information regarding competence. If the controlling aspect is strengthened, the reason for behavior turns from intrinsic to extrinsic, thus resulting in the weakening of intrinsic motivation. Intrinsic motivation is based on an individual's need to be competent and independent.

People actively look for challenges and pursue to face and beat them or minimize the instability resulting from them, thus causing the individual to feel independent and competent. Positive intrinsic and extrinsic feedback add to the feeling of competence. When the controlling aspect is weak and the informative strong, it causes a person's intrinsic motivation to either strengthen or weaken, depending on the nature of feedback. Rewards that are related to the appreciation of good work are seen as informative, therefore strengthening intrinsic motivation. For example, if a teacher favors control and aspires to teach with external rewards, it may result in the weakening of intrinsic motivation in the students. If instead the teacher favors independent initiative in the students and creates an environment for strengthening competence through feedback, intrinsic motivation is increased or preserved. (Ruohotie 1998, 38-68.)

# 5 RESEARCH

## 5.1 Aim of the study

The purpose of this thesis is to study the values effecting on the motivation of employees, volunteers and service providers working at the Gold Coast Recreation & Sports Inc. in Queensland, Australia. With the collaboration of the organization, the aim is to identify possible patterns and/or similarities in the values of the volunteers, employees and service providers working with people with disabilities.

## 5.2 Study design

The design of this study will be quantitative. Quantitative methods consist of those that require counting and measuring, and can be put into statistical form. Statistics can be *inferential* or *descriptive.* Descriptive statistics include of matters such as averages, which are used to describe and conclude data in summary fashion. Inferential statistic enable us to conclude up potentially important and meaningful assumptions from quantitative data. (Gillham 2010, 9.) Quantitative methods investigate data numerally, answering to questions such as how many, how much and how often. In a quantitative research design, data is presented, or transferred from qualitative data into numerical form. (Vilkka 2007, 14.) Qualitative methods include fundamentally of descriptive and inferential data as well as scientific research does. Qualitative methods target on evidence that comes from data that people tell or describe. (Gillham 2010, 10.) In quantitative study designs, data can be collected through multiple choice questions (closed and structured), open questions and mixed questions (Vilkka 2007, 67). The survey method and layout of the questions have been chosen due to a big number of participants. The questionnaire will consist of both open and closed questions. However, the quantitative method will be used to present data in numerical form. This design will be beneficial in analyzing, comparing and explaining the results.

5.2.1 Methods

The study will be conducted through a survey. Surveys are a tool of data collection where questions are standardized. Surveys or questionnaires are used when research focuses on individuals and factors effecting on them, e.g. opinions, attitudes, features or behavior. A survey is applicable for data collection when the population under research is large or widespread. (Vilkka 2007, 28.) Elements of surveys require many steps. Survey objectives are statements that act as goals for the outcome of the survey, in a generalized and abstract level. For example, the survey objective of this study is to investigate the values effecting on motivation. The role of research questions in a study are to make the generalized and abstract objectives into more distinct and concrete. (Punch 2003, 27.)

A fundamental feature to a practical research is, that data occurs and is collected in a very specific way. Despite this, empirical research aims to reach conclusions and explanations at a higher level of generality. Thus, creating an idea of specific data at the lowest level, generalized concepts at the highest level and a space in between these two. Disciplined research calls for creating logical relations between these levels, which can be done through research questions. Foremost, this is done by obtaining more than one transitional or connecting level. The empirical criterion for research questions is based upon the requirement that the research questions must state well what data is needed to answer them. After general and distinct research questions are established, and they meet the empirical criteria, data collection questions become relevant. Survey questionnaires operate as data collection tools and are guided by the research questions. The chosen research questions provide a list of variables and other required information that will be investigated in the questionnaire. Granted that the survey is one that has not been previously used or tested, pilot testing may be needed. Pilot testing will aid in questionnaire modification in aspects such as ethical issues, conception, clarity, length, difficulty and data collection process. (Punch 2003, 27-34.)

Variables in this study questionnaire will consist of values, attitudes, education and background. The research questions for this study will be based on the variables and expected outcome/objective of the study and a theoretical background. They will investigate the relationship between the ten basic values and staff, volunteers and service

providers at the GCRS. The questions will also investigate attitude change in the research population. A part of the survey will be based on the request of the specific research questions proposed by the service manager of the Gold Coast Recreation & Sports Inc. Conclusions and outcomes of survey data will be sent the service manager of the Gold Coast Recreation & Sports Inc. in a separate report. One section of the survey will be based on the Schwartz Theory of Basic Values. By using this theory, data from the surveys can be interpreted and explained in a universal way through their links to goals and motivation in life.

5.2.2 Participants and recruitment

The aim of a survey is to collect data from a group of people, also called a *sample group*, to obtain answers to the research questions. A sample group is collected from a population from which we want to conduct a study on. A small-scale survey project may differ considerably in sample size from surveys described in countless research method books. Logical sampling strategies create sample groups that are connected to the research questions, which therefore reflect on the validity of the study. (Punch 2003, 36-37.) Laws and research ethics effect all people conducting studies. Ethical questions arise for example in ways of data collection. Regulations concerning research effecting directly on disability populations and children vary between cultures and fields of study. (Vilkka 2007, 91.) Ethical considerations include of anonymity and confidentiality, respecting people's privacy and recognizing the rights of the sample group concerning the information they provide (Punch 2003, 35).

The Gold Coast Recreation & Sport Inc. is a community-based non-profit organization that was founded in 1979 by people in the community that wished to arrange recreational opportunities, discrimination free, for people with physical and/or intellectual disabilities. Today, the GCRS consists of staff and volunteers running different projects and programs for individuals and groups in the Gold Coast area. (GCRS Consumer Handbook, 2012) The participants of the study will include a number of service providers and both volunteers and employees of the GCRS. Recruitment of the participants will be done through email, with help of a contact person from the office at the

recreation and sport center. Service providers will be contacted and informed in person, and kindly asked to fill out the survey if interested.

5.2.3 Data collection and analysis

Survey timing and sending are reason to take into consideration when using a survey in data collection. Different survey types need to be taken into account when sending them out. Depending on the type, whether it is an electronic or printed survey, timing is important in assurance of response and return rates. Reminders can be sent out to the research population after a selected time period. (Vilkka 2007, 28.) The required data for data analysis is found in the research questions. The research questions may also imply, which data is needed for the outcome. Before the analysis of questionnaire data can begin, a proof-reading is in place. Questionnaires including unclear responses and missing data need to be examined, and decided if there is need for data cleaning.

The quality of data is measured by reliability, validity and response rates. Reliability indicates the stability of response. This refers to the question that would the respondents answer the same way to the same questions if asked again? Reliability can also be connected to the attitude or frame of mind the respondent has when filling out the questionnaire. In turn, validity tells us whether the answers we receive represent what we think they represent. Also, there is reason to question whether respondents answer truthfully and conscientiously. Further, attitudes and mindset can effect on responding to a survey, and critical thinking becomes important when analyzing the results. (Punch 2003, 42-44.) Objectivity in data analysis can be divided into two parts. The first parts consists of the *non-biased approach in the research and data process*. This is enhanced by a distant relationship between the researcher and respondents, which can prevent the researcher from having an effect on the data outcome. In the second part, *data analysis,* objectivity of the researcher and the approach to the data is effected by underlying education, theories and models. (Vilkka 2007, 16.)

Each member of staff and volunteers will get a notification email regarding the survey, which will entail details about the study, anonymity and survey return. After this, they will receive printed surveys in their personal lockers at the recreation center. Service

providers will receive the surveys personally. After a few weeks, a reminder will be sent to the staff prompting the return. All of the surveys will be handed in personally by the staff and volunteers into an envelope at the office.

5.2.4 Proposed timeline

The proposed timeline of this thesis process (Table 2) is made in agreement with the supervisor and collaborating party. The process will begin in the fall of 2015, with the planning and presentation of the thesis plan. The thesis proposal will be made in the winter of 2015 and sent to the service manager at the Gold Coast Recreation & Sports Inc. for approval. Thesis agreements will be signed and sent out for signatures. The implementation of the study including making the survey and data collection, as well as the theory part of this thesis will be conducted in the spring and summer of 2016. Data analysis and conclusions will be done in the fall term of 2016 along with the final thesis presentation and maturity exam.

| TASK | TIMELINE |
|---|---|
| Presentation of thesis plan | FALL 2015 |
| Thesis proposal | FALL/WINTER 2015 |
| Theory | SPRING 2016 |
| Survey & Data collection | SPRING 2016 |
| Data analysis and conclusion | FALL 2016 |
| Thesis presentation & Maturity | FALL 2016 |

Table 2 - Planned tasks and proposed timeline for each part of the thesis explained.

## 6 RESULTS

Of the initial sample size of 75 surveys that were handed out, 43 surveys were returned, resulting in a response rate of 57%. Eight of these surveys were not filled out comprehensively, and were reduced from the amount of surveys returned, resulting in 35 surveys to be analyzed. The 35 participants consisted of 31 (89%) staff members and 4 (11%) service providers, of which 54% were male and 46% were female. None of the volunteers returned in their surveys. 29% of the participants were aged 25-35, another 29% were aged 35-50, 26% were aged 18-25, and 17% were aged 50 and over.

When answering the question "*What was the main reason for getting involved in working with people with disabilities?*" (Figure 5) 29% responded with employment opportunity, 23% of people reported having a family member or close friend with a disability, 11% responded with having specialized education in the field and 37% responded with having some other reason. The respondents were able to specify what the other reasons were, and results varied from "wanting to make a positive impact in someone's life" to "change of work - wanting to try out something new".
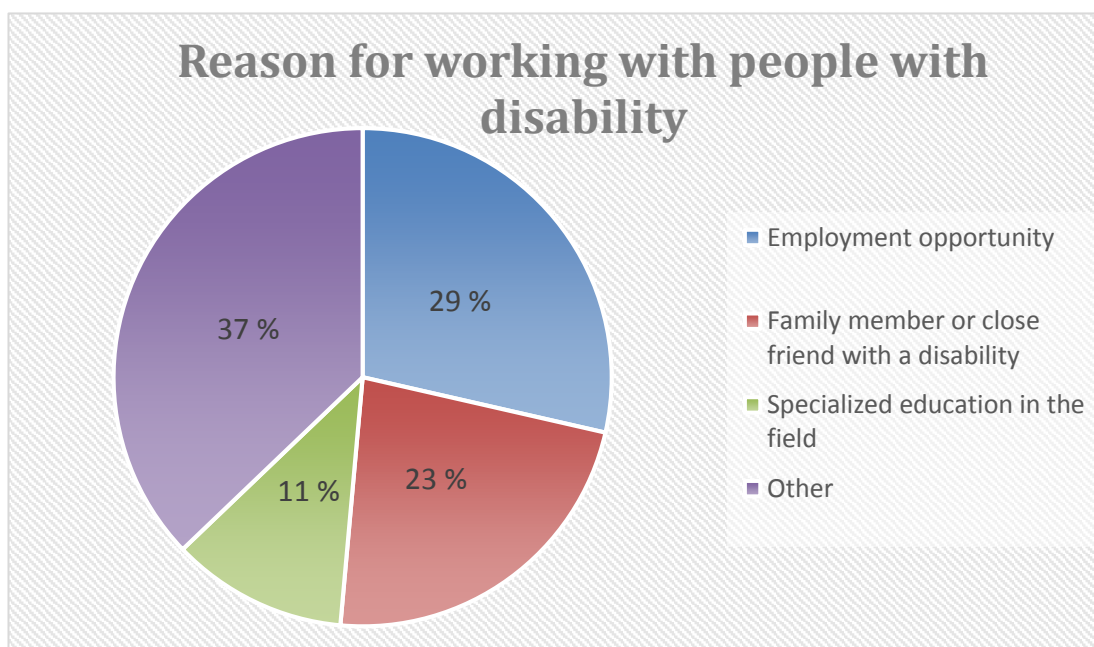


Figure 5 – Results to the question "What was the main reason for getting involved in working with people with disabilities?"

The data shows that 83% of the participants reported having a change in attitude towards people with disability since the beginning of employment at the GCRS, whereas 17% of participants reported having no change in attitude. The respondents were given the opportunity to explain for what reason their attitudes have changed or haven't changed, and responses varied from "my understanding has grown" to "I accept people for who they are".

When placing the values of the participants in order of importance (Figure 6), 57% chose self-transcendence values (universalism: 13, benevolence: 7), which stand for those values emphasizing the enhancement and preservation of welfare of all people and nature. Following, 23% chose conservation values (conformity: 2, tradition: 3, security: 3), 11% chose openness to change values (self-direction: 2, stimulation: 2) and 9% chose self-enhancement values (achievement: 3, power: 0, hedonism: 0) as their <u>most</u> important value (marked number 1 on the survey sheet) of the ten basic values. In contrast, the results showed (Figure 7) that 71% of participants chose Self-enhancement values (achievement: 0, power: 21, hedonism: 4), which emphasize personal success and social status and prestige. Succeeding, 14% chose conservation values (security:1, conformity:2, tradition:2), 9% chose Self-transcendence values (universalism:1 ,benevolence:2) and 6% of participants chose openness to change values (Self-direction: 0, stimulation: 2) as the <u>least</u> important value of the ten basic values.
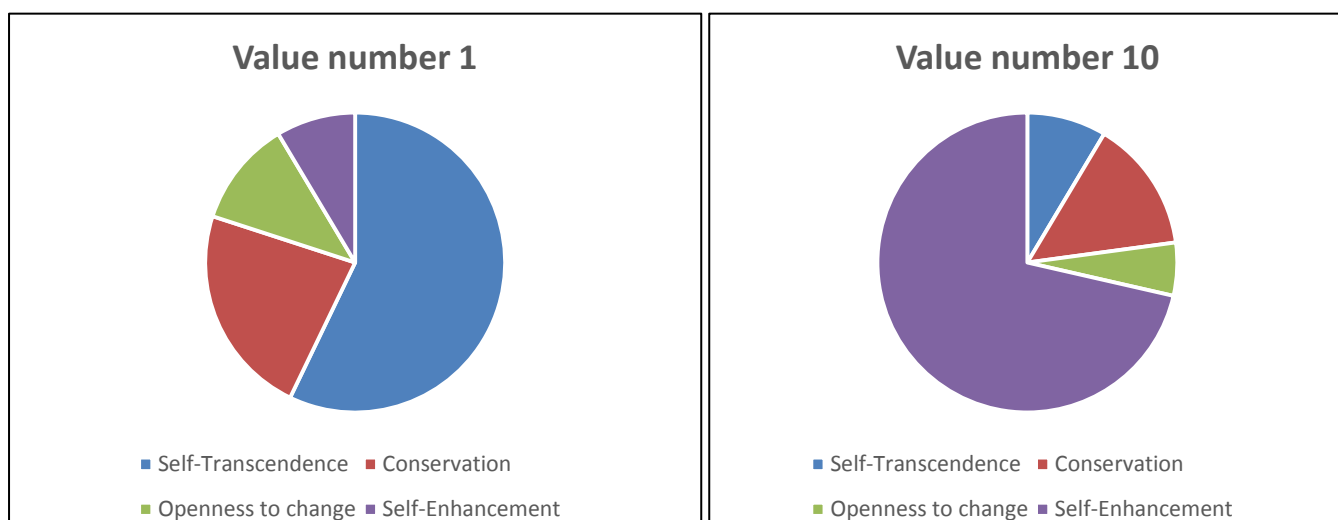


Figure 6 – Value number 1; the **most** important value of the ten basic values illustrated according to the results

Figure 7 – Value number 10; the **least** important value of the ten basic values illustrated according to the results.

When examining the relationships of variables in the results of the most important values in each age-group, both self-transcendence and openness to change values were represented each by 40% of participants aged 18-25. The remaining 20% consisted of conservation values. In the respondents aged 25-35, 70% chose self-transcendence values and 30% chose conservation values as their most important value. In the age group of 35-50 year-olds, 67% chose self-transcendence values and the remaining 33% chose openness to change, conservation and self-enhancement values with a representation of 11% in each value category. In the age group of 50 and above, 50% of respondents chose self-transcendence values, 33% chose conservation values and 17% chose self-enhancement values as their most important values of the ten basic values.

Respondents that chose *employment opportunity* as their main reason for getting involved in working with people with disabilities, also chose self-transcendence values as their most important value with 50%, conservation values with 40% and self-enhancement values with 10%. 75% of people that had *specialized education in the field* chose self-transcendence values, and 25% chose conservation values as their most important values. 50% of people that reported having a *family member or a close friend with a disability* chose self-transcendence values, 25% chose openness to change values, 13% chose conservation values and the remaining 13% chose self-enhancement values. 62% of respondents that chose the option *"other"* in the questionnaire, chose self-transcendence values, 15% chose openness to change values, another 15% chose conservation values and 8% chose self-enhancement values as their most important value of the ten basic values.

55% of the staff members chose self-enhancement values, 23% of them chose conservation values, 13% chose openness to change values and 10% chose self-enhancement values as their most important value. All of the service providers chose self-transcendence values as their most important values out of the ten basic universal values.

# 7 CONCLUSION

The value theory of ten basic universal values created by Shalom Schwartz explains, that values are principles that direct and guide life and can be put into order of importance. Further, they can be used to describe societies, cultural groups and individuals, as well as attitudes, behavior and their motivational bases. (Schwartz 2012, 3.) Motivations that represent values come from our needs. People strive to act according to their values, and therefore motivation to act in the desired way comes as a result. (Juujärvi, Myyry & Pesso 2007, 28-35.)

The results of this study suggest, that the majority of the participants working at the Gold Coast Recreation & Sports Inc. that work with people with disabilities, are motivated through self-transcendence values. Therefore, staff members and service providers are motivated by the enhancement and preservation of the welfare of those that they are in frequent contact with, and by the protection of welfare of all people and nature. The results also propose, that values which are motivated by personal success, pleasure or sensuous gratification for oneself, social status and prestige are least motivating in people that work with people with disabilities. Results from the survey further suggest, that there are no significant differences in the order of importance of values between staff members and service providers. However, the ratio between the number of service providers and staff members need to be taken into consideration critically. Therefore, no reliable conclusion can be made about the relationship between these variables.

Collected data shows a notable change in the attitudes of the majority of respondents towards people with disabilities, since the beginning of their employment at the GCRS. These results reinforce theory in the fact that values effect on our attitudes and can change them quite fast. They are a learned predisposition to think, feel and behave towards a person or object in a particular way. This implies, that the experience of the majority of staff members and service providers in working with disability groups has changed their attitudes towards their most important values which are those of self-transcendence.

When examining the relationships between different variables, results showed that the majority of each age group were most motivated by self-transcendence values. Each of the age groups listed self-transcendence and conservation values as the most important values. These results suggest, that age does not play a notable role when it comes to the most cherished values in people that work with disability groups.

The relationship between variables including the reasons for getting involved with people with disabilities, and the values rated most important by staff members and service providers were examined. 50% or more of respondents in each of these categories chose self-transcendence values as their most important value. The results imply, that factors such as employment, specialized education in the field or having a family member or close friend with a disability or any other reasons do not have a significant effect on the value order of importance.

In conclusion, staff members and service providers that work with people with disabilities at the Gold Coast Recreation & Sports Inc. share roughly the same values. The most motivating value goal in the sample group was self-transcendence, which consists of *universalism* and *benevolence* that emphasize the preservation and enhancing of welfare of those people with whom they are in frequent contact with, and of all people and nature. The least important values according to all respondents were self-enhancement values which emphasize self-enhancement. These consist of *power*, *achievement* and *hedonism* values, and emphasize personal success, pleasure or sensuous gratification for oneself, social status and prestige. Similarities in the values of staff members and service providers are evident, and clear patterns can be found.

# 8 DISCUSSION

## 8.1 Thesis process

To reach the aim of this study, research on the collaborating organization and what they provide was needed. Following, a theoretical base was formed to meet the requirements of the design of the study. A lot of literature can be found on the topics discussed in the theoretical part of this thesis, although the aim was to collect the most current, relevant and reliable information. The theoretical background provided a framework for the implementation of the survey, which I find was successful and sufficient. Data collection and analysis were successful, as well as concluding the results so that the aims of the research were met.

The opportunity for conducting the study arose before my three month placement at the Gold Coast Recreation & Sports Inc. in the spring of 2016. Ongoing discussion with the service manager and thesis supervisor in Australia allowed for clear communication regarding the type of study, the required theory and the aims of the study. When conducting the study, the co-operation of staff members and service providers was excellent. Data collection was done through assistance from a contact person at the GCRS, which helped the workload.

## 8.2 Challenges and personal development

The entirety of this thesis process was long and has created more workload than initially expected. Challenges occurred mostly in cross-cultural communication and technological competence. Communication to and from Australia was difficult and slow at times. Also, lack of technological competence on my behalf effected on the survey and thesis layout. Data analysis also created its own challenges. The numerical ratio between staff members and service providers was so vast, that real conclusions cannot be made when examining the relationships between these variables. Objectivity and validity were both compromised due to having a close relationship between myself and the sample group. There may be reason to suspect, that respondents felt obligated to answer questions in a certain way because they knew that the results would be seen

by myself and would be concluded to their employer, even though surveys were anonymized.

Likewise, reliability may have been jeopardized due to the nature of work at the GCRS; the staff members were advised to fill out the questionnaires during work time, and many did this while simultaneously interacting with clients that require a considerable amount of attention. Therefore, answers may have been rushed and questions not answered truthfully and conscientiously. In addition, previous to the survey implementation, I had not been informed that a part of the staff members included of people with some sort of disability. Thus, the ethical considerations that were taken into account previously, no longer apply in all aspects of this study.

When starting the thesis process, I made several searches about different research and thesis' discussing similar topics about values, motivation ethics and disability. Sources that had good information, were noted and compared to others. Through this method, finding sources was productive, and it also left room for critical thinking and development in source selection. The information required for the theory part was widespread and covered many topics. Not only did I expand my knowledge about disability, ethics and how our values effect on motivation, but most notably I am now able to select appropriate and relevant information and to be critical about source selection.

All in all, this process made me reflect on my own way of working and motivation towards the subject. I feel that I have developed in critical material selection and my knowledge regarding the theoretical aspect has tremendously grown. In addition, this process has given me new perspective and insight on the topics covered, and has changed my own attitude about people with disability through working at the GCRS. Moreover, I will be able to use the material covered in this thesis in my professional career as a physiotherapist. If I were to repeat this process in the future, I would make further modifications to the survey and be better prepared for the theoretical research aspect. I would also start the process a lot earlier, since there is a lot of work to be considered when creating a survey.

8.3 Suggestions for further research

Referring to the conclusion and results of this study, attitude changes towards people with disabilities happen with work experience. Therefore, it can be said that the implementation of work experience with disability groups would be extremely important in education from an early stage, especially in vocational schools and universities with degree programs in health care. This could effect on employment opportunities with the change in attitudes and further enhance the welfare and rights of people with disabilities, as they would better be understood and heard. Further, changes in attitude can be linked to the ICF model and it's aim of seeing the entirety of a human being, and not just the disability/diagnosis of him/her. Assumptions can also be made, that the work with disability groups has changed views, understanding and perhaps action of employees to be more ethically sensitive and respectful towards people with disabilities.

Additionally, the values chosen as the most important ones by the majority of respondents, including universalism and benevolence (self-transcendence values) reflect to the ICF model in a positive way, that the people working with disability groups are able to see past the diagnosis and disability of the clients. Also, they are motivated by the enhancement of welfare of all people and nature, which can be seen as substantially important in the field of health care. Moreover, the significance of these results in relation to the ICF model is, that no matter what the health condition of the client/person is, all of the factors involved in functional capacity need to be taken into consideration, including ethics, independency, self-sufficiency and individual abilities of the clients.

The results of this thesis show merely a scratch on the surface of the whole population of people working with disability groups. This study could be used as a pilot study, and the survey be further modified. Preceding, this survey could be further used to see whether there are differences between the values and attitudes of people that work for non-profit organizations and private businesses, or volunteers and paid employees, or students and working professionals for example. An interesting aspect could also be to study the differences between sample groups working in different professions, e.g.

business/marketing and health care. A cross-cultural approach could be used to investigate the attitude and employee/disability group aspects, but also to test if the ten universal basic values actually work in practice in different cultures, when using this survey.

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