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Disability Disclosure Among College Students with Psychiatric Disabilities in Professional Majors: Risks and Implications for Rural Communities

Valerie Thompson-Ebanks

Living in this small town! You really expect me to tell people on campus about my disability? And then, what happens when I apply for a social work position? The classmates I have in class everyday are the same ones who are placed in these agencies for their field placement. My [social work] instructors also have to recommend me for field [placement]. Everybody knows everybody, do you think I want them to label me as X who is clinically depressed and have them question my ability and then what? Shut me out of a job ... I am not leaving this town, this state ... disclose you ask, so it can be used against me ... no way!

The preceding comment was shared with this author in a pilot study exploring reasons why students with disabilities in a rural area prematurely withdrew from college. I had asked the participant if he had disclosed his disability while in college. The response triggered an exploration of the literature regarding the potential challenges students with psychiatric disabilities may encounter while enrolled in professional programs. This paper focuses on the interactions between (a) college student disclosure of a disability, (b) stigma, and (c) rural context. A practice model for social work education is provided.

Disclosure of Disabilities

Under the Americans with Disabilities Act (Americans with Disabilities Act [ADA], 1990), formalized support mechanisms for students with disabilities in higher education institutions are based on the premise that students will disclose their disability to the institution's disability services office. Disability disclosure, supported by professional documentation of the disability, is a

prerequisite for students with disabilities to receive "reasonable accommodations" from faculty (ADA, 1990; Madaus, 2011). Even though disclosure is required to access services, research indicates that only a small percentage of students who qualify for accommodations actually disclose, register, request, and receive disability services and accommodations (Lynch & Gussel, 1996; Matthews, 2009). While the estimated number of college students with disabilities based on self-reports is as high as 13% (Pryor, Hurtado, DeAngelo, Palucki Blake, & Tran, 2010), only 1%-3% request campus disability services (Hartman, 1993).

Students who do not formally disclose to their campus disability services generally do not access services and accommodation (Kranke, Taylor, Jackson, Floersch, & Anderson-Fye, 2013). In some instances, however, disclosure may not be necessary if the disability will not impact the student's academic performance and no accommodation is required. In other instances, faculty members informally offer accommodations to students on a case-by-case basis (Madaus, 2011).

For students who need disability services and accommodations, delayed disclosure or nondisclosure may prevent them from securing the support services and accommodations they need to succeed (Hartley, 2010; Levine, 1997). Hudson (2013) found a positive correlation between early disability disclosure (within first year of enrollment) and how soon students complete an undergraduate degree. In fact, students with nondisclosed disabilities were three and a half times more likely to not graduate in six years than those students who formally disclosed their disability to the institution. Therefore, nondisclosure or even late disclosure (beyond the first year of enroll-

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ment) is associated with the risks students face when they prolong their time in school (Hudson, 2013) and presumably even college non-completion. Scholars have also argued that non-disclosure hinders faculty from providing reasonable accommodations and prevents institutions from accurately recording, reporting, researching, and responding to the growing needs of students with disabilities (Hartley, 2010; Miller & Nguyen, 2008).

Despite the benefits of disability disclosure, students have reported several reasons why they are reluctant to self-disclose their disability identity and, in some cases, intentionally conceal their status (Kranke et al., 2013; Trammell, 2006). Such factors include: embarrassment and/or shame that they have a disability; stigmatization when they disclose their disability; impressions of a chilly campus climate toward disability; risks to identity and integrity; negative perceptions of peers and faculty; regrets with previous disclosure experiences, including rejections; a wish to be self-reliant; desire to take on a new persona from that in high school; fear of discrimination and denial of opportunities; unreceptive or uncooperative response from faculty; fear of being treated differently; social distancing; marginalization; and discrimination (Hudson, 2013; Kranke et al., 2013; Lynch & Gussel, 1996; Marshak, Van Wieren, Ferrell, Swiss, & Dugan, 2010; Martin, 2010; Thompson-Ebanks, 2014). Matthews (2009) concluded that “given prevailing attitudes towards people with impairments that often present them as pitiable or unable to help themselves, refusing to identify one’s self as disabled can be a rational choice” (p. 232).

Disability disclosure is even referred to as a “risky business” that requires students to conduct a cost-benefit analysis prior to deciding whether or not to disclose (Venville & Street, 2012, p. 19). In this analysis, students weigh the pros and cons of disclosing and only disclose when “the risks associated with nondisclosure outweigh the benefits” (Venville & Street, 2012, p. 19). If disclosure is not accompanied by tangible benefits (e.g. accommodations, positive campus climate) students will consider disclosure a risk not worth taking (Kranke et al., 2013; Lynch & Gussel,

1996).

Disabilities is a broad term and includes physical disabilities (mobility, visual, or hearing impairments), cognitive and learning disabilities (traumatic brain injuries, attention deficit hyperactivity disorder (ADHD), dyslexia), and psychiatric disabilities (anxiety and mood disorders, schizophrenia). The characteristics of some disabilities are more readily apparent to an observer than others, therefore, the decision to disclose is particularly context-based for students whose disability is not apparent. Each individual student must decide if his or her situation warrants disclosure. Disabilities that are often not immediately apparent to an observer include psychiatric disabilities, learning disabilities, autism spectrum disorders, and medical conditions such as certain forms of musculoskeletal disorders (MSDs). It can be especially daunting for students suffering from these “hidden” conditions to disclose and legitimize their need for accommodations.

Disclosure decision-making is categorized as an element of information management (Trammell, 2009) in which students consider: why disclose, when to disclose, how to disclose, how much to disclose, and to whom to disclose (Lynch & Gussel, 1996; Nutter & Ringgenberg, 1993). Although students with visible disabilities still must decide whether to formally disclose their disability to the office of disability services at a given college or university, students with non-apparent disabilities tend to face a unique set of factors when confronting the disclosure decision (Hoppe, 2010).

Psychiatric disabilities are the focus of this paper and refer to diagnosable mental disorders that can cause mild to severe personal distress and/or impairment in thinking, feeling, and relating, as well as functional behaviors that interfere with a person’s capacity to cope with life’s daily demands (Rickerson, Souma, & Burgstahler, 2004). Such disabilities include a wide spectrum of mental disorders including: “major depression and mood disorders, anxiety disorders (such as panic, obsessive compulsive, post traumatic stress), autism spectrum disorders and Asperger’s, borderline personality disorders, and psychotic and thought disorders such as schizophre-

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nia and bipolar disorder” (Belch, 2011, p. 75). Students with psychiatric disabilities are a growing population on college campuses, with emerging and often misunderstood needs (Collins & Mowbray, 2005).

Role of Stigma

Students with disabilities report stigma and stigmatizing-related issues as the primary reason they choose not to disclose their disability identity (Collins & Mowbray, 2005; Marshak et al., 2010; Martin, 2010; Salzer, Wick, & Rogers, 2008; Trammell, 2009). Stigma is defined as a negative “designation or a tag that others affix to [a] person” (Link & Phelan, 2001, p. 366) in which elements of labeling, stereotyping, and discrimination coexist to discredit an individual (Goffman, 1963). Disability service providers also perceive stigma as the primary impediment to students requesting services. Collins and Mowbray (2005) reported data from a National Survey of Campus Disability Services that disability services staff perceived stigma to be the primary barrier preventing college students from seeking services, with particular reference to their fear of disclosure. Despite the mounting evidence that disability is a stigmatized identity, Trammell (2006; 2009) stated that much of the accompanying discrimination against students with disabilities is subtle and difficult to measure, hence it is difficult to address.

Shame and stigma have been attached not only to psychiatric disabilities (i.e., bipolar disorder, depression, and anxiety disorders), but to intellectual (i.e., learning disabilities) and physical disabilities (i.e., multiple sclerosis, HIV/AIDS, or cancer) as well, although not every disability is associated with the same degree of stigma (Hinshaw, 2007; Lynch & Gussel, 1996; Thomas, 2000). However, research reveals that psychiatric disabilities, regardless of the specific diagnosis, are typically more stigmatized than other disabilities and have been called the “ultimate stigma” (Corrigan, 2006; Sartorius & Leese, 2009; Spagnolo, Murphy, & Librera, 2008; Thornicroft, Brohan, Rose, 2009). Given that disability is a stigmatized identity, Hoppe (2010) argued that

people with non-apparent disabilities can strategically shape the visibility or invisibility of their disability in an attempt to manage how they are perceived by others, thereby avoiding or minimizing stigmatization.

Types of Stigma

The National Council on Disability (2009) discussed three types of stigma that discourage people from seeking help: public stigma, self-stigma, and structural stigma. Public stigma has three components: stereotype, prejudice, and discrimination (Corrigan, Larson, & Rusch, 2009). Stereotype refers to knowledge structures that most members of one social group learn about members of other groups. Disability stereotypes related to students include labelling students with disabilities as incompetent, responsible for causing their own illness, dangerous, and incapable of full participation in higher education (Rusch, Angermeyer, & Corrigan, 2005). Prejudice occurs when people adopt negative stereotypes/labels about a group that result in negative emotional responses toward that group. For example, some people may express disgust, fear, and anger when they interact with people with disabilities (Corrigan, 2009). Discrimination describes the act of treating a group of people differently so that they are disadvantaged. In regard to students with disabilities, this could occur when an instructor penalizes students for submitting a late assignment even though their documented accommodation approves an extended time to complete assignments (Thompson-Ebanks, 2014). Collectively, public stigma can be described as the public misperceptions of individuals with disabilities, especially toward those with psychiatric illnesses, that can result in negative attitudes and actions toward them.

Self-stigma occurs when individuals internalize public stigma by applying negative disability stereotypes to themselves. Students experiencing self-stigma experience feelings of embarrassment, shame, and weakness due to having a disability (Corrigan, 2009). These students may struggle with low self-esteem issues and believe that they cannot make a valuable contribution to society.

According to the National Council on Disability (2009), structural stigma refers to institutional policies or practices that unnecessarily restrict opportunities for people with disabilities. Structural or systemic stigma and oppression can also be defined as unquestioned, "... systems of beliefs, policies, institutions, and culture that systematically discriminate against ... people with disabilities ... and other oppressed groups" (Banks, 2000, p. 132). An example of structural stigma would be a fear of disclosing your disability identity because you believe that both peers and faculty will deem you "different," and your academic endeavors will be threatened.

Corrigan, Watson, and Barr (2006) suggest that both perceived public stigma and self-stigma may hinder people from using mental health services to avoid the consequences of stigma (stereotypes, prejudice, and discrimination). Likewise, when students with disabilities perceive public stigma and internalize stigma, they may choose not to disclose and seek accommodations (Barney, Griffiths, Jorm, & Christensen, 2006; Corrigan, 2004).

Rural Settings and College Students with Disabilities

Multiple definitions have been used to identify rural areas, which may have implications for the development and implementation of educational policies. Recognizing the conceptual ambiguity of the term "rural" across educational domains, the NCES worked with the Census Bureau and the Office of Management and Budget (OMB) in 2006 to create a uniform usage of the term that could translate across educational settings. The agreed geographical classification includes three degrees of rurality, namely:

- Fringe Rural Area: less than or equal to 5 miles from an urbanized area, or an area that is less than or equal to 2.5 miles from an urban cluster;
- Distant Rural Area: more than 5 miles but less than or equal to 25 miles from an urbanized area, as well as an area that is more than 2.5 miles but less than or equal to 10 miles from an urban cluster; and

- Remote Rural Area: more than 25 miles from an urbanized area and more than 10 miles from an urban cluster (NCES, 2007).

The literature recognizes the diverse culture and attributes of rural areas across different countries, as well as across rural locations within the same country (Nicholson, 2008). This diversity prevents the development of a standardized set of characteristics pertinent to all rural communities. However, researchers agree that rural populations are more adversely affected by the stigma of mental health and psychological disorders than the populations of most other areas due to rurality attributes (Larson & Corrigan, 2010; Nicholson, 2008; Tummala & Roberts, 2009). This assertion has implications for students with disabilities living in and/or studying in rural areas and their willingness to disclose their disability identity and use services. The cultural and contextual attributes scholars associate with rural areas that could impact students with disabilities in rural colleges include: a mindset toward stoic pride and self-reliance that discourages seeking help for mental health; unwillingness to seek care; closely connected social networks; overlapping relationships; social exclusion; difficulty maintaining anonymity and confidentiality in small rural communities; and stigma regarding mental health problems (Eisenberg, Downs, Golberstein, & Zivin, 2009; Fuller, Edwards, Procter, & Moss, 2000; Nicholson, 2008; Tummala & Roberts, 2009).

College students with disabilities studying in rural communities grapple with additional factors related to their environment when deciding whether or not to disclose their identity in order to access services. Tummala and Roberts (2009) stress that in rural settings:

stigma takes on special importance because of the interdependent and overlapping relationships that exist in small communities. To be viewed negatively by others, to be avoided, and to be seen as less than a full member of the community is an extraordinary burden for a person in a rural community. (p.188)

Stigma against persons living with disabilities, especially psychiatric disabilities, is prevalent among the general population in the United States (Covarrubias & Han, 2011; Eisenberg et al., 2009), but takes on added significance for people with disabilities in rural areas in light of rurality attributes such as having closely connected work and often interrelated networks, which makes it difficult to maintain privacy (Larson & Corrigan, 2010). Several authors point out that many people with disabilities fear that their disability will become their overriding identity and overshadow their personal identity (Corrigan, 2004; Fuller et al., 2000; Goffman, 1963; Hoppe, 2010). This fear may be heightened for rural folks.

Students with Disabilities in Professional Programs

In a study designed to explore the experiences of disability disclosure among practitioners in helping professions and students in professional programs—namely nursing, social work, and teaching—Stanley, Ridley, Harris, and Manthroe (2011) found that disclosure of a disability is a risky endeavor for those seeking to practice or train in nursing, social work, and teaching as “disclosure was perceived as having the potential to exclude participants from their chosen profession” (p. 19). Admittedly, disabilities may be associated with unsafe practices in some instances, but having a disability should not be used as a barrier to practice. Rather, focus should be placed on the assessment of competence rather than the presence of a disability (Stanley, Ridley, Harris, & Manthroe, 2011). These stigmatizing views are not just held by the “uninformed general public ... but well-trained professionals from most mental health disciplines also subscribe to stereotypes about mental illness” (Corrigan, 2000, p. 49). Nordt, Rossler, and Lauber (2006) found that social workers and other professionals working with people diagnosed with mental illness have equally negative attitudes toward mental illness as those found in the general public.

Disability stigmatization among professionals may be explained in part by what Cohen and Cohen (1984) referred to as the “clinician’s illu-

sion.” Clinical illusion refers to practitioners making negative assumptions, generalizations, and predictions about the functioning and behavior of people with disabilities solely based on their personal practical experience with a few patients experiencing severe problems rather than on empirical data. Regardless of mounting data supporting the notion that people with psychiatric disabilities can recover and/or maintain optimal health and lead productive lives, some practitioners still hold the belief that recovery from psychiatric illnesses is unlikely (Harding, 2003; Spagnolo et al., 2008). As Levine (1997) points out, “if mental health professionals and students react negatively to those identifying themselves as having psychiatric disorders, it is not unreasonable to expect that faculty members without specific training or experience in mental health would react in similar ways” (p. 70). This author contends that the stakes are even higher for students with disabilities in professional programs in rural colleges (Sin & Fong, 2008; Stanley et al., 2011) such as social work, nursing, and physical therapy, and perhaps also medicine, speech therapy, and teaching. As a social work academician, I will frame much of the ensuing discussion for social work practitioners and educators.

How the Social Work Profession Can Reduce Stigma and Increase Services to College Students with Disabilities

Despite the progress made on disability rights, it is evident that the ADA and other legislation intended to improve the lives of people with disabilities cannot completely eliminate all the “imagined or real barriers, including [deeply ingrained] disability-related stigma” (Trammell, 2006, p. 32). Social work has an ethical obligation to advance the rights of people with disabilities to enjoy the same privileges and opportunities as other members of society (National Association of Social Workers, 2008). Because disability stigma plays such a crucial role in accessing health care and in college students’ willingness to disclose and access needed services, I suggest that social work education should take a leading role in embracing anti-discriminatory practice initia-

tives. Such initiatives could help tackle stereotypes of aligning incompetence with disability and challenge the belief that a disability identity defines an individual and becomes the dominant identity. There is mounting evidence that people with disabilities can be competent practitioners (Saks, 2007; Johnson, 2013; Siebers, 2013). Social work, with its aim of social justice, is well positioned to proactively demystify disability issues (Covarrubias & Han, 2011).

The professional literature has highlighted a number of evidence-based approaches to counter public disability stigma. Social psychologists have identified three strategies for decreasing public stigma: education, contact, and protest (Corrigan et al., 2001). Educational interventions, particularly those that provide factual information about people with psychiatric disabilities, have proven somewhat effective in reducing disability stigma (Corrigan et al., 2001; Covarrubias & Han, 2011). Studies show that people who seem to have increased knowledge about disabilities are less likely to adopt behaviors that stigmatize and discriminate against individuals with disabilities.

Social contact interventions, which promote direct interactions with people with disabilities to challenge negative attitudes about disabilities, especially toward those with psychiatric disabilities, have been particularly effective (Corrigan et al., 2001; Couture & Penn, 2003). Personal, interactive contact with people engaged in nonstereotypical activities, such as work, reduce stigma against people with psychiatric illnesses. In a study with MSW students, Covarrubias and Han (2011) suggested that contact with friends with serious mental illness was more likely to reduce disability stigma than contact with family members.

Protest interventions involve strategies to suppress negative attitudes toward psychiatric illnesses (Corrigan et al., 2001). Such protest interventions have not proven to be effective in reducing disability stigma. In fact, research indicates that telling people to ignore or suppress negative thoughts and attitudes toward people with disabilities may rebound and increase stigma rather than reduce it (Corrigan et al., 2001). Penn and Couture (2003), however, derived different results. They

found that suppression instructions decreased negative disability attitudes, but did not change the way people treat those with mental illness. Penn and Couture also found no evidence of a rebound effect.

Watson, Corrigan, Larson, and Sells (2007) reviewed strategies used to reduce self-stigma and found that two contrasting approaches were used. Interestingly, one set of approaches focused on altering cognition about stigmatizing beliefs and attitudes; the second set of approaches focused on encouraging participants to accept the existence of disability stigma by enhancing stigma coping skills through empowerment, self-esteem building, and improving help seeking behavior. The authors conceded that research in this area was in its embryonic stages, but recognized merit in interventions that are theoretically based.

Several social work education programs offer a course on disability. Frequently, this course is not required. Content on disabilities is often integrated in another course and may not be adequately covered. Social work, with its commitment to improve the lives of marginalized groups, should seek to elevate disabilities studies as an integral discourse and play a more prominent role in tackling disability stigma (Gormley & Quinn, 2009). Anti-stigma initiatives may lead to decreased stigma among social work students, with the prospects of “increased willingness on the part of social workers to take steps to reduce stigma in their practice and communities” (Covarrubias & Han, 2011, p. 324).

An academic social work initiative with added urgency from rural colleges is clearly warranted due to certain attributes of rural cultures, professional college programs’ expectations and the pervasive and destructive stigmatizing attitudes that exist toward people with disabilities. Recommendations for social work educators with practical guidelines are provided.

Recommendations for Social Work Education

Given the public and personal components of the disability stigma, Scheyett (2008) cautions that anti-stigma interventions must offer a multi-pronged approach. Based on the literature review

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and scholarly analysis, several specific steps designed to reduce stigma and increase services to students with disabilities, specifically psychiatric disabilities, are suggested.

First, an all-campus approach could start by requiring all college faculty members, inclusive of adjunct faculty and staff, to participate in periodic disability awareness and disability-related knowledge training. This training would equip faculty and staff with the tools they need to promote an anti-oppressive campus environment for students, faculty, and staff with disabilities and other stigmatized groups. This training could be designed to reduce the disability stigma. Such training cannot occur in a vacuum, but should augment other educational initiatives that include the regular production and distribution of newsletters, pamphlets, and letters from the directors of social work and other professional programs; workshops and presentations; and other web-based tools with the focus of building disability awareness and social inclusion for people with disabilities on campus and across communities.

Second, social work educators can also lead initiatives by offering disability awareness and advocacy webcasts to field instructors and other helping professionals, community agencies, and community members. Also, social work educators in rural communities could be encouraged to form disability advocacy group alliances that extend beyond the campus domain to build partnerships with mental health service providers and service users in the community. These alliances would help to normalize disability by adding public leverage to disability disclosure and the value of mental health and other disability services usage. Reshaping the culture around disability acceptability and inclusivity in rural areas to encourage disclosure and disability service user involvement will enhance students' self-confidence and esteem.

Third, social work educators can also create an inclusive and affirming environment in which both faculty and students with disabilities are explicitly invited to disclose a disability. This free expression of personalized disability experience can be a powerful medium to provide disability facts to begin reshaping an existing stereotypical

narrative often not grounded in reality (Corbiere, Samson, Villotti, & Pelletier, 2012; Gormley & Quinn, 2009). Faculty members could be charged with demystifying disability within their classrooms by making the classroom an affirmative place to discuss diversity and difference. According to Corbiere et al. (2012), disclosure and stigma are correlated, in that the more people willingly disclose their disability, the more likely the disability stigma will be discredited, which should lead to less disability stigmatization.

To further underwrite an anti-stigma cultural shift in rural colleges and universities for students with disabilities, especially those with psychiatric disabilities, it is important that students who disclose a disability have a positive experience with service provision and accommodations. These successful experiences should be used to promote the benefits of disclosure and treatment. The less stigma and discrimination students who disclose experience, the more likely they will be to disclose. Social work educators should be change agents in this regard.

Fourth, social work programs should also consider developing an integrative learning initiative embedded in a critical anti-oppressive framework (Holley, Stromwell, & Bashor, 2012). Such a framework resonates with social work's social justice focus, with the aim of empowering people with disabilities, addressing power imbalances, promoting disability rights, and confronting disability stigmatizing beliefs held by individuals with disabilities themselves, the general public, and mental health professionals, including social workers (Scheyett, 2008). This educational initiative would offer both knowledge-based and practice/skills based components.

A fifth component of a comprehensive strategy to address stigma involves the delivery of knowledge that would challenge the way in which disability is constructed in society; provide empirical facts about disability; and examine disability as a social, cultural, and political phenomenon as well as a natural part of the human experience. From a critical perspective, this initiative would also prepare students to critically assess the impact of structural/systemic and public stigma and oppression on marginalized groups such as those

with disabilities.

An additional strategy is experiential. Social work educators can create assignments in which students are required to talk with practitioners who have worked with people with disabilities to find out how they navigated the terrain as new practitioners, and share how their perceptions changed or remained the same over time. Furthermore, creating opportunities for students to meet with people with disabilities who are coping well, as well as advocates for people with disabilities, could help students understand these individuals' lived experiences. In this regard, faculty and academic support personnel who have personal disability experience and/or have worked with students with disabilities can serve as self-advocates and resources for students, faculty, and staff.

The practice component would expose social work students to therapeutic models and develop clinical skill sets (see Larson & Corrigan, 2010; Watson et al., 2007) to work with clients with disabilities. Students would not only build their resilience and coping skills, but also learn how to empower clients to claim their rights in addressing power imbalances. Students could also embark on research studies immersed in critical anti-oppressive participatory paradigms to further interrogate disability stigma and formulate strategies to counter this pervasive problem. Service learning projects could also target working with people with disabilities. Importantly, anti-stigma, therapeutic interventions should be assessed for their efficacy in rural settings.

Because increased social contact is associated with lower levels of stigma (Corringan et al., 2001), social work students should be provided with purposeful opportunities to interact with people with all types of disabilities, especially those with more stigmatized disability identities, such as those living with non-apparent psychiatric disabilities. Increased familiarity with people with disability should help to demystify disability and also provide counter narratives to the 'clinical illusion'.

Conclusion

The recent tragic college events in Isla Vista and Oakland, Calif., involving students with psy-

chiatric disabilities lend an even greater urgency to the need to give support and attention to students with psychiatric disabilities. This effort must occur in a collaborative and coordinated manner with college, universities, and community mental health providers. Social work educators are well positioned to lead changes in creating an anti-stigma disability campus climate and shape the new generation of social work mental health practitioners with specific reference to rural communities. With reduced stigma and increased visibility and voice, students with disabilities in professional programs such as social work should be more inclined to seek and receive the support that they need.

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