‘It’s a gift...and a curse’[1]: How COVID Reframed Our Understanding of Disability as an Intersectional Identity

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Abstract
More than any event in recent memory, the COVID pandemic compelled people worldwide to confront how decisions made at the top levels of institutions led to devastating consequences and exacerbated inequalities. People who typically experience a great deal of societal privilege were forced to reckon that the systematic failure of structure could impact them directly in previously unimagined ways. This article explores how COVID was both a gift and a curse for those who live at the intersection of invisible disabilities and other social identities. For individuals with class privilege and invisible disabilities, COVID required employers to accommodate work-from-home and flexible scheduling options on a scale previously unavailable to most workers. While this may have supported productivity for some individuals, those gains were not available to all. Given that we do not yet know how many survivors of COVID will experience long-term side effects, societies will continue to wrestle with supporting large numbers of workers who find themselves in the disabled category for the first time. This article examines how invisible disability intersects with existing social statuses in a way that holds up a mirror to society more broadly, forcing it to confront its able-bodied privilege.

Keywords: Invisible Disability, Disability as Identity, COVID, Social Model of Disability, Intersectionality, Stigma

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Introduction

Approximately 1 billion people, or 15% of the world’s population, live with a disability (World Health Organization (WHO) 2020). In the U.S., estimates range from 12% to 26% of Americans having one or more disabilities, depending on how disability is defined (Erickson et al. 2020). The Americans with Disabilities Act of 1990 defines disability as “...a physical or mental impairment that substantially limits one or more major life activities” (ADA National Network 2021, para 2). Women, older people, non-Hispanic Native Americans, and Alaskan Natives are more likely to identify with disabilities. Within the population of Americans who identify as having a disability, an estimated 74% do not use a wheelchair, walker, or crutch, indicating that their identity may qualify as an invisible disability. Invisible disabilities can be defined as (Invisible Disabilities Association 2020: para 7): “...symptoms such as debilitating pain, fatigue, dizziness, cognitive dysfunctions, brain injuries, learning differences and mental health disorders, as well as hearing and vision impairments. These are not always obvious to the onlooker, but can sometimes or always limit daily activities, range from mild challenges to severe limitations, and vary from person to person.”

While awareness about invisible disabilities and ableism has increased over the last thirty years thanks to disability rights activists, the COVID 19 pandemic forced many individuals to reckon with the possibility of living with long-term disabilities for the first time. Many of the identified potential long-term effects of

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[1] This title is a quote from the television series, *Monk*. Lead character Adrian Monk is a brilliant detective who also lives with extreme OCD - obsessive compulsive disorder. This quote summarizes Monk’s self-assessment of his disorder. The author self-identifies as having invisible disabilities including OCD, and two immune system disorders that affect daily life and ability to work/participate in the social world.

COVID, such as fatigue, body aches, brain fog, and difficulty concentrating, fit the symptom lists of several invisible disabilities. Recent studies indicate that of those hospitalized for COVID 19, 50-80% experience at least one long-term symptom (Komaroff, 2021). Given the proportion of people who experience long-term effects of COVID combined with a sizeable generational cohort of boomers aging into disability, the rate of individuals living with chronic illness and invisible disabilities is likely to increase and continue increasing over time. Post-COVID, societies will continue to wrestle with supporting large numbers of citizens who find themselves in the disabled category for the first time.

More than any event in recent memory, the COVID pandemic compelled people around the world to confront how decisions made at the top levels of institutions led to devastating consequences for citizens and exacerbated pre-existing inequalities. Elders, the mentally and physically disabled, and members of historically marginalized groups contracted and died of COVID at disproportionately high rates (Abrams et al. 2020, Williamson et al. 2020). In addition, people who typically experience a great deal of privilege were forced to reckon with the fact that the systematic failure of structure could impact them directly in previously unimagined ways.

This article explores how COVID was both a gift and a curse for those who live at the intersection of invisible disabilities and other social identities. For individuals with class privilege and invisible disabilities, COVID required employers to accommodate work-from-home and flexible scheduling options on a scale previously unavailable to many workers. While this may have supported productivity for some individuals, those gains may have been countered by parenting role demands that affected women-identifying folks unequally. Furthermore, Black Americans, Native Americans, and Hispanic Americans are more likely to contract COVID (CDC 2020a). An intersectional lens is needed to understand how COVID 19 simultaneously challenges and creates opportunities for institutions and individuals. Drawing on literature from feminist disability studies and sociological theory, this article examines how invisible disability intersects with existing social statuses in a way that holds up a mirror to society more broadly, forcing it to confront its able-bodied privilege and consider how structure constructs disability.

Literature Review

Models of Dis/ability[2]

Despite a varied and growing body of scholarly literature, considerations of disability in sociological analysis tend to be in the subfield of the sociology of medicine and illness. This is problematic because it tends to reinforce a medical model of disability that locates consideration of disability in the bodies of individuals rather than in social practices and institutions. Historically, sociology has used a functionalist or interactionist lens when theorizing disability (Oliver 1996, Thomas 2012). Medical models of disability focus on impairment understood as loss or limitation to an individual’s psychological or physiological structure. Disability as a concept, in contrast, focuses more on the ability of individuals to fully participate in social life and the typical roles expected of citizens (Oliver 1996, Wendell 1996). Visual or hearing impairment, for example, may or may not be disabling if social structures do not prevent an individual from fully participating in activities constructed as normative. Many members of the deaf community consider themselves a subculture rather than a disabled identity group because when interacting in spaces structured to support them, their impairments do not limit inclusion.

Drawing partly on Goffman’s (1963) writings on stigma, the social model of disability explores how social structure enables or disables individuals. The social model analyzes how built environments contribute to inclusion or exclusion and unpacking the social construction inherent in assumptions about “normal” bodies (Oliver 1996, Shakespeare 2013). Furthermore, as Goffman (1963) and others have argued, stigma itself is disabling. Wendell (1996), for example, elaborated how stereotypes about people with disabilities lead others to assume the underlying impairment has a totalizing effect on an individual’s ability to participate in the social world. In other words, individuals with impairments are assumed to be completely disabled and prevented from functioning in all contexts, rather than only in specific situations.

Even interactive models of disability that examine the way categories are constructed continue to be influenced by a functionalist lens that centers on assumptions about normal/abnormal bodies (Thomas 2012). While Goffman’s (1963) contribution helped frame disability as not entirely a question of impairment, by framing the experiences of disabled

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[2] Following disabilities studies scholars, I use the term dis/ability to both question our assumptions about disability and reflect the social construction of what we understand to be able bodies, and also to reference Garland-Thompson’s (2011) conceptualization of the “ability-disability” system, referenced in this article.

individuals through a normal/deviant lens, Goffman continued to other disabled groups and foment what Garland-Thompson (1997:8) terms the “normate” as taken for granted default desired category. For Thomas (2012), this results in a missed opportunity to understand and fully theorize ‘disablism’ and move sociology of disability out of the subfield of medical sociology and illness. Thomas (2010:37) conceptualizes disablism as:

> ...the social imposition of avoidable restrictions on the life activities, aspirations, and psycho-emotional well-being of people categorized as ‘impaired’ by those deemed ‘normal.’ disablism is social-relational. It constitutes a form of social oppression in contemporary society – alongside sexism, racism, ageism, and homophobia. As well as enacted in person-to-person interactions, disablism may manifest itself in institutionalized and other socio-structural forms.

Similarly, Garland-Thomson’s (2011:17) elaboration of the “ability/disability system” theorizes disability as a system of oppression that legitimates inequalities similar to how patriarchy and white supremacy structure and permeate all aspects of society.

> [The ability/disability system]...is a system for interpreting and disciplining bodily variations; second, it is a relationship between bodies and their environments; third, it is a set of practices that produce both the able-bodied and the disabled; fourth, it is a way of describing the inherent instability of the embodied self (Garland-Thomson 2011:67).

By including the construction of the able-bodied and disabled as a system of oppression, Garland-Thomson (2011) seeks to undermine assumptions that disabled bodies are inherently inferior. Instead, a feminist disability theory critically deconstructs both the labeling process and the status of those labeled to reveal how privileged identities are also produced. In this way, disablism structures micro-level interactions and social institutions and creates different identity categories with unequal access to power.

Disabled identities are not separate from other privileged and oppressed identities, however. The social construction of the normate begs the question typical for whom (Wendell 1996)? Decades of feminist scholarship have revealed how medical data has often excluded biologically female bodies from necessary research (Criado-Perez 2019). Excluding racially and ethnically diverse individuals from the research also results in a one size fits all approach to health and illness that only fits the size of able-bodied, cisgender, male, and White. This leads to problematic assumptions about disabled individuals, including the notion that everyone who finds themselves in this category wants to escape it and cannot have a full and meaningful life as a disabled person (Garland-Thomson, 2011).

In addition to encoding dangerous assumptions about individuals' values and abilities, the construction of a normal body also casts other bodies as deviant. Anyone who is then labeled as other than normal experiences stigma, and as intersectional feminists taught us, dis/ability does not exist independent of gender, race, class, and other identities. People with disabilities are more likely to be female, poor, and non-White (CDC 2020b). While data on the demographics of individuals with invisible disabilities is difficult to estimate, women are more likely to experience chronic illness and rheumatoid arthritis, the two most common types of invisible disability in the U.S. (CDC 2020d, Disabled World 2020). Gender socialization also affects how individuals are expected to perform their disability. Because women are considered weaker physically, physical impairments are less likely to raise questions about an individual’s femininity. However, the same is not true for those who are read as male[3].

Invisible Disabilities and Gendered Ableism

Like other social identities that are not immediately observable to others, invisible disabilities create unique positionality for individuals. On the one hand, individuals with invisible disabilities may be read as able-bodied and access the social and cultural privileges that accompany this identity. On the other hand, the assumptions we make around reading identities mean that individuals may need to out themselves as disabled to access accommodations and support (Jung 2011). Doing so can expose an individual to invasive investigation and lead to othering and stigmatization. Due to intense social pressure to function within the boundaries of what is constructed as normal and able-bodied, many individuals with invisible disabilities may choose not to disclose to avoid stigma and discrimination.

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[3] Here I use the phrase ‘read as male’ to indicate that an individual’s gender identity may or may not correspond to how they are perceived in the social world. That said, as sociologists we recognize that how a person is ‘read’ socially and assigned to categories (whether they personally identify with said classification) affects how they are treated by others.

In a recent study of ableism in academia, Dolan (2021) found that professors who self-identified as having invisible disabilities were unlikely to disclose or claim said identities unless forced to do so. Interviewees feared that they would be perceived as unable to meet professional expectations. When they felt they had to disclose, they were inclined to provide a body of evidence indicating that the invisible disability would not affect performance expectations (Dolan, 2021). Dolan (2021)’s work on disability in academia reveals what Garland-Thomson (2011) identified as the totalizing effect of disability - the assumption that any impairment completely disables an individual and limits performance. Fear of job loss and stigma continued to affect individuals’ decisions to disclose based on fears of perceived incompetence, even when a preponderance of evidence indicated otherwise; most of Dolan’s (2021) interviewees were full or tenure-track professors.

Fear of stigma and discrimination has also led to an interesting trend during quarantine - the hidden COVID pregnancy. In an essay for Business Insider, Professor Anna Wexler (2021) revealed that working from home allowed her to hide her pregnancy and that doing so “put her on more equal footing with her male peers.” Wexler (2021)’s ability to conceal her pregnancy made it easier for her to assimilate to academia's White, male, ableist norms. Despite her attempts to fit into male norms in academia by wearing “blazers and suit jackets,” apologizing less and interrupting more during panel discussions, Wexler felt that her gender was on display during her first pregnancy, differentiating her from her male peers. Wexler (2021) also blames her pregnancy for missing important interviews and career opportunities. While Wexler (2021) acknowledges gender inequality in academia more broadly and her privilege (partner with longer parental leave, the ability to work from home, accessible daycare for her older child), she fails to critique the structure as inherently oppressive. Instead, her assessment of how being able to attend meetings and present at conferences via Zoom while pregnant or immediately postpartum normalizes how academia is predisposed to privilege some social statuses over others and localizes the problem of pregnancy in the body of the pregnant person.

Wexler, it seems, is not alone in hiding her pregnancy. Journalist Jessica Grose tweeted that in researching motherhood for her forthcoming book, three women she spoke with hid their pregnancies during COVID because of fear of demotion or firing (Grose 2021). Grose later added that these women were freelance or contract workers without access to parental leave (Grose 2021). While four out of millions of American women who were pregnant during 2020 is an incredibly small number, it reveals that even someone as privileged as Wexler in a tenure track position felt compelled to hide her pregnancy.

Recognizing the inclusive potential of remote work, Wexler (2021) concludes her essay advocating for workplaces to continue virtual work: “...partial normalization of the virtual world would make it easier for women to navigate the challenges of pregnancy, birth, and childcare with less of an effect on their careers. It would also keep the door open for others who have been left out — because of disability, financial barriers, or other reasons.” Remote work and flexible hours may help some people more fully participate in work. However, it is a mixed blessing. It will likely continue to exacerbate existing social privileges while simultaneously cementing disability (or pregnancy) as an individual problem, rather than recognizing that working toward the inclusion of people with disabilities is a social responsibility.

In a recent study on disability and microaggressions, Olkin et al. (2019) found that in addition to previously identified common disability microaggressions, women with disabilities experienced delayed diagnosis due to medical providers not believing their self-reported symptoms. Women with invisible disabilities, in particular, reported experiencing microaggressions invalidating their impairment because they were perceived to look too healthy or young (Olkin et al. 2019). The most-reported microaggressions were: “‘Someone downplays the effects of disability on your life,’ ‘Someone assumes you need help,’ ‘You are praised for doing almost anything,’ and ‘Your right to equality is denied’ (Olkin et al. 2019:768).” Of those who reported experiencing microaggressions, the downplaying of disability and denying equal rights were most troubling.

Consistent with Olkin et al.’s (2019) results, recent research on women with polycystic ovary syndrome (PCOS) indicates that this gendered ableism in the medical community has led to the failure to recognize PCOS as a risk factor for COVID. In a clinical study of women in the UK with PCOS, Subramanian et al. (2021) found a 28% higher risk of contracting COVID 19 for women with PCOS, even after controlling for body mass index (BMI) and other risk factors for COVID-19. Individuals with PCOS may have higher levels of androgens and inflammation - two conditions associated with an increased likelihood of COVID infection and longer-term symptoms (Masi, 2021). But when Kris Nealon, a young woman with PCOS, asked her doctor whether her long-term symptoms could result from having PCOS and contracting COVID, her doctor dismissed the possibility. In Nealon’s words (Masi, 2021): "That's what it's like, just with PCOS, let alone adding COVID in...you go to a doctor with a list of symptoms, and you either get 'you're fat' or 'you're overthinking things.'"

Both external and internalized, ableism can inhibit access to appropriate accommodations for people with invisible disabilities. Because individuals with disabilities are disproportionately likely to be poor and have chronic health issues, ableism must be understood from an intersectional perspective. Just as specific identities within marginalized social categories may experience more or less oppression relative to one another, however, people experience ableism in unique ways. Like other people who may be read as “passing” as straight, White, or cisgender, people with invisible disabilities face nuanced situations in an ableist system.

In a qualitative study of 14 individuals with invisible disabilities, Kattari et al. (2018:481) identified several themes that characterized the participants’ experiences, including: “...policing of bodies, tension in roles, desire for justice, and...internalized ableism.” Because the participants’ disabilities were not always noticed, they experienced internal conflict when those around them expressed ableist attitudes or microaggressions. If they confronted the attitude or microaggression, they also risked disclosing their disability and the potential stigma. Many interviewees also stated that even if they did want to correct or educate the other person, it was emotionally and physically draining. Energy management is typically a recurring issue for people with invisible disabilities. When individuals used accommodations, they were often sanctioned for not looking disabled or being judged too healthy (Kattari et al., 2018). Internalized ableism, however, also kept individuals from both accepting their diagnoses or accessing accommodations. Several interviewees expressed attitudes of frustration with their limitations or that they should feel lucky their disability was not worse, even while recognizing this was a product of our ableist society (Kattari et al., 2018).

COVID and Invisible Disabilities

While public health scholars and sociologists have worked for decades to theorize and research the effects of systemic, historic oppression on health inequities, the realities of COVID 19 forced many Americans to confront systemic ableism for the first time. Because ableism is constitutive of and constituted by other systems of oppression - racism, sexism, classism, colorism, heteronormativity, and so on - to better understand the effects of COVID on individuals and institutions, we need an intersectional analytical perspective that integrates the social construction of disability as an integral, non-independent, structure of systemic oppression, rather than an added identity category.

Our social institutions are constructed by and for the able-bodied, cisgender, straight, neurotypical, upper-middle-class, White male to define those categories hierarchically in a way that confers the privilege to some while oppressing others, so that the privileged may benefit from both the oppression of others and obfuscate the social process that produces the hierarchy. Therefore, bodies defined as most able, typical, and preferred are also raced, classed, and gendered. Trying to separate ableism from other systems of oppression is like trying to unmix a tempera paint slurry back into individual colors after an enthusiastic toddler has thoroughly stirred it. This section explores the disparities in rates of COVID infection, hospitalization, and death by racial-ethnic group and socioeconomic status while also considering the intersection of these identity groups with underlying health conditions and disabilities. The section concludes with a discussion of how the COVID experiences of people with invisible disabilities reveal intersectional privilege or oppression *vis a vis* the dis/ability system (Thomson 2012).

Rates of COVID infection and death occur in tandem with existing social inequalities. However, important nuances exist within racial-ethnic group categories depending on the intersections of gender, level of education, income, and health conditions. For example, Native Americans, African Americans, and Pacific Islanders have higher rates of obesity and diabetes relative to Whites and LatinX Americans (CDC 2020c). Diabetes and obesity are two of the most significant pre-existing risk factors for COVID morbidity and mortality. Both diabetes and obesity, however, are also strongly associated with class and level of education (CDC 2020c).

In the United States, Native Americans, people who identify as bi or multi-racial, and Latinx Americans were disproportionately likely to acquire COVID 19 (CDC 2020a). Even though Black Americans are not disproportionately infected with COVID 19 relative to their overall percentage of the population at the national level, they do make up a disproportionate proportion of COVID deaths, as do Hispanic Americans, Native Americans, and Alaskan Natives, and Native Hawaiian or Pacific Islanders (CDC 2021b). However, one study in New York City showed a persistent association between higher infection rates and the Black or African American population, even after controlling for pre-existing conditions (DiMaggio et al. 2020). In addition, disproportionate death rates by racial-ethnic groups persist even when controlling for age, the largest associated risk for COVID morbidity and mortality.

Native Americans’ experiences with COVID reveal a disturbing intersection of the oppressive effects of colonialism, racism, and ableism. As discussed previously, Native Americans have disproportionately high rates of obesity, diabetes and are more likely to be disabled. Yet, when the Seattle Indian Health Board requested COVID testing supplies from the federal government, they received body bags instead (Oritz 2020). Like Garland-Thompson’s (2011) claims about the totalizing effect of disability, this action suggests support for Razack’s (2015) argument that the government ascribes the higher rates of obesity, diabetes, disability, and alcoholism as a problem inherent in indigenous bodies, while simultaneously disavowing itself of taking responsibility for the effects of colonialism and laying claim to Native lands.

Data is limited with respect to the percentage of people who experience long-term symptoms after COVID infection. Medical experts expect the numbers to increase over the next year, however. Early studies indicate that 50-80% of people infected with COVID continue to experience symptoms that affect their quality of life three to six months post-diagnosis (Komaroff 2021). The most frequently identified symptoms of PASC (Post-Acute Sequelae of SARS CoV2), more commonly called long-haul/long COVID, are fatigue, body aches, shortness of breath, headaches, difficulty concentrating, and difficulty sleeping (Komaroff 2021). Although little is known about who is more likely to experience long COVID, early studies suggest that over the age of 50 and having pre-existing chronic illnesses are associated with greater risk (Komaroff 2021). In addition, medical experts, including Dr. Anthony Fauci, chief medical advisor to the president and director of the National Institute of Allergy and Infectious Diseases, have recognized that long haul COVID presents in very similar ways to chronic fatigue syndrome (also known as Myalgic Encephalomyelitis or ME/CFS) (Komaroff 2021). ME/CFS is one of the most common invisible disabilities in the U.S. and frequently occurs post-viral infection in women between 40 and 50.

Given the infection rate and long haul COVID, the U.S. could experience a doubling of the number of people with ME/CFS, currently at 2.5 million, and diagnoses could increase by 10 million globally (Komaroff and Bateman 2021). Not only is COVID associated with increased long-term impairment, but it is also exponentially oppressive for those already disabled by society, who are already more likely to be marginalized by positionality in class, gender, racial-ethnic group, and other social hierarchies. In some ways, however, COVID was a gift for those who experience invisible disabilities and chronic illness. (The following section explores the intersectional privilege and oppression of the COVID pandemic).

COVID-related lockdowns throughout 2020 revealed how structural changes could enable individuals with invisible disabilities and chronic illnesses. Workplace and structural adaptations to COVID created unique situational benefits for some individuals with invisible disabilities. Flexible work hours and the option to work from home are two common workplace accommodations that support people with disabilities. Pre-COVID, however, accessing these accommodations meant disclosing one’s disability. This process of disclosure could mean going through the hassle of medical diagnosis and documentation and frequently leads to stigma, marginalization from co-workers, and microaggressions (Kattari et al. 2018, Olkin et al. 2019). When large sectors of the economy shifted to supporting remote work, people with invisible disabilities and chronic illnesses could access accommodation without experiencing the invasive process of disclosure. Not having to leave home for work, errands, and socialization was potentially beneficial in reducing risk for those who are immunocompromised while still enabling participation.

In a recent post, Blogger and Hidden Disability Advocate Christina Irene identified “11 Pandemic Trends People with Disabilities Want to Keep (Irene 2021).” Irene listed working from home, social distancing, contactless delivery, different sanitization protocols, employers supporting time off for illness and vaccination, and the shift of meetings and religious services to online formats as practices that support the inclusion of people with disabilities chronic illnesses. As Irene (2021) explained:

> I can’t tell you how hard it can be sometimes to just get food when my fibromyalgia and chronic fatigue syndrome are acting up. Grocery delivery, online ordering with curbside pickup at restaurants and stores, restaurant delivery…these have all made life a lot easier. They’re also great options for people with mental health conditions such as anxiety.

However, many of the benefits in keeping these trends going are only options for those who already experience privilege. School districts around the country struggled to provide technological solutions and support for students who had to shift to online, remote learning. Access to high-speed internet and sufficient hardware are just two of the axes of stratification that could make the lockdown experience empowering or disempowering. People who can shift to remote work are also disproportionately college-educated. Finally, a great deal of the potential for pandemic trends to be a gift rather than a curse boils down to class privilege.

People with disabilities are disproportionately likely to be unemployed and to live in poverty (U.S. Census Bureau 2018). Employment rates are lowest for Black, non-Hispanic Americans with disabilities at 29.7% (compared with employment at 74.4% for Black Americans without disabilities). The intersection of race and ethnicity with dis/ability reveals 30-40% gaps within demographic categories (Institute on Disability 2020). Even when employed, it is unlikely that most people with disabilities experienced the upsides of structural shifts to remote work, contactless delivery, and online socialization opportunities. Black and Hispanic Americans are disproportionately likely to work as essential front-line workers relative to their overall population share and face a greater risk of COVID exposure and infection (McNicholas and Poydok 2020).

Discussion and Conclusions

The current rate of COVID infection implies dramatic increases in the number of people who live with invisible disabilities and chronic fatigue syndrome in the next several years. Existing structural inequalities mean that a disproportionate number of those newly disabled people will be women, people of color, poorer people, and people with existing chronic health conditions. Thus, structural accommodation for Americans with invisible disabilities is a racial justice and social justice issue. While ensuring that remote work or school continues to be an option after lockdown, remote options will only benefit those who are privileged enough to access them unless other support systems are implemented.

The shift to remote learning for some disabled college students was more supportive and inclusive. They could access lectures and coursework from home and watch videos later or rewatch them if instructors recorded and posted them. Like many efforts to be inclusive of people with disabilities, this was enabling for other groups. Many instructors were encouraged to use captioning for video lessons - a technology not available in the face-to-face classroom. Captioning and the option to review video lessons multiple times included English language learners and people with hearing impairments. For others, however, the shift to remote learning was marginalizing. Even if Wi-Fi and computers were available, merging lifeworld and market systems meant that students could be trying to work, parent, and attend college all while at home. College students who lived with children, siblings, or family members were trying to access coursework over limited Wi-Fi connectivity and sharing bandwidth and laptops with family members.

As of the writing of this article, the increase in more infectious COVID variants may precipitate a return to lockdown in the near future. Even if public spaces' reopening continues without interruption, epidemiologists predict it is only a matter of time before the next pandemic. To minimize loss of life and dramatic financial disruption, societies would be wise to implement some pandemic adaptations more permanently, such as flexible work hours, remote work, and free, widely available vaccinations. That said, these adaptations would be most inclusive if accompanied by publicly available broadband internet access and supportive technological and financial assistance to families with school-aged children or college students.

Awareness of the potential for short- or long-term impairment needs not only to be a part of individual responsibility but should also be driving policy at institutional levels. In addition to mission and diversity and inclusion statements, organizations need pandemic response plans and inclusive disability policies that recognize and support individuals with disabilities. Pandemic or not, should we be fortunate to live long enough, we will all experience impairment. Garland Thompson stated (2011:34): “...disability is perhaps the essential characteristic of being human.” Whether or not that impairment adds up to disablement for individuals and societies depends on what we do next.

Given the rate of individuals who experience long-term effects of COVID-19, the number of people who identify as having invisible disabilities is likely to increase and persist. This article explored how pandemic adaptations, including remote work, contactless delivery, and online options for school and socialization, revealed how structures could be enabling or disabling in ways that exacerbate intersectional inequality. Sociology and society, more broadly, would benefit from a more robust understanding of disability as an intersectional identity.

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