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Nonverbal Behavior, Disability Presentation, and Impression Formation: Implications for the Rehabilitation Professional

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While a first impression may seem a singular unit of analysis, it comprises a number of elements. Those elements include facial and body appearance, expressions, eye behavior, posture, gestures, vocal characteristics, proximity, and touch (Knapp et al., 2014). Forensic vocational rehabilitation experts are tasked with analyzing several sources of assessment to develop objective conclusions related to a claimant's ability to work or to decide how to assist in the job placement process. To assist in this effort, the current paper will provide an overview related to the following topics: (a) general nonverbal behavior/communication; (b) different representations and interpretations based on culture, gender, and disability; (c) the impact of first impressions and clinical impressions; and (d) interventions to avoid erroneous interpretations of behavior on the part of the professional or others with whom the client might interact.

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As the old cliché goes: *you never get a second chance to make a first impression.* This is drummed into people because of the importance of first impressions at the beginning of important relationships. Make a poor first impression on a potential employer and there will be no job. Make one on a first date, there will be no second. Poor first impressions with law enforcement? There could be much explaining. The trick, often told, is to take active steps to manage first impressions to ensure one is viewed positively, and this is sage advice for most folks to heed. But what if that first impression is outside one's control?

First impressions are made in minutes (Lee et al., 1999), and perhaps even in milliseconds (Bar et al., 2006; Mast et al., 2011). The bases for such impressions are nonverbal cues of the face, body, or voice (Hall & Andrzejewski, 2008), and the accuracy of such impressions are, at best, contested (Gray, 2008). More important to *this* discussion is that once those first impressions are formed, people tend to adhere to them even in the face of contradictory and disconfirming information (Friedlander & Stockman, 1983; Strohmer et al., 1990). Given the above, it is especially critical that clinical professionals who regularly make diagnostic assessments and treatment recommendations of clients based on brief interactions be cognizant their judgement is significantly impacted by first impressions of those clients, and that atypical client behavior may distort those impressions unfairly or inaccurately to the detriment of all involved.

However, upon what are initial perceptions of others based? Adler (1991) stated perception is the process by which individuals choose, organize, and assign meaning to stimuli from the external environ-

ment to provide meaningful experiences for themselves. Then, what determines which things are chosen or neglected, the manner in which selections are organized, and the particular ways in which meaning is attached to those selections? Adler argued one of the key determinants of perceptions is culture. As such, cross-cultural interactions are rife with not just the possibility, but also indeed the probability, of misperception.

For example, across countries, the perception of punctuality is quite different (White et al., 2011). Were someone from Kazakhstan, Nigeria, or Malaysia to have a 1:00 p.m. job interview and arrive at 1:05, this person would likely not even consider themselves late. However, if an American, Korean, or German hiring manager were conducting the interview, their first impression of that interviewee would be quite poor. This simple nonverbal behavior—arriving 5 minutes late—has different meaning depending upon culture. Fortunately, rehabilitation professionals are overwhelmingly perceptive in attending to and accounting for the possibility of cultural representations of behavior, and therefore, provide culturally competent and humble care to diverse clients. However, those same professionals may be somewhat less savvy when broader and less traditional definitions of culture are considered in clinical interpretations and case conceptualization. For example, while race, ethnicity, faith, gender, sexual orientation and gender expression, and age are recognized as cultural domains, is disability as easily considered a cultural attribute or diversity consideration?

The notion of treating disability as culture is, while not universally accepted, every bit as valid as conceiving sexual orientation or age in this way. Brown (2002) argued there is a set of artifacts, beliefs, and expressions used by people with disabilities to describe their own life experiences, and that this is no different from any other cultural group. With 26% (nearly 1 in 4) adult Americans living with a disability (Centers for Disease Control and Prevention, n.d.), this makes the population of people with disabilities larger than the population of Hispanics or African-Americans (United States Census Bureau, n.d.). Given the prevalence of disability and its myriad presentations, rehabilitation professionals must consider the impact of nonverbal behaviors of people with disabilities as a critical parameter of cultural competence. To assist in this effort, the following will overview: (a) general nonverbal behavior/communication; (b) different representations and interpretations based on culture, gender, and disability; (c) the impact of first impressions and clinical impressions; and (d) interventions to avoid erroneous interpretations of behavior on the part of the professional or others with whom the client might interact.

Nonverbal Behavior and Impressions

While a first impression may seem a singular unit of analysis, it comprises a number of elements. Those elements include facial and body appearance, expressions, eye behavior, posture, gestures, vocal characteristics, proximity, and touch (Knapp et al., 2014). In addition, environment and artifacts/accoutrements both contribute, as does perception of time (Barrick, 2009; Bonaccio et al., 2016). These behaviors and attributes transmit information about personality, preferences, status, and power (Küster et al., 2019). In a new interaction with a client, how they appear, how they look at the counselor, what they wear, whether the meeting is in the office or their home, if they arrive on time, the volume at which they speak, the duration of their initial handshake, and a host of other similar behavioral indicators all contribute—in *seconds* and beyond—to how the professional "makes sense" of the client.

The functions of nonverbal behavior should be considered. All nonverbal behavior has the *potential* for communication; its interpretation is reliant on the perceivers' acknowledgement of it and whether implicitly or explicitly noticed (Bonaccio et al., 2016). For instance, some behavior may legitimately be perceived as *communicative* because it is intentional. If someone smiles and extends a hand, this is perceived as an explicit invitation to engage. However, much of what is seen is not so much communication, as simply *behavior*. In other words, while people may still infer information from what they witness, it may not have been produced intentionally for their benefit, but rather is a byproduct of some other necessary physical activity. If a person rises slowly and stiffly from a chair, one might con-

clude age or infirmity, but this is an inference, not a message the person chose to send (MacDonald, 1996).

Nonverbal behaviors serve several important interactional functions. First, people use them to help provide the *full* meaning of spoken words. Nonverbal behaviors can "repeat" what is said, but can also contradict the verbal message, modify it, or even replace it (Bonaccio et al., 2016). Consider someone offering a cup of coffee, and then asking if you like it. If the reply is yes and said with a smile, the consistency of the words and behavior underscores the truthfulness of the statement. If, on the other hand, you say yes while grimacing, the contradiction would serve as an indicator of lying. If instead of a grimace, you roll your eyes and then wink, this could be seen as sarcasm—lying, but doing so "on the record." If you say yes in a reverent tone while snapping upright with wide eyes, one could properly conclude you not only liked the coffee, but also positively loved it. Finally, you could simply take a big sip, and smile broadly. That would serve as a "yes" all by itself, no words required.

In addition to working in conjunction with language, nonverbal behavior carries relational information in its own right. For example, most of the "management" of interactions is handled nonverbally, through body movement (*kinesics)* and eye expressions (*oculesics*) (Bonaccio et al., 2016). Knowing with whom to speak, when to take a turn talking, or when the conversation ought to wrap up? All of these are accomplished primarily with unique combinations of eye contact and postural orientations/shifts. Initial eye contact starts conversations, bodies open toward someone to include them in the group and a shift away and glance at one's watch or the door indicates it is time to go. Posture can also intentionally project power and dominance, as a way to assert oneself in social or work situations (Küster et al., 2019).

The "nature" of relationships with others can be transmitted through nonverbal expression. Proximity, body orientation, and tactile gestures convey fluctuating levels of familiarity and intimacy (Andersen et al., 2013). While one may stand both next to a colleague and next to a significant other, it is done so quite differently. The distance (more space given between a colleague), postural orientation (hips and shoulders more "squared" with one's significant other), and touch (far more likely to touch a relational partner than a business partner) incorporated in the encounter all vary. The duration of actions, such as eye contact and physical touch, will even differ, with longer duration suggesting greater levels of trust and intimacy.

Status and power can also be communicated nonverbally through one's self-presentation to the outside world (Hess, 2015). Nicer clothes, more expensive jewelry, a fancier office, a nicer car—all suggest more affluence, and as such, more status. People with power are entitled to more space: not just a larger office, but also the one in the corner, sequestered behind thee layers of secretarial support, with its own conference space and a private restroom. People with power get to set meeting times and arrive when they are ready, even if that means they are late. In addition, with less power and lower status, all of these are reversed. People with low power and little status get little privacy, poor-quality or ill-fitting clothing, show up when they are told, and punch a clock.

Similarly, nonverbal behavior plays a significant role in personal identity. While looking in the mirror, what a person sees (and what they believe others see) has a large impact on one's sense of self. This can be simple, day-to-day perceptions, such thinking they look good before a date or a job interview, or complex perceptions, such as the evolving process of living one's authentic gender identity and expression. People may choose an item of clothing or a hairstyle to express membership in a group or affinity for a team, to express belonging to a culture, or even to demonstrate uniqueness. However, while clothing can be changed, appearance can be more of a challenge. Those perceived as physically attractive receive more positive ratings on qualities such as intelligence, competence, and health (Zebrowitz et al., 2013). People who were once heavy, but lost weight (or vice versa) may struggle to align what they see in the mirror with their sense of self. And that person who rises slowly and stiffly from a chair may shudder to think others see this and perceive them to be old, even if they are.

Though the percentage of nonverbal communication contributing to overall communication varies across contexts and cultures, the communication experience consists of verbal content, vocal qualities, and facial expressions, in addition to other characteristics noted above (Lapakko, 2007). It is

widely held that nonverbal communication dominates the interaction between and among people. Over time and across different contexts, nonverbal behavior appears to be more consistent in representing the true personality of the sender (Weisbbuch et al., 2010). Unlike spoken language, for which there is a (fairly) uniform and stable set of meanings codified in dictionaries, nonverbal behavior is all "off-book," without standard means for interpretation. Moreover, unlike language, people do not often have years of formal schooling and instruction on how to communicate nonverbally. Instead, this aspect of communication is learned primarily through observation, modeling, and trial and error. While critical to interpersonal communication and perceptions, nonverbal communication is given precious little attention. Its ubiquity, however, belies its importance, as all of the above demonstrates—especially in relation to the formation of impressions by others.

Impression Formation

Forming accurate impressions of interpersonal interactions can be a daunting task, given it involves the behaviors of the target and the experiences and perceptions of the receiver. First, recall that initial impressions are formed almost immediately, are based on nonverbal behavior, and become the filters through which, right or wrong, most judgements are based. Next, consider the *overwhelming* amount of information carried either partly or exclusively through nonverbal channels. Finally, remember that interpretations of nonverbal behaviors (i.e., how one understands and ascribes meaning to the various behaviors seen) are constructed largely on culturally bound baselines an individual has been carrying unconsciously since early childhood. From this, individuals can decipher how likely a displayed behavior falls neatly within those baselines. Many daily interactions are social in nature and carry lower stakes; however, in more consequential situations, like with a counselor or therapist, healthcare provider, hiring manager, or law enforcement official, misinterpretation of nonverbal information can have more significance. Length of time and variety of sources of social information with which to challenge initial impressions are critical to overcoming erroneous interpretations, with greater exposure to the person and more data points leading to a higher probability of truing the impression.

Impression formation is best understood through dual-process theory, which uses: (1) Type 1 processes, innate responses driven by cognitive scripts and heuristics; and (2) Type 2 processes, conscious processes relying on working memory and deliberation (Derous et al., 2016). Initial impressions are governed mostly by Type 1 processes, where the inferences, even if incorrect, are intuitive and automatic. Relying on initial impressions is relatively harmless in brief, superficial interactions, especially ones that will not develop into longer relationships or influence important decisions. For individuals in higher-cost relationships, relying on casual Type 1 impulses is not likely to be prudent; Type 2 processes are necessary to intervene and perhaps override earlier assumptions (Derous et al., 2016).

At an intuitive level, individuals use several ingrained processes to form initial impressions. *Cognitive scripts* are "knowledge structures that guide behavior in familiar situations or when interacting with targets that are familiar" (Derous et al., 2016, p. 92). *Heuristics* are cognitive "shortcuts" to process new information based on previously executed stereotypes (Pichette et al., 2002), which may be imperfectly applied. Employing these could introduce bias, at either a conscious (explicit) or unconscious (implicit) level. For the purposes here, it will be assumed people will not engage in intentional bias in their interactions, especially professional ones. However, *implicit bias* may be inadvertently utilized in social and professional situations. This could lead to discrimination and disparate treatment, even though the person forming the impression believes they are being fair (Payne et al., 2018). Since this operates without intent or awareness (Blair et al., 2011), bias can be difficult to attenuate without a solid foundation of executive cognitive processes (i.e., Type 2). Without greater cognitive scrutiny, as the relationship continues, the receiver could fall victim to *confirmation bias*, in which they search for information consistent with the initial impression and ignore information that is inconsistent or discredits it (Wright-McDougal & Toriello, 2013).

Sociologist Harold Garfinkel (1967) noted individuals "ad hoc" their way through interactions with those around them. By this he meant that, when potential problems in social interactions are encountered, people simply keep moving forward using an assumption the interaction must make sense, or will at least at some point. As such, people behave accordingly, and preserve a shared sense of the social world and shared culture. This works well in many cases, but is based on the presumption participants in the interaction are all part of the same culture. To better understand cultural miscommunication, the next sections will overview the cultural implications of nonverbal behavior and communication relevant to race, gender, and disability.

Cultural & Gender Representations of Nonverbal Behavior

Mariska and Harrawood (2013) stated: "Nonverbal gestures, expressions, and cultural norms and the "rules" regarding cultural norms play a significant role in human communication. Without an understanding of the culturally specific meaning attached to nonverbal communication, exchanges between cultures may be misunderstood" (p.2). As such, cross-cultural social situations can be tricky to decipher when the worldviews of both participants are not considered. In considering broad differences, western cultures tend to value greater displays of nonverbal expression, favoring those who are more expressive; these individuals are perceived as likely "having nothing to hide, of being open and worthy of trust, and less expressive individuals as being deceptive or untrustworthy" (Tickle-Degnen et al., 2011, p. 96). For example, East Asians value interdependence and, thus, submission of the self and humbly muting personal expressiveness is supportive of harmonious relationships. Conversely, Americans value autonomy, independence, and individuation, where drawing positive attention to one's self and opinions is acceptable (Tickle-Degnen et al., 2011). Despite this difference, English- and Germanic-speaking cultures tend to be *content* cultures, where greater emphasis is placed on words and the meaning they convey; Mediterranean, Latinx, Arab, and Asian cultures tend to be *context* cultures, where what is indirectly implied in communication is more important in the relationship (Mariska & Harrawood, 2013).

There has been some attempt to demonstrate the universality of certain nonverbal behavior across cultures, like the expression of basic human emotions, though this has been largely discredited save for a few (i.e., Jack et al., 2012). The majority of social and nonverbal cues are shaped and primed through cultural experiences (Matsumoto & Hwang, 2012). Many forms of nonverbal communication vary across cultures, such as posture, gestures, touch, physical space (*proxemics*), and eye contact. For example, the use of direct eye contact and the duration of the gaze is significant to cultural contexts. American and British cultures use moderate amounts of eye contact to convey respect; Middle Eastern cultures employ a greater amount of eye contact, where lack of eye contact portrays lack of interest and connection; and Asian, Latinx, and Native American cultures use low levels of eye contact out of deference (Mariska & Harrawood, 2013).

Physical interaction and proximity during communication, as mentioned before, are impacted by the level of the relationship, but also one's culture. Individuals from *contact cultures* (e.g., Latinx, Mediterranean, Middle Eastern) engage in touching at a greater frequency than individuals from *noncontact cultures* (e.g., northern European and Asian) (Bonacchio et al., 2016). When engaging in conversation, North Americans tend to keep greater physical space from others than Mediterraneans or South Americans (Matsumoto & Hwang, 2013). Posture can also be misconstrued in cross-cultural communication. For example, while common postures in western cultures, sitting with crossed legs may be found offensive to a native of Ghana and showing the soles of one's feet could be disrespectful to someone from Saudi Arabia (Tidwell, n.d.). Similarly, gestures that appear ubiquitous in American culture do not translate as universal in others. The "thumbs up" sign typically indicates positive sentiment in western culture, whereas it can be seen as derisive in Australia or just a digit to count to the number one in Germany (Cotton, 2013). And while University of Texas fans and rock aficionados enthusiastically raise a fist with their index and little fingers extended, it is not as well received in Italy (signifies a spouse is cheating) and Africa (viewed as a curse) (Cotton, 2013).

A final aspect of nonverbal communication to consider with respect to cultural interpretation is *paralanguage*—elements of speech such as pace, tone, pitch, volume, and even silence (Mariska & Harrawood, 2013). A change in volume could be construed as anger (Britain), loss of control (Japan), authority (Germany), impoliteness (Thailand), or be used to command attention (India) (Mariska & Harwood, 2013; Tidwell, n.d.). Silence is a nuanced paralanguage. While it would appear as merely the absence of oral information, it still conveys a message. van den Hurk (2019) postulated four functions of silence: (a) to display emotion, (b) to disempower, (c) as a turn-taking principle, and (d) as a face-saving strategy, or a way to leave certain things unsaid. Individuals from collectivist cultures (e.g., Japan, Korea) tend to use silence to convey emotions and save face more often than those from individualistic cultures (e.g., United States, Western Europe). However, the Native American culture within the United States does not conform to this. Though individual differences and customs across tribes and nations differ, native and indigenous Americans value silence, following the axiom "listen before you speak" and that it is best to be silent than show emotion (Jones-Smith, 2019).

Gender differences in nonverbal communication are well established, although it is uncertain whether this is manifest by actual behavior or the expectation of gendered behaviors and social norms. Typically, women use more smiling, nodding, gazing, facial and gestural expressiveness, and smaller interpersonal distances; woman are also found to be more accurate in judging emotions and personality through nonverbal cues, as well as remembering the nonverbal cues and appearance of others more readily (Hall & Gunnery, 2013). However, although seen as positive for both men and women to be physically expressive in American culture, not all behavior is perceived equally. Hemmesch (2014) found more negative attributions were shared toward women who masked facial expressions and demonstrated abnormal body movement than toward men. Though men are often valued more highly for physical ability, it was felt the inability of women to perform gender-stereotypical behavior, like grooming and household tasks, contributed to this rating.

Disability Presentations of Nonverbal Behavior

Age, infirmity, disability, and substance use all have considerable effect on behavior. Unlike cultural considerations of nonverbal behavior, which are socially primed and largely intended, many of the disability manifestations that affect nonverbal communication occur unconsciously or involuntarily on the part of the person. Consider behaviors such as lack of eye contact or excessive movement (e.g., fidgeting), which may communicate valuable information about the emotions or personality of the person being observed. These simple actions often communicate lack of interest or boredom in most people, but what else could be implicated in these behaviors? Might the person be on the autism spectrum? Could they be taking medication to manage a seizure disorder? Are they experiencing anxiety? Do they have low vision? Each of these scenarios could cause a reduction in eye contact or an increase in extraneous movement. However, if the observer is predisposed to "see" these behaviors as indifference, how might they be interpreted and applied? Likely not with accuracy or a favorable return.

Difficulty in interpreting emotions through nonverbal communication is a two-way street. For example, the social presentation of individuals with autism spectrum disorder (ASD), including restrictive use of gestures and flat affect (Pudlo & Pisula, 2018), makes it difficult for typically developing peers to discern their mental state, though people with ASD demonstrate difficulting determining the emotions of those around them, as well (Sasson & Morrison, 2019). Miscommunication results on both sides of the social interaction. Disorders characterized as affective processing disorders (APD), such as traumatic brain injury (TBI) and Parkinson's disease, impact the expression and interpretation of nonverbal cues, such as vocal prosody, gestures, and facial expression (Wauters & Marquardt, 2019). These impairment of processing may mean the person does not respond to humor or social pleasantries, and may not reciprocate the anticipated emotion of the exchange.

Facial expressions are a primary transmitter of human emotion in face-to-face interactions, as well as in the ever-present world of virtual meetings. A number of disabilities can affect facial muscles partially or through total paralysis. Facial paralysis can be experienced in individuals due to circumstances such as Bell's palsy, Moebius syndrome, cerebral palsy, stroke, Parkinson's disease, and other

trauma (Bogart et al., 2012). Stigma of individuals with facial paralysis occurs for various reasons, foremost being that the face, a visible and salient symbol of identity, appears differently (Bogart, 2015). This causes others to misinterpret messages and emotions transmitted through this medium. Tickle-Degnen and colleagues (2011) found that patients with Parkinson's disease were viewed more negatively for sociability when western standards (where facial expressiveness is valued) were applied. The impact to facial muscles may also result in dysarthria (muscles used to produce speech are damaged, paralyzed, or weakened) and the inability to employ other vocal qualities relevant to nonverbal communication.

Facial affect can also be impacted by mental health. Results are mixed across a number of studies and experimental conditions, though a reduction or blunting of affect and facial expressiveness has been found (Peham et al., 2015). Patients with schizophrenia reacted with less positive and negative facial affect to emotion-inducing films. Individuals with depression demonstrated a reduction in facial expressiveness, both natural and contrived, with heightened indicators of nonverbal hostility (e.g., tightening lips). Those with panic disorder displayed less fear and surprise, while those with anxiety could demonstrate social smiles, sadness, and contempt, but had a reduction in Duchenne (happiness) smiles, similar to those with anxiety. Those with posttraumatic stress disorder (PTSD) were impaired in both social and Duchenne smiles, demonstrating more facial anger expressions. Conversely, individuals with psychopathic conditions were successful at producing false facial expressions while observing emotional stimuli, such as smiling when shown a tragic or sad picture (ten Brickle et al., 2017). Although psychopathy is associated with a dearth of emotional expression, these individuals were able to adopt convincing, albeit false, emotions. Those with psychopathy have been found to lack startle response of the upper facial muscles (e.g., eyebrow furrowing), showing unconscious emotional reactions are more difficult to control (Peham et al., 2015).

Body language can covertly portray meaning, though in some cases, it can be used purposefully. For example, individuals who demonstrate psychopathy tend to use more and broader hand gestures to distract an observer's attention from the deceptiveness of their speech; however, these hand gestures, excessive blinking, and speech hesitations also increased in offenders with psychopathy when they were lying (ten Brinkle et al., 2017). Individuals with various forms of cerebral palsy (CP) may engage in extraneous body language, such as the twisting and writhing motions of athetosis, or may lack body movement altogether in the case of spasticity (Forster, 2016). Without the observer knowing the condition, individuals with CP have been falsely accused of being intoxicated, when in fact, their demonstrated gait and mobility is typical for them.

Paralanguage is also broadly influenced by disability factors. In some cases, like with individuals with ASD, the tone and prosody of the response does not seem to match the content of the conversation (Forster, 2016). This can appear disingenuous to the receiver of the message if the content is expressing excitement or pleasure but the monotone delivery indicates lack of interest. Flat affect and impairment in social pragmatics can also be apparent in individuals with TBI and other neurological and psychiatric conditions, leading to communication breakdowns due to the discorrespondence between verbal and emotional content (Wauters & Marquardt, 2019).

Many of the sources of nonverbal communication mentioned above can be generally problematic for individuals with disabilities. Nonverbal miscommunication poses a barrier to positive first impressions. Disability is a personal characteristic that is highly stigmatized by society, with those with physical disabilities stigmatized less and those with psychiatric and cognitive disabilities more (Smart, 2016). Observations of a stigma can instantly trigger emotional and physiological reactions in an observer, and stigma related to disability behaviors can speed formation of negative impressions because of this (Derous et al., 2016). Better understanding of this unintentional stigma response is important for clinicians to increase the accuracy of impressions, diagnoses, and assessment.

Practice Implications for Rehabilitation Professionals

One of the primary functions in counseling is to formulate hypotheses and opinions about client information and behaviors to assist in treatment planning. This is a process known generally as *case conceptualization*. According to Sperry (2005), case conceptualization is:

> a method and process of summarizing seemingly diverse case information into a brief, coherent statement or "map" that elucidates the client's basic pattern of behavior. The purpose of a well-articulated case conceptualization is to better understand and more effectively treat a client or client-system, namely the couple or a family. (p. 354)

For the process of case conceptualization to be effective, the counselor or evaluator needs valid information. Impressions made early in the counseling relationship, especially those predicated on inaccurate interpretation of client nonverbal communication, may be difficult to overcome, since as humans, counselors can be subject to confirmation bias. Professionals must be attuned to the underlying nature of nonverbal communication to overcome blind spots in clinical interpretation. To enhance self-advocacy, professionals should also prepare clients with disabilities and diverse backgrounds to address nonverbal behaviors that may influence interpersonal and professional interactions proactively.

Client Interactions

Clinical Impressions

Professionals who provide mental health services are often well versed in psychiatric disorders, but do not receive as much training around the other manifestations of disability experience (Jones-Smith, 2019). Generally, professionals might be aware of accommodations that should be provided under federal legislation to increase equity in services, but these policies do little to safeguard clinical impressions. When counselors have initial interactions with clients, they begin to draw conclusions about the nature of the presenting concern, the need for treatment, and the potential for outcomes like employment, but also subconsciously infer likeability and the likelihood a client will commit to change. Counselors can exhibit the same level of bias toward people with disabilities as the general public (Leigh et al., 2004), so counselors should engage in self-awareness and secondary scrutiny when considering the impact of disability in clinical decision-making. One caveat to mention is that there is a potential pitfall of attending to disability *too much* in the clinical context. If counselors overly attribute nonverbal communication as only a manifestation of disability, they may miss critical information on other underlying concerns; this tendency is known as *spread*. Spread occurs when "people without disabilities respond as if the individual's disability has a more pervasive impact than it actually does", which is a form of ableism (Jones-Smith, 2019, p. 12).

A first approach to improving clinical impressions of people with disabilities based on nonverbal communication is to examine one's own beliefs and emotional reactions about disabilities to interpret how these might influence the nature of work (American Psychological Association [APA], 2012). Oftentimes, professionals lack the knowledge and do not have a broad base of experience with people with disabilities, which could lead to stereotyped views of disability or may result in the misattribution of behavior in a clinical impression. Leigh and colleagues (2004) found 160 of their 481 psychologist respondents reported incidents of bias and inadequate or inappropriate services to people with disabilities. This included misdiagnosis from misinterpreting a physical limitation as a psychological issue, misuse or misinterpretation of test data, unresponsive treatment, and biased attitudes. For example, two professionals unintentionally diagnosed Deaf and hard-of-hearing clients with psychological impairments. Conversely, individuals with disabilities are routinely underdiagnosed for mental health needs because all concerns are attributed to disabilities, referred to as *diagnostic overshadowing* (APA, 2012). To address the lack of education and exposure to disability for counselors, the Commission on the Accreditation of Counselor Education and Related Programs (CACREP) will be including disability content within the revisions to their 2023 Standards for core curriculum.

Wright-McDougal and Toriello (2013) offered additional safeguarding against biases in impressions based on observed behaviors. Counselors should employ a scientific method to case conceptualization to minimize bias, rather than drawing solely on professional experience. Through the application of a scientific method, counselors develop hypotheses about clients and test these; the expectation is evidence will be accepted or rejected to refine the hypothesis, but counselors *must* also seek information to support the rejection of their hypothesis. In a service milieu where counselors are seeing increasingly diverse clientele with larger caseloads, a systemized, balanced method will ensure a "checks and balances" approach. Counselor supervision regarding the accuracy of hypotheses and decisions and attuning to ethical principles is also recommended.

Assessment and Evaluation

Assessment of the impact of disability related to vocational, social, psychological, and independent living barriers is an area in which rehabilitation professionals become skilled through their academic training programs, continuing education, or other mechanisms depending on their practice setting. Evaluators, rehabilitation professionals, and vocational experts must be attuned to the impact of disability throughout the assessment process, including behavioral observations, impressions, and implications for case conceptualization and findings. Rehabilitation practitioners have to be mindful of the nonverbal behavior and opportunities for impressions that can manifest in their own work. Within the private rehabilitation sector, practitioners oftentimes administer vocational assessments as a part of the employability process (Robinson, 2013). During the clinical interview, the vocational rehabilitation expert will gather data such as background information, mental health, and potential physical or psychological concerns that may affect career development to compare with the results of standardized tests administered. Although effort testing, malingering, and/or effort is sometimes assessed by the evaluator or vocational rehabilitation expert, one should consider how disability might affect the perceptions formed by the practitioner.

Layered upon this, in many cases, information reviewed for consideration was not conducted by the rehabilitation professional. For example, a forensic rehabilitation vocational expert will rely on work-related psychological limitations provided from a mental health professional (e.g., psychologist, psychiatrist) when considering pre and post-work capacity models and determining earning capacity. Disability must be considered as a lens for presentations of behavior, and the clinical impressions of those not versed in broader disability interpreted with caution. In a study of 481 psychologists, Leigh, Powers, Vash, and Nettles (2004) found barriers to service provision included funding, accessibility, lack of provider knowledge, limited training in disability issues and services, and lack of sensitivity. In other words, psychological experts may not understand disability-related issues to the degree needed to assess fully needs to maximize a claimant's quality of life. Therefore, the responsibility falls on the rehabilitation professional to determine if the impressions are not skewed by the interpretation of disability behavior (i.e., misunderstood, over-identified to the disability). Such limitations can affect the accuracy of findings and recommendations.

When working with outside professionals, the rehabilitation professional should advocate for a disability-inclusive model of assessment. The American Psychological Association (2012) created *Guidelines for Assessment of and Intervention with Persons with Disabilities*. These can be a starting point for dialogue across professions when assessing individuals with disabilities, and can be applied with rehabilitation professionals in all settings:

1. In assessing people with disabilities, professionals strive to consider disability as a dimension of diversity together with other individual and contextual dimensions (Consider the interaction between the claimant with a disability and the environment—how the individual functions over time, in varied situations, and in response to changing environmental demands [Bruyere & Peterson, 2005]).
2. Depending on the context and goals of assessment and testing, professionals strive to apply the most psychometrically sound, fair, comprehensive, and appropriate assessment approach for individuals with disabilities.

3. Professionals strive to determine whether accommodations are appropriate for clients to yield a valid test score.
4. Consistent with the goals of the assessment and disability-related barriers to assessment, professionals strive to balance appropriate quantitative, qualitative, and ecological perspectives and articulate both the strengths and limitations of assessment.
5. Professionals strive to maximize fairness and relevance in interpreting assessment data of clients who have disabilities by applying approaches that reduce potential bias and balance and integrate data from multiple sources.

The presentation of disability and associated behaviors need to be considered throughout the process. However, disability should not be a considered a universal or generic attribute. Although many people who have disabilities have experienced discrimination and barriers, each individual reacts differently to those experiences (APA, 2012). Oftentimes, in the provide sector, cases for which forensic vocational rehabilitation experts are retained may involve a claimant who has experienced major life changes, such as car accidents, war trauma, sickness and disease, or other disability that may adjust their sense of identity when such changes leave them with permanent disabilities (Zola, 1982; Jones-Smith, 2019). Jones-Smith indicated that for most individuals, the sudden onset of disability precipitates an intensive self-evaluation, and the individual may go from seeing oneself as a person without a disability to one that has a disability, thus resulting in difficulty accepting the new identity; until the individual adjusts their new identity, they will not rethink self-esteem. Karp (as cited in Jones-Smith 2019) stated, "In the ways that really matter, disability does not change you. Rather, disability threatens concepts you have held about who you are . . . Who you are impacts your adjustment to disability" (p. 140).

One method for understanding the unique influence of disability is by examining a claimant's experience with disability. Rehabilitation professionals and forensic vocational rehabilitation experts should include within their vocational assessment (a) a claimant's adjustment to disability; (b) stigma-related experiences; (c) the claimant's experience in job seeking or inaccessible workplaces; (d) claimant's perception of work-related barriers, such as lack of skills or training and transportation issues; and (e) current or previous job search strategies. Accommodations should also be included in the process based on the assessed, stated, and observed needs of the client. These include (a) altering presentation format, (b) altering response format, (c) altering timing, (d) altering test setting, (e) using only portions of the test, and (f) using substitute tests or alternative assessments (APA, 2012). For example, if medical records indicate a client has concentration-related barriers due to pain, perhaps the vocational interview can be structured to maximize concentration (if this option is available), such as taking several breaks during the interview or conducting the vocational interview on a day separate from vocational testing.

The authors of the current paper are not indicating that clients/claimants do not malinger or have secondary gain interests. For example, one should assess if the client was demonstrating proper motivation and effort. Walker and Sizemore (2019) indicated the following during a vocational assessment:

> Effort test findings should be used to clarify the validity of other psychometric results administered during the examination...If an individual is inconsistent or deceptive in response to measure of effort, the evaluator may need to conclude that the examinee set forth less than complete effort or inconsistent responses to other measures within the test battery . . . the vocational assessment may have been invalidated or sabotaged. (p. 52)

Evaluators and vocational experts should also determine efforts of clients toward *impression management* (i.e., attempts to present oneself in a positive light). Schneider, Powell, and Roulin (2015) examined the use of impression management in employment interviews. They found interviewees who used deceptive impression management, such as restrained facial behavior (i.e., less smiling) and unrestrained verbal behavior (i.e., more speaking errors, less silence), gave off the impression of being less anxious. In analyzing expressive verbal behavior, Bogart and colleagues (2012) videotaped participants with congenital and acquired disabilities while recalling emotional events. They found the

people with acquired disabilities used compensatory expressive verbal and nonverbal behavior in their language, voices, and bodies more often, thus indicating that people with acquired disabilities have greater difficulty with social functioning. In the short term, impression management may mask more prevalent concerns for the client (e.g., pervasive social skills deficits with ASD, negative symptoms associated with psychiatric disorders). It will weaken the accuracy of impressions about client suitability for career and life goals, resulting in ineffectual planning.

The standard for practice should be that rehabilitation professionals not automatically jump to conclusions and examine their own process to collecting data and the influence of biases on case conceptualization before rendering decisions. Research has shown that in some instances, service delivery is impacted by the biases of vocational rehabilitation professionals and indicated that assessing personal biases is one method of reducing this impact (Sprong et al., 2020; Sprong, Dallas et al., 2015). For example, in conducting a vocational interview, rehabilitation professional can avoid overemphasizing clues that fit an early hypothesis, but rather (a) review all of the collateral information, (b) understand how disability might influence the behaviors being identified, and (c) observe other cues that are equally as important. Similar to findings that initial impressions are found to relate more strongly to interviewer evaluations of applicant responses earlier rather than later in the structured interview (Swider et al., 2016), rehabilitation professionals can overcome incorrect early impressions to fully integrate disability presentations accurately across the assessment process.

Working with Couples and Families

Couple and family relationships often rank among the longest-lasting relationships in a person's life; the family comprises an individual's first social network, and romantic partners are often the primary person they interact with as adults (McGoldrick et al., 2015). Much of initial social learning occurs within the family, where children learn preferred methods of interaction and develop the frame of reference that will shape much of their social understandings (Becvar & Becvar, 2017). It is important to consider that this relationship is not unidirectional: the relationship and attachment system between a mother and infant, for example, is an evolving one that is determined by mutual influences of both (Shani, 2017). The impacts of this attachment process often carry into adulthood, and impact interactions between romantic couples. In turn, differences in interactional patterns and beliefs between members of a couple result in adjustments and new relational patterns (at least, in adaptive individuals). In this sense, the couple and family system constitute a culture of their own. Influence of couple and family relationships on individuals is present across most cultures and has been throughout much of history, and thus warrants attention as it relates to both the expression of nonverbal communication and its interpretation.

For an individual, the frames of reference shaped by their couple and family relationships can affect their communication style and experience. As discussed previously, cultural norms powerfully influence personal beliefs and evaluations of their own behavior. To reference a previous example, the decreased facial expression consistent with some developmental disabilities may be seen as more problematic in cultures that value independence and self-expression, such as the U.S., than in Eastern Asian cultures that value humility and submissiveness. This can be magnified based on regional and family culture within a larger cultural context. For example, in the Northeastern U.S., directness and honesty tend to be more highly valued, while in some Southern states, politeness and tact are often promoted. Because family and couple systems also have their own culture, regardless of region, some will value politeness and patience more than others will. Therefore, if an individual comes from a U.S. family that values directness and self-expression but lives with a disability that influences their ability to enhance their verbal communication with facial expressions and other nonverbal cues, they may develop an understanding of themselves as "bad at communicating." In turn, this can add to distress or frustration in future social interactions. If this individual marries another who also greatly values facial expressiveness, it can negatively affect the partner's experience of connection within the relationship, as they may perceive the lack of nonverbal communication as disinterest or coldness. The resulting couple dynamic may result in further frustration for both partners, marital discord, or a sense of incompatibility.

It is important to consider, however, that significant others who are understanding and supportive of a loved one's disability-related challenge with nonverbal behavior can create a buffering effect against related distress. The connection between support in close relationships and reduced negative outcomes of stress, particularly social stress, has been documented for over a century (Hostinar & Gunnar, 2015). An individual with such significant others may develop a self-concept as capable of maintaining communication and relationships, and a desirable significant other. Further, families and couples often develop their own methods of interaction and communication that meet the abilities and needs of members, allowing for a problem-solving, rather than pathologizing, approach to individual abilities. It can therefore be beneficial in sessions to include supportive significant others in the clinical process, to provide support, a fresh perspective, and help to tailor strategies specific to their loved one.

Conclusions

To put a point to all this, it is incumbent upon rehabilitation professionals to redouble efforts to resist the siren call of the first impression. As one completes interviews and assessments, they need to continually monitor "gut reactions," and review perceptions, however well meaning, against the many ways in which those impressions could be wrong. Knowing that human minds are predisposed to make series of quick and inaccurate judgements based solely on the first glance of a client, and knowing that in this field in particular, the likelihood that "information" received may be culturally construed, ethical practice requires considering nonverbal behaviors with additional care. Codes of professional ethics in the helping professions (e.g., APA, American Counseling Association, Commission on Rehabilitation Certification) have identified the negative impact counselor biases have on service delivery and these codes have ethical standards related to the avoidance of values imposition onto the clients receiving services (Sprong, McDermott et al., 2015). This serves as a call to reevaluate impressions of clients' behavior to maintain and objective stance and overcome inaccurate impressions.

References

Adler, N. J. (1991). *International dimensions of organizational behavior* (2nd ed.). PWS-KENT Publishing Company.

American Psychological Association. (2012). Guidelines for assessment of and intervention with persons with disabilities. *American Psychologist, 67*(1), 43–62. https://doi.org/10.1037/a0025892

Andersen, P., Gannon, J., & Kalchik, J. (2013). Proxemic and haptic interaction: The closeness continuum. In J. A. Hall & M. L. Knapp (Eds.), *Nonverbal communication* (pp. 295–329). DeGruyter. https://doi.org/10.1515/9783110238150.295

Bar, M., Neta, M., & Linz, H. (2006). Very first impressions. *Emotion, 6*(2), 269–278. https://doi.org/10.1037/1528-3542.6.2.269

Barrick, M. R., Shaffer, J. A., & DeGrassi, S. W. (2009). What you see may not be what you get: Relationships among self-presentation tactics and ratings of interview and job performance. *Journal of Applied Psychology, 94*(6), 1394–1411. https://doi.org/10.1037/a0016532

Becvar, D. S., & Becvar, R. J. (2017). *Systems theory and family therapy* (3rd ed.). Hamilton Books.

Blair, I. V., Steiner, J. F., & Havranek, E. P. (2011). Unconscious (implicit) bias and health disparities: Where do we go from here? *The Permanente Journal, 15*(2), 71–78. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3140753/

Bogart, K. R. (2015). "People are all about appearances": A focus group of teenagers with Moebius Syndrome. *Journal of Health Psychology, 20*(12), 1579–1588. https://doi.org/10.1177/1359105313517277

Bogart, K. R., Tickle-Degnen, L., & Ambady, N. (2012). Compensatory expressive behavior for facial paralysis: Adaptation to congenital or acquired disability. *Rehabilitation Psychology, 57*(1), 43–51. https://doi.org/10.1037/a0026904

Bonnacio, S., O'Reilly, J., O'Sullivan, S. L., & Chiocchio, F. (2016). Nonverbal behavior and communication in the workplace: A review and an agenda for research. *Journal of Management, 42*(5), 1044–1074. https://doi.org/10.1177/0149206315621146

Brown, S. (2002). What is disability culture? *Disability Studies Quarterly, 22*(1), 34–50. http://dx.doi.org/10.18061/dsq.v22i2.343

Bruyère, S. M., & Peterson, D. B. (2005). Introduction to the special section on the international classification of functioning, disability and health: Implications for rehabilitation psychology. *Rehabilitation Psychology, 50*(2), 103–104. https://doi.org/10.1037/0090-5550.50.2.103

Centers for Disease Control and Prevention. (n.d.). *Disability impacts us all.* Retrieved on July 24, 2020 from https://www.cdc.gov/ncbddd/disabilityandhealth/infographic-disability-impacts-all.html

Cotton, G. (2013, August 13). *Gestures to avoid in cross-cultural business: In other words, 'keep your fingers to yourself!'* HuffPost. https://www.huffpost.com/entry/cross-cultural-gestures_b_3437653

Derous, E., Buijsrogge, A., Roulin, N., & Duyck, W. (2016). Why your stigma isn't hired: A dual-process framework for interview bias. *Human Resource Management Review, 26*(2), 90–111. http://dx.doi.org/10.1016/j.hrmr.2015.09.006

Friedlander, M. L., & Stockman, S. J. (1983). Anchoring and publicity effects in clinical judgment. *Journal of Clinical Psychology, 39*(4), 637–643. https://doi.org/10.1002/1097-4679(198307)39:4<637::AID-JCLP2270390433>3.0.CO;2-Q

Forster, S. (2016). Communication with patients, parents and other caregivers. In I. L. Rubin, J. Merrick, D. E. Greydanus, & D. R. Patel (Eds.), *Health care for people with intellectual and developmental disabilities across the lifespan* (pp. 619-628). Springer. http://doi-org-443.webvpn.fjmu.edu.cn/10.1007/978-3-319-18096-0_54

Garfinkel, H. (1967). *Studies in ethnomethodology*. Prentice Hall.

Gray, H. M. (2008). To what extent, and under what conditions, are first impressions valid? In N. Ambady & J. J. Skowronski (Eds.), *First impressions* (pp. 106–128). Guilford Publications.

Hall, J. A., & Andrzejewski, S. A. (2008). Who draws accurate first impressions?: Personal correlates of sensitivity to nonverbal cues. In N. Ambady & J. J. Skowronski (Eds.), *First impressions* (pp. 87–105). Guilford Publications.

Hall, J. A., & Gunnery, S. D. (2013). Gender differences in nonverbal communication. In J. A. Hall & M. L. Knapp (Eds.), *Handbooks of communication science. Nonverbal communication* (pp. 639–669). De Gruyter Mouton.

Hemmesch, A. R. (2014). The detrimental effects of atypical nonverbal behavior on older adults' first impressions of individuals with Parkinson's disease. *Psychology of Aging, 29*(3), 521–527. https://doi.org/10.1037/a0036637

Hess, U. (2015). Nonverbal communication. In H. Friedman (Ed.), *Encyclopedia of mental health* (Vol. 2, pp. 119–138). Lawrence Erlbaum.

Hostinar, C. E., & Gunnar, M. R. (2015). Social support can buffer against stress and shape brain activity. *AJOB Neuroscience, 6*(3), 34–42. https://doi.org/10.1080/21507740.2015.1047054

Jack, R. E., Garrod, O. G., Yu, H., Caldara, R., & Schyns, P. G. (2012). Facial expressions of emotion are not culturally universal. *Proceedings of the National Academy of Sciences, 109*(19), 7241–7244. https://doi.org/10.1073/pnas.1200155109

Jones-Smith, E. (2019). *Culturally-diverse counseling: Theory and practice.* Sage.

Knapp, M. L., Hall, J. A., & Horgan, T. G. (2014). *Nonverbal behavior in interaction* (8th ed.). Wadsworth, Cenage Learning.

Küster, D., Krumhuber, E. G., & Hess, U. (2019). You are what you wear: Unless you moved—Effects of attire and posture on person perception. *Journal of Nonverbal Behavior, 43*(1), 23–38. https://doi.org/10.1007/s10919-018-0286-3

Lapakko, D. (2007). Communication is 97% nonverbal: An urban legend proliferates. *Communication and Theater Association of Minnesota Journal, 34,* 7–19. https://cornerstone.lib.mnsu.edu/ctamj/vol34/iss1/2/

Lee, D. Y., Barak, A., & Uhlemann, M. R. (1999). Forming clinical impressions during the first five minutes of the counseling interview. *Psychological Reports, 85*(3), 835–844. https://doi.org/10.2466/pr0.1999.85.3.835

Leigh, I. W., Powers, L., Vash, C., & Nettles, R. (2004). Survey of psychological services to clients with disabilities: The need for awareness. *Rehabilitation Psychology, 49*(1), 48–54. https://doi.org/10.1037/0090-5550.49.1.48

MacDonald, G. (1996). Inferences in therapy: Processes and hazards. *Professional Psychology: Research & Practice, 27*(6), 600–603. https://doi.org/10.1037/0735-7028.27.6.600

Mariska, M. A., & Harrawood, L. K. (2013). Understanding the unsaid: Enhancing multicultural competence through nonverbal awareness. In *Ideas and research you can use: VISTAS 2013.* http://www.counseling.org/knowledge-center/vistas

Mast, M. S., Bangerter, A., Bulliard, C., & Aerni, G. (2011). How accurate are recruiters' first impressions of applicants in employment interviews? *International Journal of Selection and Assessment, 19*(2), 198–208. https://doi.org/10.1111/j.1468-2389.2011.00547.x

Matsumoto, D., & Hwang, H. S. (2012). Culture and emotion: The integration of biological and cultural contributions. *Journal of Cross-Cultural Psychology, 43*(1), 91–118. https://doi.org/10.1177/0022022111420147

McGoldrick, M., Garcia Preto, N., & Carter, B. (2015). *The expanding family life cycle.* Pearson.

Payne, K., Niemi, L., & Doris, J. M. (2018, March 27). *How to think about "implicit bias".* Scientific American. https://www.scientificamerican.com/article/how-to-think-about-implicit-bias/

Peham, D., Bock, A., Schiestl, C., Huber, E., Zimmerman, J., Kratzer, D., Dahlbender, R., Biebl, W., & Benecke, C. (2015). Facial affective behavior in mental disorder. *Journal of Nonverbal Behavior, 39*(4), 371–396. https://doi.org/10.3389/fpsyg.2020.01658

Pichette, E. F., Accordino, M. P., Hamilton, M. R., Rosenthal, D. A., & Wilson, K. (2002). Susceptibility to racial and ethnic bias in intake interviews: Implications for vocational evaluators. *Vocational Evaluation and Work Adjustment Journal, 34*(1/2), 17–28.

Pudlo, M., & Pisula, E. (2018). The relationship between gestures and non-verbal communication and attentional processing in high-functioning adolescents with autism spectrum disorder. *Autism and Developmental Language Impairments, 3,* 1–11. https://doi.org/10.1177/2396941518787139

Robinson, R. (2013). *Foundations of forensic vocational rehabilitation*. Springer.

Sasson, N. J., & Morrison, K. E. (2019). First impressions of adults with autism improve with diagnostic disclosure and increased autism knowledge of peers. *Autism, 23*(1), 50–59. https://doi.org/10.1177/1362361317729526

Schneider, L., Powell, D. M., & Roulin, N. (2015). Cues to deception in the employment interview. *International Journal of Selection and Assessment, 23*(2), 182–190. https://doi.org/10.1111/ijsa.12106

Shani, L. (2017). Animal-assisted dyadic therapy: A therapy model promoting development of the reflective function in the parent-child bond. *Clinical Child Psychology and Psychiatry, 22*(1), 46–58. https://doi.org/10.1177/1359104516672506

Smart, J. (2016). *Disability, society, and the individual* (3rd ed.). Pro-ed.

Sperry, L. (2005). Case conceptualization: A strategy for incorporating individual, couple and family dynamics in the treatment process. *The American Journal of Family Therapy, 33*(5), 353–364. https://doi.org/10.1080/01926180500341598

Sprong, M. E., Currier, K., Hollender, H., Cerrito, B., & Buono, F. (2020). The influence of gender and sexism on the recommendation of certificate programs and consumer autonomy in vocational rehabilitation. *Journal of Rehabilitation, 86*(1), 4–11.

Sprong, M. E., Dallas, B. K., & Upton, T. D., & Bordieri, J. (2015). The influence of race, causal attribution, and in-group favoritism on recommendations for rehabilitation services. *Rehabilitation Counseling Bulletin, 58*(4), 227–239. doi:10.1177/0034355214562071

Sprong, M. E., McDermott, A., Matney, A., & Lucy, M. (2015). The counseling relationship. In J. Stano (Ed.), *Ethics in rehabilitation counseling: A case study approach* (pp. 49–99). Aspen Professional Services.

Strohmer, D. C., Shivy, V. A., & Chiodo, A. L. (1990). Information processing strategies in counselor hypothesis testing: the role of selective memory and expectancy. *Journal of Counseling Psychology, 37*(4), 465–472. https://doi.org/10.1037/0022-0167.37.4.465

Swider, B. W., Barrick, W. R., & Harris, T. B. (2016). Initial impressions: What they are, what they are not, and how they influence structured interview questions. *Journal of Applied Psychology, 101*(5), 625–638. http://dx.doi.org/10.1037/apl0000077

ten Brinke, L., Porter, S., Korva, N., Fowler, K., Lilienfeld, S. O., & Patrick, C. J. (2017). An examination of the communication styles associated with psychopathy and their in?uence on observer impressions. *Journal of Nonverbal Behavior, 41*(3), 269–287. https://doi.org/10.1007/s10919-017-0252-5

Tickle-Degnen, L., Zebrowitz, L. A., & Ma, H-i. (2011). Culture, gender and health care stigma: Practitioner's response to facial masking experienced by people with Parkinson's disease. *Social Science & Medicine, 73*(1), 95–102. https://doi.org/10.1016/j.socscimed.2011.05.008

Tidwell, C. (n.d.). *Non-verbal communication modes*. https://www.andrews.edu/~tidwell/NonVerbal.html

United States Census Bureau. (n.d.). *Quick facts, United States.* Retrieved on July 24, 2020 from https://www.census.gov/quickfacts/fact/table/US/PST045219

van den Hurk, A. (2019). *The influence of culture on the production and perception of silent communication.* https://pdfs.semanticscholar.org/4106/27bd3a6e59512f64c3db4dbf67b3fb9d7b52.pdf?_ga=2.136086001.1986040790.1596405589-1292838546.1594786100

Walker, J. M., & Sizemore, A. M. (2019). Effort testing in forensic vocational assessment. *The Rehabilitation Professional, 27*(1), 49–54. https://rehabpro.org/page/rehabpro_27_pre

Wauters, L., & Marquardt, T. P. (2019). Disorders of emotional communication in traumatic brain injury. *Seminars in Speech and Language, 40*(1), 13–26. https://doi.org/10.1055/s-0038-1676364

Weisbuch, M., Slepian, M. L., Clarke, A., Ambady, N., & Veenstra-VanderWeele, J. (2010). Behavioral stability across time and situations: Nonverbal versus verbal consistency. *Journal of Nonverbal Behavior, 34*(1), 43–56. https://doi.org/10.1007/s10919-009-0079-9

White, L. T., Valk, R., & Dialmy, A. (2011). What is the meaning of "on time"? The sociocultural nature of punctuality. *The Journal of Cross-Cultural Psychology, 42*(3), 482–493. https://doi.org/10.1177/0022022110362746

Wright-McDougal, J. J., & Toriello, P. (2013). Ethical implications of confirmation bias in the rehabilitation counseling relationship. *Journal of Applied Rehabilitation Counseling, 44*(2), 3–10. https://doi.org/10.1891/0047-2220.44.2.3

Zebrowitz, L. A., Montepare, J. M., & Strom, M. A. (2013). Face and body physiognomy: Nonverbal cues for trait impressions. In J. A. Hall & M. L. Knapp (Eds.), *Nonverbal communication* (pp. 263–294). DeGruyter.

Zola, I. K. (1982). *Missing pieces: A chronicle of living with a disability*. Temple University Press.

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