



*Journal of Social Issues*, Vol. 75, No. 3, 2019, pp. 757–785  
doi: 10.1111/josi.12342

This article is part of the Special Issue “Ableism,” Kathleen R. Bogart and Dana S. Dunn (Special Issue Editors). For a full listing of Special Issue papers, see: <http://onlinelibrary.wiley.com/doi/10.1111/josi.2019.75.issue-3/issuetoc>.

## The Experiences of Microaggressions against Women with Visible and Invisible Disabilities

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*Only two prior studies have examined the experiences of microaggressions for persons with disabilities. Our study was specific to women with both visible and invisible disabilities. Using mixed methods, we asked about the frequency and bothersomeness of microaggression experiences, and in six focus groups with a total of 30 women, we gained more depth about those experiences. Guiding the semistructured focus groups were the 10 domains of microaggressions reported by Keller and Galgay. The women were over age 18 and had either a visible (77%) or hidden disability (33%). Eight (27%) were women of color. Findings supported the previous 10 domains, but we found two additional microaggressions: symptoms not being believed by medical professionals and thus delaying diagnosis, and disability being discounted by others based on looking healthy or young. We make five policy recommendations: (i) curriculum on unconscious bias against women and people with disabilities for medical professionals; (ii) targeted public campaigns to reduce specific types of microaggressions; (iii) changes to public transportation systems to increase accessibility; (iv) journal policy changes to encourage more attention to intersectionality in studies; and (v) greater transparency in psychotherapy about disability-friendly practices.*

### Introduction

The concept of microaggressions (Pierce, 1970) has taken hold in psychology, yielding several thousand studies, but relatively few of them concern persons with disabilities<sup>1</sup> (PWD). Of those studies on PWD, most focus on persons with

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<sup>1</sup>This is our preferred language. Although we ally with the identity first language as discussed in Bogart and Dunn (2019), we are concerned that much of the United States still uses “disabled person” in

psychiatric or intellectual disabilities. Only three studies, including the current study, include a broader range of disabilities. The purpose of this article is to (i) describe the first two studies on experiences of microaggressions against PWD, (ii) provide details of a third study that we conducted, on women with disabilities, and (iii) compare our findings to the first two studies.

### *Language Used to Describe Beliefs and Actions toward PWD*

The concepts of stereotypes, stigma, discrimination, microaggressions, and ableism are related. “Stereotypes” are overgeneralized beliefs about a particular category of people. In and of itself, stereotyping is not necessarily negative, but rather is a way of handling vast amounts of information quickly. Stereotypes are problematic when they become “prejudice,” that is, applying stereotypes to specific individuals. “Discrimination” occurs when a person acts on the prejudice by treating someone differently. One type of discrimination is “microaggressions,” defined as commonplace verbal, behavioral, or environmental events (Sue, 2010), or educational, financial, political, and policy systems that convey hostile, negative, or derogatory insults toward persons of marginalized status, directly due to that status. The targets of discrimination, and hence microaggressions, are “stigmatized persons,” in this case people with disabilities. When that discrimination is systematized, pervasive, and unjust, it is “oppression,” and when targeted at people with disabilities, it is “ableism.” When we study experiences of microaggressions against women with disabilities, we are examining how stereotypes, prejudice, discrimination, and ableism combine against the stigmatized, generally by persons with more power (able-bodied) against persons with less power (people with disabilities). However, ableism can come from within the stigmatized group as well, and although the power differential may be neutralized, the effects on the recipient can be devastating.

Women with disabilities hold at least two stereotyped identities, each subject to prejudice, stigma, and oppression. Being an atypical member of two stigmatized groups reduces one’s ability to identify with either group fully and can make full acceptance by either group challenging. This occurrence has been termed “intersectional invisibility” (Purdie-Vaughns & Eibach, 2008). Only a handful of studies on intersectionality include disability. For example, ethnographic observations of Latinx students in special education found microaggressions in the form of lowered expectations, disregard, and bullying (Dávila, 2014). However, because there was no comparison group in special education, it could be that students of

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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). Furthermore, we do not use perceived microaggressions as we believe the qualifier is not necessary, as noted in Banks (2014).

other ethnicities likewise experienced these types of microaggressions. Further, it cannot be determined whether the microaggressions were a result of disability, race/ethnicity, or a combination of the two.

One qualitative study sought to gain a deeper understanding of women's experiences of gender microaggressions through three focus groups of four women each (Capodilupo et al., 2010). These focus groups validated six of the eight theoretically identified themes of gender microaggressions: sexual objectification, sexist language, second-class citizenship, assumption of inferiority, assumption of traditional gender roles, and environmental microaggressions. The three themes that received the fewest number of responses were "second-class citizen, environmental microaggressions, and denial of the reality of sexism" (p. 208).

Some of the work on microaggressions has centered on the therapy relationship. As noted in a study of 120 racial and ethnic minority clients, most (53%) experienced a microaggression from their therapist, and their perceptions of microaggressions were negatively related to the working alliance, especially when the microaggression was not discussed (Owen, Tao, Imel, Wampold, & Rodolfa, 2014). In one of the few studies on therapy with PWD, researchers interviewed 25 lesbians with physical disabilities (Hunt, Matthews, Milsom, & Lammel, 2006). They identified nine themes, five of which were about the women's perceptions of their counselors (satisfaction, effectiveness, awareness about sexual orientation and disability, discrimination and bias, and counselor identity). They identified three themes about the counseling process, including coming out or self-disclosure, self-advocacy, and accessibility and accommodations. The last theme was about depression. Importantly they found markers of ableism in the counseling encounter and speculated about the disruptive nature of ableism on the therapeutic relationship and process.

A number of studies have chronicled themes of microaggressions, each identifying and labeling the themes differently, making it difficult to compare across studies. For example, a study of racial microaggressions identified nine categories (Sue et al., 2007), a study on sexual minorities found seven (Shelton & Delgado-Romero, 2011), and one on gender identified six (Capodilupo et al., 2010). A unified nomenclature would be useful in determining which types of microaggressions are common across various minority and/or stigmatized statuses and which might be unique to specific groups or conditions.

### *Two Studies on Microaggressions against People with Disabilities*

One of the first studies of microaggressions experienced by PWD sought to identify the types and frequency of microaggressions experienced by individuals with a variety of disabilities (Timm, 2002). Timm, a woman with a disability, used the term "daily hassles" but conceptualized the scale as a measure of oppression. As

there were no validated measures of stressors specific to PWD, she developed the 40-item Disability-Specific Hassles Scale (DSHS), which showed good reliability ( $\alpha = .91$ ).

Participants were 235 PWD (72% female and 28% male) ranging in age from 18 to 64 years of age ( $M = 40.7$ ). Most respondents were White (86%), lived in the United States (79%), and just over half had a bachelors or graduate degree. About 52% were employed full- or part-time, yet only 20% lived on earnings only. Most (74%) of the participants had a physical disability, very broadly defined (including, e.g., cerebral palsy, Crohn's disease, Tourette's syndrome, and spina bifida), 4% had a sensory disability related to hearing or vision, and 3% had either a psychiatric disorder (bipolar, major depression, or posttraumatic stress disorder) or a neurodevelopmental disorder (e.g., autism spectrum disorder, learning disability, and ADHD); 19% fell into two or more categories. Most (67%) had a disability always visible to others and 32% sometimes visible to others. Almost half rated their disability as causing at least moderate levels of functional impairment.

Factor analysis of the DSHS yielded six factors: (i) environmental infrastructures, (ii) imposed helplessness/avoidance, (iii) violation of personal space/privacy, (iv) depersonalization: minimizing type, (v) depersonalization: aggrandizing type, and (vi) violation of civil rights. Results indicated that the average number of microaggressions (labeled "hassles" in Timm's study) was 14 over the past month, but there was a wide range from zero to 37. Ten microaggressions were endorsed by more than half of the PWD.

A second study on microaggressions experienced by PWD involved focus groups with five men and seven women (eight White and two each Latino/a and African American) with various disabilities (Keller & Galgay, 2010). Participants were recruited from two disability service organizations. The disabilities represented were visual (three), physical (seven), or multiple (two), with seven of the disabilities visible to others, and eight disabilities that occurred postbirth. The research team was led by a person who was blind and affiliated with the disability rights movement. Participants completed a demographic form and then participated in one of two focus groups. The focus groups used a semistructured interview protocol with open-ended questions and were audiotaped and then transcribed. Transcripts were coded by five students and audited by the senior researcher and a doctoral student (using consensual qualitative research). The authors developed 10 domains of microaggressions: denial of personal identity, denial of disability experience, denial of privacy, helplessness, secondary gain, spread effect, infantilization, patronization, second-class citizen, and desexualization. They asserted that two categories, namely, denial of identity and desexualization, overlapped with microaggressions against other marginalized groups, but that the majority of the categories were unique to individuals with disabilities.

What happens when people hold two or more marginalized identities? Generally, disability is considered such a defining characteristic (Olkin, 1999) that

it is studied in isolation. Participant information may include variables such as ethnicity and gender, but these variables are rarely part of the analyses. However, microaggressions can occur for more than one characteristic, and domains may overlap. For example, in a qualitative study using interviews with 19 women with disabilities (of whom 18 were White), Crawford and Ostrove (2003) examined perceived negative social constructions. The women felt that people with disabilities were perceived as universally intellectually challenged, asexual, super capable, helpless and incompetent, and nonapparent. Perceiving all people with disabilities as intellectually challenged or super capable falls in line with the “disability spread” category of Keller and Galgay (2010), whereas seeing people with disabilities as helpless and incompetent relates to the helplessness category. Perceiving the women as asexual relates to their desexualization category. Clearly there are overlapping categories of microaggressions for women and for people with disabilities. But it is unclear whether microaggressions against people with intersectional identities tend to focus on one aspect of identity more than others, or all aspects, and whether the incidence of microaggressions is increased by intersectional identities.

#### *Women with Disabilities*

Women with disabilities are assumed to be unable to play the adult social role and to be the recipients of help and not the providers (Gill, 2001), to be asexual and incompetent. In a qualitative study of 14 women with physical differences or disabilities, in-depth interviews were used to explore connections between Western expectations of women’s bodies and the lived experiences of the women themselves (Zitzelsberger, 2005). Women identified invisibility as being imposed upon them by the perceptions of others. Even when their disabilities were highly visible, their lives, abilities, and efficacy in society were overlooked. Visibility was most often introduced by assistive devices, such as canes, crutches, or wheelchairs, but those visual markers only reinforced disabled stereotypes of inability and weakness. Women with disabilities who were in the workplace found “restricted educational opportunities, discriminatory hiring, biased performance evaluations, job tracking, pay inequities, lack of support and mentoring, negative attitudes, chilly workplace climates, lack of accommodations, and general discouragement” (Noonan et al., 2004, as cited in Palombi, 2012, p. 208).

Women’s relational nature leads them to care for the well-being of others, which often motivates women with nonapparent disabilities to conceal their impairments to spare others from embarrassment or from excessive worry (Lingsom, 2008). In terms of relational-cultural theory (Miller & Stiver, 1976), these experiences make women with disabilities “relationally conscious,” which is similar to being “self-conscious” but in reference to relationships with others.

Psychological, interpersonal, and social factors are as predictive of disability as are impairments in function for women with multiple sclerosis (MS) and fibromyalgia (Phillips & Stuifbergen, 2010). A secondary analysis of two separate health intervention studies, one focused on women with MS ( $N = 118$ ) and one on women with fibromyalgia ( $N = 197$ ), used structural equation modeling to identify predictors of disability for both chronic illness groups. Several outcomes were identified, but of particular interest was that the greater the depressive symptoms, the greater the disability. This conclusion echoes the findings of other empirical research that also found depression to have a major effect on subjective perspectives of disability (Kassam & Patten, 2006; Smith & Young, 2000).

The current research is the third study to categorize disability microaggressions. We focused on women with disabilities for several reasons. In a study using vignettes depicting microaggressions ranging from subtle to obvious, women detected greater discrimination than did men, especially when the discrimination was subtle (Basford, Offermann, & Behrend, 2014). We believe that women may speak differently when among women compared with mixed gender focus groups (self-silencing; Hurst & Beesly, 2013). We were curious about gendered disability microaggressions, just as there might be gendered racism (Carr, Szymanski, Taha, West, & Kaslow, 2014). And women with disabilities experience higher rates of poverty, social isolation, and victimization than do men with disabilities (Palombi, 2012).

### *Current Study*

We describe our methods and results in keeping with COREQ (Tong, Sainsbury, & Craig, 2007). We, the research team, were four White women with disabilities, two of whom used wheelchairs (polio and spinal cord injury) and two with mostly nonvisible disabilities (MS). The two wheelchair users held doctorates in psychology and the other two were doctoral candidates in psychology. The first and second authors have expertise in disability research and the two students had immersed themselves in the literature prior to being part of the research team.

Our goal was to hear directly from women with disabilities about their experiences of microaggressions, using both quantitative and qualitative data to add richness to the findings. We used content analysis to systematically organize data into a structured format. We examined whether any microaggressions were raised as issues that might be specific to women with disabilities and sought to compare our findings with the six factors found by Timm's (2002) study on "daily hassles" and the 10 domains found by Keller and Galgay (2010).

"Disability" was defined as any condition that qualifies under the Americans with Disabilities Act. However, exclusion criteria were deafness and intellectual disability. All of the women had a disability for at least 3 years (to reduce the

influence of the effects of the disability onset and any associated trauma). The definition of “microaggressions” that was given to participants was from Sue (2010): “communications that are brief, commonplace, and verbal, behavioral, or environmental that contain a hostile message, derogatory meaning, negative slights, invalidation, or insults, and which are directed toward a person because of his or her belonging to a marginalized group.”

## Method

### *Participants*

We used purposive and snowball sampling. Recruitment included outreach to the Centers for Independent Living; disability services at community and state colleges and universities; the 11 agencies at the Ed Roberts Center for Disability; notices on Craigslist; and flyers at various accessible venues such as women’s bookstores, places in the Castro district of San Francisco, lesbian-frequented cafes, and religious institutions in predominantly ethnic communities. Women were assigned to one of six focus groups by date and visibility of disability. One focus group included women with disabilities that were always visible (e.g., wheelchair or other assistive device users, person with altered gait, amputations, and little person status). Two focus groups included women with disabilities that were mostly invisible to others (e.g., learning disabilities, MS, and lupus). The remaining three focus groups were a mixture of visible and nonvisible disabilities.

One participant knew one of the researchers as they lived in the same building complex. All 30 participants were women older than age 18 years with 23 visible (77%) and seven hidden disabilities (33%), of whom four (13%) were lesbians, and eight (27%) were women of color. Most (25) had some mobility limitations. Notably, the number reporting sexual abuse was 14 and the number reporting physical abuse was 8. More detailed demographic information is reported in Table 1 and more detailed disability information is reported in Table 2.

### *Setting*

Two focus groups were held at a small university campus in San Francisco, and four were held at the Ed Roberts Center for Disability in Berkeley, which was selected due to its proximity to public transportation and disability accessibility. As focus groups were in the evening, the buildings were almost empty except for the researchers and participants.

**Table 1.** Demographic Characteristics of Participants

Age in years ( <i>M</i> , <i>SD</i> )	52.04, 11.40
Ethnicity (%)	
White	73
Women of color (African American, Latina, or Multiracial)	27
Income in thousands of dollars ( <i>M</i> ; <i>SD</i> ; Range)	55,060; 56,842; 7,612–200,000
Education ( <i>n</i> )	
High school only	1
Some college	5
College grad	9
Grad school	12
Employment ( <i>n</i> )	
Employed FT	2
Employed PT	4
Unemployed	4
Student	3
Retired	4
Other	10
Health ( <i>M</i> , <i>SD</i> , Range)	
Physical health 0–10	5.41, 1.58, 3–8
Mental health 0–10	6.74, 2.28, 0–9
Abuse history ( <i>n</i> )	
Sexual	14
Physical	8
Emotional	18

*Note.* Three of the 30 participants did not complete any demographic information; thus, these calculations are based on an *n* of 27. An additional four participants did not enter their income; thus, this statistic is based on an *n* of 23. In 2018, low income for a single person in the bay area was \$82,200, compared to federal poverty guidelines of \$12,140.

### *Procedure*

Interested participants called a dedicated Skype phone number or emailed a Google address. Potential participants were then screened to ensure they met the inclusion criteria and were informed that they would be sent an online set of questionnaires and a consent form to be completed before the focus group. Participants were also given the option to have hard copies of the questionnaires mailed to them for completion before the date of the focus group, or to receive assistance in person just prior to the focus group. All but one participant completed the forms online prior to the focus group. Once participants arrived at the focus group location, a consent form was provided if they had not completed one online previously. A light dinner was provided, and each participant received



**Table 2.** Disability Characteristics of Participants

Number of functional limitations ( <i>M, SD, Range</i> )	2.74, 1.06, 1–6
Degree of functional impairment 0–10 ( <i>M, SD</i> )	7.30, 1.75
Uses an assistive device (%)	92.6
Visibility of disability (%)	
Always visible	51.9
Invisible except in certain situations	29.6
Always invisible unless disclosed	11.1
Invisible except during exacerbations	7.4
Disability type	Diagnosis ( <i>n</i> )
Systemic or autoimmune	Rheumatoid and osteoarthritis (6)
	Multiple sclerosis (5)
	Fibromyalgia (3)
	Chronic fatigue syndrome (1)
	Asthma (1)
	Diabetes type I (1)
	Scent sensitivity (1)
	Epilepsy (1)
	Ankylosing spondylitis
	Chronic pain (7)
	Facial paralysis (1)
	Tendonitis (1)
	Chronic repetitive strain injury (1)
Physical	Spinal cord injury (4)
	Cerebral palsy (4)
	Degenerative joint disease
	Thalidomide (1)
	Chondromalacia (runner's knee) (1)
	Plantar fasciitis (2)
Hearing	Unilateral hearing loss/profoundly deaf (3)
Vision	Low vision (4)
	Blindness (1)
Cognitive	Traumatic brain injury (1)
	Postconcussive syndrome (1)
Psychiatric	Depression (4)
	Anxiety (3)
Learning	Learning disability (1)
Other	Hemiplegic migraine (1)

*(Continued)*

Table 2. Continued

Age of onset ( <i>n</i> )	
Birth	8
Post-b., prior to 18	4
After age 18	15
Range	Birth to 52
<i>M, SD</i>	21.96, 17.70
Functional limitations ( <i>n</i> )	
Mobility	25
Hand coordination	17
Visual impairment	4
Hearing impairment	3
Other	20

a \$15 gift card to a grocery store at the end of the focus group. After participants introduced themselves and stated the nature of their disability or functional impairment, a definition of microaggressions was stated orally and in writing and accompanied by an example from the facilitator. The focus group discussions were transcribed verbatim. Analyses were conducted by the four authors using consensus.

*Quantitative measures.* Prior to attending a focus group, participants completed a packet of measures including a Demographic and Disability Questionnaire designed for this study, and a Disability Microaggressions Scale developed by the first two authors, based on the 10 domains found by Keller and Galgay (2010). Each of the 10 questions in the scale is directly connected to one of the 10 domains by Keller and Galgay (2010; see Table 3 for a comparison of domains across three studies). The purpose of this measure was to ascertain how often participants experienced a microaggression within the particular domain and how bothersome that type of experience was. The frequency of experience was measured on a scale of 0 to 3 (0 = *never*, 1 = *not very often*, 2 = *often*, and 3 = *very often*). The degree to which participants were bothered by the experiences was measured on a scale of 0 to 4 (4 = *not at all bothersome*, 3 = *just a little bothersome*, 2 = *bothersome*, 1 = *very bothersome*, or 0 = *not applicable*).

*Qualitative measure.* Six focus groups of four to nine women were conducted, for a total of 30 women. The 90-minute focus groups were video- and audio-taped and transcriptions were made from the tapes. Each of the authors led at least one group, and each was a process monitor for at least one group.

**Table 3.** Comparison of Domains in Three Studies

Olkin et al. (2019)	Keller and Galgay (2010)	Timm (2002)
Someone ignores everything about you but your disability.	Denial of personal identity	Depersonalization/minimizing type
Someone downplays the effects of disability on your life.	Denial of disability experience	Depersonalization/minimizing type
You are asked overly personal questions.	Denial of privacy	Violation of personal space/privacy
Someone assumes you need help.	Helplessness	Imposed helplessness/avoidance
Someone expects to feel good or to be praised for doing something for you.	Secondary benefits	Depersonalization/aggrandizing type
Spread; someone expects that your disability affects all of your capabilities.	Spread effect	Imposed helplessness/avoidance
You are treated like a child or a young person.	Infantilization	Imposed helplessness/avoidance
You are praised for doing almost anything.	Patronization	Depersonalization/aggrandizing type
Your right to equality is denied.	Second class citizen	Violation of civil rights; environmental infrastructures
Your sexuality and value as a romantic partner are denied.	Desexualization	

*Note.* Other areas suggested by participants in Timm's study included personal attendant issues; medical and care issues; encounters with business, public agencies, and service providers; indifference to disability; stressors related to hidden disabilities; and stressors experiences by people with visual impairments or blindness.

The leader and the process monitor disclosed their disabilities. Participants were handed a written brief definition of microaggressions and given a personal example by the leader. The leader then conducted a semistructured interview by asking about various situations using prompts to remind participants about venues or activities. Prompts, developed by the research team, included the following domains: (i) relationships, (ii) getting around and travel, (iii) shopping, (iv) independence, (v) leisure and recreation, (vi) humor, (vii) boundaries, (viii) disability business, (ix) work and school, and (x) affect management. Conversation was allowed to develop organically unless the conversation veered away from the topic at hand. In those cases, one of the facilitators would help redirect participants back to the topic of microaggressions. This allowed participants to determine their own priorities and direction of conversation.

**Table 4.** Frequency of Occurrence of 10 Types of Microaggressions

Type of microaggression	Frequency of occurrence (%)			
	Never	Not very often	Often	Very often
Someone ignores everything about you but your disability.	7.4	66.7	25.9	0
Someone downplays the effects of disability on your life.	0	44.4	37.0	<b>18.5</b>
You are asked overly personal questions.	3.7	51.9	33.3	11.1
Someone assumes you need help.	7.4	37.0	40.7	<b>14.8</b>
Someone expects to feel good or to be praised for doing something for you.	29.6	51.9	18.5	0
Someone expects that your disability affects all of your capabilities.	14.8	63.0	18.5	3.7
You are treated like a child or a young person.	18.5	59.3	11.1	11.1
You are praised for doing almost anything.	14.8	33.3	29.6	<b>22.2</b>
Your right to equality is denied.	3.7	44.4	33.3	<b>18.5</b>
Your sexuality and value as a romantic partner are denied.	29.6	37.0	18.5	14.8

*Note.* The four most frequently occurring microaggressions are indicated in bold. Percentages do not always sum to 100% due to missing data.

## Results

We first examined which microaggressions were endorsed most frequently (Table 4) and which were most bothersome (Table 5). Results indicated that the four most frequent microaggressions were “Someone downplays the effects of disability on your life,” “Someone assumes you need help,” “You are praised for doing almost anything,” and “Your right to equality is denied.” The two most bothersome items were “Your right to equality is denied” and “Someone downplays the effects of disability on your life.” Because these two items were also two of the most frequent microaggressions, this suggests that women with disabilities have a high exposure to very bothersome microaggressions.

### *Domains*

*Second-class citizenship/your right to equality is denied.* This type of microaggression occurs when the rights of people with disabilities for equal access are considered unreasonable, unjustified, or bothersome. The rights of PWD are

**Table 5.** How Bothersome Were the Experiences of 10 Types of Microaggressions

Type of microaggression	How bothersome (%)				
	N/A	Not at all	Just a little	Bothersome	Very
Someone ignores everything about you but your disability.	0	0	0	40.7	37.0
Someone downplays the effects of disability on your life.	0	0	0	<b>14.8</b>	<b>66.7</b>
You are asked overly personal questions.	0	11.1	0	29.6	37.0
Someone assumes you need help.	11.1	33.3	0	18.5	11.1
Someone expects to feel good or to be praised for doing something for you.	22.2	7.4	0	22.2	37.0
Someone expects that your disability affects all of your capabilities.	14.8	7.4	0	22.2	44.4
You are treated like a child or a young person.	14.8	7.4	0	25.9	40.7
You are praised for doing almost anything.	11.1	14.8	11.1	25.9	37.0
Your right to equality is denied.	3.7	0	0	<b>18.5</b>	<b>70.4</b>
Your sexuality and value as a romantic partner are denied.	22.2	0	0	29.6	44.4

*Note.* The two most bothersome microaggressions are indicated in bold. Percentages do not always sum to 100% due to missing data.

thus denied or disrespected. It includes environmental barriers that keep PWD from accessing locations and resources. Second-class citizenship was by far the most endorsed category in the focus groups, yielding 55 examples. The majority of these examples involved environmental barriers, including inaccessible facilities and malfunctioning or absent accommodations on public transportation. For example, one participant stated, “I love to go hiking and one of the things that commonly happens is that they place a big log in front of the trail so that motorcycles can’t get through.” Another woman shared, “. . . the orchestra I’m in now plays concerts every holiday season at a place where the stage wasn’t accessible, so I never participated.” Most participants reported experiences of being passed by buses or being treated as bothersome for requiring accommodations on public transportation. One woman stated, “Buses don’t like to pick up disabled people because it takes too long.” A second woman agreed, saying, “The [bus] drivers in San Francisco, I get the sense that they resent [picking up passengers with disabilities].” A third woman reported:

What I don't like are bus drivers that are rude because they have to lower the ramp and also when bus drivers don't stop at all, they'll just go by. [Two women nod] And other ones are very rude about having to tie . . . the chair down.

In some cases, accessible services were offered at a higher rate or with some other imposition on the PWD. For example, one woman stated, "I finally found a cab driver who was willing to take me but of course charge me twice as much as the regular service." All of these examples send the message that PWD are of a separate class.

This same woman also talked about having challenges finding an accessible psychotherapist. "It's really hard to find a psychotherapist who has an accessible office . . . . And then . . . you're limited to . . . the four people who have accessible offices, you can't even decide who you want to be your therapist; you have to decide who has an office you can go to."

This category also encompasses experiences of feeling invisible, a sub-theme that appeared in many comments within this category. Many reported being ignored in conversations or feeling like people were talking to whomever they were with instead of talking to them. For example, "People will all be in a conversation, and they'll start talking to the other person like I'm not there." She continued:

. . . you have to move the seats back [she points her finger and moves her arm back and forth] but [the bus driver] didn't know how to do that so he spent like a half hour and my husband, who also has CP, and I are trying to tell him how to do it. He's not listening because we have speech impairments.

Jokes could be a problem sometimes. A woman who worked at a nonprofit reported being called "gimp" and "crip" by coworkers who quickly stated that they were joking and that she was being too sensitive when she stood up to them. The denial of malicious intent is irrelevant in microaggressions (Sue, 2010), and this scenario of name calling followed by accusations of "oversensitivity" is a quintessential microaggression.

Being disregarded by others sends the messages that the target is less important or of a separate class. Almost all of the women reported experiencing second-class citizenship on the Disability Microaggressions Scale (half as "often" or "very often"), and almost 90% found it "bothersome" or "very bothersome."

*Denial of personal identity/someone ignores everything about you but your disability.* This type of microaggression occurs when salient aspects of a person's identity are overshadowed by the person's disability (Keller & Galgay, 2010). The disability is overemphasized while other aspects of identity are disregarded (Olkin, 1999). Examples from two participants in two separate focus groups were an assumption by someone that the woman would only date another person in a wheelchair. One woman stated, ". . . people are like, 'I didn't recognize you without the wheelchair.'" Over 90% of the women reported experiencing this type

of microaggression on the Disability Microaggressions Scale to some extent and over 75% found denial of personal identity to be “bothersome” (with one third endorsing “very bothersome”).

*Denial of disability experience/someone downplays the effects of disability on your life.* This type of microaggression happens when the perpetrator minimizes a negative or discriminatory experience, such as when an able-bodied person claims to understand the experience of a person with a disability. It can also happen when the target’s disability is denied or minimized altogether. At least one third of the women provided examples of this category. Examples included instances of others assuming that they are taking advantage of “the system” by exaggerating or faking their disabilities to receive accommodations or assistance:

And there is this attitude that somehow we have it so good. [another woman nods] You know, that we have our body servants with us and we have accessible stalls and blue spaces and like our life is cushy or something. [Two women nod] But you don’t hear how difficult it is every day.

Other participants discussed the assumption that PWD are overly litigious when they hire lawyers to enforce ADA accommodations: “. . . and when they do that [get a lawyer to enforce ADA accommodations], and then you’re one of those people that runs around suing, right?” This suggests that the primary goal is monetary gain versus gaining basic accommodations.

Several participants cited examples of being told that they “look good,” thus minimizing or denying the impact of the disability on the target’s daily life. Many comments related to the woman’s age, such as “I don’t look disabled and people tell me ‘oh you’re too young to be disabled.’” A woman stated, “I was explaining to my dad one time after my surgery, I . . . appeared a lot less disabled, and one time I was telling my dad something and he was like, “You’re barely disabled.”

Denial of disability was especially salient for women with invisible disabilities. When one woman shared her hidden limitations with others, they often respond, “What? You don’t look sick. You should be fine.” Similarly, a second woman with a traumatic brain injury was regularly invited to go to karaoke and then treated harshly when she did not go: “I have a lot of friends that like to do that but it’s really stressful for me to a point like where I’ll be in tears trying to like read the words on the screen and remember. . . . The same thing with reading, going to the movies with subtitles, like it’s just stressful. I want to cry and like I can’t read it and then pay attention to what’s going on in the movie at the same time.” Women with sporadic symptoms reported instances of missing things and then feeling quite left out: “If I’m not in contact with my social community for like two or three months during, like winter’s bad for me, like when I come back around there’re like, ‘Oh you’re not really a part of this group anymore because

you missed the whole season and you know, we're not going to fill you in on anything.'”

A young woman with a hidden disability described a situation at a night club:

“I went there one evening and . . . there was a lots of cigar smoke which is a huge trigger for my migraines, that could paralyze me quick . . . so I ask them if I could go inside to sit down, and they were like, ‘This is a VIP door only,’ and I was like, ‘No, I’m not asking like for VIP access, this isn’t an access issue, I’m disabled and I really need to go inside. I had a seizure outside, and I need to sit down and take my meds.’ And they were like, ‘Well, we can’t let you in; you’re going to have to walk around and go through the other door.’ And I was like, ‘No, I really need to sit down.’ But the bouncer was like, ‘Well if you have a seizure disorder, should you even be here?’”

Travel and transportation were lively topics of discussion in almost all the groups, whether it was trains, public transportation, driving, or using (notoriously unreliable) paratransit. For example, one woman reported, “I had the paratransit people telling me ‘you don’t really need this’ or ‘what’s your disability?’ asking all these questions, asking me out on a date, telling me they sell crack, all kinds of stuff.” For those with invisible disabilities who drove, parking in handicapped spots often engendered glares, questions, or negative comments. A woman with a hidden disability stated, “Sometimes I get out of the car and I’m like, ‘Oh, who’s around, like do I need to take out the wheelchair for show?’” Several women stated that their friends saw the handicapped placard as a perk, rather than a necessary accommodation. The seats on public transit designated for people with disabilities were another area of many conflicts. When not using an assistive device that made the disability obvious, some women hesitated to assert their need for the seating: “I have gotten into fights with people around sitting in seats and . . . this one guy asked me like, ‘What are you, pregnant? Do you need to be sitting here?’ Or I’ve had older people like ‘You need to get up because you know you can’t sit there.’” Others took their canes or other assistive device even when not needed, to avoid these conflicts.

All participants reported experiencing denial of disability experience on the Disability Microaggressions Scale to some degree (i.e., no participants said “never,” with 18.5% endorsing “very often”) and found it to be bothersome (with two thirds finding it “very bothersome”).

*Denial of privacy/you are asked overly personal questions.* This type of microaggression occurs when personal information is demanded by the perpetrator, either explicitly or subtly. It often involves questions about the disability itself (e.g., “What happened to you?”) or sensitive questions about how the disability affects the person’s life. It can also happen when a person’s boundaries are violated in some way.

At least half the women identified examples of this category. In some cases, the targets were told that they had to bring an attendant when trying to receive



services due to inaccessibility of facilities. A woman with a physical disability said, "I hate when places tell me I'm supposed to bring someone . . . because their exam table is not, like, accessible or whatever." Several participants cited examples of family members, friends, and strangers giving unsolicited medical advice, and multiple examples of targets being asked intrusive questions. A woman with some mobility limitations stated, "I get a lot of people asking me what's wrong if they see me going down stairs, like 'What happened to you? What's wrong with your leg?'"

Denial of privacy also includes violation of physical boundaries. Participants listed examples of others touching either their equipment or their bodies: ". . . and another person on the bus . . . was like touching me and trying, you know, trying to tie my chair down and he was like, 'Put the brakes on, where's the brakes,' and he's like feeling all around and it's just like, it's really intrusive." A woman who has seizures stated that she would give clear instructions to others not to touch her if she is having a seizure, but that they often ignored this admonition.

Multiple participants reported that they are bothered by accommodations that call attention to them. In the workplace, when one woman with a hidden disability got an accommodation of an assistant, others wanted to know "Why does she get that and we don't?" Others with hidden disabilities also stated that getting an accommodation at work elicited anger from coworkers. For example, a woman who worked part-time to accommodate her physical therapy schedule said, "People would say 'oh I wish I could have the day off.'"

Fluctuating symptoms often led to intrusive questions. "People get really freaked out if I get in and out of my chair." A woman with MS recalled, "I will be walking or something and then the next time that person sees me I'm going to be using my scooter and she will go, 'What happened?!' It's like you know like suddenly some horrible thing happened and I wasn't able to walk anymore. And then the next time they see me I will be walking and they would be 'well what's going on?' you know, it's like it's none of their business obviously."

Almost all participants reported experiencing denial of privacy on the Disability Microaggressions Scale (with about 11% endorsing very often). Interestingly, 11% also described these experiences as "not at all bothersome," but 37% as "very bothersome."

*Helplessness/someone assumes you need help.* This type of microaggression is based on the assumption that people with disabilities need help most of the time. Offers to help, though usually well intentioned, often happen when the person with a disability does not need or want help and send the message that people with disabilities are helpless. Most of the examples had to do with perpetrators offering to help in unnecessary situations or helping without asking first. For example, ". . . when people ask me 'Do you need help?' I often say, 'No, but do you?' I mean, why would I need more help than anybody else? I'm a pretty

together person.” A second woman stated, “. . . I had one woman tell me that her husband wanted to help me do something and she became increasingly aggressive with me to try to get me to let her husband help.” Most participants discussed being helped without requesting help and/or being given unsolicited advice. This advice came from family, friends, strangers, and acquaintances. As another woman with MS said, “Everyone wants to cure us; take this vitamin, take that vitamin.” A third woman stated:

When I got up to the counter someone dashed up and starts waving at the clerk or something, like ‘There’s someone here, there’s someone here.’ And then I was still in there a few minutes later and this woman sort of starts saying really loudly, “Oh, there’s someone in a chair that needs to get through” or something and I just said, “Leave me alone, leave me alone.”

Over 90% of participants reported experiencing helplessness on the Disability Microaggressions Scale (15% as very often), and about 11% found it very bothersome.

*Secondary benefits/someone expects to feel good or to be praised for doing something for you.* This type of microaggression happens when the perpetrator expects to feel good or be praised for doing something for a person with a disability. For example, a person may expect expressions of gratitude or approval from others when helping a person with a disability or supporting the disability community as a whole. A few participants cited examples of facilities or services claiming to be accessible when in fact they were not (thereby getting the benefit from claiming accessibility without having to provide the accommodation). For example, “. . . the places that, like the cab had a handicap sign, places that pretend. I mean, it’s not just ignorance. They pretend to be accessible [another woman nods] so that they can look good.”

Multiple participants discussed their experiences with churches or religious individuals. One explained, “One time I had some guy who was like one of those street preachers with a megaphone and so I rode by him in my wheelchair and he said, ‘If you believed in the Lord Jesus Christ as your savior you would be able to get up and walk again.’” (This could also be considered invasion of privacy, as it points to the disability in public.) Another woman stated:

It seems like [churches] are really more interested in keeping you in a place where they can provide you with charity [another woman nods] and home visits and, you know, the basket of food on the holidays. They have to have a caste or a class of people who will be the recipients of their goods.

Over two thirds of the women reported experiencing secondary benefits on the Disability Microaggressions Scale (just under 20% indicating often) and 60% found this type of microaggression to be bothersome.

*Spread effect/someone expects that your disability affects all of your capabilities.* As first identified by Wright (1963), the spread effect refers to the assumption that a limitation in one functional area leads to limitations in other areas. For example, a person with a physical disability might be treated as though an intellectual disability is present as well. This also can occur when someone assumes that the woman has special abilities in one area as compensation for the limitations in other areas. Surprisingly, no examples of spread effect were mentioned during the focus groups. However, 85% of the women reported experiencing spread effect microaggressions on the Disability Microaggressions Scale, with 22% indicating often or very often, and two thirds indicating it was very bothersome.

*Infantilization/you are treated like a child or a young person.* Infantilization occurs when perpetrators treat targets like children or young people. Examples by three women included being patted on the head, being spoken to like a child, and the assumption that the woman needs someone to take care of her. A wheelchair user stated, “. . . if somebody comes around the counter and bends over and talks to me like I am a child, ‘Let me help you with that.’”

The majority of women (82%) reported experiencing infantilization on the Disability Microaggressions Scale, although 59% indicated it was “not very often.” Nonetheless, two thirds found it very bothersome when it did occur.

*Patronization/you are praised for doing almost anything.* Patronization takes place when perpetrators are condescending or praise the PWD for doing everyday tasks. Examples from three participants had to do with targets being told that they looked good or that they looked too young to be using assistive devices. Paying an uninvited compliment on the basis of a person’s disability can be considered patronization because it betrays a sense of superiority and sends a message that one must be made to feel better about having a disability. One stated:

My favorite story was when I was coming out of an MRI and it was the time that I learned I was allergic to contrast dye and so I was pretty wobbly, really wobbly, and I had my cane, and this vet . . . said, “You’re too young to be using a cane, what are you using a cane for?”

A woman who does not use her wheelchair daily recalled how differently she is treated when she shops with her wheelchair and without. When she is using a necessary accommodation like a motorized shopping cart, “Strangers either won’t look at me or they are like ‘Hey look at you shopping by yourself!’ And it’s really funny because I will shop . . . and I’ll walk and for the most part people treat me kind of standard. And then I’ll shop in my wheelchair and it’s so different. Like suddenly people are so impressed with all my ingenuity.” Several women with hidden disabilities discussed being watched while shopping and strangers responding to unexpected abilities. “Like I’ll stand up [out of the wheelchair] at

the grocery store to like reach something and people go ‘wow!’” These examples align with Keller and Galgay’s (2010) description of being praised for completing everyday tasks. Most (85%) of the women reported experiencing patronization on the Disability Microaggressions Scale, with just under two thirds experiencing it both very often and finding it very bothersome.

*Desexualization/your sexuality and value as a romantic partner are denied.* Desexualization occurs when sexuality or sexual identity is discouraged or denied, or the value of PWD as romantic partners is minimized. Desexualization can include a lack of available medical resources for educating people with disabilities about sexuality, inaccessibility of medical equipment, and the reactions from able-bodied people about dating, relationships, and sex among people with disabilities.

Most of the examples are based on the assumption that people with disabilities do not date, or that dating must be challenging for them. As one woman stated, “A lot of times people think that you shouldn’t be in a relationship or what do you have to offer in a relationship . . .” A second woman stated, “They assume a disabled person is supposed to be out for the count, flat on their back, no life, no children, no husband, nothing, just in this world to die.” A third woman said, “. . . we do get a certain amount of, ‘Hey, you’re so good to be dating her, you take such good care of her [said to the participant’s partner].”

Although desexualization was not brought up spontaneously very often in the focus groups, over two thirds indicated experiencing desexualization on the Disability Microaggressions Scale, with one third indicating it happened often or very often, and almost 75% finding it bothersome or very bothersome.

Additionally, in our analyses, we found two microaggressions not explicitly discussed by Timm (2002) or Keller and Galgay (2010). The first was that symptoms were not believed by medical professionals, thus delaying diagnosis of disability. One woman reported that it took her awhile to get diagnosed with MS, which she attributed to doctors not taking her symptoms seriously due to her gender. She felt that she was sent the message that her complaints were “just in [her] head.” A second woman in the same focus group recalled, “I once had a doctor at [major medical provider] . . . suggest that I had brought the MS on myself because of my mental state.” A third woman who has an invisible disability stated, “I knew I was having problems, but they kept telling me ‘Oh, it’s depression.’”

The second potentially new microaggression was that the person’s disability was denied due to how she appeared. As one woman reported she was told, “you are too attractive to be disabled.” This type of comment was especially hurtful coming from family members; another woman’s father told her she was too “healthy looking” to have a disability.

## Discussion

Our research revealed two microaggressions that had not been explicitly discussed by Timm (2002) or Keller and Galgay (2010). We cannot know for sure that these are unique or even more common in women with disabilities than men with disabilities, only that they were not noted in previous studies of microaggressions against men and women with disabilities. The first microaggression was that symptoms sometimes were not believed by medical professionals, thus delaying diagnosis of disability. Considerable research supports the idea that women and people with disabilities are among the groups that receive disparate medical care (Chrisler, Barney, & Palatino, 2016; Hatzenberger, Phelan, & Link, 2013; McColl, Aiken, & Schaub, 2015; Schimmel Hyde & Livermore, 2016; Sharby, Martire, & Iversen, 2015; White & Stubblefield-Tave, 2017). One mechanism for this disparate care may be the degree to which symptoms are thought to be medical versus psychoemotional.

The second microaggression was that one woman was told “you are too healthy looking to be disabled” (or similarly, too pretty or attractive to have a disability). Although this was not frequently mentioned, we did hear similar comments from a few women, and we mention it as a possible new type of microaggression. In two studies on appearance compliments (Kahalon, Shnabel, & Becker, 2018), the authors suggest that appearance compliments subtly perpetuate gender inequality. Supposed compliments about looks convey the message that attractiveness and disability are opposites and that impairment is inherently negative (Palombi, 2012). Able-bodied privilege leads to an irrational sense of entitlement, including the right to pass judgment on PWD. Ableism is the foundational belief system that leads to oppression and microaggressions (Palombi, 2012).

Timm’s (2002) study had a large number of participants but used quantitative data only. Keller and Galgay (2010) used only quantitative data and had a small sample size of 12. It is easy for early studies to set the mark and to become enshrined. Our study both replicated and extended the previous work by examining whether the domains found by Keller and Galgay (2010) would hold. We believe we found two new domains. We cannot claim that these domains are experienced only by women with disabilities, only that they are worthy of further investigation. It is possible that different domains call for different approaches to diminish them. Some of the domains (e.g., your right to equality is denied) occur at multiple levels and require broad-based interventions across a spectrum of systems. Other domains (e.g., you are asked overly personal questions) might be reduced through educational and media campaigns that provide information about what it’s like to live with various disabilities, that is, it is not a tragedy, but a different but coequal way. And some (e.g., patronization) may be part of clinical work with clients with disabilities and their families.

There was great overlap in reported microaggressions for women with visible and hidden disabilities. However, the women with hidden disabilities were more likely to experience denial of disability, and to be challenged when using an accommodation such as a reserved seat on public transportation, handicapped parking, or workplace accommodations (as consistent with the results of Nario-Redmond, Kemerling, & Silverman, 2019). As most disability signage uses symbols (e.g., a wheelchair or Braille) that denote visible disabilities, the wide array and pervasiveness of hidden disabilities may be less well understood by the public.

### *Research Suggestions*

Research leads to new questions, best exemplified in the statement of an African American woman with a visible physical disability. In her statement about a microaggression she experienced she said, “And I know it was about my disability, not about me being Black.” This is in keeping with the study of lived experiences of Black women with disabilities, who reported disability as a more complicating factor in their lives than race/ethnicity (Nowell & Gill, 2005). But an obvious question is how the woman in our focus group decided this—what are the cognitive processes when persons with intersectional identities experience microaggressions? Does being a member in one minority group (African American) lead to a greater propensity for the social model of disability (the second minority group), and hence the illegitimacy of discrimination (as suggested by the studies of Dirth & Branscombe, 2019)?

Second, given the ubiquity and frequency of microaggressions experienced, what are methods of coping with them? Is ignorance bliss, or is it better to acknowledge the slights but use various coping mechanisms to lessen their impact? Is increased awareness of microaggressions part of the development of a positive disability identity and affiliation with disability community? Are disability microaggressions experienced from within one’s own family of origin or partnership more powerful, and do they have more harmful effects than those from others, as has been shown for race (Lowe, Okubo, & Reilly, 2012; Nadal, Sriken, Davidoff, Wong, & McLean, 2013; Schrimshaw, 2003). Further, do people with and without disabilities “demonstrate a shared understanding of the construct” of microaggressions, as was found for White and African American students regarding race (Michaels, Gallagher, Crawford, Kanter, & Williams, 2018, p. 318), but respond differently? Given the growing literature on negative psychological and physical health effects of microaggressions (Sue, 2010), especially for PWD (Branco, Ramos, & Hewstone, 2019), these are important questions. And last, if we are to study disability microaggressions, we need good metrics for frequency and bothersomeness.

### *Limitations*

Qualitative studies are best at elucidating lived experiences by persons generally excluded from research and generating material for larger and more generalizable studies. Both our study and that of Keller and Galgay (2010) did not include Deaf or hearing-impaired people or people with intellectual disabilities. Importantly, our study included only women, whereas the two previous studies included both males and females. Without a control group we cannot assert that any of our findings are more frequent, bothersome, or unique to women. The income distribution in our study was bimodal, with most women below the poverty line, and some with salaries above the San Francisco area median income, whereas nationally there is widespread unemployment among women with disabilities. Further, the San Francisco area is one base for the disability rights movement. Although we did not specifically recruit from disability service agencies, there may be more activism and rights awareness in this area of the country.

Qualitative studies rest on the quality of the analysis and others might disagree with our coding decisions. The quantitative data were completed prior to the focus groups and may have changed what was salient to the women or affected their mindset in the focus group. Their estimates of how frequently a particular type of microaggression occurred may not be reliable. We have more faith in the bothersomeness variable being less affected by faulty recall. Finally, it was difficult to know how to score the microaggressions questionnaire, whether frequency should be simple addition across all domains or averages across participants, and whether bothersomeness should be a multiplier.

### *Experiencing the Focus Groups*

We do not have data on how the women experienced the focus groups or how it affected them in the short term. Mostly the discussions were quite lively and all of the women seemed quite engaged. It appeared to us that the members mostly benefitted from sharing stories and joking about their experiences. They provided one another with supportive suggestions, stories of similar experiences, and in-group jokes that those without disabilities might not have implicitly understood. After one group, we observed two Black women exchange numbers and discuss the referral list provided to them at the conclusion of the focus group. Many thanked us after the group ended.

We do know that for the researchers watching videotapes of women discussing experiences of microaggressions was not easy. The microaggressions perpetrated by family members or close friends were especially painful experiences and that pain was palpable. Sometimes when one woman would share a story, the room would fall silent and feel uneasy. One woman wondered if her husband divorced her due to her MS. For another participant, the difference between her subjective

experience and her family's objective perceptions of her was so incongruent that they treated her as though she were lying about the severity of her symptoms. Other members nodded in understanding and tried to normalize her experience with stories of their own issues with family.

### *Policy Implications*

There are several policy implications that stem from the experiences of the women in the focus groups we conducted, as well as from the previous works on microaggressions by women and by people with disabilities. We recommend curriculum additions in medical professions related to unconscious bias against both women and people with disabilities, and on the link between early childhood stressors and subsequent effects on health (e.g., see Jakubowski, Cundiff, & Matthews, 2018 for a review and meta-analysis; also the technical report by Shonkoff, Garner, Committee on Psychosocial Aspects of Child and Family Health, Committee on Early Childhood, Adoption, and Dependent Care, & Section on Developmental and Behavioral Pediatrics, 2012). Because women with disabilities are more likely to have histories of abuse than are women without disabilities (as mirrored in the high rate amongst our participants), another addition to curricula could be conducting evaluations with such women who are triggered by the activities in a medical exam.

A second area is the need for public campaigns on several fronts, such as persons with invisible disabilities and their rights to disability accommodations such as handicapped parking; leaving access to accessible dressing rooms, public transport seats, and bathroom stalls for those who need them; and a third area relates to significant changes to public transportation systems to make them more accessible to people with all types of disabilities. This would involve everything from clarity of schedules to preventing elevators being used as bathrooms, ensuring all stops are announced clearly to reducing the time needed to board/disembark people with disabilities.

We also recommend that journal policies encourage studies of intersectionality, and that multiple minority statuses are not only reported but analyzed. Regarding psychotherapy, we need data on the percentage of accessible offices, and policies that are disability friendly (e.g., allowing for same-day cancellations due to disability symptom fluctuations or failure of equipment or nonarrival of paratransit). We need information for clients with disabilities about types, frequencies, management, and effects of microaggressions in the therapeutic encounter.

### **Conclusion**

It is possible that the passage of the Americans with Disabilities Act (1990) and its amendments (2008) have led much of the public to believe that disability



has been “handled.” But much as the Civil Rights Act (1965) has not erased racism, the ADA has not erased ableism (Bogart & Dunn, 2019). Encounters with other people may still be the most difficult and hurtful aspect to disability, and that barrier will not be brought down by law. Microaggressions are daily reminders of the stigmatized condition of disability. When discrimination is systematized, it leads to oppression. Ableism is the systemization of oppression against people with disabilities. As such, it must be examined at multiple levels. Education of nondisabled people regarding interactions with people with disabilities is just one level to approach needed changes (Dunn, 2019). Such education may need to be tailored differently to specific groups, as women and those with more contact with people with disabilities tend to show less prejudice toward people with disabilities (Harder, Keller, & Chopik, 2019). And although education about disability in general may have some effects, there may be a need for disability-specific education as well, because responses to different types of disabilities matter in perceptions of the behavior of the person with a disability (Wang, Walker, Pietri, & Ashburn-Nardo, 2019).

Microaggressions are only one aspect of oppression derived from ableism. However, they are readily apparent manifestations. By understanding experiences of microaggressions we can learn multiple areas to be targeted. In our study, we learned about perpetuation of ableism across many levels (e.g., transportation, abuse, medical professionals, and family members). Different approaches may be needed for the different levels. But clearly, we have much work ahead of us.

### Acknowledgment

This research was supported in part by a grant from the American Psychological Association Scott & Paul Pearsall Scholarship awarded to the second, third, and fourth authors.

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