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COVID SOCIETY

Introduction to the book

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Introduction

In the early 1990s, the English translation of the German sociologist Ulrich Beck's book *Risk Society: Towards a New Modernity* (Beck, 1992) introduced the concept of 'risk society' to sociologists and risk theorists internationally. Beck argued that processes of industrialisation and globalisation had led to a way of thinking in which people had become highly sensitised to the risks that had proliferated as an outcome of modernisation. His 'risk society' was a world in which ideas and understandings about selfhood, social relations and social institutions were increasingly framed through the lens of risk, associated with an intensifying sense of threat, danger and uncertainty and a desire to systematically manage these threats and insecurities. In an historical and geographical context in which environmental disasters (including the 1986 Chernobyl nuclear power plant disaster) dominated the risk landscape, Beck's work focused on the hazards and uncertainties of pollution and climate change. He defined the 'risks of modernisation' as 'irreversible threats to the life of plants, animals, and human beings' (Beck, 1992: 13).

Beck's risk society thesis sparked an outpouring of sociological work in the 1990s and early 2000s, in which social theory and empirical studies sought to identify how risks were generated, understood and managed as social processes (Lupton, 2013). In recent years, risk theory has lost much of its prominence – overtaken by other 'turns' in social theory and other preoccupations by social researchers. However, the COVID-19 crisis has brought social responses to risk into renewed prominence. Almost three decades after the publication of *Risk Society*, it could be argued that we are now living in a global 'COVID society'. The emergence and rapid spread of the COVID-19 pandemic from the early months of 2020 has preoccupied public discourse and news media reporting and has sparked upheavals worldwide.

According to the World Health Organization (WHO), the first cases of an atypical viral pneumonia from an unknown cause was reported in a media statement by officials in Wuhan, China on the last day of 2019 (World Health Organization, 2020). WHO issued its first Disease Outbreak News report about these cases on 5 January 2020 and reported that the Chinese authorities had confirmed that the pathogen was a novel coronavirus. China reported the first death on 11 January and the first case outside China was reported by Thailand on 13 January. On 21 January, the possibility of human-to-human transmission was confirmed by WHO and the USA reported its first case of COVID. The first cases in Europe were reported by French authorities on 24 January. WHO declared a public health emergency of international concern on 30 January and on 11 February announced that the novel coronavirus would be named SARS-CoV-2 and the disease it caused as COVID-19 (a contraction of ‘coronavirus disease 2019’). WHO declared that COVID-19 had reached pandemic status on 11 March, meaning that the epidemic had spread globally, crossing international borders and simultaneously affecting very large numbers of people in different parts of the world. At this point, Europe (and particularly Italy and Spain) had become the epicentre of the crisis. The UK, USA, Brazil and India were later to become the epicentres. By the end of June 2020, 10 million cases of infection with SARS-CoV-2 had been recorded globally, having doubled within six weeks, with over half a million confirmed deaths from COVID-19 (Du and Cortez, 2020).

No end is yet in sight for the pandemic, with global numbers continuing to rise, and many countries experiencing new surges of infections. The coronavirus has proven to be difficult to contain, once strict lockdown conditions are loosened. Greater tourist movements across national borders in the northern summer of 2020, for example, generated new surges of infection in countries such as Spain, Italy and France, while Australia’s second largest city, Melbourne, went into a second lockdown in July 2020 after quarantine measures for incoming travellers from overseas were badly mismanaged. By the end of September 2020, the grim global tally of over 1 million deaths from COVID-19 had been confirmed, from over 33 million confirmed cases. The USA was still the country with the highest COVID cases and deaths, but India was rapidly catching up, with Brazil and Russia following closely behind. The problems of those experiencing ‘long COVID’ illness were beginning to be documented, demonstrating that COVID-19 for some people was a long-lasting health problem (Mahase, 2020).

The COVID pandemic is far more than a massive global health problem – it is a crisis on every level: social, cultural, environmental and economic. As a zoonotic disease (originating in animals and transferring to humans), COVID-19 is a product of human–environment relationships (Braidotti, 2020): even to the point that some commentators have argued that the coronavirus is the planet’s revenge on humans for the damage it has sustained at our hands (Searle and Turnbull, 2020). However, the pandemic’s effects reach well beyond these relationships. Few areas of everyday life have been left unchanged in the wake of the emergence of this new infectious disease. The COVID crisis is a complex and ever-thickening entanglement of people with other living things, place, space, objects, time, discourse and culture.

Social impacts of COVID-19

When the pandemic began to erupt globally, it soon became evident that detailed and situated social research was vital to understanding how the crisis was affecting people across the world. Sociologists have been interested in the sociocultural and political dimensions of epidemics and pandemics for some time, pointing out how fear, moralism, blame and Othering are often major societal responses (Dingwall et al., 2013; Strong, 1990; van Loon, 2005; Bjørkdahl and Carlsen, 2019). In April 2020, Geoffrey Pleyers (2020), the vice president of research for the International Sociological Association, published what he called ‘a plea for global sociology in times of the coronavirus’. Pleyers noted that given the crisis had affected all dimensions of society – well beyond the health implications – responses to COVID required expertise in social research just as much as medical and public health expertise. He argued further that as the pandemic is a global phenomenon, a global perspective is required in addition to nation-based social research, so that researchers can learn from other countries’ experiences.

Political responses were crucial to how well nations fared in the first phase of the pandemic (Afsahi et al., 2020; Gugushvili et al., 2020). In what has been described as ‘biopolitical nationalism’ (de Kloet et al., 2020), many governments implemented strict controls over citizens’ movements and imposed surveillance and policing measures to enforce them. Nation-states retreated into themselves, erecting *cordons sanitaire* that in some cases segregated parts of cities as well imposing internal as well as international border controls in the attempt to control and contain the movements of human bodies infected with coronavirus (Afsahi et al., 2020). Citizens went through very different experiences of the COVID crisis based on how their governments and health officials reacted. Nations with liberal or populist leaders who failed to respond early enough with physical distancing measures, such as in the UK (Scambler, 2020), USA (Rocco et al., 2020; Thomson, 2020) and Brazil (Malta et al., 2020) floundered, recording far higher numbers of COVID infections and deaths (Gugushvili et al., 2020). Those countries where interventions were established earlier and with more extensive lockdown restrictions and border control measures, such as Taiwan, New Zealand, Vietnam, Australia, South Korea and Singapore, managed the spread of the pandemic much more successfully during its initial stages (Dalglish, 2020; Afsahi et al., 2020). There remains debate about countries such as Sweden, where the policy approach has been around ‘living with’ the virus and gaining ‘herd immunity’ (Pierre, 2020). All policy approaches have caused much debate about economic versus health outcomes – whether the longer term costs to societies of restrictions and lockdowns (caused by shutting down much economic activity) are outweighed by the health benefits in terms of reduced mortality, morbidity, and pressure on health systems.

Enforced quarantine, physical isolation, confinement to home, border closures, shutdowns of business, workplaces, schools and universities instituted in initial government responses to containing the spread of the virus have affected national

economies, freedom of movement, familial and social relationships and mental wellbeing. Concepts of risk, uncertainty and trust suddenly had to be reassessed and confronted (Brown, 2020). It was obvious from the early months of the global spread of the coronavirus that while everyone was at risk from contracting the infection, in most countries some social groups were more at risk than others (Afsahi et al., 2020). These included groups that were already experiencing high levels of socioeconomic disadvantage, marginalisation and low access to health services, such as people with disabilities in Singapore and Australia (Goggin and Ellis, 2020), Indigenous Australians (Markham and Smith, 2020), Roma people in Europe (Matache and Bhabha, 2020), Black, Asian and minority ethnic groups in the UK (Bhatia, 2020), low caste and Muslim people in India (Rahman, 2020), Black Americans (Egede and Walker, 2020), Asian Americans (Roberto et al., 2020) and vulnerable and marginalised groups in Sweden, such as older people, immigrants and prisoners (Rambaree and Nässén, 2020). Gendered inequalities have also been exacerbated due to restrictions requiring working and learning from home. In many countries, women's opportunities to engage in paid employment have been severely affected by caring responsibilities as they were forced to juggle working from home with supervising their children's learning when schools were closed (Craig, 2020; Bahn et al., 2020; Al-Ali, 2020). Incidents of family violence have also escalated, with women finding it more difficult to seek help as they are forced to spend more time in the home with their abuser (Williamson et al., 2020).

To avoid infection – or infecting others – people were required to take up new social behaviours, such as more frequent handwashing, maintaining a physical distance from others outside their households, staying at home as much as possible, wearing face masks, relinquishing their usual leisure pursuits and avoiding gathering in groups with family members, friends or work colleagues. As Dahiya (2020) observed, 'The lived experience of COVID-19 forcibly returns us to our bodies'. People were forced to confront the nature of embodiment and interembodiment with others, and the risks that previously benign physical encounters with not only strangers but close family members and friends could bring. New forms of sociality and intimacy had to be developed to allow people to engage with others in times of physical distancing: often involving greater use of digital media such as texting and video-calling (Nguyen et al., 2020; Watson et al., 2020). A plethora of digital tools were also created to help manage and monitor the spread of coronavirus, including contact tracing apps, dashboards of COVID metrics and wearable devices to keep track of people under isolation orders (Everts, 2020; Meijer et al., 2020). These measures have raised privacy concerns in relation to how people's personal information is being used (Kitchin, 2020). However, other commentators have highlighted the deleterious effects of the opposite problem. 'Data invisibility' can adversely affect those (the 'data poor') whose experiences and health status are not recorded in official statistics and whose plight is therefore unrecognised (Milan and Treré, 2020).

The news media have played a crucial role in publicising information about COVID, including providing regular updates about infection and death rates globally and regionally and disseminating details about how publics can best protect

themselves and others from coronavirus. There have been notable lapses, however, with concerns about the ‘infodemic’ (Orso et al., 2020) of misinformation and deliberate lies that have been spread on news and social media sites (Meese et al., 2020; Baker et al., 2020; Rodrigues and Xu, 2020). News coverage has also contributed to racism and the othering of social groups. Due to the Chinese origins of the first reported cases of COVID, racist statements and abuse were directed at Chinese people in everyday life and news media reporting in many countries, including Japan (Shimizu, 2020), Chile (Chan and Montt Strabucchi, 2020), the UK (Pang, 2020), the USA (Roberto et al., 2020) and India (Haokip, 2020).

This book

We are both sociologists who have specialised in researching health and medical topics throughout our careers. From early in the emergence and spread of the COVID-19 pandemic, we quickly recognised the importance of social researchers beginning to document the transformations in everyday life across the globe that COVID had begun to engender. At the end of March 2020, Deborah published an outline of what she described as an initial agenda for social research about COVID and post-COVID worlds (Lupton, 2020a) and sent out a call for contributions for a special section of *Health Sociology Review* she guest edited on sociology and COVID-19. This special section was published in July 2020 (Lupton, 2020b). Many excellent abstracts were submitted for consideration. As one of the chief editors of *Health Sociology Review*, Karen worked with Deborah to select the abstracts to go forward for full submission. The authors of other highly ranked abstracts were invited to contribute to an edited volume, and we were delighted to receive an enthusiastic response. Their contributions comprise the chapters in this book, providing insights into the social dimensions of COVID in Australia, France, Italy, Ireland, New Zealand, Spain, South Africa, the Netherlands, the UK, Canada and the USA.

All chapters were conceived, written, submitted, revised and finalised within seven months of the WHO’s declaration of the pandemic: a period of rapid spread and sudden changes in everyday life as nations struggled to contain the infection. Given the continuing effects of the COVID crisis, with many countries experiencing resurgences and still struggling to find the best way to deal with the coronavirus as well as its related socioeconomic effects, the book stands as a way of documenting this initial period. It is divided into topical sections. Immediately following this chapter in Part I (‘Introduction’) is Deborah Lupton’s overview of sociocultural perspectives on contagion in the literature published prior to the COVID outbreak (Chapter 2). Lupton’s chapter is designed to establish a firm context for the COVID-focused chapters that follow. The perspectives offered by social histories, political economy perspectives, social constructionism, Foucauldian theory, risk theory, postcolonial and sociomaterial approaches are explained and examples of research using these approaches are provided.

In Part II ('Space, the Body and Mobilities'), the analysis by Nicola Burns, Luca Follis, Karolina Follis and Janine Morley (Chapter 3) focuses on the UK government's response to COVID, emphasising the multi-scalar effects of state intervention and the implications for different groups in society. Some of these inequalities cohered around mobilities: those who were allowed out of their homes and expected to move in public spaces to perform essential duties, and those who were considered vulnerable or non-essential and expected to dramatically reduce their movements.

In Chapter 4, Holly Thorpe, Julie Briggs and Marianne Clark also discuss aspects of embodiment and movement. Engaging with poetic representations of experience, their chapter critically explores new questions about the risks of physically active human bodies and the 'trails' of contagion that they may disperse in and through the ebbs and flows of the natural (air, wind) and built (gym and fitness studios) environment. In so doing, they offer a critical and creative commentary on the new noticings of bodily boundaries in times of pandemic, where every puffing, panting individual encountered moving through space was a source of possible contagion via their bodily fluids and excretions.

Olimpia Mosteanu's (Chapter 5) chapter also directs attention to the socio-materialities of people's bodies with the built environment, with a focus on the ways that windows operated as parts of human-home assemblages during the COVID lockdown period in London. Drawing on a series of photographs she had taken, Mosteanu explores some of the ways in which windows not only mediate our interactions with the world around us but also actively participate in our everyday lives in a time at which many people are feeling confined, isolated and restless.

In recounting her experiences as a person living with visual impairment, Heidi Lourens (Chapter 6) demonstrates how it feels to be living with COVID risk and treated as a vulnerable person – or worse, objectified as less than human. She highlights the ways in which touch is used to help people with visual impairment and how touch has become suffused with particular risk of contagion. Lourens argues for a relational ethics of care that can encompass mutual respect and recognition of these feelings and needs for both people living with disabilities and those who are not: all of whom are faced with managing the risks of contagion, but in different ways.

Part III ('Intimacies, Socialities and Connections') begins with an analysis of how dating app companies participated in disseminating COVID health messages. David Myles, Stefanie Duguay and Christopher Dietzel (Chapter 7) show how these companies rapidly re-positioned their key strategies and messages to deal with challenges to their user base and business model. A re-invented concept, 'dating while distancing', sought to demonstrate the utility of such apps for a new relationships paradigm in which the old ways of connecting and meeting could no longer take place due to physical distancing restrictions.

In Chapter 8, drawing on interviews with young northern Italians, Veronica Moretti and Antonio Maturo show how perceptions of time, space and domestic habits changed during this period of immense disruption to everyday routines and social encounters. Moretti and Maturo describe how for young professionals, being

forced to stay at home was a cognitively ambiguous situation, in which their normal lives were in suspension.

Ryan Thorneycroft and Lucy Nicholas (Chapter 9) then interrogate sexual practices occurring during COVID-19 to imagine alternative (crip and queer) futures. They argue that understanding our moment through what they characterise as ‘crip/queer times’ provides the opportunity to open up new sexual cultures and to diversify the range of practices and pleasures to *all* people. In the place of queer casual sex, Thorneycroft and Nicholas introduce forms of (crip/queer) isolation sex as an efficacious and ethical alternative, identifying new forms of cultures and possibilities available during and after the COVID pandemic.

The contribution by Marissa Willcox, Anna Hickey-Moody and Anne M. Harris builds on the literature on social prescribing to examine therapeutic forms of arts practice and issues of ethics of care on the Instagram Live platform (Chapter 10). The entanglements between performers, audiences, the creation of community, digital media and affective forces are highlighted in their chapter. In so doing, these authors prompt a discussion around how liveness, sociality and connectivity in musical performances should be understood, arts accessibility as a measure of public health and wellbeing as well as how artists can be better supported throughout the COVID crisis.

The chapters in Part IV (‘Healthcare Practices and Systems’) move beyond the home setting to focus on how medical practitioners and hospitals dealt with the early months of the COVID crisis. In Chapter 11, Jo Murphy-Lawless explains how COVID disrupted Irish cultural norms. She observes that, for the Irish, among the profoundly stressful consequences of COVID-19 was how they were forced to do death differently. Murphy-Lawless shows how the crisis has made painfully visible the social and economic contradictions of contemporary Ireland, including the effects of years of austerity cuts on the Irish National Health Service.

In Chapter 12, Romain Lutaud, Jeremy K. Ward, Gaëtan Gentile and Pierre Verger focus on general practitioners in France and the controversial drug hydroxychloroquine that was initially touted as a preventive agent and treatment for COVID patients. Stepping back to take a longer view, the authors contextualise their case study within the broader politically fraught environment of general practitioners and health authorities in France over more than two decades, which has led to a lack of trust on the part of practitioners in these authorities. They also show how patients’ demands on their GPs can lead the practitioners to try new drug therapies such as hydroxychloroquine in situations such as the emergence of this new infectious disease where medical knowledge was still forming.

Anna Sendra, Jordi Farré, Alessandro Lovari and Linda Lombi (Chapter 13) compare the effects of the COVID crisis in Spain and Italy: both countries that were among the hardest hit in the early months of the pandemic. They identify similarities based on what they characterise as a Latin or Mediterranean approach to life, involving close physical proximity to people, cross-generational sharing of residences and regular socialising in public spaces. They also identify how the effects of the 2008 global financial crisis undermined the healthcare systems of both countries. Together,

these sociocultural and infrastructural conditions resulted in both countries experiencing similar effects of the pandemic and being forced to endure long-term severe lockdowns to gain control of the spread of the coronavirus.

Chapter 14, by Karen Willis and Natasha Smallwood, turns to the Australian context and responses by frontline healthcare workers to a survey about their experiences of dealing with COVID-19 and the impacts on their mental health and wellbeing. The sheer weight of stress carried by these healthcare workers is revealed in their answers, as they battled with a situation where they were over-worked and concerned about exposing their family members to coronavirus infection. The survey also identifies the effects of ‘spillover’: the ways that behaviours, attitudes and experiences carry over from one environment (in this case, the hospital and other healthcare settings) to another (the home).

Part V (‘Marginalisation and Discrimination’) is the final section of the book. The exacerbation of racial and religious discrimination in various regions is pointed out by several contributors. In Chapter 15, Alex Schenkels, Sakina Loukili and Paul Mutsaers discuss implications for parenting resulting from Dutch government’s interventions during COVID, with a focus on the experiences of Muslim families living in the Netherlands. The authors bring together a discussion of how norms of intensive parenting were manifested during COVID lockdown, as parents grappled with how to manage learning from home expectations for their children, with an examination of the ways that Muslim beliefs and organisations framed parenting roles. Muslim parents were faced with juggling anti-Muslim racism and mainstream Dutch parenting expectations together with faith-based pronouncements on how they should parent.

Aggie Yellow Horse (Chapter 16) then discusses what she describes as ‘the parallel pandemics of COVID-19 and racism’ in the context of the USA. She examines how anti-Asian racism and xenophobia rhetoric as well as reports of hate incidents against Asian Americans began to intensify in the USA early in the COVID outbreak. Yellow Horse argues that understanding how such a rapid increase in racist and xenophobic incidences may affect Asian Americans’ physical, mental and social health is important, as racism and xenophobia are fundamental causes of health inequalities in the USA in general and for Asian Americans in particular.

Turning to the problem of ageism, Peta Cook, Cassie Curryer, Susan Banks, Barbara Barbosa Neves, Maho Omori, Annetta Mallon and Jack Lam (Chapter 17) draw on Australian news reporting related to risk and COVID to show how the crisis has laid bare societal discourses based on age differences and stereotypes. In these news reports, young people were frequently framed as healthy, active agents engaging in risky behaviours that endanger their health and that of others. In contrast, older people were typically cast as passive and at risk: and in some extreme cases, as worthless.

Together, these contributions offer a rich account of COVID society. They provide snapshots of what life was like for people in a variety of situations and locations living through the first months of the novel coronavirus crisis, including discussion not only of health-related experiences but also the impact on family, work and social life, and leisure activities. The sociomaterial dimensions of quotidian practices are highlighted: death rituals, dating apps, online musical

performances, fitness and exercise practices, the role of windows, healthcare work, parenting children learning at home, moving in public space as a blind person and many more diverse topics are explored. In doing so, the authors surface the feelings of strangeness and challenges to norms of practice that were part of many people's experiences, highlighting the profound affective responses that accompanied the disruption to usual cultural forms of sociality and ritual in the wake of the COVID outbreak and restrictions on movement. The authors show how social relationships and social institutions were suspended, re-invented or transformed while social differences were brought to the fore. At the macro level, the book includes localised and comparative analyses of political, health system and policy responses to the pandemic and highlights the differences in representations and experiences of very different social groups, including people with disabilities, LGBTQI people, Dutch Muslim parents, healthcare workers in France and Australia, young adults living in northern Italy, performing artists and their audiences, exercisers in Australia and New Zealand, the Latin cultures of Spain and Italy, Asian Americans and older people in Australia.

Above all, these chapters bring into focus the importance of acknowledging not only the social, political and cultural contexts of COVID experiences, but also their affective, temporal, geographical and spatial dimensions. Beck's writings on risk society were frequently criticised for their generalisations and assumptions, their lack of cultural specificity and attention to the details of what it was like to live with and make sense of risk (Tulloch and Lupton, 2003). In the first phase of the COVID crisis as it has unfolded, we have already learnt that conditions can change very quickly and that complacency or the urge to adopt quick fixes rather than long-term solutions to contain the spread of the coronavirus simply result in further outbreaks and greater uncertainty about the future. As we move into the next stages of the crisis, maintaining a highly focused approach that acknowledges the complexities, affects and situated nature of lived experiences in COVID society remains a crucial research direction for social researchers.

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