**The expression of a humanistic orientation in the perception of service providers supporting adults with IDD and its correlation with the perception of service recipients regarding their abilities and their lives**

Ran Neuman, Nirit Karni-Vizer, and Shunit Reiter

Corresponding Author:

Ran Neuman, PhD

Email: rann.academy@gmail.com

Zefat Academic College, Department of Special Education & Department of Social Work

Zefat, Israel, 13206

Nirit Karni-Vizer, PhD

Email: niritkarni2@gmail.com‏

Tel Hai Academic College, Department of Special Education

Upper Galilee, 1220800, Israel

Shunit Reiter, Prof. (Emerita),

Email: shunitr@edu.haifa.ac.il

University of Haifa, Department of Special Education

Haifa, Israel

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**Abstract**

The current study examined the extent to which a humanistic orientation impacted the perceptions of service providers who work with individuals with intellectual and developmental disabilities (IDD), as well as the perceptions of their service recipients in regard to their own abilities and lives. The study aimed to redefine the system of supports that is provided to individuals with IDD. It utilized a quantitative approach and included a sample of 61 service providers and 95 of their service recipients. A distinction was found between service providers who adopted a humanistic orientation and those who had a medical perception of IDD, such that those with a humanistic orientation reported that their service recipients had higher levels of ability. Furthermore, a positive correlation was found between the assessments of the “givers” (i.e., service providers) and “receivers” (i.e., those with IDD) with regard to the abilities of the latter. However, service providers’ general statements about individuals with IDD as a whole were not associated with their service recipients’ sense of self-efficacy, future orientation, or quality of life. The study findings suggest that a humanistic orientation among service providers encourages optimism and can be used as a springboard for cultivating autonomy among individuals with IDD.

**Introduction**

From a historical perspective, the assertion that people with IDD are both entitled to make their own choices and take an active part in the decisions made about their lives has only come about recently (Neuman, 2020). Until recently, in accordance with the medical model, the dominant assumption was that people with IDD have difficulties making decisions about their lives and, as such, others were in charge of deciding things for them. However, it was thought possible to teach them skills that would allow them to function in a normative manner. According to this approach, functional ability is a prerequisite for a person’s integration into society and for making decisions about his or her life (Caldwell, 2010; Neuman, 2019).

In the late 1980’s, a protest movement involving individuals with IDD and their families began against the medical perception. This movement demonstrated that normative behavior and functional independence do not necessarily lead to the ability to make decisions freely. Rather, the source of the barriers facing individuals with IDD is not their lack of ability, rather it is society’s insensitivity towards them. At the same time, there were increased demands for making adjustments that would make the living environment of people with IDD accessible. Accordingly, the social model emerged, which asserts that IDD is a context-dependent and socially-constructed phenomenon, and a product of cultural and environmental processes, which influence the design of living conditions and the social relationships of the individual (Brants, van Trigt, & Schippers, 2016, Oliver, 1996).

In parallel to the social ideology, which emphasizes societal responsibility for individuals’ conditions, the humanist orientation developed. This orientation proposed to re-examine the capabilities of people with IDD and to formulate, accordingly, the manner in which they should be supported. From the 1990s onwards, the humanistic model was proposed as an extension of the normalization principle, with regard to the provision of support services, education, and treatment given to people with IDD. Among other things, this extension includes a shift away from an overarching emphasis on how people with IDD fit in with society’s norms, towards providing supports that allow for personal expression, self-realization and personal choice, as is expressed in the idea of personal autonomy (Brown, Cobigo, & Taylor, 2015). The model emphasizes the importance of treating the whole person, as someone who is seeking meaning in his or her life. In other words, according to this approach, each person has a unique value and is endowed with the abilities to understand oneself and one’s environment, create a set of priorities in accordance with one’s personal values, and follow one’s path towards aspirations and goals for the future (Reiter, 2008). The picture of one’s future is built throughout one’s life. According to Seginer (2009), the term “future orientation” is defined as mental, subjective, and consistent representation of the future and it consists of a cognitive component, a motivational component and a behavioral component. Thinking about the future is the compass which directs individuals as they make plans, consider their options for the future and reach decisions. According to the humanistic orientation, the overarching goal for service providers is no longer to rehabilitate individuals so that they function in a normative fashion and integrate into “typical” society, rather that the support provided to people with IDD should be based on respect for their individuality, and a sense of optimism in regard to their ability to make their own choices and manage their lives and their future. The term “self-efficacy” refers to a person’s expectation to succeed in a task or to achieve a particular outcome after exerting certain efforts. In other words, it refers to the assessment of one’s personal ability to plan and carry out necessary actions to manage in different types of situations (Bandura, 1995). Study findings have shown that high levels of self-efficacy are associated with positive thinking, high self-esteem and goal setting (Evangelos, Konstantionos & Georgios, 2007).

Another way to examine and approach the abilities of individuals with IDD from the humanistic perspective can be found in the multidimensional analysis found in the World Health Organization’s model (2016). According to this model, the concept of disability needs to be defined with consideration to the associations found among the individual, the disability, one’s level of functioning and the environment. The contribution of this new model is in its addition of two factors: the first which focuses on the individual’s characteristics, qualities, abilities, aspirations, and desires, within the context of the disability and the barriers it creates, and the second which focuses on both the physical and social environmental conditions as expressed through the larger cultural context, social institutions, community and family, technology, accessibility and more. As such, this model emphasizes the distinction between functioning as an expression of an individual’s potential and abilities from within, and functioning which is apparent in a given and dynamic situation. In regard to the services provided to people with IDD, the transition to a multi-dimensional approach provided legitimacy to people with IDD to determine their own aspirations and legitimacy to service providers to not make assumptions beforehand about the range of abilities of people with IDD (Stewart & Rosenbaum, 2003).

A humanistic orientation thus deals with the dialogue between an individual and his or her surroundings, and emphasizes the importance of listening to the individual (Reiter, 2008). The central question then becomes, “Which supports are needed to enable people with IDD to conduct themselves within the community, to take on significant social roles and to experience satisfaction, self-fulfillment and a meaningful life?” (Thompson et al., 2002). The basis for answering this question lies in the perception of service providers about the ability of people with IDD. Nowadays, we are witnessing attempts to redefine the goals of supporting people with IDD, under the assumption that they are able to take an active role in the decisions made about them; are able to remove barriers that may arise within their environments and to deal with challenges in their lives (Schalock et al., 2010); and are able to express themselves and achieve an optimal quality of life (Brown & Brown, 2009; Reiter, 2008). “Quality of life” is a complex and controversial concept in terms of its nature, its components, and the way in which it is measured. One of the central models for assessing quality of life is based upon the “goodness of fit” approach, which considers individuals’ level of fulfillment and level of satisfaction with the fulfillment of their basic needs in terms of physical, biological, psychological and social needs. The more satisfied one is with their resources, the greater their satisfaction with life, as well as their sense of competence and control over their life. The degree of agreement between an individual’s needs and the environmental conditions is anchored within one’s system of beliefs, opinions and expectations, as well as one’s worldview (Schalock, Bonham, & Verdugo, 2008).

Despite the developments and changes that have occurred in regard to attitudes towards people with IDD, it appears that oftentimes, in practice, the field continues to be based upon the medical model, such that the focus is on imparting skills that primarily promote functional independence. Although these skills increase the participation of people with IDD in the normative lifestyle, if this participation does not coincide with an individual’s preferences and expectations, its contribution to one’s quality of life is likely to be negligible. Many support providers find it challenging to allow adults with IDD to explore and make choices, and instead they focus on risk management and the advancement of functional goals.

In this context, it is important to examine the degree to which the humanistic orientation is adopted as a professional worldview among service providers of adults with IDD, and the association between a humanistic orientation and adults with IDD’s perceptions about their abilities, future orientation, and quality of life. The current study examined the degree to which a humanistic orientation is present in the field, and the extent to which it impacts the working style of service providers and the lives of service recipients. Study findings would make it possible to re-examine the system of supports that should be provided to people with IDD, as well as the training processes that would enable support providers to assist those with IDD to live as full and meaningful a life as possible.

Study aims focused both on perceptions of service providers and the relationship of service providers with their service recipients.

**Perceptions of service providers**

1. To examine whether there is a professional worldview among service providers that is based upon a humanistic orientation, as distinct from the medical model.
2. To examine whether there is an association between the orientation that service providers hold about people with IDD and their perceptions, in practice, about the abilities of service recipients.

**The relationship between service providers and service recipients**

1. To focus on the dyadic relationship between the service provider and recipient, and the association between service providers’ perceptions about their service recipients’ capabilities and the service recipients’ perceptions about their own abilities.
2. The examine the association between the general orientation of service providers towards people with IDD and the corresponding service recipients’ self-reports of their self-efficacy, quality of life, and future orientation.

The study hypotheses are as follows:

**Perceptions of service providers**

1. There will be a difference between service providers who endorse a humanistic orientation vs. those who endorse an orientation based on the medical model in regard to the general perception they hold towards people with IDD.
2. Service providers’ adoption of a humanistic orientation towards people with IDD, in general, will be demonstrated by higher ratings of self-efficacy of service recipients as compared to service providers with a medical orientation.

**The relationship between service providers and service recipients**

1. There will be a positive correlation between service providers’ ratings of their service recipients’ self-efficacy and the self-efficacy that service recipients report of themselves.
2. Service recipients who have service providers who endorse a humanistic orientation, in general, towards people with IDD will report higher levels of self-efficacy as compared to service recipients who have service providers who hold a medical orientation towards people with IDD.
3. Service recipients who have service providers who endorse a humanistic orientation, in general, towards people with IDD will report a higher quality of life as compared to service recipients who have service providers who hold a medical orientation towards people with IDD.
4. Service recipients who have service providers who endorse a humanistic orientation, in general, towards people with IDD will report higher levels of the cognitive dimension of the future orientation measure as compared to service recipients who have service providers who hold a medical orientation towards people with IDD.

**Method**

***Procedure***

For the purpose of conducting the present study, approvals were obtained from the Research, Planning, and Training Division of the Research Department within the Ministry of Labor, Social Affairs and Social Services, as well as the Ethics Committee for Research Work involving Human Participants within the Faculty of Education at the University of Haifa. The research was conducted in accordance with the rules of research and scientific efforts. Participant recruitment occurred with the approval of the service providers’ supervisors and, in the case of the service recipients, also with the approval of their guardians/families.

The study was conducted in two stages. In the first stage, after locating relevant facilities and obtaining necessary approvals, 61 service providers were identified. In the second stage, each of the service providers were asked to contact three service recipients who had been in their care for more than one year and to ask whether they would agree to participate in the study, including responding to questionnaires. Of the service recipients who were contacted, 95 agreed to participate in the study. There was at least one service recipient per service provider.

All participants were explained the purpose and procedure of the study, and were

told that they had the option to discontinue the study at any point (see Appendix 1). All service providers signed an informed consent form (see Appendix 2) and completed questionnaires about their overall perceptions of people with IDD, as well as questionnaires that were specific to the ability of each of the service recipients to which they provide support and who consented to be part of the study.

After obtaining informed consent from service recipients’ guardians (see Appendix 8), service recipients provided their consent to take part in the study (see Appendix 9) and completed self-report questionnaires about self-efficacy, quality of life and future orientation.

***Participants***

There was a total of 156 participants in the study – 61 service providers and 95 service recipients (each service provider cared for one to three service recipients). Participants were recruited from the north of Israel (convenience sample). All participants lived in supported living accommodations, which are supported and supervised by the Office of Disability Services (formerly known as the Division for the Treatment of Persons with Disabilities) within the Ministry of Social Affairs and Social Services.

Service providers worked in facilities that provide comprehensive support for people with IDD (housing, employment, leisure activities, etc.). In some cases, the housing accommodations were in dormitories and, in other cases, they were located within the community. Service providers held a wide variety of positions prior to their current one and completed various training programs, however, they all provided direct support to service recipients who were under their care during the course of the study. Most of the participants were women (80%) and identified Judaism as their religion (90%). More than half of the participants lived in a city (58%). Service providers had a mean age of 47.66 (range: 22-71) and half (50%) were college-educated or above. The average number of years within the field was 10.72 (range: 0-32), with an average of 6.39 years in one’s current workplace (range: 1-22).

All service recipients were diagnosed with mild to moderate IDD. As previously mentioned, service recipients lived either in dormitories or within the community. More than half of them were women (56%) and most identified as Jewish (98%). Service recipients’ mean age was 41.71 (range: 20-75) and the average number of years in which they lived outside of their homes was 11.12.

***Instruments***

Service providers completed the following questionnaires:

1. Personal characteristics and demographic factors (self-report).
2. Personal characteristics and demographic factors of each of their service recipients who took part in the study.
3. Attitudinal questionnaire used to examine perceptions toward people with IDD. This questionnaire consisted of two parts:
   1. Attitudes toward people with IDD (Rieter & David, 1996)
   2. Attitudes about the abilities of people with IDD (Hess & Hillel-Lavian, 2016)
4. Self-efficacy questionnaire (NGSE; Chen & Fully, 1997; Chen, Gully, & Eden, 2001). Service providers responded to this questionnaire in regard to each of their service recipients who took part in the study. The self-efficacy questionnaire was divided into two parts:
   1. Efficacy Questionnaire A – measured an individual’s degree of determination to achieve self-set goals, both with support from others and independently.
   2. Efficacy Questionnaire B – measured an individual’s self-efficacy in four separate areas: autonomy, leisure time, community relations, and personal expression.

The questionnaire was translated to Hebrew by Grant and Flomin (1998).

Service recipients completed the following questionnaires:

1. Quality of life questionnaire (Cummins & Lau, 2005a)
2. Self-efficacy questionnaire (NGSE): This is the same questionnaire that service providers completed, but this version was for service recipients to fill out about themselves.
3. Future orientation questionnaire (Seginer, Nurmi, & Poole, 1991): This questionnaire was shortened and revised to fit with the current study’s research questions. As such, the questionnaire assessed service recipients’ perceptions and evaluations of their future (the cognitive dimension of the future orientation scale) and the extent to which service recipients shared their thoughts about their future with other people such as friends, family, and their service providers.

***Data Analysis***

In order to create different categories that represented service providers’ tendency to hold a humanistic orientation, a factor analysis of the attitudinal questionnaire was performed. The validity of the questionnaire was examined through a factor analysis, and the reliability of the measures was examined using Cronbach’s alpha. Demographic variables and quantitative measures (interval and ordinal scales) are presented in tables X-X, which include frequencies and percentages. Quantitative variables (interval and ordinal scales) were evaluated using measures of central tendency (means, standard deviations) and scatterplots. Phi coefficients and Pearson correlations were used to test hypotheses that examined associations between variables. Hypotheses focused on differences between groups and were tested using t-tests for independent samples.

The results of the factor analysis indicated that 28 service providers scored above a mean of 3.5 on the humanistic model questionnaire and thus were defined as endorsing a “humanistic model,” 15 service providers who received an average of 3.0 on the medical model questionnaire were defined as endorsing a “medical model,” and the remaining 18 service providers were defined as endorsing another model.

**Results**

The first hypothesis examined whether there were cohesive patterns of perceptions about people with IDD. The hypothesis was that there would be a difference between service providers with a humanistic orientation and service providers with a non-humanistic orientation in the overall perceptions toward people with IDD. For the purpose of testing the hypothesis, the two attitudinal questionnaires that service providers completed were combined into one scale and a factor analysis was performed. The results of the factor analysis are presented in Table 1.

Table 1

As seen in Table 1, according to a factor analysis of 61 participants who responded to all questions in the questionnaire, there were six factors. Of the six factors, there were two primary factors which led to the division between the humanistic model (10 questions) and the medical/nursing model (8 questions). The percentage of variance explained after a varimax rotation was 35.35%. Among all service providers (*n* = 61), there was a tendency towards endorsing a humanistic orientation regarding people with IDD (an average of 3.35 on a scale of 1-5, which corresponds to a score of 67 on a scale of 1-100). The reliability of the factor was high (α = 0.89). Among all service providers (*n* = 61), there was a tendency towards a medical/nursing orientation (an average of 2.34 on a scale of 1-5, which corresponds to a score of 45 on a scale of 1-100). The second factor showed good reliability (α = 0.75). In other words, the humanistic orientation of service providers’ perceptions was found to be more dominant than the medical/nursing orientation. Following the factor analysis, two categories were created such that service providers who received a mean score of 3.0 or above in the eight questions regarding the medical/nursing model were considered to hold a medical orientation. Service providers who received a mean score of 3.5 or above in the ten questions regarding the humanistic model were considered to hold a humanistic orientation. Service providers who received a mean score below 3.5 in the ten questions regarding the humanistic model and a mean score below 3.0 in the eight questions regarding the medical model, were considered not to hold neither a medical orientation nor a humanistic orientation. Accordingly, in the current sample of 61 service providers, there were 28 who expressed a humanistic orientation, 15 who expressed a medical orientation, and 18 who did not associate with either orientation. Therefore, it appears that approximately half of the service providers endorsed a humanistic orientation in regard to their perceptions about people with IDD.

**These results supported the first hypothesis, such that a difference was found between service providers who endorsed a humanistic orientation and those who endorsed a non-humanistic orientation in the general perceptions they held toward people with IDD.**

The second research question regarded whether service providers who endorsed a humanistic orientation in their general perceptions towards people with IDD would indicate higher levels of self-efficacy of service recipients than service providers who endorsed a medical orientation. In order to test this hypothesis, a self-efficacy questionnaire was used. As mentioned previously, the questionnaire was divided into two parts: Efficacy Questionnaire A and Efficacy Questionnaire B.

Efficacy Questionnaire A measured the extent to which an individual demonstrates determination toward achieving one’s goals, both with the support of others and independently. Some service providers took part in the study with more than one of their service recipients. As such, there were more reports of service recipients than service providers. Accordingly, Table 2 refers to the results of 69 questionnaires in which service providers with either a humanistic orientation or a medical orientation rated the self-determination of their service recipients. The table presents the distribution of responses per item and indicates whether there was a significant difference in the mean score of each item across the two orientations.

Table 2

Table 2 shows that service providers with a medical orientation (*M* = 1.84) believed, to a lesser extent than those with a humanistic orientation (*M* = 2.17), that their service recipients would be able to accomplish difficult goals when confronted with them, *t*(64) = 2.48, *p* < .05. Eighty-one percent of service providers with a humanistic orientation expressed that, with the receipt of support, their service recipients are capable of achieving most of the goals they set for themselves, even when confronted with a difficult situation. Although there were no significant differences between service providers with a humanistic orientation and those with a medical orientation in the other self-efficacy items, it can be seen that service providers with a humanistic orientation rated the ability of their service recipients to achieve goals on their own as higher than those with a medical orientation.

Efficacy Questionnaire B measured service recipients’ self-efficacy in four different areas - autonomy, leisure time, community relations, and personal expression. Table 3 presents the means and standard deviations of each aspect across service providers with a humanistic orientation and service providers with a medical orientation, as well as the t-value that corresponded with the analysis comparing the two groups.

Table 3

Table 3 demonstrates that the two aspects of self-efficacy in which there were significant differences between service providers with a humanistic orientation and those with medical orientation were community relations [*t*(65) = 2.08, *p* < .05] and personal expression [*t*(65) = 2.12, *p* < .05]. Service providers with a humanistic orientation rated the abilities of their service recipients as significantly higher than those with a medical orientation. Although there were no significant differences in the aspects of autonomy and leisure time, there appeared to be a trend in which service providers with a humanistic orientation rated the ability of their service recipients as higher than service providers with a medical orientation. **Thus, the second hypothesis was partially supported.**

Thus far, the results focused on service providers only. The following hypothesis focused on the relationship between service providers and service recipients, which represents a supporter-supported relationship. The third hypothesis of the study was that there would be a positive correlation between service providers’ ratings of their service recipients’ self-efficacy and the self-efficacy that service recipients reported of themselves. Table 4 presents the correlation coefficients between service providers’ assessments of service recipients’ self-efficacy and service recipients’ own reports of self-efficacy. The correlation analysis was performed with the whole sample, as well as only with service providers with a humanistic orientation and only those with a medical orientation.

Table 4

As shown on Table 4, there was a significant and positive medium correlation between service providers’ self-efficacy ratings of service recipients and service recipients’ own self-efficacy ratings, *r* = .47, *p* < .001. In other words, as service providers rated service recipients’ self-efficacy as higher, recipients rated their own sense of self-efficacy as higher as well. This correlation held when examining the humanistic orientation group and the medical orientation group separately. **Thus, the third hypothesis was supported.**

Thus far, the association between service providers’ and service recipients’ ratings, within the context of a supporter-supported relationship, were examined. The next hypothesis focused on differences between two groups of service recipients – those who had service providers who held a humanistic orientation and those whose service providers held a medical orientation. Hypothesis 4 was that service recipients who had service providers who endorsed a humanistic orientation, in general, towards people with IDD would report higher levels of self-efficacy as compared to service recipients who had service providers who hold a medical orientation towards people with IDD. Table 5 presents the means and standard deviations of service recipients’ self-reports of their self-efficacy by the orientation of their service providers.

Table 5

Table 5 demonstrates that there is no significant difference between service recipients who receive care from service providers with a humanistic orientation as compared to service recipients who receive care from service providers with a medical orientation, *t*(66) = 0.73, *p* > .05. **Hypothesis 4 was not supported.**

Hypothesis 5 was that service recipients who had service providers who endorse da humanistic orientation, in general, towards people with IDD would report a higher quality of life as compared to service recipients who had service providers who held a medical orientation towards people with IDD. Table 6 presents the frequencies of service recipients’ responses to the quality of life items.

Table 6

As seen in Table 6, most service recipients indicated that they were satisfied with their current home (88%), felt safe in their home (87%), and were satisfied with their lives lately (76%). Table 7 presents the descriptive statistics of service recipients’ quality of life.

Table 7

Table 7 shows that service recipients’ self-reported quality of life was very high (a mean of 1.21 on a scale of 1-3, which corresponds with a score of 93 on a scale of 1-100). The scale had good reliability (α = 0.82). However, it appeared that participants were fairly uniform in their responses, as the majority of participants rated their quality of life as very good. This pattern of results reflects the attitudes of the country’s population as a whole, as indicated in surveys of Israelis that assess happiness/satisfaction with life (Zelekha & Zelekha, 2020). Israel ranks high in world happiness rates as compared to other countries, and thus, participants of the current study did not differ from the norm.

Next, the difference between the quality of life of service recipients who were under the care of service providers who endorsed a humanistic orientation vs. a medical orientation was examined. Table 8 presents the means and standard deviations of the two groups in terms of quality of life and the t-value that corresponded with the analysis comparing the two groups.

Table 8

Table 8 shows that there was no significant difference between the quality of life among service recipients of service providers who held a humanistic orientation as compared to service recipients of those with a medical orientation, *t*(67) = 1.27, *p* > .05. **Thus,** **hypothesis 5 was not supported.**

Hypothesis 6 stated that service recipients who had service providers who endorsed a humanistic orientation, in general, towards people with IDD would report higher levels of the cognitive dimension of the future orientation scale as compared to service recipients who had service providers who held a medical orientation towards people with IDD. Table 9 presents the extent to which service recipients imagined their future in various areas of life, as well as with whom they shared each of the aspects.

Table 9

Table 9 illustrates that about one-third of service recipients thought about the close friends that they will have in the future (37%), their future family (29%), and their financial future (29%). For the majority of the topics, participants reported talking primarily with their service providers. Table 10 presents the means and standard deviations of scores on the future orientation measure by group (service recipients who received care from providers with a humanistic orientation vs. a medical orientation), as the t-value that corresponded with the analysis comparing the two groups

Table 10

The results presented on Table 10 indicated that there was no significant difference in future orientation between service recipients of service providers who held a humanistic orientation as compared with service recipients of service providers who held a medical orientation, *t*(67) = -1.05, *p* > .05. **Thus**, **hypothesis 6 was not supported.**

**Discussion**

In recent decades, there has been a growing concern for the rights of people with IDD to have equality of opportunities and a full life (Brown, 2017). A humanistic orientation is at the core of the changes that have occurred concerning the treatment of people with IDD, and thus, also underlies the discourse about their rights. The humanistic orientation defines a person’s essence and is characterized by independent thinking, the ability of self-insight, an understanding of one’s surroundings, the ability to choose between alternatives, and the ability to set personal goals, while engaging in the pursuit of them. This essence defines the person as an autonomous agent of his or her life (Reiter, 2008). The current study examined the extent to which these changes have become integrated and have shaped the perceptions and attitudes of service providers towards their service recipients. Additionally, the study examined whether, as a result of changes in the perceptions and attitudes toward people with IDD, the perception that service recipients have about themselves and their lives have changed as well.

The study’s first finding was that the humanistic orientation was, in fact, present among service providers. Approximately half of the service providers in the sample were defined as “humanistic” and they perceived individuals with IDD as capable of “standing up for their own rights, maintaining their privacy, making informed choices, independent thinking, self-awareness, personal responsibility and self-advocacy, independent decision-making, and self-criticism.” Therefore, it can be concluded that the dimensions which characterize the humanistic perspective emphasize individuals’ abilities to act autonomously.

The next question that guided the study was whether there was a difference between service providers who held a humanistic orientation and ones who held a medical orientation in regard to their assessments of their service recipients’ abilities. In the present study, a distinction was made between the implications of the humanistic orientation at the macro-level, and its implications on the micro-level. The macro-level focuses on aspects of legislations, regulations and policies, and emphasizes the right for people with IDD to have equal opportunities, as well as an autonomous and meaningful life (United Nations, 2006). The micro-level, on the other hand, concerns the relationship between the service provider and the service recipient and the extent to which the interaction between them is based upon mutual respect, listening, and acknowledgement that the person with the disability has ownership over his or her life and decisions. At the micro-level, the question arises as to whether this relationship reflects a humanistic orientation, or whether it continues to be influenced by the discriminatory social norms which emphasize a distinction between what is normative, desired, and successful, and what is viewed as unusual, rejected and a failure (Reiter & Bryen, 2012).

The present study rested on the assumption that service providers who held a humanistic orientation would experience and describe their service recipients as having greater levels of self-determination and self-efficacy than service providers with a medical orientation. Study findings indicated that, in some of the self-determination and self-efficacy measures, service providers with a humanistic orientation rated their service recipients’ capabilities as greater than those with a medical orientation. In regard to self-determination, the difference was apparent in service providers’ assessments of service recipients’ ability to accomplish difficult goals. Similarly, service providers with a humanistic orientation rated their service recipients’ higher than those with a medical orientation in the areas of “community relations” and “personal expression.” It is important to note that, although not significant, a similar trend was found in the other measures of self-determination and self-efficacy. Thus, the second hypothesis was partially supported.

It is possible that the findings demonstrate the complex transition from the general perceptions toward people with IDD as a group that has rights – the macro-level – to an individual’s perception about a particular person with IDD who is able to manage his or her own life autonomously – the micro-level. Findings showed that, in the dimensions of “community relations” and “personal expression,” service providers with a humanistic orientation expressed more positive attitudes about the capabilities of their service recipients than service providers with a medical orientation. Interpersonal relationships and personal expression are essential and basic components of the humanistic orientation, which constitute the basis of achieving a meaningful life. On the other hand, with regard to “independent functioning” and “leisure time,” there were no significant differences between those who endorsed a humanistic orientation and those who espoused a medical orientation. From the perspective of these two orientations, these constructs serve as the basis for diagnoses and interventions that would enable people with IDD to live a more independent life in the normative society.

The third hypothesis dealt with whether there would be a correlation between service providers’ higher self-efficacy expectations of their service recipients and the recipients’ self-reported self-efficacy. Findings showed that the higher service providers rated the self-efficacy of their service recipients, the higher service recipients rated their own self-esteem. This pattern was found among the whole sample, as well as each of the groups (service providers with a humanistic orientation and those with a medical orientation). These findings demonstrated the importance of the relationship between the service provider and recipient, and the possible significance that an optimistic and positive approach on the part of the service provider can have on the service recipient.

In contrast to these findings, the fourth hypothesis – which stated that there would a difference in service recipients’ self-efficacy levels depending on whether the service provider had a humanistic orientation or a medical orientation – was not supported. This hypothesis focused on service providers’ perspectives about people with IDD as a group, rather than the individuals to whom they provided care specifically. Study findings showed that service providers’ perceptions about people with IDD, in general, were not sufficient to influence service recipients’ own perceptions about themselves. However, when service providers referred to the ability of the individuals for whom they cared (Hypothesis 3), there was an association between service providers’ assessments and service recipients’ attitudes. That is, service providers’ optimistic assessments of their service recipients were found to positively correlate with how service recipients viewed themselves. This finding emphasizes the importance of viewing the person with IDD as a whole person, rather than as someone who belongs to a particular group on the basis of diagnostic criteria. As such, it could be argued that endorsing a humanistic orientation at the micro-level is reflected through a consideration of the individual as a whole person who has, among other things, a disability, rather than someone who belongs to a “disabled” group whose rights need to be fought for, as is reflected in the macro-level perspective. A possible explanation for these findings is that service providers’ perspectives toward the group as a whole does not yet reflect their attitudes toward a single individual. In one-on-one meetings, service recipients “learn” service providers’ attitudes toward them as individuals, not their general attitudes about the abilities of all individuals who fall under the same diagnostic category. Along the same lines, the correspondence between providers’ and recipients’ assessments of service recipients’ abilities allows for a greater harmony in their shared dialogue. As such, the “humanistic” service provider offers a holistic, supportive and hopeful environment.

The importance of this relationship is further supported by the finding that regards service recipients’ perceptions of their future, which was assessed with the future orientation questionnaire. Findings showed that the primary person with whom service recipients speak to about their future were their service providers. However, there was no significant difference in service recipients’ perceptions of their future (specifically, the cognitive dimension) depending on whether they had a service provider with a humanistic orientation or a medical orientation. In this context, it is important to note that the measure of future orientation is complex and multidimensional.

Additionally, the present study examined whether service providers’ humanistic orientation (vs. medical orientation) had a direct influence on the quality of life of service recipients; no significant difference was found. In this instance as well, study findings may suggest that the satisfaction and happiness of people with disabilities is not only related to the overall perspective of their service provider towards people with ID, but rather is influenced by other factors in their lives. Another explanation for the findings may be related to how the quality of life is measured. Zelekha and Zelekha (2020) noted that one’s sense of his or her quality of life is complex and cannot be fully captured when only using an attitudinal scale. They further noted that quality of life surveys are limited such that the correlations between stated attitudes and actual life experiences and behaviors are small. They provide a number of reasons for the limitations of self-report measures. For example, people may not want to self-disclose, or they may want to respond in a way that they think pleases the interviewer. Further, there may be others who may not fully understand the questions.

In summary, the findings demonstrated that the life of a person with IDD is complex and that this complexity is expressed within the relationship between the service provider and the service recipient. A humanistic orientation was examined in the present study and was found to be an important, but not sufficient, factor to predict how people with IDD perceived themselves and their lives. According to the findings of the present study, humanism creates hope, as well as closeness in the dyadic relationship between the supporter and the supported person. It can be said that this feeling of hope and closeness is the purpose of the relationship between people with disabilities and those who care for them. The humanist perspective necessitates a level of humility among service providers. It appears that a humanistic approach among service providers can have an indirect and positive effect on service recipients’ perceptions and lives. With such an approach, supporters can encourage the cultivation of autonomy among their service recipients (Reiter, 2008).

In an attempt to understand these findings and examine how to help service providers provide tailored support which addresses the needs of their service recipients, we can utilize the International Classification of Functioning Disability and Health (ISF) model (World Health Organization, 2016). This model was created for the purpose of assisting in survey processes that would be used for categorizing people at the macro-level, but it is also currently used as a model for treatment and interventions at the micro-level. Based on a categorical diagnostic system, the model helps to define rights, policy changes, and more. A more in-depth examination of the contribution of this model suggests that it can be used for providing support and guidance on the individual level. The model suggests that IDD is dynamic and multidimensional, and is based on the assumption that every aspect of life (mental, physical, familial, social, etc.) is “connected” to all other aspects. In order to enable an overall understanding, it is not enough to acknowledge the rights of those who belong to one category or another, rather one must also recognize that the individual life of a service recipient also includes his or her needs and desires. This practical, micro-level understanding is only possible when we recognize that there is a unique dialogue that takes place in a meeting between a specific service provider and a specific service recipient. This type of meeting, when guided by a humanistic orientation, allows the service provider and service recipient to jointly assess the capabilities of the service recipient from a positive perspective.

***Implications for practice***

Study findings reinforced the changes that we have witnessed recently and attempted to redefine the goals for supporting people with IDD while, at the same time, recognizing that they are able to face challenges in their lives when they receive the appropriate support (Schalock et al., 2010). The study found that the humanist perspective has partially become incorporated into the field. In order to increase its impact, it will be important to focus efforts on training support providers on ways in which they could encourage a sense of competence in their service recipients and build a relationship that is based on mutual partnership. In order to accomplish this goal, we need to examine the ways in which we could create a change among service providers, such that they not only view their service recipients’ capabilities from an optimistic perspective, but also change their perspective about all people with IDD.

Nowadays, we are witnessing efforts focused on helping people with IDD live a full and meaningful life; however, much of the support is still focused on improving the functioning abilities of service recipients as the primary goal. Accordingly, service recipients’ skills and performance are often used as service providers’ measure of success. In accordance with the study’s findings, in order to enable change, service providers must examine their perceptions on two levels. The first level consists of their general, macro-level perceptions about the equal opportunity rights for people with IDD. The second level are their micro-level perceptions, which concern the actual interactions between the supporter and the supported person. Training programs should not solely be focused on a theoretical understanding of humanism principles and their implications for defining the rights of people with disabilities. Rather, the core of training programs should be focused on the actual interactions with individuals with disabilities. The more comprehensive and holistic the training is, the more it will enable service providers to implement the ideas underlying the humanistic orientation in their relationships with service recipients. In this context, the holistic support model, proposed by Neuman (2020) can be used. The model focuses on the cultivation of autonomy and self-determination and proposes to do so by re-examining the evaluation and support processes in regard to people with IDD. The model proposes to adopt a holistic and dynamic perspective when assessing the condition and abilities of people with IDD, which takes into account the multidimensional nature of each individual’s life. Further, the model views the reciprocal and candid interactions between support providers and recipients as the basis of the support process.

***Study limitations and recommendations for further research***

In addition to quantitative research, it is advisable to incorporate qualitative research on the current topic to more fully assess the attitudes of service providers and the perceptions of service recipients about themselves and their lives. Through the use of qualitative analyses, it will be possible to expand upon the way in which a humanistic orientation is perceived through the eyes of people with IDD, and those who support and care for them. In order to enrich our understanding of the relationship between support provider and support recipient, it is important to examine the ways in which the service recipient perceives the service provider – for example, what do service recipients expect from their service providers and to what extent are those expectations actually met. Additionally, an in-depth examination of the reciprocal dynamics between support provider and recipient may shed further light on the best ways in which to provide support to people with IDD.

Furthermore, combining both quantitative and qualitative methodology will make it possible to obtain a more “complete” picture of the future orientation and quality of life concepts. In regard to the further examination of the future orientation concept, it is recommended to consider dimensions beyond the cognitive one, including the motivational and behavioral components (Seginer, 2009). In regard to the concept of quality of life, all dimensions should be considered, including one’s health status, one’s current interpersonal and social relationships, the significance of one’s occupation in production labor, the degree of autonomy in decision-making, etc. The two key dimensions of quality of life are explicit attitudes and personal experiences; however, there is not necessarily a correlation between them (Zelekha & Zelekha, 2020).