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"I Just Want You to Know That 'Them' is Me": Intergroup Perspectives on Communication and Disability

Ellen B. Ryan
Selina Bajorek
Amanda Beaman
Ann P. Anas

It has been noted before that a telephone call can change your life forever. In my case, it was a visit to the eye doctor. I was told that I had had a retinal hemorrhage. While he admitted that this was probably the beginning of a very serious condition, he urged me not to tell anyone, especially the people at work. I was sent to a retinal specialist who looked at my eyes briefly and in a nonchalant manner noted that there was absolutely nothing that he could do for me and briskly guided me out to the hallway. Thus, the stage seemed to be set for a fight. And for a couple of years it was difficult to do anything but count the casualties. My boss informed me that if she was losing her vision, "she would kill herself." And my family doctor urged me to apply for my pension. Thus, the first battle involved the struggle to stay at work as long as possible. Eventually, however, I realized that I had lost my job but more importantly I seemed to have lost a sense of myself. Financial losses quickly followed, and I realized that losing my vision was not the tough part. It was what people did to you that was the most difficult. Thus, the battle was being waged on two fronts—with others and within myself.

Happily, the skirmishes eventually settled. I have become wiser about where I should struggle, how to find allies, and when to avoid the battle all together. My friends and family experience a similar grief to my own. They are not the enemy, and they need my patience and understanding, as I need theirs.

My volunteer work has brought me into contact with others who are also struggling alone and invisible to others, but their inner strength refuses to diminish. Allies such as these are a source of spiritual strength and endurance. The people who avoid me, who try to help by telling every salesperson that I am visually impaired, and

who yell in my ear to make sure that I can hear them—these actions no longer evoke my anger. The anger has been replaced with an inner smile of new secret knowledge. I have won the battle within myself, and occasionally I give others something to think about. (S.B.)

Acquiring a physical disability in adulthood necessitates a process of adjustment to the new social milieu, as recounted above by the second author. Negative attitudes and constraining expectations about behavior can result from a discrediting attribute, the stigma associated with disability (Goffman, 1963). Once disabled, one's conversations with able-bodied people might now be interpreted as intergroup encounters in which the person with the disability is marginalized. Intergroup communication can simultaneously affect the physically challenged person's evolving social identity and their communication patterns with others. Adjustment to the changed social milieu can lead to a limited social identity, but more positive outcomes are possible through the use of empowering communication strategies.

In this chapter, we introduce the communication predicament of disability model to provide a framework for understanding the intergroup communication challenges and threatened social identity resulting from stigma. After providing evidence for this negative feedback process, we characterize the manner in which people with disabilities can interrupt the cycle through the use of "selective assertiveness" in conversation, as well as group-empowered communication to challenge the status quo. Our discussion is constructed from the standpoint of persons with disabilities and has been informed as much as possible by *their* perspective. Examples from empirical research on communication predicaments and assertiveness in aging are provided to support interpretations and speculations about disability. Finally, we suggest productive areas for future research emerging from this intergroup conceptualization of communication and disability.

Communication Predicament of Disability Model: A Negative Feedback Cycle

Major recent reviews have outlined a variety of relevant theoretical approaches for conceptualizing communication and disability (see Braithwaite & Thompson, 2000). Interability communication theory, the one most relevant to this volume, will be discussed later in the

chapter (Fox & Giles, 1997; Fox, Giles, Orbe, & Bourhis, 2000). We introduce here an alternate model that is also derived primarily from social identity and communication accommodation (Giles, Coupland, & Coupland, 1991) theories.

The communication predicament of disability model (see Figure 1) builds on the empirical success of the communication predicament of aging model (Hummert, Garstka, Ryan, & Bonnesen, 2004; Ryan, Giles, Bartolucci, & Henwood, 1986). This new negative feedback model emphasizes the disempowerment involved in much intergroup communication experienced by individuals with a disability and draws attention to selective assertiveness as a key to re-establishing more respectful interpersonal communication. The model postulates that stereotypes of disability such as dependence, lack of control, and incompetence bias the ways in which able-bodied people treat persons with disabilities. The resulting communication modifications constrain opportunities for satisfying communication and reinforce disability-based stereotypes. The momentum of the predicament process increasingly presses upon the person with a disability to react passively or resist aggressively. Frequent interactions of this type can lead the person to withdraw socially, feel less in control, conform more to disability stereotypes, and eventually adopt a reduced sense of self as disabled. However, the model portrays the opportunity for people with a disability to interrupt the cycle through selective assertiveness, either through individual conversational strategies in dyadic situations or through group-based strategies. The following sections are organized around the model.

Stage One of Predicament: Stigmatization
Able-bodied individuals commonly stereotype persons with disabilities as dependent (Coleman & DePaulo, 1991; Fine & Asch, 1988), incompetent (Emry & Wiseman, 1987; Fox & Giles, 1996), unproductive (Chouinard, 2003; Susman, 1994), sick (Braithwaite, 1990; Emry & Wiseman, 1987), burdensome (Chouinard, 2003; Fox & Giles, 1996), unattractive (Frank, 1988; Susman, 1994), and hypersensitive and bitter (Coleman & DePaulo, 1991; Emry & Wiseman, 1987). There are many theories concerning the origin of the negative stereotypes associated with persons with disabilities (Goffman, 1963; Rubington &
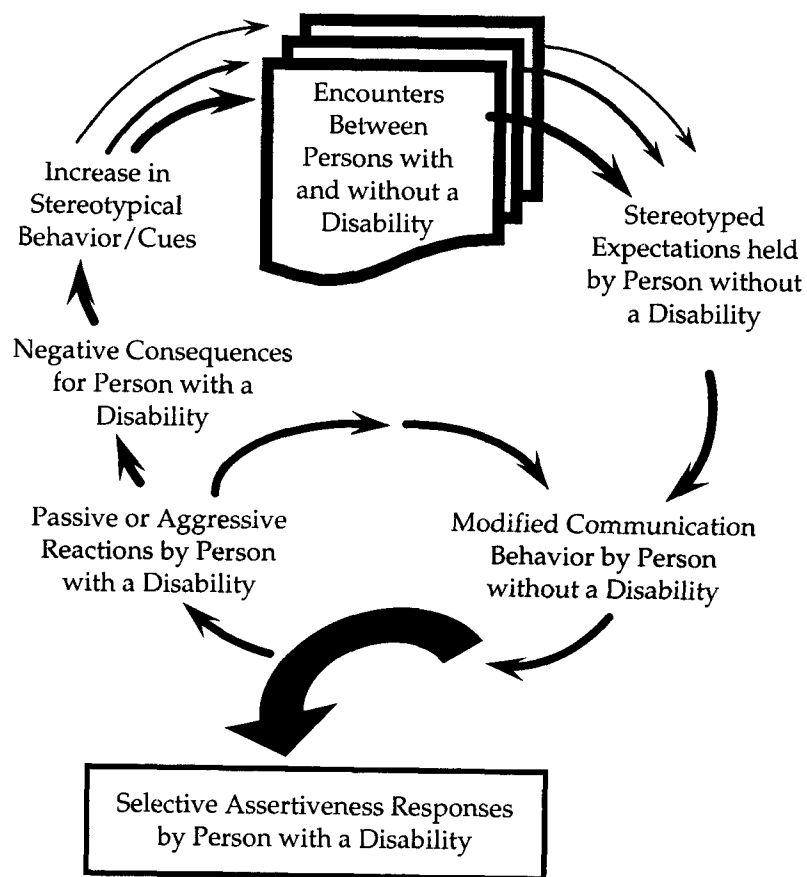
Figure 1: *The Communication Predicament of Disability: Interrupting the Cycle with Selective Assertiveness*

Weinberg, 1987; Yuker, 1988). For example, social exchange theorists argue that "unmarked" (able-bodied) individuals, in a social exchange with "marked" (person with disability) individuals, might wish to place the blame for the "mark" on the person with the disability so as to maximize the social exchange in their favor (Gramling & Forsyth, 1987). Assigning stereotypes to the marked group effectively attributes responsibility to disabled persons for their situation (e.g., they are incompetent). This "blame the victim" mentality has been documented with minority groups identified by race, gender, lan-

guage, and age (see relevant chapters in this volume). From a broader perspective, negative stereotypes and attitudes are hypothesized to be sustained by values such as Western society's emphasis on the sociocultural ideals of independence, beauty, and marketability (Livneh, 1988; Susman, 1994). As noted by Higgins (1992, p. 8), "we create disability when we accept a portion of human variation as "natural" and mark off the rest of human variation as significantly different."

Categorization of people into social groups can lead to mindless behavior whereby people minimize differences within the group and exaggerate intergroup differences (Coleman & DePaulo, 1991; Langer & Chanowitz, 1988). Individuals within the outgroup are believed to possess homogeneous characteristics, although, despite very specific labels (e.g., older native Canadians with visual impairment), there is inevitably a great deal of heterogeneity among any group's members. The able-bodied often accept the illusion of homogeneity, communicating in fixed ways with "the disabled," rather than responding to the varied backgrounds and abilities of the individuals in this population (Fox & Giles, 1997; Rubington & Weinberg, 1987).

Goffman (1963) highlighted the different issues faced in everyday interactions by persons with visible vs. invisible disabilities. Namely, those with visible disabilities (discredited) must deal with the anxiety resulting from their disability being public knowledge, while those with invisible disabilities (discreditable) contend with concealing any information that might give away their disability and the predicament of finding the appropriate time to disclose their disability to others (Fine & Asch, 1988; Matthews & Harrington, 2000).

Stereotypes can cause nondisabled people to hold rigid expectations of persons with disabilities. For example, a person with an invisible disability might require more help than a person with a visible disability, but conflicting cues regarding dependence and independence can lead to inappropriate helping. Often, witnessing one instance of dependence causes the nondisabled to overgeneralize that an individual is dependent in every situation. For example, with many types of disability, such as multiple sclerosis and arthritis, individuals might or might not need to use an assistive device from one day to the next. For many individuals, changes occur in the level of dependence across time and situations, potentially changing the visibility of a disability (Fine & Asch, 1988; Morris, 1991). In addition, an observed in

stance of dependency might not be internal to the individual but a result of environmental constraints. For example, a person with visual impairment might only need to use a white cane when the light is poor. Able-bodied individuals can become upset when the behavior of a person with a disability does not fit with an all-or-none concept of impairment (e.g., a person with hearing loss overhearing a personal comment, a blind person seeing something with peripheral vision, or a person in a wheelchair standing up) (see Emry & Wiseman, 1987).

Stage Two of Predicament: Modified Communication

> Recently, in a coffee shop, I was approached by someone who said "Hello, Selina" and she stood at our table while I tried to identify her. While most people know that I cannot see their face, they continue to refuse to adapt to a pattern of identifying themselves. My companion, sensing a moment of awkwardness, shouted at me, "Stand up, Selina and see who it is!" (SB)

Social categorization and stereotyping lead to modified nonverbal and verbal communication behaviors by both the able-bodied and the person with the disability. Communication accommodation theory argues that people draw on their existing knowledge, including negative stereotypes, to accommodate communication behaviors toward members of a particular group (Coupland, Coupland & Giles, 1991; Giles et al., 1991). Accommodations are motivated by the individual's needs to express values, attitudes, and intentions, as well as social approval or disapproval, and group loyalty (Fox & Giles, 1996; Fox et al., 2000). Encounters with disabled persons might threaten their social identity as a fully functioning human being and as a charitable person (Fox & Giles, 1997). Thus, able-bodied people often use communication strategies that emphasize their distinctiveness from their disabled conversational partner and that present themselves as "good persons" (Fox & Giles, 1997; Rubington & Weinberg, 1987).

Research on intergenerational communication with older adults is relevant, since disability stereotypes are also commonly applied to old people. Younger adults and service providers often make speech overaccommodations that communicate a patronizing attitude toward older adults (Hummert et al., 2004; Hummert & Ryan, 2001; see also Williams & Garrett, this volume). Modifications such as simplified vocabulary, simple sentences, overly familiar talk, overly directive

talk, disapproval, and baby talk (including exaggerated intonation) stem from the stereotypes of older adults as dependent and incompetent (Fox & Giles, 1996, 1997). These communication patterns are driven by two different motivations: task efficiency, which leads to impatience, and an automatic sense of nurturance, which leads to overhelping or inappropriate helping (Hummert & Ryan, 2001). Many of the same behaviors have been found to occur in conversations experienced by individuals with disabilities (Emry & Wiseman, 1987; Liesener & Mills, 1999).

Persons with disabilities have also described the tendency of the able-bodied either to center the interaction around the disability, giving it "master status," or to avoid the topic altogether (Coleman & DePaulo, 1991; Goffman, 1963). In their preoccupation with the disability, nondisabled persons might ask overly personal questions (e.g., intimate questions from strangers about grooming and sexuality) (Braithwaite, 1990). The power differential created when strangers are asked by a person with a disability for help can also give the helper a false sense of permission to ask personal questions.

Overhelping behavior is one of the most commonly cited communication modifications in interactions with persons with disabilities (Fox & Giles, 1997; Fox et al., 2000). Braithwaite and Eckstein (2003) showed that managing unwanted assistance from able-bodied others is a primary communication challenge for people with disabilities. They found that help was deemed unwanted by persons with disabilities when able-bodied helpers' communication reflected stereotypes such as incompetence and dependence. Help from a nondisabled person was unwanted when they were patronizing, they offered more help than needed, gave help when not asked, made a spectacle of helping, or put a person's safety in jeopardy by not following instructions.

Finally, avoidance behavior is thought to result from anxiety about interacting with a person with a disability (Fox & Giles, 1996; Hebl & Kleck, 2000). The initial emotional reactions of fear, surprise, or repulsion displayed in the nondisabled person's facial expressions are often not well hidden. Their failed attempts to try and replace them with more socially desirable expressions (e.g., ingratiation) are often detected by the person with the disability (Coleman & DePaulo, 1991). Braithwaite (1990) found that persons with disabilities sensed

the able-bodied person's discomfort through verbal and nonverbal signs such as fidgeting, lack of eye contact, keeping a large physical distance, staring, statements of sympathy, avoidance, or pretending the disability does not exist. There are competing responses: you want to look and you cannot (Goffman, 1963; Yuker, 1988). When a person with disability is with another person, the able-bodied often ignore them, carrying on the conversation with the companion due to their discomfort and the inappropriate assumption of incompetence (Braithwaite & Thompson, 2000; Yuker, 1988).

Stage Three of Predicament: Passive or Aggressive Reactions of the Person with a Disability
Individuals with a disability have several options for responding to the modified communication of members of the able-bodied group. However, repeated experiences of stereotype-based communication can limit their apparent options to passive or aggressive reactions. Thus, individuals might take the path of least resistance to make the interaction run more smoothly (which reinforces the dependent stereotype), or react aggressively to defend themselves, which reinforces the "sensitive" and "bitter" stereotype. Finally, they might react outwardly with passive behavior with the intention of thwarting the goals of the able-bodied individual through passive aggressiveness (e.g., inefficiency, procrastination), thereby confirming the stereotype of incompetence (Emry & Wiseman, 1987; Fox et al., 2000; Paterson, 2000). For the purposes of this chapter, we have chosen to focus on the more automatic passive and aggressive reactions.

Passive communication is characterized by an inhibited, self-denying, and apologetic style, and by language that is indirect, overly polite, and filled with hidden meaning (Paterson, 2000; Rakos, 1991). Passive responses are accompanied by stooped, sagging posture, fidgeting, lack of eye contact, and tense facial gestures. When behaving in this manner, individuals often allow others to make choices for them, usually resulting in their goals being unmet. The negative feedback loop operates to encourage acknowledgment of a physical disability as a passive response to the uncertainty of the conversational partner, allowing the interaction to run more smoothly. However, this behavior often contributes to the relinquishment of control in a conversation (Coleman & DePaulo, 1991; Hebl & Kleck, 2000). Research

with older adults has revealed that nursing home residents often passively accept patronizing communication due to fears of jeopardizing the care they receive from healthcare workers, perpetuating the perception that they are incompetent (Hummert et al., 2004). Persons with disabilities who are dependent on others for services also sometimes feel they must accept inappropriate behavior for the sake of continued services. Yet, individuals going along with the stereotypes risk being further stigmatized and might begin to believe that they are helpless (Fox et al., 2000; Scott, cited in Rubington & Weinberg, 1987).

Aggressive communication is typically identified as a controlling style involving accusatory and angry language, rigid gestures, and highly charged emotions. In terms of disability, the emotional language and bristly gestures inherent in these responses might halt inappropriate behaviors of others but, in turn, act as cues that call up negative stereotypes (e.g., sensitive, bitter) (Fox & Giles, 1997). Subsequently, as predicted by the negative feedback cycle, the nondisabled person might respond with equally stereotypical behavior, cutting the interaction short or responding in a rigid manner, spoiling the opportunity for a satisfying interaction (Coleman & DePaulo, 1991; Emry & Wiseman, 1987). While the initial aggressive reaction of the individual with the disability might be a result of their pent-up frustration with continually experiencing poor communication from others, it might only result in their needs being left unmet.

Stage Four of Predicament: Negative Consequences for Social Identity
While adaptations to one's physical environment are expected after acquiring a disability, the adjustments that must be made to a new social identity as disabled might only become apparent after living with the disability for some time (Braithwaite, 1990). Furthermore, it has been argued that it is not the physical, but the social and psychological changes described above that cause the most problems for people with acquired disabilities (Fine & Asch, 1988; Higgins, 1992; Oliver, 1996).

After exposure to stereotype-driven communication, individuals with a disability might internalize the expectations that the able-bodied assign and, in line with self-fulfilling prophecy theory, might begin acting or feeling how they think others perceive them, leading to lowered self-esteem (Coleman & DePaulo, 1991; Goffman, 1963).

The modified behaviors of the nondisabled can produce feelings of anger, humiliation, and depression in persons with disabilities. Recipients of inappropriate communication might become overly sensitive to the evaluations of others or contemptuous toward other persons with disabilities (Coleman & DePaulo, 1991; Langer & Chanowitz, 1988).

While individuals might not be consciously aware of them, implicit stereotypes held about one's own social group can have far-reaching effects on behavior. Research shows that activation of negative aging stereotypes without the participants' awareness causes older adults to behave "older" in terms of reduced memory performance, handwriting quality, and cardiovascular stress indicators. However, when positive stereotypes were primed, their memory, handwriting, walking gait, and health indicators improved (Levy, 2003). Furthermore, as compared to explicit discriminatory behaviors, it might be more difficult for stigmatized groups to defend against negative behaviors implicitly driven by stereotypes since these behaviors are often subtle or easily attributable to other causes (e.g., the other candidate was more qualified for the job) (Coleman & DePaulo, 1991; Levy, 2003). The link to communication is highlighted by the finding that marginalized individuals experience lower self-esteem and increased depression after receiving unwarranted help (Schneider, Major, Luhtanen, & Crocker, 1996).

Selective Assertiveness: Conversational Options

Given the negative consequences associated with stereotype-reinforcing reactions, persons with disabilities might cultivate other options that are more likely to elicit respectful behavior on the part of the able-bodied. As depicted in Figure 1, selective assertiveness can break the cycle of automatic intergroup conduct, creating person-to-person interactions. Of course, we offer this perspective while recognizing the great variation in relevance and implementation, given the complexity of people's lives.

Possible responses to inappropriate communication can be viewed along a continuum from passive to aggressive. Choosing an assertive response from the middle of that continuum is intended to avoid the dangers associated with the extremes and to take control over managing others' impressions of oneself (Rakos, 1991; Twenge, 2001; Wilson

& Gallois, 1993). Some authors have suggested that assertiveness is multidimensional and requires a conceptualization more like a triangle or pyramid to contrast the ideal style from passive, aggressive, offensive, and manipulative responses (e.g., Fox et al., 2000; Paterson, 2000). Assertive communication involves the tactful, straightforward expression of feelings and desires. Clear messages are associated with a confident, calm tone of voice and relaxed facial expressions and gestures. Assertive messages can be especially effective when expressing appreciation and acknowledging the conversational partner's needs (Hummert et al., 2004; Rakos, 1991).

We use the term "selective" to emphasize the goal-based, situational choices involved in when and how to be assertive. Selectively assertive people take responsibility for meeting their own goals. In contrast, passive people fail to take responsibility, while aggressive people are likely to hurt others (Fox et al., 2000; Taylor & Epstein, 1999). Our emphasis on selection derives from decades of research establishing the necessity of contextualizing assertive responses and of choosing one's battles (Rakos, 1991; Street, 2001; Wilson & Gallois, 1993).

Assertive behavior is associated with high-status, self-esteem, a positive self-concept, and empowerment (Hebl, Tickle, & Heatherton, 2000; Twenge, 2001; Wilson & Gallois, 1993). Those who engage in assertive behavior are less likely to be victimized, experience less depression, sustain increased effectiveness in interpersonal power relationships, and enjoy higher levels of social support (e.g., Hersen et al., 1995). The correlation between assertiveness and positive acceptance of disability underlies the incorporation of communication skills training into rehabilitation programs (Joiner, Lovett, & Goodwin, 1989).

Fox and Giles (1996, 1997; Fox et al., 2000) have formulated interability communication theory to account for the one-down position of people with disabilities in intergroup situations and for the limited effects of intergroup contact with disabled individuals on able-bodied people's attitudes and communication behaviors. They propose social identity motivations underlying response strategies. Passing as able-bodied motivates nonassertion, while establishing a totally separate group motivates aggression. In contrast, assertion flows from a desire for positive social identity within an intergroup exchange.

In a study of older adults with and without hearing loss, assertive responding was rated as more competent than either passive or aggressive responding and also more likely to result in satisfying interactions in the future (Ryan, Anas, & Friedman, 2004; see also Harwood, Ryan, Giles, & Tysoski, 1997). Other related studies have shown the promise of humor and appreciation as indirectly assertive responses that can be useful selectively when saving the face of the conversational partner is important (e.g., with a service provider: Hummert et al., 2004; Ryan, Kennaley, Pratt, & Shumovich, 2000).

Braithwaite (1990) derived six impression management strategies from interviews with persons with disability. These task-oriented communication strategies serve to manage the conversation so that individuals with a disability present themselves first as persons for the sake of building a relationship with nondisabled others, instead of accepting inappropriate attention to the disability. These strategies fit within our concept of selective assertiveness: 1) establish normalcy by showing the able-bodied person more likenesses than the salient difference or minimizing the disability; 2) use modeling behavior to show how one would like to be treated; 3) limit attention to an assistive device (e.g., use the device unobtrusively, or divert attention away from it); 4) limit responses to personal questions; 5) delay disclosure about the disability; 6) manage the able-bodied tendency to overhelp (e.g., ignore unwanted helping attempts, turn down the offer with humor, educate the helper with straightforward description of what is most useful, engage a formal helper) (see also Braithwaite & Eckstein, 2003; Taylor & Epstein, 1999). SB offers these illustrations: a) "I have trouble seeing" instead of "I am legally blind"; b) using a collapsible cane that can be put away once in familiar territory; c) "Please take my arm rather than pushing me."

Potential benefits of selective assertiveness include satisfying communication, positive social identity, a sense of control, managing help effectively, and generally meeting one's goals. When empowered with a sense of equality as a human being, the person with a disability can more effectively manage the communication predicaments that are part of everyday life.

Intergroup Communication Strategies of the Disability Group

Once persons with disabilities decide to be members of a disability group, intergroup communication strategies can be used selectively to meet the social identity goals of social creativity (creating positive ingroup norms) and social competition (vying for resources). These approaches focus on empowerment of the disadvantaged group as a whole rather than individual members (see Harwood, Giles, & Palomares, this volume).

Social Creativity

Social creativity involves seeking new positive dimensions for intergroup comparison to improve the self-concept of members of the disadvantaged group. The disability community has worked toward redefining models of disability. Meanings derived from the medical model or the model of "personal tragedy" focus on the internal, functional limitations of the person with the disability. For instance, care plans for disabled individuals have usually been defined in terms of a rehabilitation model. This model is inappropriate because of the assumption that it is necessary and possible for persons with disabilities to overcome their health problems (Emry & Wiseman, 1987; Zola, 1981). In addition, the competence level of the person has been traditionally defined by a healthcare professional and their family, thereby taking control away from the individual (Emry & Wiseman, 1987). Newer perspectives see the limitations as resulting from forces external to the individual (Marinelli & Dell Orto, 1999; Morris, 1991; Rauscher & McClintock, 1997). Furthermore, these alternate perspectives challenge the political and attitudinal forces that nurture a disabling environment (Oliver, 1996).

The independent living model was developed in the 1980s during the disabled persons' movement, which emphasized the competence of the person with the disability to develop their own goals and make their own care decisions (Institute on Disability Culture, 2003; Morris 1995). Contrary to the focus of rehabilitation on maximizing physica function, care under this model recognizes that an individual migh not overcome health problems. People with disabilities redefined the meanings of "independence" and "dependence" in alignment with the philosophy of independent living. The traditional Western mean

ing of independence as "self-reliant" and "self-supportive" prevented an individual who needed any assistance from being considered independent. The new independence is equated with the ability to access assistance when and how one needs it and not with the intellectual or physical ability to care for oneself. The Americans with Disabilities Act (US Department of Labor, 1990) also redefined the concept of competence in the workplace by stating that an employee with a disability is qualified if able to perform the job "with the necessary accommodations."

Labels can be powerful enough to sway the attitudes of individuals, which may cause them to modify their behavior (DePaulo & Coleman, 1986; Office for Disability Issues, 1998). By creating alternatives to negative language, persons with disabilities can separate from the stereotypes associated with a label. Advocates for persons with disabilities have attempted to educate the public regarding the effects that inappropriate language can have on persons with disabilities (Office for Disability Issues, 1998; Rauscher & McClintock, 1997). However, this process is ongoing, since previously innocuous language can inevitably become negative over time. Here again, individual-based strategies such as controlling information flow (Braithwaite, 1990) work toward the larger goal of social creativity in that they are redefining the dominant group's perception about them (e.g., persons with disabilities have many other characteristics that make them competent besides the disability).

During the 1950s, people with disabilities were referred to as "cripples" and defined as "useless" or "imperfect," which had clear consequences for them. Later, the label of "handicapped" was used but it came to mean "crippled." By creating a word that symbolizes environmental obstacles (inaccessible), the existence of the obstacles has been legitimized. People with disabilities have also deemed the phrase "the disabled" as unacceptable because the disability is equated with the person when the adjective is used as a noun (Office for Disability Issues, 1998; Susman, 1994). The use of "nondisabled" to refer to the dominant group has the unfamiliar effect of transferring negative connotation from persons with disabilities to those without. Some persons with disability suggest the term "temporarily able-bodied" to minimize the difference between themselves and members of the nondisabled group. Also, the phrase "differently abled"

switches the focus from what individuals cannot do to what they can do. However, these alternate labels can be viewed as euphemisms that perpetuate societal ignorance about disabilities. Overall, the goal of changing the language is to ensure that individuals are addressed less in terms of their disability and more in terms of their personhood (Hebl & Kleck, 2000). Hence, we have chosen to use the term "person with disability" (Office for Disability Issues, 1998; US Department of Labor, 1990). The project of reassigning meaning to disability has even extended to the establishment of disability studies programs at some universities as an important contribution to the study of diversity and an enhanced understanding of human lives (Linton, 1998).

While many groups strive to have their impairment viewed in terms of environmental limitations, others covet a definition that excludes them from the disability group altogether (Institute on Disability Culture, 2003). Deaf activists have fought to be viewed not as a disability subgroup but as a culture, no different from any other culture that has its own language (Young, 1990). Similarly, persons with limb deficiencies challenge the existence of stigma, rather than simply reacting to it, by refusing to wear prosthetic devices (Frank, 1988). Thus, these groups attempt to create new norms that could remove the stigma altogether.

Social Competition

Engaging in social competition, various disability groups strive politically to gain status and societal resources for their members. Disability advocates in North America in the 1970s gathered together across disability subgroup boundaries to fight "ableism," a newly identified source of societal discrimination (Rauscher & McClintock, 1997). Advocates were successful in obtaining equal rights "without discrimination based on... mental or physical disability" in the Canadian Charter of Rights and Freedoms (1982, section 15(1)). The Americans with Disabilities Act of 1990 challenged society's notions of competence and productivity, among many other issues, by demanding equal consideration for employment opportunities (US Department of Labor, 1990). The act stated that the decreased status of the disabled resulted from barriers in the environment such as architectural, transportation, and communication barriers. Thus, people with disabilities were *legally* considered equal to those without and, therefore, granted

resources that would allow them to take advantage of the same opportunities as the dominant group (Oliver, 1996).

Conclusion

This chapter speaks from the perspective of persons with disabilities, following the lead of Emry and Wiseman (1987) and Braithwaite (1990). We have argued that as one adjusts to an acquired disability, one can learn to interrupt the negative feedback cycle depicted by the communication predicament of disability model. By exercising control, choice, and assertiveness, one can move effectively beyond the limits imposed by stigmatization and environmental barriers (Fox & Giles, 1997; Fox et al., 2000; Marinelli & Dell Orto, 1999). One can acknowledge the social stigma of "disabled" without internalizing it. As a result, one can manage conversations with others proactively and thereby create a positive new social identity.

Nevertheless, we must not underestimate the importance of awakening the nondisabled world to their common practice of "mindless" communication. Langer and Moldoveanu (2000, p. 138) argue that mindful communication with others is really about mindful *listening*, whereby one actively listens, free of the "preexisting categories that constrain the attention of the listener to a pre-specified set of characteristics of the other." Given the ever-present stereotypes and the negative consequences of communication predicaments imposed upon persons with disability, sensitizing the nondisabled to inappropriate communication patterns should continue to be an important area of research, practice, and policy. In addition, learning that the boundary between able-bodied and disabled is illusory can help people prepare for their own possible acquisition of disability later in life (Beaulaurier & Taylor, 2001). The assertive communication techniques we have outlined could be effective beyond the issues of disability for any recipient of inappropriate attention or disempowering communication.

The most important direction for future research is to record the multiplicity of voices among people with disabilities. Social identity theory and the communication predicament of disability model provide valuable frameworks within which to interpret data concerning the intergroup predicaments faced by people with disabilities. Further extending the work of Braithwaite and colleagues, ethnographic and interview methodology could highlight the most important conversational dilemmas as well as the range of selective assertiveness and group-based strategies that might be available for managing those dilemmas. This research could elaborate distinctions in the intergroup experiences of those with visible and invisible disabilities.

Person perception studies are particularly useful for assessing the impact of group memberships and interpersonal and contextual manipulations on the interpretation of conversational strategies. This paradigm can systematically examine the range of assertive behaviors realistically available to people with different disabilities under particular circumstances (see Fox & Giles, 1996; Hummert et al., 2004). As identified earlier, the primary assertiveness issues for people with disabilities involve when and how to disclose information and how to manage helping behaviors (needed and unwanted). Future research needs to document which strategies work best for different personalities, different disabilities, and in different situations.

Dyadic experiments offer the opportunity to observe the conversational behavior of disabled and nondisabled conversational partners under controlled conditions to determine the impact of the situation, role, and interactive components of context (see Hebl & Kleck, 2000). Role-plays can be developed from these dyadic studies for use in training professional service providers (social workers, therapists, nursing staff, medical staff). As well, the dyadic conversational paradigm provides a technique for evaluating the effects of communication skills training.

Finally, links between social identity in disability and communication can profitably be addressed in terms of the following research questions: What sorts of communication experiences lead persons with an acquired disability to shift from social mobility (trying to pass as able-bodied) to identification as a disabled person? What communication experiences might lead a person with a disability to choose collective identity with people with different disabilities? How does degree of identification with disability relate to the use of assertive conversational strategies? How does the use of assertive conversational strategies in intergroup contexts relate to endorsement of social creativity and social competition group strategies?

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