# Work and the Rhetorical Enactment of Disability in U.S. Social Security Disability Insurance: How Long COVID's Ontologies Disrupt the Logic of U.S. Workfare Systems

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**Abstract:** Long COVID, a disabling chronic illness, continues to affect millions of people, changing work and health on a population level. As more people afflicted by Long COVID attempt to access workfare programs such as Social Security Disability Insurance, their experience exposes the inadequacies of such programs to humanely address the needs of all disabled people. In this essay, I draw on Annemarie Mol's multiple ontology theory and praxiography method to tease out the multiple ontologies of Long COVID and show how these ontologies exceed the bureaucratic logics of SSDI that cast disability as a static, discrete, medical phenomenon. Long COVID, with its sheer number of symptoms and its varying presentations, troubles the rigid measurement of disability length, severity, and impact on embodied capacity that SSDI depends on to disperse financial benefits to those deemed disabled enough to deserve such support. I conclude with a call for feminist rhetoricians of work and labor to both incorporate disability praxiography into their analyses and see what affordances practice-based ontologies offer to thinking about how disability, race, gender, and other identity categories are lived and experienced.

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As we enter the fifth year of the COVID-19 pandemic, the COVID virus continues to disable and kill millions. Despite the consistent, yet sometimes underwhelming, efforts of government organizations and healthcare providers to mitigate the effects of this "mass-disabling" event, the virus persists (Duggal qtd. in Arnold). Along with straining healthcare systems around the world, the pandemic has precipitated "the degradation or collapse of welfare services" caused in part by job loss and financial precarity of those disabled by Long COVID, the chronic illness that the COVID-19 (COVID) virus can trigger after even one infection (Hereth et al.; WHO). As of October

2023, an estimated 14.3% of American have experienced Long COVID, which can cause symptoms and subsequent diseases and disorders including but not limited to: fatigue, organ damage in the "lungs, heart, nervous system, kidneys, and liver," diabetes, cardiovascular disease, cognitive and memory impairment, and cancer (CDC "Long COVID: Household Pulse Survey"; Klein).

Although President Biden ended the U.S. Public Health Emergency on May 11, 2023 (Klein), COVID continues to spread. The already tenuous and blurry boundaries between disabled/abled and healthy/unhealthy are breaking down and shifting as more and more people who are affected by COVID attempt to access "workfare" programs like Social Security Disability Insurance (SSDI). Social policy researcher Maeve Quaid defines workfare as a type of welfare that requires "recipients [to] undertake some labour-market-related activities...in return for government payments" (19). Workfare, as opposed to welfare, programs "emphasize an individual's responsibility to work, but do not include supports and services that help remove wider structural barriers facing people with disabilities" (Harris et al. 823). In other words, SSDI claimants must have previous work history to qualify for benefits and are often required to undergo job training and searching activities while receiving benefits. Not only does SSDI policy emphasize an individual's responsibility to seek out or return to work, it also emphasizes their responsibility to maintain or resolve their disability, as evidenced by the repeated verification of long-term, "total" disability required for SSDI ("Annual Statistical Report" 2-4). By defining and quantifying disability as the inability to work and linking access to financial security to individual responsibility, SSDI policy employs a neoliberal framework of citizenship.

To tease out the relationship between work and disability within the context of SSDI and Long COVID, I analyze excerpts from the latest "Annual Statistical Report on the Social Security Disability Insurance Program" and SSDI guidelines for claimants, physicians, and government employees on the Social Security Administration (SSA) website. I pay particular attention to the embodied labor that is necessary for claimants to access these benefits. Through this analysis, I reveal how material, embodied experiences of disability–here, in the case of Long COVID–interact with social discourses and neoliberal institutional practices that label people "disabled." Instead of debating whether chronic illness can or should be considered a disability or theorizing meaning from disabled experience, I follow the work of Annemarie Mol and other scholars who have theorized the multiple ontological enactments of disease and disability through practice(s) rather than perspective (Card et al.; Dijkstra; Friz; Kessler; Sikka). This focus on practice helps me think through how disability exists or is brought into being through the intra-action of human and nonhuman agents specifically in this moment—the ongoing COVID-19 pandemic. The multiple ontologies of Long COVID exceed the bureaucratic logics of SSDI that cast disability as a static, discrete, medical phenomenon. Long COVID fails to cohere because of its sheer number of varying symptoms and outsized effect on the bodies and working ability of the disabled and temporarily-abled in the U.S.

I start by situating Long COVID in the context of SSDI and the logic of U.S. workfare systems. Understanding SSDI's medical definition of disability as the inability to work assumes that claimants fail to produce labor and capital through normative embodiment and that they, rather than the government, are individually responsible for managing their disabled body-minds. The languages of SSDI policies and application materials are important actants in the assemblages and practices that create and maintain multiple ontologies of disability. I draw on Mol's multiple ontology theory and praxiography method to theorize the role of language and embodied labor in such assemblages. I conclude with a call to feminist rhetoricians of work and labor and disability studies scholars to incorporate praxiography into their study of gender, disability, and work.

## SSDI and Long COVID

Disability insurance was added to the US Social Security program in 1954 and has since expanded or restricted eligibility requirements and the application process based on changing ideologies of work, disability, and the purpose of the program. Some of the aspects of SSDI that have changed over time include: the amount of financial assistance available for disabled workers and their dependents, the length of time of coinciding Medicare coverage, eligibility for benefits including work requirements, the process of initial and continued verification of disability, and the appeal process ("Annual Statistical Report" 1-2). The number of people newly receiving SSDI has decreased from approximately 648,000 in 2020 to 543,000 in 2022, as compared to the approximately 1.8 million applicants each year ("Social Security Disabled Worker"). SSDI benefit claims involving Long COVID represented approximately 1% of all applications as of 2023 (Rapaport; Konish). The SSDI application process and policy language frames disability as static and unchanging through the assumption that a condition never changes in severity or how much it affects a person's life and that it can be accurately captured at one moment through primarily physician-provided evidence. At the same time, disability is ironically assumed to be a non-permanent or variable condition requiring methodical and consistent re-verification by the SSA even when "medical improvement is not likely" ("Annual Statistical Report" 7).

Although SSDI is meant for long-term, "total" disability the insurance program continues to emphasize a focus on rehabilitation and a telos of re-entry into the workforce for claimants and beneficiaries ("Annual Statistical Report" 2).  For example, a web page informing current beneficiaries and potential claimants of what they should "report" while receiving benefits lists changes in work status, income, citizenship/immigration status, and "big improvement[s] in your medical condition" as important information to tell the SSA "right away" to determine continued eligibility ("What You Must Report"). The urgency conveyed by the phrase "right away" implies two goals: returning people to work as quickly as possible and carefully monitoring the enrollment numbers to weed out people who no longer qualify, or in other words, do not deserve the assistance. Separating deserving, legitimate applicants from undeserving, illegitimate ones is one of the moral underpinnings of workfare social policy (Quaid 9). The assumption that medical conditions that

cause disability in the SSDI framework will, or should, improve similarly supports a telos of cure while acknowledging fluidity in the physical experience of disability. This expectation of improvement exemplifies disability scholar Alison Kafer's concept of "curative time" which assumes "the only appropriate disabled mind/body is one cured or moving toward cure" in which cure "signals the elimination of impairment but can also mean normalizing treatments that work to assimilate the disabled mind/body as much as possible" (27; emphasis added). To assimilate disabled people into a normative workforce, SSA operates within Kafer's "curative time," pushing SSDI beneficiaries to return to work even while receiving benefits and conveying skepticism about the existence of long-lasting, variable disability.

SSDI beneficiaries are expected to constantly update SSA about changes in their disability. SSA requires such self-surveillance to determine beneficiaries' continued eligibility for benefits and facilitate a linear move towards re-entering the workforce. The assumption inherent within the SSDI system that some people will be successfully rehabilitated through and past disability, at least enough to perform normative embodied labor within capitalism, applies to all disabilities when improvement is a general underlying expectation of medicalized disability. This ongoing verification process is an example of what Ellen Samuels calls "biocertification," which "describes the many forms of government documents that purport to authenticate a person's social identity through biology, substituting written descriptions for other forms of bodily knowledge and authority" (122). The continuous authentication of disability refuses the permanence of some disabilities (e.g., some forms of blindness) while expecting all disabilities to improve to the point of cure. Through these reporting requirements, the SSA scrutinizes the existence, severity, and impact of claimants' disabilities on their lives, creating an individualized mandate for recipients to manage both their disability and their survival rather than being able to rely on government, community, or even workplace resources.

In our continuing pandemic context, it is crucial for rhetoricians interested in work, labor, and disability to examine institutional discourse and documentation that manage workfare programs. Additionally, scholars studying government policy and healthcare-related technical communication might attend to the SSDI application and accompanying policy documents, especially as Long COVID is challenging not only individuals' embodied capacity to produce labor but also the work-centered identity of American culture. As "a wide range of new, returning, or ongoing health problems...[that] may emerge, persist, resolve, and reemerge over different lengths of time," Long COVID can present challenges to the strict duration and severity requirements of SSDI especially because many of these symptoms are difficult to diagnose and are often misunderstood by healthcare providers (CDC "Long COVID or Post-COVID Conditions"). In an emergency message detailing SSDI policy on evaluating COVID-19 claims, the SSA defines duration as "the period during which a person is continuously unable to engage in any substantial gainful activity because of one or more MDIs [medically determinable impairments]" and goes on to state that projection of the severity and duration of an MDI-caused disability may be necessary "if it is unclear whether or when

the MDI(s) will resolve" ("Evaluating Cases"). The variety in symptoms, severity, and duration of Long COVID presents challenges for this chronic illness/disability to ontologically "hang together" (Mol 5). Mol writes of multiple disease ontologies, "objects come into being—and disappear— with the practices in which they are manipulated. And since the object of manipulation tends to differ from one practice to another, reality multiplies...far from necessarily falling into fragments, multiple objects tend to hang together somehow" (5). Due to the numerous physical symptoms and wide-ranging effects on the body, the multiple ontologies of Long COVID perhaps cannot hang together as neatly or cohesively within SSDI policy's conception of disability. Long COVID also exceeds or spills over any easy hanging together because of the massive scale at which it is affecting population-level health and working conditions.

The various evolving and fluctuating presentations and experiences of Long COVID have made it especially difficult for people with Long COVID to seek SSDI benefits within an already hostile and arduous application process. Some of these difficulties include: the lack of a positive test to show initial infection with COVID; SSDI or private health insurance companies requiring additional testing or "evidence" to validate a claim of Long COVID; the difficulty in diagnosing and proving that one has "invisible" symptoms like cognitive impairment and fatigue; and frequent reviews of a case even after it is approved (Mizuguchi, Konish). Along with the difficult and of- ten painful symptoms and experiences of Long COVID, I argue that claimants can experience "access fatigue" which Annika Konrad defines as "the everyday pattern of constantly needing to help others participate in access" or, in other words, advocating for and explaining oneself to people and institutions that are inaccessible (180). One criterion in obtaining SSDI benefits for a claimant with Long COVID is to produce proof of an initial, acute infection with the COVID virus (or undergo diagnostic verification of this acute phase) ("Evaluating Cases"). The enactment of COVID infection has many competing and incommensurable ontologies due to the nature of the disease, mis- and disinformation about spread and symptoms, and lack of access to reliable and widespread testing in the U.S. Here, I am using enactment as defined by Mol to refer to "activities [that] take place" and are made "visible, audible, tangible, knowable" (Mol 31, 33). These ontol- ogies could include COVID infection as positive rapid test; as symptoms; as diagnosis; or even as exposure to another COVID positive person. COVID infection as a positive rapid test comes about in the intra-action of the virus itself being detectable in the body (in a specific time window) with the right kind of test, and the infected person knowing how to perform the test accurately, interpret the results, and translate or record these results through a picture of the positive test, report from a medical provider, or a social media post, just to name a few agential entities in this assemblage.

Alternatively, we can consider the ontology of a COVID infection as asymptomatic or in a person who is not displaying any obvious or external symptoms of the acute illness that the virus causes. This assemblage may include a positive test (but doesn't have to), a detectable viral load in the body, the communication from a friend, family member, coworker, or acquaintance that

relates a likely or definite exposure to the asymptomatic person, viral spread levels in the community, and, importantly, —the belief that COVID is a) real and b) in the body of the asymptomatic person. Even if the enactment of a COVID infection aligns with an enactment of Long COVID, Long COVID has similar challenges "hanging together" due to the excessive scale at which it is affecting both U.S. and global populations and the number of body systems, organs, and elements within the human body. The messy, sometimes conflicting ontologies of Long COVID challenge the rigid SSDI system regarding the definition of disability and accompanying proof required to verify such a disabling condition. In the next section, I take a closer look at some of the language in SSDI policy documents that intra-act with physicians, bodies, patients, and the virus to enact multiple ontologies of Long COVID.

## The Body, Disease, Disability Multiple

Discourse, humans and nonhuman objects and phenomena, space, time, and even cells conspire to enact multiple ontologies of disease and disability. The goal of multiple ontology theory and praxiography (the ethnographic study of or "story about practices") is to understand how objects are enacted depending on the assemblage of human and nonhuman actors that catalyze particular ways of being (Mol 5). When doing praxiography, ethnographers study the practices that enact diseases (or disabilities) differently across multiple sites and contexts. For example, Mol asserts that atherosclerosis, the disease at the center of her study, is enacted across multiple sites (the clinic, the pathology department, the operating room) through multiple practices (a conversation, a physical examination, the dissection and examination of an artery, a biopsy of an artery) and that these enactments are distinct, yet related, ontologies (43-51). By studying disease enactment, Mol "shift[s] from an epistemological to a praxiographic inquiry into reality" (32). Instead of studying the perspective of patients or doctors, Mol wants to know not what disease *means* but how disease is *done* and she does this by "foregrounding practicalities, materialities, [and] *events*" (12-13; emphasis in original). In Mol's view, patients are their own ethnographers who can communicate "how living with an impaired body is done in practice" (15; emphasis in original). Mol explains, "ontologies are brought into being, sustained, or allowed to wither away in common, day-to-day, sociomaterial practices" (6; emphasis in original). Long COVID ontologies can cohere as a lack of productivity, as diagnosis, as the inability to generate sufficient income, or as the inability to work in overlapping legal, medical, and social contexts. In this section, I use Molly Margaret Kessler's rhetorical enactment theory and Nathanje Dijkstra's research on disability claims and praxiography to understand how language, as part of an assemblage, enacts disability through practices that require claimants to know about, apply for, and appeal to receive SSDI benefits.

Language, instead of representing experience or reality, is itself agential in creating Long COVID's multiple ontologies. Rhetorical scholars using feminist new material concepts like praxiography or multiple ontology theory move the focus away from an "autonomous human rhetor" as the sole actor in a rhetorical context by attending to the agency and materiality of human and

nonhuman entities, including rhetorical discourse, and these entities' contribution to ontologies (Booher and Jung 26; Moore and Richards 8; Kessler 313; Friz 182-83). This is especially true when discourses instruct and educate the supposed experts in claimants' disabilities: physicians. Language intra-acts with electronic databases, doctors, government employees, applicants and their bodies, time, and space in medical documentation and bureaucratic policy, revealing where "decision-making authority" lies because this language determines not just who can receive benefits but who is found, legally and ontologically, to be disabled (Glew 15). For example, the SSA specifies acceptable types of "objective medical evidence" that can substantiate a medically determinable impairment (the cause of disability according to SSDI) which include signs and laboratory findings where signs refer to "one or more anatomical, physiological, or psychological abnormalities that are observable, *apart from the claimant's statements* (description of symptoms)" ("Establishing a Medically Determinable Impairment (MDI)"; emphasis added). This means that a person with Long COVID cannot access benefits through personal testimony alone. If they do not have records of an acute COVID-19 infection, an initial diagnosis of COVID-19, or information from a healthcare provider about the existence of Long COVID symptoms, their case may be dismissed upon arrival. This kind of physician-provided evidence relies on the definition of disability—a cornerstone of SSDI policy. This definition is a key actant in assemblages that bring disability ontologies into and out of existence. The SSDI definition understands disability through bodily measurement of capitalist production in work settings and relies on the ethos of the medical establishment, rather than the claimant's embodied knowledge or experience, to assign truth claims to disability.

The attempt to define disability as a stable, fixed, uniform experience or characteristic is futile, but such definitions are often used to regulate disabled bodies in violent and exclusionary ways. Kafer has critiqued how workfare systems like SSDI and workplace discrimination laws like the Americans with Disabilities Act define disability as a discrete, individual characteristic (11). Kafer argues that the act of defining itself is misguided because disability is a fluid, relational, assemblage that, as Jasbir Puar has suggested, arises from "events, actions, and encounters between bodies" (Puar qtd. in Kafer 10). Kafer maintains that the institutional "desire for fixed definitions" of disability is inherently tied to "the economic effects of such fixing" (11). These economic effects, within SSDI, determine who is worthy of financial assistance and who is valid in their claims of being unable to financially support themselves in an ableist, capitalist economic society. Samuels views such definitions as attempts to find the "'truth' of disabled bodies" that depend on "the belief that disability can in fact be measured, named, and quantified" (123). Dijkstra posits that the incapacity to work and disability itself are messy, complex, multiple, and "moving target[s]" that exist differently based on intra-acting practices (71). Ultimately, the inability to work is assigned a financial amount based on a claimant's previous work history, severity of disability, and impact on their life—as reported and determined by physicians ("Disability Evaluation").

Those who apply for disability benefits through SSDI seek financial support due to an inability to generate sufficient income through work. The U.S. Social Security Administration, which runs the SSDI program, defines disability and impairment as:

> [The] inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months . . . [in which the impairment] . . . results from anatomical, physiological, or psychological abnormalities that can be shown by medically acceptable clinical and laboratory diagnostic techniques [and] must be established by medical evidence consisting of signs, symptoms, and laboratory findings. ("Annual Statistical Report" 2-3)

Instead of defining disability as a natural human variation or result of inaccessible environments, this definition emerges straightforwardly from the medical model of disability. The seemingly arbitrary measure of 12 months for a disability to be considered long-term instead of short-term contrasts with many experiences of disability, and especially Long COVID, as fluid, recursive, and non-linear or what Samuels terms "crip time" ("Six Ways"). This definition also assumes that disability can plainly "be shown" through medical examination and deliberation upon the "abnormalities" of the body or mind which is an example of "the medical language of illness" that Samuels argues "tries to reimpose the linear, speaking in terms of the chronic, the progressive, and the terminal, of relapses and stages" onto disabled bodies and lives ("Six Ways"). The "signs, symptoms, and laboratory findings" are further scientific and medical measurement tools that seek to enact disability as, for example, a blood test or a visit summary written by a physician. This medical evidence required to determine disability within SSDI is another example of Samuels' biocertification. Not only does SSDI devalue patient testimonials or lived experience, these practices of biocertification enact disability as diagnosis which then have to be reinterpreted and re-enacted as the inability to work by SSA employees.

Along with diagnosis, Long COVID can exist as a lack of productivity; as the inability to generate sufficient income, or as the inability to work. SSDI policy language, especially the definition of disability, intra-acts with the chronicity of Long COVID and its disabling symptoms, rendering its ontologies contingent, non-linear, and fluctuating. Building on Mol's multiple ontology theory, Kessler develops a theory of *rhetorical enactment* that reveals how multiple disease ontologies become meaningfully bound to (or separated from) the self through language (295). This theory further justifies a rhetorical focus on the discursive as an agent in the assemblages that enact multiple disease and disability ontologies. Long COVID as the inability to generate sufficient income is connected to Long COVID as the inability to work because SSDI measures work by the amount of substantial gainful activity (SGA) that disabled claimants can participate in ("Annual Statistical Report" 2-3). SGA is "a level of work activity that is productive and yields or usually yields remuneration or profit" ("Annual Statistical Report" 208). Instead of measuring how much money a disabled

person can produce and using this measurement to determine if they are disabled, patient's lived experiences and material realities must be privileged and valued in the distribution of financial support in workfare programs, institutional determinations of disability, and research on disability ontology. Scholars can use rhetorical enactment to examine how patient discourse about their experience with disease and disability helps to delineate the boundaries of multiple disease and disability ontologies especially as these ontologies are incorporated or related to the self (Kessler 300-301).

## Conclusion: How to Do Work and Disability Differently?

As we continue to theorize the multiple ontologies of Long COVID and disability more generally across many contexts, how can we think about or do disability differently? Given the focus on work ability in SSDI, how can we think about work differently in a way that does not perpetuate ableist ideas of productivity? How can we theorize disability and work being enacted in further feminist and disability rhetorical research? When disability is enacted as the inability to work and this inability determines disabled people's financial security in a neoliberal capitalist economy, the responsibility of surviving is wholly individual. Maintaining or accessing the right to work only serves the economy, not disabled people and their lives and well-being. Numerous scholars (Vipond, Blattner) have critiqued the argument that the "right" to work is liberatory, arguing instead that it leads to "the diminishment of social assistance and public services in favour of privatization and the deregulation of markets" (Vipond 3). In a discussion about how the right to work or pursue work is enshrined in many national and international legal documents, Charlotte Blattner critiques the idea that this right is liberatory for disabled people stating, "People expect work to give purpose and meaning to their lives...work is the linchpin of income, rights, and social belonging" (1380). In these legal documents, the right to work is often associated with achieving happiness, social relationships, greater "physical and mental health," and "self-realization" (Blattner 1380). The pre- or corequisite of paid labor to happiness and inclusion in society is especially important to critique when examining the way that disabled people are expected to receive and maintain disability benefits. Decisions regarding how to present oneself, what symptoms to share or emphasize, and constant self-monitoring required by SSDI claimants are highly rhetorical experiences that deserve more attention in rhetorical scholarship on work, disability, and institutional discourse.

Long COVID is still a new and not fully understood chronic illness that has disabled millions of people, preventing many of them from working full-time, or at all. Even years into the COVID-19 pandemic, it's unclear how COVID infections will affect individuals and populations in the future. The fluctuating and varying symptoms of Long COVID are not easily characterized as generally causing long-term or "total" disability for all individuals and trouble the binary of long- vs. short-term disability insurance or support programs precisely because Long COVID does not have a predictable, uniform timeline. In defining disability as the inability to work as measured

by a medical diagnosis of physical or mental abnormality, SSDI presents challenges for people with Long COVID due to the difficulty in receiving a diagnosis of or treatment for this disease. Additionally, the commonly experienced fatigue or energy-limitation of Long COVID is not always consistent in its severity or effect on productivity, thus making it even more difficult to definitively measure a person's ability to make money and ironically placing a higher burden on them to update SSA with their ever-changing embodied capacities. Dijkstra sees a praxiographic approach to disability studies as an interdisciplinary endeavor that can intervene in essentialist or completely cultural theories of disability as well as gender (60-61). Long COVID is neither enacted completely within the body nor completely in social discourse. Studying the multiple ontologies of Long COVID can hopefully change such narrow and complex avenues to social and financial support for disabled people, thus engaging in the ameliorative purpose of research present in much feminist, disability, and rhetorical scholarship.

The case of Long COVID underlines the importance of continuing to push for policy and social change that ensure financial security for disabled and chronically ill people and that is not contingent on the ability to work or any other neoliberal ideas of productivity and societal value. Continuing to examine the multiple ontologies of disability through new materialist theories and methodologies in feminist, rhetoric of health and medicine, disability studies, and labor contexts should center justice and improved quality of life for disabled and chronically ill people. I encourage feminist rhetoricians of work and labor to both incorporate disability praxiography into their analyses and see what affordances practice-based ontologies offer to thinking about how disability, race, gender, and other identity categories can iniform work-related rhetorical inquiry.

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