Summer 8-5-2022

Ableist Microaggressions and Well-being: Investigating the Moderating Effect of Coping Strategies

Whitney Morean

Recommended Citation
Morean, Whitney, "Ableist Microaggressions and Well-being: Investigating the Moderating Effect of Coping Strategies" (2022). *Clinical Psychology Dissertations*. 85.
https://digitalcommons.spu.edu/cpy_etd/85

Ableist Microaggressions and Well-being:

Investigating the Moderating Effect of Coping Strategies

Whitney M. Morean

A dissertation submitted in partial fulfillment

Of the requirements for the degree of

Doctor of Philosophy

In

Clinical Psychology

Seattle Pacific University

Approved by:	Reviewed by:
Jacob Bentley, Ph.D., ABPP Associate Professor of Clinical Psychology Dissertation Chair	Lynette Bikos, Ph.D. Chair Department of Clinical Psychology
Keyne C. Law, Ph.D. Assistant Professor of Clinical Psychology Committee Member	Keyne C. Law, Ph.D. Director of Research Department of Clinical Psychology
Alisha Janssen, Ph.D. Clinical Psychologist Committee Member	Katy Tagenberg, Ph.D. Dean, School of Psychology, Family & Community

DEDICATION

This dissertation is dedicated to all the participants who took the time to complete the survey and help expand research within the disability community.

ACKNOWLEDGMENTS

I want to thank my family, friends, and care team for their support. I grateful to my advisor Dr. Jacob Bentley for introducing me to rehabilitation psychology research. Finally, I want to thank the members of the Bentley RVT who helped at every stage of the research process.

PREFACE

There continues to be evolving discussions about the best practice for disability-affirmative language and the use of person-first language ‘person with a disability’ and identity-first language ‘disabled person’ in academia (Andrews et al., 2019). In clinical work it is possible to ask about individual preference; however, in academic writing, a decision must be made that represents a snapshot in time using the current norms and terminology. Both person-first language and identity-first language are allowed under APA 7th edition guidelines, with specific recommendations to follow the preference if known of specific disability subcultures. The minority and diversity models of the disability rights movement aims to raise awareness of disability identity, pride, and culture uses identity-first language **(**Andrews et al., 2019). I align with the aims of the disability rights movements use of identity-first language to represent positive disability identity and I write this preface as a white cisgender woman with acquired disabilities in the year 2022. I was born and raised in the United States, where ableist language is pervasive and “…much of the United States still uses “disabled person” in a way that categorizes and diminishes, rather than as an enlightened understanding of identity language. When media reliably switches to person-first language, we can move on to identity first language, as proposed by Dunn and Andrews (2015)” (Olkin, et al., 2019, p. 757-758). Currently, ableist language is still often used to “demonstrate the diminished status and value of people with disabilities; it is not a compliment to be called stupid, crazy, or lame. We use the term blind as a synonym for ignorant, and deaf to connote cluelessness” (Andrews, 2020, p., 79). I am aware that my choice to mainly use person-first language throughout this dissertation may seem outdated at some point in the future and I hope we get to a place when identity-first language can be more widely used to celebrate disability identity and culture. A motivating factor in doing this research for my dissertation was to help add to the scholarship about disability by disabled researchers.

Table of Contents

LIST OF TABLES

LIST OF FIGURES

ABSTRACT

Whitney M. Morean

Word Count: 347

Purpose/Objective: In prior research, ableist microaggressions have previously correlated with higher depressive symptoms in samples of members of the disability community. Since well-being is more than merely the absence of distressing mental health symptoms; the present study examines the relationship between ableist microaggressions and well-being and whether different coping strategies moderate the relationship. ***Research Method/Design:*** Adults ($N = 132$) who self-identified as having a disability or chronic health condition that significantly impacts one or more major life activities, were recruited online to complete a survey. Measures of well-being, ableist microaggressions, coping, and depression symptoms were administered via an online Qualtrics survey. ***Results:*** Participants ranged in age from 18 to 82-years-old and were Caucasian (61.4%), female (48.6%) The overall moderation model between ableist microaggressions and well-being with socially supported coping and avoidant coping as moderators with depression symptoms score and disability visibility as covariates was statistically significant $F(7,124) = 16.397$, $p <.001$, $R^2= .481$. However, the main effect of ableist microaggression scores did not significantly predict well-being ($b_1 = -.093$, $t(124) = -.690$, $p =.492$). Socially supported coping did predict well-being score; however, the interaction between ableist microaggression and socially supported coping was not significant. In the full sample avoidant coping did not predict well-being score. The covariates of depression symptoms and disability visibility did predict well-being. In post hoc analyses, disability visibility predicted higher ableist microaggressions score and higher well-being. The minimization factor from the ableist microaggression scale significantly predicted lower well-being scores and explained 12.7% of the variance. ***Conclusions/Implications***: Results broadly consistent with prior literature in the common experiences of ableist microaggression for people with disabilities. The results support that socially supported coping predicts well-being, and that well-being is conceptually different than the absence of depression symptoms. Only minimization ableist microaggressions negatively correlated with well-being. Future research is needed to analyze protective factors to explain why those with more visible report more frequent ableist microaggressions and have higher well-being. Examining positive psychological constructs as an outcome variable helps expand the focus of clinical psychology to move beyond pathologizing and study what is associated with people flourishing.

Keywords: Disability, Microaggressions, Well-being, Coping

CHAPTER I – INTRODUCTION

In 2020, the World Health Organization (WHO) estimated that more than one billion people live with some form of disability. Despite the prevalence of disability throughout the world, able-bodied identity is often not even acknowledged because it is assumed (McRuer, 2006). Assuming non-disabled as the natural state, not only denies the lived experience of disabled people, but also fails to take into consideration, that "able-bodied status is always temporary, disability being the one identity category that all people will embody if they live long enough" (McRuer, 2002, p. 95). Given the assumption of non-disabled status and the open enrollment nature of this historically marginalized heterogeneous group, further research is needed to examine factors associated with disability and well-being.

To examine the relationship between disability and well-being, it is important to have a clear understanding of who makes up the world's largest and most diverse minority group (WHO, 2020). In 2001, the World Health Organization (WHO) adopted the International Classification of Functioning, Disability, and Health (ICF), a dynamic bio-psycho-social model of disability (WHO, 2011). This model incorporates Lewin's Field Theory where behavior is understood as a function of the interaction of the person with their unique personal characteristics and environmental factors in any given situation (Lewin, 1935). Unlike the medical model of disability, where disability is defined as something within the person that needs to be fixed, or the social model where disability is defined solely as environmental and outside the person; in the ICF model disability is conceptualized as a dynamic interaction between a person's body, their current environment, their participation, and personal factors (Bentley et al., 2016; WHO, 2001). Importantly, part of the dynamic interaction includes other marginalized identities and interpersonal interactions that occur in an ableist culture (Goodley et al., 2019; Nario-Redmond, 2020).

As with other marginalized groups who have gained legal protection, prejudice and discrimination against members of the disability community did not disappear with the passage of the Americans with Disabilities Act in 1990. Indeed, modern discrimination against many minority groups has taken on less overt and more subtle forms, often referred to as microaggressions (Nario-Redmond, 2020; Sue, et al., 2007). Microaggressions, are behaviors, which may be unintended, unrecognized, or even well intentioned that are aimed at members of nondominant groups, which implicitly reinforce marginalization through subtle slights, insults, or discrimination (Lilienfeld, 2017; Olkin, 2017; Pierce, et. al, 1978; Sue et al., 2007). Microaggressions are specific to each marginalized community and have aptly been described as “death by a thousand paper cuts,” (Kattari, 2019, p. 400) implying it is the cumulative effect of the subtle slights, insults, and discrimination that cause harm. The absence of understanding of the cumulative impact of the microaggressions is one of the reasons why people whose identities fall in the majority are often unaware of the impact of microaggressions (Andrew, 2020; Kattari, 2019; Lee & Hicken, 2016; Olkin, 2017). Indeed microaggressions, “While seemingly minimal in nature, the harm they produce operates on a systemic and macro level” (Sue, 2010 p. 16). While a comment such as, “People indicate that they would not date a person with a disability,” is explicitly discriminatory, there are other situations such as, “People offer me unsolicited, unwanted, or unneeded help because I have a disability” that may be well intentioned is still harmful because it reinforces the idea that people with disabilities are helpless (Conover, et al., 2017).

People have intersectional identities and may experience microaggressions because of multiple marginalized identities (Crenshaw, 1989; Nario-Redmond, 2020). One reason disabled people experience microaggressions is because of the culture of ableism (Conover & Israel, 2019; Nario-Redmond, 2020). As with other microaggression research, which has found that marginalized group specific microaggressions have a detrimental impact on mental health, prior studies have found higher experiences of ableist microaggressions are positively correlated with higher depressive symptoms, (Conover & Israel, 2019; Conover et al., 2017; Katarri, 2020). Given that well-being is about functioning across multiple domains and not merely the absence of mental health disorders, it is important to specifically examine the impact of ableist microaggressions on well-being. Microaggressions are a specific form of stress and therefore it is imperative that the relationships between ableist microaggressions, coping and well-being is investigated.

Ableism and Disablism

***Theory and operationalization*.** A range of theoretical perspectives on disability provides insight relevant to ableism and disablism. This includes understanding the widespread use of the medical model of disability, critical disability studies theory, social dominance theory, and the minority stress model. The medical model has been the dominant model for many generations and is based on a pathologizing view of disability as ‘something wrong’ with the person with the goal of medical interventions targeting regaining or achieving ‘normal’ ability (Gill, 1997; Wright, 1983). In this model, people with disabilities and chronic health conditions are divided into 'good working parts' (i.e. the parts of their body unaffected by their illness or injury) and the 'bad parts' (i.e. the parts of their body that are affected; Gill, 1997; Wright, 1983). The medical model has contributed to ableism which, "Treats functional normality not as a statistical condition—what is merely typical or average for our species—but instead as the evolutionary ideal for humans and as intrinsically good" (Reynolds & Silver, 2017, p. 298). The continued reliance on the medical model, which views disability as a problem to be fixed, prompted disability rights advocates and theorists to develop a more person-centered approach to disability including critical disability studies theory (Goodley et al., 2019).

Critical disability studies theory is an intersectional lens that recognizes the feminist, queer, postcolonial, crip theories and critical race scholarships that "place disability in the foreground of theoretical and political debates whilst, simultaneously, demonstrating disability's relationship with the politics of race, ethnicity, gender, sexuality, class, and age" (Goodley et al., 2019, p. 977). Critical disability studies theory recognizes that as with other minority groups, disabled people are viewed and defined in relation to the dominant, non-disabled majority in a society with messages that implicitly and explicitly propagate a hierarchical dualistic message that disability is inferior to 'normality' of non-disabled individuals (Goodley et al., 2019; Nario-Redmond, 2020). The author of Disability-Affirmative Therapy Dr. Rhoda Olkin explains, "Ableism is prejudice against people with disabilities and discrimination in favor of able-bodied people that disadvantages those with disabilities" (Olkin, 2017, p. 7). A consequence of ableism is disablism which is "the rendering of persons with disabilities at a disadvantage due to environmental designs that assume able-bodied norms" (Olkin, 2017, p. 7).

Fitting within the framework of critical disabilities studies theory, social dominance theory (SDT) describes how many forms of oppression are maintained through beliefs that rationalize the social hierarchy of dominant and subordinate groups (Nario-Redmond, 2020). As with other isms, like racism and sexism, in ableism, the group in power defines the non-majority group in negative and stereotypical ways to perpetuate, "A shared sense of social devaluation, exclusion, and inferiority are common across stigmatized groups" (Nario-Redmond, 2020, p. 24).

The consequence of this ongoing social devaluation is explained by the minority stress model which addresses the additive stressors experienced by members of marginalized and oppressed groups as the result of ongoing social devaluation (Meyer, 2003). Inconsistent with the assumptions of non-disabled people, "most people with disabilities say that the hardest part [of having a disability] has to do with the reactions and behaviors of other people" (Olkin, 2017, p. 132). Empirical support for the minority stress model has found that for non-dominant group members the social stigma and discrimination they experience leads to health disparities, including those affecting mental health and well-being (Brooks, 1981; Lund et al., 2021; Meyer, 1995, 2003; Nario-Redmond, 2020).

Disability Discrimination and Well-being. A prior meta-analytic review by Schmitt and colleagues (2014) examined research about the consequence of perceived disability discrimination on psychological well-being in correlational and longitudinal studies. The correlational data support that perceptions of discrimination are negatively correlated with psychological well-being (Schmitt et al., 2014). The negative relationship was significant across different operationalizations of well-being, though it was somewhat weaker for positive outcomes such as self-esteem and life satisfaction than for negative outcomes such as depression or anxiety symptoms (Schmitt et al., 2014). When disability discrimination was perceived as pervasive it had a greater negative effect on well-being when compared to isolated discrimination (Schmitt et al., 2014). In longitudinal studies that controlled for prior levels of well-being, there was a significantly negative relationship, offering support for the hypothesis that perceived discrimination has a causal effect on well-being (Schmitt et al., 2014).

Microaggressions. Although the tolerability of overt discrimination may be less socially acceptable, one way that social hierarchy is maintained and reinforced is through microaggressions (Sue et al., 2007; Wolbring, 2008). A commonly cited definition of microaggressions comes from a study looking at racism in TV commercials, where microaggressions are described as, "subtle, stunning, often automatic, and nonverbal exchanges which are "put downs" of black offenders" (Pierce et al., 1978, p. 63).

Contemporary references to microaggressions reference the work of Sue and colleagues (2007), which focused on describing the forms of racial microaggressions. Sue et al., (2007) describe racial microaggressions as "brief and commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults to the target person or group" (p. 273). This seminal work about the experience of racial microaggressions captures how microaggressions are about the interpretation by the non-majority group member and is often cited in microaggression research with other minority groups including women, sexual minorities, and the disability community (Conover et al., 2018; Keller & Galgay, 2010).

Much of the focus of existing research on microaggressions has demonstrated a link between the experience of microaggressions and negative mental health outcomes in people of color (Nadal et al., 2014); sexual minorities (Conover & Israel, 2019); and individuals with physical disabilities (Conover et al., 2017). While there is a common negative consequence to the shared social devaluing of different socially oppressed groups; the specific microaggressions experienced are group-specific (Keller & Galgay, 2010). Different scales have been created to assess these microaggression experiences of different marginalized groups.

A taxonomy of disability microaggressions generated by focus groups conducted by Keller and Galgay (2010) is frequently cited as capturing general themes of disability-specific microaggression domains. Through a series of studies that started from the domains generated by Keller and Galgay (2010) at least two different ableist microaggression scales have been developed and validated in the last few years (Conover et al., 2017; Kattari, 2019). Conover and colleagues (2017) developed and validated a 20-item ableist microaggression scale (AMS-20) to examine lifetime experiences of disability-related microaggressions. Kattari (2019) developed and validated a 65-item ableist microaggression scale (AMS-65). Consistent with critical disabilities studies theory and the minority stress model, prior research using the AMS-20 and the AMS-65 found that higher scores are positively correlated with depressive symptoms (Conover et al., 2017; Kattari, 2020) and higher anxiety symptoms (Kattari, 2020).

In the validation study of the AMS-20, the experience of ableist microaggressions differed according to a participant’s perception of their disability visibility, but not disability type (Conover et al., 2017). Consistent with critical disability studies theory and social dominance theory people who self-report that their disability as visible reported higher ableist microaggressions scores than people who reported having semi-visible or nonvisible disabilities, suggesting that "peoples whose bodies are perceived farthest from able-bodied norm experience the most ableist microaggressions" (Conover et al., 2017, p. 591). Unlike visibility, disability type, (e.g., brain injury, chronic health condition, or spinal cord injury) does not automatically indicate how dissimilar from "species typical" a person presents, therefore in prior research disability type did not correlate with ableist microaggression score (Conover et al., 2017). Consequently, while research often focuses on specific health conditions (e.g., spinal cord injury or multiple sclerosis), this research study focuses on the shared experience of having a disability in an ableist culture where disability visibility may represent a useful distinction in terms of understanding ableist microaggressions.

Understanding that the medical model has dominated how disability is understood is useful to the theoretical framework of critical disabilities studies theory and social dominance theory, which provide conceptual models for attempting to understand ableist microaggressions. The limited empirical findings of ableist microaggressions generally suggest that experiencing ableist microaggressions is positively associated with negative mental health symptoms and with having a more visible disability. Recognizing that microaggressions are a unique form of stress it is necessary to understand cognitive appraisal and coping strategies.

Coping

Theory and operationalization. Coping is the term used to describe how people respond to stress (Caver & Connor-Smith, 2010; Stallman, 2020). There are numerous theories and ways coping has been operationalized including approach versus avoidance, cognitive versus behavioral categorizations, and problem versus emotion focused; see Caver & Connor-Smith (2010) or Stallman (2020) for some different theories of coping, measures, and limitations in conceptualizations. One of the crucial limitations of categorical approaches when conceptualizing coping is that people likely leverage multiple kinds of resources simultaneously when coping with stressors (Stallman, 2020).

One widely used theory to explain coping is based on Lazarus and Folkman's (1984) transactional theory of stress, which examined the cognitive appraisal process and the idiographic factors that contribute to an individual's interpretation and reaction to a stressor, which include coping strategy. According to Lazarus and Folkman, appraisal theory explains the cognitive way in which people orient, interpret, and then respond to stressful situations and how it is dynamic and unfolding and is divided into primary and secondary appraisals (Lazarus & Folkman, 1984). A stimulus is appraised as irrelevant when it has no consequences for a person's well-being and subsequently does not require further attention or processing, whereas a benign-positive appraisal is when something is interpreted as preserving or enhancing well-being (Lazarus & Folkman, 1984).

The three kinds of stress appraisal are harm/loss, threat, and challenge (Lazarus & Folkman, 1984). Harm/loss is when damage has already occurred, whereas threat is concern about the future when harm/loss is anticipated and is characterized by negative emotions such as fear, anxiety, and anger (Lazarus & Folkman, 1984). Challenge, like a threat, anticipates harm/loss, but there is also an anticipation of gain (Lazarus & Folkman, 1984). Threat and challenge do not have to be mutually exclusive and may be present after harm/loss has already occurred (Lazarus & Folkman, 1984). Understanding these three unique types of stress appraisal is relevant to ableist microaggressions because it is not the situation (i.e., what someone said or did) that results in the situation being appraised as a threat or challenge, but rather the personal interpretation of the situation. Overall, it is important to understand a stressor is identified by each individual differently according to whether that stressor is salient to the current situation and idiographic factors of the individual.

If a stressor is identified as relevant then coping is necessary and Lazarus & Folkman defined coping as the “cognitive and behavioral efforts to manage (master, reduce, or tolerate) a troubled person-environment relationship” (Folkman & Lazarus, 1985, p. 152). Lazarus and Folkman conceptualized two types of coping; emotion-focused coping, which is about regulating stressful emotions, and problem-focused coping aimed to remove or reduce the cause of the stressor (Lazarus & Folkman, 1984). Although this approach to conceptualizing coping has limitations, operationalizing coping behavior has become a common approach in disability research and the Brief COPE measure which is based on Lazarus and Folkman’s theory has been used in research to assess coping in different types of disabilities (Nahlen Bose, et al., 2015; Umucu & Lee, 2020; Snell et al., 2011).

Coping and Well-being. In a 2020 study looking at coping strategies in individuals with disabilities and chronic health conditions, participants who had high ratings on active coping and use of emotional support, humor, and religion; and low ratings on self-blame were found to have high ratings on well-being (Umucu & Lee, 2020). This outcome is consistent with previous findings indicating that frequent use of active coping strategies and infrequent use of avoidant coping strategies are associated with well-being (Brands et al., 2018; Mayordomo et al., 2016; Snell et al., 2011).

Prior research has established this link between well-being and positive health outcomes by identifying coping strategies as a moderator between a stressor and a patient's self-reported health rating. In a study of heart failure patients (*n* = 273) results indicated that avoidant coping moderates the association between anxiety and patient-rated physical functioning (Eisenberg et al., 2012). The negative association between anxiety and poorer physical functioning was stronger for patients who frequently used avoidant coping strategies, than for those who avoided less frequently (Eisenberg et al., 2012). In a 2018 study, higher levels of perceived discrimination and lower levels of perceived social support were associated with greater psychological distress in people with physical disabilities (Itzick et al., 2018). In experimental research, Coping Effectiveness Training (CET), which was designed to improve adjustment after spinal cord injury, found that the program improved scores on measures of depression and anxiety symptoms, but there was not a significant change in coping strategies (Kennedy et al., 2003; King & Kennedy, 1999).

Theory and research provide insight into coping processes. Research on aspects of coping among different samples of the disability community suggests that active problem-focused coping has more positive health outcomes than people who use avoidant coping (Eisenberg et al., 2012; Mayordomo, et al., 2016; Umucu & Lee, 2020). However, other research has pointed out that problem-focused coping strategies are useful when the stressor is controllable and emotion-focused coping is more suitable if the stressor is uncontrollable (Park et al., 2004). Given that ableist microaggressions are a distinctive form of uncontrollable stress it is important to specifically examine coping strategies as they relate to ableist microaggressions and well-being.

Well-being

Theory and operationalization. There does not currently exist an agreed upon conceptualization tool for assessing well-being, the way the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR) exists there is to diagnose mental disorders. Indeed, "Clinical psychologists have focused the majority of their attention on the diagnosis and treatment of pathologies, and in the quest for "fixes," scant attention has been paid to the nature of psychological health." (Sheldon & King, 2001, p. 216). Well-being, which is one way to conceptualize psychological health has been operationalized in a variety of ways and as stated previously is not merely the absence of distressing mental health symptoms, but about effective functioning and flourishing (Bech et al., 2003).

Well-being has often been conceptualized with populations interacting with the health care system through health-related quality-of-life (HRQOL) measures. As the name indicates, "HRQOL measures equate function with health, necessarily leading to a lower measured HRQOL in people with functional impairments regardless of their level of self-perceived health" (Schwartz et al., 2007, p. 529). HRQOL measures often overinflate the importance of physical functioning to quality of life as well as fail to understand the insider-outsider perspective of disability, which is "People with disabilities (insiders) know what life with a chronic condition is like (e.g., sometimes challenging but usually manageable) whereas casual observers (outsiders) who lack relevant experience presume that disability is defining, all encompassing, and decidedly negative" (Dunn et al., 2016, p. 2). Conflating physical functioning with quality of life inherently and ignorantly reinforces the idea that people with disabilities must have a lower quality of life (Dunn & Brody, 2008; Schwartz et al., 2007).

One of the dominant theories of well-being, explained by Seligman (2011) posited that no one factor is solely responsible for the well-being, rather well-being is a construct made up of several measurable elements that, taken together, each contributes to the base definition. According to Seligman (2011), there are five elements of well-being, which are positive emotion, engagement, positive relationships, meaning, and accomplishment abbreviated in the acronym PERMA. Each element of well-being in and of itself must have three distinct properties: "1. It contributes to well-being. 2. Many people pursue it for its own sake, not merely to get any of the other elements. 3. It is defined and measured independently of the other elements (exclusivity)" (Seligman, 2011, p. 44). Butler and Kerns (2016) created and validated the PERMA-Profiler as a self-report measure using the five components of well-being articulated by Seligman. According to the PERMA theory, each of the elements are interrelated and work together to promote well-being (Butler & Kerns, 2016).

Well-being among people with disabilities. Prior research that has looked at well-being in members of the disability community and the impact of discrimination on well-being have not used the same operational definitions of discrimination or well-being (Hackett et al., 2020; Umucu & Lee, 2020). In a prior meta-analytic review examining research about the consequence of perceived disability discrimination on psychological well-being, perceived discrimination had a significant negative effect on well-being (Schmitt, et al., 2014). When disability discrimination was perceived as pervasive it had a greater negative effect on well-being when compared to isolated discrimination (Schmitt et al., 2003). In a study looking at disability discrimination and well-being in an adult sample in the UK, disability discrimination, was linked to poorer well-being (Hackett et al., 2020). In the study, discrimination over the prior year was assessed by asking if participants had felt unsafe, avoided going out or being in, been insulted, called names, threatened or shouted at, and/or been physically attacked (Hackett et al., 2020). If participants answered yes to any of the forms of discrimination, they were asked to choose the reason they believed they experienced discrimination from a list including disability, sex, and ethnicity (Hackett et al., 2020). Well-being was a composite of depression symptoms, psychological distress, life satisfaction, self-rated health, emotional, mental health, and social functioning (Hackett et al., 2020). Individuals who reported disability discrimination had lower life satisfaction than those who did not report disability discrimination in the past year.

A study investigating the impact of COVID-19 stress found some unusual findings in that denial coping was found to be associated with high scores on the PERMA, which was used to measure well-being (Umucu & Lee, 2020). The authors suggest denial being associated with well-being may be due to the unusual nature of the type of stress experienced because of the COVID-19 pandemic (Umucu & Lee, 2020). Though this study was looking specifically at stress related to COVID-19 and therefore the findings may not hold for other types of stressors, it does highlight that depending upon the stressor different coping strategies may be adaptive and positively associated with well-being (Umucu & Lee, 2020).

As with most of clinical psychology, much of the research looking at outcomes in disability populations has focused on symptom measures of distress. When positively valanced outcomes are used it is often HRQOL measures, which often inappropriately assume that functional impairment automatically signifies lower quality of life. The core 15 items of the PERMA as a measure of well-being do not conflate physical ability in the same way and has been used in research with members of the disability community. In the context of ableist microaggressions, it is important to understand coping and well-being beyond studying distress.

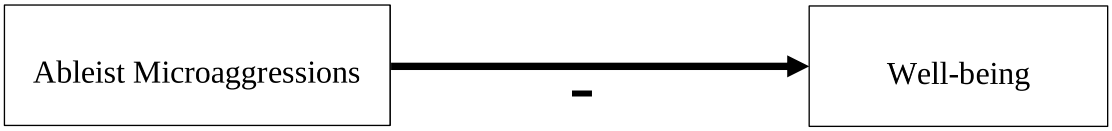
Present Study

In a prior national sample in the United States, 99% of individuals with disabilities reported experiencing at least one ableist microaggressions (Conover et al., 2017) and higher lifetime experience of ableist microaggressions was correlated with higher depressive symptoms and stress (Conover & Israel, 2019). What is not clear from existing published research is the relationship between ableist microaggressions and well-being and if coping strategies moderate the relationship. Given prior research findings and the relationship between ableist microaggressions and depression symptoms and disability visibility, depression symptoms and disability visibility were entered as covariates. Following the theoretical model and the supporting evidence described above using a cross-sectional research design, I predict that coping strategy will moderate the direct effect of ableist microaggressions on well-being. The specific statistical hypotheses are detailed below the theorized model is presented in Figure 1.

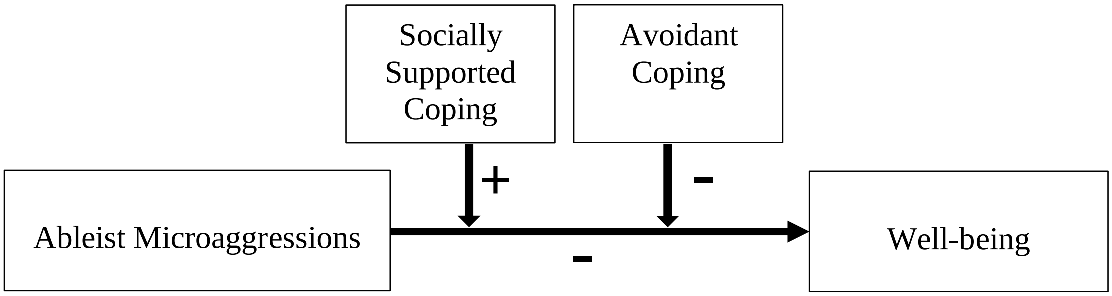
1. Based on the existing literature indicating that the effect of discrimination is negatively associated with well-being, (Schmitt et al., 2014) I hypothesize that

higher frequency of ableist microaggressions will be negatively correlated with well-being, such that higher frequency of ableist microaggressions are associated with lower levels of well-being.

2. Based on the theories of coping and well-being and the supporting evidence, (Lazarus & Folkman, 1984; Mayordomo et al., 2016) I hypothesize that different coping strategies will moderate the relationship between ableist microaggressions and well-being, which are detailed below. Specifically, I hypothesize that:
    a. Socially supported coping will buffer the effect of ableist microaggressions on well-being. Specifically, those who endorse socially supported coping strategies (emotional support and instrumental support) will have higher levels of well-being.
    b. Avoidant coping will exacerbate the effect of ableist microaggressions on well-being. Specifically, those individuals who report engaging in avoidant coping (behavioral disengagement and substance use) will have lower levels of well-being than those who endorse engaging in less avoidant coping.



Model of Hypothesis 1



Model of Hypothesis 2a & 2b

Figure 1. Proposed model of AMS and well-being as moderated by coping

CHAPTER II – METHOD

Participant Characteristics

The sample consisted of 132 adults who self-identify as having a disability or a chronic health condition that significantly impacts one or more major life activities. Participant inclusion was based on participants endorsing that they had a disability based on the Americans with Disabilities Act Amendment Act of 2008 definition of disability as "a physical or mental impairment that substantially limits one or more major life activities of such individual, a record of such an impairment, or being regarded as having such an impairment" (Section 4[a][1]). A majority of the sample identified their disability as not visible answering yes to "Most of the time people are not aware that I am disabled" (*n* = 46, 34.8%) or "Almost nobody knows that I am disabled" (*n* = 19, 14.4%). The demographic characteristics of the sample are detailed further in Table 1 in the results section.

Research Design & Procedure

This study used a non-experimental, cross-sectional research design using self-report data collected online via Qualtrics. Participants were recruited from professional listservs, the University of Washington's Institute of Translational Health Sciences (ITHS) website, and outreach to disability groups to complete an online survey. Participants accessed the survey via Qualtrics where they were provided a statement explaining the purpose of the study, the participation criteria, potential risks and benefits to participation, and informed consent. Keywords listed for this study were "well-being," "coping," "disability," and "chronic health condition that significantly impacts one or more major life activities." Participants were informed that they would be completing measures on disability, well-being, and coping. The term “microaggression” was not used in participant recruitment or data collection, as it may be suggestive to participants (Wright & Wegner, 2012). The survey was estimated to take 35 minutes to complete. At the end of the survey, participants were given the option to provide an email address to enter a drawing to win 1 of 25 $50 gift cards to either Amazon.com or Target. All study materials were approved by the Seattle Pacific University Institutional Review Board.

Power Analysis

Power analysis was conducted in G*Power Software (Version 3.1.9.6). The linear multiple regression: fixed model, R2 deviation from zero, a priori power analysis was used with seven predictors; one independent variable (the score on the ableist microaggressions scale); two moderators which were socially supported coping and avoidant coping; and two covariates depression symptoms score and disability visibility. Power analysis indicated a sample size of 103 participants would be sufficient to detect a moderate effect size f = .15 with an α of .05 and power at .80, to detect a medium effect, while balancing type I and type II error (Columb & Atkinson, 2016). With a sample size of 132, this study is adequately powered.

Measures and Covariates

Demographic questionnaire. Consistent with the suggestions provided by Hughes et al., 2016 regarding which demographic data to collect and how to ask, the demographic questionnaire assessed gender identity, age, education, race, ethnicity, and geographic location. Due to the diversity within the disability community and how disability is defined the Washington Group on Disability Statistics Questions short set on functioning was used to assess for difficulties with vision, hearing, remembering or concentrating, language, and a question assessing assistive devices. Although not part of the recommendation in the Hughes et al., 2016 article and not assessed in any of the WGS questions, given prior research with the AMS has identified group differences based on the visibility of disability and disability severity, questions were asked to assess visibility and impact. Participants were asked about disability visibility on a 4-point Likert-type scale, ranging from 1(*Almost nobody knows that I am disabled*) to 5 (*Just about everybody knows that I am disabled*), with (*I am unsure if people know that I am disabled*) as the option number 3. Participants were asked how disability impacts their life on a 4-point Likert-type scale, ranging from 0 (*minimally*) to 4 (*very severely*).

Well-being. The PERMA profiler (Butler & Kern, 2016) consists of 15 core items that assess well-being. The PERMA scale is a self-report measure developed to assess the five aspects of well-being Seligman described in his book, Flourish (2011) (i.e., positive emotion, engagement, relationships, meaning, and accomplishment). The PERMA profiler items are presented on an 11-point scale with anchors of 0 (*not at all* or *never*) to 10 (*completely* or *always*), scores are summed and averaged, with higher scores indicating greater levels of well-being (Butler & Kern, 2016). The measure assess five elements; positive emotion (e.g. “In general, how often do you feel joyful?”), relationships (e.g. “How satisfied are you with your personal relationships?”), meaning (e.g. “In general, to what extent do you lead a purposeful and meaningful life?”), and accomplishment (e.g. “How often do you achieve the important goals you have set for yourself?”). In the initial validation study with a large diverse sample (*n* = 31,966) the PERMA showed convergent validity with other measures of well-being (*r* = .80) and discriminant validity with measures of depression symptoms (*r* = -.89, Butler & Kern, 2016). The PERMA has demonstrated acceptable internal reliability (α = .96) in a sample of individuals with disabilities and chronic conditions (Umucu & Lee, 2020). Cronbach's alpha coefficients in the current study for the PERMA was .94.

Ableist Microaggressions. The Ableist Microaggressions Scale (AMS; Conover et al., 2017) investigates lifetime experiences of disability-related microaggressions. The AMS is a 20-item self-report measure with item responses provided on a 6-point Likert-type scale, ranging from 0 (*never*) to 5 (*very frequently*), scores are averaged, with scores ranging from 0 to 5, with higher scores indicating greater lifetime experience of ableist microaggressions (Conover et al., 2017). The Conover et al., 2017 ableist microaggression scale (referred to from here on as AMS) was chosen over the ableist microaggression scale developed by Kattari, 2019 to minimize response burden because the Conover et al., 2017 scale has 20 items and the scale developed by Kattari, 2019 has 65 items with two subscales interpersonal and visibility in society. In addition to minimizing response burdern, the factor analysis of Conover and colleagues (2017) found that a four-factor structure was the best fit for the AMS. The factors of the AMS (Conover et al., 2017) are helplessness (five items), minimization (three items), denial of personhood (five items), and otherization (seven items). Examples of items of each of the four factors of the Conover et al., 2017 scale include helplessness (e.g. "People express admiration for me or describe me as inspirational simply because I live with a disability"), minimization (e.g. "People minimize my disability or suggest that it could be worse"), denial of personhood (e.g. "People act as if I am nothing more than my disability"), and otherization (e.g. "People stare at me because I have a disability"). In a national US sample of adults with disabilities, the AMS has shown convergent validity with measures of depression symptoms (*r* = .29) and stress (*r* = .24) and discriminant validity with social desirability (*r* = -.13 Conover et al., 2017). The AMS has demonstrated adequate overall internal consistency alpha of .92; (Conover et al., 2017). Cronbach's alpha for the AMS was .91 in this study.

Coping. A measure created based on Lazarus and Folkman's theory was the COPE (Carver et al., 1989) and then a shorter version of the Brief COPE (Carver et al., 1997). Brief Coping Orientation to Problem Experience Inventory COPE (BriefCOPE; Carver, 1997) is a 28-item measure that assesses 14 conceptually different coping strategies. The subscales are active coping, planning, positive reframing, acceptance, humor, religion, emotional support, instrumental support, self-distraction, denial, substance use, behavioral disengagement, venting, and self-blame. Responses are provided on a 4-point, Likert-type scale ranging from 1 (*I haven't been doing this at all*) to 4 (*I've been doing this a lot*). The measure is scored by calculating the subscale scores. Many studies using the Brief COPE support a two-factor structure of, emotion-focused and problem-focused (Carver, 1997; Hagan, 2017; Litman, 2006; Mayordomo, et al., 2016). However, other studies have found three factors, with help-seeking/social coping being a separate factor from the original emotion and problem-focused coping structure (Snell et al., 2011). Still, other studies have found a four-factor structure, with avoidant coping being its own factor using the BriefCOPE (Nahlen Bose, et al., 2015). The internal consistency of the subscales varies in studies depending upon the subscales used, with Cronbach's alpha ranging from .43 to .97 in a study of people with mild traumatic brain injury (Snell et al., 2011) to .46 to .87 in a study examining the impact of COVID-19 on stress and coping strategies in individuals with disabilities and chronic health conditions (Umucu & Lee, 2020). In a study of individuals with chronic heart failure a four-factor model was the best fit and the internal consistency was alpha .78 for problem-focused coping, alpha .51 for avoidant coping, alpha .62 for socially supported coping, and .62 for emotion focused coping (Nahlen Bose et al., 2015).

Of the 14 subscales in the Brief COPE, four will be used two socially supported coping (emotional and instrumental support), and two avoidant coping subscales (behavioral disengagement and substance use). The instruction in the scale was modified to capture coping strategies related to ableist microaggressions, which were the items directly proceeding the coping subscales. The instructions said, "The next set of questions asks about ways of coping. For each of the items below how often have you been doing each behavior as a way to deal with those interactions described in the last set of questions." Cronbach's alpha for the socially supported coping (emotional and instrumental coping) was .790 and the avoidant coping subscales (behavioral disengagement and substance use) was .694 in this study.

Depression Symptoms. The Patient Health Questionnaire (PHQ-2; Kroenke et al, 2009) is a brief screening scale for depressive symptoms. Each question asks, "Over the last 2 weeks, how often have you been bothered by the following problems?" Scores are rated on a 4-point Likert-type scale, from 0 (*not at all)* to 3 ("*nearly every day*"). The two items assess for depressed mood and anhedonia. In prior studies examining stress and coping in a sample of individuals with disabilities and chronic health conditions, the depression symptom subscale was found to have internal reliability of .85 (Umucu & Lee 2020). Depression symptom score was used as a covariate with higher scores representing greater levels of depression symptoms. In the current study, depression symptom subscales were found to have .92 consistency reliability coefficients.

Data Analysis

All data analyses were performed in SPSS 28. The data was screened for missingness, violations of linearity, normality, independence, and homogeneity of variance assumptions prior to conducting the analyses. Normality was determined by skewness of -3 and 3 and kurtosis between -10 and 10 (Kline, 2011). Potential outliers were identified by reviewing Mahalanobis and Cooks distances and those with more than one score exceeding the probability $p < .001$ were going to be excluded from the primary analysis to control for outlier impact. (Tabachnick & Fidell, 2013). No cases were removed because of violating more than one of the outlier assumptions resulting; however, four cases did not complete the depression symptom questions, which was used as a covariate in the moderation model; therefore, the total sample size for the overall moderation model was $n = 132$.

Variables previously identified in the literature, specifically, disability visibility and depression symptom scores were evaluated for their correlation with the outcome variable well-being and were entered as covariates in the analysis. Moderation analyses was conducted using the PROCESS macro for SPSS (Hayes, 2018). Well-being served as the outcome variable in the model. Ableist microaggression score was entered as a predictor and socially supported coping was entered as the first moderator and avoidant coping was entered as a second moderator, with depression symptom scores and disability visibility entered as covariates using PROCESS model 2. To test hypotheses 1, 2a, and 2b, a model 2 moderation was created in PROCESS. To determine the significance of each of the models, PROCESS provided bias-corrected 95% confidence intervals for the effect of the predictor on the outcome variable at varying levels of the moderator (low = 1*SD* below the mean, moderate = *M*, high = 1*SD* above the mean). A 5,000 bootstrap sample was used to ensure the stability and reliability of the model, and 5,000 is the amount suggested by Preacher & Hayes (2008) for final reporting. Significance was determined by examining the confidence intervals and, if the interval did not contain zero, the respective effect could be considered statistically significant.

The regression coefficient b_1 estimates the relationship between ableist microaggression scores and well-being scores. The regression coefficient b_2 estimates the conditional effect of socially engaged coping on well-being score when ableist microaggression is zero while holding avoidant coping constant, and b_3 estimates the conditional effect of avoidant coping on well-being when ableist microaggression is zero while holding socially engaged coping constant. Regression coefficients b_4 and b_5 determine how much ableist microaggression score's effect is contingent on socially engaged coping and avoidant coping, respectively. More specifically, b_4 quantifies how much the conditional effect of ableist microaggression score on well-being changes as socially engaged coping changes by one unit, holding avoidant coping constant, and b_5 estimates how much the conditional effect of ableist microaggression score on well-being changes as avoidant coping changes by one unit, holding socially engaged coping constant. Tests of significance or confidence intervals based on b_4 and b_5 answer the question as to whether socially engaged coping or avoidant coping moderates ableist microaggression score’s effects on well-being respectively. Regression coefficients and confidence intervals of b_6 and b_7 determine how much the covariate variables of depression symptoms scores and disability visibility impact the overall significance of the model.

CHAPTER III - RESULTS

Recruitment and Participant Flow

The survey was accessed a total of 180 times between when it was opened on February 7, 2022, and when it was closed on May 11, 2022. The informed consent was completed 148 times, three people reported that they did not have a disability and therefore did not complete any additional questions, and two participants did not complete any items after the informed consent. Three people were removed because they reported that they were not living in the United States. Missing data analysis indicated that 12% of the cases had some missing data; 97% of the values in the model had complete data. Data from those participants that did not meet the aforementioned criteria (i.e., did not have a disability and/or had > 24% missingness when the survey was closed) were deleted for a total *n*=132. Demographic characteristics of the sample are found in Table 1.

Table 1 *Participant demographics*

	Participants (*n* = 132)
Age	
Age Range	18-82
Age in years mean, [SD]	34.59 [11.27]
Gender Identity	
Agender	3.0% (*n* = 4)
Androgyne	0.8% (*n* = 1)
Demigender	0.8% (*n* = 1)
Female	48.6% (*n* = 64)
Genderqueer or Gender fluid	4.5% (*n* = 6)
Male	43.2% (*n* = 57)
Questioning or Unsure	1.6% (*n* = 2)
Transgender Man	3.0% (*n* = 4)
Ethnicity/Race	
American Indian	2.3% (*n* = 3)
Asian	8.3% (*n* = 11)
Black or African-American	31.8% (*n* = 42)
Hispanic or Latino	3.8% (*n* = 5)
Jewish	2.3% (*n* = 3)
Mediterranean	0.8% (*n* = 1)
Middle Eastern	0.8% (*n* = 1)
White	61.4% (*n* = 81)
Disability Visibility	
Almost nobody knows that I am disabled	14.4% (*n* = 19)
Most of the time people around me are not aware that I am disabled	34.8% (*n* = 46)
I am unsure if people know that I am disabled	9.8% (*n* = 13)
Most of the time people around me know that I am disabled	17.9% (*n* = 24)
Just about everybody knows that I am disabled	22.7% (*n* = 30)
Disability Impact	
Minimally	15.2% (*n* = 20)
Moderately	38.6% (*n* = 51)
Severely	27.3% (*n* = 36)
Very Severely	18.9% (*n* = 25)
Disability Onset	
Experienced since birth	52.3% (*n* = 69)
Acquired before the age of 18	51.5% (*n* = 68)

Note. For Ethnicity/Race, Gender Identity, Disability Onset, and Employment totals exceed 100% because participants were able to choose all options that applied.

Table 1 *(continued)*

	Participants (*n* = 132)
Employment	
Disabled, not able to work	15.2% (*n* = 20)
Employed full-time (40+ hours per week)	27.3% (*n* = 36)
Employed part-time (1-39 hours per week)	23.5% (*n* = 31)
Homemaker or caregiver for another person	2.3% (*n* = 3)
Not employed, looking for work	24.2% (*n* = 32)
Not employed, Not looking for work	3.8% (*n* = 5)
Temporarily laid off	0.8% (*n* = 1)
Retired	2.3% (*n* = 3)
Sick leave	1.5% (*n* = 2)
Student	14.4% (*n* = 19)

Note. For Ethnicity/Race, Gender Identity, Disability Onset, and Employment totals exceed 100% because participants were able to choose all options that applied.

Preliminary data screening indicated normality and no evidence of nonlinear relationships between study variables. All the participants that completed the AMS (*n* = 132) endorsed experiencing more than one of the ableist microaggressions assessed by the AMS and the mean score for AMS was (*M* = 2.15, *SD* = 1.17). Means, standard deviations, and correlations for the main study variables are presented in Table 2.

Table 2 *Descriptive statistics and correlations*

Variable	*M*	*SD*	1	2	3	4	5	6
1. Well-being [a]	5.85	1.62	—					
2. AMS[b]	2.16	0.93	-.012	—				
3. SS_Coping [c]	9.43	2.96	$.246^{**}$	.170	—			
4. A_Coping[d]	6.70	2.48	$-.413^{**}$	.040	.056	—		
5. Depression[e]	2.09	2.11	$-.533^{**}$	$.217^{*}$	$.219^{*}$	$.487^{**}$	—	
6. Disability Visibility[f]	3.00	1.43	$.334^{**}$	$.404^{**}$	.103	$-.352^{**}$	-.165	—
7. Disability Impact[g]	2.50	0.97	-.079	$.323^{**}$	$.222^{*}$	.055	$.412^{**}$	$.365^{**}$

Note..[a] Well-Being = PERMA Profiler Core 15-items [b]AMS = Ableist Microaggression Scale. [c]SS_Coping = Socially Supported Coping items from the Brief COPE. [d]A_Coping= Avoidant Coping items from Brief COPE. [e] Depression = PHQ4 Depression items. [f] Disability Visibility asked on a Likert scale with lower scores indicating the participants did not believe that people around them knew that they were disabled. [g]Disability Impact was assessed on a Likert scale with higher scores representing greater impact of their on their life * $p < .05$, ** $p < .01$

Moderation Analyses

The overall model between ableist microaggressions and well-being with socially supported coping and avoidant coping as moderators with depression symptoms score and disability visibility as covariates was statistically significant $F(7,124) = 16.397$, $p < .001$, $R^2 = .481$. The moderator socially supported coping did predict well-being score ($b_2 = .188$, $t(124) = 5.074$, $p < .001$); however, the interaction between ableist microaggression scores and socially supported coping was not significant ($b_4 = .019$, $t(124) = .478$, $p = .634$, $\Delta R^2 = .001$; see Figure 2). The main effect of ableist microaggression scores did not significantly predict well-being ($b_1 = -.093$, $t(124) = -.690$, $p = .492$). Avoidant coping did not predict well-being score ($b_3 = -.087$, $t(124) = -1.675$, $p = .096$) and the interaction term for ableist microaggression scores and avoidant coping did not significantly predict well-being score ($b_5 = -.068$, $t(124) = -1.406$, $p = .162$, $\Delta R^2 = .008$ see Figure 3).

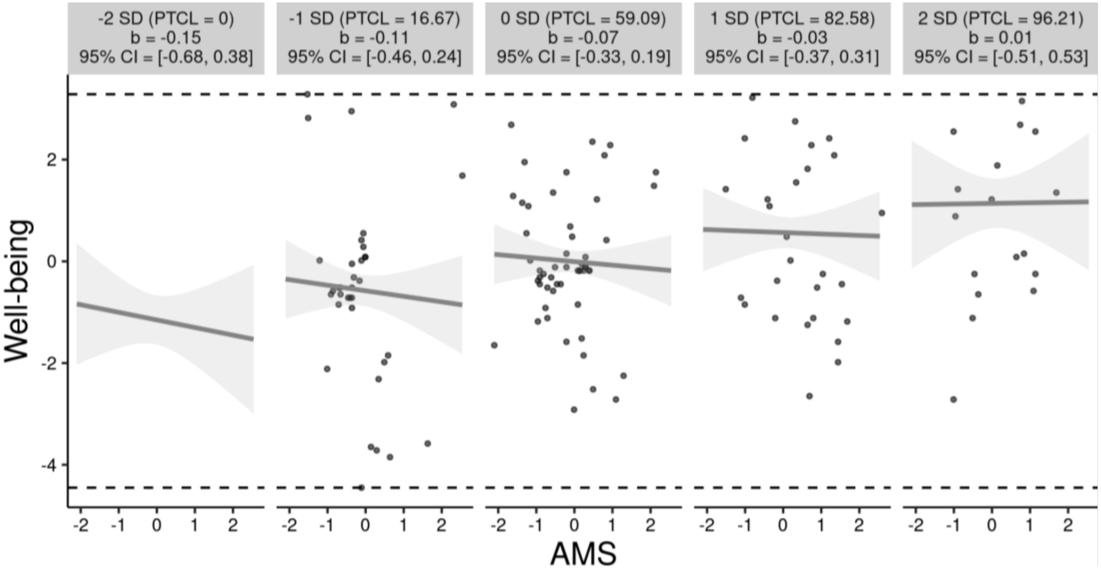


Figure 2. Level of moderator (socially supported coping)

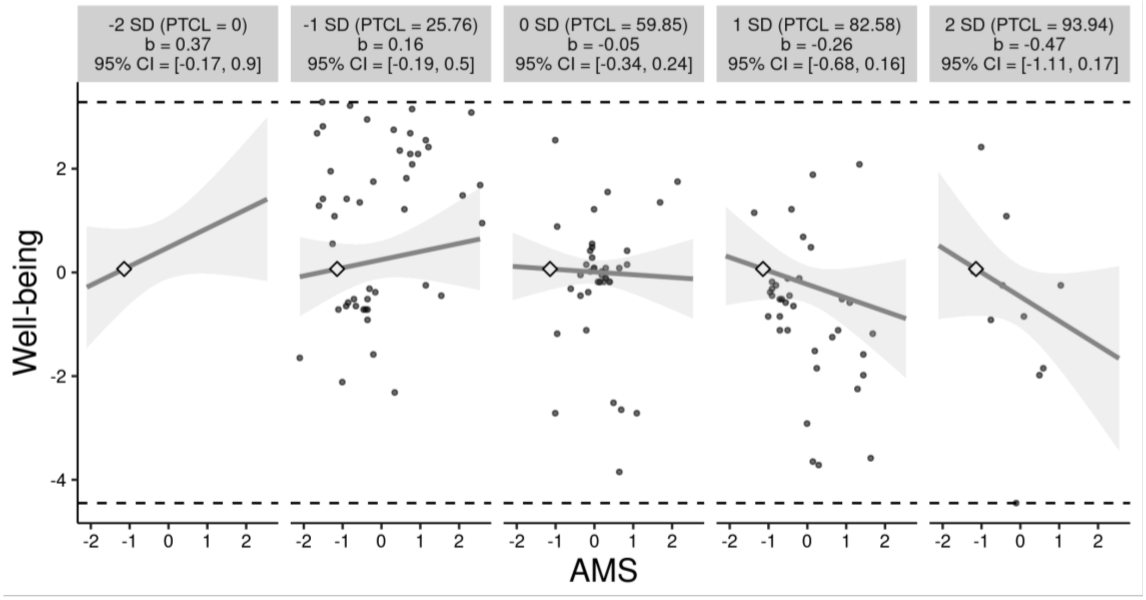


Figure 3. Level of moderator (avoidant coping)

Significant covariates. Depression symptoms score and disability visibility were significant covariates. Depression symptoms score did predict well-being score (b_6 = -.380, *t*(124) = -6.143, *p* <.001). The covariate disability visibility was also significant (b_7 =.199, *t*(124) = 2.224, *p* =.028). See Table 3 for a summary of findings and 95% confidence intervals.

Table 3 *Moderation analysis*

Effect	Estimate	*SE*	95% CI		*p*
			LL	*UL*	
Fixed effects					
Intercept**	6.044	0.326	5.398	6.691	<.001
AMS [a]	-0.093	0.134	-0.358	0.173	.492
SS_Cope [b] **	0.188	0.037	0.115	0.262	<.001
AMSxSS_Cope	0.019	0.039	-0.058	0.096	.634
A_Cope [c]	-0.087	0.052	-0.190	0.016	.096
AMSxA_Cope	-0.068	0.048	-0.163	0.028	.162
Covariates					
Depression [d] **	-0.380	0.062	-0.502	-0.257	<.001
Disability Visibility [e]*	0.199	0.089	0.022	0.375	.028

Note. [a] AMS = Ableist Microaggression Scale. [b] SS_Coping = Socially Supported Coping items from the Brief COPE. [c] A_Coping= Avoidant Coping items from Brief COPE. [d] Depression = PHQ4 Depression items. [e] Disability Visibility asked on a Likert scale with lower scores indicating the participants did not believe that people around them knew that they were disabled. CI = confidence interval; *LL* = lower limit; *UL* = upper limit $*p < .05$, $**p < .01$

Post hoc Analyses of Disability Visibility and Disability Impact

To clarify and explore the impact of disability visibility, the moderation model was run again after removing the 13 participants who endorsed feeling “unsure if people know that I am disabled.” The overall moderation model remained significant between ableist microaggressions and well-being with socially supported coping and avoidant coping as moderators, with depression symptoms score and disability visibility as covariates $F(7,111) = 15.914$, $p < .001$, $R^2 = .501$. The main effect of ableist microaggression scores still did not significantly predict well-being ($b_1 = -.112$, $t(111) = -.113$, $p = .426$). Socially supported coping did predict well-being score ($b_2 = .158$, $t(111) = 3.886$, $p < .001$); however, the interaction between ableist microaggression scores and socially supported coping was not significant ($b_4 = .033$, $t(111) = .815$, $p = .417$, $\Delta R^2 = .003$). With the removal of the 13 participants who were unsure about their disability visibility avoidant coping did predict well-being score ($b_3 = -.115$, $t(111)$

= -2.002, p =.047); however, the interaction between ableist microaggression and avoidant coping was not significant (b_5 = -.066, $t(111)$ = -1.269, p = .207, ΔR^2 = .007). As with the full dataset, the covariates depression symptoms score did predict well-being score (b_6 = -.391, $t(111)$ = -5.900, p <.001). With the removal of the participants who were unsure about the visibility of their disability, the covariate disability visibility was still a statistically significant predictor of well-being (b_7 =.190, $t(111)$ = 2.063, p =.041).

To further analyze the differences between groups based on disability visibility a one-way ANOVA was performed to compare the effect of disability visibility entered as the independent variable and AMS was entered as the dependent. The one-way ANOVA computed that there was a statistically significant difference in AMS between at least two groups ($F(3,115)$ = 7.462, p <.001 η^2 = .198; 95% C.I. = [.070, .306]). See Table 4 for means and standard deviations which includes the 13 participants who were "unsure if people know that I am disabled," though given the lack of consistency in prior research about how to categorize those participants in terms of disability visibility they were excluded from the post hoc analyses.

Table 4 *Means and standard deviations of AMS score by disability visibility*

Disability Visibility Options	*N*	*M*	*SD*
1. Almost nobody knows that I am disabled	19	1.935	0.735
2. Most of the time people are not aware that I am disabled	47	1.792	0.802
3. Most of the time people around know that I am disabled	24	2.307	0.646
4. Just about everybody knows that I am disabled	31	2.830	1.142
5. I am unsure if people know that I am disabled	13	1.889	0.485

Note. AMS = Ableist Microaggression Scale.

Tukey's HSD Test for multiple comparisons assessed that the mean value of AMS was significantly different between the "Just about everybody knows that I am disabled" and “Almost nobody knows that I am disabled” (*p* = .003, 95% C.I. = [-1.582, -.249], and between “Just about everybody knows that I am disabled” and “Most of the time people are not aware that I am disabled” (*p* < .001, 95% C.I. = [.515, 1.583]. There was no statistically significant difference in mean scores between “Most of the time people around know that I am disabled” and “Just about everybody knows that I am disabled” (*p* = .110), or between “Most of the time people around know that I am disabled” and “Most of the time people are not aware that I am disabled” (*p* = .103), or between “Almost nobody knows that I am disabled” and “Most of the time people are not aware that I am disabled” (*p* = .943), or between “Most of the time people are not aware that I am disabled” and “Most of the time people around know that I am disabled” (*p* = . 508). See Figure 4 for a visual representation of the relationship, which does include the 13 participants excluded from the ANOVA who endorsed feeling “unsure if people know that I am disabled.”

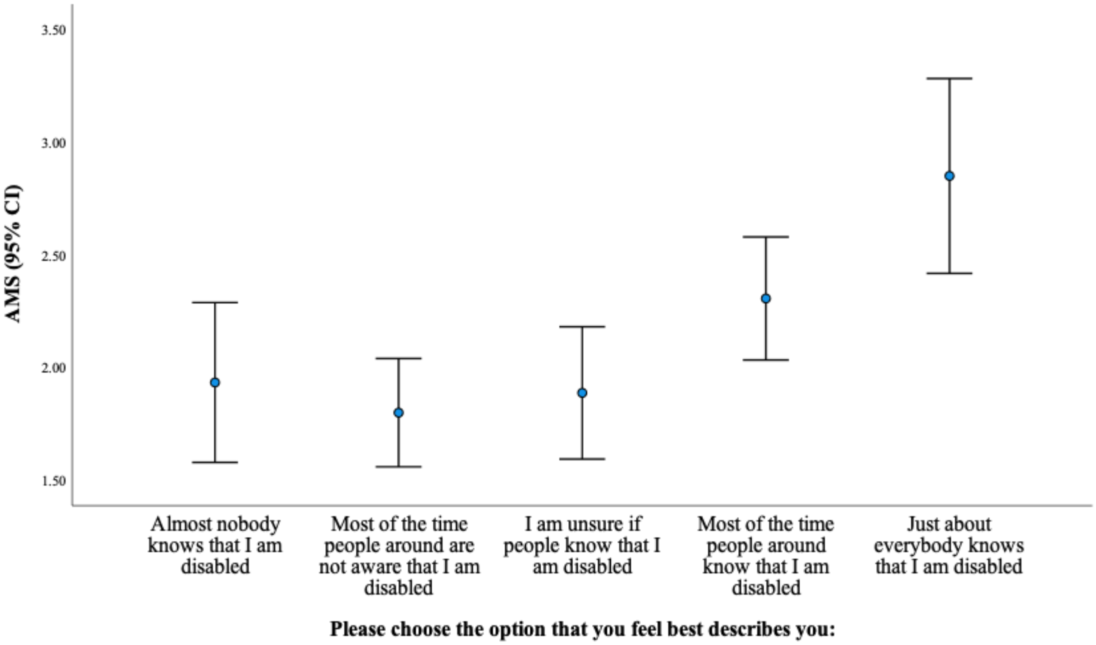


Figure 4. Mean AMS score by disability visibility

Given that there was a significant difference between group's AMS score based on disability visibility, another one-way ANOVA was performed to compute the effect of disability visibility and well-being. The one-way ANOVA explained there was a statistically significant difference in well-being between at least two groups (*F*(3,115) = 5.325, *p* =.002 η^2 = .122; 95% C.I. = [.020, .221]). See Table 5 for means and standard deviations which includes the 13 participants who were "unsure if people know that I am disabled," but who were excluded from the post hoc analysis.

Table 5 *Means and standard deviations of well-being score by disability visibility*

Disability Visibility Options	*N*	*M*	*SD*
1. Almost nobody knows that I am disabled	19	5.337	1.207
2. Most of the time people are not aware that I am disabled	47	5.415	1.583
3. Most of the time people around know that I am disabled	24	6.050	1.292
4. Just about everybody knows that I am disabled	31	6.800	2.056
5. I am unsure if people know that I am disabled	13	5.569	0.501

Note. Well-Being = PERMA Profiler Core 15-items

Tukey's HSD Test for multiple comparisons explained that the mean value of well-being was significantly different between "Almost nobody knows that I am disabled" and "Just about everybody knows that I am disabled" (*p* = .013, 95% C.I. = [-2.698, -.229], and between "Most of the time people are not aware that I am disabled" and "Just about everybody knows that I am disabled" (*p* = .002, 95% C.I. = [-2.374, -.398]. There was no statistically significant difference in mean scores between "Almost nobody knows that I am disabled" and "Most of the time people are not aware that I am disabled" (*p* = .998), or between "Almost nobody knows that I am disabled" and "Most of the time people around know that I am disabled" (*p* = .478), or between "Most of the time people are not aware that I am disabled" and "Most of the time people around know that I am disabled" (*p* = .404), or between "Most of the time people around know that I am disabled" and "Just about everybody knows that I am disabled" (*p* = .331). See Figure 5 for a visual representation of the relationship, which does include the 13 participants excluded from the ANOVA who endorsed feeling "unsure if people know that I am disabled."

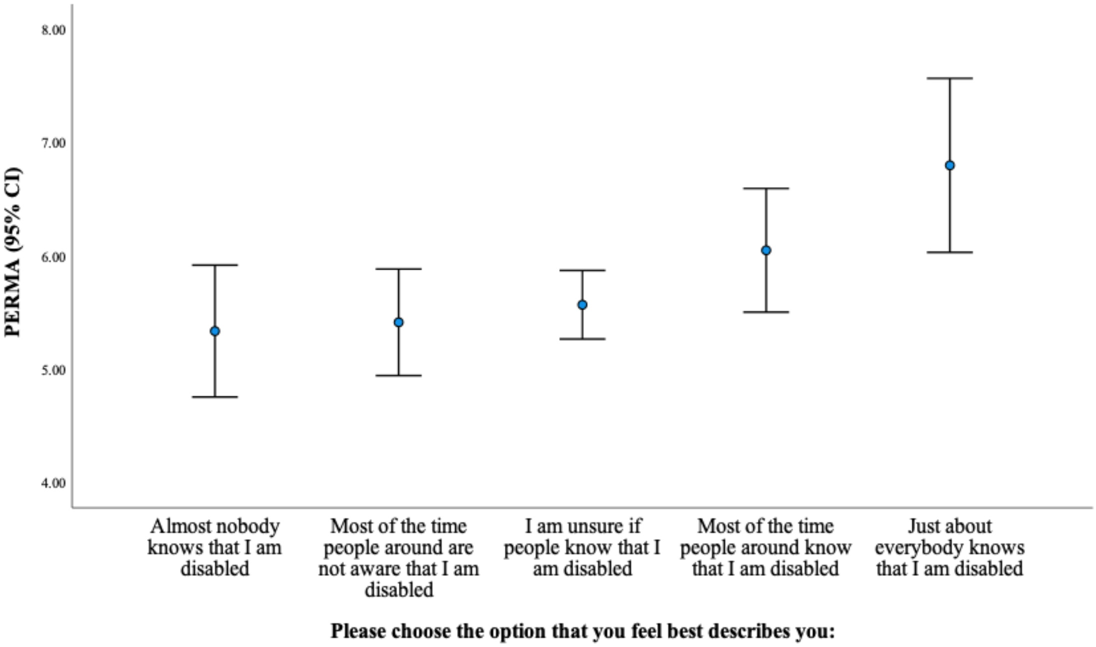


Figure 5. Mean well-being score by disability visibility

Given prior research has found differences in AMS scores based on disability severity a post hoc analysis of variance test was performed with disability impact entered as the independent variable and AMS was entered as the dependent. The model was significant *F*(3,115) = 5.273, *p* =.002. See Table 6 for means and standard deviations which includes the full data set. Tukey's HSD Test for multiple comparisons explained that the mean value of AMS was significantly different between *minimally* and *severely* (*p* = .036, 95% C.I. = [-1.548, -.036], between *minimally* and *very severely* (*p* = .003, 95% C.I. = [-1.882, -.293], and between *moderately* and *very severely* (p =.029, 95% C.I. = [-1.231, -.047]. There was no statistically significant difference in mean scores between *minimally* and *moderately* (*p* = .378), between *moderately* and *severely* (*p* = .349), or between *severely* and *very severely* (*p* = .610) See Figure 6 for a visual representation of the relationship.

Table 6 *Means and standard deviations of AMS score by disability impact*

"My disability impacts my life"	*N*	*M*	*SD*
1. Minimally	14	1.561	0.357
2. Moderately	46	2.009	0.962
3. Severely	34	2.352	0.867
4. Very Severely	25	2.648	1.076

Note. AMS = Ableist Microaggression Scale

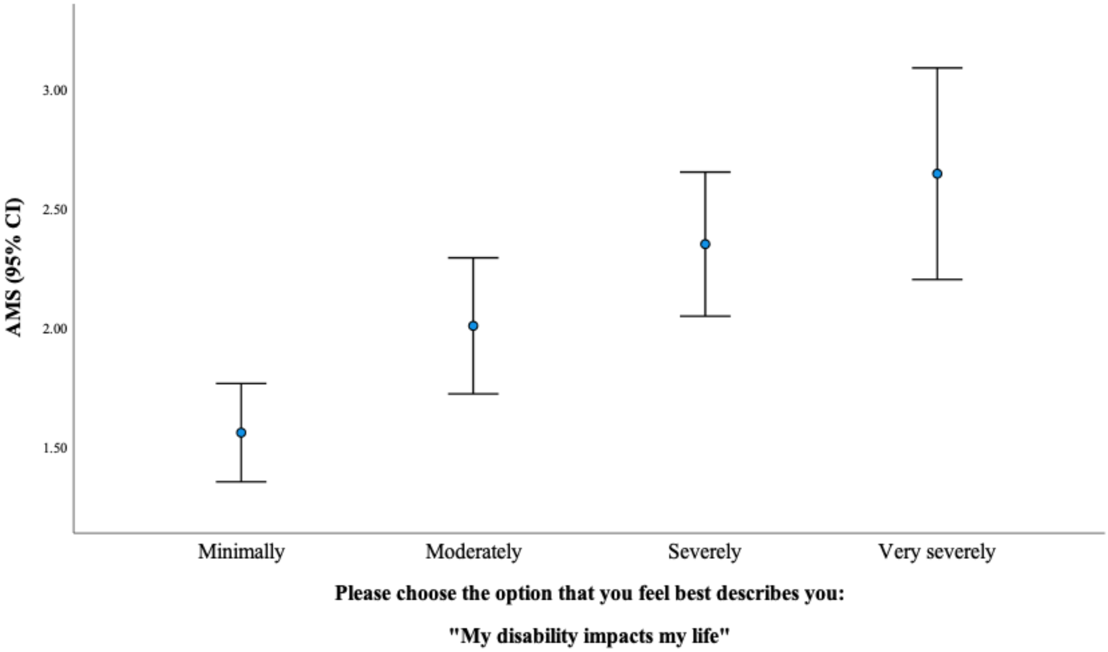


Figure 6. Mean AMS score by disability impact

Given that there was a statistically significant difference in AMS score by disability impact, an exploratory post hoc analysis was conducted to determine if there were differences in well-being scores based on disability impact. A post hoc analysis of variance test was performed with disability impact entered as the independent variable and well-being was entered as the dependent. The model was not significant *F*(3,115) = 4.119, *p* =.235. See Table 7 for means and standard deviations which includes the full data set. See Figure 7 for a visual representation of the relationship.

Table 7 *Means and standard deviations of well-being score by disability impact*

"My disability impacts my life"	*N*	*M*	*SD*
1. Minimally	14	5.557	0.333
2. Moderately	46	6.284	1.372
3. Severely	34	5.651	1.835
4. Very Severely	25	5.880	1.701

Note. Well-being = PERMA Profiler Core 15-item

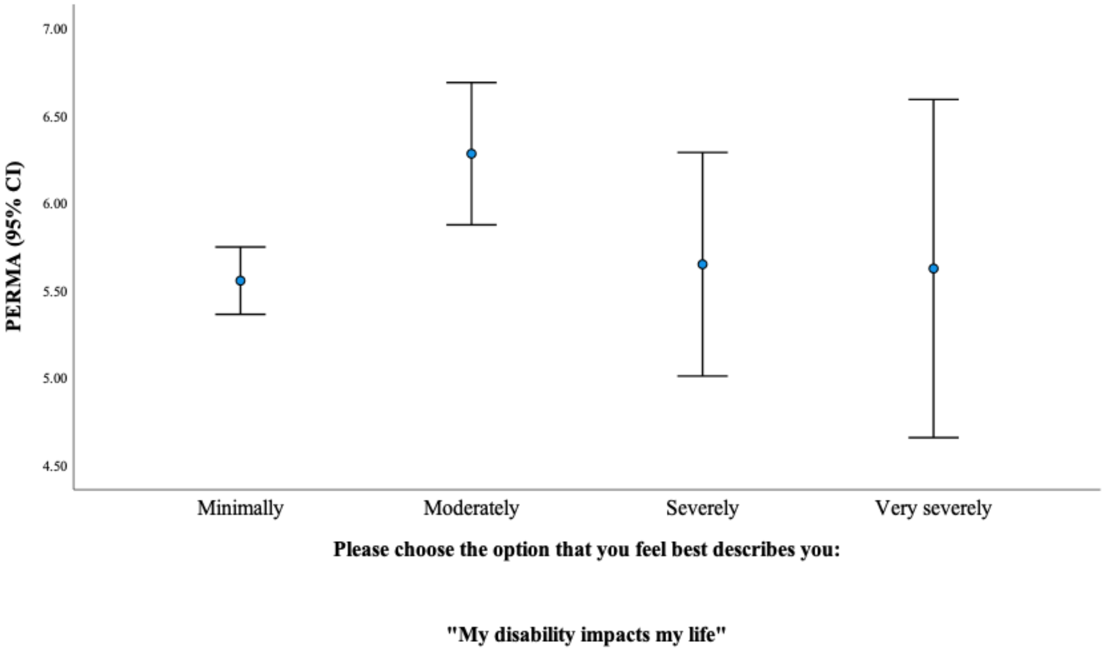


Figure 7. Mean well-being score by disability impact

Post hoc Analyses of AMS Factors

To further probe the relationship between the variables, post hoc correlational analysis was run with the four factors of the AMS. The minimization factor of the AMS negatively correlated with well-being (*r* = -.357, *p* <.01) and disability visibility

(r = -.321, p <.01), and positively correlated with depression symptoms score (r = .505, p <.01). The helplessness factor, the denial of personhood, and the otherization factors of the AMS did not correlate with well-being, see Table 8 for the follow up correlational analysis by AMS factors.

Table 8

Descriptive statistics and correlations by AMS factors

Variable	*M*	*SD*	1	2	3	4	5	6	7	8
1. Well-being[a]	5.88	1.70	—							
2. Minimization[b]	2.89	1.32	-.357**	—						
3. Helplessness[c]	2.26	1.13	.177	.010	—					
4. Denial of Personhood[d]	2.05	1.28	-.093	.142	.671**	—				
5. Otherization[e]	1.94	1.16	.058	.084	.765**	.770**	—			
6. SS_Coping [f]	9.74	2.88	.234*	.067	.121	.042	.138	—		
7. A_Coping[g]	6.82	2.46	-.463*	.358**	-.096	-.059	-.091	-.050	—	
8. Depression[h]	2.29	2.10	-.584**	.505**	.024	.155	.056	.126	.471**	—
9. Disability Visability[i]	3.00	1.50	.336**	-.321**	.537**	.375**	.449**	.112	-.374**	-.174

Note..[a] Well-Being = PERMA Profiler Core 15-items [b]Minimization Factor from the Ableist Microaggression Scale. [c]Helplessness from the Ableist Microaggression Scale.

[d]Denial of Personhood factor from the Ableist Microaggression Scale.

[e] Otherization factor from the Ableist Microaggression Scale.

[f]SS_Coping = Socially Supported Coping items from the Brief COPE.

[g]A_Coping= Avoidant Coping items from Brief COPE. [h]Depression = PHQ4 Depression items.

[i]Disability Visibility asked on a Likert scale with lower scores indicating the participants did not believe that people around them knew that they were disabled with n=13 removed who were unsure for an n = 119. * $p < .05$, ** $p < .01$

A simple linear regression was created to predict well-being based on the AMS minimization factor with those unsure about their disability visibility removed for an n = 119. A significant regression equation was found $F(1,117) = 17.052$, $p <.001$), with an R^2 of .127. A post hoc moderation model was created in the same fashion as the original study, with the AMS minimization factor entered as the independent variable in the model, well-being entered as the dependent variable, socially supported coping and avoidant coping entered as moderators, with depression symptoms score and disability visibility entered as covariates using PROCESS model 2.

The overall model between ableist microaggressions minimization factor and well-being with socially supported coping and avoidant coping as moderators and depression symptoms score and disability visibility as covariates was statistically significant $F(7,111) = 15.914$, $p <.001$, $R^2 = .501$. However, the main effect of ableist microaggression minimization factor did not significantly predict well-being ($b_1 = -.113$, $t(111) = -.799$, $p =.426$), which means that the AMS minimization factor, which was significantly negatively correlated with well-being was not significant in the moderation model. In this model socially supported coping did predict well-being score ($b_2 =.158$, $t(111) = 3.886$, $p < .001$); however, the interaction between the ableist microaggression minimization factor and socially supported coping was not significant ($b_4 = .033$, $t(111) = .815$, $p = .417$, $\Delta R^2 = .007$). Avoidant coping did predict well-being score ($b_3 = -.115$, $t(111) = -2.002$, $p =.047$); however, the interaction term for ableist microaggression minimization factor and avoidant coping did not significantly predict well-being score ($b_5 = -.066$, $t(111) = -1.269$, $p =.207$, $\Delta R^2 = .007$). Depression symptoms score did predict well-being score (b_6 =-.391, $t(111)$ = -5.900, p <.001) and the covariate disability visibility was significant (b_7 =.190, $t(111)$ = 2.063, p =.041).

CHAPTER IV - DISCUSSION

In the spirit of the foundational principles of Rehabilitation Psychology specifically, psychosocial assets, which approach working from a strengths-based perspective the aim of this study was to examine a positive psychological construct while also examining the consequences of living in an ableist culture (Dunn, Ehde, & Wegener, 2016; Stiers, 2016). Specifically, this study aimed to evaluate if coping strategies moderate the relationship between ableist microaggressions and well-being; with depression symptoms and disability visibility entered as covariates because in prior research, depression symptoms and disability visibility have been found to have a significant relationship with ableist microaggressions.

Critical disability studies theory recognizes that as with other minority groups, disabled people are viewed and defined in relation to the non-disabled majority (Goodley, et al., 2019; Nario-Redmond, 2020). The author of *Disability-Affirmative Therapy* Dr. Rhoda Olkin explains, “Ableism encompasses the bias that able-bodied is normal, typical, and desired, and therefore disability is aberrant, deviant, and undesirable” (Olkin, 2017, p. 7). Prior empirical research supports the minority stress model, which has found that for members of the nondominant group discrimination leads to health disparities including those affecting mental health (Lund et al., 2021; Meyer, 1995, 2003).

Consistent with prior findings all the participants in this study (*n* = 132) endorsed experiencing ableist microaggressions (Conover et al., 2017). The findings underscore that ableist microaggressions are a ubiquitous experience for members of the disability community. The mean score of AMS in this study (*M* = 2.16, *SD* = .93) was higher than in prior studies; however, it was within the standard deviation range of the AMS score in the initial validation study of the AMS (*M* = 1.93, *SD* = .96; Conover et al., 2017). As a result, the sample appears broadly consistent with prior literature in terms of exposure to ableist microaggressions even though average scores were somewhat higher than what has been reported from other samples.

Hypothesis 1: Higher frequency of ableist microaggressions will be negatively correlated with well-being

My first a priori hypothesis was a higher frequency of ableist microaggressions would be negatively correlated with well-being, such that a higher frequency of microaggressions would be associated with lower levels of well-being. Inconsistent with prior research and the hypothesized model AMS score was not significantly negatively correlated with well-being ($r = -.013$, $p = .885$). The lack of significance in the relationship between ableist microaggressions and well-being was not due to a lack of ableist microaggressions, because as mentioned previously, in the sample the mean AMS scores were on the high end of the range endorsed by other samples. The average well-being score in this study was (*M* = 5.85, *SD* = 1.61), and while slightly lower than prior studies, it was within the standard deviation range of the average PERMA score in a prior study that examined well-being in the disability community (*M* = 6.58, *SD* = 1.97; Umucu & Lee 2020). Therefore, both variables performed within expected range.

One explanation for the lack of a statistically significant relationship between ableist microaggression and well-being is prior research has found that discrimination has a weaker relationship with positive outcomes than with negative outcomes (Schmitt et al., 2014). As previously mentioned, a prior meta-analytic review by Schmitt and colleagues (2014), reported that the relationship between perceived disability discrimination and well-being was weaker for positive outcomes such as self-esteem and life satisfaction than it was for negative outcomes such as depression or anxiety symptoms. Indeed, the lack of support for this hypothesis and the statistically significant relationship between AMS and depression symptom score ($r = .208$, $p < .05$) is consistent with the evidence that well-being as a construct is conceptually different than the absence of distressing depression symptoms (Bech et al., 2003). Indeed, if well-being were merely the absence of depression symptoms, a similar inverse correlation between AMS score and well-being would be expected as there was between AMS score and depression symptoms. Depression symptom measures assess for low mood and anhedonia. In contrast well-being measures, specifically the PERMA assess how well people feel they are doing across five domains that taken together comprise well-being; which are positive emotion, engagement, positive relationships, meaning and accomplishments (Butler & Kern, 2016; Seligman, 2018).

Hypothesis 2a & 2b: Coping will moderate the relationship between ableist microaggressions and well-being

My second a prior hypothesis examined socially supported coping and avoidant coping as moderators. I hypothesized that socially supported coping would buffer the effect of ableist microaggressions on well-being. Specifically, those who endorsed socially supported coping strategies (emotional support and instrumental support) would have higher levels of well-being despite the frequency of microaggressions. Consistent with prior research the moderator socially supported coping did predict well-being, indicating that for every one unit in social supported coping there is a .188 unit increase in well-being. However, the interaction between ableist microaggression and socially supported coping was not significant. The lack of significance in the interaction between ableist microaggressions and socially supported coping may have been in part due to the way this study operationalized and measured socially supported coping. Socially supported coping was made up of instrumental and emotional support items. Although questions about coping asked participants to reflect only on the way they cope with ableist microaggressions, it is possible that people responded to how they cope generally. Additionally, in the context of a disability sample, social support may involve different factors that were not assessed such as assistance with activities of daily living (ADLs).

The second moderator avoidant coping did not predict well-being score and the interaction term for ableist microaggression and avoidant coping did not significantly predict well-being score. When the post hoc analyses were conducted after the removal of the 13 participants who were unsure about their disability visibility avoidant coping did predict well-being score, indicating that for every one unit in avoidant coping there is a -.123 unit decrease in well-being. Avoidant coping, which included behavioral disengagement and substance use has been associated with lower well-being in prior research (Brands et al., 2018; Mayordomo et al., 2016; Snell et al., 2011). Avoidant coping may have become significant with the removal of the 13 participants who were unsure about their disability visibility because with the removal of those participants the average AMS score increased from (*M* =2.16, *SD* = .93, *n* = 132) to (*M* = 2.19, *SD* = .96, *n* = 119). The increase in AMS score when the 13 participants who were unsure about their disability visibility were removed is consistent with critical disabilities studies theory and social dominance theory that those with more visible disabilities experience more ableist microaggressions.

The covariates depression symptoms score and disability visibility both significantly predicted well-being. The first covariate was depression symptom score, and it did predict well-being; indicating that for every one unit increase in depression there was a -.367 unit decrease in well-being. This is consistent with prior research where higher depression symptom scores were significantly correlated with lower well-being scores (Schmitt, et al., 2014). The covariate disability visibility was also a significant predictor of well-being, for every one unit increase in disability visibility there was a .190 unit increase in well-being. As mentioned above consistent with social dominance theory and critical disabilities studies people with more visible disabilities report experiencing more ableist microaggressions; however, inconsistent with the proposed hypothesis they also report higher well-being. Higher AMS score was correlated with depression and depression negatively correlated with well-being, but there was no significant relationship between AMS and well-being. This highlights the need for additional research to explore what potentially mediates the relationship between ableist microaggressions and well-being.

Post hoc Analyses

Consistent with disability studies theory and prior research using the AMS people who reported having a more visible disability had higher AMS score; however, inconsistent with prior studies people who reported having a more severe disability did not have statistically higher AMS scores. Although inconsistent with prior findings, the difference between disability visibility and disability impact is consistent with critical disability studies theory and social dominance theory, which explains that microaggressions are more likely to be experienced by people who are “perceived farthest from able-bodied norm" (Conover et al., 2017, p. 591). People may have the introspective experience that their disability significantly impacts their life; however, that does not necessarily mean that their disability is apparent to others, which was predictive of higher AMS scores.

Given that this study aimed to investigate the relationship between ableist microaggressions and well-being, exploratory post hoc analyses were conducted to determine if there were differences in well-being scores based on disability impact and disability visibility. There was no statistically significant difference in well-being scores based on disability impact; however, there was when based on disability visibility. As previously mentioned in the discussion those that reported having more visible disabilities reported higher AMS scores; however, they also reported higher levels of well-being than those with less visible disabilities. These findings suggest that while people with more visible disabilities experience more ableist microaggressions they also have higher levels of well-being.

Post hoc analyses indicated that the minimization factor of the AMS was significantly negatively correlated with well-being. The minimization factor assesses the idea that "respondents are overstating their impairment or needs and imply individuals with a disability could be able-bodied if they wanted to be or that they are actually able-bodied" (Conover et al., 2017, p. 581). In a simple linear regression, 12.7% of the variance in well-being score could be explained by the minimization factor of the AMS; however, in the moderation model, there was no direct effect or moderation effect with either socially supported coping or avoidant coping. Although combined not all types of ableist microaggressions seem to have a statistically significant detrimental impact on well-being, those microaggressions that minimize the lived experience of someone with a disability negatively impacts well-being.

Limitations

Several limitations of the present student should be considered alongside the interpretations of the results. Due to the cross-sectional study design, it is not possible to answer questions of causality between variables. There is likely an under sampling of people who are low socioeconomic status (SES). This study only sampled people who had access to technology that allowed them to connect to the internet. Furthermore, related to SES, 27.3% of the sample reported working 40+ hours per week and an additional 23.5% reported working part-time, which is higher than the national average for people with disabilities in 2022 which was 22.9% (Office of Disability Employment Policy, 2022). Therefore, it is possible that the findings may not generalize to the broader disability community even in the United States given the resources necessary to participate and the higher than national average percentage of participants who were employed.

Another limitation is regarding how different constructs were assessed. Even with the directions provided in the survey, the measure used to assess coping may have detected how participants cope generally and not specifically how they cope with ableist microaggressions. When people with marginalized identities experience microaggressions they must make an in the moment decision about how they are going to respond. Given that microaggressions are a unique type of stressor, standard coping strategies may not actually be available or safe the moment people experience an ableist microaggression (Olkin, 2017). Another limitation is that both the AMS and the PERMA scales are scored by averaging the total, therefore assuming an equal weight of the different subscales. As seen in the AMS the minimization factor was correlated with the PERMA, but because the other subscales were not, the overall relationship did not exist when all the subscales were included. Additionally, due to the response burden and additional measures needing to be included the PHQ-2 was used to assess depression symptoms, which has reduced variability in depression symptoms compared to PHQ-9 or CESD-10. Also, the lack of a standardized way of assessing disability visibility and disability impact limits the comparison to other studies even if similar constructs are measured. Finally, given the lack of relationship between ableist microaggressions and well-being, it is likely that other variables/constructs that were not measured are potentially influential on the relationships, such as disability identity formation, connection to the disability community, and or disability pride (Andrews, 2020; Forber-Pratt et al., 2022; Gill 1997; Nario-Redmond et al., 2012).

Clinical Application

A primary goal of clinical psychology is to decrease distress such as those caused by depression symptoms, and it is important for clinicians to also be aware of factors that are contributing to decreasing well-being outside of mental health symptoms. Although the full ableists microaggression scale predicted higher depression symptoms scores, only the minimization factor predicted lower well-being scores. As previously mentioned, one of the foundational principles of rehabilitation psychology is the insider-outsider distinction, and how outsiders including clinicians may view disability as all encompassing, and decidedly negative (Dunn, Ehde, Wegener, 2016). Clinicians therefore need to be aware of how this can lead to the spread effect, where disability engulfs the field of perception while working with a client with a disability (Dunn, Ehde, Wegener, 2016; Olkin, 2017). This current study highlights that in addition to not essentializing disability it is also crucial for clinicians to be aware of comments that could be interpreted as minimizing a person's disability, since those comments may negatively impact well-being.

Education about disability rights and disability pride is important for all clinicians to be able to work from a strengths-based biopsychosocial model rather than a deficits model (Goering, 2015). Additionally, books such as Dr. Olkin Disability Affirmative Therapy (D-AT) provides a framework for exploring and "gathering information, systematizing the information, and understanding the disability in the context of the individual (and family) in order to develop a case formulation that guides treatment" (Olkin, 2017, p. 2). As Dr. Olkin further explains, "The goal of this exploration is to derive a case formulation that neither overinflates nor underestimates the role of disability in the person's life and presenting problems" (Olkin, 2017, p. 3).

When working with people with disabilities, Dr. Olkin suggests that if the topic has not come up one-way clinicians can inquire about microaggressions is by using the Disability Hassles Scale (Olkin, 2017). The scale inquiries about 40 experiences in which people with physical disabilities may feel hassled in the past month, their perception of the event or how they experienced it, as well as questions about how often the person experienced hassles and how typical the last 30 days were in terms of the number of hassles experienced (Olkin, 2017). An example of one of the hassles is "Others downplayed or minimized my disability (e.g., "I never think of you as disabled")" (Olkin, 2017, p. 139). Olkin explains, that examining the microaggressions a client is experiencing can help some make connections between, “their current dysphoric, anxious, or angry mood. Making the connection can help refute the idea that feelings come out of the blue” (Olkin, 2017, p. 139). Part of the clinical work may involve helping people come up with ways to respond to typical microaggressions that they experience so that they can choose how they will respond including when to confront others, make formal complaints, and when to actively ignore the microaggression (Olkin, 2017).

As part of clinical work with members of the disability community, clinicians should also advocate for inclusive work environments that recognize disability as diversity in the staff and trainees (Andrews & Lund, 2015; Elliot et al., 2002; Lund, 2022). As Elliot and colleagues (2002) explain in a book chapter about positive growth following acquired physical disability, “To appreciate the unique perspectives of persons living with disabilities, it is prudent to hire staff members who have disabilities. This not only will enhance service provisions but also will model professionalism, independence, and self-sufficiency for the individuals served” (p. 694). A 2022 commentary discusses the value of the *insider-professional* perspective of disability that disabled psychologists and trainees bring to the profession with their lived experience with disability along with their professional expertise (Lund, 2022).

Future Directions

Building on the existing published research findings that ableist microaggressions correlate with depression symptoms and the findings of this study, future research is needed to explore what potential mediators exist to explain the lack of significant relationship between ableist microaggressions and well-being. A potential explanation for the higher well-being scores in those who report experiencing more ableist microaggressions is that people with more visible disabilities is that they have integrated disability into their identity and or have a greater sense of belonging and pride in being a member of a marginalized group than those with less visible disabilities (Forber-Pratt et al., 2022; Hahn & Belt, 2004). Future research is needed to analyze if this relationship exists in other samples and to describe resiliency and protective factors to explain why people who report higher frequency of ableist microaggressions also report higher levels of well-being.

Utilizing participatory action research methods in future research from the start will help ensure that the questions being asked are questions that members of the disability community feel are most pressing and relevant. It will also be beneficial for future research to be mindful that certain recruitment methods and sampling procedures make it easier or harder for different groups to participate in research and therefore limit the generalizability. Finally, future research should be aware if there is development in a standardized way to assess for disability visibility, disability severity, or disability impact.

Conclusion

Although disability has been often viewed from a deficits medical model, with disability rights advocates and disability studies the view of disability is shifting to a biopsychosocial perspective where disability is conceptualized as an aspect of identity diversity (Andrews, 2020, Nario-Redmond et al., 2012). With the shift to viewing disability as a component of identity, there is an increasing need for more research to examine the relationship between disability and positive psychological constructs (Elliot et al., 2002; Haque et al., 2020). As Dr. Andrews (2020) explained in her book Disability as Diversity:

> Rather than pathologizing disability and fostering dependence, positive psychology approaches help clients (re)discover their own abilities and enable them to utilize skills learned in therapy and generalize them in other areas of their lives long after rehabilitation is complete and psychotherapy has been completed (Kerkhoff & Hanson, 2015). (p. 148)

The current study is consistent with prior research that has found people with disabilities experience ableist microaggressions and that socially supported coping predicts higher well-being. Overall, findings in this study suggest that experiencing ableist microaggressions may not have a direct relationship to well-being; however, specific types of microaggressions, specifically minimization microaggressions do have a negative impact on well-being. By examining positive psychological constructs as an outcome variable this study helps to expand the focus of psychology to examine what is associated with people flourishing and not solely what is associated with psychopathology or the absence of distress.

REFERENCES

Andrews, E. E. (2020). *Disability as Diversity*. Academy of Rehabilitation Psychology. Oxford University Press.

Andrews, E. E., Forber-Pratt, A. J., Mona, L. R., Lund, E. M., Pilarski, C. R., & Balter, R. (2019). #SaytheWord: A disability culture commentary on the erasure of “disability.” *Rehabilitation Psychology, 64*(2), 111–118. https://doi.org/10.1037/rep0000258

Andrews, E. E., & Lund, E. M. (2015). Disability in psychology training: Where are we? *Training and Education in Professional Psychology, 9*, 210–216. http://dx.doi.org/10.1037/tep0000085

Bech, P., Olsen, L. R., Kjoller, M., Rasmussen, N. K. (2003). Measuring well-being rather than the absence of distress symptoms: A comparison of the SF-36 Mental Health subscale and the WHO-Five well-being scale. *International Journal of Methods in Psychiatric Research, 12*(2), 85–91. https://doi.org/10.1002/mpr.145

Bentley, J.A., Bruyere, S. M., LeBlan, J., MacLanchlan, M. (2016). Globalizing rehabilitation psychology: application of foundational principles to global health and rehabilitation challenges. *Rehabilitation Psychology, 61*(1), 65–73.

Brands, I., Bol, Y., Stapert, S., Köhler, S., & van Heugten, C. (2018). Is the effect of coping styles disease specific? Relationships with emotional distress and quality of life in acquired brain injury and multiple sclerosis. *Clinical Rehabilitation, 32*(1), 116–126. https://doi.org/10.1177/0269215517718367

Brooks, V. (1981). *Minority stress and lesbian women.* Lexington Books, Heath, and Co.

Butler, J. & Kern, M. L. (2016). The PERMA-Profiler: A brief multidimensional measure of flourishing. Available from http://www.peggykern.org/questionnaires.html

Carver, C. S. (1997). You want to measure coping but your protocol’s too long: Consider the Brief COPE. *International Journal of Behavioral Medicine, 4*, 92–100. doi:10.1207/s15327558ijbm0401_6

Carver, C, Connor-Smith, J. (2010). Personality and coping. *Annual Review of Psychology, 61*, 679-704. doi: 10.1146/annurev.psych.093008.100352

Columb, M., Atkinson, M. (2016). Statistical analysis: sample size and power estimations. *BJA Education, 16*(5), 159-161.

Conover, K. J., & Israel, T. (2019). Microaggressions and social support among sexual minorities with physical disabilities. *Rehabilitation Psychology, 64*(2), 167–178. https://doi.org/10.1037/rep0000250

Conover, K. J., Israel, T., & Nylund-Gibson, K. (2017). Development and Validation of the Ableist Microaggressions Scale. *The Counseling Psychologist, 45*(4), 570–599. https://doi.org/10.1177/0011000017715317

Crenshaw, K. (1989). Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine. Feminist Theory and Antiracist Policies. *University of Chicago Legal Forum, 1*, 139-167.

Dunn, D. S. (2015). *The social psychology of disability.* Oxford University Press.

Dunn, D. S., & Brody, C. (2008). Defining the good life following acquired physical disability. *Rehabilitation Psychology, 53*(4), 413–425. https://doi.org/10.1037/a0013749

Dunn, D. S., Ehde, D. M., Wegener, S. T. (2016). The foundational principles as psychological lodestars: Theoretical inspiration and empirical direction in rehabilitation psychology. *Rehabilitation Psychology*, 61(1), 1–6. https://dx.doi.org/10.1037/rep0000082

Eisenberg, S., Shen, B.-J., Schwarz, E., & Mallon, S. (2012). Avoidant coping moderates the association between anxiety and patient-rated physical functioning in heart failure patients. *Journal of Behavioral Medicine, 35*(3), 253–261. https://doi.org/10.1007/s10865-011-9358-0

Elliot, T., Kurylo, M., Rivera, P., (2002). Positive growth following acquired physical disability. In: Snyder CR, Lopez SJ eds. *Handbook of positive psychology*. New York, NY: Oxford University Press, 499-480.

Forber-Pratt, A. J., Price, L. R., Merrin, G. J., Hanebutt, R. A., & Fairclough, J. A. (2022). Psychometric properties of the Disability Identity Development Scale: Confirmatory factor and bifactor analyses. *Rehabilitation Psychology*, *67*(2), 120–127. https://doi.org/10.1037/rep0000445

Gill, C. J. (1997). Four types of integration in disability identity development. *Journal of Vocational Rehabilitation*, *9*(1), 39-46.

Goering S. (2015). Rethinking disability: the social model of disability and chronic disease. *Current reviews in musculoskeletal medicine*, *8*(2), 134–138. https://doi.org/10.1007/s12178-015-9273-z

Goodley, D., Lawthom, R., Liddiard, K., & Runswick-Cole, K. (2019) Provocations for Critical Disability Studies. *Disability & Society, 34(*6), 972-997, DOI: 10.1080/09687599.2019.1566889

Hackett, R. A., Steptoe, A., Lang, R. P., & Jackson, S. E. (2020). Disability discrimination and well-being in the United Kingdom: A prospective cohort study. *BMJ Open*, *10*(3), e035714. https://doi.org/10.1136/bmjopen-2019-035714

Hahn, H. D., & Belt, T. L. (2004). Disability identity and attitudes toward cure in a sample of disabled activists. *Journal of Health and Social Behavior, 45,* 453–464. http://dx.doi.org/10.1177/002214650404500407

Hagan, T. L., Fishbein, J. N., Nipp, R. D., Jacobs, J. M., Traeger, L., Irwin, K. E., Pirl, W. F., Greer, J. A., Park, E. R., Jackson, V. A., & Temel, J. S. (2017). Coping in patients with incurable lung and gastrointestinal cancers: A validation study of the brief cope. *Journal of Pain and Symptom Management, 53*(1), 131–138. https://doi.org/10.1016/j.jpainsymman.2016.06.005

Haque, O. S., Lenfest, Y., & Peteet, J. R. (2020). From disability to human flourishing: How fourth wave psychotherapies can help to reimagine rehabilitation and medicine as a whole. *Disability and Rehabilitation*, *42*(11), 1511–1517. https://doi.org/10.1080/09638288.2019.1602674

Hayes, A. F. (2018). *Introduction to mediation, moderation, and conditional process analysis: A regression-based approach* (Second ed., Methodology in the social sciences). The Guilford Press.

Hughes, J.L., Camden, A.A., & Yangchen, T. (2016). Rethinking and updating demographic questions: Guidance to improve descriptions of research samples. *Psi Chi Journal of Psychological Research, 21,* 138-151.

Itzick, M., Kagan, M., & Tal-Katz, P. (2018). Perceived social support as a moderator between perceived discrimination and subjective well-being among people with physical disabilities in Israel. *Disability and Rehabilitation*, *40*(18), 2208–2216. https://doi.org/10.1080/09638288.2017.1331380

Kattari, S. K. (2019). the development and validation of the ableist microaggressions scale. *Journal of Social Service Research*, *45*(3), 400–417. https://doi.org/10.1080/01488376.2018.1480565

Kattari, S. K. (2020). Ableist microaggressions and the mental health of disabled adults. *Community Mental Health Journal*, *56*(6), 1170–1179. https://doi.org/10.1007/s10597-020-00615-6

Keller, R. M., & Galgay, C. E. (2010). Microaggressive experiences of people with disabilities. In D. W. Sue (Ed.), *Microaggressions and marginality: Manifestation, dynamics, and impact* (pp. 241–268). John Wiley & Sons Inc.

Kennedy, P., Duff, J., Evans, M., & Beedie, A. (2003). Coping effectiveness training reduces depression and anxiety following traumatic spinal cord injuries. *The British journal of clinical psychology*, *42* (Pt1), 41-52. https://doi.org/10.1348/014466503762842002

King, C., & Kennedy, P. (1999). Coping effectiveness training for people with spinal cord injury: preliminary results of a controlled trial. *The British journal of clinical psychology*, *38*(1), 5–14. https://doi.org/10.1348/014466599162629

Kline, R. B. (2011). *Principles and practice of structural equation modeling* (3rd ed.). Guilford Press.

Kroenke, K., Spitzer, R. L., Williams, J. B. W., & Löwe, B. (2009). An Ultra-Brief Screening Scale for Anxiety and Depression: The PHQ–4. *Psychosomatics*, *50*(6), 613–621. https://doi.org/10.1016/S0033-3182(09)70864-3

Lazarus, R. S., & Folkman, S. (1984). *Stress, Appraisal, and Coping.* Springer.

Lazarus, R. S., & Folkman, S. (1987). Transactional theory and research on emotions and coping. *European Journal of Personality, 1*(3), 141–169. https://doi.org/10.1002/per.2410010304

Lee, H., & Hicken, M. T. (2016). Death by a thousand cuts: The health implications of black respectability politics. *Souls: a critical journal of Black politics, culture, and society, 18*(2-4), 421–445. https://doi.org/10.1080/10999949.2016.1230828

Lewin, K. A. (1935). *A dynamic theory of personality*. New York, NY: McGraw-Hill.

Lilienfeld, S. O. (2017). Microaggressions: Strong Claims, Inadequate Evidence. *Perspectives on Psychological Science, 12(*1), 138–169. https://doi.org/10.1177/1745691616659391

Litman, J. A. (2006). The COPE inventory: Dimensionality and relationships with approach- and avoidance-motives and positive and negative traits. *Personality and Individual Differences, 41*(2), 273–284. https://doi.org/10.1016/j.paid.2005.11.032

Lund, E. M. (2021). Examining the potential applicability of the minority stress model for explaining suicidality in individuals with disabilities. *Rehabilitation Psychology*. *66*(2), 183–191. http://dx.doi.org/10.1037/rep0000378

Lund, E. M. (2022). Valuing the insider-professional perspective of disability: A call for rehabilitation psychologists to support disabled psychologists and trainees across the profession. *Rehabilitation Psychology*. *67*(4), 582–586. https://doi.org/10.1037/rep0000452

Mayordomo, T., Viguer, P., Sales, A., Satorres, E., & Meléndez, J. C. (2016). Resilience and Coping as Predictors of Well-Being in Adults. *The Journal of Psychology, 150*(7), 809–821. https://doi.org/10.1080/00223980.2016.1203276

McCabe, C., Kim, D., & King, K. (2018). Improving Present Practices in the Visual Display of Interactions. Advances in Methods and Practices in Psychological Science, 1(2), 147-165

McRuer, R. (2006). *Crip Theory: Cultural Signs of Queerness and Disability*. New York: New York University Press.

Miller Smedema, S., Catalano, D., & Ebener, D. J. (2010). The Relationship of Coping, Self-Worth, and Subjective Well-Being: A Structural Equation Model. *Rehabilitation Counseling Bulletin*, *53*(3), 131–142. https://doi.org/10.1177/0034355209358272

Molero, F., Recio, P., García-Ael, C., & Pérez-Garín, D. (2019). Consequences of perceived personal and group discrimination against people with physical disabilities. *Rehabilitation Psychology*, *64*(2), 212–220. https://doi.org/10.1037/rep0000277

Meyer, I. H. (1995). Minority stress and mental health in gay men. *Journal of Health and Social Behavior, 36*, 38–56. http://dx.doi.org/10.2307/ 2137286

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin, 129*, 674–697. http://dx.doi.org/10.1037/0033- 2909.129.5.674

Nahlen Bose, C., Bjorling, G., Elfstrom, M. L., Persson, H., & Saboonchi, F. (2015). Assessment of coping strategies and their associations with health related quality of life in patients with chronic heart failure: The brief cope restructured. *Cardiology Research, 6*(2), 239–248. https://doi.org/10.14740/cr385w

Nario-Redmond, M. R. (2020). *Ableism: The causes and consequences of disability prejudice*. John Wiley & Sons, Inc.

Nario-Redmond, M., Noel, J., & Fern, E. (2012). Redefining disability, re-imagining the self: Disability identification predicts self-esteem and strategic responses to stigma. *Self and Identity, 12*(5), 1–21. https://doi.org/10.1080/15298868.2012.681118

Office of Disability Employment Policy. (2022). *May 2022 Disability Employment Statistics.* Department of Labor. https://www.dol.gov/agencies/odep

Olkin, R. (2017). *Disability-affirmative therapy: A case formulation template for clients with disabilities.* Oxford Press.

Olkin, R., Hayward, H., Abbene, M.S., VanHeel, G. (2019). The experiences of microaggressions against women with visible and invisible disabilities. *Journal of Social Issues, 75(3),*757-785). doi: 10.1111/josi.12342

Park, C. L., Armeli, S., & Tennen, H. (2004). Appraisal-coping goodness of fit: A daily internet study. *Personality and Social Psychology Bulletin, 30*, 558–569.

Pierce, C., Carew, J., Pierce-Gonzalez, D., & Willis, D. (1978). An experiment in racism: TV commercials. In C. Pierce (Ed.), *Television and education* (pp. 62–88)

Preacher, K.J., Hayes, A.F (2008). Asymptotic and resampling strategies for assessing and comparing indirect effects in multiple mediator models. *Behavior Research Methods* 40, 879–891. https://doi.org/10.3758/BRM.40.3.879

Reynolds, J., Silver, A. (2017). Feminism and disability. In Hay, C. (Ed.). *Philosophy: Feminism (295-315)*. Gale Cengage Learning.

Schmitt, M. T., Branscombe, N. R., Postmes, T., & Garcia, A. (2014). The consequences of perceived discrimination for psychological well-being: A meta-analytic review. *Psychological Bulletin*, *140*(4), 921–948. https://doi.org/10.1037/a0035754

Schmitt, M. T., Spears, R., & Branscombe, N. R. (2003). Constructing a minority group identity out of shared rejection: The case of international students. *European Journal of Social Psychology, 33,* 1–12. doi: 10.1002/ejsp.131

Schwartz, C. E., Andresen, E. M., Nosek, M. A., & Krahn, G. L. (2007). Response shift theory: Important implications for measuring quality of life in people with disability. *Archives of Physical Medicine and Rehabilitation*, *88*(4), 529–536. https://doi.org/10.1016/j.apmr.2006.12.032

Seligman, M. (2011). *Flourish*. New York, NY: Free Press.

Seligman, M. (2018). PERMA and the building blocks of well-being. *The Journal of Positive Psychology, 13*(4), 333–335. https://doi.org/10.1080/17439760.2018.1437466

Sheldon, K. M., & King, L. (2001). Why positive psychology is necessary. *American Psychologist, 56*(3), 216–217. https://doi.org/10.1037/0003-066X.56.3.216

Sica, C., Novara, C., Dorz, S., & Sanavio, E. (1997). Coping strategies: Evidence for cross-cultural differences? A preliminary study with the Italian version of coping orientations to problems experienced (COPE). *Personality and Individual Differences*, *23*, 1025–1029.

Skinner, E. A., Edge, K., Altman, J., & Sherwood, H. (2003). Searching for the structure of coping: a review and critique of category systems for classifying ways of coping. *Psychological bulletin*, *129*(2), 216–269. https://doi.org/10.1037/0033-2909.129.2.216

Snell, D. L., Siegert, R. J., Hay-Smith, E. J. C., & Surgenor, L. J. (2011). Factor structure of the brief cope in people with mild traumatic brain injury. *Journal of Head Trauma Rehabilitation, 26*(6), 468–477. https://doi.org/10.1097/HTR.0b013e3181fc5e1e

Stiers, W. (2016). Teaching the foundational principles of rehabilitation psychology. *Rehabilitation Psychology*, *61*(1), 54–64. https://doi.org/10.1037/rep0000078

Stallman, H. M. (2020). Health theory of coping. *Australian Psychologist*, *55,* 295–306. https://doi.org/*10.1111/ap.12465*

Sue, D. W. (2010). *Microaggressions in everyday life: Race, gender, and sexual orientation*. ProQuest Ebook Central https://ebookcentral-proquest-com.ezproxy.spu.edu

Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A. M. B., Nadal, K. L., & Esquilin, M. (2007). Racial microaggressions in everyday life: Implications for clinical practice. *American Psychologist, 62*(4), 271–286. https://doi.org/10.1037/0003-066X.62.4.271

Tabachnick, B. G., & Fidell, L. S. (2013). *Using multivariate statistics* (6th ed.). Pearson.

Umucu, E., & Lee, B. (2020). Examining the impact of COVID-19 on stress and coping strategies in individuals with disabilities and chronic conditions. *Rehabilitation Psychology, 65*(3), 193. https://doi.org/10.1037/rep0000328

World Health Organization. (2001). *International classification of functioning, disability and health: ICF*. Geneva, Switzerland: World Health Organization.

World Health Organization. (2020, December 1). *Disability and health.* Retrieved https://www.who.int/news-room/fact-sheets/detail/disability-and-health

Wolbring, G. (2008). The politics of ableism. *Development, 51*(2), 252–258. https://doi.org/10.1057/dev.2008.17

Wright, B. A. (1983). *Physical disability: A psychosocial approach* (2nd ed.). Harper Collins. http://dx.doi.org/10.1037/10589-000

Wright, A. J., & Wegner, R. T. (2012). Homonegative microaggressions and their impact on LGB individuals: A measure validity study. *Journal of LGBT Issues in Counseling, 6*, 35–54. doi:10.1080/15538605.2012.648578