Teaching About Psychosocial Aspects of Disability: Emphasizing Person–Environment Relations

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Abstract

This article presents some psychosocial aspects of disability linked to the person–environment relation that teachers should share in the psychology classroom. Disability is an often-overlooked form of diversity, one that teachers should discuss alongside race, gender, sexual orientation, social class/socioeconomic status (SES), religiosity, and aging. The experience of disability and disability culture are important topics that should be shared with and understood by secondary and postsecondary students, particularly because people with disabilities are no longer at the social margins of everyday life in the United States. To that end, I review definitions for disability as well as a nascent model for understanding the experience of disability, some select but fundamental psychosocial constructs regarding disability, and a representative negative (stigma and stereotyping) and positive (disability identity) context example from the social psychological literature on disability. I then close with suggestions for teaching about disability.

Keywords
disability, disability identity, fundamental negative bias, insider–outsider distinction, person–environment relation, rehabilitation psychology, stigma, WHO ICF model

What should teachers of psychology and their students know about disability? In psychology, the study of disability is centered on the subfield known as rehabilitation psychology (in the humanities and other social sciences, the topic is housed under disability studies; e.g., Davis, 2013; Goodley, 2011). Rehabilitation psychologists are concerned with the psychological and social consequences of disability (e.g., Frank, Caplan, & Rosenthal, 2010), and they work to identify approaches to prevent and resolve challenges associated with the experience of disability. As I will illustrate in this article, a fundamental psychosocial aspect of disability is that it results from the relation between people and the environments they inhabit. In essence, the world was designed for nondisabled people, which means that when someone with a disability has difficulty navigating within it (physically, socially, cognitively, emotionally), such difficulty emerges from the environment—a missing curb cut, no entrance ramp, a poorly placed elevator, no Braille signage, social “norms,” and so on—and not the person with the disability.

Social psychologist Kurt Lewin (1890–1947) recognized that environmental factors like these routinely override the behavioral impact of personal factors, including personality or other dispositional variables (see, e.g., Nisbett, 1980; Ross & Nisbett, 1991). Lewin discerned that the ways people perceive social and physical environments (also known as the situation) has a profound influence on both their actions and subjective experiences. Although both personal and situational factors are important, Lewin (1935) argued that the interaction between the two—the person–environment relation—is actually what produces behavior, leading to his oft-cited maxim that behavior is a function of the person and his or her perceived environment, or $B = f(P, E)$; see Dunn, 2011; Marrow, 1977).

The purpose of this article is to present some psychosocial aspects of disability linked to the person–environment relation that teachers should share in the classroom, particularly because people with disabilities (PWDs) are often treated as an invisible minority (Asch & McCarthy, 2003). Disability is a form of diversity, albeit one that is too often absent from psychology courses and the typical discipline-based textbooks, notably those in introductory psychology. In fact, teachers should discuss disability alongside race, gender, sexual orientation, social class/socioeconomic status (SES), religiosity, and age (Dunn & Hammer, 2014). I maintain that the experience of disability and disability culture are important topics that should be shared with and understood by secondary and postsecondary education students.

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students, particularly because PWDs are no longer at the social margins of everyday life in the United States. Rather, due to political and social changes, notably the Americans with Disabilities Act (ADA, 1991), increasing numbers of PWDs now pursue higher education and employment, while also demanding their civil rights and appropriate acknowledgment from the wider culture. I review definitions for disability as well as a model for understanding the experience of disability, some select but fundamental psychosocial constructs regarding disability, and a representative negative and positive example from the social psychological literature on disability. I then close with suggestions for teaching about disability.

**Defining Disability**

When psychologists use the term *disability*, what do they mean? Generally speaking, the psychological literature defines disability as a condition or characteristic connected to a particular person. The presence of a disability usually means that activities routinely executed by an individual (e.g., walking, talking, reading, writing) are in some way restricted or must be accomplished in some unaccustomed manner. Thus, a person who lost her left leg in a car accident has a disability, as does an individual with congenital deafness. However, disabilities are not just physical—they can be psychological, as when a person experiences chronic depression that is physiological in origin. Disabilities can also occur together, as when a man who had a mild stroke develops a slower gait when walking and also experiences aphasia, which slows his speech.

Professionals also use the term *impairment* to refer to disability; however, this term has a different meaning in professional contexts than in everyday language. The International Classification of Functioning, Disability, and Health (ICF) model (to be discussed shortly) uses impairment when identifying a disruption at the system level of a bodily organ (e.g., leg, arm, brain) that leads to some loss of function or an observable abnormality (World Health Organization [WHO], 2001). In addition, within the context of the ICF model, the term *abnormality* denotes a deviation from a agreed-upon norm—it most emphatically does not indicate the presence of any “defect” (WHO, 2001). Impairments are long-lasting challenges, if not necessarily permanent ones, as they most often are due to injury, disease, or some other chronic health condition. Impairments are consequential for people’s lives, as they create disruptions in emotional, cognitive, and physiological processes (e.g., Livneh, 1987).

A third term, *handicap*, is often used in daily language when discussing disability, but it, too, has a specific, psychosocial meaning. Like impairment, “handicap” does not refer to something about a person; rather, a handicap—or, more likely, a *handicapping quality*—is something found in or linked to the environment. In this context, the word *environment* entails some constraint found in a given situation (e.g., a structural feature of a building, such as steps or a steeply inclined ramp) or some challenging terrain that makes mobility difficult (e.g., uneven sidewalks). Someone who relies on a wheelchair is thus handicapped or disadvantaged by aspects of the environment; however, she is not handicapped herself.

**Disability and Biased Perceptions**

Distinctions among the terms disability, impairment, handicap, and environment are important because students, like most nondisabled observers, often view the presence of a disability as a personally defining quality. When a person is perceived by others to be disabled, such categorization “essentializes” the disability—in the minds of others, the disability represents the essence of the person, superseding all of his or her other qualities, good or bad (Dunn, Fisher, & Beard, 2013). Because disability looms large in others’ perceptions, it triggers not only curiosity (observers are drawn to differences) but also what is known as the *fundamental negative bias* (Wright, 1988), a conceptual relative of the *fundamental attribution error* (Ross, 1977). Whereas the latter bias leads perceivers to attribute the source of behavior to people’s presumed personalities rather than to situational influences (e.g., the student who is routinely late to class is lazy, not the victim of car trouble or a challenging commute), the fundamental negative bias causes them to focus on some presumed negative quality linked to PWDs.

Consider a typical example. In a public venue, an attractive young woman using a wheelchair is approached by a stranger who is entirely comfortable saying “Why, you’re much too pretty to be in a wheelchair.” What sounds like an innocent, even flattering, comment actually contains a value judgment—that attractive people do not use wheelchairs and, by implication, do not have disabilities. Salient characteristics that stand out (i.e., the wheelchair, some unknown disability) prompt the stranger, who then codes these characteristics as negative (perhaps the perceiver believes attractive people must be physically perfect). As Baumeister, Bratslavsky, Finkenauer, and Vohs (2001) persuasively argued, “Bad is stronger than good,” so much so that any perceived negative quality squelches the impact of any positive information. In fact, the sizable literature concerning nondisabled people’s attitudes toward PWD can be summed up rather concisely: At best, their attitudes are ambivalent, while in the main, they tend to be negative (Chan, Livneh, Pruett, Wang, & Zheng, 2009; Dunn, 2015; Vichinsky, Findler, & Werner, 2010).

**Understanding the Experience of Disability: The WHO ICF Model**

How should students understand the experience of disability? The ICF model is a good start (WHO, 2001). As shown in Figure 1, each PWD reacts and functions in a unique way due to the influence of *personal* (e.g., gender, lifestyle, education, age, coping style) and *environmental* (e.g., physical, cultural, attitudinal, social, familial, technological) factors identified by Lewin (1935). These contextual factors are important because they can change or otherwise influence other components in the model, including performing a given *activity* (some behavior), *participation* (involvement in some life situation, such as
attending class, making a meal, or shopping), body functions (physiological and psychological systems), structure (organs, limbs, and components therein), and health conditions (disease, injury, disorder). Simply put, a person’s health condition or impairment, coupled with contextual factors (personal, environmental), will affect body functions and structure, activity, and participation. Thus, behavior results from an array of factors that influence one another, not merely a disability per se. The dynamic complexity of the model means that one PWD can enjoy a high quality of life and relatively unrestricted activities—in other words, living a good life (Dunn & Brody, 2008)—whereas another PWD might be continually challenged by personal and situational factors that, coupled with health conditions, body functions, and structure, limit participation in a variety of desired activities (for more detailed discussion of the model, see Chan, da Silva Cordoso, & Chronister, 2009).

As a brief aside, well-intentioned, but inherently flawed, “consciousness-raising” exercises, such as having a nondisabled person use a wheelchair for an hour or two or covering the eyes of a sighted person to mimic blindness, are not appropriate ways to help students understand or experience disability (Dunn, 2005; Dunn et al., 2013). Such “snapshot” exercises lack integrity, giving participants a quick and false sense of what a disability is like. Living with a disability is not the same as acting disabled for a short time. Instead of engaging in such role-playing, for example, nondisabled persons would learn more by shadowing a disabled individual for a meaningful amount of time in order to learn how the person navigates social, psychological, and physical environments. A more fruitful approach is to help students appreciate the challenges posed by trying to adopt the perspectives of others whose experiences (like disability) vary from their own (for one activity that explores the possibility that everyone has some type of disability, consider the mine-thine exercise; Dunn, Fisher, & Beard, 2012; Wright, 1975; Wright & Lopez, 2002).

Some Fundamental Psychosocial Constructs

There are a variety of important psychosocial constructs concerning disability (Dunn, 2015; Wright, 1983). Helping students to recognize some of these constructs in action will not only help them to understand disability but may also lead them to temper their biases when interacting with PWDs in the future. These constructs include the insider–outsider distinction, adjusting to disability, assets, self-perception of bodily states, and human dignity.

Insider–Outsider Distinction

As demonstrated by the fundamental attribution error, we know that others’ behavior engulfs our field of perception, so that as observers, we routinely attribute the cause of behavior to the person rather than the situation (Ross, 1977). Tamara Dembo (1902–1993), a student of Lewin’s, added a further attributional concept related to the person–environment relation, one related to social psychology’s actor–observer effect (Jones & Nisbett, 1971). Dembo (1964, 1970, 1982) distinguished between individuals who have a disability (insiders), and know what it is like, and nondisabled observers (outsiders), who can only imagine what the experience of disability must be like. The insider–outsider distinction is an important concept for students to appreciate because, as outsiders, they, too, often assume what a disability, whether congenital or acquired, must be like—and they frequently conclude that it is not only negative and disruptive to daily living but also defining for the individual. Outsiders rarely recognize disability as one quality among many in a person’s life; instead, outsiders presume the disability is an ongoing focus, a troubling preoccupation, for the PWD.

In contrast, insiders actually know what the experience of being disabled is like, that its presence does not necessarily predict or preclude quality of life or influence well-being.
Instead, disability is one life quality among many others (e.g., mental and physical health, career, stress, hobbies and interests, role as spouse or parent, community volunteer; Duggan & Dijkers, 2001) that becomes a PWD’s focus only when others (i.e., outsiders) or situational constraints make it salient. To be sure, disability can be an important part of a disabled person’s identity, but that often renders it a positive rather than a negative quality (Dunn, 2015; Dunn & Burcaw, 2013).

Adjusting to Disability
Adjusting to disability—understanding and coping with physical, psychological, or other chronic health changes—applies to individuals who become disabled at some point in their lives, often through illness, disease, or accident. Conceptually, however, adjustment does not apply to people who have congenital disabilities, as their conditions have always been present and are, in a very real sense, part of who they are. Thus, when describing how newly disabled people cope with their conditions, rehabilitation psychologists try to be specific.

Discussing how people adapt following disability onset entails knowing how affected individuals understand the triggering event and how any psychological and physical changes are gradually integrated into their identities, body images, and daily living. Adaptation is an active process, one where the individual, family and friends, and rehabilitation professionals continually reflect on the disability’s impact. Across time, individuals with acute disabilities move toward a more idealized state known as adjustment (Livneh & Antonak, 1997; Smidana, Bakken-Gillen, & Dalton, 2009).

Adjustment occurs once individuals are satisfied with and accepting of their own person–environment relations, so that any physical or psychological losses or changes do not represent ongoing preoccupations. During adjustment, individuals adopt constructive, positive outlooks regarding their abilities, and what they believe they can accomplish moving forward (Wright, 1983). Favorable adjustment to disability is also marked by personal mastery or feelings of independence and having problem-solving skills for daily life, navigating social situations and physical environments, and developing and maintaining a positive self-concept (Dunn, 2015).

Naturally, across time, some individuals who acquire a disability cope better than others (recall the person–environment relation and Figure 1). Wright (1983) thus introduced a third process called acceptance into the general discussion of disability adjustment. An individual with a disability displays acceptance, when the disability reduces neither his or her self-worth nor future outlook, thereby representing a realistic appraisal of the circumstances accompanied by positive efforts and attention to available assets.

Assets as Important
Regardless of a disability’s severity, PWDs should be seen as either having or able to develop some psychosocial asset or set of assets (e.g., Wright, 1983). Assets are the accessible or potential and distinct resources in each person, which can serve as a point of pride or solace after disability onset. Assets refer to tangible (e.g., income) or intangible (e.g., self-concept) factors and can be personality related (e.g., sense of humor, resilience), achieved or attainable (e.g., degree, awards), motivational in nature (e.g., tenacity, self-discipline), or even an interest or hobby (e.g., watching football, reading). Assets remind PWDs about their accomplishments or capabilities for the future or about what skills they can learn or relearn following bodily changes or trauma (for more on assets, including additional examples, see Dunn, 2015). Following the onset of disability, for example, rehabilitation psychologists routinely ask about a person’s assets or strengths to promote positive outlooks for the future.

Self-Perception of Bodily States
Both social psychology and rehabilitation psychology share the view that people’s subjective perceptions affect their thoughts, feelings, and action (e.g., Wegner & Gilbert, 2000). For example, the attribution literature in social psychology is replete with studies demonstrating that people do not see reality from any sort of veridical perspective; rather, their perceptions of reality (or the reality of others) are influenced, or even biased, by their expectations, stereotypes, and past experiences (e.g., Fiske & Taylor, 2013). Within rehabilitation psychology, practitioners know that the experience of particular bodily states, such as pain or fatigue, is based on individuals’ self-perceptions of the phenomena not only the actual sensations. Such perceptions are malleable, so that they can be influenced or altered in positive or negative directions based on attitudes (their own, their family’s, or even their therapist’s), expectations (their own, those shared by family, friends, and medical staff), and environmental reinforcement (physical, social, and psychological). Rehabilitation professionals encourage disabled people to shift their perceptions in positive directions that promote adjustment to disability and a beneficial person–environment relation emphasizing their individual worth.

Human Dignity
No matter its severity, any form of disability—physical, intellectual, cognitive, or other—or the presence of some chronic illness has no bearing on any individual’s right to be respected, encouraged, and treated as a whole and deserving person. As Wright (1987) expressed it, “An essential core-concept of human dignity is that a person is not an object, not a thing” (p. 12). This core psychosocial construct should be kept in mind as I turn to the social challenges posed by disability as a stigma that can trigger stereotypic thought.

Negative Context: Stigma, Stereotyping, and Disability
To non-disabled persons, a disability often represents a stigma, that is, some quality that is construed as being broadly negative in a given context or cultural setting (Corrigan, 2014; Crocker,
When a disability is stigmatizing, it serves as a social marker so that PWDs are seen and often treated as distinctly different from nondisabled people (see also Goffman, 1963). The perceived difference can promote negative stereotypic judgments in the minds of nondisabled observers, which in turn can lead to the devaluation of PWDs, beliefs that they are somehow deviant, and attempts to maintain physical and psychological distance from them (Major & Crocker, 1993). Jones and colleagues (1984) identified six stigmatizing dimensions (see Table 1), although PWDs are most likely to be stigmatized by visible disabilities (e.g., physical differences, such as a missing limb or the inability to walk) or some indicator of the presence of a disability (e.g., a wheelchair, a leg brace or cane, a walker, salient bodily movements, or unusual gait).

Perceived stigmas often trigger emotional reactions, and the perceived difference can promote negative stereotypic judgments in the minds of nondisabled observers, which in turn can lead to the devaluation of PWDs, beliefs that they are somehow deviant, and attempts to maintain physical and psychological distance from them (Major & Crocker, 1993). Jones and colleagues (1984) identified six stigmatizing dimensions (see Table 1), although PWDs are most likely to be stigmatized by visible disabilities (e.g., physical differences, such as a missing limb or the inability to walk) or some indicator of the presence of a disability (e.g., a wheelchair, a leg brace or cane, a walker, salient bodily movements, or unusual gait).

Perceived stigmas often trigger emotional reactions, and Dovidio, Pagano, and Hebl (2011) suggested such reactions could lead to prejudice and discrimination based on normative psychological processes. In effect, perceivers categorize stigmatized others quickly and efficiently into different groups, essentially categorizing them as “like us” or “not like us,” “friend” or “stranger,” and so on (Macrae & Bodenhausen, 2001). Such categorization simplifies social life. But at the same time, individual identities are lost, differences among persons are minimized (“Those people are all alike”), and perceived between-group differences are amplified (“We are distinct, different, perhaps even unique”). Unfortunately, the perceived similarities among the out-group members and the presumed differences within the in-group are seen as character-based traits. As a result, observers are subsequently likely to apply stereotypes—associations (good or bad) or beliefs (positive or negative)—to individuals in both groups (e.g., Nelson, 2009). Such oversimplified portrayals of others nonetheless organize observers’ thoughts, beliefs, expectations, and frequently behaviors toward groups, including PWDs. Fortunately, both the experience of and research concerning disability are not all negative.

**Positive Context: Disability Identity**

Identities enable people to display their individuality while also making sense of themselves and creating connections to other people and groups (Oyserman, Elmore, & Smith, 2012). Disability identity refers to the beneficial self-beliefs that PWDs hold regarding their disabilities, as well as any ties they possess to members of the disability community (e.g., Dunn & Burcaw, 2013; Gill, 1997). Given that the process of adjustment to disability is on a continuum, PWDs can vary in terms of how well developed their disability identities turn out to be (Dunn, 2015). Those who feel very much a part of the disability community are likely to have a moderate to high level of identification, while those who are activists, seeking social, political, and economic gains for PWDs, will also tend to have a high level of identity. In contrast, individuals who can “pass” as nondisabled or who choose not to connect with the disability community are presumed to have a low or even no level of identity. A PWD who has a few friends who are also disabled but is not active in the disability community might be found more toward the middle of the continuum.

Table 2 contains a list of six themes relating to disability identity that Dunn and Burcaw (2013) examined. The first two themes—communal attachment and affirmation of disability—are linked to the notion that part of disability identity begins with connection to disability culture and affiliation with other PWDs. As aspects of disability identity, self-worth, pride, and discrimination emerged from research concerning disability politics and a desire for more civil rights and the accompanying struggle to obtain them. In addition, these three themes support PWDs by helping them to combat daily hassles, stereotypes, and the general negative attitudes held by nondisabled people regarding disability. The final entry in Table 2, personal meaning, refers to constructively thinking about and coping with the onset and aftermath of disability, just as it can also refer to an individual’s acceptance of his or her disability.

One way to learn about disability identity and the role of these themes is to read narratives (e.g., books, essays, blog entries) written by PWDs regarding their own disability experience (for a list of relevant works, see Dunn & Burcaw, 2013). Critically reading such self-narratives is one way for students and nondisabled people more generally to reflect on the insider–outsider distinction, that is, seeing such disability stories as being reliable accounts of PWDs’ experiences as opposed to rationalizations or defensive self-attributions. Social

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**Table 1. Stigmatizing Dimensions.**

| Source/responsibility for condition—Is a stigma congenital, accidental, or self-inflicted? |
| Aesthetic—Does the stigma distress or otherwise upset other people? | |
| Apparent or concealable—Is a stigma obvious (e.g., amputation) or invisible (e.g., psychological or mood disorder)? |
| Disruptiveness—Does the stigma’s presence hinder or otherwise prevent social interaction or communication? |
| Perilous—Can the stigma be seen as contagious or even dangerous to others? |
| Course of the mark—Will the stigma change over time, getting worse or even better? |

*Note. Adapted from Jones et al. (1984).*

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**Table 2. Disability Identity: Six Key Themes.**

| Communal attachment—wishes to affiliate with other PWDs |
| Affirmation of disability—holds thoughts and feelings of being part of society and of enjoying the same rights and responsibilities of other citizens |
| Self-worth—values the self with disability and feels equal to nondisabled people |
| Pride—feels proud of identity despite recognizing that disabled is often viewed by nondisabled people to be a devalued quality |
| Discrimination—aware that being a people with disability means being a recipient of prejudicial behavior in daily life |
| Personal meaning—finds significance in, identifies benefits with, and makes sense of disability |

*Note. Adapted from Dunn and Burcaw (2013).*
psychological research, for example, demonstrates that such self-narratives are constructive, allowing individuals to cope with negative life events and stressors (e.g., Pennebaker, 2004). For more on disability identity, see Bogart (2014, 2015) and Darling (2013).

**Teaching About Disability: Closing Thoughts**

Given that disability is largely ignored in the mainstream psychological curriculum, teachers of psychology will be doing a good service by introducing students to some fundamental psychosocial constructs regarding disability as well as the importance of the person–environment relation. Beyond discussing these topics, teachers should consider the fact that students’ unfamiliarity with disability is itself a social–psychological challenge. Many well-intentioned nondisabled people are uncertain of how to behave when interacting with a PWD. Attitudinal research demonstrates that meaningful, equal status exchanges between nondisabled persons and PWDs can reduce prejudicial or ambivalent feelings (e.g., Amsel & Fichten, 1988; Mason, Pratt, Patel, Greydanus, & Yahya, 2004).

Table 3 lists some useful suggestions and guidelines for helping nondisabled individuals navigate their encounters with PWDs (Dunn, 2015; Wright, 1983). The overarching goal, of course, is to treat PWDs as people, thereby respecting their privacy, integrity, and dignity. As the entries in Table 3 indicate, the PWD should guide any interaction, deciding when and whether any disclosure regarding his or her disability will take place. For their part, nondisabled people should respect the choice of PWDs in this regard, allowing them to lead.

Reducing uncertainty and promoting understanding of disability are important goals. The psychology classroom is a good place to begin, but in the end, students must learn to recognize disability as a form of diversity that will likely touch their lives at some point, when in a social interaction; when a chronic disease affects a friend or family member; or through some change to their own physical, psychological, or health condition. If we live long enough, after all, most of us may expect to experience disability at some point. Viewing disability as another important aspect of being human, then, is a way to promote the humanity of PWDs. As Michel de Montaigne (1850/1991) put it centuries ago, “I do not suffer from that common failing of judging another man by me; I can easily believe that others have qualities quite distinct from my own . . . I more readily acknowledge our differences than our similarities” (p. 257).

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