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# Disclosure Dances in Doctoral Education

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**Abstract:** This article reports on a qualitative embodied inquiry that was undertaken to explore the lived experience of disclosure amongst disabled, chronically ill, and/or neurodivergent doctoral researchers. Previous research has shown that disabled, chronically ill, and/or neurodivergent academics apply a cost–benefit analysis to help them decide whether to disclose their needs. This study specifically focused on doctoral researchers and how doctoral researchers navigate the process of disclosure. Twelve participants from the United Kingdom took part. Data collection was via interviews and additional creative submissions. Data was analyzed using reflexive, thematic analysis. The themes generated were disclosure experiences, career considerations, and navigating spaces and academic buildings. The findings show that doctoral researchers' decisions of whether to disclose depends on their individual situations and factors rather than it being a linear, either-or matter.

**Keywords:** disclosure; buildings and spaces; accessibility; chronic illness; disability; neurodivergence

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## 1. Introduction

Discourses in higher education and the wider academic community have identified a stark underrepresentation of individuals with chronic conditions, disabilities, and/or neurodivergence (Brown and Leigh 2018). Statistical reports (HESA 2017, 2020, 2023) highlight that the rate of disclosure falls at particular transition points, such as from undergraduate to postgraduate, from doctoral to postdoctoral researchers, and from junior to senior academics. In parts, these drops in disclosure rate can be explained through the fact that individuals with disabilities do not progress at the same rate as those without (Braddock and Bachelder 1994; Wilkinson and Frieden 2000; Roulstone and Williams 2014). However, research also shows that disclosing chronic conditions, disabilities, and/or neurodivergence is a significant personal and public statement and issue for the persons involved (Charmaz 2010; Stanley et al. 2011). In an environment like academia that prides itself for its productivity and effectiveness (Taylor and Lahad 2019) and that is largely linked to and associated with the male, rational, and cerebral (Valian 2005; Monroe et al. 2008), it is particularly difficult for individuals to admit to and disclose their perceived shortcomings. Disclosure has been described as a sensitive issue and a cost–benefit analysis, where for many members of academia the cost of disclosing a condition or impairment, such as stigmatization and the resulting additional emotional labor, outweigh the benefits of support individuals may receive (Brown 2020, 2021b; Brown and Leigh 2018). Research also highlights the discrepancy of policies and guidelines in relation to accessibility for students and academics (Saltes 2022; Richards et al. 2023).

The literature in relation to ableism and disabilities in academia has increased significantly in the past few years. Publications relate to theorizations of ableism (Brown and Leigh 2020) as well as experiences and lived experiences of ableism in academia (Brown 2021a; Brown and Ramlackhan 2022; Mellifont et al. 2019; Kwon 2024; Dolan 2023; Castro et al. 2024). Research also focuses on policies and initiatives (McCabe 2024; Schippers et al. 2024), on the role of advocacy work (Bromser-Kloeden 2024), and the impact of ableism on individuals (Lindsay and Fuentes 2022). However, publications relating to doctoral researchers remain sparse. The literature considers the doctoral journey as a rite of passage or initiation

(Skakni 2018; Kiley and Wisker 2009; Wisker et al. 2010) or in relation to identity formation (e.g., Fotovatian and Miller 2014; McAlpine et al. 2014; Bosanquet and Cahir 2016), but the roles disabilities, chronic illnesses, and/or neurodivergence play in navigating the doctoral journey are often not mentioned, although the decision to disclose a condition is relevant for an individual's emotional wellbeing and subsequent managing of the condition. If at all, the experiences of disabilities, chronic illnesses, and/or neurodivergence within doctoral education tend to be viewed through a lens of ensuring and fostering diversity (e.g., Peterson and Saia 2022; Ressa and Danforth 2023). Where disabled, chronically ill, and/or neurodivergent students are discussed within the academic realm, such explorations relate to policy developments (e.g., Riddell et al. 2005) or pedagogical approaches to teaching (e.g., Konur 2006) to support students or to highlight challenges to the widening participation initiatives (e.g., Fuller et al. 2004). In recent years, there have been occasional studies exploring the lived experience of disabled, chronically ill, and/or neurodivergent doctoral researchers (e.g., O'Connor et al. 2024; Boulay 2021), although explorations of personal experiences relating to health, illness, and disabilities in academia have been disseminated in public fora for a long time (e.g., Kelsky 2013).

This article reports on research that sought to contribute to the scholarship of disclosure in doctoral education. Rather than solely focusing on the lived experience of disability, chronic illness, and/or neurodivergence amongst doctoral researchers, the aim of this research was to take an embodied approach to understanding how doctoral researchers navigate disclosure. Using the cost–benefit analysis model uncovered in my previous studies with academics (Brown 2020, 2021a; Brown and Leigh 2018), I argue that doctoral researchers' approach to when, why, how, and who they disclose their conditions or impairments to is not linear. Instead, doctoral researchers consciously and unconsciously consider the benefits and drawbacks of disclosure, and then adjust their decision to disclose to the given circumstances, the result of which is likened to a dance.

## 2. Materials and Methods

### *2.1. Methodology*

This research project sought to gain a better understanding of doctoral researchers' lived experiences of disclosure when navigating the doctoral journey under the influence of disabilities, chronic illnesses, and/or neurodivergence. Previous research with disabled, chronically ill, and/or neurodivergent academics highlighted that disclosure is a cost–benefit analysis between concerns of stigmatization (Goffman [1963] 1990) and reasonable adjustments at a public level, but also that academics needed to personally commit and admit to their disability, chronic illness, and/or neurodivergence at a private level to feel they can disclose certain weaknesses and vulnerabilities (Brown and Leigh 2018; Brown 2020, 2021a). At this personal level, academics with disabilities, chronic illnesses, and/or neurodivergence consciously apply strategies of information control (Goffman [1963] 1990) to uphold their public persona. If such disclosure dances (Oldfield et al. 2016) are common amongst established academics, then it stands to reason that doctoral researchers, too, need to carefully navigate their public and private selves, particularly so as they transition from postgraduate students to emerging academics.

The research questions, therefore, were:

- How do doctoral researchers with chronic illnesses, disabilities, and/or neurodivergence navigate disclosure during their doctoral journey?
- How do disabled, chronically ill, and/or neurodivergent doctoral researchers manage their various physical surroundings and working environments in order to accommodate their specific needs?

This project was conceived as an embodied inquiry (Leigh and Brown 2021), an approach that supports a re-evaluation of the body, the role of the body and embodiment, and seeks to reconcile the Cartesian dualism believing that the body and mind cannot be seen as separate from one another. Philosophically, an embodied inquiry links its roots in phenomenology and hermeneutics with three principles about human understanding and communication: (1) the embodiedness of human understanding, (2) the limitations of language, and (3) our use of metaphors.

The fact that human understanding and experiences are fundamentally embodied (Finlay 2015) is best exemplified in how children explore and experience the world. We swaddle, hold, and rock babies so that they learn the world in an embodied way. Additionally, babies and toddlers put objects into their mouths to explore and understand them. In short, humans come into the world as embodied beings and learn the world through embodiment, alongside exposure to language. Language itself is problematic, in that it is limited and limiting, especially when individuals try to explain and describe sensations, such as pain, or other embodied and bodily experiences (Scarry 1985; Sontag 2003; Eccleston 2016). For example, if asked what a headache feels like, many people will begin describing the sensation as "throbbing", "pounding", "splitting", or "pulsating". However, the adjectives in use are not accurate enough to differentiate the experiences of a headache that comes at the onset of a fever, or the headache that is associated with a migraine, or the headache that is the result of a hangover. The words for headache are not necessarily the same, but they still do not express the experience in sufficient detail. Because of the embodiedness of human understanding and the arbitrariness of language, humans turn to metaphorical expressions and forms of communication (Lakoff and Johnson 2003). In fact, verbal expressions like "feeling down" alongside gestures like the "thumbs up" are so commonly used in human communication that, most of the time, we do not even recognize those as metaphors anymore.

These three principles connected with the study of experience (phenomenology) and the recognition that experience is interpreted (hermeneutics) mean that an embodied inquiry sees knowledge as produced, relational, and contextual. Therefore, data generation and analysis in an embodied inquiry are processes in which participants and researchers make sense of experiences together (produced and relational knowledge) whilst recognizing the specificities of the individual experience under study (contextual knowledge).

### *2.2. Sampling*

Participants were recruited via social media, as was approved by my institutional research ethics committee. I simply posted information about my planned research on Twitter (now X), LinkedIn, and in relevant Facebook groups, and I asked doctoral researchers with disabilities who have not or only partly disclosed their needs and who would be interested to take part in the research to contact me via email. Upon receipt of an email as an expression of interest, I provided potential interested parties with the information sheets and consent forms and offered calls and/or emails to clarify any questions and queries. Once a participant was content with the details and the process, and had signed the consent form, we would schedule a video call to record the conversation. As a result, my recruitment strategy, which relied on participants actively opting into the research, led to a rather homogenous sample of doctoral researchers (Jager et al. 2017) who self-selected and were therefore similarly comfortable talking about their disabilities and their navigation of disclosure.

In total, 12 participants took part in the research, 2 of whom were male participants and 10 were female. The participants were all doctoral researchers at different higher education institutions in the United Kingdom. Although there were only 12 participants, the disabilities, chronic illnesses, and/or neurodivergence listed were manifold, as many participants had multiple disabilities or were diagnosed with conditions that are known to have high levels of co-occurring diagnoses. In the following, I list the diagnoses and conditions as the participants shared them: one wheelchair user, one participant requiring the use of a white cane, three people with one or several neurodivergences, which the participants themselves described as autism, Asperger's, dyslexia, dyspraxia, and attention deficit hyperactivity disorder. Participants also mentioned mental health issues such as depression and bipolar disorder. Further, the participants had been diagnosed with fibromyalgia, narcolepsy, asthma, chronic migraines, cystitis, irritable bowel syndrome, postural tachycardia syndrome (POTS), and traumatic brain injury following an accident. Many participants also mentioned fatigue, sensory overload, headaches, and nausea, either on their own or as symptoms in conjunction with and as a result of other conditions and diagnoses.

In view of the wide range of disabilities, chronic illnesses, and neurodivergence represented in this research, the sample size of 12 participants met the criteria for a phenomenological study of a homogenous group (see Hennink and Kaiser 2022; Guest et al. 2020). This is because qualitative research exploring in depth the essence of lived experience is not aimed at generalizability or theoretical saturation, but meaning saturation (Hennink et al. 2017) and "heterogeneities in meaning" (Dworkin 2012, p. 1319). According to research, a sample size between 9 and 17 (Hennink and Kaiser 2022) or between 11 and 16 (Guest et al. 2020) provides the meaning saturation required to achieve resonance through transferability and naturalistic generalization (Tracy 2010).

### 2.3. Methods

For this study, I employed an embodied inquiry as an interpretative qualitative research framework that seeks deep understanding of situated knowledge and contextualized particulars (Willis et al. 2007). To account for individuals' expressiveness and to ensure equal opportunity in participation irrespective of personal needs because of disabilities, chronic illnesses, and/or neurodivergence, I negotiated data generation with each participant individually. Most participants chose to be interviewed with some also asking for submission of supplemental materials, such as poetry they had written or photographs they had taken. The data generated therefore included creative expressions and interviews.

The in-depth interviews that were carried out online lasted between 55 and 60 min, and were video-recorded via the meeting platform Zoom. For the interviews to best fit with the philosophical, theoretical, and methodological principles of an embodied inquiry, I assumed the role and stance of a "data traveler" (Brinkmann and Kvale 2015, p. 57ff.) in my relationship with the participants. Instead of seeing the participants as fountains of knowledge, whose expertise I was mining during a rigidly structured, positivist-like interview, I understood my participants as being on a journey together with me, during which we would collaborate to uncover what it means and feels like to disclose disabilities, chronic illnesses, and/or neurodivergence in doctoral education. The interviews, therefore, were inter-views, views between the interviewer and the interviewee, thus conversations and exchanges between me as the researcher and my participants (Brinkmann and Kvale 2015). In this context, the researcher needs to be both "empathetic and questioning [. . .] to understand, both in the sense of 'trying to see what it is like for someone' and in the sense of 'analysing, illuminating, and making sense of something'" (Smith et al. 2012, p. 36, italics in original). The transcripts therefore looked like natural conversations where I, as the interviewer, interpreted responses in the moment and on-the-fly in order to delve deeper into the interviewees' experiences. Typically, I would ask interpreting questions along the lines of "you said. . . do you mean. . ." or "is it correct to say that. . .". In short, these inter-views were opportunities for joint sense making, a philosophical stance that aligns particularly well with the hermeneutical roots of an embodied inquiry, which suggests that each spiral loop of interpretation enables researchers and participants to travel deeper into the meaning and phenomenon of a particular experience (Leigh and Brown 2021).

### 2.4. Data Analysis

Data analysis was undertaken in several stages. In line with the double-hermeneutics of the researcher making sense of the participant making sense of the data (Smith et al. 2012), joint sense making and analysis between the researcher and the participant took place within and during the interviews. Subsequently, I, as the researcher, collated all of the data, the transcripts from the interviews, along with the creative expressions, photographs, and poetry. All data was kept safe and secure in my institutional storage spaces, as per the approved ethics form. To account for the spread of data appropriately, I applied systematic visuo-textual analysis (Brown and Collins 2021), where I combined the iterative, inductive, semantic thematic analysis (Braun and Clarke 2006, 2019) with analytical approaches commonly used within and borrowed from visual methodologies (Prosser 1998; Rose 2016). The textual analysis of the transcripts was performed in NVivo, with the codes then transferred into the systematic visuo-textual analysis template to enable the combined sense making with the visuals.

In practice, I followed the process of thematic analysis (Braun and Clarke 2006, 2019), beginning with familiarization with the data to generate initial codes, which were be categorized, defined, and redefined into themes. I consistently reminded myself of my active role as an analyst taking conscious decisions around the importance of codes and "keyness" of themes rather than focusing "on quantifiable measures" like prevalence, attention, or size (Braun and Clarke 2006, p. 82). Instead, I maintained my focus on the research question and coded in an iterative spiral. This allowed me to deepen my understanding of the data and enabled me to generate bigger level themes, such as disabilities and symptoms, disclosure, and navigating academia. At this stage, I also engaged with embodied analysis through the practice of painting and collage making. For the visual materials, the two levels of interpretation during systematic visuo-textual analysis (Brown and Collins 2021) were applied. At the first level, I described the materials and what was depicted, and only then did I begin to interpret the data, bearing in mind the question "what do I make of this?". The focus of the analysis at this stage remained on exploring questions of identity and public and private selves. After I had considered all data in connection to these bigger themes, I sought to break down these broader themes into more detailed categories. I specifically looked for participants' descriptions of relationships with others regarding disclosure, of choices and justifications for disclosure and non-disclosure, of navigating physical spaces in academia, and the role of buildings in the decision to disclose. Through the process of manipulating, assembling, and reassembling the data (Deleuze and Guattari 2016) by separating, connecting, and adjusting different categories and codes, I generated the following three themes: disclosure experiences, career considerations, and navigating spaces and academic buildings. These themes are discussed in detail in the next section. To this end, I provide evidence from the interviews as, unfortunately, the creative contributions cannot be shared. The photographs submitted were so individual and contextualized that I could not guarantee my participants' anonymity and confidentiality for reasons of recognizability. As for the poetry and collages, participants granted their consent for the contributions to be used for analytical purposes, but not to be shared in public.

## 3. Results

Through data assembly and reassembly in an iterative analytical process, as described in the previous section, three main themes were generated: (1) disclosure experiences, (2) career considerations, and (3) navigating spaces and academic buildings. Although the themes appear to be clearly defined, they are, in fact, not separable from one another, as there are significant interconnections, for example, between individuals' experiences of navigating spaces in academia and their decisions to disclose. Similarly, previous experiences with disclosing their disabilities, chronic illnesses, and/or neurodivergence resulted in participants becoming more guarded about continued disclosure as they contemplated the development of their academic career more broadly.

### *3.1. Disclosure Experiences*

The matter of making choices around disclosure is not a universal experience, as some disabled, chronically ill, and/or neurodivergent doctoral researchers are quite visibly disabled and therefore openly stigmatized through the equipment and tools they use on a regular basis. For example, the participant requiring a white cane or the participant who is a wheelchair user have not had what they considered the "luxury" of deciding whether they wanted to share their disability. However, for many disabled, chronically ill, and/or neurodivergent doctoral researchers whose disabilities, impairments, and conditions are hidden, disclosure is a careful decision. There are those that disclose quite openly:

> "I did [disclose to the supervisor] because [. . .] I thought it's better if I tell her [supervisor] and not feel so guilty when I'm not as productive. Yeah, for me the reason was to not feel guilt on top of the kind of pressure to be productive." (Participant 1)

> "I knew I had to be up front [. . .] I got sent to disability services to see if there was anything they could help with and I ended up with a really, really supportive disability advisor who I relied on a lot for advice [. . .] being upfront definitely worked for me." (Participant 9)

Disclosure in these cases was seen as an opportunity to relieve pressures but also to access support. Yet, participants also discussed how they felt they were taking a very personal risk in deciding to disclose, as it is often impossible to predict the consequences:

> "I would like to be able to tell them [peers and supervisors], but it never feels right because I don't know how that will turn out." (Participant 8)

> "My fiancée is also in the department in a PhD program. So, he definitely knows but outside of that I've only told maybe two people. I wouldn't deny it, if it was ever brought up. But I haven't gone out of my way to tell people." (Participant 6)

> "I don't think it did me any good to have disclosed it. Having disclosed it to him, I just felt like he saw me as weak. The new supervisor does know and they're of a different generation of academic, and she's a lot younger in that sense [. . .] she has been very understanding." (Participant 5)

When doctoral researchers consider whether or not to disclose their particular needs, they also take into account wider discourses and societal views relating to their specific disability, chronic illness, and/or neurodivergence. Participant 1, for example, was very clear about the perceived differences of mental health issues when it comes to depression or bipolar disorder:

> "I think depression is such a common experience and it's also something that can happen from just environmental triggers. So, I think most people know somebody who was depressed. But quite few people know somebody who was bipolar. And yeah, in my opinion it's also the DSM codes for bipolar that are a bit stigmatizing, because it's always about sex and spending a lot of money." (Participant 1)

This common societal experience that Participant 1 described led to them being significantly more wary about sharing their diagnosis of bipolar disorder, whereas they were relatively comfortable about disclosing the depressive phase within the experience of bipolar disorder.

In addition, for the doctoral researchers, the decision to disclose was linked to their experience of relationships within their doctoral program, their institution, and their network of family and friends:

> "I'm more, just, worried that people will not, still not take it seriously but I'm not embarrassed to say that I am [disabled]." (Participant 10)

> "He [second supervisor] creates a really hostile environment. It's not just in seminars. It's all aspects of any meetings that involve him. I am NOT as open about anything going on with him as I am with my main supervisor." (Participant 4)

> "I've not shared with my classmates. Sadly, I never spoke up about that in class. But my professors, a couple of them had chats about like how it is to manage chronic disease." (Participant 9)

> "I picked those people [peers] because we had first perhaps talked about some aspect of mental health and I think that both of them have some experience with

> mental illness themselves so you get quite good at feeling the waters, if this is somebody who can listen and actually um understand it or at least sympathize in a way." (Participant 1)

From these statements, it emerges that disclosure is only possible once a certain level of trust has been built between the disabled, chronically ill, and/or neurodivergent doctoral researcher and those they would like to disclose to. Yet, this correlation of disclosure and relationships with people is significantly more complex, in that both disclosure and non-disclosure can harm personal relationships:

> "My self-management is mainly my scheduling and eating, and eating only home-cooked meals. I get sick anytime I eat out, so, that's obviously a barrier. How do you explain yourself to your peer friends. Like 'oh I can't go for a doughnut or coffee'. [. . .] Human relationships haven't been too lucky this past year." (Participant 9)

> "Everyone in my program, like professors, they know what's happening. But if for instance it's a visiting lecturer, I'm obviously not gonna go up before they start talking and explain why I'm sitting there [at the back, by the exit door, on the floor]. So, I do think it can make people think that I'm being disrespectful or that I don't care, that I have something better to do." (Participant 7)

As is evident across these interview excerpts, disclosure and the decision on when to disclose and to whom are not issues that are viewed and explored in isolation. Disabled, chronically ill, and/or neurodivergent doctoral researchers rely on previous experiences and connections with others to guide them through this decision phase. But most importantly, they consider the interrelationship between disclosure and wider issues of mental health and wellbeing alongside the consequences of disclosure for human bonds and career progression.

### *3.2. Career Considerations*

The disabled, chronically ill, and/or neurodivergent doctoral researchers who participated in this study spoke quite openly about the disadvantages they experience due to their personal circumstances when it comes to career progression. In contemporary academia, with its precarious contracts and relatively limited job offers, there is little sense of security, which is significantly compounded for people with disabilities, chronic illnesses, and/or neurodivergence. For some participants, having to deal with their conditions and manage specific symptoms feels at odds with the ambition of gaining a secure employment in higher education:

> "I think especially as a PhD student it looked kind of bad if you do that [leave early]. It's one thing if you're a tenure-track faculty member and you just peace out during a meeting, but you don't do that when you're in my position." (Participant 7)

> "Whether you will finish your PhD, so much of that is wrapped up in how competent you seem to your supervisor and to a team whether it's a panel or just the wider supervisory team, you know." (Participant 9)

> "I'm thinking about the people that I've spoken to. I guess the experience of having disclosed does shape the future. So, the person I spoke to this morning, and I said something similar, he has had a bad experience in the past and now he's kind of "Wow, well I'm not sure whether I want to do that, go there again." (Participant 6)

The participants' consideration about career progression was not limited to the immediate doctoral program and the direct relationships with supervisors and peers. There were much wider repercussions that were taken into account. For example, many doctoral researchers mentioned conferences and training sessions, which are often advertised as important opportunities to network, to develop professionally, and through presenting work to an audience to build a reputation as a scholar. Yet, the reality of attending such conferences and training sessions as a disabled, chronically ill, and/or neurodivergent doctoral researcher is stark:

> "I've only attended conferences within the institution thus far.[. . .] Within the institution they tend to be a bit smaller, so yeah, it'd be interesting to see how in that kind of conference and circuit how I am feeling there." (Participant 10)

> "I had one last summer and it was my first. Very overwhelming. It definitely was the moment that I realized, like, I don't know if I can do this like forever, long term." (Participant 6)

> "One of the main problems I have with conferences and training events and things like that is just the sheer volume of information being presented and the length of, the duration of them. Because it tends to be a full day of training, and then social events, or social events and networking in the evening, or like meals and things, that by this point, you know, I'm exhausted. I have a very slow processing speed. I struggle to interpret lots of information, you know. So, when I'm being presented out for the full day, by the end of it, my brain has just turned to a sieve." (Participant 5)

These statements highlight the physicality of attending a conference and what it means to navigate periods of intense information exchange with late-evening social networking opportunities as well as the actual spaces and environments. Yet, managing seminar and conference attendance is more than the mere navigation of the physicality. For disabled, chronically ill, and/or neurodivergent doctoral researchers, extra labor, time, and effort are involved in order to be able to navigate that physicality. Participant 4, for example, experiences between one and six migraines a week. For her, attending a seminar or conference means exploring opportunities to avoid triggers, such as sounds and lights. This means that disabled, chronically ill, and/or neurodivergent doctoral researchers are required to disclose their needs so that they may be able to access these elements of the doctoral program:

> "If I have a conference or if I have a seminar or something like that that I'm attending, I always have to kind of get in touch with the organizer in advance because a lot of our seminar rooms in our university and particularly the ones that our division uses, are either underground or they are they don't have any windows [. . .] certain seminar rooms I kind of almost know to the minute how long I can stay in there. There's certain seminar rooms where I know after 20 min I have to go outside, I have to walk around in the sunlight [to avoid a migraine]." (Participant 4)

Due to the importance placed on research dissemination and professional development within doctoral programs, conferences, seminars, training events, and networking opportunities are often seen as an integral component of the doctoral education. It is through attendance at conferences and training sessions that researchers build relationships that will lead to collaborations and that will provide a detailed enough CV for grant funders to offer financial support for future research. Yet, amongst disabled, chronically ill, and/or neurodivergent doctoral researchers, the consideration of the relationship between disclosure and career is not limited to conferences and training sessions. Instead, significant emphasis is placed on what disclosure may mean in terms of a career as a disabled, chronically ill, and/or neurodivergent doctoral researcher, and whether activist work is therefore then required too:

> "I don't want to be a bipolar activist in academia. I don't want to be the bipolar person. I applied for a job before my PhD as like a research assistant in a project on bipolar or mental illness. And then I thought, nah. Actually, I don't want this to be on my CV necessarily. Especially not so early in my career." (Participant 1)

> "In terms of my career plans, do I plan to become an activist? Probably yes, but that would then include disclosing to my peers. So yeah, I've just kind of taken this slow pace to be, to adapt into my own body and what I need, and the stage of what society needs for me will come later." (Participant 8)

> "I wouldn't say I am an activist, yet. Because I haven't really done anything. But I'm warming towards it, realizing that, you know, I feel like I should do something. Noone else is going to do it. At least in my University, unfortunately." (Participant 10)

It could be argued that this pressure of feeling obliged to become an activist or feeling worried about being associated with activism rather than scholarly endeavors is internalized. And that may well be the case. For disabled, chronically ill, and/or neurodivergent doctoral researchers, however, this pressure is thoroughly felt and real. Therefore, it is not surprising that there is significant contemplation in relation to disclosure in this context.

### *3.3. Navigating Spaces and Academic Buildings*

In many conversations, when asked about how they decide whether to disclose their disabilities, chronic illnesses, and/or neurodivergence, participants highlighted that disclosing often was not a free choice but a necessity. For disabled, chronically ill, and/or neurodivergent doctoral researchers, spaces and buildings in higher education often constitute a significant issue, so that disclosure either occurs naturally through their specific ways of navigating the spaces and buildings or it becomes necessary to receive help in overcoming the barriers to access:

> "Some of the adjustments that I got from the disability services here at this school was to have letters of support for my professors and assignments. Say if I had a flare-up of cystitis or something, that I could talk to them and discuss what alternative either grading or alternative deadline could be done for me." (Participant 8)

> "Light, natural light is really important. If there isn't the natural light, it has an immediate, instant effect on my mood, and it feels very hemmed in." (Participant 3)

> "So, particularly with my migraines, I find that exposure to natural light, particularly like sunlight as opposed to artificial light, reduces the chance that I'll have a migraine." (Participant 4)

Participants with mobility issues, in particular, commented on how inaccessible many university buildings are but also emphasized the message that this conveys. For disabled, chronically ill, and/or neurodivergent doctoral researchers, not being able to access the building in an ordinary manner highlights that they are not welcome in this environment because of their "dysfunctional" bodies:

> "It's one of those things. When we're looking at prejudice and we're looking at barriers, when we talk about things like LGBTQ+ rights, when we're talking about Black Lives Matter, when we're talking about feminism, you can talk. And my problem is I frequently can't even get in the building or the room to have the conversations. [. . .] I have to actually get in the room and that physical barrier, that physicality of the 'I can't even get in the room' is just as offensive as constantly being the person that stopped and searched as a black person, constantly being the person that's misgendered as a transgender person. It's a daily aggression to you, and it's not even micro because it can be a physically damaging aggression to you." (Participant 2)

> "I actually know the back of buildings on my campus so well. I'm not someone who gets in the front door of most buildings [. . .] I even walk in the back way of the library. And that to me is like the central nervous system of a university of

> knowledge. Right? How do you get into a library well, if you're not invited by the front way and you're only invited by the back?" (Participant 11)

In some conversations, Jay Dolmage's (2017) book *Academic Ableism* was mentioned as an example of a scholarly treatise of that personal, everyday experience of inaccessible grand staircases. However, participants felt that their lived experiences went far beyond Dolmage's (2017) initial chapter on staircases. For the general public, the book gives the impression of a static environment. In reality, buildings are not experienced as static at all:

> "Campuses are always changing because there are construction projects and for me that is a big deal." (Participant 6)

Once participants reflected on the non-static nature of buildings, they highlighted what impact people in the buildings have. Not only do the dynamics of the rooms and atmosphere change, but there are also some practical consequences of people navigating spaces, in that they make themselves comfortable and sit down in corridors:

> "You're in the building and I find that there isn't an awareness, you know, of, you know, just how fluid spaces can be. And I have had this warning early when I was getting my guide cane training. [. . .] I don't want to have to look down all the time to make sure I'm not missing a step or miss somebody's backpack or miss a computer cord. I just had no idea how many things people put down on the ground." (Participant 11)

It is important to note in this context that not only participants with visual impairments commented on the busyness of buildings:

> "So, when I talked about the busyness of people, I get very anxious. I can pick up vibes, pick up energies." (Participant 3)

> "You have huge surges of students going through. And as a wheelchair user, you have to use what I call American football techniques to get through crowds. You pick a blocker in front of you, preferably large male, and you follow them and they part the crowd for you. You stay behind them very closely and they do the parting and you keep going through, because, because you're seated, it's exactly the same as car drivers not seeing cyclists and bikes. You're the wrong shape and so you're not seen, and so I am literally walked into any amount of times. And within buildings obviously it's compressed". (Participant 2)

The experiences of the buildings' fluidity are not only physical on a superficial level but are deep and profoundly emotional, thus exacerbating pre-existing mental health concerns like the anxiety described by Participant 3. As a consequence, disabled, chronically ill, and/or neurodivergent doctoral researchers talked about how well they know the buildings and how they consistently plan their days around that knowledge:

> "There is a lot more planning involved. Oh, vast, vast amounts more planning. Even as much as just getting across the campus. You plan your routes." (Participant 1)

> "Sometimes I find I'll avoid certain areas. [. . .] they tend to put out these lemon-scented things to disperse the smell. And I will arrange my route to avoid them wherever they are because I find them very triggering both for my migraines and for my asthma." (Participant 4)

> "I know a lot of people with disabilities who love to teach early in the morning. So that once they leave, most people are coming in." (Participant 9)

> "The other thing is, once it becomes evening, and there aren't people about, then I generally don't work. And the reason for that is: lifts break. And that's the major reason: lifts break. [. . .] And it's not just you're stuck, oh whoa, you know, yeah, I have my mobile with me, I can phone security, they can close estates and go panic. But my wheelchair weighs 132 kg. How the hell do you get that down

> a set of stairs safely for everybody else doing it? You know, I'm not wanting to break anybody else either.". (Participant 2)

> "I know if I'm doing all right that day it's not an issue. But in particular kinds of rooms like the common rooms where people are cooking or where people are eating food because you can't necessarily stand the smell very easily, or perfume of other people, those kinds of things could potentially also mean that you have to navigate your way around back." (Participant 7)

These statements about planning timings and routes across campus and about avoiding certain areas give the impression that individuals are pro-active in dealing with the constrained relationship between their bodies and the buildings they need to navigate. In truth, however, the delivery of the statements belies the tone and nuance of the written transcription. The reflection by Participant 3 brings the matter to the fore:

> "I think, um, there's, there's a theme. It's a pattern, which is that it involves avoidance." (Participant 3)

The navigation of academic spaces and buildings, therefore, is closely connected with and practically wrapped up in the management of their conditions, impairments, and symptoms. Depending on the specific disability, chronic illness, and/or neurodivergence, some coping strategies and mechanisms to manage bodies are simple:

> "I sit in the back but I also physically crack the door, so that the latch wouldn't make a noise if I have to leave." (Participant 7)

> "I also would say that I look for bathrooms that are out of the way, too. Like if I'm going to be sick, I'd really prefer, not to have one of my students walk in, you know, at that moment. So, I try to find the low traffic areas." (Participant 8)

> "I request a quiet room where I can go and lie down and rest because if I have a migraine, I need somewhere to kind of withdraw to." (Participant 4)

On the surface, for people who do not have disabilities, chronic illnesses, and/or neurodivergence, having to navigate requests for quiet rooms, for example, may not seem important. However, there is an emotional toll. Needing to foresee and plan where to sit and what to eat means that individuals are already spending more energy than someone who does not need to plan in that way. This is about the impact disabled, chronically ill, and/or neurodivergent doctoral researchers experience when they begin reconciling their strategies to manage their needs with societal and social demands, for example. Food specifically is often associated with networking and connecting and is a truly social activity. By bringing their own food, disabled, chronically ill, and/or neurodivergent doctoral researchers are othering themselves:

> "You bring in your own foods for lunch and you have your own kind of sandwiches or snacks or wraps or whatever it is, and that makes you stand out, you know. You're avoiding situations where, where food is being eaten together." (Participant 8)

Similarly, there are expectations about open and closed doors:

> "I'm quite sensitive and it's my ADHD. I get very distracted by things around me, and the people in the corridor, and what they're doing. So, I usually shut my door [. . .] I actually feel removed in a way from everybody." (Participant 3)

It is situations like these where the inadvertent othering increases the internalized pressure on disabled, chronically ill, and/or neurodivergent doctoral researchers to disclose their needs. The true importance of pre-planning becomes clear when the planned strategies no longer work because of changes to rooms or building works, as mentioned earlier. What happens if disabled, chronically ill, and/or neurodivergent doctoral researchers cannot leave the building when they need to or if they cannot find that quiet room? In fact, participant 4 did tell of an episode where they had experienced exactly that:

> "The thing is at that point you're just in so much pain, and it's like I need this, what am I meant to do now? And then you end up, like, finding a corner under stairs or something like that, and just literally like curling up on the floor. So, the last conference I was at, um again they promised there would be a room. And it turned out that their plan was that I could use the organizer's office while they carried on using it as an office because they thought, I just needed somewhere quiet to sit. And it was the most disgusting, like, I needed to lie down somewhere, and the floor, I swear that floor had never been hoovered. It was just, it was foul." (Participant 4)

Unfortunately, plans going awry and changes to rooms being made are even more impactful when emergency procedures and evacuation plans are concerned:

> "When I came back to work with my, as I call it, "new normal", I checked what the emergency protocols were, because I was thinking "I better memorize them". I better memorize these spaces because it's also an issue of life or death. And I was actually told "We would like you to wait in your office and we'll come get you."" (Participant 2)

Within the scope of the interviews and in connection with such anecdotes where their detailed plans had failed, research participants often discussed their experiences with ableist attitudes that they encounter in academia. Questions regarding what it feels like to have a disabled, chronically ill, and/or neurodivergent body in academia enabled individuals to open up about their experiences and off-load their daily frustrations. Combined, all of these statements show that navigating buildings with disabilities, chronic illnesses, and/or neurodivergence is not a mean feat but requires careful planning, whilst also allowing for potential emotional upsets and indeed risk of danger to oneself and/or others, such as when the lift breaks with a wheelchair user in it. These experiences are symptomatic of an environment that simply assumes one kind of body and does not allow for any deviance from that norm.

## 4. Discussion

Previous research already showed that disclosure of disabilities, chronic illnesses, and/or neurodivergence is never an easy, simple decision but a sensitive one (Brown 2020) that means that academics engage in a cost–benefit analysis to consider the cost of stigmatization and othering against the benefits of receiving support and reasonable adjustments (Brown and Leigh 2018; Brown 2021a). The findings of this project also point at a cost–benefit analysis, but one that includes the consideration of specific circumstances. Instead of considering disclosure as an either-or matter, "either I disclose or I do not", disabled, chronically ill, and/or neurodivergent doctoral researchers make different choices depending on who the people are they would disclose to and what the contexts are for which they need to disclose. Hence, disclosure is best described as a dance. In their study relating to the lived experience of disclosure in the context of the rather contested diagnosis of fibromyalgia, Oldfield et al. (2016) describe how their participants revealed their illness and their needs selectively and partially in response to or depending on their exposure to scrutiny. In this study, it emerges that the exposure to scrutiny may not always be actual scrutiny but instead could be potential or perceived, as disabled, chronically ill, and/or neurodivergent doctoral researchers avoid situations where they could be subjected to scrutiny in the first place. However, not unlike the participants in Oldfield et al.'s (2016) fibromyalgia study, the doctoral researchers in this project also partially and selectively share their diagnoses and needs for fear of potentially impacting their own career opportunities.

This disclosure of partially sharing details with supervisors, close friends, and organizers of conferences, for example, but decidedly not sharing with other more senior colleagues also means that the disabled, chronically ill, and/or neurodivergent experience their "otherness" as fluid (Barnartt 2010). In a space that is shared amongst abled and disabled people and where the rhythm is set by those rushing through, people whose bodies do not allow them follow that same pattern or rhythm are made more acutely aware of their differences. This experience, although not formally articulated, is evident in most participants' stories, but most prominently in the statements by those participants who depend on others in emergency situations or when lifts break. In short, being disabled, chronically ill, and/or neurodivergent in that shared space evidences and exacerbates individuals' "special needs" beyond what is "normal" (Deegan 2010).

In effect, the physicality of the buildings impact individuals' experiences of their disabilities and "otherness", which, in turn, leads to individuals needing to adopt different kinds of behaviors (Goffman [1959] 1990; Goffman [1963] 1990). Participants in this research talked about their ordinary routines to get to and around campuses and university buildings for practical as well as emotional reasons. At a practical level, there are certain routes that are inaccessible, but at an emotional level, there are instances where individuals avoid crossing paths with colleagues or students. These avoidance techniques are common strategies employed by the stigmatized to counter those particular processes of stigmatization (Goffman [1963] 1990) in order to gain and remain in control over what is known about them (Goffman [1959] 1990). For disabled, chronically ill, and/or neurodivergent doctoral researchers, navigating university buildings therefore simultaneously represents the navigation of their self in their virtual social identity of being an academic and their actual social identity of being disabled (Goffman [1963] 1990). Props and aids, such as backpacks, medications, and canes, may well be needed for assistance, but as these are stigma symbols, they will automatically discredit individuals and out them as different and atypical (Goffman [1963] 1990). Conversely, not using particular stigma symbols or only using them in private spaces enables individuals to separate their public and private personas (Goffman [1959] 1990).

Considering the statistics and the low numbers of disabled members of academia, and considering the narratives of using quiet routes and back doors, the overall invisibility of disabled staff in academia is not surprising. Additionally, many conditions and neurodivergences are not outwardly visible, and individuals may decide to pass (Goffman [1963] 1990) rather than disclose. The resultant behaviors to counteract a narrative of "difference" and "otherness" therefore often leads to feelings of isolation and loneliness amongst those who are disabled, chronically ill, and/or neurodivergent. Additionally, however, the materiality of the buildings and their pace, patterns, and rhythms cause individuals more generally to be on their own amongst the masses.

Being on one's own and loneliness have long been discussed amongst nursing scholars and medical sociologists in connection with elderly people. In these contexts, loneliness is described as an existential anxiety (Casey and Holmes 1995), as a state of silent suffering (Moustakas 2016) or as a sadness and response to pain and desolation (McInnis and White 2001). On rare occasions, being on one's own is equated with a state of wellbeing that is reached in connection with meditative practices or prayer (de Jong Gierveld 1998), which would most commonly be described as solitude. The most relevant description for this study and for what is observable in the video and the interviews is the typology of loneliness as a form of emotional and social isolation (Weiss 1973). The social form of loneliness and isolation is the visible withdrawal from interactions and removal from busyness, whereas the emotional form is an internal experience of being on one's own. Within academia, work is often experienced as paradoxical in that academics work solitarily and yet simultaneously in collaboration (Jandrić 2022). Linked via technology and in collaborative settings, while focusing on individual developments and their own, research academics often are "alone together" (Turkle 2011), an experience that is further perpetuated by neoliberalism at play (Hill 2017). Unfortunately, the line between solitude and loneliness is thin. Where we may observe a person on their own, they may well be lonely. By contrast, some participants talked specifically about withdrawing from given situations to lie down, be on their own, and close the door because they seek solitude, which, in turn, may result in loneliness, as Participant 3 seemed to suggest.

If there is one way to sum up how disabled, chronically ill, and/or neurodivergent people experience academic buildings, it would be that they are lonely amongst the masses. On the one hand, this loneliness is due to the inaccessibility of the buildings and the barriers that inaccessibility represents (Oliver 1983, 2013). On the other hand, this loneliness is also triggered by their innermost feelings and experiences of their own disappearing bodies (Leder 1990). In this context, too, the metaphor of the disclosure dance resonates, as individuals navigate being lonely amongst the masses on emotional and physical levels.

### *4.1. Challenges and Limitations*

Every qualitative research has its challenges and limitations, and so, too, this research raises questions. I am a qualitative researcher who subscribes to an interpretative framework that crystallizes situated knowledge and contextual specificities (Willis et al. 2007) and I apply reflexive thematic analysis within the context of an embodied inquiry. As such, I regularly grapple with "'positivism creep' where positivism [such as issues of generalizability or bias] slips unknowingly into reflexive TA" (Braun and Clarke 2023, p. 2). In my practice as a reflexive thematic analyst and embodied inquirer, I therefore consciously seek ways and opportunities for positioning my coding and theme finding within the context of my own positionality, drawing out personal experiences, anecdotal evidence, and knowledge acquired from the literature. The inclusion of embodied analysis and reflexive journaling, specifically, allow me to situate myself within and in relation to my research. As a result, the themes presented from this research were not generated in relation to quantifiable measures of how many participants said what and what kinds of participants mentioned specific details. Instead, the themes are important and relevant in relation to the research objective of being able to suggest recommendations for practices. Naturally, therefore, it may appear that certain kinds of disabilities have been favored in my analysis as I discuss "navigating spaces and academic buildings". However, it is wrong to assume that only participants with mobility issues emphasized the barriers experienced in spaces and buildings. Smells, sounds, and the general busyness of spaces were also discussed by participants with neurodivergence and neurological conditions, for example. A limitation to this study, therefore, is not an issue of applicability of the themes or how the themes were generated during analysis but the participant sample. Having focused on a convenience sampling of disabled doctoral researchers who would be willing to participate in the research means that I cannot draw specific conclusions for particular kinds of disabilities or intersectional experiences. Instead, in line with previous ableism research, I focus on a holistic picture of experiences amongst doctoral researchers with disabilities.

### *4.2. Implications and Future Directions*

Bearing in mind the lived experience of disclosure and how there are very specific parameters that coalesce for individuals to feel that they can or should disclose, the question arises what the implications of these findings may be.

Above all, what disabled, chronically ill, and/or neurodivergent doctoral researchers themselves ask for is that others in higher education share their struggles and stories more openly. In theory, the Equality Act 2010 in the United Kingdom should protect individuals against discrimination and should therefore support equal opportunities. In reality, however, disability struggles are rarely talked about, and even less so in higher education. Participants were convinced that higher levels of transparency would foster a culture of disclosure, where disabilities, chronic illnesses, and/or neurodivergence are not seen as weaknesses but as facts of life. In turn, this would increase the visibility of disabilities, chronic illnesses, and/or neurodivergence in academia, which would also lead to subsequent generations of doctoral researchers having role models they can look up to and aspire to.

Linked with the first practical recommendation, an attitude shift is needed in higher education. Disabled, chronically ill, and/or neurodivergent doctoral researchers would like fewer assumptions to be made about their needs. Some individuals would like help in particular situations, whereas others do not, and it should be each individual's prerogative to make a decision about how they want to be treated and supported rather than general assumptions to be made.

Generally, disabled, chronically ill, and/or neurodivergent doctoral researchers should be fully involved in decisions and processes. For example, as offices and rooms are being rearranged, individuals need to be offered space and time to be involved in such decisions, as the positions of a desk and chair could impact the severity of their conditions and symptoms. Similarly, taking rooms or routes out of action because of building work and the like has a significant impact on people with mobility issues and visual impairments, specifically. Rather than just taking the action unannounced, advance warnings and signposting would be helpful so that university spaces are still accessible.

In relation to disclosure in doctoral education itself, participants were adamant that nobody should be advised on how to disclose, when, and to whom because the circumstances and parameters of each situation are so unique. Instead, disabled doctoral researchers consciously engage with the principles of the disclosure dance in order to protect themselves against the fallouts of disclosure whilst also being able to access accommodations and support as and where necessary.

Implementing these recommendations should go a long way to improve disclosure rates in higher education in the long term. This study has shown the impact of human connections and relationships as well as the role physical spaces in academia play in disclosure dances. Yet, more research is needed to understand which factors specifically foster and hamper disclosure amongst doctoral researchers, especially as this small-scale study did not focus on one individual form of disability, chronic illness, and/or neurodivergence.

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