COLLEGE STUDENTS WITH INVISIBLE ILLNESSES AND DISABILITIES: DISCLOSURE, HIDING, AND SUPPORT

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Abstract

College students with invisible disabilities (SWIDs) represent a hidden population whose experiences are largely unexamined. The purpose of this exploratory study was to learn about their disability disclosure experiences and the assistance they might find most useful in relation to their invisible illness or disability (IID). The study included 237 participants reporting 59 IIDs. Results indicated first disclosures were to friends and roommates and subsequent disclosures were to friends and faculty members. Additionally, most participants felt the need to hide their IID at college (64.1%). Qualitative findings pointed to the influence of stressful situations and judgmental comments on participants' hiding their IID. In addition, the study revealed SWIDs' conceptions of support, the features that enabled disclosure, and supports needed when SWIDs struggle with their IID. Implications and ideas for future research were proposed.

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The process of integrating into a college may be new and exciting for students but can pose additional challenges for marginalized students, namely students with invisible disabilities (SWIDs). SWIDs, individuals who have physical or mental diagnoses that are not, to an onlooker, visibly linked to a disability (Santuzzi et al., 2014), have experienced intrapersonal and interpersonal concerns. This includes discrimination and stigma from peers and faculty members (Marshak et al., 2010). Additionally, they have reported anxiety surrounding disability disclosure (Bolourian et al., 2018) and apprehensions about forming friendships (Ward & Webster, 2018). Likewise, SWIDs indicated struggles specifically related to the invisible nature of their disability, like trying to explain invisible symptoms to other people in a visible way (Kirsh et al., 2016) or having the legitimacy of their disability called into question (Francis et al., 2019). As a result, these interactions have, for some, contributed to the desire to hide their illness from others (Kirsh et al., 2016) and to feelings of isolation (O'Shea & Kaplan, 2018).

Similarly, there are concerns with retention and employment for students with disabilities (SWDs), as they take longer to graduate, do not graduate at the same rates (Herbert et al., 2014), and are not employed at the same rate as their peers without disabilities (National Center for Education Statistics [NCES], 2017). It is important to understand SWIDs' college experiences better, not only because data demonstrate an increase in the percentage of college students reporting a disability, but also because many of the disabilities reported are not visible to others (NCES, 2011; 2019).

Thus, the aim of this study was to learn more about SWIDs' disability disclosure experiences. Two research questions guided the inquiry: (1) where do SWIDs feel they need to hide their invisible disability? and (2) what do they desire regarding support relating to their invisible disability. Specifically, we examined the experiences of SWIDs who disclosed their invisible disability in college and those who did not.

Disability Disclosure

Disability Concealment

Statistics do not accurately represent the number of SWDs in higher education. Although many SWDs choose to initially disclose their disability to receive additional resources, others do not (Kranke et al., 2013); there are many reasons for not sharing this information. For non-disclosers, these decisions may be related to a desire for independence (Bolourian et al., 2018), a longing for normalcy, a lack of knowledge about campus resources (Marshak et al., 2010), fear (Kranke et al., 2013), an inability to articulate their need for support (Ward & Webster, 2018) or there may be a current stability in the disability symptoms (Kranke et al., 2013).

Specifically, students with autism spectrum disorder (ASD) and attention deficit hyperactivity disorder (ADHD), chose not to disclose because they did not want to be seen as different from their non-disabled peers (Bolourian et al., 2018). Individuals with ASD indicated nervousness around disclosure because they felt their confidant might see them as incompetent or extraordinary (Miller et al., 2020). Similarly, those with learning disabilities reported self-stigma and feelings of shame as reasons to conceal their disability (Orr & Goodman, 2010). Those with multiple sclerosis noted symptoms as a predictor of disclosure in that participants chose to hide their disability if their symptoms were minor (Cook et al., 2017). Conversely, those with anxiety indicated that the severity of anxiety symptoms prevented disclosure (Stein, 2013).

Disability Disclosure and Intersecting Identities

For other individuals, disclosure was influenced by intersecting identities. For example, Olney and Brockelman (2005), studying disability and gender, reported men being more concerned about disability discovery than women. Additionally, they found men were more likely to minimize the impact of the disability on their daily living than women (Olney & Brockelman, 2005). Similarly, Black adults who had a severe mental health diagnosis and/or history of addiction indicated racial stigma was a key influencer of their desire to disclose and seek help (Yu et al., 2021). College students with ADHD and ASD discussed how their identities as a student with a disability influenced disclosure and noted concealing their disability and foregoing needed accommodations (Bolourian et al., 2018). Though identity can increase complications, navigating disability disclosure is complex, and feeling the need to hide this part of themselves may be why hiding is linked to negative wellbeing (Chaudoir & Fisher, 2010).

Disability Disclosure and Academic Interactions

Academically, SWIDs have reported being afraid of their peers knowing their diagnosis because they feared their peers would perceive them as unable to complete class work (Cooper et al., 2020). This anxiousness carried into student-faculty relationships, in that SWIDs reported feeling like a burden to faculty members (Ward & Webster, 2018) and expressed uneasiness to disclose to faculty members, particularly when they were unsure if the disclosure would be welcomed (Stein, 2014) or subsequently shared with other people (Stein, 2013). For some, the fear of being stigmatized was so intense that the SWID would rather fail a class than ask for help and be seen as ‘other’ (Magnus & Tøssebro, 2014).

SWIDs may have good reason to be fearful, given reported negative interactions with faculty members. SWIDs described instructors who did not believe their disability was valid (Bolourian et al., 2018) or who struggled to believe that the SWID’s challenges in class were disability-related (Francis et al., 2019). Instead, these professors believed that the SWID was not “trying hard enough” or was not “paying attention” in class (Francis et al., 2019, p. 251). Some faculty members were unwilling to allow students to have their approved accommodations (Fleming et al., 2017).

This is not surprising when taken together with Sniatecki et al.’s (2015) findings that faculty members reported levels of disagreement concerning accommodations. Specifically, they believed providing accommodations for mental, learning, and physical disabilities would give privileges not afforded other students and believed adjustments tainted course integrity (Sniatecki et al., 2015). This may partly explain why SWIDs indicate fear when disclosing their disability to professors and their reluctance to request help (Bolourian et al., 2018).

However, faculty members are not alone in these beliefs. Paetzold et al. (2008) found that students without disabilities perceived accommodations to be unfair. In particular, these beliefs were most salient when participants without disabilities were outperformed by individuals perceived to have a disability (Paetzold et al., 2008). These beliefs about SWIDs, as a segment of SWDs, can be detrimental to their success in college (Stein, 2014) and may provide insight into why SWIDs consistently request education initiatives on college campuses (Stein, 2014).

However, it is important to mention that not all interactions are negative. The literature includes numerous positive interactions and helpful behaviors that fostered a sense of care and contributed to SWIDs’ college experiences (Francis et al., 2019). O’Shea and Kaplan (2018), who studied psychiatric disabilities, indicated when participants communicated with someone with the same psychiatric disability, this connection provided a shared understanding of what it was like to live with this type of disability. Additionally, these interactions allowed participants to explain important concepts about the disability, like terminology specifically related to the psychiatric condition (O’Shea & Kaplan, 2018).

Characteristics of Supporters

SWIDs also described personal characteristics of supporters that were found to be helpful. SWIDs indicated those who were nice (Francis et al., 2019), available, accessible, kind, helpful (Orr & Goodman, 2010), approachable, understanding, patient, respectful of SWIDs' disability information (Stein, 2014), supportive (Kain et al., 2019), and flexible (Magnus & Tøssebro, 2014) as having a positive effect on their educational experience. Additionally, SWIDs reported an appreciation and sense of gratitude for campus personnel when they went beyond contractual responsibilities and helped SWDs in ways they did not expect (Fleming et al., 2017). This ranged from being willing to help with academic struggles to aiding SWIDs to address personal concerns (Kain et al., 2019). Also, SWIDs were moved by mentors and teachers who intentionally reached out to form a relationship and were remembered by these SWIDs years later (Orr & Goodman, 2010).

We do not know, however, what transpired during the disability disclosure between SWIDs and these influential individuals. The literature indicates that acting with kindness, in general, builds relationships and helps students feel more comfortable disclosing their disability (Magnus & Tøssebro, 2014). The question becomes, what did these confidants do before and during the disability disclosure that facilitated a positive disability disclosure experience? This information may be important to understand since the degree of care and acceptance the confidant provides is related to the disclosure being seen as beneficial, influences future disclosures (Chaudoir & Fisher, 2010), and may be linked to whether SWIDs will seek or continue to seek important disability-related services (Cooper et al., 2020).

Theoretical Framework

Chaudoir and Fisher's (2010) Disclosure Process Model (DPM) provides insight into the manner in which those with concealed stigmatized identities share "personal information that is socially devalued but not readily apparent to others" (p. 236). Specifically, it is used to determine when disclosures may be deemed beneficial and how disclosers potentially use the information from the disclosure process to inform future disclosure decisions. The DPM model consists of five components: antecedent goals, the disclosure event, mediating processes, outcomes, and a feedback loop. Chaudoir and Fisher theorized that disclosure begins with either approach goals (i.e., to facilitate gratifying outcomes) or avoidance goals (i.e., to prevent unpleasant outcomes). After the discloser determines their goal, they plan and execute the disclosure event, which entails the disclosure of the identity as well as the confidant's reaction during the disclosure. To understand whether this disclosure was seen as beneficial, three mediating factors are considered: alleviation of inhibition, social support, and changes in social information. For example, whether or not the discloser felt improvement psychologically or cognitively after they disclosed, whether it allowed them to get the desired support from the confidant or avoid punishment, influences how beneficial the outcome of the disclosure is perceived. Lastly, this single disclosure event is thought to provide information about future disclosures through a feedback loop. Meaning if the disclosure event was deemed positive, then the discloser may reveal their identity again. However, if it is seen as a negative experience, it may impede future disclosures (Chaudoir & Fisher, 2010).

Understanding these disability disclosure decisions and how they influence SWIDs' future disclosures is critical. Therefore, we desired to gain insight into these disability disclosure experiences, both from SWIDs who disclosed their IID and from those who did not. Specifically, (1) where do SWIDs feel they need to hide their invisible disability? and (2) what do they desire in terms of support relating to their invisible disability?

Positionality

We also acknowledge our positionalities and how they influenced this inquiry. One author is a person with multiple disabilities who has experienced higher education as a SWID, a staff member, and an adjunct faculty member. The second author does not identify as having any disabilities but has written on the topic in relation to college housing. Collectively, these experiences informed both the creation of this study and the interpretation of findings.

Method

Participants in this study self-reported their invisible disability; therefore, we cannot confidently say participants had a disability as defined by the Americans with Disabilities Act of 1990 (2008). Therefore, we report our findings using the terms "invisible illness/disability" (IID).

Procedure

After reviewing the literature, we designed an online survey containing open-ended and closed-ended questions to gather IID disclosure information. The survey included four sections: demographic information, disclosure, social support, and campus climate and sense of belonging. The number of survey items depended upon participants' decisions surrounding IID disclosure. Those who disclosed their IID were asked 32 questions; those who did not disclose were presented with 30 questions. Eleven of each were open-ended items (e.g., "When thinking about the individuals you disclosed to, what made these people 'safe enough' for you to tell them about your illness/disability? Imagine you are disclosing your invisible illness for the first time at college, what would be the most helpful thing the other person could do to support you?"). The remaining items used forced choice, non-forced options or a 7-point Likert scale from (1) strongly agree to (7) strongly disagree. An assessment by Qualtrics, the survey platform, indicated a high level of accessibility.

Following Institutional Review Board approval, the Office of Institutional Effectiveness (OIE) mandated a maximum sample size of 3,000 students, randomly selected from all currently enrolled students. Upon meeting the inclusion criteria and completing the informed consent process, students were able to participate in the study. Survey completion time was estimated at 15 minutes. The average response time was 11 minutes.

Participants

The findings presented in this paper were taken from a larger study examining SWIDs' college experiences. This study took place at a mid-sized university in the Mid-Atlantic region, which serves approximately 8,000 undergraduate and 700 graduate students. Participants needed to be a current college student, 18 years of age or older, and self-identified as having an IID. Of the 3,000 students who received the email invitation and survey link, 237 (7.9%) students completed the survey. Participants were mostly White (86.9%) female (76.4%) and ranged in age (18-61; M = 21.6 years). The largest segment identified their class standing as Senior (35.9%), Junior (23.6%), or Sophomore (20.7%). A sizable segment reported they lived off (44.7%) or on campus (40.5%), with a few indicating living with parents or guardians (12.7%).

Participants were invited to share their IIDs. A total of 59 IIDs were shared by 230 participants (Table 1). The most frequently reported IIDs were: anxiety/anxiety-related disorders, depression, post-traumatic stress disorder/complex post-traumatic stress disorder, chronic pain, eating disorders, autism, and obsessive-compulsive disorder. Of those who shared their IID, 60.4% reported more than one IID. Almost 45% reported three or more IIDs.

Data Analysis

SPSS was used to generate descriptive statistics. Responses to open-ended items were aggregated by question. The first analysis step involved data reduction, where the data were condensed (Miles & Huberman, 1994). As a second step, data display (Frechtling & Sharp, 1997) was enacted through a series of charts and diagrams that illustrated open-ended responses in relation to the survey item, respondent status as a discloser or non-discloser, and other demographic characteristics. As suggested by Saldaña (2020), we took notes while reading and re-reading the data, identifying salient quotes, initial patterns, and discrepancies between participant responses and returned to this information during our analysis. Following in vivo coding by each author, we developed a single list of codes, separately applied them to the data, and met again to finalize coding. After categorizing the coded data, we constructed five themes in two broad areas. Finally, we drew conclusions from the data, "stepping back to consider what the analyzed data mean and to assess their implications for the questions at hand" (Frechtling & Sharp, 1997, "Conclusion drawing and verification," para. 1). The initial findings were developed by one author and reviewed by the second. The authors then engaged in a process of review and discussion to finalize qualitative findings.

Quantitative Results

Disclosure decisions are noted in Table 2. Many participants disclosed their IID at college and disclosed to friends and faculty members. Most, regardless of whether they disclosed their IID at college or not, chose to hide their IID at college (Table 3).

Qualitative Findings

Findings from the qualitative data are presented in two key areas: where participants hid their IID and support factors related to disclosure, trust, and help.

Hiding

Generally, participants reported hiding their IID from a wide variety of people (e.g., peers, friends, family) and in diverse settings. This included large groups, when SWIDs were anywhere on campus, or when SWIDs were outside their room/apartment. Many participants felt the need to hide everywhere and all the time. Two prominent themes arose within the data where participants indicated the need to hide their IID.

Stressful Situations

The college academic experience includes tension- and anxiety-inducing circumstances such as timed exams or quizzes. SWIDs were deeply affected by these academic events and other routine in-class circumstances. Mei (pseudonyms are used throughout) reported hiding when in class and when:

> I have professors who say we aren't allowed to use the bathroom for an hour and 15 min class or they will take points off the final grade. I take medication that makes me have to go to the bathroom (Lasix). I also have times that I feel like I am going to pass out (I have before) from cramps when I am in class, and hiding that pain is hard.

SWIDs spoke about stressors ranging from, "when I have to answer a question in class," being randomly called on, speaking to professors or classmates, or simply attending class, which influenced hiding. In addition to class related stressors, participants reported that the onset of IID symptoms played a role in hiding behaviors. Participants described hiding "whenever I feel like I'm going to have a breakdown because I don't want anyone to think I am crazy" or avoiding disclosure when "I feel my 'invisible illness' coming over me." This suggests, in part, a potential link between anticipated stigma and active symptoms.

"People Make Judgmental Comments"

The topics and the ways in which IID information was discussed influenced IID hiding. Notably, the need to conceal resulted from conversations pertaining to the IID itself or from comments—often made publicly—that demonstrated an ignorance of the experiences of those living with an IID. Annie noted hiding when, "certain subjects are brought up in conversations, especially ones that involve my illnesses or what happened to me that caused me to develop these problems." Michelle mentioned, "overhear[ing] people making fun of or romanticizing eating disorders," which contributed to concealing their condition. Poignantly, Masood concealed his IID "when questions about my family arise." Disparaging comments caused Nadia to "worry that staff will not think I'm fit to be a nurse with these conditions. We are expected to be perfect." The inability of those without IIDs to truly understand the experiences of those with IIDs seemed to contribute to hiding behaviors and led to SWIDs feeling unwelcome.

Support Factors

Key themes relating to support included what helped or would help participants' disclosure, trustworthiness of the listener, and the preferred aid when struggling with their IID.

Understand Me

Repeatedly, non-disclosers noted the importance of listening and empathy. They indicated a desire for supporters to listen, sometimes "being with me, even if that means just sitting in silence and understanding my situation." Empathy was closely linked to listening by non-disclosers who desired support that included "trying to understand what doesn't make sense to them," or wanted the listener to "just connect with me and show they understand." Josie a non-discloser wrote,

> Have an open mind and don't try to one-up me. You may experience migraines or anxiety, too, but I need a chance to tell my story and know that you are listening to me for just a few minutes. After I am done, then you can incorporate your own experiences.

Additionally, participants desired supporters to demonstrate understanding of not just the SWID's IID, but the SWID themselves. Adali wanted listeners to allow them "a moment just to be broke and feel that. Not force me to act like all is fine and continue with normal life. This isn't normal." Throughout, when disclosing one's IID, SWIDs reinforced the importance of campus personnel, friends, and family being open and nonjudgmental.

Disclosers reported the value of listeners sharing their IID experiences, which seemed to enhance empathy and deepen the relationship. The power of reciprocal sharing was made clear when Herbert disclosed to a faculty member:

> He then told me "I think you're doing great." He then went on to tell me that he used to doubt himself when he was younger. He motivated me a lot to do better and to focus on myself. Ever since we chatted, it stuck with me to always do great things, for myself and my school work. It really touched me when he said that, because nobody else that I told about my anxiety or depression to told me anything nice, or they didn't say anything that sounded meaningful.

Similarly, Maria described her disclosure experience:

> I was discussing POTS [postural orthostatic tachycardia syndrome] in addition to my migraines and they said "why didn't you come get help sooner? We could've gotten you assistance around campus in your classes." They didn't pry. I just told them when I had and they believed me no questions asked and understood the weight of the situation in addition to offering me solutions to my issues around campus."

Non-disclosers, unfortunately, by their decision not to disclose their IID, are deprived of these experiences.

"Because They're my Homies"

The SWID's confidence in the listener aided in developing trust, which led to a positive disclosure experience. This faith—and deeming the listener trustworthy—was an essential element for SWIDs in their IID disclosure. Repeatedly, disclosing participants indicated they sought support because they were cared about, as in here, "I know they will love me regardless," "They love me unconditionally," and "Because their [sic] my homies and love me unconditionally." Care was expressed directly, "I know they care about me," and indirectly, "They want me to be ok." Long term relationships seemed essential to trust, as one participant commented, "They've been by my side through all the hard times. I trust them the most." Feeling truly known by the confidant was important to disclosers. As one participant noted "They have been there for me my whole life and have seen who I was and how I have changed."

Additionally, disclosing and non-disclosing participants ascribed trust to university personnel based solely on their position at the institution. Participants said, "my professors care about my education," that advisors "are there to help me," and "their job description made me feel that I would be understood and not viewed negatively for something I should just 'get over'."

For other individuals, listener characteristics, and not their position, inspired trust and disclosure. These individuals described confidants as accepting, empathetic, genuine, caring, nonjudgmental, understanding, willing to help, confidential, and someone who could personally relate to the SWID's experience.

Help Me

Participants wanted supporters to offer advice, helpful referrals, options for addressing their IID, or simple outreach. This support ranged from general aid ("provide helpful feedback," "help me find ways to cope or think differently,") to specific actions ("help me find a psychologist that is right for me," "helping me do get to the doctor's [office]"). Trust and seeking support were closely linked as participants reported sharing more information with trustworthy confederates who knew the SWID's condition or knew what the SWID needed when symptomatic. For example, Alexksei wrote "[Supporters] have seen me having panic attacks and understand my condition, as well as took me to appointments and help[ed] me feel like I'm not crazy." Sometimes support was a simple physical expression as it was for Bekka, who noted "My best friend just sat with me in silence and gave me a really tight hug because she could tell I was having a panic attack. I think many people need to realize that silence and support is the solution sometimes." For other individuals, however, help was desired in simple outreach. Non-disclosers noted straight-forward suggestions: "hey, if you ever want to talk;" "Anything I can do?;" and "Here is my number." These phrases suggest that helping does not have to be complex.

Discussion

The aim of the current exploratory study was to learn more about SWIDs' disability disclosure experiences and their desires for support from those who disclosed their IID and from those who did not. SWIDs provided insight into whom they feel comfortable disclosing to, IID hiding behaviors, and revealed links between support, disclosure, trust, and help. The disclosure process is presented here in a general format, but it is highly nuanced and situation-dependent for each individual student.

Hiding

Both disclosers and non-disclosers indicated that stressful situations were reasons to conceal their IID. Participants reported struggling with traditional classroom experiences, which in part, corresponds with Kreider et al.'s (2015) and Bolourian et al.'s (2018) results. However, the current findings better explain that classroom nervousness and hiding go beyond completing assignments and working together with peers. The findings illustrate the extent to which seemingly ordinary tasks like interactions with instructors and peers, participation, being called on, and simply attending class elicit hiding responses.

IID symptoms also elicited hiding behaviors for both disclosers and non-disclosers. Hiding in this way is not novel. Ward and Webster (2018) found that students with ASD struggled to request assistance when they were in dire need of help. Hiding during the times when help is needed most can be detrimental to SWIDs' well-being; however, creating and maintaining relationships with SWIDs may help them reach out when symptomatic. In both Chaudior and Quinn's (2010) work and this current study, relationships were critical to open dialogue regarding IIDs and support. As noted in the current work, these relationships can be built through simple outreach (e.g., if you ever wanna talk; anything I can do?) and 'open door policies' that signify support without a deadline.

Disclosers and non-disclosers also indicated that judgmental comments contributed to hiding behaviors. This is not surprising considering the invisible nature of IIDs. SWIDs are privy to hearing what other people articulate about IIDs, which influences how SWIDs manage IID information and potentially their comfort level in conversation (Goffman, 1963). Being affected in this way can also indicate the degree to which SWIDs have integrated the IID into their identity. Newheiser and Barreto (2014) found that individuals who were able to acknowledge and engage in conversations about their stigmatized identity were less likely to desire hiding this part of themselves.

Support Factors

SWIDs also provided insight into what would be helpful during a disability disclosure. Non-disclosers desired listeners who connect with them in ways free of stigma, where the confidant could take on their world view and gain insight into their experiences. These findings suggest a desire for listeners to allow the SWID's thoughts and emotions to take precedence in conversations and a willingness on the listener's part to refrain from helping until the SWID feels understood. Disclosers described positive IID disclosure interactions s that included confidants sharing personal experiences with IIDs. Much as Chaudior and Quinn (2010) indicated, confidants who disclosed their concealed stigmatized identities contributed to the willingness of others with concealed stigmatized identities to do the same.

Disclosers indicated feeling cared about as an influencer of disclosure. More deeply, though, trust seemed to develop with their confidant over time. Knowing the confidant and being known indicates the importance of stable, caring relationships where students feel they will not be judged, rejected, or treated differently because of their IID. Concurrent with disclosure literature, relationships have been noted to be both predictive of (Chaudior & Quinn, 2010) and a precursor to concealed stigmatized identity disclosure (Cooper et al., 2020).

For other SWIDs, however, relationships were not relevant to IID disclosure; the confidants' personal characteristics and roles influenced disclosure. This study demonstrated that positive personal characteristics portraying humanity (Peterson & Seligman, 2004) contributed to SWIDs feeling comfortable to disclose. This broadens our understanding of these qualities as influencers of disclosure; whereas previous findings reported the impact of personal characteristics related to student empowerment, persistence (Francis et al., 2019), and long-term benefits (Orr & Goodman, 2010). Also, expanding our knowledge about disclosure is that the role of the university personnel can elicit disclosure. Believing the professional was there to assist the participant was enough to invoke feelings of safety and encourage disclosure. These findings are unique because they encompass why SWIDs choose to disclose to campus personnel.

Both disclosers and non-disclosers seemed to link the type of support desired with the relationship, specifically being 'known' by their listeners in two ways: know my condition and offer practical help and know me and how I need to be supported. These findings add to our understanding by linking the desire for informed supporters to tailored care. Participants appreciated when the supporter listened to the SWID's IID concerns and offered practical assistance (e.g., help me find a doctor). Further, they appreciated their supporters getting to know them as people and offering subsequent care based on personal knowledge of the SWID (e.g., leave them alone, offer encouragement).

Non-disclosers noted regular outreach as beneficial. The desire for ongoing support is not unexpected as SWIDs have reported feelings of loneliness and lack of connection arising from the IID (O'Shea & Kaplan, 2018). Notably, the chronicity of IIDs may also play a role in the desire for ongoing support. On a regular basis, SWIDs must handle the diagnosis of the IID, related symptoms, and barriers accompanied by the IID, which can be emotionally and cognitively taxing (Kreider et al., 2015). What is interesting about this finding, though, is the desire for ongoing support from those who do not want to disclose their IID. It may speak to the dialectic taking place within non-disclosers who actually want support but cannot seem to disclose their IID to get the support they seek.

Implications for Practice

This study revealed important information concerning SWIDs' experiences related to disclosure and support. They desired places where care, safety, and understanding were available, their experiences could take precedence, and listeners were able to balance of self-disclosure and silence. Creating environments consistent with these needs may contribute to more positive disclosure and support experiences, and promote future disclosures (Chaudoir & Fisher, 2010). However, these aforementioned desires may not be possible without Student Affairs educators developing skillsets and becoming more culturally competent.

Sue and Sue (2013) wrote extensively about being a culturally competent counselor. In their work, they noted three attributes of cultural competence: becoming aware of one's perceptions of the world, taking on the worldview of others, and developing in ways that better serve diverse populations (Sue & Sue, 2013). These attributes can serve loosely as a framework for personal and professional development surrounding SWIDs, on both individual and systemic levels.

Individually, uncovering beliefs and biases in relation to SWIDs can be initiated by asking targeted questions. For example, do I find myself more or less compassionate toward students with specific IIDs, and why, or how does my perception of the IID's origin influence what I think about the SWID? In taking on the worldview of others, the Student Affairs educator can think about what SWIDs might experience as a result of having an IID at college and how SWIDs may be affected by practitioner beliefs around IIDs. After examining personal beliefs and thinking about SWIDs' experiences, the practitioner can develop and execute directed personal and professional development goals.

On a systemic level, colleges, with the involvement of Student Affairs practitioners, can explore hidden (or not so hidden) biases and beliefs also by asking pointed questions: are there groups of SWIDs that are invisible or under-supported at the institution in policies, procedures, or at campus functions; does the campus community include faculty and staff with disabilities? Additionally, personnel can examine how these biases and beliefs affect the students, staff, and faculty members under their care and, subsequently, create focused initiatives to serve these identified populations to a greater degree.

For those in Student Affairs leadership roles, change on systemic and campus culture levels is no small task and involves intentional educational initiatives surrounding IIDs that begin with providing information to the campus community. Specifically, these initiatives can include overall education regarding IIDs and information surrounding curricular and extracurricular activities.

Generally, educational initiatives might be enacted via panels of SWIDs who share their IID experiences, so community members can hear and better understand these students' struggles. Additionally, funding outside speakers and educators to address this gap or encouraging departments to purchase curricula to use with Student Affairs professionals or other campus personnel would be beneficial, so the burden of education does not rest on the community of SWIDs. Collaborating with Counseling Centers, Health Wellness offices, and Disability Services to create and disseminate information to advise staff and faculty concerning SWIDs' needs would be useful in assisting SWIDs' overall college experience.

Academically, SWIDs in this study indicated their struggle with traditional classroom experiences, from being called on in class to participating in group work, which may impel a reevaluation of the traditional classroom. For example, if participation in class is strictly defined by verbal contributions, is this an equitable assessment for all students? Could students engage in minute papers or reflection essays as alternative ways to show their engagement if verbal contributions are problematic?

Outside of the classroom, it is critical that Student Affairs practitioners take into consideration SWIDs' experiences as they design and implement extracurricular activities. Illustrating this are events where icebreakers are used. These activities may require mobility or the ability to remember chunks of information, which some SWIDs may not be able to complete, thus thwarting the purpose of the activity. Additionally, in residence halls and within student organizations and athletic teams, discussions about topics like microaggressions, romanticizing IIDs, and the impacts of this lack of understanding can be addressed, potentially promoting a safer space for SWIDs.

Moreover, SWIDs in this study repeatedly asked for support that transcended understanding IID facts. They need to be supported by those who have practical interpersonal skills that help facilitate the relationship, positive disclosure experiences, and subsequent conversations surrounding IIDs. Training can teach personnel how to engage and facilitate uncomfortable conversations around IIDs. Relevant development topics include understanding and avoiding microaggressions, learning to allow other people's thoughts and emotions to hold precedence, crafting appropriate responses in difficult situations, understanding and managing one's anxiety in difficult conversations, and cultivating lasting relationships with SWIDs. By making the development of these skills a priority, practitioners can help prevent harmful experiences for SWIDs.

Limitations and Future Research

There were limitations to this study, namely the sample itself. Our sample included participants with depression and anxiety-related IIDs primarily; therefore, these findings may not be generalizable to the experiences of SWIDs whose IID is unrelated to these disabilities. Additionally, many participants indicated IID comorbidity, which may further complicate understanding the disclosure process and support needs, depending upon which IID is most salient at the time of disclosure or the need for support. Lastly, the use of a survey to capture disability disclosure prevented us from noting the complexities and nuances of the disclosure process.

Future research might focus on exploring IID comorbidity and its potential influences on the disclosure process and support preferences. Additionally, future researchers might focus on the hiding tendencies of SWIDs when symptomatic. In the current work, participants hid their IID when they may have needed help the most. Further inquiries that identify what may help SWIDs disclose their IID when symptomatic may be critical to keeping students safe and providing needed support.

Conclusion

It is painfully obvious that the decision to share a hidden and often stigmatized part of one's self is fraught and complex. College students may be especially poorly positioned to make themselves vulnerable to other people—particularly staff and faculty who can influence the SWID's college experience. This study highlights the importance of continuously educating and training personnel so they are well-informed on IIDs and better equipped to offer support to SWIDs. In the end, it is the responsibility of our organizations to facilitate and enable SWIDs' disclosures and to assist SWIDs in ways that can promote a positive student experience.

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Table 1

Reported Invisible Illnesses/Disabilities

Illness/Disability	*f*	Illness/Disability	*f*
Anxiety (social, GAD, anxiety)	165	Partial blindness	1
Depression	126	Psychosis	1
PTSD (CPTSD)	25	Gout	1
Chronic pain (migraines, chronic pain)	11	BPD	1
Eating disorders	9	Severe acid reflux	1
Autism/Asperger's	8	Brain injury	1
OCD	8	Idiopathic intercranial hypertension	1
ADHD	7	Histiocytosis	1
Diabetes (non-specified, type 2, type 1, insipidus)	7	Chiari malformation	1
ADD	6	ARFID	1
Bi-polar disorder	6	CRPS	1
Fibromyalgia	4	Misophonia	1
Learning disability/disorder	4	Insomnia	1
Crohn's disease	3	Trichotillomania	1
Panic attacks/disorder	3	Epilepsy	1
Post-partum/post-natal depression	3	POS	1
IBS	3	Pseudotumor cerebri	1
Endometriosis	3	Lyme's disease	1
Hyperthyroid/Hypothyroid/Hashimoto's	3	Raynaud's disease	1
Celiac disease	2	Chronic pericarditis	1
Rheumatoid arthritis	2	Growth hormone deficiency	1
Body Dysmorphia	2	Trigeminal neuralgia	1
Paranoia	2	Gastroparesis	1
Seasonal depression	2	Cutaneous t cell lymphoma	1
Ulcerative colitis	2	Postural orthostatic tachycardia syndrome	1
Hearing loss	2	Post-concussion syndrome	1
Membranous nephritis	1	Lupus	1
POTS	1	Tick vector illness	1
OCPD	1	Iris pigment dispersion transillumination syndrome	1
Blindness in one eye	1	**Total Disabilities/Illnesses**	**448**

Table 2

Disclosure Decisions

Disclosure Confidant	First disclosure		Second and subsequent disclosures	
	n	%	*n*	%
Disability Staff	24	14.8	0	0.0
Roommate	33	20.4	8	4.9
Didn't tell anyone else	n/a	n/a	19	11.7
Friend	83	51.2	68	42.0
Faculty Member	13	8.0	62	38.3
Staff Member	5	3.1	4	2.5
Other	4	2.5	1	0.6

Note: N = 162

Table 3

Participants' Hiding Preferences and Disclosure Status

Preference	Disclosers		Non-Disclosers	
	n	%	*n*	%
Hid IID	162	64.1	75	74.7