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Emotions at Work: The Case of Chronic Illnesses in Academia

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Abstract

Given the large number of reported chronic diseases across several segments of the population, the article explores the relationship between having a chronic illness, emotions, and academic work. Based on interviews with university staff, collected in Italy between 2020 and 2023 within a national research project on gender dis/advantage in academia, the essay sheds light on the hidden dimensions of universities as organizational settings in which all members participate in the dual dynamics of "emotion work" and "emotional labor" (Hochschild, 1979 & 1983): two facets of one coin, which flips unequally on multiple grounds, evermore when the social management of health conditions comes into play. Results show that academics with chronic diseases have to face daily challenges in navigating perceived stigma and adhering to over-commitment and expected performance (even more so for non-tenure track positions). However, data also show that informal solidarity and self-resilience thrive among university staff, allowing an expressive space for emotions to promote a more inclusive work ethic in academia.

Keywords: Emotion work; chronic illness; sickness; academia; inequalities.

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1 Introduction

The intersection of emotions and chronic diseases presents a multifaceted challenge, particularly in professional settings where mental stress, labor relations, and bodily disadvantage play significant roles. In academia, these dynamics are further intensified by a culture that prizes cognitive excellence, disembodied productivity, and an ethos of individual resilience. The discussion we wish to advance focuses on Italian academics' chronic illness experiences[1], in particular on the "emotion work" required to academic workers to bring their feelings in line with the emotion norms (Hochschild, 1979) of their work environment when they face a chronic disease.

The focus on the academic context is particularly interesting due to the increasing establishment of a neoliberal agenda in academia, characterized by a growing emphasis on productivity, performance, excellence, and entrepreneurialism. In this context, dominated by the intensification of time, practices of "overtime", instability and precarious conditions of work, chronic health conditions may halt or hamper academics' "body", "self" and work identities, forcing them to do emotional work to cope with the feeling rules of the 24-hour model of the "ideal academic" (Thornton, 2014; Lund, 2015; Weisshaar, 2017; Murgia & Poggio, 2019).

The article builds on nine narrative interviews with researchers and professors (both early career and advanced career), all women except one, employed in Italian universities, who have been dealing with major health concerns (as diverse as cancers, cardiovascular events, neurological or autoimmune diseases, etc.), collected between 2020 and 2023 within the "GEA-GEndering Academia" Project.

Given a large set of diseases reported, this essay compares several narrative interviews that illuminate the relationship between the experience of embodying a chronic illness and yet engaging in the seemingly neutral feeling rules of relentless top performance in academia. In doing so, the article sheds light on hidden dimensions of universities as organizational settings, in which all members participate in the dual dynamics of "emotion work" and "emotional labor" (Hochschild, 1983), yet do so unequally.

2 State of the Art: Illness and Emotions in Academia

Chronic diseases, such as diabetes, cardiovascular conditions, autoimmune disorders, and mental health issues, require a preview of how bodily frailty may be understood in the light of the biographical experiences. To this end, the notion of *embodiment* may be fruitful, particularly in the context of chronic diseases, because it refers to the lived experience of the body as both a biological and social entity (Scheper-Hughes & Lock, 1987). Embodiment, then, highlights how illness is not merely a physical condition but is also shaped by sociocultural factors, such as gender, class and individuals' life course. To describe these aspects, Nancy Scheper-Hughes and

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[1] In narrative-based medicine and critical medical anthropology (Kleinman, 1988), the triad of disease, illness, and sickness offers a framework for understanding health experiences beyond biological factors (Twaddle, 1968; Hofmann, 2002; Maturo, 2007). *Disease* refers to the pathological condition as identified by biomedical models, while *illness* encompasses the individual's subjective experience and perception of symptoms. *Sickness*, meanwhile, pertains to the social and cultural dimensions, highlighting how society views and responds to health conditions. This triad emphasizes a holistic approach to health, recognizing the interplay between biological, personal, and social influences. While acknowledging such complex interrelationships, in this article we will use all three terms, focusing, though, on the experience of *illness* (living with a long-term condition), as well as on *sickness*, and on how they affect one's job and emotion management.

Margaret Lock (*ibidem*) coined the concept of *mindful body*, which underscores the interconnectedness of body, mind, and society, where illness cannot be separated from its cultural and social context. Thus, chronic disease is not just a biological phenomenon but one deeply embedded in (gendered) social relations, making embodiment a critical concept for understanding health inequities.

In addition, the emotional stress due to chronic illnesses can have far-reaching consequences in professional environments, by intersecting with structural inequalities related to gender, labor relations, and healthcare, and exacerbating existing labor inequalities (Ahmed, 2010; Berlant, 2011).

Finally, chronic diseases, which disproportionately affect women (Goldin & Lleras-Muney, 2019; Patwardhan et al., 2021)[2], particularly in their experiences of emotional stress and labor relations, are often experienced differently by gender, due to the socially constructed roles and expectations imposed upon them (Connell, 2005; Manderson, 2011; Quaglia, 2023).

For these reasons, the final key concepts useful for our purposes are those introduced by Arlie Hochschild (1979 & 1983): "emotion work" and "emotional labor". The former was introduced by Hochschild (1979) to describe the effort required to manage and regulate emotions in different fields, including professional settings, often at the expense of one's well-being. In Hochschild's terms, emotion work (or emotion management) is "the act of trying to change in degree or quality an emotion or feeling" (Hochschild, 1979, p. 561). This process is particularly activated when individuals perceive a discrepancy, a gap, between what they should feel and what they actually feel, and try to adjust their emotions to the attitudes and behaviors indicated as appropriate by the professional and socio-normative context in which they act. Most importantly, emotions, like any other human activity, are guided by what Hochschild calls the "feeling rules", which, influenced by social factors and socially shared (though often in a latent way), direct the way we try to experience emotions and feelings.

In other words, feeling rules are social guidelines which express the magnitude, direction, and duration of a feeling or emotion in a given situation, while emotion management (or emotion work) refers to the strategies by which individuals bring their feelings in line with emotional norms (emotional rules) (cfr. also Whartorn, 2009). We are always doing emotion work, somehow, even in solitude, ubiquitously performed daily in the private sphere, but it can be part of our profession (such as hostesses, psychotherapists, physical trainers, waitresses, or teachers), and this applies to the second concept later developed by Hochschild (1983), which ends up changing the nature of our emotional management, becoming much more prescriptive, even bureaucratized, controlled and, through the drudgery of professional rules, it comes to be configured as true "emotional labor".

In academia, all the above mentioned aspects have only been partially addressed by research. In recent years, there has been a growing debate aimed at understanding the implications of the significant changes in the models of production of science that have characterized the university context. This refers to the increasing establishment of a neoliberal agenda, where the so-called "ideal academic" dominates (Thornton, 2014), and labor relations are often based on ideals of productivity, independence, and resilience (Van den Brink & Benschop, 2012; Gill &

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[2] The male-female health survival paradox, also known as the morbidity-mortality paradox or gender paradox in medicine, is the phenomenon whereby female humans experience more medical conditions and disability during their lives, but live longer than males. Women tend to have higher rates of certain chronic conditions, particularly non-fatal but disabling diseases. Additionally, data from the Global Burden of Disease Study (Patwardhan et al., 2021) revealed that women have higher disability-adjusted life years (DALYs) for mental, musculoskeletal, and neurological disorders globally.

Donaghue, 2016; see also the Symposium "Don't Fix Women, Fix Academia?", published in this Journal and edited by Cois et al., 2023).

In Italy, as elsewhere, the neoliberal "turn" has been characterized by a progressive reduction of public funding and slow turnover, an increasing emphasis on performance, excellence, entrepreneurship, and new mechanisms of competition between and within universities (Gaiaschi & Musumeci, 2020; Gaiaschi, 2021; Anzivino & Cannito, 2024; Carreri et al., 2024; Filippi, 2024). One pioneering work on emotions in academia is the research by Bellas (1999), which shows that not only women and men engage in different activities — with the former performing most of the "academic housework" (Heijstra et al., 2017) — which are differently rewarded, but even when the tasks are the same, the type and intensity of emotional labor required may differ.

Looking instead at the management of a chronic disease in academia, as it requires flexible working conditions and periods of rest, some research shows that the "sick body" disrupts the ideal of disembodied intellectualism founded on the tireless, ever-productive academic — an ideal that reflects broader neoliberal values of self-optimization, endurance, and individual responsibility (Davies, 2005; Gill, 2009). In this sense, chronic illness in academia is not merely a private matter or an unfortunate deviation from professional norms, but rather a political condition that exposes the structural violence embedded in academic institutions.

Therefore, sickness becomes a lens through which to look at the political economy of higher education: it reveals, on one side, how vulnerability is systematically devalued; on the other, how academia depends on a hidden undercurrent of emotion work to maintain its façade of rationality and performance (Brown & Leigh, 2018 & 2020; Wilkinson & Wilkinson, 2023).

Therefore, whereas the relation between emotions in academia, emotions and chronic illness, and academia and chronic illness have been studied, the emotional management related to chronic illnesses in academia still remains an under-researched topic.

3 Methodology

The essay aims at investigating how Italian academics emotionally experience and manage their illness in university settings. In particular, we want to answer the following research questions: How does the university environment influence and shape the emotional expression and management of academics with chronic illness? How do ill academics adjust their emotions to the workplace "feeling rules" and the fit or misfit with the "ideal academic" model?

The argumentation is based on nine narrative interviews with eight women and one man of different ages, who work as researchers and professors in several Italian universities, and who are affected by a chronic physical (not mental) disease. The interviews were conducted online during 2021–2022 within the scope of the "GEA-GEndering Academia" Project, whose broader aim was to study gender inequalities in Italian academia. The sample and its characteristics are illustrated in Table 1.[3]

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[3] Even if these interviews are part of a larger corpus, they were purposely collected for the scope of this part of the research, namely investigating the relationship between academia and illness. For this reason, the original interview guide was re-adapted to be comparable with the larger corpus of interviews, but also to grasp the specificities of this topic. The small size of the sample is due to the sensitivity of the topic, which forced us to rely on personal relations and on snowball sampling. This also explains the gender composition of the sample, which might be influenced by the lower willingness of men to disclose their health conditions.

Table 1. Characteristics of the Sample[4]

Pseudonym	**Gender**	**Age**	**Disease**	**Type of contract**
Rosa	Female	47	Cancer	Fixed-term research technician
Gaia	Female	38	Cancer	Tenure track researcher
Stella	Female	51	Multiple sclerosis	Fixed-term researcher
Bella	Female	32	Endometriosis	Fixed-term researcher
Mario	Male	56	Arteriovenous malformation (AVM)	Associate Professor
Sharon	Female	39	Cancer	Fixed-term researcher
Mina	Female	38	Multiple sclerosis	Fixed-term researcher
Gemma	Female	54	Systemic lupus (SLE)	Associate Professor
Isa	Female	33	Multiple sclerosis	Fixed-term researcher

We choose to use narrative interviews because they hold substantial epistemological value in sociological research, especially for exploring the lived experiences of individuals with chronic diseases. By providing a platform for participants to share their personal stories, narrative interviews capture the nuanced ways individuals construct meaning around their illness, integrating it into their identity and daily lives. Chronic diseases often entail fluctuating symptoms and a prolonged adjustment to societal expectations, which traditional survey methods may overlook. As Mishler (1986) first argued, giving way to a reflexive turn in oral methods for social science research, narrative approaches allow participants to reveal the complexities of their experiences, often highlighting tensions between health expectations and personal resilience.

As evidenced by more recent reflections about research methods in health social sciences, narrative research in this field "is both a data gathering and interpretive or analytical framework. It meets these twin goals admirably by having people make sense of their lived health and well-being in their social context as they understand it, including their self-belief-oriented stories" (Ntinda, 2019, p. 411). This aspect enriches sociological understandings of chronic illness by capturing diverse voices and insights, often transforming research subjects into active contributors to knowledge, which might be particularly fruitful when respondents are researchers themselves, as in our case.

The recordings of the interviews have been transcribed verbatim and then analyzed through a thematic grid. The codes were meant to grasp the sources, processes, and mechanisms that contribute to (re)produce gender disparities in universities, but for the purpose of the present analysis, we added some more codes to uncover the emotional and relational dimensions of the interviewees' illness, such as how they navigate work expectations, face social stigma, manage to maintain self-efficacy, and negotiate medical authority.

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[4] In the Italian academic system, there are two kinds of researchers: one is tenure-track, which almost automatically provides the possibility to become Associate Professor at the end of the contract. The other, instead, is a fixed-term contract of three years (renewable for two), which does not offer any guarantee in terms of future stabilization.

4 Results: Analysis of the Narrative Interviews

4.1 Overcoming the Incorporation of Stigma

The concept of stigma, initially theorized by Goffman (1963) and then popularized in social psychology, provides a valuable framework for understanding the lived experiences of individuals navigating chronic illness within academia. Goffman's notion of stigma refers to a social attribute that discredits an individual, distinguishing them in a way that results in judgment or marginalization. While stigma can be applied broadly, health-related stigma is particularly pertinent for those with chronic diseases, as the stigma here arises not only from the condition itself but also from societal perceptions and expectations regarding health, ability and productivity (Scambler, 2009).

From our analysis, and coherently with previous research (Brown, 2020), it emerges that, for academics with chronic illnesses, stigma may manifest as either "felt" or "enacted". Felt stigma involves the individual's internalized fear or anticipation of judgment, while enacted stigma refers to the real experiences of discrimination or differential treatment they may face if their illness is disclosed. By applying Goffman's concept of stigma to this context, it becomes possible to understand the ways in which chronic illness stigma functions as both a social and individual barrier in academia, especially in the choice to disclose one's health condition.

In fact, on the one hand, all our female interviewees feared that their colleagues or supervisors would view them as less capable, and therefore worried about the possibility of experiencing potential limitations in career advancement or of being perceived as "unfit" for (high-level) research positions. This anticipation of stigma is especially relevant in academia, where competition, performance, and productivity are highly emphasized. The perceived stigma, then, influenced their choice to disclose their chronic illness.

> "Even now, I've been lucky enough to win a university competition; I started last week [laughs], and, just to say, I was even concerned that if they did a medical exam, they'd say: 'Oh, you had this issue [...] maybe we should choose the next person in line because she is more reliable than you'. [...] In fact, from a work perspective, I haven't told anyone [...]" (Rosa, 47, fixed-term research technician, cancer).

This kind of stigma, therefore, generates anticipatory anxiety and operates as a significant psychological stressor that may lead individuals to feel isolated and unsupported in the workplace, a feeling that can be exacerbated by the competitive and often individualistic culture of academia. For those who choose not to disclose, the effort to "pass" as healthy can become an additional burden, impacting their cognitive and emotional resources. Goffman (1963) highlighted how people with stigmatized identities might employ strategies to hide or "manage" their condition to avoid discrimination.

Within academia, from the words of our interviewees, these strategies include overcompensating in work hours, declining necessary health accommodations, or self-censoring, all of which contribute to a heightened workload that may ultimately lead to burnout. Nondisclosure can, paradoxically, diminish the very productivity it seeks to preserve, by placing the individual in a position of sustained physical and emotional strain.

> "Sometimes I think how wonderful it would be to be able to overcome these cultural blocks in society. You know how often a colleague says 'I'm gluten intolerant' and then you end up talking for an hour about gluten intolerance? It would never

> occur to you, sitting at a table with colleagues, to say 'Oh, you know, I have multiple sclerosis, and sometimes when I'm tired, I really feel my leg hurting' […]. It's probably because older generations associate it more with a sense of guilt that patients carry […] I don't have that, I must say, or if I do, it's very buried deep down. But it's something that, socially, I think really affects you" (Mina, 38, fixed-term researcher, multiple sclerosis).

On the other hand, disclosure can be a double-edged sword: while transparency might foster understanding and accommodations (as we will see in section 4.4), it may also reinforce stereotypes about capability and commitment. The best model of the academic scholar often embodies traits traditionally coded as masculine: relentless work ethic, self-sufficiency, and a willingness to prioritize work above all else. Moreover, some conditions have specific gendered connotations that may worsen the management of the illness and the difficulty of disclosure (Thorne et al., 1997), and that are less likely to produce empathy and compassion, especially from the male colleagues.

> "If you don't have a uterus and ovaries, if you aren't a woman or simply a person with these organs or, in general, a person menstruating, it is very complex to understand certain things […]. [In fact] the only people I haven't told about this are the two men in the research group. Part of it is definitely due to the hierarchical relationship, [but partly it is also due to the fact that] […] sometimes people don't even talk about periods, let alone something like this. Just imagine, for example, telling your boss 'I'm not feeling well today because of period pain', […] or 'I can't come in today because I'm having a hemorrhagic period with severe cramps', […] can you imagine the jokes? The atmosphere here is that even just using gender-inclusive language in the faculty council meetings gets you mocked, not just by students, but by fellow faculty members of equal standing, that's the kind of environment we have, so imagine trying to discuss menstrual leave in a faculty council meeting" (Bella, 32, fixed-term researcher, endometriosis).

The ideal academic, in fact, implicitly valorizes workaholism, reinforcing a narrow, exclusionary notion of success that perpetuates a rigid academic culture which equates productivity with personal worth, often at the expense of mental well-being. Furthermore, this model undermines diversity by setting unrealistic expectations, fostering burnout, and limiting pathways for scholars who may bring valuable perspectives, yet do not conform to these (gendered) demanding norms.

> "I worked a lot, I was working on a European project, and I attended meetings for my European projects the day after having chemotherapy. On top of that, I enrolled in a master's program, and I even completed it" (Gaia, 38, tenure track researcher, cancer).
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> "My physical therapy sessions, they're just part of my routine. I don't add or remove anything, it's not an exceptional event. I don't ask for favors or for any kind of special accommodations. For me, it's an absolutely ordinary condition, which is exactly why I never wanted to apply for recognition under Law 104. No, I never wanted to request it because I never felt, nor ever wanted to feel or be recognized as disabled" (Mario, 56, associate professor, arteriovenous malformation).

As the interviewees remark, most of the time, the negotiation between professional identity and bodily limitation forces chronically ill academics to self-monitor, self-regulate, and often self-silence. This strategic invisibility, while sometimes necessary for survival, further reinforces ableist assumptions and isolates the sick subject from structural recognition or support. Therefore, ableism remains the unspoken assumption for a fully-fledged, productive intellectual labor (that spans seamlessly from doing research to lecturing students and public engagement) and is internalized by sick people too.

Thus, the stigma of illness becomes not only socially enacted but physically and emotionally embodied, contributing to cycles of underperformance, burnout, and self-blame that remain largely invisible within the productivity-driven culture of academia.

4.2 Feeling Rules and Emotional Labor

Beyond the management of the experienced or feared stigma, the double bond of "emotion work" and "emotional labor" requested of academics with chronic diseases is performed in several ways.

Two interviewees point out that very often people with severe diseases experience shame, underscoring the pressure people may feel to downplay their illness or its effects, worried about how others perceive them (Richards, 2019), thereby performing emotional work to conform to social norms.

Interestingly, the following quote reveals a sense of anger and frustration at the effort required to make this emotional adjustment in order not to draw attention to their struggles or to appear strong and untroubled. There is also a desire for empathy from the surrounding community, suggesting a longing for emotional validation, as well as an awareness of the emotional work that others also have to do when interacting with someone who is ill.

> "I've had the opportunity to talk with colleagues who have a cancer diagnosis, for example, and there's almost a sense of shame [...] What on earth should you be ashamed of? You have cancer; it's others who need to overcome their limits and understand. It's not you who should be feeling this way [...] yet there's this sense of modesty and shame" (Mina, 38, fixed-term researcher, multiple sclerosis).

Shame is sometimes involuntarily reinforced by colleagues' reluctance to approach people with health diseases, reflecting a common emotion work challenge: the fear of saying the wrong thing or not knowing how to engage appropriately with someone who is facing a serious health issue, eventually leading to emotional distancing. Even if this type of emotional management is crucial for maintaining social harmony, as people often strive to avoid discomfort for both themselves and others, leading to a form of emotional self-regulation, it also requires sick people to manage possible disappointment and to adjust their expectations.

> "I think there was also some reluctance among certain people to approach me about this. I don't say this as if someone did something wrong, but it seems to me that a number of people were hesitant to bring up the topic or didn't know how to ask me about it. There may have been people who could have guided me, given advice, but it's understandable; I wasn't expecting it to happen, and it didn't happen" (Sharon, 39, fixed-term researcher, cancer).

Another important element, connected with a sort of real emotional labor and emerging from the analysis, is the sense of guilt directed towards themselves and, in the case of early career researchers, towards other precarious colleagues. In the first case, the guilt is felt for prioritizing work over her health, and the interviewee's self-condemnation indicates a conflict between her needs as a chronic patient and academic expectations of commitment to work. Hochschild (1979), in fact, emphasizes that individuals often engage in emotional management not only for the sake of others, but also in a way that aligns with their internalized values and beliefs about productivity, especially as members of the academic environment.

> "You tell yourself things, and then you condemn yourself for saying them. You think, 'I have to undergo an operation that could potentially be very invasive', and the first thing is fear, and the second thing is, 'What about work?' And then you beat yourself up because you think, 'Is it possible that, with a health condition like this, the first thing I think about isn't my well-being, but work?' " (Bella, 32, fixed-term researcher, endometriosis).

Beyond the sense of guilt, Sharon's case shows that she feels she has to be grateful to the supervisors for choosing to invest in her, who is, in her view, a "higher-than-average bet". The fear of being perceived as a liability further exacerbates this guilt, highlighting how emotion work extends to how one navigates relationships with peers who share similar vulnerabilities.

> "The fact of having a chronic illness means you're a chronic patient, and while others may not discriminate against you, anyone who invests in you is making a higher-than-average bet, simply because a healthy person might face a life event, but someone who is already ill statistically has a higher probability of incidents. [...] We're seen as an investment within this absurd framework of organizational 'points'; we're a cost, and that logic has permeated all of society, including the university system. [...] So, if you don't have a permanent contract and you're a chronic patient, you live with this feeling of 'Damn, I have to be better than others because they're making an investment in me' " (Sharon, 39, fixed-term researcher, cancer).

These conflicts are also common among advanced career professors, when they actively have to align their behavior with the desired image of resilience and independence, even if this conflicts with their own emotional or physical reality. From the following quotation, an implicit "feeling rule" emerges: the feeling of being compelled to present themselves as reliable to preserve professional standing within a system that, per the speaker's account, values uninterrupted productivity over individual welfare. The underlying fear of being seen as less committed or stepping back "to the sidelines" illustrates the pressures of performativity in academia — well exemplified by the expression "I wanted to show that I could manage, just with different timing and methods" — which requires the suppression of any vulnerability and the anticipation of potential biases, navigating the constraints of institutional rigidity.

> "At that time, I was also a member of our university's Equal Opportunities Committee, and it was really difficult to gain support. The administration — basically, the Rector — had an attitude and implemented practices that completely disregarded, above all, those with family responsibilities and put a lot of pressure to come back to presence [...] [and] I tried, in a way, to be careful not to signal that I was no longer reliable or that I would step back or put myself on the sidelines. I didn't want to give that impression. Rather, I wanted to show that I could manage, just with different timing and methods" (Gemma, 54, associate professor, systemic lupus).

The results presented in this section reflect a broader academic issue related to the constant assessment of academic staff, which reduces individuals to costs and investments, while forcing sick workers to navigate their emotions within the constraints imposed by organizational structures. Hyper-performativity is often internalized and reproduced, then, particularly in response to long-term quantitative evaluation processes that are frequently public, with results shared within departments. For tenured staff, what is at stake is their reputation — both in front of and in comparison to colleagues — as well as their responsibility for the department's collective performance, which can, in some cases, influence access to funding and resources. For precarious researchers, instead, hyperproductivity is a matter of "survival" in their academic careers, as we will see in the next section.

4.3 Managing Emotions in the Face of Precariousness

The neoliberal "turn" in universities has relevant implications for working conditions and careers (Gill, 2009), as evidenced by the increasing labor instability and precariousness (Murgia & Poggio, 2019; Picardi, 2019). When precarious workers, especially those in the early stages of their careers (postdocs, non-tenure track researchers), experience chronic illness, we can observe how academic contexts (which increasingly require high levels of constant productivity) affect workers' professional and private lives, their embodied experiences, and their struggles to manage emotional work, as well as some specificities of the precarious working condition.

The first dimension that emerges in the case of academic staff in unstable or precarious conditions is the fact that the difficulty of "naming" and "disclosing" one's illness, which are somehow linked, increases when one is not in a stable position. From our interviews with early-career non-tenure track researchers, it is clear that there is an enormous amount of emotion work that the person has to do in order to reconcile the need to communicate the illness with the dominant "rules of feeling". This means, for example, that one should be "reserved" about one's chronic illness, whereas the real need and feeling is to share the situation with colleagues or the boss, i.e., one leaves behind the contradiction between one's feeling to show their chronic illness and one's fear of the consequences.

> "I immediately felt the need to share it so that it wouldn't become just another problem within the problem. I perceive in a very strong way a societal discomfort, a taboo then, if we want to say, with respect to serious chronic diseases or cancers, the fatal ones but also to those which are not. And you can feel it — it's hard to communicate, and it's not easy to know how to balance respecting the other person's sensitivity and your own. It's exhausting to continually gauge your relationship with people. If you have a chronic illness, it's like this with everyone you meet in your life: the ones who already know are aware, but the new ones? It's always about negotiating the level of intimacy. […] You have this thing, and you can't even name it […]. It's not so simple because sometimes it seems that if you talk about it too loosely, you're almost brash, other times if you talk about it too loosely it seems like you're lacking discretion. Yet you can talk about cat hair or allergies, and no one thinks you're not a private person […]" (Mina, 38, fixed-term researcher, multiple sclerosis).

Despite the fact that this early career researcher (Mina) immediately felt the need to communicate her illness, she notes how difficult it is to talk about chronic diseases because of the existence of "cultural blocks in society", because you have to "negotiate the level of intimacy", because "you have this thing you can't call it", and because she recognizes the importance of her unstable position in the university. It is hard to work in academia while at the same time having a chronic illness.

An unstable job position is a situation that makes people feel fearful because of the potential impact of one's health disclosure on their job security.

> "From a work perspective, it was a difficult thing to manage, even now in some ways [...] because it's true that these things happen, but having a precarious position, if you are someone who could potentially be ill, it's clear you can be excluded from the outset. So, I only shared this with people I trusted. In fact, there was one time [...] the day after my surgery in December, we were supposed to have an online meeting, and I had said I wouldn't be able to make it. Then I said, if I can, I'll join but without turning on my camera. However, the person I was talking to forgot, and she asked me, 'Ah, there you are! If you want to join in [...] no, turn on your camera [...] no', and it was all a bit awkward and unpleasant" (Rosa, 47, fixed-term research technician, cancer).

This story of surgery and the "camera on" also shows the huge amount of energy to manage emotion work and to align the feeling rules with the situation and the uncertain work condition. Employees in non-tenure positions, while trying to "draw the line" between their caring needs and their professional role, may feel guilty and almost apologize for the situation of sickness. They seem engaged in a constant emotional work to understand the situation and the expectations of others and to align their own emotions with the work environment's "feeling rules", which require fulfilling their commitments.

> "I mentioned that I would have to have this surgery at some point, though I didn't know when. However, I was worried they might think 'We won't renew her contract, because if she has to have surgery, she won't be able to work for three months'. I still have that doubt, though I don't think they would do that just for this reason. But, for example, I feel I have absolutely no negotiating power in this regard — almost as if I have to apologize for not working for a quarter because I need surgery. Initially, when I was talking about my illness with a colleague from Genoa, as the topic had come up and she didn't know about it, she asked me, 'But tell me, if we offer you a renewal, would you consider accepting it?' " (Bella, 32, fixed-term researcher, endometriosis).

The precarious condition also exposes people to an increased sense of vulnerability, not only because of the lack of control over their own professional life, but also because of their dependence on the supervisor's "goodness of heart", sometimes having to manage the potential letdown that comes with the lack of support. A gendered component also emerged from the interviewees' accounts, namely the emotional work that women usually invest in sustaining long-term collaborations, which is rarely recognized, both formally and informally, especially by men, yet is crucial to work relations.

> "My supervisor at the time didn't renew my scholarship, so I found myself in a situation where I was undergoing radiotherapy, completely drained, with an expiring scholarship that did, in fact, expire. Yet I kept working for that scholarship. [...] For me, the fact that the person I was working with didn't even have the decency

> to try to somehow extend this damn fellowship, or to find any type of funding for me, doing nothing — we had been working together for eight years at that point — for me, it's just […] I don't know" (Sharon, 39, fixed-term researcher, cancer).

However, at least two interviewees stressed that, despite these huge criticisms related to precariousness, working at the university also offers some advantages compared to many other jobs. In particular, on one hand, the academic career allows for a certain flexibility in working arrangements and autonomy in organizing work, which can be more compatible with managing a serious health condition.

> "I was very lucky because, despite the precariousness of relying on a scholarship, it also gives you a certain flexibility in trying to fit everything together" (Rosa, 47, fixed-term research technician, cancer).

On the other hand, it allows being in contact with people who may have greater sensitivity and more cultural resources to understand the situation, as we will also see in the next section.

> "Precariousness is always there […], but there are many people my age who are in precarious positions and in other jobs that might even be more demanding, with different rhythms. The advantage of the academic environment, though, is that you also meet a lot of people who have an ability to understand — I don't want to discriminate against those who haven't studied, but I imagine maybe a person with this pathology who works in an environment with people who have, let's say, lesser tools to understand […]" (Mina, 38, fixed-term researcher, multiple sclerosis).

4.4 Towards Collective Care and Self-Credit?

Despite these challenges, managing a chronic illness can yield significant positive effects on self-esteem and productivity. For those who successfully navigate their condition in the workplace, a sense of resilience and self-advocacy can emerge, fostering a virtuous cycle where confidence in one's abilities is reinforced. This self-assuredness not only bolsters productivity, but may also contribute to creating an inclusive workplace culture by modeling adaptive behaviors. For those managing chronic illness, especially within marginalized groups, the empowerment derived from resilience can foster both individual and collective support systems, creating a more equitable academic environment. Overcoming stigma thus transforms a potential obstacle into an asset, allowing individuals to thrive in their careers with renewed confidence.

Whether more or less fully achieved, being capable of setting goals that are desirable in university terms and reasonable for one's well-being and healthcare increases self-confidence and participation within and beyond academia.

> "Now that I have some free time to take proper care of myself, also thanks to this new flexible contract [in a private research center], I would like to adopt a child. Or rather, try fostering, maybe of a teenager […], because I am currently single […]" (Isa, 33, fixed-term researcher, multiple sclerosis).

On a different but complementary note, managing a serious health condition can also lead to forms of resistance against the ideal academic model and make individuals feel more entitled to take rest and devote time to self-care. This could provide an opportunity to challenge dominant work norms and to make visible the "frailty" of human bodies, thereby legitimizing the disclosure of sickness in the academic workplace, whether the illness is visible or not (Vickers, 1998).

> "One thing that has changed after the diagnosis is that I feel slightly more entitled at times to say, 'I'm not feeling well today; I can't do this'. Only slightly, because, of course, this conflicts a lot with the type of work in academia, where you're expected to always be extremely available. However, this aspect of the illness requires you to slow down at times or simply to listen to yourself and recognize your own needs" (Bella, 32, fixed-term researcher, endometriosis).

In addition, for many interviewees, the experience of sickness and its disclosure has been a source of positive feelings, particularly in terms of — both material and immaterial — solidarity expressed by colleagues and supervisors who enacted supportive behaviors. These experiences illustrate the supportive "emotional labor" performed by colleagues, alleviating the sick individuals' burden of feeling that they are letting down their department or disrupting the workflow. This is an interesting aspect that also sheds light on managing the collective emotional climate by rallying around and warmly welcoming a colleague in need, allowing both the individual and their peers to navigate illness with collective resilience.

> "I must say that I have some very supportive colleagues. They really covered for me — in the sense that, at a certain point, I started delegating some of the tasks I used to do myself, and they just took them over without even asking. So, there was a small group around me that understood and protected me" (Gemma, 54, associate professor, systemic lupus).
>
> "When I got sick, right in the middle of the academic year, word spread immediately. For example, even while I was still in the hospital — while I was in a coma, completely unconscious — my colleagues came to visit me. [...] I remember that when I woke up, the nurses told me what was happening on the outside, [...] the nurses joked saying 'Professor, it's like there's a happy hour happening out there'. Knowing that my colleagues were there, coming to see me, gave me a lot of comfort. I remember that when I finally got out and was able to walk on my own again, the first thing I did was go to the first department meeting, where I received a warm welcome" (Mario, 56, associate professor, arteriovenous malformation).

This is especially evident when colleagues themselves have experienced similar health conditions, highlighting the crucial role of social support systems in easing the burdens of emotion work. Such mutual understanding fosters more authentic emotional exchanges, which is particularly significant for women navigating the unique emotional and professional challenges in academia.

This dynamic opens up possibilities for politics of care grounded in embodied experience, making emotions visible within academic processes and relationships (Askins & Blazek, 2017). Indeed, self-care practices — which in themselves can serve as acts of resistance against prevailing academic work models — may lead to the recognition and enactment of collective care (Chamberlain, 2020). In this way, self-care fosters the development of collective care, and conversely, collective care can encourage scholars to take care of themselves and make their physical and psychological frailties more visible in the workplace. Consequently, self-care can become a collective practices of resistance that many academics are adopting and advocating for, as a way to counteract the individualization and competitiveness prevalent in academia, promoting instead a collective approach aligned with the ethos of "slow scholarship" (Mountz et al., 2015).

> "I was fortunate, in a way, to have these colleagues in the department who had experienced breast cancer. Even though it wasn't specifically about career issues, I felt their emotional support very strongly, as well as their willingness to share information and difficulties, trying to decode the situation in a way that's not exactly career-related but is still connected to that context" (Sharon, 39, fixed-term researcher, cancer).

Of course, as already mentioned, we have to bear in mind that the support received varies considerably depending on the type of disease — especially when it is highly gender-specific, as in the case of endometriosis — and on the stability of the academic position. Precarious researchers, in particular, are more vulnerable to exploitative practices and at higher risk of being left unsupported by their supervisors. The story of Sharon, previously mentioned, is emblematic in this regard: although she was left without a contract by her supervisor, she still received emotional support and solidarity from her peers.

Furthermore, since the COVID-19 pandemic, remote work in higher education has expanded rapidly, reshaping teaching, research, and administration. This shift has notably benefited staff with chronic illnesses, by enabling more flexible work environments that better accommodate health needs, reduce commuting-related stress, and promote inclusivity (Ferreira et al., 2022). To some extent, this innovative format for balancing academic work and life has also fostered new forms of solidarity and alliances among staff, both on-site and remote. As one interviewee shared, although the viral infection worsened her chronic condition for a while (leading to a temporary leave of absence), the overall departmental atmosphere became more inclusive, with management promptly accommodating remote hours for "fragile workers" and colleagues voluntarily offering to cover non-deferrable teaching commitments.

> "At the time, soon after I got infected, I experienced such a level of fatigue [as my immune system derailed] that I could only work from home, possibly lying in bed. My colleagues managed to replace me on some occasions, they offered to complete the lessons for my courses whenever I did not feel good enough" (Gemma, 54, associate professor, systemic lupus).

Some interviewees also reported that the sudden realization of being physically vulnerable that all workers across public service sectors experienced, including academia, afforded those with chronic conditions the chance to communicate with less discomfort, anticipating a shared understanding of health-related needs for once.

> "I never hid the disease, but I avoided talking about it if I didn't have to. Now it was my colleagues who pointed out to me that 'we were all in the same boat'. [...] Sure I never was Wonder Woman, but I felt a recognition of being tough, on top of what it takes to stay in the research industry for anyone" (Isa, 33, fixed-term researcher, multiple sclerosis).

As the latter excerpt proves, from the shock of diagnosis to the prolonged experience of a disease that is never cured but always treated, months and then years go by. Seeing the effect of time passing for such academics also means acknowledging their awareness of being able to continue pursuing their life and work ambitions, despite a major setback.

5 Concluding Remarks

The essay aimed at exploring academics' lived and embodied experiences of chronic illnesses, illustrating their emotional struggles and attempts to cope with the workplace's feeling rules and realignments that their health conditions require in order to keep up with more-than-decent work. As academics try to "draw lines" between their care needs and professional roles, key issues emerged, such as a perceived deception of one's body vis-à-vis the unattainable "ideal academic", the social stigma and individual feeling of shame associated with being sick, thus the difficult choice of whether or not to disclose their disease and to whom, also considering the lack or inadequacy of protective policy measures for those in precarious or non-tenure positions.

However, personal narratives also showed the existence of positive feelings of pride for being sick and yet being (or becoming) a successful scholar, in the face of non-linear career paths which, albeit disrupted by serious health conditions, also bear the marks of one's emotional strength and resilience. Furthermore, such attainments are made possible thanks to unexpected solidarities which academic workplaces can foster despite their intrinsic competitiveness, sometimes seeing colleagues turn into friends who are willing to offer moral and practical support in times of need. In these cases, emotions of gratitude and affection are explicitly mentioned, showing the complex and sometimes conflicting dynamics between organizational feeling rules and interpersonal emotional experiences.

It is interesting to note that many of the results of our analysis might apply to other (especially private) workplaces characterized by precarity and competitiveness. In our view, this is a further confirmation of the neoliberal "turn" in academia and of its progressive managerialization and corporatization, which have made it increasingly similar to private companies. However, we cannot deny that academic work has specific challenges connected to evaluation, individual and collective reputation, and teaching activities, all of which require specific emotional adjustment when one has a chronic illness.

Although the interviews on which this argument is based do not include those who may have left academia due to working conditions that made managing a long-term illness unsustainable — alongside other factors at play, including gender and class differences (Naldini & Poggio, 2023) — the resilience of those who have remained speaks volumes about the urgency of examining the margins of excellence models in the neoliberal university. The equation between merit and (dis)advantage is far more complex and less straightforward than it may appear on the surface of career advancement.

To conclude, this article highlights the need for structural changes that address labor inequalities in settings where intellectual work is regulated without full awareness of feeling rules and disruptions. Emotion work and feelings management, and sometimes even emotional labor, often invisible, must be acknowledged as part of the workload for academics, particularly for those with chronic conditions and especially for women, while at the same time considering how gender and ableist biases affect such discourse and its everyday practices. Therefore, acknowledging and addressing the stigma connected to sickness could foster more inclusive academic workplaces, where those with chronic conditions are not forced to choose between health and career but can keep both on track. Creating such environments could promote resilience, improve performance, and lessen the isolating impact of chronic illness stigma, benefiting individuals and institutions alike. Institutional policies should be restructured to accommodate the needs of chronically ill employees without penalizing them for their health-related challenges. As the academic workforce becomes more diverse, it is crucial to develop equitable frameworks that support all faculty members, regardless of age, gender, or health status.

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