



## Bodies and Boundaries during the COVID-19 Pandemic

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### Abstract

*Our bodies exist both as physical entities and abstractions in our minds. While informed by the biological, our “imagined bodies” also reflect cultural constructs, and they help us comprehend the world of microorganisms we know surrounds us but cannot readily perceive. The COVID-19 pandemic provides an opportunity to understand this imagined body, as the fictions and meanings that inform these conceptions become clear in public reaction to the pandemic and public health measures. Understanding this imagined body also becomes critical in scrutinizing the assumptions made by public health officials and evaluating public health measures’ efficacy.*

*I argue that what is perceived as “controllable” is part of the imagined body, while all seen as uncontrollable is considered external, even if those notions challenge biological reality. I propose that the imagined body reflects the values of its imaginers, namely Western individualism, and can be seen in public response to COVID-19. Furthermore, in coping with a threat that cannot be sensed without technology, people have attempted to make the invisible visible. Doing so allows a semblance of control to persist, harking back to larger Western narratives of the Nature/Culture divide and the latter’s supremacy.*

The camera pans to a starry sky. Beneath it, a couple stargazes: Steve, played by Steve McQueen and Jane, played by Aneta Corsaut. Suddenly, a meteor illuminates the night. The meteorite whistles through the air, and, from a distance, the sound of an explosion breaks the night's quiet. "Boy that was close," Steve exclaims. "Come on," he turns to Jane, "I want to see if I can find it." Little did he know they were about to embark on discovering the city's near demise. Thus begins the iconic 1958 B-rated horror flick, *The Blob*.

Meanwhile, an unnamed man leaves his house to find the source of the sound. Lamp in hand, he walks into the forest. As he approaches a small clearing, he hears a soft gurgling emitting from a cratered ball. He prods it with a stick, and the camera pans to his cautious but curious face. He prods it again, and it cracks open like an egg, revealing a soft, dark center. He touches the mass, and it begins to spread. It climbs his arm, and he runs in panic into the street, where he meets the young couple who then drive him to the local doctor.

Throughout the movie, the blob continues to spread. It swallows any living thing it comes in contact with and grows with each feeding. It oozes its way around town, becoming a deeper red as it grows exponentially in size (Yeaworth Jr. 1958). As in many stories, *The Blob* tells of humanity's eternal struggle, that of human beings versus nature. In a peaceful town nestled in suburban Pennsylvania, nature attacks and re-stitches the fabric of the vulnerable community.

We distinguish between these two realms: that of humans and that of nature. That the word "nature" exists indicates that people view themselves as separate from their natural environment. Historically, the relationship between the two worlds is wrought with conflict. Recent human history can, perhaps, be told by man's quest to conquer the environment. As man subordinated and exploited women, so too did he the earth's resources (Leacock 1992; King 1989). He represented the civilized order of Culture, she the base materiality of Nature (Ortner 1972). Man built cities to separate himself from nature, colonizing what he saw as the Heart of Darkness (Conrad 2007). Whether maximizing agricultural output or perfecting the suburban lawn, people try to control nature to fit their needs. The Enlightenment birthed the science of classification, where man sought to assert control over nature. Now "othered," nature was defined and made legible through its ordering.

Disease ruptures the Nature/Culture barrier man struggled to erect. The city—a locus of government power and capitalism, controlled by man and distinct from the disordered nature—becomes a hotbed of disease. Close contact between people allows for easy transmission. As the nineteenth-century founder of epidemiology John Snow learned, common resources can act as sites of disease dissemination (Paneth 2004). As famously documented by photojournalist Jacob Riis, tenements, the infamous cramped quarters of New York City's poor, became centers of disease transmission rather than exemplars of urban efficiency (Rosen 1972; Wald 2008). Diseases' invasions into human spaces challenged the notions of human control embedded in the cityscape.

By the late nineteenth century, germ theory began to gain wide acceptance. Promoted by microbiologist Louis Pasteur, germ theory identifies certain microorganisms as the sources of disease. Colloquially, they are called “germs,” the umbrella term for any microorganism that can cause disease: pathogens, fungi, and viruses, among others. As a result, a person could no longer limit her understanding of reality to that which she could see. Disease no longer existed in the world of the five senses. Prior theories on miasma, disease-causing odors, were replaced by a new theory embracing the intangible (Tucker 2011). People were forced to reckon with an invisible reality coexisting with the one they had imagined themselves in before.<sup>1</sup>

One way to understand this imagined body is by demarcating its boundaries. Where does the body end and everything else begin? It does not necessarily follow the length of skin that empirical inquiry may conclude are its bounds. In this paper, I argue that people define their bodies according to what they see as within and outside of their control. All perceived as within one’s control is internal to the body, and all outside of one’s control external. The body mimics Culture—an object of control—that exists as a haven from Nature, the untamed chaos that surrounds it.

First, I explore the relationship between the body and society and differences between biological and imagined bodies. I analyze how the body can be understood as a text of social norms and values. I then analyze the relationship between bodies and illness: when is disease embodied and what are the boundaries, if any, that exist in the ill body to distinguish between “self” and “other”? Finally, I turn to the COVID-19 pandemic and construction of the body.

The pandemic exposes the texts of culture and control inscribed upon the body. It incarnates Western individualism, a philosophy that emphasizes individual autonomy, defining bodies as loci of control within contexts of disorder. Furthermore, COVID-19 exposes the fallacy of this simple binary and blurs the boundary between chaos and control. To cope, people attempt to make the invisible visible, legible, and, therefore, controllable. By analyzing bodies in COVID-19, the flaws inherent to their construction become clear; because of their construction, people engage in potentially dangerous behaviors and the government overlooks necessary policy for ensuring equitable public safety.

## The Body and Society

Imagination cannot be disentangled from our experience of the world. People do not understand the world around them solely through the disinterested lens of biology. Rather, the objective world shines on people, and they act as prisms, refracting the objective into a colorful array of subjectivities. The spectrum each person creates reflects her experience of reality, through which she makes decisions about her life. While a spade may be a spade to some, to others it may be immersed in connotations and meanings that surpass the object’s

1. By no means did germ theory give rise to notions of imagined bodies. However, it did locate the imagined body within the corporeal.

physicality and relate to the experiences and worldview of its perceiver. In short, our subjectivities inform our experience of the world.

Given the diversity of these experiences, no single entity is understood uniformly among people. However, patterns emerge. The prisms of our minds do not emerge arbitrarily but are rather influenced by our backgrounds, cultures, and the constellations of experience that make us who we are. Members of a certain religion, for instance, may share similar understandings of a given concept because of their shared experiences and socialization. Similarly, society shapes the experiences of its members. Therefore, while Western culture may influence people's interpretation of a phenomenon like disease, not all Westerners necessarily conceptualize disease that way. Even those who do may see an idea in different shades of the same color, each hue representing their own take, influenced by their unique experiences.

To use the language of Science and Technology (STS) scholar Sheila Jasanoff, the body is "co-produced" by a person and her social environment (2004). Both play a role in the body's appearance and fashioning. The body can also act as a text for culture. It should only be understood within its social, cultural, and historical contexts (Lock 1993; Bourdieu 1977). Philosopher Michel Foucault adds that bodies are also subject to systems of power, which require certain modes of presentation. Cultural norms dictate external appearances and internal experience, creating "docile bodies." Behaviors and appearances are regulated by the "disciplinary gaze" of others and the inward gaze of self-regulation (1995). Therefore, analyzing the body can reveal the values and norms of society.

Similarly, by analyzing how the imagined body is constructed, the social values that inform this presentation also become apparent. Knowledge can only be understood within the context of its creation. Challenging the supposed objectivity claimed by scientists, feminist and STS scholar Donna Haraway argues for viewing all knowledge as "situated" (1988). No knowledge is neutral; rather, it is influenced by its creator's environment and experiences. For example, anthropologist Emily Martin describes how public understanding of reproduction demonstrates widely held sexist beliefs. The sperm is often depicted as the agentic actor. The egg waits passively, like a "damsel in distress," for the active sperm to penetrate it. However, the egg is not penetrated by a single sperm. The collective efforts of multiple sperm are needed to weaken the egg's barrier (1991). Furthermore, more recent scientific research indicates that the egg plays the dominant role in its interaction with the sperm. It selects the sperm with the best genetic makeup to ensure it creates the healthiest possible offspring (Nadeau 2017). Socially imbued, sexist notions of female gender roles informed reproductive science, which assumed that, as a default, the singular sperm is the dominant actor in its interaction with the egg (Martin 2001). Under the guise of objectivity, scientific discourse can make claims that influence society, while society's social constructs influence science. The two are co-constituting. After all, American segregationists pointed to "sciences" like craniometry to justify their racist agendas. "Scientific" concepts

like “racial pollution” were used to legitimize anti-Semitism in pre-War Germany, and “science” was instrumentalized to subjugate women in the twentieth-century West. While extreme, these examples demonstrate that scientific research operates within a world of biases and subjectivities, and the way it is understood by others is further complicated by those of its consumers. Science exists within a world of subjectivities. Facts, such as those promoted by public health officials during the COVID-19 pandemic, must also be understood within their cultural framework. They, too, are cultural products and should not be understood as simple reflections of objective truth.

In the West, the value of individualism influences facts and imaginations about bodies and disease. Western society prizes individualism, evident in its institutions and myths. Democracy elevates the individual. Capitalism prioritizes individual wealth over societal financial equality. Meritocracy assumes that a person has control over her destiny. If she works hard, she will reap the rewards of her labor. This concept underlies the “American Dream.” According to this thinking, people’s actions influence their fates. Anyone can, therefore, climb the economic ladder from the proverbial rags to riches.

Individualist logics influence the imagined body. They produce a body responsible for itself. If the body is the atomistic unit of “self,” this self is credited and faulted for the conditions of the body. The body acts as an independent entity within society. Therefore, the conditions of the body cannot be attributed to anything except the self.

However, individualism does not accurately explain the conditions of the body in its entirety. A person cannot completely control her fate. Systemic inequality, for example, acts as an external factor that affects a person’s present and future conditions. Individualism can offer only a myopic lens for understanding bodies. Bodies must be understood within their contexts, within the multitude of factors that an individualist philosophy ignores. Later on, I discuss the boundaries between the “self” and “other” in the context of disease. Despite issues with the premise of individualism, this logic constructs these boundaries along the lines of control. What can be controlled is embodied, and what cannot be lies outside.

## **Disease and Metaphor**

Just as bodies can exist on both physical and imagined planes, so too does disease exist in both the biological and abstract. To an extent, disease is socially constructed. To distinguish between the biological and social aspects of disease, psychiatrist Leon Eisenberg differentiates between “disease,” the biological condition, and “illness,” the attached social meanings (1977). While different people may experience the same biological condition, their experiences of those conditions may differ (Conrad and Barker 2010). Disease cannot be understood outside the context of the society in which it emerges. Acquired Immunodeficiency Syndrome (AIDS), for instance, exists within a larger social context. Stigma, racism, heterosexism, and the history of the United States AIDS

epidemic all color a person's experience with the disease (Bowleg et al. 2017).

Furthermore, characterization of illness through language and metaphor influences experienced subjective realities. In their formative book *Metaphors We Live By*, linguists George Lakoff and Mark Johnson demonstrate the importance of metaphors in people's understanding of the world. They act as a bridge between a familiar concept and a foreign one. These metaphors are culturally specific. For example, labor is seen as material and quantifiable in the West. Therefore, phrases like "time is money" make sense. Only because labor is seen as a quantifiable commodity can it be compared to money, another quantifiable commodity (Lakoff and Johnson 2008).

Metaphor is one form of abstraction used to construct bodies and diseases in the imagination. It provides one way to make experiences of the world comprehensible to the mind. People produce bodies and diseases in the abstract, where they engage in a complex dialogue, informed by their physical embodiments but also by their abstract manifestations.

One way to conceptualize their distinction is through the boundaries of control. In the Nature/Culture binary, culture ends where order ends. Order ends with human presence. Nature is a space devoid of humanity to establish order; it is a space beyond human control. So too, the human body's boundaries reflect the Nature/Culture divide. Where control ends, the body ends. Anything that is perceived to be controllable by the body is embodied. Anything outside its control, even if it exists within the bounds of the physical body, is considered "other," separate from the body in the imagination.

A virus for instance, is part of the "other." It invades the body, but remains a distinct entity. It is spoken of in terms of warfare: the body as the helpless victim and the virus as the mindless assailant (Wald 2008). Here, the body parallels Culture and the virus, Nature. Instead of ravaging the city, the virus ravages the body. Even Dr. Fauci, director of the National Institute of Allergies and Infectious Diseases and a common media figure during health crises, uses language that draws on this binary. In a 2011 interview on the talk show *The Colbert Report*, Fauci says, "There is always a threat of emerging and reemerging infections, and one of the real issues that we face is that nature is one of the worst terrorists in that respect." In response, Stephen Colbert quips, "I know nature is dangerous. That's why I believe in pollution. Hit 'em first. It's kill or be killed" (0:47– 1:00). With the language of terrorism, Fauci demonstrates the antagonistic relationship he perceives between culture and nature, which in this case manifests as disease. Culture/bodies represent order. Nature/disease represents chaos. In distinguishing between the two, Douglas refers to the former as a system of order and the latter as "dirt," disordered and out of place (1966).

Individualism assumes agency, and agency assumes a person's autonomy of and over her body. Therefore, space where agency cannot be exerted is seen as outside of the body. According to this logic, where agency cannot be exerted, as on the growth of a cancerous tumor, is labeled "other" rather than part of the body or "self."

Capitalism works alongside and in tandem with individualism (Turner 1988). Capitalist logics inform the metaphors used to describe bodies. The brain is compared to a computer. The spinal cord is a command center. The heart is a pump. Phrases like “her gears were turning” and textbook descriptions of breathing as mechanical ventilation indicate capitalism’s influence on widely-held understandings of the body (Lakoff and Johnson 2008; e.g. Mistovich and Karren 2014). The “Fordist body,” a body described through analogies to machinery, reinforces the ideas that we, meaning our conscious selves, control our bodies (Weiss 1997). Machines are operated by people, and, therefore, are under people’s control (Foucault 1995). Once again, what is outside the realm of that control is either a malfunction or not part of “us.”

### **Disease and Embodiment**

One way to approach how society locates bodies within the world of disease and illness is to understand the extent to which disease is embodied. Do people see disease as a part of the body, part of their notion of “self”? Or, is it completely external? In situations when the boundaries between disease and the physical body are unclear, do the boundaries between disease and the imagined body also become nebulous? Where are the lines that distinguish between what is “us” and what is “other?”

Using the lens of control, the boundary of the body can be understood as the point where perceived control ends. This boundary, however, depends on one’s perspective. To people with cancer, for example, the cancer that resides within them is not “them” (Weiss 1997). Illustrating this very point, Sontag quotes Ronald Reagan who insisted, “I didn’t have cancer. I had something inside of me that had cancer in it, and it was removed” (1989, 66). Here, the colon acts as the barrier between “self” and “cancer.” While the biological body produces cancer, the person with cancer imagines cancer as an entity that exists separate from herself. Like a parasite, it grows and feeds on the body, but is not a part of it.

In contrast, to the person who is not ill, cancer is an embodied disease. As stated explicitly by an interviewee of anthropologist Meira Weiss, “Cancer is an internal part of the body, so it should be visualized from the inside. . . . It’s part of us, part of the body, part of our genes. It is produced by our body. We are cancer, but it makes us anew” (1997, 460). Other participants without cancer in Weiss’s project created images depicting cancer as clearly located within the body. In one drawing, a participant compared cancer to a spider and its web. The spider lives inside the body and constructs its web until it fills the body’s every nook and cranny. It is not a growth with clear edges and boundaries that a surgeon can remove. Rather, it consumes the body. It becomes the body.

Distance from the experience of cancer allows for a different perspective. The body is a vessel, in this case, a corrupted one. To the outsider, cancer is controlled because it is embodied within certain individuals. It is controlled because it is non-infectious. Cancer cannot affect those outside the human vessel

in which it is confined. Disease threatens notions of agency over one's body and control of one's life. But by conceptualizing cancer as bound, the fallacy of control can be maintained.

Infectious disease, on the other hand, cannot be contained in the same way. It can threaten anyone, not restricted to bodies that are genetically predisposed. It cannot be regarded with the distance Weiss's participants experienced. Rather, infectious disease poses a threat to all. Given this lack of control, infectious disease manifests as disembodied. If bodies represent containment and control, infectious disease inherently exists outside of them. Yet, people still attempt to locate infectious diseases within certain bodies as a method of coping with this lack of control. People identify certain bodies as vessels for the disease, importantly the bodies of people deemed "other." By forcing the nebulous threat into "other" bodies, the threat can be managed. Once again, people can feel in control.

These othered bodies are, at times, labeled "superspreaders." Cultural scholar Priscilla Wald contends that social conceptualization of disease exists within a certain script. This "outbreak narrative . . . follows a formulaic plot that begins with the identification of an emerging infection, includes discussion of the global networks throughout which it travels, and chronicles the epidemiological work that ends with its containment" (2008, 2). Among the tropes of this narrative is the superspreader, the character who infects a large number of people.

Typhoid Mary typifies this role. Irish-born, Mary Mallon unknowingly spread typhoid to numerous people throughout New York and became the first asymptomatic carrier of a disease identified in the United States. Mallon became a public figure. With her renaming from Mary Mallon to Typhoid Mary, American media pathologized her, and, in the eyes of Americans, she became a symbol of Irish immigrants (Wald 2008). Historian Alan Kraut refers to this behavior as "medical nativism," where people justify their prejudice against a certain population by associating them with disease (1995). Not only Mallon but also the immigrant Irish population were assumed to carry typhoid. By locating typhoid within certain bodies, the typhoid epidemic became more manageable for the American public. Americans no longer imagined typhoid as a shapeless threat, but as a tangible, and therefore controlled, danger.

Other than ethnic identity, people also use fault as a pathway for embodiment. Regarding the rise of syphilis in the first two decades of the twentieth century, the American public associated the disease with those considered at fault for its spread: prostitutes. Men were seen as the victims and certain women as the purveyors of disease (Gilman 1987). At a time when Victorian Era morals held great weight in society, syphilis connoted sexual immorality. In other words, syphilis was a person's fault, and its carriers were sexual deviants. As a result of this thinking, policy to limit the spread of syphilis disproportionately targeted sex workers. Police cracked down on them in the name of public health, the disease becoming part of a larger campaign against what was deemed sexual immorality (Brandt 1988).



In contemporary America, fault is identified through terms like “lifestyle-related disease.” While the Affordable Care Act of 2010 forbids health insurers to refuse coverage or charge higher premiums for people with pre-existing conditions, they would still be able to discriminate based on weight. Measured by Body Mass Index, or BMI, a person’s weight can dramatically increase one’s insurance premiums. Rules proposed by the Equal Employment Opportunity Commission allow employers to charge employees who fail to meet certain health criteria (like BMI) up to 30% the cost of the health insurance plan. However, BMI does not accurately predict medical costs. BMI can be inaccurate and does not adequately differentiate between healthy and unhealthy bodies (Tomiya et al. 2016). While an overweight person may be healthy but appear unhealthy according to this metric, a slim person may have unseen medical conditions that may cause much higher medical costs. Furthermore, these policies decontextualize BMI. It becomes understood as a reflection of a person’s lifestyle habits and ignores the other socioeconomic factors that lead to people being overweight (Drewnowski and Specter 2004).

Here, overweight people are pathologized because they are seen as at fault. This thinking overemphasizes a person’s agency over her body. Tied to the value of individualism, fault places the burden on the individual. People can control their destinies, so an overweight person can choose to change hers. “Just eat better and exercise more. How hard can it be?” “Why should my hard-earned money be wasted on your gluttony?” the thinking goes. As already established, BMI is not a useful indicator of health and ignores its socioeconomic context. Locating a disease within certain bodies, however, makes sense according to individualist logic. The same is true of doctors. In one study comparing the language used by American and Japanese oncologists, American doctors framed the disease as a fight between good and bad cells. The process was internal. The ill person needed to muster her energy to fight the enemy within. Japanese oncologists, however, described the fight against cancer as a collaborative attack. The doctor and the patient were framed as co-fighters, working together to conquer their foe (Wilce and Price 2003). In the Western mindset, one’s body is one’s responsibility (Foucault 1995). Fault is a symptom of this individualist thinking and makes disease more palatable to the general public, who uses this logic to regain a semblance of control.

### *The Case of AIDS*

Over the past few decades, the public’s conceptualization of AIDS changed, demonstrating the dynamism of the disease’s relationship to the body. The relationship between AIDS and bodies can be described in three stages. In Stage I, the disease was disembodied and uncontrolled. In Stage II, people began to locate the disease within certain bodies using the strategies of control like assigning fault or superspreader status, as described above. Later, in Stage III, AIDS became more permanently embodied due to a new understanding of the

disease as chronic and, therefore, non-threatening.

Towards the beginning of the crisis, Gaetan Dugas, a Canadian flight attendant, became the face for the disease. His alleged role in causing the outbreak is described in Randy Shilts' critically acclaimed work of investigative journalism, *And the Band Played On*. Printed in August 1988, an ad in the *New York Times* announced in all caps: "WHILE EVERYONE WAS SEARCHING FOR A CURE FOR AIDS, WE DISCOVERED THE CAUSE." Beneath the title, a picture of an employee ID for airline steward Gaetan Dugas. The text below states, "The AIDS epidemic in America wasn't spread by a virus. It was spread by a single man. Young. Egocentric. The star of the homosexual jet-set. A Canadian flight attendant named Gaetan Dugas" (Display Ad, 52). About two months later, a headline in the *Chicago Tribune* exclaimed, "Patient Zero," the two words claiming nearly all of the front page. In a smaller text below, "Wherever Gaetan Dugas paused, gay men began to sicken and die" (Shilts 1987). Described in medical journals, newspapers, and books, a narrative of the AIDS crisis emerged that vilified Dugas. The 1980s media painted Dugas as a sexual predator, spreading AIDS through purposeful infection (see Shilts 2011; Worobey et al. 2016). Perpetuated by homophobic media outlets, the narrative gained traction. In the AIDS outbreak narrative, Dugas was a superspreader. Even the term "patient zero" originated from his medical documentation (McKay 2014). Every disease has its "icons," associated images in the social imagination. For the AIDS crisis, one was Dugas. By understanding disease through icons, the disease becomes controllable in the eyes of the public (Gilman 1987). Government officials now had a target. AIDS was a public health danger, and so were homosexuals.

As described by medical historian Elizabeth Fee and epidemiologist Nancy Krieger, at the beginning of the U.S. AIDS epidemic, the disease was characterized as the "gay plague." It was referred to as GRID, the "gay-related immunodeficiency disease." As scientific energy began to focus on the disease, new icons emerged in the social imaginary. Instead of just homosexual men, the "4 Hs" became AIDS's new symbols: homosexuals, Haitians, hemophiliacs, and heroin addicts. Among these four, hemophiliacs stood out. To the public, they represented innocent victims. They were infected through blood transfusions by the other guilty populations, specifically gay men (1993). Unlike Irish immigrants whom society labeled inherently "dirty," gay men gained this status based on assumed behaviors. AIDS was seen as their fault. Just as disease acted as an intermediate for prejudice in the case of the Irish, so could fault. When a disease could infect anyone, it was considered out of control. When it was seen as the result of certain actions, cerebral control could then be restored.

However, over time, the paradigm for understanding AIDS changed, transitioning into Stage III. Scientific discourse on the topic became less about prevention and more focused on therapy for people with AIDS. Americans learned that AIDS was there to stay. It no longer fit within the time frame of an epidemic narrative (Fee and Krieger 1993). It became a social disease. Those infected by

it could no longer be conceptualized as faceless victims in the grand outbreak narrative but rather members of society. The focus of research changed as well. Efforts to dispense condoms were accompanied by research into the social risk factors of AIDS: the roles race, sexuality, and stigma, for instance, may play in its incidence rate.

AIDS as an amorphous entity was threatening, so people located the disease within certain bodies. Doing so restored a sense of control. The prior conceptual embodiment of AIDS within certain populations could not sustain itself. The concept was weak. Perhaps it is strong enough to alleviate the fears of the public during an epidemic, but not enough to remain once the wave of fear has subsided. The concept broke down, and AIDS was released from its mass embodiment. AIDS now resides within the bodies of the sick, because, to the public, AIDS is controlled. AIDS cannot escape its new human containers. Medicine about-faced and focused on individuals, aiming to alleviate their suffering.

A person with AIDS may not understand her disease as embodied. To society, AIDS is controlled because it resides in the patient's body. To the patient with AIDS, the disease is uncontrolled and, therefore, disembodied. To the patient, this understanding may also change. Once she sees it as controlled, the paradigm may shift. Perhaps with medication, it joins the leagues of asthma or allergies, embodied conditions that its possessors see as controllable, though, of course, to different extents.

The disembodied disease is scary. As Wald describes, it requires humans to contemplate their mortality, the possibility of extinction, and their own decentered place in the universe (2008, 40). It exposes the illusion of control humans attempt to construct. In a world of Culture and Nature, Order and Disorder, humanity's place is not secure.

## **Bodies and Biology**

As an officer inspected the supermarket, the rest of the town's police stood outside, convinced that Steve had planned an elaborate hoax. Meanwhile, in the movie theater next door, the blob enters the projection booth as a film, *Daughter of Horror*, aptly plays in the background. The crimson mass attacks the projectionist, covering his face, mouth open in a silent scream. A moment later, the reel ends. The audience looks about in confusion and annoyance. Only when they turn around, do they see the cause of the disruption. A red sludge oozes through the windows in the back of the theater and slides onto the floor in its murderous escapade. As people rush outside in a panicked mob, the police officers finally realize that Steven had been telling the truth about the blob. As Sergeant Jim Bert approaches the theater, Lieutenant Dave waves him back. "Don't go in Jim," he says with concern. Pointing to his gun, "This won't do you any good." A beat later, the camera zooms in, "It's the most horrible thing I've ever seen in my life" (Yeaworth Jr. 1958).

In *The Blob*'s alternate universe, clear lines are set between foe and friend, the blob and the citizens. The threat is visceral, confined to the borders of its red silicone body. The citizens are uniformly innocent. No citizen aims to assist the blob in its insentient quest of world domination, and no part of the blob seeks to support humankind. No moral grays exist. However, in our world, bodies and disease, the supposed "good" and "bad" according to the Culture/Nature binary, exist in a complex, intertwined relationship. No clear division separates between "us" and "other," disease and human. Disease becomes part of our physical bodies, and our bodies become complicit in enabling disease to infect the body. Reality confounds these simplistic dichotomies.

### *Body*

The boundaries people imagine distinguishing between "self" and "disease" may serve a social need, but they do not reflect biology. The division between "us" and "other" aligns with illusions of psychic control rather than science. For example, the virus is seen as an invader. It penetrates the body and wreaks havoc. However, in reality, the biological body is complicit in the reproduction of a virus. Since a virus cannot reproduce by itself, it must use the body's cells to spread and survive.

Even the body's uncorrupted agents play a role in creating the experience of illness in the human. When made aware of the virus's presence, the immune system responds in force. It attacks the mass of viruses, creating the symptoms of illness associated with viral infection: fever, stuffy noses, sore throats, and lethargy, to name a few. The immune system may even overreact, as is the case with allergic reactions. In the case of anaphylaxis, the body misidentifies harmless substances and responds by constricting bronchial muscles, making breathing difficult, and dilating blood vessels, resulting in inadequate distribution of oxygen and nutrients (Mistovich and Karren 2014). With this reaction, the biological body may cause its death.

In the case of a virus, the immune system may also overreact and kill both healthy and corrupted cells. By doing so, the body becomes more vulnerable to common infections and opportunistic infections, which take advantage of the body's depressed immune system (Desforges et al. 2020). While the imagined body acts as a unified force against the enemy of disease, the reality is more nuanced. The biological body may aid in creating the product of its demise. It may even actively destroy the body's ability to function. In other words, the boundary between "us" and "other" is hazy. Are elements of the immune system that impede the body's functioning part of the body? Are they part of "us"? Where do infected cells fit in this division? Do they belong to one side, the other, or an unspecified liminal space? In the case of cancer, genetic mutation allows for the uncontrolled division of cells. Is cancer not unequivocally a part of the body then?

Even without disease, the body transcends simple binaries of us and other. The biological body can only function because of the hundreds of millions of

microorganisms that populate it. According to recent estimates, the ratio between human cells and microbiota is nearly one to one. According to these numbers, 50% of the human body is not “human” (Sender, Fuchs, and Milo 2016). But what is it? People are dependent on this microbiota: the bacteria, archaea, fungi, and viruses that help the body perform necessary functions, from digestion to protection from pathogenic microbes. These microorganisms exist in a mutualistic relationship with the body where both benefit.

Some, however, are parasites. They live in the body, themselves benefitting but neither helping nor harming their host (Kelly, Conway, and Aminov 2005). They have agendas distinct from those of our conscious selves. Does a definition of the body then necessarily exclude all of these microorganisms? If so, does that mean that the body is not self-sufficient as an independent entity? Rather, as I contend, the biological body and the imagined body operate in different domains. People frame their bodies differently depending on the context. Every time a person encounters a situation that requires her to imagine her body, she produces one, drawing from her understanding of the world and the array of bodies she once conceived as references. This newest formulation joins her mental repertoire of bodies. These bodies may not be able to exist within any given reality, but they apply to the various realities she experiences. In any given situation, they contradict, but in the mind, they coexist.

### *Disease*

Just as the body is not a stable entity, neither is illness. Health is often understood in relation to an imagined norm. Similar to the assumed healthy body by BMI metrics, the normal body equates the appearance of health with health. However, as disability studies scholars assert, this normal body is a fiction. It is an inaccurate and misleading mnemonic for reading bodies. Furthermore, health tends to be understood in a binary. Bodies are labeled either healthy or unhealthy while they exist along a continuum of health. Similarly, the category of psychosomatic illnesses demonstrates the ability of illness to evade simple categories of description. These illnesses are not rooted in a bodily malfunction or as a purely mental illness, which tends to be perceived as restricted to the brain (Sachs 1995). Psychosomatic illnesses bridge the mind-body divide. They border on unintelligibility, not caused by a clear exterior force like the flu or biological “mistake” like cancer. They transcend neat classification.

Diseases can be further unintelligible with the names used to classify them. Discussing malaria as uniform, for example, overlooks the multiple constellations of disease and disease contraction that may warrant the label. Four different parasites of *Plasmodium* can transfer the disease, and thirty to forty different types of mosquitoes can act as vectors of disease (Eckl 2017). Furthermore, AIDS and cancer exist in different stages. Referring to cancer or AIDS as a stable category may obscure the variations and stages in which the diseases may exist (Lochlan 2013).

## Humanity

In the narrative of disease, the human/nature binary also falters. Within the biological body, disease cannot be understood as the sole perpetrator, as a simple case of disease versus self. Just as bodies are complicit in their illnesses, so too are societies partially responsible for the effects of illness. The outbreak narrative is not as simple as an invading virus and vulnerable citizenry. Rather, human institutions allow for a virus to wreak the havoc it does. Cities bring people together and allow for viruses to more easily spread. Dietary habits bring people and animals together in spaces that allow diseases to spill over from one to the other.

In *The Blob's* final scene, the eponymous goo is finally stopped. Fire did not repel it. Electricity did no good. Only cold kept it at bay. Dozens of fire extinguishers later, the blob was paralyzed, frozen into a block. The United States National Patrol was called in to drop move the frozen mass to Antarctica, where it could forever remain inert. However, in the movie's final line, Steve makes an unknowingly prescient statement. "It's not dead is it?" he asks Lieutenant Dave. "No, it's not," Dave responds, "I don't think it can be killed. But at least we've got it stopped." "Yeah," Steve agrees, "as long as the Arctic stays cold" (Yeaworth Jr. 1958). An unintentional omen of climate change, Steve predicts that, while humanity can protect itself from nature, it cannot protect itself from itself.

The act of subjugating nature can be self-destructive. In controlling animals and using them for human ends, contact between humans and animals increases. The Severe Acute Respiratory Syndrome (SARS) virus that caused the epidemic of 2001 spilled over from bats to civets and then to humans. With Middle East Respiratory Syndrome (MERS), it was camels. With HIV it was monkeys. Swine Flu was a recombination of both pig and bird viruses. With COVID-19, the virus spilled over from bats to pangolins. Possibly because of illegal trafficking and use of the endangered creature, the virus was then able to spread to humans (Weiss 2020). Because humans try to control nature and use it for their ends, they enable pandemics like COVID-19 to occur. COVID-19 is both the product of biology and its socio-politico-economic context. COVID-19 exists both in the objective and subjective, mutually constitutive entities that depend on and influence each other. The COVID-19 pandemic forges new understandings of bodies, disease, biology, imagination, and their complex entanglement.

## COVID-19

You can almost hear the silence. Roman piazzas and Mumbai streets are disconcertingly empty. Every week or so during the early months of the COVID-19 pandemic, a new set of "Images from Around the Globe" trends

online, depicting the world's desolate urban landscapes.<sup>2</sup> Barren beaches, vacant mosques, and empty supermarket shelves that once held toilet paper and spaghetti. Perhaps a person is shown in the distance to punctuate the emptiness. Ironically, these images are reminiscent of environmental landscapes: quiet, still, a beauty unmarred by the presence of people. This false sense of peace breaks, though, within the context of millions sick and hundreds of thousands dead from the virus.

First identified in Wuhan, China, Coronavirus, or COVID-19, is an infectious disease that has since spread around the world. The pandemic has forced people to imagine their bodies in certain ways that are legible within the COVID-19 pandemic narrative. This imagined body does not necessarily differ dramatically from imagined bodies during other diseases or contexts. But Coronavirus again brings the imagined body to the fore. It makes a certain imagined body visible. The virus is not just a thing, but a phenomenon. Not confined to biology, the virus takes on meanings within its social context. It forces new subjectivities or, at least, shines a spotlight on definitions of the body that may otherwise remain obscured or unexamined. Specifically, the pandemic demonstrates two ideas about the imagined body: the body cannot be disentangled from Western individualism, and many Americans struggle to comprehend the invisible, constructing for themselves sensory landmarks as a method to cope.

### *Individualism*

On the website for the Centers for Disease Control and Prevention (CDC), the national health institute promotes six actions in the wake of COVID-19: "Know how it spreads," "Wash your hands often," "Avoid close contact," "Cover your mouth and nose with a cloth face cover when around others," "Cover coughs and sneezes," and "Clean and disinfect" (CDC "How"). As typical of expressions of Foucault's biopower, all of the directions are aimed at the individual (Foucault 1990). States that have lifted their stay-at-home directives early also place the onus of safety on the individual. Public space is no longer a guaranteed safe place. If one wants to remain healthy, she must take the necessary precautions.

Early on in the pandemic, health officials asked people to help "flatten the curve" (Roberts 2020). Medical facilities have limited capacity, and by "flattening the curve," or ensuring that a stable, manageable number of people are sick throughout the pandemic, more people overall will be able to receive necessary medical attention. Therefore, each person must do her part in keeping safe.

A popular *Washington Post* article in March 2020 simulates various social distancing scenarios. It depicts a box of dots, some still, some moving, bumping

2. See, for instance, AFP, "In Images: Effects of COVID-19 on Landmarks Around the World," *Yahoo! News*, March 19, 2020, accessed May 12, 2020, <https://news.yahoo.com/images-effects-covid-19-landmarks-slideshow-100401027.html>; Chris Urso, "See Pictures of Coronavirus Impact from Around the World, May 12," *Tampa Bay Times*, May 12, 2020, accessed May 12, 2020, <https://www.tampabay.com/news/health/2020/05/11/see-pictures-of-coronavirus-impact-from-around-the-world/>; David Foxley, "Striking COVID-19 Lockdown Images from Around the World," *Architectural Digest*, April 9, 2020, accessed May 12, 2020, <https://www.architecturaldigest.com/story/covid-19-lockdown-images-around-the-world>.

into each other like a game of digital bumper cars. Each dot represents a person. Some start infected (marked brown) and every time they hit uninfected dots (blue), those dots also become brown. As the scenario progresses, more people become ill as they come in contact with each other, and some eventually recover, turning a light purple. The article simulates different quarantine scenarios with different numbers of dots separated or standing still (staying at home), demonstrating the importance of quarantine for flattening the curve drawn above each simulation. The article claims, “a single person’s behavior can cause ripple effects that touch faraway people” (Stevens 2020). The disease is a social disease. It spreads through contact. Therefore, the burden is on the individual. Stay at home to ensure that others do not get sick. This critique is not to say that individual precautions are not important. They are. However, their overemphasis overlooks other critical strategies for combatting the coronavirus.

The government’s overemphasis on the individual can also be seen in its “one-size-fits-all” approach to supporting its citizens. “Viruses don’t discriminate,” says a poster published by the Minnesotan government, “And neither should we.” Sociologist Ruha Benjamin notes the myopic worldview the poster suggests. It describes the virus as purely biological rather than a biopolitical entity (2020). Yet, viruses do not impact all people equally. Rather, they operate along existing patterns of inequality. Emerging studies demonstrate that minorities are disproportionately affected by COVID-19 (CDC “COVID-19”). Black Americans, in particular, have been dying at alarming rates (Thebault, Ba Tran, and Williams 2020). In the words of Albany City Commissioner Demetrius Young, “when America catches a cold, black America catches pneumonia” (Willis and Williams 2020).

However, so far, no federal legislation specifically tries to make up for the virus’ disproportionate impact on minority communities.<sup>3</sup> In the eyes of the government, a person is a person; all face the same threats. U.S. Surgeon General Jerome Adams addressed this problem in a recent statement. He discussed the importance of health equity in times of crisis and the structural inequalities Black Americans face. He cited lower incomes, higher rates of comorbidities, and multigenerational households as some of the reasons why they are at a higher risk. But, towards the end of the statement, he claimed that abiding by safety precautions and stay-at-home guidelines are, therefore, “more critical in communities of color and the African American community than in even other communities” (CBN News). Despite this being a systemic problem, Adams proposed not a systemic solution, but an individual one. With this approach, the government places the burden of being healthy on vulnerable social groups. Given existing inequalities, these communities must bear a disproportionate burden even if they are less equipped to handle it. For example, many in African American, Latinx, and Native American communities work in low-earning, hourly-wage

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3. As of the writing of this article, the COVID-19 Health Disparities Action Act of 2020, created to address the racial and ethnic disparities in COVID-19’s impact, died in Congress, and little else has been done by Congress to address the issue (H.R. 8203).



jobs that can only be done in person. Aggressive social distancing measures, therefore, disproportionately threaten these workers' financial security. They are also less likely to have health insurance, more likely to live in close quarters, and more likely to have underlying illnesses, which make them further vulnerable to COVID-19, not to mention the unequal opportunities to access health resources and Coronavirus testing on top of existing structural inequalities (Bernstein et al. 2020).

In an interview with Vice, the interviewer asked Adams if he had raised concerns about health equity to the President. He said he did, and in explaining the Oval Office's approach to this problem he explained, "we're really trying to collect data from all communities so that we can make more informed recommendations to everyone out there about what they can do to stay safe" (VICE News). Again, confronted with a systemic problem, Adams obscures the issue by using language of individual responsibility. The government's role, according to this explanation, is to help provide recommendations for the public geared towards individuals and "what *they* can do." The problem cannot be solved by only individual action, but that is on whom he places the burden.

Sociologist Ruha Benjamin asserts that inequality persists in the hospital. According to the logic of triage and emergency medicine, the hospital aims to save as many lives as possible. In what she describes as "survival of the fittest algorithms," resources are allocated to ensure that this goal can be met. However, those who often have the greatest chance of living are white, wealthy men. Because of systemic inequalities, communities of color have higher rates of comorbidities. Therefore, in the hospital setting, they will be the sickest. Yet, the algorithm will favor others over them. This "eugenics of medical rationing" will systematically discriminate along racial lines (Benjamin 2020). Since health operates along patterns of inequality, public health work needs to address issues of discrimination and poverty as inherent health issues.

The boundaries of embodiment further reinforce this individualist, "viruses don't discriminate" mentality. People with underlying illnesses like asthma, hypertension, and obesity are more likely to have worse health outcomes if they contract the virus. In a New York City study, patients with comorbidities had a significantly higher rate of death due to the virus than those without underlying conditions (Richardson et al. 2020). While Coronavirus is disembodied, these comorbidities are seen as part of the body. A person *has* asthma but *gets* COVID-19. Asthma is already a part of the body. Coronavirus is the new invader. It attacks the asthmatic body and infects it. The ill person is not ill because of their asthma but because of Coronavirus. The asthma was already there. It is already a part of the person.

This distinction between embodied comorbidities and a disembodied virus naturalizes the ill body. The person is obese; she doesn't *have* obesity. It is a part of her, so it escapes examination. In the language of control, Coronavirus is seen as uncontrollable. Anyone can contract it. From the perspective of the

general public, however, conditions like diabetes cannot be. They are managed, controlled.

This thinking diffuses responsibility from the state onto the individual. It exists within the social embrace of what anthropologist Emily Martin refers to as the “complex systems model” of the body. These bodies’ conditions are determined by everything they experience. Health, for example, is understood as the product of numerous factors, from genes to air quality to what a person ate for breakfast. Everything a body undergoes explains its current state. According to the complex systems model, everything once considered extraneous must now be considered significant. This model produces “flexible bodies” that bear complete responsibility for the body’s health and overall state (Martin 1994).

Flexible bodies take responsibility away from other influential actors. It overlooks the state’s role as a cause for systematic health disparities, environmental abuse, among other social ills. This model enables further capitalist accumulation by shifting fault away from corporations that deeply impact the entangled realms of class, public health, and the environment. It echoes the flexible accumulation strategies implemented in a globalizing world.

Furthermore, using an individualist lens in a national public health response concretizes the body’s role as a unit of state control. Individuals exist in discrete units. Communities, or other categorizations of people, are illegible to the state, too amorphous for meaningful control. The state can exercise biopower more easily, however, when the body politic is divided into its composite individuals. As Foucault describes, public health can be understood as a state’s project of control. Creating “populations” and differentiating between bodies allow a state to maximize its influence and support its capitalist goals (Foucault 1990; Rabinow and Rose 2006).

From the perspective of the public, an individualist mindset may also soothe fears of helplessness. By placing the burden on the individual, public health officials support the illusion that people are the sole masters of their fates. Thinking that one’s actions control one’s health may be more comforting than realizing that they are one of many factors. Especially with the backing of authorities like the CDC, people can feel safe within these illusions of control. Perhaps this approach is also the most palatable one to a public already trained to think in individualist terms.

### *Reckoning with the invisible*

If bodies are produced, they are also interpreted. Bodies send messages and those bodies can be read. Illness is read with an implicit understanding of the culture in which it exists. A body covered in red blisters is read as ill, because that body does not appear like the “normal body” that exists in the social imaginary. A coughing body reads ill because that too strays from the norm. A step removed, symbols like casts and slings read as ill, as do slurred speech, constricted pupils, and complaints of pain. As described earlier, the “normal body” assumes that

divergent bodies are unhealthy or ill regardless of biological accuracy. Similarly, it assumes bodies that appear like the normal body are healthy, while that, too, is not a given (Davis 2005).

This reading of bodies primarily relies on visible indicators of health and illness. This reading assumes that what is observable is true. Wheezing can be perceived. Hypertension cannot. COVID-19, on the other hand, often evades detection. Since many of its carriers are asymptomatic or have mild symptoms, the coronavirus is rendered invisible to others. Moreover, the range of possible symptoms and manifestations of the virus leads to further confusion and further obstructs the reading of ill bodies. Only Coronavirus tests can tell for sure if someone has it, and even those have significant limitations (Harris 2020). Technology becomes the only way to distinguish between many healthy and ill bodies. Bodies ill with the coronavirus cannot always be read, and, therefore, new technologies of distinction become socially necessary.

During the pandemic, people fashion their bodies with masks. Masks make the invisible visible and have become the new perceivable boundary between bodies. COVID-19 is not confined by the body's physical boundaries. Rather, it spreads through droplets the body emits. It inhabits surfaces and travels through the air. The mask acts as a new container. The physical body cannot contain the coronavirus, but the right mask can. It caps the body and indicates to others that the potential dangers that may be associated with the body are contained.

Similarly, the six feet distance people are meant to keep from others makes COVID-19 perceptible in the visuospatial. Coronavirus can still spread through the air between people more than six feet apart, and people within that distance may still be safe. The number is an approximation and may underestimate the distance pathogens can travel between people (Bourouiba 2020). It originates from analyses of viral contagion on airplanes. Six feet is the distance between the seat a contagious person may inhabit and that of a passenger who does not contract the virus (Qari and Walters 2020). Yet, people have fixated on the measurement. While the CDC recommends "about 6 feet," media outlets like CNN and ABC speak about the measurement in conclusive terms ("How COVID-19 Spreads"; "Coronavirus Social Distancing"; Rogers 2020). Restaurants must seat patrons at least six feet apart and Costco shoppers stand on lines of tape measured six feet apart as they wait to enter the store. "6 feet" becomes a physical part of the world through its enactment. It gains an almost physical presence through its integration into existing social spaces and norms. Social conduct is forced to adapt in light of metrics like this. "6 feet" is no longer a health precaution but now embodies new forms of social meaning. The number of feet maintained between two friends, for instance, becomes meaningful. A person who maintains the precaution strictly may be seen as paranoid and the person who does not as careless or apathetic (Teasdale et al. 2014).

Perhaps more widespread, the coronavirus has been made visible with the assignation of superspreader status. In March and April 2020, "spring

breakers” were the target of online vitriol, the new faces of Coronavirus. In one viral video by CBS News, a young man tells the interviewer, “If I get Corona, I get Corona. At the end of the day, I’m not going to let it stop me from partying” (0:00–0:04). To many, he symbolized the apathetic Gen-Zer trope, who prioritizes hedonistic fun over the health of his family and community. Similarly, other groups of people were singled out as disseminators of the virus. In late April, for instance, New York Mayor Bill de Blasio released a tweet singling out the Haredi Jewish population for gathering illegally for a funeral, while they were not the only ones congregating (Steinbuch 2020). Most significantly, Chinese people are depicted as spreaders of the disease. Chinese- and Asian-Americans have faced an incredible amount of discrimination since the virus began, ranging from verbal harassment to physical abuse (See Jeung, Growing, and Takasaki 2020; Jeung, “March 19–25, 2020”; Jeung, “March 26–April 1, 2020”).

Take a tweet by President Donald Trump (@realDonaldTrump) about what he calls the “Chinese Virus.” In it he states:

I always treated the Chinese Virus very very seriously, and have done a very good job from the beginning, including my very early decision to close the “borders” from China—against the wishes of almost all. Many lives were saved. The Fake News new narrative is disgraceful & false!

By referring to COVID-19 as the “Chinese Virus” with both words capitalized, Chinese is no longer an adjective describing virus, but “Chinese Virus” is an entity in itself. The virus is not just *from* China, it is *Chinese*. Language like this pathologizes China and Chinese people. China is not just a country; it is a manufacturer of disease. Chinese people are not just citizens; they are carriers.

Furthermore, by evoking border security, Trump harps on xenophobic associations between foreigners and disease. The White House has used the virus as a platform for promoting border security, not just between itself and China. But viruses do not observe geopolitical boundaries (Wald 2008). Furthermore, by framing COVID-19 through ethnic terms, the virus is seen as the product of culture. Chinese culture is pathologized, inherently polluted and dirty, obscuring the poverty that allowed the virus to emerge. Diseases’ root in impoverished countries is not because of “backward” cultures, but because of geopolitical conditions that create the poverty that facilitates an emerging outbreak (Wald 2008). But, as was the case with Mary Mallon, giving disease a face, locating COVID-19 within certain bodies allows others to regain a sense of control. Even among those who deny the risk they face, that can also be understood as a means of asserting control (Teasdale et al. 2014). By denying risk, a person claims control over her body.

Overall, these patterns demonstrate that people struggle to understand a world invisible to them. Some cope with this perceived lack of control by making this invisible world visible. They wear masks and point fingers. Invisibility leaves

them powerless. Visibility gives them power. Whether wearing masks or pointing fingers, they make COVID-19 visible, legible, and therefore controllable.

This need for visibility can be traced back to the Enlightenment when people began prioritizing their senses as mediums for acquiring knowledge. As described by sociologist Steven Shapin and historian Simon Schaffer, scientists recognized the importance of “witnessing” for establishing ideas as “matters of fact.” Therefore, they did their experiments among others and detailed their procedures meticulously for others to replicate if they wished. Only through the wide acceptance of an idea, through the aggregation of witnesses, did an idea become a “matter of fact” (2011). Yet, COVID-19 cannot be witnessed. The general public trusts that scientific authorities are telling them the truth. Perhaps the strategies of visibility described above help bridge the gap between scientists and the public. Scientists push for the coronavirus to be a matter of fact accepted by society, but, given the lack of actual witnessing, these strategies of visibility act as a proxy.

## Conclusion

The imagined body is not a stable entity. It changes with the situation, adapts to new norms. Yet, it does not necessarily reinvent itself with each iteration. With COVID-19, the imagined body echoes those expressed during other disease outbreaks. All of these bodies are the products of their cultural context. Therefore, the body continues to be definably by boundaries of perceived control. Therefore, tropes like the assignation of fault or superspreaders reappear. The underlying values which co-produce bodies may not always be easily visible. Therefore, the COVID-19 pandemic provides the opportunity to examine and critique these social values through an analysis of the imagined body.

In terms of the hyper-individualism this body reveals, this approach diffuses responsibility from those who should bear it. It misdirects and places the brunt of the burden on the individual. Even from the perspective of an individual who feels empowered or in control because of this individual mindset, that notion of control is flimsy. It is more of an illusion than a reality. Especially those not privileged to think in such terms suffer the consequences of a society oriented toward submission to state and capitalist powers. This value must be reexamined. If the state truly aims to help its citizens, it must bear part of the burden of their health. Simultaneously, people must hold the government and other actors accountable.

Concerning society’s struggle with invisibility, understanding this social need for tangible representations of COVID must be understood to destabilize the acts and institutions that support xenophobia. They need to be examined to ensure public health practices address both what people understand and what will keep them safe. Fictions like Chinese pathology or the obsession over “six feet” will crumble in the process. People seek control over their lives. Perhaps the desperate quest to retain that illusion prompted the overbuying of toilet paper

and water bottles at the beginning of the pandemic. Those, people could control. The broader situation, they felt like they could not. Therefore, there needs to be more productive outlets rather than believing in xenophobic fictions or emptying supermarket shelves. Perhaps, the problem also lies in the culture of individualism. As is, the pandemic is framed as “every man for himself.” Instead, linking people in communities can enable people to feel in control of their situation and make meaningful contributions to their communities. If communities distribute responsibilities among its members, they can satisfy that need for control and make themselves less dependent on unpredictable government aid.

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In the summer of 1972, *Beware! The Blob* entered theaters. Also titled *Son of Blob*, the sequel demonstrated that Americans in this parallel universe had not learned from their mistakes. An oil pipeline layer brought a sample of the frozen goo back to his home in suburban Los Angeles. Soon, the town recreates the plot of the previous film, ironically featured on the pipeline layer’s home television. Throughout the movie, the blob trudges through the town, devouring victim after victim in its mindless rampage. Luckily for the town’s citizens, the blob arrives at an ice-skating rink, and the teen lead manages to freeze the rink in time and save the city. As is typical of the genre, the movie ends with a hint towards a dystopian future. A heat lamp melts enough of the frozen blob to allow a thin red stream to emerge and presumably wreak havoc (Hagman 1972).

Whether the cheesy horror duo continues into a series, nature will never go away. This may be the last we see of the blob, but COVID-19 will not be the last disease. Luckily for the citizens of the film’s universe, their fate is sealed with the rolling of the credits. Unlike those in the film, we must take the lessons learned from the pandemic to heart. COVID-19 must be understood as a biopolitical reality. To prevent the widespread devastation caused by this pandemic, microbiology will not be enough. The structures of society and the intellectual framework it rests on must be re-evaluated. Only then can public health work be effective.

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