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The Social Identity Approach to Disability: Bridging Disability Studies and Psychological Science

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Although mainstream psychology has received numerous critiques for its traditional approaches to disability-related research, proposals for alternative theory that can encompass the social, cultural, political, and historical features of disability are lacking. The social identity approach (SIA) offers a rich framework from which to ask research questions about the experience of disability in accordance with the critical insights found in disability studies (DS), the source for many of the most compelling critiques of disability psychology research. We review existing research considering the complementary social identity (Tajfel & Turner, 1979) and self-categorization (Turner, Hogg, Reicher, & Wetherell, 1987) theories to support our contention that the disability social category is a significant driving force in the psychological experience of disability and to demonstrate the theoretical utility of the SIA. We suggest that a bridge between the critical epistemological perspectives found in disability studies and the methodological rigor and theoretical breadth and parsimony of a social identity approach is essential for examining the social psychological experience of disability in the 21st century. To conclude we explore the emergent possibilities for research in psychological science that can follow from a social identity approach to disability.

Public Significance Statement
This article provides researchers and practitioners a generative, theory-driven approach for considering the social, cultural, and political complexities of contemporary disability psychology. This article achieves this objective by bridging the empirical rigor and theoretical breadth of the social identity approach and the critical perspectives available within disability studies scholarship to organize the extant body of research on disability identity and to recommend future research directions.

Keywords: social identity, self-categorization, disability, disability identity, stigma management

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For the past 70 years, intermittent critiques of the psychology of disability[1] have addressed how the field has conceptualized, studied, and interpreted disability-related psychological phenomena (Barker, 1948; Fine & Asch, 1988; Meyerson, 1988; Olkin & Pledger, 2003; Wright, 1983). Early critical commentary reintroduced the topic of disability as a legitimate area of study, particularly within social psychology, where a Lewinian person-environment interaction analysis could advance a more holistic understanding of people with disabilities' (PWDs) experiences (Barker, 1948; Meyerson, 1948). These pioneers recognized the ways that experiences went beyond a biological condition or an atypical physique, to include significant marginalized treatment and second-class standing in society (Meyerson, 1988). While these early voices charted much of the territory that needed to be explored, it was not sufficient to shift the rate and direction of research on disability as a social issue.

As times changed—specifically through the emergence of strong political participation by disabled people and significant policy changes that recognized PWDs' right to access valued

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[1] In this article *disability* is defined as the experience of limitation as a function of physical or psychological impairment, while the term *impairment* refers to the specific alteration in mental/physical function or structure (WHO ICF Model, World Health Organization, 2001). Though the APA style guide recommends "person-first language" when writing on the topic of disability, our usage echoes Dunn and Andrews' (2015) thesis that alternating between person-first language (people with disabilities [PWDs]) and identity-first language (disabled people) is more inclusive of those who positively identify as disabled and can potentially operate to de-stigmatize the term disability.

social domains (i.e., education, government buildings)—psychologists revisited the progress and trajectory of disability research in the field (Fine & Asch, 1988; Hahn, 1988; Meyerson, 1988; Scotch, 1988). These authors observed areas of progress, particularly in significant shifts away from reductive practices that positioned the entirety of a disability experience within an individual's body or mind (Shontz, 1977; Wright, 1983). Accounting for the recent political advancement of PWDs, several scholars have noted a convergence between disability and other minority group issues (e.g., Anspach, 1979; Hahn, 1985, 1988).

Though acknowledging the development of a disability community—a psychologically meaningful social identity—Meyerson (1988) remained skeptical of the cohesiveness of a disability *group* because of the significant geographical, temporal, and material disparities that exist between individuals with a disability classification. Other authors were more adamant about the reality of a disability community. For example, Fine and Asch (1988) called on Dworkin and Dworkin's (1976) classic definitional characteristics of a minority group—"identifiability, differential power, differential and pejorative treatment, and group awareness" (p. viii)—to define PWDs as a coherent group or community. Similarly, Hahn (1988) advanced the argument that the minority-group treatment of PWDs is fundamental to the advancement of the psychology of disability, particularly in how to develop cohesive theoretical approaches and to explore the political, structural, and cultural correlates of PWDs' experiences.

Beyond articulating disability as a coherent minority group (Anspach, 1979; Fine & Asch, 1988; Finkelstein, 1993; Hahn, 1985, 1988), critics have noted the misguided assumptions regarding the nature of disability and how these assumptions affect psychological research through the questions that are asked and the ways data are interpreted (Fine & Asch, 1988; Linton, 1998; Meyerson, 1988; Olkin & Pledger, 2003; Watermeyer, 2012). According to these critiques, the paradigmatic questions that pervade this area of research tacitly assume disability as a tragedy and a PWD as a victim of this unfortunate condition (Fine & Asch, 1988; Swain & French, 2000). Likewise, researchers traditionally assume disability to be the most significant aspect of a person's psychological experience, drowning out other more typical sources of psychological influence (e.g., personal relationships, social belonging, access to valued social domains). Critics also note that the fundamental aims of disability research—to advance rehabilitative outcomes—are incompatible with a minority-group approach (Meyerson, 1988). Ultimately, when personal adjustment—specifically the negation of impairment-related limitations and the maximization of functioning is the primary objective (Kendall & Buys, 1998; Shontz, 1977), there is little remaining conceptual space for asking questions about shared experiences of disability, including discrimination, cultural stereotypes, collective action, and identification with the disability community.

Now more than ever, it is essential that psychological research keep pace with both the rapid evolution of disability community, culture, and political activity and the acute social disparities PWDs experience. Recent estimates suggest that one in five Americans (56 million) has a disability (Centers for Disease Control and Prevention, 2015) and this population is 3.5 times less likely to be employed (US Department of Labor, Bureau of Labor Statistics, 2017) and three times more likely to be at or below the poverty line (Erickson, Lee, & Von Schrader, 2015) than their nondisabled counterparts. PWDs experience significant health disparities attributable to differential levels of health care quality, access, distribution of information, and social support (Drum, Krahn, Culley, & Hammond, 2005). Finally, PWDs continue to lag behind their nondisabled peers in graduating from college (16% vs. 34%; US Department of Labor, Bureau of Labor Statistics, 2017).

In the face of such disparities, it is important to note the disability community's ongoing political agency to sustain hard fought civil rights protections and foster more equitable outcomes. In June of 2017, for example, the disability-directed advocacy group ADAPT staged a "die-in" in the offices of Senate majority leader Mitch McConnell to protest proposed cuts to Medicaid funding which many PWDs rely on to meet essential health needs (Stein, 2017). Though the media coverage of these protests often pointed to the seemingly surprising and novel nature of these protests, they represent a long legacy of collective action conducted by PWDs for PWDs (see Fleischer, Zames, & Zames, 2011).

To better account for the social disparities and political agency of the disability community, and to advance a group-based approach to the psychology of disability championed by researchers nearly 30 years ago, we bridge two knowledge bases—disability studies and the social identity approach (SIA). When brought together, they bring into sharp relief both the social psychological reality of the disability collective identity and provide a set of theoretical propositions that afford researchers a roadmap to explore this dynamic, complex group. We will begin with an outline of the shared epistemological bases of disability studies and the SIA. We subsequently elaborate on how the social identity approach can account for a considerable breadth of disability-related phenomena elaborated within both psychological and disability studies scholarship. We will conclude by elaborating on the bidirectional contributions of this metatheoretical convergence. In other words, we propose that not only can the SIA contribute to a reinvigoration of research in the area of disability psychology, but increased attention to disability using the SIA, in accordance with disability studies insights, will challenge and strengthen the theoretical underpinnings of the SIA in significant ways. It is a function of these generative possibilities that we issue a call to action for psychologists to advance a research agenda guided by the social identity approach to disability.

Disability Studies

Disability studies (DS), a transdisciplinary approach to the study of disability, has intellectual roots in the disability rights movements of the United Kingdom and the U.S. during the 1960s and 70s, where disabled activists reconceptualized disability to match with their political experience (Finkelstein, 2001). The influx of PWDs entering academic spaces has been a significant catalyst for DS as an intellectual project, most notably following passage of Section 504 of the Rehabilitation Act of 1973 that prohibited discrimination in public education based on disability status (Fleischer, Zames, & Zames, 2011; Linton, 1998; Longmore & Umansky, 2001). What sets DS apart from other disability-related research endeavors is both in the initial assumptions it makes about disability and its intellectual priorities (Linton, 1998; Linton, Mello, & O'Neill, 1995).

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Research Agenda

Anti-individualist epistemology. DS scholarship pushes back against a variety of what it perceives to be problematic assumptions about disability that have been reproduced over history through political decision making, scientific knowledge production, and popular media (Davis, 1995; Hahn, 1985; Haller, 2010). DS identifies the *biomedical model of disability* as a conceptual framework that has historically dominated intellectual knowledge production about disability experiences, thereby generating understandings of disability that are overmedicalized (Bickenbach, Chatterji, Badley, & Ustün, 1999; Illich, 1976), objectifying (i.e., detaches the disability condition from the person; Fine & Asch, 1988), and individualistic (i.e., unit of analysis is the individual or inside the individual; Linton, 1998; Smart, 2009). One of the most pernicious consequences of the biomedical model is the overdetermined role of an individual's impairment on his or her experiences and life outcomes (Shontz, 1977; Wright, 1983). In other words, because of the reductionism that often follows from a focus on the biological/psychological features of one's impairment, there is too often a neglect of the extraindividual, sociopolitical factors that play a more significant role in disability experiences (Dirth & Branscombe, 2017; Hahn, 1988).

To counter the biomedical model of disability, DS scholarship relies on a *social model of disability*[2] that repositions disability issues as largely external to the person and irreducible to his or her idiosyncratic impairment (Shakespeare, 2006; Smart & Smart, 2006; Smart, 2009). DS scholars and activists point to factors such as negative social attitudes, institutional and public policies, social representations and ideologies that portray disability as an inferior way-of-being, and inaccessible environments as forces of disablement, imposed on top of one's impairment (Abberley, 1987; Fine & Asch, 1988; Hahn, 1985; Imrie, 1997; UPIAS, 1976). Following this logic, a uniting intellectual priority of DS across disciplines is the repudiation of perspectives that focus on the correction of individual deficits and limitations as the obvious and primary solution to disabled ways-of-being without recognition of extraindividual factors shared across PWDs (Linton, 1998; Linton et al., 1995; Oliver, 1996; Olkin & Pledger, 2003; Siebers, 2008).

Emphasis on disability as dynamic. Reconceptualizing disability according to the social model redirects researchers' attention across fields of inquiry to the structural and symbolic factors that shape both cultural understandings of disability and the personal disability experiences (Garland-Thomson, 2005; Haller, 2010; Linton, 1998). Important to this new framing is an emphasis on a sociohistorical analysis of disability to track its evolution as a significant social category (Davis, 1995; Gleeson, 1999; Stone, 1984; Stiker, 1999) and to chart the ways that it manifests itself differently in different cultural contexts (Ingstad & Whyte, 1995, 2007). The emphasis on political outcomes that guide the DS approach also provides a novel view of disability as a dynamically constructed, multilevel experience. In other words, the meaning of disability cannot be reduced to objective medical terminology but instead is fluctuating depending on personal (e.g., growing up with a disability; acquiring a disability during one's lifetime), political (e.g., passage and continued enforcement of Americans with Disabilities Act 1990), institutional (e.g., establishing a disability studies program at one's university), and even global (e.g., United Nations Convention on the Rights of Persons with Disabilities, 2006) activity. Collective actions taken by PWDs to codify changes in the way governments treat disability issues therefore feed back into the normalization of PWDs within a society.

Prioritizing marginalized perspectives. Another priority of the DS approach is emphasizing the knowledge base of PWDs as insiders and experts of disability experiences (Linton, 1998). This is in sharp contrast to traditional research and practice that tends to speak for or about PWDs and gives medical and rehabilitation professionals the final word on what is best for people with disabilities (Olkin & Pledger, 2003). Part of this marginalized or *disability*-focus includes the generation of personal narratives by PWDs that produce new concepts, concerns, and agendas for disability research and practice as dictated by PWDs. For instance, prioritizing disabled perspectives and encouraging scholarship from disabled-insiders has generated incisive critical analyses of cultural products that reproduce tragic and/or objectifying portrayals of disability (e.g., Garland-Thomson, 1997; Norden, 1994; Snyder & Mitchell, 2010), while also revealing overlooked histories of PWDs (Kudlick, 2003; Neilson, 2012) and the significance of disability to existing historical narratives (e.g., the Eugenics movement's influence on the Holocaust; Snyder & Mitchell, 2010). Finally, the disabled-focus of DS recognizes the importance of the presence/leadership of PWDs in domains that are *about* disability (e.g., rehabilitation, public policy; Fleischer, Zames, & Zames, 2011; Linton, 1998; Longmore, 2003; Shakespeare, 2006) to enable more equitable social outcomes. Relatedly, DS scholarship and activism converge in the formation of disability-directed, rights-based advocacy organizations that can help PWDs in matters of health care, legal, education, housing, and government assistance (Barnartt, Schriner, & Scotch, 2001; Dirth & Nario-Redmond, in press; McColl & Boyce, 2003).

Disability Studies Presence in Psychology

Over a decade ago, Olkin and Pledger (2003) formalized a call for the discipline of psychology to welcome DS perspectives. In their proposal, these authors reiterated critiques from years past (e.g., Fine & Asch, 1988; Meyerson, 1988) while introducing DS as a paradigmatic approach that can be used to guide future research and practice in the field, primarily by increasing adherence to a social (rather than biomedical) model and envisioning disability as a diversity (rather than a medical) issue.

Reframing disability as a diversity[3] topic seems to have the greatest influence on current psychology of disability research. This trend is evidenced by efforts to combat negative biases in research by normalizing disability as a valid and even valuable psychological experience (e.g., Dunn & Dougherty, 2005). As disability is increasingly construed as an identity rather than an objective biological characteristic, researchers are increasingly exploring identity development (see Forber-Pratt, Lyew, Mueller, & Samples, 2017 for a review), how context plays a role in

[2] There is not necessarily a singular social model that is agreed upon within DS, and debating the merits and limitations of different formulations of the social model and how it can be translated into various academic disciplines is one of the central intellectual projects of DS (Shakespeare, 2006; Shakespeare & Watson, 2002).

[3] See Anastasiou, Kauffman, and Michail (2016) for limitations of treating disability according to the multicultural connotations of diversity research and initiatives.

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identification (Read, Morton, & Ryan, 2015; Wang & Dovidio, 2011), and how self-concept and identity affects well-being outcomes for PWDs (Bogart, 2014, 2015; Dunn & Burcaw, 2013; Nario-Redmond, Noel, & Fern, 2012). Finally, research questions are emerging from the unique vantage points of PWDs' experiences, a hallmark of DS. For instance, Wang, Silverman, Gwinn, and Dovidio (2014) investigated the double-bind in which PWDs often find themselves where they cannot refuse help for fear of being perceived as ungrateful. Likewise, Silverman (2015) and Nario-Redmond, Gospodinov, and Cobb (2017) research on "disability simulations" critically considers an exercise that is often used to increase nondisabled people's awareness of different impairment experiences. Both sets of authors converged on a similar conclusion that, while disability simulations increased positive, prosocial emotions toward PWDs, they also lowered observers' expectations of PWDs' capabilities thereby reaffirming the widely shared belief that PWDs are incompetent and dependent. These findings echo commentary from PWDs who have noted that the awareness raised by such simulations is misguided and counterproductive to the everyday issues PWDs confront (Ladau, 2014).

It is evident that DS assumptions and priorities have filtered into psychology research about disability-related issues in positive and productive ways; however, we argue that insights from DS can go even further to reach their full generative potential, particularly if researchers take a renewed interest in disabled people as a meaningful social category who share experiences of systematic marginalization (Dworkin & Dworkin, 1976; Fine & Asch, 1988; Hahn, 1988). We contend that a reframing of disability as a socially and politically meaningful social category that is dynamic and dependent on the environmental, cultural, and ideological context offers tremendous compatibility with the broad, yet parsimonious set of theories comprising the social identity approach (SIA; Tajfel & Turner, 1979; Turner et al., 1987).

The Social Identity Approach

The complementary social identity (SIT; Tajfel & Turner, 1979) and self-categorization (SCT; Turner et al., 1987) theories that comprise the SIA set out to explain the complex interplay of individual psyche and social reality that produces emergent group-level phenomena (Asch, 1952; Hogg & Abrams, 1990; Turner & Oakes, 1986). The roots of the SIA can be traced back to the general urgency of the social psychological community to explain the events surrounding World War II and the Holocaust, and the broader causes and potential preventative measures of violent intergroup conflicts (Tajfel & Turner, 1979). The tide of social change enabled by the 1960s and 70s rights-based and protest movements was also formative for the underlying agenda of the SIA, both in its emphasis on the irreducibility of social behavior to the level of the individual person, and the hopeful assumptions it makes of minority groups as the fundamental authors of collective action and social change (Reicher, Spears, & Haslam, 2010). As summarized in Table 1, the SIA is compatible with the DS approach given their similar research agendas.

Research Agenda

Anti-individualist epistemology. Similar to the social model framing of disability, the SIA offers an epistemological shift away from individualism in its attempt to explain the nature of group behavior. Historically, psychologists have granted primacy to the individual, both as a unit of analysis and the source of *interesting phenomena* (Baumeister, 1987; Bellah, Madsen, Sullivan, Swidler, & Tipton, 1985; Tajfel, 1969/2010; Turner, 2006; Turner & Oakes, 1986). Following Western intellectual traditions, the personal "self" has been assumed to be the nucleus of many, if not all psychological processes, even those related to social life. This conceit, when applied to the group context, engendered theories that assumed discrete individual agents affiliating with social groups to satisfy various social needs (e.g., security, resources; Tajfel & Turner, 1979). One implication of such analyses was that participation in groups was purely utilitarian or in service of the more authentic individual "self." In the case of intergroup conflict, the individualistic framing constructed the group as frenzied, irrational, and an uncontrollable force, often operating in opposition to individuals' better natures (Oakes, Haslam, & Turner, 1994).

The paradigmatic shift of the SIA is to reconceptualize the "self" as thoroughly constructed by the social, such that the "self" exists at multiple levels of social abstraction, from the individual to the social, none more authentic than the other (Turner et al.,

Table 1
Bridging the Agendas of Disability Studies and the Social Identity Approach

Agenda	Disability studies	Social identity approach
Anti-individualist epistemology	Push back against the biomedical model of disability. Disability is irreducible to the biological/psychological condition.	Push back against a biological/psychological reductionism of social reality. Social reality is irreducible to the individual level of analysis.
Emphasis on dynamic phenomena of interest	Disability is not an objective pathology, but a complex subjectivity that emerges according to social, historical, and cultural factors.	Social identities are neither pre-existent in individual minds nor static entities in the social world; they are dynamic historical and cultural constructs that are creators of and responsive to collective action.
Prioritizing marginalized perspectives	Prioritizes the knowledge base of people with disabilities as insiders and experts. Works to re-value the disability experience by accentuating the cultural and identity production of people with disabilities.	Allows for marginalized groups' agency in social change and ways of resisting social inequalities. Allows for analytic engagement with minority-specific context and content. Allows for the recognition of the role that marginalized group members play in constructing identities for collective action.

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1987). SIT, for instance begins with the idea that social identities are vital to a person's subjectivity, defining crucial aspects of one's self-concept, and providing clarity, meaning, and purpose that enables one to navigate the social world (Tajfel & Turner, 1979). Accordingly, a driving force behind intergroup relations is the personal significance of social identity for one's psyche and the subsequent motivation to positively distinguish one's social identity from a relevant outgroup (Jetten, Spears, & Postmes, 2004; Tajfel & Turner, 1979). SCT adds to SIT's account by articulating the conditions for when people will categorize themselves as group members, and to what effect (Turner et al., 1987). For example, SCT offers the basic proposition that we always understand the self in relation to others, whether this occurs interpersonally as distinct individuals, or in an intergroup context as an interchangeable member of a group.

Emphasis on social life as dynamic. Concomitant with the fundamental significance of self-categorization and identification for shaping one's psychological reality are the effects of the sociostructural environment for shaping identities and cueing shifts in self-categorization according to context (Turner et al., 1987). While social identities are central and meaningful to one's self-concept, it is important to note their existence beyond the individual psyche, subject to historical and cultural forces (Reicher, 2004). SIA encourages a view of social life as continually in flux, and through collective activity, the content of social identities (e.g., norms, beliefs, status) are formed and transformed (Drury & Reicher, 1999). According to this view, we can reinterpret long-standing intergroup relations as the product of legitimized status inequalities and persisting social structures rather than something inherent or deterministic about human nature (Oakes et al., 1994). In sum, the SIA accounts for the dynamism inherent in social movement and social change, by appreciating not only the psychological influence of the sociostructural environment, including intergroup power relations, geopolitical conflicts and alliances, and the relative stability of the status quo, but also the power of collective action and political engagement to reshape the sociostructural environment (Reicher et al., 2010).

Prioritizing marginalized perspectives. Although popular understandings of the social identity tradition focus on its explanations for why dominant groups discriminate or perpetrate violence against subordinate groups, the roots of SIA are best acquainted with marginalized or stigmatized-group outcomes (Tajfel, 1978). As Reicher (2004) notes "the primary focus was not so much on discrimination as on resistance; it was concerned not with the inevitability of domination but the possibility of change" (p. 930). Even while it positions sociostructural factors like power differences and geopolitical conflicts as critical determinants of intergroup relations, the construction, communication, and transformation of social identities is ultimately what account for collective action and social change (or lack thereof; Reicher et al., 2010; Tajfel, 1978). From this view, the SIA has the potential to engage with myriad marginalized and oppressed groups to chart the ways in which resistance and collective action emerge through unique contextual, cultural, and historical factors. As a function of this engagement, a marginalized group like PWDs can work *with* the SIA to build efficacy, cohesion, and norms that fit within their particular historical and cultural context.

SIA's Presence in disability Psychology

While the SIA has over 40 years of research and thousands of articles to speak to its generative hypotheses, it is only within the last several years that researchers have started to address the psychology of disability with this approach. It is worth distinguishing between the well-elaborated SIA to mental and physical health outcomes (e.g., Haslam, Jetten, Cruwys, Dingle, & Haslam, 2018; Haslam, Jetten, Postmes, & Haslam, 2009) and the largely absent consideration of disability as a marginalized group more generally. While the former addresses the health and well-being outcomes of impairment groups (e.g., elderly with hearing loss; St. Claire, & He, 2009; stroke patients; Haslam et al., 2008; injured veterans; Kellezi, Reicher, & Cassidy, 2009; persons with dementia; Clare, Rowlands, & Quin, 2008), its more pressing mission has been to identify the role that "group membership" and "social identity" plays in sustaining health and well-being more generally (Haslam et al., 2009). This work can be incredibly significant and useful for the disability community as it relates to the compounding effects of existing physical/mental limitations (e.g., mobility issues, autism, depression) on well-being, to the extent that such limitations[4] serve as obstacles to sustained membership in groups. However, to the degree that the research narrative is aimed at the curative or rehabilitative properties of group membership, it tends to reproduce the negative bias toward disabled ways-of-being (Wang, 1998) and does little to combat the more urgent reality of group-based health disparities experienced by PWDs (Drum et al., 2005; Iezzoni, 2011; Kinne, Patrick, & Doyle, 2004; Rimmer, Chen, & Hsieh, 2011).

There are recent attempts to explore the contextual features and psychological consequences of self-categorization and social identification for PWDs (e.g., Bogart, 2015; Chalk, 2016; Fernández, Branscombe, Gómez, & Morales, 2012; Nario-Redmond et al., 2012; Nario-Redmond & Oleson, 2016; Read et al., 2015). Significantly, these applications of the SIA seek to understand disability not as a disparate set of conditions that are predictive of lower well-being outcomes (even if socially derived), but as a collectively conscious minority group which shares group-based processes with other minority groups (Hahn & Belt, 2004; Nario-Redmond & Oleson, 2016). In addition to measuring the effects of disability identification on well-being outcomes, this application of the SIA attempts to plot the psychological and contextual obstacles to collective identification such as culture (Fernández et al., 2012), onset of disability (Bogart, 2014), and politicization of disability (Nario-Redmond & Oleson, 2016). While these fledgling attempts at a SIA to disability are encouraging, they continue to be a blip in the overall body of research. To better guide a research agenda that adequately corresponds with DS and the SIA we outline the specific propositions of SIT and SCT in relation to a minority group conceptualization of disability, corroborating the propositions with extant empirical evidence from within and outside psychological science organized in Table 2.

[4] A recent example of such research includes Daley, Phipps, and Branscombe (2018) large study of Canadian adolescents with disabilities which found that, controlling for extent of the limitations in everyday functioning stemming from their specific impairment, exclusion from social groups and perceived discrimination predicted lower life satisfaction.

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The Social Identity Approach to Disability: Disability Social Identification

Disability social identity is the aspect of a PWDs' self-concept derived from their disability group membership[5] (Tajfel & Turner, 1979; Turner, 1985; Turner et al., 1987). SIT assumes that people strive to positively distinguish their social identities from relevant outgroups, and through this social comparative process derives a sense of the relative status of the groups to which they belong (Ellemers, 1993). Given the relatively low-status position of PWDs across economic (von Schrader & Lee, 2015), labor (McMahon & Shaw, 2005), education (Erickson, Lee, & von Schrader, 2015), and health (Krahn, Walker, & Correa-De-Araujo, 2011) domains, and the substantial empirical evidence showing unfavorable social perceptions, attitudes, and expectations of PWDs (Abrams, Jackson, & St. Claire, 1990; Dovidio, Pagotto, & Hebl, 2011; Nario-Redmond, 2010; Yuker, 1994), we would expect that PWDs are offered precious few possibilities for positive self-worth derived from their group membership. Because of the apparent devaluation of PWDs relative to nondisabled people, SIT proposes that PWDs can engage in either individual-level (*social mobility*) or group-level (*social creativity* or *social competition*) strategies to protect their personal or social identity respectively (see Branscombe & Ellemers, 1999; Branscombe, Ellemers, Spears, & Doosje, 1999; Branscombe, Fernández, Goméz, & Cronin, 2012). Which strategy they deploy will be based on their subjective perceptions of current sociostructural relations. As depicted in Figure 1, such sociostructural relations include the perceived permeability of group boundaries and the security of status relations between those with and without disabilities (Ellemers, 1993; Ellemers, van Knippenberg, de Vries, & Wilke, 1988; Ellemers, van Knippenberg, & Wilke, 1990; Tajfel & Turner, 1979; Turner et al., 1987).

Group Boundary Permeability

Believing that group boundaries are permeable opens the possibility that one can matriculate into the higher status group literally (i.e., being seen as an interchangeable member of the higher status group) or symbolically (i.e., receiving the benefits of being a high status group member without necessarily being a full member; Armenta et al., 2017; Ellemers et al., 1990). Low-status group membership, in combination with high perceived permeability of group boundaries, should lead to efforts to mobilize toward the higher status group (Ellemers et al., 1988, 1990; Tajfel & Turner, 1979).

Factors affecting permeability belief. Differences in impairment characteristics could provide an indication of how feasible it is for a person to move out of the group (i.e., Garstka, Schmitt, Branscombe, & Hummert, 2004). For instance, the prognosis of the impairment may give an indication of the relative permanence and/or stability of the condition such that we would expect a person who experiences a temporary injury like a broken leg to see group boundaries as highly permeable compared with someone who is more severely injured (e.g., spinal cord injury). However, the popularity of stories of patients "beating the odds" to walk again following acquired paralysis may also serve to increase permeability perceptions. Beyond popular narratives, formal prognoses can inform individual-centered interventions to remediate one's condition through a variety of medical, rehabilitative, and/or technological means (e.g., plastic surgery, Arndt, Lefebvre, Travis, & Munro, 1986; limb-lengthening surgery, Fernández et al., 2012).

Other impairment characteristics of note include the impairment's origin, visibility, severity, and disruptiveness. These characteristics have long been identified as fundamental to disability stigma (e.g., Jones et al., 1984; Katz, 1981; Kurzban & Leary, 2001), and more recently research has noted their significant relationship with PWDs self-identifying as disabled (Bogart, 2014; Bogart, Rottenstein, Lund, & Bouchard, 2017; Rottenstein, 2013). For example, we might expect that impairment-related characteristics, such as being nonvisible to observers, would predict a PWD's attempt at "passing" as a higher status/nondisabled group member (see Brune & Wilson, 2013). Likewise, severe and/or more disruptive impairments may foreclose the possibility of belonging to the higher status group. Finally, numerous studies have shown that people with congenital (from birth) impairments tend to show higher levels of identification with disability, versus those who acquire impairment later in life, intimating a greater rigidity of group boundaries for those with more time spent with an impairment (Bogart, 2014; Bogart et al., 2017; Hahn & Belt, 2004; Darling & Heckert, 2010).

Beyond personal impairment factors, other characteristics of a person and their day-to-day environment likely shape their view of the disability category and potential for engaging a social mobility strategy. For instance, being a member of multiply marginalized groups[6] (e.g., racial, ethnic, economic status) predicts disparities within the disability community such as reduced levels of access to advanced medical procedures and adaptive technologies, biased diagnoses and underrepresentation in special education services (e.g., Morgan et al., 2015), and increased representation in the criminal justice system (Mader & Butrymowicz, 2014; Zipper & Hing, 2014). According to Devlieger and Albrecht's (2000) analysis of disability experience in a predominantly African American neighborhood in Chicago, the impact of unemployment, racism, drug use, and poor health care tends to move PWDs away from the superordinate disability category, especially to the degree that it is prototypically populated by White, middle- and upper-class PWDs.

Intersecting disability identity with advantaged group membership like higher socioeconomic status may also influence the use of social mobility strategies. For instance, Bogart and colleagues (2017) explain their finding that socioeconomic status is negatively related to disability identification by pointing to the fact that disability may be more acutely experienced by those in a lower socioeconomic bracket. This explanation fits with a social mobility hypothesis given that those with more resources may be more capable of accessing valued social domains on personal terms.

We would also expect the pervasiveness of social and structural barriers like negative social attitudes, inaccessible buildings, and

[5] We are assuming a coherent "disability group" here, though we wish to be clear that this is not an objective, homogenous, static, and/or preconfigured entity, or even that the "disability group" is a category of which all PWDs are aware (see Finlay & Lyons, 2000). To further flesh out when the disability group is a salient and appropriate way for PWDs to categorize themselves, we will discuss the contextual factors that promote disability self-categorization (i.e., SCT) in the next section.

[6] While it is beyond the scope of this article, addressing the intersections of disability with other minority (and majority) cultural identities is crucial to fully appreciate how and when PWDs categorize themselves as disabled (Devlieger & Albrecht, 2000; Devlieger, Albrecht, & Hertz, 2007; Hanna & Rogovsky, 1991; McDonald, Keys, & Balcazar, 2007; Peterson, 2007). Intersectionality constitutes an important frontier for theorizing and conducting research in both disability studies and social identity approaches.

Table 2
Summary List of Empirical Articles Using Disability Sample and Following a Social Identity and/or Disability Studies Agenda

Article	*N*	Sample	Research question	Research method	Agenda: Social identity	Agenda: Disability studies
Bogart, 2014	226	Disability nonspecific	Is disability self-concept better developed for those with congenital vs. acquired disabilities and to what consequence?	C		✓
Bogart, 2015	106	Multiple sclerosis	Does positive disability identity decrease levels of psychological distress for persons with multiple sclerosis?	C	✓	
Bogart, Rottenstein, Lund, & Bouchard, 2017	710	Disability nonspecific	What factors predict a PWDs positive disability identification?	C	✓	✓
Bogart, Lund, & Rottenstein, 2018	710	Disability nonspecific	Can disability pride buffer the harmful effects of stigma on self-esteem?	C	✓	✓
Chalk, 2016	1,353	Adolescents; disability nonspecific	Does self-identifying as disabled protect emerging adults from harms to self-esteem?	C	✓	✓
Claire & He, 2009	50	Elderly, hearing impaired	Does self-categorizing as elderly increase perceived hearing impairment?	C	✓	
Cooper, Smith, & Russell, 2017	272	Autism spectrum	Does autism social identification predict higher self-esteem and reduced mental distress?	C	✓	
Daley, Phipps, & Branscombe, 2018	11,997	Adolescents; disability nonspecific	What is the differential impact on life satisfaction between community belongingness and impairment related limitations?	C	✓	
Darling & Heckert, 2010	388	Disability nonspecific	What is the relationship between age and orientation to disability pride?	C		✓
Devlieger, Albrecht, & Hertz, 2007	6	Spinal cord injury	How is disability experienced in a predominantly African American community context?	Q		✓
Dunn & Burcaw, 2013	n/a	Disability nonspecific	What are the dominant narrative themes associated with disability identity?	Q		✓
Fernández, Branscombe, Gómez, & Morales, 2012	108	Dwarfism	Is there an effect of cultural context on decision to pursue treatment and psychological well-being following treatment?	C	✓	
Finlay & Lyons, 2000	33	Learning disability	How do students with learning disabilities construct their self-concept by defining their category and making strategic out-group comparisons?	Q	✓	
Hahn & Belt, 2004	161	Disability nonspecific	What is the relationship between disability identity and disability activists attitudes toward a cure for their impairment?	C	✓	✓
Haslam et al., 2008	53	Patients recovering from a stroke	Does having multiple group memberships prior to experiencing a stroke, and maintaining those group memberships following a stroke, predict well-being?	C	✓	
Lundberg, Taniguchi, McCormick, & Tibbs, 2011	17	Disability nonspecific	What is the impact of adaptive sports and recreation participation for PWDs' negotiation of their stigmatized identity?	Q		✓
McVittie, Goodall, & McKinlay, 2008	8	Learning disability	How do PWDs discursively manage their disability category membership by making strategic comparisons, resisting stereotypes, and/or claiming valuable attributes?	Q		✓
Nario-Redmond, Noel, & Fern, 2012	361	Disability nonspecific	What are the differential well-being consequences for PWDs pursuing individualistic versus collectivistic coping strategies?	C	✓	✓
Nario-Redmond & Oleson, 2016	565	Disability nonspecific	What are the political benefits of positive disability identification?	C	✓	✓

(*table continues*)

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Table 2 (*continued*)

Article	*N*	Sample	Research question	Research method	Agenda: Social identity	Agenda: Disability studies
Read, Morton, & Ryan, 2015	28	Cerebral palsy	How do adults with cerebral palsy construct their personal versus social identity in the face of stigma when seeking accommodations?	Q	✓	
Rottenstein, 2013	2,764	Disability nonspecific	What factors predict a PWDs positive disability identification?	C		✓
Shattuck et al., 2014	120	Autism spectrum	What is the relationship between disability identity and self-efficacy among college students on the autism spectrum?	C		✓
Silverman & Cohen, 2014	599	Blind	Does stereotype threat affect the self-integrity and potential performance outcomes for PWDs?	C, E		✓
Silverman, Molton, Smith, Jensen, & Cohen, 2017	1,523	Disability nonspecific	Does having friends with shared Disability experiences improve well-being and decrease disability-related stressors?	C	✓	✓
Wang & Dovidio, 2011	116	Disability nonspecific	What is the impact of priming a student identity versus a disability identity on stigma consciousness and help-seeking behaviors?	E	✓	✓
Watson, 2002	28	Disability nonspecific	How do PWDs perceive self and identity relative to the disability category?	Q		✓
Zabriskie, Lundberg, & Groff, 2005	129	Disability nonspecific	What is the impact of a community therapeutic recreation program on quality of life and athletic identity for PWDs?	C		✓
Zhang & Haller, 2013	359	Disability nonspecific	What are PWD's attitudes toward media representation of disability, and do positive (vs. negative) representations affect disability identification?	C		✓

Note. Table inclusion criteria consists of articles cited in this project (not an exhaustive list) and empirical papers using a sample of people with disabilities. Method: E = experimental; C = correlational; Q = qualitative. Social identity refers to research using a sample of PWDs following the social identity theory or self-categorization theory. Disability studies refers to research with a sample of PWDs that prioritizes a DS approach (e.g., uses a social or sociopolitical model of disability; emphasizes cultural, historical, and/or political determinants of disability experiences; sees PWDs as insiders or experts on their experience; also see Table 1).

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repeated incidents of exclusionary treatment to lead a PWD to infer that mobilizing into the higher status/nondisabled group is not feasible (Jetten, Iyer, Branscombe, & Zhang, 2013). However, Daley et al. (2018) conclude that perceived belongingness to one's immediate community can be sufficient to buffer adolescents with disabilities from the harmful consequences of experiencing pervasive general disability stigma. Likewise, Haslam et al. (2008) note the importance of having *multiple* group memberships for well-being following the acquisition of an impairment later in life. Both findings may speak to the impact of available group memberships for encouraging a belief in the permeability of disability group boundaries (Ellemers, 1993; Jones & Jetten, 2011).

Finally, SIT's emphasis on the broader cultural norms and ideologies that orient people to certain strategies over others (Reicher, 2004; Tajfel & Turner, 1979) converges with DS scholarship that emphasizes the importance of historically dominant orientations toward disability, like the biomedical model, that shape how PWDs experience their disability (Gliedman & Roth, 1980; Hahn, 1993; Longmore, 1985). For instance, the biomedical model's tendency to circumscribe disability as an individual medical pathology that is a treatable—if not curable—condition (Bickenbach et al., 1999; Smart & Smart, 2006) subsequently positions PWDs as perpetual patients waiting to transition back to nondisabled status (Biklen, 1988). The individualistic approach of the biomedical model is evidenced in the popular cultural representations of PWDs *overcoming* their disability by completing (often mundane) socially valued activities with minimal accommodation (Anspach, 1979; Goffman, 1963; McVittie, Goodall, & McKinlay, 2008; Phillips, 1985; Schur, 1998; Shakespeare, 1996). Similarly, the dominant association of disability with medical, biotechnological, and rehabilitation fields, suggests to PWDs (and their families) that their first responsibility is to seek to fix one's impairment to fully rejoin the nondisabled community or at least attempt to be as *abled* as possible (Imrie, 1997; McRuer, 2006; Watson, 2002).

Forms of disability individual-level coping. A paradigmatic case of social mobility for PWDs would be curing one's diagnosed condition. For example, someone with a broken leg would likely perceive the group boundary as highly permeable, given that it is only a matter of time before his or her leg heals. In the same way, someone who acquires paralysis may be heavily invested in curing the paralysis through various surgical or therapeutic means, and view group boundaries as permeable to the degree they see this cure as attainable. In lieu of cure, there are various treatment protocols, rehabilitation therapies, and technologies that typify the stigma management strategy of social

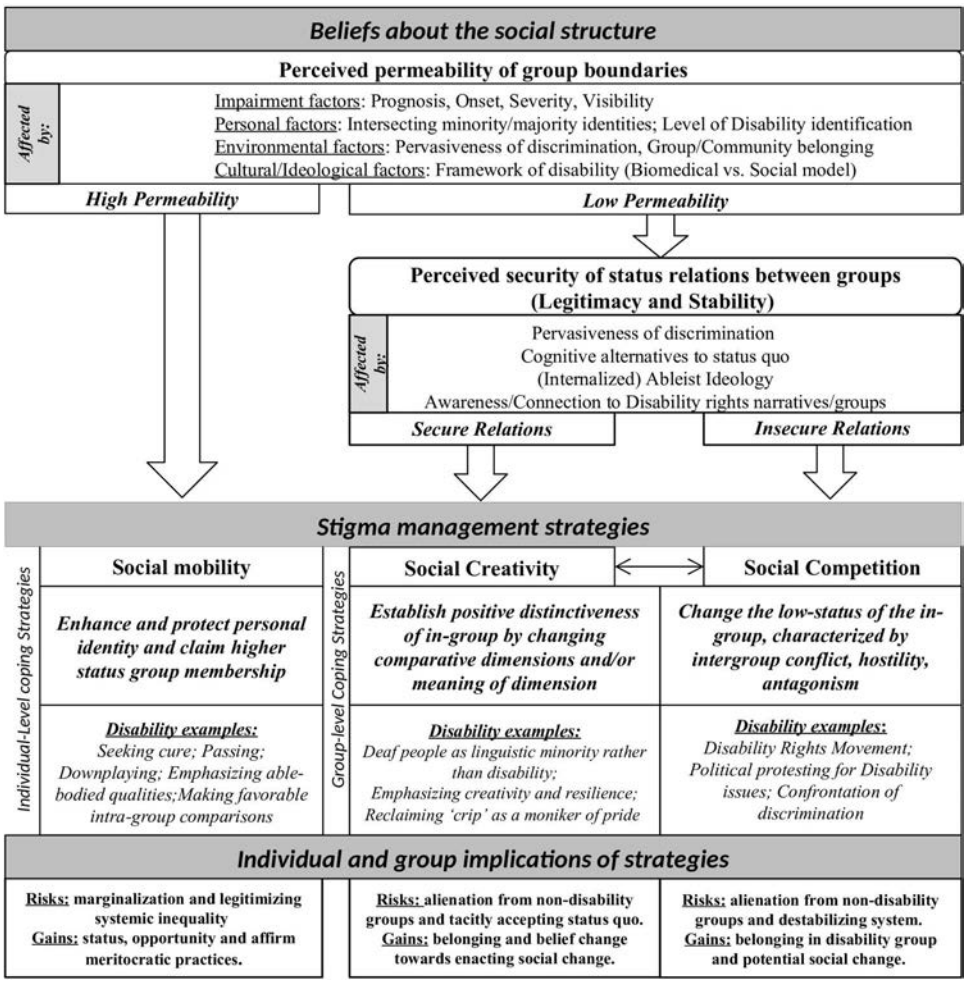


Figure 1. Beliefs about the social structure and disability stigma management strategies.

mobility to the degree that their intent is to diminish disability characteristics and increase ability characteristics toward reestablishing one's positive social value (Arndt et al., 1986; Fernández et al., 2012; Murray & Fox, 2002; Sparrow, 2005).

To be clear, pursuing treatment to mitigate the pain and discomfort of one's condition or to improve one's mobility/functioning does not, in and of itself, constitute a social mobility strategy. Indeed, the first author has had numerous surgical procedures and years of physical therapy to help mitigate pain and maximize quality of life, yet he understands that such procedures and treatment will not result in his departure from the disability category. Again, what we are stipulating is that social mobility striving is a *stigma* management strategy, not an *impairment* management strategy. Therefore, social mobility can be operationalized in the treatment context as a psychological orientation toward treatment, such that one is motivated to use medical or technological means to better approximate higher status (abled) norms, and to distance him/herself from other PWDs. Assuming disability identity is a dynamic process, however, we propose that the relative success of such treatment in increasing functioning and mitigating the severity of an impairment may negatively predict disability identification in the long-term (Bogart et al., 2017). On the other hand, the medical domain may provide a PWD with his or her earliest contact with other PWDs in a between-groups context (patients vs. doctors or nonpatients) and form the basis of a shared experience from which to build collective identity (i.e., Devlieger et al., 2007).

Often, a PWD is unable to completely avoid the devalued status associated with disability via a treatment intervention, yet she/he may continue to engage in other individual-level coping strategies to manage stigma and protect his or her *personal* identity (Branscombe & Ellemers, 1999). For instance, one may elect to use assistive devices (e.g., walker, cane, crutches) that facilitate upright walking to avoid being associated with the wheelchair[7]—the prototypical symbol of disability. Beyond one's engaging in social mobility via medical or technological means, numerous scholars have identified *normalization* as a widespread, individual-level coping strategy. Normalization is the tendency for PWDs to downplay the importance of the disability

[7] One could argue that using walking-assistance (e.g., cane, crutches) instead of a wheelchair may be pragmatically motivated by the reality that some environments are not wheelchair accessible whereas they are (more) accessible to someone using a cane or crutches. Again, we stipulate that one is using a social mobility strategy to the degree that his/her motivation is to avoid stigma and pursue physical/symbolic membership in the higher status (nondisabled) group rather than to mitigate personal obstacles and/or limitations in one's everyday life-space.

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in one's life, stressing instead their capacities that allow them to claim membership to the higher status/nondisabled group (Anspach, 1979; Darling, 2003; Schur, 1998; Shakespeare, 1996; Watson, 2002). Aligning the idea of normalization with a sense of group boundary permeability, Watson (2002) concludes that asserting *capability* and diminishing the importance of one's *difference* afforded PWDs in his interviews the possibility of decreasing the psychological distance between the disability and ability categories.

Traditional approaches to disability adjustment in rehabilitation fields are often supportive of primarily individual-level[8] strategies, to the degree that they prioritize the accommodation of impairment into one's personal self-concept and protect personal identity from the threat of disability stigma (Dunn, 2015; McCarthy, 2014). A theme corresponding to social mobility that is shared across many adjustment approaches is the effort to increase the centrality of one's capacities while downplaying the importance of one's impairment-related limitations (Bishop, 2005; Dunn & Brody, 2008; Wright, 1983). In this way, PWDs seek to reestablish and validate their membership in the higher status/nondisabled group (Gill, 1997).

Even if group-boundary permeability is perceived as low by PWDs, one can still engage in individual-level coping strategies by making strategic within-group comparisons and avoiding unfavorable between-groups comparisons (Branscombe & Ellemers, 1999). For instance, Finlay and Lyons (2000) found that students with learning disabilities made strategic downward social comparisons with other lower performing in-group members (those with learning disabilities) to protect personal self-esteem. Similarly, McVittie, Goodall, and McKinlay (2008) found that students with learning disabilities often talked about their peers in terms of their deficits and resisted making comparisons with peers unless certain those comparisons would result in favorable outcomes. These findings echo the dominant models of disability adjustment that emphasize protecting and enhancing *personal* identity while downplaying group-level identity processes (Bishop, 2005; Dembo, Leviton, & Wright, 1975; Dunn, 1996; Dunn & Brody, 2008; Kendall & Buys, 1998; Livneh, 1982; Wright, 1983).

Implications of individual-level strategies. Engaging in social mobility can have both positive and negative well-being consequences for PWDs. Successful social mobility is attainable for many with disabilities, particularly for those whose disabilities are less severe, less visible, and/or successfully accommodated through various interventions. Successful social mobility allows one to gain access to the status, resources, and opportunities of the higher status/nondisabled group thereby circumventing the unequal treatment of and negative stereotyping of people with disabilities in society more broadly. Likewise, given that the self-concept is not informed in full by one's social identities (Tajfel & Turner, 1979), we would expect that attaining positive quality of life for PWDs will be predicated on successful individual-level strategies like integrating one's impairment/body into his or her personal self-concept. Finally, successful social mobility can set a positive social example whereby organizations and institutions will start to view impairment as inconsequential to one's merit for inclusion. The status and prestige gained by a socially mobile PWD may also inspire other PWDs to persist in social mobility strategies.

Attempting mobility out of the low-status group can also entail significant risks. Unsuccessful mobilization can lead one to accept the negative stereotypes assigned to the disability group and encourage internal attributions about the source of and responsibility for dealing with impairment-related difficulties (Weiner, Perry, & Magnusson, 1988). Gill (1997) further argues that certain social mobility strategies, such as attempting to focus on one's abilities, are ultimately dependent on disavowing what one *cannot* do. This practice places PWDs in a difficult position of always devaluing at least a part of themselves and could be unsustainable (Gilson, Tusler, & Gill, 1997). Indeed, Nario-Redmond, Noel, and Fern (2012) conducted a broad survey spanning multiple disability types and found that individualistic coping strategies were negatively associated with personal self-esteem. Finally, we expect that PWDs following this social mobility strategy, as they try to accentuate their capabilities and distance themselves from the disability category, would be less inclined to request reasonable academic and/or workplace accommodations even though it is well within their right to do so (i.e., Shattuck et al., 2014). This desire to pursue social mobility by foregoing accommodation can place PWDs in a situation where they overexert relative to a nondisabled peer and therefore perform at a chronic physical/mental disadvantage.

More generally, desire for social mobility risks perpetuating inequality and the low-status nature of the disability community (Tajfel & Turner, 1979; Wright & Taylor, 1998; Wright, Taylor, & Moghaddam, 1990). In other words, social mobility strategies may depend on PWDs ignoring the contradictions and tensions that emerge in everyday social interactions like the discrepancy between the American ideal of equality and dominant social practices that produce group-based disparities (Goffman, 1963). When PWDs pursue social mobility we suspect they will be *less* likely to recognize, name, and collectively correct instances of group-based discrimination (Dirth, 2018; Nario-Redmond & Oleson, 2016). Indeed, individual efforts to escape the disability group serve to reaffirm the disabled group's lower status and unequal treatment (Ellemers, Wilke, & van Knippenberg, 1993; Wright & Taylor, 1998; Wright et al., 1990).

Security of the Intergroup Status Relations

When PWDs perceive group boundaries as impermeable, SIT predicts an increased likelihood they will engage in a group-level strategy to establish positive distinctiveness of their group and/or alter the status structure altogether (Branscombe & Ellemers, 1999; Tajfel & Turner, 1979). Which of these group-level strategies will be favored depends on whether the group member perceives an alternative to the current status relations (Ellemers, 1993; Jetten et al., 2013).

Factors affecting legitimacy and stability beliefs. One factor affecting the perceived legitimacy of a low status position and the unequal outcomes accorded to the group is the perceived pervasiveness of subsequent exclusionary treatment (Jetten et al., 2013). In other words, PWDs who construe exclusionary treatment as infrequent and only occurring in isolated contexts will be less

[8] It is important to note that the adjustment literature mainly addresses those who acquire impairment over their lifetime; therefore, more interactions with rehabilitation professionals may help to explain why those with congenital disabilities self-identify as disabled more than those with acquired disabilities (Bogart, 2014).

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likely to label it as illegitimate and contestable. Additionally, Jetten et al. (2013) suggest that pervasiveness of discrimination can interact with perceiving such treatment as legitimate such that highly pervasive yet legitimized exclusionary treatment will greatly diminish a person's willingness to engage in group-level strategies to contest such treatment (e.g., Hersby, Jetten, Ryan, & Schmitt, 2011).

Jetten et al. (2013) also conclude that the salience of cognitive alternatives to the status quo can help a group member to call into question the legitimacy of exclusionary treatment toward the group. For PWDs, an imagined future where they will be better off not as individuals but as part of a disability community enables a view of current inequalities as unjust and in need of change. Importantly, awareness of an alternative future can foster stronger disability social identification that can subsequently delegitimize the lower status position of PWDs (Zhang, Jetten, Iyer, & Cui, 2013).

Disability studies scholarship elucidates additional factors that are likely to affect beliefs about the status structure. Several researchers within DS have defined and elaborated the *ableist ideology* (Campbell, 2009; Goodley, 2014; McRuer, 2006) that pervades modern Western society. Ableism refers to the uncritical belief that ability and ablebodiedness are superior ways-of-being and that decision-making on the basis of ability status (i.e., exclusionary treatment) is justified because it is natural. Ableism is distinct from the biomedical model in that it is not simply an approach to understanding disability but rather a fundamental view of social reality and what it means to be human (Campbell, 2009; Watermeyer & Görgens, 2013). To the degree that PWDs are immersed in a culture that uncritically assumes ability differences to be a legitimate means of assigning merit and status, even if they see group boundaries as impermeable, structural relations between those with and without disabilities will be viewed as highly secure.

DS scholarship, in its elaboration of critical models of disability, provides a pathway of resistance to ableist ideology that can open possibilities for social change (Linton, 1998). For instance, awareness and subscription to the sociopolitical model and reframing disability as a historically oppressed minority group (Hahn, 1988) enables PWDs to find connection to disabled social activists who came before and who helped improve the status of the disability group. There are now numerous texts that recount the historical (and current) efforts of PWDs to gain access to their basic rights as U.S. citizens (e.g., Fleischer et al., 2011; Longmore & Umansky, 2001; Shapiro, 1993). These are crucial to cultivating the belief that not only is the unequal status quo illegitimate but that the status relations are unstable and changeable with a strong collective effort. As Little (2010) shows, this reorientation to disability is enabled by engagement with disability organizations that have a "rights-based" mission. Moreover, engagement with popular media representations of disability as a positive yet complex experience can potentially bolster PWDs willingness to identify as disabled (Zhang & Haller, 2013). In short, we expect that connecting with other PWDs who can transfer a critical view of disability would significantly alter beliefs about the structural relations between groups.

Forms of disability group-level coping. Group-level coping can consist of establishing the value of group identity (*social creativity*) or changing the status relations altogether (*social competition*; Branscombe & Ellemers, 1999; Tajfel & Turner, 1979).

Shifting comparison group. Changing the comparison group to one that is likely to offer a more favorable comparison can cultivate positive distinctiveness by serving as a downward social comparison on relevant negative dimensions (Tajfel & Turner, 1979). Because disability is complex and composed of myriad subgroups of condition categories, one can make favorable intragroup comparisons to other categories of disability besides one's own. For instance, the deaf community has historically labeled itself as a linguistic minority group, a rhetorical move that differentiates community members from lower-status, nondeaf disabled others (Lane, 2002). Similarly, injured veterans with various impairments such as traumatic brain injury (TBI), posttraumatic stress disorder (PTSD), or limb amputations, may identify as the collective "injured veterans" to distinguish themselves favorably and escape the negative cultural stereotypes attached to other nonveteran, disabled groups (Gerber, 2009).

Revaluing stigmatized dimension. Another social creativity strategy entails revaluing certain comparative dimensions traditionally viewed as negative relative to the (nondisabled) outgroup. Similar to the "Black is Beautiful" campaign started around the Civil Rights Movement, disabled scholars and activists have gone a long way in reinterpreting their physical and mental differences as creative and paradigm shifting rather than limiting or dysfunctional (Linton, 1998). Early disability activism and scholarship was highly critical of the correspondence between what is "normal" and what is "valuable," which in turn bolstered disability identity development in what has been termed a "coming out"[9] process for PWDs (Gill, 1997; Titchkosky, 2001). Coming out disabled ultimately represents a rejection of the culturally presumed inferiority of disability status and an indication by the PWD that the state of being disabled has inherent value (Titchkosky, 2001). Demonstrating the effectiveness of this strategy, Lindly, Nario-Redmond, and Noel (2014) found that revaluing the stigmatized attribute (body type) was the best predictor of well-being in their sample. We also get a glimpse of this creative process when the disabled in-group revalues derogatory labels historically used by the out-group, calling themselves "crip," "cripple," or "gimp" (Kafer, 2013; McRuer, 2006; Shapiro, 1993).

Shifting stigmatized dimension. The last social creativity strategy involves an emphasis on the valued qualities that are specific to the disability community, as a way of setting them apart from the nondisabled (Branscombe & Ellemers, 1999). In this case, the point of comparison can be shifted from physical and mental capabilities or aesthetic characteristics to other attributes that are *also* socially valuable. For example, PWDs may laud qualities like empathy, patience, work-ethic, and innovativeness, generalizing these qualities to the disability group more generally. Disability can also be reinterpreted as an opportunity for growth unavailable to nondisabled people (Swain & French, 2000). PWDs who take seriously the sociopolitical model of disability can even assert that their group's experience of other-imposed

[9] To be clear, the term "coming out" is not necessarily used in the same way as Goffman's (1963) analysis on "passing" as a refusal of disclosing a discreditable (nonvisible) stigma. In some cases, disabilities are nonvisible, but encompassing both visible and nonvisible disabilities leads us to consider the disability "coming out" narrative as an affirmative, socially creative response to a stigmatized identity. This treatment can also be found in Saguy and Ward's (2011) analysis of "coming out as fat."

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oppression has made the group, as a whole, more resilient (Little, 2010).

Social competition. Finally, social competition is a group-level strategy that entails efforts to engage the out-group to change unequal status relations that persist (Branscombe & Ellemers, 1999; Tajfel & Turner, 1979). Because social competition is likely to occur when the status relations between groups are imagined as unstable or changeable, it is notable that the U.S. disability rights movement emerged from the highly *unstable* period of the 1960s and 70s, particularly on the heels of the Civil Rights movement (Fleischer et al., 2011; Shapiro, 1993). Indeed, the paradigmatic case of disability social competition includes the collective protests that helped to eventually lead to successful passage of Section 504 of the Rehabilitation Act (1973) and the subsequent Americans with Disabilities Act (1990). The record of disability public action is well-documented (though often not widely recognized) and includes PWDs occupying legislators' offices, chaining themselves to the front of inaccessible busses, marching in disability pride parades, and engaging in highly visible public demonstrations (e.g., crawling up the Capital steps in Washington, DC; Fleischer et al., 2011). Other examples of disability social competition could include the confrontation of perceived discrimination in one's local environment through legal means (e.g., suing for accessibility provisions) and/or a PWD advocating for greater access and opportunity for others with disabilities different from one's own.

Consequences of group-level strategies. As with individual-level strategies, group-level strategies pose both risks and benefits (Branscombe & Ellemers, 1999). First, engagement in group-level strategies ultimately risks alienating oneself from valuable life domains and incurring the resentment and hostility of high status/nondisabled group members, even those who may be sympathetic to disability issues (e.g., Wang et al., 2014). Attempting to change the status relations between groups can lead to a backlash of hostility from those higher status groups who are invested in the status quo (Branscombe, Ellemers, et al., 1999). For example, society may shift the way it views the disability community from nonthreatening and sympathetic, to a group of lazy complainers and malingerers (Fiske, Cuddy, Glick, & Xu, 2002; Oakes et al., 1994).

Successful group-level strategies can be highly beneficial, both to the psychological well-being of PWDs but also to the status, resources, and collective efficacy of the entire disability community. As previously noted, the passage of the Americans with Disabilities Act (1990), in addition to significant pieces of legislation that came before (e.g., Rehabilitation Act of 1973) and after (e.g., ADA Amendments Act of 2008; United Nations Convention on the Rights of Persons with Disabilities, 2006) exemplify the benefits that accrue for the group as a whole, that stem from collective action specifically. Indeed, several pieces of research point to group-level strategies as being beneficial for psychological well-being among samples of PWDs (Bogart, 2014; Bogart, Lund, & Rottenstein, 2018; Fernández et al., 2012; Hahn & Belt, 2004; Nario-Redmond et al., 2012).

Summary

SIT offers a set of propositions regarding the management of stigmatized identity, beginning with the premise that the "self" is significantly constructed by social group memberships, and that people are sensitive to their group memberships' positive distinctiveness. When people are aware that a social group they are a part of is viewed negatively, SIT predicts they can engage in particular strategies—moving toward or away from the group—to manage the threat of being devalued. Whereas standard approaches to disability view PWDs as stigmatized by unique abnormalities and disfigurations that obscure possibilities for collective coping strategies proposed by SIT, DS scholarship theorizes that indeed disability is as much a sociopolitical minority group as much as an uniquely experienced impairment. Therefore, an examination of disability according to SIT propositions can advance a more systematic examination of both the sociostructural antecedents to identity management strategies for PWDs *and* the consequences that emerge from such strategies.

Social Identity Approach to Disability: Disability Self-Categorization

While SIT explains how status relations and belief systems influence how PWDs might manage a stigmatized identity and engage the outgroup, SCT offers a complementary account of the social and psychological variables that predict when PWDs may come to categorize themselves as disability group members in the first place, and how categorizing the self as an interchangeable member of the disability group will shape their psychological experience (Turner, 1985; Turner et al., 1987). Crucial to the present project, considering disability according to SCT propositions moves us beyond the reductionist impulse that drives the bulk of mainstream disability research by establishing the disability group as existing within the psyche of a PWD (Reicher et al., 2010).

SCT proposes that when PWDs self-categorize as disability group members, they *depersonalize* the self, abstracting their self-concept into cognitive alignment with the group (Hogg, 2001; Oakes et al., 1994; Turner, 1985; Turner, Oakes, Haslam, & McGarty, 1994). In other words, a PWD imagines certain aspects of his or her self to be shared in common with the rest of the disability group, and uses these *self-stereotypes* to inform their purpose, values, and goals as group members (Hogg & Turner, 1987). By categorizing as a disability group member, PWDs are subject to (and agents of) the group's social influence, wherein information about the nature of the group and what constitutes the prototypical group member is sought out, internalized, and continually reconstructed (Reicher et al., 2010; Turner, 1991).

SCT proposes that self-categorization functions as a cognitive means to meaningfully organize one's social reality (Turner et al., 1987), and that while social categories are plentiful, only certain categories will provide structure and meaning and be salient in each context (Hogg & Turner, 1987). Following SCT propositions, Figure 2 provides a conceptual map showing disability self-categorization at several different levels of abstraction as a function of the interaction between the *accessibility* and *fit* of the disability category in context (Oakes, 1987).

Accessibility of Category

If a category is highly accessible for a perceiver, more diverse cues and a fewer number of cues overall will render the category

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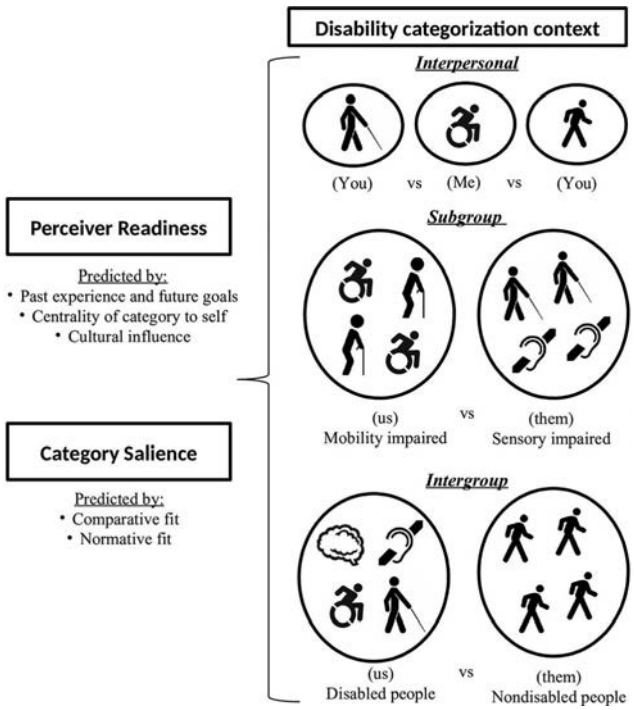


Figure 2. Factors influencing categorization context for Disability self-categorization.

a sensible organizational frame (Turner, 1985). Whether or not a category is readily accessible for a person depends on a variety of factors including what a person's prior experiences with and present goals are regarding a given context; what are one's existing group memberships and are they central to the self and differentially significant in a given context; and are certain categories culturally prominent and organizationally (ir)relevant to a given context (Hogg & Turner, 1987; Oakes, 1987).

Past experience and present goals. The reality of the disability group generally involves geographic isolation and intergenerational discontinuity (Darling, 2003; Little, 2010). Indeed, as opposed to some other minority groups (e.g., ethnic, religious), PWDs often exist as the only member of their families or immediate social network with a disability, thereby limiting disability as a sensible self-category to organize one's social field. In cases of geographic isolation or not enough time spent with a disability, PWDs may reject the other-imposed disability categorization because there are other significant groups to which they belong and draw positive esteem (i.e., family, religion, ethnicity; Barreto & Ellemers, 2003; Devlieger, Albrecht, & Hertz, 2007). Research indicating that earlier disability onset is a significant predictor of disability identification could be an indication of the chronic accessibility of the disability category that comes with a disability-inflected socialization (Bogart, 2014; Darling & Heckert, 2010; Rottenstein, 2013).

Even with the general logistical challenges to one's readiness to categorize as disabled, the rapid proliferation of disability organizations and virtual communities provide many PWDs with everyday experiences that increase their perception of social reality as an *us* (disabled people) versus *them* (nondisabled people) dynamic (Gill, 1997). As Little (2010) observed in her research on the independent living center culture, when a PWD enters the organization they are introduced to the social and/or sociopolitical model of disability and subsequently increase their interpretation of their everyday disability experiences through an intergroup lens. Indeed, institutionalization of people with mental and physical disabilities was an early catalyst of the signification of a disability category, clarifying the boundaries between the patients and the staff (Goffman, 1963; Longmore & Umansky, 2001; Shapiro, 1993). For example, Devlieger and colleagues (2007) observed that in a community environment where the disability category is often subordinate to one's racial category (i.e., African American), when one has significant contact with fellow PWDs in a long-term rehabilitation facility, the disability category emerges as a highly meaningful way to organize one's experiences.

Finally, immediate concerns and goals within a particular context are likely to influence PWDs' self-categorization. For instance, in a professional or performance setting PWDs may strive to categorize according to their particular role or organizational identity, because the disability category risks negative views from coworkers or peers or is simply irrelevant to the particular task (Ellemers, van den Heuvel, De Gilder, Maass, & Bovini, 2004; Young, Van Knippenberg, Ellemers, & De Vries, 1997). Even if one wants to be viewed as independent of his or her disability category, educational and work domains often require PWDs to self-categorize as disabled in order to legitimize their claim to necessary accommodations and/or legal protections (Anderson, 2008). As Read, Morton, and Ryan's (2015) research demonstrates, PWDs often weigh the benefits of securing accommodations with the threat that may come from the category's stigmatized status.

Centrality. The centrality or importance of a disability to the self-concept of a PWD will predict the perceiver's readiness to deploy the disability category, over other relevant categories, in any given context (Oakes, 1987). This suggests that PWDs are likely to vary on how significant their disability is (both positive and negative[10]) in their everyday lives. For instance, Watson's (2002) interviewees communicated that their diagnosed impairment was largely inconsequential to their sense of self. It is likely that significance or centrality of disability in one's self is affected by its severity and disruptiveness (i.e., Bogart et al., 2017; Rottenstein, 2013), because a highly disruptive impairment may foreclose possibilities to organize daily life according to alternative social categories (Goffman, 1963).

Another way PWDs begin to see their disability as central to their self-concept is through an affirmative orientation to their disability (Darling, 2003; Gill, 1997; Swain & French, 2000). As Darling (2003) argues, expressing one's disability *pride* entails the general refusal to assimilate into "normal" society and the establishment of disability identity as one's primary identity. Disability pride also means the general embrace of the disability community and solidarity with others who share disability group membership

[10] It is important to note that centrality of a category does not require that the category be viewed positively. People may see their disability as dominating their life with mostly negative consequences (akin to Wright's, 1983 succumbing framework). One should refer to the SIT predictions on how one might manage this threatening aspect of their self-concept following disability categorization.

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(Darling, 2003; Gill, 1997). Participating in disability activism furthers the centrality of the disability category, because it requires a critical consciousness of the ways in which the disability group is marginalized and who/what is the source of this marginalization (Anspach, 1979; Hahn, 1985; Simon & Klandermans, 2001).

Cultural influence. The relative accessibility of the disability category is likely to be influenced by culturally prominent disability narratives and representations. As DS scholarship has documented, popular cultural narratives that speak to the tragic and pathological nature of disability are pervasive in society (Campbell, 2009; Davis, 1995; Haller, 2010; Shakespeare, 1994). Specific to the categorization process, PWDs are acutely aware, and wary of, being categorized according to negative disability stereotypes (Abrams et al., 1990; Barreto & Ellemers, 2003; Branscombe, Ellemers, et al., 1999; Finlay & Lyons, 2000; Nario-Redmond, 2010). Strength of identification is likely to predict how PWDs will respond to their perceptions of negative stereotypes such that high-identified disability group members will be more sensitive to instances of personal and group-based discrimination (Dirth, 2018; Nario-Redmond & Oleson, 2016) and respond to such unwanted categorizations with affirmative responses to correct the misrepresentation (Barreto & Ellemers, 2003; Darling, 2003; Swain & French, 2000). Lower-identified PWDs, however, are likely to experience acute categorization threat and will subsequently make a concerted effort to distance themselves from the group (Branscombe, Ellemers, et al., 1999). Pervasiveness of negative disability representations and stereotypes and subsequent categorization threat may be a persistent struggle for PWDs, yet as Tajfel (1978) predicts, after prolonged exposure to this external categorization we would expect PWDs to internalize this disability category, for better or worse, as a significant organizing frame for his or her social reality. Therefore, creative narratives disseminated from within the disability community that transform the nature of the category from personal tragedy to valuable social identity are likely highly actionable for PWDs (Little, 2010; Longmore, 1985; Swain & French, 2000).

Greater accessibility of the disability category driven by dominant cultural narratives and representations of disability can also be the result of shifts in the comparative context. For example, because the biomedical model conceptualizes disability as a property of individual bodies rather than a social category, the most sensible way for a PWD to consider his or her situation is as an interpersonal difference rather than as a shared characteristic with others (Gill, 1997; Hahn, 1985; Olkin & Pledger, 2003; Smart & Smart, 2006). Contrasting the biomedical model's framing, the sociopolitical (minority group) model of disability can serve to catalyze more inter*group* categorizations within one's proximal context. For example, Schur (1998) finds that the more PWDs had politicized their disability identity, the more likely they were to perceive group-based disability discrimination in their everyday experiences.[11] In other words, construing disability as a minority-group identity, beyond an individual attribute, seemingly renders the disability category more readily available as a meaningful frame with which to understand and interpret one's immediate reality of exclusionary treatment.

Finally, accessibility of a category also depends on the form of existing intergroup relations (Oakes, 1987). For example, race-based and gender-based categorizations are particularly accessible in societies that have an ongoing legacy of organizing along these categories. Therefore, one may expect variability in accessibility of the disability category across different cultural contexts. In fact, some scholars argue that it is the modern bureaucracy that created the category "disabled" to help determine who was worthy of government compensation if unable to work (Ingstad & Whyte, 1995; Stone, 1984). Over the latter part of the 20th and into the 21st century, disability continues to be a category that is reified in modern bureaucratic institutions like education, health care, the legal system, and employment where category membership (and reception of social benefits) is predicated on a diagnosis from an expert using specified criteria in each respective domain. We argue that with the advent of the disability rights movement in the 1970s, culminating in the passage of several rights-based pieces of legislation (e.g., Americans with Disabilities Act, 1990), the intergroup relations shifted from one of public welfare directed toward PWDs, to one of PWDs contesting their persistent low-status position. In sum, while the category of disability may have emerged and formalized through modern bureaucratic formations, disability activism has been integral to shifting the meaning and significance of the disability category from other-imposed to self-determined.

Category Fit

Even if the disability category is relatively more salient than other self-categories, it must provide a sensible way of organizing the stimuli we come across in our everyday reality according to the contextual cues present in any given context (Hogg & Turner, 1987; Oakes, 1987). According to SCT, category fit can be determined along two different criteria: *comparative fit* and *normative fit*.

Comparative fit. Comparative fit means that categorization will more likely occur when one observes more similarity to others within a category than between categories (Oakes, 1987; Turner, 1985). In comparative contexts where there is elevated in-group similarity and between-groups differences, the relevant category will appear *entitative* and provide a meaningful way to organize one's reality (i.e., metacontrast ratio; Bruner, 1957; Campbell, 1958; Hogg, 2001; Turner et al., 1987). For example, at a college forum for students with disabilities, though disparate impairments may be represented, the comparative fit principle would suggest that disabled delegates would find more similarity with fellow disabled delegates as they move about campus, than with nondisabled students with which they may have contact.

Indeed, the fundamental question of comparative fit as it applies to PWDs is why, out of all the potential ways of categorizing one's self, disability would provide the greatest fit? A common skepticism is that characteristics of PWDs can be quite varied given the myriad diagnosed impairments contained within the broader dis-

[11] This finding emerged from an interview study, but it nonetheless bears some similarity to the rejection-identification model (Branscombe, Schmitt, & Harvey, 1999). Lindly et al. (2014) found similar results in a quantitative study of fat stigma. Fat identification was positively related to perceptions of fat discrimination. Schur (1998) and Lindly et al. (2014) both discuss the relationship in terms that identification predicting perceptions of discrimination whereas Branscombe, Schmitt, and Harvey (1999) model proposes that it is the perception of pervasive discrimination which elicits positive identification as a buffer to negative well-being effects. Lindly et al. (2014) did not hypothesize nor test whether identification mediated perceived discrimination's effects on well-being.

ability category (Barker, 1948; Meyerson, 1988; Tajfel, 1978). This multitude of idiosyncratic differences means that disability self-categorization is not straightforward. However, when one considers the prominent role of the comparative context in determining comparative fit, not only is it possible, but disability self-categorization will often make a good deal of sense.

According to SCT, comparisons (and therefore categorizations) are made relative to *the next more abstract level of categorization* to enable an "equivalent" inter- (or intra)group comparison (Turner et al., 1987). In other words, if PWDs are to self-categorize as disabled, the comparative out-group—nondisabled—must share a superordinate category (e.g., U.S. citizens, human beings). Demonstrating this process, a core component of the disability rights movement was the claim that PWDs deserved civil rights, because they were just as much U.S. citizens as nondisabled people (Fleischer et al., 2011; Gill, 1997; Morris, 1991). The emergence of a broad disability category depends on this direct comparison to nondisabled people that share this superordinate category of U.S. citizenry. disability self-categorization, therefore, diminishes in importance the idiosyncratic qualities which are *not* shared across disabled group members (e.g., Barker, 1948), and instead emphasizes the shared stigma and low-status that most if not all PWDs share (Abberley, 1987; Finkelstein, 1993).

Certainly, not every context will provide the necessary comparative fit to self-categorize as disabled, nor should we expect it to. As Figure 1 shows, having a disability may offer possibilities to categorize at several different levels of abstraction[12] depending on which level fits with the comparative context (Turner et al., 1987). In some cases, disability subgroup categorizations could be more suitable, specifically if the context is related to one's diagnosis (e.g., downs syndrome, multiple sclerosis, cerebral palsy) or general type of impairment (e.g., mobility, sensory, learning) particularly if the comparison is made to another group within the broader impairment category.[13] It is also the case that PWDs can self-categorize at the interpersonal level by drawing comparisons to other in-group members, especially in intragroup contexts. There is likely to be considerable variability in these interpersonal comparisons depending on the in-group under consideration (disability subgroup or nondisabled subgroup) and what dimensions are being considered (disability-related or not; Finlay & Lyons, 2000). In these cases, when category accessibility is held constant, we would expect self-categorization to be a function of "the contrast of differences between categories with differences within categories for individuals and behavior currently under consideration" (Oakes, 1987, p. 131).

Normative fit. Categories must not only be distinct from one another, but they must be distinct in the expected direction. Therefore, it is not just about recognizing the within group similarities and between group differences, but the similarities and differences must be "specific, normatively appropriate dimensions" (Oakes, 1987, p. 131). For PWDs, the disability category is likely to fit to the extent that it matches with stereotypes of dependence, incompetence, and/or asexuality—the primary cultural stereotypic characteristics associated with disability (Nario-Redmond, 2010). Therefore, in situations where PWDs are faced with structural obstacles (e.g., inaccessible facilities) or require assistance or accommodation (e.g., opening a door, special parking), we may expect the disability category to have increased salience (Dunn, 2015).

It is also the case that one's understanding of normative content is not fixed or prestored, but dependent on the demands of the situation and the target of comparison. As Oakes (1987) states "people act differently in different situations, varying the 'cues' for categorization available, and the current meaning of those cues" (pp. 131–132). Although there are dominant cultural stereotypes of PWDs as dependent, incompetent, and asexual, these stereotypic characteristics are not context independent but rather provide normative fit only in particular comparative contexts. As mentioned in the previous section, exclusionary treatment indicative of marginalization may also represent normative content for disability self-categorization (Abberley, 1987). Even counterstereotypical contexts might cue the disability category, particularly when one observes activities being done in an atypical manner or with prostheses or other devices normally associated with disability (Barnes & Mercer, 2001).

Summary

SCT complements SIT with a set of propositions about when a person will categorize him/herself as a group member, and how this categorization will affect their subsequent psychological processes. By reframing disability as irreducible to the level of the individual, as disability studies scholarship does, researchers can advance systematic research as to the context (accessibility and relative fit) of disability self-categorization. Moreover, investigating the psychological experience of disability according to SCT propositions advances an understanding the content of disability self-stereotypes, how PWDs establish and communicate norms and beliefs about being a disabled person, and how these norms and beliefs motivate subsequent behavior.

Discussion

We began with the premise that disability studies has much to offer psychological science including a more well-rounded approach to disability-related phenomena and an array of insider experiences that speak to the complexities of being a disabled person (Dunn & Andrews, 2015; Olkin, 2002; Olkin & Pledger, 2003; Watermeyer, 2012). Yet, for the many critiques and proposals for greater integration of disability studies into psychology, one of the greatest barriers to this has been a general failure to articulate a theoretical framework from which to examine disability studies insights empirically and systematically. Without a theoretical alternative that can account for the essential findings of disability studies, there can be no real expectation for a researcher invested in disability-related phenomena to stray far from standard approaches and extant models.

[12] Here we are referring specifically to different disability subgroupings. It is assumed that PWDs also have a variety of other non-disability self-categories available to them at any given point in time.

[13] There is the possibility that comparisons could be made directly from disability sub-group to the nondisabled group. For example, blind people may compare themselves with sighted people using the "human being" category as the shared group membership. For disability subgroups that have more established identities (e.g., deaf community) we would expect this to occur more often. This does not at all conflict with the predictions of SCT but rather points out the complexity of self-categorization and its dynamic and context-dependent nature.

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We argue the social identity approach serves as a theoretical bridge that can advance research in the psychology of disability arena, because it shares with disability studies a general resistance to individualism and reductionism; the assumption that phenomena of interest are dynamic rather than static and ahistorical; and the prioritization of those in low status or marginalized positions. We believe that rigorous analysis of the psychological antecedents, content, and consequences of disability social identity is untenable without the theoretical frameworks comprising the social identity approach. Yet, we also assert that a social identity approach to disability-related psychological phenomena is not possible without the theoretical and empirical scholarship produced within a disability studies' framing of disability as a thoroughly cultural, historical, and political experience (Hahn, 1988; Linton, 1998; Smart & Smart, 2006). While we have outlined how the SIA to disability provides a coherent framework with which to organize the body of literature on disability experiences, we close by highlighting the ways in which a SIA to disability markedly strengthens *both* disability research (including disability studies) *and* research using the social identity approach more generally (see Table 3 for a summary of future research directions).

Strengthening Disability Research

The SIA to disability strengthens psychology of disability research because it provides well-established theoretical propositions that can be channeled into better understanding how PWDs find meaning and direction in their experience. Through a SIA to disability, we envision a research agenda that normalizes disability as a sociopolitical construct and subsequently allows for PWDs to be affected by and co-constructors of disability identity.

Already, initial investigations into disability social identity affirm the SIT propositions that a stigmatized identity can emerge as a psychological *resource* for well-being (Bogart et al., 2018; Chalk, 2016; Fernández et al., 2012; Nario-Redmond et al., 2012) and psychological health (Bogart, 2014). Importantly, this work is also examining disability social identity as a catalyst for political engagement and collective action on behalf of the disability ingroup (Nario-Redmond & Oleson, 2016). While the recognition of PWDs political agency and collective action intentions is not an unexplored frontier for disability scholars (Anspach, 1979; Hahn, 1988; Putnam, 2005; Scotch, 1988), it is an underexplored domain for the psychology of disability literature. Especially as scholars within psychology continue to be self-reflexive about how best to work *with* PWDs to maximize full social participation (Dunn & Andrews, 2015; Gill, Kewman, & Brannon, 2003), the SIA to disability affords researchers and practitioners expanded phenomena of interest, particularly in identifying sociostructural features and the social contexts that influence how PWDs negotiate stigma and to what effect (Chalk, 2016; Nario-Redmond et al., 2012). Even more, this approach elucidates how status disparities that exist between people with and without disabilities are called into question (see Jetten et al., 2013) and how this contestation of social

Table 3
Future Research Directions for a Social Identity Approach to Disability

Theory	Disabled target's perspective	Nondisabled observer's perspective
Social identity (SIT)	How do PWDs perceive their sociostructural realities—pervasiveness of discrimination, permeability of group boundaries, status quo stability—and do these perceptions drive stigma management strategies according to SIT predictions?	When are abled group members aware of their advantaged group status and does this awareness follow similar patterns of psychological outcomes found in the privilege literature (e.g., collective guilt; identity threat)?
	When does use of medical, rehabilitative, and/or technological interventions constitute a social mobility strategy, and what effect does a social mobility orientation to treatment have on eventual psychological well-being?	How do abled group members manage their awareness that they will one day become a member of the disabled group, and is this different from other intergroup relations characterized by downward status mobility (e.g., SES, age)?
	How can we design interventions that leverage positive disability identification as a psychological resource for well-being, a buffer to social stigma, and a source of empowerment for self-advocacy and/or collective action?	How can abled group members support and advocate for more equitable outcomes for PWDs as allies without appropriating the psychological benefits of disability pride, disempowering PWDs' willingness to engage in collective activities, or avoid speaking and acting for the disadvantaged group member?
Self-categorization (SCT)	Do different models of disability (i.e., medical, social, sociopolitical) affect PWDs relative accessibility of the personal, subgroup, versus group-level category?	Are abled perceptions of PWDs malleable given shifts in perceived intergroup status relations, and can this explain the variability between various emergent disability stereotypes (e.g., inspirational vs. dangerous; super-crip vs. dependent)?
	How do the diverse subgroups within the disability community engage in "identity work" to shift and contest the content (meanings, goals, norms) of disability identity and the boundaries of who is a prototypical in-group member?	What are the social and psychological factors that promote or inhibit one's movement away from self-categorizing as abled to self-categorizing as disabled following the acquisition of impairment or as one ages?
	How do PWDs with multiply-marginalized group memberships and diverse disability experiences categorize themselves within the disability community and what role do SCT's proposed variables of accessibility and fit drive these categorizations?	What role do dominant cultural values of abled-ness (e.g., autonomy, self-regulation, freedom) play in the chronic accessibility of an abled category, and how do shifts in these values also shift the meaning of what it means to be a good abled group member?

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reality engenders collective action to change the status quo on behalf of the stigmatized group (Simon & Klandermans, 2001; van Zomeren, Postmes, & Spears, 2008).

Alongside investigations into the sociostructural factors that affect PWDs management of stigma and discrimination, more basic research is required for fleshing out the complexities of *contexts* for categorization and identification for PWDs (e.g., Bogart et al., 2017; Finlay & Lyons, 2000; Read et al., 2015; Wang & Dovidio, 2011). For instance, because there has been a dearth of systematic investigation following SCT propositions, we know very little about how the meanings, beliefs, and norms that constitute the disability community give structure and direction to those who see the disabled category as psychologically significant. For instance, how does being a part of a wheelchair basketball team differentially shape what it means to be a wheelchair user (Lundberg, Taniguchi, McCormick, & Tibbs, 2011; Zabriskie, Lundberg, & Groff, 2005)? Likewise, how would this group membership affect behavior off the court in terms of shared identification with the larger disability community, engaging in collective action on behalf of the group, and perceiving social relations in more intergroup ("we" vs. "them") rather than interpersonal ("me" vs. "you") terms.

There is a great opportunity through the SIA to disability to flesh out the differential impact of interacting accessibility and fit variables on disability self-categorization. For example, while the context of categorization may include characteristics of personal impairment such as severity, onset, and duration of condition (Bogart et al., 2017; Rottenstein, 2013), SCT propositions also direct research to examine the strength of identification as a proxy for chronic accessibility of category (e.g., Hahn & Belt, 2004), and the organizational or institutional context that can cue category fit (Fernández et al., 2012).

Lastly, the SIA to disability provides researchers with expanded domains—particularly areas of application—in which to explore psychological phenomena. For instance, the SIA has made significant advances in applied health psychology (Haslam et al., 2009). A growing body of research over the last 10 years corroborates the thesis that group processes and social identification carry the utmost significance yet remain underappreciated when it comes to accounting for numerous physical and psychological health outcomes (see Haslam, Jetten, Cruwys, Dingle, & Haslam, 2018 for review). The SIA to disability provides disability researchers and practitioners a renewed invitation to this burgeoning area of research, namely to build research and practice around the empirically validated conclusion that positive health outcomes are determined more by social integration and belongingness than by individual activity and limitations (Daley et al., 2018; Holt-Lunstad, Smith, Baker, Harris, & Stephenson, 2015; Holt-Lunstad, Smith, & Layton, 2010). Currently, there are numerous investigations that identify useful *intrapsychic* and personal lifestyle habits that can enable positive adjustment following acquired impairment (see Dunn, Uswatte, Elliott, Lastres, & Beard, 2013). The SIA to disability provides *extraindividual* prescriptions for improved quality of life and health outcomes for PWDs, particularly those related to improving social relationships and reducing social isolation (Haslam et al., 2018). For instance, by emphasizing the role of identity networks and multiple group memberships for buffering significant life transitions (Iyer, Jetten, & Tsivrikos, 2008), the SIA to disability can be theoretically and practically useful for understanding psychological adjustment to acquired impairment and establishing effective, evidence-based interventions.

As disability researchers follow a SIA to disability into applied health domains, they are encouraged to explore the ways the disability community and subcommunities play a pivotal role, independent of medical experts, of constructing meaning and significance of impairment, thereby informing interventions to advance adaptive health behaviors (i.e., physical activity, seeking out treatment, buffering discrimination). In this way, researchers are in a better position to explore the potentially positive health benefits of disability identity movements such as *Mad Pride* whose mission is to destigmatize mental disorder, normalize diverse mental states, and resist coercive psychiatric treatment (Corrigan et al., 2015; Schrader, Jones, & Shattell, 2013). Corroborating this idea a number of studies are beginning to validate with evidence the hypothesis that positive disability identification or disability *pride* can be a crucial protective buffer between perceptions of stigma and psychological distress (Bogart et al., 2018; Cooper, Smith, & Russell, 2017). Similarly, Silverman, Molton, Smith, Jensen, and Cohen (2017) find that in addition to disability identification, having friends who share disability-related experiences is crucial for buffering impairment-related stressors and predicting positive psychological well-being. Indeed, while the relationship between pervasive marginalization and deleterious physical and psychological health outcomes is well-established, especially for those with disabilities (see Schmitt, Branscombe, Postmes, & Garcia, 2014), it remains an open question as to the circumstances and the degree to which positive identity groups or movements can shield PWDs from these consequences.

Lastly, we suggest that the SIA to disability can enrich research and practice that focuses on optimizing encounters between PWDs and the nondisabled people that populate their everyday social spheres (Dunn, 2015). One of the biggest contributions of the SIA to disability to this domain may be its recognition that PWDs can be positively identified with the disability *group* and that this identification will have predictable psychological consequences. For one, PWDs may look to the disability community as a source of symbolic and informational social support which, in the context of health care consumer-based relationships, may influence a disabled client's receptivity to health messages that are emanating from the nondisabled outgroup (e.g., Oyserman, Fryberg, & Yoder, 2007) and subsequent willingness to pursue and stick with various therapeutic treatments. For example, when thinking as a disability group member, a disabled client may have significant reservations about certain clinical treatment options if they are framed as efforts to make him/her more abled.

Regarding close personal relationships, a SIA to disability emphasizes that family, friends, and romantic partners be mindful of the ways belongingness and social support are critical for health and well-being outcomes for PWDs, even outweighing impairment related limitations (Daley et al., 2018). Therefore, parents could provide opportunities for children to develop relationships with others who share experiences of disability alongside other therapeutic strategies (Silverman et al., 2017). For instance, adaptive recreation and sport programs could provide such an outlet for identity development and provide a buffer in the face of pervasive stigma (Lundberg et al., 2011; Zabriskie et al., 2005). Likewise, introducing a child, family members, or romantic partner to disability-directed advocacy organization(s) can enable a refram-

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ing of disability that externalizes stigma (Little, 2010), cultivates a network of social support, and empowers the PWD to build self and collective advocacy skills (Nario-Redmond & Oleson, 2016). In sum, the SIA to disability provides unique opportunities for researchers to flesh out the bidirectional effect of disability pride on close relationships between PWDs and nondisabled people, it provides a novel set of insights and direction for disability professionals to optimize clinical and therapeutic practice, and it offers useful considerations for nondisabled relatives and partners of PWDs to help support a high quality of life for their loved one.

Strengthening the Social Identity Approach

We contend that disability identity represents a novel construct for the social identity tradition, because of its distinctive contours and experiences (relative to other marginalized identities). First, disability constitutes a social identity that emphasizes rhetorical strategies and meaning making processes in its early and ongoing construction (Linton, 1998; Snyder & Mitchell, 2010; Swain & French, 2000). While we can assume that this is the case for other social categories that form the basis of significant social identities, the content of these identities and the meaning making processes that go into their construction are largely underexplored within the social identity tradition (Deaux, 2001; Hopkins & Reicher, 1997; Huddy, 2001, 2002; Reicher, 2004; Reicher & Drury, 1996; Reicher & Hopkins, 2001). The fact that disability represents a panoply of impairment subgroups and mostly lacks intergenerational continuity, much of the cohesiveness of the group depends on positively identified group members creating and spreading meaning through various organizations and social networks. For instance, the retelling of a group history that highlights political victories in the form of civil rights legislation serves as a strong narrative that links current PWDs to those laudable group members who came before. Likewise, the social model reconceptualization that foregrounds positive social identity exemplifies the malleability of group definition and points to a crucial site where PWDs continue to collectively contest the meaning of disability emanating from externally imposed category judgments (Dirth, 2018). Finally, through PWDs ongoing attempts to resist stigmatizing treatment and work for social change through collective action, an identified "outgroup" has distinguished itself via "ingroup" construction and transmission. Specifically, PWDs efforts to delegitimize "ableism"—the uncritical superiority of abledness (see Campbell, 2001)—provides a rich topic for investigation, not only because *ability* constitutes an undertheorized construct, but because, like Whiteness (e.g., Lipsitz, 2006) and masculinity (e.g., Vandello, Bosson, Cohen, Burnaford, & Weaver, 2008), abledness could be an advantaged identity that may come under threat with PWDs' social change efforts. We recommend that social identity scholars leverage the symbolic nature of the disability identity to advance a better understanding of how the meaning and significance of social category membership can be shaped through the telling of collective histories, rhetorical strategies that change the meaning of the category, and ongoing construction of an outgroup.

The second contour of disability identity that is particularly novel for social identity scholarship is the way in which one becomes a group member. Disability is a category that one can be born into or acquire over one's lifetime; it is a category that intersects with other stigmatized social categories; and it is a category that is fraught with ambiguities that arise from impairment-specific issues (e.g., is there a chance of recovery; is the condition visible; what are specific effects of the impairment). While it is important to keep in mind that impairment-specific issues are not determinants of overall well-being and life satisfaction (Daley et al., 2018; Shontz, 1977), it still remains to be determined the extent to which impairment groups, acquisition of impairment (see Bogart, 2014; Bogart et al., 2017), and multiple marginalized category membership (e.g., Devlieger et al., 2007) affect disability social identification. Because of these unique circumstances surrounding disability, scholarship in this area should help to answer questions about social identity formation and development processes that have been underexplored within the social identity literature (Huddy, 2001).

The final distinct contour of disability identity is its connectivity and interdependence with members of the outgroup, specifically in the form of personal assistance or caregiving relationships. Depending on a PWD's impairment, she/he may require such assistance to complete daily activities (e.g., communication, dressing, cooking, and transportation) even if he/she are engaged in more autonomous work or educational duties. Additionally, PWDs often have ongoing relationships with health care providers, clinicians, and therapists who are disproportionately nondisabled. Beyond assistance or professional services, parents, family, and friends often implicate themselves in advocacy concerns such that they engage politically on the PWD's behalf (and sometimes on behalf of PWDs in general; McColl & Boyce, 2003). This is significant for social identity scholarship because the disability group can serve as an exemplary model for how ongoing contact between ingroup and outgroup members can either advance or diminish social change intentions (e.g., Pettigrew & Tropp, 2006; Saguy & Chernyak-Hai, 2012). This issue of allyship (advantaged group members participating in marginalized group activism; Droogendyk, Wright, Lubensky, & Louis, 2016) is an important area of research that is critically considering the downsides of setting harmony-through-contact as the ultimate goal (i.e., the decline in marginalized group members' motivation to work for social change; see Dixon, Tropp, Durrheim, & Tredoux, 2010). We suggest that scholarship oriented toward marginalized-advantaged cooperation toward positive social change would do well to study political engagement within the disability community, especially in terms of how these intergroup relationships (advocates, allies, service providers, caregivers) are negotiated.

Conclusion

It is telling that one of the earliest proponents of a social psychology of disability, Roger Barker, made a distinction between the experience of disability and other marginalized groups when he stated that "the disabled person is usually in no sense a member of a real sociological or psychological group . . . he is almost inevitably an isolated individual who must meet the limitations which his underprivileged status imposes without the possibility of group support" (Barker, 1948, p. 32). There may well have been truth to this conclusion in the era in which Barker was writing; however, the emergence and evolution of the disability community over the past four decades exemplifies

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the very propositions that the SIA offers to explain the dynamism of social identity over time and the anticipated consequences that follow.

We contend that the SIA to disability is a worthy bridge to cross the metatheoretical chasm that separates generative psychological inquiry from the complexities of disability community. Indeed, the key contribution of the SIA to disability is its liberation of disability from its *specialized* area of research and practice, to one of *normal* human psychology, inflected by *both* personal experience *and* historical, political, and ecological factors. As psychologists have expressed the need to build cultural competency in psychological curriculum (e.g., Asch, 1988), training (e.g., Olkin, 2002; Smart & Smart, 2006), and scholarship (e.g., Dunn & Andrews, 2015) to be more responsive to PWDs, the SIA to disability begins with research assumptions that are, in fact, culturally competent, in so far as they acknowledge the social psychological complexities of disability. In this way, the SIA to disability expands the terrain of human experience for general psychological inquiry to produce knowledge that can substantiate culturally competent scholarship and practice.

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