

From social distancing to social containment

Reimagining sociality for the coronavirus pandemic

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Abstract

This essay develops an anthropological critique of ‘social distancing’. While the 2020 coronavirus pandemic requires us to reconfigure established forms of sociality, distancing regimes such as ‘lockdowns’ can profoundly disrupt the provision of care and support, creating practical difficulties and existential suffering. I advocate instead for strategies of ‘social containment’, outlining several of the containment arrangements people in England have developed to reconcile relational obligations with public health imperatives during the pandemic. I end by addressing some of the steps anthropologists must take when translating such ideas into policy.

Keywords

Bubbles, Containment, COVID-19, Lockdown, Moral experience, Social distancing

Introduction

‘Social distancing’ has emerged as the principal line of defence in humanity’s fight against the novel coronavirus. Since SARS-CoV-2 can be transmitted asymptotically, reducing social interactions—even between ostensibly healthy people—can dramatically slow its spread,

preventing health services from being overwhelmed by critical cases. While undoubtedly efficacious, I argue here that social distancing regimes—at least of the kind implemented in England between March and June 2020—jeopardise one of the most fundamental prerequisites of human flourishing: our capacity to care for our constituting intersubjective relationships. Moreover, they do so in ways that generate pernicious new axes of social disadvantage, punishing those who do not adhere to self-reliant nuclear household ideals.

As Atlani-Duault and Kendall (2009, 209) write, anthropologists have much to contribute during pandemics—not simply by advising on how to communicate epidemiological and public health ‘truths’ to specific audiences, but by ‘helping our colleagues rethink the problem and response’. This Position Piece thus asks how we might imagine a response to the coronavirus pandemic that goes beyond the limits of current social distancing regimes. Taking my lead from the innovative modes of ‘corona sociality’ developed by my research interlocutors, I advocate for a discursive and practical shift away from the austere, avoidance-based concept of social distancing towards more creative, flexible, and collaborative processes of *social containment*. In the final section, I outline some of the steps anthropologists can take to help translate this idea into a policy response.

Methods and scope

My discussion draws primarily on a thematic analysis of responses to open-text questions in a qualitative online survey titled ‘Life Under Lockdown in the UK’. Advertised via social media, including a national Facebook ad campaign, this survey ran from 8–15 June and received 3,602 responses. I also draw on answers to a pilot survey that ran during April and May (with 886 responses) and on the ethnographic interviews I have conducted for the LSE-funded project ‘Innovations in Care’.

The three devolved nations of the UK (Scotland, Wales, and Northern Ireland) have implemented different social distancing regimes to those introduced in England over the course of the pandemic. For simplicity, the present paper focuses exclusively on the case of England.

Social distancing in England

Between March and June 2020, three regimes of social distancing were imposed by the UK government in England. The first, introduced on 16 March, comprised *voluntary social distancing*. Alongside the requirement that anyone showing coronavirus symptoms self-isolate along with their entire household, the public was exhorted to ‘avoid social venues’ and ‘stop non-essential contact with others’ (Johnson 2020). Having been granted discretion to determine what

contact was ‘non-essential’, many continued to see friends and relatives, albeit less frequently than before: an interactional pattern that slows contagion but still establishes chains of transmission (Block et al. 2020, 594).

Seven days later, the nation entered *lockdown*. Everyone was instructed to ‘stay at home’, the only exceptions being for daily exercise, essential shopping, medical needs, or to work in essential sectors. Government scientists stressed such measures were necessary for preventing transmission between ‘household units’ (Bloom 2020). The third regime of distancing, *loosened lockdown*, beginning on 12 May, saw restrictions gradually relaxed in ways that would nevertheless prevent inter-household transmission (for instance, meetings with people from other households had to take place outdoors and at a 2-metre distance). Only on 10 June was limited provision made for the merging of certain households—a development I discuss in greater detail below. At the time of copyediting (26 August), many in England are still not allowed to touch anyone living outside their home.

While it is widely recognised that social distancing regimes are associated with downturns in subjective well-being and mental health (Torales et al. 2020), the question of who is most profoundly affected and why remains unanswered (Holmes et al. 2020, 591). While the answer is clearly complex and multi-faceted, anthropological perspectives can offer some important insights into why, when, and for whom social distancing proves challenging, whilst also moving the debate beyond the medicalised domain of ‘mental health’ towards more foundational existential concerns.

Distancing’s discontents

My theoretical point of departure is the growing anthropological literature on ‘moral experience’. Situated at the intersections of medical and psychological anthropology, this work sees human lives as structured around specific ‘ground projects’—that is, core commitments ‘that people find so deep to who they are that they might not care to go on with their lives without them’ (Mattingly 2014, 12). Ground projects are not reducible to ‘normative social behaviour’ or adherence to rules; while they may be shaped by social imaginaries of ‘the good’, they are fundamentally underpinned by ‘attuned concern for the relationality that constitutes our very existence’ (Zigon and Throop 2014, 2, 9). Care for one’s constituting intersubjective relationships thus becomes central to safeguarding a life worth living.

Such perspectives are vital if we are to understand the effects of and responses to public health interventions. During Uganda’s 2000–2001 Ebola outbreak, for instance, people in Gulu disregarded campaigns urging them not to touch sick persons not because they were blind to the risk of infection, but because it was inconceivable that they should leave their loved ones

uncared for. For Park and Akello (2017, 61), this demonstrates ‘the shortcomings of a public health ethics that attempts to persuade individuals [to act] in the interests of the common good, but fails to support caregivers materially and morally in their existential concerns to care for their loved ones’.

Social distancing mandates exhibit similar shortcomings—although there are two important mediating factors. The first is the kind of ‘active witness’ (Desjarlais 2014, 110) care for a specific relationship requires. Digital and online platforms can serve as ‘virtual technologies of care’ (Song and Walline 2020) and were rightly championed in UK government advice for their capacity to sustain relationships and well-being whilst distancing. Some forms of care, however, require physical co-presence and touch. Skylar¹ (20s, London), autistic and living alone, explained how ‘friends sometimes provide small amounts of care at my flat for me when I’m in meltdown or shutdown and they can’t in person now, which means the episodes are more frequent and more prolonged and frightening.’ Research participants stressed the importance of physical proximity for bonding with grandchildren, helping with practical caring duties, and sustaining sexual intimacy with partners. Even those who felt well cared for online had certain needs unmet: Jenny (20s, Co. Durham) found that, living alone, no amount of Zooming could assuage her ‘skin hunger’.

The second mediating factor, then, is how readily care necessitating co-presence can be provided at home. UK public health measures take ‘households’ as the basic units of disease control, but even medical anthropologists who endorse this strategy (e.g., Coreil et al. 1997, 147) differentiate ‘the household’ (a ‘physically bounded setting for everyday activities’) from ‘the family’, which is a ‘system of social relationships’. The slippage between the two has significant implications for moral experience during a regime of domestic confinement, since there is no guarantee that the morally significant relations of ‘family’ (let alone extra-familial relationships) are contained within the physical boundaries of ‘a household’. Moreover, anthropologists have long problematised the ‘household’ concept, describing a fluidity and dynamism to many living arrangements that are not readily captured by static delineations of ‘household membership’ (for a historical overview, see Chibnik 2011, 118–141). English living arrangements are no exception to that trend; indeed, many post-war sociological studies of Britain explicitly rejected ‘the household’ as a unit of analysis. Sheldon (1948, 156) preferred the term ‘family groups’; Young and Willmott (1957, 32) proposed ‘adopting the anthropologists’ term “extended family”’, emphasising that members did not necessarily live close together. Such work highlights that flows of people between residences, and especially

1 All names are pseudonyms.

the movement of women, can be vital to the successful running of seemingly autonomous 'households', with the presence of others serving as a vital source of care and support.

Contemporary studies of England reiterate these classic findings. Koch's (2015, 87) council estate ethnography shows the production and maintenance of 'family homes' to depend on 'collaborative household arrangements' between women across the estate, while Ochieng (2011, 432) highlights the importance of 'neighbourhood support networks' for Afro-Caribbean families in North Yorkshire, who 'gave each other psychological and practical support through . . . sharing childcare, meals and expressions of love'. Wheelock and Jones (2002) note that dependence on such arrangements grew in the late twentieth and early twenty-first century, as increased female participation in the labour market left ever more households with care deficits, while Jamieson and Simpson (2013, 183) show the practical and emotional support provided by 'rich social networks' to be an 'important dimension of contentment' for the growing number of Britons who are living alone. Moreover, inter-household networks often have symbolic and affective significance: Ahmed (2016, 124) explains that by linking separate domiciles into *de facto* joint family systems, London Bangladeshis are able to recreate the atmosphere of intense mutual involvement characteristic of extended family homes in Bangladesh and thereby safeguard the status of grandparents in both the family and the broader community.

Confining people to individuated and strictly bordered households, as stringent social distancing policies do, is thus profoundly disruptive, cauterising the support networks on which many people depend and leaving them with unfamiliar—and sometimes unmanageable—care burdens. Three outcomes can result: neglect, the exhaustion of those providing care, and profound guilt on the part of those who cannot assist their loved ones. All can lead to psychological distress and moral injury. Heather (50s, Berkshire), for example, knew her daughter, living elsewhere, was struggling with both anxiety and a new-born baby during lockdown. Yet she, Heather, had to stay at home. 'My mental health is suffering incredibly because of this,' she explained. 'I'm unable to help my own children, and I live with a constant level of rage.' At its most extreme, social distancing's rupturing of intersubjective ties can even result in the 'erosion, and eventual loss' of self (Carpenter-Song 2019, 54). Danielle (20s, Leicestershire) lived with a relative deemed especially clinically vulnerable to coronavirus and had thus been subject to an especially strict distancing regime, described in the UK as 'shielding'. After 11 weeks, Danielle reported incredible loneliness: she couldn't even see her loved ones—boyfriend included—for a physically distanced outdoor walk. 'I have contemplated suicide and made several plans to do so because life isn't worth living right now,' she explained. 'I don't want to just exist and be lonely. That is not life. I may as well be dead.'

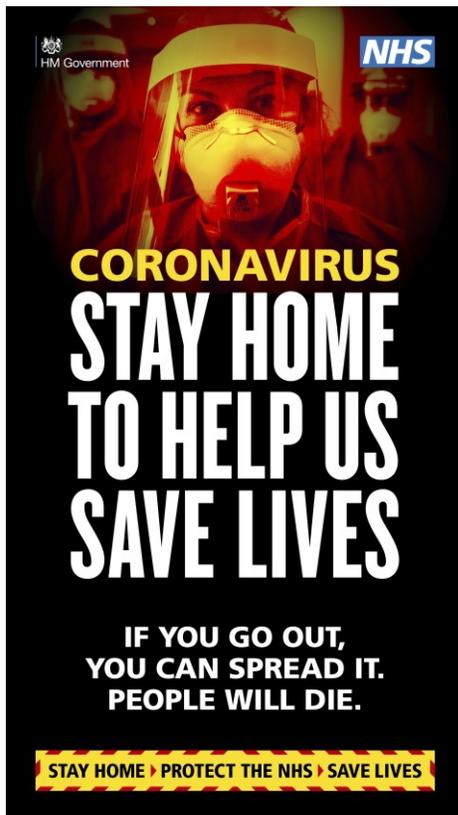
Such outcomes were not distributed uniformly. Those who lived alone (roughly 8.2 million people in the UK [ONS 2019]), those living apart from their romantic partners (around 10 percent of British adults [Duncan et al. 2013, 323]), and those with overwhelming care burdens all felt ‘punished’ or ‘discriminated against’ for not living up to either (hetero)normative ideals of cohabiting conjugality or of the self-reliant nuclear household.

Indeed, those whose core relationships were encompassed within a single home were most likely to report enjoying lockdown. While adequate housing and some degree of financial stability were necessary requisites for flourishing (Smith 2020), positive testimonies came from people of all backgrounds. Some were self-professed ‘homebodies’, ‘introverts’, or ‘loners’, all of whom felt innately suited to the lockdown lifestyle. Others, like Glenn (60s, East Sussex) found the ‘induced contact’ had led to ‘more conversation and consensus seeking’ with family members or housemates, strengthening those relationships. Many remarked that the lockdown had liberated them from pre-existing social or work obligations, allowing them to spend ‘quality time’ together, share care duties, and/or ‘reconnect’. As Katie (30s, West Yorkshire) said of herself, her husband, and their daughters, ‘we are no longer passing ships.’

Nevertheless, the socio-spatial privilege that allows people to thrive during lockdown is inherently contingent, and quickly dissolves when a loved one living elsewhere needs assistance. Whilst especially disadvantaging those with non-normative living arrangements, austere regimes of social distancing thus pose a more general existential threat.

Beyond social distancing? Strategies of social containment

The UK government presented the aforementioned challenges as unfortunate corollaries of a greater moral obligation to both one’s loved ones and the general population: social distancing. Adverts stressed that leaving home kept the virus in circulation. People would die—quite possibly one’s relatives (Fig 1). While this messaging was doubtlessly designed to maximise adherence at a time of runaway infection, it—like the very concept of ‘distancing’—propagates the idea that social contact is intrinsically dangerous and best avoided. Such attitudes were clearly in evidence among participants in my research. Carla (20s, London) charted deteriorating relationships with her housemates, noting that ‘everyone being a biohazard meant that I never had positive face-to-face contact anymore,’ while Vanessa (50s, Oxfordshire) emphasised that she ‘would really like to be able to see people as something other than a potential source of contagion!’



1. UK government public health adverts from April 2020 (HM Government 2020)²

But while the public discourse around ‘social distancing’ centred on the avoidance of transmission, it is possible to understand the purpose and efficacy of lockdown measures in a different way: as seeking to actively contain a pathogen within small, exclusive, epidemiological networks (in this case, households) so that it cannot be further spread. Such a shift in emphasis, whilst subtle, highlights containment as the agentive process at the heart of the coronavirus response. This in turn invites the question of whether and how containment could be practised differently. As noted above, the strictly bordered and individuated ‘households’ within which the UK government has sought to contain coronavirus are sociologically artificial, with confinement to such networks sometimes proving a source of great distress. Could we not imagine alternative strategies of containment that would better reflect the porosity of

2 These posters were made freely available online for printing, reposting, and public circulation. Available: <https://beta.southglos.gov.uk/wp-content/uploads/Stay-home-poster.pdf> and <https://www.seshealthandcare.org.uk/sample-page/homepage/>.

household borders; the interdependence of domestic groupings; and the flexible, dynamic nature of social relations?

This was precisely the question some of my interlocutors had been pondering as they developed innovative, if dissident, strategies to balance the public health imperative of coronavirus containment with pressing moral and relational concerns. Their accounts show the value of moving away from the conceptual terrain of *social distancing*, with its emphasis on radical avoidance and other-as-biohazard, and towards the concept of *social containment*, in which our networks of relationships become tools that we can collaboratively manipulate in order to limit the virus's spread whilst enjoying and providing the support, care, and companionship needed to live well.

One set of strategies centred on building exclusive multi-household networks. Consider the example of Jack (30s, London). Until mid-March, Jack's life had been quite good. He was enjoying work and dating a new boyfriend, Alex, who lived in the same neighbourhood. But, as the pandemic gathered pace and voluntary social distancing was introduced, he became very anxious about his job security. Then his flatmate Poppy developed a cough.

Jack felt 'overwhelmed' by the situation. Poppy's cough was chesty and productive, so it seemed unlikely to be COVID-19, but with no tests available to confirm this, Jack was required to quarantine himself for 14 days. This would mean subjecting his new relationship to a two-week hiatus at a time he really needed emotional support. Moreover, Alex had been very unhappy at the prospect of the separation; Jack feared the relationship would not survive the time apart. He considered moving in with Alex (who lived alone) but worried this in itself might strain the relationship while leaving Poppy bereft of company. Torn, he decided to repeatedly shuttle between his flat and Alex's, with Alex also committing to 14 days of self-isolation. Jack could reach Alex's flat by walking through residential back streets, wearing a face mask, and avoiding passers-by, thereby keeping whatever pathogen was responsible for Poppy's cough contained within their three-person network. Such a practice initially appears to defy common-sense notions of 'quarantine' (although people quarantining were, at the time, allowed to leave their homes for exercise); from Jack's point of view, however, he and Alex had creatively and collaboratively reinvented what it meant to be 'in quarantine' so as to minimise risks to public health whilst safeguarding the relationships they cared about and relied upon.

While Jack abandoned this arrangement once lockdown was imposed, Christine (60s, West Sussex) and her new partner 'decided to ignore government advice' so they could 'support each other during lockdown' rather than spending weeks at home alone. Christine was nevertheless scrupulous in physically distancing with anyone else she met. Some respondents infused their exclusivity with additional protective measures, such as staying 2 metres apart.

For instance, Tamar (40s, London) and her husband decided early on ‘to form a socially distanced bubble’ with one other family so that she—and, crucially, her school-age daughter—could have some social contact, albeit at a 2-metre distance. Though several felt guilty about flouting lockdown regulations, all emphasised the value of these arrangements for ‘giving strength to one another’, safeguarding mental health, and making it easier for them ‘to cope’.

A second set of strategies used quarantines as a technology for ‘resetting’ one’s risk so that prohibited forms of social contact could be undertaken safely. Rachel (30s, Berkshire) put her household into stringent isolation for two weeks before her mother’s funeral. That way, during the service, she could physically hold her father and sister, whose households had also been self-isolating. She could also share a meal with them afterwards in a small ‘wake’. These actions technically violated lockdown policies but, having quarantined, Rachel was confident that they were safe ways for her family to support each other and honour her mother’s memory. Quarantine practices also helped Fahida (teens, various locations) navigate the fallout of her brother running away from her father’s home while she was locked down with her boyfriend’s family. She left her boyfriend’s house and cared for her brother in her university flat for seven days. Her uncle then collected her brother, and she returned to her boyfriend’s, quarantining for a further seven days in case her travels had exposed her to coronavirus. While Rachel and Fahida’s use of quarantine was reactive, other interlocutors described having spent the period of mid-March (in which social distancing remained ‘voluntary’ and in which citizens could thus exercise their discretion regarding its extent and form) hatching plans for hosting freshly quarantined houseguests in dynamic, flexible arrangements that would have allowed them to safely balance multiple relational commitments over a period of months. Though the incubation period of the virus would have given their sociality a slow new pulse, it was a parameter they sought to work with in creative ways so as to be fully, physically, but responsibly present for a variety of loved ones living outside of their households.

When polarising public debates cast those who do not comply with social distancing regimes as selfish and irresponsible ‘covidiot’, anthropological perspectives add valuable nuance, showing how apparent ‘disobedience’ may in fact reflect conscientious attempts to reconcile competing obligations. Indeed, given anthropology’s tradition of prospecting through the ethnographic record ‘to speculate possibilities beyond our dystopic present’ (McTighe and Raschig 2019), we might even advocate such arrangements as prototypes of interventions that would curb the spread of coronavirus whilst avoiding the drawbacks of lockdown measures. Doing so, however, requires careful consideration of what happens when social containment practices are scaled up from private arrangements to nationwide policies.

Social containment as public policy?

On 11 May, the UK government signalled an interest in social containment as a strategy for emerging from lockdown. Specifically, it cited New Zealand's system of 'expanded bubbles'—similar in form and function to the exclusive multi-household networks designed by Jack and Christine—as a possible inspiration (HM Government 2020). Subsequent modelling showed that 'bubbling' would substantially slow the spread of coronavirus compared to voluntary social distancing (Block et al. 2020) but that its capacity to *suppress* contagion was contingent on both the profile of the epidemic at the time of introduction and, crucially, the scale of its uptake (Leng et al. 2020). Given this, suggesting alternative possibilities can only be the first step in anthropological responses to social distancing regimes.

For one, we can also investigate how such possibilities play out in contexts that have embraced them. In New Zealand, for example, colleagues and I found that messaging centred on 'keeping oneself and others safe and well' led over half our respondents to refrain from forming an expanded bubble (even once the coronavirus had been formally 'eliminated'), and encouraged members of the public to keep their bubbles exclusive and to avoid bubbling with people they considered clinically vulnerable or high infection risks (Long et al. 2020). Emphasising support also helped resolve dilemmas over who to bubble with; decisions centred on need. These findings and others like them helped inform the recommendations regarding bubbles provided to the UK government by its scientific advisory group (SPI-B 2020).

Secondly, if decisions must be made over who to prioritise for social containment arrangements, anthropological research can illuminate who might need such opportunities the most. My research to date indicates that those who struggle most with lockdown measures do not necessarily fall into established categories of structural disadvantage or into groups anticipated to be 'populations of interest' for pandemic mental health research (on which, see Holmes et al. 2020, 551). Additional axes of disadvantage have emerged specific to social distancing: living alone (especially widow[er]s, who remembered living with cherished partners), being a solo parent or carer, or living apart from a partner or vulnerable loved one. Though many such people will have been cheered by the eventual announcement on 10 June that 'support bubbles' were being permitted for England's single-adult households, some still fall through the cracks. Beryl (70s, Cumbria), for instance, was the sole carer to a husband whose catatonic schizophrenia meant he could offer her no support. Yet as a 'two-adult household', they did not qualify for a 'support bubble'. Nor did those whose disadvantage was not structural, but circumstantial: the recently bereaved, for example, or new parents. As anthropologists, we get to hear such voices; we must ensure they are not forgotten.

Thirdly, we should collaborate with epidemiologists to better understand the differentiated human experiences and contagion pathways that lie underneath the headline announcements of a given intervention's population-level effects. For instance, one reason the viability of bubbles depends on their rate of uptake is because some containment networks include members with numerous workplace contacts and are thus inherently leaky (SPI-M-O 2020, 4). Such epidemiological risk profiles are meanwhile becoming emergent social categories: in New Zealand, key workers both consciously avoided and were excluded from containment networks because of their exposure to coronavirus (Long et al. 2020, 24, 32). Bubble arrangements, for all their appeal, could easily become a privilege of home-workers, while those on the frontline remain deprived of support. There are hence strong epidemiological and social justice grounds for developing further policy interventions tailored to groups that move through the pandemic in different ways.

This ultimately returns us to the anthropological project of prospecting for possibilities. We might, for instance, take inspiration from Rachel's idea of loved ones staging mutual quarantines before physically connecting. While this also relies on the privilege of living in a household fully separable from the outside world, quarantine's temporary nature means it could potentially be undertaken by anyone, if given sufficient opportunity to step away from their work and other out-of-home responsibilities. Annual leave could be boosted for key workers; compassionate leave provisions could be enhanced for bereaved families; 'support leave' could become a new contractual entitlement.

These might or might not be good policy recommendations. They do, however, demonstrate how, by attending not only to the hardships our interlocutors suffer under distancing regimes but also to the innovative strategies they develop to overcome these, anthropologists can initiate conversations about policy reforms that might help everyone flourish in a post-lockdown world. Crucially, much becomes possible once we start seeing our relationships not as intrinsic threats to health, but as resources we can draw on in collaborative practices of social containment.

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