Covid-19, social distancing and the ‘scientisation’ of touch: Exploring the changing social and emotional contexts of touch and their implications for social work

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Abstract
In this paper, we reflect on ‘scientific’ governmental and media responses to Covid-19 in the UK, illuminating their negative impacts on complex and emergent touch forms/practices and people’s related emotions. The scientisation of the pandemic led to the government initially placing the country in lockdown and enforcing social distancing. It thereby regulated and proscribed routine and normative touch practices in order to save lives. However, such strategies were not accompanied by an awareness that increased touch deprivation could be emotionally harmful, that lockdown could exacerbate abusive touch in the privatised familial domestic sphere, and that paid care-giver touch in other contexts, such as care homes for the elderly, could also be potentially lethal. These negative consequences are important for social workers to understand and appropriately respond to, as they disproportionately impact vulnerable and marginalised groups and are heightened for service users, who are frequently members of many disadvantaged groups simultaneously.

Keywords
Service users, emotions, science, social distancing, scientisation, touch

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The transformation of touch: Scientisation, social distancing and touch constellations

Despite developments in the Social Studies of Science (SSS), [natural] science is regarded as knowledge *par excellence*, principally due to assumptions about experimentation and inherent objectivity. During the early months of Covid-19, public debate was essentially scientised through the permeation of scientific language into everyday talk, regulated largely by public health authorities and chief scientific advisors, who were widely regarded as substantially influencing the speed and direction of governmental responses. Despite this, social distancing, a behavioural strategy associated mostly with avoiding touch, remains the prima facie strategy adopted. However, this too was defined primarily in scientised terms as attempts ‘to decrease/interrupt transmission in a population by minimising contact between potentially infected and healthy individuals’ (European Centre for Disease Prevention and Control, 2020: 2).

Scientisation refers to the reification and normalisation of scientific language, knowledge and behaviours (Bäckstrand, 2003). Government policy during Covid-19 represents a prime example of overly scientised measures that attempted to regulate and quantify aspects of human existence, including emotional expressions, that are unquantifiable and cannot be regulated using public health measures alone. Social distancing measures were therefore emotionlessly translated into accessible public information directives in March 2020 such as 2 m distancing in shops and lock-downs enacted later on. Whilst these social distancing measures were mostly initially successful, in terms of public compliance and curbing population contagion, their potential touch-related human and emotional costs were not envisaged. Touch-related issues tend to be disregarded in policy, because of their multidimensionality, complexity, emotional links and qualitative dimensions. These properties assume an uneasy fit with measurement, and outcomes and evidence-based practice and policy, alongside debased assumptions about qualitative inquiry, which until recently, was seen in policy and services evaluations as manifesting mere ‘common-sense’ or polemic.

During this pandemic, novel touch constellations emerged, which challenged hitherto assumptions about the meanings of touch that were defined as ‘natural’, ‘good’ and ‘bad’ in pre-Covid times. The proscription of previously routine and culturally encouraged touch, such as physically comforting dying relatives, alongside key workers reporting trauma from having to implement strict social distancing rules in hospitals, is indicative of the scale of touch regulation. It also illustrates how previous ‘positive touch’ and human emotions were reconceptualised in terms of control and manipulation through distinctively scientific means.

‘Buying into (or out of)’ scientific discourse?

Throughout this crisis, scientific claims and governmental responses are continually changing, leading to increased scrutiny about scientific fallibility. Even as we
write, international news is characterised by global protests about the scientific bases of social distancing, while debates rage about potential human rights violations perpetrated through enforced mask wearing. In the UK, political discourses drew principally upon scientific and economic frames; the extent that social distancing could be manipulated to distances that were publically acceptable (e.g. from 2 m to 1 m), that would still prioritise economic sustainability, whilst also corresponding ostensibly to ‘best scientific’ advice on risk management. However, Loomes (2020) critiques changes in acceptable distance from 2 m to 1 m, arguing that that terms such as ‘broadly equivalent’, used by the British Prime Minister, Boris Johnson, disguise a lack of scientific evidence for the changes. Scientific opinion about controlling virus transmission is therefore continually changing. This uncertainty in government and scientific opinions presents serious challenges to social work in terms of how we conduct our work, relate to clients and work in tandem with public health authorities to control the spread of the disease, which involves some groups being potentially at much greater risk. Throughout the pandemic, different scientific hypotheses vied against each other to ‘flatten the curve’; on the one hand social distancing, and on the other, ‘herd immunity’ predicated upon maximum public exposure to the virus (Yates, 2020). In many ways, science was a pawn in an unacknowledged discursive battle regarding how many lives, and whose lives were (in)-dispensable, whilst causing minimum damage to national economies.

Despite increased public and media scrutiny on science and truth during Covid-19, scientific hegemony reigns supreme. Had a mutually respectful trans-disciplinary approach, involving social work, physical sciences and other disciplines been initially adopted by government, the heightened emotional and physical touch-related risks that certain groups were exposed to through social distancing or lockdown, might have been anticipated. However, this requires a broader acceptance of non and quasi-scientific knowledge by policy-makers, including validating the ‘practice wisdom’ of social work practitioners and eliciting and responding to citizens’ knowledge, both knowledge forms typically manifesting characteristics opposed to scientific ‘truths’, including insights that are place-specific and emotional.

Since lockdown, some minimal reference to touch is discernible in (inter)-national media coverage. However, this is limited to either anecdotal accounts from presumably privileged writers/journalists self-isolating alone, who explicate craving positive touch (e.g. Abbate, 2020), or invokes neuro-scientific or evolutionary psychological explanations deploying scientific terminologies such as the following:

‘[Touch] stems back to our history as primates, when stroking of hairy skin triggers the endorphin system in our brain’

(Professor Dunbar, cited in BBC Future, 30 April 2020)
What is glaringly missing from media and governmental accounts are complex structural and qualitative analyses of different touch configurations and their meanings, which responses to the pandemic invoke, restrict and/or exacerbate. Heightened negative effects on minority or marginalised groups, who social workers engage with, have also been neglected, or only recognised retrospectively and reported on quantitatively. Although increased domestic violence, mental ill health and child abuse, were statistically documented, their relationship to touch has barely registered.

**Touch, vulnerable groups, service users and social work**

Touch is a multifaceted, emotionally experienced sense, but is often devalued and understudied across multiple disciplines. In social work it has received limited attention but can be broadly subdivided into three categories (Green, 2017). **Good touch** is deployed and received positively and includes affectionate and supportive touch. **Bad touch** involves domination, threat and coercion, and often direct physical or sexual violations. **Absent touch** is a paucity of human touch, because the person does not desire or is fearful of touch, or conversely yearns for positive touch. Although these touch types are relevant to the pandemic, other more complex, ambiguous and paradoxical touch configurations and constellations have emerged too. These have received little general or social work attention or analysis.

While social distancing initially lowered transmission rates, the scientisation of the pandemic invisibilised the potential social and psychological consequences of touch deprivation due to social distancing, particularly for those locked down alone. Science also underestimated the heightened fear of contagion through ‘normal’ social interactions some experienced, as risk communication in media sources quoted scientific ‘facts’ fuelling citizens’ fears of going outdoors or seeking appropriate health or social care (Roxby, 2020), both during and after lockdown. The potential for increased abusive touch within the home, such as intra-familial domestic violence or child abuse, was also overlooked. The complexity of touch was further apparent in nursing homes, where carers of elderly residents transmitted well-intentioned but also paradoxically, potentially deadly, contagious touch. Because the British government initially proclaimed elderly residents in care homes at low risk, (counter to scientific claims that underpinned general social distancing measures in the community), many paid carers initially had no access to personal protective equipment (PPE) and mortality rates from Covid-19 were phenomenal (Savage, 2020). Initially neither carers nor elderly residents were virus tested, and homes reported elderly patients being discharged from hospital, having contracted Covid-19 there. Even without social work or medical knowledge it could easily be hypothesised that with a highly contagious disease, elderly people in close contact, receiving personal care from paid carers travelling from various locations, and requiring frequent visits to hospital and from professionals, would be placed in jeopardy.
Service users who live alone, such as those experiencing serious enduring mental health issues, may therefore become even more isolated. Supportive touch previously received from family, friends and professionals disappears. Even routine greetings such as shaking hands or inadvertently brushing against another person, are absent. Service users’ responses may therefore vary from craving sexual encounters, to rejecting any form of affectionate or supportive touch in the future, because they have become so unaccustomed to it. Alternatively, some individuals may have developed such a heightened fear of contagion, due to scaremongering scientised warnings, that even when social distancing measures are loosened, they may still be petrified of being in close proximity of another person.

With vulnerable people in care homes, or physically cared for in their own homes, the nature of touch changes and becomes predominantly instrumental. Also, previously skin-to-skin touch contact becomes mediated through PPE and may be both delivered and received differently. Restrictions against culturally normative touching practices, such as embracing a friend at a funeral to express empathy, are generically applicable to the wider population. Their consequences, however, may be greater and more enduring for social work service users. Aside from the normal grieving processes people transition through, the enforced absence of customary social practices involving touch could precipitate complicated grief reactions. This becomes increasingly likely if the person presents with complex mental health issues and/or learning disabilities.

For families living together, touch is not proscribed. However, social isolation, anxieties about finances and employment, and spending 24 hours each day with others, in potentially crowded accommodation, heralds potentially volatile situations, in relation to domestic violence and child abuse. For those subjected to interpersonal violence in their own homes, there are few contacts or escape routes, because what is happening is not externally visible and outside contacts may be controlled. The ‘toxic trio’ effect of domestic violence, mental health issues/learning disability and substance misuse is well documented in child protection/safeguarding literature (Cleaver et al, 2011). Given that social distancing and lockdown measures effectively imprisoned families/couples in potentially abusive homes, and that alcohol misuse increased and the wider population reported growing anxiety and mental ill health (Mental Health Foundation, 2020), it is perhaps unsurprising that reported domestic violence and child abuse also increased (Morgan, 2020).

At the same time the normal physical checks on ‘at risk’ or ‘looked after’ children by social workers and other professionals became less frequent. The Adoption and Children (Coronavirus) (Amendment) Regulations 2020, were enforced without prior consultation with social work organisations. These regulations render statutory visits and reviews for ‘looked after’ children, normally conducted according to strict time scales, to ‘when it is reasonably practicable’, allowing visits through ‘video link or other electronic means’. Social workers have criticised this legislation, because of potential time delays and the importance of corporeal
co-presence. This legislation therefore seems to place vulnerable children at increased risk of abuse and neglect (Willow, 2020), with digital audio-visual interactions substantially diminishing the nuances of verbal/non-verbal communication (Rudhovska and Sui, 2020). There is general consensus that child protection home visits require excellent observation and communication skills, including oversight of the entire house and an evaluation of who is present. Ferguson (2011) also claims social workers must physically engage with children at risk, given that in many cases where primary carers killed young children, social workers failed to physically interact with the children, missing vital, potentially lifesaving, clues about their injuries. All these factors render current provisional child protection and children’s social work interventions not only somatically and corporeally inadequate but highly risky.

Conclusions

Touch is almost invisible in Covid-19 debates, which are cloaked by an array of scientific and pseudo-scientific impersonal terminology including ‘social distancing’, and ‘the new normal’ which proscribe touch but advocate ‘keeping in touch’ electronically. Although some literature cursorily refers to touch deprivation, it is not only absent touch, that is relevant to social work in this pandemic, but bad touch and good touch assume new forms and meanings as discussions about isolated service users, institutionalised elderly people and domestic violence demonstrate. For example, what was hitherto seen as supportive or caring ‘good’ touch between friends and relatives, or from caregivers or social workers to service users, becomes ‘bad’ touch because of its potential to transmit the virus. Absent touch metamorphoses into ‘good’ touch through social distancing because it decreases virus transmission, but is also negative because of its detrimental social and psychological impacts. In relation to Covid-19’s short and long-term consequences, social work therefore may be at risk of becoming overwhelmed by the complex touch-related or generated problems various service users present with. These could include predicted elevated suicide rates (Murphy, 2020), increased mental ill health (incorporating extended and complicated grief reactions), substance misuse, and interpersonal familial and external community-based violence. With some infectious diseases such as HIV/AIDS and TB, sufferers were often initially ostracised and became stigmatised ‘untouchables’. Social work should consequentially be cognisant of the historicity of these disease narratives possibly repeating themselves with Covid-19 and marginalised service users and develop preemptive strategies to support them.

We are currently unaware what trajectories the disease will follow and what governmental responses will be in the future. However, social work should seize opportunities to elucidate the divergent and deleterious ways in which the scientised, often economically motivated, current governmental responses impact upon service users. Social work needs to argue and collectively campaign for more and better service provision to support these groups, in respect of the adverse effects of
social distancing policies or their ineffectuality with some groups, such as care
home residents. Social work must also publicly communicate that keeping vulner-
able groups ‘physically safe’, is not a straightforward, linear, scientific process, but
one that generates unpredictable and potentially enduring social, psychological,
and economic, touch-related adversities.

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