It might seem odd to start with the assertion that bodies are invisible when they are plainly in sight. We all have bodies: meaty, fleshy, breathing bodies that take us through the world. And yet much of the time many people are not aware of their bodies; for the most part, if they are working well, we can ignore them. They disappear from our awareness. Drew Leder (1990) described this as ‘the absent body. The idea is that unless we are injured, sick, in pain or – at a lesser level – hungry, cold or needing the toilet we pay little or no attention to the inner workings of our bodies. We might be aware of what they look like, particularly in the current cultural climate with so much attention given to body shape, diet, clothes and the like, but this is more concerned with the external appearance than a conscious awareness of our bodies as part of us. If they work ‘as they are meant to’, then unless our profession is such that we use them for our craft – as dancers or athletes, say – they are mostly absent from our awareness. Some might argue that even for dancers or athletes it is the pain of such work that calls them to attention (Thomas and Tarr 2009). Leder was a phenomenological philosopher, and as such he was interested in human experiences. He, like Maurice Merleau-Ponty (2002), believed that in order to incorporate the totality of someone’s experience, we needed to include the information that arose from the body. Such an approach might be called ‘embodied’. However, it is worth noting that the term ‘embodied’ is somewhat contested (Sheets-Johnstone 2015). One approach, taken in this chapter, is that to be embodied is about bringing conscious awareness to the feelings, sensations, thoughts, images and emotions that arise from the
body (Leigh 2012). As such, it is both an ongoing process and a state of being (Leigh 2019). Such awareness is not limited (as Leder postulates) to dancers, athletes and the like, but is available to anyone who chooses to pay attention to their body, and the feelings, sensations, thoughts, images and emotions that arise from it. Such attention is not limited to the able-bodied and the ‘well’ but is accessible to anyone, with any body. However, consciously drawing attention to our bodies in this way is, for most of us, a choice. Whatever the state of our bodies, we can choose to pay attention to them or not. This kind of work is hard, and can be process work (Fogel 2009). It is tiring to be self-aware and conscious of one’s body in this way, even while it is valuable, aiding reflexivity and creativity (Leigh and Bailey 2013). However, if a person is in chronic pain, or disabled by their body not working as it ‘should’, such awareness, as Leder points out, is no longer a choice but instead a constant, chronic, unavoidable reality. For those of us who live with chronic pain or disability, our bodies are continually present and reminding us of their presence – they are dys-appearing.

A profession like academia, which is competitive, cerebral (Leigh 2019) and – according to some (e.g. Bloch 2012) – devoid of emotion, is not conducive to embodied awareness of our bodies. Although we all ‘do in academia in our own way’, there are inherent tensions between the collegial and the individual, and between an embodied awareness of our bodies and the fixed structures of teaching, learning and researching. The academy values the mind, the intellect and the work of its inhabitants, in all but a few disciplines to the exclusion of their bodies. Exceptions might be in fields such as drama, dance or performance art, where practice as research is an accepted and valued contribution to knowledge (Thomson 2003). However, even within practice as research, the exegesis or written, intellectual element is an essential part of an output (Trimingham 2002). The practice is not enough on its own, and there is still a requirement for academics to foreground the cerebral rather than the embodied perspective (May 2015).

The very structure of academic work makes our bodies invisible and unimportant. In order to produce written research outputs we sit at desks, type on computers and are asked to put in many hours of work in order to meet externally driven targets (Fitzgerald et al. 2012). Hidden labour behind such work – which might involve our bodies (for example, the thinking, dreaming and moving that might underlie the creative process of writing) – is just that: hidden (Malcolm and Zukas 2009).

Other aspects of academic work, such as meetings, require us to sit, to hear, to maintain attention and to speak out; we also have to transport
ourselves from office to meeting. Likewise, with teaching, we are often constrained to teach inside lecture halls or seminar rooms full of tables and chairs, up stairs or in remote parts of labyrinthine buildings, where we sit or stand in the designated part of the room (e.g. within range of the microphone). The time and space of academia constrains us, and encourages us to ignore our bodies, and any sensations, feelings, thoughts, images or emotions that we might be having (Herring and Standish 2019), and instead to focus only on the cerebral in our thoughts and outputs. However, those academics who have a disability or chronic illness are faced with a reality in which the body makes its presence known and felt. Being an academic takes effort. Living with a disability or chronic illness also takes effort (Livneh and Antonak 1997) and impacts on quality of life (Megari 2013). Being consciously self-aware takes effort. How much more effort, in both a physical and emotional sense, does it take to be an academic with a disability or chronic illness navigating through academia with the necessary self-awareness?

Understanding disability

Although the invisibility of the body in academia on its own is problematic, the lived experience of disability in academia is complicated further as wider understanding of the disabled body is often limited. Typically, disability is understood as a physical or mental impairment that has a substantial and long-term negative effect on individuals’ ability to take part in everyday activities, and may entail accessibility issues that require accommodations. The social model of disability (Oliver 1983) considers disability from the standpoint of the pervasive barriers in society that exclude disabled people. As Oliver himself stated (2013), this social model of disability was meant to develop understanding among non-disabled medical and care professionals and to highlight the fact that every person individually, and indeed society as a whole, can take steps to prevent discrimination against the disabled. As such, the social model was intended as a teaching tool to raise awareness, which it has done. However, the social model does not enable individuals to understand the individuality of experiences. It was never meant to completely replace or overrule the individual model, which had prevailed until the 1980s. While it emphasises society’s role in creating the ‘disability’ label, the focus remains on the dichotomy of disabled versus non-disabled.

One reason the social model of disability became as popular as it did is the societal tendency to impose categories on human diversity and
bleism in academia, as in society more generally, disability is expected to take on particular forms. Examples of disability that are commonly simplified into easily understood binaries include: having a mobility impairment, equated to being completely unable to walk, and publicly signified by using a wheelchair; or having a visual impairment, equated to being completely blind, and publicly signified by using a white stick and/or a guide dog. And therein lies the problem, as accessibility issues, while increasingly considered in our environments, are often still conceived of as binary. In an abled-normative society, the absence of obvious visible identifiers such as a wheelchair results in an automatic assumption of non-disability. Impairments that are not externally visible at a glance, or visible but mistaken for temporary injuries, are not part of the general consciousness, unless the individuals concerned choose to actively and repeatedly publicise them. In this sense, public consciousness frames disability as a rare, tragic, non-normal experience that an individual must overcome (Goffman 1990/1963). In this understanding, as discussed in detail below, a person can either walk up stairs or cannot; there is no space in between. Within this, there is also the implied assumption that if the person can walk up the stairs, then they should. To decide not to take the stairs when there is the (perceived/assumed) physical possibility of doing so incurs negative judgement from others. In our society exercise has positive connotations, and with this and the environmental emphasis on saving energy, to (appear to) choose not to take the stairs and instead use a lift is difficult for able-bodied people to understand in any other framework than laziness.

Irrespective of whether individuals identify with and subscribe to the medical, the individual or the social model of disability, the premise of these approaches is the disabled body as the dis-abled, abnormal, weak body that a person is afflicted with. What if, however, a disabled person does not wish to be addressed in person-first language, but sees their disability as an inextricable part of who they are? This is the premise of crip theory (McRuer 2006). ‘Crippling’ the body means establishing the disabled body not as defunct or defect, but as a complete entity of ‘becoming, reflection and production’ (Goodley 2013, 638). We find such a multi-factor model of disability useful, where an individual’s particular capabilities and characteristics are considered in interaction with the various systems and environments they move through. After all, in reality, disability is not always black or white, but consists of shades of grey. There are diagnostic grey areas and fuzzy boundaries, overlaps and individual differences. Disability may well be understood in terms
of the limitations brought upon individuals through societal barriers, but it is at the same time a personal experience. In our abled-normative society, there is as yet particularly poor understanding of the existential spaces within and between disabilities and chronic illnesses, with pain conditions notably problematic. On the one hand, these conditions result in individuals feeling and being disabled (Deegan 2010); on the other hand, the conditions fluctuate, are often invisible and unproven, contested and doubted, as is the case for conditions that are medically unexplained in general (Kirmayer et al. 2004; Nettleton 2006). In everyday life, this means that there are those of us who use walking aids such as a cane or crutches in particular situations or on some occasions but not others. Where this is the case, we will be asked how we got injured (or how we injured ourselves again, if the person recalls previously seeing us with mobility aids). A much nastier version of this is experienced by ambulant wheelchair users who dare to take a few steps in public, or by those who use disabled parking spaces but then walk to the supermarket to do the shopping. Furthermore, even where difference from the abled norm is acknowledged, it is often assumed by others to be constant. If a person has limitations, it is assumed that these limitations will broadly be the same all the time. This is somewhat understandable as our brains like predictable patterns of simple dichotomies: right and wrong, true and false, disabled and non-disabled.

What is needed is a clear move away from the thought processes of ‘I cannot see that, therefore it is not real or true’ towards a more empathetic stance of mutual kindness, tolerance and acceptance. For disability to be understood in society generally, and more particularly in academia, it is therefore necessary to reframe the parameters for what disability is and means for the individual (see Goffman 1986/1974). Instead of considering the disabled body as non-normative, non-normal, deviant and defunct (Goffman 1990/1963), its fluctuation and variability and thus the fluidity of the disabled experience need to be emphasised (Deegan 2001). Additionally, a new frame (Goffman 1986/1974) needs to incorporate the potential invisibility of disability.

**Invisibility and fluctuation**

As we see it, there are two key issues relating to having a chronic illness as an invisible disability within an abled-normative educational environment. These are *invisibility* and *fluctuation*. 
Firstly, unlike with an ‘obvious’ physical disability, it can be hard for others to see and to recognise that a person has additional challenges in negotiating everyday work and life. In our society, there has recently been a growing voice and presence of those who have an invisible condition, calling out those who would question whether or not an individual has a disability – whether they have a right to a blue badge, to use a disabled toilet or other accommodations. Initiatives such as the purple ‘not all disabilities are visible’ campaign (https://wearepurple.org.uk/not-all-disabilities-are-visible/) have deliberately set out to raise the profile of such conditions and insert them into the conversation. More controversial initiatives such as the sunflower lanyard (see hiddendisabilitiesstore.com), which was rolled out across airports and companies in the UK in 2019, have been designed so that those with an invisible condition can be recognised and supported. These have had a mixed reception from those who might use them as potentially they could visually mark out people based on only one aspect of their identity. However helpful or concerning these schemes may be, they are not generally meant for day-to-day use within a workplace such as academia. They might help us navigate busy train stations, supermarkets or airports, but can they be of use to us as we go about teaching and research?

The second key issue, fluctuation, is similar in that it encompasses the idea that disability and illness is not static and constant. Conditions can fluctuate, so that one day an individual might need to use a wheelchair, on another they may manage with crutches or a stick, and the next week they may need no physical supports to stand or walk. This fluctuating nature of chronic conditions has been recognised in guidance documents on how the Care Act should be implemented (see for example Action for ME et al. 2014). On an individual level, this can be frustrating – not knowing from one day to the next how we might be affected. For others working or living around people with such conditions this can be confusing – e.g. why does a person need to use mobility aids one day, but not on others? Are they making it up? And what does it mean for workplace accessibility arrangements if they are only needed part of the time?

In the particular context of academia, many of our day-to-day tasks and duties can be impacted by invisibility and fluctuations. Our timetables of teaching, research deadlines, committee meetings and the like are often rigid, and have little give in them to accommodate fluctuations of health, pain or energy. We may find ourselves expected to travel across or between campuses, sit in unforgiving chairs, carry heavy loads of paper, books or materials for our students, and having to estimate how possible
this will be on a given day. The physical strength needed to command a lecture hall or teaching space for hours may ‘cost’ us more energy or exert a higher price on our health some days than others. Without visible reminders of disability, we may find ourselves repeatedly scheduled in rooms without adequate accessibility arrangements (although, as can be seen in Fiona Kumari Campbell’s chapter in this volume, physical, visible disability is no guarantee of appropriate or adequate access) or feeling as though we have to explain or justify ourselves continuously to colleagues and/or students. These two issues can play out in several ways:

• Overestimation: If a person has an invisible illness or condition, and appears to be abled, they may be expected to cope with all tasks without appropriate accommodation of needs or differences.

• Underestimation: Conversely, when a person ‘outs’ themself as having a disabling condition, colleagues may perceive them to be ‘too disabled’ to cope with tasks that are well within their capabilities. Both of these can be exacerbated with a fluctuating condition, in which tasks may be too much on some occasions and very achievable on others.

• Lack of flexibility: Academic timetables and systems are often unable to cope with fluctuations in capacity and need, and how specific accommodations might be required at different times, with little warning.

• Disability as an exclusively ‘student’ issue: While there is an increasing amount of scholarship around the support of students, there is little on the presence or support of staff with disabilities or chronic illnesses.

Some universities have disability support services for students that provide advice and equipment, with little similar provision available to staff. In this dichotomy of support there is evidence for the idea that endemic ableism impregnates academia, in the unspoken assumption that staff are not disabled and do not need such services. Indeed, the popular discourse suggests that disabled people are assumed to be not working, ‘on benefits’ or scroungers (Turner 2012), and, as experienced by Kirstein Rummery (see her chapter in this volume), as incapable of the intellectual work necessary to hold down a job in academia.
What this feels like: Using narrative to explore invisibility and fluctuations

In order to share and illustrate what this might feel like to individual academics, we have chosen to include fictionalised reflective extracts from real-life experiences of ableism specifically due to invisible and/or fluctuating conditions. One of these accounts was the basis for an article in the Guardian’s ‘Academics Anonymous’ series and was used to draw attention to and stimulate debate around invisible disability and cognitive dysfunction in academia. It has been included here, along with some of the comments, in order to demonstrate the reactions of academics to those who disclose or make visible their differences. The inclusion of these vignettes draws on fiction as research practice (Leavy 2016) and autoethnographic methods (Ellis and Bochner 2000) and serves to highlight the emotional and social as well as physical aspects of the experience. We are explicitly using them in order to evoke the reality faced and lived by people who have invisible disabilities or chronic illness in academia. Whilst individually each instance of ableism described might not be considered heinous or an intentionally ableist action, the build-up of such microaggressions (Ahmed 2012) takes a toll on the individual emotionally, and in the case of those with chronic illness or disability, often also physically, impacting on their participation in academic activity (Harris 2017).

Stairs: Calculating accessibility

I recently attended an academic event which was spread over four floors of a building with no lifts. My medical condition is not externally visible, although I often use a cane or crutches. I am usually physically able to go both up and down stairs, but often at significant cost. In this case it was acutely painful at the time, and the cumulative effect of the 16 flights in one day rendered me housebound for the following two days, with over a week for pain and mobility levels to return to their usual level. (I only skipped two of the meal/tea breaks, and by skipping all of them I could have reduced the sets of stairs to ‘only’ ten. If you wonder why I did not do this, consider how much useful networking goes on during the unstructured, social parts of conferences.) Throughout the day I observed various other attendees struggling up and
down, or deciding to miss out on sessions that required doing this. Meanwhile, nearby I overheard two of my colleagues talking about the ‘lovely’ building, and how they hoped we would use it again! It was this that actually bothered me the most, and impelled me to share my experience.

I am not suggesting that the able-bodied organisers and staff did not care that their choice of venue was physically detrimental to colleagues (and excluding of others who were not able to manage stairs at all); I think it was just out of the realm of their own current physical experience, and so not a factor in their thought processes. It is not difficult to think of many reasons why both those who do and do not consider themselves disabled might struggle significantly with stairs – musculo-skeletal pain, a fatigue condition, balance issues, breathlessness or a temporary injury. However, accessibility is often considered purely in the either/or, tick-box terms of wheelchair accessibility, and here, in the absence of a wheelchair user speaking up, it was assumed not to be an issue. This is not helped by the fact that those of us affected will often put up with significant pain or stress before complaining and risking being seen as ‘difficult’ by colleagues, or annoying those who will make decisions on future events (and thus, indirectly, who can attend them) – although it is totally understandable. And those who are not physically present may, due to abled norms, be assumed to have other reasons for not attending (if they are remembered at all). I believe these things need to be talked about, although – and perhaps because – it can be uncomfortable for all concerned.

This account demonstrates some of the internal calculations being done by individuals with chronic illness, disabilities or an injury. For example, when we look at flights of stairs we have to include:

- Pain: How much will this hurt now? How long will the (increase in) pain last? How will this affect me today? How much will it hurt later? What will the physical cost be of climbing these stairs, and how will it affect the quality of what I have to do next?
- Energy: How much energy do I have right now? If I can rest, how long will it take to recharge? If I over-exert today, will I have the opportunity to recuperate tomorrow? What will the
energetic cost be of climbing these stairs, and how will it affect the quantity of other things I can do today?

- Time: Will it make me late to locate and wait for the lift (if there is one)? What will I miss? Will I be late and cause a disturbance? If I need to travel to a venue, how much longer will the journey take if I only use step-free stations? What will the time cost be of climbing (or not climbing) these stairs?

These kinds of effects are cumulative, so it is not just important whether there are stairs, it is important how many there are. Similarly, even if there are lifts, if the distance between buildings or rooms is large (including the distance to the toilets, etc.), there will be similar cost-benefit analyses constantly running. Many people have the good fortune to go through life rarely running these kinds of calculations about everyday activities: their body is absent from these considerations; however, academics who are aiming to organise accessible events need to be conscious that some individuals do not have this luxury.

In addition to the physical, energetic and time costs that we have to weigh up, there are interpersonal aspects to consider when we think about whether to take each set of stairs, or move to another room or location. Some of these internal calculations also include: What informal but important conversations, information or opportunities will be missed if I leave to take the lift while the rest of the group walks? In a culture where individual responsibility for our environment is heightening, what will people think of me if I appear to be an able-bodied person choosing to take the lift rather than doing the ‘right’ and ‘healthy’ thing of taking the stairs? Will my colleagues think that I am unfit, weak or lazy, and judge me for it? Do I need to disclose my invisible condition? Every time? If I take the stairs one day but not another, will others think that I am faking or exaggerating the effects of my condition?

**Cognit... I can’t remember the word...**

Difficulties with environmental aspects of the workplace are physical issues. However, invisible disabilities and chronic conditions do not only affect the physical body. They can also affect cognitive function. Examples of the kinds of conditions that can affect cognitive function include brain injury (BrainLine 2018), fibromyalgia (Shiel 2017), multiple sclerosis (Multiple Sclerosis Trust 2018), chemotherapy treatment (Cancer Research UK 2017), the menopause (Biggers and Marcin 2017) and
other conditions associated with ageing, such as forms of dementia. Difficulties in cognition may carry even more stigma within academia than other work environments, as it is such a cerebral profession. If we cannot think, are we truly academics? In another fictionalised autoethnographic reflective extract, we share a story of an individual affected by such issues.

I have a chronic and disabling condition. It’s comparable to sudden-onset acquired brain injury, and it took me over a year to figure out what was going on. I struggled to process information, I had difficulty following a conversation if more than one person was talking, I had panic attacks – I got lost driving down a straight road that I had travelled many times. I didn’t know where I was. I couldn’t think, couldn’t retain information; it felt as though I was in a lonely, isolating fog. Sometimes I could see people talking, or hear the noises that they were making, but I didn’t follow what the words were. I couldn’t understand what was going on. I lost myself. I wasn’t this way before: I was driven, an over-achiever and perfectionist, known for my photographic memory and academic ability. My brain fog came suddenly without warning, and for that year was a constant, pervasive presence. For others it is more variable, as though you can get glimpses of sunshine and normality before it descends once more.

For that year I couldn’t teach. I could hardly write. If I’m honest, looking back, every paper that I wrote in that time was rejected by multiple journals. I couldn’t be creative and clear, because my brain felt like it was smothered in toxic fumes. Normal everyday tasks took longer than they used to. Marking became a marathon of effort with 2,000-word essays taking over an hour to get through. I had bone-crushing fatigue, collapsing into bed at 6 pm. My family were concerned that I had depression; maybe I did, as a result of living in a body and in a life so far removed from the one I had before. I thought I would lose my job, and was terrified to disclose what was happening, but knew that I needed help. I was referred to occupational health, and they gave me a reduced workload while I had tests and appointments with hospital consultants. My manager supported me, but I felt that my team were frustrated that I wasn’t pulling my weight. I didn’t look any different – why did they have to cover my work? I focused on surviving. I was silent in meetings. I did not put my hand up for tasks or roles that might
enhance my career progression; I was looked over and dismissed as opportunities were handed out. I had no energy or capacity to stand up for myself. I just tried to survive. Things started to ease when my consultant began medication, and now as long as I keep taking the drugs every day I can function. Maybe not where I was before this began, but I can function.

As I surfaced from that time, I took stock and began to notice the attitudes around me. They weren’t good. I was told, point blank, that I had to make up for the work I hadn’t done, which I now know goes against the Disability Discrimination Act. I had to prove myself again; I wasn’t taken seriously as a researcher any more.

If you saw me now, you’d not know there was anything wrong with me. I truly have an invisible condition. Even if I am having a bad day or miss a dose of my drugs, you might presume that I was tired, or maybe hungover. But I know that I am not ever going to recover from this. I might get better treatment, I might learn new tricks to help accommodate my capacity, but my condition is progressive. I meet both the Equality Act and the Disability Act definitions of someone who has a disability. I worry I am not seen as an ambitious, valuable scholar. I worry my disability will stop me achieving. I worry my desire to prove myself in this field is impacting negatively on my health. (Academics Anonymous 2017; Courtesy of Guardian News and Media Ltd)

As academics, are we understanding enough of stories such as this? Cognitive dysfunction might occur, as discussed, for a variety of reasons and have a later life onset. In a session delivered on academic ableism in a higher education institution this story was shared, and one reaction was vocalised loudly – ‘They are just making it up to get out of work!’ While this opinion might seem more reminiscent of tabloid newspapers than educated academics, unfortunately it seems that in today’s neoliberal culture of overwork (Davies and Bansel 2005) we are less and less understanding towards others with different needs. This can be seen in the comments sections of anonymous blogs such as that in the Guardian column ‘Academics Anonymous’ (Guardian n.d.), where more experiences of living with illness, disability and mental health have been shared. The responses can be vitriolic and heart-breaking by turn. Some, taken from the piece from which the above extract is drawn, are quoted below:
Work as an academic probably just isn’t for you.

Long hours are non-negotiable. Academic life is a profession, not a job, and you work the hours needed to get it done. Anyone who tries to do it 9–5 will find it very hard to progress and will thoroughly piss off their colleagues.

A lecturer at my university once told me to my face I had no business being there because I was partially sighted. I wish I’d reported him. He tried to ruin my future because he simply didn’t like disabled people, I would have dearly loved to hang him out to dry because that’s what he tried to do to me.

I would strongly advise minimising the effects of any disability to both staff and managers and, if need be, not being honest about the reasons for any effects a long-term condition or disability might have on working life. (Academics Anonymous 2017. Courtesy of Guardian News and Media Ltd)

These comments were made by academics or those interested in the world of academia, and they strongly suggest that if an individual is struggling with their cognitive functions, they have no place in the academic world. There was little compassion, little empathy for the nature of the injury – described as similar to sudden-onset brain injury. We may assume that had the narrative suggested a different cause – such as a chronic illness, cancer treatment or menopause – the responses would be little different. Indeed, the many anonymous blogs concerned with aspects of mental health, disability, invisible disability and ableism in this series and others suggest that this account and the reactions to it are typical. If this is the academic society that we live in, do we want to? Our options are to leave, or to change the environment and culture in which we work.

Dys-appearing bodies: Discussion and conclusion

Academia is often accused of not being diverse (Stewart and Valian 2018) or representative enough (Sian 2019). Meanwhile, we know that across the sector fewer people are disclosing disability or chronic illness than within the general working population (according to data from the Higher Education Statistics Agency). We cannot know whether this is due to academics choosing not to disclose (Brown et al. 2018) or because
they are driven out of the profession or discriminated against when attempting to enter it. We do know that even where they have disclosed, they are under-represented in leadership and senior positions, and over-represented in junior, part-time and precarious temporary positions.

If we are abled, then paying attention to our body and noticing the sensations and information that come from it is a choice. If we have a chronic condition or disability, that choice may not be open to us. Instead, pain or inability forces our bodies into the forefront of our experience (Leder 1990). Chronic pain is tiring (AbleTo 2018). Dealing with disability is tiring (Mackelden 2019). Academia, particularly within its current managerialised and metric-driven context, is tiring (Gill 2009). Academics living with chronic illness or a disability are being forced to confront their dys-appearing body at every turn, within an environment and culture that is not welcoming to difference or diversity. Their brains have to constantly run pain/energy/activity calculations alongside the work they are actually doing, so part of their cognitive ability is taken up with this even while they teach, read, research and write. If they are to attend an event, lecture or conference, they need to spend additional time organising, checking and re-checking accessibility arrangements for the travel, for the event itself, for meals. These academics have to weigh up the risks of choosing to explain and educate others on their conditions or not. This additional labour is not part of the academic load for everyone, but it is for disabled academics, and particularly those with an invisible and/or fluctuating condition.

In this chapter we have argued that working in academia has a hidden cost for persons who have an invisible disability or chronic condition. This might be emotionally draining, entailing dealing with ableism and microaggressions on a daily basis. It might be physically draining, with the demands placed on a hurting or fatigued body such as navigating across campus or up stairs, and the cognitive demands described above. It might be a cost to work–life balance – as the time taken to organise accessibility and to do ordinary tasks such as marking or writing take substantially longer than for others. These costs can have implications for the individuals involved, and also for the institutions that employ them and the sector more widely. If, in our commitment to the Equality Act (and any future legislation against disability discrimination), we want to do more than pay lip service to the law, we need to start valuing different perspectives. We need to bring to the foreground that those who dismiss initiatives aimed at redressing the balance as ‘PC nonsense’ (or similar disparaging terms) are contributing to the systematic exclusion of potential fellow contributors to knowledge. We
need to recognise that being inclusive is also about being empathetic, compassionate humans who have consideration for others. If we want to promote opportunity for our students and staff and celebrate the diversity we find in our campuses and workplaces, some small changes could help create a more inclusive academic environment.

If we take as a starting assumption the fact that there will be diversity in any group, that there will be individuals with many different needs that may not be obvious to others and that might change over time or circumstances, we can build in accessibility. This is encompassed for students in the idea of universal design for learning (Bracken and Novak 2019), and could be extended to a universal design for research, teaching and learning, so also accommodating staff. In turn, this would allow students to encounter and learn from diverse role models, which is an important part of encouraging diversity and equality (Diversity Role Models 2020) – and that diversity must include disability, visible and invisible. Simple aspects of this include looking at institutional branding and print materials and considering accessibility (Featherstone 2015), as well as considering accessibility in all events hosted by an institution as a matter of practice, with guidelines for organisers to follow (see Brown et al. 2018 for suggestions), and having a clear policy on equality, diversity and inclusion matters, backed up by a high-level strategy.

On a more individual and cultural basis, if we as academics see that one of our number is not participating in an activity (e.g. shifting chairs, volunteering to take minutes) and it is not obvious why not, we should assume they have a good reason. It should not be necessary to provide a verbal sick note or to explain every decision. Similarly, while it is appreciated when colleagues do remember impairments or support needs, it is also important not to assume that because an individual has been observed doing something in the past, they necessarily can today. Even more importantly, we should not assume the converse – that because someone could not do something on a previous occasion, it is and will always be impossible. We should trust that individuals (staff or students) know best how to ‘do academia’ in the ways that work best for them – however different those are from the ways of their colleagues. We should not assume that others work or study in the ways that we do, and need to trust their judgement and knowledge of their own body, mind and condition.

Ableism is discrimination in favour of able-bodied people, people who are not ill, who do not have a disability, who are neurotypical. Ableism is the discrimination and social prejudice against people who fall outside those normal boundaries. Ableism characterises such people
as defined by their disabilities and sees them as inferior; unfortunately, it is endemic within the culture and fabric of academia. It is up to all of us to challenge this, to acknowledge our human complexities and fluctuations, including the invisible parts of the iceberg of experience, to celebrate the vivid diversity already present in the academy, while striving for more, and to help make change.

Notes

1 The Equality Act 2010 was put in place to protect people from discrimination in the workplace and in wider society. It replaced multiple previous anti-discrimination laws (including the Disability Discrimination Act 1995) with a single Act. ‘Disability’ is currently defined as ‘a physical or mental impairment that has a “substantial” and “long-term” negative effect on your ability to do normal daily activities’ (Government Equalities Office 2011).

References


Harris, Lysnie. ‘Exploring The Effect of Disability Microaggressions on Sense of Belonging and Participation in College Classrooms’. Logan, UT: School of Psychology, Utah State University, 2017.


