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SPECIAL ISSUE

LESSONS LEARNT FROM A PANDEMIC: COVID-19 IN PERSPECTIVE

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The body and body politic 'at war' with COVID-19

Conceptualizations of the COVID-19 disease, the SARS-CoV-2 virus and their interactions with individuals and social groups have assumed various forms. The very rendering of COVID-19 as a pandemic in public and political discourse is an artifact of definition. One particularly dominant account of COVID-19, echoing historical patterns, relies heavily on the use of militaristic metaphors and on the invocation of a demonized 'Other' (Walker 2020).

Since the announcement of the COVID-19 pandemic in March 2019, militarized language and war rhetoric have permeated the speech of political leaders globally: Boris Johnson has mentioned the need to respond to the pandemic just like 'any wartime government', and Donald Trump referred to himself as a 'wartime president' called on to fight an 'invisible enemy' (Tharoor 2020). Such semantics enable the social construction of COVID-19 as not merely a health disaster, but more evocatively and polarisingly as a 'war.' Through these accounts, the virus is transformed from a collection of nucleic acids and proteins occupying an ontologically ambiguous space between life and nonlife (Gibbon et al. 2020) into an insidious autonomous agent waging a war on the citizens of our societies: our 'invisible enemy'.

Generally, military messaging is effective in imparting a sense of urgency and risk, mobilizing individuals and resources, preparing the public for trying times, and justifying exceptional socially and economically costly measures which may curtail civil liberties. It thus persuades the public to make sacrifices and accept collateral damage in accordance with these changes (Seixas 2021). To improve understanding of these proclivities to use military metaphors in portrayals of COVID-19, it is useful to mobilize Mary Douglas's (1966, 1970, 1992) symbolic/cultural approach to risk, danger, purity and containment. Seen through this framework, it can be argued that the construction of risk in Western societies supports the preservation of selfhood and social order by laying the groundwork for the (re)production of clear boundaries between the 'self' and the polluting, risky and dangerous 'other'.

Douglas (1970) emphasizes symbolic parallels between the physical body and the social body, advancing an understanding that both sorts of body are defined by boundaries that separate the inside from the outside, linking constructions of otherness at the social level with those at the bodily level. In the case of COVID-19, at the level of the human body (the physical body being 'self/us'), the enemy 'other' may be seen as the SARS-CoV-2 coronavirus. At the level of society, conversely, the concept of the enemy 'other' may extend beyond the bounds of the virus itself, taking the form of either *outsiders to* or *victims within* the social group and body politic.

Following on from this, it is possible that the prevalence of military metaphors in representations of COVID-19 may stem from their utility in reproducing social boundaries for the maintenance of the status quo as based on social stratification, therefore ensuring the maintenance of privileges for certain members of society. This inevitably involves a 'sacrifice' for those at the bottom of the social pyramid, who become the shock absorbers of the crisis. As Sarah Spellman argues in her contribution to this volume, health-care workers are described as 'soldiers' or as being on the 'frontline', and their immeasurable personal sacrifices become normalized and even expected (Khan et al. 2020). Military rhetoric may be related to a wide acceptance of material boundary-making as well. It is not surprising that, in the midst of the COVID-19 outbreak, new legislation has been passed by the UK government which puts restrictions on the right of assembly, including protests and marches (e.g. the Policing, Crime, Sentencing, and Courts Bill currently being debated in Parliament). Lockdowns, restrictions on outdoor movement, the closure of national borders and the cessation of traffic across wards, townships, cities, countries and continents have all been implemented within a year of the announcement of the pandemic.

In addition to this re-shaping of socio-institutional boundaries, a parallel process contributing to the maintenance of social cohesion and unity through the mobilization of risk consists in placing blame, as understood through Douglas's framework (1992). As Douglas states (ibid.), both victim-blaming and outsider-blaming share the purpose of preserving social cohesion and facilitating social coercion where necessary. Victim-blaming does this by creating a need for measures of social control. The monitoring and quarantining of those who are sick becomes justified not necessarily because we wish to protect our neighbours, but because we ourselves fear the carrier (Fotherby 2020). Outsider-blaming works by bolstering loyalty and acting to absolve those in power, including our governments, from responsibility and accountability for COVID-19's extraordinary death toll. Blame is shifted on to a common, malignant enemy we might collectively rally against (Fotherby 2020). This decontextualizes the pandemic and facilitates ignorance of the broader socio-political and environmental conditions that made its global emergence possible in

the first place, namely equipment shortages, failed emergency preparedness protocols, and health and social inequalities.

Importantly, blame may intersect with other facets of identity, including race, ethnicity, nationality and social class, with adverse consequences. The 'othering' of those who are perceived to be carriers of the virus (whether asymptomatic or visibly sick) may create a distinction between the healthy 'us' and the at-fault 'other' along racial and national lines. The reported vulnerability of BAME communities to COVID-19 constitutes one potential source of discrimination of this sort, in which the 'victims' are reconstituted as 'dangerous' based on their being more 'at risk'. This rhetoric has gained particular salience in a country torn by years of dispute over Brexit. 'Links between imagining disease and imagining foreignness' (Sontag 1989: 119) are not historically unprecedented: for example, cholera was blamed on Irish immigrants, and tuberculosis was labelled the 'Jewish disease' in the US in the nineteenth century (Kraut 2010; Markel and Stern 2002). At the present day, associations between the existential threats of infectious diseases and alterity have continued to be perpetuated through militarized language. We are all too familiar with the scapegoating of China as the 'Other' place from which SARS-CoV-2 emerged before 'infiltrating' the West. This narrative was played out in an especially insidious way in the United States under the Trump administration, whose use of the phrases 'war against the Chinese virus' and 'Kung flu' has allowed dangerous ethno-nationalist sentiments and xenophobia to circulate within the media and public discourse, often under the guise of a seemingly harmless appeal to patriotic solidarity.

Such militaristic narratives fulfil the dual function of both Othering and/or blaming those who may already be marginalized, while simultaneously producing a distraction from some of the starker injustices of the pandemic, such as the disproportionately heavy impact of COVID-19 within these very communities. In addition to those who are ethnically and racially 'othered', socio-economically 'othered' communities emerge as well, such as workers who lack the privilege of working from home and are forced to take public transport to get to work, or temporary non-British staff catering to tourists. These dynamics exemplify how the sociality of COVID-19, COVID-19 as sickness and its discursive domain are dominated by the state and the elite. The latter are still able to defy or circumvent restrictive policies with minimal or no consequences, like a senior advisor to the Tory government in the UK (Clarke 2021).

Language denoting military activity and an invading 'other' has embedded itself not only in 'sickness' narratives that pervade social interactions with COVID-19 as a socially visible phenomenon, but even in 'disease' accounts of the material, pathophysiological interactions of SARS-CoV-2 with our cells and organs. One *Science* publication describing the pathogenesis of

the SARS-CoV-2 invokes notions of the virus 'hijacking' cell mechanisms, 'march[ing]' down the windpipe towards the lungs and starting a 'battle' that disrupts optimal lung function (Wadman et al. 2020). Although many interpretations of the pathogenesis of SARS-COV-2 exist, this portrayal illuminates how our socio-political conditionings and agendas may unwittingly penetrate even our most sincere attempts to construct a neutral biomedical account of our plight with the virus, impelling the construction of an insidious 'other.'

Of course, framings of 'self' versus 'non-self' and militarized cells are not unique to COVID-19 but are deeply embedded in the language of biomedical understandings of general cellular and molecular interactions between components of our bodies' immune systems and non-native microbes (Martin 1990). T-lymphocytes are referred to as 'killer cells', macrophages are likened to armoured units, and complement proteins (i.e. proteins involved in the rupturing of microbial cell membranes) to mines or bombs., They all work to defend the 'self' against 'non-self' intruders, making the body potential 'battlefield' (ibid.). The militarization of notions of body and health can be traced back as far as the seventeenth century to the work of Thomas Sydenham, a physician who described the challenges of his work: '[A] murderous array of disease has to be fought against, and the battle is not a battle for the sluggard' […] 'I steadily investigate the disease, I comprehend its character, and I proceed straight ahead, and in full confidence, towards its annihilation' (quoted in Fuks 2010: 59). The notion of and belief in a 'magic bullet' soon emerged within a similar ideological context (ibid.).

Through these frameworks, we are able to see what is gained through the militarization of COVID-19: fulfilment of the impetus to preserve social order and manage uncertainty as a paramount social function of modern society (Lupton, 2013). However, despite the utility, omnipresence and historical embeddedness of military metaphors in public, political and academic discourses surrounding disease and sickness, their use should give us some pause. We are implored to consider the following: what might be lost in this pursuit of social cohesion through constructions of otherness and the placing of blame? In the following section, light is shed on the ways in which militaristic language in discourses on COVID-19 as a disease and sickness may serve to alter lived experiences or obscure narratives of COVID-19 as a pandemic or illness, potentially plaguing us with additional and unnecessary sources of suffering beyond the work of the virus itself.

The demilitarization and reimagination of illness narratives

While militaristic narratives may serve a clear function at the level of society, what of their utility and impact with regard to the individual who is living amid COVID-19 and/or experiencing it as an illness? Below I consider the ways in which militarized social portrayals of COVID-19 as a sickness may be embodied in the form of the altered subjectivities, lived experiences and narratives of the individual, whether experiencing COVID-19 as an illness or contending with a world that has been transformed by the pandemic.

First, in attempting to minimize disorder and maintain cohesion within society, war rhetoric may have inadvertent emotional costs for the individual, perpetuating excess and prolonging fear, hypervigilance and anxiety, which may have already been present due to the biomedical threat to life and physiological functioning that are posed by the virus itself (Walker 2020; Kohlt 2020). Such language has led us into a 'security trap' in which the increased securitization and militarization of social problems might counter-productively serve to produce feelings of insecurity and panic. These feelings are manifested in visible phenomena such as the mass-panic purchases of toilet paper in several countries, including the UK, US and Australia (Rijal 2020), and even of guns and ammunition in the US (Beckett 2020), as well as in a rampant mental health crisis in the UK (Jia 2020).

Additionally, in all their effectiveness in reinforcing boundaries between 'inside' and 'outside' and their inculpation of the 'other', military metaphors inevitably enable and facilitate a medicalized prejudice against that outside 'other'. Such experiences may affect both the victim, by feeding into individual illness experiences through processes of internalization, and the outsider. As mentioned previously, such processes may exacerbate the marginalization, social rejection and psychosocial distress of already vulnerable communities. For instance, within the past year and a half, persons of Chinese descent, falsely perceived as embodying the virus, have become hyper-visible, suffering a surge in discrimination and verbal and physical violence that has persisted into the second year of the pandemic and has even intensified in recent months in the US (Gover et al. 2020).

Beyond stigma, another critical consequence of the 'battle' metaphor is the production of a false dichotomy of outcomes: 'victory' versus 'defeat', a binary which aligns poorly with both individual experiences of the illness and the ecological realities of human–microbe interactions within society. As seen in the context of other diseases, such as cancer and HIV/AIDS, which are surrounded by a militarized discourse of winners and losers, complications with recovery or continued struggling with the illness may be interpreted by the ill individual as defeat or personal failure (Hendricks et al. 2018). In another study, women with breast cancer who assigned negative

meanings to their illness with words such as ‘enemy’ or ‘punishment’ experienced higher levels of depression and a poorer quality of life relative to women who ascribed alternative interpretations such as ‘challenge’ or ‘value’ to their experience (Degner et al. 2003). In these ways, physiological interactions of the virus with the body may be amplified by the negative psychosocial experiences associated with having COVID-19 (or being perceived as a carrier), hence creating avoidable and unnecessary suffering. Beyond individual encounters with the virus, from an ecological perspective it is notable that military metaphors and binaries of victory and defeat also propagate the false and problematic notion that humans must constantly be engaged in a battle with our environment and our microbial enemy ‘other’, and that winning and eradication are feasible.

In addition to the potential exacerbation of suffering due to disease stemming from either stigmatization by others or self-blame, evidence regarding the use of militaristic language in medical contexts suggests that such symbolism may lack utility with regard to individual healing processes as well (Petticrew et al. 2002). Studies of illness narratives of other stigmatized diseases, such as HIV and cancer, have found that, while making meaning of illnesses through the use of metaphors can play an important role in healing and be helpful in fostering a sense of community through shared experience, the use of military metaphors within the illness experience may be ineffective at promoting healing and may not necessarily improve survival (Nie et al. 2016; Petticrew et al. 2002).

In addition to the lack of function and the potential harm of militaristic language for the individual experiencing COVID-19, the hegemony of such symbolism in accounts of COVID-19 as sickness and disease may disregard and diminish the visibility of individual and/or non-conforming narratives that characterize the experiences of those individuals who are living the interactions between SARS-CoV-2 and their bodies that sickness and disease accounts seek to describe. Though existing COVID-19 illness narratives are sparse, one account of COVID-19 patient experiences during hospitalization in Henan, China, by Sun et al. (2020) describes narratives that contrast starkly with the negative tone of the notion of ‘fighting an enemy’ that is ‘at war’ with our bodies. Sentiments of fear, denial, stigma and anger during earlier stages of the illness, often sparked by the perception that the patient had been an innocent bystander, gradually evolved into acceptance of the disease, ease and calm in later stages. Patients reported that a sense of harmony and adequate family and social support were critical to their recovery, above other factors. As one patient described it, ‘friends are concerned about my health, government staff are also concerned about me, and I feel that the country attaches great importance to us’ (Sun et al. 2020: 19). Similarly, a study of public framings of COVID-19 expressed on Twitter revealed that, although discussions of most pandemic-related topics on social media drew on military concepts,

the topics of community and social compassion, which involved words such as ‘friends’, ‘share’, ‘trying’, ‘family’ and ‘time’, and that therefore addressed ‘intimate social relations and personal affective aspects related to COVID-19’, were unrelated to this warlike frame (Wicke and Bolognesi 2020: 15).

As Gillian Chan argues (this volume), the construction of COVID-19 as ‘mild’, as something that is easy to recover from, contrasts starkly with the militarization of COVID-19 as a dangerous ‘other’, as something that must be fought against and defeated. As Chan argues, there is an inherent inconsistency in the ways in which biomedicine constructs COVID-19 alternatively as either deadly or mild in order to satisfy the twin agendas of maintaining social control while maximizing the extent to which individuals are held responsible for their conduct. The common enemy against which social groups had been so compellingly called on to battle seems to disappear when the narrative of mildness is applied. Yet individual experiences tell a different story, as Chan explores in her essay.

Conclusions

Whether through biological, psychosocial, economic or political mechanisms, COVID-19 has caused immense suffering worldwide. It is a disease, illness, and sickness to be taken seriously, and its risk and the potential for irreversible harm must be communicated effectively, but also carefully and responsibly. The same potency that grants militaristic language its pragmatic social utility serves to make it a dangerous tool capable of exacerbating suffering; it must therefore be wielded with a wariness that is presently absent from public discourse. As many have argued, it is an illusion that such messaging requires a construction of the enemy ‘other’ in order to maintain order effectively.

The main recommendation arising out of the foregoing is for a policy that demands the demilitarization of the metaphors we use to describe COVID-19 across public, political and scientific discourses and that engages on a journey of reimaginations. Semantics are critical. Pressure to remove militarized metaphors from general COVID-19 discourse should be created by public health, scientific and political leaders. An outpouring of support for de-militarizing narratives among both experts and non-experts alike, including the #ReframeCOVID initiative, has indicated that the ‘war’ rhetoric may be losing its resonance with the public. Elena Semino has recommended that the virus itself be likened to a ‘fire’ and essential workers compared to ‘fire-fighters’ (Semino 2021). Moreover, local and national governments can reframe the very necessary strategies to prevent COVID-19 transmission that involve punitive and anxiety-provoking terms such as ‘lockdown’ or ‘quarantine’, with alternative language such as ‘physical distancing’ (but

nevertheless maintaining social closeness), 'safe contact' or 'cocooning' (Walker 2020). Such framings might encourage physical distancing as a result of empathy and caring for the vulnerable rather than fear of COVID-19 infection. Furthermore, drawing on advice regarding the reframing of illness experiences of persons affected with HIV, it may be helpful to encourage envisaging the COVID-19 illness experience as a 'journey' rather than a 'battle' (Nie et al. 2016).

Beyond the individual, demilitarization may dispel the misleading notion that COVID-19 is something that can be necessarily 'defeated' by humans, which is inconsistent with the high likelihood of COVID-19 becoming endemic and with the probability that we may need to co-exist with SARS-CoV-2 as we do with other microbes, such as the influenza virus (Walker 2020). A new vocabulary may reframe our relationships with our microbial neighbours through tropes of co-existence, balance and entanglement (Nie et al. 2016). Perhaps we can harness Douglas's demonstration of the relativity of 'dirt', rethink the impermeable boundaries between self and non-self, and reimagine what 'out of place' means for certain types of matter. Along the same lines, Emily Martin (1990) offered alternative conceptualizations of human-microbe interactions, suggesting notions of a 'harmonious life unit' or 'holobionts', rather than plotting a self versus a non-self. Additional understandings of illness and general narratives need to be better understood if alternative framings of this pandemic and future health crises are to be generated.

In conclusion, we hope to see paradigmatic shifts in discourse which will allow us to emerge from this pandemic into an improved world. The demilitarization of popular and institutionalized discourses of COVID-19 as a disease, sickness and illness may remind us that the true 'triumph' will not be a victory over the virus. Instead it will be the renewed accountability of those in power who are meant to think with us and for us, a readiness to co-exist with our human and microbial neighbours, a heightened attention to the diverse narratives of individuals who have engaged with this pandemic with their bodies and minds, and a restructuring of our systems and institutions to improve the protection of our communities from the suffering and loss associated with pandemics.

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HOW MILD IS ‘MILD’ COVID-19?

GILLIAN CHAN

The term ‘mild’ COVID-19 first emerged in China’s original descriptive report of February 2020, which defined ‘mild’ cases as those without pneumonia or with only mild pneumonia (Epidemiology Working Group for NCIP Epidemic Response, Chinese Center for Disease Control and Prevention 2020). Since then, the clinical characteristics, biomarkers and treatment pathways for ‘mild’ COVID-19 have been further elaborated in clinical research, guidelines and international health reports. As of 27 May 2020, the World Health Organization officially defines a case of ‘mild’ COVID-19 as any ‘symptomatic patient meeting the case definition for COVID-19 without evidence of viral pneumonia or hypoxia’ (WHO 2020: 13). This disease classification obscures the lived severity of ‘mild’ COVID-19. Its semantics have been co-opted by nation states in their rushed attempts to craft expedient pandemic responses. States eager to maintain legitimacy against the pathogenic anarchy of COVID-19 have privileged biological definitions of ‘mild’ COVID-19 as an individually manageable disease, thereby un-making ‘mild’ COVID-19 as sickness and removing it from the realm of social concern and governance. The result of this has been the effective social abandonment of many ‘mild’ COVID-19 patients, who are being left to manage their ‘mild’ COVID-19 with minimal health or welfare support.

In the case of ‘mild’ COVID-19, definitions of biomedical disease have been privileged in the socializing process, with clinical and diagnostic characteristics becoming socially accepted symptoms for understanding the condition. As the following section of this paper shows, such disease definitions of ‘mild’ COVID-19 tend to place it at the bottom of a universal hierarchy of severity based primarily on the clinically visible and physical aspects of the experience.

‘Mild’ COVID-19 as disease

Kim et al. (2020) produce a detailed tally of the various physical symptoms experienced by ‘mild’ COVID-19 patients in a South Korean community facility. They come to the conclusion that patients with ‘mild’ COVID-19 primarily suffer from coughing, followed by hyposmia and sputum, and suggest that these symptoms are useful markers of disease stratification (ibid.: 948.e2). Velavan and Meyer (2020) similarly identify key biomarkers predictive of disease severity based on the cumulative clinical data of COVID-19 patients across China. In addition to peripheral oxygen saturation and the presence of concurrent comorbidities (the most common risk

factors), they suggest 'low lymphocyte count as well as the serum levels of CRP, D-dimers, ferritin, cardiac troponin and IL-6' as parameters for triage (ibid.: 304).

The image of 'mild' COVID-19 that emerges from these articles is a decidedly pathological one, focused on the physical abnormalities that characterize the condition. This disease definition of 'mild' COVID-19 privileges not only the physical aspects of 'mild' COVID-19, but more narrowly the physical aspects that can be seen and reported by clinicians. Physical signs are reduced to what practitioners glean from patients verbally or through questionnaires, as in the symptom-taking conducted by Kim et al. (2020). Physical markers are also limited to biological measures that can be obtained in laboratory procedures, as in Velavan and Meyer (2020). Most commonly, physical signs are limited to what can be visualized using imaging tools, as in the common use of computerized tomography (CT) scans to confirm the absence of viral pneumonia – a widely-accepted standard for classifying a case as 'mild' COVID-19. Disease definitions of 'mild' COVID-19, rooted in a biomedical prism of understanding, thus take on the same disadvantages of medicine's epistemological approach, namely its overwhelming focus on the physical body and its reliance on 'objective' instruments for measurement. While this approach undoubtedly allows for quick and uniform treatment, it inadvertently ignores the significant diversity in physiological manifestations of COVID-19, as well as the varied affective and psychological aspects of patients' conditions and their own subjective accounts of the experience.

By focusing only on clinically observed physical markers, it is easy to think of 'mild' COVID-19 as truly mild and manageable since its physical symptoms point to common and seemingly benign signs such as coughing, sputum and the absence of blood inflammation markers or viral pneumonia. 'Mild' COVID-19 as a disease is characterized by the absence of clinically worrying markers and the presence of clinically common ones. Disease definitions of 'mild' COVID-19 as presented in clinical articles hence firmly implant 'mild' COVID-19 at the bottom of a universal hierarchy of severity, rendering it less deserving of concern and attention.

'Mild' COVID-19 as illness

While Kim et al. (2020) and Velavan and Meyer (2020) seek to establish 'mild' COVID-19 as manageable and benign, this is contradicted by contrasting patient accounts. The anthropologist Callard's (2020) article 'Very, very mild: COVID-19 symptoms and illness classification' effectively illustrates this disconnect by discussing a range of 'mild COVID-19' illness experiences. Callard notes that, while physical suffering is experienced and recognized as being mild by many 'mild' patients, many others have also reported long-term, debilitating physical symptoms, such as 'feeling as though one's lungs are in a vice, severe gastrointestinal discomfort

across many days, confusion, extreme and sudden fatigue' (ibid.: 2). Beyond the physical, Callard emphasizes the emotional distress produced by the spectre of severe COVID-19 and the anxiety surrounding the lack of institutional support. She writes that many 'mild' patients with whom she had been communicating felt 'largely abandoned, at home, by healthcare services; some wondering if, not when, they will recover from the virus; some gravely concerned that their employers will not recognize they are still ill' (Callard ibid.: 3-4). This intense affective suffering contrasts with the descriptor 'mild' and the relatively benign physical characteristics attached to it by Kim et al. (2020) and Velavan and Meyer (2020). Indeed, Callard notes the seeming insistence with which early 'mild' COVID-19 patients recount their experiences, perhaps as a pushback to the misleading notion of 'mildness' that is foisted upon them by disease classifications. One patient lamented:

> I have had 14 surgeries. I have had two children. And honestly, my mild case (of COVID-19), I would do any of those over. I can't imagine being any worse than I was. (Lang 2020: 1)

Physician Paul Garner's (2020) personal account of 'mild' COVID-19 provides us with a more intimate look into this illness experience. He recounts a 'roller coaster of ill health, extreme emotions, and utter exhaustion … frightening and long', which stretched far beyond the median two-week recovery window for mild cases described by an early WHO report (ibid.: 1). Although he noted that he 'had not had severe disease', his experience reveals markedly different psychological and affective suffering:

> I was mortified that I might have infected the staff I had worked with for over 20 years. I imagined their vulnerable relatives dying and never forgiving myself. My mind was a mess. My condition deteriorated. One afternoon I suddenly developed a tachycardia, tightness in the chest, and felt so unwell I thought I was dying. My mind became foggy. I tried to google fulminating myocarditis, but couldn't navigate the screen properly. There was nothing to do. I thought, if this is it so be it. (ibid.: 1)

In a highly visceral way, Garner's (2020) words demonstrate the gulf between chest tightness as experience and chest tightness as biological descriptor. In Garner's experience of tachycardia, intense feelings of chest tightness become intertwined with guilt, fear, disorientation and an overwhelming sense of mortality, of 'dying'. The lived physiological experience cannot be separated from its affective and psychological dimensions, which layer upon each other in the constitution of a severely felt illness. His account of his personal illness therefore makes clear the

subjectively felt severity of 'mild' COVID-19 in a way that disease definitions, with their focus on biomedical detachment, mind-body distinctions and objectivity, do not.

Moreover, Garner's account reveals the deep sense of alienation that he and fellow COVID-19 sufferers felt in having their experiences questioned. He recounts that 'the least helpful comments were from people who explained to me that I had post viral fatigue. I knew this was wrong' (ibid.: 2). Garner also spoke to others 'experiencing weird symptoms, which were often discounted by those around them as anxiety, making them doubt themselves' (ibid.). Indeed, self-doubt, alterity and isolation are equally felt aspects of the illness, which official disease definitions of mild COVID-19 both create and obscure. In privileging a specific set of common symptoms and median duration, 'mild' COVID-19 as disease erases diverse experiences of physical, psychological and affective severity, instead projecting an image of 'mild' COVID-19 as truly mild and manageable.

'Mild' COVID-19 as a sickness, pushed back to a biological disease

In advanced capitalist societies, as Frankenberg notes, 'making conflicts social is too threatening. Sickness is therefore pushed back through psychological illness to biological disease' (Frankenberg 1980: 200). This individualizing process is precisely observed in the reactions to 'mild' COVID-19 noted by Callard (2020) and Garner (2020).

Garner (2020: 2) describes how he encountered fellow sufferers of prolonged 'mild' COVID-19 whose illness experiences were met with disbelief by family members, employers and physicians:

> I joined a Facebook page (COVID-19 Support Group (have it/had it)) full of people with these stories, some from the UK, some from the US. People suffering from the disease, but not believing their symptoms were real; their families thinking the symptoms were anxiety; employers telling people they had to return to work, as the two weeks for the illness was up. And the posts reflect this: 'I thought I was going crazy for not getting better in their time frame' … 'the doctor said there is zero reason to believe it lasts this long'.

We thus see how normative definitions of 'mild' COVID-19 in the UK and US are rooted in biomedical conceptions of COVID-19, which set boundaries to the kinds of symptoms and duration that can legitimately be accepted. Experiences that fall outside this strict category are labelled 'crazy' or regarded as manifestations of 'anxiety'. The use of mental health terminology reveals how the fault is placed squarely in the minds of individual sufferers, pathologizing them rather than socializing with them. 'Mild' COVID-19 as sickness therefore appears to map on to

‘mild’ COVID-19 as disease, with the attendant individualizing effect of erasing illness experiences and denying sufferers access to adequate support. Callard’s (2020) account of ‘mild’ patients in the UK corroborates this, many of them finding themselves largely abandoned by healthcare services and left to nurse themselves at home.

In Callard’s (2020) article, the UK healthcare system is described as being faced with insufficient beds, necessitating stringent triage and the sidelining of ‘mild’ cases in favour of the survival of public health. This underlying social conflict, of an unmanageable pandemic characterized by severe public health inadequacies and poor government responses, reflects the ‘perfect’ threatening situation to which Frankenberg (1980: 200) referred – a situation ripe for individualization and the unmaking of ‘mild’ COVID-19 as sickness.

Indeed, Callard (2020) notes how this national exigency explains comments from the UK’s Home Officer Deputy Science Advisor and Chief Scientific Advisor, which stressed the ‘very, very mild symptoms’ faced by most cases. The context of public-health failures and the related desire to minimize their social and political effects necessitated interpreting mild COVID-19 as a ‘very, very mild’ biological disease. The related effect of this is that COVID-19 as a pandemic whole is rendered more palatable, manageable and governable.

At the beginning of this unmaking of ‘mild’ COVID-19 stands China, which first coined the term ‘mild’ in its original February 2020 epidemic report (Epidemiology Working Group for NCIP Epidemic Response, Chinese Center for Disease Control and Prevention, 2020). While this terminology seems to serve purely practical purposes, China’s subsequent reporting standards reveal clear political interests in the shaping of ‘mild’ COVID-19. Xie (2020) reports on this in a news article highlighting the Chinese government’s failure to include ‘mild’ and asymptomatic patients in the official tally of confirmed COVID-19 cases. According to the National Health Commission’s infection guidelines in March, mild and asymptomatic patients were classified as ‘positive cases’. Although ‘positive cases’ were isolated, only confirmed cases were included in the Commission’s official daily reports. This under-reporting reflects the Chinese government’s attempts to erase ‘mild’ COVID-19 from the public consciousness and unmake ‘mild’ COVID-19 as sickness. In many ways, this benefits the current Chinese government, which has faced significant public criticism over COVID-19’s catastrophic proliferation and what is seen as its failure to prevent it.

Therefore, in both Callard’s (2020) spotlight on the UK and Xie’s (2020) article on China, we see how nation states endorse disease classifications of ‘mild’ COVID-19 and accentuate it by attaching a greater sense of ‘mildness’ to it or obscuring the category altogether. According to Hobbes’s (1985) theory of sovereign authority, political legitimacy depends on a government’s

ability to protect the consenting governed from brutish anarchy. Epidemics such as COVID-19 present an extreme anarchy in that pathogens defy easy governance – they are rapidly evolving, elusive, multiple and highly international. The state's abject inability to order this pathogenic anarchy must therefore be minimized through the unmaking of 'mild' COVID-19 as sickness and making COVID-19 a governable disease and an individually manageable illness as its corollary. In this flurried exercise of governance, however, individual experiences of 'mild' COVID-19 are swept under the carpet, and the individuals suffering them are denied legitimate care.

Re-making 'mild' COVID-19

To resist the marginalizing process by which 'mild' COVID-19 is unmade, more illness experiences must be shared so that their diversity is not labelled anecdotal and insignificant but is treated as worthy of medical consideration, as it speaks loudly against the limiting confines of 'mild' biological symptoms. While ground-up collections are one way of achieving this, media coverage can also play an important role in focusing public and political attention on more inclusive and embodied configurations of COVID-19 as sickness. Here, medical anthropologists can also play a role in uncovering the variety of illness experiences across localities and the social relations that make or unmake 'mild' COVID-19 in oppressive and othering ways. More importantly, by placing a spotlight on the range of psychological and affective experiences, as well as the everyday concerns of 'mild' COVID-19 patients, medical anthropologists can aid in the remaking of 'mild' COVID-19 as an intense, jolting, perhaps life-changing and often ongoing sickness deserving collective and especially institutional attention.

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MULTIMODAL BIO-SOCIALITIES

PAOLA ESPOSITO

COVID-19-as-sickness is framed through the same belligerent metaphors that underlie COVID-19-as-disease, as Yasmynn Chowdhury says in her essay (this volume). Meanwhile, certain illness experiences of COVID-19 are renamed 'mild COVID-19', rather than being included in the category of COVID-19-as-sickness, thereby marginalizing 'mild COVID-19' sufferers and disenfranchising them from treatment, as Gillian Chan notes (this volume).

On one level, Chowdhury argues, these metaphors draw lines for the positive purpose of ensuring self-protection. On another level, however, they reproduce and reinforce separations and fractures along lines of race, ethnicity, nationality and social class, while for the individual body a state of war might be draining and counterproductive. Drawing on the illness narratives of people

affected by HIV and other chronic diseases, Chowdhury proposes a reframing of COVID-19 metaphors to make them less aggressive and confrontational. Thus, an illness experience may be rethought from a 'battle' into a 'journey'.

Healing involves reinstating and re-enacting our intrinsic connectedness to the world in ways that can be felt as safe and self-preserving, and metaphors can be instrumental to such processes. Anthropologist Michael Jackson (1989) argued that metaphors can help restore the interrelationships between what he called different 'domains' of self, society and nature (ibid.: 151). When the links between these domains are broken, as in a crisis, metaphors can help restore the lost sense of unity, transforming or healing one domain by acting on another (ibid.: 144-155). René Devisch (1993), in his ethnography of healing practices among the Yaka of Zaire, described ritual metaphors as 'praxeological' devices which cut through distinct semantic fields, enabling 'a blending and empowering of senses, bodies, and world', and effecting 'innovative interlinking' by disclosing and activating synesthetic forces (ibid.: 43). To this very extent, images such as the 'weave' (Devisch 1993) or, more recently, the 'meshwork' (Ingold 2011) can be understood as similar life- and health-affirming devices. Bringing these praxeological metaphors back into the picture might help nourish lives that at present feel fragmented and scattered.

Meanwhile, Chan (above) shows how the conceptualization of COVID-19 as a disease has highjacked its political and social management as a sickness, with profound implications for the ways in which individuals are experiencing and responding to the health crisis. COVID-19 is not only an acute epidemic that can be eliminated by a technocratic 'militaristic' campaign: there will be and already are many people suffering it long-term. For this reason, it is important to keep thinking of COVID-19 in the socializing terms of a 'sickness' that would grant its sufferers access to free health care. As Chan elaborates in her essay, the definition of 'mildness' in 'mild COVID-19' has been constructed against the characteristics of COVID-19-as-disease. Based on physical symptoms and biomarkers identified by medical practitioners and questionnaires, 'mild' COVID-19 is thus placed 'at the bottom of a universal hierarchy of severity', removed from the domain of governance, and conceptualized as manageable by individuals. However, lived experiences of 'mild COVID' contradict its biomedical conceptualization, with patients still experiencing physical and affective symptoms as severe. Chan theorizes this process as an 'un-making' of COVID-19 as a sickness, where 'mild COVID-19' becomes an outlier of diverse individual experiences of illness that are statistically too scattered and irrelevant, and hence easily marginalized or even erased, with sufferers being denied access to adequate and legitimate health-care and welfare support

Multimodal ways of cultivating resilience and creating community with people living with chronic conditions vis-à-vis the chronicity of 'mild COVID' and 'long COVID'

The above two contributions by Chowdhury and Chan highlight how, by using military metaphors for dealing with 'real' COVID-19 and by inventing a 'mild' COVID-19 that diminishes the severity of the illness experience, bioscientific frameworks have divested the state of responsibility and relegated the task of medical treatment to the domestic sphere. They both draw on the 'classical' medical anthropological distinctions between disease, sickness and illness, showing that this distinction continues to hold analytical force. Their work highlights how little is still known about COVID-19 *as an illness* and how it affects individuals. While this is important, we also need to think about how to reshape community in the face of disruption. Biosociality, which posits the organism and environment as interpenetrating (Ingold 2013: 11), has recently come centre-stage as a conceptual tool with which to understand the pandemic, as well as to craft responses to it (Gibbon et al. 2020; Williams et al. 2021). While arguing for the de-separation of the biological and the social, Jens et al. (2020) acknowledge that 'projections' in the space *between* the biological and the social 'constitute powerful means to establish discursive authority'. In this essay, I argue that sensory and multimodal techniques and devices can occupy such interstitial spaces productively by mobilizing the biologically grounded perceptual potential in the human body while attending to its socially oriented patterning. In addition to macro-scale, top-down strategies that spotlight individuals' conduct and adherence, more coordinated community and grassroot responses are necessary through which collective and individual subjectivities and moralities can surface and make themselves heard (Hadolt and Hardon 2017). In this section, I extend Chowdhury's and Chan's reflections to emphasize how sensory and multimodal approaches aligned with practice-based strategies can engender counter-hegemonic biosocial configurations for dealing with the pandemic and its long-term reverberations on individual and communal health.

While anchored in language, metaphor is known to inhabit the lived, moving body (Lakoff and Johnson [1980] 2003). Understood in this way, metaphors can be used as multimodal devices (cf. Varvantakis and Nolas 2019) to guide and shape sensory awareness and to re-direct the individual and social body as they project themselves and engage with the world as 'ensembles of biosocial relations' (Palsson 2013: 24).

One way of re-creating community in this fashion could be to reformulate social distancing as physical distancing. This, in turn, can be modulated through terms referring to the social morphology of seasonal movements such as the 'ebbing' or 'waning' of social contact, or evoking cyclical patterns of 'concentration' and 'dispersal' (cf. Mauss [1904] 1979, in Hsu 2017). Meanwhile, proxemic patterns (Hall 1990) could be rethought in terms of musical dynamics, or

aesthetic qualities such as 'intersperse', 'punctuate', 'counterpoint' (Ingold 2011), or alternating 'synchronicities' (cf. Hsu 2017). In this way, instead of being diminished by the 'distancing', the 'social' is being re-patterned and even enhanced through a materialist ontology of bodily movement applied to proxemic dynamics. This re-patterning would encompass the embodied perception of timing by drawing attention to bodily rhythms as 'a vital bridge between the biological and the social' and as intimately connected to our health and well-being (Williams et al. 2021). If, as Williams and colleagues have noted, the pandemic is 'an *arrhythmic biosocial event'* which has had more or less disruptive effects on life at different scales, an 'education of attention' (Ingold 2000, 2001) to bodily movement can support the reintegration of sustainable rhythms in people's lives.

Physical distancing and bodily rhythms can be ways of creating community and negotiating sociality. Using a dance-practice and choreographic approach, Elswit (2021) envisions 'new public choreographies' which revolve around the shape that breath takes around the individual in public spaces, thereby mobilizing a material conception of air as a dimension of space and of breath as a measure for that space. She refers to this as a 'coronasphere', a variation on the kinesphere as an embodied geometry devised by Rudolf Laban, but engaging specifically with the perception of breath as a sensuous dimension of bodily projection in space. The coronasphere is 'a way to imagine how breath extends the possible spaces occupied by the body and finds movement amid the radically altered sense of proximity that this produces' (ibid.: 70). Here we have an alternative narrative at work, one based on sensuous words or, better still, sensed imagery. More specifically, the tactile-kinesthetic image of the coronasphere mobilizes an embodied awareness of space that contrasts with the disembodied, optical representations of space imposed by metrics. The coronasphere is not a top-down narrative, but one that is enacted soma-aesthetically or 'from the body' (Farnell 1999). The image of 'public choreographies' can be efficacious in contrasting atomization and isolation, summoning up the sense of being part of a whole.

> New public choreographies—ones that let us feel the pleasure or passion of moving with others, while minimizing risk—will only emerge once more people hone their capacity to sense how breath forms expand beyond the skin, and to move attentively and ethically in proximity to other coronaspheres. Every person outside has a responsibility as a dancer, to train to better exist at this moment in which we are engaged in more communal movement, not less. This demands a shift toward moving with the space around us—instead of through it—and with all of the breathers that share it. It demands making physical choices in response to sensed imagery, and building kinesthetic connections to other moving bodies. (Elswit 2021: 71)

Creating community in this way thus involves a rethinking of what constitutes physical boundaries and thinking beyond the body-enveloped-by-skin (Hsu 2007). Elswit proposes a reformulation of bodily boundaries as not ending at the skin, but as extending to encompass one's breathing aura, which can expand and contract. Fixed measures of physical distance can be misleading, she argues, giving a false sense of security when in fact the distance that infective virus particles can travel varies depending on a range of factors 'from the level of ventilation to the violence of the respiratory event' (ibid.). Reliance on bodily sensitivities such as smell – e.g. so-called 'garlic-breath distance'– has recently been advocated as a better tool than metrics in assessing the risk of contagion (Marsh 2021). Elswit similarly proposes the adoption of 'experiential measurements of the extent of the body' as grounded in awareness of breath (ibid.: 71). Breath here figures as a material if invisible dimension of the body, a 'kind of touch' that can become crucial to negotiating safe sociality (ibid.: 69): '[O]nce breath becomes more material in this way, the points of contact between bodies themselves shift. The function of breath as a kind of touch calls for new skills, to understand the role of breath within that negotiation and to manage the intimacy that results' (ibid.: 70). As a 'kind of touch', breath becomes something that can be modulated. As our bodies are redefined by the range of our breath, this changes how we perceive and relate to the world and create community.

Sensuous technologies and movement sensitivities can be mobilized as low-tech, somatically grounded responses to the pandemic. These capacities have long been acknowledged in 'sensory medical anthropology' as taught at Oxford. Csordas (1993) theorized 'somatic modes of attention' as culturally patterned ways of attending to and with the body in an intersubjective milieu. Novellino (2009) spoke of 'sensory attunement' as a capacity by which things and living beings adjust to or 'tune in' the perceptual qualities of other things and living beings in an environment. Hughes-Freeland (2008) discussed the kinaesthetic enskilment the Javanese undergo as a process of embodying moral and social skills via kinaesthetically felt qualities, including rhythm, balance, posture, tension, presence and smooth, graceful movement through space. Selim (2020) described 'affective pedagogies' by which one can learn to modulate one's own affective responses to situations through 'teachable and learnable skills' (ibid.: 108) that include emotion-words. All of these techniques, skills and capacities can be engaged in for the sake of achieving particular 'transformative' effects, including regenerative and healing effects, and can be mobilized in the long-term process of dealing with the pandemic.

Techno-sensory interfaces

With digital and mobile technologies increasingly becoming part of communal and social living in the Western world, it is indeed the case that '[t]he virtual and the 'real' are not mutually exclusive dimensions of social life' (Masana 2017: 171) but become co-penetrated. As the boundaries between human and technology become permeable (Thomas 2021), our 'multimodal' lifeworld affords new types of bodily 'presences', both individual and social.

The web had already become a breeding ground for many forms of biosociality prior to the pandemic, with self-help groups and health-related networks allowing individuals to share knowledge, cultivate a sense of identity and sociality, and ease the isolation of those who are housebound with chronic conditions (Rabinow 1996; Masana 2017). During the pandemic, the potentialities of remote sociality and communication have been extended to include the social needs of healthy people in the Western world. Given to this dramatic expansion of web-based sociality, we can imagine that these touch-less, airtight social spaces will continue to play an important role in our future COVID-19-related health-care, especially for those struggling with 'long COVID' and/or with the mental health consequences.

However, if virtual biosocialities can compensate for human communication and staying in touch, they can hardly replace human co-presence, with many suffering especially the lack of human touch (Durkin et al. 2021). In response to this perceived crisis of tactility, practice-based researchers have been exploring ways to enhance the sensory experience of digital communication by activating the sense of touch by non-tactile means. Here the work of artistic explorations and medical anthropologists intersect. For instance, the artist van der Vlugt (2021: 86) asks, 'Is it possible to elicit a sense of material embodied relationality through the digital screen?' This is important particularly if we think of long-term chronic conditions, where sensory sociality needs to be actively reinforced. In ways that remind us of the pioneering work of the artist Thecla Schiphorst (2009) in the field of human–computer interactions, the work of van der Vlugt explores to what extent perceptual processes such as *transomatisation* (a bodily 'interpretation' and appropriation of non-bodily processes and events) or the 'haptic gaze' (where tactile perceptions and affects are summoned up by visual means) can be involved in this enhancing of sensory and digital online socialities (van der Vlugt 2021: 85).

Dance-researcher Thomas (2021) is exploring ways to summon up a sense of the 'presence' of touch and sensations of tactility through practices of remembering, recalling and imagining 'absent' or 'lost' touch. She too acknowledges that sensations of touch can extend to new dimensions, for instance, with the help of sound and audio-led experiences: '[W]e plan to use [binaural] technology to explore ways in which sound can invite a resonance of touch—of an

environment and between bodies (that are located remotely to one another) within it. Sound provides ways to connect bodies away from the "image," dropping visual identities[;] sound can offer a gateway into a more personal and intimate exchange' (ibid.: 95). Thomas lists different types of touch, ranging from somatically felt interoceptive sensing activated by and with one's own body-interior to non-direct 'environmental' touch, which would consist in 'attending to the way in which the environment touches us indirectly, the way in which the environment holds and contains the body within' (ibid.: 93).

With direct touch being demonized as one of the main sources of contagion in this pandemic, leading to the withdrawal of body-to-body, affective tactility as a form of care (Douglas 2021), these artistic explorations call for an extended understanding of touch as generating new forms of togetherness and 'presence' via multimodal articulations of tactility. Again, a sensory orientation in medical anthropology is key to explore healing and the therapeutic possibilities that are inherent in these articulations. Besides studies highlighting the transitivity of tactility and vision (Taussig 1993; Porath 2011), it is known that sensory perception works synergistically (Merleau-Ponty [1962] 2012; Ingold 2000: 268). This implies that particular sensory qualities can be summoned up by a range of sensory modes, with specific smells, for instance, triggering the 'enlivening' visual quality of 'greenness' (Young 2005; Hsu 2021). It has also been recognized that modulations of sound and colour can 'redeem' presence, reintegrating the sufferer into the social world (De Martino 2005 [1961]; Desjarlais 1994). Following a similar, aesthetic logic, we can also consider *ekphrastic* dialogues – where spoken words are conducive to summoning up aesthetic experiences – as another strategy for redeeming the 'lost' presence associated with sensory deprivation or impairment (Irving 2013).

Here, it is also worth considering Rapport's (2008) call for an anthropological re-evaluation of the field of 'interiority', the *terra incognita* (or *quasi-incognita*) of inner speech and unvoiced discourse that belong to the person only. While, as Rapport admits, it is utopian and impracticable for anthropologists to apprehend 'the infinitude of the personal and the private' (ibid.: 346), it is nonetheless important, from a critical medical anthropology perspective, to acknowledge the relationship between a person's 'subjectivity', mental health and bodily processes of movement and perception (Boldsen 2018). At a time when so many people have been forced to retreat into complete isolation, multimodal and bodily techniques can provide individuals and communities with affective 'scaffolding' (cf. Downey 2008) to support and nourish inner worlds. Selim's (2020) exploration of 'affective pedagogies' in contemporary Sufism in Germany is especially salient in this regard. She describes how breathwork, movement, sonic resonance and visual imagination can be mobilized for the intimate cultivation of an 'inner space' as a place of refuge,

acknowledgement of feelings and/or contact with an 'Elsewhere' that could be either secular or religious. Paying attention to the 'fleeting affects' that arise and disappear in the body as one engages in practice allows one to learn how to cultivate desirable (positive) emotions and tactics for dealing with undesirable (negative) emotions. 'These "fleeting affects" can … be taught and learned. In time, with repeated practice, the energies that move bodies become articulated emotions, sustained sentiments, and cultivated dispositions, and thus trigger and channel new affective responses' (ibid.: 108).

To conclude, multimodal devices and bodily techniques can be adopted in managing the long-term impact of the pandemic on the individual and social body. Aesthetic strategies mobilizing movement, rhythms and sensory utterances, both direct and mediated by technology, can be used to re-integrate the individual safely into the social world, creating community, and providing affective scaffolding in times of isolation and disorientation.

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