The Struggle You Can't See

Experiences of Neurodivergent and Invisibly Disabled Students in Higher Education

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2. Terminology, Categories, and Complicating Factors

Choices of language and construction of categories are always significant when discussing marginalized communities, and perhaps especially so when it comes to neurodiversity and disability. How one rhetorically organizes and refers to disabled people reflects one's own attitudes and understandings at least as much as it does the practical facts of bodies and minds. The 'correct' language is seldom a settled matter, furthermore, and valid arguments can be made for a variety of rhetorical approaches to these complex subjects. Often more important than the individual rhetorical choices is making those choices intentionally, thoughtfully, and explicitly.

Toward this end, this chapter will attempt to comprehensively define the categories and terms that will be in use throughout the remainder of this book. I will explain the ways I have chosen to organize and describe the identities of those I am here calling 'neurodivergent and invisibly disabled students,' and also why these choices are appropriate for my purposes. My framings should not be understood to represent definitive constructions or terminologies for any of the categories in question. They are simply those I have found best suited to the work of this book, and certainly neither without flaws nor necessarily suitable for other contexts. In fact, another element I will discuss as I review my framework will be its limitations, and how the practical realities of students' identities are certain to be far more complex and nuanced than what I am able to describe here.

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Categories Under Consideration

When I say this book is about the experiences of 'neurodivergent and invisibly disabled students,' to whom am I referring? This is admittedly a slightly cumbersome label, though I felt that was necessary to be as accurate and nuanced as possible, but it is still not an unambiguous one. For my purposes here, this label should be understood to include students in six rough categories of conditions, whose experiences I have examined by category and across categories. These conditions are:

1. Dyslexia and related conditions
2. Attention deficit hyperactivity disorder (ADHD)
3. Autism
4. Psychiatric disabilities
5. Traumatic brain injuries (TBI)
6. Disabling chronic physical illnesses

A more extended discussion of how I define each of these categories follows.

Dyslexia and Related Conditions

This category focuses specifically on students with reading, writing, and other lexical challenges that affect their studies. As Oslund (2014) notes, this category is somewhat mislabeled: 'In every day usage, people tend to refer to all language disorders as "dyslexia." While dyslexia is one language disorder, technically, not all language disorders are dyslexia' (p. 68). For the purpose of this work, however, I have followed the everyday usage, primarily because the label of 'dyslexia' tends to be applied to all research studies about students with language disorders, regardless of its complete accuracy. Furthermore, the 'related conditions' mentioned include dysgraphia (specific writing challenges), dyscalculia (specific mathematical challenges), and dyspraxia (specific physical coordination challenges) under this umbrella. While not all of these disabilities are alike, and those that are not 'dyslexia' proper are disabling in educational contexts in specific and unique ways, unfortunately none of the rest have been substantively and separately studied in this context, while dyslexia has. Where they appear in the literature, therefore, I have associated them with the broad 'dyslexia' label because of the taxonomical similarities, while recognizing that this is an imperfect grouping.

ADHD

This category focuses on students who have attention, concentration, memory, and executive function challenges in a higher education context. As noted in Oslund (2014), the specific symptoms and diagnostic criteria for ADHD are particularly complex, which may be compounded by the tendency of ADHD characteristics to shift and evolve over the lifetime of a person with the condition (Shea et al., 2019, p. 20). Hyperactivity, in particular, may tend to be less of an issue for many students by the time they reach college age. The primary unifying theme in ADHD symptoms, in any case, seems to be difficulty with self-regulation (Shea et al., 2019, p. 20). In literature studying student experiences, furthermore, there is a tendency to collapse students with ADHD into other categories of students with learning disabilities, often to the point of using 'ADHD' and 'learning disabilities' interchangeably. This leads into some ambiguities in what are considered characteristics of students with ADHD, as well as some conflation of ADHD symptoms with those that may more accurately be of dyslexia and related conditions. This ambiguity is made both more understandable and more challenging by the fact that there tends to be significant overlap in the symptoms of ADHD and dyslexia, as well as co-occurrence of the two conditions in the same student. These first two categories will therefore often be discussed in conjunction as student experiences are addressed in later chapters.

Autism

I have used the category of 'autism' to broadly encompass all types of expression along the autism spectrum. This means that there is sometimes wide variation in the literature between different students in this category, as by this definition, autistic students may be very different from one another in terms of their behaviors and characteristics. What they are most likely to share in common are challenges in social interaction and relationships, idiosyncratic and repeating behaviors, need for routine and predictability, particular sensitivity to sensory input, and intense focus on particular subjects. It should also be noted that a few terms appear frequently in the literature under study that I choose not to use. One of these is that some studies here refer to Asperger's Disorder (or similar phrasings), as they were published prior to the 2013 removal of Asperger's Disorder from the DSM and reorganization under Autism Spectrum Disorder. Another, however, is that I choose to reject the language of 'high-functioning' and 'low-functioning' autism. As many autistic advocates have noted, these labels prioritize facility in certain areas according to the biases of a neurotypical perspective, and create an unnecessary hierarchization of autistic characteristics and behaviors, while not actually providing meaningful information about where the autistic person in question has facility or needs support, nor recognizing that appropriate support may help them succeed regardless of inherent characteristics (ASAN, 2021). Even where studies have identified student participants using these terms, therefore, I have eschewed them, in favor of specifying characteristics where possible.

Psychiatric Disabilities

This is the term that will be used to encompass mental health disorders, mental illness, and similar chronic or acute illnesses affecting thought, emotions, and behavior. Choice of terminology in this category can be particularly loaded, as Price (2011) acknowledges in the introduction to *Mad at School*, before articulating a rationale for using the term 'mental disability' in that work: to encourage broadness of definition and invite coalition between those with various types of disability that exist within the mind. I greatly respect and appreciate Price's thoughtful choice of 'mental disability' for those purposes, even as I choose 'psychiatric disabilities' for mine: to match the language most commonly used in the research I examine to describe this population. After all, more categories in this work than this one could be referred to as 'mental disabilities,' and here it will be helpful to be more specific to contrast with those, even when there is also significant overlap between categories. 'Psychiatric disabilities' is the term I found to recur most often in research studies when referring to the types of conditions in this category, and even those that did not use it tended to use terms ('mental illness,' 'mental health disorders,' etc.) with a similar connotation of disease in need of medical treatment. This is not necessarily correct or incorrect as a rhetorical framing, but it is one that I find worth explicitly recognizing. In any case, by far the most commonly occurring conditions in this category, in the literature and typically in general, are anxiety and depression. A few studies, however, also deal with students living with others, such as post-traumatic stress disorder or psychosis.

Traumatic Brain Injuries (TBI)

This category deals with students who have experienced a physical injury to the brain that has caused disabling changes in thinking and cognition, motor coordination, emotion, behavior, or day-to-day-functioning, or combinations of any of these. While there are relatively few studies specifically on students with TBI, they are somewhat more often included in broader studies of students with multiple types of invisible disabilities. This is also arguably one of the categories with the most variation in form, presentation, and impact, leading sometimes to inconsistent conclusions between and even within research studies.

Disabling Chronic Physical Illness

While I will refer to this category simply as 'chronic illness' for the most part in the text, some qualification is useful at this definitional stage. Here I am referring specifically to chronic illness that is physical in nature, to distinguish it from other types of chronic illness, which fall under other categories in this work. I am also referring specifically to chronic illness that is disabling, to distinguish it from minor conditions that may be experienced in the long term but do not significantly impact day-to-day life activities. Those conditions still encompass a very wide variety of individual impairments, making this in many ways a slippery category with elusive boundaries. In general, I have chosen only to include conditions that cannot inherently or normally be perceived by an outside observer, and that cause a significant impact to the student's life, based on self-descriptions in the relevant studies. As with TBI, however, these criteria for inclusion have occasionally resulted in a widely varying set of presentations and conclusions.

Why These, and Why Not Others?

Of the top ten types of disabilities in students aged three through twenty-one served by IDEA, I would describe six as most likely to go unnoticed by the average external observer: specific learning disability, health impairment, autism, development delay, intellectual disability, and emotional disturbance (National Center for Education Statistics, 2023). The categories I have chosen here are what I have found to be the most commonly occurring manifestations of these disability types in studies of college students' experiences: dyslexia and related conditions are most common in terms of learning disabilities, ADHD may be classed as a learning or an intellectual disability, and traumatic brain injuries may cause symptoms that span a number of these disability types. While not all of the studies that I have examined have used these exact terms to describe their studied populations, they have all fallen into these rough categories.

Of course, this is not a comprehensive list of all invisible disabilities and neurodiversity. Visual, hearing, and mobility disabilities, for example, may also affect college students in ways that are not obvious to an outside observer. These types of disability, however, are more likely to at least affect the student's interactions with the environment in visible ways. The same is true of conditions like epilepsy, and other physical and neurological illnesses that were not included within the scope of my research. They are also less common in this age group than those that I have listed, as the NCES data shows. For my purposes here, I was interested in the specific experiences of students with a physical or mental difference that cannot be readily observed by others, and that therefore may be treated with doubt, skepticism, and lack of understanding by others, in ways that compound barriers and make supports more challenging to obtain. I was also forced to exclude some types of neurodivergence and disability—Tourette syndrome, for one notable example—simply because sufficient research had not been conducted on the experiences of students with those types of conditions. Hopefully this limitation will be removed as research continues in this area.

It is also worth noting that, in many ways, chronic illness seems like the odd category out in my chosen list. It is the only type of disability listed that does not necessarily relate to cognition, for one thing, and for another, though it is still more likely to be invisible than not, it is more likely to manifest in externally visible ways than are the others. Indeed, initially I only included chronic illness in my research out of personal interest, due to my own experiences in this area. Once I had begun to explore student experiences with chronic illness, however, I found that the population of chronically ill students significantly overlaps with the other categories I was studying, and that similar inherent issues and patterns are shared across the experiences of chronically ill students and the students in the other categories. Based on my observations, I have come to believe that chronic illness should be examined alongside disabilities relating to cognition, emotion, and behavior, if only for these reasons.

Why these Labels for the Categories?

Admittedly, the terms that I have chosen to define each of these categories tend toward medicalized diagnostic labels, which is potentially problematic. Classifying students' experiences in this way can tread in the territory of what Linton (1998) has called 'medical meaning-making,' or imposing narratives of medical impairment and rehabilitation on disabled people's experiences even when it is not appropriate. Indeed, many of the studies I have examined do not even internally use these labels to describe the students who were interviewed, even when I have classified them according to these terms for the purposes of my work. Hollins and Foley (2013), for example, classify the self-descriptions of their participants by the impact of the impairment(s) on each student's learning, which I found to be a thoughtfully nuanced and possibly more helpful approach for their purposes.

In my case, however, my system of organization has its basis in my methodology, which was a review of the literature. As a librarian, I am uniquely equipped with the skillset for this research approach, but I am also acutely aware of some of the more problematic aspects of a literature search on a topic like this, and one such aspect is the use of controlled vocabulary. In the organization of information, a controlled vocabulary is a set of terms that are used to standardize the potentially disparate language that may be used to refer to a single topic, to facilitate more effective searching and browsing. For example, a controlled vocabulary might implement 'ADHD' as the term to be used over 'attention deficit hyperactivity disorder,' 'attention deficit disorder,' and similar terms when searching for the same concept. In searching for scholarly literature, this generally takes the form of subject terms and thesauri within library databases, which can be used to help select appropriate, relevant search terms for the desired results. When searching, I used controlled vocabulary terms to guide my choices of language for each category. The main exception was the case of psychiatric disabilities, where I needed to employ a variety of possible terms, but even then I ultimately chose to name the category for the descriptor used in common by the greatest majority of studies.

Controlled vocabularies, however, are necessarily human-generated and particularly laborious to produce and maintain. Because of these factors, and because of the wide range of perspectives on a topic they must serve, they tend to be conservative in their choices of terms, and slow to adapt to social-justice-oriented shifts in language on sensitive topics relating to marginalized communities. True to form, the standard subject terms in use for the types of difference I chose to study reflect a medicalized, regimented construction of types of neurodivergence and invisible disability, which many activists and advocates would find outdated, if not outright oppressive. Nevertheless, these were the terms that were applied to the studies that I wished to locate, and that I therefore needed to use to retrieve that information. As a result, I label my categories roughly according to the vocabulary that I mainly used to conduct my literature search, both for the sake of accuracy and to implicitly acknowledge the limitations imposed by my research medium.

Problems of Defining Categories

As tidy as these categories may appear on paper, furthermore, in the actual lives of students the truth is always much more complex. While such labels are helpful in organizing and understanding the available information, they are not without their problems in application to lived experience. One significant problem is that defining these categories this way implies that each of these conditions exists as a binary system: either a student 'has ADHD' or 'is chronically ill,' definitively and completely and in all respects, or does not and is not. This is a general understanding of disability and neurodivergence, in fact, that is as prevalent as it is overly simplistic. The reality is that each of these categories in some way represents a continuum, as Fletcher et al. (2018) explain with regard to learning disabilities, along which cutoff points or boundaries have to be artificially imposed to determine what constitutes 'disabled' on one side, and 'not disabled' on the other (pp. 35–36). This will, of course, always be a source of intense discomfort for those closest to that cutoff line, from either side. Many students who would be diagnosed as nondisabled or neurotypical may have one or more significant disabled or neurodivergent traits, just not to the same degree or in the same quantity as students diagnosed as disabled or neurodivergent. The reverse is also true: some students who would be diagnosed as disabled or neurodivergent by standard criteria nonetheless may not be significantly impacted by some of the classic traits associated with that diagnosis. People who fit into these categories are not of another species; the characteristics that affect their lives are part of the complete range of variation in human minds and bodies, and those variations show up in many forms and degrees, within and without the imposed boundaries of what constitutes a disability. This is not at all to suggest, however, that students in these categories do not need or deserve supports to help them be successful, or that they are not truly disadvantaged or discriminated against in education, or that their differences are insignificant because 'everyone feels that way sometimes.' On the contrary, it is to suggest that far more students could benefit from supports, flexibility, and increased accessibility than just those who receive formal diagnoses in these categories, and that the common gatekeeping idea that only certain students are 'disabled enough' to 'deserve' supports and accommodations is fundamentally flawed.

This is particularly true because not nearly all students who *could* be diagnosed with these conditions *are* diagnosed—or share their diagnosis with their educational institutions, even if they are. As will be discussed in detail in later chapters, one of the single biggest problems in supporting invisibly disabled and neurodivergent students is how commonly they are diagnosed late in life, not diagnosed at all, alienated from their diagnosis, determined not to seek support in spite of it, or some combination of these. Even when a student, their parents, and their teachers may suspect the student is disabled or neurodivergent, obtaining a formal diagnosis is often a costly process in time and money in itself, and not necessarily available to all. Furthermore, by their inherent nature, invisible disabilities are easily overlooked, both by others and by students themselves, who have no basis for comparison for their internal experiences. Especially with disabilities that affect learning and cognition, students may assume that their struggles are universal and must simply be overcome, or internalize others' harmful and ill-informed accusations of laziness, underachievement, and lack of capacity for learning. Conditions in these categories may also vary widely enough in presentation that students with atypical symptoms may have difficulty being accurately diagnosed simply because they defy typical categorization.

Even when formally diagnosed, students may continue to doubt and blame themselves, or feel that they do not 'count' as disabled, or believe that they do not 'deserve' support. They may also resist asking for help for a variety of rational reasons, such as fear of stigma when they disclose negatively stereotyped conditions, or lack of time to navigate the bureaucracy of receiving accommodations, or lack of confidence that the available supports will be helpful even if they are obtained. Because of the uniquely malleable nature of disability, personal identification as disabled can be complex, precarious, and conditional with any type of impairment, as noted by Siebers (2016, pp. 4–6) among others. This is doubly true in those with invisible disabilities, as they do not fit the common expectation of what disability looks like. Alienation from the idea of being disabled is also, necessarily, alienation from the idea of having accessibility needs, and makes these students less likely to seek out explanations or adjustments for difficulties in learning that they may not realize are excessive.

A final factor that complicates the categories I have listed here, also, is that they are by no means as discrete from one another as my description so far has implied. As will also become apparent in later chapters, there is significant overlap and permeability between many of the categories under discussion here, where characteristics of one may not be readily distinguishable from those of another. There is also, similarly, a great deal of co-occurrence of these categories—to the point that I have found it to be more common for any given student interviewed in a research study to fit more than one of these categories than to fit only one. Some degree of psychiatric disability, in particular, is extremely likely to coexist with a disability or neurodivergence in any of the other categories, in some cases related to the other condition and in some not. This intertwining of these categories is one of the strongest reasons that I find it most logical to examine them all as a group, rather than focusing on only one or a smaller grouping.

Choices of Terminology

'Neurodivergent and invisibly disabled'

As mentioned near the beginning of this chapter, I have chosen the term 'neurodivergent and invisibly disabled' (and similar permutations) to refer to the entire population under discussion in this book, in spite of the clumsiness of the term. The obvious question would be why I do not simply say 'invisibly disabled,' if I am already defining this term in a specific way that admittedly does exclude some recognized forms of invisible disability. Some neurodivergent people might even refer to themselves as having an invisible disability. The main reason that I have chosen to use both terms, however, is that others would not identify as having a disability—even if they would identify as disabled. The distinction between the two points to a gap between different rhetorical framings of what being 'disabled' means.

The neurodiversity paradigm, which has been embraced by many activists for the civil rights of neurodivergent people, positions neurotypicality and various forms of neurodivergence as value-neutral variations in modes of human thought and behavior. It also rejects pathologizing terminology like 'disorder' to refer to neurodivergence, and prioritizes happy and healthy lives for neurodivergent people, and not 'curing' or otherwise eliminating neurodivergence. Silberman (2015), for example, uses the metaphor of computer operating systems to explain the framing, in the sense that two systems may run in quite different ways but neither is broken (p. 471). There have been critiques of the neurodiversity paradigm, claiming that it fails to adequately recognize that some neurodivergent people struggle with major difficulties because of their conditions, and that it gives outsized power to those most able to communicate and advocate in neurotypical-like ways (Russell, 2019, pp. 293–294). I and many neurodiversity advocates would argue, however, that it is instead having to operate within a neurotypically-dominated society that gives the advantage to certain neurodivergent voices, not the nature of the movement itself. Furthermore, framing neurodivergence as value-neutral does not mean that it presents no difficulties for neurodivergent people that need to be addressed. Rather, neurodiversity advocacy positions those difficulties with the biases and oppression of dominant neurotypical culture, rather than within neurodivergent people themselves. This is the crux of the distinction between 'having a disability' and 'disabled' mentioned above. As Walker (2021) frames this distinction:

> To say 'autism is a disability' is to perpetuate the frameworks of the pathology paradigm and the medical model of disability, by framing autism as a problem located within the autistic individual. To say 'autistic people are disabled,' by contrast, embraces the frameworks of the neurodiversity paradigm and the social model of disability—and opens the door to better approaches to autistic well-being—by framing autistic disablement as being the result of correctible mismatches between autistic needs and societal accommodations. (pp. 65–66)

In this framing, while the neurodivergent person does indeed experience hardship arising from their condition, that hardship is the result of navigating an environment not suited to them, not evidence that their condition is a disease to be cured.

This is not to say, however, that critiques of the neurodiversity paradigm are not substantive, nor that this is the only one. Much of the advocacy for the paradigm has been from white neurodivergent activists, for example, and DisCrit and other critiques of color of the paradigm have begun to emerge, pointing to the white-centrism of many of its constructions and priorities (Kofke & Krazinski, 2024); for one example, the serious risks of police violence that face Black autistic men deserve urgent attention and work and have yet to be prioritized by most research (Hutson et al., 2022). In theory, the neurodiversity paradigm is not by any means exclusive of addressing key intersectional concerns, but in practice its focus has a tendency to skew white, simply because of the whiteness of who is likely to self-identify and be identified as neurodivergent (as will be discussed in more detail in Chapter 6). There are also questions to be raised as to whether the specialized framing of 'neurodiversity' constitutes a form of stratification and lateral ableism, attempting to elevate and valorize one type of disability by declining to associate it with the label of 'disability' at all, and meanwhile tacitly conceding the framing of disability as inherently negative—not entirely dissimilar from the historical moves of the Deaf community described in Chapter 1. These concerns should be acknowledged and are worth considering. Nonetheless, given the embrace of the neurodiversity paradigm by the most prominent liberatory activists in this area and the positive aspects it does offer, I have chosen to make use of the term 'neurodivergent' in this context, albeit with caveats.

As Walker mentions in the quotation above, for example, the neurodiversity paradigm aligns with the social model of disability, which was developed to support advocacy for the rights of disabled people, in opposition to the medical model's focus on repairing perceived individual faults (Oliver, 1983). Shea et al. (2019) acknowledge the extension of this model into a social justice model, which focuses on the ways that disabled people are marginalized and how ableism pervades social systems, and recognizes the ways that being disabled may intersect with other marginalized identities (pp. 6–7). Gleeson (1998) also notes how this model has been deepened by theorists, including Oliver (1996), to describe disability as 'both a socially and historically relative identity that is *produced* [author's emphasis] by society' (p. 25). To perhaps oversimplify, what constitutes being disabled is contextual and linked to the norms and expectations of one's culture, and a person who is positioned as disabled in one context might not be so in another. Among other things, these framings help to clarify why disability is so difficult to concretely define: like race, rather than an empirical, biological fact, it can instead be understood as a category of marginalization, constructed by perceptions, culture, and systems in its local context.

Under this definition, as Walker (2021) also recognizes, not all neurodivergent people are disabled. Within the overlapping cultural contexts of the United States, of the West, and of higher education, there are certainly college students who I would classify as neurodivergent who nonetheless are not meaningfully disabled by the systems and perceptions around them. Even so, however, these students may have unique experiences and even hardships in higher education that are worth noting alongside those of their disabled peers. There are also neurodivergent students who are disabled, and there are also of course invisibly disabled students considered here who I would not classify as neurodivergent. For these reasons, I have chosen to include both of these overlapping categories when referring to my complete population in the interest of greatest accuracy, with the acknowledgment that sometimes both terms are referring to the same set of people, and other times not.

Person-First vs. Identity-First Language

Walker's framing of disability also highlights another contentious element of terminology, which is the choice of whether to use person-first or identity-first language. That is to say, whether to refer to 'people with disabilities' (person-first) or 'disabled people' (identity-first). Many official and professional settings, such as the American Psychological Association for example, have adopted and recommend person-first language. This serves the stated purpose of foregrounding the humanity of people with disabilities, an important response to the frequently dehumanizing history and present of disability rights, and also indicating that an impairment does not define the whole of a person. Disability rights advocates like Walker, however, contest this language for the reasons stated, out of the rhetorical framing of the social model of disability: that this language still positions a 'disability' as a fault located in the individual, and it is preferable to emphasize the 'disablement' that results from systemic failures and oppression of those with an impairment. Scholarship in disability studies has also often chosen to adopt this language for the same reasons, such as in the example of Gleeson (1998). As Shea et al. (2019) point out, however, some controversy over the terms still remains.

My personal conclusion has been that both terms have something to offer in terms of their rhetorical focus, but in most cases I do prefer to use identify-first language in this book, because my goal is to address the social justice issue of how higher education environments are disabling. In particular, I have chosen to use only identify-first language when referring to neurodivergent people and especially autistic people, as a particularly strong consensus has formed among advocates for these communities rejecting person-first language (Sinclair, 1999; Walker, 2021).

When referring to invisible disabilities more broadly, however, I have chosen to follow the professional recommendation of some psychologists to use both configurations of language (Dunn & Andrews, 2015). I vary between person-first and identity-first language throughout the text, and this is not an inadvertent inconsistency but an intentional choice. In so doing, I intend to recognize that while ableist environments and systems are indeed disabling in all cases, many invisibly disabled people *do* also experience disability as an intrinsic and unwelcome burden, from which they might prefer to be rhetorically distanced. Price (2011) acknowledges tension between the disability advocacy model and the experiences of some people with mental disabilities (pp. 12–13), for example, and Wendell (2001) discusses how disability advocacy has often framed disability in ways that exclude people with chronic illnesses.

Furthermore, I am guided by my own perspective as an invisibly disabled person, in which I personally experience suffering that is inherent to the nature of my disabling conditions, as well as suffering that is imposed from without by ableist systems, environments, and expectations—even while I recognize that this is not the experience of all disabled people, particularly not those that Wendell (2001) refers to as the 'healthy disabled.' For me, my conditions simply are not benign variations in possible ways of being, nor even necessarily identities that make me who I am, and I would not be entirely at ease with their being framed that way. They are medical conditions and, while they cannot be 'cured,' they require medical treatment for the sake of my quality of life. At the same time, there are many disabled people who feel just the opposite, and rightly resist the framing of their differences as medical disorders in need of 'curing' (i.e. elimination). Both perspectives are valid, and both belong to people who share the identity of 'disabled,' even while they represent a major divide within that category. It is nonetheless necessary, however, for us to reach across that divide for the sake of our coalition, if for no other reason than because the boundaries within our community are too blurry for us to do otherwise. Is a person with multiple sclerosis or cerebral palsy, for example, more 'disabled' or more 'ill'? For that matter, should every condition that causes suffering in itself be ousted from the category of the disabled, and further splinter a marginalized community already struggling to secure our rights?

It is in recognition of these ambiguities and points of contention that I use only identity-first language for neurodivergent people, but alternate between identity-first and person-first for invisibly disabled people in general. While I recognize that this is an imperfect way of capturing all of the nuance encompassed by these broad labels, it represents my best attempt to acknowledge in a concise phrase the many variations in experience within the conditions under discussion.

Summary and Conclusions

Many complex issues of identity, marginalization, and equity surround any discussion of disabled and neurodivergent students, and these demand care in how we handle language and categorization. With this in mind, I have chosen to identify and categorize the populations under discussion in this book as follows: dyslexic students and those with related conditions, students with ADHD, autistic students, students with psychiatric disabilities, students with traumatic brain injuries, and students with disabling chronic physical illnesses. I chose to use this language because it corresponds to the language used in searching the literature in my research, and I chose these categories because they represent the conditions most likely to invisibly affect the lives of students in my target demographic. At the same time, I also recognize that whether or not a student belongs to one of these categories is in reality a much more complex and nuanced issue than this categorization makes it appear.

I am also mindful of the contextual meaning of the word 'disabled,' and how the social model of disability encourages a view of disablement as a marginalized identity created by social context, rather than necessarily a fact originating from within the body. I have chosen to use the term ‘neurodivergent and invisibly disabled’ to refer to my entire population, to acknowledge that the students whose experiences I have studied represent two overlapping but distinct categories, and to recognize that one is not always the other even when the two may co-occur. Given prevailing sentiment among activists and advocates from these groups, I have also chosen to use only identity-first language when referring to neurodivergent people generally and to autistic people in particular. I vary between identity-first and person-first language for invisibly disabled people, however, to acknowledge that some do experience disablement as more internal, intrinsic, and debilitating. All of these intentional choices will be reflected throughout this book, as I discuss the experiences of different but overlapping populations.