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Psychological Trauma: Theory, Research, Practice, and Policy

Handling Uncertainty and Ambiguity in the COVID-19 Pandemic

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Abstract

The 2019 novel coronavirus outbreak is unprecedented. Yet some look to ready-made models to address it. This creates confusion about more adaptive responses that reflect an uncertain and ambiguous context. Those assessing associated mental health challenges must be wary of overdiagnosis. Handling the pandemic well, requires engaging the public as mature partners.

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The 2019 novel coronavirus pandemic is unprecedented in modern times. Responding to it is not a straightforward public health problem (as many commentators – and even some scientists – appear to imagine). It requires reaching beyond normal science (Kuhn, 1962) to the science of exploring the unknown. The latter is an emergent process, often involving a messy, gradual approximation towards truths. It is replete with errors, confusions, dead-ends, ambiguities and uncertainties.

While many Asian countries, where the outbreak was first identified, were able to put in place and enforce draconian containment and contact tracing measures early on in the emergency, these were less appropriate or relevant in a Western context. This appears to have confused many – both in Asia and the West – who would appear to have preferred to see conformity and simple adherence to what they understood as the new norms, including the cessation of international travel and local mobility.

It has long been understood that how a community responds to disaster depends to a considerable degree on its culture (Carr, 1932). Fear, for example, does not just depend on individual psychological profiles or the specific challenge that confront us. It is transmitted by social structures, history and our relations to others (Elias, 1982). We learn how to manage emotions (Hochschild, 1979) and handle fears (Giddens, 1991) according to cultural scripts (Garland, 2001) that are catalysed by '*fear entrepreneurs*' (Furedi, 2006).

Accordingly, responses to COVID-19 reflect, not just what is happening in the present, but the cumulative outcome of cultural messages about what to fear and how to fear imparted to us through specific incidents, narratives and social prisms over a protracted period. This was already known of in the aftermath of the 2009 H1N1 influenza pandemic, including the role played by health professionals in shaping societal responses to the outbreak well in advance of it (Durodié, 2011b).

The Holocaust survivor and psychoanalyst, Viktor Frankl, famously observed how suffering is harder to endure in the absence of meaning (1959). In emergencies, despite assertions to the contrary, it is usually not so much more information the public seek (of which there is often a surfeit, both of sources and of content) – nor even official guidance about supposed misinformation – as an '*ability to give meaning to unpredictable experiences*' (Furedi, 2020). This requires moral vision rather than science or evidence.

Equally, however, we ought not impart meaning where there is none (Durodié, 2007). A recent commentary, drawing on lessons from the Blitz for COVID-19, noted how, '*optimistic propaganda actually lowered morale*' (Niven, 2020). As Durodié and Wessely suggested, in relation to the 9/11 terror attacks, addressing '*core beliefs*' is more important in the long run than simply offering reassurance (2002, p.1901).

It is hardly surprising then that many, both in the UK and beyond, were confounded by the British government's initial response to COVID-19. This sought to safeguard essential healthcare services while noting that people could not be protected from the virus indefinitely. By proposing incremental measures, it reflected acceptance of our imperfect understanding of an evolving situation rather better than attempting to cohere the people through diktat or

seeking to reassure by asserting knowledge of supposedly indisputable facts. Consciously or not, this treated the public as mature partners in the matter.

As ensuing developments made clear, it would have been a mistake to assume agreement (even among scientists), over supposedly fixed facts in the first place. The notion that evidence is ever incontrovertible derived in no small part from past assertions about what '*the science*' of climate change supposedly instructs us all to do. This prefixing of science (an open-ended, critical process) reflects attempts to make it seem like a closed book for the purposes of pursuing a predetermined agenda (Durodié, 2011a, p.274).

Indeed, almost every element of the COVID-19 outbreak today is questioned – from its origins, extent and actions, through its infectivity, durability and lethality, to the best way to respond to, and eventually redress, the situation. Experts disagree because the interpretation of their data, models and predictions – from fatality rates, to masks and testing, let-alone behavioural responses – matters just as much as the supposed evidence itself.

Phased closures reflected a willingness to take the public seriously in this. Those countries which, like Sweden, remained more open (also in contradiction of the assumed evidence), had experts who calmly pointed to the uniqueness of the situation, as well as to the alternative risks that would be posed by lockdowns and countermeasures, while never dismissing their own doubts and uncertainties (Tegnell, 2020). A modicum of humility served well in the face of the shrill certitudes of others.

Disagreements are an essential element to this process. Accusing critics of lacking expertise is misguided and damaging. At the very least, their questions and doubts put experts under

pressure to account for themselves better, thereby restoring a relationship to the public that has long drifted into mutual incomprehension and resentment (Lewis, 2020).

Ultimately, each country will have to steer its own path through these uncertainties and ambiguities. Across Africa, for instance, only 6% of the population are aged over 65. Lockdowns make little sense where malnutrition and starvation are rife, unemployment rampant and good healthcare inaccessible to the vast majority (Broadbent and Smart, 2020).

In relation to mental health outcomes, it is worth highlighting the recent work of Durodié and Wainwright (2019), who showed the links between terrorism and trauma to be less prevalent than many presume. This ought to offer hope at this time. Yet, they also noted how the contemporary cultural proclivity to uncover victims and highlight mental vulnerabilities (Furedi, 2003) readily led to a conflation of mental health categories and an inflation of data. Overdiagnosis will diminish support for those most in need.

While pandemics offer little by way of edifying mission or purpose for society, overcoming them is essential to achieving our wider aims. But where these latter are contested or unclear in the first place (as with, for instance, the emphasis on so-called '*British values*' to tackle terrorist radicalisation in the UK) (Revell and Bryan, 2018), societies may fail to cohere in the aftermath. Pre-existing divisions will become accentuated.

Coping with the uncertainty and ambiguity of the Covid-19 pandemic requires maturity. Ensuring consent for emergency measures by engaging people in a discussion of wider goals beyond the emergency is vital (Durodié, 2020). And to project the public, or a significant proportion of it, as unable to cope, could be a self-fulfilling error.

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