Article

Fear of Stigmatisation among Students with Disabilities in Austria

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Abstract

In Austria, 12% of all students in higher education report a disability that, at least somewhat, limits their study activities. As they still face many barriers throughout their studies, support services play a key part in their academic success. However, data from the Austrian Student Social Survey demonstrate that every second student with a disability is reluctant to contact fellow students, lecturers, or institutional support in case of study-related difficulties. One in four students with disabilities does not seek any assistance because of stigmatisation fear. With respect to these tendencies, our article examines factors that promote or inhibit the reluctance of students with disabilities to seek support due to fear of stigmatisation. For this purpose, we construct a binary indicator of stigma fear, which encompasses items concerning social isolation or drawbacks to academic opportunities, inhibitions about contacting people or disclosing one's disability. In a regression model, we identify influential factors such as noticeability of disability and degree of study-related limitations as well as social factors like the feeling of anonymity and sense of belonging.

Issue

This article is part of the issue "Students with Disabilities in Higher Education", edited by Geert Van Hove (Ghent University, Belgium/VU Amsterdam, The Netherlands), Minne Bakker (VU Amsterdam, The Netherlands) and Alice Schippers (Disability Studies in the Netherlands/VU Amsterdam, The Netherlands).

1. Introduction

There is broad acceptance across multiple disciplines that disability is not just an individual health problem, but also a complex phenomenon, reflecting the reciprocal relation between naturalism and social constructivism, a person's body and the society one lives in (Kastl, 2010). This consensus is reflected in the definition of the World Health Organisation ([WHO], 2018) where disability is defined:

> As an umbrella term for impairments, activity limitations, and participation restrictions. Disability is the interaction between individuals with a health condition (e.g. cerebral palsy, Down syndrome, and depression) and personal and environmental factors (e.g. negative attitudes, inaccessible transportation and public buildings, and limited social supports).

The intertwinement of individual and collective aspects of disability has also been taken into account at the national level. According to the Austrian Federal Disability Equality Act, disability (in German: *Behinderung*) is the effect of a non-temporary (i.e., lasting more than six months) physical, sensory, mental, or intellectual impairment that impedes participation in society (bmask—Federal Ministry of Labour, Social Affairs and Consumer Protection, 2010).

These are just two examples of the institutionalised social mindset change that has been taking place since the social model—"the bedrock of disability activism" (Shakespeare, 2012, p. 129)—became popular

in the 1980s (Oliver, 1983). It distinguishes between *impairment*—mental or physical deficit—and *disability*—the social response to people with impairments (Shakespeare, 2012).

This article focuses on disability in the context of higher education. Using student-level information from the Austrian Student Social Survey, we define disability as any type of self-reported health impairment that, at least somewhat, limits students' study activities. Thus, our definition attempts to incorporate the social model of disability and to take students' individual perception and "sense of self-concept" (Kimball, Wells, Ostiguy, Manly, & Lauterbach, 2016, p. 97) into consideration.

According to the most recent report on students with disabilities (Terzieva, Dibiasi, Kulhanek, Zaussinger, & Unger, 2016), 12% of students in Austria have a health impairment which, at least somewhat, limits their study activities. Their most common problems are related to unexpected sickness absence episodes, but also to a rigid and inflexible study organisation, as well as problematic social interactions with peers and academic staff. As students with disabilities in Austria still face many barriers in the context of higher education, support services play a key role in their academic success. Terzieva et al. (2016) demonstrate, however, that students have limited knowledge of the support provided by their higher education institution (HEI). Every second student with a disability is reluctant to contact fellow students, lecturers, or institutional support in case of disability-related difficulties. Most students with disabilities are simply not aware that help is available (only 17% know about these offers); others question the benefit of such assistance or prefer to solve the problem on their own. Moreover, one in four students with disabilities does not seek any assistance because they fear social isolation or drawbacks to academic opportunities; they have inhibitions about contacting others or disclosing their disability. Fear of stigmatisation presents a significant barrier to help seeking. This is evident in all disability groups, especially among students with non-apparent disabilities such as mental health problems (Terzieva et al., 2016).

People with disabilities encounter stigma in their daily lives, regardless of whether their disability is apparent or not, disclosed or not. As this also applies to the context of higher education, we investigate both individual characteristics and environmental factors that prevent students from seeking assistance provided by the university or from contacting peers or lecturers in case of difficulties because of fear of stigmatisation.

This article addresses the following research question: which factors promote or inhibit the reluctance of students with disabilities to seek support due to fear of stigmatisation? We argue that a better understanding of the difficulties experienced by students with disabilities may enable HEIs to address and alleviate relevant issues or support students in tackling them.

The article is structured as follows: first, we focus on literature related to the experiences of students with disabilities. We define key concepts regarding disability and stigma and review relevant empirical literature. After briefly elaborating on our methodological choices, we present our findings. We conclude with a discussion of the central ideas and some recommendations that have emerged from our work.

2. Theoretical and Empirical Framework

2.1. Concept of Disability

There are many different theoretical approaches to disability, e.g., moral or social justice; however, it is the medical model and the social construction model that are most influential in both research and practice. The traditional medical model attributes disability solely to biological factors so that only medical treatment could allow a disabled person to participate fully in society. While this model problematises the individual, the social construction approach regards society as the problematic component in disability (Goering, 2015; Kimball, Vaccaro, & Vargas, 2016; Shakespeare, 2012; Waldschmidt, 2005). The social construction model distinguishes between the physical (impairment) and the social (disability) dimension, thus advocating for a shift in focus from "physical limitations of particular individuals to the way the physical and social environments impose limitations upon certain groups or categories of people" (Oliver, 1983, p. 23). These opposed conceptions of disability have been criticised for failing to address the complexity of the disability phenomenon, either by viewing disability as an individual medical problem (a bodily flaw from which social disadvantages derive) that needs to be treated, or by downplaying the health dimension of disabilities and considering social structures as the root cause of any disadvantages experienced (Kimball, Wells, et al., 2016; Shakespeare, 2012).

Disability is a multidimensional phenomenon that differs across cultural, societal and historical contexts. Approaches to measuring disability vary greatly depending on the aspects examined, their purpose and application. The ambiguity of the term might contribute to the major differences in the reported share of students with disabilities. According to the project EUROSTUDENT, though based on a standardised definition, the share of students indicating any type of health impairment or disability ranges from less than 10% in France, Georgia, Romania, Albania, and Serbia to more than 25% in Iceland, the Netherlands, and Sweden (Hauschildt, Vögtle, & Gwosc, 2018). Furthermore, it is evident that not all students with health impairment, chronic illness, mental disorder, or other long-standing health problems perceive themselves as *disabled*. Using appropriate terminology is fundamental to recognising the diversity and complexity of disability. Support services, however, often use very narrow terms, which might account for their inability to address the diverse demand of the student body (Terzieva et al., 2016).

Finally, our analyses focus on higher education students with self-reported health impairment that, at least somewhat, limits their study activities, regardless of the type of impairment. This definition attempts to take students' individual perception of their health condition into consideration and to avoid assigning them to categories with which they do not identify. In other words, if they do not perceive their impairment as a relevant aspect of their experiences on campus, they are not part of our target group.

2.2. Disability Stigma

Regardless of how disability is defined, there is widespread consensus (based on broad empirical evidence) that "people with disabilities constitute a stigmatised group and that disability stigma has a negative impact on students with disabilities in higher education settings", as pointed out by Kimball, Wells et al. (2016, p. 98).

Most closely associated with the work of Erving Goffman (1963), stigma refers to "an attribute that is deeply discrediting", perceived as "an undesired differentness from what we [the *normals*] had anticipated" (Goffman, 1963, p. 5). Goffman identifies three types of stigma: *physical stigma* (any physical deformity), *stigma of character traits* (e.g., unnatural passions, dishonesty, mental disorder, radical political behaviour), and *stigma of group identity* (e.g., race or religion) (Goffman, 1963, p. 5). Since a disability is often considered as stigma, people with disabilities are at risk to experience stigmatisation due to their physical appearance, behaviour, or the fact that they disclosed as disabled. Disability visibility does not automatically mean stigmatisation but may facilitate being stigmatised by others (Cloerkes, 2009). The extent to which individuals' disability is visible to others and possibly does not allow them to *pass for normal*, constitutes a key determinant of their experiences.

Stigma conceals a double perspective depending on whether the differentness is "evident on the spot" or "neither known about by those present nor immediately perceivable by them" (Goffman, 1963, p. 4). Those with a visible stigma—such as a physical disability—are discredited, whereas those with an invisible stigma—such as mental disease or learning disability—are discreditable, i.e., they are not automatically discredited, but face the risk of discredit. In their interaction with *normals*, the discreditable engage in a process of impression or information management with regard to their blemishes—they can decide "to display or not to display; to tell or not to tell; to let on or not to let on; to lie or not to lie; and in each case, to whom, how, when, and where" (Goffman, 1963, p. 42). Hence, not only the stigma but also the effort to conceal it "become 'fixed' as part of personal identity" (Goffman, 1963, p. 42). This impression management occurs when individuals want to convey certain attributes that render them and conceal attributes that (might) stigmatise them (Waterfield & Whelan, 2017, p. 993).

Goffman's distinction between the discredited and the discreditable as well as the process of impression management are fundamental to understanding the significance of the social environment and the decision to conceal or disclose one's disability. In addition, the concepts of public stigma and self-stigma, i.e., the societal discrimination and the "self-imposed behaviours and responses...such as internalising negative social responses, which lead to feelings of rejection" (Corrigan & Kleinlein, 2005) emphasise the relevance of disclosure in reducing or enhancing the impact of stigma. According to these considerations, we do not only focus on students who have already experienced stigmatisation, but also consider the fear of stigmatisation as equally detrimental to individual identity.

2.3. Stigma Effects

Stigma does not remain without consequences. Martin (2010) describes stigma as "a socially constructed mark of disapproval, shame, or disgrace that causes significant disadvantage through the curtailment of opportunities" (Martin, 2010, p. 261). Many researchers acknowledge through various empirical studies that students with disabilities encounter significant stigma effects and attribute their difficulties to disability stigma (Kimball, Wells, et al., 2016; Markoulakis & Kirsh, 2013).

Students with disabilities struggle with fear of stigmatisation and are reluctant to disclose their difficulties on campus in order to protect their privacy and avoid discrimination (Markoulakis & Kirsh, 2013; Martin, 2010; Tinklin, Riddell, & Wilson, 2005). They fear diminished opportunities in their studies but also in future employment endeavours, and community interactions (Martin, 2010). According to Austrian and German survey data (Poskowsky, Heißenberg, Zaussinger, & Brenner, 2018; Terzieva et al., 2016) students with disabilities indicate that their peers, lecturers, and members of administration often have little familiarity with disabilities and do not know how to interact with someone with health impairment. Some believe that their peers hold negative attitudes towards them. Thus, some students choose to deal with their problems on their own and prefer as few people as possible to know about their health condition. Moreover, students with disabilities have troubles networking with fellow students, experience social isolation, and report insufficient study-related exchange (Poskowsky et al., 2018).

Consequences of (fear of) stigmatisation may be even more severe when considering that many students are in a vulnerable position since higher education may require many adjustments—living away from home, making new friends or dealing with financial difficulties (Tinklin et al., 2005, p. 510). Drawing on case studies of students with mental problems, Tinklin et al. (2005) indicate that "the nature of higher education had exacerbated and even created some of the students' difficulties" and that "lack of understanding among lecturers, a

culture in which it was difficult to admit to having difficulties, a lack of support for learning and badly designed learning experiences had all contributed to the students' distress" (Tinklin et al., 2005, p. 510).

Disability stigma may induce a reluctance to disclose one's disability and to seek assistance or to use available services at the HEI (Denhart, 2008; Kranke, Jackson, Taylor, Anderson-Fye, & Floersch, 2013; Markoulakis & Kirsh, 2013; Weiner, 1999). However, research consistently shows that students who take advantage of support services perform better academically (Dong & Lucas, 2016; Kranke et al., 2013; Trammell & Hathaway, 2007; Trammell, 2003). Stigma can be seen as a "powerful force" in preventing students "from gaining access to appropriate support" (Martin, 2010, p. 259). Martin (2010) found that the majority of the students surveyed with mental health difficulties had not disclosed their health-related problems to university staff, even though they affected their studies. The prevalent reason is fear of discrimination and disadvantages (e.g., restricted opportunities at the university or in future employment) arising from the stigma of mental illness. Such negative experiences can leave students feeling "depersonalised, rejected, and disempowered" (Pilgrim, 2009, as cited in Martin, 2010, p. 261). In contrast, students who disclosed their mental health condition to university staff had improved outcomes and report receiving helpful assistance, primarily regarding submission deadlines (Martin, 2010, p. 261).

Kranke et al. (2013) identified three choices that students with non-apparent disabilities make regarding disclosure of their disability to faculty: 1) immediate disclosure, when the functional limitations compromise their success; 2) disclosure after some time, once the risks to their academic performance outweigh the fear of negative perceptions by professors; and 3) no disclosure—the driving force behind students' decision to not disclose is the significant fear of being stigmatised (Kranke et al., 2013, pp. 47–48).

Unlike students with hidden disabilities, those with apparent disabilities do not have the option of not disclosing in order to avoid stigma and prevent undue discrimination. Research shows that students with disabilities report that they do not "deserve" special consideration and do not want to disclose their disability to avoid being perceived as double-minded or as seeking unmerited privileges (Martin, 2010; Terzieva et al., 2016; Weiner, 1999). Some students are not aware that their disability qualified them for academic accommodations because they did not perceive themselves as disabled (Terzieva et al., 2016; Weiner, 1999).

The social environment and the personal contact with peers and faculty play a key role in the process of stigmatisation. Students without disabilities often feel uncomfortable or unsettled because they do not know how to interact with peers with health impairment (Terzieva et al., 2016). According to Fichten and Amsel (1986), stereotypes attributed by students without disabilities to their physically disabled peers can "in-

terfere with the comfortable interaction between the two groups" (Fichten & Amsel, 1986, p. 423). "Able-bodied" students often described those with physical disabilities in negative terms, e.g., "aloof-introverted, lazy-submissive, and ingenuous-unassuming" (Fichten & Amsel, 1986, p. 423), they were attributed less socially desirable traits and perceived to be the opposite of people without disabilities.

3. Methodological Approach

3.1. Data

In the following analysis, we use data from the Austrian Student Social Survey (IHS—Institute for Advanced Studies Vienna, 2016). Designed as a complete student population survey, this cross-sectional study covers a wide spectrum of topics related to the social and economic situation of students. The survey has been carried out at regular intervals since the 1970s and is thus one of the most important sources of information for higher education policy in Austria.

For the purposes of this article, we use the most recent data available—spring semester 2015. The total target population at the time of survey amounts to approximately 318,000 students. More than 47,000 students (valid cases) of all types of HEIs participated in the online survey 2015; among them, 5,424 students reported having a disability that, at least somewhat, limits their study activities (Terzieva et al., 2016, p. 8).

The most recent report on students with disabilities in Austria (Terzieva et al., 2016) shows that the female prevalence of disability is nearly 20% higher than for males (12.5% versus 10.5%), though this gender gap decreases with age. With regard to age, disabled students are on average a year older than the general student population (28.6 years old versus 27.3 years old). These age differences are closely related to different transition patterns, more frequent (health-related) study interruptions, and slower study progress. Students with disabilities tend to transfer from upper-secondary to tertiary education with a delay or enter higher education via a non-traditional route (e.g., students who do not have an upper-secondary qualification, or obtained it later in life via evening classes, adult learning, etc.). They show a comparatively slower study progress due to health-related interruptions or study-related organisational and structural difficulties. Chronic diseases (36%) and mental health problems (33%) are the most often named limitations, followed by sensory impairments (vision and hearing), mobility impairments (10%), and learning disabilities (4%). 65% of students indicate a non-apparent disability, which is a key determinant of their experiences. Noticeability aside, more than half of the students with a disability report severe disability-related limitations in their study activities. Three in four students with disabilities, especially females, face some kind of disability-related difficulties in their studies: unexpected

sickness absence episodes, exam-related barriers, rigid assessment methods, or inflexible study organisation, e.g., compulsory attendance, inflexible registration procedures, tightly arranged exam schedule, strict deadlines, etc. (Terzieva et al., 2016). 53% of students who indicate such difficulties do not seek support from others (lecturers, peers, or institutional support) to solve their issues. Those who seek help are more likely to have a noticeable disability and perceive greater support at their university; among others, every third student feels inadequately supported in their studies. In contrast, students who do not exploit support opportunities are slightly more likely to be male and to experience less disability-related limitations in their studies (Terzieva et al., 2016).

Due to the focus of our analysis, we only take disabled students who did not seek support in case of difficulties into consideration (1,919 valid cases). In order to increase the response rate, the completion time was reduced by introducing several thematic modules only visible for a random 50% of the respondents. Therefore, our logistic regression model is based on 475 cases.

3.2. Methods

We utilised a stepwise logistic regression analysis in order to investigate the determinants of stigmatisation among students with disabilities as a barrier to help seeking. The analysis restricted the sample to students with disabilities who indicate having disability-related difficulties in their studies but did not seek support (39% of all students with disabilities). These students were then asked to choose from a list of twelve motives those that explained their reluctance to seek support. These motives were grouped (ex-post, based on their content and correlations with one another) into *stigma-related* and *not stigma-related* motives (see Table 1): 47% gave at least one stigma-related reason while the remaining 53% named other reasons.

Consequently, our dependent dichotomous variable describes 0 = students with other (not stigma-related) reasons and 1 = students with a fear of stigmatisation (regardless of any additional concerns). Survey participants who did not respond to this question were excluded from the analysis. Since students seeking help were not asked about their motives, we can assume that their coping strategies regarding help seeking and disclosure (e.g., Kranke et al., 2013) may, for some, be related to a fear of stigmatisation (i.e., seeking support does not necessarily mean there is no fear of stigmatisation). Due to this missing information, they are not part of our target group, which allows a more reliable comparison.

Drawing on our theoretical and empirical discussion, the selection of the potential factors is based on the intertwinement of impairment and environment, which is fundamental to the fear of stigmatisation associated with the reluctance to seek support. In order to investigate this interplay between individual and environmental aspects, we take a closer look at its integral parts: disability-related characteristics reflect the individual aspects of impairment, while *objective* study-related and *subjective* well-being concepts account for the environmental factors (within and outside the higher education context). These key aspects of our model are illustrated in Figure 1 and will be described in detail below:

Following the control variables *gender* (0 = male, 1 = female) and age at time of survey (metric), we include specific disability characteristics in a second step: we operationalise the type of disability using two variables—*noticeability* (0 = noticeable immediately or after some time, 1 = not noticeable) and *degree of study-related limitation* (1 = low degree, 4 = high degree). We include the metric variable *size of the study programme*

Table 1. Motives for not seeking support in case of disability-related difficulties in one's studies. Source: Terzieva et al. (2016, p. 37).

	Students with disabilities who did not seek support
Stigma-related motives	
I didn't want to reveal my impairment.	33%
I had inhibitions about contacting people as a result of my impairment-related problems.	28%
Because I was afraid it would put me at a disadvantage in the rest of my studies.	10%
Because I was afraid other students would/will avoid me as a result.	7%
Not stigma-related motives	
I don't think that this would have changed my situation.	66%
It would have been too much effort.	11%
I want(ed) to resolve my problems on my own.	39%
Because nobody had been able to offer me adequate support the last time.	9%
I don't think that my problems give me the right to ask people for support.	28%
I didn't know of anyone I could contact for support/advice.	17%
I don't want to be given "special treatment".	35%
Other reasons	7%
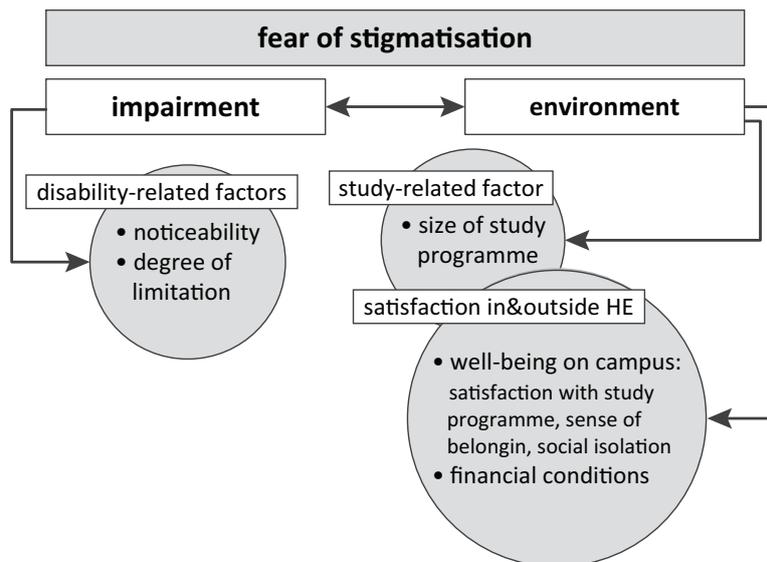
Figure 1. Determinants of fear of stigmatisation associated with the reluctance to seek help.

in step 3. This predictor is used as a proxy for the feeling of anonymity on campus, assuming that study programmes with large numbers of students are associated with a greater feeling of anonymity. When developing the model, we tested different study-related characteristics, e.g., type of HEI or field of study, but they were excluded due to non-significant results or an insufficient number of cases required for the proper performance of a regression analysis.

Finally, we assume that positive environmental conditions for studying have a beneficial effect, i.e., reduce the reluctance to seek help due to fear of stigmatisation. This last step of our model takes the following variables related to well-being on campus or in everyday life into account:

- The predictor *satisfaction with study programme and HEI* is a weighted index of four items: degree of identification with and recommendation of the study programme, fulfilment of expectations and overall satisfaction at the university. The index was built by applying a principal component analysis (revealing a single dimension) and using the factor loadings as weights;
- *A sense of belonging* at the university was measured using a five-point Likert scale (1 = strongly disagree to 5 = strongly agree);
- *A feeling of social isolation* at the university was measured using a five-point Likert scale (1 = strongly disagree to 5 = strongly agree);
- *Financial difficulties* were measured using a five-point Likert scale (1 = "not at all" to 5 = "very strongly") indicating to what extent students were facing financial difficulties at the time of the survey.

4. Results

Table 2 presents descriptive statistics regarding the motives that explained students' reluctance to seek support. Even though there are no significant gender or age differences between the two groups, students who are reluctant to seek help due to fear of stigmatisation are more likely to have severe disability-related limitations or a non-apparent disability. Three quarters report a (very) high degree of study-related limitations due to disability while this applies to half of the students with otherwise (not stigma-)motivated reluctance to help seeking. Furthermore, all variables regarding environmental factors differ significantly between the two groups: students who do not seek support due to fear of stigmatisation are less satisfied with their study programme/HEI, lack a sense of belonging or indicate social isolation. Moreover, they are significantly more likely to be affected by financial difficulties.

In a logistic regression, the dependent variable *fear of stigma* (yes or no) was regressed on a number of predictors. The values of the regression coefficients (βx) determine the direction of the relationship:

$$Y = \beta_0 + \beta_1 * gender + \beta_2 * age + \beta_3 * noticeability + \\ + \beta_4 * limitation + \beta_5 * size + \beta_6 * satisfaction + \\ + \beta_7 * belonging + \beta_8 * isolation + \beta_9 * financial$$

Table 3 presents the odds ratios ($\text{Exp}(\beta)$): values above one indicate that higher values of the explanatory variable increase the predicted probability of the first (not seek assistance due to the fear of stigmatisation) relative to the second outcome (not seek assistance due to other, not stigma-related reasons). Coefficients less than one indicate the opposite. Thus, the ratio of 1,745 for the degree of limitation in the second step of the model indicates that the odds of not seeking assistance due to fear

Table 2. Predictor variables. Data source: Austrian Student Social Survey 2015 (IHS—Institute for Advanced Studies Vienna, 2016).

| | Reluctance to seek support due to | |
	other reasons	stigma fear
Gender [chi-square (1) = 0.162, p = 0.687]		
male	40%	39%
female	60%	61%
Age (*arith. mean*) [t (1846.785) = −1.469, p = 0.142]	28.7y	28.1y
Noticeability of disability [chi-square (1) = 9.015, p = 0.003]		
noticeable	36%	30%
not noticeable	64%	70%
Degree of study-related limitation due to disability [chi-square (3) = 112.010, p = 0.000]		
low	16%	6%
medium	30%	20%
high	34%	38%
very high	20%	36%
Size of study programme (*arith. mean*) (1 unit = 100 students) [t (1911.116) = −1.441, p = 0.150]		
	19.5	17.7
Satisfaction with study programme/HEI (*arith. mean*) (1 = *very* 5 = *not at all*) [t (968.618) = −3.258, p = 0.001]		
	2,3	2,5
Lack of sense of belonging in HE [chi-square (4) = 34.725, p = 0.000]		
strongly disagree	29%	18%
disagree	25%	21%
partly	21%	20%
agree	15%	24%
strongly agree	10%	17%
Social isolation, contact difficulties [chi-square (4) = 44.724, p = 0.000]		
strongly disagree	41%	25%
disagree	20%	20%
partly	16%	16%
agree	15%	19%
strongly agree	8%	20%
Affected by financial difficulties [chi-square (4) = 39.094, p = 0.000]		
not at all	17%	12%
slightly	20%	15%
moderately	26%	23%
strongly	22%	27%
very strongly	15%	23%

of stigmatisation are 75% higher compared to not seeking assistance for other reasons, as the degree of limitation due to disability increases by one scale point.

The model achieves a Nagelkerke's Pseudo R^2 of 20.8% according to Cohen's f (1992), this corresponds to a medium effect (effect size of f = 0.21). The Omnibus tests of model coefficients (chi-square (9) = 79.540, p = .000, n = 475) prove the soundness of the model.

The demographic characteristics age and gender (used as control variables in this model) are not significantly associated with the stigma of fear as a barrier to seeking support. In contrast, the influence of disability-related characteristics is substantial. An increased degree of limitation increases the odds of not seeking

assistance due to fear of stigmatisation. Having a noticeable disability decreases the stigma-related reluctance to seeking help. These effects are significant in each step of the model; the effect strength fluctuates only moderately.

Adding the study programme size as a predictor reveals that an increase in the number of students decreases the relative odds of not seeking assistance due to the fear of stigmatisation.

Finally, the environmental factors added in the last step of the model prove to have a substantial effect on the fear of stigmatisation as a barrier to seeking support. Lacking a sense of belonging to higher education, feelings of social isolation and perceived financial difficulties

Table 3. Determinants of disabled students' reluctance to seek support due to fear of stigmatisation: results of a logistic regression (odds ratio). Data source: Austrian Student Social Survey 2015 (IHS—Institute for Advanced Studies Vienna, 2016).

	Step 1	Step 2	Step 3	Step 4
Demographic characteristics				
Gender: female (versus male)	1.299	1.211	1.258	1.329
Age	0.987	0.992	0.991	0.995
Disability-related variables				
Noticeability of disability				
not noticeable (versus noticeable)		1.652*	1.644*	1.784**
Degree of study-related limitation due to disability				
(high values = high degree of limitation)		1.745***	1.792***	1.605***
Study-related variables				
Size of study programme *(1 unit: 100 students)*			0.989**	0.986**
Satisfaction on campus				
(high values = low satisfaction)				
Satisfaction with study programme / HEI				1.129
Sense of belonging in HE				1.291**
Social isolation, contact difficulties				1.183*
Satisfaction in everyday life				
Financial difficulties *(high values = very serious difficulties)*				1.189*
Constant	1.027	0.134***	0.152***	0.025***
Nagelkerke Pseudo-R^2	0.01	0.102	0.123	0.208

Notes: n = 475; significance levels: * $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$.

are found to be significantly associated with the reluctance to seek support due to fear of stigmatisation. An increase in any of these predictors results in an increased probability of not seeking assistance due to fear of stigmatisation. In contrast, the index regarding satisfaction with the study programme and HEI has no significant influence on the dependent variable.

5. Discussion

This article highlights that the social environment on campus is a key factor in the experiences of students with disabilities and that the concept of stigma plays a decisive role. Students with disabilities are indisputably a stigmatised group and stigma has many negative effects—it upholds barriers to participation and may even exacerbate some of the students' difficulties (Kimball, Wells, et al., 2016; Tinklin et al., 2005). This is why stigma and fear of it prove to be fundamental to seeking support in case of difficulties and respectively to revealing one's health impairment.

This disclosure dilemma may put students' interactions with their social environment at risk. Revealing one's disability is often associated with difficulties regarding social contacts at the university (e.g., study groups or social networks for exchange) which are instrumental for academic success. A good student-faculty relationship is fundamental to receiving disability accommodations, e.g., modifications within courses, open discussion, and disclosure of disability. Similarly, administrative staff plays an important role in the support of students with disabilities. Nevertheless, some students have difficulties communicating with teachers or administrative staff, which can result in problems within courses, e.g., when learning materials are not usable for students, the course design makes it hard for them to participate or there is a lack of flexibility regarding the exam modes (Poskowsky et al., 2018). As our analysis reveals, increased social contact and a greater sense of belonging can decrease stigma-related reluctance to seek support and thus encourage students with disabilities to demand adequate assistance in case of difficulties. These factors prove to be more important than the satisfaction with the study programme. Furthermore, an increase in the study programme size (as a proxy for the feeling of anonymity) decreases the reluctance to contact others due to stigma fear in case of disability-related difficulties. Apart from study-related characteristics, it is the noticeability and the degree of study-related limitations that significantly influence the fear of stigmatisation as a barrier to help seeking—and thus, increase the risk of missing support opportunities. Therefore, non-apparent disabilities should be brought into focus; these are mental health problems, learning disabilities, as well as many chronic diseases.

The fear of stigmatisation regarding support seeking is also influenced by factors outside of the university. Our analysis shows that the financial condition, in particular, financial difficulties, increases the reluctance to seek help due to stigma fear. Here, a vicious cycle becomes apparent: the difficulties faced by students with disabilities go far beyond their study life. They are much more likely to be dissatisfied with their living conditions, have less well-paid jobs, struggle with financial problems, and tend

to be less optimistic about their employment prospects on the labour market, compared to their colleagues without disabilities (e.g., Terzieva et al., 2016).

Nevertheless, there are limitations to this study, which should be noted. Like most studies using student-level data, the analysis relied on self-reported information which may be inaccurate for a variety of reasons (Kimball, Wells et al., 2016; Trammell, 2009). For instance, social desirability and the associated reluctance to disclose one's disability (even in an anonymous survey) may lead to measurement errors and limit the generalisation of the results. Furthermore, some types of disability are rather associated with social stigma, which might have a great influence on the willingness to disclose one's disability (in a questionnaire) and thus lead to their underrepresentation. Participants' self-classification can also be problematic due to the complexity of disability dynamics, especially when dealing with cross-sectional data, which refers only to a specific point in time (Burchardt, 2000). Beyond that, the operationalisation of our theoretical concepts has been inevitably shaped and, to a certain extent, constrained by the data available. For instance, the differentiation between stigma-related and not stigma-related motives is based on theoretical considerations as well as a data-driven exploratory approach, not on a validated instrument. Clearly, a larger number of cases would allow including other covariates, e.g., type of health impairment, and reveal new aspects concerning stigmatisation among students with disabilities.

6. Conclusion and Recommendations

Over the last few decades, the question of the social dimension of higher education has become an issue of great importance in the European Higher Education Area (EHEA). Member states have agreed on the shared goal that entering, participating, and completing higher education (at all levels) should reflect the diversity of the broader population (EHEA, 2007, p. 5). This common vision has been guiding the development and implementation of national and international strategies ever since. However, unlike gender, socioeconomic and ethnic background, disability appears to be less relevant in these documents. In 2017, the Austrian government released a national strategy on the social dimension of higher education (bmwfw—Federal Ministry of Science, Research and Economy 2017). In regard to students with disabilities (one of the target groups), the strategy aims to improve quality and accessibility of information materials and expand support mechanisms, quiet spaces and retreats (bmwfw—Federal Ministry of Science, Research and Economy 2017, pp. 4, 7). However, (probably) due to lack of data, no quantitative goal was set in these strategy documents.

Despite such documents and relevant legislation declaring inclusive aims, many students with disabilities still report unmet needs and unwillingness to seek institutional support, also because "difficulties go be-yond the areas where support is conventionally offered" (Mortimore & Crozier, 2006, p. 247). Based on our results, we argue that addressing stigma is ultimately a cornerstone to a more inclusive higher education environment. Therefore, interventions at all levels and the involvement of all parties (policy makers, management, administration, faculty, and students) are needed. In order to ensure appropriate support for students with disabilities, it is important that HEIs promote a culture of openness and normalisation of disability more proactively, an appeal that has also been made by the participants in the Austrian Student Social Survey (Terzieva et al., 2016). Kendall (2016) calls for a cultural change and for institutions to "encourage students with a disability to disclose prior to the commencement of studies" (Kendall, 2016, p. 10). Mortimore and Crozier (2006) suggest that institutions should apply a more empowering and problem-solving model—acknowledge students' strengths, identify their difficulties and provide adequate support. However, even the best offers may be useless if they miss their target group: in Austria, for instance, an alarmingly high share of students with disabilities is not aware of the existence of support services on campus. Institutions are urged to provide more information about their support services.

Universities should provide teaching staff with "knowledge and resources to support students who may be experiencing difficulties due to their disability" (Padden & Ellis, 2015, p. 433). As suggested by Hopkins (2011), universities can introduce regular, compulsory training around disability awareness for all lecturers and actively encourage applications from disabled people for academic or other posts, especially mentors in disability support services (Hopkins, 2011, p. 724). An example of good practice comes from University College Dublin (UCD), Ireland, which has developed and implemented a communication and training strategy to improve disability awareness among academic staff (Padden & Ellis, 2015). Tips and strategies from the UCD include providing accessible learning materials, improving class delivery methods according to students' feedback, offering a choice of assessment methods, providing detailed assessment information, ensuring consistency of assessment methods, facilitating clear communication between students and faculty, etc. (Padden & Ellis, 2015, p. 443).

Organisational and structural flaws that may impede student progress should be tackled in order to improve learning conditions for both students with and without disabilities. Investigating students' experiences and identifying their needs are essential steps towards the adequate alleviation of barriers. Institutions should consider ways to improve the design of courses, introduce more flexibility in the learning environment, and address the rigidity of study requirements. Removing such barriers could not only prevent negative academic outcomes and decrease dropout rates but also help all students flourish both academically and socially. Creating a caring, sup-

portive and welcoming environment is fundamental to the individual sense of belonging, particularly for students with disabilities, as emphasised by O'Keeffe (2013). On the one hand, "care overcomes the sense of isolation and separateness that a student with disabilities feels and gives him/herself the permission to nevertheless belong and succeed in a frightening and challenging college environment" (Graham-Smith & Lafayette, 2004, as cited in O'Keeffe, 2013, p. 608). On the other hand, university staff and faculty members who disregard the needs of students with disabilities may, by doing so, exacerbate the challenges students experience (O'Keeffe, 2013). Developing a sense of belonging (through good relationships between students and faculty, well-resourced support services and welcoming diversity and difference) is crucial to students' academic success and retention (O'Keeffe, 2013) and may reduce the fear of stigmatisation associated with reluctance to help seeking, as our analysis has shown.

In conclusion, this study and previous research show that despite relevant legislative and social endeavours, there are still many attitudinal and structural barriers for students in higher education. Given the diversity of the student body and the importance of enhancing the social dimension of higher education, it is crucial to respect the interplay of individual and environmental factors as instrumental to students' well-being and success, i.e., institutions should not address issues individually but recognise and consider their interaction. The ultimate goal is to create a more inclusive environment, a culture in which revealing a health problem, admitting having difficulties and seeking support is not associated with stigmatisation, discrimination, distress, or social isolation. Clearly, this is a societal concern not limited to the higher education context—and thus a very high aim.

Conflict of Interests

The authors declare no conflict of interests.

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