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**Dare to Dream: Supporting the Changing Role of Service Providers of Adults with Intellectual and Developmental Disabilities**

Ran Neuman, Diane N. Bryen

**Abstract**

Despite the recognition that adults with Intellectual and Developmental Disabilities (IDD) have the right to lead a fulfilling life, support staff continue to focus on normalization and mainstreaming. The present research aimed to promote a change in service providers’ perceptions of their role in supporting adults with IDD. To carry out this goal, a pilot study with ten pairs of service providers and recipients was conducted, in which the *D*are to *Dream* (Bryen, 2012) processwas implemented. Data were collected through interviews with the support staff. Findings indicated that participation in the process led to a change in support staff’s perceptions of their aims and role as supporters. Their new objectives focused on encouraging adults with IDD to express their desires and dreams, as well as helping them internalize a new way to achieve autonomy. Further investigation of the use and cross-cultural applications of the *Dare to Dream* process are recommended.

*Keywords*: support staff, intellectual and development disabilities, Dare to Dream, providing support, autonomy

**Dare to Dream: Supporting the Changing Role of Service Providers of Adults with Intellectual and Developmental Disabilities**

This article addresses questions regarding the appropriate support to provide adults with Intellectual and Developmental Disabilities (IDD). Many declarations have been made regarding the rights of persons with IDD to lead a full and meaningful life (United Nations, 2006). However, despite these declarations being universally accepted as guidelines for providing support, in practice there seems to be a gap between the declarations and their implementation. Many service providers focus their efforts primarily on helping adults with IDD acquire independent living skills in order to better enable their integration into the normative lifestyle of their community and society in general (Abbott & McConkey, 2006). However, since many adults with IDD will not actually be able to achieve full independence, this “normative lifestyle” goal may not be reached. Consequently, adults with IDD remain dependent on others and are deprived of the opportunity to develop their own autonomous way of life. Indeed, in several research studies, adults with IDD reported that they struggled to achieve autonomy and that they continued to be treated like children who cannot make their own life decisions, even well into adulthood (Caldwell, 2010; Neuman, 2019). It seems that despite the important changes that have occurred regarding attitudes towards persons with IDD, theory and practice have not yet aligned in terms of finding a coherent way for providing supports to those who need them.

The understanding of disability has changed over time, shifting from the perspective of a social welfare or care model to a medical model, and more recently, to the perspective of a social model and humanistic orientation of disability. Each of these models has influenced how services and supports have been provided to individuals with IDD (Patston, 2017). Furthermore, each model has influenced how service providers have been professionally trained, which in turn influences how they conceptualize their roles as service providers. Based on their training and subsequent behaviors, the “role” and level of autonomy of the person with IDD are established as well.

According to Harris and Enfield (2003), the religious, charitable or **welfare model** of disability tended to view people with disabilities as victims of their impairments, and hence the beneficiary of charity, alms and services for which they should be thankful. Based on this model, service providers have come to view their role as primarily taking care of individuals who are dependent and, as such, should not be in charge of determining *what* nor *how* services and supports should be provided to them, nor from whom they should be provided. As victims of their impairments, they essentially become powerless in envisioning what their futures might hold for them.

Criticism of the welfare model led to a **medical model** of disability, which viewed disabled people first and foremost as having physical, sensory or mental impairments that could be cured or, at least, fixed. The disabled person is once again relegated to having a passive role, this time as a patient being treated by medical and other treatment professionals who make the decisions, even on issues that are unrelated to the impairment such as how the individual should dress or what he/she should eat. Given a focus on the impairment, medical personnel noted the functional activities the disabled person could *not* do, for example making notes such as: “can’t walk”, “can’t see” or “can’t talk” (Reiter, 2008).

In response to the traditional medical model of disability, almost 25 years ago, Michael Oliver (1996) published a book introducing the **social model of disability**.The social model of disability perceives disabled people not as individual victims of tragedy, but as collective victims of an uncaring, oppressive society. Accordingly, disability was no longer viewed as a trait of the person, but as a cultural construct of the society in which the person lives (Brants et al., 2016). In accordance with this model, environmental hindrances or barriers such as lack of lifts, steps, narrow doors and cognitively inaccessible information are vivid examples of the social construction of disability. These barriers are what limit persons with functional, cognitive, communication and/or sensory impairments, not the impairments themselves. The social model, therefore, often focuses on changes required in society and ties the solutions to social action and societal change. Notions of disability as social oppression mean that prejudice and discrimination disable and restrict people's lives much more than the impairments themselves. Importantly, the social model has provided a powerful framework for bringing disabled people together in a common struggle for equality and rights. By doing this, the social model has promoted the idea that disabled people should be actors in their own lives rather than passive recipients of care.

Underlying the social model is the **humanistic perspective,** which emphasizes each individual’s subjective quality of life, as well as the rights of adults with IDD to set goals and make their own choices about how to achieve them ([Lafferty](http://www.tandfonline.com/author/Lafferty%2C+Attracta) et al., 2013; Schalock & Verdugo, 2002; Shogren et al., 2018). Rather than emphasizing a normal lifestyle as the most desirable outcome of the services provided, the humanistic perspective focuses on an individual’s subjective quality of life. The aim of services and supports, accordingly, is to prepare individuals to choose a course of life that will enable them to enjoy a meaningful and full life, regardless of whether they are “like everyone else” or not (Schalock et al., 2008). Consequently, the aim of supports should be to assist adults with disabilities to engage in self-expression and enjoy a lifestyle of their choice, as well as experience inclusion in community life, opportunities for self-actualization, and the opportunity to hold significant social roles (Bach & Kerzner, 2010; Reiter, 2008). This orientation is further supported by the World Health Organization's 2001 definition of disability as a “dynamic multi-dimensional human condition” (World Health Organization, 2016). Stewart and Rosenbaum (2003) argue that, whereas traditional ways of thinking about interventions have used “normal” as the guidepost by which to provide support to persons with disabilities, the personal factors component of the international classification of functioning, disability and health (ICF) model recognizes the importance of individuals’ personal choices, interests, likes and dislikes. The ICF model emphasizes the importance of self-defined goals, which are to be accomplished in whichever ways that are deemed best for the person involved.

Based on the ideas presented by the social model and the humanistic perspective, a major shift in regard to the way support should be provided to adults with IDD has occurred. This shift is exemplified by the move away from viewing the individual with IDD as an object of interventions and towards interacting with the person as someone who shares in making decisions regarding his or her life (Abbott & McConkey, 2006; Bonyhady, 2016; Carney, 2013; Sims & Gulyurtlu, 2014). Though this idea is widely accepted, many service providers who assist adults with IDD have difficulty supporting them in making their own individual choices. Instead, service providers continue to focus almost exclusively on the promotion of normative abilities (Cooper & Browder, 2001). Often, service providers are faced with trying to find the balance between protection and risk management on the one hand, and the desire to enable and encourage personal choice and self-actualization on the other (Hawkins, Redley, & Holland, 2011). As a result, the subjective meanings individuals with IDD attribute to their own lives, their dreams, and their aspirations continue, in many cases, to be ignored. It is not surprising, therefore, that adults with IDD are provided messages that they must acknowledge their disability, come to terms with the reality that “emerges” from it, and develop “realistic” (in most cases low) expectations regarding their future (Bryen, 2019).

The aim of the present research was to answer the question of whether service providers might be able to change their perceptions of their role, specifically from a focus on teaching Activities of Daily Living (ADL skills) - based on a medical model - to an emphasis on personal development based on the social model and a humanistic orientation. In other words, can service providers change their view about their primary objective of their professional work, such that they shift from the central goal of teaching skills to focusing on the individual's personal identity? In order to answer this question, the present research started from practice as the beginning stage of a change of concept. Thus, instead of trying to teach service providers specific knowledge about the ideological basis that should redefine their role and expecting them to implement it in practice, the reverse procedure was adopted – service providers were asked to implement the perspective in practice, such that they position themselves in a new manner. The goal was to enable service providers to experience their role in a new way, one based on humanistic principles. Indeed, our assumption was that the humanistic orientation must be experienced in order for it to become the default professional practice for providing support.

In the present study, the *Dare to Dream* (Bryen, 2012) program was chosen. This program enables service providers to experience professional relationships that are based on a humanistic orientation. Concepts such as respect for every human being based on the appreciation that as a human being every person has an embedded value, can have an understanding of the outside 'world' and an insight into his own inner 'world', can lead a purposeful life based on his/her aims. Thus, on the basis of the humanistic orientation, people are agents of their own lives and live in accordance with their own sets of values. These values are then the criteria for decision-making, as they indicate what is more or less important, and thus provide a set of priorities that underlie one’s decision-making and everyday behavior. The humanistic orientation has contributed notions, such as the importance of living a meaningful life and having a high quality of life, to the field of disabilities. The implications of this orientation for practice imply a redefinition of the interactions between supporters and the people they support.

The *Dare to Dream* program was chosen for the present research since it adheres to humanistic principles and provides an example for how to bridge the gap between declarations regarding human rights and their implementation. *Dare to Dream* is based on a rejection of traditional views of disability whereby people with disabilities, like members of other marginalized and oppressed groups, have been “told” by the society in which live to “adjust” to the realities of their current condition and accept their limitations. The opportunity to share their life experiences is particularly important for people with IDD since it is not uncommon for them to be silent, or silenced, while other people speak on their behalf (Atkinson, 2005). Typically, it is uncommon for people with disabilities to envision a future where they can lead “everyday lives” like those who are more privileged. Additionally, it is rare for people with disabilities to be challenged to have dreamsof their own. For those with cognitive and communication disabilities, the problem is compounded by their difficulty in expressing themselves. In other words, they seldom get the opportunity to share what their dreams are for the future (Bryen, 2012). Oftentimes, they remain silent and are treated as an invisible group. However, it is important to remember that we all need to dream. We also should remember to take our dreams seriously since our dreams are the lifelines for our aspirations.

The *Dare to* *Dream*program(Bryen, 2019) was introduced and implemented as a pilot project in Israel in November 2019. The current research examined the impact of *Dare to Dream* on service providers’ perceptions regarding their professional role. Unlike other outcome studies of *Dare to Dream*, which have been mostly anecdotal in nature or have focused on the dreamer (Bryen & Odom, 2020), the present study focused on the program’s effects on the service providers, including their perceptions of the impact of the workshop and its initial implementation. More specifically, we examined:

1. Changes in participants' perceptions of the person with IDD, “the dreamer”;
2. Changes in participants' orientation in regard to their role as service providers;
3. Changes in participants' perceptions of the relationship between themselves as support champions and their partners as agents.

**Method**

The author of *Dare to Dream*, Diane Nelson Bryen, was invited to introduce the program in Israel. A one-day conference was devoted to introducing the program and its conceptual framework. This conference was followed by a full-day workshop, which was also led by Bryen. The audience of the one-day conference included professionals, academics, service providers, family members of adults with disabilities, as well as adults with disabilities. Twenty service providers enrolled in both the one-day conference and the one-day workshop. Each service provider was asked to bring along one of their service recipients who would consent to take part in the *Dare to Dream* program and who would agree to take part in the research study. In the end, ten pairs of service providers and service recipients (“dreamers”) participated in the workshop, service providers agreed to provide supports to their dreamers after the workshop, and consented to participate in the research. The workshop was conducted in two languages (English and Hebrew).

*Dare to Dream* is an interactive process involving both adults with intellectual and developmental disabilities (IDD) and their supporters. The program started with a group meeting of all of the pairs of supporters and dreamers where, through a guided process using graphic facilitation, the dreamers developed and shared their dreams with the group. Graphic facilitation refers to the use of pictures, drawings or photos to lead groups and individuals towards a goal. According to Matthews and Stansfield (2013), graphic facilitation and graphic recording are especially useful in engaging people with intellectual disabilities or low literacy skills during meetings, workshops, or conferences. Typically, large drawings are shown on a large single sheet of paper to portray difficult concepts and simple words and phrases, and is beneficial to both professionals and service recipients. Jones (2020) provides another reason for using graphic facilitation when she asks, “How does one begin to find out another’s dreams, especially someone who has been bombarded with the message that dreams are limited by a disability?” The answer to this question is that it is not easy. Some people with developmental disabilities don’t talk, some simply say what they think is available to them within the service system, and others have difficulty even understanding the concept of a “dream” or the concept of “a future.” Combining the use of graphic facilitation with astute listening helps to get at a person’s authentic, nonnegotiable dream.

Once the dream and its graphical representation were detailed, they were then shared with the other participants in a second group meeting. *Dare to Dream*, however, does not end with sharing one's dream with others. An action plan for turning the dream into a future reality is developed. Working with their support person, each dreamer then develops objectives that can lead to the fulfillment of their dreams. Objectives must be both positive (leading either to the dream or to a piece of the larger dream) and achievable (can be accomplished within one year). Through the interaction between the dreamer and the supporter, each participant’s objective was finalized based on being both positive and possible and included: (1) resources needed (e.g., XX), (2) important places to go, and (3) people needed to help them accomplish the dream-based objective. Finally, each participant and their support person committed to implementing the first steps when they returned home. In *Dare to Dream,* the adult with IDD is the agent (autonomous dreamer) and the service provider is the “champion of supported autonomy.”

The present research focused on the immediate impact of the workshop on the support staff, as well as the initial follow-up meetings between the support staff and the dreamers. In order to address the primary research focus, the interview protocol addressed the following questions:

Changes following the *Dare to Dream* workshop:

1. Did you have any new thoughts / ideas following the workshop?

If yes, what were they?

1. Did you have any personal / professional insights?
2. Have there been any changes in your perception of:
   1. your professional role?
   2. the “dreamer”?
3. Do you intend to make any changes in:
   1. your direct work?
   2. your workplace?
4. Have there been any changes in your perception of how to support the dreame?r
5. What do you think the payoff could be to the dreamer?

Program Implementation:

1. What part/s of the program is/are feasible and what do you think will be difficult to achieve? (please provide details)
2. Do you have any suggestions for improving or modifying the program? (please provide details)
3. Do you need more information / experience in order to implement the program? (please provide details)

**Procedure**

Ten pairs of service providers and service recipients who took part in the workshop volunteered to participate in the follow-up research study. Interviews were conducted individually within the month following the workshop and the initial steps of the program’s implementation. The interviews were conducted by the first author who has previous experience in conducting qualitative research, particularly in regard to issues concerning adults with IDD. Most of the interviews were held at the interviewees’ workplaces; in cases in which this was not possible, the interviews were conducted by phone. Each interview lasted about one hour and was based on the 9 questions listed earlier in the method section. The interviewees were informed that they had the right to refuse to answer any questions and/or to stop the interview at any time. They were additionally asked to provide their consent to having the interview transcribed *in situ* during the meeting.

The follow-up component of the program was intended to last up to one year, however, due to the COVID-19 epidemic, it had to be terminated much sooner and continued for only one month after the workshop. Nevertheless, the introduction of the program by its author, Professor Bryen, was a unique opportunity to evaluate its initial impact on service providers in Israel.

**Data Analysis**

Following the data analysis approach described by Lincoln and Guba (1986), two researchers coded and analyzed the interviews using thematic content analysis (TCA) (Andersen, 2007). Both coders had previous experience with this approach. Initially, each of the researchers conducted independent analyses, focusing on the narratives provided by the interviewees, which reflected their feelings, beliefs, and thoughts in regard to the study’s questions. The themes emerged organically from the responses provided by the participants. The researchers then shared the themes with one another and discussed them until mutual agreement was achieved. Following agreement, the researchers constructed a comprehensive document mapping out the themes along with relevant excerpts from the interviews. Next, in a second layer of analysis, links among various themes were identified and then grouped together to create overarching themes. Trustworthiness and credibility were accomplished by peer debriefing, whereby an expert colleague reviewed the analysis and provided critical feedback (Brantlinger et al., 2005). The external reviewer confirmed the themes and the overarching themes that were initially extracted from the interviews.

**Results**

Support staff were the focus of this study. Participants’ demographic information is presented in Table 1.

Insert Table 1 here

**Demographics**

The majority of the support providers were women with a mean age of 50.2 years (range: 28-70). All participants lived in cities in the northern part of Israel. Half of the participants reported that they have a relative with a disability, either someone with IDD or autism. Most participants had a bachelor’s or a master’s degree in education or social work. Based on the data provided in Table 1, most of the support providers have had experience working with individuals with disabilities (mean years of experience = 15.4 years) and have been working at their current workplace for an average of 5 years. Providers’ current work positions were primarily focused on providing direct service/support to individuals with IDD.

The transcribed interviews of the 10 support staff were analyzed by two of the researchers utilizing thematic content analysis (TCA) described by Andersen (2007). Transcriptions of the interviews were organized by the interview protocol’s three content areas: (1) the role of the supporter, (2) aim of provided support, and (3) challenges and obstacles faced by the supporters. Eight themes emerged under the three content areas and are described in Table 2, along with an example of each.

Insert Table 2 here

Within the first content area, three themes emerged. They included: (1) encouraging the expression of desires, wishes and dreams; (2) providing intimate and hopeful dialogue; (3) helping the dreamer turn their dream into a systematic process towards the achievement of the dream. The three themes and verbatim examples of each theme are listed below.

**Content Area 1: The Role of the Supporter**

***Theme 1: Encouraging the Expression of Desires, Wishes, and Dreams***

Verbatim examples include:

* *Giving a stage for a person with a disability to express his dreams.*
* *The supporter is non-judgmental.*
* *If a person has difficulty, support and direction are provided to him so that the dream will 'come' out.*
* *Asking members more about their deep and hidden desires and making the impossible possible for them to achieve.*
* *To know he is like anyone else, a person, therefore I believe in him and his dreams. Confidence in talking about his dreams.*
* *The simplicity of the concept of not judging someone's dream. When I hear something they want, or that they dream about, and I think it is a delusion, I realize that once I judge them I seem to limit their possibilities.*

***Theme 2: Supporting Intimate and Hopeful Dialogue***

Verbatim examples include:

* *Instead of focusing on “performance” (interaction based on instructions), be in a different kind of interaction based on a more pleasant and intimate atmosphere and make what seems distant and unattainable, real and possible.*
* *That every (!!!) dream is "true" and acting in the direction of materializing the dream (every) entails joy and hope. Even when only part of it may be fulfilled, the process itself rewards the dreamer.*
* *The process made me and my supporter closer together and there is a feeling of greater joy (on her end).*
* *To convey to them the message that, with a proper and systematic process, dreams can be fulfilled.*
* *Listening and asking many questions*.
* *Our meetings have become her time. We make the decision about when and where to meet by a joint initiative. She shared, enthusiastically, the experience of the meeting (between us and her peer group, everyone was excited as well).*

***Theme 3: Turning the Idea into a Planned and Operative Process***

Verbatim examples include:

* *While earlier the supporter was aware that the dreamer has desires dreams, etc., he / she was helpless and "blocked", i.e. did not respond, then the workshop contributed to "open up" and listen. The program gave me another "tool" - a coping method that allows me to respond to the dreams of the supported person. That the workshop gave me tools to respond in a special and different way to the dreamers.*
* *That every (!!!) dream is "true" and acting in the direction of materializing the dream (every) entails joy and hope. Even when only part of it may be fulfilled, the process itself rewards the dreamer.*
* *I learned to turn the idea into a planned and operative form of work and care.*

As illustrated above, within the first content area, “the role of the supporter,” themes were identified and verbatim examples provided. The examples demonstrated that the workshop had a clear, positive, and immediate effect on the supporters. They did not describe themselves as fixers, rehabilitators or instructors. Instead, they viewed their role as encouragers, champions, and even coaches in helping the individuals accomplish their dreams.

**Content Area 2: Aim of Support**

Within the second content area, two additional themes emerged: autonomy and self realization (Theme 4) and internalization of the process as a major goal (Theme 5).

***Theme 4: Developing Autonomy and Self-Realization***

Verbatim examples included:

* *Formation of identity and self-worth - it is a learning process that enhances the “dreamer’s” personal autonomy.*
* *I understand the importance of giving freedom of expression to fantasies and desires, as well to learn to advance and open up more possibilities in the face of expressing and realizing oneself.*
* *Become more interested in friends' dreams and desires, encourage them to think more about themselves and their way of life, and offer help to fulfill them [dreams and desires].*

***Theme 5: Internalization of the Process is the Ultimate Goal***

Verbatim examples included:

* *Internalization of the process is the important product of the program and not just the achievement of the practical realization of the dream.*
* *It does not matter if the dreamer does not fulfill his dream, only part of it may be fulfilled. The process itself rewards the dreamer.*

These two themes demonstrated the belief that the aim of support was not limited to the care and protection of the individual with IDD as one might expect under the welfare model of disability, nor did it reflect the need for rehabilitation and the teaching of functional skills as one might expect within the medical model. Instead, the two themes reflected the humanization model of disability, in which the aims of services and supports are about quality of life, autonomy, and turning individuals’ dreams into future realities, regardless of whether or not the actual dreams are actually realized.

**Content Area 3: Facing Challenges and Obstacles**

Within the third content area, three additional themes emerged: the dreamer’s self-doubt (Theme 6) and obstacles in the surrounding environment (Theme 7) and parents as a barrier (Theme 8).

***Theme 6: The Dreamer’s Self-Doubt***

*Verbatim examples included:*

* *A person with disabilities has dreams, but he has difficulty expressing them for fear that his dreams will be interpreted as unrealistic or meaningless.*
* *That the dreamer will believe in his dream and the ability to fulfill it, even if there are difficulties in the way of achieving the dream, efforts will be made to overcome them.*

***Theme 7: Obstacles in the Surrounding the Environment***

Verbatim examples included:

* *To fulfill any dream you need to remove barriers that inhibit action and “dare” to try and fulfill it.*
* *The environment is not always encouraging or supportive.*
* *Obstacles arise when materializing the dream depends on others, external factors, that are not controlled by the dreamer. There, the difficulty arises in realizing the dream – like desires that clash or getting no consent for it or not achieving cooperation - then the dream is forced to change its original character and is adapted to reality, which requires certain concessions and losses. Part of the right to dare to dream involves meeting with reality.*
* *She [the dreamer] had no moral or financial support, nor did she get support from her direct caregiver.*

***Theme 8: Parents as a Barrier***

* *Talk to the mother / gave me tools on how to present the plan and its meaning. How to best convey to the mother the plan, its meaning and its implications in order to receive full cooperation.*
* *Parental disagreement – parents are afraid of possible sexual abuse, so they do not consent to the process (that the dream implies).*
* *The program is feasible when there is a full mobilization of all the staff and family of the person, once everyone speaks the same “language” and everyone is recruited and focused on fulfilling the dream, then there will be full cooperation with the dreamer.*
* *In my case, my tenant did not receive the support of the family, and part of the difficulty in fulfilling her dream – to visit her care woman in the Philippines – was the opposition of the family.*
* *He is a dreamer and has a dream to ride a motorcycle. After hanging the chart with the drawing of dream, and his father saw it, I was indirectly informed that the father wanted to fulfill his son’s dream, i.e. take over the operation. But it was not his dream, it was his son’s dream. The father has to withdraw from*
* *There’s also an interest in having a mother who keeps him really short. She is involved in everything. Maybe he is not used to initiating new things because she usually decides for him.*
* *And so she gave up on this dream, mainly because Noah’s parents were also unresponsive and they did not support this dream.*
* *I want her to learn how to relieve the stress of being pressured by her family, pressures from her family who are trying to dissuade her from the dream. Being able to make decisions alone.*
* *I learned about the dreamer who is emotionally dependent on his mother, in addition to having a hard time making a decision on his own, having trouble standing up for himself.*

The support staff were realistic in identifying some of the barriers that they faced. They not only saw their roles change from viewing it as a career, or even an instructor, to one of supporter, facilitator, or coach of the individuals with IDD who dare to dream. Like the individuals they support, the support staff also saw that change is indeed difficult.

**Discussion**

It is widely accepted that adults with IDD have the right (like all adults) to choose their own journey in life ([Lafferty](http://www.tandfonline.com/author/Lafferty%2C+Attracta) et al., 2013; Shogren et al., 2018). Many adults with IDD continue to need assistance from others throughout their lives (Brown et al., 2015); however, this should not hinder supporters from conducting respectful dialogues rather than one-sided talks with their service recipients. They should be ready to change their points of view and to be convinced by the other. With increased dialogues, supporters and recipients will be able to both change their positions and their efforts, when needed, in accordance with the changing interaction.

In the present study, the content analysis of service providers' descriptions and insights from their experience with the *Dare to Dream* workshop indicated that they went through a professional and personal process of change. By encouraging their dreamers to expand on their dreams by drawing their dreams and describing them, service providers embarked on a novel way of understanding their role as supporters (Bryen, 2012). As Peels and Sergeant (2018) described, "the emphasis on functional verbal communication falls short when it comes to dialogues about the meaning of life, achieving a sense of belonging and discussing quality of life (QOL) issues" (p.128). There was no longer an emphasis on learning skills solely for the purpose of independent functioning and engaging in “normal” behaviors in order to be like everyone else. By applying the *Dare to Dream* process, the emphasis of support shifts away from “normalizing” the person to enabling him/her to lead a life according to his or her own aspirations, wishes, self-identity and dreams. This shift is demonstrated through the themes that emerged from the interviews. The first theme focused on service providers encouraging the dreamers to express their desires and wishes. The second theme that arose from the content analysis was the reactions of the supporters to the ideas that were brought up by the dreamers, a response that included both respect and interest. They asked clarification questions, but were not judgmental or negative; rather, they created an intimate and hopeful dialogue. Together with the dreamers, the supporters worked on how to implement their dreams. Thus, as the third theme indicated, they helped to turn ideas into a systematic process of implementation. Through this interactive process, supporters changed their focus of support from what *should* be done while taking upon themselves the lead, to encouraging the dreamer's self-expression. Supporters realized that the change in the interactive process from instruction to a dialogue gave the dreamers an opportunity to share their innermost and, at times, secret personal wishes. This process was the first step towards self-fulfillment.

The findings indicated that service providers went through a transformation in the way in which they regarded the aims of their role as supporters. From their typical protocol of accomplishing a certain objective, they now realized that the aim of their interaction with dreamers was for them to internalize a new way of problem-solving. Indeed, the **Aim of Support** was to encourage dreamers’ autonomy and self-realization by enhancing self-advocacy and self-determination, in line with findings by Curryer and colleagues (2015). This aim was made possible by both the dreamer and the supporter internalizing the process of *D*a*re to Dream*. Thus, the process itself became the aim. The message that supporters gave the dreamers was that their aspirations, i.e., a dream they had, was the basis for the interaction between them. Together, they analyzed the dream and discussed ideas about actualizing it, a process that could be applied to each and every dream. Thus, the actual outcomes of turning a specific dream into a reality is a means for dreamers to learn how to go about expressing themselves and striving to materialize their wishes.

The *Dare to Dream* experience is a way for supporters to experience a new way of enhancing, not only the independence of dreamers, but also their autonomy, their sense of being their own agents of change and having the ability to make their own decisions concerning their lives, while also identifying supports that they might need. This new perspective challenges supporters' traditional way of providing supports, and is based on a paradigm shift from the medical model to a humanistic orientation (Reiter, 2008). Although independence is important, support should be regarded as a mutual venture between two individuals that provides opportunities for developing individuation and free choice among the support recipient (Neuman, 2020). This view of support can further assist in creating the shift from a focus on the disability as the major concern to a multidimensional approach, as suggested by the World Health Organization’s definition of disability (Stewart, & Rosenbaum, 2003; World Health Organization, 2016). This paradigm shift suggests a holistic view in which personal, social, physical, and cultural factors are intertwined dynamically. However, sometimes supporters have difficulties in making the shift and taking into account the desires and wishes of the person with the disability, which may not be in line with social and cultural expectations of typical behavior.

The *Dare to Dream* program offers a way to examine the individual’s disability and its consequences alongside the aspirations and dreams of the individual. It allows those who support people with disabilities to change their attitudes in a way that will allow and encourage an encounter with the supported person's inner world. The issue at hand was not the disability itself, rather it was learning how to overcome barriers to enable the fulfillment of the dream, while also identifying supports needed. The interviewers pointed out three kinds of barriers that they might encounter in the process of turning dreams into reality: parental “inappropriate” responses, a lack of support from the social environment, and finally, dreamers' own doubts about their capacity to fulfill their dream**.** Barriers were transformed into challenges rather than becoming “dead ends.” The objective of the support providers was to listen, and then together with the dreamer, to find ways to overcome the difficulties. Indeed, the overall aim of the supporters was to prepare the dreamers into a way of life where they, like everyone else, will be confronted with barriers, but that by being creative and devising alternatives, as well as obtaining needed supports, they can reach positive solutions to the problems they encounter. In the present study, supporters experienced their role as having two purposes: turning a dream into reality and encouraging dreamers to tackle obstacles and barriers. Their role was to be there for the dreamers as a backup, and not as the ones to figure things out for them.

The following is a graphic that illustrates the new support process described by the interviewees. It is suggested that this diagram can provide guidelines for direct care staff in their interactions with adults with IDD.

As illustrated above, the central aim of the provision of support is to help dreamers internalize the process that will enhance their capabilities, as adults with IDD, to achieve autonomy and self-realization by daring to dream. The important roles of supporters are to (1) encourage the expression of desires and wishes, i.e., dreams; (2) create an intimate and hopeful dialogue; (3) help turn the dreams into an attainable and systematic process; and (4) help the dreamer face both internal and external challenges and obstacles (e.g., dreamers' self-doubt; parents who may be reluctant to support their adult children’s dreams). The diagram demonstrates the ongoing, dynamic interaction between the supporter and the dreamer. The process focuses on dream fulfillment and problem-solving as they evolve towards actualization. In summary, following the experience of the *Dare to Dream* workshop, the role of the supporter is to encourage the support recipient’s expression of desires and dreams. This goal is achieved via a systematic process based on an intimate and hopeful dialogue – what Patston (2017) refers to as being the champion for supported autonomy and where agency is key while recognizing that supports are needed.

Another aim of the present research was to uncover the extent to which a meaningful change in the role perception of support staff can be affected by an experience with a new program based on a humanistic orientation. We presumed that the practical experience with this program would be a starting point for service providers to undergo a change in the role perception. The participants that took part in the present study were asked to participate in the *Dare to Dream* program, a program which challenged them to interact with the person they supported in a new way. The results of the research demonstrated that participation in this program was an efficient way to introduce service providers to the implications of the basic principles underlying the humanistic orientation (Reiter, 2008).

Supporters not only learned a new technique, but also an entirely new orientation of behaving and interacting with recipients, as well as adopted a new perspective about their own position as supporters. As Peels and Sergeant (2018) described, instead of interpreting dreamers’ stories in the light of their own acquired knowledge, supporters should conduct an honest dialogue with adults with IDD about their future and their dreams. The basic assumption should be that people with IDD have the competence to paint their own pictures about what they want in their lives. In line with humanistic principles, supporters showed respect for the subjective narratives of the dreamers; dreamers subsequently expressed that this respect and interest was meaningful for them.

**Implications for Policy and Practice**

Despite significant advancements in the legal and conceptual approaches to the rights and well-being of persons with disabilities, these advancements do not usually emerge in the “face-to-face” interactions between persons with disabilities and those around them, whether it is with laymen or professionals. Using the concepts derived from the ecological model, we might say that gaps or barriers are present as ideas and knowledge flow down from the macro level to the micro level of social interaction. Although the current research focused on the interaction between provider and recipient (micro level), its results are relevant to policy change (macro level) as well.

***Implications for policy change***. Successful implementation of *Dare to Dream* may require policy changes at the national, regional, and program level given that many programs for adults with IDD are often still based on a medical model. Professionals, whether teachers or social workers, have been trained to pinpoint the impairment and subsequently try to fix it or reduce its effects. In contrast to the medical model, the social model and humanistic orientation helps us recognize barriers that make life harder for people with disabilities. Removing these barriers create equality and offer those with disabilities more independence, choice and control.

*Dare to Dream* is based, to a large extent, on a social model of disability. It recognizes that the major barriers for most adults with IDD are the lack of opportunities and supports to turn their dreams into their future realities. This means that the roles of service providers and other allies will also need to change from one of helper or fixer to one of supporter. This will not be an easy task. Polices may need rethinking, as well as models of research and conceptualizations of what is success. Above all, on a more individual level, we will all need to be better listeners when it comes to the dreams of people with disabilities. We will also need to truly believe in the power of their dreams.

**Implications for Practice**

We recommend to continue to use and investigate the application of the novel *Dare to Dream* process. The process was found to be effective in assisting support staff to change their perceptions and attitudes towards adults with IDD, such that they shifted from emphasizing the disability to acknowledging the aspirations and wishes of those whom they support. The process was also found to be relevant for implementing the humanistic orientation as its underlying guide. This means looking at the interaction between the supporter and the person with IDD as a holistic mutual and unique relationships between two persons, rather than as a random interchange between service provider and recipient.

We also recommend investigating the new support processes described by the interviewees. The aim of providing support, as described, and the various steps recommended to achieve this aim can be used as a guide for other initiatives to bridge the gap between declarations of rights and the actual practice of support.

**Limitations of the Study and Recommendations for Further Research**

Before recommendations can be fully implemented, we must recognize the limitations of this study. Due to the COVID-19 pandemic, the follow-up meetings were curtailed. Consequently, the long-term impact of *Dare to Dream* on the support staff could not be evaluated. Additionally, *Dare to Dream* was translated from English to Hebrew and was originally developed for American culture. As such, there was a limited amount of time to adapt it to local Israeli culture. Further, the sample of “dreamers” included only adults with mild IDD. It remains unclear if and how this process can be applied to persons with more complex cognitive disabilities. Recognizing these limitations, the following recommendations should be approached with some degree of caution.

Future research should investigate the full implementation of the *Dare to Dream* process and its long-term impact, as well as its implementation with persons with more complex cognitive disabilities. We further recommended that cross-cultural research be conducted in order to investigate how to adapt and implement the process in different cultures and languages. It may also be important to investigate the dyadic interaction between supporter and dreamer as they go through the entire *Dare to Dream* process.

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**Table 1**

*Participants’* *Demographic Information (N = 10)*

|  |  |
| --- | --- |
| Demographic Variables | Mean & Percentages (n – 10) |
| Gender   * Male * Female | 2  8 |
| Age (mean and range) | 50.2 (28 -70) |
| Place of residence   * City * Village | 9  1 |
| Relative has a disability   * No * Yes   + Intellectual Disability   + Autism | 5  5  4  1 |
| Professional role  Education   * Bachelor’s Social or education * Master’s Degree * Matriculation | Social or Rehab Worker 5  Instructor/tutor 3  Home/Communication Coord 2  4  4  2 |
| Years working with people with disabilities | Mean = 15.4 Years; Range = 1 to 36 years |
| Years in current workplace | Mean = 5.8 years; Range = 1 to 13 years |

**Table 1**

*Participants’* *Demographic Information (N = 10)*

|  |  |
| --- | --- |
|  | *n* or *M* (range) |
| Gender |  |
| Men | 2 |
| Women | 8 |
| Age | 50.2 (28-70) |
| Place of residence |  |
| City | 9 |
| Village | 1 |
| Relative with a disability? |  |
| Yes | 5 |
| Intellectual disability | 4 |
| Autism | 1 |
| Professional role |  |
| Social or rehab worker | 5 |
| Instructor/tutor | 3 |
| Home/communication coordinator | 2 |
| Education |  |
| Bachelor’s degree | 4 |
| Master’s degree | 4 |
| Matriculation | 2 |
| Years working with people with disabilities | 15.4 (1-36) |
| Years in current workplace | 5.8 (1-13) |

**Table 2**

*Themes and Examples*

|  |  |  |
| --- | --- | --- |
| 1.Role of the supporter | * Encourage expression of desires and wishes * Create intimate and hopeful dialogue * Help turn ideas into a systematic process | * *“Asking members more about their deep and hidden desires and making the impossible, possible for them to achieve.”* * *The process made me and my supporter closer together and there is a feeling of greater joy (by her).”* * *“The program gave me another "tool" - a coping method that allows me to respond to the dreams of the supported person. That the workshop gave me tools to respond in a special and different way to the dreamers.”* |
| 2. Aim of support | * Autonomy and self realization * Internalization of the process is the ultimate goal | * *“Formation of identity and self-worth. It is a learning process enhancing the 'dreamers' personal autonomy.”* * *“It does not matter if the dreamer does not fulfill his dream. Only part of it may be fulfilled. 'The process itself rewards the dreamer'.”* |
| 1. Facing challenges and obstacles | * Dreamers' self-doubt * Obstacles in the   surrounding environment   * Parents as barriers | * *“A person with disabilities has dreams, he has difficulty expressing them, for fear that his dreams will be interpreted as unrealistic or meaningless.”* * *She (the dreamer) had no moral and financial support, nor did she get support from her direct caregiver.”* * *Parental disagreement. Parents are afraid of possible sexual abuse, so do not consent to the process (that the dream implies).”* |