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**The Power of Professionals in the Recognition of Invisible Disabilities: Between
Validation and Normative Control.**

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Abstract :

This work focuses on the issue of invisible disability, a form of disability characterized by the absence of obvious external signs, making its social, medical, and administrative recognition particularly difficult. Through a sociological approach, the aim is to understand how this invisibility affects access to rights, the legitimization of suffering, and the place of those concerned in the public sphere.

The methodology is based on documentary and theoretical analysis, drawing on legislative texts, contributions from the sociology of disability, and a comparative examination of medical, psychological, sociological, and legal approaches. The study also explores the central role of healthcare professionals in the social construction of invisible disability and the resistance strategies employed by patients.

The findings show that invisible disability is often disqualified by institutions due to norms of visibility and biomedical proof, which leads to inequalities in access to recognition and rights. This observation calls for an inclusive approach based on listening to lived experiences, valuing lay expertise, and transforming professional practices towards greater social justice and symbolic recognition.

Keywords: invisible disability; recognition; suffering; inclusion; medical expertise.

Introduction

Disability is now a major social issue, situated at the intersection of health, law, education, employment, and citizenship. It shapes the life paths of many individuals, affects family dynamics, and profoundly challenges social relations. Far more than a mere medical condition, disability is a social construct: it reflects the way society designates certain limitations as problematic, according to criteria that are variable and historically situated. The people concerned form a diverse community, marked by a wide range of experiences and forms of recognition—some visible in the public sphere, others invisible, silent, or contested.

The status of “disabled person” is not solely linked to a disorder or impairment: it is designated, validated, and regulated by institutions, especially healthcare and administrative systems. The role of professionals—doctors, psychologists, social workers—is central here: they hold the power of legitimation, capable of granting or denying access to rights and accommodations. This power is not exercised neutrally; it is shaped by dominant social norms, which tend to value certain types of disabilities (visible, measurable, stable) while disqualifying others deemed ambiguous, subjective, or suspicious. Thus, the recognition of disability—particularly when it is invisible—depends as much on medical and administrative knowledge as on implicit social judgments regarding suffering, normality, or an individual’s credibility.

This dynamic raises significant issues in terms of recognition, social justice, and access to rights. In the case of invisible disabilities—such as chronic pain, psychological disorders, neurodivergence, or fluctuating conditions—the challenge is twofold: these forms of disability are not immediately perceptible to others, and they often struggle to be recognized as legitimate by institutions. In this context, healthcare and social work professionals play a decisive role. They act both as interpreters of expressed suffering and as arbiters of its institutional admissibility. They can grant access to a protected status—or, on the contrary, deny it, delay it, or discredit it.

It is within this tension—between medical expertise, dominant social norms, and unequal access to recognition—that the central question of this article arises:

How do professionals (doctors, psychologists, social workers) participate in the social and administrative construction of invisible disabilities, between legitimation, hierarchization, and exclusion?

To address this social issue, the discussion will be structured as follows:

- **Section 1:** Definition of invisible disability
- **Section 2:** The main approaches to invisible disability and their extensions
- **Section 3:** Healthcare professionals and invisible disability
- **Section 1 : Definition of invisible disability**

To propose a clear and relevant definition of this social fact, it is necessary to consider a set of factors that influence the meaning, perception, and conception of the notion. Invisible disability is a complex phenomenon,

located at the intersection of multiple disciplines—medicine, psychology, law, sociology, and anthropology—each offering a specific interpretation. In this reflection, we aim to construct a comprehensive definition that integrates the essential dimensions of these approaches, in order to lay the groundwork for a coherent sociological analysis grounded in the lived reality of those affected.

Algerian Law No. 25-01, Article 2 (ARDP, 2025), offers a general definition of disability without explicitly distinguishing between visible and invisible forms. It defines a person with specific needs as: *"Any physical person, regardless of age or gender, who suffers from a disability or long-term impairments of a genetic, congenital, or acquired nature, which limit their ability to carry out one or more essential activities in their personal and social daily life, due to an impairment of their mental, intellectual, motor, organic, or sensory functions, and who, when faced with various barriers, may be prevented from fully participating in society on an equal basis with others."*

This definition adopts a broad and inclusive approach to disability, incorporating both medical dimensions (functional impairments) and social ones (environmental barriers and participation). However, it does not specify the forms of disability most likely to be socially rendered invisible—such as mental disorders, cognitive impairments, or certain chronic illnesses—leaving a gap in the specific recognition of these situations.

Disability can therefore be defined as a situation resulting from a lasting or permanent impairment of an individual's physical, mental, sensory, cognitive, or psychological functions, which—interacting with an unsuitable environment—leads to limitations in activity and/or restrictions in social participation.

This situation may be medically objectified, socially and legally recognized, or produced by the existence of social and environmental barriers.

Institutional and legal definitions of disability generally do not specify whether the disability is visible or invisible. Yet this distinction is essential in the lived experiences of those concerned and is notably absent from normative frameworks. This suggests that the visibility or invisibility of disability is not based on strict medical or administrative criteria, but rather refers to a situated, subjective, and relational experience—shaped by the social gaze and the environment in which the individual lives.

In other words, **the invisibility of disability is socially constructed:** it depends on context, interactions, and the norms that determine what is perceived as a "legitimate difference."

From this perspective, we will propose several definitions of invisible disability in the following paragraphs. We will also outline the main differences between visible and invisible disabilities, showing how this distinction raises specific issues in terms of recognition, access to rights, and social legitimacy.

According to **Erving Goffman (1975)**, invisible disability refers to a form of lasting limitation in social interaction capacities that is not visibly apparent to others. In other words, it is a disability whose signs are not immediately

noticeable, making it difficult for those around the individual to recognize the situation as truly involving disability (Daure & Salaün, 2017).

Invisible disability refers to a condition that is not apparent to others and which, in the absence of visible signs or specific equipment (such as a wheelchair or white cane), goes unnoticed unless the person discloses it. It is therefore a lasting or temporary limitation of a person's capacities, which is not immediately perceptible in personal or professional settings.

Invisible disability refers to a situation of activity limitation or restriction in social participation due to an impairment that is not immediately apparent to others. These are disorders or conditions that do not visibly alter the person's appearance or behavior, but that have real and lasting effects on daily life.

It may include a wide range of conditions, notably (Richard, 2016):

- **Mental or psychiatric disorders** (depression, bipolar disorder, schizophrenia, etc.)
- **Cognitive or neurodevelopmental disorders** (dyslexia, dyspraxia, ADHD, autism, etc.)
- **Subtle sensory impairments** (partial deafness, low vision, color blindness)
- **Chronic or disabling illnesses** (diabetes, multiple sclerosis, epilepsy, fibromyalgia, etc.)
- **Chronic pain or non-visible musculoskeletal disorders**

Unlike visible disabilities, which spontaneously draw attention, invisible disabilities often require explanation, justification, or proof in order to be recognized. This exposes affected individuals to a **“double burden”**: living with a real functional limitation while constantly having to legitimize their status in the face of doubt, suspicion, or misunderstanding.

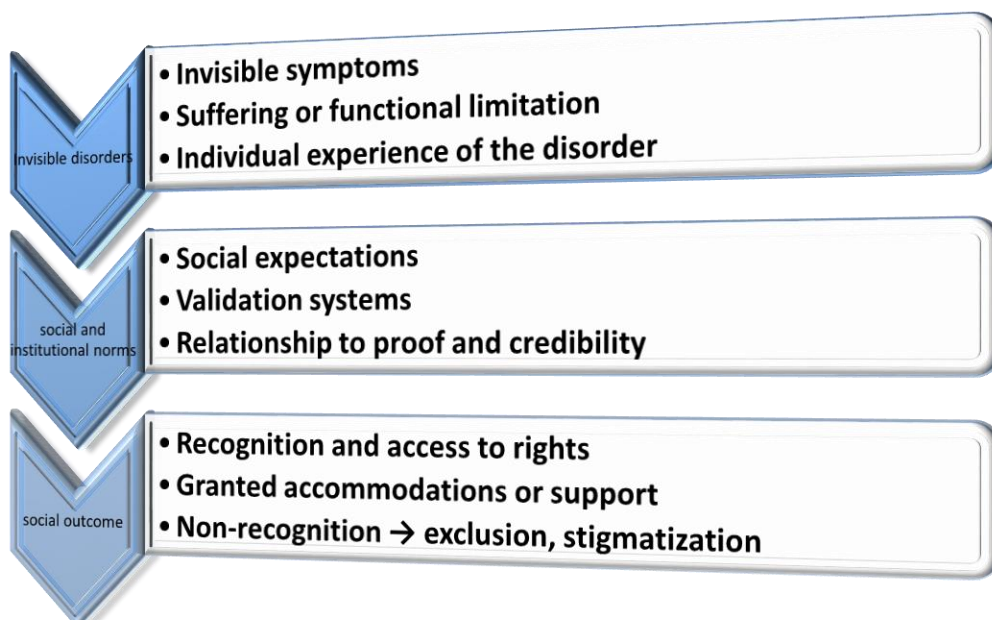
This invisibility makes it difficult to access support, accommodations, and administrative recognition, as it clashes with dominant norms of what constitutes a “real” disability—visible, stable, and medically objectifiable.

Based on these elements, we can present the structure and functioning mechanisms of disability in the following diagram:



Invisible Disability: Structure and Functioning

Invisible disability cannot be understood solely in terms of individual impairment: it takes on its full meaning through the social and institutional interactions that condition its recognition. The following diagram offers a three-level framework to grasp the social dynamics of invisible disability, from personal experience to its concrete effects in terms of rights, recognition, or exclusion.



Social process of recognizing invisible disability

Based on the elements presented above, it is essential to clarify the fundamental differences between visible and invisible disability—not only from a medical or functional standpoint, but more importantly in terms of social representation, institutional recognition, and lived experience. While both forms of disability share the same purpose—to express a limitation in social

participation—they are not perceived or treated in the same way in public spaces or in interactions with institutions.

To make these distinctions clearer, we present below a comparative table that highlights the social, symbolic, and administrative boundaries between visible and invisible disability. This table helps to better understand how the bodily visibility of disability influences access to rights, the credibility given to the voices of those concerned, and the mechanisms of stigmatization or legitimization.

Table 1: Boundaries Between Visible and Invisible Disability

Criteria	Visible Disability	Invisible Disability
Social perception	Immediately noticeable (devices, posture, gestures...)	Not apparent without disclosure or explicit signs
Spontaneous recognition	Generally recognized as a "real" form of disability	Often questioned, requires justification
Typical examples	Paraplegia, blindness, amputation, visible malformation	Depression, ADHD, fibromyalgia, "dys" disorders, partial deafness
Bodily visibility	Obvious (assistive devices, reduced mobility...)	Absent or very discreet
Relationship to institutions	Often recognized more quickly	Lengthy procedures, sometimes unsuccessful
Credibility of the complaint	Accepted with little doubt	Frequently questioned ("you don't look disabled")
Access to accommodations/rights	More systematic, due to visibility and social legitimacy	Conditional on diagnosis, documentation, and ability to "prove" disability
Subjective experience	Immediate stigmatization (stares, pity, rejection)	Double burden: suffering + constant need to justify
Stigmatization	Focused on bodily image (visible difference)	Focused on credibility, suspicion of malingering
Need for disclosure	Unnecessary: the disability "speaks for itself"	Necessary: without disclosure, no recognition or support is possible

Invisible Disability, Although It Deeply Affects the Daily Lives of Those Concerned, Remains Largely Unknown or Poorly Recognized in Social, Institutional, and Professional Spheres.

Unlike visible disability, it does not impose itself spontaneously on the gaze: it must be explained, justified, or even proven, which places the individual in a constant position of legitimizing their suffering. This invisibility, far from being an advantage, creates a double burden: living with a real limitation while facing social doubt, lack of credibility, and administrative uncertainty (Barth, 2022).

Recognition of invisible disability therefore depends on a complex process of interactions with multiple actors (health professionals, institutions, social circles) and dominant social norms that value visibility, stability, and performance. In this sense, invisible disability cannot be defined solely by medical criteria; it must be understood as a socially constructed reality, shaped by power relations, normative expectations, and validation systems that are unevenly accessible. A sociological approach thus reveals the logics of inclusion, exclusion, and hierarchy at work and opens the way to a fairer, more inclusive recognition better adapted to the diversity of lived experiences.

Section 2: Treatment Approaches to Invisible Disability and Their Extensions

Invisible disability, precisely because of its lack of immediate external signs, raises complex issues of recognition, care, and support. Its understanding cannot be limited to a single medical or administrative perspective: rather, it mobilizes a plurality of approaches drawn from different disciplines and professional practices. These “treatment approaches” — medical, psychological, sociological, legal — each define in their own way what constitutes a disability, how it should be identified, and which measures should be associated with it.

However, these approaches do not remain confined to their original fields: they extend into other domains (school, workplace, social policies), where they intersect, complement each other, or sometimes come into conflict. Understanding these dynamics of articulation and extension is essential to analyze how invisible disability is actually managed and why many affected individuals still struggle to have their situations recognized.

Subsection 1: Diversity of Treatment Approaches (Gaulot, 2018)

Paragraph 1: The Medical Approach:

The primary mode of addressing disability, the medical approach relies on identifying an impairment based on objective clinical symptoms. It uses tools such as imaging exams, cognitive tests, or specialized assessments to produce a diagnosis. This approach is central to administrative recognition of disability but tends to exclude disorders whose manifestations are difficult to measure or fluctuate, such as fibromyalgia or certain anxiety disorders.

Paragraph 2: The Psychological Approach:

This approach focuses more on the subjective dimensions of invisible disability: psychological suffering, affective disorders, attention limitations, etc. Psychologists and neuropsychologists contribute to the nuanced understanding of cognitive and emotional disorders, notably in cases of ADHD, “dys” disorders, or depression. It acknowledges the lived suffering even when it cannot be

immediately translated into numbers or images but may face social or administrative disqualification due to lack of “material evidence.”

Paragraph 3: The Sociological Approach:

Sociology seeks to understand disability as a social fact, produced by the interaction between individual limitations and social, environmental, or institutional barriers. It highlights power relations, dominant norms of visibility, and the logics of stigmatization that influence the recognition (or non-recognition) of invisible disabilities. This approach deconstructs the idea that only what is visible is real or legitimate.

Paragraph 4: The Legal and Administrative Approach:

This approach formalizes entry into official disability categories. It relies on standardized criteria necessary to grant access to rights. However, these criteria, often rigid and standardized, may exclude real situations on the grounds that they do not “fit the boxes.” Thus, this approach strongly conditions access to resources but can be disconnected from individual lived experience.

Subsection 2: Extensions of Approaches: Between Coordination and Conflict

Treatment approaches to invisible disability do not remain confined to medical offices or legal texts: they extend into other social spaces (schools, workplaces, institutions) where they are mobilized to evaluate, support, or sort cases.

For example, in schools, a diagnosed dys disorder (dyslexia, dyspraxia, etc.) by a speech therapist or neuropsychologist may lead to the implementation of a personalized support plan. But this consideration depends on the teacher’s perspective, who may judge the disorder too mild or insufficiently disruptive to warrant accommodations. Similarly, in the workplace, administrative recognition does not guarantee social acceptance of the disability: the views of supervisors or colleagues can be influenced by stereotypical representations, reinforcing feelings of disqualification (Chappe & Dumont, 2019).

These extensions can thus generate conflicts of interpretation: a situation may be medically recognized but socially denied; or conversely, be considered problematic in a given context (e.g., absenteeism at work) without being medically acknowledged as disabling (Bouchet & Revillard, 2023). Consequently, those affected often find themselves at the crossroads of contradictory logics, having to juggle disclosure, justification, and adaptation.

To conclude, the following table presents a detailed comparison of these four approaches.

Table 2: Comparative Table of Approaches to Invisible Disability

Criterion	Medical Approach	Psychological Approach	Sociological Approach	Legal/Administrative Approach
Main Focus	Functional or organic impairment	Psychological, emotional, cognitive suffering	Disability as a social construction and power relation	Legal status and access to rights

Type of Evidence Valued	Clinical exams, tests, imaging	Psychological assessments, clinical interviews	Surveys, observation, analysis of social norms	Case files, forms, official evaluations
Relation to the Person	Patient to be treated and stabilized	Suffering subject to be listened to and supported	Individual interacting with a normative environment	User/beneficiary to be evaluated within a regulatory framework
Recognition of Invisible Disability	Possible but difficult without physiological traces	Yes, but often unrecognized outside therapeutic settings	Yes, as a result of stigmatization or exclusion	Only if administrative criteria are met
Advantages	Enables medical diagnosis, prerequisite for other rights	Recognizes subjective, invisible suffering	Highlights structural inequalities and ableism	Allows formal access to support and protections
Limitations	Tends to deny what is not measurable	Risk of individualizing social problems	Lacks concrete solutions for the individual	Strict normative logic, often unsuitable for complex cases

The medical and psychological approaches mainly focus on the individual dimension of invisible disability: one through the body and its impairments, the other through the mind and subjective disorders. They are essential for establishing a diagnosis or providing support but remain dependent on objectification tools that do not always capture the lived experience.

The sociological approach, meanwhile, shifts the focus toward social interactions, dominant norms, and mechanisms of exclusion. It helps explain why certain disabilities — though real — are socially disqualified: they do not fit within collective representations of the "legitimacy" of disability.

Finally, the legal and administrative approach formalizes recognition through standardized procedures. It is indispensable for accessing rights but relies on often rigid criteria that do not take into account the complexity or variability of invisible disabilities.

Section 3: Health Professionals and Invisible Disability

Health professionals play a central role in the recognition process of invisible disability. General practitioners, psychiatrists, psychologists, and specialists are often the first contacts for affected individuals. Their expertise

allows for diagnosis, validation of suffering, and opening access to compensation mechanisms. In a context where the invisibility of the condition makes recognition difficult, the professional's voice acts as an essential intermediary between lived experience and the social and administrative legitimacy of the disability.

However, this position of authority is not without tensions. Faced with subjective, fluctuating, or non-objectivable symptoms, professionals may doubt, minimize, or disqualify the expressed complaint. Invisible disability confronts medicine with its epistemological limits: not everything can be seen, not everything can be measured. Moreover, professional practices are influenced by social biases (gender, class, ethnicity), which affect listening, belief, and recognition of suffering. Thus, the health professional's intervention in invisible disability pathways oscillates between support and gatekeeping, validation and suspicion, with decisive consequences for the individuals concerned.

Subsection 1: A Central Role in Legitimizing Invisible Disability

Paragraph 1: Professionals as Mediators Between Suffering and Recognition

In the context of invisible disability, health professionals play a decisive mediator role between the suffering experienced by individuals and its social and institutional recognition. They hold the power to name, diagnose, and certify an impairment that precisely cannot be seen. This diagnostic ability is often the gateway to recognized disability, especially when it must be presented before institutions.

Medical certificates produced by these professionals are required for entitlement to rights. In other words, without medical validation, institutional legitimization is impossible. The professional acts as a filter between individual complaint and recognition mechanisms, wielding significant symbolic power in the affected person's journey.

Paragraph 2: The Weight of Medical Diagnosis in Institutions

Medical diagnosis functions as legitimate proof in the bureaucratic world of disability (Cadic-Gautier, 2022). It is often seen as a guarantee of objectivity, a rational criterion that enables institutions to distinguish between "acceptable" cases and those that are not. Yet in the case of invisible disability, this criterion can become a major obstacle. Many disorders are difficult to measure (anxiety disorders, chronic pain, severe fatigue, neurodevelopmental disorders, etc.) and do not present tangible signs on scans or blood tests. Their legitimacy thus relies heavily on the professional's interpretation and the quality of clinical interaction.

This creates a structural inequality: disorders that resist classical medical objectification (i.e., without "objective evidence") are less recognized or even excluded from rights and support systems. People with conditions like fibromyalgia, endometriosis, or chronic fatigue syndrome often must undertake multiple procedures and consultations to hope for partial recognition of their disability. Diagnosis, far from being a neutral medical act, becomes a social act with strong normative power deciding what counts as legitimate suffering.

Paragraph 3: Expertise Unevenly Exercised

The role of health professionals in recognizing invisible disability also varies greatly according to specialty, training, and personal disposition. Some practitioners are more open to recognizing invisible disorders due to extensive clinical experience, sensitivity to social issues, or specialization in certain pathologies (e.g., neurologists, rheumatologists, psychiatrists). Others may minimize, relativize, or disqualify patient complaints, especially when no clear biomedical sign supports the patient's account.

This heterogeneity in practice results in significant injustices. Two people with the same pathology may receive radically different responses depending on the consulted doctor: one may obtain recognition and certification within weeks, while the other faces years of medical wandering or denial. This variability highlights how medical expertise is not merely technical but deeply socially situated, influenced by professional representations, beliefs, and healthcare system resources.

Subsection 2: Limits and Ambivalences of Their Intervention

Paragraph 1: Medicine Facing the Invisible — Between Science and Uncertainty

One major limit of medical intervention in invisible disability is the difficulty of objectifying suffering. The traditional biomedical model relies on detecting measurable signs — biological anomalies, imaging, standardized tests — to establish diagnosis. Yet in conditions such as fibromyalgia, chronic fatigue syndrome, or some forms of endometriosis, examinations reveal no abnormalities despite intense reported symptoms. This plunges medicine into uncertainty, where lack of visible evidence can translate into doubt about the disorder's veracity.

This uncertainty may lead to symbolic disqualification of the patient. Without "material proof," suffering is sometimes relegated to the psychological or psychosomatic domain. Phrases like "it's all in your head" or "you're just too stressed" reflect a tendency to psychologize or moralize suffering, which reinforces the invalidation felt by affected persons. The boundary between medical recognition and suspicion becomes blurred, to the patient's detriment, who is doubted despite real pain.

Paragraph 2: Social Biases in Listening and Recognition

Beyond scientific limits, medical practices are also shaped by social biases influencing how patients are listened to, heard, and recognized. Numerous studies highlight gender inequalities in complaint management: women are more often perceived as exaggerating their pain or being more emotionally sensitive, contributing to delays or refusals of diagnosis for conditions like endometriosis, fibromyalgia, or chronic migraine. This male-centered bias in the medical system fuels a lack of understanding of predominantly female disorders.

Furthermore, social or ethnic background plays a decisive role. People from working-class or racialized backgrounds have less access to specialists, fewer resources to express their suffering in the expected medical codes, and often face stereotypes: underestimation of pain, association with "laziness" or "cultural depression," etc. These biases reinforce inequalities in invisible disability

recognition, depending not only on pathology but also on the patient's social position.

Paragraph 3: Ethical and Professional Tensions

Caught between institutional demands, case complexity, and patient pressure, health professionals face real ethical tensions. They must constantly balance compassionate listening and the risk of over-reporting, solidarity with the patient and institutional suspicion (linked to fear of fraud, resource saturation, or generalized social mistrust). This tension is especially strong where diagnosis grants access to social benefits, pushing some professionals to act as "gatekeepers" of social rights.

This sometimes leads to a defensive attitude where issuing a certificate or recognizing the disability is approached with caution or reluctance. Fear of "opening rights too widely" produces implicit social control, with the professional becoming a normative filter, sorting "real" from "false" disabled persons based on often vague or subjective criteria. These tensions make the medical act highly political since it does not merely heal but assigns or withdraws social space.

Subsection 3: Patient Strategies and Resistance Toward Professionals

Faced with obstacles in the recognition process of invisible disability, many people develop adaptation, bypass, or resistance strategies toward health professionals. These strategies are not only individual: they are embedded in unequal power relations and express an attempt to reclaim control over a voice often doubted, disqualified, or ignored.

Paragraph 1: Learning to Speak the "Medical Language"

One of the first strategies patients adopt is to use the codes of the medical world to be better heard. This involves a strategic narrative of their suffering, incorporating technical terms, clinical formulations, and expected symptoms. This phenomenon, described by some researchers as constrained biographization, reflects an adjustment to dominant discourse aimed at obtaining diagnosis or administrative recognition.

To build this narrative, many people rely on digital resources: forums, online support groups, blogs, YouTube channels, or activist social media accounts. These spaces enable information exchange about symptoms, effective consultation wording, or more open-minded doctors. The internet thus becomes a tool for shared legitimation where patients educate one another to better navigate a sometimes-hostile medical system.

Paragraph 2: Bypassing or Complementing Expertise

When recognition fails or an initial diagnosis is denied, patients may multiply consultations — sometimes called "diagnostic wandering" — hoping to find a more attentive or competent professional in the relevant field. This is a form of soft resistance: persisting to find an interlocutor who can hear what has been ignored.

At the same time, patients mobilize their own lay expertise, based on lived experience of the disorder. Often devalued by institutions, this expertise is a legitimate knowledge source, enriched through contact with others affected. It

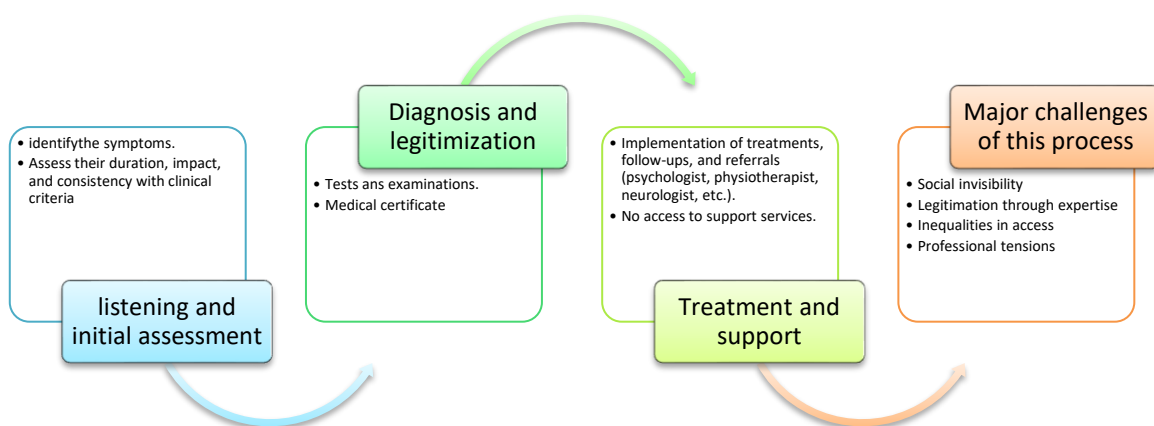
allows them to build an alternative legitimacy, independent of medical validation, asserting their own voice against normative demands of the healthcare system.

Paragraph 3: Activism and Demands for Broader Recognition

These individual strategies can also transform into collective mobilizations. In recent years, many groups and associations have emerged to denounce medical ableism — the health system’s implicit tendency to judge a life’s value or reality according to conformity with norms of productivity, autonomy, or visibility. These movements campaign for broader disability recognition, taking into account not only biological symptoms but also lived suffering, social context, and relational obstacles.

This activism uses varied tools: awareness campaigns, legal actions, public testimonies. It helps redefine legitimacy boundaries in health by demanding the right to be believed, heard, and supported even when the disorder escapes traditional proof criteria. These mobilizations pave the way for transforming professional practices by asserting a strong ethical requirement: to trust patients’ accounts without conditioning their value on visibility or medical conformity.

In the above diagram, we will present the process of invisible disability recognition by health personnel and the major challenges encountered during this process.



Process of Addressing Invisible Disability

Ultimately, healthcare professionals play a crucial role in the recognition process of invisible disability. Their power to diagnose and certify conditions determines access to rights and support systems, placing their judgment at the heart of a system where the invisibility of the disorder makes legitimization particularly complex. This power, far from being neutral, is shaped by clinical uncertainty, social biases, and institutional constraints, all of which profoundly impact the experiences of those affected.

Faced with these obstacles, patients develop strategies of circumvention, resistance, or reclaiming of medical discourse, exposing the limits of a system still

largely built around visibility and normativity. An ethical and sociopolitical reflection is therefore necessary to shift practices toward a more just, inclusive recognition that is genuinely attentive to the diversity of suffering.

Conclusion:

The recognition of invisible disability today represents a central challenge for public policies, institutions, and healthcare professionals. Long ignored or disqualified, this type of disability reveals the flaws of a system focused on visibility, measurement, and conformity to traditional medical norms. It also highlights the social inequalities that pervade the processes of diagnosis, access to rights, and accommodations.

In this context, merely adjusting existing tools is no longer sufficient: a fundamental rethinking of the very foundations of the approach to disability is required.

An inclusive approach to invisible disability involves recognizing the legitimacy of subjective experiences without systematically demanding biological objectification. It also requires training key actors — doctors, teachers, employers, social workers — to recognize and account for invisible forms of suffering in their practices.

However, inclusion cannot be decreed from above: it must be built with and by those affected, incorporating their knowledge, experiences, and demands. In this sense, an inclusive approach to invisible disability is not just a technical adjustment: it calls for an ethical and political transformation of our relationship to vulnerability, normativity, and social justice.

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