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Topical Manuscript

The Impact of Ableist Microaggressions on Identity Formation Among Adults With Disabilities

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This study examined the impact of ableist microaggressions on the formation of a disability identity, with a heavy focus on the microinsult of presumed lack of intellect. Participants were 267 adults with cognitive and/or physical disabilities, ages 18 to 65, living in the United States. Experiences of ableist microaggressions were assessed using online survey data. Our analyses indicated ableist microaggressions appear to increase pride in a person's disability instead of the negative impact that was originally hypothesized. However, the microinsult of presumed lack of intellect was correlated with increased shame towards disability as hypothesized, also negatively impacting one's acceptance of their disability identity. Results also showed there is statistical significance when comparing gender differences in amount of ableist microaggressions encountered. Strengths, limitations, clinical implications, and directions for future research are discussed.

People with disabilities are one of the largest minorities in the United States, comprising approximately one quarter of the adult population (Okoro et al., 2018). There are several generally acceptable broad categories of disabilities (e.g., physical, cognitive, and sensory; Üstün et al., 2003); this study will involve only participants with physical/sensory or cognitive disabilities. Physical disabilities include upper and lower limb impairments, conditions that impair manual dexterity, brain injuries that affect physical movement, and spinal cord injury, among others, and sensory disabilities include visual impairment, blindness, hearing impairment, or being Deaf or hard of hearing (Jiménez et al., 2002; Lund & Trieber, in press) . It is important to note that many culturally Deaf and hard of hearing people do not consider their conditions to be disabilities, even though they are viewed as such by others (Andrews et al., 2019). Physical disabilities may co-occur with intellectual or cognitive disabilities; however, presence of a physical or sensory disability does not inherently indicate the presence of a cognitive or intellectual disability.

Another major type of disabilities, and a focus of this study, are cognitive disabilities, defined by diminished intellectual, cognitive, and/or adaptive development. Intellectual functioning refers to a person's ability to reason, plan, and comprehend, and adaptive behaviors refer to applying social and practical skills in everyday life (e.g., following social norms, problem solving skills, using money; Jiménez et al., 2002; Lund & Trieber, in press). Although some cognitive disabilities, such as intellectual disability, present with diminished intellectual capacity, others (e.g., autism spectrum disorder) do not necessarily involve impairment in intellectual ability but rather impairment in other cognitive and adaptive domains (Dawson et al., 2007). However, people may still assume that all individuals with autism have co-occurring intellectual impairment—in part due to a lack of accessible or accurate IQ tests for autistic individuals (Dawson et al., 2007; Estes et al., 2011)—leading to potential stigma and discrimination (Stillman, 2003, 2009).

Disability Identity Development

Across disability types, people with disabilities often go through a process of disability identity formation (Epp, 2001; Forber-Pratt et al., 2017; Johnstone, 2004), where they incorporate (or fail to incorporate) their disability into their broader sense of identity and self. Researchers have found that disability identity development can often be broken down into four distinct stages: (1) acceptance, (2) relationship, (3) adoption, and (4) engagement (Forber-Pratt & Zape, 2017). Throughout the stages of this process, people with disabilities integrate disability more fully and completely into their sense of self, eventually involving themselves as a member of various disability communities and seeing disability as a positive aspect of their sense of self, personhood, and purpose.

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The process of identity development often involves recognizing and addressing a large amount of internalized and external ableism that rejects the idea that disability can be a positive and healthy aspect of one's identity (Andrews et al., 2019; Forber-Pratt & Zape, 2017). Throughout the process of disability identity development, individuals examine and replace negative ableist assumptions about disability that they have internalized (e.g., "I'm worth less than a non-disabled person," "I will never be able to contribute much due to my disability," "I am only good if able-bodied people don't see me as disabled"), and, as a result of positive and affirming experience with the disability community and allies, eventually reject those assumptions and replace them with disability-affirmative ones (e.g., "The disability community is a powerful and meaningful community, and I am glad to be a member of it," "I accomplish things with my disability, not in spite of it," "My disability is an important and positive part of who I am"). Therefore, understanding ableism is key to understanding disability identity development, as confronting, rejecting, and replacing ableist beliefs is a critical feature of healthy disability identity development.

Ableism

As discussed above, ableism is a common experience among people with disabilities. Ableism is defined as targeting physical, emotional, and mental differences from the social norm and considering people with these differences to be a burden, objects of pity, or problems to society, as well as incapable of any sort of independence (Bogart & Dunn, 2019). Ableism may be systemic (e.g., inaccessible buildings) or interpersonal (e.g., disability-related slurs) and can be overt or covert in nature (Bogart & Dunn, 2019). It may also take the form of micro-aggressions, which are more minor or convert enactments of ableism that are nevertheless still harmful to the person receiving them (Keller & Galgay, 2010; Sue, 2010).

Microaggressions may fall into several subcategories, such as microinsults, microinvalidations, and microassaults (Olkin, 2009). A broad example of an ableist microaggession would be calling a disabled person inspirational because they are participating in everyday task such as going to school. An example of an ableist microinsult would be a non-disabled individual stating that a wheelchair user is "too attractive" to be disabled. In addition, an ableist microinvalidation may occur if a non-disabled person were to dismiss a disabled person's experience with ableism as "not that bad" (Olkin, 2009). Finally, an ableist microassault could be characterized by a non-disabled person speaking slowly to a disabled person as if the individual does not have the intellectual capacity to understand what is being said (Olkin, 2009). This last example would fall under the broader manifestation of ableism known as "presumption of lack of intellect," which is a form of ableism that weaponizes bias against people with cognitive or intellectual disabilities towards those with other disabilities by using such prejudice to assume intellect—and therefore, a broad lack of competence—among all people who appear to be disabled. This particular manifestation of ableism will be the focus of the present study.

Purpose of Present Study

A few studies have examined the experiences of related ableist microaggressions like infantilizing and patronization (Keller & Galgay, 2010; Timm, 2002); however, we are not aware of any studies specifically examining the effects of these microaggressions on disability identity development. Therefore, the current study sought to examine the impact of ableist microaggressions on adults with physical, sensory, and/or cognitive disabilities with a specific focus on the microinsults centered around the presumption of lack of intellect. Specifically, this study sought to determine whether the amount of ableist microaggressions experienced by a disabled person is related to disability identity formation. Additionally, we also examined the effect of a specific microaggression (i.e., lack of presumption of intellect) on a disability identity and shame. The Primary Hypotheses (PH) and Secondary Hypotheses (SH) are as follows:

1. (PH I): Ableist microaggressions will be negatively associated with disability identity acceptance.
2. (PH II): Lack of presumption of intellect will be positively associated with feelings of shame.
3. (PH III): Lack of presumption of intellect will be negatively associated with disability identity acceptance.
4. (SH I): Ableist microaggressions will be positively associated with diminished achievement drive.
5. (SH II): There will be a statistically significant difference in amount the of ableist microaggressions experienced by men compared to women.

Method

Recruitment

This study received Institutional Review Board (IRB) approval through Holy Family University prior to the beginning of recruitment. Recruitment of participants occurred through several online sources including (a) Facebook disability support groups, such as Cerebral Palsy Network, Women & Cerebral Palsy, The Sunshine Foundation Facebook page, and The Disability Pride Philadelphia Facebook page; (b) online listservs, such as Society for Disability Studies, Americans with Disabilities Act Discussion Group, and Disabled Student Services and Higher Education List Serve; and (c) various websites of organizations that aid individuals with disabilities, such as Inglis House and Woods Services, Inc. The virtual recruitment flyer explained that individuals with disabilities were being recruited for a dissertation study examining ableist microaggressions towards disabled adults and their impact on disability identity formation and included a link to the survey, which was hosted on a university Qualtrics server. Before beginning the survey, participants completed an electronic informed consent form and eligibility questions regarding their age and disability. Participants were not financially compensated but were informed that their participation could help people better understand the experiences of ableism and their impacts on people with disabilities.

Participants

Eligible participants were individuals between the ages of 18 and 65, who could read English at least a fourth-grade level and complete the informed consent for the study. Participants also had to be U.S. residents and had to report having been diagnosed with at least one congenital or acquired impairment (physical/sensory or cognitive) as defined above. An individual was excluded from the study if their physical or cognitive disability is a result of body integrity identity disorder or a sexual fetish (Blom et al., 2017). This is because, if the disability is acquired as a result of the aforementioned disorder or sexual fetish, it is presumed that the disability would have been desired by the individual and therefore they would not have undergone a typical process of disability identity development (Blom et al., 2017). Thus, these individuals likely would not have experienced the same baseline experiences with ableism and internalized ableism as would individuals who did not purposefully acquire a disability.

Participants were 267 adults, including 192 women (71.9%), 50 men (18.7%) and 25 individuals who identified as non-binary (9.4%). It should be noted that while there is a disproportionate number of women who participated in the study, is relatively common within scientific literature that more women than men participate in online surveys (Smith, 2008). With respect to types of disabilities within the sample, 149 (55.8%) categorized their disability as congenital, meaning they had their disability from birth. Seventy (26.2%) categorized their disability as acquired (i.e., due to an accident, trauma, etc.). Furthermore, 48 (18%) of the participants indicated that they identified with both the congenital and acquired types of disability. When considering the category of disability (i.e., physical, cognitive, or both), 158 (59.2%) identified as having with the physical/sensory disabilities alone, 43 (16.1%) identified as having cognitive disabilities alone, 64 (24%) identified as having both cognitive and physical disabilities, and 2 (0.7%) indicted they would prefer not to provide their disability type.

Measures

The survey was composed of three separate self-report measures. These included a demographics form, the Ableist Microaggression Scale (AMS; Conover et al., 2017), and the Intellectual Capacity Stigma Measure (ICSM). The demographic form gathered information on gender and type of disability (acquired, congenital or both) and category of disability (physical, cognitive or both). All demographic and screening items and the newly developed measure can be seen in full in Appendix A.

To maximize cognitive accessibility, we used measures that have been previously tested for cognitive accessibility with multi-disability samples (i.e., ASM) or created new measures (i.e., ICSM) from previous measures that had been developed for use with diverse disabled populations (Yuker et al., 1970). We also developed the survey measure in conjunction with several members of the research team, including the first and second authors, who have both professional and lived experience with disability and experience conducting research with disabled participants.

Ableist Microaggressions Scale. The AMS, which measures the experience of ableist microaggressions, consists of 65 statements such as "Someone asked uninvited questions regarding my disability status", which the participants rate on a Likert-type scale as *never, rarely, sometimes, often*, or *always.* In this measure, higher scores indicate higher levels of microaggressions experienced. It has demonstrated strong convergent and discriminate validity in disabled and non-disabled samples and strong internal consistency in prior studies (Conover et al., 2017). In the present study, the mean score on the AMS was 199.61, with a range of 90-321 and a standard deviation of 41.97. The distribution is approximately symmetric with a skewness statistic of .081, and the internal consistency was excellent (α =.95).

Intellectual Capacity Stigma Measure. The ICSM was designed specifically for this study, as there are currently no stigma measures that examine stigma surrounding intellectual capacity and the shame associated with it. The ICSM was adapted from the Attitudes Toward Disabled Persons Scale Form A (ATDP; Yuker et al., 1970). The ADTP has demonstrated strong validity and reliability in past psychometric studies (Yuker et al., 1970). The ICSM was developed to create a set of items that specifically focused on the experiences of intellectual capacity stigma (i.e., presumptions of low intellectual abilities) among people with disabilities, as no existent measures focused specifically on this particular manifestation of ableism. By creating a new measure to assess this construct, we were able to examine participant experiences of intellectual capacity stigma in greater depth and provide a baseline measure for future research in this area. We used the format and structure of the ADTP items as a guide for wording our items; however, no items from the ADTP scale were directly used for the ICSM.

The ICSM contains a Likert-type scale with 12 items such as: "I feel as if my thoughts are dismissed due to my disability" and "I often feel non-disabled people think I am stupid" and "When in conversations with able-bodied people, they often speak slower to me, as if I don't understand." The ICSM used the same qualifiers of *never, rarely, sometimes, often,* or *always* as used in the AMS, and higher scores represent higher intellectual capacity-related stigma. In the present study, the average score on the ICSM was 31.48, with a range of 13-56 and a standard deviation of 7.06. The distribution is approximately symmetric with a skewness statistic of .384, indicating an approximately even distribution of scores. The internal consistency of the measure was just slightly below the standard .70 cut-off for acceptable reliability, with a Cronbach's alpha of .691, although such a small difference should not be a concern in terms of overall evaluation (Cho & Kim, 2015)

Disability Identity Acceptance and Disability Shame. Due to concerns about study length and participant burden, we did not include a separate measure of disability identity acceptance and disability-related shame in the present study; rather, we used specific items from the AMS and ICMS to capture these constructs. The variable of disability identity acceptance is defined as question number 12 on the ICSM, which states: “I am proud to be disabled.” Although the item is reverse scored on the ICSM for the purposes of calculating total scores, for the purposes of measuring disability identity acceptance in the present study, higher scores were used to indicate more acceptance. In other words, higher scores denote greater acceptance of disability identity. Disability-related shame was measured by item 8 on the ICSM, “I often feel ashamed of my disability.” Higher scores signify higher levels of disability-related shame.

Achievement Drive. Achievement drive is defined as item 10 on the ICSM, which states: “The more I am stereotyped the less I want to achieve.” This item has been reversed scored. As such, higher scores denote a diminished drive for achievement.

Statistical Power Analysis

Based upon the statistical power program G-Power (Faul et al., 2007) in combination with Cohen’s power tables (Cohen, 1992), it was determined that in order to achieve a power of .80 with a medium effect size (.30) and an alpha of .05, 64 participants were necessary to detect an effect if it exists for hypotheses that will utilize a bivariate correlation. Our sample size of 267 participants far exceeded this number, suggesting adequate statistical power for the planned analyses. We used Cohen’s (1992) recommended benchmarks for effect sizes for both Pearson’s *r* and Cohen’s *d*.

Data Analysis

The primary and secondary hypotheses were examined using subsequent statistical procedures. Primary Hypotheses I, II, and III and Secondary Hypothesis I were all assessed via bivariate correlations between the two variables of interest. Secondary Hypothesis II was evaluated using an independent t-test analysis examining differences in AMS scores between male and female participants. All analyses were conducted using SPSS.

Results

Primary Hypotheses

Primary Hypothesis I (i.e., ableist microaggressions will be negatively associated with disability identity acceptance) was not confirmed. While the hypothesized relationship was a negative association, results indicated there was a small, statistically significant positive correlation between ableist microaggressions and disability identity acceptance (r =.258; p = <.001). Primary Hypothesis II (i.e., presumption of lack of intellect will be positively correlated with feeling shame of disability) was confirmed; there was a moderate, statistically significant positive correlation between lack of presumption of intellect and feeling of shame toward one’s disability (r = .483*; p* = < .001). Primary Hypothesis III (i.e., presumption of lack of intellect will be negatively associated with disability identity acceptance) was also confirmed; there was a small-to-medium, statistically significant negative correlation between lack of presumption of intellect and disability identity acceptance *(r* = -.35*; p =* < .001).

Secondary Hypotheses

Secondary Hypotheses I (i.e., ableist microaggressions will be positively associated with diminished achievement drive) was confirmed. There was small, statistically significant positive relationship between ableist microaggressions and diminished achievement drive (r = -.272, p = < .001). Secondary Hypothesis II (i.e., there will be a statistically significant difference of experience of ableist microaggressions in men as compared to women) was also confirmed. Results indicated that women (*M* = 202.6, *SD* = 39.4) reported significantly more ableist microaggressions compared to men (*M* = 176.8, *SD* = 42.9) (*t*(236) = -4.031, p < .001; d = 0.63), with a medium effect size.

Discussion

In this study, we sought to examine the impact of ableist microaggressions on disability identity development among disabled adults, in particular the microinsult of presumption of lack of intellect. Using an online survey of adults with physical/sensory and cognitive disabilities, we found that more frequent presumption of lack of intellect was associated with higher levels of disability shame and lower levels of disability identity acceptance; surprisingly, experiencing more ableist microaggressions was positively associated with higher levels of disability identity acceptance but negatively associated with achievement drive. Women also reported experiencing significantly more ableist microaggressions than did men.

Although the research on ableist microaggressions is nascent, previous investigations have shown that this type of prejudice is undoubtedly harmful (Olkin et al., 2019). The positive association between ableist microaggressions and higher disability identity acceptance could possibly signify that adults who have experienced ableist microaggressions can still feel pride in themselves and their disability. Additionally, ableist microaggressions may not impact already established acceptance of identity, or the experience of ableist microaggressions could allow a person to feel more pride in their disability and want to prove their aggressors wrong. Examples of this type of reaction can be found in studies where disabled students indicated that they felt the need to perform to the point of perfectionism to debunk others’ perception of them (Gabel, 2001; Stocker, 2001). From the results of the current study, it could be argued that this perfectionism could lead to pride in one’s disability because of what they were able to achieve despite being discriminated against. Additionally, other factors, such as self-stigma, social support, and intersectionality, may have an impact on one’s acceptance of and pride towards their disability (Bogart et al., 2017, 2019).

In the second hypothesis, we found that those who feel they are treated by others as though they have low intellectual capacity report higher levels of shame about their disability. Such a result shows that it is always prudent for one to assume intelligence and competency when interacting with someone with a disability. These specific results also bolster the position that speaking "about" an individual with a disability instead of "with" them can be detrimental and distressing to the disabled individual (Stillman, 2003, 2009). By disregarding a person with a disability in this way, the individual's autonomy, indeed their entire identity as a whole person who can feel and think for themselves, is being erased (Luborsky, 1994). Likewise, in our third primary hypothesis, presumption of lack of intellect was negatively associated with disability identity acceptance. This aligns with other studies that have studied similar concepts, such as undesirability, second-class citizenship, and infantilizing, in people with disabilities (Bell, 2013; Keller & Galgay, 2010; Timm, 2002). It may be that presumed lack of intellect leads to non-disabled individuals infantilizing disabled people, which in turn can bring about feelings of undesirability and second-class citizenship among the disabled population. Future research studies should continue to investigate this construct in a variety of disabled populations.

Our finding that the more ableist microaggressions experienced by an individual then the less motivation the disabled person may have for achieving in life, while expected by the investigators, is directly contrary to previous qualitative studies that have examined achievement drive and discrimination among disabled individuals; in particular, analyses have shown that disabled college-aged adults use a drive to achieve as a way to cope with their disability, especially if the disability is visible (Gabel, 2001; Stocker, 2001). This divergence of findings between studies may be due to the age demographic within the current study, namely the wider age range in the present study. As such, participants in the current study may have had a larger array of experiences outside of academia, which may contribute to a lack of achievement drive. Additionally, studies examining prejudice toward members of other marginalized groups, such as people of color, have shown that the experience of microaggressions and prejudice can lead a person to believe negative stereotypes about themselves, thus becoming a self-fulfilling prophecy (Wang, 2014). This same type of phenomenon may be at play within the current sample and help explain our findings. Finally, the finding that women experience more ableist microaggressions than men on average may be reflective of the fact that many ableist microaggressions are also sexist or sexual in nature, such as statements like "you're too pretty to be disabled", or probing about their sexual experiences as a disabled person (Olkin et al., 2019).

Implications for Clinical Practice

These findings are important for clinicians who treat those within the disabled community because the clinicians will have a better understanding of how microaggressions can impact the quality of life and psychological well-being among those living with disabilities, such as the demonstrated link between shame and identity acceptance. At the same time, this study has also shown that, at times, ableist microaggressions can reinforce pride among those with disabilities. This finding can be used by clinicians to reframe the way in which the client may view this type of discrimination, which may help the client solidify their identity and become better equipped to face discrimination.

These findings are important in facilitating and informing educational efforts in the fields of rehabilitation counseling and related fields to help reduce harmful misconceptions about clients who are living with disabilities, including the incorrect assumption that disability automatically comes with intellectual impairment. By leading discussions about the importance of presumption of intellect among the entire disabled community as part of their advocacy duties (Commission on Rehabilitation Counselor Certification [CRCC], 2023), clinicians will also be made aware of their own internalized ableist biases and will thus be able to treat their clients with beneficence and nonmaleficence. This will hopefully aid clinicians in building a solid, ableism-free rapport and allow the clients to get the most out of therapy and counseling services (Forber-Pratt et al., 2019).

As counselors with specific expertise in disability-related coping, adjustment, and disability identity development (CRCC, 2023), rehabilitation counselors in particular are specifically tasked with and well-equipped for addressing issues of ableism and disability identity development with clients, including addressing things like the impact of microaggressions, how to best address them, and how to ameliorate their impacts on mental health. For example, a rehabilitation counselor could assist a client in identifying a microaggression they experienced from a coworker, processing any related distress, and using a disability-affirmative framework with which to cope with any future microaggression they may experience. Rehabilitation counselors and related professionals are increasingly being asked to better confront ableism in their work (Andrews et al., 2023; Atkins et al., 2023; Forber-Pratt et al., 2019), and better understanding of client experiences of ableist microaggressions, intellectual capacity stigma, and their impact on clients' feelings towards their disabilities are important to be able to do this work in a meaningful and culturally competent manner. Trainings and presentations that discuss ableism and microaggressions using evidence-based research may provide strong professional development opportunities for practitioners; likewise, practitioner and client input can help guide future research in these critical areas (Lund et al., 2022).

Limitations

As with all studies, there are some limitations of this study that should be discussed. For example, it is important to note that women are disproportionately represented in our sample. This is typical with online surveys (Smith, 2008), but may affect the generalizability of the results to men and non-binary individuals. Sample bias may also be occurring since many participants were recruited from online support groups. The participants could have a less integrated disability identity at baseline, given they were already seeking support from peers, thereby further skewing the results. As such, future investigators may want to consider collecting further data from individuals who seek aid from "brick and mortar" facilities (e.g., centers for independent living) whenever possible to capture individuals who do not seek online peer support or other forms of online community.

Researchers who wish to expand upon this study should also keep in mind is that the sample demographics have not been broken down to include sexual orientation, race, religion, and other characteristics, limiting our ability to examine intersectional and between-group differences with these phenomena, which should be explored in future studies.

Additionally, the Intellectual Capacity Stigma Measure (ICSM) should be viewed with relative caution, given it is a new measure—albeit one based on an existing and well-validated measure—and had a relatively lower internal consistency of .691. Additional research should be conducted on the psychometric properties of the ICSM, including investigations into the measure's cognitive accessibility and reading level (Nicolaidis et al., 2020). Additionally, a few participants noted that some of the questions on the AMS—or perhaps all the questions—could have been more accurately measured by adding the option "I don't know/unsure" to the rating scale. This may have been helpful to those who may have difficulty picking up on social cues to help them judge their experiences of these phenomena or who may be hesitant to answer a question about which they are unsure (Nicolaidis et al., 2020).

One limitation of this study is that some constructs (i.e., disability identity, disability shame, and achievement drive) were measured using single items. Although this is useful for reducing participant burden and appropriate for a small pilot study such as the present study, the use of single items for constructs does limit the generalizability of the results. This study could be replicated using full measures of the construct in question to examine if and how that impacts the results. Additionally, this study could be replicated with newer measures of disability identity, such as Forber-Pratt et al.'s (2020, 2022) measure, which was not publicly available when this study was conducted. Likewise, other new measures such as the Ableist Microaggression Impact Questionnaire (Aydemir-Döke & Herbert, 2022) could be used in follow-up research to expand on the findings in the present study.

Lastly, it should be noted that the results discussed above are correlational in nature. As such, the findings do not amount to any type of causal relationship between the variables and should not be interpreted in a casual nature.

Strengths of the Present Study and Conclusions

Notwithstanding the limitations discussed above, this study has notable strengths. This study was conducted as a direct response to a gap in the rehabilitation counseling and counseling psychology literature which, up until this point, has specifically investigated intellectual capacity stigma in multi-disability populations. In addition, the study also adds to the scarce body of literature on microaggressions and their relationship to identity formation in people with disabilities. Ableist microaggressions are a prevalent issue in the lives of people with disabilities and have pronounced effects on disability identity and pride that must be addressed both clinically (Olkin, 2009) and in research. Doing so will allow rehabilitation counselors, other clinicians, and researchers to provide more effective and culturally competent services to people with disabilities and better understand their lived experiences.

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Supplementary Materials

Appendix A: Demographic & Screening Questions and Instrument