

Dilemmas of stigma, support seeking, and identity performance in physical disability: A social identity approach

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Signature:

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ABSTRACT

Physically disabled people belong to a stigmatised group that is subject to negative societal stereotypes of incompetence and dependency on others. In order to maintain a positive sense of self, as well as receive needed support from others, physically disabled people need to continually navigate the stigma associated with disability. In so doing, they may face a number of dilemmas about how to express their disabled identity to others. The core argument of this thesis is that managing these identity dilemmas can have implications for support-seeking behaviour, as well as individual health and well-being. To develop this argument, this thesis aimed: first, to investigate the way in which physically disabled people experience their identity; second, to explore the role of stigma in shaping the experience and expression of identity among disabled individuals; and third, to elaborate a model of identity performance to describe how physically disabled people enact their identities in ways that navigate the twin concerns of stigma and accessing needed support.

Before presenting a series of studies designed to address these aims, Chapters 1 through 3 explore the existing literature and develop the rationale for the present work. Chapter 1 presents a substantive review of previous research into stigma and physical disability. This review includes studies of general attitudes about disability and toward disabled individuals from the perspective of the non-disabled, and studies documenting the experience of stigmatisation from the perspective of disabled individuals themselves. Chapter 2 presents the social identity approach as a general framework for understanding identity in the context of stigma, and for theorising links between these processes and individual outcomes in terms of health and well-being. This chapter extends the basic social identity approach by incorporating recent

thinking about identity performance, and considers the applicability of this to the disability context.

Chapters 4 through 6 present the empirical work undertaken as part of this thesis. Chapter 4 provides a qualitative investigation of the ways in which people with cerebral palsy experience stigmatisation when accessing support. These experiences demonstrate individual awareness of stigma in support-seeking contexts and that this awareness is associated with felt pressures to perform one's disabled identity in specific ways. In particular, respondents reported a tension between needing to be seen as sufficiently disabled in order to qualify for others' support, but also the need to downplay feelings of difference from non-disabled people when accessing this support. Chapter 5 explores this tension further via a series of three connected quantitative studies. Using self-report data, these studies assessed how the salience of stigma as an issue (Study 2), and the salience of specific stigmatising audiences (healthcare providers, the general public, educators and employers; Studies 3 and 4) might promote changes in how physically disabled people enact their selves, and the implications of this for subjective feelings of health and well-being, and willingness to engage in support-seeking behaviour. The key finding from these studies is that the salience of specific audiences (but not the issues to which these connect) can activate expectations of stigma in the form of negative meta-stereotypes, and that these activated stereotypes shape the form and consequences of individual identity expressions. Healthcare providers were associated with especially negative stereotypes about disabled people, and these stereotypes undermined individual health and well-being as well as willingness to engage with support. Consistent with our identity-based analysis of these processes, individual differences in identification were found to play a role in modifying responses to these salient audiences and the

meta-stereotypes these audiences activated in Studies 3 and 4. Finally, Chapter 6 presents a further qualitative investigation designed to build on the insights of the previous four studies. Specifically, Study 5 delves deeper into physically disabled people's experiences of stigma when interacting with healthcare providers, educators and employers, the behavioural pressures they felt when doing so, and the strategies they engaged to deal with those pressures. When interacting with healthcare providers, participants discussed concerns about their deservingness for care potentially being questioned, and so sought to perform their identity in ways that demonstrated their legitimacy or need for support. When interacting with educators and employers, participants were instead concerned about being devalued in terms of their competence, and so sought to demonstrate their identity in ways that amplified their capabilities. However, in enacting these performances, participants noted the possible negative implications these behaviours had for how they personally viewed themselves (and wanted to be viewed by others). In this sense, Study 5 demonstrated that disabled people face dilemmas in negotiating demands from their audience, while also attempting to maintain a positive view of their self.

In the concluding Chapter 7, a final discussion is completed in which the results from the five studies are reviewed and integrated, and the theoretical and practical contributions this work are noted.

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STATEMENT OF CANDIDATE'S CONTRIBUTION TO CO-AUTHORED PAPERS AND THESIS CHAPTERS

Chapters 4, 5 and 6 of this thesis were written as manuscripts for publication. As such, there is some overlap across chapters reflecting the intention that these can be read as independent pieces of work. Although the Candidate was the lead author on all the written work, because of the collaborative nature of the research all papers are co-authored and use the pronoun “we” rather than “I”. The specific contributions made to each paper are as follows:

The research in Chapter 4 was designed, and the final paper describing this was written up, by the Candidate under the supervision of Thomas Morton and Michelle Ryan. The Candidate carried out the study recruitment and qualitative analysis, and two undergraduate students, Chhavi Sachdeva and Emily Atkins, checked the reliability of the coded themes under the supervision of the Candidate. The paper was submitted to, and accepted for publication in, the journal *Disability and Rehabilitation*. The published version of this chapter is:

Read, S. A., Morton, T. A., & Ryan, M. K. (2015). Negotiating identity: A qualitative analysis of stigma and support seeking for individuals with cerebral palsy.

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For this thesis, Chapter 4 describes an elaborated version of the accepted paper. Some minor changes have also been made to the referencing and table included in the paper to ensure consistent APA formatting throughout, as well as modifying the language from US English spelling to UK English.

The papers in Chapter 5 and Chapter 6 entitled, “*Identity performance in response to situational stereotyping: The effect of ingroup ties, help-seeking and well-being in physical disability*” and ““*They feel that because I look a particular way, I 'should' act a particular way*”: *A qualitative analysis of situational identity performance in disabled individuals*” respectively have both been written in manuscript format, however neither has been submitted for publication at the time of submitting this thesis. Chapter 5 was designed by the Candidate under the supervision of Thomas Morton and Michelle Ryan. The Candidate carried out study recruitment, and on completion, analysed the data and wrote the paper under the supervision of Thomas Morton and Michelle Ryan. Chapter 6 was designed by the Candidate under the supervision of Thomas Morton. Two undergraduate students, Emily Atkins and Chhavi Sachdeva, under the co-supervision of the Candidate and Thomas Morton completed the participant recruitment and analysis of the qualitative data as part of their third year Psychology dissertation projects. The Candidate checked the reliability of the students’ coded themes, and completed further recruitment and qualitative analysis independently once the students’ dissertation modules had ended. The Candidate then wrote the paper, under the supervision of Thomas Morton and Michelle Ryan.

**STATEMENT OF THE SUPERVISORS' CONTRIBUTIONS TO CO-
AUTHORED PAPERS AND WRITTEN THESIS CHAPTERS**

The Candidate's supervisors, Professor Thomas Morton and Professor Michelle Ryan contributed to the written paper manuscripts by providing support and advice with the study designs and data analysis, as well as feedback with regards to the writing of all papers and thesis chapters.

Professor Thomas Morton

Professor Michelle Ryan

CHAPTER 1

STIGMA AND SUPPORT-SEEKING IN PHYSICAL DISABILITY

Imagine for a moment, a physically disabled person. What do you think they look like? What experiences and challenges are they likely to face? How would you feel towards them? Chances are, you may think they would use a wheelchair or other assistive devices, and this equipment may lead you to assume they experience difficulties with mobility. Consequently, you might feel sympathetic towards them, and might also want to provide them with help and support. Indeed, you may feel inclined to offer this regardless of whether they request it or otherwise say that they are in need.

Although these thoughts, feelings, and intentions are all positive, they nonetheless present a dilemma to the disabled individual in terms of how they should respond. On the one hand, because of the physical and health conditions associated with disability, the individual might welcome your support. Although unrequested, this support may help them overcome any barriers they might be experiencing, and may provide them with the resources or skills to allow them to live in a more independent way. On the other hand, acknowledging the need for support may amplify feelings of dependency that undermine the disabled individual's sense of self. And, through accepting support, their apparent dependency might contribute further to negative stereotypes about disabled people.

Imagine now that this disabled person was not in a wheelchair, and did not use assistive devices, but nonetheless needed some form of assistance from you. This

person is less likely to be perceived through the lens of disability stereotypes. Accordingly, they may also be less likely to elicit helpful thoughts and actions from others – at least not without having to demonstrate or justify their need. If this person decides to amplify the stereotypicality of their condition, for example by making their need salient, or highlighting the use of assistive devices, this may reduce the level of ambiguity you experience when interacting with them. But this action might also come at a cost for the disabled individual, because in so doing they have to endorse pre-existing stereotypical expectations that may not hold true for them. Conversely, acting in ways that feel more individually authentic may cut the individual off from the helpful intentions of others.

This example reveals the competing demands that disabled people face: they simultaneously strive to maintain a positive sense of self while also accessing needed support to achieve this. Likewise, they may also simultaneously strive to maintain a positive collective self-image, while also pursuing these individual goals. The primary aim of this thesis is to explore and understand these dilemmas. A second aim is to shed light on the ways in which physically disabled resolve these dilemmas. As a starting point for this investigation, this first chapter provides a substantive review of the literature on disability, stigma, and the self.

Definition of physical disability

Before embarking on the review of the relevant theoretical literatures, it is useful to provide a definition of “physical disability”. Disability is a broad concept and thus difficult to define precisely. Common definitions include disability as an impairment (either mental or physical) that promotes significant difficulties in performing day-to-day tasks and potentially reduced health and well-being (Equality

Act, 2010; World Health Organization, 2014). Physical disability is often viewed solely as an impairment that affects the mobility or movement of the individual. However, this definition is evolving to reflect something more inclusive – that mobility is just one aspect of a collective range of disabilities describing impairments which affect the physical body in some way (Dunn, Uswatte, Elliott, Lastres, & Beard, 2013). According to this broader definition, physical disability can also include epilepsy, respiratory diseases, and sensory, cognitive, and learning impairments. This thesis will use this latter description to define physical disability. Physical disabilities can be congenital, or acquired later in life, either as a result of disease or trauma, or as a consequence of natural human ageing (Dunn et al., 2013).

Despite the existence of such definitions, there is no definitive criteria by which to judge who is and who is not “physically disabled” (Bickenbach, Chatterji, Badley, & Üstün, 1999), nor is it possible to say at which point an impairment is sufficiently severe to describe someone “becoming” disabled (Olkin, 1999). Accordingly, disability is often defined subjectively, for example, through describing oneself as a physically disabled person (Fried, Ferrucci, Darer, Williamson, & Anderson, 2004). The subjective nature of physical disability – both for those who experience it, and those who observe it – is crucial to understanding at least some of the dilemmas faced by physically disabled people. For example, do disabled people feel they are “disabled”, and what are the consequences of this, both for how they see themselves and for when they interact with others (e.g., will others recognise their disability)?

Despite its somewhat subjective nature, physical disability has clear consequences. Physically disabled people are more likely than the non-disabled community to experience a variety of adverse health effects. These include: increased

risk of asthma, arthritis, cardiovascular disease, heart disease, high blood pressure and cholesterol, and stroke (Reichard, Stolzle, & Fox, 2011). Because of these health risks and other associated difficulties (e.g., with mobility), physically disabled people also have access to a number of supports that are not available to the rest of society, ranging from formal care, such as medical support and disability welfare or monetary payments, to informal support, such as social support from family, friends, and other disabled people (Sapey, 2001). This support can offset some of the negative health conditions associated with physical disability, including: improving psychological and physical health, and the recognition and treatment of previously undiagnosed comorbid disabilities (e.g., Robertson, Hatton, Emerson, & Baines, 2014), as well as potentially reducing the physical impairment itself (e.g., Liu & Latham, 2011). Support also provides physically disabled people with resources to achieve and maintain a desired level of competence and independence (Charlton, 2000). Indeed, an inability (or refusal) to access support can have detrimental effects on health and quality of life among physically disabled people (e.g., Cornally & McCarthy, 2011). Thus, while disability is not defined by the support that one accesses, accessing support is a routine and important issue for people who experience physical disability.

Stigma, stereotypes, and support-seeking

Although accessing support plays a vital role in the lives of many physically disabled people (Braithwaite & Eckstein, 2003; McLaughlin, 2012; Nadler & Maysseless, 1983), disabled people are also likely to experience a number of barriers when deciding to access support. These barriers can be practical, such as lack of availability of appropriate care (Beatty et al., 2003), but they can also be psychological, such as when the process of accessing support is stigmatising and

undermines the individual's willingness to access needed resources (Lee, 2002).

While the practical barriers on physical disability support are well known, stigmatisation as a barrier to accessing support has largely only been explored with mental illness (e.g., Barney, Griffiths, Jorm, & Christensen, 2006; Corrigan, 2004; Mickelson, 2001; Schomerus & Angermeyer, 2008). Accordingly, relatively little is known about how stigma affects support access among physically disabled people. This issue of stigma and support seeking is at the heart of this thesis.

In its simplest term, a stigma is “an attribute that is deeply discrediting” (Goffman, 1963; p. 204). Stigma as a concept is universal; every society has defined norms about what is and is not acceptable, and has controls in place that ensure the majority of society conforms to these norms (G. Becker & Arnold, 1986). Individuals who do not conform are subject to stigmatisation (G. Becker & Arnold, 1986; Goffman, 1963). Stigmatisation classically involved inflicting a physical mark on individuals who had behaved in a way that was counter to the expectations of society, in order to signify their devalued status (Berjot & Gillet, 2011; Goffman, 1963). Although explicit physical marking rarely occurs in modern societies, stigmatisation nevertheless remains, and individuals who hold specific devalued traits can come to be socially or psychologically marked as different from the rest of society (E. E. Jones et al., 1984). The traits that give rise to stigma can be visible or invisible (Major & O'Brien, 2005), and can vary according to their salience, appearance, disruptiveness in interactions with others, origin (congenital or acquired), and threat to others, for example, if there is a risk of contagion (E. E. Jones et al., 1984). Although varied and situational, the treatment stigmatised people experience is not due to them as individuals, but rather the negative connotations of the mark that is assigned to them by others (Biernat & Dovidio, 2000).

Once a trait is associated with stigma, the meaning and social significance it acquires, can be explained through the process of social categorisation. Psychological theory suggests that people seek to order and simplify their social environment by selectively grouping similar stimuli (e.g., people) into specific categories of interest (Tajfel, 1978a; Tajfel & Forgas, 1981). As people begin to understand their social surroundings, they will recognise similarities between particular individuals, for example, how they look, their attitudes, and how they behave, and this information forms the content (both positive and negative) by which people selectively assign others to groups. Consequently, people can look for behaviours and cues that are representative of particular groups, rather than individualised information about every person they see (Allport, 1954; Tajfel, 1978c), for example, categorising all individuals who use a wheelchair as being a disabled person.

Assigning an individual to a category (e.g., disability), in turn, forms the basis of stereotyping. Following categorisation, the observer's stored knowledge about this group's attributes is activated to create a clear expectation of the individual in question (L. C. Brown, 2013; Tajfel & Forgas, 1981). Activated stereotypes promote expectations about the individual and how they will behave. Where these expectations are negative, this may lead to a devaluing of the individual. Where these devaluing expectations are widely shared and routinely activated, this can contribute to stigmatisation, whereby the individual becomes socially marked and excluded by others (Biernat & Dovidio, 2000; Goffman, 1963; E. E. Jones et al., 1984). Stereotypes therefore form a crucial part of how society cognitively interprets stigma, as well as the associated feelings and behaviours that result on seeing the stigmatised individual (e.g., Corrigan, 2000; Dovidio, Major, & Crocker, 2000; Park, Faulkner, & Schaller, 2003). The experience of stigma also shapes the psychology of the target.

Specifically, awareness of negative stereotypes about the groups to which one belongs, leads to expectations about how one is likely to be treated in interactions with others, and activates a range of different strategies for dealing with those expectations (see Barreto & Ellemers, 2015, for a recent overview).

Stereotypical attitudes towards physical disability

Physically disabled people belong to a group that is highly stigmatised and devalued by society (L. C. Brown, 2013). Physical disabilities, and the assistive devices physically disabled people may use (e.g., wheelchairs), are often very visible, and the relative rarity of these conditions makes them highly salient when encountered (Asch & Fine, 1988; Biernat & Dovidio, 2000; L. C. Brown, 2013; E. E. Jones et al., 1984; Katz, 1981). As a consequence, physical disability is readily marked; and is typically viewed as a “master status” (Frable, 1993; Frable, Blackstone, & Scherbaum, 1990) – that is, a characteristic that is the sole focus of an observer’s attention at the expense of other less overt traits (Goffman, 1963). Consistent with this, non-disabled people often rate a person’s disability as their most salient attribute, and the one that they are most drawn to (Asch & Fine, 1988; L. C. Brown, 2013). Disability is even selected as a person’s most defining feature - above other devalued attributes such as ethnicity and gender (Louvet & Rohmer, 2006; Rohmer & Louvet, 2009). Because of this master status, physical disability is powerfully identity-determining: stereotypical knowledge is quickly applied to the physically disabled individual by their observer (Goffman, 1963).

Unfortunately, there are many negative stereotypes associated with physical disability, and it is these attitudes that are often documented as the primary reason for the (negative) treatment physically disabled people receive (DeJong & Lifchez, 1983;

Fenderson, 1984; Wright, 1983). For example, disabled individuals are typically classified as “medically abnormal”, and therefore as people who are diseased, sick, or defective (Hirschberger, Florian, & Mikulincer, 2005; Park et al., 2003). This diseased or deficient status means that they are also likely to be perceived as somehow redundant and expendable to the rest of society (Charlton, 2000), which in turn, can encourage practices of physical and verbal violence, neglect, infanticide, mercy killings, abortion, as well as corrective surgeries and rehabilitation (Charlton, 2000; Finlay & Lyons, 2000; Garland-Thomson, 2013; Mason, Pratt, Patel, Greydanus, & Yahya, 2010).

Despite the documentable negativity towards disabled individuals, stereotypes and behaviours associated with this group are not universally adverse. Instead, there has been a cultural shift towards viewing physically disabled people more favourably (Heinemann, 1990), and hostile prejudice and discrimination towards disabled individuals is now generally viewed as unacceptable (Deal, 2007). This does not, however, mean that disability stigmatisation has been eradicated or even reduced. What has changed is that discriminatory behaviours towards physically disabled people have become more subtle (Barnes, 2010; Deal, 2007). For example, physically disabled people are often stereotyped as almost entirely non-threatening. They are perceived as vulnerable, dependent, unattractive, asexual, and passive (Fichten & Amsel, 1986; Hebl, Law, & King, 2010; Linton, 2010; Nario-Redmond, 2010; Robey, Beckley, & Kirschner, 2006; Rojahn, Komelasky, & Man, 2008), as well as lacking in competence and intelligence (Nario-Redmond, 2010; Rohmer & Louvet, 2012). Assumptions of a lack of education, unemployment, and welfare dependency are also common (Taleporos & McCabe, 2002). At the same time, physically disabled people

can be perceived as being undeserving of their condition (Hebl & Kleck, 2000), and are thus treated as victims (Lynch & Thomas, 1999).

The identity of victim can encourage perceptions of disabled people as being courageous and inspirational (Charlton, 2000; Nario-Redmond, 2010), and therefore deserving of warmth, admiration, sympathy, and compassion (Heinemann, 1990; Makas, 1988). Indeed, research has demonstrated that physically disabled people are consistently rated as more likable, hard-working, and helpful by non-disabled individuals (Bailey, 1991; Mullen & Dovidio, 1992, as cited in Dovidio, Pagotto, & Hebl, 2010). These impressions are, however, paternalistic, and may therefore also encourage physically disabled people to be viewed as objects of pity who require more support and assistance than non-disabled individuals (Katz, 1981; Weiner, 1993, 1995, 1996; Weiner, Perry, & Magnusson, 1988). For example, when asking for a small amount of change, the general public were more likely to provide it when the individual making the request was in a wheelchair (Taylor, 1998). Similarly, when requesting time and assistance to complete a disability research project, non-disabled people were more willing to interact with an experimenter who kept her leg prosthesis overtly visible, than when she concealed it (Cacciapaglia, Beauchamp, & Howells, 2004). In addition, significantly fewer non-disabled people were observed parking in disabled car parking spaces (i.e., parking violation) when a wheelchair user was close by (Taylor, 1998).

Non-disabled attitudes towards physical disability can therefore be seen to be highly ambivalent – that is, they contain both positive and negative elements (Conner & Sparks, 2002; Fiske, 1998; Fiske, Xu, Cuddy, & Glick, 1999; Fiske, Cuddy, Glick, & Xu, 2002; Gibbons, 1985; Heinemann, 1990; Katz, 1981; Vilchinsky, Werner, & Findler, 2010). The ambivalence towards physical disability has remarkable

consistency across many countries and cultures (Cuddy et al., 2009). It is this paternalistic ambivalence that many disability scholars believe is the cause for much of the oppression experienced by physically disabled people (Charlton, 2000). Paternalism provides a motivation to ensure that disabled people are treated and responded to favourably (e.g., by offering support), but reinforces beliefs that disabled individuals are unable to control their own lives, and therefore must be viewed as child-like and protected, which in turn, confirms negative assumptions about their competence and dependency (Archer, 1985; Charlton, 2000). Paternalism also forms the basis for the focal dilemmas we discussed at the start of this Chapter: that is the dilemma of accessing needed and desired support from others, while also protecting the self from the negative consequences of requesting or needing this support.

Experiences of stigmatisation

Having established that physically disabled people are devalued in society, it becomes interesting and important to consider how disabled individuals experience and respond to the devaluing attitudes they face (Kutner, 2011). Unfortunately, the perspectives of physically disabled people (and indeed, individuals from many other stigmatised identities, at least until recently), have largely been ignored by research on these issues (Charlton, 2000; King, Hebl, & Heatherton, 2005; Kleck, Hebl, & Hull, 2000; Swim & Stangor, 1998). This is especially surprising since physically disabled people view stigma as a significant concern (Green, Davis, Karshmer, Marsh, & Straight, 2005; R. A. Scott, 1981) and as something that is central to their own identities and experiences (Phemister & Crewe, 2007).

Physically disabled people are likely to be aware of the paternalistic stereotypes that others hold about them. Expecting their competence and assumed

dependency to be at the forefront of interactions with others, can lead to a personal sense of difference and frustration (Charlton, 2000; Dovidio et al., 2010; Hebl, Tickle, & Heatherton, 2000; E. E. Jones et al., 1984). As a consequence, physically disabled people are often sceptical about the true motivations of those they interact with, and may be tempted to interpret innocent behaviours as evidence of hostile attitudes (Dovidio et al., 2010; Hebl & Kleck, 2000; Hebl et al., 2000). Aside from this interactional ambiguity, physically disabled people may also experience difficulty in interpreting specific negative experiences. For example, when negativity is experienced, it may still be difficult for the disabled individual to know with certainty whether this was because of their stigmatised status, or due to other factors (e.g., ‘was I offered support because the task was difficult, or because they saw me as disabled?’ or ‘was I rejected from a job interview because I did not have the skills that the employers were looking for, or because I am disabled?’; Crocker & Major, 1989).

In sum, physically disabled people are likely to be familiar with the ambivalent stereotypes about them. Awareness of these attitudes, in turn, can create difficulties in deciphering the environment and the motivations of their interaction partners. However, while this may be true in a general sense, there are also specific audiences with which disabled people interact frequently, and that raise more specific concerns about how they might be being perceived. These audiences include: a) providers of formal support (e.g., healthcare providers); b) members of staff in educational contexts, and; c) (potential) employers in the workplace environment (Asch & Fine, 1988, 1997; Olkin, 1999). In the sections that follow, we consider the issues raised by each of these more specific audiences.

Healthcare and support

Research suggests that healthcare providers (e.g., doctors, nurses, occupational therapists, physiotherapists, and medical students) can demonstrate positive attitudes towards disability in terms of highlighting the important role of disabled people in society, as well as the contributions they can make (e.g., Au & Man, 2006; Goreczny, Bender, Caruso, & Feinstein, 2011; Paris, 1993; ten Klooster, Dannenberg, Taal, Burger, & Rasker, 2009; Tervo, Palmer, & Redinius, 2004). However, research also suggests that healthcare providers may hold certain negative beliefs about disability, may not fully understand individual conditions, and may in turn promote a number of misconceptions (Drainoni et al., 2006; Lam et al., 2010).

Within the healthcare professions, the focus is often on the medical approach to disability – that is, the perspective that disabilities should be treated as illnesses and viewed as a burden that needs to be alleviated or resolved (Byron & Dieppe, 2000; Goreczny et al., 2011; Martin, Rowell, Reid, Marks, & Reddihough, 2005; Sapey, 2001; Wolff, 2009). These negative beliefs have been shown to promote specific stereotypes about patients. For example, when trainee healthcare providers watched a training video of a patient requiring use of a wheelchair or not, participants rated the wheelchair user as more sick, passive, weak, and dependent on others, as well as less competent and intelligent (Gething, 1992). Healthcare providers have also been found to devalue physically disabled people on many other dimensions, including: assumptions of asexuality, emotional instability, as well as lacking ambition and confidence (H. Becker, Stuijbergen, & Tinkle, 1997; Gething, 1992). Indeed, negative stereotypes are so prevalent in the healthcare context that providers can hold more negative attitudes towards disability than family members and individuals with no connection to disability (Rohmer & Louvet, 2004).

This simultaneous positivity and devaluation of physical disability by healthcare providers may create difficulty when interactions with disabled people are required. Specifically, while healthcare providers hold largely positive attitudes in terms of paternalistic sympathy, they may also experience negative feelings of discomfort, fear, and anxiety when interacting with disabled people (A. Brown et al., 2009; Satchidanand et al., 2012). These feelings may promote a reluctance to communicate with physically disabled people in a general sense (e.g., Martin et al., 2005), or about specific health concerns the patient has raised (e.g., Tervo, Azuma, Palmer, & Redinius, 2002).

This potential reluctance to engage also exists within support contexts outside of the healthcare domain, such as social support in the general public. Specifically, although there is a social acceptability for helping disabled people when required (Hastorf, Northcraft, & Picciotto, 1979; Heinemann, 1990), because of the ambivalent stereotypes, non-disabled people experience significant ambiguity regarding a) whether and how they should respond; and b) whether they are appropriately competent or knowledgeable to complete this request satisfactorily (Belgrave & Mills, 1981; Mills, Belgrave, & Boyer, 1984; Saucier, McManus, & Smith, 2010). Consequently, non-disabled people may experience feelings of anxiety and wanting to avoid providing help for those who need it (Pryor, Reeder, Monroe, & Patel, 2010; Saucier et al., 2010), and may be reluctant to form social and personal support relationships because of the assumed difference associated with disability (Goreczny et al., 2011).

When physically disabled people discuss their personal experiences of stigmatisation when accessing support, they often report that individuals responsible for providing care hold very limited knowledge of their disability and needs (e.g., H.

Becker et al., 1997; Iacono, Humphreys, Davis, & Chandler, 2004). This lack of knowledge may contribute further to problematic interactions through the provision of support and assistance that is inappropriate to the individual's needs (Buzio, Morgan, & Blount, 2002; Cahill & Eggleston, 1995; Gibson & Mykitiuk, 2012; Kroll & Neri, 2003). Receiving inappropriate help can trigger feelings of being ignored by healthcare providers, and concerns about being treated differently from other patients (Balandin, Hemsley, Sigafos, & Green, 2007). Indeed, if assistance is offered that is deemed to be patronising, inappropriate, or excessive, physically disabled people may feel they have no option but to reject it in order to protect their sense of self (H. Becker et al., 1997; Braithwaite & Eckstein, 2003; R. A. Scott, 1981). However, if they decide to reject this support, then they may be exposed to hostility from the helper, who may interpret rejection as illegitimate, unjust, or personally unfair given their positive intentions. This may make it more difficult for them to make future requests for help (Braithwaite & Eckstein, 2003; Wang, Silverman, Gwinn, & Dovidio, 2015).

In sum, within the healthcare and support contexts, individuals responsible for providing both formal and informal care have been shown to view physically disabled people favourably. However, at the same time, medicalised beliefs remain. These may lead to negative attitudes and stereotypes regarding the health and competence of disabled patients. Because of the stereotypes and misconceptions about physical disability, support may be provided that is unsuitable for the needs of the disabled individual. Consequently, physically disabled people may experience stigmatisation and even reluctance to access needed care.

Education and the workplace

Disabled people experience a chronic lack of educational attainment. When compared to non-disabled people, disabled individuals are significantly less likely to have further education or degree level qualifications, and are significantly more likely to have no educational qualifications at all (M. K. Jones & Sloane, 2010). Besides the educational penalty, disabled people are also at a significant disadvantage when seeking employment (Berthoud, 2011) and they are 46% less likely to be employed than non-disabled individuals (Berthoud, 2008). Those who are able to obtain employment are more likely to be assigned to positions where they are overly qualified (M. K. Jones & Sloane, 2010; Smith, 1996), and are likely to receive a reduced salary (M. K. Jones, 2008), to be less likely to be promoted (Smith, 1996), and are also much more likely to leave their profession (Rigg, 2005) compared to their non-disabled colleagues.

Although multiple barriers contribute to under-representation of disabled people in work (Smith, 1996), prejudice and discrimination are concerns in these contexts. Like the other contexts described in this Chapter, attitudes associated with disabled individuals in education and the workplace encompass both positive and negative attitudes (Deal, 2007; Louvet, 2007). On the one hand, the contribution and skills of physically disabled people in these contexts is (overtly) valued by non-disabled people. For example, physically disabled people may be viewed as having more favourable personality characteristics, and are believed to be more hardworking and to show greater effort, when compared to a non-disabled applicant (B. S. Bell & Klein, 2001; Bordieri & Drehmer, 1986; Christman & Slaten, 1991; Nordstrom, Huffacker, & Williams, 1998). Accordingly, disabled individuals can be recommended for employment and even for a greater salary. However, these positive

attitudes often reflect social desirability (Christman & Slaten, 1991; D. L. Stone & Colella, 1996), and can disguise underlying negativity. In particular, physically disabled people are frequently devalued in terms of their competence (Louvet, 2007; Louvet & Rohmer, 2010) and expected job performance (Ren, Paetzold, & Colella, 2008), as well as being seen as unqualified and incapable for specific positions (Silverman, Gwinn, & Van Boven, 2015; D. L. Stone & Colella, 1996), or even simply unemployable (Stern & Mullennix, 2010). Rohmer and Louvet (2006) have shown that regardless of qualifications and suitability for a specific job as described in a curriculum vitae, disabled applicants are viewed as less professionally qualified when compared to non-disabled candidates. Disabled people are also less likely to be interacted with, receive less workplace training, and receive less contact outside of these environments when compared to their non-disabled colleagues (Rusch, Wilson, Hughes, & Heal, 1995). Non-disabled people have also been shown to report discomfort when they believe that they will have to work with physically disabled partners (Berry & Meyer, 1995).

Within the academic context, when asking participants for directions on where to exchange textbooks, individuals in a wheelchair received significantly more directional words, and received a significantly longer communication when compared to ambulatory individuals (Gouvier, Coon, Todd, & Fuller, 1994). Moreover, non-disabled people will also provide more positive communication and feedback when working collaboratively with physically disabled people to complete tasks (Hastorf et al., 1979). While these studies appear to refute the above assumption that work and education colleagues will attempt to avoid interactions with physically disabled people, the increased information provided suggests that they are treated differently as a consequence of their disability status. Overall, these contradictory findings give

further weight to the attitudinal ambiguity that educational and work colleagues experience when interacting with physically disabled people.

Ambivalent attitudes may lead non-disabled people to discriminate against disabled individuals in subtle ways (Deal, 2007). Stereotypes and preconceptions about disability are often used when deciding whether physically disabled applicants should be selected for workplace positions (Gouvier, Sytsma-Jordan, & Mayville, 2003). For example, Louvet (2007) requested that students evaluate the suitability of one of two equally qualified applicants (either physically disabled or non-disabled) for either sales or accounting positions. Participants reported that the physically disabled applicant was less desirable for the sales job requiring significant public interaction, but not to the accounting position requiring less interaction. Similarly, Crocker and Major (1994) presented two candidates to participants: a facially scarred individual, and a wheelchair user. When assigning either a receptionist or a box-stacking role to these individuals, participants believed that for the facially scarred applicant, their disability would significantly interfere in the receptionist position (associated with face to face interaction with others), whereas the wheelchair would significantly interfere with box-stacking (associated with physical competence). In other words, participants felt it was more fair, legitimate and justifiable to deny these physically disabled applicants their respective positions, thereby potentially endorsing discrimination when preconceptions about disability are activated.

In an attempt to overcome these kinds of differential responses to the disabled, in many countries it has become unlawful to discriminate on disability grounds (e.g., UK Disability Discrimination Act, 1995, and Equalities Act 2010, and the USA Americans with Disabilities Act (ADA), 1990). Within these laws, inclusion of disabled people is actively encouraged, and organisations are legally obliged to ensure

appropriate workplace and educational support and accommodations be put in place (e.g., Colella & Bruyère, 2011). For example, in the context of education this might include altered examinations to ensure that any barriers restricting performance are removed (e.g., providing disabled students with extra time to complete their examinations; Sireci, Scarpati, & Li, 2005). Even with these laws in place, however, little change has been observed in improving disability equality (e.g., employment rates; D. Bell & Heitmueller, 2009; Hoque, Bacon, & Parr, 2014). This may be because employers are often unwilling or hesitant to provide such disability support for three main reasons: a) the perceived significant financial burden of purchasing accommodations (Kaye, Jans, & Jones, 2011); b) the assumed imposition that such equipment or support will cause for non-disabled colleagues (Baldrige & Veiga, 2006); or c) employers may question the legitimacy or severity of a disability, and therefore the apparent need for such support, as well as the benefits it will provide the disabled individual (Colella, 2001; Williams-Whitt, 2007). Additionally, if non-disabled colleagues recognise that their employer is providing accommodations to disabled people, this may promote feelings that *they* are being unfairly disadvantaged. Specifically, Paetzold and colleagues (2008) noted how non-disabled students perceived that denial of educational support for disabled people was *more* fair than when it was provided, particularly if they believed that the disabled person was already performing well.

Disabled people are also likely to be aware of how their group membership might adversely affect their educational and employment prospects, with many reporting that they had experienced either stigmatisation or overt discrimination in the workplace (e.g., Grewal, Joy, Lewis, Swales, & Woodfield, 2002; L. Snyder, Carmichael, Blackwell, Cleveland, & Thornton, 2010; Vedeler, 2014; Wilson-

Kovacs, Ryan, Haslam, & Rabinovich, 2008) and educational environment (e.g., Goode, 2007; Low, 1996; Olney & Brockelman, 2003; Taub, McLorg, & Fanflik, 2004). Physically disabled people's experiences in the workplace often encompass having to navigate employees' ambivalent attitudes recognising that they are "inspirational" for having triumphed over adversity by succeeding in education or gaining employment, while at the same time, also surprise and scepticism that they are able to complete their job requirements effectively (J.-A. Scott, 2010). Because of these attitudes, it may be difficult for physically disabled people to effectively judge their suitability for education or work, which, in turn, may make them constantly aware of their performance (J.-A. Scott, 2010). For example, in the workplace, disabled people may experience a chronic fear of making errors, as any mistakes reinforce personal (and others') concerns regarding their apparent lack of competence, and working ability (Smith, 1996; D. L. Stone & Colella, 1996). Within the educational context, similar experiences are reported. For example, Wang and Dovidio (2011) found that when disabled students were primed with their disability identity rather than their student identity, they activated fewer autonomy-related terms, particularly among those who also reported higher levels of stigma consciousness. This suggests that disabled students may have internalised aspects of the stigma associated with their condition.

The internalisation of stigma-relevant attributes can lead to behavioural displays that feed back into the source of stigma. For example, in the previously described study (Wang & Dovidio, 2011), individuals who activated fewer autonomy-related terms were also more likely to request support from others to complete an additional academic task, thereby behaving with less autonomy. However, the opposite reaction can also occur, and physically disabled people may sometimes be

less willing to accept help and support when pre-existing stereotypes about their lack of autonomy or competence could be confirmed (Hansen, 2008). Physically disabled people may also be unwilling to access support if the accommodations that are required draw attention to their individual (and therefore different) needs to the rest of the workforce – something that many find stigmatising in and of itself (S. D. Stone, Crooks, & Owen, 2013). Consequently, while support may be desired to increase physically disabled people's sense of competence and social participation, these potential benefits may be considerably outweighed by feelings of stigmatisation that follow from accepting support (e.g., Baldrige & Swift, 2013; Barnard-Brak, Lechtenberger, & Lan, 2010; S. D. Stone et al., 2013).

In sum, within the contexts of education and the workplace, physically disabled people are exposed to highly ambivalent stereotypes. On the one hand, non-disabled individuals within these environments appear to overtly promote inclusion of disabled individuals, for example, praising their personality and effort. On the other hand, non-disabled people also devalue physically disabled colleagues in terms of their competence and suitability for employment. This devaluation may also encourage non-disabled people to view workplace discrimination against physically disabled people as acceptable. Because of the difficulty disabled people have in terms of accessing educational and workplace opportunities, as well as the stigmatisation and negative attitudes that they face, they may be reluctant or refuse to access available accommodations that may allow them to overcome barriers to inclusion.

Chapter summary

In this chapter, we have compiled a substantive review of the stigmatisation of physical disability and support-seeking, both from the perspectives of non-disabled

individuals, as well as the experiences from physically disabled people themselves. Specifically, general attitudes towards physical disability often reflect paternalistic positivity, whereby favourable views of pity and sympathy are shown, as well as a motivation to ensure that disabled people have access to desired help and support. While this paternalism may be viewed with positive intentions, it is activated as a consequence of pre-existing beliefs regarding disabled people's lack of competence and possibility for future opportunities.

These attitudes also have specific situational meanings and interpretations, particularly within the contexts of healthcare, education and the workplace. Within the healthcare environment, ambivalent attitudes combine with limited knowledge or inappropriate attitudes regarding disability, such as by viewing specific conditions as illnesses or diseases that need to be cured. Within education and employment, ambivalent attitudes may be shown through highlighting the positive skills or attributes disabled people bring to these environments, while concurrently devaluing their competency and suitability for educational or workplace positions.

In highlighting the ambivalent attitudes directed at physical disability, we have also demonstrated that physically disabled people themselves are aware of their status in society. The ambivalence they face can encourage feelings of stigmatisation, particularly when attempting to access needed support in the healthcare environment, and the educational and employment contexts. It is this key issue that forms the focus of this thesis: how physically disabled people negotiate accessing support while protecting their sense of self from the possible stigma associated with this support.

CHAPTER 2

STIGMA AND IDENTITY PERFORMANCE IN PHYSICAL DISABILITY: A SOCIAL IDENTITY APPROACH

Chapter 1 described the attitudes physically disabled people have to negotiate in their daily lives. We noted that attitudes towards physically disabled people are ambivalent: although non-disabled people may express sympathy and positive intentions towards the disabled, this positivity is underpinned by paternalism and disabled people are stereotyped as passive, incompetent, and dependent. We also noted that positive attitudes might be largely expressed to conform to social expectations, but might not be fully enacted (e.g., denying disabled people employment based on assumed disability). This results in a discrepancy between the apparent valuing of disabled individuals, while behaving in ways that contribute to on-going discrimination and even hostility towards this group. Importantly, these mixed attitudes are evident among the general population, as well as in specific settings for disabled individuals, namely in the contexts of healthcare, education, and employment. Finally, disabled individuals are aware of the ambivalent attitudes they trigger and the awkward interactions these create.

What we also noted in Chapter 1 is that such attitudes can also create dilemmas for disabled people themselves about how exactly to respond. On the one hand, in response to the negative side of social attitudes, physically disabled people might want to distance themselves from negative attitudes about the disabled group. These people might seek to downplay or hide their disability as a means to asserting

their individual competence and independence. On the other hand, disabled individuals often do need the help and support of others, and might need to activate the positive, although paternalistic, attitudes that could encourage supportive action from others. These people might, therefore, highlight disability and need as a way of conforming to the stereotypic perceptions that elicit other's help. These desires to avoid stigma while simultaneously activating support might feel contradictory and create dilemmas for disabled individuals in terms of how they should behave, and what this might mean for how they are viewed and treated by others.

This chapter builds on these insights and explores how physically disabled people may respond to the stigma and stereotypes they face, and how an awareness of these stereotypes may influence how they enact their self and their identity. To develop this theoretical perspective, we draw on the social identity approach, which encompasses both social identity theory (Tajfel & Turner, 1979, 1986) and self-categorisation theory (Turner, Hogg, Oakes, Reicher, & Wetherell, 1987). Specifically, we focus on the social identity model of deindividuation effects (or SIDE model; Reicher, Spears, & Postmes, 1995), which extends and applies the social identity approach to contexts in which identity is performed to others (O. Klein, Spears, & Reicher, 2007). Within this theoretical discussion, we will highlight the distinction between personal identity and social identity, and how incorporating these respective identity dimensions as part of the self can have a significant influence over individual thoughts, feelings, and actions. We will also highlight how awareness of the stereotypes and group-based expectations of others may frame the ways in which physically disabled people demonstrate their identity in ways that either refute the relevance of stereotypes for personal identity, or refute the validity of stereotypes for collective identity. We will argue that disabled people may enact a fluid identity that

is by driven context, whereby different behaviours may be activated according to the specific audience they interact with, and the associated stereotypes that are evoked.

We will then finally highlight how physically disabled people may experience situational dilemmas in accordance with these contextual factors, both in terms of whether and how they can access support, as well as how they may navigate stigmatisation.

Physical disability, identity, and the social identity approach

An individual's self-concept, or the beliefs that they have about themselves, is created by the interplay between individual motivations and their social surroundings (Tajfel, 1974; Turner, 1982). In making sense of their environment, people have a desire to maintain a positive self-concept, and they achieve this via incorporating valued personal attributes, or valued social group memberships, into their overall identity (Abrams & Hogg, 1988; Baumeister, 1999). The social identity approach (SIA) focuses specifically on the role that group membership plays in the self-concept, and how the group guides individual thought, feeling, and action in the social world. Specifically, the SIA proposes that identity exists on a continuum between the *personal* and the *social* dimensions (Turner, 1982). Personal identity relates to how people view and describe their individual self, whereas social identity reflects "that part of an individual's self-concept which derives from his [or her] knowledge of his [or her] membership of a social group (or groups) together with the value and emotional significance of that membership" (Tajfel, 1981, p. 255). When individuals define themselves according to their personal identity, they are likely to view themselves based on their own personal traits and uniqueness in comparison to others, and through this, behave in ways that benefit them as an individual. When a social

identity is activated, thoughts and behaviours become more group-focused – that is, people are motivated to respond as a group member (Doosje, Ellemers, & Spears, 1999). These motivations can be thoughts or behaviours that benefit their social group and its members (i.e., group collaboration), or in ways that promote distinctions between their group and others (i.e., social competition).

Individuals can be members of many different groups, for example, family or friendship networks, as well as sports teams to name just a few. Each one of these groups can play an important role in how people view themselves and others. Individuals can also define themselves in terms of many different specific attributes, for example being a helpful, competitive, or friendly person. Which group membership (or personal attribute) becomes the basis for self-definition and guides action is theorised to be a product of the immediate social context, and specifically the comparisons that are made between one's own group (or the individual self) and relevant other groups (or individuals) that are present in one's environment. For example, in certain situations, individuals will be most aware of themselves as individuals, such as when the context is clearly interpersonal or when they are interacting with other individuals within a specific group. In these situations, their self-understanding will reflect the comparisons they make with those others – that is whether they are better or worse than them on some dimension (e.g., W. M. Klein, 1997). In other situations that are more clearly intergroup rather than interpersonal, such as when people attend a sports event as members of a particular team, they will be more inclined to view themselves collectively and derive their attributes from the comparisons they make with other groups – for example, whether they are collectively better or worse on some important dimension (e.g., Rabinovich, Morton, Postmes, & Verplanken, 2012). The theory also assumes that the salience of social

identity (i.e., defining one's self as a group member) reduces the salience of personal identity (i.e., the awareness of the self as a unique individual), although this specific point has proven to be controversial and contested within the theory (e.g., see Postmes & Jetten, 2006).

The SIA can be brought to bear on the experience of physical disability, and the role this plays in shaping the self-concept of disabled people. Disability identity refers to how people define their sense of self according to their condition (Darling, 2013). Disability identity is fluid and can take a variety of forms (Rapley, Kiernan, & Antaki, 1998; Watson, 2002). On the one hand, a physically disabled person may emphasise his or her personal identity by emphasising their uniqueness from others within the disabled community. On the other hand, disability activists have successfully produced social change on behalf of the disabled community (e.g., Charlton, 2000, 2010), revealing that disabled people can, and often do, identify in terms of a social group bound by common concerns (i.e., a shared social identity; e.g., Gill, 1997; Linton, 2010). Disability social identities can be condition-specific (e.g., "people with cerebral palsy"), or more inclusive of the wider disability community (Ablon, 2002), and can provide a sense of solidarity and access to support and guidance that is often desired by many disabled people (Anderson, 2009; Darling, 2013; Dunn & Burcaw, 2013; Mejias, Gill, & Shpigelman, 2014; Wright, 1983).

Following the theory, how (and when) physically disabled people choose to identify along this continuum from the personal to social identity is likely to influence how they perceive, and behave in relation to the group (Tajfel, 1978b; Tajfel & Turner, 1979). Disabled people can either behave in ways that benefit themselves as individuals, or they can act for the benefit of the group and attempt to improve the standing of disabled people in society (Ablon, 2002). Moreover, as with many

identities, physically disabled people are likely to be more aware of their disability status in certain contexts than others (Green et al., 2005). For example, in situations designed to encourage community action or spirit (e.g., disability sport; Anderson, 2009), disabled people may be more aware of their collective ties to this group, and as a consequence, behave according to their disability social identity as opposed to their personal identity. In other settings, for example within their family, the personal identity beyond disability may be more salient and structuring of the self. In other contexts, for example when receiving individual disability treatment, the exact priority of the personal versus the social identity is unclear and likely to vary across individuals and according to the specific features of treatment settings.

Although multiple individuals belong to any given group, they do not all enact this group identity to the same extent or in the same way, and therefore, individual differences play a role in the expression of social identity. Specifically, the degree to which people “socially identify” as a group member (i.e., group identification) is an individual factor that determines the level of importance they attach to the social group in question (Hogg & Abrams, 1988; Jetten, Spears, & Manstead, 2001). Individuals who identify strongly with a given group are more likely to routinely think about themselves in those terms, and to routinely act in ways that reflect collective interests (e.g., Branscombe & Ellemers, 1998). Individuals who identify less strongly with a group are less inclined to do this, at least not without other incentives, and may even react and work against the group interests of the collective identity (e.g., Jetten, Branscombe, Spears, & McKimmie, 2003).

Individual differences in social identification can also be further broken down along specific sub-dimensions: how central, focal or important the collective identity is to the individual; the level of ties or connections felt with fellow group members,

and; the valence of emotion associated with the group (Cameron, 2004; Ellemers, Kortekaas, & Ouwerkerk, 1999; Leach et al., 2008). In this sense, individuals with strong social identification are likely to view this group membership as a focal and important aspect of the self, and they are also likely to experience a bond or sense of community with the group, as well as associating group membership with positive emotions. To elaborate this using the previous sports team example, while many people can belong to a particular sports team, the specific meaning of this team, as well as how positively they view other team members, will likely change from person to person. Individuals who feel that this team is more important to them, and also feel a positive connection with other team members, are likely to show high social identification, and as such, will likely behave in ways that benefit the sports team, as well as its players and supporters (e.g., by attending games as much as possible). Conversely, individuals who do not feel that this team is an important part of their life, nor do they feel a sense of bond or community with its members, are less likely to define themselves as having social identification, and so instead will behave in ways that benefit their individual self, rather than their sports team (e.g., by attending games less frequently, such as only when their good friends will also be there with them).

Again, applying these ideas to the context of disability, individuals may experience and enact this identity very differently depending on their levels of social identification. Disabled people with low social identification may seek to distance themselves from their disability identity, whereas high identifiers may instead wish to remain with the disabled group and want to participate in collective behaviours to benefit the group as a whole (Nario-Redmond, Noel, & Fern, 2013). Although distancing the self from the group has the benefit of highlighting personal identity

(and the associated independence often desired by disabled people), choosing to remain close to the disability group (i.e., showing strong social identification) may also have benefits.

Physical disability, group identification, and stigma

Differences in social identification are not just theoretical, they have important implications for how people behave when and if the group becomes threatened (Doosje & Ellemers, 1997). For example, under conditions of identity threat (e.g., when the group is failing or otherwise devalued), individuals with weaker social identification tend to focus on their individual self and adopt individual mobility behaviours, which involve distancing themselves from the group and pursuing a positive sense of self as an individual (Tajfel, 1975, 1978d). This can be reflected in patterns of thought and behaviour that highlight dissimilarity between themselves and other group members, as well as reduced commitment to the group and stronger desires to leave the group (Ellemers, Spears, & Doosje, 1997). Conversely, under identity-threatening conditions individuals with stronger social identification instead tend to remain committed to the group, and to engage in patterns of thought and behaviour that are directed to addressing the threat and improving the group's position (Doosje et al., 1999; Ellemers et al., 1997). This motivation can be reflected in perceiving the self as more similar to other group members (i.e., show increased self-stereotyping; Schmitt & Branscombe, 2001; Spears, Doosje, & Ellemers, 1997, 1999), and distinguishing their group positively in comparison to other groups (Doosje, Ellemers, & Spears, 1995; Jetten, Spears, et al., 2001). Stronger social identification also influences the likelihood of enacting or supporting collective action behaviours (Hogg & Abrams, 1988; Kelly, 1993).

On the basis of this theoretical grounding, social psychological evidence has highlighted how people can overcome stigmatisation and discrimination, and what implications this has for their health and well-being (e.g., Branscombe, Schmitt, & Harvey, 1999; Crocker & Major, 1989). From a social identity perspective, stigmatisation exists when “a person whose social identity, or membership in some social category, calls into question his or her full humanity” (Crocker, Major, & Steele, 1998, p. 504). Moreover, “stigmatised individuals possess (or are believed to possess) some attribute, or characteristic, that conveys a social identity that is devalued in a particular social context” (Crocker et al., 1998, p. 505). In this sense, it is the social group that is devalued. However, because individuals are part of the stigmatised group, they may personally experience the devaluation associated with this group membership (Crocker et al., 1998).

Because of the intersection of stigma and identity, an individual’s group identification may have a powerful influence on how they respond. Specifically, individuals with lower social identification may seek to distance from their group in the hope of disassociating themselves from the associated negativity, thereby protecting their individual health and well-being. Such individual strategies may be reflected in concealment or “passing” behaviour, whereby individuals from stigmatised groups seek to portray themselves (and to be seen by others) as part of the majority group by hiding their group membership (Barreto & Ellemers, 2003; Tajfel, 1978d). Conversely, individuals with stronger social identification may instead seek to increase their connection with the group and enact behaviours to collectively cope and respond with the stigmatisation they are experiencing (Branscombe & Ellemers, 1998; Branscombe, Fernández, Gómez, & Cronin, 2012). Indeed, stigmatised individuals can use their group identification to cope with experienced negativity, a

possibility that is elaborated in the “rejection-identification model” (RIM; Branscombe, Schmitt, et al., 1999). This model demonstrates that if individuals belonging to a stigmatised group attribute negative treatment they experience as evidence of prejudice, this may be costly for both personal and collective self-esteem. At the same time, however, greater identification with this stigmatised group can ameliorate the relationship between attributed prejudice and self-esteem by allowing individuals to draw on the support and coping resources that their group membership provides to them. In this way, the group may protect or “buffer” the self-esteem of stigmatised people when prejudice is perceived or experienced.

Evidence for the buffering effect on well-being have been observed in a number of stigmatised groups, including: gender (e.g., McCoy & Major, 2003; Schmitt, Branscombe, Kobrynowicz, & Owen, 2002), members of minority racial and nationality groups (Armenta & Hunt, 2009; Bourguignon, Seron, Yzerbyt, & Herman, 2006; Branscombe, Schmitt, et al., 1999; Cronin, Levin, Branscombe, van Laar, & Tropp, 2012; Giamo, Schmitt, & Outten, 2012; Ramos, Cassidy, Reicher, & Haslam, 2012; Schmitt, Spears, & Branscombe, 2003), gay people (Doyle & Molix, 2014), the elderly (Garstka, Schmitt, Branscombe, & Hummert, 2004), individuals with body piercings (Jetten, Branscombe, Schmitt, & Spears, 2001), and also people with mental illness (Cruwys, Haslam, Dingle, Haslam, & Jetten, 2014; Pendry & Salvatore, 2015). On this basis, it seems that identification with a meaningful social group – even one that is stigmatised – can support people in the face of threats and contribute to individual health and well-being.

Bringing these ideas to bear on physical disability, disabled people who experience stigmatisation and discrimination have been shown to experience reduced psychological and physical health, life satisfaction, self-esteem, self-efficacy, as well

as increased severity of symptoms (e.g., Bahm & Forchuk, 2009; Corrigan, Watson, & Barr, 2006; Nosek, Hughes, Swedlund, Taylor, & Swank, 2003; Quinn & Chaudoir, 2009; Quinn & Earnshaw, 2013; Wright, 1983) - more so when compared to other stigmatised identities such as race and gender (Schmitt, Branscombe, Postmes, & Garcia, 2014). Moreover, chronic exposure to negative attitudes regarding incompetence and dependence may lead to the internalisation of such views, potentially further compromising health and well-being (Charlton, 2000, 2010). Indeed, referring back to our previous chapter, we noted how physically disabled people who experience stigma may be less willing to access desired support or maintain existing treatment programmes (also see Southall, Gagné, & Jennings, 2010; Southall, Gagné, & Leroux, 2006). Yet, despite the existence of stigma, the majority of disabled people are not affected by this negativity (Albrecht & Devlieger, 1999; Dunn, 2010; Mason et al., 2010), and often report a strong sense of self-esteem and life satisfaction (Crocker & Major, 1989; Etchegary, 2007).

These findings suggest that identification with the group may be effectively used to navigate the negative effects of disability stigma on the self. The most common form of coping examined within the disability literature is to attempt to conceal, remove, or downplay all associations with one's disability. Indeed, physically disabled people may go further still and "pass" their identity (Goffman, 1963) whenever it is possible for them to do so (Edgerton, 1993; E. E. Jones et al., 1984). Passing involves an intensive series of behaviours that go beyond simply attempting to downplay or conceal their identity, and may extend to performing as a non-disabled member of the community (Goffman, 1963; Hebl & Kleck, 2000; E. E. Jones et al., 1984; Katz, 1981). For example, physically disabled people demonstrate passing behaviour through choice of clothing, such as by wearing long-sleeved tops to

conceal arm amputations, thereby allowing themselves to pass as non-disabled (S. B. Kaiser, Freeman, & Wingate, 2014). These individual level strategies to deal with stigmatisation or discrimination may be favoured by many disabled people (Linton, 2010), as they are able to distance themselves from the associated images and stereotypes that promote dependency and incompetence, which can in turn, result in improved self-acceptance (Wright, 1983).

However, while there is evidence to suggest that disabled people engage in behaviour to distance themselves from their disability identity, other research has also noted the benefits of identifying at the group level. Indeed, Goffman (1963) highlights that self-esteem is likely to be constantly threatened due to continued awareness of their stigmatised status, and so it may be beneficial for physically disabled people to enact group-based behaviours to collectively improve their well-being. Group-based behaviours are readily demonstrated in the disabled community in a number of ways. Perhaps the most significant is advocating changes in disability models and definitions, such as shifting the emphasis from one of a medicalised approach emphasising personal illness, difference and incompetence, to one of a social dimension, highlighting the external societal barriers restricting participation of disabled people (Ryan, Bajorek, Beaman, & Anas, 2005). Behaviours that challenge stigma collectively are also shown through disability rights movements, the main purpose of which is to achieve social change by challenging the negative attitudes which promote discriminatory and unequal treatment in society, by advocating for equal rights laws (Charlton, 2000, 2010; Ryan et al., 2005), such as the ADA (1995) and the UK Equality Act (2010).

Collective strategies may also assist how individuals respond and cope with stigmatisation (Dixon, 1981; Nwuga, 1985) and subsequent health and well-being.

Specifically, the group may provide the opportunity for effective communication regarding support and stigma coping strategies (e.g., mental health support; Crabtree, Haslam, Postmes, & Haslam, 2010). This may allow disabled people to better understand and collectively overcome the negativity and ostracism directed at them (Olkin, 2002). Indeed, people with multiple sclerosis (Skår, Folkestad, Smedal, & Grytten, 2014), and intellectual disability (Jahoda, Wilson, Stalker, & Cairney, 2010) have been shown to value being part of collective disability-specific social networks, as this allowed them to share and gain knowledge of stigma coping strategies.

Identifying and having a sense of connection with other disabled people is likely to provide personal strength, resilience, and through this improved health, psychological well-being, and life satisfaction (e.g., Darling, 2013; Dingle, Brander, Ballantyne, & Baker, 2013; Dunn & Burcaw, 2013; Dunn et al., 2013; Nario-Redmond et al., 2013; Obst & Stafurik, 2010; Schulz & Decker, 1985; Wright, 1983). These health benefits may not only occur for individuals with more general disabled social identities, but may also occur in relation to social identities associated with more specific disabilities. For example, research demonstrates that people with multiple sclerosis who demonstrated high social identification with a multiple sclerosis support group reported decreased depression, anxiety, and increased life satisfaction (Wakefield, Bickley, & Sani, 2013). Several studies have also demonstrated how identification with the deaf community can have beneficial consequences for self-esteem (Bat-Cheva, 1994; Jambor & Elliot, 2005; M. A. Jones, 2002).

Beneficial consequences of disability social identification are not just observed during face-to-face contact between disabled people, but also through online disability forums and social networking pages. More specifically, these disability networks can promote meaningful opportunities for physically disabled people to

socially identify with similar others who are members of the groups, and also share and receive information about disability and support (e.g., Attard & Coulson, 2012; Braithwaite, Waldron, & Finn, 1999; Finn, 1999; Obst & Stafurik, 2010). Interactions with other disabled people online also promotes a sense of social support and community, disability pride, a desire to advocate for disability social change, as well as a reduced likelihood of enacting individual stigma coping strategies of concealing or downplaying their disability (Bannon, McGlynn, McKenzie, & Quayle, 2015; Nario-Redmond et al., 2013; Nario-Redmond & Oleson, in press; Obst & Stafurik, 2010), as well as reduced loneliness and improved self-confidence and self-esteem (Nario-Redmond et al., 2013; Stewart, Barnfather, Magill-Evans, Ray, & Letourneau, 2011).

However, both individual and collective strategies may each be associated with costs. For example, while disabled people may wish to disassociate themselves with their stigmatised group in order to distance from the associated negativity, this may lead to the unintended outcome of increasing the stigma that they feel. This may be because they can develop a chronic fear of disclosure, as well as self-doubt about whether they are passing suitably (Linton, 2010). These concerns may negatively affect their physical and psychological health (Gill, 1997; Smart & Wegner, 2000), as well as promote anxiety and self-punishment if their behaviours do not fit their perceived ideal (Joachim & Acorn, 2000; Swain & Cameron, 1999). Moreover, although passing may reduce the salience of their physical disability to others, it will not remove it entirely. Instead, disabled people may look or act in subtly different ways to others, and so complete acceptance by the non-disabled community may always be unattainable (Fernández, Branscombe, Gómez, & Morales, 2012; Grytten & Måseide, 2005). Besides the potential health difficulties, attempts to pass may also

sever contact with the disabled community, and so might result in lost opportunities for advice and support (Fernández et al., 2012; Linton, 2010).

Enacting group-based strategies and identifying with others who share their disability experiences may also be detrimental to a sense of self and well-being. These patterns of thought and behaviour may make salient and self-relevant the negativity associated with the group, such as ill health (Aviram & Rosenfeld, 2002; St Claire & Clucas, 2012). Indeed, Paterson, McKenzie, and Lindsay (2012) highlighted that although disabled individuals valued social groups, they only promoted increased self-esteem when they felt that they were less impaired compared to others within the group.

In sum, physically disabled people may seek to respond to stigmatisation both at the individual level and at the group level – that is, some disabled people can either attempt to distance themselves from the negativity associated with the group (i.e., individual level), or instead embrace their condition and develop a meaningful social identity with other disabled people (i.e., group level; Branscombe et al., 2012). Fernández and colleagues (2012) demonstrate this by showing that people with dwarfism face a decision to cope with their disability by either removing it by undergoing leg-lengthening surgery (i.e., enacting an individual-level strategy), or to develop a social identity as a “little person”. Crucially though, whichever strategy individuals with dwarfism decide to enact, there is no significant difference in reported psychological well-being, which suggests that both strategies can be equally beneficial. However, the authors also noted potential negative health implications of both strategies in that they may increase the salience of the negative connotations associated with disability.

SIDE and identity performance

Up to this point in the thesis we have discussed the social attitudes that physically disabled people experience, and how these attitudes may influence their self-concept, as well as their health and well-being. In order to understand how physically disabled people might respond to these attitudes, we have highlighted how behaviour can be influenced by competing motivations to distance from, or bind the self closer to, the disabled group (Branscombe et al., 2012). Although the SIA provides insight into the individual and group processes that translate into the formation of, and behaviour directed at, a meaningful social identity, a specific limitation of these theories is that they predominantly focus on how individuals cognitively interpret their identity in given contexts (e.g., categorisation at the personal or social level, as demonstrated by social categorisation theory (SCT)). Little attempt has been made to explore the ways in which individuals enact their identity, the unique issues that are raised by this, and the contextual demands that influence identity enactment.

When the question shifts from one of how contexts may influence the self, to how individuals perform the self in different contexts, the role of specific audiences comes more clearly into focus. In most social settings, there are audiences that may observe the individual, and who may be in a position to respond helpfully or harmfully as a function of what is displayed. The awareness of these audiences can promote specific motivations for how individuals represent their identity (O. Klein et al., 2007). As Ellemers, Barreto, and Spears (1999, p. 139) discuss,

people adapt their group membership claims to the social context in which these are voiced. People's expression of their social identity will depend on the nature of the audience, on the identity needs that the audience makes

salient and on whether they are personally accountable for their responses. Statements of group identification may thus be viewed as strategic responses to specific (personal and social) identity needs made relevant in the given context.

In other words, the enactment of social identities is not just a reflection of individual cognitions triggered by the social surroundings – this is also a communicative process in which people enact identities to navigate their environment, and sometimes to change it (Verkuyten & Yildiz, 2010; Wiley & Deaux, 2011).

More recently, researchers working within the social identity tradition have attempted to provide a theoretical framework that appreciates the importance of audiences, and performances, to identity processes (O. Klein et al., 2007; Reicher et al., 1995). The social identity model of deindividuation effects (SIDE model; Reicher et al., 1995) was derived from SCT (Turner et al., 1987), and discusses how the visibility of an individual influences deindividuation and behaviours according to their social identity in a given context. Traditional approaches to deindividuation propose that if an individual is granted anonymity within a given group, they may lose their sense of self within this environment, and consequently may act against the accepted social norms (e.g., Haney, Banks, & Zimbardo, 1973; Zimbardo, 1969). In contrast, the SIDE model provides a different viewpoint and argues that if individuals behave as part of a group, deindividuation may result in a modification of their categorisation from a personal identity, intragroup perspective to social identity, intergroup perspective (Reicher et al., 1995). In this sense, while the SIDE model acknowledges that granting an individual anonymity may influence their behaviour compared to when they are visible to others, motivations and behaviours are

consciously enacted according to the expectations of a valued social identity, rather than being random or against social norms.

The SIDE model proposes that there are two key elements that inform the enactment of social identities: first, the cognitive salience of this identity, and second, the strategic presentation of this identity to others. In the cognitive aspect of SIDE, individuals are able to interpret the specific context and define according to their personal or social self (in other words, interpret whether a specific social identity is salient and relevant in a specific context, Reicher et al., 1995). If a social identity is salient, individuals can redefine their self so that the associated group norms and values to become more salient, which in turn, promotes an increased desire to think and act in accordance to these norms (Spears, Lea, Postmes, & Wolbert, 2011).

The strategic component of SIDE refers to how an individual may translate these cognitive thoughts into actions, and how the social context (such as the own ingroup's visibility to an outgroup, as well as the power of this outgroup) may influence or impact upon what actions are performed. Specifically, minority group members may have a desire to affirm and accentuate their ingroup and its norms, and if they remain anonymous to, or there is low risk of sanctions from, a powerful outgroup audience, these motivations may be achievable (Lea, Spears, & de Groot, 2001; Reicher & Levine, 1994a). However, if minority group members are visible to an audience, the social identities they wish to enact or the norms these identities promote may not be appropriate due to differences in expectations and beliefs, therefore risking the possibility of sanctions (Reicher et al., 1995). Consequently, minority group members may feel the need to adapt their behaviours in response to majority group expectations. For example, when minority group members are visible to a powerful majority group, they may strategically alter their own behaviours so that

they are more in line with the norms of the majority outgroup (Douglas & McGarty, 2001; O. Klein & Azzi, 2001; O. Klein, Licata, Azzi, & Durala, 2003; O. Klein, Snyder, & Livingston, 2004; Reicher & Levine, 1994a; Reicher, Levine, & Gordijn, 1998), to potentially avoid punishment (Reicher & Levine, 1994b).

In sum, the SIDE model proposes that an individual's behaviour is not simply influenced by cognitive representation of their social identity, but also the contextual demands that are placed on the individual (i.e., the strategic aspect). This strategic element proposes that individuals are motivated to both affirm their social identity, but also protect themselves from possible sanctions from outgroups. Awareness of the contextual and audience demands may influence the strategy individuals choose: when they are anonymous to others or the risk of sanctions is low, they may decide to act according to the norms of their ingroup; whereas when they are at greater risk of sanctions, ingroup members may instead decide to modify their group norms to be more in line with the outgroup, though not endorsing these (Reicher & Levine, 1994a, 1994b; Reicher et al., 1995).

These strategic aspects of SIDE have been further elaborated in theoretical work on *identity performance* (O. Klein et al., 2007). Identity performances are tactical demonstrations of a meaningful social identity that either heighten the perceived salience or importance of this identity to an audience (e.g., affirming and strengthening the identity; identity consolidation), or that modify the audience's assumptions of this identity (e.g., performing an identity to change audience emotions, attitudes or responses; identity mobilisation; O. Klein et al., 2007). Identity performances can therefore be developed and enacted for many different reasons. For example, individuals will enact multiple identity performances depending on their own needs, as well as the beliefs and expectations placed on them by the various

audiences they interact with (Barreto, Spears, Ellemers, & Shahinper, 2003; O. Klein et al., 2003).

Identity performance and stigma

A focus on identity performance raises unique questions about how individuals navigate and respond to stigma based on their group membership. Individuals may be able to respond to stigma by strategically taking control of their identity, negotiating and adapting it such that specific behaviours or aspects of their identity are made visible (or invisible) to a given audience (Deaux & Ethier, 1998). Indeed, evidence of identity performance has been shown in a number of stigmatised identities, whereby individuals incorporate different strategies to ensure that they, and their group, are viewed more favourably by their situational audiences (e.g., Barreto et al., 2003; O. Klein & Azzi, 2001; O. Klein et al., 2004, 2007; Leary & Kowalski, 1990; M. Snyder, 1987; Verkuyten, 2011; Wiley & Deaux, 2011).

For example, Cheryan and Monin (2005) demonstrated that Asian Americans may adopt strategies to amplify their prototypicality as American, particularly when their identity as an American is questioned. Here, when confronted with the highly threatening statement, “*Do you speak English?*” from a White experimenter, in a later cultural knowledge quiz, participants emphasised their knowledge of American television shows. This suggests a strategic presentation of American identity to correct an audience that apparently does not recognise this. Similarly, Neel, Neufeld, and Neuberg (2013) were interested in the self-presentation strategies obese individuals and African American men endorsed when asked to think about how most people (i.e., a general audience) saw them (also termed “meta-stereotypes” in the literature: Vorauer, Main, & O’Connell, 1998). Specifically, after reflecting on the

meta-stereotype, participants were asked to rank a series of self-presentation strategies for making a good impression to others. African-American participants reported a meta-stereotype of violence, whereas obese participants reported a meta-stereotype of disease. African-American participants ranked self-presentation strategies that counteracted the meta-stereotype of violence as most important (e.g., smiling was rated as most important), whereas obese individuals instead ranked wearing clean clothes as most important, thereby distancing themselves from the associated assumptions of disease. Participants who did not anticipate these meta-stereotypes did not show these effects.

Women have also been found to draw on a variety of identity performance behaviours to navigate the experience of being sexually objectified by men. Some women may respond to this form of stigma by appealing to their male audience, for example through highlighting their feminine and sexualised features to men (e.g., via their hair style, use of clothing, and piercings; Smolak, Murnen, & Myers, 2014). Although such women might not themselves endorse male sexualised attitudes towards them, deciding to enact self-sexualisation can be a form of identity performance that is used in the hope of regaining some power from the male audience (O. Klein, Allen, Bernard, & Gervais, 2015). Conversely, other women may behave in opposition to sexist stereotypes, for example by describing themselves to others as less family-oriented, feminine, and nice when stereotypes are salient (C. R. Kaiser & Miller, 2001), or withdrawing from help under similar conditions (Wakefield, Hopkins, & Greenwood, 2012).

Finally, identity performance has also been investigated in the context of religion and how this is displayed to others. Muslims, for example, can display their religious identity visually through the use of particular garments (such as a hijab or

burkha) or growing a beard, and these behaviours can be deliberately selected to mark and consolidate collective identity to others in society, for example to ethnic and religious majorities in European societies (Verkuyten, 2011; Verkuyten & Yildiz, 2010). However, because Muslims, like many stigmatised groups, are often exposed to negative responses from the majority, this can create conflicts and dilemmas over whether and exactly how their identity is performed (Phalet, Baysu, & Verkuyten, 2010; Wiley & Deaux, 2011). This is illustrated in a qualitative investigation of British Muslim women by Hopkins and Greenwood (2013). These authors observed that British Muslim women self-categorise as Muslims, but they also feel that their Muslim identity is not fully recognised by British society. In response to this, many interviewees wore a hijab to increase the visibility of the valued, but unrecognised, identity to their audience (i.e., identity consolidation), and this public demonstration of their identity was associated with positive feelings. However, at the same time, they acknowledged possible negative consequences of wearing a hijab. Marking themselves in this way meant that they were exposed to a number of potential threats, including judgement, hostility and ridicule from prejudiced members of society, and being miscategorised as foreign. To distance themselves from these concerns, participants also adopted identity performance strategies that focussed on demonstrating the other parts of their identity – their British and gender identities – for example by speaking in a British regional accent, wearing British fashions and feminine styles, or describing how their interests were the same as non-Muslim women.

In sum, although focussed on different populations, and the specific issues they face when interacting with others, the above studies all highlight that, on the one hand, stigmatised individuals have a desire to enact an identity that reflects how they

see their self and how they want to be seen by others, but on the other hand, performing this desired identity may expose the individual to further stigmatisation. As such, it seems that individual members of stigmatised groups can experience an identity performance dilemma: presenting an important identity to provide them with a positive sense of self, while also protecting themselves from the negativity of others. These two demands may have conflicting outcomes, and each may both prove costly for the self. If stigmatised individuals perform their social identity in the way they wish to, this may contribute to positive feelings of authenticity, but might also amplify difference from others and therefore contribute to stigma (e.g., Hopkins & Greenwood, 2013). If they instead present themselves in line with the majority norms (e.g., O. Klein et al., 2015), they may encounter more favourable reactions from others (Reicher & Levine, 1994b), but may also be endorsing views that are counter to their own self-understanding (Crocker & Garcia, 2004).

Dilemmas of identity performance and help-seeking in physical disability

Bringing these ideas to bear on identities based on physical disability, disabled people may face concerns over their disability identity, and whether this is visible to, and recognised by, others (Asch & Fine, 1988; L. C. Brown, 2013). Because of this disabled people may feel as though they are “on stage”, whereby their appearance and actions may be constantly monitored when interacting with others (Goffman, 1963; Hebl et al., 2000; Wright, 1983). Of course, whether one wants disability to be visible, and how one wants this to be recognised, is likely to vary across specific audiences, for example whether these are healthcare providers, educators, potential employers, or the general public. Because of the different concerns each of these audiences raise (e.g., about receiving appropriate care versus being seen as competent), individuals

may have to continuously adapt their identity to ensure that they can regulate how individual audiences see and respond to them (e.g., with assistance or respect; L. C. Brown, 2013; S. D. Stone, 2013). As Grytten and Måseide (2005, p. 239) discuss, the disability identity “has to be intentionally choreographed and performed. Adequate performance requires the situation to be interpreted, as well as an understanding of interests invested in the social situation.”

Identity performance becomes a particular issue for physically disabled people when they attempt to access support. Although disabled people may wish to present their self in a way that protects themselves from stigmatisation (e.g., by emphasising their independence and ability), they are still reliant on support from others (Buljevac, Majdak, & Leutar, 2012; Horton-Salway, 2007; McLaughlin, 2012). Moreover, because support resources in many countries are allocated based on perceptions of need (Albrecht, 2001), in order to access needed support, disabled individuals have to confirm that they meet a particular severity of impairment or functioning threshold (Szymanski & Trueba, 1999). Disabled people may, therefore, be exposed to scepticism over whether they are “legitimately disabled” (Holloway, Sofaer-Bennett, & Walker, 2007; McLaughlin, 2012), and others’ perceptions of their degree of their disability might have consequences for how much support they actually receive (Garthwaite, 2011; Wolff, 2009).

Because of this, a significant concern for many disabled people is whether the severity of their condition will be seen as legitimate by those who are in a position to determine their access to support and care (Crooks, Chouinard, & Wilton, 2008; Grytten & Måseide, 2005; Skår et al., 2014). So that needed support is granted, disabled people may perform their identity in ways that confirm the stereotypes and norms about disability that providers of care hold (Lane, 2010; Morris, 1989; R. A.

Scott, 1981), for example by behaving in ways that are “dependent, passive, helpless and childlike because that is what is expected of them” (L. C. Brown, 2013, p. 154).

A stereotypical disability performance can be achieved in a variety of ways. For example, individuals may emphasise their disability by describing the difficult experiences associated with their condition, or justifying their legitimacy to claim their disability status by using assistive devices. Because assistive devices are so commonly associated with physical disability (Karp, 2009), and are typically very salient (Asch & Fine, 1988), any individual using such a device will almost immediately be categorised as “disabled” (Asch & Fine, 1988). In this way, assistive devices commonly used by physically disabled people (e.g., sticks, canes, wheelchairs, assistance animals) may serve far more than just an assistive purpose. They may be used as a form of identity presentation (Schlenker, 1980) that allows physically disabled people to activate assistance from others (Frank, 1988a). Consistent with this idea, Wiart, Ray, Darrah, and Magill-Evans (2010) have shown that parents of children with cerebral palsy can seek to emphasise their child’s disability by placing them in a wheelchair during interactions with others. Although this behaviour is not enacted strictly as a means of accessing support, the focus is to potentially strengthen the visibility of their child’s disability status, which is therefore likely to be beneficial if support were required.

However, in other contexts the primary concern might not be to access support, and accordingly the performance of disability should change. In the contexts of education and employment, for example, physically disabled people are more likely to be focussed on achieving recognition and respect for their competencies, rather than activating concern and support, and may therefore attempt to pass or downplay their disability as much as possible. Consistent with this idea, Louvet,

Rohmer, and Dubois (2009) demonstrated that when disabled people believed that they were presenting themselves to non-disabled people in the workplace, they described themselves as more competent than when they believed they were interacting with other disabled people. In education and workplace environments, physically disabled people have also been found to deliberately deny or reduce their access to available support (Baldrige & Swift, 2013; Barnard-Brak et al., 2010; Olney & Brockelman, 2003; S. D. Stone et al., 2013). Vickerman and Blundell (2010) noted that this strategy is particularly popular when navigating the educational environment, with approximately 25% of their sampled 504 UK disabled students refusing to disclose their disability out of fear that they would not receive a university place. Indeed, disabled students commonly discuss that their self-esteem and well-being is positively affected when forming an identity which ensures they are viewed as non-disabled, or when their disability is no longer seen as their single defining trait (Low, 1996).

However, downplaying disability is not without its problems. In order to function like the rest of their non-disabled cohort, many disabled students will need to make significant others (e.g., academic staff) aware of their needs as a disabled person (Low, 1996). Failing to do this might create additional burdens on the individual. Indeed, covering stigmatised identities, even when this is expected to improve interpersonal evaluations, is an effortful and taxing strategy (Newheiser & Barreto, 2014). The conflicting motivations to be seen as a competent and capable individual, and to be recognised as someone who has a disability and needs associated with this, highlight the strategic pressures disabled people may have to navigate depending on the specific audience with whom they are faced within educational and workplace environments. A qualitative study by Taub and colleagues (2004) demonstrates these

issues. Participants in this study reported that they attempted to downplay or conceal the salience of their disability when interacting with non-disabled students, thereby also attempting to pass as non-disabled students. Participants reported two types of identity performance to achieve this: deflection and normalisation. Deflection involved participants using kindness, friendliness, and humour to remove any potential awkwardness, which also allowed potentially negative attitudes of others to be modified into something positive. Normalisation involved participants attempting to show that their disability status was unimportant, such as by demonstrating physical competence, becoming involved in campus activities, and also rejecting available disability adjustments for work or assignments. However, while rejecting these adjustments, participants also acknowledged that some form of support was also necessary (e.g., disability parking). To navigate requesting support from staff, participants reported attempting to affirm their disability status in order to highlight their need and legitimacy for requested support, and also to discredit negative beliefs from others regarding possible malingering behaviour. In other words, Taub et al. (2004) demonstrated that physically disabled students enacted a differing identity performance to meet the situational requirements of their audience in order to navigate their support and inclusion needs. Similarly, in the workplace context, S. D. Stone (2013) provides further qualitative evidence that physically disabled people reject categorisation as a disabled person, regardless of the visibility of their condition or their assistive devices, in order to potentially remove the associated stereotypes of incompetence. However, these participants nevertheless acknowledged that they experienced mobility difficulties, and therefore wanted to access disability support in order to potentially reduce or remove these difficulties.

In sum, how physically disabled people decide to perform their identity can have important implications for experiencing and coping with stigmatisation, as well as their ability to access desired support and through this, their overall health and well-being. More specifically, disabled people face a dilemma in how they perform their identity to particular audiences, ranging from healthcare providers, and people in educational and workplace contexts, and of course the general public. If they perform in a way that confirms stereotypes of incompetence and dependence, they may be able to more easily access the support that they require, but in so doing they may also experience many unflattering and stigmatising attributes directed at their self (Taub et al., 2004). If they perform in a way that downplays their disabled identity, they may protect themselves from such stigmatisation, but support access may become more difficult (Gervais, 2010; Quinn, Kahng, & Crocker, 2004). Consequently disabled people need to be strategic about who, and to what extent, they discuss and perform their disability (Quinn, 2004) depending on the motivations they have in a given setting and what is demanded by the audiences implicated in those settings (S. D. Stone, 2013).

Chapter summary

In this second chapter, we have developed a theoretical grounding to help understand how physically disabled people may navigate the conflicting demands of accessing desired support, while also protecting themselves from stigmatisation. Specifically, according to the SIA, physically disabled people can define their identity with respect to either personal or social attributes, which in turn, may influence how they view and respond to experienced stigmatisation, as well as their health and well-being. If disabled people choose to enact their personal identity, they may seek to

respond to stigma in ways that benefit them as individuals, such as downplaying or reducing the salience of their disability. Conversely, if disabled people choose to enact the social identity, they may instead think and behave in ways that benefit their disability group as a whole.

However, little social psychological attention has been given to how physically disabled individuals strategically translate their social level thoughts into actions, such as deciding how to enact individual performances of identity to different audiences. Consequently, we may not be able to accurately describe the complex situational demands, motivations, and behaviours that physically disabled people navigate in seeking support and dealing with stigmatisation. In this sense, we have reviewed evidence from the literatures of identity performance and disability studies to elucidate this concern. From these literatures, we suggest that physically disabled people may enact many different, and strategic performances of their identity in order to cope with accessing support while protecting the self from stigmatisation. How disabled people perform their identity will change according to the associated stereotypes and social relations with the audience. Specifically, when interacting with healthcare providers, disabled people may report concerns regarding their legitimacy for desired support, which may in turn mean they are motivated to perform their identity in a way that endorses disability stereotypes. Conversely, when interacting with people in education or work, physically disabled people may instead report concerns regarding their competence and suitability for education or work, which may in turn, mean they are motivated to downplay or “pass” their disability in order to make themselves look more like the average academic or worker. However, both of these performances promote costs in terms of potential negative well-being in the context of healthcare, and inability to access support in education and workplace

environments. In this sense, when deciding to enact a context-specific identity performance, physically disabled people will likely face a dilemma between demonstrating an identity that advocates a positive sense of self in a way that protects them from stigmatisation (i.e., where their disability is not the focus), and performing an identity that affirms their disability and need for support.

CHAPTER 3

THE PRESENT RESEARCH: PHYSICAL DISABILITY AND THE DILEMMAS OF IDENTITY PERFORMANCE

Summarising the previous two chapters, the literature suggests that physically disabled people may be presented with a problem of living their lives through two conflicting forces: to identify as disabled and perform this identity to others, while attempting to maintain their individuality away from the confines of their label. By accepting and performing their disability label they can personally benefit through access to support, as well as contribute to the progression of disability rights and societal responsibility and disability understanding (Crooks et al., 2008; Frank, 1988b; Taub et al., 2004). However, by doing so, they are shifting emphasis to their disability, and therefore highlighting their difference from others (Frank, 1988b).

The difficulty with these two forces is that they reflect conflicting goals, whereby disabled people may have to negotiate a complex identity that accommodates their desire to protect themselves from stigmatisation, while also acknowledging their need for support. More specifically, physically disabled people may wish to avoid defining themselves by their disability, in order to distance themselves from the negativity and stigmatisation that may be associated with this identity. However, at the same time, they may also acknowledge that certain support is necessary, and this is only likely to be achievable if they identify and describe themselves according to their disability (Baldrige & Swift, 2013; Ho, 2004). In this sense, to ensure that providers of support acknowledge their disability, and therefore

provide necessary help, physically disabled people may have to overtly perform this social identity in a stereotypical way to their audience (e.g., by demonstrating their disability or justifying their need). The consequence of these conflicting demands is that physically disabled people may experience identity dilemmas in terms of maintaining a positive sense of individual self when stigmatisation is experienced, while also performing a desirable social identity to an audience in order to access needed support.

While some research documents how disabled individuals negotiate negative stereotypes and accessing support, these insights are currently, to our knowledge, confined to qualitative data (Crooks et al., 2008; S. D. Stone, 2013; Taub et al., 2004). These studies tend not to explore physically disabled people's awareness of potential identity dilemmas associated with these conflicting demands or how they may navigate these. Thus, additional work to explore these dilemmas both qualitatively and quantitatively is clearly needed.

Present research

From a social psychological perspective, there is a long tradition of research on issues of stigma and identity, and this research has produced many key theories that improve our understanding of the experiences of the stigmatised. However, knowledge is far greater in certain areas than in others (Barreto & Ellemers, 2010). The field of stigmatisation associated with physical disability is one area in which understanding and research activity remains poor (Dunn, 2015). Specifically, disability research tends to be side-lined in mainstream psychology due to its perceived unimportance relative to other stigmatised identities (Gervais, 2010; Nettles & Balter, 2012; Olkin & Pledger, 2003; Tate & Pledger, 2003). More than this, the

disability research that has been conducted largely focuses on the attitudes of stigmatising audiences (Dovidio et al., 2010; Dunn, 2010; Hebl & Kleck, 2000), or assumptions from non-disabled people of how disabled individuals might experience stigma (Bickenbach et al., 1999). Unfortunately, psychologists rarely acknowledge the contributions of disabled people in understanding physical disability (Dunn, 2010). As a consequence, the perspectives of physically disabled people who experience, respond, and cope with the stigma directed at them, as well as the associated health problems they may experience, have largely been ignored (Charlton, 2000; Dunn, 2015; King et al., 2005; Willis, Hendershot, & Fabian, 2005). Because of this, both disability and social psychology scholars are recognising the need to include the personal perspective of physically disabled people within new research, as this provides a first-hand experience of the stigma, prejudice and discrimination that this population experience (Asch, 1984; Hebl & Kleck, 2000). In this vein, this thesis will focus entirely on the perspective of those who are physically disabled.

To understand and address the dilemmas associated with help-seeking, stigma, and identity performance that physically disabled people experience, we will draw on the social identity approach (Tajfel & Turner, 1979, 1986; Turner et al., 1987), and the associated SIDE model (Reicher et al., 1995). Using this theoretical framework, we will explore the many ways in which they view and perform their identity to meet or refute the stereotypical assumptions of others (O. Klein et al., 2007). To do this, this thesis will answer four interlinking research questions. The first will examine physically disabled people's understanding and awareness of the expectations placed upon them by various situational audiences. Specifically, we will address physically disabled people's expectations of interacting with healthcare providers, educators, and employers, given the likely frequency of interactions with these audiences, and the

potentially negative attitudes these audiences will likely hold towards disabled people (Olkin, 1999). More specifically, we will address the question: *what are the personal experiences of stigmatisation and discrimination of physically disabled people when interacting with healthcare providers, educators, and employers?* **(RQ1)**. The second research question will explore the influence of the personal and social self in how physically disabled people navigate experiences of stigma, specifically by addressing the question: *how do physically disabled people construct their personal and social selves when interacting with healthcare providers, educators, and employers?* **(RQ2)**. The third research question will explore physically disabled people's identity performance behaviour in response to situational stigmatisation (e.g., downplaying of their disability), specifically addressing the question: *how do physically disabled people perform their identity when interacting with healthcare providers, educators, and employers?* **(RQ3)**. To bring each of these research questions in line with the help-seeking and identity dilemmas discussed, our fourth and final research question we will explore: *how do physically disabled people's constructions and performances of identity when interacting with healthcare providers, educators, and employers each independently affect their health, well-being and support-seeking behaviour?* **(RQ4)**.

These four research questions will be explored and answered across five studies. Chapter 4, reporting Study 1, qualitatively examines the issue of identity performance when attempting to access needed support, and the dilemmas disabled people face when attempting to negotiate the threats to their personal and social selves. Focusing on a specific physical disability (cerebral palsy), we will show that participants are very clear about how they expect to be (negatively) viewed by healthcare providers in terms of their apparent illegitimacy for support. These pressures in turn, create dilemmas in how they view their own identity as a disabled

person in order to protect themselves from associated stigmatisation, but also, how they should perform their identity to ensure appropriate access to support.

In Chapter 5, we present a package of quantitative research consisting of Studies 2, 3, and 4. Study 2 exposes people with cerebral palsy to different stigmatising contexts of support-seeking or everyday discrimination (i.e., reflecting the issues of accessing support and navigating stigma). In Studies 3 and 4, we will expand the sample to physically disabled people in a general sense, and substitute the stigmatising issues (support-seeking or discrimination) with an equivalent audience: healthcare providers (reflecting the issue of support-seeking), and the general public or educators and employers (reflecting the issue of discrimination). Specifically, Study 3 will investigate identity performance when interacting with healthcare providers and the general public, and Study 4 will instead focus on interactions with people in education and the workplace. Across all three studies, we investigate the degree to which context-specific concerns affect how disabled individuals demonstrate their identity, how this is reflected in their help-seeking behaviour, and how this affects their health and well-being. Across these studies, we will show that although activating the issue of stigma (i.e., support-seeking or discrimination) may promote general concerns regarding their identity and influence help-seeking and health, awareness of issues alone are insufficient to promote situational identity performances. Instead, the audience associated with the stigmatising issue (e.g., healthcare providers in the support context) is needed to promote particular threats to identity (e.g., stereotypes), which consequently promote specific identity performances.

Building on the findings of the previous four studies, Chapter 6 reports the fifth and final study included within this thesis. Here we will present a second

qualitative study that again explores physically disabled people's experiences of stigmatisation when interacting with healthcare providers to receive needed support. In addition, progressing the insights that emerge from the previous qualitative and quantitative work, this study also investigates in more detail the interaction experiences with educators and employers, and more explicitly documents the pressures individuals feel to demonstrate their disability in specific ways when interacting with different audiences, as well as the tensions they experience between personal and social identity in so doing.

Chapter 7 serves as the final Discussion chapter. Within this chapter, we will summarise all the findings to the above five studies, before noting how, together, they address the four research questions and contribute to a better understanding of the overriding issues of stigma and identity performance dilemmas in the context of disability. Future extensions to the five studies included in this thesis are considered, as are the theoretical and practical implications for the social psychology of physical disability.

Overall contribution of thesis

By Chapter 7, the contribution this research has made to disability and psychology should, hopefully, be clear. To foreshadow these contributions, we intend to provide a novel and clear progression in current understanding of the contextual identity and performance dilemmas that physically disabled people face when navigating stigma and support. Specifically, we are interested in how physically disabled people navigate the potentially conflicting demands of how they expect their audience to see their identity versus how they want to see themselves (i.e., personal or social), as well as how they want others to see them (performative or not), and the

implications these demands have on support access and exposure to stigma. In so doing, we aim to contribute a disability perspective to social psychological literatures on stigma and identity, and to contribute a social psychological framework for understanding these issues to disability studies.

CHAPTER 4

NEGOTIATING IDENTITY: A QUALITATIVE ANALYSIS OF STIGMA AND SUPPORT SEEKING FOR INDIVIDUALS WITH CEREBRAL PALSY¹

¹ This chapter is an adapted version of a paper by Read, Morton, and Ryan (2015).

Abstract

Purpose

The current research investigates how adults with cerebral palsy construct their personal and social identities in the face of stigma when support seeking, and considers the dilemmas they might face when doing so.

Method

Participants were 28 adults with cerebral palsy who completed an online survey reporting on their identity as a person with cerebral palsy and their experiences of stigma when seeking and accessing support.

Results

Qualitative analyses indicated that the majority of participants sought support to help manage their cerebral palsy. Of these, half reported experiencing stigma in these environments, although they largely continued seeking support despite this. The majority viewed both their personal identity (i.e., as a unique individual) and their social identity (i.e., as a person with cerebral palsy) as important to their sense of self. However, how participants constructed their identity also appeared to vary according to context. While they appeared to value being seen as an individual to receive support that was unique to their needs (their personal identity), they also reported valuing the group to facilitate coping with stigma (their social identity). Yet, despite their utilities, enacting their identity in each of these ways was associated with costs. In order to access desired support, they had to incorporate their social identity as similar to other disabled people, which led to stigmatisation through feelings of difference to the non-disabled. Conversely emphasising individuality and difference

from the disabled stereotype was associated with concerns about the degree to which their suitability for support might be questioned by their care provider.

Conclusions

As has been observed in many fields, stigma can complicate identity. In this domain, people with cerebral palsy face a number of threats in how they construe their identity, both in navigating stigma and maintaining access to needed support.

Introduction

Cerebral palsy (CP) is a primarily physical disability that is believed to arise from prenatal or early childhood brain damage (Rosenbaum et al., 2007). CP is a highly heterogeneous disability, with no two people having the same impairments in their physical functioning. Severity and visibility of CP therefore typically varies markedly, ranging from individuals who are ambulatory and who do not require use of assistive devices, to those who are unable to support their body unaided, and who may therefore require use of wheelchairs or continued support from others (Palisano et al., 1997). Adults with CP typically rely on formal and informal support throughout their lives to assist with their care needs (Young, 2007; Young et al., 2007), though the nature and frequency of the support they require will be highly dependent on their individual impairments. There are, however, many barriers to receiving support in adulthood, including limited contact with rehabilitation services (Bottos, Feliciangeli, Sciuto, Gericke, & Vianello, 2001) and treatment availability (Beatty et al., 2003). Consequently, many adults with CP may experience difficulties accessing support as readily as they might wish.

In addition to these practical barriers, there are psychological barriers to accessing support. Needing the support of others reinforces notions of dependency and is, therefore, stigmatising (Charlton, 2000). As such, support is something that people with CP might be reluctant to seek. This presents the individual with a dilemma that requires them to reach a balance between accessing needed support and maintaining a positive, non-stigmatised identity. Although there is a wide literature that highlights the barriers to support seeking in CP, to our knowledge, the specific role of stigma as a barrier, and the identity dilemmas this creates for individuals with

CP, has not been thoroughly addressed. The present research draws on an identity perspective to explore, and to better understand, the dilemma of support-seeking.

Stigma and CP

An individual experiences stigmatisation when their individual identity, or the social group to which they belong, is somehow ‘marked’ and negatively evaluated within broader society or within a specific social context (Crocker et al., 1998; Goffman, 1963; E. E. Jones et al., 1984). CP, like many other physical disabilities, is highly stigmatised. To varying degrees, CP is a marked condition and people with CP face negative attitudes within the general community, but also, ironically, in healthcare and support situations. For example, general practitioners, gynaecologists and medical students have all been shown to have limited knowledge about CP, which promotes misunderstanding, negative attitudes and stereotyping of patients (H. Becker et al., 1997; Iacono et al., 2004; Martin et al., 2005). Even away from these more formal healthcare settings, such as in the context of family and friends, there is evidence of misunderstanding or inappropriate knowledge that feeds into peoples’ negative attitudes and evaluations. For example, relatives of adults with CP often view the disability as having a more severe impact on important physical tasks – for example eating, drinking, personal care and movement – than do the adults themselves (Gething, 1985).

To date, research into the stigma of disability has tended to focus on non-disabled observers (e.g., family, health professionals, the general public), and quantifying the attitudes they have about disabled others. Whilst this is an important strategy for working towards alleviating stigma, disability and stigma researchers have highlighted the simultaneous need to better understand stigmatising experiences from the perspective of disabled people (Hebl & Kleck, 2000). Indeed, growing

evidence suggests that adults with CP are very much aware of the attitudes and stereotypes through which they are perceived in society, and because of this, consider stigma to be a major barrier to social participation (McNaughton, Light, & Arnold, 2002; Yeung, Passmore, & Packer, 2008). For example, adults with CP report that nurses treat them differently from other patients, such as speaking to them in a patronising way, or assuming they have intellectual difficulties (Balandin et al., 2007). Moreover, as a consequence of the limited knowledge and negative attitudes of care providers and society at large, adults with CP often report experiencing embarrassment created through unwanted attention and report that their needs are not sufficiently met when support is needed or required (Buzio et al., 2002; Cahill & Eggleston, 1995; Gibson & Mykitiuk, 2012; Kroll & Neri, 2003).

In sum, adults with CP contend with a variety of difficult and stigmatising experiences, even in the context of accessing needed support. As a consequence of these experiences, individuals with CP may feel less willing to seek desired support (H. Becker et al., 1997). If stigma does cause adults to withdraw from valued support, this is likely to prove costly to their overall health and well-being. It is therefore important to address how people with CP experience stigma when support-seeking and how they cope with, or overcome, this particular barrier to receiving support.

One way in which to understand how disabled individuals experience stigma is in reference to identity (Crocker et al., 1998). Specifically, personal stigmatisation is experienced because their disability assigns them to an identity that is negatively viewed by society (Crocker et al., 1998). If the individual feels stigmatised by others because of their disability, this challenges the possibility of a positive sense of identity, and is therefore something that they may want to manage (Branscombe et al., 2012). From this perspective, we believe that it is important to consider how people

with CP who are potentially stigmatised construct their identity and how this helps them to deal with such experiences.

Identity and stigma

Theoretical approaches to identity such as the social identity approach state that rather being viewed as a singular entity, identity is multi-faceted and incorporates both personal and social components (e.g., Tajfel & Turner, 1979; Turner et al., 1987). Personal identity reflects how people see themselves as unique individuals (and in comparison to other individuals), whereas social identity refers to how people view themselves as members of meaningful social groups (and in comparison to other groups; Tajfel, 1981; Turner et al., 1987). Importantly, recognising the social dimension of identity allows for the possibility that others can be incorporated into the individual's self-concept, and that the individual can be affected by the experiences of their social group rather than simply their own unique experiences. Along these lines, although CP can greatly influence one's personal identity (e.g., "I have CP"), it can also become an important part of their social identity, and be the basis through which people connect to others who share this disability (e.g., "I belong to the group 'people with CP'"; Ablon, 2002; Farrell & Corrin, 2001).

The distinction between personal and social identity is not just theoretical, it has practical relevance to the experience of stigma in support environments. The experience of stigma is likely to be threatening both to one's personal identity (e.g., by reducing a sense of individual competence or uniqueness as a consequence of their CP) and one's social identity (e.g., by casting negative aspersions about people with CP more generally; Charlton, 2000). It is therefore important to consider how individuals might navigate these threats to their identities and what this might say about the balance between personal and social aspects of the self.

A common way in which individuals might manage a stigmatised identity is to adopt individualistic strategies such as leaving the group or of concealing group membership from others (Linton, 2010). Such strategies prioritise the personal self at the expense of the social identity, which allows the individual to distance themselves from their negatively valued group, and therefore protect the self from the associated stigma (e.g., Branscombe & Ellemers, 1998). Alternatively, an individual may enact group-based strategies in order to collectively challenge the stigma (Branscombe et al., 2012; Nario-Redmond et al., 2013; Tajfel & Turner, 1979). There are many examples of how disabled people might wish to use the group to protect themselves from possible negativity, including receiving advice and support from other group members about how they might respond to stigma, or participating in collective action to directly challenge disability inequalities (Charlton, 2000; Ryan et al., 2005). Such strategies may indeed be the only option if group membership is fixed or visible (Asch & Fine, 1988; Katz, 1981), as in the case of CP, because leaving the group or concealing group membership may not be possible (L. C. Brown, 2013). These strategies, however, require connecting the individual self to a stigmatised group, which may be costly in terms of well-being, as it may reinforce the salience of the collective stigma and the devaluation from which they wish to disengage (Branscombe, Schmitt, et al., 1999; Branscombe et al., 2012).

Nonetheless, there is also a growing body of research suggesting that being a member of a stigmatised group does not always negatively affect well-being (Crocker & Major, 1989) and that identifying with the stigmatised identity itself might sometimes be protective against stigma (Aviram & Rosenfeld, 2002; Bat-Cheva, 1994; L. C. Brown, 2013; Fernández et al., 2012). For example, studies have demonstrated that a sense of a shared identity with other stigmatised people allows the

individual to benefit from the actual or perceived support that comes with group membership (Branscombe, Schmitt, et al., 1999; Branscombe et al., 2012). Shared identity also gives the individual access to collective resources that help combat stigma (Ablon, 2002), such as the knowledge and emotional support to challenge negativity that they may face (Crabtree et al., 2010). Through engaging collectively, individuals can reinterpret the meanings of their stigma (e.g., as something more positive) that are applied to them by others (social creativity; Tajfel, 1978c; Tajfel & Turner, 1979) in ways that allow for the maintenance of positive self-esteem (Branscombe, Schmitt, et al., 1999). They can also work with the group to bring about social change through collective action (Tajfel, 1978d; Tajfel & Turner, 1979).

As a consequence of these many benefits, embracing a disabled social identity may facilitate support-seeking in stigmatising environments (Rüsch et al., 2009). This is because a shared social identity can empower the individual to potentially cope with the negative attitudes that care providers might hold when they provide support (Crabtree et al., 2010; Fernández et al., 2012), and can also act as an informational resource regarding the availability of appropriate treatment (Griffiths et al., 2012). It may also encourage the individual to participate in collective support-seeking (e.g., helping other disabled people to advocate for positive change). As noted previously, however, the many possible benefits of social identity sometimes come at the cost of personal identity. Specifically, accessing the material or psychological support of similar others requires that the individual connects themselves and their identity to a devalued group, thereby potentially stigmatising the self. This presents a dilemma to those who personally wish to avoid such negative connections (Crabtree et al., 2010). People who wish to protect themselves from negative stereotypes, may instead emphasise their individuality (i.e., personal identity), and thus distance from the social

identity. However, enacting identity in this way may impact on their willingness and ability to access desired support and the benefits they can receive from this.

The present research

In accordance with the ideas discussed above, the current study seeks to understand the way in which adults with CP experience support-related stigma and to elucidate the implications of this for their personal and social identity. More specifically, we aimed to qualitatively investigate three main research questions:

1. What support-related stigmas do participants feel are directed at people with CP in general? (RQ 1)
2. What support-related stigmas do participants personally experience and does this impact on their willingness to access desired support? (RQ 2)
3. How do participants view their identity as an individual with CP, and how does this influence the way in which they cope with stigma and how they seek support? (RQ 3)

Method

Participants

A total of 28 White adults with CP (5 male, 22 female, 1 not reported) aged 17-58 years ($M = 31.68$, $SD = 13.05$) were recruited to participate in the study. The majority of participants were from the UK ($n = 15$), with the remainder from the USA ($n = 6$), Australia ($n = 6$) and New Zealand ($n = 1$). The sample had a broad range of educational attainment (high school or lower $n = 8$, college/higher education level $n = 7$, undergraduate degree $n = 8$, postgraduate degree $n = 5$) and severity of CP (see below). Table 1 outlines each participant's characteristics.

Table 1. *Characteristics of participants*

Participant	Gender	Age	Nationality	Education	GMFCS
1	Male	45	Australia	Postgraduate degree	4
2	Male	56	USA	Postgraduate degree	2
3	Female	26	Britain	College/Higher education level	2
4	Female	27	Britain	Undergraduate degree	2
5	Female	18	USA	No/High school level	1
6	Female	58	USA	No/High school level	2
7	Female	48	Australia	College/Higher education level	3
8	Male	52	New Zealand	No/High school level	4
9	Female	26	Britain	No/High school level	3
10	Female	22	Britain	Undergraduate degree	3
11	Male	38	Britain	Undergraduate degree	2
12	Female	22	Britain	Undergraduate degree	1
13	Female	20	Britain	College/Higher education level	1
14	Female	29	Britain	Undergraduate degree	2
15	Female	24	Britain	Postgraduate degree	4
16	Female	20	USA	Undergraduate degree	3
17	Female	39	Britain	No/High school level	2
18	Female	54	USA	Postgraduate degree	3
19	Female	25	Australia	Postgraduate degree	1
20	Female	29	Australia	Undergraduate degree	2
21	Female	17	Britain	College/Higher education level	2
22	Female	46	Britain	College/Higher education level	2
23	Female	21	Britain	College/Higher education level	2
24	Female	20	Britain	College/Higher education level	1
25	Female	20	Britain	Undergraduate degree	1
26	Female	18	USA	No/High school level	2
27	Missing	31	Australia	No/High school level	2
28	Male	36	Australia	No/High school level	3

Procedure and Materials

Participants were asked to provide written responses to open-ended questions within an online survey that was advertised through a number of social networking pages aimed at people with CP. A survey method was decided upon in order to address associated mobility and communication difficulties (Bowker, 2010) that may restrict access for traditional interview techniques. Using this method of recruiting therefore allows access to, and responses from, a larger selection of adults with CP than might have otherwise been available.

The survey was anticipated to take between 30-45 minutes to complete. Participants were first asked to specify demographic information (i.e., gender, age, education, and nationality) and the perceived severity of their CP using the *Gross Motor Function Classification System (GMFCS)* (Jahnsen, Aamodt, & Rosenbaum, 2006; Palisano et al., 1997). The GMFCS is a measure of severity of gross motor functioning disability for children and adults with CP through five levels (I-V), with higher levels representing greater impairment (McCormick et al., 2007). Participants reported their GMFCS levels between I-IV (I $n = 6$, II $n = 13$, III $n = 6$, IV $n = 3$). Finally, participants were asked to list the support they access to assist with management of their condition. The supports they listed (if any) were then fed into later questions in the survey.

Participants were then asked to describe their experiences with stigma. More specifically, they were asked to report whether or not they believed CP in general is a stigmatised condition in support settings, and if so, how they thought adults were stigmatised, regardless of whether they believed such stigma to be personally relevant. Then participants were asked to describe whether they had personal

experiences of stigma when using each of the supports they listed earlier in the survey, and if so, whether this impacted on their willingness to seek support.

Participants were then asked to describe the personal importance of their identity as an adult with CP, and the extent to which they saw themselves primarily as an individual or in more social terms. Developing on from this question, to delve further into the features of their possible social identity, participants were asked to describe how important the CP community was to how they constructed their identity, and the connection and emotion they associated with fellow group members. Finally, participants were asked to describe whether this social identity influenced their personal support-seeking behaviour or how they coped with stigmatising support experiences. For the complete survey, please see Appendix A. The Psychology Ethics Committee at the University of Exeter, UK, granted ethical approval for the research.

Analysis

The qualitative data generated from the surveys were analysed using thematic analysis (Braun & Clarke, 2006). The lead researcher read all written responses provided by participants in order to become familiarised with the content gathered. From here, the lead researcher then reread the quotes, noting patterns or “codes” that might develop into larger themes that addressed the three research questions. On finalising these codes, larger themes were then constructed, and example quotes describing these themes were recorded. Additional themes were created, and existing themes were modified, whenever a new viewpoint emerged from the recorded codes. Once the initial theme structure was completed, each individual theme was reviewed and amended where necessary to ensure that it accurately mapped onto the content of the quotes that were assigned within it. When the complete theme structure was decided upon, a final coding frame was created, which summarised all the constructed

themes, including a brief description of their meaning, as well as a list of example quotes assigned to each theme.

However, given that the lead researcher has a personal diagnosis of CP, and therefore has substantial personal experience of both support access, and stigma as a consequence of their disability, they were aware of the significant personal bias they brought to the analytic process. To attempt to minimise the impact of this bias, the data was independently coded and checked by a second researcher following the analytical process discussed above. On completion of this second coding process, the two researchers came together to review their recorded themes in order to highlight any differences in their interpretations of the data. Where disagreements emerged, the two researchers reanalysed participants' quotes, as well as the assigned codes and themes, and discussed whether any revisions could be made to the final coding frame.

Results

In presenting the results of this investigation, we consider each of the research questions in turn and provide indicative quotes that exemplify each of the themes that emerged from the analysis. These quotes are attributed to specific participants, as indicated by the number in brackets connected to each quote (see Table 1).

RQ1: What support-related stigmas do participants feel are directed at people with CP in general?

The majority of participants (71%) were aware of the stigma associated with their condition and believed stigma to be a fundamental reason why adults with CP may not seek the support they need.

(8) *“stigma has always been a barrier to many of us because of our CP.”*

Participants gave several examples of the stigma that adults with CP are likely to face. The most commonly reported example was that the disability promotes an automatic stereotype of a severely impaired person who is entirely reliant on others for assistance, or of an individual with a speech or intellectual disability. As a consequence of these stereotypes, many believed that support providers engaged in patronising communication or offered inappropriate care to adults with CP who need support.

(7) *“Yes, people with CP do experience problems due to stigma. We are often seen as unable to talk for ourselves and we are not given the opportunity to orchestrate our own care needs.”*

(5) *“People tend to see those with cerebral palsy as mentally handicapped, even if they are not. This reaction can cause them to treat the person with CP not as an adult but a young adult or child. Being talked down to restricts how much help the supporter is willing and able to provide.”*

In addition, participants felt that the majority of adults with CP do not fit the rigid and extreme stereotype held by some care providers. As a result, some were concerned that individuals responsible for providing care may not believe that those who do not fit this stereotype, such as those with milder forms of CP, actually have the disability, or may not provide necessary support to meet their needs.

(4) *“People don’t seem to be able to comprehend that CP can mean a mild or major disability and that it’s individual to each person who has it.”*

(19) *“I think there’s a stigma that society believes if you don’t look ‘that disabled’ you can’t need any extra support.”*

(10) *“People expect us to always be “severely disabled” in some respects bedridden. When they realise that is not always the case they tend to overlook the difficulties we do have.”*

RQ2: What support-related stigmas do participants personally experience and does this impact on their willingness to access desired support?

A large majority of participants indicated that they accessed some form of support (93%). Of these, when asked about the stigma they encountered when accessing support, over half (58%) reported feeling stigmatised. Personal experiences often reflected the stigmas that adults’ believed were common in support situations for those with CP more generally, as described above. However, respondents also gave other examples of how they felt stigmatised. The most commonly reported stigma was simply acknowledging they needed to access desired support, something which amplified feelings of difference from the non-disabled community.

(24) *“I feel the fact that I need so much support marks me out as different from other people”*

Many participants also experienced stigma in relation to the rigid CP stereotype outlined in the previous section. Specifically, some participants indicated that while they accepted that they needed a particular support, they often felt that those responsible for providing such support and the wider community did not share this view because they did not appear ‘sufficiently disabled’. Where disagreements around this occurred, participants felt they had to justify their need as a disabled person, something that created additional burdens on the self. However, this also caused some participants to reflect on their actual need for this support, resulting in

feelings of guilt that they may be preventing adults with more severe impairments from accessing necessary assistance.

(22) *“I feel that we have to battle to receive this support...because each time I try to access support I have to justify myself”*

(9) *“I do not look like I have “[Cerebral] Palsy”. It’s a very [unhelpful] label in my case. Because people don’t think I should have a blue badge [disabled car parking permit] or use a disabled toilet and they some times wonder why I get any help at all.”*

(19) *“If I’m made to feel like I don’t deserve it or I’m ripping off the system because I’m not as much of a severe case as someone with full blown CP, it makes me feel like I shouldn’t even ask for the support, despite needing it just as much.”*

(20) *“As a lot of my friends with disabilities have conditions that are more severe than my own, I tend to feel guilty accessing the same services they use. Even though I do need them!”*

Finally, several participants reported that care providers had a general lack of awareness of the problems associated with CP, which created uncomfortable situations for them. As a consequence, they had to acknowledge inappropriate attitudes towards them and their ability. Such experiences occurred both in, and away from, support situations.

(9) *“I hate [how] people have to be explained to about my [disability]”*

(12) *“I [find] people’s attitudes towards CP frustrating”*

(3) “GP’s do not understand what hemiplegia [a specific type of CP] is - there is not enough awareness of it - I find myself having to explain it to medical professionals who look at me confused” (sic)

(24) “[a] colleague has been very discriminatory towards me...For example, she once said I take a while. I may be slower than others at some tasks due to my hemi[plegia] arm but having it pointed out in this way made me feel dreadful”

However, despite the numerous experiences of stigma, very few participants believed that this had any detrimental impact on their support seeking. The main reason for this was due to their perception of need. Specifically, that the benefits provided by the support outweighed the possible negativity associated with accessing this help.

(20) “I do recognise how important and positive all the support that I do get is. In this area of my life, the fact that I may be viewed differently by others or discriminated against because of it, does not affect my willingness to attend.”

RQ3: How do participants view their identity as an individual with CP?

When participants reflected on how they constructed their identity in terms of whether they preferred to see themselves as individuals first and foremost or as part of a shared, social identity centred around being an adult with CP, responses were mixed. Some participants reported not feeling a sense of common identity with others sharing their condition, and instead viewed their diagnosis and life with CP in individualistic terms and as unique and personal to them.

(18) “Every CP person is...different.”

Conversely, others felt that their diagnosis was a reason to identify as part of a larger CP group.

(10) *“We all share a very common interest that relates to each of us everyday.”*

However, a large number of participants highlighted that their constructed identity contained both personal and social components, and discussed their awareness of how they ‘shifted’ their identity depending on the situational requirements.

(17) *“we are all individual but have common ground also”*

(23) *“I’m just me, everyone is different, an individual. I know that there are others with cerebral palsy but the only time I consider myself as part of a group is at an event for people with cerebral palsy”*

With respect to participants’ personal identity, the vast majority viewed their diagnosis and life as an adult with CP as unique and important to them. Many participants explained this importance through the highly salient nature of their CP status and the constant impact of this on their lives. Although the salience of this identity also made participants aware, to varying degrees, of their impairment, the majority were also very positive about their CP, through feeling that they have personally overcome challenges they have faced and will continue to face throughout their lives.

(5) *“I’m constantly aware of my CP. It affects everything I do in every part of my life.”*

(4) *“I’m proud to have success [despite] having a disability”*

Consequently, for many participants, being an adult with CP has shaped, and continues to greatly influence, their constructed personal and social identities.

(7) *“My CP has helped to form my identity. I wouldn’t be the person I am today if I didn’t have CP. I probably wouldn’t be working as a disability support worker and have the friends that I have.”*

Indeed, adopting a social identity was also positive for many participants. In particular, participants wanted to display a strong sense of community to other people with CP, and sought out interactions and relationships with them because of *“a shared history and an understanding”* (1). From disclosing and listening to experiences of other adults with CP, participants gained a better understanding of their condition and gained the feeling that they were not alone.

(7) *“I have a great deal of respect for the other folk I have recently met with CP. We are all doing great things in our lives.”*

(18) *“It is nice to talk with other CP adults.”*

(21) *“I feel I can relate to others with CP, where the majority of people around me cannot, and I also feel...some advantage of knowing to some extent how they may be feeling.”*

(7) *“It has been very liberating discovering that many of my experiences have been very similar to other adults with cerebral palsy”*

(25) *“it’s nice to know I’m not the only one with the condition”*

In addition, this sense of shared social identity appeared to provide a meaningful strategy for dealing with experienced stigma or other difficulties. In

particular, many reported that discussing these experiences with other social network and forum group members was positive.

(19) *“Venting and sharing similar stories of discrimination with people that understand you is a wonderful thing”*

(3) *“Chatting to other [people] on the hemi[plegia] Facebook pages is very comforting, as there are people with the same issues, problems and fears as me”*

With respect to how they viewed their identity in relation to their support-seeking behaviour, all participants very much viewed their own support-seeking as entirely personal to them, and thus prioritised their personal identity in order to ensure that their received care was individualised to their own unique needs.

(14) *“I seek support because of my individual needs and requirements independently and not because I identify with other adults with CP.”*

However, some did value the social group, but only as an informational resource whereby they could learn from the support experiences of others. By doing so, this allowed participants to incorporate this acquired knowledge into their own support-seeking behaviours.

(1) *“If I learn of a potential health issue from an old friend with CP, I ask my service providers about it.”*

In other words, participants again expressed motivations to portray themselves both in terms of their personal and their social identities emphasising both desired individuality for support, and also similarity to others to assist support requests.

(15) *“If a method of support has been useful to a friend with CP, I would be more likely to try it, but a lot of the support I receive is individualised and necessary for me to perform basic daily tasks.”*

Nevertheless, regardless of whether participants felt that their social identity facilitated their own support seeking, they commonly felt the need to support others who needed assistance with their seeking support and experiences of stigma.

(7) *“I find myself in an advocate/advisor role - informing other younger people about types of services they may be able to access.”*

(6) *“it is important to me to share my struggles with the hope of saving others from struggles as well.”*

Discussion

The aim of this research was to investigate the way in which adults with CP recognise and experience support-related stigma, and whether this influences their willingness to access such support. Moreover, we aimed to investigate how adults with CP construct their identity, how they incorporate both personal and social aspects into their identity, and how this identity construction influences how they cope with stigma and the support they seek.

When asked to describe the overall stigma associated with CP, the majority of participants indicated that this was a significant concern. Participants reported that they believed that care providers held rigid ideas about how an adult with CP is supposed to ‘look’ and ‘act’. They also noted that the majority of adults with CP do not fit this stereotype. The lack of fit between stereotypes and reality was seen to promote care provider scepticism regarding the legitimacy of milder (or less-

stereotypical) forms of the disability, and thus lead to difficulties in accessing desired support (Crooks et al., 2008).

The described experiences of stigma largely reflected this view, although participants also offered additional, unique experiences. Many acknowledged that they needed support, and felt they were legitimately entitled to it. However, accepting needed assistance heightened feelings of ‘being different’ from the majority of society who do not need support (Buljevac et al., 2012; Sandström, 2007). In addition, accessing support resulted in their perceived need being scrutinised. Consistent with the above, this feeling of scrutiny was especially pronounced when participants believed that they did not fit the stereotype of CP held by those providing care. Participants reported that this scrutiny also extended to the wider community beyond the support environment. As a consequence, participants continually felt the need to defend and justify their use of support services to society. This, in turn, triggered feelings of guilt about their apparent deservingness, because their own use of support might adversely affect the access of others who also need assistance, and who are perhaps ‘more deserving’. Interestingly though, despite a common awareness of these negative experiences, the majority of participants indicated that they continued to access support. This was largely because they expected that the benefits of the desired support would outweigh the costs of any negativity experienced.

When discussing identity, participants did not view their identity as primarily personal *or* social, but rather as something that displayed elements of both these aspects of self-definition. This is in line with the social identity approach, which suggests that both personal and social aspects can be important bases of self-definition (Turner et al., 1987; Turner, Oakes, Haslam, & McGarty, 1994). Unpacking this further, many participants believed that their diagnosis was unique to them, and as

such, only they can experience living with *their* disability and the associated life choices and challenges (i.e., personal identity was emphasised). However, participants were also generally positive about identifying as a member of a CP social group. In particular, participants felt a strong desire to create and maintain meaningful and positive relationships with other adults with CP (Farrell & Corrin, 2001). Moreover, recognising oneself as part of a larger CP group offered potential benefits based on mutual experience, and the feeling that others are experiencing similar difficulties (Sandström, 2007). Some participants, in turn, felt a sense of duty and empowerment to share their knowledge in order to potentially help other forum members with support access or coping with stigma (e.g., Attard & Coulson, 2012).

Although both personal and social aspects of identity were important, each of these bases of self-definition may bring potential costs in terms of stigmatisation, something that needed to be negotiated. More specifically, participants appeared to be continually balancing the need to protect their sense of individual self in relation to the CP social group, while simultaneously ensuring access to desired support. Reflecting on the priority and value placed on individuality in this sample, many preferred to distance themselves from the group in order to ensure that they were seen and treated as unique, rather than on the basis of their disability (Fernández et al., 2012; Hogan, Reynolds, & O'Brien, 2011). Yet, viewing themselves solely in personal terms may also prove costly, as they may nonetheless be associated with their disability group by others and stereotyped on that basis (Fernández et al., 2012). Perceiving themselves only in individual terms could also restrict access to the social support provided by other disabled people, as in order to use these resources, individuals need to identify as similar to this group (Branscombe et al., 2012; Fernández et al., 2012). The social support received from others via this shared social

identity may be of particular importance for personal coping, through providing mutual understanding of the individual's experience (Sandström, 2007). More specifically, online forums whereby disability is a condition of membership can provide disabled people (i.e., people with cerebral palsy) with the opportunity to not only share their personal experiences, but also to receive guidance from the experiences of others, such as recommendations or information about potentially useful healthcare support (e.g., Attard & Coulson, 2012; Braithwaite et al., 1999; Finn, 1999; Obst & Stafurik, 2010).

Similar issues are also raised when attempting to navigate the stigma of support from care providers. Specifically, because the majority recognised that support was needed, this created possible pressures to demonstrate their disability social identity in a stereotypical way to their care provider (Crooks et al., 2008; McLaughlin, 2012). Yet, demonstrating their CP social identity can also be costly, as care may become focused on the needs of the CP community as a whole rather than their personal requirements. It also may elicit dual concerns regarding feelings of difference from those who are non-disabled, but also about being “insufficiently disabled” to legitimately receive support in the eyes of their care provider (Buljevac et al., 2012; Sandström, 2007). Through being negatively associated with their social group in this way, participants discussed additional costs in terms of awareness of their impairment and feelings of guilt over their support access.

Thus, we infer from the data that there is likely to be a continual back-and-forth between different bases of self-definition (i.e., as a unique individual versus a member of the CP group) as individuals try and manage the implications of maintaining a positive view of the self and for accessing required care. This apparent shifting between personal and social identity may reflect not just the demands of the

immediate contexts, but also the on-going process through which the individual attempts to balance the relative costs and benefits of each aspect of identity.

In sum, we believe that this research provides insight into two parallel identity concerns: one of ensuring a positive personal view of the individual self in relation to the group, and one of navigating identity when stigmatisation from care providers is experienced. Within the support environment, these two concerns intersect. In order to navigate stigma, as well as ensuring support access, participants may have to construct a desirable identity that incorporates both a positive sense of individual self in relation to others, whilst also maintaining their social identity (Hornsey & Jetten, 2004). These two aspects of identity potentially conflict with the needs of the self and the requirements of the support situation (e.g., advocating their uniqueness to ensure that support is individualised to their own needs, whilst at the same time, highlighting their similarity to others to assist the support process). In attempting to address these potentially conflicting concerns, individuals may experience difficult identity dilemmas in terms of how and whether they align themselves with the CP community.

These parallel concerns raise important practical implications for both people with CP as well as the individuals providing support. From the perspective of individuals with CP, our data suggest that recognising and demonstrating their individuality was highly important, both in life and when accessing support. But, in certain contexts (e.g., support), highlighting similarity to others (i.e., their social identity over the personal identity) may be both necessary and important for overcoming potential stigma and negativity. Being similar to the “disability stereotype” marks them as the legitimate recipient of support, whereas desired uniqueness in this context may potentially preclude them from this. A sense of social identity with others was also an important basis for accessing disabled support

networks, and benefiting from the sharing of knowledge and experiences.

Accordingly, from the healthcare perspective, it is important to see patients as both individuals with unique needs, as well as part of a shared collective CP group. To do this, we recommend encouraging a view of CP as a highly heterogeneous disability, both in its visibility and severity, and that care should be personalised to suit individual needs and experiences, while at the same time also recognising the common concerns around need for support and understanding of CP (Postmes & Jetten, 2006). Allowing for both these views of identity, and promoting awareness of the importance of each to successful coping, might help to alleviate some of the tension between personal and social aspects of identity faced by individuals with a disability, and some of the stigma associated with accessing necessary support services.

Because of our chosen design and analytic strategy, we are limited in our ability to infer causally from this data. Specifically, we cannot say whether stigma was instrumental in guiding how participants negotiated their identity, nor whether the various identity constructions causally impact on support-seeking. Because of this, the interpretations of the data offered here should be treated with caution. While we believe we are correct in inferring that stigma, identity construction, and support seeking go together in interesting ways in the context of physical disability, to build on this insight, and to elucidate our claims, further research is clearly necessary. Specifically, additional qualitative work could delve deeper into the contrast between the desire to maintain individual identity and the need to engage with, and even perform, collective identity, and the dilemmas this might create for maintaining the individual's sense of self. Quantitative investigations could also explore identity navigation more closely by examining the impact of different salient concerns, or the

different audiences related to these, on how individuals with CP communicate their identity to others and the psychological processes behind these choices.

Extending this line of thought, our method of collecting qualitative data involved the use of online surveys rather than more traditional interview or focus group methods. There are many advantages to using online methods for disabled people, for example removing barriers to their participation (Dattilo et al., 2008), as well as allowing them the opportunity to think and respond to questioning at their own pace (Nicolas et al., 2010). However, a critique of online surveys is that the amount of content that is gathered will often be substantially less than that of face-to-face interviews (Nicolas et al., 2010; Synnot, Hill, Summers, & Taylor, 2014). This in turn, suggests we may be restricted in the claims we can raise from this study due to insufficient data. Yet, we potentially question this as a limitation, as when considered side-by-side, thematic content from online surveys is comparable to that of interviews (Campbell et al., 2001), as survey responses will likely be more concise and on topic, whereas interviews, while more detailed, may contain information that is potentially irrelevant and ambiguous (Nicolas et al., 2010; Synnot et al., 2014).

Nevertheless, an additional weakness of this research is the sample used. This was heavily biased towards women, and research suggests that physically disabled women may be more aware of stigma than men (e.g., Cossrow, Jeffery, & McGuire, 2001). This may have amplified the overall prevalence of stigma-related concerns within the current investigation. There was also a slight skew to participants of lower GMFCS levels to that of societal distribution (Himmelmann, Beckung, Hagberg, & Uvebrant, 2006). Due to the nature of the study and the depth of answers required, the emphasis on having sufficient motor skills may have prevented adults with the most severe impairments from participating. This is important to highlight considering

previous research has demonstrated that people with more severe CP may be more at risk of stigmatisation (Colver et al., 2011; Crandall & Moriarty, 1995). Therefore, the study may have not successfully recruited adults who experience the greatest stigmatisation. However, our results suggest that stigma experience was consistent regardless of reported GMFCS level, potentially questioning this as a limitation.

A further weakness was that our method of recruitment was entirely within existing CP social networking and forum pages. To join these online support groups, people with CP have to acknowledge that their condition is an important part of their self when compared to those who choose not to become members. Moreover, it is likely that individuals who chose to participate are more engaged with the support groups, as they would have been aware of the posts by the lead researcher alerting them to the study. This could mean that the participants who completed the survey view their disability and/or the social group more positively, and may also be more likely to use the group for advice and support when compared to people who are less engaged (e.g., Huang & Guo, 2005). As such, the level of positivity held by participants towards their social groups, and the influence these groups have in helping them navigate stigma and support-seeking concerns, may be exaggerated when compared to the wider CP community.

In sum, in acknowledging the above limitations with this study, we recognise that although the findings provide rich data on the selected participants, they cannot be generalised to the wider CP or support populations. Future research should continue to explore the influence of identity, stigma and support seeking to a wider and more representative sample of adults with CP.

Conclusion

Our research demonstrates that the experience of stigma remains an issue for many people with CP, especially within the context of seeking and receiving support. In response to this stigma, individuals face a number of difficult dilemmas in how they view and portray their identity both in terms of maintaining a positive sense of self in relation to the wider CP community, but also ensuring that they are able to access desired support from their care provider.

CHAPTER 5**IDENTITY PERFORMANCE IN RESPONSE TO SITUATIONAL
STEREOTYPING: THE EFFECT ON INGROUP TIES, HELP-SEEKING,
AND WELL-BEING IN PHYSICAL DISABILITY**

Abstract

Physically disabled people often experience stigmatisation. However, little research has investigated how these individuals respond to experienced or expected negativity, or what this means for how their identity (as individuals and disabled people) is performed. Across three studies, we examined the way in which physically disabled people self-presented their identity in different situational contexts and audiences. Study 2 activated concerns around receiving help versus avoiding discrimination. Studies 3 and 4 activated the audiences to which these concerns are linked by making participants believe that their answers would be visible to either: healthcare providers, the general public (Study 3), educators and employers (Study 4), or a no-audience control. All three studies also considered the role of ingroup ties as a possible moderator of the effect of salient concerns or audiences. Results showed no differences in self-presentation when concerns alone were activated (Study 2). However, activating the audiences with which these concerns are associated revealed interesting differences. Healthcare providers especially activated stereotypes of unworthiness, passivity, and coldness, whereas the general public and educators and employers activated stereotypes of incompetence (Studies 3 and 4). How participants presented their self in response to these stereotypes varied as a function of ingroup ties: Participants with weak ingroup ties tended to absorb the stereotypes in their own self-descriptions, whereas those with strong ties rejected the stereotypes (Study 4). These studies demonstrate how the performance of disability varies according to the audience (rather than issues), and the meaning of these for one's identity.

Physical disability is highly stigmatised in society. Physically disabled people are rarely seen as equals to the non-disabled, and are instead assumed to live a life that is somehow damaged (Wright, 1983) or incomplete (Charlton, 2000). Collectively, physically disabled people are associated with a number of negative stereotypes, including incompetence, dependency, and child-like passivity (Linton, 2010; Nario-Redmond, 2010). Such stereotypes can elicit positive, yet paternalistic, feelings of pity and sympathy (e.g., Fiske et al., 2002; Glick & Fiske, 2001).

Physical disabilities are often very visible (Asch & Fine, 1988; L. C. Brown, 2013; Katz, 1981), and are therefore difficult, if not impossible, to conceal (Branscombe et al., 2012; Nario-Redmond et al., 2013). This visibility means that the paternalistic attitudes others associate with disability may routinely result in well-intentioned interactions and offers to help disabled individuals. But, such help may not necessarily be of the kind they need or want because of the potential of helping interactions to reinforce negative stereotypes (Charlton, 2000; Cuddy, Fiske, & Glick, 2008; Wang et al., 2015). Although rejecting help might protect the individual from negative stereotypes of dependence or passivity, this might leave the individual without needed support and might disrupt the interpersonal relationship with the individual offering help (Charlton, 2000). Accordingly, physically disabled people may experience dilemmas in how they present their identity in terms of navigating potential stigma, but also, accessing desired support. It is these dilemmas of how one is seen by others, and how one should respond to those perceptions, that are the focus of the present research. Specifically, we investigate how physically disabled individuals engage in specific identity performances in response to the perceived stereotypes held by others (i.e., meta-stereotypes; Vorauer et al., 1998).

Negotiating stereotypes and identity performance

Knowledge of the stereotypes others hold about one's group has been shown to influence how individuals behave. Sometimes these influences are unconscious (e.g., in the case of stereotype threat; Silverman & Cohen, 2014; Steele & Aronson, 1995), but at other times, individuals might consciously try to address the perceived stereotypes of others through their actions (O. Klein et al., 2007). The ways in which individuals enact their self, and tailor this to respond to the specific stereotypes others are seen to hold, has been explored in the literature on *identity performance*. O. Klein and colleagues (2007) refer to identity performance as the deliberate and strategic performance behaviours that stigmatised individuals may enact to either strengthen the image of their identity to an outgroup, or attempt to alter the outgroup's opinion of their identity. In line with this, stigmatised individuals are likely to have a repertoire of different behaviours that they may enact according to the situational demands and the specific audiences with which they are interacting (Barreto et al., 2003; Wiley & Deaux, 2011).

Within the context of disability, awareness of negative stereotypes, and the implications of these for individual action, are issues that may emerge in relation to multiple audiences in, and away from, support contexts. For example, within the health-related support and care environments, stereotypes about physical disability create specific expectations about the needs and impairments of disabled people, and thus may act as a justification for support allocation or withdrawal (van Rijssen, Schellart, Berkhof, Anema, & van der Beek, 2010). To the extent that individuals are not seen to fit the stereotypic attributes or appearance of a stereotypical disabled person, health professionals and care providers may not categorise them as "in need" and may respond negatively to support-seeking requests (Chapter 4; Crooks et al.,

2008). This is particularly important considering that in order to access desired care, physically disabled people are often reliant on these powerful individuals to determine their suitability (Buljevac et al., 2012; Horton-Salway, 2007; McLaughlin, 2012). In order to negotiate these views, physically disabled people may feel the need to perform their identity in ways that confirm stereotypical expectations of how their group should act (L. C. Brown, 2013; Lane, 2010), such as being compliant and avoiding confrontation (Linton, 2010), and emphasising their need and deservingness. In so doing, however, disabled people may potentially reinforce negative stereotypes about their group, for example as being passive, weak, and dependent.

Away from support situations, salient stereotypes may place different demands on disabled individuals when they contemplate their actions, and accordingly, how they demonstrate their identity to others is likely to be quite different. For example, in educational or employment settings physically disabled people are frequently viewed as incompetent or unsuitable for study or their work position (Louvet et al., 2009; Olney & Brockelman, 2003). As such, physically disabled people who disconfirm the stereotypes of incompetence associated with their condition, such as by engaging in physical activity, are likely to be viewed especially favourably (Arbour, Latimer, Ginis, & Jung, 2007; Gainforth, O'Malley, Mountenay, & Latimer-Cheung, 2013; Tyrrell, Hetz, Barg, & Latimer, 2010). Accordingly, in such educational or employment situations disabled people may attempt to downplay, conceal, or shift the emphasis away from their impairments in order to be viewed more positively (Louvet et al., 2009; Olney & Brockelman, 2003; Wright, 1983).

One consequence of these contextually variable social expectations of disability is that disabled people may have to switch between different performances of their identity, depending on the situation and the stereotypes at play (Crooks et al.,

2008; Grytten & Måseide, 2005). There is preliminary evidence for these ideas. For example, Taub, McLorg, and Fanflik (2004) highlighted that physically disabled individuals in academic study consciously adapted their stigma coping strategies depending on the audience they faced. In everyday situations with classmates, disabled individuals reported trying to downplay their disability, therefore attempting to “pass” as a non-impaired individual (e.g., Goffman, 1963). However, when attempting to access and receive support for their academic life, they would seek to deliberately affirm their disability status in order to justify their need for support, as well as combat possible beliefs from society that they were a malingerer. Similarly, Read and colleagues (Chapter 4) found that physically disabled adults often perceive healthcare providers to hold a rigid stereotype of how they should look and behave, and that this was associated with concerns over how deviations from this stereotype could impact on their access to needed support.

Although these studies highlight disabled individuals’ awareness of multiple stereotypes, and hint at attempts to negotiate these through their own behaviour, these insights are currently confined to qualitative data. One goal of the present chapter is to delve further into the processes underlying shifting identity performances by using experimental methods that allow for the activation of different audiences, and the exploration of individual self-presentations as a function of audiences. Another goal of the research presented here is to examine how individuals might respond to the same stereotypical pressures as a function of their orientation to concerns around collective (versus individual) identity maintenance – both of which might be of concern to the disabled individual.

Group identification in identity performance

As we have seen in Chapter 2, an important factor that is likely to determine how physically disabled individuals decide to perform their identity is their sense of collective identification as a disabled person. Social psychological theories of identity, such as the social identity approach (Tajfel & Turner, 1979; Turner et al., 1987), highlight that an individual's identity includes both personal and social aspects. One's personal identity relates to how one describes and views themselves as unique and different from other individuals, whereas one's social identity reflects how one sees oneself as a member of larger groups, as distinct from other groups (Tajfel, 1981; Turner et al., 1987). Both personal and social identities are important aspects of the self, but their relative salience will vary across individuals and situations. Which particular aspect of identity is most salient has important consequences for action because different identities activate different norms that structure thoughts, feelings, and intentions. When social identity is salient, individual responses tend to be oriented towards other group members and behaviour tends to be cooperative within group boundaries (and competitive across group boundaries).

However, even when social identity is salient, individuals may orientate themselves differently to that identity as a function of the degree of personal meaning associated with group membership. For some, group membership is a central part of their self-concept and they feel a strong connection and emotional response to other group members (i.e., "high identifiers"), whereas for others, group membership is less important and less focused on interpersonal ties and feelings (i.e., "low identifiers"). High identifiers are more likely to act in ways that are seen to benefit the group, whereas low identifiers will tend to prioritise their individual self over collective concerns.

Of more specific relevance to the issue of stigma, Tajfel (1978d) originally proposed that in response to a devalued identity, individuals can enact one of three identity maintenance strategies. On the one hand, they can adopt a strategy of individual mobility, which involves distancing the self from the negatively perceived group, thereby protecting their own individual identity. On the other hand, individuals can adopt one of two group-based strategies. The strategy of social creativity involves accepting the status quo while redefining the meaning of group membership within it, whereas the strategy of social competition involves directly challenging the legitimacy of other's negative perceptions and trying to change the status quo through conflict or competition. Which strategy an individual adopts has been shown to depend on their degree of group identification (Doosje & Ellemers, 1997): individuals who feel little or no connection to their group are more likely to enact an individual mobility strategy, whereas individuals who feel a connection with fellow ingroup members are more likely to challenge the source of stigma, either creatively or conflictually (Ellemers et al., 1997).

Bringing these ideas into the context of disability, disabled people may describe themselves as primarily an individual (with a disability) or as someone who belongs to part of a larger disability group. How they construe their identity is likely to have important implications for how they deal with potentially stigmatising situations (e.g., support-seeking) and how they engage in specific forms of identity performance when interacting with an audience (e.g., reinforcing stereotypes when interacting with a healthcare provider). For example, disabled people can, and often do, decide to reduce the threat directed at them by concealing or downplaying the visibility or severity of their condition (Goffman, 1963; Linton, 2010; Taub et al., 2004). This strategy allows the disabled person to distance themselves from the

broader group, and therefore the source of identity threat (Branscombe & Ellemers, 1998). Other disabled individuals may instead decide to remain in solidarity with the group in order to benefit from the shared knowledge and expertise, to redefine the meaning of stigma, or use available group resources to reinforce personal agency (e.g., self-esteem and self-efficacy) and combat the source of prejudice (Crabtree et al., 2010; Fernández et al., 2012; Nario-Redmond et al., 2013; Southall et al., 2010; Tajfel, 1978d; Tajfel & Turner, 1979).

The latter possibility is in line with the ‘rejection-identification’ model (Branscombe, Schmitt, et al., 1999), an application of social identity theorising, which proposes that although perceiving discrimination against one’s group can be personally painful, the group itself can be a resource that protects the self against the negative effects of perceived discrimination. More specifically, these authors predict that while the perception of discrimination will negatively affect individual well-being, discrimination will positively predict identification with the discriminated ingroup. Because ingroup identification is believed to be positively associated with well-being, the effect of discrimination on ingroup identification should act as a mediator to well-being, or rather, indirectly buffer the self against the direct and negative effects of perceived discrimination. This theoretical idea of responding to perceived discrimination has received much support in studies to date, but most of this research has been conducted in the context of perceived discrimination on the basis of ethnicity/race and gender. Only very recently has research considered other forms of stigma, including physical disability, in which a replication of this model was found. Specifically, Fernández and colleagues (2012) reported how people with dwarfism who report strong and positive intragroup contact also reported improved psychological well-being when stigma was experienced.

More recent work has further broken down the concept of identification and distinguished between its different facets, each of which has been demonstrated to have different consequences for thoughts and behaviours. Most multi-faceted models of identification distinguish between identity importance (or “centrality”), the bonds felt to other group members (“ties”) and the positive emotions associated with this (“affect”; Cameron, 2004; Tajfel, 1978a; Tajfel & Turner, 1979). While each of these are an aspect of the individual’s overall identification with the group, each is thought to play a distinct role in guiding individual or collective action. Particularly, the ties component of identification has been linked to heightened responsiveness to group-based threats, coordinated ingroup action, living up to group based-commitments, and general group-based solidarity (e.g., Doosje et al., 1995, 1999; Leach et al., 2008). For this reason, ties to the ingroup should predict forms of behaviour that defend the group in the face of social identity threats, for example by strategically managing the group’s external image (Packer, 2011).

On this basis, we believe that responses to disability stigma might involve individual differences in felt ingroup ties (Dunn, 2015). In particular, ingroup ties may be important in shaping or moderating disabled people’s decisions about how they demonstrate their identity in ways that respond to the perceived stereotypes of others. We are therefore interested in resolving the two methods of stigma coping in relation to physical disability - that is, whether the ingroup can act as a buffer against the negative effects of stigmatisation (e.g., as revealed through a mediating role of this variable: Branscombe, Schmitt, et al., 1999; Fernández et al., 2012), or if the level of ingroup ties determines whether disabled individuals amplify or reduce the impact and experience of their identity in response to the perceived stereotypes of specific others (e.g., as revealed through a moderating role of this variable: McCoy & Major,

2003). Theoretically, both possibilities seem equally plausible – and indeed may coexist.

The present research

As reviewed above, physically disabled people are (a) likely to be aware of the stereotypes others hold about them, and (b) likely to be concerned about the implications of their actions for these stereotypes. Although these concerns may be salient across multiple contexts, the specific features of the stereotypes activated in a given context should give rise to variable performances of disability (Taub et al., 2004). Indeed, these ideas have been alluded to in previous qualitative research on disability (Chapter 4; Taub et al., 2004). However, we are aware of no research to date that has quantitatively explored the situational performance of physical disability. To address these issues, we draw on social identity theory, and more specific research into identity performance, and we consider how the activation of negative stereotypes and the audiences they relate to shapes individual self-presentations of disability. In line with the above literature, we also consider the role of social identification, and more specifically ingroup ties, in shaping these responses.

Study 2 begins by examining whether the activation of specific concerns (discrimination versus help-seeking) might give rise to the perception of identity performance pressures, and how this in turn might influence well-being and willingness to seek help. We also measured whether ingroup ties could protect well-being from the negative effects of the stigma concerns (Branscombe, Schmitt, et al., 1999; Fernández et al., 2012; Nario-Redmond et al., 2013). In Studies 3 and 4, rather than simply activating the concerns, we instead manipulated the salience of the specific audiences to which these concerns are attached. Study 3 manipulated the salience of healthcare professionals or the general public (as indicative of help-

seeking versus discrimination), and Study 4 contrasted healthcare professionals with academic/employment audiences. In these two studies, we assessed the stereotypes associated with the activated audiences, as well as the consequences of these for individual willingness to seek help and well-being. We also considered the role of ingroup ties with the disabled category as a moderator in shaping responses to these concerns and stereotypes (Packer, 2011).

STUDY 2

From an identity performance perspective, individual attention to audiences (i.e., how one might be seen), not just salience of specific issues (i.e., what one is thinking about), is relevant to understanding shifts in self-presentation across contexts (Barreto et al., 2003; O. Klein et al., 2007). Accordingly, Study 2 sought to determine whether the activation of specific concerns would give rise to different self-presentations among disabled individuals. To activate different concerns, we manipulated the issue that was salient to participants: accessing support for their disability (activating concerns about accessing help), or experiencing discrimination because of their disability (activating concerns about avoiding discrimination). After the manipulation, participants indicated their agreement with a series of statements to assess the pressures they felt to perform their identity in specific ways, their connections to the disabled group (i.e., “ingroup ties”), as well as their self-esteem, willingness to seek support, and subjective health.

Our expectation was that although the manipulation (i.e., accessing support versus experiencing discrimination) would equally activate identity performance pressures, these pressures would have different consequences for willingness to seek

support as a function of the situation. Specifically, perceived pressures to perform one's identity while contemplating support should activate desires to prove one's neediness and therefore increase support-seeking behaviour. In contrast, contemplating experiencing discrimination should evoke perceived pressures to prove one's independence and decrease support-seeking behaviour. We also expected that variations in willingness to seek support would have consequences for individual health and well-being more generally. Specifically, we assumed that the degree to which people reported being willing to access support from others would, in turn, be associated with better subjective health (e.g., Chapman, Hall, & Moore, 2013; Schwarzer & Leppin, 1991). In light of these expectations, a second aim of this study was to provide a further test of the rejection-identification model (Branscombe, Schmitt, et al., 1999). Here we predicted that the negative effect on well-being as a consequence of activating (or perceiving) discrimination might be offset by increased collective identification, and through this, increased self-esteem (Fernández et al., 2012; Nario-Redmond et al., 2013) - something which should indirectly support subjective health.

Method

Participants

For this study, we recruited participants with one specific type of physical disability, cerebral palsy (CP). This condition is a life-long disability that promotes impairments in gross and fine motor functioning (Rosenbaum et al., 2007). Eighty-one participants with CP (18 male, 63 female) aged 17-58 years ($M = 34.94$, $SD = 11.05$) were recruited. The majority of participants were White ($n = 77$), and the remainder were Asian ($n = 1$), and Latin American ($n = 1$), unspecified ($n = 2$). The

majority were from the UK ($n = 34$), with the remainder from Australia ($n = 18$), the USA ($n = 14$), Canada ($n = 3$), Mixed Nationality ($n = 2$), Costa Rica ($n = 1$), The Netherlands ($n = 1$), and New Zealand ($n = 1$), unspecified ($n = 7$). Participants also reflected a broad range of severity of CP (see below).

Procedure and Materials

An online survey was advertised via online CP social networking pages. Participants were first asked to specify demographic information (i.e., gender, age, race, nationality) and their perceived severity of their CP. Severity of CP was measured using the *Gross Motor Function Classification System* (GMFCS; Palisano et al., 1997). The GMFCS is a scale used to assess gross motor functioning in children and adults with CP (McCormick et al., 2007; Palisano et al., 1997) using five incremental levels (I-V), whereby level V represents greatest severity of impairment. Participants' self-reported GMFCS levels (Jahnsen et al., 2006) were: I $n = 31$; II $n = 27$; III $n = 14$; IV $n = 6$; V $n = 3$. This allowed us to control for any variation in responses that might be due to the perceived severity of the individual's condition.

Participants were then randomly assigned to one of three conditions that were designed to activate different concerns around disability stigma: support access, general discrimination, or an everyday life control. Specifically, in the support condition ($n = 25$), participants were asked to think about, and write down, up to three types of support they accessed to assist their CP. In the general discrimination condition ($n = 26$), participants were asked to think about, and write down, up to three episodes of discrimination they may have experienced because of their CP. In the everyday life control ($n = 30$), participants were just asked to think about their everyday life as a person with CP, with no writing task.

Having reflected on these different contexts in which stigma might be an issue, participants were then asked to consider how they would describe themselves at this point in time. The items that followed were intended to capture any differences in self-presentation that might have been activated by the specific stigma concerns. First we assessed self-stereotypes. Participants were given a list containing 17 disability-stereotypical words and were asked to indicate the degree to which each word described them *right now* (1 = strongly disagree, 7 = strongly agree). The list was randomised for each participant and included terms that reflected the stereotypes of physically disabled people as warm (e.g., friendly, good-natured, likeable; $\alpha = .84$), incompetent (e.g., capable, intelligent, strong; $\alpha = .87$), and passive (passive, shy, timid; $\alpha = .79$). Following this, participants were asked about their general subjective health assessed using six statements created for this study: “*My current overall health is*” (1 = very poor, 7 = very good), “*In general, I feel tired*”, “*In general, I feel ill*”, “*In general, I feel in pain*”, “*In general, I feel able*”, “*In general, I feel in control of my health*” (1 = strongly disagree, 7 = strongly agree; $\alpha = .85$ with *tired, ill, and in pain* statements reverse coded).

On the next page of the survey, participants were asked about their more conscious awareness of identity performance pressures. On seven items created for this study, participants indicated their agreement (1 = not at all, 7 = completely) with statements that included both awareness of the stereotypes associated with CP, and felt pressures to modify their behaviour in light of these: “*I am aware about how other people see me*”, “*I am aware about the stereotypes other people hold about me*”, “*I feel concerned about acting in a way that confirms other peoples’ views about me*”, “*I feel concerned about downplaying my physical ability to others*”, “*I feel concerned about how other people see cerebral palsy*”, “*I feel concerned about the stereotypes*

other people hold about cerebral palsy”, and *“I feel concerned about acting in a way that confirms other people’s views about cerebral palsy”*. These items formed a reliable scale ($\alpha = .80$) and were averaged into a single index.

In the final section of the survey, participants were asked about their ingroup ties, self-esteem, and willingness to seek support. Ingroup ties was assessed through three statements adapted from Cameron (2004): *“I feel connected with other people who also have cerebral palsy”*, *“I feel strong ties with other people who also have cerebral palsy”*, *“I feel a bond with other people who also have cerebral palsy”* (1 = strongly disagree, 7 = strongly agree; $\alpha = .96$). Self-esteem used three statements from Rosenberg (1965): *“On the whole, I am satisfied with myself”*, *“I feel I have a number of good qualities”*, *“I take a positive attitude towards myself”*; 1 = Strongly disagree, 7 = Strongly agree; $\alpha = .84$). Finally, support willingness was measured through five statements created for this study: *“In general, I can access the support I need to help with my cerebral palsy”*, *“In general, I feel able to access the support I need to help with my cerebral palsy”*, *“In general, I feel willing to access the support I need to help with my cerebral palsy”*, *“In general, I feel comfortable about seeking support I need to help with my cerebral palsy”* and *“In general, I feel happy about seeking support I need to help with my cerebral palsy”* (1 = Strongly disagree, 7 = Strongly agree; $\alpha = .91$).

A final question was included at the end of the experiment to establish the frequency of discrimination participants experienced because of their CP: *“To what extent do you experience discrimination because of your cerebral palsy?”* (1 = not at all, 7 = very frequently); see Appendix B for complete survey.

Results

In order to examine the impact of the salience of different concerns, we first conducted a series of between-participants analysis of variance (ANOVAs) on the dependent measures. These revealed no significant differences between context conditions for: self-stereotypes (competence, $F(2,78) = .14, p = .87, \eta_p^2 = .004$; warmth, $F(2,78) = .03, p = .97, \eta_p^2 = .001$; passivity, $F(2,77) = .48, p = .62, \eta_p^2 = .01$); ingroup ties, $F(2,77) = .81, p = .45, \eta_p^2 = .02$; willingness to seek support, $F(2,76) = .09, p = .92, \eta_p^2 = .002$; self-esteem, $F(2,77) = .20, p = .82, \eta_p^2 = .005$; or subjective health, $F(2,77) = .35, p = .71, \eta_p^2 = .009$. There was also no difference between conditions in identity performance concerns, $F(2,75) = .04, p = .96, \eta_p^2 = .001$. Thus, although participants were equally (moderately) aware of how they might be viewed across conditions ($M = 4.45, SD = 1.31$), the activation of different issues alone did not give rise to varied identity performances.

In the absence of significant effects for context, we collapsed across conditions and explored how individual differences in perceived discrimination frequency (i.e., the experimental conditions substituted for the individual experience of stigma) related to identity performance concerns, and how these in turn, influenced willingness to seek support and subjective health. We also investigated how perceived discrimination related to ingroup ties, and how these in turn influenced self-esteem and subjective health. Means, standard deviations, and variable intercorrelations for the whole sample are presented in Table 2. As can be seen, perceived discrimination was positively associated with identity performance concerns and negatively associated with willingness to seek support and subjective health. Additionally, self-esteem was positively associated with subjective health. Ingroup ties was not significantly associated with any variable.

Table 1. Means, standard deviations, and variable intercorrelations of discrimination frequency, identity performance concerns, support willingness and subjective health (Study 2)

	Mean	Standard Deviation	Discrimination Frequency	Identity Performance Concerns	Ingroup Ties	Self-Esteem	Support Willingness	Subjective Health
Discrimination Frequency	3.87	1.70						
Identity Performance Concerns	4.45	1.31	.23*					
Ingroup Ties	3.61	2.12	.16	.05				
Self-Esteem	5.37	1.49	-.15	-.16	.10			
Support Willingness	4.72	1.64	-.23*	-.35**	.13	.33**		
Subjective Health	4.39	1.37	-.28*	-.26*	-.16	.44**	.33**	

*p = <.05, **p = <.01.

To explore the data further we used PROCESS for SPSS to test several theoretically-driven models (Hayes, 2013). In all models, GMFCS severity was included as a covariate. First, we assessed the possibility that perceived discrimination might indirectly negatively influence willingness to seek help, and that this association might, at least in part, be mediated by the concerns to perform identity in specific ways. Furthermore, we reasoned that processes that impact on willingness to seek help were also likely to indirectly impact on subjective health, since people are likely to feel better when they are enabled to access support from others (e.g., Chapman et al., 2013; Schwarzer & Leppin, 1991). Second, we also assessed how the negative health effects associated with discrimination might be offset through ingroup ties to the social identity and subsequent bolstering of self-esteem (i.e., the rejection-identification model: Branscombe, Schmitt, et al., 1999). Overall, this equated to two independent pathways of serial mediation from perceived discrimination frequency to subjective health: the first via identity performance concerns and willingness to seek help, and the second via ingroup ties and self-esteem, with both pathways including GMFCS as a covariate (Model 6).

Identity performance concerns pathway. The results of the analysis confirmed the positive connection between discrimination frequency and identity performance concerns, $b = .18$, $SE = .09$, $t = 2.06$, $p = .04$, 95% CI: .006 and .36, the negative connection between identity performance concerns and willingness to seek support, $b = -.42$, $SE = .14$, $t = -2.98$, $p = .004$, 95% CI: -.70 and -.14, and finally, the positive connection between willingness to seek support to subjective health, $b = .26$, $SE = .10$, $t = 2.63$, $p = .01$, 95% CI: .06 and .45. A significant amount of variance was explained when all variables above were included in the analysis predicting subjective health, $R^2 = .21$, $F(4,69) = 4.47$, $p = .003$. Moreover, bootstrapping analysis of the two-step mediational pathway (with 1000 bootstrapping re-

samples) confirmed the presence of an indirect effect connecting discrimination frequency, identity performance concerns and willingness to seek support to subjective health, effect = -.02, SE = .01, 95% CIs = -.07 and -.002.

Ingroup ties pathway. The results of this analysis demonstrated no significant correlation between discrimination frequency and ingroup ties, $b = .21$, $SE = .14$, $t = 1.46$, $p = .15$, nor between ingroup ties and self-esteem, $b = .12$, $SE = .08$, $t = 1.51$, $p = .14$. However, a positive connection between self-esteem and subjective health was demonstrated, $b = .39$, $SE = .10$, $t = 4.08$, $p = <.001$, 95% CI: .23 and .55. A significant amount of variance was explained when all variables above were included in the analysis predicting subjective health, $R^2 = .27$, $F(4,72) = 6.68$, $p = <.001$. However, bootstrapping analysis of the two-step mediational pathway (with 1000 bootstrapping re-samples) revealed no significant effect connecting discrimination frequency, ingroup ties and self-esteem to subjective health, effect = .01, SE = .01, 95% CIs = <-.001 and .06.

Taken together, the results demonstrated that participants who perceived the greatest frequency of discrimination were also likely to be more concerned about performing their identity to others. These identity performance concerns, in turn, reduced their willingness to seek help, which ultimately reduced their subjective health. However, the negative health effects associated with discrimination are not offset via ingroup ties and self-esteem (Figure 1).

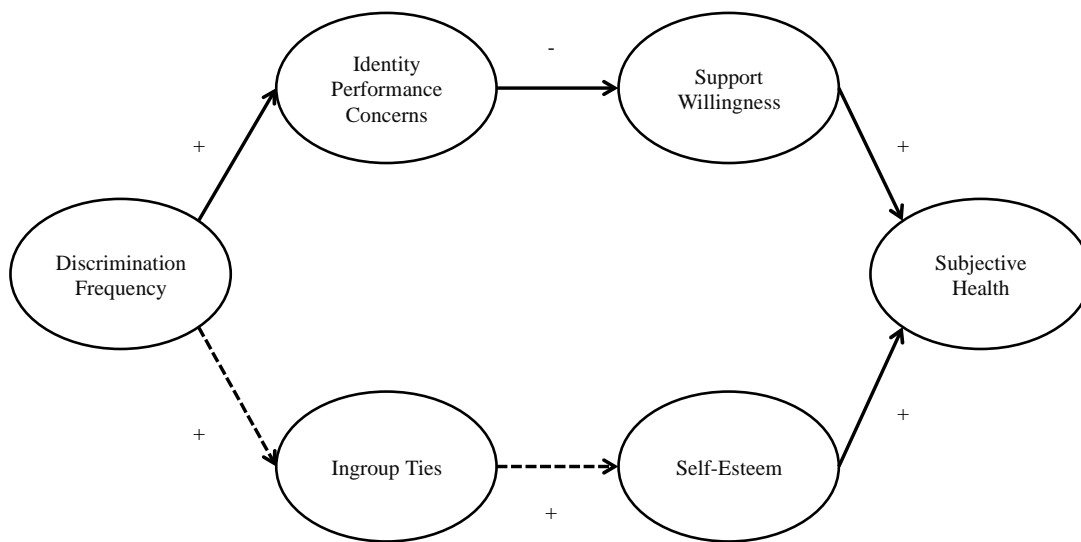


Figure 1. Diagram of pathways connecting discrimination frequency, identity performance concerns, and willingness to seek support to subjective health, and discrimination frequency, ingroup ties, and self-esteem to subjective health (solid line reflects a significant correlation at $p = <.05$; dashed line reflects a non-significant correlation) (Study 2).

Discussion

The findings from the first study revealed no significant effects of the experimental manipulation (experiences of accessing support to help with their disability versus experiencing discrimination) on participants' self-descriptions, felt identity performance concerns, ingroup ties, self-esteem, support willingness or subjective health. However, links among perceived discrimination, identity performance concerns, willingness to seek support and subjective health were observed. Specifically, the perception of frequent discrimination was associated with heightened felt identity performance concerns, which, in turn, promoted people being less willing to access support, something that was ultimately costly for individual subjective health.

One reason why the experimental manipulation may have failed to heighten performance concerns, or failed to modify how these performances played out, is because the manipulation addressed only the issues that the individual might seek to address through any identity performance. Our manipulation did not activate the *audiences* through which those issues and performances might be connected. Audiences are, however, central to the analysis of identity performances: engaging in identity performances to craft particular images of one's group only becomes relevant when there is an audience present who could witness such performances (Barreto & Ellemers, 2009; Barreto et al., 2003; Rabinovich & Morton, 2010). Our manipulation set the stage for such performances, but it did not provide any audience. To address this possible explanation for the lack of experimental effects in this study, in a second study we manipulated the presence of different audiences for the individuals' survey responses, rather than the issues with which those audiences might be associated.

We also did not find a significant connection between discrimination, ingroup ties, self-esteem and subjective health. As such, we were unable to find support for the rejection-identification model, in which identification buffers against the negative effects of discrimination (Branscombe, Schmitt, et al., 1999; Fernández et al., 2012; Nario-Redmond et al., 2013). However, the absence of such a pattern does not necessarily mean that group identification does not play a role in how physically disabled people respond to potential negativity from others. Instead, the level of ingroup ties may be important in *moderating* the way in which disabled people respond to experienced identity threats (i.e., McCoy & Major, 2003; Packer, 2011). On this basis, when disability stigma is experienced, we believe that low and highly tied disabled individuals may respond differently to assumed negativity from audiences that they are interacting with – an idea that we explored in Study 3.

STUDY 3

This third study sought to expand the findings of the previous study by introducing an audience-based rather than issue-based manipulation. To achieve this, we manipulated to whom participants believed their responses would be communicated: healthcare providers (mapping the issue of support), the general public (mapping the issue of discrimination), or a no-audience control. Similar to the logic of the previous study, we reasoned that because each audience activates different stigma-related concerns, this would result in different performances of the self in response to those concerns. Specifically, we reasoned that rather than general identity performance concerns being evoked in response to a stigmatising issue (i.e., Study 2), the salient audience (i.e., healthcare providers or the general public) would activate concerns within disabled people in the form of specific physical disability stereotypes: healthcare providers activating stereotypes of passivity, warmth, and (un)worthiness for support (indicative of help-seeking), whereas the general public activating stereotypes of incompetence (indicative of discrimination).

Also consistent with the overall rationale presented in the Introduction, and due to the lack of support for a mediating role of ingroup ties on well-being in Study 2 (i.e., Branscombe, Schmitt, et al., 1999), we instead expected that the effect of these activated stereotypes on help-seeking, subjective health and self-esteem would be moderated by ingroup ties, whereby individuals with low ties may seek to absorb anticipated negativity, whereas individuals with high ties may instead resist this. Building on the significant model observed in Study 2, we predicted that audience-activated stereotypes would influence observable identity performance behaviour in terms of willingness to access support, with further consequences for subjective health, and self-esteem. The effects on these outcomes

were expected to be moderated by individual differences in ingroup ties. These predictions are summarised in Figure 2.

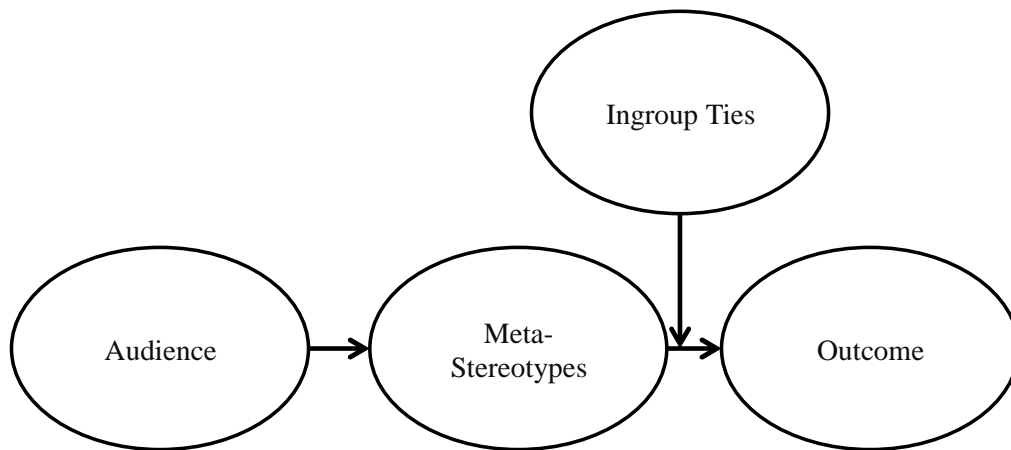


Figure 2. Schematic representation of hypothesised relationships among audience identity, stereotype activation and self-presentation outcomes.

In addition to refining the manipulation, we sought to improve the generalisability of our findings across a wider sample. The previous study was restricted to people with CP. However, people with any physical disability are likely to experience stigmatising situations (Fiske et al., 2002, 1999; Towler & Schneider, 2005). In this study, we therefore sought to expand our chosen disabled participants to include a wider spectrum of physical disabilities.

Method

Participants

Participants were 87 physically disabled people (34 male, 53 female) aged 18-79 years ($M = 39.30$, $SD = 14.63$). Most participants were White ($n = 79$), and the remainder were mixed race ($n = 4$), Chinese ($n = 1$), Latin American ($n = 1$), and Métis ($n = 1$),

unspecified ($n = 1$). The majority were from the USA ($n = 35$), with the remainder from the UK ($n = 30$), Australia ($n = 6$), Canada ($n = 4$), mixed nationality ($n = 4$), Germany ($n = 2$), Ireland ($n = 2$), Costa Rica ($n = 1$), The Netherlands ($n = 1$), Poland ($n = 1$), and Turkey ($n = 1$). Participants also reflected a range of physical disabilities such as: spinal cord injuries, CP, blindness or impaired vision, Ehlers-Danlos syndrome, arthritic conditions, and post-polio.

Procedure and Materials

As in Study 2, participants were asked to complete an online survey² that was advertised on online disability forums and social networking pages. Participants were first asked to specify demographic information (i.e., gender, age, race, and nationality), the name of their physical disability, as well as how severe they believed their disability to be. Severity was assessed using three statements: “*On a normal day, how severe do you think your condition is?*”, “*On a normal day, to what extent does your condition impact on your day-to-day activities?*” and “*On a normal day, to what extent does your condition impact on your everyday life?*” (1= Not at all - 7= Completely; $\alpha = .84$).

Participants were then randomly assigned to one of three audience conditions: healthcare provider ($n = 30$), general public ($n = 28$), or a no-audience control ($n = 29$). Depending on condition, participants were told that the purpose of the study was to feed back the experiences of physically disabled people to provide their assigned audience (i.e., healthcare providers or the general public) with a better understanding of disability. In this way, respondents believed that their answers could shape the view of their group in the eyes of specific others. In the control condition participants were just told that the purpose of the

² One participant, because of their physical impairment, felt unable to complete the survey independently, and so they instead completed a telephone survey with the lead researcher containing the same questioning. The lead researcher then recorded their vocal responses.

study was to gain a better understanding of disability and no mention was made of specific audiences.

Following this, participants were given a list of words that were stereotypical of physical disability. The list was randomised for each participant and included terms that reflected the stereotypes of physically disabled people: worthiness (deserving, legitimate, and worthy; $\alpha = .87$), given that perceived worthiness is a specific concern for disabled people when accessing help (see Chapter 4); incompetent (e.g., capable, confident, independent, intelligent; $\alpha = .92$); warm (e.g., friendly, good-natured, likeable; $\alpha = .93$); and passive (hesitant, passive, shy, timid; $\alpha = .85$). In order to further reinforce the audience manipulation participants were asked to indicate the degree to which they believed each word described how their audience viewed physically disabled people (i.e., meta-stereotypes; 1 = Strongly disagree, 7 = Strongly agree). As no audience was activated in the control group, participants assigned to this condition were instead asked to rate to what extent the terms described how *they personally* saw physically disabled people (i.e., self-stereotypes; 1 = Strongly disagree, 7 = Strongly agree).

Following this task, participants were asked about their general subjective health ($\alpha = .89$), ingroup ties ($\alpha = .94$), self-esteem ($\alpha = .82$), and willingness to seek support ($\alpha = .87$) using the same measures described in Study 2. The statements assessing ingroup ties and willingness to seek support were adapted to reflect the broader sample in this study, (e.g., replacing “*my cerebral palsy*” with “*my disability*”: “*In general, I can access the support I need to help with my disability*”); see Appendix C for complete survey.

Results

Our hypotheses predicted that specific audiences would activate specific physical disability stereotypes, and that these stereotypes would in turn influence the individual's stated willingness to seek support, with further consequences for individual self-esteem and subjective health. We also expected the activated stereotype-outcome link to be moderated by ingroup ties. To begin exploring the hypothesised pattern, we first examined the condition effects of stereotypes of worthiness, competence, warmth, and passivity using a series of one-way between-subjects ANOVAs.

For worthiness, the overall ANOVA was significant, $F(2,84) = 5.62, p = .005, \eta_p^2 = .12$ (healthcare providers, $M = 3.64, SD = 2.02$; general public, $M = 4.32, SD = 1.37$; and control, $M = 5.10, SD = 1.55$). Planned contrasts revealed that those in the control group personally rated the worthiness of disabled people (i.e., self-stereotypes) as higher than those who indicated the ratings of worthiness they would expect from healthcare providers, $F(1,84) = 11.23, p = .001, \eta_p^2 = .12$, and marginally higher than the general public respectively (i.e., meta-stereotypes), $F(1,84) = 3.09, p = .08, \eta_p^2 = .04$. There was no significant difference between those in the healthcare provider and general public conditions, $F(1,84) = 2.40, p = .13, \eta_p^2 = .03$.

For competence, the overall ANOVA was highly significant, $F(2,83) = 13.20, p = <.001, \eta_p^2 = .24$ (healthcare providers, $M = 3.58, SD = 1.65$; general public, $M = 3.35, SD = 1.28$, and the control, $M = 5.01, SD = .83$). Planned contrasts revealed that those in the control group personally rated the competence of disabled people as being significantly higher than the ratings of competence expected from healthcare providers, $F(1,83) = 17.08, p = <.001, \eta_p^2 = .17$ and from the general public, $F(1,83) = 22.37, p = <.001, \eta_p^2 = .21$. There

was no significant difference between those in the healthcare provider and general public conditions, $F(1,83) = .46, p = .50, \eta_p^2 = .006$.

For warmth, the overall ANOVA was marginal, $F(2,82) = 2.52, p = .09, \eta_p^2 = .06$ (healthcare providers, $M = 4.00, SD = 1.65$; general public, $M = 4.67, SD = 1.09$; control, $M = 4.66, SD = 1.06$). Planned contrasts revealed that those in healthcare provider condition expected to be viewed as less warm than those in the general public condition, $F(1,82) = 3.84, p = .05, \eta_p^2 = .05$, and marginally less warm than how the control group viewed the ingroup, $F(1,82) = 3.68, p = .06, \eta_p^2 = .04$. There was no significant difference between the general public and control conditions, $F(1,82) = .002, p = .97, \eta_p^2 = <.001$.

For passivity, the overall ANOVA was not significant, $F(2,83) = 2.28, p = .11, \eta_p^2 = .05$ (healthcare providers, $M = 3.59, SD = 1.50$; general public, $M = 4.32, SD = 1.26$; and control, $M = 3.93, SD = 1.08$). However, planned contrasts revealed that those in general public condition expected to be viewed as more passive than those in the healthcare provider condition, $F(1,83) = 4.56, p = .04, \eta_p^2 = .05$. There was no significant difference between the general public and control conditions, $F(1,83) = 1.28, p = .26, \eta_p^2 = .02$, or between the healthcare provider and control conditions, $F(1,83) = .96, p = .33, \eta_p^2 = .01$.

To explore whether the salience of different audiences also triggered different identity performances, we next submitted willingness to seek support, self-esteem, and subjective health to the same analysis. The analysis of support willingness revealed no effect of condition, $F(2,84) = 2.15, p = .12, \eta_p^2 = .05$. However, planned contrasts revealed that participants in the healthcare provider condition were marginally less willing to seek support ($M = 4.18, SD = 1.51$) than those in the general public condition ($M = 4.92, SD = 1.62$), $F(1,84) = 3.51, p = .06, \eta_p^2 = .04$, and marginally less than those in the control condition (M

= 4.84, $SD = 1.40$), $F(1,84) = 2.85$, $p = .095$. There was no significant difference between the general public and control conditions, $F(1,84) = .04$, $p = .84$, $\eta_p^2 = <.001$.

The analysis on self-esteem, also revealed no overall effect of condition, $F(2,84) = .47$, $p = .63$, $\eta_p^2 = .01$. Planned contrasts also revealed no significant differences between any conditions on this variable, all F s < 1 (healthcare provider $M = 5.53$, $SD = 1.32$; general public $M = 5.51$, $SD = 1.46$; control $M = 5.83$, $SD = 1.38$).

There was also no overall effect for audience condition on subjective health, $F(2,84) = 2.10$, $p = .13$, $\eta_p^2 = .05$. However, planned contrasts revealed that participants in the healthcare provider condition reported marginally reduced subjective health ($M = 3.60$, $SD = 1.70$) compared to the general public condition ($M = 4.41$, $SD = 1.57$), $F(1,84) = 3.71$, $p = .06$, $\eta_p^2 = .04$, but not to the control condition ($M = 4.25$, $SD = 1.49$), $F(1,84) = 2.41$, $p = .12$, $\eta_p^2 = .03$. There was no difference between the general public and control conditions, $F(1,84) = .15$, $p = .70$, $\eta_p^2 = .002$. In sum, the above findings provide some initial suggestion that in response to the negative stereotypes associated with healthcare providers (low worth, low competence, and low warmth), disabled individuals may have been distancing themselves from support, and that this might be reflected in reduced subjective well-being (i.e., similar to Study 2). However, the direct effects of the audience manipulation on these outcomes was weak.

Developing on the above findings, we then tested the prediction that the impact of salient audiences and activated stereotypes on outcomes (support willingness, self-esteem, and subjective health) would be moderated by ingroup ties. To test this, we constructed several models using PROCESS Model 15 (Hayes, 2013) with 1000 bootstrapping re-samples. Each model independently tested the impact of assigned audience on stereotypes of worthiness, competence, warmth, and passivity (already established by the ANOVAs above),

and whether ingroup ties moderated the subsequent link between these stereotypes and participants' support willingness, self-esteem, or subjective health. Because the independent variable in this study involves a three-level categorical variable, we dummy-coded audience condition depending on the stereotypes of interest (Hayes & Preacher, 2014). Given the above ANOVA findings, the first of these contrasts compared the two audience conditions (each .333) to the control condition (-.667), whereas the second contrast compared the healthcare provider condition (-.500) to the general public condition (.500), ignoring the influence of the control (0). Together, these contrasts capture the fact that meta-stereotypes were generally more negative when audiences were activated, but that there were also unique dimensions on which meta-stereotypes attributed to healthcare providers and the general public differed and were especially negative (warmth and passivity respectively). In the analysis of each contrast, the alternative contrast was included as a covariate. In all analyses participants' self-reported severity of their physical disability was also included as a covariate. To avoid repetition, severity was a significant predictor of stereotypes of worthiness and warmth, as well as the outcomes of support willingness, self-esteem, and subjective health, all $ps = <.04$, suggesting that people with less severe physical disabilities expected to be seen as *more worthy* and warm, and were also associated with greater support willingness, self-esteem, and subjective health. However, severity was not significantly associated with stereotypes of competence, $p = .36$, or passivity, $p = .98$. Finally, in all models, reported ingroup ties was split into three differing levels: low (scores one standard deviation below the mean), moderate (mean score), and high (scores one standard deviation above the mean; Preacher, Rucker, & Hayes, 2007).

Stereotypes of worthiness. Reflecting the ANOVA results reported previously, there was a significant effect of the focal audience contrast on stereotypes of worthiness, whereby

the audience conditions reported reduced stereotypes of worthiness (i.e., meta-stereotypes) compared to the control (i.e., self-stereotypes), $b = -1.21$, $SE = .37$, $t = -3.25$, $p = .002$, 95% CI: -1.95 and -.47. In the analyses in which the secondary contrast was substituted (comparing the two audiences), there were no significant differences in meta-stereotypes of worthiness as a function of this contrast, $b = .72$, $SE = .43$, $t = 1.67$, $p = .10$, 95% CI: -.14 and 1.57. This suggests that meta-stereotypes of worthiness are not uniquely activated by one specific audience, but instead are equivalent across both. Logically, the significant effect of the audience contrast was observed in all analyses involving meta-stereotypes of worthiness and for space reasons is not repeated.

Stereotypes of competence. In all analyses, a significant effect of the focal audience contrast on stereotypes of competence was observed, $b = -1.58$, $SE = .31$, $t = -5.18$, $p < .001$, 95% CI: -2.19 and -.97. Participants in the healthcare provider and general public conditions expected to be viewed as significantly less competent (i.e., meta-stereotypes) in comparison to how the control group viewed the competence of other disabled people (i.e., self-stereotypes). In the analyses in which the secondary contrast was substituted (comparing the two audiences), there were no significant differences in meta-stereotypes of competence as a function of this contrast, $b = -.22$, $SE = .34$, $t = -.65$, $p = .52$, 95% CI: -.91 and .46. This suggests that meta-stereotypes of competence are not uniquely activated by one specific audience, but instead are equivalent across both. Again, the significant effect of the audience contrast was observed in all analyses involving meta-stereotypes of competence, and therefore for space reasons is not repeated.

Stereotypes of warmth. In all analyses, the effect of the focal contrast on stereotypes of warmth was not significant, $b = -.43$, $SE = .30$, $t = -1.46$, $p = .15$, 95% CI: -1.02 and .16. Participants in the healthcare provider and general public conditions reported no difference in

the expected meta-stereotypes of warmth to how the control group viewed the warmth of other disabled people (i.e., self-stereotypes). However, the secondary contrast on stereotypes of warmth was significant, $b = .71$, $SE = .34$, $t = 2.11$, $p = .04$, 95% CI: .04 and 1.38, indicating that participants in the healthcare provider condition expected to be viewed as less warm than the general public condition. This in turn, means that stereotypes of (low) warmth appear to be activated uniquely in relation to healthcare providers. Again, this effect of the healthcare audience condition was observed in all analyses involving meta-stereotypes of warmth, and so for space reasons is not repeated.

Stereotypes of passivity. In all analyses, the effect of the focal contrast on stereotypes of passivity was not significant, $b = .03$, $SE = .30$, $t = .10$, $p = .92$, 95% CI: -.57 and .64. Participants in the healthcare provider and general public conditions reported no difference in the expected passivity meta-stereotypes to how the control group viewed the passivity of other disabled people (i.e., self-stereotypes). However, the secondary contrast on stereotypes of passivity was significant, $b = .73$, $SE = .34$, $t = 2.12$, $p = .04$, 95% CI: .04 and 1.41, indicating that participants in the general public condition expected to be viewed as more passive than in the healthcare provider condition. This in turn, means that stereotypes of passivity appear to be activated uniquely in relation to the general public. Once again, the significant effect of the general public audience condition was observed in all analyses involving meta-stereotypes of passivity, and so for space reasons is not repeated.

Main and interactive effects on support willingness, self-esteem, and subjective health. There was little evidence of any main or interaction effects involving audience and/or activated stereotypes and ingroup ties on these outcomes. For brevity, only the significant main and interaction effects are reported and explored in the following results. For complete descriptions of all results, see Appendix D.

The only main effect of the focal contrast was on reported self-esteem, $b = -1.93$, $SE = .91$, $t = -2.13$, $p = .04$, 95% CI: -3.74 and -.12, indicating that people in the control condition reported higher self-esteem than people in the healthcare provider and general public conditions.

The only significant main effect of stereotypes was for stereotypes of competence, which also predicted self esteem, $b = .72$, $SE = .31$, $t = 2.32$, $p = .02$, 95% CI: .10 and 1.34, whereby those who perceived more positive competence-related stereotypes also reported higher self-esteem.

Main effects of ingroup ties were observed on support willingness, $b = .49$, $SE = .25$, $t = 1.97$, $p = .05$, 95% CI: -.005 and .99, and self-esteem, $b = .44$, $SE = .22$, $t = 2.06$, $p = .04$, 95% CI: .02 and .87, whereby people with higher ties reported more support willingness and higher self-esteem.

The only significant interactions to emerge from these analyses were between: the focal contrast (audiences versus the control) and ingroup ties on self-esteem; the focal contrast and ingroup ties on subjective health (marginally significant); the secondary contrast (healthcare providers versus the general public) and ingroup ties on subjective health; and stereotypes of competence and ingroup ties on self-esteem. Each of these interactions is described in detail below.

The interaction between the focal audience contrast and ingroup ties on self-esteem.

The significant interaction between the focal contrast and ingroup ties on self-esteem, $b = -.34$, $SE = .17$, $t = 1.99$, $p = .05$, 95% CI: <.001 and .68, is depicted in Figure 3. As can be seen, audience activation was associated with reduced self-esteem at low ingroup ties, $b = -.99$, $SE = .44$, $t = -2.26$, $p = .03$, 95% CI: -1.87 and -.12, whereas this effect was tempered at

moderate ties, $b = -.33$, $SE = .30$, $t = -1.11$, $p = .27$, 95% CI: $-.93$ and $.26$, and (non-significantly) reversed at high ties, $b = .33$, $SE = .41$, $t = .80$, $p = .42$, 95% CI: $-.48$ and 1.13 .

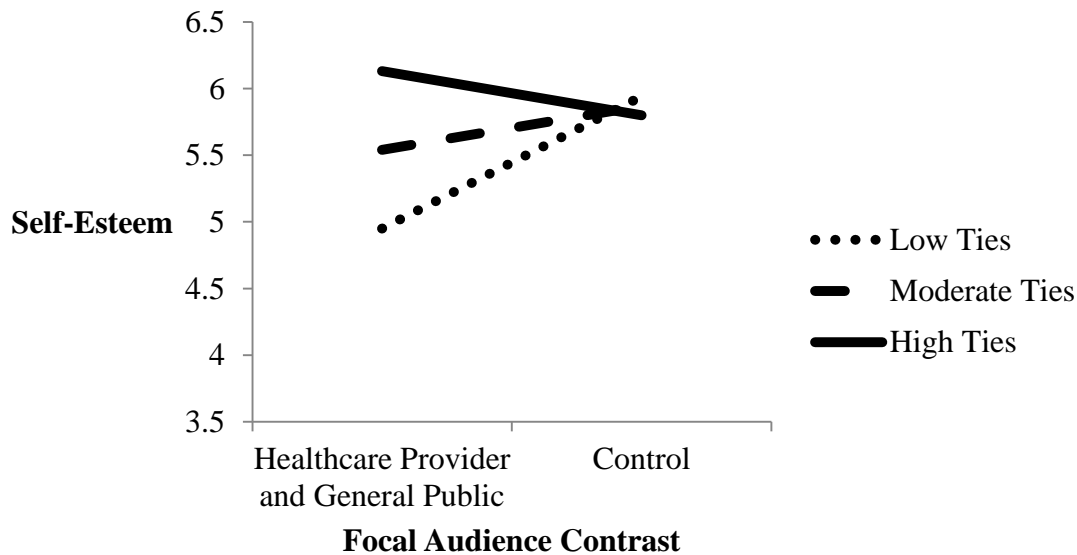


Figure 3. Diagram representing self-esteem as a function of the focal audience contrast and ingroup ties (Study 3).

The interaction between the focal audience contrast and ingroup ties on subjective health. The marginal interaction between the focal contrast and ingroup ties on subjective health, $b = -.41$, $SE = .22$, $t = -1.87$, $p = .07$, 95% CI: $-.85$ and $.03$, is represented in Figure 4. Here, the slope of the focal contrast was marginal at high ingroup ties, $b = -.84$, $SE = .49$, $t = -1.72$, $p = .09$, 95% CI: -1.81 and $-.13$, indicating that for participants with high ties, audiences were associated with reduced subjective health relative to the control. There was no effect of the audience contrast at low ties, $b = .41$, $SE = .51$, $t = .79$, $p = .43$, 95% CI: $-.62$ and 1.43 , or moderate ties, $b = -.21$, $SE = .37$, $t = -.58$, $p = .56$, 95% CI: $-.95$ and $.52$. In interpreting this pattern, it should be noted that participants with higher ties also reported better subjective health overall, an advantage that was minimised in the audience conditions.

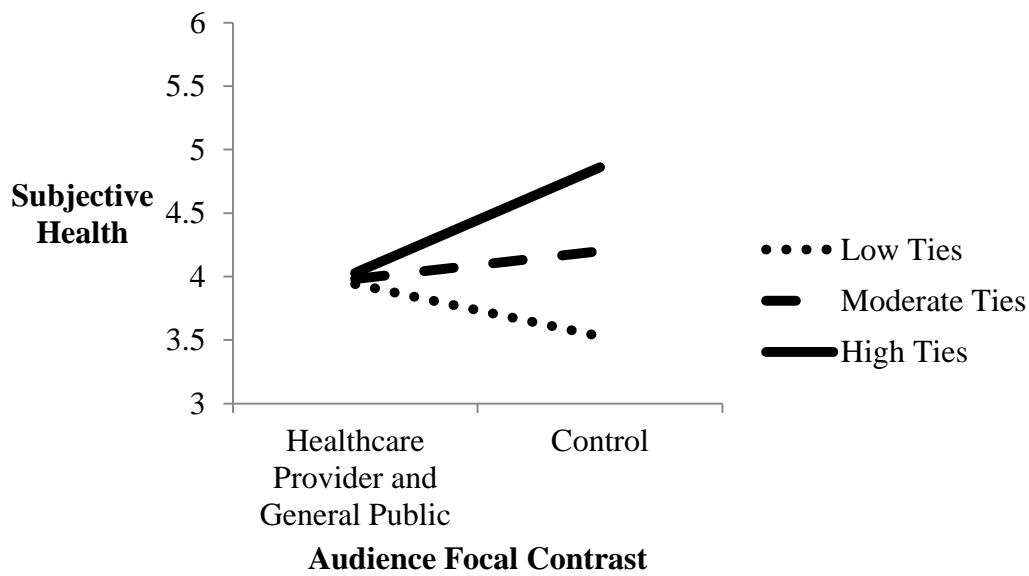


Figure 4. Diagram representing subjective health as a function of the audience focal contrast and ingroup ties.

The interaction between the secondary audience contrast and ingroup ties on subjective health. A similar pattern was observed in the significant interaction between the secondary audience contrast and ingroup ties on subjective health, $b = .40$, $SE = .20$, $t = 1.99$, $p = .05$, 95% CI: $<-.001$ and $.80$ (represented in Figure 5). Here, the slope of the audience contrast was significant for participants with moderate and high ties, $b = .74$, $SE = .37$, $t = 2.02$, $p = .05$, 95% CI: $.01$ and 1.47 , and $b = 1.45$, $SE = .52$, $t = 2.76$, $p = .007$, 95% CI: $.41$ and 2.49 respectively, indicating that for people with moderate and high ties, the healthcare provider audience was associated with reduced subjective health relative to the general public audience. No significant audience effect was observed at low ties, $b = .04$, $SE = .50$, $t = .08$, $p = .93$, 95% CI: $-.95$ and 1.03 .

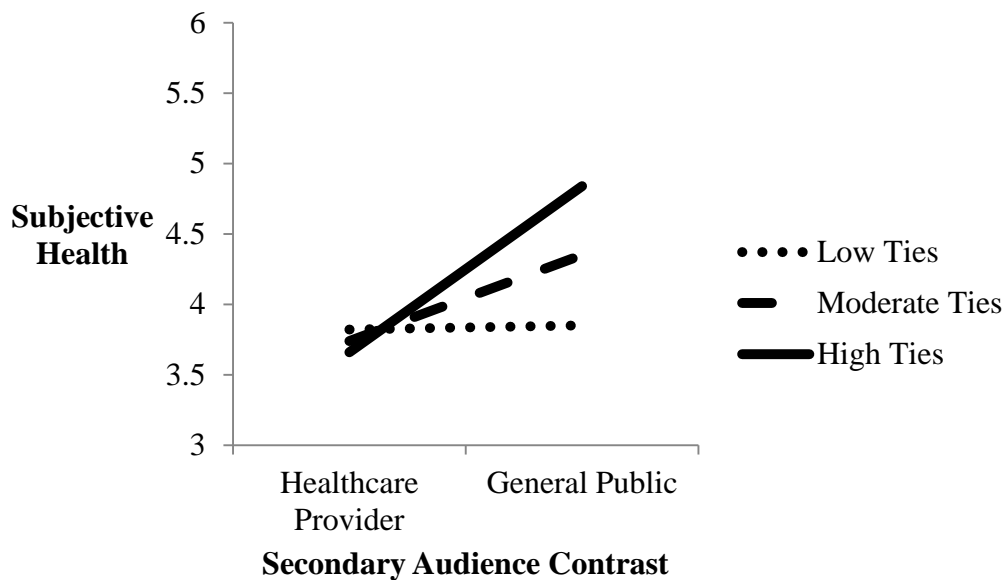


Figure 5. Diagram representing subjective health as a function of secondary audience contrast and ingroup ties.

The interaction between stereotypes of competence and ingroup ties on self-esteem.

Finally, the significant interaction between stereotypes of competence and ingroup ties on self-esteem, $b = -.12$, $SE = .06$, $t = -2.13$, $p = .04$, 95% CI: $-.23$ and $-.008$, is depicted in Figure 6. As can be seen, negative stereotypes of competence were associated with reduced self-esteem at low ingroup ties, $b = .35$, $SE = .16$, $t = 2.22$, $p = .03$, 95% CI: $.04$ and $.67$, whereas this effect was lessened at moderate ties, $b = .15$, $SE = .11$, $t = 1.36$, $p = .18$, 95% CI: $-.07$ and $.36$, and was not at all apparent at high ties, $b = -.06$, $SE = .13$, $t = -.47$, $p = .64$, 95% CI: $-.32$ and $.20$. Thus higher ingroup ties appeared to buffer against the negative implications of stereotypes of incompetence for the self.

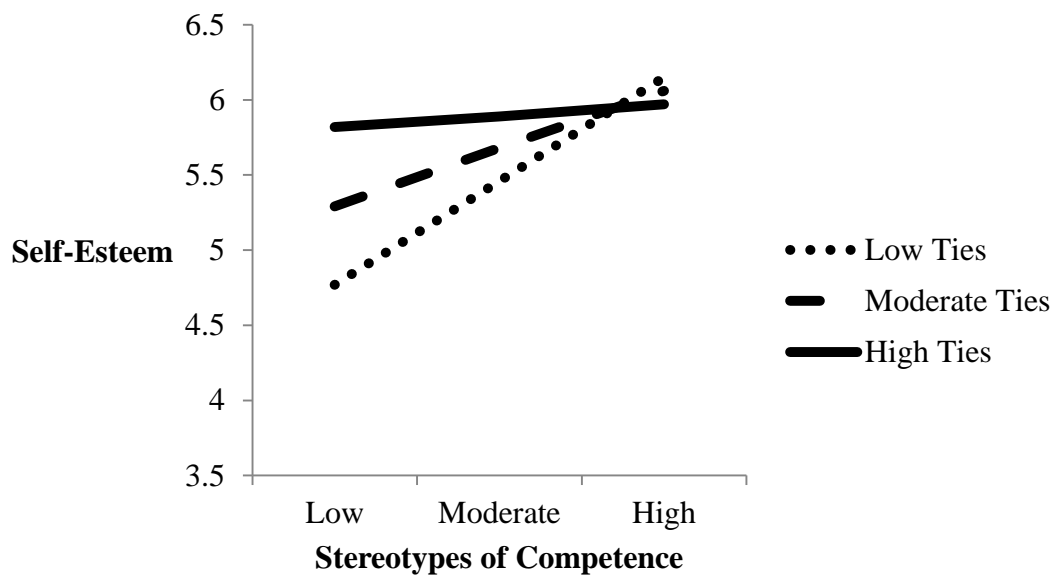


Figure 6. Diagram representing reported self-esteem according to differing levels of competence stereotypes and ingroup ties.

Given the presence of a focal audience effect on stereotypes of competence discussed above, and the interaction involving stereotypes of competence (mediator) and ingroup ties (moderator), we also explored the presence of conditional indirect pathways between audience activation and self-esteem via meta-stereotypes of competence. However, no significant effects were reported at any level of ingroup ties: low ties, effect = $-.08$, $SE = .17$, 95% CIs = $-.64$ and $.12$; moderate ties, effect = $-.03$, $SE = .08$, 95% CIs = $-.31$ and $.05$; high ties, effect = $.01$, $SE = .06$, 95% CIs = $-.04$ and $.25$.

Discussion

The findings from Study 3 suggest that participants who believed that their responses would be communicated to healthcare provider or general public audiences reported more negative perceptions of how they might be perceived. Specifically, relative to the control condition (i.e., self-perceptions), participants expected audiences to view their group as less worthy and less competent. Where there were differences between the audiences, these were only slight: healthcare providers were associated with meta-stereotypes of reduced warmth, and the general public was associated more strongly with meta-stereotypes of passivity.

However, despite the evidence of the negative expectations associated with these audiences, we found little evidence that audience activation shaped the ways in which participants engaged with support or reported their own health and well-being, neither straightforwardly nor in combination with their ingroup ties. In line with the identity performance framework we have adopted, we expected that self-presentations would be enacted to alter the perceived view an audience has of disabled people (i.e., stereotypes), and that the exact nature of this response would differ depending on the degree to which individuals prioritised their individual or social identity (as represented by low versus high ingroup ties). The fact that activated audiences, associated stereotypes, and identification (i.e., ingroup ties), either alone or in combination, seemed to be of little importance for participants' reports of willingness to seek support, subjective health, or self-esteem somewhat questions our analysis of these outcomes as reflecting "identity performances". In this sense, although the results of this study represent an elaboration of the observations in Study 2, especially through demonstrating the role of salient audiences rather than issues in driving self-presentation concerns (i.e., to activated stereotypes), we would have expected to see stronger evidence for group identification via ingroup ties as moderating these responses.

That said, there was some evidence that audiences produced different responses. Activating the healthcare provider audience was associated with marginally reduced willingness to seek support and marginally reduced subjective health. Descriptively, this was also the audience associated with the most negative meta-stereotypes – although this pattern was not statistically significant. One reason why these effects did not emerge more strongly, and why they may not have been shaped by identification, could be due to the fact that these measures of identity performance were not sufficiently nuanced to capture the dimensions on which people might seek to refute other's impressions. One might expect more self-presentational variation if other variables that directly tap how one describes their self to different audiences are included. In this regard, personal attributions of self-efficacy (what I *can* do) may be especially relevant in the context of negative stereotypes that deny competence and self-worth (i.e., personal agency). In the next study, we therefore expanded the dependent measures to include this.

Another limitation of this study is that although we have moved from issues to audiences, and observed interesting effects as a result, the manipulated audiences in this study varied quite markedly in their specificity. Although the healthcare provider audience is fairly specific, the alternative audience of the general public is quite diffuse. We therefore reasoned that replacing the general public condition with an audience that is potentially more specific may, in turn, activate more specific stereotypes, leading to clearer self-presentations of willingness to access support, subjective health, and well-being.

STUDY 4

To address the above limitations, Study 4 altered the audience manipulation slightly. We replaced the diffuse general public condition with a condition in which participants believed their responses would be communicated to educators or employers. These audiences are especially interesting given that disabled people may feel pressure to negotiate perceptions of incompetence when interacting with these groups, such as by downplaying or concealing their disability (see Chapter 6; Taub et al., 2004). Refining Study 3, we compared responses from participants who were led to believe that their answers were to be shared with either a healthcare provider audience or an employer and educator audience or a no audience control. Along these lines, Study 4 was designed to compare equally specific, and yet qualitatively different, audiences and the identity concerns and performances these might provoke.

Our expectation was again that physically disabled people would respond differently to activated stereotypes as a function of their ties to the stereotyped group. While we found little support for this prediction in Study 3, theoretically, the role of individual differences in ingroup ties should influence how disabled people decide to present their behaviour when different audience stereotypes are experienced. Specifically, high identifiers should respond in ways that protect the image of the group as a whole, whereas low identifiers should respond in ways that protect their own self-image, perhaps in contrast to the group (Figure 2). To again explore this hypothesis, we expanded our response measures to assess self-presentations via self-efficacy in addition to the effects on willingness to seek support, self-esteem, and subjective health. We predicted that when negative stereotypes were expected, self-presentations of disabled people with low ingroup ties via support willingness, subjective health, self-esteem, and self-efficacy would be crafted in such a way as to absorb this

negativity. Conversely, self-presentations of people with high ties would instead seek to challenge and reject the negativity expected from others.

Method

Participants

Participants were 148 physically disabled individuals (136 female, 9 male, 3 unspecified) aged 16-67 years ($M = 36.72$, $SD = 11.69$). The sample was predominantly White ($n = 138$), and the remainder being mixed race ($n = 5$), Black ($n = 1$), Hispanic ($n = 1$), Native American ($n = 1$), and Traveller ($n = 1$), unspecified ($n = 1$). The majority were from Britain ($n = 118$), with the remainder from America ($n = 12$), Ireland ($n = 3$), Australia ($n = 2$), Germany ($n = 2$), Finland ($n = 2$), The Netherlands ($n = 2$), Canada ($n = 1$), Portugal ($n = 1$), Russia ($n = 1$), Sweden ($n = 1$), or were of mixed nationality ($n = 1$) or unspecified ($n = 2$). Participants also reflected a range of physical disabilities such as Ehlers-Danlos syndrome, brain injury, arthritic conditions, and spina bifida.

Procedure and Materials

As in the previous studies, participants completed an online survey that was advertised on online disability forum and social networking pages. The survey was very similar to Study 3, incorporating the same layout and reusing many of the measures, including severity ($\alpha = .90$).

In this study, participants were randomly assigned to one of three audience conditions: healthcare provider ($n = 53$), educator/employer ($n = 50$), or a no-audience control ($n = 45$). As before, depending on their assigned condition, participants were then told that the purpose of the study was to feed back physically disabled people's experiences to

provide healthcare providers, or educators and employers, with a better understanding of disability, or just to gain a better understanding of disability in the control condition.

Participants were again presented with a list of disability-stereotypical terms assessing worthiness, competence, warmth, and passivity. Worthiness ($\alpha = .83$) and passivity ($\alpha = .74$) were measured using the same terms as Study 3. With competence, we reasoned that this stereotype is likely to be particularly important when interacting with educators and employers, though its specific meaning might encompass more intellectual and physical dimensions (i.e., to educators and employers respectively) in addition to the general competence we measured in Study 3. The stereotypical terms were therefore extended to include intellectual competence (clever, intelligent, knowledgeable), and physical competence (active, fit, strong), as well as the general competence we assessed in the previous study (capable, competent, confident, skilful). This collection of ten terms formed a reliable scale ($\alpha = .85$). Warmth used the terms: friendly, good-natured, likeable, and warm ($\alpha = .88$). Using the same format of Study 3, if participants were assigned to the healthcare provider or educator/employer audience conditions, they were asked to indicate the degree to which they believed each word described how their audience viewed physically disabled people (i.e., meta-stereotypes), whereas the control group were instead asked to rate how *they personally* thought the terms described physically disabled people (i.e., self-stereotypes; 1 = Strongly disagree, 7 = Strongly agree).

Following the stereotyping measures, participants were asked about their ingroup ties, self-esteem, willingness to seek support, and subjective health also using the measures in Studies 2 and 3 (ingroup ties $\alpha = .94$; self-esteem $\alpha = .76$; subjective health $\alpha = .77$; willingness to seek support $\alpha = .80$). In addition, we included five statements to assess self-efficacy (Schwarzer & Jerusalem, 1995: e.g., “*I can always manage to solve difficult*

problems if I try hard enough”, “*It is easy for me to stick to my aims and accomplish my goals*”, “*I am confident that I could deal efficiently with unexpected events*”; $\alpha = .89$). All the above measures again used a seven-point Likert scale (1= strongly disagree, 7= strongly agree); see Appendix E for complete survey.

Results

We first sought to assess differences according to audience condition. A series of one-way between-participants ANOVAs on the associated stereotype measures revealed significant between-condition differences. For worthiness, the overall ANOVA was highly significant, $F(2,141) = 9.65$, $p < .001$, $\eta_p^2 = .12$ (healthcare provider audience, $M = 3.81$, $SD = 1.33$; educator/employer audience, $M = 4.18$, $SD = .93$; and control, $M = 4.94$, $SD = 1.46$). Planned contrasts revealed that the control group rated disabled people as more worthy than the ratings participants expected from healthcare providers, $F(1,141) = 18.96$, $p < .001$, $\eta_p^2 = .12$, and educators/employers, $F(1,141) = 8.27$, $p = .005$, $\eta_p^2 = .06$. There was no significant difference between the healthcare provider and educator/employer conditions, $F(1,141) = 2.22$, $p = .14$, $\eta_p^2 = .02$.

For competence, the overall ANOVA was not significant, $F(1,142) = 1.67$, $p = .19$, $\eta_p^2 = .02$ (healthcare provider condition, $M = 3.96$, $SD = .95$; educator/employer condition, $M = 3.77$, $SD = .84$; control, $M = 4.14$, $SD = 1.13$). But, planned contrasts revealed that participants in the control condition viewed physically disabled people as marginally more competent than participants expected to be viewed by educators/employers, $F(1,142) = 3.31$, $p = .07$, $\eta_p^2 = .02$. However, no difference was observed between the healthcare provider

audience against the control, $F(1,142) = .84, p = .36, \eta_p^2 = .006$, or between the healthcare provider and educator/employer conditions, $F(1,142) = .95, p = .33, \eta_p^2 = .007$.

For warmth, the analysis revealed a marginally significant effect of condition, $F(2,141) = 2.49, p = .09, \eta_p^2 = .03$ (healthcare provider audience, $M = 4.60, SD = 1.00$; educator/employer audience, $M = 4.92, SD = .95$; control, $M = 5.07, SD = 1.26$). Planned contrasts revealed that people in the control condition personally viewed physically disabled people as significantly warmer than participants' ratings expected from healthcare providers, $F(1,141) = 4.58, p = .03, \eta_p^2 = .03$. However, no difference was observed between the educator/employer condition and the control, $F(1,141) = .45, p = .50, \eta_p^2 = .003$, or between the healthcare provider and educator/employer conditions, $F(1,141) = 2.37, p = .13, \eta_p^2 = .02$.

For passivity, the overall ANOVA was highly significant, $F(2,142) = 8.75; p < .001, \eta_p^2 = .11$ (healthcare provider audience, $M = 4.36, SD = .75$; educator/employer audience, $M = 4.27, SD = .96$; control, $M = 3.62, SD = 1.07$). Planned contrasts revealed that people in the control condition viewed physically disabled people as significantly less passive than those participants who reported the expected ratings from healthcare providers, $F(1,142) = 15.22, p < .001, \eta_p^2 = .10$, and educators/employers, $F(1,142) = 11.63, p = .001, \eta_p^2 = .08$. However, no difference was observed between the healthcare provider and educator/employer conditions, $F(1,142) = .22, p = .64, \eta_p^2 = .002$.

In sum, examination of the stereotypes reveal that the two audiences were associated with negative expectations, especially around worthiness and passivity. In addition, there were slight differences in the expectation of warmth (lower for healthcare providers versus the control) and competence (lower for educator/employers than the control).

Next, we assessed the impact of audience on identity performances (i.e., self-esteem, self-efficacy, support willingness, and subjective health). For self-esteem and self-efficacy,

no overall effects were observed (self-esteem, $F(2,145) = .86, p = .43, \eta_p^2 = .01$; self-efficacy, $F(2,144) = .09, p = .91, \eta_p^2 = .001$). For willingness to seek support, a marginally significant effect of condition was found, $F(1,145) = 2.73, p = .07, \eta_p^2 = .04$ (healthcare provider audience, $M = 4.40, SD = 1.28$; educator/employer audience, $M = 3.99, SD = 1.34$; control, $M = 3.76, SD = 1.53$). Differing from Study 3, planned contrasts revealed that participants in the healthcare provider audience were *more* willing to seek support when compared to the control condition, $F(1,145) = 5.23, p = .02, \eta_p^2 = .04$, but not in comparison to the educator/employer condition, $F(1,145) = 2.28, p = .13, \eta_p^2 = .02$. There was also no difference between the educator/employer condition and the control, $F(1,145) = .65, p = .42, \eta_p^2 = .004$. Also unlike the previous study, no between condition differences were found for subjective health, $F(2,145) = .44, p = .65, \eta_p^2 = .006$.

To fully test the possibility that disabled people might perform their identity differently to different audiences due to the stereotypes these audiences evoke, and that this might be moderated by individual differences in ingroup ties with other disabled people, we constructed several models using PROCESS Model 15 (Hayes, 2013). Each model independently tested the impact of assigned audience on each of the stereotypes, and whether differing levels of ingroup ties moderated subsequent links between these stereotypes and participants' responses in terms of reporting their support willingness, self-esteem, self-efficacy, and subjective health.

As in Study 3, prior to testing the models, we created dummy codes to represent the multicategorical independent variable (Hayes & Preacher, 2014). Following on from the reported ANOVA effects, the first dummy code contrasted the healthcare provider and educator/employer audiences (each .333) with control condition (-.667). The second dummy code contrasted the healthcare provider condition (-.500) with the educator/employer

condition (.500), ignoring the influence of the control (0). Together, these contrasts capture that meta-stereotypes were generally more negative when audiences were activated than to the self-stereotypes reported in the control condition, but that there were also certain meta-stereotypes that were especially negative when activated according to specific audiences (warmth with respect to healthcare providers, and competence with respect to educators/employers).

As in Study 3, in all models, the secondary dummy code and perceived severity of participants' physical disabilities were included as covariates. To avoid repetition, severity was a significant predictor of stereotypes of warmth, all model $ps = <.008$, and weakly with stereotypes of competence, all model $ps = <.06$, suggesting that people with less severe physical disabilities expected to be viewed as *less warm*, and *less competent*. Severity was not significantly correlated with stereotypes of worthiness or passivity, all model $ps = >.12$. In addition, severity was significantly associated with self-esteem and subjective health, all model $ps = <.003$, and marginally with support willingness and self-efficacy, certain model $ps = <.09$, thereby suggesting that less severe disabilities were associated with increased self-esteem, subjective health, and marginally increased support willingness and self-efficacy, though the specific effects will be explored further within their respective models. Also as in Study 3, with all models, reported ingroup ties was split into three differing levels: low (scores one standard deviation below the mean), moderate (mean score), and high (scores one standard deviation above the mean; Preacher et al., 2007). Once again, for brevity, only the significant main and interaction effects are explored in the forthcoming results. For complete descriptions of all results, see Appendix F.

Responses to stereotypes of worthiness

Across all analyses involving stereotypes of worthiness, participants in the healthcare provider and educator/employer audiences reported significantly more negative stereotypes of worthiness (meta-stereotypes) compared to people in the control condition (self-stereotypes), $b = -.92$, $SE = .23$, $t = -4.01$, $p = <.001$, 95% CI: -1.37 and -.46. When substituting the secondary contrast (the healthcare provider audience versus the educator/employer audience, ignoring the influence of the control condition), into these analyses, no significant effect was found, $b = .38$, $SE = .25$, $t = 1.52$, $p = .13$, 95% CI: -.11 and .86. This suggests that healthcare providers and educators/employers did not differ in their activations of worthiness stereotypes.

Self-esteem. With self-esteem as the dependent variable, significant effects were observed for stereotypes of worthiness, $b = .55$, $SE = .22$, $t = 2.50$, $p = .01$, 95% CI: .11 and .98, and ingroup ties, $b = .46$, $SE = .20$, $t = 2.29$, $p = .02$, 95% CI: .06 and .85. These findings highlight that more positive stereotypes of worthiness and stronger ingroup ties were associated with higher individual self-esteem. Severity also predicted self-esteem, $b = -.36$, $SE = .10$, $t = -3.43$, $p = <.001$, 95% CI: -.56 and -.15, suggesting that people with less severe physical disabilities report higher self-esteem.

Beyond these main effects, the interaction between stereotypes of worthiness and ingroup ties on self-esteem was significant, $b = -.09$, $SE = .04$, $t = -2.07$, $p = .04$, 95% CI: -.18 and -.004. Participants with low ties reported significantly lower self-esteem in response to stereotypes of unworthiness, $b = .25$, $SE = .10$, $t = 2.38$, $p = .02$, 95% CI: .04 and .45. This effect was not present among individuals with moderate, $b = .10$, $SE = .09$, $t = 1.19$, $p = .24$, 95% CI: -.07 and .28, or high ties, $b = -.04$, $SE = .12$, $t = -.35$, $p = .73$, 95% CI: -.28 and .20 (Figure 7). This suggests that the self-esteem of individuals with low ties was more

contingent on the activated meta-stereotype, whereas participants with higher ties were largely protected from these negative meta-stereotypes.

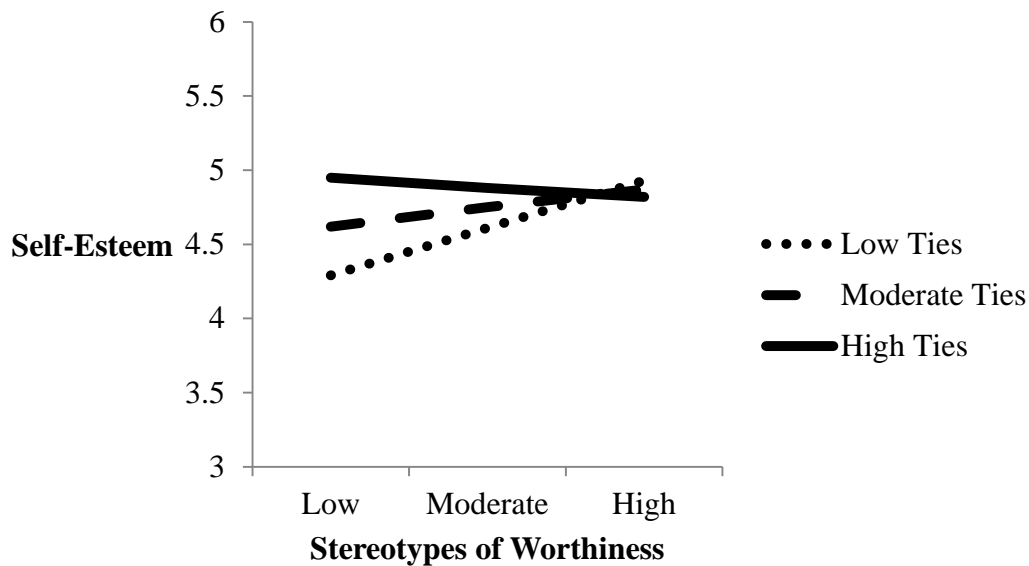


Figure 7. Diagram representing the interaction effect between stereotypes of worthiness and different levels of ingroup ties on self-esteem (Study 4).

Given the effect of audience condition on stereotypes for worthiness, and the presence of an interaction between this mediator and the moderator (ingroup ties), we also explored the presence of conditional indirect pathways between audience activations and self-esteem via meta-stereotypes of worthiness. Indeed, there was a significant conditional indirect effect for participants with low ties to the group, effect = $-.24$, SE = $.12$, 95% CIs = $-.57$ and $-.05$. This was not present at moderate ties, effect = $-.09$, SE = $.09$, 95% CIs = $-.31$ and $.07$, or high ties, effect = $.05$, SE = $.13$, 95% CIs = $-.17$ and $.34$ (Figure 8). This suggests that healthcare provider and educator/employer audiences activated stereotypes of unworthiness, which then compromised the self-esteem of individuals who were less (but not more) tied to the disabled

group. With all variables entered, the full model explained a significant amount of variance in self-esteem, $R^2 = .12$, $F(7,136) = 2.72$, $p = .01$.

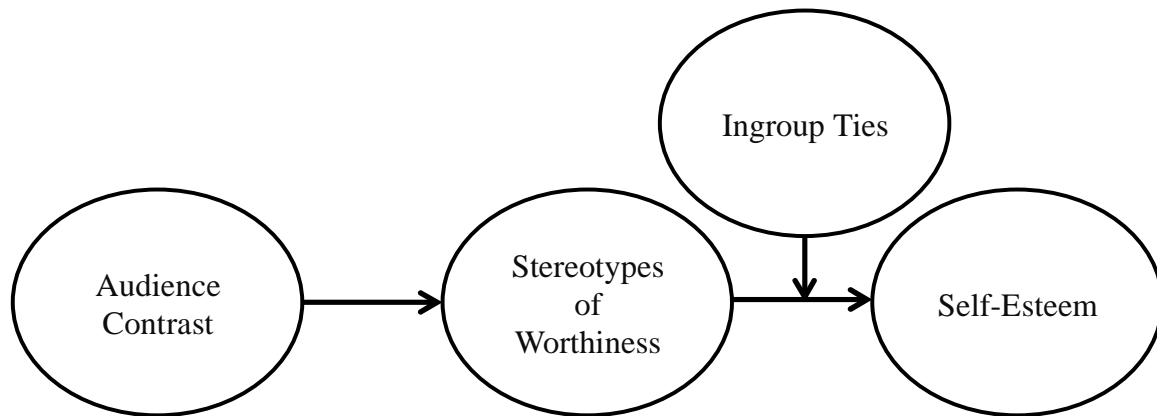


Figure 8. Diagram of conditional indirect pathways connecting audiences, to stereotypes of worthiness, and how ingroup ties moderate the impact on self-esteem.

When the analysis was repeated using the secondary contrast (comparing the two audience conditions) as the independent variable, an additional significant conditional indirect effect for participants with low ties was found, effect = .09, SE = .07, 95% CIs = .004 and .31. This was not present at moderate ties, effect = .04, SE = .05, 95% CIs = -.02 and .20, or high ties, effect = -.01, SE = .06, 95% CIs = -.17 and .07 (i.e., Figure 8). This suggests that while healthcare provider and educator/employer audiences activated stereotypes of unworthiness, which then compromised the self-esteem of individuals who were less (but not more) tied to the disabled group (i.e., in the focal contrast), people in the healthcare provider condition were particularly negatively affected.

Self-efficacy. With self-efficacy as the dependent variable, marginally significant effects were observed for stereotypes of worthiness, $b = .48$, $SE = .26$, $t = 1.84$, $p = .07$, 95% CI: -.04 and 1.00, and self-reported severity, $b = -.22$, $SE = .12$, $t = -1.75$, $p = .08$, 95% CI: -

.46 and .03, suggesting that more positive stereotypes of worthiness and less severe disabilities were associated with increased self-efficacy.

Beyond these main effects, there was a marginal interaction between the focal audience contrast and ingroup ties on self-efficacy, $b = .31$, $SE = .17$, $t = 1.83$, $p = .07$, 95% CI: $-.03$ and $.65$. Specifically, among participants with higher ties, the effect of the focal contrast was significant, $b = 1.09$, $SE = .44$, $t = 2.46$, $p = .02$, 95% CI: $.21$ and 1.97 , suggesting that participants in the healthcare and educator/employer conditions with high ties report higher self-efficacy compared to people in the control with high ties. No effect was shown with low ties, $b = -.35$, $SE = .38$, $t = -.91$, $p = .37$, 95% CI: -1.10 and $.41$, or moderate ties, $b = .37$, $SE = .30$, $t = 1.24$, $p = .22$, 95% CI: $-.22$ and $.97$ (Figure 9). With all variables entered, the full model explained a significant amount of variance in self-efficacy, $R^2 = .12$, $F(7,135) = 2.96$, $p = .007$.

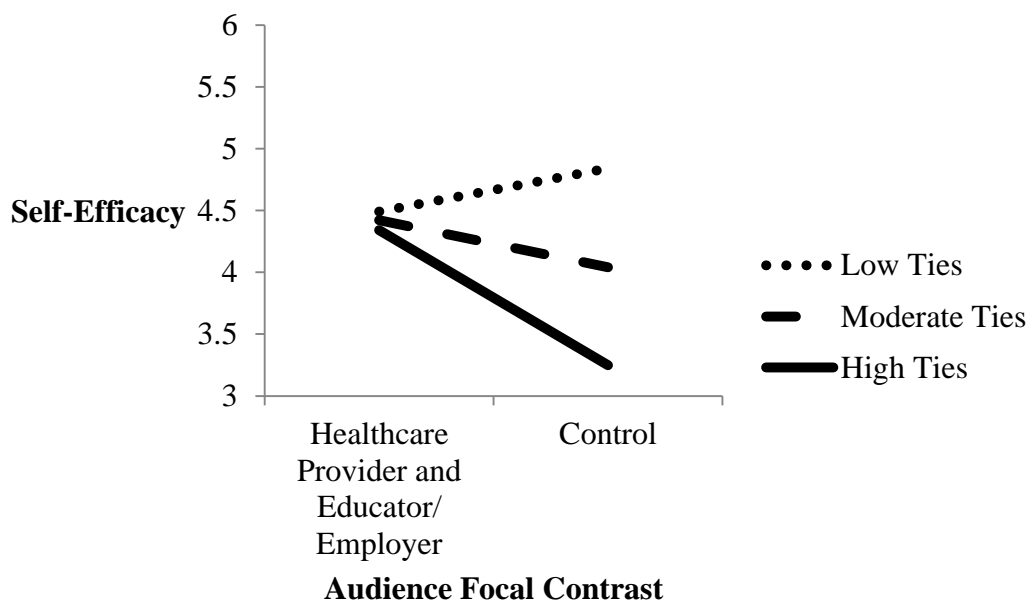


Figure 9. Diagram representing the interaction effect between the focal contrast and different levels of ingroup ties on self-efficacy.

When repeating the same analysis with the secondary contrast, aside from the patterns we have already reported, there was a significant interaction between stereotypes of worthiness and ingroup ties on self-efficacy, $b = -.11$, $SE = .05$, $t = -2.17$, $p = .03$, 95% CI: $-.21$ and $-.009$. Similar to the effect on self-esteem, among participants with the weakest ties to the ingroup, self-efficacy was most strongly affected by stereotypes of worthiness, $b = .26$, $SE = .13$, $t = 2.03$, $p = .04$, 95% CI: $.007$ and $.50$, whereas self-efficacy among participants with moderate and stronger ingroup ties was unaffected by stereotypes of worthiness, $b = .05$, $SE = .11$, $t = .48$, $p = .63$, 95% CI: $-.16$ and $.26$, and $b = -.15$, $SE = .15$, $t = -1.03$, $p = .31$, 95% CI: $-.45$ and $.14$, respectively (Figure 10).

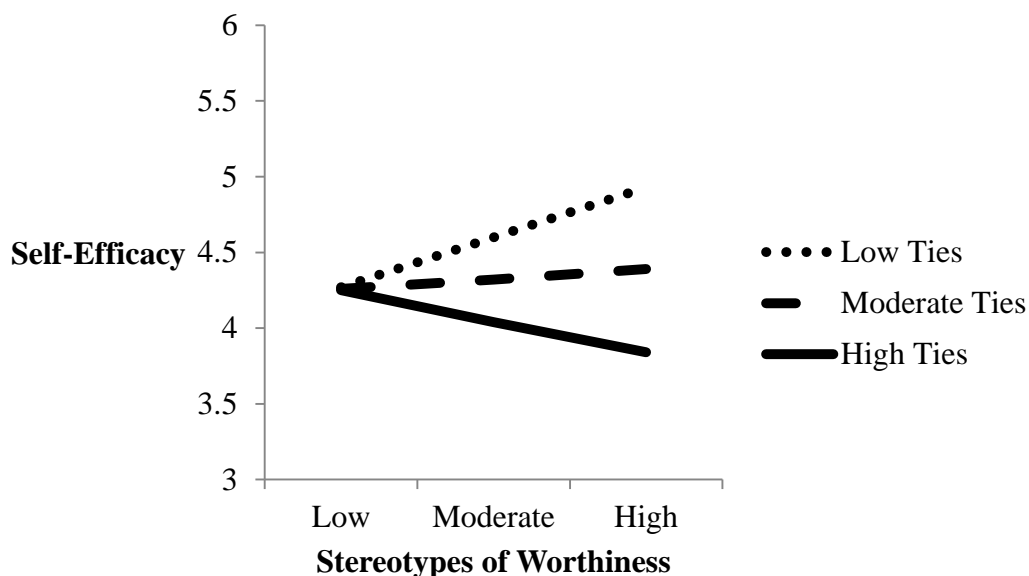


Figure 10. Diagram representing the interaction effect between stereotypes of worthiness and different levels of ingroup ties on self-efficacy.

From this, we again explored conditional indirect pathways between audiences and self-efficacy via activated stereotypes, however none of these pathways were significant: low ingroup ties effect = $.08$, $SE = .07$, 95% CIs = $-.02$ and $.28$; moderate ingroup ties effect =

.02, $SE = .04$, 95% CIs = -.05 and .14; high ingroup ties effect = -.04, $SE = .06$, 95% CIs = -.21 and .03. Thus although the self-efficacy of participants with low ties was more connected to perceived stereotypes, this was independent of the audience activated and how this fed into stereotypes of worthiness. With all variables entered, the full model explained a significant amount of variance in self-efficacy, $R^2 = .12$, $F(7,135) = 2.53$, $p = .02$.

Subjective health. The analysis of subjective health revealed a marginal effect between stereotypes of worthiness and subjective health, $b = .33$, $SE = .17$, $t = 1.92$, $p = .06$, 95% CI: -.01 and .67, suggesting that participants reporting more positive stereotypes of worthiness also experienced better subjective health. Self-reported severity was also significantly correlated with subjective health, $b = -.53$, $SE = .08$, $t = -6.55$, $p < .001$, 95% CI: -.70 and -.37, suggesting that people with less severe disabilities reported better subjective health. However, no further significant main or interactive effects were found, all $ps > .11$. With all variables entered into the model, a significant amount of variance on subjective health was explained, $R^2 = .27$, $F(7,136) = 7.17$, $p < .001$. When the analysis was repeated using the secondary contrast (comparing the two audience conditions) as the independent variable, no additional significant effects were found beyond what was previously reported.

Summary. The above analyses show that stereotypes of unworthiness were activated by salient audiences (healthcare providers and educators/employers), that these stereotypes were associated with compromised self-esteem and self-efficacy, as well as impaired subjective health. However, participants with stronger ingroup ties were better able to resist the negative implications of these stereotypes to their sense of self.

Responses to stereotypes of competence

Across all analyses involving stereotypes of competence, there was no effect of the audience (versus control) contrast on stereotypes of competence, $b = -.26$, $SE = .18$, $t = -1.45$, $p = .15$, 95% CI: $-.60$ and $.09$. When substituting the secondary contrast (the healthcare provider audience versus the educator/employer audience, ignoring the influence of the control condition), into these analyses, again, no significant effect was found, $b = -.18$, $SE = .19$, $t = -.97$, $p = .34$, 95% CI: $-.56$ and $.19$. Although this suggests that audiences did not specifically activate stereotypes around competence, we nonetheless explored whether perceived stereotypes of competence, either alone or in combination, might affect individual outcomes.

Self-esteem. When including self-esteem as the dependent variable, in addition to the significant effects of ingroup ties and severity on self-esteem, an additional significant effect on self-esteem was reported from stereotypes of competence, $b = .68$, $SE = .28$, $t = 2.45$, $p = .02$, 95% CI: $.13$ and 1.23 . This finding highlights that more positive stereotypes of competence were associated with increased individual self-esteem.

Beyond these main effects, the interaction between stereotypes of competence and ingroup ties on self-esteem was marginal, $b = -.10$, $SE = .05$, $t = -1.79$, $p = .08$, 95% CI: $-.20$ and $.01$. Participants with low ties reported significantly less self-esteem in response to stereotypes of incompetence, $b = .37$, $SE = .14$, $t = 2.72$, $p = .007$, 95% CI: $.10$ and $.64$, whereas this effect was marginal for people with moderate ties, $b = .20$, $SE = .11$, $t = 1.79$, $p = .08$, 95% CI: $-.02$ and $.42$, but non-significant for high ties, $b = .03$, $SE = .16$, $t = .20$, $p = .85$, 95% CI: $-.28$ and $.34$ (Figure 11). This suggests that the self-esteem of individuals with low and moderate ties was more contingent on the activated meta-stereotype, whereas participants with higher ties were largely protected from these negative meta-stereotypes.

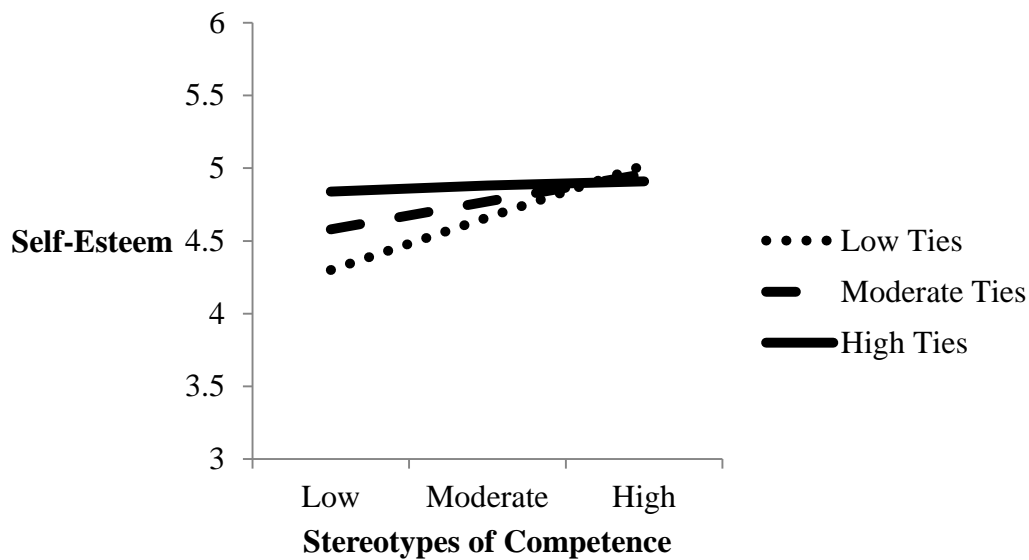


Figure 11. Diagram representing the interaction effect between stereotypes of competence and different levels of ingroup ties on self-esteem.

Given the presence of this marginal interaction between the mediator (meta-stereotypes of competence) and the moderator (ingroup ties), we also explored the presence of conditional indirect pathways between audience activations and self-esteem via stereotypes of competence. However, there were no significant indirect effects between these variables. With all variables entered, the full model explained a significant amount of variance in self-esteem, $R^2 = .12$, $F(7,137) = 2.74$, $p = .01$. When the analysis was repeated using the secondary contrast (comparing the two audience conditions) as the independent variable, no additional significant effects were found beyond what was previously reported.

Self-efficacy. With self-efficacy as the dependent variable, self-efficacy was significantly correlated with the focal contrast, $b = -1.59$, $SE = .81$, $t = -1.97$, $p = .05$, 95% CI: -3.19 and .004, suggesting that people in the control condition were associated with increased self-efficacy. However, no additional significant effects were observed beyond what was

previously reported. With all variables entered, the full model explained a significant amount of variance in self-efficacy, $R^2 = .14$, $F(7,136) = 3.07$, $p = .005$. The same analysis on self-efficacy at the secondary contrast level revealed no additional significant effects.

Subjective health. In the analysis of subjective health as the dependent variable, in addition to the previous significant main effects of severity, there was an additional significant effect of stereotypes of competence on subjective health, $b = .48$, $SE = .22$, $t = 2.21$, $p = .03$, 95% CI: .05 and .91, which highlights that more positive stereotypes of competence were associated with increased subjective health.

Beyond this main effect on subjective health, the interaction between stereotypes of competence and ingroup ties on subjective health was marginally significant, $b = -.07$, $SE = .04$, $t = -1.78$, $p = .08$, 95% CI: -.16 and .008. Participants with low ties reported significantly less subjective health in response to stereotypes of incompetence, $b = .24$, $SE = .11$, $t = 2.23$, $p = .03$, 95% CI: .03 and .44, whereas this effect was not shown for people with moderate ties, $b = .11$, $SE = .09$, $t = 1.21$, $p = .23$, 95% CI: -.07 and .28, or high ties, $b = -.03$, $SE = .12$, $t = -.21$, $p = .83$, 95% CI: -.27 and .21 (Figure 12). This suggests that the subjective health of individuals with low and moderate ties was more contingent on the activated meta-stereotype, whereas participants with higher ties were largely protected from these negative meta-stereotypes.

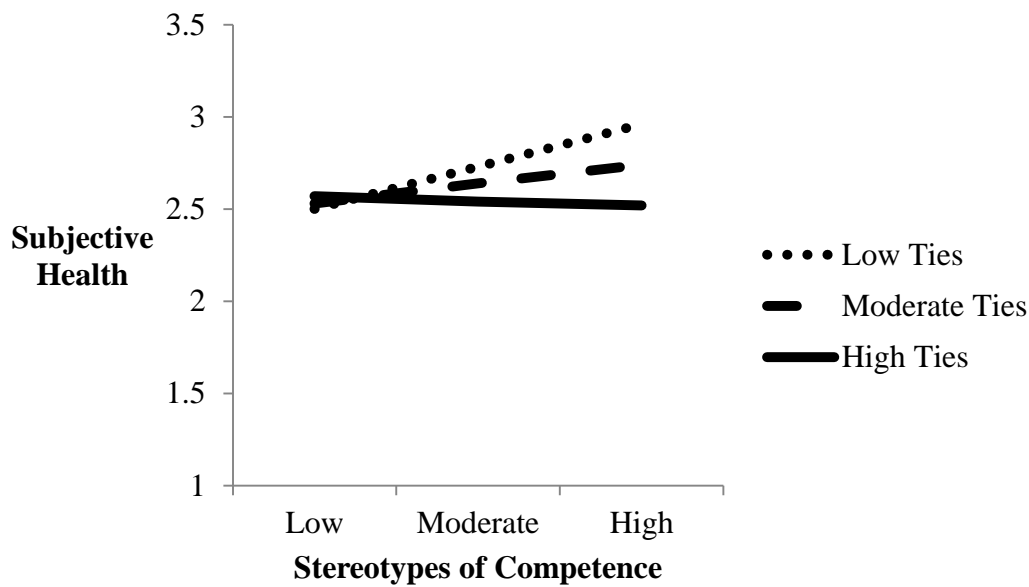


Figure 12. Diagram representing the interaction effect between stereotypes of competence and different levels of ingroup ties on subjective health.

Given the presence of this marginal interaction between the mediator (meta-stereotypes of competence) and the moderator (ingroup ties), we also explored the presence of conditional indirect pathways between audience activations and subjective health via stereotypes of competence. However, none of the indirect pathways between these variables were significant. With all variables entered, the full model explained a significant amount of variance in subjective health, $R^2 = .27$, $F(7,137) = 7.42$, $p = <.001$. When the analysis was repeated using the secondary contrast (comparing the two audience conditions) as the independent variable, no additional significant effects were reported.

Summary. The above analyses show that stereotypes of incompetence were not activated by salient audiences (healthcare providers and educators/employers), but these stereotypes were associated with reduced self-esteem, self-efficacy, and subjective health.

However, participants with stronger ingroup ties were again better able to resist the negative implications of these stereotypes for their sense of self.

Responses to stereotypes of warmth

Across all analyses involving stereotypes of warmth, there was no effect of the focal contrast (audiences versus control) on perceived stereotypes, $b = -.27$, $SE = .19$, $t = -1.42$, $p = .16$, 95% CI: $-.66$ and $.11$, or of the secondary contrast comparing the two audience conditions, $b = .33$, $SE = .21$, $t = 1.60$, $p = .11$, 95% CI: $-.08$ and $.74$. Although this suggests that audiences did not specifically activate stereotypes around warmth, we nonetheless explored whether perceived stereotypes of warmth, either alone or in combination with ingroup ties, might affect individual outcomes.

Support willingness. In the analysis of support willingness, there was a marginally significant association between severity and support willingness, $b = -.22$, $SE = .12$, $t = -1.88$, $p = .06$, 95% CI: $-.44$ and $.01$, suggesting that those with less severe disabilities were more willing to access support. With all variables entered into the model, a marginal amount of support willingness variance was explained, $R^2 = .9$, $F(7,136) = 1.86$, $p = .08$. When the analysis was repeated using the secondary contrast (comparing the two audience conditions) as the independent variable, no additional effects were observed.

Self-esteem. In the analysis of self-esteem, in addition to the significant ingroup ties and severity effects already discussed, stereotypes of warmth were marginally correlated with self-esteem, $b = .58$, $SE = .33$, $t = 1.75$, $p = .08$, 95% CI: $-.08$ and 1.24 , highlighting that more positive stereotypes of warmth were associated with increased individual self-esteem.

Beyond these main effects, the interaction between stereotypes of warmth and ingroup ties on self-esteem was marginal, $b = -.11$, $SE = .06$, $t = -1.79$, $p = .08$, 95% CI: $-.23$ and $.01$. However, no significant stereotype effects were observed at any level of ingroup

ties: low ties, $b = .22$, $SE = .15$, $t = 1.42$, $p = .16$, 95% CI: $-.09$ and $.51$; moderate ties, $b = .03$, $SE = .10$, $t = .33$, $p = .74$, 95% CI: $-.17$ and $.24$; high ties, $b = -.15$, $SE = .14$, $t = -1.06$, $p = .29$, 95% CI: $-.42$ and $.13$ (Figure 13). This suggests that although neither of the low ties or high ties simple slopes were significant, their respective patterns suggest that self-esteem was contingent on the activated stereotype, whereby individuals with low ties appeared to absorb negative stereotypes, whereas participants with higher ties appeared to reject the negative stereotypes. With all variables entered, the full model explained a significant amount of variance in self-esteem, $R^2 = .10$, $F(7,136) = 2.09$, $p = .05$. No additional significant effects were observed when the analysis was repeated using the secondary contrast (comparing the two audience conditions) as the independent variable.

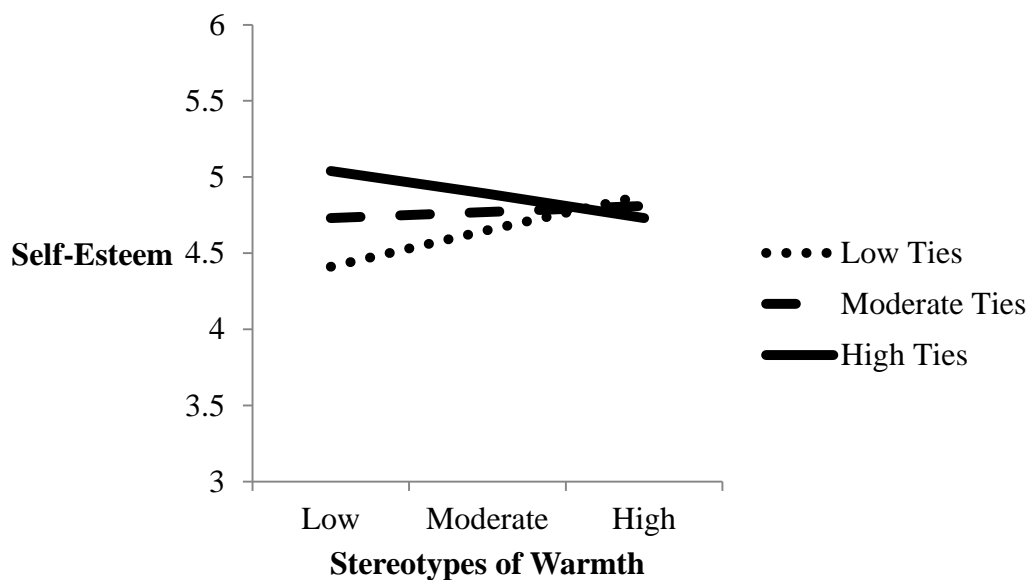


Figure 13. Diagram representing the interaction effect between stereotypes of warmth and different levels of ingroup ties on self-esteem.

Self-efficacy. In the analysis of self-efficacy, no additional significant effects were found beyond what was previously reported. With all variables entered, the full model

explained a significant amount of variance in self-efficacy, $R^2 = .10$, $F(7,135) = 2.24$, $p = .03$. The analysis involving the secondary contrast also revealed no additional significant effects.

Subjective health. The analysis of subjective health revealed no additional significant effects beyond what was previously reported. The full model explained a significant amount of variance in subjective health, $R^2 = .25$, $F(7,136) = 6.58$, $p = <.001$. When the analysis was repeated using the secondary contrast (comparing the two audience conditions) as the independent variable, again, no additional significant effects were found beyond what was previously reported.

Summary. In these analyses there was no evidence to suggest that healthcare provider and educator/employer audiences activated negative stereotypes around warmth, however, negative stereotypes of warmth impaired the self-esteem of participants with lower ties more than higher ties.

Responses to stereotypes of passivity

Across all analyses involving stereotypes of passivity, people in the healthcare provider and educator/employer audiences reported significantly stronger stereotypes of passivity (meta-stereotypes) compared to people in the control condition (self-stereotypes), $b = .69$, $SE = .17$, $t = 4.07$, $p = <.001$, 95% CI: .35 and 1.02. When substituting the secondary contrast (the healthcare provider audience versus the educator/employer audience, ignoring the influence of the control condition), into these analyses, no significant effect was found, $b = -.09$, $SE = .18$, $t = -.48$, $p = .63$, 95% CI: -.45 and .27.

Support willingness. In the analysis of support willingness, in addition to the marginal effect of severity reported previously, there was also a significant effect of stereotypes of passivity on support willingness, $b = .85$, $SE = .41$, $t = 2.08$, $p = .04$, 95% CI: .04 and 1.66, and ingroup ties on support willingness, $b = .87$, $SE = .34$, $t = 2.55$, $p = .01$, 95% CI: .20 and

1.55. Stronger stereotypes of passivity (i.e., more passive) and stronger ingroup ties were associated with greater willingness to access support.

Beyond these main effects, the interaction between stereotypes of passivity and ingroup ties on support willingness was also significant, $b = -.17$, $SE = .08$, $t = -2.20$, $p = .03$, 95% CI: $-.33$ and $-.02$. Specifically, stereotypes of passivity appeared to have a positive influence on support willingness for low identifiers, whereas for high identifiers the relationship was reversed, although neither of these effects were significant: low ties, $b = .28$, $SE = .18$, $t = 1.58$, $p = .12$, 95% CI: $-.07$ and $.62$; high ties, $b = -.32$, $SE = .19$, $t = -1.78$, $p = .09$, 95% CI: $-.69$ and $.05$. Support willingness of moderate identifiers appeared to be largely unresponsive to changes in passivity stereotypes, $b = -.02$, $SE = .12$, $t = .19$, $p = .85$, 95% CI: $-.27$ and $.22$ (Figure 14).

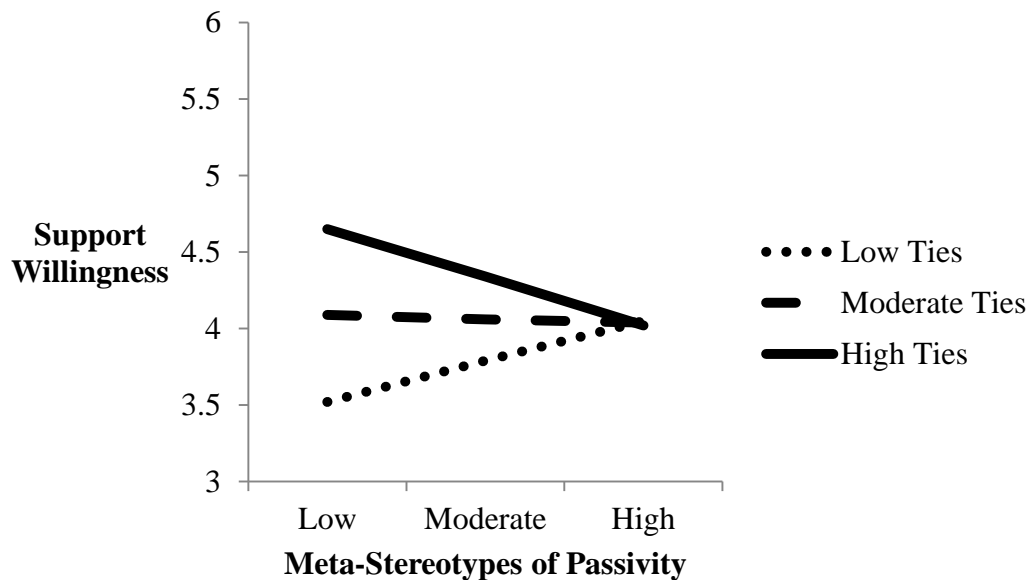


Figure 14. Diagram representing the interaction effect between stereotypes of passivity and different levels of ingroup ties on support willingness.

Given the presence of audience effects (the independent variable) on stereotypes of passivity (the mediator), and the interaction between this mediator and the moderator (ingroup ties), we also explored the presence of conditional indirect pathways between audience activations and support willingness via meta-stereotypes of passivity. However, no significant indirect effects were observed at any level of ingroup ties: low ties, effect = .19, $SE = .16$, 95% CIs = -.04 and .65; moderate ties, effect = -.02, $SE = .10$, 95% CIs = -.22 and .18; high ties, effect = -.23, $SE = .16$, 95% CIs = -.58 and .04. With all variables entered, the full model explained a significant amount of variance in support willingness, $R^2 = .11$, $F(7,137) = 2.43$, $p = .02$. When the analysis was repeated using the secondary contrast (comparing the two audience conditions) as the independent variable, no additional significant effects were found beyond what was previously reported.

Self-esteem. The analysis of self-esteem revealed no additional significant effects beyond what was previously reported. The full model did explain a significant amount of variance in self-esteem, $R^2 = .14$, $F(7,137) = 3.27$, $p = .003$. When the analysis was repeated using the secondary contrast (comparing the two audience conditions) as the independent variable, again, no additional significant effects were recorded.

Self-efficacy. The analysis of self-efficacy revealed no additional significant effects beyond what has previously been reported. With all variables entered, the full model explained a significant amount of variance in self-efficacy, $R^2 = .13$, $F(7,136) = 2.81$, $p = .009$. The same analysis on self-efficacy at the secondary contrast level again showed no additional significant effects.

Subjective health. Finally, the analysis of subjective health showed no additional significant effects beyond what was previously reported. The full model explained a significant amount of variance in subjective health, $R^2 = .25$, $F(7,137) = 6.42$, $p = <.001$.

When the analysis was repeated using the secondary contrast (comparing the two audience conditions) as the independent variable, again, no additional significant effects were found beyond what was previously reported.

Summary. In these analyses there was some evidence that healthcare provider and educator/employer audiences activated stereotypes around passivity (i.e., believing they would be viewed as more passive), and that these stereotypes of passivity appeared to influence support willingness: increasing support willingness for participants with lower ties (i.e., absorbing the stereotype), but decreasing for individuals with higher ties (i.e., rejecting the stereotype) – though neither of these simple effects were significant.

Summary of results. The above analyses show that audiences are associated with negative stereotypes (encompassing reduced worthiness and increased passivity, and to a lesser extent, reduced warmth and competence). These stereotypes have consequences for individual willingness to engage with support, self-esteem, self-efficacy, and subjective health. Moreover, there was some evidence that the effects of stereotypes on these outcomes were moderated by the level of ingroup ties with the disabled group. However, we found limited support for conditional indirect pathways connecting audience, activated stereotypes and outcomes, as moderated by ingroup ties (see Figure 8; Figure 15).

Generally, we found that while both the healthcare provider and educator/employer audiences were associated with negative stereotypes, the activation of these stereotypes only compromised individual outcomes for participants low in ingroup ties. Participants with higher ingroup ties appeared to express their self, and to engage with support, in opposition to the activated stereotypes. Thus, in the face of stereotypes of unworthiness, incompetence, and low warmth, only those with low ties experienced reduced self-esteem, self-efficacy, and subjective health. In the face of stereotypes of passivity, those with low ties to the disabled

group were willing to engage with behaviour that signalled dependency (i.e., seeking support). In comparison, those who were more tied to the disabled group maintained self-worth in the face of unworthiness, incompetence, and lack of warmth, and also resisted support in the face of perceived passivity.

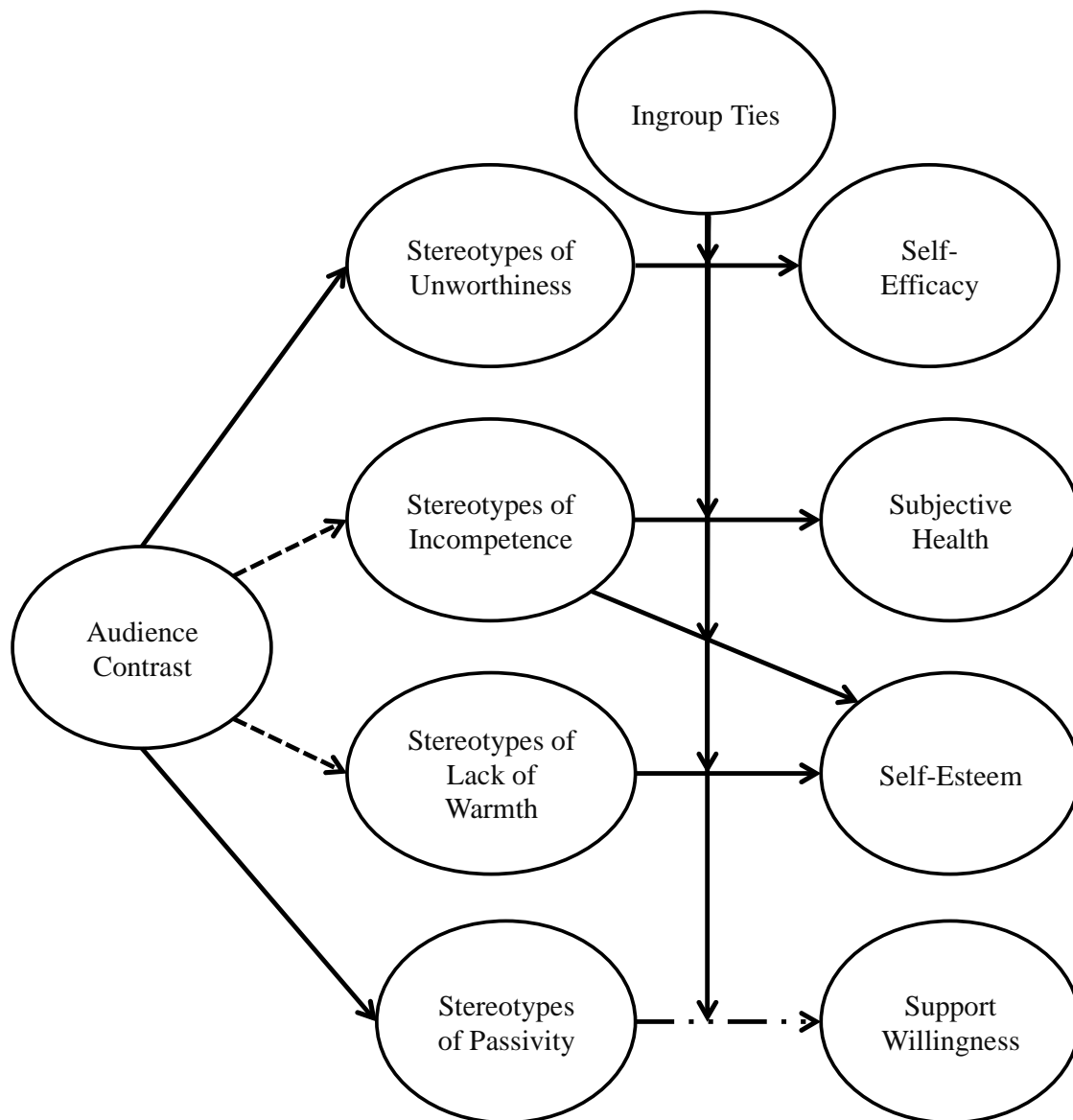


Figure 15. Diagram showing patterns of audiences activating stereotypes, and how ingroup ties in turn, moderate associated outcomes, but which *did not* report significant conditional indirect pathways (solid lines reflect a significant correlation at $p = <.05$; the line connecting stereotypes of passivity to support willingness reflects the marginal patterns shown at low

and high ties; dashed lines reflect the non-significant correlations connecting audience contrast to stereotypes of incompetence and lack of warmth).

Discussion

Together, the findings from Study 4 confirm that physically disabled individuals anticipate differing audiences to hold a range of negative stereotypes. These stereotypes include perceptions of passivity, as well as a lack of worthiness, warmth and competence. Although there appeared to be little evidence for audience-specific stereotype activation, certain stereotypes did appear to be more associated with either healthcare providers or educators and employers. Specifically, people in the healthcare provider condition appeared to more strongly predict activations of unworthiness, a lack of warmth, and increased passivity, whereas educators and employers were more associated with lack of competence.

Activation of these stereotypes, in turn, impacted on individual self-presentations in terms of reported self-esteem and self-efficacy, but also on willingness to access support and subjective health. Interestingly, the specific consequences of stereotype activation varied across outcomes: stereotypes of worthiness, warmth, and competence seemed most consequential for self-esteem, though to a lesser extent, worthiness also predicted self-efficacy, and competence also predicted subjective health. Stereotypes of passivity were instead most strongly connected to willingness to seek support. Considered side-by-side, there appears to be a match between the content of the stereotype to the audience and the specific outcome that is affected by it.

Moreover, there was also evidence that the links between stereotypes and outcomes were strongest among individuals with weaker ingroup ties to the physically disabled group: the well-being and subjective health of low identifiers was most associated on others

perceiving them as worthy, competent, and warm, and their willingness to access help when others perceived them as passive. In contrast, the outcomes of high identifiers were either unrelated or in opposition to perceived stereotypes, such as showing a potential reluctance to access support when others perceived them as passive. The results therefore confirm the expectation that responses to stereotypes in terms of confirmation or resistance, would depend on the degree to which individuals felt a sense of strong ties to the disabled ingroup.

In noting how ingroup ties may influence confirmatory or resistive self-presentations, it is important to highlight that social identification may at times be inhibitory for disabled people in terms of their responses to stigma. Specifically, we found that while individuals with high ties resisted potentially negative stereotypes, their self-presentations on certain dimensions (e.g., self-efficacy) were consistently lower than for individuals with low or moderate ties regardless of the valence of the experienced stereotypes.

However, while this study has provided support for our ideas regarding audiences activating specific stereotypes, and the role of ingroup ties in moderating responses to these activated stereotypes, we found little evidence to suggest that these two ideas are connected. Said differently, in the majority of findings where ingroup ties moderated self-presentation responses when stereotypes were experienced, these outcomes were independent of the audience that activated them. Given the theoretical grounding underpinning our progression from Study 3 to 4, we would have expected clearer evidence that the specific nature of disabled people's self-presentations as a consequence of audience-activated stereotypes would differ on strength of identification (i.e., via ingroup ties). Therefore, once again, our interpretations of the outcomes of willingness to seek support, self-esteem, self-efficacy, or subjective health as identity performances may be invalid.

General Discussion

The aims of this research were threefold: first, we sought to investigate how identity performance concerns might impact on willingness to seek help and well-being in physical disability (Study 2). Second, we examined whether these concerns alter according to the situational audience as specific stereotypes (Studies 3 and 4). Finally, we sought to explore the role of ingroup ties to a collective disability identity in influencing identity performance behaviours in response to these situational concerns (Studies 2-4).

In Study 2, we found that physically disabled people tend to acknowledge experiencing discrimination because of their identity. We demonstrated that the frequency of this experienced discrimination was related to concerns regarding identity performance (i.e., how others might see them), and that these concerns were in turn related to reported help-seeking behaviour and well-being. Specifically, feeling concerned about performing their identity in particular ways reduced participants' willingness to engage with support and through this their subjective well-being suffered.

Interestingly, the experimental aspect of Study 2 revealed that these outcomes were not affected by making the specific issues of accessing support or discrimination salient. Instead, as revealed in Studies 3 and 4, individual responses on these outcomes were affected when specific audiences connected to these issues were made salient (i.e., the issue of accessing support with healthcare provider audiences, and the issue of experiencing discrimination with general public/educator and employer audiences). The fact that responses seemed more affected by the salience of audiences rather than issues alone is consistent with our analysis of these responses as reflecting identity performance (Barreto & Ellemers, 2009; Barreto et al., 2003; Rabinovich & Morton, 2010). That is, participants seemed to tailor their

reports of willingness to access support, for example, to the audience to which they believed these responses would be visible.

More specifically, activating audiences was found to evoke distinct meta-stereotypic perceptions of the disabled ingroup. Although these meta-stereotypes largely did not differ significantly between the activated audiences (e.g., healthcare providers versus educators and employers in Study 4), what is perhaps surprising is how negative these meta-stereotype activations were, especially with respect to the healthcare provider audience. Specifically, in Studies 3 and 4, participants expected this audience to view physically disabled people as particularly unworthy, cold, and passive. Conversely, the general public and educator/employer audiences were particularly associated with perceiving the ingroup as lacking in competence. Meta-stereotypes, once activated by specific audiences, were also found to influence self-presentations, and that these presentations were contingent on the individual's identification with the disabled ingroup (i.e., ingroup ties).

Stereotypes of unworthiness, incompetence, and a lack of warmth especially impaired the self-esteem and subjective health of less identified participants. In comparison, participants who were more strongly tied to the disabled ingroup appeared to be resilient in the face of negative stereotypes and constructed their self in opposition to these. However, in noting the possible resilience that the social group may provide for disabled people, we also found evidence that social identification may be detrimental for disabled people in terms of their responses to stigma. Specifically, we found that the self-efficacy of highly tied individuals was consistently lower than for individuals with low or moderate ties when stereotypes of worthiness were experienced, as well as a possible reduction in their willingness to seek support when exposed to stereotypes of passivity.

As severity of disability was controlled for in all studies, differences in these outcomes according to specific audience stereotypes suggest a strategic expression of their identity (i.e., identity performance). Specifically, as moderately and highly identified participants largely showed limited association between health and well-being across the valence of activated stereotypes, this suggests that these outcomes are not contingent on the expectations of others (i.e., meta-stereotypes). This could mean that they have access to the necessary group resources to resist stereotypes (either positive or negative) when they are experienced (Fernández et al., 2012; Nario-Redmond et al., 2013), such as a group information and social support, as well as a meaningful sense of community and friendship (Braithwaite et al., 1999; Finn, 1999; Huang & Guo, 2005; Obst & Stafurik, 2010). However, an alternative interpretation could be that these individuals are attempting to perform their identity in a way that counters or challenges the negative stereotypes in order to benefit the group as a whole, such as by distancing themselves from support when stereotypes of passivity are most prominent, or highlighting that their self-efficacy is not dictated by others' expectations. Individuals with low ties may be performing in a different way, whereby they appear more responsive to how they expect an audience to view them, and so their behaviours seem to reflect this focus.

Implications for disability practice

The distinction between how physically disabled people perform their identity according to their level of ties highlights important implications for how they navigate the stereotypes they experience, as well as the associated identity conflicts. Specifically, as people with high ties remain relatively unresponsive to the stereotypes in terms of their health and well-being, identifying as part of a collective disability identity may provide a sense of solidarity and resilience to collectively assist in coping with potentially negative stereotypes

of others. However, at the same time, they may have a desire to counteract negativity associated with the group (e.g., to challenge assumptions of passivity by reducing their willingness to seek support). Consequently highly tied disabled people may experience a potentially unintended disadvantage over those who separate from the group, or do not view the group in high regard. That is, by using group resources to resist potentially negative attitudes, they may inhibit their self-presentations (e.g., in terms of their self-efficacy or support willingness). As access to appropriate and desired help and support is clearly valued by physically disabled people (Chapter 4), should they choose to identify in this way, it is important that they recognise the possible detrimental effect this may cause to their willingness to seek support, and as such, potentially their psychological and physical well-being. In this sense, our findings highlight potentially conflicting ideas about whether the social identity may be helpful or detrimental to an individual's ability to navigate experienced stigma (e.g., see Schmitt et al., 2014).

Conversely, the valence of the stereotypes also has important implications for health and well-being for people with low ties. As the attitudes of others appear to play a more central role in how these individuals view themselves, this may benefit them when stereotypes are favourable, but at the same time, they are also likely to be most affected when stereotypes are negative, as they may absorb the negative views of others into their own self-descriptions (Charlton, 2000). Moreover, as the group appears to be of little importance to this subsection of the sample, they may be unable (or may not choose) to associate with the group, and in turn, are unable to gain effective coping resources from the social group to effectively deal with these experiences. In sum, disabled people need to navigate stigma, and may seek to achieve this either by identifying with, or separating from, the social identity, resulting in different identity performance behaviours according to level of group

identification. However, our results demonstrate several possible costs and benefits of enacting these strategies, suggesting that neither of the above strategies can be risk-free for disabled people (Chapter 4; Chapter 6).

Because of this we believe our findings raise important implications to potentially address the societal and audience expectations which are eliciting these identity performance pressures. Specifically, we have shown that physically disabled people will likely be very aware of how they expect others to stereotype them, which in turn, can impact upon support and health and well-being outcomes. Consequently, we recommend that healthcare providers, the general public, and educators and employers recognise the negative stereotypes disabled people believe they are assigning to them, as well as the possible detrimental impact these stereotypes may be having on their health, well-being, and support-seeking behaviours. To address these issues, it is important that the audiences discussed in this paper begin to recognise the significant heterogeneity of physical disability, and so the impairment, severity and visibility will clearly vary from person to person. However, in acknowledging these many differences within the physically disabled community, we also recommend that their collective bond also be recognised. In doing so, non-disabled individuals can potentially appreciate the common difficulties and needs that are experienced by all physically disabled people (e.g., stigmatisation), and through this, advocating the possible benefits that the wider disability community can provide in terms of resistance to these issues. This will potentially diminish the salience of the associated identity pressures and stereotypes disabled people experience when interacting with these audiences.

Limitations and further directions

However, the conclusions we have made regarding our findings should be treated with caution. Because of our focus on highlighting correlational associations between

discrimination, stereotypes and identity performance concerns, group identification, and support, well-being and health, we are unable to causally infer actual outcomes from this data. We are therefore unable to report with certainty that particular stereotypes promote specific health and well-being outcomes, or that these effects can be influenced by group identification. Moreover, it is also important to highlight the ambiguity that exists across the findings of the studies. Specifically, although the stereotypes activated in Studies 3 and 4 are similar, the resulting outcome variables reported are largely different. For example, although self-esteem appears to be an important outcome for stereotypes of worthiness, competence, and warmth in Study 4, this was not the case in Study 3 (i.e., only when stereotypes of competence were activated). There were also several models that produced weak or marginal effects. It also remains unclear how the ingroup ties moderation effect that was demonstrated from activated stereotypes in Study 4 was largely absent from Study 3, particularly as the same healthcare provider audience, stereotypes and outcome variables were used. Because of this, while our results support and contribute to the growing literature highlighting the role that identity plays in assisting with disability stigma, we recognise that further exploration in this field is needed. We recommend that further quantitative research be conducted to attempt to develop and replicate our initial findings in order to provide greater evidence for the presence or absence of ingroup ties influencing identity performance behaviour when situational audience stereotypes are experienced.

In noting this limitation, however, although the results highlighted that differing audience stereotypes can encourage specific outcomes (e.g., willingness to seek support), they stop short of highlighting whether these outcomes reflect external identity performances or internal feelings. Specifically, it is unclear from the measures whether health and support outcomes are external performances in terms of strategically demonstrating their support or

health in a specific way to an audience (see Lynch & Thomas, 1999), or simply reflecting internal feelings of reduced well-being. This same issue also exists when attempting to elucidate the meaning of ingroup ties. Specifically, while these ratings could reflect how participants view their disabled social identity, they could also describe strategic performances to an audience in order to achieve a specific outcome. As participants were told in the survey that their responses would be fed back to their assigned audience, we have interpreted many outcomes as external performances (e.g., high identifiers strategically altering their willingness to seek support), particularly as subjective severity of disability was controlled. However, we recognise that this assumption may be invalid, and that ingroup ties and reported outcomes could also reflect internal feelings.

Because of the lack of clarity and consistency of the results and the inferences that can be made from them, it is important that further research attempts to elucidate the role of identity in disability identity performance more thoroughly. In particular, we recommend that additional investigations use behavioural measures of engagement with support and performances of health to distinguish behaviours indicative of internal affect or overt performance. Alternatively, we also recommend that the measures we have used to assess ingroup ties and reported outcomes be modified to effectively distinguish between identity performances from internal feelings (e.g., with regards to the subjective health statements used in this paper, “I feel I have to *perform* as tired” versus “I feel tired”).

An additional limitation with this research should also be noted. To participate in these studies, participants had to personally identify as a physically disabled person, and so, as a consequence, they may be more willing to use this categorisation as a focal attribute of their sense of self. Moreover, as all participants to these studies were recruited using existing disability charities, organisations and support groups, they may already hold stronger ingroup

ties to the disabled community when compared to disabled people who choose not to join these groups. Therefore, we might anticipate that all individuals within these studies already value their disability social group, and thus they will likely use this social network to cope with stigmatisation and access support resources (Chapter 4; Chapter 6). We have shown from Study 4 that it is people who hold low ties to the group that may potentially be most vulnerable to the negative implications of the stereotypes associated with the group. That is, although these individuals may not feel a strong sense of connection with other disabled people, they may nonetheless still be aware of the stereotypes associated with their group, and experience threats to health and well-being as a consequence. This study therefore may not have been able to directly target the physically disabled people who are most at risk of the negative effects of stigmatisation.

Conclusion

To conclude, this paper has highlighted that physically disabled people are conscious about performing their identity, both in a general sense, as well as in the presence of an audience. These pressures can be potentially threatening to the individual's sense of self, and their health and well-being. How physically disabled people construct their identity (i.e., according to their ingroup ties) may promote changes in how their health and well-being is affected by these stereotypes. However, in response to these stereotypes, disabled people may experience a difficult dilemma in how they navigate their identity. That is, while the identity performances of high and low identifiers both promote benefits, they are nevertheless also associated with costs.

CHAPTER 6

**“THEY FEEL THAT BECAUSE I LOOK A PARTICULAR WAY, I ‘SHOULD’ ACT
A PARTICULAR WAY”: A QUALITATIVE ANALYSIS OF SITUATIONAL
IDENTITY PERFORMANCE IN DISABLED PEOPLE**

Abstract

Disabled people remain a highly stigmatised minority group. However, little research has investigated the ways in which disabled people respond to potential negativity they may experience. This study qualitatively explored how disabled people (N = 48) perform their identity in the face of such stigma. Participants completed an online survey where they discussed their experiences, and the pressures they felt to perform their identity when interacting with two potentially stigmatising audiences: healthcare providers (who might evaluate them based on deservingness of care), educators/employers (who might evaluate them based on competence). Participants also described how these interactions affected their sense of personal identity and social identity. Thematic analysis revealed that participants enacted multiple situational 'identity performances' to overcome anticipated negativity from each audience. In addition, while participants viewed both their personal and social identities as important, how they constructed these identities varied according to their audience. Taken together, the results suggest that disabled people face dilemmas in navigating audience expectations while also maintaining a positive sense of individual self, and that they engage in strategic forms of identity performance to balance these demands.

Disabled people are readily exposed to paternalistic beliefs. For example, as a consequence of assumed incompetence and dependency (Charlton, 2000; Wright, 1983), people with visible disabilities are often treated with sympathy and pity (Linton, 2010; Nario-Redmond, 2010). Research into the stigma of disability has largely focused on exploring the attitudes non-disabled people have towards the disabled community, and how these are revealed in interactions, and how they might be modified (Hebl & Kleck, 2000). Attitudes about disability have frequently been investigated across a range of contexts, including healthcare, the workplace, and education, because these attitudes may represent important barriers to care, support and access to opportunities (Olney & Brockelman, 2003; Scambler, 2009; Schur, Kruse, & Blanck, 2005; Silverman & Cohen, 2014). Although stereotypes across these contexts can reflect the general pattern of paternalism, there are also more context-specific stereotypes. For example, within care environments, paternalistic attitudes may translate into decisions about support provision (Dovidio & Fiske, 2012) or even over-helping (Cuddy et al., 2008). In employment-related environments, paternalism may be combined with presumed incompetence for work positions, although disabled individuals might simultaneously be viewed as warm and conscientious (Louvet, 2007). In educational contexts, paternalism and presumed incompetence may be combined further with devalued traits of quietness, loneliness and isolation, but also positive traits like honesty (Fichten & Amsel, 1986).

Despite the specificity of the stereotypes that are associated with disability across different settings, comparatively little research has explored how disabled people believe they will be viewed in different environments, and by the audiences these environments imply (Hebl & Kleck, 2000). Nonetheless, the evidence that does exist suggests that disabled people have strong expectations of how others will view them. For example, when interacting with

educators and employers, disabled people believe that they will be viewed as passive and incompetent (Chapter 5; Louvet et al., 2009; Olney & Brockelman, 2003). In contrast, when interacting with healthcare providers, these stereotypes of incompetence and passivity are combined with additional expectations that they will be seen as unworthy and lacking in warmth (Chapter 4; Chapter 5). Despite these observations, we still know little about how individuals with disability manage themselves in the face of multiple and changing stereotypic expectations.

Navigating negative stereotypes through identity performance

One way in which to understand how disabled individuals experience and respond to salient stereotypes is in reference to identity. Specifically, individuals experience stereotyping and stigmatisation because their assigned identity is one that is devalued (Crocker et al., 1998). From a social psychological perspective, identity is a fluid, context-dependent construct that incorporates both personal and social elements (Tajfel & Turner, 1979; Turner et al., 1987). Personal identity reflects the individual and unique aspects of the self, whereas the social identity reflects how the self can be described according to meaningful social groups (Tajfel, 1981; Turner et al., 1987). Though both the personal and social dimensions of identity are essential in the formation of the self, the importance of each aspect varies according to the context and audiences that the individual is interacting with (i.e., external forces), and according to individual preferences for self-definition (i.e., internal understandings and preferences).

From this perspective, how individuals respond to stigmatising experiences should depend on whichever aspect of identity is most salient or important to the individual. For example, Tajfel (1978) noted that stigmatised individuals can respond to negativity through either enacting their personal identity and leaving the social group altogether (individual

mobility), or remaining with the group and engaging in collective action. The latter, group-based strategy can involve either redefining the meaning of the social group into something more favourable, or contesting the outgroup's negative perception of their group. Where stigmatised individuals prioritise their personal identity they are more likely to leave the group in order to protect their individual self, but where people value their social identity they will be more likely to adopt behavioural strategies that are intended to benefit the group as a whole (Ellemers et al., 1997).

Because of the varied stereotypes disabled people might experience, they may draw on different aspects of their identity to navigate these situations (e.g., Goffman, 1963; Wright, 1983). For example, disabled individuals might engage in various behaviours or expressions that negate, neutralise, or counter the anticipated views of others. In making this point, we draw on broader theoretical work on "identity performance". Within this literature, it has been noted that stigmatised individuals can demonstrate their identity in strategic and deliberate ways to attempt to alter some outgroup's opinion of them and their group (O. Klein et al., 2007). These *identity performances* are not constant and singular behaviours. Instead, performances are always situated and responsive to the specifics of the audience that is assumed to be viewing and evaluating the self, either as an individual or as a group member (Barreto & Ellemers, 2009; Barreto et al., 2003; Morton & Sonnenberg, 2011; Rabinovich & Morton, 2010). Accordingly, stigmatised individuals can evoke a number of specific identity performances and enact these depending on the needs and demands of specific situations and groups of people present (Barreto et al., 2003; Wiley & Deaux, 2011).

For example, if disabled people are concerned about potential stigmatisation from healthcare providers, they may engage in a performance of their identity that distances themselves from stereotypes of dependency and worthiness in order to protect their

individual sense of self, such as by emphasising their independence and agency (Southall et al., 2010). However, as allocation of appropriate care and assistance is clearly needed by many (Chapter 4), performing their self in this way might undermine their access to desired support. This is because disabled people often require confirmation from their healthcare provider that they are suitable or eligible for specific support (Buljevac et al., 2012; Horton-Salway, 2007; McLaughlin, 2012). To obtain this confirmation, they might sometimes need to enact an identity performance that plays to stereotypes of passivity and dependency in order to justify their legitimacy for help (Chapter 4; Chapter 5; L. C. Brown, 2013; Lane, 2010).

Although this performance may be desirable for ensuring access to support, enacting one's self in this way (i.e., as stereotypically "disabled") is likely to prompt further dilemmas for the disabled person. Endorsing a stereotypical, and potentially negative, representation of the self might conflict with how the individual personally wants to be seen by others – that is, as a unique individual and not defined solely by their disability (Gervais, 2010). By conforming to a negative, stereotypical representation of disability, the disabled individual might feel as though their identity is constrained (e.g., Morton & Sonnenberg, 2011), resulting in a compromised sense of self, and reduced self-esteem and well-being (Charlton, 2000).

In other settings, such as educational or employment contexts, identity dilemmas are also likely to be experienced, although the ways these play themselves out should be different given the different stereotypic concerns. Specifically, these situations require strong ability and proficiency, and so whilst workplace and educational assistance may be required to achieve this competence, unlike the healthcare context, support is not the focal interest. In order to navigate negativity and possible discrimination stemming from an assumed lack of

competence in these domains, disabled people might seek to enact their personal identity and consciously downplay or conceal the salience of their disability, or attempt to overtly demonstrate their competence and suitability for the workplace or education (e.g., Goffman, 1963; Louvet et al., 2009; Olney & Brockelman, 2003; L. Snyder et al., 2010; Taub et al., 2004; Wright, 1983), an identity performance that distances them from the negativity associated with their broader group (Branscombe & Ellemers, 1998; Branscombe et al., 2012; Fernández et al., 2012). Although this strategy may promise the benefits of allowing others to view them in terms of their personal competencies rather than through disability stereotypes, by emphasising the personal self they may be less able (or less willing) to access accommodations or support in this environment (e.g., disability networks) aimed at allowing them to overcome specific ability-based barriers (Baldrige & Swift, 2013; Baldrige & Veiga, 2006; Barnard-Brak et al., 2010; Taub et al., 2004). Reluctance or difficulty in accessing these accommodations might, in turn, have the ironic consequence of impairing their competence more in these environments.

In sum, disabled people face a number of situation-specific pressures with respect to how they display their self and their disability to others in light of the stereotypes they are assumed to hold. These pressures mean that disabled people must somehow navigate between a number of differing identity performances and the promises and problems these entail (Crooks et al., 2008; Grytten & Måseide, 2005; S. D. Stone, 2013). Indeed, there is some existing evidence in support for these ideas. For example, qualitative research by Taub et al. (2004) noted how in academic contexts disabled individuals would present themselves differently depending on whether accessing support was their key motivation. Specifically, when they desired support to aid academic study and to overcome associated barriers, they would overtly demonstrate their disability and justify their need in order to overcome

potential negative reactions from others. Conversely, when in non-support situations, such as interacting with their non-disabled peer group, the same individuals would try and downplay or “pass” their disability (e.g., Goffman, 1963), or try to remove potential disability anxiety through humour. Along these lines, the aim of the current work is to investigate further how disabled people navigate identity concerns across multiple situations – specifically when interacting with healthcare providers versus educators and employers – and to shed light on the dilemmas they experience in doing this.

Present research

As established above, the specific forms of stigma that are faced by disabled individuals vary across contexts and across the various audiences with which disabled individuals interact. Across these contexts and audiences, disabled individuals pursue specific goals and interests, for example, goals to maintain access to needed support, while simultaneously maintaining a positive sense of self as an individual and as a member of the disabled group. Because these goals are sometimes competing, or at least not easily aligned, this can create dilemmas for the disabled person over how they should act in specific situations and audiences. These pressures are likely to give rise to variable, shifting and strategic identity performances that reflect both what one needs (from others), but also how one wants to be seen by them.

In an attempt to explore how these situational dilemmas are navigated, this study qualitatively investigated disabled people’s experiences of stigmatisation in different settings (interacting healthcare providers versus educators and employers), and how these experiences relate to different aspects of their identity (i.e., as a unique individual, or personal identity, versus as part of a disability community, or social identity). Along these lines, in this paper we seek to answer three distinct research questions:

1. How do disabled people expect to be viewed when interacting with healthcare providers compared to educators and employers?
2. How do disabled people perform their identity in order to respond to expected stigma, and do these portrayals alter according to the situational audience?
3. How do disabled people personally view their identity, and how does this relate to any expectations that are imposed by others?

Method

Participants

A total of 48 disabled adults (39 female, 8 male, 1 unspecified) aged 19-72 years ($M = 38.31$, $SD = 14.24$) were recruited. Most participants were White ($n = 46$), and the remainder were Asian ($n = 1$) or mixed race ($n = 1$). The majority of participants recruited were from the UK ($n = 31$), with the remainder from the USA ($n = 8$), Australia ($n = 4$), Ireland ($n = 1$), Germany ($n = 1$), The Netherlands ($n = 1$), and Russia ($n = 1$) (one unspecified). Participants also reflected a range of primarily physical disabilities, including: cerebral palsy, multiple sclerosis, amputation, Ehlers-Danlos syndrome, fibromyalgia, chronic fatigue syndrome, epilepsy, spinal cord injury, deafness, as well as use of a wheelchair, but also other disabilities such as dyslexia. Three did not specify their disability. Several participants also reported having multiple disabilities, such as Ehlers-Danlos syndrome, fibromyalgia and chronic fatigue syndrome (see Table 3).

Table 3. *Characteristics of participants.*

Participant Number	Gender	Age	Ethnicity	Nationality	Disabilities
1	Female	50	White	British	Dyslexia
2	Female	28	White	British	Multiple Sclerosis
3	Male	50	White	American	Multiple Sclerosis
4	Female	37	White	British	Ehlers Danlos Syndrome
5	Female	35	White	British	Ehlers Danlos Syndrome
6	Male	68	Mixed	Russian	Leg amputation
7	Male	58	White	American	Cerebral Palsy
8	Female	48	White	British	Ehlers Danlos Syndrome
9	Female	51	White	Australian	Wheelchair user and Deafness
10	Female	57	White	Unspecified	Unspecified
11	Unspecified	41	White	British	Cerebral Palsy, Epilepsy, and Mesial Temporal Sclerosis
12	Female	31	White	British	Ehlers Danlos Syndrome, Fibromyalgia and Chronic Fatigue Syndrome
13	Female	31	White	Australian	Cerebral Palsy and Learning difficulties
14	Female	31	White	Australian	Cerebral Palsy
15	Female	29	White	British	Cerebral Palsy
16	Female	54	White	American	Cerebral Palsy
17	Female	46	White	British	Ehlers Danlos Syndrome
18	Female	46	White	British	Chronic Fatigue Syndrome, Ehlers Danlos Syndrome, Myofascial Pain Syndrome, and Fibromyalgia
19	Female	50	White	British	Unspecified
20	Female	34	White	British	Spina Bifida and Hydrocephalus
21	Male	72	White	American	Paraplegia
22	Female	40	White	British	Ehlers Danlos Syndrome
23	Female	29	White	British	Cerebral Palsy
24	Male	24	White	British	Cerebral Palsy
25	Female	40	Asian	Dutch	Cerebral Palsy
26	Female	51	White	British	Cerebral Palsy
27	Female	21	White	American	Ehlers Danlos Syndrome, Cardiomyopathy, Postural Orthostatic Tachycardia Syndrome, and Fibromyalgia
28	Female	25	White	British	Ehlers Danlos Syndrome, Fibromyalgia, and Trigeminal Neuralgia
29	Female	26	White	British	Cerebral Palsy
30	Female	36	White	American	Ehlers Danlos Syndrome

Participant Number	Gender	Age	Ethnicity	Nationality	Disabilities
31	Female	48	White	British	Ehlers Danlos Syndrome and Mixed Connective Tissue Disease
32	Female	22	White	British	Ehlers Danlos Syndrome
33	Male	37	White	Australian	Cerebral Palsy
34	Male	31	White	British	Brain Injury
35	Female	19	White	British	Cerebral Palsy
36	Male	51	White	British	Cerebral Palsy
37	Female	27	White	British	Fibromyalgia and Depression
38	Female	20	White	American	Cerebral Palsy
39	Female	37	White	American	Cerebral Palsy
40	Female	32	White	British	Cerebral Palsy
41	Female	22	White	British	Unspecified
42	Female	53	White	British	Degenerative Disc Disorder
43	Female	25	White	British	Ehlers Danlos Syndrome, Vision difficulties, Deafness, and Dyspraxia
44	Female	25	White	British	Epilepsy
45	Female	31	White	British	Ehlers Danlos Syndrome, partial Paralysis, and wheelchair user
46	Female	28	White	German	Epilepsy
47	Female	28	White	Irish	Epilepsy
48	Female	23	White	British	Epilepsy

Procedure

Participants completed an online survey that was advertised on disability charity and organisation web pages, social networking sites, and forum pages. These advertisements briefly described the study, as well as what would be asked of participants should they decide to take part in the research. Participants who accessed the survey link were then presented with a consent form, outlining the above information in more detail. Those who consented to the research were presented with a series of questions requesting demographic information (gender, age, nationality and ethnicity), as well as asking them to report the name of their specific disability or disabilities.

Participants were then asked to think about their interactions with either healthcare providers or educators and employers. To achieve this, on accessing the link to participate in the research, participants were randomly assigned to either a healthcare provider audience or an educator/employer audience. Depending on their assigned audience, participants were told that the purpose of the study was to feed back the experiences of disabled people in order to provide either healthcare providers or educators and employers with a better understanding of disability (see Chapter 5). We decided to ask participants about their interactions with educators and employers together in order to keep the survey as inclusive as possible (e.g., to overcome possible lack of educational attainment or employment history), as well as the fact that disabled people expect similar attitudes in educational and workplace environments (e.g., regarding their competence; Louvet et al., 2009; Olney & Brockelman, 2003).

Once participants had been assigned their audience, they were asked about how they expected this group to view them because of their disability, and whether they anticipated any difficulties in being viewed in the ways they described. From here, participants were asked to discuss whether they felt any pressure to perform their identity in a particular way, and if so,

why they felt the need to enact this behaviour. Participants were then asked to think about how they *personally saw* their own identity as a disabled person (rather than an identity that has been performed) when interacting with their assigned audience. Specifically, to what degree they described themselves as a unique individual, or belonging to a collective disability identity, and also, whether they felt any particular benefits or costs to viewing their identity in these terms.

Following completion of these questions, a new survey page was presented in order to focus participants to their audience they had not yet been assigned (i.e., healthcare providers or educators and employers). In this way, all participants were asked about both audiences, but in a counter-balanced way, partly to ensure the same level of depth and detail in participants' written responses and partly to avoid anchoring effects by asking about audiences in a single fixed order. The same opening statement was displayed with respect to the new audience, and the same questions described above were then repeated, again replacing the old audience with the one that they had been newly assigned. On completion of the research, participants were presented with a thorough written debrief. For the complete survey, please see Appendix G.

Analysis

We analysed the qualitative data using thematic analysis (Braun & Clarke, 2006). Three researchers independently read the written responses provided by participants. After becoming familiar with the data, the three researchers then independently reread the content and noted patterns or similarities that might indicate unique themes in relation to the three research questions discussed in the Introduction (i.e., codes in the data). From here, the recorded codes were then sorted into individual themes, and all quotes that exemplified these created themes were included. New themes were created whenever codes did not fit or

support existing themes (e.g., when a participant provided a new account or experience that could not be incorporated into an existing theme). Once the initial theme structure was completed, the researchers independently reviewed and refined their ideas to ensure that their reported themes accurately reflected the recorded data. Within this phase, existing themes were modified, expanded or removed as needed.

On the completion of each researcher's review and refinement of their reported themes, the three researchers came with their independent analyses to collectively discuss and review the data further. Within these discussions, similarities and differences in recorded codes and themes were noted. Where disagreements in the coding emerged, the three researchers collaboratively reanalysed the recorded quotes, as well as their respective codes and themes, in order to note whether any inaccuracies could be highlighted, or further refinements made. Following these discussions, a final list of themes was then created and reviewed in order to assess how completely they described the reported data. As part of this additional review process, the researchers constructed a final coding frame, which summarised all the chosen themes with a brief description of their specific meaning, as well as including a list of recorded quotes that demonstrated these themes.

Results

In describing the results, quotes will be provided to illustrate a specific theme that developed from the analysis. Each quote is assigned to a specific participant as indicated by the number in brackets connected to each quote (see Table 3).

In a general sense, many participants anticipated difficulties when interacting with others:

(11) they feel that because I look a particular way, I 'should' act a particular way.

(14) I think it's a sad but true fact, that people with disabilities do anticipate difficulties whenever they have to interact with a new person for the first time. If no difficulties do occur, we see this as a bonus!

However, the specific difficulties reported, and how participants dealt with these, varied according to whether they were describing their interactions with either healthcare providers or educators and employers. To demonstrate the findings, we first discuss participants' interactions with healthcare providers according to the three research questions before repeating the same process with educator and employer interactions.

Healthcare providers

RQ1: How do disabled people expect to be viewed when interacting with healthcare providers?

Although some participants noted that they expected their interactions with healthcare providers would be largely positive, many reported that they expected to be treated negatively in a number of ways. A common problem that many reported was that healthcare providers had a simple lack of understanding regarding their disability or their specific needs. This resulted in some participants being asked inappropriate questions that were perceived to be irrelevant to their support request, or simply having to educate their professional on what care they required.

(2) I feel like they listen to you and understand what you as a person are going through [...] I feel its good that we have someone that views us as we are and understands our situation. (sic)

(5) It is often frustrating dealing with healthcare providers as almost all do not know enough about my condition.

(18) I have frequently been asked, what I feel are incredibly intrusive and probing questions which, again I feel, are totally unnecessary to justify why I am presenting for medical support.

(17) It is difficult and frustrating not to have health care professionals in my area who provide any support for my condition. It is also frustrating I have to educate most health care professionals and I feel like the specialist.

(22) I ask if they have heard of my disability and if they have treated anyone else, this helps me know how much education I might need to do.

The most commonly reported experience was that they felt that their disability status would lead to negative attitudes or unfavourable treatment. In particular, some participants reported believing that they would be seen as less able or of lower status than the non-disabled community because of their disability.

(45) I know that as a patient, I am often viewed as less capable than an able-bodied patient. I am often asked if I want anyone with me during a consultation (before the team get to know me) when I don't feel this would be asked of an able-bodied patient [...] I am not less capable and resent being viewed in this way. It can often lead to difficulties with communication and relations in long term medical/healthcare contacts.

(8) I am viewed as inferior, non compliant and wasting their time and resources but they are obliged to go through the process.

Although participants felt that their disability needed to be at the centre of interactions with healthcare providers in order to provide desired care, many resented that they became (23) *'Just another person with a disability'* or a patient, rather than an individual with unique needs and symptoms. Being grouped as a disabled person or patient promoted negative outcomes, such as experiencing misconceptions about their physical or communicative ability.

(9) I think I get lumped into the category with all other wheelchair users and seen as incapable of managing without one [...] I still need the wheelchair when out and about, as my balance is not always good and I can't walk far. I also sometimes feel invisible in my wheelchair and get ignored or passed over, and instead my partner will be spoken to

(20) I think I am viewed sometimes purely as a patient rather than a person although this does vary from professional to professional. I have also been mistaken for a patient whilst actually visiting someone else in hospital, I assume because I am a wheelchair user and was with another wheelchair user at the time (nurse on corridor "I'll just let these patients into the lift")

Conversely, other participants reported paradoxical experiences of feeling that they not be seen as 'disabled enough' for available support in the eyes of their professional. Through feeling like their legitimacy would be questioned, these participants reported that they may be viewed as a malingerer or exaggerating their symptoms or need for support.

(11) Normally, when I see healthcare 'professionals', they constantly tell me that I don't know what I'm talking & accuse me of being a liar & making my symptoms up.

(15) I sometimes feel I'm not disabled enough for them to take my pains etc. seriously, so I find it hard [to] get what I need across.

These paradoxical experiences often appeared to stem from the fact that their disability was less visible, or – once again – feeling as though their healthcare provider did not have a thorough enough understanding of their disability or needs. The consequence of this negative experience led to some participants being unable to communicate their needs, or even avoiding these interactions altogether.

(4) I think I am generally viewed as non-disabled because my difficulties are not usually visible. I fear that some health professionals think that I am exaggerating my difficulties because they can't see them easily. Other professionals, who have visited me at home e.g. my community physiotherapist, have a very good understanding of how I am disabled.

(17) I feel more disabled than I look....so people tend not to believe what you say....I therefore fail to disclose everything I feel, for fear of not being believed.

(18) I am always nervous that because I look 'normal' they will not take me seriously and often leave things until they get to crisis point before I ask for medical help.

RQ2: How do disabled people perform their identity in order to respond to expected stigma when interacting with healthcare providers?

Unsurprisingly, when interacting with healthcare providers, participants frequently felt the need to enact specific behaviours in order to reduce the threat experienced by negative or hostile attitudes directed at them. A commonly reported strategy was to demonstrate their behaviour in a way that maximised their chances of receiving desired care.

This could be through performing in a stereotypical or ‘more severe’ way. Others felt that they had to justify their need for support, or challenge any healthcare provider assumptions that questioned their legitimacy.

(6) It is necessary to provide the ‘right’ answers or help is lost.

(20) I feel that there is an expectation to behave submissively towards medical professionals who feel they know best

(22) I sometimes feel the need to exaggerate to be taken seriously

(32) I am always asked to show proof of my hypermobility such as demonstrating through the [assessments] which can be very painful on bad days and is time wasting and irritating. I feel if I do not express just how severe my pain is on a daily basis I will not be listened to [...] Because if I don’t demonstrate it I will not be believed when explaining my symptoms and requests for help.

(43) I get very hostile and try and fight my corner from the offset

Others also felt the need to perform their identity to ensure that healthcare providers would view their disability as an entirely physical one, rather than also incorrectly assuming they had additional comorbid problems and intellectual difficulties.

(14) Health Care Providers are aware that I have a disability. However, I do make an effort to come across as intelligent and articulate, so that they can see that my disability is purely physical.

When participants did not feel the need to perform their identity, their reasons for this encompassed three dimensions. First, some felt that it was important that they remain honest

and upfront about their needs in order to ensure that they could participate in an accurate dialogue with their healthcare provider.

(36) I [don't] feel any pressures. I try to be open and honest with everyone, I expect healthcare providers to be open and honest [in] return [...] [Openness] and honesty is being professional and polite.

Second, a small number of participants felt their disability was already very visible and relatively stereotypical (e.g., use of assistive devices), and thus felt no pressure to enact a specific identity performance.

(3) They see I [use] a cane. No pressure

Third, because there were some participants who reported positive experiences in RQ1, unsurprisingly, they also felt no pressure to perform their identity because they knew that their healthcare provider would work to ensure the best support outcome for them.

(2) I feel that I can show my true identity with them. I can finally show my true colours and they will help as best they can [...] I feel its important that you can talk to someone as it can be too much to hide how you are and not tell it how it really is feeling. (sic)

RQ3: How do disabled people personally view their identity when interacting with healthcare providers?

When interacting with healthcare providers, although many participants recognised that they were tied to a collective disability label, they nevertheless wanted to be seen on individual terms because their disability and needs are unique and personal to them.

(39) In this situation it is very important to be seen as an individual, everyones health care is different even if the disability is the same (sic)

However, despite being aware of the benefits that were received through identifying as an individual, some participants were also aware of the possible difficulties or costs to viewing themselves only in this way. Specifically, they felt that healthcare providers needed to categorise patients' needs according to their disability label in order to allocate care resources, and by distancing themselves from this categorisation, they may be disadvantaged when attempting to access support. Others also felt that emphasising individual uniqueness might make it more difficult to access group resources and support from other disabled people, which may be personally useful to them.

(9) Being seen as an individual makes it harder to get assistance when needed, as healthcare providers need to fit you into their categories of 'disabled', 'wheelchair user', 'deaf', etc. and the system doesn't work for individuals.

(5) I generally don't want to talk to other sufferers of my condition as I don't like to dwell on it or 'whinge' about it, I have had experience of this when meeting the 2 people with EDS [Ehlers-Danlos syndrome]. It puts me off joining any 'groups' but I do wonder if it may help to do so as I feel I have such little understanding within the healthcare system.

Consequently, where participants viewed their identity as part of a collective disability group, this was largely to receive mutual support and treatment advice from others. Indeed, this desire for advice encouraged some to view themselves as both an individual and a group member: an individual in order to receive personalised care from their providers, but as a group member in order to benefit from shared experiences or act for the benefit of others.

(2) As a larger disability group as I feel that we all come together to help each other [...] you can always find someone to talk to and to listen

(17) Individual to health care.....but part of a group in order to get support and advice.....eg Facebook groups as this is the only place where you can speak and are understood without explanation.

(20) it is important to be treated as an individual when discussing care or treatment but in terms of understanding and coping there can be benefits to being part of a collective [...] A bit of both, I obviously want to be treated as an individual but I have raised issues or made complaints in the past 'for the greater good' to prevent other disabled people experiencing the same thing.

Having analysed the experiences of participants when interacting with healthcare providers, we then sought to examine their experiences when interacting with educators and employers to see whether their accounts promoted differing expectations and constructions of identity.

Educators/Employers

RQ1: How do disabled people expect to be viewed when interacting with educators and employers?

Although directed to specifically discuss experiences with educators and employers, participants often reported experiences that were very similar to those given with respect to healthcare providers. Once again, a commonly reported problem was that many educators and employers had an inappropriate understanding of disability in general, or how their needs could be accommodated. Educators and employers commonly demonstrated this misunderstanding by incorrectly assuming that participants lacked intellectual competence.

(23) Lack of understanding and support

(38) Many people, through no direct fault of their own, view physical disabilities as inextricably linked with mental deficiencies. Professors often see my physical disability and assume that I am mentally compromised in some way.

(34) Brain injury is hidden somewhat. [I] Have to explain issues to help people understand my difficulties ie speech, fatigue etc. [...] Some people see me as having a “learning difficulty”. People don’t understand the effects of a brain injury.

From this lack of understanding, many participants believed that education and work staff would view them negatively because of their disability. These negative assumptions were anticipated with respect to perceived competence and reliability for the job, but also the financial and time costs that could be required to ensure that they are actively able to participate in the educational setting or workplace. Indeed, as a consequence of these negative assumptions, participants reported that they would be overlooked for educational or workplace positions, and in some instances, reported that they were reluctant to actively seek out study or employment.

(9) [Employers see me] As a hassle.....too much trouble.....as they don't have the time or can't be bothered communicating effectively with me; and too much of [a] problem to rely on because of doctors/specialist/hospital appointments; pain limitations; physical restrictions, etc. [It is] Easier to employ someone without all the problems I have. Educators have to worry about all their students and don't have time to work one on one, especially with a disabled person who needs more time and help.

(20) I think that I have been viewed as a problem [...] needing reasonable adjustments which cost in terms of time or money and potential for being less reliable or productive compared to a non disabled person.

(5) I walk with crutches & sometimes need to use a wheelchair so I do worry that this would put employers off.

(4) I do fear that if I went for a regular job I would be seen as a liability. There is no doubt that I would take more time off than a non-disabled person. I have numerous hospital appointments for a start - at least one or two a month. My symptoms fluctuate and I always have at least three days a month when I am utterly incapable of work.

RQ2: How do disabled people perform their identity in order to respond to expected stigma when interacting with educators and employers?

From the above experiences, unsurprisingly, the vast majority of participants felt the need to perform their identity when in the educational and workplace context. The most commonly reported experience was to attempt to downplay or overcome their disability as much as possible, in order to ensure that they would be seen as sufficiently competent, or to remove feelings of difference to their non-disabled colleagues. This motivation regularly encouraged participants to strategically alter their visible appearance, to take on more work or ‘over perform’ to their non-disabled colleagues, or to conceal their impairments and reduced health as much as possible. The problematic consequence of these behaviours was that in some instances, their health and well-being suffered in the longer term.

(1) I feel I need to use all my strategies so as not to appear dyslexic. If I make a mistake then I laugh it off as being due to my dyslexia, but act as if it isn't really a

problem [...] Because I feel I will not be taken seriously in academic circles if I can not produce the work to the desired standard.

(44) I try to present an appearance of being stronger than I might feel, and go out of my way to show I can achieve the same as everybody else... Firstly out of a need to not be seen as different, but also to prove to people that epilepsy in general does not control [my] life.

(39) I do try to keep in mind the way I dress or how I walk to make it less obvious. I don't use my wheelchair or assistive devices at work so as not to make it obvious or make a point of it.

(20) I feel a pressure to work harder than other colleagues and to take less sick leave to make up for the time I am allowed for medical appointments, even where this might be detrimental to my health

(5) When in employment I tend to 'push through' the pain barriers as I don't want employers to think I can't cope & don't want to let them down. However, the more I try to suppress the symptoms the worse they get & then I am unable to work at all.

Other strategies involved participants emphasising their approachability or professionalism, so that they could be viewed on individual merits, rather than a disabled person.

(16) I attempt to act in a professional manner at all times. I work hard to treat people with respect and kindness in each encounter I have with my supervisors and coworkers. I try my best to present myself first and foremost, NOT my disability [...] I just need to present myself as a capable, intelligent, reliable woman who is dependable and trustworthy and someone who will get the job done.

(43) I tend to laugh and joke with people, particularly about my disabilities as it puts them at ease, and also because if I act seriously all the time about it I'll get upset or depressed about things I can't control.

However, there were also a small number of participants who did not feel the need to downplay their disability, instead valuing an honest and upfront approach about what they would and would not be able to achieve in the educational or workplace setting. Some participants felt that by being honest about their disability improved workplace relations, as colleagues could correctly understand potential difficulties they might face, rather than questioning their competence.

(40) I feel it is important to explain exactly what your disability is and be honest about what you may have difficulties with and explain the ways that you overcome issues that come up. It is important that people realise that you are a person in your own right and not just a disability [...] So that you are not judged on preconceptions which stem from previous experience or judgements of your disability.

(32) I feel I must explain on some occasions as my disability cause mind fogs on occasions particularly as a response to stress [...] So that I am not viewed as less capable or less intelligent than other people who may be equally or even less intelligent than myself.

Unfortunately, for other participants, they occasionally noted that whichever strategy they enacted in terms of downplaying or disclosing their disability and needs to others, no positive outcome would occur.

(37) Unless I disclose my disability, [I am viewed] as an able-bodied and able-minded person who is disorganised and takes too many sick days. When I disclose my

disability, [I am viewed] as a disabled person who uses her disability as an excuse for being disorganised, fat, and taking too many sick days. Yes. Obviously – I'm not seen as a reliable or ideal employee.

RQ3: How do disabled people personally view their identity when interacting with educators and employers?

When interacting with educators and employers, participants once again overwhelmingly appeared to prefer viewing themselves as a unique individual. The reasons for this reflected a common motivation for identity performance: participants wanted to be seen as different from other disabled people, so as to distance themselves from associated stigmatisation, and that their own merits and accomplishments could be acknowledged. Despite this, some were aware that identifying in this way was not entirely positive for the self. By viewing themselves as unique, participants noted that they may be distancing themselves from other disabled people, and therefore, the associated benefits that the social group would provide, such as mutual support for overcoming stigmatisation.

(39) As an individual. Many people with C.P. [cerebral palsy] have intellectual disability or are worse off than me and I don't want to be seen that way but for who I am and what I can do [...The] Benefits are I can be viewed for my accomplishments and not just my disability.

(27) While it feels safer to identify with a group, I find it's easier to identify as an individual [...] As an individual, it's easier to negate stereotypes and assumptions that people might have about a group, and to educate people on what you need from them. However, it also means that you're alone in this venture, and generally don't have anyone to back you up.

As such, where participants valued identifying as part of a collective identity, this was often because of the benefit to the self in terms of disability assistance or accommodations that may be available, as well as providing greater empowerment for collective change. However, like with personal identity, seeing their self only in this way promoted costs to the self and their well-being, as they were categorised and evaluated just according to their disability status.

(22) Being part of a disability group at work offers a sense of protection, as well as being able to share knowledge and types of reasonable adjustments that can be made.

(21) In some cases groups can exert more power to bring about needed changes.

(24) People may be impressed by you because of your disability. This is a benefit in terms of material advantages (job opportunities etc.) but a disadvantage in terms of self and other evaluations (I am not just a disability).

Discussion

The aim of this research was to investigate the identity performance pressures disabled people experience when interacting with others in healthcare versus educational and employment settings. We also sought to investigate how participants viewed their own sense of self (i.e., via personal and social dimensions) when interacting with these respective audiences.

With respect to healthcare providers, participants experienced a number of negative attitudes. In particular, they discussed conflicting stereotypes regarding their apparent lack of competence, but also, their level of impairment as being insufficient to warrant needed care. Those who believed that they would not be seen as ‘disabled enough’ expected to be negatively viewed by their healthcare provider in terms of their legitimacy or need should

they decide to access support. From these experiences, participants reported performing their identity in a number of ways. In particular, they commonly felt the need to demonstrate their legitimacy or need for support, and achieved this by justifying the severity or impact of their disability, as well as conforming to stereotypical expectations. However, participants appeared to perform their identity in a way that ensured that healthcare providers, and their associated support, were focused on any physical impairment they had, rather than an (incorrectly) assumed intellectual impairment. Where participants did not feel the need to demonstrate their identity in these ways, this was largely because they felt that honesty and openness about their disability would lead to more suitable and personalised support, or because their condition was already fairly stereotypical (e.g., wheelchair use), they felt no pressure for further identity performance.

With respect to educators and employers, participants once again reported experiencing a number of negative assumptions directed at them because of their disability. In particular, they felt that because of their disability status, they would be viewed unfavourably when attempting to seek educational development or employment because of their assumed lack of competence (Louvet et al., 2009; Olney & Brockelman, 2003), as well as the associated costs and accommodations that would be required to ensure equal opportunities (Baldrige & Veiga, 2006). To address these negative assumptions, participants again reported a number of distinct identity performances. The most common of these was to downplay or conceal their disabled identity as much as possible, in order to demonstrate their competence and suitability for education or employment (Taub et al., 2004). Like with interactions with healthcare providers, where participants did not feel the need to demonstrate their identity in this way, this was largely because they felt that honesty and openness would be beneficial when interacting with non-disabled others, as this allowed them to communicate

an accurate account of their skills and potential difficulties they might experience (Jans, Kaye, & Jones, 2012).

In terms of how participants constructed their own identity – specifically with respect to the personal and social elements of identity (following Tajfel & Turner, 1979; Turner et al., 1987) – the majority of participants clearly prioritised personal identity relative to collective concerns. This viewpoint was essentially the same regardless of the audience, however, the reasons for viewing themselves in this way did appear to be influenced by differing contextual expectations. With healthcare providers, participants appeared to strongly value personal identity in order to emphasise their individual need for support (Chapter 4). This motivation changed to one of highlighting their competence and professionalism when interacting with educators and employers. Yet, in the same vein, participants were also aware that social support and information received from other disabled people (i.e., connected to their social identity) may provide them with the necessary resources to maintain their individuality.

It therefore appears that the identity of disabled individuals is highly variable, and will adapt and change depending on the needs of the situation and motivations of the individual (e.g., not only how they perform their identity to others, but also how they view themselves in relation to other disabled people: Chapter 4; Crooks et al., 2008; Grytten & Måseide, 2005; Tajfel & Turner, 1979; Taub et al., 2004; Turner et al., 1987). Indeed, this is consistent with broader social scientific conceptions of identity (e.g., Tajfel & Turner, 1979; Turner et al., 1987), not just disability. Disabled people are therefore likely to need to navigate simultaneously-activated pressures to both preserve the positivity and integrity of individual identity, while also needing to move towards the group to access support and resources as well as refuting illegitimate negative stereotypes that are applied collectively.

As healthcare providers, educators, and employers are likely to each bring their own situational expectations, we infer that further demands may be placed on disabled people in terms of how to present their identity. With healthcare providers, embracing a sense of personal identity may assist with ensuring that support received is unique and individualised to the needs of each disabled person, rather than to the disabled community as a whole. However, by emphasising their individuality and distancing their self from their disability, some acknowledged that they might be severing any opportunity to gain valuable information from the group that may be of use to them. These included recommendations from fellow disabled people on specific treatments, or coping resources in which to deal with anticipated discrimination, which were all valued as a means of maintaining their individuality.

In this sense, participants may feel the need to recognise and enact their social identity, both to benefit from informational resources and social support, but also to make their needs and impairments more stereotypical to ensure (potentially) more straightforward support access from healthcare providers (Chapter 4; Crooks et al., 2008). Yet, at the same time, using their social identity in this way might be problematic, as it may increase disability categorisation behaviour from others (Gervais, 2010), resulting in participants being viewed as a patient or disabled person rather than as an individual. Because of healthcare providers' reported lack of understanding surrounding disability, this categorisation may promote stereotypical assumptions of incompetence and comorbid intellectual disability – something that participants found frustrating and did not want to encourage.

Similarly, when interacting with educators and employers, attempting to demonstrate their personal identity may allow their individual merit and competencies to be acknowledged and appreciated. This was therefore highly desired by participants, because it provided an opportunity to communicate their suitability for education and employment

effectively. The dilemma is that, as many participants noted, this performance strategy requires considerable effort, which may be detrimental to their longer-term health, and thus suitability for education or work. Enacting this behaviour may also mean they distance themselves from the social group, which in turn may restrict their ability to access equal opportunities (e.g., assistive devices) designed to remove the education and workplace barriers associated with disability. As such, enacting their personal identity at the expense of social identity in these environments may have the ironic and unintended consequence of making their disability and associated barriers, as well as potential ill health, more salient to others.

Enacting their social identity, in comparison, may provide participants with the necessary support resources and information in which to potentially overcome difficult education and workplace scenarios. This may also provide the individual with a degree of control regarding the amount of information they share about their disability, and with who (Braithwaite, 1991); as well as potentially providing clarity about their disability and needs to their non-disabled colleagues and potentially improving working relations through this (Hebl et al., 2000). However, demonstrating their social identity through disclosure may promote unintended consequences of actually harming relationships with others, as people may question the legitimacy of their disability or need.

In sum, we believe that disabled people may experience two key identity concerns that may threaten their health and well-being. The first involves attempting to maintain a sense of individuality (often at the expense of the group), whilst the second involves still ensuring that they are able to access desired support and assistance from others if and when required. These two identity concerns may require contradictory responses in how the disabled person performs their identity to others. Specifically, they will need to emphasise

their uniqueness to other disabled people to ensure individualised healthcare, and that personal skills and competencies are recognised within education and the workplace. However, at the same time, they also need to potentially demonstrate how they fit the stereotypical expectations of others to gain access to these support resources (medical or non-medical). Accordingly, we believe that this research demonstrates that disabled people face difficult dilemmas in not only how they perform their identity to specific audiences, but also how they construct a sense of identity for themselves that balances personal and social dimensions.

As is clear from the findings we have discussed, although employing specific identity performances and constructing their own sense of self (i.e., personal or social identities) can be beneficial for the disabled person in achieving a specific outcome, they are nevertheless both associated with costs in terms of stereotypes and negative attitudes from non-disabled people. These findings therefore raise important implications for how service provision and educational and workplace inclusion can be improved. Specifically, the findings have provided key insights into why disabled people construe their identity in specific ways (i.e., as a consequence of experiencing stigmatisation when interacting with healthcare providers, educators, and employers). It is therefore important to use these insights to attempt to remove the audience barriers that are preventing disabled people from viewing and behaving in a way that is authentic to them. To do this, we recommend that non-disabled people are encouraged to recognise that disability severity, visibility, and specific needs will vary from person to person, but they are nonetheless tied to a collective disability community, and thus share similar issues and concerns. In this sense, it may be beneficial to highlight the support networks that exist for disabled people, so that these individuals can potentially learn and gain resilience from the experiences of others. Advocating this dual-natured focus to identity

may assist disabled people by removing some of the associated identity pressures they experience, but also provide them with the resources to overcome potential future stigmatisation.

In noting the implications this research provides to disability practice, there are limitations which should be highlighted. In particular, the purpose of this study was to explore the identity pressures disabled people face when interacting with different, and potentially stigmatising audiences. Although participants provided detailed insights into their experiences of stigmatisation, as well as the pressures and dilemmas they felt regarding how they view and perform their identity to an audience, we are unable to confirm stigmatisation was causally responsible for this. Therefore, it is important to conduct additional research to develop and further our findings. Specifically, we believe that additional qualitative work is clearly necessary to explore the importance of maintaining a personal identity, while also needing to engage with the social, and what implications this has for their health and well-being.

Expanding this point, two further limitations should also be noted. First, we wanted to keep the definitions of 'healthcare providers' and 'educators and employers' as broad as possible to allow participants to discuss their experiences thoroughly. As such, experiences reflected general interactions with these targets. It is not clear from the findings whether a specific group within these respective audiences was more prejudiced or evoked a greater identity performance pressure than others. For example, within the healthcare context, there are myriad available supports, each with their own trained professionals to administer them, and therefore all evoke unique identity performance pressures within disabled people. It is important that further research go beyond the general audiences we note in this paper, to

investigate whether specific healthcare providers, educators or employers promote unique stereotypes and identity performances.

Second, due to the heterogeneous nature of the sample, there was a wide variation in disabilities, and accordingly in the severity and visibility of these. This variation may have contributed to how individuals constructed or performed their identity when stigmatisation was experienced (Jans et al., 2012; Joachim & Acorn, 2000). Specifically, disabled people may seek to downplay or conceal their identity and sever ties with their social group unless it is impossible or impractical to do so (Goffman, 1963; Linton, 2010) – at least, when support access is not the interest (Taub et al., 2004). In this sense, we may predict that people with more visible disabilities or assistive devices may enact differing identity performances other than downplaying or concealing (Nario-Redmond et al., 2013), such as honesty (Jans et al., 2012) and humour (Taub et al., 2004), or using their assistive devices strategically (Frank, 1988a; Wiart et al., 2010). This may go some way to explain why other behaviours were sometimes enacted over downplaying when interacting with educators or employers. We recommend that future research investigate whether there are performance differences according to the visibility and severity of an individual's disability, as well as other individual differences (e.g., in personality), in an attempt to clarify the variation in reported behaviours.

Conclusion

This paper has demonstrated that disabled people are exposed to a number of contextually specific negative stereotypes and expectations that promote equally specific performances of their identity as a disabled person. These situational demands that are placed on the individual create dilemmas in how they present their identity, both in terms of how they wish to see themselves, but also how they want others to see them.

CHAPTER 7

GENERAL DISCUSSION

“A power relationship between care providers and patients exist, and when one is dependent on the services/etc providers control, it gets complicated. I want to be seen as who I am and convey accurate information, but if I break out of stereotypes (or fall too closely into them, depending on the stereotype) I run the risk of losing access to services I need.”

Study 3 Participant

“I accentuate my disability by using a walking stick – because otherwise my disability is invisible, which makes it hard to access certain things. However, people treat me more negatively once my disability is visible, expect me to do certain things – which I then want to disprove in order to be treated better, at which point I am perceived to no longer need help”

Study 3 Participant

This thesis documents, and provides a social psychological analysis of, a specific dilemma that is experienced by many physically disabled people throughout their lives – that is, the identity-based dilemma that arises from the tension between accessing needed help and support from others, and protecting the self from the negative assumptions others associate with their disability. The nature of this dilemma is that each of these goals requires different performances of the self – as being needy and deserving versus being competent and independent – and that each of these self performances can have both positive and negative consequences, both for the disabled individual, and for the perception of disabled people as a group.

While previous research in disability studies has alluded to this dilemma, it remains poorly understood from a social psychological perspective. This thesis therefore draws on theories of attitudes and stereotyping with respect to disabled people (e.g., Charlton, 2000; Heinemann, 1990; Katz, 1981; Nario-Redmond, 2010), the social identity approach (Tajfel & Turner, 1979; Turner et al., 1987), and the associated literature on social identity performance (O. Klein et al., 2007; Reicher et al., 1995) to guide four interconnected research questions: *what are the personal experiences of stigmatisation and discrimination of physically disabled people when interacting with healthcare providers, educators, and employers? (RQ1); how do physically disabled people construct their personal and social selves when interacting with healthcare providers, educators, and employers? (RQ2); how do physically disabled people perform their identity when interacting with healthcare providers, educators, and employers? (RQ3); and finally, how do physically disabled people's constructions and performances of identity when interacting with healthcare providers, educators, and employers affect their health, wellbeing and support-seeking behaviour? (RQ4).* Before discussing the answers to these questions that have arisen from this research, and what this

might mean for ideas in disability studies and social psychological perspectives on identity, we first briefly summarise the key results that emerged from the specific studies conducted.

Summary of results

Empirically, this thesis is based on five distinct, but interconnecting, studies, which encompassed both qualitative (Studies 1 & 5) and quantitative/experimental methods (Studies 2, 3, & 4). Our goal in using this combination of methods was to elucidate the experience of stereotypes, and their meaning in terms of identity, as articulated by disabled individuals themselves (i.e., qualitative studies), and to explore in more detail the stereotypes associated with particular contexts, and how activation of these stereotypes might have consequences for identity processes and individual outcomes (i.e., quantitative studies).

Drawing on qualitative data about experiences of receiving health care, Study 1 (Chapter 4) found that individuals with cerebral palsy reported that receiving care marked them as “different”. But, at the same time they sometimes felt as though they were not different enough to legitimately qualify for the support they needed, at least in the eyes of others. In the context of these feelings of illegitimacy, participants reported feeling pressure to justify their individual need for assistance. These dual concerns around difference were also observed in how participants viewed their own identity as a person with cerebral palsy. The majority of participants wanted to be seen as an individual who was separate from other people with cerebral palsy; and emphasised that their diagnosis and experience of life was unique to them alone (i.e., describing the self via their personal identity). However, participants also recognised their similarity to other individuals with disability based on shared experiences, and the benefits they (could) receive from positive social relationships with this support network (i.e., describing the self and others via their shared social identity).

In other words, participants seemed to describe and endorse an identity that incorporated both personal and social aspects (Sandström, 2007). Overall, the findings of the first study provided insight into physically disabled individuals' awareness of other's expectations of them (e.g., healthcare providers) – in terms of how they look and act, and how this might be interpreted in the context of accessing support – and the pressures individuals with disability face as they try to negotiate the expectations of others while also maintaining a positive and authentic view of their own self and identity.

Developing on the qualitative findings of Study 1, Studies 2, 3, and 4 quantitatively explored the self-presentational behaviours evoked in response to healthcare providers, but also other (dis)ability-relevant audiences (i.e., the general public, and educators/employers), and the specific stereotypes that were associated with these. Across all three studies, we also assessed the influence of ingroup ties on subjective health, wellbeing, and support outcomes when these stereotypes were experienced. Specifically, we wanted to explore whether attachment to the ingroup could act as a buffer between stereotypes and outcomes (i.e., as indicated in Branscombe, Schmitt, et al., 1999; Fernández et al., 2012; Nario-Redmond et al., 2013), or if the level of ingroup ties influenced how physically disabled people view and respond to these stereotypes (i.e., McCoy & Major, 2003; Packer, 2011).

The first study in this line of research (Study 2) sought to assess whether people with cerebral palsy experience different identity performance concerns across differently stigmatising *contexts* (i.e., the contexts of support-seeking versus discrimination). However, we found no evidence of contextual differences in identity performance concerns. Nonetheless, the extent that individuals experienced identity performance concerns was predicted by perceived discrimination, and via this effect on identity performance concerns, perceived discrimination reduced the individual's willingness to seek help, which in turn,

reduced their overall subjective health. Alongside this pathway, we also assessed whether subjective health might be protected when discrimination is experienced, through activating disabled people's ingroup ties and subsequent bolstering of self-esteem (i.e., the rejection-identification model: Branscombe, Schmitt, et al., 1999). We did not find consistent support for this model.

Moving on from this initial experimental study, we reasoned that for the identity performance concerns to be enacted, the relevant audience for these concerns (e.g., healthcare providers in the context of support) also needs to be present to witness those performances (Barreto et al., 2003; Wiley & Deaux, 2011). Responding to this idea, in both Studies 3 and 4, we modified the manipulation of stigmatising contexts (support-seeking versus discrimination) with a manipulation using their associated audiences (i.e., healthcare providers versus the general public in Study 3, and educators and employers in Study 4). In addition, given the lack of support for the rejection-identification model, we reasoned that the level of identification physically disabled people hold towards their disability social identity (i.e., differing levels of ingroup ties) may instead influence how physically disabled people present their identity in response to experienced stigma (i.e., via absorbing or challenging negativity). Therefore, in both Studies 3 and 4, we modified our analytic approach to explore whether disabled people with low and high ties to their disability social identity respond differently to activated audience concerns.

Across both audience studies, we found that although there was little difference in activated stereotypes according to audience, healthcare providers evoked surprisingly negative stereotypes in terms of unworthiness and lack of warmth, whereas the general public and educators/employers especially activated stereotypes of incompetence. Contrary to our expectations, however, audience-activated stereotypes in combination with ingroup ties

promoted very little change on health and support outcomes in Study 3 (i.e., between low and highly tied individuals). Where changes on health and support outcomes were demonstrated as a function of different levels of identification, this was largely in response to the activated audience, rather than the influence of stereotypes. However, in Study 4, in which the general public audience was replaced with educators and employers, we did find evidence for changes to health and support outcomes in response to activated stereotypes and as a function of different levels of ingroup ties. Within this study, connections between activated audience stereotypes and outcomes were strongest among individuals with weaker ingroup ties to the physically disabled ingroup. Specifically, the self-esteem and subjective health of low identifiers was most associated with believing that their audience views them as worthy, competent, and warm, and their willingness to access support if they believed that their audience would perceive them as passive. In contrast, the outcomes of high identifiers were largely unresponsive to activated stereotypes, and indeed, we found some evidence that may indicate motivations to challenge negative stereotypes, such as of passivity through decreasing their willingness to seek support.

This pattern of changing responses according to different levels of ingroup ties is suggestive of differing identity performances, or at least different motivations in the face of different audiences. Specifically, individuals with low ties may be motivated to present their identity in a way that is congruent with audience expectations (e.g., decreasing their self-esteem when they expect to be stereotyped as unworthy). Conversely, identity performance behaviours for individuals with high ties are largely not dictated by how they expect an audience to view them. Said differently, those less attached to a collective disabled identity seem to present their identity in ways that confirm and absorb the negative stereotypes directed at them, whereas those more attached to a collective identity instead seem to present

their identity in ways that challenge these views. Therefore, the collective findings of Studies 2, 3 and 4 highlight that while disabled people anticipate stigma in terms of stereotypes and concerns about identity performance, identifying with a disability social identity may entail different strategies for responding to these negative experiences. More specifically, individuals with high ties may be more likely to use their disabled online networks to help them resist stereotypes when they are experienced (e.g., as the group may provide them needed information, but also social support and empowerment; Braithwaite et al., 1999; Fernández et al., 2012; Finn, 1999; Nario-Redmond et al., 2013; Obst & Stafurik, 2010). By contrast, people with low ties may not choose to (or be unable to) access this group support to help them in responding to stigma.

Our final study comprised a second qualitative investigation that built on, and sought to bring together, the findings from the previous four studies. Specifically, in this study we asked participants to report experiences with healthcare providers versus educators and employers, and to self-reflect on their strategic identity performances to these groups. Here, we found once again that participants discussed felt pressures to perform their identity, as well as describing the performances that they enacted. When interacting with healthcare providers, participants described performances that commonly reflected similar concerns to those described in Study 1, whereby participants felt that they had to justify or exaggerate their impairment in order to fit a specific disability category. Conversely, when interacting with educators and employers, participants instead described enacting a strategy of downplaying their disability identity so that their competence and suitability for a specific role would potentially be demonstrated to others.

When exploring how participants viewed and constructed their own identity, they once again noted the desire for identifying at the personal level so that their own needs could

be met for support, and that educators and employers could acknowledge their own skills and abilities. However, participants also acknowledged that they needed to be categorised as a disabled person (i.e., in terms of social identity) in order to access professional support, as well as the possible social support and informational resources that would be available to them via association with this category of people.

Taken together, the five studies reported in this thesis highlight that physically disabled people are aware of the stereotypes directed toward them – both in general (i.e., the general public), but also with respect to their interactions with specific audiences (e.g., healthcare providers and educators/employers; RQ1). These audiences, and the stereotypes they are associated with, in turn appear to play some role in influencing how disabled people construct (RQ2) and perform (RQ3) their identity. Specifically, when navigating the dual concerns of avoiding stigma and accessing needed support, disabled individuals seem to balance the costs and benefits associated with the personal and social aspects of identity. Thus, although most prioritised being seen as a unique individual (i.e., personal identity), they also recognised the need for their social identity to act as a gateway to receiving support. However, awareness of stereotypes held by others, and felt pressures to perform their identity in specific ways, caused disabled people to either seek or avoid support, a pattern that was sometimes contingent on their ties to other disabled individuals (i.e., social identification; RQ4).

Interpretation of findings

In attempting to elucidate the difficulties that physically disabled people might face when attempting to access support and protect themselves from stigma, the research contained in this thesis demonstrates that there are two key areas of concern that they have to

negotiate: a) how they (should) view their own identity (i.e., encompassing the personal and social aspects), and what this identity means to them in relation to other disabled people (i.e., social identification), and; b) how they (should) enact their identity according to the unique needs and expectations of specific audiences.

Identity concerns

On the one hand, physically disabled people have a need to see that their desired self (i.e., as a unique individual) is recognised and accepted by the others with whom they interact, and within society more generally, thereby challenging negative stereotypes and protecting the individual self from stigma. On the other hand, they also have to align themselves with the category of disabled people, and to resemble this category themselves, in order to access needed support (social, healthcare and equality accommodations) without their deservingness being questioned, as well as to collectively cope with, and respond to, the negative stereotypes directed towards their group. The difficulty with balancing these two motivations, however, is that they require physically disabled people to view themselves, as well as present their identity to others, in ways that might sometimes seem contradictory, whereby they may be required to both amplify and downplay the prominence of their disability.

Moreover, while each of these versions of the self is associated with benefits, each side can also have costs, which may in turn impact on the desired identity that disabled people wish to create. For example, disabled people may wish to identify at the personal level and to present an identity to others in a way that emphasises their individuality away from their disability. This ensures that their individual needs are recognised in the context of support, and that their competencies can be recognised in the contexts of education and employment. Prioritising the personal identity also disconnects the individual self from the

stigma associated with the disabled category. However, while physically disabled people may prefer to enact their identity in these terms, this strategy may be difficult or impossible to achieve in the long term, and may negatively impact on their health and well-being, which may in turn, reinforce the negative connotations of disability that they wish to avoid (Chapter 6). Viewing themselves via their personal identity may also restrict disabled people's ability to access social support from other disabled people, as well as undermining their access to healthcare, education and workplace accommodations. Specifically, in order to use these resources, individuals need to identify at the social level and to be recognised as a legitimate recipient of such provisions (Branscombe et al., 2012; Fernández et al., 2012; Ho, 2004). This is important in relation to social identification because, as we observed in Studies 3 and 4, it was largely people with low ties to the group that seemed to be most vulnerable to the negative implications of activated stereotypes. Therefore, individuals with little connection or desire to connect with their disability social identity may be at a particular disadvantage when attempting to navigate stigmatisation both in terms of their vulnerability to stigma, coupled with their lack of avenues to social support to help them cope with these experiences.

To overcome these difficulties, physically disabled people may seek to enact their social identity, as this may provide them with more opportunities to access information and support from other disabled people, as well as support from others more generally (i.e., healthcare or educational/workplace accommodations; Chapter 4; Chapter 6). By constructing their identity in this way, however, disabled people potentially expose themselves to being categorised as disabled (Gervais, 2010), and therefore to stereotypical assumptions from others based on their category membership. Exposure to negative stereotypes can, in turn, negatively affect the individual's sense of self and their wellbeing more generally. In addition, from a social identity perspective, because of possible desires of

highly tied individuals to challenge stereotypes of others, this may have a detrimental effect on their support needs and well-being (e.g., support willingness and self-efficacy; Chapter 5).

Identity performance and audience

In addition to the dilemma of whether and how individuals construct their own sense of identity in relation to other disabled people, there may be times social categorisation and identification at this level may not be enough. Instead, disabled people may also feel the need to deliberately perform to or against the stereotypes associated with their social identity, and that the specific nature of this performance will likely be dictated by the contextual audience they are interacting with. Said differently, this thesis has demonstrated that disabled people believe healthcare providers, educators, and employers bring unique expectations and demands, which in turn, require them to present their identity accordingly to meet or refute these expectations.

With healthcare providers, if disabled people embrace and perform their desired personal identity, they may be able to access support that is individualised and targeted to their personal needs – rather than the needs of the disabled community more generally. However, disabled people may need to embrace their disability social identity in order to appear as “disabled enough” in the eyes of their healthcare provider to qualify for the support they are attempting to access (Chapter 4; Chapter 6; Crooks et al., 2008). To the extent that performances of disabled identity are “strategic”, and individuals are conscious of this, there is also the potential added cost of feelings of personal guilt arising from concerns that their own access to support might negatively impact on the access available to other “more deserving” disabled people, and because of this contribute negatively to their respective health outcomes (Chapter 4).

When interacting with educators and employers, disabled people embracing and performing their personal identity may allow their individual strengths and competencies to be recognised, which in turn, may reinforced others' perception about their academic and work ability. The difficulty with this strategy is that it may require considerable and long-term effort, which may in turn backfire, and cause unintentional impairing of their health and well-being, and their ability to remain in the educational or workplace environment. If they perform their social identity, this may allow them to access needed education and workplace accommodations (e.g., Baldrige & Swift, 2013), and also advises other colleagues about their specific needs and difficulties, thereby possibly improving working relationships (Chapter 6; Hebl et al., 2000). However, performing their disability social identity via disclosure may worsen relationships with others, particularly if support is required, as these individuals may be sceptical of their ability or need for support (Chapter 6; Paetzold et al., 2008).

In sum, these findings suggest that striking a balance between the goals of both accessing support and protecting the self from stigma is difficult. Moreover, these two goals, and the strategies that are enacted, can at times be conflicting. Accordingly, the individual is likely to experience dilemmas around how to enact the self in order to navigate between these goals, and to maintain an authentic self in so doing.

Theoretical implications

The insights that have emerged from the research presented in this thesis have a number of implications for social psychology and for disability studies. Perhaps most importantly, we have elucidated the experiences of stigmatisation from the perspective of physically disabled people themselves, and how these experiences can impact on their

support-seeking, health, and well-being. Although social psychological research on stigma has increasingly been interested in the target's perspective, this focus has been applied to certain stigmatised groups more than others. A criticism of this field is the continued lack of attention to physically disabled people, and how they navigate the stigmatising attitudes to which they are exposed (Dovidio et al., 2010; Dunn, 2010, 2015; Hebl & Kleck, 2000). This thesis directly addresses this gap: the data gathered in all five studies were entirely from the perspective of disabled people themselves. Consequently, our findings substantially progress empirical understandings of the experiences of stigma within this group, both quantitatively and qualitatively.

Moreover, the knowledge gained through exploring these experiences has implications for more general theories of identity within stigmatised groups. One important theoretical perspective that underpinned this research was the social identity approach (SIA: Tajfel & Turner, 1979; Turner et al., 1987). Specifically, the key contribution of this research to the SIA is that we have demonstrated how physically disabled people construct and define their identity (i.e., via personal or social aspects) when stigmatising attitudes are anticipated or experienced. Moreover, we have also demonstrated how identity can influence how disabled people respond to these attitudes, and the implications this might have for individual health and well-being (e.g., by distancing themselves from support, to challenge negative assumptions of passivity). We have also contributed to the understanding of how concerns around stigma and stereotypes influence how physically disabled people enact their self differently across contexts, thereby connecting to the more specific literature on social identity performance (O. Klein et al., 2007).

But, rather than just documenting the different ways in which individuals might define and enact their self in terms of personal and social identity, and the consequences that

can follow from this, we have sought to highlight the dilemmas that are encountered as people engage with these questions. In noting these dilemmas (particularly from the insights gathered from the qualitative research of Studies 1 and 5), we have provided further nuance to debates about whether social identity is helpful or harmful in the face of stigma (e.g., see Schmitt et al., 2014). Through our focus on dilemmas, we have noted that physically disabled people are very aware of the contextual and audience-related demands that are placed upon them when support is required and stigma is experienced. That is, disabled people are conscious of having to effectively perform their identity to negotiate these demands, while also being aware of the costs and benefits of different identity performance strategies. These kinds of points have been made in the more specific literature surrounding disability studies (Crooks et al., 2008; S. D. Stone et al., 2013; Taub et al., 2004), however, we develop and extend this literature using a more social psychological framework, grounded in the SIA and associated literature on identity performance. This builds a potential bridge across which the insights from this theoretical perspective can be brought to bear more squarely on the practical issues associated with disability stigma and support. For example, the SIA allows a greater appreciation of the importance of both personal and social identity to the individual self-concept, and of the psychological costs and benefits that are associated with each of these in the context of stigma. Greater awareness of these identity dynamics permits a better understanding of how physically disabled people navigate the dilemmas of stigma and support seeking (Dunn & Burcaw, 2013; Hogan et al., 2011).

Practical implications: Designing an intervention

In addition to the above theoretical innovations, the findings from this research could have important implications for practice. Most significantly, our findings suggest that in the

context of disability, an exclusive emphasis on personal identity (i.e., uniqueness or individuality) or on social identity (i.e., disability) may not be appropriate for meeting the needs of disabled individuals, be this in terms of their needs for accessing support or for coping with stigmatisation. Disabled individuals cannot ignore social identity if they want to access support, nor can they ignore the personal identity if they want to be recognised on individual terms and potentially protect themselves from stigmatisation associated with disability. Reciprocally, addressing disabled individuals exclusively in either of these terms is unlikely to leave them feeling fully supported or understood.

Both personal and social aspects are crucial components of the self, but they are often construed as entirely separate, at least in theory. For example, it is often assumed from a theoretical perspective that personal identity cannot be enacted while social identity is salient (Jetten & Postmes, 2006). However, there are many instances in life where individuals may wish to balance their desire to form and enact individual beliefs and goals while also remaining committed to meaningful social identity (Hornsey & Jetten, 2004). Bringing this idea to the context of physical disability, our findings suggest that disabled people can benefit from identifying with a disability social identity, but also that it is crucial to them to maintain a sense of individuality within this broader category.

Accordingly, and based on the themes that emerged in this research, we would recommend that any intervention aimed at addressing the stigma of disability, and the way this can manifest in support-relevant contexts, be designed to address both personal and social identity concerns. To address these concerns, we recommend that interventions consist of effective training programmes designed to directly target the negative attitudes of physically disabled people held by healthcare providers, the general public, educators, and employers. By targeting the audience rather than the actions of disabled people themselves,

this moves the responsibility of disability away from disabled people to general society (i.e., participants reported stigma due to inappropriate attitudes of others), thus endorsing the social model of disability (see Shakespeare, 2013).

To achieve this goal of attitude change and stigma reduction at the audience level, it is important to highlight how stereotypical assumptions or expectations from others contribute to the barriers physically disabled people encounter when trying to access support, education, and employment. Although many barriers are recognised in these contexts, a further barrier can be the constraints that are placed on the individual for demonstrating the identity that they wish to portray to others. Therefore, it is important for healthcare providers, the general public, educators, and employers to understand the variable nature of physical disability, and to accept that all disabled people will likely experience disability in different ways, as well as have their own unique skills and support needs. In recognising this individuality, audiences can begin to view and categorise disabled people according to their personal identity, thereby appreciating their individual skills and competences. Moreover, viewing disabled people in this way may also ensure that their support needs can be met, and that their individual displays of competence does not necessarily mean that their need for support is diminished. In doing so, attitudes towards disabled people may potentially change from stereotypical into something more positive, as non-disabled audiences will be able to see the competencies and contributions the disabled colleague brings to their environment.

At the same time, however, it is also important for these audiences to recognise the collective disability community, and that physically disabled people may wish to belong to this also and to see this community valued rather than devalued. In noting this aspect of their identity, healthcare providers, the general public, educators, and employers may consequently become more aware of collective barriers and negative experiences disabled people are likely

to face (e.g., stigmatisation and discrimination). It is important for these audiences to recognise and confront situations where discrimination or prejudice may exist, as well as advocating for and supporting effective social support networks with which disabled people can engage (e.g., online support groups or disabled staff forums). Such groups will potentially support disabled people with needed help and solidarity (e.g., in terms of responding to stigma or how to request reasonable adjustments are made), through being able to share their experiences and learn from the guidance of others (see Baldrige & Swift, 2013; Braithwaite et al., 1999; Finn, 1999; Obst & Stafurik, 2010). This dual-focused intervention may allow physically disabled people to construct an identity that they wish to present within the healthcare, education or workplace context (i.e., through improved attitudes from non-disabled individuals), while at the same time, also enact coping strategies (i.e., from other disabled people) and identity performance behaviours when discrimination and stigmatisation are experienced.

Limitations and future directions of the research

While acknowledging the contributions this thesis has made to social psychology and to disability studies, there are several limitations of the research that place limits on the certainty of our arguments. The first overarching limitation is our difficulty in understanding what the “disability identity” actually is and means to physically disabled people and how this identity may be influenced by other coexisting stigmatised identities (such as gender), but also how disability identity is interpreted by different theoretical approaches. The second overarching limitation relates to methodological concerns, surrounding such factors as: recruitment avenues (i.e., via existing disability support groups and organisations), the use of self-reported data, the lack of variation in the audiences and support chosen for our studies

(i.e., just healthcare providers, the general public, educators and employers, and support, in a general sense), as well as how we have conceptualised and created the quantitative measures used in this thesis. Finally, a third overarching limitation relates to the lack of clarity around whether identity performances can be considered “strategic”, and how these strategies actually work in practice. Each of these overarching limitations is discussed in turn below.

The meaning of the disability identity

Perhaps the most significant conceptual limitation of this work is the lack of clarity surrounding how disability feeds into an individual’s self-concept (either as part of their personal or social self). Specifically, we have only addressed how physically disabled people view and construct their personal and social identities in a general sense – we have not attempted to explore whether the qualitative descriptions of identity within Studies 1 and 5, or the quantitative ratings of ingroup ties in Studies 2, 3, and 4 (e.g., participants’ reported sense of identification with other disabled people), describe an accurate reflection of their feelings about their social group, or whether they reflect a strategic performance.

From a social identity perspective, while many disabled people wish to identify with other disabled people, and consider this a vital part of their self (e.g., Gill, 1997), other disabled people may not believe their condition is a central aspect of their identity (Finlay & Lyons, 2000; Yunker, 1994), and may actively avoid classifying themselves as disabled and interacting with other disabled people (Shattuck et al., 2014; Watson, 2002). From this (lack of) identification, it is often assumed that *no* physical disability identity exists (Wehmeyer, 2013). If physically disabled people do choose to categorise and identify according to their disability, they will more likely do so according to their individual disability label than with the larger physical disability or general disability community (Dovidio et al., 2010). For example, it is readily argued that although deaf and hearing-impaired individuals often

identify as part of the deaf community, they do not wish to be associated with the larger disabled community (Peters, 2000). There are several reasons for this pattern of identifications: there is no large-scale collective disability movement that is common in other stigmatised groups – only smaller, and potentially more exclusive networks; it is difficult to communicate and receive support from other disabled people because the spectrum of physical disability is so broad (Bickenbach et al., 1999; Charlton, 2000; Wehmeyer, 2013); or they simply do not know any other physically disabled person (Bogart, 2014).

From an identity performance perspective, an alternative argument surrounding a possible lack of disability social identity could also be made. Crooks and colleagues (2008) noted a particular identity dilemma of physically disabled women whereby they sought to perform as a disabled person (e.g., to obtain support), but did not personally view themselves as disabled, nor having any connection with the disabled community. Extending this idea to our participants, disability identification could reflect a strategic decision to emphasise similarity to other disabled people in order to be categorised to an audience, and therefore potentially benefit from the associated resources, but not *personally identifying* at this level (S. D. Stone, 2013). In doing so, this may mean that physically disabled people may be categorised as a member of this social group by an audience, but this does not necessarily mean that they will personally view themselves as a disabled person (Branscombe, Ellemers, Spears, & Doosje, 1999; Fernández et al., 2012). Therefore, it could be argued that disabled people may be happy to categorise themselves as disabled in order to receive some material gain (Schneider, 1988), but strategically discount this aspect of their identity when away from this support environment (S. D. Stone, 2013). As such, it is important to investigate which situations, and to what degree, physically disabled people are willing to be categorised and

identify as “disabled”, and whether this reflects an accurate description of the self, or a strategic identity performance to an audience.

A similar limitation regarding presentation of identity performance can also be noted with the outcome measures of support willingness, subjective health, and well-being in Studies 2, 3, and 4. Specifically, as disabled people may use support strategically according to contexts and audiences (e.g., Baldrige & Swift, 2013; Barnard-Brak et al., 2010; Lynch & Thomas, 1999; Olney & Brockelman, 2003; S. D. Stone, 2013), we believed that if participants were primed with a particular stigmatising audience, they would not only demonstrate this behaviour in support, but also other health and well-being variables, for example, strategically modifying the description or demonstration of their subjective health. While both Studies 3 and 4 assessed whether the level of social identification influenced how physically disabled people respond to audience-activated stereotypes, they both revealed inconsistent results. This not only includes the absence and presence of ingroup ties influencing identity performances to activated stereotypes, but also that the outcome performances found to be enacted were different. For example, while self-esteem was not a significant measure in Study 3, it was significant with both stereotypes of worthiness and competence in Study 4. We are unclear as to why these differences emerged across the two studies, especially considering that the measures used were similar, and the healthcare provider audience was a common condition to both investigations. Moreover, as we did not include measures designed to separate whether these outcomes were interpreted by participants as external identity performances or internal reflections, we are unable to definitively state that these findings are evidence for individual identity performances. It is for these reasons that the insights gathered, and the theoretical and practical contributions made, by this thesis have come predominantly from the qualitative studies of Chapters 4 and

6 because participants have provided more detailed accounts of their identity performance pressures when they experienced stigma. Nevertheless, we recognise that additional quantitative research allowing us to separate the performance behaviours and motivations from meaningful internal feelings regarding their disability identity may help clarify and substantiate the claims we have raised (e.g., such as by adapting the measures to include both felt statements, “I feel ill” and performative pressures, “I feel pressure to perform as though I am ill”).

Gender, multiple identities, and performance

Incorporating the above insights of identity performance, the majority of the existing literature describing strategic presentations of physical disability (Crooks et al., 2008; Taub et al., 2004), and indeed the five studies included in this thesis, predominantly focus on experiences of women. While this thesis focuses on how individuals’ disabilities associate with stigmatisation and support, in reality, many other identities that form part of their self-concept are stigmatised (e.g., gender and race), which will in turn, influence how they are viewed by others (Vernon, 1999). This is important to note, since each of these identities (e.g., gender versus disability) might exaggerate the stereotypes or concerns that are activated in a given context, such as perceived incompetence of women and disabled people in the workplace (Asch & Fine, 1997). Therefore, in relation to the disability-based identity dilemmas we have focussed on, alternative identities (such as being a women) may provide additional resources, or create further conflicting demands, as individuals navigate between support and stigma, and enact their identities in so doing (Crooks et al., 2008). This is also true when assessing the potential benefits to health and well-being when disabled people identify with multiple identities (Brook, Garcia, & Fleming, 2008; Cruwys et al., 2013; Haslam et al., 2008; J. M. Jones et al., 2012; for a review, see Jetten, Haslam, Haslam,

Dingle, & Jones, 2014). As such, the experiences that our participants provided in terms of navigating stigma and support while protecting their health and well-being may be more complicated when a wider view of the self is taken, one that incorporates other dimensions of similarity and difference. We therefore recommend that further research establishes how focal the disability identity is to disabled people in relation to their other group memberships (e.g., gender), and how these multiple identities in turn, influence identity performance concerns and stereotype activations as well as any identity performances that are demonstrated.

However, additional questions are also raised about why the samples across the thesis were heavily biased towards women. This includes not only whether disabled men experience stigma differently to disabled women, but also whether disabled men are less likely to engage with disability social networks. For example, in relation to support access, generally, disabled males are often less willing to acknowledge and seek help when compared to disabled women (e.g., Galdas, Cheater, & Marshall, 2005; Willis et al., 2005). Extending these ideas into the context of disabled online forums and social networking sites, it may be predicted that disabled men are more likely to perceive barriers to joining these social groups and/or participating within these groups (e.g., through feelings of difference or awareness of stigma more generally). Therefore, the possible lack of engagement of disabled men may indicate that they are experiencing barriers to accessing support in the online setting, which may in turn, have implications for their ability to respond to stigmatising experiences. Additional research is therefore necessary to more completely address the possible barriers to online participation for disabled men, and whether this influences their identity construction and well-being, but also, how these potential barriers can be limited or removed.

Theoretical approaches to the disability identity

Extending the above limitations further, our theoretical approaches to the disabled identity (i.e., SIA, SIDE and identity performance) may be insufficient. Specifically, social psychological perspectives of identity often assume that an identity is held within the individual, and that it becomes activated in the relevant context and audience (e.g., activating a disability social identity when interacting with other disabled people). Once this identity becomes activated, norms and behaviours will also follow (e.g., viewing and acting in ways that reflect the expectations of the disability group). In other words, if a disabled person were to move their active identity from personal to social, the expected norms and behaviours of the active social identity would now also be active (i.e., Turner et al., 1984). However, limitations with this perspective are a lack of clarity both over when social identity becomes salient to the individual and how this identity is enacted (Antaki, Condor, & Levine, 1996; Reicher et al., 1995).

While this thesis has attempted to develop on these issues through the perspectives of SIDE and identity performance, there are other theoretical perspectives that view identity as an action, and something that is 'done' through overt presentation. One such approach is conversation analysis, which attempts to understand the naturally-occurring back-and-forth of communication between two or more individuals within an interaction, and the social consequences that result (Antaki et al., 1996). More specifically, conversation analysis proposes that communication utterances have functional importance in achieving particular actions or outcomes during interactions with others, and one of these outcomes will be the enactment of particular identities (Antaki, Finlay, & Walton, 2007; Williams, 2011).

Therefore, SIA and conversation analysis both provide insight into the development of identity, but offer fundamentally different approaches to how identity is interpreted. SIA

would refer to the identity according to personal and social components, and something that is stored and activated according to experienced contextual demands (Tajfel & Turner, 1979; Turner et al., 1984). Conversation analysis instead seeks not to assume when identities will be salient (e.g., personal versus social identity), but instead focuses on when, and in what way, identities are used in communications (Antaki & Widdicombe, 1998; Rapley et al., 1998; Weatherall & Gallois, 2003). From the conversation analysis approach, identity is not cognitively activated, but rather, emerges, develops, and changes according to the local context of communication (Antaki & Widdicombe, 1998). For example, if an individual was to interact with a healthcare provider, social identity perspectives might assume that salient identities of “patient” and “doctor” would be activated. However, a conversation analysis perspective would be interested in how the doctor and patient identities are enacted or changed fluidly as a consequence of the content and direction of interactions, rather than because of an assigned category membership (Antaki et al., 1996). Therefore, conversation analysts propose that the understanding of identity can be developed and strengthened by moving away from a predominantly cognitive assessment of SIA, to one which is grounded within, and responsive to, the situational contexts of communication (Antaki et al., 1996).

Conversation analysis has received significant attention within the fields of disability, including how disabled people construct an identity that fluidly encompasses complementary and contradictory components as a consequence of their communication with others (Rapley, 2004; Williams, 2011). For example, Rapley and colleagues (1998) highlight that within interactions, people with learning disabilities construct a sense of identity which acknowledges a desire to “pass” their disability in order to be seen as “ordinary”, and that their disability acts as a validation for negative treatment (i.e., a “toxic identity”), but also, an acknowledgement that this toxic identity is unjust and should therefore be challenged.

Similarly, while healthcare providers may advocate for disability equality and inclusion, when interacting with disabled people, they may use their position of power to ask and frame questions in specific ways that assign disabled people to an identity that is powerless and devalued (Antaki et al., 2007; Jingree, Finlay, & Antaki, 2006). Taken together, these insights into identity construction and negotiation from a conversation analysis approach may suggest that the identity that disabled people (and their interaction partners, e.g., healthcare providers) wish to create and portray is responsive to their immediate interaction with others, and one which fluidly moves between a variety of different positions and actions.

In relation to the data reported in this thesis, conversation analysis would be inappropriate given the lack of free-flowing conversations between disabled people and their audiences. However, the conversation analysis approach to identity provides an alternative perspective to the identity construction and enactment strategies our participants experienced. For example, when interacting with healthcare providers, educators, and employers, participants described situations where they had to discuss their individual support needs and skills, share knowledge about their disability, and potentially disagree and challenge with the views of disability held by these audiences (see Chapters 4 and 6). In response to these changes in conversation content, the disabled person will likely need to shift the discussion of their identity in multiple and potentially conflicting ways which both follow on from the previous turn of talk, but also in ways that influence specific arguments or motivations (e.g., as a patient; listener; learner; teacher; collaborator; challenger).

Yet, while conversation analysis may provide a different, but meaningful and valid interpretation of the findings discussed in this thesis, this approach provides little insight into presentations of identity that are not communicated. Social identity and identity performance theorists would argue that communication to an audience is one part of a larger self-

presentation. Said differently, expected norms of an active social identity can include myriad non-behavioural aspects, such as an individual's choice of clothing. While aspects of the self may not be discussed within a conversation, they still hold significant influence over the direction and content of this conversation (e.g., garments to indicate Muslim identity; Hopkins & Greenwood, 2013). For example, a disabled person may use an assistive device when interacting with an audience, and while the device may not be discussed or used within this interaction, it may still influence how they are viewed in terms of their identity and perceived need or legitimacy for support, and therefore, the content and direction of the communication. In this sense, non-interactional cues can become powerful presentations of identity in their own right, which in turn, suggests the disabled identity, both in terms of its construction and performance to an audience, may be more nuanced than simply how disabled people communicate it.

In sum, this thesis has attempted to theoretically explore and explain the disability identity through the SIA. In doing so, we have highlighted the distinction between the personal and social selves, as well as how the enactment of the self differs according to the contextual demands of support access and coping with stigma, and the identity dilemmas that are experienced when doing so. However, we recognise that there are limitations in its ability to describe the disability identity in ways that are authentic to physically disabled people when navigating stigma and support access. Therefore, other theoretical perspectives, such as the interpretation of identity construction within conversation analysis, may provide a markedly different perspective to the findings reported in this thesis, and indeed, offer a more nuanced and action-oriented approach to identity than SIA (e.g., avoiding viewing disability as something fixed via personal and social identity dimensions). We recommend that additional qualitative research using conversation analysis be conducted developing on the

findings discussed in this thesis in order to more completely explore what the disability identity is and means to disabled people, but also how they communicate their identity to an audience in order to navigate both accessing needed support and protect themselves from stigma.

Methodological issues

Use of disability support groups. One of the key inclusion criteria for these studies was that only people who personally saw themselves as disabled could take part in the surveys. This could mean that only those who viewed their disability as a more central part of their self would have chosen to participate. In addition, due to the relative difficulty accessing disabled people to complete the research, our recruitment avenues were centred around existing disability organisations or charities. This could mean that disabled people who volunteered to participate may have had stronger ingroup ties to the disabled community when compared to disabled people who choose not to join these groups, and therefore did not appear as participants in our studies. However, what constituted low ties in this study was relative, and we do not know how people who are more fully disconnected from the disabled community might respond to our manipulations and questions. As a result, the studies included in this thesis may not have tapped into the responses and experiences of physically disabled people who potentially are likely to be particularly negatively affected by stigma, but also with limited options for receiving support from disability support groups.

It is also important to note the role that disability support groups themselves play in identity construction and performance. Specifically, this thesis has noted at length about the possible support resources that social networks provide to disabled people (e.g., information to assist with stigma coping or support access). However, rather than simply joining social groups, stigmatised individuals need to feel motivated to actively participate within that

group in order for beneficial consequences to well-being to be appreciated (see Cruwys et al., 2014; Pendry & Salvatore, 2015), for example disabled people actively participating and sharing their experiences within the social networks. Indeed, the greater the amount of time physically disabled people spend communicating with others online is associated with increased social capital in terms of an improved sense of online community (i.e., indicative of social identification), friendships, group trust, as well as increased online support (Huang & Guo, 2005; Obst & Stafurik, 2010). While this thesis did not assess disabled people's level of participation within the online groups they are members of, the qualitative insights of Studies 1 and 5 highlight that some participants are actively engaged within these groups (e.g., by feeling a sense of duty to help other members). Therefore, we may predict that the disabled people within this thesis may be more willing to use these online groups to receive or provide support when compared to the wider disabled population (e.g., to raise concerns about how they might respond to stigmatising experiences), which may in turn, influence their identity construction motivations and identity performance intentions (i.e., group-based over individual coping strategies).

Consequently, two possible limitations with the data we have collected are: a) that we are unable to determine whether there are variations in sense of identity and performance motivations between disabled people who are or are not actively engaged in online or social network groups; and b) that we are unable to demonstrate if disabled people who are members of these groups manage or perform their identity differently to individuals who do not wish to join. We therefore recommend that further research investigates not only the possible differences in sense of identity construction and performance, as well as subsequent influences to health and well-being, between disabled people who do and do not actively

participate with the group, but also whether there are any additional differences between disabled people who are and are not members of online forums and social networking sites.

Self-reported data. Although participants' self-reported data is insightful in providing understanding of the experience of stigmatisation (Shelton, Alegre, & Son, 2010) and the consequences of this for health and well-being (Ubel, Loewenstein, Schwarz, & Smith, 2005), identity performance behaviour is exactly that: a performance of one's identity. As with any performance, it is a disabled person's *behaviour* that an audience observes, and through this behaviour makes assumptions about the individual and their motivations or needs (Goffman, 1963; Hebl et al., 2000; Wright, 1983). Related to this, our self-report measures were taken online, and therefore under conditions of anonymity. This is important, since research has demonstrated that stigmatised individuals can react differently to identity threats when they are personally accountable to others versus when they are anonymous (e.g., Douglas & McGarty, 2001; Lea et al., 2001; Reicher & Levine, 1994a, 1994b; Reicher et al., 1998; Wiley & Deaux, 2011). Along these lines, it could be expected that how physically disabled people demonstrate their identity when being observed by situational audiences (i.e., when they are "on stage"; Goffman, 1963; Hebl et al., 2000; Wright, 1983) might differ substantially to when they are self-reporting anonymously. As such, we recommend that additional behavioural research be conducted to explore behavioural variations when disabled individuals interact with different audiences (e.g., healthcare providers), and how specific behaviours might be used to communicate the self to these audiences. Such studies would complement and clarify the insights we have gathered from self-reported data.

Manipulation of specific audiences. An additional limitation of the research is the relatively fixed nature of all our chosen contextual audiences. Specifically, we only asked participants to discuss their experiences with healthcare providers, the general public, and

educators and employers in a general sense. These audiences were chosen because they are likely to play important roles in the lives of disabled people, but also because each audience entails slightly different concerns that we reasoned would impact on the individual's self and behaviour differently. However, the chosen audiences are not singular entities, and include a number of individual groups within them. In relation to healthcare providers, for example, there are many disability supports available to disabled people, each with their own specialists responsible for administering them. Accordingly, there may be further variability in the stereotypes and meta-stereotypes that are active in this context. For example, accessing disability welfare payments is one such support that may be particularly emotive. Media representations of welfare claimants are almost universally negative in their approach, describing them as lazy, workshy and a drain on society and the country's finances (Garthwaite, 2011; Garthwaite, Bamba, & Warren, 2013). These representations may heighten the expected stereotypes we have discussed throughout this thesis regarding the legitimacy or severity of a disabled person's disability (i.e., worthiness), which in turn, may reinforce the need to demonstrate their suitability for welfare support. In this sense, it may be predicted that accessing disability welfare will be a particularly difficult experience for many disabled people, which may in turn, promote a unique identity performance to overtly demonstrate their neediness in a way that is perhaps not as salient in other support contexts, particularly if their disability is less visible or concealable (see Gilson & DePoy, 2008).

In relation to educators and employers, as individuals responsible for allocating work positions may discriminate on the basis of disability stereotypes (e.g., when assessing suitability for work positions; Colella, DeNisi, & Varma, 1998; Crocker & Major, 1994), the specific nature of the educational or workplace role may contribute to the nature or intensity of meta-stereotypes that are activated. Workplace positions that are stereotypically more

physically or intellectually demanding may evoke stronger meta-stereotypic activations of lack of competence to other less strenuous positions. We therefore believe it is important that further research be conducted that develops on our existing research designs to delve deeper into the different subgroups of healthcare providers, educators, and employers to see whether these individual audience groups activate unique stereotypes or identity performance behaviours. This additional variation might also account for the lack of clarity in findings across the studies that manipulated specific audiences (Studies 3 and 4).

Measures of specific types of support. It is also important to address the relatively fixed nature of our support measures. For example, because willingness to access support has been a key focus across this thesis, we largely did not require disabled people to reflect on any *specific* support they accessed (e.g., physiotherapy, disability welfare etc.) This means that we are unable to establish whether participants were more or less willing to access specific types of support over others. This is relevant because different forms of support can reflect differently on the self and identity. In the help-seeking literature, for example, it has been found that people are more willing to access or accept support which gives them the skills or resources to improve and maintain their future independence and autonomy, rather than support that reinforces their dependence on others (Nadler, 2002; see Wang et al., 2015). Moreover, stigmatised individuals with a strong sense of group identification may be especially unwilling to accept dependency-oriented support, as this may confirm an incorrect stereotype regarding their assumed incompetence (Wakefield et al., 2012).

The findings from Study 4 suggest a possible rationale for extending these ideas of autonomy-oriented and dependency-oriented support to disability. Specifically, as willingness to access support was most associated with activated stereotypes of passivity, disabled people may also be particularly aware of whether the support they are contemplating

is autonomy- or dependency-oriented. In response to these concerns, individuals with high ties to the disabled group may be less willing to access dependency-oriented support when passivity stereotypes are activated, but may be less concerned about autonomy-oriented help. To disentangle this further, future research could manipulate the specific types of support being asked about (i.e., either independency- or dependency-oriented) and investigate whether group identification influences how willing the disabled person is to accept these types of assistance in the face of different meta-stereotypes.

Conceptualisation of ingroup ties. An additional limitation is how we have conceptualised ingroup ties to the disability social identity. Specifically, we have interpreted ingroup ties as reflective of group identification, through the sense of solidarity, belonging, and group commitment that physically disabled people feel to other ingroup members (Cameron, 2004; Doosje et al., 1999; Leach et al., 2008). In so doing, we assumed that people with high ties to the group will likely feel a greater sense of connection and desire to behave in ways that benefit the ingroup when compared to individuals with low ties.

However, it is important to note that the dimensions of ingroup ties are also similar to that of social capital (e.g., sense of connection is also similar to group friendship, trust, and community support; Huang & Guo, 2005; Obst & Stafurik, 2010). Existing evidence highlighting the qualitative distinction between ingroup ties and social capital notes that social capital may develop as a consequence of identification (e.g., the sense of connection felt towards the group (ingroup ties) may in turn promote feelings of friendship and social support (Horvat, Weininger, & Lareau, 2003). Therefore, there is a lack of clarity whether the statements of ingroup ties used in this thesis are assessing disabled people's sense of social identification or the benefits they perceive from this (i.e., social capital). Additional qualitative and quantitative work is therefore needed to explore disabled people's

perspectives regarding the possible distinctions between ingroup ties and social capital (e.g., whether disabled people feel connected to other group members, and if so, what that sense of connection means to them, and what benefits are received through viewing themselves in this way).

Creation of the numerical scales. A number of the numerical scales used in Studies 2, 3, and 4 were adapted from existing validated and reliable measures in order to be relevant to samples of physically disabled people (e.g., ingroup ties; Cameron, 2004), whereas others were newly created (e.g., assessments of identity performance concerns, meta-stereotypes, support willingness and subjective health in Studies 2, 3, and 4). The reason for this approach was because of a limited availability of existing measures that were believed to be both valid and reliable for use with disabled people. Therefore, while the chosen scales often appeared to be reliable and generalise effectively to different disability samples (i.e., all scales had a high degree of internal consistency), the conclusions raised by our quantitative research should be treated with caution. We recommend that further psychometric testing be completed on the measures within this thesis in order to better determine their psychological meaning (e.g., as an internal feeling or external performance), but also to see whether the scales could be improved (e.g., addition or removal of items, as well as changes in item terminology; Furr, 2011).

Can situational identity performance work in practice?

Above all these limitations, given the highly practical concerns that motivated this research, a particularly important issue that has yet to be explored, and one that we would consider vitally important for contributing to the disability field, is whether identity performances can actually be beneficial for achieving particular outcomes (e.g., help-seeking behaviour, well-being, favourable ratings). In other words, while we have highlighted the

pressures physically disabled people report in performing their identity to achieve particular outcomes, this thesis did not assess what implications these performances have for how they are viewed by their audiences, and in turn, how their audience responds to them.

There is some existing evidence that suggests strategic use of assistive devices can promote differing impressions and behavioural responses from the community when compared to those without such devices. For example, healthcare provider ratings of disabled people became far more negative simply when they were in a wheelchair – even when no mention of disability was observed (Gething, 1992). These negative attitudes associated with wheelchair use included impaired social and psychological adjustment (e.g., unlikable, less trustworthy, less intelligent, more mentally unstable, less healthy, and less positive) and reduced coping ability (e.g., passivity, incompetence, dependence, submissiveness, and cowardice). Moreover, use of assistive devices can encourage increased staring and avoidance behaviours from others (Perlman & Routh, 1980).

From this evidence, we therefore suggest that if assistive devices promote these changes in attitudes and response behaviours in a stereotypical fashion, then the disabled person could incorporate these into any identity performances they decide to enact (Frank, 1988a) – at least when assistive devices are likely to positively influence impressions from an audience (e.g., support-seeking). For example, for individuals who do not fit stereotypical expectations of disability, and therefore may anticipate being judged as unworthy of support, the strategic performance of identity through assistive devices may help to make them look *more worthy* when they attempt to access support from a healthcare provider (i.e., as indicated by the participant quote at the beginning of the chapter), and therefore might actually result in better care. Conversely, when interacting with educators and employers, physically disabled people may choose to make themselves look more competent by denying

their disability or avoiding use of their assistive devices (see Chapter 6), and therefore result in more inclusion. It is important for disability practice that the qualitative insights we have gathered be investigated behaviourally to see whether contextual demands and stereotypes from audiences (e.g., requesting support or employment) can be affected by visual and strategic demonstrations of disability and therefore result in materially different outcomes for the individual. If so, this would highlight the clear and important need for further training on behalf of professionals regarding how stereotypical expectations are influencing their decision-making outcomes.

Final Conclusions

To conclude, this thesis sought to elucidate the identity challenges physically disabled people face when attempting to navigate accessing support, while simultaneously protecting their self from the negative effects of stigmatisation. The research contained in this thesis demonstrates that concerns over who disabled people are (i.e., identity) and how they enact their identity to others (i.e., performance) are part of these challenges. Defining the self as a disabled individual, both in terms of the personal and social identity, plays a central role in how physically disabled people experience, and respond to, stigmatisation when attempting to access support. Identifying as a physically disabled person means that experiences of contextual stereotyping and stigmatisation remain very real concerns in their lives, and this is compounded further when acknowledging the need for, and accessing, needed support. Downplaying disability, and instead emphasising individuality might free the self from the damaging consequences of group-based negative stereotypes, but in the context of disability this can interfere with smooth access to needed support. Because of this, we have argued that physically disabled people are likely to face difficult dilemmas in both how they maintain a

positive representation of their own sense of self in relation to other disabled people, but also ensuring that they have access to the support they require to achieve this desired sense of self. The research presented in this thesis has also suggested that variations in identity can guide how the self is enacted in response to stigmatising experiences. Those less attached to a collective disabled identity seem to present their identity in ways that confirm and absorb the negative stereotypes directed at them, whereas those more attached to collective identity instead seem to present their identity in ways that challenge these views. Accordingly, we offer an analysis of disability that is performative and directed to navigating between disabled people's desired sense of identity, their needed support, and the expectations of others. In this sense, interventions to improve the experiences of disabled individuals should address not just stigmatising attitudes and expectations of others, but also recognise the influences of the personal and social identities in the lives of disabled people.

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APPENDIX A: STUDY 1 SURVEY

Section 1: More about you

In this first section we would like to know a little bit more about you.

What is your gender?

What is your age?

How many years have you spent in education?³

What is your highest completed level of education?

- No high school education
- High school education
- College/further education
- Undergraduate university degree/higher education
- Postgraduate university degree

How would you describe your race/ethnicity? For example: White, Black, Asian, Mixed etc.

What is your nationality?

Think about your socio-economic status. How would you describe your socio-economic status relative to other people in the country where you live?

Section 2: Your cerebral palsy

In this next section we would like to know a little about your cerebral palsy.

What is your level of mobility? Please indicate by selecting one of the levels of motor functioning below that is most applicable to you:

Level I: You can walk indoors and outdoors and climb stairs without limitations. You can perform gross motor skills including running and jumping but speed, balance and coordination are reduced.

Level II: You can walk indoors and outdoors, and climb stairs holding onto a railing, but experience limitations when walking on uneven surfaces and inclines, and walking in crowds or confined spaces. You have at best only minimal ability to perform gross motor skills such as running and jumping.

Level III: You can walk indoors or outdoors on a level surface with an assistive mobility device. You may climb stairs holding onto a railing. You use a wheelchair when travelling for long distances or outdoors on uneven terrain, but may propel your wheelchair manually.

³ The questions “How many years have you spent in education?” and “Think about your socio-economic status. How would you describe your socio-economic status relative to other people in the country where you live?” were not included in our qualitative paper.

Level IV: You may rely more on a wheelchair to move around at home and in the community. You may achieve self-mobility using a powered wheelchair.

Level V: You have difficulty with all areas of motor functioning. You still have functional limitations in sitting and standing even with adaptive equipment and assistive technology. You have no means of independent mobility, though may achieve self-mobility using a power wheelchair with extensive adaptations.

Do you have any medical conditions other than your cerebral palsy?⁴

- Vision difficulties
- Hearing difficulties
- Speech and communication difficulties
- Mental health problems
- Epilepsy
- Autistic spectrum disorder
- Any other medical condition

⁴ The question, “Do you have any medical conditions other than your cerebral palsy?” was not included in our qualitative paper.

Section 3: Support

Thank you for your responses on the previous pages.

In this next section we would like you to think about the different forms of support you access to help with your cerebral palsy.

This can include more formal support, such as medical treatment or care, specialist equipment or disability welfare, or informal support, such as support from family and friends.

Please can you write down what support you access as an adult with cerebral palsy.

Included below are boxes for you to specify a maximum of ten different supports.

If you feel you access more than ten different supports, please specify the ten you feel are most helpful to you.

If you do not feel you access any support, please click the answer stating "I do not access any support" at the bottom of the page.

Support	
1st Support	<input type="text"/>
2nd Support	<input type="text"/>
3rd Support	<input type="text"/>
4th Support	<input type="text"/>
5th Support	<input type="text"/>
6th Support	<input type="text"/>
7th Support	<input type="text"/>
8th Support	<input type="text"/>
9th Support	<input type="text"/>
10th Support	<input type="text"/>

I do not access any support



Section 4: Stigma

Thank you for your responses to the questions on the previous pages.

People can report a number of barriers when seeking or accessing support.

One that comes up frequently is stigma. Such experiences can often vary from overt or obvious discrimination to feeling negative by perceiving they are marked, different or excluded.

Think about your experiences living with cerebral palsy, and the experiences of others you know who have cerebral palsy.

Do you think that there are any stigmas associated with cerebral palsy that might affect people's access to either formal or informal sources of support? If so, what are these, and how do they affect support-seeking?

Remember, we are not asking about your own personal experiences of stigma in this question, but rather what you perceive more generally.

Just to remind you that if you would like to increase your typing space, please click on the triangle symbol on the bottom right-hand corner, and drag to the size you wish. You can also do this for any other question where text boxes are provided.



2. Now we would like to know about your own experiences of stigma when accessing the forms of support you specified on the previous pages.

The first support you entered was ""⁵

2i. Do you feel marked, different, excluded or discriminated when accessing this support? (Yes/No).⁶

2ii. Can you tell us a little about what it is specifically when accessing this support that causes you to feel this way?

For example, these feelings could arise from the support itself, or maybe aspects around the support such as: booking appointments to seek support, using waiting

⁵ "" refers to the first support answer that participants entered in the Support section question.

⁶ If participants answered "yes" to this question, they were then presented with questions 2ii – 2vi. If they answered "no" then these follow-up questions were not visible. Question 2i was repeated for each additional support the participant entered in the Support section question (i.e., up to a maximum of 10 times). For each additional support that participants answered "yes" to for question 2i, they were also presented with questions 2ii-2vi (i.e., again, up to a maximum of 10 support entries). If participants reported not accessing any support in the Support section, the entirety of the Stigma Question 2 section was removed from their survey.

rooms, attitudes from staff, family or friends or feelings you get from these individuals or other patients.

2iii. How negative do you see these experiences?⁷

1 = Extremely Mild, 2 = Very Mild, 3 = Somewhat Mild, 4 = Neither Mild nor Negative, 5 = Somewhat Negative, 6 = Very Negative, 7 = Extremely Negative

2iv. How frequently do you feel this way with this support?

1 = Never, 2 = Almost Never, 3 = Infrequently, 4 = Sometimes, 5 = Frequently, 6 = Almost Always, 7 = Always

2v. Does feeling marked, different, excluded or discriminated with this support impact on your willingness to access this support?

1 = Never, 2 = Almost Never, 3 = Infrequently, 4 = Sometimes, 5 = Frequently, 6 = Almost Always, 7 = Always

2vi. Can you please tell us a little bit about why you feel this way with this support?

Section 5: Identity

Thank you for your responses to the previous page.

People can be members of a large number of different groups or categories, for example, as a family member or workplace employee.

Please can you think about yourself as a person with cerebral palsy.

1i. Is being an adult with cerebral palsy important to you?⁸

1 = Completely Unimportant, 2 = Mostly Unimportant, 3 = Somewhat Unimportant, 4 = Neither Unimportant nor Important, 5 = Somewhat Important, 6 = Mostly Important, 7 = Completely Important

⁷ As Questions 2iii, 2iv, and 2v were quantitative arrays, they were not included in the qualitative analysis. We chose to include these items to potentially judge the level of emotion and frequency of participants' answers to the qualitative questions of 2ii and 2vi.

⁸ Like in the Stigma section of the survey, Questions 1i, 2i, 3i, 4i, 5i, 6i, and 7i were quantitative arrays, and therefore were not included in the qualitative analysis. We chose to include these items to potentially judge the level of emotion of participants' answers to the qualitative questions 1ii, 2ii, 3ii, 4ii, 5ii, 6ii, and 7ii.

1ii. Please take a moment to think about your above answer. What were you thinking about to come up with your rating?

2i. Some adults with cerebral palsy like to see themselves as an individual with the condition, whereas others like to see themselves as a member of a larger cerebral palsy group. How do you like to view yourself?

1 = Completely Individual, 2 = Mostly Individual, 3 = Somewhat Individual, 4 = Neither Individual nor Group, 5 = Somewhat Group, 6 = Mostly Group, 7 = Completely Group

2ii. Please can you explain your answer?

3i. To what extent do you feel your cerebral palsy is a central part of your identity?

1 = Not at all, 2 = Very Slightly, 3 = Slightly, 4 = Somewhat, 5 = Moderately, 6 = Very Much, 7 = Completely

3ii. Please can you explain your answer?

4i. To what extent do you feel positive about other adults with cerebral palsy?

1 = Not at all, 2 = Very Slightly, 3 = Slightly, 4 = Somewhat, 5 = Moderately, 6 = Very Much, 7 = Completely

4ii. Please can you explain your answer?

5i. To what extent do you feel connected with other adults with cerebral palsy?

1 = Not at all, 2 = Very Slightly, 3 = Slightly, 4 = Somewhat, 5 = Moderately, 6 = Very Much, 7 = Completely

5ii. Please can you explain your answer?

6i. Does your identification with other adults with cerebral palsy influence your support seeking?

1 = Never, 2 = Almost Never, 3 = Infrequently, 4 = Sometimes, 5 = Frequently, 6 = Almost Always, 7 = Always

6ii. Please can you explain your answer?

7i. If you feel marked, excluded or discriminated because of your cerebral palsy when accessing support, does your identification with other adults with cerebral palsy influence your ability to cope with these experiences?⁹

1 = Never, 2 = Almost Never, 3 = Infrequently, 4 = Sometimes, 5 = Frequently, 6 = Almost Always, 7 = Always

7ii. Please can you explain how you would cope with these experiences?

⁹ Questions 7i and 7ii were only included for participants who stated that they accessed support in the Support section question. If participants stated that they did not access support, their final question was 6ii.

APPENDIX B: STUDY 2 SURVEY

Section 1: More about you

In this first section we would like to know a little more about you.

What is your gender?

Female

Male

What is your age?

How would you describe your race/ethnicity? For example: White, Black, Asian, Mixed etc.

What is your nationality?

Thinking about your cerebral palsy, what is your level of mobility? Please indicate by selecting one of the levels of motor functioning below that is most applicable to you:

Level 1: I can walk indoors and outdoors and climb stairs without limitations. I can perform gross motor skills including running and jumping but speed, balance and coordination are reduced.

Level 2: I can walk indoors and outdoors, and climb stairs holding onto a railing, but experience limitations when walking on uneven surfaces and inclines, and walking in crowds or confined spaces. I have at best only minimal ability to perform gross motor skills such as running and jumping.

Level 3: I can walk indoors or outdoors on a level surface with an assistive mobility device. I may climb stairs holding onto a railing. I use a wheelchair when travelling for long distances or outdoors on uneven terrain, but I may propel my wheelchair manually.

Level 4: I may rely more on a wheelchair to move around at home and in the community. I may achieve self-mobility using a powered wheelchair.

Level 5: I have difficulty with all areas of motor functioning. I still have functional limitations in sitting and standing even with adaptive equipment and assistive technology. I have no means of independent mobility, though I may achieve self-mobility using a power wheelchair with extensive adaptations.

Section 2: Context manipulation

Support condition: We are interested in the support you access to help with your cerebral palsy. Please think about up to three situations where you access such support. This can include formal support, for example physiotherapy, surgery or disability welfare, or informal support, for example family and friends. Please list them below and describe in a sentence or two how this support helps you.

1

2

3

Discrimination condition: We are interested in how adults with cerebral palsy may feel discriminated against because of their condition. Please think about up to three situations where you experience or may have experienced discrimination in life because of your cerebral palsy. This can include situations in everyday life, for example

interactions with society, or experiences in work or education. Such examples can often vary from obvious discrimination to feeling overlooked because of your cerebral palsy. There may also be situations where you are unsure, but perhaps think you might be discriminated against. Please list them below and describe in a sentence or two how you feel or felt discriminated.

- 1
- 2
- 3

Control condition: We are interested in how you think about your everyday life as an adult with cerebral palsy.

All participants:

Below is a list of words that are commonly used to describe people. How much do these words describe how you feel **right now**? Please try to avoid spending too long thinking about this section - **select the first judgement that comes to you for each term and then move on to the next word.**¹⁰

1=Not at all, 2=Very Slightly, 3=Slightly, 4=Somewhat, 5=Moderately, 6=Very Much, 7=Completely

Competent: Competent, Confident, Capable, Efficient, Intelligent, Skillful, Strong

Warm: Warm, Friendly, Likeable, Nice, Trustworthy, Good-natured, Sincere

Passive: Passive, Shy, Timid

Neutral: Frank, Demure, Objective

Now we'd like you to think in a bit more detail about your cerebral palsy in everyday life. Please read the statements below and rate how you view yourself and your condition.

1=Perfectly Easy, 2= Easy, 3=Fairly Easy, 4=Neither Easy nor Difficult, 5=Fairly Difficult, 6= Difficult, 7= Impossible.

On most days, walking indoors and outdoors is

On most days, climbing stairs is

On most days, gross motor skills including running and jumping are

On most days, maintaining balance and coordination¹¹

My current overall health is – 1=Very Poor, 2= Poor, 3= Fairly Poor, 4= Neither Poor nor Good, 5= Fairly Good, 6= Good, 7= Very Good

1= Strongly Disagree, 2= Moderately Disagree, 3= Slightly Disagree, 4= Neither Disagree nor Agree, 5= Slightly Agree, 6= Moderately Agree, 6= Strongly Agree.

In general I feel tired

In general I feel ill

In general I feel in pain

In general I feel able

In general I feel in control of my health.

¹⁰ All participants were presented with the above list of twenty terms, and asked to judge how much each term described their current feelings (i.e., self-stereotypes). The list was randomised for each participant. However, this self-stereotyping measure was not included in the final analysis.

¹¹ The four statements reflecting participants' mobility (e.g., "On most days, walking indoors and outdoors is") were not included in our final analysis.

I am a typical adult with cerebral palsy
 I am very similar to the average adult with cerebral palsy
 I am a good example of an adult with cerebral palsy
 I have a lot in common with other adults with cerebral palsy¹²

Section 3: Identity performance manipulation

Support condition:

Thinking about your support experiences to help with your cerebral palsy, to what extent do you feel any of the following?

Discrimination condition:

Thinking about your discrimination experiences because of your cerebral palsy, to what extent do you feel any of the following?

Control condition:

Thinking about everyday life as an adult with cerebral palsy, to what extent do you feel any of the following?

All participants

1=Not at all, 2=Very Slightly, 3=Slightly, 4=Somewhat, 5=Moderately, 6=Very Much, 7=Completely

I am aware about how other people see me
 I am aware about the stereotypes other people hold about me
 I feel concerned about acting in a way that confirms other peoples' views about me
 I feel concerned about downplaying my physical ability to others
 I feel concerned about accentuating my physical ability to others
 I feel concerned about how other people see cerebral palsy
 I feel concerned about the stereotypes other people hold about cerebral palsy
 I feel concerned about acting in a way that confirms other peoples' views about cerebral palsy

1= Strongly disagree, 2= Moderately disagree, 3= Slightly disagree, 4= Neither disagree nor agree, 5= Slightly agree, 6= Moderately agree, 7= Strongly agree.

I feel my cerebral palsy is a central part of my identity
 I often think about the fact that I am an adult with cerebral palsy.
 In general, being an adult with cerebral palsy is an important part of my self-image.
 I feel connected with other adults with cerebral palsy
 I feel strong ties to other adults with cerebral palsy.
 I feel a bond with other adults with cerebral palsy.

On the whole, I am satisfied with myself
 I feel I have a number of good qualities
 I take a positive attitude towards myself
 At the moment I am pleased to be an adult with cerebral palsy
 At the moment I have a good feeling about being an adult with cerebral palsy
 At the moment I am satisfied about the fact that I am an adult with cerebral palsy

¹² In this study we also assessed participants' perceptions of disability prototypicality; however, this measure was not included in the final analysis.

In general, I can access the support I need to help with my cerebral palsy
In general, I feel able to access the support I need to help with my cerebral palsy
In general, I feel willing to access the support I need to help with my cerebral palsy
In general, I feel comfortable about seeking support I need to help with my cerebral palsy
In general, I feel happy about seeking support I need to help with my cerebral palsy

1=Not at all, 2=Very Rarely, 3=Rarely, 4=Occasionally, 5=Fairly Frequently,
6=Frequently, 7=Very Frequently

To what extent do you access support because of your cerebral palsy?

To what extent do you experience discrimination because of your cerebral palsy?

APPENDIX C: STUDY 3 SURVEY

Section 1: More about you

In this first section we would like to know a little bit more about you.

What is your gender?

Female

Male

What is your age?

How would you describe your race/ethnicity? For example: White, Black, Asian, Mixed etc.

What is your nationality?

What is your physical disability?

Which category or categories would you classify your physical disability?

Mobility disability

Spinal cord disability

Brain disability or injury

Visual disability

Hearing disability

Cognitive disability

1= Not at all, 7= Completely:

On a normal day, how visible do you think your condition is?

On a normal day, how severe do you think your condition is?

On a normal day, to what extent do you need assistive devices to help you get around e.g., wheelchair, cane?

On a normal day, to what extent do you need assistive devices to help you complete activities?

On a normal day, to what extent does your condition impact on day-to-day activities?

On a normal day, to what extent does your condition impact on your everyday life?

Section 2: Stereotyping manipulation

Healthcare provider audience

The purpose of this survey is to collect information about physically disabled people's experiences so that we can feed on information to health care providers. This is important because we hope to provide this group with a better understanding of the experiences of people with a physical disability.

First, we are interested in your interactions with health care providers. Please read the statements below and rate the extent to which you agree or disagree with them.

1=Strongly disagree, 2= Moderately disagree, 3=Slightly disagree, 4=Neither disagree nor agree, 5=Slightly agree, 6=Moderately agree, 7=Strongly agree.

In general I feel positive when interacting with health care individuals.

In general I feel at ease when interacting with health care individuals.

In general I feel comfortable when interacting with health care individuals.

We would like to know more about how you think individuals with your disability are seen by health care providers. Below is a list of descriptive terms that are commonly used to describe people. Please read this list. In your opinion, how likely are health care providers to use these terms to describe people with your disability? Do not worry if you are unsure about your answer, there are no right or wrong answers here, so your first response is probably the right one.

General public audience

The purpose of this survey is to collect information about physically disabled people's experiences so that we can feed on information to the general public. This is important because we hope to provide this group with a better understanding of the experiences of people with a physical disability.

First, we are interested in your interactions with the general public. Please read the statements below and rate the extent to which you agree or disagree with them.
 1=Strongly disagree, 2= Moderately disagree, 3=Slightly disagree, 4=Neither disagree nor agree, 5=Slightly agree, 6=Moderately agree, 7=Strongly agree.
 In general I feel positive when interacting with the general public.
 In general I feel at ease when interacting with the general public.
 In general I feel comfortable when interacting with the general public.

We would like to know more about how you think individuals with your disability are seen by the general public. Below is a list of descriptive terms that are commonly used to describe people. Please read this list. In your opinion, how likely are the general public to use these terms to describe people with your disability? Do not worry if you are unsure about your answer, there are no right or wrong answers here, so your first response is probably the right one.

Control

The purpose of this survey is to collect information about physically disabled people's experiences in order to gain a better understanding of disability.

First we would like to know more about how you see individuals with your disability. Below is a list of descriptive terms that are commonly used to describe people. Please read this list. In your opinion, how descriptive are these terms of people with physical disabilities in general? Do not worry if you are unsure about your answer, there are no right or wrong answers here, so your first response is probably the right one.

All participants

1= Not at all likely, 2= Very Unlikely, 3= Unlikely, 4= Neither Unlikely nor Likely, 5= Likely, 6= Very Likely, 7= Completely

Competence: Competent, Confident, Capable, Independent, Intelligent, Skilful

Warmth: Warm, Friendly, Likeable, Trustworthy, Good-natured, Nice,

Passivity: Passive, Shy, Timid, Hesitant

Worthiness: Worthy, Legitimate, Needy, Deserving.

Now, please read this list again and this time rate how much each of these words describes you right now. Again, do not worry if you are unsure about your answer, there are no right or wrong answers here, so your first response is probably the right one¹³.

¹³ All participants were presented with the above list of terms, and asked to judge how much each term described their current feelings (i.e., self-stereotypes). The list was randomised for each participant. However, this self-stereotyping measure was not included in the final analysis.

Section 3: Identity performance and health manipulation

Healthcare provider audience

Now we would like you to think about how your physical disability affects you. Specifically, we are interested in providing health care providers with an impression of how your disability affects your daily life. Please read the statements below and rate the extent to which you agree or disagree with them.

General public audience

Now we would like you to think about how your physical disability affects you. Specifically, we are interested in providing the general public with an impression of how your disability affects your daily life. Please read the statements below and rate the extent to which you agree or disagree with them.

Control

Now we would like you to think about how your physical disability affects you. Please read the statements below and rate the extent to which you agree or disagree with them.

All participants

1=Strongly disagree, 2= Moderately disagree, 3=Slightly disagree, 4=Neither disagree nor agree, 5=Slightly agree, 6=Moderately agree, 7=Strongly agree.

On a normal day:

I can walk indoors and outdoors independently

I climb stairs independently

I can perform gross motor skills including running and jumping independently

My balance and coordination are unimpaired

I can complete everyday tasks such as eating, dressing or bathing independently.

I can prepare a meal independently.

I can reach for, lift and hold heavy objects independently.

I can complete difficult manual tasks independently.

Most of the things I do in everyday life I can do independently.

Most of the things I do in everyday life I require assistance from others.

1= Not at all, 7= Completely

How dependent are you on assistive devices to help you get around?

How dependent are you on assistive devices to help you complete activities¹⁴?

Aside from these specific issues, how do you feel about your health in general?

My overall health is: very poor – very good.

1= Strongly Disagree, 7= Strongly Agree:

In general I feel tired

In general I feel ill

In general I feel able

In general I feel in pain

In general I feel in control of my health.

Section 4: Identity, support, and well-being

Now we would like to know a little bit more about how you feel about yourself in relation to other people who also have your disability. Please read the statements below and rate how much you agree that they describe you.

¹⁴ The twelve statements reflecting participants' mobility (i.e., "On a normal day, I can walk indoors and outdoors independently" to "How dependent are you on assistive devices to help you complete activities?") were not included in our final analysis.

1= Strongly Disagree – 7= Strongly Agree:

I feel connected with other people who also have my disability
 I feel strong ties with other people who also have my disability
 I feel a bond with other people who also have my disability.
 I am very similar to the average adult who also has my disability
 I have a lot in common with other adults who also have my disability
 I am quite typical of adults with my disability
 I feel my disability is a central part of my identity
 I often think about the fact that I have my disability
 In general, being a person with my disability is an important part of my self-image¹⁵.

On the whole, I am satisfied with myself
 I feel I have a number of good qualities
 I take a positive attitude towards myself
 At the moment, I am pleased to be a person with my disability
 At the moment, I have a good feeling about being person with my disability.
 At the moment, I am satisfied about the fact that I am a person with my disability.
 At the moment I have access to the support I need to help with my disability¹⁶.

In general, I feel able to access the support I need to help with my disability.
 In general, I feel willing to access the support I need to help with my disability.
 In general, I feel comfortable about accessing the support I need to help with my disability.
 In general, I feel happy about accessing the support I need to help with my disability.

Section 5: Identity performance manipulation

Healthcare provider audience

Lastly, we would like you to think again about your experiences with health care providers. When interacting with these people, do you ever feel any of the following things?

General public audience

Lastly, we would like you to think again about your experiences with the general public. When interacting with these people, do you ever feel any of the following things?

Control

Lastly, we would like you to think again about your experiences. When interacting with others, do you ever feel any of the following things?

All participants

1= Not at all, 2= Very Slightly, 3= Slightly, 4= Somewhat, 5= Moderately, 6= Very Much, 7= Completely

People expect me to act in particular ways.
 I sometimes feel pressure to accentuate my abilities.
 I sometimes feel pressure to downplay my abilities.
 I sometimes feel pressure to confirm stereotypes held about me.
 I sometimes feel pressure to disconfirm stereotypes held about me.

¹⁵ The above statements assess ingroup ties, ingroup prototypicality, and ingroup centrality, however, only the statements assessing ingroup ties were included in the final analyses.

¹⁶ In addition, the above statements assess both self-esteem and collective self-esteem, however, only the statements assessing self-esteem were included in the final analyses.

Looking back at the answers you gave to the set of statements above, can you tell us a little more about what you were thinking when you answered?



To what extent do you access support to help with your condition?

To what extent do you experience discrimination because of your condition?

1= Not at all, 2= Very rarely, 3= Rarely, 4= Occasionally, 5= Fairly Frequently, 6= Frequently, 7= Very frequently.

APPENDIX D: STUDY 3 PROCESS RESULTS

Responses to stereotypes of worthiness

Support willingness. First, we investigated whether the focal contrast (audiences versus control), influenced reported willingness to access support via the activation of meta-stereotypes of worthiness (the mediator), and whether the effects of activated audience and/or meta-stereotype were contingent on ingroup ties (the moderator; PROCESS Model 15). Reflecting the ANOVA results reported previously, there was a significant effect of the focal audience contrast on stereotypes of worthiness, whereby the audience conditions reported reduced stereotypes of worthiness to the control, $b = -1.21$, $SE = .37$, $t = -3.25$, $p = .002$, 95% CI: -1.95 and -.47. In the analyses in which the secondary contrast was substituted (comparing the two audiences), there were no significant differences in meta-stereotypes of worthiness as a function of this contrast, $b = .72$, $SE = .43$, $t = 1.67$, $p = .10$, 95% CI: -.14 and 1.57. This suggests that meta-stereotypes of worthiness are not uniquely activated by one specific audience, but instead are equivalent across both. Severity also predicted worthiness, $b = -.31$, $SE = .13$, $t = -2.39$, $p = .02$, 95% CI: -.56 and -.05, suggesting that people with less severe physical disabilities expect to be seen as *more worthy*. Logically, these significant effects were observed in all analyses involving meta-stereotypes of worthiness. To save space, this effect is not repeated in the analyses of the other dependent measures.

The full model including all predictors explained a significant amount of variance in support willingness, $R^2 = .21$, $F(7,79) = 2.91$, $p = .009$. However, the only significant effects in the model were for ingroup ties, whereby participants with higher ties reported a greater willingness to access support, $b = .49$, $SE = .25$, $t = 1.97$, $p = .05$, 95% CI: -.005 and .99, and severity, whereby people with less severe disabilities reported being more willing to access support, $b = -.24$, $SE = .12$, $t = -2.08$, $p = .04$, 95% CI: -.47 and -.01. No additional significant

effects were found, all $ps > .12$. Similarly, when the secondary contrast was substituted, effects in the model were observed for ingroup ties, whereby participants with higher ties reported a marginally greater willingness to access support, $b = .46$, $SE = .25$, $t = 1.85$, $p = .07$, 95% CI: $-.005$ and $.99$, and severity, whereby people with less severe disabilities reported being more willing to access support, $b = -.24$, $SE = .12$, $t = -2.04$, $p = .04$, 95% CI: $-.47$ and $-.006$. No additional significant effects were observed, all $ps > .15$.

Self-esteem. Next, we investigated whether the focal contrast and/or activated stereotypes of worthiness, in combination with ingroup ties, influenced reported self-esteem. Beyond the significant effect of audiences on meta-stereotypes of worthiness (reported above), there were also significant effects on self-esteem of: the focal contrast, whereby the audience conditions reported reduced self-esteem to the control, $b = -1.93$, $SE = .91$, $t = -2.13$, $p = .04$, 95% CI: -3.74 and $-.12$; ingroup ties, whereby participants with higher ties reported greater self-esteem, $b = .44$, $SE = .22$, $t = 2.06$, $p = .04$, 95% CI: $.02$ and $.87$; and severity, whereby people with less severe disabilities reported greater self-esteem, $b = -.30$, $SE = .10$, $t = -2.99$, $p = .004$, 95% CI: $-.50$ and $-.10$. However, stereotypes of worthiness were not significantly correlated with self-esteem, $b = .32$, $SE = .26$, $t = 1.22$, $p = .22$, 95% CI: $-.20$ and $.84$.

Qualifying these main effects, the interaction between the focal contrast and ingroup ties was significant, $b = -.34$, $SE = .17$, $t = 1.99$, $p = .05$, 95% CI: $<.001$ and $.68$. This interaction is depicted in Figure 3. As can be seen, audience activation was associated with reduced self-esteem at low ingroup ties, $b = -.99$, $SE = .44$, $t = -2.26$, $p = .03$, 95% CI: -1.87 and $-.12$, whereas this effect was tempered at moderate ties, $b = -.33$, $SE = .30$, $t = -1.11$, $p = .27$, 95% CI: $-.93$ and $.26$, and (non-significantly) reversed at high ties, $b = .33$, $SE = .41$, $t = .80$, $p = .42$, 95% CI: $-.48$ and 1.13 . There was no interaction between stereotypes of

worthiness and ingroup ties on self-esteem, $b = -.06$, $SE = .05$, $t = -1.16$, $p = .25$, 95% CI: $-.15$ and $.04$. When the above analysis was repeated using the secondary contrast (comparing the two audience conditions) as the independent variable, the only significant effects in the model were for ingroup ties, whereby participants with higher ties again reported greater self-esteem, $b = .53$, $SE = .22$, $t = 2.42$, $p = .02$, 95% CI: $.09$ and $.96$, and severity, whereby people with less severe disabilities again reported greater self-esteem, $b = -.30$, $SE = .10$, $t = -2.96$, $p = .004$, 95% CI: $-.51$ and $-.10$. No additional significant effects were found, all $ps > .12$.

Subjective health. Subjective health was then submitted to the same analysis. Beyond the significant effect of audiences on stereotypes of worthiness, severity significantly correlated with subjective health, with people with less severe physical disabilities reporting higher subjective health, $b = -.50$, $SE = .11$, $t = -4.40$, $p < .001$, 95% CI: $-.72$ and $-.27$. There were no other significant effects in this model, all $ps > .11$, although the overall model did explain a significant amount of variance in subjective health, $R^2 = .32$, $F(7,79) = 5.33$, $p < .001$. When the above analysis was repeated using the secondary contrast (comparing the two audience conditions) as the independent variable, severity once again significantly correlated with subjective health, with people with less severe physical disabilities reporting higher subjective health, $b = -.48$, $SE = .11$, $t = -4.30$, $p < .001$, 95% CI: $-.70$ and $-.26$. There was also a significant interaction effect between the secondary audience contrast and ingroup ties, $b = .40$, $SE = .20$, $t = 1.99$, $p = .05$, 95% CI: $<-.001$ and $.80$. Specifically, people in the general public condition with moderate and high ties reported higher subjective health to people in the healthcare provider condition, $b = .74$, $SE = .37$, $t = 2.02$, $p = .05$, 95% CI: $.01$ and 1.47 , and $b = 1.45$, $SE = .52$, $t = 2.76$, $p = .007$, 95% CI: $.41$ and 2.49 respectively, whereas no significant effect was observed at low ties, $b = .04$, $SE = .50$, $t = .08$, $p = .93$, 95%

CI: -.95 and 1.03 (Figure 5). No other main or interactive effects involving this contrast were observed, all $ps > .24$.

Responses to stereotypes of competence

The above set of analyses were repeated with stereotypes of competence substituted into the model as a possible mediator of audience activation effects. In all these analyses, a significant effect of the focal audience contrast on stereotypes of competence was observed, $b = -1.58$, $SE = .31$, $t = -5.18$, $p = <.001$, 95% CI: -2.19 and -.97. Participants in the healthcare provider and general public conditions expected to be viewed as significantly less competent (i.e., meta-stereotypes) in comparison to how the control group viewed the competence of other disabled people (i.e., self-stereotypes). In the analyses in which the secondary contrast was substituted (comparing the two audiences), there were no significant differences in meta-stereotypes of competence as a function of this contrast, $b = -.22$, $SE = .34$, $t = -.65$, $p = .52$, 95% CI: -.91 and .46. This suggests that meta-stereotypes of competence are not uniquely activated by one specific audience, but instead are equivalent across both. Severity did not predict stereotypes of competence, $b = -.10$, $SE = .11$, $t = -.93$, $p = .36$, 95% CI: -.32 and -.12.

Support willingness. In the analysis with support willingness as the dependent measure, severity was significantly associated with support willingness, whereby people with less severe disabilities reported being more willing to access support, $b = -.33$, $SE = .12$, $t = -2.82$, $p = .006$, 95% CI: -.56 and -.10. No further significant effects were found, all $ps > .38$. However, when all variables were entered into the model, a significant amount of variance in support willingness was explained, $R^2 = .26$, $F(7,78) = 3.84$, $p = .001$. When the analysis was repeated using the secondary contrast (comparing the two audience conditions) as the independent variable, severity once again significantly predicted support willingness, whereby people with less severe disabilities reported being more willing to access support, b

= -.32, $SE = .12$, $t = -2.71$, $p = .008$, 95% CI: -.55 and -.08, though there were no further main or interactive effects involving this contrast, all $ps > .61$.

Self-esteem. In the analysis of reported self-esteem there was a significant effect of ingroup ties, whereby participants with higher ties reported higher self-esteem, $b = .54$, $SE = .26$, $t = 2.09$, $p = .04$, 95% CI: .03 and 1.06; and severity, whereby people with less severe disabilities reported greater self-esteem, $b = -.33$, $SE = .10$, $t = -3.24$, $p = .002$, 95% CI: -.54 and -.13. There were no further significant effects, all $ps > .13$. When all variables were entered into the model, a significant amount of variance in self-esteem was explained, $R^2 = .28$, $F(7,78) = 4.42$, $p = <.001$. When the analysis was repeated using the secondary contrast (comparing the two audience conditions) as the independent variable, we found significant effects on stereotypes of competence and self-esteem, whereby improved stereotypes of competence were associated with greater self-esteem, $b = .72$, $SE = .31$, $t = 2.32$, $p = .02$, 95% CI: .10 and 1.34; ingroup ties and self-esteem, whereby participants with higher ties reported greater self-esteem, $b = .69$, $SE = .23$, $t = 3.01$, $p = .004$, 95% CI: .23 and 1.15; severity, whereby people with less severe disabilities reported greater self-esteem, $b = -.34$, $SE = .10$, $t = -3.28$, $p = .002$, 95% CI: -.54 and -.13. No effect between the secondary audience contrast and self-esteem was observed, $b = -.41$, $SE = .93$, $t = -.44$, $p = .66$, 95% CI: -2.27 and 1.45.

Qualifying these main effects, the interaction between stereotypes of competence and ingroup ties was significant, $b = -.12$, $SE = .06$, $t = -2.13$, $p = .04$, 95% CI: -.23 and -.008. This interaction is depicted in Figure 6. As can be seen, negative stereotypes of competence were associated with reduced self-esteem at low ingroup ties, $b = .35$, $SE = .16$, $t = 2.22$, $p = .03$, 95% CI: .04 and .67, whereas this effect was lessened at moderate ties, $b = .15$, $SE = .11$, $t = 1.36$, $p = .18$, 95% CI: -.07 and .36, and at high ties, $b = -.06$, $SE = .13$, $t = -.47$, $p = .64$,

95% CI: -.32 and .20. There was no interaction between the secondary contrast and ingroup ties on self-esteem, $b = .05$, $SE = .18$, $t = .28$, $p = .78$, 95% CI: -.31 and .41.

Given the presence of this interaction between the mediator (meta-stereotypes of competence) and the moderator (ingroup ties), we also explored the presence of conditional indirect pathways between audience activations and self-esteem via meta-stereotypes of competence. No significant effects were reported at any level of ingroup ties: low ties, effect = -.08, $SE = .17$, 95% CIs = -.64 and .12; moderate ties, effect = -.03, $SE = .08$, 95% CIs = -.31 and .05; high ties, effect = .01, $SE = .06$, 95% CIs = -.04 and .25. Thus although the self-esteem of participants with low ties was more connected to perceived stereotypes, this was independent of the audience activated, and how this fed into stereotypes of competence.

Subjective health. In this model, severity significantly correlated with subjective health, with people with less severe physical disabilities reporting higher subjective health, $b = -.59$, $SE = .12$, $t = -5.15$, $p < .001$, 95% CI: -.82 and -.36, though no further main effects of the predictor variables (audience contrast, stereotypes of competence, ingroup ties) were significant, all $ps > .13$. However, there was a marginal interaction between the focal contrast and ingroup ties on subjective health, $b = -.41$, $SE = .22$, $t = -1.87$, $p = .07$, 95% CI: -.85 and .03. Specifically, the slope of high ingroup ties of the focal contrast was marginal, $b = -.84$, $SE = .49$, $t = -1.72$, $p = .09$, 95% CI: -1.81 and -.13, suggesting that participants in the control condition with high ties may report higher subjective health to people in the healthcare provider and general public conditions with high ties. No effect was shown with low ties, $b = .41$, $SE = .51$, $t = .79$, $p = .43$, 95% CI: -.62 and 1.43, or moderate ties, $b = -.21$, $SE = .37$, $t = -.58$, $p = .56$, 95% CI: -.95 and .52 (Figure 4). No significant interaction effect between stereotypes of competence and ingroup ties on subjective health was observed, $b = -.04$, $SE = .07$, $t = -.56$, $p = .58$, 95% CI: -.18 and .10. When all variables were entered into the model, a

significant amount of variance of subjective health was explained, $R^2 = .33$, $F(7,78) = 5.55$, $p = <.001$.

When the analysis was repeated using the secondary contrast as the independent variable, severity once again significantly correlated with subjective health, with people with less severe physical disabilities reporting higher subjective health, $b = -.56$, $SE = .11$, $t = -4.86$, $p = <.001$, 95% CI: $-.79$ and $-.33$. The only additional significant effect was the interaction between the secondary contrast and ingroup ties on subjective health, $b = .43$, $SE = .20$, $t = 2.14$, $p = .04$, 95% CI: $.03$ and $.84$. Specifically, while the low ties slope was non-significant, $b = .08$, $SE = .50$, $t = .17$, $p = .87$, 95% CI: $-.91$ and 1.07 , the slopes of moderate and high ties were both significant, $b = .85$, $SE = .36$, $t = 2.36$, $p = .02$, 95% CI: $.13$ and 1.58 , and $b = 1.63$, $SE = .51$, $t = 3.16$, $p = .002$, 95% CI: $.60$ and 2.65 respectively. These findings suggest that participants in the general public condition with moderate or high ties reported higher subjective health to people in the healthcare provider condition with moderate or high ties (i.e., Figure 5). All other ps were recorded at $>.24$.

Responses to stereotypes of warmth

The set of analyses was repeated a third time with stereotypes of warmth substituted into the model as a possible mediator of audience activation effects. In all these analyses, the effect of the focal contrast on stereotypes of warmth was not significant, $b = -.43$, $SE = .30$, $t = -1.46$, $p = .15$, 95% CI: -1.02 and $.16$. Participants in the healthcare provider and general public conditions reported no difference in the expected meta-stereotypes of warmth to how the control group viewed the warmth of other disabled people (i.e., self-stereotypes). However, the secondary contrast on stereotypes of warmth was significant, $b = .71$, $SE = .34$, $t = 2.11$, $p = .04$, 95% CI: $.04$ and 1.38 , indicating that participants in the healthcare provider condition expected to be viewed as less warm than the general public condition. This in turn,

means that stereotypes of (low) warmth appear to be activated uniquely in relation to healthcare providers. Severity also predicted warmth, $b = -.24$, $SE = .11$, $t = -2.28$, $p = .03$, 95% CI: $-.45$ and $-.03$, suggesting that people with less severe physical disabilities expected to be seen as more warm.

Support willingness. In the analysis with support willingness as the dependent measure, severity was significantly associated with support willingness, whereby people with less severe disabilities reported being more willing to access support, $b = -.31$, $SE = .12$, $t = -2.54$, $p = .01$, 95% CI: $-.56$ and $-.07$. A marginal main effect between ingroup ties and support willingness was also shown, $b = .63$, $SE = .34$, $t = 1.84$, $p = .07$, 95% CI: $-.05$ and 1.32 , suggesting that higher ties promoted greater willingness to access support. No further significant effects were found, all $ps > .22$. When all variables were entered into the model, a significant amount of variance in support willingness was explained, $R^2 = .23$, $F(7,77) = 3.23$, $p = .005$. When the analysis was repeated using the secondary contrast (comparing the two audience conditions) as the independent variable, severity was once again significantly correlated with support willingness, whereby people with less severe disabilities reported being more willing to access support, $b = -.30$, $SE = .12$, $t = -2.44$, $p = .02$, 95% CI: $-.54$ and $-.06$. A similar marginal, positive main effect between ingroup ties and support willingness was also shown, suggesting that people with higher ties were more willing to access support, $b = .66$, $SE = .35$, $t = 1.93$, $p = .06$, 95% CI: $-.02$ and 1.35 . However, no further main or interactive effects were reported, all $ps > .11$.

Self-esteem. In this model with self-esteem as the dependent measure, a significant main effect of the audience contrast was reported, $b = -1.81$, $SE = .88$, $t = -2.05$, $p = .04$, 95% CI: -3.56 and $-.06$, suggesting that the control condition reported greater self-esteem to people in the healthcare provider or general public conditions. Severity was also significantly

correlated with self-esteem, whereby people with less severe disabilities reported greater self-esteem, $b = -.31$, $SE = .10$, $t = -2.95$, $p = .004$, 95% CI: $-.51$ and $-.10$. A marginally significant interaction effect on self-esteem between the focal audience contrast and ingroup ties was also reported, $b = .30$, $SE = .17$, $t = 1.79$, $p = .08$, 95% CI: $-.03$ and $.64$. Specifically, a significant effect at low ties was reported, $b = -.83$, $SE = .41$, $t = -2.05$, $p = .04$, 95% CI: -1.64 and $-.02$, but this effect was tempered at moderate ties, $b = -.33$, $SE = .28$, $t = -1.16$, $p = .25$, 95% CI: $-.89$ and $.23$, and non-significantly reversed at high ties, $b = .18$, $SE = .40$, $t = .44$, $p = .66$, 95% CI: $-.62$ and $.98$, suggesting that participants in the control condition with low ties report higher self-esteem to people in the two audience conditions with low ties (i.e., Figure 3). No further main or interaction effects were reported, all $ps > .26$. When all variables were entered into the model, a significant amount of variance in self-esteem was explained, $R^2 = .26$, $F(7,78) = 3.99$, $p = .001$. When the analysis was repeated using the secondary contrast (comparing the two audience conditions) as the independent variable, severity once again was significantly correlated with self-esteem, whereby people with less severe disabilities reported greater self-esteem, $b = -.32$, $SE = .10$, $t = -3.08$, $p = .003$, 95% CI: $-.53$ and $-.11$, though no further significant effects were found, all $ps > .31$.

Subjective health. In this model with subjective health as the dependent measure, severity significantly correlated with subjective health, with people with less severe physical disabilities reporting higher subjective health, $b = -.55$, $SE = .12$, $t = -4.62$, $p = <.001$, 95% CI: $-.79$ and $-.31$. A marginal interaction effect on subjective health between the focal audience contrast and ingroup ties was also reported, $b = -.34$, $SE = .20$, $t = -1.72$, $p = .09$, 95% CI: $-.72$ and $.05$. Specifically, a significant effect at high ties was reported, $b = -.91$, $SE = .46$, $t = -1.99$, $p = .05$, 95% CI: -1.83 and $.002$, but this effect was non-significant at moderate ties, $b = -.33$, $SE = .32$, $t = -1.02$, $p = .31$, 95% CI: $-.97$ and $.31$, and low ties, $b =$

.25, $SE = .46$, $t = .55$, $p = .58$, 95% CI: -.67 and 1.18, suggesting that participants in the control condition with high ties may report higher subjective health to people in the healthcare provider and general public conditions with high ties (i.e., Figure 4). No further main or interaction effects were reported, all $ps > .20$. When all variables were entered into the model, a significant amount of variance in subjective health was explained, $R^2 = .33$, $F(7,77) = 5.50$, $p = <.001$.

When the analysis was repeated using the secondary contrast (comparing the two audience conditions) as the independent variable, severity once again significantly correlated with subjective health, with people with less severe physical disabilities reporting higher subjective health, $b = -.50$, $SE = .12$, $t = -4.29$, $p = <.001$, 95% CI: -.73 and -.37. A significant interaction effect on subjective health between the audience contrast and ingroup ties was also reported, $b = .47$, $SE = .21$, $t = 2.30$, $p = .02$, 95% CI: .06 and .88. Specifically, a significant effect at high ties was reported, $b = 1.44$, $SE = .51$, $t = 2.81$, $p = .006$, 95% CI: .42 and 2.47, as well as a marginal effect at moderate ties, $b = .65$, $SE = .37$, $t = 1.76$, $p = .08$, 95% CI: -.08 and 1.38, but no significant effect at low ties was shown, $b = -.15$, $SE = .50$, $t = -.30$, $p = .76$, 95% CI: -1.15 and .85 (i.e., Figure 5), suggesting that participants in the general public condition with high and moderate ties may report higher subjective health to people in the healthcare provider condition with high and moderate ties. No further main or interaction effects were reported, all $ps > .12$.

Responses to stereotypes of passivity

The set of analyses was repeated a final time with stereotypes of passivity substituted into the model as a possible mediator of audience activation effects. In all these analyses, the effect of the focal contrast on stereotypes of passivity was not significant, $b = .03$, $SE = .30$, $t = .10$, $p = .92$, 95% CI: -.57 and .64. Participants in the healthcare provider and general

public conditions reported no difference in the expected passivity meta-stereotypes to how the control group viewed the passivity of other disabled people (i.e., self-stereotypes).

However, the secondary contrast on stereotypes of passivity was significant, $b = .73$, $SE = .34$, $t = 2.12$, $p = .04$, 95% CI: .04 and 1.41, indicating that participants in the general public condition expected to be viewed as more passive than participants in the healthcare provider condition. This in turn, means that stereotypes of passivity appear to be activated uniquely in relation to the general public. Severity was not significantly correlated with stereotypes of passivity, $b = .003$, $SE = .11$, $t = .03$, $p = .98$, 95% CI: -.21 and .22.

Support willingness. In the analysis with support willingness as the dependent measure, severity was significantly associated with support willingness, whereby people with less severe disabilities reported being more willing to access support, $b = -.35$, $SE = .12$, $t = -2.99$, $p = .004$, 95% CI: -.59 and -.12. However, no further significant effects were found, all $ps > .11$. When all variables were entered into the model, a significant amount of variance in support willingness was explained, $R^2 = .22$, $F(7,78) = 3.19$, $p = .005$. When the analysis was repeated using the secondary contrast (comparing the two audience conditions) as the independent variable, severity was again significantly associated with support willingness, whereby people with less severe disabilities reported being more willing to access support, $b = -.34$, $SE = .12$, $t = -2.88$, $p = .005$, 95% CI: -.58 and -.10. A marginal main effect between ingroup ties and support willingness was also shown, $b = .51$, $SE = .29$, $t = 1.75$, $p = .08$, 95% CI: -.07 and 1.09, suggesting that higher ties promoted greater willingness to access support. However, no further main or interactive effects were reported, all $ps > .33$.

Self-esteem. In this model with self-esteem as the dependent measure, a significant main effect of the audience contrast on self-esteem was reported, $b = -2.13$, $SE = .91$, $t = -2.34$, $p = .02$, 95% CI: -3.93 and -.32, suggesting that the control condition reported greater

self-esteem to people in the healthcare provider or general public conditions. Severity was also significantly correlated with self-esteem, whereby people with less severe disabilities reported greater self-esteem, $b = -.35$, $SE = .10$, $t = -3.34$, $p = .001$, 95% CI: $-.55$ and $-.14$. A significant interaction effect on self-esteem between the focal audience contrast and ingroup ties was also reported, $b = .35$, $SE = .18$, $t = 2.00$, $p = .05$, 95% CI: $.002$ and $.70$. Specifically, a significant effect at low ties was reported, $b = -1.03$, $SE = .43$, $t = -2.40$, $p = .02$, 95% CI: -1.88 and $-.18$, suggesting that participants in the control condition with low ties report higher self-esteem to people in the two audience conditions with low ties; but this effect was tempered at moderate ties, $b = -.42$, $SE = .29$, $t = -1.47$, $p = .15$, 95% CI: -1.00 and $.15$, and non-significantly reversed at high ties, $b = .18$, $SE = .41$, $t = .43$, $p = .67$, 95% CI: $-.64$ and 1.00 (i.e., Figure 3). No further main or interaction effects were reported, all $ps > .21$. When all variables were entered into the model, a significant amount of variance in self-esteem was explained, $R^2 = .26$, $F(7,78) = 3.99$, $p = .001$. When the analysis was repeated using the secondary contrast (comparing the two audience conditions) as the independent variable, severity once again significantly correlated with self-esteem, whereby people with less severe disabilities reported greater self-esteem, $b = -.37$, $SE = .11$, $t = -3.51$, $p < .001$, 95% CI: $-.58$ and $-.16$. However, no significant effects were found, all $ps > .31$.

Subjective health. In this model with subjective health as the dependent measure, severity significantly correlated with subjective health, with people with less severe physical disabilities reporting higher subjective health, $b = -.61$, $SE = .12$, $t = -5.26$, $p < .001$, 95% CI: $-.84$ and $-.38$. A marginal interaction effect on subjective health between the focal audience contrast and ingroup ties was also reported, $b = -.35$, $SE = .20$, $t = -1.76$, $p = .08$, 95% CI: $-.74$ and $.04$. Specifically, a significant effect at high ties was shown, $b = -1.02$, $SE = .46$, $t = -2.22$, $p = .03$, 95% CI: -1.94 and $-.11$, but this effect was lessened at moderate ties, b

= -.42, $SE = .32$, $t = -1.30$, $p = .20$, 95% CI: -1.06 and .22, and low ties, $b = .19$, $SE = .48$, $t = .39$, $p = .70$, 95% CI: -.77 and 1.14, suggesting that participants in the control condition with high ties report improved subjective health to people in the two audience conditions with high ties (i.e., Figure 4). No further main or interaction effects were reported, all $ps > .22$. When all variables were entered into the model, a significant amount of variance in subjective health was explained, $R^2 = .32$, $F(7,78) = 5.24$, $p = <.001$.

When the analysis was repeated using the secondary contrast (comparing the two audience conditions) as the independent variable, severity was once again significantly correlated with subjective health, with people with less severe physical disabilities reporting higher subjective health, $b = -.57$, $SE = .11$, $t = -4.98$, $p = <.001$, 95% CI: -.80 and -.34. A significant interaction effect on subjective health between the secondary audience contrast and ingroup ties was also reported, $b = .42$, $SE = .21$, $t = 2.03$, $p = .05$, 95% CI: .008 and .83. Specifically, significant effects at moderate ties, $b = .82$, $SE = .37$, $t = 2.21$, $p = .03$, 95% CI: .08 and 1.57, and high ties were reported, $b = 1.56$, $SE = .54$, $t = 2.92$, $p = .005$, 95% CI: .50 and 2.63, but no significant effect at low ties was shown, $b = .09$, $SE = .50$, $t = .17$, $p = .86$, 95% CI: -.91 and 1.09, suggesting that participants in the general public condition with moderate and high ties may report higher subjective health to people in the healthcare provider condition with moderate and high ties (i.e., Figure 5). No further main or interaction effects were reported, all $ps > .26$.

APPENDIX E: STUDY 4 SURVEY

Section 1: More about you

In this first section we would like to know a little bit more about you.

What is your gender?

What is your age?

How would you describe your race/ethnicity? For example: White, Black, Asian, Mixed etc.

What is your nationality?

What is your physical disability?

Which category or categories would you classify your physical disability?

Mobility disability

Spinal cord disability

Brain disability or injury

Visual disability

Hearing disability

Cognitive disability

1= Not at all, 7= Completely:

On a normal day, how visible do you think your disability is?

On a normal day, how severe do you think your disability is?

On a normal day, to what extent do you need assistive devices to help you get around e.g., wheelchair, cane?

On a normal day, to what extent do you need assistive devices to help you complete activities?

On a normal day, to what extent does your disability impact on day-to-day activities?

On a normal day, to what extent does your disability impact on your everyday life?

Section 2i: Stereotyping manipulation

Healthcare provider condition: The purpose of this survey is to collect information about physically disabled people's experiences so that we can feed on information to healthcare providers. This is important because we hope to provide this group with a better understanding of the experiences of disabled people.

We would like to know more about how you think individuals with your disability are seen by healthcare providers. Below is a list of descriptive terms that are commonly used to describe people. Please read this list. In your opinion, how likely are healthcare providers to use these terms to describe people with your disability?

Your thoughts are important to us regardless of how often you interact with healthcare providers. Do not worry if you are unsure about your answer, there are no right or wrong answers here, so your first response is probably the right one.

Employer/educator condition: The purpose of this survey is to collect information about physically disabled people's experiences so that we can feed on information to employers and educational bodies. This is important because we hope to provide these

groups with a better understanding of the experiences of disabled people. We would like to know more about how you think individuals with your disability are seen by employers or educators (such as teachers or lecturers). Below is a list of descriptive terms that are commonly used to describe people. Please read this list. In your opinion, how likely are employers or educators to use these terms to describe people with your disability?

Your thoughts are important to us regardless of whether you are currently in work or education or not. Do not worry if you are unsure about your answer, there are no right or wrong answers here, so your first response is probably the right one.

Control condition: The purpose of this survey is to collect information about physically disabled people's experiences in order to gain a better understanding of disability.

First we would like to know more about how you see individuals with your disability. Below is a list of descriptive terms that are commonly used to describe people. Please read this list. In your opinion, how descriptive are these terms of people with your disability in general?

Your thoughts are important to us regardless of how often you interact with people with your disability. Do not worry if you are unsure about your answer, there are no right or wrong answers here, so your first response is probably the right one.

All participants

1= Not at all likely, 2= Very Unlikely, 3= Unlikely, 4= Neither Unlikely nor Likely, 5= Likely, 6= Very Likely, 7= Completely

Competence: Fit, Active, Strong, Intelligent, Knowledgeable, Clever, Capable, Competent, Skillful, Confident

Warmth: Warm, Friendly, Likeable, Trustworthy, Good-natured

Passivity: Passive, Shy, Timid, Hesitant

Worthiness: Worthy, Legitimate, Deserving.

Now, please read this list again and this time rate how much each of these words describes you right now. Again, do not worry if you are unsure about your answer, there are no right or wrong answers here, so your first response is probably the right one¹⁷.

Aside from these specific terms, how do you feel about yourself overall? Please read the statements below and rate the extent to which you agree or disagree with them.

1=Strongly disagree, 2= Moderately disagree, 3=Slightly disagree, 4=Neither disagree nor agree, 5=Slightly agree, 6=Moderately agree, 7=Strongly agree.

In general, I feel I am a physically competent person.

In general, I feel I am an intellectually competent person.

In general, I feel I am a competent person overall.

In general, I feel I am a warm person.

In general, I feel I am a passive person.

In general, I feel I am a deserving person¹⁸.

¹⁷ All participants were presented with the above list of terms, and asked to judge how much each term described their current feelings (i.e., self-stereotypes). The list was randomised for each participant. However, this self-stereotyping measure was not included in the final analyses.

Section 2ii: Health manipulation

Healthcare provider condition: Now we would like you to think about how your physical disability affects you. Specifically, we are interested in providing healthcare providers with an impression of how your disability affects your daily life. Please read the statements below and rate the extent to which you agree or disagree with them.

Employer/Educator condition: Now we would like you to think about how your physical disability affects you. Specifically, we are interested in providing employers and educational bodies with an impression of how your disability affects your daily life. Please read the statements below and rate the extent to which you agree or disagree with them.

Control condition: Now we would like you to think about how your physical disability affects you. Please read the statements below and rate the extent to which you agree or disagree with them.

All participants

1=Strongly disagree, 2= Moderately disagree, 3=Slightly disagree, 4=Neither disagree nor agree, 5=Slightly agree, 6=Moderately agree, 7=Strongly agree.

On a normal day:

I can walk indoors and outdoors independently

I climb stairs independently

I can perform gross motor skills including running and jumping independently

My balance and coordination are unimpaired

I can complete everyday tasks such as eating, dressing or bathing independently.

I can prepare a meal independently.

I can reach for, lift and hold heavy objects independently.

I can complete difficult manual tasks independently.

Most of the things I do in everyday life I can do independently.

Most of the things I do in everyday life I require assistance from others¹⁹.

1= Not at all, 7= Completely

How dependent are you on assistive devices to help you get around?

How dependent are you on assistive devices to help you complete activities?

Aside from these specific issues, how do you feel about your health in general?

My overall health is: very poor – very good.

1= Strongly Disagree, 7= Strongly Agree:

In general I feel tired

In general I feel ill

In general I feel able

In general I feel in pain

In general I feel in control of my health.

¹⁸ In this study, in order to further assess self-stereotyping behaviour, we asked them six additional statements reflecting the stereotypes they had just read. However, this additional measure was also not included in the final analyses.

¹⁹ Like in Study 2, the statements reflecting participants' mobility (i.e., "On a normal day, I can walk indoors and outdoors independently" to "Most of the things I do in everyday life I require assistance from others") were not included in our final analysis.

Section 3: Identity, support, and well-being

Now we would like to know a little bit more about how you feel about yourself in relation to other people who also have your disability. Please read the statements below and rate how much you agree that they describe you.

1= Strongly Disagree – 7= Strongly Agree:

I feel connected with other people who also have my disability

I feel strong ties with other people who also have my disability

I feel a bond with other people who also have my disability.

I am very similar to the average adult who also has my disability

I have a lot in common with other adults who also have my disability

I am quite typical of adults with my disability

I feel my disability is a central part of my identity

I often think about the fact that I have my disability

In general, being a person with my disability is an important part of my self-image²⁰.

On the whole, I am satisfied with myself

I feel I have a number of good qualities

I take a positive attitude towards myself

At the moment, I am pleased to be a person with my disability

At the moment, I have a good feeling about being person with my disability.

At the moment, I am satisfied about the fact that I am a person with my disability²¹.

I can always manage to solve difficult problems if I try hard enough.

It is easy for me to stick to my aims and accomplish my goals.

I am confident that I could deal efficiently with unexpected events.

I can solve most problems if I invest the necessary effort.

If I am in trouble, I can usually think of a solution.

At the moment I have access to the support I need to help with my disability.

In general, I feel able to access the support I need to help with my disability.

In general, I feel willing to access the support I need to help with my disability.

In general, I feel comfortable about accessing the support I need to help with my disability.

In general, I feel happy about accessing the support I need to help with my disability.

Section 4: Identity performance manipulation

Healthcare provider condition: Lastly, we would like you to think again about your experiences with healthcare providers. When interacting with these people, do you ever feel, or have you ever felt any of the following things? Again, your thoughts are important to us regardless of how often you interact with healthcare providers.

Employer/educator condition: Lastly, we would like you to think again about your experiences with employers or educators. When interacting with these people, do you ever feel, or have you ever felt any of the following things? Again, your thoughts are important to us regardless of whether you are currently in work or education or not.

²⁰ Like in Study 3, the above statements assess ingroup ties, ingroup prototypicality, and ingroup centrality, however, only the statements assessing ingroup ties were included in the final analyses.

²¹ Also like in Study 3, the above statements assess both self-esteem and collective self-esteem, however, only the statements assessing self-esteem were included in the final analyses.

Control condition: Lastly, we would like you to think again about your experiences. When interacting with others, do you ever feel, or have you ever felt any of the following things?

All participants

1= Not at all, 2= Very Slightly, 3= Slightly, 4= Somewhat, 5= Moderately, 6= Very Much, 7= Completely

Pressure to accentuate my abilities.

Pressure to downplay my abilities.

Pressure to confirm stereotypes held about me.

Pressure to disconfirm stereotypes held about me.

People expect me to act in particular ways.

Looking back at the answers you gave to the set of statements above, can you tell us a little more about what you were thinking when you answered?

To what extent do you access support to help with your disability?

To what extent do you experience discrimination because of your disability?

1= Not at all, 2= Very rarely, 3= Rarely, 4= Occasionally, 5= Fairly Frequently, 6= Frequently, 7= Very frequently

APPENDIX F: STUDY 4 PROCESS RESULTS

Responses to stereotypes of worthiness

Across all analyses involving stereotypes of worthiness, people in the healthcare provider and educator/employer audiences reported significantly more negative stereotypes of worthiness (meta-stereotypes) compared to people in the control condition (self-stereotypes), $b = -.92$, $SE = .23$, $t = -4.01$, $p = <.001$, 95% CI: -1.37 and -.46. When substituting the secondary contrast (the healthcare provider audience versus the educator/employer audience, ignoring the influence of the control condition), into these analyses, no significant effect was found, $b = .38$, $SE = .25$, $t = 1.52$, $p = .13$, 95% CI: -.11 and .86. This suggests that healthcare providers and educators/employers do not differ in their activations of stereotypes of worthiness. To avoid repetition, severity was not a significant predictor of stereotypes of worthiness in any model, all $ps = >.12$.

Support willingness. In the analysis with support willingness as the dependent measure, no significant effects were found, all $ps > .10$. However, with all variables entered into the model, a significant amount of support willingness variance was explained, $R^2 = .10$, $F(7,136) = 2.07$, $p = .05$. When the analysis was repeated using the secondary contrast (comparing the two audience conditions) as the independent variable, again, no significant effects were reported, all $ps > .11$.

Self-esteem. When including self-esteem as the dependent variable, the focal contrast was not significantly correlated with self-esteem, $b = .43$, $SE = .72$, $t = .61$, $p = .55$, 95% CI: -.98 and 1.85. There were, however, significant effects on self-esteem from stereotypes of worthiness, $b = .55$, $SE = .22$, $t = 2.50$, $p = .01$, 95% CI: .11 and .98, and ingroup ties, $b = .46$,

$SE = .20, t = 2.29, p = .02, 95\% \text{ CI: } .06 \text{ and } .85$. These findings highlight that more positive stereotypes of worthiness and stronger ingroup ties were associated with increased individual self-esteem. Severity also predicted self-esteem, suggesting that people with less severe physical disabilities report increased self-esteem, $b = -.36, SE = .10, t = -3.43, p = <.001, 95\% \text{ CI: } -.56 \text{ and } -.15$.

Beyond these main effects, there was no significant interaction between the focal audience contrast and ingroup ties on self-esteem, $b = -.07, SE = .14, t = -.50, p = .62, 95\% \text{ CI: } -.35 \text{ and } .21$. However, the interaction between stereotypes of worthiness and ingroup ties on self-esteem was significant, $b = -.09, SE = .04, t = -2.07, p = .04, 95\% \text{ CI: } -.18 \text{ and } -.004$. Participants with low ties reported significantly less self-esteem in response to stereotypes of unworthiness, $b = .25, SE = .10, t = 2.38, p = .02, 95\% \text{ CI: } .04 \text{ and } .45$. This effect was not present among individuals with moderate, $b = .10, SE = .09, t = 1.19, p = .24, 95\% \text{ CI: } -.07 \text{ and } .28$, or high ties, $b = -.04, SE = .12, t = -.35, p = .73, 95\% \text{ CI: } -.28 \text{ and } .20$ (Figure 7). This suggests that the self-esteem of individuals with low ties was more contingent on the activated meta-stereotype, whereas participants with higher ties were largely protected from these negative meta-stereotypes.

Given the presence of this interaction between the mediator (meta-stereotypes of worthiness) and the moderator (ingroup ties), we also explored the presence of conditional indirect pathways between audience activations and self-esteem via meta-stereotypes of worthiness. Indeed, there was a significant conditional indirect effect for participants with low ties to the group, effect = $-.24, SE = .12, 95\% \text{ CIs} = -.57 \text{ and } -.05$. This was not present at moderate ties, effect = $-.09, SE = .09, 95\% \text{ CIs} = -.31 \text{ and } .07$, or high ties, effect = $.05, SE = .13, 95\% \text{ CIs} = -.17 \text{ and } .34$ (Figure 8). This suggests that healthcare provider and educator/employer audiences activated stereotypes of unworthiness, which then compromised

the self-esteem of individuals who were less (but not more) tied to the disabled group. With all variables entered, the full model explained a significant amount of variance in self-esteem, $R^2 = .12$, $F(7,136) = 2.72$, $p = .01$.

When the analysis was repeated using the secondary contrast (comparing the two audience conditions) as the independent variable, significant main effects were observed between meta-stereotypes of worthiness and self-esteem, $b = .51$, $SE = .21$, $t = 2.40$, $p = .02$, 95% CI: .09 and .93, ingroup ties and self-esteem, $b = .41$, $SE = .19$, $t = 2.15$, $p = .03$, 95% CI: .03 and .79, and severity and self-esteem, $b = -.34$, $SE = .10$, $t = -3.39$, $p = <.001$, 95% CI: -.54 and .14. These findings highlight that more positive stereotypes of worthiness, stronger ingroup ties, and people with less severe physical disabilities were associated with increased individual self-esteem.

A significant interaction between stereotypes of worthiness and ingroup ties on self-esteem was also reported, $b = -.08$, $SE = .04$, $t = -1.95$, $p = .05$, 95% CI: -.16 and .001 (i.e., Figure 7). No further main or interaction effects were reported, all $ps > .79$. We also again explored the presence of conditional indirect pathways between audience activations and self-esteem via meta-stereotypes of worthiness. There was a significant conditional indirect effect for participants with low ties to the group, effect = .09, $SE = .07$, 95% CIs = .004 and .31. This was not present at moderate ties, effect = .04, $SE = .05$, 95% CIs = -.02 and .20, or high ties, effect = -.01, $SE = .06$, 95% CIs = -.17 and .07 (i.e., Figure 8). This suggests that while healthcare provider and educator/employer audiences activated stereotypes of unworthiness, which then compromised the self-esteem of individuals who were less (but not more) tied to the disabled group (i.e., in the focal contrast), people in the healthcare provider condition are particularly negatively affected.

Self-efficacy. When including self-efficacy as the dependent variable at the focal contrast level, self-efficacy was marginally correlated with stereotypes of worthiness, $b = .48$, $SE = .26$, $t = 1.84$, $p = .07$, 95% CI: $-.04$ and 1.00 , and self-reported severity, $b = -.22$, $SE = .12$, $t = -1.75$, $p = .08$, 95% CI: $-.46$ and $.03$, suggesting that more positive stereotypes of worthiness and less severe disabilities were associated with increased self-efficacy. No further significant main effects on self-efficacy were reported, all $ps = > .14$.

Beyond these main effects, there was no interaction between stereotypes of worthiness and ingroup ties on self-efficacy, $b = -.08$, $SE = .05$, $t = -1.58$, $p = .12$, 95% CI: $-.19$ and $.02$, though there was a marginal interaction between the focal audience contrast and ingroup ties on self-efficacy, $b = .31$, $SE = .17$, $t = 1.83$, $p = .07$, 95% CI: $-.03$ and $.65$. Specifically, the slope of high ingroup ties of the focal contrast was significant, $b = 1.09$, $SE = .44$, $t = 2.46$, $p = .02$, 95% CI: $.21$ and 1.97 , suggesting that participants in the healthcare and educator/employer conditions with high ties report higher self-efficacy to people in the control with high ties. No effect was shown with low ties, $b = -.35$, $SE = .38$, $t = -.91$, $p = .37$, 95% CI: -1.10 and $.41$, or moderate ties, $b = .37$, $SE = .30$, $t = 1.24$, $p = .22$, 95% CI: $-.22$ and $.97$ (Figure 9). With all variables entered, the full model explained a significant amount of variance in self-efficacy, $R^2 = .12$, $F(7,135) = 2.96$, $p = .007$.

The same analysis on self-efficacy at the secondary contrast level again showed that stereotypes of worthiness were positively correlated with self-efficacy, $b = .60$, $SE = .25$, $t = 2.36$, $p = .02$, 95% CI: $.10$ and 1.10 , and severity was negatively correlated, $b = -.26$, $SE = .12$, $t = -2.13$, $p = .04$, 95% CI: $-.50$ and $-.02$. Thus, the more worthy participants thought their group was (perceived to be), and the less severe their disability, the greater their self-efficacy. However, no further main effects were found, all $ps = > .20$.

There was also no significant interaction between the secondary audience contrast and ingroup ties on self-efficacy, $b = -.15$, $SE = .18$, $t = -.83$, $p = .41$, 95% CI: $-.51$ and $.21$, but there was a significant interaction between stereotypes of worthiness and ingroup ties on self-efficacy, $b = -.11$, $SE = .05$, $t = -2.17$, $p = .03$, 95% CI: $-.21$ and $-.009$. Similar to the effect on self-esteem, among participants with the weakest ties to the ingroup, self-efficacy was most strongly affected by stereotypes of worthiness, $b = .26$, $SE = .13$, $t = 2.03$, $p = .04$, 95% CI: $.007$ and $.50$, whereas self-efficacy among participants with moderate and stronger ingroup ties was unaffected by stereotypes of worthiness, $b = .05$, $SE = .11$, $t = .48$, $p = .63$, 95% CI: $-.16$ and $.26$, and $b = -.15$, $SE = .15$, $t = -1.03$, $p = .31$, 95% CI: $-.45$ and $.14$, respectively (Figure 10).

From this, we again explored conditional indirect pathways between audiences and self-efficacy via activated stereotypes, however none of these pathways were significant: low ingroup ties effect = $.08$, $SE = .07$, 95% CIs = $-.02$ and $.28$; moderate ingroup ties effect = $.02$, $SE = .04$, 95% CIs = $-.05$ and $.14$; high ingroup ties effect = $-.04$, $SE = .06$, 95% CIs = $-.21$ and $.03$. Thus although the self-efficacy of participants with low ties was more connected to perceived stereotypes, this was independent of the audience activated and how this fed into stereotypes of worthiness. With all variables entered, the full model explained a significant amount of variance in self-efficacy, $R^2 = .12$, $F(7,135) = 2.53$, $p = .02$.

Subjective health. The analysis of subjective health revealed a marginal effect of stereotypes of worthiness, suggesting that participants reporting more positive stereotypes of worthiness also experienced better subjective health, $b = .33$, $SE = .17$, $t = 1.92$, $p = .06$, 95% CI: $-.01$ and $.67$. Self-reported severity was also significantly correlated with subjective health, suggesting that people with less severe disabilities reported better subjective health, $b = -.53$, $SE = .08$, $t = -6.55$, $p < .001$, 95% CI: $-.70$ and $-.37$. However, no further significant

main or interactive effects were found, all $ps > .11$. With all variables entered into the model, a significant amount of variance on subjective health was explained, $R^2 = .27$, $F(7,136) = 7.17$, $p = <.001$. When the analysis was repeated using the secondary contrast (comparing the two audience conditions) as the independent variable, again, a marginal effect of stereotypes of worthiness on subjective health was shown, $b = .32$, $SE = .17$, $t = 1.92$, $p = .06$, 95% CI: $-.01$ and $.66$, and a significant effect for severity, $b = -.53$, $SE = .08$, $t = -6.65$, $p = <.001$, 95% CI: $-.69$ and $-.37$, again suggesting that more positive stereotypes of worthiness and less severe disabilities were associated with increased subjective health. However, no further significant effects were reported, all $ps > .10$.

Responses to stereotypes of competence

Across all analyses involving stereotypes of competence, people in the healthcare provider and educator/employer audiences did not report significant changes to the stereotypes of competence (meta-stereotypes) compared to people in the control condition (self-stereotypes), $b = -.26$, $SE = .18$, $t = -1.45$, $p = .15$, 95% CI: $-.60$ and $.09$. When substituting the secondary contrast (the healthcare provider audience versus the educator/employer audience, ignoring the influence of the control condition), into these analyses, again, no significant effect was found, $b = -.18$, $SE = .19$, $t = -.97$, $p = .34$, 95% CI: $-.56$ and $.19$. To avoid repetition, severity was a marginal predictor of stereotypes of competence across all models, suggesting that stereotypes of increased competence were associated with participants with *more severe* disabilities, $b = .15$, $SE = .08$, $t = 1.92$, $p = .06$, 95% CI: $-.004$ and $.29$.

Support willingness. In the analysis with support willingness as the dependent measure, no significant effects were found, all $ps > .30$. However, with all variables entered into the model, a marginal amount of support willingness variance was explained, $R^2 = .9$,

$F(7,137) = 1.88, p = .08$. When the analysis was repeated using the secondary contrast (comparing the two audience conditions) as the independent variable, again, no significant effects were reported, all $ps > .27$.

Self-esteem. When including self-esteem as the dependent variable, the focal contrast was not significantly correlated with self-esteem, $b = .07, SE = .68, t = .11, p = .92, 95\% CI: -1.28$ and 1.42 . However, significant effects on self-esteem were reported from stereotypes of competence, $b = .68, SE = .28, t = 2.45, p = .02, 95\% CI: .13$ and 1.23 , ingroup ties, $b = .44, SE = .22, t = 1.99, p = .05, 95\% CI: .004$ and $.88$, and severity, $b = -.36, SE = .10, t = -3.45, p = <.001, 95\% CI: -.56$ and $-.15$. These findings highlight that more positive stereotypes of competence, stronger ingroup ties, and less severe disabilities were associated with increased individual self-esteem.

Beyond these main effects, there was no significant interaction between the focal audience contrast and ingroup ties on self-esteem, $b = <.001, SE = .14, t = .005, p = >.99, 95\% CI: -.27$ and $.27$. However, the interaction between stereotypes of competence and ingroup ties on self-esteem was marginal, $b = -.10, SE = .05, t = -1.79, p = .08, 95\% CI: -.20$ and $.01$. Participants with low ties reported significantly less self-esteem in response to stereotypes of incompetence, $b = .37, SE = .14, t = 2.72, p = .007, 95\% CI: .10$ and $.64$, whereas this effect was marginal for people with moderate ties, $b = .20, SE = .11, t = 1.79, p = .08, 95\% CI: -.02$ and $.42$, but non-significant for high ties, $b = .03, SE = .16, t = .20, p = .85, 95\% CI: -.28$ and $.34$ (Figure 11). This suggests that the self-esteem of individuals with low and moderate ties was more contingent on the activated meta-stereotype, whereas participants with higher ties were largely protected from these negative meta-stereotypes.

Given the presence of this marginal interaction between the mediator (meta-stereotypes of competence) and the moderator (ingroup ties), we also explored the presence

of conditional indirect pathways between audience activations and self-esteem via stereotypes of competence. However, none of these pathways were significant: low ingroup ties effect = $-.09$, $SE = .08$, 95% CIs = $-.31$ and $.02$; moderate ingroup ties effect = $-.05$, $SE = .06$, 95% CIs = $-.23$ and $.01$; high ingroup ties effect = $-.008$, $SE = .06$, 95% CIs = $-.17$ and $.08$. This suggests that although the self-esteem of participants with low ties was more connected to perceived stereotypes, this was independent of the audience activated and how this fed into stereotypes of competence. With all variables entered, the full model explained a significant amount of variance in self-esteem, $R^2 = .12$, $F(7,137) = 2.74$, $p = .01$.

When the analysis was repeated using the secondary contrast (comparing the two audience conditions) as the independent variable, significant main effects were observed between meta-stereotypes of competence and self-esteem, $b = .70$, $SE = .28$, $t = 2.53$, $p = .01$, 95% CI: $.15$ and 1.25 , ingroup ties and self-esteem, $b = .45$, $SE = .22$, $t = 2.04$, $p = .04$, 95% CI: $.01$ and $.88$, and severity and self-esteem, $b = -.36$, $SE = .10$, $t = -3.50$, $p < .001$, 95% CI: $-.56$ and $-.15$. These findings again highlight that more positive stereotypes of competence, stronger ingroup ties, and less severe disabilities were associated with increased individual self-esteem.

A marginally significant interaction between stereotypes of competence and ingroup ties on self-esteem was also found, $b = -.10$, $SE = .05$, $t = -1.85$, $p = .07$, 95% CI: $-.20$ and $.007$ (i.e., Figure 11). No further main or interaction effects were reported, all $ps > .49$. We also again explored the presence of conditional indirect pathways between audience activations and self-esteem via meta-stereotypes of competence. However, once again, no significant effects were observed: low ties effect = $-.07$, $SE = .08$, 95% CIs = $-.27$ and $.05$; moderate ties effect = $-.04$, $SE = .05$, 95% CIs = $-.18$ and $.02$; high ties, effect = $-.005$, $SE = .04$, 95% CIs = $-.13$ and $.06$.

Self-efficacy. When including self-efficacy as the dependent variable at the focal contrast level, self-efficacy was significantly correlated with the focal contrast, $b = -1.59$, $SE = .81$, $t = -1.97$, $p = .05$, 95% CI: -3.19 and .004, and marginally with severity, $b = -.23$, $SE = .12$, $t = -1.85$, $p = .07$, 95% CI: -.47 and .02, suggesting that people in the control condition and with less severe disabilities were associated with increased self-efficacy. No further significant main effects on self-efficacy were reported, all $ps = >.13$.

Beyond these main effects, there was also no significant interaction between stereotypes of competence and ingroup ties on self-efficacy, $b = -.05$, $SE = .06$, $t = -.83$, $p = .41$, 95% CI: -.18 and .07, though there was a significant interaction between the focal audience contrast and ingroup ties on self-efficacy, $b = .38$, $SE = .16$, $t = 2.40$, $p = .02$, 95% CI: .07 and .70. Specifically, the high ingroup ties slope of the focal contrast was significant, $b = 1.05$, $SE = .43$, $t = 2.46$, $p = .02$, 95% CI: .20 and 1.89, suggesting that participants in the healthcare provider and educator/employer conditions with high ties reported higher self-efficacy to people in the control with high ties. No effect was shown with low ties, $b = -.36$, $SE = .37$, $t = -.98$, $p = .33$, 95% CI: -1.09 and .37, or moderate ties, $b = .34$, $SE = .28$, $t = 1.21$, $p = .23$, 95% CI: -.22 and .90 (i.e., Figure 9). With all variables entered, the full model explained a significant amount of variance in self-efficacy, $R^2 = .14$, $F(7,136) = 3.07$, $p = .005$.

The same analysis on self-efficacy at the secondary contrast level showed that stereotypes of competence were marginally correlated with self-efficacy, $b = .62$, $SE = .33$, $t = 1.87$, $p = .06$, 95% CI: -.03 and 1.28, and severity was significantly correlated with self-efficacy, $b = -.28$, $SE = .12$, $t = -2.30$, $p = .02$, 95% CI: -.52 and -.04. Thus, the more positive meta-stereotypes of competence, and participants with less severe disabilities, the greater their self-efficacy. However, no further effects were found, all $ps = >.18$.

Subjective health. When including subjective health as the dependent variable, significant main effects were observed with stereotypes of competence, $b = .48$, $SE = .22$, $t = 2.21$, $p = .03$, 95% CI: .05 and .91, and severity, $b = -.54$, $SE = .08$, $t = -6.55$, $p = <.001$, 95% CI: -.70 and -.38, which highlights that more positive stereotypes of competence and less severe disabilities were associated with increased subjective health; all other main effect $ps = >.16$.

Beyond this main effect on subjective health, there was no interaction between the focal audience contrast and ingroup ties on subjective health, $b = -.005$, $SE = .11$, $t = -.05$, $p = .96$, 95% CI: -.21 and .20. However, the interaction between stereotypes of competence and ingroup ties on subjective health was marginal, $b = -.07$, $SE = .04$, $t = -1.78$, $p = .08$, 95% CI: -.16 and .008. Participants with low ties reported being significantly reduced subjective health in response to stereotypes of incompetence, $b = .24$, $SE = .11$, $t = 2.23$, $p = .03$, 95% CI: .03 and .44, whereas this effect was not shown for people with moderate ties, $b = .11$, $SE = .09$, $t = 1.21$, $p = .23$, 95% CI: -.07 and .28, or high ties, $b = -.03$, $SE = .12$, $t = -.21$, $p = .83$, 95% CI: -.27 and .21 (Figure 12). This suggests that the subjective health of individuals with low ties was more contingent on the activated meta-stereotype, whereas participants with higher ties were largely protected from these negative meta-stereotypes.

Given the presence of this marginal interaction between the mediator (meta-stereotypes of competence) and the moderator (ingroup ties), we also explored the presence of conditional indirect pathways between audience activations and subjective health via stereotypes of competence. However, none of these pathways were significant: low ingroup ties effect = $-.06$, $SE = .06$, 95% CIs = $-.24$ and $.01$; moderate ingroup ties effect = $-.03$, $SE = .04$, 95% CIs = $-.14$ and $.03$; high ingroup ties effect = $.007$, $SE = .06$, 95% CIs = $-.07$ and $.19$. Thus although the subjective health of participants with low ties was more connected to

perceived stereotypes, this was independent of the audience activated and how this fed into stereotypes of competence. With all variables entered, the full model explained a significant amount of variance in subjective health, $R^2 = .27$, $F(7,137) = 7.42$, $p = <.001$.

When the analysis was repeated using the secondary contrast (comparing the two audience conditions) as the independent variable, the only significant main effect was with stereotypes of competence and subjective health, $b = .48$, $SE = .22$, $t = 2.21$, $p = .03$, 95% CI: .05 and .91, and with severity and subjective health, $b = -.54$, $SE = .08$, $t = -6.79$, $p = <.001$, 95% CI: -.70 and -.38, which highlights that more positive stereotypes of competence and less severe disabilities were associated with increased subjective health; all other main effect $ps = >.15$.

Beyond this main effect on subjective health, there was no significant interaction between the secondary audience contrast and ingroup ties on subjective health, $b = -.004$, $SE = .12$, $t = -.03$, $p = .97$, 95% CI: -.23 and .23. However, the interaction between stereotypes of competence and ingroup ties on subjective health was again marginal, $b = -.07$, $SE = .04$, $t = -1.78$, $p = .08$, 95% CI: -.16 and .008 (i.e., Figure 12). We also again explored the presence of conditional indirect pathways between audience activations and subjective health via meta-stereotypes of competence. However, once again, no significant effects were observed: low ties effect = $-.04$, $SE = .05$, 95% CIs = $-.20$ and $.03$; moderate ties effect = $-.02$, $SE = .03$, 95% CIs = $-.13$ and $.01$; high ties, effect = $.005$, $SE = .04$, 95% CIs = $-.05$ and $.12$.

Responses to stereotypes of warmth

Across all analyses involving stereotypes of warmth, people in the healthcare provider and educator/employer audiences did not report significant changes to activated stereotypes of warmth (meta-stereotypes) compared to people in the control condition (self-stereotypes), $b = -.27$, $SE = .19$, $t = -1.42$, $p = .16$, 95% CI: $-.66$ and $.11$. Moreover, when substituting the

secondary contrast (the healthcare provider audience versus the educator/employer audience, ignoring the influence of the control condition), into these analyses, again, no significant effect was found, $b = .33$, $SE = .21$, $t = 1.60$, $p = .11$, 95% CI: $-.08$ and $.74$. To avoid repetition, severity was a significant predictor of stereotypes of warmth across all models, with more positive stereotypes of warmth being associated with participants with *more severe* disabilities, $b = .23$, $SE = .08$, $t = 2.78$, $p = .006$, 95% CI: $.07$ and $.39$.

Support willingness. In the analysis with support willingness as the dependent measure, severity produced a marginal effect with support willingness, suggesting that those with less severe disabilities were more willing to access support, $b = -.22$, $SE = .12$, $t = -1.88$, $p = .06$, 95% CI: $-.44$ and $.01$. However, no further significant effects were found, all $ps > .20$. With all variables entered into the model, a marginal amount of support willingness variance was explained, $R^2 = .9$, $F(7,136) = 1.86$, $p = .08$. When the analysis was repeated using the secondary contrast (comparing the two audience conditions) as the independent variable, again, severity produced a marginal effect on support willingness, suggesting that those with less severe disabilities were more willing to access support, $b = -.19$, $SE = .11$, $t = -1.73$, $p = .09$, 95% CI: $-.42$ and $.03$, but all other effects were non-significant, all $ps > .30$.

Self-esteem. When including self-esteem as the dependent variable, the focal contrast was not significantly correlated with self-esteem, $b = .23$, $SE = .73$, $t = .32$, $p = .75$, 95% CI: -1.22 and 1.68 . However, ingroup ties were significantly correlated with self-esteem, $b = .60$, $SE = .31$, $t = 1.94$, $p = .05$, 95% CI: $-.01$ and 1.20 , as was severity, $b = -.32$, $SE = .10$, $t = -3.05$, $p = .003$, 95% CI: $-.53$ and $-.11$, and stereotypes of warmth were marginally correlated with self-esteem, $b = .58$, $SE = .33$, $t = 1.75$, $p = .08$, 95% CI: $-.08$ and 1.24 . These findings highlight that more positive stereotypes of warmth, stronger ingroup ties and reduced disability severity were associated with increased individual self-esteem.

Beyond these main effects, there was no interaction between the focal audience contrast and ingroup ties on self-esteem, $b = -.04$, $SE = .14$, $t = -.26$, $p = .80$, 95% CI: $-.32$ and $.25$. However, the interaction between stereotypes of warmth and ingroup ties on self-esteem was marginal, $b = -.11$, $SE = .06$, $t = -1.79$, $p = .08$, 95% CI: $-.23$ and $.01$. However, no significant moderation effects were reported at any level of ingroup ties: low ties, $b = .22$, $SE = .15$, $t = 1.42$, $p = .16$, 95% CI: $-.09$ and $.51$; moderate ties, $b = .03$, $SE = .10$, $t = .33$, $p = .74$, 95% CI: $-.17$ and $.24$; high ties, $b = -.15$, $SE = .14$, $t = -1.06$, $p = .29$, 95% CI: $-.42$ and $.13$ (Figure 13). This suggests that although neither of the low ties or high ties simple slopes were significant, their respective patterns suggest that self-esteem was contingent on the activated stereotype, whereby individuals with low ties appeared to absorb negative stereotypes, whereas participants with higher ties appeared to reject the negative stereotypes.

Consistent with the marginal nature of the interaction, and the lack of significant simple effects, there were no significant conditional indirect effects connecting audience, stereotypes of warmth, and self-esteem at any level of ingroup ties: low identifiers effect = $-.06$, $SE = .08$, 95% CIs = $-.34$ and $.02$; moderate identifiers effect = $-.01$, $SE = .04$, 95% CIs = $-.16$ and $.04$; high identifiers effect = $.04$, $SE = .06$, 95% CIs = $-.02$ and $.26$. With all variables entered, the full model explained a significant amount of variance in self-esteem, $R^2 = .10$, $F(7,136) = 2.09$, $p = .05$.

When the analysis was repeated using the secondary contrast (comparing the two audience conditions) as the independent variable, a significant effect between severity and self-esteem was observed, suggesting that those with less severe disabilities reported better self-esteem, $b = -.32$, $SE = .10$, $t = -3.05$, $p = .003$, 95% CI: $-.53$ and $-.11$. Marginal significant main effects were also observed between meta-stereotypes of warmth and self-esteem, $b = .56$, $SE = .33$, $t = 1.70$, $p = .09$, 95% CI: $-.09$ and 1.21 , and ingroup ties and self-

esteem, $b = .57$, $SE = .30$, $t = 1.87$, $p = .06$, 95% CI: $-.03$ and 1.17 . A marginally significant interaction between stereotypes of warmth and ingroup ties on self-esteem was also reported, $b = -.10$, $SE = .06$, $t = -1.72$, $p = .09$, 95% CI: $-.22$ and $.02$ (i.e., Figure 13). No further main or interaction effects were reported, all $ps > .78$. We also again explored the presence of conditional indirect pathways between audience activations and self-esteem via meta-stereotypes of warmth. However, once again, no significant effects were observed: low ties effect = $.07$, $SE = .07$, 95% CIs = $-.007$ and $.32$; moderate ties effect = $.01$, $SE = .04$, 95% CIs = $-.05$ and $.13$; high ties, effect = $-.05$, $SE = .06$, 95% CIs = $-.20$ and $.02$.

Self-efficacy. When including self-efficacy as the dependent variable at the focal contrast level, self-efficacy was marginally correlated with the focal contrast, $b = -1.51$, $SE = .86$, $t = -1.74$, $p = .08$, 95% CI: -3.21 and $.20$, suggesting that people in the control condition were associated with increased self-efficacy. No further significant main effects on self-efficacy were reported, all $ps = >.13$.

Beyond these main effects, there was no significant interaction between stereotypes of warmth and ingroup ties on self-efficacy, $b = -.04$, $SE = .07$, $t = -.54$, $p = .59$, 95% CI: $-.18$ and $.10$, though there was a significant interaction between the focal audience contrast and ingroup ties on self-efficacy, $b = .36$, $SE = .17$, $t = 2.13$, $p = .04$, 95% CI: $.03$ and $.70$. Specifically, the high ingroup ties slope of the focal contrast was significant, $b = .98$, $SE = .43$, $t = 2.26$, $p = .03$, 95% CI: $.12$ and 1.83 , suggesting that participants in the healthcare provider and educator/employer conditions with high ties reported higher self-efficacy to people in the control with high ties. No effect was shown with low ties, $b = -.36$, $SE = .38$, $t = -.96$, $p = .34$, 95% CI: -1.11 and $.39$, or moderate ties, $b = .31$, $SE = .29$, $t = 1.06$, $p = .29$, 95% CI: $-.26$ and $.88$ (i.e., Figure 9). With all variables entered, the full model explained a significant amount of variance in self-efficacy, $R^2 = .10$, $F(7,135) = 2.24$, $p = .03$.

The same analysis on self-efficacy at the secondary contrast level showed a marginal effect between severity and self-efficacy, $b = -.24$, $SE = .13$, $t = -1.92$, $p = .06$, 95% CI: $-.49$ and $.007$, suggesting that people with less severe disabilities reported better self-efficacy. However, no further significant main or interaction effects were reported, all $ps = >.32$.

Subjective health. The analysis of subjective health also revealed that severity was significantly negatively correlated with subjective health, $b = -.52$, $SE = .08$, $t = -6.21$, $p = <.001$, 95% CI: $-.68$ and $-.35$, which highlights that less severe disabilities were associated with increased subjective health. However, no further main or interactive effects of the variables were reported, all $ps >.23$, although the full model did explain a significant amount of variance in subjective health, $R^2 = .25$, $F(7,136) = 6.58$, $p = <.001$. When the analysis was repeated using the secondary contrast (comparing the two audience conditions) as the independent variable, again, while severity was significantly negatively correlated with subjective health, highlighting that less severe disabilities were associated with increased subjective health, $b = -.52$, $SE = .08$, $t = -6.33$, $p = <.001$, 95% CI: $-.68$ and $-.35$, no further significant effects were reported, all $ps >.22$.

Responses to stereotypes of passivity

Across all analyses involving stereotypes of passivity, people in the healthcare provider and educator/employer audiences reported significantly greater stereotypes of passivity (meta-stereotypes) compared to people in the control condition (self-stereotypes), $b = .69$, $SE = .17$, $t = 4.07$, $p = <.001$, 95% CI: $.35$ and 1.02 . When substituting the secondary contrast (the healthcare provider audience versus the educator/employer audience, ignoring the influence of the control condition), into these analyses, no significant effect was found, $b = -.09$, $SE = .18$, $t = -.48$, $p = .63$, 95% CI: $-.45$ and $.27$. To avoid repetition, severity was not a significant predictor of stereotypes of passivity in any model, all $ps = >.28$.

Support willingness. In the analysis with support willingness as the dependent measure, the focal contrast was not significantly correlated with support willingness, $b = .24$, $SE = .78$, $t = .31$, $p = .76$, 95% CI: -1.29 and 1.78. There were, however, significant effects on support willingness from stereotypes of passivity, $b = .85$, $SE = .41$, $t = 2.08$, $p = .04$, 95% CI: .04 and 1.66, and ingroup ties, $b = .87$, $SE = .34$, $t = 2.55$, $p = .01$, 95% CI: .20 and 1.55, and severity produced a marginal effect with support willingness, $b = -.19$, $SE = .11$, $t = -1.73$, $p = .09$, 95% CI: -.41 and .03. These findings highlight that increased stereotypes of passivity (i.e., more passive), stronger ingroup ties and less severely disabled people were associated with increased willingness to access support.

Beyond these main effects, there was no significant interaction between the focal audience contrast and ingroup ties on support willingness, $b = .02$, $SE = .15$, $t = .15$, $p = .88$, 95% CI: -.28 and .33. However, the interaction between stereotypes of passivity and ingroup ties on support willingness was significant, $b = -.17$, $SE = .08$, $t = -2.20$, $p = .03$, 95% CI: -.33 and -.02. Specifically, stereotypes of increased passivity appeared to have a positive influence on support willingness for low identifiers, whereas for high identifiers the relationship was reversed, although neither of these effects were significant: low ties, $b = .28$, $SE = .18$, $t = 1.58$, $p = .12$, 95% CI: -.07 and .62; high ties, $b = -.32$, $SE = .19$, $t = -1.78$, $p = .09$, 95% CI: -.69 and .05. Support willingness of moderate identifiers appeared to be largely unresponsive to changes in passivity stereotypes, $b = -.02$, $SE = .12$, $t = .19$, $p = .85$, 95% CI: -.27 and .22 (Figure 14).

Given the presence of this interaction between the mediator (meta-stereotypes of worthiness) and the moderator (ingroup ties), we also explored the presence of conditional indirect pathways between audience activations and support willingness via meta-stereotypes of passivity. No significant effects were reported at any level of ingroup ties: low ties, effect

= .19, $SE = .16$, 95% CIs = -.04 and .65; moderate ties, effect = -.02, $SE = .10$, 95% CIs = -.22 and .18; high ties, effect = -.23, $SE = .16$, 95% CIs = -.58 and .04. With all variables entered, the full model explained a significant amount of variance in support willingness, $R^2 = .11$, $F(7,137) = 2.43$, $p = .02$.

When the analysis was repeated using the secondary contrast (comparing the two audience conditions) as the independent variable, significant main effects were observed between meta-stereotypes of passivity and support willingness, $b = .85$, $SE = .39$, $t = 2.17$, $p = .03$, 95% CI: .07 and 1.62, and ingroup ties and support willingness, $b = .86$, $SE = .33$, $t = 2.64$, $p = .009$, 95% CI: .22 and 1.51, and severity produced a marginal effect with support willingness, $b = -.19$, $SE = .11$, $t = -1.76$, $p = .08$, 95% CI: -.41 and .02. These findings again highlight that increased stereotypes of passivity (i.e., more passive), stronger ingroup ties, and less severely disabled people were associated with increased willingness to access support. A significant interaction between stereotypes of passivity and ingroup ties on support willingness was also reported, $b = -.17$, $SE = .08$, $t = -2.30$, $p = .02$, 95% CI: -.32 and -.02 (i.e., Figure 14). No further main or interaction effects were reported, all $ps > .70$. We also again explored the presence of conditional indirect pathways between audience activations and support willingness via meta-stereotypes of passivity. However, once again, no significant effects were observed: low ties effect = -.02, $SE = .06$, 95% CIs = -.20 and .06; moderate ties effect = .002, $SE = .02$, 95% CIs = -.03 and .07; high ties, effect = .03, $SE = .06$, 95% CIs = -.06 and .20.

Self-esteem. The analysis of self-esteem using the focal contrast revealed a significant effect between severity and self-esteem, suggesting that less severely disabled participants reported improved self-esteem, $b = -.33$, $SE = .10$, $t = -3.28$, $p = .001$, 95% CI: -.53 and -.13. However, no further significant main or interaction effects were reported, all $ps > .45$,

although the full model did explain a significant amount of variance in self-esteem, $R^2 = .14$, $F(7,137) = 3.27$, $p = .003$. When the analysis was repeated using the secondary contrast (comparing the two audience conditions) as the independent variable, again, no significant effects other than severity were reported, suggesting that less severely disabled participants reported improved self-esteem $b = -.33$, $SE = .10$, $t = -3.39$, $p = <.001$, 95% CI: $-.53$ and $-.14$; all other $ps > .51$.

Self-efficacy. When including self-efficacy as the dependent variable at the focal contrast level, self-efficacy was marginally correlated with the focal contrast, $b = -1.65$, $SE = .86$, $t = -1.93$, $p = .06$, 95% CI: -3.34 and $.05$, suggesting that people in the control condition were associated with increased self-efficacy. No further significant main effects on self-efficacy were reported, all $ps = >.11$.

Beyond these main effects, there was no interaction between stereotypes of passivity and ingroup ties on self-efficacy, $b = -.02$, $SE = .09$, $t = -.21$, $p = .83$, 95% CI: $-.19$ and $.15$, though there was a significant interaction between the focal audience contrast and ingroup ties on self-efficacy, $b = .42$, $SE = .17$, $t = 2.46$, $p = .02$, 95% CI: $.08$ and $.75$. Specifically, the high ingroup ties slope of the focal contrast was significant, $b = 1.14$, $SE = .44$, $t = 2.61$, $p = .01$, 95% CI: $.28$ and 2.01 , suggesting that participants in the healthcare provider and educator/employer conditions with high ties reported higher self-efficacy to people in the control with high ties. No effect was shown with low ties, $b = -.28$, $SE = .38$, $t = -.74$, $p = .46$, 95% CI: -1.03 and $.47$, or moderate ties, $b = .43$, $SE = .30$, $t = 1.45$, $p = .15$, 95% CI: $-.16$ and 1.02 (i.e., Figure 9). With all variables entered, the full model explained a significant amount of variance in self-efficacy, $R^2 = .13$, $F(7,136) = 2.81$, $p = .009$.

The same analysis on self-efficacy at the secondary contrast level showed a significant effect between severity and self-efficacy, $b = -.24$, $SE = .12$, $t = -1.97$, $p = .05$,

95% CI: -.48 and .001, suggesting that people with less severe disabilities reported better self-efficacy. However, no further significant main or interaction effects were reported, all $ps > .28$.

Subjective health. Finally, the analysis of subjective health using the focal contrast revealed that severity was significantly negatively correlated with subjective health, $b = -.50$, $SE = .08$, $t = -6.20$, $p < .001$, 95% CI: -.67 and -.34, which highlights that less severe disabilities were associated with increased subjective health. However, no further main or interaction effects were observed, all $ps > .77$, although the full model did explain a significant amount of variance in subjective health, $R^2 = .25$, $F(7,137) = 6.42$, $p < .001$. When the analysis was repeated using the secondary contrast (comparing the two audience conditions) as the independent variable, again, severity was significantly negatively correlated with subjective health, highlighting that less severe disabilities were associated with increased subjective health, $b = -.51$, $SE = .08$, $t = -6.32$, $p < .001$, 95% CI: -.67 and -.35, but no further significant effects were reported, all $ps > .72$.

APPENDIX G: STUDY 5 SURVEY

Section 1: More about you

In this first section we would like to know a little bit more about you.

What is your gender?

What is your age?

How would you describe your race/ethnicity?

What is your nationality?

What is your disability?

Which category or categories would you classify your disability?

Mobility disability

Spinal cord disability or injury

Brain disability or injury

Mental disability

Visual disability

Hearing disability

Cognitive disability

Intellectual disability

Other

1= Not at all, 7= Completely:

On a normal day, how visible do you think your disability is?

On a normal day, how severe do you think your disability is?

On a normal day, to what extent do you need assistive devices to help you get around e.g., wheelchair, cane?

On a normal day, to what extent do you need assistive devices to help you complete activities?

On a normal day, to what extent does your disability impact on day-to-day activities?

On a normal day, to what extent does your disability impact on your everyday life?

Section 2: Healthcare Providers

Thank you for your responses on the previous page. The purpose of this survey is to collect information about how disabled people respond to different groups of people.

We'd first like you to think about interacting with the care individuals responsible for providing support to help with your disability. This is important, as we hope to feed your opinions back to healthcare providers in order to provide this group with a better understanding of the experiences of disabled people.

Your thoughts are important to us regardless of how often you interact with healthcare providers. Do not worry if you are unsure about your answer, there are no right or wrong answers here, so your first response is probably the right one.

Please think about your identity as a disabled person. When interacting with healthcare providers, how do you think you will be viewed? Below this question is a text box for you to tell us your opinion. If you would like to increase your typing space, click on the triangle symbol on the bottom right-hand corner, and drag to the size you wish. You can also do this for all the upcoming survey questions.

Do you anticipate any difficulties about being viewed in this way?

When interacting with healthcare providers, do you feel any pressure to show your identity in particular ways? If so, can you tell us the pressure or pressures you face, and how you demonstrate your identity. For example, this could be regarding how you look or behave, or how you respond to questioning.

Can you tell us why you feel the need to demonstrate your identity in this way when interacting with healthcare providers?

Disabled people can construct their identity in a number of ways. Some disabled people like to see themselves as an individual, others like to see themselves as a member of a larger disability group, and others believe their identity contains elements of both. When interacting with healthcare providers, how do you like to you view yourself?

Also, are there benefits and possible difficulties to viewing yourself in this way? For example, this could include personal reasons, such as the ease of which you are able to interact with your healthcare provider or access available support, or collective reasons, such as accessing disability group help, assistance, understanding or coping resources. Please can you explain your answer?

Educator/Employer

Thank you for your answers so far. In the second part of the survey, we'd now like you to think about interacting with educators or employers. This is important as we hope to feed your opinions back in order to provide these groups with a better understanding of the experiences of disabled people in work or education.

Below are the same questions you answered when thinking about interacting with healthcare providers. We are interested in how your interactions with educators or employers may be similar and/or different to interacting with healthcare providers.

Your thoughts are important to us regardless of whether you are currently in work or education or not. Do not worry if you are unsure about your answer, there are no right or wrong answers here, so your first response is probably the right one.

Please think about your identity as a disabled person again. When interacting with educators or employers, how do you think you will be viewed?

Do you anticipate any difficulties about being viewed in this way?

When interacting with educators or employers, do you feel any pressure to show your identity in particular ways? If so, can you tell us the pressure or pressures you face, and how you demonstrate your identity. For example, this could be regarding how you look or behave, or how you respond to questioning.

Can you tell us why you feel the need to demonstrate your identity in this way when interacting with educators or employers?

Once again, disabled people can construct their identity in a number of ways. Some disabled people like to see themselves as an individual, others like to see themselves as a member of a larger disability group, and others believe their identity contains elements of both. When interacting with educators or employers, how do you like to view yourself?

Also, are there benefits and possible difficulties to viewing yourself in this way? For example, this could include personal reasons, such as the ease of which you are able to interact with educator or employer or access available support, or collective reasons, such as accessing disability group help, assistance, understanding or coping resources. Please can you explain your answer?