

University of Texas Rio Grande Valley

ScholarWorks @ UTRGV

---

School of Rehabilitation Services & Counseling  
Faculty Publications and Presentations

College of Health Professions

---

2018

## Stigmatizing Effects of Visible Versus Invisible Disabilities

Noel A. Ysasi

*The University of Texas Rio Grande Valley*

Alicia B. Becton

Roy K. Chen

*The University of Texas Rio Grande Valley*, [roy.chen@utrgv.edu](mailto:roy.chen@utrgv.edu)

Follow this and additional works at: [https://scholarworks.utrgv.edu/rhc\\_fac](https://scholarworks.utrgv.edu/rhc_fac)



Part of the [Rehabilitation and Therapy Commons](#)

---

### Recommended Citation

Ysasi, N., Becton, A., & Chen, R. (2018). Stigmatizing effects of visible versus invisible disabilities. *Journal of Disability Studies*, 4(1), 22-29.

This Article is brought to you for free and open access by the College of Health Professions at ScholarWorks @ UTRGV. It has been accepted for inclusion in School of Rehabilitation Services & Counseling Faculty Publications and Presentations by an authorized administrator of ScholarWorks @ UTRGV. For more information, please contact [justin.white@utrgv.edu](mailto:justin.white@utrgv.edu), [william.flores01@utrgv.edu](mailto:william.flores01@utrgv.edu).



## Stigmatizing Effects of Visible Versus Invisible Disabilities

Noel A. Ysasi<sup>1\*</sup>, Alicia B. Becton<sup>2</sup>, Roy K. Chen<sup>3</sup>

*1 Northern Illinois University, USA. 2 California State University, Fresno, USA. 3 University of Texas Rio Grande Valley, USA.*

Submitted on: April 18, 2018 Accepted on: August 3, 2018

### ABSTRACT

The concept of disability is complex and has been interpreted in a variety of ways. The degree to which a disorder is “disabling” depends on the interchange between the condition and other factors including the individual’s environment. Modern society’s emphasis on self-sufficiency and productivity contribute to the tendency to devalue those who are perceived as unable from these valued characteristics. Research suggests the visibility of a condition may lead to stigmatization, a concept generally associated with feelings of shame due to discontentment and devaluation of others. The authors present literature related to persons with visible and invisible disabilities, and the stigmatizing effects, while demonstrating the varying nature of stigma related to hiring practices and deliberate concealment, a phenomenon known well among persons with invisible disabilities. Additionally, the societal attitudes which lead to common barriers, negative experiences among persons with disabilities, and implications for practitioners are discussed

*Keywords: Disability, stigma, self-efficacy, employment*

### INTRODUCTION

appearance, persons having a visible disability can experience an array of stigmatizing effects and challenges when differing from the norm. Examples include but are not limited to: (a) aesthetic aversion, (b) the spread phenomenon, (c) discriminatory hiring practices, and (d) difficulty adjusting to one’s disability. Though body image can create a positive reinforcing tool for living a healthy lifestyle, it can also have debilitating effects when individuals perceive themselves as different and are unwilling to accept themselves for the attributes they possess. Western society emphasizes cosmetic beauty, thinness, and a body-fit physique among women, while men are strongly encouraged to maintain an athletically physique if one is to find a mate. Media and cultural environments have been notorious for placing standards of what it means to be attractive for both genders. For instance, since the early 1960s, models in the fashion industry generally weighed 140 pounds or less (63.5 kilograms), and only recently did Sports Illustrated show their first plus-size swimsuit model (McAfee, 2016). This created much backlash as the magazine was criticized for promoting obesity and unhealthy living (McAfee, 2016). Unfortunately, female-oriented

magazines often stress the need to be thin (i.e., “lose 15 pounds in 2 weeks”) and identifies slim bodies as attractive, rarely focusing on overall healthy living (Garner, Garfinkel, Schwartz, & Thompson, 1980; Silverstein, Perdue, Peterson, & Kelly, 1986). It should be noted; however, this phenomenon does not solely pertain to females. Abercrombie and Fitch has been known to hire athletic males specifically for “modeling” their physique outside their department store, further influencing adolescents and young adults to adhere to what is considered attractive by societal standards. The aforementioned examples often influence females and males to take drastic measures to ensure body perfection through special diets, excessive hours in the gym, and the use of anabolic steroids (Castle, Rossell, & Kyrios, 2006). Research has revealed the need to obtain the ideal body image has been positively correlated among persons who are teased as a result of physical appearance, societal pressure, media imagery, cultural expectations, and Hollywood publicity (Castle et al., 2006; Wroblewska, 1997).

### Sexuality and Disability

People with disabilities have experienced the stigma of having a disability and being asexual, lacking a sex drive, being incapable of sexual performance, being sexually deviant, and lacking necessary social skills and judgement to be sexually appropriate (Aunos & Feldman, 2002; Olkin, 1999). Stigmas associated with sex and disability can vary depending on gender, such as the myth that men with a spinal cord injury are incapable of having sex or are uninterested, or inactive (Farrow, 1990). Women with disabilities have been viewed as unable to have children and if they are a parent, are incapable of nurturing qualities (Danek, 1992). Women with disabilities have

\*Corresponding Author  
Email: nysasi@niu.edu

Cite as: Ysasi, N. A., Becton, A. B., & Chen, R. K. (2018). Stigmatizing effects of visible versus invisible disabilities. *Journal of Disability Studies*. 4(1), 22-29.

©IS Publications ISSN: 2454-6623 <http://pubs.iscience.in/jds>



also been identified as being asexual, even if they engaged in sexual relations prior to acquiring a disability (Hanna & Rogovsky, 1991). Furthermore, and as discussed earlier, the social constructs of physical characteristics have profound impacts on how men and women are objectified. "Many men dream of a *Playboy*-type sexual partner: a beautiful body performing a variety of sexual services. However, few men think of a visibly disabled woman as a sex object..." (Hanna & Rogovsky, 1991, p. 56).

### **Stigmas of Persons with Visible Disabilities**

When persons come into contact with a person with a visible disability, there are varying emotions frequently exhibited and are generally the cause of internal conflicts; the person without a disability may feel anxious and uneasy as a result of stigmas created over time, such as the stigma associated with PWDs and having sinned for past discretions and therefore being punished by God (Livneh, 1991). Taking from the notion that a person has obtained a disability for past sins can spur levels of discomfort, anxiety-provoking behaviors, discriminatory acts, and decreased contact among believers of this stigma. The literature has provided vast amounts of explanations as to why individuals may stigmatize PWDs and treat those with a visible disability differently (Hanna & Rogovsky, 1991; Livneh, 1991).

Aesthetic-sexual aversion, occurs when society finds individuals visually pleasing or repulsive (Livneh, 1991). Research suggests people who are rated as more attractive are seen as more kind, intelligent, interesting, outgoing, sociable, competent, and more likely to advance in their career, and create favorable impressions in comparison to persons perceived as less attractive (Yuker & Hurley, 1987). For instance, Biddle and Hamermesh (1998) found lawyers who are rated as more attractive had greater yearly earnings as clients preferred to engage with attorneys deemed better-looking, as they perceived that the monetary return would be favorably greater. Additionally, the researchers hypothesized the following: (a) clients' choices are purely the result of discrimination among persons identified as visibly unattractive, and (b) judges, juries, and opposing attorneys treat a clients' advocate more favorably when viewed as good-looking, generating pecuniary gains for the client.

In addition to attractiveness, competency is also rated higher, while individuals with physical disabilities are considered less competent (Marini, 2012). Beatrice Wright (1983) defines the concept of the "spread phenomenon" as persons without disabilities assuming that persons with physical disabilities must also have a lower IQ. A prime example of stigma and lack of awareness is when individuals find the need to speak louder when a person is blind. Although it may seem humorous, these occurrences frequently take place and can be a challenge for PWDs when the initial perception is one of a lower IQ, which may lead to several other barriers specifically related to employment.

### **Self-Efficacy and the Visibility of the Disability**

Individuals will generally feel good about themselves when they have a job, are socially active, are accepted by others, and are able to live independently. Yet, when a person is viewed as

inherently different from what society deems as the norm, they can be viewed as outsiders, unable to establish friendships and romantic relationships, ultimately affecting self-efficacy; the beliefs people hold of themselves are the foundation of motivation, personal accomplishment, and well-being (Pajares & Urda, 2005). Moreover, when stigmatizing beliefs occur toward a PWD, such as punishment for having sinned and the spread phenomenon (i.e., having a lower IQ), PWDs can experience feelings of hopelessness, anxiety, depression, and resentment. Although people who act as advocates for PWDs (i.e., practitioners in rehabilitation counseling or related disciplines), generally do not see these types of discriminatory acts and/or negative beliefs and attitudes of others, these perceptions persist and can impede the services provided to clients.

People with disabilities have also been characterized as weak and vulnerable (Silvers, Wasserman, & Mahowald, 1998). Although it goes without saying that persons with visible disabilities are a target for mistreatment, it does explain why news coverage on sexual, verbal, and physical abuse among this population continues to persist. When faced with the continuous fear of others, whether as a parent of a child with a disability or a child or adult with a disability, the attitudes and treatment exhibited by others can have detrimental effects on self-efficacy.

### **Visible Disabilities and Employment**

As demonstrated through the example of attorneys who are good-looking, there is a greater emphasis on employing individuals who are perceived as attractive or who have the "right look" and penalizing persons perceived being as less attractive or who have the "wrong look" (Warhurst, van den Broek, Hall, & Nickson, 2009). The stigma associated with visible disabilities is overwhelming, and frequently affects both males and females. For instance, women with facial scarring have been rated as dishonest and less attractive, while men with facial scarring have been rated as less warm, less sincere, and having fewer friends (Bull & David, 1986). Likewise, the need to employ individuals possessing specific physical qualities unrelated to the essential functions of the job, create barriers for job opportunities among PWDs. To illustrate, a study conducted by Siperstein, Romano, Mohler, and Parker (2006) found 22% of employers who had little or no contact with PWDs, believed persons with a visible sensory disability or physical disability were less capable of performing the essential functions normally, were unable to work, were challenged, or were in poor health. To further demonstrate, Gouvier, Steiner, Jackson, Schlater, and Rain, (1991) found when the functions of the job required increased contact between the applicant and the public, persons with more visible disabilities would be less likely to be chosen for the position.

As demonstrated through the aforementioned research, it is evident that PWDs continuously encounter discriminatory practices among employers, subsequently affecting self-efficacy among the targeted population, often creating a self-fulfilling prophecy. Specifically, when people with visible disabilities combat stigma and discriminatory behaviors from employers,

subsequently hindering job placement, the following can occur: (a) levels of uncertainty, (b) lowered self-confidence, and (c) nervousness during future interviews. These self-destructive yet understandable beliefs and attitudes can make any person with a disability skeptical in seeking future job opportunities or even refusing altogether to apply for job openings regardless of possessing the necessary qualifications. As human service professionals continue to work with the population, it is essential to empower the client to self-advocate, increase their confidence, and practice job interviewing skills to counter any stigmatizing attitudes by the interviewer (i.e., have the client emphasize their strengths and qualifications), while simultaneously educating employers as to why the client is a good-fit for their agency.

### **Invisible Disabilities**

Generally, when individuals hear someone has a disability, many assume the person uses a wheelchair or has some sort of physical impairment. According to Davis (2005), "there are many individuals with conditions, illnesses, and structural and biomechanical anomalies that are life limiting but not readily discernible to others" (p.153). Contrary to popular belief, it has been reported that out of 26 million Americans with a severe disability, 19 million are considered to have an invisible disability (Invisible Disabilities Association, 2012). An invisible disability can be defined as a chronic condition that interferes with a person's activities of daily living (ADL), but there are no outward physical signs or other cues to indicate limitations, to the casual observer. In 2008, there was an amendment to the American with Disabilities Act of 1990, which stated "learning, reading, concentrating, thinking, communicating and working are now recognized as major life activities" (Adams et al., 2010, p. 459). Specifically, disabilities including hearing impairments and deafness, learning disabilities and other health impairments were added. Additional examples of hidden disabilities include but are not limited to medical conditions such as diabetes, epilepsy, sickle cell anemia, cystic fibrosis, HIV and AIDS, cancer, and heart, liver and kidney complications. The list of invisible or "hidden" disabilities is extensive and the effects of the conditions vary.

Oftentimes we may find ourselves asking, "How does having an invisible disability affect a person as they are able to hide it from others and therefore, the labeling, negative attitudes, and stigmatizing beliefs, are relatively low and/or non-existent in comparison to persons with a visible disability?" To answer this question, consider the following: Murray and Chambers (1991) researched attitudinal differences among student nurses who worked with three groups of clients: (a) older adults, (b) people with physical disabilities, and (c) people with intellectual disabilities. The results suggested persons with intellectual disabilities were viewed most negatively of the three groups. Slevin and Sines (1996) found 31% of participants carried stereotypical attitudes toward persons with intellectual disabilities, and perceived them as having poor expectations and peculiar behavior. In addition, 47% expressed fears of people who have an intellectual disability, and 31% stated they should be placed in a "side ward" due to their behavior, while believing

other patients need to be considered priority as persons with intellectual disabilities take extended time to work with. The level of stigma associated with possessing an invisible disability is a major reason, persons with invisible disabilities tend not to disclose their condition, especially in the workplace.

### **Self-Efficacy and Stigma**

Individuals with invisible disabilities are often presumed to be members of the majority group; however, they often live with emotional stress due to the lack of identification and contact with others similar to them (Smart & Wagner, 2000). Internal obstacles of identity concerns, feelings of inferiority, self-hate, and shame have a major impact (Lenhardt, 2004). The private shame that diminishes self-esteem and causes an increase in self-doubt effects employment, education and societal interactions (Corrigan, 2002). Additionally, Blankertz (2001) suggested self-efficacy is influenced by negative cognitions and self-esteem. Specifically, self-efficacy can be defined as people's beliefs about their abilities to reach certain levels of functioning.

Contrary to popular belief, there is often a challenge for persons with invisible disabilities to prove they have a disability. For example, Davis (2005) describes "the handicapped parking space challenge." This particular example provides context of the stigma and negative attitudes individuals with invisible disabilities face on a regular basis. For illustration purposes, a handicapped parking space is provided to individuals who have proven to have a disability; therefore, the individual has the right to park in the designated spaces at any time. However, when an individual with an invisible disability parks in the same space as someone with a physical one (e.g., wheelchair user), they are faced with a high possibility of being confronted by a stranger who may feel the need to explain the parking spaces are reserved for "real handicapped people." This assumption and judgment places a burden and large amount of stress on individuals with invisible disabilities, such as the need to disclose let alone prove they indeed have a disability. The need to substantiate having a disability emphasizes increased attention on the disability itself, and creates limitations, which can exacerbate symptoms, intensify pain and augment the disability (Davis, 2005).

As a consequence of stigmatizing attitudes, persons with invisible disabilities frequently attempt to pass for a person without a disability by not disclosing their condition, known as deliberate concealment. Deliberate concealment is when individuals desire to fit in with the majority and not stand out (Lenhardt, 2004). In this case, individuals with invisible disabilities choose not to disclose their disability to avoid the negative attitudes, stigma and discrimination which often occur particularly within the workplace. Social identity theory considers how people use social constructs to label or judge someone who is different from the majority of society. Goffman (1963) introduced the concept where society or large groups within societies, evaluate people to determine if they fit social norms. We can apply this concept to various populations identified as having invisible disabilities such as individuals with mental illness. Contrary to social identity theory, self-

stigma is an internal evaluation process whereby individuals judge themselves (Overton & Medina, 2008). At times the internal judgment follows messages received from the societal stigma, but ultimately the individuals create the judgment themselves. In turn, the internal judgment causes feelings of inadequacy and decreases self-esteem as the persons with invisible disabilities may continue to tell themselves that they do not belong (Blankertz, 2001).

### **Invisible Disability and Employment**

In comparison to people with visible disabilities, persons with an invisible disability (i.e., cognitive or emotional disabilities) are rated less desirable among job applicants (Combs & Omgig, 1986; Stone & Sawatzki, 1980). In a study conducted by Combs and Omgig (1986) to assess employer willingness to hire persons with physical disabilities, neurological disorders, cognitive disabilities, and mental health disorders, the authors found the following: (a) employers were more likely to hire persons with a physical disability 95% of the time, and (b) those with an intellectual disability would be hired 20% of the time. This study was performed 30 years ago, and one may be left with the statement, "But things have changed and people's attitudes have evolved through time as a result of advocacy and legislation." To address this common misconception, Gouvier, Sytsma-Jordan, and Mayville (2003) conducted research to determine whether employers favored hiring persons with either a physical (visible) or mental health disability (invisible). Their findings were consistent with Combs and Omgig (1986) in that persons with a physical disability were rated favorably across employers in contrast to persons with a visible disability. Additionally, attributional ratings revealed persons with a back injury were rated as having higher levels of interpersonal skills and job performance in comparison to those with a mental health disorder, development disability, or closed head injury, "seemingly indicating bias favoring the applicant with a physical disability" (p. 179). Furthermore, applicants with a back injury had higher employability ratings than applicants with a developmental disability. In contrast, both had higher ratings than persons with a mental health disorder.

Many may wonder, why are employers less inclined to hire individuals with a mental health disorder? Unfortunately, people diagnosed with a mental health illness are perceived as violent, unpredictable, and unable to work, or live independently (Corrigan & Bink, 2016). Likewise, employers may fear hiring a person with a mental health disorder due to fear of harming coworkers (Corrigan & Bink, 2016). For example, there is the stigma associated with veterans diagnosed with posttraumatic stress disorder and the belief they may become uncontrollable at any given moment. Moreover, individuals with a mental health disorder (i.e., major depression) requesting time-off and/or performing less than desirability may be faced with affirming attitudes by employers. These affirming attitudes are the beliefs people with a mental health illness are able to recover and make independent life choices (Corrigan & Bink, 2016). A case in point: a person who has been physically injured on the job is generally expected to take time off to recover, yet a

person exhibiting depressive symptoms who calls in sick or has a decrease in work performance, may be perceived as lazy and unprofessional. Consequently, the affirming attitudes exhibited by others can produce discriminatory actions by employers and negative attitudes among coworkers.

Persons with invisible disabilities also face challenges when seeking employment and while employed. When applying for employment, for instance, there can often be concern whether to disclose the disability for fear of discrimination. If employed, there is general concern whether employers may react unfavorably to a request for accommodations, and whether coworkers may stigmatize and display negative attitudes when a disability is identified. Researchers have suggested individuals with invisible disabilities are regularly challenged by society to deny and/or defend whether their disability actually exists (Davis, 2005). Incidentally, when individuals are provided accommodations to assist PWDs to perform the essential functions of the job, the person may be perceived as malingering or wanting to take the "easy way out." Aside from ensuring a successful working relationship between employer and employee, coworkers can also affect how a person successfully adjusts to a working environment, and generally determines whether a person will stay at their current place of employment.

### **Barriers to Living with Invisible Disabilities**

A common myth regarding PWDs is the greatest barriers tend to revolve around physical challenges. Sue and Sue (2008) suggested attitudinal barriers including stigma and discrimination are the ultimate impediments for individuals with disabilities. Furthermore, persons with invisible disabilities face psychological and lifestyle barriers while functioning in society by often being misunderstood and receiving reactions of skepticism. A shared barrier for persons with invisible disabilities continues to be societal attitudes. Several scholars employ a social model, rather than medical, which views disability as the result of disabling social relations (Riddle & Watson, 2003; Titchkosky, 2001). A general misconception is people with invisible disabilities are objects of charity, rather than citizens with rights, opportunities, and the ability to participate in society as individuals without disabilities. This particular mindset has hindered individuals with invisible disabilities in several aspects, such as education, employment, transportation and even willingness to integrate into society. As discussed earlier, stigma refers to characteristics some individuals in a society are believed to possess, and are discreditable and devalued within a particular social context (Crocker, Major & Steele, 1998; Goffman, 1968).

**Mental Health and Stigma.** Historically, individuals with mental health concerns have been "... among the most stigmatized, discriminated against, marginalized, disadvantaged and vulnerable members of our society" (Johnstone, 2001, p. 201). Mental health and illness have been referred to as a spectrum of behaviors, cognitions, and emotions which affect personal relationships in addition to responsibilities required for employment (Johnstone, 2001). People who have a mental health disorder can experience an array of stigmatizing attitudes



from the general public, ultimately resulting in discrimination. Specifically, mental illness has been associated with being dangerous and violent and as a result, avoidance and withdrawal can ensue (i.e., landlords evicting veteran tenants for having post-traumatic stress disorder; Corrigan & Bink, 2016). Although societal stigmas are generally linked to discriminatory acts, stigma can also have profound and indirect outcomes as a consequence. To clarify, a study conducted by Mojtabai et al. (2011) found 97.4% of persons with a mental health disorder and recognizing the need for treatment (e.g., counseling), reported stigma as the primary reason for not seeking assistance, followed by structural barriers at 22%. Structural barriers occur when institutions restrict and limit options for persons with a mental illness (e.g., prohibiting parental rights because of past history of mental illness; Corrigan, Markowitz, & Watson, 2004). As demonstrated, the implications of stigma and mental health disorders are profound. Subsequently, individuals with mental health disorders who experienced or witnessed highly stigmatizing attitudes as a result for having a mental health disorder, will tend to avoid negative attitudes by hiding their disability and choosing not to seek appropriate support services (Schumacher et al., 2003).

**Families with disabilities and Stigma.** Rehabilitation practitioners must also empathize and understand the challenges and stresses family members face when caring for an individual with an invisible disability. For example, parents whose children are diagnosed with attention deficit hyperactivity disorder or autism spectrum disorder often experience shame and may feel judged by strangers when their children fail to exhibit age-appropriate behaviors in public places. Parents with children who have special needs should be taught not to feel guilty and ashamed. The ability to empathize with a parent's distress is crucial, but only the starting point when providing services for children with disabilities (Crastrnopol, 2009). The stigma of bad parenting is unfairly placed upon parents who have children with invisible disabilities, and this topic deserves future research (Francis, 2012).

Overall, persons with and individuals carrying for invisible disabilities are often misinterpreted and undervalued. Employees returning to work following a traumatic brain injury or a stroke may appear not to have a disability on the outside even when their cognitive functions are compromised. Research suggests individuals with invisible disabilities will have better employment levels than individuals with visible disabilities, although there is paucity of research comparing the two (Martz, 2003). Additionally, the author recommends individuals with invisible disabilities learn to present their strengths to employers. By shifting the employer's attention from their deficits to their strengths, these individuals begin to be known for characteristics other than their disability, and the focus on the disability begins to fade (Martz, 2003).

#### **Visible and Invisible Disabilities**

There is a stigma associated with having a disability, and the idea society is placed with a burden to provide accommodations for this population. Yet, one of the world's greatest theoretical physicists and cosmologists, (Stephen William Hawking), has

provided global contributions and continues to do so. Although he is an anomaly, he has been a person who has created much success and advancement for persons with disabilities, regardless of having a disability himself. Millions of PWDs contribute to our society despite the stigmas placed on them. Unfortunately, we see perceptions as the ones provided below that continuously pollute the minds of others.

"We should recognize that both public and private special services programs for people with disabilities are aimed at individuals whose participation is feared to disrupt the efficiency of our ordinary transactions. If wheelchair users ride paratransit rather than regular buses, for example, nondisabled bus riders and drivers are not inconvenienced by the need to lower and raise wheelchair lifts to board some passengers, nor need transit companies install such lifts in their buses and try to train their drivers to use them (Silvers et al., 1998, p. 21)."

"To take another example, with the advent of special schools and special education programs, children whose type of impairment would not previously have kept them out of school were diverted from mainstream education to fill segregated classrooms... To create segregated facilities is to develop a cadre of professional staff... Thus, there is a dimension of disability policy that evokes the larger societal debate about the extent to which a homogeneous, as opposed to a diverse, culture is an orderly and thereby efficient one. The more diverse are the tastes, values, backgrounds-and bodies and minds- of those who are active in the commercial and civic spheres, the more our having to be flexible and open-minded in response to their diversity threatens the orderliness secured by the normal or conventional practices of a homogenous population... The reader should keep in mind how disruptive disability can be of current practice, and how profound the changes in it would have to be to facilitate the fully embracing inclusion of people with disabilities (Silvers et al., 1998, p. 21)."

These two examples provide a clear indication of how individuals may feel about PWDs, and the idea that a problem is placed on society as a result of having a disability (whether visible or invisible). Even professions within the health sciences, human services, and other related disciplines, continue to incorporate a medical model of disability within their educational instruction. Specifically, the medical model defines disability as a functional limitation caused by a physical or mental impairment (Altman, 2001; Darling & Heckert, 2010; Nario-Redmond, Noel, & Fern, 2013; Williams, 2001). Although having a disability comes with challenges (i.e., societal stigma and environmental barriers), PWDs are often able to overcome and adapt to a disability if equality existed for this population. Therefore, rather than emphasizing PWDs as having limitations, societal barriers often create the limitations rather than the disability itself. Consider the following scenario, which explains the social model of disability whereby limitations and disadvantages are externally imposed by society.

Imagine a hotel 20 stories high, with no stairs or elevators. How would you get to the top floor? If you are like most, the idea sounds ludicrous. Houses, restaurants, and buildings all have either steps or stairs, but for individuals who use a

wheelchair, entering any of these dwellings becomes a challenge and considering 40% of PWDs are 65 years of age and older, the probability of either a grandparent or parent (and even yourself) using a wheelchair at some point in life is significantly high. So, what if your relative became diagnosed with diabetes and at some point had a foot or leg amputated and had to use a wheelchair? Would you feel like an undue burden is placed on society if businesses are required to have ramps in place? Would it be your relative who has a limitation if he/she chooses to continue working, but public transportation does not exist for individuals who use wheelchairs? Unfortunately, humankind can be inherently self-centered, and until a person is directly affected, they may not consider the discussion of equal access and opportunities for all.

Lastly, stigmas associated with PWDs (whether visible or invisible) can be the catalyst for negative attitudes, as described by Goffman (1963). He further described the “deviancy cycle” by which people who are devalued by society will exhibit behaviors in accordance with the deviant label and therefore, reinforce society’s negative perceptions (While & Clark, 2010). Livneh (1982) provided a comprehensive literature review discussing research found on the attitudes and beliefs people may have among those with a disability. A list and description of each cause specifically associated with visible disabilities can be found in Table 1.

Table 1. Explanations for negative and stigmatizing attitudes towards persons with visible disabilities

Term	Description
Threat to body image	Seeing a person with a physical disability creates feelings of discomfort as a result of what is expected to be “normal” and the perceived reality. A person’s own body image may therefore be threatened when in the presence of a person with a disability.
Fear of losing one’s physical integrity	When in the presence of individuals with a physical disability, a person can become highly anxious about acquiring a disability and feel extreme discomfort.
Separation anxiety	The loss of a body part or functionality (i.e., spinal cord injury – unable to walk) may exhibit levels of narcissistic concerns and infantile anxieties stemming from separation from parental figures.
Fear of contamination or inheritance	The fear of acquiring a disability when interacting with a person with a disability results in callous attitudes.
Level of severity	Negative attitudes will occur more often when the disability is more severe.
Degree of visibility	The more visible a disability is, the increased likelihood negative attitudes will transpire among persons without a disability.
Disability as a reminder of death	The loss of a body part or functionality is associated with death (i.e., the death of that body part) and creates levels of anxiety when a person without a disability comes into contact of a person with a disability.

*Source:* Livneh (1982)

### Hiring Practices among Employers

As mentioned above, employment is an essential factor in social inclusion and well-being that can be studied from different perspectives. Researchers have found employers tend to have unfavorable attitudes when requesting their preference toward hiring and retaining individuals with disabilities. Although many studies seeking a participant’s opinions and thoughts may provide meaningful data on perceptions and preferences, it has been documented that what employers say they may do, often does not match what they actually do in regards to hiring individuals with disabilities (Diksa & Rogers, 1996). Despite evidence showing the positive outcome of PWDs requesting workplace accommodations on job retention (McNulty, 2007), the request and use of workplace accommodations is low among this group (Hutton, 2005).

Although employers have indicated varying opinions on their inclination to hire PWDs, no clear explanation or justified reasons can be given as to why employers prefer one type of disability over the other (aside from a concern over whether PWDs can perform the essential functions of the job), but some plausible explanations can be given. For instance, the size and type of a company may be a factor in its willingness to hire persons with a specific type of disability. Compton and Vinton (1978), found companies with larger number of employees were more inclined to hire PWDs in comparison to smaller businesses. For example, a small company (i.e., apartment complexes) may hire someone to be responsible for general landscaping and clean-up, regular indoor custodial duties, and even electrical and mechanical maintenance. Generally, larger businesses will employ individuals for each of these job duties and multiple personnel are often required. Overall, disability can often have a considerable impact on a person’s everyday life, which can initially have an adverse effect on employment opportunities.

### Implications for Practitioners

There are several implications for practitioners. Individuals working with PWDs must develop a thorough understanding of the medical, psychosocial and vocational aspects of both visible and invisible disabilities. Pre-service human service professionals should explore internship opportunities to work with groups whose clients have visible and invisible disabilities. Continuing education programs such as workshops and conferences provide a way for practitioners to keep abreast of cutting-edge skills and up-to-date knowledge. Wide-reaching studies have aimed to raise awareness and understanding about the most effective strategies to fight discrimination and stigma among highly stigmatized groups including persons with mental health concerns and other invisible disabilities. Three general approaches have been discussed throughout the literature, including (a) education, (b) communication, and (c) protest (Corrigan & O’Shaughnessy, 2007). Service providers, educators, and families can utilize the following approaches when overcoming stigma associated with invisible disabilities.

A. Educate the general public and health professionals by replacing misconceptions and false assumptions with accurate information and facts.

B. Implement strategies that focus on building relationships and shifting attitudes pertaining to individuals with invisible disabilities. Face-to-face contact has been recommended as one of the most effective ways to reduce stigma (Corrigan & O'Shaughnessy, 2007).

C. Advocate at various levels to convey accurate and anti-stigma messages. In addition, coordinating educational groups, empowerment groups and advocacy activities may be effective in diminishing negative attitudes.

## REFERENCES

- Adams, M., Blumenfeld, W. J., Castaneda, C., Hackman, H. W., Peters, M. L., & Zuniga, X. (2010). *Readings for diversity and social justice* (2nd ed.). New York, NY: Routledge.
- Aunos, M., & Feldman, M. (2002). Attitudes towards sexuality, sterilization and parenting rights of persons with intellectual disabilities. *Journal of Applied Research in Intellectual Disabilities*, *15*(4), 285-296. doi:10.1046/j.1468-3148.2002.00135.x
- Biddle, J. E., & Hamermesh, D. S. (1998). Beauty, productivity, and discrimination: Lawyers' looks and lucre. *Journal of Labor Economics*, *16*(1), 172-201. doi: 10.1086/209886
- Blankertz, L. (2001). Cognitive components of self-esteem for individuals with severe mental illness. *American Journal of Orthopsychiatry*, *71*(4), 457-465. doi: 10.1037/0002-9432.71.4.457
- Bull, R., & David, I. (1986). The stigmatizing effect of facial disfigurement Nigerian and English nurses' and office workers' ratings of normal and scarred faces. *Journal of Cross-Cultural Psychology*, *17*(1), 99-108. doi: 10.1177/0022002186017001007
- Castle, D. J., Rossell, S., & Kyrios, M. (2006). Body dysmorphic disorder. *Psychiatric Clinics of North America*, *29*(2), 521-538. doi: 10.1016/j.psc.2006.02.001
- Compton, M., & Vinton, D. (1979). *Employment of handicapped people in leisure occupations*. Washington, D.C.: President's Committee on Employment of the Handicapped.
- Corrigan, P. W. (2002). Empowerment and serious mental illness: Treatment partnerships and community opportunities. *Psychiatric Quarterly*, *73*(3), 217-228. doi: 10.1023/A:1016040805432
- Corrigan, P. W., & Bink, A. B. (2016). The stigma of mental illness. *Encyclopedia of Mental Health*, *4*, 230-234. doi: 10.1016/B978-0-12-397045-9.00170-1
- Corrigan, P. W., Markowitz, F. E., & Watson, A. C. (2004). Structural levels of mental illness stigma and discrimination. *Schizophrenia Bulletin*, *30*(3), 481-491.
- Corrigan, P. W. & O'Shaughnessy, J. R. (2007). Changing mental illness stigma as it exists in the real world. *Australian Psychologist*, *42*(2), 90-97.
- Corrigan, P. W., River, L. P., Lundin, R. K., Penn, D. L., Uphoff-Wasowski, K., Campion, J., Mathisen, J., Gagnon, C., Bergman, M., Goldstein, H., & Kubiak, M. A. (2001). Three strategies for changing attributions about severe mental illness. *Schizophrenia Bulletin*, *27*(2) 187-195.
- Crastnopol, M. (2009). Coming to terms with invisible disability—beyond empathic resonance: Commentary on paper by Lauren Levine. *Psychoanalytic Dialogues*, *19*(4), 474-479. doi: 10.1080/10481880903088617
- Crocker, J., Major, B., & Steele, C. (1998). Social stigma. In D. Gilbert, S. Fiske, & G. Lindzey (Eds.), *The handbook of social psychology* (pp. 504-553). Boston, MA: McGraw Hill.
- Davis, A. N. (2005). Invisible disability. *Ethics*, *116*(1), 153-213.
- Danek, M. M. (1992). The status of women with disabilities revisited. *Journal of Applied Rehabilitation Counseling*, *23*(4), 7-13.
- DeLoach, C. P. (1994). Attitudes toward disability: Impact on sexual development and forging of intimate relationships. *Journal of Applied Rehabilitation Counseling*, *25*(1), 18-25.
- Farrow, J. (1990). Sexuality counseling with clients who have spinal cord injuries. *Rehabilitation Counseling Bulletin*, *33*(3), 251-260.
- Francis, A. (2012). Stigma in an era of medicalisation and anxious parenting: How proximity and culpability shape middle-class parents' experiences of disgrace. *Sociology of Health & Illness*, *34*(6), 927-942. doi: 10.1111/j.1467-9566.2011.01445.x
- Garner, D. M., Garfinkel, P. E., Schwartz, D., & Thompson, M. (1980). Cultural expectations of thinness in women. *Psychological Reports*, *47*(2), 483-491. doi: 10.2466/pr0.1980.47.2.483
- Gouvier, W. D., Steiner, D. D., Jackson, W. T., Schlater, D., & Rain, J. S. (1991). Employment discrimination against handicapped job candidates: An analog study of the effects of neurological causation, visibility of handicap, and public contact. *Rehabilitation Psychology*, *36*(2), 121-129. doi: 10.1037/h0079077
- Hanna, W. J., & Rogovsky, B. (1991). Women with disabilities: Two handicaps plus. *Disability, Handicap & Society*, *6*(1), 49-63.
- Hutton, C. C. (2005). The role of work self-efficacy in sustaining employment among individuals with arthritis. *Dissertation Abstracts International: Section B: The Sciences and Engineering*, *67*(2), 1150.
- Internal Revenue Service (2016). *Tax benefits for businesses who have employees with disabilities*. Retrieved from <https://www.irs.gov/pub/irs-pdf/t8826.pdf>
- Invisible Disabilities Association. (2012). *What is an invisible disability?* Retrieved from <https://invisible disabilities.org/what-is-an-invisible-disability/>
- Johnstone, M. J. (2001). Stigma, social justice and the rights of the mentally ill: Challenging the status quo. *Australian and New Zealand Journal of Mental Health Nursing*, *10*(4), 200-209. doi: 10.1046/j.1440-0979.2001.00212.x
- Lenhardt, R. A. (2004). Understanding the mark: Race, stigma, and equality in context. *New York University Law Review*, *79*, 803-931.



- Livneh, H. (1982). On the origins of negative attitudes towards people with disabilities. *Rehabilitation Literature*, 43(11-12), 338-347.
- Marini, I. (2011). Societal attitudes and myths about disability: Improving the social consciousness. In I. Marini, N. M. Glover-Graf, & M. J. Millington (Eds.), *Psychosocial aspects of disability: Insider perspectives and strategies for counselors*. New York, NY: Springer Publishing Company.
- Martz, E. (2003). Invisibility or disability and work experience as predictors of employment among community college students with disabilities. *Journal of Vocational Rehabilitation*, 18(3), 153-161.
- McNulty, K. (2007). Coping with multiple sclerosis: Considerations and interventions. In M. Erin & L. Hanoch (Eds.), *Coping with chronic illness and disability: Theoretical, empirical, and clinical aspects*. New York, NY: Spring Science and Business Media.
- Mojtabai, R., Olfson, M., Sampson, N. A., Jin, R., Druss, B., Wang, P. S., Wells, K. B., Pincus, H. A., & Kessler, R. C. (2011). Barriers to mental health treatment: Results from the National Comorbidity Survey Replication. *Psychological Medicine*, 41(8), 1751-1761. doi: 10.1017/S0033291710002291
- Olkin, R. (1999). *What psychotherapists should know about disability*. New York, NY: Guilford Press.
- Ouellette-Kuntz, H., Burge, P., Henry, D. B., Bradley, E. A., & Leichner, P. (2003). Attitudes of senior psychiatry residents toward persons with intellectual disabilities. *The Canadian Journal of Psychiatry*, 48(8), 538-545. doi: 10.1177/070674370304800805
- Overton, S. L., & Medina, S. L. (2008). The stigma of mental illness. *Journal of Counseling & Development*, 86(2), 143-151. doi: 10.1002/j.1556-6678.2008.tb00491.x
- Pajares, F., & Urdan, T. C. (2006). *Self-efficacy beliefs of adolescents*. Greenwich, CT: Information Age Publishing.
- Phelan, J. C., Link, B. G., & Dovidio, J. F. (2008). Stigma and prejudice: one animal or two? *Social Science and Medicine*, 67(3), 358-367. doi: 10.1016/j.socscimed.2008.03.022
- Phillips, K. A. (1991). Body dysmorphic disorder: the distress of imagined ugliness. *American Journal of Psychiatry*, 148(9), 1138-1149. doi: 10.1176/ajp.148.9.1138
- Riddle, S., & Watson, N. (2003). *Disability, culture and identity*. Harlow, UK: Pearson Education Limited.
- Silvers, A., Wasserman, D. T., & Mahowald, M. B. (1998). *Disability, difference, discrimination: Perspectives on justice in bioethics and public policy* (Vol. 94). Lanham, MD: Rowman & Littlefield.
- Silverstein, B., Perdue, L., Peterson, B., & Kelly, E. (1986). The role of the mass media in promoting a thin standard of bodily attractiveness for women. *Sex Roles*, 14(9-10), 519-532. doi: 10.1007/BF00287452
- Siperstein, G. N., Romano, N., Mohler, A., & Parker, R. (2006). A national survey of consumer attitudes towards companies that hire people with disabilities. *Journal of Vocational Rehabilitation*, 24(1), 3-9.
- Slevin, E., & Sines, D. (1996). Attitudes of nurses in a general hospital towards people with learning disabilities: influences of contact, and graduate/non-graduate status, a comparative study. *Journal of Advanced Nursing*, 24(6), 1116-1126.
- Stoddard, S. (2014). *2014 Disability statistics annual report*. Durham, NH: University of New Hampshire.
- Stone, C. I., & Sawatzki, B. (1980). Hiring bias and the disabled interviewee: Effects of manipulating work history and disability information of the disabled job applicant. *Journal of Vocational Behavior*, 16(1), 96-104. doi: 10.1016/0001-8791(80)90041-X
- Sue, D. W., & Sue, D. (2008). *Counseling the culturally diverse: Theory and practice* (5th ed.). Hoboken, NJ: Wiley & Sons.
- Thompson, M. S., & Keith, V. M. (2001). The blacker the berry: Gender, skintone, self-esteem, and self-efficacy. *Gender & Society*, 15(3), 336-357. doi: 10.1177/089124301015003002
- Titchkosky, T. (2001). Disability: A rose by any other name? People first language in Canadian society. *Canadian Review of Sociology*, 38(2), 125-140. doi: 10.1111/j.1755-618X.2001.tb00967.x
- U.S. Census Bureau. (2012). *Americans with disabilities: 2010. Household economic studies*. Retrieved from census.gov.edgekey-staging.net
- Warhurst, C., van den Broek, D., Hall, R., & Nickson, D. (2009). Lookism: The new frontier of employment discrimination? *Journal of Industrial Relations*, 51(1), 131-136. doi: 10.1177/0022185608096808
- While, A. E., & Clark, L. L. (2010). Overcoming ignorance and stigma relating to intellectual disability in healthcare: A potential solution. *Journal of Nursing Management*, 18(2), 166-172. doi: 10.1111/j.1365-2834.2009.01039.x
- Wright, B. A. (1964). Spread in adjustment to disability. *Bulletin of the Menninger Clinic*, 28(4), 198-208.
- Wroblewska, A. M. (1997). Androgenic-anabolic steroids and body dysmorphia in young men. *Journal of Psychosomatic Research*, 42(3), 225-234. doi: 10.1016/S0022-3999(96)00302-9
- Yuker, H. E., & Hurley, M. K. (1987). Contact and attitudes toward persons with disabilities: The measurement of intergroup contact. *Rehabilitation Psychology*, 32, 145-154.

**Source of Funding:** None

**Conflict of interest:** None