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SARS and New York's Chinatown: The politics of risk and blame during an epidemic of fear

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Abstract

This paper examines the production of risk and blame discourses during the 2003 SARS epidemic and responses to those messages in New York City's Chinatown, a community stigmatized during the SARS epidemic despite having no SARS cases. The study consisted of 6 weeks participant observation and 37 semi-structured, open-ended interviews with community members. Stigmatizing discourses from the late 19th century resurfaced to blame Chinese culture and people for disease, and were recontextualized to fit contemporary local and global political-economic concerns. Many informants discursively distanced themselves from risk but simultaneously reaffirmed the association of Chinese culture with disease by redirecting such discourses onto recent Chinese immigrants. Legitimizing cultural blame obfuscates the structural and biological causes of epidemics and naturalizes health disparities in marginalized populations. This research demonstrates that myriad historical, political, and economic factors shape responses and risk perceptions during an unfamiliar epidemic, even in places without infection.

Keywords: Risk perceptions; SARS; United States; Stigma; Emerging infectious disease; Chinese–Americans

Introduction

> For those of you who eat in Chinatown, please be advised that SARS has hit that area. As of today I heard that the owner's son(s) & the entire staff of Fancy Pho have been infected with the SARS. The owner was infected & has passed away recently due to what have seemed to be flu like symptoms. I think its best that you either stay away from that area or eat in. Please pass this along for those who I might have missed. [Email dated April 1, 2003, found at http://urbanlegends.about.com/library/bl-sars-restaurants.htm, errors in original]

During the height of the severe acute respiratory syndrome (SARS) epidemic in spring 2003, stories of infection and warnings (such as the e-mail above) to avoid Asian areas circulated throughout the United States. News media speculated on the possibility of a domestic epidemic, despite the fact that only eight people nationally had laboratory evidence of SARS—and most of these had contracted the virus abroad (Schrag et al., 2004). Fourteen percent of Americans reported avoiding Asian businesses (Blendon et al., 2003), and New York City's Chinatown experienced heightened anxiety and fear of stigmatization (Chen & Tsang, 2003). The above rumor and its news coverage caused a tremendous drop in business and tourism in Chinatown. Even without a single case of SARS,

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the community was identified quickly as a site of contagion and risk. The American public, including Chinatown, had become infected with an epidemic of fear, not of disease.

This research draws on anthropology, sociology, history, and media studies to examine the production of the dominant American risk discourses during the 2003 SARS epidemic, focusing specifically on those who blamed the disease on Chinese culture. I then use ethnographic research to investigate how these discourses played out in New York City's Chinatown. I use the term *discourse* in the Foucauldian sense to refer to the contested field of possible ideas, images, and metaphors that structure the ways in which people understand diseases. Many informants rejected community association with infection while simultaneously deploying dominant discourses to blame recent Chinese immigrants as potential infectors. This discursive strategy distances the self from biological and social risk, echoes discourses produced globally and disseminated by the media, and reflects local concerns related to the community's changing demography. The collected narratives illustrate that many historical, political and economic factors shape responses to an epidemic, even in places without infection.

Background

SARS is a virus spread by close contact with non-specific presentation. Patients generally exhibit a fever of over 100.4 °F, a dry cough, diarrhea, vomiting, and eventually pneumonia (Fan et al., 2006; Liu et al., 2004). From the first known case in November 2002 to its containment in summer 2003, mounting infections and deaths from this unfamiliar disease caused fear and economic disruption as the virus spread from Guangdong, China, to Hong Kong, Vietnam, and other countries including Canada. By the end of its course, over 8000 probable cases were identified worldwide and approximately 900 people had died (CDC, 2003). Fear of contagion spread far beyond infected areas, likely bolstered by the uncertainty of how the virus spread and its non-specific presentation.

Psychosocial responses to unfamiliar epidemics include fear, stigmatization, explanation, and action based on little available information (Strong, 1990). The public and media draw on historical, political and economic metaphors, as well as personal experiences, to interpret and explain the origin of an epidemic, resulting in the collective construction of multiple and diverse narratives (Briggs & Mantini-Briggs, 2003; Farmer, 1992; Moeller, 1999). Narratives can be recontextualized to fit other temporal and social settings, becoming "authoritative" representations of truth in the process (Briggs & Mantini-Briggs, 2003). A historical political-economic perspective that considers both the local and global is therefore crucial for understanding the production of risk and blame.

High levels of fear and blame during a deadly epidemic are associated with lack of information and perceived loss of control (Des Jarlais, Stuber, Tracy, Tross, & Galea, 2005; Nelkin & Gilman, 1991; Van Damme & Van Lerberghe, 2000). Individuals and groups may project the risk of infection and death onto an "Other" in order to reduce the powerlessness experienced during a deadly epidemic (Crawford, 1994; Joffe, 1999). In this process of othering, disease origins and risk of infection are explained through moralizing metaphors of cultural superiority so as to locate risk and responsibility among marginalized populations. Such discourses often define community membership vis-à-vis one's relationship to modernity, a contemporary metaphor representing purity. Those who are labeled as *unsanitary subjects* (Briggs & Mantini-Briggs, 2003) threaten community health because of their cultural inferiority and thus their status as matter out of place (Douglas, 1966). This othering is crucial to the maintenance of a healthy identity because the boundaries of the healthy self are never secure (Crawford, 1994). The identification of a 'risk group' is part of this boundary maintenance that creates and legitimizes the stigmatization of already marginalized populations, resulting in their identification with a disease (Goldin, 1994).

The media makes distant, often unaffected, populations aware of an epidemic and disseminates the dominant framework by which it is interpreted: the cause, explanation, and vocabulary of risk and responsibility (Briggs & Mantini-Briggs, 2003; Farmer, 1992; Herzlich & Pierret, 1989; Joffe & Haarhoff, 2002; Kasperson, Jhaveri, & Kasperson, 2001; Ungar, 1998). It provides an effective medium for health communication by bridging medical discourses and society, but it also contributes to the formation of social relations and representations around the disease by explaining epidemics in terms of social processes (Herzlich & Pierret, 1989; Joffe, 1999). Further, the media emphasizes dramatic