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An intergroup and multilevel approach to disabled people's health and well-being

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Doctor of Philosophy (PhD) in Psychology

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December, 2022

CIÊNCIAS SOCIAIS
E HUMANAS

Department of Social and Organizational Psychology

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Abstract

This thesis analyses the impact of societal and group factors on the health and well-being of disabled people, considering two approaches to health: a social psychological approach to health (group level; based on the social identity approach and intergroup contact theory) and the approach of the social determinants of health (societal/macro level; based on social equality). For this purpose, I conducted four studies. At the group level, a cross-sectional study (European Social Survey - ESS; n = 18 660; 32 countries; 7 waves) showed that ‘ableism’ was more negatively associated with health and well-being than were other types of group-based discrimination, between and within subjects. Additionally, a 7-day diary study (n = 83; observations = 400), and a 3-year longitudinal study (n = 87; 3 waves), showed that positive intergroup contact attenuated the adverse effects of negative intergroup contact on well-being and ingroup affect, and, in turn, facilitated ingroup ties among disabled people. At the societal level, a cross-sectional study (ESS; n = 18,924; 31 countries; 7 waves) showed that social equality was only positively associated with the health and well-being of disabled people when legislation on personal assistance was present. The equality-health relationship was explained by greater public participation, satisfaction with democracy and the economy, and more positive opinions about health services. These findings are discussed through the integration of the two approaches used. This thesis contributes to empirical and theoretical debates in the distinct fields of social psychology, social psychology of disability, and disability studies.

Keywords: ableism; disability; intergroup contact; social identity; social equality; health and well-being.

PsycINFO Classification Categories and Codes:
3000 Social Psychology
3020 Group & Interpersonal Processes

Resumo

Esta tese analisa o impacto de fatores sociais-macro e grupais na saúde e bem-estar das pessoas com deficiência, considerando duas abordagens da saúde: uma abordagem psicológica social (nível grupal; baseada na abordagem da identidade social e na teoria do contacto intergrupal) e a abordagem dos determinantes sociais da saúde (nível macro; baseada na igualdade social). Ao nível grupal, um estudo transversal (Inquérito Social Europeu – ISE; n = 18 660; 32 países; 7 vagas) demostrou que o *ableism*/ capacitismo estava mais negativamente associado à saúde e bem-estar do que outros tipos de discriminação grupal, quer inter-sujeitos quer intra-sujeitos. Além disso, um estudo de diário durante 7 dias (n = 83; observações = 400) e um estudo longitudinal de 3 anos (n = 87; 3 vagas), mostraram que o contacto intergrupal positivo atenuou os efeitos adversos do contacto intergrupal negativo no bem-estar e no afeto grupal, e facilitou laços grupais, entre as pessoas com deficiência. Ao nível macro, um estudo transversal (ISE; n = 18 924; 31 countries; 7 vagas) demonstrou que a igualdade social estava positivamente associada à saúde e bem-estar das pessoas com deficiência, apenas quando existia legislação em assistência pessoal. A relação igualdade-saúde foi explicada por uma maior participação pública, satisfação com a democracia e economia, e opiniões mais positivas sobre os serviços de saúde. Estes resultados são discutidos integrando as duas abordagens utilizadas. Esta tese contribui para o debate empírico e teórico nos campos da psicologia social, da psicologia social da deficiência, e dos estudos da deficiência.

Palavras-chave: capacitismo; deficiência; contacto intergrupal; identidade social; igualdade social; saúde e bem-estar.

Categorias e códigos de classificação PsycINFO:
3000 Social Psychology
3020 Group & Interpersonal Processes

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Introduction

Disability is probably the least studied category in social psychological research on prejudice and discrimination. Is it because we are afraid of it, as some evolutionary theories try to explain disability stigma, or is it simply because we have been looking at disability from a pathological and individualized perspective?

For a long time, the dominant disability paradigm in psychology was what was known as ‘the functional limitations framework’ (Jones, 1996). In this paradigm, disability is seen as a functional limitation derived from malfunctioning in the bodies of individuals with impairments. This means that impairment is the central condition of disabled people’s experience and the explanation of the problems experienced by disabled people. Thus, research-based on this paradigm was focused on individual adaptation and rehabilitation (Meyerson, 1948, 1988), ignoring the impact of the social environment. Based on functions, research was divided by specific impairment conditions (e.g., physical, sensorial, learning, mental, e.g., Nario-Redmond, 2019) and was mainly focused on the adaption of people with acquired disabilities (e.g., Bogart, 2014), through their normalization and accommodation (Dirth & Branscombe, 2018). This perspective contributed to a reductive and stigmatized vision of disability (Jones, 1996).

In 1948, invited by Roger Barker, Lee Meyerson (1948, 1988) edited the first special issue (Volume 4, Issue 4) of the *Journal of Social Issues* (JSI) concerned with the social-psychological aspects of disability. Inspired by Lewin's (1935) person-environment theory, this special issue covered a body of work that recognized the importance of social factors in the experiences of disabled people. Person-environment theory (Lewin, 1935) pointed out the importance of the social environment, arguing that behaviour is a function of personal and environmental factors. Therefore, disability was conceptualized as the result of the interaction between the person and the environment, unveiling issues of discrimination and marginalization. These experiences, as they were shared among all members, allowed the framing of disabled people’s experiences in terms of their membership in a minority group, making this approach known as the ‘minority group paradigm’ (Hahn, 1988). In the rehabilitation field, Beatrice Wright (1972) had an important role in constructing an affirmative perspective of rehabilitation based on Lewin’s person-environment theory. This paradigm was crucial to shift from a reductionist perspective that positioned the experience of disability in the individual's body, to a practice that considered the impact of the environment. However, this was not enough to change the status of disability from an individual problem to a social issue, because disability was, still, conceptualized as an individual limitation (Fine & Asch, 1988). Moreover, despite considering the influence of the environment, it did not challenge it (Asch, 1984).

In the 80s, Michelle Fine and Adrienne Asch (1988) edited the second JSI special issue on disability (Volume 44, Issue 1), in which they reframed disability as a social construct and disabled people as a minority group, with common structural, cultural, and political experiences, such as other social groups. In this perspective, a limitation is just a characteristic, *"…it is the attitudes and institutions of the non-disabled (…) that turn characteristics into [disabilities]* (Fine & Asch, 1988, p. 7). This implies that the beliefs about disability result from the meanings created by non-disabled people, which allows them to challenge these assumptions and direct their attention toward social change (Fine & Asch, 1988; Jones, 1996). Therefore, this approach has become known as the social constructivism approach paradigm (i.e., disability is socially constructed; Jones, 1996). These critics also emphasized the misguided assumptions about the nature of disability underlying research questions and interventions made from the perspective of non-disabled people (Asch, 1984; Fine & Asch, 1988).

Despite these efforts to change the disability paradigm, for a long-time, research on disability continued to be based on the 'functional limitations' paradigm (i.e., based on rehabilitation), and disability, as a category, remained marginalized in psychology (Olkin & Pledger, 2003). Although disabled people are considered the largest minority group, with 15 million people worldwide (World Health Organization, 2011), they have received less attention as a social category exposed to discrimination. For instance, attitudes towards disability receive little attention compared to race and gender attitudes (B. A. Nosek et al., 2007). The same happens in the research on the effects of group-based discrimination on health and well-being, in which disability is missing or appears in an inferior number compared to other categories (Pascoe & Smart-Richman, 2009; Schmitt et al., 2014). In the early 2000s, Olkin and Pledger (2003) called for an integration of psychology and disability studies, based on a new paradigm of disability, congruent with the social constructivism paradigm (similar to the social model of disability, which will be discussed in Chapter I). That meant: a shift to a systemic and societal perspective, instead of a pathologized one; framing the major problems of disability as social, political, economic, and legal, instead of intrapersonal factors; being grounded in the belief that civil rights have been denied to disabled people; and seeking remedies in social policy, legislation, and systemic programmatic changes (Olkin & Pledger, 2003).

The shift in the disability paradigm was most noticed, however, in the last decade, in which researchers have increasingly explored disability *identity* (e.g., Bogart, 2014, 2015; Cooper et al., 2017; Crabtree et al., 2010; Nario-Redmond et al., 2013; Nario-Redmond & Oleson, 2016). Recently, Dirth and Branscombe (2018) called for a bridge between the social identity approach and disability studies, since both agendas comprise an anti-individualist epistemology, emphasize a dynamic phenomenon of interest, and prioritize marginalized perspectives. Finally, in 2019, Kathleen Bogart and Dana Dunn edited the third JSI special issue on disability (Volume 75, Issue 3), and the first specifically on ableism, to which I contributed an article (Branco et al., 2019; Chapter IV). Bogart and Dunn (2019) defined ableism, similarly to other types of oppression, as follows: "*Ableism is stereotyping, prejudice, discrimination, and social oppression toward people with disabilities*" (p. 651), reaffirming disability as an oppressed category. Additionally, in the same year, Michelle Nario-Redmond (2019) published the book *Ableism: The Causes and Consequences of Disability Prejudice*. This thesis intends to contribute to this paradigm shift in disability social psychology, approaching the health and well-being of disabled people from a social constructivist perspective.

1. This thesis – general problem and question, specific problems, and contributions

Given that disability has mostly been treated as an individual and medical factor, the implications of societal and social psychological factors for the well-being of disabled people remain under-researched. Therefore, this thesis intends to answer the general question: How is the health and well-being of disabled people affected by societal and social psychological factors? Considering the major problems of disability as social, political, and structural, this question is analysed through two lines of research: an approach based on group-level social-psychological determinants of health, grounded on the social identity approach, and another approach based on the social determinants of health (i.e., equality across groups in society) (see Figure 1).

At the group level, I consider the impact of discrimination/ableism, both negative and positive intergroup contact between non-disabled and disabled people, and disability identity on disabled people's health and well-being. First, ableism remains under-researched, despite having a larger effect size on well-being (Schmitt et al., 2014) and being more persistent (Charlesworth & Banaji, 2019) than are other types of prejudice. Second, although research on disability identity has increased in the last years, the potential of disability identity to protect disabled people's well-being from negative intergroup experiences (i.e., the Rejection-Identification Model; Branscombe et al., 1999) remains under-researched. In addition, the potential of positive experiences (positive intergroup contact) to attenuate the consequences of negative experiences on health and well-being remains unexplored, as does their influence on ingroup identification. Overall, there is also a lack of evidence on the consequences of intergroup contact for disadvantaged group members.

At the societal level, I explore the interaction between equality across groups in society and the social policy of ‘personal assistance’ (a policy which advocates a state support service to enable disabled people to live autonomously and manage their daily living activities) on disabled people's well-being, through specific socio-psychological mediators. Given that disability has been approached through a medical lens, the influence of (macro) social factors (e.g., equality) on the well-being of disabled people is under-researched (Reichard et al., 2014), as are its socio-psychological mechanisms. It thus remains unknown how macro-level variables affect disabled people’s well-being and what the mechanisms are that underpin such an effect. Moreover, the debate about the relationship between personal assistance and equality (Mladenov et al., 2015), lacks evidence.

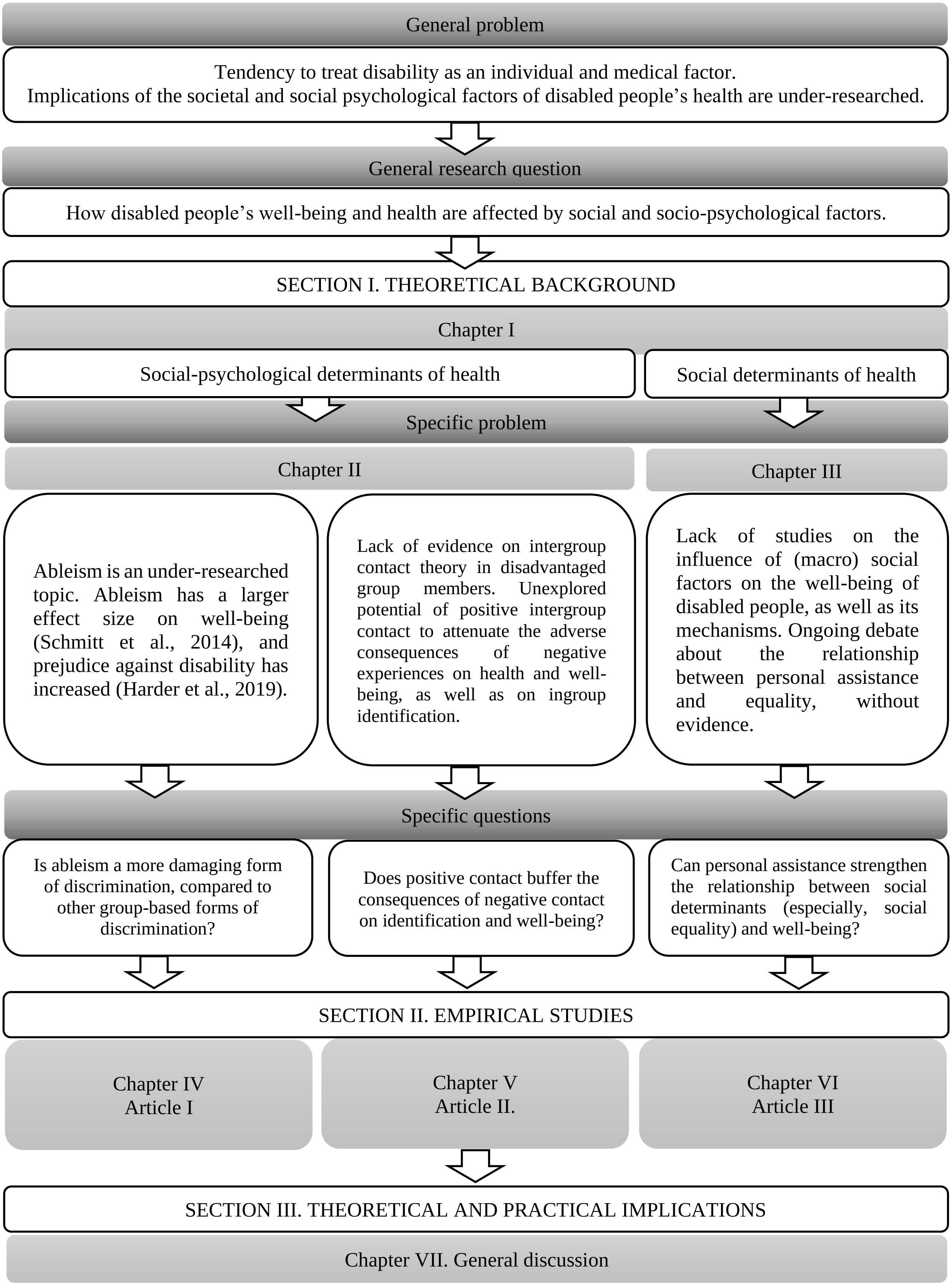
Therefore, the main theoretical novelty of this work is to go beyond individual and interpersonal approaches to disability, using a social psychological lens to examine the social and group factors that influence disabled people's well-being. Furthermore, this work extends the previous theoretical framework on social psychology, mainly, in three important ways:

- Unveiling a form of discrimination that can be the most pervasive or resistant, which can advance relevant issues on social categorization and stigma.
- Integrating research on the social identity approach to the health of disadvantaged group members (i.e., the Rejection-Identification Model) with research on intergroup contact theory. By doing that, this work expands knowledge on the influence of both negative and positive contact on disadvantaged group members; and explores the consequence of negative intergroup experiences at the personal level (i.e., frequency of negative intergroup contact), instead of at the group level (perceived group-based discrimination).
- Addressing the importance of social factors (equality, social policy) through a social psychological lens, to identify the psychological mechanisms involved.

In addition, this work provides knowledge to inform interventions designed to promote the well-being of disabled people, inform disability social policy, and promote the rights of disabled people. Overall, this work contributes to the social psychology of disability, combining and advancing both the study of disability issues and the scope of the social psychological theoretical framework.

2. Structure of this thesis

This dissertation has seven chapters. Section I, from Chapters I to III provide the theoretical framework that supports this thesis, exploring the concepts and theories relevant to this work, including research questions and aims. Chapter I starts with a definition of disability, considering the main models of disability. The chapter develops the conceptualization of health and well-being, as well as how group-based discrimination and health could be explained through a social identity approach. Chapter II follows with the explanation of how disability-based discrimination (i.e., ‘ableism’) can influence well-being, and how this relationship can be shaped by group identification and intergroup contact, integrating the rejection-identification model and intergroup contact theory. Chapter III presents what is the social policy of personal assistance and propose how it can interact with social equality to influence disabled people’s well-being. Section II includes three chapters presenting the empirical studies, and section III summarizes and discusses the main findings of this thesis in one chapter (see Figure 1).


General problem

Tendency to treat disability as an individual and medical factor.
Implications of the societal and social psychological factors of disabled people’s health are under-researched.

General research question

How disabled people’s well-being and health are affected by social and socio-psychological factors.

SECTION I. THEORETICAL BACKGROUND

Chapter I

Social-psychological determinants of health

Social determinants of health

Specific problem

Chapter II

Ableism is an under-researched topic. Ableism has a larger effect size on well-being (Schmitt et al., 2014), and prejudice against disability has increased (Harder et al., 2019).

Lack of evidence on intergroup contact theory in disadvantaged group members. Unexplored potential of positive intergroup contact to attenuate the adverse consequences of negative experiences on health and well-being, as well as on ingroup identification.

Chapter III

Lack of studies on the influence of (macro) social factors on the well-being of disabled people, as well as its mechanisms. Ongoing debate about the relationship between personal assistance and equality, without evidence.

Specific questions

Is ableism a more damaging form of discrimination, compared to other group-based forms of discrimination?

Does positive contact buffer the consequences of negative contact on identification and well-being?

Can personal assistance strengthen the relationship between social determinants (especially, social equality) and well-being?

SECTION II. EMPIRICAL STUDIES

Chapter IV
Article I

Chapter V
Article II.

Chapter VI
Article III

SECTION III. THEORETICAL AND PRACTICAL IMPLICATIONS

Chapter VII. General discussion

Figure 1. Schematic outline of this thesis: problem, research questions and studies.

SECTION I.

Theoretical Background

CHAPTER I.

Disability, and Health and Well-Being

1. Disability and disabled people: Definitions, models, and language

The definition of disability as well as the language used to designate disabled people depends on the perspective from which disability is seen. Three psychological frameworks for the study of disability were identified in the introduction: the functional limitations framework, the minority group paradigm, and the social constructivism approach (Jones, 1996). These frameworks are related to theoretical models of disability, which encompass distinct conceptualizations of disability.

1.1.Theoretical models of disability

Four theoretical models of disability are relevant to understanding how disability and disabled people have been defined over time: the moral (or religious), the medical, the social, and the biopsychosocial model of disability (e.g., D. S. Dunn, 2015; Nario-Redmond, 2019; Petasis, 2019). Figure 1.1 shows the similarities and differences between these models and psychological frameworks for studying disability.

Moral model

We can consider that the *moral or religious model of disability* was the primordial one until the Renaissance period. In this model, disability is seen as a divine *punishment* for the sins of the person or their family. During this time, disabled people were more likely to be murdered or abandoned and lived mainly by begging, and either as jesters or circus attractions (Braddock & Parish, 2001). Although this model is more retrograde and other models have emerged later, it continues to exist and may be the root of the stigma (related to blaming) associated with some diseases and impairments. In addition, this perspective also serves to justify the belief in a just world (Lerner, 1980), in the sense that it blames people (or families) for an event they had no control over, protecting the belief that the world is just and, therefore, "non-sinful" people could stay free from that "punishment".

Medical model

With medicine's progress, the *medical model of disability* emerged (congruent with the functional limitations framework), which we can consider the most influential model to date.

In this model, disability is seen as a *disease*, that is, a problem that requires treatment and cure (Brisenden, 1986). Therefore, in this perspective, the problem remains with the person, who is subjected to the passive role of the patient, dependent on care. By contrast, the decision power about disabled people's lives is held by health and social services professionals, as well as by formal and informal caregivers. Contextualizing disability as a pathological issue validated responses strictly related to rehabilitation and care, and naturalized social barriers as a matter of functional limitations. Additionally, these perspectives, the medical model and the functional limitation framework, resonate with the notion of the fundamental attribution error (Ross, 1977), by attributing to personal traits the behaviours or individual circumstances that could be attributed to environmental and situational explanations (e.g., Nario-Redmond, 2010). From this perspective, disabled people were considered unable to work and subjected to paternalistic welfare policies (Mladenov, 2017). Several institutions emerged, where disabled people were institutionalized and excluded from society, as did charities and social institutions, managed by non-disabled people, with vertical and patriarchal power structures.

Social Model

During the 1980s, a socio-political perspective on disability emerged in England from a proposal of the collectives of The Union of the Physically Impaired Against Segregation and The Disability Alliance (1976), which was formalized later as the *social model of disability* (Oliver, 1983, 2013). Congruent with the social constructivism approach in psychology, this model views disability as a *social construction,* distinguishing between impairment and disability. It defines impairment as a body limitation, part of the human condition. Disability itself arises from social, attitudinal, and environmental barriers, rather than from individuals' bodies (Oliver, 1996). Thus, in this model disability is constructed by social barriers, which enabled a change of focus for the problem from the individual to the social environment. In this way, it sets the responsibility for change on social institutions and not on the individual; in other words, the environment must adapt to people and not people to the environment. This is the most radical model as it departs completely from the biomedical perspective and challenges the social system. Moreover, this model, along with the independent living philosophy, empowered disabled people to fight for equal rights, personal assistance, inclusive education, anti-discrimination laws, and legal reforms to access buildings and public transportation (Nario-Redmond, 2019; Oliver & Barnes, 2010).

Biopsychosocial model of disability

The *biopsychosocial model of disability* (congruent with the minority group paradigm in psychology) emerged from an attempt to integrate the medical and social models, in the adoption of the International Classification of Functioning – ICF (2001) by the World Health Organization, which replaced the International Classification of Diseases, based on the medical model. In this perspective, disability is evaluated as an interaction between impairment (body functions), limitations (activities), and restrictions (participation), which are influenced by both environmental and personal factors. This model was first proposed by Aylward and Waddell (2005) in the context of pensions assessments in England, which was based on the biopsychosocial approach to health proposed by the psychiatrist George Engel in the 1970s (Shakespeare et al., 2017). Despite some differences in the conceptualization of these models, they all have in common the opposition to a biological reductionist approach and the principle of the interaction between person and environment. However, this integration, as the noun indicates, does not completely separate itself from the medical model (e.g., Kazou, 2017). Thus, although this model includes social factors as relevant in the assessment of disability, it still considers personal characteristics as part of the problem and does not challenge the environment by attributing to it the responsibility for change. Ultimately, in this view, disability is not seen as a social construction, but as an interaction between the person's characteristics and the environment.

As noted previously (Nario-Redmond, 2019), the problems faced by disabled people and the solutions available to them (e.g., laws, social policy) depend on the perspective used to understand disability. While the medical perspective promotes solutions based on treatment and accommodation of "special needs", the social perspective promotes solutions that are based on accessibility and inclusion. For example, when accessible adaptations are called "special needs", they are not identified as civic rights, but as extra arrangements because of functional limitations, and ultimately, as favours to disabled people - "*an entire tragic persons' industry exists for those with special needs*" (Nario-Redmond, 2019, p. 14). On the other hand, the conceptualization of disability as a person-environment interaction (i.e., biopsychosocial model) has been criticized as a way of redirecting attention to the individual and impairment, which has contributed to the withdrawal of social benefits based on impairment differences (Oliver, 2013).

Disability models	Disability frameworks - psychology	Definition of disability	Problematization
Moral model	-	Disability is a *punishment*	Focus on the impairment
Medical model	Functional limitations framework	Disability is a *disease*	Focus on the impairment
Biopsychosocial model	Minority group paradigm	Disability is an *interaction* between person and environment	Focus on the impairment in interaction with the environment
Social model	Social constructivism	Disability is a *social construction*	Focus on the environment/ social barriers

Figure 1.1. Disability models and frameworks.

1.2.Identity-first language

The use of person-first versus identity-first language (i.e., “people with disabilities” versus “disabled people”) has been subject to debate (e.g., D. S. Dunn & Andrews, 2015). Supporters of person-first language justify the use of "people with disabilities" as more appropriate because it highlights the person first and does not reduce their essence to "disability" (e.g., D. S. Dunn, 2015). However, if the disability is a social construction, it cannot be *essentialized*. “People with disabilities” is, in my view, a term more compliant with the medical or biopsychosocial model, in the sense that it puts the disability in the person (the person has the disability and not the environment). On the other hand, we might still think that the argument that disability is something essentialist if used in the first place (rather than something existentialist) may be itself essentialist. If the disability is seen as a social construction, then it is existentialist. If the disability is seen as individual and biological, then it is essentialist. On the other hand, the term “disabled people” is considered more adequate to the social/constructivist model since it means that people are disabled by social, attitudinal, and environmental barriers (e.g., European Network on Independent Living, n.d.). Identity-first language has been used and supported by disabled academics and activists as the most appropriate term because it reflects an oppressive historical-socio-political identity shared by disabled people (Linton, 2006). In other words, like other types of oppression, the personal experiences of disabled people are rooted, not in their impairment, but in their historical-socio-political situation of oppression.

Therefore, the difference between these terms lies in exactly how we define disability. Those who support person-first language are defining disability as an individual problem and therefore they choose to highlight the person. Those who support identity-first language are defining disability as a social construction and therefore they choose to highlight the social category/ identity. Others consider that person-first language and other euphemistic words like "differently-abled" are used to disguise the oppression faced by a group that is disabled by society (D. S. Dunn & Andrews, 2015; Marks, 1997). For these reasons, throughout this work, I use "disabled people" (note that, "disabled people" is different from "the disabled", which is an abstract adjective).

This is done, however, with one exception. I use person-first language in our data collection in Portugal and general communication with the Portuguese. This is because the identity-first term in English does not have an adequate translation into Portuguese (in Portuguese grammar, the person always comes first), and because of this, due to the specific characteristics of the Portuguese context, the most common term among the disability community is still the person-first language. Moreover, compared to other countries, and also due to the late development of the Portuguese Welfare State (Fontes, 2009), the disability social movement took a long time to develop in Portugal (Fontes, 2014), and this is perhaps the reason why there is no parallel term yet.

1.3.Who are disabled people?

The Convention on the Rights of Persons with Disabilities (2006) defines "people with disabilities" as "those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others" (Article 1, p. 4). The definition of disabled people should include all characteristics considered as limitations or impairments, whether attributed by the person or by others. For instance, Bogart and Dunn (2019) note that, from a social model perspective, anyone who self-identifies or is identified by others as a disabled person can be considered as such. The convention does, however, still uses a person-environment interaction to define "people with disabilities" (and person-first language) (e.g., Kazou, 2017). Considering a social constructivist model (and identity-first language), it would be more adequate to define disabled people in terms of environmental/social factors. In that way, disabled people can be considered as those who are oppressed by social, attitudinal, and environmental barriers on the basis of a physical, sensory, intellectual, developmental/learning, or mental disability (i.e., on the basis of ability).

Statistics on disabled people are scarce. According to the World Health Organization (2011), there were 15% (1 million) disabled people in the world in 2011, from which nearly 200 million experienced "considerable difficulties in functioning". The ageing population, as well as the global increase in chronic health conditions (e.g., diabetes, cardiovascular disease, cancer and mental health disorders), contributes to the increase in the number of disabled people. In Portugal, these statistics are even more scarce. The latest national statistics available on the number of disabled people in Portugal are from 2001. In that year, 636 059 persons[1] (6%) reported having a disability. In 2011, national statistics included questions about chronic illness and functionality, in a person-environment approach. About 16% of people between 15 and 64 years old had both long-term health problems and difficulties performing daily living activities[2]. Despite allowing a broader perspective on health problems and limitations in daily activities, this approach led to a less clear understanding of the situation of disabled people in Portugal. In general, this scarce and incomplete information reflects disabled people's social position and the discrimination to which they are subject.

2. Approaches to health and well-being

Health has been defined as a multidimensional construct. In the Constitution of the World Health Organization, health is defined as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (1948, p. 1). Therefore, health includes not only the physical aspect of health, but also mental health, and psychological well-being. Well-being is usually referred to as optimal psychological experience and functioning, resulting from positive subjective well-being (i.e., affect, feelings of happiness and satisfaction with life) and the fulfilment of the basic psychological needs for competence, autonomy, and relatedness, which are promoted by intrinsic goal pursuits, autonomous regulation, and mindful engagement (Ryan & Deci, 2000).

Just as health is made up of different dimensions, so are the factors that determine health. There are several approaches to health that differ in the way they take into account the biological, psychological and social determinants of health (see Haslam et al., 2018).

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[1] Available at Pordata: https://www.pordata.pt/Portugal/Popula%C3%A7%C3%A3o+residente+com+defici%C3%AAncia+segundo+os+Censos+total+e+por+tipo+de+defici%C3%AAncia+(2001)-1239

[2] Saúde e Incapacidade em Portugal: 2011. (2012). Instituto Nacional de Estatística, IP.

2.1.Traditional approaches to health

Biomedical and psychological approaches

The biomedical approach is the most influential perspective on health. This approach sees health as the absence of disease, that is, a dysfunction in "normal" biological and physiological functioning (Haslam et al., 2018). Therefore, it focuses on treating the source of the disease or malfunctioning. Despite this approach being helpful in the treatment of several diseases, it discards the influence of social and psychological factors on health. In addition, it pathologizes health conditions considered different from "normal" functioning. It is not surprising that, from a biomedical perspective, disability is seen as a disease.

Engel (1977) criticized the biomedical approach as reductionist, proposing the biopsychosocial approach in which biological, psychological, and social dimensions of health should play an equal role in explaining health outcomes. He recognized that health is affected by structural factors such as culture and socio-economic status, that impact the cognitive, emotional and behavioural dimensions of a person’s health. However, this model has failed in integrating these different dimensions and health practices remain dominated by the biomedical model (Deacon, 2013; Suls et al., 2010).

In the last decades, psychological approaches emerged in an attempt to explain the cognitive and behavioural dimensions of health (e.g., Theory of Planned Behaviour; Ajzen, 1991). These approaches were mainly focused on explaining health behaviours (e.g., smoking; exercise) and outcomes (e.g., depression) based on a person's thoughts (cognitive) and feelings (emotions), or even on personality traits. However, most of these approaches are focused on individual-level processes, and by doing that, they fail to understand and integrate the influence of the collective on individuals’ behaviours and outcomes (Haslam et al., 2018).

Social approaches: The social determinants of health

Social approaches try to understand how health is structured by an individual's social context. The most influential approach to this is the ‘social determinants of health’ approach which has focused on the relationship between social inequality and health. Originating in public health and epidemiology, it shows that the social conditions in which people live, such as unequal distribution of resources (i.e., social inequality), are responsible for health inequalities within and between countries (Marmot, 2005). This is because social injustices that produce poverty, unemployment, poor education, violence, and inadequate housing, reduce access to health services and health behaviours. Moreover, research has shown that social inequalities have important implications for the general health and well-being of the population, in the way that higher inequality has been associated with poor health outcomes, such as higher mortality, lower life expectancy, self-reported health and mental health (Kondo et al., 2009; Mansyur et al., 2008; Wilkinson & Pickett, 2006). Therefore, this approach is focused particularly on reducing inequality through greater equality in the distribution of resources, which would impact community resilience and individual health (Haslam et al., 2018). Although the social capital approach to health is considered a different social approach (e.g., Haslam et al., 2018), we can consider that these approaches are intertwined since the relationship between inequality and health has been explained by social capital (Kawachi & Kennedy, 1999; Wilkinson & Pickett, 2010).

While this approach is relevant due to a higher emphasis on the social dimensions of health, it is less clear in explaining the conditions and the socio-psychological processes (including at the group-level) by which inequality affects health.

2.2.Explaining discrimination and health through group-level processes

Individuals and interpersonal relations are influenced by the meanings derived from belonging to particular groups (Tajfel & Turner, 1979). When we talk about social inequalities, we are talking about discrimination of certain social groups that share a certain characteristic (e.g., discrimination on the basis of gender, race, age, disability). This group-based discrimination is maintained, legitimized, or challenged by processes at the intergroup level. For instance, culturally shared stereotypes serve as justification for the negative treatment of one social group over another (Jost & Banaji, 1994). Group-based discrimination can be considered a particular determinant of lower health and well-being (Pascoe & Smart-Richman, 2009; Schmitt et al., 2014). In the next chapter, we will explore the negative effects of discrimination on health. Here, I will explain how group processes, such as group membership, influence discrimination and health. While group identity can help to explain processes of group discrimination, it also has major implications for health and well-being, in the form of adherence to healthy behaviours, but also as a source of well-being for disadvantaged group members (Haslam et al., 2018; Jetten et al., 2017). Understanding how groups are formed and how groups influence behaviour are central questions in social psychology. Social identity theory (Tajfel & Turner, 1979), along with self-categorization theory (Turner et al., 1987), has been the most used theoretical framework to explain how group membership impacts intergroup behaviour, as well as individual outcomes (i.e., health) influenced by these group memberships or identities.

Brief historical contextualization

Early perspectives trying to explain individuals' behaviour in group settings failed to recognize the role of the group in explaining individuals' behaviours. For instance, the perspectives of earlier scholars such as Le Bon (crowd psychology; 1908, first published in French in 1896), McDougal (group mind; 1924), F. H. Allport (individual mind; 1920), Dollard and colleagues (frustration-aggression hypothesis; 1939), and Adorno and colleagues (authoritarian personality; 1950) were characterized as individualistic and reductionist ways to approach group behaviour, by focusing on the individual in the group, instead of the group in the individual (Hogg & Abrams, 1998). On the other hand, the work of social psychologists, since the 1930s, on conformity to norms (Asch, 1956) and intergroup conflict (Sherif, 1936, 1961), was important in introducing the group to explain intra and intergroup behaviour, given that individuals internalize collective products (e.g., norms, values, stereotypes) through social interaction (see more in Hogg & Abrams, 1998).

Sherif's (1936) experiments on conformity to social norms showed that perception is dependent on frames of reference in the form of social norms. In his experiment, participants had to estimate the illusory movement of a point of light (autokinetic effect) in a darkened room (ambiguous setting). Participants that made successive judgments in a group setting, gradually converging their responses until a norm was established.

Later, Asch's (1956) paradigm on social conformity reinforced the idea that individuals act in a shared structure of mutual reference (i.e., norms). In his experiment, participants had to make judgements about the length of stimulus lines. However, in the condition of the group setting a confederate was present to give erroneous judgements. While 25% of naïve participants resisted group pressure – contesting the idea that group influence is an irrational process, 33% conformed to the majority on half or more of the (33) trials. However, these experiments, in Sherif (1936) and Asch (1956), were considered to be mainly about informational influence, since the participants did not receive instructions on forming a group. Thus, normative influence would be incidentally created by the group setting, rather than specific group membership (Deutsch & Gerard, 1955).

Trying to understand intergroup conflict, Sherif conducted his series of 'Robbers cave' field studies, conducted at a boys' summer camp, starting in 1954 (Sherif et al., 1961). During the summer camp, at some point, participants (young boys aged around 11 years) were divided into two groups to live in separate cabins, and initial friendships formed were broken up by allocating friends to separate groups. This group formation led to the establishment of group norms and the emergence of leaders, codes, nicknames, and jargon, and after some time 90%

of the boys indicated a best friend from their new cabin (instead of the previous best friends now in the other cabin). When the two groups had to compete for a prize in a tournament, conflict and hostility emerged between the groups. Sherif introduced the idea that intergroup behaviour is a consequence of competition for the same resources. The Robbers' cave experiment was replicated twice, and Sherif and colleagues found that conflict was attenuated by cooperation for superordinate goals.

Minimal group experiments

In the 1970s, Tajfel and colleagues (1971) conducted so-called minimal group experiments to assess the effect of group categorization on intergroup behaviour, when neither self-interest nor previously hostility between groups could determine intergroup discrimination. The minimal group paradigm is a method in which participants are randomly and anonymously assigned to one of two groups based on trivial criteria, such that there is no history between the groups. In the first experiment, participants had to give points to other participants (not to themselves) that would be converted into real money at the end of the experiment. The results showed that participants gave more money to members of their group, maximizing the gains of their group, instead of maximizing everyone's winnings. In a second similar experiment, participants were also required to allocate points, which would be translated to money. However, this time they could use three possible strategies: maximum joint profit for both groups, maximum in-group profit regardless of the reward of the outgroup, and maximum difference between the amount allocated to ingroup and outgroup, in favour of the ingroup. Results showed that participants preferred a maximum difference between the groups, even if it meant lost points for their group, that is, at the expense of maximum in-group profit – which was known as ingroup favouritism. In the following experiments replicating the minimal group experiments, researchers found that ingroup favouritism through intergroup difference was not due to the similarity between participants (Billig & Tajfel, 1973), nor monetary self-interest (i.e., money was not a necessary condition; Turner et al., 1979).

Therefore, the authors (Tajfel et al., 1971), interested in the minimal conditions necessary for intergroup discrimination, concluded that mere categorization into groups produced ingroup favouritism, that is, people prefer to favour the ingroup by creating social distance between the groups, even at the expense of the maximum gains for everyone or their group.

2.2.1. Social identity theory

Social identity theory (Tajfel & Turner, 1979) was driven by the findings of the minimal group experiments, resulting in an integrative theory of the cognitive and motivational basis for intergroup differentiation (Haslam, 2004). According to Tajfel's definition, social identity is "that part of an individual's self-concept which derives from his knowledge of his membership of a social group (or groups) together with the emotional significance attached to that membership" (Tajfel, 1974). Given that people strive to achieve or maintain a positive social identity, group members are motivated to maintain a positive *distinctiveness* from relevant outgroups on value dimensions of social comparison, engaging in *ingroup favouritism* (Tajfel & Turner, 1979). In the minimal group experiments, when participants identified with one of the groups, they tried to achieve *positive distinctiveness* for their own group, *by* comparing the ingroup with the outgroup on the unique dimension available: rewards/points allocations. Given that the minimal group experiments were not based on incompatible group interests, the *social competition* based on ingroup favouritism was considered distinct from realistic competition based on conflict of interest (e.g., Tajfel & Turner, 1979; Turner, 1975).

According to Tajfel and Turner (1979), ingroup favouritism is dependent on whether group membership is significant for the self-concept; the situation allows for intergroup comparisons on a relevant relational attribute; and the outgroup is a relevant comparison group. Social categorizations, or group memberships, provide a system of orientation that helps to define the "individual's places in society" (Tajfel & Turner, 1979), having implications for how people or groups perceive each other. When people identify with a group, they perceive more similarities within the same group and differences between different groups, accentuating within-group similarities and intergroup differences (Tajfel, 1957). To achieve a positive group identity, individuals may engage in several strategies depending on the permeability of group boundaries, and the stability and legitimacy of group status (this topic will be discussed in the next chapter).

Social identity theory (Tajfel & Turner, 1979) proposed that any interaction between a member, or members, of the ingroup and outgroup can be located along a hypothetical continuum of interpersonal-intergroup behaviour, in which at the (pure/extreme) interpersonal level, behaviour is only determined by the characteristics of the individual, associated with interpersonal behaviour, and at the (pure/extreme) intergroup level, behaviour is only determined by group membership, associated with intergroup behaviour. However, Tajfel (1978) argued that group membership, existing in the minds of the interactants, would always have some influence in interactions at the interpersonal level, and mostly in professional encounters (e.g., student-teacher, doctor-patient). Self-categorization theory (Turner et al., 1987) provided a more developed explanation of how individuals categorize themselves into social categories.

2.2.2. Self-categorization theory

Self-categorization theory (Turner et al., 1987) is usually seen as an analysis of the cognitive processes associated with social identity (Haslam, 2004). While social identity theory focuses on the relations between the groups, apparently isolated from other levels of abstraction (i.e., relationship to other groups), self-categorization theory provides a hierarchical structure with levels of inclusiveness, in which groups share a superordinate category that provides meaning to intergroup comparison (Sindic & Condor, 2014).

Self-categorization is defined as the cognitive representation of the self-concept as a member of a particular category, in which people are perceived to be equivalent in that category, but distinct from other people in other categories (Turner et al., 1987). These categories exist at *different levels of abstraction*, which are inclusive of one another. There are three important levels of social self-categorization: the *superordinate human* level (vs. other species); the *intermediate social* level as an ingroup member (distinct from outgroups); and the *subordinate personal* level as a unique individual (different from ingroup members). Therefore, higher levels include the lower levels, and lower-level categories are defined in terms of comparisons made at the higher level, that is, the categorization varies as a function of the *comparative context*. As one of these levels becomes more salient, self-categorizations at the other levels become less salient (*functional antagonism)*. The salience of a category is partly determined by comparisons between a category's properties at a more inclusive level of abstraction, which means that differences at one level are based on similarities at a higher level. That is, for groups to compare with each other at the lower level of abstraction, it is necessary that they agree on a similarity at a higher level of abstraction.

Category salience is the product of the interaction between accessibility and fit (Oakes, 1987). *Accessibility* or readiness of a certain category depends on a variety of factors that determines the salience of the category in a given context, such as the person's past experiences related to the category, the cultural prominence of the category, how the membership is central to the person's self-concept, and the person's present goals (Oakes, 1987; Turner et al., 1994). Another crucial determinant of the salience of a social category is the *fit* between the category and reality, and it has two components: *comparative* and *normative* (Haslam, 2004; Oakes, 1987; Turner et al, 1987). Comparative fit is defined by the principle of *meta-contrast*, that is, the differences between members of a given category are perceived to be smaller than the differences between members of that category and other relevant categories, in a particular context. Normative fit is the consistency between perceived expectations and the content of a category in terms of similarities and differences between members.

When a category is more salient and accentuated, *depersonalization* occurs through a process of self-stereotyping in which the individual becomes categorically similar to ingroup members, adopting the behaviour and beliefs congruent with the norms and values of that category. However, depersonalization does not involve a loss of selfhood like the concept of deindividuation (e.g., Le Bon, 1896; McDougal, 1921), proposed in earlier individualistic perspectives but, rather, a switch in the salient identity (Hogg & Abrams, 1998). Thus, categorization at all levels of abstraction is seen equally as a reflection of a person's true self (Haslam, 2004). Depersonalization and mutual attraction between group members, caused by the perceived similarity between them, leads to a common social identity in terms of group interests, goals, needs and motives, which favours social influence and cooperation (Turner et al., 1987). A member of a category will be perceived to be more *prototypical* of a category to the extent that they are less different from ingroup members in comparison to other outgroup members, in a given *context*. Therefore, the attractiveness of a specific person depends upon their perceived prototypicality in comparison with other group members.

After a long period of focusing on the psychology of the advantaged in which research was more interested in the social psychological processes occurring within members of dominant groups, the social identity approach was the growing field for the psychology of the disadvantaged. Social identity theory and its broader approach became the optimal framework to study not only the processes occurring between groups (e.g., prejudice, competition) and within the groups (e.g., ingroup cooperation; collective action), but also how group memberships influence the well-being of disadvantaged group members.

Social identity theory proposes that people are motivated to maintain a positive self-concept, and the groups to which they belong contribute to a more positive or negative self-concept. Therefore, we can expect members of high-status groups to have more positive levels of well-being because having access to more resources increases their sense of a positive identity (Haslam et al., 2009; Jetten et al., 2017). On the other hand, we might think that members of low-status groups have lower levels of self-esteem and well-being because their group is stigmatized, which can contribute to a negative sense of identity. However, it is not that simple. Indeed, although the well-being of members of disadvantaged groups is negatively influenced by their perception of discrimination (e.g., Schmitt et al., 2014), this does not necessarily mean that these people identify less with their group, or that this identification does not bring positive consequences for their well-being. On the contrary. Research on the impact of social identity on well-being has been known as the "social cure" precisely because group identity can act as a "cure" for disadvantaged groups in the face of stigma and discrimination.

2.2.3. The social identity approach to health - “Social Cure”

The social identity approach to health, known as the social cure agenda, gives particular attention to the influence of group processes on health, specifically those processes related to group identification. It is based on the general assumption that not only are social groups important for health, but specifically people's psychological identification with those groups is key (Haslam et al., 2018). This body of work entails the social identity approach, composed of social identity theory (Tajfel & Turner, 1979) and self-categorization theory (Turner et al., 1987), and is based on the principle that the group (or groups) a person identifies with has (have) relevant consequences for their health and well-being, as they are closely intertwined with people's self-understanding and behaviour (e.g., Haslam et al., 2009; Jetten et al., 2017). Most of the hypotheses proposed and tested by the social identity approach to health are related to these theories and can be found in Jetten and colleagues (2017). In this section, I highlight how group identity influences health.

Group identification can affect the adoption of health or risk behaviours (e.g., eating healthily; smoking) through social norms and social influence. When a person identifies with a group, they feel more motivated to act in accordance with the norms and values of that group, and because group members share an identity, they will be more likely to influence each other (Turner et al., 1987; Jetten et al., 2017). On the other hand, group identification can offer psychological resources that can be beneficial to well-being even, and foremost, in the case of discrimination.

According to research on the "social cure", group identity is more likely to positively impact the well-being of members of disadvantaged groups when group membership gives them a sense of social connection, is meaningful, provides social support and a sense of control (Jetten et al., 2017). As proposed by the authors, social identity gives a sense of connection with other group members because they share the same group membership (e.g., Cacioppo & Patrick, 2008; Cruwys et al., 2014). In addition, because group members share collective aims and, in most cases, put energy into activities to try to achieve group outcomes, they have a sense of common direction, meaning and purpose (e.g., Cruwys et al., 2014). Since people are more likely to give support to those whom they recognize as one of the group, group membership increases the likelihood of having social support (e.g., Levine et al., 2005). Finally, because group membership gives psychological resources such as meaning, connection and support, it gives group members the sense that they have more control over their lives, through collective efficacy (e.g., Avanzi et al., 2015).

This approach has been useful in explaining individuals' perceptions, experiences, and behaviours, in a range of contexts (e.g., stigma, trauma and resilience, ageing, stress) and across various health conditions (e.g., chronic pain, addiction, depression; Haslam et al., 2018). In addition, the influence of group identification on health and well-being has been studied in a variety of social groups such as Black Americans (e.g., Branscombe et al., 1999), sexual minorities (e.g., Begeny et al., 2017), women (e.g., Schmitt et al., 2002), and disabled people (e.g., Bogart, 2014; Nario-Redmond et al., 2013). The effect of disability identity on health and well-being will be discussed in the next chapter, as well as the model through which identity buffers the negative consequences of discrimination on well-being (i.e., the rejection identification model).

3. This thesis: Health approaches and indicators

From all the health approaches presented in this chapter, both the social identity approach to health and social determinants of health are more in line with the social constructivist approach to disability, than the traditional approaches to health (e.g., biomedical and individual psychological approaches). According to the social model of disability, or the social constructivism approach, disabled people constitute a social category that is influenced by the social system and social attitudes. Therefore, disabled people's health is influenced by social-macro factors, such as inequality, but also through group processes, such as intergroup relations and social identification.

Both approaches are social, however, while the social identity approach focuses on meso-level (group) determinants, the social determinants approach focuses on macro-level (e.g., social equality) determinants. Additionally, an integration of these models would allow a more structured approach to the dimensions that affect health. While the approach of the social determinants of health does not account for how groups affect an individual's psychology to, in turn, shape an individual's well-being, the influence of social (macro) determinants, such as inequality or social policies, are often underestimated in social psychological approaches to health.

In this thesis, these two approaches are integrated to analyse disabled people's health and well-being (Figure 1.2). Through the social identity approach, I explore how group-based discrimination and group identification affect disabled people's well-being. In addition, because the potential of positive intergroup experiences to attenuate the consequences of negative experiences on health is missing in these models, in this thesis, I integrate the rejection identification model (based on the social identity theory) with intergroup contact theory. Because of this integration, I opted to name it a social psychological (rather than social identity) approach to health. In addition, through the approach of the social determinants of health, I explore how equality and personal assistance (a social policy) impact disabled people's well-being, considering socio-psychological mechanisms at the intrapersonal level, such as public participation. Although the goal of this work is not to empirically integrate these two approaches by examining societal/macro and group-level processes in the same study, the application of these approaches can add important contributions to the study of disabled people's health, from a social constructivist perspective. Moreover, this work could constitute a first step for the methodological integration of these two perspectives in the future.

Measuring health and well-being

Throughout this work, I often use the term “health and well-being” to highlight the multidimensionality of health. However, to make reading easier, I also use "health" and "well-being" alone, while still considering them as multidimensional concepts. These terms have been indiscriminately used in research to refer to a range of health states. For instance, across 134 studies on the association between discrimination and health (Pascoe & Smart-Richman, 2009; Schmitt et al., 2014), published between 1986-2007, health outcomes included mental health problems such as depression, anxiety, paranoia, and suicidal ideation; negative moods; lower overall well-being; physical health problems including cardiovascular disease (e.g., blood pressure, intermedial thickness, plaque, and heart rate variability), diseases and physical conditions (e.g., hypertension, cardiovascular disease, pelvic inflammatory disease, diabetes, yeast infections, and respiratory conditions); and other general indicators of illness (e.g., nausea, pain, and headaches). In addition, research on the social identity approach to health has used, as measures of health and well-being, stress, depression, anxiety, affect, self-esteem, general health, and satisfaction with life (Haslam et al., 2018). Similarly, the common indicators used in the research on the social determinants of health – i.e., on the relationship between inequality and health - are life expectancy, mortality, self-rated health, mental health (e.g., depression), happiness, but also indicators of public health, such as violent crime (e.g., homicides) and drug abuse (Oishi et al., 2011; Wilkinson & Pickett, 2006; Wilkinson & Pickett, 2010).

Considering the multiple dimensions of health – physical, mental, well-being – in this work I use, particularly, self-reported health, satisfaction with life and happiness, as measures of health and well-being. Using these measures allows me to establish a more reliable perspective on the general health of disabled people, showing that the key findings of the studies reported in this thesis generalise across these measures.

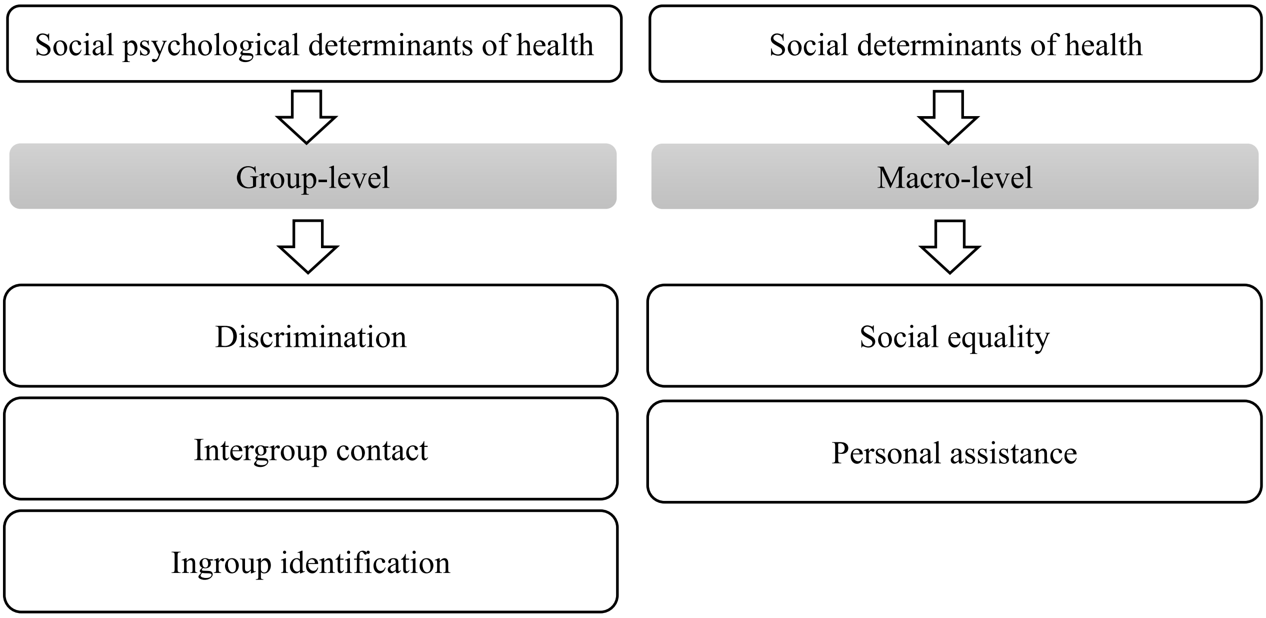

Figure 1.2. Social and social psychological determinants of disabled people's well-being, used in this thesis.

CHAPTER II.

Group-level determinants of health: Discrimination, identification, and intergroup contact

1. Ableism and its effects on health and well-being

1.1. Defining ableism

The term ableism emerged from the disability rights movement and was first referenced in 1981 in the women's newspaper *Off Our Backs*, according to Nario-Redmond (2019). The term has been defined in an interdisciplinary way and is used as a parallel to other terms related to social oppression, such as racism and sexism. As in other “isms”, oppression is the result of the privilege attributed to one characteristic that distinguishes a group from another, which privileges one group at the expense of another. In this case, the ability is privileged, and thus, disability is oppressed. Society and its institutions assume able-bodiedness as a norm and by doing so they exclude and make disabled people the “invisible others” (Chouinard, 1997). More specifically, ableism is based on a set of beliefs and practices that settles an abled corporal standard that is considered superior and fully human, which relegates disabled people to a “diminished state of being human” (Campbell, 2001). Ableism is based on the assumption that impairment is inherently negative, and the cause of the problems experienced by disabled people (Campbell, 2008). Because of that, I argued that ableism is intertwined with the medical and individual model of disability (Branco et al., 2019), which legitimates the status quo (Dirth & Branscombe, 2017) and justifies the segregation and institutionalization of disabled people.

1.2. Disability stigma: Stereotypes, prejudice, and discrimination

Ableism is one type of social stigma. According to Goffman (1963, 2006), the term stigma originated with the Greeks, who used to refer to body signs (cuts, burns) that exposed the moral status of the considered deviant persons, such as slaves, criminals and traitors - blemished and polluted persons to be avoided. Later, in Christian times, stigma was used to refer to body signs of holy grace or as a medical allusion to body signs considered a physical disorder. Nowadays, stigma is generally used to refer to an “attribute that is deeply discrediting” and serves as a motive to “believe that a person with a stigma is not quite human” (Goffman, 1963, 2006). Stigma is a multidimensional process composed of three related components (Biernat & Dovidio, 2000; Fiske, 1998): a cognitive component, involving the beliefs and stereotypes about a certain attribute or group (e.g., the belief that disabled people are incompetent or threatening); an affective and emotional component consisting of prejudice (e.g., pity or fear); and a behavioural component comprising discrimination (e.g., unwanted help or avoidance). Similarly, Allport (1954) had previously organized prejudice in three intertwined components concerning cognitive, motivational, and sociocultural processes.

Disability stereotypes

Stereotypes are described as “a set of beliefs about the personal attributes of a group of people” (Ashmore & Del Boca, 1981, p. 16). Stereotypes, primarily associated with "pictures in our heads" (Lippmann, 1922), were often defined as a negative generalization of a category, given that it is a "fixed impression which conforms very little to the fact it pretends to represent (Katz & Braly, 1935, p. 181) and “an exaggerated belief associated with a category” (Allport, 1954, p. 191).

Based on a functional limitation approach, literature on disability stereotypes was more focused on one type of impairment (e.g., physical, sensory, mental, learning or intellectual). However, a later study shows evidence for the existence of cultural stereotypes of disability that are cross-impairment (Nario-Redmond, 2010). In this study, disabled people were characterized as dependent, incompetent, asexual, weak, passive, unattractive, and heroic, regardless of gender or impairment specification. This is not to say that there are no differences in the stereotypes and attitudes towards different types of disability. For instance, attitudes toward intellectually or mentally disabled people are less positive than those with other types of disability, supposedly because they are considered more unpredictable and threatening (for a systematic review see Z. Wang et al., 2021). People also tend to have less positive attitudes towards people with more visible physical impairment. Moreover, illnesses or disabilities (i.e., AIDS, addictions, psychosis, depression) considered more controllable or unstable (i.e., recoverable) are considered less acceptable because people with these conditions are considered responsible for their situation (Corrigan et al., 2000). However, contrary to the claim that there is not a set of consensual stereotypes related to disability (e.g., Biernat and Dovidio, 2000), there is a common representation of disabled people, which is congruent with a social constructivist approach (Nario-Redmond, 2010). Similarly, earlier studies showed that (certain) disability stereotypes were shared across impairment types. For instance, blind, deaf, and wheelchair users were characterized as less aggressive, less intelligent, and more courageous, compared to non-disabled people (Weinberg, 1976).

The Stereotype Content Model [SCM] (Fiske et al., 2002) identifies two dimensions of stereotype content by which groups are characterized: competence and warmth. The classification of these dimensions depends on perceived group status and its perceived orientation towards competition or cooperation. For instance, disabled people are stereotyped as *incompetent* because of their perceived low status, but as *warm* because they are perceived as not competitive, in relation to other social groups that are perceived as *competent* but *cold*.

Stereotypes help to justify the system of oppression (Jost & Banaji, 1994). When stereotypes are associated with group membership, they also serve to distinguish groups from one another, keeping intergroup boundaries clear (Tajfel & Turner, 1979). If disabled people are characterized as dependent and incompetent, by contrast, non-disabled people are independent and competent. This mechanism justifies the social oppression of one group in favour of another, legitimizing situations of discrimination, for example in access to employment and education, but also welfare and institutionalizing policies that favour the dependency of disabled people (Nario-Redmond, 2019).

Media, movies, documentaries, and popular discourse have perpetuated the stereotypes of disabled people as supercrip tragic characters, villains and goofs (e.g., Brylla, 2018.; Haller, 2010; Morris, 1991; Nario-Redmond, 2019). Physical and mental disabilities have been used to represent evil and badness (from Captain Hook to The Phantom of the Opera, to Marvel villains; Morris, 1991; Nario-Redmond, 2019). Filmmakers are not portraying disabled people's lives, but exploring dependency and vulnerability, especially of men (as a way of reinforcing masculinity beliefs; Morris, 1991). This evokes pity and inspiration, which leads to paternalistic prejudices based on sympathy (instead of empathy; Brylla, 2018). Moreover, this type of representation perpetuates the representation of disability and disabled people in terms of abnormality and otherness (Brylla, 2018). Often disability is also represented as a burden to the disabled person and their family, which justifies a mercy killing (e.g., as in the films *Million Dollar Baby* and *Me Before You*; Morris, 1991; Nario-Redmond, 2019). The tragic position of disabled people is conveyed with descriptions of disabled people "suffering from" and those in wheelchairs as "wheelchair-bound" or "confined to a wheelchair", instead of portraying wheelchairs as a way to have freedom and autonomy (Haller, 2010; Nario-Redmond, 2019).

Disability prejudice and discrimination

Allport (1954, p. 7) defined prejudice as "an aversive or hostile attitude toward a person who belongs to a group, simply because he [she/they] belongs to that group and is therefore presumed to have the objectionable qualities ascribed to the group". Considering the dimensions of the stereotype content model, disabled people are stereotyped as having low competence and high warmth. This type of ambivalent stereotype elicits sympathy and pity emotions and thus paternalistic prejudice, which results in (unwanted) helping, condescension and infantilizing behaviours. However, the expression of prejudices may be dependent on whether the targets behave in way that are consistent or inconsistent with stereotypes (Glick & Fiske, 2001). The victim of benevolent prejudice is often seen as ungrateful and is the target of aggressive behaviours when refusing what may appear, and be intended as, "positive prejudice". Blind targets were rated as ruder and less warm after confronting patronizing help (K. Wang et al., 2019). Therefore, paternalistic prejudice can be displayed when disabled people behave in accordance with the stereotype of being dependent and incompetent (i.e., subordinate and passive way), but hostile forms of prejudice (e.g., anger, resentment) can emerge in reaction to those who challenge the status quo (e.g., Nario-Redmond, 2019).

The brave and heroic stereotype is another commonplace, associated with feelings of admiration and inspiration, which objectifies disabled people as a source of self-contentment and motivation while justifying inequalities by focusing on the individual effort to overcome any barrier (Nario-Redmond, 2010). It assumes that if one person can do it, the others can do it too, so they must do their best to overcome barriers and be heroes, which is highly dehumanizing and penalizing in terms of social policies. Related to this is the phenomenon of tokenism that occurs when very few members of a disadvantaged group are accepted into positions that are usually occupied by members of the advantaged group, and thus systematically denied to the majority of disadvantaged group members (Wright & Taylor, 1998). Therefore, tokenism is often a symbolic gesture that does not involve genuine inclusion (Beckwith et al., 2016), while justifying the myth of individual merit - that is, group boundaries are permeable and individual mobility is possible if one tries very hard or has the ability and competence to do so. Disadvantaged group members in token positions have often to deal with negative outcomes (e.g., feedback-seeking and discounting of performance feedback, Roberson et al., 2003; lack of support and adaptations, Beckwith et al., 2016), while tokenism may reduce the likelihood of collective action by the disadvantaged group against the systematic discrimination (Wright and Taylor, 1998).

Another facet of prejudice can be resentment, envy and anger, when disabled people are perceived as having privileges (such as "special" accommodations) that challenge the status of the dominant group (e.g., Nario-Redmond, 2019).

Attitudes towards disability have also been measured at the implicit level with the Implicit Association Test (IAT). In this type of test, people associated negative terms (e.g., sad, awful, failure, war) with disability-related terms (e.g., “disabled”, “impaired”) faster than with non-disability related terms (e.g., “nondisabled,” “able-bodied,”; Robey et al., 2006). On the contrary, they associated positive terms (e.g., happy, joy, love) with non-disability related terms (strikingly, these findings were obtained from a study of caregivers in a facility for disabled people, whom one might have expected, and hoped, would not hold such prejudice). While disabled people are stereotyped as low in competence but high in warmth, in research using explicit measures, at an implicit level, disabled people can be associated with both low competence and low warmth (Rohmer & Louvet, 2012), a profile associated with dehumanization (Harris & Fiske, 2006). A review of data from more than 2.5 million completed IAT and self-reports (between 2000-2006) found that the preference for non-disabled people compared to disabled people was among the strongest implicit and explicit effects across social groups (B. A. Nosek et al., 2007).

A comparative analysis using 4.4 million tests of implicit and explicit attitudes, over 13 years (2004-2016), examined the patterns of long-term change in several social-group attitudes (i.e., sexual orientation, race, skin tone, age, disability, and body weight), using time-series models (Charlesworth & Banaji, 2019). Explicit responses showed a change toward attitude neutrality for all social-group attitudes. Implicit responses also showed change toward neutrality for sexual orientation, race, and skin-tone attitudes, but they showed stability over time for age and disability attitudes. However, another study using data from the same database (Project Implicit), but focused only on the disability IAT, conducted temporal analyses (2004–2017) among over 300 000 US residents (with and without disabilities) and indicated that explicit bias showed a decline over the same period, whereas implicit prejudice increased over time (Harder et al., 2019). The differences between these two studies (Charlesworth & Banaji, 2019, and Harder et al., 2019), regarding the implicit prejudice (stability versus increasing, respectively) could be due to methodological differences. Despite using samples of the same data project, methodological decisions (i.e., sample-weighted data, demographic controls, criteria exclusion, data range) and different procedures of analysis (i.e., times-series model; linear regression analysis) may explain these differences. Nevertheless, these studies suggest that implicit prejudice toward disability may be stronger and more resistant than other types of group-based prejudice, which could translate into harmful effects on disabled people’s well-being.

Accordingly, in recent studies, disabled people's experiences of ableism were associated with paternalism (e.g., unwanted help, infantilization), but also with dehumanization, objectification, and hostility (Nario-Redmond et al., 2019) and, with invalidation and denial of equal rights (Olkin et al., 2019).

1.3.Impact of discrimination on health and well-being

Discrimination has negative consequences for the well-being of disadvantaged group members (e.g., Pascoe & Smart-Richman, 2009; Schmitt et al., 2014). At the systemic level, stigmatized groups have diminishing opportunities for education, employment, and housing (for a review see Sidanius & Pratto, 1999), which has negative consequences for overall well-being. Due to ableism, disabled people have less access to education and employment, and are more vulnerable to violence and abuse (World Health Organization, 2011). In addition, disabled people receive fewer preventive health services and have poorer health status (e.g., cardiac disease, high blood pressure, high cholesterol, diabetes, stroke, asthma) than non-disabled people (Reichard et al., 2011, 2014).

Additionally, perceived discrimination has negative consequences for mental and physical health. For instance, a meta-analysis of 134 studies (published between 1986 and 2007) shows that perceived discrimination was associated with more mental and health problems (Pascoe and Richman, 2009). This association revealed a more negative trend for chronic (long-term) discrimination. Moreover, this study shows that perceived discrimination influences health through the stress responses, such as heightened physiological stress responses, more negative psychological stress responses, increased participation in unhealthy behaviours, and decreased participation in healthy behaviours. In the same meta-analysis, the most common type of perceived group-based discrimination measured was racial or ethnic discrimination, followed by gender and sexual orientation (i.e., there was no data on disability discrimination in this meta-analysis). Most of the research on the impact of discrimination on the well-being of disadvantaged group members has been focused on the experiences of ethnic minorities, women, and sexual minorities (Major & O’Brien, 2005; Pascoe & Smart-Richman, 2009; Schmitt, et al., 2014). This is because disability has mostly been addressed as a functional and individual problem, instead of a social category affected by the social environment.

A further meta-analysis across 328 studies (published up to 2012) shows that perceived discrimination is negatively associated with psychological well-being (e.g., self-esteem, depression, anxiety, psychological distress, life satisfaction), mostly for disadvantaged groups (Schmitt et al., 2014). Moreover, this study distinguishes between different types of discrimination, including disability discrimination. Compared to discrimination based on gender or race, effect sizes of perceived discrimination on well-being were stronger for mentally and physically disabled people (as well as for people stigmatized as overweight). The general effect of discrimination on well-being remained significant in experimental studies that manipulated general perceptions of discrimination. As noted by the authors, the types of group-based discrimination that have weaker effects, such as racism and sexism, are those perceived as more socially illegitimate, while those with larger effects, such as disability (as well as ageism and heterosexism), tend to be perceived as more legitimized. The number of studies addressing disability discrimination could be a reflection of this legitimization. In this meta-analysis only eight studies focused on disability discrimination, comparing to 211 focusing on racism, 23 on sexism, and 21 on heterosexism.

2. This thesis: Research question and aim – Article 1

Based on this evidence – a larger effect of ableism on well-being and ableism stability (or increasing) over time, than is found for other stigmatized groups – in Chapter IV/Article 1, I explore whether ableism is more harmful to well-being, compared to other types of group-based discrimination, even when disability intersects with other social categories (e.g., disabled women). In a previous study, disabled targets were immediately described by disability, independent of their sex or ethnicity, whereas non-disabled targets were primarily described by gender and ethnicity (Rohmer & Louvet, 2009). In two experiments, the authors compared participants' descriptions of targets with or without disability (in a wheelchair or on a bike), female or male, and Black or White (the latter only in Study 2). In both studies, disability was mentioned in all descriptions and in the first position by 60% of respondents. In contrast, the bike was mentioned in the first position by only 10% (Study 1) or one participant (Study 2), and not mentioned at all in 15% (Study 1) and 18% (Study 2) of the descriptions. In addition, targets in a wheelchair were described in less detail regarding gender and ethnicity than were targets on a bike. Interestingly, targets on a bike were never defined regarding ability, similarly to white targets never being defined regarding ethnicity. Therefore, the authors suggested that disability is a more salient category, compared to gender and ethnicity, proposing disability as a superordinate category.

Furthermore, disabled people face distinct challenges that differ from those faced by other socially disadvantaged groups, which can put them in a more vulnerable position. These arguments are explored in Chapter IV/Article 1.

Chapter IV/Article 1

Question:
Is ableism a more damaging form of group-based discrimination, compared to other types of group-based discrimination (such as racism, sexism, ageism)?

Aim:
Compare the effects of ableism on health and well-being against the effects of other types of group-based discrimination.

3. The role of group identification and intergroup contact

The consequences of negative intergroup experiences, such as discrimination, are well established in the literature. Nevertheless, the perception of discrimination and its impact can vary depending on other factors such as group identification (e.g., Schmitt et al., 2014). In addition, as noted previously (Dovidio et al., 2017), research on the relationship between discrimination and well-being has focused only on the negative dimension of intergroup experiences, leaving unanswered the question whether positive intergroup contact has the potential to attenuate the deleterious effects of negative experiences on the health and well-being of disadvantaged group members. In this chapter, I explore how identity and positive intergroup contact can shape the relationship between discrimination/negative intergroup contact and well-being.

3.1. Disability identity

Approaching disability from a social constructivist perspective, in which disability is a social product and disabled people are a minority group, meant that disability could be perceived as a social identity. Research on disability identity has primarily been focused on the development and meaning of the identity, based on Erikson's (1968) theory of psychosocial development (see Forber-Pratt et al., 2017, for a systematic review). This theory approaches identity throughout the lifespan (e.g., childhood, adolescence, adulthood), in which the self-concept is affected by the ongoing interactions between the person and the social environment, such as family, peers, gender, ethnicity, sexual orientation, as well as by disability. Components of the development of disability identity include acceptance and affirmation of disability, sense of self-worth and personal meaning, feeling of belonging and communal attachments, pride, perceptions of discrimination, engagement in a common cause and collective action (Forber-Pratt et al., 2017).

While disability identity, namely its development, was firstly addressed in the field of disability studies through qualitative studies, only more recently have researchers begun to approach disability identity through social identity theory and quantitative (or mixed method) studies. Despite the theoretical differences between these approaches (i.e., theory of psychosocial development and social identity theory), findings on disability identity development reflect the assumptions of social identity to some extent. Applying the social identity definition (Tajfel, 1974; Tajfel & Turner, 1979), disability identity is the part of a person's self-concept that derives from their knowledge of their membership in the disability group, with the value and emotional meanings attached to that membership. In other words, disability identity involves a person's acknowledgement and affirmation as a disabled person, and the incorporation of this group membership into their self-concept, their identity (Bogart, 2015). As an important part of the self-concept, group membership influences how people perceive themselves, their worth and meaning. In addition, perceived similarities with other ingroup members provide them with a sense of belonging, which favours the creation of collective goals and actions.

According to self-categorization theory, disability will be more accessible for self-categorization or identification to the extent that the disability category is a central category for the self-concept, in a given context, over other categories (Oakes, 1987; Turner et al., 1987). The repetition of these experiences over time, accumulating over a lifetime, may turn disability into a central category for one's self-concept. For instance, congenital disability and severity of impairment (i.e., the extent to which it affects daily living) have been associated with disability identification (Bogart, 2014; Bogart et al., 2017). We can conceive that disabled people have multiple experiences throughout their lifetime that make the disability category salient (see Dirth & Branscombe, 2018). The institutionalization of disabled people, the rehabilitation settings, the lack of accessibility, and the dependence on disability organizations (e.g., Braddock & Parish, 2001; Longmore & Umansky, 2001) provide disabled people with multiple daily experiences that distinguish disabled people ("us") from non-disabled people ("them"; Dirth & Branscombe, 2018). Paternalistic prejudice and relations that reinforce the passive role of disabled people and the superiority of health or social professionals (e.g., Longmore, 1995), help to reinforce the distinction between disabled and non-disabled people. In addition, due to bureaucratic procedures, disabled people must disclose that they are disabled persons in order to have access to social benefits or accommodations created on the disability criteria (e.g., Lindsay et al., 2018; Matthews, 2009), to achieve their educational and employment goals. On the other hand, the development of the disability rights movement may turn disability into an accessible category to understand experiences of discrimination (Dirth & Branscombe, 2018).

Strategies to deal with a low-status group membership

Moreover, research on disability identity based on the social identity approach has tried to explain the conditions in which people identify with disability (for previous applications of social identity theory to disability identity, see Dirth & Branscombe, 2018; Nario-Redmond, 2019). According to the social identity theory (Tajfel & Turner, 1979), when a group has lower status, individuals may try to maintain a positive social identity depending on three important sociostructural variables: stability, legitimacy, and permeability. When disadvantaged group members perceive the boundaries between groups as permeable, they may adopt the strategy of social mobility, passing from a low to a high-status group. Group members were found to disidentify with the low-status group, when they perceived group boundaries as permeable, and to identify more with the low-status group when mobility between groups was impossible (Ellemers et al., 1988). For disabled people mobility may include seeking a cure or pass as a non-disabled person (Darling, 2003). Cultural norms and socio-economic status can also influence the likelihood of disabled people identifying with the disability group or engaging in social mobility. In Spain, where support organizations are recent, some people with dwarfism sought to leave their former group and enter the group of the majority through limb-lengthening surgery. In contrast, in the USA, where there is a long-standing organization of people with dwarfism that encourages pride in being a “little person”, a coping strategy based on empowering the minority group prevailed (Fernández et al., 2012).

However, for those who have impairments that are more visible, and impossible to hide from others, for a disabled person to pass as non-disabled becomes an impossible task. In addition, disabled people in a lower socioeconomic position may have less access to resources that could facilitate social mobility (e.g., have access to treatment and technological aids; access to employment and participation in social domains that could promote membership in other groups), and because of that, they are more likely to identify with the disability group (Bogart et al., 2017). On the other hand, those who try to escape from disability membership identity could experience even more psychological distress (e.g., lower self-esteem; Nario-Redmond et al., 2013) than those with unconcealable stigma, because they do not have access to the benefits that could come from sharing a group membership with similar others (Frable et al., 1998). In addition, they may avoid requesting accommodations related to disability, at the expense of their needs (e.g., Lindsay et., 2018). Moreover, avoiding disability identity may prevent the recognition of discrimination (Nario-Redmond & Oleson, 2016) which can contribute to the perception of (low) group status as legitimate (Jetten et al., 2013). On the other hand, the pervasiveness of ableism, in the form of discrimination and environmental barriers, may lead disabled people to deduce that group boundaries are not permeable, and that it is not feasible to move into a higher category (e.g., Branscombe et al., 1999; Jetten et al., 2013). Yet, while individual-level strategies (social mobility) attempt to improve the status of the person, only group-level strategies (social change) can attempt to improve the status of the group.

The low permeability of group boundaries and cognitive alternatives to the status quo may enhance group identification and engagement in group-level strategies to change the group status quo (Jetten et al., 2013). When disadvantaged group members perceive group boundaries as impermeable (i.e., there is no possibility to move to a higher status group), but their ingroup status as secure (i.e., legitimate, stable), they may adopt a strategy of social creativity to achieve positive distinctiveness for the ingroup. Examples of social creativity strategies are shifting the comparison group, revaluing a group dimension, or shifting the group dimensions that are stigmatized (Ellemers & Rijswijk, 1997). For instance, deaf people (Lane, 2002) and “disabled veterans” (Gerber, 2000) have tried to differentiate themselves from the general category of disabled people. Another example is revaluing the group dimension that is stigmatized by reinterpreting these characteristics as positive and valued, as in the re-appropriation of historically derogatory terms such as “crip” or “cripple” (Kafer, 2013).

However, when the boundaries are perceived as impermeable, but insecure (i.e., illegitimate, unstable), disadvantaged group members may engage in social competition, which involves collective efforts to change the unequal status between the groups. Group members identified more with the low-status group when they perceived group status as illegitimate (Ellemers et al., 1993). The collective actions engaged in by the disability rights movement (e.g., protests, petitions, advocacy, associative organizations) are an example of a social competition strategy to improve disability status (an example of a social policy promoted by the disability rights movement will be discussed in Chapter III). Disability identification predicted greater use of collective strategies (Nario-Redmond et al., 2013), disability-rights advocacy, stronger perceptions of solidarity with other disabled people, and a stronger awareness of discrimination (Nario-Redmond & Oleson, 2016), among a sample of people with different types of impairments. Despite these types of strategies being more subject to outgroup hostility (e.g., Kaiser & Miller, 2001; Kaiser & Pratt-Hyatt, 2009), disability identity has been associated with positive health outcomes, as shown below.

3.2. Impact of disability identification on well-being

Research on the relationship between disability identification and well-being has adopted cross-sectional methods. Disability identity was positively associated with self-esteem (Nario-Redmond et al., 2013) and satisfaction with life (Bogart, 2014), among people with different types of impairment. Similarly, disability identity was associated with lower depression and anxiety in people with multiple sclerosis (Bogart, 2015). Other studies have explored the mediators of the relationship between disability identity and well-being. Autism identification was associated with higher personal self-esteem (through collective self-esteem), which in turn was associated with lower levels of anxiety and depression (Cooper et al., 2017). In another study, group identification (with a mental support group) was associated with higher self-esteem among people with mental health problems, through increased social support, stereotype rejection and stigma resistance (Crabtree et al., 2010).

3.2.1. The Rejection-identification Model

The rejection-identification model (Branscombe et al., 1999) proposes that (1) attributions of negative outcomes to prejudice have negative effects on well-being. However, (2) attributions of negative outcomes to prejudice can increase ingroup identification, especially when prejudice is seen as pervasive. In turn, (3) ingroup identification has been associated with positive outcomes for well-being. That is, prejudice attribution would be part of a coping mechanism among disadvantaged group members when prejudice is perceived as pervasive and stable, that is, illegitimate. According to the authors, it is the perceived illegitimacy of the rejection (i.e., negative outcome) that leads to the process suggested by the rejection-identification model, which is different from the attributional discounting view (Crocker & Major, 1989; which suggests that attributing prejudice to single events or personal attributes could protect self-esteem). The authors proposed that the need for belongingness can be one reason to explain why attributions to prejudice increase ingroup identification. Because disadvantaged group members feel that they are not accepted by the advantaged group, identifying with the ingroup would be the most adaptative strategy for feeling accepted. In a cross-sectional study, Branscombe and colleagues (1999) used, with a sample of 'African Americans', past experience with discrimination and attributions to prejudice across situations to measure the willingness to make attributions to stable and pervasive prejudice. They showed that ingroup identification partially mediated the association between attributions to prejudice and both personal (measured with negative emotions and personal self-esteem) and collective (measured with private and member collective self-esteem) well-being[3]. Subsequent studies have adopted the perception of discrimination instead of attributions to prejudice (e.g., Ramos et al., 2012). That is, perceived discrimination has a direct negative effect on (personal and collective) well-being, but this pattern of attribution also increases ingroup identification, which, in turn, has a positive effect on well-being (Figure 2.1).

The rejection-identification model was original in identifying the potential to alleviate the negative effects of discrimination and it emphasized the promotion of ingroup identities as a crucial strategy to improve the well-being of disadvantaged groups. Several subsequent studies replicated the rejection identification model in other groups such as women (Schmitt et al., 2002), international students (Schmitt et al., 2003) and older adults (Garstka et al., 2004). Few studies have, however, explored the rejection-identification model with disabled people. A recent study shows that disability pride partially mediated the association between perceived stigma and self-esteem (Bogart et al., 2018), suggesting that disability identity (specifically pride) could be a potential way to protect self-esteem against stigma. However, these were cross-sectional studies, which precludes drawing conclusions about the causality of the relationships.

Other studies have contested the causal effect of perceived discrimination on group identity. The central critique of the model is that the reverse effect is possible, to the extent that people who are more identified with their ingroup are more likely to make attributions of prejudice and discrimination to negative events, in a self-protective way (Major et al., 2003). For instance, when exposed to an ambiguous event (i.e., an event that could be considered to be discrimination in some but not all instances), disadvantaged ethnic/racial group members who were more identified with the ingroup were more likely to attribute these events to discrimination, when compared to those with lower identification (Crocker et al., 1991; Operario & Fiske, 2001; Shelton & Sellers, 2000).

However, research on this topic has shown that disadvantaged group members are more likely to under-estimated, rather than over-estimated, the occurrence of discrimination that targets them, due to several reasons related to meritocratic, system justifying and just world beliefs, the difficulty of recognising (and react to) subtle forms of discrimination, contextual cues (e.g., power asymmetries), and personal motivation (e.g., goals and self-regulatory strategies; Barreto & Ellemers, 2015). Besides, attributions to discrimination may have negative

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[3] Despite not being relevant for the conceptualization of the rejection-identification model, the authors also show in the same study that attributions to prejudice were associated with higher hostility toward the dominant group, “white people”.

consequences. Disadvantaged group members that made attributions to discrimination were considered complainers and devalued, compared to those who made other external attributions (Kaiser & Miller, 2001). Moreover, (white) individuals show more negative attitudes towards racially disadvantaged group members strongly identified with their group, compared to those weakly identified (Kaiser & Pratt-Hyatt, 2009).

Studies supporting the causal link between identification and perceived discrimination are based on experimental situations in which participants are exposed to an isolated incident of discrimination (e.g., Major et al., 2003) which could have different implications than pervasive and stable discrimination (Branscombe et al., 1999; Ramos et al., 2012). According to social identity theory (Tajfel and Turner, 1979), low-status groups that perceive their situation as illegitimate (which is the case of general social categories) are more likely to identify with their ingroup and initiate social change strategies to improve their status. Therefore, identification with the disadvantaged group comes from the realization that one fits a social category, or has membership within a group, that is, illegitimately, discriminated against in society. An experimental study (Jetten et al., 2001) shows that disadvantaged group members who perceive discrimination as illegitimate identify more with their ingroup.

Ramos and colleagues (2012) tested longitudinally the effect of perceived discrimination on ingroup identification, which allowed them to test the bidirectionality of the effect. In a sample of international students, they collected data at two-time points, separated by 1 year. Perceived discrimination was measured in a latent factor composed of experiences of discrimination, day-to-day discrimination, outgroup privilege and attributions to prejudice. They found that perceived discrimination at an earlier time point was positively associated with ingroup identification (centrality) at a subsequent time point, but the reverse effect was not verified. That is, identity was not positively associated with perceived discrimination. In fact, in this case, ingroup centrality was negatively associated with perceived discrimination, which is in the opposite direction of the reverse hypothesis in which people who are more identified attribute more discrimination.

These results are consistent with the perspective that, because the group is relevant to the self-concept, disadvantaged group members are motivated to minimize the perceptions of discrimination to avoid threat and devaluation (Schmitt & Branscombe, 2002). In this perspective, attributions of discrimination are not self-protective but, rather, have harmful consequences on well-being. Therefore, disadvantaged group members identify with their ingroup to cope with the suffering that came from perceived discrimination (Schmitt et al., 2002; Schmitt & Branscombe, 2002).

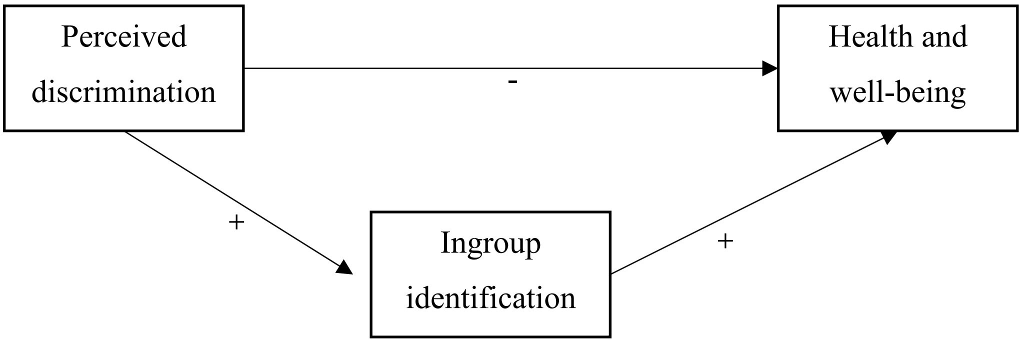

Figure 2.1. Illustration of the rejection-identification model (Branscombe et al., 1999).

3.2.2. The multidimensionality approach to group identification

Research on the rejection-identification model has adopted a unidimensional approach to identification. That is, despite measuring different components of identity (such as cognitive and affective components; e.g., Branscombe et al., 1999; Schmitt et al., 2002), they are factored together in a single measure. However, researchers have argued for the importance of distinguishing between the dimensions of social identity (e.g., Cameron, 2004; Ellemers et al., 1999; Ramos et al., 2012), since the relationship between discrimination-identification can vary as a function of the dimension of identification. In other words, the different dimensions of identification can have different and conflicting meanings for group members. Ramos and colleagues (2012) used a multidimensional approach to group identification, adopting the three-factor model of identification, proposed by Cameron (2004), in which social identity is composed of three core components: centrality (i.e., cognitive accessibility of group membership), ingroup affect (i.e., emotional valence), and ingroup ties (i.e., attachment to the group).

In a longitudinal study, Ramos and colleagues (2012) found that perceived discrimination was positively associated with subsequent ingroup centrality, which is in accordance with the rejection-identification hypothesis and previous studies (e.g., Eccleston & Major, 2006). However, the association between negative contact and centrality was not confirmed in a recent longitudinal study (Reimer et al., 2017). In addition, in Ramos and colleagues' (2012) study, perceived discrimination was not associated with ingroup ties or ingroup affect, but perceived discrimination was associated with lower ingroup affect, cross-sectionally. This finding was consistent with the authors' hypothesis and previous studies showing that perceived discrimination was associated with negative evaluations (i.e., lower self-esteem) of ingroup membership, among Latino-Americans and women (e.g., Eccleston & Major, 2006; McCoy &

Major, 2003). In addition, the link between negative contact and ingroup ties has not been confirmed, while personal discrimination and solidarity were associated in a longitudinal study (Reimer et al., 2017).

The relationship between the different components of identity and well-being is also inconsistent, as two experimental studies have shown that when identity was central to the self-concept, self-evaluative emotions (self-esteem and depression) was lower in the face of discrimination (e.g., McCoy & Major, 2003). Therefore, perceptions of discrimination would be associated with negative group affect, which in turn would be negatively associated with self-esteem and well-being. In addition, ingroup ties among disadvantaged group members were associated with well-being (Spencer-Rodgers & Collins, 2006). However, in a longitudinal study, Ramos (2010) did not find evidence for the rejection-identification model, since the three components of identity did not buffer the effects of perceived discrimination on well-being. Ramos found that (increasing) centrality and (decreasing) ingroup affect (due to perceived discrimination) were negatively associated with well-being, while perceived discrimination was not associated with ingroup ties but ingroup ties were positively associated with well-being. These conflicting results show the importance of disentangling the different components of identification.

Therefore, in this thesis, building on the previous work of Ramos and colleagues (2012), I adopt a multidimensional approach to identity, distinguishing between the three core dimensions, proposed by Cameron (2004): ingroup affect, centrality and ingroup ties. These dimensions are congruent with the three different components of identification proposed by other authors (Ellemers et al., 1999; Jackson, 2002): a cognitive component (self-categorization); an evaluative component (group self-esteem); and an emotional/attachment component (commitment to the group; solidarity; common fate). These three components correspond to the self-investment dimension proposed by the two-dimensional model of social identification (Leach et al., 2008), which is composed of satisfaction, centrality and ingroup ties (whilst the dimension of self-definition is composed of self-stereotyping and group homogeneity). Because Leach's multidimensional scale of identification was adapted to Portuguese (Ramos & Alves, 2011), in this thesis I use this scale to access the three components of identification: ingroup affect (or satisfaction, according to Leach et al., 2008), centrality and ingroup ties (or solidarity, according to Leach et al., 2008).

3.3.Integrating the rejection-identification model and the intergroup contact theory

Several studies support the rejection-identification model (Branscombe et al., 1999), which suggests that perceived discrimination by an outgroup can lead disadvantaged group members to identify more with their ingroup, thereby buffering them from the negative effects of discrimination. However, these models did not account for the potential of positive intergroup contact to interact with negative experiences, such as perceived discrimination, to influence well-being and ingroup identification.

Moreover, research on intergroup contact theory has been conducted mainly from the perspective of advantaged group members and the potential for (positive) intergroup contact to attenuate the harmful effects of negative experiences on well-being remains underexplored (Dovidio et al., 2017). In this thesis, research on these approaches - intergroup contact theory and rejection-identification model – are integrated to analyse (a) how positive-negative intergroup contact interacts to impact the well-being of disabled people, and (b) how group identification is affected by this process. In addition, by addressing the personal negative intergroup experiences of individuals, instead of the perception of discrimination against the general group, this approach could provide a more accurate analysis of the relationship between negative experiences, group identification and well-being. For instance, the association between discrimination and health is larger for personal discrimination, compared to group discrimination (Schmitt et al., 2014). At the same time, a group-level analysis is maintained since social categories are, typically, salient (e.g., contact with non-disabled people) in intergroup contact (Pettigrew & Tropp, 2006).

Brief historical contextualization

Driven by and based on intergroup contact theory (Allport, 1954; Brown & Hewstone, 2005), research on intergroup contact has a long, influential and debated history. The ‘contact hypothesis’, formulated by Allport (1954) in his book, *The nature of prejudice*, posits that intergroup contact reduces prejudice towards the outgroup, when contact takes places under four optimal conditions: equal status, common goals, intergroup cooperation and support from authority (e.g., norms).

Allport's hypothesis was based on the previous debate and studies that emerged in the first part of the 20th century (for historical reviews see Dovidio et al., 2003, 2017; Pettigrew, 2021; Pettigrew & Tropp, 2005). According to Pettigrew and Tropp (2005), until then, the 19th century was dominated by pessimistic ideas that were born in the context of Social Darwinism, such that intergroup contact was an inevitable setting of hostility and conflict. However, after

World War II, a more optimistic view began to contest these ideas. For instance, Lett (1945) pointed out the importance of intergroup exposure to mutual understanding and respect. At this time, the debate was centred on inter-racial, “Black-White” relations in the U.S. and the first empirical evidence emerged from military, public housing and public-school field studies (see Dovidio et al., 2003; Pettigrew & Tropp, 2005).

In general, field studies showed that racial desegregation in contexts of work, school or housing were associated with more positive racial attitudes. In the Merchant Marines, the number of voyages that White seamen took with Black seamen were correlated with positive racial attitudes (Brophy, 1945). In a quasi-experimental study, titled the "American Soldier", White American soldiers who fought side by side with Black American soldiers in the Battle of the Bulge (1944-5) had more positive racial attitudes than those who did not (Stouffer et al., 1949). Similarly, Kephart (1957) showed that White police in Philadelphia who had worked with Black colleagues showed more positive racial attitudes than those who did not, including fewer objections to teaming or taking orders from Black partners or officers (Dovidio et al., 2003). In addition, another quasi-experimental study, by Deutsch and Collins (1951), conducted at a racially desegregated public housing project, showed that white residents (housewives) in the integrated housing project had more frequent and positive intergroup contact, than those in segregated projects, and they reported more positive intergroup attitudes (Dovidio et al., 2003; Pettigrew, 2021).

In his monograph on intergroup relations, *The Reduction of Intergroup Tensions*, sociologist Williams (1947) stated what we can consider as an initial formulation of intergroup contact theory (e.g., Pettigrew & Tropp, 2005), suggesting that intergroup contact would more strongly reduce prejudice when: (a) the two groups share similar status, interests, and tasks; (b) the situation fosters personal, intimate intergroup contact; (c) the participants do not fit the stereotyped conceptions of their groups, and (d) the activities cut across group lines.

3.3.1. Intergroup contact theory

In the 1950s, Allport formulated the contact hypothesis based on the previous field studies and Williams' (1947) earlier formulation, but also on the work of his doctoral students, in which he noted the contradictory effects of intergroup contact, reducing or exacerbating prejudice (Pettigrew & Tropp, 2005). To account for these inconsistencies, Allport (1954) formulated the hypothesis of prejudice reduction through intergroup contact when four optimal conditions were present: (a) equal status between the groups, (b) common goals, (c) intergroup cooperation, and (d) the support of authorities, law, or custom.

There is now a broad body of evidence that intergroup contact typically reduces prejudice, even when the optimal conditions are not present. In a meta-analysis with 713 independent samples of 515 studies, published between 1940 and 2000, Pettigrew and Tropp (2006) found that greater levels of intergroup contact are typically associated with lower levels of prejudice. Despite the majority of these studies were correlational, the effect remained and was larger for experimental studies. In addition, they found stronger effects in studies that used intergroup friendship as a measure of contact – a proxy for the four conditions proposed by Allport - or studies with contact situations structured to meet Allport's optimal conditions. However, intergroup contact was still negatively associated with prejudice even when these conditions are not presented, although not as strongly, showing that these conditions enhance the effect of contact, but are not essential. In addition, findings from a meta-analysis (with 73 studies; Lemmer & Wagner, 2015), on the effect of contact-based interventions, showed that (direct and indirect) intergroup contact improved ethnic attitudes and this effect remained over time.

A vast body of research has since developed, not only to test the effect and the optimal conditions of contact but also to discover the mechanisms and moderators of the link between intergroup contact and prejudice reduction (for literature reviews see Dovidio et al., 2003; Pettigrew, 1998). For instance, reduced intergroup anxiety is an important mediator between intergroup contact and prejudice (Brown & Hewstone, 2005; Islam & Hewstone, 1993), mostly when group salience is high (Voci & Hewstone, 2003). Interestingly, contact can reduce feelings of anxiety and threat about future intergroup interactions (Paolini et al., 2004).

In addition, studies have extended the focus beyond racial and ethnic groups to other disadvantaged groups based on age, sexuality, and disability (Pettigrew and Troop, 2006). Another important finding in the meta-analysis of Pettigrew and Troop (2006) was that the average effect size of contact on prejudice varied across different groups. Contact involving gays or lesbians showed the largest effects. In addition, contact involving physically disabled people showed a larger than average effect, and contact involving mentally disabled people showed average size effects. Contact involving racial and ethnic intergroup contact also showed average size effects. In turn, contact involving mentally ill people or elderly people held much smaller effects.

Only more recently has research on intergroup contact expanded the debate to include the effects of both positive and negative types of contact. Researchers began to point out the need to examine more comprehensive models, considering the effects of negative contact since people do not experience only positive contact in their intergroup interactions (e.g., Pettigrew and Troop, 2006). Negative intergroup experiences can enhance feelings of anxiety and threat that could inhibit the consequences of positive intergroup contact (Plant & Devine, 2003).

Initial work on positive-negative contact proposed an asymmetry hypothesis (Barlow et al., 2012) after showing that the deleterious effects of negative contact were consistently stronger than the beneficial effects of positive contact. In a cross-sectional study, the authors found that negative contact was a strong and more consistent predictor of prejudice towards black Americans, black Australians, Muslim Australians and asylum seekers, than positive contact, although the latter is more common. This asymmetry could be explained, they argued, through a valence-salience effect (Paolini et al., 2010) whereby negative intergroup contact makes group categories more salient and thus readily generalized. In the same direction, a survey conducted in five European countries (Austria, the Czech Republic, Germany, Poland and Slovakia) showed that although positive contact was more common, negative contact was more influential in predicting outgroup attitudes (Graf et al., 2014).

The asymmetry hypothesis seemed to call into question the potential of intergroup contact, since negative contact appeared to have more influence than positive contact. However, more recently, this hypothesis was put into question since some studies have found little difference between positive and negative contact, and others show a greater effect for positive contact (Árnadóttir et al., 2018). In addition, in a cross-sectional study, Árnadóttir and colleagues (2018), proposed an interaction effect between (direct) positive and negative contact on intergroup orientations: positive contact buffers the negative effects of negative contact (buffering effect), and negative contact enhances the benefits of positive contact (facilitation effect). This could be in some way explained, they argued, by differential group salience: positive contact decreases category salience during negative interactions, and negative contact increases category salience during positive interactions. This assumption was, in some part, based on previous work with experimental studies on the moderation of the valence-salience effect, which showed that past experiences of positive contact buffered the effects of negative intergroup contact on category salience in the present (Paolini et al., 2014).

Although Árnadóttir and colleagues (2018) found evidence for the buffering and facilitation effects between negative and positive contact on intergroup orientations, they found no evidence that positive contact decreased category salience during negative interactions. In fact, the association between negative contact and category salience was stronger for those with more positive experiences. In addition, they found no association between positive contact and category salience for those with more negative experiences, while this association was in fact negative among those with fewer negative experiences. The interaction effects of negative and positive contact on intergroup orientations were found for both advantaged and disadvantaged groups, but weakly for the disadvantaged group. Given that the effects of positive contact were as strong as the effects of negative contact, the authors found no evidence for the asymmetry hypothesis.

3.3.2. Implications of intergroup contact among disadvantaged group members

Focused on the achievement of positive intergroup outcomes, such as prejudice reduction, it is natural that research on intergroup contact was, for a long time, mainly focused on intergroup attitudes, and especially among advantaged-group members. Only more recently did research expand to consider the effects of intergroup contact for socially disadvantaged groups, especially with a focus on whether contact might have the unintended effect of blunting collective action. While intergroup contact research has largely focused on its potential to reduce prejudice, paradoxically, researchers on collective action have been concerned with how positive contact can weaken perceptions of discrimination among disadvantaged group members and consequently undermine their efforts for social change (Dixon, Durrheim, et al., 2010; Dixon, Tropp, et al., 2010). Positive experiences could discourage collective action, presumably, because they were associated with reduced ingroup identification, lower perceptions of discrimination, less anger about discrimination, and more favourable outgroup attitudes (Dixon, Durrheim, et al., 2010; Tausch et al., 2015; Verkuyten et al., 2010).

Two studies examined both negative and positive contact among disadvantaged group members. Negative but not positive contact with heterosexual people was associated with sexual minority students’ engagement in collective action, via group identification and perceived discrimination (Reimer et al., 2017). However, inconsistently, neither positive nor negative contact predicted group identification (centrality and solidarity) longitudinally. In another study, negative contact with White Americans predicted greater collective action among black and Hispanic Americans, compared to positive contact, through perceived discrimination and intergroup anger (Hayward et al., 2018), without evidence of the role of group identification. Therefore, this field of research (a) has been only focused on the influence of intergroup contact for collective action, (b) leaves inconclusive the role of intergroup contact for group identification, and (c) has adopted an asymmetric approach, instead of an interaction approach, of positive-negative contact.

In addition, the asymmetric approach of negative-positive contact on collective action seems to be based on a negative perspective, as it implies that disadvantaged groups shouldn't have positive intergroup interactions, as this would diminish their mobilization for change. Such a perspective does not consider the negative effects of discrimination for these groups, nor the positive effects that can come from positive intergroup contact. In addition to reducing prejudice, positive intergroup contact has been associated with support for egalitarian policies among the advantaged group members (Pittinsky & Montoya, 2009) and increased commitment to activism for the advantaged group (Reimer et al., 2017), which can hold positive consequences for the disadvantaged group in terms of social change. Moreover, positive contact did not invariably undermine participation in collective action among disadvantaged group members, but it depended on perceptions of the legitimacy of intergroup inequality (Becker et al., 2013). Furthermore, positive contact may reduce the negative effects of discrimination, impacting positively the well-being of disadvantaged group members.

4. This thesis: Research question and aim - Article 2

Considering the lack of research on intergroup contact from the perspective of disadvantaged group members, in this thesis, I examine how negative and positive intergroup contact interact to shape disabled people's well-being. In addition, I examine how the interaction between negative-positive intergroup contact influences group identification (Figure 2.2), considering the three core components of identification: ingroup affect, centrality and ingroup ties. These relationships are discussed in Chapter V/Article 2.

Chapter V/ Article 2

Question:
Does positive intergroup contact buffer the effect of negative intergroup contact on identification and well-being?

Aim:
Examine how negative and positive intergroup contact interacts with the well-being of disabled people and their ingroup identification.

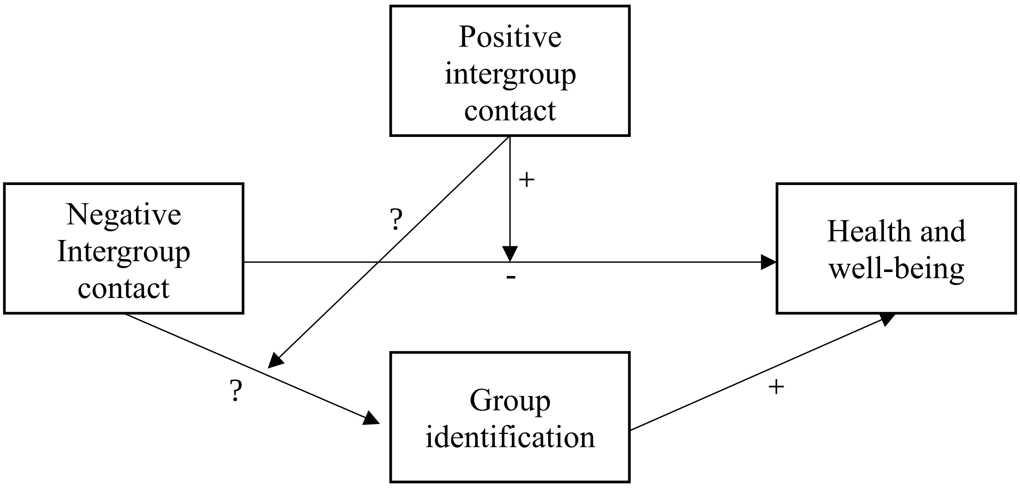

Figure 2.2. Integration of positive and negative intergroup contact and the rejection-identification framework.

CHAPTER III.

Social determinants of health

The impact of inequality on disabled people’s health is underexplored since disability is often treated as an outcome (of inequality), rather than a social category that is oppressed by inequality. In addition, personal assistance has been discussed as a central policy to promote disability equality (Mladenov et al., 2015), yet there is no direct empirical evidence about the role of this policy for equality. From a social psychological perspective, codes of behaviour established by legislation and social institutions are fundamental in establishing antiprejudicial norms (Allport, 1954). In addition, increasing the opportunity for intergroup contact, by favouring the participation of disabled people in joint activities with non-disabled people, can help to reduce prejudice (Allport, 1954, Pettigrew & Tropp, 2006). Moreover, equality-based recognition has been conceptualized as an important predictor of positive intergroup attitudes (Simon, 2007). Despite this thesis not contemplating a direct connection between personal assistance and intergroup relations, it consists of a first attempt to demonstrate empirically the importance of personal assistance to equality, with relevant implications for disabled people’s participation and well-being.

1. Social determinants of health: Wealth and inequality

Social approaches to health try to understand how health is influenced by the social context, namely by the wealth and income inequality of the country. Despite the social determinants of health approach having been more focused on the relationship between inequality and health, the importance of wealth, once considered a crucial determinant of health, remains an open debate. Economic growth was especially relevant for the improvement of health conditions (sanitation, hygiene, services, education) and the decrease of poverty, which together make economic growth more relevant for health in low-income countries (S. Anand & Ravallion, 1993; Deaton, 2006). For instance, research showed that after reaching a middle threshold point, the relationship between happiness and economic growth levels off (Layard, 2006). On the other hand, despite the economic growth and improvement of health services, high-income countries still face several public health issues, such as violence, drug abuse, and mental illness (Wilkinson & Pickett, 2010). Therefore, the claim "wealthier is healthier" (Pritchett & Summers, 1993) was questioned by income inequality.

It seems, in fact, that both wealth and inequality could be relevant depending on the context. Biggs and colleagues (2010) found that wealth was positively associated with health (i.e., lower mortality, higher life expectancy) across several countries in Latin America, but this relationship was influenced by poverty and inequality levels. That is, the relationship between increasing wealth and health was stronger during times of decreasing or constant poverty and inequality, compared to an irrelevant or marginal relationship when poverty or inequality were increasing. As the authors noted, “the benefits of wealth to health strongly depend on how that wealth is distributed” (Biggs et al., 2010, p. 271), that is, on inequality. Therefore, the wealth or income of the country (such as the gross domestic product), as well as the income inequality within countries (or geographic areas) are two ways in which income at the country level is related to the health of the population (Marmot, 2002).

Despite doubts expressed about the inequality-health effect (e.g., Beckfield, 2004), several studies have supported the relationship between inequality and health. A meta-analysis of 54 articles (published between 1997-2008; Kondo et al., 2009), and a review of 155 articles (published between 1975-2005; Wilkinson and Pickett, 2006) concluded that countries with higher income inequality had lower levels of health (e.g., higher mortality and poor self-rated health). This research included international, national and regional studies, in which larger-scale studies were more supportive of the relation between income inequality and health. The most common indicators used to measure health outcomes are life expectancy, mortality, self-rated health, and mental health (e.g., depression), but also indicators of public health such as violent crime (e.g., homicides) and drug abuse. More recently, a literature review, within an epidemiological causal framework, was supportive of a causal relationship between inequality and health, considering the criteria of temporality, biological plausibility, consistency, and lack of alternative explanations (Pickett & Wilkinson, 2015).

1.1.Mechanisms explaining the inequality-health relationship

The social gradient interpretation (Marmot, 2002) suggests that the lower the social status, the poorer the health, because people of low socioeconomic status have lower control over their life and public participation than people of higher status (which could be predicted by income and education). In addition, two main approaches, related at some level, try to explain the mechanisms through which income inequality affects health, related to social comparison and social capital. First, the social comparison approach suggests that inequality leads to stress and anxiety, decreasing social trust and increasing competition (Wilkinson & Pickett, 2006; Wilkinson & Pickett, 2010). Second, the social capital approach suggests that inequality decreases social capital, through lower civic trust and public participation, which conducts to poorer health (Kawachi et al., 1997; Kawachi & Kennedy, 1999).

Social capital (or social cohesion) has been defined as the characteristics of social organizations that facilitate cooperation, such as public participation, trust in others, norms of reciprocity, and values of solidarity, equality, and mutual tolerance (Coleman, 1990; Putnam, 1993). Low levels of civic trust and associational membership (e.g., sports groups, fraternal organizations, labour unions) were found to be positively correlated with income inequality and mortality, suggesting that social capital could mediate the effect of inequality on mortality (Kawachi et al., 1997). Another possible path is that income inequality is negatively associated with trust, which in turn predicts lower public participation (Uslaner & Brown, 2005).

Given that inequality was associated with lower political trust (Zmerli & Castillo, 2015), political participation (Solt, 2008), and voter turn-out (Cancela & Geys, 2016), and associated with higher corruption, debt, and financial crashes (Iacoviello, 2008; Wisman & Baker, 2011; You & Khagram, 2005), inequality could be a threat to democracy. In turn, the political and economic context influences the investment in public infrastructure and material conditions, such that inequality influences the resources available to health and medical expenditure (Lynch et al., 2000).

Disabled people have poorer health status on secondary conditions (e.g., cardiac disease, high blood pressure, high cholesterol, diabetes, stroke, asthma) and receive fewer preventive services than non-disabled people (Reichard et al., 2011, 2014). Yet research has focused on the relationship between inequality and impairment (e.g., mental illness, physical morbidity), but not on how inequality determines the health and well-being of disabled people. Moreover, I contend that despite the existence of social policies - such as personal assistance – with positive consequences for the health and well-being of disabled people, the effectiveness of these policies and their interaction with the social determinants of health remains unknown. Therefore, in this thesis, I explore the association between (a) wealth and health, (b) equality and health, as well as (c) the role of personal assistance in these relationships, among disabled people. In addition, (d) I explore the role of socio-psychological mechanisms such as public participation, satisfaction with the political and economic situation, and perception/opinion about the health services, in the relationship between equality and health. In this work, I am especially interested in the effect of equality and its interaction with personal assistance, due to the possible relevance of personal assistance for disability equality.

2. Personal Assistance – A social policy for equality

Personal assistance [PA] is a support service for daily living activities, directed to disabled people and enacted by the state. It is based on the *independent living philosophy* created by the disability rights movement, which posits that disabled people should have the same *choice* and *control* over their lives as non-disabled citizens, through ensuring an accessible built environment, access to information and communication, and availability of technical aids and *community-based services*, like personal assistance (European Network on Independent Living, n.d., 2022a; Morris, 2004). In that sense, personal assistance is a tool for disabled people to have control over their lives and have the opportunity to live and participate in the community, like other citizens. Therefore, based on autonomy and self-determination, the core principle of personal assistance is that disabled people must have full control over the service, including the recruitment, selection, training, and management of assistants and schedules. Therefore, PA differs from traditional home care services (as the terminology of *assistance* versus *care* indicates), in which the users are treated as patients and have few or no choices over the services (Beatty et al., 1998). Another central principle of this policy is the practice of peer support through user-led organizations (e.g., centres for independent living) that should support users with related tasks such as advertising, recruitment, wages, employment law, training, and decision-making processes for those who need support in these tasks (Barnes, 2007; Ratzka, 2004). The characteristics of personal assistance, as well as its development, are presented based on the dimensions of Nancy Fraser's theory of social justice, which may help to explain the role of PA for equality.

2.1. Personal assistance under the theory of social justice

Fraser's theory of social justice (1995, 1996) is a political philosophical theory that conceptualizes social justice and has been a powerful critical theory for exploring social injustices, including gender, race, class, and sexuality. In addition, social justice theory has been applied to disability studies and politics. For instance, Mladenov explored social justice from the perspective of disability (2016), and analysed disability politics in the post socialist countries of Central and Eastern Europe through social justice theory (2017).

Fraser (1995, 2006) defines social justice as "parity of participation", composed of three distinct but intercorrelated dimensions: economic redistribution, cultural recognition and political representation. While the dimension of redistribution concerns the material resources needed to participate in social life, the recognition dimension refers to the value of difference and respect of people as full participants in social life. In addition, political representation refers to the inclusion of those who are affected by public decision making about policies that concern them, such as redistribution and recognition matters. Like other social movements, the disability rights movement, and specifically personal assistance, demands equality not only through the redistribution of economic resources, but especially through the recognition of disabled people as equal citizens, with the right to choose and exert control over their own lives, and, therefore, through political representation.

Personal assistance and economic redistribution

Personal assistance [PA] has been considered an essential tool for inclusion and deinstitutionalization (e.g., European Network on Independent Living, n.d., 2022b), which means the transfer of economic resources from residential institutions to services in the community, such as personal assistance. In addition, personal assistance is based on the principle that to guarantee full control over the service, the money should be channelled through the recipient (i.e., through *direct payments* or *personal budgets*), who will be the employer of the service. This implies a reconfiguration of the redistribution of economic resources from traditional care services to disabled people themselves and to user-led organizations. Several European countries have enacted personal assistance, but the characteristics of PA schemes vary widely (e.g., in terms of level of administration, funding arrangements, amount of control disabled people have over the service, and criteria of selection). There are countries in which PA is still only a regional or municipal scheme (as is the case of Belgium, where PA is available in the regions of Flanders and Wallonia, or in the case of Bulgaria, in which PA is available in Sofia municipality), or could be provided through a national project or user-led organizational projects (as is the case in Slovenia, Iceland, and Ireland; see more about PA in European Countries in European Network on Independent Living, 2015)[4]. It was the pressure from

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[4] In Portugal, a national pilot project on personal assistance was ratified in 2017 and participants started to have personal assistance in 2019. The project should eventually be enshrined in legislation; however, at present, it has been extended for one more year. In the case of Portugal, we can consider that independent living and personal assistance arose from the collective actions of disabled people, especially from the creation of the "Movement of the Disabled Outraged" (free translation of "Movimento dos (d)Eficientes Indignados") in 2012 and a relevant conference led by the movement in 2013. However, there was also political support, more precisely from the municipality of Lisbon, which carried out the first pilot project of personal assistance in 2015, for 5 people, for 3 years. At this time, the first independent living centre was created in Portugal. In addition, the 21st Portuguese Government (elected in November 2015), a Socialist Government with the support of the left-wing parties, enacted this national project on personal assistance.

international policy together with the availability of EU Structural Funds that pushed the adoption of PA legislation in central and eastern European countries (Mladenov & Petri, 2019).

Personal assistance and cultural recognition

The social philosophical recognition theory (Honneth, [1992] 1996) distinguishes three forms of recognition from which individuals perceive themselves as self-determining agents: needs-based recognition in the form of care and love, characteristic of intimate relationships; achievement-based recognition in the form of social esteem, typical of professional and market relations; and equality-based recognition in the form of respect, distinctive of legal and political relations. Therefore, equality-based recognition is specially embedded in the modern laws and constitutions of equal rights and dignity for all people, providing a solid institutional basis for respect based on equality. In the same direction, the theory of social justice argues that cultural recognition is an essential pilar of "parity of participation" along with economic redistribution, as both dimensions should be mutually indispensable (Fraser, 1995).

The Convention on the Rights of Persons with Disabilities provides a legal and institutional basis for the recognition of disabled people's rights concerning "living independently and being included in the community", on an equal basis with others, through access to a range of community-based services, including personal assistance (2006, Article 19). In addition, legislation on personal assistance provides a legal framework in which disabled people are recognized as a valued and respected group in society, while it implies an economic redistribution. Moreover, the core principle of personal assistance is the choice and control that disabled people have over their lives, that is, over the service. A previous analysis of the understandings of the human being underlying the principles of Personal Assistance associates the principles of autonomy and independence with Heidegger's ([1927] 1962) notion of *being in the world*, in the sense that "free choice and subject-centred control are nevertheless mediated by choice-facilitating practices in which humans engage in their being-in-the-world" (Mladenov, 2012, p. 252). In accordance, the notion of individuality as self-determination (autonomy or independence), as opposed to individuality as differentiation, means universal equality among people because it is based on the removal of social constraints and people's freedom from restrictions (see Simon, 2007). Therefore, personal assistance is driven by the recognition of disabled people as equal citizens and thus (equally) respected by the government/society.

Personal assistance and political representation

PA was driven by the disabled people's movement and constrained by political systems and ideologies. Until the end of the 1980s, disability was understood mainly through a medical-productivist lens, in which disabled people were considered unable to work and subjected to paternalistic welfare policies, that placed them in a cycle of poverty and segregation (Mladenov & Petri, 2019). In the 1960s, a disability rights movement named the independent living movement started in the USA and originated with the establishment of the first Centre of Independent Living in California, followed by the creation of a network of centres and the first personal assistance schemes in the USA during the 1970s (DeJong, 1979).

The movement expanded through Europe with the development of a network of Centres for Independent Living, which promoted peer support and collective action for personal assistance policies (Madlenov, 2012; see Askheima et al., 2014 for more about PA in the Scandinavian context). It started with the creation of the first centre for independent living, in Sweden (Ratzka, 1993), and then in the United Kingdom (Evans, 2003), which led to the adoption of PA legislation in both countries during the 1990s. Since then, PA has been implemented in different welfare regimes, such as social-democratic (e.g., Sweden), liberal (e.g., the United Kingdom), and conservative-corporatist (e.g., Germany, Switzerland), although countries with conservative-corporatist welfare regimes seem to provide less supportive opportunity structures for policy change regarding PA, in comparison to other welfare regimes (Tschanz, 2018). On the other hand, neoliberal politics viewed personal assistance, as well as *personalization*, as an opportunity to improve economic efficiency through marketization and privatization of services (Clarke, 2006; Mladenov, 2012; Mladenov et al., 2015; Prandini, 2018). However, although both types of services – PA and person-centred services – are anchored in the same values of greater autonomy and choice for service users, and share some problems in their implementation (e.g., marketization), disability scholars and activists have argued that they are distinct social policies (see Madlanov et al., 2015, for a cross-sectorial perspective considering personalization in disability services and personalization in healthcare). The main difference is in their genealogy: while personal assistance/ direct payments are based on a bottom-up process sustained by a collective identity and inclusive agendas, personalization never ceased to be a top-down process dominated by professional and biomedical agendas (Mladenov et al., 2015). In addition, personal assistance / direct payments are strongly based on collectivism, through the establishment of peer support as an essential key to self-determination (Mladenov, 2012), which is not the case for any another type of personalized service. Therefore, personal assistance is usually a bottom-up process that implies the participation and political representation of disabled people.

2.2. Direct outcomes of personal assistance

The impact of PA has been primarily studied in the USA context with positive effects reported on variables related to the service as well as on the health and well-being of disabled people. Regarding the outcomes related to the service, people receiving personal assistance had higher levels of satisfaction with the delivery of services, including the cost of services, control over assistants' schedule, availability of assistants, safety, and consumer-assistant interactions, than people in the waiting-list group (Beatty et al., 1998). Through cross-sectional studies, researchers collected several measures with a survey and compared the results between those who managed their personal assistance and those who received home care services from an agency. Participants with personal assistance reported having more satisfaction with the service, more choices over the service, a higher sense of security, fewer unmet needs in daily living activities, and greater control over the service, than agency-directed participants (Benjamin et al., 2000; Fleming-Castaldy, 2011; Hagglund et al., 2004). A longitudinal study measured the outcomes of participants who received assistance from an agency and then changed to personal assistance, and found that participants reported more satisfaction and safety with the service, and fewer unmet needs after receiving personal assistance than after receiving assistance from an agency (M. J. Clark et al., 2008).

Regarding the impact of PA on well-being, people that received personal assistance reported better health outcomes, with fewer re-hospitalizations for preventable conditions, better life satisfaction and lower costs, than those receiving care from an agency (Mattson-Prince, 1997). In addition, compared to people receiving agency care services, people receiving personal assistance reported greater quality of life, which measured participants’ satisfaction with several domains of life, including major occupational roles (i.e., friend, home maintainer, family member and worker), diverse activity dimensions (i.e., creativity, learning, helping and play), individual characteristics (i.e., self-esteem), and several environmental contexts (i.e., home, neighbourhood and community; Fleming-Castaldy, 2011).

A literature review (J. C. Anand et al., 2012) including studies from the UK, Ireland, The Netherlands, USA and Canada, reported positive outcomes for users of direct payments or personal budgets, such as more choice and control over how support is provided, improved personal dignity, better health, better economic well-being, greater quality of life, and support in order to have paid employment, vocational skills training, to take part in volunteer activities and enrol in postsecondary education. They also reported reduced nursing facility use and improved medication management as benefits from personal budgets.

Knowing the direct outcomes of personal assistance, in this thesis, I explore the indirect effects of personal assistance in the relationship between equality and health.

2.3. Indirect effects of personal assistance for equality

The debate on personal assistance and equality has been based on the idea that personal assistance is a key tool for disability equality. As mentioned above, personal assistance includes important features of social justice such as the redistribution of economic resources to enable disabled people's self-determination and *participation*, the cultural recognition of disabled people as equal (respected) citizens, who should have *control* and choice over their lives, and the political representation of disabled people on the matters that concern them, namely on the implementation of the personal assistance policy.

Therefore, personal assistance seems to be an important tool for disabled people to have control over their lives and increase their public participation, the two key ingredients that may explain the relationship between equality and health (e.g., Marmot, 2002), which without personal assistance could be unreachable (for those who need assistance) even in the face of more (income or educational) equality. Similarly, in the case of disabled people, personal assistance may be essential to promote their social capital, that is civic trust and public engagement, another mechanism explaining the relationship between equality and health (Kawachi & Kennedy, 1999; Kawachi et al., 1997). Therefore, personal assistance could be essential to enable the link between equality and health, through specific socio-psychological mechanisms. First, disabled people could be excluded from public participation, due to the social barriers (e.g., lack of accessibility to built environments, political information, and communication; Priestley et al., 2016), that could be overcome by personal assistance, which promotes inclusion in a broad range of social activities (von Granitz et al., 2017). Second, the existence of PA could promote satisfaction with the political and economic context given that a country is investing in egalitarian and inclusive policies for disabled people. Moreover, although policy should be based on human rights *per se*, PA is less expensive than other models of care for public investment (Hurstfield et al., 2007a) and costs at the individual level (Mattson-Prince, 1997). Third, PA could contribute to positive perceptions of health services, given that its presence makes services more accessible to disabled people, who, on average, experience more difficulty in accessing health care and receive less preventive care than the general population (Reichard et al., 2014; World Health Organization, 2011). Moreover, PA has positive health outcomes and is related to fewer re-hospitalisations for preventable conditions (Mattson-Prince, 1997).

Thus, the effects of increasing equality may not have an impact on specific groups without implementing policies that meet the specific needs of each group. In this case, increased equality (represented in income or education) may not affect the health of disabled people if their specific needs are not addressed through other policies, such as personal assistance.

3. This thesis: Research question and aim - Article 3

In Chapter VI/Article 3 I explore how personal assistance may interact with the social determinants of health to shape the well-being of disabled people. In a first step of the analytical approach, I begin by examining the direct relationship between the social determinants at the country level (i.e., wealth and social equality) and the health and well-being of disabled people, and how personal assistance interacts with these relationships. In a subsequent step, I examine how personal assistance moderates the indirect relationship between social equality and the health and well-being of disabled people, through the socio-psychological mechanisms of public participation, satisfaction with democracy and economy, and perception of health services (Figure 3.1).

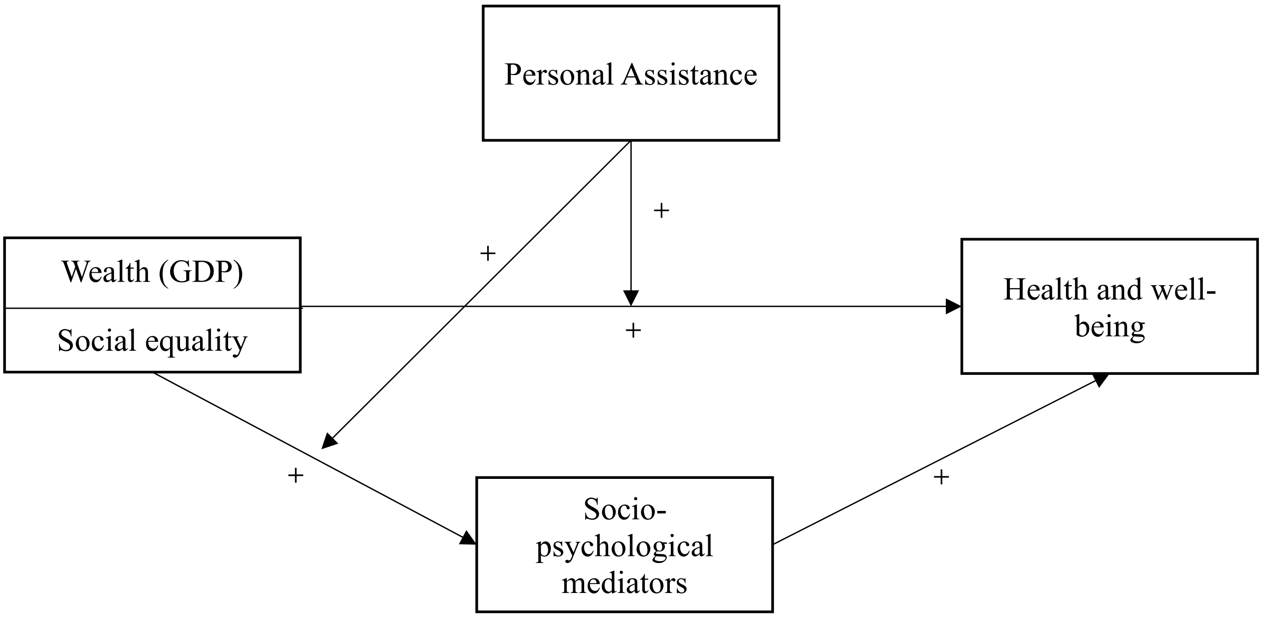
Chapter VI/ Article 3

Question:

Can personal assistance strengthen the relationship between key social determinants (wealth and, especially, social equality) and disabled people's well-being?

Aim:

Analyse the association of both country wealth and social equality with the health and well-being of disabled people, and how the existence of personal assistance could shape this relationship. Identify specific socio-psychological mechanisms underpinning the relationship between social equality and health.



Note. Socio-psychological mediators include public participation, satisfaction with democracy and economy, and perception of health services.

Figure 3.1. Interaction of personal assistance with social equality on health and well-being.

4. Thesis and overview of models

Figure 3.2 illustrates the empirical models in this work. This section (I), from Chapter I to Chapter III, ends with this overview, explaining the content of the remaining sections and chapters while summing up the aims of this work. Section II includes three chapters reporting the empirical studies. Chapter IV (Article 1) compares the effects of ableism on health and well-being against the effects of other types of group-based discrimination. Chapter V (Article 2) includes two studies examining how negative and positive intergroup contact interact to influence the well-being of disabled people and their ingroup identification. Chapter VI (Article 3) analyses the association of both country wealth and social equality with the health and well-being of disabled people, and how the existence of personal assistance (at the country level) could shape this relationship. Additionally, it identifies specific socio-psychological mechanisms (e.g., public participation) underpinning the relationship between social equality and health, moderated by personal assistance. Finally, Chapter VII summarizes and discusses the main findings of these studies, reflecting on their theoretical implications for social psychological framework, as well as practical implications for interventions and social policy in the specific area of disability.

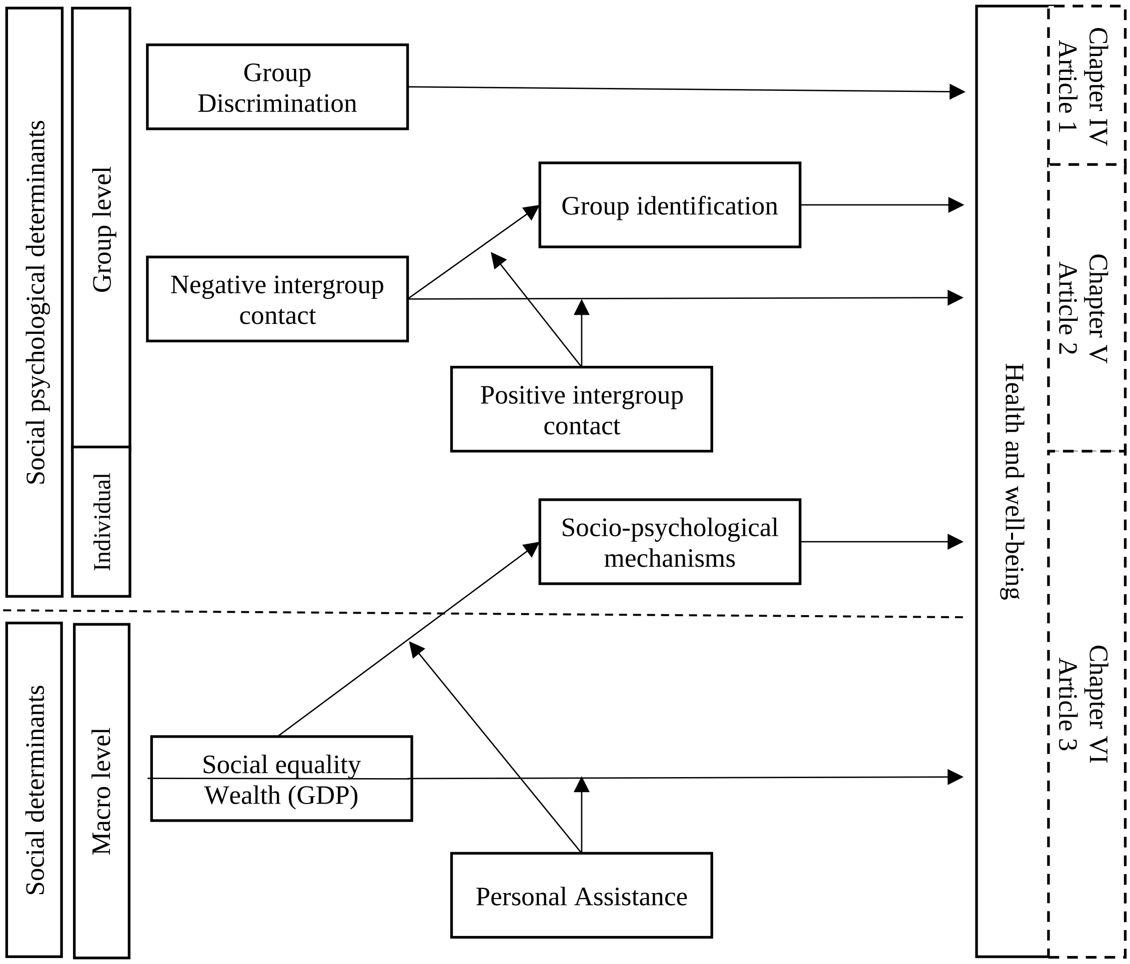


Figure 3.2. Illustration of the empirical models in this thesis.

SECTION II.

Empirical studies

CHAPTER IV.

The association of group-based discrimination with health and well-being: A comparison of ableism with other “isms”

This chapter is published as

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1. Abstract

Discrimination has negative consequences for the health and well-being (HWB) of individuals belonging to disadvantaged groups. Due to social and attitudinal barriers, we argue that disabled people comprise one of the groups most affected by discrimination. Using data from the European Social Survey, including representative samples from 32 countries surveyed in seven waves (2002-2014), we compared the effects of ableism on HWB with discrimination targeting other groups (e.g., sexism, ageism). We tested these effects *between* individuals (i.e., comparing the effects of individuals belonging to different disadvantaged groups) and *within* individuals (i.e., examining the case of individuals belonging to multiple disadvantaged categories). Results indicated that facing ableism is associated with lower HWB, and that this effect has a greater magnitude when compared to the effect of being discriminated because of other disadvantaged group memberships. Our findings highlight the significance of addressing ableism in research and social policy.

Keywords: Discrimination; disability; ableism; health and well-being.

2. Introduction

Group-based discrimination has deleterious consequences for the health and well-being of individuals belonging to disadvantaged groups (Pascoe & Smart-Richman, 2009; Schmitt et al., 2014).These are well-known and established effects, but a curious paradox remains in this field of research – although disabled people are one of the largest social minorities (15% of the world's population; World Health Organization [WHO], 2011), they have received much less societal and academic attention than other disadvantaged groups (e.g., racial minorities). This is, for example, evident with the use of Google searches, which have been validated as measures of social attitudes (Stephens-Davidowitz, 2014) and we use them here to illustrate the relative salience of societal attitudes towards disadvantaged groups. Examining the relative 'popularity' of Google searches worldwide in the last ten years, we found that "racism" averaged a popularity of 43.5, compared with "sexism" (18.1), "ageism" (1.6), and "ableism" (1.04)[5]. Using other more common terms such as "disability discrimination" instead of ableism, or "age discrimination" instead of ageism, revealed the same order of popularity. This paradox is likely to reflect extant norms and societal priorities, whilst mirroring this group's status in multiple societies. In this study, we compare the effect of group-based discrimination against different groups (e.g., ableism, ageism, sexism) on health and well-being. We argue that disabled people may comprise one of the disadvantaged groups that suffers the most from discrimination and, in the face of such evidence, it would be appropriate to challenge this relative lack of knowledge of their plight.

2.1.Conceptualizing disability

According to the social model of disability (Oliver, 1983; Oliver & Barnes, 2010; Shakespeare, 1996), disability derives directly from environmental, social, and attitudinal barriers, contrasting with the individual and medical model (Brisenden, 1986), which focuses the problem on individuals' bodies and minds. Defining disability as a societal problem derived from social barriers, rather than an individual issue, places the onus of change on society (Olkin & Pledger, 2003). Throughout this research, in line with the social model of disability and in accordance with the Movement and Organizations of Disabled People, we use the term "disabled people" to mean that "people are disabled by environmental, systematic, and

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[5] We used Google Trends, which compares terms searched during a specified period of time and provides a "popularity score" for each term, ranging from 0 to 100. One-hundred represents peak popularity, 50 represents medium popularity, and 0 means there were no data available for that term. This analysis was performed on the 13th of March 2019.

attitudinal barriers in society, rather than by their impairment" (European Network on Independent Living, n.d.). In fact, this term has been commonly used by disability rights activists and in disability studies, since the early 90s, as a marker of identity of a group bounded by common social and political experiences (Linton, 2006). It allows disabled people to claim disability as an important aspect of their identity (D. S. Dunn & Andrews, 2015), while the onus of social construction and change remains on society.

Disability has become a broader category over time, incorporating people with a wide range of conditions. According to the Convention on the Rights of Persons with Disabilities (2006, art. 1, p. 4), disabled people are "those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others". Therefore, mental, neurological, or chronic health conditions causing long-term impairments, which in interaction with various barriers may hamper full participation in society, could be considered disabilities. In addition, Bogart and Dunn (2019) note that, from a social model perspective, anyone self-identified or identified by others as having a disability can be considered as such. This broad and inclusive definition of disability is adopted throughout our research.

2.2.Ableism: Discrimination toward disabled people

Stigma is generally based on an attribute and serves as a motive to discount a person and to believe that they are not quite human, supporting discrimination and reducing the target's life opportunities (Goffman, 2006). Ableism has been mostly addressed in disability studies and conceptualized as a set of beliefs and practices that marginalize disabled people and subject them to a "diminished state of being human" (Campbell, 2001, p. 44), through the postulation of an abled corporeal standard that is essential and fully human. It is based on the belief that impairment is inherently negative and the cause of the problems experienced by disabled people (Campbell, 2008), masking the role of the social environment. As such, we argue that ableism is in line with the individual and medical perspective on disability. Moreover, the endorsement of such a perspective is related to the legitimization of the status quo (Dirth & Branscombe, 2017) and justifies the social segregation of disabled people. In this study, we adopt the broad definition, proposed by Bogart and Dunn (2019), equivalent to social psychological definitions of other "isms": *"*Ableism is stereotyping, prejudice, discrimination, and social oppression toward people with disabilities" (*p.* 651).

Research shows that able-bodied individuals tend to have negative attitudes towards disabled people, as well as negative emotional reactions, such as anxiety, avoidance and ambivalence (Dovidio et al., 2011; Vilchinsky et al., 2010). A meta-analysis showed a consistent pattern of moderate to strong negative implicit attitudes toward disabled people (Wilson & Scior, 2014). Over the years, research has identified multiple sources of negative attitudes toward disabled people. These include, for example, social and cultural conditioning, moral beliefs about disability (perception of disability as a punishment for a committed sin or as a justification for a future evil act, triggering unconscious fear), fear of death due to the parallelism between disability and death, and negative stereotypical reactions typically associated with marginalized group members (D. S. Dunn, 2015; Livneh, 1982, 1988).

According to the stereotype content model (Cuddy et al., 2008; Fiske et al., 2002), there are two fundamental dimensions of social perception – warmth and competence – that, in combination, generate distinct emotions of admiration, contempt, envy, and pity. Disabled people have been associated with low competence and high warmth, a combination that elicits pity and sympathy emotions, and thus paternalistic prejudice (Cuddy et al., 2008; Fiske et al., 1999, 2002). At an implicit level, however, disabled people are associated with both low competence and low warmth (Rohmer & Louvet, 2012) - the least positive of the four quadrants that result from crossing low/high warmth with low/high competence. This profile is associated with dehumanization (Harris & Fiske, 2006) and is often only attributed to marginalized groups such as drug addicts and homeless people[6]. Recent studies have shown that implicit prejudice toward disability increased over time between 2004-2017 (Harder et al., 2019). In addition, disabled people's experiences of ableism are associated with paternalism (e.g., unwanted help, infantilization), dehumanization, objectification, hostility (Nario-Redmond et al., 2019), and with denial of equal rights and invalidation (Olkin et al., 2019).

Our argument is that ableism targets a particularly vulnerable group and, as such, may have critical and deleterious consequences for disabled people's health and well-being. One of the reasons for this vulnerability stems from the poor socioeconomic conditions and multiple forms of social exclusion to which they are exposed. Due to social and attitudinal barriers, disabled people tend to have poorer access to health services, education, and employment, together with a higher risk of exposure to violence and poverty (United Nations, 2015; World Health Organization, 2011). Compared to the nondisabled, disabled people have a higher prevalence of secondary chronic diseases and are less likely to receive preventive care (Reichard et al., 2011).

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[6] This discrepancy, between explicit and implicit levels, could be explained by the fact that implicit measures offer less opportunity to control responses, blocking the explicit stereotype content associated with the normative protected group (Rohmer & Louvet, 2012).

Moreover, evidence shows that disability seems to play a central role when compared to other social categories. For instance, the magnitude of socioeconomic disadvantage is lower between disabled women and men, compared to the magnitude between nondisabled women and men (Kavanagh et al., 2015). Perceived gender differences are minimized between disabled women and men, when compared to perceived gender differences between nondisabled men and women (Nario-Redmond, 2010). In line with these findings, research has also shown that blind targets were rated as ruder and less warm after confronting patronizing help, regardless of their gender (K. Wang et al., 2019). In addition, Rohmer and Louvet (2009) found that disabled people are immediately described by disability, independent of their sex or ethnicity, suggesting that disability could be a primary, superordinate and highly salient category. This is supported by a meta-analysis reviewing the effects of perceived discrimination on psychological well-being (Schmitt et al., 2014). Although this work did not compare directly between different types of discrimination, the meta-analysis revealed weaker effect sizes for racism and sexism and larger effect sizes for ableism. Taken together, this body of work suggests that, due to the vulnerable position of disabled people, ableism could be one of the most damaging forms of group-based discrimination.

2.3.The present study

We compare the effects of ableism with the effects of facing discrimination as a member of other disadvantaged groups on health and well-being. We hypothesized that, compared to discrimination against other stigmatized groups (e.g., sexism), discrimination against disabled people would have a stronger (negative) effect on health and well-being. To test this hypothesis, we examined these effects *between* individuals (i.e., comparing the effects of individuals enduring different types of group discrimination; Analysis 1) and *within* individuals (i.e., examining the case of disabled individuals belonging to multiple disadvantaged categories; Analysis 2). While Analysis 1 allows for a comparison between individuals who belong to various stigmatized groups and thus accounts for a broad range of demographic backgrounds, Analysis 2 focuses only on disabled individuals who also belong to at least another stigmatized category. The latter analysis provides a comparison between disabled people and tests, within this group, whether being discriminated on the grounds of disability has a stronger effect on health and well-being than other types of discrimination. In Analysis 2, because all individuals are disabled, it serves to mitigate the effects of unmeasured variables associated with the different stigmatized groups.

3. Analysis 1 – effects of group-based discrimination between individuals

3.1.Respondents and procedure

To address our research question, we analyzed data from the European Social Survey (ESS). This large cross-country survey included nationally representative samples, generated through random probability sampling, from 36 European countries and, at the time of our study, seven waves of cross-sectional data. The ESS is an academically driven and repeated cross-national survey conducted across Europe from 2001 until the present year. Data were collected through face-to-face interviews and included a wide range of measures assessing attitudes, beliefs, and behavior patterns. The ESS has been used across various disciplines (e.g., sociology, social policy, psychology), resulting in multiple publications relevant for social policy and practice.

We selected for analysis all individuals who responded affirmatively to the question "Would you describe yourself as being a member of a group that is discriminated against in this country?", resulting in a total sample available for analysis of 18,660 respondents, from 32 countries. Of these respondents, 53% were female, 34% were disabled, 26% were from an ethnic minority background, and 13% were older adults (i.e., individuals who were 65 and above). On average, respondents of this sample were 42.8 years old (*SD* = 16.5) and had 12.7 years (*SD* = 4.2) of full-time education completed. More details about our sample are reported in see Table 4.1.

3.2.Measures

Group-based discrimination

The perception of discrimination based on group background was measured with the question, "On what grounds is your group discriminated against?*"* in which respondents could choose either "no" (0) or "yes" (1) across several options from the following list: "Color or race", "Nationality", "Religion", "Language", "Ethnic group", "Age", "Gender", "Sexuality", and "Disability". For our analysis, all of these options were used as separate dummy variables and introduced in our model as independent variables to assess perceptions of group-based discrimination. Table 4.2 shows the number of respondents that responded "yes" to each option and percentages by country.

Table 4.1. Sample socioeconomic information by country.

	Country										
Variables	Austria	Belgium	Switzerland	Czech Republic	Germany	Denmark	Estonia	Spain	Finland	France	Great Britain
N	402	726	532	468	804	394	892	524	958	1265	1848
Sex (%)											
Male	51	55	46	45	52	49	44	52	44	47	49
Female	49	45	54	55	48	51	56	48	56	53	51
Age (years)											
M	41.6	43.4	41.8	51.2	41.1	45.2	46.6	38.5	46.6	42.9	47.0
SD	17.1	17.0	14.8	16.5	15.1	16.0	17.1	14.0	17.8	15.4	16.7
Education (years)											
M	12.8	12.8	12.3	12.3	13.5	13.4	13.0	13.4	13.2	13.0	13.9
SD	4.0	4.1	4.1	2.5	3.8	4.9	3.1	6.2	4.3	4.0	4.1
Born in country (%)											
Yes	71	75	62	96	76	77	62	75	93	81	86
No	29	25	38	4	24	23	38	25	7	19	14
Belong to minority ethnic group (%)											
Yes	25	24	36	14	25	21	69	20	6	14	19
No	75	76	64	86	75	79	31	80	94	86	81
Hampered (%)											
Yes	32	30	29	52	39	44	28	15	48	33	33
No	68	70	71	48	61	56	72	85	52	67	67
Belonging to a religion (%)											
Yes	62	54	55	29	52	61	52	62	57	50	54
No	38	46	45	71	48	39	48	38	43	50	46
Marital status (%)											
Married	33	47	46	49	41	45	52	44	44	35	44
Separated	2	2	2	1	1	2	1	2	1	1	3
Divorced	12	12	10	16	12	12	14	5	15	15	13
Widowed	8	4	3	17	3	4	9	2	5	4	6
Never married	45	34	38	18	43	36	24	47	35	44	34
Employment status (%)											
Employed	82	85	85	91	89	91	92	87	85	91	86
Self-employed	16	14	13	9	10	8	7	12	13	8	12
Working for own family business	1	1	2	1	1	1	1	1	2	0	1
Ever unemployed (%)											
Yes	40	42	34	37	50	47	40	50	46	52	34
No	60	58	66	63	50	53	60	50	54	48	66
Feeling about household's present income (%)											
Living comfortably	17	25	37	7	16	46	6	24	16	19	30
Coping	49	41	36	29	46	37	44	39	53	48	44
Difficult	22	24	18	35	26	12	32	25	21	26	19
Very difficult	12	10	9	30	11	5	19	12	10	7	7

Table 4.1. (continued)

	Country										
Variables	Hungary	Ireland	Israel	Lithuania	Netherlands	Norway	Poland	Portugal	Sweden	Slovenia	Bulgaria
N	567	639	1683	196	944	616	497	343	920	267	551
Sex (%)											
Male	49	50	50	37	45	51	50	42	36	51	42
Female	51	50	50	63	55	49	50	58	64	49	58
Age (years)											
M	41.8	41.5	39.4	52.1	43.5	42.0	43.8	44.2	43.8	41.3	49.2
SD	15.2	15.6	16.1	17.2	16.1	16.0	16.7	17.2	17.9	15.9	16.5
Education (years)											
M	10.8	14.1	13.3	13.1	13.4	13.8	12.4	8.8	13.5	12.6	10.0
SD	4.1	4.3	3.9	3.1	4.2	4.1	3.6	4.6	3.7	3.8	3.9
Born in country (%)											
Yes	97	69	83	92	77	82	99	62	79	90	99
No	3	31	17	8	23	18	1	38	21	10	1
Belong to minority ethnic group (%)											
Yes	43	18	46	25	27	16	3	21	13	9	50
No	57	82	54	75	73	84	97	79	87	91	50
Hampered (%)											
Yes	40	24	16	56	43	39	45	27	42	43	27
No	60	76	84	44	57	61	55	73	58	57	73
Belonging to a religion (%)											
Yes	56	66	95	88	45	57	84	72	36	60	83
No	44	34	5	12	55	43	16	28	64	40	17
Marital status (%)											
Married	48	39	62	49	40	39	53	41	36	48	51
Separated	1	8	0	0	1	2	2	3	1	0	1
Divorced	15	5	7	16	13	10	6	8	14	5	9
Widowed	6	5	3	18	5	3	9	9	4	3	14
Never married	30	44	28	17	42	46	30	39	45	44	24
Employment status (%)											
Employed	94	85	84	97	87	88	82	83	90	90	94
Self-employed	5	14	15	2	12	11	16	16	9	5	5
Working for own family business	1	1	1	1	1	1	2	1	1	5	2
Ever unemployed (%)											
Yes	52	45	28	31	38	31	41	45	36	36	65
No	48	55	72	69	62	69	59	55	64	64	35
Feeling about household’s present income (%)											
Living comfortably	2	17	15	10	29	44	6	5	41	28	1
Coping	22	40	40	41	41	37	40	34	38	49	12
Difficult	29	24	27	27	21	13	45	32	16	15	20
Very difficult	47	18	18	22	8	5	10	29	5	8	67

Table 4.1. (continued)

Variable	Cyprus	Greece	Iceland	Italy	Luxembourg	Slovakia	Turkey	Ukraine	Kosovo	Croatia
N	166	495	165	64	110	315	338	259	626	86
Sex (%)										
Male	39	43	37	61	51	43	46	43	39	55
Female	61	57	63	39	49	57	54	57	61	45
Age (years)										
M	41.3	42.4	45.6	43.4	36.8	43.3	33.1	50.7	48.6	51.7
SD	16.4	16.4	16.9	15.4	13.4	16.0	12.1	17.9	18.2	16.4
Education (years)										
M	12.5	10.6	14.8	13.0	12.5	12.2	7.5	12.3	12.4	11.8
SD	4.3	4.2	4.2	5.7	3.9	3.8	4.5	3.5	3.2	4.1
Born in country (%)										
Yes	78	63	95	89	52	97	99	80	90	85
No	22	37	5	11	48	3	1	20	10	15
Belong to minority ethnic group (%)										
Yes	13	30	4	13	25	32	33	14	21	14
No	87	70	96	88	75	68	67	86	79	86
Hampered (%)										
Yes	27	20	33	23	29	32	19	63	51	43
No	73	80	67	77	71	68	81	37	49	57
Belonging to a religion (%)										
Yes	98	90	47	66	55	78	92	67	60	74
No	2	10	53	34	45	22	8	33	40	26
Marital status (%)										
Married	54	58	45	56	53	57	60	55	41	69
Separated	0	1	6	2	3	0	1	1	1	0
Divorced	11	5	10	5	5	6	2	9	18	5
Widowed	5	8	6	2	3	8	4	21	20	11
Never married	30	28	33	36	37	28	33	13	19	15
Employment status (%)										
Employed	83	71	85	70	91	91	79	95	94	89
Self-employed	12	28	12	26	9	7	18	3	5	7
Working for own family business	6	1	3	4	0	2	3	2	1	4
Ever unemployed (%)										
Yes	33	45	24	42	27	49	25	43	33	48
No	67	55	76	58	73	51	75	57	67	52
Feeling about household’s present income (%)										
Living comfortably	10	6	36	21	37	4	9	2	3	22
Coping	32	25	33	49	35	33	44	12	25	38
Difficult	35	34	18	24	14	32	28	39	39	20
Very difficult	24	35	13	6	15	30	20	48	33	20

Table 4.2. Percentages of individuals affirming that they belong to a group that is discriminated in society by type of discrimination and country.

	Group-based discrimination								
Countries	Race/color	Nationality	Religion	Language	Ethnicity	Age	Gender	Sexuality	Disability
N	2754	3578	3278	2002	2421	2460	2021	944	1404
Austria	8.7	23.9	15.9	12.4	8.7	10.7	15.2	11.2	4.7
Belgium	18.7	18.3	23.1	9.9	5.9	6.6	4.5	5.9	7.4
Switzerland	10.2	29.1	16.9	5.5	11.1	5.1	11.8	8.6	6.4
Czech Republic	16.5	6.2	5.3	1.5	6.6	39.7	15.6	3.4	16.2
Germany	5.6	22.9	13.1	10.0	13.8	5.7	9.0	9.0	9.1
Denmark	17.0	11.9	20.3	7.1	11.9	10.7	5.3	5.1	9.6
Estonia	.1	55.5	2.0	59.3	3.6	12.7	6.8	1.5	4.8
Spain	16.4	23.3	16.4	9.9	5.0	5.2	11.5	7.4	5.2
Finland	2.5	3.0	7.6	9.5	2.9	15.8	7.7	4.9	5.9
France	22.3	9.6	13.4	2.8	6.6	6.2	11.5	5.5	7.0
Great Britain	25.7	14.7	22.3	2.2	8.9	16.6	13.4	7.6	6.9
Hungary	34.9	18.7	6.0	1.8	34.9	15.2	3.5	.7	8.3
Ireland	11.4	19.2	14.9	2.8	6.3	12.4	11.6	5.8	7.8
Israel	24.0	44.7	46.8	31.9	28.0	11.5	16.2	7.0	8.0
Lithuania	1.0	6.1	6.6	13.8	12.8	46.9	6.6	3.6	13.8
Netherlands	19.1	18.0	21.3	3.8	10.7	11.0	7.9	10.8	9.5
Norway	7.8	8.6	18.3	3.1	11.5	6.7	11.5	6.2	11.5
Poland	.8	2.0	15.7	1.0	1.0	13.7	9.7	1.0	14.1
Portugal	21.6	19.2	13.1	2.0	5.0	12.0	3.5	3.5	5.5
Sweden	5.8	11.6	9.0	5.5	9.1	15.1	33.3	3.6	8.4
Slovenia	5.6	3.4	19.5	2.6	15.7	9.7	10.5	5.2	15.4
Bulgaria	10.9	6.9	7.8	5.6	43.6	31.4	5.4	.4	7.6
Cyprus	7.2	22.9	9.0	4.2	2.4	7.8	7.2	10.2	6.0
Greece	15.2	37.8	10.9	6.1	4.2	14.1	10.3	2.6	3.6
Iceland	1.8	1.8	3.0	1.2	2.4	16.4	24.8	1.8	8.5
Italy	7.8	10.9	20.3	0.0	4.7	6.3	9.4	9.4	3.1
Luxembourg	8.2	38.2	7.3	10.0	1.8	0.0	4.5	3.6	8.2
Slovakia	23.8	15.2	4.4	4.8	20.0	20.3	9.2	.6	7.3
Turkey	6.8	16.3	24.9	25.7	23.7	14.8	4.7	2.7	.6
Ukraine	6.6	3.9	7.7	18.1	10.8	20.8	3.1	.4	9.7
Kosovo	5.4	4.8	8.3	4.0	22.0	31.3	7.7	3.0	12.6
Croatia	0.0	5.8	9.3	0.0	2.3	27.9	7.0	1.2	12.8

Note. *N* is the number of respondents that nominated each group-based discrimination. Percentages are relative to the number of respondents that nominated each group-based discrimination in each country (row).

Health and well-being (HWB)

The Constitution of the World Health Organization (1948, p. 1) defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". Thus, health (and well-being) cannot be reduced to a single factor. As such, we measured health and well-being by averaging answers to questions on self-rated happiness, satisfaction with life, and health: "Taking all things together, how happy would you say you are?" (answers ranging from 1, "extremely unhappy" to 10, "extremely happy"); "All things considered, how satisfied are you with your life as a whole nowadays?" (answers ranging from 0, "extremely dissatisfied" to 10. "extremely satisfied"); and "How is your health in general?" (answers ranging from 1, "very good" to 5, "very bad"), which was reversed-scored. Responses to the three questions were standardized and then averaged to yield a measure of HWB (α = 0.71, with only one factor explaining 65% of the variance emerging from an exploratory factor analysis). A higher score on this variable indicated better HWB. Table 4.3 shows HWB mean scores by group-based discrimination and country. In support of our measure, self-reported measures of general health, happiness, and satisfaction with life have been widely used to measure health and well-being (e.g., Pascoe & Smart-Richman, 2009; Schmitt et al., 2014), and these three measures have been found to be highly correlated in previous research (A. E. Clark & Oswald, 1994; Kahneman & Sugden, 2005).

Individual-level controls

We controlled for a wide range of relevant individual-level characteristics, associated with health and well-being (e.g., Wilkinson & Marmot, 2003). We included the following variables and coding: sex (1 = Male), born in country (1 = No); belonging to minority ethnic group in country (1= Yes); hampered in daily activities by illness/disability/infirmity/mental problem (1 = Yes); belonging to a religion (1 = No); marital status coded with 4 dummies, using the reference group "Married" (1 = Separated; 2 = Divorced; 3 = Widowed; 4 = Never married); employment status, coded with 2 dummy variables, with the reference group "Employee" (1 = Self-employed, and 2 = Working for own family business); ever unemployed and seeking work for a period more than three months (1 = Yes); and, feeling about household's income, coded with 3 dummy variables, using the reference group "Coping on present income" (1 = Living comfortably on present income; 2 = Difficult on present income; 3 = Very difficult on present income). We also controlled for other continuous and ordinal variables for which we maintained the original coding. These included age; years of education completed; how often meet socially with friends, relatives or colleagues; take part in social activities compared to others of same age; state of education in country; and state of health services in country.

Table 4.3. Mean health and well-being (HWB) scores by type of discrimination and country.

	Group-based discrimination								
Countries	Race/color	Nationality	Religion	Language	Ethnicity	Age	Gender	Sexuality	Disability
M	2.03	2.11	2.57	2.00	1.83	1.47	2.36	2.53	1.14
Austria	2.56	2.30	2.23	2.37	2.59	1.84	2.09	2.39	1.84
Belgium	2.35	2.47	2.62	2.65	2.53	2.19	2.72	2.66	.98
Switzerland	2.22	2.66	2.73	2.81	2.39	2.86	2.59	2.92	.87
Czech Republic	1.31	1.42	.75	2.07	1.68	1.08	1.85	1.95	.52
Germany	1.72	2.20	2.31	2.21	2.13	1.50	2.06	2.23	.84
Denmark	2.88	3.01	2.95	2.75	3.10	2.85	2.66	2.90	1.66
Estonia	1.55	1.42	1.70	1.45	1.69	.77	1.84	2.93	.10
Spain	2.32	2.16	2.63	2.53	1.94	2.20	2.31	2.27	1.85
Finland	2.90	2.48	3.20	3.08	2.60	2.50	2.66	2.78	2.17
France	1.83	1.86	2.09	2.04	1.83	1.20	2.02	2.31	1.06
Great Britain	2.34	2.23	2.66	2.29	2.24	2.27	2.49	2.70	1.34
Hungary	.79	.80	1.59	1.04	1.00	.09	.77	1.98	.08
Ireland	2.11	2.32	2.72	2.69	2.08	2.13	2.05	2.24	1.53
Israel	2.53	2.65	2.93	2.52	2.53	2.17	2.71	2.52	2.04
Lithuania	-1.92	1.80	1.55	.95	1.64	.79	1.41	1.88	-.44
Netherlands	2.60	2.55	2.84	2.24	2.53	2.20	2.62	2.79	1.54
Norway	2.70	2.66	3.14	2.71	2.89	2.46	2.88	2.77	1.98
Poland	2.20	1.11	2.29	1.96	2.95	.85	1.80	1.35	1.20
Portugal	1.92	1.90	1.70	1.93	1.38	.77	2.17	1.93	.36
Sweden	2.33	2.62	2.89	2.56	2.36	2.38	2.78	2.93	1.83
Slovenia	1.97	1.59	2.50	2.88	1.68	1.55	2.48	2.76	.75
Bulgaria	-.26	.27	1.06	.49	.25	.03	.33	.51	-.34
Cyprus	1.86	1.72	2.92	1.66	2.37	2.33	1.52	2.21	.57
Greece	1.33	2.04	2.27	2.04	1.49	1.00	1.92	2.99	.36
Iceland	2.99	1.99	3.44	2.04	2.88	2.83	3.50	3.22	2.17
Italy	2.48	1.65	2.46	-	3.07	.63	2.68	2.18	.43
Luxembourg	2.04	2.33	2.28	2.91	2.28	-	3.38	3.23	1.46
Slovakia	1.73	1.01	2.00	1.77	1.19	.89	1.95	4.25	1.04
Turkey	.54	.76	1.57	.72	.67	.47	1.50	3.00	-.04
Ukraine	1.41	1.86	1.11	.34	.73	-.30	.44	1.22	.11
Kosovo	1.34	.97	1.99	1.87	1.63	.48	1.55	.76	.09
Croatia	-	2.57	3.42	-	.45	1.24	2.04	4.22	-.48

Note. HWB scores are standardized. Minimum value was -3 and maximum value was 7. Mean of HWB was 2.01 (*SD* = 1.708) in the sample of Analysis 1.

Country-level controls

To account for contextual variables associated with individual health and well-being (Marmot et al., 2012), we included additional variables at the country-level. These variables included macro-level indicators such as country wealth, social inequalities, and life expectancy. Country wealth was measured with the gross domestic product (GDP per capita in current US$) using World Bank data. We created a social inequalities measure using a dissimilarity index (Massey & Denton, 1988) containing respondents' educational distributions. Life expectancy was measured with life expectancy at birth (in years) using World Bank data. These data were matched by country and year. A higher score on these variables indicates, respectively, higher wealth, social equality, and life expectancy.

3.3.Data analysis

The ESS is not longitudinal and in each wave different respondents were sampled. With this characteristic in mind, we performed a multilevel repeated cross-sectional analysis (Fairbrother, 2014) within the structural equation modeling (SEM) framework, using Mplus 8.0. This approach allowed us to account for dependence due to the hierarchical structure of the data (i.e., individuals nested within countries and waves), through a three-level model in which respondents were nested within country-waves, which in turn were nested within countries. With this model specification, it is possible, at a higher hierarchical level, to control for differences between countries by introducing a coefficient representing the mean of each country-level variable across all available waves for each country. It also allowed us, at an intermediate level, to control for within country changes by introducing a coefficient representing how much a country had changed in each wave relative to its mean value across waves. Therefore, we had two coefficients per variable by disaggregating each variable into a between-country coefficient (time-invariant) and a within-country coefficient (time-variant, representing change). We also included in our equation a linear effect of time, through the inclusion of a variable corresponding to survey year, to account for time trends in coefficients. This method provided the added value of accounting for differences between countries, whilst accounting for within-country changes. Moreover, this modeling technique allowed us to take full advantage of all waves of the ESS and to consider the evolving nature of the social context in which respondents were embedded.

At the individual-level, we coded all "don't know", "refuse to answer", and no responses as missing values. The total number of missing values in the ESS is generally low (around 5%). We used full information maximum-likelihood estimates with robust standard errors (MLR), which allows estimation with missing data and produces less biased results than other methods (Little & Rubin, 2002). This estimation method has the advantage of using all observed data.

In addition, we used a variable to weight the sample, composed by an interaction of design weight and population size weight. Design weight allows us to correct for possible sample selection bias, related to the inclusion probabilities of some individuals in the population. Population size weight guarantees that each country is represented in proportion to its population size. These weights are provided by the ESS to adjust for sampling error, allowing us to obtain more accurate estimates based on the proportion of individuals in society.

In this analysis, we compared the effects of group-based discrimination on the HWB of people belonging to different disadvantaged groups, by simultaneously introducing all types of group-based discrimination in our analysis. We first estimated a model without control variables, followed by a model controlling for both individual- and country-level variables. We then used a z test to compare dependent and overlapping correlations (O. J. Dunn & Clark, 1969) between group-based discrimination against the different groups. To avoid having multiple comparisons of all groups, we compared only those who showed a statistically negative effect of group-based discrimination on HWB.

4. Results

The SEM multilevel model yielded a good fit as shown by the comparative fit index (CFI), root mean square error of approximation (RMSEA), and standardized root mean square residual (SRMR) indices (CFI = 0.99; RMSEA = 0.001; SRMR = 0.001). Comparison between models revealed that the model including the control variables had higher predictive power than the model without the controls, as shown by the lower scores in the fit indicators (i.e., log-likelihood, Akaike information criterion, and Bayesian information criterion) and by a lower proportion of unexplained variance (Table 4.4)[7]. Results showed that only discrimination based on age, $b = -.133$; $p < .001$, and disability, $b = -.267$; $p < .001$, were negatively and significantly associated with lower HWB. When compared to the effect of being discriminated based on age, the effect of discrimination based on disability had a greater magnitude, $z = -13.4726$, $p < .001$.

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[7] Main effects were the same in both models (except for gender which was significant without control variables), indicating that control variables did not cancel out or reverse the main effects.

Table 4.4. Effects of group-based discrimination between individuals.

		Health and Well-being	
	Variables	Without control variables	With control variables
Within level coefficients	Discrimination based on:		
	Color or race	-0.082 (0.084)	-0.063 (0.079)
	Nationality	-0.028 (0.543)	-0.040 (0.226)
	Religion	0.426 (0.000)***	0.195 (0.000)***
	Language	-0.065 (0.440)	-0.022 (0.706)
	Ethnic group	-0.096 (0.153)	-0.024 (0.532)
	Age	-0.444 (0.000)***	-0.133 (0.000)***
	Gender	0.276 (0.000)***	0.007 (0.800)
	Sexuality	0.354 (0.000)***	0.126 (0.010)*
	Disability	-0.918 (0.000)***	-0.267 (0.000)***
Within level coefficients (control variables)	Sex (male)	-	0.134 (0.000)***
	Age	-	-5.362 (0.004)**
	Education	-	0.017 (0.000)***
	Born in country	-	-0.051 (0.164)
	Belong to minority ethnic group	-	0.090 (0.051)
	Hampered	-	-0.672 (0.000)***
	Belonging to a religion (no)	-	-0.028 (0.303)
	Marital status: ref. married		
	Separated	-	-0.594 (0.000)***
	Divorced	-	-0.365 (0.000)***
	Widowed	-	-0.403 (0.000)***
	Never married	-	-0.280 (0.000)***
	Employment status: ref. employed		
	Self-employed	-	-0.020 (0.666)
	Working for own family business	-	-0.084 (0.439)
	Ever unemployed	-	0.241 (0.000)***
	Feeling about household’s income: ref. coping on present income		
	Living comfortably on present income	-	0.344 (0.000)***
	Difficult on present income	-	-0.466 (0.000)***
	Very difficult on present income	-	-1.084 (0.000)***
	Socially meet	-	0.101 (0.000)***
	Take part in social activities	-	0.165 (0.000)***
	State of education	-	0.052 (0.000)***
	State of health services	-	0.099 (0.000)***
Unexplained variance		2.424 (0.000)***	1.678 (0.000)***
Between level coefficients (control variables)	Wave	-	0.071 (0.043)*
	GDP (average)	-	0.613 (0.020)*
	GDP (change)	-	-0.352 (0.148)
	Equality (average)	-	0.671 (0.204)
	Equality (change)	-	1.512 (0.191)
	Life expectancy rate (average)	-	0.028 (0.202)
	Life expectancy rate (change)	-	-0.056 (0.271)
Unexplained variance		0.428 (0.000)***	0.070 (0.004)**
Fit indicators	Loglikelihood	-43032.340	-31439.821
	Akaike information criterion (AIC)	86088.681	62959.643
	Bayesian inform. criterion (BIC)	86185.185	63273.008
Sample Size	Countries; country-waves;	36; 176;	32; 166
	Respondents	22971	18660

Note. Total sample changes between models, because variables are not available in all countries and respondents. *$p < .05$. **$p < .01$. ***$p < .001$.

This finding suggests that discrimination based on disability (i.e., ableism) has a stronger negative effect on HWB, compared to the effects of discrimination based on membership of other disadvantaged groups, supporting our hypothesis. Discrimination scores based on race, *b* = -.063; *p* = .079, nationality, *b* = -.040; *p* = 0.226, language, *b* = -.022; *p* = 0.706, ethnicity, *b* = -.024; *p* = .532, and gender, *b* = .007, *p* = .800, did not have statistically significant impacts on HWB. In contrast, some disadvantaged groups showed a positive association with HWB. This was the case for discrimination based on religion, *b* = .195; *p* < .001, and sexuality, *b* = .126; *p* = .010. One reason that could explain weaker effects of discrimination would be the perceived illegitimacy of discrimination based on some of these groups (Schmitt et al., 2014), which is associated with a higher minority group identification (Jetten et al., 2011). Positive effects of discrimination have been reported in previous research where there is a strong minority group identification. Research has shown that ingroup identification emerges in the face of discrimination, acting as a buffer of the negative effects of discrimination on well-being (Branscombe et al., 1999; Ramos et al., 2012).

5. Analysis 2 – Effects of group-based discrimination within individuals

5.1.Respondents and procedure

In this analysis we also used ESS data but with a different approach as we considered for analysis only disabled individuals. We used a combination of disability together with other social categories (i.e., sex, age and ethnicity), which appeared in combination with disability, resulting in five subsamples in which disability was always present: disabled women (*n* = 39,091), disabled person over 65 years old (*n* = 25,659), disabled person with a minority ethnic group background (*n* = 3,699), disabled women over 65 years old (*n* =15,199), and disabled women with a minority ethnic group background (*n* = 2,065). These are the most common associations of multiple categories including disability in the literature. Note that we also considered the possibility of including individuals who belonged to more than three disadvantaged groups, but this resulted in small sample sizes, producing unreliable estimates. Moreover, as a more conservative test of our hypothesis, we excluded categories that showed a positive association with HWB in Analysis 1 (religion and sexuality) or were not available in the survey to select as a subsample.

5.2.Measures and data analysis

We used the same measures and analysis strategy as in the previous analysis. However, we now selected the subsample of individuals who were disabled by including all those who had responded “Yes a lot” and “Yes to some extent” to the question, “Are you hampered in your daily activities in any way by any longstanding illness, or disability, infirmity or mental health problem?” In this analysis, we compared the effects of group-based discrimination within the five subsamples of multiple social categories described above. As in our previous analysis, we used a z test (Dunn & Clark, 1969) to compare the statistically negative effects of group-based discrimination on HWB.

6. Results

The SEM multilevel models yielded a good fit to the data (CFI = 0.99; RMSEA = 0.001; SRMR = 0.001). Results supported our initial findings, such that discrimination based on disability had a stronger negative impact on HWB, when compared to the effect of multiple disadvantaged social categories (see Table 4.5). We report below all group combinations and compare the effects of being discriminated on the grounds of disability with the effects of being discriminated because of another category.

Gender and disability. The effect of discrimination based on disability, $b = -0.522$; $p < .001$, had a greater magnitude, $z = 63.709$, $p < .001$, on the HWB of *disabled women* compared to the effect of being discriminated based on gender, $b = -.130$; $p = .037$.

Age and disability. The effect of discrimination based on disability, $b = -.646$; $p < .001$, had a greater negative effect, $z = 51.3635$, $p < .001$, on the HWB of *disabled people over 65 years old* compared to the effect of being discriminated based on age, $b = -0.327$; $p < .001$.

Ethnicity and disability. The effect of discrimination based on disability, $b = -.438$; $p = .003$, had a greater negative effect, $z = 11.1559$, $p < .001$, on the HWB of *disabled people belonging to a minority ethnic group* compared to the effect of being discriminated based on ethnicity, $b = -.217$; $p < .001$,.

Gender, age and disability. The effect of discrimination based on disability, $b = -.630$; $p < .001$, had a greater negative effect, $z = 38.1461$, $p < .001$, on the HWB of *disabled women over 65 years old* compared to the effect of being discriminated based on age, $b = -0.324$; $p < .001$. Discrimination based on gender was not statistically significant, $b = -.072$; $p = .726$.

Table 4.5. Effects of group-based discrimination within individuals.

		Health and Well-being				
	Variables	Disabled women	Disabled over 65 years	Disabled of minority ethnic group	Disabled women over 65 years	Disabled women of minority ethnic group
Within level coefficients	Discrimination based on:					
	Ethnic group	-	-	-0.217 (0.000)***	-	-0.153 (0.043)*
	Age	-	-0.327 (0.000)***	-	-0.324 (0.000)***	-
	Gender	-0.130 (0.037)*	-	-	-0.072 (0.726)	-0.400 (0.154)
	Disability	-0.522 (0.000)***	-0.646 (0.000)***	-0.438 (0.003)**	-0.630 (0.000)***	-0.703 (0.012)*
Within level coefficients (control variables)	Sex (male)	-	0.063 (0.013)	0.129 (0.010)*	-	-
	Age	-0.663 (0.508)	-	0.590 (0.814)	-	2.504 (0.371)
	Education	0.015 (0.000)***	0.014 (0.000)***	0.019 (0.003)**	0.012 (0.008)**	0.023 (0.021)*
	(Not) Born in country	-0.094 (0.021)**	-0.006 (0.874)	-0.053 (0.438)	-0.044 (0.351)	-0.033 (0.666)
	Belong to minority ethnic group	0.073 (0.275)	0.003 (0.969)	-	-0.067 (0.356)	-
	Belonging to a religion (no)	-0.047 (0.048)*	-0.091 (0.000)***	-0.017 (0.774)	-0.075 (0.002)**	-0.018 (0.803)
	Marital status: ref. married					
	Separated	-0.422 (0.000)***	-0.420 (0.000)***	-0.167 (0.552)	-0.402 (0.013)*	-0.118 (0749)
	Divorced	-0.359 (0.000)***	-0.381 (0.000)***	-0.412 (0.000)***	-0.314 (0.000)***	-0.394 (0.000)***
	Widowed	0.326 (0.000)***	-0.320 (0.000)***	-0.386 (0.000)***	-0.280 (0.000)***	-0.404 (0.000)***
	Never married	-0.206 (0.000)***	-0.270 (0.000)***	-0.128 (0.103)	-0.166 (0.001)***	-0.050 (0.627)
	Employment status: ref. employed					
	Self-employed	0.047 (0.012)*	0.084 (0.000)***	-0.148 (0.161)	0.127 (0.007)**	-0.066 (0.740)
	Working for own family business	0.088 (0.179)	0.115 (0.129)	0.058 (0.765)	0.185 (0.063)	-0.302 (0.437)
	Ever unemployed	0.153 (0.000)***	0.123 (0.004)**	0.194 (0.000)***	0.173 (0.001)***	0.186 (0.009)**
	Feeling about household's income: ref. coping on present income					
	Living comfortably	0.334 (0.000)***	0.284 (0.000)***	0.444 (0.000)***	0.283 (0.000)***	0.502 (0.000)***
	Difficult	-0.526 (0.000)***	-0.465 (0.000)***	-0.476 (0.000)***	-0.486 (0.000)***	-0.364 (0.000)***
	Very difficult income	-1.078 (0.000)***	-0.932 (0.000)***	-0.981 (0.000)***	-0.928 (0.000)***	-0.880 (0.000)***
	Socially meet	0.097 (0.000)***	0.080 (0.000)***	0.075 (0.000)***	0.088 (0.000)***	0.076 (0.000)***
	Take part in social activities	0.213 (0.000)***	0.209 (0.000)***	0.218 (0.000)***	0.207 (0.000)***	0.256 (0.000)***
	State of education	0.066 (0.000)***	0.070 (0.000)***	0.063 (0.000)***	0.072 (0.000)***	0.077 (0.000)***
	State of health services	0.096 (0.000)***	0.102 (0.000)***	0.116 (0.000)***	0.104 (0.000)***	0.116 (0.000)***
Unexplained variance		1.593 (0.000)***	1.492 (0.000)***	1.882 (0.000)***	1.530 (0.000)***	1.910 (0.000)***

Table 4.5. (continued)

		Health & Well-being				
	Variables	Disabled women	Disabled over 65 years	Disabled of minority ethnic group	Disabled women over 65 years	Disabled women of minority ethnic group
Between level coefficients (control variables)	Wave	0.010 (0.710)	-0.016 (0.532)	0.090 (0.045)*	-0.036 (0.229)	0.089 (0.103)
	GDP (average)	0.897 (0.009)**	1.156 (0.007)**	0.566 (0.201)	1.210 (0.004)**	0.693 (0.150)
	GDP (change)	-0.390 (0.169)	-0.280 (0.273)	-0.080 (0.868)	-0.106 (0.733)	0.006 (0.992)
	Equality (average)	1.481 (0.016)*	2.030 (0.003)**	1.105 (0.077)	2.613 (0.000)***	0.582 (0.508)
	Equality (change)	-0.231 (0.787)	0.116 (0.849)	3.770 (0.157)	-0.037 (0.970)	3.684(0.320)
	Life expect. rate (average)	0.027 (0.147)	0.033 (0.125)	0.024 (0.326)	0.029 (0.194)	0.023 (0.495)
	Life expect. rate (change)	0.033 (0.333)	0.046 (0.131)	-0.103 (0.118)	0.080 (0.035)*	-0.134 (0.098)
Unexplained variance		0.062 (0.000)***	0.065 (0.001)***	0.109 (0.000)***	0.079 (0.001)***	0.121 (0.001)***
Fit indicators	Loglikelihood	-64759.504	-41708.230	-6477.596	-24938.668	-3639.702
	Akaike information criterion (AIC)	129581.008	83478.460	13017.192	49939.335	7341.404
	Bayesian inform. criterion (BIC)	129846.791	83731.192	13209.882	50175.834	7516.023
Sample size	Countries; country-waves;	32;166	32; 166	32; 166	32; 166	32; 166
	Respondents	39091	25659	3699	15199	2065

Note. *$p < .05$. **$p < .01$. ***$p < .001$.

Gender, ethnicity and disability. The effect of discrimination based on disability, $b = -.703$; $p = .012$, had a greater negative effect, $z = 24.1525$, $p < .001$, on the HWB *of disabled women belonging to a minority ethnic group* compared to the effect of being discriminated based on ethnicity, $b = -.153$; $p = .043$. Discrimination based on gender was not statistically significant, $b = -.400$; $p = .154$.

In all five combinations of multiple social categories, the effect of discrimination based on disability had a greater magnitude when compared to the effect of discrimination based on gender, age, or ethnicity.

6.1.Additional analyses

To account for the possibility that the reported effects could be due to disabled people having worse health, we tested our model in Analysis 1, but this time controlling for health when assessing the effects of belonging to different disadvantaged groups on well-being. For the well-being measure, the ESS questions on happiness and life satisfaction were averaged in one variable (Spearman-Brown Coefficient = .80, with only one factor emerging and explaining 84% of the variance)[8]. The self-reported health measure was introduced as a predictor in our model. In this model, only discrimination based on age, $b = -.224$; $p < .001$, and race, $b = -.111$; $p = .009$, were statistically significant. However, compared to our proposed model, this model had a poor fit to the data (see Table 4.6), which could be due to the interdependence between health and well-being. This finding, in itself, highlights the importance of examining the effects of health and well-being together as we propose in our analyses and emphasizes the relevance of treating heath as an outcome of discrimination instead of a predictor. Moreover, note that in Analysis 1 we had controlled for whether individuals felt hampered in their daily activities as this could indicate the presence of ill health. Note also that, in Analysis 2, all individuals were disabled, so the fact that disabled individuals might have lower levels of health is irrelevant for this analysis and our results were still supported.

Overall, we believe that the argument suggesting that disabled people have inherently worse health (compared to the remaining sample) is supportive of an individual or medical approach and neglects the impact (and relevance) of social factors in disabled people's lives. In our research, we followed the approach promoted in a large body of work examining effects of

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[8] Results revealed the same pattern for all three variables in the comparisons between disability and age. The only exception was for happiness, a variable in which discrimination based on age had a higher magnitude than discrimination based on disability.

discrimination on health and well-being (Pascoe & Smart-Richman, 2009; Schmitt et al., 2014). If the health of social minorities is affected by social factors (e.g., discrimination, poor access to health services), we would expect the same for disabled people. The tendency of prior research to treat disability as an individual and medical factor has potentially obscured important aspects of how health is produced and maintained, undermining efforts to eliminate health disparities and the social factors interfering with these processes.

Table 4.6. Comparison of fit indicators between the proposed model and an alternative model.

Fit indicators		Proposed model	Alternative model
Unexplained variance at within level		1.678 (0.000)***	3.224(0.000)***
Unexplained variance at between-level		0.070 (0.004)**	0.124(0.000)***
Fit indicators	Loglikelihood	-31439.821	-37479.945
	Akaike information criterion (AIC)	62959.643	75042.890
	Bayesian inform. criterion (BIC)	63273.008	75363.037

Note. The proposed model is the model of analysis 1 and the alternative model tests the same variables on well-being, controlling for health.

7. Discussion

Our results indicated that facing ableism is associated with lower health and well-being (HWB) and that this effect was greater when compared to the effect of being discriminated against because of other disadvantaged group memberships (e.g., sexism, racism). These effects were evident in analyses *between* individuals (i.e., Analysis 1, comparing the effects of individuals experiencing different types of group discrimination) and *within* individuals (i.e., Analysis 2, examining the case of disabled individuals belonging to multiple disadvantaged categories).

These effects may be due to the vulnerability of this specific group. Disabled people are more likely to endure social isolation, not only due to prejudice, but also due to environmental barriers, which in turn may result in a lack of social support. Disabled people are perhaps more likely to internalize that they are not as capable as other individuals and, for this reason, may be disposed to believe that some experiences of discrimination are justified. Research has shown that responses to discrimination could be undermined when discrimination is perceived as legitimate, resulting in lower group identification and reduced intentions to engage in collective action (Jetten et al., 2011). In contrast, perceiving that discrimination is illegitimate is associated with high self-esteem and empowerment (Rüsch et al., 2006).

An interesting finding emerging from our analyses relates to the fact that group-based discrimination based on age (i.e., ageism) was also one of the most harmful forms of discrimination, emerging as the second type of discrimination most negatively related with health and well-being. Indeed, ableism and ageism share some similarities that might help us to understand in further detail the reasons that both groups face such harsh consequences. For example, older adults are also more vulnerable to social isolation and paternalism (assuming low competence and low agency of both groups). Both ableism and ageism incorporate biological normative beliefs, related to body uniformity, ability, independence and energy, which are used to justify ableist and ageist oppression (Overall, 2006). Another interesting similarity pertains to the fact that both groups seem to be somewhat heterogeneous. For instance, disabled people's attitudes toward different groups of impairment could prevent them from forming a homogeneous and strong minority group identification (Deal, 2003). A number of factors related to the nature, duration, and type of disability have been associated with disability prejudice from disabled people (Harder et al., 2019). Similarly, older people's distancing themselves from ageist stereotypes and behaviours prevents them from becoming aware of discrimination against their group, and engaging in collective action against ageism (Minichiello et al., 2000). In some cases, this heterogeneity may prevent disabled people and older adults from forming a strong minority group identification, which is critical for buffering the deleterious effects of discrimination (Branscombe et al., 1999), and mobilizing collective action on behalf of their group.

With this research, we unveil another side of our initial paradox: one of the largest disadvantaged groups – disabled people – is, despite receiving less societal and academic attention, one of the most affected by discrimination. Our results show the importance of addressing disability and ableism in social research – specifically, in social psychology – which has paid less attention to this issue than to discrimination faced by other disadvantaged groups (e.g., see the small number of studies addressing disability, 8, in Schmitt et al.'s (2014) meta-analysis, when compared to racism, sexism, and heterosexism, 211, 23, and 21, respectively).

7.1.Limitations and future directions

In the ESS, a low percentage of disabled people self-identified as being a member of a group discriminated by society and, in fact, low percentages were found across all disadvantaged groups. Only 7% of the total sample mentioned that they belonged to a group that is socially discriminated, suggesting that experiences of discrimination were perhaps underreported. One reason might be due to socially desirable responding that could have been enhanced by face-to-face interviews. In addition, responses were binary (i.e., belonging or not belonging to a group discriminated against by society) and, perhaps, a Likert type scale tapping into perceptions of discrimination would be more sensitive to different experiences. In this study, we benefited from the large data set, but were restricted to the available data. For researchers designing their own studies, it could be fruitful to include a scale tapping into perceptions of personal discrimination given that in their meta-analysis, Schmitt and colleagues (2014) found larger effect sizes for perceptions of personal discrimination compared to group discrimination.

The data used in our analyses were cross-sectional and this prevented us from testing the causal direction of the proposed relationships. Furthermore, while our study offered the added value of testing our hypothesis with representative samples in a Europe-wide context, it limits more fine-grained analysis at the individual level that would require psychological variables missing from these surveys. An avenue for future research would be to test the effects of ableism in a smaller scale longitudinal survey, which could allow researchers to draw more confident conclusions about causality and to identify the psychological mechanisms leading to poor well-being and health outcomes.

7.2.Implications for social policy

Our findings have critical implications for social policy. This research shows the strong implications of the discrimination endured by disabled people, and addressing this issue is likely to require intervention in multiple layers of our societies. To produce much-needed social change, efforts should be directed at both social and individual levels.

At the social level, it is crucial to raise awareness of the plight of disabled people and to develop synergies challenging current stereotypes. This might be achieved, for example, with campaigns showing counter-stereotypical group members (Ramasubramanian, 2011). Another relevant effort, would be the promotion and endorsement of the social model of disability, given that this model creates awareness of structural discrimination, which in turn produces policy support among nondisabled people (Dirth & Branscombe, 2017). Another potential intervention to reduce intergroup prejudice would be the promotion of positive intergroup contact (Allport, 1954; Brown & Hewstone, 2005) through various activities and spaces designed to facilitate such contact. A meta-analysis with different outgroup targets found that intergroup contact reduces prejudice and that effects for physically and mentally disabled people were of larger-than-average and average size, respectively (Pettigrew & Tropp, 2006).

At the individual level, efforts should be channeled toward a greater empowerment and resilience of disabled people by creating a positive disabled identity. The rejection-identification model (Branscombe et al., 1999) states that positive ingroup identification acts as a buffer of the negative effects of perceived discrimination, protecting self-esteem. More recent research found that a disability identity was associated with higher self-esteem (Bogart et al., 2018; Cooper et al., 2017; Nario-Redmond et al., 2012), satisfaction with life (Bogart, 2014), increased social support, stereotype rejection and stigma resistance (Crabtree et al., 2010), greater use of collective strategies (Nario-Redmond et al., 2012; Nario-Redmond & Oleson, 2016), and lower psychological distress (Bogart, 2015). Another potential path for interventions is to address the perceived legitimacy of some experiences. As we argued, perceived legitimacy could be related to the recognition of ableist behaviours, and research has found that perceiving discrimination as illegitimate is associated with high self-esteem and empowerment (Rüsch et al., 2006). Therefore, it is important to address perceived legitimacy of discrimination and promote awareness about what is discrimination/ableism. It is critical to show that this form of treatment is not justified, and to provide means of reporting any instances to legal authorities. This could perhaps be achieved by promoting the social model given that this model is associated with the perception of discrimination as illegitimate (Dirth & Branscombe, 2019). Moreover, given that disability intersects with other social categories, it is important to take an intersectional perspective to address disability and ableism (for a social justice framework, see Liasidou, 2013). Overall, to ensure self-determination and empowerment of disabled people, it is of paramount importance to address social policies in coordination with the organizations representing disabled people, to meet the moto “nothing about us, without us” (Charlton, 1998).

8. Conclusion

This study shows that ableism is associated with lower health and well-being, and that this effect has a greater magnitude when compared to the effects of being discriminated against because of other disadvantaged group memberships (e.g., sexism, racism). Our findings show that the quality of life of disabled people can no longer be ignored. It is imperative for academics and policy makers to work in tandem with the organizations of disabled people and governements to ensure that, accordingly the Convention on the Rights of Persons with Disabilities, “States Parties shall prohibit all discrimination on the basis of disability and guarantee to persons with disabilities equal and effective legal protection against discrimination on all grounds” (2006, art. 5, p. 7).

CHAPTER V.

Exploring the interaction between negative and positive intergroup contact among disabled people

The content of this chapter is under-review.

Note: There are additional tables (e.g., Tables S…) that are available in the supplementary online materials [SOM] in the following link: https://osf.io/7phz6/files/osfstorage/63ac9d02e48ccc03f94fd440

1. Abstract

This study integrates research on the intergroup contact hypothesis and the rejection-identification model to examine how negative and positive contact interact to influence both group identification (assessed as ingroup affect, centrality and ingroup ties) and the well-being of disabled people. We analysed data from a diary study (Study 1; *n* = 83), conducted over a week, and a longitudinal study (Study 2; *n* = 87), with three waves separated by 1 year. Results showed that positive contact can reduce, or even cancel out, the association between negative contact and lower well-being and ingroup affect (buffering effect). In addition, we found that negative contact was associated with higher ingroup ties only among those with higher levels of positive contact (facilitation effect). This research shows the potential of positive contact to reduce the adverse effects of negative contact on disadvantaged group members' outcomes, and its potential to facilitate non-harmful effects.

Keywords: intergroup contact; social identity; health and well-being; disability; disabled people.

2. Introduction

Extensive research has shown that perceived group-based discrimination has harmful effects on the well-being of disadvantaged group members (Pascoe & Smart-Richman, 2009; Schmitt et al., 2014). Research on group identification (i.e., the rejection-identification model; Branscombe et al., 1999), however, showed that identification with the disadvantaged group attenuates the negative association between perceived discrimination and well-being. Such prior research on the negative side of intergroup experiences, while of vital importance, left unexplored the potential of positive intergroup contact to attenuate the consequences of negative experiences on health and well-being (Dovidio et al., 2017).

Additionally, for a long period research on intergroup contact was dedicated to studying the effects of positive intergroup contact on reducing advantaged-group members' prejudice toward disadvantaged outgroups (intergroup contact hypothesis, Allport, 1954; Brown & Hewstone, 2005; see Pettigrew & Tropp, 2006, for a meta-analysis). Researchers only belatedly considered the joint effects of both positive and negative contact on prejudice (e.g., Barlow, 2012) and, only more recently, investigated the simultaneous effects of both positive and negative intergroup contact for disadvantaged group members to understand, specifically, their effects on intentions for collective action (Hayward et al., 2018; Reimer et al., 2017).

The present paper proposes a novel integration of research on the rejection-identification model and intergroup contact to examine how negative and positive intergroup contact interact to influence both the well-being and group identification of members of one disadvantaged group, disabled people. As a social category, disability remains relatively overlooked in social psychology (e.g., Olkin & Pledger, 2003), despite disability-based discrimination yielding a stronger negative association with well-being, when compared to other types of group-based discrimination (Branco et al., 2019; Schmitt et al., 2014).

2.1. Interaction of negative and positive contact on social identification and well-being

Social identification is often considered a protective factor for the well-being of disadvantaged groups facing discrimination (Jetten et al., 2017). The rejection-identification model (Branscombe et al., 1999) suggests that perceived discrimination by an outgroup can lead disadvantaged group members to identify more strongly with their ingroup, thereby buffering the negative effects of discrimination on well-being. The rejection-identification model has been replicated among several groups, including women (Schmitt et al., 2002), international students (Schmitt et al., 2003), older adults (Garstka et al., 2004) and disabled people (Bogart et al., 2018). In the present research, we argue that, in addition to social identification, positive intergroup contact could also buffer the deleterious effects of negative experiences on well-being. Intergroup contact has been positively associated with the well-being of the general population (Ramos et al., 2019) and disadvantaged groups (i.e., refugees; Tip et al., 2019). In this work, we integrate theorizing on both intergroup contact and rejection-identification to analyze the interaction of positive intergroup contact on the association between (1a) negative intergroup contact (instead of group discrimination) and well-being, and (1b) negative intergroup contact and group identification.

Initial work on contact and prejudice proposed a positive-negative contact asymmetry hypothesis (Barlow et al., 2012; Graf et al., 2014), that is, the deleterious effects of negative contact are consistently stronger than the beneficial effects of positive contact. However, other studies showed that the effects of positive contact were stronger than the effects of negative contact (e.g., Arnadóttir et al., 2018). An interaction model of negative and positive contact was proposed building on valence-salience effects on both category salience (Paolini et al., 2014) and outgroup attitudes (Arnadóttir et al., 2018). In this interaction model, positive contact buffers the effects of negative contact (buffering effect) on intergroup orientations, especially for dominant group members (Arnadóttir et al., 2018). One explanation proposed was that negative contact makes group categories more salient than positive contact (a so-called valence-salience effect; Paolini et al., 2010). Other authors support this interaction conceptualization, arguing that more frequent experiences of one form of contact do not imply fewer experiences of the other form of contact (Schäfer et al., 2021).

2.2. Assumption 1a: Positive contact buffers the association between negative contact and well-being

Negative, but not positive contact, with advantaged-group members was positively associated with perceived group discrimination (Hayward, et al., 2018; Reimer et al., 2017). Negative contact, by increasing group membership salience (Paolini et al., 2010), may increase intergroup comparisons and facilitate the perception of ingroup threats such as discrimination (Wright, 2013). On the contrary, positive experiences (e.g., having friendships with advantaged group members) were negatively associated with perceptions of personal and group discrimination (Dixon et al., 2010; Tropp et al., 2012). Previous studies showed that positive contact buffered the association between negative contact and category salience (Paolini et al., 2014), which may have consequences for perceived ingroup threats and, consequently, members' well-being. Therefore, we expect a similar interaction effect in this study, such that positive intergroup contact buffers the association between negative contact and lower health and well-being among disabled people.

2.3. Assumption 1b: Positive contact buffers the association between negative contact and group identification

Negative, but not positive, contact with advantaged group members was associated with group identification (Reimer et al., 2017, Study 1). However, neither positive nor negative contact predicted group identification longitudinally (Reimer et al., 2017, Study 2). The same inconsistencies were noted regarding the longitudinal association between perceived discrimination and group identification (e.g., Ramos et al., 2012). This mixed pattern of results may make more sense if we adopted a multidimensional perspective on identity as the relationship between discrimination-identification can vary as a function of identity dimensions (Ramos et al., 2012). The three-factor model of identification (Cameron, 2004) identifies three core dimensions of identification: *ingroup affect,* which reflects the emotional evaluation of group membership; *ingroup ties,* which reflect the psychological ties that bind the self to the group; and c*entrality,* which reflects the extent to which the group membership is important to one's self-concept.

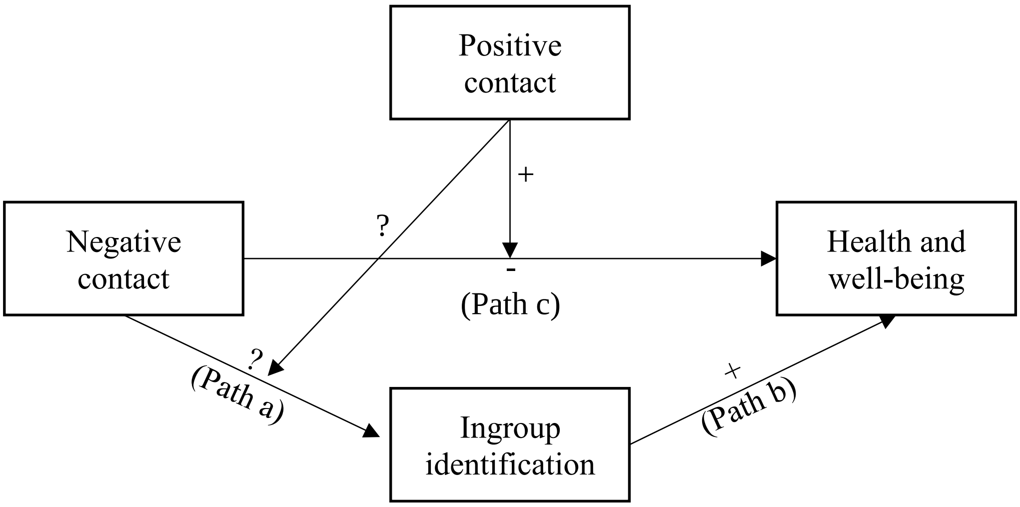
In a longitudinal study, Ramos et al. (2012) found that perceived discrimination was positively associated with ingroup centrality, but not with either ingroup affect or ingroup ties. Perceived discrimination was, however, associated with lower ingroup affect cross-sectionally. This was in accordance with previous studies showing that perceived discrimination was negatively associated with ingroup affect (Crabtree et al., 2010; Eccleston & Major, 2006; McCoy & Major, 2003). In addition, despite perceived discrimination being positively associated with centrality (Eccleston & Major, 2006), a recent study did not confirm the longitudinal association either between group discrimination and centrality or between negative contact and centrality (Reimer et al., 2017, Study 2). Similarly, longitudinal research has not confirmed the association between either perceived discrimination and ingroup ties (Ramos et al., 2012), or between negative contact and ingroup ties (Reimer et al., 2017, Study 2).

In the present research, we expect that positive contact will interact with negative contact to impact group identification. However, due to the previous mixed evidence on the dimensions of social identification, we adopt an exploratory perspective as we cannot draw specific predictions for each dimension. However, given that group identification is positively predicted by discrimination (Branscombe et al., 1999) and by negative contact (Reimer et al., 2017, Study

1), group identification should be reduced because positive contact attenuates the effects of negative contact (e.g., Paolini et al., 2014).

2.4.The present research

This research aims to examine how the interaction between negative and positive intergroup contact affects the well-being and group identification of disabled people (see Figure 5.1), differentiating between the three dimensions of group identification (i.e., ingroup affect, centrality, and ingroup ties). We collected data using a diary study (Study 1), conducted over a week, and a longitudinal study (Study 2), with three waves separated by 1 year. While the diary study allowed us to examine daily fluctuations, the longitudinal study captured longer-term effects. We hypothesized that positive contact would moderate the effects of negative contact on outcomes, such that the association between negative contact and both well-being (H1a) and group identification (H1b) would be diminished under higher than lower levels of positive contact. To address the differences between the dimensions of identity, we analyze the results for each dimension (ingroup affect, centrality and ingroup ties) separately.



Note. A plus sign for a moderation indicates that the higher the positive contact the less negative is the main effect of negative contact. An interrogative sign between negative contact and ingroup identification indicates that the direction of this relationship may depends on the dimension of ingroup identification. We expect, however, that positive contact reduces the association between negative contact and ingroup identification.

Figure 5.1. Proposed model.

3. Study 1

3.1.Participants and procedure

Participants were 83 disabled people, in Portugal, who participated in an online diary study up to seven times a week (seven times: 35 respondents; six times: 8; five times: 6; four times: 7; three times 6; twice: 10; once: 11), yielding a total of 400 observations. The main results in our analysis below are replicated when excluding the participants who responded on only one or two days. As the multilevel analysis used below is robust in cases where there are few observations per cluster, and we had a small sample, we chose to preserve all participants in the analysis.

This sample included 47 females (56.6%) and 36 males (43.4%); the majority were single (69.9%), with ages ranging from 21 to 65 years (*M*=40.1, *SD*=10.81). Participants had, mostly, university (57.8%) and higher (20.5%) education, were employed (42.2%) and were pensioners or retirees (23.8%). Generally, they were physically impaired (92.8%), and they had an acquired (66.3%) and visible (89.2%) impairment. Participants also reported hearing (2), visual (3), intellectual (3), and developmental/learning (2) impairments. They reported that they were, mostly, hampered "a lot" (50.6%) or "to some extent" (33.7%) in their daily living activities.

Participants were recruited through social networks and organizations in the field of disability. One hundred and fifteen people signed up to participate in the study, from whom 72.2% participated in the study from 1 to 7 days. Participants received 5€ if they completed the questionnaires for a total of 5 days, or 10€ if they completed all questionnaires (7 days).

Data was collected through Qualtrics. In a first step, participants were asked if they would be interested in taking part in a one-week/seven-day diary study and given information about the specific dates of the study (i.e., week of data collection). Participants read the informed consent with information about the purpose of the study, approximate duration, confidentiality/anonymity, and right to withdraw at any time. If they agreed, they completed a socio-demographic questionnaire, after which they were asked for their contact details so that they could receive an email with the survey link at the beginning of the study. On each day of the study, participants received an email in the afternoon to remind them to fill out the questionnaire for that day.

3.2.Measures[9]

Positive and negative intergroup contact. Participants reported their experiences of positive and

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[9] A version of the questionnaire is available in Annex A.

negative contact with non-disabled people, excluding their family relatives, on each day of the study. We used a single item to measure each type of contact, in terms of contact frequency: "Today, how often did you have negative/positive contact with non-disabled people?" to which participants answered from 0 to more than 20 times.

Group identification. We adapted the multidimensional scale of identification (Leach et al., 2008; Portuguese version, developed by Ramos & Alves, 2011) to measure the three dimensions of group identification: ingroup affect, centrality and ingroup ties, with two items for each dimension (in this scale, ingroup affect and ingroup ties are named as satisfaction and solidarity, respectively). Response scales for all items were 7-point scales ranging from 1‘strongly disagree’ to 7 ‘strongly agree’. We measured the dimensions as follows: *ingroup affect* with two items: “It is pleasant to belong to the disabled people’s community” and “Being part of the disabled people’s community gives me a good feeling”; *centrality* with two items: “The fact that I am a disabled person is an important part of my identity” and “Being a disabled person is an important part of how I see myself”; and *ingroup ties* with three items: “I feel ingroup ties with disabled people” and “I feel committed to disabled people”. The three dimensions of group identification showed a substantial item-level reliability across the seven days (lower and upper values of the Spearman-Brown coefficient: $r_{\text{ingroup affect}} = 0.867 – 0.962$; $r_{\text{centrality}} = 0.787 – 0.953$; $r_{\text{ingroup ties}} =0.763 – 0.969$).

Health and well-being. We used a single item to measure self-reported health (“Overall, how would you describe your state of health today?”, answered on a scale from 1 ‘very bad’ to 7 ‘very good’) and happiness (“Taking all things together, how happy would you say you feel today?”, answered on a scale from 1 ‘extremely unhappy’ to 7 ‘extremely happy’). We measured depression using two items (adapted from the 8-item version of CES-D: Center for Epidemiologic Studies - Depression Scale; Missinne et al., 2014; Radloff, 1977): “Thinking about how you felt today, please indicate how often you…”: “…felt depressed?” and “…felt lethargic and lacked motivation?”, answered on a scale from 1 ‘always’ to 7 ‘never’. These two items were reverse coded to indicate the absence of depression and combined in one factor (lower and upper values across the days: $r = 0.685 – 0.943$). The combination of self-reported health, happiness and (absence of) depression showed a good reliability across the seven days (upper and lower values: $\alpha = 0.759 – 0.843$). These three variables – self-reported, happiness and (absence of) depression – were combined in a latent variable to measure health and well-being. In latent variables, it is a standard procedure to constrain to 1 the loading of one of the observed variables, generally, the variable that will have a higher loading on the latent variable. Because of this, the loading of happiness was constrained to 1.

Sociodemographic variables. We included the following sociodemographic variables associated with health and well-being: sex, coded with 1 dummy for “male”, using “Female” as reference group; age, used as scale variable (in years); education (1 ‘no schooling’, 2-4th year, 3-7th year, 4-9th year, 5-11th year, 6-high school, 7- higher education), used as scale variable; marital status, coded with 1 dummy for “Married”, using the reference group “Single/not married” (including those separated, divorced, or widowed); employment status, coded with 2 dummies (Unemployed; Non-employed (other), which included retired, pensioner, students), with the reference group “Employed”; feeling about household’s income, coded with 1 dummy for “Difficult or very difficult on present income”, using the reference group “Living comfortably or coping on present income”; impairment origin, coded with 1 dummy for “Congenital”, using “Acquired” as reference group; impairment visibility, coded with 1 dummy for “Invisible”, using “Visible” as reference group; and, hampered in daily living activities, coded with 2 dummies (To some extent; Not at all), using “A lot” as reference group.

3.3.Data analysis

To investigate if positive intergroup contact moderates the relationship between negative contact and well-being, via group identification, we conducted a multilevel conditional process analysis (Hayes, 2018), within the Structural Equation Modelling framework, using Mplus 8.0 (Stride et al., 2015). We ran a model for each of the three dimensions of group identification: ingroup affect, centrality and ingroup ties. In each analysis, following the recommendations for repeated measurements with diary studies (Bolger & Laurenceau, 2013), at level-1 (within) we introduced the time variant variables, that is, the daily observations on intergroup contact, group identification and well-being. At level-2 (between), we introduced the time invariant variables, that is, the sociodemographic variables (e.g., sex, age). Independent variables (negative contact, positive contact and time, at within level; age and education, at between level) were grand mean centred and we introduced a time control variable at level-1.

In each conditional process model, we introduced negative intergroup contact as the independent variable, group identification as a mediator, and well-being as the dependent variable. We introduced positive intergroup contact as a moderator in the relationship between negative contact and group identification (path a, see Figure 5.1), and between negative contact and well-being (path c). Because in previous studies (1) positive contact was more common than negative contact (e.g., Graf et al., 2014), and (b) effects of negative contact were neutralized under higher levels, rather than average and low levels, of positive contact (Arnadóttir et al., 2018; Paolini et al., 2014), we plot the traditional values of the moderator for the mean, and +1SD and -1SD relative to the mean; but also plot the maximum score of positive contact, to better explore buffering and cancelling effects (i.e., lower-average-higher-highest values).

We used MLR (maximum likelihood) parameter estimates with robust standard errors, and three goodness-of-fit indices: the chi-square, comparative fit index (CFI), and root mean square error of approximation (RMSEA). The chi-square measure shows the exact fit of the model, with *p*-values above .05 implying an exact fit. Models with CFI values > 0.90 were considered to have acceptable fit, and models with a CFI > 0.95 good fit; RMSEA values < 0.08 indicate acceptable fit, and <0.05 good fit (Bentler & Bonett, 1980; Hu & Bentler, 1999).

4. Results and Discussion

As in previous research, the frequency of negative contact was lower than the frequency of positive contact (see Table 5.1 for means, standard deviations and correlations). Participants reported a mean of one daily experience of negative (*M* = 1.12, *SD* = 2.86) and six daily experiences of positive (*M* = 5.76, *SD* = 5.27) contact. In addition, on average, participants reported a somewhat positive disability identity, in terms of all three components (ingroup affect: *M* = 4.16, *SD* = 1.39; ingroup centrality: *M* = 4.89, *SD* = 1.39; ingroup ties: *M* = 5.65, *SD* = 1.11). On average, participants reported a relative positive level of health (*M* = 4.80, *SD* = 1.11), happiness (*M* = 4.66, *SD* = 1.11) and low levels of depression (*M* = 5.69, *SD* = 1.27).

Fit indicators of multilevel conditional process analysis showed a good fit for the model of ingroup affect (χ^2_{32} = 38.354, *p* = 0.204, RMSEA = 0.023, and CFI = 0.976), ingroup ties (χ^2_{32} = 30.888, *p* = 0.523, RMSEA < 0.001, and CFI = 0.999), and centrality (χ^2_{32} = 31.605, *p* = 0.487, RMSEA < 0.001, and CFI = 0.999).

Ingroup affect model. We did not find a significant direct association between negative contact and well-being (*b* = -.040, *p* = .322), nor did we find that positive contact moderated this relationship (*b* = .004, *p* = .226; see Table S1 in supplementary online materials [SOM] for more details), contrary to our Hypothesis (1a). However, the association between negative contact and lower ingroup affect (*b* = -.244, *p* = .003) was moderated by positive contact (*b* = .014, *p* = .014), supporting our hypothesis (1b).

Table 5.1. Means, standard deviations, and correlations of the main variables under analysis (Study 1).

	M	*SD*	NC	PC	IA	IC	IT	Health	Happiness	Depression (reversed)
Negative contact (NC)	1.12	2.86	1	.275***	0.057	0.035	-.130**	0.018	-0.078	-0.015
Positive contact (PC)	5.76	5.27	.275***	1	.181***	-0.003	-0.007	.260***	.315***	.292***
Ingroup affect (IA)	4.16	1.39	0.057	.181***	1	.427***	.170**	.292***	.428***	.261***
Ingroup centrality (IC)	4.89	1.37	0.035	-0.003	.427***	1	0.078	.169**	.202***	.162**
Ingroup ties (IT)	5.65	1.11	-.130**	-0.007	.170**	0.078	1	.286***	.349***	.207***
Health	4.80	1.11	0.018	.260***	.292***	.169**	.286***	1	.819***	.621***
Happiness	4.66	1.11	-0.078	.315***	.428***	.202***	.349***	.819***	1	.693***
Depression (reversed)	5.69	1.27	-0.015	.292***	.261***	.162**	.207***	.621***	.693***	1

Note. $^{*}p < 0.05$ (; $^{**}p < 0.01$; $^{***}p < 0.001$. *M* = mean. *SD* = Standard deviation. NC = Negative contact. PC =Positive contact. IA = Ingroup affect. IC = Ingroup centrality. IT = Ingroup Ties. HWB = Health and well-being.

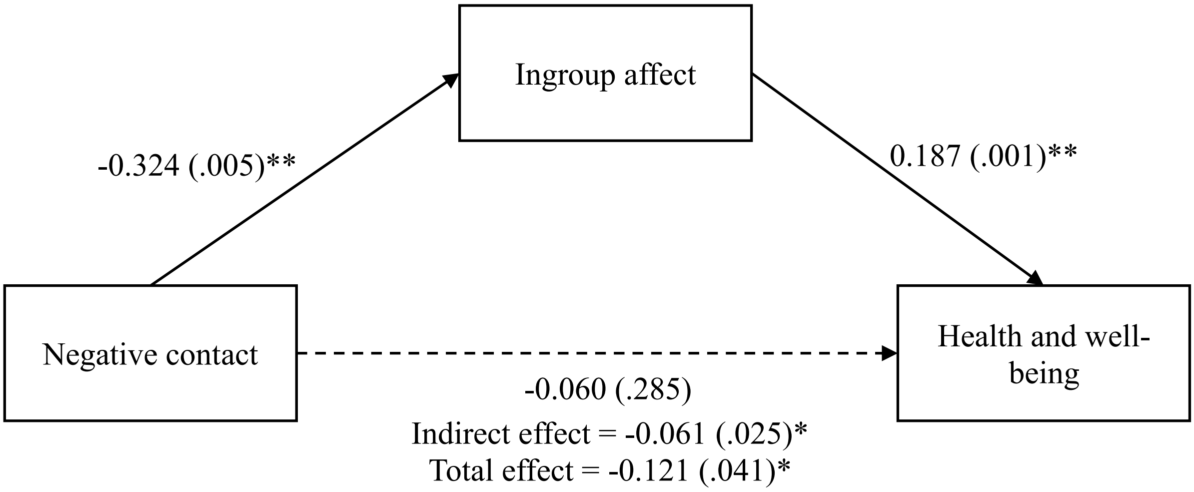
This means that the association between negative contact and lower ingroup affect was somewhat stronger for those who had lower positive contact (*b* = -.335, *p* = .005) and became progressively weaker for higher (*b* = -.153, *p* = .001) and highest (*b* = -.033, *p* = .036) levels of positive contact (Figure 5.2 presents the model for the lower and highest values of positive contact).

Therefore, negative contact was associated with lower well-being via ingroup affect (*b* = -.046, *p* = .021), while this association was stronger for participants with lower positive contact (*b* = -.0.63, *p* =.025) and weaker for participants with higher positive contact (*b* = -.029, *p* = .015), whilst it was neutralized for participants with highest positive contact (*b* = -.006, *p* =.079). Similarly, the total effect of negative contact on health and well-being, via ingroup affect, was significant and negative for those with lower positive contact (*b* = -.126, *p* = .041) and became progressively weaker until it became non-significant for those with higher (*b* = -.046, *p* = .071) and highest (*b* = .007, *p* =.654) levels of positive contact.

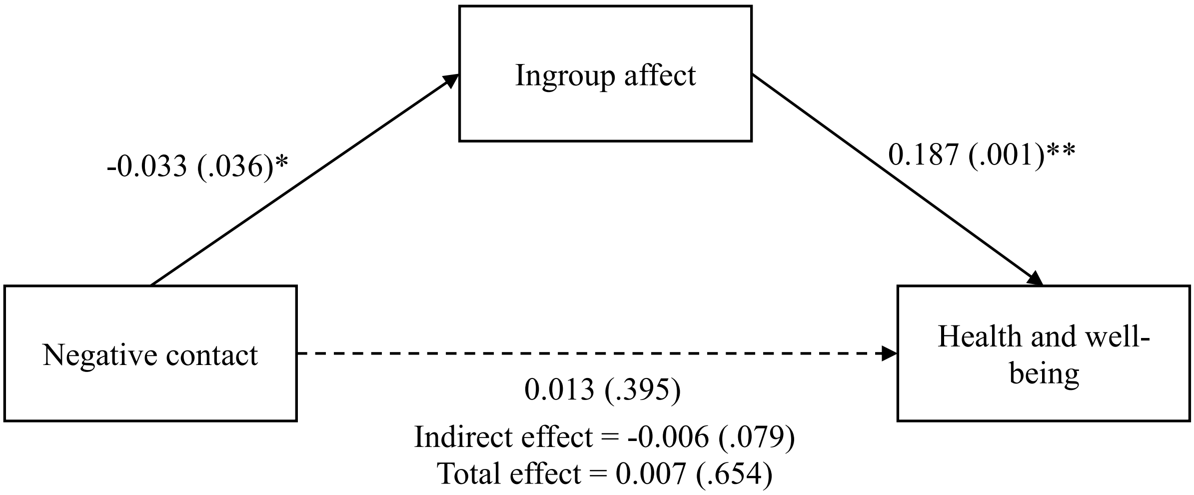
Ingroup ties model. We did not find a significant direct association between negative contact and well-being (*b* = -.050, *p* = .171), nor did we find that positive contact moderated this relationship (*b* = .004, *p* = .131; see Table S2 in SOM for more details), contrary to our Hypothesis (1a). However, the association between negative contact and lower ingroup ties (*b* = -.294, *p* = .048) was moderated by positive contact (*b* = .023, *p* = .022), supporting our hypothesis (1b). This means that the association between negative contact and lower ingroup ties was stronger for those who had lower positive contact (*b* = -.447, *p* = .037) and became progressively weaker until it became non-significant for respondents with higher levels (*b* = -.140, *p* = .088) of positive contact. However, this association became positive for those who had highest positive contact (*b* = .062, *p* = .001; see Figure 5.3). Therefore, we partially confirmed our Hypothesis (1b) for ingroup ties. Positive contact attenuated the association between negative contact and lower ingroup ties at both average and higher levels of positive contact. At the highest level of positive contact, we found an effect in the opposite direction: negative contact was associated with higher ingroup ties.

The indirect effect of negative contact on well-being via ingroup ties became significant and positive only for participants with the highest positive contact (*b* = .011, *p* = .031). In addition, the total effect of negative contact on health and well-being was negative and stronger for participants with lower positive contact (*b* = -.152, *p* = .044.), while it became non-significant for participants with highest positive contact (*b* = .020, *p* =.189).

Low positive contact



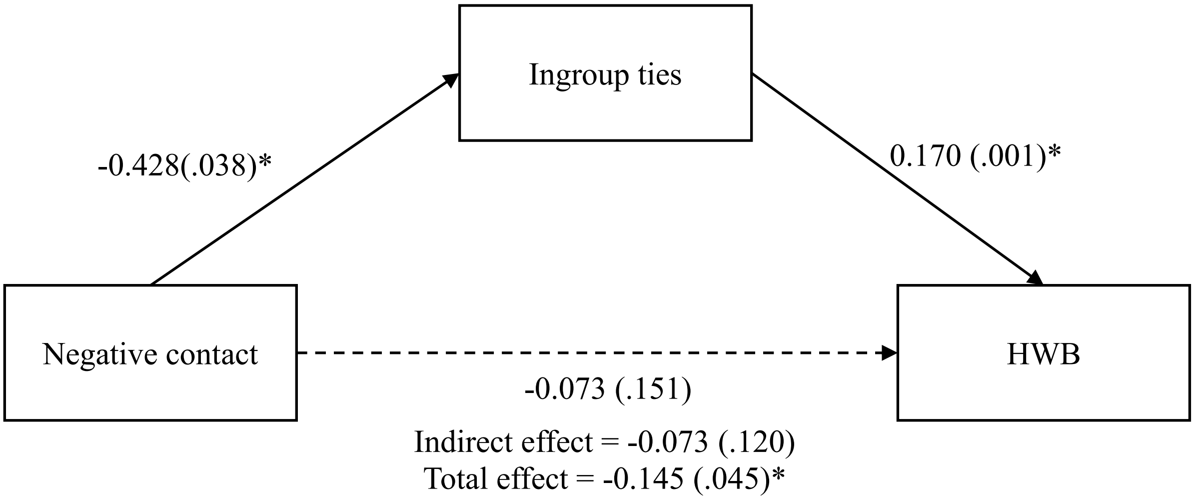
High positive contact



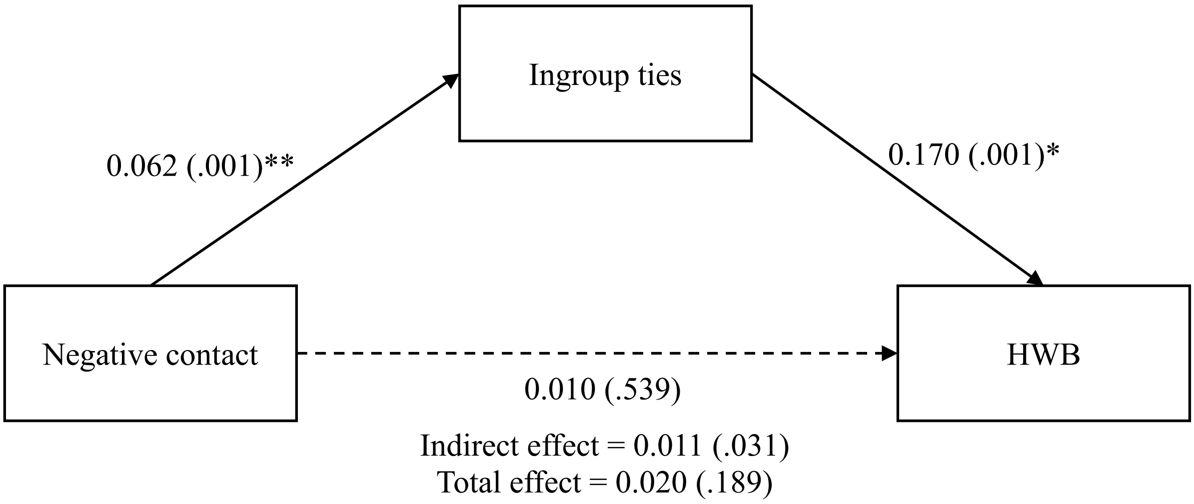
Note. *p <0.05; **p <0.01; ***p <0.001.

Figure 5.2. Unstandardized estimates from conditional process analysis, via ingroup affect (Study 1).

Low positive contact



High positive contact



Note. **p* <0.05; ***p* <0.01; ****p* <0.001.

Figure 5.3. Unstandardized estimates from conditional process analysis, via ingroup ties (Study 1).

Ingroup centrality model. There was not a direct effect of negative contact on well-being (*b* = -.047, *p* =.229) nor did positive contact moderate this relationship (*b* = .004, *p* =.161). In addition, we found no moderation of positive contact (*b* = .009, *p* = .153) in the association between negative contact and lower centrality (*b* = -.178, *p* =.044) (see Table S3 in the SOM for more details). Therefore, we did not confirm our hypothesis (1b) in this model.

In sum, across all models, we did not find a direct association between negative contact and well-being, nor did positive contact moderate this relationship, contrary to our Hypothesis (1a).

However, as stated in Hypothesis (1b), the negative association between negative contact and ingroup affect or ingroup ties was reduced under higher compared to lower levels of positive contact. Yet, a reverse pattern was found in which the association between negative contact and ingroup ties was positive under the highest level of positive contact.

In Study 2, we again examine, in a longitudinal, rather than a week-long diary study, so that we could reexamine over a longer period (two years) the moderation of positive contact on these relationships separately, that is, on the association between negative contact and well-being, and between negative contact and (each dimension of) group identification. This allows us to observe the increase or reduction of well-being and ingroup identification after measuring the frequency of negative contact, and the reverse effects, across the groups of lower and highest positive contact.

5. Study 2

5.1. Participants and procedure

One hundred and fifty-one disabled people, in Portugal, participated in a longitudinal online study, with three waves separated by one year. Due to dropout, 99 disabled people participated in the second wave (retention rate of 65.6%) and 87 disabled people participated in the third wave (retention rate of 87.9%). This study focused on data obtained from the 87 disabled people who participated in all three waves of the study. This sample included 44 females (50.6%) and 43 males (49.4%), the majority of whom were single (59.8%), with ages ranging from 20 to 76 years (M=44.41, SD=11.76). Participants had, mostly, university (55.2%) and higher (27.6%) education, were employed (51.7%) or were pensioners or retirees (26.4%). Generally, they were physically (94.3%) impaired, and they had an acquired (66.7%) and visible (88.5%) impairment. Participants also reported hearing (3), visual (4), intellectual (4), and developmental/learning (3) impairments. They reported that they were hampered "a lot" (50.6%) or "to some extent" (39.1%) in their daily living activities.

To examine whether there were sociodemographic differences between those who participated in all waves of the study and those who dropped out at time 2 or 3, we performed a binary logistic regression. The outcome variable was coded as ‘0’ (participated in all waves) and ‘1’ (dropped out). We found that demographic variables did not predict study drop-out ($\chi^2 = 22.203$, $p = 0.330$). Although those who were retired ($\beta = 1.864$, $p = 0.005$) or were pensioners ($\beta = 1.249$, $p = 0.045$) were more likely to drop out of the study, no other variables such as sex, age, education, marital status, or variables related to disability, such as type, visibility, nature (congenital or acquired), or extent of hampering in daily living activities predicted drop out.

We recruited disabled people through social networks and organizations in the field of disability. Five prizes (€50 each) were randomly drawn on the first wave and 3 prizes (€50 each) on the second and third waves. Data was collected through Qualtrics. Participants were asked if they would be interested in taking part in a longitudinal study with three waves separated by one year. Before starting the survey, participants read an informed consent with information about the purpose of the study, approximate duration, confidentiality/anonymity, and right to withdraw at any time. At the end of the survey, they were asked for their contact details so that they could participate in the next phases of the study.

5.2.Measures[10]

Positive and negative intergroup contact. Participants were asked to report on their experiences of positive and negative contact with non-disabled people, excluding their family relatives. We used a single item to assess each type of contact, in terms of contact frequency: "In general, how often do you have negative/positive contact with non-disabled people?*"*, which participants answered on a 7-point scale: (1) Never, (2) Less than once a month, (3) Once a month, (4) Several times a month, (5) Once a week, (6) Several times a week, or (7) Every day.

Group identification. We again measured the three dimensions of group identification (ingroup affect, centrality and ingroup ties) with the multidimensional scale of identification (Leach et al., 2008; Portuguese version, Ramos & Alves, 2011). We measured the three dimensions as follows: *ingroup affect*, four items*:* “I think that disabled people have a lot to be proud of”, “It is pleasant to belong to the disabled people’s community”, “Being part of the disabled people’s community gives me a good feeling”, and “I am glad to be part of the disabled people’s community”*; centrality,* three items: “I often think about the fact that I am a disabled person”, “The fact that I am a disabled person is an important part of my identity, and “Being a disabled person is an important part of how I see myself”*; ingroup ties,* three items: “I feel a bond with disabled people”, “I feel ingroup ties with disabled people”, and “I feel committed to disabled people”. Participants responded on 7-point scales ranging from 1 ‘strongly disagree’ to 7 ‘strongly agree’. The items showed a substantial item-level reliability for ingroup affect ($\alpha_{T1} = 0.897$; $\alpha_{T2} = 0.907$; $\alpha_{T3} = 0.843$), ingroup centrality ($\alpha_{T1} = 0.717$; $\alpha_{T2} = 0.718$; $\alpha_{T3} = 0.767$) and ingroup ties ($\alpha_{T1} = 0.723$; $\alpha_{T2} = 0.821$; $\alpha_{T3} = 0.777$).

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[10] A version of the questionnaire, used in the first wave, is available in Annex B.

Health and well-being. We assessed this construct with three items: A self-reported health question ("All in all, how would you describe your state of health?", answered on a scale from 1 'very bad' to 7 'very good'), a happiness question ("Taking all things together, how happy would you say you feel?", answered on a scale from 1 'extremely unhappy' to 7 'extremely happy'), and a life satisfaction question ("How satisfied are you with your life in general?", answered on a scale from 1 'extremely unsatisfied' to 7 'extremely satisfied'). We averaged responses across the three items, resulting in one factor reliably measuring health and well-being (α_{T1} =0.817; α_{T2} = 0.837; α_{T3} = 0.840).

5.3.Data analysis

We used the Cross-Lagged Panel Model (CLPM; Kenny 1975; Kearney, 2017), a structural equation modelling approach to examine longitudinal data. We conducted CLPM with multiple group analysis (i.e., compare the same model for different groups; e.g., Mulder & Hamakar, 2021) to investigate the moderation of positive contact on the longitudinal relationship between negative intergroup contact and (a) well-being, and negative contact and group identification (b). We do not present a mediation model of negative contact on well-being via group identification; this complex model in a multiple group analysis is not relevant, because group identification was not associated with health or well-being in a cross-lagged analysis, on any of the dimensions of identity.

We ran a separate CLPM with multiple group analysis for each dependent variable: the three dimensions of group identification and well-being. For each dependent variable, we compared the model fit and the cross-lagged effect across two models: (1) a constrained model in which lagged parameters were constrained to be equal across groups, and (2) an unconstrained model in which lagged parameters were freely estimated across groups. To account for the stability of constructs as well as the nature of the relationships between constructs over time (i.e., stationarity; e.g., Kenny, 1975; Kearney, 2017), the lagged parameters were constrained to be equal across time (i.e., time-invariant). We compared the fit across the two models to understand which better fit the data and if there was a difference between groups in the specific cross-lagged effect of negative contact on identification/ well-being. To define these groups, we used the median of positive contact at both waves 1 and 2, which corresponds to the highest value of positive contact (7 'Every day'), in both waves. This meant that one of the groups indicates a daily frequency of positive contact at both waves 1 and 2, and the other group indicates none to some amount of positive contact (several times a week). Therefore, we compare the groups of "lower" versus "highest" levels of positive contact. We are especially interested in comparing the highest value of positive contact against lower values because (1) positive contact is more frequent than negative contact (e.g., Graf et al., 2014) and (2) in Study 1 we found that some effects emerge only at highest level of positive contact.

We tested models with Mplus 8.0, using ML – maximum likelihood parameter estimates with conventional standard errors and chi-square test statistics. Because constraints over time are imposed on the unstandardized coefficients, standardized coefficients can still differ (slightly) over time, and therefore all presented results are standardized coefficients.

6. Results and Discussion

As in Study 1, the frequency of negative contact was lower than the frequency of positive contact (see Table 5.2 for means, standard deviations and correlations). Participants' mean level of contact was "once a month" for negative (e.g., $M_{T1} = 3.38$, $SD_{T1} = 1.88$), whereas it was "several times a week" ($M_{T1}= 6.05$, $SD_{T1} = 1.48$) for positive contact in all waves. In addition, participants reported, on average, a somewhat positive disability identity, in terms of all three identity components (ingroup affect: $M_{T1} = 4.22$, $SD_{T1} = 1.70$; ingroup centrality: $M_{T1} = 4.40$, $SD_{T1} = 1.59$; ingroup ties: $M_{T1} = 5.33$, $SD_{T1} = 1.28$). On average, participants reported a relatively good level of health and well-being ($M_{T1} = 4.52$, $SD_{T1} = 1.17$).

Multiple group analysis for well-being

We first compared the constrained model across groups (equal parameters across groups) with an unconstrained model across groups (free parameters across groups). The latter model had better fit, and we found different effects between groups in the specific cross-lagged path we wanted to test (Constrained model across groups: $\chi^2_{(20)} = 25.674$, $p = 0.177$, RMSEA = 0.081, CFI = 0.968; Unconstrained model across group: $\chi^2_{(16)} = 18.421$, $p = 0.300$, RMSEA = 0.059, CFI = 0.986; see Table S4 in SOM).

The negative cross-lagged path of negative contact on subsequent well-being was significant over time, but only for those who had lower positive contact (T1 to T2: $\beta = -.187$, $p = .022$; T2 to T3: $\beta = -.153$, $p = .025$; see Figure 5.4, and Table 5.3). In turn, we found no significant cross-lagged path of negative contact on subsequent well-being for those who had highest positive contact (T1 to T2: $\beta = -.121$, $p = .216$; T2 to T3: $\beta = -.118$, $p = .209$. This means that the cross-lagged association between negative contact and lower well-being was cancelled out at the highest level of positive contact, supporting our Hypothesis (1a).

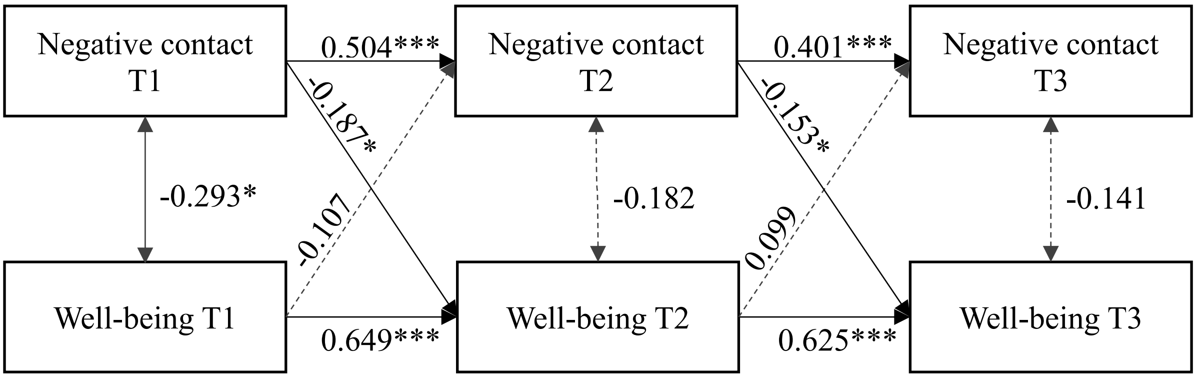
			Negative contact (NC)			Positive contact (PC)			Ingroup affect (IA)			Ingroup centrality (IC)			Ingroup ties (IT)			Health and well-being (HWB)		
	M	*SD*	NC_T1	NC_T2	NC_T3	PC_T1	PC_T2	PC_T3	IA_T1	IA_T1	IA_T1	IC_T1	IC_T2	IC_T3	IT_T1	IT_T2	IT_T3	HWB_T1	HWB_T2	HWB_T3
NC_T1	3.38	1.88	1	,544***	,298**	0.145	-0.064	-0.055	0.031	-0.160	-0.041	0.108	0.149	0.113	-0.017	0.102	0.192	-0.158	-,254*	-,235*
NC_T2	3.45	1.66	,544***	1	,579***	0.096	0.090	-0.087	0.048	0.016	-0.029	0.126	,214*	0.140	0.032	0.142	0.205	-0.134	-,265*	-,317**
NC_T3	3.29	1.84	,298**	,579**	1	-0.022	0.102	0.123	0.063	0.027	0.028	0.122	0.073	0.171	0.053	0.105	0.175	-0.059	-0.039	-0.189
PC_T1	6.05	1.47	0.145	0.096	-0.022	1	,341**	-0.090	-0.005	-0.123	-,245*	-0.003	-0.038	-0.083	-0.039	-0.103	-0.187	,287**	0.101	0.154
PC_T2	5.98	1.46	-0.064	0.090	0.102	,341**	1	0.075	-0.070	0.004	-0.075	0.114	0.060	0.003	-0.060	-0.048	-0.056	0.138	0.190	0.119
PC_T3	5.88	1.45	-0.055	-0.087	0.123	-0.090	0.075	1	0.111	0.201	,230*	0.125	-0.147	0.008	0.079	-0.198	0.114	0.146	,218*	,340**
IA_T1	4.23	1.70	0.031	0.048	0.063	-0.005	-0.070	0.111	1	,665**	,503**	,271*	0.052	0.002	,371***	,346**	,270*	0.194	0.077	0.134
IA_T2	4.27	1.61	-0.160	0.016	0.027	-0.123	0.004	0.201	,665**	1	,645**	,234*	0.106	0.011	,294**	,425***	,332**	0.207	,294**	,258*
IA_T3	3.97	1.52	-0.041	-0.029	0.028	-,245*	-0.075	,230*	,503**	,645**	1	0.124	0.095	,219*	0.125	,226*	,434***	0.135	,264*	,237*
IC_T1	4.41	1.59	0.108	0.126	0.122	-0.003	0.114	0.125	,271*	,234*	0.124	1	,527**	,543**	,325**	,309**	,246*	-0.040	-0.075	-0.065
IC_T2	4.64	1.57	0.149	,214*	0.073	-0.038	0.060	-0.147	0.052	0.106	0.095	,527**	1	,552**	0.163	,496**	,309**	-0.163	-0.142	-0.165
IC_T3	4.35	1.85	0.113	0.140	0.171	-0.083	0.003	0.008	0.002	0.011	,219*	,543**	,552**	1	0.154	,270*	,319**	0.044	-0.020	-0.157
IT_T1	5.33	1.28	-0.017	0.032	0.053	-0.039	-0.060	0.079	,371***	,294**	0.125	,325**	0.163	0.154	1	,507**	,369***	0.070	0.110	0.014
IT_T2	5.04	1.37	0.102	0.142	0.105	-0.103	-0.048	-0.198	,346**	,425***	,226*	,309**	,496**	,270*	,507**	1	,645**	-0.086	-0.081	-0.154
IT_T3	5.03	1.38	0.192	0.205	0.175	-0.187	-0.056	0.114	,270*	,332**	,434***	,246*	,309**	,319**	,369***	,645**	1	-0.016	0.000	-0.056
HWB_T1	4.52	1.17	-0.158	-0.134	-0.059	,287**	0.138	0.146	0.194	0.207	0.135	-0.040	-0.163	0.044	0.070	-0.086	-0.016	1	,704**	,621**
HWB_T2	4.46	1.21	-,254*	-,265*	-0.039	0.101	0.190	,218*	0.077	,294**	,264*	-0.075	-0.142	-0.020	0.110	-0.081	0.000	,704**	1	,697**
HWB_T3	4.47	1.22	-,235*	-,317**	-0.189	0.154	0.119	,340**	0.134	,258*	,237*	-0.065	-0.165	-0.157	0.014	-0.154	-0.056	,621**	,697**	1

Note. $*p$ <0.05 (; $**p$ <0.01; $***p$ <0.001. *M* = mean. *SD* = Standard deviation. NC = Negative contact. PC =Positive contact. IA = Ingroup affect. IC = Ingroup centrality. IT = Ingroup Ties. HWB = Health and well-being. T1= Time 1. T2 = Time 2. T3 = Time 3.

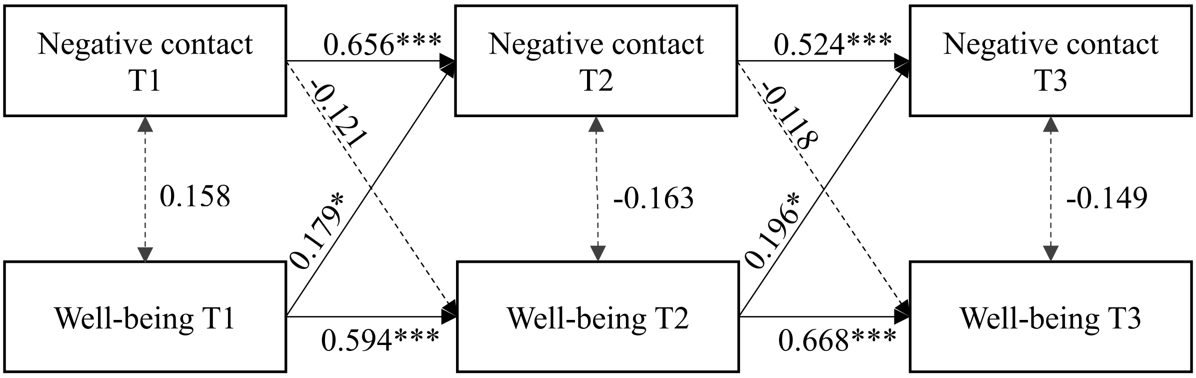
Table 5.2. Means, standard deviations, and correlations of the main variables under analysis (Study 2).

We found a reverse association for those with highest positive contact; that is, the cross-lagged path of well-being on subsequent negative contact was significant (T1 to T2: β = .179, *p* = .049; T2 to T3: β = .196, *p* = .033). Auto-regressive paths were significant for well-being and similar between the two groups (Table 5.3), which means that well-being was stable over time.

Low positive contact



High positive contact



Note. Estimates from the unconstrained model across groups are presented. *p* <0.05; ***p* <0.01; ****p* <0.001.

Figure 5.4. Standardized estimates from multiple group analysis, for well-being (Study 2).

Table 5.3. Standardized estimates from multiple group analysis for well-being (Study 2).

	Health and well-being (HWB)	
	Low PC	High PC
	β (p-value)	β (p-value)
NC T1 -> NC T2	0.504 (0.000)***	0.656 (0.000)***
NC T2 -> NC T3	0.401 (0.000)***	0.524 (0.000)***
HWB T1 -> HWB T2	0.649 (0.000)***	0.594 (0.000)***
HWB T2 -> HWB T3	0.625 (0.000)***	0.668 (0.000)***
HWB T1 -> NC T2	-0.107 (0.271)	0.179 (0.041)*
HWB T2 -> NC T3	-0.099 (0.254)	0.196 (0.033)*
NC T1 -> HWB T2	-0.187 (0.022)*	-0.121 (0.216)
NC T2 -> HWB T3	-0.153 (0.025)*	-0.118 (0.209)
Wave Intra-correlation		
NC T1 <-> HWB T1	-0.293 (0.019)	0.158 (0.353)
NC T2 <-> HWB T2	-0.182 (0.172)	-0.163 (0.336)
NC T3 <-> HWB T3	-0.141 (0.298)	-0.149 (0.382)
Sample size		
N	54	33

Note. Estimates from the unconstrained model across groups are presented. Fit indicators are shown in Table S4 in supplementary online materials. NC = Negative contact; PC = Positive contact; HWB = Health & Well-being. **p* <0.05; ***p* <0.01; ****p* <0.001.

Multiple group analysis for group identification

We again compared the constrained model across groups of lower versus highest levels of positive contact (equal parameters across groups) with an unconstrained model across groups (free parameters across groups). The latter model showed a better fit and we found different effects between groups in the specific cross-lagged path we wanted to test, for two of the three dimensions: (1) ingroup affect (Constrained model across groups: $\chi^2_{(20)}$ = 13.544, *p* = 0.853, RMSEA < 0.001, CFI = 0.999; Unconstrained model across groups: $\chi^2_{(16)}$ = 9.013, *p* = 0.913, RMSEA < 0.001, CFI = 0.999) and (2) ingroup ties (Constrained model across groups: $\chi^2_{(20)}$ = 10.859, *p* = 0.950, RMSEA < 0.001, CFI = 0.999; Unconstrained model across groups: $\chi^2_{(16)}$ = 6.582, *p* = 0.981, RMSEA < 0.001, CFI = 0.999; see Table S4 in SOM).

Ingroup affect model. The negative cross-lagged path of negative contact on subsequent ingroup affect was significant (T1 to T2: β = -.175, *p* = .023; T2 to T3: β = -.146, *p* = .016) for those who had lower positive contact. In contrast, we found no significant cross-lagged path of negative contact on subsequent ingroup affect (T1 to T2: β = -.069, *p* = .437; T2 to T3: β = -

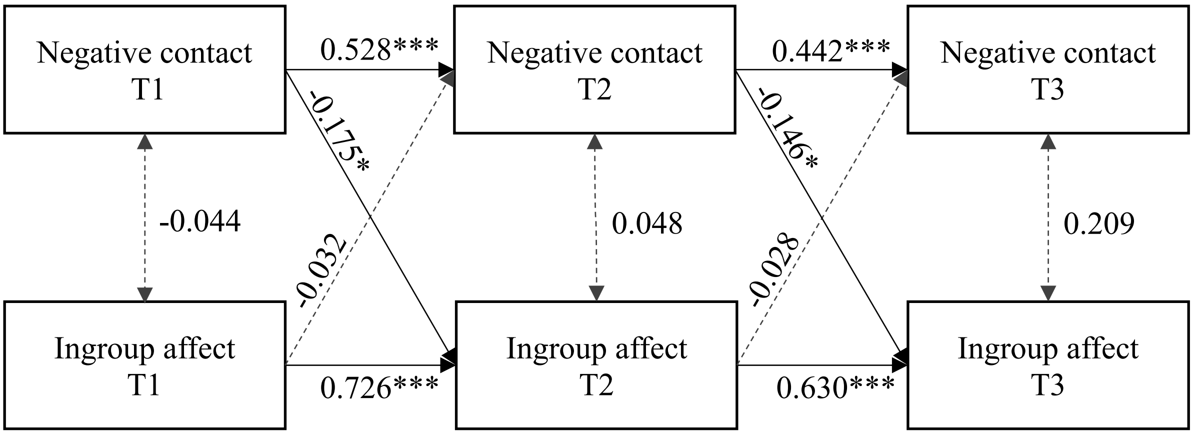
.080, *p* = .435) for those who had highest positive contact (see Figure 5.5, and Table 5.4). This indicates that the cross-lagged association between negative contact and lower ingroup affect was cancelled out at the highest level of positive contact, supporting our Hypothesis (1b).

Ingroup ties model. In this case, we found that the positive cross-lagged path of negative contact on subsequent ingroup ties was significant for participants who had highest positive contact (T1 to T2: β = .232, *p* = .021; T2 to T3: β = .216, *p* = .018). We found no significant cross-lagged path of negative contact on subsequent ingroup ties for those who had lower levels of positive contact (T1 to T2: β = .047, *p* = .575; T2 to T3: β = .044, *p* = .574; see Figure 5.6, and Table 5.4). Therefore, positive contact did not attenuate the cross-lagged association between negative contact and ingroup ties, as predicted in our Hypothesis (1b). On the contrary, positive contact at the highest level enhanced the association between negative contact and higher ingroup ties.

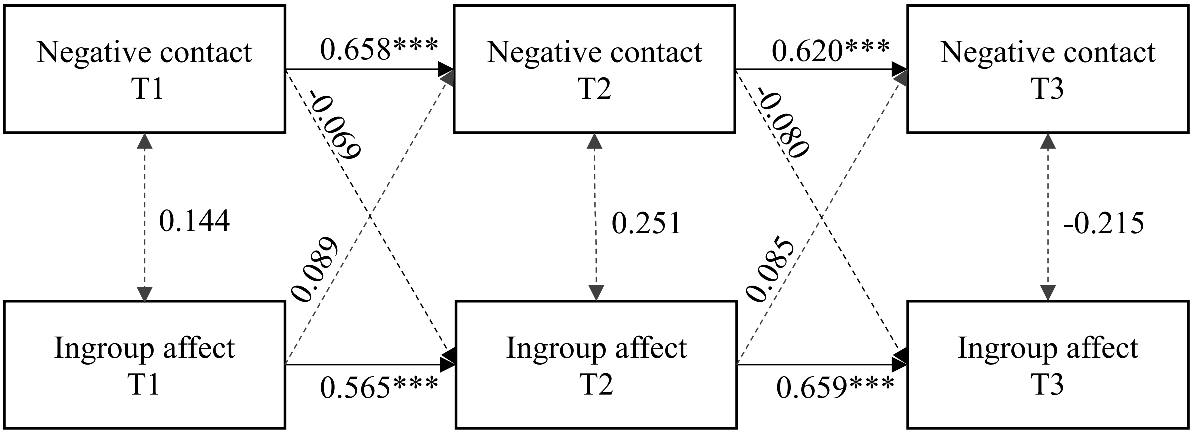
Ingroup centrality model. In the case of ingroup centrality, the constrained model across groups showed a better fit than the unconstrained model across groups (Constrained model across groups: $\chi^2_{(20)}$ = 29.262, *p* = 0.083, RMSEA = 0.103, CFI = 0.929; Unconstrained model across groups: $\chi^2_{(16)}$ = 25.779, *p* = 0.057, RMSEA = 0.119, CFI = 0.925; see Table S4 in SOM). This indicates that there were no differences between groups (of positive contact), and because of this we presented the results for the constrained model across groups. Therefore, we did not confirm our Hypothesis (1b) for centrality, as positive contact did not moderate the association between negative contact and centrality. In addition, we found no significant cross-lagged path of negative contact on subsequent ingroup centrality (e.g., lower positive contact: T1 to T2: b = .083, *p* = .279; T2 to T3: b = .068, *p* = .290; see Table 5.4).

The reverse associations, that is, the cross-lagged path from each dimension of identity (ingroup affect, ties and centrality) to subsequent negative contact were non-significant (see Table 5.4). In addition, negative contact and the three dimensions of identity predicted the same measures of the subsequent wave (i.e., auto-regressive paths), which means that they were stable over time.

Low positive contact

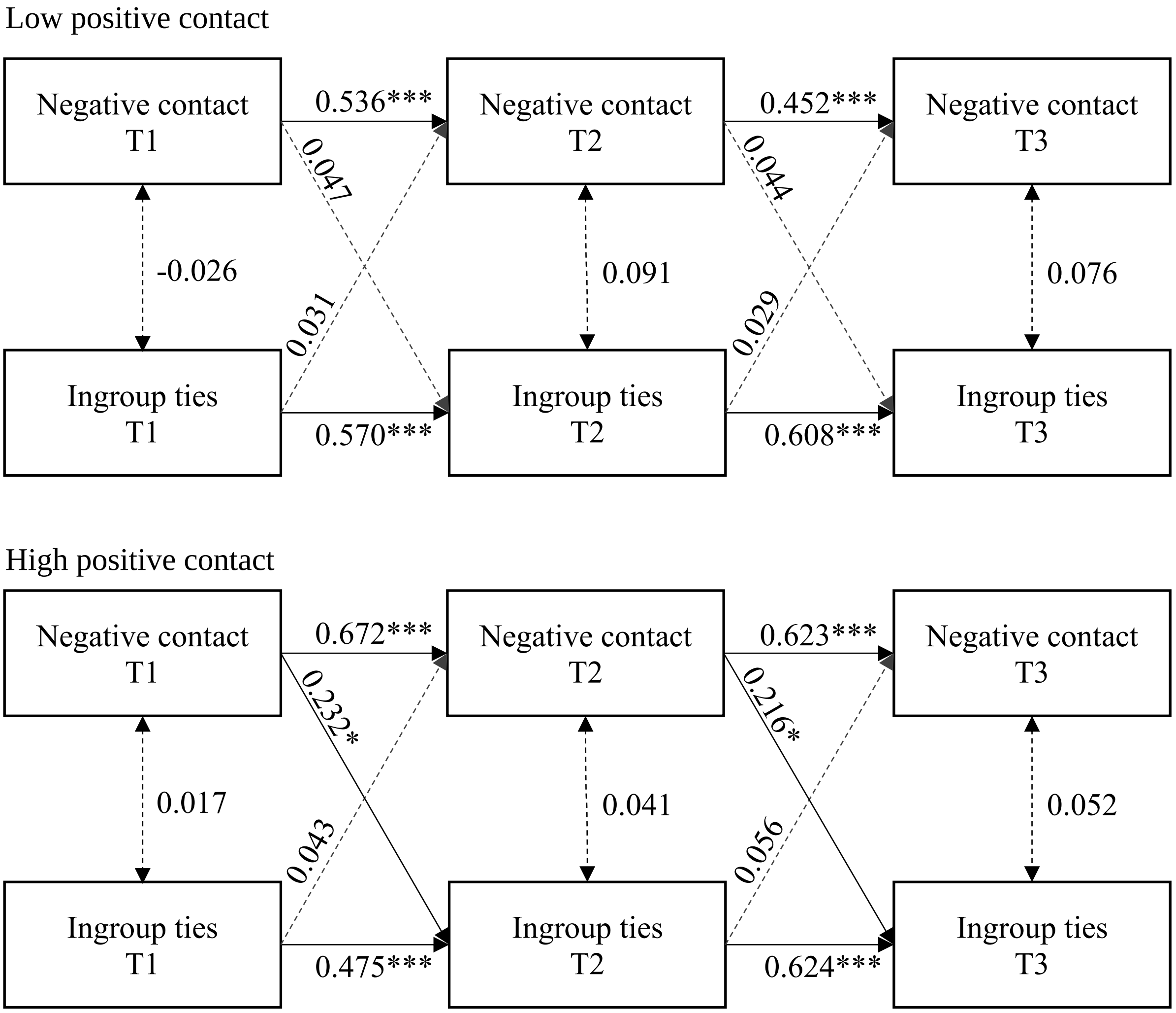


High positive contact



Note. Estimates from the unconstrained model across group are presented. $p < 0.05$; $**p < 0.01$; $***p < 0.001$.

Figure 5.5. Standardized estimates from multiple group analysis, for ingroup affect (Study 2).



Note. Estimates from the unconstrained model across groups are presented. p <0.05; **p <0.01; ***p <0.001.

Figure 5.6. Standardized estimates from multiple group analysis, for ingroup ties (Study 2).

Table 5.4. Standardized estimates from multiple group analysis for group identification (Study 2).

	Group identification (ID)					
	Ingroup affect		Ingroup ties		Ingroup centrality	
	Low PC	High PC	Low PC	High PC	Low PC	High PC
	β (p-value)	β (p-value)	β (p-value)	β (p-value)	β (p-value)	β (p-value)
NC T1 -> NC T2	0.528 (0.000)***	0.658 (0.000)***	0.536 (0.000)***	0.672 (0.000)***	0.590 (0.000)***	0.613 (0.000)***
NC T2 -> NC T3	0.442 (0.000)***	0.620 (0.000)***	0.452 (0.000)***	0.623 (0.000)***	0.539 (0.000)***	0.551 (0.000)***
ID T1 -> ID T2	0.726 (0.000)***	0.565 (0.000)***	0.570 (0.000)***	0.475 (0.000)***	0.599 (0.000)***	0.475 (0.000)***
ID T2 -> ID T3	0.630 (0.000)***	0.659 (0.000)***	0.608 (0.000)***	0.624 (0.000)***	0.485 (0.000)***	0.518 (0.000)***
ID T1 -> NC T2	-0.032 (0.718)	0.089 (0.342)	0.031 (0.722)	0.043 (0.602)	0.008 (0.898)	0.008 (0.898)
ID T2 -> NC T3	-0.028 (0.717)	0.085 (0.340)	0.029 (0.722)	0.056 (0.597)	0.008 (0.898)	0.010 (0.898)
NC T1 -> ID T2	-0.175 (0.023)*	-0.069 (0.437)	0.047 (0.575)	0.232 (0.021)*	0.083 (0.279)	0.069 (0.294)
NC T2 -> ID T3	-0.146 (0.016)*	-0.080 (0.435)	0.044 (0.574)	0.216 (0.018)*	0.068 (0.290)	0.058 (0.302)
Wave Intra-correlation						
NC T1 <-> ID T1	-0.044 (0.747)	0.144 (0.398)	-0.026 (0.850)	0.017 (0.922)	0.080 (0.555)	0.175 (0.298)
NC T2 <-> ID T2	0.048 (0.726)	0.251 (0.123)	0.091 (0.505)	0.041 (0.811)	0.105 (0.442)	0.180 (0.288)
NC T3 <-> ID T3	0.209 (0.111)	-0.215 (0.195)	0.076 (0.579)	0.052 (0.764)	0.198 (0.135)	0.111 (0.522)
Sample size						
N	54	33	54	33	54	33

Note. Estimates from the unconstrained model across groups are presented for ingroup affect and ties. Estimates from the constrained model across group are presented for ingroup centrality. Fit indicators are shown in Table S4 in supplementary online materials. NC = Negative contact; PC = Positive contact; ID = Group identification. **p* <0.05; ***p* <0.01; ****p* <0.001.

7. General Discussion

This research investigated how the interaction between negative and positive intergroup contact influence the well-being and group identification of disabled people. We analysed data from a one-week diary study (Study 1) and a three-wave, two-year longitudinal study (Study 2).

We found partial support for our main hypothesis, which posits that positive contact moderates the effects of negative contact on well-being (1a) and group identification (1b). Although there are differences across the two studies, there is a basic consistency in our key findings, despite the different methods used. We discuss these results in terms of buffering effects of positive contact on well-being and group identification. In addition, we also explore negative or null effects between negative contact and identification, and identification and well-being, which could open directions for future research. Finally, we conclude by acknowledging some limitations of the present research.

7.1.H1a: Buffering effects of positive contact on well-being

In line with our Hypothesis (1a), results show that positive contact can mitigate and even neutralize the association between negative contact and well-being. This is more evident in Study 2, in which negative contact was directly associated with lower well-being over time for lower levels of positive contact, but there was no association for the highest level of positive contact. However, in Study 1, we did not find a direct association between negative contact and well-being nor did we find that positive contact moderated this relationship. A negative association between negative contact and well-being is in line with previous studies showing that perceived discrimination was associated with lower health and well-being (Pascoe & Smart-Richman, 2009; Schmitt et al., 2014). In this study, we extended these findings to the association between negative contact and well-being, showing that positive contact can attenuate and even cancel out this association. This effect was expected, since previous research found that negative contact was associated with category salience (Paolini, 2010) and group discrimination, but positive contact was not associated with group discrimination (e.g., Reimer et al., 2017). Therefore, positive contact may decrease the effects of negative contact by reducing category salience (Arnadóttir et., 2018; Paolini et al., 2014) and the consequent threats to well-being. Another possible explanation could be that positive contact may promote the perception of intergroup respect, which could have positive consequences for well-being (Huo et al., 2010).

7.2.H1b: Buffering (and facilitation) effects of positive contact on group identification

In line with our Hypothesis (1b), results show that negative contact was more strongly associated with lower ingroup affect particularly for those who had lower positive contact, in Study 1. Similarly, in Study 2, the cross-lagged association between negative contact and lower ingroup affect was significant only for respondents with lower levels of positive contact. The negative association between negative contact and ingroup affect is in line with previous studies showing that perceived discrimination was negatively related to ingroup affect (Ramos et al., 2012). Here, however, we found that this association was significant and strong (Study 1) or significant (Study 2) only for lower levels of positive contact.

In the case of ingroup ties, however, the moderation of positive contact took a different direction than expected, for the highest level. In Study 1, negative contact was associated with lower ingroup ties for lower-than-average levels of positive contact (buffering effect). Although this association became positive for the highest level of positive contact. Similarly, in Study 2, negative contact was associated with higher ingroup ties, but only for those who had highest positive contact. Although the association between perceived discrimination (or negative contact) and ingroup ties has proved difficult to confirm in previous studies (e.g., Ramos et al., 2012; Reimer et al., 2017), a positive association between them is expected due to feelings of belongingness and social support among ingroup members (e.g., Jetten et al., 2017). In this research, we did find a positive association between negative contact and ingroup ties, but here it only occurred for the highest level of positive contact, suggesting a facilitation effect.

A buffering effect of positive contact on the association between negative contact and lower ingroup affect (Study 1 and 2), or ingroup ties (Study 1), was expected, since group membership was more salient in contexts of negative contact (versus positive contact; Paolini, 2010). More unexpected was the facilitation effect of positive contact in the association between negative contact and higher ingroup ties. However, previous studies have supported buffering and facilitation effects of positive contact on the association between negative contact and attitudes toward the outgroup (Arnadóttir et., 2018). While positive contact decreases category salience (buffering), a facilitation (or exacerbation) effect may occur when positive contact creates a more extreme contrast from the presumed neutral point (Arnadóttir et., 2018). Moreover, in these studies, positive contact did not only buffer but actually neutralized some of these effects under higher-than-average levels of positive contact. In our research, cancelling (Study 2) and facilitation (Studies 1 and 2) effects were visible mostly for the highest value of positive contact. This could be due to differences in methodology (especially in Study 2 in which positive contact was divided into two groups for cross-lagged multiple group analysis), but also because positive contact is generally more common (and we found the same in our studies) than negative contact (e.g., Graf et al., 2014).

Another possible explanation could be that positive contact may promote the perception of intergroup respect fulfilling the (identity) need of empowerment of disadvantaged group members (Nadler & Shnabel, 2015), which, on the one hand, could attenuate the adverse consequences of negative contact on ingroup affect, and on the other hand, could promote positive ingroup ties, due to the valorization of ingroup identity along with a positive identity on the superordinate group (e.g., Hässler, 2021).

In both studies, we found no evidence that positive contact moderated the association between negative contact and centrality, whereas it did for ingroup affect and ingroup ties. Moreover, we found a negative association between negative contact and centrality in Study 1, but we did not find a longitudinal association these variables in Study 2. This result goes against a positive association between perceived discrimination and centrality over time (Ramos et al., 2012), but it is in line with a previous study showing a null effect of negative contact and centrality over time (Reimer et al., 2017).

7.3. Considerations on the relationship between negative contact and identification, and identification and well-being

A possible explanation for a negative (or null) association between negative contact and group identification relies on the difference between negative contact and perceived group discrimination. Although negative contact has been associated with perceived group discrimination (Hayward, et al., 2018; Reimer et al., 2017), negative contact may have different implications for group identification once it is focused on negative experiences at the personal level (i.e., frequency of negative contact with members of another group). In line with this, the experience of personal discrimination has been strongly associated with lower psychological well-being (e.g., self-esteem), compared with group discrimination (Bourguignon et al., 2006; Schmitt et al., 2014). Therefore, negative contact could be more associated with negative emotions (ingroup affect) related to group membership and avoidance or downplaying of group membership (centrality). Moreover, disadvantaged groups are more likely to underestimate discrimination against themselves, even when they recognize group discrimination (see Barreto & Ellemers, 2015, for a review). This would underline the perceived illegitimacy of negative treatment, an important condition for perceived discrimination to increase group identification (Branscombe et al., 1999; Jetten et al, 2011).

This could be more difficult in the case of disabled people because disability may be both more stigmatizing and more legitimized, than other types of discrimination. Discrimination based on disability is more negatively associated with well-being than other types of discrimination (Branco et al., 2019; Schmitt et al., 2012), and disability prejudice has proved more intractable over time than other forms of prejudice (Charlesworth & Banaji, 2019; Harder et al., 2019). Moreover, disabled people are subject to several forms of benevolent and paternalist discrimination (e.g., pity; unwanted help, infantilization; Nario-Redmond et al., 2019) that could be more difficult to recognize as illegitimate.

In addition, we found evidence for the association between group identification and higher well-being in Study 1, but not in Study 2. This could mean that this association may be present cross-sectionally, but it may not be maintained over time. Although the association between group identification and well-being is supported through literature on both rejection-identification (Branscombe et al., 1999) and the social cure (Jetten et al., 2017), the majority of available evidence is correlational. Future studies should adopt both longitudinal and experimental methodologies to verify the impact of identity on well-being.

7.4.Limitations

Although we tried to recruit as many people as we could from local organizations and social networks, the samples obtained for analysis in both studies are small. Both studies required repeated completion of measures, increasing the challenges of data collecting, but providing a much-needed dynamic perspective in this field of study. In addition, because of the demands of a daily diary (Study 1), we used only one or two items per construct, so the diary could be completed in just a few minutes each day. Still, less than half of the participants completed the diary across all seven days. Despite these challenges, our key findings are consistent across the two studies, using different methodologies (i.e., diary and three-wave survey). In addition, due to our small samples, we were unable to test more complex models with the three dimensions of identity as mediators in the same model, which means that there may be some covariance component that was not considered in these models. Finally, in the absence of experimental data, we could only assess the associations between the constructs, that is, between contact and both identity and well-being.

Despite these limitations, this research comprised two samples of disabled people, a group which is underrepresented in the literature, and in both studies data was collected over time. Moreover, this research is the first to test the interaction between negative and positive contact on well-being and group identification among disadvantaged group members. The approach used here represents a major advance in the study of intergroup contact for disadvantaged group members.

8. Conclusion

This research shows that positive contact has the potential to attenuate the adverse consequences of negative contact on well-being and ingroup affect, supporting the expected buffering effect of positive contact. In addition, our findings show that positive contact can facilitate a positive association between negative contact and ingroup ties, suggesting a facilitation effect of positive contact. These results support the proposition that positive contact does not necessarily have a negative impact on collective action for social change, through reduced group identification (e.g., Hässler, 2021). On the contrary, this research shows the importance of promoting positive intergroup contact to protect the well-being and social identity of disadvantaged group members, and, in particular, disabled people. Finally, this research highlights the importance of considering both negative and positive intergroup contact for disadvantaged group members and demonstrates the importance of considering the specific dimensions of group identification in the dynamics between negative and positive intergroup contact.

CHAPTER VI.

The interaction between social equality and personal assistance: A cross-country analysis

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1. Abstract

Several countries have enacted personal assistance (PA) legislation over the past few decades. Although this policy has been associated with improvements in the quality of life, here we explore how it interacts with the social environment. We examine how the existence of PA legislation influences the effect of social equality on the health and well-being of disabled people. Multilevel analysis was performed using data from the European Social Survey (n = 18,924), including 31 countries and 7 waves of data (2002-2014). Results show that social equality has a positive effect on well-being, but only in countries with PA. The relationship between social equality and well-being, in countries with PA, is explained by increased public participation, satisfaction with the political and economic situation, and a more positive opinion about the health services. Our findings highlight the importance of PA in influencing disability equality and improving disabled people's well-being.

Keywords: social factors of health and well-being; inequality; personal assistance; disabled people; disability equality.

2. Introduction

The wealth and social equality of a country are critical factors of the health and well-being of the general population (Marmot, 2005; Marmot et al., 2012). Despite disabled people being one of the largest social minorities (15% of the world's population; World Health Organization [WHO], 2011), they have received much less academic attention than other disadvantaged groups (Olkin & Pledger, 2003) and the impact of social factors[11], such as wealth and social equality, on this group is still under-researched. Disabled people face particular social disparities due to discrimination based on disability, defined as ableism. "Ableism is stereotyping, prejudice, discrimination, and social oppression toward [disabled people]" (Bogart & Dunn, 2019, p. 645). Due to ableism, disabled people tend to have poorer access to health services, and lower levels of education and employment (World Health Organization, 2011). Implicit prejudice towards disabled people has increased (Harder et al., 2019), or maintained over time in contrast to prejudice against other disadvantaged groups that has decreased in the last decades (Charlesworth & Banaji, 2019). Moreover, research has shown that ableism is more adverse for well-being compared to other types of group-based discrimination (Branco et al., 2019).

However, due to the tendency to treat disability as an individual and medical factor, it is still unclear what are the implications of the social environment for the well-being of this group. In this study, we analyse the association of country's wealth and social equality with the health and well-being of disabled people and the role of personal assistance in shaping this association. In addition, we identify specific socio-psychological mechanisms explaining the relationship between social equality and health.

2.1.Disability and personal assistance

The Convention on the Rights of Persons with Disabilities [CRPD] define 'people with disabilities' as 'those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others' (2006, p. 4). Although the CRPD has a human-rights based approach that could be considered a social approach, it still uses a person-environment interaction to define disabled people and disability (i.e., Kazou 2017). We agree that the definition of disabled people should include all characteristics considered as impairments,

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[11] Throughout this chapter, which reflects the published article, "social factors" was used instead of "social determinants", to be more accessible to a greater number of readers.

whether attributed by the person or by others. However, considering the social model of disability, we argue that it is more adequate to define disabled people in terms of social oppression. The social model of disability (Oliver, 1983; Oliver & Barnes, 2010) emerged with the spread of the disability movement throughout Europe, during the 80s', arguing that disability derives directly from environmental, social and attitudinal barriers, rather than from individuals' bodies and minds, as argued by the prior individual and medical model of disability (Brisenden, 1986). In social psychology there is a similar paradigm (although it had no impact for a long time, Olkin & Pledger, 2003). The social constructivism approach defines disability as a social construction, implying that disability results from the meanings, attitudes and institutions of the non-disabled people, rather than by individual limitations (Fine & Asch, 1988).

Therefore, considering a social/constructivist model, and the definition of ableism, we define disable people as those who are oppressed by social, attitudinal and environmental barriers on the basis of a physical, sensory, intellectual or developmental/learning disability, or mental illness (i.e., on the basis of ability). In addition, an identity-first language (i.e., the term disabled people) is more congruent with the social model, than person first language (i.e., persons with disabilities). Disabled people is used to emphasize the group identity marked by common historical, social and political experiences (Linton, 2006). It also means that 'people are disabled by environmental, systematic and attitudinal barriers in society, rather than by their impairment' (European Network on Independent Living [ENIL], n.d.). On the other hand, 'persons with disabilities' seems more congruent with the medical and individual model of disabilities as it puts disability on the person (i.e., the person has the disability and not the environment). Therefore, throughout this work we use the term 'disabled people'.

Driven by the independent living movement that started in the USA in the '60s (DeJong, 1979), personal assistance is based on the independent living philosophy. This philosophy claims that disabled people should have the same choice and control over their lives as non-disabled citizens, through the combination of a range of tools, such as personal assistance (Morris, 2004; ENIL, n.d., 2022a).

Personal Assistance (PA) is a support service, enacted by the state, for daily living activities, in which disabled people must have full control over the service, recruiting, selecting, training, and managing their assistants and daily schedule. The disabled person is considered an active recipient of the service, contrasting with the traditional home care services that offer few or no choices over the selection of assistants, type of activities involved, and how these activities are scheduled and performed (Beatty et al., 1998). Ideally, in its full empowering form (based on the experiences and policy recommendation of disabled people’s movements; Ratzka, 2004), PA should be funded by the state and funds should be channelled through the recipient (i.e., direct payments or personal budgets), making the user the employer of the service. Shaped by a strong component of collective action, peer-support is a strong element of PA as service users need appropriate support with tasks management, such as advertising, recruitment and employment of assistants, which should be provided through user-led organizations (Barnes, 2007; Morris, 2004; Ratzka, 2004).

Currently, several countries in Europe have enacted legislation on PA, but the characteristics of PA schemes vary widely across and within countries. PA services are mostly funded by the state through municipalities or regional agencies (ENIL, 2013, 2015). However, these schemes can vary at the level of administration (national, municipal), funding arrangements (e.g., option for direct payments), amount of control that disabled people have over the service (e.g., choice of providers) or in the availability of services (e.g., restrictions in age and type of disability, hour limit).

The impact of PA (commonly termed consumer-directed PA in this literature), primarily studied in the USA context, has been associated with better outcomes, compared to home care services (commonly termed agency-based PA). These outcomes are related to greater empowerment, satisfaction with the service, better quality of life (Hagglund et al., 2004), higher levels of safety and fewer unmet needs (M. J. Clark et al., 2008; Benjamin et al., 2000), greater control over the services (Fleming-Castaldy, 2011; Beatty et al., 1998), lower costs, and better health outcomes (i.e., fewer re-hospitalisations for preventable conditions; Mattson-Prince, 1997). More recently, a literature review (J. C. Anand et al., 2012) based on studies from UK, Ireland, Netherlands, USA and Canada showed that service users of direct payments or personal budgets have more choice and control over how support is provided, improved personal dignity, better health, better economic well-being, greater quality of life, and support for having paid employment, vocational skills training, to take part in volunteer activities and enroll in postsecondary education.

However, to understand how PA interacts with wealth and social equality, research needs to adopt new models accounting for these services together with societal variables. As an essential tool for disabled people’s inclusion and self-determination, PA should have an important role in disability equality.

2.2.The social factors of health: Wealth and social equality

For a long period, the level of wealth of a country, commonly measured through the Gross Domestic Product (GDP), was considered the main factor of its population's health. However, this is no longer the best indicator of health in developed countries, given that, despite their economic growth, some countries still have a high level of public health issues (e.g., drug abuse, violence, teenage births). Given that differences in income within societies are more strongly associated with health than are differences in income between countries (R. Wilkinson and Pickett 2010), the level of social inequality within a country emerged as a key determinant of health. The common interpretation of this relation is that inequality leads to chronic stress and anxiety that affects health and social relationships, by decreasing social trust and increasing status competition (Kawachi & Kennedy, 1999; Wilkinson & Pickett, 2006, 2010).

In a review of 155 papers and 168 analyses, published between 1975 and 2005, a large majority of these analyses (70 per cent) concluded that health is worse in societies with larger income inequalities (Wilkinson & Pickett, 2006). Additionally, a meta-analysis of 54 articles, published between 1997-2008, revealed that income inequality was associated with both mortality and poor self-rated health (Kondo et al., 2009).

Research has focused on how these socio-economic factors influence the health of the general population, including the prevalence of conditions related with impairment (e.g., mental illness, physical morbidity), but not on how these factors determine the health and well-being of disabled people. A national survey in the USA revealed that disabled adults receive significantly fewer preventive health services and have poorer health status on secondary conditions (e.g., cardiac disease, high blood pressure, high cholesterol, diabetes, stroke, asthma) than non-disabled adults (Reichard et al., 2011, 2014). Although these differences are attributed to social factors rather than impairment, there is a lack of research linking disabled people's health with social factors. Moreover, we argue that despite the existence of social policies - such as personal assistance – with a positive impact on well-being of disabled people, the impact of these policies along with social factors remains unknown.

In fact, there is an ongoing debate about the relationship between personal assistance and equality. On the one hand, PA is considered a way to achieve social justice through greater autonomy, choice, and inclusion. On the other hand, there is a concern that the introduction of PA without considering specific needs or characteristics of different groups could result in more inequalities (Mladenov et al., 2015). The idea is that user-centred models can increase inequalities by being more accessible for those who have certain characteristics (e.g., more educated, have a larger social network, being middle class) over others in a more disadvantaged position and with fewer resources (e.g., racial or ethnic minorities; J. C. Anand et al., 2012; Clarke, 2006; Gadsby, 2013). In addition, the majority of PA schemes exclude disabled people based on their age and or type of disability (ENIL, 2013, 2015). Therefore, it seems that in contexts with more inequality, in which some groups are less educated and have less economic and social resources, PA could enhance the negative impact of such inequalities, in cases where the cause of those inequalities is not addressed in its implementation. This can be more serious when PA is decentralized, promoting inequalities between regions (Brennan et al. 2017); administrations do not guarantee users' control over the service; cuts or inappropriate funding leads to low number of assistance hours and failure to cover all expenses associated with users' training and peer support, which harms the maintenance of user-led organizations (Barnes, 2007; Mladenov, 2020). PA itself should not, however, be a factor of inequality; on the contrary, PA should be an enabler of social justice by promoting autonomy, participation and equal access to social goods and services. PA has been defended by disability advocates and in international documents as a crucial condition for disability equality, such as in the Convention on the Rights of Persons with Disabilities [CRPD]. The CRPD (2006, article 19) recognises the right of disabled people concerning to living independently and being included in the community, on an equal basis with others, through access to a range of community-based services, including personal assistance. Similarly to other social movements, the pursuit for disability justice is not only a matter of welfare rationality (i.e., economic distribution) but also a demand for cultural recognition (i.e., respecting and valuing difference) and political representation (for an application of Fraser's [1996] work to disability equality, see Mladenov, 2017). In this study, we seek to contribute to the understanding of how PA interacts with social equality.

In our analytical approach, we examine how personal assistance may interfere with the relationship between country's indicators (i.e., wealth and social equality) and disabled people's health and well-being, with a focus on within-country effects.

2.3.The socio-psychological mechanisms explaining equality effects

There is some evidence from parallel work focusing on the mechanisms between inequality and health, that might be generalized to the context of the present study to understand the moderating role of PA – how PA interact with social equality to produce positive outcomes for disabled people. These mechanisms include public participation, the political and economic situation, and the state of the health services.

Public participation. One of the main mechanisms suggested by previous work is that income inequality leads to the loss of civic trust and participation. More specifically, income inequality is positively correlated with low levels of civic trust and associational membership (e.g., sports groups, fraternal organizations, labour unions; (Kawachi et al., 1997). Besides, it has been shown that income inequality decreases political participation (Solt, 2008) and voter turn-out (Cancela & Geys, 2016). In other words, income equality is associated with increased public participation. For disabled people, however, this could be still undermined if PA is not available. For instance, PA leads to fewer unmet needs regarding daily living activities (M. J. Clark et al., 2008) and it includes activities related to social participation, such as assistance in transportation, communication, and use of public infrastructure, which all promote inclusion in a broad range of social activities (von Granitz et al., 2017). On the other hand, disabled people are often excluded from activities related to political participation due to social barriers (e.g., lack of accessibility to build environments, political information, and communication; (Priestley et al., 2016), that could also be overcome by PA.

Political and economic situation. Previous work suggests that income inequality threatens democracy given that it decreases political trust (Zmerli & Castillo, 2015), political participation (Solt, 2008), and voter turn-out (Cancela & Geys, 2016). On the other hand, income inequality is a threat to the economic system as it is likely to increase corruption in government and society (You & Khagram, 2005), and leads to debt and financial crashes (Iacoviello, 2008; Wisman & Baker, 2011). In other words, equality has a positive association with democracy and economic development, both positively associated in previous studies (Burkhart & Lewis-Beck, 1994; De Haan & Siermann, 1995). For disabled people, however, PA could be an essential feature to enable a higher satisfaction with the democratic and economic system in the country. PA allows disabled people to participate in a major range of activities, including political activities, which would favour the democratic process. In addition, since PA is based on democratic and social justice values, it could promote a more positive perception of the democratic system. On the other hand, the economic redistribution of funding for PA, in addition to improving democracy, can also be a contributing aspect to the economic system. Public investment in community services should be based on human rights and social justice despite its economic value. Although evidence shows that from a financial perspective this is also the right policy to adopt, as PA can be the most cost-effective way of supporting disabled people. PA appears to be less expensive than the agency and residential models, and it generates employment for personal assistants and promotes disabled people's active participation in society, as customers, workers, students, and taxpayers (Doty et al., 1996; Hurstfield et al., 2007b). Furthermore, PA is related to lower costs at the individual level, compared to home care services (Mattson-Prince, 1997).

Health services. Income inequality is associated with cuts on health insurance, social welfare, and expenditure on medical care, which are expected to lead to poor health (Lynch et al., 2000). Additionally, primary care is positively associated with health status and serves as a pathway through which inequality affects health (Shi et al., 1999). In other words, equality is associated with the improvement of healthcare services. However, its positive effects are not necessarily extended to disabled people, who on average experience more difficulty in accessing health care and receive less preventive care than the general population (Reichard et al., 2014; World Health Organization, 2011). PA could be an important feature enabling better health services and more positive perceptions of it, given that its presence makes services more accessible to disabled people. Furthermore, PA is related to better physical and mental health (M. A. Nosek, 1993), fewer re-hospitalisations for preventable conditions (Mattson-Prince, 1997), reduced nursing facility use and improved medication management (J. C. Anand et al., 2012). In contrast, inadequate PA led to extended hospital stays, threats to safety, poor nutrition, and poor personal hygiene (M. A. Nosek, 1993).

2.4.The present study

The aim of this study is to analyse the association of both country wealth and social equality with the health and well-being of disabled people, and how the existence of personal assistance could shape this relationship. We bring to bear one of the largest data sets related to disability by conducting a secondary analysis of 12 years of data across 31 European countries. Moreover, most comparative studies examining the association between social equality and health are based on between-country comparisons, but it is not clear whether these comparisons would translate into similar within-country effects (i.e., tracking this association within countries and over time). In our work, we used a novel methodological approach (Fairbrother, 2014), allowing us to disentangle between- from within-country effects.

We first test the direct relationship of wealth and social equality with the health and well-being of disabled people, which is followed by testing the moderating effect of personal assistance on this relationship. We hypothesise that better country-level socioeconomic conditions (i.e., higher levels of wealth and higher social equality) should have a positive impact on the health and well-being of disabled people and that these effects, especially that of social equality, should be strengthened in countries with personal assistance. In a second step, we perform conditional process analysis (Hayes, 2018) to examine the role of personal assistance on the relationship between social equality and the health of disabled people through specific socio-psychological mechanisms. We hypothesise that the relationship between social equality and health is explained through increased public participation, satisfaction with the political and economic situation, and more positive opinions about the health services, only in countries with personal assistance.

3. Method

3.1.Respondents and procedure

We used secondary data from the European Social Survey (ESS), a repeated cross-national survey conducted across 36 European countries, including nationally representative samples. We analysed seven waves of cross-sectional data (from 2002 to 2014), containing a wide range of measures assessing attitudes, beliefs, and behaviour patterns, which have been used in multiple publications relevant for social policy and practice. Data was collected through face-to-face interviews, using show cards containing the answer options to facilitate responses.

We selected for analysis all individuals who responded: ‘Yes, a lot’ to the question ‘Are you ‘hampered’ in your daily activities in any way by any longstanding illness, or disability, ‘infirmity’ or ‘mental health problem’?’ resulting in a total sample of 18 924 respondents, from 31 countries. This type of question is based on a functional, individual and medical approach to disability, which may not be the best way to measure disability (e.g., we do not know if people are hampered due to barriers or lack of support; there are disabled people who are not hampered in daily activities). However, this was the question available that most resembled disability and of those who could benefit directly from personal assistance. Of these respondents, 59% were female, 46% were married, and 15% were in paid work and 50% were retired in the last 7 days. Respondents were on average 61.75 years old (*SD* = 16.9; range from 15 to 102 years old) and had completed 10 years (*SD* = 4.17) of full-time education (see Table 6.1 for more details about the sample).

3.2.Measures

Country-level variables: GDP and Equality

Country wealth was measured with the Gross Domestic Product (GDP per capita in current US$) using World Bank data. We used the dissimilarity index (Massey & Denton, 1988) to compute a country-level measure of social inequality based on respondents’ educational distributions.

Table 6.1. Sample demographics by country.

	Countries										
Variables	Austria	Belgium	Switzerland	Czech Republic	Germany	Denmark	Estonia	Spain	Finland	France	Great Britain
N	347	632	400	673	1240	539	1040	600	1087	850	1498
Sex (%)											
Male	39	44	47	42	49	44	38	37	45	43	44
Female	61	56	53	58	51	56	62	64	55	57	56
Age											
M	58	59	58	62	60	57	63	66	62	61	62
SD	19	17	17	15	17	18	17	17	17	17	17
Education											
M	11	11	10	11	12	12	11	7	10	10	12
SD	3	4	3	3	3	5	4	5	4	4	3
Born in country (%)											
Yes	92	89	76	95	92	92	70	97	98	91	93
No	8	11	24	5	8	8	30	3	2	9	7
Belonging to a religion (%)											
Yes	79	51	70	43	54	58	40	82	71	55	57
No	21	49	30	57	46	42	60	18	29	45	43
Marital status (%)											
Married	40	49	50	41	53	43	45	54	50	40	41
Separated	1	2	2	1	1	1	1	2			2
Divorced	13	17	15	15	13	18	13	3	16	18	16
Widowed	24	15	15	32	17	14	24	27	16	22	22
Never married	23	17	19	11	16	24	18	14	17	20	19
Employment status (%)											
Retired	181	224	131	396	616	229	633	218	701	411	733
Permanently sick/ disabled	23	211	120	128	190	94	143	133	93	190	483
Paid work	80	84	92	79	227	93	199	63	198	153	145
Unemployed	19	24	10	24	72	26	29	22	43	39	33
Ever unemployed (%)											
Yes	30	33	22	22	34	37	24	26	33	34	27
No	70	67	79	78	66	63	76	74	67	66	73
Feeling about household's income (%)											
Living comfortably	83	111	113	15	254	230	22	91	149	105	368
Coping	149	252	166	220	607	210	455	258	635	309	718
Difficult	62	187	82	245	256	50	364	180	203	194	280
Very difficult	49	78	36	169	118	39	191	65	91	45	130

Table 6.1. (continued)

	Countries										
Variables	Hungary	Ireland	Lithuania	Netherlands	Norway	Poland	Portugal	Sweden	Slovenia	Bulgaria	Cyprus
N	898	533	508	898	627	795	556	764	944	361	215
Sex (%)											
Male	43	51	31	39	46	43	29	42	44	39	37
Female	57	49	69	61	54	57	71	58	56	61	63
Age											
M	64	58	66	58	56	63	65	59	63	66	62
SD	15	17	13	17	18	16	16	18	15	14	18
Education											
M	10	12	10	12	12	9	4	11	10	9	8
SD	4	4	4	4	4	4	4	4	3	4	5
Born in country (%)											
Yes	98	89	93	92	91	98	97	86	89	99	97
No	2	11	7	8	9	2	3	14	11	1	3
Belonging to a religion (%)											
Yes	73	85	91	45	57	95	92	33	67	84	97
No	27	15	9	55	43	5	8	67	33	16	3
Marital status (%)											
Married	47	47	34	43	48	53	56	45	54	53	60
Separated		7	1	1	2	1	1		1	1	
Divorced	13	4	15	16	14	6	5	18	6	4	6
Widowed	29	16	41	17	12	28	28	12	25	37	25
Never married	10	25	9	22	24	12	11	24	14	5	9
Employment status (%)											
Retired	565	164	304	261	189	558	335	289	553	231	106
Permanently sick/disabled	171	178	90	321	189	63	52	175	65	50	33
Paid work	52	64	71	137	146	85	57	196	135	35	34
Unemployed	26	24	23	40	22	25	23	33	45	18	8
Ever unemployed (%)											
Yes	23	25	24	24	25	18	17	27	23	23	15
No	77	75	76	76	75	82	83	73	77	77	85
Feeling about household's income (%)											
Living comfortably	22	91	20	248	277	9	12	319	182	1	16
Coping	269	228	188	363	215	304	150	295	445	36	76
Difficult	360	124	165	188	88	390	210	99	195	82	67
Very difficult	244	84	129	97	47	84	183	49	116	242	53

Table 6.1. (continued)

	Countries								
Variables	Greece	Iceland	Italy	Luxembourg	Slovakia	Turkey	Ukraine	Kosovo	Croatia
N	404	59	49	93	392	134	1059	610	119
Sex (%)									
Male	36	46	35	58	42	33	29	29	35
Female	64	54	65	42	58	67	71	71	65
Age									
M	65	55	64	57	62	49	64	66	68
SD	17	19	21	16	16	18	15	14	14
Education									
M	7	13	8	10	11	5	10	10	8
SD	4	5	6	4	3	4	4	4	4
Born in country (%)									
Yes	96	93	100	62	96	98	85	93	87
No	4	7	0	38	4	2	15	7	13
Belonging to a religion (%)									
Yes	96	44	80	76	81	98	79	69	86
No	4	56	20	24	19	2	21	31	14
Marital status (%)									
Married	51	34	53	61	47	74	42	35	47
Separated	1	5	6	2	1	1	1	1	1
Divorced	5	20	2	9	8	3	9	10	2
Widowed	32	10	27	18	31	15	42	47	40
Never married	10	31	12	10	14	8	6	7	11
Employment status (%)									
Retired	233	11	23	42	246	14	747	425	94
Permanently sick or disabled	22	17	0	15	72	8	66	73	3
Paid work	50	15	11	10	35	19	125	76	9
Unemployed	16	1	3	2	12	19	32	3	4
Ever unemployed (%)									
Yes	21	29	31	23	22	17	24	14	26
No	79	71	69	77	78	83	76	86	74
Feeling about household's income (%)									
Living comfortably	25	18	7	27	10	8	7	15	8
Coping	92	20	26	39	108	45	118	123	42
Difficult	138	10	9	16	145	33	388	222	33
Very difficult	149	10	5	11	125	47	538	241	35

We followed the procedure used by Ramos, Bennett, Massey, and Hewstone (Ramos et al., 2019) and adjusted these distributions with the statistical weights provided by the ESS, to minimise sampling bias and guarantee that these data were nationally representative. Moreover, the dissimilarity index is highly correlated with other inequality measures, such as Gini and Atkinson indices, suggesting that they all measure similar properties (Massey & Denton, 1988). Note that the dissimilarity index provides a number ranging between 0 and 1, where 1 indicates maximum inequality. However, for our analyses, we reverse-scored this measure and multiplied the scores by 100 to get a percentage index with one-unit changes. Both country-level variables were matched by country and year and a higher score on these variables indicates, respectively, more wealth and social equality (see Tables 6.2 and 6.3 for the original scores of GDP and social inequality by country and wave).

Note that we could not use a measure based on respondents' income because these data were missing from several countries and waves. Other typical inequality measures, such as the Gini index, had similar issues given that there were missing data for some years of the ESS and that would have resulted in analysis with several omitted country-waves. Nonetheless, education levels are a reliable indicator of social status and, as such, served as an indicator of social equality in our study.

Personal assistance (PA)

A PA measure was created using a dichotomous variable (1 = With PA or -1 = Without PA) covering the (non)existence of national legislation on PA in each country and year of the survey, based on the ENIL (European Network on Independent Living 2013, 2015) and Academic Network of European Disability Experts (of European Disability Experts 2017) database. The data was collected between 2002-2014, every two years, and the countries considered having PA legislation at the national level were Sweden (2002-2014), Great Britain (2002-2014), Estonia (2001-2014), Denmark (2002-2014), Italy (data available only for the years of 2002 and 2012), Germany (2002-2014), Norway (2002-2014), France (2002-2014), Spain (2006-2014), Czech Republic (2008-2014), Finland (2010-2014), Slovakia (data available between 2004-2012), and Switzerland (2012-2014). Countries considered without PA legislation at the national level were Austria, Belgium, Hungary, Lithuania, Netherlands, Poland, Portugal, Slovenia, Bulgaria, Cyprus, Greece, Ireland, Turkey, Ukraine, Kosovo, and Croatia (see Table 6.4 for the codification of national legislation on PA by country and wave). PA was contrast coded as -1 or 1, a recommended procedure to avoid problems of multicollinearity while allowing a centred distribution in interactions (Aiken & West, 1991).

Table 6.2. GDP (Gross domestic product per capita in current US$) by country and wave.

Country	Mean GDP	W1 (2002-03)	W2 (2004-05)	W3 (2006-07)	W4 (2008-09)	W5 (2010-11)	W6 (2012-13)	W7 (2013-14)
Austria	40 093	32 103	38 242	46 587	-	-	-	43 439
Belgium	41 097	25 052	35 590	38 852	48 425	47 700	44 731	47 328
Switzerland	66 738	41 337	53 256	57 349	72 120	74 277	83 209	85 617
Czech Republic	16 839	8 012	11 668	-	22 649	21 657	19 814	17 231
Germany	39 292	25 205	34 166	36 401	45 699	41 788	44 011	47 774
Denmark	54 479	40 459	46 488	52 041	64 182	57 648	59 819	60 718
Estonia	13 965	-	8 851	16 586	14 726	14 641	17 491	20 148
Spain	27 611	17 261	24 919	28 483	35 579	31 832	29 371	25 832
Finland	43 208	26 834	37 636	41 121	53 401	46 205	47 416	49 843
France	38 941	29 691	34 880	36 545	45 413	40 706	42 628	42 726
Great Britain	40 032	28 301	38 306	42 534	45 195	38 293	41 295	46 297
Hungary	11 462	6 646	11 156	11 392	12 948	13 009	12 820	12 259
Ireland	52 026	41 170	50 816	61 314	51 900	52 828	51 815	54 339
Lithuania	14 744	-	-	-	-	14 367	15 692	14 172
Netherlands	46 359	28 817	39 955	44 011	56 929	53 537	49 128	52 139
Norway	79 734	43 061	57 570	74 115	96 881	87 646	101 564	97 300
Poland	10 410	5 197	6 640	9 000	13 906	12 598	13 036	12 495
Portugal	20 221	12 882	18 784	22 780	23 064	23 195	21 619	19 223
Sweden	48 875	29 572	42 442	46 257	55 747	52 076	57 134	58 899
Slovenia	20 889	11 814	17 261	19 726	27 502	23 439	22 478	24 002
Bulgaria	5 902	-	-	4 456	6 956	7 750	7 657	-
Cyprus	30 528	-	-	26 455	34 950	31 837	28 868	
Greece	24 164	18 478	22 552	-	29 711	25 915	-	-
Iceland	50 352	-	56 446	-	-	-	44 259	-

Table 6.2. (Continued)

Country	Mean GDP	W1 (2002-03)	W2 (2004-05)	W3 (2006-07)	W4 (2008-09)	W5 (2010-11)	W6 (2012-13)	W7 (2013-14)
Italy	32 082	27 399	-	-	-	-	35 421	-
Luxembourg	69 820	64 670	74 971	-	-	-	-	-
Slovakia	15 807	-	10 655	16 015	18 604	16 555	17 207	-
Turkey	8 176	-	7 727	-	8 624	-	-	-
Ukraine	2 750	-	1 829	2 303	3 891	3 570	4 030	-
Kosovo	-	-	-	-	-	-	-	-
Croatia	14 059	-	-	-	-	14 542	-	-

Table 6.3. Social equality for each country and wave.

Country	Mean equality	W1 (2002-03)	W2 (2004-05)	W3 (2006-07)	W4 (2008-09)	W5 (2010-11)	W6 (2012-13)	W7 (2013-14)
Austria	32.83	32.01	33.70	33.54	-	-	-	31.80
Belgium	29.92	29.52	31.30	29.04	29.80	29.80	29.57	30.46
Switzerland	30.36	30.52	30.78	30.85	29.67	30.54	29.15	30.79
Czech Republic	35.66	33.09	35.93	-	35.90	35.98	35.98	36.02
Germany	31.83	31.33	31.72	31.61	32.08	31.30	32.25	32.51
Denmark	26.24	30.23	30.43	24.35	25.27	24.55	24.24	25.01
Estonia	30.84	-	29.47	31.34	30.86	30.54	31.24	31.58
Spain	19.54	16.70	17.77	19.60	20.17	20.78	20.07	20.99
Finland	27.33	27.38	27.15	26.55	27.69	27.19	28.00	27.24
France	28.16	26.96	26.69	28.46	28.43	28.26	28.62	29.34
Great Britain	31.23	31.72	32.72	30.87	30.73	30.97	30.93	31.05
Hungary	29.71	28.16	31.47	28.82	28.65	29.58	30.57	30.55
Ireland	31.74	31.46	30.87	31.65	30.84	31.94	32.47	32.53
Lithuania	32.02	-	-	-	-	29.80	32.93	32.82
Netherlands	28.89	29.08	29.27	27.80	28.25	28.58	28.91	30.20
Norway	29.91	30.58	30.48	30.01	29.92	30.32	27.19	30.77
Poland	29.76	29.01	30.36	29.82	29.00	29.93	29.81	30.58
Portugal	12.08	11.22	11.34	9.79	11.71	10.43	16.65	14.01
Sweden	30.06	29.33	29.83	29.65	30.03	29.90	31.17	30.62
Slovenia	29.08	29.44	29.10	28.54	28.27	29.05	28.91	30.35
Bulgaria	26.68	-	-	29.10	27.33	22.79	27.57	-
Cyprus	23.33	20.20	20.03	-	27.93	25.69	-	-
Greece	28.48	-	27.16	-	-	-	29.50	-
Iceland	21.72	20.77	-	-	-	-	22.91	-

Table 6.3. (Continued)

Country	Mean equality	W1 (2002-03)	W2 (2004-05)	W3 (2006-07)	W4 (2008-09)	W5 (2010-11)	W6 (2012-13)	W7 (2013-14)
Italy	26.55	27.76	25.41	-	-	-	-	-
Luxembourg	32.83	32.01	33.70	33.54	-	-	-	31.80
Slovakia	33.17	-	32.69	31.80	33.66	33.88	33.67	-
Turkey	10.96	-	9.77	-	11.87	-	-	-
Ukraine	30.85	-	30.33	28.27	30.64	33.04	31.93	-
Kosovo	24.97	-	-	-	-	-	24.97	-
Croatia	29.47	-	-	-	-	29.47	-	-

Note. This table shows our social equality measure. It was computed using a dissimilarity index computed with respondents' educational distributions that was then multiplied by 100, so it would range from 0 to 100. In this measure, 0 indicates complete lack of equality, while 100 indicates total equality.

Table 6.4. Existence of national legislation on personal assistance by country and wave.

Country	W1 (2002-03)	W2 (2004-05)	W3 (2006-07)	W4 (2008-09)	W5 (2010-11)	W6 (2012-13)	W7 (2013-14)
Austria	No	No	No	-	-	-	No
Belgium	No	No	No	No	No	No	No
Switzerland	No	No	No	No	No	Yes	Yes
Czech Republic	No	No	-	Yes	Yes	Yes	Yes
Germany	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Denmark	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Estonia	-	Yes	Yes	Yes	Yes	Yes	Yes
Spain	No	No	Yes	Yes	Yes	Yes	Yes
Finland	No	-	No	No	Yes	Yes	Yes
France	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Great Britain	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Hungary	No	No	No	No	No	No	No
Ireland	No	No	No	No	No	No	No
Lithuania	-	-	-	-	No	No	No
Netherlands	No	No	No	No	No	No	No
Norway	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Poland	No	No	No	No	No	No	No
Portugal	No	No	No	No	No	No	No
Sweden	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Slovenia	No	No	No	No	No	No	No
Bulgaria	-	-	No	No	No	No	-
Cyprus	-	-	No	No	No	No	-
Greece	No	No	-	No	No	-	-
Iceland	-	No	-	-	-	No	-
Italy	Yes	-	-	-	-	Yes	-
Luxembourg	No	No	-	-	-	-	-
Slovakia	-	Yes	Yes	Yes	Yes	Yes	-
Turkey	-	No	-	No	-	-	-
Ukraine	-	No	No	No	No	No	-
Kosovo	-	-	No	No	No	No	-
Croatia	-	-	-	-	No	-	-

As previously mentioned, there is some variability in PA schemes across Europe, for example on the amount of control disabled people have over the service (e.g., option for direct payments, choice of providers, limit of hours) or in the availability of services (e.g., restrictions in age and type of disability, limit of hours; see Table 6.5 for details about the differences in PA schemes between countries). Service characteristics could even differ between municipalities.

Due to this variability and because we lack individual measures on PA schemes in this type of survey, we measured only the existence of national PA-related legislation in each country. In addition, we only included in the sample respondents who answered: 'Yes, a lot' to the question 'Are you hampered in your daily activities (…)?' as this sample is more likely to need assistance in daily living activities and thus benefit from PA. Some individuals answered 'Yes, to some extent', but, for the reasons above, they were not included in our analyses.

Public participation

Public participation was measured by summing answers to three dichotomous (0-No, 1-Yes) questions relating to political and civic participation, which loaded on a single factor: 'During the last 12 months, have you done any of the following? Have you…' '…contacted a politician or government official?', '…worked in a political party or action group?', and '…worked in another organization or association?'; ranging from 0 to 3 behaviours of public participation in the last year and explaining 51% of the variance.

Satisfaction with the political and economic situation

We measured satisfaction with the political and economic situation by averaging responses to questions on satisfaction with the state of democracy and satisfaction with the state of the economy together on a single factor (Spearman-Brown coefficient = .724): 'And, on the whole, how satisfied are you with the way democracy works in [country]' and 'On the whole how satisfied are you with the present state of economy in [country]' (answers ranging from 0-extremely dissatisfied to 10-extremely satisfied). As democracy has been associated with economic development in previous studies (Burkhart & Lewis-Beck, 1994; De Haan & Siermann, 1995), we factored them together as a measure of socio-political context to simplify the analysis.

Table 6.5. Information about personal assistance schemes by country.

Country and law	Administration level	Are direct payments available?	Is choice of provider allowed?	No limit on PA hours?	Inclusive to all types of disabilities?	Inclusive to all Ages?	Are there restrictions on activities?
Switzerland Invalid Insurance law, 2012.	Invalid insurance – (obligatory insurance covering all Swiss).	Yes.	Yes. However, only self-employed personnel are allowed.	Maximum of 8 hours per day, plus a fixed amount for the night (max. 2 hours).	Restrictions for persons w/ cognitive or mental impairments; victims of accidents are excluded.	Not available to children w/ medium or low assistance needs and persons above 65 years old.	Restrictions on activities during night (e.g. toilet)
Czech Republic Act on Social Services No. 108/2006 Coll.	N.A.	N.A.	N.A.	N.A.	N.A.	Yes.	N.A.
Germany Social Code Book for Rehabilitation and Participation of Disabled People, 2001	Local.	Yes.	Yes.	Yes.	Yes.	Yes.	N.A.
Denmark Social Service Law, 1998	Municipal and regional.	Yes.	Yes.	Yes.	People with psychosocial impairments are excluded. People with intellectual impairments do not receive it because of lack of support.	Restricted to 18- 65 years old, and to those who acquired PA before the age of 65.	PA is not allowed to do gardening or remove snow.
Estonia Social Welfare Act, 1995.	Municipal.	Depends on the municipality. It happens mainly in smaller municipalities.	Depends on the municipality.	Depends on the municipality.	Yes. However, the target group are usually people with mobility-or visual impairments.	Yes.	No.
Spain National Law 39/2006	Regional.	Yes. However, due to the difficultly in hiring, PA is provided as a service.	Yes.	On average, people receive 3h/day.	Some regions deny access to people w/ intellectual impairments.	Some regions deny access to children.	No leisure or social activities.

Note. Adapted from ENIL (2013, 2015) and DOTCOM (ANED, 2017) datasets. N.A. means that sufficient information was not available. PA denotes Personal Assistance.

Table 6.5. (Continued)

Country and law	Administration level	Are direct payments available?	Is choice of provider allowed?	No limit on PA hours?	Inclusive to all types of disabilities?	Inclusive to all Ages?	Are there restrictions on activities?
Finland Disability Service Act, 2009	N.A.	Yes.	Yes.	N.A.	Yes.	N.A.	N.A.
France Disabled law, 1975; Act 2005-102.	Local.	Yes.	Yes.	Yes.	Restrictions for people w/ mental impairments, blind and deaf people, and for children.	Not available for people who become disabled after 65 years of age.	Does not include household tasks or shopping and travel. Also very limited for working.
Great Britain Community Care (Direct Payments) Act, 1996.	Local.	Yes.	Yes.	Yes.	Yes.	Available to people over 16 years old.	Some local authorities try to restrict PA to only personal care.
Norway Act on Social Security 2000, 2009, 2012.	Municipal.	Only in rare cases, depending on the municipalities.	Depends on the municipality.	Depends on the municipality.	Yes.	People above the age of 67 are excluded.	Users have to pay a fee for the hours spent on practical tasks, e.g., washing the floors.
Sweden Assistance Allowance Act, 1993.	State and Municipal.	Yes.	Yes.	Yes.	Persons w/ hearing and/or seeing impairments are excluded.	People over 65 have a right to PA only if it was acquired before the age of 65.	Activities such as gardening, shoveling of snow, depending on the region.
Italy National Act 104/1992, 162/1998, 328/2000.	Municipal and region.	Depends on the municipality.	Depends on the municipality.	Depends on the municipality.	People with low or moderate disability are excluded.	Available to people between 16-64 years old.	Depends on regulations.
Slovakia Act on Social Assistance, 1988; Act on Direct Payment for Compensation of Severe Disability, 2009.	Local.	Yes.	Yes.	Maximum of 20 hours per day.	Available only for severe disabilities.	Available for people between 6-65 years old, and above 65 only when they were users before this age.	N.A.

Note. Adapted from ENIL (2013, 2015) and DOTCOM (ANED, 2017) datasets. N.A. means that sufficient information was not available. PA denotes Personal Assistance.

Opinion about the health services

Opinion about the health services was measured with a single question: 'Please say what you think overall about the state of health services in [country] nowadays' (answers ranging from 0-extremely bad to 10-extremely good).

Health and well-being (HWB)

Health cannot be reduced to a single aspect. As such, we measured HWB by averaging answers to questions on self-rated happiness, satisfaction with life, and health: 'Taking all things together, how happy would you say you are?' (answers ranging from 1, 'extremely unhappy' to 10, 'extremely happy'); 'All things considered, how satisfied are you with your life as a whole nowadays?' (answers ranging from 0, 'extremely dissatisfied' to 10, 'extremely satisfied'); and 'How is your health in general?' (answers ranging from 1, 'very good' to 5, 'very bad'). The last question was reverse-scored. Responses to the three questions were standardized and then averaged to provide a single measure of HWB ($\alpha = 0.703$), with only one factor emerging from an exploratory factor analysis explaining 65% of the variance. A higher score on this variable indicated better HWB. These three measures were highly correlated in previous research (A. E. Clark and Oswald 1994; Kahneman and Sugden 2005) and have been widely used to measure HWB.

Individual-level controls

We controlled for a wide range of relevant individual-level characteristics, associated with health and well-being (Bartley et al. 2003). We included the following variables and coding: sex (0 = Female; 1 = Male), born in the country (0= Yes; No = 1); belonging to a religion (0 = Yes; 1 = No); group discrimination on the grounds of disability (0 = Not marked; 1 = Marked); marital status coded with 4 dummies (Separated; Divorced; Widowed; Never married), using the reference group 'Married'; employment status, coded with 3 dummies (Doing activity in the last 7 days: Permanently sick or disabled; Paid work; Unemployed), with the reference group 'Retired'; ever unemployed and seeking work for a period more than three months (0 = No; 1 = Yes); and feeling about household's income, coded with 3 dummies (Living comfortably on present income; Difficult on present income; Very difficult on present income), using the reference group 'Coping on present income'. We also controlled for other continuous and ordinal variables on which we maintained the original coding. These included age; years of education completed; how often meet socially with friends, relatives or colleagues (from 1-

Never to 7-Every Day); and, whether respondents take part in social activities compared to others of the same age (from 1-Much less than most to 5-Much more than most).

3.3.Data analysis

We performed a multilevel repeated cross-sectional analysis (Fairbrother, 2014) within the structural equation modelling (SEM) framework, using Mplus 8.0. This procedure was based on a three-level model in which respondents were nested within country-waves and then in turn nested within countries. With this specification, we accounted for dependence due to the hierarchical structure of the data. Moreover, it was possible, at a higher level, to control for differences between countries by introducing a coefficient representing the mean of each country-level variable across all waves for each country. In addition, at an intermediate level, it allowed us to control for within-country changes by introducing a coefficient representing how much a country had changed in each wave relative to its mean value across waves. Therefore, we have two coefficients per country variable (i.e., GDP and social equality) by disaggregating each variable into a between-country coefficient (time-invariant, representing the mean of the 7 waves) and a within-country coefficient (time-variant, representing the change from the mean). We also included in our equation a linear effect of time (i.e., survey year), to account for time trends in our coefficients. Accounting for differences between countries and within-country changes, this method allows us to consider the evolving nature of the social context in which respondents were embedded. For these reasons, we were particularly interested in the within-country change coefficient.

At the individual level, we coded all ‘don’t know’, ‘refuse to answer’, and no responses as missing values. We used full information maximum-likelihood estimation with robust standard errors (MLR), which allows estimation with missing data and produces less biased results than other methods (Little & Rubin, 2002).

First, in three initial steps, we estimated: (1) a model without control variables, testing the association of both GDP and social equality with health and well-being (HWB); (2) a model introducing both individual and country-level controls; and (3) a model including personal assistance (PA) and the interaction between PA and, respectively, GDP and social equality variables.

Second, we used conditional process analysis (Hayes, 2018) to understand the effect of PA on the relationship between social equality and HWB through specific socio-psychological mechanisms (indirect effect). We specified three separate models in which we introduced, respectively, public participation, satisfaction with the political and economic situation, and opinion about the health services as mediators. In all models, we considered equality as the independent variable, HWB as the outcome variable, and PA as a moderator. In these analyses, we expected equality to interact with PA to predict HWB indirectly through the respective mediators.

4. Results

For our initial analysis, the SEM multilevel model revealed a good fit as shown by the comparative fit index (CFI), root mean square error of approximation (RMSEA), and standardized root mean square residual (SRMR) indices (CFI = 0.99; RMSEA = 0.001; SRMR = 0.001). Comparisons between models revealed that the full model with interactions fitted the data better than the other models, since fit indicators (i.e., log-likelihood, Akaike information criterion, and Bayesian information criterion) and unexplained variance were lower in this case (Table 6.6).

Results show that between-country Gross Domestic Product (GDP) was positively associated with health and well-Being (HWB) ($b = 0.983$; $p < .001$), but changes in within-country GDP were not associated with HWB ($b = 0.071$; $p = 0.695$; Table 6.6, model 3). It seems that in countries with higher levels of GDP, disabled people have higher levels of HWB, but that a change in GDP does not have an impact on well-being. Conversely, between-country social equality was not associated with HWB ($b = 0.003$; $p = 0.695$), but changes in within-country social equality were positively associated with HWB ($b = 0.021$; $p = .004$), only when PA was included in the model.

The interaction effect between changes in social equality and PA was significant ($b = 0.020$; $p = .002$), indicating that the effect of social equality on HWB depends on the existence of PA in the country (Table 6.6, model 3). In fact, changes in terms of increasing social equality had a positive effect on HWB only for countries with PA ($b = 0.042$; $p = .001$; Figure 6.1), whilst there was a null effect for countries without PA ($b = 0.001$; $p = 0.897$). This finding suggests that changes in terms of increasing social equality do not translate into better health for disabled people unless the country has national legislation on PA. However, the opposite is true, because decreases in social equality (or increased inequality) lead to poor health in countries with PA legislation. In the discussion we mentioned some possible causes and ways to overcome inequalities that may be directly related to PA.

As a robustness check, we replicated the same findings with an additional relevant country-level variable in the model: Social Protection Expenditure (% of GDP; Eurostat data), which includes social protection expenditure on disability and old age. In this additional analysis, both main and interaction effects remained statistically significant, while Social Protection Expenditure revealed no significant effects on our dependent variable (Table S6 in supplementary online materials [SOM]).

Table 6.6. Direct and interaction effects of country-level variables on health and well-being.

		HWB		
		Model 1	Model 2	Model 3
	Variables	b (B)	b (B)	b (B)
Individual-level coefficients (control variables)	Sex (male)	-	0.015 (-0.019)*	-0.0380 (-0.022)**
	Age	-	-0.953 (-0.022)	-0.380 (-0.009)
	Education	-	0.005 (0.022)*	0.005 (0.026)**
	Born in country (no)	-	-0.027 (-0.009)	0.010 (0.003)
	Belonging to a religion (no)	-	-0.064 (-0.035)***	-0.055 (-0.031)***
	Marital status: ref. married			
	Separated	-	-0.198 (-0.025)***	-0.203 (-0.026)***
	Divorced	-	-0.194 (-0.072)***	-0.188 (-0.070)***
	Widowed	-	-0.203 (-0.100)***	-0.205 (-0.102)***
	Never married	-	-0.096 (-0.040)***	-0.097 (-0.041)***
	Employment status: ref. retired			
	Permanently sick or disabled	-	-0.185 (-0.084)***	-0.169 (-0.077)***
	Paid Work	-	0.127 (0.053)***	0.117 (0.048)***
	Unemployed		-0.063 (-0.014)	-0.061 (-0.014)
	Ever unemployed	-	-0.092 (-0.047)***	-0.081 (-0.042)***
	Feeling about household's income: ref. coping on present income			
	Living comf. on present income		0.185 (0.077)***	0.183 (0.077)***
	Difficult on present income	-	-0.288 (-0.148)***	-0.297 (-0.154)***
	Very difficult on present income		-0.600 (-0.273)***	-0.620 (-0.282)***
	Discrimination based on disability	-	-0.214 (-0.051)***	-0.207 (-0.050)***
	Socially meet	-	0.055 (0.120)***	0.053 (0.116)***
	Take part in social activities	-	0.137 (0.170)***	0.140 (0.175)***
Unexplained variance		0.717 (1.000)***	0.556 (0.753)***	0.547 (0.750)***
R^2		-	0.247***	0.250***
Country-level coefficients	Wave	-	0.008 (0.059)	0.008 (0.061)
	GDP (average)	1.631 (0.800)***	0.931 (0.668)***	0.983 (0.725)***
	GDP (change)	0.182 (0.035)	0.058 (0.016)	0.071 (0.02)
	Social equality (average)	0.001 (0.004)	0.004 (0.069)	0.003 (0.051)
	Social equality (change)	0.011 (0.034)	0.011 (0.050)	0.021 (0.100)**
	Personal assistance (PA)	-	-	-0.023 (-0.086)
	GDP (change)*PA	-	-	0.261 (0.073)
	Social equality (change)*PA	-	-	0.02 (0.105)**
Unexplained variance		0.056 (0.358)***	0.039 (0.536)***	0.035 (0.492)***
R^2		0.642***	0.464**	0.508***
Fit indicators	Loglikelihood	-26202.66	-22180.97	-21315.66
	Akaike information criterion (AIC)	52419.31	44415.94	42691.31
	Bayesian inform. criterion (BIC)	52474.90	44628.73	42926.76
Sample	Countries; country-waves;	32; 171	32; 171	31; 166
Size	Respondents	20767	19553	18924

Note. Total sample size changes between models because of missing individual' and country-level data. b = unstandardized coefficient; B = standardized coefficient bStdYX; PA = Personal assistance; GDP = Gross domestic product; **p* <0.05; ***p* <0.01; ****p* <0.001.

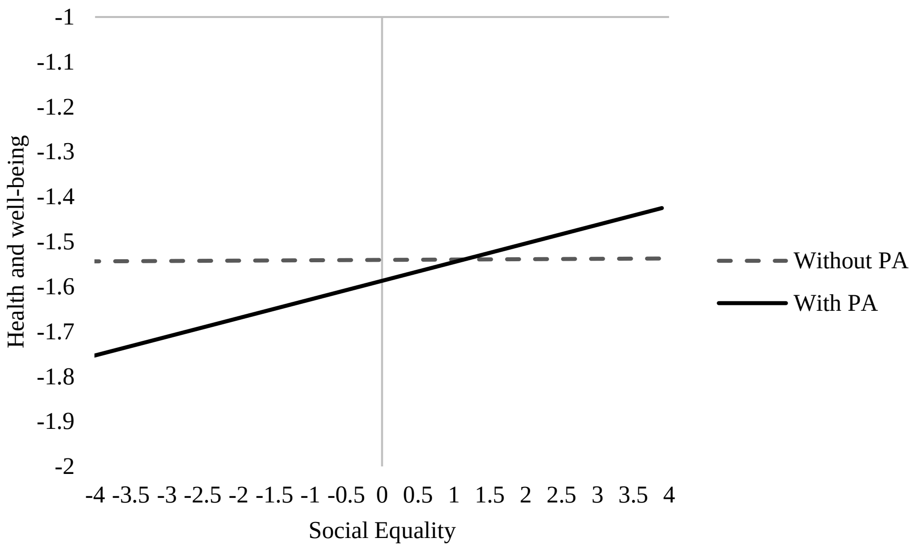
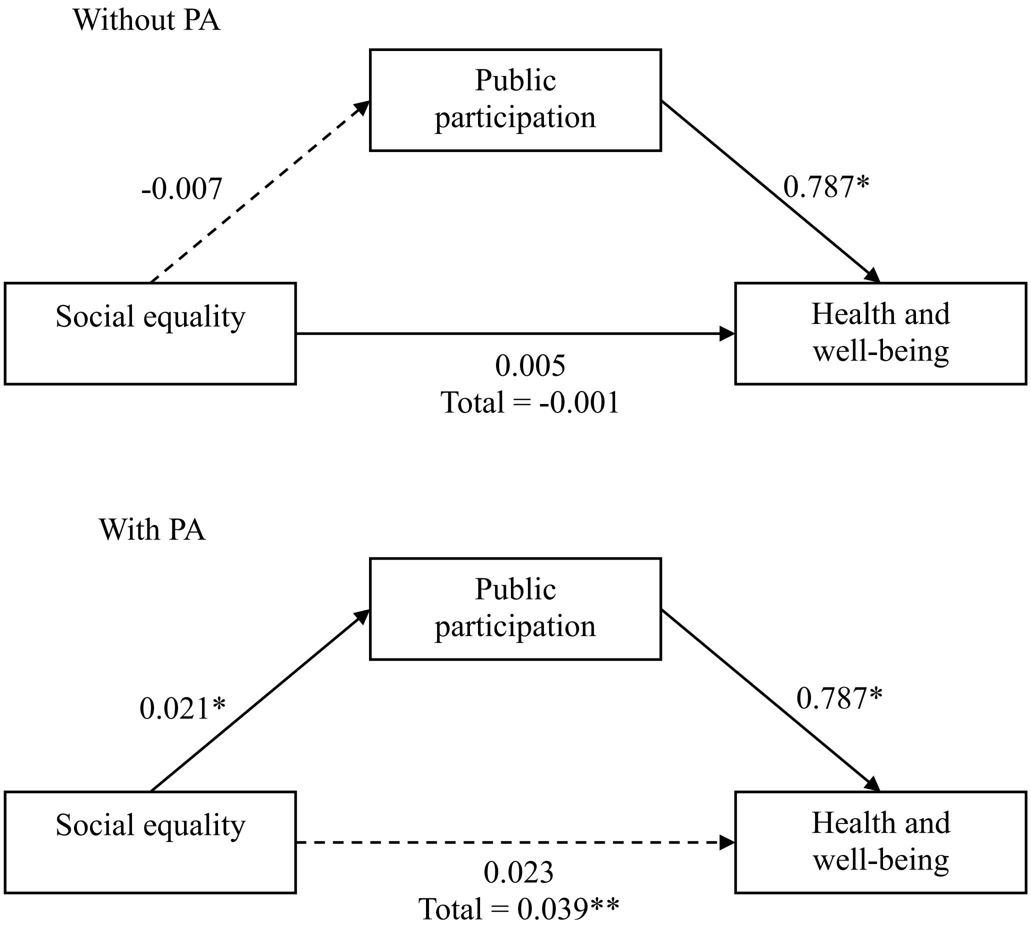


Figure 6.1. Interaction effect between social equality and personal assistance (PA) on health and well-being.

In a subsequent step of our analyses, we used conditional process analysis to test the effect of PA on the relationship between social equality and health via public participation, satisfaction with the political and economic situation and opinion about the health services. All three SEM multilevel models revealed a good fit to the data (CFI = 0.99; RMSEA = 0.001; SRMR = 0.001). Results showed significant positive interactions of social equality with PA on each of the mediators: public participation (*b* = 0.014; *p* = .012), satisfaction with the political and economic situation (*b* = 0.080; *p* = .027), and opinion about the health services (*b* = 0.066; *p* = .047). In turn, these mediators were positively associated with HWB (*b* =0.787; *p* = .023; *b* = 0.122, *p* < .001; and *b* = 0.119, *p* < .001, respectively; see Tables S7-S9 in SOM, for more details about these models). Below, we tested the effect of social equality in HWB via the mediators (i.e., indirect effect) for each level of PA, the moderator (countries with versus countries without PA).

Public participation. Results revealed a marginally significant indirect effect of social equality on HWB via public participation for countries with PA (*b* = 0.016; *p* = .082), whilst countries without PA showed a null effect (*b* = -0.005; *p* = .364; Figure 6.2).

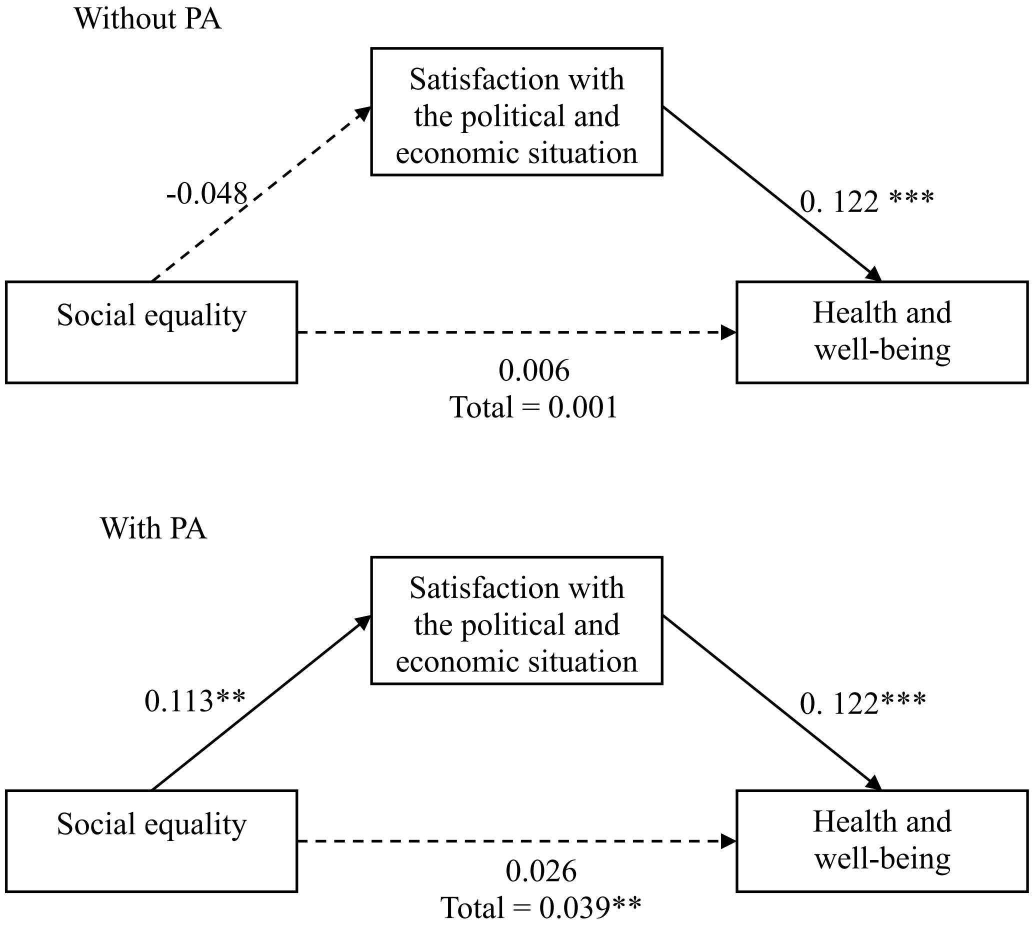


Note. Unstandardized coefficients are presented; *p <0.05; **p <0.01; ***p <0.001. For more details about this model, see Table S7 in SOM.

Figure 6.2. Effects of social equality on health and well-being via public participation in contexts with and without Personal Assistance (PA).

Satisfaction with the political and economic situation. There was a significant indirect effect of social equality on HWB via satisfaction with the political and economic situation for countries with PA (b = 0.014; p = .027; Figure 6.3). Conversely, the indirect effect was not significant for countries without PA (b = -0.006; p = .455).

Opinion about the health services. There was a marginal indirect effect of social equality on HWB via opinions about the health services for countries with PA (b = 0.012; p = .071; Figure 6.4). In contrast, for countries without PA, the indirect effect was not significant (b = -0.004; p = .538). The direct effect of social equality on HWB was significant only for countries with PA (b = 0.026; p = .025).

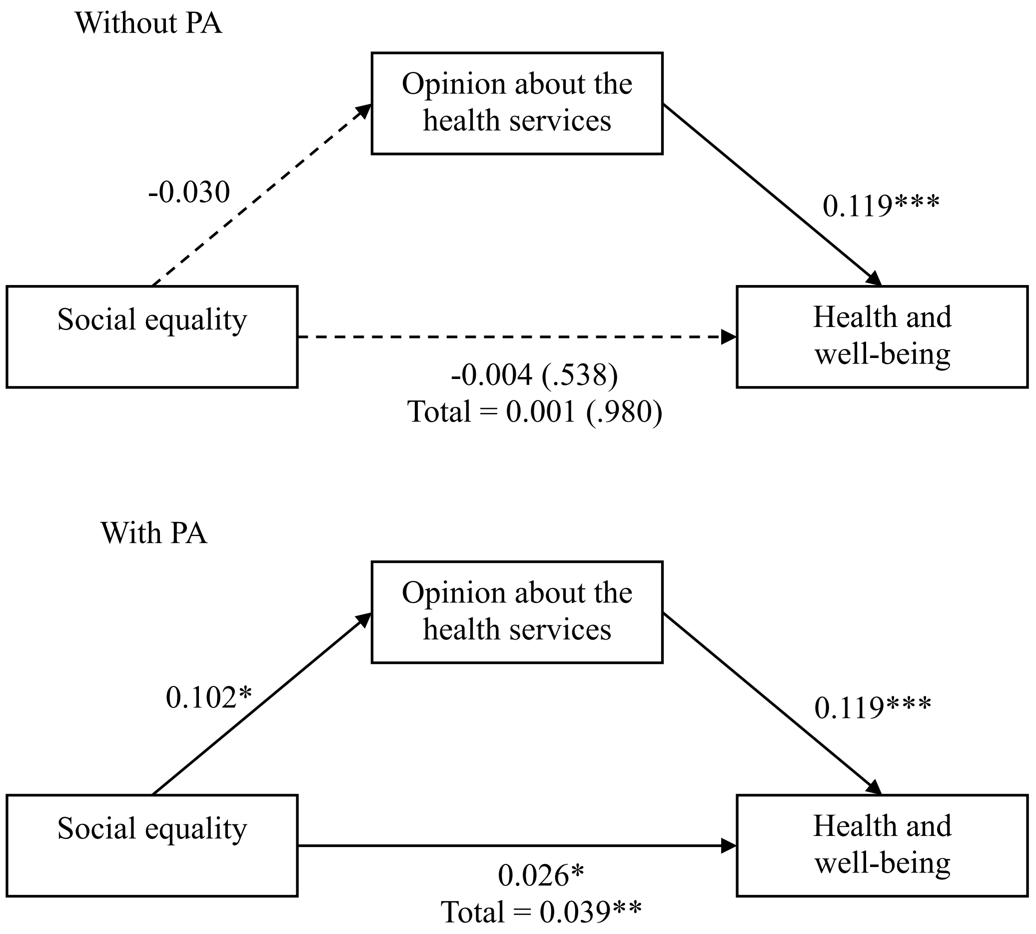


Note. Unstandardized coefficients are presented; **p* <0.05; ***p* <0.01; ****p* <0.001. For more details about this model, see Table S8 in SOM.

Figure 6.3. Effects of social equality on health and well-being via satisfaction with the political and economic situation in contexts with and without Personal Assistance (PA).

These findings indicate that an increase in social equality is associated with greater disabled people's public participation, satisfaction with the political and economic situation, and more positive impressions of the health services, only in countries with PA.

Significant total effects of social equality on HWB were found only for countries with PA. These include the direct and indirect effects via public participation (*b* = 0.039; *p* = .002), satisfaction with the political and economic situation (*b* = 0.039; *p* = .002), and opinion about the health services (*b* = 0.039; *p* = .003).



Note. Unstandardized coefficients are presented; *p <0.05; **p <0.01; ***p <0.001. For more details about this model, see Table S9 in SOM.

Figure 6.4. Effects of social equality on health and well-being via opinion about the health services in contexts with and without Personal Assistance (PA).

Other mediators considered in the literature on the socio-psychological mechanisms behind the link between equality and health were tested in this analysis: trust in others, trust in government, and collective action, for which we did not find any significant conditional effect (see section B in SOM for results with these mediators). There were, however, some direct associations between PA and these variables. Results showed that PA has a positive association with disabled people's trust in others and collective action, which seems to indicate that in countries with PA legislation, disabled people trust more in others and get more involved in collective action activities.

5. Discussion

Past research has mainly treated disability as an individual and medical factor, disregarding the implications of the social environment for the well-being of this group. Moreover, there is a lack of evidence to inform the ongoing debate about the association between personal assistance (PA) and equality. The aim of this study was to analyse the moderating role of PA in the association of country wealth and social equality with the health and well-being of disabled people. Results showed that an increase in Gross Domestic Product (GDP) was not associated with health and well-being in an analysis of 12 years of European data, controlling for relevant individual- and country-level variables. We found, however, that increasing social equality was positively associated with health and well-being – an association that was only present in countries with PA. This association between equality and health is explained by increased public participation, higher satisfaction with the political and economic situation, and more positive impressions of health services. These findings are in accordance with previous research with the general population (Kawachi & Kennedy, 1999; Wilkinson & Pickett, 2006), but, in this study, we found that among disabled people this is only manifested in countries with PA legislation. Therefore, this finding confirms our hypothesis concerning the effect of social equality, but the same hypothesis was not confirmed for the effect of GDP.

Although within-country changes in GDP were not associated with well-being, we found that the average levels of GDP between countries, across the 12 years represented by the ESS data, were positively associated with the well-being of disabled people. As such, our findings may suggest that a short-term increase in GDP is not associated with an improvement in the well-being of disabled people, but sustained and higher levels of GDP may, in the long-term, translate into higher levels of well-being.

Moreover, we found an association between within-country changes in social equality and well-being, but a null association with between-country correlations. These findings may suggest that immediate changes in one’s context, in terms of increasing social equality, may prove particularly effective for improving the quality of life of disabled people. These differences between within-country and between-country associations illustrate why it is critical to model this distinction in studies to better planning policy intervention.

Our results support the ideas formulated in the debate on the association between equality and PA (J. C. Anand et al., 2012; Clarke, 2006; Gadsby, 2013; Mladenov et al., 2015). PA enables the positive outcomes of increasing social equality. It is, however, a linear relationship, which means that an increase in inequality still has negative outcomes for disabled people in countries with PA. In contrast, social in/equality has no effects at all in countries without PA.

This supports the hypothesis that PA is a crucial condition for disability equality but also underlines the concern that in contexts of increasing inequality, PA can promote social disparities. This is more evident when PA schemes have relevant constraints (e.g., lack of direct payments, decentralization of services, restrictions in the number of hours, restrictions based on age and type of impairment). Therefore, this study emphasises the importance of adopting a PA policy to promote disability equality, considering the relevance of overcoming the barriers in its implementation to prevent social disparities.

First, social disparities in access to PA services must be prevented. User-centred models can be less accessible for those in a more disadvantaged position and with fewer resources (e.g., racial and ethnic minorities) (J. C. Anand et al., 2012). Moreover, older people or people with mental or intellectual impairments may be excluded by frontline workers, based on bias and stereotypes about who is best suited to have more choice and control over their lives (Gadsby, 2013). Besides, these users experience more stress as a result of the administrative and bureaucratic requirements (J. C. Anand et al., 2012). Policy and services should guarantee that PA is equally available across age, gender, race and type of impairment, through proper legislation and funding at the national level that also safeguards equal access across the country (for more details about the centralisation of PA schemes, (Barnes, 2007; Brennan et al., 2017). PA funding by a state authority frees users from dependence on charities, reduces administrative work and vulnerability in case of disputes among funders, and increases users' control over their assistance and daily lives (Ratzka, 2004).

Second, policy and services should guarantee users' control and choice over the service. Research has shown that life satisfaction is positively associated with perceptions of greater choice and control over the service (Mattson-Prince, 1997). On the contrary, obstacles to self-managed PA are associated with decreased life satisfaction and autonomy (Fleming-Castaldy, 2011). More recently, a survey conducted among PA users in Europe showed that the opportunity to choose one's assistant and have control over the timing of the assistance are essential enablers of choice and control; and, conversely, restrictions over these aspects are among the greatest barriers to choice and control (Mladenov, 2020). The best way to ensure users' control is through legislation that covers direct payments to disabled people (Glasby & Littlechild, 2009; Stainton & Boyce, 2004). The continuity of traditional and bureaucratic models of service delivery, based on paternalism, control and inflexibility, with a high-level management and lack of a restructuring of funding has been a central barrier to person-centered services (Dowling et al., 2006; Innes et al., 2006; Prandini, 2018).

Third, governments should guarantee an adequate amount of funding for PA. In fact, several problems related to PA funding have been reported – inadequate personal budgets, low number of assistance hours, failure to cover all expenses associated with PA, including user's training and peer support, and erosion of PA provision due to cuts (Mladenov, 2020). An insufficient number of hours of PA results in unmet needs and adverse health consequences (LaPlante et al., 2004). On the other hand, 'independent living' and 'personal assistance' have often been appropriated and exploited by companies not controlled by disabled people, to serve the interests of capital through marketization and privatization of services (Clarke, 2006; Mladenov et al., 2015; Prandini, 2018). Consequently, user-led organizations have disappeared due to under-funding and limited resources, which places them in a seriously disadvantaged position in the competitive market (Barnes, 2007). Therefore, among the costs that should be covered by the scheme are those related to peer-support, training and advocacy activities related to PA (Ratzka, 2004).

Services, and social policies, should be designed, managed and delivered in co-production with the users, for instance, through the inclusion of user-led non-governmental organizations in that process (Howlett et al., 2017). Two principles should shape people-centered legal processes, which are the participation in the decision process of all parties that are affected by those decisions and the accountability of those who make and implement the decisions (Grossman & Bradlow, 1993).

Finally, governments should also facilitate the access to relevant data to improve research, and support advocacy and legislation. Governments should report on PA key indicators such as the number of users, hours provided, funds invested, number and wages of personal assistants, factors controlled by users (e.g., choice of PA, management of PA hours), type of administration (e.g., national vs. municipal), and type of payment (i.e., direct payments or indirect payments through public entity).

5.1.Limitations and future directions

In this study, there isn't a detailed analysis at the individual level regarding the use of PA schemes and their characteristics, since this type of information is missing from these surveys and there is a lack of systematic information within and between countries. Therefore, despite finding an interaction between personal assistance and equality we can only rely on previous research to draw some conclusions on the characteristics of the PA schemes that can promote equality or inequality. Future research should test the effects of different PA schemes in a more specialized longitudinal survey, which could help researchers make stronger comparisons between schemes. Moreover, no previous studies examined the relationship between PA and social inequalities, which limits the possibility of comparing our results with other studies. In addition, we used a question to select disabled people based on a functional approach, however, definitions of disability and disabled people may vary between studies, which can make comparisons difficult and complex. Nevertheless, this study contributes to the debate on the interaction between equality and personal assistance with evidence from representative samples in a Europe-wide context and hopes to motivate new studies in the future.

6. Conclusion

This study provides additional understanding of the influence of social factors on the well-being of disabled people, as well as on the importance of the adoption of personal assistance (PA) for the promotion of disability equality. Our findings indicate that social equality is associated with better health and well-being outcomes, but only in countries with PA legislation. Therefore, national governments need to enact PA legislation, following the Convention on the Rights of Persons with Disabilities (2006) Article 9 and Independent Living Movement principles, to ensure that '[disabled people] have access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community'.

SECTION III.

Theoretical and practical implications

CHAPTER VII.

General Discussion

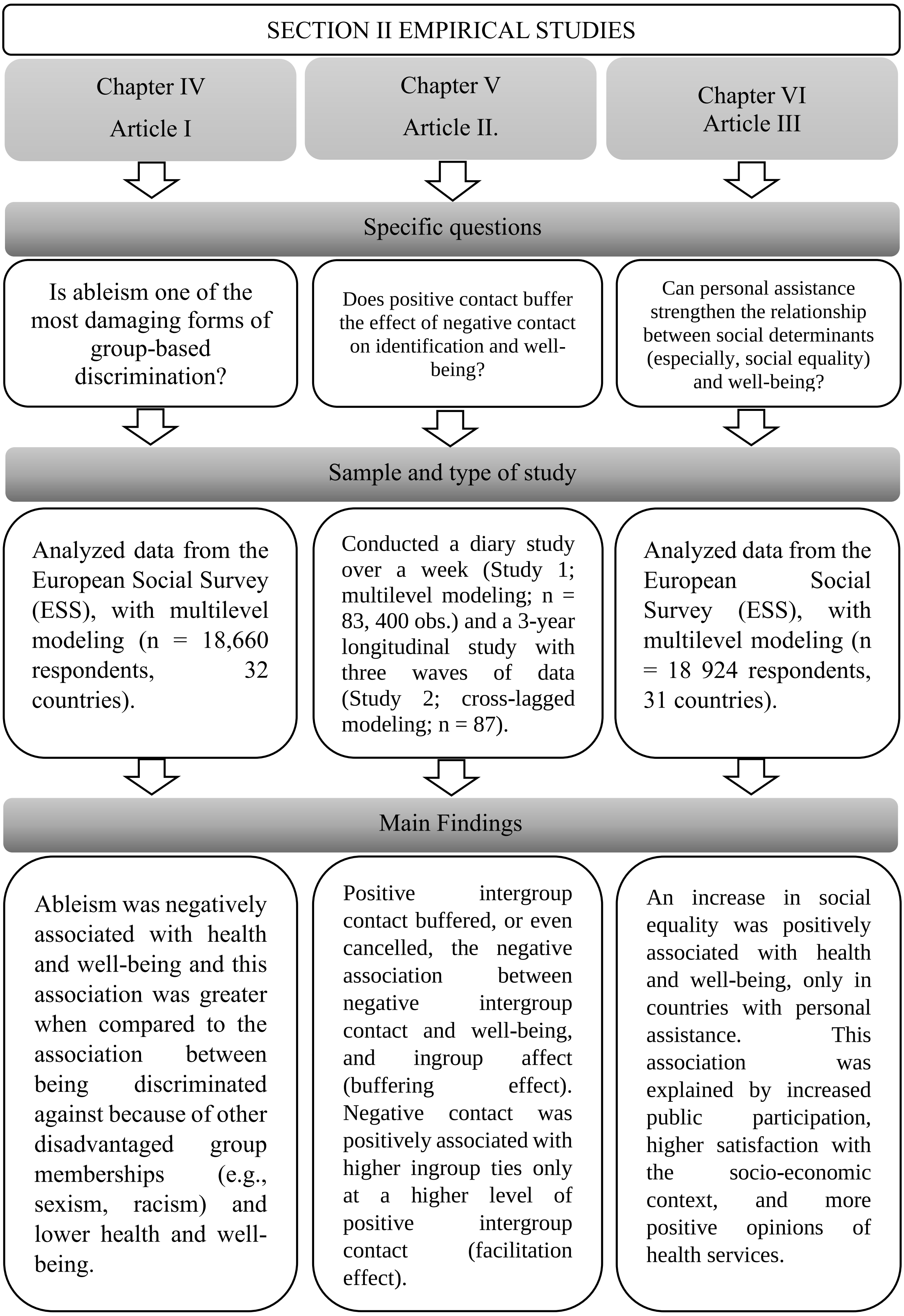
This chapter provides a review of the main aims, questions, and findings of this thesis, discussing their theoretical implications and possible future directions. In addition, it identifies the general limitations of this work, closing with a reflection on the practical contributions to disability interventions and policies.

1. Main findings and major implications

The main aim of this thesis was to examine how societal and social psychological factors affect disabled people's health and well-being. Considering disability from a social constructivist perspective, this question was analysed through two lines of research: a line based on group-level social-psychological determinants of health (grounded on the social identity approach), and a line based on the social determinants of health (e.g., equality across groups in society). At the group level, it was considered the impact of discrimination/ableism, both negative and positive intergroup contact, and disability identity on disabled people's health and well-being. At the social (macro) level, the interaction between social equality and personal assistance on disabled people's well-being was explored, through specific socio-psychological mediators. More specifically, this study attempted to answer the following three questions:

- Is ableism one of the most damaging forms of group-based discrimination? (Chapter IV)
- Does positive contact buffer the effect of negative contact on identification and well-being? (Chapter V)
- Can personal assistance strengthen the relationship between key social determinants (wealth and, especially, social equality) and disabled people's well-being? (Chapter VI)

To answer these questions, I conducted four studies presented through three chapters in Section II – empirical studies. Figure 7.1 summarizes the main findings in these chapters.



SECTION II EMPIRICAL STUDIES

Chapter IV Article I	Chapter V Article II.	Chapter VI Article III
Specific questions		
Is ableism one of the most damaging forms of group-based discrimination?	Does positive contact buffer the effect of negative contact on identification and well-being?	Can personal assistance strengthen the relationship between social determinants (especially, social equality) and well-being?
Sample and type of study		
Analyzed data from the European Social Survey (ESS), with multilevel modeling (n = 18,660 respondents, 32 countries).	Conducted a diary study over a week (Study 1; multilevel modeling; n = 83, 400 obs.) and a 3-year longitudinal study with three waves of data (Study 2; cross-lagged modeling; n = 87).	Analyzed data from the European Social Survey (ESS), with multilevel modeling (n = 18 924 respondents, 31 countries).
Main Findings		
Ableism was negatively associated with health and well-being and this association was greater when compared to the association between being discriminated against because of other disadvantaged group memberships (e.g., sexism, racism) and lower health and well-being.	Positive intergroup contact buffered, or even cancelled, the negative association between negative intergroup contact and well-being, and ingroup affect (buffering effect). Negative contact was positively associated with higher ingroup ties only at a higher level of positive intergroup contact (facilitation effect).	An increase in social equality was positively associated with health and well-being, only in countries with personal assistance. This association was explained by increased public participation, higher satisfaction with the socio-economic context, and more positive opinions of health services.

Figure 7.1. Summary of the main findings from the empirical studies.

In general, the results of the studies conducted contributed to extending our knowledge of the impact of the social and intergroup factors on the well-being of disabled people, providing some support for our propositions and theoretical contributions to social psychology. The specific results and contributions of each study were discussed in the related chapter/article. Therefore, in this general discussion, I intend to make a broad and joint reflection on the results that inform the original research questions. In addition, I reflect on the connection between the social (macro) and the group-level social-psychological determinants of health, proposing a joint approach to (disabled people's) health and well-being along these lines.

1.1.The adverse effects of ableism

In Chapter IV (Article 1) I compare the effects of the association between ableism and well-being against the effects of other types of group-based discrimination. Analysing data from the European Social Survey (ESS), with a total sample of 18,660 respondents, from 32 countries, I examined, using multilevel modelling, the effects of individuals enduring different types of group discrimination (effects *between* individuals, e.g., ableism, sexism, ageism) and the case of disabled individuals belonging to multiple disadvantaged categories (effects *within* individuals, e.g., disabled women; intersectionality). Results showed that ableism was associated with lower health and well-being, and this effect was greater than the effect of being discriminated against because of other disadvantaged group memberships. These results were consistent across analyses between individuals and within individuals.

Therefore, these results show that ableism is more negatively associated with health compared to other types of discrimination, even for disabled people who are subject to other types of discrimination. These results may be due to disability being a more salient (or superordinate) category and, therefore, more stigmatizing. In the same vein, a previous meta-analysis demonstrated that discrimination based on disability had stronger effect sizes on well-being than other types of discrimination (Schmitt et al., 2014). In addition, implicit prejudice concerning disability seems to be more stable over time whereas other prejudices tend to decrease towards neutrality (Charlesworth & Banaji, 2019). Another study has shown that disability-based implicit prejudice tends to increase over time (Harder et al., 2019).

Our findings, along with previous research, underline the importance of thinking about dis/ability as a more salient or superordinate category. At this level, two hypotheses could be explored in future studies: the hypothesis of ability as a superordinate category and as a dimension of social perception (similar to competence).

Disability as a superordinate category

The idea of disability as a superordinate category was previously advanced by Rohmer and Louvet (2009) in a study comparing the salience of disability with the salience of gender and race in person perception. These authors found that disabled people in a wheelchair were defined primarily on the basis of disability, regardless of their gender or race, whereas non-disabled targets were primarily identified by gender and race. Therefore, they argue that disability, specifically visible disability, has primacy in person perception and could be considered a superordinate categorical attribute. An asymmetry in category salience has been explained in terms of perceptual and cognitive mechanisms such as numerical distinctiveness of group composition, and social aspects such as the category membership of low-status groups (Brewer & Lui, 1989; Pichevin & Hurtig, 1996). Due to social barriers, disabled people are excluded from public contexts, having less access to education and employment, which is why it is natural that they are fewer in number and therefore their characteristics are more distinctive and salient. In addition, as we have seen, disabled people are a low-status group strongly stigmatized. Because normative beliefs on ability are so deeply embedded in our societies, through cultural ideologies of productiveness, individualism and efficiency, disabled people, stereotyped as incompetent and dependent (e.g., Fiske et al., 2002; Nario-Redmond, 2010) may form a distinct, and primal, social category for person perception. Consistent with this line of reasoning, in a previous study perceived gender differences were blurred between disabled men and women, compared to non-disabled men and women (Nario-Redmond, 2010).

Disability as a superordinate category helps to explain why disabled people can be dehumanized, that is, not fully human (e.g., Campbell, 2001). In a previous study (Röhmer & Louvet, 2012), disability was implicitly related to low warmth and low competence, the quadrant in the stereotype content model (Fiske et al., 2002) that is related to dehumanization (Harris & Fiske, 2006). Non-disabled people embody the characteristics of what is culturally idealized as being human, and in contrast, disabled people embody characteristics of something that is not fully human or that challenges this construction. Thus, disabled people would be a different and contrasting category from non-disabled people, and therefore, disabled people would be more strongly stigmatized, independently of other social categories.

Ability as a dimension of social perception

Ability, because it is strictly linked to notions of competence, may itself constitute a dimension of social perception, equivalent to the competence dimension of the stereotype content model (Fiske et al., 2002). An earlier perspective (Wolbring, 2008) suggested that ableism cuts across all stigmatized social categories, although in this approach there is no relationship with the stereotype content model or other theories of social/person perception. This proposition was based on the idea that all social categories are discriminated against based on the level of ability attributed to them, and, therefore, ableism cuts across all social categories (Wolbring, 2008). That is, as ableism is so ingrained in society through productivity and competitiveness, all social relationships are judged based on abilities. Social categories perceived as a subordinate group, that is, incompetent, as in the case of disabled people, elderly and women in traditional roles, are to some extent considered incapable of performing certain activities or professions. The lack of ability, or competence, at the physical (i.e., because they were considered fragile, dependent) or cognitive (i.e., because they were considered less cognitively able, or less intelligent) level has served as an ableist judgement to justify discrimination across several types of oppression, such as sexism, racism, and ageism. Moreover, these judgements are directly connected to the discrimination of certain body structures or functions (i.e., the female body in sexism, the colour of the skin in racism, and the age of the body in ageism), compared to an ideal and fully human body (i.e., white, male, adult). In the same line, Wolbring (2008) purposed that ableism functions as an umbrella for other types of "ism" and should be seen, not just toward disabled people, but from a broader cultural perspective.

In turn, the stereotype content model (Fiske et al., 2002) proposes that stereotypes are captured by the dimensions of competence and warmth, depending on how groups are perceived in terms of social status and competition (for resources), respectively. These dimensions – competence and warmth – fit the functional idea that people want to know others' intent (warmth) and their capability to pursue it (competence). Low-status groups, such as disabled people, women (in traditional roles), and the elderly, are seen as incompetent (i.e., not capable, efficient, intelligent), and as non-competitive, because (presumably) they have neither the intent nor the capability to do so (and thus they are considered warm). Therefore, the conceptualization of competence is intricately linked with notions of capability, or ability, meaning that this dimension could be equivalent to an ability dimension of stereotypes, which would cross all social categories/groups. If the dimension of competence was replaced by the dimension of ability, disabled people would be rated extremely low in ability, probably closer to elderly people, due to the salience of this stereotype in these categories. An interesting finding from Chapter IV shows that age-based discrimination (i.e., ageism) appeared as the second type of discrimination most negatively related to health and well-being. In fact, ageism is very similar to ableism to the extent that both types of oppression are directly connected to biological normative beliefs related to ability, independence, and energy (Overall, 2006), and both groups are perceived as incompetent, but warm (Fiske et al., 2002). Other categories such as women, black people, or other social minorities, would be somewhere between low and high ability, while high-status groups (i.e., rich people, business people; people who embody characteristics associated with ability, energy, independence, competence) would be rated extremely high in ability. Thus, disabled people would have greater salience on the dimension of ability (extreme low), and therefore would be more stigmatized and dehumanized compared to other groups.

Contextualizing ability from a broader cultural perspective could help us to understand why ableism seems to be more harmful and resistant, as well as how to contest cultural ideologies related to ability. This is not to say, however, that “all people are disabled” and that all social categories share the same experiences related to disability stigma. Wearing eyeglasses does not carry a stigma as it is an accepted "deficiency", unlike being blind, using a wheelchair, or using a prosthesis. Women or racialized people are not discriminated against in access to work or education in the same way that disabled people are. Critics of ongoing views of disability suggest that a “disability continuum” can be a universal or assimilationist approach, which covers and legitimizes the discrimination and inequalities experienced by disabled people (while their voices can be drowned out by non-disabled people, under the ban “we are all disabled”; (Gill, 1994). This is why I used the term ability continuum instead of disability continuum (disability refers only to disabled people) and a continuum approach should be cautious in preserving the experiences and cultural identity of disabled people.

1.2.The potential effects of positive intergroup contact

In Chapter V (Article 2) I examined how positive intergroup contact interacts with negative contact to influence the well-being of disabled people and their ingroup identification (i.e., ingroup affect, centrality, and ties), across two studies. I conducted a diary study over a week (Study 1; n = 83; observations = 400) and a 3-year longitudinal study with three waves of data (Study 2; n = 87). In Study 1 (diary study), using a multilevel modelling framework, I analysed within-level associations between negative intergroup contact and well-being, via the mediation of ingroup identification and the moderation of positive intergroup contact. In Study 2 (longitudinal study), using structural equation modelling, I analysed cross-lagged associations (a) between negative contact and ingroup identification, (b) and between negative contact and well-being, for respondents low vs. high in positive intergroup contact. Results showed that positive contact can attenuate, and even cancel out, the association between negative contact and lower well-being, as well as the association between negative contact and lower ingroup affect (buffering effect). In Study 1, negative contact was associated with lower health and well-being, via lower ingroup affect (indirect effect) and lower ingroup ties (total effect), only for lower levels of positive contact. In Study 2, negative contact was associated with lower well-being over time, only for respondents who reported lower positive contact. This was in accordance with previous studies showing that perceived discrimination was associated with lower health and well-being (Pascoe & Smart-Richman, 2009; Schmitt et al., 2014); here, however, it was shown that positive contact can attenuate and even cancel out the association between negative contact and well-being.

Similarly, negative contact was associated with lower ingroup affect more strongly for those who had lower positive contact, in Study 1. In Study 2, negative contact was associated with lower ingroup affect only for those who had lower positive contact. This was in accordance with previous studies showing that perceived discrimination was associated with lower ingroup affect (Ramos et al., 2012); here, however, it was shown that this association was strong (or only significant) only at lower levels of positive contact.

In an opposite direction, negative contact was associated with higher ingroup ties among disabled people, but only for respondents with higher levels of positive intergroup contact (facilitation effect). In Study 1, negative contact was associated with lower ingroup ties for those with lower positive contact, although this association became positive for those with higher positive contact. Similarly, in Study 2, negative contact was associated with higher ingroup ties, but only for those who had a higher level of positive contact. The direct association between perceived discrimination and ingroup ties was not confirmed in previous studies (e.g., Ramos et al., 2012; Reimer et al., 2017); here, however, this association was confirmed but only for the higher level of positive contact.

In addition, negative contact was associated with lower ingroup centrality in Study 1, but this association was not significant in Study 2, and positive contact did not moderate this relationship in both studies. This result goes against a previous study showing a positive association between perceived discrimination and centrality over time (Ramos et al., 2012), but it is in line with a recent study showing a null effect of negative contact and centrality over time (Reimer et al., 2017). Possible differences between negative contact and perceived discrimination could be associated with these distinct findings, which should be addressed in future research. Negative contact may have different implications for group identification as it addresses experiences at the personal level (i.e., frequency of negative contact with members of another group), without directly referring to whether that was due to group-related discrimination. Research on perceived discrimination has used measures of personal and group perceived discrimination, in which personal discrimination addresses personal experiences due to group membership (e.g., ‘I am discriminated against because I am a member of x group’) while group discrimination addresses experiences at the group level (i.e., members of group x are discriminated against in society). As personal discrimination could be more threatening to self-esteem, compared with group discrimination (Bourguignon et al., 2006; Crosby, 1984; Schmitt et al., 2014), negative contact could be more associated with negative emotions related to group membership (ingroup affect) and downplaying of group membership (centrality).

Overall, these findings reveal that positive contact attenuates or even cancels out the association between negative contact and lower well-being and ingroup affect, among disabled people. In addition, positive contact may facilitate the association between negative contact and higher ingroup ties. Thus, this study demonstrates the relevance of positive contact in issues related to disadvantaged groups. This is important as positive contact has been undervalued in research on disadvantaged group outcomes, and even more with an interactive approach of investigating both types of contact simultaneously.

Explaining the moderation of positive contact

Previous studies on the interaction between negative and positive contact may help to explain these results and suggest new directions for future research. In previous studies, positive contact attenuated the association between negative contact and outgroup orientations (buffering hypothesis; Árnadóttir et al., 2018). Previous research has argued that positive contact may decrease the association between negative contact and category salience (Paolini et al., 2014). In this case, positive contact may attenuate the association between negative contact and lower well-being, through a decrease in category salience produced by negative contact. Moreover, in previous studies the association of negative contact with outgroup orientations was neutralized for those with higher levels of positive contact (Árnadóttir et al., 2018). In turn, an exacerbation effect would be present when positive contact exacerbates the association between negative contact and outgroup orientations, supposedly by creating a more extreme contrast from the neutral point towards the negative pole (Árnadóttir et al., 2018). However, in our study, positive contact exacerbated a positive association between negative contact and ingroup ties, not a negative one. Therefore, it seems more reasonable to frame it as a facilitation effect, in which negative contact could be correlated with some benefits in the presence of positive contact (a facilitation effect was proposed by Árnadóttir et al., 2018, however, it was relative to the moderation of negative contact). Future studies could explore the role of category salience as well as the conditions under which positive contact can neutralize the adverse effects of negative contact or enhance favourable effects.

Is positive contact bad for identification (and social change)?

Literature on collective action has been concerned with the possible mitigating effects of positive contact on collective action intentions, through a decrease in the perception of discrimination and group identity (e.g., Dixon et al., 2010). However, our findings suggest that positive contact can attenuate the association between negative contact and lower ingroup affect, while it can facilitate the association between negative contact and higher ingroup ties. These results suggest that positive contact may be positively linked to group identification in the face of negative contact.

At this level, it is important to differentiate between common and dual identity perspectives. The idea that positive intergroup contact can undermine intentions for collective action assumes that intergroup contact can change the level of inclusiveness of categories to a common identity (e.g., Gaertner et al., 1993), at the expense of subgroup identity and recognition of inequalities between groups (Hässler et al., 2021). In two experimental studies, increasing the salience of a common (national) identity resulted in lower intentions of collective action among ethnic groups, through a reduction in group-based anger, efficacy beliefs, and recognition of group-based inequalities (Ufkes et al., 2016). However, in the same study (Experiment 2), increasing the salience of the common ingroup and separate group identities simultaneously (i.e., a dual identity), did not decrease collective action intentions. In the same vein, intergroup contact was negatively associated with intentions of collective action among members of a disadvantaged ethnic groups, through decreased ethnic identification, only among those with lower national identification, and not for those who identified strongly with the national group (Pereira et al., 2017).

Consistent with the foregoing results, recent studies reveal that when the dominant group recognizes the illegitimacy of social inequalities between groups, positive contact does not diminish intentions for collective action among disadvantaged group members (Becker et al., 2013). In addition, positive contact increases the dominant group's support for equality (Reimer et al., 2017). On the other hand, perceiving a strong distinction between groups (us versus them) can favour ingroup favouritism and competition (Tajfel and Turner, 1979), undermining intergroup collaborations (e.g., with allies) for social change (Hässler et al., 2021). Thus, a better strategy may be to preserve the differences between the groups through a dual identity model (Hässler et al., 2021).

Thus, while social identity theory focuses on how low status groups may challenge the status quo through social competition strategies (such as collective action) and, in turn, high status groups may defend their position (depending on whether they perceive their superiority as legitimate or illegitimate; Tajfel & Turner, 1976), research on intergroup contact and collective action has shown that both low and high-status groups can support social change (e.g., Hässler et al., 2022; Reimer et al., 2017). Therefore, it is incorrect to argue that positive contact will be detrimental to collective action and consequent social change, without considering the benefits from the support of the dominant group to social change.

Disability-related aspects for identification and well-being

In our study (Chapter V), negative contact was associated with lower ingroup affect and higher ingroup ties. This is in line with previous studies showing that perceived discrimination was negatively related to ingroup affect (Ramos et al., 2012) and positively associated with ingroup ties (in the case of personal discrimination; Reimer et al., 2017). Here, however, the positive association between negative contact and ingroup ties only occurred when there were high levels of positive contact. In addition, results showed that negative contact was associated with lower centrality (Study 1) or was not related to centrality (Study 2), whereas perceived discrimination was associated with higher centrality in previous studies (Ramos et al., 2012). In addition to the possibility that disability-based stigma could be more stigmatizing and harmful to well-being, other factors can influence coping strategies such as group identity. Assuming that identity has positive consequences, such as positive effects on well-being (Chapter V; Jetten et al., 2017), or leads to collective actions aimed at changing the status of the group (van Zomeren et al., 2008), it can be harder for disabled people to have a positive identity.

On the one hand, because disability-based prejudice is more stigmatizing, it can lead to disabled people distancing themselves from a disability identity or seeking membership in other higher-status groups (see van Veelen et al., 2020, for a literature review). This could be because, through negative contact, disabled people experience social devaluation and for a negative stereotype of their own group, which threatens certain needs such as the need for positive self-esteem (Tajfel & Turner, 1979). Concerning this, because paternalistic (e.g., pity, infantilization, unwanted help) and benevolent (e.g., being described as inspirational or a super hero) forms of discrimination faced by disabled people (Nario-Redmond et al., 2019) may be more difficult to recognize, they may lead disabled people to believe that some experiences of discrimination are legitimate. Moreover, as ableism is strongly interconnected with normative beliefs of ability, competence, and independence (e.g., Overall, 2006), disabled people may be more inclined to believe that some experiences of discrimination are justified. A cross-sectional study showed that how disabled people conceptualize disability was associated with perceptions of discrimination as illegitimate (Dirth & Branscombe, 2019). Specifically, the endorsement of the social model (i.e., the social barriers are the problem causing disability) was positively associated with perceptions of discrimination as illegitimate, while, in contrast, the endorsement of the medical model (i.e., the individual/impairment is the problem causing disability) was negatively associated with perceptions of discrimination as illegitimate. Thus, conceptualizing disability as an individual problem may lead disabled people to believe that discrimination is legitimate. In turn, perceiving discrimination as legitimate undermines group identification and intentions to engage in collective action (Jetten et al., 2011).

On the other hand, some characteristics related to the context of this category can lead to obstacles in the construction of a more cohesive community in which experiences of discrimination could be shared and identified. As mentioned before, disabled people are often geographically isolated from one another and face more constraints to participation in activities (e.g., structural inaccessibility; Scotch, 1988). In addition, they are often the only disabled person within their family, which means they are more isolated from a cultural community with similar role models (Nario-Redmond, 2019). Another important point is that disability has been differentiated over time into different types of disabilities. This can be seen in traditional social responses, in which there are institutions geared towards specific types of disabilities. This classification may have contributed to disabled people themselves having prejudice against different types of disability. For instance, disabled people could attempt to differentiate from who are "real" disabled people, such that physically disabled people could see their ingroup as more oppressed (and thus, "real" disabled) than disabled people with learning disabilities (Deal, 2003). Disabled people who perceive their disability as more severe may feel more legitimized to identify as disabled people (Santuzzi & Waltz, 2016). Consequently, severity or limitations in performing activities was positively associated with disability identification (Bogart, 2014; Bogart et al., 2017). In addition, disabled people that do not correspond to the (Western) prototype of disabled people - male, white, and middle/upper class, wheelchair users - may feel they do not belong and distance themselves from the community (Dirth & Branscombe, 2017), which, in turn, may result in holding more prejudice towards disabled people. Participants with mental or emotional disabilities, lower severity, greater concealability, and lower contact with others who shared the disability were related to higher prejudice, compared to those with physical (or both mental and physical) disabilities, higher severity, lower concealability and higher contact (Harder et al., 2019).

1.3.The enabling effects of personal assistance

In Chapter VI (Article 3), at the social-macro level, I analysed the association of both country wealth and social equality with the health and well-being of disabled people, and how the existence of legislation on personal assistance (PA) could shape these relationships. I analysed data from seven waves of the European Social Survey (ESS; 2002-2014), with a total sample of 18 924 respondents, from 31 countries, controlling for relevant individual-level variables. Using multilevel modelling, I first tested the moderating effect of personal assistance on the association of wealth and social equality (predictors) with the health and well-being of disabled people. In a second step, I conducted conditional process analysis to examine the role of personal assistance in the relationship between social equality and well-being through specific socio-psychological mechanisms.

Results showed that an increase in gross domestic product (GDP; within-country) was not associated with health and well-being, although the average levels of GDP between countries were positively associated with the well-being of disabled people. These findings are consistent with the idea that sustained higher levels of GDP, in the long-term, translate into higher levels of well-being, through the improvement of resources; however, after reaching a certain level, economic growth is no longer relevant to determining well-being (Wilkinson & Pickett 2010). Moreover, there was no evidence that personal assistance moderated the association between (change) GDP and the well-being of disabled people.

In addition, results showed that increasing social equality (within-country) was positively associated with the health and well-being of disabled people, but only in countries with personal assistance legislation. Moreover, there was no association between the average country-level of social equality and well-being, following previous assumptions that differences in income within societies are more strongly associated with health than differences in income between countries (Wilkinson & Pickett, 2010). These differences in within-country and between-country associations demonstrate the importance of distinguishing these effects to understand the influence of the social determinants on health.

Additionally, further analysis showed that the association between social equality and health was explained by increased public participation, satisfaction with the political and economic situation in the respondent’s country, and a more positive opinion about their country’s health services. These findings follow previous research on the mechanisms between inequality and health within the general population (Kawachi & Kennedy 1999; Wilkinson & Pickett 2006). However, here, it was shown that among disabled people these relationships were only manifested in countries with PA legislation, which may help to explain its role. For instance, income inequality is positively correlated with lower civic trust, associational membership (e.g., sports groups, fraternal organizations, labour unions) and political participation (Kawachi et al., 1997; Solt, 2008; Uslaner & Brown, 2005), which threatens democracy (Zmerli & Castillo, 2015). In addition, income inequality is associated with corruption in government and society (You & Khagram, 2005) and underinvestment in health services (Lynch et al., 2000). This means that, in turn, income equality has been associated with public participation, a better-functioning democracy, economy, and health services.

However, as disabled people are often excluded from public participation due to specific social barriers (e.g., lack of physical, informational and communicational (e.g., sign language, subtitles, audio descriptions, easy read, braille) accessibility; Priestley et al., 2016), personal assistance could be the main vehicle to enable public participation as it facilitates the performance of daily living activities related to social participation (e.g., transportation, communication, and use of public infrastructure; von Granitz et al., 2017). In turn, higher public participation should increase the perception of a more democratic process. Moreover, as PA is based on democratic and social justice values, it could promote a positive perception of democracy when it is enacted. In addition, as PA promotes disabled people's active participation in society – as customers, workers, students, and taxpayers (Hurstfield et al., 2007a) – it could promote satisfaction with the economy. Finally, as disabled people experience more difficulty in accessing health care and preventive care than the general population (Reichard et al., 2014; World Health Organization, 2011), PA could be an important feature enabling a more positive perception of health care services given that the presence of PA makes services more accessible to disabled people. Furthermore, PA is related to better physical and mental health (M. A. Nosek, 1993), fewer re-hospitalisations for preventable conditions (Mattson-Prince, 1997), reduced nursing facility use and improved medication management (J. C. Anand et al., 2012).

In contrast, in contexts without PA, social efforts in terms of having higher levels of social equality may not be associated with public participation, satisfaction with the socio-political context (i.e., democracy and economy), and better perception of health services, given that the specific needs of disabled people are not being addressed. Therefore, these findings indicate that for disabled people, and probably disadvantaged groups in general, other factors are important to enable the relationship between social equality and well-being. Social equality could be more important for socially disadvantaged groups, however, social policy towards specific groups/issues should exist along with an increment of general indicators of equality (such as education or income distribution), so that the positive effects of equality are extended to those groups.

Interpreting the role of PA for in/equality

In a reverse reading, a decrease in equality (or increase in inequality) was associated with negative outcomes for disabled people in countries with legislation on PA. In contrast, social (in)equality was not associated with well-being at all in countries without PA. These findings address with empirical evidence the theoretical debate on personal assistance and equality (J. C. Anand et al., 2012; Clarke, 2006; Gadsby, 2013; Mladenov et al., 2015), supporting the hypothesis that PA is crucial for disability equality, but showing that it can also promote inequalities. It seems that in contexts with more inequality, PA may enhance inequalities by being more accessible to some groups (e.g., more educated, with more economic and social resources) over others in a more disadvantaged position (e.g., J. C. Anand et al., 2012; Clarke, 2006; Gadsby, 2013), increasing inequality within the category of disabled people. In this study, there is no information regarding the use of PA schemes and their characteristics at the individual level; however, previous research can help us to understand the characteristics of the PA schemes that may support equality or inequality.

As mentioned, one of the factors that could enhance in/equality is access to PA services. Most PA schemes exclude disabled people based on their age and or type of disability (ENIL 2013, 2015; Chapter VI). Moreover, older people and people with mental or intellectual disabilities could be excluded from the assessment, based on biases about autonomy and capacity for decision making (Gadsby 2013). Second, research has shown that obstacles to choice and control over the service (e.g., choosing one's assistant and having control over the timing of the assistance) are negatively associated with life satisfaction and autonomy (Fleming-Castaldy, 2011; Mattson-Prince, 1997; Mladenov, 2020). Third, several problems can emerge from insufficient PA funding, such as inadequate personal budgets, a low number of assistance hours, and erosion of PA provision due to cuts (Mladenov, 2020), which can result in unmet needs and adverse health consequences for the users (LaPlante et al., 2004), including extended hospital stays, threats to safety, poor nutrition, and poor personal hygiene (M. A. Nosek, 1993). These factors are considered in more detail in the discussion of Chapter VI (Article 3). Overall, these findings and previous research demonstrate the importance of overcoming the barriers in the implementation of PA to prevent social disparities and promote social equality.

1.4.The secret ingredient? Explaining positive intergroup contact and personal assistance moderation effects through recognition and respect

Other explanatory hypotheses for the moderation effect of positive contact and PA deserve attention in the future. Respect (namely, through equality-based recognition) could be an explanatory mechanism for the effects of positive contact and PA, as well as for a circular process between them (see Figure 7.2).

Positive intergroup contact

Groups that are seen as not competent, but warm, are liked (and pitied; paternalistic stereotype) but not respected. The concept of respect has been applied in intergroup relations from a pluralist and multicultural perspective (Huo & Molina, 2006; Urbiola et al., 2019). Subgroup respect was defined as the feeling “that one’s subgroup is recognized, accepted, and valued by the members of the common group (i.e., the social category the subgroups share in common)”, and has been considered to explain why pluralist or dual identities are a better way to achieve *unity amidst diversity*, in comparison to assimilationist strategies (Huo & Molina, 2006, p. 360). Similarly, “equality-based respect” has emerged as an experience of recognition as an equal, based on the Kantian notion of equal respect for all persons because of their inherent human dignity (Simon, 2007). In this view “respectful treatment by others symbolizes and is experienced as recognition as an equal and that this experience underlies, to a large extent, the effectiveness of respect in social life” (Simon, 2007, p. 319). These perspectives have been applied to intergroup relations, showing that when people respect other persons (Laham et al., 2009; Lalljee et al., 2009) or groups/identities (Simon et al., 2019), they hold more positive attitudes towards them. On the other hand, when people feel that their group is respected, valued and recognized by society, they hold more positive attitudes toward others (Huo et al., 2010; Huo & Molina, 2006; Simon & Grabow, 2014), but also more positive individual outcomes such as higher (school) engagement and health (Huo et al., 2010).

Respect is strongly related to the needs-based model of intergroup reconciliation (Nadler & (Nadler & Shnabel, 2015; Shnabel & Nadler, 2008), which proposes that both, or all, groups feel identity threats and needs for identity restoration that must be met so that reconciliation between the groups can take place. Because disadvantaged group members are perceived as non-agentic or non-competent (Abele & Wojciszke, 2013, for the Big Two; Fiske et al., 2002, for the SCM), they experience a need for empowerment (i.e., apology, acknowledgement of group's value, competence and respect) to restore their group identity as agentic and competent.

Therefore, in this case, the moderation effects of positive contact could be due to the disadvantaged group (disabled people), through positive experiences of contact, feeling that their group is respected and acknowledged, meeting their need for empowerment. This means that positive contact could not be necessarily associated with a lower category salience, but with a category salience in terms of positive recognition, compared to salience in stigmatizing terms. These experiences of positive contact would make the disadvantaged group feel more respected and recognized (empowered), attenuating or cancelling the adverse effects of negative contact on well-being and ingroup affect. In turn, feeling more respected and empowered, allows them to feel more solidarity (ingroup ties) towards their ingroup in the face of negative experiences. These mechanisms could be explored in future studies.

On the other hand, advantaged group members are perceived as non-moral and non-warm (Abele & Wojciszke, 2013; Fiske et al., 2002), due to their high-status position at the expense of disadvantaged groups. Therefore, they experience a moral-social threat to their identity and a need for acceptance (i.e., forgiveness) to restore their group identity as moral and warm (Nadler & Shnabel, 2015). The restoration of both group identities, through empowerment and acceptance, would result in an increasing willingness to reconcile and be a catalyst for social change, through the promotion of collective action among members of disadvantaged groups and support toward equality among members of advantaged groups (Nadler & Shnabel, 2015; integrated contact-collective action model, Hässler et al., 2021), which would be beneficial for the enactment of policies such as personal assistance.

Another important aspect of this process is dual identification among disadvantaged group members. Feeling that our subgroup is respected by the common group has been related to both subgroup identification (ethnic identity) and collective identification with the common group (national identity) (Huo & Molina, 2006, Huo et al., 2010, Simon & Grabow, 2014). In turn, a dual identification may promote collective action among disadvantaged group members (Hässler et al., 2021; Pereira et al., 2017).

Personal assistance

A related explanation for the moderation effect of personal assistance is that this policy may facilitate the effects of equality on health through the perception of equality-based recognition and respect. Honneth's social philosophical recognition theory (Honneth, 1995) defines respect as a form of recognition as an equal, distinctive of legal and political relations. That is, the existence of legislation on personal assistance can make disabled people feel respected by being recognized by governmental institutions as equal to other citizens. This recognition can be transmitted by the characteristics of this policy – egalitarian, self-determining, resulting from the effort of the disability movement (e.g., Mladenov, 2012, 2017) – but also by the changes and possibilities that it entails. For instance, greater social equality (by itself) does not increase public participation of disabled people, unless there is legislation on personal assistance. Thus, this policy could be related to a perception that disabled people are recognized as citizens who have parity of participation, that is, on an equal basis with others (for previous applications of Nancy Fraser's work to disability justice, see Mladenov, 2016, 2017). Feeling recognized as an equal was the strongest indicator of feeling respect, in an internal meta-analyis (Schaefer et al., 2021). Therefore, the positive effects related to PA may be to some extent driven by the recognition of disabled people as equal citizens underlying this policy, and thus by the feeling of being (equally) respected by the government/society.

Studies in social psychology have applied the concept of equality-based respect as an important tool in intergroup relations (Renger et al., 2017; Simon & Grabow, 2014). However, so far, no study has measured recognition through a policy or law. It would be interesting to analyse, in the future, the perception of recognition and respect transmitted by policies such as personal assistance, and how this recognition influences intergroup and intragroup relations (identity). Institutional laws or policies are important vehicles of communication of societal norms on how groups should be treated (Allport, 1954; Kauff et al., 2021). Therefore, personal assistance could promote intergroup relations through the cultural recognition of disabled people and the establishment of egalitarian norms. This could benefit dual identification through the perception of group respect and recognition as an equal, which, in turn, could foster more positive intergroup relations (Hässler et al., 2021).

In addition, facilitating the public participation of disabled people also favours opportunities for positive intergroup contact (diversity is more likely to increase positive than negative contact, e.g., Kros & Hewstone, 2021). Again, intergroup contact can lead to reduced prejudice among advantaged group members (Allport, 1954), more feelings of respect and empowerment among disadvantaged group members (Nadler & Shnabel, 2015), more positive intergroup attitudes and willingness to social change for both groups (Hässler et al., 2022).

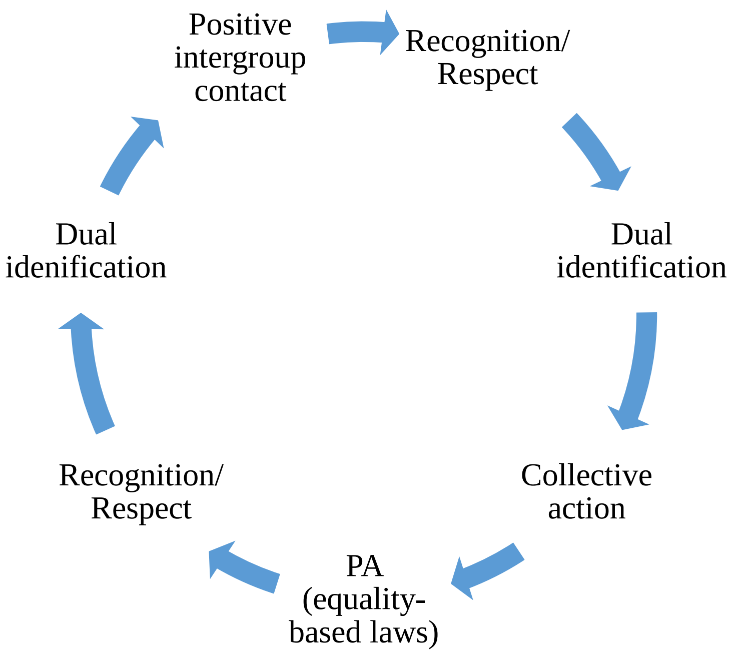


Figure 7.2. Circular process of the relationship between positive intergroup contact and personal assistance, through respect.

1.5. Model: Suggestions for a comprehensive approach to health and well-being

In this work, I used two approaches to analyse the health and well-being of disabled people: the ‘social determinants of health’ and the ‘social-psychological determinants of health’ approaches. While the approach to the social determinants of health is focused on how social inequality affects the health of the population, the social-psychological approach to health focuses on the influence of group processes on health. The social-psychological approach, as termed in this thesis, is an integrative approach to the group processes related to health and is based on the social identity approach to health (also known as the social cure agenda), along with the rejection-identification model and intergroup contact theory.

These approaches were selected because they are in accordance with the social constructivism approach to disability, in the sense that, disabled people are a social category, and their health is influenced by social factors. Despite not examining the social-macro and group-level processes in the same study, the findings of this work add important contributions to the understanding of how the well-being of disabled people is influenced by both social (macro) and social-psychological determinants. The social determinants include, for example, equality and legislation on personal assistance, and the social-psychological determinants at the (inter and intra) group level include determinants such as discrimination, intergroup contact and social identification. Moreover, I rely on previous theories and research to understand how these two approaches to health are connected and influence each other, proposing here the integration of these two perspectives for a comprehensive model of the determinants of health.

Considering these approaches together allows us to overcome some limitations of these perspectives when taken individually, as well as, considering how the various levels of analysis can influence each other. For instance, the social determinants (inequality) approach does not consider the level of intergroup relationships to explain the mechanisms through which equality influences the health and well-being of the population. In turn, research on group-level psychological determinants often misses the impact of social determinants on intergroup processes. Therefore, an integration of these models would allow a more comprehensive and structured approach to the dimensions that affect health and well-being.

Thus, in a model that integrates these approaches (Figure 7.3), we will have three levels that influence health and well-being. At a third level, the social-macro level referring to the social determinants of health, such as countries indicators and laws that influence individuals' lives and health. At a second level, the group level referring to the social-psychological determinants of health, similar to the social position in Doise's (1980) levels of explanation, which includes the effects of differences in social status. Finally, at a first level, similar to Doise (1980), the intrapersonal level referring to intra-individual socio-psychological factors[12], through which individuals organize their perceptions, evaluations and behaviours in relation to the social environment. These levels contain each other, from the more macro to the more micro-level, and interact with each other.

More specifically, the social level includes social macro factors such as social equality and personal assistance. This thesis shows that legislation on personal assistance enabled the relationship between social equality and higher well-being among disabled people (Chapter VI). In addition, results showed that the relationship between equality and well-being was explained by socio-psychological mechanisms (at the intrapersonal level) such as public participation, which in this case only happened in countries with legislation on personal assistance.

The group level includes inter and intra group-level factors, such as group discrimination, intergroup contact, and identity. This thesis showed that disability-based discrimination was negatively associated with the health and well-being of disabled people and that this association

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[12] This work is mainly focused on the two approaches of the social determinants of health and the social psychological determinants of health. However, in Chapter VI intrapersonal socio-psychological mechanisms were included to explain the relationship between social equality and well-being.

was stronger than other types of discrimination (Chapter IV). In addition, results showed that positive intergroup contact mitigated (or even cancelled out) the association between negative contact and lower health and ingroup affect, and facilitated higher ingroup ties (Chapter V). In turn, identity was positively associated with health and well-being (Chapter V, Study 1; Jetten et al., 2017).

The two levels – societal/macro and group - influence each other. As mentioned before, institutional norms embedded in laws, policies, and media, influence how groups treat each other (Kauff et al., 2021). The support of the authorities in terms of norms is one of the criteria that favour the reduction of prejudice through intergroup contact (Allport, 1954). Therefore, the adoption of legislation on personal assistance (or equality-based policies) can support intentions for intergroup contact and reduction of prejudice among the advantaged group. In turn, positive intergroup contact (and dual identification) can encourage both disadvantaged group members to engage in collective action on behalf of their own group and advantaged group members to support social change that benefits the other group (Hässler et al., 2021, 2022), which can impact the adoption of policies and laws at the social level that affects health and well-being (see Section 1.4 of this chapter for a more detailed explanation on how personal assistance and intergroup contact can influence each other). The analysis of the systems of beliefs, representations and norms could be an intermediate level of analysis between the societal (macro) and group levels, previously included in Doise's (1980) levels of explanation as the higher-level in experimental social psychology.

Finally, the socio-psychological intrapersonal level contains variables such as public participation and satisfaction with various sectors of the state. These factors are influenced by social determinants such as social equality (Chapter VI; Kawashi & Kennedy, 1999) and group level determinants. For instance, group identification is associated with collective action (Nario-Redmond et al., 2013; Nario-Redmond & Oleson, 2016), which should increase public participation. In turn, it is natural that public participation increases the opportunity for intergroup contact which may strengthen common and group identification (Hässler et al., 2021).

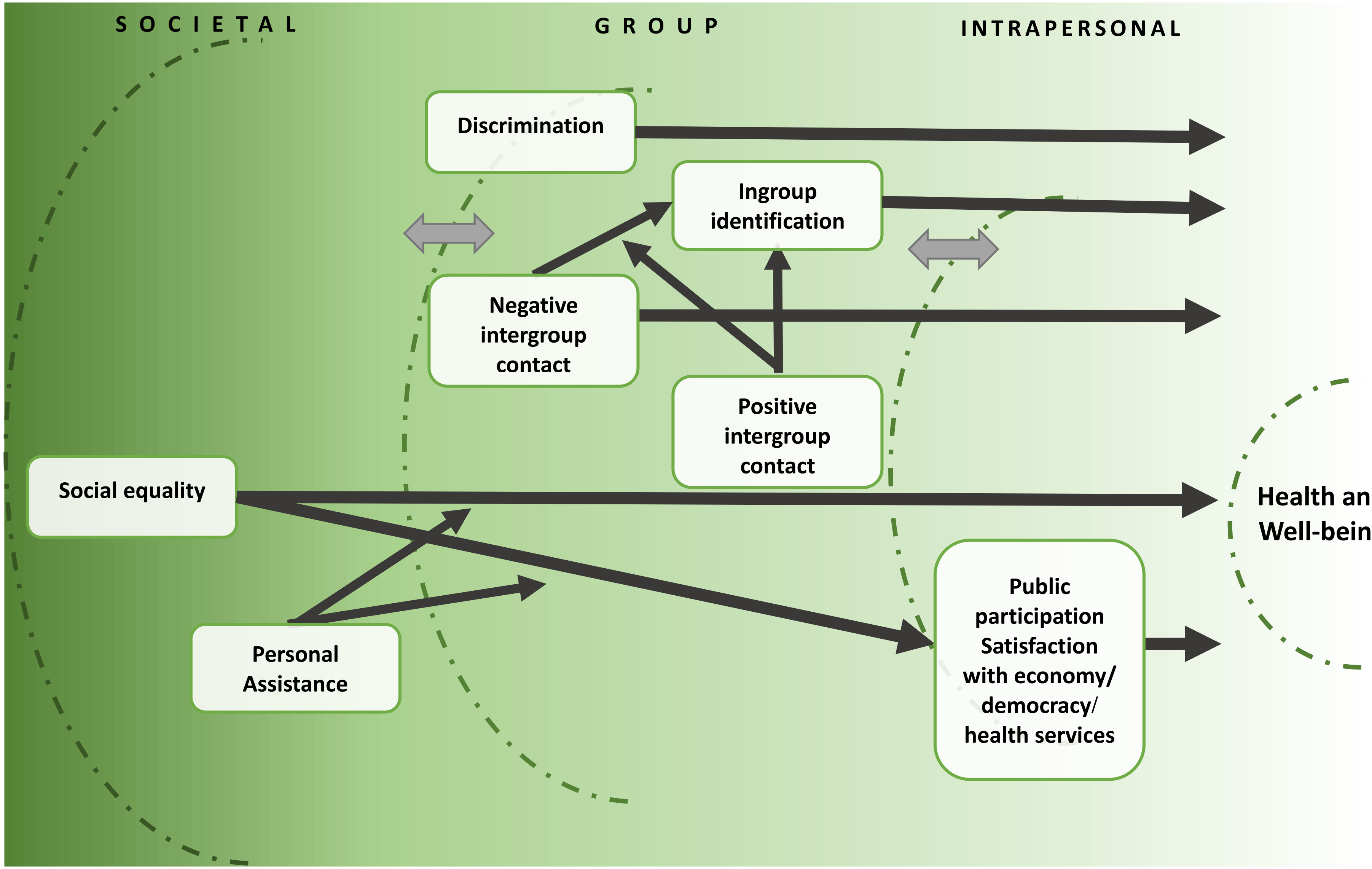
It is worth mentioning that sociodemographic variables, such as sex, age, education, and income, were included in most of the studies in this thesis as individual control variables. These variables would be more proximal to health and well-being and are generally considered to be characteristics of the individual; however, the fact that they are important for health is due to social factors, such as inequalities and stigma.

1.5.1. Integrating social identity theory and intergroup contact theory for a social psychological approach to (not only) health

The findings of this work (Chapter V), highlight the importance of considering the interaction between negative and positive intergroup contact on disadvantaged group outcomes, such as identification and well-being. For this reason, I propose a broader approach by joining social identity theory and intergroup contact theory in the study of the group processes related to health, and generally in the study of disadvantaged groups' outcomes. On the one hand, social identity theory (Tajfel & Turner, 1979) gives us access to processes related to group identification and categorization (along with self-categorization theory, Turner et al., 1987), namely how group membership develops, why and how members favour the ingroup, and how interpersonal and intergroup relationships are defined by the relationship between groups. For instance, social identity theory has been helpful in explaining how discrimination affects identification and how identity affects the well-being of group members (i.e., the rejection identification model) and strategies for social change. However, it does not consider how positive experiences with members of the (dominant) outgroup can alter the well-being and the identification processes of disadvantaged group members.

On the other hand, intergroup contact theory (Allport, 1954; Pettigrew & Tropp, 2006) was primarily focused on reducing prejudice among members of dominant groups, neglecting the impact of contact on disadvantaged groups. Subsequently, intergroup contact has been used specifically to explain intentions for collective action among disadvantaged group members (e.g., Hayward et al., 2018; Reimer et al., 2017). A similar suggestion was made on the integration of social identity theory and intergroup contact to explain collective action among advantaged and disadvantaged group members, namely through the role of the three sociostructural variables (perceived stability, legitimacy, and permeability; di Bernardo et al., 2021). However, research on intergroup contact among disadvantaged group members has left uncovered other outcomes, such as health and well-being. Therefore, the integration of social identity, namely the rejection-identification model (Branscombe et al., 1999), with intergroup contact allows us to establish the processes by which ingroup (e.g., identity) and individual (e.g., well-being) issues can be influenced by negative and positive contact between groups.

Furthermore, the integration of social identity theory and intergroup contact allows us to consider the influence of social factors, such as laws, on group-level processes (through the influence of institutional norms on intergroup relations), and vice versa (through the support for social change, e.g., Hässler et al., 2021; Kauff et al., 2021).


SOCIETAL
GROUP
INTRAPERSONAL
Discrimination
Ingroup identification
Negative intergroup contact
Positive intergroup contact
Social equality
Personal Assistance
Public participation Satisfaction with economy/ democracy/ health services
Health and Well-being

2. Overall limitations and contextual considerations

As we have come to see throughout this discussion, this work provides important findings and reflections on the determinants of health and well-being, from a social-macro (i.e., inequality) and group (i.e., intergroup contact; identity) point of view, but also on the integration of relevant theories from social psychology. However, this work has limitations that must be addressed, and itself raises new questions and opens up new avenues for future research. Given that several limitations relating to each study have already been addressed in their respective chapters/articles, here I address limitations related to the general theoretical and methodological approaches applied in this thesis.

The limitation that probably stands out the most is the lack of empirical integration of the two approaches used to analyse the health and well-being - the social determinants and the social psychological determinants approaches to health. I propose that these two approaches are important in explaining the well-being of disabled people, and socially disadvantaged groups in general, and reflect on the implications that each of these approaches has for the other. However, I do not present a study that verifies these assumptions. In fact, one of the studies planned in this thesis project was an experimental study on the impact of personal assistance on intergroup orientations and disability identity. However, due to the pandemic situation in recent years, this study could not be undertaken. Nonetheless, it is valuable to reflect on how these two approaches are intertwined in the above discussion, which can guide future studies that empirically test these relationships.

A second limitation is related to the non-verification, in empirical terms, of the differences between perceived discrimination and negative contact, when integrating intergroup contact and the rejection-identification model. I propose the integration of these two approaches, to consider the impact of positive contact on the identity and well-being of disadvantaged groups (as well as on other outcomes in general). However, these two approaches have used different constructs – perceived discrimination and negative intergroup contact – which may have different implications. Although this comparison is not an objective of this work, it can raise some questions when I seek to achieve this integration. I have reflected on these differences throughout this work, and although I do not compare these differences empirically, I hope that this work could be a starting point for the comparison of these effects in future studies.

Third, the methodologies presented here are quantitative, and although they are advanced and allow certain types of conclusions to be drawn, such as the relationship between the constructs and their generalization, the lack of qualitative methodologies means that I do not have access to certain details related to the content of the constructs. Future studies could combine different methodologies integrating qualitative methods with a quantitative approach to further develop these questions.

Fourth, in this work, I do not have samples with diverse types of disability (or access to this information). I did not intend to focus on one type of disability, because the distinction between types of disabilities, or the focus on certain types, previously served to individualize the experience of disability (as an individual problem) and to delay the recognition of disabled people as a social category. Furthermore, there is evidence of cultural stereotypes that are common to various types of disabilities (Nario-Redmond, 2010). To be more inclusive and increase our samples, I opened the participation to disabled people in general. However, in two of my studies (with the ESS database), I did not have access to information on the different types of disabilities, and in the other two studies, most of the participants had physical disabilities. Although it was not my objective to focus on one type of disability or distinguish between the type of disability, research must include the experience of people with various types of disabilities (using more accessible methodologies), namely the most marginalized.

In addition, most of the participants of the studies in chapter V (i.e., diary and longitudinal studies) had university education (despite only half of the sample being employed) and reported a relatively positive level of health and well-being. These aspects could mean that our sample could be in a somewhat better position compared to the general category of disabled people. However, (a) these constraints are common in research (i.e., people with more education or resources are more likely to participate), and (b) the samples are from a disadvantaged group, somewhat difficult to collect, and therefore, I did not attempt to have representative samples. More importantly, (c) the findings of these studies showed the expected association between negative contact and well-being/identity and the key results were consistent across samples.

Finally, it is important to mention that this study was carried out in a western European context, which means that it was conducted mainly in modern and capitalist societies. Impairment and disability are inseparable from global poverty and inequality produced by industrial capitalism and globalization, impacting disabled people in western/ “developed” and “developing” countries (Barnes & Mercer, 2005; Gleeson, 1998). However, despite disabled people experiencing discrimination and oppression with devastating consequences for their lives and health worldwide, their origins, consequences and interpretations could differ across cultural contexts. For instance, while in western and “developed” countries the focus is on civil rights and access to the various areas of society within the typical level of modern societies, in most “developing” countries the focus is on survival and the establishment of networks of connection (see Dirth & Adams, 2019, for a critical perspective on disability studies and decolonized perspectives). Capitalist values and related ideologies (i.e., individualism) in modern society permeate the views about ability, as well as the distinction between impairment and disability (Barnes & Mercer, 2005; Dirth & Adams, 2019).

Despite these limitations and considerations, this work makes important contributions to highlighting and understanding the role of social and social-psychological determinants of the well-being of disabled people, which may be extended to other socially disadvantaged groups. This is even more important in the case where this social category is understudied or studied from an individual point of view. The systematic application of these approaches should have the immodest but Lewinian (Lewin, 1951) aim of seeking to establish evidence that could help to design better-informed interventions and policies.

3. Applied contributions to disability interventions and policies

Our findings have critical implications for interventions and social policy, at multiple levels of society. At the group level, this work shows that disability-based discrimination and negative intergroup contact have important implications for the well-being of disabled people, as well as for their group identification. On the other hand, this work shows that positive intergroup contact has the potential to attenuate the adverse consequences of negative intergroup contact, and even facilitate favourable consequences. Therefore, interventions and policies should be directed at, on the one hand, reducing disability-based discrimination and negative intergroup contact and, on the other hand, promoting positive intergroup contact and group identification. At the societal level, this works shows that personal assistance facilitates the association between equality and disabled people’s well-being. This shows the importance of enact social policies that can promote transformative changes and, consequently, have implications at the group level. I'll go through each of these areas of intervention next. Despite will not develop that here, when designing interventions and policies it is important to consider intersectional perspectives (e.g., Liasidou, 2013) and incorporate the disability community and user-led organizations into project planning and implementation (e.g., Charlton, 1998).

Reducing disability-based discrimination and negative intergroup contact has been approached through several strategies such as education and training (Smythe et al., 2020), disability simulation, and direct or indirect intergroup contact (see Nario-Redmond, 2019 for a review). A well-known intervention, often used by organizations, is the simulation of disability, an emotion-based approach. The simulation of disability generally implies the use of a wheelchair, earplugs (for noise reduction) or a blindfold by non-disabled people in order to simulate an experience of disability (i.e., physically disabled, deaf/hearing loss, or blind; e.g., Nario-Redmond, 2019). The idea is to induce positive emotions, such as empathy, through the stepping into “other people's shoes”. Rather than just imagining what it is like for others to experience disability, simulation requires a personal experience of it. However, despite being well-intentioned, these types of interventions have shown mixed or negative effects (see Flower et al., 2007 for a meta-analysis and Ando et al., 2011 for a systematic review specifically on schizophrenia). Nario-Redmond and colleagues (2017) conducted two experiments on simulation in low vision, hearing or mobility impairment, or dyslexia. In both experiments, disability simulations made participants feel more confused, embarrassed, helpless, and more vulnerable to becoming disabled themselves. Yet, undermining their value as interventions, perceived warmth (related to paternalistic prejudice) toward disabled people increased while attitudes about interacting with them did not improve. Anxiety, embarrassment, and helplessness were highest for those who simulated a mobility impairment or dyslexia. Critics of these interventions (e.g., French, 1992) have highlighted the misguided intentions of these interventions since disability experience cannot be apprehended or understood based on a simulation of a couple of hours. On the contrary, these experiences increase anxiety and fear, because they are focused on the loss of certain functionality (with no time to cope and explore another way of function), instead of focusing on social-environmental barriers (French, 1992; Nario-Redmond et al., 2017).

A review of interventions to reduce stigma towards disabled children and their families, in middle- and low-income countries, showed that education/training was the most common intervention, which was delivered mostly at the institutional/organizational level (Smythe et al., 2020). Despite most of the studies showing a reduction in stigma, based on a list of assessment criteria, the authors found that most of the studies had a high risk of bias. In another meta-analysis, the authors showed similar concerns regarding the recommendation of interventions due to lack of robust data (Seewooruttun & Scior, 2014). That is why interventions aimed at reducing discrimination should be interpreted with caution. Corrigan and colleagues’ (Corrigan et al., 2001) studies on the reduction of mental stigma (related to depression and psychosis) show complementary results, in which education/training produced positive results; however, indirect contact (parasocial contact via video) with someone with a mental disorder produced stronger results on stigma reduction, compared to education/training. Similarly, in a meta-analysis of 79 independent studies, both education and contact improved attitudes and behavioural intentions toward people with mental illness, but contact produced a higher change than education, especially among adults (Corrigan et al., 2012).

Promoting (indirect or direct) positive intergroup contact is a well know strategy to reduce intergroup prejudice. Interventions on intergroup contact could and should be promoted in diverse practical settings such as education, work, sport and leisure activities. Contact with disadvantaged group members counteracts the stereotypical information about the group, by increasing knowledge, but mostly by increasing empathy and reducing anxiety (Pettigrew & Tropp, 2008). Moreover, intergroup contact has the potential to generalize change of attitude from the one or more outgroup members encountered to the entire disadvantaged group, when the outgroup member is considered a typical member of that group (instead of just someone to be considered as atypical, or an exception). In a meta-analysis, the effect sizes of intergroup contact on prejudice reduction towards physically and "mentally" disabled people were of larger-than-average and average size, respectively (Pettigrew & Tropp, 2006). For instance, attitudes were less negative among (hearing) individuals who had more contact with hearing impaired or deaf individuals (LaBelle et al., 2013). A review of 17 studies, including studies of both direct and indirect contact, with intellectually disabled people revealed favourable effects on attitudes in most studies, while some of the studies included education/training facilitated by the disabled person (Seewooruttun & Scior, 2014). Interventions involving indirect contact included studies using documentary films, web presentations, and photographs. Indirect contact through storybooks (Cameron & Rutland, 2006) and imagined contact (Cameron et al., 2011) among non-disabled children increased positive attitudes and behavioural intentions toward disabled children.

Nevertheless, despite both direct and indirect contact producing significant effects, direct contact produced stronger effects (Corrigan et al., 2012), especially direct contact that facilitates interpersonal friendship (Brown & Hewstone, 2005). In addition, contact that counteracts the stereotype of dependency (Seewooruttun & Scior, 2014), but in which the target is typically described as a member of the (disability) group, yielded better outcomes (Cameron & Rutland, 2006). This is in accordance with the mutual intergroup differentiation model, which proposes that intergroup interactions should be structured to recognize group membership and group strengths (Brown & Hewstone, 2005).

Concerns about prejudice reduction were related to the assumption that while contact improved attitudes toward disabled people that did not mean that they improved support for social change and disability rights (e.g., Nario-Redmond, 2019). However, recent studies have shown that positive contact can promote the engagement of the dominant group in strategies for social change (Dixon & McKeown, 2021; Hässler et al., 2022; Reimer et al., 2017). Promoting intergroup experiences where the dominant group acknowledge the illegitimacy of social inequality promotes the engagement of the disadvantaged group in collective action for social change (Becker et al. 2013). This leads us to the importance of promoting positive intergroup contact that fulfils the (identity) needs of empowerment and respect of the disadvantaged group (and the need for acceptance of the advantaged group: Nadler & Shnabel, 2015). Our studies (Chapter V) show that positive contact had an important role in attenuating the association between negative contact and lower ingroup affect or in facilitating higher ingroup ties. In addition, other strategies could increase positive group identification.

Promoting a positive group identification could increase the well-being of disabled people since disability identification has been associated with positive health outcomes (e.g., Bogart, 2014, 2015; Nario-Redmond et al., 2013). However, according to the social cure agenda, identification must be associated with social connection, meaning, social support and a sense of control (Jetten et al., 2017). The creation of conditions for disabled people to meet more frequently would be important since the sharing of experiences is crucial to recognize discrimination as both a function of social category membership (rather than individual characteristics) and illegitimate, which is associated with group identification (Jetten et al., 2001), as well as high self-esteem and empowerment (Rüsch et al., 2006). Another way of promoting the perception of illegitimacy is through the 'social model of disability' (Dirth & Branscombe, 2019), since this model is associated with the perception of discrimination as illegitimate.

In turn, disability identification is associated with collective strategies for social change. Re-categorization (and colourblind) approaches (e.g., Gaertner & Dovidio, 2000), in which differences between groups are diluted in a subordinate group to promote similarities are not recommended. These types of strategies have been considered universalizing and assimilationist strategies, which may lead to resistance and intergroup bias since they are difficult to sustain in the long term and threatens groups needs for distinctiveness (Dovidio et al., 2009, 2016). Moreover, they fail to recognize social inequalities and the experience of disadvantaged group members. Instead, dual identities, also described as multiculturalism or pluralism, suggests that groups could respect each other differences with positive outgroup attitudes (Dovidio et al., 2009, 2016; Huo & Molina, 2006). Therefore, more recent literature on intergroup contact and social change has proposed a dual identity model, in which disadvantaged group members can identify with a subgroup and a superordinate group, to promote the support for collective action from disadvantaged and advantaged group members (Hässler et al., 2021).

Since the disability group is composed of several subgroups of disabilities (which can promote intragroup prejudices and prevent group cohesion; Deal, 2003; Harder et al., 2019) it would be important to bring this dual identity into the group itself, to recognize and validate the different experiences of the members with different disabilities, but at the same time promoting a common disability identity that encompasses all disabilities. In this line, intragroup respect has been associated with collective identification and ingroup cooperation (Simon & Stürmer, 2003; Smith & Tyler, 1997).

Promoting social policy and transformative changes at the social-macro level, however, has the potential to impact all other levels of society, including the intergroup level above (Figure 7.4). Norms established by legislation are fundamental in determining antiprejudicial norms and principles on how groups should interact with each other (Allport, 1954; Kauff et al., 2021), as well as the norms embodied in institutions, media, and political content (White et al., 2021). Therefore, transformative changes in inequality at the structural level are more effective (and really transformative). For Fraser (1996), transformative changes for equality (i.e., parity of participation), need a (transformative rather affirmative) redistribution of resources, cultural recognition, and political representation. Personal assistance seems to be an example of a social policy that includes these characteristics (as we saw in the theoretical introduction and previous sections of this chapter). This work (Chapter VI) shows that legislation on personal assistance plays an essential role in enabling the association between equality and disabled people's well-being, via socio-psychological mediators such as public participation. Nevertheless, to reduce inequality with personal assistance it is necessary to safeguard several aspects such as equal access to the service, full user control and choice over the service, adequate funding for all activities related to this policy, including direct payments, management activities, training and peer support, co-participation and political representation of disabled people (see Article 3 for more details on personal assistance).

Another point would be the reinforcement and compliance of social policy and laws that are already enacted, such as non-discrimination and accessibility laws. Despite the existence of laws, such as the ADA - Americans with Disabilities Act in the USA (the same happens in Portugal), there is no monitoring or effective compliance (e.g., Nario-Redmond, 2019). Therefore, it is essential to develop procedures that are effective in reporting any instances of discrimination (including lack of accessibility) to legal authorities, which must have objective results.

Norms, beliefs and stereotypes are constructed and perpetuated through media. Media and movies have contributed to the maintenance of disability stereotypes through the representation and communication of disability and disabled people in terms of abnormality, tragedy, dependency and vulnerability (Brylla, 2018.; Haller, 2010; Morris, 1991; Nario-Redmond, 2019). In addition, media are channels of indirect intergroup (so-called parasocial) contact with disabled people. Therefore, as a channel of contact and reinforcement of society's norms, media are an important place to contest negative disability-related stereotypes, for example, showing counter-stereotypical personalities. Images or news stories about counter-stereotypic African American media personalities reduced stereotypical perceptions, symbolic racist beliefs, internal attributions, and hostile feelings, and increased support for social change, as compared to stereotypical ones (Ramasubramanian, 2011, 2015). Movies and documentary films need to adopt different practices to reconfigure disability stereotypes (see the strategy of narrative fragmentation in Brylla, 2018; Brylla, 2019).

As in the case of personal assistance, social policies that support disability equality should be based on principles of social justice, the rights of disabled people and the social model of disability. The social model of disability has been shown to create awareness of structural discrimination, among disabled and non-disabled people, and increase policy support among nondisabled people (Dirth & Branscombe, 2017, 2019). Therefore, a transformative change from the medical to the social model, at the level of government institutions, media, and politics, would translate into positive consequences at the group and individual levels, such as a decrease in discrimination and negative intergroup contact, and an increase in positive contact, group identity, and well-being. Additionally, at this level it would be interesting to develop interventions or practices to contest "legitimizing myths", such as the Protestant work ethic, meritocracy, individualism, and the belief in a just world, that are used to justify system inequalities (see Jost & Hunyady, 2010, for a review). Interestingly, a cross-cultural meta-analysis (459 studies covering 660 samples in 36 countries) of the contact-prejudice effect showed that egalitarianism was related to a stronger negative association between contact and prejudice, while hierarchy values and social dominance orientation were related to weaker associations between contact and prejudice (Kende et al., 2018). As previously noted, radical socio-political transformations are required to unravel a phenomenon so deeply enmeshed in historical, economic and political forces, as is prejudice (Brown, 2010), including ableism.

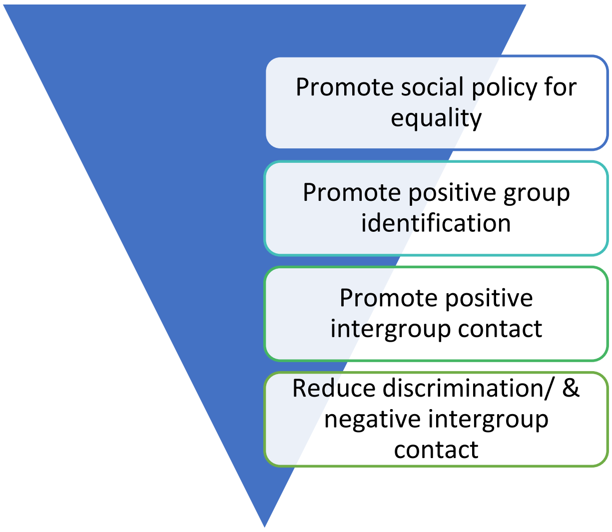


Figure 7.4. Practical interventions to the health and well-being of disabled people.

Conclusion

The main aim of this thesis was to analyse how societal and social psychological factors affect the health and well-being of disabled people. This question was analysed through two approaches: an approach based on the social-psychological determinants of health (group-level), grounded in the social identity approach, and a second approach based on the social determinants of health (e.g., equality across groups in society; societal/macro-level). At the group level, findings showed that ableism was associated with lower health and well-being and that this effect was stronger compared to other types of group-based discrimination (e.g., racism, sexism; Chapter IV). In addition, findings showed that positive intergroup contact can attenuate (and even cancel out) the adverse effects of negative contact on well-being and ingroup affect, and in turn facilitate ingroup ties (Chapter V). At the societal level, findings show that legislation on personal assistance enables the association between social equality (within country) and health and well-being, among disabled people, which was explained by increased public participation, higher satisfaction with the socio-economic context, and more positive opinions of health services (Chapter VI).

Therefore, given that disability has been studied mostly from individual and medical perspectives, the main contribution of this work was the use of a social psychological lens to examine the societal and intergroup factors that influence the well-being of disabled people. Specifically, this work contributed to unveiling a form of group-based discrimination that has been under-researched, but that, paradoxically, can be the most pervasive (and resistant) form of discrimination among stigmatised groups. In addition, it contributed to a body of theoretical work on social psychology through the integration of research on social identity theory (e.g., the Rejection-Identification Model) with research on intergroup contact theory, expanding knowledge on intergroup contact among disadvantaged group members. Finally, it addressed the importance of societal factors, such as social equality and social policy, and explored, from a theoretical point of view, the relationship between societal- and group-level factors, suggesting a comprehensive approach to health and well-being.

Furthermore, this work has relevant contributions not only to the social psychology of disability but also to the theoretical debate on disability models and paradigms. In the present work, ableism appeared as one of the most harmful forms of discrimination for health and well-being, and, in previous research, it appeared as a more resistant (implicit) prejudice (Charlesworth & Banaji, 2019; Harder et al., 2019). Perhaps because ableism is deep-rooted in cultural ideologies of productivity and competence, and disability is the very representation of the opposite of able-bodiedness, this makes ableism a more salient stigma.

Because ableism is based on the discrimination of certain body characteristics that are in opposition to the normative ideal of an able-bodied, some authors (e.g., Campbell, 2008; Wolbring, 2008) have emphasized the importance of moving from disability (or disablism) to ability and ableism. Campbell (2001, p. 44) defines ableism as "a network of beliefs, processes and practices that produces a particular kind of self and body (the corporeal standard) that is projected as the perfect, species-typical and therefore essential and fully human". Thus, the concept of difference (or disability) would not exist if there were not an ontological division between disabled and abled, posited by ableism, and which is continuously performed in the (violent) discourses and practices of normativity and normalization (Campbell, 2008). Similarly, Siebers (2017) called the *ideology of ability* (i.e., ableism) the preference for able-bodiedness that "defines the baseline by which humanness is determined, setting the measure of body and mind that gives or denies human status to individual persons (p. 312)". Because it is exclusionary, it creates disability (identity) as a social location outside of it, which in turn critiques and disturbs its framework.

Therefore, if disability is created by (ableist) social attitudes and barriers, these attitudes and barriers are created regarding to what is not able-bodied, that is, regarding impairment. Thus, the impaired body is viewed through the lens of (the ideology of) ability. The dualistic distinction between impairment and disability has been one of the main criticisms of the social model of disability, a distinction also presented in the social constructivist paradigm in disability social psychology. This criticism arises, for example, from authors of critical disability studies (e.g., Shakespeare, 2006; Siebers, 2017), feminist perspectives on disability studies (e.g., Morris, 1991; Wendell, 1996), and the sociology of the body (e.g., Hughes & Paterson, 1997). The main reason is related to the denial or invisibility of the personal experiences of disabled people that are caused by impairment, namely in situations of pain and chronic illness. Another argument is that despite disability being de-medicalized, impairment remains relegated to the field of medicine and medical discourse, and consequently impaired bodies remain invisible and oppressed, treated as the “other”.

In this sense, Hughes and Paterson (1997) have argued for a sociology of impairment, calling for a political and theoretical debate on the body, through contributions on post-structuralism and phenomenology. From a post-structuralist perspective, the impaired body is viewed as a discursive construction, embedded in history, beliefs, and cultural meanings. From a phenomenological perspective, the impaired body is not only an object but a *lived body*, an experiencing subject and agent. In a similar vein, the theory of complex embodiment (Siebers, 2017) views the relationship between disability and the body as reciprocal and mutually transformative. In this way, disability influences the experience of the body, but some conditions derived from the body - chronic pain, ageing - affect disability as well, not as deviations but as part of human variation and life cycle.

However, this debate is more complex in the case of disability, due to the longest tradition of pathologizing. Attempts to find a balance in a paradigm that does not fall into biological or cultural essentialism, have supported an interactionist approach between biology (impairment) and society (disability) (e.g., Anastasiou & Kauffman, 2013), similar to the biopsychosocial model. However, these interactionist approaches have been criticized for redirecting attention towards the impairment as deviation and cause of disability, which contributed to justify the cutting or removal altogether of benefits and services for disabled people in the face of economic crises (Oliver, 2013).

While it seems important not to shift the focus from the ableist attitudes and social barriers as producers of disability, for a deconstruction of ableism it seems unavoidable, if progress is to be made, to move towards a paradigm that takes more account of perceptions about ability and impairment, along with ableism and disability. A clarification of these processes can contribute to the reduction of ableism towards disabled people, but also to the understanding of related attributes (e.g., competence) that impact multiple disadvantaged groups. As argued before, by authors such as Olkin and Pledger (2003), Dirth and Branscombe (2017), and Bogart and Dunn (2019), social psychology has a rich theoretical framework to make sense of the processes related to disability and ableism. Namely, a distinct intergroup perspective that is often missing in interdisciplinary approaches (Nario-Redmond, 2019), but related to complex phenomena and multiple levels of explanation, as this thesis illustrated. This thesis took a subject that has, over time, been considered mostly from an individual perspective – in this case, the health and well-being of disabled people – and demonstrated how societal, interpersonal, and intra-individual processes are illuminated by an intergroup approach.

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Annex A. Questionnaire of the diary study (Chapter V)

Start of Block: Introdução

Diário de Interações Sociais

Este estudo tem como objetivo aprofundar o tipo de interações (positivas e negativas) que as pessoas *com* deficiência têm no seu dia-a-dia, com pessoas *sem* deficiência. Os participantes deste estudo devem ser pessoas com deficiência, maiores de 18 anos.

A participação neste estudo consiste no preenchimento de um questionário ao longo de 7 dias, **durante a semana de 11 a 17 de março**. Salientamos, no entanto, que a **sua participação é voluntária** e pode desistir a qualquer altura do processo.

As respostas são **anónimas**. Não existem respostas certas nem erradas. Estamos interessados nas experiências genuínas das pessoas, por isso, por favor, responda de forma mais honesta possível. No final, haverá um espaço onde pode deixar comentários/ sugestões, se o desejar.

O questionário leva em média 5-10 minutos a ser preenchido, devendo ser completado entre as 18h e as 24h de cada dia da semana. Caso não preencha o questionário num dos dias, pode continuar a preencher nos restantes dias, pois é muito importante para o desenvolvimento do estudo que haja o máximo de dados por pessoa.

Ao participar estará a contribuir para um estudo que visa apoiar a melhoria das condições sociais das pessoas com deficiência. Para além disso, os participantes que responderem ao total dos 7 dias receberão um Vale Pingo Doce de 10€. E, os participantes que responderem no mínimo durante 5 dias receberão um Vale Pingo Doce de 5€.

Muito obrigada pela sua colaboração! A sua participação é muito importante para este estudo.

Se tiver alguma questão sobre este estudo, contacte:
Carla Branco
Estudante de doutoramento em Psicologia Social, CIS-IUL, ISCTE-IUL, LiSP
carla_branco@iscte.pt

Confirmo que sou uma pessoa com deficiência, maior de 18 anos, e aceito participar neste estudo:

○ Sim

○ Não

Skip To: End of Survey If Confirmo que sou uma pessoa com deficiência, maior de 18 anos, e aceito participar neste estudo: = Não

Page Break

Definições

Contacto: uma interação ou experiência **cara-a-cara**, com outra pessoa ou grupo, tipicamente uma conversa ou troca de sinais não verbal, como por exemplo um aceno. O contacto pode ser de qualquer medida; com alguém que conhece bem ou um estranho. Pode incluir também situações que tenha observado, sem ter participado diretamente (por exemplo, ver pessoas a conversarem ou debaterem algo).

Contacto positivo ou negativo: refere-se a como se sentiu em relação ao contacto. Cabe-lhe a si o que considera ser “positivo” e “bom” ou “negativo” e “mau”. Na descrição das experiências poderá referir detalhes sobre o contacto em questão e poderá explicar o que é que exatamente no contacto fez com que sentisse que foi positivo ou negativo.

End of Block: Introdução

Start of Block: Código

Código de participante

Como este estudo consiste no preenchimento de um diário ao longo de 7 dias, precisamos de definir um código para si, de forma a garantir o seu **anonimato** e ao mesmo tempo **podermos emparelhar as suas respostas** ao longo dos dias. Para definir o seu código, responda por favor à seguintes questões:

A primeira letra do primeiro nome da sua mãe

▼ A ... Z

O dia do seu aniversário

▼ 01 ... 31

O mês em que você nasceu

▼ JAN ... DEZ

*

A sua idade (indique apenas 2 digítos)

____

Page Break

O seu código é o ${Q2.2/ChoiceGroup/SelectedChoices}${Q2.3/ChoiceGroup/SelectedChoices}${Q2.4/ChoiceGroup/SelectedChoices}${Q2.5/ChoiceTextEntryValue}

Não necessita de guardar este código. Da próxima vez que responder ao nosso estudo faremos as mesmas questões de forma a gerar o mesmo código.

Hoje é: *(Indique o dia da semana)*

○ Segunda-feira

○ Terça-feira

○ Quarta-feira

○ Quinta-feira

○ Sexta-feira

○ Sábado

○ Domingo

End of Block: Código

Start of Block: Contacto intergrupal positivo

As minhas interações positivas hoje...

Quantas vezes teve **contacto positivo** com pessoas *sem* deficiência hoje?

▼ 0 ... Não sei

Pense na primeira experiência que lhe vier à cabeça de um contacto **positivo** que tenha tido com uma pessoa *sem* deficiência durante o dia de hoje (não familiares). Por favor, descreva essa experiência em algumas palavras (pode descrever o contacto como desejar, por exemplo, pode descrever a(s) pessoa(s) envolvida(s), o tipo de situação, o contexto, e ou coisas especificas que aconteceram).

____

____

____

No geral, como é que avalia essa experiência de **contacto positivo** que descreveu?

○ 1 Ligeiramente positivo

○ 2

○ 3

○ 4

○ 5

○ 6

○ 7 Extremamente positivo

E, até que ponto é que se sentiu afetado/a pessoalmente pela **experiência positiva** que descreveu?

○ 1 Nada

○ 2

○ 3

○ 4

○ 5

○ 6

○ 7 Muítissimo

End of Block: Contacto intergrupal positivo

Start of Block: Contacto intergrupal negativo

As minhas interações negativas hoje...

Quantas vezes teve **contacto negativo** com pessoas *sem* deficiência hoje?

▼ 0 ... Não sei

Pense na primeira experiência que lhe vier à cabeça de um contacto **negativo** que tenha tido com uma pessoa *sem* deficiência durante o dia de hoje (não familiares). Por favor, descreva essa experiência em algumas palavras (pode descrever o contacto como desejar, por exemplo, pode descrever a(s) pessoa(s) envolvida(s), o tipo de situação, o contexto, e ou coisas especificas que aconteceram).

____

____
____

No geral, como é que avalia essa experiência de **contacto negativo** que descreveu?

○ 1 Ligeiramente negativo

○ 2

○ 3

○ 4

○ 5

○ 6

○ 7 Extremamente negativo

E, até que ponto se sentiu afetado/a pessoalmente pela **experiência negativa** que descreveu?

○ 1 Nada

○ 2

○ 3

○ 4

○ 5

○ 6

○ 7 Muítissimo

End of Block: Contacto intergrupal negativo

Start of Block: Identificação grupal

O que penso sobre as pessoas com deficiência hoje...

Por favor, responda em que medida concorda com as seguintes afirmações, sobre como se identifica com esta comunidade, hoje:

	Discordo totalmente	Discordo	Discordo em parte	Não concordo nem discordo	Concordo em parte	Concordo	Concordo totalmente
É agradável pertencer à comunidade de pessoas com deficiência.	○	○	○	○	○	○	○
Fazer parte da comunidade das pessoas com deficiência dá-me uma sensação agradável.	○	○	○	○	○	○	○
O facto de ser uma pessoa com deficiência é uma parte importante da minha identidade.	○	○	○	○	○	○	○
Ser uma pessoa com deficiência é uma parte importante de como eu me vejo a mim mesmo/a.	○	○	○	○	○	○	○
Sinto solidariedade para com as pessoas com deficiência.	○	○	○	○	○	○	○
Sinto dedicação para com as pessoas com deficiência.	○	○	○	○	○	○	○

End of Block: Identificação grupal

Start of Block: Saúde e bem-estar

Como me sinto hoje...

No global, como se sente em termos de saúde hoje?

- ○ 1 Muito mal
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
- ○ 7 Muito bem

Pensando na sua vida em geral, quão feliz se sente hoje?

- ○ 1 Muito infeliz
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
- ○ 7 Muito feliz

Pensando em como se sentiu hoje, por favor, indique com que frequência se sentiu ao longo do dia:

	Nunca 1	2	3	4	5	6	Sempre 7
Se sentiu deprimido/a.	○	○	○	○	○	○	○
Se sentiu apático/a e sem motivação para fazer as coisas.	○	○	○	○	○	○	○

Indique, por favor, em que medida concorda com as seguintes afirmações sobre como se sente hoje:

	Discordo totalmente	Discordo	Discordo em parte	Não concordo nem discordo	Concordo em parte	Concordo	Concordo totalmente
Tenho uma boa opinião de mim próprio/a.	○	○	○	○	○	○	○
De um modo geral sinto-me um/a fracassado/a.	○	○	○	○	○	○	○
Sinto que sou livre de decidir como viver a minha própria vida.	○	○	○	○	○	○	○
Sinto que posso ser eu próprio/a.	○	○	○	○	○	○	○
Sinto-me realizado/a com aquilo que faço.	○	○	○	○	○	○	○
Sinto que sou muito capaz.	○	○	○	○	○	○	○
Considero que as pessoas com quem interajo regularmente são minhas amigas.	○	○	○	○	○	○	○
As pessoas que fazem parte da minha vida preocupam-se comigo.	○	○	○	○	○	○	○

Page Break

Pode utilizar este espaço caso queira deixar algum comentário e ou sugestão.

____

____

____

De seguida será direcionado/a para outro formulário de forma a deixar-nos o seu email, para registar a sua participação e podermos atribuir-lhe um Vale de acordo com a sua participação no estudo ao longo da semana.

Os participantes que responderem ao total dos 7 dias receberão um Vale Pingo Doce de 10€. E, os participantes que responderem no mínimo durante 5 dias receberão um Vale Pingo Doce de 5€.

End of Block: Saúde e bem-estar

Annex B. Questionnaire of the longitudinal study (Chapter V)

Start of Block: Introdução

O impacto da assistência pessoal na vida das pessoas com deficiência
1ª fase/ 1º questionário

Este estudo tem como objetivo perceber o impacto da assistência pessoal no bem-estar das pessoas com deficiência.

Os/As participantes do estudo **devem ser pessoas maiores de 18 anos e que sejam ou pretendam ser candidatos/as** a assistência pessoal pelo projeto-piloto nacional de Vida Independente (MAVI - Modelo de Apoio à Vida Independente).

A participação neste estudo consiste no preenchimento de um total de **3 questionários** (semelhantes), **separados por períodos de 1 ano (3 fases)**. Salientamos, no entanto, que a sua **participação é voluntária** e pode desistir a qualquer altura do processo.

O questionário leva em média **20 minutos** a ser preenchido. As respostas são **anónimas** e **confidenciais**. Não existem respostas certas nem erradas, estamos interessados apenas na sua experiência.

Participe até 31 de Julho!

Muito obrigada pela sua colaboração! A sua participação é muito importante para este estudo.
Se tiver alguma questão sobre este estudo, contacte:

Carla Branco
Estudante de doutoramento em Psicologia Social, CIS-IUL, ISCTE-IUL, LiSP
carla_branco@iscte.pt

Confirmo que sou uma pessoa com deficiência, maior de 18 anos, sou ou pretendo ser candidato/a a assistência pessoal pelo projeto-piloto nacional (MAVI), e aceito participar neste estudo.

○ Sim

○ Não

End of Block: Introdução

Start of Block: Código

Código de participante
Como este é um estudo com 3 fases, precisamos de definir um código para si, de forma a

garantir o seu **anonimato** e ao mesmo tempo **podermos emparelhar as suas respostas** de hoje com as suas respostas nas fases seguintes. Para definir o seu código, responda por favor à seguintes questões:

A primeira letra do primeiro nome da sua mãe

▼ A ... Z

O mês em que você nasceu

▼ JAN ... DEZ

O dia do seu aniversário

▼ 01 ... 31

Page Break

O seu código é o ${Q1.4/ChoiceGroup/SelectedChoices}${Q1.5/ChoiceGroup/SelectedChoices}${Q1.6/ChoiceGroup/SelectedChoices}
Não necessita de guardar este código. Da próxima vez que responder ao nosso estudo faremos as mesmas questões de forma a gerar o mesmo código.

Page Break

As suas experiências de interação social Ao vivermos em sociedade temos contacto com outras pessoas. Isto é, temos interações sociais que por vezes são mais negativas ou mais positivas. Gostaríamos de lhe fazer algumas questões sobre as experiências de contacto positivo e negativo que tem com pessoas *sem* deficiência, no seu dia-a-dia, **excluindo os seus familiares**.

End of Block: Código

Start of Block: Contacto intergrupal positivo

No geral, com que frequência tem **contacto positivo** com pessoas *sem* deficiência?

- ○ Nunca
- ○ Menos do queuma vez por mês
- ○ Uma vezpor mês
- ○ Várias vezespor mês
- ○ Uma vez por semana
- ○ Várias vezespor semana
- ○ Todosos dias

No geral, como é que avalia esse **contacto positivo** com pessoas *sem* deficiência?

- ○ 1 Ligeiramente positivo
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
- ○ 7 Extremamente positivo

E, geralmente até que ponto é afetado/a por essas **experiências positivas** com as pessoas *sem* deficiência?

- ○ 1 Nada
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
- ○ 7 Extremamente

End of Block: Contacto intergrupal positivo

Start of Block: Contacto intergrupal negativo

No geral, com que frequência tem **contacto negativo** com pessoas *sem* deficiência?

- ○ Nunca
- ○ Menos do que uma vez por mês
- ○ Uma vez por mês
- ○ Várias vezes por mês
- ○ Uma vez por semana
- ○ Várias vezes por semana
- ○ Todos os dias

No geral, como é que avalia esse **contacto negativo** com pessoas *sem* deficiência?

- ○ 1 Ligeiramente negativo
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
- ○ 7 Extremamente negativo

E, geralmente até que ponto é afetado/a por essas **experiências negativas** com as pessoas *sem* deficiência?

- ○ 1 Nada
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
- ○ 7 Extremamente

End of Block: Contacto intergrupal negativo

Start of Block: Contacto intergrupal - outras

No geral, durante o seu contacto com pessoas *sem* deficiência, até que ponto está consciente sobre ter uma deficiência?

○ 1 Nada consciente

○ 2

○ 3

○ 4

○ 5

○ 6

○ 7 Completamente consciente

Por favor, pense no **contacto positivo** que tem com pessoas *sem* deficiência. Em geral, durante as suas experiências de **contacto positivo** com pessoas *sem* deficiência, até que ponto está consciente sobre ter uma deficiência?

○ 1 Nada consciente

○ 2

○ 3

○ 4

○ 5

○ 6

○ 7 Completamente consciente

Por favor, pense no contacto negativo que tem com pessoas *sem* deficiência. Em geral, durante as suas experiências de contacto negativo com pessoas *sem* deficiência, até que ponto está consciente sobre ter uma deficiência?

○ 1 Nada consciente

○ 2

○ 3

○ 4

○ 5

○ 6

○ 7 Completamente consciente

Page Break

Durante o meu **contacto positivo** com pessoas *sem* deficiência, geralmente sinto-me:

○ Muito inferior

○ Bastante inferior

○ Inferior

○ Igual

○ Superior

○ Bastante superior

○ Muito superior

Durante o meu **contacto negativo** com pessoas *sem* deficiência, geralmente sinto-me:

- ○ Muito inferior
- ○ Bastante inferior
- ○ Inferior
- ○ Igual
- ○ Superior
- ○ Bastante superior
- ○ Muito superior

Page Break

Gostaríamos de lhe perguntar sobre a discriminação em relação às pessoas com deficiência, em Portugal. Até que ponto concorda com a seguinte afirmação:

Em Portugal, existe muita discriminação e comportamentos injustos em relação às pessoas com deficiência.

- ○ 1 Discordo totalmente
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
- ○ 7 Concordo totalmente

Nos últimos cinco anos, com que frequência foi pessoalmente discriminado ou tratado de forma injusta por ser uma pessoa com deficiência?

- ○ 1 Nunca
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
- ○ 7 Muitas vezes

Page Break

Pense, por favor, no seu grupo de pessoas amigas e responda às seguintes questões.

X→

No seu grupo de amigos chegados, quantas são pessoas com deficiência?

▼ 0 ... Não respondo

X→

No seu grupo de amigos chegados, quantas são pessoas *sem* deficiência?

▼ 0 ... Não respondo

End of Block: Contacto intergrupal - outras

Start of Block: Identificação grupal

Opinião sobre as pessoas com deficiência
Nesta parte estamos interessados em saber o que pensa sobre as **pessoas com deficiência** e em que medida se identifica com esta comunidade.

Por favor, responda em que medida concorda com as seguintes afirmações:

	Discordo totalmente 1	2	3	4	5	6	Concordo totalmente 7
Penso que as pessoas com deficiência têm muito de que se orgulhar.	○	○	○	○	○	○	○
É agradável pertencer à comunidade de pessoas com deficiência.	○	○	○	○	○	○	○
Fazer parte da comunidade das pessoas com deficiência dá-me uma sensação agradável.	○	○	○	○	○	○	○
Estou contente por pertencer à comunidade das pessoas com deficiência.	○	○	○	○	○	○	○

Penso muitas vezes no facto de que sou uma pessoa com deficiência.	○	○	○	○	○	○	○
O facto de ser uma pessoa com deficiência é uma parte importante da minha identidade.	○	○	○	○	○	○	○
Ser uma pessoa com deficiência é uma parte importante de como eu me vejo a mim mesmo/a.	○	○	○	○	○	○	○

Page Break

Continuação

	Discordo totalmente 1	2	3	4	5	6	Concordo totalmente 7
Sinto uma ligação com as pessoas com deficiência.	○	○	○	○	○	○	○
Sinto solidariedade para com as pessoas com deficiência.	○	○	○	○	○	○	○

Sinto dedicação para com as pessoas com deficiência.	○	○	○	○	○	○	○
Tenho muito em comum com a habitual pessoa com deficiência.	○	○	○	○	○	○	○
Sou parecido/a com a habitual pessoa com deficiência.	○	○	○	○	○	○	○
As pessoas com deficiência têm muitos pontos em comum entre si.	○	○	○	○	○	○	○
As pessoas com deficiência são muito parecidas.	○	○	○	○	○	○	○

Page Break

Pensando nas pessoas com deficiência física, **até que ponto acha que elas são um grupo coeso** (ex. têm muitas características em comum, cooperam umas com as outras, partilham um passado comum/ laços sociais fortes)?

○ 1 Nada coeso

○ 2

○ 3

○ 4

○ 5

○ 6

○ 7 Muito coeso

Pensando em ações ou atividades coletivas como a participação em associações de pessoas com deficiência, manifestações, fóruns/grupos de discussão e ou assinatura de petições, indique:

	Nada provável 1	2	3	4	5	6	Extremamente provável 7
Até que ponto seria provável envolver-se em ações ou atividades para enfrentar a discriminação contra as pessoas com deficiência?	○	○	○	○	○	○	○
Até que ponto seria provável envolver-se em ações ou atividades para defender os direitos das pessoas com deficiência em Portugal?	○	○	○	○	○	○	○

Em que medida se descreve a si próprio/a como alguém que está ativamente envolvido/a na promoção dos direitos das pessoas com deficiência?

- ○ 1 Nada envolvido
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
- ○ 7 Extremamente envolvido

End of Block: Identificação grupal

Start of Block: Saúde e bem-estar

Bem-estar físico, emocional e social Nesta parte gostaríamos de lhe fazer algumas questões sobre como se vê a si próprio/a e as suas relações interpessoais.

No global, como descreveria o seu estado de saúde nos últimos tempos?

- ○ 1 Muito mau
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
- ○ 7 Muito bom

Alguma vez sentiu ou foi lhe diagnosticado algum destes problemas de saúde, **independentes** da sua condição de incapacidade física? Por favor, indique quais.

- ☐ Dores de cabeça fortes/ enxaquecas
- ☐ Alergias
- ☐ Problemas respiratórios (ex. Asma, Bronquite crónica, Enfisema)
- ☐ Problemas do coração (ex. Angina, insuficiência cardíaca, ataque de coração)
- ☐ Pressão alta
- ☐ Hipertiroidismo ou Hipotiroidismo
- ☐ Artrite
- ☐ Dores nas costas e ou no pescoço
- ☐ Dores musculares ou articulares (nos braços, mãos, pernas e/ou pés)
- ☐ Problemas de pele
- ☐ Problemas psicológicos (ex. ansiedade, depressão)
- ☐ Outro problema. Qual? ____
- ☐ Nunca tive nenhum problema de saúde

Page Break

Já foi impedido/a de ir a uma consulta médica ou receber um tratamento que precisava por alguma das seguintes razões? Indique quais, por favor.

☐ Não pude deslocar-me por falta de transporte acessível.

☐ O edifício (ex. consultório, clínica, posto médico) não era acessível.

☐ Não tive apoio de uma terceira pessoa para me deslocar ao serviço de saúde.

☐ Não pude ser observado/a porque o equipamento técnico (ex. maca) não era acessível.

☐ Não havia comunicação acessível no serviço.

☐ Por falta de recursos económicos para pagar a consulta.

☐ A lista de espera era muito grande.

☐ Outra razão. Qual?
____

☐ Nunca fui impedido/a de ir a nenhuma consulta ou tratamento médico.

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Considerando todas as áreas da sua vida, nos últimos tempos quão satisfeito se sente com a sua vida no geral?

○ 1 Totalmente insatisfeito

○ 2

○ 3

○ 4

○ 5

○ 6

○ 7 Totalmente satisfeito

Pensando na sua vida em geral, até que ponto diria que é feliz?

○ 1 Muito infeliz

○ 2

○ 3

○ 4

○ 5

○ 6

○ 7 Muito feliz

Page Break

Por favor, indique em que medida concorda ou discorda com as seguintes afirmações, sobre como se sente em relação a si próprio.

	Discordo totalmente	Discordo	Discordo em parte	Não concordo nem discordo	Concordo em parte	Concordo	Concordo totalmente
De um modo geral estou satisfeito/a comigo próprio/a.	○	○	○	○	○	○	○
Por vezes penso que não presto.	○	○	○	○	○	○	○
Sinto que tenho algumas boas qualidades.	○	○	○	○	○	○	○
Sou capaz de fazer coisas tão bem como a maioria das outras pessoas.	○	○	○	○	○	○	○
Sinto que não tenho motivos para me orgulhar de mim próprio/a.	○	○	○	○	○	○	○
Por vezes sinto que sou um/a inútil.	○	○	○	○	○	○	○
Sinto que sou uma pessoa de valor.	○	○	○	○	○	○	○

Gostaria de ter mais respeito por mim próprio/a.	○	○	○	○	○	○	○
De um modo geral sinto-me um/a fracassado/a.	○	○	○	○	○	○	○
Tenho uma boa opinião de mim próprio/a.	○	○	○	○	○	○	○

Page Break

Pensando em como se tem sentido, por favor, indique com que frequência na **última semana:**

	Nunca 1	2	3	4	5	6	Sempre 7
Se sentiu deprimido/a.	○	○	○	○	○	○	○
Sentiu que era um esforço fazer qualquer coisa.	○	○	○	○	○	○	○
Teve um sono agitado.	○	○	○	○	○	○	○
Se sentiu feliz.	○	○	○	○	○	○	○
Se sentiu sozinho/a.	○	○	○	○	○	○	○
Desfrutou da vida.	○	○	○	○	○	○	○
Se sentiu triste.	○	○	○	○	○	○	○
Se sentiu apático/a e sem motivação para fazer as coisas.	○	○	○	○	○	○	○

Page Break

ndique, por favor, em que medida concorda com as seguintes afirmações sobre si e a forma como perceciona a sua vida.

	Discordo totalmente	Discordo	Discordo em parte	Não concordo nem discordo	Concordo em parte	Concordo	Concordo totalmente
Sinto que sou livre de decidir como viver a minha própria vida.	○	○	○	○	○	○	○
Geralmente sinto que posso expressar as minhas ideias e opiniões livremente.	○	○	○	○	○	○	○
Sinto que posso ser eu próprio/a no meu dia-a-dia.	○	○	○	○	○	○	○
As pessoas que me conhecem dizem-me que sou competente naquilo que faço.	○	○	○	○	○	○	○
Na maior parte dos dias sinto-me realizado/a com aquilo que faço.	○	○	○	○	○	○	○

Muitas das vezes sinto que sou muito capaz.	○	○	○	○	○	○	○
No geral dou-me bem com as pessoas com quem comunico.	○	○	○	○	○	○	○
Considero que as pessoas com quem interajo regularmente são minhas amigas.	○	○	○	○	○	○	○
As pessoas que fazem parte da minha vida preocupam-se comigo.	○	○	○	○	○	○	○

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Com que frequência é que se encontra **socialmente** com amigos/as ou colegas?

○ Nunca

○ Menos do que uma vez por mês

○ Uma vez por mês

○ Várias vezes por mês

○ Uma vez por semana

○ Várias vezes por semana

○ Todos os dias

Comparando com as outras pessoas da sua idade, com que frequência diria que participa em atividades sociais?

○ Muito menos do que a maioria

○ Menos do que a maioria

○ O mesmo que a maioria

○ Mais do que a maioria

○ Muito mais do que a maioria

End of Block: Saúde e bem-estar

Start of Block: Incapacidade e AP

Caracaterização da incapacidade e assistência pessoal
Vamos agora fazer-lhe algumas questões relacionadas com o tipo de incapacidade e as atividades do dia-a-dia para as quais necessita de assistência pessoal.

Como descreveria o seu tipo de incapacidade?

☐ Física/motora

☐ Auditiva

☐ Visual

☐ Intelectual

☐ De aprendizagem/ desenvolvimento

☐ Outra. Qual? ____

Como descreveria a sua incapacidade em termos de natureza?

○ Congénita

○ Adquirida

E em termos de (in)visibilidade ao olhos das outras pessoas?

○ Visível

○ Invisível

Em que medida é que a sua incapacidade dificulta-lhe ou o/a impede de realizar as suas atividades do dia-a-dia.

○ Nada

○ Pouco

○ Em certa medida

○ Muito

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Por favor, indique quais as funções ou actividades em que tem dificuldades devido a incapacidade. (Pode referir mais do que uma opção)

- ☐ Mobilidade (andar e/ou subir degraus)
- ☐ Levantar, transportar ou mover objetos
- ☐ Destreza manual (usar as mãos para realizar as tarefas diárias)
- ☐ Continência (controle da bexiga e do intestino)
- ☐ Audição (mesmo usando um aparelho auditivo)
- ☐ Visão (mesmo usando óculos ou lentes de contacto)
- ☐ Comunicação ou problemas de fala
- ☐ Memória ou capacidade em se concentrar ou aprender
- ☐ Compreender os outros ou fazer-se entender
- ☐ Reconhecer quando está em perigo físico
- ☐ Coordenação física (ex. equilíbrio)
- ☐ Dificuldades com o cuidado pessoal (ex. vestir-se, tomar banho)
- ☐ Outra função

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Em que atividades da vida diária precisa de assistência pessoal? (Pode referir mais do que uma opção)

☐ Cuidado pessoal (Levantar e deitar, higiene diária, vestir/despir, comer)

☐ Tarefas domésticas (Limpeza da casa, confeção de refeições, tratamento da roupa)

☐ Deslocações (Transportes públicos, condução de veículo)

☐ Atividades profissionais e/ou de formação (Acompanhamento; escrita ou uso de objetos; ida ao W.C.)

☐ Atividades de lazer (Desporto, leitura, cinema, praia, etc.)

☐ Comunicação (Língua gestual, sistemas alternativos/ aumentativos de comunicação)

☐ Coordenação (Planificação do dia-a-dia e ajuda na tomada de decisões)

☐ Outras

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*

No geral, quem é que lhe costuma dar apoio/assistência nas atividades do dia-a-dia? Por favor, indique no quadrado em baixo de cada opção, quantas <u>horas por dia</u> recebe de apoio/assistência em em cada uma das opções que selecionar.

☐ Familiares ____

☐ Amigos ____

☐ Cuidadores ao domicílio (através de uma instituição ou associação) ____

☐ Assistente(s) pessoal(ais) pago(s) por mim ou pela minha família ____

☐ Outro. Qual? ____

Se respondeu outro, em média, quantas horas por dia recebe de assistência através do apoio que mencionou?

▼ 0 ... 24

Em média, quantas horas por dia precisa de assistência pessoal?

▼ 0 ... 24

É candidato/a ou prentende candidatar-se a assistência pessoal pelo projeto-piloto nacional de apoio à vida independente (MAVI)?

○ Sim

○ Não

Display This Question:

If É candidato/a ou prentende candidatar-se a assistência pessoal pelo projeto-piloto nacional de ap... = Sim

Pode indicar qual é a entidade (IPSS) pela qual se candidatou ou pensa candidatar-se ao projeto piloto-nacional?

○ Sim. Qual? ____

○ Ainda não sei qual será a entidade pela qual me vou candidatar.

○ Prefiro não indicar.

End of Block: Incapacidade e AP

Start of Block: Sociodemográficas

Caracterização sociodemográfica
 Por último, vamos fazer-lhe algumas questões sociodemográficas para caracterização da amostra.

Sexo

○ Feminino

○ Masculino

○ Outro

*

Idade (indique apenas os dois digítios referentes à idade)

____

Estado civil

▼ Solteiro ... Viúvo

Escolaridade

▼ Sem escolaridade ... Ensino superior (Licenciatura, Pós-graduação, Mestrado, Doutoramento)

Situação perante o trabalho

▼ Empregado/a por conta própria ou dono/a de empresa ... Outra

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Display This Question:

If Situação perante o trabalho = Empregado/a por conta própria ou dono/a de empresa

Or Situação perante o trabalho = Empregado/a por conta de outrem

Tipo de contrato

- ○ A recibos verdes
- ○ A part-time/ a tempo parcial
- ○ A full-time/ tempo integral – a termo certo/determinado
- ○ A full-time/ tempo integral – a termo incerto/indeterminado
- ○ Bolsa de investigação
- ○ Sem contrato
- ○ Outro. Qual? ____

Distrito onde reside

▼ Açores ... Viseu

Tipo de residência

- ○ Residência própria, alugada ou comprada, a morar com ascendentes (ex. pais, tios, avós)
- ○ Residência própria, alugada ou comprada, a morar sozinho/a ou com companheiro/a e/ou filhos
- ○ Residência da família, alugada ou comprada (ascendentes, ex. pais, tios, avós, irmãos)
- ○ Lar residencial para pessoas com deficiência
- ○ Lar para idosos
- ○ Outro. Qual? ____

O alojamento onde reside é acessível ou está adaptado às suas necessidades?

○ Sim

○ Não

Por favor, considere o rendimento de todos os elementos do seu agregado familiar. De onde vem a **maior parte do rendimento** do seu agregado familiar?

○ Salários de empregos por conta de outrem

○ Salários de empregos por conta própria

○ Pensões e subsídios sociais (relativos à condição de incapacidade)

○ Subsídios de desemprego

○ Rendimento social de inserção (RSI)

○ Pensão de reforma

○ Rendas (juros, rendimentos de capitais/ propriedades)

○ Outra fonte. Qual ____

Qual das seguintes descrições se aproxima mais do modo como se sente em relação ao rendimento atual do seu agregado familiar?

○ O rendimento atual permite viver confortavelmente

○ O rendimento atual dá para viver

○ É difícil viver com o rendimento atual

○ É muito difícil viver com o rendimento atual

Tem descendentes/filhos a seu cargo?

○ Sim, tenho descendentes que estão a meu cargo/ vivem comigo.

○ Sim, tenho descendentes, mas não estão a meu cargo/ não vivem comigo.

○ Não.

Display This Question:

If Tem descendentes/filhos a seu cargo? != Não.

Quantos descendentes tem?

▼ 1 ... Mais do que três

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Deseja ser contactado para participar nas próximas fases deste estudo?

○ Sim

○ Não

Necessitamos do seu contacto para podermos pedir-lhe que responda ao questionário nas próximas fases deste estudo. Se responder sim, será direcionado para outra página de modo a garantir que as suas respostas continuam a ser anónimas (e o IP também não será registado), ou seja o seu contacto não ficará associado às suas respostas.

Nota: Mesmo respondendo "sim", não fica obrigado a participar nas fases seguintes do estudo, pois a sua participação é voluntária e pode desistir a qualquer momento.

End of Block: Sociodemográficas